

***CREATIVITY, COLLABORATION,  
AND NOW COURAGE:***

**THE MASSACHUSETTS CASE STUDY**

**A Report on Local Health Department Regionalization**

*Prepared for the*  
**National Association of County and City Health Officials**

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# ***CREATIVITY, COLLABORATION, AND NOW COURAGE***

## **I. THE BAY STATE LANDSCAPE: AN INTRODUCTION**

Ask someone to name the nation's most liberal state, and the response is likely to be Massachusetts.

Yet, the Bay State has a flinty or conservative side—and not just because of its Puritan heritage rooted in 1620. Political tradition in the self-styled “Cradle of Liberty” is firmly linked to *home rule*, the doctrine that communities should be free to resist state intervention in the practices of local government. “There’s a cultural tradition going back to 1776 that every town should stand on its own,” notes John Grieb, a former local health planner now serving the state.

In public health terms, home rule allows Massachusetts to be sprinkled with 351 local health departments (LHDs)—far more than dot any other state. Basically, every town as well as every city has its own. Nowhere is the case for regionalizing local health services quite so clear.

This report describes the evolving views of participants in an ongoing project to facilitate LHD regionalization in Massachusetts. The National Association of County and City Health Officials (NACCHO) supported the project during the full calendar year 2008, with funding from Robert Wood Johnson Foundation. The project began a few years earlier and continues after the end of NACCHO support. Project leadership has consisted entirely of public health professionals within the state.

Information used to develop this NACCHO report came primarily from 14 interviews with project participants and from the writer's observations of selected project meetings. Some participants were interviewed both early in the project and after its conclusion, to obtain before-and-after snapshots.

Part II summarizes the report and offers findings and conclusions. Following this summary, Parts III through VI offer more detailed information, expanding on information provided in Part II:

- Part III describes the local health landscape in the Bay State
- Part IV provides a history of the recent regionalization effort
- Part V provides a snapshot of conditions at the beginning of 2009, just after the NACCHO support ended, and
- Part VI discusses the role of external communications in regionalization.

This account is primarily intended to help LHD leaders in other states decide, *first*, whether regionalization is right for them, and *second*, how they can affect the regionalization process to assure that it will benefit their department and their community.

## **II. SUMMARY, FINDINGS, AND CONCLUSIONS: BRINGING THE INVISIBLE TO LIGHT**

### ***The Site***

Although the Bay State is densely populated, about half of its 351 local health departments serve populations of less than 10,000, and the budgets of some are tiny. Massachusetts LHDs are generally small (some consist only of a local board of health with a skeletal staff) and differ widely in services and competencies. This makes it difficult for residents to gain a reliable sense—as true for one community as for another community—of what LHDs can and actually do.

Besides the multitude of LHDs, other features of the state landscape include:

- *the near absence of functioning county governments*, so that towns and cities are the sole providers of local government services<sup>1</sup>
- *the lack of direct state support for LHDs*, which must compete for nearly all funds on the local level against other municipal services, such as police and schools, and

<sup>1</sup> “Most Massachusetts counties currently exist only as geographic regions, and have no county government.” Commonwealth of Massachusetts website, <http://www.mass.gov/?pageID=mg2topic&L=3&L0=Home&L1=State+Government&L2=County+Government&sid=massgov2>.

- *a strong emphasis on environmental health services as the primary function of LHDs*, as opposed to personal health care as delivered by nurses and other health care professionals.

(This landscape, broadly summarized in the next few paragraphs, is described in detail in Part III, “The Challenge of Practicing Local Health in Massachusetts.”)

Local health advocates complain about a proliferation of unfunded state mandates and about state de-funding of extremely effective local tobacco control programs. There also has been a drop in technical assistance to LHDs. But, State Commissioner of Public Health John Auerbach, a former LHD director, is credited with trying to turn the state into a trusted partner of the local health community.

One artifact of the strict adherence to home rule is that individual LHDs have their own personnel standards; the state is mostly silent on the qualifications that health directors and staff must meet. In addition, the lack of direct state funding for LHDs means there is no systematic accountability to the state for their performance.

Creating some uniformity in structure, procedures, program strategies, training requirements, or public expectations across 351 separate agencies, staffed in very divergent ways and each reporting to a different local board, is not feasible in the absence of collective or state action. Without regionalization, providing all Ten Essential Health Services to all residents of the Commonwealth—the ultimate goal, in the view of one commenter, LHD director Brent Reagor—is a distant vision.

Kathleen MacVarish, administrator of the Massachusetts Public Health Regionalization Project, believes that “public health work is invisible” in the state. Harold Cox, chair of the project’s Working Group, agrees: Public health “doesn’t have any ‘rap.’” Yet, as noted by long-time LHD director Donna Moultrup, each of the diverse local health services has a constituency. The problem is that, as in other states, these constituencies are fragmented and are not mobilized to support local health as a whole.

Despite tall obstacles, LHDs in Massachusetts have been remarkably successful—in tobacco control and other important public health

arenas. Through the years, they have built a solid foundation—a foundation that could help them to provide, eventually, the full panoply of public health services.

### ***Regionalization Makes Its Mark***

The Massachusetts Public Health Regionalization Project has excelled at several functions:

- rallying much of the local health community around regionalization
- raising the profile of local health in the State House, and
- designing and disseminating regionalization models and tools.

This Massachusetts effort is a home-grown, evolving campaign to encourage local boards of health and LHDs to regionalize programs in order to expand the scope of services they can provide and improve the quality of those services. (The effort, broadly summarized in the next few paragraphs, is described in detail in Part IV, “The Rise of Regionalization.”) The project’s explicit “guiding principles” are:

- respect for home rule
- the creation of incentives for voluntary regionalization
- alternative regional models, because “one size does not fit all”
- state financial support, and
- the need to “augment, not reduce” the public health workforce.<sup>2</sup>

Headed by a Working Group encompassing diverse local health perspectives, the project has undertaken multiple and successful efforts to communicate with rank-and-file local health directors and state policy-makers. In February 2008, the Working Group hosted a statewide meeting where participants, in a series of instantaneous electronic votes, overwhelmingly supported regionalization.

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<sup>2</sup> Specifically, the principles are: “The system must respect existing legal authority of local health agencies. As [the system is] a voluntary initiative, communities need incentives, not mandates, to participate. One size does not fit all; different models of regional structures and operations will allow communities to cluster in ways that will meet their needs. Full implementation of the system will require adequate and sustained state funding. The system will augment, not reduce, the existing local public health workforce.” Massachusetts Public Health Regionalization Project, “Summary Report of the Working Group to the Statewide Steering Committee” (January 28, 2008), revised by Working Group, October 17, 2008.

In January 2009, Governor Deval Patrick signed into law a regionalization bill—largely crafted by project participants—removing several statutory hurdles to regionalization. The regionalization bill has served to enhance awareness of regionalization among LHDs and support for local health among state legislators.

*Where would regionalization lead?* Its advocates believe it would generate a stronger local health infrastructure. Specialized expertise in fields like epidemiology would become more readily available. Public health outcomes for targets like obesity likely would improve. Greater quality improvement would enrich programs from food safety inspections to communicable disease control. New models for cooperation across towns and cities would appear.

And, inevitably, regionalization would lead to some staffing reconfiguration. For example, a number of current health directors might exchange directing all local health services in one town for heading a single area of service, such as food-related inspections and associated disease control efforts, for several adjacent towns. Or, adjacent towns could form a district with its own local health staff, amalgamating the towns' staffs.

In addition, regionalization could help LHDs qualify for grants from private and public sources, which tend to be interested in services directed to larger, rather than smaller, populations. Indeed, LHDs would be better able to muster the resources needed to prepare credible grant applications.

And, regionalization would fortify LHD influence in dealing with local and state officials. Much of the initiative's success, though, will depend on the availability of start-up funding.

Geoff Wilkinson of the State Department of Public Health foresees a “slow investment trajectory” in regionalized local health. Originally, the Working Group strategy was to seek state funding for multiple pilot projects and a rejuvenated Office of Local Health, but the global recession and new fiscal realities intervened, and the new regionalization law does not include funding. As a result, the project must pursue a different long-term strategy for funding regionalization.

Some health directors fear that regionalization could cost them their jobs. This fear runs counter to workforce trends in the 2000s toward a shortage of public health professionals. An additional fear, articulated by veteran LHD director Ruth Clay, is that regionalization could weaken health directors' carefully nurtured local networks and impair LHDs' ability to marshal local resources.

One regional model depicted by the Working Group consists of a *comprehensive service district*, in which the health staffs of two or more municipalities are fully merged, although local boards of health may remain in place. The other model consists of a *shared service district*, in which neighboring boards of health selectively agree to share certain staff (such as an animal control officer or epidemiologist) or to make one municipality responsible for a set of public health functions (such as clinic operations or disease outbreak investigations) throughout the district. Cities large enough to sustain their own full-service LHD provide another model.

In 2009, after NACCHO support for the project ended, a series of Working Group subcommittee reports is being produced. (The current situation, broadly summarized in the next few paragraphs, is described in detail in Part V, "Regionalization at a Crossroads.") The Working Group is paying special attention to issues of personnel credentialing, such as establishing statewide qualifications for directing a regionalized LHD. This activity, in particular, is informed by the development of national standards for voluntary accrediting of LHDs, although the move toward accreditation may not be the major driver of regionalization efforts in this particular state.

### ***The Crossroads***

Money appears in two forms along the regionalization journey in Massachusetts, as in other states considering regionalization. Many Working Group members perceive that money can be used as a carrot—a positive incentive for regionalization to improve or expand services. But, many local health directors in fiscal crisis now see money mostly as a stick—a tool for forcing them to give up significant portions of what they do to protect public health. (In the latter view, the stick is wielded when money is reduced, directed to fewer programs, or given under more stringent conditions.)

Eyeing a longer horizon, advocates for regionalization see various prospects. Harold Cox believes that, when the economy eventually bounces back, LHDs that regionalized—for whatever reason—will be well equipped to expand services. In the meantime, he says, “the economic downturn provides an incentive to find new ways to deliver services.” Geoff Wilkinson sees local health as progressing toward its full potential along two tracks—an outside track consisting of regionalization and other externally influenced processes, and an inside track consisting of quality improvement, credentialing standards, and other internally driven measures.

Many health directors, including Brent Reagor and Ruth Clay, already are engaging in negotiations, or at least discussions, about regionalizing with neighboring LHDs. Obstacles include:

- nuts and bolts issues, such as differences in the way towns fund services, which upended efforts to regionalize firefighting in the state
- union protections and other human resources requirements, such as civil service rules, titles, and pay levels
- the lack of time available to LHD directors to pursue regionalization while struggling with rising pressures on their departments, and
- differences in public health regulations from town to town, each of which has adopted its own standards.

As budgets shrink, the local health community must show leadership. So, Donna Moultrup points out, “we have to provide our own model,” to avoid being forced into deep, poorly conceived cuts. Kathleen MacVarish, for one, talks about a disturbing new Massachusetts trend toward “regionalism,” the idea of crudely cutting expenses by regionalizing programs, as opposed to carefully improving and expanding services through regionalization.

Regionalizing will not always save money, in the sense of reducing overall expenditures. John Grieb comments, “There isn’t a lot of waste now in local public health to produce savings.” Regional community services director Phoebe Walker observes that rural Western Mass, where she works, has few existing services left to regionalize, after regionalizing its health inspections. She sees

regionalization as a way to improve or expand services—for example, by assigning to professionals some of the functions now performed by volunteers, or not performed at all. In this way, regionalization could produce greater results while costs are held constant, or could produce *far* greater results at only a slight increase in costs.

The recession could affect demand for local health services. As of February 2009, demand appears to have increased for “free” human service programs, but it may have decreased for immunizations and other health services that require small fees. Decreases also may be in store for restaurant inspections (if some restaurants close) and perhaps some other services, as consumer spending declines.

LHDs are rapidly approaching a three-way intersection. They face a choice among the home-rule *status quo*, harsh “regionalism,” or—if they muster enough creativity, collaboration, and courage—a thoughtful approach to regionalization that can improve services.

### ***The Communications Spotlight***

“The only way regionalization will happen,” Cox asserts, is through developing “a very broad-based constituency.” He is talking about regionalization to improve services, not “regionalism” to slash costs. The latter is likely to gain steam in the absence of proactive efforts by the local health community. “Regionalism” probably would not be a step forward for local health. In some ways, it would be the opposite of regionalization as sculpted around the Working Group’s five “guiding principles.”

To discuss forthcoming Working Group subcommittee reports, the group is considering another statewide meeting, building on the success of the February 2008 gathering. (This and other aspects of communications related to the regionalization project, summarized here, are described in detail in Part VI, “Spotlight on Communications.”) The agenda could reflect ideas emerging from subcommittee work on social marketing, workforce and performance standards, governance structures, and the size of districts. Alert to the importance of communicating with the local health community about regionalization, the Working Group also has engaged a

professional writer to help produce cogent reports and is planning an e-newsletter.

Communicating with policy-makers, interest groups, and the general public about the importance of local health is a less prominent aspect of Working Group activity. Reagor suggests that local health may need something akin to a brand, and John Grieb says it “almost needs a public relations campaign.”

“The problem with public health,” adds Grieb, “is that when we do our job really, really well, no one knows about it”—a prevented disease outbreak is essentially a secret. Besides being victimized by its own success, public health is betrayed by its own breadth. As Cox notes, “Helping people understand public health is incredibly complicated, because it includes such an amazing array of activities and fields.”

Now, the economic catastrophe presents the project with a problem not of its own making and not foreseen when the Working Group developed its initial strategy. To meet this threat, the group may need to intensify efforts to demonstrate to new and broader audiences the importance of local health and the opportunities afforded by regionalization to improve services. A strategic communications approach—that is, including a communications component in all major project activities, carefully focusing on messages and audiences, and nurturing enduring coalitions—would be consistent with the project’s character and could help assure its future success.

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*[End of “Summary, Findings, and Conclusions”]*

### III. THE CHALLENGE OF PRACTICING LOCAL HEALTH IN MASSACHUSETTS

#### ***Background***

The Commonwealth of Massachusetts is a populous state, home to 6,450,000 people.<sup>3</sup> Seven in eight residents are white, and one in ten lives below the poverty level. Population density and education rates are high. The Legislature— anachronistically named the General Court—is predominantly Democratic, and Governor Deval Patrick also is a Democrat.

Almost one in ten Massachusetts residents lives in Boston, the bustling harbor city anchoring the mixed urban-suburban, eastern part of the state. Western Massachusetts, by contrast, is mostly rural and nestled in the lovely Berkshire Mountains; this is, quite literally, Norman Rockwell country.<sup>4</sup>

Boston and “Western Mass” are two of the state’s six regions for purposes of state health and human services coordination. The others are Metro West, Northeast, Central, and Southeast—mostly suburban areas of the state (with mixes of cities and rural communities) and oriented, to a greater or lesser degree, to Boston. Another slicing method: For the specific purpose of emergency preparedness, the state is divided into seven main regions, some of which are further divided into sub-regions.

By the turn of the millennium, Massachusetts had all but forsworn county government. Only Barnstable County, consisting of Cape Cod and the picturesque islands nearby, appears to maintain a more traditional county system. In the rest of the state, cities and towns alone provide virtually all local services, although a regional approach is used in part of Western Mass.

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<sup>3</sup> 2007 U.S. Census estimate. For the populations of individual cities and towns, *see* Boston.com, [http://www.boston.com/news/local/massachusetts/articles/2008/07/09/2007\\_mass\\_population/](http://www.boston.com/news/local/massachusetts/articles/2008/07/09/2007_mass_population/).

<sup>4</sup> Rockwell (1894-1978) was probably the foremost popular American illustrator of the 20<sup>th</sup> century, famous for rendering idyllic scenes of American life. He spent his later years in Stockbridge, Mass., where the Norman Rockwell Museum displays much of his work.

The state Department of Public Health is one of more than a dozen departments and programs clustered in the state's Executive Office of Health and Human Services.<sup>5</sup> The Department exerts little jurisdiction over LHDs and provides them with virtually no direct funding.

Instead, LHDs depend for funding authorizations mainly on local boards of selectmen and the old-fashioned New England town meetings that epitomize direct democracy. In turn, the cities and towns receive from the state a combined \$5 billion a year in local aid—similar to block grants—with each locality deciding how to allocate its portion among education, public safety, health, and other services. The state department also provides LHDs with some technical assistance, but funding for that has declined.

Besides lacking direct, dedicated *state* aid, Bay State LHDs also lack a system of *mutual* aid. By contrast, neighboring public safety departments typically have protocols in place for supporting each other in times of extraordinary pressure.

Local public health programs in Massachusetts revolve around environmental health protection, such as inspections of restaurants, wells, and septic systems.<sup>6</sup> (In the other NACCHO-supported site, Kansas, local public health revolves instead around nursing services, such as home health care of elderly residents and maternal and child health.<sup>7</sup> Of course, LHDs in both states provide additional protections—immunizations, disease control and surveillance, and preparations for bioterrorism and pandemic influenza, for example.)

Given the emphasis on environmental health, Massachusetts LHDs relate not just to the Department of Public Health but also to the Department of Environmental Protection.

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<sup>5</sup> The Executive Office forms a layer of decision-making between the state commissioner of public health and the governor. It does not include the Department of Environmental Protection.

<sup>6</sup> The state Department of Public Health mostly bypasses LHDs in providing personal health services to Massachusetts residents. For this purpose, according to Department official Geoff Wilkinson, it maintains direct contracts with 700 private agencies at a cost of over \$500 million. In addition, implementation of the landmark Massachusetts Health Care Reform Act of 2006 has greatly broadened access to health insurance, partly through state subsidies. *Acts of 2006, ch. 58.*

<sup>7</sup> See the companion paper to this report, "I Wouldn't Want to Be Anywhere Else: The Kansas Case Studies."

In one manifestation of home rule, LHD directors and field personnel face no state requirements for training or credentialing. Some public health advocates believe this lack of state standards may impair program effectiveness and limit LHDs' credibility and prestige.

At times, the credentialing situation appears totally unstructured. In some small communities, for example, individual members of the board of health apparently conduct certain inspections themselves, despite a lack of directly relevant professional qualifications.

### ***State-erected Barriers to Local Public Health Advancement***

Advocates say that challenges to local public health in the Commonwealth start with state policy.<sup>8</sup> These challenges are broader than the lack of direct funding. To begin with, what may be termed the state's "benign neglect" of LHDs is more fiscal than programmatic. Through the years, the Legislature has saddled LHDs with extensive and unfunded mandates.

Brent Reagor, youthful director of the Concord Health Department and vice-president of the Massachusetts Health Officers Association, says state mandates are the biggest challenge facing LHDs. Reagor and others list septic inspections, food inspections, day camp inspections, pool and beach oversight, and tanning regulation as areas where the Legislature has responded to health concerns by requiring local authorities to act while providing no funds to do so.

The burden of these mandates restricts the LHDs' freedom to develop their own agenda and priorities. "More and more is being put on the local board of health's plate," says Phoebe Walker, community service director for the Franklin Regional Council in Western Mass. Walker's region consists of 26 small towns, each with its own board of health.

Moreover, the state has proved itself a fickle partner. After providing funding to LHDs in the 1990s to create community-based tobacco

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<sup>8</sup> 'Commonwealth' and 'state' are used in this report interchangeably. Massachusetts—like Kentucky, Pennsylvania, and Virginia—uses the commonwealth moniker. There are no practical consequences.

control programs, the state abruptly withdrew this support, ending Massachusetts' truly global leadership role in tobacco control.<sup>9</sup> Whether fairly or unfairly, local public health advocates often mention this turnabout as a bitter experience.

Even Geoff Wilkinson, a senior policy adviser in the state Department of Public Health and champion of the regionalization project, concedes the state doesn't sufficiently support local public health. The tepidness of state support is only one dimension of a weak local infrastructure. "Our state community organization system is in some disintegration," he adds.

Local health advocates credit the Patrick administration—especially state Commissioner of Public Health John Auerbach—with attempting to transform the Commonwealth into a reliable partner for LHDs. But, the lack of funding and the troubled history of state-local relations impede the transformation.

### ***351 Departments as a Barrier***

The sheer number and diversity of LHDs pose additional challenges. Creating some sort of uniform structure, procedures, program strategies, training requirements, or public expectations across 351 separate agencies, each reporting to a different local board, is not feasible in the absence of collective (or state) action.

Consequently, LHDs diverge widely in the competencies they maintain and in their ability to respond to specific types of problems. There is no way, then, for the general public to obtain a consistent, statewide sense of what LHDs can and actually do.

Being so numerous, LHDs tend to be small. All but 25 of the 351 LHDs serve communities with fewer than 50,000 people. Four in five serve fewer than 25,000 people. Half of all LHDs in the state serve populations below 10,000.<sup>10</sup> A small size, of course, sharply limits the functions an LHD can provide.

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<sup>9</sup> For an excellent account of the rise and fall of Massachusetts's widely touted tobacco control campaign, see Howard K. Koh *et al.*, "The First Decade of the Massachusetts Tobacco Control Program," Feature Article, *Public Health Reports* 120: 482-495 (2005).

<sup>10</sup> Boston.com, note 3, above.

The great exception and largest department is the city of Boston's Public Health Commission, which lays claim to being the nation's very first LHD, established in 1799 by midnight rider Paul Revere.<sup>11</sup> Auerbach, the state commissioner, formerly served as executive director of the Boston commission.

The great majority of LHDs serve towns, not cities. And, a 2006 survey found enormous differences in town budgets for public health.<sup>12</sup>

### ***Service Gap***

The consequences of paltry budgets are no surprise. In the same 2006 study, more than two-thirds of LHD officials said their staffs were too small to allow them to fulfill their responsibilities to the public on a consistent basis.<sup>13</sup> So, says Reagor, the *second* biggest problem facing the state's LHDs, after unfunded state mandates, is the gap between the services that are in fact provided and the Ten Essential Public Health Services that *should* be provided.<sup>14</sup>

Foreclosed from obtaining direct state funds, LHD officials and public health advocates feel they also are unable to compete effectively for funds on the local level. They believe they occupy a second tier, below police, firefighting, and schools. "We're down there neck and neck with recreation, libraries, and senior citizen centers," says Kathleen MacVarish, a veteran public health official, now based at the Boston University School of Public Health, who administers the Massachusetts Public Health Regionalization Project.<sup>15</sup>

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<sup>11</sup> City of Boston Public Health Commission, <http://www.cityofboston.gov/publichealth/>.

<sup>12</sup> Justeen Hyde and Alison Tovar, "Strengthening Local Public Health in Massachusetts: A Call to Action," report prepared for Coalition for Local Public Health (Cambridge, Mass: Institute for Community Health, 2006).

<sup>13</sup> *Ibid.*

<sup>14</sup> The Ten Essential Public Health Services consist of monitoring health status, diagnosing and investigating health problems, informing and educating people about health issues, mobilizing community partnerships, developing policies and plans, enforcing laws and regulations, linking people to needed personal health services, assuring a competent workforce, evaluation, and research. These services form the basis of new standards to accredit state and local health departments. See, e.g., U.S. Centers for Disease Control and Prevention, <http://www.cdc.gov/od/ocphp/nphpsp/essentialphservices.htm>.

<sup>15</sup> State fiscal policies also complicate public health. Brent Reagor notes that local property taxes are generally allowed to increase only 2.5 percent per year, so even communities that *want* to allocate more resources to public health would be hard-pressed to do so. Geoff Wilkinson notes that state revenues are

Donna Moultrup agrees. Director of Health in Belmont for the past 14 years, Moultrup says towns are especially resistant to new expenditures. Despite a widely perceived need in her relatively affluent town, “we couldn’t even fund a half-time public health nurse,” she notes.

This apparent lack of competitiveness for local funding may be intertwined with LHDs’ small size. It is unrealistic to expect a tiny, low-profile department, which can provide only very limited services, to devote communications resources to *showing* the value of local health to the public.

### ***The Public Profile of Public Health***

Partly as a result of the inability to educate the public, “people don’t know what public health is,” comments Harold Cox, associate dean for public health practice at the Boston University School of Public Health. “Public health doesn’t have any ‘rap,’ either positive or negative.”

John Grieb, who collaborated with Cox to get the regionalization project up and running, has a similar view. “Somewhere in people’s minds they think public health is valuable,” Grieb says, “but there’s no conscious awareness of what we do.”

To enhance the image of public health, Cox asserts, “we have to bring more people into the conversation.” By this he means involving representatives of fields outside public health in discussions of public health policy, just as people outside public safety affect policies governing police forces.

His colleague MacVarish says, “Public health work is invisible.” And, in these troubled times, what community would generously fund an activity whose positive impact it does not see?

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largely dependent on a fairly regressive sales tax—that is, one that hurts lower-middle class families disproportionately—and that programs are not addressing the social determinants of health that harm lower socioeconomic groups.

Still, the image of local public health in the Bay State may not be as shadowy as Cox, Grieb, and MacVarish assume. As Donna Moultrup of Belmont suggests, “Each thing we do is valued by a different constituency.” The problem is that these separate constituencies aren’t mobilized for a common purpose. Thus, Concord’s Reagor muses, “I find myself wondering how public health can create a brand.”

### ***Achievements and Frustrations***

The litany of woes has not kept LHDs in Massachusetts from registering substantial gains in recent years. Donna Moultrup’s experience in Belmont is an example. She expanded her department’s staff, developed regulations on activities from dumpsters to biotechnology to tobacco control, toughened food safety, and helped set up a hazardous waste collaborative among eight towns.

Brent Reagor credits the state’s local public health community with perseverance:

The biggest accomplishment is we’re still making it work, despite a lack of funding, disparity of funding, no standardization, and no qualifications for personnel or members of boards of health. The workforce is extremely dedicated and is succeeding in protecting the citizens of the state.

Wilkinson in the state department and Cox at Boston University both believe that even tobacco control remains an area of strength, notwithstanding the loss of state funding. LHDs helped achieve a statewide provision to protect workers and workplace visitors from second-hand smoke. They started by sharing best practices in order to obtain clean indoor air provisions in a critical mass of cities and towns, until a tipping point was reached that led the state to follow the local lead.

The health directors’ frustrations mirror the funding problems. To Ruth Clay in Melrose, more mental health services are needed, as inpatient psychiatric beds and outpatient care slots in the community

are being curtailed. She also wishes she could develop programs on youth exercise and chronic disease prevention.

Some see assisting immigrants—from countries as diverse as Haiti, Portugal, and Guatemala—as another unmet need. Moultrup puts a well-baby clinic and immunizations on the missing list. Harold Cox notes simply, “Improvements aren’t sustained, especially when issues lose currency, as HIV/AIDS has.”

#### **IV. THE RISE OF REGIONALIZATION**

##### ***The Regionalization Project***

Aimed at overcoming the challenges of meeting huge expectations with small local departments and fragmented policies, the Massachusetts Public Health Regionalization Project has an impressive history. Efforts began around 2005, when several LHD officials formed the Working Group, in order to explore ways to develop regional models for improving and expanding local public health services.

NACCHO support arrived some two years later. By then, the Working Group had expanded to include representation from a wider array of LHDs across the state as well as state officials and university-based public health professionals.

Early in 2007, the Working Group released recommendations for regionalizing services and began meeting with dozens of public health constituencies, such as regional emergency preparedness coalitions. Taking into account feedback from these meetings and other outreach efforts, the group issued a report in early 2008.

The 2008 report articulated five “guiding principles” (later revised slightly):

- The system must respect existing legal authority of local health agencies.
- As [the system is] a voluntary initiative, communities need incentives, not mandates, to participate.

- One size does not fit all; different models of regional structures and operations will allow communities to cluster in ways that will meet their needs.
- Full implementation of the system will require adequate and sustained state funding.
- The system will augment, not reduce, the existing local public health workforce.

As a whole, these principles served to allay concerns, expressed by some LHD directors, that regionalization could undercut their job security, their autonomy, and the local connections that undergird LHD performance.

Soon after releasing the 2008 report, the Working Group intensified its activity. Benefiting from NACCHO's new involvement and support from the Department of Public Health, the group hosted a carefully planned, one-day, statewide meeting, or "conversation."<sup>16</sup> Nearly 200 participants attended—twice the number initially expected.

Participants in the statewide meeting included LHD directors, other LHD staff, and members of the local boards of health (either elected or appointed) that oversee LHD activity. They heard several speakers describe the local public health situation in the state. And, they took part in many rounds of instantaneous electronic voting to register their perspectives on local public health capacity and needs.

Most significantly, participants in the 2008 statewide meeting voted overwhelmingly that now was the time to pursue regionalization. In a vote taken earlier in the meeting, only ten percent voted against regionalization itself, while 13 percent said they were neutral. Participants also voted in favor of establishing credentialing standards.

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<sup>16</sup> NACCHO supplied the regionalization project with the services of several consultants—providing local public-health-related expertise in economics, law, communications, and evaluation—and participation in meetings offering a national perspective on LHD regionalization. The Massachusetts Department of Public Health offered support for meetings and a sort of "home" for the project, as well as services provided by Geoff Wilkinson, who had left the post of head of the Massachusetts Public Health Association to become a policy adviser in the office of Commissioner John Auerbach. In addition, the Boston University School of Public Health, which manages the project, has received grant support from Robert Wood Johnson Foundation for a Practice-Based Research Network in Public Health to study regionalization effects in conjunction with the regionalization project.

## ***A Legislative Result***

The capstone of the NACCHO project was laid January 15, 2009, when Governor Patrick signed into law a bill that establishes new structures for regionalized public health services and removes earlier statutory barriers to regionalization.<sup>17</sup> The Working Group, toiling cooperatively with key legislative staff, had crafted the measure over several months in 2008.

Accompanying the signing was a touch of drama; Patrick acted on the very last day of the bill's legally designated signing period. ("We had all but given up hope," says Kathleen MacVarish.) In signing, the governor apparently overrode the advice of key aides to hold out for broader legislation regionalizing many different types of local services, not just public health.<sup>18</sup>

The new law has only limited effect. It carries no funding. Basically, the law makes it easier for cities and towns to form a regional public health structure, and it lays out several options for doing so. (The old law generally required waves of town meetings in order to set up a regional structure.) Yet, enactment represents a head-turning victory for the regionalization project.

What accounts for the significance of the success is the fact that legislation is not easily enacted in Massachusetts. The success shows that the Working Group has:

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<sup>17</sup> *Acts of 2008, ch. 259*. The Act, passed as *S-2784*, includes the following provisions: a statutory basis is created for eventually funding the start-up and operations of health districts; the Department of Public Health, in consultation with the Department of Environmental Protection, is mandated to develop qualifications for district health directors and performance standards; communities that regionalize may preserve home rule by choosing to maintain their own board of health; regionalizing communities have flexibility in designing their structures and financial agreements; employee rights and benefits—including civil service, retirement, and compensation rights of full- and part-time municipal employees transferred into health districts—are protected; boards of health must approve the formation of full-fledged health districts; and cities (not just towns) may co-hire health directors. In addition, the Act allows existing health districts to expand to include more communities, and it shortens the minimum term of existence for a district from five to three years.

<sup>18</sup> Aides to the governor also may have been concerned about potential cost implications. The bill contains no fiscal note, but it does contain a provision establishing a basis for state support of regionalized LHDs.

- developed fruitful collaborative relationships with State House policy-makers
- helped bring local public health to the attention of influential legislators in both the Senate and House, and
- fostered the Legislature and governor's approval of LHD regionalization.

And, after painstakingly laying the groundwork over several years, it achieved all this in the single calendar year of 2008.

### ***Anticipated Impact of Regionalization***

If LHD regionalization advances in Massachusetts, its advocates believe, the local health infrastructure would gain strength. For example, says project administrator Kathleen MacVarish, specialized expertise in fields like epidemiology would become more readily available. She anticipates that, under regionalization, some current health directors would exchange directing all local health services in one town for heading an area of service, such as inspections and disease control related to food service, for a group of adjacent towns.

During most of the 2008 project year, participants in the regionalization project believed that fiscal incentives would be needed to persuade communities to commit to a regionalized structure. As MacVarish says, "We've always assumed we need financial incentives."

Concord's Brent Reagor, for example, said early on that regionalization would have an impact only "if it came with state funding—that's the key." He believed there has to be a state match for additional local expenditures. Similarly, Phoebe Walker in rural Western Mass said at about the same time that "regionalization will go nowhere without money."

John Grieb, then with the Cambridge LHD and now a contractor for the state Department of Public Health, offered a more nuanced view. "Regionalization will put us in a position where we won't *lose* funding," Grieb said. In his view, regionalization would protect LHDs from budget reductions resulting from their lack of competitiveness with more highly valued local services.

The Working Group's funding strategy was to push for an appropriation to reestablish the Office of Local Public Health in the state department and seed several pilot regionalization projects. Now, in the absence of an appropriation, the department's Wilkinson predicts "a slow investment trajectory." He hopes for enough of a state contribution to help build momentum for regionalization while fostering local "creativity and collaboration."

(As Part V of this report discusses, the recession has forced the Working Group to reevaluate its strategy.)

### ***Views on Regionalization***

Participants in the project have various concepts about how regionalization could measure and demonstrate success. Ideas include:

- Outcomes for obesity and other health problems would improve, the problem of not enough public health nurses would go away, and supermarkets and restaurants would be adequately inspected (Harold Cox)
- New local models would appear, as towns worked out their differences (John Grieb)
- More resources would be devoted to local health (Geoff Wilkinson)
- A lot of regionalized health districts would be created, and quality monitoring would be improved for programs ranging from food safety inspections to communicable disease control (Phoebe Walker)
- Residents would have access to all Ten Essential Public Health Services (Brent Reagor)
- More services would be provided, and staff would be hired on the basis of meeting high qualifications (Ruth Clay), and
- National performance standards for LHDs would be met (Kathleen MacVarish).

Participants also entertain differing views about how regionalization would affect their own jobs. Donna Moultrup believes her job would disappear, as Belmont's department would merge with those of two neighboring towns with younger health directors—although she

intends to stay active in public health. Reagor anticipates added resources and capacity, ending departmental inadequacies.

But, some LHD directors in the state still fear losing their jobs. The link between local health jobs and interest in regionalization is multi-faceted. Wilkinson, whose state duties include public health workforce development, sees emerging workforce shortages as a driver of regionalization. As in other states, directors of many Massachusetts LHDs—and key staff members—are fast approaching retirement age.<sup>19</sup>

Several project participants or observers admit to some reservations, despite their overriding enthusiasm for regionalization. Bringing to bear his experiences from four states in the South and Southwest, Reagor says some initial or pilot efforts could fail. To prevent this, the models have to be dynamic and adaptable to unique circumstances, he says. He also notes that every local health director's primary mission is to protect his or her own community, rather than an amalgam of communities.

Ruth Clay, of Melrose, sees regionalization as a risk to her own comfort. "My personal reservation is that I spent 12 years establishing my department as part of the community and have been networking to get a lot of things done," Clay says. She prefers spending significant time in the field—"if I didn't want to be in the field, I'd be working for the state health department"—to coordinating the work of others. Under regionalization, she believes, "I couldn't possibly spend personal time with people in Melrose, and I would have to become a different kind of manager, delegating more responsibilities."

To Wilkinson, "in the short term, the progress won't be measurable, especially in terms of health outcomes." Cox notes that regionalization is "just one approach" to improving local public health. "My gut tells me it's the right approach, because it's a pooling of resources." But, labeling himself a "healthy skeptic," Cox calls for

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<sup>19</sup> Brent Reagor emphasizes that, in 2006, the Massachusetts Coalition for Local Public Health (a group of five public health professional associations) conducted a workforce assessment (cited in note 12 above) that revealed that one-fifth of the state's public health workforce would become eligible to retire by 2008. And, he adds, "Youth is not coming up—there's no replacement generation."

frequently questioning the regionalization approach as the process continues.

### ***Regional Models***

Even before the new local public health regionalization law was enacted in January 2009, Massachusetts statutes permitted the establishment of health districts. Under the old law, two or more cities or towns could choose to:

- hire a single health director, appointed by vote of their combined boards of health,<sup>20</sup> *or*
- create a regional board of health, following specifications in the law for the composition of regional boards and the qualifications for a board-appointed regional health director.<sup>21</sup>

The latter, fully merged health district model remains an abstraction. None exist, even though the old law offered the possibility of state funding to defray start-up expenses.<sup>22</sup>

The Working Group now sees two viable regionalization models:

- *Comprehensive service district*, in which a single set of employees provides all local health services to residents of two or more municipalities. Policy-making authority in this model is retained by the separate local boards of health or delegated to a regional health district. This model is facilitated by the new law's removal of several barriers to forming districts.<sup>23</sup>
- *Shared service district*, in which neighboring boards of health selectively agree to share certain staff (such as an animal control officer, epidemiologist, public health nurse, or sanitarian) or to make one municipality responsible for a set of public health functions (such as clinic operations or disease outbreak investigations) throughout the district. In short,

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<sup>20</sup> M.G.L.A. 111 s. 27A.

<sup>21</sup> M.G.L.A. 111 s. 27B. The regional director is required to be a physician with demonstrated expertise in public health.

<sup>22</sup> Possible reasons why fully merged health districts were not formed under the old law include that law's complicated procedural requirements and the deeply ingrained attitude of home rule. State funding is also possible under the new law.

<sup>23</sup> For details, *see* note 17, above.

municipalities may choose this model in order to retain some services in-house, for its residents alone, while merging others.

Another model, already established, consists of *stand-alone* health boards or departments that do not belong to a district and provide the full range of public health services to the municipality's residents. This non-regional model appears most applicable to cities that are large enough to sustain the full range of local health services on their own. One noted feature of this model is that city mayors expect to be able to deploy their LHD rapidly to respond to citizen complaints, without having to ask for help from a regional authority.

Several regionalization advocates prefer the comprehensive model. For example, Donna Moultrup and Phoebe Walker believe the shared model is inferior, because it would allow towns to avoid regionalizing all but a few services. The comprehensive model is especially popular in Western Mass, where local boards have few of their own resources.

But, Clay suggests that, in the near term, shared services may be more realistic than districts in some parts of the state: "You have to take baby steps toward regionalization to show that it's not a threat."

### ***Views on the Regionalization Project***

"The Working Group members should be applauded for their efforts," says Brent Reagor. He's impressed with the quality of the group's products, the success in getting the new law enacted,<sup>24</sup> and the inclusiveness and outreach that the group has displayed.

For example, Reagor has been pleased with the opportunity to attend occasional Working Group presentations to local health officers.

The Working Group's process has been a regular topic of internal discussion. Walker called early on for the creation of subcommittees. Her view was that too much centralization had slowed the pace. Similarly, Cox, who chairs the Working Group meetings, said the

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<sup>24</sup> The Working Group did not lobby for enactment of the new law but frequently provided timely information to aides to important legislators, like Senator Susan C. Fargo and Representative Peter J. Koutoujian, the two Middlesex Democrats heading the Joint Committee on Public Health.

group had grown so large that less was getting accomplished. The Working Group then did establish a series of subcommittees, and, at this writing in early 2009, subcommittee reports on key topics like workforce credentialing are being finalized.

Most leaders of the regionalization project had little prior experience with NACCHO. Wilkinson and Reagor concede they had none, while Clay and Walker each say their prior NACCHO involvement consisted of attending a single conference. Only Cox says he was truly active in NACCHO before NACCHO's involvement in the project began.

## **V. REGIONALIZATION AT A CROSSROADS**

### ***New Law, New Economic Conditions***

Asked what's needed to move regionalization forward now, following enactment of the new regionalized services law, most LHD directors don't miss a beat. "Money," answer Phoebe Walker, Ruth Clay, and Brent Reagor.

The Working Group strategy driving the legislation was to remove structural impediments to regionalization that existed in the old law, and then to obtain state funding of regional pilot projects. Except for new money, LHD directors saw little reason to leave their local bastions to mount regional efforts.

Unforeseen when the legislation was developing was the once-in-a-generation recession that has emptied the coffers of state and local governments, along with those of everyone else. As John Grieb says, "The economy is shrinking rapidly and drastically." Regionalizing services now holds appeal to the very mayors, selectmen, and town managers who long resisted it. But, most of these local officials are interested in what some call "regionalism" or "forced consolidation," that is, regionalizing not to improve and expand services, but rather to cut costs.<sup>25</sup>

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<sup>25</sup> See the section on "Effects of Recession on Regionalization," below. A broad exception to the local interest in using regionalization to cut costs may exist in Western Mass, where few opportunities to cut costs exist and the need for greater services is most evident.

The money issue, therefore, has two faces. In the Working Group's vision, it can lead to better local public health; in some local officials' vision, it can lead to cutbacks.

### ***Old Obstacles, New Opportunities***

Harold Cox, Working Group chair and a gifted communicator, is sanguine. "I'm pleased with how we're moving," Cox says on a day when the governor—who just slashed local aid<sup>26</sup>—is publicly mulling over a large gas tax increase as one of several steps needed to right the state's fiscal boat.

Cox allows as how the state, so financially strapped, is unlikely to fund pilot projects anytime soon. But, he sees the Working Group and the regionalization project as equipped to provide regionalizing entities with technical assistance and evaluations. "We need to start where people are," he says, meaning that even regionalization undertaken to produce savings, rather than to improve services, could lay the groundwork for eventual improvement.

In other words, Cox takes the long view. Someday the economy will bounce back. When that happens, LHDs that regionalized to save money probably will be positioned to expand services.

Geoff Wilkinson at the Massachusetts Department of Public Health sees the regionalization project as progressing along two tracks. The outside track is directed toward financial incentives. The inside track is directed toward providing technical assistance and promoting credentialing standards and other infrastructure or quality improvements, using existing resources. The train will advance incrementally, on whichever track offers the surest ride over a particular patch of terrain.

The legislation and woeful economy have combined to produce a sort of "teachable moment" in regionalization. Donna Moultrup, in

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<sup>26</sup> Governor Patrick announced a cut of \$128 million, or nearly two and one-half percent, in the \$5.3 billion that the state allocated in aid to cities and towns for FY 2009. Matt Viser, "Patrick to Cut Local Aid by \$128m: Will Be State's Biggest Midyear Reduction Ever," *Boston Globe* (Jan. 24, 2009), [http://www.boston.com/news/local/massachusetts/articles/2009/01/24/patrick\\_to\\_cut\\_local\\_aid\\_by\\_128m/](http://www.boston.com/news/local/massachusetts/articles/2009/01/24/patrick_to_cut_local_aid_by_128m/). The cuts appear to affect cities more than towns.

Belmont, says that a lot of the structure for regionalization existed under the old law, but that it took the publicity surrounding the new law to acquaint most LHD directors with the opportunities to regionalize.

Concord's Reagor and Melrose's Clay both have entered regionalization discussions with neighboring towns. In Reagor's case, the discussions involve services provided at comparable levels in each community, so he's optimistic that the negotiations will produce a broader level of service at no additional cost, by eliminating redundancies.

Clay says there are no savings to be had from regionalizing with Melrose's neighbor of Wakefield, which now offers almost no local health services, but that even having the discussion, which is being reported in local media, is "huge." (And the two towns subsequently moved beyond the discussion stage to the agreement stage, with Clay slated to head the new enterprise.)

Obstacles remain. Moultrup lists three, which are often overlooked:

- *Nuts and bolts of running a department.* Efforts to regionalize firefighting services in the state reportedly foundered on issues of funding differences between towns, local control, and personnel.<sup>27</sup>
- *Unions.* How do you regionalize unionized and non-unionized towns, she asks, and develop a pay structure?
- *Time management.* We're all too busy to pursue complicated negotiations, she says.

Home rule poses thorny practical problems. MacVarish notes that towns have different regulations for, say, body art. A district inspector would have to switch to a different rulebook when crossing a town line, or else all towns in a district would have to develop a common

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<sup>27</sup> "Five South Shore towns . . . formed a committee in the early 1990s to consider providing shared fire services. . . . Despite the potential savings, the effort foundered. The primary obstacles were funding disparities between large and small communities, an unwillingness to relinquish local control of budgets and services, and resistance by employees—both union and management—to change." Steve Poftak and Aaron Powers, "A Regional Approach: Massachusetts' Cities and Towns Simply Cannot Afford to Be Islands: Savings from Regionalized Services Can Help Them Trim Budgets Without Compromising Services," Commentary, Quincy (Mass.) *Patriot Ledger* (January 12, 2009).

rulebook—surely a time-consuming and sometimes contentious process.

To overcome these and other obstacles—including the paramount barrier of unavailability of a financial incentive to regionalize—John Grieb says there has to be “almost a public relations campaign” to convince LHD directors, local office-holders, and community leaders to light the regionalization flame.

### ***Effects of Recession on Regionalization***

“The economic downturn provides an incentive to find new ways to deliver services,” notes the optimist Harold Cox.

There is a dark side to the incentive for cities and towns to combine services, though. When a health district is formed, services above and beyond those offered by the smallest LHD in the district may be slashed; municipal officials may seek the lowest common denominator.

“We have to provide our own model, or this will be forced on us,” says Donna Moultrup. By “this,” she means deep cuts.

In many situations, regionalization will not save money. Phoebe Walker observes that Western Mass has few services to regionalize, unless money to pay for them is added to the mix. John Grieb, a former hospital planner, comments that the lesson from hospital mergers is that cost savings often fail to meet original expectations. “There isn’t a lot of waste now in local public health to produce savings,” he adds.

Kathleen MacVarish distinguishes regionalization from “regionalism,” which she describes as an almost undifferentiated effort by cities and towns to shed expenses by regionalizing programs. She believes localities are being prodded toward regionalism by the Massachusetts Municipal Association, the organization representing town managers and other local officials. Ironically, the association was long seen as *opposing* efforts to regionalize programs.

As of February 2009, cuts are becoming a fact of life. Already, Moultrup lost \$30,000 for a youth commission. Walker says “every town faces cutbacks.” Reagor finds that “directors in the best situation are level-funded.” He notes that cuts in office supplies, mileage reimbursement, and conference attendance and even layoffs are increasingly widespread. “The governor’s cut in state aid for the current year is especially hard, because communities counted on it,” he says.<sup>28</sup>

The recession could affect demand for local health services, too, although the jury considering the question is still out. So far, demand appears to have increased for heating oil subsidies, food pantries, and other human service programs provided at no charge. But, demand may have *decreased* for immunizations and other health services for which small fees are charged.

Decreases also may be in store for restaurant inspections—some restaurants may not survive the recession—and some other services, as consumer spending declines. For example, one view is that real-estate-related inspections will fall, although a contrasting view is that septic systems and other facilities still will need to be inspected, and that such inspection services tend to remain constant during economic downturns.

Moultrup sums up the early 2009 demand situation by saying, “We haven’t felt a new demand yet.” In this regard, LHDs in Massachusetts differ from those in states like Kansas; the former concentrate on environmental health services, while the latter concentrate on personal health services, where demand rises during a recession, especially as people lose employer-based health insurance.

### ***Next Steps***

Progress is taking place along Geoff Wilkinson’s “inside track” of quality improvements. For example, his Department of Public Health is buttressing its regional offices. This effort could provide LHDs with

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<sup>28</sup> Moultrup, Walker, and Reagor all expressed these views in late January or early February 2009.

more accessible state backup and could improve statewide coordination in public health.

Within the regionalization project, as many as 11 subcommittees have been meeting, discussing such issues as funding formula, governance, credentialing, performance standards, district population thresholds, evaluation, and development of needs-based evidence to make a compelling case for regionalization. Results soon will be shared with the local health community.

MacVarish expresses amazement at the continuing commitment of Working Group members. They meet frequently (usually face-to-face), fulfill daunting homework assignments, and cooperate cheerfully.

“Now,” says Reagor, “we need to get the economic piece in place.” Seed money for pilot projects could, at least in theory, come from the state, or it could come from private sources like foundations, which Grieb finds a more likely prospect. In addition, in Reagor’s view, there has to be resolution of certain administrative issues, such as who pays for supplies and travel when LHDs regionalize.

The regionalization project is moving forward against a backdrop of the national effort to work toward accrediting state and local health departments. Moultrup and MacVarish are among those who see a close relationship between the two efforts. “What we’re finding is that all this is coming together,” Moultrup remarks.

Much is afoot, to be sure. Take personnel requirements. Moultrup leads the Working Group’s credentialing subcommittee, which has been considering qualifications for certain LHD positions. Meanwhile, the Local Public Health Institute of Massachusetts has been developing competency recommendations for specific positions. The new law authorizes the state Department of Public Health, with consultation from the Department of Environmental Protection, to set minimal standards for health directors of newly formed districts. On the national level, MacVarish admires the links among the new standards of the Public Health Accreditation Board, the National Public Health Performance Standards, and the Ten Essential Public

Health Services—all of which provide a basis for defining competencies.

Still, developing personnel standards for the Bay State’s numerous LHDs is no cakewalk. Reagor notes that his town of Concord is two-thirds septic while its neighbor is almost entirely served by sewers. He says differences like that extend to programs in lead abatement, summer camps, public swimming pools, and other areas. As a result, field competencies vary from town to town.

Grieb thinks that pressure to gain accreditation could push LHDs to regionalize. But, Walker thinks accreditation, at least at present, only concerns the “academics.” She says LHDs in Massachusetts see no benefit to accreditation, because they’re too decentralized and small to attract funding from any foundation or agency that cares about accreditation.

Cox is one academic who agrees. “We could be one of the last states involved in accreditation, because we have so many local departments, and they don’t want to change,” he says. He feels that issues of economies of scale are more important than accreditation in encouraging departments to regionalize.

### ***Altered Perspectives***

By early 2009, several project leaders had grown even more convinced of the necessity for regionalization. Grieb believes that regional LHDs will be in a far stronger position than small, traditional LHDs to obtain funding from foundations and other sources of grants. (Grant-related factors mentioned by Grieb and others are that funders tend to be interested in supporting projects serving larger, rather than smaller, populations, and that small LHDs find it difficult to find the time and expertise to develop successful proposals.) Moultrup says that regionalization will create a “power bloc” to deal with entrenched forces, such as mayors.

Wilkinson, wearing his workforce analyst hat, says that some LHDs and community health agencies are considering regional positions in

order to fill local vacancies.<sup>29</sup> Overall, he sees the public health landscape in the Bay State as rapidly changing, sometimes in unpredictable ways. “It feels like a spinning top bumping into so many forces while trying to stay on the tabletop.”

Cox is sure that local health leaders “are looking for opportunities and new approaches. When times get tough, people are open to new ideas.” Although public health is grossly underfinanced, he believes leaders who “are willing to do something different from what they’re doing now” can “make great things happen,” by reallocating and redirecting existing resources.

Public awareness and support for local health may have grown during the project. Reagor points to several developments that show public health and disease prevention in a flattering light:

- Massachusetts is the national leader in tackling universal health coverage, which helps people at greatest risk and underscores the importance of prevention strategies to reduce acute care costs
- Commissioner Auerbach is undertaking an initiative to provide caloric information on chain restaurant menus and a “Mass in Motion” program to promote physical activity through community efforts, and
- news coverage in January 2009 about the national peanut-borne salmonella outbreak<sup>30</sup> and coverage of other threats create a focus on health inspections.

“We’re at the table and have a higher profile,” says Walker. In part, this is because emergency preparedness provided a place for LHDs to sit with police and fire departments to address common problems.

What Walker sees on the local level is mirrored by Wilkinson’s observations on the state level. “There are some new players in the

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<sup>29</sup> Wilkinson also says there is interest in training people from other fields to fill local health positions, due to the public health workforce shortage.

<sup>30</sup> In January 2009 some 125 products were recalled as the Food and Drug Administration and other authorities learned of six deaths and hundreds of cases of disease linked to ingestion of peanut butter and other products containing salmonella, distributed in whole or part by a processing plant in Blakely, Georgia. See Mary MacVean, “Salmonella Peanut Product Recall Grows,” *Los Angeles Times* (January 21, 2009), [http://www.latimes.com/news/nationworld/nation/la-sci-peanut22-2009jan22.0,7913919\\_story](http://www.latimes.com/news/nationworld/nation/la-sci-peanut22-2009jan22.0,7913919_story). Subsequently, the H1N1 flu epidemic also served to increase awareness about public health.

Legislature” advancing public health, he says.<sup>31</sup> He credits “buzz over the regionalization bill” as a cause for local health’s higher State House profile.

Some do not think the profile has been sufficiently raised, however. “As a result, we’re discouraged,” says Moultrup, “especially because of all the expectations with emergency preparedness.” Grieb laments, “People just don’t think about public health.”

## VI. SPOTLIGHT ON COMMUNICATIONS

### ***Communicating About Regionalization to Improve Services***

Geoff Wilkinson speaks up for social marketing. He practiced it, he says, as executive director of the Massachusetts Public Health Association. There, he commissioned a 30-minute video for cable television on how local public health protects people, and he appeared before senior groups to promote immunization.<sup>32</sup>

Now at the state Department of Public Health, Wilkinson tells the Department’s regional directors to meet face-to-face with local boards of health. He sees outreach like this as a communications initiative related to social marketing. He believes the outreach—part of the “inside track” of regionalization—will strengthen the state-local public health nexus and help improve the quality and scope of local health services. “It’s a two-way street. We have to listen and not just sell.”

John Grieb, who says local health in general “*almost* needs a public relations campaign,”<sup>33</sup> believes a narrower and coordinated

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<sup>31</sup> One legislator mentioned as a new advocate for public health is Rep. Will Brownsberger, Democrat of Belmont.

<sup>32</sup> Although ‘social marketing’ sometimes is used to describe efforts to promote non-profit organizations and the interests they represent, it more strictly refers to use of selected sales-oriented marketing techniques to persuade large numbers of people to change their behavior toward more socially and personally beneficial practices, such as smoking cessation. See Philip Kotler and Nancy R. Lee, *Changing Behaviors for Good* (Thousand Oaks, Cal.: SAGE Publications, 2008). The New York-based international public relations firm Porter Novelli helped popularize social marketing; its former leader Bill Novelli went on to become chief executive officer of AARP. More recently, the “Turning Point” project, co-sponsored by Robert Wood Johnson Foundation and the W.K. Kellogg Foundation, brought social marketing principles to state and local health departments.

<sup>33</sup> See the “Old Obstacles, New Opportunities” section of Part V, “Regionalization at a Crossroads,” above.

communications program “*has to happen,*” to persuade local boards of health to regionalize to improve services. Boards respond to demands raised by residents of the community, and, so far, residents show little interest in regionalization to improve services.

To Harold Cox, too, “the only way regionalization will happen” is to get public support and “a very broad-based constituency.”

Of course, regionalization—in the guise of “regionalism,” as described by Kathleen MacVarish—could come about as a crude way of reducing the costs of city and town government at a time of fiscal crisis. This result probably would not be a step forward for local health. It would not constitute regionalization to improve services. In some ways, it would be the opposite of regionalization as sculpted around the Working Group’s five “guiding principles.”<sup>34</sup>

MacVarish anticipates holding another statewide meeting, or perhaps regional meetings, to discuss Working Group reports. The nature of this gathering would reflect ideas emerging from subcommittees, such as the subcommittee on social marketing. The winter 2008 statewide meeting was so successful in building momentum for regionalization that a follow-up effort offers substantial promise.

Certainly, the Working Group is alert to the importance of communications. It engaged an experienced professional writer in the Bay State to help produce cogent reports, and it’s planning an e-newsletter to reach local health officials.

### ***Communicating About the Importance of Local Health***

Brent Reagor speaks up for greater visibility for public health. “People are always intrigued by our wide scope of programs and the fact that there’s something unique in each community.” The unique aspects can consist of wildlife, subpopulations, or physical features, like archeological sites, that pose special environmental-health challenges. Reagor, who believes local health would benefit from

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<sup>34</sup> See the “Regionalization Project” section of Part IV, “The Rise of Regionalization,” above.

establishing a “brand,”<sup>35,36</sup> advocates proactive communications to avoid being fed a strict diet of budgetary crumbs.

Donna Moultrup notes that Bay State local health directors regularly engage in communications to support their departments. “We all write articles for the local papers.” Directors place printed inserts into home utility bill mailings, speak at town meetings, and participate in health fairs, town days, and other community events. But, despite these occasional and perhaps fragmented efforts, “people don’t think about public health until they need us.”

And, maybe not even then. LHDs have faced difficulty mobilizing residents’ support, even when residents knew services would be cut.

The Franklin region has tried a particularly ambitious communications effort to increase popular support for local health. Phoebe Walker describes the effort as including “buttons and hats with the public health logo to enhance our profile, along with car signs, vests, and posters, all developed by a marketing consultant.” The campaign, which was not being evaluated, was ongoing through much of 2008.

“The problem with public health,” says John Grieb, “is that when we do our job really, really well, no one knows about it”—a prevented disease outbreak is essentially a secret. Besides being victimized by its own success, public health is betrayed by its own breadth. As Cox notes, “Helping people understand public health is incredibly complicated, because it includes such an amazing array of activities and fields.”

### ***A Strategic Approach***

The Massachusetts Public Health Regionalization Project has excelled at developing and implementing methods for rallying much

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<sup>35</sup> See the “Public Profile of Public Health” section of Part III, “The Challenge of Practicing Local Health in Massachusetts,” above.

<sup>36</sup> ‘Branding’—perhaps the essence of visibility for an enterprise or organization, and therefore the key to its influence—is about meaning: What does the organization denote and connote? The Johnson & Johnson brand famously came to represent trustworthiness, when the company began using tamper-proof packaging after the 1982 Tylenol poisoning episode and engaged in disaster relief and other socially conscious undertakings. Branding also includes, but certainly is not limited to, a visual identity or image expressed through an organization’s name, tagline, logo, color scheme, and other identifiers.

of the local health community around regionalization, for raising the profile of local health in the State House, and for designing and disseminating regionalization models and tools. A strategic communications approach—that is, including a communications component in all major project activities, carefully focusing on messages and audiences, and nurturing enduring coalitions—would be consistent with the project’s character and could help assure its continued success.

LHDs in Massachusetts are heading into a three-way intersection. They might veer off toward rough, cost-cutting “regionalism.” They might proceed in the direction they came, remaining true to home rule and the perpetuation of 351 separate units. Or, they might muster the creativity, collaboration, and, indeed, courage to bring about regionalization to improve services.

Ever since the ride of Paul Revere—coincidentally, a pioneer in local health—Massachusetts has been recognized as the “Cradle of Liberty.” In increasingly difficult times, the regionalization project and its Working Group are struggling to assure that the cradle will not be the grave of public health regionalization.