

# The 2021 MetroWest Public Health Infrastructure Evaluation Report

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## LIST OF ACRONYMS

ASTHO: Association of State and Territorial Health Officials

CHA: Community Health Assessment

DMH: Department of Mental Health

DPH: Department of Public Health

HIPPA: The Health Insurance Portability and Accountability Act of 1996

LBOH: Local Board of Health

LHD: Local Health Departments

MA: Massachusetts

MOU: Memorandum of Understanding

NU-PEL: Northeastern University Public Evaluation Lab

PHAB: Public Health Accreditation Board

SDH: Social Determinants of Health

SLA: Service Level Agreement

## ACKNOWLEDGMENTS

We are pleased to present the 2021 MetroWest Public Health Infrastructure Evaluation Report to the MetroWest Health Foundation and all the community members of the MetroWest region of Massachusetts.

The public health infrastructure in MetroWest region of Massachusetts has been tested during the COVID-19 pandemic. It is clear there are strengths as well as challenges and opportunities. This report analyzes the current public health infrastructure in the region, including local health departments as well as organizations in the community that provide healthcare and work on issues related to social determinants of health. The goal is to better understand what is working well, where the greatest challenges are and where there are opportunities to improve the infrastructure. The work takes place within the framework of health equity. The analysis focuses on how challenges may disproportionately impact some residents, as well as on opportunities to create greater equity through public health systems change.

We wish to thank the MetroWest Health Foundation for provided the funding for this important project. We also are deeply grateful to everyone who completed our online survey or agreed to be interviewed for this project.

We would also like to thank the Northeastern University Public Evaluation Lab (NU-PEL) faculty advisor, Dr. Alisa Lincoln, and student researchers who assisted in the data collection, analyses, and report writing: Sushant Kumar, Gemma McFarland, Ashley Houston, Ecom Lu, and Nihala Razack.

Copies of this report can be downloaded from the foundation's website at [www.mwhealth.org](http://www.mwhealth.org).

We also invite your comments and feedback on this report, which can be sent to us at [info@mwhealth.org](mailto:info@mwhealth.org).

Suggested citation: Yom, T., Senier, L., MacLeish, H., and Lee-Shaw, R. 2021. *The 2021 MetroWest Public Health Infrastructure Evaluation Report*. Boston, MA: Northeastern University Public Evaluation Lab

## I. EXECUTIVE SUMMARY

### Introduction

Across the MetroWest region, there is wide heterogeneity in health department capacity. The current public health infrastructure of the MetroWest region includes not only local health departments (LHDs) and their municipal elected officials, but also a multi-sector network of providers of clinical services, human and social services, and local and regional non-profit agencies. In the spring of 2021, leaders at the MetroWest Health Foundation undertook a study to understand the impact of the COVID pandemic on the public health infrastructure of the region, and to identify ways to strengthen it by encouraging partnerships and collaboration. To that end, they contracted with the Northeastern University Public Evaluation Laboratory (NU-PEL) to conduct a needs assessment of the region's public health infrastructure.

### Methods

To understand current capacity, pressing challenges, and practices around collaboration in the MetroWest Region, NU-PEL researchers devised a mixed-methods data collection strategy to gather information in all 25 MetroWest communities. The NU-PEL team worked with the MetroWest Health Foundation to develop an online survey of key stakeholders in all 25 communities, supplemented by in-depth, semi-structured interviews with 29 people in a subset of communities. The survey elicited feedback on experiences with past collaborations, while the interviews gauged receptivity to eight hypothetical collaborative scenarios. The NU-PEL team designed the eight scenarios so that they touched on all the Core Public Health Functions and so that they represented multi-scalar collaborations. Three scenarios proposed collaborations that would engage municipal health departments horizontally across the region, three scenarios depicted cross-sector collaborations, and two scenarios described collaborations to address underlying social determinants of health.

### Key Findings

The survey data show that there are many collaborative projects ongoing in the region to improve health and mitigate health inequities, and that by and large, participants in those partnerships find them beneficial and important. That said, the survey did identify some areas of need.

- Many respondents said that their current staffing levels and funding are barriers to engaging fully in collaborations, and that a lack of resources sometimes hinders a partnership's goals.
- Mirroring national trends, LHD staffers forecast an urgent need to recruit and retained talented personnel.
  - Approximately half of LHD staffers responding anticipate leaving their position within the next two years, and approximately three-fourths of them anticipate leaving within five years.
- About a third of respondents said that they found negotiating relationships in partnerships challenging, or that they had difficulty identifying and engaging suitable partners for collaborative work.
- A small group of survey respondents said that they wished there was some type of centralized infrastructure in the region to help facilitate collaborations.

The interviews revealed varying degrees of enthusiasm for and ambivalence towards the hypothesized partnerships outlined in the eight scenarios (Figure 1). The first three scenarios (Scenario #1, Scenario #2, Scenario #3), which proposed collaboration across communities, were

Figure 1. Hypothetical Scenarios Guiding Interviews

Scenarios	
1	♥ Collaboration Between Towns
2	🚫 Collaboration Across the Region
3	✖ Service Districts Within the Region
4	👤 Cross-sector Partnership within the Community
5	🍲 Community Food Partnerships
6	👤 Local School Health Coalition
7	🏥 Regional Clinical Partnership
8	🎓 Partnerships to Improve Social Determinants of Health

least favorably received. Among these three scenarios, the only one that generated some interest was Scenario #2, which proposed a collaboration across multiple communities on a health promotion campaign. Local health department officials were skeptical about Scenario #1, which proposed collaborating across communities to pool resources on certain regulatory functions of LHDs (e.g., restaurant inspections). Health department staffers and elected officials were especially hostile to

Scenario #3, which proposed a comprehensive service district that would replace LHDs and serve the needs of participating communities.

Scenarios #4, #5, and #6 described cross-sector partnerships that could take place either within a single community or across multiple communities, on a range of specific topics. These scenarios were generally received very favorably, largely because participants have already had positive experiences with them. Discussions from Scenario #4, Scenario #5, and Scenario #6 identified some parties who could be drawn into such partnerships but are sometimes forgotten, especially faith-based organizations, law enforcement departments, and hospitals or health centers. Respondents liked the idea of youth-oriented programming for child and adolescent health depicted in Scenario #6, but said that given limited resources and scheduling/transportation issues that youth face, leadership and execution of such programming should remain with school departments, with LHDs playing a supporting role.

The final two scenarios (Scenario #7, Scenario #8), which proposed collaborative projects to expand geographic access to clinical services or programming to address underlying social determinants of health (e.g., poverty, the lack of affordable housing), provoked the most contradictory results. While all respondents agreed in principle that such projects would be worthy undertakings, many LHD staffers and their local elected officials expressed skepticism that overburdened health departments could participate productively in such initiatives, especially in the face of the ongoing pandemic. Health department officials also said that they lack frameworks to guide program development and evaluation in these areas. They said that while they recognize that programming to address underlying social determinants of health could be powerful in improving population health, they would need much greater financial resources to do it well.

## Conclusions

Recognizing that a “one size fits all” approach is unlikely to work in MetroWest, because communities have distinct needs and the LHDs have widely varying levels of capacity, we recommend the following strategies to build and sustain public health capacity across the region:

- Create educational and training opportunities to help local elected officials, town administrators, and elected or appointed members of Boards of Health.
- Increase awareness of and appreciation for cross-jurisdictional sharing, in all its variations.
- Support regional collaboration on public health promotion objectives.
- Prepare communities to respond to emerging public health crises.
- Advocate on behalf of LHDs in the region.
- Build capacity of LHDs in the MetroWest region by helping LHDs apply for external sources of funding and creating mentoring and networking opportunities for LHD staffers.

The health departments in the region are staffed by dedicated and insightful leaders who have an earnest desire to strengthen public health capacity and build on community assets. COVID-19 has highlighted the need for a coordinated response to public health in the region. Over the past two years, LHDs have cooperated with schools, local hospitals, and community health centers to present unified public health education and easily accessible resources such as COVID-19 testing and vaccines. While it is important to draw attention to progress, it is equally important to highlight emerging and entrenched public health challenges. Towns of different populations and budgets have contrasting views on how to partner effectively on a host of issues ranging from health promotion to housing to food security. This report maps these challenges and identifies differences in public health experiences from leaders currently playing the largest role in the MetroWest region. Formal partnerships and collaborations have great potential to strengthen public health infrastructure, foster policy development, and improve social determinants of health, allowing all MetroWest residents to live a life of dignity.

## II. INTRODUCTION

### A. Background

In the spring of 2020, the COVID pandemic took hold in the United States and exposed many inadequacies of our healthcare and public health systems. Federal, state, county, and local health departments across the country rallied to combat the pandemic, providing testing and contact tracing services, as well as guidance and education for policy makers and the public. Our national public health system has, however, been struggling for decades under declining budgets, workforce shortages, and aging and inadequate infrastructure. COVID-19 exposed these inadequacies in dramatic fashion, in addition to illuminating the racial and socioeconomic inequities in healthcare quality and access. Perhaps not surprisingly, these forces drove inequitable morbidity and mortality from the COVID pandemic, and exhausted and frustrated many public health officials (Scales et al. 2021; Stone et al. 2021).

In the spring of 2021, leaders at the MetroWest Health Foundation embarked on an initiative to understand the impact of the COVID pandemic on LHDs throughout the region, and to identify ways to strengthen capacity in local public health through partnerships and collaboration. To that end, they contracted with the Northeastern University Public Evaluation Laboratory (NU-PEL) to conduct a needs assessment of LHDs.

Massachusetts stands out among US states as having a strong tradition of local home rule, and as a result, LHDs are decentralized. Historically, each of the 351 municipalities in the commonwealth has had its own LHD, funded primarily from the community's property tax base. There is therefore wide heterogeneity in the size and capacity of LHDs, which reflects both a community's size and its socioeconomic profile (PHDIG 2015).

Each community's public health workforce includes a Local Board of Health (a group of elected or appointed officials who have the legal authority to set policies and make regulations to protect public health and the environment) and an LHD (a municipal agency staffed by professionals who carry out key public health functions such as environmental inspections, monitor and control tobacco sales, and offer immunization clinics). Board of Health members serve on a volunteer basis and may or may not have any health or policy expertise to inform their decision making. Staffing capacities in LHDs vary widely. A 2006 nationwide study by the Institute for Community Health found that among small communities (<5,000 residents) 78% had no full-time public health staff, 50% had no health inspector, and 90% had no public health nurse (PHDIG 2015). A 2006 survey of local health directors in Massachusetts reported that nearly all of them said they did not have enough staff to consistently fulfill their responsibilities to the public; 89% could not consistently enforce basic environmental regulations, 97% said they could not maintain a competent and adequately trained public health workforce, and 98% said they found it challenging to prevent chronic disease injury prevention programs (Hyde and Tovar 2006).

MetroWest communities exemplify these national and state trends. For example, in the 25 communities in the Foundation's catchment area, health departments range in size. Although Framingham, the largest city in the region has 13 FTE staff, 15 of the communities in the region have LHDs that are supported by less than three FTE staff (including administrative and clerical support staff).<sup>1</sup> Under these circumstances, many MetroWest LHDs struggled to provide

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<sup>1</sup> MetroWest Health Foundation, personal communication, April 2021.

comprehensive public health services even before the pandemic. As a result, any effort to understand potential strengths and challenges facing LHDs must also engage other local government departments and the nonprofit sector. Consequently, NU-PEL designed a data collection strategy that would engage LHD directors, municipal management officials, and elected officials in the 25 communities across the region, as well as partners in other municipal agencies, healthcare institutions, and community-based nonprofits.

Although there are plentiful examples of cross-sector partnerships throughout the region including many projects supported by the Foundation, we know relatively little about how local officials view the benefits and barriers to collaboration. Some obstacles to collaboration are easy to identify, but not necessarily easy to address, such as time constraints, limited funding, or lack of material resources. Other barriers, however, may remain unrecognized, including mistrust and skepticism among potential collaborators, or a lack support by local elected officials for their LHD. Indeed, a survey of LHDs in Massachusetts conducted by researchers at the Boston University School of Public Health found that the single strongest predictor of whether a LHD was able to meet its statutory obligations was whether elected officials in that community understood what the key public health functions are (Hyde et al. 2012).

For a complex, large system of different stakeholders to work together successfully, strong communication pathways and high levels of trust are needed. The Foundation sought a needs assessment that would illuminate how various stakeholders perceive barriers and benefits to collaboration, and to assess their levels of trust in partnering organizations. The goal is to strengthen existing partnerships and identify opportunities for new collaborations that will fuel a coordinated, holistic approach in addressing health and well-being throughout the region. These findings have the potential to inform the foundation's future organizational and programmatic decisions.

## **B. National-level Trends and Challenges Facing Local Health Departments**

### ***i. Dwindling Budgets***

Although the US spends more than \$3.6 trillion annually on health, less than 3% of that funding is directed to public health promotion. Federal agencies with responsibility for public health (including the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Health Resources Services Administration) have received only modest funding increases over the past 20 years. The CDC's budget for the current fiscal year, for example, remains just above its level in fiscal year 2008 (after adjusting for inflation). Many states have mimicked Congress's habit of underfunding public health programs; 11 states slashed state health agency budgets between fiscal years 2019 and 2020 (Trust for America's Health 2020). While the Massachusetts legislature increased the state Department of Public Health's budget 9.6% in fiscal year 2019, there is no direct funding from the state health agency to LHDs in Massachusetts. Local health departments are funded out of a community's operating budget, largely supported by property taxes, and current LHD funding levels are inadequate to fully address the broad range of public health problems, even before the onset of the COVID-19 pandemic.

## ***ii. Aging and Shrinking Workforce***

Another major challenge facing state, county, and local health departments over the past decade is an aging and shrinking workforce. Between 2016-2019, the number of full-time staff people working in state health agencies shrank from 98,877 to 91,540 (Association of State and Territorial Health Officials [ASHTO] 2016). At the local level, LHDs lost an estimated 56,360 staff positions due to funding issues in the past decade. In 2017, 51% of large LHDs (defined as those serving >500,000 people) reported job cuts (ASTHO 2016). Job losses have been driven not only by funding cuts but also by retirements. A 2016 report by the Association of State and Territorial Health Officials (ASTHO) forecasted that as much as 25 percent of state health agency staff would be eligible for retirement by 2020 (ASTHO 2016). And perhaps not surprisingly, given these patterns, job burnout is a substantial problem. A 2017 survey of public health professionals showed large proportion of workers were considering leaving their organization in the next year, in part because of the pressure of having to do more with less, and in part due to inadequate pay. The COVID pandemic has only exacerbated these patterns (Stone et al. 2021).

## ***iii. Emerging Public Health Threats***

In this context, LHDs are hard pressed to address longstanding problems such as chronic disease prevention, communicable disease control, injury prevention, and environmental public health, let alone some of the emerging public health crises that have surfaced over the past decades, including an epidemic of opioid abuse, climate-induced crises such as smoke from wildfires, and vaping-related lung injuries. Nationally, our public health agencies at every level of organization (federal, state, county, and local) are fighting 21<sup>st</sup> century crises with 20<sup>th</sup> century resources. These emerging public health issues are also encroaching on MetroWest communities. Over the past five years, approximately 2000 people have died annually from opioid overdoses in MetroWest communities (Massachusetts Department of Public Health [MA-DPH] 2021). In the summer of 2019, the detection of Eastern Equine Encephalitis in MetroWest communities discouraged many people from exercising outdoors.

## ***iv. Accreditation***

Over the past decade, there has been a growing national movement to accredit LHDs. Accreditation helps to assess an organization's capacity to carry out essential functions and meet its mission. Accreditation allows public health departments to demonstrate that they meet standards established by the Public Health Accreditation Board (PHAB). Although there are presently only three LHDs in the Commonwealth that are accredited (e.g., Boston, Cambridge, and Worcester), there has been a steadily increasing trend of LHDs becoming accredited nationally. According to the US Department of Health and Human Services, accreditation of health agencies has jumped from 13.4% in 2019 to 14.6% in 2021 (Healthy People 2030). Accreditation may soon become an expected best practice for LHDs, and elected officials and LHD personnel would do well to begin learning more about the benefits of accreditation and to familiarize themselves with the process of becoming accredited. Appendix B of this report contains more information about accreditation.

### **C. Public Health Infrastructure and Challenges Facing MetroWest**

The current public health infrastructure of MetroWest includes a multi-sector network of providers of clinical services, human and social services, municipal health departments, and local and regional non-profit agencies. These agencies provide services to MetroWest individuals and families across the following 25 communities: Ashland, Bellingham, Dover, Framingham, Franklin, Holliston, Hopedale, Hopkinton, Hudson, Marlborough, Medfield, Medway, Mendon, Milford, Millis, Natick, Needham, Norfolk, Northborough, Sherborn, and Southborough.

A comprehensive Community Health Assessment (CHA) conducted by the Foundation in 2019 identified several barriers in accessing clinical services, including long waits for an appointment, the cost of care, a lack of providers who are accepting new patients, and unfamiliarity with the array of medical services available. Due to the limited availability of in-person and telehealth services, access to healthcare services—especially for behavioral health services—is a major issue. These inadequacies of the clinical care delivery system are exacerbated by shortcomings in supportive services. For example, there is a lack of “off-peak” or late-night transportation services. Additionally, as many health-care services have pivoted to telehealth platforms, inequities in technology and health literacy have become more salient in exacerbating existing health inequities in the region. The 2019 Community Health Assessment (CHA) MetroWest report found that the health concerns perceived to have the largest impact on the community from 2013-2019 were overweight/obesity, aging problems, and mental health issues (MetroWest Health Foundation 2019).

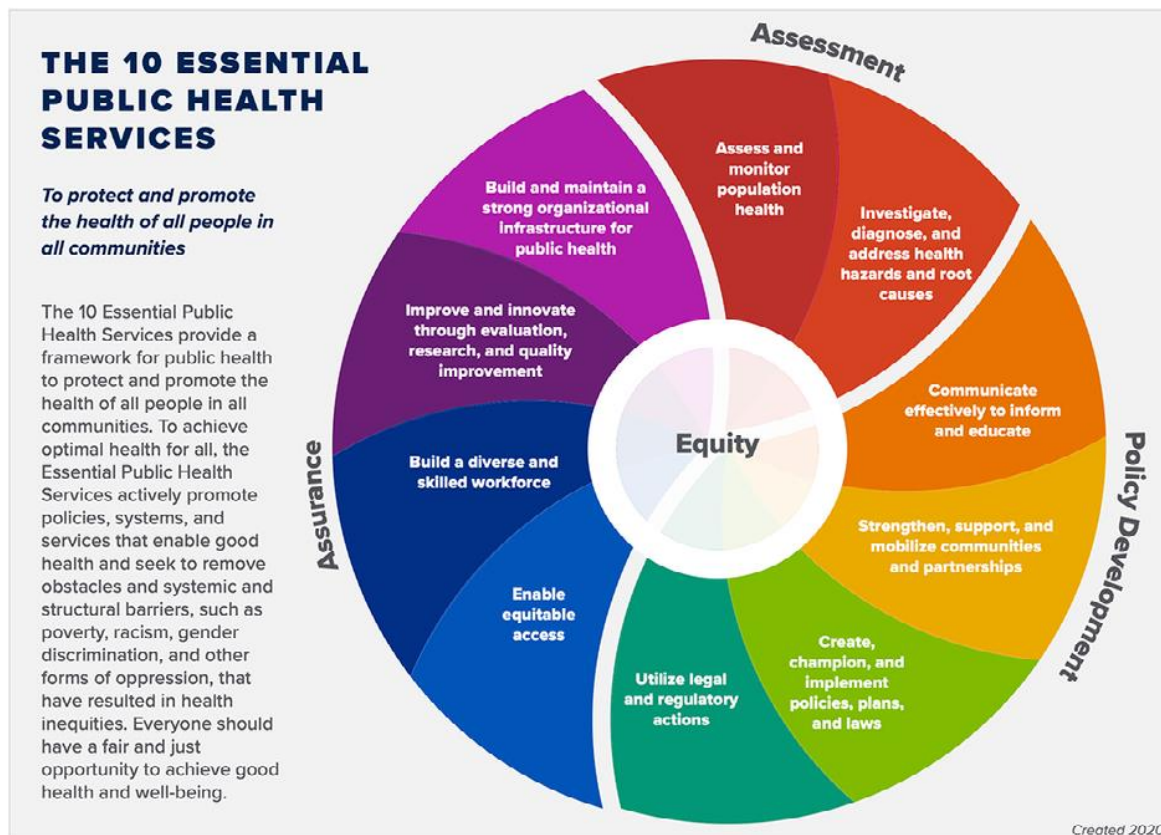
These inequities have, of course, been exacerbated by the COVID-19 pandemic. According to data maintained by the Foundation, Marlborough, Hudson, Framingham, Milford, and Northborough had the highest COVID-19 incidence rates, in addition to having highest percentages of uninsured residents, foreign-born residents, households below poverty level, and residents who speak languages other than English at home (MetroWest Health Foundation 2021). Residents of these communities were also more likely to be “essential workers” or work in service sector jobs, where working from home was not feasible during the pandemic. Unemployment increased substantially in all 25 communities during 2020, driving more households to rely on social services agencies for support. As financial hardships have soared, many residents (especially those who identify as a member of a racial or ethnic minority) have reported high burdens of psychological distress. In the Foundation’s 2019 Community Health Assessment, residents and providers throughout the region reported difficulty in finding bilingual facilitators and providers, and the pandemic has exacerbated this.

## D. Public Health Frameworks and Models for Potential Solutions

### i. *Organizing Visions for Public Health Systems*

A robust public health infrastructure should encompass diverse functions, known as the Ten Essential Public Health Services, typically organized around three core areas of assessment, assurance, and policy development (Figure 2).

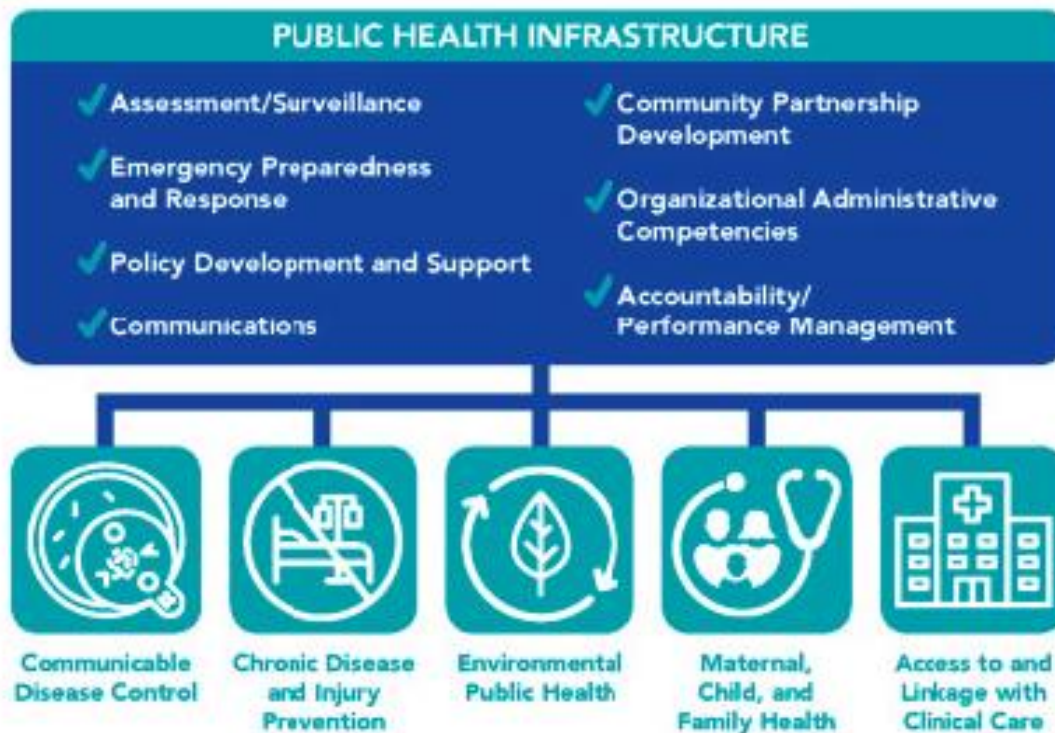
Figure 2. The Core Public Health Functions



SOURCE: <https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html> and the Public Health National Center for Innovations.

In 2012, a working group sponsored by the National Academies of Science, Engineering, and Medicine further refined the typology of core public health functions, to make explicit that a robust department should not only be able to perform certain key functions, it should also have expertise across five major health issues (Figure 3).

Figure 3. Public Health Foundational Capabilities (*DeSalvo et al. 2021*)



## ii. ***Public Health Systems—A Collective Good and a Collective Responsibility***

In addition to being responsible for monitoring population health, enforcing compliance with sanitary codes, and educating the public about health topics, LHDs also frequently act as conveners, building community partnerships that can be powerful forces in combating multifaceted population health problems (DeSalvo et al. 2021). Local health departments nationally and in MetroWest play a pivotal role in their communities, building partnerships and collaborations to tackle public health challenges in a holistic way. A recent example of public health partnerships and collaboration is the Tobacco Control Through a Regional Collaborative funded project in the MetroWest (MetroWest Health Foundation Year End Report 2022). The lack of funding at all levels of government, however, hobbles health departments from meeting their collaborative mission, and thus denies our communities the benefits that could be gained from comprehensive public health programming. An even more robust public health infrastructure at the local level could help LHDs leverage partnerships more broadly, resulting in improvements in population health and reducing healthcare spending.

In the earliest days of the pandemic, a report by the Trust for America's Health argued forcefully that we must, as a society, muster the political will to invest in public health infrastructure. Their report identified four specific priorities: 1) increase funding to strengthen the public health infrastructure (including workforce development and modernizing system-level surveillance and data capacities); 2) invest in chronic disease prevention and suicide prevention

activities; 3) improve preparedness so that agencies can respond more effectively to a range of crises such as infectious disease outbreaks or climate-related emergencies; and 4) address social determinants of health, with special focus on monitoring for health inequities and taking action to remediate them (TFAH 2020).

The team at NU-PEL, in collaboration with Foundation staff took the Trust for America’s Health recommendations into account in designing the data collection strategy for this needs assessment. Our needs assessment embraced both the Core Public Health Functions and the Foundational Capabilities.

### **iii. Cross-Jurisdictional Sharing**

In response to the challenges they face, health departments at all levels of government across the country have begun sharing resources. A 2016 report by ASTHO found the proportion of state health departments sharing resources with other states rose from 9 to 27% between 2012-2016, and a 2019 report by the National Association of City and County Health Officials found that 55% of LHDs engaged in some type of cross-jurisdictional sharing (ASTHO 2016; NACCHO 2019). Because of Massachusetts’s cherished tradition of home rule, however, cross-jurisdictional sharing is a bit less common here than in other parts of the country. The tradition and mythology of Yankee independence can, however, cloud recognition of several successful regional collaborations in the Commonwealth. Approximately 1.25 million Massachusetts residents (about 23% of the overall population) are already served by one of 15 regional public health districts (PHDIG 2015).

While there is a great deal of heterogeneity in how communities may structure and administer shared services, it is possible to sort them into four general categories (Figure 4). The most informal type of arrangement has towns providing “as needed” assistance to one another, often by sharing equipment, staff time, or expertise on an ad hoc basis. The next step up is “service-related arrangements,” where communities will establish a Memorandum of Understanding (MOU) to provide services such as immunization clinics or assisting with restaurant or septic inspections. A more formal arrangement would entail “shared programs or functions,” where communities may band together to offer health promotion programming on a specific problem (e.g., HIV control), or for a shared capacity (e.g., hiring an epidemiologist to serve multiple communities). The highest level of integration is seen in regionalization, in which several health departments will merge to create a new organizational entity.

Figure 4: Four General Kinds of Cross-Jurisdictional Sharing Arrangements (Center for Sharing Public Health Services)

Category 1	Category 2	Category 3	Category 4
“As Needed”	Service-related Arrangements	Shared Programs or Functions	Regionalization

*\*Increasing in structure and formality*



In 2010, the Massachusetts Department of Public Health offered grants to communities to experiment with cross-jurisdictional sharing arrangements, with a special focus on encouraging collaborations in Categories 3 and 4, Shared Service Districts or Comprehensive Service Districts. This project resulted in a wealth of pragmatic advice and best practices that could inform future

collaborative efforts. It also demonstrated persuasively that the participating communities reaped many benefits, including not only an increased capacity for meeting essential public health services but also increased success at securing external grant funding, augmenting the amount of funding the individual municipalities had budgeted to support public health services (PHDIG 2015).

Collaboration allows for a greater potential for equitable protection for population-level health outcomes. The benefits of collaboration may include:

1. Improved consistency and equity in services that are provided to towns and districts. In equalizing the delivery of health services and goods, the communities involved can better their health outcomes.
2. Access to a broader range of services and expertise than available in one individual health department which can allow communities to have greater knowledge and expertise in tackling different areas of public health. Increased access to better, qualified staff and services, which can help communities achieve performance standards for accreditation.
3. Improve the impact of health departments on their community and surrounding areas with limited resources.
4. Have a greater chance of receiving opportunities to better the health department and public health goods and services.
5. Avoid municipal liability for health problems arising from unmet responsibilities.

Although it is true that there are some obstacles and challenges in migrating to a shared service system, it is also true that remaining independent has serious drawbacks. Appendix A has more information about models and governance practices that can structure cross-jurisdictional sharing and provides examples of current or recent cross-jurisdictional partnerships in the MetroWest region, the Commonwealth of Massachusetts, or elsewhere.

### III. DATA COLLECTION AND METHODS

To understand the challenges and opportunities for public health partnerships and collaborations in the MetroWest Region, NU-PEL researchers devised a mixed-methods data collection strategy to gather information on public health systems in all 25 MetroWest communities. Informed by the principles of Community-Based Participatory Research (CBPR) the NU-PEL research team worked with the MetroWest Health Foundation team to develop an interview protocol that recruited important community figures in a subset of 10 communities, and an online survey that engaged stakeholders in all 25 communities.

#### A. Surveys

The team designed the survey to identify and understand strengths and areas of growth within the existing public health infrastructure of the MetroWest communities, priority areas of concerns, community engagement practices, perceived benefits of collaboration, and levels of trust among collaborators. To the extent possible, we adapted survey items from existing, validated scales (Wells et. al, 2021). For example, questions about trust were adapted from surveys used in an ongoing study conducted by Northeastern University, MIRA (Massachusetts Immigrant and Refugee Advocacy Coalition), and the MA ACLU (American Civil Liberties Union). Because the pandemic has been so disruptive, the survey asked respondents to reflect on and report on partnerships and collaborations they had engaged in during 2019, rather than focusing on the past year.

We sent a link to a Qualtrics survey to 97 individuals across the 25 communities. The survey questionnaire comprised 39 items, which included 10 free-response questions. Between July 19 and July 30, we received a total of 45 responses. After cleaning the data, eliminating duplicate surveys, and checking for missing data, we retained 28 responses in the analyses reported here. The small number of surveys returned, and the low response rate prevent us from applying any sophisticated statistical analyses. In this report, we provide frequencies and percentages from the survey data. All analyses were conducted in SPSS.

Every municipality within the region was represented by at least one respondent in the survey, with the exception of Mendon and Norfolk. The largest percentage of respondents worked in Framingham (35%), Natick (27%), Milford and Sudbury (both 19%). A considerable proportion of participants (40%) represented LHDs, while 21% worked at human service organizations, 10% at charitable organizations, and 10% at schools. The remaining respondents worked at a range of other organizations, such as healthcare organizations and local governments. Most respondents held a leadership role in their organization and had considerable institutional experience. Nearly 70% held the title of director and 84% managed a team in their work. Nearly a third had been with their organization for 6-10 years, and an additional 45% had been there for more than 10 years.

#### B. Qualitative Interviews: Design, Recruitment, and Analytic Approach

To gain an in-depth understanding of how people in MetroWest communities view the potential power of partnerships and collaborations, the NU-PEL research team worked with the Foundation team to develop an interview guide and recruitment strategy.

We employed a purposive recruitment strategy, to focus on recruiting interviewees from five towns (Table 1). We began by reaching out to the LHD directors in Framingham, Marlborough,

Milford, Westborough, and Northborough, and then sought additional interviews with leaders in those communities, including elected and appointed officials, school health personnel, and leaders of community-based nonprofits. We focused our interview efforts on these communities to capture variation across the region with respect to community size, demographic characteristics (e.g., poverty levels, racial and ethnic diversity), and to seek representation from communities with the most serious health inequities or that have been hit hardest by the COVID-19 pandemic. We augmented this interview strategy by conducting interviews with seven people in Ashland, Natick, Needham, Sudbury, and Wayland.

We also conducted 4 interviews with key informants—experts at state and federal public health agencies and academic public health researchers, to better contextualize our findings in MetroWest relative to state and national trends.

The interview guide elicited information about recent experiences with collaborations (both positive and negative) and included scenarios that we designed to assess receptivity to varying possibilities for collaborations. We tested a draft of the interview guide in a pilot interview with an official from an LHD that did not fall into our sampling frame.

Between August 2021 to October 2021, we conducted 29 virtual interviews via a HIPAA-compliant Zoom platform. All interviews were transcribed verbatim. To extract common themes from the interviews, we developed a codebook that extracted what interviewees had to say about the benefits and drawbacks of the eight scenarios, and what they had to say about recent experiences with collaborations.

## **i. Scenario-Based Interviews**

Our interview guide showcased eight hypothetical scenarios, to understand what has made collaborations successful or difficult, to identify factors that built or inhibited trust among this group of stakeholders, and to identify the potential for new partnerships. Scenario-based interview designs are commonly used in public policy research (Vollmar et al., 2015; Jackson et al., 2015; Reeder & Turner, 2011; Wollenberg et al., 2000) and present respondents with scenarios or stories. Scenarios typically are constructed to assess the relative desirability of possible future conditions. Questions and follow-up probes invite respondents to thread key decisions, events, and consequences throughout the scenario narrative (Vollmar et al., 2015). Responses to scenarios serve as critically important input for strategic planning in public health, helping practitioners to mitigate or eliminate the element of surprise and improve communication between stakeholders (Veneble et al., 1993).

We designed our scenarios to test receptivity toward a variety of cross-jurisdictional sharing arrangements and cross-sectoral partnerships (Table 2). We made sure that the eight scenarios we developed engaged as many of the Essential Public Health Services as possible (Figure 2), as well as each of the health conditions identified in the Foundational Capabilities (Figure 3). For purposes of the interviews, we defined collaboration as cooperation between organizations within or across communities with a goal of improving a common public health issue or goal. Scenarios #1, #2, and #3 address the potential for streamlining public health by allowing communities to share services regionally, among a minimum of three towns. These scenarios assessed receptivity to a variety of cross-jurisdictional sharing arrangements. Scenarios #4, #5, and #6, presented examples of cross-sector partnerships that were designed around specific public health topics, and which might engage stakeholders across multiple communities or within a single

community. Scenarios #7 and #8 were developed to assess support for and interest in collaborations that would ameliorate underlying fundamental causes of health inequities, either by providing clinical services or by addressing social determinants of health. The interview guide specifically invited respondents to express support for scenarios, as well as asking questions about how partnerships could be structured to ensure their success. For example, we asked questions about whether or how it might matter which type of agency took the lead in a partnership.

Table 1: Hypothetical Scenarios Motivating the Qualitative Interviews

Scenario	Description
1. Collaboration Between Towns (Specific Services)	Shared service arrangements through formalized collaborations between two or more towns to share responsibility for responsibilities of local health departments (e.g., food inspections, tobacco compliance, emergency preparedness).
2. Collaboration Across the Region (Specific Health Promotion Topic)	Several towns collaborate to hire a regional coordinator to support program planning, delivery, and evaluation related to a specific health education topic (e.g., smoking cessation, sun protection, injury prevention).
3. Collaboration to Create Comprehensive Service Districts Within the Region	Develop comprehensive service districts where all local health department functions are carried out by a single entity serving two or more municipalities.
4. Single-Community Cross-Sector Partnership	A local health department partners with local agencies and community organizations to tackle a specific public health issue in their community (e.g., local health department collaborating with law enforcement agencies and community groups on Narcan distribution).
5. Single-Community Cross-Sector Partnership	Local health department partners with local farms and food banks or public housing agencies to organize farmer's markets and improve access to fresh foods.
6. Local School Health Coalition	Local health department partners with local school district to provide education and programming for child and adolescent health (e.g., STD prevention, substance abuse, teen reproductive health).
7. Regional Clinical Partnership	Local health department partners with hospitals or health clinics and other community organizations to provide accessible clinical services.
8. Regional Partnership to Improve Social Determinants of Health	Local health departments partner with municipal agencies, school districts, community groups to improve educational attainment, housing security, or job training throughout the region.

## IV. FINDINGS

### A. Demographics of Survey Respondents

Survey respondents worked at a range of organizations across the MetroWest region. Of the 28 respondents who participated in the survey, 11 worked at LHDs, six worked at human service organizations, three at charitable organizations, and three at schools. The remaining respondents worked at a range of other organizations (e.g., community health centers, city councils or select boards).

Table 2: Survey Participants by Organization Type

<b>Organization</b>	<b>Number of Respondents</b>
Local Health Department	11
Human Services Organization	6
Charitable Organization	3
School	3
Other	5

The vast majority held full-time positions (n=22) and most respondents occupied a leadership role in their organization, with 18 serving as a director and one as a manager. Three respondents were administrators, while the remaining respondents worked as an at-large city councilor, a health officer, coordinator, health department board member, and public health nurse. Many respondents had been working at their current organization for a significant length of time. Six had been at their organizations for between six and 10 years and 12 had been at their organizations for over 10 years. Only three respondents were with their organizations for two or fewer years.

Figure 5: Length of Time Working for Current Organization, All Survey Respondents



Table 3. Survey Respondents, by Organization Size

<b>Number of People in Immediate Department</b>	<b>Number of Respondents</b>
1 to 10	15
11 to 20	6
21 to 30	0
31 to 40	1
41 to 50	3
More than 50	2

Most respondents worked in small to moderate sized departments within their organizations, with 15 working in departments with 10 or fewer people and six working in departments with between 11 and 20 people (Table 4).

All towns across MetroWest were represented by at least one respondent in the survey, except for Mendon and Norfolk (Table 5). The largest number of respondents worked in Framingham (n=9), Natick (n=7), Milford (5) and Sudbury (n=5).

Table 4. Survey Respondents by Town

<b><i>Towns Represented</i></b>	<b><i>Number of Respondents</i></b>
Framingham	9
Natick	7
Milford	5
Sudbury	5
Hudson	4
Marlborough	4
Southborough	4
Wayland	4
Ashland	3
Holliston	3
Hopkinton	3
Medway	3
Sherborn	3
Dover	2
Franklin	2
Medfield	2
Needham	2
Northborough	2
Wellesley	2
Westborough	2
Bellingham	1
Hopedale	1
Millis	1
Mendon	0
Norfolk	0

## **B. Survey Findings on Partnerships and Collaborations**

In the survey, partnerships and collaborations were defined as cooperation between or within organizations that have worked together on a common public health issue or goal in the MetroWest region.

### ***i. Areas of Strength***

**Partnerships and Collaborations are Commonplace.** Survey respondents reported that partnerships and collaborations were commonplace, with 86% having participated in at least one during 2019, the year before the COVID-19 pandemic began.

**Partnerships are Viewed as Productive and Beneficial.** Most survey respondents viewed previous partnerships as useful and valuable. Many survey respondents (83%) felt their collaborations in 2019 had been highly productive in relation to its goals, 86% felt their organization benefited from participation, and 90% agreed or strongly agreed that its accomplishments would have been difficult for any one single organization to achieve alone.

**High Levels of Mutual Respect, Commitment, and Trust Amongst Partners.** Survey respondents also reported high levels of mutual respect, commitment, and trust across partnerships. Of those who participated in a collaboration in 2019, all but one person agreed or strongly agreed that their partners exhibited a high level of commitment and 95% of respondents agreed that all members of their group wanted the project to succeed.

Every respondent who completed the survey item agreed or strongly agreed that they had a lot of respect for others involved in their collaboration. Further, 88% felt partners were supportive of each other and nearly 80% agreed or strongly agreed that all partners' contributions were valued equally, whether or not the majority agreed with their view. No respondents agreed with the statement that sharing new ideas or areas for discussion was not welcomed among partners. Most survey respondents also reported little mistrust in their collaborations, with 90% disagreeing or strongly disagreeing that there was mistrust present among partners.

**Good Communication and Flexibility Amongst Partners.** The survey data also suggests no major barriers to successful partnerships emerging from communication styles or flexibility of collaborative work approaches. For example, 85% of survey respondents agreed or strongly agreed that people communicated openly with one another, 80% agreed or strongly agreed that they were informed as often as they should have been about what went on in the collaboration, and 95% agreed or strongly agreed that the people who led their collaboration communicated well with its members. Further, survey respondents largely had positive perceptions of their collaborations' openness when it came to various approaches to work. Over 80% agreed or strongly agreed that there was a lot of flexibility when decisions were made and that people in the partnership were opened to discussing different options. Nearly 86% indicated people in their collaboration were open to different approaches to how they could do their work and were willing to do consider different ways of working. Only one survey respondent disagreed with the statement that people involved in their collaboration were willing to compromise on important aspects of the project.

## *ii. Areas of Growth*

**Over a Third of Respondents Find Partnerships Challenging.** Despite the largely positive perceptions of previous collaborations, approximately a third (35%) of survey respondents nevertheless found working in a partnership challenging. Additionally, though 86% percent of respondents felt they had benefited from a partnership in 2019, there was a substantial decline in collaborative activity within towns (55% of respondents) and across towns (53% of respondents) since the onset of the pandemic.

**A Lack of Resources Undermines Partnerships' Abilities to Achieve Goals.** Another challenge to partnerships identified by some survey respondents surrounds the inadequacy of available resources, especially funding, staff, and time. Approximately 25% of survey respondents felt that a lack of funding prevented their collaborations from accomplishing its goals. Over 40% indicated that their partnerships did not have enough 'people power,' or staffing capacity, to achieve what they had set out to do. One survey respondent wrote, "The overall [problem] is staffing capacity and funds. Most are willing to collaborate with others if there is a direct benefit to themselves or their agency." Finding the time needed to facilitate partnerships also appeared to be an area of difficulty. While 85% of respondents felt their partnerships took on an appropriate amount of work at a conducive working pace, only 60% of survey respondents agreed or strongly agreed that they were able to keep up with the work necessary to coordinate all the people, organizations, and activities related to collaborations. In a similar vein, only 67% of survey respondents agreed or strongly agreed that when their collaborative group made important decisions, there was always enough time for members to take information back to their own organizations to confer with colleagues.

**Recruiting Necessary Stakeholders as Partners is a Challenge for Some Respondents.** Recruiting needed stakeholder organizations as partners in collaborations was also an issue for a considerable portion of survey respondents. When asked the extent to which they agreed with the statement, "All the organizations that we needed to be members of this collaboration became members of the group," nearly 40% disagreed and over 14% neither agreed nor disagreed. In other words, less than half of respondents were able to secure the participation of organizations needed to accomplish the goals of collaborative efforts. When asked the extent to which they agreed that people in the community thought the organizations involved in their partnerships were the ones most suited for the work, only 57% of survey respondents agreed or strongly agreed and 43% reported ambivalence by selecting neither agree nor disagree. Difficulty recruiting necessary

stakeholders may shape community perceptions of the likely success of collaborations, which may in turn impact the willingness of potential partners or stakeholders to offer their support in future endeavors.

**Lack of a Centralized Infrastructure to Facilitate Collaborations Across Towns was a Barrier for Some Respondents.** Though the survey did not specifically ask about the organizational structure of LHDs in the state or the region, five respondents noted in open response questions that the lack of a regional infrastructure for public health resulted in what one respondent called “fractured local systems” that are unable to pool resources and coordinate efforts. Three respondents specifically noted the absence of regular opportunities for public health organizations to meet and discuss issues, identify gaps, and collaborate on innovative solutions. One respondent also noted that the Massachusetts Department of Public Health’s funding strategy is typically tied to a single municipality, which further hinders collaborations across communities.

### *iii. Areas of Support Needed*

Survey respondents highlighted multiple areas where they felt support was needed to accomplish their public health goals. The central areas of need identified by survey respondents involve the public health workforce, funding, stakeholder engagement, and a regional infrastructure to facilitate collaboration.

**Public Health Work Force.** The execution of public health objectives is dependent on an adequately funded and trained workforce. Survey respondents pinpointed three problem areas that currently undermine their organizations’ public health efforts.

- **Staffing Capacity.** When asked to plan for the next five years, more staffing capacity was one of the types of support most frequently cited by respondents from most organization groups, tied with greater funding for preventative health programs, as discussed below. As noted above, survey respondents reported that a lack of staffing capacity undercut the success of previous collaborations.
- **Staff Retention.** Across all respondents surveyed, approximately 55% of respondents surveyed intend on leaving their organization within the next five years. Staff retention appears to be a particularly pressing issue for LHDs, with nearly half of respondents from LHDs planning to leave in two years or less and about three quarters in five years or less. One possible explanation may surround dissatisfaction with career advancement opportunities. Nearly three quarters of respondents across all organization types felt there were insufficient opportunities for themselves at their current workplace.
- **Workforce Development and Training.** Approximately half of respondents surveyed had formal public health training in their careers (e.g., Bachelors, Masters, or Doctoral degrees in public health, professional certifications, continuing education courses) while half did not. Further, though 71% felt their team had adequate skills for the job, only 42% of respondents thought their team had adequate formal public health training. Of the survey respondents that elaborated on the additional skills they felt their teams needed, 29% listed more public health program specific skills (e.g., food inspections, soil testing) and 43% listed broader skills that encompass the core public health functions (e.g., program development and implementation, program evaluation, conducting public health research).

Additionally, three quarters of respondents felt they needed support in the next five years to develop greater cultural and linguistic competencies among their workforces.

**Funding.** Over 80% of survey respondents said they needed greater funding specifically for core preventive public health programs such as immunizations and diabetes prevention. Funding for preventative public health programs was an especially important area of need for LHDs, with every respondent from an LHDs stating it was a need. Additionally, three quarters of all survey respondents said they needed greater funding and real-time surveillance data for public health emergency and preparedness.

**Stakeholder Engagement.** As noted above, 40% of survey respondents did not feel their previous partnerships included all the organizations necessary to accomplish the partnerships' goals. When asked which types of stakeholders they needed support from in the future, survey respondents most frequently mentioned town officials (83%), the local Board of Health (79%), town residents (67%), the LHD (63%), and finally, the choice coalition coordinator (33%). Survey respondents also indicated they would need greater support from the state (both the Massachusetts Department of Public Health and the state legislature), faith-based organizations, community-based organizations, foundations, other non-profits, and local hospitals.

**A Regional Infrastructure to Facilitate Collaboration.** As noted above, on a free-response question where survey respondents were invited to list additional needed areas of support, five respondents expressed a desire for a centralized infrastructure across towns, to encourage collaboration, streamline efforts, and pool resources. Two respondents specifically pointed to the need for a "convenor" to bring public health organizations throughout the region together on a recurrent basis. One respondent further elaborated that the convening organization should be one that is eligible for both state and federal funding, such as a regional planning council.

### C. Demographic Data of Interviewees

Table 5 shows the characteristics of our interviewee respondents, by community and by type of organization.

Table 5: Qualitative Interview Respondents

<b>Category of Respondents</b>	<b>Number</b>
<i>Framingham, Marlborough, Milford, Westborough, and Northborough</i>	
Health department director (or their designee)	5
Other (elected officials, school department partners)	6
<i>Ashland, Natick, Needham, Sudbury, Wayland</i>	
Health department personnel, elected officials	7
<i>Regional Institutions</i>	
Hospitals, health centers, human service agencies	7
<i>Key Informant Interviews</i>	
Officials in state or national public health agencies and academic researchers	4
<b>TOTAL</b>	<b>29</b>

In what follows, we have masked the identity of our interviewees. Some interviewees did not feel comfortable expressing views on collaboration that could be politicized, taken out of context, or used against them.

#### D. Scenario-Based Interview Findings

##### SCENARIO #1: Collaboration Between Towns

*Shared service arrangements through formalized collaborations between two or more towns to share responsibility for responsibilities of local health departments (e.g., food inspections, tobacco compliance, emergency preparedness).*

**Health department staffers were concerned about the feasibility of this scenario because towns or cities might have place-specific inspectional requirements, and it would be cumbersome to hire and train inspectors who would be conversant with each city or town's requirements.** For example, although state law says that restaurants must meet a minimum set of sanitary criteria, towns and cities can impose additional requirements. Sharing inspectional services across municipalities may be more attractive for smaller communities, however, which have fewer camps, pools, and restaurants than larger cities, which may have enough establishments to warrant hiring a full-time employee to monitor them. **Health department personnel also pointed out that a regional coordinator may be strained by having multiple "bosses,"** in the sense of reporting to LHD directors, boards of health, and town managers in multiple communities. Establishing lines of reporting and communication would be crucial for success.

**In contrast, elected officials expressed some cautious interest in this type of shared service arrangement.** Some elected officials viewed these multi-town arrangements as practical, especially in smaller communities, where it may not be financially possible to support a team of full-time employees, each of whom has expertise in a specific area. Additionally, elected officials recognize that pool and camp inspections are seasonal, meaning that a community may not need a full-time employee all year. A few elected officials saw regionalizing emergency preparedness as sensible, since many kinds of emergencies (e.g., winter storms) impact multiple communities. At the same time, however, **elected officials expressed concern that entering a shared service arrangement for emergency services might mean that the needs of other communities get prioritized,** and that their town's needs may not be met in a timely fashion.

Some of these **concerns would be alleviated by carefully crafting formal agreements to structure such partnerships,** spelling out how individual towns would have oversight over the staff members conducting the inspections, for example, and **allowing towns to end such agreements if they felt their needs weren't being met.** One elected official believes strongly that such arrangements are feasible, but shared:

*"We need to put in place a service level agreement [SLA] or quality of service metrics, right? Before coming together, you must have consensus on how are we going to measure success? How are we going to hold people accountable? And what are we entitled to as a contributing community? So, if we don't put those SLAs in place, then there's no way for you to objectively have a conversation saying you're underperforming or you're putting too much attention to this community and not enough attention to that community."*

A proposal to share inspectional services across communities may **raise worries among business owners**, especially small business owners, who have developed individual working relationships with LHD personnel. As one health department staffer shared,

*“Food is the only [service] that [we’d be skeptical about] ... it’s local business’s nature. You may want to keep that function more local. [Business owners] want to know the person that they need to call.”*

**If inspections are not carried out smoothly under a shared service agreement, businesses may be negatively impacted.** This concern could be alleviated by monthly or quarterly drop-in hours, where business owners or town representatives can meet with regional inspectors to discuss concerns, unmet needs, or strategies to improve service quality.

**Regional shared service districts can generate capital needed to pay a qualified and competent coordinator.** Health department staffers pointed out that inspector positions tend to have a high turnover rate. Collaborating might make it possible to offer a regional coordinator higher pay or better benefits, improving retention and allowing an inspector to develop proficiency and sustain quality of services above what towns are currently experiencing. To ensure sustainability of such endeavors, it would be critically important to ensure that funding for a regional coordinator was directly allocated by participating communities, rather than grant-funded.

SCENARIO #1
Key Findings
<ul style="list-style-type: none"> <li>Health department staffers point out the complexities of training and supervising a regional coordinator who could adequately meet the needs of specific towns.</li> <li>Elected officials are interested in the possibility of some shared inspectional services agreements or emergency preparedness, provided that participating communities are treated equitably.</li> </ul>

## SCENARIO #2: Collaboration Across the Region

*Several towns collaborate to hire a regional coordinator to support program planning, delivery, and evaluation related to a specific health education topic (e.g., smoking cessation, sun protection, injury prevention).*

Of the three regional collaborations we tested in our interviews, this one garnered the most interest from health department personnel, town administrators, and elected officials. **Health department personnel reported that staying in compliance with compulsory environmental health activities and required inspections often eclipses health education and promotion activities that are not obligatory.** As one town health department director stated:

*“I think every town wants someone to tell their residents to wear sunscreen, use bug spray, and wear long pants when you’re walking through the woods, so you don’t get ticks. ... So, if [that messenger is] someone in my town, my employee, or my health division’s employee, that’s great. But if it’s a collaboration when it’s a different logo or something, there’s still value in that. I think people feel less threatened because it’s a fairly innocuous message that most people think is positive.”*

In a few instances, interviewees expressed fear of losing competent staff who have loyally served the local community. But overall, health department staffers did not view this as a threat to their professional autonomy or a detriment to their departments.

**Most respondents also viewed this as a low-stakes endeavor.** Because health education is typically not compulsory or time sensitive, it will not negatively impact the community if a partnership turns out to be unsuccessful. Several interviewees mentioned a recent successful collaboration funded by the MetroWest Health Foundation that brought together nine communities on a tobacco control initiative. Successful partnerships in regional health promotion can act as stepping stones, to increase interest in and support for future collaborations within the region.

**Several interviewees recognized the potential for cost savings in this strategy.** Town administrators and health department staffers believe that it may be possible to save money by hiring a qualified health education professional or public health nurse to provide health education and outreach across multiple towns. It may also be possible for towns to pool resources and develop health education campaigns on common issues. Most health department staffers could readily identify potential partners (e.g., other town departments, faith-based groups, community non-profits) who already have the trust of local residents, and who could contribute expertise to developing materials or bolster dissemination by connecting with their constituencies. **Interviewees did say, however, that they would like a designated liaison in each town who could relay concerns, suggestions, and feedback to the regional coordinator.**

Although overwhelmingly positive, a minority of interviewees pointed out that **towns do sometimes have unique health promotion needs.** Preferred methods of health promotion and health communication may differ from town to town. A regional coordinator may be overburdened or unable to properly meet the needs of each community they are serving. Some communities are proud of health promotion programs they have in place and may not want to relinquish control of programs they have built from the ground up. Finally, some health directors expressed concern about onboarding a regional coordinator and that they might incur financial burdens or duplication of effort if they also had to continue paying a local staffer throughout the transition.

SCENARIO #2
Key Findings
<ul style="list-style-type: none"> <li>Many local leaders find this scenario attractive, especially if it frees up health department staff to focus on compulsory activities and results in savings by hiring a regional coordinator to serve multiple towns.</li> <li>Many health department staffers believe it is possible to develop health promotion materials and methods to address health challenges that are common across multiple communities.</li> <li>Health department staffers could readily identify partnering organizations to collaborate on such ventures or local health experts who could help develop materials.</li> <li>Health department staffers might benefit from consultation with experts on developing novel dissemination channels (e.g., social media).</li> </ul>

### SCENARIO #3: Service Districts within the Region

*Develop comprehensive service districts where all local health department functions are carried out by a single entity serving two or more municipalities.*

**The key informants (experts at state and national agencies and academic researchers) we spoke with emphasized the multiple benefits of shared service arrangements.** First, they allow communities to attract and retain a highly skilled, specialized, and professionalized workforce at the district level. In the words of one expert:

*"it allows the hiring of people with more specialized skills. If you've got five towns that each have one person, and then they pull together into a single area you could have an epidemiologist full-time... a full-time educator... a full-time community sanitation person, and an infectious disease nurse. I mean, you could really pull together a team of people where each one of them has a certain beat and focus with a good deal of experience and skill."*

Second, key informants emphasized that **regionalizing public health services can save money and reduce redundancy** across the district. This would allow communities to re-direct money to better address local needs and priorities. A regional service district may help municipalities establish a policymaking voice at the regional or state level. Research has also shown that communities with cross-jurisdictional sharing are more competitive when applying for state and federal grants, thus increasing the funding flowing into a region for public health services (PHDIG 2015).

In contrast, **nearly all the health department staffers and elected officials we interviewed were hesitant, some even hostile**, to entertain thoughts of a comprehensive service district. Moreover, there was a **very poor understanding about the variety of ways shared service arrangements could be structured**, and great **confusion about how and whether sharing services would affect the local Board of Health, the LHD, or both**.

**Larger and wealthier towns are proud of the quality of public health services they currently offer and fear that smaller communities or towns with less capital would not pay their fair share in a comprehensive service district.** Health department staffers and elected officials would not want their residents to miss out on the quality of public health services they currently enjoy. Elected officials and town administrators worried greatly that their community may not get enough attention from a regional district. Public health leaders do not want to be forced to collaborate with towns who may have been difficult partners in the past. Despite a potential for efficiency and savings, elected officials and town administrators are reluctant to yield responsibilities that local residents have entrusted to them.

**Both elected officials and health department staffers believe that transitioning to a comprehensive shared service district would make it harder to manage human resources.** Elected officials and town administrators expressed concern that a regional district would limit their capacity to hire and fire. Additionally, each town has different hiring practices, as well as distinct collective bargaining agreements with labor unions, which might be affected by efforts to share staff or pool functions across communities. Moreover, if towns are on different schedules with respect to negotiating their collective bargaining agreements, that could become an obstacle in initiating a comprehensive service district. Finally, some health department staffers (especially in larger communities with larger health departments) believe that regionalization might remove

opportunities for promotion, professional advancement, and retention for their staff. They claimed that regionalization does not honor the loyalty and hard work of employees or elected officials who have served their community.

**Some of the elected officials we interviewed harbored a misconception that collaboration would, by definition, minimize their ability to choose to invest in what they think is best for their community.** If the town loses the ability to advocate for its needs, the character of the town may change in a way that residents did not expect.

**Even partners who were not affiliated with town government *per se* had concerns about this scenario, saying that regional service districts could undermine proactive problem solving if cost savings are prioritized above all else.** A representative from a human services organization said:

*"A lot of cities and towns primarily think about themselves as business operations with a reactive function and that's where public health doesn't line up well with that kind of thinking. So, the risk here is this is a way to consolidate ... This is a way to essentially keep things at a minimal staffing level that's only prepared to react and meet only the very basic needs to hold on by your fingernails, as opposed to really invest in a substantial kind of health department."*

**Across all communities, there was deep confusion about whether a shared service agreement would necessarily affect both the local Board of Health and the LHD.** Some interviewees in a few of the smaller communities we spoke to were opened to regionalizing their board of health, in addition to receiving services from a comprehensive service district, saying that they have had difficulty recruiting qualified residents to serve on a board of health. This was not the case for people from most communities, however. As one health department staffer noted:

*"I don't think you'll ever make a sell for a community to give up their authority of their board of health. I guess I personally find that sort of unfortunate because the success of a board of health ebbs and flows based off the skillset, passion, and dedication of the members on that board or their own personal motives, unfortunately. And so, there's just such inconsistency."*

**Among health department staffers, most stated that they would prefer to retain their current structure, having a local Board of Health and an LHD,** rather than transition to a regional Board of Health and a shared service district. All the health department staffers we interviewed stated their local Board of Health is irreplaceable in offering specialized medical expertise or environmental health insights. Without these dedicated board volunteers who were invested in the local community and easy to reach, health directors feared they would not be able to make decisions quickly and felt that this would compromise the quality of services they could provide to residents. Furthermore, they expressed concern that a regional Board of Health will not understand the specific needs of each community. Both health department staffers and elected officials alike feared that if they were to shift to a shared service district with LHDs and a regional Board of Health that LHDs would have to compete for the attention of a regional public health district.

This, however, **represents a misconception about how shared service districts are typically structured and governed.** As reviewed earlier, shared service districts in Massachusetts have most frequently entailed keeping a local Board of Health but sharing LHD personnel across towns in a regional district. Although this arrangement would keep local Boards of Health functioning at the local level, and thus preserve Massachusetts's cherished tradition of local home rule, it would nevertheless have major implications for board operations. First, it would make it

even more crucial for communities to make sure that they could attract a variety of qualified volunteers to serve in this capacity. For example, interviewees cautioned against including too many doctors or clinicians on Boards of Health, because while these professionals have a wealth of clinical expertise, they may not be resourceful in creatively combatting public health issues or understanding that most health department work currently is environmental health rather than clinical services.

Second, **shifting to a regional service district could potentially make relations between the local Board of Health and other elected officials more visible and more contentious.** Currently, LHDs report to a town administrator or manager, but also often must mediate relationships between their Board of Health, the town manager, and the Board of Selectmen or Mayor. At least some of the interviewees we interviewed recognized that in a shared service district, if the LHD personnel were hired by a regional district, they could be insulated from potential political conflict between a local Board of Health and other elected officials, and they saw this as a benefit.

Among interviewees who were cautiously receptive to the idea of a shared service arrangement, they had quite specific preferences and concerns. First, they said that these **collaborations should not be larger than about three or four towns.** Second, the planning phases should ensure that each participating community dedicates enough financial resources to the program to make it possible to hire and retain qualified staff. One health department staffer mentioned:

*"I don't feel like all regional public health services are the same. And I don't think they're good because the quality of your health department and your programming is all about the people. And it's really hard to keep routine staff that have to drive around seven, eight towns. Often these regional services pay the lowest. And you know, there's a lot of high turnover in some of the regional models you've seen, it's like a train and drain program."*

Acknowledging these challenges in the planning stages might allow for creative strategies to prevent some of these potential problems. In general, the interviewees we spoke to who were most receptive to **regional service districts were in smaller communities, who feel they cannot currently offer the breadth of services to residents that should be standard.**

SCENARIO #3
Key Findings
<ul style="list-style-type: none"> <li>There were many misconceptions about how a shared service district could be structured.</li> <li>Towns do not want to be forced to regionalize</li> <li>Interviewees erroneously believed that regionalizing or collaborating would necessitate eliminating a local Board of Health and surrendering local control over public health programming to a regional district.</li> <li>Elected officials and LHD staffers alike fear that they might not receive sufficient attention from a shared service district, and that the quality of services their residents would receive would necessarily suffer.</li> <li>LHD staffers mentioned fears about job loss and lost opportunities for professional advancement and promotion.</li> <li>LHDs want to retain their local Board of Health</li> </ul>

#### SCENARIO #4: Cross-Sector Partnership

*A local health department partners with local agencies and community organizations to tackle a specific public health issue in their community (e.g., local health department collaborating with law enforcement agencies and community groups on Narcan distribution).*

**Almost all interviewees spoke positively about cross-sector partnerships, largely because they have experienced success in a current or previous partnership.** As one elected official said:

*“Our health department works really closely with the school superintendents. And I think the ability to lean on each other and bounce things off each other and share information that each group is getting from the state level has been really helpful during this pandemic. If the law enforcement entity has an interest in this and they don't have that expertise, then I don't see why there couldn't be a partnership between the health department and law enforcement. In a community like ours, departments work very, very closely together.”*

Many interviewees believed that collaborating across sectors increases the efficiency, efficacy, and reach of these collaborations.

**A town manager also argued that cross-sector partnerships enable the town to provide more holistic support to families in crisis.** They said:

*“if you have, let's say a kid who finds him or herself in trouble a lot and is in contact with the school resource officer... my hope was that kid and his or her family would then have the ability to access a number of services. Maybe you find out the father has issues with mental health and substance abuse. Maybe that person is a veteran. You know, maybe that's what led to some of the mental health issues that contributed to the home environment, which in turn contributes to this kid's behavior growing up. So again, the whole thought process for that was to have all of these different social service and health agencies and law enforcement agencies really talk to each other so they could provide wrap-around services for our community members.”*

Based on previous successful experiences with cross-sector collaborations, interviewees offer the following suggestions for ensuring success. **First, decision makers and partners want data demonstrating the efficacy and value of cross-sector collaborations.** A health department staffer acknowledged:

*“One thing health departments haven't been good at is collecting data. Now, if you think about what transpired over the past two years with the pandemic, health departments did contact tracing with enforcement of policies and guidelines that the state was putting out. We had no way of tracking that data and it's a shame. We did excessive work. What we did wasn't really tracked and measured. So, moving forward, we need to do a much better job. If we're going to go out and need funding and enhance local public health, we need the data to support it. Data must be collected on current and future cross-sector partnerships.”*

**Second, privacy standards, such as Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations can make some collaborations difficult.** A town leader mentioned:

*“I think people could be very hesitant to share information just because they don't know if it's the right thing to do, or they might feel like that person that they're in contact with wouldn't want that information to be shared.”*

Departments and organizations may face ethical issues in how much information they share about a resident and for what purpose. Residents should be included in decisions about what types of data are shared between departments and for what reason.

**Policies from one department or organization will not be immediately transparent or understood by another department, which may delay program planning and initiation.** A town representative stated:

*"I think with most organizations, they put blinders on and just see things through the lens that they're trained to see it through. And so, you end up kind of breaking up into silos. So that, that silo effect is something that is an obstacle."*

**Faith-based groups are an often-forgotten potential partner.** Several interviewees reported collaborating less frequently with faith-based groups, unless their community had an existing interfaith council to help broker relationships. Faith-based groups are in very frequent communication with their members, however, **and are therefore well positioned to understand the needs of residents and offer insights that the health department may not be aware of.** A health department staffer said:

*"When we were doing the food access program, we started working with some regional faith-based organizations and a big part of their service arm was around food and food access. They are very compelling players in our work. I often think of them as fairly place-based too."*

That said, respondents believed that faith-based groups are often better positioned to serve as partners in local collaborations, rather than regionally.

**Health department staffers and community-based nonprofits view law enforcement as potential partners, especially insofar as they are first responders in certain situations (e.g., drug use, domestic violence).** In recounting a story about a successful cross-sector partnership with police, an interviewee stated:

*"We worked at the police department, so we actually were able to connect. We worked with any domestic violence victims there. We provided not only the legal support, but we put them into shelters. We worked with the hotels to provide us rooms when we had an emergency situation where we had to put a family in hiding."*

**Local hospitals and clinics also serve drug users and domestic violence victims, although they are not called on to collaborate as frequently as they would like.** In the words of one health administrator:

*"Typically, you know, when, when we're called upon to help in some way, we're available, but I don't know that we're as proactive in the partnerships as, as we should be and as we want to be. So, we're certainly interested and eager to be a good partner."*

Such partnerships may involve partial hospitalization programs in which people may stay at a hospital yet participate in programming in the community. Hospital administrators are open to improving referrals to community-based programming which may prevent substance abuse users and domestic violence victims from falling through the cracks.

**Some elected officials are hungry for cross-sector partnerships that can mediate relationships, keep track of town resources, and provide continuity of care for families who need it.** A town leader shared:

*"I would love to get to a point ... where we can almost do something like a case management type of format where our social worker, or we have a staff [member] that can take on different people in our community and really kind of shepherd them and help them navigate some of the assistance programs that we have."*

SCENARIO #4
Key Findings
<ul style="list-style-type: none"> <li>▪ The majority of interviewees are currently participating in and satisfied with cross-sectoral partnerships they have in place.</li> <li>▪ All participants in such collaborations would like evaluations to determine whether partnerships are yielding increased efficiency, lower costs, and better quality of services.</li> <li>▪ Several LHD staffers believe that cross-sectoral partnerships can help LHDs address challenges beyond their bread-and-butter concerns of inspectional services and health promotion campaigns. This is especially true for emerging public health crises such as climate change, social determinants of health, and calls for racial equity and anti-racism work in public health and human service sectors.</li> </ul>

#### SCENARIO #5: Community Food Partnership

*Local health department partners with local farms and food banks or public housing agencies to organize farmer's markets and improve access to fresh foods.*

**Many elected officials said that they have active Farmer's Markets, but they are run by community-based groups rather than the health department.** These interviewees reported that the health department usually just performs sanitary inspections. Some markets, but not all, accept Women, Infants, and Children (WIC) aid cards, expanding access to fresh and healthy foods to families living in poverty.

**Although partnerships with public housing are less common, many interviewees were open to this idea.** And although some leaders worry that undocumented immigrants may be reluctant to participate in a community food partnership for fear of discovery by immigration authorities, other towns report this has not been an issue. As one person said:

*"Oftentimes the families who are in most need are afraid of something bad happening if they are identified. Whether it's immigration, you know, if I get on the food delivery list, is immigration going to catch up with me and then my uncle? There's a lot of fear, a lot of confusion."*

But a key informant expressed an (admittedly cynical) view that this may be misleading, and that people may be relying on that explanation as an excuse not to be proactive in this area.

**On a related point, many community leaders fear that needy families will not come forward to seek food out of shame.** Kids may be embarrassed to take food home on the school bus, while adults may be embarrassed to be seen at a pick-up location. The stigma of poverty may even prevent town leaders from accurately understanding the extent of food insecurity in a community.

**Delivering food directly to families may be the best solution to combatting shame and transportation issues.** Travelling to a farmer's market may be challenging for people in poverty

due to variable work schedules, lack of childcare, and transportation barriers. In the words of one health department leader:

*“We need to make it convenient. Nobody’s going to go to the farmer’s market that’s once a week on a Wednesday night. We’ve got to bring it to the people, and I think we need to bring it to affordable housing and to our senior complexes.”*

**A few interviewees identified organizational barriers to sustaining food partnerships and reported that some initiatives have ebbed from lack of sustained funding and inability to attract residents.** For example, advertising farmer’s markets or food programs in different languages and reaching ethnic minorities has proven challenging. Elected officials might only support expanding community food partnerships if there is an identified community need and the organizer, such as a town employee or social worker, is not diverted from other priorities. Expanding a food partnership may be difficult for small towns that already have staffing issues.

**In general, health department staffers, town leaders and elected officials show interest in expanding food partnerships both locally and regionally.** Food pantries are generally run by faith-based or volunteer groups, meaning that they do not pose a strain on municipal budgets. Interviewees expressed a desire for greater coordination among groups carrying out independent food assistance programs, to reduce duplication of effort and communicate clearly to families in need.

**Notwithstanding the above, interviewees report that food insecurity is a public health issue and would like to see food distribution systems (farmers markets, food pantries) take on related health issues.** A health department staffer shared:

*“Our prior health director started [a general town health campaign] a long time ago that later partnered with Mass in Motion. They were even trying to get healthier menus and restaurant support and really trying to build this up. I’ve heard of some communities giving senior citizens farmer’s market vouchers, so they could actually get the food.”*

Healthy eating and physical activity complement one another in maintaining a healthy BMI and preventing onset of many chronic diseases. Programs and organizations that promote both healthy nutrition and physical activity can have substantial impact on population health, especially if they can reach populations such as the elderly, undocumented immigrants, and low-income families. Moreover, interviewees are eager for more ideas on expanding food partnerships, to include nutrition education programming, Community Supported Agriculture (CSA), and shared community gardens. Many towns reported that community-based nonprofit organizations host annual fundraisers to raise funds to pay a social worker to coordinate such efforts—a model that could be replicated in other communities. **Finally, health department staffers and elected officials believe that community food partnerships have potential to build trust between residents and health departments, which may in turn help health departments forge other connections with residents who need services.**

SCENARIO #5
Key Findings
<ul style="list-style-type: none"> <li>▪ Farmer’s Markets exist currently in many communities</li> <li>▪ Town leaders open to community groups leading this endeavor, e.g., YMCA, faith-based organizations</li> <li>▪ Must serve residents while avoiding stigma</li> <li>▪ Must be properly advertised so those in need know where and how to access food</li> </ul>

## SCENARIO #6: Local School Health Coalition

*Local health department partners with local school district to provide education and programming for child and adolescent health (e.g., STD prevention, substance abuse, teen reproductive health).*

**Several interviewees mentioned that regional youth health education programs have been successfully implemented in the past.** A town administrator enthusiastically reported:

*“we did have a substance abuse prevention coordinator on staff... funded through a grant program through SAMHSA (Substance Abuse and Mental Health Services Administration) ... our coordinator actually has somebody who works for her. Now they work with our school department to talk about mainly substance abuse issues. But if we could expand it to teen pregnancy, STI prevention, I think that'd be awesome.”*

**Many town administrators and elected officials, however, believe that child and adolescent health education currently offered in schools is adequate and they do not want to create duplicate programming.** Additionally, some health departments (especially in smaller communities) stated they are not as well funded as schools and do not have money to invest in school-based health education programs. These health department staffers say they would prefer to invest in public health programs that have been identified as a clear need and not offered elsewhere.

Perhaps not surprisingly, **there is a lack of coordination between schools and health departments on youth and adolescent health education, and a potential for duplication of effort.** Moreover, health departments are aware they have much less funding than school departments, constraining their ability to provide education programming in schools. Aside from youth vaccination and contact tracing related to COVID-19, health directors report limited communication with schools.

**Youth health education programs run outside school may be poorly attended, because most youth cannot drive, face transportation challenges, participate in other after school programs, or are not interested in adult-run programs.** Future programs should be well advertised, and outreach should be conducted in different languages to be inclusive of all community members. Without adequate attendance, the town may not notice positive health outcomes from education programs.

Some town leaders and health department staffers expressed concern about facing criticism from parents who disagree with health education lessons, especially on topics that are usually seen as falling within the province of the family, such as control of sexually transmitted infections or teen pregnancy. In those cases, they were happy to let the school department do most of the program development and implementation but would be willing to serve in an advisory capacity if needed.

**Finally, interviewees were quite open-minded about the leadership of local school health coalitions.** Although one person pointedly asserted that such an effort should be led by the school department, because *“we know the kids,”* in most communities, town leaders, school officials, and health department staffers were much more agnostic. To be successful, however, a coalition should draw in a wide array of partners, including health department staffers and school nurses (to provide technical expertise), law enforcement, and mental health professionals. Last, but certainly not least, it is vital to recognize the target beneficiary, and several interviewees say that youth

should be actively involved in the planning effort. A human service organization representative said:

*“it’s maybe not a barrier, but maybe an oversight that there isn’t as much youth leadership within the work itself.”*

**That said, health department leaders and school officials stated they desperately need financial support from elected officials and town managers to hire and retain qualified public health nurses.** For nurses in these positions, pay has been low and turnover high. As one health department staffer shared:

*“We’ve had a lot of changeover in staff and a lot of our senior nurses have either resigned or left the town, mostly for financial reasons. We’re working on trying to get our salary up to par. We’ve had a lot of people leave for other towns that are paying more money. And so that’s a big challenge right now to keep school nurses here working in town.”*

Because school nurses may not stay in their role for long, health education program collaboration between the school and health department cannot gain traction. And at least one interviewee stated that this nursing shortage predated the pandemic, saying, *“it’s a big part of the job right now with, with COVID and everything. The needs of the students have really increased over the past five to six years. We’re looking for more support for our nursing offices. If we can get support to build that into our budget... through grants and monies then I think it would be better.”* **Elected officials and town managers must understand how collaborations can fill gaps in youth and family health programming. Schools and health departments are interested in expanding youth health education services but need more funding and support for these activities.**

**In addition, all interviewees request greater investment in social work within schools, the health department, and community at large.** A health department staffer strongly stated:

*“I tell people if you want to improve health, make sure you have a nurse in your department, but if you want to really systematically change things like determinants of health, having a social worker on the front lines can make an extremely meaningful difference in just assessing the actual need that needs to be done.”*

SCENARIO #6
Key Findings
<ul style="list-style-type: none"> <li>Many towns feel schools already offer and should continue to lead youth health education programs</li> <li>State level data can justify need for youth education programs</li> <li>With increased funding, health department and schools would be opened to initiating health education partnerships</li> <li>Towns request increased funding for public health nurses and social workers</li> </ul>

## SCENARIO #7: Regional Clinical Partnerships

*Local health department partners with hospitals or health clinics and other community organizations to provide accessible clinical services.*

Many interviewees viewed such partnerships as desirable, but a **major concern was geographic proximity to services due to transportation and work schedule constraints.** Several interviewees reported that a mobile clinic may better serve a community:

*“Our vaccine clinics are all out in the neighborhoods, in the community going to where people are... I think mobile clinics are here and real and the way.”*

**Health department and hospital/clinical partnerships have proven necessary and effective in managing COVID-19.** A town manager recalled:

*“We had the hospital involved. We set up a COVID task force and we made certain to make the CEO of the hospital part of our group. We held remote meetings every week where not only the CEO updated us on the number of cases, the type of cases, the number of people on ventilators, he also set up the vaccine [clinic] right at the hospital and provided us with a website where people could register.”*

This successful collaboration could springboard efforts to meet both acute and chronic medical needs, as well as providing screening services.

**Informing the larger MetroWest region about a regional clinical partnership may be difficult and especially challenging to convey in multiple languages.** Without sufficient resident use, partners will not see a return on investment. Most health departments and clinics are currently understaffed which may hinder the organization of such partnership and ability to delivery services in a timely and cost-effective manner. Data sharing between organizations may pose a legal issue given HIPAA restrictions. Medical providers may feel their authority is diminished if the health department and other organizations are influencing their operations. Services offered in this partnership may overlap with those offered at Community Health Centers.

**Regional clinical partnerships allow health departments to identify public health needs and clinics to offer services to meet those needs.** Interviewees are optimistic that a regional clinical partnership would be prime for regional grant funding. A health care organization leader shared:

*“We share a lot of things already with DPH (Department of Public Health) or DMH (Department of Mental Health) ... we share certain outcomes for DRG (Diagnosis Related Group), a specific diagnosis we share, we share capacity and beds and resources that are needed. We share some specific data for primary care touch points and specific trends that we're seeing within a primary care setting. And it can be simple things... What is the rate of annual mammograms that we're seeing within a population? What about colonoscopies, health screenings. From the population that we're seeing, we can share either needs, outcomes, gaps, and those kinds of things.”*

This occurs currently in a well-defined capacity when communities and tax-exempt hospitals collaborate every three years to publish community health needs assessments as required by the Affordable Care Act. It should be noted that not all hospitals in MetroWest are tax exempt, yet the participation of these hospitals in needs assessments would be highly valuable to both the hospitals and the surrounding towns.

**In collaboration, organizations are less wasteful of health supplies that could expire and mindful of cost savings.** Operating a clinical partnership proves financially cumbersome at the local level. A health department staffer shared:

*"When you have smaller communities... you're not going to order bulk varicella shot or TB tests because maybe you only need two shots and you know, a [staff member] has never handled it and what if [residents] don't come that day? And so really regionalizing, this makes a lot of sense. Or even them having like a mobile vehicle to come around to buildings."*

Health departments and elected officials must be presented with data showing successful regional clinical partnerships in other parts of the state and country.

**A regional effort should involve Community Health Centers to understand which needs remain unmet and why.** Community health centers have been effective with helping residents obtain health insurance. Generally, clinics who primarily treat Medicaid patients cannot offer competitive pay to healthcare providers. A former health department staffer relented:

*"Because of the capacity at the community health center, because the reimbursement is so low, they are not able to pay good salaries to retain their clinical staff. They're almost always understaffed,".*

WIC services could be incorporated into a regional clinical partnership. Regional clinical partnerships allow for collecting individual and community health data in one place instead of each individual organization wasting resources collecting the same data. In a collaboration, information about services can be disseminated by each collaborating organization to increase resident participation. The inclusion of schools appears vital to capture and serve youth health needs. In a limited capacity, current collaboration on youth COVID-19 contact tracing exists between clinics and schools. This partnership can be expanded to include health screenings, insuring the uninsured, etc. Towns report interest in partnering with other towns of similar demographics and neighboring borders. When interested stakeholders lack capacity individually, they may increase capacity collectively through a regional clinical partnership.

**When multiple hospitals and clinics exist in one area, collaborators must be mindful of competition.** As one interviewee stated:

*"You have to be careful that you're not finding yourself in a situation where there's more than one facility that you're not, you know, you're not creating that competition that... by seeming to endorse the services of a particular facility over another."*

Due to the nature of health care, diffident facilities only accept certain insurances, thus a partnership with the health department may unintentionally neglect residents who do not have a certain insurance.

**Leaders of such partnership would likely include public health directors and nurses, clinical leaders, and school nurses.** Permission from elected officials and town decisions makers would be necessary and has been granted in the past. A town leader recalled a clinical partnership led by the Select Board:

*"They coordinated and set up the task force through me to organize the meetings and determined who was going to be involved. We had the police, fire, and hospital, board of health, a number of departments involved with this, we even reached out to the churches to get them involved, as well as business leaders. So, this one crossed all districts here in town."*

SCENARIO #7
Key Findings
<ul style="list-style-type: none"> <li>▪ Currently exists in limited capacity between school and clinics ex. Immunizations, COVID-19 contact tracing, etc.</li> <li>▪ With increased funding, LHDs, clinics, and schools are interested in expanding clinical services without becoming medical home of residents</li> <li>▪ Towns fear financial waste if residents are unable or choose not to utilize services</li> <li>▪ Mobile clinics may be preferable service delivery option for population limited by transportation and time ex. elderly</li> </ul>

### SCENARIO #8: Partnerships to Improve Social Determinants of Health

*Local health departments partner with municipal agencies, school districts, community groups to improve educational attainment, housing security, or job training throughout the region.*

**Interviewees were the least enthusiastic about this potential collaboration because they feel health departments do not have enough funding to offer essential public health services as is.** Moreover, each MetroWest community has some distinct demographic characteristics and challenges, and therefore addressing social determinants of health (SDH) regionally was not logical to many. Because public health funding is time limited, many effective programs cannot be permanently implemented. Additionally, it is difficult for short term programs to prove effectiveness.

**Many towns identified housing and transportation as top priorities to lessen the harms of SDH.** Undocumented immigrants were the most identified population as needing services to combat SDH. As such, resources for these individuals could be discussed and offered regionally. Town leaders feel traditional white suburbs are continually diversifying regionally and nationally, consequently negative impacts of SDH are more apparent in schools and need to be addressed. School and Boards of Health have engaged in SHD initiatives currently. Additionally, some towns have partnered with the housing authority and enforced Chapter 40B to increase affordable housing. Town leaders wish they had more time and resources to engage various department and school groups on this issue. In this way, creative ideas and solutions could be tapped from professionals with a wide array of experiences and varied interactions with residents.

**Some town leaders express frustration that residents claim to care about SDH, yet all too often oppose investing in these types of programs because they and their families would not find them personally useful.** A health department staffer said:

*"I think there are social determines of health that really do get into some areas where people don't espouse the values that they say they do... I love seeing the signs of like, 'hate has no place here and everyone is welcome' and seeing the same people at community meetings fighting against housing."*

State, regional, and local political views can change unpredictably, thus impacting support for SDH programs.

**Town leaders express dismay that there is no model or framework on how a public health department should engage in combatting SDH.** A health department staffer shared:

*"Surveys are not going to tell you what you need to know. It's actually talking to people using a clipboard, walking the street and talking to residents one at a time. We want to find out what are the things that are affecting their daily life and looking at them from a social determinants of health lens... I don't think many communities are able to do something like that, to really find out what exactly, more than just looking at the data from the census bureau or some other sources. But really looking at community engagement to find out what's going on... I think another stakeholder that I don't think it's been mentioned enough, are the residents."*

Gathering local SDH data is challenging because residents who need SDH services are not the same people who have time to fill out surveys. As residents are the target beneficiary their participation in program planning and follow through is necessary for buy-in and success.

**Leaders assume that immigrants who do not speak English may be a population in need of SDH programs.** While it is true that language barriers are significant obstacles in connecting populations in need with existing services, they are not the only type of barrier. Communities may incorrectly infer residents do not need services, when in fact other barriers such as lack of internet access or transportation may be at play. Many leaders wished school, health clinics, and other local governmental staff groups were more diverse, and representative of the residents being served.

**Taking on this issue is complicated as each municipal department has claim to different parts of SDH issues.** For example, social workers may address homelessness through the lens of connecting homeless residents with resources. Schools may offer homeless children's meals through assistance programs. Police may choose to remove homeless individuals who loiter.

**With external funding, health department directors express some interest in improving social determinants of health.** SDH are addressed in a limited capacity currently through school or public health nurses and social workers. Additionally, hospitals and clinics partner with colleges to offer nursing and other health related internships. Larger towns with greater socio-economic diversity are more interested in addressing social determinants of health. Smaller towns with limited finances are interested in a regional SDH program because they currently cannot afford to employ a full-time local worker to engage in this effort.

**Respondents understand that well-designed SDH programming can address several issues at once.** An elected official shared:

*"Our retired community is a group of people that we don't access well enough that have tremendous experience, value and understanding... I just love the idea of a kindergarten in an elderly home. It's one that I've always felt like or a preschool that's where it should be, because there's just so much, so much benefit on both sides for that."*

**For many public health leaders, elected officials, and town appointed decision makers, addressing SDH represent a new approach to public health they have not yet experienced.** This is likely due to the reactive rather than proactive health department structure. Most health department are structured to address environmental and regulatory health concerns rather than implement health promotion and prevention initiatives.

SCENARIO #8
Key Findings
<ul style="list-style-type: none"><li>▪ Health departments consider social determinants of health of least priority as they currently lack adequate staff, funding, and time to complete essential public health tasks</li><li>▪ Some towns do not want to engage regionally if they feel their residents largely are not impacted by SDH</li><li>▪ Addressing SDH calls on the expertise of many municipal agencies, health care organizations, and human service agencies rather than one clear organizational leader</li></ul>

## V. RECOMMENDATIONS

Among the 25 communities in the MetroWest region, there is wide variation in size and capacity of the LHDs. And while the region faces some widespread public health challenges, communities also have their own distinct needs and capacities. We offer these recommendations to help strengthen public health infrastructure in the region. All stakeholders will need to take action—not only personnel in LHDs but also the elected officials who support them and their partners throughout municipal government, in healthcare organizations, and in the human services sectors.

- ⇒ Create educational and training opportunities to help local elected officials, town administrators, and elected or appointed members of Boards of Health with:
  - Valuing public health activities and functions
  - Recruiting and retaining talented and credentialed health department staffers
  - Understanding models for cross-jurisdictional sharing
  - Building capacity in collection and analysis of local health data
  - Understanding accreditation process for local health departments
- ⇒ Increase awareness of and appreciation for cross-jurisdictional sharing, in all its variations by:
  - Continue to support current cross-jurisdictional efforts (e.g., MetroWest Tobacco control work)
  - Convening groups of communities that are interested in collaborating on inspectional services, helping them to harmonize regulations.
  - Developing service-performance metrics that health department directors, elected officials, and town administrators can use to monitor quality and assess the benefits of continued participation in such partnerships.
  - Clarifying the relationships between local Boards of Health, local elected officials, and regional health departments in a comprehensive service district.
  - Adapting existing templates for legal agreements and contracts that would support shared services.
  - Helping LHD directors and elected officials identify areas where cross-jurisdictional sharing may not be feasible or would not address the specific needs of the community.
  - Identifying pathways for professional development and promotion from LHDs to district-level agencies, to reward the hard work and dedication of LHD staff.
- ⇒ Support regional collaboration on public health promotion objectives by:
  - Identifying partners in diverse sectors (including community nonprofits, municipal agencies, and faith-based groups) that have common interests.
  - Developing cross-sector coalitions that span communities to address major health inequities in the region.
  - Identifying the organizational entity that will be most effective at spearheading cross-sector collaborations, with respect to program design, evaluation, and administration.
  - Providing contractual models to elected officials, town administrators, and town counsels that will structure these collaborations to make sure that participating communities are treated equitably.
  - Securing external funding to help those coalitions develop education and outreach materials that speak to common public health challenges across those communities.
  - Securing stable funding from participating communities to sustain such initiatives.

- ⇒ Prepare communities to respond to emerging public health crises by:
  - Continuing to support and monitor progress in responding to the opioid epidemic and the COVID pandemic.
  - Helping LHD directors identify health inequities in their communities, identify policies or practices that drive those inequities, and develop plans to change those systems and practices.
  - Raising awareness of the deleterious impacts of climate change (floods, heat waves, vector-borne illnesses), recognizing their disparate impact on vulnerable subpopulations, and identifying resources to respond effectively.
  - Developing funding sources to provide clinical services in communities and identify sites that will meet the needs of vulnerable residents.
- ⇒ Advocate on behalf of LHDs in the region by:
  - Working with state and federal legislators to understand potential funding opportunities that support local public health as they emerge from Congressional infrastructure bills.
  - Fostering dialogue among LHD directors, town administrators, and elected officials with the Massachusetts Department of Public Health, to better understand the grant mechanisms through which federal aid is channeled to communities.
  - Advocating for the availability of timelier data on community-level health outcomes, especially disaggregated by race, age, income, and educational attainment.
- ⇒ Build capacity of LHDs in the MetroWest region by:
  - Helping LHD directors to develop plans that will improve their likelihood of securing external grants that will support additional staff (e.g., through the CDC's Public Health Associate Program, the MA-DPH Academic Health Consortium, and Public Health AmeriCorps).
  - Helping LHD directors cultivate expertise among their local boards of health, whether elected or appointed.
  - Creating mentorship and networking opportunities for LHD staff to connect with peers and colleagues throughout the region.

The LHDs in the region are staffed by dedicated and insightful leaders who have an earnest desire to strengthen public health capacity and build on community assets. COVID-19 has highlighted the need for a coordinated response to public health in the region. While it is important to draw attention to progress, it is equally important to highlight emerging and entrenched public health challenges, and identify opportunities for innovative collaborative solutions. Formal partnerships and collaborations have great potential to strengthen public health infrastructure, foster policy development, and improve social determinants of health, allowing all MetroWest residents to live a life of dignity.

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## VII. APPENDICES

### Appendix A: Cross-Jurisdictional Sharing—Structures, Benefits, and Case Studies

In response to the challenges they face, local health departments across the country have begun sharing resources. Here we review state and national trends in cross-jurisdictional sharing, review recent research that demonstrates the benefits of cross-jurisdictional sharing, and put forth a typology of how cross-jurisdictional sharing agreements can be structured and governed. We close by highlighting some case studies of other Massachusetts communities that have employed such models and providing links to resources for MetroWest leaders who may wish to learn more about cross-jurisdictional sharing.

#### A1: National and State Trends in Cross-Jurisdictional Sharing

A 2016 report by the Association of State and Territorial Health Officials (ASTHO) found the proportion of state health departments sharing resources with other states rose from 9 to 27% between 2012-2016 (ASTHO 2016). Likewise, a 2019 report by the National Association of City and County Health Officials (NACCHO) found that 55% of local health departments engaged in some type of cross-jurisdictional sharing (NACCHO 2019). These cross-jurisdictional sharing arrangements usually addressed emergency preparedness (because many emergencies, such as earthquakes and weather events, affect multiple areas simultaneously), or the provision of certain types of expertise (e.g., epidemiologic analysis, data science).

Between 2016-2019, there were substantial increases in the proportion of local health departments that had formal agreements for resource sharing with healthcare organizations, other government agencies, or community-based organizations (NACCHO 2019). Nationally, more than 1/3 of LHDs receive functions or services from another LHD or provide function or services for another LHD.

Sharing can take a variety of forms, including joint contracting with a nursing agency for public health nursing services, collaborating on a community health needs assessment, sharing equipment, or sharing information and health promotion resources. To be successful, sharing entails regularly scheduling meetings, establishing written agreements, and clarifying lines of reporting for health department personnel (1-3).

Because of Massachusetts's long history of home rule, however, cross-jurisdictional sharing is a bit less common here than in other parts of the country. The tradition and mythology of Yankee independence can, however, cloud recognition of several successful public health partnerships in the Commonwealth.

Approximately 1.5 million Massachusetts residents (about 23% of the overall population) are already served by one of 15 regional public health districts<sup>2</sup>. Some of these collaborations date back to the early decades of the 20th century, whereas others have taken hold more recently (Regionalization Advisory Committee, 2010). While these districts have historically served rural communities (especially in Berkshire County and the Cape and the Islands), the past decade has seen several regional districts emerge in more urban areas, including the North Shore Shared Public

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<sup>2</sup> <https://www.mass.gov/service-details/public-health-shared-services> visited January 17, 2022.

Health Services district (serving eight communities around Salem and Lynn<sup>3</sup>) and the North Suffolk Public Health Collaborative (serving Chelsea, Revere, and Winthrop<sup>4</sup>).

In 2010, the Massachusetts Department of Public Health received federal funding to sponsor the Public Health District Improvement Grant program. Under this program, five new regional health districts were created, including the Central Massachusetts Regional Public Health Alliance, which comprises six communities around Worcester<sup>5</sup>.

In addition to collaborating with other municipal health departments, local health departments may also benefit from partnering with hospital systems, community health centers, and schools of medicine and public health.

## **A2: Benefits of Cross-Jurisdictional Sharing—What Does the Research Show?**

Research over the past two decades has shown that Massachusetts's local health departments are limited in their capacity to meet essential public health services. National data show that health departments that serve large communities tend to have more staff, more highly trained staff, and that they are better equipped to fulfill essential public health services. Yet only 8% of Massachusetts's health departments serve communities of more than 50,000 people, and half serve communities with less than 10,000 (Hyde et al. 2018). A 2006 statewide needs assessment of health department directors showed that 89% had difficulty enforcing basic environmental health regulations (Hyde & Tovar 2006). A 2005 independent audit of food inspections found that two-thirds of Massachusetts communities consistently failed to meet statutory requirements for biannual restaurant inspections, putting residents at risk of food-borne illnesses (State Auditor's Office 2005). A 2012 survey of Massachusetts health departments found that communities with the greatest need (as measured by population size, greater density, and higher poverty rate) were most likely to be able to provide essential public health services (Hyde et al. 2012).

In this context, collaborating across jurisdictions can augment a community's capacity to meet its basic public health obligations, especially for smaller rural and suburban communities. A 2018 mixed-methods study of health department personnel in Connecticut and Massachusetts showed that personnel in shared services districts perceived significant benefits, including the capacity to attract and retain highly qualified staff, capacity to offer public health services over and above regulated mandates, greater flexibility and ability to adapt to evolving community health needs, and greater consistency in being able to meet regulations. In contrast, those who served in health departments that served a single community reported difficulty meeting state-mandated responsibilities, difficulty hiring and retaining staff with necessary expertise, and loneliness and professional isolation (Humphries et al. 2018). A 2012 survey of health department directors in 70% of Massachusetts communities found an overall mean score of only 43.5 out of 100 in ability to perform all ten essential public health services. As a consequence, very few of the participating communities were able to offer comprehensive public health services. The two essential public health services that Massachusetts health departments were most likely to be able to provide were in the areas of communicable disease control and enforcing rules and regulations, and only in those areas because the state requires mandatory reporting and a timetable of inspections.

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<sup>3</sup> <https://nssphsp.weebly.com/>, visited January 14, 2022.

<sup>4</sup> <https://www.northsuffolkassessment.org/>, visited January 14, 2022.

<sup>5</sup> <http://www.worcesterma.gov/public-health/regional-public-health>, visited January 14, 2022.

Here in Massachusetts, the Public Health District Improvement Grant program concluded that shared districts brought several notable benefits to their communities (PHDIG 2015). Across the five districts established in 2012 through that program, the participating communities benefited in the following ways: (1) increased capacity to meet state inspectional requirements; (2) improvements in the quality of public health services to residents in participating communities; (3) increased capacity to provide health communication and health education programming; (4) efficiencies in developing and implementing public health services; and (5) an increase in the recognition of the value of public health departments in creating healthy communities. These changes are impressive given that they manifested in a very short period (during the 3-year grant). Most impressively, shared service districts were highly successful in securing external grant funding, augmenting the amount of funding the individual municipalities had budgeted to support public health services (PHDIG 2015).

### **A3: Structure and Governance of Cross-Jurisdictional Sharing Arrangements**

While there is a great deal of heterogeneity in how regional health districts may be governed, it is possible to sort them into four general categories.<sup>6</sup> The most informal type of arrangement has towns providing “as needed” assistance to one another, often by sharing equipment, staff time, or expertise. The next step up is “service-related arrangements,” where communities will establish a Memorandum of Understanding (MOU) to provide services such as immunization clinics or assisting with restaurant or septic inspections. A more formal arrangement would entail “shared programs or functions,” where communities may band together to offer health promotion programming on a specific problem (e.g., HIV control), or for a shared capacity (e.g., hiring an epidemiologist to serve multiple communities). The highest level of integration is seen in regionalization, in which several health departments will merge to create a new organizational entity.

Here in Massachusetts, the Massachusetts Public Health Regionalization Project has been especially focused on encouraging communities to collaborate around two forms of shared districts.

1. Shared Services District
  - a. The local health departments would be restructured into a single health district serving all communities.
  - b. Each individual community retains its own elected or appointed Board of Health.
  - c. Formal agreement among two or more municipal boards of health to share some staff like public health nurse, animal control personnel and services like immunizations and inspections.
2. Comprehensive Shared District
  - a. Each individual municipality retains its local Board of Health and its local health department but agrees to either share all services of a certain type across communities (e.g., public health nursing, septic inspections), or that they will provide a cafeteria style menu of services, allowing participating communities to have services provided by the district or by the local health department.
  - b. Formal agreement that all local public health services for two or more municipalities are carried out by one set of employees.

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<sup>6</sup> Center for Sharing Public Health Services. <https://phsharing.org/resources/spectrum-of-cross-jurisdictional-sharing-arrangements/>, visited January 15, 2022

The Massachusetts Public Health District Incentive Working Group proposed these two forms of sharing arrangements in recognition of the fact that communities have different needs and capabilities, and that a “one size” fits all approach would not work. Either a Shared Service District or a Comprehensive Service District could be structured in a way that provided some efficiencies of scale in services, while still allowing Massachusetts communities to preserve their cherished sense of independence and home rule tradition.

#### **A4. Case Studies of Cross-Jurisdictional Sharing**

##### Nashoba Associated Boards of Health District

The Nashoba Associated Boards of Health district was formed in 1931 with fiscal support from the Commonwealth Fund, a private foundation and guidance from Harvard University of Public Health. The Nashoba Associated Boards of Health serve as the Board of Health for 16 member towns, providing environmental and public health services to many communities. The towns include Ashburnham, Ashby, Ayer, Berlin, Bolton, Boxborough, Dunstable, Groton, Harvard, Lancaster, Littleton, Lunenburg, Pepperell, Shirley, Stow and Townsend. During the last 90 years, the towns have expanded the agency’s capacities to also provide clinical services, especially in nursing and hospice.

##### Berkshire Public Health Alliance

The Berkshire Public Health Alliance is a collaboration among 22 Berkshire Communities that have collaborated on an Inter-municipal Agreement to provide professional public health services and programs for member communities. The alliance focuses on improving the delivery of public health services and programs as well as improving the overall health of Berkshire communities. The alliance was established and is supported by the District Incentive Grant Program offered by the Massachusetts Department of Public Health. It was established in 2011 by the 22 Berkshire municipalities of Adams, Alford, Becket, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Lanesborough, Mt. Washington, New Marlborough, North Adams, Peru, Richmond, Sandisfield, Savoy, Sheffield, Washington, West Stockbridge, Williamstown, and Windsor.

The Berkshire Public Health Alliance has created legal structures and contracts by setting up a workable and fair fee structure and adjusting to the budget challenges that are a result of providing services for a large and diverse area. The Alliance has focused on listening to their member communities and adjusting their delivery of goods and services to fit the needs of those communities. The Alliance can expand not only the number of municipalities it serves, but the types of programming, services, and education that is desired by the municipalities and community members of Berkshire County as a whole.

According to a final report from the Berkshire Public Alliance, they have seen improvements in

1. Access to specific, requested support and assessment services
2. Lower training costs
3. Support for Board of Health initiatives
4. Flu clinics that better the needs of all residents

##### Central MA Regional Public Alliance

The Central MA Regional Public Health Alliance (CMRPHA) unifies six municipalities (Grafton, Holden, Millbury, Shrewsbury, West Boylston, and Worcester) in a regional public health district

that provides a comprehensive array of services through an organization managed by Worcester's Division of Public Health. The mission of CMRPHA is to improve and promote health and safety of residents in Massachusetts municipalities through forming strong community bonds and improving health education. CMRPHA utilizes performance measures to improve and sustain high quality employees and create a health department committed to improving quality. The City of Worcester is Massachusetts's first accredited health department, a testament to its ability to provide comprehensive and high-quality public health services.

## **A5. Resources for Learning More About Cross-Jurisdictional Sharing**

Massachusetts now has substantial experience with cross-jurisdictional sharing arrangements, and participating communities have generated model policies and procedures that can be adapted for local use.

The Center for Sharing Public Health Services (<https://phsharing.org/>) has a Roadmap to Develop Cross-Jurisdictional Sharing Initiatives, as well as a wealth of model documents, templates, and sample agreements that communities can adapt. This include sample bylaws and Memoranda of Understanding that have been developed by other communities across the country.

The Center for Sharing Public Health Services and the Network for Public Health Law have created a checklist to guide conversations between communities that are trying to establish a cross-jurisdictional sharing arrangement. (Available at: <https://phsharing.org/wp-content/uploads/2019/06/GuideForDevelopingLegalDocumentsGoverningCJSArrangements.pdf>).

The State Action for Public Health Excellence, an initiative of the Massachusetts Department of Public Health Office of Local and Regional Health, provides grants to established regional health districts or groups of communities that want to explore cross-jurisdictional sharing. The grants support communities in planning for or expanding sharing of staff and resources to improve efficiency and effectiveness. Framingham received a SAPHE grant to explore cooperation with Ashland, Hudson, and Holliston on contracting for public health nursing services.

## **A6. Conclusion**

During the COVID-19 pandemic, local health departments in Massachusetts struggled to ensure resources and support for their communities. Many health departments were overwhelmed and lacked the necessities to provide their community with the best resources. Cross-jurisdictional sharing may be the solution to local health departments having access to the disparities in health services and resources. In fact, becoming involved in cross-jurisdictional sharing may be more favorable since the pandemic demonstrated the importance of stable public health resources.

## **Appendix B: Accreditation**

### ***i. Background and History***

A recent development in the governance of local health departments is accreditation. Accreditation helps to assess an organization's capacity to carry out essential functions and meet its mission. Accreditation usually entails a structural process of self-assessment and reflection and is usually followed by peer review to ensure how well organizations are performing in relation to agreed-upon benchmarks (Riley et al 2012; Riley, Bender, and Lownik 2012). The movement to accredit local health departments (LHDs) was initiated in 2011, with funding from the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF). This project established a national voluntary accreditation program for state, local, and territorial health departments. The Public Health Accreditation Board (PHAB) was established in 2011 and serves as the independent accrediting body. PHAB launched the national accreditation program on September 14, 2011 (Riley, Bender, and Lownik 2012).

Accreditation allows public health departments to demonstrate that they meet standards established by the Public Health Accreditation Board (PHAB). The PHAB accreditation demonstrates that health departments are meeting national standards of essential public health services (the Ten Essential Public Health Services).

As of 2016, only 3 LHDs in Massachusetts are accredited including Boston, Cambridge, and Worcester. There is an upwards trend of health departments becoming accredited. According to the US Department of Health and Human Services, accreditation of health agencies has jumped from 13.4% in 2019 to 14.6% in 2021. The Healthy People 2030 campaign from the Office of Disease Prevention and Health Promotion encourages health departments to take the steps for accreditation and sets target of a 17% increase in accreditation. Health departments in Massachusetts, such as the city of Worcester, have benefited from accreditation like performance improvement and emergency preparedness<sup>7</sup>.

### ***ii. Accreditation Benefits***

Health departments concur that accreditation holds significant benefits especially through strengthening overall utilization of available resources while using evidence-based practices. This includes stimulating quality improvement, improving accountability, transparency, and the capacity of high-quality programs and services a department is expected to provide. Health departments in accredited agencies also perceive stronger relationships with key partners in other sectors, such as education and social services (e.g., childcare, mental health services, transportation.) In addition, accreditation helps health departments utilize health equity as a lens for identifying and addressing priorities.

Accreditation also helps public health departments stay in alignment with best practices in the field, such as performance management and quality improvement. A 2019 survey of more than 350 local health departments found that accredited agencies had more resources available for evidence-based decision making and greater capacity to evaluate public health programming (Allen et al. 2019).

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<sup>7</sup> <https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure/increase-proportion-local-public-health-agencies-are-accredited-phi-02> visited January 17, 2022

Accreditation activity requires considerable time, resources, and expertise on the part of both local health department personnel and appointed or elected Board of Health members. The importance of support from a Board of Health or elected officials cannot be overstated. Shah et al. (2019) found that communities with high-functioning Boards of Health were more likely to have recently completed a community health needs assessment, developed a strategic plan, and be engaged in accreditation activities.

### ***iii. Process of Accreditation***

The Guide to National Public Health Department Initial Accreditation provides an in-depth overview about how public health departments can obtain accreditation through PHAB. The document explains expectations and requirements for successfully completing the accreditation process. The PHAB Standards and Measures document provides official standards and measures needed for accreditation. These qualifications are considered authoritative and apply to health departments from a local, state, territorial, and tribal level. This document is a standard tool for reviewing ongoing applications from departments seeking accreditation (Riley et al. 2012).

Table 1 depicts the 7 steps needed to obtain accreditation through PHAB. The process ensures that health departments meet the standards needed to reach accreditation and helps guide health department employees in the application process.

Table 6: 7 Steps of Accreditation

7 Steps of Accreditation	Assessments
<b>1. Preapplication</b>	Accreditation Readiness Checklist to help health departments determine if they are ready to begin the application process. The checklist addresses eligibility, completion of prerequisites, internal processes, and initial preparation tasks
<b>2. Application</b>	The application is formal notification to PHAB of a health department's official commitment to initiate the public health department accreditation process. The application is an agreement that the applicant will abide by the current and future rules of PHAB's accreditation process to achieve and maintain accreditation status for the five-year accreditation period.
<b>3. Document Selection and Submission</b>	The process of identifying and uploading documents that demonstrate the health department's conformity with the standards and measures is one of the most important components of the accreditation process. The documentation submitted by the health department is what the site visit team will review and use to determine the health department's conformity with the standards and measures.
<b>4. Site Funds</b>	Site visits will be conducted by a peer team of three to four PHAB-trained site visitors. The visit serves several purposes: verify the accuracy of documentation submitted by the health department, seek answers to questions regarding conformity with the standards and measures, and provide opportunity for discussion and further explanation. Site visits will typically last two to three days, depending upon the complexity of the application
<b>5. Accreditation Decision</b>	The Accreditation Committee, appointed by the PHAB Board of Directors, will review and determine the accreditation status of applicant health departments. The Accreditation Committee will make accreditation decisions based on the site visit report, including the site visit team's scores and descriptive information.
<b>6. Reports</b>	The submission of annual reports is required of all accredited health departments. Annual reports describe how the health department has addressed areas identified by the Accreditation Committee as priority areas for improvement.
<b>7. Reaccreditation</b>	Each accredited health department will be required to submit a new application in the reaccreditation process and may be required to receive additional training.

## Appendix C: Survey Tool

Standard: Introduction (1 Question)

Block: I. Background (6 Questions)

Standard: II. Perception of Trust (4 Questions)

Standard: III. Perception of Collaborations (14 Questions)

Block: IV. Areas of Support (14 Questions)

Block: V. Best Practices and Recommendations (1 Question)

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### Start of Block: Introduction

Intro text The MetroWest Health Foundation has selected the [Northeastern University Public Evaluation Lab, NU-PEL](#), to lead a comprehensive evaluation project, in order to understand and improve the current regional public health infrastructure in the MetroWest region.

We, the NU-PEL research team, invite you to complete our brief, anonymous, voluntary survey by July 30th, 2021. The estimated time for survey completion is 10-15 minutes. Your decision to participate or not participate in this survey will not impact your current or future relationship and work with the MetroWest Health Foundation.

Your survey participation will be handled in a confidential manner. Any reports or publications based on this research will use only group data and will not identify you or any individual as being affiliated with this project.

By proceeding with the survey, you are providing your consent to participate in our evaluation project.

We very much appreciate your time and support in this important work. If there are any questions and/or issues, please contact Rebecca Gallo at [rgallo@mwhealth.org](mailto:rgallo@mwhealth.org).

### End of Block: Introduction

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Start of Block: I Q1 I. Background The following section will ask general questions about your role/position, experience, team, and location of your organization.

Which of the following best describes your organization?

- ☐ Community health center (1)
- ☐ Local health department (2)
- ☐ Other government unit or agency (3)
- ☐ Charitable organization (4)
- ☐ Hospital (5)
- ☐ Human services organization (6)
- ☐ Other (please specify) (7) \_\_\_\_\_

Q2 What is your role or position in the organization?

- ☐ Director (1)
- ☐ Administrator (2)
- ☐ Assistant Director (3)
- ☐ Manager (4)
- ☐ Health Agent/ Officer (5)
- ☐ Secretary (6)
- ☐ Other (please specify) (7) \_\_\_\_\_

Q3 Which town do you work in? (Please check all that apply)

- ☐ Ashland (1)
- ☐ Bellingham (2)
- ☐ Dover (3)
- ☐ Framingham (4)
- ☐ Franklin (5)
- ☐ Holliston (6)
- ☐ Hopedale (7)
- ☐ Hopkinton (8)
- ☐ Hudson (9)
- ☐ Marlborough (10)
- ☐ Medfield (11)
- ☐ Medway (12)
- ☐ Mendon (13)

- ☐ Milford (14)
- ☐ Millis (15)
- ☐ Natick (16)
- ☐ Needham (17)
- ☐ Norfolk (18)
- ☐ Northborough (19)
- ☐ Sherborn (20)
- ☐ Southborough (21)
- ☐ Sudbury (22)
- ☐ Wayland (23)
- ☐ Wellesley (24)
- ☐ Westborough (25)
- ☐ Other (please specify) (26) \_\_\_\_\_

Q4 Is your position part time or full time?

- ☐ Part-time (1)
- ☐ Full-time (2)

Q5 How many people are in your immediate department?

- ☐ 1-10 (1)
- ☐ 11-20 (2)
- ☐ 21-30 (3)

- ☐ 31-40 (4)
- ☐ 41-50 (5)
- ☐ More than 50 (6)
- ☐ I don't know (7)

Q6 How long have you been working with this organization?

- ☐ 0-2 years (1)
- ☐ 3-5 years (2)
- ☐ 6-10 years (3)
- ☐ 10+ years (4)

End of Block: I. Background

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Start of Block: II. Perception of Trust

**Q7 II. Perception of Trust**

This next set of questions are aimed to gather a baseline understanding of your experiences working in any \*partnership(s) since 2019. We are asking for you to reflect back to 2019, given the extraordinary nature of this past year 2020-21.

*\*Partnership: Cooperation between or within organizations that have worked together on a common public health issue or goal in the MetroWest region.*

Did you engage in a partnership in 2019?

- ☐ Yes (1)
- ☐ No (2)

*Skip To: End of Block If II. Perception of Trust This next set of questions are aimed to gather a baseline understanding... = No*

Q8 If you have participated in a partnership in 2019, did you find working in this partnership challenging? If you have participated in more than one partnership in 2019, did you find working in any of those partnerships challenging?

- ☐ Yes (2)
- ☐ No (3)

Q9

Reflecting on this partnership experience, please rate your level of agreement with the following set of statements about ***commitment and working style between the partners***:

	Strongly Agree (1)	Agree (2)	Neither Agree nor Disagree (3)	Disagree (4)	Strongly disagree (5)	Not Applicable (41)
Partners exhibited a high level of commitment. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The purpose of partnership was understood clearly by all participants. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The partnership was highly productive in relation to the goals of the partnership. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners behaved in ways that benefited the partnership as a whole. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners were supportive of each other. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners eagerly volunteered to take on	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

tasks  
associated  
with the  
partnership.  
(7)

The  
contributions  
of all  
partners  
were valued  
equally,  
regardless of  
whether a  
majority  
agreed or  
disagreed  
with their  
point of  
view. (9)



Q10 Continuing with your perception of the challenging partnership, please rate your level of agreement with the following set of statements about the **trust between partners**:

	Strongly Agree (1)	Agree (2)	Neither Agree nor Disagree (3)	Disagree (4)	Strongly Disagree (5)	Not Applicable (7)
There was mistrust among partners. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners had hidden agendas and brought these into the partnership. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners withheld information of relevance to the partnership. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners felt that their time was not used appropriately. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sharing new ideas or areas for discussion was not welcomed among partners. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners met in unofficial groups to advance their own agenda, in ways that undermined the collective	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

End of Block: II.Perception of Trust

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Start of Block: III. Perception of Collaborations

Q11

III. Perception of Collaborations

This next set of questions are aimed to gather a baseline understanding of your experiences working in any \*collaboration(s) since 2019. Given the extraordinary nature of the last year (2020-21), we would like you to think back to 2019 when responding to statements in this section about your perceptions of and experiences with collaborations\* among and within organizations in the MetroWest region.

*\*Collaboration- Cooperation between or within organizations that have worked together on a public health issue or goal in the MetroWest region.*

Were you part of a collaboration in this period?

☐ Yes (5)

☐ No (3)

*Skip To: End of Block If III. Perception of Collaborations This next set of questions are aimed to gather a baseline und... = No*

Q12 If you have participated in a collaboration in 2019, did you find working in this collaboration challenging? If you have participated in more than one collaboration in 2019, did you find working in any of those collaborations challenging?

☐ Yes (2)

☐ No (3)

Q13

With that specific collaboration in mind, please rate your level of agreement with the following set of statements about the **history of collaboration, legitimacy of the collaborative group, political and social climate for the collaboration and mutual respect and trust:**

	Strongly Agree (11)	Agree (12)	Neither Agree nor Disagree (14)	Disagree (15)	Strongly Disagree (17)	Not Applicable (18)
Organizations in our community have a history of working together. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The time was right for this collaboration. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Our community has often tried to solve problems through collaboration(s). (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The political and social climate seemed to be well-suited to start a collaborative project like this one. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People involved in our collaboration always trusted one another. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have a lot of respect for the other people involved in this collaboration. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Leaders in the community who were not part of our collaborative group seemed hopeful about what we could accomplish. (3)

Others in the community, ***who were not a part of this collaboration,*** would agree that organizations involved in this collaboration were the most-suited for this work. (4)



Q14: Continuing with that collaboration experience in mind, please rate your level of agreement with the following set of statements about the ***appropriateness collaboration styles, benefits, and ability to compromise and commitment of collaborative members:***

	Strongly Agree (11)	Agree (12)	Neither Agree nor Disagree (14)	Disagree (16)	Strongly Disagree (18)	Not Applicable (17)
The people involved in our collaboration represented a cross section of those who had a stake in what we were trying to accomplish. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All the organizations that we needed to be members of this collaboration became members of the group. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My organization benefited from being involved in this collaboration. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People involved in our collaboration were willing to compromise on important aspects of our project. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The organizations that belonged to our collaborative group invested the right amount of time in our collaborative efforts. (5)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Everyone who was a member of our collaborative group wanted this project to succeed. (6)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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There was a high level of commitment among the collaboration participants. (7)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

When this collaborative group made major decisions, there was always enough time for members to take information back to their own organizations to confer with colleagues. (8)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Q15 Continuing with this collaboration experience in mind, please rate your level of agreement with the following set of statements about ***participation, flexibility, clarity of goals, and adaptability***:

	Strongly Agree (12)	Agree (13)	Neither Agree nor Disagree (15)	Disagree (17)	Strongly Disagree (18)	Not Applicable (19)
There was a lot of flexibility when decisions were made; people were open to discussing different options. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People in this collaboration were open to different approaches to how we could do our work. They were willing to consider different ways of working. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People in this collaboration had a clear sense of their roles and responsibilities. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There was a clear process for making decisions among the partners in this collaboration. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This collaboration was able to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership. (6)

Despite any major changes in its plans, in order to reach its goals, this group was able to continue its work. (7)



Q16 Continuing with this collaboration experience in mind, please rate your level of agreement with the following set of statements about ***pace of development, nature of communication, and informal relationships:***

	Strongly Agree (11)	Agree (12)	Neither Agree nor Disagree (14)	Disagree (16)	Strongly Disagree (17)	Not Applicable (18)
This collaboration took on an appropriate amount of work at a conducive working pace. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We were able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People in this collaboration communicated openly with one another. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was informed as often as I should have been about what went on in the collaboration. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The people who led this collaboration communicated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

well with the members. (5)

Communication among the people in this collaborative group happened both at formal meetings and in informal ways. (6)

I personally had informal conversations about the project with others who were involved in this collaboration. (7)



Q17 Continuing with this collaboration experience in mind, please rate your level of agreement with the following set of statements about **concrete, attainable goals and objectives and shared vision**:

	Strongly Agree (1)	Agree (2)	Neither Agree nor Disagree (3)	Disagree (4)	Strongly Disagree (5)	Not Applicable (6)
I had a clear understanding of what our collaboration was trying to accomplish. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People in our collaboration knew and understood our goals. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People in our collaboration had reasonable goals for the project. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The people in this collaboration were dedicated to the idea that we could make this project work. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My ideas about what we wanted to accomplish with this collaboration seemed to be the same as the ideas of others. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q18 Continuing with this collaboration experience in mind, please rate your level of agreement with the following set of statements about ***uniqueness of purpose, sufficiency of funds, staff and material and skilled leadership***:

	Strongly Agree (18)	Agree (19)	Neither Agree nor Disagree (21)	Disagree (23)	Strongly disagree (24)	Not Applicable (25)
What we were trying to accomplish with our collaboration would have been difficult for any single organization to accomplish by itself. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No other organization in the community was trying to do exactly what we were trying to do. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Our collaboration had adequate funds to do what it wanted to accomplish. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Our collaboration had adequate "people power" to do what it wanted to accomplish. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The people in leadership positions for this collaboration had good skills for working with other people and organizations.  
(5)

☐ ☐ ☐ ☐ ☐ ☐

Q19 Thinking about collaborations **WITHIN** towns in the MetroWest region, where some public health resources are shared, *such as animal control, nursing, and inspection services*, is your own organization currently benefiting from such collaborations?

☐ Yes (1)

☐ No (2)

Display This Question:

If Thinking about collaborations WITHIN towns in the MetroWest region, where some public health reso... = Yes

Q20 If yes, what are the ways in which these collaborations might be further improved?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Display This Question:

If Thinking about collaborations WITHIN towns in the MetroWest region, where some public health reso... = No

Q21 If no, what do you think have been the barriers to successful collaborations **WITHIN** towns in the MetroWest region?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Q22 Thinking about collaborations **ACROSS** towns throughout the MetroWest region, where some public health resources are shared across municipalities, *such as animal control, nursing, and inspection services*, is your own organization currently benefiting from this collaboration?

☐ Yes (1)

☐ No (2)

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Display This Question:

If Thinking about collaborations ACROSS towns throughout the MetroWest region, where some public hea... =  
Yes

Q23 If yes, what are the ways in which these collaborations might be further improved?

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Display This Question:

If Thinking about collaborations ACROSS towns throughout the MetroWest region, where some public hea... =  
No

Q24 If no, what do you think have been the barriers to successful collaboration **ACROSS** towns throughout the MetroWest region?

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End of Block: III. Perception of Collaborations

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Start of Block: IV. Areas of Support

#### Q25 IV. Areas of Support

The next set of questions are aimed at looking ahead for the next 3-5 years. Please reflect on the types of support (*e.g., training and professional development, personnel capacity, etc.*) are needed to promote public health and health equity across MetroWest communities. Please note that we understand that health department and human service organizations may have different areas of support than that of town administrators and/ or elected officials. Therefore for town administrators and/ or elected officials, please think about what the needs of your health department. Did you have a formal public health training in your career in the past (*e.g., a degree or certificate in public health or allied disciplines, Continuing Education Credits (CEUs), internships, fellowships, apprenticeships, etc.*) ?

☐ Yes (45)

☐ No (46)

*Display This Question:*

*If IV. Areas of Support The next set of questions are aimed at looking ahead for the next 3-5 years.... = Yes*

Q26 If you had formal public health training in the past, please share the type of training you completed.

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Q27 Do you feel you have adequate skills needed in your line of work?

☐ Yes (1)

☐ No (3)

*Display This Question:*

*If Do you feel you have adequate skills needed in your line of work? = No*

Q28 If you do not feel that you have adequate skills for your current job, please share some of the skills and/ or resources needed that can help you do your job better.

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Q29 Do you manage a team in your current role in your organization?

☐ Yes (1)

☐ No (2)

Q30 Do you think your team has adequate formal public health training?

- ☐ Yes (1)
- ☐ No (3)

Q31 Do you think your team has adequate skills needed for their job?

- ☐ Yes (1)
- ☐ No (3)

*Skip To: Q33 If Do you think your team has adequate skills needed for their job? = Yes*

Q32 If no, what are some the skills that your team can use to do their job better?

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Q33 In planning ahead for the next five years, please list the types of support that you may need (please check all that apply):

*Please note that we understand that health department and human service organizations may have different areas of support than that of town administrators and/ or elected officials. Therefore for town administrators and/ or elected officials, please think about what the needs of your health department.*

More staffing capacity (1)

- ☐ Updated IT infrastructure (2)
- ☐ Interdisciplinary training programs (3)
- ☐ Cultural and linguistic competencies (4)
- ☐ New data science skills to keep up with the demands of the job (5)
- ☐ Development of health education and health promotion services (6)

- ☐ Greater funding and real time surveillance for public health emergency preparedness (7)
- ☐ Continuously available health department to address public concerns in a timely manner (8)
- ☐ Greater funding for core preventive public health programs like immunization, diabetes prevention etc. (9)
- ☐ Other (please specify) (10)

Q34 Apart from the types of support listed above, what other types of support do you think are needed for better attaining public health goals?

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Q35 Below is a list of different stakeholders that you may need support from, please check all of the stakeholders you will need support from:

- ☐ Local Board of Health (1)
- ☐ Local health department (2)
- ☐ Town officials (3)
- ☐ Town residents (4)
- ☐ Coalition Coordinator (5)
- ☐ Other (please specify) (6) \_\_\_\_\_

Q36 Apart from the types of stakeholders listed above, what other types of stakeholders are needed for better attaining the public health goals of the MetroWest communities?

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Q37 How long do you intend to remain with your organization? (*As a remember, this is an anonymous survey, so your response will not be linked back to you.*)

- ☐ Less than 1 year (1)
- ☐ 1-2 years (2)
- ☐ 3-5 years (3)
- ☐ 5-10 years (4)
- ☐ More than 10 years (5)
- ☐ Unsure (6)

Q38 Do you think there are sufficient career advancement opportunities in your organization for yourself?

- ☐ Yes (1)
- ☐ No (3)

End of Block: IV. Areas of Support

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Start of Block: V. Best Practices and Recommendations

Q39 V. Best Practices and Recommendations

*This is the final section and question. Therefore after submitting an answer to the question below, you cannot go back to the previous survey questions.*

Are there any additional information or recommendations that you would like to share with us and/ or would be helpful to know?

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End of Block: V. Best Practices and Recommendations

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## Appendix D: Scenario-based Interview Guide

### Introduction Script:

*Thank you for agreeing to share your knowledge of and experience with public health infrastructure in the MetroWest region. We are evaluation researchers based at Northeastern University [introduce interviewer], working with the MetroWest Health Foundation to assess the public health infrastructure in your area. You have been invited to take part in this interview because you and your agency have been identified by the Foundation as a key leader and stakeholder in public health efforts in the region.*

*Recognizing the continued impacts of the COVID-19 pandemic and understanding the increased responsibility of those in public health roles, we are interviewing health department and other community leaders in communities with the most serious health inequities or that have been hit the hardest by the COVID-19 pandemic. The purpose of this interview is to look at partnerships and collaborations in the region, to understand what has made collaborations successful or difficult identify existing partnerships in an effort to understand factors that build or inhibit trust among this group of stakeholders, and to identify the potential for new partnerships. We also hope to identify challenges on the horizon and to understand how those challenges may exacerbate existing health inequities in MetroWest or give rise to new ones.*

*Your participation in this interview is **entirely voluntary**. You may decide to stop being a part of the evaluation study at any time. This interview will take approximately 60 to 90 minutes, but may be less. If you are comfortable, we would like to record your answers for the purpose of accurately capturing the information you share with us. You do **not** have to agree with this conversation being recorded in order to participate in this interview. If you do agree, then all recordings will be destroyed within one year of completion of the evaluation study. **Your responses will be kept confidential**. Only the trained research team will have access to this data. We will take care to not identify you in any way. All data will be grouped together and reported in aggregate, and all names will be deleted from final transcriptions.*

*Is it ok if we audio record this interview? \_\_\_\_ yes or \_\_\_\_ no*

*May we begin? Thank you!*

### Section 1: Participant Background

- So first I'd like you to me a little bit about yourself, your background and experience, and your role in your organization?
- How long have you been at this organization?
- Can you tell us a little bit about where you work, such as populations served, and number of staff involved?
- What are some of your favorite things about your current role / organization?
- What are some of the health-related areas in the MetroWest region you think might benefit from increased attention?
- For health department staff:
  - What other organizations do you collaborate with in your work?
- For everyone else?
  - How does your organization engage with the local health department?

## Section 2: Partnerships and Collaboration: Background

First I am going to ask you a few questions about existing partnerships and collaborative efforts at your organization. For the purpose of this interview, we define partnership and/or Collaboration as cooperation between or within organizations that have worked together on a common public health issue or goal in a particular region. Cultivating community partnerships and collaborative efforts can be powerful forces in combatting multiple public health problems.

- Can you tell us a little bit about the ways your organization partners with or collaborates with other organizations across the MetroWest region?
- Do you see any areas where you think increased collaboration would be useful? Please elaborate.
- What are some of the challenges with collaboration in your work, either across the region or within the community itself?
- Can you provide an example of a time where your organization attempted a partnership or collaboration that didn't pan out? What was that like?
- Are there any specific public-health related areas that you think would benefit from increased collaboration in MetroWest? What are some examples?

## Section 3: Partnerships and Collaboration: Scenarios

Intro from interviewer: For the next portion of the interview, I'm going to provide you with some scenarios and/or hypothetical situations that describe examples of potential collaborative efforts, partnerships, and infrastructure changes in MetroWest. Scenario-based design can be a useful tool for engaging community stakeholders in the evaluation of local public health infrastructure, as scenarios allow interviewees to respond to potential real-life situations without having to quantify their interpretation as they would in, for example, survey research. I am going to describe a handful of hypothetical examples of collaboration and partnerships in public health and ask you to respond. There is no right answer, we are really just looking to see how community stakeholders feel about future collaborative efforts and partnerships. Do you have any questions? Ok, let's get started!

The first three scenarios address the potential for streamlining public health services either regionally or across a minimum of three towns:

- The development of shared services districts by investing in shared service arrangements. This would mean formalized collaboration between towns on a particular public health function, such as public health nursing; food, camp, and pool inspections; septic / title v related expertise; emergency preparedness; tobacco compliance; and health education and health promotion. A single, full time employee would be shared by a minimum of 3 towns for 1-2 years.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?
  - Which organizations do you think would be positioned to spearhead this effort? What other organizations or groups should be involved?
- Employ a regional coordinator for health education and health promotion development (such as tobacco, the importance of wearing sunscreen, or injury prevention). This coordinator would work with a consortium of municipalities and community organizations to support community health assessment, program planning and development, and public health coalition development.

- How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
- What are some potential roadblocks or challenges you might encounter if this were implemented?
- Develop comprehensive service districts, where all public health services are carried out by one set of employees for two or more participating municipalities (making up a “comprehensive service district”). Participating municipalities may choose to retain their own boards of health or opt to delegate all authority to a regional board of health.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?

Thank you for your responses! The next set of scenarios describe more specific collaboration around public health functions.

- Local health departments across MetroWest partner with their local law enforcement and relevant community organizations/ nonprofits to provide trainings and education to police in particular public health areas, such as Narcan training, domestic violence training (de-escalation, cycle of violence, cyclical patterns of abuse in both heterosexual and LGBTQ relationships), and needle exchange programming.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?
- A local health department partners with community organizations to provide accessible clinical services to the community, such as immunizations, TB testing, or health screenings. Communication and outreach materials could make a special effort to engage undocumented and/or immigrant communities.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?
- Local health departments partner with local agriculture, farmers markets, and/ or public housing to organize a farmers market and/ or bi-weekly event providing access to inexpensive (WIC and EBT accessible) fresh produce (i.e, coordinating with an organization like [Fresh Truck](#), which parks a school bus-converted farm stand in low-income areas). This event could be held at public housing sites, community health centers, or local school parking lots.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?
- Local health departments partner with community organizations and/ or local nonprofits to provide education and programming that is relevant to child and adolescent health, such as alcohol abuse, smoking, teen pregnancy, STI prevention, psychological well-being.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?

- Local health departments partner with school administrators and local colleges / universities (such as Framingham State University) to offer special seminars and/ or after school events that would provide education and training activities surrounding college admissions for under resourced high school students, with a goal of increasing access to higher education.
  - How would you feel if this were implemented in your area? Do you think it would be effective or ineffective?
  - What are some potential roadblocks or challenges you might encounter if this were implemented?

#### **Section 4: Wrap-up**

Thank you for your responses to those! Just a few follow-up questions –

- Out of the scenarios I just described, which did you think was the most appealing examples of collaboration? Why or why not?
- Out of the scenarios I just described, which were the least appealing? Why or why not?
- Did any scenario jump out as a good idea, but too challenging to execute in your community? Please elaborate.

Those are all of our questions. Did you have any questions for us about the project or anything you'd like to add that was not covered by our questions?

Great, well thank you so much for agreeing to participate. Again, your responses will be kept confidential, and your information will be deidentified. Thank you so much for your time and generosity in sharing your knowledge and experiences!