

The Path to Multi-Jurisdictional Models of Public Health Service Delivery in Massachusetts: What do Local Community Leaders Face in Planning for Change?

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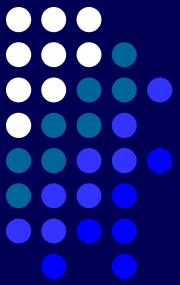


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Disclosure & Acknowledgements

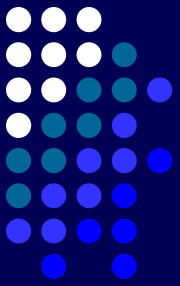


- I have not had any relevant financial relationships during the last 12 months.
- I do not intend to discuss an off-label use of a product during this presentation.

Acknowledgement

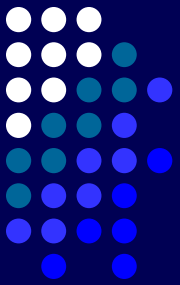
- Research was subcontracted by MA DPH with funding from the CDC's National Public Health Improvement Initiative

Educational Need/Practice Gap



This paper adds to the literature on public health service sharing and furthermore has implications for understanding how to effectively plan for multi-jurisdictional models as future communities explore service sharing as a strategy to provide essential public health services and meet accreditation standards.

Objectives



Participants will be able to:

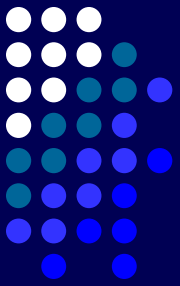
- Describe effective strategies to plan for service sharing
- Identify strategies for engaging local stakeholders
- Explain potential strengths to benefit from

Expected Outcome

Participants will have increased understanding:

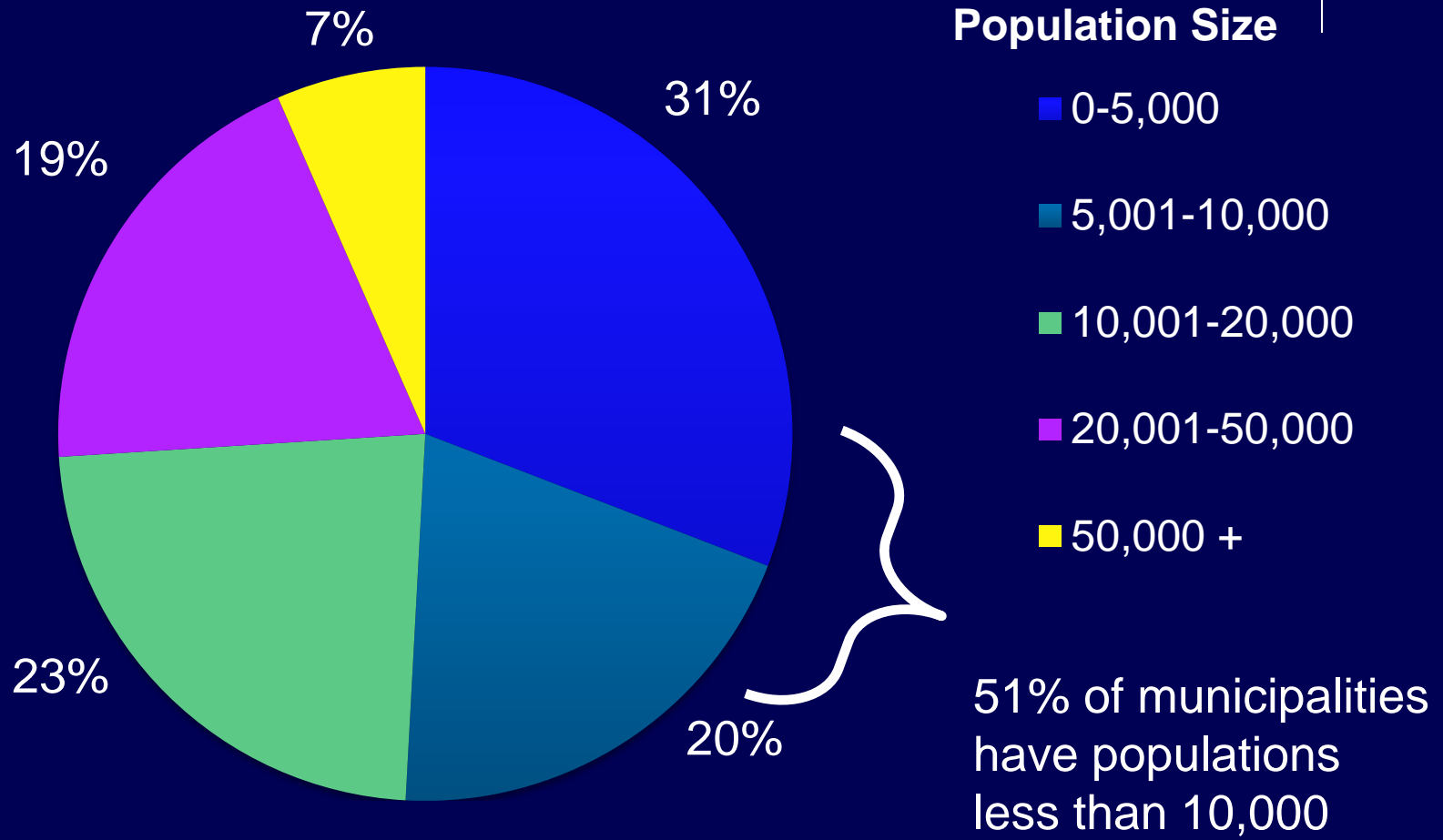
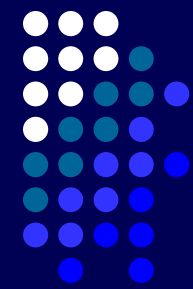
- Driving forces, strategies and circumstances that influence local public health and municipal leaders in service sharing
- Strategies employed to plan for service sharing
- Strengths and challenges
- Recommendations and Lessons Learned

MDPH District Incentive Grant Program Goals



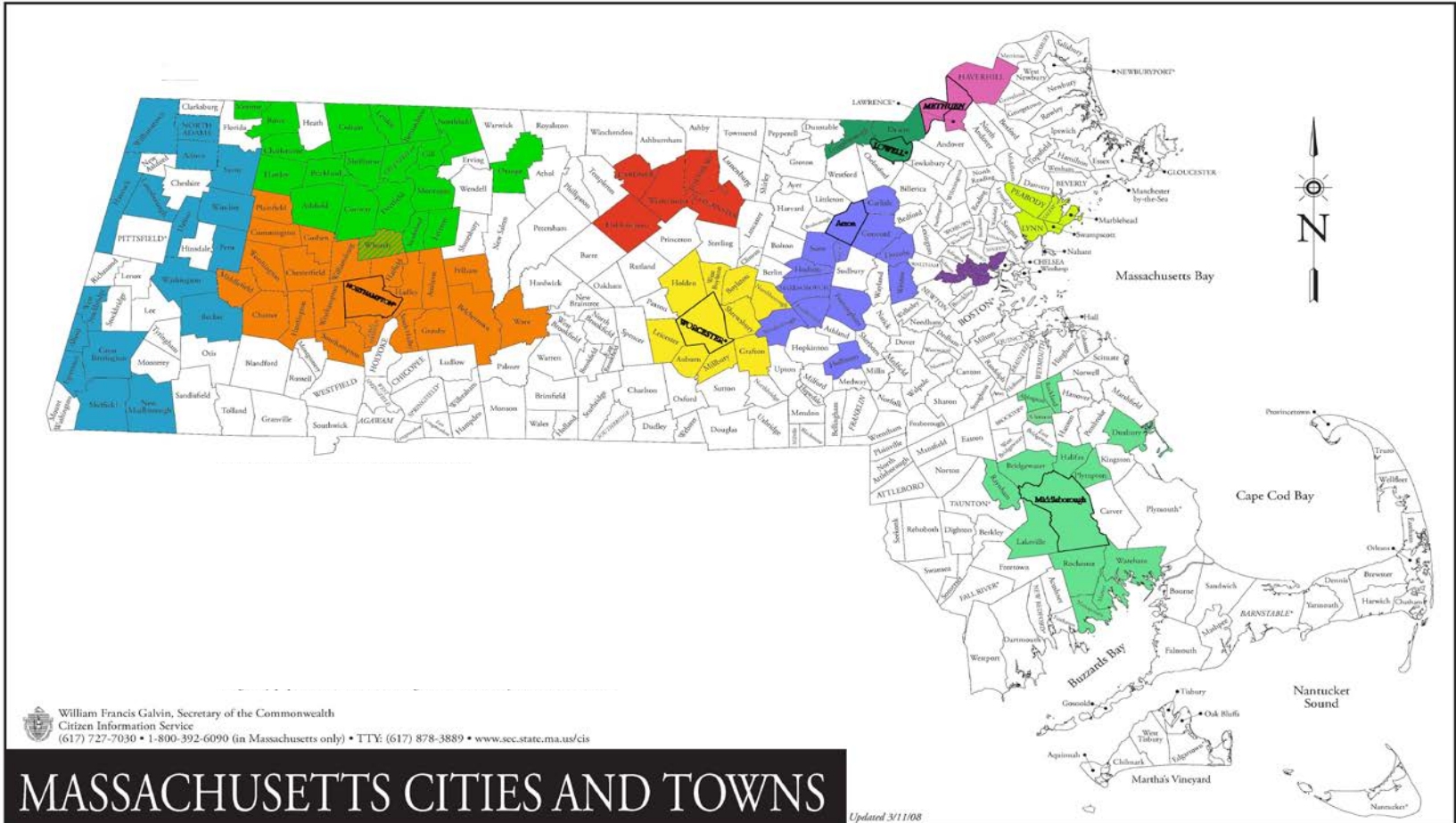
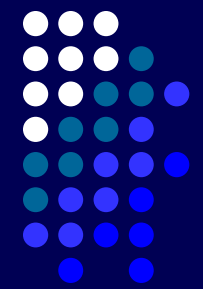
- Funded by the Centers for Disease Control, National Public Health Improvement Initiative to:
 - Improve scope and quality of LPH services
 - Reduce regional disparities in LPH capacities
 - Improve efficiencies in LPH service delivery
 - Policy change to improve population health
 - Strengthen workforce qualifications
 - Prepare for voluntary national accreditation
- Planning phase and 4 year Implementation

Local Public Health in Massachusetts

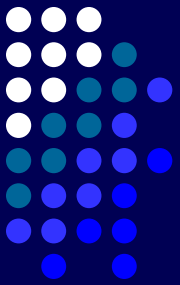


351 Municipalities
351 Local Boards of Health

District Incentive Planning Grantees

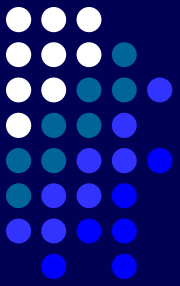


Methods



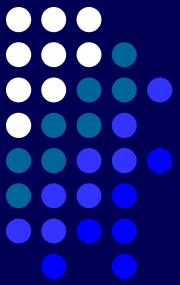
- Semi-structure interviews over the phone
- Measures
 - Planning phase
 - Motivation, Approach, Successes, Challenges, Lessons Learned, Outcomes
- Sampling
 - 2 public health leaders selected from each planning group
 - 1 lead agency, 1 randomly selected municipality
 - 2 municipal / political leaders

Sample Description



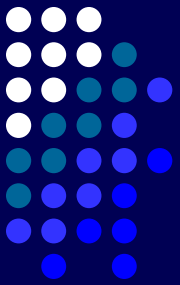
- 30 Respondents from 11 planning groups
 - 21 Public Health Officials
 - 9 Elected Municipal Officials
- Of 30 participants, 27 from communities who applied for implementation grants
- 7 of 9 municipal leaders familiar with DIG

Results: Motivations



- Recognized lack of capacity to provide state mandated services (PH)
- Desire to expand public health services offered to public (PH)
- Lower costs of public health service delivery (PH)
- Opportunity to expand existing regional partnerships (PH/ ML)
- Perceived strength in numbers (PH/ ML)
- Increase efficiencies in service delivery/staffing (PH/ML)
- Fiscal responsibility (ML)

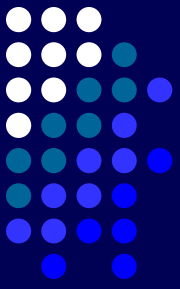
Results: Desired Outcomes



Municipal leaders-

- Increase staffing
- More professional response
- Cost effective (using \$ better)
- Using data to inform work
- Establish shared performance measures/ key indicators
 - Cost savings
 - Expand services (health education, campaigns, policy)
 - Improvements in health

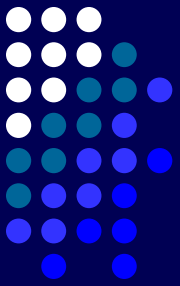
Results: Planning Strategies



Public Health Leaders-

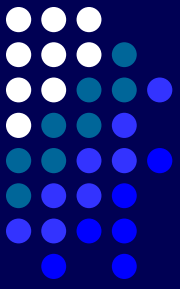
- Utilize outside consultant to facilitate strategic planning
 - Perceived of as neutral party
 - Difficult to find one with skills and LPH knowledge
- Frequent meetings with local public health
- Initial visioning activities
- Data collection to examine budgets, volume of services, staffing, salaries
- Examination of most appropriate models
- Joint meetings with BOH and elected officials

Results: Challenges



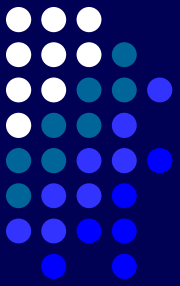
- Requirements of grant did not match interests or sense of what could be accomplished (PH)
- Heterogeneous municipalities with respect to size, demographics, governance, SES (PH/ ML)
- Differential investment in local public health across municipalities (PH/ML)
- Issues of control- local control and micromanaging (ML)
- Mistrust (ML)
- “All talk no action”/ Inertia (ML)

Lessons Learned & Recommendations



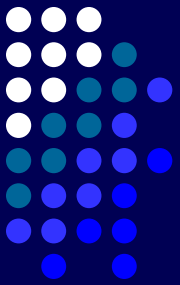
- Clarify your municipality's goals (PH)
- Identify a lead agency who is respected (PH)
- Involve diverse representatives from interested municipalities early in the planning process (PH)
- Planning infrastructure change time intensive (PH)
- Find like-minded partners- attitude matters (PH/ML)
- Requires investment in relationship building & trust (PH/ML)
- Be flexible and open-minded (PH/ML)
- Success brings success (ML)
- Avoid Micromanaging- meet most not all needs (ML)

Recommendations for Technical Assistance/ Support Entity



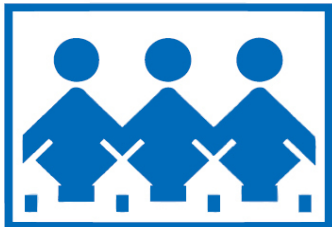
- Technical assistance around legal issues was valuable (PH)
- Refine tools developed for planning purposes, make them available to others (PH)
- Allow for communities to create service sharing models that will work for them (PH/ML)
- Provide guidance earlier on what will be expected of grantees (PH/ML)
- Provide standard Performance Measures (ML)

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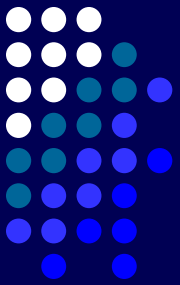


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Results: Models



Planning groups worked to address issues of:

- governance
- staffing
- identification of host agent for implementation
- overall model for service delivery

**Coordinated
Service Delivery**

**Menu-style/Partial
Shared Services**

**Comprehensive
Service Delivery**

Host agent provides
central coordinating
function for
contracted public
health services

Sharing 1-2 staff
positions
Based on core of public
health nursing and
prevention

Hybrid model –
comprehensive
with a menu
option