

Public Health Regionalization Initiative Meeting  
Meeting Minutes  
January 9, 2008

Present: Betsey Andrews Parker, Joan Ascheim, Bobbie Bagley, Mary Ann Cooney, Wendy Dumais, Ellen Fernandes, Kate Frey, Tracy Gay, Yvonne Goldsberry, Louise Hannan, Denise Horrocks, Judy Jervis, Nicole LaPointe, Chris LeClaire, Martha McLeod, Kim McNamara, Mary Miller, Heidi Peak, Kristin Shaw, Rick Silverberg, Janice Southwick, Jonathan Stewart, Danielle Thompson, Neil Twitchell.  
Recording Secretary: Jennifer R. Dutch

**1. Opening and Welcome**

Mary Ann Cooney welcomed members of the Public Health Regionalization Task Force to the meeting.

**2. Moving Toward a Regional Public Health System in New Hampshire**

Joan Ascheim reviewed the progress made so far and gave an overview of the discussions from previous meetings. She noted that the overall goal of the process is to develop a performance-based public health delivery system, which provides all 10 essential public health services throughout New Hampshire. Some of the work done to date includes:

- ◆ Reviewed potential framework for a tiered system
- ◆ Reviewed potential staffing patterns
- ◆ Gathered information to determine the function of a local health agency versus form Reviewed the ongoing role of the state at the local level
- ◆ Explored the local/regional perspective
- ◆ Examined the role of the health officer
- ◆ Learned about the county perspective

During the last meeting, the group conducted a “Case Study” exercise. Members of the group broke down into smaller groups to look at a series of questions including:

- ◆ What the region might look like – a map
  - Consensus was that this will be difficult
- ◆ How the regions might be organized
  - Consensus – don’t abandon the local roles
- ◆ Who else should be involved in the discussions
  - County Commissioners
  - Legislators/Local Officials
  - Consumers
- ◆ Points of tension
  - Local vs. County
  - Staffing
  - Funding
  - Existing Organizations
  - Health Officer
  - Legal
  - Map
- ◆ Any additional information that is needed
  - Strengths and weaknesses of current system
  - Legislative changes
  - Sample agreements
- ◆ Input on the process
  - Keep going

- Have the discussion locally
- ◆ Next steps
  - Clarify government entity
  - Rumor control

### 3. **Presentation**

Martha McLeod and Nicole Lapointe gave a presentation on the activities underway in the North Country. They noted that they cover the area “north of the notches”. There is no formal public health entity. Their work is not through citizen organizations, but is based in the health provider world through a Health and Human Services provider network. They said that they work with their partners and provide technical assistance, addressing services and the region together. The region includes 53,000 people in a large geographic area that crosses two counties. They face a lot of challenges related to health status, resources and location. They are a very rural area and lack monetary resources.

Some of the duties they have taken on include convening, facilitation, bringing people together around issues, technical assistance, project management, and grants management. Working with a provider-based system it can be difficult to bring the population based versus patient based focus.

Nicole Lapointe noted some of their strengths from the CDC assessment include workforce development, increasing access, mobilizing community partnerships, and health education. She said that they have begun working with data sets for Coos County and the region which have been showing what was previously known anecdotally – that the North Country faces some challenges relative to the rest of the state, especially in the areas of cardiovascular health, youth drug and alcohol use and abuse, tobacco, diabetes and other disparities. They have been focusing areas of advocacy on policy development and assessment. The lowest score on the CDC assessment was in enforcement. Berlin is the only city with a health department. The public health infrastructure at the local level is usually one person who may or may not have training.

Martha McLeod noted that there had been discussion about whether or not a nurse was a necessary part of staffing. She said that the needs in the North Country are different. With issues around resources, access, and health status, there is a high need for the expertise of a nurse. The North Country has a different type of population from the rest of the state with lower incomes and lower education levels. The rate of cardiovascular disease is twice the rest of the state and access is a definite issue. It is a rural area with a small population spread over a wide area. She noted that they would not use a population-based formula. She said that the clinical experience of a nurse is needed to respond to the health status needs of the North Country. She underscored that the North Country is an area with very different resources and population from the other regions of the state. Income is 30% less than the rest of the state and only 12% have an education level above high school. There needs to be a different response to the public health challenges in the North Country. That is why there needs to be a lot of technical assistance and help with capacity building. There is no cookie cutter response that would fit. Other areas of the state might be similar, but not face the same disparities.

Kim McNamara noted that Portsmouth is also very different from the rest of the state, but for different reasons than the North Country. Portsmouth has high-income levels and high education levels. There are already a lot of services in place and she would not want to reinvent the wheel. Many of the 10 Essential Services are already provided in the area.

Martha McLeod noted that different functions are needed in each area and assessment of needs is an important part. For example, while it is important to have credentialed professionals, making it a requirement of certain positions might make a greater struggle for the North Country where finding individuals with certain credentials is very difficult. She said that it is important not to create an even bigger disparity than what already exists.

Mary Ann Cooney noted that these were very good points. She said that it would be an important step to define the differences in needs within the regions and that it would be based on assessments. The assessments would help to determine where the gaps in the 10 Essential services are for each region. The

duty of the public health entity would be the assurance of those 10 essential services. The public health entity would be regionally located with its roles and responsibilities defined regionally.

Kim McNamara asked if the goal was to reduce the number of health officers by replacing them with a regional health director. Mary Ann Cooney replied that it is not a matter of telling the local communities what to do. The job of the regional public health entity would be to coordinate with the local health officers. Joan Ascheim added that it is important to remember that this is an evolutionary process. It will not happen overnight and it depends on what works well. Kim McNamara noted that part of the problem is that some health officers play a large role locally and others do not. She said that it is important for health officers to be qualified. Joan Ascheim noted that was part of the project that Fred Rusczeck is working on. Denise Horrocks noted that it would not be unrealistic to move to a regional health officer with defined competencies. She said that it is important to establish a place for the health officer locally and then make sure that they are expected to meet the competencies of the job. Joan Ascheim noted that model Fred is working on is based on two types of health officers – full-time and part-time. Competencies would bring the part-time health officers up to the same standard through trainings and education. Judy Jervis noted that this was voluntary. Joan Ascheim noted that once standards are set people in New Hampshire it might not be difficult to get local buy-in, especially when taking into account liability issues. She said that voluntary programs tend to work in New Hampshire.

Betsey Andrews Parker asked when something might be put in writing that could be brought to the towns and cities. She said that it would allow them to provide feedback on the process. She said that for many it is not real yet. Mary Ann Cooney said that it isn't real yet. She said that there is progress being made. Betsey Andrew-Parker said that they are interested and concerned about funding issues.

Rick Silverberg asked that once there is concrete proposal, that the regions be given enough time to bring the document to the local level, gather partners and discuss. Mary Ann Cooney replied that it is an evolutionary process. She said that it would be a major change in infrastructure and capacity building. There will need to be statutory changes and they will include dates of what needs to be done when. She said that the implementation would take a long time.

Bobbie Bagley noted that there has been a lot of discussion about Health Officers and a lot of discussion about nurses. She said that it is important to remember that someone has to bring the public health training and knowledge to the region. Mary Ann Cooney noted that the job descriptions and roles and responsibilities would include those requirements. She said that it would be important to offer public health training opportunities throughout the state. Joan Ascheim noted that workforce competency is part of the public health improvement process. She said that there is a workgroup focusing on this issue and they are currently determining who to develop competencies for.

Jonathan Stewart noted that part of the process is looking at increasing regional capacity by looking at what capacity currently exists locally and at the state level and exploring how that capacity can be shifted or be parallel. This is part of the planning process.

Martha McLeod noted that there seem to be a lot of assumptions being made and it is important to clearly state what those assumptions are before the process is too far down the road. For example, there is the assumption that credentialing improves quality, but it can also increase disparity. Mary Ann Cooney said that there would need to be subcommittees to look at some of these issues such as assumptions, job description development, relationships between state and local. She said that the group is talking in broad generalities now and it can be very frustrating. But, it is part of defining something this huge that changes the direction of the state.

Kim McNamara cautioned about resource shifting. She said that tattoo inspections have been moved locally and it is a responsibility that they are trying to assume, but it is on top of everything else like lead, etc.

#### **4. Defining a Regional Public Health Governmental Entity**

Mary Ann Cooney said that one of the first things to do when thinking about a Regional Public Health Governmental Entity is to take away thoughts of bricks and mortar and think in terms of authority and ability to act. This will allow for representation of every municipality and county and will be recognized in state statute as the responsible entity that is held accountable.

Some requirements include maintaining a regional public health council, having elected/appointed public officials as the majority of voting seats, and allowing for additional members to be named to the council.

Kim McNamara noted that she would be opposed to a Board of Health. She said that it would not create efficiencies. Mary Ann Cooney asked what would be lost. Kim McNamara said that they would lose the ability to act quickly and she would not want to go outside of Portsmouth for the ability to act. Yvonne Goldsberry said that in her area the technical capacity is in Keene. A lot of towns call on Keene for assistance and they help with a system of given and take, but they do not have any authority. A regional system would clarify roles, but would not preempt enforcement in Keene. Mary Ann Cooney said that this process is not taking away local authority, but establishes the abilities across a region. Communities will still have their own laws. Betsey Andrews Parker noted that the regions would act broadly giving a yay or nay on funding, but towns would maintain their own laws. Mary Ann Cooney said that a good example are tobacco coalitions. They receive money from the state and the coalition makes the decision on how to use that money in the region. However, it does not preclude specific towns from making a decision to take on tobacco as an issue.

Jonathan Stewart said one question around regionalization is the “local control dance”. Joan Ascheim said that there would need to be a legal review of any proposal. The group would propose a model and then there would be a legal consultation. Mary Ann Cooney said that there would need to be laws developed to support what needs to happen.

Mary Ann Cooney said that other requirements of the governmental entity would include activating the regional public health response plan, implementing additional public health activities, accepting and expending funds, and designating a fiscal agent. Betsey Andrews Parker asked what would happen with communities who say no. Mary Ann Cooney said that communities can opt out, but they would have no voting power. They would need to comply with the region during emergencies. Neil Twitchell said that an example would be that the region has the authority to stand up an ACC. A town may have opted out of planning for the ACC, but that ACC still serves the population for that town. Betsey Andrews Parker asked what the incentive to participate would be if there would be a plan in place anyway. Neil Twitchell said that the incentive is that otherwise they will not know what is going on. Mary Ann Cooney said that communities would hopefully see the benefit of participating.

Wendy Dumais noted that cost is where the conversation stops. She said that currently the law is per capita. Betsey Andrews Parker agreed that if towns were forced to put in a substantial chunk of funding they would not participate. Nicole LaPointe noted that capacity is more than just funding. She said that in her area some towns are not able to participate they just allow regionalization to happen because they do not have the capacity to participate.

Wendy Dumais noted that the responsibility to activate the plan is different than the responsibility to respond. Mary Ann Cooney said that response is part of the responsibility.

Rick Silverberg noted that it is important to include private non-profits in the ability to accept and expend funds. He noted that there are many grants where government entities are not able to apply. One example is federal prevention funds.

Joan Ascheim reviewed models for delivery of Essential Public Health Services for a selection of the 10 Essential Services. For example, for Essential Service #1, the government entity ensures ongoing objective assessments, community health improvement plans, and other activities.

Mary Ann Cooney noted that the health officer often responds to building, plumbing, and sewer complaints. She said that it could expand to the role of the regional health officer. Denise Horrocks said that she often refers to health officers as annoyance officers. She said that the function would not be able

to be taken away locally, but needs to be competent and consistent. She said that consistency is lacking in the state.

Rick Silverberg noted that his area had a regional public health officer. That person worked on sanitary issues, indoor air quality, and much more. She worked with local health officers and became the deputy health officer in six towns. The local health officers were able to call on the regional health officer for help. He said that it was a system that worked well. Mary Ann Cooney said that the issue is authority. Rick Silverberg said that she had authority in the towns where she was a deputy and acted as a consultant in the other towns. Kim McNamara said that her concern would be that as the health officer for Portsmouth she often accesses the Portsmouth legal department, but would not be able to do that for work for other towns since it is a Portsmouth resource. Rick Silverberg said that access to legal department resources could be written into the agreement between towns.

Betsey Andrews Parker said that enforcement, prevention, policy development are huge responsibilities that are too big for one person and the roles should be divvied up. She said that it would be difficult to find all of those skills in one person. There is a role for an administrator, a role for an Environmentalist/Health Officer and others. Rick Silverberg said that it is important to look at defining responsibilities, not people. Some responsibilities can be contracted or designated elsewhere. For example, hospitals do community education and that piece can be contracted out to them.

Eileen Fernandes said that the regions would have the authority to look at the 10 Essential Services in their own regions. They will be able to see who does what and what is the best way to get it done in their own regions. Each region will have its own resources and will be able to develop a way to use them to the best of their ability. She said that they will not be reinventing the wheel or having a cookie cutter region.

Joan Ascheim said that they are looking at what a regional governmental entity would look like with current resources. She said that there are roles that are important to government, but that they recognize that non-governmental entities are doing good work. There are some good starting places, such as expanding existing legislation beyond emergency management. Kim McNamara asked about primary versus comprehensive. Joan Ascheim said that they recognize that not all regions have the resources to create a comprehensive public health entity. The primary responsibilities are a different level. It is what is realistic and reasonable for the region. It does not prevent regions from moving into the comprehensive level. Kim McNamara asked if there were certain things wanted for the regions to be primary. Joan Ascheim said that there are basic things. Neil Twitchell added that the regions would reach the level over time. Joan Ascheim said that the intent with the governmental entity is to ensure objectivity, authority, and assurance. Jonathan Stewart said that it is important not to lose the accountability to one another. He said that hospitals have certain resources and the community holds the hospital responsible for using funds for prevention.

Rick Silverberg said that it was important to think about long-term implications. While there needs to be government authority, there is a need for long-term partnerships. He said that there is a collectively responsibility, including private non-profits. There needs to be a regional system approach that is not redone every two years. Jonathan Stewart added that it is important that the governmental entity not become a bottleneck to tunnel through. It needs to be able to leverage power through the community and partnerships. Mary Ann Cooney said that it is important to remember that as statutes are being developed that they include the flexibility for regions to define for themselves in determining how to carry out functions, as long as they are carried out. A good example is the Manchester Coordinating Council.

Yvonne Goldsberry said that there is a downside to formalizing informal cooperation. She said that informal cooperation is very strong right now in her area. She said that if it is formalized onto a piece of paper there is a potential to lose out. Currently, they act together outside the traditional "pie" and formalizing that agreement would change the dynamic. Today, they are not told they have to do it, so it gets done. The partners are very pro-collaboration. Instead of looking at things and asking if it is their role or responsibility, they want to participate because it is good and the right thing to do. If it is formalized, there is an element of the automatic opt-out.

Betsey Andrews Parker noted that another danger is like what happened with SPF. They were coordinating well before, but now there are substantial paperwork requirements. She also asked if the fiscal agent could be a municipality or a non-profit and if the staff comes out of the fiscal agent or the government agency. Mary Ann Cooney replied that either could be the fiscal agent. For the staff, the region would define the structure and it might be a different scenario.

Betsey Andrews Parker said that one thing that is missing is the blessing that you are the public health entity like in 156. Joan Ascheim said that it is dependent on statutory changes.

## 6. Next Steps

Mary Ann Cooney said that it is time to move onto the next step: defining the regions. She said options for designating public health regions include:

- based on a public health/healthcare delivery infrastructure
- based on counties

either option allows for a government entity based on statute.

Rick Silverberg said that they are ready to begin defining the geographic region and are having those discussions. Wendy Dumais said that it would be helpful to have number in mind of total regions. Nicole LaPointe said that it would be helpful to identify any low hanging fruit and allow them to form regions and then see what is left on the map.

Mary Ann Cooney said that the range she is looking at is 8-14 that is a manageable number with the money available. She said that the next meeting they could come with the dollar amount for funding. Bobbie Bagley said that it would also be helpful to have the maps of the regions that already exist like AHHR, PHN, SPF.

Christopher LeClaire said that there seemed to be a lot of questions without answers to be moving forward. Mary Ann Cooney said that it is the work of the task force to begin defining the statute. Neil Twitchell said that it was not so much questions without answers as different options. Joan Ascheim said that one of the next steps is to pull out what we do know, the assumptions, and options.

Rick Silverberg said that it does feel like the state office is really hearing the input from the group. He said that it is important to remember that one size does not fit all so there will need to be time allowed for input from the local partners to confer on options and then time to go to the constituents in the smaller towns. He said that it might take a while to do that before defining a map.

Yvonne Goldsberry said another responsibility is to respect the process. She noted that with the SPF process there was a lot of work put into determining the regions and then they got back a map that did not look like what they had discussed.

Betsey Andrews Parker noted that if she brings the plan to her Board and 8 out of 10 say no, she will vote not. She asked what the formal process for accepting it will be. Neil Twitchell suggested adding developing a formal decision making process to the agenda of the next meeting. Kim McNamara noted that Portsmouth was not given the option of participating on the Task Force originally and it would not be fair not to be able to vote. Louise Hannan noted that one health officer was appointed to the Task Force and was not able to make any of the meetings.

Betsey Andrews Parker noted that she has been told about what the group has "agreed to" but it is not clear that the group has agreed to anything. Rick Silverberg noted that he has shared copies of the meeting minutes to show what has been discussed. Yvonne Goldsberry noted that Mary Ann Cooney had participated in a discussion and presentation in her region.

Jonathan Stewart noted that when defining the regions it is important not to base it on current funding, but base it on what is effective over the long term. Once that is determined, the regions will work to get the resources to support what is needed to make it work.

7. **Schedule and Goals of Future Meetings**

Scheduled dates for future meetings of the Public Health Regionalization Task Force. All meetings will occur at 9:30 AM – 12:00 PM at a location to be determined.

02/06/2008

03/12/2008

04/11/2008

05/14/2008

06/13/2008 (if needed)

Respectfully submitted, Jennifer Dutch, Recording Secretary