CHAPTER 3
ORGANIZATIONAL OPTIONS

OVERVIEW

The administrative structures of Massachusetts cities and towns vary depending upon municipal size and local tradition. In some small towns, the board of selectmen retains all public health responsibility, while many larger cities support complex city health departments with highly specialized staff. Regardless of size and structure, each local public health entity is responsible for enforcing the State Sanitary and Environmental Codes and for protecting the public health of each city or town by enforcing state laws, adopting reasonable local health ordinances, and by carrying out preventive programs.

Throughout this Guidebook the term "board of health" is used (as it is in state statutes and regulations) to mean "the appropriate and legally designated health authority of the city, town, county, or other legally constituted governmental unit within the Commonwealth having the usual power and duties of the board of health of a city or town or its authorized agent or representative". The composition and structure of boards of health in Massachusetts vary greatly, depending upon how the town or city charter and bylaws establish the "legally designated health authority"

ORGANIZATION OF BOARDS OF HEALTH AND HEALTH DEPARTMENTS

Statutory authority for boards of health includes the following variations:

- Towns may elect the board of health (usually three members for three-year staggered terms, as provided in M.G.L. c.41 §1).
- If the town does not provide for a board of health, the selectmen shall act as the board of health (M.G.L. c.41 §1).
- Towns may vote to have the selectmen act as a board of health, or to have the selectmen appoint a board of health (M.G.L. c.41 §21).
- Towns adopting a town manager form of government may include in the town charter, as one of the duties and powers of the town manager, the duty and power to appoint the board of health. An increase or decrease in the size of the boards may also be included in the town manager's powers (Town Manager's Act, Chapter 11, Acts of 1951 and Chapter 512, Acts of 1972; M.G.L. c.43 §103).
- In cities, the mayor appoints the board of health (three members including one physician, provided that none is a member of the city council), unless the city charter provides otherwise (M.G.L. c. 111 §26).

- Cities or towns may vote to accept M.G.L. c.111 §§26A-26E and establish a health department with a commissioner of health and a mandatory advisory council of nine members including two physicians and five non-professionals. The advisory council is appointed by the mayor (city) or board of selectmen (town).

- Municipalities may enter into agreements with other towns or cities to obtain services on a regional basis. Two or more towns may jointly appoint a health officer to be responsible to the regularly constituted boards of health of those towns. A joint committee composed of the board of health of the member towns appoints and determine components and duties of the health officer (M.G.L. c.111 §27A).

- Two or more towns or cities may form a regional health district with a regional board of health to takes the place of the local towns' boards of health except insofar as the regional health district may, by majority vote, delegate certain powers and duties to the constituent municipalities. In this instance a regional board of health hires a full-time director of health who is either a physician or lay person with professional academic training and experience in public health administration (M.G.L. c.111 §27B). Such regional health districts may apply to the Commissioner of the Massachusetts Department of Public Health for partial reimbursement of initial capital outlays for establishing a regional district (M.G.L. c.111 §27C).

- Towns may vote to increase the size of the board of health according to procedures outlined in M.G.L. c.41 §2.

ORGANIZING STAFF

There is considerable variation from town to town in the mix of tasks performed by health department staff depending on the size, composition, and environment of the community. Health departments and boards of health employ physicians, public health nurses, sanitary inspectors, food inspectors, health officers, clerks and other specialized personnel depending on the needs of the community. Where there are no staff, responsibilities are assumed by board members or other town officials such as the town clerk.

M.G.L. c.111 §27 provides in general for the governance of boards of health:

> *"Every such board shall organize annually by the choice of one of its members as chairman. It may make rules and regulations for its own and for the government of its officers agents and assistants. It may appoint a physician to the board who shall hold his office during its pleasure, may choose a clerk, who in a city shall not be a member of the board, and may employ the necessary officers, agents and assistants to execute the health laws and its regulations. It may fix the salary or other compensation of such physician and its clerks and other agents and assistants."*

Staff may be full-time and have responsibilities in specific program or specialty areas or may be part-time and have limited responsibilities in specific program or specialty areas or may be part- time and

have limited responsibilities. Several titles are commonly used to identify the administrative officer of a local health department:

- Commissioner of Health (M.G.L. c.111 §26A)
- Agent and/or Director of Public Health (M.G.L. c.111 §30)
- Inspector of Health or Sanitarian (M.G.L. c.41 §102 and M.G.L. c.111 §27).

Many boards find it useful to prepare an outline of responsibilities and draw up an organizational chart for the health department. Lines of authority and responsibility should be established but be flexible in order to accommodate the skills and personalities of staff, the needs of the community, and functions to be performed. A typical community is continually changing; the structure and staff of the health department must be adaptable. A board of health may appoint a health officer, part- or full-time, who is responsible for the employment of all other personnel and the assignment of tasks. Members of the staff, in this case, are ultimately responsible to the health officer who, in turn, is responsible to the board.

The board of health may appoint an agent who may be one of its members or the administrative officer of the board or of an association of boards of health subject to its direction and control to act on its behalf in case of emergency, or if the board cannot conveniently meet. Such an agent has all the authority of the board, but is required to report emergency actions to the members within two days for their approval.

ADVISORY COUNCILS AND COMMITTEES

Cities with a commissioner of health and a health department are required to have a health advisory council (as defined in M.G.L. c.111 §26C) which advises and assists the commissioner of health. In addition, boards of health providing home health services certified by the Medicare and Medicaid programs have professional advisory committees to advise them on services, procedures, and evaluation.

In addition to such mandated advisory groups, boards of health may establish either standing or ad hoc advisory committees to assist them in evaluating services, planning to meet anticipated needs, or providing ideas and recommendations regarding policy issues. Other chapters in this Guidebook, such as "Outreach and Education", suggest additional ways the board of health may involve the community in discussion of public health issues and how they can best be addressed.

SHARING STAFF

The inter-municipal employment of qualified health personnel may provide professional health expertise at a reasonable cost to constituent towns while retaining the autonomy of local boards of health. Commonly, in arrangements like this, staff implement public health programs and routine enforcement tasks and rely on each local health board when key policy decisions must be made. Under the authority of M.G.L. c.111 §27A, two or more towns (not cities) may form a district for the purpose of employing health agents.

The association is completely voluntary and non-binding and staff employed by such an association are considered employees of each cooperating community and under their joint jurisdiction. The joint committee:

- appoints personnel and sets compensation;
- determines the relative amount of service which employees will render to each town;
- estimates, each June, the amount of funds needed to operate the district for the coming fiscal year; and
- determines the proportion of costs and expenses to be paid by each town.

Any constituent town may withdraw from the district association by vote before December 1st. Formal withdrawal takes place on January 1st following a vote of the Town Meeting.

Each town retains the authority for making "reasonable health regulations" which are then enforced by the association's employees acting as the town's agents. (M.G.L. c.111 §31).

Local boards can and do charge their own fees for certain local board services. In towns that follow this procedure, the rationale is that local services (particularly administrative support) justify the fees. As with most fees, however, a fee must be used to support a specific service; it cannot be used for raising general revenue or it may be challenged in court.

EXAMPLES OF INTER-MUNICIPAL COOPERATION

The Nashoba Example: Nashoba Associated Boards of Health (NABH) was created in 1931 as a result of a provision in M.G.L. c.111 §27A which permits towns to formally join together to provide health services. Its membership includes the towns of: Ashburnham, Ashby, Ayer, Berlin, Bolton, Boxborough, Dunstable, Groton, Harvard, Lancaster, Littleton, Lunenburg, Shirley, and Townsend. Under this provision of the law, Nashoba functions as the agent for the elected boards of health in its member communities. The fourteen member towns elect an Executive Committee under mutually agreed upon bylaws. Meetings of both the Executive Committee and full Association are held quarterly.

While the local boards of health retain their autonomy and full authority, the Nashoba organization conducts the day-to-day inspections and provides the boards with its findings and recommendations. Nashoba is a public non-profit agency that derives its support from funds assessed from its member towns and fees charged to users of the agency's services. The assessments and fees are established by vote of the members of the association. In the past decade there has been a concerted effort to reduce assessments and rely increasingly on user fees to support specific services.

The following sections describe in detail the broad range of services that Nashoba Associated Boards of Health continues to provide on a daily basis.

Nashoba services include nursing, social work, dental and environmental programs designed to protect and improve public health in the Nashoba service area. Since its founding in 1931, the Nashoba Associated Boards of Health has expanded its range of service from traditional tasks such as social work, nursing visits and disease prevention to increasingly contemporary needs such as AIDS education, well permitting, and general environmental protection. As the Agency has worked to provide this wider range of services, its staff has grown to over 175 individuals reflecting an increasing degree of expertise and sophistication. To meet the challenge, Nashoba staff includes registered

sanitarians, certified health officers, registered nurses, registered physical therapists, registered social workers, registered dental hygienists, and certified home health aides.

Nashoba's Environmental Health Department enforces state regulations governing safe and sanitary housing, swimming pools, bathing beaches, and recreation camps for children and families. They inspect restaurants and retail food stores, and enforce laws which prevent health hazards and nuisance conditions. The staff also provides information and consultation to residents of the 14 communities regarding a variety of environmental and public health issues such as water quality protection, pollution abatement, and incident response.

The Nashoba Nursing Service provides medical services funded by local boards of health and available to area residents. It also provides fee-for-service visiting nurse care both on a private pay and third-party insurance reimbursement basis. In 1966, NABH was certified by the Federal Health Care and Finance Administration and the Massachusetts Department of Public Health (DPH) to provide home health care to Medicaid and Medicare eligible patients. This fee-for-service program, delivered by the agency's non-profit Nashoba Nursing Service, is a natural extension of Nashoba's public health tradition. This program includes visiting nurses, physical, occupational, and speech therapists, certified home health aides, and medical social services.

Nashoba also acts as a distribution station for vaccines and immunizations provided by DPH. Area physicians look to Nashoba as the source for critical supplies of tetanus/pertussis, diphtheria, polio, measles, mumps, rubella, flu and pneumonia vaccines and TB screening materials.

Nashoba Nursing and Dental Programs, funded through local boards of health, are designed to promote good health and prevent the spread of disease. These programs include work site, well adult, and senior clinics to screen for diabetes and to monitor blood pressure and cholesterol levels. The NABH nurses also administer flu immunizations and conduct preventive health education workshops. Acting as "town nurses," Nashoba nurses visit people at home during illnesses, provide help with newborns and prenatal care, and teach general health procedures and preventive measures for communicable diseases.

NABH has long provided basic preventive dental health services to its member towns through its School Dental Program. Funded solely through the local assessment to the towns, Nashoba's registered dental hygienists provide oral screening, chair-side dental instruction, dental cleaning, and fluoride treatment (with parental permission) for grades 2 and 4, and classroom dental health education in grades K, 1 and 3. Children with dental problems are referred to their own dentists for follow-up. Nashoba's school dental program has also secured state grants for materials used in an optional fluoride rinse program which has been made possible in many Nashoba communities through the generous cooperation of local teachers and parent volunteers. Nashoba's dental program directly services over two thousand school children in its member towns.

Other Examples of Inter-municipal Cooperation:

- Two or more cities or towns may form a regional health district with a regional board of health, a director of health, and staff (M.G.L. c.111 §27B). The regional board must be composed of at least one representative from each constituent municipality, or more depending upon population size. Unless certain powers are specifically delegated to constituent municipalities, a regional health district has all the powers normally held by boards of health or health departments.

- A county-wide health department may be formed. Barnstable County, a county-wide system was established in 1926 by a special legislative act. While there is no specific enabling legislation to permit the formation of a county system, special legislation may be introduced. Under Barnstable County's system, the Health Department is funded through the County Commissioners and acts to supplement and coordinate activities of individual boards of health within the county.

REMOVAL, RESIGNATION OF MEMBERS

A municipality is prohibited from removing members of a board established under state law, even where there is cause for removal, unless there is statutory or charter authorization for removal. Since there are no statutory provisions for the removal of members of a town board of health, they cannot be dismissed or removed in mid-term unless a charter provision or special legislation so provides. A mayor, however, may remove a member of a city board of health for cause and fill the vacancy by appointment (M.G.L. c.111 §26) (Benes et.al.1995).

No resignation of a town official is effective until it is filed with the town clerk or until such later time as specified in the resignation (M.G.L. c.41 §109). An appointed board member may resign by voluntarily tendering his or her resignation and having it accepted by the appointing authority (Benes et.al.1995).

FILLING A VACANCY

Elected Boards: If there is a vacancy on an elected town board of health, the selectmen, along with the remaining members of the board of health, shall fill such vacancy. The board of health must notify the selectmen in writing within one month of the vacancy. In the case of a resignation, the town clerk must notify the executive officers of the town. The selectmen must give one week's notice of the meeting at which the vacancy will be filled. A roll call majority vote of the combined boards is required for appointment. If the board of health fails to notify the selectmen within one month of the vacancy, the vacancy shall be filled by the board of selectmen (see M.G.L. c.41 §11).

Appointed Boards: If the board is appointed, any vacancy will be filled by the appointing authority (Benes et.al.1995).

CHARTER PROVISIONS

M.G.L. c.43B, as well as the Home Rule Amendment, permits municipalities to adopt home rule charters governing their form of government. A charter may establish a unique blend of appointed and elected boards for a particular municipality, may determine the number of members of a board, the term of office, and may merge or divide the responsibilities of local offices. A town charter is the functional equivalent of law. A town charter may make other provisions for the election or appointment of a board of health. A town charter supersedes any General Laws to the contrary regarding whether a local board (such as the board of health) is to be appointed or elected, and regarding its make-up and appointing authority, and the appointing authority for town officers and employees (M.G.L. c.43B §20) (Benes et.al.1995).

CONTRACTING FOR PROFESSIONAL SERVICES

Boards of health may provide or expand services by entering into contractual agreements with other agencies and organizations. Such agreements may be designed specifically to help a board of health meet its needs, and can be incorporated in the overall program planning process. Authority to contract for services provides a board of health with a broad base of resources to draw on including:

- increased flexibility in meeting changing needs;
- access to specialized community, district, regional or other services, in proportion to town needs;
- saved administrative time, as well as reduced overhead and start-up costs;
- reduced duplication of services and need for staff development;
- strengthened capacity of community agencies to provide comprehensive services; and
- increased opportunity to devote time to other public health duties.

Examples of types of services that boards of health in Massachusetts have purchased by contract include:

- nursing services;
- environmental sanitation inspections;
- home health services for premature infants and other high-risk infants, children, or adults;
- Clinics - well baby, well adult, screening for selected problems, immunization, dental, etc.;
- school health services; and
- health education programs.

Legal Authority to Enter Service Contracts: No bylaw or ordinance can be passed that would conflict with a law established by the general court (Massachusetts Constitutional Amendment Article II, Section 1). Due to the expressed legislative mandate in M.G.L. c.111 §27, giving boards of health power of appointment, removal, and the ability to fix the salary and compensation of its agents, a bylaw or ordinance establishing a practice otherwise would be in conflict with an act of the legislature.

Town governments and/or boards of health have the authority to contract for services for the exercise of their corporate powers. Towns may appropriate funds to meet needs, including those related to public health and the performance of the duties of the board of health (M.G.L. c.40 §5[19]). "Contracts for health services may be made by the board of health or any legally constituted board performing the powers and duties of a board of health" (M.G.L. c.40 §4).

Towns may also make contractual arrangements for such services as public health nursing services, homemaker services, sanitation, waste disposal, and such services may be managed by the selectmen, board of health, or other officers having charge thereof (M.G.L. c.40 §4). Greater flexibility is further provided through M.G.L. c.40 §4A which provides that any government unit may enter into a contractual agreement with one or more other government units to perform jointly, or for the other unit, or units, any service which each contracting unit is authorized by law to perform.

Procedures for contracting for professional services may differ among towns because boards of health differ in their relationships with their local governments, and because towns may have bylaws regulating contracting for services.

Local boards can, and do, charge their own fees for certain local board services. In towns that follow this procedure, the rationale is that local services (particularly administrative support) justify the fees. As with most fees, however, a fee must be used to support a specific service. It cannot be used for raising general revenue or it may be challenged in court.

Notes on Contracting for Professional Services: While contracted services may be, in certain circumstances, more feasible than additional staff, the expense should be justified with a cost-benefit analysis. Foresight is needed in planning for contracted professional services, and board of health budgets should anticipate the need for contractual agreements when appropriate. In order to retain authority and responsibility for services a board must make its goals clear, and require periodic reporting on services rendered from contracted service providers.

In order for boards of health to meet growing demand for public health services on the local level, alternatives to direct service (such as contracting for professional services) may help boards take advantage of resources already available in the community in a cost-effective manner. For example, while retaining full authority for licensing and monitoring standards , DPH successfully provides millions of dollars worth of public health services through private contracts in local communities statewide.

STAFF EVALUATION AND EDUCATION

It is key that a board of health specify, in writing, the expected duties of staff (including both general and specific responsibilities). Commonly, a board of health will prepare a job description for the administrator, who in turn will be responsible for the preparation of other job descriptions and standards.

Professional associations may also be able to suggest guidelines or performance standards for a particular profession, such as nursing or sanitary engineering. Formal accreditation, certification, and registration mechanisms exist in many health fields to ensure minimum levels of competence.

Continuing education opportunities in universities and colleges provide a means for board of health staff to refresh or broaden their knowledge. In-service education programs, arranged by the board of health staff, also can be used to upgrade the quality of staff.