A Public Health Mutual Aid Agreement in Massachusetts

By Kerry C. Dunnell, MSW and R. Lynn Schoeff, M.Ed.

Public health departments in Massachusetts are staffed by a variety of types of public health professionals, including sanitarians, public health nurses, and inspectors. The duties of public health departments vary based upon the community infrastructure (septic vs. sewer) and administrative structure. For example, communities with sewer services have little need for skilled septic tank inspectors, while other communities rely predominantly on septic systems, and could not do without those skilled inspectors. Another common variation in staffing is whether school nurses are employed by the health department or by the school department.

There is generally no such thing as a typical health department in terms of its capabilities. Most local health departments do an admirable job of addressing the varying public health needs of their communities with a relatively small staff. However, few, if any, health departments have sufficient staff to provide medication to large numbers of residents. For one public health region in Massachusetts, the impact of a food handler working at a popular local restaurant while infected with hepatitis A provided a stark illustration of the need for public health mutual aid.

The Arlington Event

In June of 2004, Arlington MA health officials discovered that a food worker at a popular family restaurant had been diagnosed with hepatitis A, a liver disease that is not life-

threatening, but is highly contagious. Hepatitis A can cause flu like symptoms, jaundice, and in rare circumstances, more serious liver complication; the illness can be spread through contaminated food or drink if an infected individual does not wash his or her hands after using the restroom. As a precaution, health officials held clinics to provide immune globulin shots to individuals who had dined at the restaurant during the worker's infectious period, as they may have been exposed to the illness. At the end of the clinics, approximately 2800 people had received prophylaxis.

While the health department had done significant planning for the clinics, they had not anticipated such a large demand for the intervention. And, with a staff of 2.5 FTEs, they were not equipped to provide education, screening and medication for that many people. To accomplish this, health officials requested assistance from neighboring communities. These requests were answered with whatever resources communities felt they could provide, ranging from clipboards to non-clinical and clinical staff. The challenge of providing assistance absent a mutual aid agreement was apparent in the decision of some communities to send only non-clinical staff because of potential exposure to liability.

Development of a Public Health Mutual Aid Agreement

A public health mutual aid agreement was drafted by a working group comprised of staff from the Cambridge Advanced Practice Center for Emergency Preparedness, Massachusetts Department of Public Health staff, and attorneys representing the Massachusetts Association of Health Boards, and the City Solicitors & Town Counsels Association. The group reviewed state statutes, public health mutual aid agreements

from other states, and mutual aid arrangements for public safety and fire officials in the Commonwealth. Drafting of the public health agreement focused on whether a declaration of emergency was required to request mutual aid (it was not), whether the provision of aid was compulsory for any party to the agreement (it was not), and whether staff operating outside their communities would remain employees of their communities while operating elsewhere (they would).

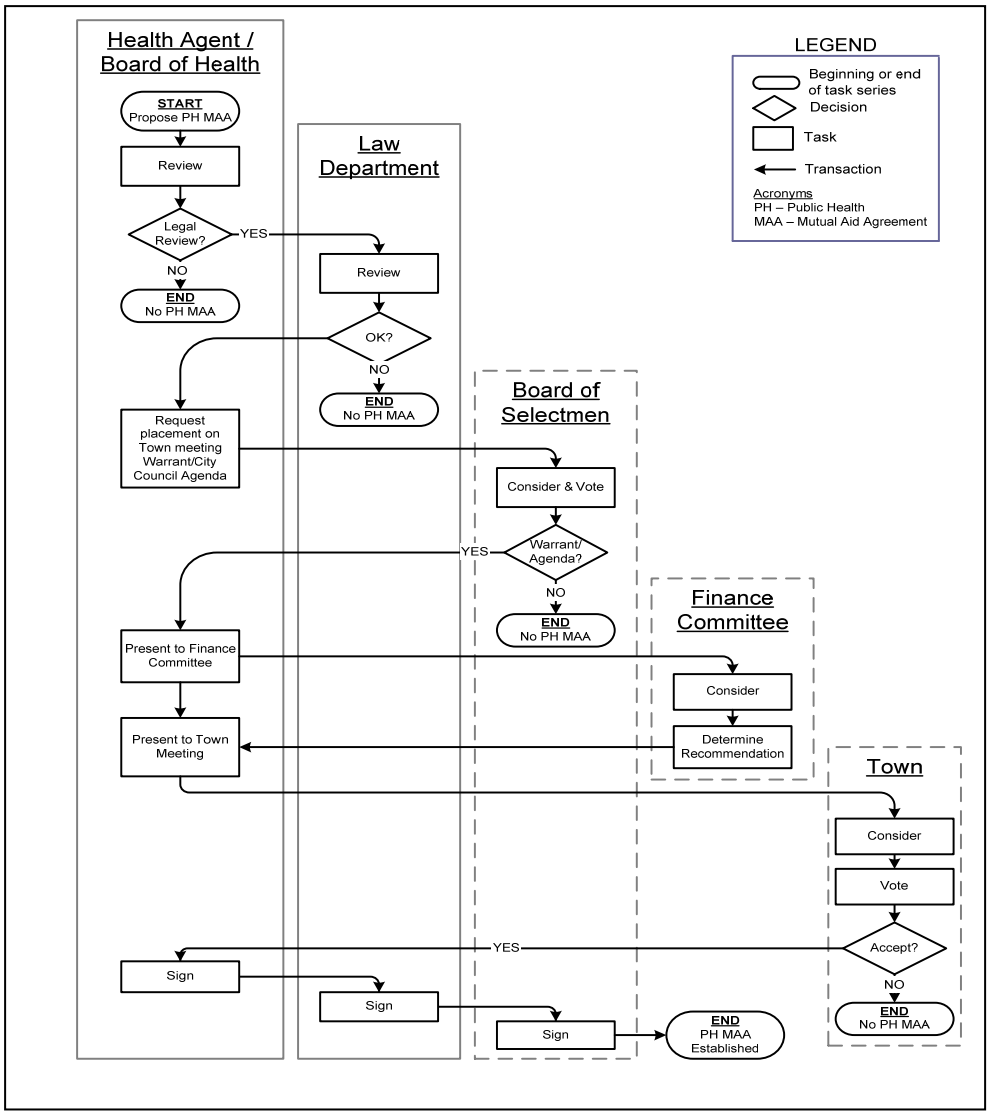
The resulting agreement was part of a public health mutual aid kit made available to all health officials in Massachusetts in December 2005. The kit included an explanation of the agreement, as well as likely scenarios that would benefit from mutual aid, and a *Frequently Asked Questions* document. These support materials were developed for the local health departments and health boards that would be reviewing the agreement and asking for its adoption in their communities.

Since its release, the agreement has been adopted by 24 communities in Public health Region 4b, as well approximately 100 communities in other public health regions in Massachusetts.

Implementation Process

In Massachusetts, there is no specific state statute to permit public health mutual aid among municipal health departments. State statutes do permit mutual aid activities for both public safety and fire departments. Without any specific statute, public health departments have relied upon the authority of municipalities to enter into intermunicipal

agreements pursuant to Massachusetts General Law Chapter 40 4A. The statute requires that any intermunicipal agreement be approved by town meeting in towns, and by city council in cities. (For those not from New England, town meeting is an annual meeting of the governing body of a town. The membership may be comprised of all voting residents of a community, or of a representative number of voting residents.) The steps for each of these types of approval are similar; however, the time frame for communities governed by town meeting is much narrower, as town meetings are generally annual events. In contrast, city government is a continuously seated body, so an agreement may move at any time in the calendar year. The following diagram depicts the process for adoption of the mutual aid agreement in towns in Massachusetts. The diagram shows that the health agent must participate in each portion of the process, and that each party in the process has equal power to accept or to end consideration of the agreement.



Educating and Advocating

Health department officials in Region 4b began the work of moving the public health mutual aid agreement through their communities in December of 2005. Cambridge APC staff reviewed all components of the kit with staff and offered technical assistance through phone conference, individual meetings and attendance at municipal meetings.

The varying capacity of health departments throughout the region was reflected in the questions posed by municipal boards. Boards uniformly pressed on the questions of how

health department staff would be made available, and used by, other communities. In a system with limited resources, officials asked for assurances that entering into such an agreement would not allow neighboring communities to rely on the agreement to provide basic services not funded in their own communities but would be invoked only during extreme need. Well-resourced communities needed to be persuaded that they would not be exploited by the use of mutual aid. Some boards in relatively well-resourced towns questioned whether their communities really needed to enter into a public health mutual aid agreement.

Telling the story of the Arlington Hepatitis A incident was an effective and valuable illustration of the potential need for mutual aid in any community.

Communities with fewer resources, acknowledging the possible need for outside support, would worry that a mutual aid agreement might require them to send aid any time it was requested. This concern was addressed with a provision in the agreement, requires each party only to *consider* the request, and send aid as they could.

Command and Control

Safety of employees was another common question raised in deliberations. Having recognized that no single health department could handle the number of clients that were seen in Arlington, boards expressed concerns about how to protect their staff members operating in other communities. The agreement had been written to allow "sending" communities to retain control of their employees operating in another community. This

allows a community to call its employees back because of safety or changing local needs. In addition, the agreement clarifies the issue of liability, by making clear that employees are, at all times, employees of their municipality.

"There ought to be a law"

During the period of drafting and subsequent adoption of the Public Health Mutual Aid agreement, legislation was also filed to permit communities to enter into intermunicipal agreements, including public health mutual aid agreements. Approximately 7000 bills are filed during each two year session of the Massachusetts legislature. Given the deliberate pace of legislation in the Massachusetts General Court and a sense from local health officials that the need was more pressing than legislative time would permit, staff made the strategic decision to pursue local agreements while continuing to advocate for legislative support.

In the current session (2007-2008), the bill has progressed to the House Committee for 3rd reading.

Progressing Community by Community

The agreement was thoroughly discussed and well received in municipalities in Region 4b. By April 2006, 17 communities in the Region had completed the process of review and adoption. Most city council and town meetings for consideration of the agreement were held in the evening – some stretched on until 10:00 pm. The efforts were rewarded in Region 4b; in May of 2007, 21 communities in Region 4b had adopted the agreement.

As of May 2008, 24 communities have adopted the agreement, and the remaining three cities in the region will be considering it during the calendar year.

Conclusion

Local health officials need to be able to cross community borders to request or provide assistance in a wide range of public health events – situations that may involve a few individuals exposed to a highly infectious disease such as measles, or as many as several thousand as in large-scale hepatitis A clinics. Health officials who work toward adoption of mutual aid agreements commit themselves to a lengthy process, and can benefit from technical assistance. Armed with a strong grasp of the provisions, and a good working relationship with their governing bodies, health officials, the process of education and advocacy can lead to adoption of this critical enabling tool. Public health officials will need to continue to be patient and persistent in their pursuit of approval of public health mutual aid.