



Blueprint for Public Health Excellence

Recommendations for Improved Effectiveness and Efficiency of Local Public Health Protections

REPORT OF THE SPECIAL COMMISSION ON
LOCAL AND REGIONAL PUBLIC HEALTH

EXECUTIVE SUMMARY

JUNE 2019

ABOUT THE SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

The Special Commission on Local and Regional Public Health was created by a legislative resolve signed by Governor Charles Baker in August 2016. The 25-member body's charge was to "assess the effectiveness and efficiency of municipal and regional public health systems and to make recommendations regarding how to strengthen the delivery of public health services and preventive measures."

This is the executive summary of the final report of the Special Commission on Local and Regional Public Health.

The final report, executive summary and other information about the Commission are available on the Massachusetts Department of Public Health website at:

www.mass.gov/dph/olrh



MESSAGE FROM PUBLIC HEALTH COMMISSIONER MONICA BHAREL

Dear Colleague,

As the Massachusetts Department of Public Health celebrates its 150th anniversary and its extraordinary public health accomplishments, the Commonwealth's public health infrastructure is at a turning point. Studies over the past two decades document significant differences across cities and towns in the quality, depth, and breadth of public health protections. Recognizing the need to reassess the Massachusetts local and regional public health system and make recommendations to improve it, the legislature passed and Governor Baker signed into law Chapter 3 of the Resolves of 2016 to establish the Special Commission on Local and Regional Public Health. As chair of the Commission, it is my pleasure to share the executive summary of its findings and recommendations and to invite you to join us as we follow the path outlined by the Commission to strengthen the Massachusetts local public health system.

The report reflects the participation of a wide range of stakeholders who were actively engaged in the nearly two years of study and discussion by the Commission. To ensure that its recommendations represented a diverse set of interests in the wellbeing of residents of the Commonwealth, the Commission was structured to include members of the legislature, designees of the leadership of key executive branch agencies, representatives of public health and other key stakeholders, and appointees by the governor. We have been fortunate that the people selected to serve on the Commission have brought extraordinary wisdom, passion, and experience to its work. For that reason, readers of this report can trust that it is the product of careful, thoughtful, and informed deliberation on ways to strengthen our local and regional public health system.

I hope that this report will foster continued discourse on strengthening local public health capacity and add to the Commonwealth's legacy as a public health leader and innovator.

Sincerely,

Monica Bharel, MD, MPH, Commissioner
Massachusetts Department of Public Health
Chair, Special Commission on Local and Regional Public Health

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

EXECUTIVE BRANCH REPRESENTATIVES

Department of Public Health

Dr. Monica Bharel, MD, MPH, Commissioner, Chair, Special Commission on Local and Regional Public Health

Executive Office of Administration and Finance

Sean Cronin¹, Senior Deputy Commissioner of Local Services

Department of Environmental Protection

C. Mark Smith, PhD, MS, Director, Office of Research and Standards

Department of Agricultural Resources

Lorraine O'Connor, DVM, Chief Veterinary Health Officer, Division of Animal Health

APPOINTMENTS BY THE GOVERNOR

Research/Academic Institution

Justeen Hyde, PhD, Health Sciences Researcher, U.S. Department of Veterans Affairs

Community Health Center

Maria Pelletier, MPA, BSN, RN, Administrative Director, Pediatrics, East Boston Neighborhood Health Center

Hospital System

David McCready, Brigham Health

Workforce Development

Charles Kaniecki, local public health consultant

Municipality with population greater than 50,000

Sharon Cameron, MPA, RS, Director, Peabody Department of Health and Human Services

Municipality with population between 5,000 and 50,000

Vacant²

Public Health District (at least one town with population less than 5,000)

Phoebe Walker, MPPA, Director of Community Services, Franklin Regional Council of Governments

At Large

Dr. Carmela Mancini, DO, MPH, FACP, physician, Marblehead

¹ Replaced Lauren Peters, May 2018

² Although this seat was vacant, several members of the Commission have current or past work experience in municipalities with populations between 5,000 and 50,000.

APPOINTMENTS BY LEGISLATIVE LEADERSHIP

Senate President

Senator Jason M. Lewis, Fifth Middlesex District

Senate Minority Leader

Senator Ryan Fattman³, Worcester and Norfolk District

Speaker of the House

Edward Cosgrove, PhD, Chair, Needham Board of Health (designee of Rep. Denise Garlick⁴, Thirteenth Norfolk District)

House Minority Leader

Representative Hannah Kane, Eleventh Worcester District

REPRESENTATIVES OF NAMED ORGANIZATIONS

Massachusetts Municipal Association

Kevin Mizikar, Town Manager, Town of Shrewsbury

Massachusetts Taxpayers Foundation

Eileen McAnneny, President

Massachusetts Public Health Association

Bernard Sullivan, MPH, CHO, RS, independent public health consultant

Massachusetts Health Officers Association

Sam Wong, PhD, Director of Public Health, City of Framingham

Massachusetts Association of Health Boards

Cheryl Sbarra, JD, Director of Policy and Law

Massachusetts Environmental Health Association

Steven Ward, MA, MPH, RS/REHS, Public Health Solutions, LLC

Massachusetts Association of Public Health Nurses

Terri Khoury, RN, DNP, Public Health Assistant Nursing Professor, Worcester State University

Western Massachusetts Public Health Association

Laura Kittross, JD, MPH, Public Health Program Manager, Berkshire Regional Planning Commission

Public Health Regionalization Working Group

Harold Cox, MSSW, Associate Dean for Public Health Practice, Boston University School of Public Health

³ Replaced Senator Richard Ross, December 2018

⁴ Replaced Representative Stephen Ultrino, December 2018

EXECUTIVE SUMMARY

No other government agencies are as far-reaching—and invisible—as local public health departments. No matter where you are—at home, at work, at school, or at play, local public health departments are responsible for ensuring your safety and wellbeing. Massachusetts is unique in the country in that it has a board of health for each of its 351 cities and towns and a long and proud history of home rule. Its tiny, standalone boards of health,⁵ many formed over a century ago, stand in contrast to the county or regional organization of local public health authority in most other states. Their budgets, often bare bones, are the sole responsibility of individual cities and towns with no dedicated state funding. Their ever-expanding duties are determined by a patchwork of state laws and regulations in addition to local ordinances and by-laws. They report to numerous officials, yet there are few systems in place to assess their performance and no benchmarks for their overall success.

Many of Massachusetts' local health departments are already struggling to meet existing mandates to address communicable diseases, food safety, housing, sewage, well water, and environmental hazards. But in the 21st century, their list of duties has ballooned to include protecting the environment, planning for natural and manmade disasters, preventing new insect and tick-borne diseases, reducing substance addiction, reducing the prevalence of chronic diseases, and improving mental health. The Commonwealth's local public health system has mostly been unable to keep up with these new demands.

Local public health systems can help improve health, build a stronger Massachusetts, and reduce health care costs. If local health departments can forestall just one in one thousand preventable hospitalizations in Massachusetts, it would represent a savings of hundreds of thousands of dollars.⁶ If they can, by educating the public and providing opportunities to eat right and exercise, steer those at risk for chronic diseases to healthier paths, the savings could be millions more. Finally, safe and healthy communities are more likely to have happy and productive residents, increasing the value and reducing the healthcare costs of the state's human capital, a critical component of its thriving educational, medical, biotech, technology, financial, and other industries.

⁵ Throughout this report, reference is made to local boards of health (the policy-making elected or appointed public body) and local health department (the staff who carry out day-to-day public health responsibilities). In most municipalities, the local health department reports directly to the board of health.

⁶ Based on data in "Quality and Access: Preventable Hospitalizations in Low-Income Communities." Massachusetts Health Policy Commission. (August 27, 2017)

If adequately structured, the existing system can improve health for all. Building on existing infrastructure and respecting local autonomy, Massachusetts can offer new ways to organize and support local health departments to raise standards, strengthen collaboration, better use technology, improve skills, and stabilize resources. This report, the findings of the Special Commission on Local and Regional Public Health (SCLRPH), shows how, providing six interlocking recommendations and a detailed roadmap to achieve them. It is time to move the Massachusetts local public health system to a position of national leadership.

KEY COMMISSION FINDINGS

Current State of the Massachusetts Local Public Health System

- Many Massachusetts cities and towns are unable to meet statutory requirements and even more lack the capacity to meet rigorous national public health standards.
- Massachusetts has more local public health jurisdictions than any other state (351)—one for each city and town—and cross-jurisdictional sharing of services is limited despite evidence that it improves effectiveness and efficiency.
- While other states have county or regional systems, most Massachusetts municipalities operate standalone health departments that are unable to keep up with a growing list of duties.
- Because Massachusetts lacks a comprehensive system to collect local public health data, there is limited capacity to measure local public health system performance and to use local data to plan public health improvements.
- The Massachusetts local public health system does not adequately support its workforce with standards and credentials that align with the capacity to meet current mandates and future standards.
- Funding for local public health is inconsistent and inequitable in its ability to meet the current mandates and the needs of a 21st century local public health system.

Evidence to Support System Improvements

- National public health standards provide a framework for a minimum package of services and a roadmap to strengthen the system to meet those standards.
- Massachusetts and national evidence supports cross-jurisdictional sharing as a means to improve effectiveness and efficiency.
- The best practices for data collection and disease surveillance in Massachusetts and other states hold promise for improved data reporting and gathering capabilities.
- While there is an emerging effort to set national workforce standards, many states already have minimum qualifications for some members of the local public health workforce. In Massachusetts, minimum qualifications exist for other municipal officials such as building commissioners and library directors.
- The nationally recognized Foundational Public Health Services framework provides a means for costing out local public health services. Massachusetts and many other states face the challenge of limited investment of resources to ensure local capacity to provide 21st-century public health protections.

Below is a summary of the Commission’s findings and recommendations in response to the Commission’s charge. These findings and recommendations correspond to six areas—standards, shared services, data, credentials, resources, and continuity—around which the remainder of the report is organized.

PUBLIC HEALTH STANDARDS

Massachusetts’ 351 boards of health are tasked by multiple statutes and state regulations to provide a broad array of protections to residents. Over two decades of academic, government, and non-profit studies and the Commission’s own observations show that many local public health departments are falling short of meeting requirements.

Massachusetts has not kept pace with national standards for the local public health system. While not alone among the states, the Massachusetts standard, implicit in its decades-old statutes and regulations, has not been raised to a level that even addresses an older set of standards (the Ten Essential Public Health Services) recommended by the U.S. Centers for Disease Control and Prevention over two decades ago. These standards are the underpinning for the present-day expectations for our public health system.

To improve, the local public health system must first have clear, comprehensive, uniform, and quantifiable goals. The nationally accepted Foundational Public Health Services (FPHS), a set of seven cross-cutting capabilities and five program areas that all health departments should have, is best suited to elevate standards in Massachusetts.

A two-step process is the most realistic for this transformation. The first step is to bring local health departments into compliance with existing statutes and regulations. The second is to help them meet the criteria for FPHS in readiness for when these are adopted at the state level. Higher standards will compel a higher level of functioning across the local public health system, improving outcomes and reducing disparities.

Massachusetts can learn from the experience of several other states that have adopted FPHS or are in the process of doing so. The process of capacity assessment, priority setting, and implementation has been well documented, particularly for Oregon, Washington, and Ohio—three pilot states that have used FPHS as the cornerstone of public health modernization efforts.

While an even more rigorous system—voluntary, national public health accreditation—is currently out of reach for many municipalities, the Foundational Public Health Services can be a stepping stone to it. The Worcester-led Central Massachusetts Regional Public Health Alliance, Boston, and Cambridge are currently the only accredited local health departments in the Commonwealth. The Massachusetts Department of Public Health is one of 36 state health departments that are accredited.

PUBLIC HEALTH STANDARDS

KEY FINDINGS

- Many Massachusetts cities and towns are unable to meet statutory requirements and even more lack the capacity to meet rigorous national public health standards.
- National public health standards provide a framework for a minimum package of services and a roadmap to strengthen the system to meet national standards.

RECOMMENDATIONS

Elevate the standards for and improve the performance of local public health departments by:

- Finding ways to help cities and towns meet existing statutory and regulatory requirements, and
- Evaluating timeline and appropriate phases of implementation of the Foundational Public Health Services (FPHS) as the minimum set of services that every Massachusetts resident can expect to receive.

CROSS-JURISDICTIONAL SHARING

Massachusetts has 351 local public health jurisdictions, far more than any other state, and a long history of local autonomy. Most states, by contrast, organize their local public health system at the larger county and district levels, a structure demonstrated to improve effectiveness and efficiency by the Center for Sharing Public Health Services. Despite its obvious value, Massachusetts' cities and towns have been slow to embrace models for shared public health services.

By pooling resources, functions, and expertise, a consortium of cities and towns, especially those that are smaller or less prosperous, can improve compliance with their statutory and regulatory mandates and expand the protections and opportunities they offer residents.

Cross-jurisdictional sharing (CJS) has many advantages. It can offer both division of labor and economies of scale. Individual boards of health do not give up statutory authority, and taxpayer investment is maximized.

The Commonwealth already has a long history of public health resource sharing, often in response to a crisis or Massachusetts Department of Public Health (DPH) funding. Today, some Massachusetts municipalities participate in public health districts or other shared services arrangements. A sample of compliance measures for Massachusetts cities and towns in a federally-funded pilot program for shared services showed marked improvement in food inspections; use of Massachusetts Virtual Epidemiologic Network

(MAVEN), the state’s electronic epidemiological surveillance system; and the capacity to do lead determinations during housing inspections.

Progress has been made, but Massachusetts’ local public health system remains a patchwork, and most residents are not receiving the full complement of services and protections. This deficiency is exacerbated by new 21st century challenges. Further cross-jurisdictional sharing is the natural next step in the evolution of Massachusetts’ local public health system.

In its efforts to build upon its experience with cross-jurisdictional sharing, the Commonwealth can look to best practices in Massachusetts and nationally for tools, roadmaps, and similar evidence-based resources.

CROSS-JURISDICTIONAL SHARING

KEY FINDINGS

- Massachusetts has more local public health jurisdictions than any other state (351)—one for each city and town and cross-jurisdictional sharing of services is limited despite evidence that it improves effectiveness and efficiency.
- While other states have county or district-based systems, most Massachusetts municipalities operate standalone health departments that are unable to keep up with the growing list of duties.
- Massachusetts and national evidence supports cross-jurisdictional sharing as a means to improve the effectiveness and efficiency of the Massachusetts local public health system.

RECOMMENDATIONS

- Increase cross-jurisdictional sharing of public health services to strengthen the service delivery capabilities of local public health departments, take advantage of economies of scale, and coordinate planning.
- Increase the number and scope of comprehensive public health districts, formal shared services agreements, and other arrangements for sharing public health services.

DATA REPORTING AND ANALYSIS

In the Commonwealth, local health departments maintain three dozen different kinds of records, according to the Massachusetts Association of Health Boards. These include records of inspections, immunizations, court filings, meetings, and complaints. Only a few are required by statute or regulation to be reported to DPH, impeding the state’s ability to support the local public health system and to do statewide monitoring and planning.

Local health departments in Massachusetts implement and enforce regulations from both DPH and the Massachusetts Department of

Environmental Protection (DEP). Yet neither DPH nor DEP have a comprehensive system for processing and analyzing information about how well local health departments are protecting the public. DPH has limited capacity to gather and share data with local health departments—data that could inform and improve local planning and decision-making. A comprehensive data system would allow DPH and DEP to do this.

The Commission’s Data Subcommittee sought to assess compliance of Massachusetts’ local health departments with mandated reporting to DPH, but the results were inadequate because response rates were low and the state agency’s ability to follow up was limited. An important next step in the improvement of Massachusetts’ local and state public health system is a robust capacity assessment as has been done in other states to determine if it can deliver the FPHS services model.

In other states, local health departments have begun to use public health informatics to help acquire, store, and use information to improve population health. Many of these states have implemented mandatory local health “report cards” that can be reviewed by state and local administrators, the state legislature, and consumers.

Massachusetts’ local data infrastructure and data-related workforce capacities are underdeveloped. National studies suggest that local health departments are eager for more data-related training and professional development, especially in using and interpreting data. Adopting higher standards such as the Foundational Public Health Services will create an even greater demand for informatics proficiency.

DATA REPORTING AND ANALYSIS

KEY FINDINGS

- Because Massachusetts lacks a comprehensive system to collect local public health data, there is limited capacity to measure local public health system performance and to use local data to plan public health improvements.
- The best practices for data collection and disease surveillance in Massachusetts and other states hold promise for improved data reporting and gathering capabilities.

RECOMMENDATIONS

Improve state and local public health departments’ planning and system accountability by:

- Creating a standardized, integrated, and unified public health reporting system, and
- Strengthening the DPH, DEP, and local public health capacity to collect, analyze, and share data.

WORKFORCE CREDENTIALS

In Massachusetts, the lack of uniform standards for experience, training, credentialing, and staffing for board of health members and local health departments creates differences in local public health capacity across the state. Where you live determines not only the depth and breadth of public health protections that are available, but also the qualifications of the individuals providing the services.

The personnel crisis is even worse in small towns and rural areas, hamstrung by small budgets, geographic isolation, and a lack of infrastructure. (The Commonwealth may want to examine workforce size as it prepares to adopt the Foundational Public Health Services.) Lower salaries and part-time positions make it challenging to recruit and retain employees with cutting-edge public health training. Those that are hired and want to acquire or update credentials may have difficulty doing so. The Commonwealth should determine the size of the workforce needed to meet Foundational Public Health Services standards.

The Commission's Workforce Credentials Subcommittee gathered data from over 275 local health departments on staff positions and qualifications, training and training budgets, staffing budgets, permits, and inspections. It found differences in service delivery resulting from disparities in support and funding and the lack of workforce standards. The subcommittee concluded from its survey and other studies that the following contributed to those disparities: 1) lack of incentives or penalties for ensuring a qualified staff; 2) limited return on investment for individuals investing in training and credentialing; and 3) high turnover, high rates of retirement, and challenges in recruitment and retention.

Overall, the health districts and other shared services arrangements in the survey, 11 of 15 statewide, outperformed the standalone health departments, with a higher rate of certified and credentialed staff and better pay for management and clerical staff. The survey also revealed that many Massachusetts health departments have little or no budget for professional training, often lack coverage for staff to attend training, face long travel times to training programs, or have limited internet access to online training. In some cases, health departments so poorly understand their role that they simply do not know what they need to know.

Massachusetts' institutes of higher learning do not offer undergraduate majors or programs in municipal public health, so there is no pipeline of students field-trained to inspect food establishments and housing, oversee waste disposal, respond to chemical hazards, or support other common local public health needs. This problem will be exacerbated by the large number of experienced workers who are expected to retire in the next few years.

While free and low-cost voluntary training programs for the Massachusetts public health workforce exist, including online, web-based, and blended classroom training and other formats, they are offered infrequently and in limited parts of the state. That these are voluntary may also widen existing disparities, since, when combined with work demands, distance, and other considerations that impede participation, it often means that those who could most benefit, often cannot or do not.

WORKFORCE CREDENTIALS

KEY FINDINGS

- The Massachusetts local public health system does not adequately support its workforce with standards and credentials that align with the capacity to meet current mandates and future standards.
- While there is an emerging effort to set national workforce standards, many states already have minimum qualifications for some members of the local public health workforce. In Massachusetts, minimum qualifications exist for other municipal officials such as building commissioners and library directors.

RECOMMENDATIONS

Set education and training standards for local public health officials and staff and expand access to professional development while ensuring diversity by:

- Implementing the local public health workforce credentialing standards adopted by the Commission,
- Making training available and accessible to local public health departments, and
- Developing a system to track and monitor workforce credentialing.

RESOURCES TO MEET SYSTEM NEEDS

Unlike most other states which distribute state funding to local health departments, in Massachusetts, local public health relies almost exclusively on municipal property taxes and fees for funding. Many or most are already straining to provide necessary services.

System-wide changes recommended by the Commission to improve the local public health system such as grant programs, technology, training, and technical assistance will clearly benefit individual cities and towns. However, while municipalities have some incentive to financially support such efforts on their own, the reality is they may not without state-level support.

These changes will also improve state-level outcomes, reducing health costs overall and helping to create a healthy workforce, indirectly bolstering the economy—a significant public good. It is therefore appropriate that the Commonwealth consider providing funding to modernize the local

public health system so it can meet its existing mandates and the expanded expectations of the 21st century.

Local health department budgets in Massachusetts vary wildly and are almost always subject to the many and competing demands of other municipal departments. Some large and mid-size health departments fare well but most are unable to provide essential public health services to their residents. The half of Massachusetts health departments that represent towns of 10,000 or fewer residents face significant challenges with resources.

States that have modernized their local public health systems usually provide direct aid to municipal health departments. Massachusetts does not, although it does offer more than \$1 billion in Unrestricted General Government Aid (UGGA) to cities and towns.⁷ Many other local government departments in Massachusetts, such as schools, libraries, and councils on aging, have dedicated state funding with credentialing and performance requirements which allows them to consistently provide high-quality services to residents and to plan and carry out long-term projects. This type of stable resource should be considered for the local public health system.

Existing resources should be used more efficiently. One of the most impactful strategies is the formation of multi-municipal districts. This pools budgets, staff, and functions and can improve effectiveness and efficiency as compared to standalone health departments. In doing so, local health departments are better able to partner with hospitals and other health and human services providers to expand the scope of public health protections available to residents.

RESOURCES TO MEET SYSTEM NEEDS

KEY FINDINGS

- Funding for local public health is inconsistent and inequitable in its ability to meet the current mandates and the needs of a 21st century local public health system.
- The nationally recognized Foundational Public Health Services framework provides a means for costing out local public health services.
- Massachusetts and many other states face the challenge of limited investment of resources to ensure local capacity to provide 21st-century public health protections.

RECOMMENDATIONS

- To ensure optimal health protections and wellness opportunities for all Massachusetts residents, the Commonwealth should commit appropriate resources for the local public health system changes proposed by the Commission.

⁷ The state also provides approximately \$5B for education via Chapter 70 funding.

CONTINUITY AND SUSTAINABILITY

Modernizing Massachusetts' local public health system is a monumental but necessary task. Like any project of this magnitude, it has progressed slowly but steadily toward the goal. To keep the state moving forward on its journey, it is critical that there be an oversight body to monitor progress, that the relevant state entities have appropriate authority and resources, and that stakeholders continue to be partners in the process.

CONTINUITY AND SUSTAINABILITY

KEY FINDINGS

The Massachusetts local public health system depends on the continuing engagement of the stakeholders who have laid out an actionable path to effectiveness and efficiency.

RECOMMENDATIONS

- Continue to engage a wide range of stakeholders to provide ongoing support for the recommendations for local public health systems improvement.
- Give DPH and DEP the infrastructure and authority to support the recommendations for local public health system improvement.
- Identify and address administrative actions at DEP and DPH that can support the recommendations of the Commission.

Every day about 200 lives begin in Massachusetts. Another 150 end.⁸ Between those two bookmarks, there is no other entity more important to ensuring the health and wellbeing of residents than their local health departments. While each of the individual measures recommended in this report is beneficial by itself, they are intended to be adopted as an interlocking set, reinforcing and magnifying each other. Only this type of systemic change will help make Massachusetts a leader in the local public health modernization process and give all the Commonwealth's inhabitants the services and protections they need to lead healthy, productive lives.

⁸ Massachusetts Department of Public Health. "Massachusetts Births 2016" (May 2018) and "Massachusetts Deaths 2016." (December 2018)

KEY COMMISSION FINDINGS

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SUMMARY OF COMMISSION RECOMMENDATIONS

- Elevate the standards for and improve the performance of local public health departments.
- Increase cross-jurisdictional sharing of public health services to strengthen the service delivery capabilities of local public health departments.
- Explore improvements in the current platforms to report, analyze, and interpret data.
- Set education and training standards for local public health officials and staff and expand access to professional development.
- Commit appropriate resources for the local public health system changes proposed by the Commission.
- Ensure continuity of stakeholder engagement in the implementation of the Commission's recommendations.