Maine Public Health Work Group

Submitted by: **Cumberland County Coordinating Council for Public Health (C4PH)**
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Background on C4PH

In early 2005, the City of Portland's Public Health Division convened the many partners in the local public health system (LPHS) to undergo the CDC LPHS performance assessment, facilitated by the Maine Center for Public Health. More than 40 people committed a half-day each week for six straight weeks to complete the intensive process. The results indicated a strong need for data; expanded authority; and improved collaborative planning and implementation.

In 2006, the City's Public Health Director led the Public Health & Human Services Committee of the Cumberland County Strategic Planning process. The committee unanimously concluded that there should be a pilot of county-wide public health services and programs.

At the same time, key providers in the community worked with Portland Public Health to determine whether or not to pursue a new Federally Qualified Health Center in Portland. Throughout this process, the need for data, expanded authority, and improved collaborative planning and implementation were underscored. The group will submit an application this December, 2007.

As the regional/district coordinating council, C4PH (comprised of many of the participants in the LPHSA, the County committee, and the FQHC initiative) was first convened following PHWG's issuance of consensus recommendations on regional public health functions and infrastructure, in late December 2006, to determine how best to ensure coordination and consistent delivery of public health services throughout the Cumberland district. The group consists of nearly 60 members, with representation from towns, hospitals, city and county government, non-profits, Comprehensive Community Health Coalitions (CCHCs), emergency medical services, MCDC, schools, and others. The full group meets every other month; the steering committee meets on the odd month. There are 5 committees: Fundraising, Governance & Financing, Health Data, Legislative, and the Steering Committee.

- The Fundraising Committee has been successful in securing funds from most organizations comprising C4PH as well as a newly-available CDBG grant.
- Governance & Financing has overseen a municipal public health inventory conducted via personal interviews with most town managers and some town staff.
- Health Data has compiled all relevant town-level health data and is now refining and ensuring validity so that this local data and the priorities they show can be shared with each town.
- Legislative is tracking the implementation of LD 1812 and the results of Muskie's public health statute review.
- The Steering Committee ensures that all the committees and the full group continue to move forward thoughtfully and carefully.

Gap or overlap in current governmental public health duties and accountabilities that must be addressed:

Without a sub-state public health infrastructure, there is no one on a local/regional level able to coordinate the most effective use of fragmented resources, assure delivery of the ten Essential Public Health Services to all parts of Maine, and provide on-the-ground, cross-jurisdictional prevention of and response to infectious disease outbreaks including pandemic influenza.

Draft proposal for necessary change to address identified gap or overlap in current governmental public health duties or accountabilities, within parameters of LD 1812 as above:

A. Summary of suggested change addressing governmental duties, accountabilities, and scope of functions within the 10 EPHS that would be performed:

- Please see the attached diagram for graphic description of the following.

- Eight DHHS districts, each with a **District Health Officer** (DHO) who:
  - is responsible for ensuring and coordinating delivery of the 10 EPHS throughout the district;
  - holds all MCDC contracts for the district (fiscal agent) as the MCDC's liaison, so that the MCDC can hold the DHO responsible for the efficacy of all MCDC-funded public health programs in the district;
  - would have an MPH and 5 years' experience
  - coordinate with other agencies related to public health, such as DEP
  - coordinates with MCDC on all-hazards public health emergency planning
  - works with the district coordinating council
  - could be team leader or supervisor for co-located staff, including Public Health Nurses, Regional Sanitarians, Regional Epidemiologists

- DHOs would report to **District Boards of Health** and the MCDC, and work within the structure either of local/regional government or be an MCDC employee (on an interim basis)
  - DHOs would be hired/fired and supervised by the District Board of Health with input from MCDC
  - The District Boards of Health could be formed from existing/fledgling regional coordinating councils and/or CCHC boards, ensuring geographical and sectoral representation; perhaps 9-13 board members, including a physician, a dentist, a veterinarian, a mental health professional, towns, and others from the PHWG's "all relevant entities" list.
  - District Boards of Health would be advisory or governing, depending on the level at which the district functions (see Authority below); would review budgets, strategic planning, provide accountability for the DHOs, ensure outcomes/evaluation

- The **District Coordinating Councils** would continue, comprised of all stakeholders and interested parties, to:
  - discuss public health-related activities in the district and seek ways to collaborate, coordinate, and leverage so that activities are provided to all residents of the district
  - provide input on needs and direction for strategies and implementation
  - ensure most effective use of resources

- **Local Health Officers** (LHOs) would work under the revised statutes and work with the DHOs to review policies, refer questions to the right branch of the State, etc.

- Districts and MCDC work out **5-year plans** for management of operations

- **Authority**
  - Because there are 8 districts with varying capacity and needs, perhaps there should be 1-3 levels, with increasing authority
    - Could use National Public Health Performance Standards and/or National Association of City and County Health Officials (NACCHO) local health department accreditation standards to create thresholds for each level
    - Level 1 would require the most direct involvement with MCDC, with MCDC staff covering most functions. Would develop a training and technical assistance plan to build capacity.
    - Level 2 would be more able to deliver core functions without significant MCDC staff assistance.

        - Level 3 would have capacity to deliver all 10 Essential Public Health Services, and would continue to work for and with the MCDC
    - All levels must work in close partnership with the MCDC, ensuring open communication and adherence to state policies

- **Financing**
    - Decisions about funding allocation must be delayed until sufficient research can be conducted on district-level costs and existing resources
    - Additional resources will be needed
    - Previously available $50,000 per district should be awarded next fiscal year for district structure development; already organized districts would use more money for services, others would use more to build their organizational infrastructure
    - Boards and DHOs should seek other public and private sources of funding

- **C4PH next steps**
    - Continue to educate towns (have met with most town managers regarding the district-wide work and their current public health activities and needs)
    - Continue to work with Greater Portland Council of Governments
    - Refine town-level health data; aggregating towns to meet minimums; district broken into 9 regions
    - Meet with town managers again once data analysis complete to present local data
    - Hire full-time project coordinator – need funds

B. How this change meets the goal of ensuring access to public health services:

Because there is no statewide local/regional infrastructure, there is significant fragmentation of public health services and many that go undelivered, especially to towns further from service centers. Part of ensuring access for all is to maximize scarce resources. By coordinating, collaborating and leveraging on the regional level, and by streamlining contracting processes, the burden on the State is reduced (e.g., the infamous 550 contracts issued by the MCDC), accountability at the regional level is greatly increased, and Maine's citizens all benefit from a public health system.

C. How this change improves the effectiveness and efficiency of public health services delivery:

- Streamlines MCDC contracting, grant management, and reporting functions
- Increases accountability by having one person responsible for the effective functioning of all MCDC-funded programs in each district
- Improves coordination of all public health-related services in the district, especially emergency preparedness
- Ensures that all towns in each district can access needed public health information and services, regardless of distance from service-center towns

D. Why this change is necessary:

- Extremely limited resources and significant fragmentation of services mean that many services are provided at an insufficient level while funding is underutilized due to duplication of administrative structures at the many programs.
- In order to assure delivery of all 10 EPHS to all towns in Maine, the additional capacity, resources, and local relationships of DHOs are necessary.

Crosswalk to PHWG Consensus Recommendations for Regional Public Health Functions and Infrastructure (Based on the Ten Essential Public Health Services)

Long term = by late 07-08
Short term = by mid to late 07, and ongoing

EPHS 1: Monitor health status to identify community health problems.			
	DHHS/MCDC currently does	**DHHS/MCDC will do**	**District will do**
1.1 Assure coordination and consistency for community health status monitoring, local health assessments and in the development of Community Health Profiles, including use of compatible data management systems.		Long term	Long term
1.2 Promote broad-based participation in local health assessments and collaborate with all relevant entities to assure timely region-wide collection, analysis and dissemination of data.			Long term
1.3 Develop a Regional Health Profile based on key indicators identified in the State Health Plan.			Short term
EPHS 2: Diagnose and investigate health problems and health hazards in the community.			
2.1 Carry out health inspection and licensing activities, surveillance, and investigation of outbreaks.	Will continue		Possibly long term
2.2 Participate in emergency and all-hazards preparedness planning and carry out roles as defined.	Yes		Short term
EPHS 3: Inform, educate and empower people about health issues.			
3.1 Develop collaborative networks with all relevant entities to assure effective and efficient region-wide distribution of culturally and linguistically appropriate public health information, public health programs and health promotion activities.			Short term
EPHS 4: Mobilize community partnerships to identify and solve health problems.			
	DHHS/MCDC currently does	**DHHS/MCDC will do**	**District will do**
4.1 Convene and facilitate partnerships among all relevant entities for regional programs and initiatives.			Short term
4.2 Organize and facilitate a communications system among all relevant entities.	Short term		Short term
4.3 Mobilize partnerships to leverage new and existing resources.			Short term
EPHS 5: Develop policies and plans that support individual and community health efforts.			
5.1 Integrate the Regional Health Profile, State Health Plan and Community Health			Long term

Improvement Plans to develop a Regional Health Improvement Plan.			
5.2 Gain regional input to and communicate about the State Health Plan.			Short term
5.3 Facilitate development and coordination of local policies within the region and coordinate policy advocacy at the regional level.			Long term
EPHS 6: Enforce laws and regulations that protect health and ensure safety.			
6.1 Link communities to technical assistance on issues related to public health law.	Yes		
6.2 Identify, recommend and advocate for improvements in regional enforcement of public health policies, laws, regulations, ordinances and/or codes.	Yes		Short term
EPHS 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.			
7.1 Develop and support strategies to close gaps in personal health services as specifically identified within the Regional Health Improvement Plan (RHIP).			Long term
EPHS 8: Assure a competent public health and personal health care workforce.			
8.1 Coordinate and provide for region-wide training and technical assistance for public health and personal health care best practices that support implementation of the RHIP.	Long term		Long term
8.2 Develop and support recruitment, education and training strategies related to goals identified in the RHIP.	Long term		Long term
EPHS 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.			
9.1 Coordinate and build capacity for high-quality program, organizational and system evaluation within the region.	Long term		Long term
EPHS 10: Research for new insights and innovative solutions to health problems.			
	DHHS/MCDC currently does	**DHHS/MCDC will do**	**District will do**
10.1 Periodically participate in research activities related to Maine's public health system, the RHIP, and the State Health Plan.	Yes		Long term
10.2 Translate and promote use of best practice research to modify and develop public health policies, initiatives and programs.	Yes		Long term