Maine Public Health Work Group

Full Text of Submissions

Governmental Public Health Duties or Accountabilities: Gaps, Overlaps and Proposals for Change

10/23/07

NOTE: GAPS, OVERLAPS AND PROPOSALS IN THIS DOCUMENT HAVE NOT BEEN ENDORSED BY THE MAINE PUBLIC HEALTH WORK GROUP, THE GOVERNOR'S OFFICE ON HEALTH POLICY AND FINANCE, NOR THE MAINE CDC.

In preparation for the 10/22/07 meeting of the PHWG, Members and Interested Parties were invited to:

- Identify gaps or overlaps in current governmental public health duties and accountabilities in Maine that must be addressed; and to
- Develop draft proposals for any necessary changes to Maine governmental public health duties or accountabilities. Proposals are to follow the LD 1812 requirements of being "within existing resources over the next 5 years with the goals of ensuring access to public health services and of improving effectiveness and efficiencies of public health services delivery."

12 submissions were received by the deadline. The full text of each submission follows.

#0 Submitted by: Maine Municipal Association, Kate Dufour

#1 Submitted by: Healthy Communities of the Capital Area; Joanne Joy

#2 Submitted by: Megan Hannan

#3 Submitted by: Brenda Joly with Andy Coburn

#4 Submitted by: Family Planning Association of Maine; George Hill

#5 Submitted by: ACCESS Health (CCHC for Sagadahoc County); Marla Davis

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan

#7 Submitted by: Executive Committee of Maine Public Health Association, Richard Veilleux

#8 Submitted by: York County Healthy Maine Partnerships, Emily Rines

#9 Submitted by: Barbara Ginley

#10 Submitted by: Healthy Peninsula Steering Committee, Barbara Peppey

#11 Submitted by: Maine County Commissioners Association, Nancy Rines

#0 Submitted by: Maine Municipal Association, Kate Dufour

I don't have a "gap" concern, but rather a concern with how solutions to the identified gaps will impact municipal responsibilities and finances. Our members, key elected officials in Maine's 489 communities, are concerned that the ideas generated by the group will require communities to provide services that they are not equipped to provide. It is important that the members of the Maine Public Health Work Group understand how local governments are designed (i.e., the significant role of the local legislative body – town meeting or council) and the resources available (i.e., tax dollars) to fund desired local services and programs.

In addition, the Association would stress the need to ensure that existing public health-related resources are maximized not only to meet existing needs, but also to be potentially available to fund, if necessary, the identified gaps in the system.

#1 Submitted by: Healthy Communities of the Capital Area; Joanne Joy

Gap – Behavioral Health, Dental Health, Schools Wellness should all be at a public health district ~ Community Coalition table. There may be others, but at this point in time, these should be prioritized.

Within existing resources – no new staff, etc. Just a plan to have the appropriate people at the table. This was suggested in the Regional Coordinating Council membership.

This is not necessarily a governmental change – but a systems change at this point. Governmental change may need to be considered after we pilot the district coordination for some period of time – 1 -3 years like the CCHC time period.

#2 Submitted by: Megan Hannan

Here is my greatest concern: that we prioritize state, region, and local public health funding and initiatives based on data, not anecdote and/or regional "concerns." The regional staff and coordinating body should be sure to keep the locals on track with that, as that is the historical problem with local issue definition and problem solving. Also the reason some of the CCHCs have been, and some continue to, resist categorical funding.

#3 Submitted by: Brenda Joly with Andy Coburn

Accountability

GAP: Data to Assess our Capacity and Delivery of the 10 ESPH

Although our current system includes programmatic performance assessments, there is currently no systematic process to routinely evaluate our capacity and delivery of the 10 EPHS in Maine. While an assessment of this magnitude poses challenges given our existing infrastructure and resources, there are a number of existing tools, public health standards and assessment programs that we can draw upon at both the state and local level to operationalize and measure our collective efforts. As our efforts to enhance our existing infrastructure continue, it remains critical to collect information that we can use to better understand and document our progress, service gaps, and systems-level needs. It also is essential to begin linking our system-wide enhancement efforts to public health outcomes. Without data and formal mechanisms in place, accountability of our system will be difficult.

GAP: Leader in Accountability

Many states have specific programs or offices at the state level that focus on assessment, accreditation and/or quality improvement for the purpose of accountability. Given my experience with RWJ's Multi-State Learning Collaborative, these programs often provide significant leadership in issues related to public health performance and accountability. They also frequently serve as a liaison between the state public health agency and local agencies. Perhaps we need to consider implementing such a program in Maine that provides leadership, advocates for accountability mechanisms, participates in the national dialogues currently taking place specific to public health performance and accountability, and builds from the lessons we've learned from many other states that are eager to share their experiences.

Duties

GAP: Lack of Clarity

As we continue to enhance our infrastructure by defining specific roles and authority, it will be important to clearly articulate the: 1) alignment of local and state functions and 2) the functions that will be/need to be state state-led (e.g., surveillance) or the minimum capacity/requirements needed in a community to share in those duties (e.g., having trained epis on staff devoting 80% to surveillance). Having formal accountability mechanisms in place that reflect the duties (both state and local level) should help to provide clarity.

#3 Submitted by: Brenda Joy with Andy Coburn (continued)

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:

GAP: Data to Assess our Capacity and Delivery of the 10 ESPH

Implement an accountability system for the state and the new districts to assess our ability to deliver the 10 ESPH.

GAP: Leader in Accountability

Reorganize staff and create a program (even if it's one person) at the state level focusing on public health performance, assessment, accountability and/or quality improvement with the goal of improving health outcomes.

GAP: Lack of Clarity regarding Duties

As the duties and type of system (e.g., centralized versus shared/mixed) is defined, it will be important to provide education on the roles, duties, and accountability process.

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

GAP: Data to Assess our Capacity and Delivery of the 10 ESPH

A rigorous, formal assessment will provide us with the mechanism to determine whether or not we are ensuring access. The data can also be used to set priorities and re-allocate resources based on system needs.

GAP: Leader in Accountability

Having state leadership in this area will provide an additional accountability mechanism, particularly if contracts begin to include system performance measures as other states have done (e.g., New Hampshire)

GAP: Lack of Clarity regarding Duties

Increased clarity on the roles and duties should theoretically help to ensure that system partners are aware of their specific contribution to public health.

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

GAP: Data to Assess our Capacity and Delivery of the 10 ESPH

An ongoing assessment process can be used to evaluate our effectiveness at both the state and local level, therefore guiding our decision-making process and allocation of resources.

#3 Submitted by: Brenda Joy with Andy Coburn (continued)

GAP: Leader in Accountability

Having strong leadership and a central program at the state that focuses on accountability of our system would ideally keep this issue a priority, particularly if it is woven into contracts and existing evaluation efforts.

GAP: Lack of Clarity regarding Duties

Increased clarity on the roles and duties should theoretically help to ensure that system partners are aware of their specific contribution to public health.

D. Why this change is necessary:

GAP: Data to Assess our Capacity and Delivery of the 10 ESPH

We need to be able to assess our efforts, measure progress, and link our systems-level enhancements to health outcomes.

GAP: Leader in Accountability

Having strong leadership and a central program at the state ensures that this issue will remain a priority.

GAP: Lack of Clarity regarding Duties

To some extent, the lack of clarity regarding duties is causing misrepresentation among some system partners regarding their capacity to deliver the 10 ESPH.

#4 Submitted by: Family Planning Association of Maine; George Hill

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

Gap Specific to Family Planning: Data available through the MCDC indicates that certain Maine towns and cities continue to experience teen pregnancy rates that are higher than the statewide average.

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:

The Family Planning Association of Maine and its statewide network of family planning providers will work with Regional Coordinating Councils/HMPs/Local Public Health Districts to identify towns and cities experiencing higher than average teen pregnancy rates and to develop strategic, educational and clinical interventions to address the problem in communities motivated to do so.

#4 Submitted by: Family Planning Association of Maine; George Hill (continued)

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

No change in governmental duties would be required beyond those already made to create the RCC/HMP structure.

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

Monitoring health status of Maine teens is already performed through the Youth Risk Behaviour Survey. Although under-funded, the State Office of Research, Data and Vital Statistics provides adequate reproductive health data and can do so on a town-by-town basis.

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

Closer coordination at the local level should improve community responsiveness to potentially controversial health issues.

Adequately funding ORDVS would make it possible to identify important health trends in vulnerable populations and to initiate more timely interventions.

D. Why this change is necessary:

The Family Planning Association of Maine is responsible for administering (and providing) comprehensive family planning services AND comprehensive family life education programming. Both can be controversial depending on the community in which such services could be made available. Greater coordination at the community level will help provide the momentum needed to overcome the objections of the few over the wishes of the many when it comes to providing medically accurate, unbiased information to young people at risk for unintended pregnancy and the lifelong consequences that accompany it.

Additional Thoughts:

If health care priorities at the local level are established, at least in part, by the financing available to support them, then it may be fair to say that function will follow financing.

If so, greater coordination at the local level might be achieved by convening health care organizations that receive MCDC funding within regional geographic areas and having them establish a list of priority issues to be worked on within specific regions. This model has been adopted by the behavioral health community and includes not only DHHS-funded not for profits but is also flexible enough to accommodate "interested parties" that may have a mission-related stake in the needs being addressed at the local level.

#5 Submitted by: ACCESS Health (CCHC for Sagadahoc County); Marla Davis

GAP:

Maine's LHO and CCHC system are inadequately connected to elected general purpose government and other vital preparedness, health and safety efforts at the County level and creating a dangerous "disconnect" with the system formally designated for Emergency Preparedness at a time of enhanced concerns about our lack of organized public health preparedness

DRAFT PROPOSAL:

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

The EPHSs envision an entity with jurisdiction to develop, adopt, and enforce public health policies. Currently the CCHC's as funded lack this authority (with the exception of those linked to city/county government formally). The system of Local Health Officers (LHOs), while linked to town, is both too diffuse and underpowered to fulfill this link. The national standard for a population base adequate to sustain such functions is approximately 35,000 or greater (REF: NACCHO national survey, 2006).

FORMALLY DESIGNATE THE COUNTY LEVEL (OR MULTI-COUNTY JURISDICTIONS) AS THE IMPLEMENTING PARTNER FOR THE LOCAL PUBLIC HEALTH INFRASTRUCTURE. This can be accomplished in at least three ways within Maine Statute:

(1) the "upward delegation authority", much as is currently done with police functions by towns which cannot accomplish all of the obligations of local police, permitting contracts for service with Counties (the sheriff system) or

(2) "deeming" as was done by the reformed Emergency Management structure, in which the township laws were repealed and replaced by a county-based system, or

(3) mandating pilot projects

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

County government has the "standing" to actually ENSURE. Particularly with regards to essential services which require the power of government for enforcement, which include surveillance, mandatory reporting, environmental protections, and making formal policy, such standing is vital for effective local function.

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

It builds on the existing community development work of the HMPs which do outstanding work on essential services three and four.

D. Why this change is necessary:

The system as currently constructed lacks "standing".

#5 Submitted by: ACCESS Health (CCHC for Sagadahoc County); Marla Davis (continued)

GAP:

Maine's Local Health Officers Network is in disarray

DRAFT PROPOSAL:

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

(1) REVISE THE STATUTORY AUTHORITY MRSA Title 22 General powers and duties Part 2: State and Local Health Agencies, Chapter 153: Local Health Officers (inter alia), regarding the responsibilities and functions of the LHOs, update the statutes regarding individual functions and consolidate them into a single master proposal, clarify the tasks and relationships with other pubic health functions AND

(2) TRAIN AND OTHERWISE STRENGTHEN THE LHO NETWORK by defining the competencies for work as a LHO, a training program to help them meet those competencies, and a certification program for training

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

All public health in, inherently, local. Maine's grand tradition of town-based governance needs to be recognized and built upon. The volunteers (or near volunteers) who work as local health officers deserve support and clarity of their work, and the citizens deserve the assurance that they are protected by a competent local public health workforce.

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

Builds on a grand tradition and a currently neglected resource and assures local governmental ties to the rest of the evolving public health infrastructure

D. Why this change is necessary:

The LHO system in its current form is wasteful, and provides a false sense of security at the local level (as well as considerable frustration for those who are doing the work).

Gap:

Data is needed for communities to address the Ten Essential Public Health Services. This data needs to be county level, web accessible, free, and up to date within 2 years.

We are not aware of the current data systems for the state and are therefore not able to make proposals.

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan

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.

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan (continued)

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

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan (continued)

- 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

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan (continued)

- **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.

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan (continued)

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

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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 Improvement Plans to develop a Regional Health Improvement Plan.			Long term
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

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#7 Submitted by: Executive Committee, Maine Public Health Association, Richard Veilleux

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

There is currently no systematic, ongoing process to assess capacity and our system's ability to delivery of the ten essential public health services at the state and local level.

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:

Establish a systematic, ongoing process to assess capacity and delivery of the ten essential public health services at both the state and local level. Establish a position in MCDC to 1) provide oversight on state and local level performance assessment and quality improvement efforts, and 2) provide leadership on the accountability of our system.

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

In order to ensure access to public health services there must be good data to identify current capacity and service delivery, to identify critical needs and provide reliable information on where to focus resources. In order to improve access then we must have comparative data to determine if efforts to enhance our infrastructure are effective and achieving the anticipated outcomes that will ultimately help to improve the public's health.

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

With systematic, ongoing data there will be reliable information on which to base decisions and allocate resources. This is an essential and necessary element of improving effectiveness and efficiency. Without data we cannot track our progress at the state and local level, identify systems-level needs, or determine where we could best focus limited resources to achieve the greatest impact.

D. Why this change is necessary:

This change is necessary in order to establish whether the State public health system has the current capacity to deliver the 10 EPHS and to determine the impact of interventions to improve such capacity.

#8 Submitted by: York County Healthy Maine Partnerships, Emily Rines

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

Without a formal sub state public health infrastructure no one person, organization or agency is currently responsible for the coordination of all state public health related contracts at the district level, i.e. HMP, WIC, regional epis, LHO, Emergency Preparedness. The lack of infrastructure may translate into an ineffective use of resources and a lack of coordination at the district level. DHHS offers this oversight at the state level, but does not have enough resources to provide these services at the district level statewide.

A sub-state structure would facilitate grantees and DHHS / MCDC programs working together in more coordinated and efficient ways. This would also ensure that the limited resources available be used in the most efficient and effective way possible, increase coordination, assure delivery of 10 essential public health services and be able to be responsive to both immediate and emerging public health needs (i.e. pandemic flu or increase in childhood obesity rates).

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:

This proposal includes the creation of a District Board of Health and a District Health Officers (state positions perhaps moved from central office in Augusta to districts). The District Health Officer would work across state contracts and state agencies, act as a liaison between the district communities and DHHS, coordinate services, reduce the number of project officers or restructure to decrease overlap. This position would be a critical and strong link between state agencies and district partners and stakeholders. They would facilitate the work of a District Board of Health and set a foundation for collaborative process. This would ensure a coordinated assessment and delivery of the 10 Essential Public Health Services through all districts. It would also ensure that each district has a public health professional that can address gaps and offer technical assistance in districts that are struggling to meet and or understand the EPHS. Having a District Health Officer would provide state agencies with one district person to ensure that programs are efficient and in times of public health crisis provide them with 8 people across the state (someone in each district) to communicate with.

The District Board of Health would be a diverse and strong board representative of the district. They would ensure coordination of the delivery of the 10 Essential Public Health Services and be responsible to ensure district assessments occur and that program priorities align with that assessment data. They would also have strong links to District Health Officer and provide a two-way communication and dialogue between state agencies and district stakeholders and organizations. This body would ensure that

#8 Submitted by: York County Healthy Maine Partnerships, Emily Rines (continued)

district public health work is reaching the entire district, that organizations and state grantees are working together and that appropriate district individuals are involved in the assessment, planning and program implementation phases.

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

They would ensure district wide coordination and the delivery of 10 EPHS at the district level among community based agencies, grantees and other state contracts. It would also ensure that work is responsive to district needs (and reflective of assessment data), is evidence based and gets work done in an effective and efficient manner reaching the entire district.

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

The formation of the district officer and health board would ensure community engagement and increase opportunities for coordination. It would streamline Maine DHHS / CDC contracting work (grant management and reporting) for both the district and state. It will build an infrastructure that data collection can be built (and shared) off of. It also improves coordination of the delivery of 10 Essential Public Health Services in the district and ensures that the entire district is receiving appropriate services.

D. Why this change is necessary:

Resources are limited but this structure allows Essential Public Health Services to be assessed and delivered in a more efficient and effective manner – i.e. reduce fragmentation and increase coordination of limited resources. The formation of the voluntary District Board of Health and a District Health Officer creates a forum for critical district and state links to occur.

#9 Submitted by: Barbara Ginley

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

Currently there is no program within the ME CDC to address refugee and immigrant health needs.

Continued need for advocacy and enforcement on language access issues. Many health providers (public and private) still see arranging for and more importantly reimbursement for interpretation to be a "hassle" and not worth the time and effort.

Geographical and resource parity: currently there is great disparity when one compares the public health infrastructure across the eight districts. It is unclear how each district will be supported to effectively execute the 10 essential PH services, and/or if there will be varying levels of compliance/expectations depending on existing infrastructure. The

#9 Submitted by: Barbara Ginley (continued)

parity issue reaches beyond the performance standards, but has graver implications when looking at core functions that link directly to health status.
Greater delineation of public health duties: In many ways, Maine has made do without local or regional public health agencies, as it moves forward it will be important to clearly communicate who is responsible and accountable for specific core functions (i.e. are the HMPs responsible for core functions # 3 & 4?). To entities outside of the ME CDC there is not always clarity on this, and it could prevent future overlaps or gaps. Along those same lines, recognition that FQHCs can be part of the solution to delivering essential services (i.e.#7 linking people to care). Health centers are focused on being responsive to community or special population needs, and that in doing so, the health centers deliver many community-based public health services: case management, care management, health education and outreach.

Immunizations, as Maine's rates have fallen dramatically in the past several years, this issue presents a system change that requires immediate redress. Having both greater fiscal support of state purchased vaccine as well as the ME CDC identifying why the system is no longer able to insure that children are receiving their age-appropriate immunizations and how to better support access for adults.

Emergency Preparedness- on-going participation of the ME CDC in the county, regional and statewide efforts. Their presence at the table is essential in meeting core PH functions but would also enhance the communication between stakeholders.

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:

Implementation of a "Refugee Health Committee" or "Division" within the Maine CDC or DHHS. This Committee or Program would oversee all refugee health issues for the state of Maine. The Office of Minority Health would be an important participant/leader of this Committee.

In a perfect world----we would have centers set up in a one-stop shop public health model that would meet the needs of everyone in a community. We literally don't have a total county infrastructure that would be capable of doing that job. However, if the 8 districts are set up and operational that might be a place to focus on the idea.

#10 Submitted by: Healthy Peninsula Steering Committee, Barbara Peppey

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

- Lack of clarification of roles for CCHC's and RCCs re: regional public health districts; lack of resources for local coalitions and LHO to assume functions delegated to same.
- Lack of public health data by local service areas, counties and districts
- Inadequate mental health, dental and substance abuse services, especially in rural areas—both inpatient and outpatient services
- Lack of awareness and coordination of various parts of the "system" , resulting in duplication or gaps and few collaborations
- Clarification needed regarding authority delegated from CDC to various entities—hospitals, LHO, CCHC's etc.
- Though we are asked to consider this in light of "no new resources" we do not believe we can assume additional public health functions with 30% cut in funds from CDC---we need to move SLOWLY in planning the system, based on current resources….not so quickly so as to make mistakes.

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:

We hope the CDC and PHWG will recognize the unique distinctions structurally, resource-wise, and organizationally between rural and urban centers and realize that we could have different models to address similar functions. We have the capacity, with no new resources, to establish a RCC in Downeast Maine, but will need time, guidance from PHWG and CDC to assess our capacity and needs….hope not to have a system placed on us without our active involvement…and from the key players here….so building on our current capacity to meet with regional CDC staff taking lead "staff" role to develop system and integrate key players…then some type of MOU, etc to establish clear roles and authority……
A communication and IMS must be set up…not sure this can be done with existing resources, but some of it can be.

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

By assuring a planning process at the local and regional levels that will have integrity for what we are currently contributing, and enable us to engage others who can play a key role. We advocate for an organic process that builds on our assets….a top down approach might look good on paper, but will likely not work with "No new resources"…….this approach is most likely to get buy in at local an regional levels AND increase awareness and coordination among the current stakeholders/organizations who contribute to public health already.

NOTE: GAPS, OVERLAPS AND PROPOSALS IN THIS DOCUMENT HAVE NOT BEEN ENDORSED BY THE MAINE PUBLIC HEALTH WORK GROUP, THE GOVERNOR'S OFFICE ON HEALTH POLICY AND FINANCE, NOR THE MAINE CDC.

#10 Submitted by: Healthy Peninsula Steering Committee, Barbara Peppey (continued)

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

Coordination and collaboration should save $ and will assure improvements particularly to the consumer…it is now a confusing system to access.

D. Why this change is necessary:

For all of the above reasons

#11 Submitted by: Maine County Commissioners Association, Nancy Rines

Proposal Regarding the Role of County and Municipal Elected Officials in the Public Health System (12/13/2006)

Principles:

- Many of the components of a public health infrastructure already exist in the state of Maine, but lack adequate coordination.
- While most of these existing components are in the private and not-for-profit sectors, they form the core of our public infrastructure, as it currently exists, and must be heavily relied upon in the emerging public health system.
- Municipal and county officials around the state have expressed frustration at the lack of coordination and planning for public health emergencies.
- Elected officials at all levels of government are the *generalists* who oversee and rely upon *specialists* in their chosen fields, e.g. public safety, environmental protection, insurance regulation, public health and so forth.
- The connection between the deliverers of public health services and the taxpayers is tenuous, existing through a single appointed state office.
- There is apparent agreement among members of the Public Health Working Group that a regional approach to public health needs to be established.
- Regional and local government, through their elected officials, can provide increased taxpayer support for and communications with the public health community so that our public health system is, in fact, a *public* system. Elected officials do not seek a "takeover" of the system.
- A regional approach needs to provide a central role for regional and local general-purpose government, i.e. counties and municipalities, through their elected officials.

#11 Submitted by: Maine County Commissioners Association, Nancy Rines (continued)

Structure:

1. Each of the public health regions will be defined by county boundaries, whether a single county or multiple counties.
2. The elected officials within these political-geographic boundaries will play a vital role in providing support for, communicating with, and assisting in the planning processes of the experts within the public health community of providers.
3. The county commissioners of each public region are authorized to convene all of the key players in the public health community, both public and private, who will sit as a body. (This body could be called a board of public health or a public health coordinating council.)
4. Appointments to this body would be made by either the county commissioners, or a combination of county commissioners and municipal officers.
5. The majority of the seats on this body would be designated positions in order to ensure the representation of key players, including but not limited to: hospitals, community health coalitions, health care professionals, emergency management, public safety, designee of the state Public Health Director, and other relevant entities.

Role and responsibilities (to be performed in conjunction with the state Center for Disease Control):

a. To conduct a public health needs assessment of the region.
b. To develop a public health plan for the region.
c. To provide periodic reports to the people of the region--through their elected representatives--on the state of public health and the expenditure of public resources in the region.
d. To seek out or develop additional sources of funding for regional public health activities.

Attachment following submitted by: Maine County Commissioners Association, Nancy Rines.

MODUS OPERANDI
SAGADAHOC HEALTH IMPROVEMENT PROJECT
ADVISORY BOARD

"The County Board of Health"

June 30, 2006

VISION: Healthy People in Healthy Protected Communities

MISSION: Advise the County Commissioners on public policies and programs needed to assure the ten essential services of public health and perform the functions which only government can provide.

ORGANIZATION: The Board of Health is constituted as an official advisory board to the County Commissioners under applicable MRSA provisions and subject to all applicable rules and regulations governing official boards and committees. The Board will receive staff support from the Director of the Sagadahoc Emergency Management Agency and an officially appointed County Health Officer.

MEMBERSHIP: Individuals will be appointed to the Board to serve a three year term, renewable once only. Members will be named from among those nominated by the citizens of the County and their several leadership organizations. They will be chosen to assure representation from the organizations and sectors representing various critical elements of a healthy community, to include representation from Medicine, Nursing, Dentistry, Veterinary Medicine and Pharmacy; from Hospitals and healthcare organizations, business and industry, and community voluntary service agencies; from among advocates for health for the elderly, children, the poor, the homeless, the underserved, the minority community. All municipalities within the county will be invited to nominate. In naming the Board, the Commissioners will consider geographic representation. Members will be expected to represent issues important to the sector from which they were nominated and to keep their associates apprised of issues and efforts from the SHIP. However, they serve as individuals.

TERMS OF SERVICE: Members will serve three year terms, renewable once only. Founding members (those named in June 2006) will serve an initial term of one, two, or three years, to be determined by lot, informed by preference. After this, each will be eligible for a single additional three year term. All members will be eligible for re-nomination for additional terms after a one year hiatus in service.

GOVERNANCE: The Board will elect a Chair and a Chair-elect from its membership. The chair will serve for a single two year term. The secretariat for the Board will be provided by EMA staff.

MEETINGS OF THE BOARD: The Board will convene upon call of the Chair. Meetings of the Board will be public with exceptions for executive sessions as permitted under 1 MRSA § 405 et seq.

CONDUCT OF THE BOARD: In general, the Board will meet every two months on the First Friday of the alternating month. Roberts Rules of Order will be followed. Minutes of each meeting will be issued as required by law, circulated to members beforehand, and officially adopted at the subsequent meeting.

THE SAGADAHOC HEALTH IMPROVEMENT PROJECT: The Board will advise the Commissioners and, as requested, may advise or oversee specific programs and projects of the SEMA related to public health. These are conducted under the authority of the County Action, January 1, 2005, as the Sagadahoc Health Improvement Project, and will include surveillance and assessment of the County's needs for services. As needed, the SHIP may propose to the County the establishment of new projects and programs compatible with available funding. These efforts may include, with County's informed prior assent, the request for external funding, grants, and contracts, from suitable public and private resources to fulfill the County's role in assuring the provision of the ten essential services of public health. The fundamental premise of these projects is that they should complement, not compete with, the community's programs already serving the County.

"Ex Officio" MEMBERS: The SHIP functions as a collaboration with the many public and private leaders and workers in the health and health care system. Several among these collaborate specifically by virtue of their official roles as State employees working in public health and assigned to duties with geographic responsibility in Sagadahoc County.
These individuals will be recognized as "ex officio" members of the Board. These include:

- Public Health Nurses employed by the Maine CDC and assigned to serve the County (with offices at the Wing Farm)
- Public Health Consultants financed by the Maine CDC but employed by other public health agencies providing regional services which include Sagadahoc County, including the Regional Medical Officer and planning staff in the Portland Health Department and
- Public Health Advisors for Bioterrorism and Preparedness, including the Regional Epidemiology office in Union.

CHANGES TO THIS MODUS OPERANDI: These rules were accepted by the Board of County Commissioners and formally adopted by the first Board at its first meeting. They may be amended at any time by a process which follows: Any member or citizen at large may propose a change to this document. The Board of Health by simple majority may adopt the changes and propose them to the Board of Commissioners for ratification. The Board of Commissioners must agree by a simple majority.

Adopted this 30th Day of June, 2006.