Assessing & Improving Public Health in Maine

Public health is what we do together as a society to ensure the conditions in which everyone can be healthy.
IOM, 1988

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Abstract: Maine's public health system has seen dramatic changes over the past several years, including substantial cuts to employment, funding, and the organized delivery of public health services statewide. Maine is not alone. Across the country states are re-assessing their public health delivery: systems, services, and workforce readiness. In this report, we share findings from an assessment of the national landscape, as well as from surveys and interviews conducted in Maine. The State has dedicated substantive time, money and other resources to understanding gaps in services, opportunities for collaboration, priority public health issues, and roles and responsibilities for stakeholders. We summarize key findings, and conclude with proposed recommendations for assuring the health of Maine's people and places.

PUBLIC HEALTH: AN OVERVIEW

What is Public Health?

Public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals." — CEA Winslow

What are the 10 Essential Public Health Services?

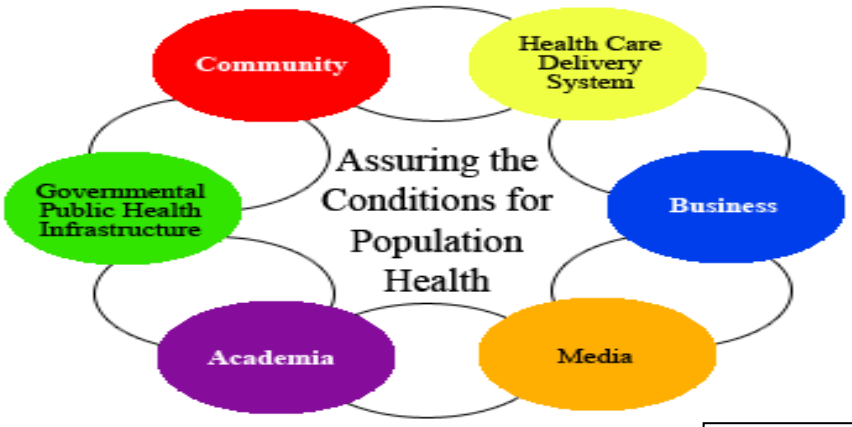
1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnership to identify and solve health problems
5. Develop policies and plans that support health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care
8. Assure a competent public health and health care workforce
9. Evaluate the effectiveness, accessibility, and quality of services
10. Research for new insights and innovative solutions to health problems

What are the Core Functions of Public Health?

1. Assessment of the health of the community
2. Assurance of the public's health
3. Policy Development in the public's interest

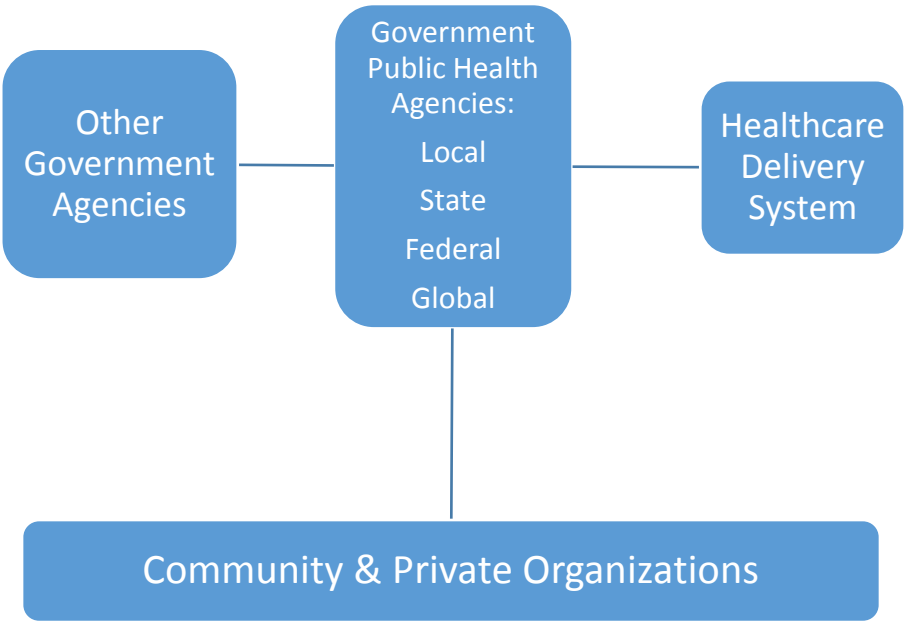
What is the Public Health Infrastructure?

According to the Centers for Disease Control and Prevention (Healthy People 2010, 2020, 2030), the *public health infrastructure is comprised of Organizations, Workforce, Fiscal Resources, and Information Resources*. These are described in more detail below.



Public Health Organizations (IOM, 2003)

Governmental Public Health Infrastructure



There are different models of government relationships in public health service delivery – both state and local health departments can deliver services. There are four types of service delivery models: 1) Centralized; 2) Shared; 3) Mixed; and 4) Decentralized (ASTHO, 2012).

Centralized/Largely Centralized: Local health units are primarily led by employees of the state and the state retains authority over most fiscal decisions (Centralized states: AR, DE, DC, HI, MS, NM, RI, SC, VT; Largely centralized states: AL, LA, NH, SD, VA)

Shared: Local health units may be led by employees of the state or of local government. If they are led by state employees, then local government has authority to make fiscal decisions and/or issue public health orders (Shared states: FL, GA, KY; Largely shared states: MD)

Mixed: Some local health units are led by employees of the state and some are led by employees of local government. No one arrangement predominates in the state (Mixed states: AK, **ME**, OK, PA, TN, WY)

Decentralized/Largely Decentralized: Local health units are primarily led by employees of local governments and the local governments retain authority over most fiscal decisions (Decentralized states: AZ, CA, CO, CT, ID, IL, IN, IA, KS, MA, MI, MN, MO, MT, NE, NJ, NY, NC, ND, OH, OR, UT, WA, WV, WI; Largely decentralized states: NV, TX)

In states with local public health departments, the 10 most frequently provided services and activities, provided directly through the local health department are (NACCHO National Profile of Local Health Departments, 2010):

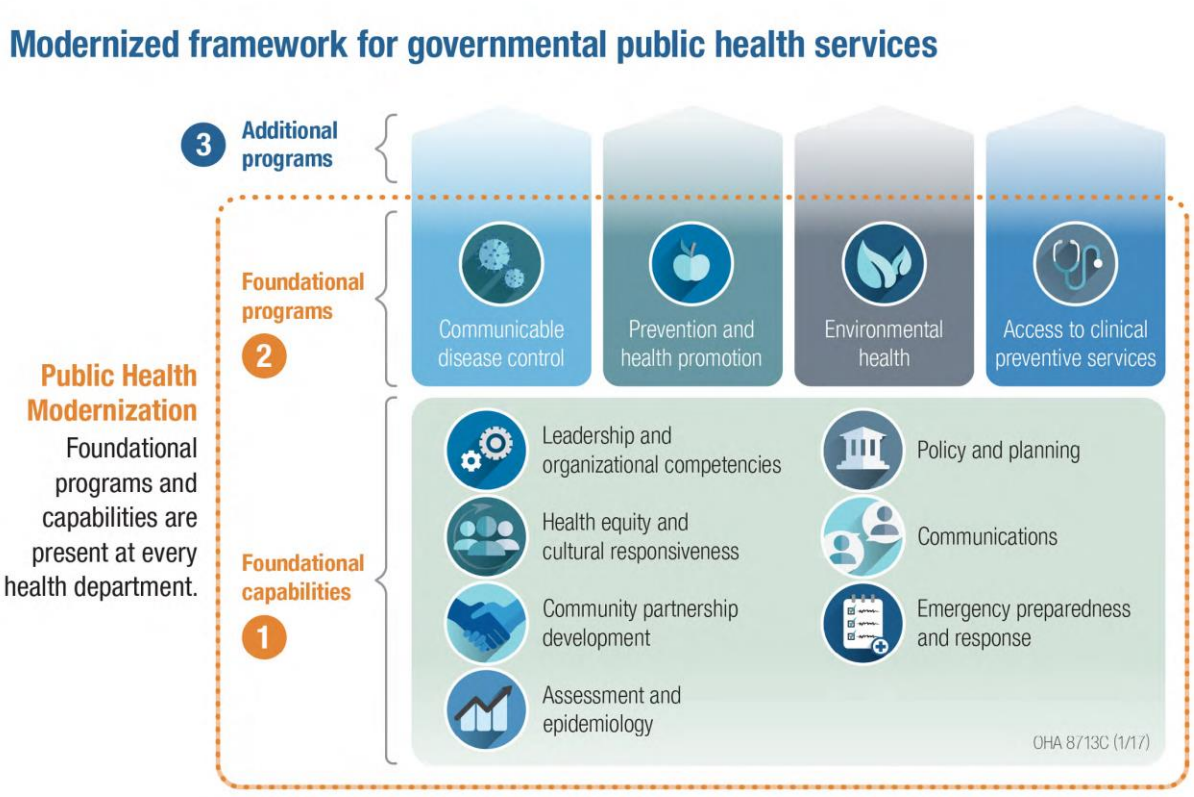
1. Adult immunization provision
2. Communicable/Infectious Disease Surveillance
3. Child Immunization Provision
4. Tuberculosis Screening
5. Food Service Establishment Inspection
6. Environmental Health Surveillance
7. Food Safety Education
8. Tuberculosis Treatment
9. Schools/Daycare Center Inspection
10. Population-Based Nutrition Services

Fiscal Resources

Mamaril and colleagues (2017) published an analysis assessing financing in public health delivery. The authors found substantial variation in costs exists across communities in resources currently devoted to implementing Foundational Public Health Services (FPHS; defined by the Public Health Leadership Forum, 2004 – see image below), with even larger variation in resources needed for full attainment. The authors found the average agency- incurred costs was $48 per capita implementing FPHS at their current attainment levels with a coefficient of variation (CV) of 16%. Achieving full FPHS implementation would require $82 per capita (CV=19%), indicating an estimated resource gap of $34 per capita. In order to reduce geographic inequities in delivering FPHS, novel financing mechanisms and delivery models, which allow health agencies to have robust roles within the health system, could be explored.

SCAN of NATIONWIDE MODERNIZATION EFFORTS

In 2016, RWJF and the Public Health Accreditation Board (PHAB) awarded 21st Century Public Health Modernization grants to three states: Washington, Ohio and Oregon.



Grantees in Washington State held a public health roundtable with labor partners, nurses, physicians and hospitals. Arising from this roundtable, organizers identified and defined core services for each jurisdiction in Washington (the state has 38 local health departments), as well as ancillary service options. These services reflected intentional focus on cross-jurisdiction work that was already happening, particularly in rural areas, and the identification of areas of strength within and across local health departments. Organizers requested $16 million in state funding, and received $10 million, which represented $2 million to the state's health department and smaller allocations for each jurisdiction. Appendix A presents their final framework.

Grantees in Ohio were focused on cost determination, including how local health departments bill insurance companies and Medicaid, and how local health departments share collaborative services (e.g. billing). Ohio has 117 local health departments, and the state's Public Health Partnership continues to work with RWJF and PHAB to estimate the cost of providing public health core services and to explore models for shared services between local public health districts.

Grantees in Oregon built from recently passed legislation to evaluate the state's public health infrastructure. The state's endeavor to ensure a core level of public health service for everyone across the state began in 2013, when the Oregon legislature set out to modernize the state's public health system with the passage of House Bill 2348. The task force developed recommendations for a modern public health system. Those recommendations were shared with the Oregon Legislature. In 2015, the Legislature passed House Bill 3100, which adopted foundational capabilities and programs — core services that must be available to everyone in the state wherever they live. State and local public health authorities may have additional programs based on local needs and available resources, but the foundational capabilities and programs establish a common set of essential services that must be available in all areas of the state. In 2017, the Legislature passed House Bill 2310, which clarified how foundational capabilities and programs will be implemented across the public health system.

Oregon's modernized public health system is built upon seven foundational capabilities and four foundational programs. Foundational capabilities are the knowledge, skills and abilities needed to successfully implement foundational programs. Foundational programs include topic- and disease-specific work to achieve improved health outcomes, such as a decrease in the prevalence of a particular disease or health risk behavior. Historically, foundational capabilities were not consistently present to support effective foundational programs. The foundational capabilities are needed for governmental public health to meet its charge to improve the health of everyone in Oregon. The foundational capabilities are: Leadership and organizational competencies; Health equity and cultural responsiveness; Community partnership development; Assessment and epidemiology; Policy and planning; Communications; and Emergency preparedness and response.

Each capability is essential — and requires adequate staffing and resources — to carry out the essential, complex and often life-saving work of governmental public health. The health equity and cultural responsiveness and community partnership development capabilities are defined separately, but support all of the foundational capabilities and programs of governmental public

health. The state recognized that the burden of health disparities will not be eased without a commitment to equity in all aspects of governmental public health work.

With an allocation of $500,000 from the Oregon legislature, the public health task force developed an extensive library of resources related to modernization, including a manual and guidelines for clinical/community collaboration.

In Massachusetts (not a recipient of RWJF/PHAB funding), each town or city has its own Board of Health, which is responsible for assuring services are offered, per statute. While state funds are not dedicated for supporting local efforts, in 2012, the state established a Prevention & Wellness Trust Fund, which allocates funds to support local public health core services. The Fund is comprised of the Prevention and Wellness Trust Fund Grantee Program, which is made up of nine partnerships, and Massachusetts Working on Wellness. By directing healthcare funding into community disease prevention, the legislature created a new opportunity for improving health and reducing spending (dual goals of Chapter 224, which established the Fund). In addition, PWTF focuses on:

- Reducing rates of the most prevalent and preventable health conditions;
- Increasing healthy behaviors;
- Increasing the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers;
- Addressing health disparities; and
- Developing a stronger evidence-base of effective prevention programming.

The membership of the Fund's Advisory Board represents public officials, public health advocates and stakeholder organizations. The Advisory Board is charged with:

- Making recommendations to the Commissioner of the Department of Public Health on the administration and allocation of PWTF
- Advising the Department of Public Health on its annual report to the legislature
- Evaluating PWTF and making a report to the legislature on the findings of this evaluation with a recommendation to the legislature about whether PWTF should continue

Public Health National Center for Innovations

The Public Health National Center for Innovations is a national learning community to identify, implement and spread innovations in public health practice. The Center is co-funded by RWJF and PHAB, and through research and synthesis, it has identified the below programs, activities and services as specifically within the purview of health departments (matched with community needs):

- Foundational Areas: Communicable Disease Control, Chronic Disease & Injury Prevention, Environmental Public Health, Maternal, Child & Family Health, Access to & Linkages with Clinical Care
- Foundational Services: Assessment (surveillance, epi, lab capacity); All Hazards Preparedness/Response; Policy Development/Support; Communications; Community Partnership Development; Organizational Competences (leadership/government, health equity, accountability /performance management, QI, information technology, HR, financial management, legal)

Maine is divided into 9 public health districts, including a tribal district, based on geography, population, hospital service areas, and county borders. Each district has a coordinating council, district liaison to the statewide coordinating council, and a public health unit, which (should) staff a public health nurse, regional epidemiologist, health inspector, and drinking water staff. Formerly, each district had a Healthy Maine Partnership – a health coalition that delivered public health education and programming, mostly focusing on chronic disease prevention. The below review presents data gleaned from statewide reports related to public health priorities and responsibilities.

SCAN of COMMUNITY HEALTH ASSESSMENT QUALITATIVE DATA in MAINE

INTRODUCTION

This report reviews findings from a scan of community health assessments in Maine with a focus on community engagement. The report offers summaries of Shared Community Health Needs Assessments (CHNA) community engagement results and observations about their process. The review samples other community sector needs assessments and project evaluation reports with community engagement used at some point in planning. The assessments were conducted within the past 15 years, most within the last eight. Materials were obtained solely from online sources.

Underlying reviewer assumptions are based on public health standards and practices related to the ten essential services, use of the social ecological approach for population health interventions and for Frieden's Health Impact Pyramid interventions. Limitations of this review include no scan of public school and/or college needs assessments. The review offers more commentary framed by public health standards for community health improvement assessment than nonprofit hospital IRS 990 requirement and community benefit concerns. The rationale is that hospital needs assessments all reference the Shared CHNA community engagement results. The hospitals' plans of action, usually, then use their own hospital's stakeholders to review, refine, and rank hospital-specific action priorities.

Public health assessment and planning frameworks involve engaging both stakeholders and/or community members. In terms of community engagement, these frameworks can vary over several dimensions:

- which community groups are targeted for outreach and if that outreach is successful
- for what purpose (e.g. information sharing, priority ranking, and/or action planning)
- what forms of communication are used (e.g. face-to-face, telephone, mail or online survey)
- how the type of lead organization(s) influences the assessment's design
- if community groups are approached as partners or as service consumers/patients
- if results are shared with the community to establish partnerships for action

This report looked at two types of community health assessments: comprehensive and categorical. A comprehensive community health assessment monitors over time the health status of an entire population. It looks at a wide range of health issues and causal factors as well as disparities in health burden experienced by different groups within the general population. A categorical assessment focuses more directly on certain types of data and on a narrower issue, such as chronic disease or cancer; substance abuse or opioid addiction; social justice or Somali

refugees in Lewiston. Such assessments can choose to focus on more broadly inclusive issues, such as social justice or social capital, with fewer or nontraditional metrics.

This scan neither synthesizes nor quantifies the various health topics and factors identified among the assessments; nor, does it simply duplicate the Shared Assessment State Report. The scan does not contrast the action priorities chosen by District Coordinating Councils compared to hospitals. However, results have been listed for comparison among like assessments, such as Shared CHNA priorities among all counties and among all districts; or among CAP agencies, etc. in appendices.

SIX SUMMARY OBSERVATIONS

1. Community sectors other than health may not be aware of how their mission, policies and practices have an impact on population health. Different sectors directly or indirectly contribute to the social determinants of health [SDOH]. These have an impact on health status, and create disparities among different groups. In Maine, it appears we are still figuring out how to operationalize that information at the state and local levels. The CHNA community engagement process showed that our public health and health care stakeholders recognize poverty, transportation, and housing as key factors impacting community health. However, *our health workforce, when queried among different institutions and sectors, still identify individuals as holding the most responsibility for improving a majority of ten specific health problems*. The Frameworks Institute, when researching how people explain health status, coined the term "health individualism" to describe the thinking barriers for people considering the role of systems in preventing or mitigating such problems.

2. The Shared CHNA's statewide community engagement methods include stakeholders and community leaders who build awareness of and relationships between organizations, and specific, measurable health issues. Survey respondents help rank priorities among given issues for organizational planning purposes. The process facilitates synergy and alignment among area health and social service agencies who can use sound data to address shared objectives. Public Health Districts report the Shared CHNA will help Districts apply a Collective Impact approach and collaborate with hospitals that are working to "activate communities" in their service areas. However, it is unclear if limited time and resources, fixed categorical funding, and a top-down approach to health improvement create barriers for *self-defined* local communities to achieve measurable change.

3. Lack of institutional supports in the forms of administrative reorganizations and turnover in the state public health agency, an absence of key legislation and public health funding lines, and the dependence of the Shared CHNA upon a public/private contractual agreement leaves the function of community health assessment at risk of disruption or quality erosion at any given time. There appears to be lack of a common understanding of what is included under the term "local community." The Shared CHNA Stakeholder survey suggests there are varied perceptions of the responsibilities of public health partners in the system responsible for protecting, improving and assuring population health.

4. Categorical assessments of smaller geographic areas or populations designed by a Tribe or a single agency, such as a foundation or city health department, appear to incorporate the time to build trust in relationships between funder and community members. They support outreach design and story collection to uncover perceived root causes and barriers. Private funds have the flexibility to go outside traditional categorical topics to address, for example, stigma and social isolation where the evidence for measurement is still developing. The communities are supported in stepwise planning processes and receive technical assistance for capacity building. Health philanthropy can fill potential gaps in modelling how to develop partnerships with communities. It is unclear if pilot projects are scalable to the statewide level.

5. Some disempowered communities are mobilizing and not waiting to be "activated" with the help of targeted funding. So far in Maine, Tribes, refugee, LGBTQ and older adults are conducting their own assessments, with technical assistance, to bring their voices and issues to the table and to identify where partnerships are desired.

6. Community health improvement progress will be unable to effectively address complex community needs without engaging the community. We need ecological and community-wide interventions that go beyond traditional, and even innovative, clinical interventions by health systems. It is certainly possible to strengthen coordination among health and social service agencies for improved personal care services for individual patients for the purposes of self-management. However, it is another level of magnitude to help entire communities to apply community-wide intervention models, using the policy and planning levels (e.g. to improve the built environments in which people make behavioral choices). [See Appendix 2.3 How We Think About Health.]

HISTORY OF HEALTH PLANNING

State Health Planning in Maine: 1976-2011

Over the past 40 years, the State of Maine has created various versions of a State Health Plan:

1976:	Federal recognition of the Maine Department of Health and Human Services as state agency with responsibility to conduct statewide health planning.
1997:	Legislation passed states Maine DHHS shall adopt a State Health Plan that addresses "health care, facility and human resources needs in the state." The Maine Bureau of Health responsible for the development of the State Health Plan.
2003-2010:	Governor's Office of Health Policy and Finance (GOPHF) established and required to issue a biennial state health plan. GOPHF collaborates with Maine DHHS to issue three bi-annual state health plans (2006, 2008, 2010).
2011:	The Maine statute requiring a biennial State Health Plan repealed.
2011:	Maine DHHS administration approves Maine CDC's intent to seek national public health accreditation, which incidentally requires a State Health Assessment and Improvement Plan.

HISTORY OF COMMUNITY ENGAGEMENT in HEALTH PLANNING

Maine has a strong history of using stakeholder and community engagement as part of creating comprehensive public health improvement, assessment and improvement plans for more than two decades.

- The Bureau of Health engaged public health stakeholders in the development of two successive ten-year *Healthy People* state plans to rank priorities for action. Stakeholders helped rank objectives.
- *Over the same period*, community health coalitions serving multi-town service areas were established and funded through the Bureau's Community Health Promotion Program using Preventive Health Block Grant funds. These coalitions received contracts for comprehensive community health assessments/planning, which used frameworks requiring local community input:
    - PATCH [Planned Approach to Community Health] U.S. CDC (1988-1994)
    - Healthy Cities/Healthy Communities WHO (1995-2005)
    - MAPP [Mobilizing for Action through Planning and Partnerships] NACCHO (2006-2010)

Funding support was supplemented with categorical public and private grants. Such support was bolstered when the coalitions started to receive funding from a formula engineered from Maine's share of the national Tobacco Master Settlement. Funds and technical assistance also came to some, if not all, of the coalitions from Maine's health philanthropies, such as Maine Health Access Foundation (MeHAF) and the Bingham Program. Additional support came from hospitals and universities working with coalitions as their fiscal agents.

Working cooperatively with the Maine Bureau of Health, the nonprofit, Maine Center for Public Health, in 1999, received a two-year Robert Wood Johnson Foundation Turning Point planning grant to address public health infrastructure needs. This autonomous process included engaging more than 200 stakeholders, including community health coalition leaders.

After community health advocacy, the Governor's Office of Health Policy and Finance established a formal Public Health Work Group to establish and clarify sub-state public health infrastructure. Comprehensive health coalitions and regional health Districts were given essential public health service roles, with the coalitions responsible for conducting community health assessments for their now formalized service areas. The regional Districts, which included the coalitions, were convened through the use of the Local Public Health System Assessment, and soon were also assigned an assessment function for their jurisdiction.

Once Maine CDC formally moved toward national public health accreditation in 2011, the state public health system became more formalized as it reoriented itself to the ten Essential Public Health Services for performance guidance.

- Public health stakeholders from state and local levels convened for one State and eight District public health system assessments (2011-2012). Stakeholder perspectives were collected for a picture of the assets within and coordination of state and local public health systems for delivery of the ten essential public health services.
- A formal, standardized State Health Assessment debuted in 2012, providing indicators selected through epidemiological analysis and stakeholder input, and was the basis for 8 public health district indicator profiles.

- The first statewide public/private SHNAPP [Shared Health Needs Assessment Planning Process] report debuted in 2016. This framework provided a standardized approach for developing needs assessments and action plans for both state government and for Maine's nonprofit hospitals and health systems. This provided wide engagement of health stakeholders and community leaders at both the state, district, and county level that mapped assets and ranked priorities for action. The MaineHealth System-affiliated hospitals each produced their own action plans soon after.
- The Shared CHNA supported the State governmental public health agency in meeting national public health service standards for performance for accreditation. It also allowed MaineHealth Systems to meet new IRS Regulation 990, which stated that nonprofit hospitals conduct assessments and actions plans. The SHNAPP framework, now known in 2017, as the Shared CHNA, continues today in assuring that stakeholder and community perspectives will be collected using standardized tools and reporting forms.

LEGAL INCENTIVES & SUPPORTS FOR COMMUNITY HEALTH ASSESSMENT

One core function governmental public health has is to assess population health status: analyze trends and identify disparities. Maine does not have a network of local public health agencies. Currently, there does not exist a State mandate for community health assessments; this absence, in turn, has implications for whether public funds are sustainably budgeted by the State and made available.

National level:

- There is no federal law, and no dedicated federal funding line, which requires all states to assure that local health status assessments of local jurisdictions are conducted with their community stakeholders engaged.
- National standards for state and local public health agency accreditation require that community health assessments engage community members. Maine legislation statutes do not require that the Maine CDC, the state's public health agency, meet and maintain national accreditation.
- IRS federal rule 990 requires non-profit hospitals to conduct periodic community needs assessments and action plans for their service areas. The legislation is explicit that community stakeholders be engaged in the process.

State Level:

- The most recent legal requirement for a State Health Plan was repealed more than five years ago.
- The Maine CDC, formerly known as the Bureau of Health, until recently, has had leaders trained in public health practice [MD/MPH]. There is no language in state law or regulations mandating the Maine CDC deliver the ten essential public health services, which includes population health assessment. When Maine CDC became accredited, its umbrella department, the Department of Health and Human Services (DHHS), was recognized as its governance structure. However, the Department, itself, has no legislative mandate to conduct state health improvement assessment and planning. The current administration reserves the right to adjust the Maine CDC State Health Improvement Plan (SHIP) for additional priorities. The Maine CDC is dependent upon DHHS and the Legislature to assure that its population health

assessment will be sufficiently resourced, and collaboratively and transparently conducted, with the input of stakeholders and community leaders.

Regional and Local Level:

- Legislation enacted in 2010 established sub-state public health infrastructure in the form of community health coalitions known as Healthy Maine Partnerships (HMPs). They were charged with conducting local community health assessments. The HMPs already had more than a decade of experience in doing so, and had established strong local relationships. HMPs have now been defunded and visibly erased by the LePage DHHS administration. Originally, regional public health districts and councils were established for coordinating purposes. Since the HMPs have become invisible, DHHS now refers to the Districts as "local." They do not have a legislative mandate to conduct health assessments but do so in practice.
- Maine counties derive their power from the State, and do not have a constitutional or legislative mandate to address population health but only public safety; although, they conduct assessments and engage the community for that purpose.
- Maine is a home rule state, and municipalities are only required by the State to appoint Local Health Officers [LHOs]. While some choose to participate in the Shared CHNA, LHOs are not required by the State to conduct local health assessments, except if their municipal charter requires them to do so. Most Maine towns cannot support municipal health departments with the capacity to conduct community health assessments. Only the largest cities have pursued community health assessments, such as the City of Portland.
- All municipalities are required by state law to periodically conduct a municipal land use growth and development plan. While these plans require community engagement (and also address elements of public health), no one is required to have a community or public health background, and there does not appear to be much specificity about health indicators or issues.
- The Land Use Planning Commission [LUPC] is responsible, by statute, for the unorganized and de-organized civil divisions of Maine (townships and unincorporated islands). Its duty is to assure use of sound planning, zoning and development principles, with the first objective to protect public health, safety and the general welfare of the 9,000 people living within them. It is unclear how this principle is implemented or how it relates to the Shared CHNA.
- Maine Tribes, as separate governments, do not formally participate in state or local assessments to serve their Tribal members; however, they do have their own Waponahki Health Assessment and individual tribal profiles that engage Tribal members throughout the process. If the Wabanaki Tribal Health District achieves national Tribal public health agency accreditation, it will be expected to formally interface with Maine's other public health districts.

SELECTED SOURCES OF COMMUNITY HEALTH ASSESSMENTS with COMMUNITY ENGAGEMENT

Shared Community Health Needs Assessment [Shared CHNA]

The Shared Health Needs Assessment Planning Process [SHNAPP] was initiated in 2012 (since 2016, called the Shared Community Health Needs Assessment [CHNA]), and provides Maine

with a credible, standardized, and scientifically sound health assessment process. It combines health indicators at the state, health district, and county levels with input from service providers, health stakeholders, and community leaders and, to a lesser extent, community residents. Data produces priority ranking and area asset identification for follow-up action plans developed by the State, health districts, and hospitals. The Shared CHNA is a collaborative endeavor sponsored by the state public health agency and Maine's four major hospital systems. Community engagement includes a statewide online survey, and standardized schedule, tools and facilitated process for face-to-face community discussion.

The State Report's section on community engagement (see page 6), aggregated data addressing ranked health problems, health disparities, the factors influencing those health problems, and the drivers behind those factors. Respondents answered questions about which sectors and organizations held responsibility for problem improvement. Perceptions of which health problems or factors might be improved locally were explored. These data offer opportunities to explore underlying conceptual frameworks for health improvement from which planners and respondents are working; and, possibly, perceptions of capacity and political will (not just resources) to address those problems.

Public Health Districts

- Public Health Districts, District Coordinating Councils [DCCs], and the District Liaisons established in Maine statute to Maine CDC/DHHS
- Districts, upon establishment in Maine statute in 2009, conducted a Local Public Health System Assessment [LPHSA] to look at the regional system's capacity for coordination and its resources. This assessment collected perspectives of multisector public health stakeholders to address coordination, process, assets, and system capacity to deliver the 10 essential public health services after reports were published (2009-2010)
- District Health Improvement Plans [DPHIPs] built on quantitative/qualitative data, in recent years through Shared CHNA
- More specific localized input for priority setting and District action plans occur after the Shared CHNA results are disseminated

Example: Cumberland District Local Public Health System Assessment
Example: Cumberland District Health Improvement Plan

"Community Health Improvement" could be interpreted to mean

- Reducing differences in life expectancy and healthy life expectancy between communities
- Improving wider determinants of health (factors that affect health and wellbeing)
- Helping people to live healthy lifestyles and make healthy choices
- Protecting the population's health from major incidents and other threats
- Reducing the number of people living with preventable ill health and people dying prematurely

OTHER GOVERNMENTAL HEALTH-RELATED ASSESSMENTS
City and Town Municipal Health Needs Assessments

- Portland: The longstanding city health department conducts a Community Health Assessment with community engagement elements given its status as a nationally

accredited local public health agency. It conducts categorical assessments for selected neighborhoods and for minority populations as planning and funds support.

- Bangor: The city's health department does not post a city jurisdiction health assessment separate and distinct from that of the Penquis Shared CHNA process.
- Lewiston/Auburn: Neither city has a designated public health agency, although each municipality provides some functions relevant to population health status protection. However, these do not include conducting comprehensive community health improvement assessments. The several years old voluntary joint Lewiston/Auburn Public Health Committee, which held a cooperative agreement with both city councils, disbanded in the last year, and only the Lewiston Health Committee exists. Grant-funded categorical health assessments are regularly conducted by a sponsoring agency and builds on the legacy HMP work serving Androscoggin County.

The Shared CHNA apparently plays a useful role in indirectly supporting the needs for an assessment under the circumstances. The former HMP, Healthy Androscoggin, which is based in Lewiston, provides a key community engagement service to the area.

Other municipalities: Given home rule, each municipality's charter or constitution frames the degree to which the city or town has explicit legal language that supports public health versus the more general terms of the "welfare" or "common good" of the community. This is a general impression, as the Maine CDC has never canvassed all municipalities or worked with the LUPC to determine public health service delivery. They may cover individual care (clinical health and/or social services) but less often, population health management. Municipalities are required by state law to appoint a town LHO but their role does not include formal assessment. Municipalities also address local building code, and food and lodging enforcement, which supports aspects of population health. However, to the best of our knowledge, there has not been surveillance research conducted about which legal supports exist in all municipalities to address community-wide health. Maine Municipal Association (MMA) appears to focus its resources on government employee health insurance and chronic disease prevention/health promotion programs to reduce workforce costs. Again, to the best of our knowledge, the Maine CDC does not engage the MMA in terms of health promotion, but only on the topic of LHOs.

County and Municipal Assessments related to health protection:

- Maine's sixteen counties' emergency management programs each develop and update
  - Emergency operations plan
  - Hazard mitigation plans
  - All hazards emergency preparedness plans
- Each municipality in the county is expected to develop emergency preparedness plans and to send a copy to the county
- The State provides all counties with a template for developing county and municipal emergency response plans. The hazard mitigation plan template calls for documenting how the public is involved during the drafting stage.
- HHS Districts and Tribal Health Districts have participated in preparedness planning, including a vulnerable population's assessment.
- It is unclear if stakeholder engagement includes community asset mapping or priority setting.

Example: Oxford County Hazard Mitigation Plan

FQHC [Federally Qualified Health Center]

- Sliding scale ambulatory care clinics receive core funding/contract management by the federal government [HRSA]
- Needs assessment is required "on a periodic basis" (3-5 yrs.); however, there is no standardized schedule across all ME FQHCs
- Needs assessments focus on quantitative data (population; area service providers; some health indicators), but no community engagement is required
- Some exceptions:
    - RMCL [Regional Medical Center at Lubec] has conducted "community conversations" to establish consumer dialogue
    - Pines Health Center, a FQHC serving Aroostook County, is an Aroostook Health Alliance partner participating in the next Shared CHNA, so will benefit from community engagement
    - Greater Portland Health, FQHC serving Portland/South Portland, participates in area community health needs assessments

CAP [Community Action Program] sponsored by Community Action Agencies [CAAs]

- Anti-poverty nonprofit agencies receive core funding/contract management by the federal government [US Office of the Administration for Children and Families]
- Required to conduct a needs assessment every 3 years with consumer/stakeholder input
- Data used to identify stakeholder priorities among varied needs
- Input has been collected by online or paper surveys, supplemented with focus interviews
- Reports include Shared CHNA quantitative data
- Some reports integrate consumer opinion data from local Head Start Programs' needs assessments

AAAs [Area Agency on Aging]

- Service for older adults and those with disabilities provided by nonprofit agencies; receive core funding and contract management by the federal government [DHHS AoA]
- Required to conduct needs assessments for strategic planning every 3 years
- AAA capacity to engage regional consumers and stakeholders is useful for the State's Office on Aging and Disability [OADS] for its own action planning

Summary observations: AAA needs assessments offer useful summaries of older adult and caregiver perspectives related to health and quality of life, especially related to SDOH. Of interest is the level of priority needs related to home repairs, food security, affordable housing, and transportation.
Example: Eastern Area Aging Agency

NGO HEALTH ASSESSMENTS
Healthy Maine Partnerships [HMPs]
A few of the legacy, comprehensive community health coalitions, particularly those with strong institutional stakeholder support and no coalition leader turnover, conduct categorical needs assessments, some with a strong community engagement component.
Example: Healthy Communities of the Capital Area Annual Report 2016 (see page 5)

2016 SHARED CHNA: Three Methods of Community Engagement
Community stakeholders participated in one or more of three channels for sharing their perspectives on local or regional health issues between 2015-2016.

May-June 2015	**SHNAPP Stakeholder Survey**
	Online SHNAPP Stakeholder Survey using existing health agency and workforce networks for distribution to state, regional, and local stakeholders (statewide). The SHNAPP collected demographics, and asked opinions about the health issues perceived as having the greatest impact, and perceptions of determinants, disparities, and priorities for improvement. An open-ended section invited unstructured input.
October/November 2015 to March/April 2016	**Community Forums and Community Events**
	– Shared area health indicator data, and compared with state rates – Asked to rank which issues should be prioritized for further action – Asked to map area assets that could help improve the issue/s – Explored next steps in terms of who and how action should be taken
May 2016	**Community Engagement Follow-up Survey**
	Collected follow-up information about SHNAPP data presented at Forums/Events. Survey sent to 868 individuals, producing usable, completed material from 204 individuals. Survey measured Forum/Event attendee "community feelings towards the data shown, and if they found them to be effective"…. "Overall participants found the Community Events to be helpful, but did not feel this strongly. The questions regarding future action received the lowest average scores." [SHNAPP State Report 2016].
	Note: Some individuals participated more than once or in one way

SHNAPP STAKEHOLDER SURVEY
This survey was widely distributed by the original state level SHNAPP planning committee members' agencies and professional networks, and was intended to assure wide reach in order to obtain diverse, local perspectives about health-related topics. The survey offered a list of 25 health "concerns" and 26 health "factors." Respondents ranked the degree to which they believed the concerns and factors impacted area resident health, who was responsible for addressing the issues, if there were enough resources in the area to address the topic, and perceptions of feasibility to make improvements. More than 80 organizations and businesses were reached, resulting in responses from 1,639 people, who, besides answering structured questions, provided more than 12,000 comments in response to open-ended questions. Of participating sectors, health care agencies, public health agencies, law enforcement, schools, municipalities, local businesses, social service agencies, and nongovernmental organizations were most represented. Slightly more than half of the participants were from the health workforce. Such participants came from hospital or healthcare systems (38%), a "local public health agency" [see CHNA Summary Observations/process qualifier], or state public health agency (3%). Of the other 49%, 14% came from a nonprofit or social service agency, and nearly 10% were business owners or employees. Geographic service or work area included:

- 22% worked statewide or represented statewide interests
- 18% worked at county level
- 26% worked at a hospital or health service area
- 27% worked at the town or regional level

Nearly 50% of respondents worked with populations experiencing health disparities, whether that was a primary or indirect focus.

COMMUNITY FORUMS

After the online survey, Community Forums were offered by eight District-Hospital CHNA community engagement planning committees. These volunteer committees were organized by the District Liaison, District Coordinating Council leaders, designated hospital staff, and other area stakeholders. A limited number of Forums for each District were planned to cover the regional geography. Interested stakeholders and community leaders traveled to a site (donated by a local stakeholder agency) for what was, usually, a 2.5-3 hour discussion after a review of highlights from an analysis of area health indicators, which was developed for the State Health Assessment. A PowerPoint presentation was followed by breakout sessions about that summarized indicator analysis. Multiple breakout sessions gathered input about:

1. Summary statements about the categorical issue and/or its effect on the community
2. Identification of local assets and resources to address the issue
3. Named barriers in addressing the health issue and/or identifying needed details before feeling able to address the issue
4. Ideas for next steps:
    a. How to solve the health issue
    b. Who to include
    c. What the community should look like in the *future*

COMMUNITY EVENTS

In contrast to the Forums, community events consisted of previously scheduled events hosted by an agency, civic organization, school or business, and were somewhat opportunistic in terms of how they were approached by the planning committees. Events were often less formal and more time limited. CHNA representatives were given a slot on the agenda; briefly reviewed area health indicator highlights, and then gathered feedback and ranked opinions, if there was time. The events allowed the planning committee to increase its reach within the area.

***THREE-COUNTY DISTRICT EXAMPLE*:** Western District

COMMUNITY FORUM Priorities:

Participants concurred with **Stakeholder Survey results** (previously compiled with input from all state and local stakeholders)**,** which presented the list of 25 Health Issues and 26 Health Factors. Participants reviewed the area health indicator data analysis, indicated the degree of concurrence with the findings, and provided their perspective on additional health issues and/or health factors.

Health Concern Priorities:

1. Physical Activity and Nutrition, including Obesity (mentioned within **all 3** counties)
2. Substance Abuse (mentioned within **all 3** counties)
3. Mental Health (mentioned in 2 counties)

4. Poverty (mentioned in 1 county)
5. Transportation (mentioned in 1 county)

Other **Health Issues** Identified by Forum Participants: Oral health/Dental care and access to services (mentioned within **all 3** counties)

Health Factors Identified by Forum Participants:

1. Interpersonal violence (e.g. ACEs, domestic violence, sexual assault, bullying; within **all 3** counties)
2. Poverty (2 counties)
3. Health Literacy (2 counties)
4. Employment/Livable wages (2 counties)

COMMUNITY EVENT Priorities

- Substance abuse (**13 of 21** events)
- Mental Health/Depression (**12** of 21 events)
- Obesity, including Physical Activity/Nutrition (**10** of 21 events)
- Poverty (**9** of 21 events)
- Lack of transportation (5 of 21 events)
- Child abuse/neglect; children's exposure to parent's drug/alcohol abuse (5 of 21 events)
- Drug affected babies (3 of 21 events)
- Dental care (3 of 21 events)
- Diabetes (3 of 21 events)
- STDs/Chlamydia/Gonorrhea (3 of 21 events)

Note: The SHNAPP process also made Community Engagement opinion forms available online and downloadable; however, it is unknown how many were submitted. While Tribal Health Liaisons participated in Community Forums, the Wabanaki Health District chose not to formally participate in the CHNA, given their own tribal public health assessment and planning activities. This decision was administratively and culturally supported by the Maine CDC given the government-to-government relationship the Tribes have with the State.

NOTABLE OBSERVATIONS from the 2015-2016 SHARED CHNA

RESULTS:

- Less than half of respondents in all counties identified cancer as an important/critical issue for their area.
- Only 4% identified concerns about infant mortality.
- Given tobacco's role in health status, it was intriguing that it was not identified in all counties as a major problem. This is especially so given that state data suggests that 1 in 5 adults are current tobacco users.
- The community engagement component of the Shared CHNA largely focused on health indicators, topics, and factors related to SDOH and health disparities. Therefore, participants did not have much opportunity to address community planning itself. The Stakeholder Survey did provide one clue: "community capacity" was the third topic chosen by participants, after risk factors (#1) and mental health (#2), in identifying which issues should be allocated available resources.

- There is a strong perception that the state legislature has a key role in health improvement. In contrast, municipal governments are not seen as having the same degree of responsibility for improving specific health problems, a number of which are chronic diseases that can be prevented or mitigated by local policy and built environment interventions.
- The CHNA Stakeholder Survey raises interesting questions about the framework/s respondents are using as they consider population health improvement. Pending orientation to public health in their training and employment, there are very different frameworks that will then prompt priority selection for action. For example, in considering the 25 health topics that have been identified as a major issue in their area, respondents identified health literacy as most likely to be improved with existing resources, although it was not as highly ranked as other health problems.

PROCESS:

- The Stakeholder Survey indirectly functioned as a two-month long snapshot of the health care and public health workforce's content knowledge, skills and attitudes regarding community health improvement and health promotion. Findings could be further mined to identify workforce training and development, particularly in strengthening stakeholder understanding of evidence-based health promotion and of governmental public health mission and services.
- There is no description in the State Report of 2016 as to how or if social media platforms and other media outreach were used to raise awareness and/or enhance participation.
- Until the HMPs and the DCCs were placed in statute as legislatively recognized "sub-state public health infrastructure," there were only two autonomous local public health departments (in Portland and Bangor) that were legally mandated and with sufficient capacity to deliver population health services to municipal residents. Since the HMPs and DCCs were established, there has been some conceptual confusion about the nature of the HMPs, in particular, as:
    - Collaborative and independent nonprofit partners
    - Community health coalition contractors serving state-assigned municipalities
    - The State's local public health representative due to recognition in state statute with responsibility for defined public health services (essential services #1, 3, 4, 5 & 7)

While the HMPs may be perceived (by themselves and others) as any or all of the above, they are not legal municipal or county public health departments, nor do they have a legal mandate to protect and improve population health status in the towns they serve. The same, of course, is true for the nonprofit health systems and hospitals in Maine. Although they do have an IRS mandate as nonprofits to demonstrate they benefit the communities who use their services, they, likewise, have no legal and fiduciary authority to deliver foundational public health services. Furthermore, while HMPs and hospitals have played key stakeholder roles in state and local public health systems, neither are governmental public health agencies. Without the existence of a glossary of terms to standardize a definition of "local public health organizations," it is unknown as to the thinking in identifying their responsibility to address health problems.

- CHNA guidance was to prioritize 3-4 health issues for action. Several counties chose more, simply clustering the topics. Several districts with multiple counties did not have all counties select the same topics. It is not known how this translated into follow up District Public Health Improvement Plans (DPHIPs) and whether single counties in multi-county Districts were supported in pursuing their own priorities with District resources made available. Fortunately, such Districts almost always have a local hospital serving each county.
- Service areas for hospitals and health systems crisscross the state, with at least four counties holding the homes of two or more hospitals, either independent or affiliated with a larger health system (Cumberland, Kennebec, Oxford, Somerset).
- MaineHealth, the corporate body of a network of hospitals, had a planning committee representing all affiliated hospitals. The Maine Medical Center's action planning had representation from key partners in local health improvement for its service area, including a city health department and a religiously affiliated hospital.
- 2016 DPHIPs are not currently accessible online at the Maine CDC website within its webpages related to Health District activities. It is unclear whether this is due to technical barriers or staffing delays. Three DPHIPs were located through Google searches on three different private websites used by the respective DCCs. This does not lend itself to promoting the work of the District or to engaging new stakeholders and updating community leaders.

Future of Public Health in Maine

Multi-Sector Partnerships

As Maine faces a range of increasingly complex health challenges and political environments, working in multi-sectoral partnerships will be an important strategy for improving community health. The vision for these partnerships could be increased intentionality between the HMPs, businesses and hospitals – work that existed before the coalitions were dismantled, but a more formalized (and publicized) structure could be developed.

Public Health Workforce

An effective public health workforce includes a diverse range of professionals, including administrators, clinical staff, epidemiologists, environmental health specialists, policy analysts, and health educators. Bolstering Maine's public health workforce capacity is essential for protecting and improving the health of Maine people.

Gaps in skills result from a limited workforce. These gaps are worsened by the barriers public health organizations experience in hiring trained public health professionals, including being unable to provide competitive pay and attract candidates with the appropriate competencies. Addressing these challenges and growing Maine's public health workforce is crucial to ensuring safe and healthy communities.

The Maine Public Health Association is working closely with the Maine Area Health Education Center Network to develop a comprehensive public health training for professionals in the field of public health. We are exploring funding options for the training, and the opportunity to (soft) require it for all members of District Coordinating Councils.

SIX SPECIFIC IDEAS FOR NEXT STEPS:

1. Develop state legislation to clarify and better articulate the governmental public health agency's scope of role. This will improve State leadership awareness (state agencies and legislators) of Maine's public health mission and infrastructure, identify stable funding sources within reasonable limits, and thus reduce the vulnerability of and instability in the public health system. Explore Robert Wood Johnson Foundation public health law resources and grants to gather data for such work.
    a. Maine legislation statutes do not require that the Maine CDC, the state's public health agency, meet and maintain national accreditation.
    b. The most recent legal requirement for a State Health Plan was repealed more than five years ago.
    c. In statute, it is not required that the State Health Officer have public health education or experience.
    d. There is no language in state law or regulations mandating the Maine CDC deliver the ten essential public health services, which includes population health assessment.
    e. Maine counties derive their power from the State, and do not have a constitutional or legislative mandate to address population health.
    f. Maine is a home rule state, and municipalities are only required by the State to appoint Local Health Officers (LHO). LHOs are not required by the State to conduct local health assessments, except if their municipal charter requires them to do so.
    g. All municipalities are required by state law to periodically conduct a municipal land use growth and development plan. While these plans require community engagement (and also address elements of public health), no one is required to have a community or public health background, and there does not appear to be much specificity about health indicators or issues.
    h. The Land Use Planning Commission [LUPC] is responsible, by statute, for the unorganized and de-organized civil divisions of Maine (townships and unincorporated islands). Its duty is to assure use of sound planning, zoning and development principles, with the first objective to protect public health, safety and the general welfare of the 9,000 people living within them. It is unclear how this principle is implemented or how it relates to the Shared CHNA.
    i. To the best of our knowledge, there has not been surveillance research conducted about which legal supports exist in all municipalities to address community-wide health.
    j. Without the existence of a glossary of terms to standardize a definition of "local public health organizations," it is unknown as to the thinking in identifying HMPs and hospitals' responsibility to address health problems.

2. Enlarge the community health stakeholder pool for participation in the Shared CHNA. Assure the existing Maternal/Child Health Block Grant assessment has better linkage with the Shared CHNA and ensure greater maternal/child, adolescent health, and aging advocates stakeholder participation.

3. Conduct early outreach and education to municipal government, land use planners, public safety and environmental health stakeholders to engage them in the community engagement planning so that SDOH and policy change interventions receive more attention in strategic planning. Encourage Shared CHNA planning committee members' intentional participation in comprehensive municipal plan development and their community engagement activities.

4. Increase the number of agencies already required to conduct regularly scheduled assessments to explore the potential for assessment on shared indicators, especially those who work with and/or are from communities experiencing disparities (poverty, ethnicity, gender, age, etc.).

5. Hold a summit between philanthropies (MeHAF, Bingham, etc.) and health stakeholders to share lessons learned about Collective Impact, community engagement for reaching the hard to reach, and what state and regional infrastructure exists or should exist to support sustainable technical assistance for local community capacity building.

6. Examine needed legislation at the state and municipal levels to improve recognition and support for governmental public health to once and for all recognize and invest in sub-state jurisdictions so that local communities build the capacity for self-directed community health improvement. Currently, the State has renamed its regional health districts, composed of three single-county and five multi-county regions, as well as the Wabanaki District, as "local" public health. Examination needs to uncover whether this involves regional and local community building to create a culture of health; and consideration of a multi-year plan to modernize the public health system and align it with Public Health 3.0 and Healthy People 2030.

Appendices

Appendix A: Washington State Public Health Framework