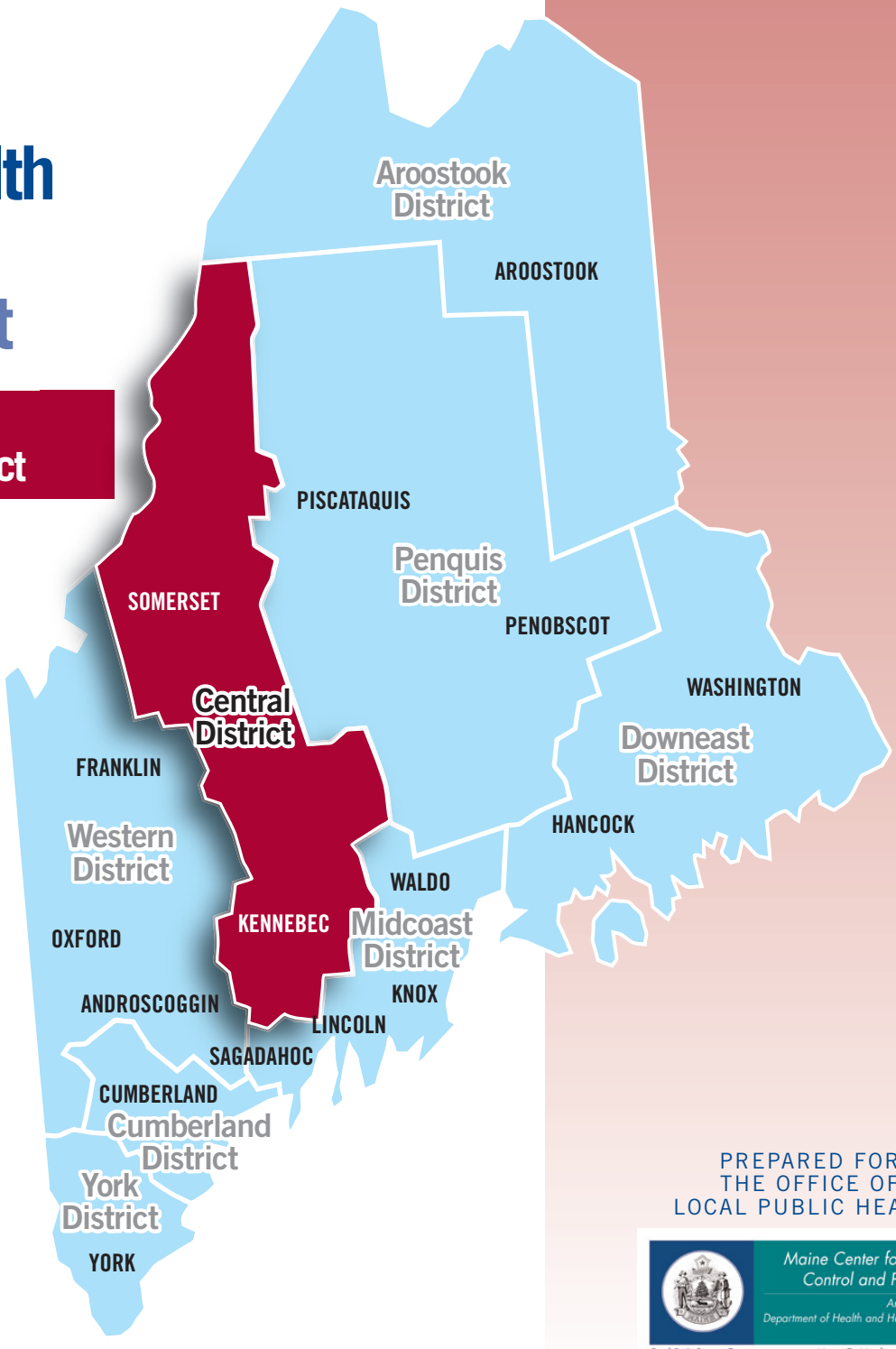
2010

# Local Public Health System Assessment

## Central Public Health District

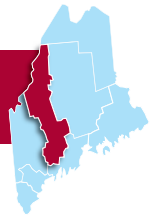



PREPARED FOR
THE OFFICE OF
LOCAL PUBLIC HEALTH

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

BY

MAINE CENTER for Public Health



# Acknowledgements

This report was prepared by Karen O'Rourke, MPH and Joan Orr, CHES from the Maine Center for Public Health in 2010 for the Office of Local Public Health at the Maine Center for Disease Control and Prevention.

**District Public Health System Assessment Team:**

Maine Center for Public Health team
Office of Local Public Health/Maine CDC team

Office of Primary Care/Maine CDC:
Division of Family Health/Maine CDC

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Preventive Health & Health Services Block*
Public Health Preparedness and Response*
Fund for a Healthy Maine^

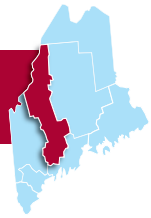
Healthcare Research & Services Agency*
Maternal/Child Health Block Grant*

**federal grant funds*
*^State funds (Tobacco Settlement)*

We would like to express our sincere gratitude to Mark Griswold and Chris Lyman for their leadership and vision of public health in Maine. Also to the District Liaisons for their creative ideas, constructive advice and assistance which was invaluable in the assessment process.

Aroostook . . . . . Stacy Boucher
Central . . . . . Paula Thomson
Cumberland . . . . . Becca Matusovich
Downeast . . . . . Alfred May
Midcoast . . . . . Jennifer Gunderman-King
Penquis. . . . . .Jessica Fogg
Western. . . . . MaryAnn Amrich
York. . . . . .Sharon Leahy-Lind

We want to convey a special thank you to the District's public health stakeholders who committed their time and knowledge of local areas activities, resources, gaps and challenges. Without their participation, we would not have been able to develop this snapshot in time.



November 2010

Dear Colleague:

Public health's core functions include assessment, policy development, and assurance. This report constitutes a systematic look at how public health services are coordinated, aligned and delivered by organizations of this public health District for the people who live, work, study and visit here.

The Department of Health and Human Services' Maine Center for Disease Control and Prevention provided funding support for the use of a nationally recognized public health system tool to assess regional public health systems in Maine's eight health districts.

These DHHS Districts were codified in state statute by the Legislature in 2009, based on the work of the Governor's Office of Health Policy and Finance, in partnership with a host of local, regional, and state-level public health stakeholders. The legislation describes the different components of Maine's emerging public health infrastructure, and within this description were the seeds of necessary public health steps that produced the report you see before you.

All District Public Health System Assessment Reports are available for downloading at www.mainepublichealth.gov. A limited number of paper copies have been made available to your District Health Liaison and Coordinating Council, as well as your nearest Healthy Maine Partnership, whose contact information can also be located at the link above.

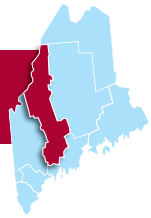
If you have comments or questions about the findings, please contact the District Liaison whose contact information is available inside.

The Assessment findings are a snapshot in time. It sets a baseline from which to measure progress and collaborative work to improve and to protect District community health and quality of life. It is a qualitative tool, but a necessary one to move forward. It is one step in many innovative efforts to better support local efforts to protect and improve community health and quality of life, reduce disparities in health status among groups in the District, and make Maine the healthiest state in the nation.

Thank you for your interest in the health of Maine's people.

Sincerely,

Dora Anne Mills, MD, MPH
State Health Officer
Director, Maine Center for Disease Control and Prevention
Maine Department of Health and Human Services



# From the Office of Local Public Health:

Local knowledge and perspective of participants built the picture you have before you of the District's public health system's assets. Part of the fun and challenge was to capture an understanding of *where* in this district services are being delivered. For a single county District, this might not be a challenge. But in a multi-county District, stakeholders had to look at services across all parts of a wider geography and meet more stakeholders than usual.

Our shared experience in applying the Local Public Health System Performance Assessment tool allowed us all to develop a better awareness of public health terms, definitions, and expectations for what a public health system can do. It helped everyone think in terms of systems, rather than one organization or sector. We looked at relationships *between organizations,* not only the people in them, and considered how to serve groups of people rather than individuals.

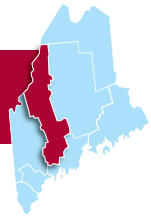
The results of this Assessment are being integrated into two types of planning documents. Healthy Maine Partnership coalitions are using the results to look at what's happening in their own local service areas as part of developing Community Health Improvement Plans. District stakeholders and members of the District Public Health Coordinating Councils are using the results to identify action steps for District System quality improvement priorities as part of District Health Improvement Plans.

Having District Public Health System Assessments will help Maine work towards achieving national public health agency accreditation, which is an objective of the 2010 State Health Plan.

The organizations and people who came together to create this report took a major step in strengthening their District public health system. More than ever, we appreciate that public health happens at the local level.

Mark Griswold
MPH Director, OLPH

Christine Lyman, MSW, CHES
Senior Advisor, OLPH



# We of the Central District Public Health System

Thanks to all who participated and contributed to our successful first Local Public Health System Assessment for the Central Health District.

We appreciate the use of meeting space at:

Maine Children's Home for Little Wanderers

Alfond Youth Center/YMCA of Waterville

Skowhegan Community Center

*Special thanks go to:*

Denise Delorie for meeting logistics support.

**The LPHSA Planning Committee included:**

Mark Griswold

Joanne Joy

Dawn Littlefield

Natalie Morse

Denise Delorie

Renee Page

Bill Primmerman

Emelie Van Egan

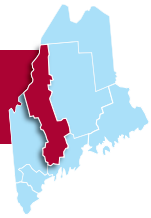
Alison Webb

*Thanks to all!*

Doug Michael
Downeast DCC
Executive Committee Co-Chair

Cheryl Zingman-Bagley
Downeast DCC
Executive Committee Co-Chair

Alfred May
District Liaison
Downeast Public Health Unit



# Central District Characteristics

## How the District is organized

- The Central Public Health District covers Kennebec and Somerset counties.
- There are 62 municipal governments, including small cities, towns, and plantations.
- The District serves all parts of its jurisdiction, including its townships, some of which have year-round or seasonal residents.

## Who we are*

- 172,336 people with 35.9 persons per square mile (Census 2008 est.).
- 9,110 of us are younger than 5 years old, 35,722 are 18 years old, and 25,100 over 65 years old.
- 44.2% of our children are eligible for free or reduced school lunch.
- 16.1% of us are adults with a lifetime status of having less than a high school degree.
- We are enriched by the number of us with Franco-American heritage.
- Much more data on who we are can be found at www.mainepublichealth.gov.

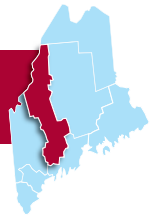
## How the public/private Public Health System of the District is organized

- The District has its own webpage: www.mainepublichealth.gov, under *Local Public Health Districts.*
- A multi-sector District Coordinating Council and its leaders partner with the District Liaison.
- A DCC elected representative sits as a voting member of the State Public Health Coordinating Council.
- Healthy Maine Partnerships (HMP) coalitions serve their towns within the District.
- All HMPs are members of the District Coordinating Council.
- Each town can appoint a Local Health Officer (LHO) who is trained/certified by Maine CDC.
- A District Liaison serves the entire District and is located in Augusta at the DHHS office.
- The District Liaison provides oversight of LHOs, and technical assistance to LHOs and HMPs.

## The governmental District Public Health Unit includes the District Liaison plus

- 3 public health nurses
- 1 field epidemiologist
- 2 drinking water protection specialists
- 1 health inspector

**see updated data from the new census at www.census.gov*



# List of Central Local Public Health Assessment Participants*

Sharon Abrams
Home for Little Wanderers

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United Way of Mid Maine

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Central DCC Support Staff

Laurie Dennis
RFGH/Education

Abigail Densmore*
District Tobacco Coordinator

Ofc.Todd Burbank
Waterville Police Department

Cindy Flye
Maranacook School Health Center

Steve Garascia
MCDC/Public Health Nursing

John Garofalo, MD
New Horizons Health Care

Mark Griswold*
Central District Liaison (acting)

Donna Guppy
Central District PH Unit/MCDC

Bob Higgins*
Somerset EMA

Steve Johndro
Greater Waterville PATCH

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Healthy Communities Coalition

Abigail M. Lourie
Crisis and Counseling Centers

Karen Martin
MSAD59/Coordinated School Health

Bill McPeck
State Employee
Health & Safety Program

Pam Morin
Southern Kennebec
Child Development Center

Natalie Morse
Maine General Hospital

Chia Murdock*
Greater Waterville PATCH

Renee Page
Healthy Communities of
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Somerset Heart Health

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Reddington-Fairview General Hospital

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Maine General/Horizon HIV Clinic

Kristen Simoneau*
Inland Hospital student

Melonie Thompson
Veterans Administration/Togus

Penny Townsend
RSU 19/School Health Coordinator

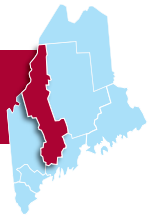
Emelie Van Eagan
Health Reach

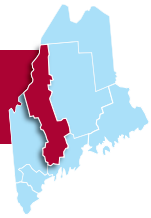
Terri Vieira
Sebasticook Valley Hospital

Suzanne Walsh
KVCAP Family Planning

Ellen Wells
Inland Hospital

**representing these organizations at the time*





# Background

The Maine Center for Disease Control and Prevention (MCDC) contracted with the Maine Center for Public Health (MCPH) to lead a formal assessment process during 2009. The assessment was designed to identify the strengths, limitations, gaps, and needs of the current public health system in each of the eight newly forming public health districts. The results depicted in this report are intended to serve as the impetus for the development of a district strategic improvement plan building up to coordinated statewide strategies as appropriate.

MCPH was responsible for facilitating the formal assessment using a nationally recognized public health performance standards tool. The Center was selected to lead the assessment process given their training and experience in this area.

## Overview of Public Health Performance Standards

The Centers for Disease Control and Prevention spearheaded and established in 1998 a national partnership initiative, the National Public Health Performance Standards Program (NPHPSP), to improve and strengthen the practice of public health, enhance systems-based performance, and support public health infrastructure.[1] To accomplish this mission, performance standards for public health systems have been collectively developed. These standards represent an optimal level of performance that needs to exist to deliver essential public health services within a public health system.

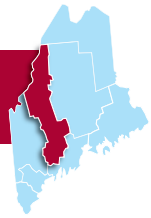
The NPHPSP is intended to improve the quality of public health practice and the performance of public health systems by:

1. Providing performance standards for public health systems and encouraging their widespread use;
2. Engaging and leveraging state and local partnerships to build a stronger foundation for public health;
3. Promoting continuous quality improvement of public health systems; and
4. Strengthening the science base for public health practice improvement.

As part of this initiative, three assessment instruments were created to help delineate model standards and evaluate performance. The tools include the following:

- State Public Health System Performance Assessment Instrument focuses on the "state public health system" and includes state public health agencies and other partners that contribute to public health services at the state level.

[1]Centers for Disease Control and Prevention—National Public Health Performance Standards Program. Available at: http://www.cdc.gov/od/ocphp/nphpsp/



- Local Public Health System Performance Assessment Instrument focuses on the "local public health system" or all entities that contribute to the delivery of public health services within a community. This system includes all public, private, and voluntary entities, as well as individual and informal associations.
- Local Public Health Governance Performance Assessment Instrument focuses on the governing body ultimately accountable for public health at the local level. Such governing bodies may include boards of health or county commissioners.

## Public Health Core Functions

The three core public health functions include assessment, policy development, and assurance.


### ASSESSMENT

This function includes the regular collection, analysis and sharing of health information about risks and resources in a community. The purpose of it is to identify trends in illness, injury, and death, including the factors that lead to these conditions.

### POLICY DEVELOPMENT

Information collected during the assessment phase is often used to develop state health policies. Good public policy development involves the community and takes into account political, organizational, and community values.

### ASSURANCE

This function includes the assurance of the availability of quality and educational programs and services necessary to achieve the agreed-upon goals.

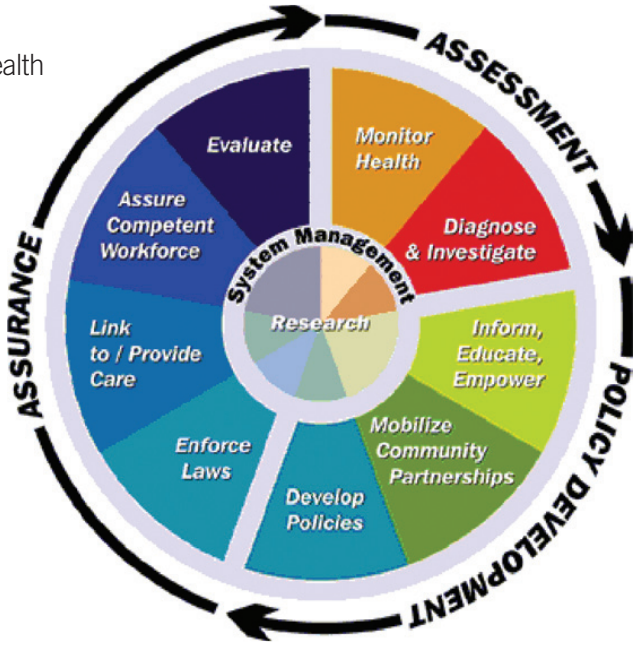
## Concepts Guiding Performance Standards Development and Use

Four concepts have helped to frame the National Public Health Performance Standards into their current format.

I. For each tool, performance is assessed through a series of questions **based on the 10 Essential Public Health Services (EPHS)** Framework. This framework delineates the practice of public health. The essential services include:

*Assessment*

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.




*Policy Development*

3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.

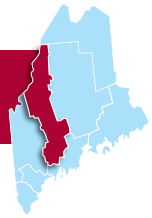
*Assurance*

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 when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

*Serving All Functions*

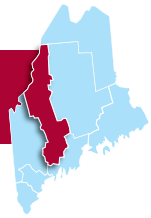
10. Research for new insights and innovative solutions to health problems.

II. The standards **focus on the overall District Public Health System,** rather than a single organization. By focusing on the District Public Health System, the contributions of all entities are recognized that play a role in working to improve the public's health.



III. The standards **describe an optimal level of performance,** rather than provide minimum expectations. This assures that the standards provide benchmarks which can be used for continuous quality improvement and stimulate higher achievement.

IV. The standards are explicitly intended to **support a process of quality improvement.** System partners should use the assessment process and results as a guide for learning about public health activities and determining how to improve services.



# Assessment Process

The formal assessment was conducted during a series of three meetings followed by a report-back meeting to present preliminary results and ensure content accuracy.

This report provides a description of the district assessment process and a comprehensive review of the quantitative and qualitative results. Assessment findings should be used as the basis to identifying strategic direction for enhancing performance.

The intended audience for this report includes:

- Participants involved in the formal assessment process
- District and State Public Health Coordinating Councils
- Public health practitioners and stakeholders
- Others interested in supporting local public health system-based efforts

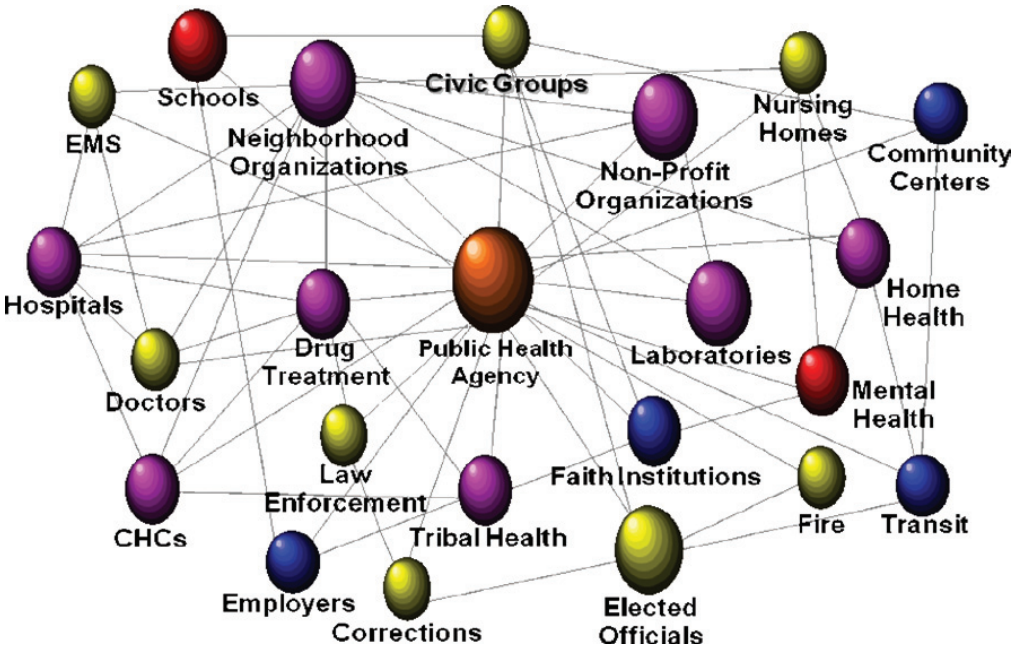
This report begins by providing a brief overview of national public health performance standards. This overview is then followed by a description of the district assessment process, including the purpose, tool, benefits and limitations. The report also provides a comprehensive review of the quantitative and qualitative results.

This document is intended to be used as a spring-board for discussion in the second phase of this initiative known as the system improvement planning process; a process that will be led by each District Coordinating Council. Assessment findings will be used as the basis to begin identifying next steps, future strategies, suggestions for enhancing performance, and priority areas. Additionally, districts might engage in more coordinated decision making, leverage system partners for identified priorities, and pool resources to achieve shared objectives.

## Stakeholder Participation

Invitations were sent to a broad range of disparate partners representing the District jurisdiction, including municipal public health agency, county government, regional offices of state agencies, community-based organizations, academic institutions, hospitals, health systems, community health centers, school systems and nonprofit organizations such as United Way, YMCAs, environmental organizations, anti-poverty agencies' substance abuse and mental health services, area aging agencies, etc. Additionally, invitations were sent to first responders, elected officials, social service providers, librarians, administrators, diversity advocates, and others representing local governmental or quasi-governmental entities such as planning commissions, police departments and adult education programs.

## The Public Health System




## Benefits of a Strong System

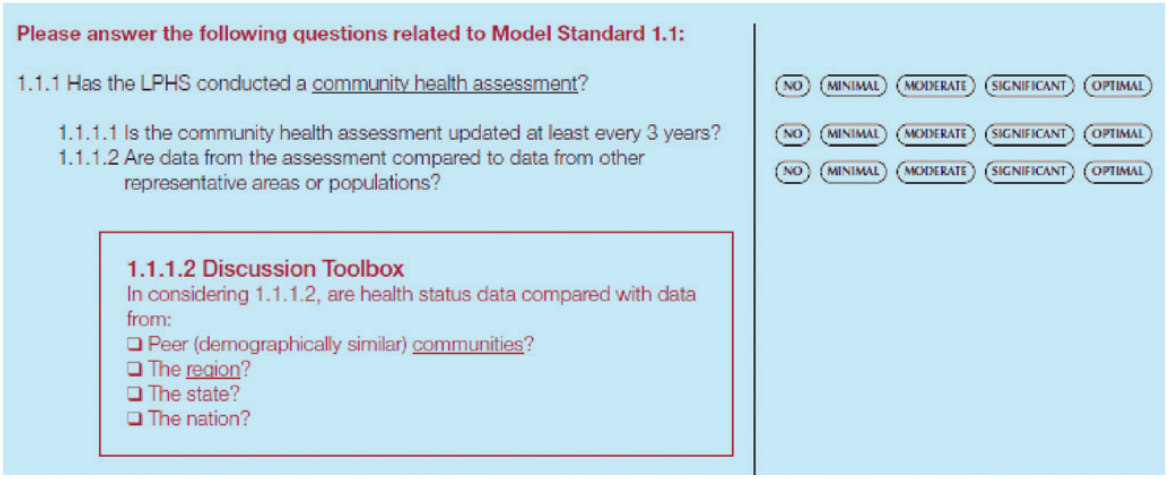
Strong and effective public health systems have the ability to…

- Improve the health of the public
- Protect the public's health
- Carry out the essential public health services
- Advocate on behalf of what's in the best interest of the public's health
- Work collaboratively with stakeholders, communities, volunteers, and others
- Decrease rising health care costs
- Secure federal funds and foundation dollars for public health activities

## Assessment Tool

Intention of the tool is to help improve organizational and community communication, bring partners to the same table, promote cohesion and collaboration, provide a systems view of public health and provide a baseline for Maine's emerging district public health system.

The 69-page assessment tool was developed by the CDC and other national partners. The tool was revised in 2008 and is comprised of a total of 325 questions and 30 model standards assessing the major activities, components, and practice areas of the ten essential services within the District public health system. The assessment questions serve as the measure and all questions are preceded by model standards which represent the optimal levels (gold standard) of performance based on a set of indicators that are unique to each essential service. The tool can found at: http://www.cdc.gov/od/ocphp/nphpsp/TheInstruments.htm



**Please answer the following questions related to Model Standard 1.1:**

1.1.1 Has the LPHS conducted a community health assessment? — NO | MINIMAL | MODERATE | SIGNIFICANT | OPTIMAL

1.1.1.1 Is the community health assessment updated at least every 3 years? — NO | MINIMAL | MODERATE | SIGNIFICANT | OPTIMAL

1.1.1.2 Are data from the assessment compared to data from other representative areas or populations? — NO | MINIMAL | MODERATE | SIGNIFICANT | OPTIMAL

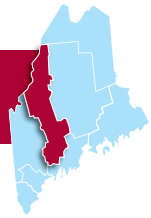
**1.1.1.2 Discussion Toolbox**

In considering 1.1.1.2, are health status data compared with data from:

- ❑ Peer (demographically similar) communities?
- ❑ The region?
- ❑ The state?
- ❑ The nation?

## National Database

To complete the local public health system assessment process, responses are submitted to a national database. This database is managed by the CDC and includes information on the local public health agency, the jurisdiction, the governing structure, entities represented during the assessment, and the final assessment scores.



## Response Options

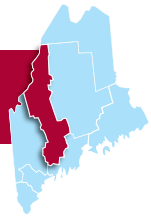
There were five response options available to classify the activity that was met within the District public health system. Because the assessment was completed in eight newly formed DHHS administrative jurisdictions, MCPH, Maine CDC, and a group of stakeholders further defined the response options to help ensure consistency across all eight that address the needs of a newly forming system. For this same reason and because some functions are provided at a state level in Maine, selected questions within essential services 2, 5, and 6 were scored the same in all Districts statewide (see results section). The response options were defined as follows:

| SCORE | DEFINITION |
|---|---|
| No<br>0% | No activity. |
| Minimal<br>>0 and 25% or less | Some activity by an organization or organizations within a single service/ geographic area. Not connected or minimally connected to others in or across the District. |
| Moderate<br>>25% but no more than 50% | Activity by one or more agency or organization that reaches across the District and is connected to other organizations in the District but limited in scope or frequency. |
| Significant<br>>50% but no more than 75% | Activity that covers the entire district [is dispersed both geographically and among programs] and is connected to multiple agencies/organizations within the District Public Health System. |
| Optimal<br>Greater than 75% | Fully meets the model standard for the entire district. |

## Scoring, Data Entry, and Data Analysis

An algorithm, developed by the CDC, was utilized to develop scores for every Essential Public Health Service. Each question was assigned a point value and given a weight depending on the number of questions and tiers. The score range was 0 to 100 with higher scores depicting greater performance in a given area. The scoring scheme and algorithm are available upon request. Each response was entered into the CDC database for analysis, with a report generated highlighting the quantitative results.

In addition to the scores that were collectively assigned, qualitative information was recorded and assessed by MCPH. The comments by participants were captured on a laptop computer throughout the meetings for each question addressed. While not an inventory of activities, the comments were used to identify themes, provide a context for scores, and identify strengths, weaknesses, gaps and recommendations for improvement or collaboration for the District.



## Assessment Benefits and Limitations

**THE BENEFITS** of this type of assessment process have been well documented by the US CDC and other partners. This process served as a vehicle to:

- Improve communication and collaboration by bringing partners to the same table.
- Educate participants about public health, the essential services, and the interconnectedness of activities.
- Identify strengths and weaknesses that can be addressed in quality improvements through the use of a nationally recognized tool.
- Collect baseline data reflecting the performance of the district public health system.

Despite the advantages of an assessment such as this, there are limitations related to the process, tool, data collection, and generalizability of results that warrant attention. They include the following:

### PROCESS LIMITATIONS

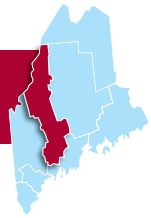
- Although attempts were made to encourage participation from multiple stakeholders, some representatives were missing from the process as noted on the summary page of results. The assessment format and anticipated commitment level during the assessment process may have prevented some participants from engaging in the series of meetings.
- The group process may have deterred introverted individuals who prefer less interactive approaches.
- The time commitment may have hindered the ability of some to participate due to lack of employer support or conflicting priorities.
- Additionally, differences in knowledge can create interpretation issues for some questions.

### TOOL LIMITATIONS

- The tool was detailed and cumbersome to complete in a consensus-building process. Reaching true consensus on each question was deemed to be unattainable in the given timeframe. After discussion of each question, facilitators suggested a score and asked for participant agreement.

### DATA COLLECTION LIMITATIONS

- The response options delineated in the tool were awkward to grasp by the newly forming infrastructure. Participants were frequently reminded of the district context.
- The scores were subject to the biases and perspectives of those who participated and engaged in the group dialogue.
- The comments made during the assessment may have been difficult to accurately capture due to multiple people speaking at once, individuals who could not be heard, or comments that were spoken too quickly. Every attempt was made to capture the qualitative comments, yet gaps exist. The intent of the report-back session was to improve on these limitations.



### GENERALIZABILITY OF RESULTS

- The results of this assessment were based on a facilitated group process during a specific time period. Changes to the District public health system at all levels constantly occur. This assessment provides a snapshot approach.
- The assessment process was subjective, based on the views of those who agreed to participate.

## Quality Improvement

The NPHPSP assessment instruments are intended to promote and stimulate quality improvement. As a result of the assessment process, the respondents identified strengths and weaknesses within District public health systems. This information can pinpoint areas that need improvement. To achieve a higher performing health system, system improvement plans must be developed and implemented. If the results of the assessments are not used for action planning and performance improvement, then the hard work of the assessments will not have its intended impact.

A few possible action steps are outlined at the end of the results section of each Essential Service. These steps are not meant to be a comprehensive nor inclusive list. Prioritization, additions, omissions, or edits to these action steps are open to the discretion of the OLPH and the DCC. Criteria for the possible action steps cited include:

- Must be actionable at a District level
- Must come from the data
- Will improve the District score (i.e. address one of the Model Standards)

# Results

## Overview

Central District Public Health System Assessment took place on March 24, 31 and April 8, meeting for approximately 3.5 hours each time. A total of 34 individuals participated in at least one of the three meetings with an average attendance of 21. Because a limitation of this process is that the scores are subject to the biases and perspectives of those who participated in the process, the planning group attempted to recruit broadly across the district. Individuals at the meetings represented HMPs, health care providers, hospitals/VA, emergency management agency, social service agencies, state agencies, mental health, law enforcement, United Way, and schools. Faith-based community, elderly groups and other vulnerable population groups, colleges and environmental health groups are potential gaps in representation.

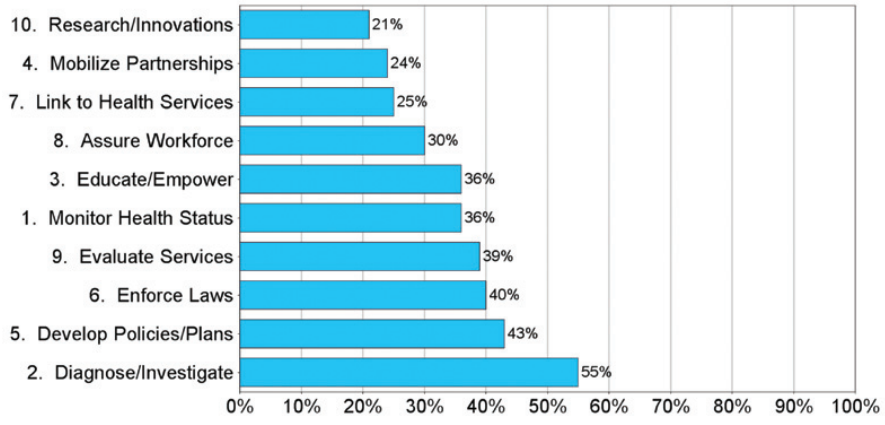
## Summary of Scores

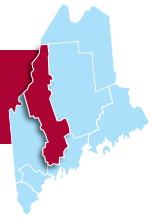
| EPHS | SCORE |
|---|---|
| 1. Monitor Health Status to Identify Community Health Problems | 36 |
| 2. Diagnose and Investigate Health Problems and Health Hazards | 55 |
| 3. Inform, Educate, and Empower People about Health Issues | 36 |
| 4. Mobilize Community Partnerships to Identify and Solve Health Problems | 24 |
| 5. Develop Policies and Plans that Support Individual and Community Health Efforts | 43 |

| EPHS | SCORE |
|---|---|
| 6. Enforce Laws and Regulations that Protect Health and Ensure Safety | 40 |
| 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable | 25 |
| 8 Assure a Competent Public and Personal Health Care Workforce | 30 |
| 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services | 39 |
| 10. Research for New Insights and Innovative Solutions to Health Problems | 21 |

**Overall Performance Score 35**

## Rank ordered performance scores for each Essential Service, by level of activity





# Essential Service 1

## Monitor Health Status to Identify Community Health Problems

This essential service evaluates to what extent the District Public Health System (DPHS) conducts regular community health assessments to monitor progress towards health-related objectives. This service measures: activities by the DPHS to gather information from community assessments and compile a community health profile; utilization of state-of-the-art technology, including GIS, to manage, display, analyze and communicate population health data; development and contribution of agencies to registries and the use of registry data.

## Overall Score: 36

This service ranked fifth out of 10 Essential Services. This score is in the moderate range, indicating that some district-wide activities have occurred.

## Scoring Analysis

- Community health assessments have been developed by HMPs. State-developed community health assessments and District Health Data Comparison tables are available, but do not have all the components to meet the definition of a comprehensive Health Profile.
- Assessments have been distributed to coalition partners, but there is not a media strategy for data dissemination.
- The lowest score is the lack of a comprehensive District community health profile.
- The district has limited use of state-of-the-art technology, including GIS.
- There are state and local registries on many health issues, but there is minimal use of the data.

## District Context

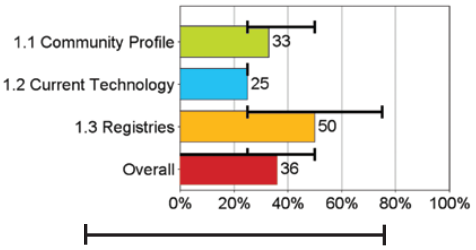
- In addition to the State-produced District Health 2009 Profiles and Comparison Tables, the hospitals/health systems, schools, school-based health centers, and other statewide surveys are conducted and compile assessment data. Some hospitals are planning to collaborate on a statewide assessment.
- Not everyone knows what data is available and how to access it. Local data on racial and ethnic minority health is a gap.
- HMPs are developing Community Health Profiles after statistics are compiled as part of the MAPP process.
- Assessment data is available on health systems websites, has been used at community forums and other presentations and has been distributed to DCC members but there is no coordinated dissemination plan.
- GIS is used by some state agencies, schools and health systems, but barriers to wider use of GIS for health-related purposes include lack of training for interested parties, cost and clinical data confidentiality issues.

- Clinical registries are available throughout the District for several health issues, but are not widely used for planning or other purposes. Local adult immunization registries and registries for some chronic diseases are gaps.

## Possible Action Steps

- Coordinate data sources and topics across the district to reduce duplication, identify gaps, increase awareness of what is available and ensure data is easily accessible in one place.
- Develop Community Health Profile—integrate locally collected data into State-produced assessment and ensure access to the profile in multiple formats, including GIS mapping.

**EPHS 1. Monitor Health Status**

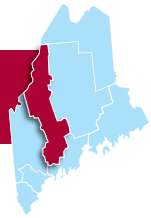



*Range of scores within each model standard and overall*

| EPHS 1. Monitor Health Status to Identify Community Health Problems: Overall Perfomance Score | 36 |
|---|---|
| ★ 1.1 Population-Based Community Health Profile (CHP) | 33 |
| Community health assessment | 50 |
| Community health profile (CHP) | 25 |
| Community-wide use of community health assessment or CHP data | 25 |
| ★ 1.2 Access to and Utilization of Current Technology to Manage, Display, Analyze and Communicate Population Health Data | 25 |
| State-of-the-art technology to support health profile databases | 25 |
| Access to geocoded health data | 25 |
| Use of computer-generated graphics | 25 |
| ★ 1.3 Maintenance of Population Health Registries | 50 |
| Maintenance of and/or contribution to population health registries | 75 |
| Use of information from population health registries | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components

**"I gained a better on-the-ground understanding of the 10 EPHS through the assessment process."**



# Essential Service 2

## Diagnose and Investigate Health Problems and Health Hazards

This essential service measures the participation of the District Public Health System (DPHS) in integrated surveillance systems to identify and analyze health problems and threats as well as the timely reporting of disease information from community health professionals. This service also measures access by the DPHS to the personnel and technology necessary to assess, analyze, respond to and investigate health threats and emergencies including adequate laboratory capacity.

## Overall Score: 55

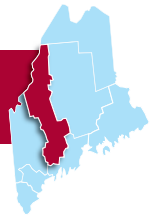
This was the highest scoring Essential Service overall. This score is in the significant range, indicating that most activities are district-wide.

## Scoring Analysis

- Because most surveillance activities and laboratory oversight occur at the state level, these areas were scored the same for all districts (in green), with the exception of emergency response ability.
- The District scored high on its emergency response ability in general, but lower on connections to community leaders across the district, ability to mobilize volunteers and evaluation of response incidents.

## District Context

- There are a number of surveillance systems at the State. Some gaps/issues identified include: surveillance data is not always integrated; lack of surveillance for drug overdose, accidental poisonings and air quality as it relates to wood burning. Data is not getting reported back to communities in a timely way; GIS is not being used in the District to identify disease patterns.
- Local providers and schools contribute to surveillance systems. Some barriers to reporting include knowledge about infrequent or unusual events and overburdened providers. Additional education/support on what and how to report is needed.
- State epidemiologists conduct State surveillance and analysis. However, as these are funded through categorical federal grants, they address State public health program priorities, as opposed to their services being accessible for individual communities to address local priorities. (Local community agencies often can't afford their own epidemiologist.)
- Protocols for communicable disease and toxic exposure follow-up are not well known by all district agencies or by Local Health Officers.

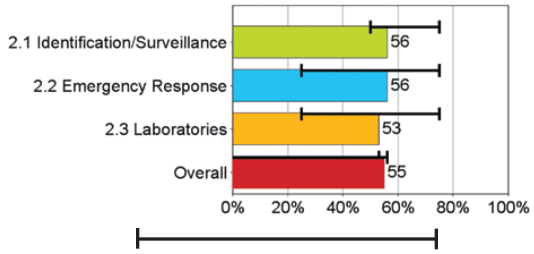


- Because of staff turnover, the two counties may not have the same level of preparedness and coordination; there may be some jurisdictional issues to resolve. Two different hospital-based Regional Resource Centers cover this jurisdction from either side. Capacity to mobilize volunteers in a disaster is being built, however additional table tops and "after action" reports are needed.
- Gaps in access to laboratories exist for the northern part of the District and for providers after regular business hours.

## Possible Action Steps

- Coordinate surveillance needs and identify potential data sources for gaps (e.g., drug overdose).
- Work with providers to increase number and timeliness of submission of reportable disease data and use EMRs as a tool to do that.
- Provide district-wide training and support for Local Health Officers and others on communicable disease and toxic exposure follow-up protocols (if appropriate for their scope of role).
- Increase emergency response training and coordination in the district and use "After Action" reports each time to update protocols and plans.

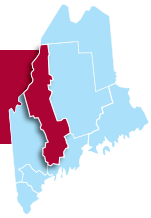
**EPHS 2. Diagnose/Investigate**




*Range of scores within each model standard and overall*

| EPHS 2. Diagnose and Investigate Health Problems and Health Hazards | 55 |
|---|---|
| ★ 2.1 Identification and Surveillance of Health Threats | 56 |
| Surveillance system(s) to monitor health problems and identify health threats | 67 |
| Submission of reportable disease information in a timely manner | 50 |
| Resources to support surveillance and investigation activities | 50 |
| ★ 2.2 Investigation and Response to Public Health Threats and Emergencies | 56 |
| Written protocols for case finding, contact tracing, source identification, and containment | 50 |
| Current epidemiological case investigation protocols | 75 |
| Designated Emergency Response Coordinator | 63 |
| Rapid response of personnel in emergency/disasters | 69 |
| Evaluation of public health emergency response | 25 |
| ★ 2.3 Laboratory Support for Investigation of Health Threats | 53 |
| Ready access to laboratories for routine diagnostic and surveillance needs | 50 |
| Ready access to laboratories for public health threats, hazards, and emergencies | 38 |
| Licenses and/or credentialed laboratories | 50 |
| Maintenance of guidelines or protocols for handling laboratory samples | 75 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 3

## Inform, Educate, and Empower Individuals and Communities about Health Issues

This essential service measures health information, health education, and health promotion activities designed to reduce health risk and promote better health. This service assesses the District Public Health System's partnerships, strategies, populations and settings to deliver and make accessible health promotion programs and messages. Health communication plans and activities, including social marketing, as well as risk communication plans, are also measured.

## Overall Score: 36

This was the sixth highest scoring Essential Service overall. This score is in the moderate range, indicating that there are some district-wide activities.

## Scoring Analysis

- There are significant evidence-based and district-wide health promotion campaigns and activities targeted to those with a higher risk of poor health outcomes, but there is minimal coordination among all organizations across the district to plan, conduct, and implement those activities.
- There is not a district-wide communication plan, or identified and trained spokespersons for the district, although there are relationships with the media in the district.
- The highest score was for the district's coordinated emergency communication plans but the district scored lower on having policies and procedures for public information offices including communication "Go Kits."

## District Context

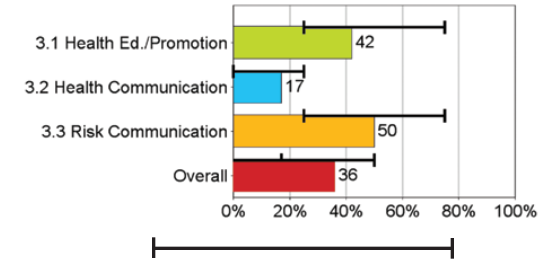
- Information to the public and policy makers is provided by some organizations on a number of health-related topics, but there are a number of issues in this district that are not being addressed or only addressed at the state level.
- There is a coordinated district-wide worksite wellness initiative underway led by the Healthy Maine Partnerships.
- Health promotion/education efforts are evidence-based; most target higher risk individuals but many activities occur in silos. The DCC could help coordinate many of those activities.
- Relationships with the media exist in the district, particularly with smaller papers and local cable TV, but there is little coordination among all organizations generating health information in working with the media.
- There is no District communications plan and no clarity on who can speak for the District on public health issues. (Note: Full-time District Liaison had not yet been appointed.)
- The Health Alert Network is used by the District to ensure rapid communication response. Reverse 911 is available in some parts of the district.

- Few health promotion/education activities have been evaluated at the local or district-level.

## Possible Action Steps

- Develop collaborative and coordinated district-wide health promotion/education campaigns on topics (e.g., immunizations, air quality) not already funded under HMP grants. Reach out to groups not previously engaged (e.g., schools without school health coordinators).
- Develop coordinated communication plans to strengthen media marketing and promotion in the district. Provide training to information officers and/or spokespersons, clarify role of all personnel at all levels in responding to the media.
- Provide input on the best way to access and utilize the HAN system by district organizations.

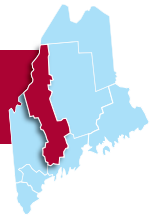
**EPHS 3. Educate/Empower**




*Range of scores within each model standard and overall*

| EPHS 3. Inform, Educate, and Empower People About Health Issues | 36 |
|---|---|
| ★ 3.1 Health Education and Promotion | 42 |
| Provision of community health information | 50 |
| Health education and/or health promotion campaigns | 52 |
| Collaboration on health communication plans | 25 |
| ★ 3.2 Health Communication | 17 |
| Development of health communication plans | 0 |
| Relationships with media | 25 |
| Designation of public information officers | 25 |
| ★ 3.3 Risk Communication | 50 |
| Emergency communications plan(s) | 75 |
| Resources for rapid communications response | 50 |
| Crisis and emergency communications training | 50 |
| Policies and procedures for public information officer response | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 4

## Mobilize Community Partnerships to Identify and Solve Health Problems

This essential service measures the process and extent of coalitions and partnerships to maximize public health improvement within the District Public Health System (DPHS) and to encourage participation of constituents in health activities. It measures the availability of a directory of organizations, communication strategies to promote public health and linkages among organizations. This service also measures the establishment and engagement of a broad-based community health improvement committee and assessment of the effectiveness of partnerships within the DPHS.

## Overall Score: 24

This Essential Service ranked ninth out of the 10 Essential Services overall. This score is in the minimal range, indicating that there are few district-wide activities.

## Scoring Analysis

- Many key public health stakeholders have been identified, and outreach has occurred to develop partnerships to enhance public health activities.
- An accessible and comprehensive directory of organizations is not available, although some of that information has been collected.
- There are few communications campaigns used in the District to build awareness of the importance of public health.
- The formation of a Community Health Improvement Committee for the District is beginning.
- No systematic review and assessment of the effectiveness of community partnerships and strategic alliances have occurred.

## District Context

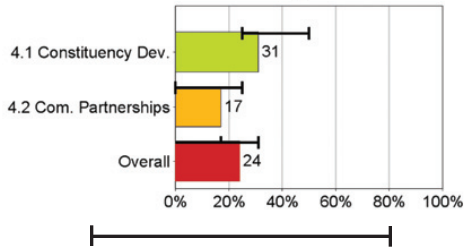
- Stakeholders have been identified through the Health Alert Network, pandemic flu planning and District Coordinating Council development, as well as by HMPs and other organizations. However, there is no consistent format used and lists are not consolidated and made available.
- District organizations engage constituents in many ways: through the MAPP process; in schools; through programs such as *Move More,* colorectal health and substance abuse; in worksite wellness initiatives; through use of volunteers.
- It is difficult to leverage participation of health care providers across the district by health promotion organizations such as HMPs.

- Need better coordination between the state, district and local communities on communicating the importance of public health.
- Facilitated communication across health promotion organizations in the Dstrict appears to be limited to the priorities of HMPs (e.g., lack of coordination between HMPs and family planning agencies).
- There are numerous partnerships with many agencies within the District, but the mechanisms to maximize coordinated community health improvement across the District are not yet in place. The DCC will help to make that happen through the development of the DCC and beginning a Health Improvement Committee.

## Possible Action Steps

- Consolidate and make available lists of current partnerships and strategic alliances; identify gaps and strategies to engage new partners.
- Assess effectiveness of current partnerships and strategic alliances to strengthen and improve capacity.
- Coordinate with the State to develop a district-wide communication strategy for promoting public health with messages that are short, clear and reach low literacy audiences.

**EPHS 4. Mobilize Partnerships**

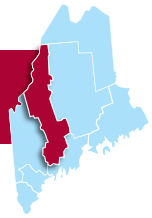



*Range of scores within each model standard and overall*

| EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems | 24 |
|---|---|
| ★ 4.1 Constituency Development | 31 |
| Identification of key constituents or stakeholders | 50 |
| Participation of constituents in improving community health | 25 |
| Directory of organizations that comprise the LPHS | 25 |
| Communications strategies to build awareness of public health | 25 |
| ★ 4.2 Community Partnerships | 17 |
| Partnerships for public health improvement activities | 25 |
| Community health improvement committee | 25 |
| Review of community partnerships and strategic alliances | 0 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components

**"I'm thrilled that we are moving toward a functioning public health infrastructure."**



# Essential Service 5

## Develop Policies and Plans that Support Individual and Community Health Efforts

This essential service evaluates the presence of governmental public health at the local level. This service also measures the extent to which the District Public Health System contributes to the development of policies to improve health and engages policy makers and constituents in the process. The process for public health improvement and the plans and process for public health emergency preparedness are also included in this essential service.

## Overall Score: 43

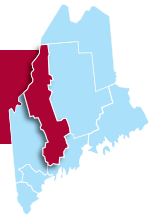
This Essential Service rated high—second of the 10 Essential Services. This score is in the high-moderate range, indicating that there are a number of district-wide activities.

## Scoring Analysis

- The District is developing a governmental presence at the local level, here defined as the District jurisdiction. District stakeholders contribute to the development of public health policies and engage policy makers but have not systematically reviewed the impact of public health policies that exist.
- The process for community health improvement planning through MAPP is underway in the District, but strategies to address objectives have not yet been identified.
- There has been significant planning for public health emergencies in the District.

## District Context

- Once implemented, a District Public Health Unit is co-locating State public health staff who cover the district.
- Policy work has happened across the district as a significant part of the work of the HMPs. Examples of coordinated efforts include: Central Maine Behavioral Health Tobacco Treatment Collaborative, support of state-level efforts to ban smoking in cars, worksite wellness policies, school substance abuse policies. Policies related to mental health is a gap.
- Known work on policies is focused on HMP grant priority areas. Some parts of the district have not been reached.
- District HMPs have engaged policy makers by convening legislative breakfasts, bringing information to boards and leaderships teams, sending letters, and responding to Health Policy Partners' alerts.
- Some review of policies is done by RSUs, hospitals and health centers. Many policies are never reviewed.
- MAPP process will result in Community Health Improvement Plan but there are questions about how HMP MAPP work will feed into the District and how local stakeholders will be engaged at the district-level.

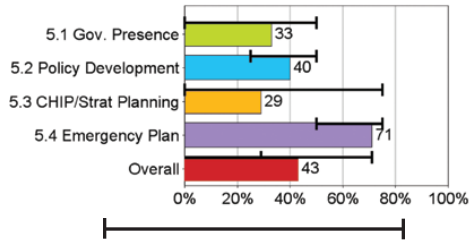


- The District has two separate emergency response plans developed by each county. These only come together at the state level. Plans have been tested through mock drills but not everyone was notified. Some gaps in the plans still exist.

## Possible Action Steps

- Use MAPP process to identify and address local public health policy needs beyond tobacco, physical activity, nutrition and substance abuse. Develop a process to engage local stakeholders in district-level planning and public health improvement activities.
- Identify organizations/groups not involved in emergency preparedness planning. Develop creative strategies to engage them in education campaigns related to non-HMP topics (e.g., immunizations, air quality). Reach out to groups not previously engaged (e.g., schools without school health coordinators).
- Develop coordinated communication plans to strengthen media marketing and promotion in the District. Provide training to information officers and/or spokespersons. Clarify roles of all state, district and local stakeholders in responding to the media.
- Provide input on the best way to access and utilize the HAN system in the District.

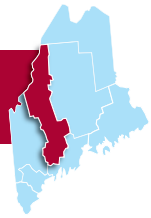
**EPHS 5. Develop Policies/Plans**




*Range of scores within each model standard and overall*

| EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts | 43 |
|---|---|
| ★ 5.1 Government Presence at the Local Level *(Note: This indicator was scored the same for all Districts.)* | 33 |
| Governmental local public health presence | 21 |
| Resources for the local health department | 28 |
| LHD work with the state public health agency and other state partners | 50 |
| ★ 5.2 Public Health Policy Development | 40 |
| Contribution to development of public health policies | 46 |
| Alert policy makers/public of public health impacts from policies | 50 |
| Review of public health policies | 25 |
| ★ 5.3 Community Health Improvement Process | 29 |
| Community health improvement process | 63 |
| Strategies to address community health objectives | 25 |
| Local health department (LHD) strategic planning process | 0 |
| ★ 5.4 Plan for Public Health Emergencies | 71 |
| Community task force or coalition for emergency preparedness and response plans | 75 |
| All-hazards emergency preparedness and response plan | 75 |
| Review and revision of the all-hazards plan | 63 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 6

## Enforce Laws and Regulations that Protect Health and Ensure Safety

This essential service measures the District Public Health System's (DPHS) activities to review, evaluate and revise laws, regulations and ordinances which protect health. It also measures the actions of DPHS to identify and communicate the need for laws, ordinances, or regulations on public health issues that are not being addressed and measures enforcement activity.

## Overall Score: 40

Note: All districts were scored the same on this Essential Service, as the District Public Health Unit is the District link to Maine CDC related to official local and regional health protection. District Liaisons interface with Local Health Officers regarding public health nuisances and disease outbreaks, and county EMA(s) for regional emergencies whenever hazard to public health is a concern. This service ranked third out of 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

## Scoring Analysis

Agencies are aware of laws and municipalities have access to legal counsel, if needed.

- There is some activity to identify local public health issues not adequately addressed through current laws, regulations or ordinances, and to provide information to the public or other organizations impacted by the laws.
- Local officials have the authority to enforce laws in an emergency but gaps were identified.
- There has been minimal activity in the District to assess compliance with laws, regulations or ordinances.

## District Context

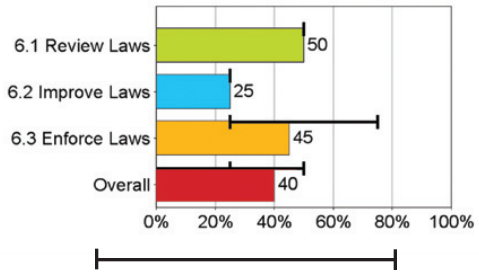
- Challenges to enforcement were identified including: tobacco laws are not a priority to enforce; lack of knowledge of laws by Local Health Officers; policies are sometimes unenforceable; too few law enforcement officers for a large area; shortage of inspectors.
- There are emerging public health issues that are not being addressed, including substandard housing and wood smoke exposure.
- Better coordination is needed in the District for identifying and developing policies to address health issues.
- There is a good relationship between public health and law enforcement, although there is no district-level coordination.
- Laws have been recently expanded to address public health authority in the event of a public health emergency; such roles are defined by the State.

- While there are limited funds for informing the public and others about laws, regulations or ordinances, this is done in part by Local Health Officers, Code Enforcement Officers, police and Health and Drinking Water Inspectors. In addition, there are community efforts to inform the public about underage drinking laws and to work with retailers, although funding for these efforts is also limited.

## Possible Action Steps

- Provide training on public health laws for law enforcement personnel and Local Health Officers.
- Review and map existing laws/ordinances in the District and address gaps in a coordinated way.

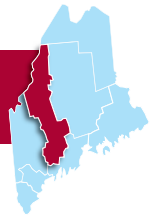
**EPHS 6. Enforce Laws**




*Range of scores within each model standard and overall*

| EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety | 40 |
|---|---|
| ★ 6.1 Review and Evaluate Laws, Regulations, and Ordinances | 50 |
| Identification of public health issues to be addressed through laws, regulations, and ordinances | 50 |
| Knowledge of laws, regulations, and ordinances | 50 |
| Review of laws, regulations, and ordinances | 50 |
| Access to legal counsel | 50 |
| ★ 6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances | 25 |
| Identification of public health issues not addressed through existing laws | 25 |
| Development or modification of laws for public health issues | 25 |
| Technical assistance for drafting proposed legislation, regulations, or ordinances | 25 |
| ★ 6.3 Enforce Laws, Regulations, and Ordinances | 45 |
| Authority to enforce laws, regulation, ordinances | 50 |
| Public health emergency powers | 75 |
| Enforcement in accordance with applicable laws, regulations, and ordinances | 50 |
| Provision of information about compliance | 25 |
| Assessment of compliance | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 7

## Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

This essential service measures the activity of the District Public Health System (DPHS) to identify populations with barriers to personal health services and the needs of those populations. It also measures the DPHS's efforts to coordinate and link the services and address barriers to care.

## Overall Score: 25

This service ranked eighth of the 10 Essential Services. This score is in the minimal range, indicating that there are few district-wide activities.

## Scoring Analysis

- There are activities to identify populations and personnel health service needs, but no district-wide activities.
- There is no District assessment of the availability of services to people who experience barriers to care.
- Linking and coordination of health care services as well as health care with social services occurs, but is not connected across the District and is limited in scope.
- There are initiatives to enroll people eligible for public benefit programs.

## District Context

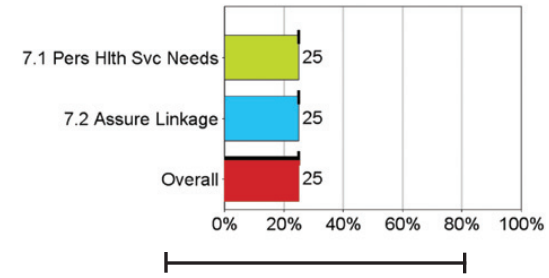
- Assessments across the District identify specific populations in need of services, conducted by HMPs, hospitals, social service agencies, schools/school-based health centers, state agencies, the VA system, and EMAs. The information collected is used for internal planning but is not coordinated or shared with the community.
- Populations with barriers to services include the underinsured, LGBT youth, homeless, migrant workers, non-English-speaking groups, people with opiate addictions, those who live in Canadian border towns, and those in need of skilled care.
- There is a lack of understanding by providers and the public about what community services are available and how to access them and use them appropriately (e.g., community health centers did not reduce visits to the emergency department). Not all needed services are available in all parts of the District (e.g., services for people with diabetes, oral health services, transportation).
- There are a number of efforts to link people to services, including Care Partners, VA, school based health centers, primary care offices that do outreach to homes, initiatives to coordinate transportation, and medical home providers.

- There are some initiatives in the District to co-locate services (e.g., Kennebec Behavioral Health brings services to schools; FQHC co-locates dentists; case management at Togus; MaineHealth initiative to co-locate mental health and social work in primary care offices).

## Possible Action Steps

- Expand and coordinate current successful initiatives, including co-location of services and medical homes, to link populations to needed services across the District.
- Increase outreach to providers and the community about services that are available and how to access them.
- Coordinate assessment information of underserved populations and gaps in services and use for district-wide planning to reduce gaps and address barriers.

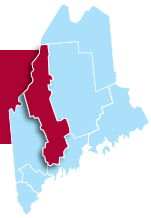
**EPHS 7. Link to Health Services**




*Range of scores within each model standard and overall*

| EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable | 25 |
|---|---|
| ★ 7.1 Identification of Populations with Barriers to Personal Health Services | 25 |
| Identification of populations who experience barriers to care | 25 |
| Identification of personal health service needs of populations | 25 |
| Assessment of personal health services available to populations who experience barriers to care | 25 |
| ★ 7.2 Assuring the Linkage of People to Personal Health Services | 25 |
| Link populations to needed personal health services | 25 |
| Assistance to vulnerable populations in accessing needed health services | 25 |
| Initiatives for enrolling eligible individuals in public benefit programs | 25 |
| Coordination of personal health and social services | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 8

## Assure a Competent Public and Personal Health Care Workforce

This essential service evaluates the District Public Health System's (DPHS) assessment of the public health workforce, maintenance of workforce standards including licensure and credentialing and incorporation of public health competencies into personnel systems. This service also measures how education and training needs of DPHS are met, including opportunities for leadership development.

## Overall Score: 30

This service ranked seventh out of 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

## Scoring Analysis

- There has been no assessment of the public health workforce in the District.
- Many organizations have job descriptions and conduct performance evaluations.
- There are few assessments of training needs and few resources or incentives available for training.
- Some training programs on core competencies exist but there is little interaction with academic institutions.
- Some leadership development is available in the district.

## District Context

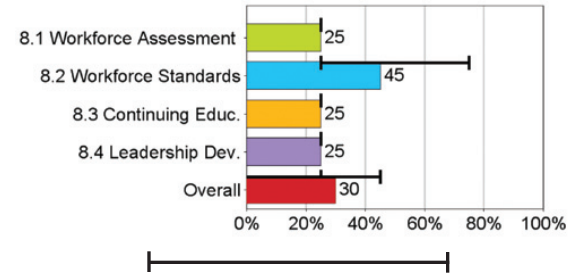
- There are assessments of the health care workforce that hospitals and academic institutions conduct to identify gaps but there is no formal District or State assessment of the public health workforce.
- Certification and licensure are required for numerous health-related positions, but there is nothing specific to Healthy Maine Partnerships.
- Certification training is now required of Local Health Officers.
- There are many training opportunities within the district, such as distance learning technology, though that could be better utilized were more funding for organizations available.
- District stakeholders are developing "mini-training modules" available at the end of the summer. Plans for compiling a list of free or low cost trainings are underway.
- Mentoring by HMP staff is offered, but requires clarification for time commitments.
- Training gaps identified include cultural competency, understanding of the ten Essential Services, and social determinants of health. Training should be coordinated across the district to cover gaps and not left to individual interests.

- There are some, but not sufficient, funds available for training for HMPs. Greater emphasis on this is needed to adequately develop public health capacity.
- There are some ties to UMaine Farmington and Muskie for students, interns and other support.
- There are opportunities for leadership development in and out of the district; many District stakeholders have taken on leadership roles in the state.

## Possible Action Steps

- Assess, coordinate and prioritize District workforce training needs and develop partnerships (e.g., distance learning resources, libraries) to address those needs.
- Develop a list of free or low cost training opportunities and promote availability of "mini-training modules."

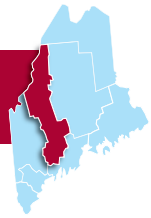
**EPHS 8. Assure Workforce**




*Range of scores within each model standard and overall*

| EPHS 8. Assure a Competent Public and Personal Health Care Workforce: Overall Perfomance Score | 30 |
|---|---|
| ★ 8.1 Workforce Assessment Planning and Development | 25 |
| Assessment of the LPHS workforce | 25 |
| Identification of shortfalls and/or gaps within the LPHS workforce | 25 |
| Dissemination of results of the workforce assessment/gap analysis | 25 |
| ★ 8.2 Public Health Workforce Standards | 45 |
| Awareness of guidelines and/or licensure/certification requirements | 50 |
| Written job standards and/or position descriptions | 50 |
| Annual performance evaluations | 75 |
| LHD written job standards and/or position descriptions | 25 |
| LHD performance evaluations | 25 |
| ★ 8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring | 25 |
| Identification of education and training needs for workforce development | 25 |
| Opportunities for developing core public health competencies | 25 |
| Educational and training incentives | 25 |
| Interaction between personnel from LPHS and academic organizations | 25 |
| ★ 8.4 Public Health Leadership Development | 25 |
| Development of leadership skills | 25 |
| Collaborative leadership | 25 |
| Leadership opportunities for individuals and/or organizations | 25 |
| Recruitment and retention of new and diverse leaders | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 9

## Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services

This essential service measures the evaluation activities of the District Public Health System (DPHS) related to personal and population-based services and the use of those findings to modify plans and programs. This service also measures activity related to the evaluation of the DPHS.

## Overall Score: 39

This service scored fourth out of the 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

## Scoring Analysis

- There is some evaluation of population-based programs in the District, but it is limited in scope and coverage.
- Evaluation of, and consumer satisfaction with, personal health services occurs throughout the district. Results are used to modify services.
- The Local Public Health System Assessment evaluates the DPHS and will contribute to a system improvement plan.
- No partnership assessments have been conducted.

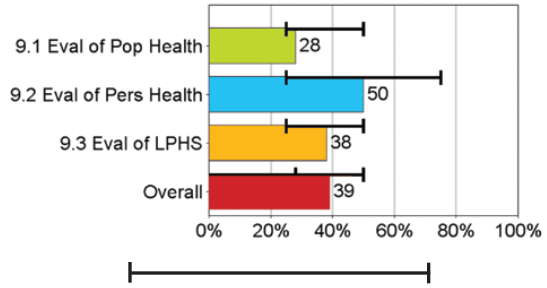
## District Context

- Different types of evaluations for numerous population-based programs occur including: immunizations, substance abuse prevention, HMP activities, and STD prevention, but these are categorical and not integrated or coordinated.
- Hospitals, physician offices, public health nursing, dental services, and school-based health centers conduct client satisfaction surveys. This information is generally not shared outside each organization.
- Electronic medical records are used by some but not all providers. However there is an inability to link across the District between providers, including with Togus.
- Evaluation of services is used for strategic planning by health care organizations.
- This Public Health System Assessment is the beginning of a process to identify organizations that contribute to the delivery of the essential public health services as part of an ongoing process.

## Possible Action Steps

- Identify district-wide evaluation priorities among stakeholders. Develop the expertise and strategies needed to plan, implement and analyze the evaluation results.
- Ensure that any existing evaluation of personal or population-based services is used to modify or improve current programs or services or create new programs or services.
- Use the results of the Public Health System Assessment to identify gaps, improve linkages with community organizations and to create or refine community health programs.

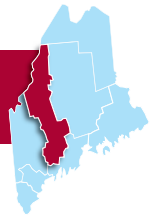
**EPHS 9. Evaluate Services**




*Range of scores within each model standard and overall*

| EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services | 39 |
|---|---|
| ★ 9.1 Evaluation of Population-Based Health Services | 28 |
| Evaluation of population-based health services | 38 |
| Assessment of community satisfaction with population-based health services | 25 |
| Identification of gaps in the provision of population-based health services | 25 |
| Use of population-based health services evaluation | 25 |
| ★ 9.2 Evaluation of Personal Health Care Services | 50 |
| Personal health services evaluation | 50 |
| Evaluation of personal health services against established standards | 50 |
| Assessment of client satisfaction with personal health services | 75 |
| Information technology to assure quality of personal health services | 25 |
| Use of personal health services evaluation | 50 |
| ★ 9.3 Evaluation of the Local Public Health System | 38 |
| Identification of community organizations or entities that contribute to the EPHS | 50 |
| Periodic evaluation of LPHS | 50 |
| Evaluation of partnership within the LPHS | 25 |
| Use of LPHS evaluation to guide community health improvements | 25 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components



# Essential Service 10

## Research for New Insights and Innovative Solutions to Health Problems

This essential service measures how the District Public Health System (DPHS) fosters innovation to solve public health problems and uses available research. It also assesses the DPHS's linkages to academic institutions and capacity to engage in timely research.

## Overall Score: 21

This service ranked lowest of all the Essential Services. This score is in the minimal range, indicating that there are few district-wide activities.

## Scoring Analysis

- Agencies are encouraged to develop new solutions for public health issues; some have various methods of monitoring, research and best practice.
- There are few opportunities for organizations to propose public health issues for inclusion in the research agenda of research organizations nor have they participated in the development of research.
- There are some affiliations with academic institutions and organizations in the District.
- The DPHS does not systematically access researchers.

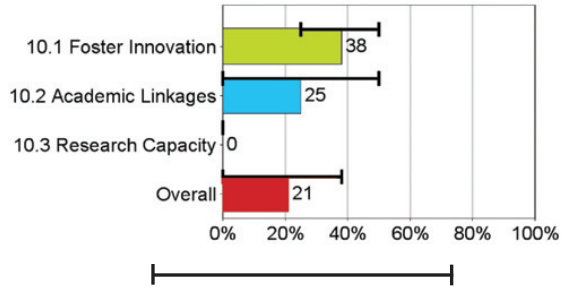
## District Context

- There have been examples of developing innovative solutions to health problems, including the Central Maine Behavioral Tobacco Cessation Group and Move More, but funding other than the HMP grant is needed to address other areas.
- There have been times when research was proposed to academic institutions including UMaine, KVCC, Colby, and Thomas College. Organizations have collaborated with researchers on projects including worksite initiatives, 5-2-1-0 projects and Move More.
- Organizations stay current on best practices through a number of channels, including requirements by funders, but not all programs are best practice.
- Organizations have the capacity to collaborate with researchers, but efforts to do that have not been successful.
- School-based health centers and other organizations take on interns or are involved as training sites for health professionals.

## Possible Action Steps

- Develop an ongoing formal District collaboration with one or more academic institutions.
- Develop a District research agenda; identify possible academic institutions and researches interested in collaboration.

**EPHS 10. Research/Innovations**

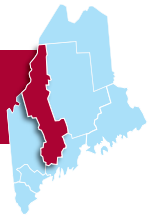


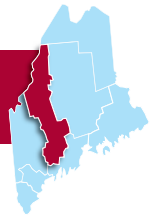

*Range of scores within each model standard and overall*

| EPHS 10. Research for New Insights and Innovative Solutions to Health Problems | 21 |
|---|---|
| ★ 10.1 Fostering Innovation | 38 |
| Encouragement of new solutions to health problems | 50 |
| Proposal of public health issues for inclusion in research agenda | 25 |
| Identification and monitoring of best practices | 50 |
| Encouragement of community participation in research | 25 |
| ★ 10.2 Linkage with Institutions of Higher Learning and/or Research | 25 |
| Relationships with institutions of higher learning and/or research organizations | 25 |
| Partnerships to conduct research | 0 |
| Collaboration between the academic and practice communities | 50 |
| ★ 10.3 Capacity to Initiate or Participate in Research | 0 |
| Access to researchers | 0 |
| Access to resources to facilitate research | 0 |
| Dissemination of research findings | 0 |
| Evaluation of research activities | 0 |

★ = Model Standard Score
❖ = Items scored the same across all districts
Impact of possible action steps on model standard components

**"I envision assessment findings in the future being used to identify new collaborative efforts leading to improvement."**

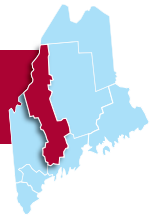




# Appendices

## Acronyms

| | |
|---|---|
| **AHEC** | Area Health Education Center |
| **BMI** | Body Mass Index |
| **CAP** | Community Action Program Agencies |
| **CBPR** | Community Based Participatory Research |
| **CEO** | Code Enforcement Officer |
| **CERT** | Community Emergency Response Team |
| **CHES** | Community Health Education Specialist |
| **CMMC** | Central Maine Medical Center |
| **COAD** | Community Organizations Active in Disasters |
| **COG** | Council of Governments |
| **CTI** | Center for Tobacco Independence |
| **DCC** | District Coordinating Council |
| **DPHS** | District Public Health System |
| **EAAA** | Eastern Area Agency on Aging |
| **EBSCO** | see www.ebsco.com |
| **ED** | Emergency Department |
| **EMA** | Emergency Medical Associates |
| **EMHS** | Eastern Maine Health System |
| **EMR** | Electronic Medical Record |
| **EMS** | Emergency Medical Services |
| **EOC** | Emergency Operations Center |
| **EPI** | Epidemiologist |
| **GIS** | Geographic Information System |
| **GLBT** | Gay, Lesbian, Bisexual, Transgender |
| **HAN** | Health Alert Network |
| **HAZMAT** | Hazardous Materials (e.g., Team, supplies, protocols) |
| **HEDIS** | Healthcare Effectiveness Data Information Set |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HMPs** | Healthy Maine Partnerships |
| **ICL** | Institute for Civic Leadership |
| **IM** | Instant Messaging |
| **ImmPact** | Maine Information Immunization Registry |
| **IO** | Information Officer |
| **JCAHO** | Joint Commission on Accreditation of Healthcare Organizations |
| **KVCC** | Kennebec Valley Community College |
| **L/A** | Cities of Lewiston/Auburn |
| **LGBT** | Lesbian, Gay, Bisexual, Transgender |
| **LHO** | Local Health Officer |
| **LPHSA** | Local Public Health System Assessment |
| **MAPP** | Mobilizing for Action through Planning and Partnerships |
| **MARVEL** | State Library access portal to health journals, books |
| **MCDC** | Maine Center for Disease Control |
| **MCH** | Maternal/Child Health |
| **MCPH** | Maine Center for Public Health |
| **Meds** | Medications |
| **MeHAF** | Maine Health Access Foundation |
| **MEMIC** | Maine Employers' Mutual Insurance Company |
| **MMC** | Maine Medical Center |
| **MOU** | Memorandum of Understanding |
| **MPH** | Masters in Public Health |
| **MPHA** | Maine Public Health Association |
| **NAMI** | National Alliance on Mental Illness |
| **NNE Poison** | Northern New England Poison Control Center |
| **NIMS** | Training National Incident Management System |
| **NP** | Nurse Practitioner |
| **OSA** | Office of Substance Abuse |
| **OT** | Occupational Therapy |
| **Ped Paths** | Pedestrian Paths |
| **PPH** | Portland Public Health [City of Portland Division of Public Health] |
| **PROP** | People's Regional Opportunity Program |
| **PT** | Physical Therapy |
| **RSU** | Regional School Unit |
| **RSVP** | Regional Seniors Volunteer Program |
| **SES** | Socioeconomic Status |
| **SMAA** | Southern Maine Agency on Aging |
| **SMRRC** | Southern Maine Regional Resource Center |
| **SNAP** | Supplemental Nutrition Assistance Program |
| **STD** | Sexually Transmitted Disease |
| **UMF** | University of Maine-Farmington |
| **UMO** | University of Maine-Orono |
| **UNE** | University of New England |
| **USM** | University of Southern Maine |
| **VA** | Veterans Administration |
| **VNA** | Visiting Nurse Association |
| **WIC** | Women, Infants & Children |



## Glossary and Reference Terms

| | |
|---|---|
| **Community Health Assessment** | Community health assessment calls for regularly and systematically collecting, analyzing, and making available information on the health of community, including statistics on health status, community health needs, epidemiologic and other studies of health problems. |
| **Community Health Profile** | A comprehensive compilation of measures representing multiple categories, or domains, that contributes to the description of health status at a community level and the resources available to address health needs. Measures within each domain may be tracked over time to determine trends, to evaluate health interventions or policy decisions, to compare community data with peer, state, national or benchmark measures, and to establish priorities through an informed community process. |
| **District Public Health Unit** | "District Public Health Unit" means a unit of State public health staff set up whenever possible in each district in department offices. These staff shall include, when possible, public health nurses, field epidemiologists, drinking water engineers, health inspectors, and district public health liaisons. |
| **Go Kits** | Packages of records, information, communication and computer equipment, and other items related to emergency operation. They should contain items that are essential to support operations at an alternate facility. |

## Results of Participant Evaluations

| District | # Participants |
|---|---|
| Aroostook | 36 |
| Central | 32 |
| Cumberland | 64 |
| Downeast | 41 |
| MidCoast | 30 |
| Penquis | 43 |
| Western | 51 |
| York | 65 |
| **Total** | **362** |

Response rate 39% (141 out of 362 universe)
# responses/% of total

"The assessment findings can be used in the future to help guide and direct policy, funding determinations, and collaborative approaches."

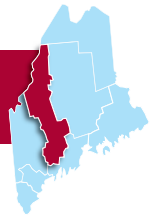
### HIGHLIGHTS

**85%** said meeting organization was good/excellent

**83%** thought meeting facilitation was good/excellent

**74%** found the process to be a good/excellent opportunity to learn about the DPHS

"Comprehensive, inclusive, educational!"



### DID YOU PARTICIPATE IN THE ASSESSMENT MEETINGS?

| Yes | No | Skipped |
|---|---|---|
| 137/97% | 4/3% | 0 |

### DID YOU PARTICIPATE IN THE ORIENTATION SESSION AS PART OF THE FIRST MEETING?

| Yes | No | Skipped |
|---|---|---|
| 79/56% | 50/35% | 12/9% |

### BASED ON YOUR INVOLVEMENT IN THE ASSESSMENT MEETINGS, PLEASE RATE THE ITEMS BASED ON THE SCALE BELOW

| Skipped | Very Poor | Poor | Fair | Good | Excellent |
|---|---|---|---|---|---|
| **Meeting Organization** | | | | | |
| 9/6% | 0 | 1/1% | 11/8% | 74/52% | 46/33% |
| **Meeting Facilitation** | | | | | |
| 9/6% | 2/1% | 2/1% | 12/9% | 71/51% | 45/32% |
| **Meeting Format** | | | | | |
| 11/8% | 0 | 3/2% | 20/14% | 78/55% | 29/21% |
| **Opportunity to provide input about the District system** | | | | | |
| 9/6% | 2/1% | 4/3% | 7/5% | 77/55% | 42/30% |
| **Opportunity to learn about the District system** | | | | | |
| 9/6% | 1/1% | 4/3% | 22/16% | 76/53% | 29/21% |
| **Opportunity to learn more about District resources** | | | | | |
| 9/6% | 0 | 2/1% | 30/21% | 74/53% | 26/19% |
| **Opportunity to learn more about public health** | | | | | |
| 9/6% | 2/1% | 5/4% | 31/22% | 71/51% | 23/16% |

### DO YOU FEEL AS A RESULT OF THE PROCESS THAT YOU IDENTIFIED POTENTIAL NEW RELATIONSHIPS AND OPPORTUNITIES FOR COLLABORATION?

| Yes | No | Skipped |
|---|---|---|
| 108/77% | 24/17% | 9/6% |

### DO YOU FEEL A PART OF THE DISTRICT PUBLIC HEALTH SYSTEM?

| Yes | No | Skipped |
|---|---|---|
| 113/80% | 18/13% | 10/7% |

"I enjoyed meeting with different resources in the area and look forward to making them more united."