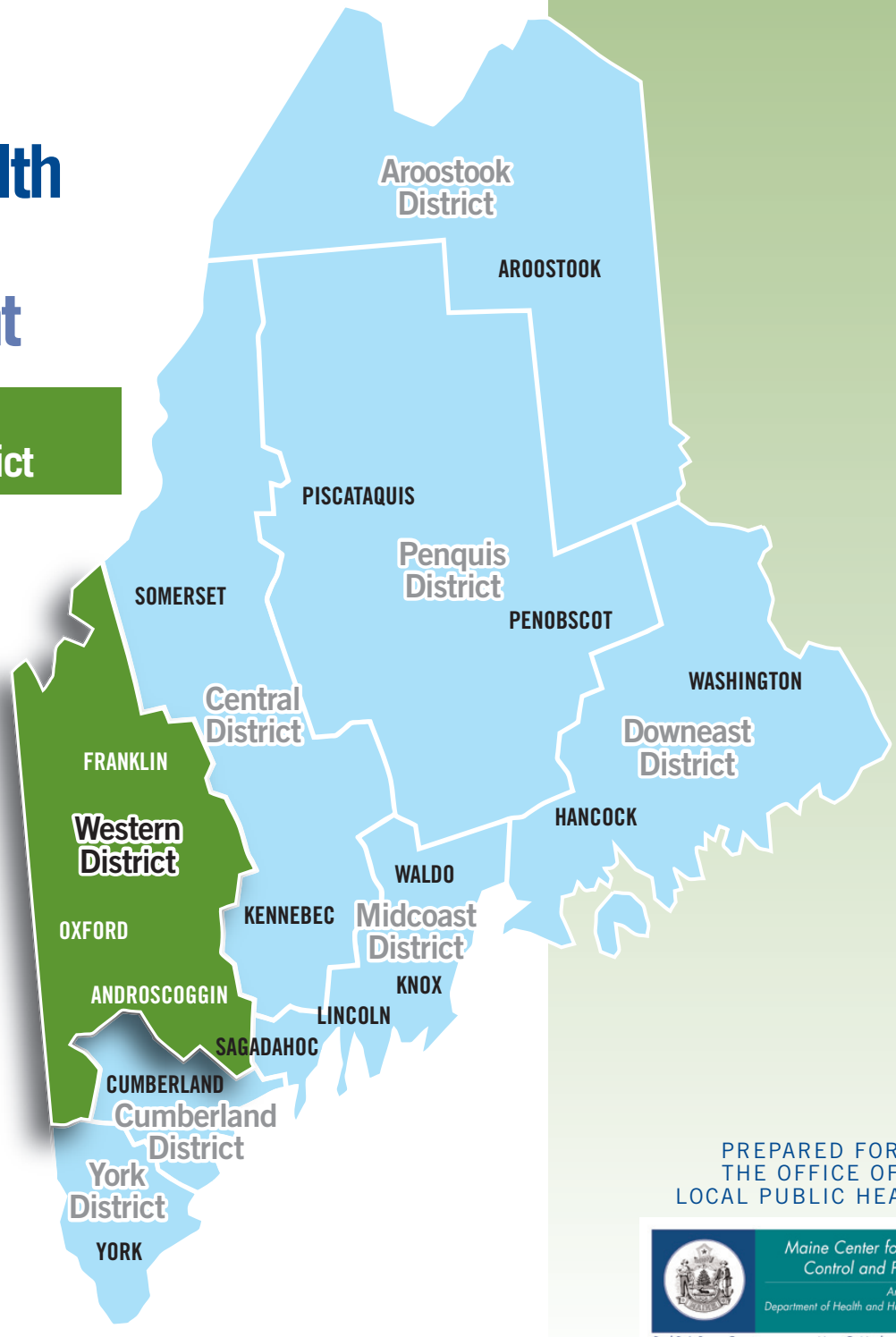
2010

Local Public Health System Assessment

Western 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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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 Western District Public Health System

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

Special thanks go to:

Shelemiah Baiei and Rachel Black, meeting administrative support persons through Healthy Androscoggin in setting up our meeting in the District's midpoint of Turner.

The LPHSA Planning Committee included:

Ken Morse, Healthy Oxford Hills

Patty Duguay, River Valley Healthy Communities

Heather Davis, Healthy Community Coalition

Nicole Ditata, Healthy Community Coalition

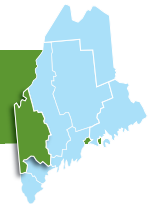
Tin Barton-Caplin, Healthy Androscoggin

Mike Hatch, Western Maine Health

Pat Cook, Western Maine Health

Julie Shackley, Androscoggin Home Health & Hospice

Thanks to all!



Western District Characteristics

How the District is organized

- The Western Public Health District covers Androscoggin, Franklin, and Oxford counties.
- There are 71 municipal governments, including a city, towns, plantations and townships.
- The District serves all parts of its jurisdiction, including its townships, some of which have year-round or seasonal residents.

Who we are*

- 193,475 people with 45.6 persons per square mile (Census 2008 est.).
- 11,271 of us are less than 5 years old, 41,369 are 18 years old, and 27,939 over 65 years old.
- 47.9% of our children are eligible for free or reduced school lunch.
- 18.6% 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, Hispanic, and African 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 each 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 whole District and is located in Lewiston at a 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

- 8 public health nurses
- 1 field epidemiologist
- 4 drinking water protection specialists
- 2 health inspectors

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

List of Western Local Public Health Assessment Participants*

MaryAnn Amrich
Western District Public Health Unit

Ginny Andrews
Western ME Community Action

Emma Ansara
Western ME Family Practice

Tin Barton-Caplin
Healthy Androscoggin

John Bastin
Central Regional Resource Center/ CMMC

Kelly Bentley
Healthy Community Coalition

Dennis Brown
Wilton Police Dept

Donna Burke
Sacopee Valley Health Center

Mike Burke
Community Concepts

Jerry Cayer
Franklin Community Health Network

Mark Chretien
Livermore Falls Fire Department

Joan Churchill
Community Concepts

Ned Claxton
CMMC – Family Practice Residency

Pat Cook
Stephens Memorial Hospital

Chris Copeland
Tri-county Mental Health

Heather Davis
Healthy Community Coalition

Nicole Ditata
Healthy Community Coalition

Patty Duguay
River Valley Healthy Communities

Dave Duguay
Oxford County Commissioners

Erin Guay
Healthy Androscoggin

Chris Guild
Occupational Medical Consulting

Jason Hall
Good Shepherd Food Bank

Mike Hatch
Stephens Memorial

Bill Haynes
Town of Waterford

Susan Horton
CMMC – Cardiac Administration

Susan Isenman
Community Dental Health

Susan Jennings
University of Maine – 4-H Camp

Connie Jones
Seniors Plus

Rosemary Kooy
L-A Safe Schools/Healthy Students

Lisa Laflin
United Way

Tom Lequin
St. Joseph's Church

Wendy Low
Region 9 Schl of Applied Technology

Larry Marcoux
Androscoggin United Way

Ruth Marden
Jay Town Office

Paul Montague
Town of Wilton

Ken Morse
Healthy Oxford Hills

Phil Nadeau
City of Lewiston

Annie O'Shea
Livermore Falls High School

Paula Paladino
Rumford Group Home

Scott Parker
Oxford EMA

Craig Phillips
Common Ties Mental Health

Barbara Poirier
USM/Muskie School

Joanne Potvin
Androscoggin EMA

Sue Pratt
Mount Blue Reg. School District

Cindie Rice
CMMC - Wellness Solutions

Dave Robie
FCHN Northstar Ambulance

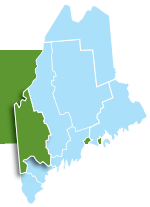
Julie Shackley
Androscoggin Home Care & Hospice

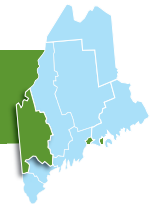
Ray Therrien
MSAD 9 Adult Education

Kawika Thompson
UMF

Allen Wicken
Governor's Council on Physical Activity

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.

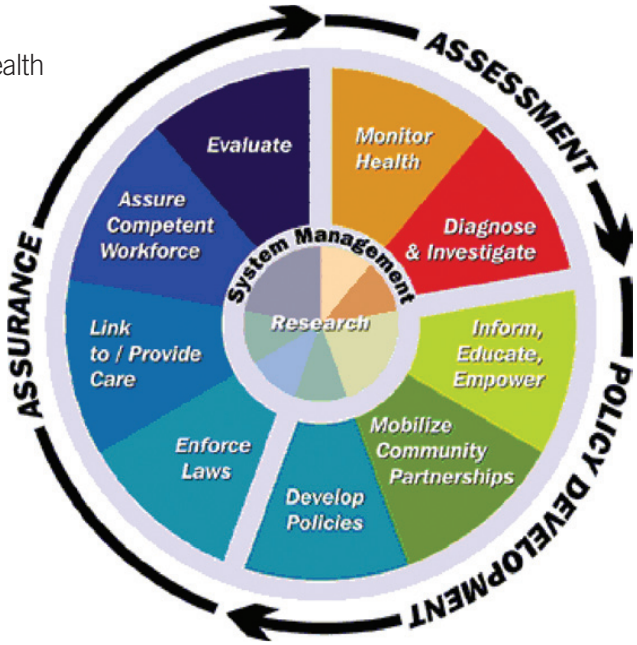
Concepts Guiding Performance Standards Development and Use

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.

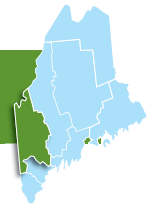
Assurance

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

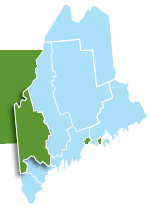
10. Research for new insights and innovative solutions to health problems.

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

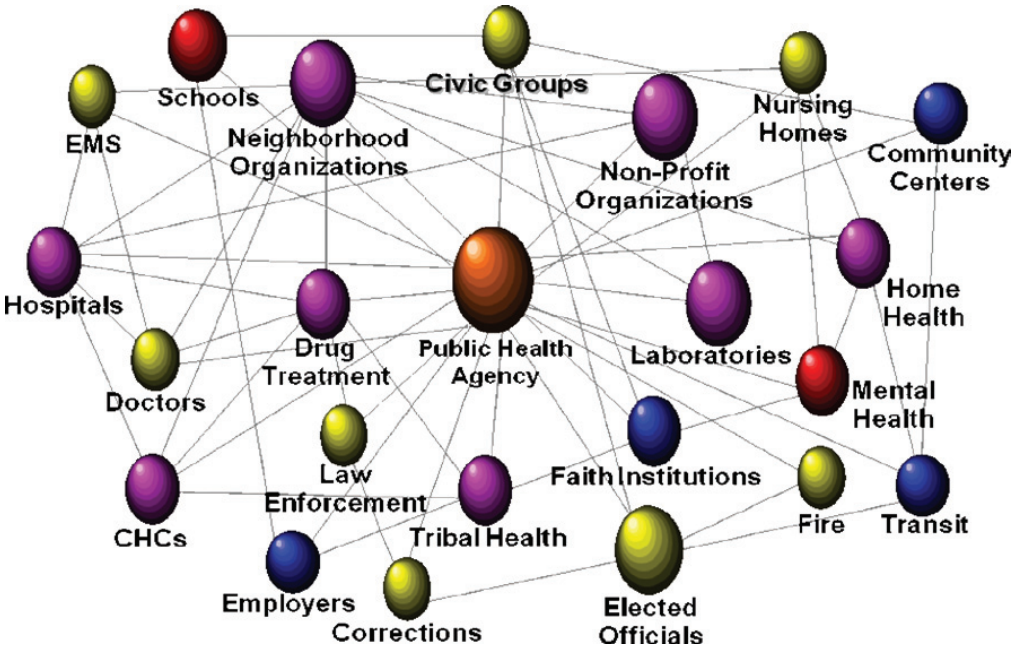
This report begins by providing a brief overview of national public health performance standards. This overview is then followed by a description of the district assessment process, including the purpose, tool, benefits and limitations. The report also provides a comprehensive review of the quantitative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

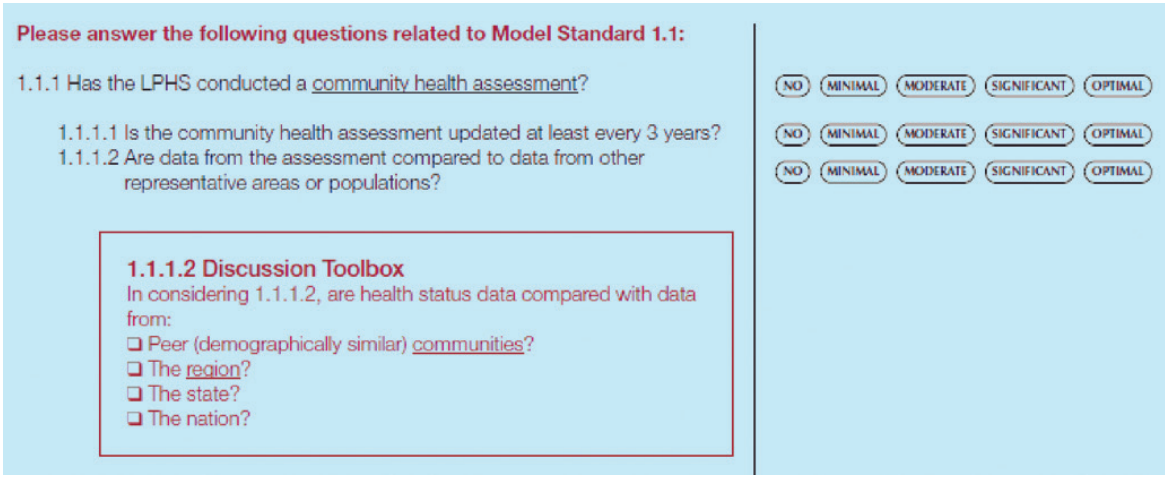
Strong and effective public health systems have the ability to…

- 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 0%	No activity.
Minimal >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 >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 >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 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

Western District Public Health Systems Assessment took place on September 25, October 23 and 30, meeting for approximately 3.5 hours each time. A total of 49 individuals participated in at least one of the three meetings with an average attendance of 26. 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, community health centers, emergency management agencies, homecare/hospice, social service and CAP agencies, State agencies, universities/colleges, municipalities, mental health agencies, schools and Adult Education, area aging agencies, Local Health Officers, first responders, and community organizations. Environmental health groups and faith-based organizations are potential gaps in representation.

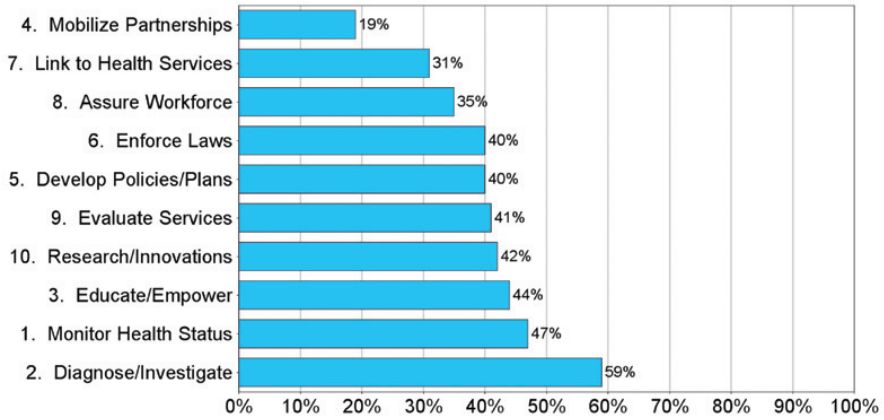
Summary of Scores

EPHS	SCORE
1. Monitor Health Status to Identify Community Health Problems	47
2. Diagnose and Investigate Health Problems and Health Hazards	59
3. Inform, Educate, and Empower People about Health Issues	44
4. Mobilize Community Partnerships to Identify and Solve Health Problems	19
5. Develop Policies and Plans that Support Individual and Community Health Efforts	40

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	31
8 Assure a Competent Public and Personal Health Care Workforce	35
9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	41
10. Research for New Insights and Innovative Solutions to Health Problems	42

Overall Performance Score 40

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: 47

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

Scoring Analysis

- The lowest score is the lack of a comprehensive District community health profile.
- State-of-the-art technology including GIS is available in the District.
- There are state and local registries on many health issues, and that data has been used by organizations.

District Context

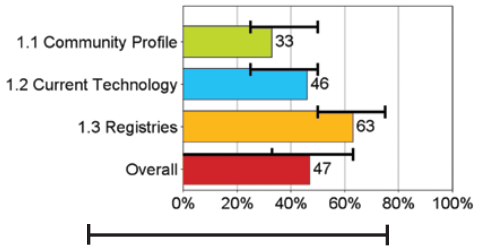
- Community health assessments have been developed by HMPs. State-developed community health assessments and District health data comparison tables are available, but do not have all the components for meeting the definition of a comprehensive Health Profile with analysis summarized.
- Assessments have been distributed to coalition partners, but there is not a media strategy for data dissemination.
- In addition to the State-developed assessments, there have been a number of other assessments completed by other organizations including: Healthy Androscoggin, Healthy Community Coalition, United Way, Tri County Mental Health, Community Concepts, Western Mountain Alliance. MaineHealth with other major health care systems will be conducting an assessment in the future.
- Community health profiles were completed by all District HMPs in 2004. These included health data, demographics, socioeconomic indicators, some environmental health, social and mental health, and some maternal child health data.
- The District system has not yet looked at data for the District or identified those contributing as possible data sources. HMPs are compiling their own data now. How to compile and analyze District data and how to fund such an effort has not yet been determined.

- Assessment data have been used by a number of agencies in the District for planning services, grant writing, allocation funds and strategic planning.
- GIS is used throughout the District. Franklin County has used GIS mapping extensively; some have attended the GIS summer institute; GIS mapping is being used for a District lead poisoning prevention program; a community food security assessment uses GIS, Maine schools map some data, Seniors Plus mapped home-delivered meals and identified pockets of people over 65, EMA/first responders map residences and other locations. GIS has not been used in the District to map race, gender or poverty. The Council of Governments for the 3 counties now has GIS capacity.
- There are a number of patient registries in the District including trauma, chronic disease, immunizations, lead, rabies and Lyme disease. Data from these registries has been used in planning (e.g., pandemic flu), programs (e.g., lead) and grant proposals (e.g., cancer and other chronic diseases).

Possible Action Steps

- Coordinate data sources and topics across the District to create a District Health Profile that includes HMP-collected data as well as assessment data from other sources.
- Develop a district-wide strategy to disseminate assessment data and increase use.
- Build on existing GIS projects to map District health disparities.

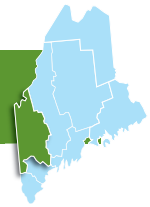
EPHS 1. Monitor Health Status



Range of scores within each model standard and overall

EPHS 1. Monitor Health Status to Identify Community Health Problems: Overall Perfomance Score	47
★ 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	46
State-of-the-art technology to support health profile databases	38
Access to geocoded health data	50
Use of computer-generated graphics	50
★ 1.3 Maintenance of Population Health Registries	63
Maintenance of and/or contribution to population health registries	75
Use of information from population health registries	50

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



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: 59

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 (all areas in green), with the exception of emergency response ability.
- The District scored high on its emergency response to disasters, access to needed personnel, and evaluation of the effectiveness of response activities.

District Context

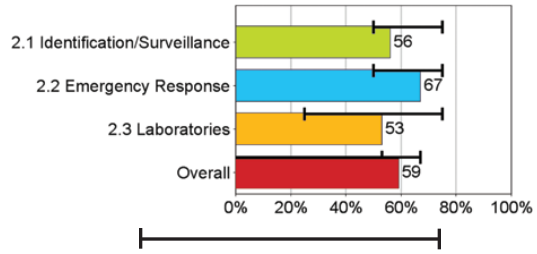
- Surveillance activities in Maine are coordinated at the state level by MaineCDC and other agencies and with the support of the New England Poison Control Center for after hours.
- Most data is collected and compiled at the county level.
- The All-Payer Claims Database could be useful but there is a cost to obtain the data. Access to disparities data has been identified as a gap.
- Reporting by health professionals works well if it goes through the lab or by homecare providers—not as well if individual physician offices report.
- There are Maine CDC regional infectious disease epidemiologists in the District and some staff in the HMPs have EPI training and skills.
- There is significant collaboration among the three County EMA Directors and the District Liaison and there is coordination with community leaders.

- The District's county EMAs have access to needed personnel to respond within two hours with a few exceptions. There has been an enormous amount of work to address hospital surge capacity and develop networks of alternate sites.
- The system to identify, train, and do background checks on emergency preparedness volunteers is progressing and is being coordinated by Maine Responds (out of the SMRRC). A number of District agencies have recruited medical volunteers.
- Emergency response plans have been tested but not fully evaluated at a local level for the ability to carry on operations if 30-40% of the workforce is out sick.
- The State Lab's timeliness to report confirmation of H1N1 cases has been an issue in the District.

Possible Action Steps

- Coordinate surveillance needs and identify sources for disparities data.
- Work with providers to increase number and timeliness of reportable disease.
- Evaluate the capacity of organizations to respond to a public health emergency with a high percentage of workers out sick and make changes to plans as needed.

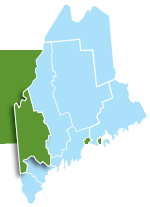
EPHS 2. Diagnose/Investigate



Range of scores within each model standard and overall

EPHS 2. Diagnose and Investigate Health Problems and Health Hazards	59
★ 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	67
Written protocols for case finding, contact tracing, source identification, and containment	50
Current epidemiological case investigation protocols	75
Designated Emergency Response Coordinator	75
Rapid response of personnel in emergency/disasters	72
Evaluation of public health emergency response	63
★ 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: 41

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

Scoring Analysis

- There are district-wide health promotion campaigns and District stakeholders inform the public and policy makers about health needs.
- Individual communities tailor health promotion efforts to populations at higher risk and/or within specific settings, and there are some coordinated district-wide efforts.
- Individual organizations have communication plans and trained spokespersons. There are relationships with the media in each part of 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 officers.

District Context

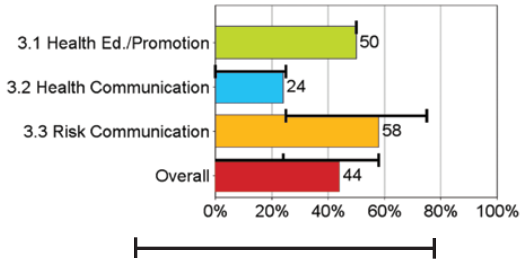
- District-wide health promotion/education efforts include: lead paint, tobacco control, worksite wellness, access to local food, substance abuse prevention, "Living Well," "A Matter of Balance." Hospitals have collaborated on promoting consistent messages for flu.
- Health promotion campaigns reach people in many different settings. There could be greater collaboration with faith-based organizations and recreational facilities. Many health promotion programs in the area are evaluated and many funders require evaluation when doing evidence-based programs.
- A number of District agencies work with advocates and provide educational forums on health issues and the HCC does "Health Beat" radio show.
- The EMAs have very mature communication plans to reach the public and health care organizations and a telephone network to disseminate information. The information sharing capabilities are growing (e.g., webinars, IM).

- Challenges exist in the L/A area due to the number of non-English-speaking residents. There is concern about the ability to communicate effectively with this group in an emergency. Homecare reaches some non-English-speaking individuals and has a contract for interpreters.
- Getting messages to low SES groups or individuals who are not connected to providers, schools or other groups also presents logistical challenges.

Possible Action Steps

- Identify priority health issues and develop collaborative district-wide health promotion campaigns targeted to individuals at higher risk of negative health outcomes and involve new partners (e.g., faith-based organizations).
- Coordinate existing communication plans across the District and/or develop a district-wide communication plan.
- Enhance current communications plans to increase ability to reach non-English-speaking and low SES individuals in an emergency.

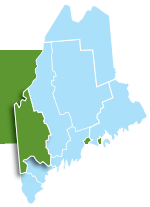
EPHS 3. Educate/Empower



Range of scores within each model standard and overall

EPHS 3. Inform, Educate, and Empower People About Health Issues	41
★ 3.1 Health Education and Promotion	50
Provision of community health information	50
Health education and/or health promotion campaigns	50
Collaboration on health communication plans	50
★ 3.2 Health Communication	24
Development of health communication plans	23
Relationships with media	25
Designation of public information officers	25
★ 3.3 Risk Communication	58
Emergency communications plan(s)	69
Resources for rapid communications response	69
Crisis and emergency communications training	50
Policies and procedures for public information officer response	44

★ = 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: 19

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

Scoring Analysis

- The District has identified many of the key stakeholders and has reached out to develop partnerships with many organizations to maximize public health activities.
- An accessible and comprehensive directory of organizations is not available, although information has been collected.
- There are communications strategies in the District about the importance of public health, but not district-wide.
- The formation of a Community Health Improvement Committee has not occurred.
- No systematic review and assessment of the effectiveness of community partnerships and strategic alliances has occurred in the District.

District Context

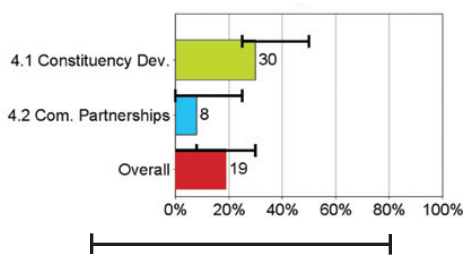
- A list has been compiled of key constituents for building the DCC; the Steering Committee reviews the list and identifies gaps. This process is an "inside-out" process—few people outside of the DCC are aware of its purpose. Involvement of 211 coordinators would be beneficial because of their connection with many organizations. Many organizations in the District do significant constituency building.
- Each of the HMPs has had participation of constituents in their work, but this has not been coordinated district-wide.
- Most organizations are listed in the 211 directory. For refugee and immigrant issues, 211 is not as helpful. Businesses are generally not included. The DCC list has gaps including colleges/universities, and economic development groups. Some people want to be involved in DCC but can't come to meetings.

- There are challenges in this District because there are 3 counties with both rural and urban areas. As the governance structure for the DCC evolves, these issues will be addressed. There has been great evolution of the EMA structure over many years and public health "needs to move in that direction."
- There are some activities in the District to build awareness about public health including: HMP participation in MPHA's "This is public health" campaign; a district-wide newsletter now being produced by the HMPs; the L/A Public Health Committee is bringing issues to the city councils; and through community events.
- Although not coordinated across the District, there are examples of partnerships to improve public health including: L/A trying to improve public health for immigrant and refugee populations, efforts to integrate services, a dental health clinic now serves all 3 counties, Androscoggin Home Health agency is collaborating with physicians for ways to improve acute and chronic care.

Possible Action Steps

- Consolidate and make available lists of current district-wide partnerships and strategic alliances, then identify gaps and strategies to engage new partners, particularly those unable to attend meetings.
- Assess effectiveness of current partnerships and strategic alliances across the District to strengthen and improve capacity.
- Develop a district-wide communication strategy for promoting public health.
- Create a District public health improvement committee.

EPHS 4. Mobilize Partnerships



Range of scores within each model standard and overall

EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems	19
★ 4.1 Constituency Development	30
Identification of key constituents or stakeholders	44
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	8
Partnerships for public health improvement activities	25
Community health improvement committee	0
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

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 is also included in this Essential Service.

Overall Score: 40

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

Scoring Analysis

- The District has begun to develop a governmental presence at the local level.
- District stakeholders contribute to the development of public health policies and engages 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

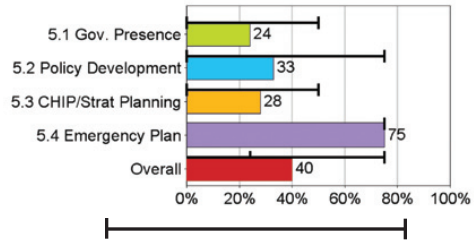
- Many District groups participate in the development of policies including: tobacco, physical activity, nutrition, substance abuse, chickens in urban areas, farm to school, "Work Healthy," household hazardous waste, wind power and climate change, prescription drug issue.
- Some District organizations inform policy makers of the health impact of policies (e.g., FCHN took a lead in advocating against reduction in mental health funds).
- The MAPP process is underway with individual HMPs taking the lead in their area. The process includes broad participation although some gaps may be business, faith-based organizations, transportation, managed care.
- Strategies to address community health objectives for the District will be established, but the geographic area of this District and the diverse populations will make it difficult.

- There are emergency preparedness committees in the District that are knit together by the Regional Resource Center. LHOs have not all been involved and HMPs have only recently been part of the planning. Some vulnerable populations have been hard to reach and involve for many reasons.
- The alignment of hospital and county emergency preparedness plans is closer now than it has been in past years. One gap in planning has been procedures for deployment from Strategic National Stockpile.

Possible Action Steps

- Use MAPP process to identify and address new public health policy needs and coordinate activity on a District level.
- Inform and educate local policy makers on public health impact of such policies.
- Identify organizations/groups not involved in emergency preparedness planning (e.g., ethnic/cultural groups, low SES) and develop creative strategies to engage them beyond participation on a committee.

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	40
★ 5.1 Government Presence at the Local Level *(Note: This indicator was scored the same for all Districts.)*	24
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	25
★ 5.2 Public Health Policy Development	33
Contribution to development of public health policies	75
Alert policy makers/public of public health impacts from policies	25
Review of public health policies	0
★ 5.3 Community Health Improvement Process	28
Community health improvement process	47
Strategies to address community health objectives	25
Local health department (LHD) strategic planning process	13
★ 5.4 Plan for Public Health Emergencies	75
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	75

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

"…good opportunity to bring a diversity of people and resources together."

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 designed to 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 RE: public health nuisances and disease outbreaks, and county EMA(s) for regional emergencies whenever hazard to public health is a concern. This service tied for seventh out of 10 Essential Services. This score is in the moderate range indicating that there are some district-wide activities.

Scoring Analysis

- Enforcement agencies are aware of laws and municipalities have access to legal counsel if needed.
- There is minimal activity to specifically identify local public health issues that are not adequately addressed through current laws, regulations or ordinances, or 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

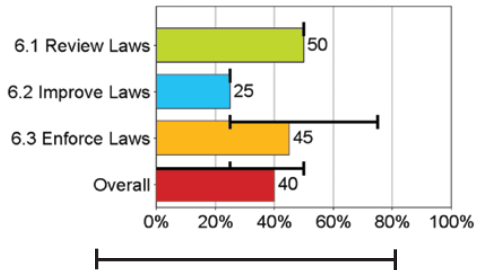
- Organizations (e.g., HMPs) have identified issues to be addressed through laws/regulations/ordinances in some local areas for issues such as tobacco control and planning for trails and bikes/pedestrians.
- Some barriers to addressing issues through laws/regulations/ordinances at a local level include: public health issues compete with high visibility issues such as property taxes, so rarely get on town meeting agendas; local elected officials often believe public health problems are being addressed by someone else; process for handling some issues is not effective (e.g., property management sanitation issues require selectmen review in order to go to court).
- Not all Local Health Officers are aware of their role (e.g., assess problems v.s. enforcement) but the new formal training will help. Often knowledge about laws/regulations/ordinances is "in-time learning."

- Some local law enforcement officials don't feel it is their job to enforce public health laws and sheriffs do not enforce local ordinances.
- HMPs work to support enforcement efforts on issues such as: sales to minors, breastfeeding and worksite laws, tobacco control, and other substance abuse prevention initiatives.

Possible Action Steps

- Provide training on public health laws for law enforcement personnel and enhance partnerships to support enforcement.
- Identify opportunities to enhance collaboration with Local Health Officers across the District.
- Identify one or more issue that is not adequately addressed by existing laws/regulations/ordinances across the District and provide technical assistance to communities and elected officials to pass/change laws.

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 efforts to coordinate and link the services and address barriers to care.

Overall Score: 31

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

Scoring Analysis

- There are few district-wide activities to identify populations and personnel health service needs.
- There is no District assessment of the availability of services to people who experience barriers to care or District-wide activities to link people to services.
- There are some district-wide efforts to coordinate health care services and social services.
- There are some district-wide initiatives to enroll people eligible for public benefit programs.

District Context

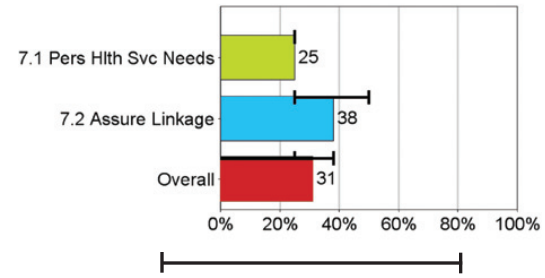
- There are a number of gaps in services in the District that have been identified: dental health, mental health services for children, family planning services, services for people near the NH border or far from service centers, services for trauma survivors, substance abuse treatment, chronic disease management services.
- Barriers to obtaining services have been identified: transportation, lack of family physician, language and culture, lack of knowledge about eligibility for services, ability to navigate the health system, few residential beds for youth, elders won't go to doctors they can't understand or are unwilling to see other health providers (e.g., NP), reimbursement issues (e.g., for home health services), waiting time for MaineCare services.
- Examples of population groups that have difficulty accessing services are: immigrants/refugees in rural area, homeless youth, people who come out of correctional facilities, veterans, people who recently lost their job, migrant farm workers, low SES groups.
- There has not been a district-wide assessment to look at needs and service gaps, but many organizations are looking at the needs of the people they serve including: schools and school-based health centers, rural health centers, United Way, hospitals, Head Start, home health services, mental health providers, area aging agencies. Most of these efforts are not linked.

- Some efforts in the District to link services to people in need include: several organizations are working on homeless adult and youth issues; coordination between schools and mental health providers for kids who can't get to services; expansion of Community Dental Health throughout the District; efforts to link immigrant community to services.
- Some co-location of services has occurred: behavioral health with health centers, schools and health care facilities; a mobile van travels to health centers and provides social services and other services; the B Street clinic has co-location of services.

Possible Action Steps

- Expand to all counties and coordinate across the District current successful initiatives to reach populations in need of services.
- Coordinate an assessment across the District on health service gaps (e.g., substance abuse treatment) and barriers (e.g., transportation) and identify strategies to address the gaps.

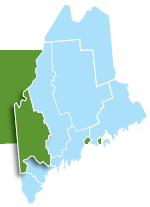
EPHS 7. Link to Health Services



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	31
★ 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	38
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	50
Coordination of personal health and social services	50

★ = 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: 35

This Service ranked eighth 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 across the District of the public health workforce.
- Few organizations connect job descriptions and performance evaluations to public health competencies.
- There are few assessments of training needs and few resources or incentives available for training.
- Some training programs on core competencies exist. There are some interactions with academic institutions within the DPHS.
- Leadership development is available in the District.

District Context

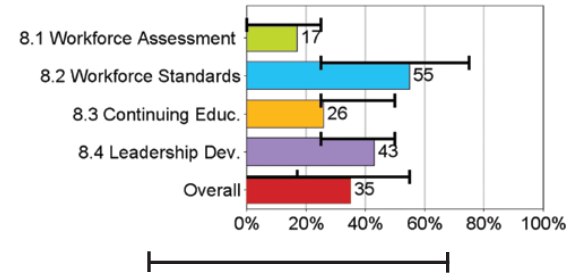
- There has not been a coordinated assessment across the District of the workforce or of training needs.
- Organizations in the District look at their own workforce including assessment of training needs (e.g., HMPs, Androscoggin Home Health). The School of Applied Technology has done a survey of needs in the community to guide their curriculum.
- Health care agencies are aware of, and comply with, licensure and certification requirements.
- Not all Local Health Officers in the District have completed the required training.
- The Healthy Community Coalition works with UMaine Farmington on their community health curriculum to prepare undergraduate students for the workforce. Mental health organizations have brought in national speakers for training.
- Agencies in the District provide field placement for students at UNE, Tufts, UMaine Farmington, USM, CMMC. Placement of interns in rural communities is often more difficult.

- There are a number of opportunities for training and leadership development in the District. Possible gaps/training needs include: basic public health science skills, additional comprehensive cultural competency (e.g., in schools), social determinants of health. There is no coordination of training in the District.
- The District promotes collaborative decision making. Not all activities and decisions go beyond the DCC members and DCC communication expectations need to be clarified.

Possible Action Steps

- Assess needs and identify or develop training programs including webinars, conferences, etc., to address priorities.
- Develop a District calendar or listserv of training opportunities.
- Develop strategies to reach out to Local Health Officers to encourage 100% participation in the LHO training.

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	35
★ 8.1 Workforce Assessment Planning and Development	17
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	0
★ 8.2 Public Health Workforce Standards	55
Awareness of guidelines and/or licensure/certification requirements	75
Written job standards and/or position descriptions	25
Annual performance evaluations	25
LHD written job standards and/or position descriptions	75
LHD performance evaluations	75
★ 8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring	26
Identification of education and training needs for workforce development	28
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	43
Development of leadership skills	47
Collaborative leadership	50
Leadership opportunities for individuals and/or organizations	50
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 program. This service also measures activity related to the evaluation of the DPHS.

Overall Score: 41

This Service scored fifth 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 geography.
- Evaluation of, and satisfaction with, personal health services occurs throughout the District. Results are used to modify services.
- This Public Health System Assessment evaluates the DPHS and will support HMP Community Health Improvement Plans and a District Health Improvement Plan.

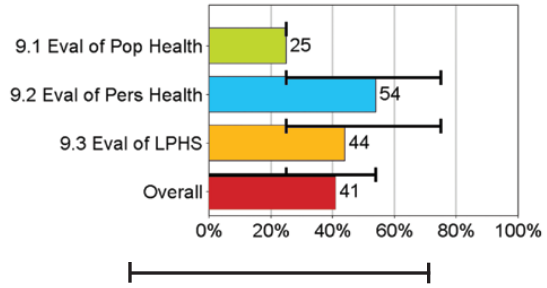
District Context

- Some population-based services in the District are evaluated (e.g., worksites, HMPs, substance abuse prevention programs), and most federal and state grant funded programs require evaluation. Evaluation is not coordinated across the District and programs are created but not evaluated.
- There are established criteria that could be used for evaluation (e.g., *Healthy Maine 2010* data) and grants have evaluation criteria. United Way will be using a community impact tool for funding decisions.
- Most personal health services are evaluated using standards, but most of the information is not shared widely. Client satisfaction surveys are done, but also not shared, and potential clients are generally not surveyed.
- When numbers of acute care beds comes up for discussion, the District could use data to help inform the discussion.
- EMRs are becoming widespread in the District although they don't always talk to each other. Examples where technology has worked well include: mental health workers access EMR from primary care provider; Network of Care has a web-based portal for people to put in their own health stories and health information.
- Many stakeholder organizations have been identified for this Local Public Health System Assessment but faith-based organizations, advocacy groups and environmental groups are potential gaps.

Possible Action Steps

- Identify district-wide evaluation priorities and use the expertise in the District to plan, implement and analyze 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 this Public Health System Assessment to improve linkages with community organizations, and to create or refine community health programs district-wide.

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	41
★ 9.1 Evaluation of Population-Based Health Services	25
Evaluation of population-based health services	25
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	54
Personal health services evaluation	75
Evaluation of personal health services against established standards	75
Assessment of client satisfaction with personal health services	25
Information technology to assure quality of personal health services	44
Use of personal health services evaluation	50
★ 9.3 Evaluation of the Local Public Health System	44
Identification of community organizations or entities that contribute to the EPHS	75
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 linkages to academic institutions and capacity to engage in timely research.

Overall Score: 42

This Service ranked fourth of the 10 Essential Services. This score is in the moderate range indicating that there are few district-wide activities.

Scoring Analysis

- Agencies in the District are encouraged to develop new solutions for public health issues and have various methods of monitoring research and best practice.
- Some organizations in the District have proposed public health issues for inclusion in the research agenda of research organizations and have participated in the development of research.
- There are some affiliations with academic institutions and organizations in the District.
- The DPHS has some access to researchers.

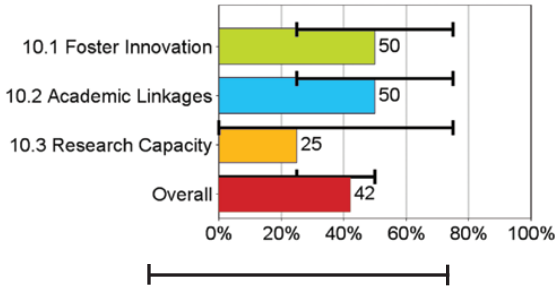
District Context

- There have been opportunities for innovative solutions to problems (e.g., MeHAF mental health integration project).
- District organizations have worked with researchers on research projects (e.g., Maine Hospice Council with Muskie, USM and Bates worked on community foods CBPR project, River Valley Health Community internet health information project).
- There are relationships with institutions of higher learning including: UMASS, UMF, Tufts, UNE, Dartmouth, community colleges.
- There has not been an exchange of faculty but academic sites have partnered in education programs (e.g., CMMC mini-medical school, University of Maine Cooperative Extension SNAP training).
- The District does not have formal relationships to access researchers, but some may be available—health economics may be a gap in terms of researcher focus.

Possible Action Steps

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

EPHS 10. Research/Innovations

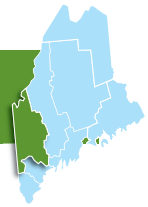


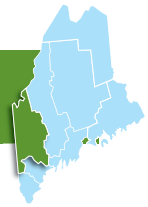
Range of scores within each model standard and overall

EPHS 10. Research for New Insights and Innovative Solutions to Health Problems	42
★ 10.1 Fostering Innovation	50
Encouragement of new solutions to health problems	50
Proposal of public health issues for inclusion in research agenda	50
Identification and monitoring of best practices	75
Encouragement of community participation in research	25
★ 10.2 Linkage with Institutions of Higher Learning and/or Research	50
Relationships with institutions of higher learning and/or research organizations	75
Partnerships to conduct research	25
Collaboration between the academic and practice communities	50
★ 10.3 Capacity to Initiate or Participate in Research	25
Access to researchers	25
Access to resources to facilitate research	75
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

"Not only myself but others made new contacts and learned about activities underway in the district that we were not aware of."





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
EBSCO	see www.ebsco.com
ED	Emergency Department
EMA	Emergency Medical Associates
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EPI	Epidemiologist
FCHN	Franklin Community Health Network
GIS	Geographic Information System
GLBT	Gay, Lesbian, Bisexual, Transgender
HAN	Health Alert Network
HAZMAT	Hazardous Materials (e.g., Team, supplies, protocols)
HCC	Healthy Community Coalition (Farmington-based)
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
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
NH	New Hampshire
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
SMCC	Southern Maine Community College
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."