

The 2013 State Health Improvement Plan: Presentation to the State Coordinating Council

Dec. 13, 2012



*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

State Health Planning History

- 1976: Federally recognition of Dept. of Human Services as State agency with responsibility to conduct statewide health planning.
- 1997: DHHS shall adopt a State Health Plan that addresses “health care, facility and human resources needs in the state.”
- 2003: Governor’s Office of Health Policy & Finance established and required to issue a bi-annual state health plan
- 2004-2010: GOPHF collaborates with DHHS to issue 3 biannual state health plans (2006, 2008, 2010)
- 2011: DHHS endorses Maine CDC plan to seek national accreditation. State Health Improvement Plan part of Public Health Accreditation Board standards

The “New” State Health Improvement Plan

Driven by Public Health Accreditation

PHAB standards require:

- Statewide health priorities,
- Measureable objectives,
- Improvement strategies,
- Performance measures with measurable and time-framed-targets

The “New” State Health Improvement Plan

Driven by Public Health Accreditation

PHAB standards require:

- Broad participation of public health partners
- Information from the State Health Assessment
- Issues and themes identified by stakeholders
- Identification of state assets and resources
- A process to set priorities

The “New” State Health Improvement Plan

Driven by Public Health Accreditation

PHAB standards require:

- Demonstrated implementation of the State Health Improvement Plan

SHIP Roles and Responsibilities

- Maine CDC is the lead as the agency being accredited.
- Building on partnerships with others in the state.
- The SCC serves in advisory capacity to the process.

SHIP Roles and Responsibilities

- Priorities selected may give Maine CDC direction, but may not override legislative mandates and commitments via federal funding.
- We hope these priorities will also inform our partners for their priority setting and planning.

What does it mean to be a SHIP priority?

- Maine CDC focus, based on available resources.
- Potential focus for work with partners, with Maine CDC taking a lead role.
- Careful tracking of performance during the implementation of the SHIP, to hold us accountable.

SHIP Time Frame

- PHAB standards state 3-5 years.
- In 2016, the the State Health Assessment will be re-done in conjunction with the Community Health Needs Assessment (CHNA) required of non-profit hospitals by IRS regulations.
- We anticipate the next version of SHIP following after this – perhaps drawing on the CHNAs as a new input.

SHIP Inputs

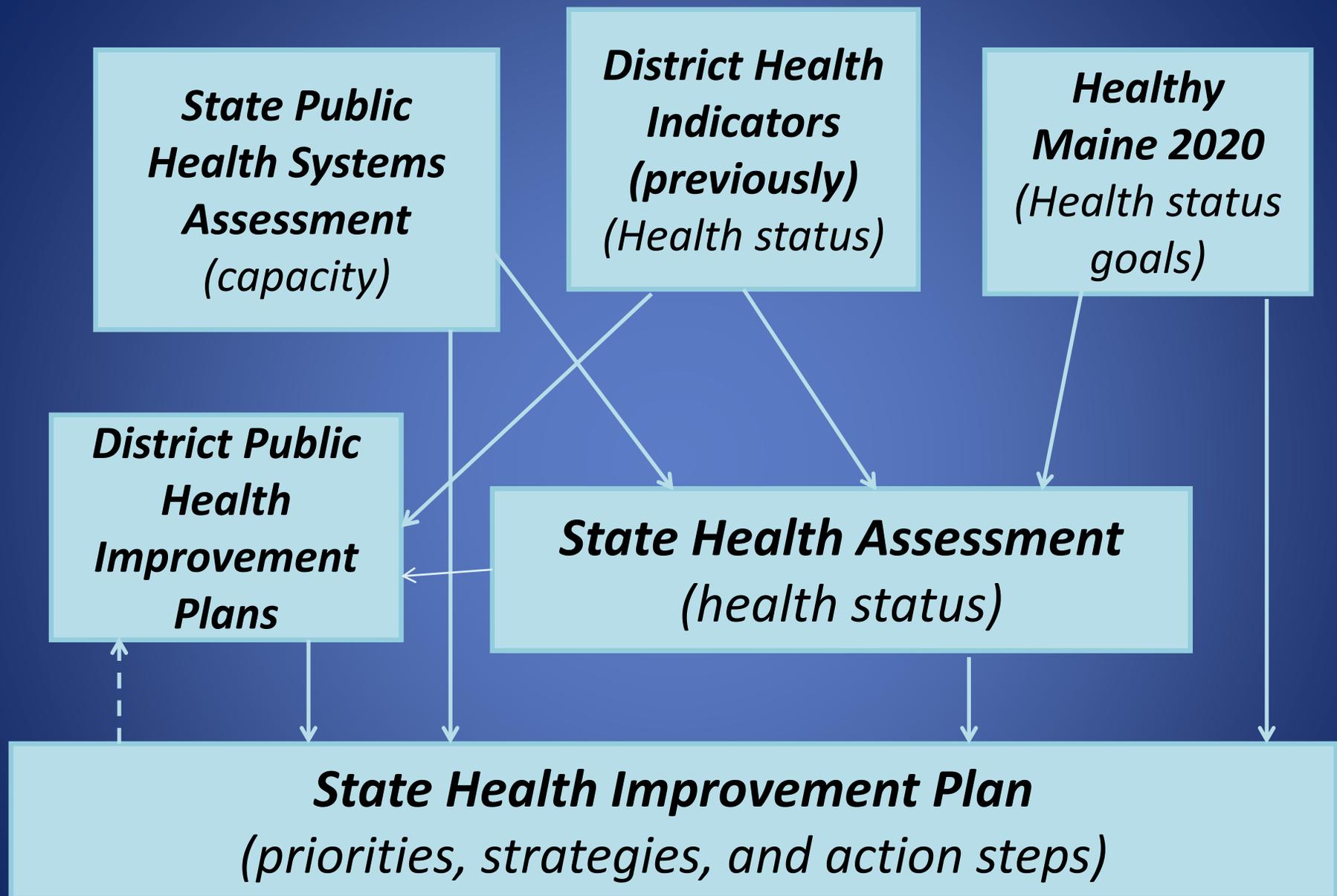
The SHIP will be informed by:

- The State Health Assessment
- Healthy Maine 2020
- The State Public Health System Assessment (SPHSA) and the Local Public Health Systems Assessments (LPHSA)
- Maine CDC's Strategic Plan

SHIP Inputs

The SHIP will be informed by:

- District Public Health Improvement Plans
- This SCC meeting
- An electronic survey for all public health stakeholders.
- Feedback from DCCs via webinars
- Subject matter expert input from Maine CDC staff and other public health partners



Development Timeline

Today	Criteria setting
Dec -Feb (starting today)	Priority selection
Feb – March:	Refinement of the framework and goals
March 28th, 2013	Feedback from SCC and others on the priorities and goals

Development Timeline

April – May	Selection of strategies via sub-committees of subject matter experts
May – June	Finalization of the Plan, including: Identification of Maine CDC resources Identification of partners and their commitments

Development Timeline

June 27th, 2013	Dissemination of the Plan: (presentation to the SCC)
Starting July, 2013	Implementation of the Plan

Questions?

Setting Criteria for Selecting Priorities

Criteria setting

- Many sets of criteria have been developed
- Using the evidence-base: meta analysis by Los Angeles County Health Department*
- Our goal is a manageable list of criteria to use.
 - Too many can be confusing, and lead to less adherence to the criteria.
 - Aiming for 6-8 total.

*JD Gunzenhauser, KN Smith, JE Fielding, Quality Improvement Brief: Priority-setting in Public Health, Los Angeles County Dept. of Public Health

Criteria Setting

- Four “buckets”
 - Two select what issues to be addressed:
 - Two select how to address the selected issues
 - *These criteria could also affect the best choice of priority issues.*

Criteria Setting

- Issue selection criteria:
 - Generally: Effectiveness of Interventions
 - Generally: Feasibility of Implementation of Interventions
 - In more detail: Magnitude of the Public Health Issue (Quantitative)
 - In more detail: Other Factors Related to the Importance of the Public Health Issue (Qualitative)

Criteria Setting

- “Bucket #1” specific criteria (pick 2-3):
 - Percent of population at risk
 - Mortality rate, premature death rate, prevalence, incidence, Years of Potential Life Lost, or other measure of the impact on the population
 - Magnitude of measure disparity (#2) between various groups (e.g., county versus other county, state, or federal comparisons; comparisons between various groups)
 - Economic burden on the population

Criteria Setting

- “Bucket #2” specific criteria (pick 2-3):
 - A health inequity exists for the issue
 - Alignment with national, state or local health objectives, including organizational strategic goals
 - Public health has a clearly established role to address the issue
 - Extent of public concern on the issue – urgency of the problem

Criteria Setting

- “Bucket #2” specific criteria (pick 2-3):
 - Level of support from community members and other stakeholders
 - Impact on systems or health
 - Work on this issue is “mandated” by statute or other authority
 - Legal or ethical concerns related to the issue
 - Linkage to an environmental concern, including safety

Criteria Setting

- Step 1: Are there any possible important criteria missing?
- Step 2: Narrowing down the criteria to 6-8

The State Health Assessment

State Health Assessment Indicator Selection

- Internal Maine CDC committee identified 17 indicator sets. (early 2011)
- Broad SHA workgroup selected 168 indicators (mid 2011)
- Organized and analyzed the data. (2012)

Data Included

- Health status, behavior, or determinant
 - Not public health capacity
 - Not a measure of policy or strategy
 - Example: physical activity, but not physical education mandate
- High-level “summary” measure:
 - Captures the bigger picture
 - Example: infant mortality, but not neonatal or post-neonatal mortality

Data Included

- Existing data
 - Routinely collected
 - Will be available in the future.
 - Consistent with Maine CDC program requirements (existing analyses).

Data Included:

- 168 indicators in 22 topic areas:
 - Demographics
 - SES measures
 - General Health Status
 - Access
 - Health Care Quality
 - Environmental Health
 - Occupational Health
 - Emergency Preparedness

Data included

- 168 indicators in 22 topic areas:
 - Cardiovascular Health
 - Respiratory Health
 - Cancer
 - Diabetes
 - Physical Activity, Nutrition and Weight
 - Substance Abuse
 - Tobacco Use

Data Included:

- 168 indicators in 22 topic areas:
 - Maternal and Child Health
 - (includes reproductive health, birth defects and children with special health needs)
 - Unintentional Injury
 - Intentional Injury
 - Mental Health
 - Oral Health
 - Immunization
 - Infectious Disease

Data included

Where possible and applicable:

- County and public health district.
- Gender, race, ethnicity, and age (state level only).
- Some breakdowns by educational status, income, sexual orientation, depending on the data source (state level only).
- Years may be aggregated in some cases.

Excluded indicators with no reliable Maine data

Data Limitations

- Health status does not change quickly.
- Most recent data is not “this year”
- Some data have limited trends, due to changes in data collection or methodology
- Some data required using multiple years, due to small numbers.
- Some data is not available, due to small numbers, even after aggregating years

Data Limitations

- Significant differences are based on confidence intervals, which are not always available.
- Some state and national data have different years available, and therefore are not comparable.
- Some of the national data sources use different methodologies and therefore are not comparable.

Data Limitations: Disparities

- Language barriers may reduce survey responses
- Some additional disparities may be extrapolated from the state data
 - Race & ethnicity
 - Gender, sexual orientation, age, income, education
- Additional disparities are known from other reports (not analyzed in the SHA)
 - Rural/urban
 - Other Social determinants
- Without additional resources, further analysis may be limited.

Data Presentation

- Tables available on the Maine CDC website :
www.maine.gov/dhhs/mcdc/phdata/sha
- Selected district data
- Today's summary
- Other possible formats to be determined

Data Presentation

- The SHA summary:
 - 158 indicators
 - A few indicators do not fit well into a single table
 - Some national comparisons included.
 - Some trends noted
 - Further data in tables on web.

What about Healthy Maine 2020?

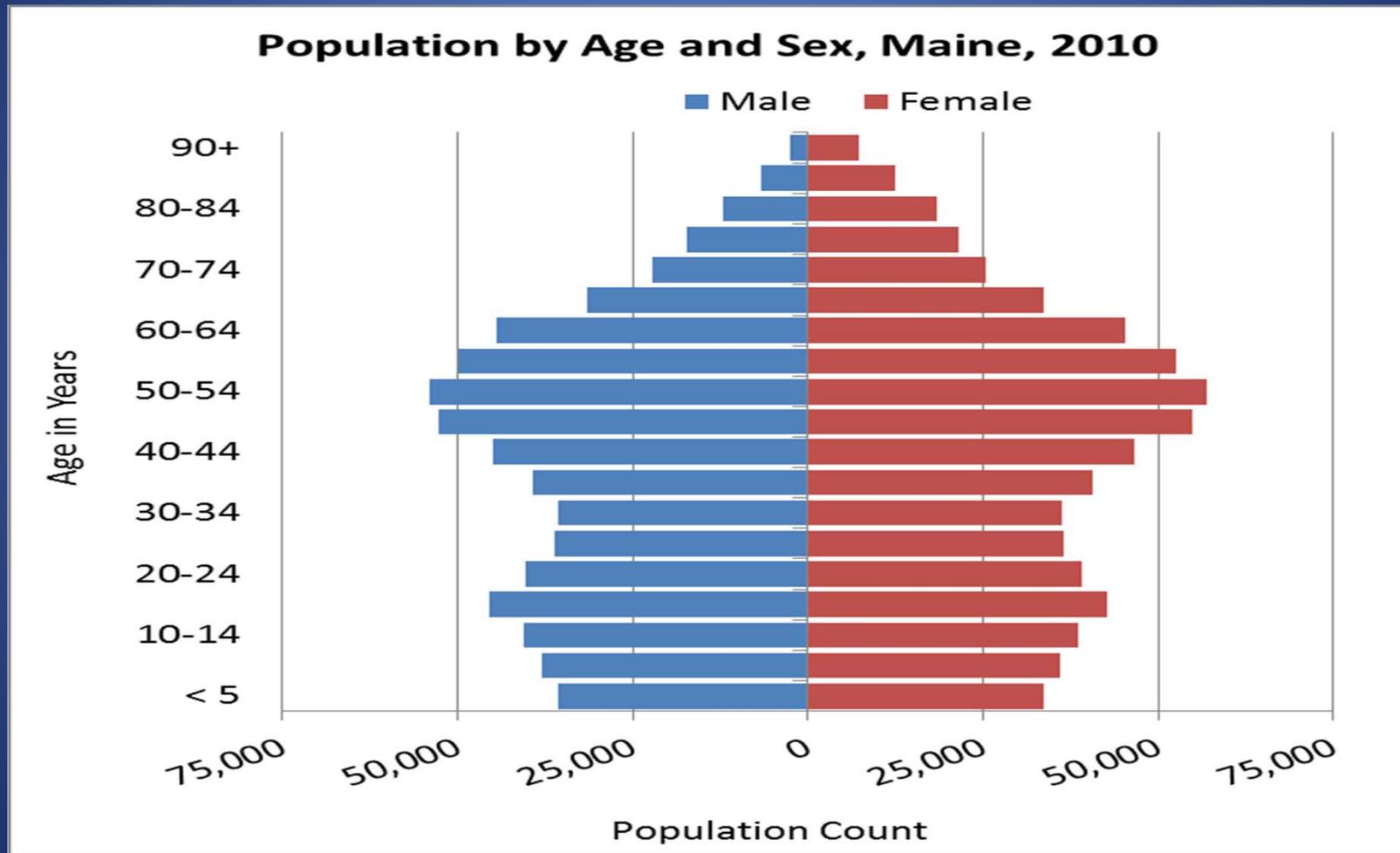
- Still in draft form.
- Expected to be released by the end of 2012.
- Overlaps with the State Health Assessment, with some difference:
 - Healthy Maine 2020 focuses on GOALS – where we hope to be in 2020,
 - Includes health status and some strategies
 - The State Health Assessment focuses on health status

Selected State Data

Maine's Population

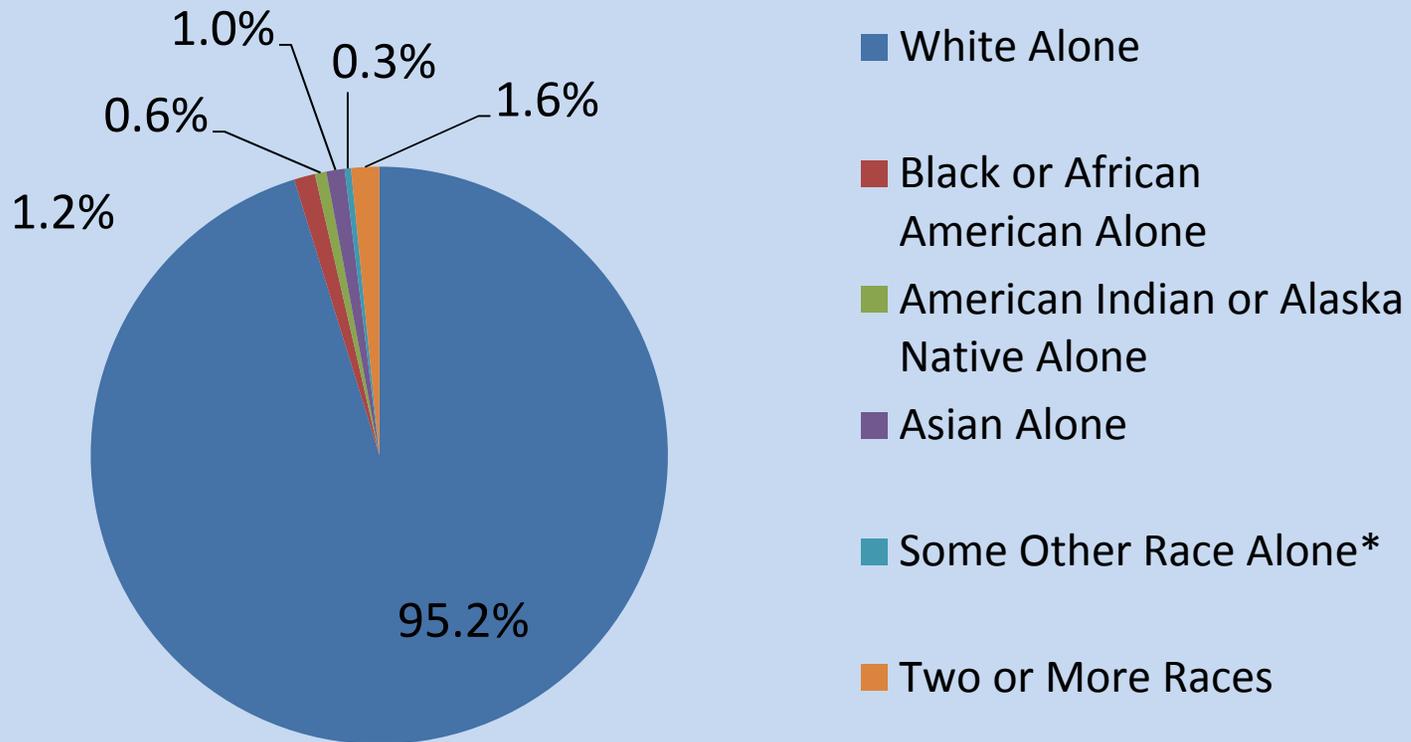
- 2011: 1.328 million
 - 678,125 females
 - 650,063 males
 - 3.8% increase from 2000 to 2010
 - 43.1 people per square mile (2010)

Maine's Population



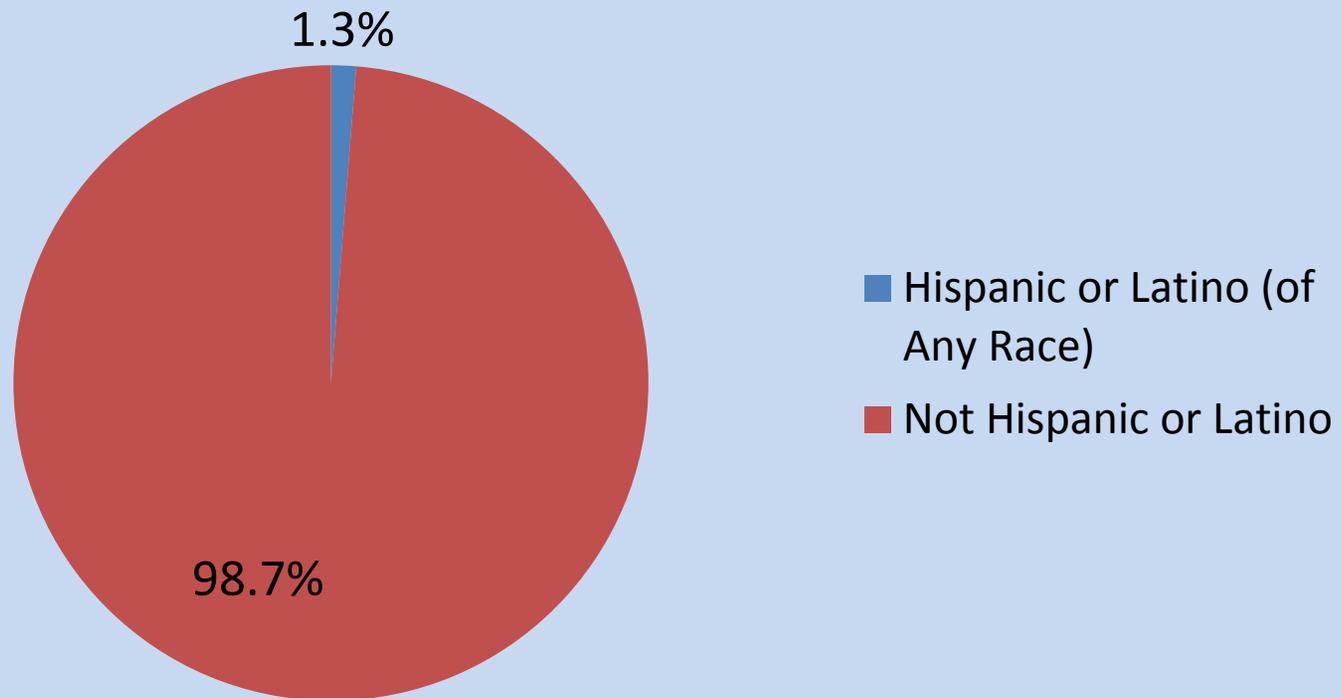
Maine's Population

Population by Race, 2010



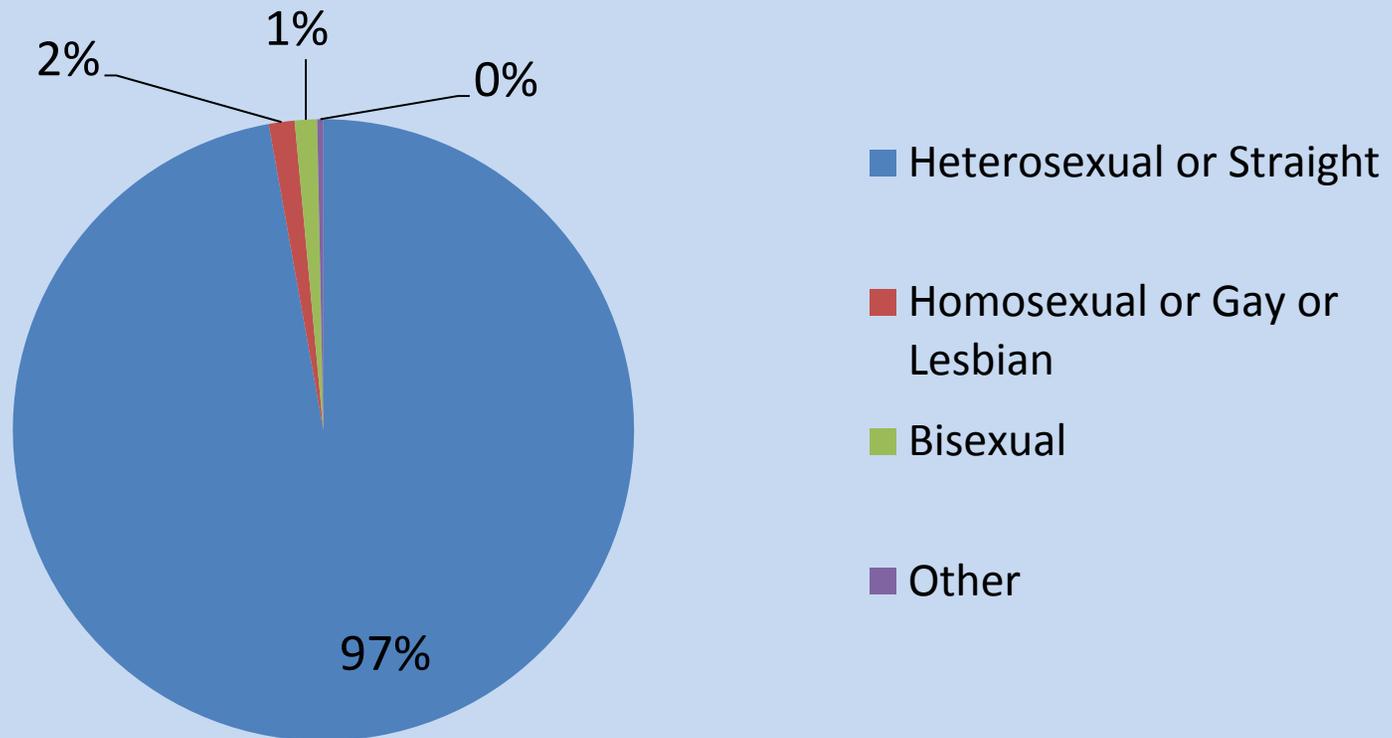
Maine's Population

Population by Hispanic Ethnicity, 2010

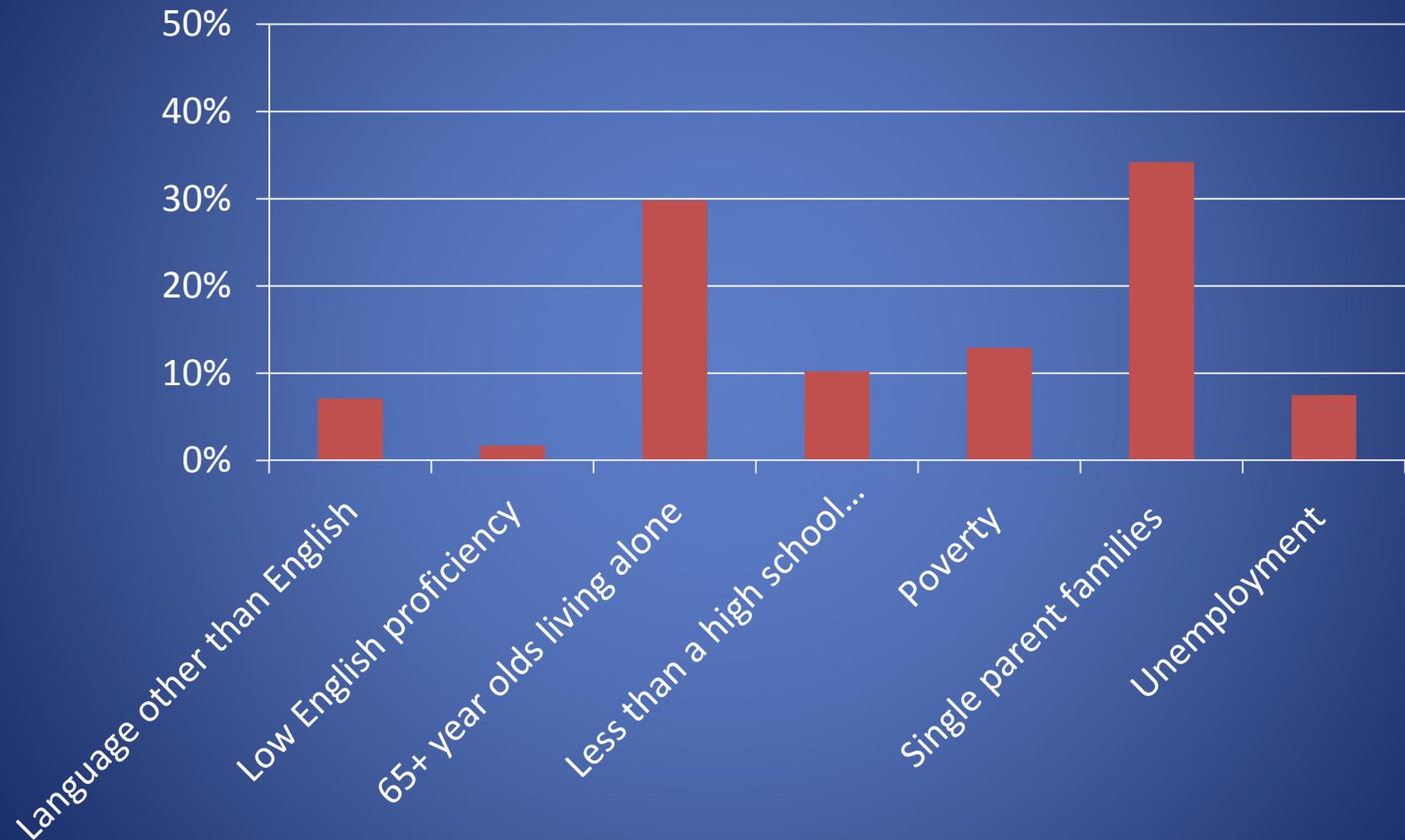


Maine's Population

Population by Sexual Orientation, 2010



Socio-economic factors

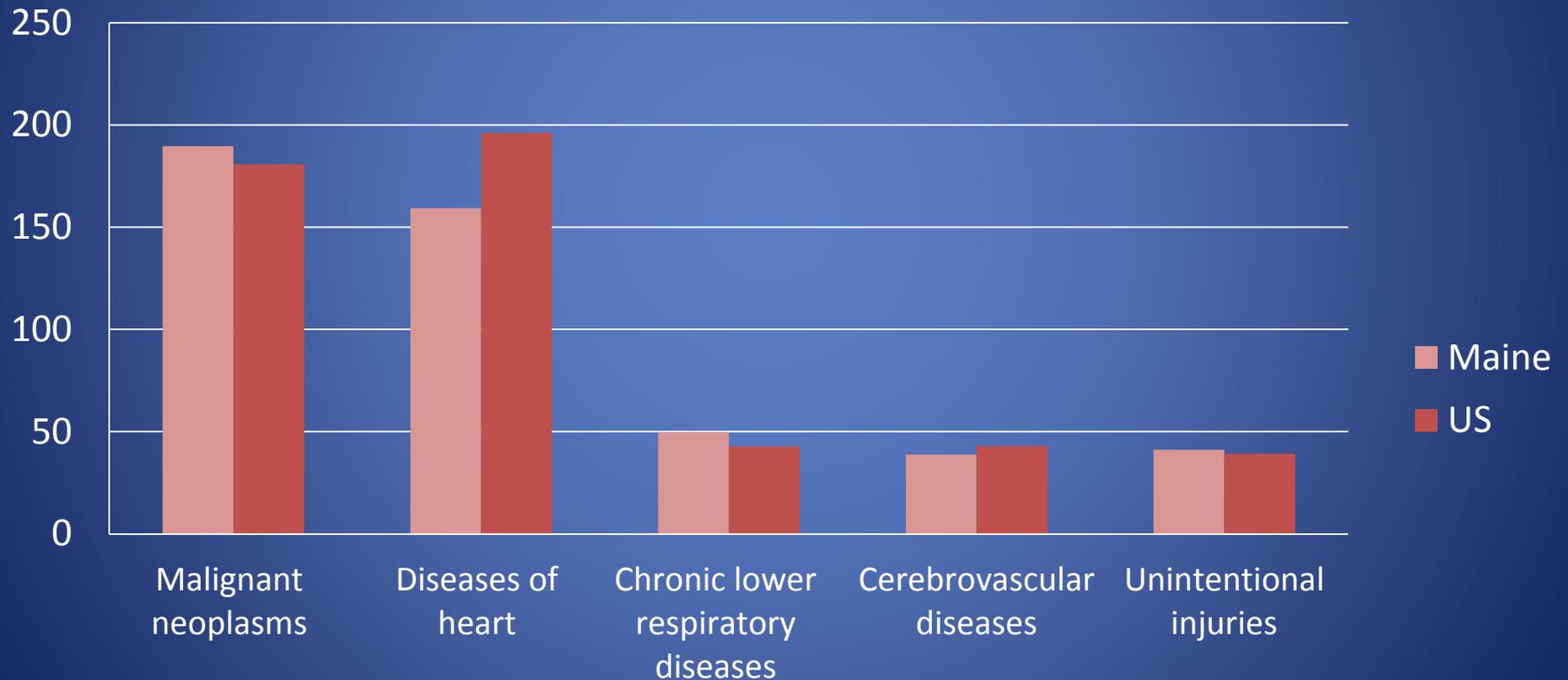


Re-visiting Bucket 1 Criteria: Percent of Population at Risk

- Flu vaccines
- Breast-feeding at 6 months
- Unintended births
- No dental care in the last year
- Fruit and vegetable consumption – adults & youth
- Physical activity – youth
- Overwt & Obesity – adults
- Illicit drug use - youth

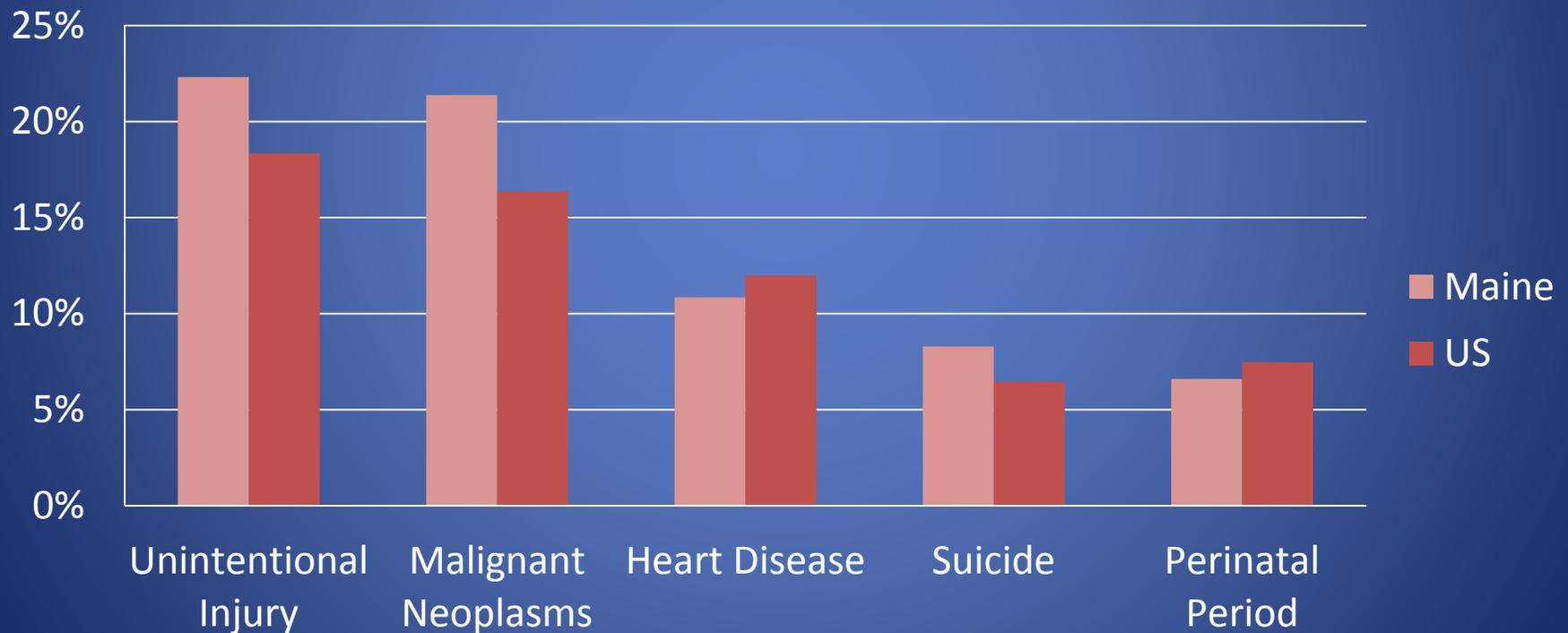
Re-visiting Bucket 1 Criteria: Mortality rates (Leading causes of death)

Age-adjusted Rates of Death, Per 100,000



Re-visiting Bucket 1 Criteria: Years of Potential Life Lost (YPLL)

Percentage of Total YPLL by Cause



Re-visiting Bucket 1 Criteria: Federal Comparisons

	Maine	US
Chronic lower respiratory disease deaths per 100,000 (2009)	48.6	42.3
Non-fatal child maltreatment (2010)	11.9	9.2
Suicide deaths per 100,000 (2009)	14.0	11.8
Lyme disease per 100,000 (2011)	75.7	7.8
Pertussis rates per 100,000 (2011)	15.4	8.9
High blood pressure (2009)	30.0%	28.7%
Incidence - all cancers per 100,000 (2009)	480.8	469.1

Re-visiting Bucket 1 Criteria:

Another measure: direction of the trend

- Pap smears
- High blood pressure
- High cholesterol
- Diabetes ED visits
- Pertussis
- Lyme
- Chlamydia
- Gonorrhea
- TBI ED visits
- Fall-related ED visits
- Poisoning deaths
- Children with special health needs
- Birth control pill use – HS students
- Overwt – HS students
- Obesity – adults
- COPD hospitalizations

Re-visiting Bucket 1 Criteria: District or County Disparities

	Aroostook	Central	Cumb.	Downeast	Midcoast	Penquis	Western	York
No dental visit in past year	X	X						
Bronchitis & asthma ED visits	X	X		X				X
COPD hosp.	X					X	X	
Diabetes hosp.						X	X	
Lyme disease			X		X			X
Prenatal care			X					
Teen births	X	X		X				
ED visits due to falls	X	X					X	
Motor vehicle crash deaths		X		X				
Tooth loss		X		X				
Child mal-treatment				X		X	X	

Re-visiting Bucket 1 Criteria: Other Disparities

- Black or African American:
 - Unintended births, pre-natal care, low birth weight, infant mortality
 - Youth seatbelt use, Unintentional injury deaths
 - HIV, Chlamydia, Gonorrhea, Hepatitis B
- Asian:
 - Greatest language barriers

Other Resources for Additional Data

- Maine Environmental Public Health Tracking Network
- Burden of Disease/Injury on Specific Topics
- Maine CDC Infectious Disease Reports
- County Health Rankings/America's Health Rankings
- One Maine Community Health Needs Assessment
- Kids Count
- Substance Abuse Profiles
- Public Health Emergency Hazard and Vulnerability Scores (in development)
- Others?

Questions?

Choosing Priorities for Action to Strengthen Maine's Public Health Systems

Maine State Coordinating Council
December 2012

A Well-Functioning Public Health System has...

- Strong partnerships, where partners recognize they are part of the PHS
- Effective channels of communication
- System-wide health objectives
- Resource sharing
- Leadership of governmental PH agency
- Feedback loops among state, local, federal partners

Laura Landrum, ASTHO Accreditation consultant, May 2010 Augusta Maine.

Assessing a Public Health System

National Public Health System Performance Standards Program
[NPHSPS]

**2002: tools developed by national partners (on right);
Revised 2007**

- Based on 10 Essential Public Health Services
- Focus on the overall public health system
- Describes an optimal level of system performance
- Supports quality improvement of system

4 Instruments

State System Assessment

Local System Assessment

Health Dept. Percent of Contribution Assessment

Governance of Health Dept. Assessment



Using Results for Performance Improvement: Examples from the Field

Changing Laws

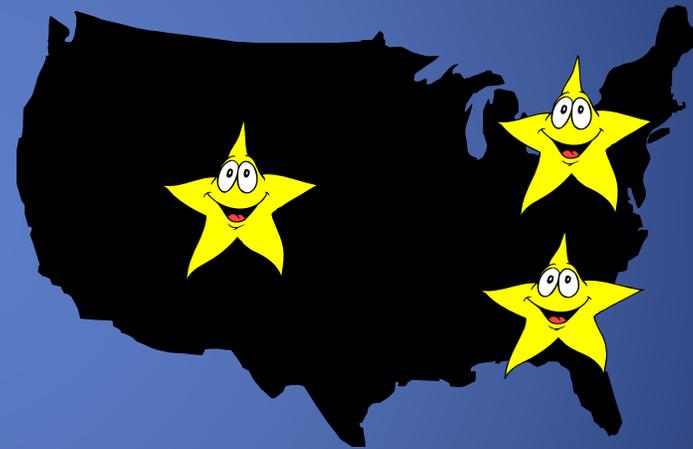
- Illinois
- New Hampshire

Improvement Planning

- Colorado
- New Hampshire

New Partnerships

- Access to care
- Workforce
- Epidemiologic Capacity
- Health Information Systems



See: <http://www.astho.org/programs/accreditation-and-performance/>

Laura Landrum, ASTHO Accreditation consultant, May 2010 Augusta Maine

Public Health System Assessment in Maine

2006	<u>Portland</u>	Health Dept	Local Instrument
2007	<u>Bangor</u>	Health Dept	Local Instrument
2009-2010	8 Public Health	<u>Districts</u>	Local Instrument
2011	<u>State</u>	Public Health	State Instrument
2013	<u>Wabanaki</u>	Health District	in planning stage

Other applications of NPHSP Instruments in Maine:

2005	Maine Bureau of Health	Diabetes Prgm.	Local Instrument
2010	Washington County		Local Instrument

ME: Local PH System Assessment Process

2009-2010 8 District LPHSAs: T=320 participants (av: 40; range 30-68)

1. invitees identified by each DCC LPHSA planning team

- stakeholders drawn from all geographic parts of jurisdiction
- core team of 12 attends 3 assessment meetings
- relevant stakeholders for specific EPHS meetings
- obtains participant perceptions of EPHS service delivery across whole jurisdiction *as if it were one whole regional PH system*
- **No** activity/**Minimal** activity/**Moderate** activity/**Optimal** activity
- trained facilitators and scribes capture comments/themes

2. draft findings for feedback meeting and initial priority setting exercise

Limitations:

- Districts were new
- Rating cards not used
- Emergency services ranked the same for all districts
- Final reports not widely disseminated

District Public Health System Assessments.

Prepared by: Karen O'Rourke and Joan Orr, Maine Center for Public Health 2010.

Maine: Local PH System Assessment Results

10 Essential Public Health Services

one overarching score per EPHS

29 model standards

2-4 per EPHS

ME: State System Assessment Process

2010 MAY

- invitees identified by each Maine CDC division & EPHS service
- ~110 state & regional stakeholders (multiple sectors, agencies)
- rating cards: perceived state system performance
- **No** activity/**Minimal** activity/**Moderate** activity/**Optimal** activity
- trained facilitators and scribes capture comments/themes

Limitations:

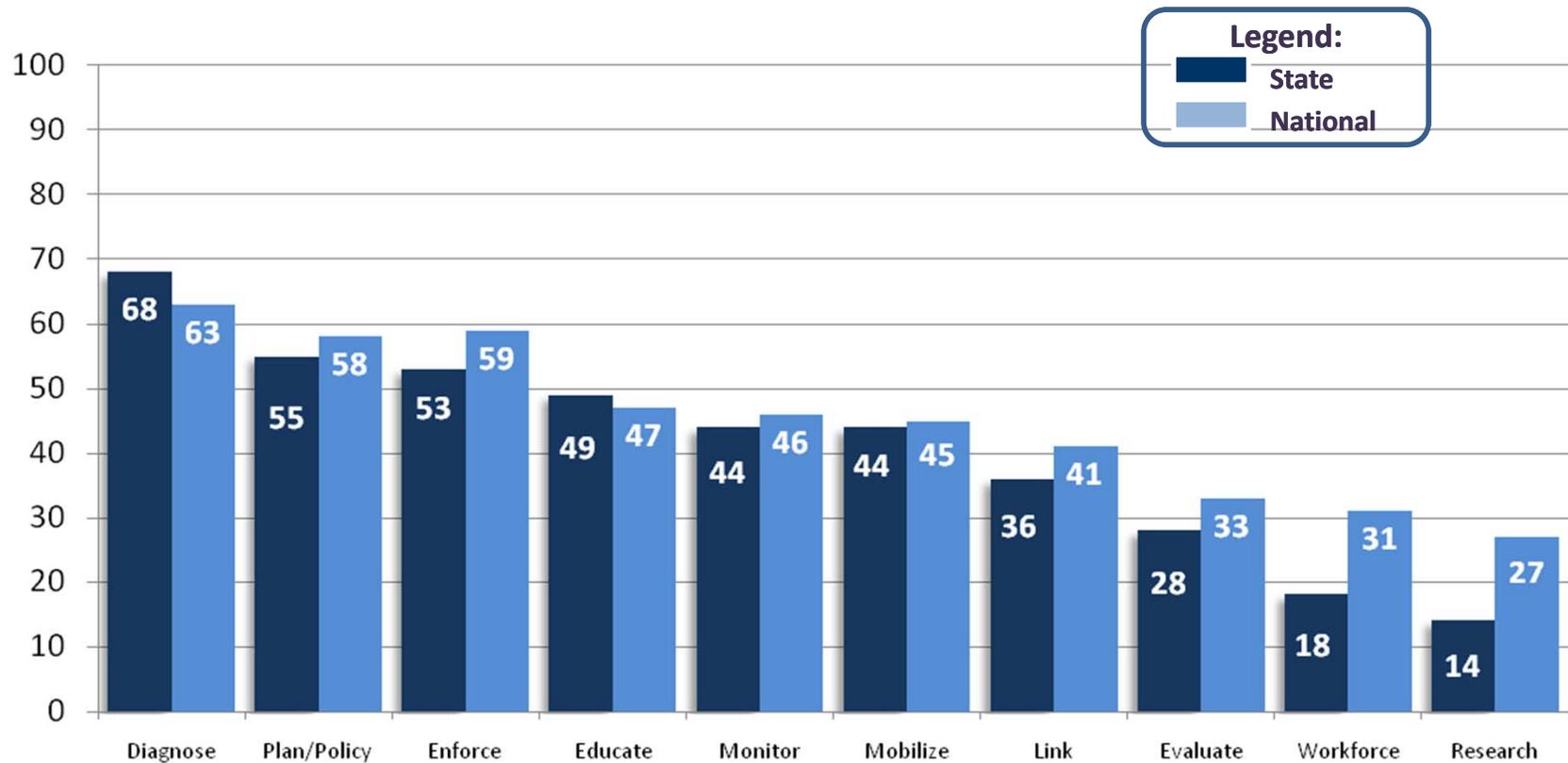
- Intensity and speed of process
- Participation (availability; Nat. Hospital Week); attrition rates
- No anonymity in voting
- Element of subjectivity and knowledge among participants

2010 JUNE:

- *am*: identify state public health agency contributions (not system)
- *pm*: regroup to hear initial findings, consultant speaker on next steps

Maine vs. National Scores

Essential Services in Descending Order



ME: State System Assessment Results

Top 3 performing EPHS:

EPHS #2 Diagnose/investigate health problems/hazards

EPHS #5 Develop policies and plans

EPHS #6 Enforce laws/regulations that protect health/ensure safety

Overall score 41 (range 14-68).

Lowest:

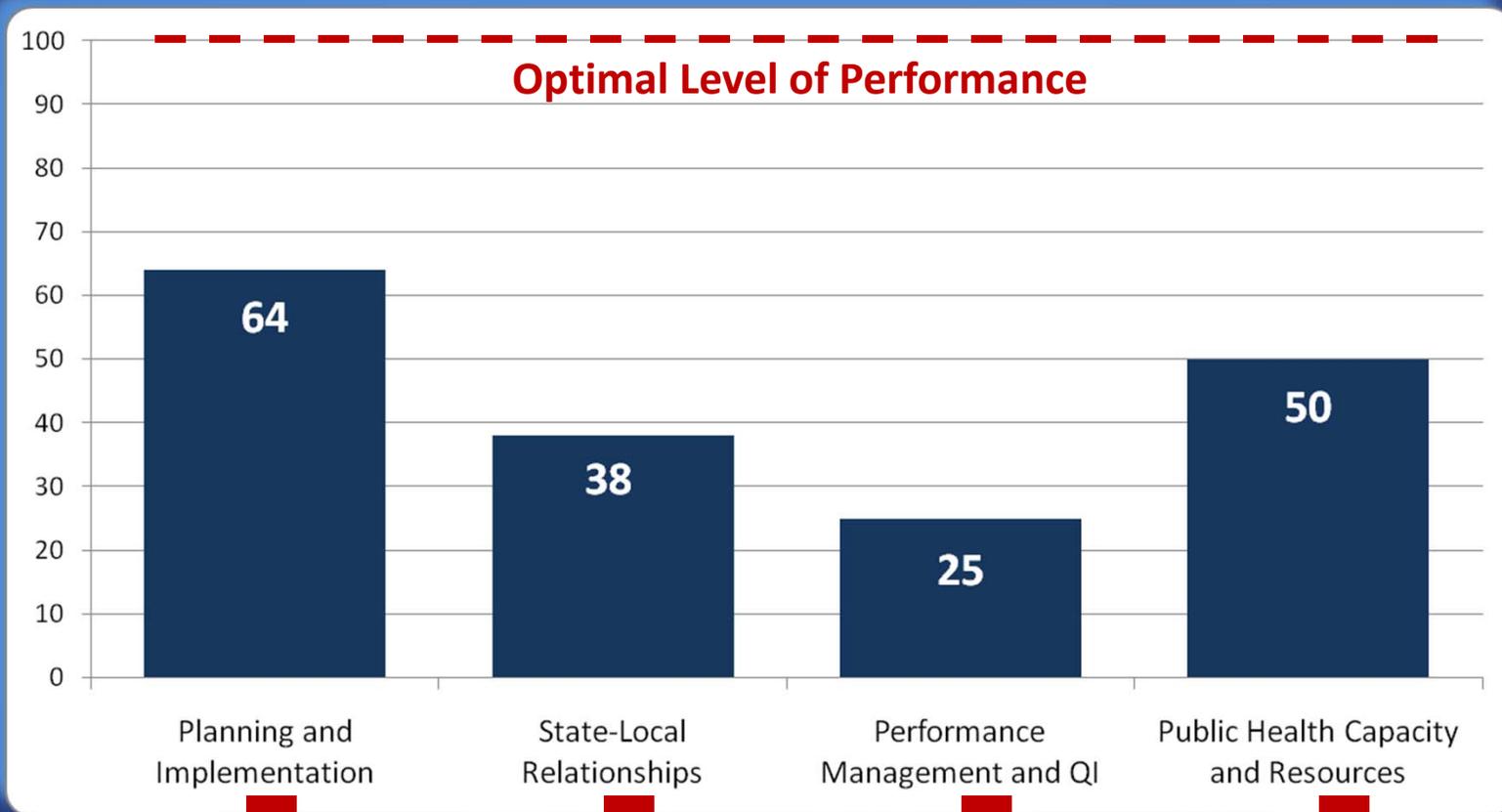
EPHS #8 Workforce

EPHS #10 Research

Maine's overall strength: planning/implementation for many EPHS

Tool organized into 4 model standards.....

EPHS #4: Mobilize Communities



Level of Activity

Significant

Moderate

Minimal

Significant

EPHS #8: Public & Personal Health Workforce

Key Findings:

- No workforce development plan
- No single database with basic information on our non-clinical PH workforce
- Few \$\$ resources/incentives to support degree programs/lifelong learning

Possible Next Steps:

- Expand DOL workforce database to include the major categories of PH professionals in ME
- Conduct a workforce enumeration
- Develop a workforce development plan for ME including strategies for recruitment and retention

State Public Health System Assessment: Final Report Sept. 2010. Prepared by: Brenda Joly, George Shaler, Maureen Booth, Muskie School, University of Southern Maine

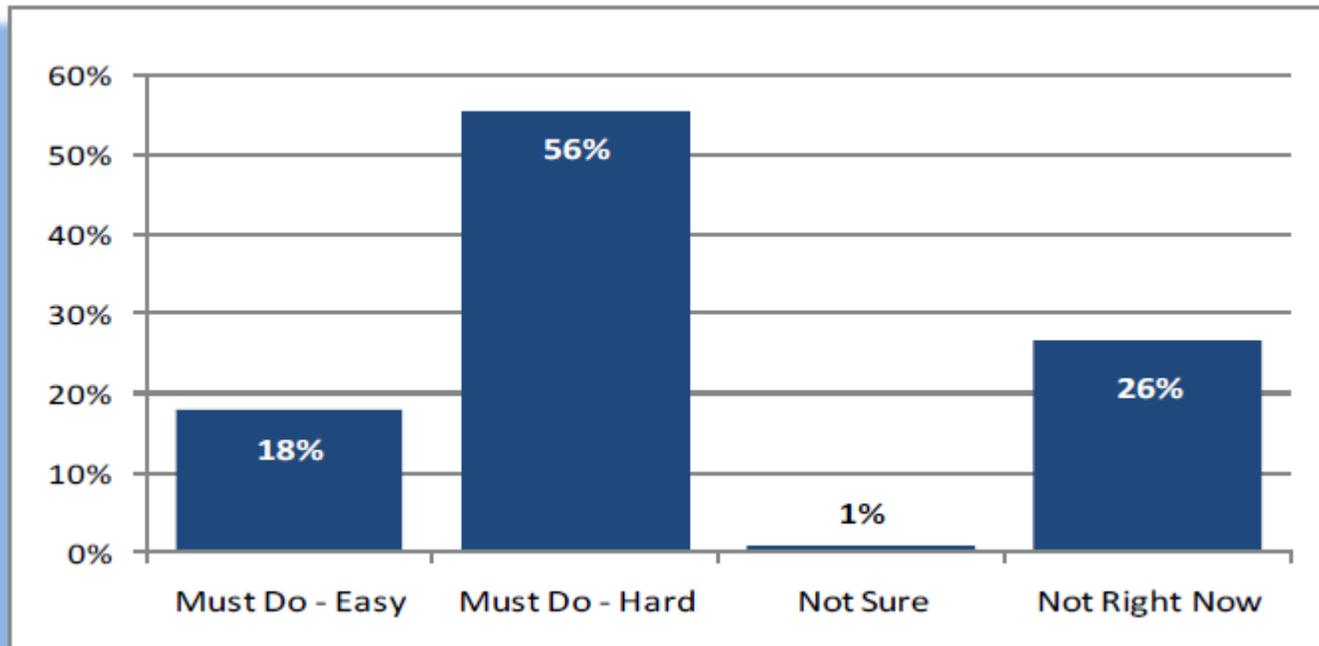
ME: State Assessment Priority Setting: The Process

2010 SEPT: Kickoff meeting for improvement planning process
~ 75 of the original assessment participants

- 1. Automated, anonymous voting using Turning Technology.**
 - Review 117 items reviewed
 - Asked to rate each item
- 2. Obtained feedback generated from priority setting process**
 - Small groups divided up by area of interest
 - Each group voted on 1-3 priority areas for initial focus
 - Root cause analysis exercise (“5 whys”)
- 3. If time available, brainstorm strategies based on root causes**

ME: State Assessment Priority Setting: 117 items reviewed and prioritized

CHART 1. PRIORITY SETTING RESULTS ACROSS ALL ESSENTIAL PUBLIC HEALTH SERVICES



ME: State Assessment Priority Setting: Examples of the 19 Key Priorities

- Conduct review of existing/proposed PH laws
- Integrating statewide strategies in community health plans
- Mobilize assets to reduce health disparities
- Developing a public health research agenda

ME: State Assessment Priority Setting: Small Group Discussion: Example A

EPHS #7: *Problem statement:*

- 1) Health care services and programs do not provide adequate access for all Mainers
- 2) Public health services and programs are not adequately mobilized to reduce health disparities, including in emergencies”.

Strategies based on root cause analysis:

- ✓ Develop local communications plans and standards for communicating and sharing
- ✓ Define and implement “core” infrastructure requirements for basic prevention and health care services
- ✓ Develop local action plans and pilots to realize vision with statewide support where necessary

ME: District & State Rankings & Priorities compared

No great variation in scores between SPHA & LPHSAs except for EPHS 1-6.

State Numerical Rankings:

EPHS 3	3 rd out of 10
EPHS 4	4 th out of 10
EPHS 7	6 th out of 10

District EPHS Priorities

8 Districts chose EPHS 7 (link)

6 Districts chose EPHS 3 (inform) and EPHS (partner)

What does this tell us?

District priorities do not correlate with the rankings in the SPHSA with the exception of EPHS 7 (Fox et.al, 2012)

SCC SPHSA Next Steps Subcommittee. March 2012 progress report.

Stephen Fox, Chair, and J.Bernard, J.Joy, J.Mando, K.Perkins, P.Thomson, A.Westhoff

How should we select the capacity improvement objective?

Degree of specificity?

- One entire EPHS to be used ongoing and thematically

OR

- One specific model standard for time bound measurable progress

Effort invested already? time frames?

- Embrace the priorities solely derived from the Sept 2011 meeting

OR

- Integrate new information based on progress since 2010 to inform the final selection of the priority?

Target of change and metric for progress:

- One system change objective which improves state level system capacity, which everyone champions, so that if it occurs it will have impact statewide *and* all substate systems equally?

OR

- One change objective, applied differently given each system's configuration (state, district, municipal, tribal), with greater challenge to find a shared metric to document progress

- Choose one of the 19 priority recommendations from the earlier priority setting dialogue, and develop strategies to accomplish
- Select one of the 10 root cause problems from the Sept 2010 meeting and select from the strategies
- Review all sources for strategies once the core capacity building target has been identified (SPHSA, LPHSA, DPHIP) as the starting points

Questions?

Input to Priority Setting

What reactions and thoughts do you have about the State Health Assessment data?

Input to Priority Setting

What reactions and thoughts do you have about the State Public Health Systems Assessment data?

Input to Priority Setting

What are your initial thoughts about PRIORITIES
for the SHIP?