REPORT

Healthy Maine Partnerships' FY13 Contracts and Funding –HMP Lead Selection Approach Appropriate but Process Poorly Implemented and Allowed for Manipulation; Funding Consistent Across HMPs Based on Role; Documentation Insufficient to Support Key Decisions

Report No. SR-CDCHMP-13

Issues OPEGA noted during this review:

- Existing HMP performance data was not useful for lead selection; criteria used lacked measures relevant to key lead responsibilities in new structure. (pg. 26)
- Multiple weaknesses in MCDC's scoring methodology undermined credibility of the process and presented opportunity for MCDC to manipulate final outcomes. (pg. 26)
- MCDC's process was not well documented making it difficult to confirm accounts of how, and on what basis, key decisions were made. (pg.28)
- Contract for the Tribal District HMP was handled differently than the other HMPs. (pg. 30)

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

December
2013
(as revised
January 2014)

GOVERNMENT OVERSIGHT COMMITTEE OF THE 126TH LEGISLATURE

Senator Emily Ann Cain, Chair
Senator Roger J. Katz
Senator David C. Burns
Senator Margaret M. Craven
Senator Christopher K. Johnson
Senator Edward M. Youngblood

Representative Chuck Kruger, Chair
Representative Paul T. Davis, Sr.
Representative Andrea M. Boland
Representative H. David Cotta
Representative Lance Evans Harvell
Representative Matthew J. Peterson

OFFICE OF PROGRAM EVALUATION & GOVERNMENT ACCOUNTABILITY

Director Beth Ashcroft, CIA

Staff
Wendy Cherubini, Senior Analyst
Scott Farwell, Analyst
Matthew Kruk, Analyst
Etta Connors, Administrative Secretary

Maura Pillsbury, Contracted Analyst

Mailing Address:
82 State House Station
Augusta, Maine 04333-0082
Phone: (207) 287-1901
Fax: (207) 287-1906
Web: http://www.maine.gov/legis/opega/
Email: etta.connors@legislature.maine.gov

ABOUT OPEGA & THE GOVERNMENT OVERSIGHT COMMITTEE

The Office of Program Evaluation and Government Accountability (OPEGA) was created by statute in 2003 to assist the Legislature in its oversight role by providing independent reviews of the agencies and programs of State Government. The Office began operation in January 2005. Oversight is an essential function because legislators need to know if current laws and appropriations are achieving intended results.

OPEGA is an independent staff unit overseen by the bipartisan joint legislative Government Oversight Committee (GOC). OPEGA's reviews are performed at the direction of the GOC. Independence, sufficient resources and the authorities granted to OPEGA and the GOC by the enacting statute are critical to OPEGA's ability to fully evaluate the efficiency and effectiveness of Maine government.

Requests for OPEGA reviews are considered by the Government Oversight Committee in accordance with a standard process. Requests must be made in writing and must be initiated or sponsored by a legislator. Individual legislators or citizens should review the process and FAQ that are posted on OPEGA's website at http://www.maine.gov/legis/opega/ProcessProducts.html. There is also a form there to help facilitate the GOC's consideration of the request. Legislative committees can request reviews directly through a written communication to the Government Oversight Committee.

Copies of OPEGA's reports are free.
Reports are available in electronic format at:
http://www.maine.gov/legis/opega/

Hard copies of reports may be obtained by contacting OPEGA at:

(207) 287-1901

Office of Program Evaluation & Government Accountability

82 State House Station • Augusta, ME • 04333-0082

Table of Contents

Introduction 1
Questions, Answers and Issues 2
In Summary 4
Background 7
Overview of HMP Program 7
Monitoring HMP Performance 8
Overview of MCDC HMP Lead Selection Process and Timeline 9
DHHS Internal Review of Scoring Methodology 12
Lack of Competitive Process Was Not Ideal, Although MCDC Followed DAFS Guidance 12
DAFS Purchases Division Advised MCDC that an RFP Process Was Not Necessary for FY13 Contracts 12
Lack of Competitive Process Was Not Ideal 13
MCDC's Lead Selection Process Was Poorly Implemented and Allowed for Manipulation 14
MCDC Managers Were Integrally Involved in the Lead Selection Process 14
Atypical Methodology Used for Survey of Project Officers and District Liaisons 17
Criteria and Weighting Changed During the Lead Selection Process 18
Scoring Methodology Inconsistent and Emphasized Subjective Criteria 18
Scoring Methodology Possibly Adjusted to Influence Outcome in Penquis District 20
HMP Funding Was Divided Evenly Based on Role, Resulting in a Large Decrease for Some HMPs 22
Incomplete Documentation of the Lead HMP Selection Process Maintained 24
Agency Decision Making Process Was Not Fully Documented 24
Staff Were Instructed to Destroy Documents 25
Recommendations 26
Agency Response 31
Acknowledgements 31
Appendix A. Scope and Methods 32
Appendix B. Map of Local Healthy Maine Partnerships 33
Appendix C. MCDC Public Description of the Lead Selection Criteria and Scoring Methodology 35
Appendix D. MCDC Public Description of HMP Structure and Funding Changes for FY13 38
Appendix E. Healthy Maine Partnerships Scoring Matrix as Publicly Released by MCDC 41
Agency Response Letter

This page left intentionally blank.

Healthy Maine Partnerships' FY13 Contracts and Funding – HMP Lead Selection Approach Appropriate but Process Poorly Implemented and Allowed for Manipulation; Funding Consistent Across HMPs Based on Role; Documentation Insufficient to Support Key Decisions

Introduction

The Healthy Maine Partnerships Program is administered by the Maine Center for Disease Control and Prevention and implemented through independent, local HMP coalitions.

For FY13, MCDC made significant changes to the HMP program structure and funding distributions to the HMP coalitions. These changes were announced in June 2012 and public questions quickly arose about the process MCDC used to make its decisions.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of the Healthy Maine Partnerships' Contracts and Funding for Fiscal Year 2013 (FY13). This review was performed at the direction of the Government Oversight Committee (GOC) for the 126th Legislature.

The Healthy Maine Partnerships program is a community based approach to affecting policy and environmental changes in support of healthier schools, work places and communities. The program is administered by the Maine Department of Health and Human Services' (DHHS) Center for Disease Control and Prevention (MCDC) and implemented through independent, local coalitions known as Healthy Maine Partnerships (HMP). The program is primarily supported by appropriations from the Fund for a Healthy Maine (FHM). Historically MCDC has awarded grants based on a competitive process directly to between 27 and 28 local HMPs collectively serving the State's eight Public Health Districts. Beginning in FY12, MCDC also provided funding to establish a dedicated Tribal Healthy Maine Partnership under the authority of Maine's four Tribal Nations. Total FHM funding distributed to the HMPs and Tribal Health District in FY12 was $7.5 million.

MCDC made significant changes to the program's organizational structure and funding distribution for FY13 to absorb funding cuts included in the DHHS-MaineCare Emergency Supplemental Budget. MCDC selected and distributed funding to one lead HMP in each of the eight Public Health Districts, as well as the Tribal District HMP. The lead HMPs were directed to subcontract with, and provide a set amount of funding to, the other HMPs in their Public Health Districts now referred to as "supporting" HMPs. Under MCDC's new structure, lead HMPs received more funding than supporting HMPs with most supporting HMPs realizing significant cuts from prior year funding.

In June 2012, MCDC announced the new HMP organizational structure, the lead HMPs, and funding distributions for FY13. Public questions quickly arose about the process MCDC used to determine the lead HMPs and funding amounts. In July 2012, legislators representing Lewiston-Auburn pursued explanations from DHHS regarding the lead agency selected for the Western Maine Public Health District and the Lewiston Sun-Journal submitted a Freedom of Access Act (FOAA) request to DHHS seeking documents supporting MCDC's decisions.

Allegations made by a MCDC senior manager in April 2013 prompted renewed legislative concerns about the process used to select lead HMPs and the potential shredding of related documents. Those concerns were the focus of OPEGA's review.

In April 2013, a senior manager at MCDC who participated in the HMP lead selection process filed a complaint with the Maine Human Rights Commission, claiming she had been asked by her supervisor to shred documentation related to the selection process, and alleging the process was biased and flawed. In July 2013, the senior manager resigned. She has since filed a civil suit against DHHS alleging, among other things, that she was subjected to a hostile workplace because she did not shred documentation when instructed to do so. As of December 2013, this lawsuit is still ongoing.

These allegations prompted renewed legislative concerns resulting in an April 2013 request for an OPEGA review signed by five legislators, including those representing the Western Maine Public Health District. The request included concerns about MCDC's alleged shredding of documents related to the FY13 HMP awards, and the process used to select lead HMPs and distribute funds among the various HMPs. These concerns were the focus of OPEGA's review. The questions addressed by OPEGA were approved by the GOC prior to the review's initiation. See Appendix A for complete scope and methods.

Questions, Answers and Issues

1. Did the Maine CDC use appropriate and consistent processes for scoring HMPs, selecting lead HMP agencies, awarding contracts and determining how funds would be allocated among the HMPs for FY13?

see page 14 for more on this point

OPEGA found the lack of a new request for proposal (RFP) process for the FY13 grant awards was not ideal given the change in roles and responsibilities for HMPs selected as leads. However, MCDC did not have sufficient time to complete its typical RFP process and followed guidance from Department of Administrative and Financial Services' Division of Purchases in deciding to pursue an alternative approach.

OPEGA also found that while the overall approach MCDC envisioned for selecting lead agencies could have been an appropriate alternative, the manner in which it was implemented – selecting criteria, scoring HMPs and final selection of leads – was neither appropriate nor consistent. Multiple problems with the process undermined the integrity and credibility of the results and created an opportunity for MCDC to intentionally manipulate the lead selection. There are strong indications, including accounts from multiple interviewees, that such intentional manipulation may have occurred in the selection of the lead for the Penquis District.

The means for determining the funding distribution among HMPs differed from prior years, but was consistent across HMPs. Previously, a population-based funding formula was used. For FY13, MCDC determined a base level of funding for each HMP's programmatic work and then distributed additional funds to the lead HMPs for their administrative role and public health infrastructure work. According to MCDC, the base level of funding for each HMP was determined based on an analysis of the amount of funding needed for operating expenses and one full-time staff person.

2. Did Maine CDC maintain adequate documentation supporting key HMP scoring, selection and funding decisions for FY13? Were any documents related to the scoring, selection or funding decisions for the FY13 HMP contracts disposed of or concealed?

see page 24 for more on this point

OPEGA found that MCDC did not maintain sufficient documentation to support key decisions in the course of its FY13 HMP lead selection process. MCDC staff provided OPEGA with several documents related to the FY13 HMP scoring and selection decisions. However, OPEGA had difficulty reconstructing details of the events that occurred, in part due to lack of sufficient documentation created by MCDC during what became an iterative process for selecting criteria and scoring HMPs.

DHHS told OPEGA that in making revisions to the scoring matrix, MCDC had saved over previous versions of the file. MCDC management acknowledged that there was direction or guidance that only documentation showing final results of their process should be retained; not "working copies". However, MCDC staff saved several versions of the scoring sheet and provided them to OPEGA for review.

Based on accounts provided by MCDC managers, there was a next to final version of the scoring matrix which showed a different outcome for lead selection in the Penquis District prior to final adjustments to criteria and/or scoring methodology. Several interviewees acknowledged that a paper copy of this version of the matrix existed at a June 13, 2012 meeting – the day before MCDC's public announcement of its lead selections – but it was considered a "working copy". This document was not provided to OPEGA, nor in response to any Freedom of Access Act requests (FOAA). To date, there has also been no electronic version of this document located through searches of computer files and backup tapes performed by Maine's Office of Information Technology.

OPEGA did not identify any documentation that was withheld in response to the FOAA requests DHHS received. However, we know a document similar in description to the scoring matrix referenced above is claimed to have been in the files of a former MCDC senior manager and it has not been provided in response to her FOAA request.

OPEGA identified the following issues during the course of this review. See pages 26-30 for further discussion and our recommendations.

- Existing HMP performance data was not useful for lead selection and criteria used lacked measures relevant to key lead responsibilities in new structure.
- Multiple weaknesses in MCDC's scoring methodology undermined credibility of the process and presented opportunity for MCDC to manipulate final outcomes.
- MCDC's process was not well documented making it difficult to confirm accounts of how, and on what basis, key decisions were made.
- Contract for the Tribal District HMP was handled differently than the other HMPs.

In Summary

In early 2012, MCDC planned to absorb expected funding cuts by restructuring the HMP program from 27 local HMPs to nine. DAFS Purchases advised a new RFP process was not needed and MCDC began exploring how to identify the "best" HMP in each Public Health district.

In December 2011, the Department of Health and Human Services proposed cutting nearly all funding for the Healthy Maine Partnerships (HMP) program as part of its FY13 Emergency Supplemental Budget in order to address a funding shortfall in the MaineCare program budget. Anticipating that the Legislature would approve some portion of this cut, MCDC began formulating a plan to restructure the HMP program from 27 local HMPs to nine, one for each of the eight Public Health Districts and one for the Tribal District. MCDC consulted with the Department of Administrative and Financial Services' Purchases Division (DAFS Purchases) in late February 2012 to determine whether a new competitive request for proposals (RFP) process was needed to reduce the number of HMPs. DAFS Purchases advised that MCDC did not need to issue a new RFP to reduce the contract scope and terminate contracts with some HMPs. DAFS Purchases also advised, however, that MCDC establish a transparent and justifiable process for doing so.

In May 2012, the Legislature passed a budget cutting funding for the HMP program by about one-third and requiring that MCDC continue funding all 27 HMPs. MCDC decided to restructure by selecting nine lead HMPs that would subcontract with the other 18 supporting HMPs.

A core group of MCDC managers and staff began meeting in April 2012 to determine how to identify the "best" HMPs in each Public Health District. They developed a survey for the Project Officers and District Liaisons that worked closely with HMPs and explored other relevant criteria that could be measured. In May 2012, the Legislature passed the Emergency Supplemental Budget, reducing FHM funding for the HMP program by approximately one-third, from $7.5 million to $4.7 million. The budget included a provision requiring MCDC to continue funding all 27 HMPs. MCDC decided to move forward with its plan to restructure the program by funding nine lead HMPs that would subcontract with the 18 others as supporting HMPs.

A core group at MCDC chose selection criteria, discussed scoring results and revised criteria and scoring methodology. Based on total scores, they selected eight lead HMPs – one for each district. The one HMP in the Tribal District was also designated a lead HMP. MCDC announced the changes in structure and funding in mid-June 2012.

The core group continued to meet throughout May and June 2012 to choose selection criteria for the lead HMPs, discuss scoring results, and revise the criteria and scoring methodology. They selected eight lead HMPs based on five criteria including: cost of operations; salary guide compliance; support and promotion of developing infrastructure; survey of project officers; and survey of district liaisons. One tiebreaker criterion - average completion of tobacco-related and physical activity and nutrition-related milestones – was applied for Central Public Health District only. The Tribal District HMP was not included in this process as there is only one HMP in that District. The results of the selection process were announced in mid-June 2012 and grants were awarded under the new structure beginning in FY13. The grant awards were renewed for FY14. MCDC plans to renew them again for FY15 and issue a new RFP for the FY16 award.

OPEGA acknowledges that MCDC did not have sufficient time to complete its typical RFP process and followed guidance from DAFS Purchases by pursuing an alternative approach. The lack of a new RFP process in light of the new lead HMP role, however, was not ideal. MCDC gave lead HMPs new responsibilities as subgrantee administrators to the supporting HMPs, including monitoring the supporting HMPs' performance and service delivery, and as leaders in developing the public health infrastructure in their districts. According to DAFS Purchases, MCDC did not consult with them further when the plan switched from reducing the number of HMPs to reorganizing to a lead and supporting HMP structure.

MCDC did not have time to complete a typical RFP process, but the lack of a competitive process in this situation was not ideal. Although MCDC's overall approach to lead selection was an appropriate alternative, it was implemented in an inappropriate and inconsistent manner.

OPEGA also found that while the overall approach MCDC envisioned for selecting lead agencies was an appropriate alternative for its typical process given the time constraints faced, it was implemented in an inappropriate and inconsistent manner. According to MCDC, existing HMP performance data was not useful for lead selection and the selection criteria evolved throughout the process. Some criteria were eliminated from consideration because they were either too subjective or, after scoring, they did not sufficiently differentiate the HMPs from each other. OPEGA found the criteria ultimately used lacked measures relevant to key responsibilities in new structure.

OPEGA also found that the scoring methodology was flawed and inconsistent, concurring with DHHS's Office of Quality Improvement Services (OQIS) that the scoring methodology was made overly complex by the use of aggregate scores, rankings, weightings, and an extra measure used as a tie breaker. The weighting also led subjective criteria to be emphasized more than objective criteria. Additionally, the selection criteria and scoring methodology changed throughout the process. In order to maintain the integrity of the process, MCDC should have selected criteria and set the scoring methodology at the outset, before initiating scoring. Multiple problems with the lead selection process undermined the integrity and credibility of the results and created an opportunity for MCDC to intentionally manipulate the outcome of the lead selection. OPEGA found strong indications, including accounts from multiple interviewees, that the scoring results may indeed have been intentionally manipulated to alter the outcome in the Penquis District.

Multiple issues with the scoring methodology undermined the integrity and credibility of results and created an opportunity for MCDC to manipulate the outcomes. There are strong indications that such intentional manipulation may have occurred in selecting the lead for the Penquis District.

Regarding HMP funding levels, OPEGA found that the means for determining the funding distribution among HMPs differed from prior years, but was consistent across HMPs. Previously, a population-based funding formula had been used. For FY13, MCDC determined a base funding level of $120,000 for each HMP's programmatic work and then distributed additional funds to the lead HMPs - $28,336 for their administrative role and $134,605 for public health infrastructure work. According to MCDC, the base funding each HMP received was determined based on an analysis of the amount of funding needed for operating expenses and one full-time staff person per HMP. The Tribal District received an additional $235,000 in funding for two Tribal District Liaisons and their administrative support. MCDC said these positions perform functions similar to the Public Health District Liaisons employed by MCDC which includes District-wide work outside the HMP program. OPEGA noted that the Tribal District HMP contract was handled differently than the other HMP contracts.

Regarding HMP funding levels for FY13, OPEGA found that the means for determining the distribution among HMPs differed from prior years, but was consistent across HMPs.

OPEGA also found that MCDC maintained incomplete documentation of the HMP lead selection process. The electronic version of the scoring matrix was apparently overwritten as the criteria and weightings changed and MCDC acknowledges that documents it considered "working" documents or drafts were not expected to be retained.

MCDC maintained incomplete documentation of the HMP lead selection process making it difficult for OPEGA to confirm accounts of how, and on what basis, key decisions were made. Two core group members were either instructed or advised to destroy documents but said they did not.

Two members of the core group said they had been instructed to destroy documents by a superior because only the final product should remain at the end of the process. They did not destroy their documents and OPEGA was able to obtain and review them. The superior who advised them to destroy documentation acknowledged doing so, but the accounts of the tenor and circumstances of these discussions differs among the three. Management at MCDC told OPEGA that they believed this instruction may have resulted from a desire for version control, or to keep survey responses confidential, rather than to intentionally cover something up.

OPEGA notes that an agency cannot reasonably be expected to retain every working document. However, in this instance the working documents were the only written record of MCDC's process generated during the process. Consequently, it was difficult for OPEGA to confirm accounts of how, and on what basis, key decisions were made.

OPEGA did not identify any documentation provided to us that was withheld in response to FOAA requests. However, a next to final version of the scoring matrix apparently existed in paper copy at least until mid-June 2012. It was not provided to OPEGA or in response to FOAA requests. According to DHHS, it was considered a working copy that was not expected to be retained.

OPEGA did not identify any documentation provided to us that was withheld in response to the FOAA requests DHHS received. However, we were not provided a next to final version of the scoring matrix referenced by multiple interviewees which showed a different outcome for the lead HMP in the Penquis District. We also did not locate it among the electronic documents resulting from a search of back-up tapes and computer drives conducted by the Office of Information Technology. This document is acknowledged to have existed in paper copy up until at least June 13, 2013 – the day before MCDC publicly announced the new HMP structure and funding decisions – but was considered a "working" document. OPEGA is aware that the former MCDC Director of Local Public Health, who was part of the core group, claims she had a paper copy of a document similar in description to this in her files, but it has not been provided in response to her FOAA request and was not provided to OPEGA by DHHS.

Background

Overview of HMP Program

Maine's HMP Program is consistent with efforts by the U.S. CDC to address tobacco use and chronic diseases. HMP activities build upon CDC's approach toward four specific goals.

Maine's HMP Program is a community based approach to affecting policy and environmental changes in support of healthier schools, work places and communities. According to MCDC, this approach is evidence-based and consistent with current efforts by the United States Centers for Disease Control and Prevention (CDC) to address tobacco use and chronic diseases. In Maine, the HMP activities reflect and build upon CDC's Healthy Communities approach to addressing chronic disease and tobacco use.

The specific goals of the HMPs are to:

1. Ensure Maine has the lowest smoking rate in the nation.
2. Prevent the development and progression of obesity, substance abuse, and chronic diseases related to or affected by tobacco use.
3. Optimize the capacity of Maine's cities, towns, and schools to provide health promotion, prevention, education, and self-management of health.
4. Develop and strengthen local capacity to deliver essential public health services across the State of Maine.

HMP activities are primarily carried out by grantees, referred to as local HMPs, that work with a variety of community partners and school districts. In FY13, MCDC established a new HMP structure and now contracts with a lead HMP in each public health district. The lead subcontracts with other HMPs in that district.

The activities to obtain these goals are primarily carried out by grantees, referred to as local HMPs, that work with a variety of community partners and school districts in their service areas. Appendix B contains a listing of the local HMPs and their locations as well as a graphic illustrating the HMP structure. As described in the Introduction, beginning in FY13 MCDC established a new HMP structure and now contracts with a lead HMP in each of the eight geographic public health districts. Lead HMPs subcontract with other HMPs in their districts.

HMP results are policy or environmental changes that support the initiative's goals. For example, an HMP grantee may work with a local school district to establish a policy that reduces unhealthy food available in vending machines. Achievement of this strategy links this environmental change to the HMP initiative's goals of preventing the development and progression of obesity and of optimizing the capacity of towns and schools to provide health promotion.

Lead HMPs are also tasked with developing and strengthening local capacity to deliver essential public health services across their district. According to MCDC, this capacity allows HMPs to assess local public health needs and develop plans to address these needs. The infrastructure/capacity development component includes conducting the following activities: coalition development, supporting the implementation of specified assessment activities and products, convening and support of the District Coordinating Council for public health, and organization and oversight of local responses to public health emergencies and issues.

Statute also establishes District and Statewide Coordinating Councils made up of public health stakeholders as components of the State's public health infrastructure.

Statute establishes District Coordinating Councils (DCC) and a Statewide Coordinating Council for public health (SCC) as components of the State's public health infrastructure. These are representative bodies of public health stakeholders working toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system.[1] The SCC is required to report annually to the Joint Standing Committee on the Health and Human Services and the Governor's office on public health system progress made as a result of its work.

Monitoring HMP Performance

DHHS employees are responsible for supporting and monitoring the work of the HMPs. These include District Liaisons in MCDC's Division of Local Public Health and other staff from MCDC and SAMHS that act as Project Officers.

Although HMP work is carried out by grantees working in collaboration with schools and communities across Maine, employees of DHHS are responsible for monitoring that work and ensuring it is completed effectively and efficiently. According to MCDC, DHHS staff from MCDC and Substance Abuse and Mental Health Services (SAMHS) act as Project Officers supporting local HMP work.

Each HMP is under the oversight of, and supported by, a District Support Team, comprised of a HMP Project Officer from one of the component programs of the HMP initiative, a District Liaison from the Division of Local Public Health, and program specialists. The District Support Team is responsible for assuring that each HMP receives necessary monitoring and support of all HMP contractual activities and deliverables. Together, the Project Officers and District Liaisons provide oversight and technical support to grantees through regular contact with local HMP staff. They also review information and data entered into a web-based monitoring system. The Team monitors contract compliance of the lead HMP, and work plan implementation and overall performance of all HMPs, within their assigned district.

According to MCDC, it has historically collected data and information to use in assessing HMP performance through several avenues.

According to MCDC, the following information has historically been available for use in assessing performance. OPEGA did not review the available data as part of this project.

- Quarterly Narrative Reports – all HMPs, as part of their Knowledge-based Information Technology system reporting requirements, briefly describe their efforts over the past quarter, including significant successes and barriers they have encountered. HMPs are also asked to provide examples of successes they have had in their local work.
- Knowledge-based Information Technology (KIT) Data – all HMPs are required to report on their work plan activities in KIT. The HMPs enter reporting data through a web portal. This data becomes available in real time for MCDC staff to review. MCDC uses this data to assess each HMP's progress toward accomplishing their work plan objectives; for example, the different strategies each HMP is implementing, the effort directed to various populations, how completion of the work plan is progressing and what specific efforts are planned in each Health Promotion Category.

[1] 22 MRSA §412.4 and §412.6

- Site Visits – conducted by the Project Officers responsible for each HMP. Visits are conducted several times annually. These informal site visits occur throughout the contract year as necessary and convenient for the local HMPs.
- Statewide Surveillance Statistics from the Behavioral Risk Factor Surveillance System (BRFSS) – administered by the federal CDC. This is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors throughout the United States and its territories. About 6,500 Maine adults participate in the survey each year.
- Statewide Surveillance Statistics from the Maine Integrated Youth Health Survey (MIYHS) – administered by MCDC, SAMHS and Department of Education. This instrument combines several State health surveys with the Youth Risk Behavioral Survey, a national health surveillance survey for school-aged children.
- HMP Evaluation Data – The University of New England's Center for Community & Public Health is contracted by MCDC to evaluate the HMP initiative. For example, the Evaluation Team has used KIT data to produce data sheets highlighting HMP accomplishments statewide and by district in the areas of tobacco, nutrition, chronic disease, physical activity and coordinated school health.

Overview of MCDC HMP Lead Selection Process and Timeline

In January 2012, in anticipation of funding cuts, MCDC began exploring changing the HMP funding structure as a means to reduce the program's administrative costs and create a more efficient way to deliver the most needed preventive health services.

In December 2011, the Maine Department of Health and Human Services (DHHS) faced a significant FY13 funding shortfall resulting from Maine Care cost overruns. The Governor submitted an Emergency Supplemental Budget bill to the Legislature that proposed cutting nearly all funding to the Healthy Maine Partnerships (HMP) program, which is primarily funded by the Fund for Healthy Maine. The Maine Center for Disease Control and Prevention (MCDC), anticipating that the Legislature would approve some level of cuts to the program, began exploring how to reduce the program's administrative costs and create a more efficient way to deliver the most-needed preventive health services to Maine communities.

MCDC was considering reducing the number of HMPs from 27 to nine and identifying a more focused set of program objectives. DAFS Purchases advised MCDC did not need to issue a new RFP in that instance and MCDC proceeded with an alternative approach to select the "best" HMP in each public health district.

MCDC decided this could be accomplished by changing the HMP funding structure and identifying a more focused set of program objectives beginning in FY13. In January 2012, MCDC staff began discussing the scenario of moving from 27 local HMPs to nine – one for each of the State's eight Public Health Districts and one for the Tribes. MCDC met with Department of Administrative and Financial Services' Purchases Division (DAFS Purchases) in February 2012 to obtain guidance on whether a new RFP was needed if they reduced the number of HMPs. As described in more detail on page 12, DAFS Purchases advised that a new RFP was not needed and MCDC proceeded with an alternative approach because the existing grant awards to the 27 HMPs were already based on a formal competitive request for proposal (RFP) process. By April 2012, a core group of MCDC managers and staff began discussing the criteria they would use for selecting the "best" HMPs in each Public Health District.

The budget passed in mid-May 2012 cut funding for the program by one-third and required that MCDC continue to fund all 27 HMPs. MCDC's approach to restructuring shifted from reducing the number of HMPs to selecting nine lead HMPs using the same criteria and a scoring process.

The Legislature passed the Emergency Supplemental Budget in May 2012, resulting in cuts to the HMP program of more than one-third, from $7.5 million to $4.7 million. Just prior to passage, the budget was amended to include a requirement that MCDC continue funding the same number of HMPs – all 27. Despite this requirement, MCDC decided to proceed with a change in the HMP structure to move from directly funding 27 HMPs to directly funding nine lead agencies that would subcontract with the remaining 18 HMPs. The lead HMPs would each receive funding for supporting local public health infrastructure and capacity development in their districts, as well as programmatic work. The lead HMPs would be required to provide a set amount of funding for programmatic work to each of the remaining HMPs as well.

MCDC's approach shifted from reducing the number of HMPs from 27 to nine to selecting nine lead HMPs using the same selection criteria and a scoring process described further beginning on page 14.[2] MCDC initiated the scoring process in early May 2012 with surveys of the Project Officers (POs) and District Liaisons (DLs) that worked closely with the HMPs. From May to June 2012, the core group met multiple times to revise the criteria and scoring methodology.

MCDC initiated the scoring process in early May 2012 with surveys of the POs and DLs. A core group at MCDC met multiple times from May to June to revise the criteria and scoring methodology. The new lead structure and funding distributions were publically announced on June 14, 2012.

In late May 2012, MCDC met with stakeholders from the Friends for a Fund for Healthy Maine to solicit input on the planned changes. The stakeholder group included the Statewide Coordinating Council Co-Chair who was closely affiliated with the Bangor Region Public Health and Wellness HMP and, according to MCDC, served as a representative of the HMP perspective. MCDC did not seek information or input from individual HMPs as part of its planning and selection process.

The HMP scoring process was completed in June 2012. The new lead structure and funding distribution was announced by the MCDC Director on June 14, 2012 at a meeting of the Statewide Coordinating Council. MCDC posted several documents to its website that day describing the changes and the process used to make the lead selections. All HMPs selected as leads were contacted by June 18, 2012 and agreed to assume the lead role. Supporting HMPs were also contacted at that time.

From mid-June through the end of July 2012, MCDC and DHHS responded to questions and concerns from individual HMPs and legislators about these changes and the selection process. MCDC also began receiving media inquiries and received the first of several official Freedom of Access Act information requests on July 2, 2012.

[2] MCDC intended that the nine HMPs would be one for each of the eight Public Health Districts plus the HMP for the Tribal District. Since there was only one HMP in the Tribal District, MCDC did not include that District or HMP in its scoring process.

Table 1 provides a detailed timeline of events relevant to this review, the HMP lead selection process and the overall changes in FY13 HMP structure and funding.

Table 1: Timeline of Relevant Events Related to HMP Lead Selection

Time Frame	Description
November 2010	Bidders conference held to begin RFP process for FY12 HMP award.
July 1, 2011	Contracts awarded to 26 HMPs as a result of RFP process. Tribal HMP contract also awarded.
December 2011	DHHS proposes cuts to HMP program in FY13 Emergency Supplemental Budget.
January 2012	MCDC begins strategizing about possible move to nine HMPs.
February 29, 2012	MCDC core group members meet with DAFS Purchases for guidance on whether an RFP process is needed to reduce the number of HMPs.
April 2012	MCDC core group begins meeting to select criteria for determining best performing HMPs.
May 3, 2012	MCDC conducts surveys of District Liaisons.
May 8, 2012	Provision requiring MCDC to fund all 27 HMPs is added to the budget.
May 16, 2012	FY13 Supplemental Budget passes, including one-third cut in HMP funding, from $7.5 million to $4.7 million, and requirement for MCDC to fund all 27 HMPs.
May 16, 2012	MCDC conducts surveys of Project Officers.
Late May 2012	Purpose of HMP selection shifts from choosing nine HMPs to choosing nine lead HMPs.
May 29, 2012	MCDC meets with stakeholders from the Friends for a Fund for Healthy Maine to solicit input on the planned changes.
May through June 2012	Criteria and scoring methodology are revised multiple times.
June 6, 2012	MCDC core group meets with the Director of MCDC to present the results of their lead selection process.
June 13, 2012	Director of MCDC and core group members meet with the Commissioner of DHHS to present the results of their lead selection process.
June 14, 2012	Director of MCDC announces new HMP structure, funding distribution and lead selection at State Coordinating Council meeting.
June 18, 2012	MCDC has contacted lead HMPs who have agreed to serve in that role and is in process of contacting supporting HMPs.
Mid-June through July 2012	MCDC responds to questions from HMPs and concerned legislators.
July 1, 2012	Contracts awarded to nine lead HMPs, terminated with 18 supporting HMPs.
July 2, 2012	Lewiston Sun Journal submits initial Freedom of Access Act request to DHHS. This FOAA is the first of multiple requests DHHS receives from various parties.
April 26, 2013	DHHS Office of Quality Improvement Services completes report on the HMP selection process identifying multiple issues.
July 1, 2013	Contracts renewed with nine lead HMPs for FY14.

Source: As determined by OPEGA from interviewee accounts and documentation reviewed.

DHHS Internal Review of Scoring Methodology

In April 2013, DHHS' Office of Quality Improvement Services completed an internal review of MCDC's scoring methodology. The resulting report noted some strengths of the process but ultimately concluded that there were a number of shortcomings impacting the integrity and credibility of the scoring and selection process.

In response to both internal questions and external scrutiny, the Commissioner of DHHS asked the DHHS Office of Quality Improvement Services (OQIS) to review the scoring component of the HMP selection process. OQIS works with internal and external stakeholders to assist in policy development and decision-making through the evaluation of service outcomes, analysis of reliable data structures and research.

The OQIS review, completed in April 2013, utilized interviews with key MCDC staff and review of multiple documents and data sources. The resulting report identified strengths and weaknesses of the process and ultimately concluded that "the process established to identify lead HMPs had a number of shortcomings that, when taken together, lead to doubts about the overall integrity and credibility of the scoring system and the resulting selection process." OPEGA reviewed the OQIS report and relied on the results included in it.

Lack of Competitive Process Was Not Ideal, Although MCDC Followed DAFS Guidance

MCDC consulted DAFS Purchases in February 2012 about whether an RFP process was needed to move to a new service model for the FY13 HMP grant award renewals. At this time, MCDC was planning to reduce the total number of HMPs – the lead structure had not been considered yet.

DAFS Purchases advised that a new RFP was not needed given the scenario MCDC described. DAFS Purchases further advised that MCDC use a consistent, justifiable process to select the HMPs it would continue to fund, though MCDC was not required to do so.

DAFS Purchases Advised MCDC that a RFP Process Was Not Necessary for FY13 Contracts

In late 2010 and into 2011, MCDC conducted a competitive process via a formal RFP to award HMP grants for FY12. The grants were renewable annually for a five year period. In accordance with State procurement rules, DAFS Purchases assisted MCDC with this RFP process and dealt with the appeals that followed the announcement of the awards. MCDC and DHHS Division of Contract Management (DHHS Contracting), which oversees the administration of the HMP contracts, defer to procurement guidance provided by DAFS Purchases.

MCDC and the DHHS Contracting consulted DAFS Purchases in February 2012 regarding the need to conduct another RFP process for the FY13 HMP grant award renewals. According to DAFS Purchases, MCDC was concerned about how to correctly move to a new service model due to significantly reduced funding. MCDC described the new service model as a reduced scope of services and fewer HMPs. DAFS Purchases advised that a new RFP was not necessary because MCDC planned to reduce, rather than expand, the scope of work for services that had already been competitively procured. There are also provisions in the HMP contracts allowing for the State to terminate them in this situation. Consequently, DAFS Purchases advised MCDC that it could exercise its professional judgment in selecting some HMPs for contract renewal, and terminate its contracts with others.

According to DAFS Purchases, MCDC did not have time to conduct a RFP process and the proposed changes for FY13 were considered to be a scoping down of work that had previously been competitively awarded.

DAFS Purchases was not involved in the selection process, and advised MCDC to use its programmatic expertise to determine how to select the HMPs using a consistent, justifiable process. DAFS Purchases told OPEGA that MCDC was not required to undertake such a selection process according to DAFS rules, but they advised MCDC to do so because it would make the agency's decision making process more transparent.

DAFS Purchases told OPEGA that there was no precedent for what to do in a situation where funding had been reduced and a program quickly needed to change its service model in order to continue operating. Because the program was in flux, and due to the complexity of the RFP process for this particular program, DAFS told OPEGA it would have been impossible for MCDC to conduct an RFP process to have contracts in place for the start of FY13. Since MCDC had completed a competitive RFP process for the FY12 contract year; DAFS saw the FY13 renewals as a scoping-down of previously competitively awarded work.

OPEGA concluded that MCDC did not consult with DAFS Purchases again when its plans changed to discuss whether the HMP lead role constituted an expansion of scope.

OPEGA concluded that at the time MCDC consulted with DAFS Purchases, its plan was to reduce the number of HMPs to nine. When MCDC changed its approach from selecting nine HMPs to selecting nine lead HMPs, it did not consult with DAFS Purchases again regarding whether the new lead role constituted an expansion or reduction in scope.

Lack of Competitive Process was Not Ideal

MCDC expanded the roles and responsibilities of the HMPs selected as leads for FY13. OPEGA observed that the lack of a competitive RFP process given this change was not ideal.

MCDC expanded the scope of work from the FY12 to FY13 contracts for the HMPs selected as leads. The lead HMPs gained responsibilities as subgrantee administrators for the supporting HMPs, including monitoring the supporting HMPs' performance and service delivery, and as leaders in developing the public health infrastructure in their districts. Although there were similar tasks included in the prior HMP contracts[3], the lead roles were new and carried greater responsibilities and expectations than MCDC had placed on HMPs in the past.

OPEGA observed that the lack of a competitive process with such a change in scope of work was not ideal. Additionally, MCDC chose not to solicit additional information from the HMPs on their ability or desire to fulfill the lead role, and instead excluded them from this process.

Although MCDC faced a limited timeframe to make changes to the program in light of funding cuts, the cuts were proposed by DHHS six months prior, and MCDC was thinking about changes to the program at least five months prior, to the contract expiration. MCDC stated, however, that it could not be confident in the budgetary outcome, and noted the budget was amended just prior to passage in May 2012 to include a requirement for 27 HMPs. This left MCDC very little time to form an alternate strategy, perhaps contributing to problems in the resulting selection process as described in the next section of this report.

[3] For example, previously HMPs were expected to subcontract with schools to implement the Coordinated School Health Program, and were also permitted to subcontract with other entities in order to serve all towns within their service area. In addition, HMPs had previously been expected to help build the local public health infrastructure in collaboration with other HMPs in their districts.

MCDC renewed the contracts with the nine lead HMPs for FY14 and plans to continue with annual renewals through the current five year grant cycle. Plans are for a RFP to be issued for the new grant cycle that begins in FY16.

MCDC told OPEGA that the contracts with the nine lead HMPs were renewed for FY14 without significant changes although the agency had time to initiate a new RFP process. According to MCDC, although possible, this would have been difficult to successfully achieve given the amount of time necessary to initiate and complete a standard RFP process, which for this award is at least six months. MCDC plans to complete the current five-year grant cycle, beginning a new grant cycle in FY16. They plan to issue a new RFP at that time. The Commissioner of DHHS told OPEGA that while she was not completely satisfied with the HMP lead selection process, she did not see a need to throw it out and start over at this time.

MCDC's Lead HMP Selection Process Was Poorly Implemented and Allowed for Manipulation

MCDC Managers Were Integrally Involved in the Selection Process

The HMP lead selection process was carried out by a core group of MCDC senior management and program staff.

MCDC formed a core group, including senior management and program staff, to carry out the HMP lead selection process. Based on accounts from interviewees and document review, OPEGA determined that those primarily involved in the lead selection process included the Deputy Director; the Directors of the Office of Health Equity, the Division of Local Public Health (DLPH), and the Division of Population Health (DOPH); and the Senior Program Manager responsible for administering the HMP program. MCDC staff told OPEGA it was atypical for management at this level to be involved in the HMP contracting process; typically only the DOPH staff would oversee the process and the Director of DLPH would be responsible for providing the contract language related to public health infrastructure.

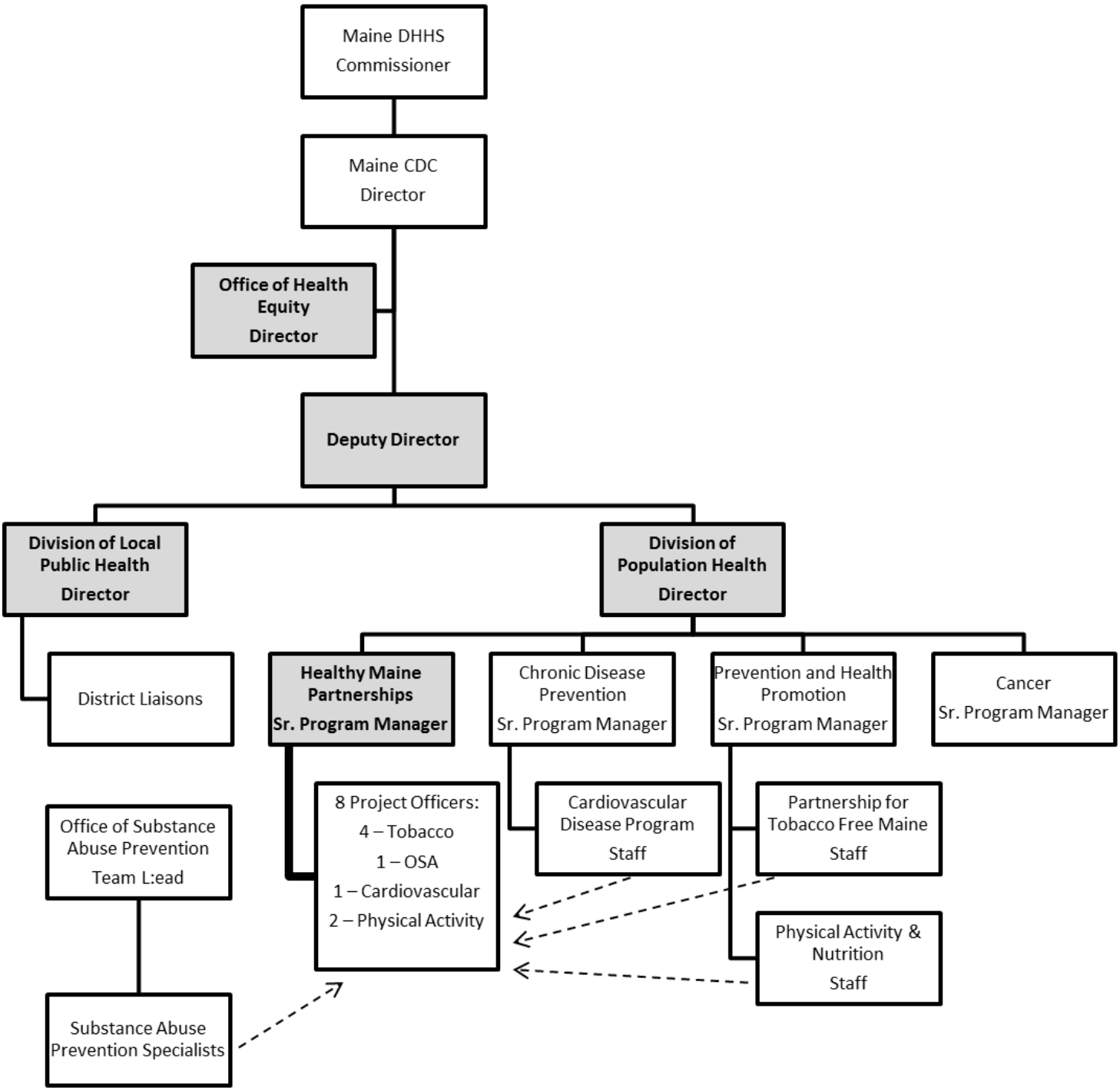
The MCDC Director provided input at key milestones and final results of the process were reviewed and approved by the DHHS Commissioner.

Others involved included the Director of the MCDC who provided input at key milestones. Final results of the process were reviewed and approved by the DHHS Commissioner. Project Officers and District Liaisons had limited involvement in this process; they completed a survey that was used in the HMP scoring.

OPEGA had difficulty discerning the precise extent of involvement or decision making authority of some members of the core group. Some of the core group members OPEGA spoke with characterized their involvement differently than others in the group. For example, some members tended to minimize their own role in certain decisions or actions while others characterized them as having a greater role. Therefore, in the remainder of this section, OPEGA has included only information on staff roles that we found to be described consistently and/or were supported by documentation we reviewed.

Figure 1 is a partial organization chart of MCDC as existed in the Spring of 2012 with members of the core group in shaded boxes. Staff from several different MCDC program areas and the Office of Substance Abuse served as HMP Project Officers and in that work were overseen and directed by the Senior Program Manager for the Healthy Maine Partnership program.

Figure 1: Partial Maine CDC Organizational Chart – Spring 2012



Notes: Shaded cells indicate HMP selection process core group members. Dashed lines indicate the provision of Project Officers. The bold line indicates the oversight and direction of the Project Officers.
Source: As described to OPEGA by Maine CDC staff.

The core group met several times from April – June 2012 to choose selection criteria and review scoring methodology and results.

The core group met several times from April-June 2012 to choose selection criteria and review the scoring methodology. Five final criteria and one tiebreaker were ultimately used in generating total scores for the HMPs with double weight given to two categories. As shown in Table 2, the HMP with the highest total score in each Public Health District was selected as the lead HMP for that District. Appendix C is MCDC's publicly released description of each of these categories, which are:

- Cost of Operations
- Salary Guide Compliance
- Support and Promotion of Developing Infrastructure (double weighted)
- Project Officer Discussions (double weighted)
- District Liaison Discussions
- Average Completion of Tobacco-related and Physical Activity and Nutrition-related Milestones (tiebreaker rating used for one District only)

Five final criteria and one tiebreaker were ultimately used in generating total scores for the HMPs. Double weight was given to two categories – Support and Promotion of Developing Infrastructure and Project Officer Discussions.

Table 2. HMP Final Scores by District

District	HMP	Final Score
Aroostook	**Healthy Aroostook**	**19**
	Power of Prevention	12
Central	**Greater Somerset Public Health Collaborative**	**23**
	Healthy Communities of the Capital Area	21
	Healthy Northern Kennebec	20
	Healthy Sebasticook Valley	19
Cumberland	**Healthy Portland**	**26**
	Healthy Casco Bay	21
	Healthy Lakes	19
	Healthy Rivers	16
Downeast	**Healthy Acadia**	**15**
	Washington County: One Community	12
Midcoast	**ACCESS Health**	**25**
	Healthy Waldo County	18
	Knox County Community Health Coalition	17
	Healthy Lincoln County	14
Penquis	**Bangor Region Public Health and Wellness**	**20**
	Partnership for a Healthy Northern Penobscot	18
	Piscataquis Public Health Council	18
Western Maine	**River Valley Healthy Communities Coalition**	**26**
	Healthy Androscoggin	17
	Healthy Oxford Hills	15
	Healthy Community Coalition	11
York	**Coastal Healthy Communities Coalition**	**21**
	Choose To Be Healthy	15
	Partners for Healthier Communities	11

Source: Districts and HMP names from MCDC map in Appendix B. Final scores from MCDC scoring matrix in Appendix E. Appendix E also contains scores for individual criteria.

Atypical Methodology Used for Survey of Project Officers and District Liaisons

The rankings for the two criteria called PO and DL Discussions were based on surveys completed by POs and DLs during group conference calls where the questions were read to them.

The basis for the rankings of the two criteria called Project Officer (PO) and District Liaison (DL) Discussions was the result of a survey completed by POs and DLs using a web-based survey tool. Despite the name of this category, these rankings were not generated from discussions with the POs and DLs, but rather from the sums of ratings on survey questions.

The core group agreed on the survey questions and conducted what they called a "blind survey process." The Senior Program Manager and the Director of the Division of Local Public Health conducted the surveys of the POs and DLs, respectively, via conference calls with each group. During the calls, POs and DLs were read each survey question and instructed to enter their rating for each HMP in their District on a 1-5 Likert scale into the web-based survey form.

POs and DLs were intentionally not informed of the purpose of the survey or how their ratings would be used. They also were not allowed to see the survey questions in writing.

POs and DLs were intentionally not informed of the true purpose of the survey or how their ratings would be used. They also were not allowed to see the survey questions in writing - only question numbers and response options were included in the survey form – and were instructed not to write down the questions or any other notes. According to some members of the core group, the survey was deployed in this manner due to concerns that the HMPs would become aware of their efforts, questions could leak, and they wanted to keep the responses confidential. Others explained that they were concerned about getting the most objective responses from the POs and DLs as possible.

The Director of the OQIS[4] said he did not think it was necessary to do a blind survey in order to keep the responses objective and he would have focused more on getting complete information. This survey methodology was also atypical compared to OPEGA's own experience with survey deployment and best practice guidance OPEGA identified.

OPEGA observed that this survey methodology was atypical and may have impacted the quality of responses. However, most POs and DLs said they were comfortable with the ratings they gave even after learning the true purpose of the survey.

The fact that participants did not know the true purpose of the survey, and were not provided guidance on scoring (e.g. what merited a higher or lower score), may have impacted the quality of responses. The circumstances under which DLs and POs completed it, without seeing the questions and within the timeframe of a conference call, also did not allow them to give as much thought to their ratings as might otherwise have occurred. However, it is not possible to tell whether ratings would have been very different had a different process been used. Most POs and DLs indicated they were comfortable with ratings they gave even after learning true purpose of survey, although comments on some surveys indicate they might have given different ratings had they known.

[4] DHHS Office of Quality Improvement Services conducted a review of the scoring methodology as described on page 12.

Criteria and Weighting Changed During the Lead Selection Process

According to core group members, the selection criteria evolved and changed multiple times during the scoring process, in part because MCDC did not have useful data for what it wanted to measure.

According to MCDC core group members, the criteria were not established at the outset. Instead they evolved and changed multiple times during the scoring process, in part because MCDC did not have useful data for what it wanted to measure. The Senior Program Manager determined what data was available to support the desired criteria, and the group discussed the strengths and weaknesses of available data, as well as the merits of the metrics and their appropriateness. This was an iterative process. Due to data quality issues, certain criteria originally selected ultimately were not used, including the quality of quarterly KIT reporting and effectiveness in addressing health disparities. MCDC staff told OPEGA some of these criteria were eliminated from consideration because they were too subjective or, after ratings were given to them, they did not sufficiently differentiate the HMPs from each other (i.e. the ratings were very close). (See Recommendation 1.)

In addition, decisions to weight certain criteria and what criteria to use as a tie breaker did not occur until after criteria were scored, multiple weighting scenarios were tested and initial total scores for each HMP had been derived.

In addition to changing criteria, the decision to weight certain criteria and the decision on what additional criteria to use as a tie breaker did not occur until after the criteria were scored, multiple weighting scenarios were tested, and total scores for each HMP had been derived. The core group member responsible for compiling the scoring explained that the weightings occurred after the PO and DL survey results were obtained because the initial scoring efforts (across multiple other categories) showed little variation in the scores among HMPs in some districts. MCDC staff also told OPEGA that the Support and Promotion of Developing Infrastructure criterion was added late in the process, after weightings were assigned to other criteria and initial scores had been totaled.

OPEGA found that the continual changing of criteria and weightings throughout the scoring process impacted the integrity of the final results.

The State of Maine's Division of Purchases' Request for Proposals and Award Activity Schedule, a step-by-step schedule of the RFP process, notes that the development of scoring material should occur at the same time as the initial development of the RFP—well before proposals are reviewed and scored. The Director of OQIS at DHHS also questioned why MCDC had not decided on the criteria, scoring protocol and weighting at the beginning of the process. OPEGA found that continually changing criteria and weightings throughout the scoring process impacted the integrity of the final results. (See Recommendation 2.)

Scoring Methodology Inconsistent and Emphasized Subjective Criteria

Several issues with the scoring methodology were noted by OQIS and also concerning to OPEGA. It was made overly complex, was not consistently applied and emphasized subjective criteria more than objective criteria.

Several issues with the scoring methodology and process were noted by DHHS's OQIS that also concerned OPEGA. OQIS concluded that the scoring methodology was made overly complex by the use of aggregate scores, rankings, weightings, and an extra measure used as a tie breaker. In addition, OPEGA found that the scoring methodology was not consistently applied. The weighting also led subjective criteria to be emphasized more than objective criteria. (See Recommendation 2.)

The following specific weaknesses in how total scores were derived were noted:

Rankings were used for all criteria except SPDI which was rated on a Likert scale of 1 to 5. The use of rankings limited the differentiation in the results making it more difficult to determine a clear winner. Lack of differentiation is what led MCDC to weight certain criteria.

Use of rankings reduced differentiation in scores. Rankings were used for all the criteria except "Support and Promotion of Developing Infrastructure" (SPDI) which was rated on a Likert scale of 1-5. The use of rankings instead of raw scores or ratings limited differentiation in the results making it more difficult to determine a clear winner. The use of rankings effectively removed the variability between HMPs because it minimized the degree of separation between the HMPs. For example, HMPs with results differing by a significant margin on the criteria "Compliance with Salary Guidelines" (e.g. 29% versus 57% for two HMPs in Cumberland District) or that had widely different total ratings on the PO and DL surveys (e.g. 27 versus 59 for two HMPs in the Western Maine District) ended up with rankings that were only one or two points apart. According to the MCDC core group member responsible for creating the scoring spreadsheets, weights were introduced due to the lack of variability in the total HMP scores within districts. OPEGA notes that there were also instances where rankings resulted in increasing the differentiation between HMPs that were separated by only slight margins. For example in Central District, there was only a difference of .35% between the two top HMPs on the Cost of Operations criterion but the rankings assigned (e.g. 3 and 4) created a full one point spread between them.

Ratings of 1-5 were given to the HMPs for the SPDI category.

Rankings of each HMP in relation to the other HMPs in the district were used as number scores for all the other categories.

Using rankings for the two objective criteria and a Likert rating for the subjective SPDI category also meant that SPDI potentially carried more emphasis in the total scores even before weights were applied.

Additionally, the use of rankings for the more objective criteria of "Operating Costs and Administrative Efficiency" and "Compliance with Salary Guidelines" meant HMPs could only score a maximum number of points equal to the number of HMPs in the district in these categories, while they could be awarded a maximum of five points in the more subjective SPDI category. Consequently, this subjective measure already potentially carried more weight in the total scores than the objective measures (even before weighting of criteria was introduced), and carried more weight in some districts than others. In the Aroostook District for example, there were only two HMPs, resulting in all criteria other than SPDI being awarded a maximum of two points before weighting. For this district, the SPDI category represented 38% (5 out of 13) of possible points before weights were added. After weightings, it increased to 50% (10 out of 20) of possible points.

OQIS' analysis showed that every HMP that won the SPDI category was selected as the lead HMP. The SPDI criterion was added late in the process and ratings were assigned by two core group members. OQIS found the concepts on which these ratings were based were not sufficiently defined.

Scoring criteria for key category not well defined. The weighting ultimately double counted SPDI and the Project Officer surveys. The OQIS analysis showed that every HMP that won the SPDI category was selected as the lead HMP. The SPDI criterion was added late in the process and the rating was assigned on a 1 to 5 scale by two core group members closest to the HMPs. OQIS found the concepts on which these ratings were based was not defined sufficiently to support a consistent and reliable measurement.

OPEGA noted that the detailed description of the SPDI category and how it was scored, which were released as part of a FOAA request, was prepared in July 2012 after the scoring and selection was complete. This indicated to OPEGA that perhaps there was not a strong justification for the scoring of that category at the time, and MCDC had attempted to document the reasoning to support the scores after the fact. We also noted there was also conflicting information between the OQIS report and MCDC staff accounts of whether staff reviewed and considered DL responses to survey questions related to public health infrastructure development in assigning the SPDI ratings.

Inconsistencies in the District Liaison surveys for Western Maine District. The District Liaison survey responses to several questions were missing for the Western Maine District and, therefore, all responses related to the capacity to serve the district were excluded from the totaled survey points in this district.[5] The specific questions with no ratings were:

The DL surveys for Western Maine District were handled differently than the other districts in a couple of ways. Although all Western Maine District HMPs were rated in the same way, the survey process in this district was a departure from the overall process.

- degree to which addressing health disparities is a priority;
- completeness and integrity of implementation of Mobilizing for Action through Planning and Partnership;
- degree of achievement of intent of Core Competencies; and
- formation and effective functioning (independent of paid staff) of a governance or advisory board.

In addition, the DL survey responses for this district were determined differently from other districts. OPEGA was told that three individuals worked collaboratively to assign ratings to each question for each of the HMPs in the district in the wake of the departure of the previous DL. Accounts from individuals involved differed regarding details of how the ratings were assigned and there was no related documentation. It is unclear how the individual ratings on each question were determined and who entered them into the web-survey form. MCDC staff were unable to tell us who entered the responses, and some who MCDC publicly reported had been involved did not claim responsibility for assigning any ratings to survey questions for this district. Although it can be argued that all of the Western Maine District HMPs were rated under the same conditions, the survey process in this district was a departure from the overall process.

Scoring Methodology Possibly Adjusted to Influence Outcome in Penquis District

Changing the criteria and weighting during the scoring process created opportunity for MCDC to manipulate outcomes. OPEGA found strong indications that the scoring may indeed have been intentionally manipulated to alter the outcome in the Penquis District. (See Recommendation 2.)

OPEGA noted that changing the criteria and weighting during the scoring process allowed MCDC opportunity to manipulate outcomes. We found strong indications that intentional manipulation may have occurred to alter the outcome in the Penquis District.

The MCDC core group member responsible for compiling the scoring results maintains that the various weightings scenarios he tried out were only an attempt to increase differentiation in total scores between the HMPs. He said he was not pressured, nor was there any intention, to create a certain outcome, i.e. for a particular HMP to come out on top. He also said, however, that in trying combinations of weightings, some of the leads may have changed, especially in

[5] Project Officer and District Liaison survey questions are provided in Appendix C.

those districts where the scoring was close such as the Penquis and Central districts.

Multiple MCDC managers described a meeting during which a version of the scoring matrix with a HMP other than Bangor Region Public Health and Wellness (Bangor) as high scorer in the Penquis District was reviewed and discussed. Some of them said a final adjustment must have been made to the scoring methodology, because in the end Bangor was the top scorer, but they did not know what was done or why. Others said there was specific discussion and a directive that Bangor should be the lead, although it did not have the highest score at that time, because the Co-Chair of the Statewide Coordinating Council was closely affiliated with that HMP and had been a good partner to MCDC. [6]

The OQIS report contains an analysis of six scoring scenarios developed with different methodologies that could have been applied. In two of the eight districts, these different scenarios resulted in different lead HMPs - with one of those districts being Penquis. While the total scores for the three HMPs in Penquis District were very close under all OQIS scenarios, Bangor had the highest score under only three of the six scenarios. Healthy Northern Penobscot was the winner under two scenarios and Piscataquis Public Health was the winner in one scenario. In possible scoring scenarios OPEGA generated based on staff descriptions, the addition of the SPDI criteria, and the specific combination of double weighting the rankings for the Project Officer surveys and SPDI, were critical to Bangor coming out as the top scorer.

MCDC also had opportunity to manipulate the outcome in Central District by virtue of the tie breaker criteria chosen, but OPEGA heard no accounts of MCDC desiring a particular outcome in that district.

The other district where the top scorer changed in the various OQIS and OPEGA scenarios was the Central District. In this district, there was a tie between two HMPs after MCDC applied the final scoring methodology. A tiebreaking measure (average completion percentage of tobacco, physical activity, and nutrition milestones) was selected and applied. Selection of this tiebreaker further raises questions about the integrity of the process, but OPEGA heard no accounts of MCDC desiring a particular outcome in this district.

There were concerns about the outcome of the lead selection in the Western Maine District that prompted this OPEGA review. According to OQIS's findings, under several different weighting and scoring scenarios, the winner of the lead role in that district (Healthy River Valley) remained unchanged. The same is true under OPEGA's scenarios. Healthy Androscoggin was not the highest ranked HMP in any of the individual categories.

[6] Bangor Region Public Health and Wellness describes itself as a division of City of Bangor's Health and Community Services agency. The Co-Chair of the Statewide Coordinating Council is the Director of that agency.

HMP Funding was Divided Evenly Based on Role, Resulting in a Large Decrease for Some HMPs

According to MCDC staff, they were trying to make funding decisions quickly in an uncertain environment. They report being concerned that cuts to the HMP program would be so significant that if they divided the remaining funds evenly, none of the 27 HMPs would have enough funding to stay open. The proposed cuts to the program were much larger than the actual cut of approximately one-third passed in the final Emergency Supplemental Budget in May 2012.

In the past, funding amounts for each HMP were determined by a formula based on population and rural/urban classification. For FY13, MCDC determined a base funding amount of $120,000 for each HMP and distributed funding based on that.

MCDC told OPEGA they decided to move to a new structure with lead and supporting HMPs with funds distributed according to role to optimize reduced funding and maintain all the HMPs. In the past, funding amounts for each of the 27 HMPs were determined according to a formula based on population and rural/urban classification. For FY13, MCDC senior management determined a base funding amount of $120,000 was what each HMP would need to continue operations with one full-time staff person and distributed funding based on that.

Each lead HMP received the $120,000 for programmatic work and additional funding of $134,605 for public health infrastructure work and $28,336 for administering the subcontracts with the supporting HMPs. Though the number of HMPs varies by district, the funding provided to the lead for contract administration is the same regardless of how many subcontracts the HMP administers. Each supporting HMP received $120,000 via subcontract with their district's lead HMP for programmatic work. Additional funding is provided to the HMPs by DHHS's Office of Substance Abuse and Mental Health Services (SAHMS) in the amount of $20,000 to $60,000 per HMP depending on the number of HMPs per district.

Lead HMPs received additional funding for public health infrastructure work and administering subcontracts to supporting HMPs. The change in funding structure and scope of work resulted in some HMPs experiencing a reduction in funds from FY12, for other it was an increase.

The FY13 HMP contract for the Tribal District also includes $235,000 to support two Tribal District Liaisons and administrative support. Funding for these positions was also provided to the Tribal District in FY12. According to MCDC, these positions perform functions similar to the Public Health District Liaisons employed by MCDC, which includes District-wide work outside the HMP program. OPEGA noted that the contract for the Tribal District HMP was handled differently within MCDC and DHHS than the other HMPs. (See Recommendation 4.)

The funding for each lead and supporting HMP is summarized in Table 3. The change in funding structure and scope of work resulted in some HMPs experiencing a reduction in funds from FY12, while others received an increase. FY12 amounts include funds for School Health Coordinators which were eliminated with the FY13 cuts. However, all HMPs, regardless of lead or support status were still expected to work on school objectives for tobacco, physical activity and nutrition, and substance abuse.

Table 3: Funding to Healthy Maine Partnerships for FY12 and FY13 by Public Health District

Districts and Local Healthy Maine Partnerships	FY 12 Funding	FY 13 Funding	Difference
Aroostook District			
Healthy Aroostook	$347,629	$322,941	($24,688)
Power of Prevention	$273,671	$160,000	($113,671)
Central District			
Greater Somerset Public Health Collaborative	$238,432	$302,941	$64,509
Healthy Northern Kennebec	$277,126	$140,000	($137,126)
Healthy Communities of the Capital Area	$415,038	$140,000	($275,038)
Healthy Sebasticook Valley	$225,510	$140,000	($85,510)
Cumberland District			
Healthy Portland	$255,147	$302,941	$47,794
Healthy Casco Bay	$366,632	$140,000	($226,632)
Healthy Rivers	$376,388	$140,000	($236,388)
Healthy Lakes	$307,964	$140,000	($167,964)
Downeast District			
Healthy Acadia	$460,416	$322,941	($137,475)
Washington County: One Community	$319,446	$160,000	($159,446)
Midcoast District			
ACCESS Health	$317,763	$302,941	($14,822)
Healthy Lincoln County	$253,565	$140,000	($113,565)
Healthy Waldo County	$276,269	$140,000	($136,269)
Knox County Community Health Coalition	$267,859	$140,000	($127,859)
Penquis District			
Bangor Region Public Health and Wellness	$437,413	$309,607	($127,806)
Partnership for a Healthy Northern Penobscot	$297,831	$146,667	($151,164)
Piscataquis Public Health Council	$279,355	$146,667	($132,688)
Western Maine District			
River Valley Healthy Communities Coalition	$242,161	$302,941	$60,780
Healthy Androscoggin	$403,215	$140,000	($263,215)
Healthy Community Coalition	$227,920	$140,000	($87,920)
Healthy Oxford Hills	$234,500	$140,000	($94,500)
York District			
Coastal Healthy Communities Coalition	$373,156	$309,607	($63,549)
Choose To Be Healthy	$413,112	$146,667	($266,445)
Partners for Healthier Communities	$276,934	$146,667	($130,267)
Wabanaki District			
Tribal District	$370,000	$597,941	$227,941

Notes: Bolded HMPs are leads. FY12 amounts included funding for School Health Coordinators which were eliminated in FY13. Tribal District funding for FY13 includes $362,942 in funding specific to HMP and $235,000 for two Tribal liaisons and administrative support that also perform some non-HMP district wide work similar to District Liaisons employed by MCDC. FY12 amounts for the Tribal District includes funding for these positions as well.
Source: OPEGA summary of MCDC data.

Incomplete Documentation of the Lead HMP Selection Process Maintained

Agency Decision Making Process was Not Fully Documented

There was limited email traffic and limited documentation was created or kept during the during the HMP lead selection process.

MCDC staff told OPEGA that, although the core group discussions about changing the HMP structure were for internal consideration only, there was a perception that this information had somehow leaked to the HMPs early on in the process. As a result, staff said there were strict directives to keep information confidential. There was very limited email traffic during the process, and limited documentation was created or kept.

Following the announcement of the changes to the HMP program structure at the Statewide Coordinating Council Meeting on June 14, 2012, MCDC publicly released three documents—a description of the lead selection process, including the criteria used (see Appendix C); an outline of the plan to fund the HMPs in light of the funding reduction (see Appendix D); and the scoring matrix showing the selection results (see Appendix E). This was the first time the HMPs or program staff, including District Liaisons and Project Officers, were made aware of the decision. MCDC staff told OPEGA that some of this documentation was developed in order to describe the selection process because such information was not documented during the process.

OPEGA obtained documentation from DHHS and interviewees for this review. We also obtained electronic files from searches of network drives and backup tapes conducted by OIT. We did not identify any documentation given to us that was withheld in response to FOAA requests.

Additional documentation was released by MCDC in response to FOAA requests. The Attorney General's Office (AG) conducted an investigation into whether full and complete documentation was provided by DHHS in response to these FOAA requests. At the request of the AG's office, the Office of Information Technology (OIT) searched network drives and back-up tapes at MCDC, and the hard drive of the former Director of Local Public Health, in an effort to identify documentation that may have been destroyed or concealed. At the time of this report, the investigation was not yet complete. OPEGA had the opportunity to review the documentation obtained by the Attorney General's office.

We were unable to locate a next to final version of the scoring matrix referenced by multiple MCDC staff that existed as late as mid-June 2012. This document may have been similar to one requested through FOAA that MCDC did not provide.

OPEGA did not identify any documentation provided to us that was withheld in response to the FOAA requests DHHS received. However, we were unable to locate a version of the scoring matrix referenced by multiple MCDC staff which showed a different outcome in the Penquis District. According to accounts, this document existed as late as a June 13, 2012 meeting with the Commissioner of DHHS - one day before the public announcement of the selection. OPEGA is aware that the former MCDC Director of Local Public Health claims to have had a similar document in her files and that document has not been provided to OPEGA nor in response to her FOAA request.

In making revisions to the scoring matrix, MCDC had saved over previous electronic versions. It also seems there was general agreement among some core group members that working copies or documents should not be retained.

Two core group members were instructed or advised to destroy documents by a superior but said they did not. Accounts of the tenor and context of these conversations differ among those involved.

DHHS told OPEGA they had determined that, in making revisions to the scoring matrix, MCDC had saved over previous electronic versions. It also seems there was agreement among some members of the core group that "working copies or documents" should not be retained. (See Recommendation 3.)

Staff Were Instructed to Destroy Documents

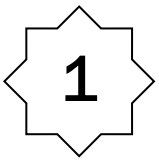
Two core group members OPEGA spoke with, including the former Director of Local Public Health, said they had been instructed to destroy documents by a superior. They said they were instructed to do so because only the final product should remain at the end of the process, not the working documents. The two gave different accounts of the tenor and context of these conversations. The superior who advised the staff to destroy documentation acknowledged doing so, but her explanation of the discussions differed as well.

Two other staff members at MCDC, including a senior manager, told OPEGA these employees had come to them at the time with concerns and to seek advice about whether to shred documents. The senior manager in this instance advised one of the employees to do "what they thought was right." The employees' concerns were not escalated further.

Management at MCDC told OPEGA they believed the instruction or advice to destroy documentation may have resulted from a desire for version control, or to keep survey responses confidential, rather than an intention to cover something up. DHHS and MCDC management also told OPEGA they considered these to be working documents, and did not have the expectation that they should be kept.

The two employees asked to destroy documents said they did not do so. OPEGA obtained and reviewed documents in their possession. Several observations from this report were made possible based on the documentation they retained.

Recommendations



MCDC Should Gather Relevant Performance Data

MCDC did not have relevant, consistent, objective data available to measure the performance of the individual HMPs, which led to a reliance on more subjective information. MCDC had difficulty identifying data that spoke to individual HMP performance particularly in areas relevant to the lead role. In the scoring process, the MCDC core group also did not include criteria related to what OPEGA considers to be key or different responsibilities of the new lead role, including: subcontracting and monitoring of subcontractor performance; collaboration with other HMPs and schools; and capacity to serve the entire district.

Since the lead HMP role was new, the fact that MCDC was not already collecting relevant data is somewhat understandable. However, OPEGA would expect agency efforts to focus on ensuring better data collection in the future. MCDC told OPEGA that efforts are currently underway to collect data on lead performance.

Recommended Management Action:

MCDC should gather relevant, objective performance data on lead HMPs in the future based on the key responsibilities of the HMPs in this role.

MCDC Should Ensure Integrity of Future Processes Used to Determine Funding Awards or Make Selections Among Competing Grantees

DHHS's Office of Quality Improvement Services (OQIS) and OPEGA noted a number of issues with MCDC's scoring methodology and process. These weaknesses, described in more detail on pages 17-21, include:

- using atypical methodology in deploying the survey of Project Officers and District Liaisons;
- inconsistencies in District Liaison survey ratings for HMPs in the Western Maine District;
- lacking a well-defined basis for ratings assigned to the key criteria of Supporting and Promoting Developing Infrastructure (SPDI);
- using rankings for four of the five selection criteria; and
- changing selection criteria and weightings throughout the scoring and lead selection process.

These weaknesses resulted in a greater emphasis on subjective criteria, with a particular focus on each HMP's cooperation and collaboration with MCDC and support for development of public health infrastructure. The quality of the subjective input was also less than optimal given issues with the PO and DL surveys and the basis for the SPDI criterion.

The scoring methodology ultimately put significant emphasis on the ratings for the subjective Support and Promotion of Developing Infrastructure criterion. OQIS observed that the HMP in each district with the highest rating in this category received the top score and was selected the lead HMP in each district. The SPDI criterion was introduced late in the scoring process and the ratings for it were assigned by two core group members closest to the HMPs. OQIS found the concepts on which these ratings were based were not defined sufficiently to support a consistent and reliable measurement.

The decision to alter the selection criteria during the process, and the timing of the introduction of weights and tie breakers to the scoring methodology, also create questions about the credibility of the process and allowed opportunities for manipulation of the outcome. All managers and staff OPEGA interviewed described the group's desire to have an overall process that was as objective as possible. The core group member responsible for compiling the scoring results also maintains that any changes to the scoring methodology were only to increase differentiation in total scores among HMPs, not to create particular outcomes.

Nonetheless, OPEGA heard accounts from multiple MCDC managers that some final adjustment was made to the scoring methodology at the end of the selection process that changed the outcome in the Penquis District. Some of these accounts also suggest that the adjustment was intentional as there was a desire for Bangor Region Public Health and Wellness (Bangor) to be the lead.

Various weighting scenarios presented in the OQIS report show the different scenarios producing different top scorers in Penquis District. In three of six scoring methodology scenarios illustrated in the OQIS report, Bangor was not the top scorer. OPEGA observes that the addition of the SPDI criteria late in the process may also have been related to a final adjustment to the scoring methodology. In possible scoring scenarios OPEGA generated based on staff descriptions, it appears that the addition of the SPDI criteria, and the specific combination of double weighting it and the rankings for the Project Officer surveys, were critical to Bangor coming out as the top scorer.

OPEGA finds that the OQIS scenarios, and our own, support the possibility that Bangor was not the top scorer in the next to final round of scoring results the MCDC core group reviewed, and that the scoring methodology finally applied was preferred because it resulted in that HMP receiving the highest score. However, because there was no record of the actual criteria and weighting iterations that occurred during the process, OPEGA could not determine for certain whether or not the changes made at various stages were done with intent to create that specific outcome.

The various weighting scenarios, and addition of SPDI criteria, did not change which HMPs were top scorers in six of the Public Health Districts. The only other District where scores were close enough to be affected was the Central District which ended up being decided with a tie breaker criterion, also added at the end of the scoring process. Applying a tie breaker criterion that had not been designated before scoring began also introduced an opportunity to manipulate the outcome in that District, but no one OPEGA interviewed gave any indication that this was the case.

In a formal competitive request for proposals process, the selection criteria and weighting methodology are established in advance – prior to any scoring being done – and remain consistent throughout the process. MCDC is familiar with the protocols of an RFP process, having conducted HMP RFPs in the past. Although this effort did not involve a RFP, the approach for selecting the best or lead HMPs was designed in a similar fashion. In OPEGA's opinion, following protocols similar to those established for an RFP process would have maintained the integrity of the scoring process and removed the opportunity for results to be manipulated.

Recommended Management Action:

In future instances where a formal competitive proposal process cannot be used to determine funding awards or select among competing grantees, MCDC should adhere to the relevant protocols for an RFP process as closely as possible and consult with experts within the organization and/or DHHS to ensure valid and reliable methodologies are used.

3

DHHS Should Provide MCDC with Guidance and Clarification on Documentation Retention Policies

DHHS and individuals interviewed provided many documents to OPEGA, including several early versions of the scoring matrix. However, overall there was limited documentation kept during the scoring and selection process that supported MCDC's descriptions of the process or how final results were derived. As a result, OPEGA encountered difficulty in reconstructing the events that occurred and we relied heavily on testimonial evidence, which was at times inconsistent.

MCDC kept no formal documentary record of what weighting scenarios may have been tried, nor what changes were made to the methodology; incomplete documentation was maintained of when and why various criteria were introduced into the process. OPEGA was able to review multiple versions of the scoring matrix provided by MCDC staff, but DHHS told OPEGA that some draft electronic versions of the scoring matrix were saved over previous iterations. MCDC staff told OPEGA that there was an effort to make the scoring process and staff survey confidential. There was very limited email traffic during the process, and limited documentation was kept.

As a result, MCDC ended up developing some documents in response to FOAA requests because relevant documentation had not been maintained during the process. For example, OPEGA noted that the detailed description of the SPDI category and the rationale for the ratings assigned, which DHHS released in response to a FOAA request, was prepared in July 2012 after the scoring was completed and MCDC's selections made public. OPEGA received no other documents created during the timeframe of MCDC's selection process that supported these descriptions, indicating to us that MCDC had attempted to document the reasoning to support the ratings after the fact.

Members of the core group acknowledge there was discussion among members of disposing of documents related to the PO and DL surveys and versions of the scoring matrix that were "working" documents or drafts. However, accounts vary as to the tenor (i.e. directed vs. advised) and timing of those discussions, who was present, and the reasons for the directive or advice to destroy the documents.

Two MCDC core group members OPEGA spoke with described an air of secrecy around the whole process due to concerns at MCDC that information about their plans were being, or would be, leaked to the HMPs. These same group members said they had been instructed to destroy documents by a superior because only the final product should remain at the end of the process. They said they did not do so and provided what they had from their files to OPEGA.

The MCDC superior who gave the instruction to discard documents acknowledged being part of these conversations and giving advice to other core group members who were concerned about maintaining the confidentiality of survey results on behalf of the POs and DLs. The superior also described a discussion about discarding a draft scoring sheet so it would not be confused with the final version. Others, including the Director of MCDC and Commissioner of DHHS, recalled version control being discussed as well.

OPEGA did not find any documentary evidence that MCDC or DHHS had intentionally destroyed or concealed specific documents in responding to FOAA requests or OPEGA's requests for documents. However, statements by multiple members of the core group, the Director of MCDC and the Commissioner of DHHS, indicate that at least one document existed in the late stages of the scoring and selection process which was not provided by DHHS and which we could not locate in documents resulting from a search of electronic files conducted by OIT.

The version of the scoring matrix described showed an HMP other than Bangor as the high scorer in the Penquis District and prompted a discussion about these results. We believe this document may have been reviewed by members of the core group in late May or early June 2012 prior to final changes being made to the scoring methodology. There is also acknowledgement that a paper copy of this version of the scoring matrix existed as late as a June 13, 2012 meeting with the Commissioner – the day prior to MCDC's public announcement of its lead HMP structure and selections. The document was described as a "working" draft and, according to the MCDC Director, she gave it to the Deputy Director at the end of that meeting.

Counsel for the former Director of Local Public Health submitted a FOAA request for a paper document similar in description to this, which she believed was in her paper files at her MCDC office. DHHS said it was unable to locate the document and did not provide it in response to her FOAA request. It was also not among documents from her files that DHHS provided to OPEGA. OPEGA does not know whether the document she sought is the same version of the scoring matrix that has been described to us by others.

OPEGA notes that an agency cannot reasonably be expected to retain every working document and we did not identify formal guidance at the State or Department level on what documentation should be retained for agency processes or decisions in situations such as this. However, in this instance the working documents were the only written record of MCDC's process and not keeping them has resulted in a lack of transparency and questions about the outcomes.

Recommended Management Action:

OPEGA observes generally that major agency decisions, and justifications for them, should be transparent. The extent of documentation necessary to achieve this objective should be set out in clear and relevant guidance. DHHS and MCDC should consider the adequacy of their existing policies and guidance on appropriate actions and document retention in situations such as the FY13 HMP structure change and lead selection process that are anticipated to have significant stakeholder or public impact. Policies and other guidance should be developed or updated as necessary.

4

MCDC Should Clarify the Roles and Responsibilities for the Tribal Contract and Make Them Consistent with Those for Other HMPs

The FY13 Tribal District HMP contract was for over half a million dollars and is effectively a sole source contract as there are no other competing HMPs in the Tribal District. OPEGA noted that the contract for the Tribal District HMP was developed and processed differently than the contracts for the other HMPs. OPEGA was unable to discern from the interviews who was responsible for developing, reviewing and approving the FY13 contract for the Tribal District HMP. We ultimately identified an email that confirmed the contract was developed by the Office of Health Equity despite the fact that the director of that office had been unsure who developed it, though she said she signed it.

Recommended Agency Action:

MCDC should clarify the roles and responsibilities for developing, approving, processing and monitoring the Tribal District HMP contract. This contract should be handled as consistently as possible the contracts for the other HMPs.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided the Department of Health and Human Services an opportunity to submit additional comments on the draft of this report. DHHS's response letter can be found at the end of this report.

Acknowledgements

OPEGA would like to thank the management and staff of both the Maine Center for Disease Control and Prevention and the Maine Department of Health and Human Services for their cooperation during this review, as well as former MCDC employees who met with us. We would also like to thank the management and staff in the Department of Administrative and Financial Services' Office of Information Technology and Division of Purchases, as well as the Legislature's Office of Fiscal and Program Review for their assistance in providing information.

Appendix A. Scope and Methods

The scope for this review, as approved by the Government Oversight Committee, focused narrowly on the events in question. OPEGA's methodology included:

- Conducting interviews with current and former Maine Center for Disease Control and Prevention (MCDC) staff involved in the lead HMP selection process, including managers, division directors, District Liaisons, and Project Officers;
- Conducting interviews with Department of Health and Human Services (DHHS) and Department of Administrative and Financial Services (DAFS) staff with knowledge of events related to the HMP selection process;
- Reviewing documentation (including files and emails) provided by MCDC, DHHS, and DAFS staff, including paper and electronic files, pertaining to the lead HMP scoring and selection process;
- Reviewing electronic files provided by the Attorney General's office resulting from their investigation;
- Initiating a request for the Office of Information Technology to retrieve appointments and emails for certain key staff from the time period in question, and reviewing the results;
- Reviewing best practices in survey methodology; and
- Reviewing DHHS documentation provided to third parties in response to FOAA requests.

Appendix B. Map of Local Healthy Maine Partnerships

See the following page. Source: Maine Center for Disease Control and Prevention

Local Healthy Maine Partnerships

★ **Aroostook District**
1. Healthy Aroostook
2. Power of Prevention

★ **Central District**
3. Greater Somerset Public Health Collaborative
4. Healthy Northern Kennebec
5. Healthy Communities of the Capital Area
6. Healthy Sebasticook Valley

★ **Cumberland District**
7. Healthy Casco Bay
8. Healthy Portland
9. Healthy Rivers
10. Healthy Lakes

★ **Downeast District**
11. Healthy Acadia
12. Washington County: One Community

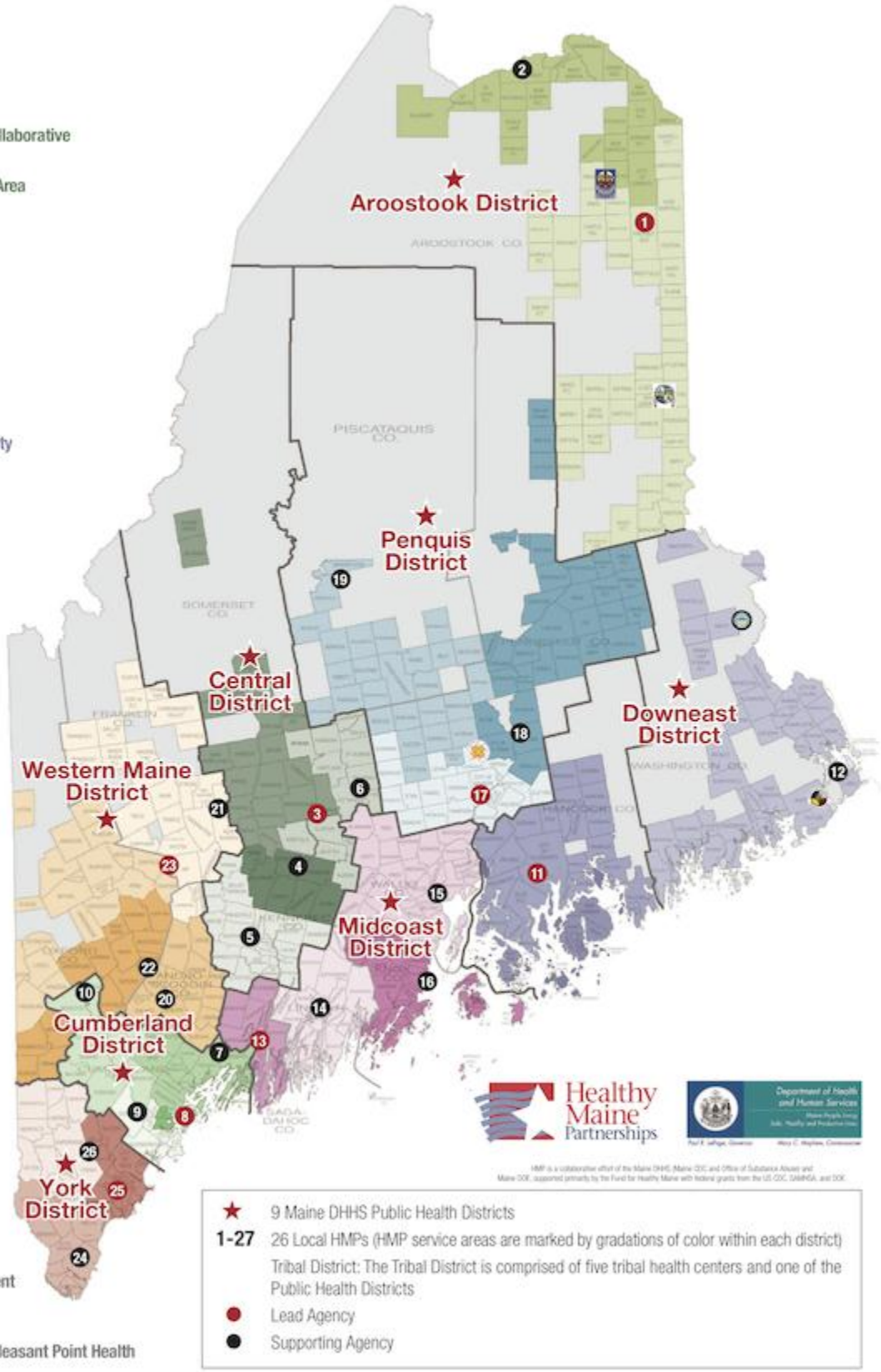
★ **Midcoast District**
13. ACCESS Health
14. Healthy Lincoln County
15. Healthy Waldo County
16. Knox County Community Health Coalition

★ **Penquis District**
17. Bangor Region Public Health and Wellness
18. Partnership for a Healthy Northern Penobscot
19. Piscataquis Public Health Council

★ **Western Maine District**
20. Healthy Androscoggin
21. Healthy Community Coalition
22. Healthy Oxford Hills
23. River Valley Healthy Communities Coalition

★ **York District**
24. Choose To Be Healthy
25. Coastal Healthy Communities Coalition
26. Partners for Healthier Communities

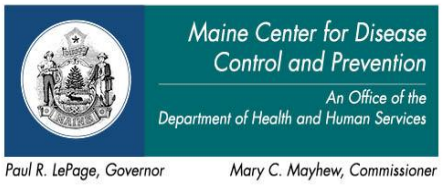
★ **Wabanaki District**
27. Tribal District
- Aroostook Band of Micmac Indians – Micmac Service Unit
- Houlton Band of Maliseet Indians Health Department
- Penobscot Nation Health Department
- Passamaquoddy Health Center – Indian Township
- Passamaquoddy Health Center – Pleasant Point Health



The gray areas on this map are unorganized territories, plantations, and townships with a population size of less than 50 people and/or a geographic size of more than 100 square miles with population density less than one person per square mile. These areas are not officially assigned to an HMP contract for outreach, but people living in these areas who wish to get involved in HMP-related activities are encouraged to contact the HMP located closest to them. All gray areas are recognized as part of the public health district within which they are located.

Appendix C. MCDC Public Description of the Lead Selection Criteria and Scoring Methodology

Source: Maine Center for Disease Control and Prevention



Selection of Lead and Supporting Healthy Maine Partnerships for FY13

With a reduction in funding approved by the Legislature from approximately $7.5 million to $4.7 million, Maine CDC is making changes to support continuation and sustainability of the Healthy Maine Partnerships (HMPs). Maine CDC understands that these funding cuts are difficult for local HMPs, and that some HMPs are experiencing significant reductions as a result of these changes.

Previously, 27 HMP community Partnership directors and 31 HMP school health coordinators were located across the 9 public health districts and 164 school administrative units. HMPs were asked to assess the needs in their community and choose from a menu of approximately 70 objectives to develop a work plan.

Starting July 1st, there will be 9 Lead HMPs and 18 Supporting HMPs spread across Maine. Each HMP will retain its individual service area. HMPs will have a more focused set of objectives, including both community and school settings. There will be flexibility to choose objectives within the defined set of objectives, but HMPs will be required to address school objectives as part of the work plan with priority schools. Priority schools will be identified by Maine CDC and the Department of Education in order to ensure the most vulnerable children are benefiting from the HMP work.

This plan reduces administrative overhead, duplication of work and reduces the administrative burden for State government (nine contracts vs. twenty seven). It also focuses the limited resources available on those health factors that put people most at risk. In order to move to a lead and supporting HMP structure, Maine CDC assessed each HMP for the following qualities:

- The HMP's demonstrated ability to meet the expectations of the contract
- Efficient use of public resources
- Collaborative partnership with Maine CDC
- Ongoing support and promotion of new and developing public health infrastructure

Please see the attached spreadsheet for total scores. All scores provided the highest points to those that best met the condition required within each respective district. Example: Power of Prevention received a "2" and ACAP a "1" for Overhead and G&A because Power of Prevention's rate was lower. In those instances where there was a tie, the same score was awarded to each coalition that made up the tie. At the end, scores were aggregated to reach a total award.

Summary Explanation of Total Scoring

- **Cost of Operation Column:** All Operating Costs and General and Administrative (G&A) were derived from the FY12 contract numbers. Total contract amounts minus school health coordinator funding were used to determine the percentage. Scoring was done on a ranking basis within each District with the HMP with the lowest G&A awarded the highest score.

- **Salary Guide Compliance Column:** Staff within salary guidelines was determined by the hourly salary rate from each FY12 budget compared to the recommendations contained in RFP 201010788. Scoring was conducted on a ranking basis within each District with the HMP with the greatest percentage of salaries within guidelines given the highest score.

- **Infrastructure Development Column:** The 'Support and Implementation of Developing Infrastructure' score was determined from staff knowledge of coalition activities and progress in this area. Each HMP was scored in a Likert scale (rating scale) within each District.

- **Project Officer and District Liaison Columns**: These discussions focused on questions that assessed grantee collaboration with Maine CDC, compliance with Maine CDC direction, implementation of Maine CDC initiatives at the local level, and support of Maine CDC's district level work. Each HMP was rated by applying a Likert scale of 1-5 to questions that were designed to show the individual HMP performance in key areas of leadership (as opposed to programmatic performance) that were determined to be important to Maine CDC. These ratings were aggregated to provide a total score within the Project Officer/District Liaison discussion columns. HMPs were then rated within their district dependent on their aggregated score.

- **Tie Breaker Column:** Where aggregate scores tied, a tie breaker was used. The tie breaker consisted of the measure of completion of tobacco-related and physical activity and nutrition-related milestones as reported by each grantee in the HMP KIT monitoring system. This score was a strict percentage of completion of milestones with the HMP completing the highest percent of their milestones given the highest score.

- **Aggregate Subtotal:** The aggregate subtotal score was derived from totaling the rating score from each column after applying a weighting to two areas determined to be most significant, Support and Promotion of Developing Infrastructure and responses from the Project Officer Discussions. These areas were selected because of Maine CDC's investment in developing the public health infrastructure at the district level. In addition, because the project officers have worked closely with the HMPs for a significant number of years and are very familiar with their respective strengths and weaknesses their input was considered key. The formula used to reach the aggregate subtotal compiled the ratings in the following way: Cost of Operations + Salary Guideline Compliance + (Support and Promotion of Developing Infrastructure *2) + (Project Officer discussions*2) + District Liaison discussions.

- **Total Score:** The total score is this aggregated subtotal, except in the Central District where the aggregate subtotal resulted in a tie score for two coalitions. In that case, scoring from the **Tie Breaker Column** was added to the aggregated subtotal.

Attachment 1

Each coalition was ranked on a score of 1-5, with 1 being the least and 5 indicating the most.

Questions asked of Project Officers

Collaboration with MCDC

1. Degree of cooperation with Maine CDC
2. Willingness and ability to follow Maine CDC guidance and direction
3. Openness to technical assistance from Project Officer
4. Facilitates engagement between coalition board and project officer
5. Staff of the HMP conduct themselves professionally

Capacity to Serve the District

6. Degree to which addressing health disparities is a priority
7. Degree to which the HMP has served their entire service area

Efficient Use of Resources

8. Effectiveness at implementing their work plans within the parameters given by Maine CDC
9. History of engaging capable partners in HMP service area

Questions asked of District Liaisons

Collaboration with MCDC

1. Degree of cooperation with Maine CDC
2. Willingness and ability to follow Maine CDC leadership and direction
3. Engages district liaison in professional and collegial manner
4. Facilitates engagement between coalition board and district liaison
5. Staff of the HMP conduct themselves professionally

Support of Public Health Infrastructure

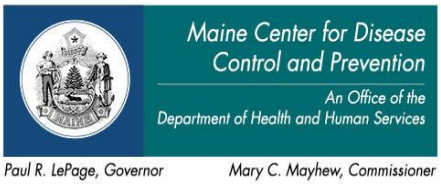
6. Rate the understanding of the HMP regarding their role in the public health infrastructure
7. Degree to which the HMP has been positively involved in developing or supporting development of the public health infrastructure
8. Rate the contribution of the HMP to the development of the public health infrastructure
9. Degree of positive engagement in DCC and DCC activities
10. Rate the degree of flexibility of the HMP in allowing other public health entities to take a lead role in DCC and the public health infrastructure

Capacity to Serve the District

11. Degree to which addressing health disparities is a priority
12. Completeness and integrity of MAPP implementation
13. Degree of achievement of intent of Core Competencies
14. Formation and effective functioning (independent of paid staff) of a governance or advisory board

Appendix D. MCDC Public Description of HMP Structure and Funding Changes for FY13

Source: Maine Center for Disease Control and Prevention



Healthy Maine Partnership Funding from Maine CDC
June 2012

Below are highlights about the plan to fund Healthy Maine Partnerships (HMPs), with a reduction in funding approved by the Legislature from approximately $7.5 million to $4.7 million:

- Mirroring Maine CDC's public health infrastructure that established eight regional public health districts and one tribal health district, nine current HMPs were chosen to be the 'lead HMPs.'
- The lead HMPs will receive approximately $281,000 and will also take on the responsibility of supporting district public health infrastructure efforts and leading local infrastructure and capacity development within their respective districts.
- The lead HMPs are required to subcontract with the remaining 18 'supporting HMPs,' which will each receive $120,000 from Maine CDC.
- Because school based health coordinators will no longer be funded, all HMPs will be expected to reach out to priority schools, as identified by Maine CDC and the Department of Education.
- This plan reduces administrative overhead, duplication of work and reduces the administrative burden for State government (nine contracts vs. twenty seven). It also focuses the limited resources available on those health factors that put people most at risk.

The Lead HMPs that were selected are:

- Healthy Aroostook (Aroostook County Action Program)
- Greater Somerset (Redington Fairview Hospital)
- Healthy Portland (City of Portland)
- Healthy Acadia (Healthy Acadia)
- Access Health (Mid Coast Hospital)
- Healthy River Valley (River Valley Healthy Communities Coalition)
- Coastal Healthy Communities (University of New England)
- Bangor Regional (Bangor Health and Welfare)
- Tribal Healthy Maine Partnership

The selection of the Lead HMPs was based on ratings of:

- The HMPs demonstrated ability to meet the expectations of the contract
- Efficient use of public resources
- Collaborative partnership with Maine CDC
- Ongoing support and promotion of new and developing public health infrastructure

How does the HMP work plan for FY13 differ from that of FY12?

- Status of work plans for contract ending 6-30-12:
- 27 HMP community project directors were located across the 9 public health districts. HMPs were asked to assess the needs in their community and choose from a menu of approximately 70 objectives to develop a work plan. Some of the 70 objectives pertained to schools; however, HMPs could choose whether to work with schools based on the objectives chosen.

- Each of the 31 HMP school health coordinators was employed by one of the 164 school administrative units across Maine. The 31 school health coordinators were required to address objectives specific to the school setting.

- Work plans for contracts to be effective 7-1-12:
- HMPs will have a more focused set of objectives, including both community and school settings. There will still be flexibility to choose objectives within the defined set of objectives, but HMPs will be required to address school objectives as part of the work plan with priority schools.
- Priority schools will be identified by Maine CDC and the Department of Education to ensure the most vulnerable children are benefiting from the HMP work.

How will schools be connected to the work of HMPs?

- HMPs will be required to work with priority schools to address school-related objectives outlined in their contracts.
- HMPs will be unable to replicate all of the work that the 31 full-time school health coordinators accomplished in the districts in which they were employed.
- In order to be successful addressing the school-related objectives, it will be important for school districts to work with the HMPs to make progress toward meeting these objectives.

How can HMPs address sustainability?

- It is understood that these funding cuts are difficult for local HMPs, and that some HMPs are experiencing significant reductions.
- HMPs are encouraged to secure additional private and public funding. Many HMPs have been successful at this in the past.
- Supporting HMPs may have the opportunity to obtain funding from the lead HMP to contribute toward carrying out District-wide activities.
- It is believed that $120,000 will allow a supporting HMP to function effectively, especially with more regional administration.
- The range of contractual funding provided to each community HMP by Maine CDC prior to the reduction in the Fund for a Healthy Maine was from $135,000 to $344,000 (excluding funds to school heath coordinators). Just two HMPs statewide were above the $300,000 amount.

How will the work of HMPs be monitored to ensure quality services for Maine communities and schools?

- Maine CDC requires quarterly reporting on HMP objectives.
- Each HMP has a project officer from Maine CDC to provide support and technical assistance. If a Maine CDC project officer notes that an HMP is not meeting its milestones for an objective, the project officer will contact the HMP to provide technical assistance. Maine CDC project officers can follow up to determine how the technical assistance is implemented, and whether further assistance is necessary.
- At year's end, Maine CDC will assess the performance of the HMPs and will make decisions regarding contracting and funding for the coming year based on the overall performance of the HMP, which will include performance on school-related objectives.
- Maine CDC staff is in discussion with the Contracted Services Unit of DHHS to develop more refined performance based measures for these contracts in order to hold the HMPs accountable for meeting the objectives of their contracts.

Information Superintendents may want to know about the HMPs:

- School-health coordinators, once funded as part of the HMP funding line, will not be funded in the contracts effective July 1, 2012.
- In order to connect to schools located in their respective communities, all HMPs will be expected to reach out to priority schools, as identified by Maine CDC and the Department of Education.
- HMPs will be required to choose specific school-related objectives in the new contract year.
- The number of objectives and focus of objectives will be determined by Maine CDC to assure that appropriate levels of work are being conducted with schools.
- The school-related objectives have been drawn from the previous programming menu and have been assessed as appropriate and do-able without the additional resource of a school health coordinator.
- Maine CDC project officers will closely follow the progress of the HMPs as reported in the monitoring system, and will actively work with those HMPs that do not meet the expectations.
- Maine CDC project officers will work with the Department of Education to assure that any technical assistance necessary for HMP work with schools is appropriate for the setting.
- Because this work will be conducted in partnership with a school, HMPs will be held accountable for their contribution to the partnership. HMP project officers will assess whether the HMP is meeting the expectations that have been set and also review how the technical assistance provided has been implemented.

Appendix E. Healthy Maine Partnerships Scoring Matrix as Publicly Released by MCDC

Source: MCDC, with formatting adjusted by OPEGA

HMP	Cost of Operations		Salary Guide Compliance		Support and Promotion of Developing Infrastructure	Project Officer Discussions		District Liaison Discussions		Sub Total	Average comp. Tobacco & PAN Mile-stones	Tie-breaker Rating	Final Score
	All operating costs+ G&A as % of Community Total	Over-head Rating	Percent of staff within salary guidelines	Salary Rating		Total	Rating	Total	Rating				
Healthy Aroostook (Aroostook County Action Program)	17.00%	1	80.00%	2	5	43	2	57	2	19			19
Power of Prevention (Cary Medical Center)	5.51%	2	66.67%	1	3	34	1	54	1	12			12
Healthy Communities Capitol Area	4.65%	4	75.00%	1	3	36	4	27	1	20	53.83%	1	21
PATCH (MaineGeneral Health)	7.38%	2	100.00%	2	3	33	1	61	4	16	81.43%	4	20
Greater Somerset (Redington Fairview Hospital)	11.87%	1	100.00%	2	5	34	2	59	3	20	73.67%	3	23
Healthy SV (Sebasticook Valley Hospital)	5.00%	3	100.00%	2	3	34	2	28	2	17	56.31%	2	19
Healthy Portland (Portland, City of)	8.29%	3	28.57%	1	5	39	4	60	4	26			26
Healthy Casco Bay (Portland, City of)	7.48%	4	57.14%	2	3	38	3	59	3	21			21
Healthy Lakes (People's Regional Opportunity Program)	18.76%	1	60.00%	4	4	36	2	58	2	19			19
Healthy Rivers (People's Regional Opportunity Program)	16.33%	2	40.00%	3	3	36	2	57	1	16			16
Healthy Acadia	17.35%	1	80.00%	2	4	34	1	56	2	15			15
Washington Co. One (Washington, County of)	9.36%	2	66.67%	1	2	35	2	35	1	12			12
Access Health (Mid Coast Hospital)	12.01%	2	42.86%	2	5	40	4	58	3	25			25
Healthy Lincoln Co. (Youth Promise)	24.52%	1	100.00%	4	2	25	2	44	1	14			14
Knox Co. Healthy Com. (Penobscot Bay YMCA)	8.98%	4	33.33%	1	3	22	1	59	4	17			17
Healthy Waldo Co. (Waldo County General Hospital)	11.59%	3	33.33%	1	3	37	3	57	2	18			18
Bangor Regional (Bangor Health and Welfare)	13.04%	1	75.00%	2	5	36	3	44	1	20			20
Healthy No. Penobscot (Katahdin Shared Services)	8.66%	3	100.00%	3	4	34	1	49	2	18			18
Piscataquis Pub Health (Mayo Regional Hospital)	10.47%	2	66.67%	1	4	35	2	50	3	18			18
Healthy Androscoggin (Central Maine Community Health)	10.00%	1	66.67%	1	3	38	3	30	3	17			17
Healthy Comm. Coalition (Healthy Community Coalition Greater Franklin Cty)	7.32%	3	100.00%	2	1	27	1	17	2	11			11
Healthy River Valley (River Valley Healthy Communities Coalition)	9.33%	2	100.00%	2	5	40	4	46	4	26			26
Healthy Oxford Hills (Western Maine Health)	5.87%	4	100.00%	2	2	28	2	16	1	15			15
Partners for Healthier Comm (Goodall Hospital, Inc.)	16.05%	1	66.67%	3	2	29	1	29	1	11			11
Coastal Healthy Comm (University of New England)	13.32%	2	50.00%	2	5	35	2	62	3	21			21
Choose to be Healthy (York Hospital)	9.38%	3	25.00%	1	3	36	3	35	2	15			15

Summary Explanation of Total Scoring

Cost of Operation Column: All Operating Costs and General and Administrative (G&A) were derived from the FY12 contract numbers. Total contract amounts minus school health coordinator funding were used to determine the percentage. Scoring was done on a ranking basis within each District with the HMP with the lowest G&A awarded the highest score.

Salary Guide Compliance Column: Staff within salary guidelines was determined by the hourly salary rate from each FY12 budget compared to the recommendations contained in RFP 201010788. Scoring was conducted on a ranking basis within each District with the HMP with the greatest percentage of salaries within guidelines given the highest score.

Infrastructure Development Column: The 'Support and Implementation of Developing Infrastructure' score was determined from staff knowledge of coalition activities and progress in this area. Each HMP was scored in a Likert scale (rating scale) within each District

Project Officer and District Liaison Columns: These discussions focused on questions that assessed grantee collaboration with Maine CDC, compliance with Maine CDC direction, implementation of Maine CDC initiatives at the local level, and support of Maine CDC's district level work. Each HMP was rated by applying a Likert scale of 1-5 to questions that were designed to show the individual HMP performance in key areas of leadership (as opposed to programmatic performance) that were determined to be important to Maine CDC. These ratings were aggregated to provide a total score within the Project Officer/District Liaison discussion columns. HMPs were then rated within their district dependent on their aggregated score.

Tie Breaker Column: Where aggregate scores tied, a tie breaker was used. The tie breaker consisted of the measure of completion of tobacco-related and physical activity and nutrition-related milestones as reported by each grantee in the HMP KIT monitoring system. This score was a strict percentage of completion of milestones with the HMP completing the highest percent of their milestones given the highest score.

Aggregate Subtotal: Aggregate subtotal score was derived from totaling the rating score from each column after applying a weighting to two areas determined to be most significant, Support and Promotion of Developing Infrastructure and responses from the Project Officer Discussions. These areas were selected because of Maine CDC's investment in developing the public health infrastructure at the district level. In addition, because the project officers have worked closely with the HMPs for a significant number of years and are very familiar with their respective strengths and weaknesses their input was considered key. The formula used to reach the aggregate subtotal compiled the ratings in the following way: Cost of Operations + Salary Guideline Compliance + (Support and Promotion of Developing Infrastructure *2) + (Project Officer discussions*2) + District Liaison discussions.

Total Score: The total score is this aggregated subtotal, except in the Central District where the aggregate subtotal resulted in a tie score for two coalitions. In that case, scoring from the Tie Breaker Column was added to the aggregated subtotal.