Maine Public Health Work Group

SUMMARY WORKING DRAFT 2

Governmental Public Health Duties or Accountabilities: Gaps, Overlaps and Proposals for Change

10/22/07

NOTE: GAPS, OVERLAPS AND PROPOSALS SUMMARIZED IN THIS WORKING DRAFT DOCUMENT HAVE NOT BEEN ENDORSED BY THE MAINE PUBLIC HEALTH WORK GROUP, THE GOVERNOR'S OFFICE ON HEALTH POLICY AND FINANCE, NOR THE MAINE CDC.

In preparation for the 10/22/07 meeting of the PHWG, Members and Interested Parties were invited to:

- Identify gaps or overlaps in current governmental public health duties and accountabilities in Maine that must be addressed; and to
- Develop draft proposals for any necessary changes to Maine governmental public health duties or accountabilities. Proposals are to follow the LD 1812 requirements of being "within existing resources over the next 5 years with the goals of ensuring access to public health services and of improving effectiveness and efficiencies of public health services delivery."

12 submissions were received by the deadline and are summarized here. The full text of the submissions will be provided to PHWG and Interested Parties on 10/22.

#0 Submitted by: Maine Municipal Association, Kate Dufour

#1 Submitted by: Healthy Communities of the Capital Area; Joanne Joy

#2 Submitted by: Megan Hannan

#3 Submitted by: Brenda Joly with Andy Coburn

#4 Submitted by: Family Planning Association of Maine; George Hill

#5 Submitted by: ACCESS Health (CCHC for Sagadahoc County); Marla Davis

#6 Submitted by: Cumberland County Coordinating Council for Public Health (C4PH); Julie Sullivan

#7 Submitted by: Maine Public Health Association, Richard Veilleux

#8 Submitted by: York County Healthy Maine Partnerships, Emily Rines

#9 Submitted by: Barbara Ginley

#10 Submitted by: Healthy Peninsula Steering Committee, Barbara Peppey

#11 Submitted by: Maine County Commissioners Association, Nancy Rines

Gap or overlap in current governmental public health duties and accountabilities that must be addressed:

G0. **Impact on Municipal Responsibilities and Finances:** Concern that the ideas generated by the PHWG will require communities to provide services that they are not equipped [financially and otherwise] to provide.

G1. **Parties at Table:** Behavioral Health, Dental Health, Schools Wellness should all be at a public health district ~ CCHC table. There may be others, but at this point in time, these should be prioritized.

G2. **Assessment Design and Data:** State region, and local public health funding and initiatives should be prioritized based on sound assessment design and data.

G3a. **Data to Assess our Capacity and Delivery of the 10 EPHS:** Although system includes programmatic performance assessments, there is currently no systematic process to routinely evaluate our capacity and delivery of the 10 EPHS in Maine.

G3b. **Leader in Accountability:** Lack of a specific program or office at the state level that focuses on assessment, accreditation and/or quality improvement for the purpose of accountability and that participates in national dialogues specific to public health performance and accountability.

G3c. **Clarity Regarding Duties:** Need to clearly articulate and have formal accountability mechanisms in place that reflect 1) alignment of local and state functions and 2) the functions that will be/need to be state-led or the minimum capacity/ requirements needed in a community to share in those duties.

G4a. **Teen Pregnancy Rates:** Certain Maine towns and cities continue to experience teen pregnancy rates that are higher than the statewide average.

G4b. **Identification of Health Issues and Timely Intervention:** Identification of important health issues in vulnerable populations and initiation of timely interventions is constrained because state Office of Research, Data and Vital Statistics (ORDVS) is under-funded.

G5a. **Connection with General Purpose Government and Emergency Preparedness System:** Maine's LHO and CCHC systems are inadequately connected to elected general purpose government and other vital preparedness, health and safety efforts at the County level and creating a "disconnect" with the system formally designated for Emergency Preparedness.

G5b. **Local Health Officers Network:** Need to address LHO responsibilities, functions, clarity of tasks and relationships with other public health functions, define competencies and provide training and certification.

G6. **Sub-State Public Health Infrastructure:** Without a sub-state infrastructure, there is no one on a local/regional level to coordinate the most effective use of fragmented resources, assure delivery of the 10 EPHS to all parts of Maine, and

provide on-the-ground, cross-jurisdictional prevention of and response to infectious disease outbreaks, including pandemic influenza.

G7. **Assessment of capacity and ability to deliver 10 EPHS:** There is currently no systematic, ongoing process to assess our capacity and our system's ability to deliver the 10 EPHS at the sate and local level.

G8. **Sub-State Public Health Infrastructure:** Without a formal sub-state infrastructure, no one person, organization or agency is currently responsible for the coordination of all state public health related contracts at the district level, e.g. HMP, WIC, regional epis, LHO, Emergency Preparedness.

G9a. **Refugee and immigrant health needs:** Currently there is no program within the ME CDC to address refugee and immigrant health needs; continued need for advocacy and enforcement on language access issues.

G9b. **Geographical and Resource Parity:** currently there is great disparity when one compares the public health infrastructure across the eight districts. It is unclear how each district will be supported to effectively execute the 10 essential PH services, and/or if there will be varying levels of compliance/expectations depending on existing infrastructure.

G9c. **Greater Delineation of Public Health Duties:** it will be important to clearly communicate who is responsible and accountable for specific core functions. To entities outside of the ME CDC there is not always clarity on this, and it could prevent future overlaps or gaps.

G9d. **Immunizations:** as Maine's rates have fallen dramatically in the past several years, this issue presents a system change that requires immediate redress.

G9e. **Emergency Preparedness:** Need on-going participation of the ME CDC in the county, regional and statewide efforts.

G10a. **Clarity of Roles and Authority; Coordination:** Lack of clarity of roles for CCHCs and Regional [District] Coordinating Councils; lack of clarity of delegated authority to CCHCs, LHOs, hospitals and others; lack of resources for CCHCs and LHOs to assume delegated functions; lack of awareness and coordination of various parts of the "system" resulting in duplication or gaps; for consumer, a confusing system to access.

G10b. **Public Health Data:** Lack of public health data by local service areas, counties, districts.

G10c. **Adequacy of Services:** Inadequate mental health, dental and substance abuse services, especially in rural areas – both inpatient and outpatient.

G11. **Regional [District] Coordination:** Many of the components of a public health infrastructure already exist in the state of Maine, but lack adequate coordination. A regional approach needs to provide a central role for regional and local general-purpose government, i.e. counties and municipalities, through their elected officials.

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Draft proposal for necessary change to address identified gap or overlap in current governmental public health duties or accountabilities:

P0. **Impact on Municipal Responsibilities and Finances:** Ensure that existing public health-related resources are maximized not only to meet existing needs, but also to be potentially available to fund, if necessary, the identified gaps in the system.

P1. **Parties at Table:** Develop a plan to have Behavioral Health, Dental Health, Schools Wellness and other identified parties at District ~ CCHC table.

P2. **Assessment Design and Data:** District staff and coordinating body should assure reliability of local assessment design and data.

P3a. **Data to Assess our Capacity and Deliver of the 10 EPHS:** Implement an accountability system for the state and the new districts to assess our ability to deliver the 10 EPHS.

P3b. **Leader in Accountability:** Reorganize staff (even if one person) and create a program at the state level focusing on public health performance, assessment, accountability and/or quality improvement with the goal of improving health outcomes.

P3c. **Clarity Regarding Duties:** Put formal accountability mechanisms in place that reflect 1) alignment of local and state functions and 2) minimum capacity/ requirements needed in a local community to share in those duties.

P4a. **Teen Pregnancy Rates:** Have Family Planning Association work with District Coordinating Councils, HMPs and others to identify towns and cities experiencing higher teen pregnancy rates and develop strategic, educational and clinical interventions in communities motivated to do so.

P4b. **Identification of Health Issues and Timely Intervention:** Adequately fund ORDVS to make it possible to identify important health trends in vulnerable populations and initiate more timely interventions.

P5a. **Connection with General Purpose Government and Emergency Preparedness System:** Formally designate the county level (or multi-county jurisdictions) as the implementing partner for the local public health infrastructure.

P5b. **Local Health Officers Network:** Revise the statutory authority MRSA Title 22 General powers and duites Part 2: State and Local Health Agencies, Chapter 153: Local Health Officers; train and otherwise strengthen the LHO Network.

P6. **Sub-State Public Health Infrastructure:** Establish a State Board of Health, 8 District Boards of Health (advisory or governing), 8 District Health Officer positions (hired and supervised by District Boards of Health with input from MCDC), and 8 District Coordinating Councils.

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P7. **Process to assess capacity and ability to deliver 10 EPHS:** Establish a systematic, ongoing process to assess capacity and delivery of the 10 EPHS at both the state and local levels; establish a position in MCDC to provide oversight on performance assessment, quality improvement, and provide leadership on accountability.

P8. **Sub-State Public Health Infrastructure:** Establish 8 District Boards of Health and 8 District Health Officer Positions (hired and supervised by MCDC).

P9a. **Refugee and Immigrant Health Needs:** Implement a "Refugee Health Committee" or "Division" within the Maine CDC or DHHS. This Committee or Program would oversee all refugee health issues for the state of Maine. The Office of Minority Health would be an important participant/leader of this Committee.

P9b. N/A

P9c. **Greater Delineation of Public Health Duties:** Recognize that FQHCs can be part of the solution to delivering essential services (i.e.#7 linking people to care). Health centers are focused on being responsive to community or special population needs.

P9d. **Immunizations:** Have greater fiscal support of state purchased vaccine as well as the ME CDC identifying why the system is no longer able to insure that children are receiving their age-appropriate immunizations and how to better support access for adults.

P9e. **Emergency Preparedness:** Have on-going participation of the ME CDC in the county, regional and statewide efforts. Their presence at the table is essential in meeting core PH functions but would also enhance the communication between stakeholders.

P10a. **Clarity of Roles and Authority; Coordination:** Build on current capacity, engage other key players, and recognize the unique distinctions structurally, resource-wise, and organizationally between rural and urban centers. Realize that we could have different models to address similar functions.

P10b. N/A

P10c. N/A

P11. **Regional [District] Coordination:** (per 12/13/2006 proposal) Authorize the county commissioners of each public region [district] to convene all of the key players in the public health community, both public and private, who will sit as a body - board of public health or a public health coordinating council.

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