Janet T. Mills
Governor

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Commissioner

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Statewide Coordinating Council for Public Health
Final Meeting Minutes of September 19, 2019
Bangor DHHS
11:30 a.m. – 2:00 p.m.

Voting Member Attendance:

Seat	Roll Call	Name	Organization	Representing
1	x	Betsy Kelley	Partners for Healthier Communities	York District
2	x	Courtney Kennedy	Good Shepherd Food Bank	Cumberland District
3	x	Erin Guay	Healthy Androscoggin	Western District
4	x	Melissa Fochesato	Mid Coast Hospital	Midcoast District
5	x	Denise Delorie	Mid Maine Substance Use Prevention	Central District
6	x	Patty Hamilton	Bangor Public Health Department	Penquis District
7	x	Maria Donahue	Healthy Acadia	Downeast District
8	x	Jo Barresi Saucier	Aroostook Area Agency on Aging	Aroostook District
9	X	Nirav Shah	Maine CDC	State Government
10	x	Victor Dumais	Office of Substance Abuse & Mental Health Services	Department of Health & Human Services
11	x	Emily Poland	Maine Department of Education	Department of Education
12	x	Kerri Malinowski	Department of Environmental Protection	Department of Environmental Protection
13		Kenney Miller	Maine Health Equity Alliance	Essential Public Health Services
14	x	Kalie Hess	Partnership for Children's Oral Health	Essential Public Health Services
15	x	Doug Michael	Eastern Maine Health Systems	Essential Public Health Services
16	x	Peter Michaud	Maine Medical Association	Essential Public Health Services
17	x	Meg Callaway (resigned)	Penquis	Essential Public Health Services
18	x	Erika Ziller	Maine Rural Health Research Center	Essential Public Health Services
19		Kolawole Bankole	Portland Public Health	Essential Public Health Services
20	X	Joanne LeBrun	Tri County EMS	Essential Public Health Services
21	x	Abdulkerim Said	New Mainers	Essential Public Health Services
22		Kristi Ricker		Wabanaki Public Health District
23	x	Carol Zechman	MaineHealth	Essential Public Health Services

Attending:	20	Attending by Phone:	#
Planned absent:	1	Absent:	#2
Vacant Seat:	0		
Total Council Makeup	23		

Total Voting Members Attending: 20; 12 = Quorum = Quorum **Achieved**

Interested Parties and Stakeholders Attending

Dora Anne Mills; Randy Schwartz, public health consultant; Erik Gordon, Nancy Birkhimer, Nancy Beardsley (MCDC)
Christine Lyman, Midcoast Public Health Council
Jessica Fogg, Drexell White, Adam Hartwig, James Markiewicz, Andy Finch, Jamie Paul, Al May (MCDC)
Kenneth Lewis, Tory Rogers, Sue Mackie Andrews, Clay Graybeal, Jo Morrissey, Maine Shared CHNA

MEETING NOTES		
Agenda	**Discussion**	**Next Steps/ Resolution/ Assigned To**
Dr. Shah welcome	Comments regarding the SCC's work and the work of the CDC: MCDC Priorities: staffing – CDC has lost over 100 positions and filling vacancies is a priority. Initial thoughts about the public/private partnership and the current system? There are benefits and drawbacks to a hybrid system. There may be a need for an assessment.	n/a
PHHSBG Revision	A revision is underway and Nancy Birkhimer will email a draft to the SCC. A public hearing will be held and approval needed for a change in the workplan. An assessment of the local public health systems will take place. Question: Last year, this council advised a LPHS assessment as a facet of that approach. Is another public hearing necessary? Answer: Because there is an approved plan that does not call that out specifically, we have to go through the approval process through the Federal CDC; in order to get their approval we have to go through the formal steps of hearing and SCC vote.	
Annual Report	This Council's Government is still in revision mode; a final draft needs to be brought to the SCC and reviewed/approved. Volunteers were solicited for drafting the Annual Report which is submitted to the Joint Standing Committee on Health and Human Services. James Markiewicz, Nancy Birkhimer, Kerri Malinowski, Kalie Hess and Betsy Kelly volunteered.	The Steering Committee will undertake a draft for the December or March meeting.
Public Health Improvement Plans	Maine CDC/DPH has asked the DCCs to partner to implement the Local Public Health Systems Assessment during 2020. Communication from DLs to DCCs today that will lay out the timeline and framework. Focusing on systems work next year.	
Breakout session # 1 Notes:	Discussion Question: Future State: If the SCC and MeCDC were working extremely well together, how might we enhance and strengthen our public/private public health system in Maine? What would be different? What would success look like? How might we enhance and strengthen our public/private PH system? What is our system? Can we have a definition? Maybe what would be improved is clarity. Would like to pass on successful PH improvement programs in communities and statewide. We need more tangible outcomes, and with those the state could create a repository of what works in order to replicate.	

	Using same terms and concepts for PH. RWJF project funded project recognizes we are all using different definitions. Ie: help people understand the 10 essential public health services. One thing I've noticed is the varying levels of PH competency across the state. It's gotten better, but workforce development is needed. But administrative and by-laws can take up a lot of time and replace conversation about the topics at hand. There is incredible talent around the table. Once we identify a priority, perhaps addressing that priority through the health in all policies lens. By that I mean, use the SCC and DCC time in divvying up or decide how to collaborate on addressing the health needs of all Mainers. Say, for instance, the health priority is reducing obesity. We can all have a role. For instance, at the DOE, the whole school, whole community, whole child model takes all those aspects into consideration when addressing a DOE priority. So, when looking to decrease absenteeism, how can school lunch, physical education, or the library services address that issue? Me CDC juggles many mandates and the SCC can give counter advice to how the staff must meet those mandates. Because of the MeCDC structure, the members of the SCC are either previous or current contractors or subcontractors, and there's a CI issue. So then it comes down to doing the actual work it's not a coalition but a member of the coalition. Need clarity of roles to be able to move forward. Question: how is the SCC supposed to enrich our infrastructure and activities? Agreement: how do we move towards an SCC that has a more substantive role in implementing PH? Defining roles, and the CDC has a lot of 'masters' The SCC was developed to guide the MeCDC. Is there a way for the SCC to strengthen the representation and needs of New Mainers? Are we fulfilling the mandate from the statute? http://legislature.maine.gov/legis/statutes/22/title22sec412.html Success includes clear and coordinated communication. We would all know where to turn for the information we needed.	

	What about addressing equity? Assessing health equity? Using assessment tools to identify HE and help build health improvements based on the identified needs?	
Breakout session # 2 Notes:	Question #2: What key elements of the public health system in Maine on which we might want to assess current structure and functional performance? 1. Role and structure of DCCs a. Clarify the role of the SHIP and how it informs/aligns with DCC b. Structure of the SHIP, how it is created, and how DPHIPs inform the SHIP and vice versa. 2. DCCs to provide systems development support? Concern in the group about the capacity of DCCs to do this currently. a. Funding for district public health system development activities? District assessment will inform what resources are necessary to do systems development at the local level, but the functional reality is that DCCs are largely volunteer-led and lacking resources to undertake the level of work that might come out of the district assessments that James mentioned. b. Funded staff at district level not available to do this work - need to look at how to bring funding to do this work in districts/local level c. Additionally, during the district assessments James mentioned, we need to ensure that we are reaching out to look at who is at the table. DCCs are not always representative of the folks who are addressing all the public health needs of the district, so would need to look beyond DCCs to ensure the "system" of public health in the district is being represented. 3. Role and structure of contracts and contractors funded by the Maine CDC 4. Assess current structure and performance of the SCC a. Do we need conflict of interest policies, things in place to ensure transparency, what else do we need to model? Need to model a solid structure from the top if we are going to be assessing DCCs and the rest of the system. b. What are the structures needed to support whatever the new role of the SCC is? c. Assess membership gaps at SCC. Vendors of public health services are not at the table, or, are we heavy in one sector? d. Essential public health services to inform this, and is there anything needed beyond essential public health services that we need? 5. Public health happens beyond the SCC and the DCCs	

	a. How do you prioritize what elements of the public health system need to be assessed and how do you determine what you need to know? We can't assess everything. b. Hospital systems, EMS, community coalitions, and those who aren't at the table (Why not? Where are they? Do we need to assess this?)	
Breakout Session # 3 Notes:	SCC small group discussions Question 3 1. (Possible planning tools to utilize) What kinds of tools and planning process might help us to assess current state and set our collective sites on a desired future state? – this may include Asset/Gap analysis, NACCO System Assessment tools, other planning processes like SWOT etc. The group had questions about the MAPP process used by many districts - mobilizing for action for planning and process (MAPP) includes a set of four questions. This was initially the tool CDC required the HMP's to use. It delves into community health conversations "forces of change" i.e. what are outside forces economics transportation etc. Mt. Desert does this q 3 years and adds in CHNA. Also, still used in other states by city & county health depts. It is a NACCHO validated tool. Discussed the CDC desire to use LPHS assessment. This too is a NACCHO validated tool based on the 10 EPHS. This was the tool used in 2009 so using it again will give the state comparative data. With this tool a review of standards is conducted and to be successful it is desirable to have all relevant (to the standard) public health people in the room. LPHSA—results use a subjective approach, participants rate how they are doing at the particular EPHS standard and the score is entered into algorithm. In 2009 a lot of the district's LPHS assessment the standard addressing research or workforce were very weak because the district model was new. Tribes were part of districts were not their own. How did assessment fit into DHIP? This was unclear. One desire was to minimize the cost of hospital and health care especially related to emergency rooms. Go back to model that looks at structure like the early EPHS evaluation , now hospitals have 'community benefit' and how could these dollars improve the connection between CHNA and state SHIP Does this LPHSA help with accreditation? We are not sure, this was done to assist the SHIP (we do not have a health plan). Other tools are healthy people 2020 or 2030; many states are using this	

	Which is most fundamental in assessing PH in the state? What is key piece to explain to neighbor or legislator what works here? does state plan build off of local action? What is best way to measure this movement or action in the plans. This is something that SCC should examine, we don't have something at the very local level. Thinking about future SCC agendas' we might want a primer on 10 EPHS. Attending meetings and engaging partners in the LPHSA really helped us at the local level, people began to understand their role in relationship to Public health activities. When we didn't continue to do this, people left and haven't returned (for example to DCC tables) At Maine CDC level they should be looking at new ideas and best practices this should help guide gaps at local level. Mecdc staff try to bring this to the table but it's not always lined up. At the strategic level having these conversations helps to develop local plans an example is 'all hazards vulnerability plan'. Not something SCC would do but looking at accreditation reports may also help, how healthy is lead agency (MeCDC)—lens thru accreditation one of the SCC roles. Accreditation should validate that the work is beneficial, that we are doing right thing for right reasons. At the local level this is an opportunity to make more of a connection Health equity alliance recently conducted a meeting and discussed transportation, housing for at risk groups, IDU, HIV etc. they got down to the root causes of these barriers, a more productive approach. Quality improvement is on MeCDC's list for DCC's to take on some QI projects. This could be done over time and would bring a variety of people to the table. State PH system assessment has not been done for 9 years this should also happen. Opportunity for MeCDC, Public Health re-imaginged , DCC's and others to talk about the system. This could be done over the course of 2020, opportunity for SCC to promote State health improvement assessment How was this paid for in the past? Possible block grant $$ Tool that is all about infrastructure we need to figure out how to market this idea to get the money to pay for it and market it to the legislators NACCHO, ASTHO potential grant opportunities to pay for this.	
	Meetings Quarterly meetings but longer? 0 Monthly meetings, shorter Every other month OK Location: Move around? Or Augusta?	