

Acknowledgements

This report was prepared by Karen O'Rourke, MPH and Joan Orr, CHES from the Maine Center for Public Health in 2010 for the Office of Local Public Health at the Maine Center for Disease Control and Prevention.

District Public Health System Assessment Team:

Maine Center for Public Health team
 Office of Local Public Health/Maine CDC team

 Office of Primary Care/Maine CDC:
 Division of Family Health/Maine CDC

Funding Support

Preventive Health & Health Services Block*
 Public Health Preparedness and Response*
 Fund for a Healthy Maine^

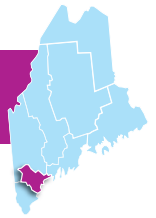
 Healthcare Research & Services Agency*
 Maternal/Child Health Block Grant*

**federal grant funds*
^State funds (Tobacco Settlement)

We would like to express our sincere gratitude to Mark Griswold and Chris Lyman for their leadership and vision of public health in Maine. Also to the District Liaisons for their creative ideas, constructive advice and assistance which was invaluable in the assessment process.

Aroostook Stacy Boucher	Midcoast Jennifer Gunderman-King
Central Paula Thomson	Penquis. Jessica Fogg
Cumberland Becca Matusovich	Western. MaryAnn Amrich
Downeast Alfred May	York. Sharon Leahy-Lind

We want to convey a special thank you to the District's public health stakeholders who committed their time and knowledge of local areas activities, resources, gaps and challenges. Without their participation, we would not have been able to develop this snapshot in time.



November 2010

Dear Colleague:

Public health's core functions include assessment, policy development, and assurance. This report constitutes a systematic look at how public health services are coordinated, aligned and delivered by organizations of this public health District for the people who live, work, study and visit here.

The Department of Health and Human Services' Maine Center for Disease Control and Prevention provided funding support for the use of a nationally recognized public health system tool to assess regional public health systems in Maine's eight health districts.

These DHHS Districts were codified in state statute by the Legislature in 2009, based on the work of the Governor's Office of Health Policy and Finance, in partnership with a host of local, regional, and state-level public health stakeholders. The legislation describes the different components of Maine's emerging public health infrastructure, and within this description were the seeds of necessary public health steps that produced the report you see before you.

All District Public Health System Assessment Reports are available for downloading at www.mainepublichealth.gov. A limited number of paper copies have been made available to your District Health Liaison and Coordinating Council, as well as your nearest Healthy Maine Partnership, whose contact information can also be located at the link above.

If you have comments or questions about the findings, please contact the District Liaison whose contact information is available inside.

The Assessment findings are a snapshot in time. It sets a baseline from which to measure progress and collaborative work to improve and to protect District community health and quality of life. It is a qualitative tool, but a necessary one to move forward. It is one step in many innovative efforts to better support local efforts to protect and improve community health and quality of life, reduce disparities in health status among groups in the District, and make Maine the healthiest state in the nation.

Thank you for your interest in the health of Maine's people.

Sincerely,

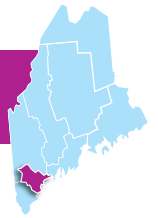
A handwritten signature in black ink that reads "Dora Anne Mills".

Dora Anne Mills, MD, MPH

State Health Officer

Director, Maine Center for Disease Control and Prevention

Maine Department of Health and Human Services



From the Office of Local Public Health:

Local knowledge and perspective of participants built the picture you have before you of the District's public health system's assets. Part of the fun and challenge was to capture an understanding of *where* in this district services are being delivered. For a single county District, this might not be a challenge. But in a multi-county District, stakeholders had to look at services across all parts of a wider geography and meet more stakeholders than usual.

Our shared experience in applying the Local Public Health System Performance Assessment tool allowed us all to develop a better awareness of public health terms, definitions, and expectations for what a public health system can do. It helped everyone think in terms of systems, rather than one organization or sector. We looked at relationships *between organizations*, not only the people in them, and considered how to serve groups of people rather than individuals.

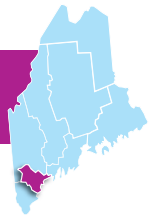
The results of this Assessment are being integrated into two types of planning documents. Healthy Maine Partnership coalitions are using the results to look at what's happening in their own local service areas as part of developing Community Health Improvement Plans. District stakeholders and members of the District Public Health Coordinating Councils are using the results to identify action steps for District System quality improvement priorities as part of District Health Improvement Plans.

Having District Public Health System Assessments will help Maine work towards achieving national public health agency accreditation, which is an objective of the 2010 State Health Plan.

The organizations and people who came together to create this report took a major step in strengthening their District public health system. More than ever, we appreciate that public health happens at the local level.

Mark Griswold
MPH Director, OLPH

Christine Lyman, MSW, CHES
Senior Advisor, OLPH



We of the Cumberland District Public Health System

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

Thanks to Toho Soma and Portland Public Health for their leadership in organizing the process and preparing for LPHSA meetings. Thanks, too, to the City of Portland, Town of Gorham, and Freeport Community Services for meeting space.

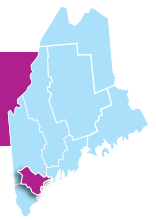
The LPHSA Planning Committee included:

Toho Soma, Portland Public Health, Chair
Naomi Schucker, MaineHealth
Shane Gallagher, Portland Public Health
Marice Tran, Portland Public Health
Elizabeth Trice, Cumberland County
Mark Griswold, Maine CDC

Thanks also to the Cumberland District Coordinating Council 2010 Executive Committee

Colleen Hilton, Chair, VNA Home Health & Hospice
Malory Shaughnessy, Vice Chair, formerly Cumberland County Commissioner
Julie Sullivan, Secretary, Portland Public Health
Dick Farnsworth, Treasurer/Finance Committee, Woodfords Family Services
Deb Deatrck, CDPHC Representative to the SCC, MaineHealth
Becca Matusovich, District Public Health Liaison, Maine CDC/DHHS
Toho Soma, Health Data Committee Chair, Portland Public Health
Lucie Rioux, Healthy Cumberland Committee Chair, People's Regional Opportunity Program
Meredith Tipton, Membership Committee Chair, Tipton Enterprises
Valerie Landry, Advocacy Committee Chair, Mercy Hospital

Thanks to all!



Cumberland District Characteristics

How the District is organized

- The Cumberland Public Health District covers Cumberland County.
- There are 28 municipal governments, including Maine's largest city, and towns.
- The District serves all towns and islands, some of which have year-round or seasonal residents.

Who we are*

- 276,047 people with 330.4 persons per square mile (Census 2008 est.).
- 15,505 of us are less than 5 years old, 59,301 are 18 years old, and 37,029 over 65 years old.
- 27.3% of our children are eligible for free or reduced school lunch.
- 9.9% of us are adults with a lifetime status of having less than a high school degree.
- We are enriched by our density and diversity, including New Mainers originally from other countries.
- Much more data on who we are can be found at www.mainepublichealth.gov.

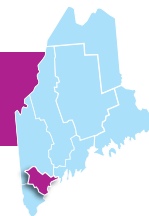
How the public/private Public Health System of the District is organized

- The District has its own webpage: at www.mainepublichealth.gov, see under *Local Public Health Districts*.
- A multi-sector District Coordinating Council and its leaders partner with the District Liaison.
- A DCC-elected representative sits as a voting member of the State Public Health Coordinating Council.
- Healthy Maine Partnership (HMP) coalitions each serve their towns within the District.
- HMPs are members of the District Coordinating Council.
- Each town can appoint a Local Health Officer (LHO), who is trained/certified by Maine CDC.
- A District Liaison serves the whole District and is located in Portland's DHHS's regional office.
- The District Liaison provides oversight of LHOs, and technical assistance to LHOs and HMPs.

The governmental District Public Health Unit includes the District Liaison plus

- 7 public health nurses
- 1 field epidemiologist
- 1 drinking water protection specialist
- 2 health inspector

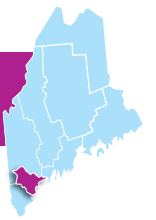
*see updated data from the new census at www.census.gov

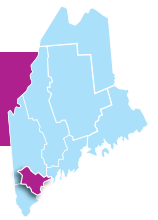


List of Cumberland Local Public Health Assessment Participants*

Katie Addicott Portland Public Health Div.	Steve Fox City of South Portland	Becca Matusovich Maine CDC	Dan Sizemore Northern New England Poison Center
Sharon Bagalio Mercy Hospital	Arian Giantris Catholic Charities Maine	Rebecca Miller No. New England Poison Ctr	Janet Smith MaineHealth
Kolawole Bankole Portland Public Health Div.	Sandy Hale Westbrook School Dept.	Zoe Miller People's Regional Opportunity Program	Pam Smith Bridgton Hospital
Lisa Belanger Portland Public Health Div.	Tom Handel Community Television Network	Helen Peake-Godin USM College of Nursing	Julie Sullivan Portland Public Health Div.
Laura Blaisdell ME National Children's Study	Kate Herrick CarePartners	Tina Pettingill Maine Public Health Assoc.	Cindy Tardif Cape Elizabeth Middle School
Jim Budway Cumberland County EMA	JoAnna Hillman Portland Public Health Div.	Kate Phillips Maine CDC	Jim Tasse Portland Public Health Div.
Linda Christie ACCESS Health	Colleen Hilton VNA Home Health and Hospice, Mercy Hospital	Tony Plante Town of Windham	Caroline Teschke Portland Public Health Div.
Andy Coburn USM Muskie School	Judy Johnson Portland Public Health Div.	Lucie Rioux People's Regional Opportunity Program	Ted Trainer So. Maine Agency on Aging
Pau Coleman Cumberland County Jail	Brenda Joly USM Muskie School	Gwen Rogers Maine Medical Center	Heather Treadwell Family Crisis Services
Tim Cowan MaineHealth	Sandi Kazura MaineHealth	Debra Rothenberg Maine Medical Center	Elizabeth Trice Cumberland County
Margaret Cushing Child Care Connections	Carri Kivela Bowdoin College	Mike Russell Portland Public Health Div.	Steve Trockman* So. ME Regional Resource Center
Faye Daley Towns of Bridgton and Harrison	Tara Kosma People's Regional Opportunity Program	Bethany Sanborn Portland Public Health Div.	Nat Tupper Town of Yarmouth
Deborah Deatrick MaineHealth	Ann Lemire Portland Public Health Div.	Barbara Shaw USM Muskie School	Emily Wolff 21 Reasons, Medical Care Development, Inc.
Susan Doran Portland Trails	Jo Linder Maine Medical Center	John Shoos United Way of Greater Portland	Edie Woodward Cumberland County Jail
Lynn Doxey MaineHealth	Rob Lindstedt So. ME Community College	Toby Simon Portland Public Health Div.	Carol Zechman CarePartners
Beth Eilers Portland Public Health Div.	Jessica Loney Mid Coast Hospital		
Dick Farnsworth Woodfords Family Services			

**representing these organizations
at the time*





Background

The Maine Center for Disease Control and Prevention (MCDC) contracted with the Maine Center for Public Health (MCPH) to lead a formal assessment process during 2009. The assessment was designed to identify the strengths, limitations, gaps, and needs of the current public health system in each of the eight newly forming public health districts. The results depicted in this report are intended to serve as the impetus for the development of a district strategic improvement plan building up to coordinated statewide strategies as appropriate.

MCPH was responsible for facilitating the formal assessment using a nationally recognized public health performance standards tool. The Center was selected to lead the assessment process given their training and experience in this area.

Overview of Public Health Performance Standards

The Centers for Disease Control and Prevention spearheaded and established in 1998 a national partnership initiative, the National Public Health Performance Standards Program [NPHPSP], to improve and strengthen the practice of public health, enhance systems-based performance, and support public health infrastructure.¹ To accomplish this mission, performance standards for public health systems have been collectively developed. These standards represent an optimal level of performance that needs to exist to deliver essential public health services within a public health system.

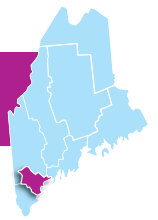
The NPHPSP is intended to improve the quality of public health practice and the performance of public health systems by:

1. Providing performance standards for public health systems and encouraging their widespread use;
2. Engaging and leveraging state and local partnerships to build a stronger foundation for public health;
3. Promoting continuous quality improvement of public health systems; and
4. Strengthening the science base for public health practice improvement.

As part of this initiative, three assessment instruments were created to help delineate model standards and evaluate performance. The tools include the following:

- State Public Health System Performance Assessment Instrument focuses on the “state public health system” and includes state public health agencies and other partners that contribute to public health services at the state level.

¹Centers for Disease Control and Prevention—National Public Health Performance Standards Program. Available at: <http://www.cdc.gov/od/ocphp/nphpsp/>



- Local Public Health System Performance Assessment Instrument focuses on the “local public health system” or all entities that contribute to the delivery of public health services within a community. This system includes all public, private, and voluntary entities, as well as individual and informal associations.
- Local Public Health Governance Performance Assessment Instrument focuses on the governing body ultimately accountable for public health at the local level. Such governing bodies may include boards of health or county commissioners.

Public Health Core Functions

The three core public health functions include assessment, policy development, and assurance.

■ ASSESSMENT

This function includes the regular collection, analysis and sharing of health information about risks and resources in a community. The purpose of it is to identify trends in illness, injury, and death, including the factors that lead to these conditions.

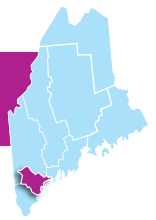
■ POLICY DEVELOPMENT

Information collected during the assessment phase is often used to develop state health policies. Good public policy development involves the community and takes into account political, organizational, and community values.

■ ASSURANCE

This function includes the assurance of the availability of quality and educational programs and services necessary to achieve the agreed-upon goals.





Concepts Guiding Performance Standards Development and Use

Four concepts have helped to frame the National Public Health Performance Standards into their current format.

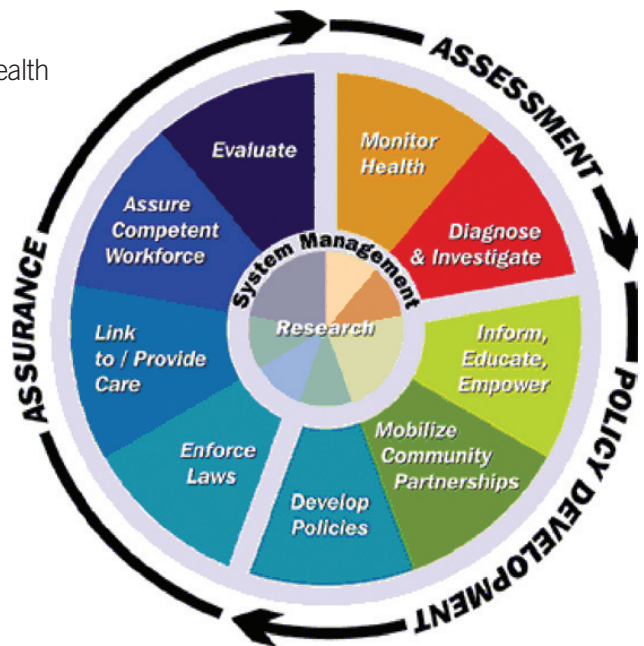
I. For each tool, performance is assessed through a series of questions **based on the 10 Essential Public Health Services (EPHS)** Framework. This framework delineates the practice of public health. The essential services include:

Assessment

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.

Policy Development

3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.



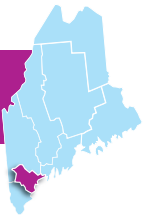
Assurance

6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

Serving All Functions

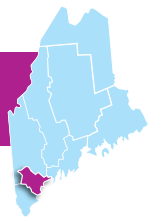
10. Research for new insights and innovative solutions to health problems.

II. The standards **focus on the overall District Public Health System**, rather than a single organization. By focusing on the District Public Health System, the contributions of all entities are recognized that play a role in working to improve the public's health.



- III. The standards **describe an optimal level of performance**, rather than provide minimum expectations. This assures that the standards provide benchmarks which can be used for continuous quality improvement and stimulate higher achievement.

- IV. The standards are explicitly intended to **support a process of quality improvement**. System partners should use the assessment process and results as a guide for learning about public health activities and determining how to improve services.



Assessment Process

The formal assessment was conducted during a series of three meetings followed by a report-back meeting to present preliminary results and ensure content accuracy.

This report provides a description of the district assessment process and a comprehensive review of the quantitative and qualitative results. Assessment findings should be used as the basis to identifying strategic direction for enhancing performance.

The intended audience for this report includes:

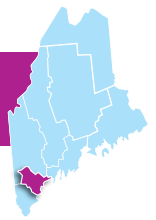
- Participants involved in the formal assessment process
- District and State Public Health Coordinating Councils
- Public health practitioners and stakeholders
- Others interested in supporting local public health system-based efforts

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

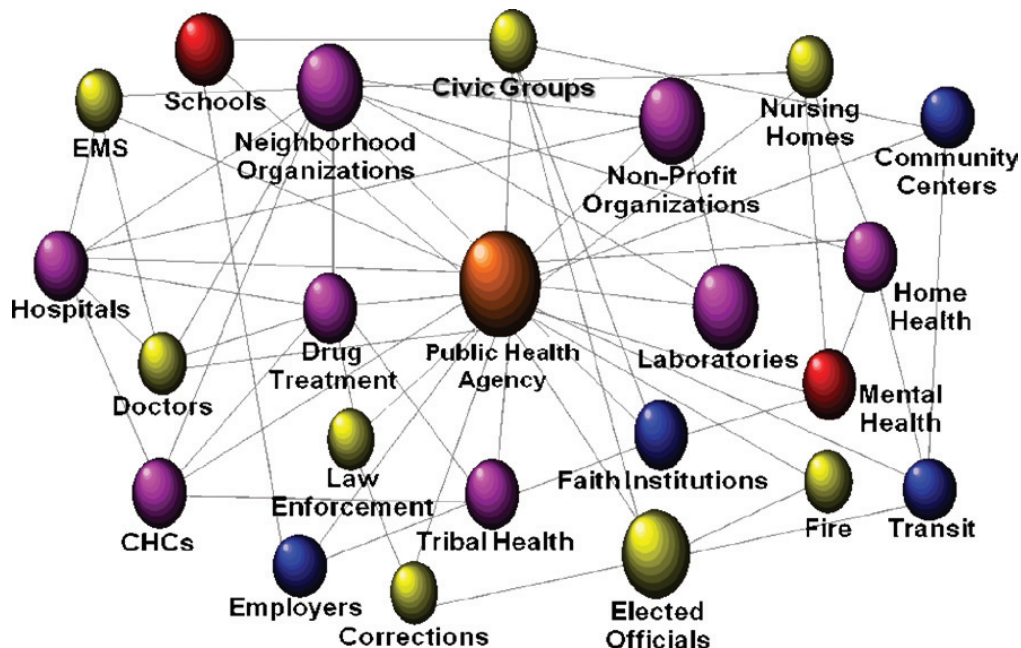
This document is intended to be used as a spring-board for discussion in the second phase of this initiative known as the system improvement planning process; a process that will be led by each District Coordinating Council. Assessment findings will be used as the basis to begin identifying next steps, future strategies, suggestions for enhancing performance, and priority areas. Additionally, districts might engage in more coordinated decision making, leverage system partners for identified priorities, and pool resources to achieve shared objectives.

Stakeholder Participation

Invitations were sent to a broad range of disparate partners representing the District jurisdiction, including municipal public health agency, county government, regional offices of state agencies, community-based organizations, academic institutions, hospitals, health systems, community health centers, school systems and nonprofit organizations such as United Way, YMCAs, environmental organizations, anti-poverty agencies' substance abuse and mental health services, area aging agencies, etc. Additionally, invitations were sent to first responders, elected officials, social service providers, librarians, administrators, diversity advocates, and others representing local governmental or quasi-governmental entities such as planning commissions, police departments and adult education programs.



The Public Health System



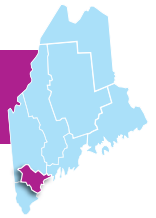
Benefits of a Strong System

Strong and effective public health systems have the ability to...

- Improve the health of the public
- Protect the public's health
- Carry out the essential public health services
- Advocate on behalf of what's in the best interest of the public's health
- Work collaboratively with stakeholders, communities, volunteers, and others
- Decrease rising health care costs
- Secure federal funds and foundation dollars for public health activities

Assessment Tool

Intention of the tool is to help improve organizational and community communication, bring partners to the same table, promote cohesion and collaboration, provide a systems view of public health and provide a baseline for Maine's emerging district public health system.



The 69-page assessment tool was developed by the CDC and other national partners. The tool was revised in 2008 and is comprised of a total of 325 questions and 30 model standards assessing the major activities, components, and practice areas of the ten essential services within the District public health system. The assessment questions serve as the measure and all questions are preceded by model standards which represent the optimal levels (gold standard) of performance based on a set of indicators that are unique to each essential service. The tool can found at: <http://www.cdc.gov/od/ocphp/nphpsp/TheInstruments.htm>

Please answer the following questions related to Model Standard 1.1:

1.1.1 Has the LPHS conducted a community health assessment?

1.1.1.1 Is the community health assessment updated at least every 3 years?

1.1.1.2 Are data from the assessment compared to data from other representative areas or populations?

1.1.1.2 Discussion Toolbox
 In considering 1.1.1.2, are health status data compared with data from:

- Peer (demographically similar) communities?
- The region?
- The state?
- The nation?

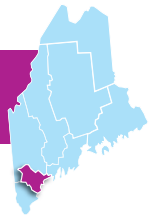
NO MINIMAL MODERATE SIGNIFICANT OPTIMAL

NO MINIMAL MODERATE SIGNIFICANT OPTIMAL

NO MINIMAL MODERATE SIGNIFICANT OPTIMAL

National Database

To complete the local public health system assessment process, responses are submitted to a national database. This database is managed by the CDC and includes information on the local public health agency, the jurisdiction, the governing structure, entities represented during the assessment, and the final assessment scores.



Response Options

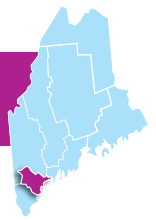
There were five response options available to classify the activity that was met within the District public health system. Because the assessment was completed in eight newly formed DHHS administrative jurisdictions, MCPH, Maine CDC, and a group of stakeholders further defined the response options to help ensure consistency across all eight that address the needs of a newly forming system. For this same reason and because some functions are provided at a state level in Maine, selected questions within essential services 2, 5, and 6 were scored the same in all Districts statewide (see results section). The response options were defined as follows:

SCORE	DEFINITION
No 0%	No activity.
Minimal >0 and 25% or less	Some activity by an organization or organizations within a single service/ geographic area. Not connected or minimally connected to others in or across the District.
Moderate >25% but no more than 50%	Activity by one or more agency or organization that reaches across the District and is connected to other organizations in the District but limited in scope or frequency.
Significant >50% but no more than 75%	Activity that covers the entire district [is dispersed both geographically and among programs] and is connected to multiple agencies/organizations within the District Public Health System.
Optimal Greater than 75%	Fully meets the model standard for the entire district.

Scoring, Data Entry, and Data Analysis

An algorithm, developed by the CDC, was utilized to develop scores for every Essential Public Health Service. Each question was assigned a point value and given a weight depending on the number of questions and tiers. The score range was 0 to 100 with higher scores depicting greater performance in a given area. The scoring scheme and algorithm are available upon request. Each response was entered into the CDC database for analysis, with a report generated highlighting the quantitative results.

In addition to the scores that were collectively assigned, qualitative information was recorded and assessed by MCPH. The comments by participants were captured on a laptop computer throughout the meetings for each question addressed. While not an inventory of activities, the comments were used to identify themes, provide a context for scores, and identify strengths, weaknesses, gaps and recommendations for improvement or collaboration for the District.



Assessment Benefits and Limitations

THE BENEFITS of this type of assessment process have been well documented by the US CDC and other partners. This process served as a vehicle to:

- Improve communication and collaboration by bringing partners to the same table.
- Educate participants about public health, the essential services, and the interconnectedness of activities.
- Identify strengths and weaknesses that can be addressed in quality improvements through the use of a nationally recognized tool.
- Collect baseline data reflecting the performance of the district public health system.

Despite the advantages of an assessment such as this, there are limitations related to the process, tool, data collection, and generalizability of results that warrant attention. They include the following:

PROCESS LIMITATIONS

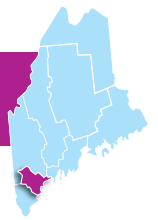
- Although attempts were made to encourage participation from multiple stakeholders, some representatives were missing from the process as noted on the summary page of results. The assessment format and anticipated commitment level during the assessment process may have prevented some participants from engaging in the series of meetings.
- The group process may have deterred introverted individuals who prefer less interactive approaches.
- The time commitment may have hindered the ability of some to participate due to lack of employer support or conflicting priorities.
- Additionally, differences in knowledge can create interpretation issues for some questions.

TOOL LIMITATIONS

- The tool was detailed and cumbersome to complete in a consensus-building process. Reaching true consensus on each question was deemed to be unattainable in the given timeframe. After discussion of each question, facilitators suggested a score and asked for participant agreement.

DATA COLLECTION LIMITATIONS

- The response options delineated in the tool were awkward to grasp by the newly forming infrastructure. Participants were frequently reminded of the district context.
- The scores were subject to the biases and perspectives of those who participated and engaged in the group dialogue.
- The comments made during the assessment may have been difficult to accurately capture due to multiple people speaking at once, individuals who could not be heard, or comments that were spoken too quickly. Every attempt was made to capture the qualitative comments, yet gaps exist. The intent of the report-back session was to improve on these limitations.



GENERALIZABILITY OF RESULTS

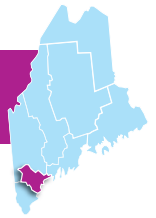
- The results of this assessment were based on a facilitated group process during a specific time period. Changes to the District public health system at all levels constantly occur. This assessment provides a snapshot approach.
- The assessment process was subjective, based on the views of those who agreed to participate.

Quality Improvement

The NPHPSP assessment instruments are intended to promote and stimulate quality improvement. As a result of the assessment process, the respondents identified strengths and weaknesses within District public health systems. This information can pinpoint areas that need improvement. To achieve a higher performing health system, system improvement plans must be developed and implemented. If the results of the assessments are not used for action planning and performance improvement, then the hard work of the assessments will not have its intended impact.

A few possible action steps are outlined at the end of the results section of each Essential Service. These steps are not meant to be a comprehensive nor inclusive list. Prioritization, additions, omissions, or edits to these action steps are open to the discretion of the OLPH and the DCC. Criteria for the possible action steps cited include:

- Must be actionable at a District level
- Must come from the data
- Will improve the District score (i.e. address one of the Model Standards)



Results

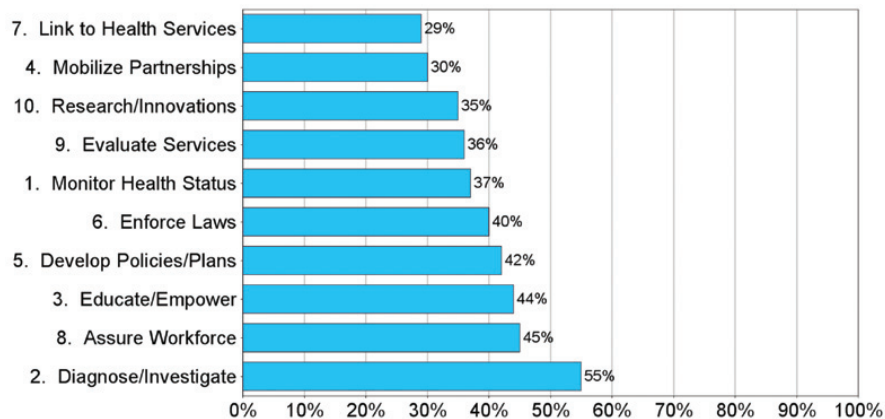
Overview

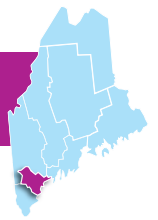
The Cumberland District Public Health Systems Assessment took place on September 22, October 2, and 20, meeting for approximately 3.5 hours each time. A total of 63 individuals participated in at least one of the three meetings with an average attendance of 28. Because a limitation of this process is that the scores are subject to the biases and perspectives of those who participated in the process, the planning group attempted to recruit broadly across the district. Individuals at the meetings represented HMPs, health care providers, hospitals, health system, local public health department, community health center, emergency management agencies, media, child care, homecare/hospice, social service/CAP agencies, state agencies/organizations, universities/colleges, municipalities, mental health agencies, substance abuse, schools, Adult Education, aging agencies, Local Health Officers, first responders, public health and home visiting nurses, and community organizations. Environmental health groups and faith-based organizations are potential gaps in representation.

Summary of Scores

EPHS	SCORE	EPHS	SCORE
1. Monitor Health Status to Identify Community Health Problems	37	6. Enforce Laws and Regulations that Protect Health and Ensure Safety	40
2. Diagnose and Investigate Health Problems and Health Hazards	55	7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	29
3. Inform, Educate, and Empower People about Health Issues	44	8. Assure a Competent Public and Personal Health Care Workforce	45
4. Mobilize Community Partnerships to Identify and Solve Health Problems	30	9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	36
5. Develop Policies and Plans that Support Individual and Community Health Efforts	42	10. Research for New Insights and Innovative Solutions to Health Problems	35
Overall Performance Score 39			

Rank ordered performance scores for each Essential Service, by level of activity





Essential Service 1

Monitor Health Status to Identify Community Health Problems

This Essential Service evaluates to what extent the District Public Health System (DPHS) conducts regular community health assessments to monitor progress towards health-related objectives. This service measures: activities by the DPHS to gather information from community assessments and compile a community health profile; utilization of state-of-the-art technology, including GIS, to manage, display, analyze and communicate population health data; development and contribution of agencies to registries and the use of registry data.

Overall Score: 37

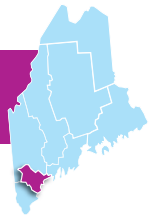
This service ranked sixth out of 10 Essential Services. This score is in the moderate range, indicating that some district-wide activities have occurred.

Scoring Analysis

- The District scored in the significant range on the development of community health assessments. State-developed community health assessments and District Health Data Comparison tables are available, but do not have all components to meet the definition of a comprehensive Health Profile.
- Health assessments have been distributed to coalition partners and are used throughout the District.
- The lowest score is the lack of a comprehensive District community health profile with a summary analysis.
- The District has limited use of state-of-the-art technology including GIS.
- There are state and local registries on many health issues, but there is minimal use of the data for assessments.

District Context

- City of Portland Division of Public Health (PPH) created a data profile book for each of the towns in the district. There were challenges in obtaining actionable data, but this will be used to track trends and is available on the Portland Public Health website.
- Other current assessments in the District include: the HMPs in the district are doing assessments as part of the MAPP process; an assessment for the refugee population in Portland across 13 ethnic groups has just been completed; assessments have been done in schools; an underage and illegal drinking assessment was completed.
- In 2010 major health care systems did a statewide health assessment and data is available by district.
- Data from assessments is on the DCC webpage and promoted by individuals and members of the DCC. There has not been a media strategy to promote the use of the data.

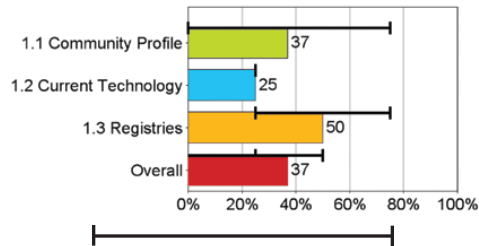


- Data from assessments have been used in a number of ways (e.g., by School Health Advisory Committee and substance abuse programs in Westbrook; by Portland Public Health; for school budget planning; by PROP’s HMP substance abuse action teams; grant writing).
- GIS mapping is just beginning to be used in pockets in the district including: dispatching fire and rescue to identify areas of multiple visits; inventories of built environment and existing sidewalks in Yarmouth; towns of Falmouth and Freeport have GIS; CTI uses GIS to track patients and those trained to deliver programs.
- There are a number of state and local registries in the District and some data is used in assessments and for internal provider tracking. IMMPACT data is difficult to extract for general population information so has not been used.

Possible Action Steps

- Build on existing assessment data to develop Community Health Profile(s) and ensure access to the Profile in multiple formats including GIS mapping.
- Develop a media strategy to increase data dissemination and use by District organizations.

EPHS 1. Monitor Health Status



Range of scores within each model standard and overall

EPHS 1. Monitor Health Status to Identify Community Health Problems: Overall Performance Score

37

★ 1.1 Population-Based Community Health Profile (CHP)

37

Community health assessment 69

Community health profile (CHP) 0

Community-wide use of community health assessment or CHP data 42

★ 1.2 Access to and Utilization of Current Technology to Manage, Display, Analyze and Communicate Population Health Data

25

State-of-the-art technology to support health profile databases 25

Access to geocoded health data 25

Use of computer-generated graphics 25

★ 1.3 Maintenance of Population Health Registries

50

Maintenance of and/or contribution to population health registries 75

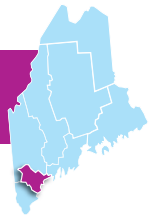
Use of information from population health registries 25

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components

“I gained a better on-the-ground understanding of the 10 EPHS through the assessment process.”



Essential Service 2

Diagnose and Investigate Health Problems and Health Hazards

This Essential Service measures the participation of the District Public Health System (DPHS) in integrated surveillance systems to identify and analyze health problems and threats, as well as the timely reporting of disease information from community health professionals. This service also measures access by the DPHS to the personnel and technology necessary to assess, analyze, respond to and investigate health threats and emergencies including adequate laboratory capacity.

Overall Score: 55

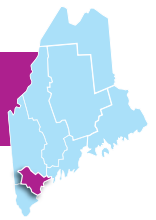
This was the highest scoring Essential Service overall. This score is in the significant range, indicating that most activities are district-wide.

Scoring Analysis

- Because most surveillance activities and laboratory oversight occur at the state level, these areas were scored the same for all districts, with the exception of emergency response ability.
- The district scored high on its emergency response ability and on its response to disasters, access to needed personnel, and evaluation of the effectiveness of their response activities.

District Context

- Maine CDC works closely with district hospitals and schools to track infectious disease. At the Poison Control Center every call is uploaded within 10 minutes to look for clusters. They also track substance abuse trends.
- Organizations in the district collecting/providing surveillance data include: schools, Head Start, providers.
- Data is collected to monitor environmental concerns such as ozone, beach closures, ozone levels, and red tide.
- Some barriers to use of surveillance data include: data does not come back to district organizations or it doesn't include town level data; there is no consistent feedback loop of data on a county level or below that includes interpretation; not all schools participate in the Youth Integrated Health Survey; legal issues are a barrier to obtaining certain town level data; there is not one place where trends across the district are regularly reviewed.
- Most providers do a good job of reporting data, but timeliness is sometimes an issue so not all reportable conditions are captured.
- There is the technology in the district to support surveillance. Portland Public Health has recently lost EPI capacity.

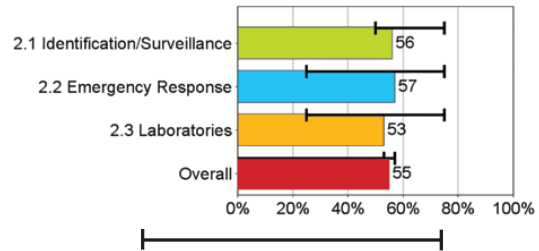


- The state provides written protocols for investigation, but does not have full capacity due to staffing and there is no district-level monitoring of activity.
- The EMA director’s role in a public health emergency was not clear to all groups. Some types of emergency response (e.g., HAZMAT teams) in the district have not coordinated with the public health system. There could be more coordination with the local health officers. Volunteer mobilization is a challenge but there are some CERT teams—many are going to “just in time” training.
- There are preparedness drills in the district and they require after action reports.
- Timeliness of reports from the state laboratory is a concern and the courier system needs improvement.

Possible Action Steps

- Coordinate within the district a review of surveillance data across health topics and identify actionable trends.
- Increase coordination in the district on implementation of protocols for communicable and toxic exposures.
- Increase understanding of the roles of all emergency response personnel in a public health emergency.

EPHS 2. Diagnose/Investigate



Range of scores within each model standard and overall

EPHS 2. Diagnose and Investigate Health Problems and Health Hazards **55**

★ 2.1 Identification and Surveillance of Health Threats **56**

Surveillance system(s) to monitor health problems and identify health threats	67
Submission of reportable disease information in a timely manner	50
Resources to support surveillance and investigation activities	50

★ 2.2 Investigation and Response to Public Health Threats and Emergencies **57**

Written protocols for case finding, contact tracing, source identification, and containment	50
Current epidemiological case investigation protocols	75
Designated Emergency Response Coordinator	44
Rapid response of personnel in emergency/disasters	66
Evaluation of public health emergency response	50

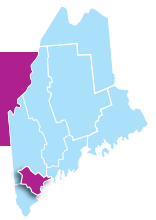
★ 2.3 Laboratory Support for Investigation of Health Threats **53**

Ready access to laboratories for routine diagnostic and surveillance needs	50
Ready access to laboratories for public health threats, hazards, and emergencies	38
Licenses and/or credentialed laboratories	50
Maintenance of guidelines or protocols for handling laboratory samples	75

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 3

Inform, Educate, and Empower Individuals and Communities about Health Issues

This Essential Service measures health information, health education, and health promotion activities designed to reduce health risk and promote better health. This service assesses the District Public Health System's partnerships, strategies, populations and settings to deliver and make accessible health promotion programs and messages. Health communication plans and activities, including social marketing, as well as risk communication plans are also measured.

Overall Score: 44

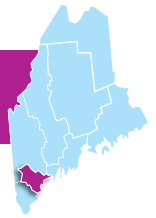
This was the third highest scoring Essential Service overall. This score is in the moderate range, indicating that there are some district-wide activities.

Scoring Analysis

- There are multiple district-wide health promotion campaigns and the district informs the public and policy makers about health needs.
- Health promotion efforts across the district are tailored to populations at higher risk and/or within specific settings.
- There is not a district-wide communication plan or identified and trained spokespersons for the district, although there are relationships with the media.
- There are emergency communication plans and significant resources for rapid communications response, but the district scored lower on having policies and procedures for public information officers.

District Context

- District organizations inform the public, policymakers and others about health issues (e.g., H1N1 information; breast feeding promotion; substance abuse prevention; tobacco control; food safety; obesity).
- Examples of how this information is provided include: annual legislative gatherings; schools connect with parents on substance abuse prevention information; by HMPs through the MAPP process; Let's Go works with school districts; local hospitals reach public and private stakeholders.
- Many efforts in the district reach high risk individuals including: education in senior housing sites; substance abuse campaigns related to sexual orientation; synchronizing messages to address cultural barriers; annual multicultural health event; addressing SES in many efforts, including how substance abuse parent meetings are adapted; adapting healthy eating messages based on ethnic/culture needs. Barriers/gaps may be: infectious disease information in other languages; reaching deaf and hard_of-hearing individuals; and the challenges of quality assurance in translated materials.

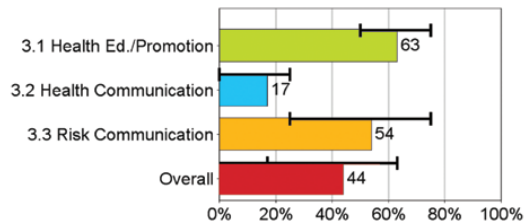


- Health promotion efforts reach people in many settings in the district including: schools, worksites, neighborhoods, churches, colleges/universities, correctional facility, school yards. There is less being done in early child care settings.
- Evaluation of health promotion/education programs is limited and not coordinated in the district.
- Organizations work together across the district, but there continue to be some silos, e.g., mental health.
- There are individual emergency communication plans, but not one as a public health system. Plans have improved in last 6 years but more integration with public health is needed. Good plans reach most people, but some populations continue to be missed. HAN, reverse 911, ham radio, etc., are tools that are being used and improving communications.

Possible Action Steps

- Develop a district-wide education campaign for the public on community health status (e.g., heart disease rates, cancer rates, environmental risks) and provide context to make the data meaningful.
- Coordinate a district-wide effort to review evaluation results to strengthen programs.
- Build on current health promotion campaigns targeted to individuals at higher risk of negative health outcomes to reach those who are not currently being reached (e.g., deaf/hard of hearing, early child care settings).
- Develop coordinated communication plans that better integrate emergency management and the public health system.

EPHS 3. Educate/Empower



Range of scores within each model standard and overall

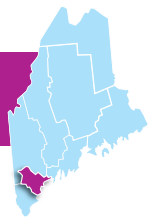
EPHS 3. Inform, Educate, and Empower People About Health Issues

★ 3.1 Health Education and Promotion	63
Provision of community health information	69
Health education and/or health promotion campaigns	69
Collaboration on health communication plans	50
★ 3.2 Health Communication	17
Development of health communication plans	0
Relationships with media	25
Designation of public information officers	25
★ 3.3 Risk Communication	54
Emergency communications plan(s)	47
Resources for rapid communications response	75
Crisis and emergency communications training	50
Policies and procedures for public information officer response	44

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 4

Mobilize Community Partnerships to Identify and Solve Health Problems

This Essential Service measures the process and extent of coalitions and partnerships to maximize public health improvement within the District Public Health System (DPHS) and to encourage participation of constituents in health activities. It measures the availability of a directory of organizations, communication strategies to promote public health and linkages among organizations. This service also measures the establishment and engagement of a broad-based community health improvement committee and assessment of the effectiveness of partnerships within the DPHS.

Overall Score: 30

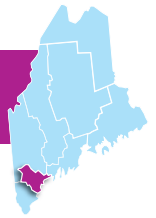
This Essential Service ranked ninth out of the 10 Essential Services overall. This score is in the moderate range, indicating that there are some district-wide activities.

Scoring Analysis

- The district has identified many of the key stakeholders and has reached out to develop partnerships with many organizations to maximize public health activities.
- There is access to a directory of organizations that comprise the district public health system.
- There are few communications strategies used in the district to build awareness of the importance of public health.
- The formation of a community health improvement committee is beginning.
- No systematic review and assessment of the effectiveness of community partnerships and strategic alliances has occurred in the district.

District Context

- Through the HMPs and development of the District Coordinating Committee key stakeholders have been identified.
- There are a number of ways that district organizations have encouraged the community to identify issues including: HMPs participation on the DCC; specific grants seek community input; PPH presented data to town managers; through Greater Portland Council of Governments.
- There are many opportunities for volunteers in the district including: free clinics, HMP efforts, flu clinics, COAD, Meals on Wheels, Maine Response Program.
- 211 lists most organizations and some gaps may be environmental health and some health issues and the ability of non-English-speaking people to access the information.

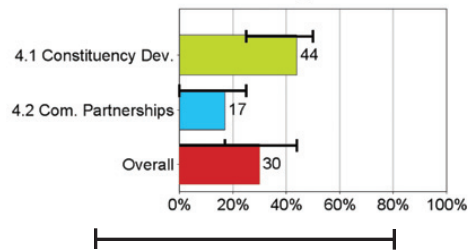


- There are no district-wide efforts to build awareness for the importance of public health. “This is public health” was one effort by some organizations. Resources to do this are not available.
- Not all partnerships in the district have aligned activities related to the 10 Essential Public Health Services.

Possible Action Steps

- Conduct a district-wide assessment of the effectiveness of current partnerships and strategic alliances to identify gaps, and strengthen and improve public health capacity.
- Develop a district-wide communication strategy for promoting public health using available town resources (e.g., town cable, meetings, media, etc.).

EPHS 4. Mobilize Partnerships



Range of scores within each model standard and overall

EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems **30**

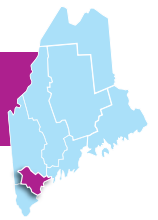
★ 4.1 Constituency Development	44
Identification of key constituents or stakeholders	50
Participation of constituents in improving community health	50
Directory of organizations that comprise the LPHS	50
Communications strategies to build awareness of public health	25
★ 4.2 Community Partnerships	17
Partnerships for public health improvement activities	25
Community health improvement committee	25
Review of community partnerships and strategic alliances	0

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components

“I’m thrilled that we are moving toward a functioning public health infrastructure.”



Essential Service 5

Develop Policies and Plans that Support Individual and Community Health Efforts

This Essential Service evaluates the presence of governmental public health at the local level. This service also measures the extent to which the District Public Health System contributes to the development of policies to improve health and engages policy makers and constituents in the process. The process for public health improvement and the plans and process for public health emergency preparedness is also included in this Essential Service.

Overall Score: 42

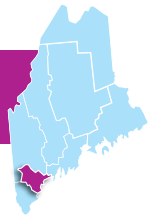
This Essential Service rated fourth of the 10 Essential Services. This score is in the moderate range, indicating that there are a number of district-wide activities.

Scoring Analysis

- In addition to a municipal health department, a governmental presence at the local level is in development.
- District organizations contribute to the development of public health policies and engage policy makers, but has not systematically reviewed the impact of policies that exist.
- The process for community health improvement planning through MAPP is underway in the district, but district-wide strategies to address objectives have not yet been identified.
- There has been significant planning for public health emergencies in the district.

District Context

- A Public Health Unit in the district is being developed and will co-locate the district liaison, public health nurses, epidemiologist, health and water inspectors.
- Local health officers are in every town—experience, knowledge, compensation and size of jurisdiction varies. Current training curriculum does not tie their duties to the 10 Essential Public Health Services.
- Portland Public Health serves communities outside of Portland and has a mission and legal responsibilities. Portland has a health officer but reports to City Council rather than a local board of health. Resources to address some essential public health services are limited.
- District organizations are actively engaged in public health policy. Some examples include Casco Bay issues, smoking in restaurant and outdoor environments, road planning/bike/ped paths, school policies, nutrition policies at organizations, fluoridation, needle exchange, substance abuse policies, enforcement of tobacco laws, alternative to suspension policies.

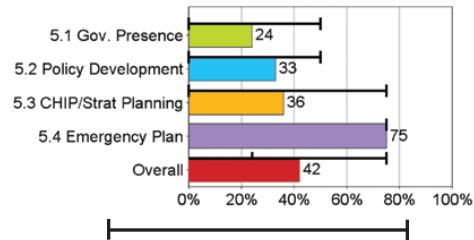


- The impact of policies is relayed to policy makers through planning committees and legislative gatherings.
- District HMPs are completing the MAPP assessments and there is broad participation across the district. Not all groups invited have participated; gaps include transportation, managed care, public safety, and environmental groups.
- Organizations participate in emergency preparedness and response planning. Potential gaps include veterinarians and the coroner's office. There is a district-wide plan and there are mutual aid agreements so resources are shared.
- Protocols are clearly outlined although the mass casualty care plan is not quite completed. Significant testing of the plan and modifications have been made based on after action reports.

Possible Action Steps

- Build on successes and use MAPP process to identify and address additional priority health policy needs. Inform and educate local policy makers on public health impact of such policies.
- Identify organizations/groups not involved in the MAPP process and develop creative strategies to engage them beyond.

EPHS 5. Develop Policies/Plans



Range of scores within each model standard and overall

EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts

42

★ 5.1 Government Presence at the Local Level

(Note: This indicator was scored the same for all Districts.) 24

Governmental local public health presence	21
Resources for the local health department	28
LHD work with the state public health agency and other state partners	25

★ 5.2 Public Health Policy Development

33

Contribution to development of public health policies	50
Alert policy makers/public of public health impacts from policies	50
Review of public health policies	0

★ 5.3 Community Health Improvement Process

36

Community health improvement process	71
Strategies to address community health objectives	25
Local health department (LHD) strategic planning process	13

★ 5.4 Plan for Public Health Emergencies

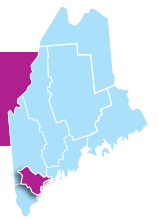
75

Community task force or coalition for emergency preparedness and response plans	75
All-hazards emergency preparedness and response plan	75
Review and revision of the all-hazards plan	75

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 6

Enforce Laws and Regulations that Protect Health and Ensure Safety

This Essential Service measures the District Public Health System's (DPHS) activities to review, evaluate and revise laws, regulations and ordinances designed to protect health. It also measures the actions of DPHS to identify and communicate the need for laws, ordinances, or regulations on public health issues that are not being addressed and measures enforcement activity.

Overall Score: 40

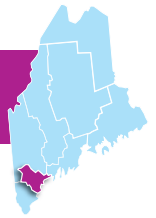
Note: All districts were scored the same on this Essential Service, as the District Public Health Unit is the District link to Maine CDC, related to official local and regional health protection. District Liaisons interface with Local Health Officers RE: public health nuisances and disease outbreaks, and county EMA(s) for regional emergencies whenever hazard to public health is a concern. This service ranked fifth out of 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

Scoring Analysis

- Enforcement agencies are aware of laws and municipalities have access to legal counsel if needed.
- There is minimal activity to specifically identify local public health issues that are not adequately addressed through current laws, regulations or ordinances, or to provide information to the public or other organizations impacted by the laws.
- Local officials have the authority to enforce laws in an emergency.
- There has been minimal activity in the district to assess compliance with laws, regulations or ordinances.

District Context

- Some public health laws/ordinances/regulations have been reviewed by district organizations for issues including: food safety; swimming pool safety; housing issues; pesticide application; bike/pedestrian issues; enforcement of tobacco and alcohol laws.
- Not everyone is who should be aware of laws are knowledgeable.
- The public often doesn't know who to call for issues. A co-located Maine CDC staff may help improve ability to solve problems quickly.
- Hospitals regularly review laws that pertain to their operations.



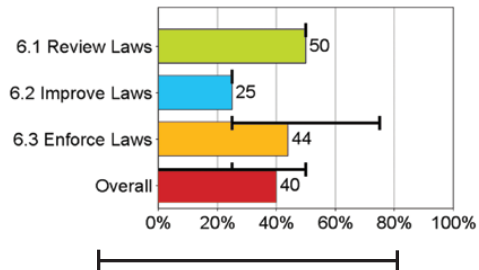
- Towns don't always know if they have the authority to enforce health and safety laws. That information is in the town charter but they are often not aware of what public health issues fall under their authority.
- It is unclear to many who has authority to enforce quarantine and isolation orders.
- There is a lack of clarity among system stakeholders on the scope of legal authority and roles between PPH and MaineCDC.

Possible Action Steps

- Provide technical assistance to towns to clarify their roles and authority to address public health issues.
- Coordinate resources to address needs related to enforcement of building codes, environmental concerns, civil rights, and other health-related issues.



EPHS 6. Enforce Laws



Range of scores within each model standard and overall

EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety 40

★ 6.1 Review and Evaluate Laws, Regulations, and Ordinances 50

Identification of public health issues to be addressed through laws, regulations, and ordinances	50
Knowledge of laws, regulations, and ordinances	50
Review of laws, regulations, and ordinances	50
Access to legal counsel	50

★ 6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances 25

Identification of public health issues not addressed through existing laws	25
Development or modification of laws for public health issues	25
Technical assistance for drafting proposed legislation, regulations, or ordinances	25

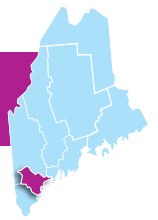
★ 6.3 Enforce Laws, Regulations and Ordinances 45

Authority to enforce laws, regulation, ordinances	50
Public health emergency powers	75
Enforcement in accordance with applicable laws, regulations, and ordinances	50
Provision of information about compliance	25
Assessment of compliance	25

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 7

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

This Essential Service measures the activity of the District Public Health System (DPHS) to identify populations with barriers to personal health services and the needs of those populations. It also measures the DPHS's efforts to coordinate and link the services and address barriers to care.

Overall Score: 29

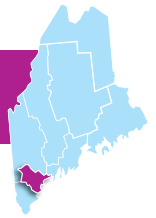
This service ranked tenth of the 10 Essential Services. This score is in the low-moderate range, indicating that there are few district-wide activities.

Scoring Analysis

- There are activities to identify populations and personnel health service needs but they are not coordinated across the district.
- There is not a coordinated district-wide assessment of the availability of services to people who experience barriers to care.
- Linking and coordination of health care services and connections with social services occurs but is limited.
- Organizations in the district engage in initiatives to enroll people eligible for public benefit programs.

District Context

- There are a number of organizations that link people to needed health services in the district including: Care Partners; SMAA; refugee program; Cumberland County jail; PROP; town general assistance programs; CTI; VNA/public health nurses; free clinics. Few organizations identify people who have barriers to service unless they seek assistance, but a good network of services is available.
- Groups with barriers to services include: developmentally disabled who don't come in for services; people with language barriers; individuals in military families not eligible for military health services.
- HMPs provide resource information to 211, Community Health Outreach Workers (CHOW) help people navigate the health system. Funding for CHOW is limited and needs ongoing infrastructure support to maintain it.
- Over the last two years the DCC has coordinated among many groups, but not all are part of the DCC.
- Gaps in services were identified: end-of-life care; services for people in the outer parts of the county who need to travel to Portland for services; services for immigrants and refugees outside of Portland; low income people not eligible for MaineCare.



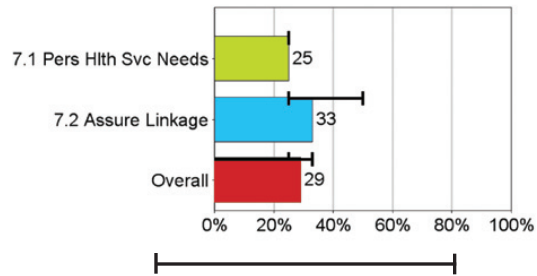
- Initiatives to enroll people in public benefit programs exist, but they are not coordinated or proactive except when people walk through the door.
- Some organizations (e.g., PROP, Bridgton Community Center) coordinate for social services (e.g., food pantry), but minimal co-location of services in the district.

Possible Action Steps

- Expand to all parts of the district and coordinate current successful initiatives to reach populations in need of services.
- Coordinate an assessment across the district on health service gaps (e.g., end-of-life care) and barriers (e.g., transportation to Portland) and identify strategies to address the gaps.



EPHS 7. Link to Health Services



Range of scores within each model standard and overall

EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable 29

★ 7.1 Identification of Populations with Barriers to Personal Health Services 25

Identification of populations who experience barriers to care 25

Identification of personal health service needs of populations 25

Assessment of personal health services available to populations who experience barriers to care 25

★ 7.2 Assuring the Linkage of People to Personal Health Services 33

Link populations to needed personal health services 50

Assistance to vulnerable populations in accessing needed health services 25

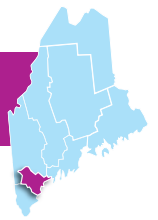
Initiatives for enrolling eligible individuals in public benefit programs 25

Coordination of personal health and social services 31

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 8

Assure a Competent Public and Personal Health Care Workforce

This Essential Service evaluates the District Public Health System's (DPHS) assessment of the public health workforce, maintenance of workforce standards including licensure and credentialing and incorporation of public health competencies into personnel systems. This service also measures how education and training needs of DPHS are met including opportunities for leadership development.

Overall Score: 45

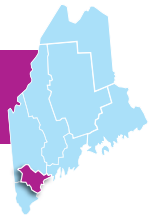
This service ranked second out of 10 Essential Services. This score is in the moderate range, indicating that there are district-wide activities.

Scoring Analysis

- There has been no assessment across the district of the public health workforce.
- Organizations connect job descriptions and performance evaluations to public health competencies.
- There are some assessments of training needs, but few resources or incentives are available for training.
- Training programs on core competencies and leadership development opportunities are available in the district.
- Recruitment and retention of new and diverse leaders is limited.

District Context

- There have been some assessments on the personal health care workforce (e.g., Mercy Hospital and MaineHealth) and emergency response needs and competencies, but few of the public health workforce.
- Workforce shortages have been identified through the State's Rural Primary Care office and other national organizations. Portland Public Health does not get many applicants that have public health training.
- Organizations are aware of and comply with licensure/credentialing requirements.
- Some assessments of training needs have been done (e.g., HMPs, Portland Public Health staff, Mercy Hospital, USM), but it is not coordinated across the district.
- There is an opportunity to provide public health training to physicians who think broadly about health.
- There are many opportunities for training and leadership development including: Portland Public Health one-day courses (e.g., epidemiology); PH 101 is offered to all Maine CDC employees, USM Certificate program; Muskie Health Policy program; MPHA; UNE, MCPH; Hanley Health Leadership, ICL, Maine Development Foundation, Martin's Point and MaineHealth leadership course.

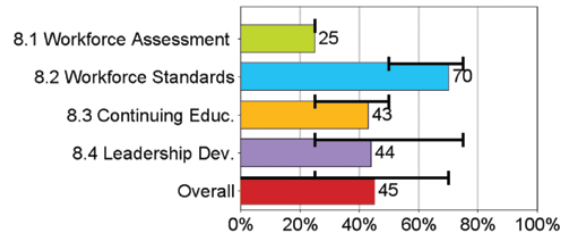


- Hanley developed a mentoring program with past graduates, but other mentoring is done informally.
- Some organizations provide funding for training and tuition reimbursement, but career advancement is a major concern.
- Area academic/research institutions are well engaged, e.g., MMC's Center for Outcomes Research and USM. Many organizations take interns.
- Collaborative leadership is encouraged in the District. A number of Hanley Leadership program graduates are now on the DCC and can help spread collaborative leadership model. The DCC has a Facebook page and listserv.
- The Minority Health Program and CHOWs are developing leaders and Head Start has a leadership group of parents.

Possible Action Steps

- Assess training needs in the district, disseminate results and identify resources and expertise to deliver priority training needs (e.g., distance learning, webinars, in-person).
- Develop strategies to engage new and diverse leaders that are representative of the community.

EPHS 8. Assure Workforce



Range of scores within each model standard and overall

EPHS 8. Assure a Competent Public and Personal Health Care Workforce: Overall Performance Score 45

★ 8.1 Workforce Assessment Planning and Development 25

Assessment of the LPHS workforce	25
Identification of shortfalls and/or gaps within the LPHS workforce	25
Dissemination of results of the workforce assessment/gap analysis	25

★ 8.2 Public Health Workforce Standards 70

Awareness of guidelines and/or licensure/certification requirements	75
Written job standards and/or position descriptions	75
Annual performance evaluations	75
LHD written job standards and/or position descriptions	75
LHD performance evaluations	50

★ 8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring 43

Identification of education and training needs for workforce development	50
Opportunities for developing core public health competencies	46
Educational and training incentives	25
Interaction between personnel from LPHS and academic organizations	50

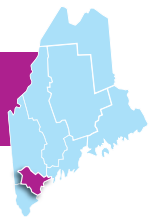
★ 8.4 Public Health Leadership Development 44

Development of leadership skills	25
Collaborative leadership	50
Leadership opportunities for individuals and/or organizations	75
Recruitment and retention of new and diverse leaders	25

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 9

Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services

This Essential Service measures the evaluation activities of the District Public Health System (DPHS) related to personal and population-based services and the use of those findings to modify plans and program. This service also measures activity related to the evaluation of the DPHS.

Overall Score: 36

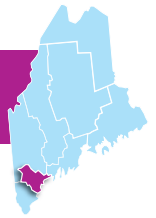
This service scored seventh out of the 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

Scoring Analysis

- There is some evaluation of population-based programs in the district, but it is limited in scope and geography.
- Evaluation of, and satisfaction with, personal health services occurs throughout the district. Results are used to modify services.
- The public health system assessment just completed evaluates the DPHS and will result in a community health improvement plan.

District Context

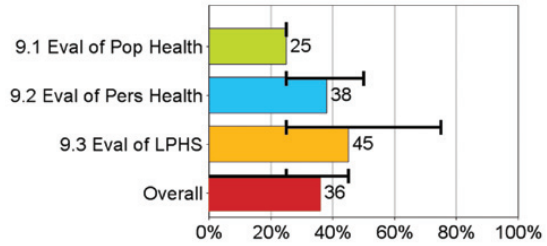
- Organizations in the district do some evaluation of population health services including HMPs and CTI, however, this is not strong throughout the district.
- Many health care organizations in the district evaluate personal health services using established criteria such as HEDIS and JCAHO.
- Client satisfaction with personal health services is done by most health care organizations, although potential users are generally not assessed and information is not shared.
- Information technology is not used currently for evaluation but it may be in the future. Not all EMR systems talk to each other.
- The public health system is being assessed through the LPHS assessment—some gaps in participation include insurance companies and others who were invited but did not attend. MOUs exist among organizations and the LPHS will be used to guide community health improvements.



Possible Action Steps

- Identify district-wide evaluation priorities and develop the expertise and strategies needed to plan, implement and analyze the evaluation results.
- Ensure that any existing evaluation of personal or population-based services is used to modify or improve current programs or services or create new programs or services.
- Use the results of the public health system assessment to improve linkages with community organizations and to create or refine community health programs.

EPHS 9. Evaluate Services



Range of scores within each model standard and overall

EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services **36**

★ **9.1 Evaluation of Population-Based Health Services** **25**

Evaluation of population-based health services	25
Assessment of community satisfaction with population-based health services	25
Identification of gaps in the provision of population-based health services	25
Use of population-based health services evaluation	25

★ **9.2 Evaluation of Personal Health Care Services** **38**

In personal health services evaluation	25
Evaluation of personal health services against established standards	50
Assessment of client satisfaction with personal health services	38
Information technology to assure quality of personal health services	25
Use of personal health services evaluation	50

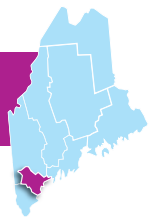
★ **9.3 Evaluation of the Local Public Health System** **45**

Identification of community organizations or entities that contribute to the EPHS	75
Periodic evaluation of LPHS	54
Evaluation of partnership within the LPHS	25
Use of LPHS evaluation to guide community health improvements	25

★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components



Essential Service 10

Research for New Insights and Innovative Solutions to Health Problems

This Essential Service measures how the District Public Health System (DPHS) fosters innovation to solve public health problems and uses available research. It also assesses the DPHS's linkages to academic institutions and capacity to engage in timely research.

Overall Score: 35

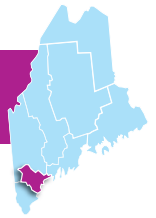
This service ranked eighth of the 10 Essential Services. This score is in the moderate range, indicating that there are some district-wide activities.

Scoring Analysis

- To a limited extent, agencies in the district are encouraged to develop new solutions for public health issues and have various methods of monitoring research and best practice.
- Few organizations in the district have proposed public health issues for inclusion in the research agenda of research organizations or have participated in the development of research.
- There are many relationships with academic institutions and organizations in the district.
- The DPHS has limited access to researchers.

District Context

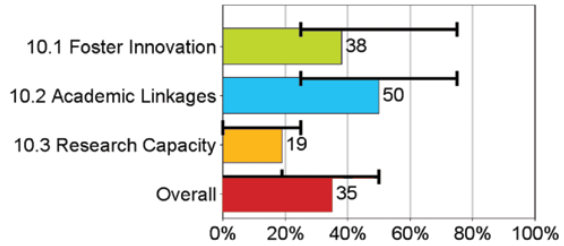
- Some innovative solutions to problems have been developed by agencies through pilot programs or joint efforts (e.g., SAAA and HMPs have developed an older adult adventure activity program, the Poison Control Center mines data to come up with new ideas). Grant funding is often a limitation.
- Attempts by district organizations to propose research to be included in a research agenda have not been successful. There are few public health research projects in the district.
- Organizations have a number of strategies available to them for staying current on best-practice.
- There are many relationships with institutions of higher learning including: internships; participation on boards, use as faculty, regional epidemiologists. There are barriers to collaboration and it is not coordinated at a district-level.



Possible Action Steps

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

EPHS 10. Research/Innovations



Range of scores within each model standard and overall

EPHS 10. Research for New Insights and Innovative Solutions to Health Problems 35

★ 10.1 Fostering Innovation 38

Encouragement of new solutions to health problems	25
Proposal of public health issues for inclusion in research agenda	25
Identification and monitoring of best practices	75
Encouragement of community participation in research	25

★ 10.2 Linkage with Institutions of Higher Learning and/or Research 50

Relationships with institutions of higher learning and/or research organizations	75
Partnerships to conduct research	25
Collaboration between the academic and practice communities	50

★ 10.3 Capacity to Initiate or Participate in Research 19

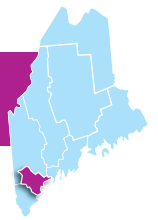
Access to researchers	25
Access to resources to facilitate research	25
Dissemination of research findings	25
Evaluation of research activities	0

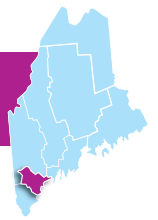
★ = Model Standard Score

❖ = Items scored the same across all districts

Impact of possible action steps on model standard components

“I envision assessment findings in the future being used to identify new collaborative efforts leading to improvement.”

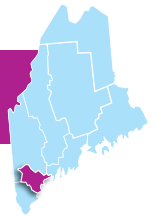




Appendices

Acronyms

AHEC	Area Health Education Center	MAPP	Mobilizing for Action through Planning and Partnerships
BMI	Body Mass Index	MARVEL	State Library access portal to health journals, books
CAP	Community Action Program Agencies	MCDC	Maine Center for Disease Control
CBPR	Community Based Participatory Research	MCH	Maternal/Child Health
CEO	Code Enforcement Officer	MCPH	Maine Center for Public Health
CERT	Community Emergency Response Team	Meds	Medications
CHES	Community Health Education Specialist	MeHAF	Maine Health Access Foundation
CMMC	Central Maine Medical Center	MEMIC	Maine Employers' Mutual Insurance Company
COAD	Community Organizations Active in Disasters	MMC	Maine Medical Center
COG	Council of Governments	MOU	Memorandum of Understanding
CTI	Center for Tobacco Independence	MPH	Masters in Public Health
DCC	District Coordinating Council	MPHA	Maine Public Health Association
DPHS	District Public Health System	NAMI	National Alliance on Mental Illness
EBSCO	see www.ebsco.com	NNE Poison	Northern New England Poison Control Center
ED	Emergency Department	NH	New Hampshire
EMA	Emergency Medical Associates	NIMS	Training National Incident Management System
EMR	Electronic Medical Record	NP	Nurse Practitioner
EMS	Emergency Medical Services	OSA	Office of Substance Abuse
EOC	Emergency Operations Center	OT	Occupational Therapy
EPI	Epidemiologist	Ped Paths	Pedestrian Paths
FCHN	Franklin Community Health Network	PPH	Portland Public Health (City of Portland Division of Public Health)
GIS	Geographic Information System	PROP	People's Regional Opportunity Program
GLBT	Gay, Lesbian, Bisexual, Transgender	PT	Physical Therapy
HAN	Health Alert Network	RSU	Regional School Unit
HAZMAT	Hazardous Materials (e.g., Team, supplies, protocols)	RSVP	Regional Seniors Volunteer Program
HCC	Healthy Community Coalition (Farmington-based)	SES	Socioeconomic Status
HEDIS	Healthcare Effectiveness Data Information Set	SMAA	Southern Maine Agency on Aging
HIPAA	Health Insurance Portability and Accountability Act	SMCC	Southern Maine Community College
HMPs	Healthy Maine Partnerships	SMRRC	Southern Maine Regional Resource Center
ICL	Institute for Civic Leadership	SNAP	Supplemental Nutrition Assistance Program
IM	Instant Messaging	STD	Sexually Transmitted Disease
ImmPact	Maine Information Immunization Registry	UMF	University of Maine-Farmington
IO	Information Officer	UMO	University of Maine-Orono
JCAHO	Joint Commission on Accreditation of Healthcare Organizations	UNE	University of New England
L/A	Cities of Lewiston/Auburn	USM	University of Southern Maine
LGBT	Lesbian, Gay, Bisexual, Transgender	VA	Veterans Administration
LHO	Local Health Officer	VNA	Visiting Nurse Association
LPHSA	Local Public Health System Assessment	WIC	Women, Infants & Children



Glossary and Reference Terms

Community Health Assessment	Community health assessment calls for regularly and systematically collecting, analyzing, and making available information on the health of community, including statistics on health status, community health needs, epidemiologic and other studies of health problems.
Community Health Profile	A comprehensive compilation of measures representing multiple categories, or domains, that contributes to the description of health status at a community level and the resources available to address health needs. Measures within each domain may be tracked over time to determine trends, to evaluate health interventions or policy decisions, to compare community data with peer, state, national or benchmark measures, and to establish priorities through an informed community process.
District Public Health Unit	“District Public Health Unit” means a unit of State public health staff set up whenever possible in each district in department offices. These staff shall include, when possible, public health nurses, field epidemiologists, drinking water engineers, health inspectors, and district public health liaisons.
Go Kits	Packages of records, information, communication and computer equipment, and other items related to emergency operation. They should contain items that are essential to support operations at an alternate facility.

Results of Participant Evaluations

District	# Participants
Aroostook	36
Central	32
Cumberland	64
Downeast	41
MidCoast	30
Penquis	43
Western	51
York	65
Total	362

Response rate 39% (141 out of 362 universe)
responses/% of total

“The assessment findings can be used in the future to help guide and direct policy, funding determinations, and collaborative approaches.”

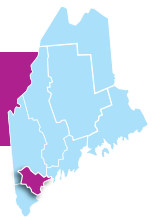
HIGHLIGHTS

85% said meeting organization was good/excellent

83% thought meeting facilitation was good/excellent

74% found the process to be a good/excellent opportunity to learn about the DPHS

“Comprehensive, inclusive, educational!”



DID YOU PARTICIPATE IN THE ASSESSMENT MEETINGS?

Yes	No	Skipped
137/97%	4/3%	0

DID YOU PARTICIPATE IN THE ORIENTATION SESSION AS PART OF THE FIRST MEETING?

Yes	No	Skipped
79/56%	50/35%	12/9%

BASED ON YOUR INVOLVEMENT IN THE ASSESSMENT MEETINGS, PLEASE RATE THE ITEMS BASED ON THE SCALE BELOW

Skipped	Very Poor	Poor	Fair	Good	Excellent
Meeting Organization					
9/6%	0	1/1%	11/8%	74/52%	46/33%
Meeting Facilitation					
9/6%	2/1%	2/1%	12/9%	71/51%	45/32%
Meeting Format					
11/8%	0	3/2%	20/14%	78/55%	29/21%
Opportunity to provide input about the District system					
9/6%	2/1%	4/3%	7/5%	77/55%	42/30%
Opportunity to learn about the District system					
9/6%	1/1%	4/3%	22/16%	76/53%	29/21%
Opportunity to learn more about District resources					
9/6%	0	2/1%	30/21%	74/53%	26/19%
Opportunity to learn more about public health					
9/6%	2/1%	5/4%	31/22%	71/51%	23/16%

DO YOU FEEL AS A RESULT OF THE PROCESS THAT YOU IDENTIFIED POTENTIAL NEW RELATIONSHIPS AND OPPORTUNITIES FOR COLLABORATION?

Yes	No	Skipped
108/77%	24/17%	9/6%

DO YOU FEEL A PART OF THE DISTRICT PUBLIC HEALTH SYSTEM?

Yes	No	Skipped
113/80%	18/13%	10/7%

“I enjoyed meeting with different resources in the area and look forward to making them more united.”