Note: The Public Health Improvement Plan (PHIP) for Maine is the result of discussions and activities that took place from June 1999 through June 2001. Not all participants agree with all findings and recommendations. A significant challenge in publishing a document such as this, is attempting to document the status of the discussion at a specific point in time, when in-fact the discussion continues.

The PHIP describes a vision to be accomplished over the next 10 years and as the status of public health "on the ground" changes, the PHIP will need to be revised and updated. It is our hope that the dialogue that began with Maine Turning Point and resulted in the PHIP will continue. Implementation and undertaking changes described herein, as well as the revised vision that is bound to emerge in the years ahead, is and will always be the responsibility of a wide range of individuals, organizations, and government agencies.

Key Recommendations for the New Millennium

Infrastructure development is critical to creating a strong community-based public health system. Without it we cannot plan ahead, allocate resources wisely, assure adequate support and assistance to each geographic section, address the unique needs of various populations, or have a collaborative effort working toward common goals. Mainers will only become healthier if we can put in place adequate services provided by well-trained individuals, located in accessible places and coordinated to maximize individual impact and minimize societal cost. By creating a strong public health infrastructure that combines government and private resources, Maine can assure every individual the opportunity to develop healthy behaviors.

With that in mind, the Maine Turning Point Steering Committee has identified the following steps, that we believe will help Maine reduce long-term health care costs and provide residents with the tools they need to improve their health and well being. To improve health status in Maine and achieve Healthy Maine 2010 goals it is essential to do the following by 2006:

1. Develop a strong, statewide, coordinated public health constituency and foster local development and advocacy programs that increase awareness of public health programs and services in communities.
2. Secure Legislative appropriations of no less than $3,875,000 per annum (approximately $3.00 per capita, initially) to provide professional staff to regional Health District Coalitions. This staff support is essential to the Coalition's ability to facilitate local efforts to achieve health status improvements outlined in Healthy Maine 2010. By 2010 the Health District should have a mix of state and other funding. However, the state funds should continue to provide a stable level of funding for each Health District based on a per capita formula with appropriate modifications for geographic and other barriers to access.
3. Facilitate medical leadership in the community on public health issues.
4. Provide technical assistance, education, and training to strengthen the knowledge and capacity of people and organizations involved with public health.

The model that we propose is not unlike the education model currently in use. For example:

	Education System	**Proposed Public Health System**
State Level outcome expectations	Learning Results	Healthy Maine Indicators
Regional approach to provision of services	School Districts	Health Districts
Local Control over process and strategies used to achieve outcomes	School Boards	Health District Coalitions
Statewide shared financial responsibility	State Funding (per capita + formula)	State funding (per capita + formula)
Local match and option of enhancements	Municipal Funding	Local, Municipal, or Private Funding
Single point of contact and portal for accountability as well as information / referral	SAD/SAU Superintendent	Health District Coordinator

<u>The need for Health Districts and community capacity to address public health concerns:</u>

1. Need – how this issue impacts cost[10]
   a. Research has shown that human health status depends 50 percent on lifestyle and behavior, 20 percent on environment and socio-economic class, 20 on heredity, and only 10 percent on medical care and access.

b. High quality health care has made America a great place to be sick. However, we have not made America, or Maine, a place where citizens become and stay healthy. A community-based approach to changing behavior and environment helps us reduce the incidence and prevalence of diseases and health problems that contribute to our high healthcare costs by addressing the lifestyle, behavior, environment, and socio-economic class concerns that drive 70% of health status.

2. Best Practices/lessons learned or "why this approach"
   a. We have a limited ability to have an impact on medical care cost and access and no opportunity to change hereditary factors that contribute to health status. However, we certainly can and should attempt to have an impact on the other 70 percent of factors that effect health status: lifestyle and behavior, environment, and socio-economic class.

   b. Personal and community health is largely the product of our social environment, education, income, and the choices we make as individuals and as members of our communities. Generally speaking, chronic and acute health conditions do not arise from lack of medical technology or access to medical professionals, because most of the time they are caused by behavioral choices and personal practices encouraged (or condoned) by family members, neighbors, friends and fellow citizens. Healthy environments that support shared responsibility enhance healthy choices. As examples, we can look to the cost benefit of two

[10] National Association of Healthier Communities website

changes that have taken place over the last 20 years in societal attitudes toward and response to seat belt use and drunk driving.[11]

c. In the U.S. there are presently an estimated 1200 cross-sector community initiatives that collaborate in pooling and allocating limited resources in new ways that have an impact on the overall health of the communities they serve.[12] Examples of these kinds of initiatives in Maine are the Healthy Community Coalitions and Communities for Children (which use the HCC approach but focus on children's issues).

d. The Health District approach plays to Maine's strengths: local control of process, community focus, ingenuity, and problem solving.

3. Approach description
   a. Health Districts that provide an opportunity for community-based approaches to public health provide an opportunity to effectively address health related issues and achieve a high health status through broad-based community involvement. The formal and informal community systems that contribute to "healthy communities" include: education, learning and skill building; safe and adequate housing; recreation and culture; public safety; youth mentors; voluntarism; the workplace; jobs that pay a living wage; family; non-profit organizations; healthy start; health promotion and prevention services; the faith community; media government; transportation, and many more. Healthy Communities focus on the total community – social, economic, geographic, and political – as the ideal context for health promotion. Private citizens and the business, non-profit and governmental sectors must work cooperatively to identify issues and find solutions to them.[13]

   b. Health District Coalitions should have the following characteristics:
      - Commitment to enhancing the community's health;
      - Ability to work effectively with all types of organizations and professionals;
      - Commitment to coordination and collaboration;
      - Expertise to carry out public health functions from assessment to assurance to policy development;
      - Commitment to evidence-based strategies;
      - Ability to involve formal and informal local leadership;
      - Strong linkage to local government;
      - Administrative capacity to manage grants and contracts.[14]

   c. A key element of building a Health District Coalition is that the Coalition staff not be expected to provide any direct "services," e.g., the staff is not there to provide health education, per se. The staff is there to: bring people and organizations to the table; to work for and with the Coalition members to develop solutions and find the financing to

[11] National Association of Healthier Communities website and Steven Isaacs and Steven Schroeder, "Where the Public Good Prevailed," The American Prospect, online Vol. 12 No 10, June 4, 2001
[12] National Association of Healthier Communities website
[13] National Association of Healthy Communities website
[14] Maine Turning Point – see PHIP Section 2.4 for additional details

implement the plans; to facilitate, cajole, and entice broad capacity development and community building.

d. The State needs a local entity that is accountable for monitoring, planning, and evaluating population-based health indicators and other essential public health services. Creating these local entities is essential. They would identify gaps, know in great detail what the health status levels are in their local communities, have "real" data on situations such as number of smokers, know what programs exist and be able to identify gaps and reduce duplication, have the skills and knowledge base to measure health status changes and evaluate the impact of local programs. The State does not have the staff or other resources to be able to undertake these activities in all of Maine's municipalities. A regional Health District Coalition composed of local community-based service providers, if funded and staffed appropriately, would be able to identify and help bring resolution to health problems at the local level.

e. This is "the art of the possible." A community-focused regional approach to improving health status challenges all Mainers to take control of their health status, to band together locally to create the kind of community and environment that support their neighbors and themselves to make healthy choices, to focus on preventing or reducing problems rather than just having to "fix what's broken" through the health care system.[15]

4. Cost estimate
   a. Burgess Record, M.D., testified before the Maine Legislature in February 2000 that the base-operating budget for the Franklin Community Health Network, which is set up in a manner similar to the proposed Health Districts but has more staff, is approximately $200,000 per year.

   b. Maine Turning Point has estimated that the base cost to create and maintain a healthy community coalition that has sufficient capacity to be a community change catalyst is in the range of $100,000 per year.

   c. Case study: A three year old Health District Coalition using a "Healthy Community" model in Maine has an annual budget of approximately $110,000 (20% of funds from Bureau of Health, 20% cash and in-kind support from the local hospital). This Coalition has been able to successfully compete for and bring in to their service area more than $321,000 over the last three years to support public health service programs. Thus the direct financial return on investment (ROI) on the 40% of their budget that comes from state (federal block grant dollars, not general revenue funds) and the hospital is 1: 2.4. That is, for each dollar budget cost per year they have "drawn down" an additional $2.40 from other sources. This ROI does not include the other financial support and grants that they have helped individual organizations and sub-sets of their coalition member organization to research and bring into their communities. However, the Bureau of Health limits the duration of these federally funded grants to three years per community. This limit on the number of years of funding endangers the organization's ability to provide key functions that make the cited ROI possible. Furthermore, there are additional returns for which we do not yet have data, such

[15] National Association of Healthy Communities website

as economic development, local capacity and resources available to area citizens, as well as improvements in health status and related reduced health care costs.

5. Immediate action steps
   a. Protect the Fund for a Healthy Maine from any changes in funding distribution for at least five years to allow initiatives started with these funds to have a local impact and prove their worth. Grantees won't be able to focus on change health status if they have to worry about making payroll next month.

   b. Build on the Tobacco Settlement expenditures allocated from the Fund for a Healthy Maine and maximize the ability of those coalitions to expand their mission by providing staff that does not have categorical line responsibilities.

   c. Appropriate $3.875 million annually from the General Fund or an increase in the Tobacco Tax to provide support for Health District activities ($125,000 x 31 current grantees if the current Community and School grantees) and local public health service capacity development. This level of support is necessary because there is no ongoing support available from any other sources. Until now the few existing groups have hobbled together funds from a variety of private sources and occasionally received federal pass through grants that are limited to three years.

<u>Goal: Establish a network of local public health physicians</u>

1. Need – how this issue impacts health care costs
   a. Failure to locally identify and respond to emerging infectious diseases results in delayed response, larger numbers of infected individuals, and higher costs to provide health care for those individuals. Successful identification of and response to emerging risks provides opportunities to limit the spread of contagion through public health measures and to identify effected individuals earlier in the disease process when it is generally easier and less expensive to treat the identified medical condition.

   b. Failure to propagate physician knowledge and use of evidence-based health promotion and disease prevention interventions results in less effective health care provision which ultimately increases costs to the health care system.

   c. Failure to create a social and physical environment that supports individuals to make healthy life choices reduces the potential impact of any one public health intervention to be successful. Communities that have effective long term community-based health promotion coalitions that also include a wide range of clinical providers are more likely to succeed in reducing rates of chronic disease and other health problems that are bankrupting our health care system and having a negative impact on the quality of life for Maine residents. Physician participation is an important component of community-based health promotion coalitions.

2. Best Practice/lessons learned or "why this approach"
   a. Background
      i. Most states have a formal public health infrastructure that includes municipal or county health departments. Within these structures there are individuals and even divisions (depending on the population size and spread) specifically assigned to the responsibilities

we describe for the Health District Medical Officer. These individuals are known to the community-based medical and social service providing organizations as well as staff at the state-level health departments and provide an effective vehicle for information and best practices to flow among local clinicians as well as up and down the state-county-local information channels. These established staff positions and communication channels allow these states to prepare for and be aware of emerging infectious diseases and biologic threats. The state agency in Maine does an admirable job under the circumstances but in the absence of a formal public health infrastructure, does not have the human or other resources needed to fully identifying and react to these important public health threats. Please note that the role of the Health District Medical Officer is distinctly different from and does not overlap with the existing, "Health Officer" positions that exist in many municipalities.

ii. Maine faces enormous public health challenges that cannot be handled only at the state level. For instance, we face emerging infectious diseases such as Lyme Disease, West Nile Virus, Group A Streptococcus, and bioterrorism threats. Currently the Bureau of Health provide surveillance for these diseases but is hampered by limited staff and other resources. We would like them to be able to be more proactive in their efforts to provide clinical guidance and public health leadership throughout the state for these many entities, especially in the case of widespread disease. Primary care physicians to whom the Bureau of Health provides public health training can assist in disease surveillance and provide local public health leadership for dealing with these emerging infectious diseases.

iii. The State of Maine has a vested interest in assuring that purchased public services make use of research based effective standards of practice. The Bureau of Medical Services and the Bureau of Health currently do not have a mechanism for promoting enhanced implementation of prevention measures to assure local use of evidence-based secondary (risk-reduction) and tertiary (disease management) strategies. The State also needs better opportunities to disseminate effective standards of practice.

b. Just as information alone does not frequently change individual health risk behaviors, information alone cannot be relied upon to change clinical provider behavior. In the tradition of "Grand Rounds" the Health District Medical Officer strategy uses physicians to lead local practice change initiatives that are data driven and for which there would then be ongoing peer support and monitoring at the local level.

c. Community-based health promotion coalitions are a viable mechanism for creating the social capitol and citizen participation in community-focused programs to promote health and reduce disease. These are the activities that help to create and maintain the social and physical environment that supports individuals to make healthy life choices. The absence of these efforts to improve community norms about health behaviors reduces the potential impact of any one public health intervention. Physician participation is an important component of community-based health promotion coalitions.

Project Coordinator Job Description:

- Convene local public health service providers and concerned citizens to develop healthy community style coalition and to facilitate communication among participants;
- Coordinate local public health needs assessments, data collection, and health planning activities in cooperation with state agencies;
- Work with local participants to design, develop, and evaluate local public health policies and services in cooperation with state agencies;
- Write or provide technical assistance to service providing agencies to write applications for grant and contract funding from private sources and government agencies.
- Provide technical assistance to local service providers and partners;
- Facilitate local understanding of and access to state and federal policies and funding for categorical programs and services;
- Mobilize community partners to inform, educate, and empower people to make healthy choices personally and about health issues generally.

Health District Medical Officer Position Description

The Bureau of Health would contract with each of the Health District Coalitions to identify and engage a Health District Medical Officer for each of the Health Districts. These individuals would be expected to work, on average, eight hours a week on behalf of the state and in cooperation with the Health District Coalitions in three specific domains:

a. Emerging Infectious Diseases: Assist the Bureau of Health in disease surveillance and provide local public health leadership for dealing with emerging infectious diseases;
b. Practice Standards: Promote and support clinical implementation of evidence-based health promotion and disease prevention (secondary and tertiary) interventions;
c. Community Health: Provide linkages for health coalitions focusing on primary prevention (health promotion) with a wide range of clinical health providers and promote clinician cooperation with, support of, and participation in local primary prevention activities.

Sample Budget:[16] ($125,000 from increase in Tobacco Excise Tax increase, $15,000 from local municipalities or other community resources)

Average Annual Cost per Health District	
Coalition Coordinator	$40,000
Administrative Assistant	$24,000
Fringe Cost	$22,400
Office Rent	$ 5,000
Supplies	$ 4,000
Printing, copying, postage	$ 3,000
Telephone	$ 6,000
Travel/misscellaneous	$10,600
Health District Medical Officer	$25,000
Total	$140,000

[16] Local staff costs and travel are likely to vary significantly among HDs based on local pay scales and geographic attributes. However, it is essential to have salary and fringe benefits adequate to recruit and retain experienced and well-trained (masters level or equivalent experience/continuing education) public health professionals.