Report on the Cross-Jurisdictional Sharing Discussion Groups

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Brief Summary Report

Prepared for:

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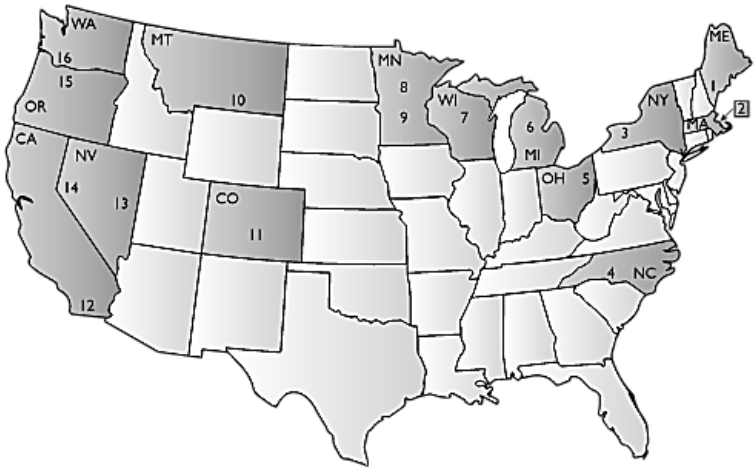
Overview

The City of Portland's Public Health Division (PPH) received a grant from the Robert Wood Johnson Foundation (RJWF) to explore various approaches for organizing, structuring and providing public health services in the Cumberland county area. This grant, known as the *Cross Jurisdictional Sharing* (CJS) initiative supports the investigation of models or approaches that lead to improved public health capacity and efficiency. The structure of the grant is designed to help health departments and policy makers explore and test different arrangements for providing or expanding programs, services, and resources.

Grantees

As seen in Figure 1, Portland was one of 16 sites funded. Each site includes a team from the health department that participates in the CJS national learning community. This learning community is designed to identify and share best practices based on the experiences of grantees in using different types of CJS arrangements.

FIGURE 1. GRANTEE MAP



#1: Cumberland County, Maine CJS
#2: Central Massachusetts Regional Public Health Alliance
#3: Genesee and Orleans Counties, New York, Public Health
#4: Project Smile North Carolina
#5: Northeast Ohio
#6: Northwest Michigan CJS
#7: Northwoods Shared Services Project Wisconsin
#8: Minnesota System Wide
#9: Horizon Minnesota
#10: Yellowstone/Carbon Counties Montana
#11: San Luis Valley, Colorado
#12: San Diego/Imperial Counties – Baja California Region
#13: Northern Nevada Shared Services
#14: Carson City – Douglas County, Nevada
#15: Central Oregon CJS Preparedness
#16: Southwest Washington

Portland Public Health's Role in Maine

PPH is uniquely positioned in Maine's public health system. Most parts of the state rely primarily on the Maine Center for Disease Control to oversee and deliver public health services. PPH is one of only two local health departments in Maine and many of its programs serve recipients outside the Portland jurisdiction. Maine's unusual public health structure creates both challenges and opportunities, and the CJS initiative is an attempt to harness what has been learned at home with lessons from elsewhere to effectively and efficiently deliver services.

Purpose of Report

To inform their deliberations and guide the direction of the project, the grant Leadership Team (see Appendix A) proposed that a series of discussion groups be held with community leaders and stakeholders in Cumberland County. The purpose of the discussion groups was to solicit perceptions about public health services throughout the region and to identify opportunities for strengthening public health capacity through coordination, consolidation and collaboration. This report summarizes the process and preliminary findings and offers potential avenues for moving forward.

Discussion Groups

The discussion groups were designed to listen to stakeholders about the role of public health in their communities and strategies for sustaining a vital public health presence in an environment of diminishing federal, state and local support. They also provided an opportunity to assess interest in the project from public health partners and to identify the local public health issues that were of most concern to participants.

About the Groups
Four discussion groups were held during the summer of 2013. The locations – Portland, Gorham, Yarmouth, and Naples – were chosen, in large part, to reflect the Healthy Maine Partnership service areas. Invitations were sent by Portland Public Health to 269 individuals, comprised of municipal officials, elected officials, schools, health care and social service providers, Healthy Maine Partnerships and other community partners. All discussion groups were facilitated by the University of Southern Maine's Muskie School of Public Service and lasted approximately two hours. A note taker was present at each meeting and representatives from PPH were in attendance to provide background information and answer questions.

Attendance across the groups varied in number and representation. The Portland session had the largest attendance, with eleven people, including two elected officials. Gorham had seven attendees, Yarmouth had four, and Naples three. While one must be careful making inferences from the overall low response rate (25 out of 269, or 9.3%), it does suggest a lack of prioritization for public health among the stakeholders.

There was significant representation at most sessions from EMS services (primarily fire and rescue, but also police), as well as from clean air nonprofit organizations. Local schools were represented at some sessions. Hospitals and medical services were well represented at the Portland session, along with one hospital representative at the Freeport session, but absent elsewhere. The Portland session was also the only one with elected officials in attendance. Despite invitations, several sectors did not participate. For example, there were no town managers or local public health officers who attended. The business community, represented by the leaders of the local chambers of commerce, also did not respond to the invitations.

Focus of Discussion
The groups all had a similar format guided by a protocol developed by the Muskie School. Following introductions, the Muskie discussion leader spoke about the meeting's goals and expectations and a brief summary of the CJS project was provided. A structured discussion was then held about each of the following seven core public health areas:

- Active living
- Chronic disease services
- Environmental health
- Infectious diseases
- Safety net clinical services
- Mental health/substance abuse
- Safety

Discussion Questions
After each area was described, attendees were asked to rank the core areas in order of priority so that areas of highest interest were addressed first. Three questions then were posed to the participants to guide the conversation:

1. What services within each category are most important to your community or constituents?
2. From your perspective, is the delivery and quality of services adequate? How do we know if needs are being met or not?
3. Can the service be improved through a regional approach or other strategy?

Key Findings

The variability in size and composition of the discussion groups limits the inferences that can be made about how well findings reflect community sentiment. At best, we are able to identify themes across groups and areas where interests varied. It is also important to note that all findings are heavily influenced by those who participated in the discussions and their individual perspectives on each issue. Following are two specific recurring content areas that are on the minds of communities, as well as one important local concern.

1. All but one group emphasized the increasing incidence of homelessness, mental illness and substance abuse and its impact on local emergency medical services (EMS) in their communities. No longer seen as a "Portland problem," attendees stressed that their communities were often ill-equipped to address this growing problem, yet town officials have not made it a priority. EMS staff increasingly view themselves as front line providers in situations where they lack sufficient training, especially those involving persons with mental illness and substance abuse problems. Chief among their concerns was their lack of knowledge about appropriate resources to handle situations and effective strategies for addressing the problem directly. EMS saw a role for Portland Public Health in advocating for greater awareness of mental health and substance abuse as a public health issue and as a partner for providing necessary training and support.

2. There was strong desire expressed at two groups to partner with Portland Public Health to educate the public, including the medical establishment, about environmental factors that can contribute to health problems. A few participants were especially concerned about educating and working with medical providers to integrate environmental health factors into clinical work-ups for conditions such as asthma. Indoor air quality was cited as a particular challenge, due to recent changes in building codes that are designed to make buildings tighter, as well as a push to reduce airflow in older homes to improve energy efficiency. These have had the cascade effect of worsening health conditions linked to poor air quality.

3. Falls prevention was seen as an opportunity to reduce costs and to improve the quality of life of residents in one community. EMS staff expressed concern that their resources were being inappropriately deployed to homes and residential care facilities to assist individuals who have fallen. One EMS provider indicated that at least two calls a day relate to falls at residential care facilities, oftentimes repeat calls to the same location. EMS staff saw a role for public health in raising awareness on this issue and working to change state licensure expectations that staff of residential care facilities be adequately trained to prevent falls and to transfer residents that have fallen.

Opportunities for Regionalization and Partnerships
Our discussions explored opportunities to better coordinate existing services or to develop regional models for service delivery. The discussions revealed the following opportunities.

- Public health should participate in regional transportation planning efforts to assure adequate access to public health services that by necessity are located in Portland but which serve communities throughout the county. Participants were accepting of having to travel for specialized clinics (and actually saw value in the anonymity Portland offered, such as clinics for sexually transmitted diseases) but identified the lack of transportation as an important barrier to access.

- Maine's recent efforts to build networks of medical homes and health homes with neighborhood-based community care teams (e.g., Mercy Hospital Neighborhood model) offer a potential infrastructure for public health involvement. By building relationships with these teams, public health could extend its outreach into surrounding communities and better integrate public health into these emerging service delivery models.

- There was strong interest in public health becoming the focal point for regional training of providers on priority public health issues. For example, EMS providers currently lack training in how best to respond in cases involving individuals with mental health/substance abuse problems (not currently part of existing training efforts or accreditation). Understanding effective strategies and available resources for referral could greatly reduce emergency room visits and use of other critical care services.

- Public health could serve an important role through impacting policy and law around indoor air quality (e.g., consequences of over-insulation, mold, carbon monoxide, increased fire risks, etc). Participants suggested that a regional approach be taken in helping towns change building codes and develop educational messages to the public and to providers.

Similarities and Differences
While our focus in this report is to draw out common themes from the discussion groups, it is also important to note that there were significant differences.

Major similarity:
Attendance and participation by EMS, police and fire officials in all but the Naples group indicates high level of interest and potential opportunities for enhanced public health collaboration with these stakeholders.

Major differences:
The Portland session was the only one to attract participation from elected and town government officials. While we can only speculate on what they may have added to the discussion, some of the discussants where local officials were not present noted that their elected officials tend not to focus on key public health issues, such as problems with mental illness and substance abuse in their towns. Without viable (and budget neutral) strategies to address these issues, several participants felt that it was hard to get them on the agenda of town meetings.

The Naples session differed significantly from the others both in terms of the absence of EMS personnel and the dominant presence of local school representatives. Either because of the composition of the group or the nature of the community itself, there was a much stronger interest in active living, which two of the participants saw as critical to chronic disease, environmental health, safety, and mental health/substance abuse. A third participant, was more in line with the other sessions. An important but perhaps not representative finding of the Naples discussion group was their willingness to travel for services. Participants spoke of "volunteer fatigue" and the need for supplemental resources, especially in time of crisis. The Naples participants also spoke more about the shortcomings in their own community:

What We Didn't Hear

The sessions were deliberately designed to give the participants space to consider a variety of possibilities for consolidating public health work, rather than explicitly presenting them with a proposed cross-jurisdictional model. Participants did express interest in regionalizing some public health work, but findings demonstrate that the greatest area of shared interest is service oriented, such as education and advocacy, rather than structural.

We did not hear complaints about public health services, a finding that may reflect general happiness with current PPH offerings. An explicitly favorable viewpoint was expressed at the Naples session.

Next Steps

The discussion groups help guide the next phase of the CJS project by suggesting a model that relies on a more incremental approach to structural reform. They were also instrumental in identifying several individuals who expressed interest in actively participating in the project.

The next phase of work will be to consider how Portland Public Health can more efficiently provide its existing services and potentially expand service delivery and access. A feasibility study will review models for restructuring that assure the financial sustainability and quality of services. Establishing the focus and scope of the feasibility study will be an important agenda item for the leadership team.

Appendix A.

Portland's Cross-Jurisdictional Sharing Learning Community Leadership Team

Name	Title and Organization
Julie Sullivan	Director, Portland Public Health (PPH)
Toho Soma	Health Equity and Research Program Manager, PPH
Shane Gallagher	Community Health Promotion Specialist, PPH
Michael Brennan	Mayor, City of Portland
Ed Suslovic	District 3 Councilor, City of Portland
Dr. Sheila Pinnette	Director, Maine CDC
Chris Zukas	Deputy Director, Maine CDC
Becca Matusovich	Cumberland District Liaison, Maine CDC
Mitchell Berkowitz	Town Manager, Bridgton
Tony Plante	Town Manager, Windham
Nat Tupper	Town Manager, Yarmouth
Peter Crichton	Manager, Cumberland County
Jim Cloutier	Commissioner, Cumberland County
Mark Grover	Commissioner, Cumberland County
Neal Allen	Executive Director, Greater Portland Council of Governments
Meredith Strang Burgess	Former State Representative, 108th District
Anne Graham	State Representative, 109th District
Linda Sanborn	State Representative, 130th District
Peter Stuckey	State Representative, 114th District
Deb Deatrick	Vice President of Community Health, MaineHealth
Colleen Hilton	CEO, VNA Home Health Hospice, Mercy Hospital Mayor, City of Westbrook
Brenda Joly	Professor, USM Muskie School of Public Service
Maureen Booth	Senior Research Associate, USM Muskie School
Barbara Shaw	Senior Policy Analyst, USM Muskie School