

# Developing A Local Public Health Infrastructure: The Maine Turning Point Experience

Paul Campbell and Ann Conway

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This article describes the efforts of public health leaders to develop local public health capacity across Maine. Over 200 individuals representing both government and nongovernmental organizations became engaged in the Robert Wood Johnson Foundation–sponsored Turning Point project in 1999. The state has in recent years only had two local (city) health departments, only one of substantial capacity covering an extremely small proportion of the total state population. This article describes Maine Turning Point organizational efforts, challenges, successes and failures, from the perspective of 3 individuals involved in the process. Five years later, a new network of state-financed, community-based partnerships focused on chronic disease risk factors has been established, apparently strong enough politically to survive in an era of severe state budget cuts. Tobacco use has been reduced. Many other serious public health issues, however, from obesity to mental illness and substance abuse, remain to be successfully addressed. The development of a sustainable statewide network of local agencies providing the essential public health services remains an elusive goal.

**KEY WORDS:** collaboration, community-based public health improvement, community health improvement partnerships, local public health departments, public health improvement

The need to strengthen local public health capacity has been recognized nationally as well as within Maine. The Institute of Medicine has highlighted the important role of communities in its two national assessments of public health. The most recent report, *The Future of the Public's Health in the 21st Century*,<sup>1</sup> report described “a healthy community (as) a place where people provide leadership in assessing their own resources and needs, where public health, social infrastructure and policies

support health, and where essential public health services, including quality health care, are available.” [AQ1]

In Maine, public health leaders have recognized the need for strengthening public health capacity at the local level. The state has serious public health problems to address with limited resources in a predominantly rural environment. Maine has the lowest population density of any state east of the Mississippi River and ranks 36th in per capita income. Currently, only the cities of Bangor and Portland have city health departments, with the latter the only one of real size and capacity. Few citizens are covered by Portland’s health agency; only 60,000 (5%) of the state’s nearly 1.3 million residents live within the city’s boundaries. Most public health responsibilities, therefore, fall to state agencies, in particular the Bureau of Health (BOH) within the state Department of Human Services. Much of the work is accomplished through myriad nonprofit statewide and local organizations under contract to the BOH. The two city health departments must compete for BOH and other state contracts with nonprofit agencies as well; in most cases they do not have special legal or administrative status despite their different, governmental, base. BOH officials, as well as leaders of nonprofit agencies, sought support from the Turning Point Program to address the lack of local public health capacity and began planning discussions in 1999.

## ● Maine’s Public Health Problems

Cancer, cardiovascular disease, chronic lung disease, and diabetes currently account for approximately 70%

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of all deaths in Maine.<sup>2</sup> Maine has unfortunately been a national leader in this epidemic with the 4th highest death rate nationally due to chronic disease in recent years. State public health leaders have identified tobacco use, poor diet, and lack of physical exercise as the critical underlying causes to address. Maine has had a poor track record relative to these factors. In 1999, as the Maine Turning Point planning process began, the state led the nation in the percentage of its young adults using tobacco.

The recent nationwide epidemic of overweight or obesity is equally alarming. According to 2000 data, fully 36% of Maine adults are overweight and 20% obese, for a total of 56%.<sup>2</sup> Again, Maine has not been faring well in a relative sense; the state leads the New England region in the percentage of the population that is overweight or obese.

There are other important sources of ill health in Maine besides tobacco use, poor diet, and lack of physical activity. Maine citizens also have very serious mental health and substance abuse problems. Officials at the Maine Department of Behavioral and Developmental Services believe that nearly 40,000 children (0–20 years) are in need of treatment for mental illness.<sup>2</sup> One in five adolescents and adults (through age 64) has a diagnosable mental disorder in any given year.<sup>2</sup> Binge drinking steadily increased from 1990 through 1999 for Maine males, to over 24% of those queried in an annual survey conducted for the Centers for Disease Control and Prevention. Over 5% of boys in Maine high schools reported using heroin one or more times, greater than the number (3.8%) reported for the nation as a whole.<sup>2</sup> The result is that mental health and substance abuse problems (often intertwined) have an important impact on morbidity and mortality in Maine.

### ● Maine Turning Point

Public health leaders in Maine received a grant from the Robert Wood Johnson Foundation (RWJF) that funded a two-year (1999–2001) planning process with the mandate to strengthen Maine’s public health system. (Four years of implementation support followed, which will end in 2005.) A Maine Turning Point (MTP) Steering Committee was formed at the outset with approximately 40 members representing both government and nonprofit organizations from across the state. (Larger meetings and task forces involved several hundred peo-

ple.) MTP included representatives from all 16 Maine counties, as well as a mix of rural, urban, coastal, inland, mountain, and French-speaking citizens. Even more were involved in the many subcommittees and workgroups spawned by Steering Committee discussions. The project also conducted “community dialogues” in 18 towns around the state and a “Public Health Skill and Training Needs Assessment Survey,” with over 800 individuals responding.

Based partially upon epidemiological and other information (eg, the need to successfully respond to chronic disease and its underlying behavioral risk factors), the Steering Committee made a series of decisions to narrow the project’s focus. *Committee members decided to make the development of a sustainable statewide local public health infrastructure their primary goal.*

### ● Maine’s Local Infrastructure Gap

Maine public health professionals know from in-state experience that sustained progress with lifestyle issues like smoking, obesity, mental illness, and substance abuse will require a combination of state and local public health strategies. Less than 20 years ago, the state had one of the highest teenage pregnancy rates in the nation. Many lacked hope for any change, citing Maine’s relatively poor economic conditions as well as the lack of educational achievement among teenage girls and their parents. Others, however, took advantage of available federal financial resources and identified local leaders throughout the state. Those leaders organized a network of regional nongovernmental organizations across Maine that has provided clinical services, counseling, and community (including school-based) education. They also implemented statewide media campaigns and policy initiatives. The result is that Maine now has one of the lowest teenage pregnancy rates in the nation; pregnancies among adolescent girls fell from 37 per thousand in 1987 to 24 per thousand by 1998.<sup>2</sup>

MTP planners have not relied on their in-state experience alone. They researched the public health structure and systems found in other states and involved out-of-state experts including Dr. Hugh Tilson, a participant in the 2003 IOM national assessment of public health mentioned earlier,<sup>1</sup> a seasonal resident in Maine and a Senior Fellow at the Maine Center for Public Health. They examined many models from the dominant county government based model, used in states like North Carolina and Oregon, to decentralized state government models like Vermont’s. (Vermont’s Department of Public Health operates through ten regions covering the state.) They found the 10 essential public health services to be a very useful reference point in their

**BOX 1 ● Essential Public Health Services\***

1. Monitor health status to identify community problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
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.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

\*Organizations endorsing the Essential Public Health Services listed include the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, the National Academy of Sciences' Institute of Medicine, and the US Public Health Service.

deliberations (see Box 1). They focused at length on those services, aware that in organizational processes, “form follows function.”

Maine Turning Point deliberations highlighted the following serious deficiencies in their own state related to their lack of a substate public health infrastructure:

1. There is very little *strategic planning* at the local level related to health promotion and disease prevention, especially for population-based health issues. Many local organizations do participate in program implementation, but their involvement is in response to a state agency's request for proposals (RFP), which in turn often results from a federal funding initiative. The RFP is also usually categorical (ie, relating to one or more targeted health issue[s]) and is therefore unlikely to contribute to the development of a basic public health-oriented infrastructure that can enhance community response to a continually evolving set of issues. This reactive and “top-down” model means that local needs and preferences may never be defined and resources are underrealized.

In fact, many areas in Maine, especially the more rural regions, have not had local organizations to respond to the state-issued RFPs for public health initiatives. These communities have not even had the opportunity to be reactive because they have no one watching for potential new resources. The result is that those few areas with effective organizers

and grant writers have won a disproportionate share of the limited federal and state resources for public health purposes.

2. Local public health efforts lack sufficient *coordination and collaboration*. At the state level, progress has been made among the myriad agencies involved in public issues. A *Children's Cabinet* has been established for example, involving the leadership from 6 different state agencies including human services, education, medical services, corrections, and behavioral and developmental services. Mental health services have been coordinated regionally. A similar substate entity that cuts across public health issues (including, for example, education, substance abuse, mental health, aging, and youth), *as well as addresses multiple age groups*, however, has not existed. Mental health and social services have been coordinated regionally, though largely on the side of delivery, not planning and evaluation.

Coordination has also been a serious challenge between traditional public health organizations and their health care counterparts, hospitals, and medical practices of all kinds. Few of Maine's medical professionals, including policy leaders, would identify themselves as “public health” advocates. Addressing the serious lifestyle issues facing Maine citizens will require a combination of population-based and clinical (primary and secondary) interventions. Maine, like many if not all states, has not been able to optimize the resources of the medical care system to meet public health challenges. Doctors and nurses and those initiating community-based public health programs need to be collaborators. Strong leadership from both medical and nonmedical communities is required to develop and implement this kind of coordination.

MTP is seeking a statewide local public health system capable of maximizing the involvement of many organizations, including:

- School systems
- Hospitals and health systems
- Managed care organizations
- Medical practices and community health centers
- Area agencies on aging
- Local police departments
- Nonprofit organizations (eg, lung, cancer, heart)
- Municipal governments
- Community and home health nursing
- Extension service
- Faith communities
- Colleges and universities
- Economic development organizations
- Tribal health programs
- Environmental and other advocacy groups

3. Perhaps most serious deficiency identified by MTP advocates has been the relative lack of *accountability* at the local level. The concern is not about contract management that the BOH handles as well as do most state agencies. Maine lacks a network of local leaders who will hold public health providers, whether governmental or nongovernmental, accountable for results in a defined geographic area. This is essential to creating ongoing feedback loops that could lead to continual, locally tailored and measurable improvements.

The focus upon the traditional core public health functions of assessment, policy development, and assurance led to long conversations about the critical need to involve *county or local government* officials in governance structures of regional public health units. Elected municipal and county officials, to date, have largely been left out of the public health arena. That is unlike most other states, where municipal or county officials hold responsibility for public health. Maine has relied upon nonprofit agencies (including hospitals) rather than government to deliver most public health and social services. Nonprofit organizations have worked well, providing a wide range of services and interventions efficiently and creatively; they have also enabled state government agencies to add and subtract services while remaining relatively lean. Nonprofit organization leaders, however, do not have the same level of accountability as government officials. The public does not elect board members of nonprofit agencies, unlike municipal and county officials.

The lack of local government involvement in Maine public health highlights a deeper problem in the state that is not limited to health issues. Local government is perhaps the “Achilles’ heel” of Maine government. Local government in Maine is stymied by: (1) the state’s relatively large number of municipalities (492), as well as (2) the lack of strong regional entities (eg, counties, capable of providing appropriate economies of scale). MTP leaders are aware that only a regional-based, versus municipal, substate public health system makes sense for efficiency reasons alone. Current Governor John Baldacci has acknowledged the importance of this issue when discussing economic development and land-use planning, but he has yet to connect the problem to health. He has offered financial incentives for local governments to collaborate or merge to provide services such as police and K-12 education.

Mainers have traditionally justified the New England tradition of municipal-centered government by referring to Yankee frugality as well as a strong desire for local autonomy. The reality is that current municipal and county government structure is neither fru-

gal nor effective in ensuring local control. Evan Richert at the Portland, Maine-based Muskie School of Public Service has documented the inefficiency in a convincing manner, using local data as well as national norms for comparison.<sup>3</sup> He points out that Idaho, with a comparable population (1.3 million), operates with far fewer local government employees per citizen as well as fewer nonteacher school staff. If Maine delivered local services with the same proportion of full-time equivalent staff as Idaho, it would reduce its costs by \$141 million per year.<sup>3</sup> Maine has a very expensive model that stems from its colonial past; it cannot be justified in 2004 by references to Yankee frugality.

The local autonomy argument presents a similar mirage. State and federal government agencies have rarely engaged either county or municipal government as a resource and, more importantly, never as the governing body. Nonprofits are responsible for nearly 12% of total employment in Maine as a result, versus 7% nationally.<sup>4</sup> Millions of federal and state dollars are distributed to these agencies that operate across Maine to address tobacco use, overweight and obesity, mental health issues, and substance abuse. Nonprofit organizations are excellent at innovation, but nearly always incapable of assuring statewide replication of successful experience. The Institute of Medicine report<sup>1</sup> cited earlier also highlighted the important role to be played by government, especially in this post 9/11 period. Unfortunately, in Maine, local government outside of the cities of Portland and Bangor is not involved in public health activities.

Mainers, however, are not likely to either give up their municipal governments or strengthen their regional or county governments very quickly. There are over 300 years of history and many entrenched interests. The lack of efficient local or regional government though is not the only barrier to the development of a statewide government-anchored local public health system. To be successful, MTP must deal with many citizens’ general distrust of government at any level, as well as well-publicized and far-reaching government budgetary deficits, an eroding tax base, and a history of state government unfunded mandates for municipal authorities. These are all difficult problems. But perhaps the most difficult challenge facing MTP advocates has been the challenge of selling “infrastructure development.” Citizens and political leaders can be mobilized to address a specific issue, such as teenage pregnancy that was cited earlier. Those same citizens are much less likely to get engaged in a struggle to promote a goal as abstract as “local public health infrastructure.” MTP leaders realized over time that the concepts and tools of social marketing are critical to the ultimate success of their efforts.

## ● Turning Point Results

Despite the serious challenges listed above, MTP did lead to substantial positive change, albeit not to the degree sought by most of those involved in the process. Plans to strengthen local public health infrastructure were aided by a fortuitous turn of events. The steering committee's deliberations came to fruition with the arrival, in Maine, of tobacco settlement funds. The then-Governor Angus King and the Maine Legislature had already determined (with input from many public health advocates) that these monies should be used only for health purposes. The Maine Turning Point focus upon building statewide public health capacity was extremely influential as state leaders decided how to use the new money. BOH officials, all of whom had been involved in the Turning Point deliberations, decided to facilitate a more geographically equitable process for distribution of the portion of these funds dedicated to community and school interventions. This approach had been taken previously by the BOH with other initiatives (breast and cervical cancer early detection outreach and education efforts, for example). The critical difference with the tobacco settlement funds is that they were of sufficient amount to build real capacity, and they had a broader purpose (multiple risk factors and multiple chronic diseases).

The BOH designated 30 geographic regions that covered the state, largely following hospital service areas. They made it clear that one proposal would be selected for funding from each area (except for Portland, with two awards). Thus, all regions of the state received at least some funding for new entities, Healthy Maine Partnerships (HMP), organized to address tobacco, nutrition, and physical activity issues. The new structure can be diagrammed as shown in Figure 1.

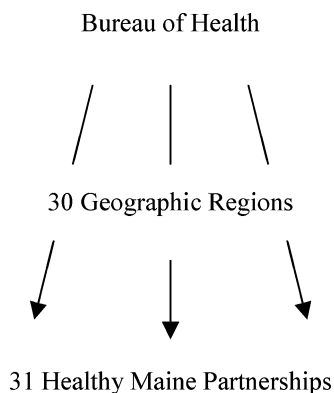
Each of the local partnerships works to reduce tobacco-related chronic diseases by developing and implementing comprehensive community-level interventions that promote and support tobacco use prevention

(eg, increased physical activity and healthy eating), primarily through policy and environmental change. The partnerships are all based in nongovernmental organizations (with the exception of the City of Portland Department of Public Health) and, as required by the BOH, they all include a substantial collaboration with at least one local school district and one health care organization (eg, hospital or community health center). They have been designed to achieve three primary goals:

1. To reduce tobacco use and tobacco-related chronic diseases, disability, and deaths through state programs and interventions developed and delivered across all community settings (schools, health facilities, worksites, etc.) with particular attention to high-risk and disparate populations.
2. To ensure the accessibility of coordinated services for the early identification and referral for risk factors leading to tobacco-related chronic diseases (cardiovascular disease, cancer, lung disease and diabetes) with particular attention to disparate populations. These risk factors include tobacco addiction, overweight/obesity, poor nutrition, physical inactivity, elevated blood pressure, elevated blood cholesterol, and family history.
3. To implement a coordinated school health program in HMP-affiliated schools that emphasizes comprehensive school health education and incorporates the Centers for Disease Control (CDC) Division of Adolescent and School Health (DASH) guidelines for tobacco use prevention, physical activity, and healthy eating.

The establishment of geographic regions and the Healthy Maine Partnerships were not the only outcomes related to Maine Turning Point. For one, MTP succeeded in selling the need to develop a consistent local fabric to many state officials. The following year, when federal dollars became available for substance abuse prevention (the so-called "One Maine Program"), the Healthy Maine Partnership geographic areas were targeted as the principal vehicles. MTP achieved other supportive public health improvements. Those changes include:

1. *Education and training.* Maine has not had in-state graduate public health education—a serious problem in a state seeking to upgrade the skills of local, as well as state, public health workers. The University of New England responded to MTP recommendations in this area by initiating a graduate certificate program in public health with academic credits that may be used toward a master's degree in public health from neighboring University of New Hampshire. Concurrently, the University of Southern Maine developed a summer Institute in Public



**FIGURE 1.** New funding structure.

Health, offering credit-granting courses for undergraduate (as well as graduate) degrees and a certificate. MTP also led to the development of a Maine Public Health Education and Training Committee that meets quarterly to stimulate the provision of high priority continuing education courses throughout the year.

2. *Information systems.* MTP recommendations regarding the development of data collection and analysis produced a task force that drafted a plan for a Web-based “community health information system,” with funding from a local foundation. That effort has since been subsumed into a larger information system development effort funded and organized by the BOH.
3. *Coordination, collaboration, and advocacy.* Maine Turning Point has led to the development or strengthening of 3 important statewide collaborative non-profit public health organizations. The Turning Point grant-writing process hastened the development of the Maine Center for Public Health (MCPH), an organization established by state law (but unfunded) in 1996. The MCPH Board of Directors has guided the project since its inception and when Turning Point dollars ended for planning purposes, secured local foundation monies to continue the process. The MCPH has steadily grown, since private dollars enabled operations to begin in 1999, to take on numerous projects beyond Turning Point and is now one of approximately 20 growing public health institutes across the country. The Maine Network of Healthy Communities was also organized during the first phase of Turning Point by local coalition leaders and been partially supported since then by TP grant funds. The Maine Public Health Association, established approximately 20 years ago, has been the primary legislative advocacy organization throughout the Turning Point process.
4. *Evidenced-based practice.* The MTP call for greater evidenced-based public health practice supported the development of the Maine-Harvard Prevention Research Center, a collaborative project involving the Harvard School of Public Health and the CDC, as well as the BOH and MCPH. The center is part of a national CDC network organizing community research projects, education and training programs, and technical assistance, all designed to foster evidence-based practice. Maine’s center currently focuses upon the epidemic of childhood obesity.

having daunting challenges to face. Data from annual CDC surveys have revealed substantial reductions in the level of smoking in Maine. The state no longer leads the nation in the percentage of its young adult population using tobacco.<sup>5</sup> The most recent results indicate that cigarette smoking among teenagers, estimated at 29% in 1999 when Maine Turning Point began, has declined to 21% in 2003.<sup>6</sup> (Healthy Maine 2010 has set a goal of 15% for this critical population.) The trend has strengthened the resolve to continue the use of tobacco settlement funds for prevention efforts, including the support of the Healthy Maine Partnerships. Similar efforts have not been successful in other states. Maine is one, if not the only, state remaining that dedicates 100% of settlement dollars to health purposes. The partnerships have also revealed the political strength of the new infrastructure. When prevention funding was threatened, HMP leaders throughout the state mobilized their constituents and legislators, and the threat was overcome.

Maine continues to be a leader in health policy and certainly leads the nation in the number and depth of reform efforts. The Dirigo Health Plan, enacted by the legislature and governor a year ago, promises to revolutionize the way health care is provided in Maine, not just for the currently insured.<sup>7</sup> At the same time, elected and state officials are currently also engaged in large-scale state government reorganization deliberations, currently focused upon the merger of the Departments of Human Services (including the Bureau of Health) and Behavioral and Developmental Services (Maine’s mental health and substance abuse agency). Public health leaders, seasoned by the years of MTP discussions, are influential in both processes. They have recently proposed that a “Maine Center for Disease Control and Prevention” replace the current Bureau of Health.

The national mission of Turning Point is “to transform and strengthen the public health system in the United States to make the system more effective, more community based and more collaborative.”<sup>8(p377–378)</sup> Certainly, the progress cited above in Maine documents that the process has achieved results. MTP leaders have also found that this effort is never-ending. The state and local discussions, studies, social marketing efforts, training, documentation of effectiveness, and recruitment of new and diverse partners will have to continue if Maine’s public health system is going to survive this era of increasing resource constraints, much less expand.

## ● The Future

Maine is now in the fifth year of the Turning Point project. Organizers have much to celebrate, as well as

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[AQ2]

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