FINAL REPORT

Fund for a Healthy Maine Programs–

Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved

Report No. SR-FHM-08

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

October
2009

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Report Highlights

OPEGA Report No. SR-FHM-08

Fund for a Healthy Maine Programs - Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved

What questions was this OPEGA review intended to answer?

Are existing managerial and oversight systems (frameworks) adequate to help ensure that activities supported by the Fund for a Healthy Maine (FHM):

- are cost-effective and carried out in an efficient and economical manner; and
- have sufficient transparency and accountability for results and expenditures?

What was OPEGA's overall conclusion?

For the four FHM programs OPEGA reviewed in depth, adequate frameworks were in place for ensuring cost-effectiveness of specific activities. However, there does not appear to be a process for periodically reassessing Fund allocations to the various health-related efforts to assure the Fund as a whole is advancing the State's health vision and goals in the most cost-effective manner. The ability to have on-going, meaningful conversations regarding the Fund and the activities it supports is currently challenged by:

- an apparent reluctance to deviate from the agreement made 10 years ago regarding the original menu of activities and funding levels;
- lack of clarity as to which State entity is formally responsible for assuring the Fund as a whole is cost-effectively supporting State health goals and strategies;
- incomplete financial and performance data at the activity level (unless the activity is captured solely by one budgetary program or contract);
- general, vague and sometimes inaccurate descriptions of budgetary programs in budget documents submitted by the Governor to the Legislature; and
- poor alignment of financial and performance information between budgetary programs, the key activities within them, and the administrative functions that support them.

Some of these challenges are not unique to the Fund for a Healthy Maine. In fact, OPEGA has commented on similar weaknesses in the financial and performance information available to policy and decision-makers in several reports over the last four years.

What actions has OPEGA suggested?

OPEGA suggested the Legislature consider taking action to:

- ⇨ Initiate an effort to assess whether the existing FHM allocations still make sense within the current health environment.
- ⇨ Formally assigning responsibility for periodically reassessing the Fund allocations to a specific State entity or entities.
- ⇨ Improve the alignment of budgetary programs and cost information with the State's health goals, efforts and related performance information.
- ⇨ Require agencies to provide certain desired information within the program descriptions that are submitted with the Governor's Budget.

OPEGA recommended that management take action to:

- ⇨ Develop and implement policies and procedures necessary to ensure budgetary program descriptions are as current, complete, specific and accurate as is practical.
- ⇨ Use the State's accounting system to track costs for the major activities associated with budgetary programs.

To get a copy of the full report, or for more information, visit the website listed at the bottom of this page or contact OPEGA at (207) 287-1901

October 2009

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Acronyms Used in This Report

BRFSS – Behavioral Risk Factor Surveillance System
CCHC – Comprehensive Community Health Coalition
CDC – Center for Disease Control and Prevention
CTI – Center for Tobacco Independence
DAFS – Department of Administrative and Financial Services
DHHS - Department of Health and Human Services
FHM – Fund for a Healthy Maine
FY - Fiscal Year
GHS – Goold Health Systems
GOC- Government Oversight Committee
HHS – Legislative Joint Standing Committee on Health and Human Services
HMP – Healthy Maine Partnerships
KIT – Knowledge-based Information Technology
MeCDC – Maine Center for Disease Control and Prevention
MCPH – Maine Center for Public Health
MRSA – Maine Revised Statutes Annotated
MSA – Maine Sheriff's Association
MYAN – Maine Youth Action Network
MYDAUS – Maine Youth Drug & Alcohol Use Survey
NRT – Nicotine Replacement Therapy
OPEGA - Office of Program Evaluation and Government Accountability
OSA – Office of Substance Abuse
PHI – Public Health Infrastructure
PMP – Prescription Monitoring Program
PRC – Prevention Research Center
PTM – Partnership for a Tobacco Free Maine
RFP – Request for Proposal
RVR – Retailer Violation Rate
SBHC – School Based Health Center
TMSA – Tobacco Master Settlement Agreement
U.S. CDC – United States Center for Disease Control and Prevention

FULL REPORT

Fund for a Healthy Maine Programs- Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved

Purpose

FHM receives revenue primarily from Maine's share of the Tobacco Master Settlement Agreement, ranging from $45 million to $58 million per year since 2000. The Fund is currently allocated among 22 budgetary programs, one of which has five sub-accounts.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of programs funded by the Fund for a Healthy Maine. OPEGA conducted this review at the direction of the joint legislative Government Oversight Committee (GOC) of the 123rd Legislature, in accordance with 3 MRSA §§991-997.

In the fall of 2008, the Joint Standing Committee on Health and Human Services (HHS) requested an OPEGA review of Fund for a Healthy Maine (FHM) programs. FHM is currently divided among 22 budgetary programs, one of which has five sub-accounts. Dedicated revenue that flows into FHM primarily comes from Maine's share of the Tobacco Master Settlement Agreement (TMSA) and has ranged from $45 million to $58 million each year since 2000. Since 2006, the Fund has also received a set percentage of racino revenues. Racino revenues have ranged from $1.7 million to $3.7 million annually and are intended for the FHM – Drugs for the Elderly program. The Fund is also supplemented by investment revenue with significant annual variance.

OPEGA's review sought to determine whether frameworks are adequate to ensure cost-effectiveness, transparency and accountability for programs and activities supported by FHM.

OPEGA addressed the request from HHS in two phases. The first phase included a comparison of Maine to other states with regard to the proportion of TMSA funds that are spent on preventive health services. Those results were released in an Information Brief in March, 2009. The first phase also produced an inventory of FHM-supported programs and their key activities which can be found in Appendix A.

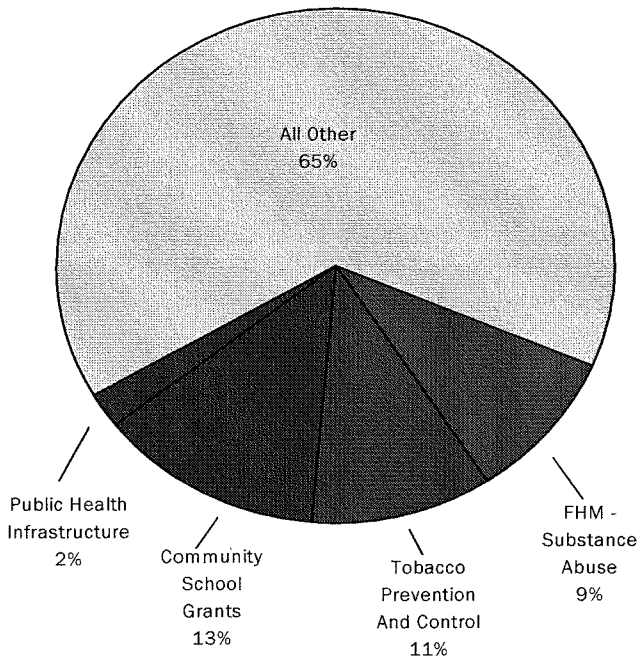
The second phase of our review has involved conducting a broad analysis of the efficacy, efficiency, transparency and accountability of FHM programs by focusing on the following question:

> *Are existing managerial and oversight systems (frameworks) adequate to help ensure that activities supported by the Fund for a Healthy Maine:*
>
> - *are cost-effective and carried out in an efficient and economical manner; and*
> - *have sufficient transparency and accountability for results and expenditures?*

Scope and Methods

In conducting this review, OPEGA considered the frameworks in place for the Fund as a whole, but also focused on the specific activities encompassed within four of the FHM budgetary programs. Each budgetary program is identified in the State's budget and accounting system by a numeric or alpha-numeric code. These codes have been included in this report with the program names to assist readers in connecting programs and activities with official budget documents.

Figure 1. FHM FY09 Program Allocations Highlighting Programs Focused on in OPEGA's Review



Program #	Program Name	FHM Funds
Z015	Drugs For The Elderly & Disabled	$13,912,727
0953-07	Community School Grants	$9,059,743
0960	Medical Care	$8,776,069
0953-02	Tobacco Prevention And Control	$7,377,596
0948	FHM - Substance Abuse	$6,554,080
0953-06	FHM - Home Visits	$5,432,713
Z070	FHM - Dirigo Health	$5,000,000
0961	FHM - Purchased Social Services	$4,605,435
0959	FHM - Head Start	$1,582,460
0953-08	Public Health Infrastructure	$1,470,000
Z048	Immunization	$1,258,000
0953-01	Oral Health	$973,897
0956	Family Planning	$884,240
0957	Service Center	$720,101
0951	FHM - Dental Education	$277,735
0964	FHM - Fire Marshal	$262,906
Z068	FHM - School Breakfast Program	$224,925
0947	FHM - Attorney General	$198,684
0952	FHM - Quality Child Care	$167,792
0955	Bureau Of Medical Services	$140,497
0950	FHM - Area Health Education Centers	$117,235
0963	FHM - Judicial	$110,686
0949	FHM - School Nurse Consultant	$103,670
0962	Bone Marrow Screening	$93,712
0954	BFI - Central	$61,898
0958	Donated Dental	$42,562
Total for all programs		$69,409,363

Note: All programs ending with a two digit suffix are sub-accounts of the budgetary program #0953, FHM - Bureau of Health, which is the program that appears in the Governor's Budget as presented to the Legislature.

The four programs selected for more in depth review were Community/School Grants (#0953-07), Public Health Infrastructure (#0953-08), Tobacco Prevention and Control (#0953-02) and FHM - Substance Abuse (#0948) - the first three of which are sub-accounts of FHM-Bureau of Health (#0953). As illustrated in Figure 1, these four programs received 35% of FHM allocations in fiscal year 2009 (FY09). They were also selected because of the complex nature of the activities they encompass, the interrelationships between those activities, and the degree of contracted services involved.

OPEGA focused on the activities associated with four selected FHM budgetary programs.

OPEGA assessed whether the following elements for ensuring cost-effectiveness, transparency and accountability were in place with regard to the specific activities conducted during fiscal year 2008 (FY08):

- programs have clear purposes;
- program activities have goals that are reasonably aligned with the program purpose;
- key contracts include performance expectations or measures;
- there is regular monitoring/assessment of whether performance expectations and goals are met;
- competitive bid processes or other measures are in place to assure that services procured from third parties are obtained at reasonable cost for the desired quality and quantity;
- managers have sufficient, relevant financial data available to them;
- there is monitoring of actual versus expected costs and review of whether expenditures are appropriate, reasonable and necessary;
- information gathered about performance and costs is used by managers to adjust programs, activities or related agreements with third parties;
- roles and responsibilities for the Fund as a whole and the programs and activities it supports are clear and appropriate such that there is accountability for performance and cost;
- there is sufficient information publicly reported and readily available describing the programs/activities FHM is supporting, what they cost and what the results are over time;
- information provided, or available, to the Legislature on programs/activities supported by FHM is useful for performing oversight, making decisions about funding allocations or considering policy changes; and
- information available to the Legislature and public allows for easy identification of which State agencies/managers are responsible and accountable for FHM programs and expenditures.

Cost-effective: Economical in terms of tangible benefits produced by money spent, OR productive or effective in relation to its cost.

~ Merriam-Webster On-line Dictionary

OPEGA assessed whether 12 key elements for ensuring cost-effectiveness, transparency and accountability were present in the management and oversight frameworks for each activity.

Transparency: The state of being transparent - free from pretense or deceit; easily detected or seen through; readily understood; and/or characterized by visibility or accessibility of information especially concerning business practices.

Accountability: The state of being accountable - subject to giving an account (answerable) and/or capable of being accounted for (explainable).

~ Merriam-Webster On-line Dictionary

Information necessary to understand programs and activities and assess these elements was obtained through:

- conducting research on the public health environment including reviewing the State Health Plan, Healthy Maine 2010 and descriptions of public health initiatives at the national and state level;

- interviewing management and staff in the Department of Health and Human Services (DHHS) associated with the programs;
- reviewing sample contracts, RFPs, and other documents associated with contract management; and
- reviewing reports and other documentation of program and activity results.

Overview of FHM Programs

History of Allocations

The Legislature established the Fund for a Healthy Maine in 1999 to receive Maine's annual Tobacco Master Settlement Agreement payments. 22 MRSA §1511 limits Fund uses to eight health-related purposes:

The Fund for Healthy Maine was established in 1999. Maine Statute limits uses of the Fund to eight health-related purposes and specifies that the Fund must be used to supplement, not supplant, appropriations from the General Fund.

- Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;
- Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;
- Child care for children up to 15 years of age, including after-school care;
- Health care for children and adults, maximizing to the extent possible federal matching funds;
- Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;
- Dental and oral health care to low-income persons who lack adequate dental coverage;
- Substance abuse prevention and treatment; and
- Comprehensive school health and nutrition programs, including school-based health centers.

The statute also contains certain other restrictions including that allocations from the Fund must be used to supplement, not supplant, appropriations from the General Fund. Unencumbered allocation balances remaining at the end of any fiscal year lapse back to the Fund for a Healthy Maine and may not be made available for expenditure without specific legislative approval.

The statutory limitations, as well as original Fund allocation amounts, resulted from a legislatively-led, statewide, participatory process.

The specific uses in the FHM statute and original allocation amounts were the result of a legislatively-led statewide participatory process involving many organizations, individuals and community groups. This process created a broad base of support for the uses specified in statute.

Shortly after the establishment of the Fund, specific programs were established in the State budget to facilitate tracking FHM allocations (see Appendix A for a listing of FHM budgetary programs). The original baseline budgets for some of these programs specified particular activities or organizations. Examples are FHM - Head Start (#0959) which supports those agencies in the State that are Head Start

Specific programs were established in the State budget to facilitate the tracking of allocations and expenditures from the Fund. Many State efforts supported by the Fund through the FHM budgetary programs also receive other state and/or federal funding.

recipients and FHM - Fire Marshal (#0964) which supports fire inspection services for child care facilities. Original allocations for other programs, such as FHM - Medical Care (#0960), were assigned at a more general level for more broadly defined purposes.

Many State efforts supported by these FHM budgetary programs also receive other State and/or federal funding. For example, Drugs for the Elderly & Disabled is partially funded from a dedicated portion of racino revenue that flows through a FHM program (#Z015). It also is supported by the General Fund through a separate budgetary program. Similarly, child care providers may receive federal Social Services Block Grant funds as well as FHM funding. Some efforts supported by FHM programs, however, have no other source of State funding – examples include Home Visits and Donated Dental. FHM dollars in several programs are used by providers and/or the State to leverage federal funds.

Annual fluctuations in Tobacco Settlement payments have typically been allocated proportionally across all FHM programs. However, since 2001, State agency staff have generally not proposed budget initiatives to increase or decrease FHM baseline allocations to the various programs - even though there may have been changes to the levels of funding some efforts receive from other sources. Staff report a general awareness of the FHM statute, its history, the original 2000-01 allocations, strong outside advocates and the statutory intent that FHM not be used to supplant General Funds. Changes that have been made to baseline FHM allocations over time and new FHM programs that have been added, such as the School Breakfast Program and Public Health Infrastructure, have emerged from budget deliberations at the Department of Administrative and Financial Services (DAFS), with the Governor, and ultimately by the Legislature.

OPEGA observed that in the last 10 years there has not been a comprehensive reassessment of how FHM is being allocated to support health-related efforts and there is some reluctance to do so.

OPEGA observed that in the last 10 years there has not been a comprehensive reassessment of how FHM is being allocated to support health-related efforts and there is some reluctance to do so. No one in the Administration is charged with looking broadly at FHM allocations in light of current and future needs, and the availability of other State and federal resources. Reasons for this reluctance include concerns that advocates will resist any changes to FHM programs, and the possibility of changes not being based on public health expertise and science. See Recommendation 1 for further discussion.

Focus on Public Health

There has, however, been consistent adherence to the Legislature's intent to use TMSA revenues to support health-related efforts.

Statute makes it clear that the Legislature's intent has been to use TMSA revenues to support health-related efforts and OPEGA noted that there has been consistent adherence to that intent. In fact, OPEGA's analysis in Phase I of this review found that 99.7% of dollars received from the TMSA are being utilized to prevent risks for disease, reduce existing risks for disease or reduce the impact of diagnosed disease.

Some FHM budgetary programs are targeted to address specific health issues within Maine or areas where past funding had been inadequate to meet needs. For example, the FHM programs for Area Health Education Centers, Dental Education and Donated Dental appear intended to address the problem of not

having enough access to health and dental care in underserved areas or for underserved populations.

Other FHM programs, though, are clearly avenues for implementing Maine's State Health Plan[1] which articulates the State's vision, goals and strategies for public health, including a description of the design for Maine's Public Health Infrastructure. These concepts are summarized in an Issue Brief entitled "Is Maine Prepared to Become the Healthiest State in the Nation" that was prepared for the Legislative Policy Forum in January 2009 and has been included in this report as Appendix C.

Some FHM programs and associated activities are avenues for advancing Maine's State Health Plan and national strategies to affect the overall state of public health on a more comprehensive level.

OPEGA further noted that some FHM programs and associated activities are also avenues for advancing national strategies to affect the state of public health on a more comprehensive level. They include the FHM Community/School Grants, Public Health Infrastructure and Tobacco Prevention and Control programs which fund activities and efforts based on nationally recognized models and best practices.

For example, Maine's Healthy Maine Partnerships (HMPs), which are funded, or receive other support, through all three of these programs, are a community based approach to affecting policy and environmental changes in support of healthier schools, work places and communities. This approach is consistent with current efforts by the United States Centers for Disease Control and Prevention to address tobacco use and chronic diseases. The U.S. CDC has identified four overarching Health Protection Goals to address and improve the health of the nation. One of these goals is Healthy People in Healthy Places and one of the national CDC programs addressing it is the Healthy Communities Program. In Maine, the Healthy Maine Partnerships and Tribal Health Liaison activities reflect and build upon CDC's Healthy Communities approach to addressing chronic disease and tobacco use.

For example, Maine's Healthy Maine Partnerships are the implementation of a national community based approach to affecting policy and environmental changes in support of healthier schools, work places and communities.

Related U.S. CDC Goals and Programs

Goal:
Healthy People in Healthy Places
The places where people live, work, learn, and play will protect and promote their health and safety, especially those at greatest risk of health disparities.

Program:
Healthy Communities
Engaging communities and mobilizing national networks to focus on chronic disease prevention. Communities are working to change the places and organizations that touch people's lives every day – schools, work sites, health care sites, and other community settings – to turn the tide on the national epidemic of chronic disease.

~http://www.cdc.gov

Similarly, the FHM Tobacco Prevention and Control program funds efforts carried out by Maine's Partnership for a Tobacco Free Maine (PTM) that are overseen by Maine Center for Disease Control and Prevention within DHHS. PTM closely follows the national CDC best practice guidelines, and includes activities in all four of the recognized components in the *National Tobacco Control Program* model. PTM activities closely match the specific recommendations for tobacco prevention and control efforts contained in the CDC's *Guide to Community Preventive Services: What Works to Promote Health.* Maine is one of two states that the national CDC has

Similarly, tobacco prevention and control activities supported by FHM are derived from U.S. CDC best practice guidance and closely match CDC's specific recommendations.

[1] http://www.maine.gov/dhhs/boh/phdata/state_health_plan.htm

highlighted on their website by presenting a comprehensive case study of the Maine's activities and results as an example for other states to emulate.

Excerpt from Task Force on Community Preventive Services' *The Guide to Community Preventive Services: What Works to Promote Health?*

"Based on the evidence of effectiveness documented in the scientific literature, recommendations from the Task Force support the following population-based tobacco prevention and control efforts:

- Clean indoor air legislation prohibiting tobacco use in indoor public and private workplaces.
- Federal, state, and local efforts to increase tobacco product excise taxes as an effective public health intervention to promote tobacco use cessation and to reduce the initiation of tobacco use among youth.
- The funding and implementation of long-term, high-intensity mass media campaigns using paid broadcast times and media messages developed through formative research.
- Proactive telephone cessation support services (quit lines).
- Reduced or eliminated co-payments for effective cessation therapies.
- Reminder systems for healthcare providers.
- Combinations of efforts to mobilize communities to identify and reduce the commercial availability of tobacco products to youth.

~ Taken from Appendix C of the U.S. CDC's Best Practices for Comprehensive Tobacco Control Program found at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf

Selected FHM Programs and Associated Activities

This section of the report describes the frameworks in place for ensuring cost-effectiveness, transparency and accountability for the individual activities supported by the four FHM programs selected for more detailed examination in this review.

OPEGA noted that activities in one FHM budgetary program are sometimes entwined with activities in other FHM programs. Complex interrelationships between FHM budgetary programs and non-FHM programs that support the same activities or focus on the same health goals were also noted.

OPEGA noted that activities in one budgetary program are sometimes entwined with activities in other budgetary programs. For example, the evaluation contract for Healthy Maine Partnerships funded through the Community/School Grants program also receives funding from, and provides data for assessing the performance of, the Tobacco Prevention and Control program. Similarly, local HMPs —a group of contractors that perform a substantial portion of the work in this Community/School Grants program—are also under contract to perform much of the work for the Public Health Infrastructure program. Given the interconnected structure of some of these activities, it is difficult to discuss each of them in isolation. OPEGA attempted to understand the specific intent and effort involved in each activity, and to understand how they are expected to contribute to goals that may be shared with other programs.

In addition, the interrelationships between FHM and non-FHM funding sources, budgetary programs, their associated activities and the health goals being pursued become complex. This complexity, coupled with a lack of activity-level cost data, make it difficult to connect total dollars allocated, appropriated and spent from all funding sources with the results being achieved. See Recommendations 2, 3 and 4 for further discussion.

These conditions make it difficult, and somewhat inappropriate, to assess individual FHM programs and activities in isolation.

These conditions also make it difficult, and somewhat inappropriate, to assess individual FHM budgetary programs in isolation. While our review focused only on activities that received some FHM funding, our assessment of the frameworks

for maximizing effectiveness and controlling costs did relate to the activity as a whole rather than just the portion funded by FHM.

Community/School Grants Program (#0953-07)

The stated purpose of the Community/School Grants program is to reduce tobacco use, tobacco-related chronic disease, and associated risk factors.

The stated purpose of the Community/School Grants program is to reduce tobacco use, tobacco-related chronic disease, and associated risk factors by addressing these issues at the local level. The program had a budget of approximately $8.9 million in fiscal year 2008, and is managed by the Maine Center for Disease Control and Prevention (MeCDC or Maine CDC) within DHHS. Primary activities funded within this program are listed in Table 1 below. Each activity is described further in the report sections that follow.

Table 1. Community/School Grants Program at a Glance

ACTIVITY	FHM FY08 BUDGET	GOALS	PRIMARY DELIVERY
Healthy Maine Partnerships	$6.7 million	1. Ensure Maine has the lowest smoking rate in the nation. 2. Prevent the development & progression of obesity, substance abuse, and chronic diseases related to or affected by tobacco use. 3. Optimize the capacity of cities, towns and schools to provide health promotion, prevention, education, and self-management of health.	Contracts with community entities
Support and Training	$250,000	1. Enhance the capacity of HMPs to reach goals. 2. Increase the effectiveness of strategies targeting youth by involving youth.	Contract and state employees
Office of Local Public Health	$260,000	1. Strengthen and improve public health services. 2. Support the emerging public health infrastructure.	State employees
Tobacco and Chronic Disease Work with the Tribes	$250,000	Eliminate tribal health disparities by ensuring tribes have equal access to public health resources in ways that are culturally appropriate and therefore more effective.	Contract with the tribes
School Breakfast	$80,000	*These funds were transferred to Department of Education's School Nutrition Program.*	
Statewide Tobacco Enforcement	$185,000	1. Prevent tobacco sales to youth. 2. Enforce State Smoke-Free laws.	Contract and state employees
Physical Activity and Nutrition	$175,000	Increase physical activity, reduce obesity and improve nutrition through an applied research program.	Contract
School Based Health Centers	$627,000	Improve access to health care and provide health safety net for adolescents.	Contracts with schools and/or medical providers

Source Note: The figures shown here are estimates for key activities provided by the program director. There may be additional costs not attributed to any specific activity, and activities may receive other funds in addition to the FHM dollars shown in this table. Activity level budgets are informal and maintained at the discretion of program directors. OPEGA has not confirmed these estimates. FY08 estimates for this program were not available and we have instead used FY09 estimates that were provided as an approximation for FY08.

Activity: Healthy Maine Partnerships

The specific goals of the Healthy Maine Partnerships (HMP) activity are to:

1. Ensure Maine has the lowest smoking rate in the nation.
2. Prevent the development and progression of obesity, substance abuse, and chronic diseases related to or affected by tobacco use.
3. Optimize the capacity of Maine's cities, towns and schools to provide health promotion, prevention, education, and self-management of health.

The Healthy Maine Partnerships receive the majority of the FHM funds allocated to the Community/School Grants program, an estimated $6.7 million in FY08. Local HMPs are also supported by federal funds associated with other State programs that are funneled through the same contracts.

Most of the FHM funds allocated to the Community/School Grants program go to the Healthy Maine Partnerships activity, an estimated $6.7 million in FY08. HMP results tend to be policy or environmental changes that support the activity's goals.

The activity is primarily carried out by 28 contractors, referred to as local HMPs, who work with a variety of community partners and school districts in their service areas. Appendix B contains a listing of the local HMPs and their locations as well as a graphic illustrating the HMP structure.

HMP results tend to be policy or environmental changes that support the activity's goals. For example, an HMP contractor may work with a local school district to reduce the fatty or sugary foods available in vending machines. The activity links this environmental change to its goals of preventing the development and progression of obesity and of optimizing the capacity of towns and schools to provide health promotion. This approach is laid out in the HMP logic model as published in the HMP January 2009 Evaluation Plan (see Figure 2).

Each local HMP is required to partner with at least one school that is receiving funding for a Coordinated School Health Program. To accomplish this, the school administrative unit hires a School Health Coordinator paid for with FHM funds from the Community/School grant which flows through the HMP.

This activity is carried out by 28 contractors working in collaboration with schools and communities across Maine. Maine CDC staff are responsible for monitoring that work and ensuring it is completed effectively and efficiently.

Although the HMP work is carried out by contractors working in collaboration with schools and communities across Maine, employees of Maine CDC are responsible for monitoring that work and ensuring it is completed effectively and efficiently. MeCDC staff have a number of tools available for use in assessing performance, both in accomplishing short term tasks and in meeting intermediate and long range goals. Tools used to monitor progress in the near term include:

- Quarterly Narrative Reports – provided by each of the 28 HMPs briefly describing their efforts over the past quarter, including significant successes and barriers they have encountered.
- Knowledge-based Information Technology (KIT) Data – entered by the HMPs through a web portal and available in real time for Maine CDC staff to review. Available data can be useful for assessing the different strategies each HMP is implementing, the effort directed to various populations, how completion of the work plan is progressing, what specific efforts are planned in each Health Promotion Category, and how each HMP's efforts involve youth.

- Site Visits – conducted by the project officers responsible for each HMP, who may be staff of MeCDC, Office of Substance Abuse or the Department of Education. These visits are formally conducted on an annual basis to meet with HMPs, observe their progress, and discuss any adjustments that are needed. Staff have begun documenting these annual visits in formal reports. Informal site visits also occur throughout the contract year as necessary and convenient for the local HMPs.

Maine CDC staff use statistics and evaluation data to gauge how well current HMP strategies are working, identify specific populations or health objectives that are not being fully addressed, and guide decisions about how future efforts should be targeted.

Progress toward longer term outcomes is monitored through assessment of:

- Statewide Surveillance Statistics from the Behavioral Risk Factor Surveillance System (BRFSS) – administered by the federal CDC. This is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors throughout the United States and its territories. 6,500 Maine adults participate in the survey each year.
- HMP Evaluation Data – provided by the evaluation contractor, the Maine Center for Public Health (MCPH). Maine CDC receives analysis of how the KIT data described above is converging with BRFSS health statistics and what these pieces of data say about the long term results of HMP efforts. MCPH gathers additional information via case studies, surveys, and observations, as necessary to complete their analysis. The Evaluation activity is further described on page 24.

The contracts with local HMPs are also supported by federal funds and are awarded through an RFP process.

Maine CDC staff use these statistics and evaluation results to gauge how well current strategies are working, identify specific populations or health objectives that are not being fully addressed, and guide decisions about how future efforts should be targeted.

If review of the short or long term performance data indicates an HMP is underperforming, Maine CDC staff report they identify the underlying issues then work with the HMP to address them. The process begins with cooperative discussions and, if correction does not occur, it escalates to changes in the contractor's level of funding or responsibilities as deemed necessary. OPEGA was provided with a recent example of a HMP contractor that was not performing to the expectations. It eventually lost the HMP contract.

Prior to the beginning of the new contract year, contractor budgets are approved by MeCDC, thus setting the expectation for what funds should be spent on. Cost settlements are performed after the period has ended to assure contractor costs were appropriate and to identify any final payments due to or from the contractors.

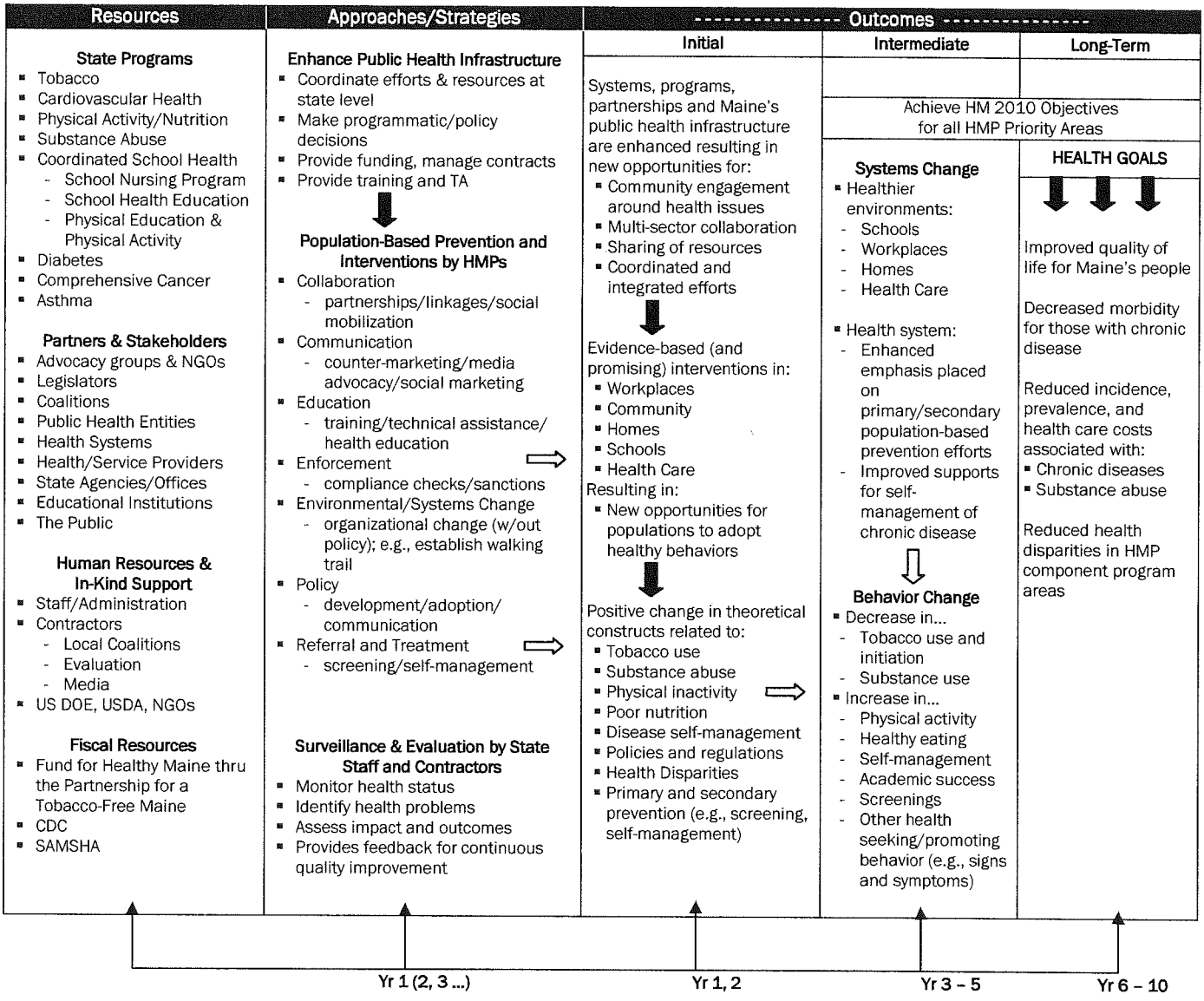
The contracts for the local HMPs are awarded through an RFP process, most recently conducted in 2007. This RFP specified the amount of funding available for each DHHS region based on a formula using population data. Since the amount of money available to each region was predetermined, bids were not evaluated on cost, but were instead scored based on the scope and reasonableness of the work plans proposed by the bidders. The proposed budgets were also scored for appropriateness and accuracy.

Cost settlement is a process by which the DHHS Division of Audit reviews each contractor's costs to ensure they were appropriate as specified by the initial contract and approved budget. Cost settlement also determines whether any funds went unspent so they can be collected from the contractors or used to offset future contract payments.

Prior to the beginning of the new contract year, each contractor's specific budget is approved by MeCDC, setting the expectation for what funds should be spent on. The contract is then cost settled after the contract period has ended. Since these two bookends are in place to

assure the appropriateness of costs, MeCDC does not review detailed invoices or cost reports during the contract period. Instead, MeCDC staff focus their energy on monitoring how well contractors are meeting their goals and on maximizing the value of the contract while it is active. As long as contractors are meeting their contractual obligations, invoices will be approved.

Figure 2. Healthy Maine Partnership Expanded Logic Model (from 2009 Evaluation Plan)



Activity: Support and Training

Support and Training activities support the effectiveness of the HMPs. This is accomplished through providing training and technical assistance to the local HMPs, and more effectively engaging youth through Youth Involvement and Leadership work provided under contract with the Maine Youth Action Network (MYAN). The primary goals of the training and other support services carried out by contractors in collaboration with employees of Maine CDC are to:

1. enhance the capacity of HMPs to reach their goals; and
2. increase the effectiveness of strategies targeting youth by involving them (this goal is specific to MYAN).

Support and Training activities seek to support the effectiveness of the HMPs by enhancing the capacity of HMPs and increasing the effectiveness of strategies targeting youth.

Support and Training activities received approximately $250,000 in FHM funds through the Community/School Grants program in FY08. This activity also received some additional FHM funds through the FHM-Substance Abuse program. $175,000 of the funding for this activity went to the MYAN contract and some of the remainder supported a contract with Medical Care Development to provide more generalized training for the HMPs.

Although the Support and Training activities are primarily associated with the Community/School Grants program, they also provide support to other related efforts: mainly the Tobacco Prevention and Control program, the Physical Activity and Nutrition program and the Substance Abuse Prevention program.

Long term, determining whether the Support and Training activities are effective is largely based on whether the HMPs are able to meet their goals. In the shorter term, however, Maine CDC monitors whether these activities are productive via the following tools:

- Evaluations or Surveys – completed by trainees after completion of each training session or conference and used by Maine CDC staff to determine whether the individual training met its goals.
- Monthly Narrative Reports – provided by MYAN to Maine CDC staff. These reports include numbers of individuals served, website hits, and details about plans for upcoming events.
- Annual Report on Outcomes – provided by MYAN, summarizing key accomplishments for the year and providing data on key indicators such as the percentage of individuals attending trainings who reported gaining information, skills and resources needed to create positive change in their communities.

Larger contracts for these activities are generally awarded through a competitive process that considers the cost information provided as one selection criteria.

Larger contracts for these activities are generally awarded through a competitive bid process that takes cost into account to some degree. OPEGA reviewed the most recent Youth Involvement and Leadership RFP awarded to MYAN which included scoring criteria with 25 points (out of 100) for cost or budgetary considerations, including:

- Budget is accurate and without math errors.
- Allocation of budget to programming is maximized, as compared to other proposals.
- Administrative costs are appropriate and reasonable to fulfill functions, as compared to other proposals.
- Direct costs are reasonable, as compared to other proposals.
- Activities/expenses are appropriate, as compared to other proposals.
- Indirect costs are reasonable, as compared to other proposals (defining reasonable as no more than 15%).
- Budget is consistent with proposed plan, as compared to other proposals.

Activity: Office of Local Public Health

The goals of the Office of Local Public Health are to strengthen and improve public health services across the eight DHHS districts and to support the emerging public health infrastructure. This relatively new effort began in 2008.

Maine CDC has an Office of Local Public Health, which is staffed by a number of Local Public Health Liaisons. This activity within the Community/School Grants program partially funds those liaisons and the Office Director. The goals of the Office are to:

1. strengthen and improve public health services across the eight DHHS districts; and
2. support the emerging public health infrastructure.

Local Public Health Liaisons were supported by an estimated $260,000 in FHM funds in FY08. They were also supported by federal Public Health Emergency Preparedness funds, as well as funds from the federal Maternal and Child Health grant and General Fund dollars that serve as the required local match for that grant.

This is a relatively new effort, with the staff only being hired in the spring of 2008. With development of the infrastructure also in its early stages, the liaisons are currently rather process focused – working to train and coordinate PHI participants as needed, and monitoring the progress contractors are making in achieving early PHI milestones.

Local Public Health Liaisons are supported by the Fund for a Healthy Maine, federal Public Health Emergency Preparedness funds, the federal Maternal and Child Health grant, and General Fund dollars.

Since the work for this activity is performed by State employees, how effectively and efficiently they are performing these tasks is assessed by their supervisor, the Director of the Office of Local Public Health, and reflected in their performance evaluations similar to any other State employee. Supervisory intervention is initiated as needed to address any performance issues. Maine CDC staff expressed that the liaisons will be determined a success in the long term if the Public Health Infrastructure (PHI) program is successful.

OPEGA noted that although the Community/School Grants program partially funds these liaisons, their goal seems primarily related to the Public Health Infrastructure program described on page 19.

Activity: Tobacco and Chronic Disease Work with the Tribes

The Tobacco and Chronic Disease Work with the tribes seeks to eliminate tribal health disparities by ensuring tribes have equal access to public health resources in ways that are culturally appropriate and therefore more effective.

The goal of this activity is broadly to eliminate tribal health disparities by ensuring tribes have equal access to public health resources in ways that are culturally appropriate and therefore more effective. Other supporting objectives include:

- building trust between Maine CDC and the tribes;
- improving the health data the State gets from the tribes; and
- two-way collaboration between Maine CDC and the tribes.

Tobacco and Chronic Disease Work with the Tribes was supported by an estimated $250,000 in FHM funds in FY08. It is also receives federal and other special revenue funds.

This activity is supported by FHM through the Community/School Grants program, and is also funded by federal and other special revenue funds.

Prior to FY09, the MeCDC had pursued these objectives by giving grants to the tribes to fund efforts at improving specific health conditions, for example cardiovascular health and obesity. The tribes, however, did not have the staffing available to do the agreed upon work and the health concerns were not being effectively addressed. Consequently, MeCDC decided to pool the funding for all tribes and all specific health issues to pay for Tribal Liaisons who would be able to do the work and would be points of contact for MeCDC with the tribes.

Although these Liaisons are funded by Maine CDC, and they work with all four Maine tribes, they are actually employees of the Houlton Band of Maliseets and were screened, interviewed, and hired at the end of 2008 by the Maliseet Tribal Council. MeCDC chose this structure because it seemed more cost effective, resulted in low overhead, and allowed the tribe's management structure and leadership to supervise and administer the work.

According to MeCDC staff, appropriateness of costs incurred is also monitored through pre-approval of contract budgets, review of invoices and cost settlements.

The contract for this activity was not awarded through a competitive bidding process. Maine CDC chose to award the contract to a specific tribe because they believed:

a. the contractor must be a tribal entity in order for the activity to be implemented in a culturally competent way that would be effective; and
b. because they believed one specific tribal entity already had a good infrastructure in place that could effectively manage the contract and supervise the staff that would be hired with contract funds.

According to MeCDC, all four tribes agreed with this decision.

The Tribal Liaisons that carry out this activity work with all four Maine tribes, but are actually employees of the Houlton Band of Maliseets. MeCDC monitors performance on a quarterly basis through reports from the Liaisons.

Since this activity underwent a substantial overhaul in 2008, long term assessment of how effectively the new structure is meeting its goals is not currently possible. However, the fact that such substantial changes were implemented suggests that Maine CDC monitors the activity's performance and makes adjustments when necessary. Near term performance of the new structure is being tracked based on:

- Quarterly Progress Reports – provided by the Liaisons to summarize actions taken to address current health objectives and quantify outputs to the degree possible (for example, 2,200 newsletters were delivered to families in the tribal communities in the first quarter of 2009).
- Quarterly Narrative – provided by the Liaisons to describe their focus and challenges during the expired quarter and their plans for the following quarter.

- Quarterly Newsletter – created and distributed by the Liaisons. Reviewing this document gives MeCDC an idea of what the Liaisons are communicating to the tribal communities and what planned events they are promoting.

Maine CDC reports there have been no performance issues to date with this fairly new contract, but that if issues of non-performance arose, they could impact payments made under the contract.

Whether activity funds are being spent appropriately is monitored in much the same way as described in detail under the Healthy Maine Partnerships activity (see page 10), with budget approval up front and cost settlement to ensure costs have been appropriate once the contract has ended. In addition Maine CDC staff say that during the contract period invoices are reviewed in relation to performance to see if the work is progressing as anticipated.

Activity: Statewide Tobacco Enforcement

The specific goals of the Statewide Tobacco Enforcement activity are to prevent tobacco sales to youth and enforce the State's Smoke-Free laws.

The Statewide Tobacco Enforcement activity has a specific goal of preventing tobacco sales to youth and enforcing the State's Smoke-Free laws. Some of the FHM funding provides for a contract with the Maine Sheriff's Association (MSA) for inspections of tobacco retailers. Most of it, however, supports a position in the Attorney General's Office that coordinates enforcement activity including:

- managing the contract with MSA;
- receiving and investigating complaints about violations of the Smoke-Free laws;
- monitoring the occurrence of illegal sales; and
- handling merchant training and compliance issues.

The Statewide Tobacco Enforcement activity had a total FY08 FHM budget of approximately $185,000, with additional support from other funding sources.

Some of the FHM funding for this activity provides for contracted inspections of tobacco retailers conducted by the Maine Sheriff's Association. Most of it, however, supports a position in the Attorney General's Office that coordinates enforcement activity.

The Retailer Violation Rate (RVR) is the primary statistic used to gauge how successfully this activity is meeting its primary goal of preventing tobacco sales to youth. However, the activity coordinator also monitors MSA's inspections of tobacco retailers via data entered by inspectors in real time on hand-held devices.

According to the activity's coordinator, Maine's RVR was 5.8% as of FY08, well below the 20% maximum violation rate beyond which State's may be penalized and lose federal substance abuse grant funds. The coordinator reports that Maine has maintained an RVR that is at or below 10% for eleven consecutive years.

The inspectors enter data concerning the time and location of the inspection, descriptive information about the youth who attempted to purchase tobacco and the products they attempted to purchase, and comments about whether the retailer allowed the youth to make the purchase or not. The activity coordinator receives this data, initiates enforcement action as necessary and uses the data to verify that inspections occurred during normal business hours at licensed retailers. This data is also used to prepare the Annual Synar Report on all inspections, violation rates and penalties assessed for submission to the Federal Center for Substance Abuse Prevention.

The Retailer Violation Rate is used to gauge how successfully this activity is meeting its goal of preventing tobacco sales to youth. The performance of the contracted inspectors is monitored via data entered by inspectors in real time on hand-held devices.

The Maine Sheriff's Association has held the contract for conducting inspections since 1996 and the contract does not appear to be subject to a regular RFP process for renewal. Apparently, the Attorney General's Office requires that the enforcement services be provided by an organization affiliated with law enforcement and there are only two organizations in Maine that meet the criteria. We understand that the Maine Chiefs of Police Association is periodically contacted about this opportunity, but that organization has not been interested in offering a proposal.

The activity coordinator reports there have been very limited performance issues with the inspection contractor. Such issues may be identified either through review of the inspection data or through comments from retailers or other parties. The two such issues identified to date have been brought to the attention of the contractor, who took prompt action to remedy the situations.

FHM funding for the Tobacco Enforcement activity has been relatively static over time but OPEGA was provided examples of several efficiency improvements that allowed the activity coordinator to get more for the limited resources available.

The funding for this activity has been relatively static over time, but the coordinator has found ways to make it more efficient, getting more for the limited amount of money available. Keeping the RVR low, for example, reduces the amount of court time needed, allowing some funds to be freed up and redirected to maintain and increase the MSA inspection contract. In addition, implementing the hand-held data entry for inspectors has saved resources by eliminating the need for data entry after the fact. Future planned improvements intended to increase efficiency include implementing online training for inspectors in order to save the cost of travel to and from training locations.

Activity: Physical Activity and Nutrition Research

Physical Activity and Nutrition Research seeks to increase physical activity, reduce obesity and improve nutrition through an applied research program. The research results are used to help maximize the impact of Maine's efforts.

The Physical Activity and Nutrition Research activity has a goal of increasing physical activity, reducing obesity and improving nutrition through an applied research program. The research results are used in designing Maine's efforts at improving physical activity and nutrition to ensure maximum impact.

Physical Activity and Nutrition Research had a total FY08 Fund for a Healthy Maine budget of approximately $175,000.

The research is carried out via a contract with the Maine Center for Public Health (MCPH) that is overseen by staff in Maine CDC. Specific strategies implemented by MCPH include:

- disseminating information and providing education to managers of local and state health programs;
- providing technical assistance and training to assist program managers with evaluation and measurement of their activities;
- providing research and technical assistance to communities and policy makers to support policy initiatives; and
- performing research to address specific topics such as connections between weight and mental health among children/families.

According to Maine CDC it would not be possible to evaluate the Physical Activity and Nutrition Research activity separately because its long term results are intertwined with other efforts to improve physical activity and nutrition and would

take years to be apparent. However, progress in accomplishing annual work plan tasks is monitored and reported to Maine CDC in quarterly narrative reports. MeCDC staff reported they have never had a situation where the contractor was not performing as expected and so have not needed to take any action regarding non-performance.

The research is carried out via a contract with the Maine Center for Public Health (MCPH). The contract is overseen by staff at MeCDC who monitor MCPH's progress in accomplishing its annual work plan.

The vast majority of Physical Activity and Nutrition Research funds support the contract with MCPH, which is a sole source contract. The justification for the sole source arrangement is based on MCPH's contractual relationship with the Harvard Prevention Research Center (PRC). According to MeCDC, Maine benefits from this link to the resources and research at the Harvard School of Public Health. This setup is similar to other PRCs around the country which are also connected to academic institutions.

Activity: School Based Health Centers

The goal of School Based Health Centers is to improve access to health care and provide a health safety net for adolescents. In addition to FHM, the SBHC activity is supported by federal funds, special revenue, General Fund, MaineCare and insurance reimbursements.

The primary goal of MeCDC's School Based Health Center activity is to improve access to health care and provide a health safety net for adolescents. Most of the FY08 FHM funding for this activity was distributed to 19 School Based Health Centers (SBHC) around the State. About 10% went to the Muskie School at the University of Southern Maine for evaluation and reporting on SBHC performance, as well as providing ongoing data quality control and technical assistance to them.

This activity had a total FY08 FHM budget of approximately $625,000. Additional funding sources for School Based Health Centers include federal, special revenue, general funds, MaineCare, and insurance reimbursements.

A School Based Health Center has nurse practitioners, physician's assistants or physicians who can provide a full menu of medical services to students whose parents have signed a consent to care form. Some SBHCs also provide mental health and/or oral health services. SBHCs do not take the place of school nurses who can respond to medical emergencies and monitor vaccinations and other health status indicators for the entire school population. Whether or not to have a SBHC is a decision left up to the local community.

There are approximately 28 existing Maine SBHCs but the State currently only has enough resources to provide funding to 19 of them. The 19 SBHCs currently funded were selected through a RFP process. Their funding is on a 5 year cycle because it takes a number of years for a school community—including parents, students and school personnel—to understand the service is available and begin to make use of it.

In FY08, most of the FHM funds for this activity were distributed to 19 SBHCs across the State that were selected via an RFP process.

Maine CDC staff have a number of tools and extensive data available to assist them in assessing the effectiveness of School Based Health Centers. To measure success in reaching long term objectives, the Muskie School analyzes data reported by the SBHCs and provides reports to Maine CDC on indicators such as:

- how many students have used SBHCs;
- how many of the Centers' users are uninsured;
- the number of visits to each SBHC;
- whether adolescents have a medical home (i.e. primary care provider), and if not, can the SBHC find them one; and
- what portion of adolescents had a regular physical in the past 2 years.

MeCDC staff utilize a number of tools and extensive data to assess the effectiveness of SBHCs. Highly effective Centers may receive financial bonuses to reward their efforts and to encourage continuous quality improvement

For shorter term assessment of individual centers Maine CDC considers:

- Quarterly Narrative Reports – provided by each SBHC. These reports describe significant challenges or successes experienced, progress made with planned strategies, and quality improvement initiatives undertaken. The report also includes current statistics on the long term indicators listed above.
- Annual Scorecards – prepared based on data provided by the SBHCs to the Muskie School evaluator. These scorecards show how each SBHC has performed compared to the goals it had set for the year in areas such as substance abuse treatment services provided, portion of students with biennial physical exams, and portion of students enrolled to receive services.

About 10% of the FHM funding for the SBHC activity went to the Muskie School at USM for evaluation and reporting on SBHC performance, as well as technical assistance for SBHCs. This Muskie School work is part of a larger Cooperative Agreement between the School and DHHS.

Maine CDC staff also report they compare SBHCs to one another to identify potential best practices, and also compare individual centers to standards and to compliance requirements in their contracts. If performance issues arise, Maine CDC will work with contractors to seek improvements. In one instance a contract was not renewed due to on-going, unresolved compliance issues directly related to reporting requirements. Centers that appear to be highly effective may receive financial bonuses to reward their efforts and to encourage continuous quality improvement.

Centers also submit quarterly financial reports, which Maine CDC staff say they review to ensure revenues and expenses are appropriate and match the intention of the original budget. Maine CDC staff also say they check to make sure all required reports and data have been received before approving payment of monthly invoices. Budget approval and cost settlement are handled similarly to HMPs (see page 10 for a detailed description).

The Muskie School's work on technical assistance, training, and evaluation receives approximately $36,000 of the FHM funding allocated to SBHCs. This particular effort is only a small part of a Cooperative Agreement with the Muskie School that also includes the delivery of many other services to many other DHHS programs at a total cost of roughly $260,000. Cooperative Agreements are exempt from competitive bidding requirements under 5 MRSA §1825-B.

The Muskie School's work is monitored based on the evaluation products they produce for Maine CDC and quarterly reports they submit describing the specific

technical assistance and training they provided to Centers over the quarter. Maine CDC reported no performance issues with this contract.

Public Health Infrastructure (#0953-08)

The purpose of the FHM Public Health Infrastructure program is to establish a system at the broad community level that can respond to public health issues.

The Public Health Infrastructure (PHI) program is relatively new, having only gotten underway in 2008. The primary activities funded under this program are listed in Table 2.

The program's stated purpose is to establish a system at the broad community level that can respond to public health issues. The more specific objectives are to:

- strengthen local public health capacity statewide and assure a more coordinated system of public health; and
- strengthen consistent statewide delivery of essential public health services in all Maine communities.

The philosophy underlying development of a public health infrastructure is that no single agency can effect the kind of large scale environmental change needed to support improved health. Instead a multi-level approach is required to affect change at all levels: individual, family, people around the individual, institutions and organizations, and social norms. The 124th Legislature passed legislation that recognizes and formally establishes the design for the public health infrastructure and prepares the system for national federally recognized public health accreditation. [2]

Table 2. Public Health Infrastructure Program at a Glance

ACTIVITY	FHM FY08 BUDGET	GOALS	PRIMARY DELIVERY
Public Health Infrastructure	$1.3 million	Establish a system at the broad community level that can respond to public health issues.	Contracts with community entities
Other Supporting & Operating Costs	$70,000	Establish a system at the broad community level that can respond to public health issues.	Contract for training

Source Note: The figures shown here are estimates for key activities provided by the program director. There may be additional costs not attributed to any specific activity, and activities may receive other funds in addition to the FHM dollars shown in this table. Activity level budgets are informal and maintained at the discretion of program directors. OPEGA has not confirmed these estimates.

Activities in this program are executed primarily by the 28 HMP contractors. The local HMPs use FHM funds from the Public Health Infrastructure program to create, develop, and then strengthen Comprehensive Community Health Coalitions (CCHCs).

The PHI program is managed by Maine CDC and activities in this program are executed primarily by the Healthy Maine Partnerships contractors described in the Community/School Grants program on pages 9-11 of this report. The FY08 Fund for a Healthy Maine budget for Public Health Infrastructure was approximately $1.4 million. These funds are used by the local HMPs to create, develop, and then strengthen Comprehensive Community Health Coalitions (CCHCs).

[2] The design and development of the public health infrastructure is described in a Power Point presented entitled "Public Health Infrastructure Update" found at http://www.maine.gov/dhhs/boh/olph/scc/news.shtml

The activities of the local HMPs, in the role of CCHCs, are focused on making larger community level changes that will support improved public health.

The activities of the HMPs, in the role of CCHCs, are focused on making larger community level changes. They work in cooperation with some of the other activities described within this report, particularly the Office of Local Public Health activity in the Community/School Grants program (see page 13). Initially, CHCCs will assess local community health needs and develop local health improvement plans to inform the State Health Plan[3]. Over the long term, CCHCs will be part of implementing the Plan in communities.

The Public Health Infrastructure is in the early stages of implementation and MeCDC staff are measuring progress by the achievement of tasks required to get the infrastructure in place and functioning.

Because the Public Health Infrastructure is a substantial undertaking that is still in the early stages of implementation, it is not currently reasonable to assess how effectively it is meeting its long term goals and objectives. Instead, Maine CDC staff are measuring its progress in achieving the tasks required to get the infrastructure in place and functioning. The tools available to them for this task include quarterly narrative reports describing progress on milestones and minutes from meetings.

> Maine CDC recognizes that public health can be difficult for people to understand concretely. To illustrate the concept of a public health infrastructure they provided the following example:
>
> A person who has had a heart attack and comes out of the hospital with a stent can not go back to the same lifestyle he had before. He needs to change his eating habits, stop smoking, lose weight, and reduce stress, but these things do not happen with education alone and are hard changes to make. The public health infrastructure Maine CDC is creating will make the environment a person returns to supportive of those changes needed to maintain or improve health.

Tobacco Prevention and Control Program (#0953-02)

The FHM Tobacco Prevention and Control program funds the efforts of the Partnership for a Tobacco Free Maine (PTM). The activities associated with this program are primarily carried out by contractors. Long term effectiveness of the activities is measured by whether or not the program goals are being achieved.

The Tobacco Prevention and Control program funds the efforts of Partnership for a Tobacco Free Maine (PTM). As implied by its title, its purpose is to prevent and control tobacco use. More specific objectives include:

1. Preventing youth and young adults from starting to use tobacco.
2. Motivating and assisting tobacco users to quit.
3. Protecting nonsmokers from the hazards of secondhand smoke.
4. Eliminating disparities related to tobacco use among population groups.

The program had a budget of approximately $6.8 million in fiscal year 2008, and is managed by Maine CDC. Less than 10% of this budget funds personnel and administrative costs within State government, while the majority is paid to contractors. Primary activities funded within this program include those listed in Table 3. Each activity is described further in the report sections that follow.

[3] The 2008 State Health Plan was issued in April 2008 by the Governor's Office of Health Policy and Finance with the Advisory Council on Health System Development. The plan sets out a goal of completing implementation of a new public health infrastructure as part of its roadmap for making Maine the healthiest state in the nation .

Table 3. Tobacco Prevention and Control Program at a Glance

ACTIVITY	FHM FY08 BUDGET	GOALS	PRIMARY DELIVERY
Public Education and Media	$2.5 million	Promote youth prevention, tobacco cessation, and educate Maine people about exposure to secondhand smoke.	Contract
Tobacco Treatment	$1.8 million	Maximize the number of smokers brought into treatment programs, the number of participants who stay with the program, the number of individuals who opt to use pharmaceuticals and, in the end, the number of smokers who quit.	Contract
Treatment Pharmaceuticals	$900,000	Support tobacco treatment activities by authorizing pharmaceuticals for Maine residents who are attempting to quit smoking.	Contract
Evaluation	$440,000	Evaluate and monitor the principal programmatic activities of three state level programs as well as their combined community intervention sites.	Contract

Source Note: The figures shown here are estimates for key activities provided by the program director. There may be additional costs not attributed to any specific activity, and activities may receive other funds in addition to the FHM dollars shown in this table. Activity level budgets are informal and maintained at the discretion of program directors. OPEGA has not confirmed these estimates.

The long term effectiveness of these activities is measured by whether or not the goals and objectives of the Tobacco Prevention and Control Program are being achieved. Primary data sources used to assess progress toward those goals include the Maine Youth Drug & Alcohol Use Survey (MYDAUS), the Maine Adult Tobacco Survey, and the Behavioral Risk Factor Surveillance System (BRFSS) previously described in detail under the Healthy Maine Partnerships activity on page 10 of this report.

Activity: Public Education and Media

Public Education and Media activities serve to promote youth prevention, tobacco cessation, and educate Maine people about exposure to secondhand smoke. This is accomplished through a contract with CD&M Communications which is overseen by staff of Maine CDC. The contract requires delivery of the following core services:

The Public Education and Media activities seek to promote youth prevention and tobacco cessation, and to educate Maine people about exposure to secondhand smoke. This is accomplished through a contract with CD&M Communications that is overseen by MeCDC staff.

In FY08, approximately $2.5 million of the FHM funds allocated to the Tobacco Prevention and Control Program were budgeted for the Public Education and Media activities. This activity is also supported by federal funds.

- Support the Youth Prevention Initiative through a new youth prevention website using social networking and one to one social marketing.
- Update and maintain the Partnership for a Tobacco-Free Maine's web site and various Maine CDC program websites.
- Provide support and technical assistance for media for Healthy Maine Partnerships.
- Prepare cessation and educational materials, summaries of laws concerning tobacco use, fact sheets, reports and other printed resources.

CD&M Communications was selected as the contractor in 2005 through an RFP process that considered the cost information provided as one of the selection criteria.

- Prepare television, radio and web spots to support the Youth Prevention and Secondhand Smoke campaign messages and to promote quitting and use of the Maine Tobacco HelpLine.

The near term progress of Public Education and Media activities is monitored primarily through weekly status reports sent to Maine CDC by the contractor, CD&M Communications. These reports list all of the current tasks and provide a concise status for each one. CDC staff review them regularly, and if progress is not satisfactory the issues are immediately addressed. The staff could not recall any occurrences where the original objectives of the contractor were not achieved unless changes to the deliverables or timelines had been pre-approved by MeCDC management.

The contractor submits weekly status reports to MeCDC. MeCDC also periodically contracts for evaluations specifically designed to assess the impact of the Public Education and Media activities.

Maine CDC also attempts to assess long term outcomes specifically connected to Public Education and Media through periodic evaluations specific to this activity. The most recent evaluation was completed by the Maine company Critical Insights, in April 2008 and included a survey of Maine residents. The evaluator reported on how many of those surveyed had seen any of the media produced by this activity, what portion are considering quitting smoking, how many have favorable views about disallowing smoking in public places, and other similar questions.

The Media contract was awarded to CD&M Communications through an RFP process in 2005. Rankings given for bidders' proposed budgets accounted for 25% of the total score, and through the RFP process Maine CDC worked to negotiate what they felt was a good value for the funds they had to spend on this activity. MeCDC's contract managers say they use prior years' cost and performance data when renewing the contract to try to get improved or expanded services for the funds available.

Activity: Tobacco Treatment

The Tobacco Treatment activity seeks to maximize the number of smokers that are brought into and remain in treatment programs, the number of individuals who opt to use pharmaceuticals and the number of smokers who quit smoking.

The Tobacco Treatment activity is intended to maximize the number of smokers brought into treatment programs, the number of participants who stay with the program, the number of individuals who opt to use pharmaceuticals[4] and, in the end, the number of smokers who quit. The efforts are carried out through a contract with the Center for Tobacco Independence (CTI), which is part of MaineHealth. According to MeCDC, the contract was awarded through an RFP process.

The Tobacco Treatment activity was budgeted for approximately $1.8 million in FHM funds in FY08 and was also supported by federal funds.

Specific strategies involved in Tobacco Treatment are detailed in the contract with CTI. They include:

- Coordinating the system of tobacco treatment statewide by collaborating with other treatment entities, the Public Education and Media Activity contractor, the Evaluation contractor, healthcare providers and school districts.

[4] According to Maine CDC, national CDC data indicates a higher quitting success rate for smokers who use pharmaceuticals to support their attempted cessation.

The efforts are carried out through a contract with the Center for Tobacco Independence. MeCDC staff receive reports that are used to monitor whether near term plans are being accomplished.

- Operating the Maine Tobacco Helpline to offer live tobacco cessation counseling to callers seeking it.
- Providing specific and targeted tobacco treatment education and training to healthcare providers, school personnel, and Helpline specialists.
- Maintaining the tobacco treatment medication program to authorize treatment pharmaceuticals for eligible helpline callers.

Maine CDC notes that "maximizing" is a difficult target to define because the targeted population has been diminishing as the programs have been successful in reducing smoking and remaining smokers are more likely to be those for whom quitting is more difficult. Periodic comprehensive assessments of the long term results are prepared for Maine CDC by the evaluator contracted for the Evaluation activity described on page 24. This data allows CDC to see how tobacco use in Maine is trending based on age, gender, and geographic location.

Maine CDC also uses data collected through more comprehensive evaluations to see how tobacco use in Maine is trending based on age, gender, and geographic location.

To monitor whether near term plans are being accomplished, Maine CDC staff review the following reports:

- Tobacco Helpline Fiscal Year Report – Monthly activity report for the Helpline based on data collected by the contractor as calls are received. It includes statistics about the quantity of calls received, information about where the caller heard about the quit line, and demographic and personal health information.
- Medication Voucher and Training Program Report – Data on the number of callers to the Helpline who used medication vouchers and on the number of trainees attending different training sessions.
- Partnership For A Tobacco-Free Maine Treatment Initiative Quarterly Report – A narrative report that describes the quarterly activity related to the core services contracted for.

Maine CDC works collaboratively with the contractor to adjust strategies as needed.

The information in these reports is used by Maine CDC to work collaboratively with the contractor to adjust strategies as needed. An example of an adjustment described by MeCDC involves training provided to physicians by the contractor, CTI. In the past, CTI provided short "Lunch and Learn" training sessions with physicians' offices to teach them about the tobacco Helpline, with the objective of increasing referrals to the Helpline. After reviewing performance reports (including data from the Helpline survey about how callers learned of the service) and reviewing literature on similar programs in other states, CTI and Maine CDC management concluded these efforts were not leading to improvements proportional to the effort being put in. They said the interactions with the physicians' offices were subsequently redesigned.

Activity: Treatment Pharmaceuticals

The Treatment Pharmaceuticals activity facilitates access to pharmaceuticals necessary for tobacco treatment through a contractor, Goold Health Systems.

The Treatment Pharmaceuticals activity works with the Tobacco Treatment activity in that it facilitates access to pharmaceuticals necessary for treatment through a contractor, Goold Health Services (GHS). This contract was awarded through an RFP process in 2006.

The FY08 FHM budget for the Treatment Pharmaceuticals activity was approximately $900,000.

Helpline counselors work with callers to develop a plan for their tobacco cessation. If the plan includes Nicotine Replacement Therapy (NRT) pharmaceuticals, the counselor will submit a voucher to GHS requesting the pharmaceuticals. These vouchers may also be submitted by other entities, i.e. physicians, for eligible citizens who are attempting to quit smoking.

When they receive a voucher, GHS processes it and submits a prior authorization to the pharmacy selected by the individual interested in quitting. This allows the individual to simply walk into their pharmacy and pick up the pharmaceuticals without having to pay anything for them. GHS will later reimburse the pharmacy after they submit a claim for the transaction.

This activity is task-oriented in nature and MeCDC monitors effectiveness through reports that provide statistics on the level of pharmaceutical use.

The Treatment Pharmaceuticals activity is task-oriented in nature and, as such, is most effectively monitored in the short term. For that purpose Maine CDC receives the following reports:

- Tobacco Treatment Programs Supplemental Report – a report that summarizes data on the number of clients served and the claims paid for each type of NRT. Data is broken out by the referring entity: Community Practice, Clinic Specialist, or Helpline.
- Tobacco Program Annual Narrative Summary – a report provided by GHS that summarizes annual performance, including the number of vouchers and claims processed.

Activity: Evaluation

The Evaluation activity assesses efforts and provides performance data on other activities to assist in making them more effective. The activity is primarily carried out through a contract with the Maine Center for Public Health that was awarded via a competitive bidding process.

The Evaluation activity within the Tobacco Prevention and Control program exists to evaluate and monitor the principal activities of three State level programs as well as their combined community intervention sites. Rather than delivering a service that prevents youth from smoking or helps smokers quit, this activity supports all the other activities by assessing their efforts and providing performance data to assist in making them more effective.

In FY08, the Evaluation activity received approximately $440,000 of the FHM funds allocated to the Tobacco Prevention and Control Program. It also received an estimated $55,000 in FHM funds from the Community/School Grants program. In addition, this activity is supported by federal funds associated with the other efforts being evaluated.

According to Maine CDC, public health evaluation is often integrated into program operations but Maine has chosen to contract with a third party entity specializing in public health evaluation for assistance. The current contract is held by the Maine Center for Public Health (MCPH) and it was awarded through an RFP process in 2005.

The participatory evaluations conducted focus on three specific MeCDC programs and the Healthy Maine Partnerships efforts. They seek to assess the outcomes of initiatives and to improve work processes.

The three MeCDC programs evaluated through this activity are the:

1. Tobacco Prevention and Control program.
2. Physical Activity and Nutrition program.
3. Cardiovascular Health program.

In addition, the evaluation assesses some of the Healthy Maine Partnerships efforts funded by the Community/School Grants program described on pages 9-11 of this report. The HMPs are an avenue for achieving the goals of these three programs as well as other health-related efforts discussed in this report. The logic model that describes this avenue and drives the HMP evaluation plan can be found in Figure 2 on page 11.

MeCDC staff describe this activity as a participatory evaluation in which the program itself is involved as one of the stakeholders. The evaluation looks to the outcomes of the public health initiatives and also looks to the processes and the work that is going on in order to improve the work itself. The long term effectiveness of the Evaluation activity can be measured by whether it contributes to more effective programs.

MeCDC monitor whether the contractor is producing deliverables required by the contract in a timely fashion through monthly update meetings. The evaluation workplan as whole is also reviewed every 6 months.

In the shorter term, Maine CDC staff hold monthly update meetings to monitor whether the evaluator, MCPH, is producing the deliverables required by their contract in a timely fashion. Contract managers also describe meeting every 6 months to review the evaluation workplan as a whole, ensure the deliverables are progressing according to plan, and consider what else they might want to ask of the evaluators given costs, potential outcomes and evaluation results to date.

Beginning in FY08, MeCDC implemented a new tool for tracking deliverables. This new tool is called a Deliverable Completion Approval Form and is used to approve and document successful completion of contractual deliverables by the evaluator.

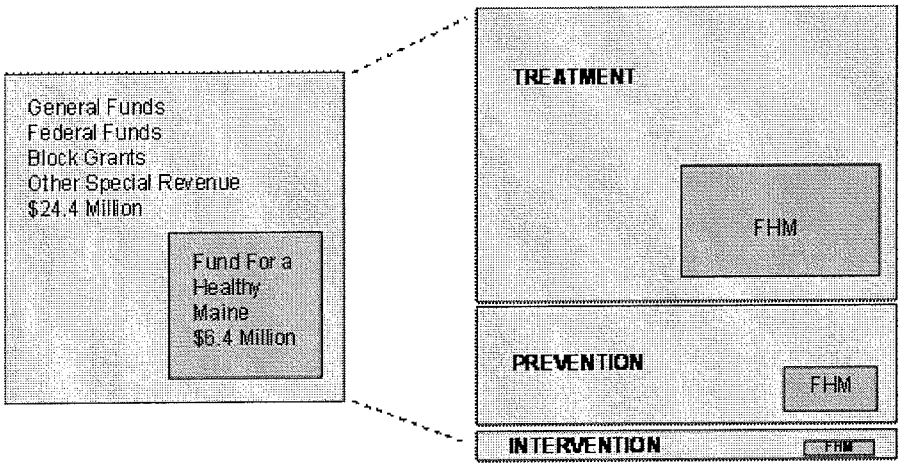
FHM - Substance Abuse Program (#0948)

The Office of Substance Abuse's goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

The Office of Substance Abuse (OSA) within DHHS is the single State administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office's goal is to enhance the health and safety of Maine citizens through reducting the overall impact of substance use, abuse, and dependency.

Although the FHM - Substance Abuse program supports some of the Office's activities, the Office itself has additional costs and activities outside of those the FHM participates in. See Figure 3 for an illustration of how the FHM program and the Office intersect.

Figure 4. Office of Substance Abuse Activities and Funding Sources FY08



The FHM – Substance Abuse program had a FHM FY08 budget of $6.4 million. None of this funding went to pay the salaries or other personnel costs of OSA's staff. Instead, it was used in combination with the Office's other funding sources to support a range of services within the three primary activities of treatment, prevention and intervention. Table 4 below provides a high level summary of each activity which are described further in the report sections that follow.

Table 4. Office of Substance Abuse Program at a Glance *

ACTIVITY	FHM FY08 BUDGET	GOALS	PRIMARY DELIVERY
Treatment	$5.5 million	Help to fund treatment services for those people that do not have access to other resources.	Contracts
Prevention	$650,000	Prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.	Contracts
Intervention	$188,000	Prevent and detect prescription drug misuse and diversion.	Contract

Source Note: The figures shown here are estimates for key activities provided by the program director. There may be additional costs not attributed to any specific activity, and activities may receive other funds in addition to the FHM dollars shown in this table. Activity level budgets are informal and maintained at the discretion of program directors. OPEGA has not confirmed these estimates.

Activity: Treatment

The Treatment activity helps fund substance abuse treatment for those people that do not have access to other resources. These services are delivered by contracted providers.

The Treatment activity helps fund substance abuse treatment services for those people that do not have access to other resources, such as non MaineCare eligible or persons in the correctional system. It also seeks to address co-occurring disorders (mental health and substance abuse). These services, which are delivered by contracted providers, can be broken down into the following categories:

Treatment activities received about $5.5 million of FHM in FY08, and also were supported by state General and federal funds.

- Adult Drug Courts – a special court given the responsibility to handle cases involving drug-using offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives.
- Juvenile Offenders – providing treatment and support services to youth in correctional facilities.

- Adult Offenders – providing evidence based treatment services in both correctional and community settings to adults involved with the criminal justice system.
- Detoxification – including assessment, diagnosis and medically assisted detoxification for persons having acute problems related to withdrawal from alcohol or other drugs.
- Adolescent Community-Based Treatment – a structured program of substance abuse assessment, diagnosis and treatment services in a setting which does not include an overnight stay.
- Residential Treatment – providing services in a full (24 hours) residential setting.
- Outpatient Treatment – providing services in an outpatient setting.
- Co-occurring Services – providing substance abuse treatment services in combination with mental health services in an integrated way for those individuals with diagnoses in both areas.

Providers report data that help OSA monitor the overall effectiveness of the Treatment activities.

OSA uses a handful of key indicators, based on data reported by providers, to monitor the overall effectiveness of FHM Treatment activities. These indicators include:

- the number of client admissions to Treatment services;
- how quickly a client receives service;
- the percent of clients who remained in a Treatment program for 90 days (the industry standard to have a positive outcome according to OSA);
- the percent of clients who attended at least four sessions of treatment; and
- the percent of clients who complete a Treatment program.

OSA's contracts for outpatient services include performance standards and outcome measures for individual providers. The contracts also include performance incentives.

In the shorter term, OSA monitors the effectiveness of individual Treatment providers in a number of ways. Each provider contract contains performance standards and outcome measures. OSA staff, working with staff from the DHHS Division of Purchased Services, are assigned specific contracts to monitor. This monitoring may include reviewing period data submitted by the provider, ensuring contract requirements are met, and conducting site visits. OSA also provides technical assistance to help providers meet the performance measures. If a provider continues to severely under perform, fails to improve, or fails to meet contract requirements, termination of the contract would be pursued.

OSA's contracts for outpatient services also include performance incentives for providers to help measure achievement of contract goals and motivate contractors to make improvements themselves when they are not meeting goals. Incentive contracts essentially set a baseline for expected provider performance and adjust the provider's final funding based on how their actual

An example contract OPEGA reviewed showed that the provider would receive an incentive of as much as 9% or a penalty as steep as -9%, with a wide range of potential incentives in between depending on the provider's performance. The contract also included the specific performance baselines set for the individual provider for each quarter.

Since these contracts are performance-based, statute allows them to be renewed without being re-bid as long as performance standards are being met.

performance compares to the baseline. In addition, OSA's Director explained that through the process of creating and monitoring the incentives, the overall provision of treatment services is monitored and improved.

Since OSA's contracts with providers for treatment services are performance based, statute allows them to be renewed without being re-bid as long as performance standards are being met.[5] This has allowed treatment services to maintain a high level of continuity. However, OPEGA noted that it has been a number of years since most of the treatment contracts have been through a competitive process to ensure the State receives the best value possible.

Activity: Prevention

The goal of the Prevention activity is to prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.

The prevention services supported by FHM are delivered by contractors and administered by OSA. These activities have a goal of preventing and reducing substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine. Most prevention efforts are focused on youth who have been identified by various means to be at risk, for example:

In addition to some federal funding, Prevention activities received about $650,000 of FHM money in FY08.

- Student Intervention Reintegration Program – targeting "high risk" youth who have violated school alcohol and drug policies and providing educational intervention for both the youth and their parents.
- Big Brothers/Big Sisters – an intervention combining weekly support group meetings and participation in the Big Brothers/Big Sisters mentoring program, focused on teens in middle and high schools identified as "at risk" for substance abuse or teen pregnancy.
- Back on Track – an intervention program targeting youth who have been expelled or suspended, or are at risk of same, involving mediation, community service, goal setting, and family support services.
- Project REACH – an intervention and transition program involving alternative education for middle school students.
- Passages Program – an alternative educational option to allow pregnant or parenting teenagers who have dropped out of conventional high school to earn a diploma.
- Media Campaign – media services related to prevention initiatives targeting parents.

Prevention services are delivered by contractors and administered by OSA. Contracts are competitively bid somewhat regularly and the RFP process considers the bidders' proposed budgets as one selection criteria.

Prevention contracts are competitively bid somewhat regularly and OPEGA noted that a recent RFP process included scoring the bidder's proposed budget on accuracy, reasonableness, appropriateness, and whether indirect costs exceeded 15% of the total budget. Once a contract is awarded and a budget approved, OSA will make scheduled payments throughout the contract period, and a cost

[5] 5 MRSA §20005 paragraph 6-A.

settlement will occur at contract's end to assure all funds from the State were used appropriately.

OSA uses a number of indicators to monitor the effectiveness of FHM Prevention activities. Some of these indicators include:

OSA uses several indicators to monitor the overall effectiveness of FHM Prevention activities. OSA also monitors performance on individual contracts through fiscal and narrative reports as well as site visits.

- Satisfaction levels with the programs among participants;
- Reduction in substance use/abuse among participants;
- Increased attendance rates in the programs;
- Reductions in detention rates;
- Increased Grade Point Average among participants;
- Participants who completed graduation requirements;
- Increased awareness of community resources; and
- Number of people made aware of underage drinking issues by media campaign.

The Maine Youth Drug and Alcohol Use Survey is another tool OSA uses to assess the long-term effectiveness of its activities. The purpose of the survey is to quantify the use of alcohol, tobacco and other substances among middle and high school students in Maine, and to identify the risk and protective factors that influence a student's choice of whether or not to engage in these and related harmful behaviors.

In the near term, staff at OSA explained that individual contracts are monitored through review of fiscal and narrative reports and through site visits. If OSA has any questions or concerns, they will contact the provider via email or phone to discuss and they may also conduct working progress meetings with providers quarterly, or more frequently, depending on the deliverables and type of contract. They also provide technical assistance similar to that described under the Prevention activity.

Activity: Intervention

The Prescription Monitoring Program is the primary Intervention activity supported by FHM. Its goal is to prevent and detect prescription drug misuse and diversion.

The Prescription Monitoring Program cost approximately $188,000 in FY08 and was funded solely by the Fund for a Healthy

The Prescription Monitoring Program (PMP) is the primary Intervention activity supported by the Fund for a Healthy Maine. Its goal is to prevent and detect prescription drug misuse and diversion. OSA contracts with Goold Health Systems Data Processing Inc (GHS) to collect prescription drug information from drug dispensers regarding schedule II, III and IV drugs[6].

GHS also maintains a database of all transactions for these substances dispensed in the State of Maine. Any health service provider with a Drug Enforcement Agency number may register to request patient reports and to receive online access to the

[6] According to the federal Controlled Substance Act (CSA), schedule II, III, and IV drugs are those that are currently accepted for medical use in treatment in the United States which have potential for abuse and which may lead to some level of physical or psychological dependence. The schedules decline in severity, with schedule II having more potential for abuse and dependence, and schedule IV having less.

OSA contracts with Goold Health Systems (GHS) to collect prescription drug information from dispensers and to report statistics to OSA.

database. These patient reports enhance the ability of clinicians to coordinate care and add to their toolkit for preventing and intervening against misuse and diversion of prescription drugs. Clinicians also receive reports automatically when any of their patients use a number of prescribers and/or pharmacies during a given quarter that exceed the thresholds set by OSA. The Office of Substance Abuse also receives reports from GHS summarizing statistics for prescriptions of controlled substances, and uses these reports to target its other efforts as needed.

The contract for this activity was competitively bid in 2004 and has been renewed periodically since that time. OSA approves invoices monthly and says that prior to approval they check to make sure the contractor is meeting all performance goals and deliverables applicable at that point in time. As long as there is no issue with performance, the full scheduled payment will be made. The Office reports it has not experienced any issues with the contractor's performance to date.

According to the Office of Substance Abuse, the Intervention activity is currently also being supported by federal grant funds. These include:

- $40,514 for federal FY10 from the U.S. Department of Health and Human Services to enhance the Prescription Monitoring Program; and
- $398,449 for the two year period 9-1-08 thru 8-31-10 from the U.S. Department of Justice, Harold Rogers Prescription Drug Monitoring Program enhancement grant.

OSA monitors whether the contractor is performing its duties effectively through regular reports.

OSA has a number of tools to keep track of whether the contractor is performing its duties effectively. These include:

- quarterly reports sent to OSA summarizing the number of threshold reports issued to prescribers and the data collected for the quarter;
- reports sent to OSA summarizing the number of prescriptions by age group and county, and listing the top 10 drugs prescribed for the month; and
- OSA staff monitoring to ensure the contract deliverables are received timely.

OSA also monitors prescribers' use of the on-line prescription database and prescriber requests for patient-specific reports as indicators of the long-term effectiveness of the Intervention activity. However, this data does not indicate whether providers took any action based on the information they accessed.

OSA also monitors prescribers' use of the on-line database and requests for patient-specific reports as primary indicators of whether the Intervention activity is meeting its long term goal of preventing and detecting prescription drug misuse and diversion. OPEGA notes that these seems like good measures of intermediate progress, but may not speak to whether the long term goals are being met. This is because increases in users of the prescription drug data would indicate the data is being accessed, but the fact that providers are accessing the data does not necessarily result in any action to prevent or end prescription drug misuse or diversion. To truly see whether the long-term goals are being met, OSA would need to determine whether providers who accessed the data later took action to address any issues it raised.

Conclusion

Adequate frameworks were in place for ensuring cost-effectiveness of specific activities supported by FHM in the four programs OPEGA reviewed.

For the four FHM programs OPEGA reviewed in depth, adequate frameworks were in place for ensuring cost-effectiveness of specific activities supported by FHM. Programs do have purposes and there are stated goals for individual activities that are generally aligned with the program purposes although some purposes and goals are more specific than others. The responsible agency managers are working to maximize the effectiveness of their individual activities and assure the State is getting the most value for dollars spent – particularly when it comes to managing individual contracts or grants.

Many of the activities for these programs are primarily carried out through agreements with third parties and the financial and performance information available to agency managers was best at the contract level. OPEGA noted that most contracts include performance expectations, required deliverables or benchmarks and, in some cases, there are performance incentives as well. Agency managers are actively engaged in monitoring short-term work progress on individual contracts against those expectations. For several activities, this includes the regular capture of performance-related data from contractors through electronic means that allows State staff to monitor performance in real-time and address issues identified more quickly. We also observed that there were on-going program evaluation components built into many of the programs which were being used to identify needed adjustments to programs and activities and assess progress on achieving the related longer term health goals.

Budgets for individual contracts are proposed by potential contractors and are reviewed, negotiated and approved by agency managers prior to agreements being finalized. The focus is on the reasonableness of the categories of expenditures and the level of expenditure for each, i.e. the proportion of administrative to non-administrative expenses. Agency managers are also reviewing budgets in the context of how much work the potential recipient has indicated can be accomplished for that amount. At the end of the contract period, some of the contracts undergo a cost settlement or audit by DHHS Division of Audit to assure that agreement expenditures were allowable and consistent with the approved budget.

However, there does not appear to be a process for periodically reassessing Fund allocations to the various health-related efforts to assure the Fund as a whole is advancing the State's health vision and goals in the most cost-effective manner.

While OPEGA found frameworks for managing the cost-effectiveness of activities funded by FHM to be reasonably adequate, we noted that there does not appear to be a process for periodically reassessing Fund allocations to the various health-related efforts. Ideally, there should be on-going conversations among legislators, administrators and stakeholders about how to most cost-effectively spend the FHM dollars among the portfolio of efforts meant to advance the State's health vision and goals. Such conversations require having accurate, complete and meaningful information about both cost and performance at various levels of effort. They also require the transparency that comes with the capture and public reporting of this information in a way that makes clear what specific efforts or activities the State is funding, what the results are and how those results are contributing to overall goals.

From OPEGA's perspective, the ability to have meaningful conversations about cost-effectiveness regarding the Fund as a whole is currently challenged by the following:

The ability to have meaningful conversations about cost-effectiveness of the Fund as a whole is currently challenged by several factors, some of which also inhibit transparency. Several of these factors are not unique to the Fund for a Healthy Maine.

- an apparent reluctance to deviate from the agreement made 10 years ago regarding the original menu of activities that would be funded and the funding levels for each;
- lack of clarity as to what State entity is formally responsible and accountable for assuring the Fund as a whole is spent in a way that supports the State health goals and strategy in the most cost-effective manner;
- lack of complete financial and performance data at the activity level (unless that activity is captured solely by one budgetary program or one contract);
- lack of clarity, specificity and sometimes accuracy in the descriptions of budgetary programs that are included in the budget documents submitted by the Governor to the Legislature; and
- lack of alignment between budgetary programs, the key activities/efforts within them and the agreements and administrative functions that support them as regards financial and performance information.

Some of these challenges are not unique to the Fund for Healthy Maine. In fact, OPEGA has commented on similar weaknesses in the financial and performance information available to policy and decision-makers in several reports over the last four years. These weaknesses affect legislators' and the public's perception of transparency and accountability in State government. The criticality of having sufficient, well-aligned financial and performance data on government activities and efforts becomes especially evident in times when revenues are lagging and decisions about where to allocate scarce resources have to be made. Consequently, we have made several recommendations to address the identified weaknesses. They are discussed in the next section of this report.

OPEGA also observed that there is a complex web of relationships involving the State employees responsible for managing the programs, the outside entities contracted to deliver services and the contractors that offer supportive research or assessment. All parties should remain mindful of the potential for perceived, or actual, conflicts and biases that could occur.

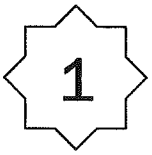
In the course of this review, OPEGA also observed that there is a complex web of relationships involving the State employees responsible for managing the programs and activities, the outside entities contracted to deliver the services, and the contractors that offer supportive research or assess the effectiveness of the health initiatives. Although these relationships can be valuable in advancing the State's efforts, they can also be problematic because they present a risk of perceived or actual conflict of interest. Relationships that develop when State managers and providers work closely together over a long period of time or on multiple efforts can also lead to bias in awarding contracts or a lack of objectivity in evaluating contractor performance. We did not see evidence of any actual improprieties occurring and we have made no specific recommendations regarding our observation. However, we do encourage all parties involved in these relationships to remain mindful of the potential for perceived or actual conflicts and biases that can undermine public confidence in State programs. State agencies should build measures into their processes to guard against such situations as appropriate.

Recommendations

Recommendations 2, 3 and 4 address issues with the budgetary and accounting structure that are not unique to the FHM programs. However, we believe that the FHM programs, and the non-FHM programs with which they share common activities and goals, offer a special opportunity to pilot some changes that should enhance the State's ability to match up financial and performance information for policy and decision-makers in a meaningful way. These particular programs are good candidates because some required elements are already in place. These elements include well defined State health goals and strategies and the existence of established efforts for performance monitoring, program evaluation and the reporting of results.

OPEGA recognizes that implementing Recommendations 2 and 4, even for just FHM programs and related non-FHM programs, will require thoughtful consideration and may take significant time and resources. However, we believe the benefits to be gained make these recommendations deserving of serious consideration. The enhancements we suggest have the potential to improve efficiency in the budgetary process and bring additional transparency to how public funds are being expended and the results being achieved for those dollars. We point out that the timing of implementing these two recommendations would be contingent upon whether the Legislature decides to implement Recommendation 1.

In addition to the issues addressed by these recommendations, OPEGA noted some specific situations related to cost-effectiveness or transparency for individual programs and activities that we discussed with management. OPEGA will also share those that are pertinent to legislative policy-making and oversight with the appropriate joint standing committees.



Allocation of FHM Funds Should be Reviewed in Context of Changing Health Environment and Goals

Ten years have passed since the Maine Legislature established the FHM in statute and decided, through a statewide participatory process, which specific programs and efforts—sometimes even what specific organizations—would receive allocations from the Fund. In those ten years, the allocations have remained quite stable and it does not appear that any entity has taken a comprehensive look at the allocations to determine whether adjustments should be made in light of current preventive health priorities, financial priorities, and the efficacy of current programs. For example, as activities have been successful in achieving their intended outcomes, the degree and nature of support needed may be different.

OPEGA's work suggests that this may be, in part, because the Fund is allocated among a number of Executive Branch departments and it is unclear who has responsibility for suggesting it is time to reconsider distribution. It also appears that arriving at the initial distribution was a time-consuming and challenging process due to the number of stakeholder groups involved. Some stakeholders seem to feel their allotments are, or should be, protected, and as a result there may

be some reluctance to engage in a process that could result in changes to the allocation of funds.

Another factor may be Maine's baseline budgeting system, which results in programs essentially being funded at the same level forever unless there are specific initiatives by the Administration or the Legislature. Although this provides a stability that can be useful, it can also get in the way of responding flexibly to developments in public health needs and, in the extreme, can lead to continually funding old concerns while emerging issues go unaddressed. For example, while the use of tobacco remains a primary cause of disease and disability, the increasing rate of obesity in Maine presents a new and significant threat to Maine's health.

Suggested Legislative Actions:

A. The Legislature should consider initiating an effort to assess whether the existing FHM allocations still make sense within the current health environment. OPEGA recognizes that the Legislature's intent in establishing the Fund and the statutory criteria for its use was to ensure that payments from the Tobacco Master Settlement Agreement would be primarily used to advance public health efforts. We are not suggesting that the overall intent be revisited. However, in our conversations with management and discussions we have overheard in legislative committees, we noted that there may be opportunities to use Fund dollars more cost-effectively in addressing current needs in the public health arena.

B. In addition, given the static nature of funding under baseline budgeting and the fact that the allocations span multiple State agencies, the Legislature should consider formally assigning responsibility for periodically reassessing the Fund allocations to a specific State entity or entities. This entity would be expected to, and be held accountable for, assuring the Fund as a whole is spent in a way that supports the State health goals and strategy in the most cost-effective manner. The responsibility would include suggesting adjustments to the allocations as warranted by changes in the public health environment.

Budgetary Programs Should be Better Aligned with State's Health Goals, Efforts and Related Performance Information

When the FHM was established in 1999, it was not set up with its own fund code in the accounting system like the General Fund (010) or the Highway Fund (012) but was instead considered part of Other Special Revenue (014). Consequently, the current budgetary programs that are specific to FHM were created to provide for the tracking of FHM allocations and expenditures. We note, however, that the current budgetary structure for FHM programs and related non-FHM programs is not well aligned with the State's key public health efforts, their goals or the way in which they are administered.

We noted that the dollars associated with significant State efforts are sometimes splintered into pieces within multiple budgetary programs each potentially supported by different funds. Or, activities allocated to one budgetary program are more directly related to the goals of another. This makes it more difficult for the

Legislature to see all the dollars associated with specific efforts in one place. Examples include:

- OSA's primary budgetary program (#0679) includes the Office's General, Federal, Special Revenue, and Block Grant funding, but the FHM dollars that support many of the same efforts within the Office are shown under a separate budget program (#0948).
- Inspections of child care facilities conducted by the State Fire Marshall's Office are funded through both the Fire Marshall's primary budgetary program (#0327) and the FHM-Fire Marshall program (#0964).
- Maine CDC receives substantial funding through Health – Bureau of (#0143) and FHM – Bureau of Health (#0953) and there are myriad specific interrelated activities being undertaken that are funded through both programs.
- The allocation to MeCDC's Community/School Grant program (#0953-07) includes funds that are intended for, and ultimately transferred to, programs in the Department of Education. In FY08, this transfer was approximately $80,000 and went to DOE's School Nutrition program. According to DAFS, a similar allocation and transfer was made in FY09 and is also planned for FY10, although that transfer will likely be to DOE's FHM – School Breakfast program (#Z068).
- The Tobacco Enforcement activity that is funded and accounted for in the Community/School Grants program (#0953-07) seems more directly related to the goals of the Tobacco Prevention and Control program (#0953-02).
- The Office of Local Public Health activity funded and accounted for in the Community/School Grant program seems more directly related to the Public Health Infrastructure program (#0953-08).

We also noted that there is a significant amount of publicly available, well-presented information that describes the State's health goals, strategies used, and related results. However, it is difficult to easily associate the information available with the State's budgetary programs. Many of the materials we reviewed referred to programs like the Cardiovascular Health Program, the Physical Activity and Nutrition Program and the Partnership for a Tobacco Free Maine. While it is relatively easy to understand how those relate to the State Health Plan, it is challenging to trace, through the State's budget and expenditure records, how those specific health issues are being supported by FHM dollars. The Challenges and Results[7] report published annually by MeCDC comes the closest to linking FHM allocations and actual efforts being undertaken, but even it is not aligned cleanly with the Fund's budgetary programs, and it has historically included only those FHM programs managed by DHHS.

[7] "An Overview of Maine Department of Health and Human Services Use of Tobacco Settlement Fund (Fund For A Healthy Maine) Allocations SFY08 and SFY09", http://www.maine.gov/dhhs/boh/documents/Challenges_Results_Jan_2009.pdf

Because FHM allocations have been split out into distinct budgetary programs of their own in ways that are not always reflective of the actual goals and efforts at the agency level, the Legislature is less able to identify how adjustments to funding levels for one or more funding sources are impacting specific State health efforts. This lack of alignment also impacts legislators' ability to consider the cost-benefit of State efforts since it is often not possible or desirable to track and report results – particularly outcome measures - specific to each funding source.

Suggested Legislative Actions:

A. The Legislature, with input from the Administration, should consider improving the alignment of existing FHM activities and programs by moving the allocations related to School Nutrition/Breakfast, Tobacco Enforcement and Local Public Health Liaisons activities from the Community/School Grants program to the programs and goals they seem more closely related to as noted in the bullets above.

B. To address the issue of alignment more comprehensively, the Legislature should consider directing the Administration, in consultation with the Legislature's Office of Fiscal and Program Review, to propose a new budgetary structure for FHM allocations that better aligns budgetary programs with the State's significant health goals, efforts and related performance information. The Legislature may then direct that a new budgetary structure be implemented if the benefits to be gained in transparency, accountability and increased efficiencies outweigh the cost of implementation and other impacts.

   There are multiple ways in which the budgetary structure could be adjusted but some possible changes to consider include:

   - assigning the FHM a distinct fund code so it can be shown as just one funding source for each budgetary program it supports instead of as a distinct budgetary programs;
   - replacing current budgetary programs that are large, general or encompass many activities with multiple goals with programs that are specific to either the health issues being targeted or the significant activities being performed.

   For example, the Bureau of Health (#0143) and FHM – Bureau of Health (#0953) programs might be replaced with issue-specific programs like Cardiovascular Health, Physical Activity and Nutrition, Chronic Disease (or more specifically Cancer Prevention, Diabetes, etc.) and Tobacco Prevention and Control. FHM could have its own fund number and could be shown as one of several funding sources for each of these efforts. It appears that program evaluation work specific to these programs/issues is already being conducted and thus information on performance and results achieved for the broader goals could readily be made available to legislators when they are reviewing these budgetary programs. Ideally, agencies would also be able to clearly describe the specific activities or avenues being used to implement these programs, i.e. Healthy Maine Partnerships and School Based Health Centers, and how successful those activities are in advancing program goals.

Alternatively, the existing Bureau of Health budgetary programs might be replaced with activity-based programs like Healthy Maine Partnerships, School Based Health Centers, Tobacco Enforcement, and Research and Evaluation. There does appear to be some performance information, typically related to outputs, already being captured on this basis that could be shared with legislators. Again, FHM would be one of the multiple funding sources shown for these programs and, ideally, agencies would be able to clearly articulate which State health goals or issues these programs were addressing and how much of an impact they were having.

Budget Descriptions Should be Updated and More Specific

The budget descriptions that accompany the Fund for a Healthy Maine programs in the Governor's Budget as presented to the Legislature often do not clearly, specifically or accurately reflect what the funds currently support. This can inhibit transparency and interfere with sound legislative decision-making.

An example is the FHM - Bureau of Medical Services program (#0955) which has a description in the budget that reads: "This program administers the Medicaid program in a cost-effective manner and ensures that administrative support services meet high quality standards." However, the program actually funds one Office of MaineCare Services' position responsible for overseeing Drugs for the Elderly, which is not a Medicaid program.

Another example is the FHM – Bureau of Health program (#0953) which had a FY09 allocation of $24 million and includes five different sub-accounts: Oral Health, Tobacco Prevention and Control, Home Visits, Community School Grants and Public Health Infrastructure. The description in the budget documents for the 2010-2011 biennial budget read: "This program promotes health through education, motivation, surveillance and implementing public health policies." This seems like a somewhat vague description for such a large and diverse budgetary program.

Suggested Legislative Action:

In order to ensure critical documents supporting budgetary decisions contain accurate and meaningful program descriptions, the Legislature should consider giving guidance for the program descriptions that are submitted with the Governor's Budget and requiring agencies to adhere to that guidance. For example, the Legislature could specify that the description include a listing of the key activities or functions associated with the program and, where applicable, the populations targeted. The Legislature might also specify that the descriptions should reference the names and program numbers of other associated programs.

Suggested Management Action:

The Department of Administrative and Financial Services Bureau of the Budget should develop and implement the policies and procedures necessary to ensure budgetary descriptions are updated each budget cycle and are as complete and

accurate as is practical. Any guidance provided by the Legislature should be incorporated into those policies and procedures.

Costs for Major Activities Within Budgetary Programs Should be Tracked Within the State's Accounting System

Within each FHM budgetary program there are often a number of significant activities taking place, some of which are closely related and others that are less so. The accounting structure currently in place at the responsible agencies, however, does not allow the complete costs of each of these activities to be tracked. As a result, the cost of most activities can only be estimated based on the individual contracts that support them. There is no real sense of the total cost, which would also include the resources used within the State to manage the activity and its associated contracts. There is also no capture of the total costs associated with activities supported by more than one program perhaps in multiple agencies.

When we asked program managers for complete financial data at the activity level they expressed a desire to have it themselves. We found some that had created their own "off-system" spreadsheets to track costs for the activities they managed. Although these are commendable, an "off-system" accounting is not an adequate substitute. It is more open to human error, may be discontinued if the individual who created it leaves their position, and is usually not accessible to all interested parties including upper management, legislators and legislative staff.

Suggested Legislative Action:

The Legislature should consider directing departments with responsibility for FHM programs to develop a sub-account structure that would allow for the assignment of costs directly to the activity level within the State's accounting system - including the State employee time spent on the activity. Activity level cost accounting would facilitate the management and oversight of each activity, and the related programs, by ensuring activity level financial data would be collected consistently as costs were incurred and would be available to all interested parties.

It is our understanding that the State's new accounting system, AdvantageME, does have the capability for agencies to establish sub-account codes for specific activities and to assign expenditures to those codes. This would, of course, require agencies to identify their key activities and would likely require support and guidance from the appropriate Service Centers and/or State Controller's Office. There should also be some centralized coordination, perhaps by the DAFS Service Center or the Controller's Office, to assure that codes were consistent across those agencies involved in the same activity.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided the Department of Health and Human Services and the Department of Administrative and Financial Services an opportunity to submit comments on the draft of this report.

Acknowledgements

OPEGA would like to thank the management and staff of the Department of Health and Human Services' Center for Disease Control and Prevention and Office of Substance Abuse, for their cooperation during this review. We would also like to thank the management and staff in the following agencies for their assistance in providing information and perspective:

- Department of Administrative and Financial Services' (DAFS) Division of Purchasing;
- DAFS DHHS Service Center;
- DAFS Bureau of the Budget;
- Attorney General's Office; and
- the Legislature's Office of Program and Fiscal Review and Office of Policy and Legal Analysis.

Appendix A. Summary of Current FHM Programs by Responsible Agency

Legend	
Acronyms for Agency Names **AG** – Attorney General **DOE** – Department of Education **DHHS** – Department of Health and Human Services **CDCP** – Center for Disease Control & Prevention **IS** – Integrated Services **OCFS** – Office of Child & Family Services **OIAS** – Office of Integrated Access & Support **OSA** – Office of Substance Abuse **QHM** – Quality and Healthcare Management **LRS** - Licensing and Regulatory Services **OMS** – Office of MaineCare Services **DPS** – Department of Public Safety **FAME** – Finance Authority of Maine	**Codes for Other Funds Column** **F** – Federal funds also support one or more activities in this program. **FL** – Federal funds, leveraged by the State and/or service providers with Fund for Healthy Maine funds, also support one or more activities in this program. **GF** – State General Funds also support one or more activities in this program. **SR** – Other Special Revenue. **N** – There are no other State or federal funds supporting activities in this program. **Codes for Performance Evaluation Column** **C** – Performance-related data is collected and resides in agency. **F** – Federal government also monitors these activities. **R** – Performance-related data is formally collected and reported to either State or federal entities. **O** – Other information exists that could be used to evaluate performance. **N** - No performance data is collected or reported for this program.
Note: FY09 budget figures included in Table 2 are taken from the Bureau of the Budget including PL 2009, Chapter 1. All other Information in the Table is derived from interviews with agency management and staff and/or review of agency prepared documents. OPEGA has not yet verified this information.	

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency

Program Info	Purpose	Key Activities Funded	Other Funds	Perf Eval
Program #: 0947 **Name:** FHM – Attorney General **FY08/09 Budget:** $198,684 **Responsible Agency:** AG	To ensure tobacco companies which are signatories to the Master Settlement Agreement meet their full obligations per that agreement.	One and a half Assistant AG positions to: • enforce the Tobacco Manufacturer's Act and the Tobacco Distributor's Act.	N	O
Program #: 0963 **Name:** FHM - Judicial **FY08/09 Budget:** $110,686 **Responsible Agency:** Judiciary	To support Adult Drug Courts in supporting recovery from drugs and alcohol and reducing recidivism.	One Drug Court Coordinator to: • work with all adult drug courts; • liaison with parties involved in drug court cases; • problem solve with the courts; and • write grants to obtain additional resources and administer grants received.	F	R
Program #: 0964 **Name:** FHM – Fire Marshal **FY08/09 Budget:** $262,906 **Responsible Agency:** DPS - Fire Marshal	To provide timely fire safety inspections of child care facilities seeking new or renewed licenses. FHM funds offset charges made to DHHS for child care inspections done for the department.	Three inspectors and one half support staff positions to: • conduct fire safety inspections.	SR	R

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency				
Program Info	**Purpose**	**Key Activities Funded**	**Other Funds**	**Perf Eval**
Program #: 0949 **Name:** FHM – School Nurse Consultant **FY08/09 Budget:** $103,670 **Responsible Agency:** DOE	Provide statewide school nursing leadership, consultation and direction for coordinated school health care programs.	One DOE position to: • serve as liaison and resource for school nurses; • develop and conduct school nurse training programs; • participate in committees dealing with school health issues; and • collaborate with other states.	N	O
Program #: Z068 **Name:** FHM – School Breakfast Program **FY08/09 Budget:** $224,925 **Responsible Agency:** DOE	Increase number of children actually receiving school breakfast that are eligible for reduced fee breakfasts.	Cover family contribution of $.30 per meal for federally subsidized school breakfasts.	N	R
Program #: 0950 **Name:** FHM – Area Health Education Centers **FY08/09 Budget:** $117,235 **Responsible Agency:** FAME	To attract and retain health care personnel in underserved areas of the State or to provide services to underserved cultural groups through educational system incentives.	Contract with University of New England to: • provide continuing education courses to promote professional development for rural health professionals; • provide clinical placements for health professions students in rural and underserved areas; and • expose students in rural areas to health professions through summer career camps and other educational experiences;	FL	R
Program #: 0951 **Name:** FHM - Dental Education **FY08/09 Budget:** $277,735 **Responsible Agency:** FAME	Increase the number of dentists practicing in Maine in underserved areas or for underserved populations.	Loans to dental students who are Maine residents and potential forgiveness of loans for those who practice in Maine under specified conditions. Dental education loan repayments for dentists practicing in Maine that meet specified conditions.	N	C
Program #: 0952 **Name:** FHM – Quality Child Care **FY08/09 Budget:** $167,792 **Responsible Agency:** FAME	To increase the skills of people working in child care by providing educational grants for related education.	Distribution of funding to colleges and universities to be used for: • scholarships for post-secondary students enrolled in child development and early childhood education courses.	N	C
Program #: 0948 **Name:** FHM – Substance Abuse **FY08/09 Budget:** $6,554,080 **Responsible Agency:** DHHS - IS - OSA	To decrease substance use, abuse & dependency in Maine through the implementation of prevention, intervention and treatment services.	Contracts with multiple entities to provide: • adult and youth prevention services; • prevention media campaigns; • prescription monitoring program for health care providers; • adolescent and adult community based outpatient and residential treatment services; and • corrections based treatment services for adolescents and adults.	FL GF	C F

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency				
Program Info	**Purpose**	**Key Activities Funded**	**Other Funds**	**Perf Eval**
Program #: 0954 **Name:** BFI - Central **FY08/09 Budget:** $61,898 **Responsible Agency:** DHHS – IS – OIAS	To assist in providing services for MaineCare.	One OIAS position to: • determine eligibility for MaineCare.	N	N
Program #: 0959 **Name:** FHM – Head Start **FY08/09 Budget:** $1,582,460 **Responsible Agency:** DHHS – IS - OCFS	To increase the number of children in full day, full year Head Start programs and early Head Start infant/toddler care.	Grants to agencies receiving federal Head Start funding to: • provide comprehensive developmental child care.	F FL GF	C F
Program #: 0961 **Name:** FHM – Purchased Social Services **FY08/09 Budget:** $4,605,435 **Responsible Agency:** DHHS – IS - OCFS	To increase availability of affordable, quality child care for low income parents.	Distribution of child care vouchers to low income parents. Contracts with child care providers and after school programs for subsidized: • child care slots; • odd hour child care; • child care for at risk children; and • 12-15 year old care. Contracts with other multiple entities to: • run resource development centers; and • provide quality improvement programs.	F FL GF	C F
Program #: 0953-06 **Name:** FHM – Home Visits **FY08/09 Budget:** $5,432,713 **Responsible Agency:** DHHS – IS - OCFS	To support and assist new and adolescent parents in understanding child development so children have better health outcomes, developmental issues are identified earlier and child abuse is prevented.	Contracts with multiple entities to: • conduct home visits; • train home visitation staff; and • evaluate the home visits program.	N FL	C R
Program #: 0953-01 **Name:** Oral Health **FY08/09 Budget:** $973,897 **Responsible Agency:** DHHS –CDCP	To improve access to oral health care services for low income individuals without dental insurance.	Contracts with providers who agree to certain conditions to: • subsidize the cost of services they provide to certain categories of individuals.	N	O

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency				
Program Info	**Purpose**	**Key Activities Funded**	**Other Funds**	**Perf Eval**
Program #: 0953-02 **Name:** Tobacco Prevention and Control **FY08/09 Budget:** $7,377,596 **Responsible Agency:** DHHS - CDCP	To prevent youths from using tobacco products and to assist youths and adults who currently use tobacco products to discontinue that use.	Four positions in CDCP manage implementation of all functions in Tobacco Prevention & Control and Community/School Grants. Contracts with multiple entities to: • provide a tobacco helpline, treatment and medication assistance for individuals seeking to stop smoking; • conduct tobacco-related public education and media campaigns; • evaluate effectiveness of tobacco-related program components; and • provide support for other statewide tobacco initiatives.	FL	R C
Program #: 0953-07 **Name:** Community/School Grants **FY08/09 Budget:** $9,059,743 **Responsible Agency:** DHHS - CDCP	To reduce tobacco use, tobacco-related chronic disease, associated risk factors and substance abuse by addressing these issues at the local level.	Contracts with multiple entities, including 28 Healthy Maine Partnerships, to: • promote, coordinate and organize policy and environmental change activities within schools and communities to support healthy behaviors and lifestyles; • establish School Based Health Centers for adolescents; • provide support for engaging youth in Healthy Maine Partnership work; • provide training and technical assistance for Healthy Maine Partnership work; • conduct research on obesity reduction and prevention; • partial funding for School Breakfast program; and • enforce tobacco laws statewide.	FL	C R
Program #: 0953-08 **Name:** Public Health Infrastructure **FY08/09 Budget:** $1,470,000 **Responsible Agency:** DHHS – CDCP	To establish a system at the broad community level that can respond to public health issues.	Contracts with the 28 Healthy Maine Partnership organizations to: • organize community health coalitions; • assess community health needs; and • develop local health improvement plans to inform the State Health Plan.	N	O
Program #: Z048 **Name:** Immunization **FY08/09 Budget:** $1,258,000 **Responsible Agency:** DHHS - CDCP	To supply influenza and pneumonia vaccinations to targeted populations.	Purchase vaccines at a discount through the federal government which then distributes the vaccines to providers.	N	R

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency				
Program Info	**Purpose**	**Key Activities Funded**	**Other Funds**	**Perf Eval**
Program #: 0956 **Name:** Family Planning **FY08/09 Budget:** $884,240 **Responsible Agency:** DHHS - CDCP	To reduce teen pregnancy rate.	Contract with Family Planning Association of Maine to: • fund clinics; and • conduct community education and outreach.	F GF	F R
Program #: 0958 **Name:** Donated Dental **FY08/09 Budget:** $42,562 **Responsible Agency:** DHHS - CDCP	To increase availability of donated dental services for disabled persons who could otherwise not afford them.	Contract with National Foundation for Dentistry for the Handicapped for a part-time coordinator to: • recruit dentists to donate services; and • coordinate with laboratories for discounted or donated prosthetics.	N	R
Program #: 0962 **Name:** Bone Marrow Screening **FY08/09 Budget:** $93,712 **Responsible Agency:** DHHS - CDCP	To increase the number of identified potential bone marrow donors on the national registry.	Contract with the Maine Leukemia Foundation to: • provide outreach throughout Maine to attract new potential donors to the national bone marrow registry; • run screening clinics; and • pay for screening tests.	SR	R
Program #: 0960 **Name:** Medical Care **FY08/09 Budget:** $8,776,069 **Responsible Agency:** DHHS – OMS	To cover costs of pharmaceuticals for Medicaid eligible individuals.	Transfer of Medicaid eligible pharmaceutical expenditures from General Fund to FFHM to free up General Fund allotment for other Medicaid expenses.	FL GF	N
Program #: Z015 **Name:** Drugs for the Elderly & Disabled **FY08/09 Budget:** $13,912,727 **Responsible Agency:** DHHS - OMS	To increase the availability of affordable prescription drugs for low income elderly and disabled individuals who are not eligible for Medicaid.	Contracts with multiple entities for: • pharmaceutical subsidies; • Medicare premiums; and • outreach and education.	GF SR	C
Program #: 0955 **Name:** Bureau of Medical Services **FY08/09 Budget:** $140,497 **Responsible Agency:** DHHS - OMS	To oversee and administer Drugs for the Elderly and Drugs for the Elderly Medicare support programs.	One position in OMS to: • oversee and administer programs.	FL	N
Program #: 0957 **Name:** Service Center **FY08/09 Budget:** $720,101 **Responsible Agency:** DHHS – QHM - LRS	To assure safety and quality care for children in child care and children's residential treatment facilities.	Ten positions in Licensing and Regulatory Services to: • conduct licensing inspections of child care and residential treatment facilities; • investigate complaints about providers; and • investigate allegations of abuse in out of home situations (i.e. foster homes).	GF	O

Summary of Current Fund for a Healthy Maine Programs by Responsible Agency				
Program Info	**Purpose**	**Key Activities Funded**	**Other Funds**	**Perf Eval**
Program #: Z070 **Name:** FHM - Dirigo Health **FY08/09 Budget:** $5,000,000 **Responsible Agency:** Dirigo Health	To expand access to comprehensive, affordable health care coverage.	Dirigo Health provides the DirigoChoice insurance program currently offered through Harvard Pilgrim Health Care. FHM funds are used for subsidies for low income members.	GF	C R

Appendix B. Additional Information About Healthy Maine Partnerships

Local Healthy Maine Partnerships

Aroostook District
1 Healthy Aroostook
2 Power of Prevention

Central District
3 Greater Somerset Public Health Collaborative
4 Greater Waterville PATCH
5 Healthy Communities of the Capital Area
21 Sebasticook Valley Healthy Communities Coalition (also Penquis District)

Cumberland District
6 Healthy Casco Bay/Healthy Portland
7 Communities Promoting Health

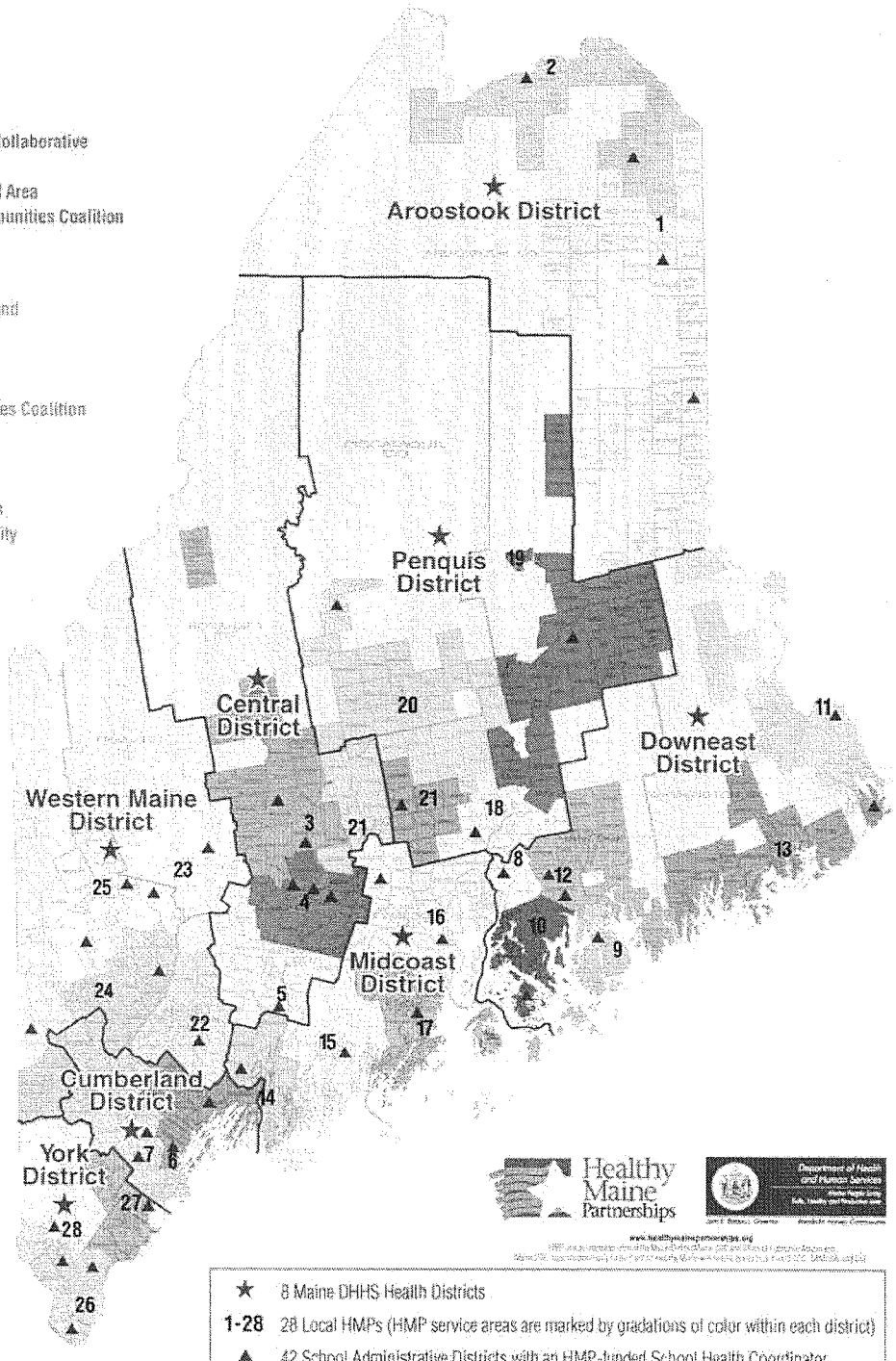
Downeast District
8 Bucksport Bay Healthy Communities Coalition
9 Healthy Acadia
10 Healthy Peninsula
11 St. Croix Healthy Communities
12 Union River Healthy Communities
13 Washington County One Community

Midcoast District
14 ACCESS Health
15 Healthy Lincoln County
16 Healthy Waldo County
17 Knox County Community Health Coalition

Penquis District
18 Bangor Region Public Health and Wellness
19 Partnership for a Healthy Northern Penobscot
20 Piscataquis Public Health Council
21 Sebasticook Valley Healthy Communities Coalition (also Central District)

Western Maine District
22 Healthy Androscoggin
23 Healthy Community Coalition
24 Healthy Oxford Hills
25 River Valley Healthy Communities Coalition

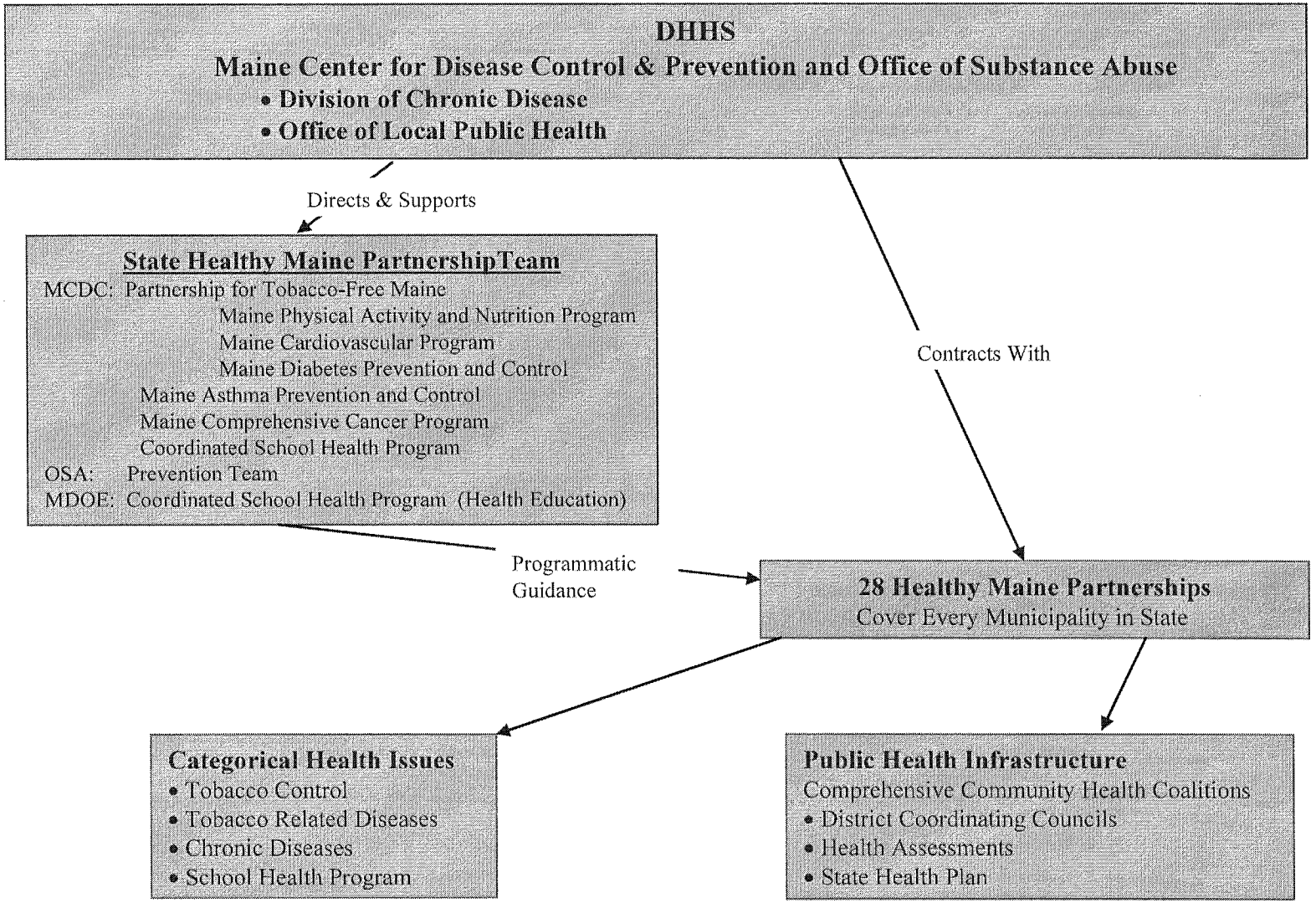
York District
26 Choose To Be Healthy
27 Coastal Healthy Communities Coalition
28 Partners for Healthier Communities



The gray areas on this map are unorganized territories, plantations, and townships with a population size of less than 50 people and/or a geographic size of more than 100 square miles with population density less than one person per square mile. These areas are not officially assigned to an HMP contract for outreach but people living in these areas who wish to get involved in HMP-related activities are encouraged to contact the HMP located closest to them. All gray areas are recognized as part of the public health district within which they are located.

Note: Map obtained from: http://www.healthymainepartnerships.org/documents/HMP_Map.pdf

Relationship of State and Local Healthy Maine Partnerships in Public Health Infrastructure and Categorical Health Efforts



Source: Amended version of a diagram provided to OPEGA by Maine CDC.

Appendix C. 2009 Issue Brief: Is Maine Prepared to Become the Healthiest State in the Nation?

January 2009

Issue Brief

Is Maine Prepared to Become the Healthiest State in the Nation?

Public health policies and systems seek to improve the health of populations. Our public health system in Maine assures that we have safe drinking water, are prepared to respond to disasters, and have community-based prevention programs to decrease injury, disease, and premature death. While the term public health is often misunderstood and linked with indigent care, the system encompasses far more and provides essential health improvement services. These include:

- Preventing epidemics and the spread of disease
- Protecting against environmental hazards
- Preventing injuries
- Promoting and encouraging healthy behaviors
- Responding to disasters and assisting communities in recovery
- Assuring the quality and accessibility of health services[1]
- Developing policies in the public's interest
- Assessing the health of populations

The Maine Center for Disease Control and Prevention within the Department of Health and Human Services has the primary responsibility for public health in our state and serves as the hub of our public health system. This system also includes public and private organizations that play an important role. The Institute of Medicine's 2003 report titled *The Future of the Public's Health in the 21st Century* identified five actors who, together with the government public health agencies, are in a position to act powerfully for health. While policymakers have not been singled out, they also play a critical role in the public health system.

The State of the Public's Health in Maine

Maine's State Health Plan articulates the goal of making Maine the healthiest state in the nation.[2] While a laudable goal, is it do-able? The answer depends on how willing we are to invest in a population-based approach and build a public-private system for improving health in Maine.

As the State Health Plan indicates, Mainers suffer from high rates of preventable chronic illnesses. While the medical system plays a critical role in treatment and rehabilitation of individuals, to have the greatest impact on our state's health, we need to focus on disease prevention strategies and public health approaches that support behavior change. There are multiple determinants of health including access to medical care, genetic predisposition, social circumstances such as income, education and employment, environmental exposures, and individual behavioral choices.[3] However, what most people don't realize is that our behavioral patterns and social and environmental circumstances play a far more significant role in mortality than access to high quality medical care.

In Maine, approximately 70% of deaths each year are a result of: 1) heart disease and stroke, 2) diabetes, 3) chronic lung disease, and 4) cancer.[4] Given what we know about the leading causes of death in this country (e.g., tobacco use, poor diet, physical inactivity, alcohol use)[5] and the relationship of these factors to disease and death rates, we can make dramatic improvements in health by modifying behavioral patterns through proven public health prevention and intervention efforts. The question is whether we are willing to make the investments

Fast Facts

- There are multiple determinants of health including access to medical care, genetic predisposition, social circumstances such as income, education and employment, environmental exposures, and individual behavioral choices.
- In Maine, approximately 70% of deaths each year are a result of: 1) heart disease and stroke, 2) diabetes, 3) chronic lung disease, and 4) cancer
- Current estimates reveal a dramatic decline in tobacco use among young people in Maine since 1997 – 64% among high school students and 73% among middle school students

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that require long-term commitments and adequate resources given that health improvements often come years down the road. And if so, what do we need to do to get there and what successes can we build on?

New Challenges in Public Health: Emergency Preparedness

Given the events of 9/11, the Severe Acute Respiratory Syndrome (SARS) outbreak and the recent attention to natural disasters, it is clear that our communities, our state, and our nation need to be prepared to detect and respond to these situations. While chronic diseases continue to claim the lives of our family members, friends, co-workers, and neighbors, we also need to be mindful of new public health challenges so that our public health system can continue to protect the health of our population. Maine has taken on this challenge with federal funding that supports statewide efforts for bioterrorism and public health emergency preparedness. These funds are having a direct impact on our "ability to detect, treat and prevent injury and diseases that threaten the health of Maine citizens as a result of natural or man made events."[6] Our state public health agency is helping to protect our communities by building a coordinated system that will address natural disasters (e.g., pandemic influenza, floods, ice storms) and acts of terrorism.

Our capacity in Maine to respond to this new public health challenge has dramatically increased over the past several years and we are more prepared to protect the health of all Mainers. Examples of our increased capacity include:

- The establishment of a 24 hour statewide system of infectious disease reporting, tracking and investigation, including the location of field epidemiologists in each district;
- The creation of Regional Resource Centers for Public Health Emergency Preparedness in each of three care centers (Maine Medical Center, Central Maine Medical Center, and Eastern Maine Medical Center);
- The establishment of a Health Alert Network (HAN) that enables the 24 hour alerting of thousands of health care providers and public health workers with information on key public health events;
- The enhancement of our public health laboratory in the Maine CDC to test for all major biological, chemical, and nuclear terrorism agents.

The collective efforts highlighted above, and many others, would likely not have been possible without the influx of funds that Maine received. Promoting and protecting the health of our population is an ongoing responsibility with long-term investments, but it is critical if we truly want to be the healthiest and most prepared state in the nation.

The Power of Public Health: A Success Story in Maine

Maine has been a leader among states in having committed a substantial portion of funds from the Master Tobacco Settlement Agreement to public health. These dollars are often referred to as The Fund for a Healthy Maine and are used to support public health initiatives that target smoking and other health improvement priorities.

This investment in public health is paying off. To date, one of our most powerful successes has been the reduction of youth tobacco use. Maine has implemented and evaluated a comprehensive approach that uses proven strategies to help prevent children and young adults from using tobacco. This hallmark approach includes policies, changes in the environment and a list of other strategies used to tackle the issue from multiple angles. Current estimates reveal a dramatic 64% decline in smoking among Maine high school students, and a 73% decline among middle school students in the 10 years since 1997. This remarkable decrease is particularly noteworthy given the fact that Maine was once known to have the highest youth smoking rates in the country. Given what we know about the addictive nature of tobacco and the research suggesting that nearly one in five deaths in this country are attributed to tobacco, a decrease of this magnitude is a significant accomplishment with benefits that are far-reaching.

So, what do we need to do to build on our successes and to make a commitment to the health of Maine's population? The Fund for a Healthy Maine directly impacts our ability to deliver essential public health services in our communities and continued use of these funds to support public health efforts is critical. The allocations for state fiscal year 2007 are depicted below.

Are We Prepared to Become the Healthiest State in the Country?

While Maine's public health system has an enviable track record of community partners, Maine CDC, and other statewide entities working together to successfully address such health problems as youth smoking rates, teen pregnancy, and infant mortality, our system has also been challenged by fragmentation and the inability to address a myriad of public health issues. For instance, often driven by Federal requirements, community-based funding has been administered through a wide array of entities in Maine, with over 500 different grants addressing some aspect of public health.

With Maine's health care spending, the second highest in the nation, fueled in part by high rates of chronic illness, and with nearly half of health care cost increases attributable to five often preventable diseases (cardiovascular disease, diabetes, cancer, chronic lung diseases, and depression), it was imperative that we streamline our public health system if we are indeed to become the healthiest state in the nation. With public health system accreditation upon us in 2011 and future funding being tied to accreditation, we also face the challenge of need-

ing to build a more coordinated system for integrating quality improvement strategies required by accreditation.

Ten Essential Public Health Services:

EPHS #1 Monitor health status to identify community health problems.
EPHS #2 Diagnose and investigate health problems and health hazards in the community.
EPHS #3 Inform, educate, and empower people about health issues.
EPHS #4 Mobilize community partnerships to identify and solve health problems.
EPHS #5 Develop policies and plans that support individual and community health efforts.
EPHS #6 Enforce laws and regulations that protect health and ensure safety.
EPHS #7 Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
EPHS #8 Assure a competent public health and personal health care workforce.
EPHS #9 Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
EPHS #10 Research for new insights and innovative solutions to health problems.

Public Health Work Group

The 2005 State Health Plan charged the 40-member Public Health Work Group (PHWG) to implement a statewide community based public health infrastructure that works hand in hand with the personal heath care system. In 2006 the Legislature enacted a resolve charging the PHWG with developing core competencies, functions, and performance standards for comprehensive community health coalitions. In 2007 the Legislature again called on the PHWG to streamline administration, strengthen local community capacity, and assure a more coordinated system of public health. That legislation set forth requirements for membership on the Public Health Work Group to assure broad representation while limiting membership to forty people, who worked tirelessly over several years to make this plan a reality. In 2007 the Legislature also enacted legislation seeking a plan from Maine CDC, with input from the PHWG, to modernize the Local Health Officer system. The results of the PHWG's various efforts are summarized here.

Public Health Work Group Results

The Maine CDC, which is situated within the Maine Department of Health and Human Services is the nucleus of Maine's public health system. For the first time the system links and coordinates local, sub-state, and state public health activities using existing resources more efficiently. This system also includes representation from and links to the state and county emergency preparedness system. The system uses the framework of the 10 essential public health services that is the standard framework for public health functioning and for upcoming accreditation.

Maine's Public Health Geographical Framework and Some Major Components:

Local – Local Health Officers, Healthy Maine Partnerships (comprehensive community health coalitions)

Districts – District Coordinating Councils, Maine CDC Public Health Units

State – Maine CDC/DHHS and Statewide Coordinating Council

District

Districts were formed by the PHWG for those functions that are more efficiently and effectively provided at the district level than the local or state level as well as for issuing funds and for determining state public health system roles. Districts were formed based on four factors: population, geographical size, hospital service areas, and county borders. They are: Aroostook; Penquis; Downeast; MidCoast; Central; Western; Cumberland; and York. They are also the same districts as are used by law enforcement for the District Attorneys, by tourism for the Tourism Districts; and are aligned with the emergency medical system districts.

Healthy Maine Partnerships = Comprehensive Community Health Coalitions

A major step in streamlining and assuring a more coordinated public health system was put in place in 2007 by integrating the existing Healthy Maine Partnerships and other community health coalitions into one statewide system of comprehensive community health coalitions that strengthen local public health capacity statewide. This streamlining resulted in over 100 state grants and contracts to health coalitions being bundled to 28 contracts. This network is also called the Healthy Maine Partnerships (or HMPs) and now provides statewide coverage for the essential public health services related to local health assessment, education, policy, and community mobilizing.

Currently, the majority of their funding focuses their efforts on tobacco, physical activity, nutrition, obesity, substance abuse prevention, and chronic disease prevention and management. As other funding becomes available to address other health issues, the Healthy Maine Partnerships (often in partnership with the DCCs) will continue to extend their capacity to deliver these essential public health services for other priority topics as well.

Local Health Officers

The Local Health Officer (LHO) system provides a linkage between state public health and every local municipality. It is a system that has been in place for over 100 years. The Legislature charged Maine CDC/DHHS with proposing revisions to assure the laws governing LHOs are appropriate for the 21st Century. An Act to Modernize the Local Health Officer Statutes was enacted by the Legislature in 2008. The resulting revisions streamlined a myriad of statutory duties and removed redundancies, while strengthening and focusing the system on the municipal governmental functions related to controlling and reporting local public health nuisances and potential communicable disease threats.

District Coordinating Councils (DCC)

As part of Maine's public health infrastructure, District Coordinating Councils (DCCs) are designated by the Maine CDC based on recommendations from each of the eight districts and with review and comment by the Statewide Coordinating Council. DCCs are the district-wide representative body for collaborative planning and decision-making for functions that are more efficiently and effectively accomplished at the district level and for assuring accreditation of the state's public health system in that district.

District Maine CDC/DHHS Units

An effective and efficient statewide public health system requires coordinated planning and calls for certain other functions to be carried out at the district level. To improve the administration of state programs and policy and to assure state policy reflects the different needs in each of the eight DHHS districts, Maine CDC is out-stationing positions and co-locating existing district staff, and establishing District Maine CDC/DHHS units. These will be linked to District Coordinating Councils. The Maine CDC/DHHS Units are to include: Maine CDC Public Health Units within each DHHS district are forming, and consist of co-located Public Health Nurses, District Nurse Epidemiologists, Health Inspectors, Drinking Water Engineers, and District Public Health Liaisons. These Public Health Units may perform certain public health functions that are more efficiently and effectively provided by them, such as some district or county-level functions and some public health emergency functions.

In the case of public health emergencies, the District Public Health Liaisons will serve in the county emergency operations centers (EOC) as liaisons between state and local public health entities. In those districts that consist of multiple counties, the District Nurse Epidemiologist and/or Public Health Nurses may also serve as EOC liaisons as well as back-up to the District Liaison.

Statewide Coordinating Council (SCC)

A Statewide Coordinating Council (SCC) will build on the work of the PHWG to implement a statewide public health infrastructure that streamlines administration, strengthens local community capacity, and assures a more coordinated system for delivery of essential public health services. The SCC will be the representative body for review and guidance to the Maine CDC on strategic state level policies related to federally-recognized national accreditation and the aligned system of Local Health Officers, Healthy Maine Partnerships, District Coordinating Councils, and on other policy issues directly related to public health infrastructure, roles and responsibilities.

Summary of Public Health Infrastructure

Through an extensive collaborative process, Maine's public health stakeholders have examined its centralized but fragmented public health infrastructure at the sub-state level. By streamlining and coordinating existing resources, Maine's emerging local and district public health system is more efficient, more effective, more ready for accreditation, and most importantly, better able to serve the public's health needs.

How Do We Become the Healthiest State in the Country?

So, how do we achieve our laudable goal of becoming the healthiest state? We begin by addressing our public health challenges and system deficiencies. To tackle these challenges we need to strengthen our public health constituency and work with all of our public health partners to advocate for and implement comprehensive solutions that will impact the health of all people in Maine. If Maine is to accomplish its goal, and if it does become the healthiest state in the country, our public health system will have another success to celebrate and all people in Maine will have another reason to be proud to live in this state.

For More Information

State Public Health Initiatives (including The Fund for a Healthy Maine)
Contact: Dora Anne Mills, MD, MPH
Director, Maine Center for Disease Control & Prevention

State Health Plan
Contact: Trish Riley
Director, Governor's Office for Health Policy and Finance

Websites of Interest

- Centers for Disease Control and Prevention: www.cdc.gov
- Public Health Foundation: www.phf.org
- National Association of City and County Health Officials: www.naccho.org
- Association of State and Territorial Health Officials: www.astho.org
- American Public Health Association: www.apha.org

- Maine Center for Disease Control and Prevention: http://www.maine.gov/dhhs/boh/
- Maine Public Health Association: www.mcph.org/mpha/MPHAindex.html
- Maine Center for Public Health: www.mcph.org
- Maine Network of Healthy Communities: www.thehcnetwork.org

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