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For Our Health: Partnerships in Maine

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Capstone

For Our Health: Partnerships in Maine

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Executive Summary

The Maine Shared Community Health Needs Assessment (Maine Shared CHNA) has created a mature network of local collaborations that come together every three years to conduct a statewide needs assessment. This capstone looks into whether there have been successful partnerships that continue collaborating on health improvement planning and implementation post CHNA. Key questions included, “Where there were successful collaborations, what was it that made them successful? What are the challenges to forming and maintaining a collaboration and how have groups overcome those challenges?” A comparative case study approach was used in order to compare and contrast two sites, each demonstrating different levels of joint action as defined by the National Association of County and City Health Officials (NACCHO). Case study #1 demonstrated collaboration based on the number of organizations cross referenced in their work plans. Case study #2 did not demonstrate organizational cross references. Interview subjects were chosen based on whether they still work at their respective organizations, and whether their organizations were cross referenced (or not) in other health improvement plans within a county.

Findings show common themes among successful collaborations including institutional leadership support, presence of a convening organization, social cohesion and trust among partners, perseverance, and a shared vision, mission, and strategic plan. These elements appeared to mitigate against the complicated, and sometimes controversial, role funding can play in collaborative partnerships. Findings also show these elements can help institutional leaders justify dedicating resources due to the clarity and transparency these elements provide. Finally, strong leadership, guidance from a convening organization, social cohesion, perseverance and a shared mission, vision, and strategic plan can provide guidance to collaborations in bolstering and sustaining their efforts through inconsistent funding cycles.

The Maine Shared CHNA structure already has many of these elements in place. These include institutional leadership support, a shared vision and mission, a centralized backbone infrastructure in order to provide support to local teams. In order to move into a planning collaboration the Maine Shared CHNA may wish to consider further empowering local teams, developing change management plan, incentivize partners, foster local innovation, and revise the Charter and Memorandum of Understanding.

I. Introduction

Every three years the Maine Shared Community Health Needs Assessment identifies, collects, and analyzes 200 health indicators and compiles one state, sixteen county, five public health district, three city profiles, and health equity summaries. The Maine Shared CHNA uses these health profiles and summaries to conduct two or more community engagement activities in every county (e.g., forums, surveys, focus groups, and key informant interviews). During the fall of 2018, over 2,000 people in Maine participated in assessing their community's health. At the local level, these efforts were led by sixteen Community Engagement partnerships made up of representatives from one or more of Maine's thirty-three non-profit acute care hospitals, eight District Public Health Liaisons and their District Coordinating Councils, and countless community coalitions, non-profits, local and other state government agencies, and community volunteers. The results are twenty-two Community Health Needs Assessment reports (one state, sixteen county, five public health district reports). All of this effort is supported and coordinated by the Maine Shared CHNA Steering Committee with day to day oversight by a Program Manager.

Hospitals and public health districts, as well as community partners, then use these CHNA Reports to produce their own health improvement plans to address the identified health needs in their communities. For hospitals and local public health districts, these three-year plans are then implemented and their progress monitored in order to meet their institutional regulatory or accreditation requirements. The Maine Shared CHNA is an enormous effort which requires pooling of significant financial and human resources between Maine's largest public-private entities. The question that is often asked is, "So what?"

We know that when health issues and strategies to address them are collaboratively identified and chosen by the community, the resulting health improvement plans are more likely to be accepted and followed by the community. This results in greater improvement on the public's health. The issue or challenge is that not all Maine Shared CHNA partners continue collaborating on health improvement planning once the assessment phase is complete. This presents a lost opportunity to leverage and align scarce resources.

The goal of this project is to identify the key elements that supported a Maine Shared CHNA collaboration that continued working together on planning and implementation after their work on assessment activities were complete. Three key questions were explored. 1.) Has the

Maine Shared CHNA fostered ongoing collaborative partnerships across the state? 2.) How do collaborative partnerships form? 3.) What are the barriers and challenges partnerships face in attempting to collaborate—and how did they overcome those barriers? Lastly, should findings warrant it, the final goal is to share results so other Maine Shared CHNA collaborations can apply any lessons learned in order to move from assessment collaborations to planning and implementation collaborations.

II. Description of the Issue

Background

There are two major forces of change that inspired this project: the 2014 Affordable Care Act (ACA) and the 2011 release of the Public Health Accreditation Board's (PHAB) version 1.0 of the PHAB Accreditation Standards and Measures. These both require health needs assessments to identify local health issues and devise community health improvement plans. In Maine, these common requirements accelerated an existing collaborative that was established in 2007. Then known as the OneMaine Health CHNA, this partnership between MaineGeneral Health (MGH), MaineHealth (MH) and Northern Light Health (NLH—then known as EMHS), contracted with the University of New England's Center for Community and Public Health in collaboration with the University of Southern Maine and Market Decisions to conduct a statewide CHNA. First reports were published in 2010.

In 2012, MGH, MH, and NLH were joined by Central Maine Healthcare (CMHC). After discussions with the State Coordinating Council, the Maine Center for Disease Control and Prevention (MeCDC), a division of the Department of Health and Human Services, joined the collaboration. In 2014, health system CEOs and the Director of DHHS signed a memorandum of understanding which outlined the structure of this new collaborative. What was then known as the Shared Health Community Needs Assessment and Planning Process (SHNAPP) was *at the time* the first and only public-private statewide partnership in the nation. Benefits from this collaboration are still enjoyed today, including pooled funding from the healthcare systems with generous in-kind support from the MeCDC.

Since 2007, two more Maine Shared CHNA's have been conducted. One over the winter of 2015-2016 and one during the fall of 2018. The 2015-2016 assessment was the first that non-profit hospitals in Maine used in filing their IRS required Community Health Needs Assessments

and Implementation Strategies. The State of Maine as well as the City of Portland used the 2015-2016 SHNAPP to successfully apply to become accredited health departments through the PHAB. It is this set of plans that this research is based on since as the time of this research, the 2019 plans have not yet been developed.

Literature review

Given the recent enactment of the ACA, a review of the academic literature on this topic using the Ebsco databases on dissertation and academic papers, resulted in seventeen unique publications. These minimal findings are in contrast to the scope of the impact the ACA's policy has had on the requirement that every non-profit hospital in the country conduct a community health needs assessment and plan and implement health improvement plans based on the findings. Despite the paucity in the academic literature on this subject, the research does provide some valuable insights.

The community benefit requirements for non-profit hospitals present an opportunity for hospitals to impact the overall health of the people who live within their services areas. Required Community Health Needs Assessments (CHNAs) ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities (ASTHO, n.d.). The sheer size and scale of these efforts represent a potential opportunity to increase health promotion of a community

NACCHO Levels of Joint Action	
Networking	exchange information
Coordination	exchange information and link existing activities for mutual benefit
Cooperation	share resources for mutual benefit and to create something new
Collaboration	work jointly to accomplish shared vision and mission using joint resources

Table 1

(Ainsworth, 2013, p. 870). However, there is limited evidence from the literature that in communities where local health departments and hospitals routinely collaborate on CHNAs, they were any more likely to continue their collaboration into planning and implementation than those that did not (Carlton, 2018). One study looked at local health department and hospital health improvement plans through the lens of NACCHO's Levels of Joint Action (Table 1) to identify collaborations on implementation plans based on CHNAs. In analyzing the levels of joint action described in thirty-four of Missouri's 167 hospitals' CHNA's, where hospitals and health

systems collaborated to perform a community health needs assessment, only 2.9% demonstrated collaboration on planning and implementation (Beatty, 2015).

As Ainsworth noted, sustained CHNA collaborations into a planning collaboration can solve identified health priorities that cannot be solved alone. One example of such a collaboration was the establishment of a federally qualified health center. (Beatty, 2015). In Mercer County, New Jersey, two hospitals, the Federally Qualified Health Center (FQHC), and the City of Trenton's Division of Health collaborated on their CHNAs and subsequently created a unified Community Health Improvement Plan for the City of Trenton, N.J. (Perry, 2013). Rhode Island's statewide CHNA ensured that members of their collaboration crafted health improvement plans that were aligned (RI Collaborates, 2017). These unified, collaborative health improvement plans may not increase the community benefit dollars already being spent by non-profit hospitals, but they can align community resources to more effectively address identified community health needs (Singh, 2017).

To make this sustained collaboration happen, the literature also includes several elements necessary to sustain CHNA efforts into planning and implementation. These include leadership support of subordinates' efforts to continue collaboration, social bonding or cohesion between agencies and among local committee members, convening entity with expertise in group process, shared measures of success, and a tolerance for risk to name a few. Yet, in reviewing the literature and health improvement plans in Maine, these types of sustained collaborations seem to be the exception, not the norm. The assumption is that if Maine can lead the nation in conducting a statewide public-private needs assessment, Maine should also lead the nation in collaborative health improvement planning and implementation. This study outlines some of the successes, as well as some challenges and barriers to such a sustained collaboration here in Maine.

III. Methodology

Goals

The goal of this study was to identify collaborative partnerships that emerged from the SHNAPP that continued to collaborate on health improvement planning at the same level of collaboration they had put into their health assessment activities. Some key questions included:

- a. How did such a collaboration form?
- b. What makes public-private collaborations successful?

- c. Were there challenges to forming those collaborations? If so, how were these challenges resolved?

Site Selection

Two comparison case studies were chosen through a three-phase selection process. The time frame for initial selection was the 2016 health improvement planning phase immediately following the 2015-2016 SHNAPP. The geographic boundaries were defined as any of the sixteen counties in Maine, since the assessments were primarily conducted at the county level by local implementation teams.

The first phase in case identification was to locate all thirty-three non-profit acute care hospital 2016 CHNA hospital Implementation Strategies and the eight 2016 District Public Health Improvement Plans ($n=41$). Exclusion criteria included specialty hospitals, such as rehabilitation or psychiatric hospitals, and the 9th public health district, the Tribal Public Health. Specialty hospitals' focus is too narrow for the purpose of this study and the Tribal District is a population-based district, so the county geographic lines include this population and this district had been working independently on their own needs assessment. A listing of Public Health Districts and Maine's non-profit acute care hospitals can be found in Appendix B. Hospital Implementation Strategies are, by law, posted on each hospital's website. Most hospitals have a Community Health Needs Assessment page listing their Implementation Strategies. Each of the eight District Health Improvement Plans (DPHIPs) are found by searching for Maine's public health districts. Links for each district lead to the District Coordinating Council page.

All forty-one plans were reviewed and placed on a grid according to their highest "Level of Joint Action" as demonstrated in their plans. Consideration was given to plans that fit on either end of NACCHO's scale of Joint Action. Eight of the forty-one plans developed in 2016 described implementation strategies that appeared to either require collaboration as defined by NACCHO, or not working with outside partners at all.

From these eight plans, four were eliminated from consideration as case studies for the following reasons:

- 1.) In one county, incomplete plans for one or more hospitals made analysis for how organizations intended to partner difficult to determine without further investigation.

- 2.) Within another county, the Principle Investigator for this study was an Executive Committee member of the Public Health District Coordinating Council and therefore was eliminated to avoid a potential conflict of interest.
- 3.) The last two counties were eliminated from consideration as case studies because their plans did not offer enough information on how their work was to be accomplished to determine whether they intended to work collaboratively with outside community members.

The third and final phase for case study identification was to look at the remaining plans in the context of their respective county partnerships. In order to make this final determination, the following criteria were used for choosing case studies for comparison between a collaborative and a networking partnership. Criteria are listed in order in which they were applied and include **whether or not**

- 1.) partner roles moved beyond ‘pulling in a resource’ to mutually committing resources
- 2.) partner organizations mentioned in the plans represent multiple sectors (law enforcement, schools, businesses, faith-based, community, etc.).
- 3.) their 2018 CHNA forum presentations demonstrated continued efforts on their original plans.
- 4.) planning efforts demonstrated the use of data to either drive decisions or measure progress (benchmarks/goals).

This resulted in two case study sites. Case study site #1 was selected because there was at least one coalition that was referenced in multiple 2016 health improvement plans and this coalition is still active today. Many of the health improvement plans within this site also contained details on objectives, strategies, measures, partners and their roles. Case Study #2 did not demonstrate the presence of this criteria. The health improvement plans in case study site #2 had limited references to other agencies within their regions. Some improvement plans contained no references to other organizations at all. Many of the health improvement plans reviewed in this region lack details on objectives, strategies, measures, partners or their roles.

Subject Selection

Interview subjects were selected based on whether the primary staff who were part of the 2015-2016 SHNAPP effort were currently in same or similar roles. Six requests for interviews were sent, four were successfully completed, two per case study—one public health and one health care representative each. Interviews were conducted by phone and were recorded with the subject's permission. Interviews lasted from forty-five minutes to an hour. More information on recruitment and interview questions can be found in Appendix D: Interview Protocol.

Analysis

Notes from all four interviews were analyzed using a coding system in order to align interview commentary with key research questions. Codes that were used include networking, coordination, cooperation, collaboration, policies, leadership, convener, align resources, social, financial, challenges, and overcome (challenges). The codes for networking, coordination, cooperation, and collaboration were in reference to NACCHOs levels of joint action. Findings from each case study were then compiled by code and summarized.

Major themes began to emerge regarding leadership, social cohesion, and financial considerations. After collating these major themes by case study, case studies were then compared to one another looking for contrasting elements. Which elements were strong in Case Study #1 and were, by contrast weak or missing in Case Study #2?

Institutional Review Board

The University of Southern Maine Office of Research Integrity and Outreach (ORIO) assigned this project Protocol Human Research Protection Program #022219-29. On Monday, February 25, 2019 ORIO issued a determination that this project does not fall under the definition of research as described in 45 CFR Sect. 46.102(d), and therefore does not require full Institutional Review Board review. The determination letter can be found in Appendix C.

IV. Findings

In the final analysis, there were three major areas which emerged as important to fostering collaboration: leadership, social cohesion, and clarity on financial roles and responsibilities. In addition, findings from the interviews revealed unique ways the SHNAPP influenced their efforts to collaborate.

Leadership

There are two primary aspects of leadership that all informants mentioned: **institutional leadership and support, and the presence of a convening organization.**

Institutional leadership support:

A seemingly seminal aspect of forming and maintaining collaborations is the support of an organization's leadership. One coalition's website in Case Study #1 states the importance of leadership support directly on their homepage with, "*Equally important was the creation of a collaborative that removed barriers between agencies and worked together to change the quality of services and the outcomes for people in [Our] County.*" Informants in Case Study #1 mentioned that without institutional leadership and support they would not be able to participate on local committees, volunteer their time to committee work, or commit other institutional resources. It was important to this informant that these issues were addressed early on to avoid any future barriers to their participation. "*Being able to share resources, especially when others can provide things you can't, and you have resources to exchange in return.*" was highlighted by one informant as a key ingredient to forming a collaborative, and impossible to provide without leadership approval. This also fits with the NACCHO definition for a collaborative level of joint action, "work jointly to accomplish shared vision and mission using joint resources."

Organizational leadership also holds staff accountable for the progress a partnership demonstrates on their health improvement plan. For those working collaboratively, they mentioned annual reports and regular meetings with their leadership on their progress as a positive influence in keeping the collaboration on task. One informant noted that working with community partners on their identified health needs was written into their organization's strategic plan and that the roles and responsibilities for each strategy were coordinated at each organization's senior leadership level. As a committee member, the informant was then held responsible for progress on the strategies assigned to their organization. This accountability was mentioned as a key factor in building social cohesion and interagency trust.

Conversely, in case study #2, one informant stated, "*...if people or organizations want to work on something outside of the SHNAPP findings they did. So, people did what they wanted.*" The informant goes on to describe a number of efforts that fit NACCHO's definition of

networking, coordination, and cooperation, such as holding quarterly meetings to let other partners know what it was they were working on.

Backbone organization

There were a number of examples in Case Study #1 of the important role a trusted a backbone organization played in forming and maintaining a collaboration. A trusted convener can foster trust in inter-agency relationships, provide administrative support, and help provide direction and organization for the group.

As one example of how a convener provided direction and organization in Case Study #1 is the leadership role the District Coordinating Council provided in developing their District Health Improvement Plan. Their executive committee organized meeting times to convene work groups in each of the identified priority areas. The executive committee then revisited the gaps, resources, and health indicators identified during the CHNA process to better understand the needs of their communities. They continued to meet with community stakeholders to make sure they were interpreting the findings accurately. For instance, they met with the Superintendent's Association which identified mental health as a pressing health priority, which helped to identify appropriate health improvement strategies.

They then collaboratively developed objectives and strategies for each of the identified priorities using time set aside during their regularly scheduled meetings. While the strategy choosing process included discussions on whether there was available funding to support their identified strategies, it was not a driving force in decision making. The informant describes the elements which made this work a success included a predictable meeting schedule, regular attendance, and a convener to guide the process.

In another example, one of the local coalitions in this region describes themselves on their website as, "*a backbone organization that convenes and supports partners in incubating programming that is effective and collective. [We utilize our] history, partnerships and values to respond to new areas that must be addressed collaboratively in order to improve lives in [Our] County.*" Their website goes on to link to 46 organizations with whom they identify as partners.

In Case Study #2, subjects also described how their District Council conducted a health improvement planning process similar to a process outlined in Case Study #1. There were a series of planning meetings, and collaboration on exploring the findings from the SHNAPP with

more focus groups and referencing the data. The difference here is the final health improvement plans published in Case Study #2 region lacked the level of detail as those in Case Study #1.

The major barrier to sustained collaboration in both Case Studies is the seeming lack of evaluation of the outcomes due to lack of support of a backbone type of organization. Additionally, in Case Study #2, there was no mention of how their plans were kept alive past the initial planning phase through any type of follow up or evaluation.

Social

Themes on social networks, cohesion, and mutual trust came up in all interviews as an important part of forming—or in their absence—not forming a collaboration. Informants from Case Study #1 mentioned the importance of learning how partners want to or are able to participate in a project in order to head off potential future conflict. Not all organizations have the same capacity, staff time, skill set or regulatory freedom to contribute in ways their partners may expect. Understanding how such limitations may prohibit an organization's contributions to a collaborative effort was mentioned as important. For example, one hospital was unable to address opioid dependent clients in their emergency department in the way their local coalition would have liked. The hospital did introduce new policies and protocols within their hospital guidelines, yet some partners seemed to have difficulty understanding why the hospital could not do more or follow the protocols the collaboration would have preferred. The informant reports that through frank, open, and respectful conversations, the group came to understand the hospital's restrictions and worked to identify other local organizations that could fill in the gaps in services the hospital was unable to provide in the clinical setting. This is one example of how social cohesion is an important asset in planning and implementation (Ainsworth, 2013). Instead of giving up and disbanding, the group continued discussions to devise a solution that worked for all.

One informant mentioned an example of how a local collaboration built trusting relationships among its membership right at the project launch. The project's initial focus was dedicated to team building and visioning before any discussions on work plans arose. Subsequently, every year, during their annual meeting, they repeat a visioning exercise and review successes and challenges from the previous year.

Other barriers to social trust and cohesion that were mentioned include when participants promote ideas that are not rooted in knowledge about local resources and people. This was mentioned as a source of reluctance to working with outsiders who can be perceived as not understanding the community. Other social challenges that stand in the way of forming a collaboration include not following through on a commitment, the poor impression that is left when asking someone just before a grant deadline to sign onto the effort; inconsistent attendance at meetings; and either too many or the wrong people at the table, especially those with a bias and are unwilling to learn about how or why others do what they do. These types of actions were described as disrespectful to existing efforts, to others in the partnership, or to the value of another's time.

Elements to overcoming social barriers include having partners who want to help whether or not there is financial gain and who participate because they have passion for the work. For instance, an informant in Case Study # 1 stated: *“It’s great to be able to go out and see what others are doing, communicate, and see how we can help. It helps our organization feel a part of the community and hopefully other people feel that way about us.”*

When asked about what happens when projects aren't successful, this same informant reported:

“That happens a lot. It doesn’t ruffle me, frankly we have a lot of things that are not successful in our area for many of the same reasons—we don’t have a lot of services, not a lot of money, not a lot to work with. When we can figure out a way to make something work—that goes a long way to making you feel like, OK, people putting their heads together and collaborating can really make a difference.”

Another example of a barrier to forming a collaboration was how long-held distrust in either inter-agency or inter-personal relationships have led to community partners being unable to move past these feeling to see the benefit of working together. Informants mentioned instances where such barriers were removed with the change in a partner's organizational leadership. New leadership brought a fresh perspective, renewed skills, and removed the interpersonal or interagency conflicts that stood in the way of collaboration.

Social networks, trust and cohesion were not a topic that came up in Case Study #2. As a region, there were few health improvement plans that named partners with whom an organization was going to work with on any priorities or strategies. One health improvement plan didn't name

any community partners at all. When pressed for examples of how hospitals and public health organizations collaborate on their health improvement planning, one respondent noted,

“I think we are aware of each other? We are careful that we don’t go into their swim lane because they are doing it, so we are always very careful about duplication. If there is someone who has always done that work, is funded to do that work, they have a history of doing that work, we just let them do the work and see if there are things we can do to supplement it or promote it, but really we of let them go forth and do it.”

In response to the interview question, “Are there other collaborative organizations [in your region] doing health improvement work?” both subjects for Case Study #1 mentioned the same organization. One informant described how this organization underwent a slow, thoughtful, and methodical strategic planning process with equal input from all partners. As a result, their mission is guided by a strategic plan which guides their work, their decisions, and aides in resolving conflict. According to the informant, the commitment to their strategic plan is also evident in their grant writing practice. They only pursue funding that furthers their mission.

When asked the same question about collaborations within their region, both informants in Case Study # 2 struggled to answer the question. One went on to describe a dearth of organizations within their community with whom they could collaborate on health improvement planning.

Financial

Informants described the complicated role funding plays in how partnerships function to both the benefit and detriment of forming a collaboration.

Case Study # 1 mentioned the importance of a backbone entity to serve as a neutral, respected, and trusted entity to serve as a fiscal agent. As an example, one informant mentioned the same collaboration that spent so much effort on, and continually adheres to, its strategic plan to guide their decisions on grant writing as the reason the community partners trust this organization to apply for grants on their behalf. Partners in this collaboration trust that this backbone organization will use funding opportunities to bring in and coordinate resources and training that benefit all the partners in the region in accordance to the collaboratively developed strategic plan.

In contrast, in Case Study #2, one informant described how funding can work against any level of joint action by creating a competitive environment. The informant went on to say they have observed how competitive members in a partnership have held back their expertise in the hopes of failure for the currently funded partner so they could take their place.

Another financial consideration to the forming of a collaboration was partner organization's **tolerance for risk**. As mentioned earlier, without the support of their organizational leadership, staff would not be able to spend time participating on local committees. Financially, if an organization, or their grant funders, do not allow for a portion of staff time to be used for any extraneous activities, they could be found in violation of their employer's or funder's guidelines and risk financial consequences. As an example, one informant laid out how each of their grants fund specific portions of each staff person's time, and that none of their grants allow for any flexibility in how a staff member can use grant supported the time. It was explained that this type of staffing allocation breeds fear of committing, especially if an organization is stretched thin and feels committing staff time could jeopardize their ability to fulfill their contractual obligations. Both informants mentioned that in order to commit to participating in any type of partnership, they needed a high level of confidence something is going to come of the effort, and a clear picture of how the collaboration can help them reach their funded objectives. If an organization's leadership is unwilling to risk potential failure or unable to mitigate FTE restrictions with organizational financial support, collaboration was viewed as impossible.

This conundrum was echoed by one informant who said, "*You know what they (hospitals) are going to work on even before the CHNA process is complete because they are going to work on whatever they are funded for.*"

Neither subject in Case Study #1 mentioned this type of constraint as a reason not to collaborate. One informant said, "*We're a community that is rural, mostly poor, with limited resources, so we really truly value what other organizations are doing because no one organization can do it [work on these issues] alone.*" Neither subject mentioned competition for funding. They did mention a high level of confidence the collaborations in which they were a part of could help them reach their own organizational objectives.

Each informant in Case Study #1 mentioned that financial resources do not have to be in the form of dollar contributions. Instead they described collaborations that succeeded had the assistance of trusted, socially connected, and skilled staff who acted as leaders and conveners to

align organizational resources already being expended to address a common need. As one informant put it, *“it is not about the infrastructure or the level of wealth in a region or the state.”*

For instance, in Case Study #1 there were a number of collaborative efforts where partners pooled organizational resources that were already being expended to address a shared mission. One example is the collaborative effort between a food pantry and a special needs organization to deliver food to vulnerable members of the community following a model similar to Meals on Wheels. Both of these organizations wanted to contribute to the health and wellbeing of their community. Both were already committing resources to fulfill their own work plan, so combining their efforts did not increase their expenditures. In the end, the special needs organization used their clients and their transportation vans to deliver food from the food pantry to their clients who were unable to travel to them to pick up food.

Another collaborative is attempting to break the cycle of poverty by helping single moms get their GED, associate’s degree, or transition to college. While caregivers attend classes, the program enrolls their dependents in early childhood education sessions. Collaboration partners contribute existing organizational resources such as car repair (to ensure participants have a reliable personal vehicle), educational sessions on household budgeting, or Career Centers and educational institutions support participants in enrolling for any benefits for which they may be eligible. These wrap-around services were in response to assessing barriers and finding evidence-based strategies to move families out of generational poverty that collectively are necessary and could not be provided without collaboration.

A financial barrier to forming sustainable collaborations identified by all informants were inconsistent funding streams and lack of sustainability planning. For example, when partners within a collaboration were asked to continue working on initiatives beyond a funding cycle it was met with resistance. There had been no discussion of this expectation at any point in the planning process. Without a long-term understanding of how to sustain the effort partners were unwilling to continue to work on initiatives for free for which they were once paid. When pressed for examples of sustainability beyond funding, the subject mentioned using the funding period to institutionalize work flows, or to change a policy should a funded initiative prove to be successful, Short funding cycles do not give partners enough time to demonstrate a project’s viability and address sustainability. Short-term projects without a sustainability plan was also

tied to an organization's tolerance of risk. Innovative projects and pilot programs do not always work the first time and leadership needs to have some level of tolerance for failure.

Influence of the SHNAPP

Informants identified or discussed how the SHNAPP influenced their health improvement planning and implementation in discrete yet influential ways. For instance, all informants mentioned the SHNAPP brought people to the table who may not normally be there. All informants also reported increased conversation about commonly identified health priorities and identified gaps where the community could then work together to fill. It was also mentioned the important role the SHNAPP forums and events played in starting community conversations that helped people understand what the issues were, what could be done to treat and prevent health problems, and to raise awareness of each community member's role in addressing public health concerns. Finally, they each report that the SHNAPP consolidated data, as well as information on community level resources, gaps, and needs in one triennial assessment effort as opposed to having many siloed overlapping efforts. Having data compiled in reports for future reference was considered one of the greatest benefits of the SHNAPP. One informant stated that having this data resource available has increased the demand for, and use of, data in driving their planning.

V. Discussion

It is clear that each informant and their respective organizations are working to the best of their abilities to address the health needs of the communities in which they serve. While neither case study demonstrated the same scale of collaboration on health improvement planning as that of conducting SHNAPP activities, there are many contrasts between the case studies in their level of readiness to do so.

Case Study #1 has strong local examples of collaboration with strong engagement from the community. Informants reported institutional leadership and support that then helped to guide and instruct, as well as hold staff accountable for planning efforts. In Case Study #2, this seemed to be lacking as evidenced by reports that some partners did not feel the need to base their health improvement planning on the outcomes of the assessment effort.

In Case Study #2, informants struggled to name examples of collaborative organizations within their region. There was a lack social cohesion either due to lack of other organization with

whom to partner, or even a reference to organizational competition for funding. There also seemed to be some financial barriers in the description of the inability to commit staff time beyond what they were funded to do.

In both case studies, the focus on filling gaps that were identified through the SHNAPP when developing a district health improvement plan risks putting partnerships on a course away from being able to form a true collaboration as defined by NACCHO (e.g., working jointly to accomplish shared vision and mission using joint resources). Filling gaps is an isolated initiative and is not visionary in the sense it does not coalesce a group around an understanding of what it is they are working towards. This lack of vision could make it challenging for leadership to know what it is they are supporting in the long run, since filling a gap can be a short term effort.

The existence of a trusted local backbone organization was central to the existence or lack of existence of collaborative initiatives in both these regions. In Case Study #2, one informant mentioned the influence the HMPs had on the SHNAPP process and the planning and implementation that followed. This informant mentioned there used to be dedicated staff whose HMP contract allowed them to participate in SHNAPP activities. Without an HMP funded position, the FTEs for the current staff were fully allocated to work on other grants, and they were reluctant to spend time on non-grant funded activities for fear of violating their funding contracts. In addition, their organization did not financially support the remaining staff time to back fill the time once paid for by the HMP to participate in community coalitions at the same level as the previous staff person.

Even with the support of local backbone organizations, one informant in Case Study #1 mentioned the lack of an accredited, accountable, local or district-wide public health infrastructure as a challenge. According to 22 M.R.S. §412 (2011) coordination of public health infrastructure components include local health offices, Healthy Maine Partnerships (HMP), District public health units, District Coordinating Councils for public health, municipal and tribal health departments, and a Statewide Coordinating Council for public health. The Healthy Maine Partnerships, which are no longer in existence, were to,

“...provide appropriate essential public health services at the local level, including coordinated community-based public health promotion, active community engagement in local, district and state public health priorities and standardized community-based health assessment, that inform and link to districtwide and statewide public health system activities....The department and other appropriate state agencies shall provide funds as available to coalitions in

Healthy Maine Partnerships that meet measurable criteria as set by the department for comprehensive community health coalitions.”

Currently, the district coordinating councils for public health are the primary partner in conducting the shared health needs assessments. According to 22 M.R.S. §412 (4)(A), (1,4) (2011) the district coordinating council for public health “*shall participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and ensure that the essential public health services and resources are provided for in each district in the most efficient, effective, and evidence-based manner possible.*”

District Coordinating Councils are essentially intended to hold partners accountable. It is not their charge to promote active community engagement to conduct local assessment and planning activities that link to district and state plans, nor to receive and expend funds which meet measurable guidelines. One informant stated, it is a challenge to collaborate with a potential partner who is not held to the same level of accountability, nor have comparable resources to share. The absence of backbone organizations that are held accountable and do have resources to share have left some regions, like in Case Study #2, challenged to be able to form collaborations.

Finally, it should be noted that despite the high level of readiness in Case Study #1’s region, there was still a challenge mentioned in the parallel planning processes undertaken by the District Coordinating Council and the local hospital’s planning efforts. Despite providing input on district work and presenting opportunities for collaboration to the hospitals, the informant reports the hospitals, “*came up with their own plans.*” Whether this was due to lack of leadership support, or whether hospitals were not able to tolerate risk in partnering in new ways, or were being driven by the need to fulfil their organizations strategic plans is still unclear. In order to determine the exact reason, further interviews would be needed with hospital informants.

VI. Recommendations

Maine is a national leader in conducting collaborative public-private shared health assessments. Because of this, Maine is well poised to take advantage of the social cohesion fostered by the CHNA to move towards collaborative public-private health improvement planning at the local, county, regional, and state level. Yet, based on this review of two Districts’ planning efforts post CHNA assessments, it appears Maine lacks a systematic process for

addressing population health needs, consistent leadership support for such a process, and an infrastructure to oversee these efforts at the local level.

In 2010, the Institute of Medicine (IOM) was asked by the Centers for Disease Control and Prevention and the Health Resources and Services Administration to convene a committee to study how they could work collectively to improve the public's health by integrating primary care and public health. In short, the IOM reported that they found a common set of principles for the successful integration of primary care and public health:

- A shared goal of population health improvement;
- Community engagement in defining and addressing population health needs;
- Aligned leadership that:
 - bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity.
 - clarifies roles and ensures accountability.
 - develops and supports appropriate incentives.
 - has the capacity to manage change.
- Sustainability, key to which is the establishment of a shared infrastructure and building for enduring value and impact;
- The sharing and collaborative use of data and analysis. (IOM, 2012)

Some of these principles are already in place through the efforts of the Maine Shared CHNA. That is to say, the Maine shared CHNA has a shared and collaboratively developed set of health indicators that is used to conduct a community engagement process to define population health needs. What follows is a list of recommendations based on the IOM principals, NACCHO's definition of collaboration, and the examples of collaborations discussed by interview subjects.

Recommendation #1: Develop a shared vision between hospital and public health leaders of what a public health and hospital collaboration is intended to achieve and a mission that would guide staff at all levels of their respective organizations on how to achieve that vision. This is both an IOM recommendation and an example of what is working to keep a collaboration together in the Case Study #1 region. A shared vision supports the alignment of resources from multi-sector collaborative in order to realize collective impact.

Recommendation #2: Create an approach for health improvement planning that is as robust as the Maine Shared CHNA assessment, with a timeline, methodology, and a set of defined

deliverables. The Maine Shared CHNA has experience at performing as a statewide collaborative. Building on that experience could prove instructive. One direction this approach could take is to integrate the identified local health priorities, objectives, and strategies into one regional strategic plan that then delineates each partner's roles and responsibilities, and a commitment to integrate those assigned roles into each organization's strategic plan. Not only would this framework help a collaboration stay on task and be able to hold members accountable, it would help alleviate tension that can arise during decision making on potential grant writing opportunities. Common strategic plans also make it easier to evaluate progress and share findings with constituents, as was demonstrated in one of the collaborations in Case Study #1.

Recommendation #3: Identify local backbone organizations, or create ones, that could act as a convener for both assessment efforts and planning and implementation efforts. Local backbone organizations provide the needed structure and organization to sustain relationships. They also ensure the social cohesion formed during CHNAs are sustained into planning and implementation. Local backbone organizations could also be responsible for ensuring that the collaborative efforts envisioned by their leaders were vertically aligned and dispersed from CEOs and Directors, to Presidents, Steering Committee, Program Manager on down into their communities.

Local backbone organizations set predictable meeting schedules, encourage regular attendance, and guide the planning process. Local backbone organizations would also be responsible for recruitment and retention of collaboration partners to ensure a robust representation of the appropriate organizations. A portion of the staff at these local backbone organizations would need to be funded outside of grant funding in order to provide them with the latitude to participate in local committees and collaborations. A good convener should also demonstrate perseverance and resilience in the face of adversity. In order to ensure statewide cohesion, these local backbone organizations would need a process expert who could maintain focus and help to support meeting design, facilitation, and accountability.

Backbone organizations would also act as conveners for local strategic planning. These efforts would result in locally developed strategic plans which include measurable outcomes, short and long-term objectives, strategies, and name partner roles and expectations. These partners could then weave these roles and responsibilities and measurements into their own

respective strategic plans in order to ensure their respective leaders understand how their resources are expended and to hold each other accountable.

Finally, local backbone organizations are the ideal place in which to develop interventions and foster innovation. One example from the IOM report is the Durham, North Carolina Health Innovations project. Working at the neighborhood level, 10 local planning teams were funded to develop new ways to address locally identified health needs. Each team included clinicians and public health staff and an oversight committee. Locations for implementation planning were chosen based on readiness for change and whether they were likely to benefit from the initiative.

Recommendation #4: Create a charter modeled after the Maine Shared CHNA's charter outlining rules for designing and planning. This type of document should be developed by leadership and used to guide and instruct local planning collaborations and outline roles and responsibilities. Such a charter could provide guidance on how to align strategies to health needs, suggested resources to look to for evidence-based strategies, as well as guidelines and suggestions for determining whether a strategy and the community 'fit' together. Lastly, a charter would provide guidance on a decision-making process at all levels of the collaboration. The IOM report refers to such a document as *Principles of Community Engagement*. Such a document helps to coordinate assets, leverage existing resources in order to achieve the Triple Aim (improve patient experience, population health, and lower cost of care).

Recommendation #5: The IOM report suggests that the leadership incorporate change management into any new process for conducting health improvement planning and implementation. This could include public health workforce development and training, sustainability, and succession planning. In looking back on the barriers informants mentioned, public health work force development should include training for non-clinical partners on the laws, guidelines, rules, and regulations and reporting requirements for healthcare and clinical settings. For instance, as part of the curriculum at George Washington School of Public Health and Health Services, students must work in a clinical health care setting. Conversely, training for healthcare should include information on assets and resources public health partners can provide, especially in addressing a patients' Social Determinants of Health. One example of this from the IOM report is the REACH-Futures program in Chicago. Working with Community Health Outreach Workers who were trained in public health, registered nurses embarked on a home visiting program to recruit young mothers in order to reduce infant mortality. Another example

includes the Primary Care Leadership Track at Duke University School of Medicine where part of physician training includes causes of the Social Determinants of Health and a focus on quality improvement to better meet patient needs. (IOM, 2012, page 58) There would also need to be an orientation on any documents or agreements which were developed in forming this new process. Finally, sustainability planning should become an ongoing element to shore up against changes in leadership and funding streams. As was noted, new leadership can be considered an opportunity to think strategically about filling vacancies with staff that have the necessary skills and sensitivities necessary to keep a collaboration going.

Recommendation # 6: The IOM suggests a collaboration should research, develop and support incentives for collaboration at the local, district and state level. For instance, are there billing codes that primary care providers can use for prescribing preventative care? Are there medical training modules for which Continuing Medical Education credits could be awarded for attending trainings on the availability of local prevention services? Are there ways local public health organizations could facilitate the extension of the delivery of primary care services into the community? Are there a high number of patients with costly chronic diseases for whom local agencies, governments, or non-profits could support outside of the clinical setting that could ultimately reduce the financial burden on the health system? (IOM, 2012, pages 127-128) Incentives could also be in the form of supporting innovation and the willingness for local groups to pilot programs. As one collaboration in Case Study #1 stated, they, “...*support(s) partners in incubating programming that is effective and collective. [We utilize our] history, partnerships and values to respond to new areas that must be addressed collaboratively in order to improve lives in [our] County.*” As another informant noted, when those innovative ideas work out, it incentivizes the whole community with new energy to continue collaborating.

Recommendation #7: While the Maine Shared CHNA has a robust set of indicators, the IOM report suggests using the health information derived from electronic health records in order to solidify the bridge between clinical outcomes and population health initiatives. (IOM, 2012, pages 130-137). The current Maine Shared CHNA set of indicators are updated every three years and are largely dependent upon self-reported behaviors. As Maine moves toward realizing meaningful use of the data collected through electronic health records, the Maine Shared CHNA should continue to explore how to incorporate this data.

VII. Conclusion

There are a number of public health improvement initiatives that are being conducted by dedicated, passionate public health staff and clinical population staff. Much of this work is being done in isolation without clear connections to how these isolated efforts fit into making Maine the healthiest state in the nation. This is putting Maine at risk of not realizing the full collective impact in addressing some of Maine's most pressing health issues. There are a number of identified challenges and barriers, none of which are permanent conditions, and many are not costly to remedy. The Maine Shared CHNA was a visionary project for Maine. With the structure and systems this project has developed, Maine is ready to consider what's next.

Limitations

At the time the 2016 Health Improvement plans were under development, there was a large shift in the public health delivery system underway. The LePage administration was in the process of replacing the Healthy Maine Partnerships with Maine Prevention Services through a competitive grant process. The Maine CDC sought to increase the capacity of the District Coordinating Councils to deliver essential public health services by yet another competitive grant process for agencies to provide Council Administration. In addition, Councils were provided with \$60,000 in funding and instructed to collaboratively decide how to distribute the funds within the community to support their District Health Improvement Plans with little guidance, experience, training, or support on how to make these decisions. Understanding the operational impacts from these forces of change is beyond the scope of this project. Due to these circumstances, results of this research should be interpreted with caution. For instance, it is unclear whether the lack of comprehensive descriptions in the 2016 Health Improvement plans was due to a lack of collaboration, or the result of the loss of skilled staff to draft well-written plans. There is a wide range in the level of detail included in those plans which, as a result, may under represent the levels of joint action actually taken.

The small number of key informant interviews conducted for this project represents another limitation. Collaborations are complex. Ideally it would be most beneficial to interview a number of informants from various partnering agencies to get a full picture of how they operate. With the limited number of informants, and a lack of capacity to delve further into both hospital and district health improvement plans, there is a strong possibility that county or district-wide

collaboratives may exist. If they do, they are not prominently displayed in their hospital implementation strategies or district plans.

Further Study

As mentioned, one informant stated attempts to integrate district health improvement plans with the hospital implementation strategies under development at the same time were unsuccessful. Further study is needed to understand the hospital health improvement planning process and its relationship to the District Health Improvement planning. The 2015-2016 community engagement and planning process was very different than the 2018-2019 community engagement and planning process for several reasons. The current field has greater experience and more stability than in the past. Despite this stability in the field, the State of Maine has postponed developing District Health Improvement Plans until 2020 while the new administration considers future direction and awaits its new Director of the Maine CDC. It is yet to be seen whether the future process for developing District Health Improvement Plans and the State Health Improvement Plan will attempt to be integrated with hospital implementation strategies currently being developed.

Appendix A: References

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Appendix B: Listing of Public health districts and non-profit hospitals in Maine

Table 2: Public Health Districts and Hospitals	
Public Health Districts	Non-Profit Acute Care Hospitals
District 1, York	
York County	Southern Maine Health Care, MaineHealth, Biddeford York Hospital, York
District 2: Cumberland	
Cumberland County	Bridgton Hospital, Central Maine HealthCare, Bridgton ⁺ Maine Medical Center, MaineHealth, Portland Northern Light Mercy Hospital, Portland
District 3, Western	
Androscoggin County	Central Maine Medical Center, Central Maine HealthCare, Lewiston St. Mary's Regional Medical Center, Lewiston
Oxford County	Rumford Hospital, Central Maine HealthCare, Rumford ⁺ Stephens Memorial Hospital, MaineHealth, Norway ⁺
Franklin County	Franklin Memorial Hospital, MaineHealth, Farmington
District 4, Mid Coast	
Sagadahoc County	Mid Coast Hospital, Brunswick
Lincoln County	LincolnHealth, MaineHealth, Damariscotta ⁺
Waldo County	Waldo County General Hospital, MaineHealth, Belfast ⁺
Knox County	Pen Bay Medical Center, MaineHealth, Rockport
District 5, Central	
Kennebec County	MaineGeneral Health, Augusta Northern Light Inland Hospital, Waterville
Somerset County	Redington-Fairview General Hospital, Skowhegan ⁺ Northern Light Sebasticook Valley Hospital, Pittsfield ⁺
District 6, Penquis	
Penobscot County	Millinocket Regional Hospital ⁺ Northern Light Eastern Maine Medical Center, Bangor Penobscot Valley Hospital, Lincoln ⁺ St. Joseph Hospital, Bangor
Piscataquis County	Mayo Regional Hospital, Dover-Foxcroft ⁺ Northern Light CA Dean Memorial Hospital, Greenville ⁺
District 7, Downeast	
Washington	Calais Regional Hospital, Calais ⁺ Down East Community Hospital, Machias ⁺
Hancock County	Mount Desert Island Hospital, Bar Harbor ⁺ Northern Light Blue Hill Hospital, Blue Hill ⁺ Northern Light Maine Coast Hospital, Ellsworth
District 8, Aroostook	
Aroostook County	Cary Medical Center, Caribou Houlton Regional Hospital, Houlton ⁺ Northern Light AR Gould Hospital, Presque Isle Northern Maine Medical Center, Ft. Kent
District 9, Tribal	
Aroostook, Penobscot, and Washington Counties	This is a population-based district. See individual counties for hospital listings.

⁺Critical Access Hospitals

Appendix C: Protection of Human Subjects

Protocol HRPP # 022219-29

TO: Joanna Morrissey and Andrew Coburn FROM: Tina Aubut DATE: Monday, February 25, 2019

RE: Click or tap here to enter text. Notice of Evaluation- Not Research 45 CFR 46.102 (d)

The Office of Research Integrity and Outreach (ORIO) has evaluated the information provided in the Request for Determination of Research Involving Human Subjects form and subsequent correspondence. Based on the information you have provided it has been determined that the activity is not designed to develop or contribute to generalizable knowledge. Our understanding is that you intend to conduct interviews to determine whether the Maine Shared Community Health Needs Assessment has fostered community collaborations. You do not intend to generalize your findings. If this is not accurate, please contact us immediately. This activity is not a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge; it does not fall under the definition of research as described in 45 CFR Sect. 46.102(d), and therefore does not require further review or determination.

The Office of Research Integrity and Outreach (ORIO) and the USM Institutional Review Board appreciate your efforts to conduct research in compliance with federal regulations that have been established to protect human subjects in research.

Please consult with the ORIO whenever questions arise about whether planned changes to the activity might qualify the activity as research involving human subjects. If you have any questions please feel free to contact us at 207-780-4517 or by email at usmorio@maine.edu.

Date of Determination: 2/25/2019

Sincerely,

Tina Aubut
Administrative Specialist
Office of Research Integrity and Outreach

Appendix D: Interview Protocol

Recruitment emails were sent to four subjects (two for County #1 and two for County #2) between March 13 and 18, the body of which stated:

Subject line: Request for Interview

Dear [],

My name is Jo Morrissey. I am currently the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) Program Manager. I am also an MPH candidate with the Muskie School of Public Service working on my Capstone project—the final step before earning my degree.

I am conducting research for my Capstone to determine if and how Maine Shared CHNA Community Engagement partnerships have made the bridge from collaborating on assessment activities to also collaborating on planning and implementation activities.

It is also the intent of this research to learn about any challenges or barriers to collaboration on planning and implementation activities, and if there were, how those were resolved—or not.

I am writing to you because your local public health improvement plan indicates you are partnering to work on plans developed after the 2015 the Maine Shared CHNA process (then known as the Shared Health Needs Assessment and Planning Process).

Would you be willing to set up a time to discuss how partnering on health improvement planning and implementation has gone over the last few years? If appropriate we could also discuss how your current planning is going. This interview will take approximately 45 minutes to one hour.

These interviews solely pertain to my Capstone and have no impact on the relationship you, your organization, or your partnerships have with the Maine Shared CHNA. That said, should anything I learn from my research be valuable to share, I do intend to do so. Neither your name nor your organization will be identified in any products related to this Capstone.

If this is something you are willing and able to participate in, please respond with two options from the times listed in the table below.

Muskie School of Public Service

Sincerely,

Jo Morrissey
MPH Candidate, Muskie School of Public Service

There were two different protocols developed, one for a suspected collaboration, and one for a suspected partnership. Each interview included specific questions on each subjects' health improvement plan as well in order to garner specific examples.

Case Study # 1 Interview Questions

- 1.) Thinking back to when you were beginning to formulate your plans in 2016, how did you and the other organizations in [____] County go about choosing priorities and strategies?

(Prompt): Did the statewide effort to collaborate on Maine Shared CHNA assessment activities impact how organizations within your county went about health improvement planning?

(Prompt): How did you decide which strategies to work on in partnership with other organizations?

- 2.) I see from reviewing the presentation from the 2018 CHNA forums

(Prompt) It must have been pretty hard to get everyone to agree how this was going to work.

(follow up: ask about barriers or why they think things went so smoothly)

- 3.) I also notice that there seems to be a lot of partners working together to improve...

Can you tell me this work? How's it going expanding the [*local initiative*]?

(Follow up) ask about barriers or why they think things went so smoothly

- 4.) The last accomplishment I want to ask you about is the work being done by with the [*community coalition*] around ...

Can you tell me more about this work?

(Prompt): Have there been any challenges in reaching consensus? If so, how did the group overcome these challenges? If not, what made it go so smoothly?

- 5.) In reflecting back at those three examples of collaborative work in [____] County, what you think brings all those other organizations to the table?

(Prompt): What are the benefits for those who continue to work together?

- 6.) Are there other collaborations doing health improvement work in [____] County?

(Prompt) If so, who brings all those organizations together?

(Prompt): How does [this entity] function? (ie: How are meeting agendas, minutes, or other records produced, meetings scheduled?)

(Prompt): How does [this entity] keep track of decisions?

- 7.) Stepping back a bit and looking at the big picture, what are one or two things you that are key to forming and keeping collaborations working together?
- 8.) What do you enjoy most about being a part of these collaborations?
- 9.) What has been the greatest challenge for working collaboratively?
- 10.) Is there anyone else in your area you think I should talk to about the collaborative work they are doing?

Case study #2 Interview Questions

- 1.) Thinking back to when you were beginning to formulate your plans in 2016, how did you and the other organizations in [_____] County go about choosing priorities?

(Prompt): Did the statewide effort to collaborate on Maine Shared CHNA assessment activities impact how organizations within your county went about creating their health improvement plans?

(Prompt): How did the [_____] District Coordinating Council choose which strategies to include in their Health Improvement Plan?

- 2.) I see from reviewing the presentation from the 2018 CHNA forums the priorities chosen throughout [_____] County included []. Of those everyone is working on [].
 - a. What do you think are the biggest accomplishments in addressing [] in [_____] County?
 - b. What do you think are some of the biggest barriers in addressing [] in [_____] County?
 - c. Are there any underlying drivers for [] in [_____] County that are too large for one organization to tackle alone?

(follow up: have there been any conversations on how to partner to address those bigger issues?)

- 3.) I also notice that the PowerPoint from the 2018 CHNA forums mentions [*all the hospitals and the District*] are all working on strategies and activities to address []. Are there other organizations in [_____] County who may also be working on improving []?

(Prompt): Are there many organizations who have similar interests?

(follow up): has there been any effort to collaborate with any of these organizations on any health improvement strategies? If so, how'd it go?

- 11.) In looking back at the common priorities being addressed through the health improvement plans in [_____] County, how would you describe the communication between the hospitals and the district coordinating council on how things are going?
- 12.) In reflecting back at those two examples of work being done in [_____] County, why do you think there aren't more organizations coming to the table to address some of the common concerns?
- 13.) Are there other collaborations outside of the [*identified coalition*] doing health improvement work in [_____] County?
 - (Prompt) If so, who brings all those organizations together?
 - (Prompt): How does [this entity] function? (ie: How are meeting agendas, minutes, or other records produced, meetings scheduled?)
 - (Prompt): How does [this entity] keep track of decisions?
- 14.) In your opinion, what are some of the potential benefits of working with other organizations?
- 15.) Stepping back a bit and looking at the big picture, what are one or two things you think are key to forming and keeping collaborations working together?
- 16.) What do you think are the greatest challenges to forming and keeping collaborations working together?

Appendix E: Integration of knowledge and professional goals

MPH 525 American Health Systems

- Describe and assess the organizations of health care and public health in the U.S.
- Discuss the contributions of the medical and public health systems to overall health

MPH 565 Social and Behavioral Health

- Describe the determinants of population health
- Demonstrate team building
- Apply evidence-based practices to public health
- Effectively deliver an oral presentation
- Develop a program theory or logic model
- Write measurable objectives

MPH 650 Applied Public Health Research and Evaluation

- Develop data collection tools
- Select quantitative and qualitative data collection methods appropriate for a given public health context
- Interpret results of data analysis for public health research, policy or practice
- Propose strategies to identify stakeholders and build coalitions/partnerships for influencing public health outcomes
- Apply principles of leadership, governance, management (e.g., creating vision, fostering collaboration)
- Select communication strategies for different audiences and sectors
- Communicate audience-appropriate public health content, both in writing and through oral presentation
- Perform effectively on inter-professional teams

MPH 655 Public Health Practice

- Discuss important aspects of leadership based on experiences of key public health leaders

MPH 660 Health Policy

- Identify key stakeholders in health policy and their role in influencing the policy process
- Analyze health and public health policies, assess their potential impact using evidence, and articulate the strength of the evidence base

MPH 681

- Research and evaluate current trends in policy, delivery systems, interventions, and treatment in the field of behavioral health.
- Demonstrate effective written and oral communication skills through evidence-informed discussions of behavioral health policies.