PLACEMATTERS

Community Centered Funding Models for Maine

An exploration of literature and frameworks for local community-driven funding strategies to improve Maine's public health outcomes

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THE BINGHAM PROGRAM

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- → Improve relationships and communication between health-related state funding and collaboratives active in communities.
- → Strengthen peer-to-peer networks and develop more communities of learning.
- → More flexible public and private funding with reliable backbone, data, and capacity supports.
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Introduction

Maine has a history of local collaboration and collective efforts to address public health challenges and there are many local and regional efforts active today.[i] However, the ability of these collaboratives and organizations to effectively address unmet needs, deliver services, evaluate impact, and overcome systemic inequities that impact public health is limited in scope. These efforts are not equitably distributed statewide, and often lack sufficient, sustainable funding and capacity. In the last 5 years, many of these inequities have come to light as a result of the COVID-19 pandemic and associated federal, state, and local response. More recent research in Maine reveals widening gaps in the state's healthcare and behavioral health systems as well as critical challenges impacting the health and wellbeing of local communities. These challenges include a shortage of affordable housing, limited access to transportation, and a lack of educational and employment opportunities.[ii] There is strong evidence that these challenges disproportionately impact Maine's rural communities and historically marginalized populations.[1] Community-driven and participatory decision-making combined with a strong regional support network can help alleviate some of these inequities by shifting power to communities who are typically left out of conversations and decisions.[2]

Existing community-based organizations in Maine have the potential to bring in significant funds and to make optimal use of them. They have the capacity to catalyze effective community health interventions and ensure a steady flow of funds from a variety of public and private sources. In addition, the distribution of federal funds to local governments, particularly in response to crises such the COVID-19 pandemic and opioid epidemic, has highlighted both the strengths and limitations of Maine's current localized models. There is an opportunity to invest consistently and adequately in the capacity of these organizations to improve health outcomes across the state.

These recent events and circumstances have inspired a coalition of partners to join in efforts to explore, research, and design a more localized community funding model for Maine. They aim to strengthen local, multi-sector partnerships and collaborations across the state and bring more funding directly to communities to meet their public health needs. To support this effort, this project explored community participatory and local funding models and opportunities. It also examined the missed opportunities caused by underinvesting in local organizations that fill critical public health roles in the state. This review compared Maine's approach and allocation of funds with other states and explored alternative models and methods with the potential to increase the efficacy of public health investments in Maine. It revealed commonsense measures and investment opportunities for leaders and philanthropies to contribute to a healthier future for communities and people across Maine.

i For example, the current public health district councils, the Maine West partnership, and Healthy Acadia.

ii The Place Matters report series has multiple reports on these topic areas. Visit https://placemattersmaine.org/research-resources/

Methods

The goal of this report was to develop recommendations for how to more effectively center community health needs in local and regional decision making. To develop these recommendations, we explored local and national models, held key informant interviews, and investigated recent experiences with large funding opportunities.

To answer these questions, the Place Matters team at the University of Southern Maine conducted a literature review of secondary research and publicly available data and completed five key informant interviews with leaders in local public health, community collaboration, and direct service organizations. All data collection activities were completed between September and December 2024. The team summarized and coded findings from the literature review and interviews to identify major themes.

The primary research questions included:

1. **What localized or participatory funding models exist that might serve as a framework for Maine?**
2. **What are the benefits and challenges associated with county-level or other local decision-making infrastructures?**
3. **How has Maine handled recent major funding opportunities (such as American Rescue Plan Act) and what can be learned to improve future outcomes?**

LIMITATIONS OF THIS RESEARCH AND REPORT

This research was exploratory and focused on examining publicly available secondary research and conducting a small number of interviews. The qualitative nature of this research and the small sample size limit our ability to draw population-level conclusions. The themes in the interviews are not representative of all communities or locations in Maine. The findings in this report are meant to inform future research, policy, and strategy development.

Background

A Review of the Literature: Frameworks for Effective Community-Led Funding

Research from around the globe shows that enabling communities to lead their own way to health and wellbeing, as opposed to more traditional top-down approaches, has many benefits to funders and to the communities in which they work.[3] When done well, community-led funding can generate important benefits including strengthened relationships, opportunities for collaboration between other organizations, community knowledge about the grantmaking process, flexibility, innovation, and increased transparency between communities and the funders investing in them.[4] Further, community-centric, place-based models can address inequities and ensure funding and resources are responsive to the most relevant needs for all community members.[5]

PLACE-BASED FUNDING MODELS HELP TO ADDRESS INEQUITIES

Place-based philanthropy recognizes the importance of contributing and connecting to specific geographic locations to address systemic and historical inequities that are rooted in those places. Place-based funding focuses on a specific geographic boundary such as a neighborhood, city, or region. It is an investment in that place that includes long-term collaboration with partners across systems.[6]

There is strong potential for a place-based collaborative, if sustainably resourced, to serve as the backbone of community wellbeing and self-determination. In addition to the resources required to ensure ongoing collaborative capacity, decision makers and funders must cede some level of control to local organizations to achieve the gold standard in place-based collective stewardship: **community ownership.**[7] In order to make this happen, philanthropic actors must "trust the know-what and the know-how" of the local organizations taking responsibility for place-based engagement and collaboration work.[8]

Six Essential Activities of Backbone Organizations[iii, 9]

1. Guide vision and strategy
2. Support aligned activities
3. Establish shared measurement practices
4. Advance policy
5. Build public will
6. Mobilize funding

iii For more information visit https://collectiveimpactforum.org.

PARTICIPATORY GRANT MAKING GIVES COMMUNITIES DECISION-MAKING POWER IN RESOURCE ALLOCATION

The Participatory Grant Making (PGM) framework, also known as decentralized or community-centric philanthropy, shows promise in including communities in decisions about how philanthropic funding is spent, echoing the common refrain, "Nothing about us without us."[10] PGM is an innovative approach that can be used to promote incremental or radical change, includes creative processes, applies new approaches to the social sector, and is, by design, user- or client-driven.[11]

Participatory Grant Making

A theory and process that shifts decision-making power about grants, including the design, the criteria, and the award selection, to the people and communities that are most directly impacted. PGM has been defined as both an "ethos and a process that places the communities a foundation aims to serve at the center."[12]

PGM models can be practiced in different ways to meet the needs of funders and the communities they serve but often involve varying levels of community members as "peers" on foundation boards, as foundation staff, on peer-review panels and selection committees, and as a part of the evaluation process for grantees. An important consideration is the level of decision-making power given to peers. With legitimate power, peers are truly in a position to make decisions and foundations avoid tokenism.[13, 14, 15] When fully realized in this way, PGM brings resources where they will be most effective and at the same time builds leadership capacity in the community, utilizes the diverse experiences and skills of community members, creates connections between community members and funders, and can help to navigate potential challenging community dynamics.[16]

While reviews of PGM implementations have shown many benefits, they have also unearthed several potential challenges. A key challenge is the shift in prioritization of efficiencies to trust and relationships. While PGM processes take more time and resources to do well, they also generate additional value for everyone involved, including connections, philanthropic fluency, and leadership building, which have a greater payoff in the longer term.[17] Other challenges include complex logistics, conflicts of interests among decision-makers, managing diverse income streams, building representative decision-making bodies, and bias in the decision-making process.[18, 19] The experiences of PGM practitioners have highlighted recommendations in process, cohort selection, and program development that address the challenges involved with shifting toward full-practice PGM. These include recommendations such as transparency in processes, acknowledgement of power imbalances, intentional inclusion of diverse communities, and clear intentions.[20] PGM programs have been expanding in recent decades and there is wide agreement that when implemented well, they offer strong benefits and function as an effective intermediary between organizations implementing work on the ground and funders.

INTERMEDIARY REGIONAL HUBS PROVIDE COLLABORATION AND CONNECTION TO LARGER SYSTEMS OF SUPPORT

Regional hubs play a key role in connecting local departments, community organizations, and service providers with regional and statewide networks of support. **Rural Development Hubs**[21] are place-based organizations that function as an **intermediary or backbone** in a region. This model focuses on inclusive resource allocation and systemic impact in rural communities and offers a framework for effective collaboration and coordination of resources. Rural Development Hubs provide a variety of services while also connecting with and voicing local needs to state and federal agencies, foundations, and other larger systemic decision-making bodies.[22] Hubs are committed to designing effective, long-term, systemic solutions to community challenges. They facilitate local collaboration between partners working together to address challenges, resource community needs, and transform systems to improve health, well-being, and opportunities for thriving.

While Hubs can be vital to effective regional work, there are many challenges that prevent more communities from participating in regional hubs: the lack of a business model/ blueprint for hubs, the need for leaders with specific sets of skills, community resistance to change, and histories of systemic oppression. Additionally, a key challenge is the lack of funding directed specifically at building capacity and supporting the backbone work of collaborations. [23] Research suggests that for a hub to be effective it must focus on the region and facilitating dialogues, bridging issues and silos, and building trust. Effective hubs also create structures and systems of support and act as innovators, who analyze systems to identify gaps, tolerate risk, and hold themselves and the communities they serve accountable. [24]

COUNTY-LEVEL INFRASTRUCTURES LOCALIZE DECISION-MAKING

Public health systems are structured differently across the country and rely on a "fragmented assortment of individual agencies, states, and communities to develop strategies … and to identify and deploy the resources necessary to accomplish them."[25] While more than half of states have a county-level public health government structure, a distinguishing feature of Maine's public health system is the lack of this decision-making authority at the county-level. A 2022 study found that 69% of local health departments (LHDs) nationwide were county-based. In 30 states, all local health departments were locally based governance structures, while five had state-only government health departments, and the remaining had a mixed or shared governance structure. Maine has a mixed structure with a state-level government decision-making department and a handful of larger municipalities with a locally controlled division.[26] While Maine has administrative regional health districts for service provision, most Maine counties do not have the infrastructure or public health decision-making authority given to counties in other states.[27]

A review of national data from the COVID-19 pandemic showed that the history of recent expenditures on county-level public health was a strong indicator of the magnitude of COVID-19 impact in counties, both across states and within them.[28] While there is no definitive way to determine what public health infrastructure works best for every community and policymakers should not implement a one-size-fits all approach,[29] researchers propose that "the time is right for an extended dialogue that includes federal, state, and local public health officials regarding, essentially, who should do what." To clarify the state's public health structure, Maine should develop and publicize a strategic approach to public health infrastructure that accounts for residents' preference for more local authority in addition to providing regional support and accountability to ensure that communities across the state have access to adequate and equitable health information and services.

Key Lessons From Recent Events & Past Experiments

THE HEALTHY MAINE PARTNERSHIPS INITIATIVE: AN ATTEMPT TO ESTABLISH STATEWIDE LOCAL-REGIONAL PUBLIC HEALTH COLLABORATIVES

The Healthy Maine Partnerships (HMP) initiative, a collaboration between state and local partners, was formed in 2001 with funding from the Tobacco Master Settlement Agreement. This statewide network of community coalitions was administered by the Maine Center for Disease Control and Prevention (CDC) and aimed to create a more localized model for public health improvements and emergency response.[30]

The HMP initiative awarded grants to 27 community partners including health care providers, hospitals, municipal health departments, and local nonprofits to participate in regional coalitions. **The coalitions acted much like a county-level health department, engaging in public health efforts focused on smoking prevention and nutrition.** The coalitions were community-based efforts that brought together schools, healthcare systems, and consumers to coordinate activities and make policy changes that promoted healthy behaviors at the population level. Each local coalition included a lead agency that operated as the fiscal agent and a partnering school district.[31] The HMP initiative was successful in improving policy and practice statewide and connecting local partners to a network.[32]

Following significant funding cuts in 2012, the Maine CDC narrowed the objectives of the initiative and changed the structure to include nine lead partners in each of the nine regional health districts, and 18 supporting partners. This change helped limit the administrative and data tracking burden by reducing the number of contracts from 27 to 9. The initiative continued until funding was re-allocated in 2016.[33] The State announced it would end the HMP network and award contracts to a small number of statewide partners focused on specific topic areas.[34] The end of this initiative shocked many involved and left a gap in Maine's community health system.[35, 36]

This example revealed the vulnerability of initiatives that depend on state funding which can change dramatically from administration to administration. Despite the dramatic end to the initiative, many organizations that started under HMP like **Healthy Acadia** and **Healthy Lincoln County** still operate today as independent nonprofits and they continue their work locally without the statewide network. This fact speaks to the success of the localized structure and to the continued need for a similar model.

ARPA COVID-19 RELIEF FUNDING: A LARGE-SCALE INFLUX OF FEDERAL FUNDS DIRECT TO LOCAL GOVERNMENTS

The 2021 American Rescue Plan Act (ARPA), the federal response to the COVID-19 pandemic, allocated $350 billion to state, local, and tribal governments through the State and Local Fiscal Recovery Funds (SLFRF) program.[37] Local governments, including those in Maine, were directed to use ARPA funds strategically to address the economic and public health impacts of the pandemic. Decision-making related to the distribution of ARPA funds significantly challenged the capacity of the municipal and county governments tasked with distributing funds and as a result the distribution and use of these funds varied widely in communities across the country.[38]

Nationally, in areas where counties rather than cities received and distributed the funding, **a higher percentage of ARPA funds went directly to public health (14% vs. 7%) and community aid (14% vs. 8%).**[39] Conversely, cities dedicated a larger proportion of their funding towards government operations, and economic or infrastructure investments (48% vs. 37%).[40] While these funds were welcomed, many local governments, particularly smaller rural areas,[41] faced challenges distributing funds due to tight timelines and lack of capacity. While those with established governance structures (e.g. county-level governance, city councils) and existing strategic plans were able to make quick investment decisions, others needed to invest in planning first before distributing the funds. Many local governments hesitated to use the funds to invest in new initiatives or hire new staff because of the lack of long-term sustainability.[42]

Additionally, analysis of ARPA funds' impact on local governance also revealed the importance of community engagement and collaboration to advance equity in resource allocation.[43] A 2022 analysis identified several equity-focused spending categories and found that **large cities and counties invested 29% of their SLFRF funds to help economically disadvantaged communities,** including projects focused on areas such as housing, mental health, small business supports, and broadband access.[44, 45] Much of the research on ARPA has revealed that collaboration and robust community engagement was an essential part of ensuring more equitable strategies and allocation of ARPA funding, particularly in areas like infrastructure, housing, and public health.[46, 47]

ARPA FUNDING IN MAINE

Maine received over $4.5 billion in ARPA funds, most of which was directed by the legislature towards specific programs to bolster COVID-19 recovery efforts, and towards statewide investments under the Maine Jobs and Recovery Plan.[48] **In total, Maine's local and county governments received $500 million in ARPA funds.** Maine's larger cities and counties received funds directly from the U.S. Treasury[49] and the state government also allocated $119.2 million of passthrough ARPA funds to smaller local towns and cities.[50,51] County funding totaled $261 million and ranged dramatically from $3.26 million going to Piscataquis County to $57.3 million going to Cumberland County. Five metropolitan cities also received over $121 million with the largest amount going to the City of Portland which received $46.29 million.[52] The State allocated funding to over 400 towns[iv] with a range of $2,854 (Kingsbury Plantation) to $2.24 million (Sanford). Sixteen of Maine's smaller cities and towns received over one million dollars from the State.

Maine is one of the most rural state's in the U.S.[53] Similar to national trends, many of the rural towns and counties were dealing with limited and disrupted revenue sources,[v] and for many, the ARPA funds represented amounts nearly equal to their annual budgets.[54, 55, 56]
ARPA funding was an opportunity for local governments to

iv For more information on the towns and cities that received these payments see the reports on the State of Maine Department of Administrative and Financial Services website here.

v In addition to state restrictions on these sources, the state's revenue sharing program, which allocates a percentage of state income and sales tax revenues to municipalities, was cut from 5% to 2% in 2016 (Maine Municipal Association, 2021). This funding was finally restored to a full 5% in 2022 (Office of Governor Janet T. Mills, 2022). Additionally, many of Maine's towns and cities lost large sums of revenue due to the COVID-19 pandemic and a reduction in recreational spending and tourism statewide.

not only alleviate the impacts of the pandemic, but also to invest in long-term resiliency building projects and take action on the most pressing local challenges.

A notable outcome is that Maine did not follow national trends regarding county-level use of funding. Due to weak county-level public health and social services governance infrastructure, most counties in Maine perform fewer functions compared to counties in other states. Maine counties' public health and safety services include criminal legal functions through institutions like county jails, Sheriff's Offices, and court systems. They also often provide emergency response dispatch services. While they all participate in regional public health collaborations, only a few have a county-level public health governance structure.[vi] Additionally, many Maine counties have little capacity to implement programs or conduct community engagement and research. These factors explain the decisions made by many counties to invest in projects related to criminal legal systems as opposed to more direct public health-related investments.[57,58] For example many Maine counties used ARPA funds to upgrade vehicles for Sheriff's Departments, upgrade software systems, and make facility upgrades to court buildings or jails.[59, 60, 61] In contrast to these prevalent decisions to invest in law enforcement and courts, the Maine Center for Economic Policy[62] recommended investment for many counties that included strategies related to food insecurity, substance use disorder harm reduction and recovery, and housing security, among many other options.[63] Counties and municipalities that engaged community partners and solicited community feedback made investments that more directly served the community's needs and addressed pressing challenges.[64] Some counties delayed spending to conduct a process (such as surveys and town meetings) for engaging community input on needs, others participated in a grant application process to award funds to local nonprofits. The City of Bangor, for example, conducted town meetings, surveys, and solicited ideas from the community and provided multiple opportunities for public input and review of proposed projects.[65] Bangor used the funds to invest in affordable housing and emergency shelters, childcare and youth programming, workforce development, literacy, recovery, and community health.[66] Hancock County took time to gather public input on other project needs and invested a large sum to expand broadband access to rural communities. They also created a nonprofit community grant application to give funds directly to local nonprofits.[67, 68]

While ARPA was an unprecedented funding opportunity, it highlights the value of regional and local collaboration, and of ongoing local capacity to ensure available funding is invested in efforts that maximize the potential to address the varied needs of local communities. The long-term impact of ARPA in Maine communities is still being determined as funds continue to be utilized over the next two years.

vi For more information about Maine's Public Health Districts and their roles, see https://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/index.shtml

Reflections from Key Stakeholder Interviews

Interviews with public health stakeholders revealed several themes highlighting the challenges of the current infrastructure and opportunities to build a more efficient model in Maine. Challenges included themes related to the instability of the grant funding model, the interrelated needs of communities, systemic conditions that impact health and well-being, the importance of community engagement, and making effective use of funding. Interview participants emphasized the importance of relationships and collaborations in addressing public health issues. Participants also discussed the essential skills that they felt were necessary in creating an effective community-engaged collaboration to sustainably address public health challenges.

> “All of these things are connected. [Some solutions] just put a burden someplace else in the system. So by working together we're really starting to see that kind of intersectional, interconnected dependency where pulling a lever in one place may do good things in another place, but it also may do some bad things in another place.

Challenges with the Current Public Health Funding Infrastructures

PARTICIPANTS HIGHLIGHTED THE COMPLEXITY OF SUPPORTING LOCAL NEEDS THAT ARE DRIVEN BY INTERRELATED SYSTEMIC ISSUES.

All interviewees mentioned the challenges of working on complex, systemic issues, with many specifically mentioning community conditions of health such as housing, employment, and connection to community. One participant mentioned the **Adverse Community Experiences and Resilience Framework,**[vii] “The idea behind it is that people, places and equitable opportunity are how you build a community that can be resilient to all sorts of issues.” This framework explores the impact that trauma has on a community and emphasizes how communities can heal together and build structures of support that lead to improved wellbeing and safety. One such healing strategy in this framework is “power-sharing” which is defined to include participatory budgeting and shared decision-making.[69]

Another participant mentioned the challenge of measuring the success of programs when contributing factors external to the program are opposing the program's intended outcomes, “The ecosystem is changing around us as we're attempting to work on these topics. Describing that ecosystem, is that our responsibility as people doing the prevention work?” Demonstrating the impact of services, particularly preventative services, is challenging for organizations who may not have the capacity or resources to dedicate to data and evaluation. These challenges are furthered by complex external factors that may be impacting the success of initiatives.

> “There needs to be more stability and more appetite for that long-term funding. Without it, I think we're going to continue to see only short-term results.

vii For more information on the Adverse Community Experiences and Resilience (ACE|R) Framework visit: https://www.preventioninstitute.org/focus-areas/adverse-community-experiences-and-resilience

THE INSTABILITY AND COMPETITIVE NATURE OF GRANT FUNDING CREATES AN UNSUSTAINABLE ENVIRONMENT AND LIMITS LONG-TERM RESULTS.

All five interviewees discussed challenges related to fluctuations and delays in funding. One interviewee talked about having to take out a bridge loan to pay staff while waiting for grant funds that had been promised months earlier. Timely and steady funding is key to developing robust, meaningful programs. Many nonprofits do not have the capacity to ride through revenue shortfalls. One interviewee mentioned a recent trend in delays in state funding that had led to significant loss of public health jobs and even whole nonprofit organizations in rural Maine.

> **“It’s difficult to exercise vision when we’re more often caught up in just making sure we meet those deliverables from that prescriptive funding so that we can be on the good list for receiving it again.**

Similarly, interviewees mentioned the challenge of political changes impacting funding levels for public health. As one said, “We now have four years of probably less money, money being taken away from us probably more than anything.” Additionally, many discussed the lack of sustainable funds to implement programs long enough to create real, sustainable change. A regional community health convener called for better state-level coordination to ensure that programs have adequate time to reach a point of sustainability. Another collaborative facilitator said that current funding strategies leave “limited capacity to really do the level of work that it takes to make change.”

> **“I don’t think there’s trust. I don’t think there’s trust at the state level of the organizations that are doing this work… I think that a huge piece of this is that there isn’t trust that we’re going to be effective stewards.**

Related to this is the time and complexity of pursuing grants and meeting funder requirements when trying to implement a program. Time expended on meeting the requirements of programmatic grants can get in the way of seeking grants to do more strategic work, resulting in a vicious cycle, “So now that more of my time is funded through these different grants… and pulled in so many different directions that it’s difficult to have the time to actually do the grant seeking to build more capacity.”

DEEPENING RELATIONSHIPS AND BUILDING TRUST BETWEEN PUBLIC AGENCIES AND LOCAL ORGANIZATIONS IS KEY TO EFFECTIVELY ADDRESSING PUBLIC HEALTH NEEDS IN MAINE.

Several interviewees brought up challenges they have experienced and ideas about how to improve the efficacy of collaborative work between state government and community-based public health organizations. Underlying many of the challenges was a need to build more trust. One interviewee stated, “There’s lingering distrust between state staff and community groups resultant from [the Healthy Maine Partnerships] work.” Interview participants highlighted the need for a model that allows for more relationship building rather than just the process-oriented model that exists today. Stronger relationships could lead to better mutual understanding so that community partners have more freedom to be creative and state agencies can better understand the impact of the funds they are providing.

> **“The way we’re doing it now is scurry, scurry, scurry… It’s not effective… This is crazy. My grant application is written better so my people get the money and your people don’t. It makes no sense to me.**

MORE LOCALIZED DECISION-MAKING INFRASTRUCTURE COULD HELP ENSURE MORE EFFECTIVE USE OF PUBLIC HEALTH FUNDS.

In the absence of local and county public health decision-making capacity, large funding opportunities flowing through county and municipal governments do not always engage communities in decision-making and therefore risk not being used to address local community needs. As one interviewee said, "In a place like Maine without a strong public health infrastructure, you don't have enough people who know how to do [community decision making]."

> **"We don't have local health departments throughout the state. These coalitions really are, and community organizations really are, our public health in a lot of places.**

As happened with ARPA funding, three interviewees mentioned that in the absence of local capacity and a lack of relationships with community partners, law enforcement and corrections leaders are often where public officials turn to make the decisions. As one interviewee said, "Who's the staff who knows anything about the problem? Well, it's law enforcement because no one else... there's no public health people there. There's no prevention people there". As another interviewee mentioned, when funds flow to municipalities with budget challenges, especially in the absence of strong local public health capacity, they often get creative about using funds to offset current or potential municipal expenditures.

One participant highlighted that accountability and oversight are necessary to ensure funds are being spent effectively. They recalled recent experiences with the COVID-19 pandemic when widespread misinformation negatively impacted local decisions around public health responses and funding allocations. This highlights the need for ongoing collaboration between funders and community partners that allows for innovation and flexibility while also including processes for accountability, and information sharing around best practices. Further, local communities need support in building capacity to make data informed decisions, engage with their communities, and evaluate their impact.

> **"We're shifting [the funding] to communities who are not prepared to do this work as opposed to the organizations that are already doing this work. And I think there's a lot of that kind of thing... It just feels like one hand doesn't know what the other is doing sometimes.**

ORGANIZATIONS NEED DEDICATED RESOURCES TO SUPPORT ENGAGEMENT SO THEY CAN UNDERSTAND AND ADDRESS VARIED COMMUNITY NEEDS.

The interviews all explored topics of the variability of community needs and experiences around the state. While this was widely seen as a strength it also presents challenges in deploying effective health systems statewide. This underscores the importance of participatory practices such as community engagement and giving decision-making authority to local community members with direct experience. However, as this research found, participatory practices take more time, capacity, and resources.

Four of the five interviewees said that community engagement was a growth edge—important to their work but not being done as effectively as they would like. Many also said that they are mostly doing community engagement by proxy, through partnerships with local service organizations that represent the people they serve. One regional health collaborative leader explained that they had found significant success in engaging often underrepresented populations through facilitators acting as cultural brokers. However, they had recently lost that capacity due to the end of a funding cycle that included stipends for these facilitators. As a result, the collaborative experienced a significant reduction in participation from these hard-to-reach community members.

> **"I don't think we've hit the mark on [community engagement] yet. I think often, especially with topics like the opioid problem, the people who've been most impacted have so much trauma and so much grief so how much do you engage them in conversation?**

Opportunities and Best Practices for a More Efficient Community-led Public Health Funding Infrastructure

INTERVIEWEES EMPHASIZED THE NEED FOR MORE RELATIONSHIP BUILDING, COLLABORATION, AND COORDINATED RESOURCE SHARING IN ADDRESSING LOCAL PUBLIC HEALTH NEEDS.

All interviewees talked about their experience coordinating or participating in collaborative efforts. While the collaboratives with which they work vary from formal to informal, all participants shared experiences related to what one public health nonprofit leader described as, "facilitating networking, resource sharing, funding. We would apply for funding and then reallocate it to groups to help with transportation or isolation..." Though interviewees held a variety of different roles they all emphasized the importance of this type of collaboration.

Many highlighted examples of how collaboratives led to funding opportunities or increased capacity, which resulted in a greater impact. One interviewee gave the example that a connection made through their collaborative helped them get a major source of funding through ARPA. They emphasized that this coordination of funding, including collaborations with public agencies, were key opportunities to build strong relationships and do more meaningful work. Others also mentioned that collaborating on programs can to build effective relationships, though they often found that when program funds ended, relationships and collaboration tended to lose steam as well.

All five interviewees spoke about the importance of relationships, including their experience with the resources and dedication necessary to build effective collaborative relationships over time. As one regional collaborative leader said, "[Our collaborative] has a very relationship-focused approach to public health and that's with organizational partners as well as individual partners. And relationships take time to establish in the first place, but also to nurture." Another interviewee recalled collaborating with service providers to conduct a survey which revealed that transportation was a key barrier resulting in patients missing appointments. Strong relationships in this collaborative provided a solid basis upon which partners developed an effective solution.

> "
> **You need a local footprint, you need the trust, you need the people that can sit at the table together.**

One participant highlighted that collaborating with organizations and individuals who already have established relationships and connections with communities allows for more widespread and meaningful community engagement. They stated, "The way I've seen [community engagement work] done best is when you give funding to community-based organizations who already have the connections and the relationships and you support them to do the engagement... They understand the cultural relevance or cultural implications." Partnering with established local community organizations helps address the capacity challenge and allows for more culturally competent approaches to community engagement efforts.

COMMUNITY HEALTH COLLABORATIVES ARE BETTER SUPPORTED WITH A DEDICATED ORGANIZATION THAT CAN PROVIDE INTERMEDIARY, BACKBONE SUPPORT.

A theme that emerged from all the interviews was the value of funding an **intermediary or backbone**[viii] organization to support coalition building, coordination, facilitation, and data capacity. The takeaway was that sufficient funding for backbone capacity catalyzes effective community health work while its absence leads to a variety of challenges, including lack of coordination, loss of relationships, and lack of evidence of the impact of community public health work.

> “
> You need all three layers—state, regional, local... You need a regional hub that then is supporting community hubs.

Several interviewees shared a vision for a tiered approach to public health infrastructure, which was seen as important to provide coordination, reduce the communication overhead for state government, introduce efficiencies in domain expertise, and enable learning communities. One said, *“It has to be connected to a mid-layer of public health infrastructure that can support it and listen and hear it. ‘OK, I hear this happening in South Portland and this happening in Windham and this happening over here.’ ... You need this middle layer because the local to the state, that’s too far.”* Another interviewee had a slightly different vision of more domain-focused backbones as an intermediary layer, saying, *“It seems like there could be two levels of backbone. So, one backbone is within the community, but then there’s a kind of thematic or domain backbone.”*

Interviewees were optimistic about the costs and the cost-benefit ratio for investments in coalition-building capacity. They had experienced the big differences in outcomes that small amounts of funding could make and lamented that these impacts were not widely understood. In fact, one interviewee described how a perception that collaborative funds represent overhead sometimes leads organizations to underreport the use of funding for collaborative purposes. As one coalition leader said, “We can scale this in a way that doesn’t have huge overhead, but that creates the conditions for sustainability and addressing local needs.” This participant predicted that funds invested in backbone capacity would yield a minimum of a fivefold return on investment in health cost savings and health improvement.

viii See the previous section for more information about the role of an intermediary/backbone organization.

THE BUILDING BLOCKS FOR EFFECTIVE COMMUNITY ENGAGEMENT AND COLLABORATIVE ACTION IN MAINE

Interviewees spoke about various skills they identified as being key to effective collaborations. As one said, *"It's not rocket science, actually, but it follows a thing in which we all feel good about what we decide on at the end because we had a process that made sense."* The same interviewee spoke to how Massachusetts filled a skills gap by bringing in outside help for **community engagement,** *"[The consultant] worked with their Public Health Departments that were part of their municipalities to do community engagement... So, their ARPA dollars went to way more things that the community was asking for and wanted."*

Another interviewee talked about the **importance of data literacy,** saying *"Good data can really help make progress and it also helps people who are doing that work demonstrate their progress better."* Unfortunately, speaking about their experience working in Maine, *"I just think there's always challenges with data collection, with data analysis and interpretation and dissemination."*

Two interviewees mentioned that they saw opportunity in the **learning communities forming among collaborative leadership in Maine.** One said, *"When you go to do the deeper community conditions work with deep community engagement and figuring out these big problems, you need people with you and you need a learning community."* Another mentioned the Community Collaboratives Network, which they described as an active learning community among practitioners that was helping with skills transfer and with counteracting the impact of what can be lonely, isolating work.

Public communication, storytelling, and transparency were also seen as important skills for public health and collaborative leaders. As one interviewee said, *"So the transparency isn't just with the public, it's also with the people who hold the purse strings... [and] get to decide how it's spent."* Another said, *"People in public health need to get out and talk more about what they're doing, whether it's with an elected official or with community or other community members. I think that helps because legislators will fund things they understand... but they don't understand a lot of the work we do in public health."* This connection between understanding and funding opportunities emerged across several themes in the interviews.

Beyond skills, there are certain structural elements that were called out as necessary by interviewees. Several mentioned the need for more streamlined processes and requirements, at the local, state, and federal level, that enable organizations to better **braid funding from multiple sources,** *"You need mechanisms for pooling money to then do this stuff, which I think we can figure out."* One was more specific that that money needs to be held outside of government saying, *"You need an overall coordinating body and some place that holds the purse strings outside of state government and then that money is dispersed out to the participants."* These structural suggestions point to a **fiscal backbone that acts as an intermediary** between funders, public agencies, and local community partners making decisions about their greatest needs.

Community-led Models

The following section provides examples of local and national models of effective participatory, community-led practices, collaborative networks, and innovation to address public health challenges. This list is not exhaustive. It is meant to provide examples of the themes discussed in the literature and interviews to inform strategies to implement or expand effective practice in Maine.

Examples of National Collaborative Models

ACCOUNTABLE COMMUNITIES OF HEALTH

- For more information visit: https://www.cachi.org/

The Accountable Communities of Health (ACH) model, used in the California Accountable Communities of Health Initiative (CACHI), shows how local, participatory decision making can be used to deliver effective community health interventions and maximize funding opportunities.[70] The ACH model was designed to create collaborative capacity for a diverse set of organizational partners and community residents. ACHs in California invested in 13 communities across the state where partners collaborated with community members to design and deliver interventions that fundamentally changed health outcomes in a sustainable way. ACHs were enhanced by centralized technical assistance providers who supported community engagement, financing and sustainability, and data strategy efforts. CACHI demonstrated the effectiveness of backbone organizations in fostering cross-sector partnerships to address community health issues. Key elements such as shared vision, data sharing, and sustainability planning enabled ACHs to develop new funding streams, improve collaboration, and catalyze systems change. Effective stewardship of funds benefitted from transparent governance, equity-focused engagement, and the creation of coalitions to enhance capacity and reduce duplication.[71]

THE INDIGENOUS WOMEN'S FLOW FUND

- For more information visit https://kindleproject.org

The Indigenous Women's Flow Fund (IWFF) is an Indigenous led grantmaking project focused on resourcing community initiatives that are transforming systems. The collaboration is grounded in trust and participatory approaches. The IWFF includes two cohorts, the Indigenous Women's Cohort, and the Donor Cohort, supported by a backbone organization, the Kindle Team, who have created a community of shared learning and practice and a culture of mutual caring and support. The Women's Cohort designed the themes and process and is empowered to make both individual and group funding decisions and awards. While some donors simply donate to the fund, others participate in a peer learning community. The Kindle Project provides facilitation, administration, fundraising, and education support to the collaborative. Grantees are Indigenous-led groups or individuals who are often underrepresented in philanthropy. Since 2020, the IWFF has awarded $1.8 million to 78 grantees.[72]

RHODE ISLAND: HEALTH EQUITY ZONES

- For more information: https://health.ri.gov/health-equity/rhode-islands-health-equity-zone-hez-initiative

While Rhode Island is one of the few states with state-only public health governance, the state has developed an innovative model for local participation. In 2015, Rhode Island created a structure called Health Equity Zones (HEZ). Fifteen HEZs across the state use participatory budgeting and a focus on transforming social, environmental, and economic conditions to build safe, healthy, resilient communities.[73] Rhode Island's theory was that the development of a sustainable place-based community infrastructure and an alignment of resources aimed at community needs would positively impact social and environmental determinants of health leading to population level improvements in health.[74] As a result of investments in local participatory capacity in community health, when the COVID-19 pandemic began HEZs were "already uniquely poised to respond to critical needs that quickly emerged."[75] HEZ capacity allowed communities in Rhode Island to effectively provide information, support testing and vaccination efforts, and facilitate access to services including basic needs like food and rental assistance for communities across the state.

Maine Organizations Implementing Participatory Models

HEALTHY ACADIA

- For more information visit: https://healthyacadia.org/

Healthy Acadia is a longstanding community health coalition that acts as a hub and engages with hundreds of partners and thousands of community members to deliver on their mission to "empower people and organizations to build healthy communities together."[76] Their work in Washington and Hancock Counties includes a wide range of community health improvement initiatives including early childhood, healthy aging, physical wellness, food access, basic needs, and substance use prevention and recovery programs. Healthy Acadia's started as a partner under the Health Maine Partnerships initiative but has continued to be supported by a diverse pool of corporate and foundation funders, individual donors, and public grant funds totaling $5.8 million in 2023.[77] In addition to their coalition partners, Health Acadia has a community Advisory Council which meets twice a year to engage community members in strategic planning and set priorities for future work.

HELPING HANDS WITH HEART

- For more information visit: https://centralhallcommons.org/helping-hands-with-heart/

Helping Hands with Heart is a community coalition that convenes and coordinates resources to improve access to services and quality of life for residents in Piscataquis County.[78] The coalition's monthly meetings bring together providers and community members to strategize and problem solve for individuals and families who are referred for basic support and needs as well as for longer-term community health needs. They are especially focused on children and families experiencing poverty, working to "improve access to resources for all residents, coordinate existing services, identify gaps, and advocate for our rural region and all our residents and communities."[79] This initiative has been successful in engaging rural communities, advocating for community needs, piloting initiatives such as Bundle and the Bundle Box Program,[ix] and collaborating with state and regional partners to bring resources to the Maine Highlands Region[x].

OXFORD COUNTY WELLNESS COLLABORATIVE

- For more information visit: https://www.ocwcmaine.org/

In 2010, Oxford County was ranked last of Maine's 16 counties in overall health by County Health Rankings.[80] Oxford County Wellness Collaborative was formed to fill a gap in community health infrastructure in the county, to reduce duplicated efforts, and to coordinate activities among community organizations. OCWC is now staffed by Healthy Oxford Hills, part of the Maine Health system. Their work focuses on identifying and communicating the root causes of poor health outcomes; building relationships among organizations and with community members; and convening workgroups focused on active living, behavioral health, community engagement, community safety, and healthy food. A core tenet of OCWC's work is to engage diverse groups of community stakeholders, which facilitates the sharing of lived experiences and provides an opportunity to build relationships and connections among community members. OCWC is an example of an organization that provides a critical backbone role in Oxford County, leading with relationships, flexibility, and responsiveness.[81]

ix Bundle is an online resource guide for families with young children designed to help connect them with services and support. The Bundle Box Program provides free care boxes to every family with a new baby in the Maine Highlands region. For more information visit: https://bundlemaine.com/

x The Maine Highlands Region is a recipient of a Working Communities Challenge grant in collaboration with Helping Hands with Heart, the United Way, and other regional partners. For more information visit: https://www.bostonfed.org/workingplaces/communities-challenge/maine.aspx

Key Recommendations

The themes from the literature review and interviews point to several key recommendations for Maine to develop a stronger public health infrastructure and better center community needs. Taking advantage of this opportunity will require coordinated effort among Maine's collaborative leaders, state policymakers, and philanthropies. Some of these recommendations are highlighted below.

Survey Maine's collaborative community health landscape to more thoroughly understand strengths and gaps.

Understanding the current landscape is critical to defining the work of improving Maine's community health outcomes. While this research makes it clear that there is effective community health work happening around the state, more information needs to be gathered about which communities have capacity for participatory work and which lack these vital resources.

Improve relationships and communication between health-related state funding and collaboratives active in communities.

A key theme that emerges from this research is the need for more effective communication between local community health initiatives and state agencies. Leaders in state government and in community collaboratives can more effectively align strategic funding initiatives and deliver improved community health outcomes if they mutually prioritize strong, trusting relationships. As suggested by interviewees, the development of a structure that includes regional or topically focused intermediaries between the local and state levels could improve the flow of communication.

Strengthen peer-to-peer networks and develop more communities of learning.

Interviewees emphasized the desire for more peer support among people doing collaborative community health work. Several interviewees mentioned needing peers who could understand their situation in challenging moments. Additionally, these peer networks could also be used as a learning community, to share skills and practices that have been shown to be effective and build shared understanding and capacity among partners.

More flexible public and private funding with reliable backbone, data, and capacity supports.

To address community needs, collaboratives need a backbone and funding that is sustainable, reliable, and allows for community participatory design. Community health collaborative leaders expressed their understanding that accountability and trust are key to maintaining strong relationships with funders, including governments. Current models, however, often leave little room for the creativity of community members to design and implement programs that address their local needs. More flexible and participatory funding would not only improve outcomes but would also build local community and backbone capacity for times when large-scale opportunities arise.

Analyze costs and benefits of collaborative community health capacity investment options.

Interviewees suggested that both providers and the state government would benefit financially from investments in collaborative capacity to improve public health outcomes in Maine communities. There are likely other parties, including employers and community members themselves, who would see a strong return on investment from improved community wellbeing. Given the state's forecasted DHHS budget of $4.5 billion in 2026-2027,[82] increasing the effectiveness of public health expenditures could realize benefits that far exceed costs. A variety of models exist for analyzing the costs and benefits, which could help identify areas for piloting more community-centered health initiatives.

Conclusion

Community health initiatives built upon the voices, needs, and strengths of community members have the potential to significantly improve wellbeing in Maine communities. Effective participatory community health work and collaborative initiatives are happening in pockets across the state, but these initiatives and their impacts are not consistently distributed statewide. Reliable investments in effective community health collaboratives can maximize the use of future large-scale opportunities and even bring in additional funds from other sources. Implementing the recommendations included here and developing a more sustainable and efficient funding model for collaboratives in Maine is an opportunity to transform long-term health, wellbeing, and thriving across Maine in an informed, community-driven, and cost-effective way.

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