

SHIP Priority Setting (scoring for each criteria on a 1 to 6 basis)

	Burden	Disparity	Integration	Alignment	Evid. Based	Feasibility	Total
Tobacco	5	5	6	6	5	3	30
<p><u>Burden:</u></p> <ul style="list-style-type: none"> • “Leading cause of preventable death”- • long-term consequences of life-long use. • (note: we have no smokeless data) <p><u>Disparities:</u> 1 in 3 pregnant women on MaineCare smoking, 43% MaineCare recipients</p> <p><u>Integration:</u></p> <ul style="list-style-type: none"> • many links between behavioral health and tobacco use, • primary care providers have a strong role with cessation, • dental providers may also have a role. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • continuing issue at national and public health district levels, • fits in with HM2020 <p><u>EB:</u></p> <ul style="list-style-type: none"> • How many of the EB strategies do we have in place, can we count the policies such as indoor smoking laws that we have “done”? • For pregnant women smoking we don’t know if there is a high evidence-base of what works to get them to quit smoking. <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Difficult but possible. • Can public health and partners act on policies? • It may not be within Maine CDC’s scope of work, for example: raising cigarette taxes. 							
Cardiovascular	5	5	5	5	5	5	30
<p><u>Burden:</u></p> <ul style="list-style-type: none"> • a leading cause of death. • Mortality is high in terms of prevalence, • hospitalization is lower. <p><u>Disparities:</u></p> <ul style="list-style-type: none"> • multiple types of disparities noted for many CVH indicators. • For many indicators, we do not have income and education data. <p><u>Integration:</u></p> <ul style="list-style-type: none"> • clear role for hospitals and primary care providers, • behavioral health linkage due to co-morbidities <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • continuing issue at national level, • less represented at the public health district levels, • fits in with HM2020 <p><u>EB:</u></p> <ul style="list-style-type: none"> • Clear strategies, we are making good progress. • We have had a very robust program for a long time and reduced our rates on heart attack. • They are now working on stroke and hypertension. <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Current activities show that implementation is feasible, although resources may be limited. • Need to look at other things already rated and how they may be pre-cursors to CVD. (e.g. reductions in Tobacco use have had a huge impact on hear attacks.) 							

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Substance Abuse	6	4	6	6	5	3	30
<p><u>Burden:</u> The major theme from the survey within substance abuse was Prescription Drug Abuse.</p> <ul style="list-style-type: none"> The prevalence for prescription drug use is low but prevalence for drug use overall is high (binge drinking, marijuana) alcohol use in general is much higher. The % of kids on some sort of medication that is legally prescribed is relatively high in Maine. Also, burden is high because of multiple consequences, impacts on those who are not abusing substances. Prescribing practices may be a contributing factor Marijuana use on the rise, because of the legalizing for medicinal purposes Data based on self-reporting <p><u>Disparities:</u> Native American/Blacks do report higher use</p> <p><u>Integration:</u></p> <ul style="list-style-type: none"> behavioral health obvious, also integration with primary care and hospitals is necessary. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> continuing issue at national level (especially prescription drug use); while not all DPHIPs have this as a priority, it is still part of the work that is being done, fits in with HM2020 <p><u>EB:</u> strong for many strategies, sub-issues</p> <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> Access to treatment? Costly, enforcement, issue of shrinking federal resources of education and prevention. We have good programs (evidence-based) but not the same funding going to them as in the past. Education of providers to change prescribing habits is feasible. Enforcement can be difficult in some small towns that do not have their own police department and depend on county sheriff department for coverage – therefore resource intense. There is also the cultural issue – what is abuse? 							
Obesity	5	5	6	6	4	3	29
<p><u>Burden:</u> very high when overweight is included.</p> <p><u>Disparities:</u> On the high end</p> <p><u>Integration:</u></p> <ul style="list-style-type: none"> Health care could be doing more, There are many links between obesity and behavioral health. Hospitals may have a greater role here than for PAN. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> continuing issue at national and public health district levels, fits in with HM2020 <p><u>EB:</u> some exists, but lack of progress shows that we need more EB strategies</p> <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> Costs for statewide effective interventions may be high, convincing health care providers to act on BMI information may be challenging, possible shrinking federal resources of education and prevention 							

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PA/Nutrition	6	4	5	6	5	3	29
<p>When you address PA/Nutrition it addresses all chronic diseases. We need to instill habits of good physical activity and nutrition at a very young age.</p> <p><u>Burden:</u> High – most people do not meet recommended guidelines.</p> <p><u>Disparity:</u></p> <ul style="list-style-type: none"> • mostly income and education, • less in other areas, because everyone is doing poorly <p><u>Integration:</u></p> <ul style="list-style-type: none"> • Health care could be doing more, • There are many links between physical activity, nutrition and behavioral health. • Hospitals may have a smaller role. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • continuing issue at national and public health district levels, • fits in with HM2020 <p><u>EB:</u></p> <ul style="list-style-type: none"> • A lot of Studies around Physical Activity, • Fewer evidence for nutrition, • If this would become a priority, this could drive the choices in coming up with objectives. <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Primary Care providers are often seen only once a year, daily choices every day, • we have wellness policies at work, school, where do we go next? • Time and initially costly, changing culture. • Ongoing issue, somewhat difficult but possible. 							
Immunization	4	2	5	5	6	6	28
<p><u>Burden:</u></p> <ul style="list-style-type: none"> • rates are relative good, • lower than we would like, • rates for flu are low. <p><u>Disparities:</u></p> <ul style="list-style-type: none"> • Limited data, • Vaccination rates are known to have pockets within the groups that we have data for. <p><u>Integration:</u></p> <ul style="list-style-type: none"> • Strong links for primary care and hospital, • Less so for behavioral health. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • Continuing issue at national and public health district levels, especially flu, • Fits in with HM2020 <p><u>EB:</u></p> <ul style="list-style-type: none"> • Strong EB on methods we are using and on immunization in general . <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • With Universal vaccination, we have a strong system to make improvements, • resources are available, • ACA provides opportunities. 							

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Maternal Child Health – Birth Outcomes	4	4	6	4	6	4	28

MCH is very wide Rate a specific issue now? **Birth outcomes**

Burden: affects a smaller number of people, but has large implications, such as lifelong needs (e.g. special education).

Disparities:

- Tobacco use among MaineCare members,
- LBW especially for the Somalian population
- Others based on income and education

Integration:

- Strong links for primary care and hospitals;
- behavioral health link around drug-affected babies.

Alignment:

- winnable battle at national
- very little focus at public health district levels, possibility due to historical issues,
- fits in with HM2020

EB:

- Community guide does not have many,
- there are other sources and a clear EB for making improvements exists.
- There are standards in the state for health care providers and Maine CDC is reaching out to promote and see that the standards are being followed.

Feasibility: Some strategies require more resources, but existing efforts show promise.

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	Burden	Disparity	Integration	Alignment	Evidence Based	Feasibility	Total
Mental Health	6	4	6	4	4	3	26

Note that suicide is currently included Suicide under Intentional Injury

Burden:

- MH impacts 50% of the population.
- especially regarding depression,
- a lot not reported,
- self medicating with substance abuse.
- Maine is the oldest state in the nation and has high rates of Alzheimer's, mostly women.

Disparities:

- Self reporting shows no disparities. People of all ages, income levels, all places are having MH issues so it is less sensitive to one or the other.
- Access to treatment, access to services, early screening, access to care in rural areas
- higher income do not get treatment because of stigma, ,
- ED rates are very high,

Integration:

- behavioral health obvious,
- also integration with primary care and hospitals is necessary.

Alignment:

- Some in the national prevention strategy, particularly depression,
- HM2020,
- no district priorities.

EB:

- In the treatment area there is a lot of data, can it fully address the issue?
- opportunities to screening via primary care

Feasibility:

- very expensive,
- Mental Health Parody in the Health Insurance Law, don't know if [parity law meets the EB
- What about early screening? If we screen but then what do we do?
- tough but possible

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	Burden	Disparity	Integration	Alignment	Evidence Based	Feasibility	Total
Health Care Quality	5	5	4	4	4	4	26
<p>This is an area where there is limited data, The group then discussed whether or not to rate this issue given the lack of data. Ultimately it was decided to include because it is an important part of health care costs and it is one of the cornerstones of ACA in turning health care costs around.</p> <p><u>Burden:</u></p> <ul style="list-style-type: none"> • there is an economic burden in terms of medical errors or could be • it doesn't affect many people. • A lot of people don't know what good healthcare is. • No data from Primary Care system included <p><u>Disparities:</u></p> <ul style="list-style-type: none"> • no data, • in the literature Economic, Substance Abuse, Mental Health, • There also may be some geographic differences. <p><u>Integration:</u></p> <ul style="list-style-type: none"> • Cornerstone of ACA • not necessarily through Public Health, • Public health supporting quality health care through HMPs (Training on Quality codes from MaineCare) <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • winnable battle at national level, • part of HM2020, • not in district priorities, more so with Hospitals <p><u>EB:</u></p> <ul style="list-style-type: none"> • Not necessarily in Community Guide, • best practices and early interventions exist, (such as QI methodologies) • little things that add up like washing your hands, improve care in the Primary Care office you will reduce hospital care, • Quality metrics through ARC <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Difficult but Possible, • Potential higher outcomes down the road because of Affordable HealthCare 							

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Oral Health	5	5	5	2	3	3	23

Burden:

- The impact on physical health, nutrition is high.
- We do a good job with fluoride treatment,
- there are underlying access issues: MaineCare covers children but many dentists don't accept patients covered by MaineCare.
- Adult women are typically only covered by MaineCare if they are pregnant.

Disparities:

- income and education,
- geographic, (rural)

Integration:

- obviously with dental providers
- primary care providers (FQHCs especially)
- hospital linkage through ED visits,
- behavioral health care linkage with drug abuse associated with dental pain.

Alignment:

- Part of HM2020,
- not in national prevention strategies or district priorities,

EB:

- data on fluoridation,
- strategies for children's oral health,
- additional promising practices

Feasibility:

- Possible but difficult,
- tends to cut when it comes to legislative policies, due to costs
- There are some workforce activities underway with UNE and PCHC.
- Have done a lot with expanded functions.

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Unintentional Injury	4	4	5	4	3	3	23
<p><u>Burden:</u></p> <ul style="list-style-type: none"> • High Years of Potential Life Lost, • Leading cause of death for many age groups. • Falls a greater concern as our population ages more <p><u>Disparities:</u></p> <p><u>Integration:</u></p> <ul style="list-style-type: none"> • Poisonings and alcohol-related injuries are linkages to behavioral health, • ED usage and preventable hospitalizations. • There is a lot of work with the geriatric population in primary care on preventing falls, not taking medication and driving and drinking and driving. <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • Part of HM2020, • MV crashes in national prevention strategies, • not in district priorities, <p><u>EB:</u></p> <ul style="list-style-type: none"> • some, fall prevention, graduated licenses • but many EB policies are already in place <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Possible but difficult, • tends to get cut in legislative policy • Possible partnerships with the Office of Elder Affairs and AAAs • Not sure what costs for interventions are • Limited current infrastructure we have for injury prevention. 							

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Cancer – (Screenable cancers)	3	2	3	3	6	5	22
<p>Do we consider all cancers? Decided to focus on screenable cancers: Breast, Colorectal, Cervical</p> <p><u>Burden:</u></p> <ul style="list-style-type: none"> • overall is high incidence/mortality, • less so for specific cancers. • Not that high compared to other topics discussed. • It is the leading cause of death in terms of YPLL. • Reducing heart disease means that people are living longer, therefore greater likelihood of other disease such as cancer. • Screening rates are fairly good. <p><u>Disparities:</u></p> <ul style="list-style-type: none"> • Low SES for screening. • Other disparities limited. <p><u>Integration:</u></p> <ul style="list-style-type: none"> • screening has links with primary care providers and hospitals, • less linkage with behavioral health care <p><u>Alignment:</u></p> <ul style="list-style-type: none"> • Part of HM2020, • Not in national prevention strategies. • Limited in district priorities, <p><u>EB:</u> screening is solidly evidence-based, but methods to increase screening may not be.</p> <p><u>Feasibility:</u> ACA mandates will help with resources to screen</p>							

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Access	3	3	6	5	1	2	20
<p><u>Burden:</u></p> <ul style="list-style-type: none"> • ED rates are driving burden. • We should separate access to care and access to treatment as they are two different things. People have access to treatment which is causing over utilization but not necessarily access to care. • A challenge for this issue is the rollout of ACA and insurance exchange – not sure how this will impact coverage. • In the survey, access to care was ranked #1, <p><u>Disparities:</u></p> <ul style="list-style-type: none"> • In some areas (i.e., income and education) disparities were high; • the overall average for disparities was 3. <p><u>Integration:</u></p> <ul style="list-style-type: none"> • It should be the norm. • There are lots of opportunities to do so (Public Health, Mental Health, Oral Health, Primary Care, Behavioral Health and Hospitals). • There isn't enough currently but should be more. <p><u>Evidence Based:</u> very little data in regards to access.</p> <p><u>Feasibility:</u></p> <ul style="list-style-type: none"> • Looking at the Survey results we see a very broad response as to what people regard as ACCESS – lots of options for interventions, but less clear on what will result in the right changes. • Roles of accountable care and FQHC's are new opportunities 							

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Emergency Preparedness	Move to Infrastructure – Very little data, depending on Kris and Sean for information. Kris not sure if EP should be a priority here... as a Strategic Priority yes and Infrastructure Building. Do we rate or move into the Infrastructure discussion? Agreed to move to infrastructure						
Note: <i>The following were rated after the meeting by a portion of the attendees, but were discussed briefly.</i>							
Diabetes	4	4	4	4	5	4	25
Not rated at the meeting – Interventions are focused on management of diabetes and pre-diabetes, and a focus on PAN interventions to prevent diabetes. It is being looked at through Health Care Quality, CV, PAN, Obesity. Issue and interventions overlaps with high priority topics: PAN, Obesity, (prevention & management) CVH (management). Decided to not consider this as a separate topic.							
Respiratory Health	3	4	5	4	5	4	25
Not rated at the meeting – Discussed possible links to other chronic disease topics.							
Intentional Injury	3	4	3	3	4	4	21
Not rated at the meeting – Perceived low burden, limited public health interventions							
Infectious Disease	3	3	3	3	5	3	20
Not rated at the meeting – Low burden, few known disparities							
Environmental Health	3	3	2	4	4	3	19
Not rated at the meeting – Not a lot of disparity data. If it comes to air and water we can do things about monitoring water. Our air pollution we can't control. We are doing a good job testing the water but as a public health agency we have less control in other areas.							
Occupational Health	2	3	3	3	3	2	16
Not rated at the meeting – Low burden, closely related to injury							