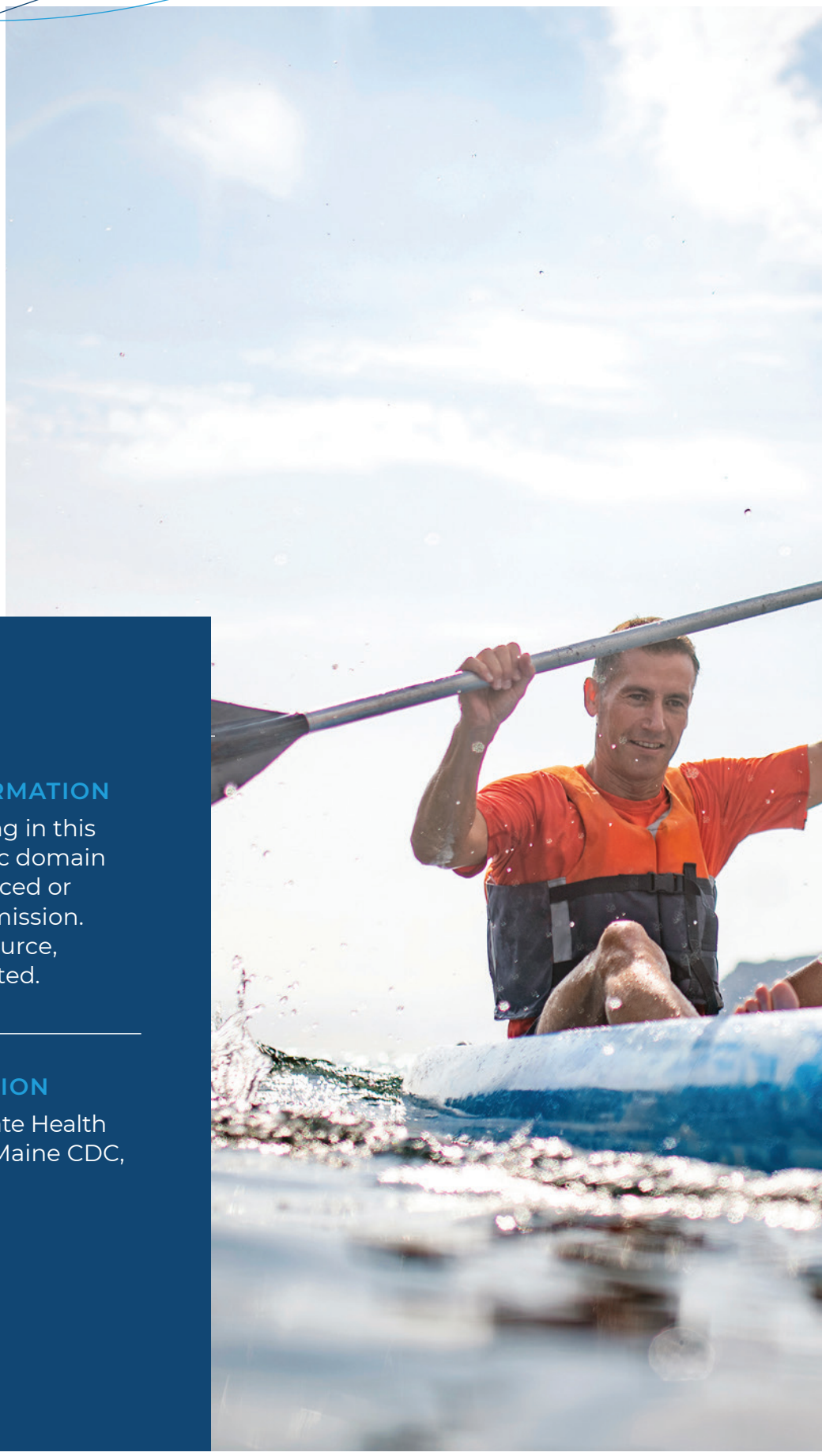
2024–2029

Maine State Health Improvement Plan

Maine Center for Disease Control and Prevention

286 Water St #11, Augusta, Maine 04333 | December 2024



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Maine 2024–2029 State Health Improvement Plan, Maine CDC, December 1, 2024

ACKNOWLEDGEMENTS

The *Maine 2024–2029 SHIP State Health Improvement Plan* was developed by members of the Maine SHIP Planning Team, comprised of health experts, stakeholders, and residents from throughout the state, and led by the Maine Center for Disease Control and Prevention.

The Planning Team's Priority Area Planning Work Groups formulated goals, objectives, and strategies for their respective Priority Areas, and are acknowledged on the first page of each Priority Area section of this Plan.

Many CDC and other state agency staff provided subject matter expertise, staffing for the Priority Area Planning Work Groups, and baseline data for this plan. Their names are listed in Appendix B to recognize their invaluable contribution to the Plan and the Maine 2024–2029 state health planning initiative.

We gratefully acknowledge the contributions of our consultant, Health Resources in Action (HRiA) Boston, MA for facilitating and coordinating the activities of the SHIP Advisory Council and Working Groups, and for developing and compiling this Plan, in cooperation with Maine CDC.

MAINE CENTER FOR DISEASE CONTROL AND PREVENTION

Sara Gagné-Holmes
Commissioner, Maine Department of Health and Human Services

Puthiery Va, DO
Director, Maine Center for Disease Control and Prevention (Maine CDC)

Dear Colleagues,

I am pleased to present the next iteration of the Maine State Health Improvement Plan, a collaborative framework for ensuring all people in Maine have a fair and just opportunity to attain their highest level of health. Equally important is that we, collectively, address and influence the health outcomes of all Maine people through cross-sector collaborations, partnerships, and population-based strategies.

The plan was developed following an unprecedented time for our state and nation. The COVID-19 pandemic, the tragic shootings in Lewiston last year, and the multiple severe storms in 2023 and 2024 have reinvigorated our aim to protect all Maine people from all health hazards. This includes not only infectious diseases but injuries, environmental risks, cancers, chronic disease, and conditions that lead to the poor health of our population. These examples also magnified the importance of effectively addressing the health needs of our most vulnerable populations and the pervasive impacts of social and structural inequities in our communities. People who were already disadvantaged by their race and ethnicity, age, disabilities, residence, socio-economic conditions, and other contributing factors have also been disproportionately impacted by these recent events. Our goal moving forward is to build upon collaborative relationships, invest in critical systems and infrastructures, remain ready to address emerging public health issues, and center our actions on the most structurally and historically disempowered.

This Plan is based on findings from the 2021 Maine Shared Community Health Needs Assessment. It focuses on four priority areas that have been consistently identified by our communities as critical for healthy people and healthy communities:

- Mental Health
- Access to Health Care
- Safe and Healthy Housing
- Substance Use

These priorities are centered on the root causes of health inequities and extend beyond the work of Maine CDC alone.

As part of the implementation of this Plan, Maine CDC intends to work with the State Coordinating Council for Public Health to monitor the SHIP's implementation and outcomes, including the continued engagement of multi-sector partners.

Thank you and congratulations to our many SHIP partners and the Maine CDC staff who contributed to this important process. I hope this Plan serves as a useful resource for your personal and organizational efforts to improve health, and I invite you to join us in fulfilling our vision of a healthy, safe, and resilient Maine.

Sincerely,

Dr. Puthiery Va, Director
Maine Center for Disease Control and Prevention

JANET T. MILLS
Governor

SARA GAGNÉ-HOLMES
Commissioner

Maine Department of Health and Human Resources
Maine Center for Disease Control and Prevention

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Introducing a collaborative framework for ensuring all people in Maine have a fair and just opportunity to attain their highest level of health.

Executive Summary

A State Health Improvement Plan (SHIP) is a strategic plan which provides guidance to the Maine Center for Disease Control and Prevention (Maine CDC), its sister agencies within the Maine Department of Health and Human Services, other state departments and agencies, and its many community partners for improving the health of the state's population.

The SHIP is the result of a **collaborative process** with multi-sector partners that **aligns** priorities and initiatives across communities to identify ways to advance them, remove or reduce barriers at the state level, eliminate redundancies, and coordinate efforts for maximum collective impact. **As a collaborative process, accountability for implementing strategies and meeting objectives is shared.**

The SHIP is based on four key priority areas that emerged from the 2021 Maine Shared Community Heath Needs Assessment, which extend beyond traditional public health programs and interventions.

THIS SHIP INCLUDES:

PRIORITIES

Statewide health priorities identified from the Maine Shared Community Health Needs Assessment (MSCHNA)

GOALS & OBJECTIVES

State-level Goals with measurable and evidence-informed Objectives to address the SHIP priorities through Policy, Systems, Environmental Change, and Primary Prevention strategies

DATA

Tracking data for each objective, including indicators, baselines, targets, and sources

Once launched, the SHIP will be implemented via Annual Action Plans that include activities, person(s) responsible for implementation, and participating partners. **These annual action plans will outline specific commitments of what actions will be undertaken, by whom, and by when.**

The Maine CDC engaged Health Resources in Action, Inc. (HRiA), a Boston-based, nonprofit public health consulting firm, in the facilitation and development of the *Maine 2024–2029 State Health Improvement Plan*. The process included a multi-sector, collaborative planning process in January 2024, as well as several rounds of feedback and editing by Maine CDC partners.

A key value that emerged during the planning process included a firm commitment to the principle that all Maine residents deserve to experience health and well-being throughout their lifetimes. The Maine CDC and its partners recognize that impacting the root causes of these issues requires a collaborative state-wide approach to change the practices, policies, environments, and systems that perpetuate inequities. *The Maine 2024–2029 SHIP* offered an opportunity for Maine CDC, the SHIP Advisory Council, and its partners to incorporate health and racial equity thoughtfully and meaningfully into the SHIP from the beginning of the planning process. We recognize achieving health equity is an ongoing effort, and anticipate that through the life of the SHIP, these elements will continue to grow and evolve.

THIS PLANNING PROCESS HAS RESULTED IN THE FOLLOWING GOALS AND OBJECTIVES FOR THE SHIP:

Priority Areas	Goal Statements	Objectives
 1. Mental Health	**GOAL 1:** Maine has an inclusive and equitable culture of mental health, resiliency, and well-being for all.	1.1: Increase mental health literacy among all youth and adults across the state and across all Maine's diverse communities and cultures. 1.2: Decrease stigma around mental health. 1.3: Improve access to mental health services. 1.4: Increase awareness and adoption of effective non-clinical culturally driven community supports for mental health. 1.5: Decrease the percentage of students who report an Adverse Childhood Experiences (ACEs) score of 4 or more. 1.6: Increase coordination and collaboration across formal and informal systems of care.

Priority Areas	Goal Statements	Objectives
 **2. Healthy & Stable Housing**	**GOAL 2:** Maine has housing that equitably meets the diverse needs of all.	**2.1:** Decrease the number of people experiencing homelessness. **2.2:** Increase the services available that support stable housing. **2.3:** Improve the quality, safety, and ADA accessibility of existing housing stock and the surrounding environment. **2.4:** Increase the number of collaborations among health, employers (public and private), and state and local housing organizations and agencies. **2.5:** Increase the supply of affordable housing in Maine.
 **3. Access to Care**	**GOAL 3:** Maine is a place where all people have equitable access to care that promotes health and well-being.	**3.1:** Improve the experience of care for all, incorporating cultural humility, linguistic competence, and trauma-informed practices into care delivery. **3.2:** Increase opportunities for regular system integration conversations among geographic healthcare providers and systems, public health, and community-based organizations. **3.3:** Increase the effectiveness of recruitment and retention efforts to have the necessary number and diversity of providers in underserved areas. **3.4:** Decrease the percentage of people in Maine for whom cost is a barrier to healthcare access. **3.5:** Increase the collection and utilization of shared, inclusive, and actionable data for use by communities, health systems, and state agencies. **3.6:** Build upon existing collaborative efforts to advance transportation and telehealth solutions.
 **4. Substance Use**	**GOAL 4:** All people living in Maine thrive in a healing, supportive environment that equitably addresses substance use, from prevention to recovery, and its impacts on individuals, families, and communities.	**14.1:** Enhance prevention efforts to decrease the percentage of people in Maine misusing substances. **4.2:** Increase the availability and use of community-based supports along the substance use continuum of care for anyone impacted by substance use. **4.3:** Increase the availability and use of intervention, harm reduction, treatment, and recovery services. **4.4:** Reduce stigma and bias associated with substance use. **4.5:** Advance substance policies to better meet the public health needs of communities.

History & Retrospective: The Path to The Maine 2024–2029 SHIP

BACKGROUND

The **Maine 2024–2029 SHIP** is intended to provide a framework for state and local government, communities, and organizations to use in leveraging resources, engaging partners, and identifying strategies for collective action. The plan is based on findings from the 2021 Maine Shared Community Health Needs Assessment (MSCHNA).

While the state health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. Historically, public health issues are identified by state or national public health experts and advocates, specific funding streams are developed to address the identified health issue, and Maine CDC or another related state agency is tasked with managing those funds and implementing programs based on specific guidance and restrictions, including contracting with other organizations to ensure adequate capacity is created to achieve the specific goals.

This approach has often limited Maine CDC and its partners in building true collaborative efforts that cut across these siloed funding streams, resulting in less coordinated efforts and a limited ability to engage a full array of participants that bring alternative perspectives to both planning and implementation efforts. Often the most potential for partnership are upstream efforts to address root causes and social determinants of health. However, Public Health Agencies are not always funded for such efforts, since they are often within the missions of other state agencies and organizations. Equally challenging for full coordination are those health issues for which multiple state agencies and other organizations have responsibilities or fall between the siloed efforts of multiple agencies and organizations.

Maine state, district, and local partners have recognized the value of building cross-sector collaborations, and they continue to strive for collective impact in addressing common issues that affect the health and well-being of Maine people. The priorities selected in the 2021 MSCHNA reflect this, as well as the need for further collaboration.

Maine's first state health improvement plan, Healthy Maine 2010, was developed in 2001 and built on the Healthy People framework, with goals that stretched over ten content areas, and ten years. Its successor, Healthy Maine 2020, added a specific focus on health disparities. Legislation to enhance Maine's Public Health Infrastructure in 1998 called for a three-year State Health Plan with a focus on those health issues that were driving health care costs and premature deaths, including chronic diseases and tobacco use. District Public Health Plans were created as part of this process.

In 2012, Maine CDC joined with three health systems, Maine Health, Maine General, and Eastern Maine Health Care (now Northern Light Health), to create the Shared Community Health Needs Assessment and Planning Process. This partnership, now including Central Maine Health Care and the Maine Community Action Partnership, has evolved into the MSCHNA completing a new health assessment every three years. Based on the 2013 MSCHNA, Maine created a new State Health Improvement Plan for 2015–2020. This plan narrowed its focus to five content areas, updating the previous plans. Due to limited resources during the COVID-19 Pandemic, a final report for this plan was not completed.

PHAB ACCREDITATION

The Maine Center for Disease Control and Prevention was accredited in 2016, an indicator that the agency **meets or exceeds rigorous public health standards** as determined by the Public Health Accreditation Board (PHAB). After delays due to the Pandemic, Maine CDC is currently engaged in documentation for reaccreditation.

PHAB requirements for reaccreditation are clear and primarily focused on an evidence-based process. PHAB requires the SHIP:

- To be based on a comprehensive State Health Assessment (the MSCHNA);
- To set community priorities for action; to identify measurable outcomes or indicators of health improvement and priorities for action;
- To consider Social Determinants of Health, causes of higher health risks and poorer health outcomes, and health inequities;
- To include plans for policy and system level changes for the alleviation of identified causes of health inequity; and
- To designate individuals and organizations that have accepted responsibility for implementing strategies.

PHAB requirements for implementation are likewise clear: PHAB requires that the SHIP be implemented, tracked, and reported on; and that the SHIP be a dynamic document that has flexibility in strategies and activities to accommodate changes in the environment.

Developing The Maine 2024–2029 SHIP Framework

The Maine Center for Disease Control and Prevention engaged Health Resources in Action, Inc. (HRiA), a Boston-based, nonprofit public health consulting firm, in the facilitation and development of the *Maine 2024–2029 State Health Improvement Plan (SHIP)*. A State Health Improvement Plan (SHIP) is a strategic plan which provides guidance to health departments, community partners, and organizational/agency stakeholders for improving the health of the state's population.

THIS SHIP INCLUDES:

PRIORITIES

Statewide health priorities identified from the Maine Shared Community Health Needs Assessment (MSCHNA)

GOALS & OBJECTIVES

State-level Goals with measurable and evidence-informed Objectives to address the SHIP priorities through Policy, Systems, Environmental Change, and Primary Prevention strategies

DATA

Tracking data for each objective, including indicators, baselines, targets, and sources

A SHIP is a collaborative process with multi-sector partners that aligns priorities and initiatives across communities to identify ways to advance them, remove barriers at the state level, eliminate redundancies, and coordinate efforts for maximum collective impact. **As a collaborative process, accountability for implementing strategies and meeting objectives is shared.**

FOCUS ON EQUITY

The Maine 2024–2029 SHIP offered an opportunity for Maine CDC, the SHIP Advisory Council, and its partners to incorporate health and racial equity thoughtfully and meaningfully into the SHIP from the very beginning of the planning process. As always, the work to build relationships that allow us to do this while working within systems that are historically rooted in discrimination and racism is challenging and on-going. With this in mind, our focus on equity is intended to be both aspirational in our goals and concrete in specific actions that can lead to those goals.

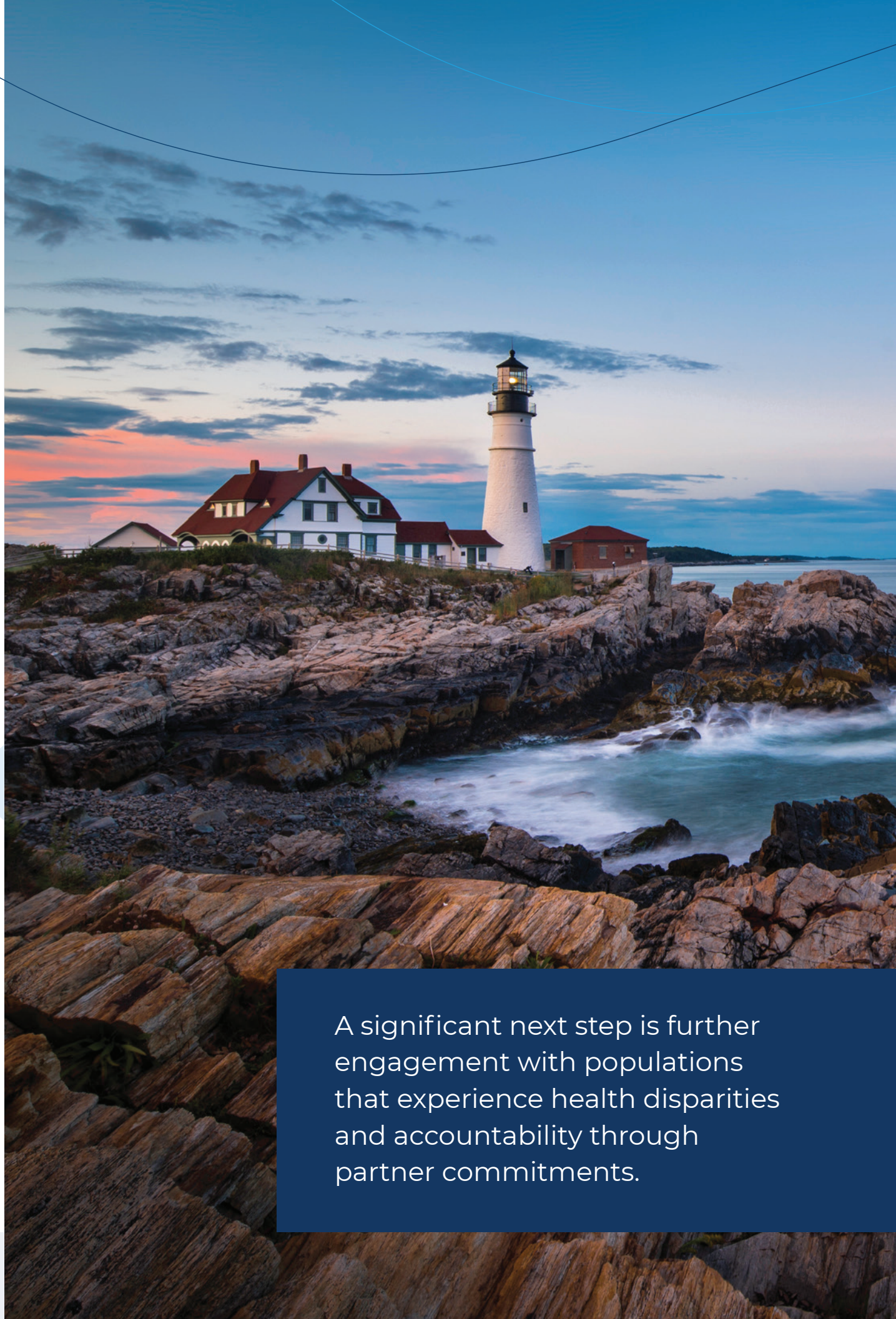
A key value that emerged during the launch of planning included a firm commitment to the principle that all Maine residents deserve to experience health and well-being throughout their lifetimes. This principle recognizes that no one entity can advance health equity in isolation and that a multi-sector and community-engaged approach is necessary to effectively understand and address the root causes of health disparities. A cornerstone of this principle is the acknowledgement that structural racism is a public health issue, and a racial equity analysis is a useful lens by which to also examine barriers to equity beyond race.

- **Health equity** is defined as the attainment of the highest level of health for all people, regardless of age, sex, race, or ethnicity, gender identity, sexual orientation, disability status, socioeconomic status, or geographic location factors that contribute to an individual's ability to achieve good health.

- **A health disparity** is a preventable difference in health status, risk factors, and/or health outcomes among subgroups of the population. Health disparities often stem from social, economic, or environmental disadvantages, which are collectively referred to as the Social Determinants of Health.

- **The Social Drivers of Health** are the conditions in which people are born, grow, live, work, age, and die that impact health, including the health system. While sometimes referred to as the social determinants of health, the alternate term "drivers" recognizes that these conditions significantly impact health outcomes but do not necessarily fully determine poor outcomes. Structural racism and other forms of systemic discrimination are among these social drivers of health. The social drivers of health disproportionately impact vulnerable or marginalized populations such as children and young people; people with disabilities; seniors; veterans; immigrants regardless of status; Black, Indigenous and People of Color; people recently or currently incarcerated; people with low or no income; people experiencing homelessness or experiencing housing insecurity; people with substance use disorders; and lesbian, gay, bisexual, pansexual, transgender, genderqueer, queer, intersex, agender, asexual and other queer-identifying (LGBTQIA+) people.

The Maine CDC and its partners recognize that impacting the root causes of these issues requires a collaborative state-wide approach to change the practices, policies, environments, and systems that perpetuate inequities.



A significant next step is further engagement with populations that experience health disparities and accountability through partner commitments.

The Planning Process

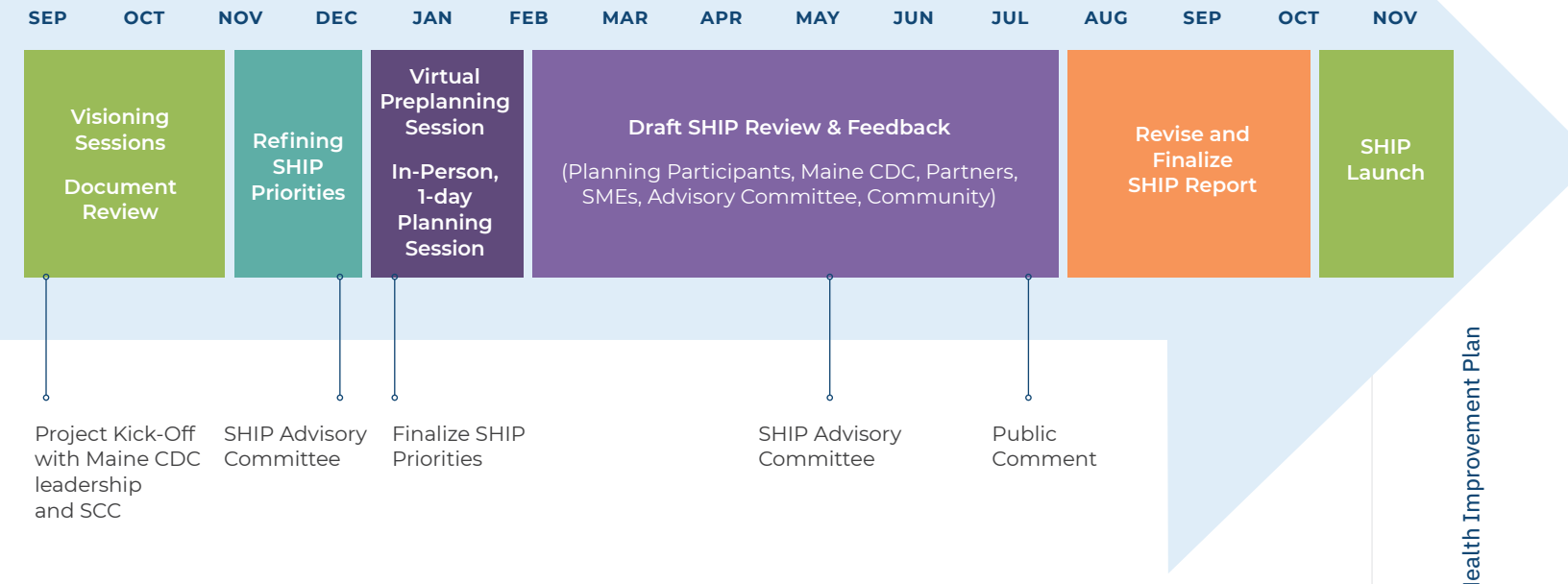
PLANNING MODEL

Development of this Plan utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[1]

Local public health agencies participated in both the Planning Work Group sessions and on the SHIP Advisory Council and provided important perspectives on *systems capacity from various regions* of the state.[1]

As this is a "living" document, Maine CDC expects that information-gathering and sharing will be an ongoing process that will be facilitated by Maine CDC during Plan implementation. A significant next step is further engagement with populations that experience health disparities and establishing accountability through partner commitments.

PLANNING TIMELINE



PARTNER AND COMMUNITY ENGAGEMENT

Accountable and effective public health practice depends upon comprehensive and strategic health improvement planning that engages a wide range of partners. Development of this Plan was led by the Maine Center for Disease Control and Prevention in collaboration with SHIP partners from across the state. Partner engagement is on-going and will expand throughout implementation.

Health Resources in Action (HRiA), a non-profit public health institute and consulting organization based out of Boston, MA, provided technical assistance, strategic guidance, and facilitation throughout the SHIP processes. HRiA was engaged to provide this guidance based on their experience working with several states to develop State Health Improvement Plans using a proprietary, trademarked, Facilitating Alignment and Strategic Thinking (FAST)™ planning process, as well as their commitment to addressing health equity.

Community engagement at multiple levels is critical throughout all components of a health improvement planning process, from conducting the state health assessment, to developing and implementing the goals, objectives, and strategies of the state health improvement plan. Involving a broad range of stakeholders and developing multi-sector partnerships led to the creation of this actionable and sustainable Plan. Stakeholders participated in SHIP prioritization activities, engaged in Priority Area Planning Work Groups, and responded to electronic feedback requests. Subject Matter Experts in each of the key priority areas were engaged by Maine CDC to help define indicators, baselines, targets, and data sources for each of the SHIP's objectives. Community members were invited to provide input via an online public comment period, which was promoted via Maine CDC distribution lists and extended networks and made accessible via the Maine CDC website.

IDENTIFICATION OF PRIORITY AREAS

The Maine 2024–2029 SHIP addresses the following four Priority Areas:

These four Priority Areas were identified through close examination of State Health Assessment data with Maine CDC leadership, and dialogue with critical partners in health (Maine SCC, SHIP Advisory Committee, and key subject matter experts) over a series of months.

They represent upstream factors that have large impacts on the health and well-being of Maine people, rather than specific health topic areas. The feedback from these engagements validated the approach and focus for this SHIP.

THE PLANNING SESSIONS

Planning for the Maine 2024–2029 SHIP took place in person in Augusta, Maine on January 31, 2024. Maine CDC leadership developed data sheets for participants in each of the four identified priority areas and recruited participants to engage in a one-day, facilitated planning session. All Coalition partners were invited to participate in a pre-planning webinar conducted by HRiA to ensure planning participants were well prepared for the planning session, understood the evolution and context for the SHIP framework, and were clear about expectations for engagement.

The planning session was structured in small and large group formats to develop plan components. The session was facilitated by HRiA and included opportunities for cross-priority feedback and refinement of each of the core elements of the plan.

MOVING FROM PLANNING TO ACTION

Maine 2024–2029 SHIP is designed to be a broad framework for state health improvement. It has been developed and written in a way that engages multiple perspectives, so that all community groups and sectors — private and nonprofit organizations, government agencies, academic institutions, community and faith-based organizations, and consumers — can unite to improve the health and quality of life for all people who live, work, study, and play in the state of Maine. This engagement is intended to be on-going, with new partners and perspectives added throughout the life of this plan.

The Plan reflects a thoughtful and cultivated engagement of diverse partners and stakeholders to collaborate in addressing shared issues in a systematic and accountable way. The next phase of the Plan will be to solidify a framework for implementation, including the outreach, confirmation, and convening of partners for Priority Area Action Teams; a Health Equity committee to ensure on-going inclusion of strategies to address a diversity of needs; and the development of annual action plans (work plans) that delineate responsibilities and accountability for implementing strategies in each priority area. The implementation phase will include ongoing communication with and between partners and stakeholders on plan activities and progress, monitoring and evaluation of plan metrics and deliverables, and ongoing cultivation of SHIP partners.

REFINING THE PLAN WITH EMERGING ISSUES

The 2022 Maine Shared CHNA was developed prior to the full impact of COVID-19, substantial work on a Public Health Response to Climate Change, and the mass shooting in Lewiston. These events demonstrate the need for public health to be responsive to changes in conditions, resources, and external environmental factors, while not losing sight of on-going and persistent public health needs. The Maine 2024–2029 SHIP should be modified and adjusted as these changes emerge. The SHIP will be monitored quarterly and adjusted annually as workplans are developed to accommodate emerging issues that were not part of the initial prioritization, and to adjust strategies as needed for more effective implementation.

HOW PARTNERS CAN USE THIS PLAN

In addition to the annual action plans that will be implemented collaboratively, the SHIP can also serve as a guide for separate action for a variety of stakeholders and organizations:

Community/Nonprofit/Faith-based Organizations:

- Seek to identify and understand systemic challenges, including institutional racism, and promote priority issues among the community members and stakeholders served.
- Talk with community members about the importance of wellness and connect them with available resources.
- Align activities and outreach efforts with health improvement needs and recommendations in this Plan.
- Advocate for changes that improve health by interacting with policy makers and legislative officials.

Government (Local, State)

- Seek to understand and promote priority issues in the community.
- Identify systemic barriers to health in the community and state, including institutional racism, and collaboratively make plans for effective action.
- Invest in programs, services, systems, and policy changes that will support the health needs of the community and state, while assuring equity for all Maine residents.
- Embrace the interconnectedness of all Social Drivers of Health in communities and utilize a health and equity lens when developing or improving policies and systems or making broad reaching decisions.

Businesses/Employers

- Seek to understand priority issues in this Plan and how they apply to/impact the workforce.
- Change work environments and enhance benefits plans to support healthier employees.
- Educate management teams and employees about the link between employee health and work productivity.
- Consider investments in employee retention and career development.

Individuals and Families

- Seek to understand and promote priority issues among family members and friends.
- Create opportunities to educate others and take action at schools, churches, workplaces, etc. to support the objectives in this Plan.
- Volunteer for service organizations in the community that address the Social Drivers of Health identified in this Plan.
- Get involved in state or local health improvement efforts by contacting local health departments.
- Learn about the impact of institutional racism on health.

Hospitals

- Incorporate recommendations into Community Benefits and organizational strategic planning.
- Lead organizations and the health care industry in responding to the health needs of the community and state.
- Partner with communities in catchment areas to address upstream issues impacting the long-term outcomes of patients and community residents.
- Identify how organizations could contribute to the development of a statewide health education framework.
- Explore ways that institutions can improve access, cultural competence, and cultural humility.

Health Care Professionals

- Identify important health issues and racial/ethnic/cultural barriers that exist for clients and use recommended practices to make changes
- Share the information in this Plan with colleagues.
- Lead peers in advocating for actions that will improve the health of the community.
- Explore ways to improve access, cultural competence, and cultural humility.

Health Insurers/Payers

- Educate employers and other health insurance purchasers about the benefits of preventive health care and responding specifically to the health needs of the state.
- Identify how organizations could contribute to the development of a statewide health education framework.
- Consider how organizations assist communities in addressing the Social Drivers of Health identified in this Plan.
- Explore the ways that institutional racism may be a contributing factor in organizations.

Education Institutions

- Understand and promote priority health issues in this Plan and incorporate them as educational lessons in health, science, social studies, and other subjects, or when designing research studies or service projects within the community and state.
- Create opportunities for action at schools to support the objectives in this plan that affect students, faculty, staff, and parents.
- Identify how organizations could contribute to the development of a statewide health education framework.
- Work with state and local partners to develop meaningful student engagement opportunities to better understand and address the Social Drivers of Health identified in this Plan.

The Plan

PRIORITY AREA 1	PRIORITY AREA 2	PRIORITY AREA 3	PRIORITY AREA 4
Mental Health	Healthy & Stable Housing	Access to Services	Substance Use

LEGEND

Indicates strategies that address **health equity**

Indicates a term defined in the **Glossary of Terms** (*Appendix E*)

MAINE SHIP SNAPSHOT

Priority Areas	Goal Statements	Objectives
1. Mental Health	**GOAL 1:** Maine has an inclusive and equitable culture of mental health, resiliency, and well-being for all.	1.1: Increase mental health literacy among all youth and adults across the state and across all Maine's diverse communities and cultures. 1.2: Decrease stigma around mental health. 1.3: Improve access to mental health services. 1.4: Increase awareness and adoption of effective non-clinical culturally driven community supports for mental health. 1.5: Decrease the percentage of students who report an Adverse Childhood Experiences (ACEs) score of 4 or more. 1.6: Increase coordination and collaboration across formal and informal systems of care.

Priority Areas	Goal Statements	Objectives
 **2. Healthy & Stable Housing**	**GOAL 2:** Maine has housing that equitably meets the diverse needs of all.	**2.1:** Decrease the number of people experiencing homelessness. **2.2:** Increase the services available that support stable housing. **2.3:** Improve the quality, safety, and ADA accessibility of existing housing stock and the surrounding environment. **2.4:** Increase the number of collaborations among health, employers (public and private), and state and local housing organizations and agencies. **2.5:** Increase the supply of affordable housing in Maine.
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 **4. Substance Use**	**GOAL 4:** All people living in Maine thrive in a healing, supportive environment that equitably addresses substance use, from prevention to recovery, and its impacts on individuals, families, and communities.	**14.1:** Enhance prevention efforts to decrease the percentage of people in Maine misusing substances. **4.2:** Increase the availability and use of community-based supports along the substance use continuum of care for anyone impacted by substance use. **4.3:** Increase the availability and use of intervention, harm reduction, treatment, and recovery services. **4.4:** Reduce stigma and bias associated with substance use. **4.5:** Advance substance policies to better meet the public health needs of communities.

PRIORITY AREA 1

Mental Health

WHAT IS MENTAL HEALTH

Mental Health was a top priority identified across all counties and community-sponsored events in the 2023 Maine Shared Community Health Needs Assessment. Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also determines how we handle stress, relate to others, and make healthy choices.[2]

The availability of providers is the most frequently mentioned issue raised by stakeholders related to mental health. There is concern that the current health care workforce cannot meet mental health needs. This shortage of providers increases mental health emergencies and the use of the emergency department for care. A second key theme is a concern for youth mental health — depression, suicide ideation, stress/anxiety, and mental health impacts of adverse childhood experiences. In 2019, 32.1% of high school students and 24.8% of middle school students reported feeling sad or hopeless for two or more weeks in a row, while 16.4% of high school students and 19.8% of county middle school students seriously considered suicide. The effect of the COVID-19 pandemic on mental health has been recognized across the state, including increased isolation, trauma, and stress. Those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services.[3]

GOAL STATEMENT:

Maine has an inclusive and equitable culture of mental health, resiliency, and well-being for all.

GOAL 1:

Maine has an inclusive and equitable culture of mental health, resiliency, and well-being for all.

Objective 1.1:

Increase mental health literacy among all youth and adults across the state and across all Maine's diverse communities and cultures.

Outcome Indicators	Baseline	Target	Data Source
Percentage of students who agree or strongly agree that in their community they feel like they matter to people*	**49.5%** (2023)	**53.0%** (5% improvement reversing recent trend)	Maine Integrated Youth Health Survey
Disparities between population groups in the percentage of high school students who answered that in their community, they feel like they matter to people. (Current populations with significantly worse percentages are listed in the baseline.)*	**43.2%** of Hispanic students **39.9%** of American Indian or Alaskan Native students; **45.1%** of Black or African American students **43.3%** of multiracial students **35.7%** of LGBTQ students; Students in Franklin, Sagadahoc and Somerset Counties	No significant differences between population groups	Maine Integrated Youth Health Survey
Percentage of Maine Schools that teach students how to get help for troublesome thought, feelings, or actions for themselves and others	**90.5%** (2022)	**98%** (benchmarked to "best state")	US CDC School Health Profiles
Percentage of schools that include mental and emotional health in a required course in any of grades 6–12	**98%** (2022)	**100%**	US CDC School Health Profiles
Adult mental health literacy indicator(s) as they are identified	To be determined	To be determined	To be determined

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

1.1.1 Identify or develop indicators to measure progress on adult mental health literacy.

1.1.2 Conduct an environmental scan of evidence-based mental health literacy programs across the lifespan.

1.1.3 Assess mental health education services provided across the state to identify gaps in services, including geographic deserts.

1.1.4 Identify programs that are culturally and linguistically diverse and address issues across the lifespan, and encourage their implementation.

1.1.5 Explore funding options to increase support for health educators to implement Maine Learning Results program (DOE) in health education at elementary levels.

1.1.6 Partner with law enforcement personnel to improve their awareness of mental health resources and to implement evidence-based interventions for responding to mental health service calls.

1.1.7 Identify social media strategies that include mental health literacy information and local resources and seek support for implementation.

1.1.8 Develop partnerships with Wabanaki Nations to implement culturally appropriate mental health literacy initiatives.

1.1.9 Develop partnerships with other organizations representing populations with disparate mental health outcomes to implement culturally appropriate mental health literacy initiatives.

1.1.10 Seek expansion of classroom-based mental health education curricula with particular attention to middle school and anti-bullying.

1.1.11 Identify peer-led modeling programs that promote mental health and seek avenues to implement these.

1.1.12 Work to expand the administration of the Maine Integrated Youth Health Survey to all Maine Schools. (*See also 4.1.10.*)

Objective 1.2:

Decrease stigma around mental health.

Outcome Indicators	**Baseline**	**Target**	**Data Source**
Among high school students who have ever felt sad or hopeless during the past 12 months, the percentage of students who answered that they got help from an adult*	**35.0%** (2023)	**33.3%** (5% improvement reversing recent trend)	Maine Integrated Youth Health Survey
Disparities between population groups in the percentage of high school students who answered that they got help from an adult (Current populations with significantly worse percentages are listed in the baseline.)*	**45.3%** of Hispanic students **48.4%** of American Indian or Alaska Native students **44.6%** of Native Hawaiian or Other pacific Islander students **45%** of multi-racial students, **60%** of LGBTQ students **40.5%** of Sagadahoc County students	**25%** decrease in differences	Maine Integrated Youth Health Survey
Percentage of respondents who report that they experience stigma related to a mental health diagnosis*	To be determined	To be determined	Office of Behavioral Health Block Grant consumer survey (future implementation)

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

1.2.1 Identify evidence-based stigma campaigns for implementation throughout Maine that address intersectionality, identity, and causality of mental health issues, and seek support for implementation.

1.2.2 Collaborate with partners to mount education campaigns in various settings: schools, workplaces, agencies on aging, supermarkets, faith communities and faith leaders, community centers, community radio and TV, etc.

1.2.3 Conduct a scan of healthcare training programs to determine baseline of mental health topics incorporated into programs.

1.2.4 Encourage the incorporation of education curricula about stigma in mental health in medicine/nursing/allied healthcare.

1.2.5 Engage populations with lived experience of mental health concerns who are disproportionately affected by stigma in the decision-making processes for the selection, design, and implementation of anti-stigma campaigns.

Help decrease stigmas related to a mental health diagnosis in Maine.

Objective 1.3:

Improve access to mental health services.

Outcome Indicators	**Baseline**	**Target**	**Data Source**
Number of people accessing higher acuity mental health services under Section 17	To be determined	To be determined	Office of Behavioral Health
Number of people with MaineCare coverage accessing outpatient Mental Health services	To be determined	To be determined	Office of Behavioral Health
Median wait-time between referrals and first appointment for MaineCare members needing clinical mental health services	To be determined	To be determined	Office of MaineCare Services and/or Office of Behavioral Health
Ratio of mental health providers per population	**180:1** (2023)	**162:1** (10% improvement same rate at 2018 to 2023)	Center for Medicaid and Medicare, National Provider Identification Registry via the County Health Rankings and Roadmaps
Reduction in hospital emergency department psychiatric/crisis visits	To be determined	To be determined	Maine Health Data Organization Inpatient & Outpatient Hospital Discharge Data or Syndromic Surveillance data
Reduction in Psychiatric Hospital Inpatient Length of Stay (State Hospitals)	To be determined	To be determined	Dorothea Dix Psychiatric Center and Riverview Psychiatric Center
Percentage of adults who experience poor mental health 14 or more days per month	**12.6%** (2020)	**12.0%** (5% improvement)	Behavioral Risk Factor Surveillance System

Outcome Indicators	Baseline	Target	Data Source
Disparities between population groups in the percentage of adults who experience poor mental health 14 or more days per month. (Current populations with significantly worse percentages are listed in the baseline.)*	**27.4%** of American Indian and Alaska Natives **22.4%** of multiracial adults **29.6%** of those with a household income less than $15,000, **24.2%** of those with MaineCare **32.5%** of those identifying as bisexual, **18.3%** of those who identify as lesbian or gay	Reduce differences by **25%**	Behavioral Risk Factor Surveillance System
Percentage of adults with mental health disorders who receive treatment	**59.6%** (2016–2019)	**62.6%** (5% improvement)	National Survey on Drug Use and Health
Percentage of children with mental health disorders who receive treatment	**51.2%** (2018–2019)	**56.3%** (10% improvement target matches best sub-population rate)	National Survey of Children's Health
Percentage of secondary schools that provide confidential mental health screening for students	**79.5%** (2022)	**83.5%** (5% improvement)	School health Profiles
Rate of deaths by suicide	To be determined	To be determined	Maine CDC Vital Records Statistical Death File

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

1.3.1 Evaluate and seek to improve incentives to increase and retain the number of mental health programs, agencies, and providers throughout the state, especially in rural areas, including those who accept MaineCare and provide services at low or no cost.

1.3.2 Explore the potential for tuition reimbursement programs for mental health service providers to work in remote rural areas of Maine. (*See also Objective 3.3*)

1.3.3 Promote peer to peer mental health practitioner tracks/programs.

1.3.4 Collaborate with universities to explore possible 2–year programs for mental health practitioners.

1.3.5 Seek to improve culturally appropriate mental health assessments and education for asylum seekers and undocumented immigrants.

1.3.6 Seek avenues to expand evidence-based universal mental health promotion and supports and regular screening in schools (e.g., guidance counselors, nurses).

1.3.7 Review policies related to education requirements for various MaineCare mental health community supports and explore possible recommendations that might expand access to services.

1.3.8 Explore new incentives and recruitment strategies to increase the number of mental health providers with the cultural and linguistic capacity to serve communities in need.

1.3.9 Explore incentives for rural community health workers (CHWs) and telehealth clinicians that might expand mental health access in schools.

1.3.10 Work to expand the inclusion of social workers in first response teams.

1.3.11 Explore options to increase mental health services and programs situated in community-friendly settings, and seek avenues to implement and promote such services.

1.3.12 Expand cultural competency training for existing and new mental health providers. (*See also Objective 3.1*)

1.3.13 Seek new strategies and expansion of capacity to address mental health needs that arise during emergencies.

1.3.14 Continue to expand evidence-based suicide prevention training and interventions.

1.3.15 Work to ensure that mental health services are accessible to all by identifying strategies that reduce transportation barriers and expand transportation options. (*see also Goal 3*)

Objective 1.4:

Increase awareness and adoption of effective, non-clinical, culturally-driven community supports for mental health.

Outcome Indicators	Baseline	Target	Data Source
Percentage of students who have support from adults other than their parents	**54.1%**	**56.8%** (5% improvement)	Maine Integrated Youth Health Survey
Disparities between population groups in the percentage of high school students who answered that in their community, they feel like they matter to people. (Current populations with significantly worse percentages are listed in the baseline.)	**45.2%** of Hispanic students **44.8%** of American Indian or Alaskan Native students **44.8%** of Asian students **47.6%** of Black or African American students **38.2%** of Native Hawaiian or Other Pacific Islander students **47.3%** of multiracial students **45.2%** of LGBTQ students **49.3%** of students in Lincoln County	**25%** decrease in differences	Maine Integrated Youth Health Survey
Percentage of secondary schools that implement school-wide trauma-informed practices	**84%** (2022)	**88%** (5% improvement)	School Health Profiles

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

1.4.1 Seek to identify or develop best practices for diverse, informal and non-traditional community supports for mental health, and foster skill development in these practices.

1.4.2 Develop indictors to measure the impact of community supports on mental health and to measure the spread of adoption of best practices in mental health promotion.

1.4.3 Foster collaborations and connections between youth and older people and establish pipelines in community settings to keep youth and older people engaged.

1.4.4 Explore grant opportunities for community-based organizations that provide culturally responsive, less "formal" therapies including traditional arts and nature connection.

1.4.5 Foster collaborations between larger health institutions and immigrant-run nonprofits to provide linguistically appropriate and culturally responsive community outreach and supports.

1.4.6 Collaborate with Maine's livable/age friendly communities to enhance social connectedness of older adults and reduce negative impacts of loneliness and isolation.

1.4.7 Explore training options to develop volunteer coaches and community leaders in trauma-informed, culturally sensitive skills (faith community, music theater, etc.).

1.4.8 Work to expand peer-support training in all 16 counties.

1.4.9 Work to expand supportive criminal justice diversions and treatment for people in Department of Corrections custody.

Objective 1.5:

Decrease the percentage of students who report an Adverse Childhood Experiences (ACEs) score of 4 or more.

Outcome Indicators	Baseline	Target	Data Source
Percentage of students who have support from adults other than their parents	**26.7%**	**25.4%** (5% improvement)	Maine Integrated Youth Health Survey
Disparities between population groups in the percentage of high school students who have reported four or more Adverse Childhood Experiences*	**33.6%** of Hispanic students **42.9%** of American Indian or Alaskan Native students **40.5%** of multiracial students **43.8%** of LGBTQ students	**25%** decrease in differences	Maine Integrated Youth Health Survey
Percentage of secondary schools that implement school-wide trauma-informed practices	To be determined	To be determined	Maine Young Adult Survey

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

1.5.1 Explore further expansion of in-school mental health services.

1.5.2 Identify and share national ACEs resources throughout public schools.

1.5.3 Work to expand ACEs awareness and education among teachers, parents, and providers.

1.5.4 Review current early detection and referral of risk factors for ACEs at childcare settings, Head Start, Home Visiting, and other child services and work to expand successful strategies..

1.5.5 Encourage assessments of ACEs among asylum-seeker children using language and culturally appropriate tools and seek to address identified needs.

1.5.6 Explore MaineHealth Pediatrics ACEs screening program for potential replication.

1.5.7 Promote policies and programs that support healthy families.

Objective 1.6:

Increase coordination and collaboration across formal and informal systems of care.

Outcome Indicators	Baseline	Target	Data Source
Percentage of secondary schools that have linked parents and families to health services and programs in the community	74% (2022)	78% (5% improvement)	School Health Profiles, Principal Survey
Percentage of children in foster care services that receive a mental health assessment	To be determined	To be determined	Office of Child and Family Services
Percentage of children in foster care services that receive access to mental health treatment or support services	To be determined	To be determined	Office of Child and Family Services

Strategies

1.6.1 Seek to improve consistent Care Coordination Unit (CCU) utilization for length of stay for emergency department patients.

1.6.2 Encourage regular care coordination meetings to increase understanding, remove barriers, and improve relationships.

1.6.3 Explore opportunities, including models from other states, for information-sharing between school health providers, primary care providers (PCPs), oral health providers, and/or mental health providers.

- Seek resources to implement a pilot

1.6.4 Seek avenues to incentivize regional collaboration.

1.6.5 Work with community-based organizations representing historically and currently marginalized and under-served populations to improve culturally competent care coordination for these populations.

Increase percentage of children in foster care services that receive access to mental health treatment or support services.

PRIORITY AREA 2

Healthy & Stable Housing

Healthy and stable housing is essential for overall health and well-being.

Homelessness is defined by the U.S. Department of Housing and Urban Development (HUD) as individuals and families who lack a fixed, regular, and adequate nighttime residence; including those who will imminently lose their nighttime residence; homeless under other federal statutes, or those fleeing domestic violence, assault, stalking, or other violence against an individual or family member.[4]

The lack of permanent shelter can lead to a complex set of challenges, many of which can impact an individual's ability to secure a fixed residence. This cycle can be difficult to break given a lack of a fixed address to receive mail, store and prepare food, or securely store belongings and medications. The inability to meet even these primary needs makes meeting daily social, emotional, and physical needs challenging.[5]

GOAL STATEMENT:

Maine has housing that equitably meets the diverse needs of all.

GOAL 2:

Maine has housing that equitably meets the diverse needs of all.

Objective 2.1:

Decrease the number of people experiencing homelessness.

Outcome Indicators	Baseline	Target	Data Source
Number of people (includes unhoused, unsheltered, and people in emergency shelters)	**6,000** (2023)	**5,700** (5% improvement reversing recent trend)	Homeless Management Information System (HMIS) plus Hub estimates of unsheltered homelessness
Most marginalized*	Black African Americans (**47%** of total) (2023)	Reduce disparities by **25%**	Maine Point in Time survey
Number of children under 18*	**1,236** (2023)	**1,113** (10% improvement)	Maine Point in Time survey
Number unsheltered	**299** (2023)	**167** (reduce to 2022 level)	Maine Point in Time survey and Hub estimates
Number of people chronically homeless	**370** (2023)	**351** (5% improvement)	HMIS Data
Other marginalized populations*	Unaccompanied children (**24**), young adults (**145**), veterans (**123**), domestic violence survivors (**245**), people with serious mental illness (**674**), transgender and nonbinary individuals (**51**), asylum seekers (baseline unknown) (2023)	**10%** improvement	Maine Point in Time survey

Outcome Indicators	Baseline	Target	Data Source
Median length of stay in Emergency Shelters, Safe Haven	**35 days** (2022)	**31 days** (10% improvement)	Homelessness Management Information System
Percent of those leaving Emergency Shelters, Safe Haven or Transitional Housing who return within 24 months	**16%** (2022)	**15%** (5% improvement)	Homelessness Management Information System
Percentage of HS students who did not usually sleep in their parent's or guardian's home or school housing in the last month	**2.6%**	**2.3%** (10% improvement)	Maine Integrated Youth Health Survey
Disparities in student housing instability*	**10.7%** of Hispanic students **9.3%** of American Indian or Alaskan Native students; **6.2%** of Asian students; **8.7%** of Black or African American students **24.1%** of Native Hawaiian or Other Pacific Islander students **7.7%** of multiracial students **4.7%** of LGBTQ students; **3.7%** of students in Franklin County	Reduce disparities by **25%**	Maine Integrated Youth Health Survey

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

2.1.1 MaineHousing and homelessness organizations will partner to ensure successful data collection initiatives across the state, including in rural areas, include annual homelessness count.

2.1.2 Amplify success of housing navigation initiatives and seek additional resources to increase the number of housing navigator positions to work with the most marginalized populations.

2.1.3 Work with populations who are disproportionately impacted by homelessness to identify and address barriers to stable housing.

2.1.4 Provide support for efforts to address homelessness:

- MaineHousing and Office of Behavioral Health will work together to encourage qualified developers and service providers to apply for Housing First projects where needed throughout the state (*See also 2.2.7*).
- Facilitate statewide coverage and collaboration for public health street outreach, outreach shelters, case management, and supportive housing.
- Support efforts to ensure the viability of low barrier emergency shelters across the state, including through the utilization of opioid settlement funds at the local, county and state level.
- Provide social risk screenings and services, including linkages to housing, through Federally Qualified Health Centers.

2.1.5 Support the growth and strengthening of the Homeless Hub System.

2.1.6 MaineHousing and the administrator(s) of the new eviction prevention pilot program will work with additional partners to identify households eligible for and in need of such assistance.

2.1.7 Work with foster youth and those recently timed out of foster care to improve support systems for foster youth to prevent aging out directly into homelessness.

2.1.8 Work with national decision makers to streamline the process for asylum seekers to secure work permits.

2.1.9 Assist Maine's Continuum of Care in improving the coordinated entry intake system.

2.1.10 Work with state and local policymakers to improve planning to mitigate housing issues as a result of disasters and emergencies.

Objective 2.2:

Increase the services available that support stable housing.

Outcome Indicators	Baseline	Target	Data Source
The number of Housing First units that include services for • single adults • families • youth and young adults*	To be determined	To be determined	Maine Housing Authority
The number of MaineCare members who have received supportive housing services	To be determined	To be determined	Office of MaineCare Service
The number of beds available in Recovery Houses	**1000**	**1050** (5% improvement)	Maine Association of Recovery Residences

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

2.2.1 Expand home visits for new families to identify those at risk of losing stable housing and connect them to services.

2.2.2 Catalog and promote existing housing services and where they are available, especially for people in low income/ public housing (e.g., by holding housing council meetings where people are).

2.2.3 Explore additional sources of funding for expansion of equitable housing services:

- Housing stabilization support workers to help people stay in current housing or increase skills to stay in new housing (could be same as a navigator but would need ongoing supports)
- Housing Opportunities for Maine (HOME) Fund allocations to MaineHousing to serve more people experiencing homelessness
- Specific programs for supporting LGBTQ+ youth and young adults who are experiencing housing instability
- Maintenance assistance staff to maintain and improve existing housing stock
- Visiting nurses and others to care for people in their home (e.g., those with substance use disorder and mental health challenges). (*See also Priority 1*)
- Renters and homeowners' insurance, including flood insurance

2.2.4 Explore strategies to improve recruitment and retention of Personal Support Specialist (PSS) workers.

2.2.5 Identify improvements for home support including for older adults, people with disabilities and MaineCare members.

2.2.6 Explore an 1115i waiver from Centers for Medicaid & Medicare Assistance (CMS) (MaineCare) to serve a greater number of tenants with housing support services. (*See also 2.5.2*)

2.2.7 Promote and assist in application and implementation of Housing First strategies equitably across the state. (*See also 2.1.4*)

2.2.8 Facilitate navigation by connecting residents with service providers to do one-on-one service reviews.

2.2.9 Map current mechanisms used to access public housing and housing assistance to relevant agencies, and work with Community Based Organizations to identify additional or new mechanisms to ensure equitable access for new and multigenerational BIPOC individuals.

2.2.10 Identify barriers to access public housing and housing assistance for other populations with increased rates of housing instability and unhoused status and implement changed or new mechanisms to ensure equitable access.

Objective 2.3:

Improve the quality, safety, and ADA accessibility of existing housing stock and the surrounding environment.

Outcome Indicators	Baseline	Target	Data Source
Percentage of children tested for elevated blood lead levels at both ages 1 and 2	**40%**	To be determined	Maine CDC Childhood Lead Poisoning Prevention Program
Percentage of adults in households with private well water who have tested their water*	**82%**	To be determined	Behavioral Risk Factor Surveillance System
Percentage of adults in households with private well water who have tested their water for arsenic*	**56%**	To be determined	Behavioral Risk Factor Surveillance System
Percentage of adults in households who have tested their indoor air for radon*	**35%**	To be determined	Behavioral Risk Factor Surveillance System
Households that experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities*	**13%** (2016–2020)	**12%** (5% improvement)	Comprehensive Housing Affordability Strategy data from HUD/ US Census
Number of Maine Housing Authority completed accessibility projects	**23** (2023)	**25**	Maine Housing Authority Program data
Number of Maine Housing Authority completed weatherization projects	**298** (2022)	**300**	Maine Housing Authority Program data
Efficiency Maine insulation and weatherization data	To be determined	To be determined	Efficiency Maine

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

2.3.1 Review existing standards for housing that receive public funding to determine if they should be strengthened.

2.3.2 Work with the Maine municipal association to support or create local programs to implement housing inspection and enforcement of housing standards for non-subsidized and non-rent restricted units.

2.3.3 Assess current supports for housing renovations and improvements to identify gaps and resources.

2.3.4 Work with partners, such as Maine Housing and CAPs, to weatherize and upgrade the energy efficiency of existing substandard housing stock, including through the utilization of federal energy efficiency investments.

2.3.5 Explore low-cost 'chore store' to fix minor problems affecting safe housing.

2.3.6 Increase reach of "Healthy Homes" programs across the state that provide support for renters and landlords to improve safety and ADA accessibility of housing and surrounding environment.

Healthy Homes Program should include:

- In-home and environmental testing
  - Lead
  - PFAs
  - Drinking water
  - Indoor air, radon, and dust exposures
  - Soil
  - Arsenic
- Promoting regulations and exploring incentives for landlords to regularly test water for arsenic, radon, and other contaminants.
- Identifying and obtaining funding for water and air quality testing remediation (including operation costs).

2.3.7 Work with environmental justice organizations to support people with greatest barriers and assist them to make improvements to their housing/environment.

2.3.8 Improve the quality of farm worker/migrant worker housing.

2.3.9 Promote existing on-demand, online resources (information) for renters and landlords.

2.3.10 Support organizations to ensure culturally and linguistically responsive communications regarding housing resources.

2.3.11 Advocate for primary care providers to ensure requirements for blood lead testing for children under 3 are met.

2.3.12 Explore the availability of Efficiency Maine services to address housing upgrades.

Objective 2.4:

Increase the number of collaborations among health, employers (public and private), and state and local housing organizations and agencies.

Outcome Indicators	Baseline	Target	Data Source
Number of collaborations	To be determined	To be determined	To be determined
Number of sectors involved in housing collaborations	To be determined	To be determined	To be determined

Promote existing on-demand, online resources (information) for renters and landlords.

Strategies

2.4.1 Assess current state of collaboration and available data.

2.4.2 Regularly host a Maine Housing Summit to bring together all potential collaborators.

2.4.3 Expand diverse participation in the Statewide Homeless Council to have healthcare workers at the table for housing conversations.

2.4.4 Create a standing council/committee on housing and health

- Identify potential collaborators, including service providers, and establish contact people
- Meet quarterly

2.4.5 Build partnerships between employers, towns, and state agencies to assess and address housing needs.

2.4.6 Explore lessons learned by communities that have tried affordable housing strategies and share good ideas and effective solutions.

2.4.7 Identify and adopt effective policies that promote housing where people work, with housing connected to transportation and other essential conditions.

2.4.8 MaineHousing, DHHS and Department of Education will continue to strengthen their collaborative efforts to house youth experiencing homelessness, especially in implementation of the new state-funded pilot program created for this purpose.

2.4.9 Promote community planning and development that creates intentional communities designed to enhance connection; social, behavioral, and psychological supports; and age-appropriate resilience for diverse populations.

2.4.10 Collaborate with primary care providers on education of providers and patients on housing quality — well water, radon, lead, and others.

2.4.11 Develop or implement incentives for more public/private partnerships.

Objective 2.5:

Increase the supply of affordable housing in Maine.

Outcome Indicators	Baseline	Target	Data Source
Percentage of households that spend 50% or more of their household income on housing*	**12%** (2018–2022)	**11%** (5% improvement)	US Census American Community Survey
Number of units available for vouchers	To be determined	To be determined	Maine Housing Authority
Number of new affordable housing units broken down by income thresholds for households at: • 80% area median income • 50% area median income • 30% area median income (the 30% being the hardest and least to be produced despite our state's deep poverty rates)	To be determined	To be determined	MaineHousing
Total number of project-based rental assistance units (site based)	To be determined	To be determined	HUD and MaineHousing should be able to measure this annually to show increasing supplies of rental assistance across the years.
Total number of tenant-based rental assistance vouchers (mobile and portable) available in Maine	To be determined	To be determined	HUD and MaineHousing should be able to measure this annually to show increasing supplies of rental assistance across the years.

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

2.5.1 Complete an asset map of existing available and potential housing stock that could be renovated to increase supply.

2.5.2 Leverage MaineCare to apply for Health-Related Social Needs (HRSN) waiver (1115i). (*See also 2.2.6*)

2.5.3 Leverage Housing First funding to develop new partnerships for housing.

2.5.4 Support the continuation of robust funding for affordable housing throughout the state, including through tax credits for developers building affordable/mixed use housing.

2.5.5 Explore policy changes and promote incentives to ensure Maine people have first access to new homes/spaces (not 2nd homes for out-of-staters).

2.5.6 Review property tax policies to find opportunities to increase equity regarding

- Primary homestead benefit
- Vacant housing units (including vacation homes)
- Affordable housing, including long-term affordability and additional types of housing that could be made affordable.

2.5.7 Develop criteria for municipalities for best practices on zoning, planning, and coding for private housing units transitioning to Airbnb or rentals.

2.5.8 Amplify and support housing plans that include:

- The construction or rehabilitation units at various AMIs
- Identification of capital funding for modular design housing for 100 persons/year
- Work with students from vocational schools to complete housing renovations at low cost

2.5.9 Develop consistent best practice criteria for homeowners and contractors for renovating older-adult occupied homes to add on a helper rental unit/ accessory dwelling unit (ADU).

2.5.10 Promote innovative/less traditional housing options (e.g., tiny homes for transitional or permanent options).

2.5.11 Identify strategies to increase sustainable transitional housing, including support for capital, operational, and service needs.

2.5.12 Increase the sustainability and affordability of in-home supports and housing maintenance for aging population.

2.5.13 Improve the use of vouchers for affordable housing, including increasing the number of vouchers and the number of landlords who will accept them.

PRIORITY AREA 3

Access to Care

WHAT IS ACCESS TO CARE?

Access to care means having the timely use of health services to achieve the best possible health outcomes. It consists of four main components: insurance coverage, availability of services, timeliness of access, and the provider workforce. Access to care was a top priority identified across all counties in the 2023 Maine Shared Community Health Needs Assessment.

Cost barriers to care and a lack of health insurance are on-going concerns expressed by stakeholders. Between 2015 and 2017, 10.6% of adults reported there was a time in the last 12 months when they needed to see a doctor, but could not, due to the cost. In 2019, 8.0% of Mainers were uninsured. Members highlighted the challenges in getting health insurance, notably among those with disabilities.[6]

Another theme regarding access to care relates to workforce issues, including the number of primary care providers throughout the state. In 2019, 20.0% of primary care visits across the state were more than 30 miles from the patient's home. In some counties, particularly in the more rural parts of the state, it is difficult to recruit and retain providers. There are increasing needs for culturally competent and educated providers.[7]

GOAL STATEMENT:

Maine is a place where all people have equitable access to care that promotes health and well-being.

GOAL 3:

Maine is a place where all people have equitable access to care that promotes health and well-being.

Objective 3.1:

Improve the experience of care for all, incorporating cultural humility, linguistic competence, and trauma-informed practices into care delivery.

Outcome Indicators	Baseline	Target	Data Source
Patient satisfaction from survey data*	To be determined	To be determined	To be determined
Percentage of health care providers that work with community health workers	To be determined	To be determined	To be determined

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

3.1.1 Assess the experience of care for diverse populations, especially those whose access to care has been restricted, to establish a baseline and inform further strategies.

3.1.2 Seek more diverse standardized patients/case studies for use in health care training programs and seek avenues to implement these.

3.1.3 Seek expansion of CLAS, patient-centered and trauma-informed care training for health care providers, including front desk, administrative, and system staff.

3.1.4 Seek to expand and support communities of practice for health care providers that integrate community health workers (CHWs).

3.1.5 Explore supports for collaborations between hospitals and other healthcare systems to ensure all patient information is in plain and preferred language (e.g., implementation of language access plan).

3.1.6 Explore supports for health care providers in collecting data on accommodation requests and outcomes of those requests.

3.1.7 Expand the use of best practices to all hospitals regarding patient advisory boards including community representation and engagement (e.g., providing feedback on all policy changes).

3.1.8 Seek to expand offerings of diversity, equity, and inclusion training as offerings for CEU's for licensure.

3.1.9 Encourage education for health care providers and staff about the detrimental impact of discriminatory practices based on a person's age on health outcomes for older people and strategies to counter them.

3.1.10 Seek to ensure that strategies to increase access are inclusive of all types of care such as dental, mental, substance use, and pediatrics, as well as services that address related social needs, such as nutrition and transportation.

Objective 3.2:

Increase opportunities for regular system integration conversations among geographic healthcare providers and systems, public health, and community-based organizations.

Outcome Indicators	Baseline	Target	Data Source
Number of regional conveners	To be determined	To be determined	To be determined
Number of regional participants and sectors	To be determined	To be determined	To be determined
Number of multi-disciplinary meetings held	To be determined	To be determined	To be determined

Strategies

3.2.1 Assess current status of regional system integration convenings to establish a baseline.

3.2.2 Understand and build upon existing collaboration efforts, ensuring that structures exist to support representation and engagement by CBOs serving ethnic and racial minority communities

3.2.3 Explore avenues to provide technical assistance to support organizational collaboration, regionalization of services, and multi-disciplinary and multi-sector cooperation.

3.2.4 Explore how to create space for system integration conversations and identify a lead convener.

3.2.5 Seek to identify stakeholders and sectors for engagement, including healthcare providers, supporting public health of CBOs in each public health district.

3.2.6 Encourage commitment and participation of stakeholders across multiple sectors through outreach.

3.2.7 Seek to ensure that strategies to increase system integration are inclusive of all types of care such as dental, mental, substance use, and pediatrics, as well as services that address related social needs, such as nutrition and transportation.

Objective 3.3:

Increase the effectiveness of recruitment and retention efforts to have the necessary number and diversity of providers in underserved areas.

Outcome Indicators	Baseline	Target	Data Source
Number of providers by type and geographic area, disaggregated by key demographic factors*	To be determined	To be determined	To be determined
Ratio of population to primary care physicians	To be determined	To be determined	Health Resources and Services Administration

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

3.3.1 Explore data and recommendations from health systems and community-based organizations on how to support provider recruitment and retention, including pay inequities across provider types.

3.3.2 Seek to expand efforts to reduce barriers to entering the workforce, including licensing for foreign-trained health care professionals.

3.3.3 Explore data on provider and staff shortages to establish baseline and identify gaps.

3.3.4 Explore incentives for providers to support innovation in care delivery, particularly across the long-term services and supports (LTS&S) continuum of care.

3.2.5 Develop recommendations for creating and/or enhancing resources (e.g., networks, workforce development programs, temporary career placement for high school students in long-term care or assisted living facilities, etc.) to encourage individuals to explore care delivery as a career.

3.3.6 Engage trusted community leaders/champions to learn about community perspectives and what community members can provide to improve the cultural competency and appropriateness of services, and to determine who to recruit for workforce related initiatives.

3.3.7 Engage with community health workers through Maine Community Health Worker Initiative (MECHW) to identify opportunities to expand the pool of CHWs and alleviate ER, EMS and PCP burden.

3.3.8 Explore incentives to encourage needed providers to work in underserved geographic areas and sectors of the health care system for a defined period of tenure.

3.3.9 Seek to expand services and supports for provider burnout, vicarious trauma, etc.

3.3.10 Promote existing pipeline programs for care careers.

3.3.11 Explore tuition reimbursement programs and other opportunities to incentivize young professionals to stay in Maine.

Objective 3.4:

Decrease the percentage of people in Maine for whom cost is a barrier to healthcare access.

Outcome Indicators	Baseline	Target	Data Source
Percentage of people enrolled in MaineCare *	**29.1** (2020)	To be determined	Office of MaineCare Services
Number of people who are eligible for MaineCare who are not enrolled*	To be determined	To be determined	Office of MaineCare Services
Percentage of people who are uninsured*	**8.0%** (2019)	To be determined	US Census
Number of people who are underinsured*	To be determined	To be determined	To be determined
The percentage of adults who report that they did not get health care they needed because of cost*	**9.4%** (2020)	**8.9%** (5% improvement)	Behavioral Risk Factor Surveillance System

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

3.4.1 Gather and review data to further identify specific populations without health insurance to better target interventions.

3.4.2 Seek to expand outreach to those who are eligible for, but not enrolled in MaineCare and CoverMe.gov (the State Based Marketplace).

3.4.3 Review potential opportunities to simplify and streamline enrollment processes on MaineCare, for example:

- Identify and eliminate duplication with other benefits program requirements
- Consider changes to MaineCare forms to make it easier to complete
- Expand to use of a single form to sign up for all state programs

3.4.4 Seek to expand the promotion of programs that reduce out of pocket health care expenses for uninsured/ underinsured people.

3.4.5 Explore strategies to improve equity in the cost of medical care across insurance companies/payors.

3.4.6 Encourage public and private payors to reimburse for coordination of care, assessing Social Determinants of Health, and navigation to services.

Objective 3.5:

Increase the collection and utilization of shared, inclusive, and actionable data for use by communities, health systems, and state agencies.

Outcome Indicators	Baseline	Target	Data Source
Number of data stewardship and sharing agreements	To be determined	To be determined	To be determined
Number of reports with disaggregated data	To be determined	To be determined	To be determined

Strategies

3.5.1 Explore and promote opportunities, such as a forum, where healthcare organizations can connect with community organizations and include more stakeholders to discuss what data they are collecting and analyzing in addition to data collected with state resources (BRFSS, etc.).

3.5.2 Seek avenues to increase the diversity and inclusiveness of those providing input to data collection, analysis, interpretation and dissemination of data, such as via a community data advisory board.

3.5.3 Explore ways to recognize and highlight the value of qualitative data and support collection, analysis, and dissemination with quantitative data findings.

3.5.4 Expand support for the integration of more community voices in community health needs assessments.

3.4.5 Explore and define data usage rights among community members and state agencies (e.g., ownership, control, access, possession).

3.5.6 Expand requirements and support for state grantee recipients to collect demographic data on known communities experiencing health disparities (e.g., disabled community) and to disaggregate data in all reports.

Objective 3.6:

Build upon existing collaborative efforts to advance transportation and telehealth solutions.

Outcome Indicators	Baseline	Target	Data Source
The number of MaineCare claims for transportation paid for by MaineCare by type	To be determined	To be determined	Office of Maine Care Services
The number of MaineCare claims that indicated the visit was received via telehealth	To be determined	To be determined	Office of Maine Care Services
Number of providers providing care via telehealth	To be determined	To be determined	Maine Health Data Organization, All Payer Claims Database
Number of patient encounters using the telehealth option*	To be determined	To be determined	Maine Health Data Organization, All Payer Claims Database

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

3.6.1 Seek ways to enhance the accessibility of online medical tools and platforms. (e.g., websites, patient portals, online registration forms/kiosks, telehealth and/or video conferencing platforms, telephone systems/phone trees, and broadband access).

3.6.2 Explore how Maine can improve the administration of Medicaid transportation, including expansion of the types of rides and bus fares.

3.6.3 Explore options to support, enhance, and promote mobility management programs to help people get to where they need to go in the community.

3.6.4 Explore the implementation of statewide plans for growth of public transportation that connects communities, includes rural areas (covers the full state), and integrates transportation services and systems. (*Consider a state-wide collaborative summit.*)

PRIORITY AREA 4

Substance Use

WHAT IS SUBSTANCE USE?

Substance and alcohol use was identified as a top priority among all counties across the state in the *2023 Maine Shared Community Health Needs Assessment*. Recurring use of alcohol and/or drugs can cause clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance and alcohol use has also been linked to co-occurring mental health issues such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), among others.[8]

Drug overdose deaths have been identified as a top health indicator of concern by stakeholder groups. Indeed in 2020, the rate of overdose deaths in Maine per 100,000 residents was 37.3, which is much higher than the 2019 rate of 21.5 in the U.S. overall. Furthermore, it is recognized these deaths do not occur in isolation, and that substance use disorder has rippling effects across families and communities across the state.[9]

An overall lack of preventive services and treatment options across the state, such as psychiatrists, counselors/social workers, and harm reduction and prevention outreach is another concern in the state.

Due in part to this lack of preventive services, hospital utilization for overdoses is also of concern. These issues continue despite the effectiveness and impact of recent efforts to support individuals with substance use issues.[10]

The objectives and strategies below overlap with the *Maine Opioid Crisis Strategic Action Plan*. Where they do, efforts will be coordinated with the Governor's Office of Policy, Innovation and the Future. (*see www.maine.gov/future/sites/maine.gov.future/files/inline-files/GOPIF_OpioidReport_2023.pdf*)

GOAL STATEMENT:

All people living in Maine thrive in a healing, supportive environment that equitably addresses substance use, from prevention to recovery, and its impacts on individuals, families, and communities.

GOAL 4:

All people living in Maine thrive in a healing, supportive environment that equitably addresses substance use from prevention to recovery and its impacts on individuals, families, and communities.

Objective 4.1:

Enhance prevention efforts to decrease the percentage of people in Maine misusing substances.

Outcome Indicators	Baseline	Target	Data Source
High school students who used marijuana use in the last 30 days	**18.3%** (2023)	**17.4%** (5% improvement)	Maine Integrated Youth Health Survey
Disparities in marijuana use*	**18.3%** Hispanic students **29.9%** American Indian and Alaska Native students **26.7%** multiracial students **25.5%** LGBTQ students	Elimination of any significant difference	Maine Integrated Youth Health Survey
High school students who drank alcohol in the last 30 days	**20.5%** (2023)	**19.5%** (5% improvement)	Maine Integrated Youth Health Survey
Disparities in alcohol use*	**18.3%** Hispanic students **29.9%** American Indian and Alaska Native students **26.7%** multiracial students **25.5%** LGBTQ students	Elimination of any significant difference	Maine Integrated Youth Health Survey
High school students who perceive that it is easy to get cannabis	**53.5%** (2023)	**50.8%** (5% improvement)	Maine Integrated Youth Health Survey

Outcome Indicators	Baseline	Target	Data Source
Disparities in perceived ease of access*	**18.3%** Hispanic students **29.9%** American Indian and Alaska Native students **26.7%** multiracial students **25.5%** LGBTQ students	Elimination of any significant difference	
Adult marijuana use	**21.3%** (2021)	**21.3%** (5% improvement)	Behavioral Risk Factor Surveillance System
Disparities in adult marijuana use*	American Indians and Alaska Natives, Multiracial individuals, gays and lesbians, and bisexual individuals all higher rates (2017–2020**)**	Elimination of any significant difference	Behavioral Risk Factor Surveillance System
Adults at risk for poor health consequences due to heavy drinking	**8.2%** (2021)	**7.8%** (5% improvement)	Behavioral Risk Factor Surveillance System
Disparities in heavy drinking*	Hispanics, Black or African Americans, Gays and Lesbians and bisexual individuals all have slightly higher rates	Elimination of any significant difference	Behavioral Risk Factor Surveillance System
Percent of schools that taught All 9 Alcohol- And Other Drug-Use Prevention Topics	**49.2%**	**54.1%** (10% improvement)	School Health Profiles
Number of lockable containers distributed (multiple storage?)	To be determined	To be determined	Maine CDC Substance Use Prevention Program
Eyes Open media campaign reach	To be determined	To be determined	Maine CDC Substance Use Prevention Program

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

4.1.1 Seek to expand collaboration between schools and service providers to provide evidence-informed education and support for youth starting in early childhood to reduce the risk of substance misuse.

4.1.2 Explore options to expand Multi-tiered Systems of Support (MTSS) approaches embedded in schools and to build out behavioral health supports in each tier (Tiers: 1. Schools need help and resources to build out tier 2 and 3 responses).

4.1.3 Seek to expand support for alternative schools, youth groups, and outdoor school programs for at-risk youth.

4.1.4 Expand the education and dissemination of tools and strategies for safer storage and disposal for substances and medication.

4.1.5 Identify and seek avenues to promote both strength-based approaches and evidence-based approaches to prevention that recognize community assets and needs.

4.1.6 Explore the needs and opportunities for local prevention providers to enhance their work in improving the community conditions in which young people live which are drivers of early substance use.

4.1.7 Seek to expand the use of Safe Sport by all school departments.

4.1.8 Work to expand education and training for athletic directors, coaches, choir, band and theater directors, and other adults leading extracurricular activities on positive youth development, and restorative approaches to responding to substance use.

4.1.9 Seek opportunities to expand the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) public health approach for persons at risk of or who are living with or experiencing substance use disorder.

4.1.10 Work to expand administration of the Maine Integrated Youth Health Survey in all Maine Schools. (*See also 1.1.12*)

Objective 4.2:

Increase the availability and use of community-based supports along the substance use continuum of care for anyone impacted by substance use.

Outcome Indicators	Baseline	Target	Data Source
Number of medical drop boxes and Narcan pick-up points (T1 — public data vs T2 — anonymous)	To be determined	To be determined	Office of Behavioral Health
Percentage of schools that provide assessment for alcohol or other drug use, abuse, or dependency for students	**30.3%**	**33%** (10% improvement)	School Health Profiles
Number of kinship caregivers receiving support for children affected by SUD	To be determined	To be determined	Office of Behavioral Health
Number of participants in family support groups	To be determined	To be determined	Office of Behavioral Health
Options Media campaign reach	To be determined	To be determined	Office of Behavioral Health
Number of people accessing Maine OD-ME app to get naloxone	To be determined	To be determined	Office of Behavioral Health

Strategies

4.2.1 Assess current or existing community-based supports to create a resource map that is updated, shared, and promoted widely.

4.2.2 Seek to expand the integration of Continuum of Care Coordinators and community health workers in every public health district to assess community-based supports, facilitate coordination of services, and identify gaps.

4.2.3 Explore opportunities to increase awareness of community-based supports and holistic healing opportunities through educational campaign and promotional materials (e.g., websites, flyers, notecards), information sheets for provider use, and information designed to inform minors of their rights to access services for substance use disorder.

4.2.4 Seek options to increase the number of medical drop boxes and Narcan pick-up points.

4.2.5 Seek to expand supports for family members' transportation to services.

4.2.6 Seek to expand behavioral health services in elementary schools.

4.2.7 Seek additional resources and financial support for kinship caregivers (foster and non-foster parents) of children affected by SUD who have been removed from their homes.

4.2.8 Explore options to expand the use of support groups and wrap around support services for family members of people who have died from overdose.

4.2.9 Seek to ensure that community-based support providers have knowledge and skills regarding best practices for assisting families and others affected by substance use.

Objective 4.3:

Increase the availability and use of intervention, harm reduction, treatment, and recovery services.

Outcome Indicators	Baseline	Target	Data Source
Number of mental health service providers trained in needs of children affected by substance misuse	To be determined	To be determined	Office of Behavioral Health, Children's Behavioral Health Program
Number of recovery services available by type	To be determined # of Recovery Centers # of Coaches # of Support Groups	To be determined	Office of Behavioral Health
Number of individuals served by recovery centers and coaches*	To be determined	To be determined	Office of Behavioral Health
Number of Opioid Treatment Plan (OTP) providers using Medications for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT)	To be determined	To be determined	Office of Behavioral Health
Number of inpatient beds	To be determined	To be determined	Office of Behavioral Health
Admissions for SUD treatment (in- and out-patient) for MaineCare members*	To be determined ____ Inpatient ____ Outpatient	To be determined	Office of Behavioral Health / Office of MaineCare Services
Number of new certified units of recovery residences	To be determined	To be determined	Maine Association of Recovery Residences

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Strategies

4.3.1 Explore options to expand training for children's mental health service providers to address the needs of children affected by substance misuse in the home.

4.3.2 Seek to better understand strengths, needs, and gaps of substance use services especially for populations/ communities disproportionately affected.

4.3.3 Explore opportunities for additional recovery supports including: additional rehabilitation facilities and beds, additional transitional housing units, more peer recovery centers, and expansion of residential recovery housing services for women with children.

4.3.4 Enhance collaboration between health care providers and those providing substance use services to improve care coordination for those with substance use disorders.

4.3.5 Explore ways to financially support transportation options/availability to intervention, harm reduction, treatment, and recovery services.

4.3.6 Analyze increases in MaineCare reimbursement for outpatient and inpatient treatments and services to inform future possible improvements.

4.3.7 Work to expand restorative justice practices in all Maine schools for youth substance use.

4.3.8 Work to expand the use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model to all adolescents in school-based health centers and primary care offices, as well as for older adult screening.

4.3.9 Work to continue and expand education offerings for medical providers to increase the use of Medications for Opioid Use Disorder (MOUD) and Medication-Assisted Treatment (MAT).

Objective 4.4:

Reduce stigma and bias associated with substance use.

Outcome Indicators	Baseline	Target	Data Source
Number of survey respondents who report incidences of stigma and bias (from Substance Abuse Prevention and Treatment Block Grant (SAPT BG))*	To be determined	To be determined	Office of Behavioral Health
Number of community members engaged in social media campaigns (Number of clicks (depending on type of campaign))	To be determined	To be determined	Office of Behavioral Health

**Indicators for which data source allows disaggregation by key demographic factors (e.g., race, ethnicity, socio-economic background, gender, sexual orientation, language spoken, disability status and type).*

Seek to better understand strengths, needs, and gaps of substance use services especially for populations/ communities affected.

Strategies

4.4.1 Explore methods to improve data on a baseline for stigma and bias experiences, including exploring new data collection, analysis and dissemination.

4.4.2 Identify and seek opportunities to promote evidence-based anti-stigma/bias programs.

4.4.3 Work to expand education programs for substance use prevention for school-aged children that are sensitive to stigma and bias. (*See also 4.2*)

4.4.4 Work to expand content on stigma and bias in provider training for substance use disorder treatment by engaging people with lived experience in facilitated conversations with medical professionals.

4.4.5 Explore opportunities to use social media to engage youth to decrease the stigma of accessing help and supports.

4.4.6 Seek avenues to promote and support recovery-friendly workplaces to support ongoing employment for those affected by substance use disorder.

4.4.7 Explore options for educational anti-stigma materials that can be used in training for employees, schools, medical offices, police/law enforcement, etc.

Objective 4.5:

Advance substance policies to better meet the public health needs of communities.

Outcome Indicators	Baseline	Target	Data Source
Development of state policy agenda	To be determined	To be determined	To be determined
Number of policies with oversight/enforcement	To be determined	To be determined	To be determined
Number of municipalities that have policies following best-practice principles	To be determined	To be determined	To be determined

Strategies

4.5.1 Assess opportunities for improvements to current state and local substance use policies and explore a state policy agenda for substance use.

- Potentially model the Climate Action Plan

4.5.2 Seek avenues to further support current initiatives that might revise policies and provide policy oversight/enforcement (e.g., support to criminal justice system to reduce availability of substances).

4.5.3 Explore ways to support municipalities to implement existing policies effectively.

Appendices

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SHIP Advisory Committee Participants

APPENDIX B:
Planning Work Group Participants

APPENDIX C:
Acronyms

APPENDIX D:
Glossary of Terms

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APPENDIX C:

Acronyms

AA/AI
Alcoholics Anonymous/Alanon

AAP
American Academy of Pediatrics

AARP
American Association of Retired Persons

ACEs
Adverse Childhood Experiences

ADA
The Americans with Disabilities Act

ADU
Accessory Dwelling Unit

BIPOC
Black, Indigenous, and other People of Color

BRFSS
Behavioral Risk Factor Surveillance System

CAP
Community Action Partnerships

CCSM
Consumer Council System of Maine

CCU
Care Coordination Unit

CDC
Centers for Disease Control & Prevention

CHC
Community Health Center

CLAS
Culturally and Linguistically Appropriate Services

CMS
Centers for Medicaid & Medicare Assistance

DHHS
Department of Health and Human Services

DOE
Department of Education

EMS
Emergency Medical Services

ER
Emergency Room

FQHC
Federally Qualified Health Center

HOME
Housing Opportunities for Maine Fund

HRSN
Health Related Social Needs

HUD
US Department of Housing and Urban Development

LGBTQ
Lesbian, Gay, Bisexual, Transgender, Queer

LTS&S
Long-term Services & Supports

MAT
Medication Assisted Treatment

ME
Maine

MECHW
Maine Community Health Worker Initiative

MEHAF
Maine Health Access Foundation

MCDC
Maine Center for Disease Control & Prevention

MEIR
Maine Immigration & Refugee Services

MOUD
Medications for Opioid Use Disorder

MPHA
Maine Public Health Association

MRBN
Maine Resiliency Building Network

MTSS
Multi-tiered Systems of Support

NA
Narcotics Anonymous

NAMI
National Alliance on Mental Illness

OADS
Office of Aging and Disability Services

OD-ME
Overdose Maine mobile phone app

OTP
Opioid Treatment Plan

PCP
Primary Care Provider

PSS
Personal Support Specialist

SAPT BG
Substance Abuse Prevention and Treatment Block Grant

SBIRT
Screening, Brief Intervention, and Referral to Treatment

SHIP
State Health Improvement Plan

SUD
Substance Use Disorder

YMCA
Young Men's Christian Association

TV
Television

APPENDIX D:

Glossary of Terms

ACEs:
Adverse childhood experiences, which can have long-term impacts on health, opportunity and well-being. Adverse childhood experiences are common, and some groups experience them more than others.

At-Risk (youth, adults):
Those in danger of being harmed by practices, policies, environmental factors, or systems.

Cultural Competence/Humility/ Responsiveness/Sensitivity:
Cultural *competence* is the ability to work respectfully with people from diverse cultures, while recognizing one's own cultural biases. Cultural *humility* is the ability to recognize one's own limitations in order to avoid making assumptions about other cultures. Cultural *responsiveness* involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural *sensitivity* is being aware that cultural differences and similarities between people exist without assigning them a value, positive or negative.

Efficiency Maine:
Office of Maine state government that provides programs and incentives to help upgrade the efficiency of homes and businesses.

Equity:
The quality of being fair and impartial, ensuring that everyone has access to the same rights and opportunities regardless of their background, gender, race, or other characteristics.

Evidence-Based Practice:
Using the best available research/data for decision-making and providing efficient and effective solutions based on science.

Formal Systems of Care:
Care provided by paid employees or volunteers in a clinical setting, such as a hospital, nursing home, or assisted living facility.

Health Literacy:
Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. *Organizational health literacy* is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Holistic Health:
An approach to wellness that simultaneously addresses the physical, mental, emotional, social, and spiritual components of health.

Housing First:
A policy, relatively new in Maine, that prioritizes getting someone into stable housing and then addressing substance use disorders, mental health conditions or whatever else may be contributing to chronic homelessness.

Informal/Nontraditional Community-Based Supports:
Arrangements where unpaid care and support provided by a relative, friend, neighbor, or community group.

Information Sharing:
the process of making the same data resources available to multiple applications, users, or organizations.

Intentional Communities:
An intentional community is a voluntary residential community which is designed to have a high degree of social cohesion.

Lived Experience:
People with lived experience are those directly affected by social, health, public health, or other issues and the strategies that aim to address those issues. This gives them insights that can inform and improve systems, research, policies, practices, and programs.

Long Term Care Continuum:
Long-term care (LTC) is one piece of a continuum of care that stretches from living at home completely independently to the 24–hour supervision and care provided in LTC facilities like assisted living and nursing homes.

MaineCare:
Provides free and low-cost health insurance to Maine residents who meet certain requirements, based on household composition and income.

Marginalized/Disproportionately Impacted Populations:
A population that has historically and systematically been denied access to services, resources and power relationships, which has resulted in poor outcomes across the spectrum. *Disproportionate impact* refers to a situation where a policy or practice affects a particular group of people more negatively than others, even if the policy or practice is not intended to discriminate.

New Family:
A new group of two or more persons related by birth, marriage/relationship, or adoption who live together; all such related persons are considered as members of one family.

Recovery Friendly:
Recovery Friendly Workplaces support their communities by recognizing recovery from substance use disorder as a strength and by being willing to work intentionally with people in recovery to support sustained and successful employment.

Resiliency:
The process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress.

Restorative Practices:
Restorative practices include ways of creating community that honor the importance of relationships amongst all members in the community; as well as practices to repair relationships when harm has been caused. Restorative practices address the needs of all people impacted by the harm.

Safe Sport:
Policy and practices for building a sport community where participants can work and learn together in an atmosphere free of emotional, physical, and sexual misconduct.

Social Determinants of Health (Social Drivers of Health):
The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Strength-Based Practice:
A social work practice theory that emphasizes people's self-determination and strengths. It is a philosophy and a way of viewing clients as resourceful and resilient in the face of adversity.

System Integration:
The process of connecting multiple, different systems or tools into a single, larger system that functions as one.

Structural racism:
Laws, policies, and practices, which may be explicit or implicit and written or unwritten, that create, condone, and perpetuate unfair treatment of people based on their race or perceived race.

Substance Use Continuum of Care:
The stages of care for those experiencing substance use disorder, from treatment and early recovery to maintenance and community support.

Trauma-Informed:
A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation.

Vicarious Trauma:
The emotional residue of exposure to traumatic stories and experiences of others through work; witnessing fear, pain, and terror that others have experienced; a pre-occupation with horrific stories told to the professional.

References & Notes

[1] MAPP, a comprehensive, planning process for improving health, is a strategic framework that local public health departments across the country have utilized to help direct their strategic planning efforts. MAPP is comprised of four distinct assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: https://www.naccho.org/programs/public-health-infrastructure

[2] Centers for Disease Control and Prevention. Available from: https://www.cdc.gov/mental-health/index.html

[3] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 7.

[4] HUD Exchange, Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Homeless Final Rule. Last accessed 4/15/2022: https://www.hudexchange.info/resource/1928/hearth-defining-homeless-final-rule/ United States Interagency Council on Homelessness, Maine Homeless Statistics. Last accessed 4/15/2022: https://www.usich.gov/homelessness-statistics/me/

[5] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 37.

[6] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 13.

[7] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 13.

[8] SAMHSA, https://www.samhsa.gov/find-help/disorders.

[9] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 16.

[10] State of Maine Community Health Needs Assessment Report 2022, Maine Shared CHNA, www.mainechna.org, 16.

Maine Center for Disease Control and Prevention

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