The Maine State Health Improvement Plan 2013-2017

Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Table of Contents

Executive Summary

The Maine Center for Disease Control and Prevention (Maine CDC), an office of the Maine Department of Health and Human Services (DHHS), is responsible for providing essential public health services that preserve, promote, and protect health. Many organizations, both public and private, share this goal. This Plan reflects the public health priorities of the Maine CDC and Maine DHHS, with significant input from our public health partners.

The State Health Improvement Plan (SHIP) is designed to improve the health of all Maine people. It focuses on six health priorities, with goals, objective, and strategies for achieving measurable success over the next three years. The first four priorities are categorical, or subject-specific, and the remaining two priorities are focused on public health infrastructure:

Categorical	Infrastructure
Immunizations	Inform, Educate and Empower the Public (Essential Public Health Service # 3)
Obesity	
Substance Abuse and Mental Health	Mobilize Community Partnerships (Essential Public Health Service # 4)
Tobacco Use	

The Maine CDC developed priorities and objectives for the SHIP by using data from:

2010:
Local Public Health System Assessments

2011:
District Public Health Improvement Plans;
State Public Health System Assessment;
Healthy Maine 2020

2012:
State Health Assessment

2012-2013:
Updated District Public Health Improvement Plans

Further input was gathered from:

- Private stakeholders, such as health care providers and community members
- Maine CDC staff
- Other Maine DHHS staff
- Other public stakeholders, including colleagues throughout local and state governments

Members of both Maine CDC leadership and the Statewide Coordinating Council for Public Health (SCC) selected priorities, based on criteria developed by the SCC. These priorities were then approved by Maine DHHS leadership and the SCC.

Six workgroups of subject matter experts developed measurable objectives, which were also approved by DHHS and the Statewide Coordinating Council for Public Health. These workgroups also developed strategies and identified potential partners for implementation.

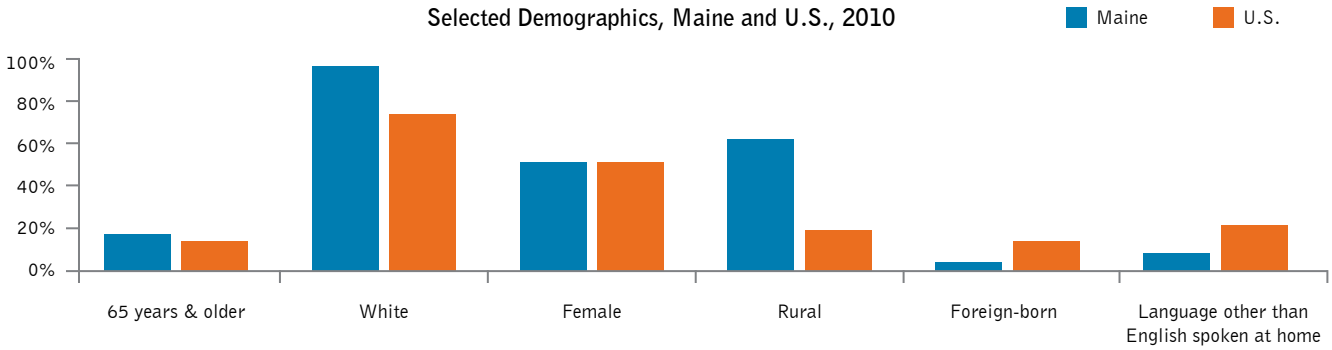
The final review process included Governor LePage and his staff, Maine DHHS leadership, and the Statewide Coordinating Council for Public Health.

The State of Maine's Health

Maine is a rural, older, primarily white, English-speaking state. Some of these factors can pose unique public health challenges, including higher rates of chronic disease, and fewer resources for low-English-proficiency residents.

According to the U.S. Census:

- 61% of Maine's population lives in rural areas.[1]
- Of Maine's 1.3 million residents, 17% are over 65 years of age, compared to 14% nationally.[2]
- The state's population is gradually becoming more racially diverse: the 2010 census shows Maine is 95% white, decreasing from 97% in the 2000 census.[3]
- Furthermore, 3% of the state's population is foreign born, compared to 13% nationally. 7% speak a language other than English at home.
- Women represent 51% of Maine's population.[2]



[1] U.S. Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports, 2010. Available at: http://www.census.gov/geo/reference/ua/urban-rural-2010.html

[2] U.S. Census Bureau. Maine People QuickFacts, 2012. Available at: http://quickfacts.census.gov/qfd/states/23000.html

[3] U.S. Census Bureau. 2010 Census Interactive Population Search. Available at: http://www.census.gov/2010census/popmap/ipmtext.php?fl=23

Maine State Health Improvement Plan Priority Areas

Immunizations

Increase youth and adult immunizations

- Increase routine childhood vaccinations
- Increase routine adolescent vaccinations
- Increase human papillomavirus (HPV) vaccinations
- Increase school-based access to influenza vaccinations
- Promote standard practices for tetanus, diphtheria, and pertussis (Tdap) vaccinations among obstetric providers
- Increase pneumococcal vaccinations among seniors

Obesity

Reduce youth and adult obesity

- Reduce consumption of sugar-sweetened beverages
- Increase consumption of fruits and vegetables
- Increase adult physical activity during leisure time
- Increase youth physical activity
- Increase infant breastfeeding

Substance Abuse and Mental Health

Reduce substance abuse and improve mental health

- Increase developmental screening of children birth to three years of age
- Promote drug-prescribing protocols in health care settings
- Increase Screening, Brief Intervention, Referral and Treatment (SBIRT) services
- Increase depression and substance abuse screening in health homes
- Increase adoption of evidence-based suicide prevention, screening and assessment in health care and school settings
- Increase access to substance abuse and mental health services via primary care providers

Tobacco Use

Reduce tobacco use and exposure to tobacco smoke

- Increase access to and use of state tobacco treatment programs
- Increase number of smoke-free environments
- Reduce exposure to indoor tobacco smoke in homes
- Increase partnerships with organizations serving vulnerable populations to promote or increase awareness of tobacco treatment, prevention, and control resources.
- Increase youth involvement in anti-tobacco initiatives

Inform, Educate & Empower the Public

Increase the community's awareness of public health

- Implement a system for distributing public health messages
- Increase use of plain language best practices

Mobilize Community Partnerships

Increase the community's active involvement in public health

- Increase community engagement in public health activities
- Increase awareness of the value of public health

Background

In 2011 the Maine Department of Health and Human Services (DHHS) began a process to engage public health partners in the creation of a statewide plan to improve the health of Maine people. As the State's public health agency, the Maine Center for Disease Control and Prevention (Maine CDC) has the responsibility to provide essential public health services to preserve, promote, and protect health. With many organizations, both public and private, sharing this goal, an engaged public-private collaboration assures efficient and effective services and systems.

Limited resources require careful choices on which priorities to address as well as a strong collaboration with our partners in non-governmental organizations to leverage resources.

This Plan reflects the public health priorities of the Maine DHHS, with significant input from our public health partners. We are committed to working collaboratively with our partners across the State to build on existing strengths and to respond to emerging priorities in an effort to improve the health of Maine people.

Maine's Public Health System

Maine has a centralized public health system, meaning that its public health administration is housed at one state level agency. While Maine's two largest cities, Portland and Bangor, have local public health departments, the state does not have any county health departments. The state's capacity to provide many public health services locally is through contracts with non-governmental organizations such as community non-profit organizations and health care providers.

Maine's public health agency, the Maine CDC, is an office of the Maine DHHS, whose overarching vision is: "Maine people living safe, healthy and productive lives." This vision is accomplished through its mission to: "Provide integrated health and human services to the people of Maine to assist individuals in meeting their needs, while respecting the rights and preferences of the individual and family, within available resources."

Maine DHHS programs and services are planned and delivered by the Maine CDC as well as by MaineCare Services (State Medicaid Program); Substance Abuse and Mental Health Services; Aging and Disability Services; Family Independence; and Child and Family Services.

Lead Agency

As an office of the Maine DHHS, the Maine CDC's vision and mission are aligned with the vision and mission of DHHS. During 2012, the Maine CDC Senior Management Team (SMT) developed a Strategic Map to engage and build statewide collaboration to shape the future of public health in Maine. This map (included on the following page), is the foundation for the State Health Improvement Plan (SHIP). The Maine CDC is the lead agency for the Maine DHHS in the development of the SHIP. Other DHHS offices and agencies, and public health partners throughout the State have contributed to the Plan through their participation on committees and workgroups.

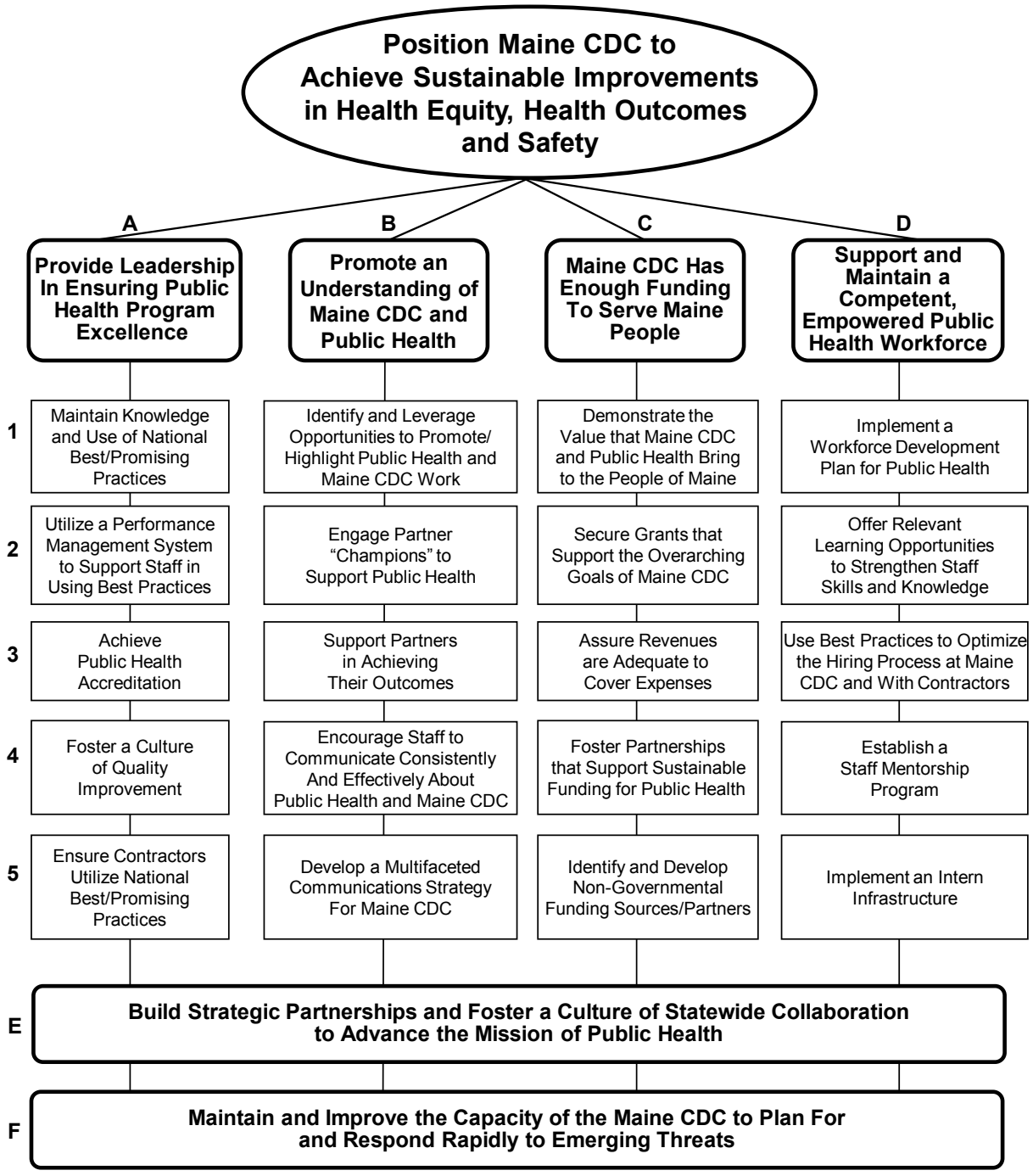
Maine CDC Vision

"A strong, safe and healthy Maine"

Maine CDC Mission

"To provide the leadership, expertise, information and tools to assure conditions in which all Maine people can be healthy."

Maine Center for Disease Control and Prevention
Department of Health and Human Services
Strategic Map: 2012-2015



(Revised 7/11/13)

District Infrastructure

In 2009, the Maine DHHS and State Legislature established **eight geographical public health districts, created from 16 counties**. Each district has a District Coordinating Council for Public Health. In 2011, the legislation was amended to create a **Tribal Public Health District (Wabanaki Public Health).** It is comprised of Maine's five Tribal jurisdictions and spreads across many of the geographical public health districts. The district level infrastructure also includes the Healthy Maine Partnerships (HMPs), a statewide network of comprehensive community health coalitions and an enhanced local health officer system.

The current public health infrastructure law is included as Appendix F.

Maps delineating the Maine DHHS District Offices, Tribal Health Geographic Areas, and the HMPs appear on the following pages.

Pubilc Health Districts Coordinating Councils were established to enhance effectiveness and efficiency of public health services by:

- Creating a geographic framework for greater consistency and equity in statewide delivery of the 10 Essential Public Health Services;
- Providing a consistent basis for regional planning and coordinating across the public, nonprofit, and business sectors;
- Building sustainable infrastructure through regional co-location of Maine CDC and other Maine DHHS staff.

The District Coordinating Councils (DCCs) help assure coordinated, effective, and efficient public health delivery in each district and provide information to the Statewide Coordinating Council for Public Health (SCC). District Public Health Improvement Plans specific to each of the Maine DHHS geographic public health districts have been undergoing renewal since their creation in 2011, and provided further input to the State Health Improvement Plan.

Statewide Infrastructure

The Statewide Coordinating Council for Public Health (SCC) is a representative body of public health stakeholders for statewide collaborative public health planning and coordination. The SCC advises the Maine CDC in its efforts to achieve and maintain accreditation. It also assists in planning for the 10 Essential Public Health Services and resources to be provided in each district and across the State in the most efficient, effective, and evidence-based manner possible.

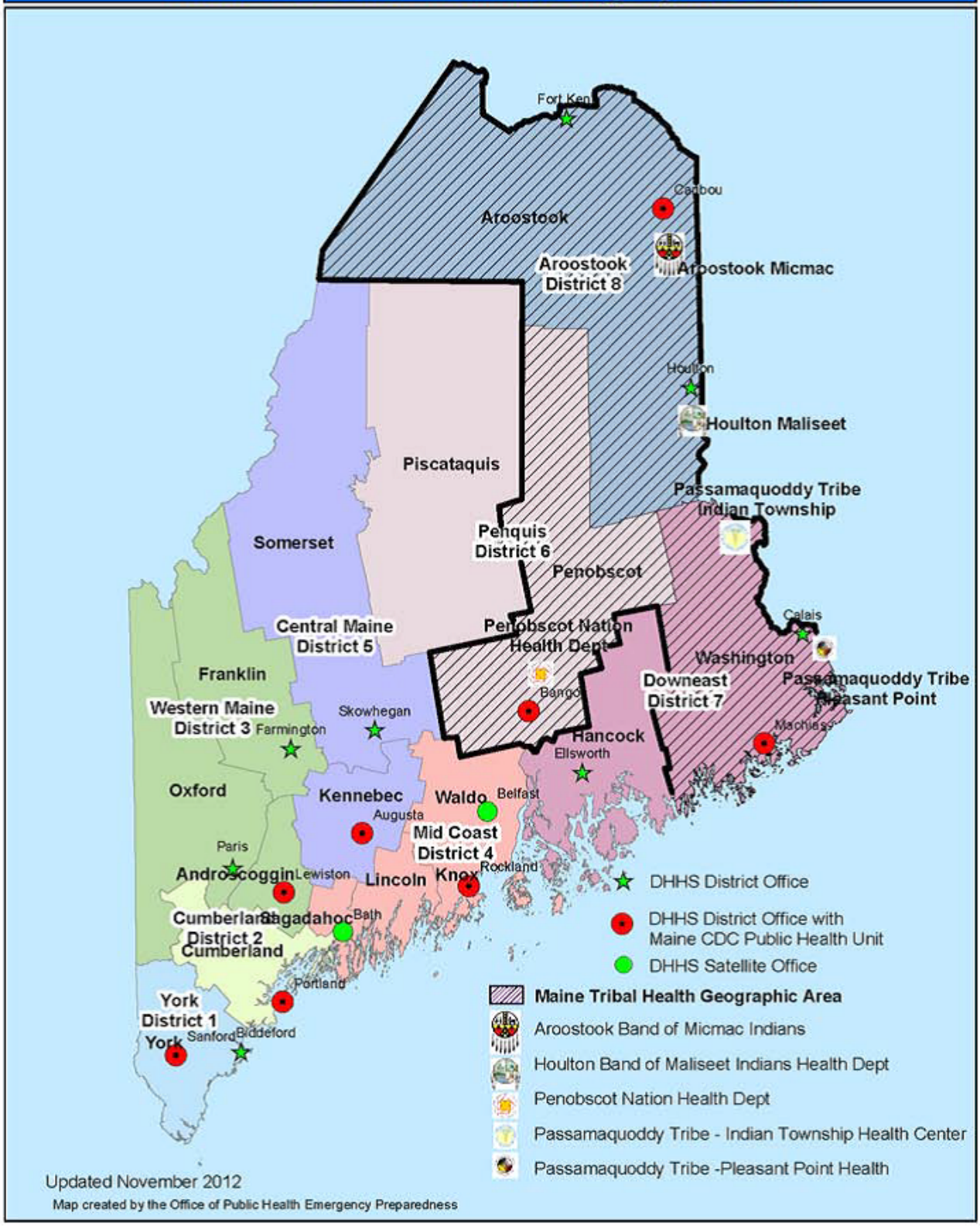
The SCC and DCCs provided input from their members on goals, objectives and strategies to be considered for inclusion in the State Health Improvement Plan. In addition, District Public Health Improvement Plans specific to each of the eight Maine DHHS geographic public health districts, initially created in 2011, have been undergoing renewal and provided some input.

State Health Planning in Maine: 1976-2011

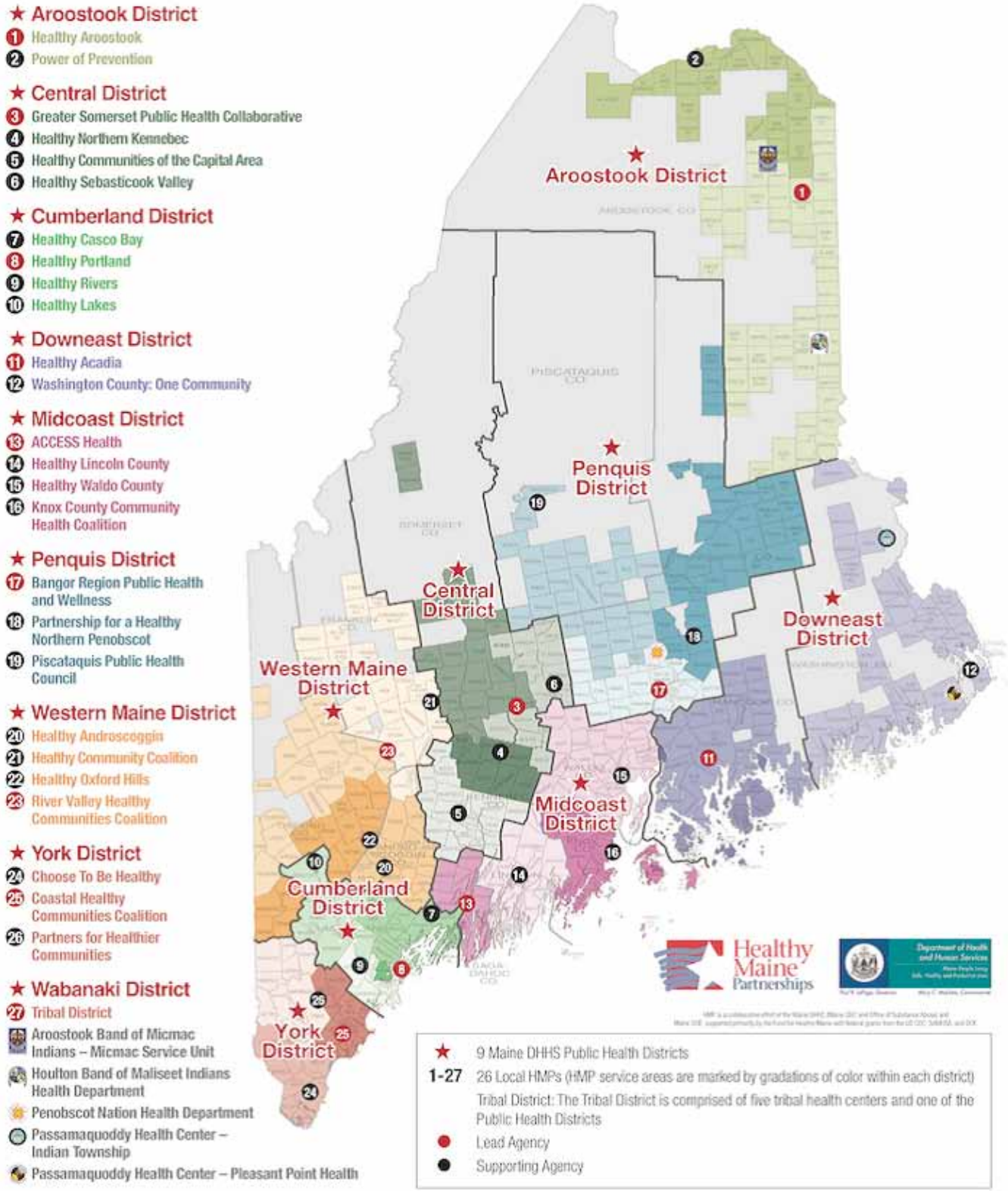
Over the past 40 years, the State of Maine has created various versions of a State Health Plan:

1976	1997	2003	2004-2010	2011
Federal recognition of the Maine Department of Health and Human Services as State agency with responsibility to conduct statewide health planning.	Legislation passed that stated Maine DHHS shall adopt a State Health Plan that addresses "health care, facility and human resources needs in the state." The Maine CDC (then Bureau of Health) was responsible for the development of this State Health Plan.	Governor's Office of Health Policy and Finance (GOPHF) established and required to issue a biennial state health plan.	GOPHF collaborates with Maine DHHS to issue three bi-annual state health plans (2006, 2008, 2010.)	The Maine Statute requiring a biennial State Health Plan was repealed; Maine DHHS endorses Maine CDC plan to seek national public health accreditation, which included a requirement for a State Health Improvement Plan.

Maine Department of Health & Human Services District Offices and Maine Tribal Health Geographic Area



Local Healthy Maine Partnerships



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

State Health Assessments

The State Health Improvement Plan was guided by state, district, and local assessment and planning efforts over the past several years.

Since 2010, there have been six processes that delineated assets, needs, or priorities:

2010	2011	2012-2013
Local Public Health System Assessments	District Public Health Improvement Plans State Public Health System Assessment Healthy Maine 2020	State Health Assessment Updated District Public Health Improvement Plans

These six processes have contributed to progress made in the development of public health infrastructure and the implementation of public health strategies across Maine. In addition, Maine CDC programs frequently conduct assessment and planning for specific populations and health issues. These assessments were incorporated in the SHIP process via input from Maine CDC staff.

1. Local Public Health System Assessments (LPHSAs)

In 2010, each of the eight geographical public health districts conducted Local Public Health System Assessments. These assessments were based on the National Public Health Performance Standards Program, using the Local instrument. The assessment reviewed public health system activities and capacity in each District and determined how well each was providing the 10 Essential Public Health Services. As a result of this process, all eight districts selected Essential Public Health Service # 7 (Link to essential health services); six of the eight selected EPHS # 4 (Mobilize community partnerships); and six of the eight chose EPHS # 3 (Inform, educate and empower) as priorities to address.

The 10 Essential Public Health Services are:

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

2. State Public Health System Assessment (SPHSA)

In May 2011, the Maine CDC contracted with the University of Southern Maine to conduct a State Public Health System Assessment using the Centers for Disease Control and Prevention's National Public Health Performance Standards Program State instrument. The assessment reviewed the state public health system's current activities and capacities, determining how well it was providing the 10 Essential Public Health Services. A group of approximately 110 stakeholders within Maine's public health community and in other related fields, such as education, transportation, and business, were invited to participate in an assessment meeting with five breakout sessions. Prior to the breakout sessions, an overview of the assessment process, tool, and expectations was provided. Participants were assigned to one of five groups, each focusing on a different set of essential services and questions. Rating cards were used to signify a participant's perception of the system's performance on elements within the 10 Essential Public Health Services. When perceptions varied widely during the initial vote, further discussion took place and the comments were recorded. A follow-up meeting was held in June to identify the specific contributions of the state public health agency and to share preliminary results. This assessment revealed the following strengths and challenges for Maine's public health system:[4]

Strengths
Diagnosing and investigating health problems and health hazards through a well-functioning public health laboratory system
Informing, educating, and empowering people about health issues by partnering with many agencies and organizations across the state.
Communicating efforts about public health threats and emergencies such as the 2009 H1N1 influenza epidemic and the 2012-2013 influenza season in a coordinated manner
Successfully convening planning processes to develop policies and plans that support individual and community health efforts, with a strong history of collaboration
Basing public health laws on science – Several public health system organizations routinely monitor public health-related laws that aid in allowing the enforcement of laws and regulations that protect health and ensure safety

Challenges
Assuring a competent public and personal health care workforce: it was recommended that Maine design a workforce development plan for the State that includes strategies for recruitment and retention
Conducting research for new insights and innovative solutions to health problems, utilizing existing research capacity more fully

3. District Public Health Improvement Plans (DPHIPs)

The 2008-2009 Maine State Health Plan called for the development of health improvement plans specific to each of Maine's eight geographic public health districts. Each of the eight districts used the DCC as the planning group for the **District Public Health Improvement Plan,** and based these plans on two sets of data: the **Local Public Health System Assessments** and the *Call to Action Report*.

In 2009, the *Call to Action Report* was created for each public health district. Forums were held in each of the eight geographic districts in the spring of 2010 to present the process and the *Call to Action* indicators.

The districts developed a review of the two data sources and a prioritization process in early 2010. In some districts, more emphasis was placed on the results of the **Local Public Health System Assessments;** in other districts, the emphasis

[4] Joly, B., Shaler, G., Booth, M. (2010). *State Public Health System Assessment: A Brief Review of the Findings.* Portland, Me: University of Southern Maine, Muskie School.

was on the *Call to Action*. All districts developed priorities and strategies based on both data sources. By January 2011, most of the eight districts had voted on their final **District Public Health Improvement Plan** and started implementing the strategies and actions.

The purpose of the **District Public Health Improvement Plans** is to address specific and unique strengths and health needs of all the communities within each district with plans to revisit and update priorities and plans every two years. District level plans have been prioritized based on a variety of data/indicator sources. Each **District Public Health Improvement Plan** is the result of the collective thinking and engagement of local partners committed to improving health across each public health district. The plans serve as the public health planning document that explores opportunities for significant public health improvements and is driven by data that matters locally and is comparable statewide.

These **District Public Health Improvement Plans** are in the process of being updated. The current **District public health priorities** are included as Appendix E.

4. Healthy Maine 2020 (HM2020)

Modeled after the national Healthy People series, Healthy Maine 2020 was developed in 2012 with input from a wide range of stakeholders to create key public health indicators in thirteen public health areas. These included the ten focus areas of Healthy Maine 2010 with the additions of public health emergency preparedness and public health infrastructure/health information technology. The thirteenth focus area is health equity, which is interwoven in the other twelve chapters of Healthy Maine 2020.

These indicators were selected from Healthy People 2020 indicators, and were supplemented with additional indicators when Maine-specific data was not available, or when stakeholders felt that indicators not included in Healthy People 2020 were more relevant or actionable. Workgroups were established, online surveys were developed, and meetings were convened to develop objectives and strategies to address the priorities.

Healthy Maine 2020 is available at: http://www.maine.gov/dhhs/mecdc/healthy-maine/index.shtml

Healthy Maine 2020 Chapters

1. Health Equity
2. Access
3. Chronic Disease
4. Environmental Health
5. Infectious Disease
6. Injury
7. Mental Health
8. Occupational Health
9. Physical Activity, Nutrition and Weight Status
10. Public Health Emergency Preparedness
11. Public Health Infrastructure and Health Information Technology
12. Reproductive Health
13. Substance Abuse

5. State Health Assessment (SHA)

Essential Public Health Service #1 calls for public health agencies to monitor the health of the population in its jurisdiction. To fulfill this service, the Maine CDC collects health-related data, analyzes that data and data from secondary sources, and shares this data along with that analyzed by other parties.

The purpose of the 2012 Maine State Health Assessment (SHA) is to provide a broad overview of the health of Maine residents, and to serve as a resource for state and local organizations and individuals needing population-health data.

In early 2012, the Maine CDC formed a steering committee comprised of internal staff to design and prepare for the SHA, oversee the collection and analysis of data, and compile results. A larger SHA Workgroup formed, whose nearly 100 members included representation from local public health departments, university research units, community coalitions, non-profit organizations, and other offices within the Maine DHHS as well as other state departments. Organizations and individuals who served in the workgroup ensured that broad community involvement was achieved and that content expertise was provided to the SHA. The workgroup's charge was to provide recommendations for data collection and to gather community input.

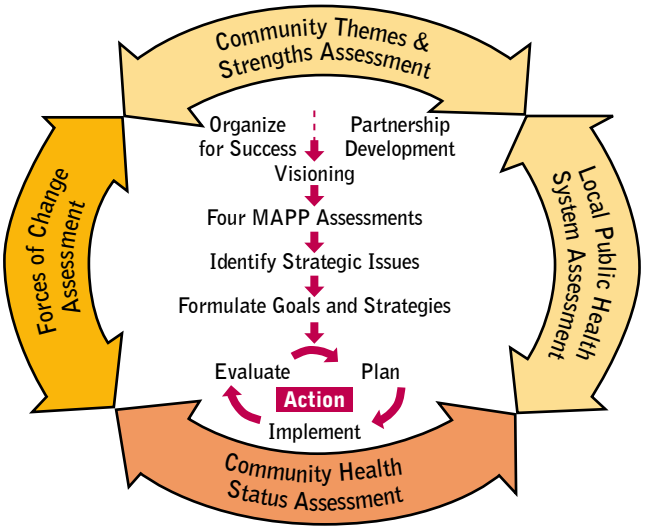
The Maine SHA provides population health status data for 167 public health indicators across 22 health topics. The list of indicators was developed with input from the SHA Workgroup, subject matter experts within the Maine CDC. HM2020 objectives and indicators used by other national and in-state health assessments were considered in the development of the SHA.

The 2012 SHA, including a summary, can be found at: http://www.maine.gov/dhhs/mecdc/navtabs/data.shtml

6. Community Health Improvement Plans (CHIPs)

Healthy Maine Partnerships (HMPs) are a statewide network of comprehensive community health coalitions. The HMPs receive funding from the Maine CDC and the Maine DHHS Office of Substance Abuse and Mental Health Services.

HMPs seek to make healthier the communities in which Maine residents live, work, learn, and play by reducing the incidence of chronic diseases: cardiovascular disease, chronic lung disease, cancer, diabetes, and substance abuse. All HMPs were required to utilize the Mobilizing for Action through Planning and Partnership (MAPP) framework in developing their CHIPs.



Source: http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/mapp/main

Mobilizing for Action through Planning and Partnership (MAPP) is a community-wide strategic planning tool for improving public health and quality of life. Use of the MAPP by the HMPs for the CHIPs began in the fall of 2010. In turn, the CHIPs have been used to inform the District-level Public Health Improvement Plan updates.

SHIP Prioritization Process

In 2009, Maine submitted a successful funding proposal to the US CDC to participate in the National Public Health Improvement Initiative (NPHII). This federal grant served as the springboard to the State Health Improvement planning process. In December of 2010, Public Health Performance Improvement (PHPI) was established as a unit within the Maine CDC's Division of Public Health Systems to implement the activities of the NPHII grant, with contracted staffing support from the University of Southern Maine. The PHPI Director formed a State Health Improvement Plan (SHIP) Core Planning Team, comprised of a diverse leadership group within the Maine CDC. The group began meeting weekly in the fall of 2011.

Priority Selection Process

In the summer of 2012, the SHIP Core Planning Team began to prepare for engaging statewide stakeholder input into selection of the SHIP priorities. Using a meta-analysis by the Los Angeles County Health Department of priority selection methods, the group developed a list of criteria as a guide in selecting priorities. This list was presented to the Maine CDC Senior Management Team (SMT), the Statewide Coordinating Council for Public Health (SCC), and the Maine DHHS Executive Management Team (EMT) for their feedback and approval.

The SHIP Core Planning Team then began soliciting input on the priorities to be included in the SHIP. During February 2013, approximately 500 stakeholders representing local community and public health organizations, hospitals, health care professionals, universities, and Maine CDC staff were invited to participate in an online survey; 190 responded to the survey. Stakeholders were provided with the results of the State Public Health Systems Assessment, the State Health Assessment, Healthy Maine 2020 objectives, National Prevention Strategy Strategic Directions and Priorities, and the priority selection criteria. They were asked to apply the criteria in making a determination of the public health issues to be addressed in the SHIP by ranking the topics in order of importance, with number one as the most important.

The top 10 ranked public health topics were:

- access to health services,
- physical activity and nutrition,
- tobacco,
- substance abuse,
- obesity,
- mental health,
- maternal and child health,
- health disparities, and
- health care quality.

The top three infrastructure areas identified were:

- Assure a competent workforce (Essential Public Health Service (EPHS) # 8),
- Link to health services (EPHS # 7), and
- Monitor health status (EPHS # 1).

The final agreed upon criteria are:

Categorical Selection Criteria	Infrastructure Selection Criteria
Magnitude of measure disparity between various groups (e.g., county versus other county, state, or federal comparisons; comparisons between various groups)	Alignment with national, state or local health objectives, including organizational strategic goals
Economic burden on the population, using mortality rates, prevalence, and incidence as proxy measures	Effectiveness of improvements
Integration with primary care, behavioral health care and hospitals	Feasibility of implementation of improvements
Alignment with national, state or local health objectives, including organizational strategic goals	Time and money that could be saved with infrastructure improvements
Effectiveness of interventions	Magnitude of measure disparity between various groups (between public health districts, using the local public health system assessments, Maine versus national averages)
Feasibility of implementation of interventions	Integration with primary care, behavioral health care and hospitals

In late February, the State Coordinating Council for Public Health (SCC) Executive Committee and Maine CDC's Senior Management Team attended a half-day session to select two to four categorical and one to two infrastructure priorities. Through a facilitated consensus process, the group rated each of the priority issues on a scale of one to six using the same selection criteria as the online survey. Seven categorical priorities were selected based on the highest overall scores. A subsequent session was held via web-conferencing to determine the infrastructure priorities: two priorities were selected.

The results of the sessions were summarized and the top ranked priorities were presented to the Maine CDC Senior Management Team. Further discussion resulted in six priorities being recommended for review and approval by the Maine DHHS Executive Management Team and the SCC.

Priorities

The SCC and DHHS Executive Management Team approved the following SHIP priorities:

Categorical Selection Criteria	Infrastructure Selection Criteria
Immunizations	Inform, Educate, and Empower the Public
Obesity	
Substance Abuse and Mental Health	Mobilize Community Partnerships
Tobacco Use	

Priority Workgroup Recruitment and Charge

In May of 2013, the Maine CDC contracted with MCD Public Health to convene and facilitate priority workgroups. These groups then met to develop an action plan to address the six SHIP priorities.

To move the work forward in each priority area, 78 public health subject matter experts committed to participate in workgroups to develop objectives, strategies, and performance measures and to garner Maine CDC and external partner commitment. Workgroup members were also instructed to make recommendations for monitoring implementation and progress of the plan.

A series of three meetings were held between May and July 2013 for each priority.

These workgroup participants had three options for participation: attend all in-person meetings, participate on a subcommittee, or be a reviewer. Between meetings, the workgroups communicated by using Google docs, email, conference calls, and in-person subcommittee meetings.

Each workgroup was given the goal for its priority; categorical priority goals were based on Healthy Maine 2020 and infrastructure priority goals were developed by the SHIP Core Planning Team. Each workgroup:

1. Reviewed and approved the goal,
2. Identified three to six major categories to drive objective development with an accompanying rationale for each objective,
3. Drafted objectives,
4. Developed strategies and measures,
5. Obtained additional expert input from stakeholders not participating in the workgroup, and
6. Submitted these documents to the workgroup for editing.

SHIP Approval Timeline

SHIP Core Team Review and Approval	July, 2013
Maine CDC SMT Approval	August, 2013
Maine DHHS EMT Approval	November, 2013

Maine's SHIP Goals, Objectives & Strategies for 2013-2017

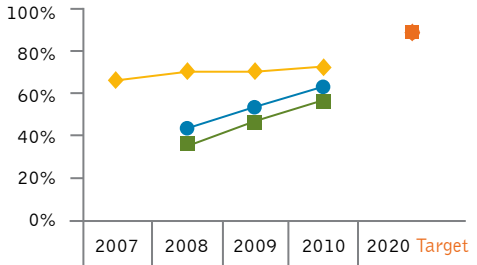
Below, the goals, objectives, rationale and strategies for each priority are listed. Appendices A–C provide additional information including measures for each objective, recommendations from the planning workgroups and DHHS staff, and references demonstrating the evidence base for each strategy.

Categorical Priority 1

Immunizations

While some vaccination rates are higher than U.S. rates, Maine adolescent vaccination rates are lower than U.S. rates, rates for Influenza vaccinations are particularly low, and none meet our Healthy Maine 2020 goals. There is a strong link to primary care, and this is a national priority. The evidence-base for immunization and for the strategies proposed for increasing rates is strong, and improvements are feasible given our Universal Vaccinations law, available federal resources, and the incentives provided via the Affordable Care Act.

Percentage of children routinely vaccinated, by vaccination type and age group, Maine, 2007-2010



	2007	2008	2009	2010	2020 Target
Children ages 19-35 months	66.5	70.6	70.5	72.7	90.0
Adolescents ages 13-17 years, one dose of Tdap booster		43	54	63.2	90.0
Adolescents ages 13-17 years, one dose of meningococcal vaccine		35.6	47.3	56.4	90.0

Data source: National Immunization Survey

Goal

Increase immunization rates in Maine by an average of 10% by June 2017. *(This is approximately 50% toward the Healthy Maine 2020 goals.)*

Objectives

Objective 1 Childhood Routine Immunization Schedule

Rationale/ Justification for the Objective: Immunization has been shown to be the most effective public health campaign in preventing disease. After a period of low childhood immunization rates, Maine has attained a significant increase in childhood immunization rates. Without continued maintenance and attention to routine childhood immunizations, another decline is possible. Adequate childhood immunization rates are necessary to maintain "herd immunity," to protect those too young or unable to be vaccinated. Existing data and resources facilitate monitoring of clinical practice and vaccination rates.

By June 30, 2017, Maine will increase routine childhood vaccination rates in children 24-35 months of age, assessed as of 24 months of age, by 10% — to be measured from 2011 baseline rates from the Maine Immunization Program (MIP) Quarterly Report Assessments.

STRATEGIES:

1.1. Educate health care providers on use of reminder/recall system.

1.2. Encourage provider enrollment and use of state registry.

1.3. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere.

1.4. Provide quarterly assessment reports to health care providers that are fully integrated into the ImmPact system (Maine immunization information system).

1.5. Conduct Assessment, Feedback, Incentives, eXchange of Information (AFIX) site visits to a minimum of 25% of Maine health care providers enrolled in the Vaccines for Children (VFC) program.

Objective 2 Adolescent Routine Immunization Schedule

Rationale/ Justification for the Objective: Immunization has been shown to be the most effective public health campaign in preventing disease. Adequate childhood immunization rates are necessary to maintain "herd immunity," to protect those too young or unable to be vaccinated. Existing data and resources facilitate monitoring of clinical practice and vaccination rates.

By June 30, 2017, Maine will increase routine immunization rates in adolescents 13-18 years of age by 10% — to be measured from 2011 baseline rates from the MIP Quarterly Report Assessments.

STRATEGIES:

2.1. Educate health care providers on use of reminder/recall system.

2.2. Encourage provider enrollment and use of state registry.

2.3. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere.

2.4. Provide quarterly assessment reports to health care providers that are fully integrated into the ImmPact system.

2.5. Conduct AFIX site visits to a minimum of 25% of Maine health care providers enrolled in the VFC program.

Objective 3 Adolescent Human Papillomavirus (HPV)

Rationale/ Justification for the objective: HPV vaccine offers the first vaccination for cancer prevention. Education and information are essential to the success of an HPV campaign.

By June 30, 2017, Maine will increase human papillomavirus (HPV) immunization rates in females and males 13-18 years of age by 10%.

STRATEGIES:

3.1. Provide assessment and feedback information to health care providers on current HPV vaccination rates and suggestions for methods to improve clinical rates.

3.2. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere.

3.3. Provide quarterly assessment reports to health care providers that are fully integrated into the ImmPact system.

3.4. The Maine Immunization Coalition will disseminate best practice information to health care providers and school based health centers on HPV vaccinations.

Objective 4 Seasonal Flu

Rationale/ Justification for the Objective: US CDC has issued new recommendations for universal influenza vaccine for all individuals greater than six months of age. School Located Vaccine Clinics (SLVCs) increase access to immunizations by reducing time away from school and work. SLVCs offer an efficient and cost-effective method to provide influenza vaccine. Influenza vaccination of children provides herd immunity to the entire community.

By June 30, 2017, increase the number of public school students in Maine who have access to a flu vaccine at their school by 10%.

STRATEGIES:

4.1. Identify underserved areas of need and work with School Administrative Units (SAUs) to increase the number of SAUs offering seasonal influenza vaccine.

4.2. Identify and recruit community partners to support and assist with school located vaccine clinics (SLVC).

4.3. Build a sustainable billing structure to cover vaccine administration costs associated with conducting SLVCs in Maine schools to include private health insurance reimbursement.

Objective 5 Adult Pertussis

Rationale/ Justification for the Objective: The US CDC has recently changed its recommendations to include pregnant and post-partum women in pertussis vaccination campaigns. Maine has seen an increase in the incidence of community pertussis outbreaks. Maternal pertussis vaccination is an effective and efficient "cocooning" method that provides protection for infants who are too young to receive the vaccine.

By June 30, 2017, 80% of all medical providers who perform obstetric services in Maine will receive information and tools to follow Advisory Committee on Immunization Practices (ACIP) tetanus, diphtheria, and pertussis (Tdap) guidance.

STRATEGIES:

5.1. Develop a packet of information for obstetric providers to include: the need and rationale for pertussis vaccine in pregnancy, recommended guidelines for administering pertussis vaccine, and reminder/recall systems.

5.2. MIP will send information packet to all enrolled providers.

5.3. Work with provider organizations to establish a baseline of providers who have new Tdap guidelines.

Objective 6 Pneumococcal Vaccination Among Seniors

Rationale/ Justification for the Objective:
Pneumococcal vaccine is one of the most highly effective vaccinations. The penetration rate and gaps in Maine are not well known. Pneumococcal vaccine resources are readily available.

By June 30, 2017, increase the percentage of Maine adults over age 65 who have received a pneumococcal vaccination, from 71.8% in 2010 to 79% in 2016 (a 10% increase).

STRATEGIES:

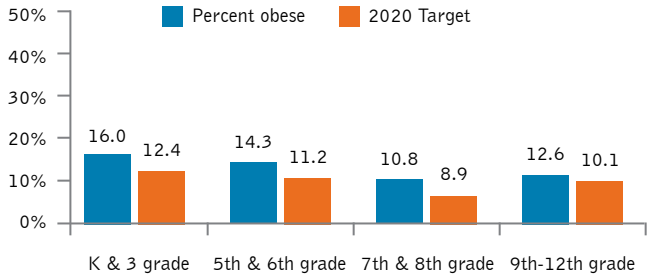
6.1. Explore possibilities for accessing, aggregating, and analyzing relevant population-level data for pneumococcal vaccinations in order to identify areas of need and facilitate strategic targeting of vaccinations and tracking of progress toward this objective.

6.2. Increase public and provider awareness of the recommendations for pneumococcal vaccination and execute proven communication strategies to engage both primary care providers and community partners/organizations who serve seniors in promoting pneumococcal vaccination.

Obesity

Obesity and being overweight are health issues for a significant portion of Maine's population. There are disparities based on race, ethnicity, income, education, and geography. There are roles for both public health and health care, and a strong link between obesity and behavioral health. This is also a national issue, and a priority for a number of public health districts in Maine.

Proportion of children who are obese by grade, Maine, 2009



Data source: Maine Integrated Youth Health Survey

Goal

Reduce adult obesity in Maine by 5% and youth obesity by 10% by June 30, 2017. *(This is approximately 50% toward the Healthy Maine 2020 goals.)*

Objectives

Objective 1 Decrease Sugar-Sweetened Beverage Consumption

Rationale/ Justification for the Objective:
There is very strong evidence of the connection between obesity and sugar-sweetened beverage consumption and research suggests that sugar-sweetened beverages are driving the obesity epidemic in the United States.

By June 2017, decrease the proportion of Maine adults and youth consuming one or more sugar-sweetened beverages a day by 10% for youth, grades k-12 (rate for adults will be established with baseline data). (NOTE: The definition of "sugar-sweetened beverage" is derived from the Maine Integrated Youth Health Survey (MIYHS)

STRATEGIES:

1.1. Increase outreach and education to the public and to partners, using currently available resources to decrease consumption of sugar-sweetened beverages.

1.2. Implement a media campaign to raise public awareness of the relationship between sugar-sweetened beverages and obesity.

1.3. Encourage school departments to limit access to sugar-sweetened beverages in schools.

1.4. Encourage providers to include screening and counseling on sugar-sweetened beverage consumption as part of routine medical care.

1.5. Discourage the consumption of sugar-sweetened beverages by seeking a waiver from the federal government to disallow the use of Supplemental Nutrition Assistance Program (SNAP) benefits for purchase of sugar-sweetened beverages.

Objective 2 Increase Fruit and Vegetable Consumption

Rationale/ Justification for the Objective:
There is a very strong association between fruit and vegetable consumption and overall health indices. A healthy diet is related to a decrease in chronic diseases. Increased consumption of fruits and vegetables displaces consumption of other unhealthy foods. This objective is easily measured.

By June 30, 2017, increase by 10% the proportion of the Maine population (adults and children) who consume five or more servings of fruits and vegetables a day.

STRATEGIES:

2.1. Increase outreach and education to the public and to partners, using currently available resources, to guide increased consumption of fruits and vegetables.

2.2. Promote Food Policy Councils as a way to increase access to affordable healthy foods for all Maine people.

2.3. Increase or expand fruit and vegetable market outlets such as farm to institution, farm to school, farmers' markets.

2.4. Increase participation in Fresh Fruit and Vegetable Program (FFVP) by maximizing the use of federal funds so that more schools can join.

Objective 3 Increase Physical Activity

Rationale/ Justification for the Objective:
There is a strong association between physical activity and physical and mental health as well as a reduction in chronic diseases. Physical activity has been called the "miracle drug." Physical activity is easily accessible and cost effective.

3a By June 30, 2017, increase by 10% the proportion of Maine adults who engage in some leisure-time physical activity.

STRATEGY:

3a.1. Work with municipalities to increase opportunities for active transportation and access to indoor and outdoor recreational facilities. This includes, for example, increased sidewalks, bike path trails for public use, and 'complete street' components, and would be done in compliance with Americans with Disabilities Act Accessibility Guidelines (ADAAG).

3b By June 30, 2017, increase by 10% the proportion of Maine youth (grades k-12) who engage in vigorous physical education that promotes cardio-respiratory fitness three or more days per week for 20 minutes or more each time.

STRATEGIES:

3b.1. Work with school departments to increase the number of schools that provide public access to indoor and outdoor school facilities for out-of-school physical activity.

3b.2. Work with childcare centers to increase the number of centers using evidence-based approaches (e.g. Nutrition And Physical Activity Self-Assessment for Child Care (NAP SACC), Let's Move!) to implement policies and create environments that support physical activity and meet safety guidelines.

3b.3. Work with schools to increase the proportion of middle and high school students who attend daily physical education classes, including increasing school offerings of daily physical education classes and student participation in them.

Objective 4 Breastfeeding

Rationale/ Justification for the Objective: There is a strong association between the health of a mother and baby and a long-term decrease in the probability of obesity. Breastfeeding is associated with employer cost savings and fewer days absent from work. Breastfeeding helps to lower infection rates in infants and lower pediatric health care costs.

By June 30, 2017, increase the percentage of infants in Maine who are ever breastfed to 80% and who are breastfeeding at six months of age to 45% by June 2017.

STRATEGIES:

4.1. Educate employers on how to comply with Maine Workplaces Support Nursing Moms law in order to support employees who are breastfeeding (including a private location to pump, flextime, and breast milk storage space).

4.2. Educate mothers about Maine Workplaces Support Nursing Moms law along with other applicable laws and resources for lactation support.

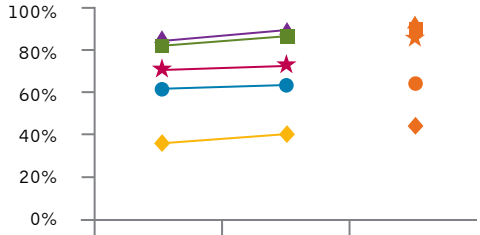
4.3. Educate child care centers on how to create and implement policies and environments that support breastfeeding.

4.4. Educate birthing facilities in Maine on the Baby-Friendly Hospital Initiatives 10 Steps to Successful Breastfeeding in order to increase the percentage of infants ever breastfed (including infants in a Maine neonatal intensive care unit (NICU) setting).

Substance Abuse and Mental Health

Substance abuse and mental illness affect many people in Maine, both directly and indirectly, through the consequences of behaviors and impacts on families and others. There are disparities based on race, income, and education. Better integration with primary care is a priority for Maine, and this a priority at both the national level and in some public health districts. There are many evidence-based strategies that can be implemented and a number of state and local resources that have been identified for this priority.

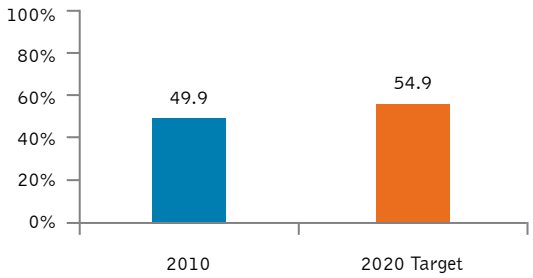
Percent of Adolescents Never Using Substances, Maine, 2000-2010



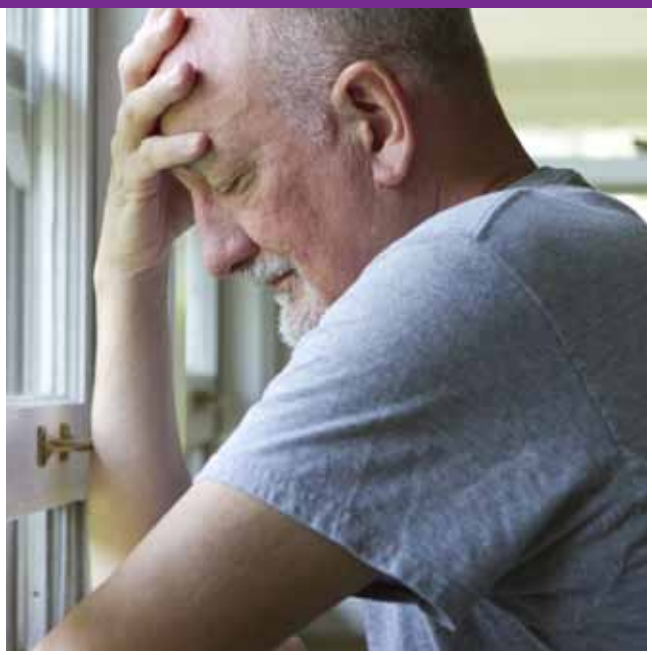
	2009	2011	2020 Target
Never had alcohol	35.9	40.6	44.5
Never used marijuana	61.8	63.6	65.0
Never taken prescription drug not prescribed	82.3	85.4	89.0
Never used inhalents to get high	83.9	88.1	92.0
Never smoked cigarettes	70.6	73.4	84.4

Data source: Maine Behavioral Risk Factor Surveillance System

Proportion of adults with moderate to severe depression, who report that they are receiving counseling or medication for their mental health, Maine, 2010



Data source: Maine Behavioral Risk Factor Surveillance System



Goal

Reduce substance abuse and improve mental health in Maine by 5% by June 2017. *(This goal encompasses a number of specific Healthy Maine 2020 objectives and approximately 50% toward the Healthy Maine 2020 goals.)*

Objectives

Objective 1 Early Intervention

Rationale/ Justification for the Objective: There is strong evidence of the negative long-term impact of adverse early childhood experiences throughout the adult years resulting in higher medical costs, lost productivity, and increased costs to society, including those caused by substance abuse or resulting in mental health issues. Home visiting and public health nursing services which support new families to address challenges in healthy ways have the potential to reduce such adverse experiences.

By June 30, 2017, increase the use of standardized screening tools in MaineCare health home practices for all children birth to three years of age.

STRATEGY:

1.1. Continue education of MaineCare health home practices in the use of developmental screening tools and in the submission of claims for the screenings through Improving Health Outcomes for Children (IHOC), the Patient Centered Medical Home (PCMH) Learning Collaborative administered by Maine Quality Counts, and the training being developed and implemented under the State Innovation Model (SIM) grant for primary care practices serving children with developmental disabilities.

Objective 2 Physician Drug Protocols

Rationale/ Justification for the Objective: The rates of prescription drug misuse are increasing exponentially. Maine has the highest rate of hospital admissions for opiate addiction treatment in the country. Practitioners are seeking guidance for prescribing protocols. Consistent prescribing practices and reductions in variation is good medical practice. There are health systems in Maine that have already developed model protocols.

By June 30, 2017, at least 80% of all hospitals, health systems, and Federally Qualified Health Centers will have controlled drug-prescribing protocols in place.

STRATEGIES:

2.1. Develop and distribute a fact sheet with key elements for drug-prescribing protocols and resources.

2.2. Identify Continuing Medical Education (CME) opportunities that are quality and user-friendly; obtain approval and buy-in from Maine Medical Association (MMA), Maine Osteopathic Association (MOA), Nurse Practitioner and Physician Assistant associations, and Maine Primary Care Association (MPCA).

2.3. Identify a method to assess the status of drug-prescribing protocols within a system of care.

2.4. Investigate how to integrate drug-prescribing protocols into electronic medical records (EMR).

Objective 3 Coordination of Care

Rationale/ Justification for the Objective: By treating underlying mental health or substance abuse issues, overall health is improved. Early intervention leads to a greater use of outpatient services and reduces the incidence of crises and hospital admissions. Tools such as Screening, Brief Intervention, Referral and Treatment (SBIRT) provide consistent, reliable, evidence-based and easy-to-use methods for providers to incorporate screening into routine health care.

Completed suicide and suicide attempts significantly affect the mental health of those who attempted and the loved ones left behind when someone dies by suicide. There are also significant associated health care expenditures. The greatest need perceived by people experiencing suicidal thoughts is for therapy or counseling.[1] Primary health care providers are in a unique position to assess suicidality in their patients. In the United States, primary care, including school-based health centers, is the number one source for mental health care, and in many areas, especially rural ones, it is the patient's only source for mental health treatment.[2]

Several prevention strategies have strong evidence of effectiveness, including screening and treatment for depression in primary care practices and emergency departments, community-based education, and comprehensive school-based programming. Maine's Federally Qualified Health Centers have begun integrating suicide prevention into their practices. Assessment is performed

by primary care providers, with mental health treatment provided on-site by psychiatrists and therapists, or through formal referral and treatment protocols with off-site mental health providers. Published studies using random controlled trials of integrated primary care, suicide assessment, and treatment for depression have found significant decreases in suicidal behavior.[3] Consistent assessment of suicide risk of patients by health care providers is an opportunity to intervene early, provide appropriate referral for necessary services and decrease health care costs.

3a. By June 30, 2017, the number of patients receiving Screening, Brief Intervention, Referral and Treatment (SBIRT) services in Maine will increase by 50% above 2013 baseline data.

STRATEGIES:

3a.1. Educate physician practices in the use of SBIRT tools and billing codes.

3a.2. Explore and learn more about the use of SBIRT in electronic medical records developed by Eastern Maine Healthcare Systems.

3b. Increase the number of MaineCare health home practices that perform depression and substance abuse screening using nationally recognized, evidence-based standard tools.

STRATEGY:

3b.1. Educate MaineCare health home practices in the use of depression and substance abuse screening tools through the Patient Centered Medical Home Learning Collaborative.

3c. By June 30, 2017, increase the number of primary care practices and schools implementing evidence-based suicide prevention screening and assessment as a standard model of care.

STRATEGIES:

3c.1. Provide education and training to primary care providers, including staff of school-based health centers, on the integration and use of nationally recognized evidence-based suicide prevention screening and assessment tools.

3c.2. Provide Maine's Gatekeeper training to all public school staff: a one day program that includes skills practice and has been shown to significantly increase a respondent's knowledge of warning signs and risk factors for suicide as well as enhanced confidence in the ability to intervene.

Objective 4 Access to Care

Rationale/ Justification for the Objective:
One of the primary reasons people do not seek care for mental health or substance abuse issues is the discrimination and stigma related to these issues. Initial strategies must focus on reducing discrimination and stigma. Reduction in discrimination and stigma will lead to increased access to care and early intervention.

By June 30, 2017, increase access to substance abuse and mental health services via primary care provider settings by 10%.

STRATEGIES:

4.1. Develop a train-the-trainer program based on Substance Abuse and Mental Health Services Administration's Mental Health First Aid program.

4.2. Promote public service announcements using messages already developed (bringchangetomind.org).

4.3. Engage physician practices in a learning collaborative to adopt NIATx (Network for Improvement of Addiction Treatment Services) principles that have been shown to consistently influence efforts to overcome barriers to

process improvement (http://www.niatx.net/Content/ContentPage.aspx?NID=131).

4.4. Explore resources to expand telehealth to areas in Maine with few mental health resources.

4.5. Explore resources for education for primary care providers to reduce stigma-related barriers to care via the SIM grant and behavioral health home training initiative.

[1] Pagura J, Fotti S, Katz LY, et al. (2009). Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors. *Psychiatric Services*, 60(7), 943-949.

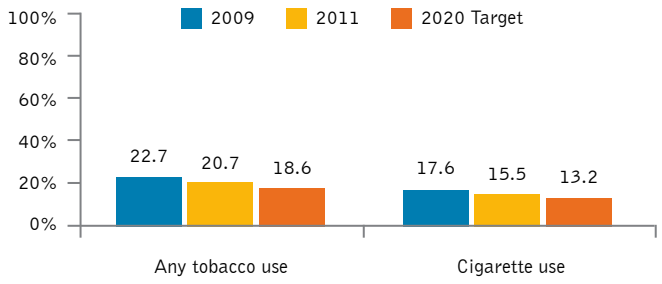
[2] Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf.

[3] Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry*, 51(3) 143-154; Unutzer J, Tang L, Oishi S, et al. (2006). Reducing suicidal ideation in depressed older primary care patients. *Journal of the American Geriatric Society*, 54(10), 1550-1556.

Tobacco Use

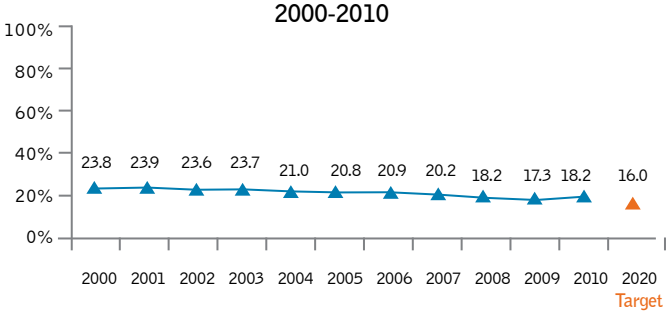
Tobacco use remains the leading cause of preventable death in Maine, with long-term consequences of life-long use. There are significant disparities among those on MaineCare. Many links to both behavioral health and primary health care exist, and this is a continuing priority at national and public health district levels.

Percent of High School Students Who Use Tobacco Products, Maine, 2009



Data source: Maine Integrated Youth Health Survey

Percentage of adults who are current smokers, Maine, 2000-2010



Data source: Maine Behavioral Risk Factor Surveillance System

Goal

Reduce adult and adolescent tobacco use in Maine by 5% by June 2017. *(This is approximately 50% toward the Healthy Maine 2020 goals.)*

Objectives

Objective 1 Treatment

Rationale/ Justification for the Objective: By reducing the long-term morbidity and mortality caused by tobacco use, tobacco treatment offers one of the most effective and cost-effective public health interventions. Tobacco treatment offers the second greatest public health return on investment after immunization. Maine has one of the country's most effective tobacco treatment resources.

By June 30, 2017, increase access and utilization of state tobacco treatment programs by 5%.

STRATEGIES:

1.1. Promote Partnership for a Tobacco-Free Maine (PTM) clinical outreach sessions to increase brief tobacco interventions in clinical settings.

1.2. Promote PTM basic skills training to increase brief tobacco interventions in clinical settings.

1.3. Promote Intensive Tobacco Cessation training.

Objective 2 Policy and Environmental Change

Rationale/ Justification for the Objective: Environmental change is one of the most cost-effective tools for changing the health context where people live, work, and play.

By June 30, 2017, increase the number of evidence-based laws, ordinances, and policies that provide greater access to smoke-free environments.

STRATEGY:

2.1. Increase the number of organizations and local communities that have voluntarily adopted smoke-free or tobacco-free policies and maintain current strong protections from secondhand smoke under Maine law.

Objective 3 Second Hand Smoke

Rationale/ Justification for the Objective: The home is the primary area where people are exposed to secondhand smoke. Children in homes where parents don't smoke are 50% less likely to smoke.

By June 30, 2017, decrease the number of children and adults exposed to environmental tobacco smoke in the home by 10%.

STRATEGIES:

3.1. Implement a statewide public awareness campaign about environmental tobacco smoke exposure and the effects on children in the home.

3.2. Work with partners to increase the number of families who have rules against smoking in their home by adopting the smoke-free homes pledge.

3.3. Work with partners to increase the number of landlords and property managers of subsidized housing, such as those accepting Section 8 vouchers, who have adopted smoke-free policies.

3.4. Train childcare and head start staff on messaging about the dangers of environmental tobacco smoke exposure and tobacco treatment resources available through the Maine Helpers' Training Program.

Objective 4 Disparities

Rationale/ Justification for the Objective: Populations with health disparities (identified in the objective) smoke at a rate that is 33% to 90% higher than that in the general population. Persons with a lower socioeconomic status also have a higher rate of tobacco use and tobacco-related illness.

By June 30, 2017, increase engagement with partner organizations by a minimum of 10 to promote or increase awareness of tobacco treatment, prevention, and control resources.

STRATEGIES:

4.1. Promote clinical outreach and attendance at PTM basic skills training among providers that currently serve populations with health disparities. These partner organizations include Federally Qualified Health Centers, Indian Health Centers, behavioral health agencies, OB-GYN providers, and providers to Lesbian, Gay, Bi-sexual, Transgender (LGBT) individuals that currently serve populations with health disparities. These populations include: individuals with a behavioral health diagnosis, LGBT individuals, refugees and immigrants, pregnant women insured through MaineCare, Native Americans, and low socio-economic populations.

4.2. Promote the development of comprehensive tobacco-free policies for all provider sites; refer to Breathe Easy Coalition standards.

4.3. Promote electronic communication such as websites, listserves, Twitter, Facebook and newsletters that are specific to the population such as Project Integrate for Behavioral Health populations.

4.4. Promote the Maine Helpers' Program to organizations that currently serve populations with health disparities.

Objective 5 Youth

Rationale/ Justification for the Objective:
Tobacco use is currently at epidemic rates. Influencing youth not to initiate tobacco use and dependency is an essential step toward lowering the rate of tobacco use in Maine.

By June 30, 2017, increase by 15% the number of organizations that promote and/or implement programs that involve youth in anti-tobacco initiatives.

STRATEGIES:

5.1. Support organizations that provide leadership training to youth around tobacco cessation.

5.2. Implement evidence-based tobacco prevention curricula in schools.

5.3. Engage youth in supporting the development and implementation of evidence-based tobacco prevention policy changes.

Essential Public Health Service #3:

Inform, Educate and Empower the Public

If we can have a better informed and empowered population, many cost savings in chronic diseases could be realized. There are significant differences in capacity between public health districts. The population needing behavioral health services should be a focus for educational messages.

Goal

Increase Maine's capacity to inform, educate and empower Maine people about health issues by June 2017.

Objectives

Objective 1 Message Delivery System

Rationale/ Justification for the Objective: This objective seeks to understand and improve the public health messaging infrastructure in Maine. Understanding and improving the reach of the current message delivery system will ensure messaging is accessible and actionable for all Maine people.

By June 30, 2017, implement a coordinated system at the Maine CDC to deliver messages that include policies and procedures for distribution, channels for distribution, and a quality assurance or evaluation process for public health communications.

STRATEGIES:

1.1. Map the public health information, health education, and health promotion delivery system to identify and address gaps, including message accessibility.

1.2. Develop a customer usage survey to understand and improve the reach of the current messaging delivery systems to identify accessibility, understanding, and applicability. The survey is intended to be used by Maine CDC, HMPs, hospital systems, Federally Qualified Health Centers, Tribal Health Departments, and others.

1.3. Convene quarterly Maine CDC meetings for health educators and other health education staff for knowledge sharing and skill building on public health communications.

1.4. Develop a Memorandum of Understanding between DCCs and partner organizations for dissemination of Maine CDC health messages.

Objective 2 Cross-Cultural, Plain Language Communication

Rationale/ Justification for the Objective: Health information can be complex and difficult to understand. When culturally appropriate and plain English is used, people are better able to make decisions about their health care. It is not clear at this time what processes are already in place. It is important to understand the impact of messaging on diverse populations.

By June 30, 2017, increase coordination and partnerships in Maine to improve the development and sharing of plain language resources that are appropriate across different cultures within Maine.

STRATEGIES:

2.1. Identify and convene stakeholders from different public and private sectors who are willing to collaborate on developing and sharing plain language resources that are appropriate across different cultures within Maine.

2.2. The Maine CDC will develop procedures for development and review of plain-language and culturally and linguistically appropriate communications.

2.3. Identify and/or create measures to determine who is accessing cross-cultural, plain language materials and how.

2.4. Develop a statewide process for dissemination of cross-cultural plain language resources.

Essential Public Health Service #4:

Mobilize Community Partnerships

Public health needs strong partnerships, and these partnerships can help leverage various resources, possibly saving costs. Gaps in the capacity to mobilize communities varies across the state and are felt to be more prevalent at the local level, although some progress has been made in the past few years. Building better partnerships with health care and aligning public health and health care are needed. Given the current momentum and opportunities, this area seemed to have strong potential for further development.

Goal

Increase Maine's capacity to mobilize community partnerships and action to identify and solve health problems by June 2017.

Objectives

Objective 1 Increase Community Partnerships

Rationale/ Justification for the Objective: This is a foundational step. "Meaningful engagement" can only be measured once there is an understanding of who is involved and who has not yet been engaged. Public health work cannot be carried out in silos; it is meant to be interactive and comprehensive. This objective is realistic and doable as it builds on existing work.

By June 30, 2017, increase the number of individuals and organizations mobilized in public health planning, securing of resources, and action via local coalitions, DCCs, and the SCC.

STRATEGIES:

1.1. Local coalitions and health departments will identify gaps in representation and recruit to ensure all target populations are being adequately represented in our efforts.

1.2. Each DCC will review representation annually, identify gaps in representation, and seek to fill those gaps.

1.3. The SCC will annually review representation, identify gaps, and seek to fill those gaps.

Objective 2 Increase Awareness of Public Health to Increase Visibility and Encourage Engagement

Rationale/ Justification for the Objective: One important way to ensure public health support is to continually raise awareness about the importance of public health. The visual of seeing a message everywhere is critical. It validates the extent of public health in everyday lives and communities. This approach offers a quick explanation of the value of public health.

By June 2017, implement/use common messaging that promotes the awareness of the value of public health for 100% of local, district, and state public health mobilization and implementation activities.

STRATEGIES:

2.1. Identify resources such as This is Public Health stickers, use of national public health logo, posters, etc.

2.2. Distribute resources to community public health partners.

2.3. Initiate discussions with Maine CDC administration about strategies to raise awareness of what public health is and its value.

Complete details of the SHIP goals, objectives and strategies, including rationale for objectives, measures and potential public health partners, are included in Appendices.

Moving Forward

Implementation of Maine's State Health Improvement Plan (SHIP), a process developed by our many partners and stakeholders, will begin in 2014.

The following chart outlines the steps that will be taken over the next three years. It includes finalizing SHIP, convening implementation teams, collecting/analyzing and reporting data and progress annually, and providing a summary report of success.

SHIP's success will be the result of partners who have contributed to its creation and committed to carrying out the work. Through this partnership, Maine can be healthy and safe.

SHIP Implementation Plan

	Jan - Feb	Apr - May	July - Aug	Oct - Nov	Jan - Feb	Apr - May	July - Aug	Oct - Nov	Jan - Feb	Apr - May	July - Aug	Oct - Nov	Jan - Feb
	2014				2015				2016				2017
Final plan published	X												
Implementation teams draft interim milestones		X											
Implementation teams meet		X	X	X	X								
Annual report & revisions					X								
Implementation teams meet						X	X	X	X				
Annual report & revisions									X				
Implementation teams meet										X	X	X	X
Final report													X

Acknowledgements

Maine's State Health Improvement Plan (SHIP) is the result of hard work and the contributions of the many public health partners across the State who are committed to improving the lives of Maine people. Individuals involved included DHHS and Maine CDC staff, members of the State Coordinating Council for Public Health, local health department representatives, health care providers and other organizations and individuals. These partners participated in every step of this process, including assessment and development of priorities, goals, objectives and strategies. Seventy-eight individuals participated in workgroups that met at least monthly over three months Their time and effort is much appreciated.

Appendices

Appendix A
Measures for SHIP Objectives

Priority: Immunizations

1. Objective: increase routine childhood vaccinations
Measure: percentage of children assessed who are up to date. ***Data Source:*** Maine Immunization Program (MIP), Immunization Information System- ImmPact system, Quarterly Report Assessments. (***NOTE:*** assessment is based on 4DTaP, 3Polio, 1MMR, 3HIB, 3HepB, 1Var, 4PCV – 4:3:1:3:3:1:4 – antigen series).

2. Objective: increase routine adolescent vaccinations
Measure: percentage of adolescents assessed who are up to date. Data will come from MIP ImmPact system Quarterly Report Assessments. (***NOTE:*** assessment is based on 3HepB, 1meng, 2MMR, 2var, 1Tdap – 3:1:2:2:1 antigen series.)

3. Objective: increase human papillomavirus (HPV) vaccinations
Measure: percentage of female and male adolescents, 13-18 years of age, who received HPV vaccine. ***Data Source:*** MIP Immunization Information System - ImmPact system Quarterly Report Assessments.

4. Objective: increase school-based access influenza vaccinations
Measure: enrollment count of schools registered in ImmPact and Department of Education (DOE). ***Data Source:*** MIP ImmPact System and DOE record

5. Objective: Promote standard practices for tetanus, diphtheria, and pertussis (Tdap) vaccinations.
Measure: to be determined

6. Objective: increase pneumococcal vaccination among seniors
Measure: number of responses in Behavioral Risk Factor Surveillance Survey (BRFSS). ***Data source:*** BRFSS as reported in Maine State Health Assessment (SHA).

Priority: Obesity

1. Objective: reduce consumption of sugar-sweetened beverages
Measure: number of responses to questions about sugar-sweetened beverage consumption in BRFSS and MIYHS. ***Data Source:*** BRFSS and MIYHS) ***NOTE:*** Questions about sugar-sweetened beverages should be added to Module 5 in BRFSS to collect adult data.

2. Objective: increase consumption of fruits and vegetables.
Measure: # of responses to questions about fruit and vegetable consumption in BRFSS and MIYHS. ***Data Source:*** BRFSS and MIYHS as reported in the SHA

3a. Objective: increase adult physical activity during leisure time
Measure: # of responses to physical activity questions in BRFSS. ***Data source:*** BRFSS

3b. Objective: increase youth physical activity.
Measure: # of responses to physical activity questions in MIYHS. ***Data source:*** MIYHS

4. Objective: increase infant breastfeeding.
Measure: # of responses to breastfeeding questions. ***Data Sources:*** Pregnancy Risk Assessment Monitoring System (PRAMS); National Immunization Survey (NIS)

Priority: Substance Abuse and Mental Health

1. Objective: Increase developmental screening of children birth to three years of age.
Measure: Number of MaineCare claims using CPT code 96110 for general developmental screening (Children's Health Insurance Program Reauthorization Act (CHIPRA) Initial Core Set of Children's Health Care Quality Measure #8 and CPT codes 96110HI and 96111HK for autism-specific screening IHOC Measure #9) ***Data Source:*** MaineCare claims data.)

2. Objective: Promote drug-prescribing protocols in health care settings.
Measure: number of hospitals, health systems and Federally Qualified Health Centers with drug prescribing protocols. ***Data Sources:*** Maine Osteopathic Association (MOA), Maine Medical Association (MMA), Substance Abuse and Mental Health Services (SAMHS), Maine Hospital Association (MHA), Maine Association of School Psychology (MASP)

3a. Objective: Increase Screening, Brief Intervention, Referral and Treatment (SBIRT) services.
Measure: number of times SBIRT billing code appears in MaineCare and Maine Health Data Organization (MHDO). ***Data Sources:*** MaineCare billing data; MHDO billing data

3b. Objective: Increase depression and substance abuse screening in health homes
Measure: number of times screening billing codes appear in MaineCare. ***Data Sources:*** MaineCare billing data

3c. Objective: Increase adoption of evidence-based suicide prevention, screening and assessment in health care and school settings.
Measure: number of primary care practices implementing evidence based suicide prevention screening and assessment as standard care. ***Data Source:*** Maine CDC contractor quarterly reports (National Alliance on Mental Illness)

4. Objective: increase access to substance abuse and mental health services via primary care providers.
Measure: number of times the billing code appears. ***Data Sources:*** MaineCare, MHDO billing data. Treatment Data System (TDS) at SAMHS website

Priority: Tobacco Use

1. Objective: increase access to and use of state tobacco treatment programs.
Measures: # of referrals to Maine Tobacco HelpLine (MTHL); # of MTHL callers; # of Maine Certified Tobacco Treatment Specialists; # of providers trained. ***Data sources:*** MTHL, Partnership For A Tobacco-Free Maine (PTM)

2. Objective: increase the number of smoke-free environments.
Measures: # of new laws, ordinances and policies; # of organizations and communities with smoke-free tobacco or tobacco-free policies. ***Data Source:*** MPHA Tobacco Policy Committee

3. Objective: reduce exposure to indoor tobacco smoke in homes
Measure: responses to BRFSS and MIYHS questions about secondhand smoke exposure in the home. ***Data Sources:*** BRFSS and MIYHS

4. Objective: Increase partnerships with organizations serving vulnerable populations to promote or increase awareness of tobacco treatment, prevention, and control resources.
Measures: # of clinical outreach engagements to Federally Qualified Health Centers, Indian Health Centers, behavioral health agencies, OB-GYN providers, identified providers to LGBT persons; #of comprehensive tobacco-free policies among behavioral health provider agencies and organizations ***Data Source:*** PTM Clinical Outreach Program reports; Breathe Easy Coalition

5. Objective: increase youth involvement in anti-tobacco initiatives.
Measures: # of organizations that work with Maine Youth Action Network (MYAN), # of Drug-Free Community Coalitions that integrate tobacco prevention into their substance abuse prevention efforts. ***Data Sources:*** MYAN, SAMHS

Priority:
ESSENTIAL PUBLIC HEALTH SERVICES #3:
Inform, Educate and Empower the Public

1. Objective: implement a system for delivering public health messages.
Measure: identified policies and procedures, identified channels, identified evaluation process.
Data Source: Maine CDC administration

2. Objective: increase the use of plain language best practices.
Measure: # of cross-cultural, plain language documents available on Maine CDC website, # of organizations represented in consortium, documentation of statewide dissemination plan.
Data Source: Maine CDC Office of Health Equity

Priority:
ESSENTIAL PUBLIC HEALTH SERVICES #4:
Mobilize Community Partnerships

1. Objective: increase community engagement in public health activities.
Measures: # of individuals and # of sectors mobilized at the local level (coalition, health departments boards, etc.), at the district level (DCC) and at the state level (SCC). ***Data Sources:*** HMP, DCC and SCC memberships

2. Objective: increase the awareness of the value of public health.
Measure: # of times common messaging appears.
Data source: annual audit or sample of local, district and state posters, websites, maine.gov, etc.

Appendix B
Recommendations for Implementation

From the Immunizations Priority Work Group:

Objectives 1&2: The Maine Immunization Program should be involved in monitoring the implementation and progress of these strategies. The Maine Immunization Coalition offers a good venue for understanding provider behavior and communicating to providers and vaccine manufacturers. In 2017 SHIP, use Improving Health Outcomes for Children (IHOC) guidelines for immunization rate assessment.

Objective 3: The MIP should be involved in monitoring the implementation and progress of these strategies. Identify data collection method for adolescent males. For the 2017 SHIP, begin to monitor HPV vaccinations in males.

General: Data should be available at that time. Increased capacity for data exchange between electronic medical record systems and ImmPact (MIP Immunization Information System) will allow tracking vaccinations by individuals and provide more accurate immunizations data. For all strategies, work closely with the Maine Immunization Coalition. The Coalition meets quarterly; a representative from the Maine CDC usually attends the meeting.

From the Obesity Priority Work Group & DHHS staff:

Objectives 1-3: measures for youth should follow MIYHS segments: kindergarten, 3rd grade, 5th grade, 6th grade, 7-8 grades, 9-12 grades.

Objective 1: The implementation team should define what "encourage" looks like and how will it be measured to determine its success.

Objective 2: Explore if FFVP funding has been maximized and if not, what other barriers exist for school participation.

Objective 3: The implementation team should identify barriers preventing schools from providing public access to indoor and outdoor school facilities for out-of-school physical activity and what work with school depts. is needed to reduce these barriers? Consider a strategy to bolster the child care health consultant workforce, since implementing policies with no technical assistance probably won't sustain the policy implementation. Consider strategies to give other teachers, such as math and English, new ways to teach that allow for physical activity as part of the learning. Also consider how physical activity as part of physical education may compete with health curriculum requirements, leading to sitting at a desk as part of the physical education classes.

Objective 4: The implementation team should consider exploring other barriers and strategies such as access to affordable pumps and pump rentals and leveraging the public health education that is being conducted already.

General: Add Healthy Maine 2020 numbers to SHIP goals, not just rates. When sending letters to potential partners, list who is committed and who else was invited – maybe include workgroup members. When sending letters to potential partners, be clear that the SHIP is a plan for the statewide public health system and potential partners are not being invited to work on Maine CDC-specific projects. Be clear that Maine CDC is the convener. Several District Coordinating Councils (DCCs) have selected obesity as a focus in their District Health Improvement Plans. They can play a role in implementing SHIP obesity objectives. There needs to be transparency between partners. Partners should be convened to share information and resources. Could be convened as a SHIP Obesity Implementation Workgroup. Be mindful of disparities and the elderly when implementing the SHIP. While they

were not specifically spelled out in the strategies, groups who are underserved should receive attention during the implementation phase. Define the term "disability" in BRFSS. Incorporate language from the strategies in the Community Health Needs Assessments.

From the Substance Abuse and Mental Health Priority Work Group & DHHS staff:

Objective 1: Monitor funding and resources for Maine Families Home Visiting Program. MaineCare Health Home Initiative, MaineCare Children's Services and IHOC will be tracking the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life. Need to ensure that this continues to be tracked after the end of the IHOC grant in 2015.

Objective 2: The protocols should include self-monitoring tools. The Prescription Monitoring Program is a good tool for tracking. MaineCare pharmacists review drug prescribing practices. Maine Medical Association may have a survey to help assess status/usage of drug prescribing protocols.

Objective 3: Practice-reported implementation can be tracked through quarterly MaineCare health home reports. Explore capturing assessment and screening from electronic health record data through MaineCare clinical dashboard being developed in partnership with HealthInfoNet under the SIM grant. For strategy 3a, the implementation team may need to clarify how often SBIRT services are happening, to determine if providers are doing this work, but not coding for it or just not doing it. The Maine CDC contracts with NAMI and its sub-recipients to track and report quarterly on strategies outlined in Objective 3c.

Objective 4: Maine DHHS, Office of Quality Improvement has access to the all-claims database for MaineCare. For strategy 4.2, specifics on how PSAs are "promoted" will need to be determined by the implementation committee, dependent on available resources. For strategy 4.3, the implementation team may want to work with the Department to consider the impact of the cumulative expectations on primary care if all of the department wide strategies of learning collaboratives were actually implemented. Maine Behavioral Health Workforce Development Collaborative (http://www.mainebehavioralhealthworkforce.org/) can help with provider training. A great NIATx resource is: http://www.niatx.net/Content/ContentPage.aspx? For strategy 4.5: Consider other resources in addition to the initiative listed.

From the Tobacco Use Priority Work Group & DHHS staff:

Objective 1: Monitor BRFSS responses. Review the MTHL Annual Report to PTM. Share all results with partners. For strategy 1.3, it may be helpful to specify to whom the training should be promoted.

Objective 2: MPHA Tobacco Policy Committee is the lead agency for these strategies. Maine CDC should communicate with MPHA to monitor progress. Resources for policies include: Americans for Non-Smoker Rights. Review the ALA-Maine Annual Report Card.

Objective 3: Smoke-free pledges are reported annually to PTM. CTI maintains Maine Helpers' Training records. The implementation team should work with programs that have performance measures related to the reduction of children's exposure to tobacco and other substances, and possibly leverage existing efforts/training on this subject matter.

Objective 4: Connect with the two CTG work groups; behavioral health and LGBT. MPCA is a good source for Federally Qualified Health Center information. Define what provider sites should be included in strategy 4.2. Pay attention to both the disparity populations and organizations listed in the objective.

Objective 5: The implementation team should define what youth engagement looks like, and check in with youth on what it means to them.

From the Mobilize Community Partnerships Priority Work Group & DHHS staff:

Objective 1: For strategy #1, include District Liaisons, hospitals, MPCA, and diverse community stakeholder organizations.

Objective 2: Engage the Maine CDC Office of Health Equity in all strategies. Several resources are available for use in developing resources including:

- Simply Put: A guide for creating easy-to-understand materials. Strategic and Proactive Communication Branch, Division of Communication Services, Office of the Associate. Atlanta, GA. April 2009, Third Edition
- http://www.thinkculturalhealth.org
- https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf
- US DHHS, Office of Disease Prevention and Health Promotion (2010). National Action Plan to Improve Health Literacy. Washington, DC.
- http://www.biomedcentral.com/1472-6947/5/16
- http://www.clearlanguagegroup.com/plain-language/
- http://www.mainehealth.org/mh_body.cfm?id=6719

Consider adding additional QA strategies, especially when we reflect on the marketing to reduce smoking that includes images reinforcing unsafe sleep environments for infants. The implementation team should be aware of the public awareness campaigns listed in other priorities in this plan and coordinate regarding those.

From the Mobilize Community Partnerships Priority Work Group & DHHS staff:

Objective 1: HMPs report in KIT Solutions the number of volunteers by strategy. Maine CDC should consider asking KIT Solutions to report on sector representation. Maine CDC should seek to better understand well-functioning HMPs with diverse sector representation and determine what distinguishes their success. This information should be shared with other HMPs. For DCCs, include "interested parties." Most DCCs have a defined, finite membership. DCCs would benefit from including interested parties to capture any increase in representation. Consider how we can allow for and document short term engagement of the public in PH efforts.

Objective 2: Look for places where the brand is not appearing and attempt to determine why. For example, immunizations are often not perceived as public health activities yet they represent one of the most effective public health campaigns. Consider strategies that help public health to become more infused in the efforts of other disciplines and break down the public health silo (which asks others to come to the public health table). Maybe public health could go to the tables of others and, through relationship building, listen to how other groups do things that could be considered public health and help those groups understand that promotion of public health can be part of the core work people already do (not replacing the work they do).

From Work Groups & DHHS staff regarding all Priority Areas:

Consider whether the strategies yield results that can be measured, analyzed, interpreted and reported on by the end of the project period? Does the data get collected with enough frequency for all of these goals to be measured as attributable to the SHIP strategies? Progress reports may lean towards qualitative data, but implementation groups will be asked to provide these updates with all data that is obtainable. If further work for attribution is determined to be necessary, and we have the resources to do it, we will direct the implementation workgroups accordingly.

Appendix C
Evidence-based References for Strategies

Priority: Immunizations

Strategy #1.1: The Guide to Community Prevention Services: *Client Reminder & Recall Systems*
Strategy #1.2: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #1.3: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #1.4: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #1.5: The Guide to Community Prevention Services, *Provider Assessment & Feedback*
Strategy #2.1: The Guide to Community Prevention Services: *Client Reminder & Recall Systems*
Strategy #2.2: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #2.3: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #2.4: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #2.5: The Guide to Community Prevention Services, *Provider Assessment & Feedback*
Strategy #3.1: The Guide to Community Prevention Services, *Provider Assessment & Feedback*
Strategy #3.2: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #3.3: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #3.4: 1. The Guide to Community Prevention Services, *Immunization Information Systems.* 2. The Community Guide, *Vaccinations in Schools.* 3. The Community Guide, *Reducing Out of Pocket Costs.*
Strategy #4.1: 1. The Community Guide, *Universally Recommended Vaccinations: Vaccination Programs in Schools & Organized Child Care Centers*. 2. "Promising Practices for School-Located Vaccination Clinics: Part II: Clinic Operations and Program Sustainability", John Lott and Jennifer Johnson, Pediatrics 2012; 129, S81.
Strategy #4.2: 1. The Community Guide, *Universally Recommended Vaccinations: Vaccination Programs in Schools & Organized Child Care Centers*. 2. "Promising Practices for School-Located Vaccination Clinics: Part II: Clinic Operations and Program Sustainability", John Lott and Jennifer Johnson, Pediatrics 2012; 129, S81.
Strategy #4.3: The Community Guide, *Reducing Out of Pocket Costs.*
Strategy #5.1: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #5.2: The Guide to Community Prevention Services, *Immunization Information Systems*
Strategy #5.3: The Community Guide, *Increasing Appropriate Vaccination: Community-Based Interventions Implemented in Combination.*
Strategy #6.1: The Community Guide, *Data Collection Instrument and Procedure for Systematic Reviews*
Strategy #6.2: The Community Guide, *Increasing Appropriate Vaccination: Community-Based Interventions Implemented in Combination.*

Priority: Obesity

Strategy #1.1: Khan, L.K., Sobush, K., Keener, D., Goodman, K., Lowry, A., Kakieteck, J. & Zaro, S. (2009). *Recommended community strategies and measurements to prevent obesity in the United States. Recommendations and reports: Morbity and mortality weekly report*, 58(RR-7), 1-26.
Strategy #1.2: 1. CDC Guide to Strategies for Reducing the Consumption of Sugar Sweetened Beverages. March 2010. 2. Yale Rudd Center for Food Policy and Obesity; Seminar: Unsweetened: Can a Focused, Outcomes-Based, Sugary Drink Campaign Reduce Childhood Obesity? March 2013.
Strategy #1.3: 1. Koplan, J., Liverman, C.T., & Kraak, V.I. (2005). *Preventing childhood obesity: health in the balance*. National Academy Press. 2. Stallings, V.A., & Yaktine, A.L. (Eds.). (2007) *Nutrition standards for foods in schools: Leading the way toward healthier youth*. National Academy Press.
Strategy #1.4: 1. Barlow, SE and the Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary Report. Pediatrics. 2007: 120 (Suppl 4): S164-192. 2. Pediatric Obesity and Nutrition Resource Package: American Academy of Pediatrics. https://www.nfaap.org/
Strategy #1.5: Recommended by Maine DHHS.

Strategy #2.1: 1. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6046a3.htm 2. Food Research and Action Center (2011). Nutrition and Physical Activity Resource Guide: For Child and Adult Food Care ProgramsServing Children with Special Health Care Needs. From http://www.frac.org.

Strategy #2.2: 1. http://www.cdc.gov/obesity/downloads/FoodPolicyCouncils.pdf.
2. http://www.cdc.gov/healthyplaces/healthytopics/healthyfood_environment.htm

Strategy #2.3: 1. http://blogs.usda.gov/2013/05/03/snap-new-rules-aim-to-expand-access-to-farmers'-markets/ 2. http://www.usda.gov/documents/7-Healthyfoodaccess.pdf. 3. Fang, Michelle, Buttenheim, Alison, Havassy, Joshua & Gullust, Sarah. "It's Not an 'If You Build It They Will Come' Type of Scenario": Stakeholder Perspectives on Farmers' Markets as a Policy Solution to Food Access in Low-Income Neighborhoods. This article was downloaded by: [University of Maine - Orono] On: 16 July 2013, At: 06:06 Publisher: Taylor & Francis, Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK; 4. http://www.usda.gov/documents/6-farmtotinstitution.pdf. 5. http://sustainableaged.org/topics/farmtoinstitution/tabid/78/Default.aspx

Strategy #2.4: http:///www.fns.usda.gov/cnd/FFVP/

Strategy #3.1: Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases; The CDC Guide to Strategies to Increase Physical Activity in the Community. Atlanta: U.S. Dept. of Health and Human Services; 2011.

Strategy #3.2: Best-Practice Guidelines for Physical Activity at Child Care; Christina McWilliams, Sarah C. Ball, Sara E. Benjamin, Derek Hales, Amber Vaughn, and Dianne S. Ward; Pediatrics December 2009; 124:6 1650-1659; published ahead of print November 16, 2009, doi:10.1542/peds.2009-0952

Strategy #3.3: 1. Guide to Community Preventive Services. Environmental and policy approaches: street-scale urban design and land use policies. Www.thecommunityguide.org/pa/environmental-policy/streetscale.html. 2. A Conceptual Framework for Improving the Accessibility of Fitness and Recreation Facilities for People with Disabilities; Barth B. Riley, James H. Rimmer, Edward Wang and William J. Schiller. Journal of Physical Activity and Health, 2008,5,158-168.

Strategy #3.4: Guide to Community Preventive Services. Behavioral and social approaches to increase physical activity: enhanced school-based physical education.

Strategy #4.1: 1. Fair Labor Standards Act – Break Time for Nursing Mothers Provision http://www.dol.gov/whd/nursingmothers/Sec7rFLSA_btnm.htm. 2. http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf pg. 7

Strategy #4.2: 1. Fair Labor Standards Act – Break Time for Nursing Mothers Provision http://www.dol.gov/whd/nursingmothers/Sec7rFLSA_btnm.htm. 2. http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf pg. 7

Strategy #4.3: 1. Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Early Education Programs. 2. The United States Breastfeeding Committee: Breastfeeding and Childcare http://usbreastfeeding.org/Issue-Papers/Childcare.pdf

Strategy #4.4 1. CDC Morbidity and Mortality Weekly Report (Vital Signs: Hospital Practices to Support Breastfeeding----United States, 2007 and 2009; 2. Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Snowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technology Assessment 2000;4(25):1–171. 3. DiGirolamo AM, Grummer-Strawn LM, Fein S. Maternity care practices: implications for breastfeeding. Birth 2001;28(2):94–100; 4. World Health Organization/UNICEF. Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services. A joint WHO/UNICEF statement. Geneva: World Health Organization, 1989 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6030a4.htm?s_cid=mm6030a4_w

Priority: Substance Abuse and Mental Health

Strategy #1 1. The California Evidence-Based Clearinghouse for Child Welfare, Screening and Assessment Tools for Child Welfare, http://www.cebc4cw.org/assessment-tool/ages-and-stages-questionnaire/; 2. Virginia early Childhood Foundation, Smart Beginnings Evidence-Based Directory http://www.smartbeginnings.org/Portals/5/PDFs/EvidenceBasedDirectory.pdf (page 27); 3. Agency for Healthcare Research and QualityHQ's National Guidelines Clearinghouse http://www.guideline.gov/content.aspx?id=2822#Section424; 4. American Academy of Pediatrics, Screening and Assessment http://www2.aap.org/sections/dbpeds/screening.asp 5. Agency for Healthcare Research and Quality HQ's National Guidelines Clearinghouse http://www.guideline.gov/content.aspx?id=2822#Section424

Strategy #2.1: www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf
Strategy #2.2: www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf
Strategy #2.3: www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf
Strategy #2.4: www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf
Strategy #3a.1:1. Antoinette Krupski, Jutta M Joesch, et al. *Testing the effects of brief intervention in primary care for problem drug use in a randomized controlled trial: rationale, design, and method. Addict Sci Clin Pract. 2012; 7(1): 27. Published online 2012 December 14. doi: 10.1186/1940-0640-7-27; 2.* Lauren Matukaitis Broyles, Keri L Rodriguez, et al. *A qualitative study of anticipated barriers and facilitators to the implementation of nurse-delivered alcohol screening, brief intervention, and referral to treatment for hospitalized patients in a Veterans Affairs medical center. Addict Sci Clin Pract. 2012; 7(1): 7. Published online 2012 May 2. doi: 10.1186/1940-0640-7-7*
PMCID: PMC3533719
Strategy #3a.2: 1. U.S. Substance Abuse and Mental Health Services Agency, Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf; 2. Bertha K. Madras, Wilson M. Compton, Deepa Avula, Tom Stegbauer, Jack B. Stein, and H. Westley Clark, *Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple health care sites: Comparison at intake and six months* National Institutes of Health, National Library of Medicine, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/
Strategy #3b.1:1. Screening for Depression in Medical Settings with the Patient Health Questionnaire (PHQ): A Diagnostic Meta-Analysis; Simon Gilbody, MB DPhil MRCPsych, David Richards PhD, Stephen Brealey DPhil, Catherine Hewitt PhD Journal of General Internal Medicine Volume 22, Issue 11 , pp 1596-1602 2007-11-01; 2. The Alcohol Use Disorders Identification Test (AUDIT): A Review of Recent Research Duane F. Reinert*, John P. Allen Alcoholism: Clinical and Experimental Research, Volume 26, Issue 2, pages 272–279, February 2002; 3. Diagnostic Validity of the Drug Abuse Screening Test in the Assessment of DSM-III Drug Disorders DOUGLAS R. GAVIN, HELEN E. ROSS, HARVEY A. SKINNER, British Journal of Addiction, Volume 84, Issue 3, pages 301–307, March 1989; 4. John R. Knight, MD; Lon Sherritt, MPH; Lydia A. Shrier, MD, MPH; Sion Kim Harris, PhD; Grace Chang, MD, MPH, Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients *Arch Pediatr Adolesc Med.* 2002;156(6):607-614. doi:10.1001/archpedi.156.6.607
Strategy #3c.1:Western Interstate Commission for Higher Education. A Primer for Primary Care Providers. Boulder, Colorado. http://www.sprc.org/for-providers/primary-care-tool-kit; http://www.cssrs.columbia.edu/about_cssrs.html
Strategy #3c.2:U.S. Substance Abuse and Mental Health Services Agency, National Registry of Evidence-based Programs and Practices http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=suicide prevention gatekeeper
Strategy #4.1: Pinto-Foltz, M. and Logsdon, M. Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing. Archives of Psychiatric Nursing, Vol. 23, No. 1 (February), 2009: pp 32-40.
Strategy #4.2: Mehta, D., Williams, K. et al. Reducing stigma and improving access to mental health care for youth. BC Medical Journal. Vol. 53, No. 6, July/August 2011. www.bcmy.org.
Strategy #4.3: 1. Gustafson, D.H. (2013) A systems engineer meets the system. The Journal of the American Medical Association. 2013 Jan 16; 309(3): 247-248; 2. Gustafson DH, Quanbeck AR, Robinson JM, Ford JH 2nd, Pulvermacher A, French MT, McConnell KJ, Batalden PB, Hoffman KA, McCarty D. Which elements of improvement collaboratives are most effective? A cluster-randomized trial. Addiction. [Epub 1 Mar 2013] 3. NIATx (Network for Improvement of Addiction Treatment Services) webiste (http://www.niatx.net/Content/ContentPage.aspx?NID=131)
Strategy #4.4: American Telemedicine Association, Evidence-Based Practice for Telemental Health, July 2009, http://www.americantelemed.org/practice/standards/ata-standards-guidelines/evidence-based-practice-for-telemental-health

Priority: Tobacco Use

Strategy #1.1: 1. 2008 PHS Guideline 2. "Working with Healthcare Delivery Systems to Improve the Delivery of Tobacco-Use Treatment to Patients: An Action Guide" CDC
Strategy #1.2: 1. 2008 PHS Guideline 2. "Helping Patients Quit" Partnership for Prevention
Strategy #1.3: Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service. May 2008 Pp, 69-70

Strategy #2.1: Guide to Community Prevention Services; *Decreasing tobacco use among workers; smoke-free policies to reduce tobacco use.*

Strategy #3.1: Guide to Community Preventive Services; *Reducing tobacco use and secondhand smoke exposure; mass-reach health communication interventions.*

Strategy #3.2: 1. EPA (http://www.epa.gov/smokefree/), 2. Centers for Disease Control (http://www.cdc.gov/pcd/issues/2013/12_0218.htm)

Strategy #3.3: 1. Centers for Disease Control (http://www.cdc.gov/healthyhomes/healthy_homes_manual_web.pdf), 2. US Dept. Housing and Urban Development NOTICE: H 2012-22,3; 3. King BA, Dube SR, Homa DM. Smoke-Free Rules and Secondhand Smoke Exposure in Homes and Vehicles Among US Adults, 2009-2010. Prev Chronic Dis 2013; 10:120218

Strategy #3.4: Casteneda et al., 2008; Campbell et al., 2007; Muramoto et al., 2010.

Strategy #4.1: 1."Bringing Everyone Along: Resource Guide", 1/2008"; 2."A Meta-Analysis of Smoking Cessation Interventions with Individuals in Substance Abuse Treatment or Recovery", J. Prochaska et. al 2004; 3."Alcohol Alert", number 71, 1/2007; 4."Addressing Tobacco Use in Homeless Populations: Recommendations of an Expert Panel, 10/2009; 5."Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers, 1/2009; 6. Williams & Ziedonis, Addic Behav 29, 2004, Addressing Tobacco Among Individuals with Mental Illness or an Addiction, p 1067-1083; 7. Ziedonis D et al, Am J Med Sci, 2003, V326#4, Serious Mental Illness & Tob addiction: A Model Prog to Address Common but Neglected Issue, p 223-230; 8. Ranney L et al, Ann Int Med V145#11, Systematic Review: Smok Cess Strategies for Adults and Spedial Populations, p 845-856; 9. Castaneda, H., Nichter, Mark, Nichter, Mimi, Muramoto, M. "Enabling and Sustaining the Activities of Lay Health Influencers: Lessons From a Community-Based Tobacco Cessation Intervention Study." Health Promot Pract. 2010 Jul;11(4):483-92

Strategy #4.2: The Guide to Community Preventive Services: *Decreasing tobacco use among workers; smoke-free policies to reduce tobacco use.*

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Strategy #5.1: The Guide to Community Preventive Services: *Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products*

Strategy #5.2: The Guide to Community Preventive Services: *Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products*

Strategy #5.3: The Guide to Community Preventive Services: *Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products*

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Strategy #1.2: 1. Kiernan, Nancy Ellen (2001). Designing a Survey to Increase Response and Reliability: Tipsheet #53, University Park, PA: Penn State Cooperative Extension; 2. Eglene, O., Dawes, S., and Schneider,

C. Authority and Leadership Patterns in Public Sector Knowledge Networks. The American Review of Public Administration. March 2007. Vol. 37, No. 1, 91-113; 3. Zhang, Jing and Dawes, Sharon. Expectations and Perceptions of Benefits, Barriers, and Success in Public Sector Knowledge Networks. Clark University. Center for Technology in Government. University at Albany/SUNY; 4. Kok, G., Schaalma, H., et al. Intervention Mapping: Protocol for Applying Health Psychology Theory to Prevention Programmes. Erasmus University, The Netherlands; 5. Grier, S. and Bryant, C.A. Social Marketing in Public Health. Annual Review of Public Health. 2005. 26:319-39.

Strategy #1.3: 1. Torres, R.T.; Preskill, H.; Piontek, M. (In press). *Evaluation strategies for communicating and reporting: Enhancing learning in organizations.* Thousand Oaks, CA: Sage; 2. Eglene, O., Dawes, S., and Schneider, C. Authority and Leadership Patterns in Public Sector Knowledge Networks. The American Review of Public Administration. March 2007. Vol. 37, No. 1, 91-113; 3. Zhang, Jing and Dawes, Sharon. Expectations and Perceptions of Benefits, Barriers, and Success in Public Sector Knowledge Networks. Clark University. Center for Technology in Government. University at Albany/SUNY; 4. Kok, G., Schaalma, H., et al. Intervention Mapping: Protocol for Applying Health Psychology Theory to Prevention Programmes. Erasmus University, The Netherlands; 5. Grier, S. and Bryant, C.A. Social Marketing in Public Health. Annual Review of Public Health. 2005. 26:319-39.

Strategy #1.4: 1. Eglene, O., Dawes, S., and Schneider, C. Authority and Leadership Patterns in Public Sector Knowledge Networks. The American Review of Public Administration. March 2007. Vol. 37, No. 1, 91-113; 2. Zhang, Jing and Dawes, Sharon. Expectations and Perceptions of Benefits, Barriers, and Success in Public Sector Knowledge Networks. Clark University. Center for Technology in Government. University at Albany/SUNY; 3. Kok, G., Schaalma, H., et al. Intervention Mapping: Protocol for Applying Health Psychology Theory to Prevention Programmes. Erasmus University, The Netherlands; 4. Grier, S. and Bryant, C.A. Social Marketing in Public Health. Annual Review of Public Health. 2005. 26:319-39.

Strategy #2.1: Milstein, B; Homer, J. Background on system dynamics simulation modeling, with a summary of major public health studies. Atlanta (GA): Syndemics Prevention Network, Centers for Disease Control and Prevention; 2005.

Strategy #2.2: Kiernan, Nancy Ellen (2001). Designing a Survey to Increase Response and Reliability: Tipsheet #53, University Park, PA: Penn State Cooperative Extension.

Strategy #2.3: Torres, R.T.; Preskill, H.; Piontek, M. (In press). *Evaluation strategies for communicating and reporting: Enhancing learning in organizations.* Thousand Oaks, CA: Sage.

Strategy #2.4: Torres, R.T.; Preskill, H.; Piontek, M. (In press). *Evaluation strategies for communicating and reporting: Enhancing learning in organizations.* Thousand Oaks, CA: Sage.

Priority: Mobilize Community Partnerships

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Strategy #2.1: 1. Literature Review: State Mass Media Campaigns to Prevent and Reduce ATOD Use DRAFT 8 22 2011; 2. http://www.thisispublichealth.org/toolkit/documents/ASPH_TIPH_Report.pdf

Strategy #2.2: 1. Literature Review: State Mass Media Campaigns to Prevent and Reduce ATOD Use DRAFT 8 22 2011; 2. http://www.thisispublichealth.org/toolkit/documents/ASPH_TIPH_Report.pdf

Strategy #2.3: 1. Literature Review: State Mass Media Campaigns to Prevent and Reduce ATOD Use DRAFT 8 22 2011; 2. http://www.thisispublichealth.org/toolkit/documents/ASPH_TIPH_Report.pdf

Appendix D

District Public Health Improvement Plan Priorities for 2013 to 2015

District: Aroostook	
Categorical Priorities	**Infrastructure Priorities**
Not applicable	Inform, educate, and empower
	Mobilize community partnerships
	Link people to needed public health services and assure the provision of health care when otherwise unavailable
	Assure competent public health and personal health care workforce
	Evaluate effectiveness, accessibility, and quality of personal and population-based health services
	Research for new insights and innovative solutions to health problems

District: Central	
Categorical Priorities	**Infrastructure Priorities**
Link people to behavioral health screening and services	Not applicable
Oral health	
Increase rates of physical activity	

District: Cumberland	
Categorical Priorities	**Infrastructure Priorities**
Influenza vaccination	Not applicable
Health equity	
Healthy homes	
Obesity/nutrition/physical activity	
Public health preparedness	
STDs/reproductive health	
Mental health and substance abuse	
Tobacco	

District: Downeast	
Categorical Priorities	**Infrastructure Priorities**
Environmental health	Inform, educate and empower
Clinical health systems	Link people to needed personal health services and assure the provision of health care when otherwise unavailable
Food policy and access	

District: Midcoast	
Categorical Priorities	**Infrastructure Priorities**
Behavioral Health (including substance abuse and mental health)	Transportation

District: Penquis	
Categorical Priorities	**Infrastructure Priorities**
Obesity/diabetes	Communication and education
Poverty/Adverse Childhood Experiences (ACES)	

District: Western	
Categorical Priorities	**Infrastructure Priorities**
Influenza vaccination	Electronic communication network for providers
Obesity	
Behavioral health	

District: York	
Categorical Priorities	**Infrastructure Priorities**
Public health emergency preparedness	Not applicable
Physical activity/nutrition/obesity	
Behavioral health	

Appendix E
Maine Revised Statute Title 22, Chapter 152

PUBLIC HEALTH INFRASTRUCTURE

Table of Contents

Subtitle 2. HEALTH

Part 2. STATE AND LOCAL HEALTH AGENCIES

Section 411. DEFINITIONS

Section 412. COORDINATION OF PUBLIC HEALTH INFRASTRUCTURE

COMPONENTS

Section 413. UNIVERSAL WELLNESS INITIATIVE

22 §411. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2009, c. 355, §5 (NEW).]

1. Accreditation. "Accreditation" means a national federally recognized credentialing process resulting in the approval of a public health system or a municipal health department by a national federally recognized review board certifying that a public health system or a municipal health department has met specific performance requirements and standards. Accreditation provides quality assurance, credibility and accountability to the public, to government officials and to public health fund sources. As applicable to a Tribal health department or health clinic, "accreditation" means a recognized credentialing process by a national federally recognized review board for Indian health.

[2011, c. 306, §1 (AMD) .]

2. Comprehensive community health coalition. "Comprehensive community health coalition" means a multi-sector coalition that serves a defined local geographic area and is composed of designated organizational representatives and interested community members who share a commitment to improving their communities' health and quality of life and that includes public health in its core mission.

[2009, c. 355, §5 (NEW) .]

3. District coordinating council for public health. "District coordinating council for public health" means a representative district-wide body of local public health stakeholders working toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system.

[2009, c. 355, §5 (NEW) .]

4. District public health unit. "District public health unit" means a unit of public health staff set up whenever possible in a district in department offices. A staff must include when possible public health nurses, field epidemiologists, drinking water engineers, health inspectors and district public health liaisons.

[2009, c. 355, §5 (NEW) .]

5. District. "District" means one of the eight districts of the department, including Aroostook District, composed of Aroostook County; Penquis District, composed of Penobscot County and Piscataquis County; Downeast District, composed of Washington County and Hancock County; Midcoast District, composed of Waldo County, Lincoln County, Knox County and Sagadahoc County; Central District, composed of Kennebec County and Somerset County; Western District, composed of Androscoggin County, Franklin County and Oxford County; Cumberland District, composed of Cumberland County; and York District, composed of York County, and the tribal district, composed of any lands belonging to the Indian tribes in the State and including any member of a tribe living outside of tribal lands.

[2011, c. 306, §1 (AMD) .]

6. Essential public health services. "Essential public health services" means core public health functions identified by a national public health performance standards program, a national federally recognized review board or a national federally recognized review board for Indian health that help provide the guiding framework for the work and accreditation of public health systems or municipal health departments.

[2011, c. 306, §1 (AMD) .]

7. Health risk assessment. "Health risk assessment" means a customized process by which an individual confidentially responds to questions and receives a feedback report to help that individual understand the individual's personal risks of developing preventable health problems, know what preventive actions the individual can take and learn what local and state resources are available to help the individual take these actions.

[2009, c. 355, §5 (NEW) .]

8. Healthy Maine Partnerships. "Healthy Maine Partnerships" means a statewide system of comprehensive community health coalitions that meet the standards for department funding that is established under section 412, including the tribal district.

[2011, c. 306, §1 (AMD) .]

8-A. Indian tribe. "Indian tribe" or "tribe" means a federally recognized Indian nation, tribe or band in the State.

[2011, c. 306, §1 (NEW) .]

9. Local health officer. "Local health officer" means a municipal employee who has knowledge of the employee's community and meets educational, training and experience standards as set by the department in rule to comply with section 451.

[2009, c. 355, §5 (NEW) .]

10. Municipal health department. "Municipal health department" means a health department or division that is established pursuant to municipal charter or ordinance in accordance with Title 30-A, chapter 141 and accredited by a national federally recognized credentialing process.

[2009, c. 355, §5 (NEW) .]

11. Statewide Coordinating Council for Public Health. "Statewide Coordinating Council for Public Health" means the council established under Title 5, section 12004-G, subsection 14-G.

[2009, c. 355, §5 (NEW) .]

12. Tribal district. "Tribal district" means an administrative district established in a memorandum of understanding or legal contract among all Indian tribes in the State that is recognized by the department. The tribal district's jurisdiction includes tribal lands, tribal health departments or health clinics and members of the tribes anywhere in the State.

[2011, c. 306, §1 (NEW) .]

13. Tribal health department or health clinic. "Tribal health department or health clinic" means a health department or health clinic managed by an Indian tribe that is eligible for funds from the United States Department of the Interior, Bureau of Indian Affairs, Indian Health Service and other federal funds. For the purposes of this subsection, each director of a tribal health department or health clinic has a tribal role and a role defined by the Indian Health Service that is equivalent to the role of a director of an accreditation-eligible municipal health department.

[2011, c. 306, §1 (NEW) .]

SECTION HISTORY

2009, c. 355, §5 (NEW). 2011, c. 306, §1 (AMD).

22 §412. COORDINATION OF PUBLIC HEALTH INFRASTRUCTURE COMPONENTS

1. Local health officers. Local health officers shall provide a link between the Maine Center for Disease Control and Prevention and every municipality. Duties of local health officers are set out in section 454-A.

[2009, c. 355, §5 (NEW) .]

2. Healthy Maine Partnerships. Healthy Maine Partnerships is established to provide appropriate essential public health services at the local level, including coordinated community-based public health promotion, active community engagement in local, district and state public health priorities and standardized community-based health assessment, that inform and link to district-wide and statewide public health system activities.

Healthy Maine Partnerships must include interested community members; leaders of formal and informal civic groups; leaders of youth, parent and older adult groups; leaders of hospitals, health centers, mental health and substance abuse providers; emergency responders; local government officials; leaders in early childhood development and education; leaders of school administrative units and colleges and universities; community, social service and other nonprofit agency leaders; leaders of issue-specific networks, coalitions and associations; business leaders; leaders of faith-based groups; and law enforcement representatives. Where a service area of Healthy Maine Partnerships includes a tribal health department or health clinic, Healthy Maine Partnerships

shall seek a membership or consultative relationship with leaders and members of Indian tribes or designees of health departments or health clinics of Indian tribes.

The department and other appropriate state agencies shall provide funds as available to coalitions in Healthy Maine Partnerships that meet measurable criteria as set by the department for comprehensive community health coalitions. As funds are available, a minimum of one tribal comprehensive community health coalition must be provided funding as a member of a Healthy Maine Partnerships coalition. The tribal district is eligible for the same funding opportunities offered to any other district. The tribal district or a tribe is eligible to partner with any coalition in Healthy Maine Partnerships for collaborative funding opportunities that are approved by the tribal district coordinating council or a tribal health director.

[2011, c. 306, §2 (AMD) .]

3. District public health units. District public health units shall help to improve the efficiency of the administration and coordination of state public health programs and policies and communications at the district and local levels and shall ensure that state policy reflects the different needs of each district. Tribal public health programs and services delivered by the tribal district or a tribal health department or health clinic must help improve the efficiency of the administration and coordination of publicly and privately funded public health programs and policies and communications at local, district, state and federal levels.

[2011, c. 306, §2 (AMD) .]

4. District coordinating councils for public health. The Maine Center for Disease Control and Prevention, in consultation with Healthy Maine Partnerships, shall maintain a district coordinating council for public health in each of the nine districts as resources permit. If the district jurisdiction includes tribal lands and tribal members, and is not the tribal district, the district coordinating council for public health may not represent the tribe or tribes but shall consider Indian health status and pursue a consultative relationship with the tribe or tribes. Tribal representatives may choose to participate in the district coordinating council for public health as members or function in a consultative relationship. The tribal district shall have a tribal district coordinating council.

A district coordinating council for public health, after consulting with the Maine Center for Disease Control and Prevention, shall develop membership and governance structures that are subject to approval by the Statewide Coordinating Council for Public Health except that approval of the Statewide Coordinating Council for Public Health is not required for the membership and governance structures of the tribal district coordinating council.

A. A district coordinating council for public health shall:

(1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and

(4) Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible. [2011, c. 90, Pt. J, §7 (AMD).]

A-1. The tribal district coordinating council shall:

(1) Participate as appropriate in department district-level activities to help ensure the tribal public health system in the tribal district is ready and maintained for tribal public health accreditation; and

(2) Ensure that the national goals and strategies for health in tribal lands and the tribal district health goals and strategies are aligned and that tribal district health goals and strategies are appropriately tailored for each tribe and tribal health department or health clinic. [2011, c. 306, §2 (NEW).]

B. The Maine Center for Disease Control and Prevention, in consultation with Healthy Maine Partnerships, shall ensure the invitation of persons to participate on a district coordinating council for public health and shall strive to include persons who represent the Maine Center for Disease Control and Prevention, county governments, municipal governments, Indian tribes and their tribal health departments or health clinics, city health departments, local health officers, hospitals, health systems, emergency management agencies, emergency medical services, Healthy Maine Partnerships, school districts, institutions of higher education, physicians and other health care providers, clinics and community health centers, voluntary health organizations, family planning organizations, area agencies on aging, mental health services, substance abuse services, organizations seeking to improve environmental health and other community-based organizations. [2011, c. 306, §2 (AMD).]

C. In districts, other than the tribal district, that contain tribal members, population health assessments and health improvement plans and strategies developed by municipal health departments, Healthy Maine Partnerships and district coordinating councils for public health must consider Indian health issues and disparities. Data used for these assessments must be sound and at the most local level available. Assessments must include any quantitative or qualitative data the tribes agree to share. Tribal health assessments and tribal health improvement plans and strategies may focus exclusively on tribal members but may be conducted only at any tribe›s discretion. [2011, c. 306, §2 (NEW).]

D. Population and personal health programs, interventions and services that formally include or focus on tribal members must be developed in close consultation with tribes and must be culturally competent in design and implementation. In addition, tribes must be consulted prior to their inclusion in any grant applications. [2011, c. 306, §2 (NEW).]

[2011, c. 306, §2 (AMD) .]

5. Municipal and tribal health departments. Municipal health departments or tribal health departments or health clinics may enter into data-sharing agreements with the department for the exchange of public health data determined by the department to be necessary for protection of the public health. A data-sharing agreement under this subsection must protect the confidentiality and security of individually identifiable health information as required by state and federal law.

[2011, c. 306, §2 (AMD) .]

5-A. Tribal district. The tribal district shall deliver components of essential public health services through the tribal district's public health liaisons, who are tribal employees, and report to the tribes, the department's office of minority health and any other sources of funding.

Responses to federal and state requests for applications may be issued by one tribe, two or more tribes collectively or the tribal district as the recipient of funds. The directors of the tribal health departments or health clinics serve as the tribal district coordinating council for public health in an advisory role to the tribal district. The council may establish subcommittees to work on specific projects approved by the council.

[2011, c. 306, §2 (NEW) .]

6. Statewide Coordinating Council for Public Health. The Statewide Coordinating Council for Public Health, established under Title 5, section 12004-G, subsection 14-G, is a representative statewide body of public health stakeholders for collaborative public health planning and coordination.

A. The Statewide Coordinating Council for Public Health shall:

(1) Participate as appropriate to help ensure the state public health system is ready and maintained for accreditation;

(4) Assist the Maine Center for Disease Control and Prevention in planning for the essential public health services and resources to be provided in each district and across the State in the most efficient, effective and evidence-based manner possible;

(5) Receive reports from the tribal district coordinating council for public health regarding readiness for tribal public health systems for accreditation if offered; and

(6) Participate as appropriate and as resources permit to help support tribal public health systems to prepare for and maintain accreditation if assistance is requested from any tribe. The Maine Center for Disease Control and Prevention shall provide staff support to the Statewide Coordinating Council for Public Health as resources permit. Other agencies of State Government as necessary and appropriate shall provide additional staff support or assistance to the Statewide Coordinating Council for Public Health as resources permit. [2011, c. 306, §2 (AMD).]

B. Members of the Statewide Coordinating Council for Public Health are appointed as follows.

(1) Each district coordinating council for public health, including the tribal district coordinating council, shall appoint one member.

(2) The Director of the Maine Center for Disease Control and Prevention or the director's designee shall serve as a member.

(3) The commissioner shall appoint an expert in behavioral health from the department to serve as a member.

(4) The Commissioner of Education shall appoint a health expert from the Department of Education to serve as a member.

(5) The Commissioner of Environmental Protection shall appoint an environmental health expert from the Department of Environmental Protection to serve as a member.

(6) The Director of the Maine Center for Disease Control and Prevention, in collaboration with the co-chairs of the Statewide Coordinating Council for Public

Health, shall convene a membership committee. After evaluation of the appointments to the Statewide Coordinating Council for Public Health, the membership committee shall appoint no more than 10 additional members and ensure that the total membership has at least one member who is a recognized content expert in each of the essential public health services and has representation from populations in the State facing health disparities. The membership committee shall also strive to ensure diverse representation on the Statewide Coordinating Council for Public Health from county governments, municipal governments, tribal governments, tribal health departments or health clinics, city health departments, local health officers, hospitals, health systems, emergency management agencies, emergency medical services, Healthy Maine Partnerships, school districts, institutions of higher education, physicians and other health care providers, clinics and community health centers, voluntary health organizations, family planning organizations, area agencies on aging, mental health services, substance abuse services, organizations seeking to improve environmental health and other community-based organizations. [2011, c. 306, §2 (AMD).]

C. The term of office of each member is three years. All vacancies must be filled for the balance of the unexpired term in the same manner as the original appointment. [2009, c. 355, §5 (NEW).]

D. Members of the Statewide Coordinating Council for Public Health shall elect annually a chair and co-chair. The chair is the presiding member of the Statewide Coordinating Council for Public Health. [2009, c. 355, §5 (NEW).]

E. The Statewide Coordinating Council for Public Health shall meet at least quarterly, must be staffed by the department as resources permit and shall develop a governance structure, including determining criteria for what constitutes a member in good standing. [2009, c. 355, §5 (NEW).]

F. The Statewide Coordinating Council for Public Health shall report annually to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the Governor's office on progress made toward achieving and maintaining accreditation of the state public health system and on district-wide and statewide streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of essential public health services. [2011, c. 90, Pt. J, §9 (RPR).]

[2011, c. 306, §2 (AMD) .]

SECTION HISTORY

2009, c. 355, §5 (NEW). 2011, c. 90, Pt. J, §§7-9 (AMD). 2011, c. 306, §2 (AMD).

22 §413. UNIVERSAL WELLNESS INITIATIVE

The Maine Center for Disease Control and Prevention, the Statewide Coordinating Council for Public Health, the district coordinating councils for public health and Healthy Maine Partnerships shall undertake a universal wellness initiative to ensure that all people of the State, including members of Indian Tribes, have access to resources and evidence-based interventions in order to know, understand and address health risks and to improve health and prevent disease. A particular focus must be on the uninsured and others facing health disparities. [2011, c. 306, §3 (AMD).]

1. Resource toolkit for the uninsured. The Maine Center for Disease Control and Prevention and the Governor's office shall develop a resource toolkit for the uninsured with information on access

to disease prevention, health care and other methods for health improvement. Healthy Maine Partnerships, the district coordinating councils for public health, the Maine Center for Disease Control and Prevention and the Statewide Coordinating Council for Public Health shall promote and distribute the toolkit materials, in particular through small businesses, schools, school-based health centers, tribal health departments or health clinics, and other health centers. Healthy Maine Partnerships, each district coordinating council for public health and the Statewide Coordinating Council for Public Health shall report annually to the Maine Center for Disease Control and Prevention on strategies employed for promotion of the toolkit materials.

[2011, c. 306, §3 (AMD) .]

2. Health risk assessment. Healthy Maine Partnerships, the district coordinating councils for public health, the Statewide Coordinating Council for Public Health and the Maine Center for Disease Control and Prevention shall promote an evidence-based health risk assessment that is available to all people of the State, with a particular emphasis on outreach to the uninsured population, members of Indian tribes and others facing health disparities. These health risk assessments and their promotion must provide linkages to existing local disease prevention efforts and be collaborative with and not duplicative of existing efforts.

[2011, c. 306, §3 (AMD) .]

3. Report card on health. The Maine Center for Disease Control and Prevention, in consultation with the Statewide Coordinating Council for Public Health, shall develop, distribute and publicize an annual brief report card on health status statewide and for each district by June 1st of each year. The report card must include major diseases, evidence-based health risks and determinants that impact health.

[2009, c. 355, §5 (NEW) .]

The Maine Center for Disease Control and Prevention and the Governor's Office of Health Policy and Finance shall provide staff support to implement the universal wellness initiative in this section as resources permit. Other agencies of State Government as necessary and appropriate shall provide additional staff support or assistance. [2009, c. 355, §5 (NEW).]

SECTION HISTORY

2009, c. 355, §5 (NEW). 2011, c. 306, §3 (AMD).

Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

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