

STATEWIDE COORDINATING COUNCIL FOR PUBLIC HEALTH  
DECEMBER 21, 2017  
AGENDA

10:00 – 12:00 Council Meeting

12:00-1:00 – Working Lunch (please feel free to bring your lunch)

**Call-in Information:** CDC Call number: 877-455-0244; Passcode: 879 303 3495

- 10:00** Welcome- *Patty Hamilton and Kristi Ricker (Co-Chairs)*
- 10:05** Introductions -*All*
- 10:15** Review of Agenda - *Chair*  
Review of prior meeting Minutes
- 10:20** Administrative Items
- Seatholder Status/Vacancies/Nominations/New Members(*Patty Hamilton*)
  - Website Update
- 10:30** Data Research and Vital Statistics Dashboard (*Kim Haggan*)
- 11:00** Maine Integrated Youth Health Survey (*Reid Plimpton*)
- 11:30** District Reports
- 12:00** Break
- 12:15** Working Lunch – Standing Item: State Health Improvement Plan (SHIP) (*Nancy Birkhimer*)
- 12:45** Working Lunch – Standing Item: Public Health and Health Services Block Grant (PHHSBG) (*Nancy Birkhimer*)
- 1:15** Working Lunch - SCC Reports: Health Report Card, Report to HHS Committee, CEC Administrative Report (*Nancy Birkhimer*)
- 1:30** Next Steps, Next Agenda, Evaluation (*Lead*)  
Choices for March:
- Adverse Childhood Events (ACES) updates around the table
  - Presentation by DHHS on the Prescription Monitoring Program
- 2:00** Adjourn

Reid Plimpton

MIYHS Project Coordinator

MCDC/ MCDPH

# The Maine Integrated Youth Health Survey (MIYHS)

## Looking at the 2017 Data, and How to use it



*Maine Center for  
Disease Control and Prevention*

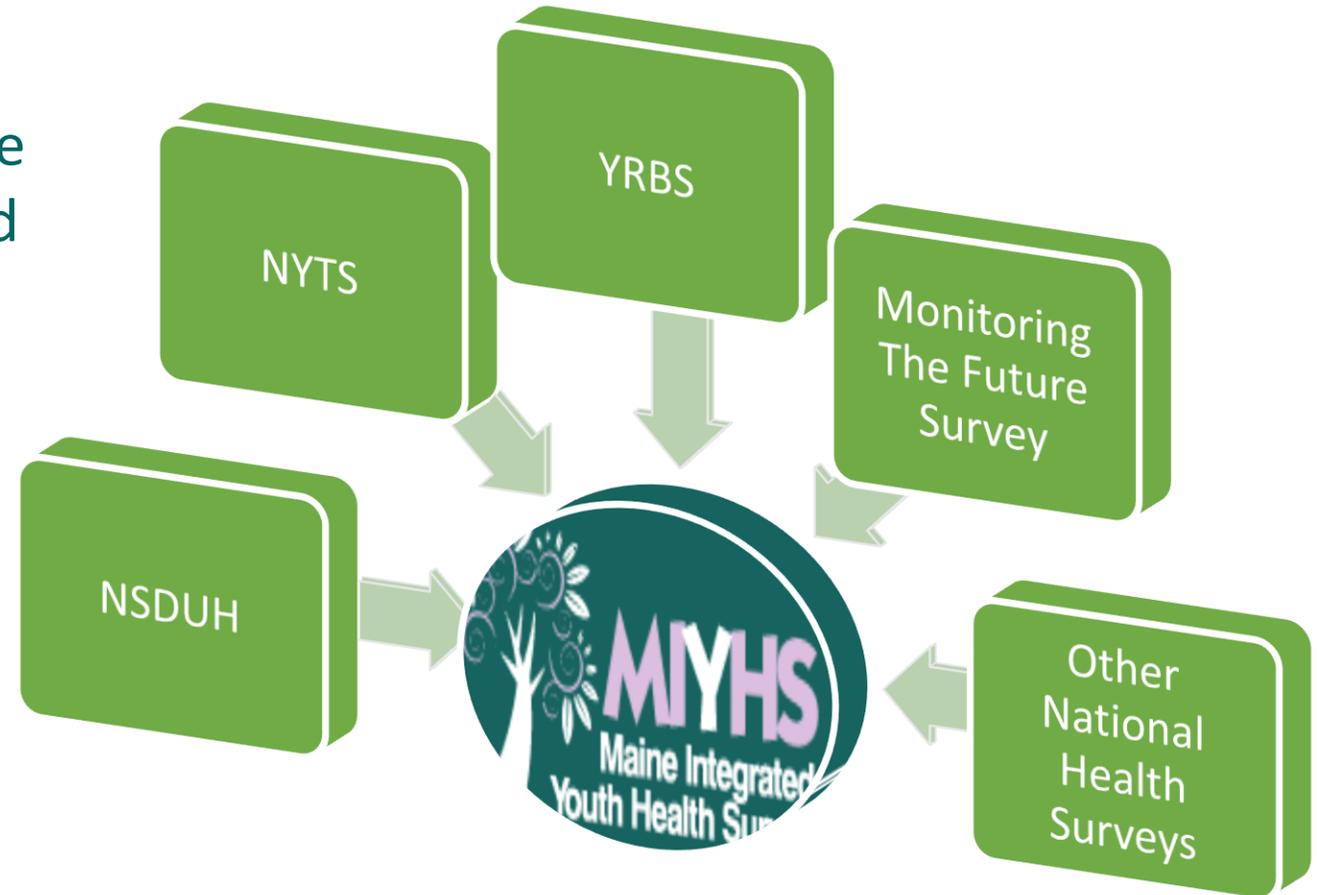
*An Office of the  
Department of Health and Human Services*

*Paul R. LePage, Governor*

*Ricker Hamilton, Commissioner*

# MIYHS Background

- Comprehensive youth health survey
- First year of the project was 2009, and the project is administered in February of odd years
- The MIYHS is a result of combining multiple national survey instruments together
  - To minimize educational interruption
  - And maximize data availability
- Collaboration between the Maine Department of Health and Human Services and the Maine Department of Education.



# Explanation of Survey Modules and Sample Design

Module	Survey Design	Participants	Survey Question Method	Data Depth
<b>Kindergarten &amp; Third Grade</b>	Sample (w/ replacements)	<b>Survey Questions:</b> Parents <b>Oral Health Screening:</b> Students	Paper or Phone Call	State Level Data
<b>5<sup>th</sup> &amp; 6<sup>th</sup> Grade</b>	Sample (+volunteer schools)	Students	Paper during normal class period	-State Level Data -Public Health District Data  -School Level Data* -School District Level Data*
<b>Middle School (7<sup>th</sup> &amp; 8<sup>th</sup> Grade)</b>	Census			-State Level Data -Public Health District Data -County Level Data
<b>High School (9<sup>th</sup>-12<sup>th</sup> Grade)</b>	Census			-School Level Data* -School District Level Data*

# 2017 MIYHS- Fast Facts

[Data.mainepublichealth.gov/miyhs](https://data.mainepublichealth.gov/miyhs)

OR

[Maine.gov/MIYHS](https://maine.gov/MIYHS)

- Over **350** schools participated
- Surveying **61,000+** students.
- Over **80%** of all Middle Schools (MS) & High Schools (HS)
- **All** Counties and PHD's are reportable (!!!)

# 2017 MIYHS Data- A Few Highlights

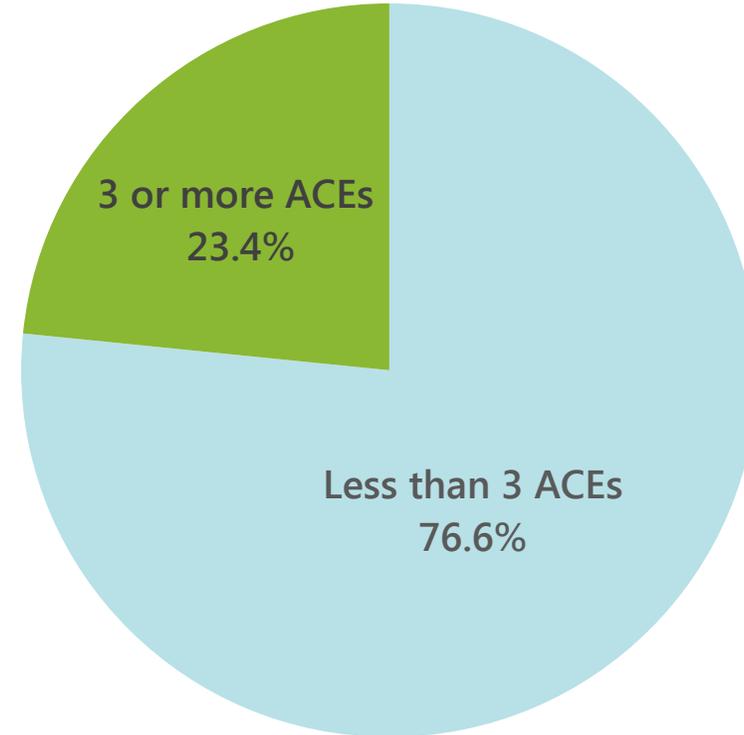
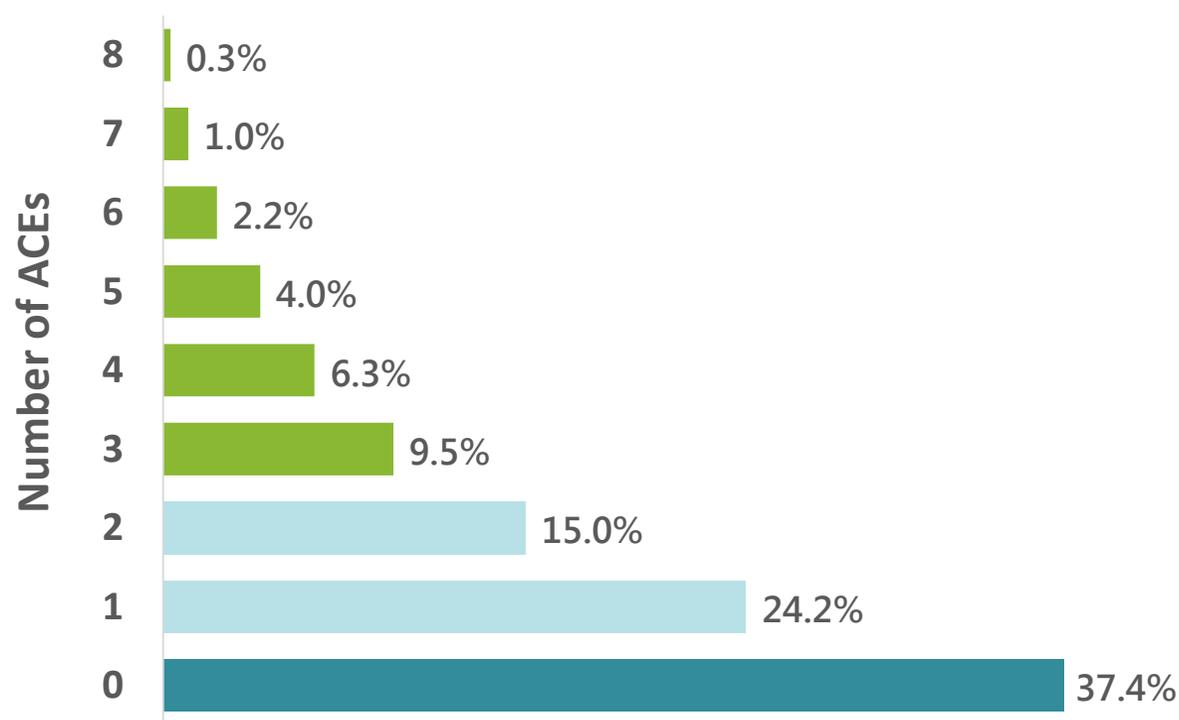
- 11% of Maine HS students reported being of LBG sexual orientation
- 1.5% of Maine HS students reported identifying as transgender
- 22% of Maine HS students reported being bullied on school property *in the past year*
- 46% of Maine MS students reported being bullied on school property *in their lifetime*
- Significantly more Maine HS students agreed that “at least one of their teachers really cares and is there for help and support” as compared to 2015 (81.5% vs. 79.7%)
- 22% of Maine 5<sup>th</sup>&6<sup>th</sup> grade students reported being home alone for more than 2 hours on an average school day.

# 2017 MIYHS Data- A Few Highlights

- Significantly fewer Maine HS students reported smoking a cigarette in the past 30 days as compared to 2015 (8.8% vs. 10.7%)
- Significantly fewer Maine MS students reported smoking a cigarette in the past 30 days as compared to 2015 (1.9% vs 2.7%)
- About 22.5% of Maine HS students and about 4% of Maine MS students have tried alcohol in the past 30 days
- About 19% of Maine HS students and about 4% of Maine MS students have tried marijuana in the past 30 days
  - About 65% of Maine HS students reported a low perception of harm in using marijuana once or twice a week
  - About 52% of Maine HS students reported a high ease of access to marijuana

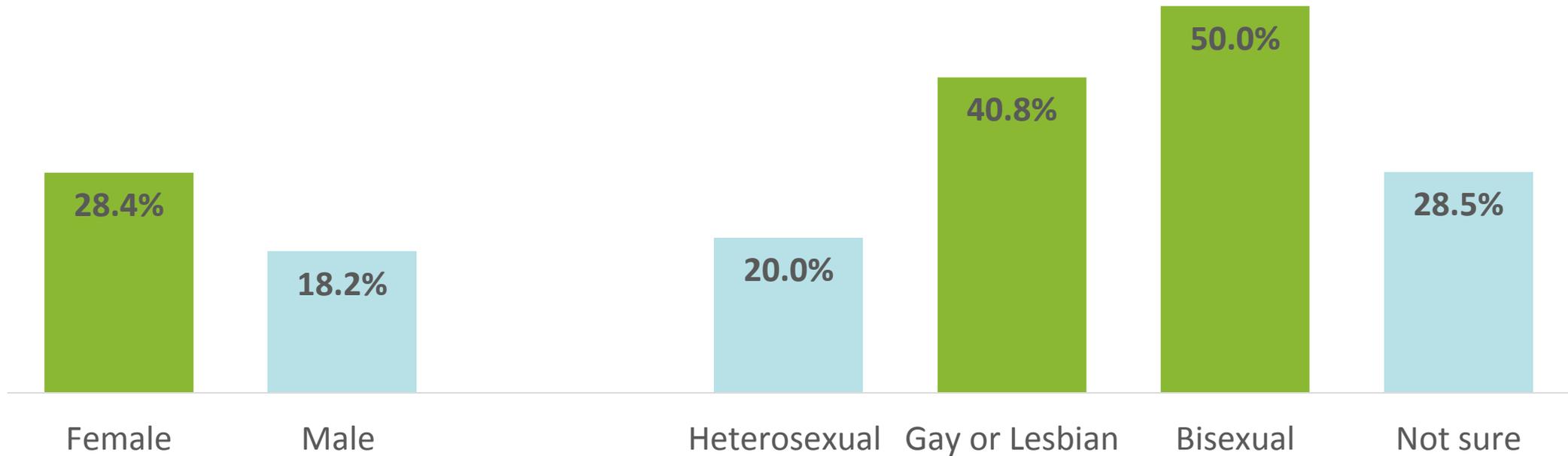
# ACEs overall

Nearly **1 in 4** Maine high school students have experienced **3 or more ACEs**.  
The **majority** have experienced **less than 3**; **over one-third** have experienced **no adverse events**.



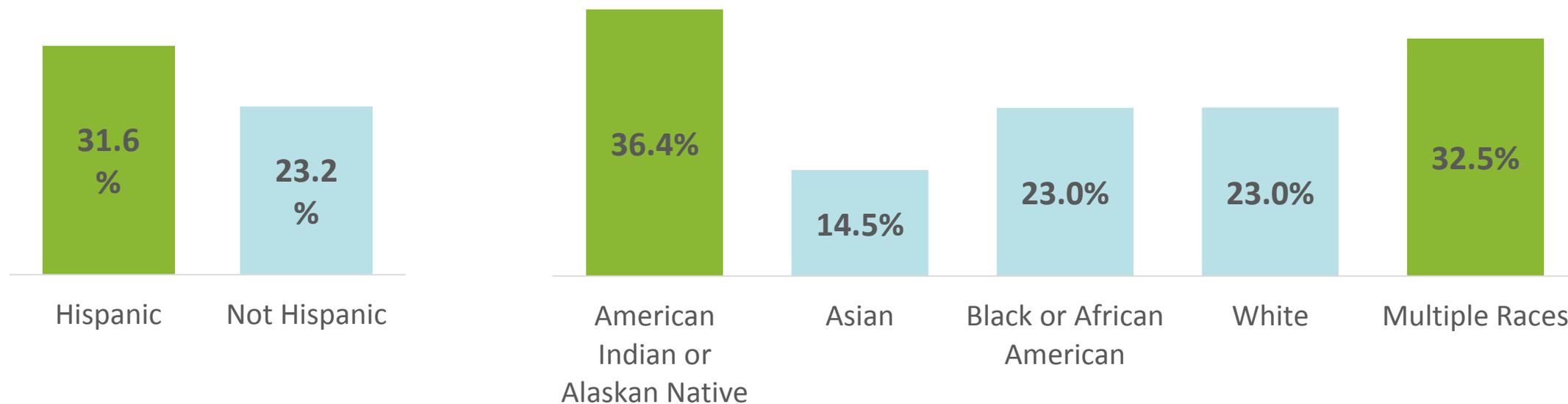
# Experiencing 3 or more ACEs...

... was more common among **girls** and **LGB students** compared with **boys** and **heterosexual students**.



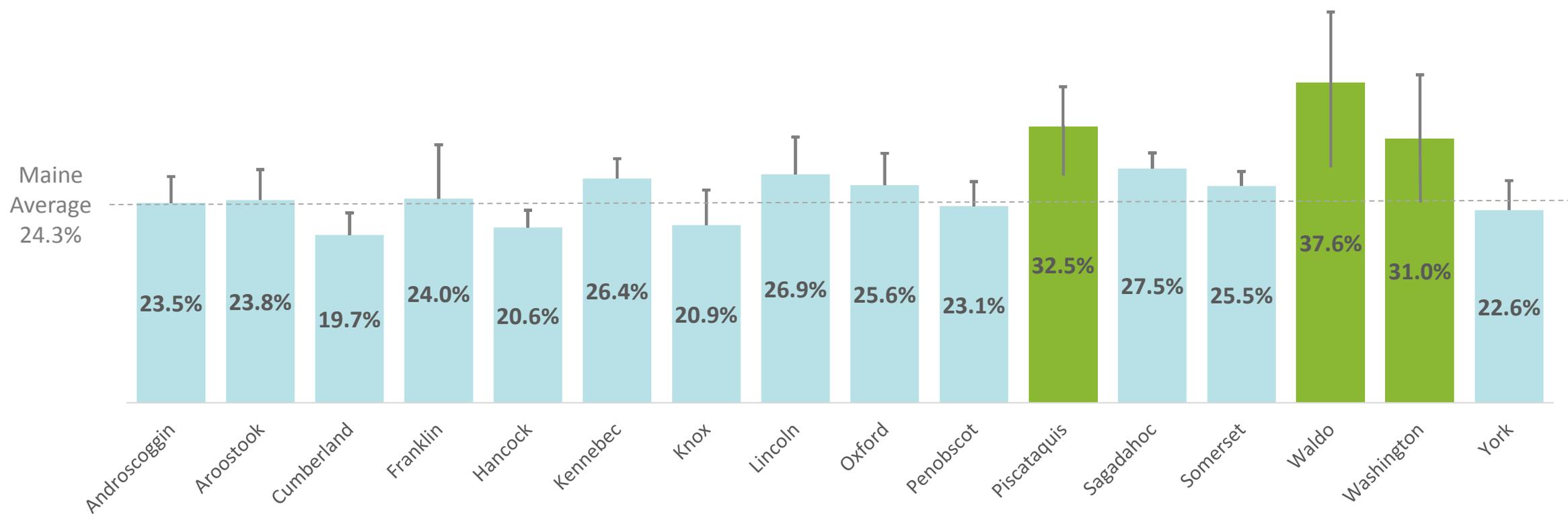
# Experiencing 3 or more ACEs...

... was more common among **American Indian, Multiracial** and **Hispanic/Latino students** relative to students of **other races** or **non-Hispanic ethnicity**.

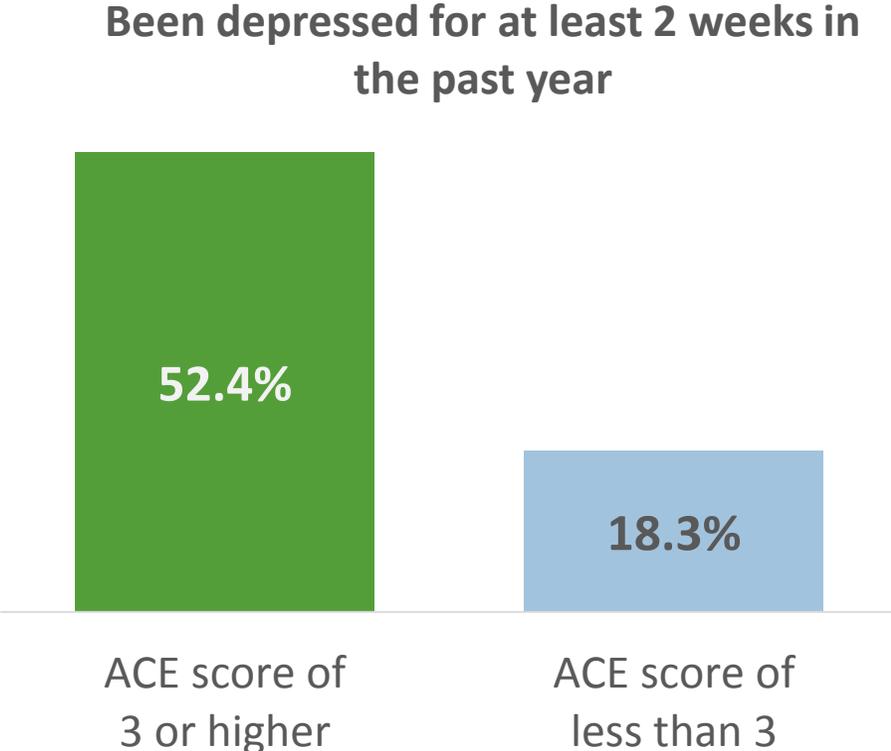
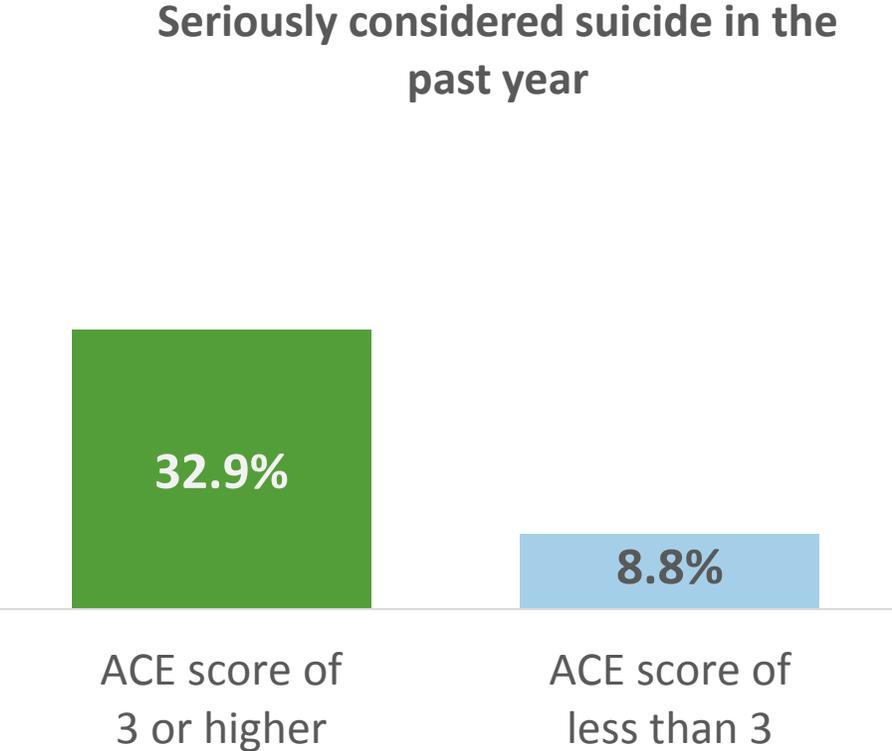


# Experiencing 3 or more ACEs...

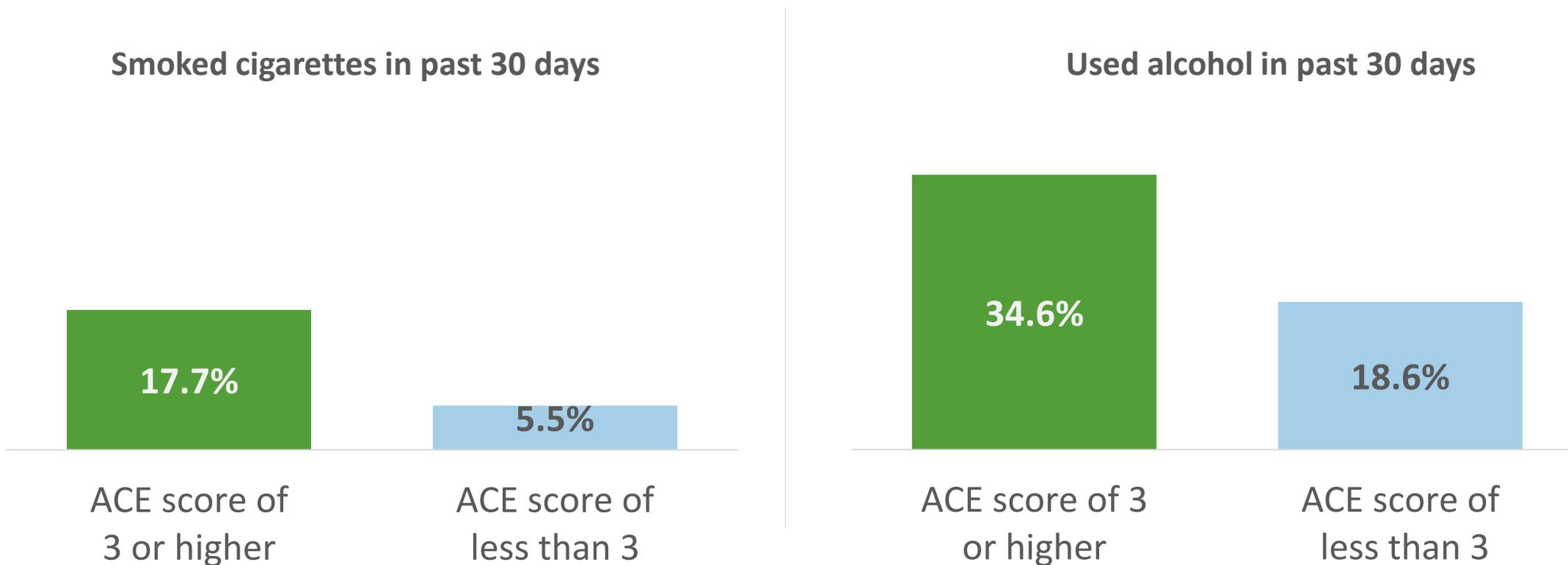
... was more common in **Piscataquis, Waldo** and **Washington** counties.



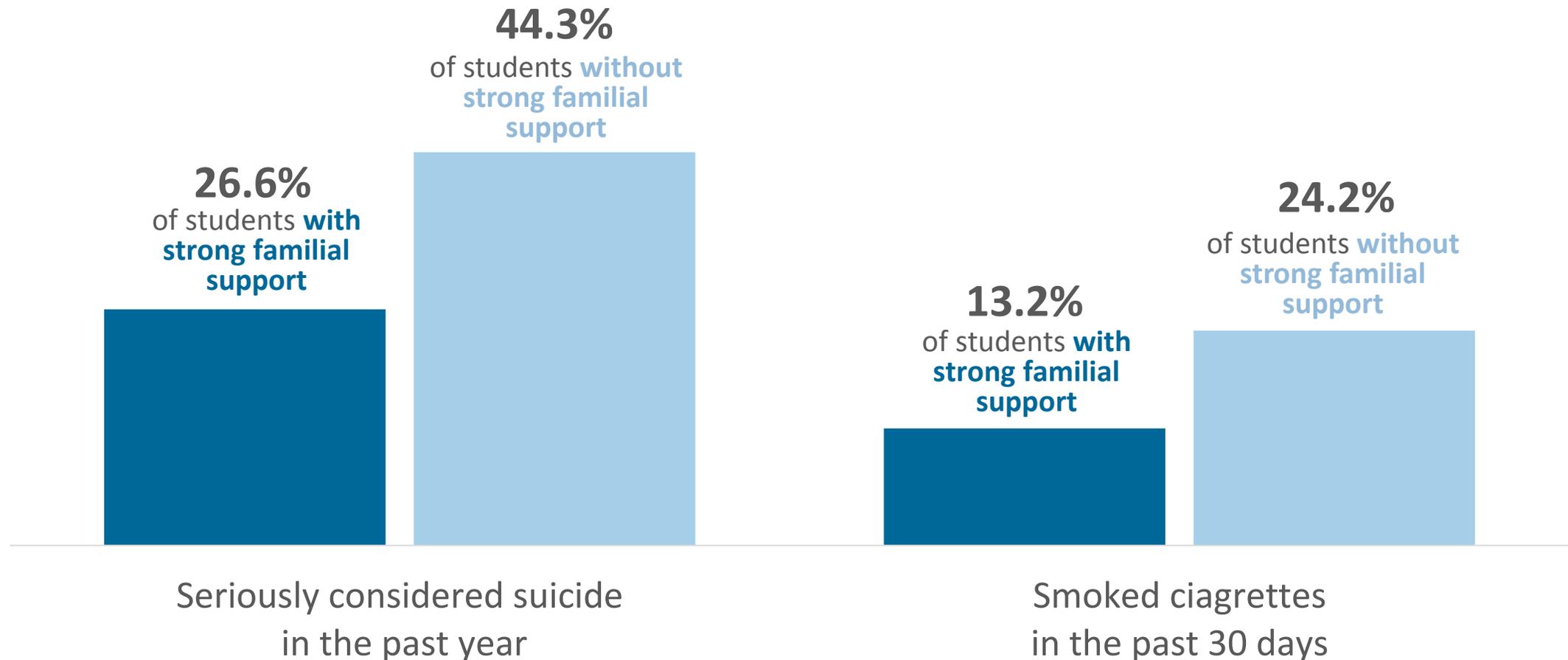
# Suicidal ideation and depression were **higher** among students with **3 or more ACEs** compared to students with **less than 3 ACEs**.



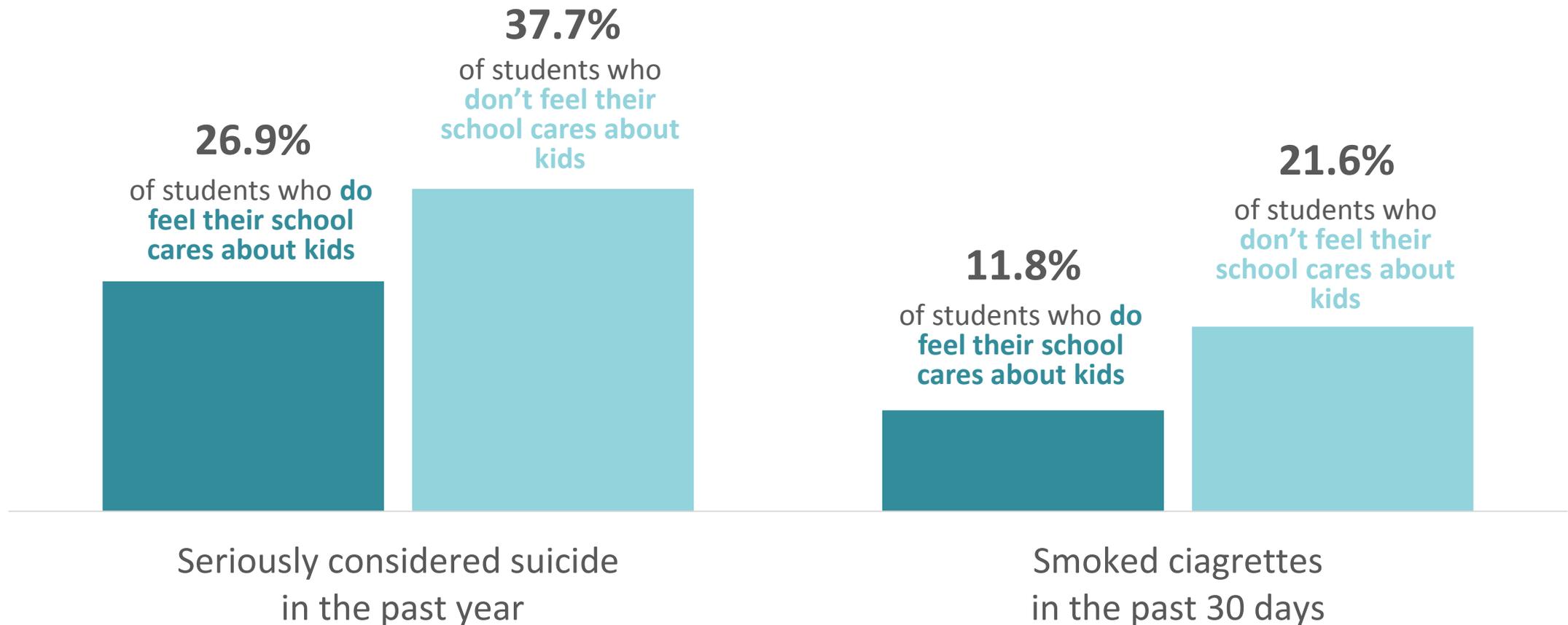
# Smoking cigarettes and using alcohol in the past 30 days were both **higher** among students with **3 or more ACEs**.



# Strong familial love and support was protective against suicide consideration and smoking among higher ACE students.



Higher ACE students who felt their **school “cares about kids”** were less likely to experience suicidal ideation or to smoke.



# Housing Stability

- Question: During the past 30 days, where did you usually sleep?
- Answer options:
  - A. In my parent's or guardian's home
  - B. In the home of a friend, family member, or other person because I had to leave my home or my parent or guardian cannot afford housing
  - C. In a shelter or emergency housing
  - D. In a motel or hotel
  - E. In a car, park, campground, or other public place
  - F. I do not have a usual place to sleep
  - G. Somewhere else

# Housing Stability

- Asked on both the MS and HS surveys
- HS Response Rates: (Highlighted answer is the “*Answer of Interest*” (percentage reported in public reports))

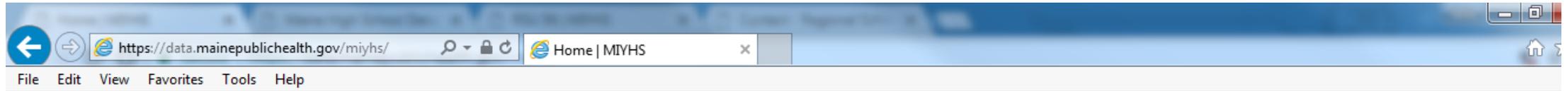
(h247)During the past 30 days, where did you usually sleep?	Weighted Frequency	Percent	95% Confidence Limits for Percent	
A. In my parent's or guardian's home	53063	96.39	95.93	96.86
B. In the home of a friend, family member, or other person because I had to leave my home or my parent or guardian cannot afford housing	702	1.27	1.12	1.43
C. In a shelter or emergency housing	139	0.25	0.18	0.32
D. In a motel or hotel	110	0.20	0.16	0.24
E. In a car, park, campground, or other public place	190	0.34	0.29	0.40
F. I do not have a usual place to sleep	176	0.32	0.25	0.39
G. Somewhere else	669	1.22	0.86	1.57

# Housing Insecure

- HS Response Rates: Calculated Variable
- 'No'= Percentage that reported "In my parent's or guardian's home"
- 'Yes'= Anything else

Housing Insecure (binary variable)	Weighted Frequency	Percent	95% Confidence Limits for Percent	
No	53063	96.39	95.93	96.86
Yes	1985	3.61	3.14	4.07

# The Website



## RELATED SURVEY LINKS

[MYDAUS](#)

[US YRBS](#)

[Monitoring the Future](#)

## RELATED PARTNER SITES

[Maine Center for Disease Control and Prevention](#)

[Substance Abuse and Mental Health Services](#)

[Department of Education](#)

[Maine Coordinated School Health Programs](#)

## Maine Integrated Youth Health Survey Data

The Maine Integrated Youth Health Survey (MIYHS) was first administered in 2009 and will be offered in February of odd-numbered years. The MIYHS is the result of collaboration between the Maine Department of Health and Human Services and the Maine Department of Education. Its purpose is to quantify the health of Kindergarten and Grade 3 students through parent interviews, and the health-related behaviors and attitudes of 5th through 12th graders by direct student survey. The MIYHS data on this website has two main portions: 1) Reports and fact sheets that present Maine, County and Public Health District reports (at the "Reports and Fact Sheets" tab above); and 2) the access-code-protected **Local Data** (see box to the right) with school reports.

For questions about the content of reports or how to access **Local Data**, please contact Reid Plimpton at [reid.plimpton@maine.gov](mailto:reid.plimpton@maine.gov). If you would like to submit make a special request of MIYHS data analytics, please fill out this [form](#), with an explanation in the detailed description of your request.

## What's New!

[2017 MIYHS Data Results](#)

[2017 MIYHS Fact Sheets](#)

[Resources Page](#)

[Interactive Data Dashboard](#)

[Upcoming Survey Information](#)

## Local Data Search

Username \*

Password \*

[Request new password](#)

# The Website



HOME DATA RESULTS FACT SHEETS METHODOLOGY RESOURCES FAQs 2017 SURVEY INFORMATION

[MIYHS MIDDLE SCHOOL AND HIGH SCHOOL DATA DASHBOARD](#) [2017 DATA RESULTS](#) [2015 DATA RESULTS](#) [2013 DATA RESULTS](#) [2011 DATA RESULTS](#) [2009 DATA RESULTS](#)

## Methodology & data requests

The full methodology details are in the report attached here. In addition, there is a fact sheet with some key points, our privacy policy and data request information and forms.

- [2015 MIYHS Methodological Report](#)
- [Understanding the Data - State, County, And Public Health District Data](#)
- [Understanding the Data: School Reports](#)
- [Modified Variables in the 2015 MIYHS](#)
- [Data Release Policy](#)
- [Confidentiality Agreement for Release of Disaggregated Data](#)
- [Confidentiality Agreement for Release of Disaggregated Data-SAU Permission Addendum](#)

## Results by topic

As resources allow, reports by topic area may become available and will be posted here. This is generally the data in the full report, but may include additional analyses.

## Detailed results by county, public health district and state

As resources are available, reports of the MIYHS by county, public health district, and state will be posted here. This is the same data as provided in the full report, but is organized by the geographic region, rather than by topic. Reports for some geographic regions are not available due to low response rates.

**Note: All PDF report versions**

Only secure content is displayed. [What's the risk?](#)

Show all content x



HOME DATA RESULTS FACT SHEETS METHODOLOGY RESOURCES FAQs 2017 SURVEY INFORMATION

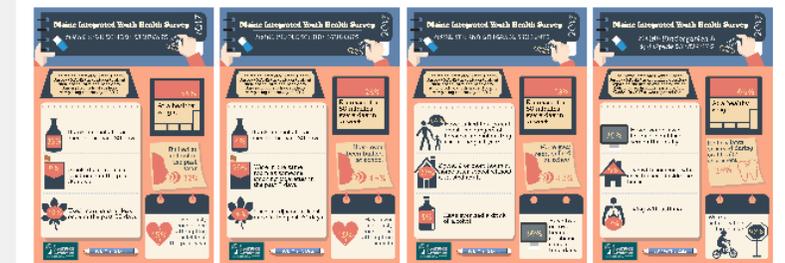
[2017 FACT SHEETS](#) | [2015 FACT SHEETS](#)

## Snapshots

Each state level snapshot provides a one page overview that includes:

- Six key findings from the 2017 MIYHS survey
- Ideas for parents, youth and schools to help youth stay healthy
- How to get more information

Click on the thumbnails below to view each snapshot:



# Thank you!

- Questions?
- Contact information:

Reid Plimpton- [reid.plimpton@maine.gov](mailto:reid.plimpton@maine.gov) or 207-287-5084

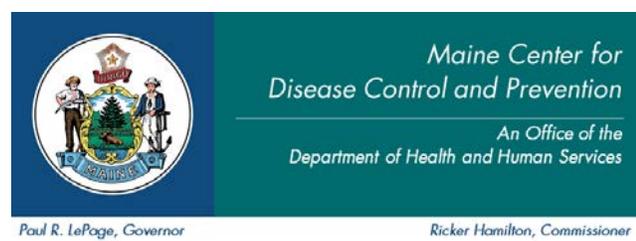


*Department of Health  
and Human Services*

*Maine People Living  
Safe, Healthy and Productive Lives*

*Paul R. LePage, Governor*

*Ricker Hamilton, Commissioner*



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## *The Maine Integrated Youth Health Survey (MIYHS)*

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**Purpose:** To quantify the health of Kindergarten and Grade 3 students through parent interviews, and the health-related behaviors and attitudes of 5th through 12th graders by direct student survey.

### **Kindergarten and Third Grade Survey**

- Sample Survey (subset of schools invited to participate)
- Designed to report at the State level
- Parent Survey
- Student Oral Health Screening-
- *Screening assistance provided by Registered Dental Hygienist*
- Student height/weight assessment
- 24 Schools sampled for 2017
- 22 of those sampled participated

### **5<sup>th</sup> and 6<sup>th</sup> Grade Survey**

- Sample Survey (subset of schools invited to participate) + Volunteers welcomed
- Designed to report at the State and Public Health District levels
- School and School District reports available w/permissions
- Student survey with age appropriate questions
- Height/Weight assessed for 5<sup>th</sup> grade only
- About 129 Schools sampled for 2017
  - Over 75 of those sampled participated
  - About 25 volunteer schools

### **Middle School (7<sup>th</sup>-8<sup>th</sup> Grade) Survey**

- Census Survey (all schools invited to participate)
- Designed to report at the State, Public Health District, and County levels
- School and School District reports available w/permissions
- Student survey with age appropriate questions
- Self-reported height/weight
- 4 Survey Modules
  - Total question pool of about 90
  - Module question counts  
Lowest: 80 Highest: 81
- Over 120 Schools participated in 2017



Paul R. LePage, Governor

Ricker Hamilton, Commissioner

### **High School (9<sup>th</sup>-12<sup>th</sup> Grade) Survey**

- Census Survey (all schools invited to participate)
- Designed to report at the State, Public Health District, and County levels
- School and School District reports available w/permissions
- Student survey with age appropriate questions
- Self-reported height/weight
- 4 Survey Modules
  - Total question pool of about 115
  - Module question counts
    - Lowest: 99 Highest: 110
- Over 105 Schools participated in 2017

#### **Depending on the survey module, the survey covers the following topics:**

- Alcohol, tobacco and drug use
- Bullying
- Sexual health
- Injury
  - Intentional
  - Unintentional
- Vehicle Safety
- Housing Stability
- Physical activity
- Nutrition
- Mental health
- Protective factors
- Self confidence
- Perception of (harm, supports, assets, etc.)
- Grades
- School Climate
- Hours of Sleep

**Website:** [www.data.mainepublichealth.gov/miyhs/](http://www.data.mainepublichealth.gov/miyhs/)

#### **Contacts:**

Reid Plimpton- Maine CDC, (207) 287-5084 or [reidplimpton@maine.gov](mailto:reidplimpton@maine.gov)

Jean Zimmerman- Maine DOE, (207) 624-6687 or [jean.zimmerman@maine.gov](mailto:jean.zimmerman@maine.gov)



# Statewide Coordinating Council for Public Health District Coordinating Council Update

Template updated 03/2012

<b>District: Aroostook District</b>	<b>Date: December 8, 2017</b>
<p><b>Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district’s website at: <a href="http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml">http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml</a></b></p> <ul style="list-style-type: none"> <li>➤ Overview of Maine Medical Marijuana Program</li> <li>➤ Dates of note in Aroostook District: <ul style="list-style-type: none"> <li>• Next DCC Meeting: February 7, 2018</li> <li>• Next Access to Care committee Meeting: January 25, 2018</li> </ul> </li> </ul>	
<p><b>Ongoing or upcoming projects or priority issues:</b></p> <ul style="list-style-type: none"> <li>➤ Continued work on Standard Operating Procedure</li> <li>➤ Analysis of Partnership Self-Assessment results; definition of next steps to further improve DCC functionality and Member benefit</li> </ul>	
<p><b>Progress with District Public Health Improvement Plan:</b></p> <ul style="list-style-type: none"> <li>➤ Aroostook DCC supporting a partner application to Maine Cancer Foundation for tobacco cessation work with defined low income populations</li> </ul>	
<p><b>Structural and Operational changes, including updates in membership.</b></p> <ul style="list-style-type: none"> <li>➤ Jim Davis is relocating to the West Coast – Lisa Caron, COO, Pines Health Services will be assuming his seat on the DCC.</li> <li>➤ Joy Barresi Saucier will be re-joining the DCC representing the Aroostook Agency on Aging</li> <li>➤ Terry Wood, Central Aroostook Council on Education, will be joining the DCC as the k-12 sector representative.</li> </ul>	
<p><b>In-district or multi-district collaborations:</b></p> <ul style="list-style-type: none"> <li>➤ Aroostook DCC is collaborating with the Northern Maine Development Commission, the Aroostook Association of Solid Waste Directors, and the University of Maine at Presque Isle on a food waste reduction project.</li> </ul>	
<p><b>Other topics of interest for SCC members:</b></p> <ul style="list-style-type: none"> <li>➤ Recovery Aroostook opened the first sober house in the County last week.</li> </ul>	

District Name : Aroostook

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22 M.R.S. §412 (2011).

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.

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



# Statewide Coordinating Council for Public Health District Coordinating Council Update

<b>District: Central</b>	<b>Date: December 21, 2017</b>
<p><b>Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district’s website at:</b>  <a href="http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml">http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml</a> At the October 24 DCC meeting we heard updates from our SCC Representative, DCC workgroups, district Field Epidemiologist, and meeting attendees. Jamie Cotnoir, Maine CDC Infectious Disease Supervisor, presented district Sexually Transmitted Disease (STD) data and helped us understand what we’ve been seeing for high rates in the district and the state, as well as what services are available for prevention and support. Malindi Thompson from Maine General Health then led a round of ‘Sex and Drugs Jeopardy’ to demonstrate how their staff use it and to show DCC participants how to modify the game for their own education/outreach and facilitation efforts.</p>	
<p><b>Ongoing or upcoming projects or priority issues:</b> refining strategies and workgroup charges to reflect loss of funding for DPHIP implementation; coordination with hospital Implementation Strategies and the coming new round of Shared CHNA; MGMC/District Oral Health Implementation Grant Community Health Worker (CHW) expansion to whole district and increasing/sustaining resources for community health workers; transportation services, and volunteer efforts; recruiting/maintaining sector membership; coordinating with recipients of the Maine Prevention Services contracts; vulnerable populations HAN; ongoing sustainability of successful initiatives</p>	
<p><b>Progress with District Public Health Improvement Plan (DPHIP):</b> <i>Activities planned for completion during the quarter and whether activities are able to be completed on schedule</i></p> <ul style="list-style-type: none"> <li>▶ Use Central District Public Health Unit updates and DCC website to communicate important information to DCC, LHOs, and partners – ongoing task with updates going out weekly as needed</li> <li>▶ Establish and implement DCC Vaccination Workgroup and communication network – ongoing</li> <li>▶ The Adverse Childhood Experiences (ACEs) Workgroup was asked to re-convene and assist with district Drug-Free Communities (DFC) grantees’ school and community efforts to build resiliency</li> <li>▶ DCC Leadership has been reviewing workgroup charges and possible partnering alternatives to determine how to proceed with the elimination of funding</li> </ul> <p><i>Successes achieved</i></p> <ul style="list-style-type: none"> <li>▶ District Oral Health Grant increased to expand Community Health Worker services to cover the whole district – 39 children connected to dental appointments this quarter with outreach to/referrals from district pediatric practices, school nurses, Maine Families, KVCAP, WIC, and the Children’s Center</li> <li>▶ ACEs Workgroup updated it’s charge and membership, began environmental scan of community and school efforts in the district, and will highlight success stories at the January DCC meeting</li> </ul> <p><i>Barriers encountered</i></p> <ul style="list-style-type: none"> <li>▶ Volunteers for DCC initiatives are reporting that they are increasingly being asked to serve beyond the scope of their funding sources</li> <li>▶ The Substance Use/Mental Health Workgroup has identified creating recovery supports as a priority yet does not have resources or grassroots engagement to advance the priority</li> </ul>	
<p><b>Structural and Operational changes, including updates in membership:</b> adding Alternate Membership to DCC Bylaws; updating Committee/Workgroup charges; ongoing review of membership and adjusting to turnover/filling gaps in sector representation; filling school nurse gaps in Vaccination Workgroup coverage</p>	

**In-district or multi-district collaborations:** Oral Health Grant; MaineGeneral HRSA application and PICH Sustainability/Communications; Senior Transportation and Neighbors Driving Neighbors pilot; Poverty Action Coalition; UWMM and Drug-Free Communities Grant recipients collaboration on ACEs/resiliency

**Other topics of interest for SCC members:** Steadily building participation in and awareness of the DCC has led to more interest in using the DCC to recruit partners and ‘asks’ to take on work as a district – a good success, but one that highlights our lack of resources to complete some work identified by the DCC.

*Central District*

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12/21/17

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22 M.R.S. §412 (2011).

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# Statewide Coordinating Council for Public Health District Coordinating Council Update



**District: Cumberland**

**Date: 12/21/2017**

**For agendas and copies of minutes, please see district's website at:**  
<http://portlandmaine.gov/218/Cumberland-District-Public-Health-Council>

## ***Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:***

At the September 29<sup>th</sup> full Council meeting in Windham, 20 members and interested parties discussed the convening of working conversation groups to review the progress made under year 1 of the current DPHIP – specifically in the wake of district-level funding cuts. Working groups will be organized according to DPHIP priority as follows; Care of Children Ages 0-6; Oral Health; Substance Misuse; Healthy Weight. We also received two briefings; one from Cumberland Emergency Management Agency Director, Jim Budway and an influenza vaccination update by Cathy Bean of Visiting Nurses Association.

On November 3<sup>rd</sup> an Executive Committee meeting was held to plan for the implementation of DPHIP working conversation group – each of which will have the District Liaison and at least one EC member as co-facilitators. The EC members determined a process for selecting a student representative to serve on the EC. EC members discussed leadership succession, as the current Chair of the DCC, Kristen Dow's term finishes in January. The City of Portland has held the DCC Chair position for a decade and the EC members discussed the process for electing a new Chair. The City of Portland will remain active in the DCC, and as representative of the DCC's fiscal agent, Kristen Dow will continue to participate in the work of the EC as well.

At the November 17<sup>th</sup> full Council meeting in South Portland, 40 members and interested parties attended. There were presentations by; Jo Morrissey and Ellen Freedman of MaineHealth on the MESCHNA process; Zoe Miller of GPCOG presented on Transportation and Community Engagement Network opportunities; Ron Jones of CEMA and Medical Reserve Corps presented information on the most recent storm, including shelter, charging and warming centers, power outages and implications for people with electronic medical devices. Liz Blackwell Moore led the discussion around DPHIP working conversations, and sign-up lists were circulated for these. A new member, Emily Bartlett, a UNE MPH student and Salvation Army staff was voted in. The group was also asked to contact the District Liaison if there is interest in standing for or nominating a new Chair, with a vote taking place electronically before the next full Council meeting.

An Executive Committee meeting is scheduled for December 15<sup>th</sup>. DPHIP priority working conversation meetings will take place between December 15<sup>th</sup> and January 15<sup>th</sup>, with reports and recommendations presented at the next full Council meeting, January 19<sup>th</sup>.

# Statewide Coordinating Council for Public Health District Coordinating Council Update



## *Ongoing or upcoming projects or priority issues:*

The DL continues to provide functional technical support to the DCC and EC. Workgroups for each of the DPHIP priorities are being convened, with broad-based participation from CDPHC members and interested parties. These review and planning meetings will inform the Council's planning and DPHIP implementation in light of the recent funding cuts. The conversations are scheduled to take place December 15<sup>th</sup> to January 15<sup>th</sup>. Two additional standing committees have been created; Sustainability, which will look at ways to obtain funding and resources for Council projects and priorities in the wake of funding cuts; and Advocacy which will encourage broad-based support of public health.

## *Progress with District Public Health Improvement Plan:*

There were a total of 6 sub-recipients of DPHIP funds (including 7 initiatives), implementing the four priority work plans. The District provided oversight on priority work plan implementation and the DC and DL conducted post-project interviews with DPHIP fund recipients to better determine what next steps were indicated for subsequent DPHIP work. Working conversations organized by priority will meet to assess next steps forward. While priorities will remain the same under the DPHIP, strategies under these will be reviewed and revised accordingly.

## *Structural and Operational changes, including updates in membership:*

The Executive Committee continues to approach individuals from specific sectors, organizations and geographic areas to invite them to join the DCC.

At the September 29<sup>th</sup> full Council meeting, two students from USMs MPH program, Ashley and Leah, were voted on as members to the Council. At the November 17<sup>th</sup> full Council meeting, UNE MPH student Emily Bartlett was elected to the Council. The Executive Committee created a selection process for a student representative to the EC and student members of the Council have been informed. (Last year, two students shared the EC student representative slot, but have since graduated)

Zakia Nelson stepped down as member, due to a change in employment which makes it impossible for her to attend the requisite number of meetings.

There are currently 35 voting members of the CDPHC.

In January 2018, the current Council Chair's term will end and a new Chair will be selected by the January 19<sup>th</sup>, 2018 full Council meeting.

# Statewide Coordinating Council for Public Health District Coordinating Council Update



## *In-district or multi-district collaborations:*

The Cumberland DL is participating in the Community Engagement Advisory Group for the Maine SCHNA.

## *Other topics of interest for SCC members:*

N/A

### 22 M.R.S. §412 (2011).

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# Statewide Coordinating Council for Public Health District Coordinating Council Update

Template updated 03/2015 (CTG section removed)

**District: Down East**

**Date: December 21, 2017**

**Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district's website at: <http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district7/index.shtml>**

## **District Public Health Council Meetings**

**September 22 at Mano en Mano Office in Milbridge** with eighteen participants (eleven in person and seven by telephone/Adobe Connect).

The agenda action items:

- Healthy Acadia did a summary of their Prevention Services Work
- Discussed how the district council can move forward on the DPHIP with no funding
- Discussion on Connecting Maine Kids to Coverage initiative
- DPHIP Funded Project Presentation on Substance Use Prevention and Fishing Workplace

**November 17 at Mano en Mano Office in Milbridge** with twelve participants (ten in person and two by telephone/Adobe Connect).

The agenda action items:

- Conducted Public Health Resource/Program Eco-Mapping by DPHIP Priority Area
- Discussed how to develop better SCC Connections and Communication
- Discussed development of Emergency Preparedness Committee

***2017 Meetings: 1/27, 3/24, 5/26, 7/28, 9/22 and 11/17***

## **Executive Committee Meetings**

**October 27 by conference call**

- Discussed DPHIP Priorities: Ongoing Work
- Need to plan for Member Recruitment/Executive Committee Slate
- Establish 2018 District Council Meetings: Site, Timeframe, Agenda

## **Ongoing or upcoming district projects or priority issues:**

- Cancer
  - Increase breast cancer screening rates in Washington County
  - Increase radon awareness and testing across district

Downeast District

1

December 13, 2017

<sup>1</sup>Section 5. 22 MRSA c. 152

**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;
2. Provide a mechanism for district-wide input to the state health plan under Title 2, section 103;
3. Ensure that the goals and strategies of the state health plan are addressed in the district; and
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# Statewide Coordinating Council for Public Health District Coordinating Council Update

- Drug and Alcohol Use
  - Community Prevention Pilot in Fishing Workplace
- Mental Health
  - Increase training opportunities in behavioral health for early childhood providers and school staff

### **Progress with District Public Health Improvement Plan:**

- Conduct Eco-Mapping of current public health work being done in the four priorities.

### **Structural and Operational changes, including updates in membership:**

- Form Emergency Preparedness Committee
  - In 2018, coordinate regional and community site emergency plan exercises
  - In 2018, develop emergency communication networks

### **In-district or multi-district collaborations:**

- Aging Related Committees at community and county level (Thriving in Place, Aging Task Force, Housing and Transportation, and Wraparound Services)
- Drug/Alcohol Use: Downeast Substance Treatment Network and Washington County Substance Use Response Collaborative
- Food Security Networks (both counties)
- National Diabetes Prevention Program Lifestyle Coaching Program
- Stanford Chronic Disease Self-Management and Chronic Pain Self-Management Programs

### **Maine Community Health Needs Assessment (Maine CHNA):**

- Community Engagement Committee members by county have been identified.
- Committee meetings to start in January 2018.

### **Questions/Comments for SCC:**

Key points to share from Downeast Public Health Council Meetings:

- Without state funding and with four priorities, it can be overwhelming for our council to do this. What can the council take on in a short time to keep members engaged while measuring success/outcomes and being able to market the council?
- We have started a resource mapping project (eco-mapping) by inventorying partner work in our district priorities by county and hospital service area.

Downeast District

December 13, 2017

<sup>1</sup>Section 5. 22 MRSA c. 152

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## Statewide Coordinating Council for Public Health - District Coordinating Council Update

*Template updated 03/2015 (CTG Section Removed)*

District: Midcoast

Date: December 21, 2017

*Brief review of decisions and outcomes from Steering Committee and District Coordinating Council (DCC) meetings held since last Statewide Coordinating Council (SCC) meeting. For agendas and copies of minutes, please see District's website at:*

<http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district4/publications.shtml>

Steering Committee Meeting – October 10, 2017 – LincolnHealth Education Center, Damariscotta, ME

- *Reviewed Council meeting-format. Consensus to have educational presentation followed by business*
- *Consensus to have an oral presentation from one Prevention Services Domain sub recipient at each meeting, highlighting work of all District sub recipients in the District for the last quarter. Other Domains District sub recipients to provide written highlights of quarterly work to the Council*
- *Accepted calendar of Steering Committee and Council meeting dates for 2018*
- *Continued review of membership gap analysis and current Council vacancies*

District Coordinating Council (DCC) Meeting – November 14, 2017 at the Knox County Emergency Management Agency (EMA), Rockland, ME

- *Presentation on Food Insecurity by Mary Turner of the Midcoast Hunger Prevention/Food Security Coalition*
- *Breakout sessions conducted by District DPHIP priorities Oversight Committees to identify and report out about ways to further District DPHIP priorities in 2018*
- *Received District Substance Use Disorder (SUD) Prevention Services work update from Don Finnegan, SUD Program Manager, Knox County Community Health Coalition.*
- *Reviewed membership gap analysis in anticipation of Council membership elections at the February 2018, meeting.*

2018 Council Meetings – February 13<sup>th</sup>, April 10<sup>th</sup>, June 12<sup>th</sup>, September 11<sup>th</sup>, November 13<sup>th</sup>

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## Statewide Coordinating Council for Public Health - District Coordinating Council Update

District: Midcoast

Date: December 21, 2017

Ongoing or upcoming projects or priority issues:

- *Identify action items for implementing DPHIP strategies, ranging from items that may be accomplished using existing Council/District resources to items for which funding must be sought*

Progress with District Public Health Improvement Plan:

- *Priority Oversight Committees continue to meet to identify action items for 2018 DPHIP work*

Structural and Operational changes, including updates in membership.

- *Work continues around Council policies and procedures to strengthen Council's governance framework*
- *Leadership and Council members continue review of membership gap analysis in preparation for annual elections*

In-district or multi-district collaborations

- *Representatives of island communities in the Midcoast and Cumberland Districts met to discuss challenges and opportunities in November. The meeting, organized and hosted by Cumberland District Liaison Kristine Jenkins featured Seacoast Mission's Doug Cornman, speaking about the organization's mission and outreach to Maine island populations.*
- *Waldo Community Action Partners (CAP), the MaineCare Transportation Brokerage, and Maine Department of Transportation public transportation provider in the Midcoast District are convening Civic Transportation Work Groups in the District. The Work Groups will focus on the advancement and improvement of public transportation in the Midcoast.*

Other topics of interest, or questions for SCC members: *With Council attendance and participation always a challenge, we are interested in DCC attendance around the State, the makeup of attendees (i.e., sector representation) and the ratio of council members to interested parties, that attend. What best practices have other DCCs learned about, and used, to recruit members and keep them engaged?*

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# Statewide Coordinating Council for Public Health District Coordinating Council Update

**Template updated 03/2012**

<b>District:</b> Penquis District	<b>Date:</b> December 8, 2017
<p>Brief review of decisions and outcomes from Steering Committee and DCC meetings held since last SCC meeting.</p> <p><b>District Public Health Improvement Plan (DPHIP) Implementation:</b>          The steering committee and DCC has been working on an eco-mapping activity that will help identify programming at the local level and map it in the DCC region. The DCC will begin working with an intern who is supported through the City of Bangor, to take finding of the eco-mapping out to the communities to further drill down into specific programming. As there is no funding going directly to the district, the group will focus on sharing the finding of the eco-mapping activity with the broader public health community to infuse new and promising practices in communities that do not have existing programming to address DPHIP priorities. The DCC continues to weave poverty strategies to the other three DPHIP priority areas of substance misuse, behavioral health and obesity.</p> <p><b>Shared Community Health Needs Assessment:</b>          The first time the Community Forums were held two large forums occurred in Penobscot (Brewer- hosted by PCHC, EMHS, and the DCC) and Piscataquis (Dover-Foxcroft-hosted by Mayo, CA Dean and the DCC) Counties. Two smaller sessions were hosted in Lincoln by PVH, the DCC, EMHS, and HAN and then one was held in Millinocket hosted by the DCC and MRH.</p> <p>Nicole Hammar (EMHS) and Jessica Fogg (District Liaison) have shared responsibility for creating the new Community Engagement Planning Committee in the Penquis District. They have already recruited more than ten members who will begin meeting after the new year.</p> <p>First action item will be identifying locations to hold forums in the fall of 2018.</p>	
<p><b>Ongoing or upcoming projects or priority issues:</b></p> <ul style="list-style-type: none"> <li>➤ Hepatitis B Workgroup in Penobscot County- Penobscot County has the highest rate of hepatitis B in the over 40 population; were not vaccinated through childhood vaccine. Partners include: Maine CDC MIP, Field Epidemiologist, District Liaison, City of Bangor, Maine Health Equity Alliance, Acadia Hospital, and VNA. The group is increasing access to vaccine in high-risk population, IV drug users, through clinics at Acadia Hospital. There is planning underway to add a vaccination clinic at the Maine Health Equity Alliance needle exchange program. We will also increase messaging at those locations with educational material.</li> </ul>	
<p><b>Structural and Operational changes, including updates in membership.</b>          none</p> <p><b>New members:</b> Heather Blackwell &amp; Theresa Knowles-PCHC</p>	
<p><b>In-district or multi-district collaborations:</b></p> <ul style="list-style-type: none"> <li>➤ United Way Community Planning</li> <li>➤ EPA Planning Grant-Health People, Healthy Communities</li> <li>➤ Prevention Service Grant-Maine CDC</li> </ul>	



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## Statewide Coordinating Council for Public Health District Coordinating Council Update

- Community Health Leadership Board, Greater Bangor
- Thriving in Place (MeHAF Grant Initiative), Millinocket, Old Town, Orono, Veazie, Dover-Foxcroft,
- Healthy Communities (MeHAF Grant Initiative), Dover-Foxcroft, Bangor

**Other topics of interest for SCC members:**

None



# Statewide Coordinating Council for Public Health District Coordinating Council Update

<b>District:</b> Tribal District	<b>Date:</b> 12/21/17
<p><b>Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district’s website at:</b>  <a href="http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml">http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml</a></p>	
<p><b>Ongoing or upcoming projects or priority issues:</b></p> <ul style="list-style-type: none"> <li>• The Tribal leaders from all five communities are continuing to meet and work together to explore ways to address the substance use epidemic</li> </ul>	
<p><b>Progress with District Public Health Improvement Plan (DPHIP):</b></p> <ul style="list-style-type: none"> <li>• Year One Implementation is complete, and reports have been generated based on the assessments of strengths and gaps in each of the Tribal communities to address substance use, behavioral health, and elder issues.</li> <li>• Funding is being sought to continue implementation for the subsequent years.</li> <li>• Evaluation of how current work fits into the DPHIP is also on going.</li> </ul>	
<p><b>Structural and Operational changes, including updates in membership.</b></p> <ul style="list-style-type: none"> <li>• New members have been added to the Tribal District Coordinating Council               <ul style="list-style-type: none"> <li>✓ Cathy St. John, Tribal Council (Maliseet)</li> <li>✓ Michelle Barrows, Health Director (Maliseet)</li> <li>✓ Candy Henderly, Health Director (Penobscot)</li> <li>✓ Dena Winslow, Tribal Planner (Micmac)</li> </ul> </li> </ul>	
<p><b>In-district or multi-district collaborations:</b></p> <ul style="list-style-type: none"> <li>• District Liaison continues to attend Penquis, Downeast, and Aroostook DCC meetings, including the Penquis Steering Committee</li> <li>• In-District Collaboration:               <ul style="list-style-type: none"> <li>✓ Partnering with the Aroostook Band of Micmacs on Phase Three of their Healthy Communities Grant, a MeHaf Initiative. The Community Health Navigator is now a trained Recovery Coach Academy Trainer. She has also worked with the community to create an expanded resource guide for the Aroostook Band of Micmacs.</li> </ul> </li> </ul>	
<p><b>Other topics of interest for SCC members:</b></p>	

Tribal District

12/21/17

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**Statewide Coordinating Council for Public Health  
District Coordinating Council Update**

**District: Western**

**December 21, 2017**

For agendas and copies of minutes, please see district's website at:  
<http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml>

***Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:***

**October, 2017 DCC Meeting** - Nate Miller from Seniors Plus was nominated and voted in as co-chair.

Presentation: Healthy Living for ME: SeniorsPlus and the Well Care Network

SCC Report: Erin provided SCC report stating that there was discussion at the previous SCC meeting about Legislative Advocacy and DCC were given the "green light" by Sheryl to pursue this. The DCC discussed having a legislative roundtable after the elections in November. This will be a separate meeting from the DCC meeting in December. Erin will reach out to Peggy Rotundo, Ken will research number of legislators in our district and find a location for this meeting. If needed time will be allotted at the December 8, 2017 DCC meeting to finalize plans for this meeting.

There were two grant opportunities discussed the HRSA and the Maine Cancer Foundation Grant. There were a couple of partners (Healthy Androscoggin and Healthy Community Coalition of Greater Franklin County that were already applying for the Maine Cancer Foundation Grant.) Discussion focused on what grants DCC would qualify for and does the group want to apply on behalf of the DCC or pair up with each other to partner? More discussion is needed around how this will work. Jennifer McCormack will research HRSA grant and report back to group.

Ken provided insight about costs spent on actual healthcare services and preventative services for several countries.

**November 10, 2017 DCC Meeting** - Cancelled due to Veteran's Day Holiday.

**December 8, 2017 DCC Meeting**

Presentation: Androscoggin Home Care & Hospice Community Care Team by Michelle Couillard and Angela Richards

Prevention Services Update:

In 2018 Prevention Service updates, will become a regular agenda item and each of the subcontractors and/or vendors will provide the DCC with updates. See attached schedule.

DCC Discussion:

January DCC meeting will be used to determine what priorities the DCC will focus on for the next year. Steering Committee will bring ideas/suggestions to larger group for consideration.

# Statewide Coordinating Council for Public Health District Coordinating Council Update

## *Ongoing or upcoming projects or priority issues:*

DCC decided to plan legislators breakfast for the March DCC meeting.  
Action needed: Ken Albert will be drafting invitation letter to legislators and convening group work on this meeting. If you are interested in working on this, please contact Ken at ken.albert@ahch.org

## *Progress with District Public Health Improvement Plan:*

**DCC will be using meeting in January to identify what work is being done throughout the district to identify partners that the DCC may collaborate with and work on ongoing projects or initiatives. It will also consider grant opportunities that district partners can collaborate with each other or on behalf of the DCC.**

## *Structural and Operational changes, including updates in membership:*

Nate Miller from Seniors Plus was voted in as new co-chair.

## *In-district or multi-district collaborations:*

## *Other topics of interest for SCC members:*

### 22 M.R.S. §412 (2011).

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# Statewide Coordinating Council for Public Health District Coordinating Council Update



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**Statewide Coordinating Council for Public Health  
District Coordinating Council Update**



**District: York District**

**Date: 12/21/2017**

For agendas and copies of minutes, please see district's website at:  
<http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml>

***Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:***

The Executive Committee continues to meet regularly.

The full council meeting on 12/4/2017 focused on finding new strategies for our DPHIP priorities. The meeting was held at the University of New England. It was decided that the council would reformulate priority workgroups. Workgroup chairs were selected for each and will reconvene shortly.

***Ongoing or upcoming projects or priority issues:***

The York District Shared CHNA planning and engagement group will utilize the council structure and some members, as we plan for and undertake activities.

***Progress with District Public Health Improvement Plan:***

**NUTRITION & OBESITY**

Leads: Betsy, Megan, Ted, Adam

STRATEGY: Increase collaboration among agencies and individuals working on issues of nutrition/obesity/physical activity

- 1) Create mailing list of active individuals/agencies (to include Gather, Let's Go, WIC, SNAP-Ed, former PFHFYC, etc)
- 2) Convene working group meetings
- 3) Establish working group's mission, purpose, frequency of meeting, etc

**ORAL HEALTH**

Leads: Jackie, Clay, Adam,

STRATEGY: Implement school health partnership program, connecting UNE Dental Hygiene school with York County Public Schools

# Statewide Coordinating Council for Public Health District Coordinating Council Update

- 1) Explore transportation linkages through Nasson
- 2) Explore funding through Bingham Foundation
- 3) Explore connections with Community Dental
- 4) Explore equipment/chair through WIC

## SUBSTANCE MISUSE

Leads: Adam, Betsy,

STRATEGY: Promote the value of keeping provider agency information up to date in 211

- 1) Get instructions on how to update 2-1-1 agency information from Barb
- 2) Contact providers in YDPHC resource guide
- 3) Contact providers in CPPC resource guide
- 4) Will reestablish a Substance Misuse work group.

## *Structural and Operational changes, including updates in membership:*

## *In-district or multi-district collaborations:*

ME CDC in partnership with the York District Coordinating Council, University of New England, the Medical Reserve Corps, and others to held an Alternate Care Site functional exercise. The exercise on October 20<sup>th</sup> was a great success. In all over 250 people were vaccinated. An after action report is currently being completed.

## *Other topics of interest for SCC members:*

# Statewide Coordinating Council for Public Health District Coordinating Council Update

22 M.R.S. §412 (2011).

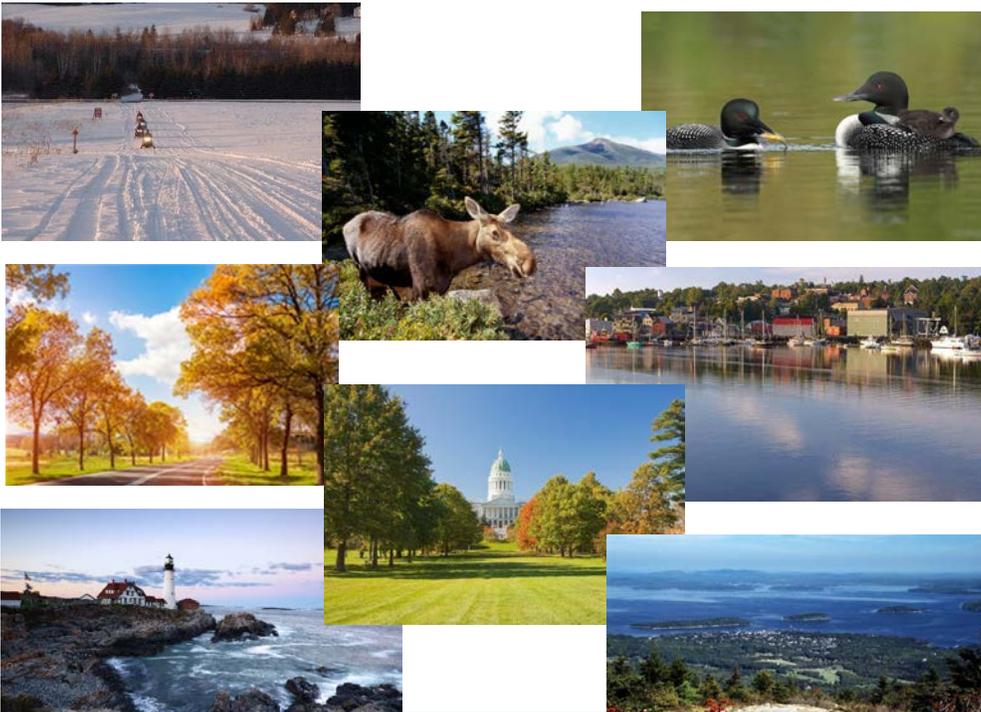
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# State Health Improvement Plan 2018 – 2020



*Maine Center for  
Disease Control and Prevention*

*An Office of the  
Department of Health and Human Services*

*Paul R. LePage, Governor*

*Ricker Hamilton, Commissioner*

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## Public Health in Maine

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.

Maine's Public Health Districts were formed in 2008 and the Tribal Public Health District was established as Maine's ninth Public Health District in 2011. The establishment of the nine Districts was designed to ensure the effectiveness and efficiency of public health services and resources.

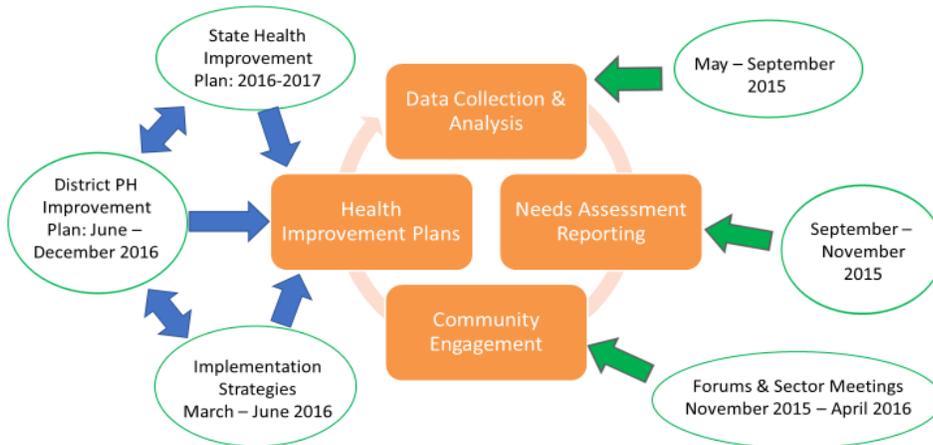
## State Health Improvement Planning Process

The State Health Improvement Plan (SHIP) identifies the public health priorities and creates a multi-year plan of objectives, strategies, and outcomes for state-wide action. It includes the work of the Maine CDC, of other Maine Department of Health and Human Services Offices, of other state agencies where applicable and of non-governmental public health partners who have committed to working towards the selected goals. In addition to state-level priorities and action, each of the nine Public Health Districts in Maine have developed District Public Health Improvement Plans (DPHIPs). These DPHIPs encompass the work of District Coordinating Councils (DCCs) and are an integral part of improving health outcomes for Maine People. Together, the state-level actions under the five priority areas, and the actions outlined in the DPHIPs reflect work at the state, regional and local levels through community-based, multi-sector partnerships to improve the public's health.

In 2015-2016, a collaborative process called the Maine Shared Needs Assessment and Planning Process (SHNAPP), was created by Maine CDC and Maine's four largest health-care systems – Central Maine Healthcare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, MaineHealth – to integrate public health and health care needs assessment and community engagement. This is now known as the Shared Community Health Needs Assessment (Shared CHNA).

The graphic above shows the planning process over the past year portraying a four-phase approach— (1) collection and analysis of quantitative and qualitative data; (2) creating a Shared CHNA for each county, each district and the state; (3) partnering with hospitals to facilitate community input; and (4) creating implementation strategies (hospital community plans) DPHIPs (public health districts) and the SHIP (Maine CDC and state partners).

## Phases of the SHNAPP Process



The data in the Shared CHNA (see [www.maine.gov/dhhs/mecdc/phdata/MainCHNA/](http://www.maine.gov/dhhs/mecdc/phdata/MainCHNA/)) provides a starting point for discussing the health issues that face Maine people. The indicators chosen for the Shared CHNA cover a broad range of topics, and allow for comparisons between counties, districts, the state of Maine, and the United States. Data is also available to look at disparities between different groups of people in Maine, to help make sure that a diverse set of needs are met.

A community engagement process was used to bring the numbers to life. Thirty-four community forums and fifty-two smaller events with more narrow audiences such as business leaders, or healthcare providers were held across the state, with over 3,000 attendees. A selection of the data from the Shared CHNA was presented at each event, and

participants discussed their priorities, assets and resources to address the issues, community needs and barriers, and next steps and solutions. The discussions were captured by facilitators and recorders and compiled for each district. Summaries from the community engagement events provided support for the next planning steps.

Criteria based on the Collective Impact framework was adapted by the State Coordinating Council for Public Health (SCC) to assist in choosing priorities. The SCC then voted on priorities for the state based on the following:

- **Data driven:** Based on the 2016 Maine Shared Community Health Needs Assessment, consider what the data show to be significant issues. This may include areas where Maine has

significantly poorer outcomes than the nation as a whole, where stakeholder identified ongoing challenges or where there are greater impacts or higher prevalence than for other issues.

- Strengthen/Assure Accountability: Consider whether change can be meaningfully measured and whether the public health community can hold itself accountable for changes in outcomes.
- Maximize impact and optimize limited resources: Assess existing work being done in the state and determine how best to enhance and not duplicate these efforts. This criterion also speaks to collaboration across state-level partners and leveraging existing resources.
- Best addressed at the state level: In Maine, many community actions are very local. However, some issues may be better addressed at a state level. Consider whether the State Health Improvement Plan can provide a platform for collaboration of non-typical partners or be an avenue for policy and environmental change that is more difficult to achieve at the local community level.
- Gaps in prevention services: Consider whether a health issue has not been adequately addressed across the state or in some parts of the state. Discussions on root causes, barriers to

services, or gap analyses may be an appropriate way to address this.

- Focus on Prevention: While some issues may be addressed through treatment in the health care system, the State Health Improvement Plan should focus on whether poor outcomes can be prevented. This may include primary prevention (focus on the entire population), secondary prevention (focus on those at highest risk), or tertiary prevention (focus on those with existing conditions). Social determinants of health (social and physical environmental factors impacting health) should also be considered.
- Involve multiple sectors: The State Coordinating Councils includes membership from multiple sectors across the public health continuum. Consider those health issues that can best be addressed by involving multiple sectors.
- Stakeholder Support: Be aware of the priorities around the state and seek common ground across the various stakeholders and agencies, as well as in different sectors. Even when stakeholders may not necessarily agree on specific strategies, there may be agreement on what the priorities are.
- Address health disparities: Consider whether health disparities can be reduced by addressing a specific issue. Populations to consider as having

potential health disparities include racial and ethnic minorities, immigrants, migrant farm workers, lesbian, gay, bisexual, and transgender people, people at low income levels, people with veteran's status, people with lower levels of educational attainment, people with physical

impairments (include deafness, blindness and other physical disabilities), people with mental impairments (including those with developmental disabilities and mental illness), people over sixty years old, and youth.

### **2018-2020 State-level Priorities**

The top public health priority areas chosen by the State Coordinating Council for state-wide health improvement efforts over the next three years include:

- Cancer
- Chronic Diseases
- Obesity
- Mental Health
- Substance Abuse, including Tobacco Use

Based on guidance from federal funders, public health evidence-based practices, and Maine CDC leadership, along with input from stakeholders and partners, Maine CDC programs have developed the agency response to these priorities. In addition, these programs and the State Coordinating Council for Public Health reached out to other state level partners to identify their contributions. For each priority, goals, objectives and strategies have been identified and will guide detailed implementation work plans to meet the outcomes.

## Implementation Plan Design

Once priority areas were identified, objectives were created and strategies selected.

Objectives are based on the SMART model: Specific, Measureable, Achievable, Realistic or Relevant, and Time-limited. SMART objectives are used to provide a structured approach to systematically monitor progress toward a target and to succinctly communicate intended impact and current progress to stakeholders.

Strategies or action steps were identified and designed to meet the outcomes of the objective. They may lead to short term impacts or intermediate outcomes that are clearly linked to the objectives. Not all possible strategies are able to be addressed within the SHIP. The DCC

considered possible strategies and selected one that met criteria such as those used in selecting the priority areas:

- Does it maximize impact and use of limited resources?
- Is it evidence-based?
- Is it population-based?
- Is it feasible at the state level?
- Does the data support the use of the strategy?
- Do Maine CDC or other DHHS offices have resources available to implement the strategy?
- Is there another organization who has resources available that is willing to take the lead?
- Does it fill a gap?

## Priority: Cancer

<i>Description/Rationale/Criteria:</i>			
Cancer is the leading cause of death in Maine. In 2014, 8,703 Maine people were diagnosed with Cancer and 3,209 died of cancer. Many cancers are preventable and screening can prevent some cancers, while improving treatment outcomes for others.			
Goals	Objectives	Strategies	Partners
1. Reduce overall cancer risk in Maine due to selected modifiable risk factors (behaviors)	1.1 Increase by 5 percent the percentage of teens who complete the recommended Human papillomavirus (HPV) vaccination series among teens ages 13-18 by 2020. <i>(Baseline: July 2017: 58% for females, 48% for males)</i>	1.1.A. Provide assessment and feedback information to health care providers by emphasizing HPV vaccinations at regular "AFIX" visits.	<b>Maine CDC Immunization Program</b> Health care providers
		1.1.B. Education health care providers on the importance of keeping patient immunization history information up-to-date.	<b>Maine CDC Immunization Program</b> Health care providers
		1.1.C. Provide quarterly assessment reports to health care providers.	<b>Maine CDC Immunization Program</b> Health care providers
		1.1.D. Dissemination of best practice information to health care provide on HPV vaccinations via distributions of HPV toolkits, information in the MIP provider Reference manual, presentations at regional trainings and outreach to dental offices.	<b>Maine Immunization Coalition</b> Maine CDC Immunization Program Health care providers Dental care providers
2. Provide evidence-based cancer screening and follow-up services for detectable cancers.	2.1 Reduce late-stage diagnoses of breast cancer. <i>(Data source: Maine Cancer Registry, baseline: 40.6 per 100,000 (2012), target: 38 per 100,000)</i>	2.1.A. Increase access to evidence-based breast cancer screening and follow-up services to eligible Maine Women <ul style="list-style-type: none"> <li>o Ages 40-64</li> <li>o Uninsured and Under-insured (excluding MaineCare members, or those with Medicare Part D)</li> <li>o ≤250% of Federal Poverty Level</li> </ul>	<b>Maine Breast and Cervical Cancer Program</b> Health care providers
		2.1.B Distribute information to and support health care providers to adopt USPSTF breast cancer screening recommendations	<b>Maine Breast and Cervical Cancer Program</b> Health care providers
		2.1.C. Outreach to and educate under-served Maine women who have not received a mammogram in the past two years	<b>Maine Breast and Cervical Cancer Program</b> Health care providers

<b>Priority: Cancer (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
2. Provide evidence-based cancer screening and follow-up services for detectable cancers. (continued)	2.1 Reduce late-stage diagnoses of breast cancer. (continued)	2.1.D. Support community-based strategies with health systems and employers that improve self-management behaviors that reduce the risk for developing cancer.	<b>Maine CDC Chronic Disease Program</b> , Maine Breast and Cervical Cancer Program, Health care providers, Employers
	2.2 Reduce late-stage diagnoses of lung cancer to 71.4% (Data source: Maine Cancer Registry baseline: 75.2% (2012))	2.2.A. Conduct annual survey to assess availability of Low-Dose Computed Tomography services in Maine for lung cancer screening to identify gaps in screening services	<b>Maine CDC Chronic Disease Program</b>
		2.2.B. Collaborate with partners to address lung cancer prevention by increasing communities' awareness to radon, how it relates to cancer, and importance of testing	<b>Maine Lung Cancer Coalition</b>
		2.2.C. Support community-based strategies with health systems and employers that improve self-management behaviors that reduce the risk for developing cancer	<b>Maine CDC Chronic Disease Program</b> , Maine Breast and Cervical Cancer Program, Health care providers, Employers
3. Support the cancer survivorship infrastructure and increase awareness and utilization of it.	3.1 Reduce the percentage of cancer survivors who use any tobacco products to 11.9 percent and the percentage who use cigarettes to 9.4 percent by 2020. (Baseline: Tobacco products – 16.9 percent, Cigarette use – 14.4 percent, BRFSS 2012)	3.1.A. Promote the availability of and participation in tobacco treatment training for oncology offices to increase the number of referrals to the Maine Tobacco HelpLine	<b>Tobacco and Substance Use Prevention and Control Program</b> Comprehensive Cancer Program Oncology Offices

## Priority: Chronic Diseases

<i>Description/Rationale/Criteria:</i>			
Chronic disease is a leading cause of death, disability and financial burden in Maine. More than half the deaths among Maine residents were caused by chronic disease in 2015. (US CDC Wonder) Approximately one in eight (12.2%) adults in Maine have asthma, one in ten (10.6%) adults have diabetes (2016 BRFSS) and one in three (34.1%) adults have high blood pressure (2015 BRFSS). Managing these diseases well can reduce the burdens they cause.			
<i>Note: During 2017-2018 the Maine CDC will be responding to new guidance from the US CDC to address chronic disease based on the latest evidence-base practices. The State Health Improvement Plan will be updated to reflect changes to US CDC funding requirements.</i>			
Goals	Objectives	Strategies	Partners
1. Increase self-management of asthma.	1.1 Increase the number of people with asthma and/or their caregivers who are provided with evidence-based asthma self-management education that is funded by Maine CDC* (Data source: Maine CDC Chronic Disease Prevention and Control Program, baseline (2016) 50, target: 650 by 2020) <i>*no data source exists for all people who have had asthma self-management education, therefore, this objective is focused on only that which Maine CDC funds.</i>	1.1.A. Provide training to health care worker staff (Community Health Workers, Community Paramedics, Head Start staff, others as identified) to enable them to provide patient self-management education to patients with poorly controlled asthma	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , United Ambulance
		1.1.B. Provide asthma specific-training to community partners to enable these service providers to provide evidence-based self-management education.	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , Community Health Workers, Community Paramedics, Head Start
2. Increase self-management of pre-diabetes and diabetes.	2.1. Increase the number of people with pre-diabetes who have completed the National Diabetes Prevention Program (NDPP) (Data source: U.S. CDC DPRP State level data report, baseline (August 2017) 1500, target: 3000 by 2020)	2.1.A. Develop and implement policies/ protocols that facilitate referral and navigation to U.S. CDC-recognized National DPP provider sites. (see <a href="http://rethinkdiabetes.org/wp-content/uploads/2014/07/PFH_PAC-1305_Pre-Diabetes-Algorithm_October-2014.pdf">http://rethinkdiabetes.org/wp-content/uploads/2014/07/PFH_PAC-1305_Pre-Diabetes-Algorithm_October-2014.pdf</a> ) See also: <a href="http://www.cdc.gov/diabetes/prevention/pdf/S_TAT_toolkit.pdf">http://www.cdc.gov/diabetes/prevention/pdf/S_TAT_toolkit.pdf</a> )	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , US CDC recognized DPRP\NDPP sites

<b>Priority: Chronic Diseases (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
2. Increase self-management of pre-diabetes and diabetes. (continued)	2.1. Increase the number of people with pre-diabetes who have completed the National Diabetes Prevention Program (NDPP) (continued)	2.1.B Increase reimbursement for provision of the National DPP	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , Office of MaineCare Services
	2.2. Increase the number of people with Diabetes who report that they have taken a formal Diabetes self-management course in the last year (Data source: Maine CDC DSMT records, baseline: 5233 (2016) target: 6,500 (2020))	2.2.A. Increase the number of locations where accredited DSMT sites offer DSMT services.	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , Accredited DSMT sites in Maine
		2.2.B Increase reimbursement for AADE-accredited, ADA-recognized, State-accredited/certified, or Stanford-licensed DSME programs.	<b>US CDC, Center for Chronic Disease Prevention and Health Promotion</b> , Maine CDC Chronic Disease Prevention and Control Program
		2.2.C. Increase participation in Stanford-licensed DSME programs among older Mainers via Area Agencies on Aging.	<b>Maine Office of Aging and Disability Services</b> , Area Agencies on Aging
3. Increase self-management of high blood pressure.	3.1 Increase the proportion of adults who are aware that they have high blood pressure. (Data source: BRFSS, baseline 34.1% (2016), target: 36% (2020))	3.1.A. Implement the Million Hearts initiative – primary care settings follow evidence-based protocols for BP screening and follow-up for patients not at goal for BP.	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , Health Information Exchange(HIE) subscribing healthcare organizations.
	3.2 Increase the number of people who monitor their own blood pressure monitoring with clinical support (Data source: Chronic Disease Measures Dashboard, baseline and target expected April 2018)	3.2.A. Develop and implement policies/ protocols that facilitate the use of the Million Hearts algorithm in care setting supporting patients not at goal for BP control. (see <a href="https://millionhearts.hhs.gov/tools-protocols/protocols.html">https://millionhearts.hhs.gov/tools-protocols/protocols.html</a> )	<b>Maine CDC Chronic Disease Prevention and Control Program</b> , Clinical partners implementing policy and protocol health system interventions

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Priority: Chronic Diseases (continued)			
Goals	Objectives	Strategies	Partners
4. Increase self-management of chronic disease among MaineCare Members	4.1 Increase the number of Maine Care members who are enrolled in Health Homes or Behavioral Health Homes (Data source: Office of MaineCare Services, baseline: target:)	4.1.A. Expand the number of MaineCare Health Homes (HH) and Behavioral Health Homes (BHH)	Office of MaineCare Services
		4.1.B. Support MaineCare Health Homes (HH) and Behavioral Health Homes (BHH) through technical assistance and the Data Focused Learning Collaborative (DFLC) to meet MaineCare Section 91 & 92 requirements.	Office of MaineCare Services Contracted MaineCare HH & BHH practices
	4.2 Increase the number of MaineCare members on anti-psychotic medications who have their Hemoglobin A1c tested at least twice per year (Data source: Office of MaineCare Services, baseline: target:)	4.2.A. Provide education to providers on the intersection between Mental health medications and diabetes	Office of MaineCare Services, Behavioral Health Homes
		4.2.B. Increase monitoring of diabetes in Behavioral health homes.	Office of MaineCare Services, Behavioral Health Homes
	4.3 Increase the number of Maine Care members with Chronic Obstructive Pulmonary Disease (COPD) whose disease is managed via annual spirometry testing (Data source: MaineCare claims, baseline: target 66%)	4.3. Increase spirometry testing in Health Home members with COPD via provider technical assistance and public reporting	Office of MaineCare Services, Health Homes

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## Priority: Obesity

*Description/Rationale/Criteria:*

Like the United States, overweight and obesity are epidemic in Maine. In 2015, 67% of Maine adults were either overweight (37%) or obese (30%) (BRFSS) and 31% of Maine High School youth were either overweight (17%) or obese (14%) (MIYHS). Being overweight or obese puts individuals at risk for many chronic diseases such as diabetes, cardiovascular disease and cancer as well as burdens our health care systems.

*Note: During 2017-2018 the Maine Obesity Council was convened and has been reviewing the US CDC’s 24 recommended strategies to address obesity. In 2018, this Council will make recommendations for additional goals, objectives and strategies. In addition, the Maine CDC will be responding to new guidance from the US CDC to address obesity based on the latest evidence-base practices in the next year. The State Health Improvement Plan will be updated to reflect changes to US CDC funding requirements and the recommendations of the Obesity Council where resources to implement then are identified.*

Goals	Objectives	Strategies	Partners
1. Increase healthy eating	1.1 Increase the proportion of youth who eat five or more servings of fruits and vegetables per day ( <i>Data source: MIYHS, baseline: 15.6% (HS) (2017), target: 16.5% (2019)</i> )	1.1.A. Promote the adoption of food service guidelines/ nutrition standards in schools.	<b>Let’s Go!</b> /Let’s Go Coordinators, Dept. of Education Child Nutrition Services School Administrative Units (SAUs), Maine CDC
		1.1.B. Increase the number of Early Care and Education (ECE) providers that use Child and Adult Care and Feeding Program (CACFP) and/or meet the equivalent standards for providing snacks and meals for children in their service.	<b>Dept. of Education CACFP Program</b> , ECE providers, Physical Activity and Nutrition in ECE Workgroup, Maine Roads, Let’s Go!, Snap-Ed coordinators, University of New England
		1.1.C. Implement policies and practices that create a supportive nutrition environment, including establish standards (including sodium) for all competitive foods; prohibit advertising of unhealthy foods; and promote healthy foods in schools, including those sold and served within school meal programs and other venues.	<b>Let’s Go!</b> /Let’s Go Coordinators, Dept. of Education Child Nutrition Services/Maine CDC, School Administrative Units (SAUs)

<b>Priority: Obesity (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
1. Increase healthy eating (continued)	1.2 Increase the proportion of adults who eat at least one serving of fruits and one serving of vegetables per day. (Data source: BRFSS, baseline: 64.8% (F), 81.7% (V) (2015), target: 66.0% (F), 83.0% (V) (2019))	1.2.A Promote the adoption of food service guidelines/nutrition standards in worksites	<b>Healthy Maine Works Workgroup (Maine CDC), Let's Go!, Snap-Ed/ University of New England</b>
	1.3 Increase access to healthy foods through WIC (Data source: WIC Spirit; baseline: 79.7% (SFY2017) target for 2020: 80%)	1.3.A Promote usage of fruit and vegetable vouchers year-round, and seasonally at farmers markets.	<b>Maine CDC WIC program, WIC community agencies, Maine Federation of Farmers Markets</b>
		1.3.B. Provide education with clients to encourage children trying new fruits and vegetables,	<b>WIC community agencies</b>
		1.3.C. Provide food demonstrations and recipes	<b>WIC community agencies</b>
	1.4 Increase the proportion of adults ages 65 and older who eat at least one serving of fruits and one serving of vegetables per day. (Data source: BRFSS, baseline: 71.5% (F), 80.7% (V) (2015), target: 73.0% (F), 82.0% (V) (2019))	1.4.A. Provide Meals on Wheels meeting dietary standards to eligible Mainers over the age of 60	<b>Office of Aging and Disability Services, Healthy Aging Program, Area agencies on Aging</b>
		1.4.B. Provide meals at senior and other community centers meeting dietary standards to eligible Mainers over the age of 60.	<b>Office of Aging and Disability Services, Healthy Aging Program, Area agencies on Aging</b>
		1.4.C. Provide restaurant vouchers for meals meeting dietary standards to eligible Mainers over the age of 60.	<b>Office of Aging and Disability Services, Healthy Aging Program, Area agencies on Aging</b>
	1.5 Increase the number of screenings for food insecurity from X to Y by 9/30/2018. (Data source: EMHS food service data)	1.5.A. Educate health practices on the value of screenings, protocols and referral resources.	<b>Eastern Maine Health System Providers</b>
		1.5.B. Track the number of screenings provided, the number of providers using the screening tool, and the number of positive screens	<b>Eastern Maine Health System</b>
	1.6 Increase by 3 the number of healthier food options offered in hospitals by 9/30/2018. (Data source: EMHS food service data)	1.6.A Reformulate 3 recipes to improve the nutritional content of food options offered at foodservice venues (cafeteria, vending, catering), U.S. DHHS and CDC's Health and Sustainability Guidelines for Federal Concessions and Vending Operations Guidelines.	<b>Eastern Maine Health System</b>

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<b>Priority: Obesity (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
2. Increase breastfeeding	2.1 Increase the average maternity practices in infant nutrition and care (mPINC) scores for birthing hospitals ( <i>Data source US CDC mPINC state report baseline: 84 out of 100 (2015) target: 86 in 2019.</i> )	2.1.A Implement practices supportive of breastfeeding in prenatal practices and birthing facilities via education, consultation, communication, technical support and quality improvement collaboratives	<b>State Breastfeeding Specialist</b> WIC Breastfeeding Coordinator IBCLCS/CLCS (international board of certified lactation consultants/ certified lactation consultants) Birthing facilities in Maine, Obstetric and pediatric care providers
	2.2 Increase breastfeeding initiation among WIC clients enrolled during the pregnancy ( <i>Data source: WIC Spirit, baseline: 78% (SFY2017), target: 81% (2020)</i> )	2.2.A Provide counseling and consultation to new mothers by certified lactation specialists and peer mothers.	<b>Maine CDC WIC program, WIC community agencies</b>
2.2.B. Loan high quality breast pumps to WIC mothers who are breast-feeding		<b>Maine CDC WIC program, WIC community agencies</b>	
3. Increase physical activity	3.1 Increase the proportion of youth who are physically active for at least 60 minutes during 7 out of 7 days. ( <i>Data source: MIYHS, baseline: 20.3% (HS) (2017), target: 21.5% (2019)</i> )	3.1.A Promote the adoption of multi-component physical education policies for schools.	<b>Maine Dept. of Education, Maine CDC Let's Go!, SAUs</b>
		3.1.B Promote the adoption of recess policies for schools.	<b>Maine Dept. of Education, Maine CDC Let's Go!, SAUs</b>
		3.1.C Develop and implement, comprehensive physical activity programming before, during, and after school, such as recess, classroom activity breaks, walk/bicycle to school, physical activity clubs).	<b>Maine Dept. of Education, Maine CDC Let's Go!, SAUs</b>
		3.1.D Promote the adoption of physical activity (PA) in early care and education (ECEs).	<b>Maine CDC, ECE Providers, PAN in ECE Workgroup, Maine Roads, Let's Go!</b>
		3.2.C. Increase the number of municipalities that have recognized Active Community Environment Teams (ACET)	Bicycle Coalition of Maine, Municipalities, Dept. of Agriculture, Conservation and Forestry, Maine CDC

<b>Priority: Obesity (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
3. Increase physical activity <i>(continued)</i>	3.2 Increase the proportion of adults who meet recommended levels of aerobic physical activity. <i>(Data source: BRFSS, baseline: 53.9% (2015) target: 55% (2019))</i>	3.2.A Promote the adoption of physical activity (PA) in worksites.	<b>Healthy Maine Works Workgroup (Maine CDC)</b>
		3.2.B. Design streets and communities for physical activity.	Maine Dept. of Transportation Active Community Environments State Work group (ACEW), Municipal planners, Regional Planning Associations
		3.2.C. Increase the number of municipalities that have recognized Active Community Environment Teams (ACET)	Bicycle Coalition of Maine Municipalities, Dept. of Agriculture, Conservation and Forestry, Maine CDC

<b>Priority: Obesity (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
3. Increase physical activity <i>(continued)</i>	3.2 Increase the proportion of adults who meet recommended levels of aerobic physical activity. <i>(continued)</i>	3.2.D. Increase the number of municipality planners and Regional Planning Offices that utilize and promote existing recreational opportunities.	Municipalities Regional Planning Offices ACEW
	3.3 Increase the proportion of adults over the age of 65 who meet recommended levels of aerobic physical activity. <i>(Data source: BRFSS, baseline: 55.8% (2015) target: 58% (2019))</i>	3.3.A Provide exercise and physical activities at senior and community centers.	<b>Office of Aging and Disability Services, Healthy Aging Program, Area agencies on Aging</b>
		3.3.B. Provide evidence-based falls prevention classes at community and senior centers	<b>Office of Aging and Disability Services, Healthy Aging Program, Area agencies on Aging</b>

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## Priority: Mental Health

Rationale:			
Xx % of Maine adults have 14 or more days in a month in which their mental health is poor. 24% of Maine adults have been diagnosed with depression in their lifetime, and xx% have been diagnosed with anxiety. (2015 BRFS) Maine DHHS spends \$XX on mental health services for qualified individual per year. xx people die by suicide every year.			
Goals	Objectives	Strategies	Partners
1. Improve timely access to care	1.1. Maintain waitlists to functional zero ( <i>Data Source: SAMHS, baseline: Section 17: 0%; other services: baseline to be determined</i> )	1.1.A. Meet with all clients face-to-face within seven days of initial contact	<b>Office of Substance Abuse and Mental Health Services,</b> community agencies
		1.1.B. Ensure contract compliance via internal processes and adequate staff ratios.	
		1.1.C. Ensure Prior Authorizations for treatments are reviewed and approved as appropriate timely	
		1.1.D. Reallocate funding in contracts as needed to address unmet needs and excess capacity	
		1.1.E. Increase cross-agency referrals when caseloads exceed 1:40 ratio	
2. Reduce barriers to employment	2.1. Increase employment among clients eligible for Section 17 Mental Health to greater than 20% ( <i>Data Source: SAHMS/OFI; baseline: 12%</i> )	2.1.A. Administer “Need for Change” Assessment as part of Individual Service Plans	<b>Office of Substance Abuse and Mental Health Services,</b> community agencies
		2.1.B. Assist in finding appropriate employment opportunities, including volunteering.	
		2.1.C. Complete career profiles for all Assertive Community Treatment clients	
3. Increase stable and appropriate housing	3.1. Increase appropriate housing placements when clients are discharged from hospitals and residential treatment programs ( <i>Data source: SAMHS assessment tools, Baseline and target to be determined</i> )	3.1.A. Coordinate efforts between providers, OADS, and Complex Care Unit	<b>Office of Substance Abuse and Mental Health Services,</b> Office of Adult and Disability Services, community behavioral health providers, hospitals
		3.1.B. Analyze assessments for appropriate treatment and housing placements	

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<b>Priority: Mental Health</b> <i>(continued)</i>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
4. Reduce suicide deaths	4.1 Reduce suicide deaths in adults ages 25 and over ( <i>Data source: Maine Vital Records, Baseline: 22.24/100,000 (2015) and target for 2020: 21.14/100,000</i> )	4.1. Expand suicide-safer care practices within Maine's Behavioral Health Homes	<b>Maine CDC,</b> Behavioral Health Homes
		4.1.B. Implement the Towards Zero Suicide model within three community mental health agencies	<b>Maine CDC,</b> Sweetser, Aroostook Mental Health Centers, Crisis and Counseling Services
		4.1.C. Increase community follow up and connection to care for individuals following a suicide attempt or suicidal crisis thorough better collaboration among hospitals, emergency rooms, and inpatient mental health programs and local crisis service providers.	<b>Maine CDC,</b> hospitals, crisis service programs
	4.2 Reduce suicide deaths in adults ages 10-24 ( <i>Data source: Maine Vital Records, Baseline: 9.04/100,000 (2015) and target for 2020: 8.59/100,000</i> )	Provide training to educators, medical and mental health providers, and youth serving agencies on strategies for assessing, referring, and treating youth at risk of suicide	<b>Maine CDC, NAMI</b> Maine, Schools
		Engage to increase support and referral for students at risk of suicide or experiencing unmet mental health needs	<b>Maine CDC, NAMI</b> Maine, universities, community colleges, and job training programs ...

## Priority: Substance Use, including Tobacco

### Rationale:

Tobacco remains the leading underlying cause of death in Maine, while Alcohol Use and illicit drug use are the third and tenth underlying causes. Substance Abuse in general has significant health and social costs. Consequences resulting from addiction includes but is not limited to, untimely death, lower productivity, child abuse and neglect, other crime, physical and mental illness, and injuries. In 2015, 472 people in Maine died from drug and alcohol-related causes, and 2,400 died from smoking-related causes. Nearly one in three of all motor vehicle crashes resulting in fatalities involved alcohol and/or drugs. In 2016, there were a total of 376 overdose deaths due to substance use in Maine, representing a 38 percent increase since 2015. Four out of five of these deaths involved an opiate or opioid.

Decreasing substance use and its consequences is most effectively accomplished through a combination of prevention, intervention, and treatment services. Through multiple strategies across multiple domains (such as individual, family, community, and society) the prevention of initiation of use is critical while also providing treatment and recovery services for those who live with an addiction. Engagement of a partners across many sectors including schools, public safety, and businesses is a key part of this multilateral approach. Strategies listed below may show under one objective, but often affect multiple objectives, and work best in combination with other strategies. Specific strategies may vary in different communities, depending on the partners engaged and that data regarding the most critical needs.

Goals	Objectives	Strategies	Partners
1. Reduce non-medical use of prescription drugs	1.1 Reduce past 30-day prescription drug misuse among Maine's 7th-8th graders from 1.5% in 2017 to xx% in 2019 (MIYHS) and among Maine's HS students from 5.9% in 2015 to xx% in 2019 (MIYHS)	1.1.A. Education for various audiences including parents, youth, and youth serving professionals on the dangers of prescription drug misuse, sharing medications, safe storage and disposal of medication, parental monitoring and modeling for youth substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		1.1.B. Information dissemination through brochures, posters, flyers, social media, TV and radio on safe storage and disposal, the risks and dangers of prescription drug misuse.	Rinck Advertising AdCare Educational Institute, Schools <b>Maine CDC</b> , University of New England & 22 Community sub-recipients.
		1.1.C. Identify high risk youth and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC</b> , University of New England & 22 Community sub-recipients.

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<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
1. Reduce non-medical use of prescription drugs (continued)	1.2 Reduce past 30-day prescription drug misuse among Mainers ages 18-25 from 7.1% in 2014 to 6.1% in 2019 (BRFSS)	1.2.A. Education for various audiences including parents, young adults, and young adult serving professionals on the dangers of prescription drug misuse, sharing medications, safe storage and disposal of medication, parental monitoring and modeling for young adult substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients, Rinck Advertising, AdCare Educational Institute, Schools, Eastern Maine Health Systems
		1.1.B. Information dissemination through brochures, posters, flyers, social media, TV and radio on safe storage and disposal, the risks and dangers of prescription drug misuse.	<b>Maine CDC</b> , University of New England & 22 Community sub-recipients.
		1.1.C. Identify high risk young adults and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC</b> , University of New England & 22 Community sub-recipients.
2. Reduce the number of opiates prescribed per capita in Maine	2.1 Reduce the annual number of narcotic prescriptions dispensed per capita from 920 per 1,000 people in 2015 to 740 per 1000 people in 2020	2.1.A Train providers in safe prescribing practices	<b>Maine CDC, Office of Substance Abuse and Mental Health Services, Office of Substance Abuse and Mental Health Services</b> , Maine Medical Association, AdCare Educational Institute, University of New England & 22 Community sub-recipients, Eastern Maine Health System.
		2.1.B Promote the use of the prescription monitoring program among providers to reduce access and availability of opiates and prevent patients getting prescriptions from multiple doctors	
		2.1.C. Encourage pain management alternatives to prescriptions for MaineCare members	<b>Office of MaineCare Services</b> , Change Health Health care providers
	2.1.D. Encourage use of non-opioid prescriptions for Maine Care members	<b>Office of MaineCare Services</b> , Change Health Health care providers	
	2.2 Compliance with limits of prescription doses (100 Morphine Milligram Equivalent (baseline: 93%; target 100%))	3.3.A. Identify high prescribers and address via academic detailing and/or non-compliance process	<b>Office of Substance Abuse and Mental Health Services</b>

<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
3. Reduce the number of opiate-related overdose deaths in Maine	3.1 Reduce the number of opiate related overdose deaths in Maine from 269 in 2014 to 222 in 2019	3.1.A Develop and implement a statewide media campaign on safe storage and disposal of medication, the dangers of sharing medication and the dangers associated with opiate addiction.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program, Office of Substance Abuse and Mental Health Services</b> Rinck Advertising
4. Increase access to effective substance abuse treatment services	4.1 Reduce waitlists for substance abuse services	4.1.A. Map and analyze Medicine Assist Treatment (MAT) waitlist data	<b>Office of Substance Abuse and Mental Health Services,</b>
		4.1.B Use hot-spotting and syndromic data to identify and critical needs	<b>Office of Substance Abuse and Mental Health Services,</b> Maine CDC, Infectious Disease Epidemiology Program
		4.1.C. Include law enforcement and other stakeholders in data analytics	<b>Office of Substance Abuse and Mental Health Services,</b> Department of Public Safety
		4.1.D. Align OTP regulations with federal regulations	<b>Office of Substance Abuse and Mental Health Services</b>
		4.1.E. Address other barriers to services by developing additional resources where necessary	<b>Office of Substance Abuse and Mental Health Services</b>
		4.1.F. Maintain substance abuse medicine assisted treatment (MAT) locator via Maine 211	<b>Office of Substance Abuse and Mental Health Services</b>
		4.1.G. Provide SBIRT, warm hand-offs, 3-day and 30-day check-ins via 211	<b>Office of Substance Abuse and Mental Health Services</b>
		4.1.H. Increase the number of qualified Medication Assisted Treatment (MAT) prescribers.	<b>Eastern Maine Health Systems</b>
	4.2. Increase the number of Opioid Health Homes where patients with substance abuse disorders received integrated health care and substance abuse treatment	4.2.A. Create Opioid Health Homes that ensure best practices of Medicated assisted treatment are integrated with patients' other health needs.	<b>Office of Maine Care Services</b>

<b>Priority: Substance Use, including Tobacco</b> <i>(continued)</i>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
	4.3 By 9/30/2018, increase the number of qualified Medication Assisted Treatment (MAT) prescribers from X to Y.	4.3.A Encourage providers to become Medication Assisted Treatment (MAT) prescribers.	<b>Eastern Maine Health Systems</b>

<b>Priority: Substance Use, including Tobacco</b> <i>(continued)</i>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
5. Increase employment among Mainers who have substance abuse disorders	5.1. Increase employment among clients under Sections 65 and 97 to greater than 50% 48% baseline	5.1.A. Administer “Need for Change” Assessment as part of Individual Treatment Plans	<b>Office of Substance Abuse and Mental Health Services</b> , community agencies
6. Increase stable housing among Mainers who have substance abuse disorders	6.1 Increase housing among clients under Sections 65 and 97 in the community Section 65 and 97 are housed (SAMHS, Baseline TBD)	6.1.A Provide housing resources via Individual Treatment Plans	<b>Office of Substance Abuse and Mental Health Services</b> , community agencies
7. Reduce the number of substance-exposed infants due to illicit substances	7.1 Reduce the number of substance-exposed infants due to illicit substances <i>(Data source: DHHS, baseline and target TBD)</i>	7.1.A Improve data collection to distinction between women in MAT versus illicit use	<b>Maine DHHS, hospitals</b>
		7.1.B. Promote the use of the evidence-based Snuggle ME guidelines to increase screening of pregnant women for substance abuse	<b>Maine CDC Maternal and Child Health Program</b> , Maine CDC Substance and Tobacco Use Prevention and Control Program
		7.1.C. Provide TA to Behavioral Health Homes to implement Snuggle ME guidelines	<b>Maine CDC Maternal and Child Health Program</b> , Office of Maine Care Services, Maine CDC Substance and Tobacco Use Prevention and Control Program
		7.1.D. Promote substance abuse treatment for women who are pregnant or may become pregnant via targeted social media messaging and sponsored search results	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising

<b>Priority: Substance Use, including Tobacco</b> <i>(continued)</i>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
8. Reduce underage drinking among persons aged 12 to 20	8.1. Reduce the past 30-day alcohol use among 7 <sup>th</sup> & 8 <sup>th</sup> graders from 3.7% in 2017 to 3.3% in 2019 (MIYHS) and among HS students from 22.5% in 2015 to 20.8% in 2019 (MIYHS)	8.1.A Education for various audiences including parents, youth, and youth serving professionals on the dangers of underage drinking and binge drinking, parental monitoring and modeling for youth substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.  Rinck Advertising AdCare Educational Institute, Schools
		8.1.B Information dissemination through brochures, posters, flyers, social media on underage drinking, binge drinking, the risks and dangers of alcohol use, and the importance of parental modeling/monitoring.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		8.1.C. Identify high risk youth and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		8.1.D. Implementation of policies including local ordinances, pricing and promotion of alcohol, underage drinking law enforcement details.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		8.1.E. Implementation of mass reach health communications on underage drinking.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising
	8.2. Reduce the past 30-day alcohol use among Mainers ages 18-20 from 41.6% in 2014 to 39.5% in 2020 (BRFSS)	8.1.A Education for various audiences including parents, young adults, and young adult serving professionals on the dangers of underage drinking and binge drinking, parental monitoring and modeling for youth substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.  Rinck Advertising AdCare Educational Institute, Schools
		8.1.B Information dissemination through brochures, posters, flyers, social media on underage drinking, binge drinking, the risks and dangers of alcohol use, and the importance of parental modeling/monitoring.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.

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<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
8. Reduce underage drinking among persons aged 12 to 20 (continued)	8.2. Reduce the past 30-day alcohol use among Mainers ages 18-20 (continued)	8.1.C. Identify high risk young adults and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		8.1.D. Implementation of policies including local ordinances, responsible beverage server training, pricing and promotion of alcohol, underage drinking law enforcement details.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		8.1.E. Implementation of mass reach health communications to raise awareness about underage and binge drinking.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising
9. Reduce marijuana use among persons aged 12 to 20.	9.1. Reduce the past 30-day use of marijuana among 7 <sup>th</sup> & 8 <sup>th</sup> graders from 3.6% in 2015 to 3.x% in 2019 (MIYHS) and among HS students from 19.3% in 2015 to 18.6% in 2019 (MIYHS)	9.1.A Education for various audiences including parents, youth, and youth serving professionals on the dangers of marijuana use, responsible adult use, parental monitoring and modeling for youth substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients. Rinck Advertising
		9.1.B Information dissemination through brochures, posters, flyers, social media on youth marijuana use, the risks and dangers of youth use, responsible adult use, safe storage and disposal, and the importance of parental modeling and monitoring.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.C Environmental. Implementation of policies and local ordinances to reduce access and availability of marijuana for youth and to increase the perception of harm of use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.D Identify high risk youth and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.F Implementation of mass reach health communications to raise awareness about the risks and dangers of marijuana use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising

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<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
9. Reduce marijuana use among persons aged 12 to 20.	9.2. Reduce the past 30-day use of marijuana among Mainers ages 18-25 from 29.7% in 2014 to 28.2% in 2019 (NSDUH)	9.1.A Education for various audiences including parents, young adults, and young adult serving professionals on the dangers of marijuana use, responsible adult use, parental monitoring and modeling for youth substance use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients. Rinck Advertising
		9.1.B Information dissemination through brochures, posters, flyers, social media on young adult marijuana use, the risks and dangers of young adult use, responsible adult use, safe storage and disposal, and the importance of parental modeling and monitoring.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.C Environmental. Implementation of policies and local ordinances to reduce access and availability of marijuana for young adults and to increase the perception of harm of use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.D Identify high risk young adults and provide interventions using the Prime for Life curriculum including the Universal Program and Student Intervention and Reintegration Program (SIRP)	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> University of New England & 22 Community sub-recipients.
		9.1.F Implementation of mass reach health communications to raise awareness about the risks and dangers of marijuana use.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising
10. Prevent initiation of tobacco use.	10.1. Reduce past 30-day tobacco use among 7 <sup>th</sup> & 8 <sup>th</sup> graders from 2.5% (2017) to xx% in 2019 and among high school students from 13.9% (2017) to xx% by 2019. (MIYHS)	10.1.A. Increase the number of tobacco retail stores that implement evidence-based strategies to decrease youth access to tobacco from 854 in FFY17 to 860 in FFY18 (baseline 854; increase of 6 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub- recipients
		10.1.B. Increase the number of policies (i.e. school and recreational) that reinforce non-smoking as a social norm among youth from 104 in FFY17 to 124 in FFY18 (baseline 104; increase of 20 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub- recipients

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<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
10. Prevent initiation of tobacco use. (continued)	10.1. Reduce past 30-day tobacco use among high school students (continued)	10.1.C. Increase the number of community-level policy and environmental changes initiated by youth groups from 5 in FFY17 to 10 in FFY2018 (baseline 5; increase of 5 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients
		10.1.D. Increase the number of tailored campaigns targeting youth with tobacco-related health disparities from 0 in FFY17 to 2 in FFY18 (baseline 0; increase of 2 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising
		10.1.E. Increase public and retailer awareness of the new Tobacco 21 law in Maine through information dissemination and educational sessions as well as the dissemination of tools and resources such as calendars, window clings, and the like to assist retailers with carding youth and young adults for tobacco sales.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients Rinck Advertising
11. Eliminate nonsmokers' exposure to secondhand smoke	11.1. Reduce exposure to secondhand smoke in the home environment among 7 <sup>th</sup> and 8 <sup>th</sup> graders from 22.8% (2017) to xx% in 2019 and among high school students from 31.1% (2017) to 25% by 2019.	11.1.A. Increase the number of Maine families that have pledged to keep their home smoke-free via EPA's smoke-free pledge program from 5,071 in FFY17 to 6,071 in FFY18 (baseline: 5,071 FY17; increase 1000 for the year ).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients
		11.1.B. Increase the number of public settings (hospitals, colleges, and behavioral health organizations) that maintain a tobacco-free policy from 57 in FFY17 to 67 in FFY18 (baseline 57; increase of 10 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients
		11.1.C. Raise awareness via signage and support materials of the current Maine state smoke-free laws for workplaces, outdoor dining establishments, state parks, beaches and vehicles.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients

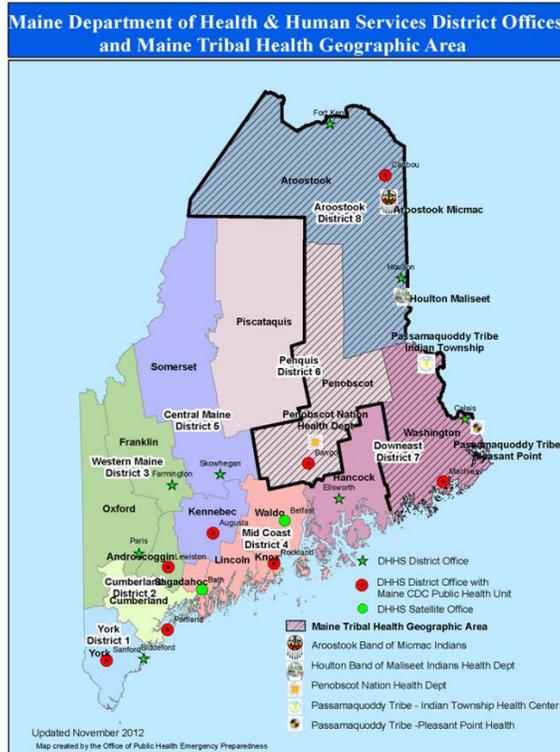
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<b>Priority: Substance Use, including Tobacco (continued)</b>			
<b>Goals</b>	<b>Objectives</b>	<b>Strategies</b>	<b>Partners</b>
11. Eliminate nonsmokers' exposure to secondhand smoke <i>(continued)</i>	11.1. Reduce youth exposure to secondhand smoke in the home environment <i>(continued)</i>	11.1.C. Disseminate materials that create awareness and provide educational sessions highlighting the link between secondhand smoke exposure and certain types of cancer that can affect youth and adults.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence and community sub-recipients
		11.1.D. Collaborate with chronic disease programs within the Division regarding the linkages between chronic disease and SHS for both youth and adults.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b>
12. Promote quitting smoking	12.1. Reduce past 30-day smoking among adults from 19.3% to 15.3% by 2020.	12.1.A. Maintain the existence and capabilities of the Maine Tobacco Helpline (MTHL).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence
		12.1.B. Increase the number of tailored campaigns for the Maine Tobacco Helpline targeting the priority populations (MaineCare beneficiaries, pregnant women, Maine State employees) from 1 in FFY17 to 3 in FFY18 (baseline 1; increase of 2 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> Rinck Advertising
		12.1.C. Increase the number of individuals trained on evidence-based tobacco assessment and treatment methods from 620 in FFY17 to 740 in FFY18 (baseline 620; increase of 120 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence
		12.1.D. Increase the number of tailored treatment approaches for tribal and LGBTQ youth from 0 in FFY17 to 2 in FFY18 (baseline 0; increase of 2 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence
		12.1.E. Increase the number of health providers initiated referrals for tobacco users to the Maine Tobacco Helpline from 2,350 in FFY17 to 2,435 in FFY18 (baseline 2,350; increase of 85 for the year).	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b> MaineHealth-Center for Tobacco Independence
		12.1.F. Provide oversight and maintenance of the tobacco portion of the Pharmacy Benefit Manager contract for the distribution of Nicotine Replacement Therapy.	<b>Maine CDC Tobacco and Substance Use Prevention and Control Program</b>

## Appendices

### Maine's Public Health Districts



For more information on Maine's Public Health Districts, please visit the Maine CDC website at <http://www.maine.gov/dhhs/mecdc/> and choose *District Public Health* from the menu.

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## State Coordinating Council for Public Health

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Placeholder: Description of SCC including role in developing the SHIP

Council Members as of 2018		

# State Health Improvement Plan

## Current Draft

## Next Steps

## December 20, 2017



*Paul R. LePage, Governor*

*Maine Center for  
Disease Control and Prevention*

*An Office of the  
Department of Health and Human Services*

*Ricker Hamilton, Commissioner*

# So far...

- Priorities selected:
  - Obesity vs. Healthy Weight
- Objectives drafted
  - Currently based on Maine DHHS strategies and resources
- Still seeking more input from non-DHHS partners

# Next:

- Confirmation of partner activities
  - Limited thus far,
    - » **Are there more to include?**
  - Partner commitments confirmed for:
    - EMHS
  - Partner commitments not fully confirmed for:
    - University of Maine System Wellness Program
    - HEAL
    - Caring Connections
    - NAMI Maine

# Next:

- Approval from SCC:
  - Today?
  - Via e-mail?
- Approvals from DHHS
- Implementation starting in January 2018

# Preventive Health and Health Services Block Grant Update



*Paul R. LePage, Governor*

*Maine Center for  
Disease Control and Prevention*

*An Office of the  
Department of Health and Human Services*

*Ricker Hamilton, Commissioner*

# F2016 project period

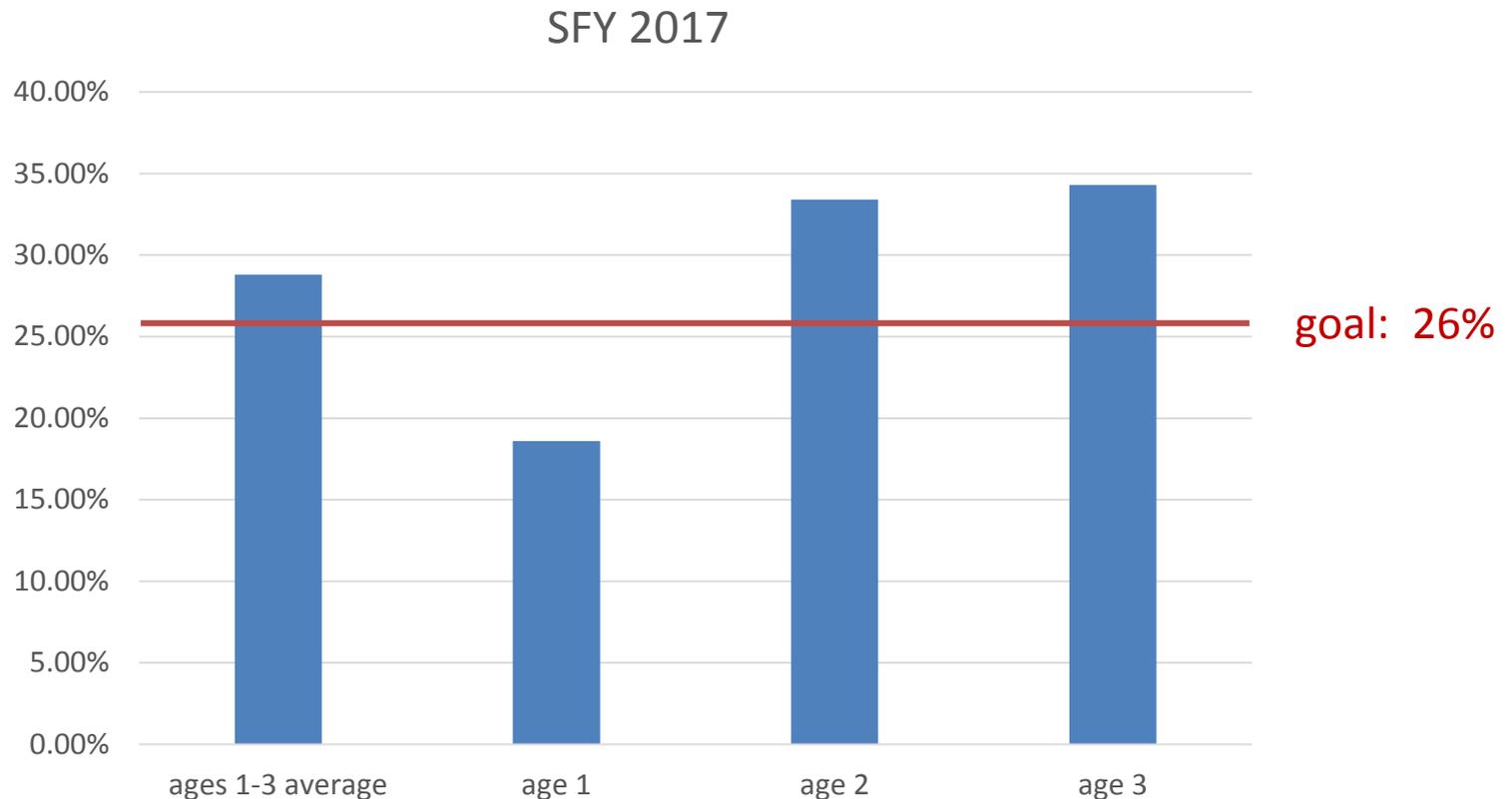
## – final report due Dec 29

- Ended September 30, 2017
- Some completed activities:
  - **Lead module in ImmPact:** Will go live with the new version of ImmPact (est. April)
  - **Sexual Assault Prevention** work with underserved populations:
    - Human trafficking network and training
    - Services for LGBTQ victims (increased the proportion of LGBTQ clients from 1% to **7%**)
    - Also worked with correctional facilities and on services for older Mainers

# F2016 project period

– final report due Dec 29

- Developmental Screening rates continue to exceed goals set for this project.



# F2016 project period

- final report due Dec 29

- Continuing work (reporting not complete):
  - Sexual Assault Prevention (school-based)
  - Epidemiology
  - Prenatal Substance Exposure: Social Media

# Accreditation activities

- First annual report to PHAB was accepted.
  - Successes included:
    - Advancing our Performance Management System.
    - Increased number of QI projects completed.
  - Opportunities for improvement included:
    - Conducting continuous evaluation of the performance management system.
    - Strengthening QI activities.

# Accreditation activities

- Work on a new Workforce development plan has begun
- Planning for the 2019 Shared Community Health Needs Assessment is well underway
  - Initial data analyses in Summer 2018
  - Community engagement Sept. 2018 – March 2019
  - Data updates and final reports released March – June 2019
- SHIP
  - Report for last SHIP has been drafted and is being reviewed
  - New timeline to complete the next SHIP: December 2018

# F2017 – Spending began October 1, 2017

Community Based Prevention	39%
Epidemiology	24%
Prenatal Substance Use	5%
Accreditation	29%
Sexual Assault Prevention	2%
Administration	2%

# SCC Reporting



*Paul R. LePage, Governor*

*Maine Center for  
Disease Control and Prevention*

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Department of Health and Human Services*

*Ricker Hamilton, Commissioner*

# SCC reporting

- Health Report Card
  - Usually submitted in June
  - Charge includes to report on the health status of Maine people by District
  - Plan to use Shared CHNA key indicators for 2018

# SCC reporting

- Report to HHS Committee
  - Usually submitted in December.
  - Charge includes to report on Accreditation, State and district public health services
  - Draft distributed.
  - Discussion?

# SCC reporting

- CEC Administrative Report;
- Report to Defunct Commission

# Questions?

Nancy Birkhimer,  
Accreditation and Performance Improvement  
Nancy.birkhimer@maine.gov



*Paul R. LePage, Governor*

*Ricker Hamilton, Commissioner*

# SHIP Implementation Progress

Year 3

June 2016 – July 2017



*Paul R. LePage, Governor*

*Maine Center for  
Disease Control and Prevention*

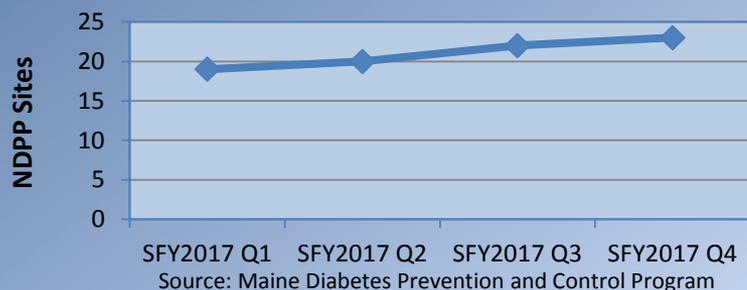
*An Office of the  
Department of Health and Human Services*

*Ricker Hamilton, Commissioner*

# Diabetes

## National Diabetes Prevention Program

The number of sites has increased each quarter, allowing more access for prevention behaviors in persons with pre-diabetes.

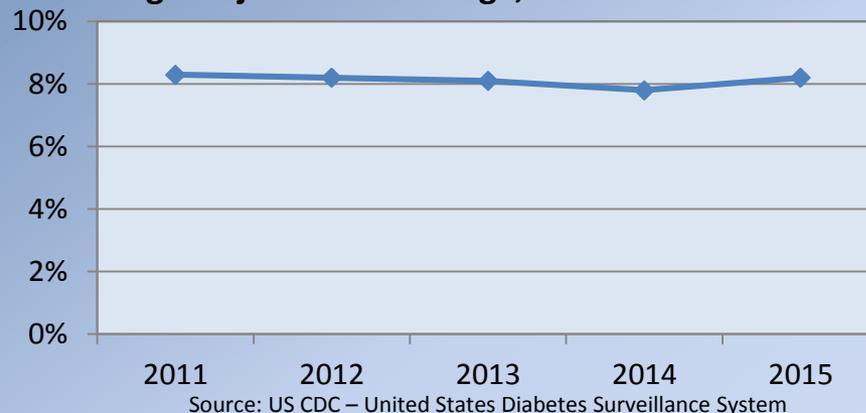


## Diabetes Self-Management Training Program

The number of sites delivering nationally accredited DSMT programming remained consistent for Year 3. While the strategy to increase the number of sites was not realized, there was also not a decrease in sites.

The availability of formal training is important in order to promote the knowledge, skills, attitudes and behaviors needed to achieve/maintain diabetes control, prevent/manage complications and live well with diabetes.

## Age-Adjusted Percentage, Adults with Diabetes



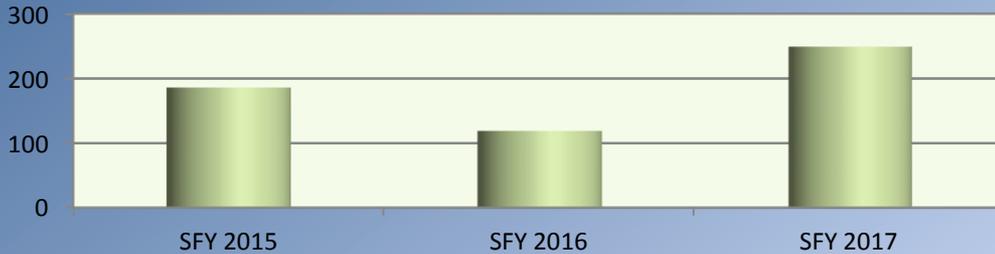
### Not implemented...

More work is needed to increase consumer awareness of pre-diabetes, promote the use of the Pre-Diabetes Risk Quiz, and access to/participation in the NDPP through member communication.



# Immunizations

SFY 2017 had 249 AFIX visits, an increase over past years



Source: Maine Immunization Program

## AFIX Visits

AFIX visits assist and support healthcare personnel by assessing HPV vaccination rates and identifying opportunities for improving vaccine delivery practices. AFIX is made up of four parts: Assessment, Feedback, Incentives and eXchange.

266

Providers received  
assessment reports each  
quarter

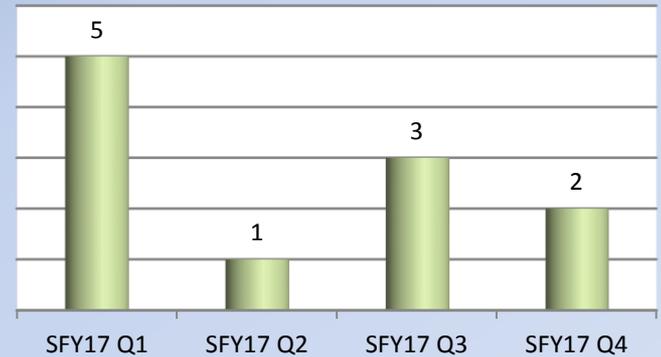
## Childhood and Adolescent Routine Immunization Schedule

The percentage of children assessed who are up-to-date on their routine immunizations increased slightly over the last 4 quarters.

## Vaccines for Children Program (VFC)

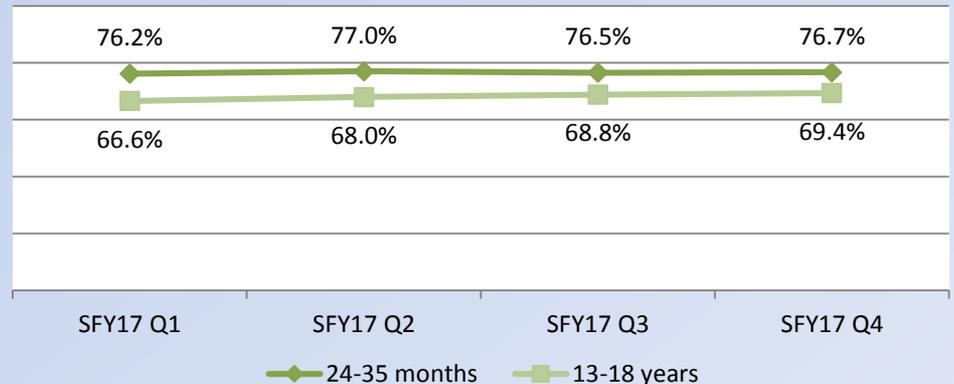
VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors who serve them. By encouraging provider enrollment in VFC, more children will benefit from the program. More children will have a better chance of receiving their recommended vaccinations on schedule.

### Number of new providers enrolled in VFC



Source: Maine Immunization Program

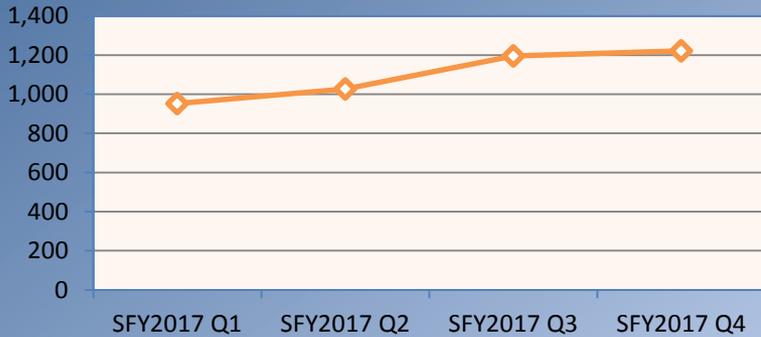
### Immunization rates increased slightly during Year 3



Source: Maine Immunization Program

# Obesity

The number of sites acting to reduce sugar-sweetened beverages has increased



Source: Maine Nutrition, Physical Activity and Healthy Weight Program

## Decreasing sugar-sweetened beverage consumption

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.

## Physical Activity

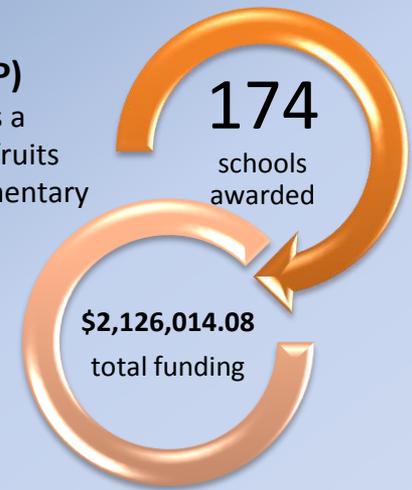
*Let's Go!* works with child care centers and K-12 schools to increase the number of sites using evidence-based approaches to implement policies and create environments that support physical activity and meet safety guidelines.



## Fresh Fruit and Vegetable Program (FFVP)

The Fresh Fruit and Vegetable Program (FFVP) is a federally assisted program providing free fresh fruits and vegetables to students in participating elementary schools during the school day.

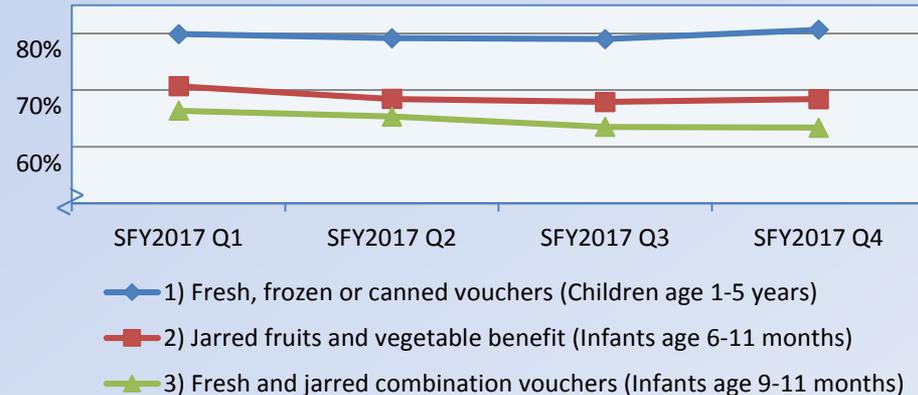
By maximizing the use of federal funds, more schools can join. As a result, more youth have access to fruits and vegetables by increasing participation in FFVP.



## WIC Fruit and Vegetable Vouchers and Benefits

The WIC program implemented several programs targeted at increasing fruit and vegetable consumption in infants and children. The redemption rate indicates how many recipients took advantage of these programs once they were issued vouchers/benefits. A decreasing redemption rate may indicate that more outreach is needed to educate the recipients on the importance of fruit and vegetables.

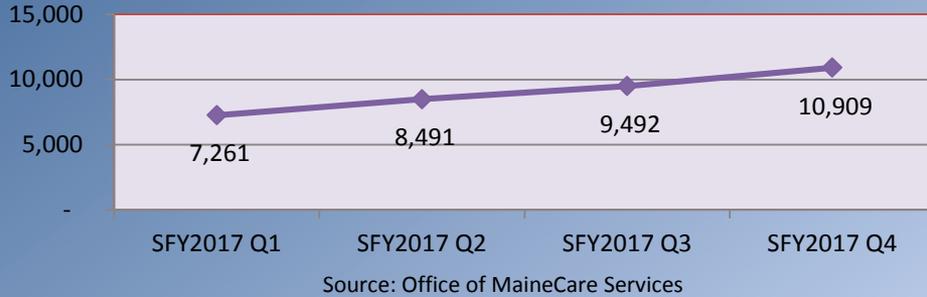
The redemption rate for WIC Fruits and Vegetables benefits and vouchers decreased over the 2017 reporting year



Source: Maine WIC Nutrition Program

# Substance Abuse and Mental Health

The number of MaineCare members enrolled in a Behavioral Health Home has increased over the last 4 quarters



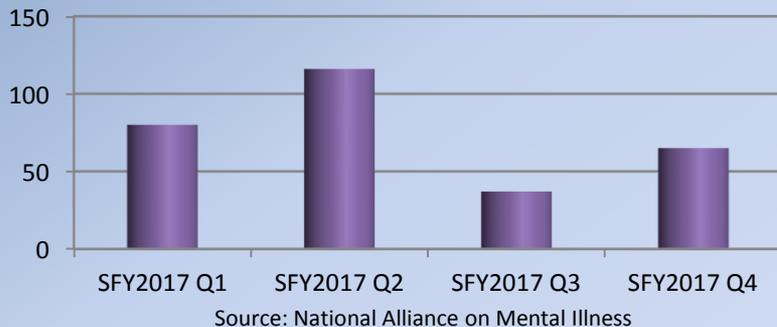
Number of evidence-based suicide-prevention Gatekeeper trainings offered to public school staff



## Coordination of Care

Behavioral Health Homes are a partnership between a licensed community mental health provider and one or more Health Home practices to manage the physical and behavioral health needs of eligible adults and children. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers.

Number of medical and behavioral health providers receiving training or TA on suicide-safer care practices



Develop statewide steering committee: Towards Zero Suicide: Implementing Suicide – Safer Care

SFY2017 Q3: Organizations recruited to participate in Zero Suicide implementation

SFY2017 Q4: Proposal submitted for federal funding to support Zero Suicide implementation

# Tobacco Use

**213**  
worksites using Healthy US Scorecards to implement smoke-free policies that exceed current Maine state laws

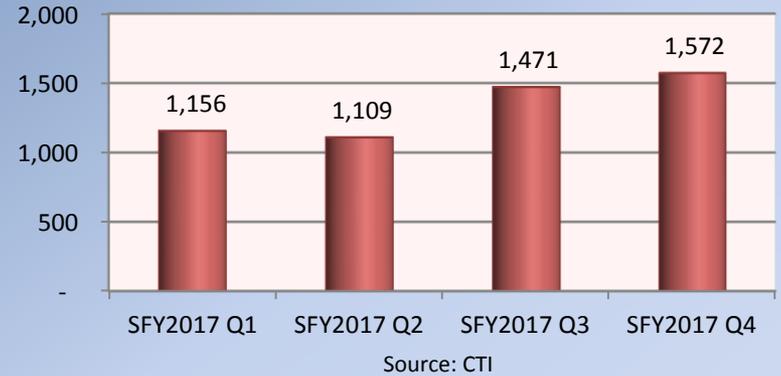
## Partnership for a Tobacco-Free Maine clinical outreach sessions aiming to increase brief tobacco interventions in clinical settings



## Tobacco Interventions

The Partnership for a Tobacco-Free Maine informs clinical providers of resources available, such as the Maine Tobacco Help Line. Increasing awareness of services can increase access and utilization of these services to assist in successful tobacco cessation.

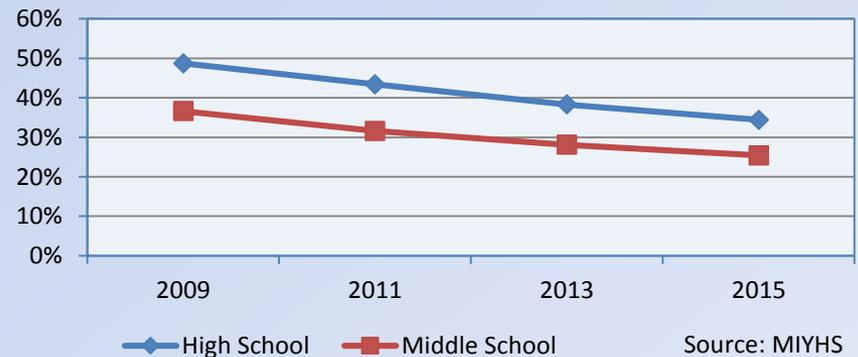
## The number of medication vouchers provided to eligible tobacco users generally increased for each quarter



## Secondhand Smoke

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. There continues to be progress on working with partners (such as childcare providers, home visitors and health care providers) to encourage families to implement smoke free home pledges.

## Decreasing trend of middle and high school youth who were exposed to environmental tobacco smoke in the past 7 days



# Inform, Education and Empower the Public



## Communication coordination:

- 13 projects implemented using pilot communication plan
- 8 Public Health Updates disseminated



## Maine CDC website:

- Guidance and policies developed for website updates
- Revised architecture approved and implementation phases planned



## Communication at the Public Health District level

- All 9 Districts have communication plans

# Mobilize Community Partnerships



## District Coordinating Councils:

- 9 DCCs have established MOUs with Fiscal Agents for the contract year
- 9 DCCs have Communications, Operations SOPs, and By-Laws in place



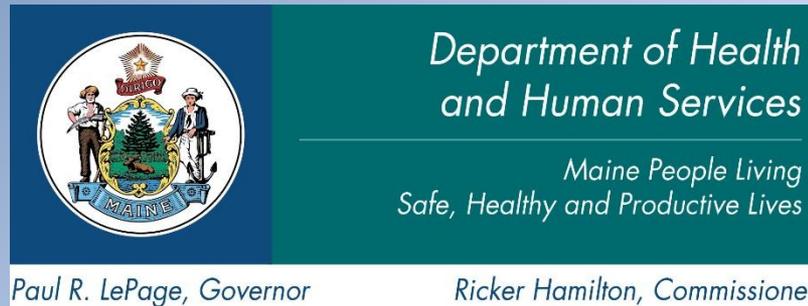
## Support, guidance and technical assistance:

- TA given on Communication SOPs, By-law development, strategy development and measures



## Engaging local partners

- 69 partners engaged for District Public Health Improvement Plans (DPHIP) implementation



The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), TTY users call Maine relay 711. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.



*Paul R. LePage, Governor*

*Ricker Hamilton, Commissioner*

# Statewide Coordinating Council for Public Health

## Annual Report

# 2017

The Statewide Coordinating Council for Public Health (SCC) is required under Title 2, Section 104 to report annually to the Joint Standing Committee of Health and Human Services on progress made toward achieving and maintaining accreditation of the state public health system and on streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of public health services.

The Statewide Coordinating Council is a representative statewide body of public health stakeholders that engages in collaborative planning and coordination. Its members provide several key functions, including ensuring that the state public health system is ready for accreditation and helping to determine how best to deliver essential public health services across the State in the most efficient, effective and evidence-based manner possible.

The Statewide Coordinating Council has been integrally involved in the planning and implementation of the improved local public health system that now exists in Maine. This document highlights key activities and successes of the infrastructure at both the State and local levels.

## **Accreditation**

The goal of public health accreditation is to protect and improve the health of Maine people by advancing the quality and performance of the Maine CDC's programs and services. Maine CDC achieved national accreditation by the Public Health Accreditation Board (PHAB) in May 2016. The agency will go through reaccreditation in 2020, when PHAB will require us to demonstrate that we can meet the revised standards, have maintained the standards we met at the time of our accreditation, and improved on standards that we partially met. Prior to 2020, Maine CDC will maintain our accredited status via annual reports to PHAB. These reports include updates on:

- The State Health Assessment, also known in Maine as the Maine Shared Community Health Needs Assessment (CHNA);
- The State Health Improvement Plan (SHIP);
- An agency-wide Strategic Plan;
- Performance Management; and
- Quality Improvement.

In 2017, Maine CDC reported that three measures previously ranks as "slightly met" have now been met, including:

- Additional documentation of environmental health hazards investigations;
- Annual reports and updates to the SHIP; and
- Annual updates to the Strategic Plan.

Maine CDC also reported on 20 Quality Improvement projects, including a project at the Health and Environmental Testing Laboratory (HETL), where expenses had been greater than revenues. HETL looked to improve sustainability of their operations to continue to be able to provide all current services to the public. They knew that private water test kits were being distributed at no charge, but had not evaluated how many were never returned for testing with payment, resulting in a cost to the lab for the unreturned test kit.

Data showed that >4,000 kits had not been returned for testing in the years 2005-2016. The cost of the unreturned test kits was “estimated” for the year 2015. This was considered needless spending. At a current cost of approximately \$11.70 per kit (not including the cost of the test), it was estimated that \$20,428 was spent needlessly (1,746 kits) in 2015 and justified the up-front payment of all future private water tests (pre-payment of test, which includes cost of kit).

As reported to PHAB, in June 2017, 1,204 private water test kits had been distributed and \$54,674 in test pre-payment has been collected. Average collection per kit was \$45.40 in 2017 (including test cost). As of 7/14/17, 618 pre-paid kits had not been returned, which is on pace with previous years, although we do not know how many of these will still be sent in for testing. This is an estimated (year-to-date) gain of \$28,057.

Pre-payment not only eliminates the cost to the lab of distributing unused private water test kits, but it may also decrease the amount of unreturned test kits, and may improve the rate of completed tests.

### **Accomplishments of the Planning and Advisory Structures**

- Under the leadership of District Liaisons, the District Coordinating Councils (DCCs) standardized their operating principles and finalized District Public Health Improvement Plans (DPHIPs) in late 2017. Results from the 2017 Maine Shared District-level CHNAs were used to select priorities.
- Implementation of the DPHIPs began in early 2017. Districts collaborated with Maine CDC state prevention services contractors in several priority areas, and used District contract funds to advance additional District-selected priorities. While funding cuts has slowed implementation, the following accomplishments were seen in 2017 (more detailed reports are submitted quarterly to the SCC.):
  - The **Aroostook** DCC selected priorities of cardiovascular health, substance use and healthy weight and funded twelve initiatives in these areas. Among funded projects were initiatives to engage business in worksite hypertension education, screening and referrals and to increase access to regular hypertension screening in three community centers, with a focus on implementing blood pressure BP screening clinic for older Mainers and facilitating engagement with providers.
  - In **Cumberland** District, where seven initiatives falling under four priorities were funded, a comprehensive scan was produced of resources, efforts and gaps in opiate misuse prevention across the district and in the state. A tool-kit was also created for towns and schools with best practices for addressing opiate abuse. The toolkit has been distributed widely through the Greater Portland Council of Governments network and at opiate roundtables and workshops funded under the DPHIP.
  - The **Central** DCC, serving Kennebec and Somerset Counties, identified District-specific approaches to address barriers to entering substance misuse treatment, to address root causes of substance misuse and chronic disease; to increase fruit and vegetable

consumption in district food serving institutions; and to reduce sugar sweetened beverage consumption and promote water as the beverage of choice in different settings in the district. In addition, a project to improve oral health continued, employing a community health worker to connect children and families to needed care and provide one-on-one education on the importance of personal oral health. 125 families received oral health education and 71 children were linked to a dental home. On-going partnerships were facilitated with 55 service provider sites.

- The **Downeast** DCC, serving Hancock and Washington Counties, funded a total of seventeen projects, including included oral health prevention outreach, school based cardiovascular health planning, improving nutrition education, healthy eating, and food access for children and seniors, county wide implementation of neighborhood walking trails and bicycle usage, expansion of school based and police assisted drug and alcohol use programs, community outreach pilot prevention of drug and alcohol use in the fishing workplace, and county wide assessment of behavioral health needs in early childcare centers and schools. One of the oral health projects expanded on the current Sunrise Opportunities Tooth Fairy Mobile Unit, which provided preventative educational and oral health services to 500 school age children at school sites in Washington County during May/June 2017.
- The **Midcoast** DCC, serving Knox, Lincoln, Sagadahoc and Waldo Counties, administered ten grants that increased awareness, use and usability of low-to-no-cost physical activities throughout the District. Among the projects, public use trails throughout the district were improved and their use promoted, a youth swimming program was established on one of the District's island communities, and television spots were created and broadcast throughout the District, highlighting outdoor physical activity opportunities. In order to inform it's continued DPHIP work, the Council also sought input from District school systems, youth organizations, public health partners, social service agencies and medical professionals to identify District-specific challenges in its DPHIP priorities of *Elevated Lead Levels*, *Youth and Adult Mental Health*, and *Obesity*.
- Five initiatives funded through the **Penquis** DCC, serving Penobscot and Piscataquis Counties, were completed, including several healthy food access projects. For example, PCHC, in collaboration with Hope House Health and Living Center, managed and sustained the Giving Hope Garden, a 15-raised bed organic garden in Bangor, Maine. The project provided nutritious produce and food security to vulnerable populations in the broader Bangor community.
- After completing a gap analysis to identify opportunities for improved services in the **Western** District (Androscoggin, Franklin, and Oxford Counties), the Western DCC partnered with Not Here Justice in Action Network to increase the number of organizations, providers and community members who have knowledge that will empower them to impact substance use through better appreciation of root causes, specifically adverse childhood experiences (ACEs).
- The Wabanaki Public Health District... [\[waiting for more information\]](#)

- In **York** County, a partnership between University of New England School of Dental Hygiene and eight schools was developed to provide oral health screenings to children. The project working towards also offer oral health screenings during kindergarten and pre-K Screening and registration. This was one of five initiatives funded in three priority areas.
- The 2013-2017 SHIP was completed (report attached).
- The State Coordinating Council used the DPHIP priorities and the 2017 Maine Shared State-level CHNA to select priorities for the next SHIP. Maine CDC staff have identified objectives and strategies that are supported by current funding.
- Planning has begun for the 2019 Maine Shared CHNA. Data analyses will be completed in 2018, and community forums are planning for the fall/winter of 2018/2019.

DRAFT



**PHAB Annual Report  
Section I  
Release Date: January 8, 2014  
For Health Departments Accredited Under Version 1.0**

Accredited health departments are required to submit an annual report to PHAB. The health department will gain access to the Annual Report module in e-PHAB at the beginning of the quarter in which the Annual Report is due. The annual report is due at the end of the quarter in which the health department was accredited.

The Annual Report is comprised of two sections. Section I of the annual report is an opportunity for the health department to report on one or more of the following categories, as appropriate:

1. Circumstances that would potentially jeopardize continued conformity with the standards and measures under which accreditation was initially awarded;
2. Specific measures the Accreditation Committee requested that the health department address in its Annual Report; and
3. Adverse findings or communications related to oversight or control from federal or state funding agencies that indicate the health department is at risk for loss or reduction in those funds. For more information about the meaning of this category, see the definition of high risk grantee in the PHAB Glossary.

After Section I has been completed, the health department should upload it to e-PHAB to be reviewed by PHAB staff. The health department will receive notification that it has access to Section II of the Annual Report or may be requested to provide additional information. On Section II, the health department will provide information related to improvement activities; continuing processes; and emerging public health issues and innovations.

Instructions for Section I: If the health department has nothing to report for any one of those categories, place an X in the box to indicate that there is nothing to report and then skip the rest of the questions associated with that category.

Health Department Name
Maine Center for Disease Control and Prevention

<b>Category 1: Circumstances that would potentially jeopardize continued conformity with the standards and measures under which the accreditation was initially awarded.</b> (This would include updated health department profile information that includes leadership changes and any other changes, such as budget, personnel, governance, or program changes that potentially jeopardize the health department's ability to be in conformity with the standards and measures.)	
<b>Does the health department have anything to report on Category 1?</b> <i>(Place an X in the column to the left of the answer.)</i>	
<input checked="" type="checkbox"/> <b>Yes (Answer the questions below)</b>	<input type="checkbox"/> <b>No (Skip this section)</b>

Circumstance	Description of the change
<b>Leadership (e.g., changes in the Health Department Director) – Please provide name and job title</b>	Sheryl Peavey Chief Operating Officer

<b>Budget</b>	\$134,500,000
<b>Number of FTE</b>	486
<b>Number of employees</b>	483
<b>Governance</b>	No change
<b>Structure (e.g., mergers, transition from stand-alone agency to superagency or vice versa)</b>	The DHHS Division of Licensing and Regulatory Services merged with the Maine CDC. Maine CDC no longer has a separate Office of Health Equity. Other Divisions have changed names, and some programs have been moved from one division to another.
<b>Programs or services that the health department provided at the time accreditation was conferred that it does not provide now</b>	none
<b>Other circumstances</b>	none

<b>Please describe how the circumstances listed above might affect the health department's continued conformity with the standards and measures.</b>
None of the above circumstances should affect the health department's continued conformity with the standards and measures. The majority of the work of the Division of Licensing and Regulatory Services is outside of the purview of PHAB. However, the staff in this unit are being integrated in applicable accreditation activities. The functions of the Office of Health Equity have been absorbed by other divisions, and health equity continues to be integrated in all program work. Maine CDC budget has decreased from the amount reported on our application for SFY 2014. While the budget reflects some reductions in program activities in some areas, meeting PHAB standards is continually prioritized and savings are focused on achieving efficiencies via process improvement. Budget reductions have not affected our ability to conform to PHAB standards to date. Other organizational changes did not change the broad scope of work being done.

<b>Category 2: Specific measures the Accreditation Committee requested that the health department address in its Annual Report</b>			
<b>Did the Accreditation Committee request that the health department address a specific measure?</b>			
<i>(Place an X in the column to the left of the answer.)</i>			
<input checked="" type="checkbox"/>	<b>Yes (Answer the questions below)</b>	<b>Yes, but the health department has already reported in a previous annual report that it has fully addressed the measure (Skip this section)</b>	<b>No (Skip this section)</b>

	<b>Response from Health Department</b>
<b>First Measure</b>	
Measure Number:	2.1.3
Measure Text:	Demonstrate capacity to conduct investigations of non-infectious health problems, environmental, and/or occupational public health hazards.
Site Visit Report Comment on the Measure:	"The non-infectious disease health problem that was submitted for an Outbreak of respiratory and ocular complaints at an open swim meet at a college pool that occurred December 10-12, 2010 is a preliminary findings report dated 2/16/11 and was not the completed investigation report, as required."
Health Department Actions:	In 2015, the Environmental and Occupational Health Program completed an investigation on arsenic exposure in households using bottled water or point-of-use treatment systems to mitigate well water contamination. Common mitigation strategies to prevent well water arsenic exposure were assessed. It was found that these strategies were less able to prevent exposure when arsenic levels were greater than 40 µg/L. The investigation also found that bathing was not a significant arsenic

	exposure source for children or adults and that untreated water use explained more arsenic exposure in adults than children. Complete compliance with a mitigation strategy is important in reducing exposure. This investigation resulted in an article in the journal <i>Science of the Total Environment</i> .
<b>Second Measure</b>	
Measure Number:	5.2.4
Measure Text:	Monitor progress on implementation of strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners.
Site Visit Report Comment on the Measure:	RD1: Two annual evaluation reports were not included. However, documents provided show notes that the SHIP did not begin implementation of strategies until late 2014. Quarterly reports via an excel sheet started in October 2014 and are available up to March 2014 (2 quarters). The excel sheet includes a tab for each of the six priorities. Updates are provided for the two quarters and if data is not available, an explanation is included in the outcome or performance measure box. RD2: No updated SHIP was provided. An implementation timeline was provided which notes that implementation of the SHIP did not begin until later 2014 and a full year will not be completed until September 2015. The Health Department states that the SHIP will not be revised until after the first full year of implementation has occurred and evaluation of progress can be conducted.
Health Department Actions:	In September 2015, an implementation plan report of activities over the first year of implementation (July 2014-June 2015) was completed, along with an implementation plan for the second year. In October 2016, an implementation plan report of activities over the second year of implementation (July 2015-June 2016) was completed, along with a summary report of the first two years of implementation and an implementation plan for the third year. Reporting on the third year of implementation (July 2016-June 2017) is still in progress. In addition, a new State Health Improvement Plan for the period 2017-2020 is under development, and expected to be finalized by September 2017.
<b>Third Measure</b>	
Measure Number:	Measure 5.3.3
Measure Text:	Implement the department strategic plan
Site Visit Report Comment on the Measure:	RD1 includes a strategic plan annual report released in 2014. The Strategic plan was initiated in February 2013. The report included a discussion on each of the four priorities and noted accomplishments as of that date. An implementation worksheet was included that is used to monitor the activities, but did not include updates on achieving the stated work. A 2015 report was not included as it had not been completed by the Health Department's document submission date.
Health Department Actions:	2015 and 2016 reports for the strategic plan have been completed. A new strategic plan was developed for state Fiscal Year 2017 (July 2016 – June 2017) and progress on activities in this plan are being reported on a quarterly/monthly basis. This plan was recently updated to add activities for state Fiscal Year 2018 and a three year plan is in development.

**Category 3: Adverse findings or communications related to oversight or control from federal or state funding agencies that indicate the health department is at risk for loss or reduction in those funds**

**Has the health department received an adverse finding or communication related to oversight or control?**

*(Place an X in the column to the left of the answer.)*

<b>Yes (Answer the questions below. If the health department received multiple adverse findings/communications, please complete a separate table for each.)</b>	<input checked="" type="checkbox"/>	<b>No (Skip this section)</b>
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<b>Adverse Finding/Communication #1</b>
<b>What is the name of the funding agency?</b>
<b>Summarize the concerns raised by the funding agency.</b>
<b>Describe the results of this adverse finding/communication. (Did the health department lose funding? What actions, if any, did the health department take in response?)</b>

<b>Adverse Finding/Communication #2</b>
<b>What is the name of the funding agency?</b>
<b>Summarize the concerns raised by the funding agency.</b>
<b>Describe the results of this adverse finding/communication. (Did the health department lose funding? What actions, if any, did the health department take in response?)</b>

<b>Adverse Finding/Communication #3</b>
<b>What is the name of the funding agency?</b>
<b>Summarize the concerns raised by the funding agency.</b>
<b>Describe the results of this adverse finding/communication. (Did the health department lose funding? What actions, if any, did the health department take in response?)</b>



**PHAB Annual Report**

**Section II**

**Approval Date: November 2014 Effective Date: January 2015  
For Health Departments Accredited Under Version 1.0**

On this form, you will report on the health department’s activities related to improvement; continuing processes; and emerging public health issues and innovations. Please provide brief responses to these questions. Each question should have a response of no more than 500 words. When you have completed this form, please log on to e-PHAB and upload this document. Upload the document as a Word file; do NOT convert it to a PDF.

<b>Health Department Name</b>
Maine Center for Disease Control and Prevention

**Performance Management and Quality Improvement**

**1. How has the health department implemented and/or changed its performance management system over the past year? Please provide an example of how the health department has tracked its performance. (Word limit: 500)**

Maine CDC re-vamped its performance management system in 2016/2017. The new system began with measures of interest to the Commissioner of the Department of Health and Human Services (the umbrella department for Maine CDC). These measures were outcome-based, reflected Departmental investments and had data that could be updated no less frequently than quarterly.

Building on the limited number of measures reported to the Commissioner, the Maine CDC Executive Management Team used Maine CDC’s Strategic Priorities to expand to sixteen measures for a more comprehensive dashboard. While some of these measures are outcome-based, others are more focused on process data that are more continually updated. These are being linked to annual outcome data that are being developed for a public facing reporting tool. Next steps are to expand further for each Division within Maine CDC, and eventually to all programs.

As an example, current smoking by adults is a key long-term outcome indicator. However, given the multiple influences on this measure, and the lack of new data more frequently than yearly, Maine CDC has focused its performance in this area on smoking cessation and is measuring the number of Maine residents and MaineCare (Medicaid) members who access the Maine Tobacco Help Line, which is a key strategy that the Department is investing in to influence current smoking rates.

**2. How has the health department implemented and/or changed its quality improvement (QI) plan over the past year? (Word limit: 500)**

In order to increase QI reporting, we developed three additional templates for reporting QI projects. Additionally, we have started trainings at every QI Team meeting, continued bi-annual QI culture survey, and included QI in Senior Management Team meetings.

**3. Which of the following most accurately characterizes the QI culture in the health department? (See <http://qiroadmap.org/assess/> for a description of these phases. Place an X in the column to the left of the phase that best applies.)**

<b>Phase 1: No knowledge of QI</b>	X	<b>Phase 4: Formal QI implemented in specific areas</b>
<b>Phase 2: Not involved with QI activities</b>		<b>Phase 5: Formal agency-wide QI</b>
<b>Phase 3: Informal or ad hoc QI</b>		<b>Phase 6: QI Culture</b>

**4. Has there been a change in the health department’s phase of QI culture in the past year? If so, what has changed and why? (Word limit: 500)**

There has not been a change. The most recent survey evaluation of the QI culture (June 2017) indicated there is an increase in formal (and also informal) QI activity in various areas. New members have been recruited for the QI Team. We are in the process of revamping our communication strategies, including

collection of information on QI activities. . These activities are intended to further engage staff and advance the QI culture.

**5. The table below lists several characteristics of a QI culture. Please complete the table below to indicate one concrete step the health department has taken over the past year to improve each characteristic listed and one step it plans to take next year. If the health department has not worked on a characteristic or has no plans to work on it in the coming year, leave that part of the table blank. (See <http://qiroadmap.org/assess/> for a description of these characteristics. Two characteristics – QI model/plan and performance management system - have been omitted from the table because they were previously described in questions 1 and 2.) (Word limit: 100 words per row)**

<b>Characteristics</b>	<b>Steps Taken Last Year</b>	<b>Steps Planned for Next Year</b>
<b>Leadership</b>	Maine CDC has included QI as a standing agenda item on Senior Management Team meetings.	Maine CDC will include a review of performance measures and progress as a standing agenda item on Senior Management Team meetings and include discussion of QI activities needed to make further progress. SMT will share success stories with their staff.
<b>QI Champions</b>	The QI Team has recruited new/more members from different divisions for better representation across the agency.	QI Champions will be developing strategies to mentor new staff and ensure all new staff receives basic QI training as part of on-boarding.
<b>QI Training</b>	We've added QI training to all QI Team meetings.	Maine CDC will integrate QI training at all Senior Management Team meetings, and conducting Lunch and Learns focused on QI.
<b>Staff engagement</b>	A QI culture survey was administered to staff with revised questions based on feedback from the previous survey.	The QI Team will be offering more training based on feedback from the QI survey, and will be challenging the Maine CDC to complete one QI project, per program, per calendar year. We will also be developing a communication plan which will highlight QI activities.
<b>Resources</b>	Maine CDC recently hired two new staff for Performance Improvement, Accreditation and Workforce Development. QI is integrated into both positions.	Maine CDC is creating a more user friendly intranet and will be adding QI training resources and tools to it.
<b>Data</b>	Maine CDC leadership developed new performance measures aligned with our Strategic Plan.	Maine CDC will be expanding indicators on the performance management system to include all programs.

**6. Please provide a brief overview of QI projects conducted in the past year. Include the number of projects, their type (administrative or programmatic), and the proportion of health department program areas/offices that engaged in one or more of them. Please indicate whether this is an expansion over the past year (e.g., the number and/or type, extent of participation, etc.). (Word limit: 500)**

Maine CDC completed 20 QI projects in the last year. Of these, 3 were administrative, and 17 were programmatic. This is an increase of 10 total QI projects over the previous year. This increase is in part due to better reporting of program QI activities. This includes projects in five of five divisions.

**Select one QI project to describe in greater detail below**

**7. What issue did this QI project address? How was that need determined (e.g., Accreditation Committee, Site Visit Report, customer survey, audit, etc.)? What was the QI initiative aim (including the specific measurable goals set for the activity)? (Word limit: 500)**

At the Health and Environmental Testing Laboratory (HETL), expenses are greater than revenues. HETL looked to improve sustainability of their operations in order to continue to be able to provide all current services to the public. They knew that private water test kits were being distributed at no charge, but had not evaluated how many were never returned for testing with payment, resulting in a cost to the lab for the unreturned test kit.

**8. How was the QI project implemented? What methods and tools were used? Was a pilot conducted? (Word limit: 500)**

A sustainability review of laboratory data from StarLims was conducted in December 2016 using brainstorming and root cause analysis. The team working on this review determined that they wanted to eliminate the total number of private water test kits that were being distributed at no charge and not returned for testing. The group used the PDCA cycle for this project.

Data showed that >4,000 kits had not been returned for testing in the years 2005-2016. The cost of the unreturned test kits was "estimated" for the year 2015. This was considered needless spending. At a current cost of approximately \$11.70 per kit (not including the cost of the test), it was estimated that \$20,428 was spent needlessly (1,746 kits) in 2015 and justified the up-front payment of all future private water tests (pre-payment of test, which includes cost of kit).

2015 data was used as it was believed that some test kits distributed in 2016 could still be sent in for testing and the likelihood of 2015 test kits being returned for testing was much less likely. (At the time of the StarLims review, 2,449 test kits distributed in 2016 had not been returned for testing.)

Once the decision was made to begin requesting pre-payment, a form was redesigned to allow for easy up-front collection of private water tests. Personnel in the shipping and receiving department were trained on how to use the form and request the payment. The "pre-payments" have been tracked weekly since 1/9/2017.

**9. Did the health department gain information and/or understanding in the course of implementing the QI project that led the health department to make changes in this project or in other QI work? (Word limit: 500)**

1. A form/information sheet was created to send to callers who do not want to provide credit card information over the phone. The order form can be returned with a check or sometimes credit card information that would not be given over the phone.
2. More clients are directed to the website if they would like to order tests via the website and pay by credit card there.
3. It is no longer necessary to send out letters informing private water clients that their tests are complete and that payment must be received before the results are sent, which has reduced administration time.
4. When the sample is received there is less record-keeping than before because payments no longer accompany the samples and do not have to be entered onto the chain of custody. This also reduces in administration time.
5. During the "Check" cycle, it was found that some pre-payments were missed. Sometimes a caller was transferred to an analyst if they had questions about which kit to order. Not all analysts were aware of the change to up-front payment, so early on, some kits were sent without pre-payment. Training was adjusted and offered to more analysts, and that eliminated this problem.

**10. What are the outcomes of the QI project (including progress towards the measurable goals that were set)? Please provide specific data. (Word limit: 500)**

The cost of unreturned test kits no longer has to be absorbed by HETL. While administrative efforts have had to increase to manage up front collections (pre-payment), post-testing notification to the client to request payment is no longer necessary for private water tests.

As of 6/9/2017, 1,204 private water test kits have been distributed and \$54,674 in test pre-payment has been collected. Average collection per kit was \$45.40 in 2017 (including test cost).

As of 7/14/17, 618 pre-paid kits have not been returned, which is on pace with previous years, although we do not know how many of these will still be sent in for testing. This is an estimated (year-to-date) gain of \$28,057, which would have otherwise resulted in a minimum estimated loss of \$7,230.

Pre-payment not only eliminates the cost to the lab of distributing unused private water test kits, but it may also decrease the amount of unreturned test kits, and may improve the rate of completed tests.

**11. Does the health department plan to do additional work related to this QI project next year? This could include standardizing the initiative or replicating it to other units, service lines, or organizations. (If yes, please describe below. If no, please leave the next box blank.) (Word limit: 500)**

Yes, HETL intends to continue tracking pre-payment rate and plans to explore other opportunities for up-front payment of tests. HETL also plans to explore opportunities to improve the collection process and is currently reviewing "Pay Maine" for electronic collections.

**12. To which PHAB measure(s) does this QI project apply?**

11.2, 2.3

## Continuing Processes

### **13. Describe how the health department has updated and/or expanded the community health assessment over the past year. Include information about the process as well as the resultant changes. (Word limit: 500)**

In 2016, Maine CDC, in partnership with four major health systems in Maine (Central Maine Healthcare, Eastern Maine Health System, MaineGeneral, and MaineHealth) released the Maine Shared Community Health Needs Assessment (Shared CHNA). This updated and replaced our 2012 State Health Assessment, and included reports for each of our eight geographic public health districts and each of our sixteen counties, as well as a state-level report. Analyses included stratification on a number of demographic and socio-economic variables. Sortable and filterable data tables were posted on the Maine CDC website.

Over the past year, a further assessment of the availability of data for populations with disparate health outcomes was completed, with several recommendations from that report implemented, including the inclusion of transgender questions on the Maine Behavioral Health Risk Factors Survey and the Maine Integrated Youth Health Surveys. A report on Social Determinants of Health has been drafted and will be finalized this summer. This report will include data summaries for a number of populations with disparate health outcomes, building on the indicators included in the Shared CHNA.

The Shared CHNA partnership has begun planning for the 2019 Shared CHNA. Indicators are being reviewed, as well as possible options for improvements to our community engagement process.

### **14. Describe how the health department has implemented and/or revised the community health improvement plan over the past year. Include information about the process as well as the resultant changes. (Word limit: 500)**

A revised implementation plan for the final year of the 2013-2017 State Health Improvement Plan (SHIP) was developed in the summer of 2016 (for the state fiscal year July 2016 – June 2017). The workgroups contributing to this plan are reporting on a quarterly basis, and the final report on this SHIP will be finalized by October 2017.

Based on the 2016 Shared CHNA, each of the nine Public Health Districts have developed a District Public Health Improvement Plan (DPHIP), and began implementation in January 2017. These District plans are being incorporated into the next SHIP. The State Coordinating Council for Public Health selected state-level priorities for the 2017-2020 SHIP. - Objectives and strategies are still draft at this time.

### **15. If the health department has observed improvements in any of the health status measures in the community health improvement plan, please provide examples here. (Word limit: 500)**

Maine CDC has seen improvements in several health status measures related to its current State Health Improvement Plan:

- Childhood vaccinations increased from 75% (2014) to 76.7% (2017).
- Adolescent vaccinations increased from 55% (2004) to 69.4% (2017).
- Pneumococcal Vaccinations for adults ages 65 and older increased from 70.7% (2012) to 77.5% (2015).
- The percentage of adults who had their diabetes under control increased from 36% (2016) to 41% (2017).
- Daily sugar-sweetened beverage consumption decreased from 26.2% (2013) to 23.1% (2015, high school) and 23.4% (2013) to 20.2% (2015, middle school).
- Misuse of prescription drugs decreased from 7.1% (2011) to 4.8% (2015, high school) and from 36.6% (2011) to 25.4% (2015, middle school). There was no improvement in self-reported adult rates of prescription drug misuse.
- Exposure to secondhand smoke decreased from 10.6% (2012) to 9.9% (2015, adults, non-significant change), 43.4% (2011) to 34.4% (2015, high school) and from 3.2% (2011) to 2.2% (2015, middle school).
- Thirty-day (should this be “30-day”) youth cigarette use decreased from 15.5% (2011) to 10.7% (2015, high school) and from 4.2% (2011) to 2.7% (2015, middle school).
- 1,535 people with pre-diabetes or at high risk for developing Type 2 diabetes, completed the National Diabetes Prevention Program (NDPP).
- 5,233 people with diabetes received formal diabetes training, known as Diabetes Self-Management.

Training (DSMT).

**16. Describe how the health department has implemented the strategic plan over the past year. (Word limit: 500)**

Maine CDC made progress on all four of its current strategic priorities in the past year. Some examples of progress include:

- **Data:** Implementation of a chronic disease dashboard using data from the state's health information exchange, showing key indicators, such as the percentage of adults who had their diabetes under control and the percentage of adults with hypertension who had their blood pressure under control (increased from 32% to 47% in first year); completed expansion of ALMS system to track licensing for behavioral health and substance abuse treatment facilities, and launched the public query for behavioral health licenses (Substance Abuse and Mental Health) which includes service level detail. (<https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchCompany.aspx>); made public water system compliance sample results available on-line. The data for these on-line reports are updated on a weekly basis. (<http://www.maine.gov/dhhs/mecdc/environmental-health/dwp/pws/onlineSamples.shtml>)
- **Partnerships:** Re-focused on the activities of the State Coordinating Council for Public Health on the Preventive Health and Health Services Block Grant, and the State Health Improvement Plan, implemented contracts for District Coordinating Council supports and implementation of District Public Health Improvement Plans.
- **Laws & regulations:** Promulgated new lead investigation rules to require inspections for new US CDC standards and hired staff to increase capacity to meet new rule requirements; launched an on-line tool enabling property owners or potential buyers access to septic system permits (which includes the system design) from 2004 to the present: <https://www1.maine.gov/cgi-bin/online/mecdc/septicplans/index.pl>.
- **Efficiency:** Established core business hours to address staffing coverage issues; implemented electronic document archival for savings in space and time required to retrieve historical records; obtained hiring freeze exemptions and filled 73 critical vacancies to ensure adequate staffing.

**17. Sharing Your Work - Please indicate how the health department has provided support to other health departments or shared its experiences with others outside of the department, related to quality improvement, performance management, or accreditation.**

*(Select all that apply. Place an X in the column to the left of the activity.)*

	<b>Submitted an example to PHQIX</b>		<b>Gave a presentation at a meeting</b>
x	<b>Provided one-time consultation to staff at another health department</b>		<b>Provided ongoing assistance to staff at another health department</b>
	<b>Published an article in a journal</b>		<b>None</b>
	<b>Submitted an example to NACCHO's Toolbox</b>		

**18. If the health department provided support or shared its experience with other health departments in a way not listed in question 17 above, please list it below.**

Maine CDC staff participate in both national and New England based workgroups and networking opportunities. For example, Performance Improvement Coordinators and Accreditation Coordinators from the six New England states meet monthly via conference call to shared experiences and ideas for improvements to processes and problem-solving. Maine CDC participates in networks and workgroups established by ASTHO, including the Public Health Performance Improvement Network, the Accreditation Coordinators Learning Collaborative, and Eastern Border Health Initiative (currently infectious disease and emergency preparedness focused).

**19. Please describe one of the activities above (questions 17-18) of which the health department is most proud. (Word limit: 500)**

Maine CDC's Manager for Performance Improvement and Accreditation participated in ASTHO's workgroup to develop an issue brief on health equity and accreditation. By providing Maine's experience and perspective, the needs to address health equity in a smaller, rural state will be better represented in this resource.

<b>Emerging Public Health Issues and Innovations</b>			
<b>20. Has the health department conducted work in any of the following areas?</b> <i>(Select all that apply. Place an X in the column to the left of the issue.)</i>			
x	<b>Informatics</b>	x	<b>Emergency preparedness</b>
x	<b>Health equity</b>	x	<b>Workforce</b>
x	<b>Communication science</b>	x	<b>Public health/health care integration</b>
x	<b>Costing Services/ Chart of Accounts</b>	x	<b>Public health ethics</b>
x	<b>Climate change</b>		

**21. If the health department is engaged in addressing another emerging area or developing another innovation (not included in question 20), please describe it below.**

Substance exposed infants, recreational and medical marijuana, and transition to long-term care.

**22. If the health department is engaged in work in an emerging area, please tell the story of the health department's work in one area. (Word limit: 500)**

Through Maine's State Innovation Model (SIM) grant from the Centers for Medicaid and Medicare Services, Maine CDC was a partner in bringing population health to health care transformation in Maine. The Innovation Center, described below in #23, is continuing this work with a predictive analytics pilot that focuses on patients at risk for hospitalization or re-hospitalization because of hypertension, diabetes and other high risk chronic conditions. Maine CDC has partnered with one hospital system, St. Joseph's in Bangor, the state-wide health information exchange (HIE) and MaineCare to use HIE data to identify patients whose social determinants of health increase their risk of preventable hospitalizations. A registered nurse at the HIE has developed protocols for outreach to patients who have been identified to connect them, not only to preventive health services, but also to community services that assist with other identified needs such as housing, social connections, and reliable transportation. This outreach and referrals to existing assistance are proving to assist patients in better chronic health condition management. - The next steps are to expand this model to other communities and health systems.

**23. Please describe the health department's approach to pursuing innovation. (Word limit: 500)**

As part of the SIM grant, Maine CDC was a key partner in pursuing the triple AIM through strong public health and health care integration. Specifically, Maine CDC played strong roles in the development of protocols to support Community Health Workers in a rural state, using predictive analytics by leveraging data from the Statewide Health Information Exchange, and strengthening management of chronic disease. As that funding ended, the Department developed an Innovation Center housed in the Commissioner's Office to continue health care transformation by testing new ideas with staff who are not burdened with other day to day job requirements. When an idea is tested and found to be worthwhile, it is then rolled out to the relevant DHHS Office. This Center will be governed by SIM leadership in the Office of MaineCare Services, Maine CDC and the Commissioner's Office.

**Overall Improvements**

**24. Aside from what has previously been reported in this report, has the health department made any improvements that have had a significant impact on the health department or the community it serves in the past year? (OPTIONAL, Word limit: 500)**

*What has been the impact on the health department and/or the community? How was that impact measured? Please provide specific data, if available, to demonstrate measurable impact.*