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.

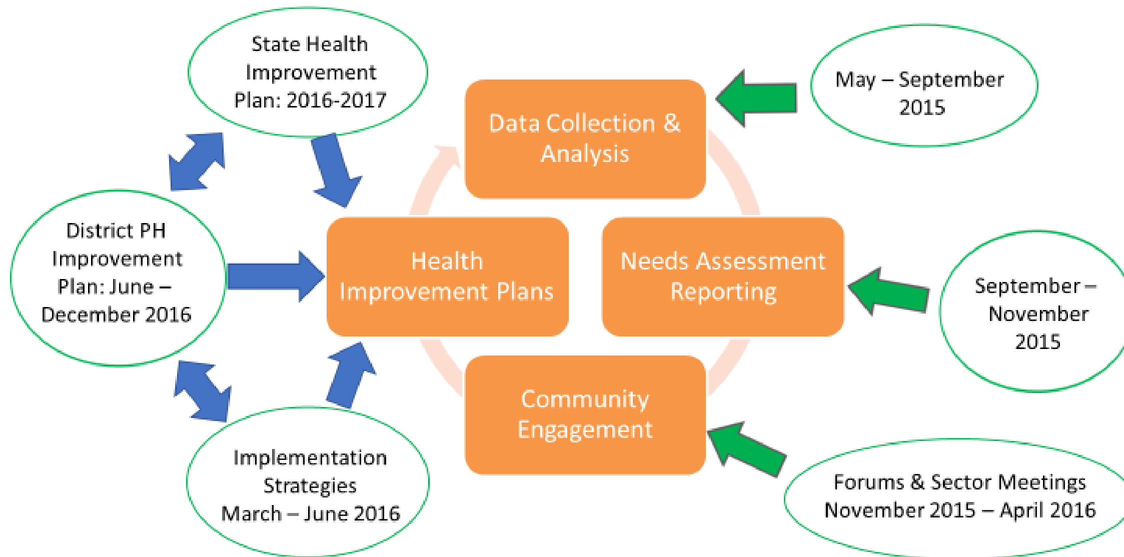
Maine's Public Health Districts were formed in 2008 and the Tribal Public Health District was established as Maine's ninth Public Health District in 2011. The establishment of the nine Districts was designed to ensure the effectiveness and efficiency of public health services and resources.

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, other Maine Department of Health and Human Services Offices, other state agencies where applicable, and 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 though 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, and 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 below 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).



The data in the Shared CHNA (see www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/) 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 compasions between counties, districts, the state of Maine, and the United States. Data is also available to look at disparties 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 recorded by facilitators 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 priorites. 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 stakeholders 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 including 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 (including 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
- Healthy Weight
- Mental Health
- Substance Use, 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.

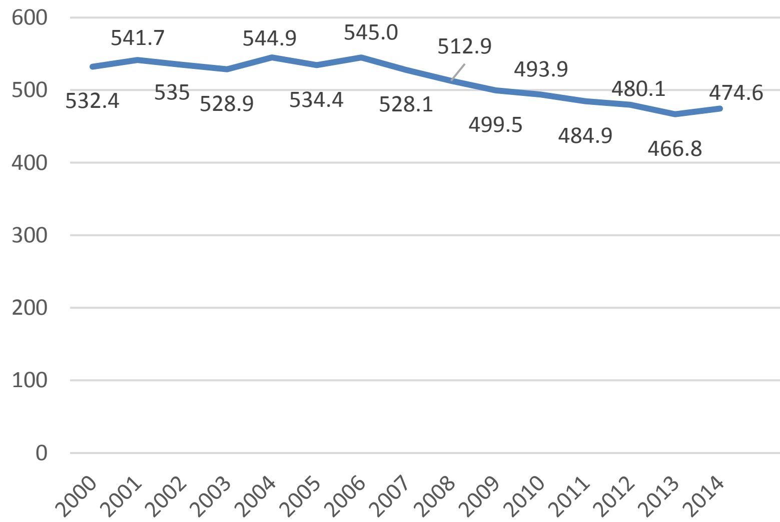
Objectives are based on the SMART model: Specific, Measureable, Achievable, Realistic or Relevant, and Time-limited. SMART objectives are used to provide a structured approach to systematically monitor progress toward a target and to succinctly communicate intended impact and current progress to stakeholders.

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:

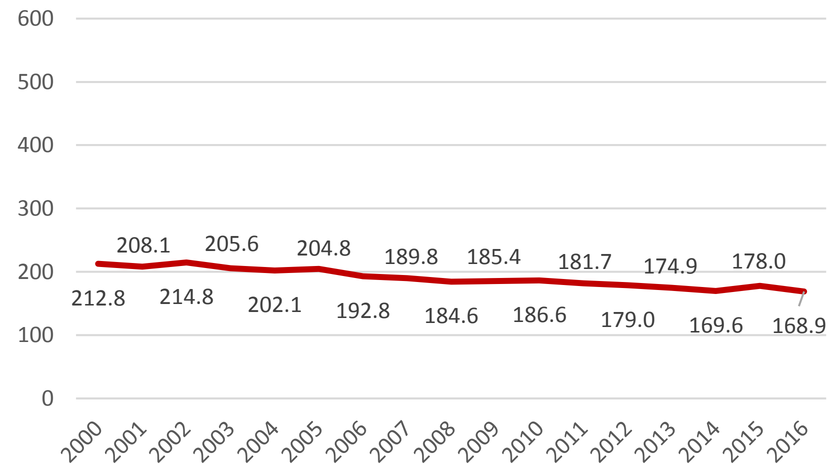
- Does it maximize impact and use of limited resources?
- Is it evidence-based?
- Is it population-based?
- Is it feasible at the state level?
- Does the data support the use of the strategy?
- Do Maine CDC or other DHHS offices have resources available to implement the strategy?
- Is there another organization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

Priority: Cancer

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. (Maine Cancer Registry) Many cancers are preventable and screening can prevent some cancers, while improving treatment outcomes for others.



Data source: Maine Cancer Registry



Data source: Maine Cancer Registry

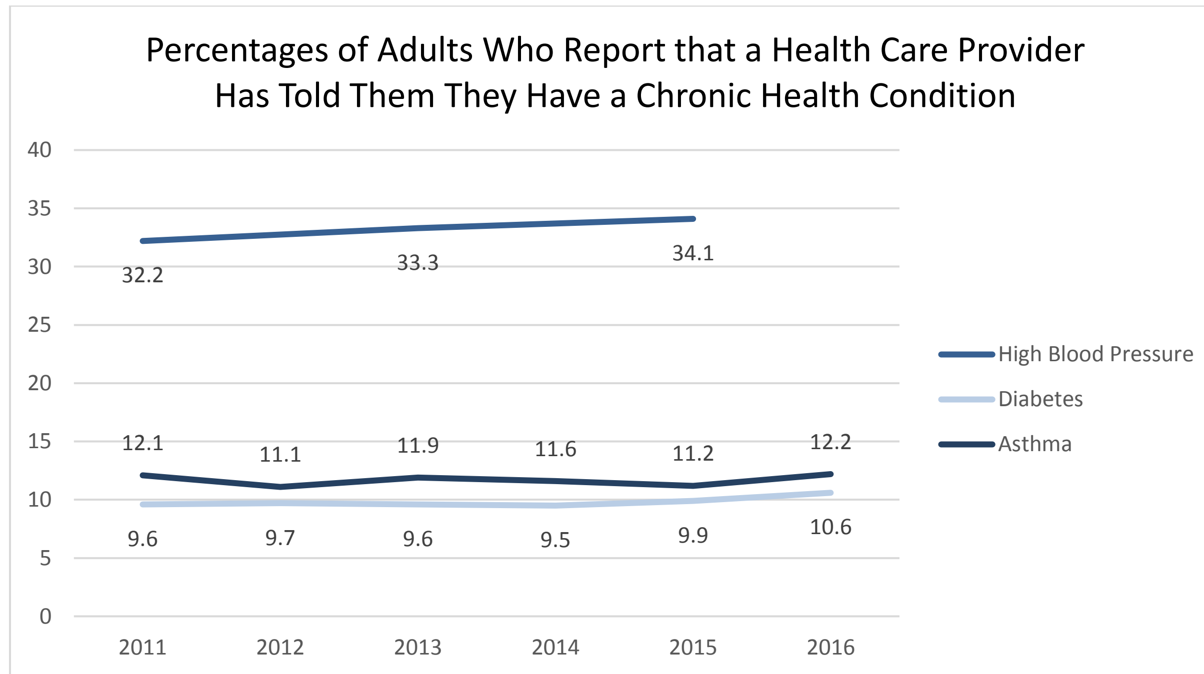
Priority: Cancer			
Goals	**Objectives**	**Strategies**	**Partners**
1. Reduce overall cancer risk in Maine due to selected modifiable risk factors (behaviors)	1.1. Increase by 5% the percentage of teens ages 13-18 who complete the recommended Human papillomavirus (HPV) vaccination series by 2020. *(Baseline: July 2017: 58% for females, 48% for males)*	1.1.A. Provide assessment and feedback information to health care providers by emphasizing HPV vaccinations at regular "AFIX" visits.	**Maine CDC Immunization Program,** health care providers
		1.1.B. Educate health care providers on the importance of keeping patient immunization history information up-to-date.	**Maine CDC Immunization Program,** health care providers
		1.1.C. Provide quarterly assessment reports to heath care providers.	**Maine CDC Immunization Program,** health care providers
		1.1.D. Disseminate best practice information to health care providers on HPV vaccinations via distributions of HPV toolkits, information in the MIP Provider Reference Manual, presentations at regional trainings and outreach to dental offices.	**Maine Immunization Coalition** 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 to 38 per 100,000 by 2020. *(Data source: Maine Cancer Registry, baseline: 40.6 per 100,000 (2012))*	2.1.A. Increase access to evidence-based breast cancer screening and follow-up services to eligible Maine Women o Ages 40-64 o Uninsured and Under-insured (excluding MaineCare members, or those with Medicare Part B) o ≤250% of Federal Poverty Level	**Maine Breast and Cervical Cancer Program,** health care providers
		2.1.B. Distribute information to and support health care providers to adopt USPSTF breast cancer screening recommendations.	**Maine Breast and Cervical Cancer Program,** health care providers
		2.1.C. Provide outreach to and educate under-served Maine women who have not received a mammogram in the past two years.	**Maine Breast and Cervical Cancer Program,** Health care providers

Priority: Cancer *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
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.	**Maine CDC Chronic Disease Program,** Maine Breast and Cervical Cancer Program, health care providers, employers
		2.1.E. Increase cultural competency of health and public health professionals around messaging to the LGBTQ+ community and increase awareness of cancer disparities within the LGBTQ+ community among health care providers and patients.	**Health Equity Alliance (HEAL)/Healthy Communities of the Capital Area (HCCA)**
		2.1.F. Promote screening practices among LGBTQ+ patients	**HEAL/HCCA**
	2.2. Reduce late-stage diagnoses of lung cancer to 71.4% by 2020 *(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.	**Maine CDC Chronic Disease Program**
		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.	**Maine Lung Cancer Coalition**
		2.2.C. Support community-based strategies with health systems and employers that improve self-management behaviors that reduce the risk for developing cancer.	**Maine CDC Chronic Disease Program,** Maine Breast and Cervical Cancer Program, health care providers, employers

Priority: Cancer *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
3. Improve cancer survivorship in Maine through selected modifiable risk factors.	3.1. Reduce the percentage of cancer survivors who use any tobacco products to 11.9% and the percentage who use cigarettes to 9.4% by 2020. *(Baseline: Tobacco products – 16.9%, Cigarette use – 14.4%, 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** Comprehensive Cancer Program, oncology offices

Priority: Chronic Diseases

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.



Data source: Maine Behavior Risk Factor Surveillance System

Priority: Chronic Diseases

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.

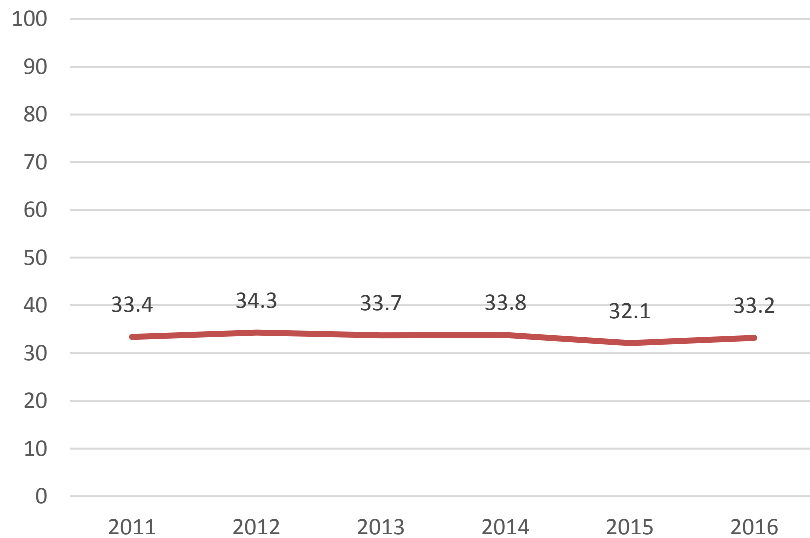
Goals	Objectives	Strategies	Partners
1. Increase self-management of asthma.	1.1. Increase the number of people with asthma and/or their caregivers who are provided with evidence-based asthma self-management education that is funded by Maine CDC* to 650 by 2020. *(Data source: Maine CDC Chronic Disease Prevention and Control Program, baseline (2016) 50)* **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.*	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.	**Maine CDC Chronic Disease Prevention and Control Program,** United Ambulance
		1.1.B. Provide asthma specific training to community partners to enable these service providers to provide evidence-based self-management education.	**Maine CDC Chronic Disease Prevention and Control Program,** 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) to 3,000 by 2020. *(Data source: U.S. CDC DPRP State level data report, baseline: 1,500 (August 2017))*	2.1.A. Develop and implement policies/ protocols that facilitate referral and navigation to U.S. CDC-recognized National DPP provider sites. (see http://rethinkdiabetes.org/wp-content/uploads/2014/07/PFH_PAC-1305_Pre-Diabetes-Algorithm_October-2014.pdf See also: http://www.cdc.gov/diabetes/prevention/pdf/STAT_toolkit.pdf)	**Maine CDC Chronic Disease Prevention and Control Program**, US CDC recognized DPRP\NDPP sites
		2.1.B Increase reimbursement for provision of the National DPP.	**Maine CDC Chronic Disease Prevention and Control Program,** Office of MaineCare Services

Priority: Chronic Diseases *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
2. Increase self-management of pre-diabetes and diabetes. *(continued)*	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 to 6,500 by 2020. *(Data source: Maine CDC DSMT records, baseline: 5,233 (2016))*	2.2.A. Increase the number of locations where accredited DSMT sites offer DSMT services.	**Maine CDC Chronic Disease Prevention and Control Program,** Accredited DSMT sites in Maine
		2.2.B Increase reimbursement for AADE-accredited, ADA-recognized, State-accredited/ certified, or Stanford-licensed DSME programs.	**US CDC, Center for Chronic Disease Prevention and Health Promotion**, 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.	**Maine Office of Aging and Disability Services,** 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 to 36%* by 2020. *(Data source: BRFSS, baseline 34.1% (2016), *may be adjusted in the future to reflect new guidelines)*	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 blood pressure.	**Maine CDC Chronic Disease Prevention and Control Program,** 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 settings supporting patients not at goal for blood pressure control. (see https://millionhearts.hhs.gov/tools-protocols/protocols.html)	**Maine CDC Chronic Disease Prevention and Control Program,** Clinical partners implementing policy and protocol health system interventions

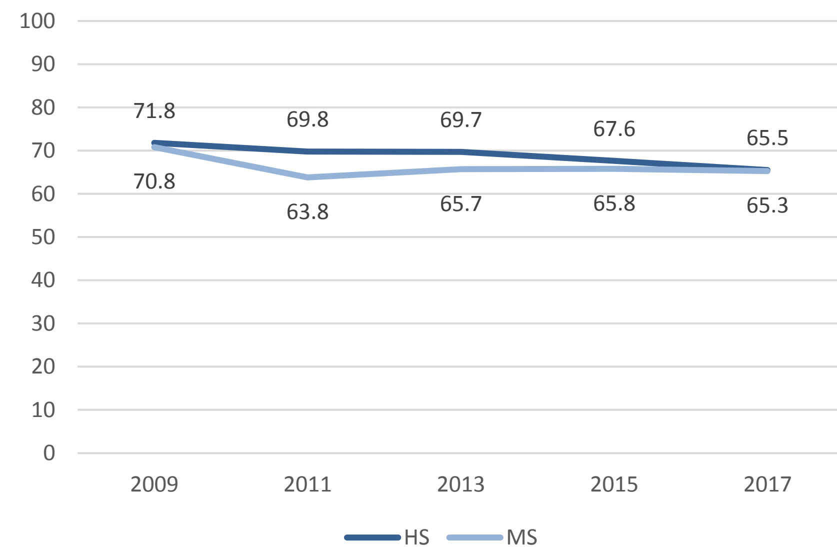
Priority: Chronic Diseases *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
4. Increase self-management of chronic disease among MaineCare members.	4.1. Increase the number of MaineCare members who are enrolled in Health Homes or Behavioral Health Homes *(Data source: Office of MaineCare Services, baseline: TBD target: TBD)*	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 percentage 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: TBD target: TBD)*	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 percentage of MaineCare members with Chronic Obstructive Pulmonary Disease (COPD) whose disease is managed via annual spirometry testing to 66% *(Data source: MaineCare claims, baseline: TBD)*	4.3. Increase spirometry testing in Health Home members with COPD via provider technical assistance and public reporting.	**Office of MaineCare Services**, Health Homes

Priority: Healthy Weight

Like the United States, many people in Maine struggle to maintain a healthy weight and overweight and obesity are epidemic. In 2015, only 33% of Maine adults were at a healthy weight, with 37% overweight and 30% obese (BRFSS). 66% of Maine High School (HS) youth were at a healthy weight, down from 72% in 2009. 17% were overweight and 14% were obese (MIYHS). Middle School (MS) students have a similar pattern of weight status. Being overweight or obese puts individuals at risk for many chronic diseases such as diabetes, cardiovascular disease and cancer, as well as placing burdens our health care systems.



Data source: Maine Behavior Risk Factor Surveillance System



Data source: Maine Integrated Youth Health Survey

Priority: Healthy Weight *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 healthy weight and obesity based on the latest evidence-based 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 them 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 to 16.5% by 2019 *(Data source: MIYHS, baseline: 15.6% (HS) (2017))*	1.1.A. Promote the adoption of food service guidelines/ nutrition standards in schools.	**Let's Go!**, 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.	**Dept. of Education CACFP Program**, 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.	**Let's Go!**, Let's Go Coordinators, Dept. of Education Child Nutrition Services/Maine CDC, School Administrative Units (SAUs)
	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)*	1.2.A. Promote the adoption of food service guidelines/ nutrition standards in worksites.	**Healthy Maine Works Workgroup (Maine CDC),** Let's Go!, Snap-Ed/ University of New England, employers
		1.2.B. Promote healthy eating via incentives in employer wellness programs.	University of Maine System (RiseUp)

Goals	Objectives	Strategies	Partners
	(2019))		
Priority: Healthy Weight *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
1. Increase healthy eating. *(continued)*	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.	**Maine CDC WIC program,** WIC community agencies, Maine Federation of Farmers Markets
		1.3.B. Provide education with clients to encourage children to try new fruits and vegetables.	**WIC community agencies**
		1.3.C. Provide food demonstrations and recipes.	**WIC community agencies**
	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.	**Office of Aging and Disability Services, Healthy Aging Program,** Area agencies on Aging
		1.4.B. Provide meals at senior and other community centers meeting dietary standards to eligible Mainers over the age of 60.	**Office of Aging and Disability Services, Healthy Aging Program,** Area agencies on Aging
		1.4.C. Provide restaurant vouchers for meals meeting dietary standards to eligible Mainers over the age of 60.	**Office of Aging and Disability Services, Healthy Aging Program,** Area agencies on Aging
	1.5. Increase the number of screenings for food insecurity by 10,000 by 9/30/2018. (*Data source*: *EMHS Community Health and Grants internal data, baseline: TBD*)	1.5.A. Educate health practices on the value of screenings, protocols and referral resources.	**EMHS Providers**
		1.5.B. Track the number of screenings provided, the number of providers using the screening tool, and the number of positive screens.	**EMHS (Eastern Maine Health Systems)**
	1.6. Increase by 3 the number of healthier food options offered in hospitals by 9/30/2018. (*Data source*: *EMHS Community Health and Grants*	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.	**EMHS (Eastern Maine Health Systems)**

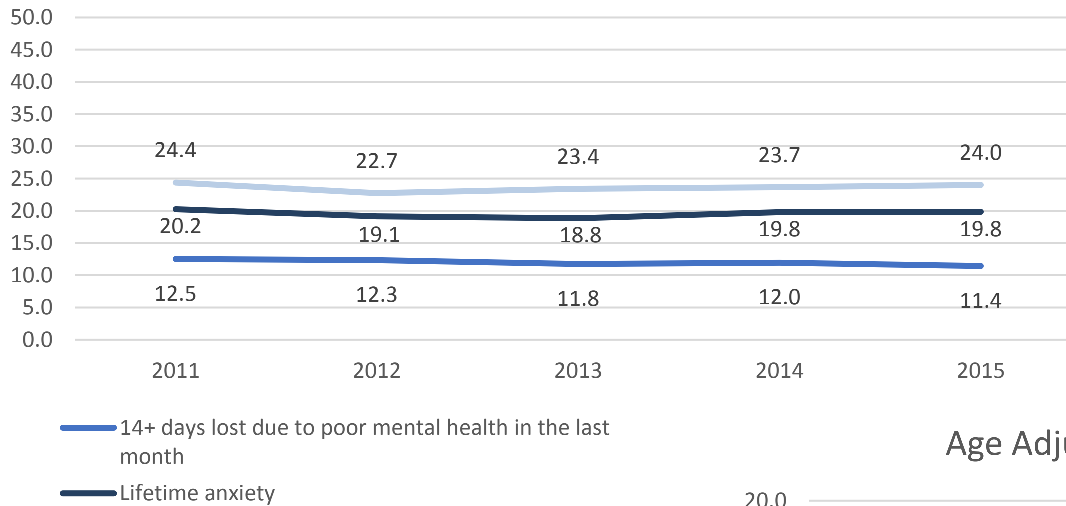
	internal data baseline: TBD)		
Priority: Healthy Weight *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
2. Increase breastfeeding.	2.1. Increase the average maternity practices in infant nutrition and care (mPINC) scores for birthing hospitals to 89 in 2019. *(Data source US CDC mPINC state report baseline: 84 out of 100 (2015))*	2.1.A Implement practices supportive of breastfeeding in prenatal practices and birthing facilities via education, consultation, communication, technical support and quality improvement collaboratives.	**State Breastfeeding Specialist,** 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 to 81% in 2020. *(Data source: WIC Spirit, baseline: 78% (SFY2017))*	2.2.A Provide counseling and consultation to new mothers by certified lactation specialists and peer mothers.	**Maine CDC WIC program,** WIC community agencies
		2.2.B. Loan high-quality breast pumps to WIC mothers who are breastfeeding.	**Maine CDC WIC program,** WIC community agencies
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. *(Data source: MIYHS, baseline: 20.3% (HS) (2017), target: 21.5% (2019)*)	3.1.A Promote the adoption of multi-component physical education policies for schools.	**Maine Dept. of Education,** Maine CDC Let's Go!, SAUs
		3.1.B Promote the adoption of recess policies for schools.	**Maine Dept. of Education,** Maine CDC Let's Go!, SAUs
		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).	**Maine Dept. of Education,** Maine CDC Let's Go!, SAUs
		3.1.D Promote the adoption of physical activity (PA) in early care and education (ECEs).	**Maine CDC,** ECE Providers, PAN in ECE Workgroup, Maine Roads, Let's Go!

Priority: Healthy Weight *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
3. Increase physical activity *(continued)*	3.2. Increase the proportion of adults who meet recommended levels of aerobic physical activity to 55% by 2019. *(Data source: BRFSS, baseline: 53.9% (2015))*	3.2.A. Promote the adoption of physical activity (PA) in worksites.	**Healthy Maine Works Workgroup (Maine CDC),** University of Maine System (RiseUp)
		3.2.B. Design streets and communities for physical activity.	Maine Dept. of Transportation Active Community Environments State Workgroup (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
		3.2.D. Increase the number of municipality planners and Regional Planning Offices that utilize and promote existing recreational opportunities.	**ACEW**, Municipalities Regional Planning Offices
	3.3. Increase the proportion of adults over the age of 65 who meet recommended levels of aerobic physical activity to 57% by 2019. *(Data source: BRFSS, baseline: 55.8% (2015))*	3.3.A Provide exercise and physical activities at senior and community centers.	**Office of Aging and Disability Services, Healthy Aging Program,** Area agencies on Aging
		3.3.B. Provide evidence-based falls prevention classes at community and senior centers	**Office of Aging and Disability Services, Healthy Aging Program,** Area agencies on Aging

Priority: Mental Health

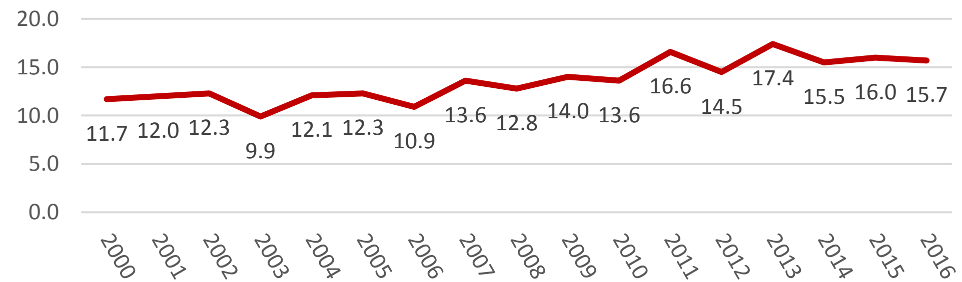
11% of Maine adults have 14 or more days in a month in which their mental health is poor. 24% of Maine adults have been diagnosed with depression in their lifetime, and 20% have been diagnosed with anxiety *(2015 BRFSS)*. On average, 27 people die by suicide every year *(Maine Vital Records, 2011-2015)*.

Percentages of Adults with Poor Mental Health, Anxiety and Depression, Maine



Data source: Maine Behavior Risk Factor Surveillance System

Age Adjusted Suicide Deaths, Maine



Data source: Maine Data, Research, and Vital Statistics, Maine CDC

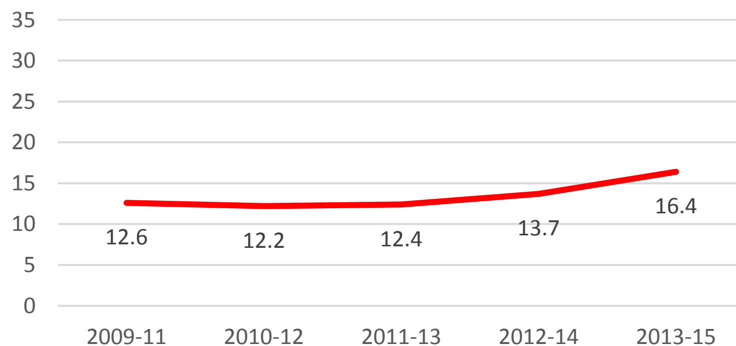
Priority: Mental Health			
Goals	**Objectives**	**Strategies**	**Partners**
1. Improve timely access to care.	1.1. Maintain waitlists to functional zero (*Data Source: SAMHS, baseline: Section 17: 0%; other services: baseline to be determined*)	1.1.A. Meet with all clients face-to-face within seven days of initial contact.	**Office of Substance Abuse and Mental Health Services**, 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 on time as appropriate.	
		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% by 2020. (*Data Source: SAHMS/OFI; baseline: 12%*)	2.1.A. Administer "Need for Change" Assessment as part of Individual Service Plans.	**Office of Substance Abuse and Mental Health Services**, 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. (*Data source: SAMHS assessment tools, Baseline and target to be determined*)	3.1.A. Coordinate efforts between providers, OADS, and Complex Care Unit.	**Office of Substance Abuse and Mental Health Services**, Office of Adult and Disability Services, community behavioral health providers, hospitals
		3.1.B. Analyze assessments for appropriate treatment and housing placements.	
4. Reduce suicide.	4.1. Reduce suicide deaths in adults ages 25 and over to 21.14 per 100,000 by 2020 (*Data source: Maine Vital Records, Baseline: 22.24/100,000 (2015))*	4.1.A. Expand suicide-safer care practices within Maine's Behavioral Health Homes.	**Maine CDC,** Behavioral Health Homes

Priority: Mental Health *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
4. Reduce suicide *(continued)*	4.1. Reduce suicide deaths in adults ages 25 and over *(continued)*	4.1.B. Implement the Towards Zero Suicide model within three community mental health agencies	**Maine CDC,** 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 through better collaboration among hospitals, emergency rooms, inpatient mental health programs and local crisis service providers.	**Maine CDC,** hospitals, crisis service programs
	4.2. Reduce suicide deaths in adults ages 10-24 (*Data source: Maine Vital Records, Baseline: 9.04/100,000 (2015) and target for 2020: 8.59/100,000*)	4.2.A. 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	**Maine CDC,** NAMI Maine, Schools
		4.2.B.Engage educators, medical and mental health providers, and youth serving agencies to increase support and referral for students at risk of suicide or experiencing unmet mental health needs	**Maine CDC,** NAMI Maine, universities, community colleges, and job training programs

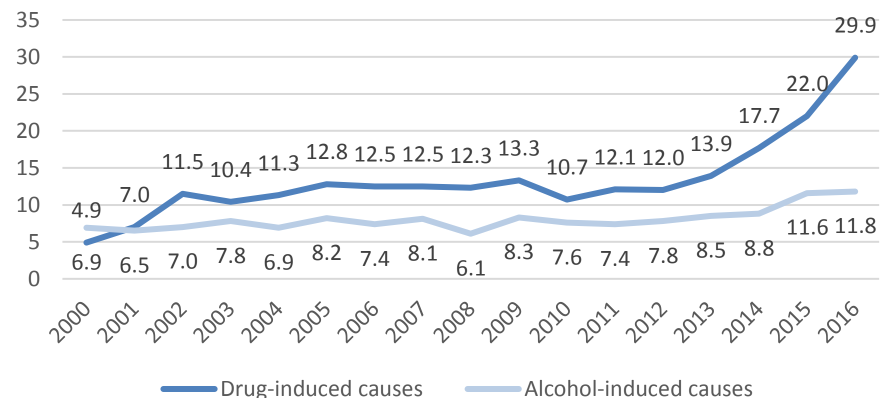
Priority: Substance Use, including Tobacco

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 use 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%t increase since 2015. Four out of five of these deaths involved an opiate or opioid.

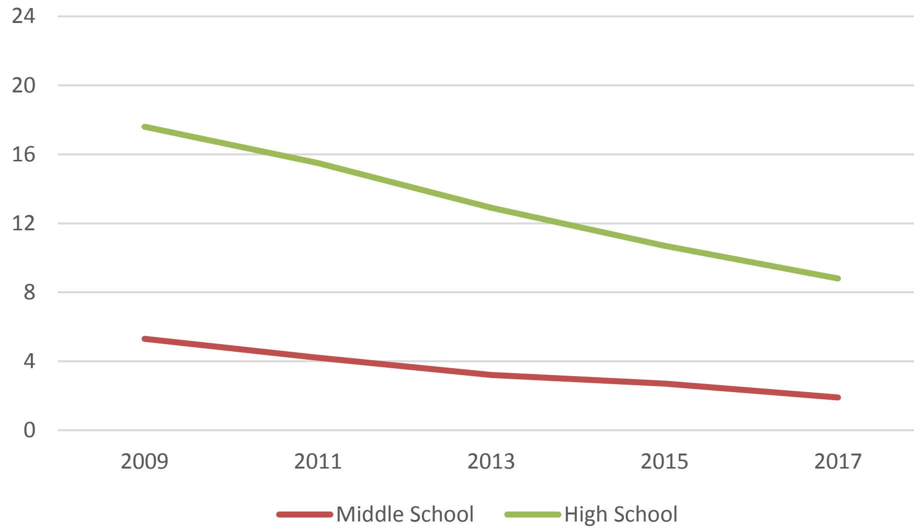
Decreasing substance use and its consequences is most effectively accomplished through a combination of prevention, intervention, and treatment services. Through multiple strategies across multiple domains (such as individual, family, community, and society) the prevention of initiation of use is critical while also providing treatment and recovery services for those who live with an addiction. Engagement of 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 what the data show to be the most critical needs.



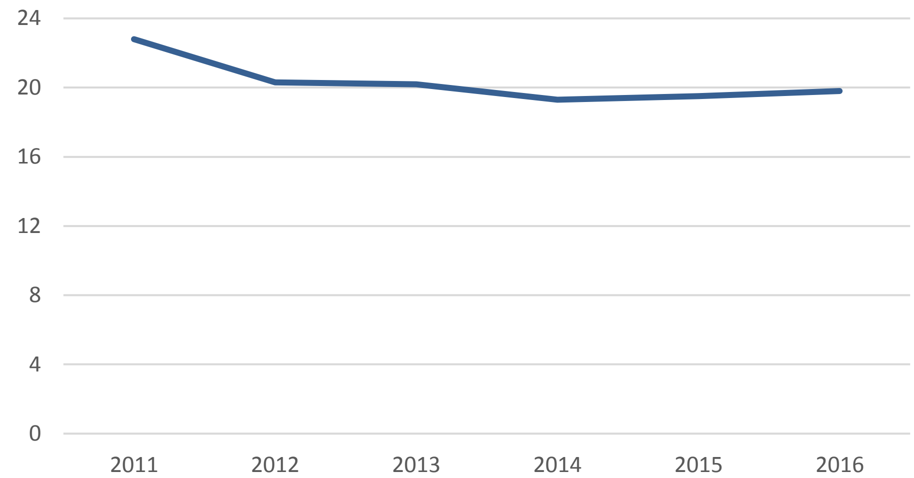
Data source: Maine Data, Research, and Vital Statistics, Maine CDC



Data source: Maine Data, Research, and Vital Statistics, Maine CDC



Data source: Maine Integrated Youth Health Survey



Data source: Maine Behavioral Risk Factor Surveillance System

Priority: Substance Use, including Tobacco			
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 1.46% in 2019 (MIYHS) and among Maine's HS students from 5.9% in 2015 to 5.75% in 2019 (MIYHS).	1.1.A. Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients, Rinck Advertising, AdCare Educational Institute, Schools
		1.1.B. Disseminate Information through brochures, posters, flyers, social media, TV and radio on safe storage and disposal, and the risks and dangers of prescription drug misuse.	**Maine CDC,** 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).	**Maine CDC,** University of New England & 22 Community sub-recipients
	1.2. Reduce lifetime prescription drug misuse among Mainers ages 18-25 from 9.4% in 2013-15 to 9.17% in 2017-19 (BRFSS).	1.2.A. Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients, Rinck Advertising, AdCare Educational Institute, Schools, EMHS (Eastern Maine Health Systems)
		1.1.B. Disseminate information through brochures, posters, flyers, social media, TV and radio on safe storage and disposal, and the risks and dangers of prescription drug misuse.	**Maine CDC,** 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).	**Maine CDC,** University of New England & 22 Community sub-recipients.

Priority: Substance Use, including Tobacco *(continued)*

Goals	Objectives	Strategies	Partners
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 1,000 people in 2020.	2.1.A Train providers in safe prescribing practices	**Maine CDC, Office of Substance Abuse and Mental Health Services,** Maine Medical Association, AdCare Educational Institute, University of New England & 22 Community sub-recipients, EMHS (eastern Maine Health Systems)
		2.1.B Promote the use of the prescription monitoring program among providers to reduce access and availability of opiates and prevent patients from getting prescriptions from multiple doctors.	
		2.1.C. Encourage pain management alternatives to prescriptions for MaineCare members.	**Office of MaineCare Services,** Change Health, Health care providers
		2.1.D. Encourage use of non-opioid prescriptions for MaineCare members.	**Office of MaineCare Services,** Change Health, Health care providers
	2.2. Compliance with limits of prescription doses (100 Morphine Milligram Equivalent) (baseline: 93%; target 100%).	2.2.A. Identify high prescribers and address via academic detailing and/or non-compliance process.	**Office of Substance Abuse and Mental Health Services**
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 state-wide media campaign on safe storage and disposal of medication, the dangers of sharing medication and the dangers associated with opiate addiction.	**Maine CDC Tobacco and Substance Use Prevention and Control Program, Office of Substance Abuse and Mental Health Services,** Rinck Advertising
		3.1.B. Promote syringe exchange statewide and safer drug use education.	**Health Equity Alliance (HEAL)** & Maine Harm Reduction Alliance (MEHRA)
		3.1.C. Distribute Naloxone among people who use drugs state-wide.	**HEAL** & MEHRA
		3.1.D. Promote Law Enforcement Assisted Diversion – Bangor.	**HEAL**
		3.1.E. Increase HIV/HCV testing.	**HIV service organizations**, including HEAL

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
4. Increase access to effective substance use treatment services.	4.1. Reduce waitlists for substance use services. *(Baseline and target to be determined.)*	4.1.A. Map and analyze Medicine Assist Treatment (MAT) waitlist data.	**Office of Substance Abuse and Mental Health Services**
		4.1.B Use hot-spotting and syndromic data to identify and address critical needs.	**Office of Substance Abuse and Mental Health Services**, Maine CDC, Infectious Disease Epidemiology Program
		4.1.C. Include law enforcement and other stakeholders in data analytics.	**Office of Substance Abuse and Mental Health Services**, Department of Public Safety
		4.1.D. Align OTP regulations with federal regulations.	**Office of Substance Abuse and Mental Health Services**
		4.1.E. Address other barriers to services by developing additional resources where necessary.	**Office of Substance Abuse and Mental Health Services**
		4.1.F. Maintain substance use medicine assisted treatment (MAT) locator via Maine 211.	**Office of Substance Abuse and Mental Health Services**
		4.1.G. Provide SBIRT, warm hand-offs, 3-day and 30-day check-ins via 211.	**Office of Substance Abuse and Mental Health Services**
		4.1.H. Increase the number of qualified Medication Assisted Treatment (MAT) prescribers.	**EMHS (Eastern Maine Health Systems)**
	4.2. Increase the number of Opioid Health Homes where patients with substance use disorders receive integrated health care and substance use treatment. *(Baseline and target to be determined.)*	4.2.A. Create Opioid Health Homes that ensure best practices of Medicated assisted treatment are integrated with patients' other health needs.	**Office of MaineCare Services**

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
4. Increase access to effective substance use treatment services.	4.3. By 9/30/2018, increase the number of qualified Medication Assisted Treatment (MAT) prescribers *(baseline and target to be determined)*	4.3.A Encourage providers to become Medication Assisted Treatment (MAT) prescribers.	**EMHS (Eastern Maine Health Systems)**
5. Increase employment among Mainers who have substance use disorders.	5.1. Increase employment among clients under Sections 65 and 97 to greater than 50% *(Data source: SAMHS, baseline: 48%)*	5.1.A. Administer "Need for Change" Assessment as part of Individual Treatment Plans.	**Office of Substance Abuse and Mental Health Services**, community agencies
6. Increase stable housing among Mainers who have substance use disorders.	6.1. Increase housing in the community among clients under Sections 65 and 97 *(Data source: SAMHS, baseline and target TBD)*	6.1.A Provide housing resources via Individual Treatment Plans.	**Office of Substance Abuse and Mental Health Services**, 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 *(Data source: DHHS, baseline and target TBD)*	7.1.A Improve data collection to distinguish between women in MAT versus illicit use.	**Maine DHHS, hospitals**
		7.1.B. Promote the use of the evidence-based Snuggle ME guidelines to increase screening of pregnant women for substance use.	**Maine CDC Maternal and Child Health Program,** Maine CDC Substance and Tobacco Use Prevention and Control Program
		7.1.C. Provide technical assistance to Behavioral Health Homes to implement Snuggle ME guidelines.	**Maine CDC Maternal and Child Health Program,** Office of MaineCare Services, Maine CDC Substance and Tobacco Use Prevention and Control Program

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
7. Reduce the number of substance-exposed infants due to illicit substances *(continued).*	7.1. Reduce the number of substance-exposed infants due to illicit substances *(continued).*	7.1.D. Promote substance use treatment for women who are pregnant or may become pregnant via targeted social media messaging and sponsored search results.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** Rinck Advertising
8. Reduce underage drinking among persons aged 12 to 20.	8.1. Reduce the past 30-day alcohol use among 7th & 8th graders from 3.7% in 2017 to 3.61% in 2019 and among HS students from 22.5% in 2015 to 21.94% in 2019 (MIYHS).	8.1.A Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients, Rinck Advertising, AdCare Educational Institute, Schools, EMHS
		8.1.B Disseminate information through brochures, posters, flyers, and social media on underage drinking, binge drinking, the risks and dangers of alcohol use, and the importance of parental modeling/monitoring.	**Maine CDC Tobacco and Substance Use Prevention and Control Program** 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** University of New England & 22 Community sub-recipients.
		8.1.D. Implement policies including local ordinances, pricing and promotion of alcohol, underage drinking law enforcement details.	**Maine CDC Tobacco and Substance Use Prevention and Control Program** University of New England & 22 Community sub-recipients.
		8.1.E. Implement mass reach health communications on underage drinking.	**Maine CDC Tobacco and Substance Use Prevention and Control Program** Rinck Advertising

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
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 from 41.6% in 2014-15 to 40.56% in 2018-19 *(BRFSS)*	8.2.A Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients, Rinck Advertising, AdCare Educational Institute, Schools, EMHS
		8.2.B Disseminate information through brochures, posters, flyers, and social media on underage drinking, binge drinking, the risks and dangers of alcohol use, and the importance of parental modeling/monitoring.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients
		8.2.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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients
		8.2.D. Implement policies including local ordinances, responsible beverage server training, pricing and promotion of alcohol, underage drinking law enforcement details.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients
		8.2.E. Implement mass reach health communications to raise awareness about underage and binge drinking.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** Rinck Advertising

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
9. Reduce marijuana use among persons aged 12 to 20.	9.1. Reduce the past 30-day use of marijuana among 7th & 8th graders from 3.6% in 2015 to 3.51% in 2019 and among HS students from 19.3% in 2015 to 18.82% in 2019 (MIYHS).	9.1.A Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients, Rinck Advertising, EMHS
		9.1.B Disseminate information through brochures, posters, flyers, and 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients
		9.1.C Implement policies and local ordinances to reduce access and availability of marijuana for youth and to increase the perception of harm of use.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients.
		9.1.F Implement mass reach health communications to raise awareness about the risks and dangers of marijuana use.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** Rinck Advertising
	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)*	9.2.A Educate 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients. Rinck Advertising

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
9. Reduce marijuana use among persons aged 12 to 20 *(continued).*	9.2. Reduce the past 30-day use of marijuana among Mainers ages 18-25 *(continued).*	9.2.B Disseminate information through brochures, posters, flyers, and 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients.
		9.2.C Implement policies and local ordinances to reduce access and availability of marijuana for young adults and to increase the perception of harm of use.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients.
		9.2.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)	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** University of New England & 22 Community sub-recipients.
		9.2.E Implement mass reach health communications to raise awareness about the risks and dangers of marijuana use.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** Rinck Advertising
10. Prevent initiation of tobacco use.	10.1. Reduce past 30-day tobacco use among 7th & 8th graders from 2.5% (2017) to 2.44% in 2019 and among high school students from 13.9% (2017) to 13.55% 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** MaineHealth-Center for Tobacco Independence and community sub-recipients

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
10. Prevent initiation of tobacco us *(continued).*	10.1. Reduce past 30-day tobacco use among 7th & 8th graders *(continued).*	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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** MaineHealth-Center for Tobacco Independence and community sub-recipients
		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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** 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, etc. to assist retailers with carding youth and young adults for tobacco sales.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** MaineHealth-Center for Tobacco Independence and community sub-recipients, Rinck Advertising

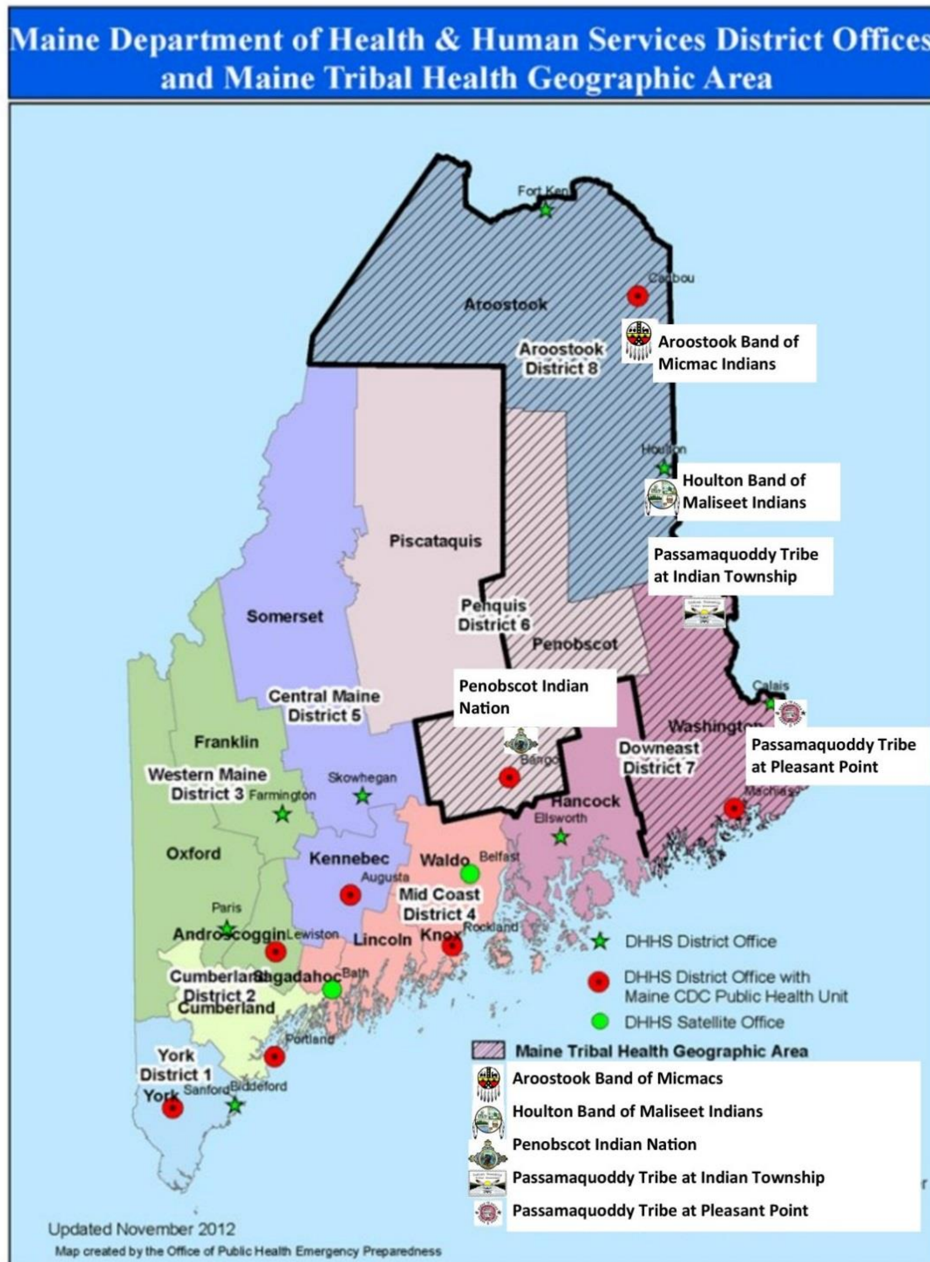
Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
11. Eliminate nonsmokers' exposure to secondhand smoke.	11.1. Reduce exposure to secondhand smoke in the home environment among 7th and 8th graders from 22.8% (2017) to 22.23% in 2019 and among high school students from 31.1% (2017) to 30.32% by 2019. *(MIYHS)*	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 by 1,000 for the year).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** 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 by 10 for the year).	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** MaineHealth-Center for Tobacco Independence and community sub-recipients
		11.1.D. 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program,** MaineHealth-Center for Tobacco Independence and community sub-recipients
		11.1.E. Collaborate with chronic disease programs within the Division regarding the linkages between chronic disease and SHS for both youth and adults.	**Maine CDC Tobacco and Substance Use Prevention and Control Program**

Priority: Substance Use, including Tobacco *(continued)*			
Goals	**Objectives**	**Strategies**	**Partners**
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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** MaineHealth-Center for Tobacco Independence
		12.1.D. Increase the number of tailored treatment approaches for tribal and Lesbian, gay, Bisexual, transgender and Queer youth from 0 in FFY17 to 2 in FFY18 (baseline 0; increase of 2 for the year).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** MaineHealth-Center for Tobacco Independence
		12.1.E. Increase the number of health care provider 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).	**Maine CDC Tobacco and Substance Use Prevention and Control Program** 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.	**Maine CDC Tobacco and Substance Use Prevention and Control Program**

District Public Health

Improvement Plans

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.

Aroostook

Priority Area 1: Drug and Alcohol Abuse

Priority Statement: Increase resources needed to meet the challenge posed by drug and alcohol abuse.			
Description/Rationale/Criteria: According to the 2015 Shared Community Health Needs Assessment data, 80% of 110 Aroostook District stakeholders rated drug and alcohol abuse as a major or critical health challenge in the county. Those stakeholders also identified that greater access to drug/alcohol treatments; greater access to substance abuse prevention programs; and more substance abuse treatment providers were among the community resources necessary to address the health challenge. These sentiments were echoed by participants at each of three regional Community Engagement forums conducted throughout the District. The recommendations are consistent with the fact that 65% also felt that the health system (including public health) did not have the ability to significantly improve access to behavioral care/mental health care with the current investment of time and resources. This suggests that coordination, collective effort, and additional resources should be directed to addressing Drug and Alcohol Use as a district-wide public health priority.			
Goals	**Objectives**	**Strategies**	**District Partners**
1. Reduce the impact of drug and alcohol abuse by supporting and enhancing the behavioral health of Aroostook County residents.	1.1. Access to Intervention and Treatment Resources: Enhance the continuum of care for Aroostook County residents who struggle with substance abuse issues.	1.1.A. Increase behavioral health service capacity in Aroostook District by increasing the number of individuals who enter the profession by 20 professionals by June 2019.	Aroostook Mental Health Center (AMHC), University of Maine at Fort Kent, Pines Health Services, Cary Medical Center, Northern Maine Community College, The Aroostook Medical Center (TAMC)
		1.1.B. Increase the collaboration between behavioral health and primary care providers, through adoption of integration models such as Behavioral Health Homes or Community Care Teams.	Pines Health Services, Fish River Rural Health Services, TAMC/BEACON CCT, Aroostook Mental Health Center
		1.1.C. Increase the number of primary care providers that perform substance abuse screening as a regular practice by implementing SBIRT or other evidence- based screening tools.	Fish River Rural Health Services
		1.1.D. Increase the availability of resources for Aroostook District residents to provide support for individuals with substance abuse issues.	Aroostook Mental Health Center, MSAD # 1

Aroostook Priority Area 1: Drug and Alcohol Abuse *(continued)*

Goals	Objectives	Strategies	District Partners
1. Reduce the impact of drug and alcohol abuse by supporting and enhancing the behavioral health of Aroostook County residents *(continued)*	1.2. Public Education: Increase awareness of substance abuse issues (for prevention resources, etc.) for adult populations in Aroostook District.	1.2.A. Increase awareness of the impact of substance abuse in Aroostook District	Cary Medical Center
		1.2.B. Increase awareness of resources for Aroostook District residents to support individuals with substance abuse issues.	Cary Medical Center, Aroostook Mental Health Center, MSAD # 1

Aroostook Priority Area 2: Cardiovascular Health

Priority Statement: Reduce the incidence of morbidity and mortality of chronic cardiovascular disease so Aroostook residents live longer, healthier lives.

Description/Rationale/Criteria:

Aroostook District has a number of statistically significant cardiovascular related health indicators that rank the District highest among all public health districts in the State of Maine. These include:

- Acute myocardial infarction hospitalizations per 100,000 [Aro=39.5; ME=23.5]
- Acute myocardial infarction mortality per 100,000 [Aro=40.0; ME 32.3]
- Coronary heart disease mortality per 100,000 [Aro=111.8; ME= 89.8]
- Hypertension prevalence [Aro= 40.7%; ME= 32.8%]
- Hypertension hospitalizations per 100,000 [Aro= 70.1; ME= 28.0]
- Diabetes mortality (underlying cause) per 100,000 [Aro=24.3; ME=20.8]
- Current smoking (adults) [Aro=22.8%; ME= 20.2%; US= 19.0%]
- Current smoking (high school students) [Aro= 16.4%; ME= 12.9%; US= 15.7%]

Goals	Objectives	Strategies	District Partners
2. Reduce the health impacts of cardiovascular disease on Aroostook residents.	2.1. Leadership and Collaboration: Build capacity of communities in Aroostook County to work together to optimize population-based cardiovascular health at the individual and community level by engaging the business community.	2.1.A. Increase the number of employers offering evidence-based wellness programming, such as Healthy US, to their employees.	Pines Health Services, Cary Medical Center, Aroostook County Action Program, Inc. (ACAP), Visiting Nurses of Aroostook, University of Maine at Fort Kent, TAMC

Aroostook Priority Area 2: Cardiovascular Health *(continued)*

Goals	Objectives	Strategies	District Partners
2. Reduce the health impacts of cardiovascular disease on Aroostook residents. *(continued)*	2.2. Promote Evidence-based Preventive Services, Resources and Secondary Prevention Practices: Increase the use of evidence-based preventative services, resources, and secondary prevention practices to reduce the incidence and impact of cardiovascular disease.	2.2.A. Increase the number of policies that facilitate low cost/no cost hypertension screening opportunities for Aroostook District residents.	
		2.2.B. By December 31, 2018, increase the percentage of worksites that offer a wellness program, which includes blood pressure screening, for all employees.	Aroostook County Action Program, Inc.
		2.2.C. By June 2018, increase the number of health care providers utilizing the National Diabetes Prevention Program or other evidence-based diabetes prevention guidelines to 100%.	
		2.2.D. By December 2019, increase access to evidence based tobacco cessation programming.	Aroostook County Action Program, Inc.
	2.3. Nutrition: Decrease the number of Aroostook District residents that eat a diet that places them at increased risk of cardiovascular disease.	2.3.A. By December 2017, increase access to nutritionally sound foods for vulnerable populations at increased risk of diet related cardiovascular/ diabetic complications.	Northern Maine Development Commission
	2.4. Public and Professional Education: Increase awareness of evidence based strategies for improving cardiovascular health.	2.4.A. Increase cardiovascular health promotion and disease prevention education activities to enhance behavior and lifestyle changes at the community level.	Fish River Rural Health Services
		2.4.B. Increase the number of health organizations that utilize emerging technology, such as tele- health for the management of cardiovascular disease in Aroostook District from 1 to 3 by 2019.	Visiting Nurses Home Health and Hospice

Aroostook Priority Area 3: Nutrition and Physical Activity

Priority Statement: Increase opportunities for Aroostook County residents to be active and eat healthier foods.			
Description/Rationale/Criteria: According to the 2015 Shared Health Needs Assessment stakeholder survey, "Obesity" was rated as the "biggest health issue in Aroostook County". This assertion is evidenced by statistical data as well. In 2013, 38.3% of adults in Aroostook were obese (BMI of 30 or more) compared to 28.9% for the State of Maine and the national average of 29.4%. Statistics also suggest that as a population, Aroostook residents are more sedentary, eat less fruits and vegetables and drink more sports drinks and sodas. These factors are complicated by economics in Aroostook District. There are more people living in poverty [Aro= 16.3%; ME= 13.6%] and a lower median household income [Aro= $37,855; ME= $48,453; US= $53,046] in the County. Since Physical Activity, Nutrition and Weight indicators can also be linked to cardiovascular disease prevention, making obesity and overweight a priority has a cumulative effect in the overall mission to improve health outcomes for residents of Aroostook District.			
Goals	**Objectives**	**Strategies**	**District Partners**
3. Reduce the impact of obesity and unhealthy weight in Aroostook District.	3.1. Food Insecurity: Decrease food insecurities among Aroostook District residents by increasing access to food sources such as food pantries and meal centers.	3.1.A. Complete a baseline assessment of Aroostook District food pantries and meal sites in order to determine access issues.	ACAP, University of Maine Cooperative Extension, Northern Maine Recreation Directors, Houlton Regional Hospital, TAMC
		3.1.B. Assist Aroostook District food pantries and meal sites in recruitment of volunteers to expand hours of operation by 20%.	
	3.2. Physical Activity: Increase the percentage of adults who have met physical activity recommendations.	3.2.A. Increase the number of sites that offer low cost or free access to physical activity through collaboration with organizations that focus on physical activity.	
		3.2.B. Promote what is available in the community to increase physical activity for families where childcare could be an issue.	Presque Isle Community Garden
	3.3. Healthy Foods: Increase the number of Aroostook County residents consuming a healthy diet.	3.3.A. Increase the number of Aroostook District residents with access to nutrition education.	University of Maine Cooperative Extension, Houlton Adopt-A-Block
		3.3.B. Increase awareness of the opportunities to learn healthy food preparation and consumption.	University of Maine Cooperative Extension, Presque Isle Community Garden

Central

Priority Area 1: Substance Use (including tobacco)

Description/Rationale/Criteria: Decreasing substance use, including tobacco, was identified as a top priority during the Community Health Needs Assessment and the DCC meetings in 2016. It is a preventable health risk that can lead to increased medical costs, injuries, cardiovascular disease, numerous cancers, and death. According to the Maine Shared Community Health Needs Assessment, district rates of alcohol related mortality, opiate poisoning, and drug affected baby referrals are all slightly above State averages. All District tobacco indicators are slightly above State averages as well, with secondhand smoke exposure among youth being significantly higher in Somerset County (46.6% v. 38.3%). Objectives are focused on reducing stigma - a recommendation of the May 2016 report of the Maine Opiate Collaborative; improving supports for those seeking treatment; and building resilience to prevent beginning substance use or relapse of those in recovery.

Selected References:

Substance Abuse and Mental Health Services Administration Prevention Approaches http://bit.ly/2m8MLjs
Maine Community Health Needs Assessment Data Summary Central - Full list
MIYHS/BRFSS Data for Maine/Central District http://bit.ly/2narZN4
Maine Opiate Collaborative Recommendations: http://bit.ly/2oCIHpv

Goals	Objectives	Strategies	District Partners
1. Reduce substance use in the District.	1.1. Increase the number of district resources available to reduce stigma associated with seeking treatment for substance use/ mental health disorders and tobacco use.	1.1.A. Complete district inventory and gap analysis of available resources for prevention, treatment, or recovery, that address stigma.	Alfond Youth Center, Eastern Maine Health System, Educare, Community Care Teams, Crisis & Counseling Center, Discovery House Central Maine, Good Will-Hinckley, Health Reach Community Health Centers, Healthy Communities of Capital Area, Healthy Northern Kennebec, Healthy Sebasticook Valley, Inland Hospital, Kennebec Behavioral Health, Kennebec Valley Community Action Program, Kennebec Valley YMCA, Maine Alliance for Addiction Recovery, Maine CDC, Maine Children's Home for Little Wanderers, MaineGeneral Health, Redington-Fairview General Hospital, Sebasticook Family Doctors, Sebasticook Valley Hospital, Skowhegan Family Medicine, School Health Coordinators, Nurses, Resource Officers, Somerset Public Health, Somerset County Association of Resource Providers, Spectrum Generations, Togus VA, United Way of Mid-Maine, Youth Matter, full DCC
		1.1.B. Develop and implement district-specific marketing and communication strategy to reduce stigma.	

Central Priority Area 1: Substance Use (including tobacco) *(continued)*

Goals	Objectives	Strategies	District Partners
1. Reduce substance use in the District *(continued).*	1.2. Increase the number of district schools and community groups that use evidence based/ best practice programs that promote resilience and healthy decision-making.	1.2.A. Conduct an inventory / gap analysis of programs that promote resilience and healthy decision making.	Organizations listed above, plus full DCC
		1.2.B. Host community gatherings in at least 3 school districts to highlight the need for resilience / healthy decision making programs and promote those currently available.	Organizations listed above, especially Drug-Free Communities Grantees, plus full DCC
		1.2.C. Increase educational opportunities for school administration and staff on programs that promote resilience, healthy decision making, and other positive behavioral interventions.	Organizations listed above, especially Drug-Free Communities Grantees, plus full DCC
		1.2.D. Partner with schools to implement programs and policies that promote resilience, healthy decision making, and other positive behavioral interventions as alternatives to suspension for substance/tobacco use infractions.	Organizations listed above, especially Drug-Free Communities Grantees, plus full DCC
	1.3. Improve the effectiveness and increase the number of supports for individuals seeking treatment for, or in recovery from, substance use disorder or tobacco use.	1.3.A. Work with community partners to improve referral process to appropriate interventions.	Organizations listed above, especially care navigators and the health care system, plus full DCC
		1.3.B. Develop plan to increase the number of trained recovery coaches in the District.	Organizations listed above, plus full DCC
		1.3.C. Identify or create a system to connect recovery coaches to those in need of a recovery coach.	Organizations listed above, plus full DCC

Central Priority Area 2: Adverse Childhood Experiences

Description/Rationale/Criteria: Adverse childhood experiences (ACEs) were identified as a top priority during the Community Health Needs Assessment and the DCC meetings in 2016. They are a broad spectrum of stressful or traumatic events which have a strong correlation to the development and prevalence of a wide range of detrimental health outcomes across the lifespan. In the Central District, there is a higher than average poverty rate among children (18.5 % Statewide v.19.9% in the District; 24.9% in Somerset County), and the rate of substantiated abuse and neglect claims has risen since 2013 from 22% to 27% in Kennebec County and from 32% to 35% in Somerset County (OCFS Annual Report). Work on ACEs and improving resilience in the district is intended to also help address the other identified health improvement priorities (substance use and obesity).

Selected References:

CDC-Kaiser ACEs Study: Summary http://bit.ly/2bE4USy *Full Study:* http://bit.ly/1EGRH0J

American Journal of Preventive Medicine: Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults http://bit.ly/1EGRH0J

2014 Annual Meeting of the Population Association of America: Long Term Physical Health Consequences of Adverse Childhood Experiences http://bit.ly/2m9jncH

Center on the Developing Child at Harvard University (2016). From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families. Retrieved from www.developingchild.harvard.edu

Center on the Developing Child at Harvard University (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13. Retrieved from www.developingchild.harvard.edu

Maine Community Health Needs Assessment Data Summary Central - Full list

Goals	Objectives	Strategies	District Partners
2. Reduce ACEs and increase resilience in the District.	2.1. Increase the knowledge of the health impact of ACEs -- among Law Enforcement, Early Educators, Businesses, Child Serving Organizations, and other relevant Community Organizations.	2.1.A. Assess and analyze current knowledge of the health impact of ACEs.	Organizations listed above, plus/especially Law Enforcement, Early Educators, Businesses, Clinicians, and Child-Serving Organizations; and the Maine Resilience Building Network
		2.1.B. Create a plan to increase awareness of the health impacts of ACEs.	
	2.2. Increase the use of ACEs screening tools.	2.2.A. Assess the current use of ACEs screening tools.	
		2.1.B. Create a plan to increase the use of ACEs screening tools.	
		2.2.C. Provide training on health impacts of ACEs and value of ACEs screening.	
	2.3. Increase the number of professionals trained in and using practices that develop resilience.	2.3.A. Assess number of professionals using practices that develop resilience.	
		2.3.B. Plan, promote, and offer 3-6 resilience trainings in locations throughout the District.	

Central Priority Area 3: Obesity

Description/Rationale/Criteria: Obesity reduction and prevention was identified as a top DPHIP priority during the Community Health Needs Assessment and the DCC meetings in 2016. Obesity in the Central District is higher than State averages among both high school students (15.2% vs. 12.7%) and adults (30% vs. 28.9%). Additionally, the consumption of sugar sweetened beverages among teens is 1.7% higher in the District than State averages. Among adults, fruit consumption is 10% lower, and vegetable consumption is 2.3% lower than State averages. The interventions below focus primarily on obesity prevention through improved nutritional choices.

Selected References:

Institute of Medicine Recommendations to Accelerate Progress in Obesity Prevention http://bit.ly/2lskTCE
CDC Data / Statistics on Sugar Sweetened Beverage Intake: http://bit.ly/2cb0KS3
CDC Impact of reducing Sugar Sweetened Beverage Intake http://bit.ly/29ZL6Yz
CDC Guide to Increase Fruit and Vegetable Consumption: http://bit.ly/2lULiN6
Maine Community Health Needs Assessment Data Summary Central - Full list
MIYHS and BRFSS Data for Maine / Central District: http://bit.ly/2narZN4

Goals	Objectives	Strategies	District Partners
3. Decrease obesity in the District.	3.1. Decrease the use of sugar sweetened beverages (SSB).	3.1.A. Identify or develop district/ population appropriate SSB messages and point of decision prompts to promote water at local businesses, school, and community settings.	Organizations listed above, plus/especially Businesses, Schools, and Community Organizations serving SSB
		3.1.B. Identify format and delivery channels for SSB messages and point of decision prompts.	
		3.1.C. Disseminate SSB messages through appropriate delivery channels.	
		3.1.D. Disseminate point of decision prompts to local businesses, schools, community organizations.	
	3.2. Increase fruit and vegetable consumption.	3.2.A. Convene stakeholders to determine barriers to increasing fruit and vegetable consumption in food serving institutions.	Organizations listed above, plus/especially Schools, child care, Hospitals, Nursing Homes, and Community Institutions serving food
		3.2.B. Create plan to address barriers to increasing fruit and vegetable consumption in food serving institutions.	

Cumberland

Priority Area 1: Substance Use Prevention

Description/Rationale/Criteria: Substance Use Prevention was chosen because it was identified by multiple stakeholders and partners that it was of top priority. It was selected by 100% of Cumberland District hospitals as an implementation strategy through their community health needs assessments; was identified as a community goal through United Way of Greater Portland's Thrive 2027 initiative; and received the most votes among Cumberland DCC members and interested parties. According to the 2015 Cumberland County CHNA Summary (CHNA), binge drinking of alcoholic beverages was much higher for adults in Cumberland County (20.7%) than in Maine (17.4%) and the U.S. (16.8%). Chronic heavy drinking in adults was also found to be higher in Cumberland County (9.0%) than in Maine (7.3%) and the U.S. (6.2%).

Goals	Objectives	Strategies	District Partners
Goal 1: Reduce substance use rates in populations aged 25 years and older.	1.1. Enhance coordination of district-wide substance use prevention efforts.	1.1.A. Conduct a community scan to identify which stakeholders should be invited to district-wide forums of substance use prevention stakeholders, taking into account communities experiencing health disparities. (Community-based Process).	Prevention services grantees, hospitals, Drug-free Communities grantees, municipalities, community-based organizations, community members, law enforcement
		1.1.B By June 30, 2019, convene at least 3 District-wide forums of substance use prevention stakeholders with the goal of identifying and coordinating the various activities, as well as to exchange ideas and network.	
	1.2. Increase awareness of substance use prevention, intervention, treatment and recovery resources.	1.2.A Update local service directories on substance use prevention, intervention, treatment and recovery services.	Prevention services grantees, hospitals, Drug-free Communities grantees, municipalities, community-based organizations, community members, law enforcement
		1.2.B. Disseminate local service directories on substance use prevention, intervention, treatment and recovery services to substance use prevention stakeholders.	
	1.3 By June 30, 2019, 10 municipal ordinances will be passed that address responsible marijuana vending practices.	1.3.A. Provide information to municipal officials on their authority to enact ordinances related to retail marijuana. (Education)	Municipal officials, law enforcement, marijuana growers and vendors, community partners.
		1.3.B. Provide ongoing technical assistance on best practice marijuana ordinances to 10 municipal officials and local vendors. (Education)	
	1.4 By June 30, 2019, 10 municipalities will pass policies increasing the availability of naloxone in municipal buildings.	1.4.A. Assess which municipalities are interested in having naloxone available in their municipal buildings. (Community-based Process)	Municipal officials and employees, community partners
		1.4.B. Provide technical assistance to 10 municipalities in crafting a policy around naloxone availability in municipal buildings. (Education)	

Cumberland Priority Area 2: Healthy Weight

Description/Rationale/Criteria: Obesity prevention was determined to be a top DPHIP priority as a result of several community processes including the Cumberland District CHNA and SHNAPP forums, the United Way of Greater Portland's Thrive 2017 process and most recently, the Cumberland DCC's DPHIP priority-setting discussion, stakeholder survey and content expert focus groups. The DPHIP Goals outlined below seek to prevent obesity and promote healthy weight by increasing physical activity and consumption of fruits and vegetables by children and adults in Cumberland District. Objectives and strategies include a focus on health equity. According to Maine Kids Count 2015-2016, the percentage of Maine children aged 0-17 who are overweight (17.0%) is up from the previous percent calculated (15.3%), and is greater than the national percentage (15.6%).

Goals	Objectives	Strategies	District Partners
1. Increase physical activity among children and adults in Cumberland District.	1.1 Increase use of active transportation (walking, biking, wheeling, and transit use for daily travel) by June 30, 2019.	1.1.A. Provide technical assistance to at least two towns to help them adopt Complete Streets policies and/or utilizing CS approaches.	Municipalities, PACTs, ACETs
		1.1.B. Increase number of major employers and educational institutions that support active transportation by implementing travel policies and practices such as employer incentives for walking, biking, ride-sharing and transit use, as well as participation in bike share programs.	Major employers and educational institutions, PACTs, ACETs
		1.1.C. Implement a plan for district-wide community-based social marketing campaign to promote and increase use of active transportation.	PACTs, ACETs, UMaine Cooperative Extension
2. Increase fruit and vegetable consumption among children and adults in Cumberland District.	2.1. Reduce transportation barriers to accessing grocery stores, food pantries and community gardens in underserved communities by 2019.	2.1.A. Assess needs and feasibility of emerging solutions including "grocery shuttles" and mobile markets in rural locations.	Municipalities, Transportation, Food retailers, UMaine Cooperative Extension
	2.2. Increase consumer variety of fruits and vegetables at places they purchase or receive food including emergency food programs, retail locations, farmer's markets and farm share programs.	2.2.A. Support pilot to help food producers to disseminate un-used/sold produce to those in need.	Emergency food programs, retailers, Cumberland County Food Security Council, UMaine Cooperative Extension

Cumberland Priority Area 3: Oral Health

Description/Rationale/Criteria: Oral health is an integral part of overall health, and many individuals face barriers to accessing oral health care. Some of the barriers include individuals' low oral health literacy and an unfamiliarity with Maine's oral health system and resources; no dental insurance (or underinsured) with high out-of-pocket cost for services; difficulty finding dentists that accept MaineCare and subsequent long waiting periods, and transportation issues. According to the 2015 Cumberland County CHNA Summary (CHNA), health professionals and community stakeholders reported that access to oral health care was one of the top five health factors resulting in poor health outcomes for Cumberland County residents. Further, the 2015 CHNA indicated that 52.9% of MaineCare members in Cumberland County under the age of 18 visited the dentist in the past year, compared to the state rate of 55.1%.			
Goal	**Objectives**	**Strategies**	**District Partners**
Increase the use of preventative oral health services.	1.1. Increase access to oral health services for vulnerable populations, including but not limited to new Americans, children, parents, seniors.	1.1.A. Update 2-1-1's oral health resources by June 30, 2017.	Dental health providers, United Way
		1.1.B. Promote and market 2-1-1 among vulnerable populations and individuals or groups who serve those populations.	Dental health providers, medical offices, health departments, community centers
		1.1.C. Assess existing resources to identify potential additional untapped resources and underutilized capacity and ongoing gaps.	Dental health providers, medical offices, health departments, community centers, oral health program partners and stakeholders
	1.2. Increase vulnerable populations' Patient Activation Measure (PAM) scores on their understanding of how to access dental care and ability to make financial plans in order to do so.	1.2.A. Engage Community Health Outreach Workers (CHOWs) and Community Financial Literacy to assist vulnerable populations in health savings planning.	CHOWs, CFL
		1.2.B. Work with dental providers to enhance patient outreach and education such as alternative methods of appointment reminders.	Dental health providers, oral health program partners and stakeholders
	1.3. Increase awareness about oral health hygiene best practices, including the effect of diet on oral health.	1.3.A. Develop materials that provides information about oral health hygiene best practices, taking CLAS Standards into account	Dental health providers, oral health program partners and stakeholders
		1.3.B. Disseminate newly developed and increase dissemination of existing education materials (ex. From the First Tooth, Smile Partners resources).	Dental health providers, medical offices, health departments, community centers, oral health program partners and stakeholders

Downeast

Priority Area 1: Cardiovascular Health

through Food Security, Nutrition and Physical Activity

Description/Rationale/Criteria: The incidence and severity of Cardiovascular disease is rising in the Downeast District. Public health initiatives for prevention, diagnosis, and changes in environment and lifestyle can significantly reduce onset and manage consequences of cardiovascular disease. Increasing food security reduces stress, leads to better nutrition and health outcomes. Programs, including improving food access, teaching food preparation skills, and improving diet and increasing physical activity, can significantly reduce excess weight and obesity and related incidence of disease.

Goals	Objectives	Strategies	Partners
Planning The DEPCH will plan a program for reducing cardiovascular disease at the community-level through nutrition and physical activity.	Create a plan by June 2017. - Food security - Nutrition - Physical Activity.	Convene planning team Survey regional assets Identify SWOT Draft three-year plan E.g. Hi 5 Worksite Obesity Prevention Program	Hospitals Health Clinics Community Health Coalition Regional Planners Food Pantries Towns Schools
Screening Persons at risk of cardio-vascular disease will know it. Screening for being over-weight or obese will include appropriate counselling and services to assist participants to maintain a healthy weight and reduce related diseases.	More effectively identify persons at risk of food insecurity, obesity and cardio-vascular disease. - 1 pilot by June 2017. - integrated program by June 2018. - 15% increase in screening by June 2018.	E.g. Million Hearts Toolkit E.g. Continuing care project Thriving in Place - Patient Screening - Public screening events - Coordinate with towns	Hospitals Health Clinics Community Health Coalition Schools
	School-based screening will identify food insecurity or weight issues and make appropriate referrals. - 1 pilot by June 2017. - integrated program by 2018. - 15% increase in screening by June 2019.	Evidence-Based Interventions for Schools (RHIhub)	
Food Systems Improving the food system will contribute to food security and reduce unhealthy eating patterns.	Growing and gleaning The amount of healthy food available for food insecure persons will increase. - 4 new agreements with producers by June 2017. - 15% increase in LGF by 2019	Healthy Acadia program	Community Health Coalition Hospitals Health Clinics Food Pantries Grocery Stores

Downeast Priority Area 1: Cardiovascular Health *(continued)*

Goals	Objectives	Strategies	Partners
Food Systems Improving the food system will contribute to food security and reduce unhealthy eating patterns. *(continued)*	Food access Essential, healthy foods will reach people that need it most. - 1 pilot program by June 2017. - 2 programs by June 2018	E.g. Fruit and Vegetable Prescription Program (FVRx)	Community Health Coalition Hospitals Health Clinics Food Pantries Grocery Stores
	Food safety and preparation Food insecure persons will learn how to stretch their budgets while improving their diets by learning how to prepare meals at home. - 1 educational program planned by June, 2017. - 4 education programs implemented by June 2018.	E.g. Farm Fresh Rhode Island Food Hub E.g. South Dakota Harvest of the Month Program	
Diet and Nutrition Educational information will be available for consumers at food hubs, including schools, food pantries, grocery stores and convenience markets.	Schools will include curriculum on benefits of healthy diets through their cafeterias. - 1 educational program planned by June, 2017. - 4 education programs implemented by June 2018.	E.g. 5210 Let's Go Mobile Delivery E.g. Farm Fresh Rhode Island Food Hub	School districts Healthy Acadia
	Senior meal sites and pantries will provide education about the impact of diet on health. - 1 educational program planned and tested by June 2017. - 4 education programs implemented by June 2018.	E.g. Thriving in Place	Meals on Wheels/3D Eastern Area Agency on Aging
Oral Health Education and environmental change will encourage better diets that reduce tooth decay, improve nutrition and reduce obesity.	Schools will reduce offerings of sugary beverages and other foods and beverages known to contribute to tooth decay. - 1 educational program planned by June 2017 - 2 schools adopt policy by 2018 - 2 schools adopt policy by 2019	E.g. 5210 Let's Go E.g. School-Based Health Center Dental Outreach	Community Health Coalition Hospitals Schools Caring Hands of Maine Dental Center Dental care providers Maine Dental Association
	Families will receive information about strategies to protect children's oral health. - 1 educational program implemented by June 2018 - 2 educational programs implemented by 2018	E.g. 5210 Let's Go E.g. School-Based Health Center Dental Outreach E.g. RHI Rural Oral Health Toolkit	

Downeast Priority Area 1: Cardiovascular Health *(continued)*

Goals	Objectives	Strategies	Partners
Physical Activity The Downeast District will foster healthy, active communities where physical activity is the easy choice.	Physical activity programs will reduce risk of developing cardio-vascular disease. **Schools and Towns** - 2 assessments plans prepared by June 2017 - 2 demonstration programs implemented by 2018 - 2 demonstration programs implemented by 2019	E.g. Center for Training and Research Translation Community Strategies E.g. 5210 Let's Go E.g. Rural FitKids360 E.g. Hi-5 School-based Programs to Increase Physical Activity E.g. CDC Guide to Strategies to Increase Physical Activity E.g. Winter Kids	Hospitals Health Clinics Community Health Coalition Regional Planners Towns Governments Schools Land trusts Acadia National Park Businesses

Downeast Priority Area 2: Alcohol and Drug Use

Description/Rationale/Criteria: Substance misuse, including alcohol, heroin, methamphetamine and prescription drugs, has risen significantly in the Downeast District in recent years. Substance misuse is associated with violence, property crimes, car crashes, infectious, mental and chronic disease. Public health initiatives to prevent, treat and rehabilitate persons that misuse alcohol and drugs can have significant individual and societal benefits.

Goals	Objectives	Strategies	District Partners
Planning The Downeast District will formulate priorities for preventing alcohol and drug misuse.	Partners will create a district-wide alcohol and drug use prevention plan by June 2017	Convene planning group Identify priorities for drug and alcohol misuse programs	Healthcare Providers Law Enforcement Open Door Recovery Community Health Coalition, MaineCDC
Prevention The Downeast District will increase efforts to prevent drug and alcohol misuse.	- Create plan for work-place prevention by June, 2017 - Increase awareness of workplace substance misuse impacts and assistance programs by June 2018	Convene substance abuse prevention program for farming, fishing and forestry Support ongoing program to identify and resolve substance misuse challenges E.g. Healthy Workplace E.g. Wellness Outreach at Work	Drug Free Communities, Community Health Coalition, Open Door Recovery, MaineCDC Lobsterman Assoc., Clammer Assoc., Island Institute, Maine Sea Coast Mission, Penobscot East Res Center, Schools
	Prevent or delay onset of substance misuse among middle school and high school students. - 1 educational program planned by June 2017 - 4 education programs implemented by June 2018	E.g. All Stars E.g. Stop Underage Drinking E.g. School Connect	

Downeast Priority Area 2: Alcohol and Drug Use *(continued)*

Goals	Objectives	Strategies	District Partners
Treatment The Downeast District will support treatment options for drug and alcohol misuse.	Initiating recovery - Demonstrate a hub and spokes system in 2017	E.g. ED-BNI + Buprenorphine for Opioid Dependence	Hospitals, Regional Medical Centers Open Door Recovery AMHC Downeast Substance Treatment Network AA/NA, Operation Hope
	Sustaining sobriety - Provide training for Recovery Coaches in 2017	E.g. Mind-Body Bridging Substance Abuse Program (MBBSAP)	
Support for recovery and harm reduction The Downeast District will offer support for persons recovering from drug and alcohol addiction.	Enhance Information network – improving 211		Acadia Family Center Maine Health Equity Alliance HOME Next Step Domestic Violence Project
	Reduce the risk of infectious disease transmission.	Syringe Service Programs	

Downeast Priority Area 3: Mental Health

Description/Rationale/Criteria: Mental health is an ongoing challenge in the rural Downeast District. Services are sparse and problems can go undetected and untreated at all ages. Challenges include early childhood and primary school intervention, substance misuse, and reaching isolated, impoverished and aging residents. Public health programs for early intervention, community networking, teacher training and rural outreach can help to identify and treat mental and behavioral health.

Goals	Objectives	Strategies	District Partners
Planning	Assessment of current practices for identification and treatment of behavioral and mental health.	Convene planning meetings to identify practices and needs and options for improving processes.	Community Health Coalition, Hospitals, Clinics Schools, Sunrise Opportunities, Maine Health and Human Services, Cobscook Community Learning Center, Community Caring Collaborative, AMHC
Screening Children will be screened for mental health issues upon entry in infant, pre-school, kindergarten and primary school.	Training teachers to recognize potential mental health issues. - 1 pilot program implemented by June 2017. - 2 programs implemented by 2018.	Teacher in-service training	Sunrise Opportunities Maine Health and Human Services, Schools, Cobscook Community Learning Center, Community Caring Collaborative, AMHC
		Follow-up on the job training through classroom monitoring.	
		E.g. Behavioral Health Screening Programs	

Downeast Priority Area 3: Mental Health *(continued)*

Goals	Objectives	Strategies	District Partners
Engaging students in learning through coordinated educational programs.	- 1 pilot program implemented by June 2018 - 2 programs implemented by 2019	E.g. Building Assets Reducing Risks E.g. Ready by 21 E.g. Hi 5 School-based Programs for Violence Prevention Hi 5 Early Childhood Education	Schools, Cobscook Community Learning Center
Activities for Youth Children and youth will have opportunities for afterschool and vacation activities to reducing risk behavior, isolation.	- 2 Schools will offer beneficial afterschool programs by June 2018.	E.g. Harvard Database of Evidence-based Programs E.g. Blueprints Program List	4H, Boy Scouts, Girl Scouts, YMCA, etc., Schools, Town Recreation Dept., Libraries EdGE, Law enforcement
Treatment There will be a seamless transition from screening to treatment for children and youth with identified mental health issues.	Qualified students will be referred to mental or behavioral health services. - 1 Pilot Program by June 2017 - 2 Programs by June 2018 - Peers will engage in supporting positive social behavior in 2 schools by June 2019	E.g. Early Pathways E.g. Attachment and Biobehavioral Catch-up (ABC) E.g. Peer Coping Skills Training (PCS)	Acadia Hospital Maine Coast Mem Hosp Kidspeace Law enforcement Schools Mental health institutions NAMI-Maine

Midcoast

Priority Area 1: Mental Health

Description/Rationale/Criteria: Mental health is a growing concern in the Midcoast District. Challenges include adverse childhood experiences (ACEs), youth interventions, substance abuse, and increasing rates of youth suicidal ideation and feelings of hopelessness. Older adult focused community partner organizations have expressed a need for increasing access to mental health services for older adults and their families and non-professional caregivers. In addition, mental health has been included in the implementation strategies for both Lincoln Health and Mid Coast Hospitals.

Goals	Objectives	Strategies/	District Partners
1. Improve the mental health of youth in the Midcoast District.	1.1. Increase the number of depression and/or suicide prevention programs in communities by one in each county.	1.1.A. (Yr. 1) Conduct assessment with 75% of district schools and youth serving organizations to determine existing informal and formal supports to youth: • Who is providing services? • Where and what are the gaps? • What is their capacity? • Use of existing tools.	District school departments District schools, Parent groups, National Alliance on Mental Illness (NAMI) Sweetser, ME Behavioral Healthcare, Mid Coast Hospital, Lincoln Health
		1.1.B. (Yr. 1) Establish communication with and engage school administration to build support and interest for implementation of peer social network programs.	District school departments District schools Parent groups
		1.1.C. (Yr. 2) Provide resources for school staff training for implementation of Sources of Strength (peer social network) in priority schools.	
		1.1.D. (Yr. 3) Expand Sources of Strength implementation to additional schools in the district.	
	1.2. Increase prevention messaging PSAs on local media outlets.	1.2.A. Implement media campaigns.	Sexual Assault Support Services of Midcoast Maine (SASSMM), New Hope for Women, Community Health Coalitions

Midcoast Priority Area 1: Mental Health *(continued)*

Goals	Objectives	Strategies	District Partners
2. Improve the mental health of adults in the Midcoast District.	2.1. By June 30, 2017, assess mental health services for older adults and their caregivers in the district.	2.1.A. (Yr. 1) Perform gap assessment to identify suicide and depression prevention/reduction mental health services and current outreach and mental health education for older adults and their caregivers in the district. • Conduct focus groups with providers. • Community forums to engage the District's older adults, caregivers and stakeholders to identify mental health services status, barriers and opportunities in the Midcoast District. • Mapping services. • What is needed? • Gap in understanding.	Spectrum Generations NAMI, Senior Housing People Plus, United Way SAGE Maine, AARP Age Friendly Community Initiative, Aging in Place Initiatives, Maine Health Access Foundation, Tri State Learning, WISE Program, Municipalities, Local Health Officers, MaineHealth, District Hospitals, Emergency Medical Services, Code Enforcement Officers Churches, TRIAD, Maine Alzheimer's Association Island Institute, ME Seacoast Mission, Office of Adult Disability and Aging, 211
	2.2. By September 30, 2017, DCC will use the gap analysis results to develop an action plan to respond to the needs identified in the gap analysis.	2.2.A. Based on the gap analysis results, DCC will create partnerships and build network to support implementation of CDSM program at district level.	
		2.2.B. (Yr. 2) Facilitate education process, i.e. conference or workshop, about mental health for DCC members and interested partners/stakeholders.	
		2.2.C. Convene stakeholders and service providers.	
	2.3. By June 30, 2019, implement, through district partners, at least 1 evidence based strategy across the district.	2.3.A. Implement educational campaign for older adults and their families and non-professional caregivers, for example early identification of warning signs of Alzheimer's/dementia.	
		2.3.B. Research and identify evidence based strategies for year 3 implementation.	
		2.3.C. Monitor and assure existing programs.	
		2.3.D. Implement evidence based pilot program.	
		2.3.E. (Yr. 3) Assure implementation of at least one evidence based program for older adults, such as *Senior Reach, Age Well Pittsburg, Final Acts Healthy Ideas.*	

Midcoast Priority Area 2: Elevated Blood Lead Levels

Description/Rationale/Criteria: The Midcoast District has significantly lower lead screening rates among one to two year olds than the state of Maine. The district screening rate for 2009-2013 for one year olds is 34% compared to the statewide rate of 49.2%. The district rate for two year olds is 15% compared to the statewide rate of 27.6%. Increasing lead screening rates is a priority and implementation strategy for district hospitals, Pen Bay Medical Center/Waldo County General Hospital and Mid Coast Hospital, and is also a priority for the United Way of Midcoast Maine.

Goals	Objectives	Strategies	District Partners
1. Reduce lead exposure in Children.	1.1. By June 30, 2019, increase the rate of blood lead screening in 1 year olds from 34% to the State average of 49% and increase the rate of blood lead screening in 2 year olds from 15 to 27%.	1.1.A Conduct a root-cause-analysis regarding clinical sites' barriers to in-office testing, commitment to screening, number of MaineCare children seen at practice, to include: • Use of 4 question risk assessment by physicians. • Success rate of referrals. • Pediatric, family physician, & GP offices – what are their approaches & commitment to screening? • Identify number of MaineCare children under age of 3 in their practices and the number of those kids who have had screening test. • Understanding of barriers at physicians' offices. • Determine the baseline of non-clinical sites i.e. Head Start, WIC offices, offering lead screening.	Pen Bay Medical Center Waldo County Hospital Mid Coast Hospital Lincoln Health Martins Point Health Care Belfast Pediatrics Pen Bay Medical Center Waldo County Hospital Mid Coast Hospital Lincoln Health Martins Point Health Care Belfast Pediatrics Head Start CAP agencies Head Start Lead program Pediatric champion Parent organizations
		1.1.B. (Yr. 1-3) Establish and convene district lead taskforce, including pediatric physician champion, parents & other stakeholders to identify barriers to widespread testing and parents getting their children tested, and to increase screening opportunities.	
		1.1.C. (Yr. 2 & 3) Develop home lead assessment tool for home care visitors, Maine Families, and case management workers.	
		1.1.D. (Yr. 2 & 3) Convene task force and engage pediatric patient providers to increase their capacity to provide in office screening, including training staff on screening, obtaining mobile testing units, distributing education materials to parents.	

Midcoast Priority Area 2: Elevated Blood Lead Levels *(continued)*

Goals	Objectives	Strategies	District Partners
1. Reduce Lead Exposure in Children	1.1. By June 30, 2019, increase the rate of blood lead screening in 1 year olds from 34% to the State average of 49% and increase the rate of blood lead screening in 2 year olds from 15 to 27%.	1.1.E. Create partnerships between non-clinical sites and hospitals/providers with mobile screening units for expansion of mobile testing, by clinicians, at non-clinical sites.	United Way of Midcoast Maine Bath Head Start District hospitals Pediatrics & family physicians
	1.2. By June 30, 2019, decrease elevated blood lead levels in one and two year olds from 3.3% to 2.5%, the 2015 state average.	1.2.A. Determine a pilot program for targeting municipalities in the Midcoast based on estimated children with blood lead levels.	Maine Families of Midcoast area
		1.2.B. Engage and conduct outreach with municipalities, code enforcement, fire department, & LHOs.	District Municipalities Local Health Officers (LHOs) Code Enforcement Fire Department

Midcoast Priority Area 3: Obesity

Description/Rationale/Criteria: The District levels for obesity and overweight are not significantly higher than the state rates, obesity remains a priority of the Midcoast District. Current obesity prevention funding focuses solely on youth populations. In order to compliment this youth focused work, strategies that incorporate adults and families need to be implemented. Obesity was selected as a hospital implementation strategy for Mid Coast Hospital and Lincoln Health Care and was included in the cardiovascular health priority for Pen Bay Medical Center/Waldo County General Hospital.

Goals	Objectives	Strategies/	District Partners
1. Decrease the impact of Chronic Disease in the Midcoast District.	1.1. By June 30, 2019, increase the number of chronic disease self-management (CDSM) programs in the Midcoast District.	1.1.A. (Yr. 1) Conduct a District assessment to Identify those organizations providing Chronic Disease Self-Management programs, to include: • Programs, by organization. • Program costs. • Delivery Method. • Participant eligibility requirements. • Fees charged to participants in CDSMP programs. • Target audience. • Whether program is evidence based.	Mid Coast Hospital Bath Iron Works YMCAs (Lincoln, Pen Bay, Bath) Coastal Health Care Alliance

Midcoast Priority Area 3: Obesity

Goals	Objectives	Strategies/	District Partners
1. Decrease the impact of Chronic Disease in the Midcoast District *(continued).*	1.2. By June 30, 2019, assure implementation of community education and lifestyle coach mentoring programs in the district.	1.2.A. (Yr. 2 & 3) Amplify awareness campaigns about Diabetes Prevention Program (DPP) and CDSM for primary care providers	District primary care and general physicians District hospitals DPP Lifestyle coaches
		1.2.B. (Yr. 2 & 3) Host two learning sessions on successes in the district for lifestyle health coach mentoring systems	
		1.2.C. (Yr. 2 & 3) Adapt Swan's Island media success story model and implement in Midcoast	
2. Increase public use of existing low or no cost physical activity resources	2.1. By June 30, 2019, implement a Midcoast Moves campaign and/or mobile app.	2.1.A. (Yr. 1-3) • Assess readiness for technology options • Develop and implement technology options to promote use of existing free or low-cost physical activity resources such as outdoor trails, indoor walking routes, playgrounds	Bowdoin College Land Trusts, Conservation Groups Mid Coast Hospital Pen Bay Medical Center, Waldo County Hospital, Lincoln Health, YMCAs Pemaquid Watershed Association, Midcoast Conservancy, Damariscotta River Assoc., WinterKids Realtors, Municipalities Non-Governmental Organizations
		2.1.B. (Yr. 1-3) Convene and collaborate with district land trusts and conservation groups to assess partnerships and work plans, how to increase public use of their resources	

Penquis

Priority Area 1: Drug & Alcohol Abuse and Tobacco Use

Description/Rationale/Criteria: Data shows that substance abuse continues to be the most significant health issue in Penobscot and Piscataquis counties. Partners from around Penquis Public Health District are engaged in focused efforts to decrease its impact, and substance abuse strategies are included in the Department of Health and Human Services Strategic Plan, many local hospital implementation strategies, and it is a priority for local community collaborations such as the Bangor Public Health Advisory Board and the Community Health Leadership Board.			
Goals	**Objectives**	**Strategies**	**District Partners**
1. Reduce drug and alcohol abuse and tobacco use.	1.1. Increase awareness among adults of the impacts of drug and alcohol abuse and tobacco use.	1.1A. Implement harm reduction media campaign targeting adults.	Acadia Hospital, Bangor Area Recovery Network, Blue Sky Counseling, Charles A. Dean Memorial Hospital, City of Bangor, Community Health Leadership Board, Eastern Maine Medical Center, Health Access Network, Health Equity Alliance, Helping Hands with Heart, Maine Opiate Collaborative, Maine Quality Counts Mayo Regional Hospital, Maine Health Access Foundation Healthy Communities Grantees, Millinocket Regional Hospital, Penobscot Community Health Care, Penobscot Valley Hospital, Penquis, Public Health Advisory Board, Sebasticook Valley Health, St. Joseph's Hospital, Wabanaki Health and Wellness
		1.1.B. Connect worksites to drug free workplace education and resources.	Organizations listed above, regional Chambers of Commerce, and the Wellness Council of Maine
		1.1.C. Increase opportunities for education around substance use disorder treatment and recovery.	Organizations listed above.

Penquis Priority Area 2: Food Security, Obesity, Physical Activity, & Nutrition

Description/Rationale/Criteria: According to the Maine Shared CHNA data, obesity, and physical activity and nutrition, rank as two of the top five health issues in the Penquis Public Health District. District partners, including those organizations listed below, have developed strategies and are dedicating resources to address these issues. Strategies below were chosen to address existing gaps and underserved populations.

Goals	Objectives	Strategies	District Partners
2. Improve nutrition and increase physical activity in the Penquis Public Health District.	2.1. Increase access to nutrient rich foods among the food insecure.	2.1.A. Partner with food insecurity and hunger relief organizations to achieve or make measurable progress on organizational goals identified in self-assessment.	City of Bangor, Eastern Area Agency on Aging, Eastern Maine Healthcare Systems-Partnerships to Improve Community Health Grant, Good Shepherd Food Band, Helping Hands with Heart, local food pantries, Mayo Regional Hospital, Millinocket Regional Hospital, Penobscot Community Health Care, Penobscot Nation, Penquis, Piscataquis Healthy Community, Piscataquis Regional YMCA, Sebasticook Valley Health, St. Joseph Healthcare, United Way of Eastern Maine, University of Maine Cooperative Extension
	2.2. Increase access to physical activity opportunities and nutrition resources.	2.2.A. Partner with worksites to identify gaps and implement policies and programs.	Health Access Network, Millinocket Regional Hospital, Penobscot Valley Hospital, regional Chambers of Commerce, Wellness Council of Maine
	2.3. Increase access to physical activity opportunities.	2.3.A. Engage existing Active Community Environment Teams to solicit a plan for a project to increase access to physical activity.	Active Community Environment Teams, Organizations listed above.

Penquis Priority Area 3: Access to behavioral care/mental health care

Description/Rationale/Criteria: According to the Maine Shared CHNA data, mental health ranks as one of the top five health issues in Penquis Public Health District and access to behavioral care/mental health care as one of the top five health factors. A number of partner organizations have included mental health and access to mental health care/behavioral care as a priority of focus.			
Goals	**Objectives**	**Strategies**	**District Partners**
3. Decrease stigma around mental health issues.	3.1. Increase public awareness around mental health disorders and available resources.	3.1.A. Provide education to the community about disorders and available resources.	Acadia, Blue Sky Counseling, Charles A. Dean Memorial Hospital, Charlotte White Center, City of Bangor, Community-based organizations, Community Health and Counseling Services, Health Access Network, Helping Hands with Heart, Maine Resilience Building Network, Mayo Regional Hospital, Millinocket Regional Hospital, National Alliance on Mental Illness Bangor, Pathways of Maine, Penobscot Community Health Care, Penobscot Valley Hospital, Schools, Sebasticook Valley Health, St. Joseph Healthcare. Wabanaki Health and Wellness

Penquis Priority Area 4: Poverty

Description/Rationale/Criteria: According to Maine Shared CHNA data, poverty is the number one health factor in both Piscataquis and Penobscot counties. As the number one health factor, it has the greatest impact and results in poor health outcomes for residents.			
Goals	**Objectives**	**Strategies**	**District Partners**
4. Reduce the impacts of poverty.	4.1. Increase the number of organizations that adopt poverty best practices.	4.1.A. Affect organizational change though implementation of Poverty Competencies for Leaders, particularly in social services agencies.	Adoptive and Foster Families of Maine, Bangor Area Homeless Shelter, Charlotte White Center, City of Bangor, Department of Health and Human Services, Eastern Area Agency on Aging, Families and Children Together, Food Pantries, Federally Qualified Health Centers, Helping Hands with Heart, Millinocket Regional Hospital, Municipalities, Penobscot Nation, Schools, St. Joseph Healthcare, Penquis, Thriving in Place Grantees, United Way of Mid-Maine, University of Maine, Wabanaki Health and Wellness
		4.1.B. Partner with social services organizations to apply the two-generational approach to systems, polices, and programs.	
		4.1.C. Increase cultural competencies around poverty.	

Western District

Priority Area 1: Substance Use Disorder

Description/Rationale/Criteria: Substance Use Disorder was selected as a priority area because it was identified as important across several sectors of the Western District. All three counties' community engagement activities (forums and events) as well as the majority of the district hospital's highlighted Substance Use Disorder as a top priority. Additionally, Western District community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 identified alcohol and drug use as one of the top five health issues. Substance Use Disorder is a complex health issue, the DCC has recognized a need to focus on the underlying cause. The DCC sees value in taking a proactive approach to prevent Substance Use Disorder and expand the view of Substance Use Disorder.

Goals	**Objectives**	**Strategies**	**District Partners**
1. Promote education and reduce substance use disorder by addressing root causes of substance use disorder.	1.1. By 2018, increase awareness of existing and needed resources for the general public and providers throughout the district.	1.1.A. Complete an inventory and gap analysis.	Mental Health services providers Healthy Community Coalitions ACEs trainers Maine Resilience Building Network School Districts Hospitals Community Service Agencies Oxford County Wellness Collaborative United Way Child Abuse and Neglect Councils
		1.1.B. Distribute district-wide inventory to district partners by 2019.	
	1.2. Increase number of DCC members, organizations, providers and community members educated about root causes of substance use disorder by 2019.	1.2.A. Increase number of trainings and educational opportunities offered in district on a root cause of substance use disorder.	
	1.3. By 2019, increase education of ACEs screenings for Substance use disorder.	1.3.A. Assess substance use disorder providers who are currently using an evidence based tool to screen for ACEs by 2018.	
		1.3.B. Increase the number of substance use disorder providers using evidence based tool by 2019.	
	1.4. By 2019, increase awareness of social service providers regarding tools and strategies that build resiliency.	1.4.A. Increase number of opportunities for social service provider's education in becoming trauma informed (ACEs) and building resiliency by 2019.	
	1.5. Support alignment and collaboration of existing and developing resources that address a root cause of substance use disorder by 2019.	1.5.A. Conduct district-wide inventory of identified best practices, emerging and evidence informed strategies by 2019.	
		1.5.B. Develop a district wide plan to address district wide resource gaps.	
		1.5.C. Distribute district wide resource directory to district partners by 2019.	

Western Priority Area 2: Mental Health/Depression

Description/Rationale/Criteria: Mental Health and Depression are a priority area because both were identified as important across several sectors of the Western District. All three counties' community engagement activities (forums and events) as well as the majority of the district hospital's listed Mental Health and/or Depression as top priorities. Additionally, Western District community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 identified both Mental Health and Depression as two of the top five health issues. Since Mental Health is clearly a large and important issue across the District the DCC has recognized a need to focus on the underlying cause of mental illness. The DCC sees value in taking a proactive approach to prevent poor mental health outcomes.

Goals	Objectives	Strategies	District Partners
1. Reduce the impact of mental illness and depression.	1.1 Enhance coordination of district-wide mental health and depression services.	1.1.A. Increase collaboration between behavioral health and primary care providers through the adoption of integration models such as Behavioral Health Homes and Community Care Teams by 2019.	Mental Health Services providers School Districts Hospitals Community Service Agencies Federally Qualified Health Centers United Way Agencies on Aging NAMI Maine Employee Assistance Programs ACEs trainers Child Abuse and Neglect Councils
	1.2 Increase awareness of mental illness and depression throughout Western District as a means to reduce stigma.	1.2.A. Convene community forums throughout all three counties in the district to educate the public on key issues contributing to the stigma of mental illness such as negative stereotypes, social distancing, and exclusionary behaviors of persons with mental illness by 2019.	

Western Priority Area 3: Healthy Weight, Physical Activity and Nutrition

Description/Rationale/Criteria: Healthy Weight, Physical Activity and Nutrition were selected as a priority area because all three were identified as important across several sectors of the Western District. All three counties' community engagement activities (forums and events) as well as the majority of the district hospitals listed either obesity, physical activity, nutrition or all three as top priorities. Additionally, Western District Community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 list obesity and physical activity with nutrition as two of the top five health issues. Since obesity is clearly a large and important issue across the District the DCC has recognized a need to focus on the underlying cause of unhealthy weight and obesity. The DCC sees value in taking a proactive approach to prevent poor health outcomes.

Goals	**Objectives**	**Strategies**	**District Partners**
1. Reduce obesity among Western District residents by addressing root causes of obesity, physical inactivity and poor nutrition.	1.1. Increase regular physical activity among Western District residents by 2019.	1.1.A. Increase the opportunities for low cost/no cost physical activity throughout district by 2019.	Hospitals, Healthy Community Coalitions, School Districts, Community Service Agencies, Oxford County Wellness Collaborative, United Way, University of New England, Employee Assistance Programs Western Maine Community Action (WIC)
		1.1.B. Increase awareness of physical activity opportunities throughout district by 2019.	

Western Priority Area 3: Healthy Weight, Physical Activity and Nutrition *(continued)*

Goals	Objectives	Strategies	District Partners
1. Reduce obesity among Western District residents by addressing root causes of obesity, physical inactivity and poor nutrition. *(continued)*	1.2. Increase the awareness of social service professionals on the potential of ACEs to impact unhealthy weight and obesity.	1.2.A. Assess current educational opportunities on ACEs as a root cause of obesity for professionals by 2018.	See above
		1.2.B. Provide educational opportunities for professionals on the adverse health effects of ACEs with a focus on obesity and unhealthy weight.	
	1.3. Increase participation in WIC by 2019.	1.3.A. Collaborate with WIC to increase enrollment in program.	
	1.4. Increase awareness and participation in Farmer's Market Harvest Bucks Program by 25% by 2019.	1.4.A. Increase collaboration and communication among all participating farmers in the Western District by 2018.	
		1.4.B. Convene an annual gathering of farmers' market participants and stakeholders, looking for efficiencies, cost savings and capacity building.	
	1.5. Increase healthy lifestyle choices made by college aged students in the Western District by 2019.	1.5.A. Offer education on college campuses on the potential of ACEs to affect unhealthy weight/body image by 2019.	
		1.5.B. Provide opportunities for college students to participate in Cooking Matters/Healthy Cooking on a Budget Classes.	

York

Priority Area 1: Nutrition and Obesity

Description/Rationale/Criteria: Eating a healthy diet, being physically active and maintaining a healthy weight are essential for an individual's overall health. These three factors can help lower the risk of developing numerous health conditions, including high cholesterol, high blood pressure, heart disease, stroke, diabetes and cancer. They also can help prevent existing health conditions from worsening over time. According to the 2015 SHNAPP, high schoolers in York County are eating fewer fruits and vegetables as compared to the state average, and adult obesity rates in York County are 28.4%.

Goal	Objectives	Strategies	District Partners
1. Promote health and reduce chronic disease risk through the consumption of healthful diets.	1.1. By 2019, increase fruit and vegetable consumption for all by implementing Fruit and Vegetable Prescription (FVRx) Program.	1.1.A. Engage Wholesome Wave for technical assistance.	TBD
		1.1.B. Build capacity by creating partnership with one large supermarket in York County to accept FVRx.	
		1.1.C. Build capacity by engaging health care providers and encouraging them to give FVRx vouchers to patients.	
	1.2. Increase proportion of physician office visits that include education related to nutrition or weight by 2019.	1.2.A. Providers will educate patients by distributing nutrition education information at visit, targeting only dentists and OBGYNs to broaden Let's Go Strategies.	
		1.2.B Providers will refer patients to community based nutrition resources (SNAP-ED Classes, WIC workshops, UMaine: Eat Well Nutrition Program).	
	1.3. Increase participation in WIC by 2019.	1.3.A. Collaborate with WIC to increase enrollment in program.	
	1.4. Increase participation in Market Bucks by 2019.	1.4.A. Participating health care providers will include information on how to use Market Bucks with their	

York Priority Area 2: Oral Health

Description/Rationale/Criteria: Access to timely, appropriate, high-quality and regular oral health care and preventive oral health services is a key component of maintaining health. Good access to oral health care can be limited by financial, structural, and personal barriers. Access to oral health care is affected by location of and distance to dental clinics, limited number of providers, availability of transportation and the cost of obtaining the services – including the availability of insurance, the ability to understand and act upon information regarding services, the cultural competency of oral health care providers and a host of other characteristics of the system and its clients. According to the 2015 SHNAPP, 51.5% of MaineCare members in York County under 18 visited the dentist in the past year, compared to the state rate of 55.1%.			
Goal	**Objectives**	**Strategies**	**District Partners**
1. Increase availability of treatment options available to residents	1.1. By 2019, increase percent of low income children and adolescents in York County who received any preventative oral health or dental services in the past year to align with state averages	1.1.A. Expand school based oral health care partnership with the University of New England from one school to four schools.	TBD
		1.1.B. Increase the number of elementary schools to offer oral health education at schools, including preventative oral health services, such as dental screenings, to children and adolescents.	
	1.2. Increase awareness for parents about the importance of oral health by 2019	1.2.A. Develop and implement a comprehensive public education/parent education campaign on the benefits of good oral health	
	1.3. Increase the number of schools that have oral health education included in health policies that include oral health screenings to ensure that all students have access to at least one screening per year by 2019	1.3.A. Conduct gap analysis to understand which schools in York County need comprehensive oral health care policies.	
		1.3.B. Work with PTO/PTA and school nurses to help schools develop policies that do not already have them in place.	

York Priority Area 3: Substance Misuse

<table>
<tr><td colspan="4">Description/Rationale/Criteria: Substance misuse and dependence are preventable health risks that lead to increased medical costs, injuries, related diseases, cancer and even death. Substance misuse also adversely affects productivity and increases rates of crime and violence. According to the 2015 SHNAPP, in York County, past-30-day marijuana use for high school students in York county is at 22.7%, as compared with the state rate of 21.6%. Past 30-day-day marijuana use for adults is at 8.8%. Drug induced mortality rates are slightly higher in York County than the State rates, similarly with emergency medical service overdose response rates.</td></tr>
<tr><th>Goal</th><th>Objectives</th><th>Strategies</th><th>District Partners</th></tr>
<tr><td rowspan="2">1. Reduce substance use rates to protect the health, safety, and quality of life for all.</td><td rowspan="2">1.1. Increase awareness of available community resources for prevention, treatment, and recovery by 2019.</td><td>1.1.A. Complete inventory of existing community resources and gap analysis of community resources (211, asset map, SAMHS, etc.).</td><td rowspan="2">TBD</td></tr>
<tr><td>1.1.B. Increase public awareness and use of community resources by compiling information and developing an electronic resource guide.</td></tr>
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Tribal Public Health District

Priority Area 1: Mental Health and Substance Use Disorders – Alcohol, Commercial Tobacco and other Substances

Goal	Objective	Strategies	Partners
Improve the availability and quality of culturally-appropriate substance abuse services	By June 30, 2017, the Tribal District will conduct one assessment to determine current substance use disorder services and needs (**Assessment**)	• Assess surrounding area substance abuse programs • Assess Hospital Substance Use Disorder programs • Assess Tribal medication assistant treatment clinics • Assess historical loss and trauma • Assess SUD treatment options • Assess family support and aftercare programs	Tribal Health Centers, Tribal Behavioral Health Programs, Acadia, Northeast Occupational Exchange, Local Hospitals, Wabanaki Health and Wellness, Community members, Wellness Court
		• Determine data-related activities • Research BRFSS, Census, American Community Survey • Determine Tribally-based data sources	IHS, Maine CDC, USET Epidemiology
	By June 30, 2018 the Tribal District will develop a minimum of three culturally appropriate tools and/or strategies to address substance use disorder needs (**Planning and Capacity**)	• Develop tools and strategies based on evidence-informed practice • Determine strategies to address historical trauma	Tribal Health Centers, Tribal Behavioral Health Programs, Wabanaki Health and Wellness, Community members, Nashville Area IHS, Canadian First Nations
		Determine funding sources to implement tools and strategies	State, Federal, and Philanthropy
		Expand upon current use of Insight Vision for performance metrics	Insight Vision
	By June 30, 2019, the Tribal District will implement a minimum of two tools and/or strategies (**Implementation and Evaluation**)	Implement funded tools and strategies	TBD
		Track usage of tools and strategies to determine progress and effectiveness	Insight Vision, TBD
		Conduct evaluation	TBD

Tribal Priority Area 1: Substance Use Disorder – Alcohol, Commercial Tobacco and other Substances *(continued)*

Goal	Objective	Strategies	Partners
Improve the availability and quality of culturally-appropriate mental health services	By June 30, 2017, the Tribal District will conduct one assessment to increase knowledge of the current mental health system **(Assessment)**	• Assess surrounding area mental health programs • Assess hospital-based behavioral health programs • Assess Tribal behavioral health programs • Assess Early Childhood and Youth-serving mental health programs • Assess availability of programs that address historical loss and trauma	Tribal Health Centers, Tribal Behavioral Health Programs, Acadia, Northeast Occupational Exchange, Local Hospitals, Wabanaki Health and Wellness, Community members, Wellness Court
		• Determine Data-related activities • Research BRFSS, Census, American Community Survey • Determine Tribally-based data sources	IHS, Maine CDC, USET Epidemiology
	By June 30, 2018, the Tribal District will develop a minimum of three tools and/or strategies to improve the cultural appropriateness of mental health services (**Planning and Capacity**)	• Develop tools and strategies based on evidence-informed practice • Determine strategies to address historical trauma	Tribal Health Centers, Tribal Behavioral Health Programs, Wabanaki Health and Wellness, Community members, Nashville Area IHS, Canadian First Nations
		Determining funding sources to implement tools and strategies	State, Federal, and Philanthropy
		Expand upon current use of Insight Vision for performance metrics	Insight Vision
	By June 30, 2019, the Tribal District will implement a minimum of two tools and/or strategies (**Implementation and Evaluation**)	Implement funded tools and strategies	TBD
		Track usage of tools and strategies to determine progress and effectiveness	Insight Vision, TBD
		Conduct evaluation	TBD

Tribal Priority Area 2: Health Across the Lifespan

Goal	Objectives	Strategies	Partners
Increase Opportunities for Youth Advocacy, Skill Building and Leadership	By June 30, 2017, the Tribal District will conduct one assessment to determine the needs of Tribal youth **(Assessment)**	• Assess Tribal youth-based programming • Assess areas for needed life skills • Assess services for new families • Assess employment and educational opportunities	Tribal education and recreation departments, Boys and Girls Club, Youth Councils, Tribal Vocational Rehabilitation
		Assess possible sources of youth data	Tribal government, Boys and Girls Club
	By June 30, 2017, the Tribal District will develop at least two programs for Tribal Youth **(Planning and Capacity)**	• Work with Youth Council to develop tools and strategies based on evidence-informed practice • Provide capacity building training to Youth Council • Convene Intertribal Youth Council for planning activities	Tribal Youth Council
		Determining funding sources to implement tools and strategies	State, Federal, and Philanthropy
		Expand upon current use of Insight Vision for performance metrics	Insight Vision, TBD
	By June 30, 2018, the Tribal District will establish at least two new relationships with partners to support youth engagement **(Implementation and Evaluation)**	Implement funded tools and strategies	TBD
		Track usage of tools and strategies to determine progress and effectiveness	Insight vision, TBD
		Conduct evaluation	TBD

Tribal Priority Area 2: Health Across the Lifespan *(continued)*

Goal	Objectives	Strategies	Partners
Improve systems for Elders	By June 30, 2017, the Tribal District will conduct one assessment to understand issues facing Elders in the community **(Assessment)**	• Assess surrounding area Elder programs • Assess Tribal Elder programs	Tribal Elders programs
		• Determine Data-related activities • Determine Tribally-based data sources	Tribal Government
	By June 30, 2018, the Tribal District will develop at least three tools and strategies to address Elder needs **(Planning and Capacity)**	Develop tools and strategies based on evidence-informed practice	TBD
		Determining funding sources to implement tools and strategies	State, Federal, and Philanthropy
		Expand upon current use of Insight Vision for performance metrics	Insight Vision
	By June 30, 2019, the Tribal District will implement at least two tools and strategies **(Implementation and Evaluation)**	Implement funded tools and strategies	TBD
		Track usage of tools and strategies to determine progress and effectiveness	Insight Vision, TBD
		Conduct evaluation	TBD
Promote cultural activities as prevention	By June 30, 2017, the Tribal District will conduct one assessment of cultural activities **(Assessment)**	• Assess current cultural events • Create an inventory of community members who are able to teach ceremonies and/or traditional healing activities	TBD
		• Determine Tribally-based data sources	TBD
	By June 30, 2018, the Tribal District will determine at least three new cultural activities **(Planning and Capacity)**	• Develop tools and strategies based on evidence-informed practice • Determine how to incorporate cultural and spiritual healing into current services • Assess language immersion programs	TBD
		• Determining funding sources to implement tools and strategies	State, Federal, and Philanthropy
		• Expand upon current use of Insight Vision for performance metrics	Insight Vision
	By June 30, 2019, the Tribal District will implement at least two tools and strategies **(Implementation and Evaluation)**	• Implement funded tools and strategies	TBD
		• Track usage of tools and strategies to determine progress and effectiveness	Insight Vision, TBD
		• Conduct evaluation	TBD

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