District Public Health Improvement Plan

2017 – 2019

Downeast Public Health Council

Information Contacts:

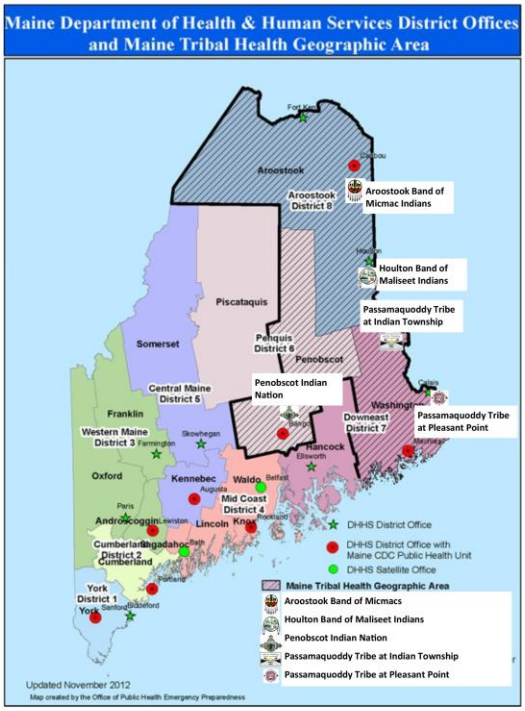
Alfred May, Downeast District Liaison
(207) 255-2017 alfred.may@maine.gov

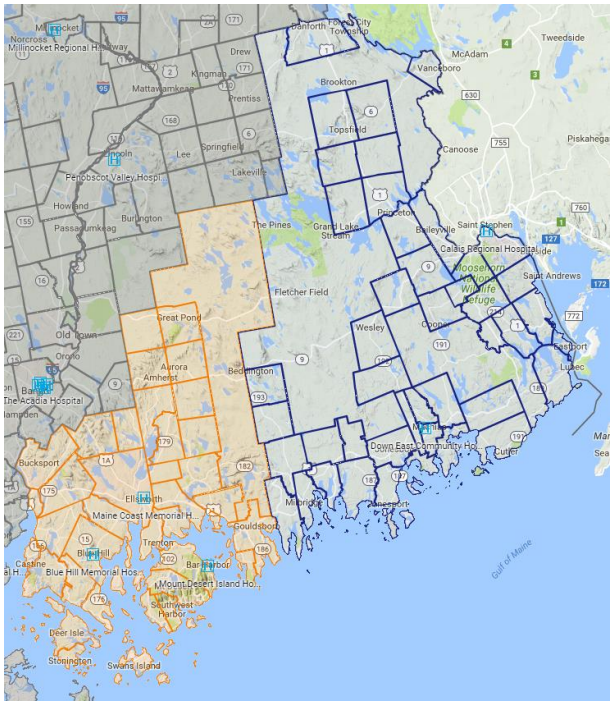
James Fisher, Downeast District Coordinator
(207) 479-9548 jfisher@whcacap.org

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Contents

Maine's Public Health Districts





The Downeast Public Health District includes Hancock and Washington Counties in eastern Maine. The district covers 5,606 square miles with a population of 54,845, giving it a population density of 9.8 persons per square mile. The Downeast District's largest municipalities by population include Ellsworth, Bar Harbor, Bucksport, and Calais.

The Downeast District is home of Acadia National Park and is a major destination for summer tourism and seasonal residents. A large amount of its area composed of unorganized townships and plantations where there are limited services and seasonal populations.

Downeast Public Health Council

The Council's mission is to promote the health of all our communities by providing public health information, coordination, collaboration, and advocacy.

Leadership: Executive Committee for 2016/2017		
Name	**Leadership**	**Organization**
Helen Burlock	Chair, SCC Voting	Community Health and Counseling Services
Maria Donahue	SCC Alternate	Healthy Acadia – Hancock County
Alfred May, MPH	District Liaison	Maine CDC
Angela Fochesato		Healthy Acadia – Washington County
Shirar Patterson		United Way Eastern Maine
Sarah Strickland		Strategic Wisdom Partners
Lee Umphrey		Harrington Family Health Center

2016/2017 Council Members and Contributors		
Name	**County**	**Organization**
Angela Gilberti	Washington	Wabanaki Public Health
Andrew Sankey	Hancock	Hancock County EMA
Brad Nuding	Hancock	Hancock County Emergency Management
Catherine Princell	Hancock	Blue Hill Memorial Hospital
Chris Kennedy	Washington	Downeast Community Hospital
Claire Connor	Hancock	Visiting Nurse Assn, Healthy Peninsula
Dee Dee Travis	Washington	Calais Regional Hospital
Dorathy Martel	Both	Next Step Domestic Violence Program
Doug Keith	Hancock	Maine Coast Memorial Hospital
Elizabeth Lyles	Hancock	Healthy Acadia
Elsie Flemings	Hancock	Healthy Acadia – Hancock County
Heather Lindloff	Hancock	Child and Family Opportunities
Holly Gartmayer-DeYoung	Washington	Eastport Healthcare Inc.;
Janet Lewis	Hancock	Healthy Peninsula
Joe Perkins	Both	Washington Hancock Community Agency
Julie Hixson	Washington	Downeast Community Hospital
Karen Mueller	Hancock	Mount Desert Island Hospital
Katie Freedman	Hancock	Healthy Acadia
Kelly Brown	Hancock	Next Step Domestic Violence
Kelly McKenney	Hancock	Child and Family Opportunities
Lynn Leighton	Hancock	Mount Desert Island Hospital
Marilyn Hughes	Washington	Regional Medical Center at Lubec
Mark Green	Both	Washington Hancock Community Agency
Marleen Athorp	Hancock	Public Health Nursing
Mary Jane Bush	Hancock	Bucksport Bay Healthy Communities
Michael Hinerman	Washington	Washington County EMA
Nicole Hammar	Both	Eastern Maine Health Care Systems
Patricia Patterson-King	Hancock	Maine Coast Memorial Hospital
Rose Saint Louis	Washington	Community Health and Counseling Services
Sandra Seamans	Washington	Harrington Family Health Center
Sandra Yarmal	Washington	Wabanaki Public Health
Sara Martin	Hancock	Bucksport Bay Healthy Communities
Tara Young	Hancock	Healthy Acadia
Terri Woodruff	Washington	Healthy Acadia
Timothy Oh	Hancock	Caring Hands of Maine Dental Center

Maine's District Public Health Infrastructure

Public Health Districts and District Coordinating Councils

The Public Health Districts were formed in 2008 as part of Maine's Statewide Public Health System Development Initiative called for in the 2007 Public Health Work Group Recommendations (22 MRSA §412). The Tribal Public Health District was established as Maine's ninth Public Health District in 2011, with the Act to Amend the Laws Regarding Public Health Infrastructure (22 MRSA §411). The establishment of the nine Districts was designed to ensure the effectiveness and efficiency of public health services and resources.

According to Maine law, the Maine Center for Disease Control and Prevention "shall maintain a district coordinating council for public health (DCC) in each of the nine districts as resources permit (22 MRSA §412). This is a representative district wide body of local public health stakeholders working toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system." (22 MRSA §411)

The statutory language further states:

"A district coordinating council for public health shall:

(1) participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and
(2) ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible." (22 MRSA §412)

District Public Health Planning Process

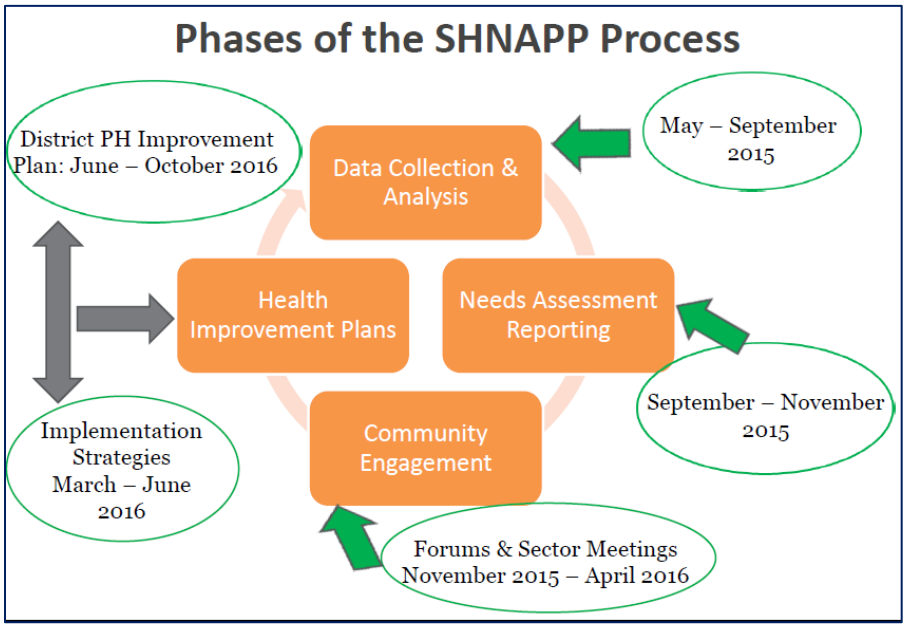
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health Improvement Plan (SHIP).

The purpose and importance of creating and implementing a DPHIP is based on the ten essential public health services through assessment, policy development, and assurance. Through the DPHIP, the DCC is working locally and regionally to meet public health accreditation and national public health standards through a community-based, multi-sector partnership to improve the public's health.

The Maine CDC is required to create and implement a State Health Improvement Plan (SHIP), designed to improve the health of all Maine people. The previous versions of the DPHIPs and SHIP were developed simultaneously, and partially aligned. In 2017, a new SHIP will be developed. In order to better coordinate health improvement efforts and resources between the state, districts, and Maine's people, priorities selected for the DPHIPs will inform this new SHIP. This is the third Downeast District Public Health Improvement Plan with previous versions created in 2008 and 2012.

In 2015-2016, a collaborative process called the Shared Health Needs Assessment and Planning Process (SHNAPP) was created by Maine's four largest health-care systems – Central Maine Healthcare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, MaineHealth – and Maine CDC to integrate public health and health care needs assessment and community engagement. The SHNAPP serves as a platform for developing the current DPHIPs.

The graphic below shows the planning process over the past year portraying a four phase approach—collection of quantitative (health indicator statistics) and qualitative (survey of professionals and community organizations of field knowledge) data, creating a "Shared Community Health Needs Assessment (Shared CHNA)" for each district, partnering with hospitals to facilitate community input, and then creating implementation strategies (hospital community plans) and district public health improvement plans (public health districts).



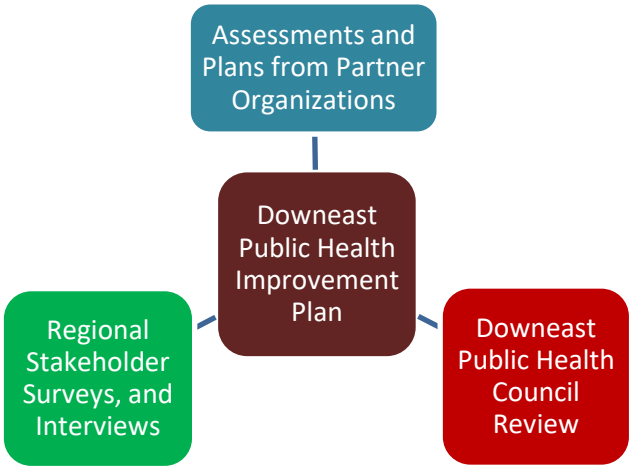
The data in the Shared CHNA (see Appendix 1 for district data summary) provides a starting point for discussing the health issues that face Maine people. The indicators chosen for the Shared CHNA cover a broad range of topics, but are not intended to be an

exhaustive analysis of all available data on any single health issue. District-shared CHNAs can be used to compare a health indicator in the district, in the counties making up the district, in the State of Maine, and to the national values.

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

Downeast District Planning Process

The Downeast Public Health Council employed a three prong strategy to generate and prioritized goals, objectives and strategies. The DL, DC and executive committee reviewed existing documents including community engagement summaries, data from the CHNA and SHNAPP, stakeholder business plans, needs assessments and other documents. DEPHC areas of concern were cross-tabulated with concerns identified in stakeholder documents.



Stakeholder outreach took several forms. The DL conducted an online survey to narrow the possible focus areas. A series of six thematic stakeholder conference calls were held in October, 2016 in order to broaden input on goals, objectives and strategies. The DL and DC also made numerous site visits to health clinics, hospitals and other stakeholder facilities as well as community coalition meetings to identify priorities and explore opportunities for collaboration.

The DEPHC held monthly meetings alternating between the full council and the Executive Committee. These meetings enabled the DEPHC to prioritize objectives analysis, discussion and negotiation. Meeting minutes document the process and are available online at www.downeastpublichealth.wordpress.org.

The process enabled the DEPHC to distill many options to three final priorities for this plan. Other important areas of concern were retained in the appendices.

All the districts were presented with a set of criteria based on the Collective Impact framework. The Downeast District used the following criteria

Primary Criteria

- **Best addressed at the district level**: In Maine, many community actions are very local. However, some issues may be better addressed at a district level. The district should consider whether it 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.

- **Maximize impact and optimize limited resources**: District partners should first assess existing work being done in the district and determine how best to enhance and not duplicate these efforts. This criterion also speaks to collaboration across district partners, bringing the priority home to the specific organization, and leveraging existing resources.

- **Community Support**: Districts should be aware of the local priorities within the district, and seek common ground across the community, as well as in different sectors in the districts. Even when communities within the same county may not necessarily agree on specific strategies, there may be agreement on what the priorities are.

Additional Criteria

- **Gaps in prevention services:** The district should consider if a health issue has not been adequately addressed across the district or in some parts of the district. An appropriate discussion on root causes, barriers to services, or gap analysis may be an appropriate way to address this.

- **Strengthen/Assure Accountability**: The district should consider whether change can be meaningfully measured and whether they can hold themselves accountable for changes in outcomes.

- **Use evidence-based strategies and population-based interventions**: Districts should invest time in doing research on evidence-based strategies used successfully for a specific disease area. For example, the Guide to Community Preventive Services (http://www.thecommunityguide.org/) provides recommendations for best practices for prevention services by a national task force of subject matter experts at the federal CDC. Additional sites listing evidenced-based strategies are included in the appendices.

- **Involve multiple sectors**: District coordinating councils require active recruitment of multiple sectors across the public health continuum. Districts need to actively engage all partners that have the value of health as their mission. Districts should consider those health issues that can best be addressed by involving multiple sectors.

- **Address district health disparities**: The district should consider whether they can reduce health disparities between their district and the state or within their population by addressing a specific issue. Populations to consider as having potential health disparities include racial and ethnic minorities, immigrants, migrant farm workers, lesbian, gay, bisexual, and transgender people, people at low income levels, people with veteran's status, people with lower levels of educational attainment, people with physical impairments (include deafness, blindness and other physical disabilities), people with mental impairments (including those with developmental disabilities and mental illness), people over sixty years old, and youth.

- **Focus on Prevention**: While some issues may be addressed through treatment in the health care system, for the Public Health Improvement plans districts should focus on whether 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.

- **Data driven**: Based on the planned three-year cycle for health improvement plans, districts should be able to track short-term and long-term changes using data indicators. Although some data indicators may not change substantially in a short time frame, being able to consistently use these data to measure change is important. However, shorter-term impacts and intermediate outcomes may also provide important information on determining if specific actions will lead to population health improvement.

Downeast District Public Health Improvement Plan

Community Health Improvement Priories

The top public health priority areas chosen by the Downeast Public Health Council for focused district wide community health improvement efforts over the next three years (2017 – 2019) include:

- Cancer
- Cardio-Vascular Disease

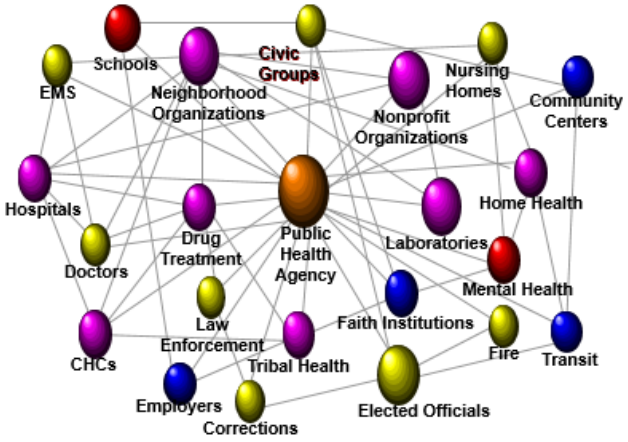
- Drug and Alcohol Misuse
- Food Security
- Mental Health
- Obesity, Nutrition and Physical Activity

The remainder of this plan provides more in-depth information about each of the public health priority areas listed above and plans for improvement. Through district and community based workgroups, council partners have identified goals, objectives and strategies, and will develop detailed work plans to meet their outcomes. Each programmatic plan seeks to identify phases that address some of the ten essential services of public health as well as the key partners that can help us to achieve our objectives.

Ten Essential Services of Public Health

Source: **www.cdc.gov/nphpsp**

Public Health System



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 and 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.

Primary criteria

- Is there adequate community support, or can this be built?
- Does it maximize impact and use of limited resources?

Rules

- Is it feasible at the district level?

- Is it evidence-based?
- Is it population-based?
- Can the DEPHC hold itself accountable for achieving the impact or outcome?

Additional Considerations

- Do the data support the use of the strategy?
- Does it involve multiple sectors and partners?
- Does it address district disparities?
- Is it prevention-focused?
- Is there an organization that is willing to take the lead?
- Does it fill a gap?

Priority #1: Cardiovascular Health through Food Security, Nutrition and Physical Activity

Description/Rationale/Criteria:

The incidence and severity of Cardio-vascular 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 cardio-vascular disease. Increasing food security reduces stress, leads to better nutrition and health outcomes. Programs may include improving food access, teaching food preparation skills, 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 cardio-vascular disease at the community-level though 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 Coal. 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 Coal 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 Coal. Hospitals Health Clinics Food Pantries Grocery Stores
	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)	
	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.	E.g. Farm Fresh Rhode Island Food Hub E.g. South Dakota Harvest of the Month Program	

Goals	Objectives	Strategies	Partners
	- 1 educational program planned by June, 2017 - 4 education programs implemented by June 2018		
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	
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 Coal Regional Planners Towns Governments Schools Land trusts Acadia National Park Businesses

Priority #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 Co 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 Coal Open Door Recovery MaineCDC Lobsterman Assoc. Clammer Assoc. Island Institute Maine Sea Coast Mission Penobscot East Res Cntr 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	
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	

Priority #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 Co Hospitals Clinics Schools Sunrise Opportunities Health and Human Svc 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 recognizing potential mental health issues and contacting - 1 pilot program implemented by June, 2017 - 2 programs implemented by 2018	Teacher in-service training Follow-up on the job training through classroom monitoring. E.g. Behavioral Health Screening Programs	Sunrise Opportunities Health and Human Svc Schools Cobscook Community Learning Center Community Caring Collaborative AMHC
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	Qualified students will be referred to mental or behavioral health services. - 1 Pilot Program by June, 2017	E.g. Early Pathways E.g. Attachment and Biobehavioral Catch-up (ABC)	Acadia Hospital Maine Coast Mem Hosp Kidspeace Law enforcement Schools Mental health institutions

Goals	Objectives	Strategies	District Partners
identified mental health issues.	- 2 Programs by June, 2018		NAMI-Maine
	- Peers will engage in supporting positive social behavior in 2 schools by June, 2019	E.g. Peer Coping Skills Training (PCS)	

Appendices

Downeast District 2015-2016 Health Profile: this is a health profile of the district using a set of quantitative indicators established by the Maine CDC Data Work Group and qualitative input. The quantitative indicators come from sources that Maine CDC uses to report disease incidence and prevalence data, including the Behavioral Risk Factor Surveillance System, Maine Health Data Organization (hospitalization data), US Census, and other health surveillance systems. The qualitative stakeholder input on the first page is a summary of the top five health issues and top five health factors in the district determined from a survey instrument that was distributed electronically to partners in each district.

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.

For more information on the Downeast Public Health Council, please contact Alfred May, District Liaison, at alfred.may@maine.gov, Jim Fisher, DEPHC Coordinator at jfisher@whcacap.org, or Helen Burlock, DEPHC Chair and SCC Representative, at hburlock@chcs-me.org.

For more information on evidence-based strategies, visit the following websites:

- CDC Health in Five Years Evidence-based Priorities
  www.cdc.gov/policy/hst/hi5
- Community Guide for Evidence-based Programs
  www.thecommunityguide.org/tools/community-guide-comparison-tool
- Rural Health Information Hub
  www.ruralhealthinfo.org
- SAMSA Registry of Evidence-based Substance Misuse Programs
  www.samhsa.gov/nrepp

Appendix 1: Additional Public Health Areas of Concern

Priority #4: Cancer
Description/Rationale/Criteria: Cancer persists in many forms in the Downeast District. Public health efforts to raise awareness of risk factors, reduce high risk behaviors, particularly smoking tobacco, and risky environments such as homes with high levels of radon, can result in lower cancer rates. Screenings such as mammograms and colonoscopies can catch infections at an early stage, reducing costs and improving outcomes.

Goals	**Objectives**	**Strategies**	**Partners**
Awareness	Enhance awareness of multiple cancer risks and opportunities to act.		Community Health Coal Hospitals MaineCDC Washington County Health and Wellness
Prevention	Reduce tobacco consumption	Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies	Community Health Coal Hospitals Schools PTFM/Maine Lung
	Reduce exposure to radon/uranium in homes.	Well water testing Radon testing Water filtration Radon Mitigation	Community Health Coal HCPC WCCOG Local Governments Health & Environmental Testing Lab
	Reduce UV exposure in tanning salons and outdoors.	-Skin Cancer: Primary and Middle School-Based Interventions -Multi-Component Community-wide Interventions	ME Cancer Foundation Community Health Coal
Screening	Increase skin cancer screening.	Barbering and Cosmetology initiative	Community Health Coal Hospitals Support/Advocacy Groups ME Cancer Foundation Caring Hands of Maine Dental Center
	Increase colorectal cancer screening.	Cancer Screening Client Reminders	
	Increase breast cancer screening.	Cancer Screening: One-on-One Education for Clients – Breast Cancer	
	Increase prostate screening		
	Increase oral cancer screening		

Goals	Objectives	Strategies	Partners
Patient Navigation	Increase access to support services for people with cancer - Navigators assist 75 clients by Dec 2017	Patient Care Connect	Beth Wright Center Community Health Coal Washington County Health and Wellness Maine Health Access Foundation Network Community Caring Collaborative Thriving in Place

Patient and Caregiver Support	- Increase attendance in exercise programs 20% by Dec 2017
	- Training for 5 volunteers to reach 25 care givers
	- Access to Care
	  - Financial Assistance
	  - Transportation
		Exercise Programs
		UMaine Machias
		Harrington – Coastal Therapy LLC
		Blue Hill – Yoga Center
		Ellsworth – BW Center
		Bucksport	

Maine Shared Community Health Needs Assessment District Summary: 2015

Downeast District

Updated: October 2015

Qualitative Stakeholder Input

A survey of 191 health professionals and community stakeholders in the Downeast Public Health District provided insight into the most critical health issues and determinants impacting the lives of those living in the area. According to these stakeholders, the following five health issues and health factors have the most impact on the District resulting in poor health outcomes for residents.

Top five health issues

- Drug and alcohol abuse
- Obesity
- Cardiovascular disease
- Diabetes
- Depression

Top five health factors

- Poverty
- Employment
- Health care insurance
- Health literacy
- Access to behavioral care/mental health care

Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Demographics						
Total Population	2013	87,035	54,845	32,190	1,328,302	319 Mil
Population – % ages 0-17	2013	18.1%	17.6%	18.9%	19.7%	23.3%
Population – % ages 18-64	2013	61.0%	61.7%	59.7%	62.6%	62.6%
Population – % ages 65+	2013	20.9%	20.7%	21.4%	17.7%	14.1%
Population – % White	2013	94.9%	96.7%	92.0%	95.2%	77.7%
Population – % Black or African American	2013	0.6%	0.6%	0.6%	1.4%	13.2%
Population – % American Indian and Alaska Native	2013	2.2%	0.5%	5.1%	0.7%	1.2%
Population – % Asian	2013	0.9%	1.0%	0.5%	1.1%	5.3%
Population – % Hispanic	2013	1.5%	1.3%	1.7%	1.4%	17.1%
Population – % with a disability	2013	17.5%	15.7%	20.5%	15.9%	12.1%
Population density (per square mile)	2013	NA	34.3	12.8	43.1	87.4
Socioeconomic Status Measures						
Adults living in poverty	2009-2013	16.0%	14.0%	*19.5%*	13.6%	15.4%
Children living in poverty	2009-2013	23.3%	21.5%	*26.2%*	18.5%	21.6%
High school graduation rate	2013-2014	86.2%	84.3%	89.4%	86.5%	81.0%
Median household income	2009-2013	NA	$47,460	*$37,236*	$48,453	$53,046
Percentage of people living in rural areas	2013	100.0%	100.0%	100.0%	66.4%	NA

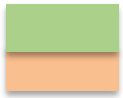
Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Single-parent families	2009-2013	35.6%	34.7%	37.0%	34.0%	33.2%
Unemployment rate	2014	7.5%	7.0%	8.4%	5.7%	6.2%
65+ living alone	2009-2013	42.6%	41.4%	44.3%	41.2%	37.7%
General Health Status						
Adults who rate their health fair to poor	2011-2013	17.2%	15.2%	*20.4%*	15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	10.9%	9.9%	12.6%	12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	12.6%	11.6%	14.4%	13.1%	NA
Adults with three or more chronic conditions	2011, 2013	28.4%	26.6%	31.6%	27.6%	NA
Mortality						
Life expectancy (Female)	2012	NA	82.4	80.1	81.5	81.2
Life expectancy (Male)	2012	NA	77.7	74.7	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	768.2	*702.2*	*875.0*	745.8	731.9
Access						
Adults with a usual primary care provider	2011-2013	*84.9%*	85.7%	*83.6%*	87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	9.8%	9.9%	9.6%	11.0%	15.3%
MaineCare enrollment	2015	29.8%	23.6%	40.3%	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	48.6%	40.4%	61.5%	41.8%	48.0%
Percent uninsured	2009-2013	14.1%	*14.7%*	*13.7%*	10.4%	11.7%
Health Care Quality						
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,677.3*	1,600.0	*1,809.0*	1,499.3	1458
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*5,181.2*	4,321.8	*6,645.8*	4,258.8	NA
Oral Health						
Adults with visits to a dentist in the past 12 months	2012	63.2%	67.6%	*56.9%*	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	58.1%	55.8%	60.5%	55.1%	NA
Respiratory						
Asthma emergency department visits per 10,000 population	2009-2011	*83.6*	62.5	*118.0*	67.3	NA
COPD diagnosed	2011-2013	7.6%	7.0%	8.6%	7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	207.2	220.8	187.7	216.3	NA
Current asthma (Adults)	2011-2013	10.4%	10.5%	10.2%	11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	7.1%†	4.4%†	10.9%†	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	*891.4*	*558.4*	*1,429.8*	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	*487.5*	347.7	*714.0*	329.4	NA
Cancer						
Mortality – all cancers per 100,000 population	2007-2011	186.1	171.4	*210.5*	185.5	169
Incidence – all cancers per 100,000 population	2007-2011	*525.1*	521.4	533.3	500.1	453
Bladder cancer incidence per 100,000 population	2007-2011	30.5	35.0	24.0	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	21.4	19.9	23.8	20.0	21.5

Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	43.3	40.7	47.1	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	124.8	125.6	122.7	126.3	124
Mammograms females age 50+ in past two years	2012	77.6%	82.9%	*70.0%*	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	13.7	13.0	14.9	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	25.2	24.2	26.4	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	49.7	47.8	52.8	43.5	42.0
Colorectal screening	2012	70.1%	73.0%	66.3%	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	53.2	48.0	61.8	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	78.9	70.1	*92.8*	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	19.2	24.0	*11.1*	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	80.5%	79.0%	82.6%	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	30.1	30.7	29.1	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	147.3	149.8	143.8	133.8	141
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	36.7	31.0	46.3	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	95.0	93.8	97.9	91.9	81.7
Cardiovascular Disease						
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*35.5*	*33.2*	*39.4*	23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*50.5*	*40.3*	*66.8*	32.2	32.4
Cholesterol checked every five years	2011. 2013	*76.3%*	76.6%	75.7%	81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*113.2*	*102.1*	*130.8*	89.8	103
Heart failure hospitalizations per 10,000 population	2010-2012	*24.1*	21.9	*27.8*	21.9	NA
Hypertension prevalence	2011, 2013	38.1%	37.3%	39.7%	32.8%	31.4%
High cholesterol	2011, 2013	42.6%	40.7%	*45.9%*	40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	27.7	27.5	27.3	28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	*22.8*	23.0	22.5	20.8	NA
Stroke mortality per 100,000 population	2009-2013	36.4	42.0	27.4	35.0	36.2
Diabetes						
Diabetes prevalence (ever been told)	2011-2013	9.5%	8.9%	10.4%	9.6%	9.7%
Pre-diabetes prevalence	2011-2013	5.2%	6.5%†	*3.4%†*	6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	NA	NA	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	NA	NA	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	NA	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	NA	NA	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	222.8	*181.1*	294.1	235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	11.0	11.0	10.9	11.7	NA
Diabetes long-term complication hospitalizations	2011	60.1	53.8	70.3	59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	23.3	16.6	*33.9*	20.8	21.2
Environmental Health						

Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	*1.4%*	*1.5%*	*1.2%*	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	4.3%	3.3%	*5.3%*	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	47.4%	*54.9%*	*34.1%*	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*65.7%*	*56.3%*	*79.5%*	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	*36.1%*	26.5%	*50.5%*	27.6%	NA
Immunization						
Adults immunized annually for influenza	2011-2013	39.8%	38.4%	42.0%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	*64.5%*	*62.3%*	68.0%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	6.5%	10.0%	0.4%	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	68.0%	NA	75.0%	NA
Infectious Disease						
Hepatitis A (acute) incidence per 100,000 population	2014	1.2†	1.8†	0.0†	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	2.3†	1.8†	3.1†	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	3.5†	1.8†	6.3†	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	104.0	91.4	125.8	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	1.2†	1.8†	0.0†	8.1	NA
Lyme disease incidence per 100,000 population	2014	154.9	219.4	44.0†	105.3	10.5
Pertussis incidence per 100,000 population	2014	55.5	14.6†	125.8	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.2†	1.8†	0.0†	1.1	3.0
STD/HIV						
AIDS incidence per 100,000 population	2014	0.0†	0.0†	0.0†	2.1	8.4
Chlamydia incidence per 100,000 population	2014	161.8	164.5	157.2	265.5	452
Gonorrhea incidence per 100,000 population	2014	8.1†	3.7†	15.7†	17.8	110
HIV incidence per 100,000 population	2014	1.2†	1.8†	0.0†	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	24.7	25.5	23.3	21.4	NA
Syphilis incidence per 100,000 population	2014	2.3†	0.0†	6.3†	1.6	19.9
Intentional Injury						
Domestic assaults reports to police per 100,000 population	2013	257.5	177.0	394.6	413.0	NA
Firearm deaths per 100,000 population	2009-2013	*13.4*	11.2	*17.0*	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	3.4†	0.0†	9.3†	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	18.0	16.1	21.1	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	100.0	56.6	174.0	125.0	368
Unintentional Injury						
Always wear seatbelt (Adults)	2013	80.5%	82.9%	*75.8%*	85.2%	NA

Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Always wear seatbelt (High School Students)	2013	NA	NA	*42.6%*	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*65.7*	*64.5*	*67.9*	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	12.1	10.0	15.6	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	7.7	6.4	9.8	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	349.5	*309.8*	*415.6*	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	*16.4*	14.5	*19.5*	10.8	10.5
Occupational Health						
Deaths from work-related injuries (number)	2013	NA	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	695.0	446.0	249.0	13,205.0	NA
Mental Health						
Adults who have ever had anxiety	2011-2013	17.5%	15.7%	20.1%	19.4%	NA
Adults who have ever had depression	2011-2013	21.8%	21.1%	23.0%	23.5%	18.7%
Adults with current symptoms of depression	2011-2013	9.2%	7.6%	11.4%	10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	17.0%	14.9%	20.1%	17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	38.1%	NA	40.0%	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	*1,748.0*	*1,564.4*	2,061.2	1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	NA	NA	28.7%	24.3%	29.9%
Seriously considered suicide (High School Students)	2013	NA	NA	15.4%	14.6%	17.0%
Physical Activity, Nutrition and Weight						
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	NA	NA	14.0%	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	33.9%	33.2%	35.4%	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	52.6%	55.9%	45.9%	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	NA	NA	41.6%	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	23.0%	20.1%	*27.9%*	22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	NA	NA	*34.7%*	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	16.4%	14.7%†	19.7%	17.9%	22.9%
Obesity (Adults)	2013	30.0%	29.8%	30.4%	28.9%	29.4%
Obesity (High School Students)	2013	NA	NA	15.9%	12.7%	13.7%
Overweight (Adults)	2013	36.5%	37.3%	35.0%	36.0%	35.4%
Overweight (High School Students)	2013	NA	NA	17.1%	16.0%	16.6%
Pregnancy and Birth Outcomes						
Children with special health care needs	2009-2010	NA	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	4.0	3.8	4.3	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	88.2%	90.9%	84.3%	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	23.0	19.2	*28.7*	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	5.7%	6.4%	4.7%	6.6%	8.0%

Maine Shared CHNA Health Indicators	Year	Downeast	Hancock	Washington	Maine	U.S.
Substance and Alcohol Abuse						
Alcohol-induced mortality per 100,000 population	2009-2013	9.5	8.7	11.0	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	NA	NA	17.8%	14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	16.2%	15.7%	17.0%	17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	8.6%	8.7%	8.3%	7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	10.0%	7.6%	13.9%	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	NA	11.6	18.7	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	334.1	301.7	389.8	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	21.3	21.5	20.8	25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	11.4	11.6	11.1	13.2	NA
Past-30-day alcohol use (High School Students)	2013	NA	NA	28.2%	26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	NA	NA	4.8%	3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	10.0%	10.9%†	8.8%†	8.2%	NA
Past-30-day marijuana use (High School Students)	2013	NA	NA	23.6%	21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	0.7%†	1%†	0.3%†	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	NA	NA	4.2%	5.6%	NA
Prescription Monitoring Program opioid prescriptions (days' supply/pop)	2014-2015	7.1	6.0	9.0	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*248.5*	*184.4*	360.0	328.1	NA
Tobacco Use						
Current smoking (Adults)	2011-2013	19.1%	14.2%†	28.8%	20.2%	19.0%
Current smoking (High School Students)	2013	NA	NA	19.7%	12.9%	15.7%
Current tobacco use (High School Students)	2013	NA	NA	23.6%	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	NA	NA	*53.2%*	38.3%	NA



Indicates district/county is significantly better than state average (using a 95% confidence level).
Indicates district/county is significantly worse than state average (using a 95% confidence level).

† Results may be statistically unreliable due to small numerator, use caution when interpreting.