Maine Injury Prevention Program

Your link to training, data and resources

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Maine Injury Prevention Program 2008 Symposium Report

MIPP Vision: Working together to keep Maine people safe from injuries.
MIPP Mission: Provide leadership and coordination to agencies statewide, to integrate effective injury and violence prevention into their organizational practices.

The Maine Injury Prevention Program (MIPP) is a program of the Division of Family Health in the Maine CDC, DHHS. The MIPP addresses an important public health problem and is undergoing numerous advances through a comprehensive strategic planning process. The MIPP has decided to reframe future work using injury morbidity and mortality data, align the workplan with the ten essential public health services and to address injury prevention across the lifespan.

The MIPP seeks to:

- Increase coordination of injury prevention efforts,
- Improve MIPP services and resources and promote linkages to effective injury prevention training, data and resources and,
- Strengthen current relationships and build new ones to meet mutual goals to improve the public's health.

To inform development of next steps, the MIPP convened a symposium on July 23, 2008. The purpose of the symposium was to enhance awareness of the injury problem in Maine, to increase knowledge of the services and resources the program provides and to learn more about the Public Health Districts and Healthy Maine Partnerships (HMPs). Attendance at the symposium included several public health and injury prevention leaders.

Strong partnerships and effective collaborations are needed to successfully prevent injuries in our state. The symposium provided an opportunity to discuss with key representatives of these systems how the training, data and resources offered by the MIPP can best support their work thus ensuring optimum use of MIPP resources. Invitees were selected because of their leadership role, their experience and knowledge of injury prevention and/or public health.

Recognizing that the emerging public health districts and HMPs are fine tuning their structure and functions, and that the mission and structure of the injury prevention program is evolving, the desired outcome for the meeting was that the MIPP, the Public Health Districts and HMPs would gain information on initial strategies with "doable" action steps to promote forward movement.

Four participant discussion groups were formed to discuss the following three questions:

1) What are the best strategies for linking the Maine Injury Prevention Program training, data and resources with the Public Health District Coordinating Councils and the Healthy Maine Partnerships (HMPs)?
2) What strategies are reasonable, feasible, and achievable?
3) What concrete, doable beginning action steps do you suggest?

An overview of the highlights of the day follows.

Overview of Recommendations to the Injury Prevention Program

GENERAL

- Identify what other programs are doing with the same populations to avoid duplication.
- Map injury prevention efforts across the state; develop an inventory of injury prevention efforts statewide and assess what injury prevention activities are taking place in each district.
- Create large umbrella of "injury"; identify different strategies for different audiences.
- Offer resources to districts; be opportunistic about and build upon local conditions.

TRAINING

- Connect to the work of the Healthy Maine Partnerships (HMPs) professional development team and explore opportunities for coordination of effort.
- Provide district liaisons and HMPs tools for injury prevention awareness and training. Share best practices and resources with them. Engage them as partners to raise awareness of injury prevention needs and training opportunities.
- Communicate a broad perspective on injury and link the occurrence of injury to daily life. Develop and provide basic injury prevention talking points.
- Develop and offer varying levels of training. Train local champions and link them to injury prevention training opportunities.
- Use a social marketing approach to raise awareness of leading types of injuries and injury prevention.

DATA

- Assess injury prevention needs at district level using district level data sets. Relate injury messages to vulnerable populations.
- Use district level data to portray the injury problem; develop district level injury profiles. Conduct presentations in districts using the injury profiles to promote the need for injury prevention.
- Keep injury messages simple to get the public's attention. Develop common data definitions of frequently used terms.
- Engage the districts in discussions about injuries in disparate populations.

RESOURCES

- Relate injury prevention to the 10 Essential Public Health Services. Coordinate resources and activities with other programs with common objectives.
- Map injury prevention activities and data indicators to Minimum Common Program Objectives used by the HMPs.
- Offer mini-grants to a few districts to pilot district injury prevention models for future statewide dissemination.
- Develop an injury prevention resource directory informing about contacts, data, activities and opportunities for collaboration for different types of injuries.
- Offer on line tools and resource kits for use by local partners. Develop press tool kits and resource packets on specific injury topics for community use.

The Maine Injury Prevention Program will use the findings from the symposium to develop short and long-term priorities and activities to advance prevention of the leading causes of injury across the lifespan.

KEY WORDS

District Coordinating Councils (DCC)
DCCs exist in each district to coordinate and integrate public health activities. They are comprised of a broad spectrum of public and private sector partners engaged in health and public health activities.

District Liaison (DL)
Maine CDC employees who are part of the Office of Local Public Health, and coordinate public health activities at the District level.

Healthy Maine Partnerships (HMP)
Community coalitions engaged in providing public health services at the local level, including chronic disease prevention and strengthening of local public health infrastructure.

Local Health Officers (LHO)
Municipal employees or appointees charged with mitigating local public health nuisances, and notifying the Maine CDC of any public health threats at the local level.

Maine Center for Disease Control and Prevention (Maine CDC)
Located within the Dept. of Health and Human Services, houses the Office of Local Public Health.

Maine Department of Health and Human Services (DHHS) Districts
Eight DHHS Districts and the Counties that comprise them are:

Aroostook – Aroostook County,
Penquis – Piscataquis and Penobscot Counties
Central Maine – Somerset and Kennebec Counties
Western Maine – Franklin, Oxford and Androscoggin Counties
Mid Coast – Waldo, Knox, Lincoln, and Sagadahoc Counties
Cumberland – Cumberland County
York – York County
Downeast – Washington and Hancock Counties

Maine Injury Prevention Program (MIPP)
Lead agency for injury prevention training, data, and resources to public health infrastructure and other key stakeholders and partners. Housed within Maine CDC.

Minimum Common Program Objectives (MCPO)
A range of required and optional objectives used by Healthy Maine Partnerships.

Mobilizing for Action through Planning and Partnerships (MAPP)
A community-wide strategic planning tool for improving public health.

Office of Local Public Health (OLPH):
Coordinates and strengthens local public health infrastructure – housed within Maine CDC

Public Health Statewide Coordinating Council
Ten (10) Essential Public Health Services (10 EPHS)

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

Statewide Coordinating Councils (SCC)

(Formerly the Public Health Workgroup)
Make recommendations about core public health work for Healthy Maine Partnerships and about district-level public health infrastructure, and maintains focus on the 10 EPHS.

SYMPOSIUM REPORT
Injury Prevention Program Symposium
of the Maine Injury Prevention Program
Maine Center for Disease Control and Prevention, DHHS
Maple Hill Farm, Hallowell, Maine
July 23, 2008 - 8:30 a.m. to 1:30 p.m.

The Maine Injury Prevention Program (MIPP) convened this symposium with the purpose of increasing awareness of the public health burden of injury in Maine and understanding of the MIPP commitment to link partners of the public health infrastructure to injury data, resources and training. In addition, MIPP recognized and appreciated the opportunity to strengthen the public health infrastructure by using an injury prevention focus to demonstrate the interconnectedness of the offices and functions within the infrastructure.

Participant notebooks provided attendees information integral to the symposium. (See Appendices for notebook contents)

Presentations by the following individuals set the foundation for later discussions:

- Dora Anne Mills, M.D., Director, Maine CDC
- Cheryl DiCara, Director, MIPP, Maine CDC
- Cindy Mervis, Epidemiologist, University of Southern Maine
- Mark Griswold, Director, Office of Local Public Health, Maine CDC
- Sharon Leahy-Lind, York District Public Health Liaison, Maine CDC
- Christine Lyman, Senior Advisor, Office of Local Public Health, Maine CDC

The symposium was designed to ensure that representatives from the public health infrastructure and injury prevention stakeholders could contribute ideas and suggestions for realistic and effective injury prevention collaborations between MIPP and the public health districts.

The forum was facilitated by Laura Moorehead of Moorehead Consulting Partners. Process guidelines included:

- Keep your eye on the prize of injury prevention.
- We need everyone's input. Share the airtime.
- Start with your headline (the big idea), then be concise with your elaboration.
- Be curious. Seek to understand. Acknowledge common ground and explore differences.
- Listen for insights.
- Help manage time.
- Be fully present. Silence electronics.

SMALL GROUP DISCUSSIONS

During the symposium, four pre-selected participant groups, facilitated by Cheryl DiCara, Katharyn Zwicker, Joseph Riddick and Cindy Mervis, discussed the following questions:

> What are the best strategies for linking the Maine Injury Prevention Program training, data and resources with the Public Health District Coordinating Councils and the Healthy Maine Partnerships (HMPs)?
>
> What strategies are reasonable, feasible, and achievable?
>
> What concrete, doable beginning action steps do you suggest?

The charted discussion notes and the facilitators' summary notes from each group's discussion are included in the consolidated recommendations below.

Recommendations from the Small Group Discussions

IN GENERAL

Identify what other programs are doing with the same population. Avoid duplication.

- Look at co-occurring "disorders," such as depression and suicide prevention, to break down the silos and offer an integrated view.
- Putting two programs together may reveal new collaborators.

Map injury prevention efforts across the state. An inventory of injury prevention efforts in Maine should focus on:

- Relationships between organizations
- Inventory of programs, staff
- Resources available/needed
- Other programs that are doing injury prevention but not naming it as that

Create a large umbrella under which injury can stand. Then, identify different strategies for different audiences.

Keep the MIPP eye on the forest, not the trees. Focus on the system, not just the specific programs.

Be strategic about MIPP work. Work smarter, not harder. Look at ALL links.

Go to the districts and say, "This is what we bring" not this is what we want. Be opportunistic about local conditions.

MIPP should provide national, statewide, and local prevention perspectives and keep asking if injury prevention issues are being covered at that level.

TRAINING

Don't call it training or approach it solely as a training program. People don't necessarily perceive it as such. It is more about getting people's attention and connecting data to concerns.

Work with the newly-formed Healthy Maine Partnerships (HMP) professional development team. (Geoff Miller and Dawn Littlefield are members)

- The team is going to be developing an assessment tool to look at staff development and core competencies.
- The goal would be to coordinate training among different content areas (e.g., if offering training on motivational interviewing, it will be relevant to a number of content areas/programs).
- Identify an injury prevention skill set.

Injury prevention training/awareness needs to be promoted by Local Health Offices and District Liaisons. Meet with them first before going to the communities. Provide them with tools to use in their work with partners.

- Raise awareness with them that injury is a problem and needs to be part of their thinking.
- As a first step, assess what the district is doing for the top ten injuries. Create an electronic assessment for this purpose and build in links to where they can go for further information.
- MIPP should monitor District Coordinating Council (DCC) meeting minutes via the Maine CDC website for activities where MIPP could be connected to identify and share best practices and resources around injury prevention.
- Put efforts into local injury programs that are sustainable and integrated.
- Identify who within the district could be local, grass roots level injury prevention champions, in general and/or for specific topics. They could be instrumental in bolstering the entire infrastructure, given the interconnected nature of injury issues.
- Convene public health representatives and injury prevention champions at the district level.

Offer injury prevention training and education in different formats and at different levels in order to raise awareness. Offer a broader perspective on injury. Ask about what injuries people see in their daily lives. Help people understand how to look at situations through an injury lens. Help them recognize opportunities to teach others in the moment.

Specific ideas for training and awareness building:

- Work on common vocabulary. Use language understood by the general public.

- Map all state and local programs that provide injury prevention programs.

- Design training based on district level data, rather than perceived trends. Use data to frame discussions in training programs.

- Train local health officers and link them with MIPP related training.
  - Identify evidence based and/or best practice programs. Make trainers and local health officers aware of them. Do not duplicate existing training programs.
  - Provide follow-up support as needed and evaluation of MIPP training (did training meet their needs?).

- Subcontract training and focus on larger systems issues.

- Create a speakers bureau of injury based prevention as a resource to the DCCs. In this way, they don't need to be an expert on suicide or poison, for example, but instead can have access to expertise when needed.

- Provide "Injury prevention 101" talking points and (one-page) information sheets with resources to use during training and local, specific situations. Suggested ideas include:
  - Make sure that those who are doing injury related work have the talking points they need.
  - Develop injury prevention key concepts for inclusion in school health through the Department of Education.
  - Integrate injury prevention information in driver education classes.
  - Help local level HMPs and DCCs educate legislators about injury prevention legislation by providing materials and data.

- Identify and inventory injury issues.

- Identity and inventory best practices.

- Post training activities on the Maine Prevention Calendar.

- Use Health Alert Network to broadcast injury info.

- There should be a broad Public Health News Bulletin with an injury section. Archive past bulletins on a Web site for future reference.

- Gather a lot of info into a single email, rather than sending multiple emails, similar to the women's health emails Sharon Leahy-Lind sent when she was the Women's Health Coordinator at Maine CDC. Those emails included a listing of relevant news stories, research findings, prevention materials, conferences/meetings/trainings, and other items of interest. A very brief description was given for each item, along with a link for further information.

- Package or brand simple, positive messages. Use a social marketing approach to raise awareness.
  - Identify experts in the field of injury prevention
  - Find a champion who may not be the voice of "public health" to talk about injury, i.e. Stephen King

A cultural shift is needed to begin to talk about injury in its many forms, including those that are difficult to talk about. For example, safety topics for training and education include injuries related to physical activity and health promotion through school health coordinators. Subjects that still seem to be taboo include sexual assault, suicide, and domestic violence and need to be included in injury prevention messages in Maine.

Identify the top five injury areas that can be addressed and for which effective approaches exist and provide tools for awareness and training. Communicate what train-the-trainer topics MIPP can provide.

DATA

Assess injury prevention needs at a district level. Use data and data charts to get the public's attention and to relate injury messages to vulnerable populations and local concerns. Use data headlines at the local level and relate them to prevention interventions. There will be different priorities for different districts; a #1 priority in one community may be #10 in another.

Suggestions for ways of looking at and disseminating Maine injury data include:

- Use Top Ten Leading Causes of Death
- Mental health issues and their impact on injury
- Geographic comparison data
- Tie data to headlines in the popular press – synergy
- User friendly data sets
- Dollar outcomes
- Workforce productivity
- Trend data
- Use anecdotes-(qualitative data) along with numbers (quantitative data)

Develop district and county data sets. District rankings on injury indicators would catch people's attention. District injury profiles, as described earlier in symposium, also would be helpful. Once the profiles are released, MIPP would need to do presentations at a district or coalition level to show people how to use the data to sell injury prevention.

It is difficult to get enough data about disparities as a district level. Instead, engage the communities in conversation about disparate populations to gather anecdotal data.

Keep the messages simple for public consumption. For example, injury is the #1 cause of death for 1 to 44 year olds.

RESOURCES

Create a one-page fact sheet on the Maine Injury Prevention Program, including what the program can provide and how it can assist.

Ideas for connecting MIPP to existing activities:

- The ten Essential Public Health Services (EPHS) drive the work and resource allocation. MIPP needs to relate injury to the ten EPHS. Then, determine how to coordinate resources and connect the players with common objectives and strategies.

- Map intersection of injury prevention activities and data indicators to the Minimum Common Program Objectives (range of required and optional objectives) used by HMPs. (Geoff Miller will email the full list of objectives to Cindy Mervis.)
  - Show how injury relates to the strategies in the objectives. For example, if there's an alcohol-related objective, they could be talking about drinking and driving
  - Involve MIPP partners in this mapping/cross-referencing process. Link to what's already being done and ask them how the injury piece can happen.
  - HMPs are already inundated with work. Help them identify what is injury related that is already part of their workload.

  Identify and advocate for the natural linkages of MIPP to DCCs and HMPs. (Anne Rogers can be a resource.)

- MIPP could offer mini-grants - one for each district and linked to Minimum Common Program Objectives – to develop model programs that help them administer injury prevention. Or, focus funding on a few districts at a time (based on indicator rankings) and then expand to other districts. Develop model programs that can be disseminated throughout the state. A grant might be given to an HMP, for example, to focus on school health coordinators' work on injury prevention.

- Comprehensive School Health has twelve objectives under four strategies where HMPs can select from the menu of activities.

- This fall, there will be one start-up project in each district, with concrete tasks that ensure DCC vitality.

- The DCC/HMP approach is to create opportunities for districts with like data to work together on initiatives.

- OSA's Information Resource Center could become a broader clearinghouse.

Develop an injury prevention resource directory

- Who to call in the district/state if you have questions about a given topic
- An initial directory could be organized around those MIPP-related activities that mapped to Minimum Common Program Objectives.

Develop common data definitions – e.g., what do "unintentional" and "injury prevention" mean in this context?

Provide an inventory of injury issues and the data and resources available for each issue area.

Offer on-line tool/resources kits. Develop press tool kits and resource packets for topics like suicide where a community response would be needed.

Use CD&M (Marketing and Public Relations Firm) to test messages and concepts.

FUNDING

"Core functions" funding to Districts is limited. MIPP either needs more funds for staff or needs to partner with those who have funds available.

Possibly distribute funds through DCCs funneled through partners such as Safe Community Coalitions or Comprehensive Community Health Coalitions that have a fiscal agent.

Use funds to build capacity in phases across the state versus working throughout the state from the start. Figure out what works and have the data to support it before going statewide. (DCCs may already have assessed what is working in an area. Identify who is doing that work and connect with them.)

SYMPOSIUM CLOSE

The small group facilitators met with Laura Moorehead to discern common themes among the groups. Cheryl DiCara then presented key themes to the participants.

Katharyn Zwicker, Assistant Director of MIPP, thanked everyone for their active and insightful participation and closed the symposium. Participants completed symposium evaluations. (See Appendix for tabulated results).

Participants were told that they would receive notes from the small group discussions. This report will be sent to them for that purpose. In addition, participants were informed that the report from the Symposium would be used at a MIPP staff planning retreat on August 4th and would inform the future work of MIPP.

Respectfully submitted by Laura Moorehead

Appendix I - Agenda

Maine Injury Prevention Program Symposium
Maple Hill Farm – Hallowell, Maine
July 23, 2008

The **Expected Outcomes** of the day are to increase the understanding of:

1) The public health burden of injury in Maine;
2) MIPP's commitment to providing linkage to training, data and resources;
3) The structure and functions of the Office of Local Public Health, Public Health District Coordinating Councils, and the Healthy Maine Partnerships; and
4) Strategies and initial steps to develop injury prevention collaborations.

8:00	Registration and Coffee / Muffins
8:30	Overview of the Day ***Injury Prevention Program Staff and Laura Moorehead, Facilitator***
8:45	Welcome ***Dr. Dora Anne Mills***
9:00	The Maine Injury Prevention Program: Your Link to Training, Data & Resources ***Cheryl DiCara***
9:20	Public Health Burden of Injury in Maine ***Cindy Mervis***
9:45	Break
10:00	Public Health Infrastructure: Structure & Functions and Opportunities & Challenges for Collaboration ***Mark Griswold, Chris Lyman and Sharon Leahy-Lind***
11:00	Small Group Discussions ***What are the best strategies for linking the Injury Prevention Program's training, data and resources with the new District Coordinating Councils and Healthy Maine Partnerships to reduce the burden of injuries in Maine?***
12:00	Networking Lunch
12:45	Recommendations for Moving Forward ***Symposium Participants***
1:30	Adjourn

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Appendix III – Speaker Information

Meet Today's Facilitator

Laura Moorehead
Ms. Moorehead holds a Masters in Organization Development from American University. Her facilitating experience includes assisting organizations as they evolve to new stages of purpose and work. This involved working with leadership teams and boards of directors to plan strategic directions, reshape the organization, and develop change strategies.

Meet Our Speakers

Dr. Dora Ann Mills
Dr. Mills conducted her internship and residency in pediatrics from 1987-1990 at Children's Hospital in Los Angeles. In 1997, she obtained her Masters of Public Health from Harvard University School of Public Health. Since 1996, she has been serving as Maine's Public Health Director and the Director of the Maine CDC.

Cheryl DiCara
Ms. DiCara holds a Bachelor of Arts in Social Welfare with a minor in Psychology and Health from the University of Southern Maine. Cheryl serves as the Director of the Maine Injury Prevention Program and since 1997, Coordinator of the Maine Youth Suicide Prevention Program.

Cindy Mervis
Ms. Mervis obtained her Master of Public Health degree, with a specialization in Epidemiology, from Emory University in 1992. Cindy is a Research Associate at the University of Southern Maine, providing epidemiology support to programs in the Family Health and Chronic Disease Divisions at the Maine CDC.

Sharon Leahy-Lind
Ms. Leahy-Lind holds a Master's Degree in Public Policy and Management, with dual concentrations in Public Finance and Organizational Management from the Edmund S. Muskie School of Public Service**,** University of Southern Maine, a BS in Urban Studies and a certificate in Gerontology from Worcester State College, Worcester, Massachusetts. Sharon is the York District Public Health Liaison with the Office of Local Public Health. For six years, she led the Women's Health Initiative within the Maine CDC.

Mark Griswold
Mr. Griswold is the Director of the newly-formed Maine CDC/DHHS Office of Local Public Health, created in 2008 and charged with implementing and strengthening local public health infrastructure in the state. Beginning his career as a public health educator, he worked with community-based organizations to coordinate HIV/STD prevention and testing efforts. As HIV/AIDS Surveillance Coordinator, he developed strong relationships with community-based organizations, advocates and health care providers to improve public health reporting of HIV, provide technical assistance on HIV epidemiology, and communicate with the public on issues related to HIV and sexually transmitted disease. Mark is a graduate of Bates College, and has an M.Sc in public health from Laval University in Quebec.

Christine Lyman
Ms. Lyman is the Senior Advisor in the Office of Local Public Health in Maine CDC. In addition, Chris coordinates the Preventive Health Block Grant. Prior to this, Chris worked 10 years in the Community Health Promotion Program addressing community health improvement, working directly with Healthy Communities and Healthy Maine Partnership Coalitions.

Appendix IV – Speaker Presentations

Maine Injury Prevention Program
Your link to training, data and resources

Cheryl DiCara, Director
Maine Injury Prevention Program
Coordinator, Maine Youth Suicide Prevention Program
Maine CDC, Div. of Family Health
DHHS

Injuries are the #1 cause of death for Maine residents ages 1-44.

Each year in Maine

an average of:

710 Maine residents die

And

8,200 residents are hospitalized from injuries

In a recent 5 year period

From 2001 – 2005:

709 Maine youth and young adults ages 10-24 died

…of this number

525 were injury related deaths – 74%

In Maine, 15-19 year old girls have the highest rate of hospitalization for self-inflicted injury of any age or gender group

Male residents in Maine die from injuries at a rate that is more than two times higher than females

For Maine residents aged 25-44: Unintentional poisoning is the leading cause of injury death and…

Self-inflicted poisoning is the leading cause of injury hospitalizations

Injuries are

PREVENTABLE…

we all have a role to play

We are here today because

The program is reframing our future work to:

1. Align with the 10 essential public health services
2. Better assist partners involved in injury prevention
3. Strengthen current and build new relationships to meet mutual goals that improve the public's health

To develop useful injury prevention resources and to increase linkages…

Your expertise and ideas are needed

The Injury Prevention Program Offers

TRAINING

Child Passenger Safety

Suicide Prevention

More To Be Developed…

The Injury Prevention Program Offers

DATA

Fact Sheets and Reports

Access to select national, state and district injury data

Surveillance

Analyses of key injury priorities and of data accessibility and quality issues

The Injury Prevention Program Offers

RESOURCES

- CPS seats, Fitting stations and trained technicians
- Educational materials and publications
- Information on and links to local, state, and national injury prevention resources
- Evaluation assistance
- Website
- Mini-grants

The Burden of Injury in Maine

Cindy Mervis
Maine Injury Prevention Program Symposium
July 23, 2008

Outline

- Why are injury data important?
- What data does the Maine Injury Prevention Program routinely use?
- What state-level reports does the Maine Injury Prevention Program produce?
- What district-level injury data can the Maine Injury Prevention Program provide?

Importance of injury data

- Document importance of injury as a public health problem
- Identify and track patterns and trends
- Use in developing injury prevention strategies
- Evaluate effectiveness of prevention activities

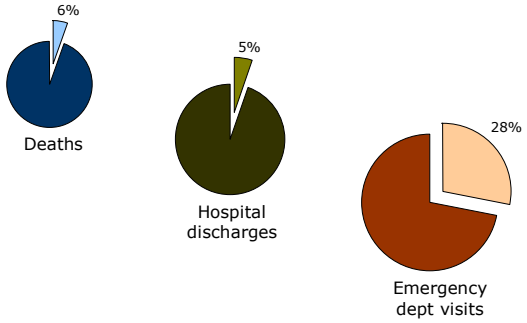
Injury data used by the Maine Injury Prevention Program

- Death certificate dataset
- Hospital discharge dataset
- Hospital outpatient dataset (emergency department visits)
- Survey data
  - Behavioral Risk Factor Surveillance System
  - Youth Risk Behavior Survey
- Other more focused datasets

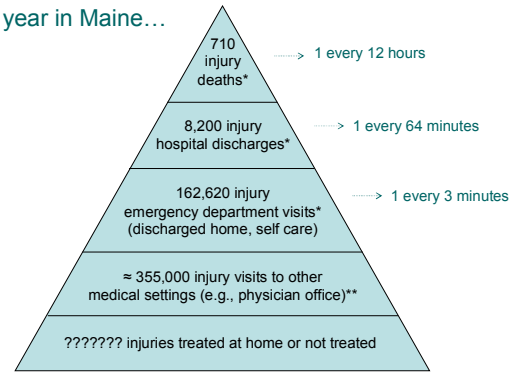
Burden of injury: Deaths among Maine residents

- Unintentional injury was the leading cause of death among 1-44 year olds and the 5th leading cause of death overall
- Suicide was the 2nd leading cause of death among 15-34 year olds and the 10th leading cause of death overall
- Homicide, while rare, was the 5th leading cause of death among 15-34 year olds

Burden of injury: % of events that are due to injury, Maine



Each year in Maine…



* Maine residents; counts have been rounded to nearest 10
** Estimate based on finding from national study

Burden of injury: Cost of injury for Maine residents injured in a single year

Type of cost	Fatal*	Nonfatal hospital admitted**
Lifetime medical costs	$7,797,200	$219,790,900
Lifetime work loss costs	$595,256,000	$268,711,700

* Year 2004 dollars, based on 1999-2002 average incidence
** Year 2005 dollars, based on year 2003 incidence
Source: Children's Safety Network Economics & Data Analysis Resource Ctr

- Cost burden shared by individuals, families, taxpayers, insurers, employers, public welfare programs

Using data to develop injury prevention strategies

- Identified leading causes of injury deaths and hospital discharges
  - Overall, by age, and by sex
  - Trends
- Four priority areas
  - Motor vehicle traffic crashes
  - Suicide
  - Unintentional poisoning
  - Unintentional falls among 65+ year olds
- Periodic reviews to see if changes needed in priority areas

Maine Injury Prevention Program: State-level data products

- Strategic Plan – 2007-2010 Revision http://www.maine.gov/dhhs/bohdcfh/inj/documents/MIPPOctober2007PlanCD(2).pdf
- Annual Injury Report – 2005 Report http://www.maine.gov/dhhs/bohdcfh/inj/documents/AnnualReport2005KZ.pdf
- State Injury Indicators Report – 3rd edition, 2004 http://www.cdc.gov/ncipc/profiles/core_state/State_Injury_Indicators_Report.pdf
- Suicide and Self-Inflicted Injury Surveillance Report http://www.maine.gov/suicide/docs/surveillance/surveillance2006.pdf
- Leading Causes of Injury Tables

Maine Injury Prevention Program: District-level data products

- Available now…
  - District Profiles
    - Motor vehicle traffic crash deaths
    - Suicide deaths
    - Hip fracture hospitalizations among 65+ year olds
    - Reported rapes
    - Domestic assaults reported to police
  - Full profiles: http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm
  - Comparison tables: http://www.maine.gov/dhhs/boh/documents/DistrictHealth-ME-US-Comparisons-FINAL.pdf

Maine Injury Prevention Program: District-level data products

- Under development…
  - District injury profiles
    - Injury counts and rates
    - Leading causes of injury tables
    - Deaths, hospital discharges, emergency department visits
    - Overall, by age, and by sex
    - One-pager summarizing highlights of injury data
- Future???
  - County injury profiles

Limitations: District-level hospital discharge data

- Two limitations of hospital discharge data impact our ability to do district-level cause-of-injury analyses
  - Likely also true for emergency department data
  - Not a concern for death certificate data

Limitation #1

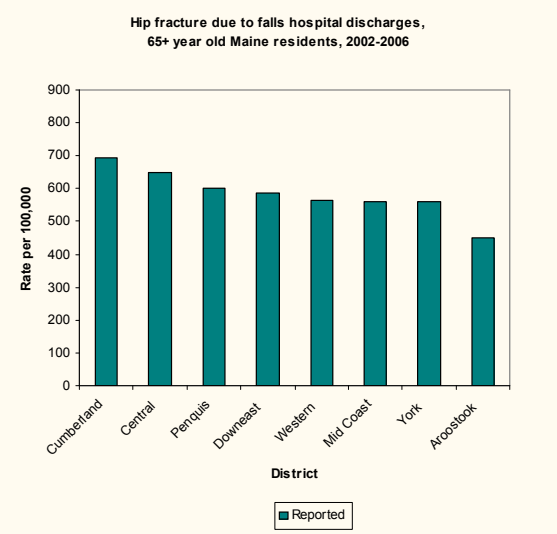
- Maine residents hospitalized out-of-state are not included in Maine hospital discharge dataset
  - % of injury hospital discharges of Maine residents that are from NH hospitals differs by district
    - 1% or less of injury discharges of residents of districts other than York
    - 13% of injury discharges of York District residents
  - Not an injury-specific issue

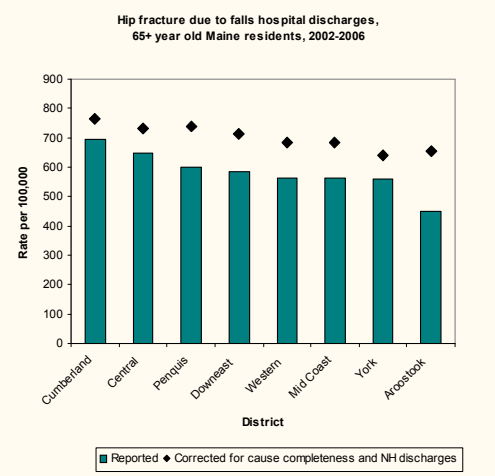
Limitation #2

- Hospital discharge dataset does not always document the cause of injury
  - Include information on the type of injury, but not what caused it
  - % of injury hospital discharge records that include cause of injury differs by district
    - Lowest: 72% of injury discharges of Aroostook District residents include cause information
    - Highest: 98% of injury discharges of York District residents include cause information

Limitations: District-level hospital discharge data

- Can result in:
  - Underestimating the number of injury hospital discharges overall or due to a specific cause
  - Reaching invalid conclusions when comparing districts
- Example: Hip fracture hospital discharges due to falls among 65+ year olds
  - 65+ year olds account for 44% of injury hospital discharges
  - 38% of discharges in this age group involve hip fractures





Addressing limitations of district-level data

- NH hospital discharge limitation impacts primarily York District
  - Know degree to which Maine hospital discharge data will underestimate hospitalizations of York residents
- Completeness of cause information limitation is more problematic
  - Differences between districts are decreasing
  - Maine Injury Prevention Program has project underway to identify reasons for incomplete cause reporting and work with interested groups to address the problem

Summary

- Injury is an important public health problem
- Priority areas identified
- Future uses of injury data will include evaluation of the effectiveness of prevention activities
- State-level injury data available in numerous Maine Injury Prevention Program reports
- Limited district-level data available now; more extensive reports being developed
  - Need to be a savvy consumer when looking at district data; ask questions and understand limitations of data

District Public Health

Sharon Leahy-Lind, MPPM
York District Public Health, Office of Local Public Health, Maine Center for Disease Control and Prevention, DHHS
Injury Symposium-July 23, 2008

District Liaisons: Who & Where

- MaryAnn Amrich,Western District
  - Located in Lewiston DHHS Office
- Jennifer Gunderman-King, Midcoast District
  - Located in Rockland DHHS Office
- Sharon Leahy-Lind, York District
  - Located in Sanford DHHS Office

Activities Underway

- Meet with Local Health Officers (LHO)
  - Learn from LHOs on the Frontline
  - Assist with LHO Training and Support
  - Link LHO to Maine CDC Resources
- Link with County Emergency Management
  - Protocol to be developed to describe the involvement of District Liaisons in public health emergencies
  - District Liaisons to be trained in local EOC operations for public health
  - District Liaisons assigned to local EOC (for public health response) in actual emergencies or exercise

Examples from the Field

- Respond to LHO Resource Requests
  - Immunization Information
  - Bed Bugs
  - Lead Screening Resources
  - Child Welfare Issues
  - Adult Protective Concerns
  - Healthy Pregnancy Information
- Partnership with Municipal GA Office
  - Request for a District wide Public Health Forum

District Public Health Activities

- Co-located District Public Health Units
  - Composition
  - Convene Monthly
  - Developing Organizational Structure
  - Shared Leadership Model
  - Linkage to DCC and Potential Subcommittees
- Co-convened District Coordinating Councils
  - In partnership with local HMPs

District Council Activities

- Underway-Developing Structure and Operating Principles
  - Partnership with the District Public Health Liaison
  - Volunteer Planning Committee
  - Discerning Governance
- Potential Activities for Year 1:
  - Begin Planning for a Local Public Health Assessment
  - Subsequent development of a district public health improvement plan
  - Strengthen Collaborations & Coordination with Community Partners

York District Coordinating Council

- Evaluation Results from 1st Meeting - June 17, 2008:
  - 96% of Members strongly agree that the presentations increased their understanding of the background & history and the structure and function of the emerging district/local public health system.
  - 83% of Members strongly agree that the relevance of the 10 Essential Public Health Services to their work is becoming clear.
  - 87% of Members strongly agree that the first meeting of the York District Public Health Council met their expectation

More Evaluation Results

- What interests you most about the emerging public health infrastructure for York District:
  - *Coordination, collaboration and policy development*
  - *Opportunity to create a public health structure to focus on gaps;*
  - *Connectivity with other agencies in order to better serve the community*
  - *Effectively use resources*
  - *Better organized and informed advocacy for local needs*
  - *Local planning*
  - *The willingness for all groups to work together*

Review of Local Headlines

- Just take a look at the Injury-related headlines:
  - ***Statewide forums tackle topic of domestic violence***
    - *So far, 70% of homicides this year are domestic violence related*
  - ***Traffic fatalities in July on record pace***
    - *17 people have perished in crashes so far this month*
  - ***Police Make An Arrest In Hit And Run Motorcycle Accident***
  - ***Charges filed in fatal hit-and-run in Maine***
    - *Two men turned themselves in today in connection with the hit and run death of Deborah Archer, a mother of six who died after being struck by a van in Berwick on May 27th.*
  - ***Maine Still Dealing with Flooding, Power Outages, Washed-Out Roads***
    - *The storm with gusts topping 80 mph and rainfall topping 7 inches felled utility poles, knocked over trees and created raging floodwaters*

Injury Concerns in the Districts

- More headlines:
  - ***Recent Stage Neck Inn fires ruled arson***
    - *York landmark blaze is the second this month*
  - ***Lightning sparks fires in two homes***
    - *More lightning strikes appear to be the cause of two fires in Springvale and in Kennebunk on Tuesday*
  - ***New details emerge in murder in Old Orchard Beach***
    - *The U.S. Marshal's Service says a 45-year-old Old Orchard Beach man was bound with a bag over his head and had a bottle of rum forced down his throat when he was found murdered in his home last month.*
  - ***Selectmen will hold public hearing on skate park plans***
    - *Selectmen will hold a public hearing on July 1 to get input about the Parks Committee's plan to put a skateboard park on the playground located at the former Ogunquit Village School.*

Community Health Profile Data & Indicators

- Injury and Violence Indicators
  - Motor Vehicle Traffic Crash Deaths (age-adjusted rate per 100,000 and average number per year) [2001-2005]
  - Hip Fracture Hospitalizations Among 65+ Year Olds (rate per 100,000 and 5 yr. count) [2001-2005]
  - Reported Rapes (rate per 10,000 female population and average number per year) [2001-2005]
  - Domestic Assaults Reported to the Police (rate per 10,000 population and count) [2005]

Partnership

- Looking Forward to Direction from Today's Breakout Sessions
- District Liaison's Guiding Theme:
  - *If you want to go fast, travel alone, but if you want to go far, travel together. – African proverb*

Appendix V – Injury Fact Sheets

Unintentional M/V = Blue Unintentional Poisoning = Red
Unintentional Fall = Green Suicide Firearm = Purple Suicide Suffocation = Purple/orange Suicide Poisoning = Purple/red

	10 Leading Causes of Injury Deaths, by Age Groups - Maine, 2001-2005, All Races, Both Sexes												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Unintentional MV traffic Unintentional Suffocation 3 each (tie)	Unintentional MV traffic 6	Unintentional MV traffic 12	Unintentional MV traffic 11	Unintentional MV traffic 226	Unintentional Poisoning 140	Unintentional Poisoning 154	Unintentional MV traffic 111	Unintentional MV traffic 69	Unintentional MV traffic 83	Unintentional Fall 124	Unintentional Fall 147	Unintentional MV traffic 925
2		Unintentional Drowning 5	Unintentional Fire/burn 3	Unintentional Drowning Suicide Firearm 3 each (tie)	Unintentional Poisoning 90	Unintentional MV traffic 123	Unintentional MV traffic 137	Unintentional Poisoning 109	Suicide Firearm 60	Suicide Firearm 63	Unintentional MV traffic 106	Unintentional Unspecified 85	Unintentional Poisoning 537
3	Unintentional Fall Unintentional Fire/burn Undetermined Suffocation 1 each (tie)	Unintentional Suffocation 4	Unintentional Other land transport 2		Suicide Firearm 54	Suicide Firearm 56	Suicide Firearm 59	Suicide Firearm 80	Suicide Poisoning 30	Unintentional Fall 49	Unintentional Unspecified 44	Unintentional Suffocation 57	Suicide Firearm 432
4		Unintentional Fire/burn Unintentional Struck by, against 3 each (tie)	Unintentional Drowning Unintentional Fall Unintentional Pedestrian, other Homicide Suffocation 1 each (tie)	Unintentional Other land transport Unintentional Poisoning Suicide Suffocation Undetermined Suffocation 2 each (tie)	Suicide Suffocation 33	Suicide Suffocation 33	Suicide Poisoning 38	Suicide Poisoning 38	Unintentional Fall 27	Unintentional Suffocation 20	Unintentional Suffocation 40	Unintentional MV traffic 38	Unintentional Fall 398
5					Unintentional Drowning Unintentional Other land transport 11 each (tie)	Suicide Poisoning 21	Suicide Suffocation 35	Suicide Suffocation 30	Unintentional Poisoning 23	Unintentional Unspecified 12	Suicide Firearm 33	Suicide Firearm 24	Unintentional Unspecified 162
6		Unintentional Pedestrian, other Unintentional Poisoning Homicide Unspecified 2 each (tie)				Unintentional Other land transport 11	Unintentional Drowning 17	Unintentional Fall 22	Unintentional Drowning 12	Adverse effects 10	Adverse effects 17	Adverse effects 12	Unintentional Suffocation 159
7					Homicide Firearm 9	Homicide Firearm 10	Unintentional Fall 16	Unintentional Drowning 15	Suicide Suffocation 11	Suicide Poisoning 9	Unintentional Drowning 10	Unintentional Natural/ environmental 6	Suicide Suffocation 154
8				Six Tied 1	Homicide Cut/pierce 7	Unintentional Other spec, classifiable 8	Unintentional Other land transport 13	Unintentional Other transport 14	Unintentional Suffocation 10	Unintentional Fire/burn 8	Unintentional Fire/burn 7	Unintentional Fire/burn Unintentional Poisoning 5 each (tie)	Suicide Poisoning 147
9		Unintentional Fall 1			Unintentional Fall Unintentional Suffocation 6 each (tie)	Unintentional Drowning 7	Undetermined Poisoning 9	Unintentional Fire/burn 11	Unintentional Other land transport 7	Unintentional Poisoning 7	Three Tied 5		Unintentional Drowning 85
10						Unintentional Fire/burn 5	Three Tied 8	Unintentional Natural/ environmental 9	Two Tied 6	Two Tied 5		Two Tied 3	Unintentional Fire/burn 61

10 Leading Causes of Injury Hospital Discharges, by Age - Maine, 2002-2006, All Races, Both Sexes

Unintentional M/V = Blue Unintentional Poisoning = Red Unintentional Fall = Green Self-Inflicted Poisoning = Brown

	By Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Unintentional Fall 43	Unintentional Fall 159	Unintentional Fall 192	Unintentional Fall 243	Unintentional MV traffic 1,221	Self-inflicted Poisoning 701	Self-inflicted Poisoning 955	Unintentional Fall 1,376	Unintentional Fall 1,708	Unintentional Fall 2,486	Unintentional Fall 5,119	Unintentional Fall 5,012	Unintentional Fall 18,147
2	Assault Other spec, classifiable 22	Unintentional Poisoning 126	Unintentional MV traffic 57	Unintentional Transport, other 123	Self-inflicted Poisoning 838	Unintentional MV traffic 669	Unintentional Fall 871	Self-inflicted Poisoning 650	Unintentional MV traffic 412	Unintentional MV traffic 314	Unintentional MV traffic 319	Unintentional Unspecified 165	Unintentional MV traffic 4,612
3	Unintentional Fire/burn 13	Unintentional Other spec, classifiable 48	Unintentional Pedal cyclist, other 41	Unintentional MV traffic 108	Unintentional Fall 434	Unintentional Fall 504	Unintentional MV traffic 733	Unintentional MV traffic 604	Self-inflicted Poisoning 212	Unintentional Poisoning 136	Unintentional Unspecified 204	Adverse effects 139	Self-inflicted Poisoning 3,544
4	Unintentional Poisoning	Unintentional MV traffic 45	Unintentional Transport, other 39	Unintentional Struck by, against 91	Unintentional Transport, other 343	Unintentional Poisoning 217	Unintentional Transport, other 239	Unintentional Poisoning 273	Unintentional Poisoning 170	Unintentional Unspecified 118	Adverse effects 166	Unintentional MV traffic 123	Unintentional Poisoning 1,722
5	Unintentional Suffocation	Unintentional Fire/burn 38	Unintentional Struck by, against 27	Self-inflicted Poisoning 81	Unintentional Poisoning 298	Unintentional Transport, other 205	Unintentional Poisoning 234	Unintentional Transport, other 198	Unintentional Transport, other 90	Unintentional Overexertion 101	Unintentional Poisoning 157	Unintentional Overexertion 69	Unintentional Transport, other 1,391
6	Assault Unspecified 12 each (tie)	Unintentional Natural/ environmental	Unintentional Natural/ environmental 18	Unintentional Pedal cyclist, other 59	Unintentional Struck by, against 176	Unintentional Struck by, against 92	Undetermined Poisoning 119	Unintentional Struck by, against 116	Unintentional Overexertion	Adverse effects 88	Unintentional Overexertion 118	Unintentional Poisoning 62	Unintentional Struck by, against 845
7	Unintentional Unspecified 10	Unintentional Struck by, against 21 each (tie)	Unintentional Poisoning 16	Unintentional Poisoning 21	Undetermined Poisoning 128	Assault Struck by, against	Unintentional Struck by, against 112	Unintentional Overexertion 114	Unintentional Unspecified 86 each (tie)	Unintentional Transport, other 75	Unintentional Other spec, classifiable 63	Unintentional Struck by, against	Unintentional Unspecified 829
8	Unintentional MV traffic 7	Unintentional Suffocation 18	Unintentional Other spec, classifiable 10	Unintentional Cut/pierce 18	Assault Struck by, against 101	Undetermined Poisoning 86 each (tie)	Unintentional Overexertion 97	Undetermined Poisoning 104	Unintentional Struck by, against 65	Unintentional Struck by, against 54	Unintentional Struck by, against 51	Unintentional Other spec, classifiable 36 each (tie)	Unintentional Overexertion 732
9	Unintentional Other spec, classifiable	Unintentional Unspecified	Unintentional Fire/burn 9	Unintentional Other spec, classifiable 16	Unintentional Fire/burn 68	Unintentional Fire/burn 70	Unintentional Fire/burn 82	Unintentional Unspecified 82	Adverse effects 59	Self-inflicted Poisoning 53	Unintentional Transport, other 46	Unintentional Other spec, NEC 34	Adverse effects 573
10	Undetermined Unspecified 5 each (tie)	Assault Other spec, classifiable 9 each (tie)	Unintentional Unspecified 8	Unintentional Unspecified 15	Unintentional Cut/pierce 66	Unintentional Overexertion 63	Unintentional Other spec, classifiable 73	Unintentional Machinery 67	Unintentional Fire/burn 49	Unintentional Fire/burn 33	Unintentional Natural/ environmental 39	Unintentional Transport, other 26	Undetermined Poisoning 516

10 Leading Causes of Death, Maine - 2001 - 2005, All Races, Both Sexes

	Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 92	Unintentional Injury 26	Unintentional Injury 20	Unintentional Injury 23	Unintentional Injury 376	Unintentional Injury 320	Unintentional Injury 396	Malignant Neoplasms 1,255	Malignant Neoplasms 2,643	Malignant Neoplasms 3,971	Malignant Neoplasms 4,894	Heart Disease 5,993	Malignant Neoplasms 15,713
2	Short Gestation 66	Congenital Anomalies 9	Malignant Neoplasms 8	Malignant Neoplasms 14	Suicide 96	Suicide 124	Malignant Neoplasms 354	Heart Disease 723	Heart Disease 1,336	Heart Disease 2,384	Heart Disease 4,640	Malignant Neoplasms 2,457	Heart Disease 15,437
3	SIDS 32	Malignant Neoplasms 9	Congenital Anomalies 3	Heart Disease 6	Malignant Neoplasms 40	Malignant Neoplasms 67	Heart Disease 264	Unintentional Injury 322	Chronic Low. Respiratory Disease 392	Chronic Low. Respiratory Disease 985	Chronic Low. Respiratory Disease 1,534	Cerebro-vascular 1,814	Chronic Low. Respiratory Disease 3,969
4	Maternal Pregnancy Comp. 22	Influenza & Pneumonia 5	Heart Disease 1	Congenital Anomalies 5	Heart Disease 24	Heart Disease 59	Suicide 149	Suicide 168	Diabetes Mellitus 269	Cerebro-vascular 479	Cerebro-vascular 1,319	Alzheimer's Disease 1,505	Cerebro-vascular 3,941
5	Placenta Cord Membranes 20	Heart Disease 4	Homicide 1	Suicide 5	Homicide 19	Homicide 19	Diabetes Mellitus 47	Liver Disease 115	Cerebro-vascular 200	Diabetes Mellitus 439	Alzheimer's Disease 769	Chronic Low. Respiratory Disease 946	Unintentional Injury 2,576
6	Bacterial Sepsis 15	Benign Neoplasms 3	Meningitis 1	Influenza & Pneumonia 4	Influenza & Pneumonia 8	Diabetes Mellitus 14	Cerebro-vascular 37	Diabetes Mellitus 101	Unintentional Injury 177	Unintentional Injury 209	Diabetes Mellitus 662	Influenza & Pneumonia 866	Alzheimer's Disease 2,439
7	Intrauterine Hypoxia 13	Homicide 2	Nephritis 1	Five Tied 1	Congenital Anomalies 7	Cerebro-vascular 9	Liver Disease 36	Chronic Low. Respiratory Disease 84	Liver Disease 141	Nephritis 194	Influenza & Pneumonia 455	Nephritis 479	Diabetes Mellitus 1,967
8	Neonatal Hemorrhage 9	Six Tied 1		Five Tied 1	Four Tied 3	Influenza & Pneumonia 8	HIV 20	Cerebro-vascular 82	Suicide 111	Influenza & Pneumonia 145	Nephritis 422	Diabetes Mellitus 432	Influenza & Pneumonia 1,573
9	Labor /Delivery Complications 8	Six Tied 1		Five Tied 1	Four Tied 3	Liver Disease 6	Homicide 20	Viral Hepatitis 38	Nephritis 79	Liver Disease 142	Unintentional Injury 350	Unintentional Injury 349	Nephritis 1,219
10	Unintentional Injury 8	Six Tied 1		Five Tied 1	Four Tied 3	Two Tied 5	Chronic Low. Respiratory Disease 18	Two Tied 29	Septicemia 74	Alzheimer's Disease 138	Parkinson's Disease 288	Pneumonitis 218	Suicide 810

WISQARS™ **Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention**

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Appendix VI – Evaluation Summary

The Maine Injury Prevention Program – Your Link to Training, Data, & Resources

Speaker: Cheryl DiCara	**Excellent**	**Above Average**	**Average**	**Below Average**	**Poor**
Knowledge of the topic	18	4	1		
Ability to communicate	11	9	3		
Ability to stimulate interest	10	8	3	1	
Responsive to audience	10	9	1		
Clarity of materials	13	6	3		
Content relevant to Outcomes	13	5	4		
Able to utilize information and materials in work setting	11	5	3		

Comments: Don't apologize
Brought the past together into the future well.
Good info. and thanks for pulling this together.

Public Health Burden of Injury in Maine

Speaker: Cindy Mervis	**Excellent**	**Above Average**	**Average**	**Below Average**	**Poor**
Knowledge of the topic	20	3			
Ability to communicate	16	5	2		
Ability to stimulate interest	13	7	3		
Responsive to audience	15	5	3		
Clarity of materials	16	5	1		
Content relevant to Outcomes	17	6			
Able to utilize information and materials in work setting	12	9	1		

Comments: A day / one program where each pertinent state agency (or agencies that can cover the state) can all talk about their programs and what they can offer to the HMP and DCCs.
Always an intriguing speaker with new insight and information.
Very nice job!
Excellent resources and useful information – good snap shot

Public Health Infrastructure

Structure, Functions and Opportunities and Challenges for Collaboration

Speakers: Mark Griswold Chris Lyman Sharon Leahy-Lind	**Excellent**	**Above Average**	**Average**	**Below Average**	**Poor**
Knowledge of the topic	**23**	**1**			
Ability to communicate	**13**	**10**			
Ability to stimulate interest	**14**	**9**			
Responsive to audience	**17**	**5**			
Clarity of materials	**15**	**8**			
Content relevant to Outcomes	**19**	**4**			
Able to utilize information and materials in work setting	**15**	**6**	**1**		

Comments:

Good thorough overview
Sharon was excellent
Appreciated Chris's using injury related info. in her presentation
Chris's presentation was concise and surprisingly clear
Well done
This was extremely informative
Chris was excellent and brought it all together

Overall Symposium Evaluation Form

In order to continue to improve the quality of our education programs, please take a few moments to complete this questionnaire. You may leave the questionnaire at the registration desk. Thank you. Your input is important and appreciated.

1. What is your overall evaluation of the program?

16 Excellent 7 Good ☐ Adequate ☐ Poor

2. Appropriateness of the topic for your educational and/or work needs.

13 Excellent 9 Good 1 Adequate ☐ Poor

3. Practical value of the program to your daily practice.

9 Excellent 14 Good ☐ Adequate ☐ Poor

4. Effectiveness of learning aids used (e.g. audio-visual, handouts, etc.).

10 Excellent 10 Good 3 Adequate ☐ Poor

5. Please rate the facility.

20 Excellent 3 Good ☐ Adequate ☐ Poor

Comments: I don't like the bell.
Nice setting. Facilitator did a nice job keeping everyone on schedule.
Very good
Extremely good opportunity to share
Great job!!
Great start to a collaborative effort as we move forward
I better understand the PH structure in the state and feel we are definitely heading in the right direction.
Thanks for moving us all forward on making PH infrastructure work for Maine people.
Thanks for inviting me.
More time for group discussion and little less time for the presentations.
Great job! Thank you for holding this event.

Suggestions and/or topics for future programs:
I would like to see a stronger, maybe clearer response to how MIPP relates to some issues where it is not the lead, such as around DV. We need to know you're on top of it…
How to get down to the local level.

DHHS - Non-Discrimination Notice

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