



Cumberland District Public Health Council
Full Council Meeting
May 18, 2012
10:00 p.m. — 12:00 p.m.
Planned Parenthood of Northern New England
443 Congress Street, Portland

Present: Jim Budway, Steve Fox, Megan Hannan, Colleen Hilton, Becca Matusovich, Emily Rines, Lucie Rioux, Toho Soma, Ashley Soule, Julie Sullivan, Ted Trainer, Anne Tricomi, Carol Zechman ; Shane Gallagher ; Joan Ingram, Caity Hager, Alex Hughes, Claire Schroeder, Fred Wolff

Absent: Neal Allen, Anita Anderson, Denise Bisailon, Faye Daley, Deb Deatruck, Sandra Hale, Paul Hunt, Valerie Landry, Bernice Mills, Dianne North, Karen O'Rourke, Cathy Patnaude, Helen Peake-Godin, Erica Schmitz, Pamela Smith, Peter Stuckey, Helen Twombly, Eileen Wyatt

Topic	Discussion	Actions
Annual Report	Colleen Hilton briefly reviewed the contents of the Annual Report (See Appendix A). The report covered the work of the Council over the past year.	Shane Gallagher will email the Annual Report pdf to the Council and post it on the web site. Becca Matusovich will post the Annual Report pdf on the Cumberland section of the Office of Local Public Health web page.
Financial Report	Toho Soma reviewed the financial report, which can be found in the Annual Report (See Appendix A).	No actions required.
Officer Elections—Chair, Vice Chair, and Secretary	Colleen Hilton and Emily Rines presented the slate of officers (See Appendix B). The	Shane Gallagher will send out an electronic vote on the slate of officers.

Topic	Discussion	Actions
	<p>officer slate included Toho Soma (Chair), Colleen Hilton (Vice Chair), and Julie Sullivan (Secretary). Due to a lack of quorum, the vote will be held electronically.</p>	
<p>Cumberland County Community Health Forums and District Public Health Improvement Plan</p> <p><i>Access to Care:</i></p>	<p>After the Community Health Forums in January, several work groups formed around identified priorities. Seven of the groups reported on activities to date.</p> <p>Becca Matusovich presented information on two different Access to Care initiatives. The first focused on immigrants and refugees and the second focused on the Lakes region of Cumberland County.</p> <p>The Greater Portland Immigrant and Refugee Collaborative (see Appendix E) started as a partnership between the State and Portland, but quickly expanded to multiple partner organizations. The collaborative developed a short list of priorities. The next meeting is in June.</p> <p>The Lakes region access to care breakout group from the St. Joseph’s College CHNA forum recently reconvened after a hiatus for background research, and identified</p>	<p>These collaborations (and others relevant to the district’s priorities) are listed in the attached “collaborations chart” (see Appendix C). Anyone interested in more information or in getting involved should contact the people listed as the leads for each group. If you need contact information for anyone, email Becca.matusovich@maine.gov.</p>

Topic	Discussion	Actions
<i>Mental Health and Substance Abuse:</i>	<p>potential needs and opportunities for work on this issue. The next step for the group is to have a conference call to determine who else needs to be involved and what priorities within access should the group's effort be focused on.</p> <p>Emily Rines reported on the Mental Health and Substance abuse group. The group had to cancel a meeting in April due to scheduling conflicts. The next meeting will be on June 5, 2012.</p>	No action required.
<i>Immunization Group:</i>	<p>Becca Matusovich reported on the activities of the Flu/Pneumococcal Immunization group. The group reconvened in March. Becca distributed copies of the draft 2012 work plan (see Appendix F). Due to last year's mild flu season, Becca sought the advice of the Council on the proposed work plan.</p>	If any Council members have influential contacts in either the Scarborough school district or the Cumberland/North Yarmouth school district, those are the two school districts that the workgroup would like to encourage to consider school flu clinics this fall.
<i>Sexual and Reproductive Health:</i>	<p>Alex Hughes provided the update from the Sexual and Reproductive Health group on behalf of Jennifer Thibodeau. The group forged solid relationships with Family Planning and Planned Parenthood. The group also developed a survey, which is</p>	No action required.

Topic	Discussion	Actions
<p><i>Cardiovascular/High Blood Pressure/Cholesterol Group:</i></p> <p><i>Physical Activity/Nutrition/Obesity Group:</i></p> <p><i>Tobacco Group:</i></p>	<p>ready to be distributed.</p> <p>Anne Tricomi reported on the Cardiovascular group. The group met several times. Currently they plan to focus on small employers and will target high blood pressure as a topic. The focus will be to leverage existing strategies, such as “Know Your Numbers” and the Million Hearts Campaign.</p> <p>Anne Tricomi reported for the Physical Activity and Nutrition group. The group met last week. There will be overlap between the group’s work and the work of the Cardiovascular group and CTG, so there may not be a need for a separate PAN group.</p> <p>Fred Wolff and Claire Schroeder reported for the Tobacco Group. The handout they provided at the meeting is included as Appendix G.</p>	<p>No action required.</p> <p>No action required.</p> <p>No action required.</p>
<p>Community Transformation Grant Report Out</p>	<p>Shane Gallagher provided an update (see Appendices H and I) on Community Transformation Grant achievements since the last Council Meeting. In addition, he</p>	<p>Shane Gallagher will continue to provide updates on the Community Transformation Grant, as appropriate.</p>

Topic	Discussion	Actions
	<p>also provided a list current activities and important dates for the grant.</p> <p>Joan Ingram and Lucie Rioux provided an overview of the draft first year work plans for the Physical Activity and Nutrition (see Appendices J and K), and Active Community Environment (see Appendix L) work groups. The Oversight Subcommittee approved the draft versions of the work plans at the April 23, 2012 meeting.</p> <p>The present members endorsed the draft work plans for both the Community Transformation Grant work groups.</p>	<p>Joan Ingram and Lucie Rioux will work on the revised work plans and provide updates to the Council, as appropriate.</p>

Next Meeting: Full Council—July 20, 2012 at MaineHealth Building, 110 Free Street, Portland ; Executive Committee— June 25, 2012 at Portland City Hall, 389 Congress Street, Portland.

**Cumberland District
Public Health Council**



Public Health
Prevent. Promote. Protect.

May 18

2012

Annual
Report

Introduction

The Cumberland District Public Health Council (Council) continues to work toward its vision of making communities in Cumberland District among the healthiest in the state. Over the past year, the Council formed work groups to address issues such as influenza, coordinated communication and health equity. The Council received a Community Transformation Grant to improve physical activity, nutrition and active communities across the district. This annual report contains information on the Council's activities, the Council's fiscal health, committees and workgroups, and all members whom were active over the past fiscal year.

History

The Council convened in December 2006 immediately following the statewide Public Health Work Group's decision to create eight public health districts, each with a district coordinating council (DCC). The Council built the initial membership from participants in the Portland Public Health Division's Local Public Health System Assessment in January and February 2005, and the Cumberland County Strategic Planning Committee's Public Health and Human Services Subcommittee in July 2006. In November 2008, the Council restructured with the adoption of official by-laws.

Council Officers

At the May 2011 Annual meeting, the Membership voted on three officer positions. The Membership elected Toho Soma as the Council Vice-Chair, Deb Deatrck as the Council Treasurer, and Steve Fox as the Council Representative to the State Coordinating Council. The current officers of the Council are:

Council Chair—Colleen Hilton (term ending May 2012)

Council Vice Chair—Toho Soma (term ending May 2013)

Council Secretary—Julie Sullivan (term ending May 2012)

Council Treasurer—Deb Deatrck (term ending May 2013)

Council Representative to the State Coordinating Council—Steve Fox (term ending May 2013)

Maine CDC District Liaison—Becca Matusovich

Committees and Workgroups

The Council maintained six standing committees, as set forth in the Council by-laws. The standing committees include the Advocacy Committee, Communications Committee, Finance & Fundraising Committee, Health Data Committee, Healthy Cumberland Committee, and

Membership Committee. These committees had varying level of activity over the past year. The Healthy Cumberland Committee stands out as the most active committee over the past year. They Health Cumberland Committee worked hard to move toward acting as the advisory board for all four Healthy Maine Partnerships in Cumberland County and will continue to work toward this goal.

One ad-hoc committee was established (see Oversight Sub-committee under the Community Transformation Grant) to work on a grant. In addition, the Executive Committee continued meeting every other month to discuss and administer Council business.

The Council also maintained three work groups. The Flu & Pneumococcal work group and the Communications work group focused on the District Public Health Improvement Plan priorities for the two respective topics. The Healthy Equity work group formed in June 2011 in response to a Federal Government effort to address health disparities, and the Council's interest in pursuing efforts locally.

District Public Health Improvement Plan

With leadership provided by the Maine CDC Cumberland District Liaison and active engagement by many Council members and other district partners, the Flu & Pneumococcal Work Group, the Communications Work Group, and the Greater Portland Refugee and Immigrant HealthCare Collaborative all worked on priorities set forth in the District Public Health Improvement Plan.

The Flu & Pneumococcal Workgroup continued meeting monthly, implementing a 3-pronged work plan. The work plan focused on organizing school flu clinics, coordinating adult public clinics to ensure access for vulnerable populations, and a coordinated communications strategy. During the spring, the work group completed an issue brief on school flu clinics, presented the brief to the Cumberland County Superintendents' Association and distributed it to all school nurses.

The Flu & Pneumococcal Work Group recruited a University of New England graduate student as a summer intern. The work group's summer activities focused on strengthening the clinic infrastructure and developing a sustainable business model for non-profit public flu clinics. Specifically, the work group developed a community partner guide for supporting local flu clinics, created a mechanism for assessing countywide coverage and coordinating planning across the 5 clinic providers, worked with 211 to improve clinic listings on the 211 website, and adapted York District's employer toolkit to suit the needs of Cumberland District.

The Flu & Pneumococcal Work Group went on hiatus in August of 2011 as the flu season began. The work group reconvened on March 21, 2012 to begin work for next year's flu season.

The Communications Work Group also continued meeting monthly. In the last year, the work group developed a shared principles and agreements document as the core of the Communications Plan, designed a planning tool for coordinated communications strategies, developed a corporate sponsorship policy, tested tools and processes (using residential mold as a case study), field-tested a Local Health Officer “Quick Reference Guide” and tenant and landlord fact sheets. A graduate-level intern from the University of New England assisted in the development of many of the tools and documents produced by the Communications Work Group.

In addition, the Communications work group developed a second coordinated communications strategy for flu vaccination (materials created include an Implementation Guide, poster, newspaper ad, newsletter “drop-in article”, and clinic listings), and drafted a “Communications Dissemination Network” to identify and develop agreement with all relevant partners in the county who do or could play a role in disseminating public health messages to the public, including those with the ability to reach vulnerable populations.

Although the Cumberland District has a reputation for robust health care infrastructure, concerns about disparities in access to care for vulnerable populations drove the selection of “Access to Care” as one of Cumberland’s District Public Health Improvement Plan priorities. One of district partners’ greatest concerns focuses on the barriers to care experienced by refugees and immigrants, who are an increasing proportion of the Cumberland County population and a group with particularly complex health needs.

Therefore, in May 2010, the Maine CDC’s Cumberland District Public Health Unit in collaboration with Portland Public Health, convened an ad hoc group that came to be called “the Greater Portland Refugee & Immigrant Healthcare Collaborative.” The initial goal was simply to coordinate efforts and share information across the range of state and local government programs, local primary care providers and hospitals, social service agencies, and academic partners who all share a role in ensuring access to culturally appropriate health care services.

The Collaborative’s early discussions created a common understanding of the various categories of immigrants and the impact of their categorization on access to services. Each organization knew its own niche in the fragmented safety net but it was necessary to develop a shared picture of the whole system of services. The Healthcare Collaborative identified four initial priorities (dental care, mental health, vision care, and primary care/initial health assessment recommendations) and established workgroups; nutrition education and flu vaccination have also been a focus. The many actively engaged partners are committed to maximizing their collective impact to coordinate the patchwork quilt of services and develop strategic solutions to what can seem like an overwhelming array of challenges. Collaborative

grant proposals are in development to support innovations that hold promise for reducing both high health care costs and disparities in both access to care and health outcomes.

Examples of what the Collaborative has been able to produce in its first year include:

- Exploration of collaborative grant opportunities to ensure access to vision care, preventive dental care, oral health promotion, and nutrition education
- Partnership with Portland Community Health Center and Casco Bay EyeCare to develop optician services at the federally-qualified health center, which has a patient population that is as much as 2/3 refugees and immigrants.
- A community resource guide to assist primary care providers and case managers in making referrals for health care and preventive services more efficiently.
- An inventory of mental health services and assessment of the capacity of Portland area mental health providers to meet refugee needs.

The mid-term report card for the Cumberland District Public Health Improvement Plan can be found in Appendix A. The following instructions explain the scoring methodology.

- Up Arrow: Movement toward improvement.
- Down Arrow: Action was taken but has hit barriers.
- Equal Sign: District took minimal to no action during this timeframe.
- Gold Star: significant improvement and success.
- Red Flag: Needs attention.

Cumberland County Community Health Needs Assessment Forums

In January 2011, two Cumberland County Community Health Needs Assessment (CHNA) Forums were held – one in Standish and one in Portland. MaineHealth convened a planning group that included all of the hospitals in the county, the Cumberland District Coordinating Council, the ME CDC District Liaison, the City of Portland, the Healthy Maine Partnerships, and the United Way of Greater Portland. This planning group decided to frame the priorities for discussion and follow-up work emerging from the forums around the priorities that are shared between the District Public Health Improvement Plan, the Healthy Maine Partnerships' Community Health Improvement Plans, and the hospital/health system strategic priorities. This has infused additional energy and engagement in the work toward these priorities. Between January and May 2011, follow-up conversations have been convened on the following priorities. The

leaders have committed to report back to the Council on a regular basis on any strategies that are identified for collaborative work on these priorities.

- Tobacco
- Cardiovascular health
- Physical activity, nutrition, & obesity
- Access to care (with a targeted focus on the Lakes Region)
- Mental Health and Substance Abuse

Community Transformation Grant

The Community Transformation Grants are Federal pass-through grants authorized under the Affordable Care Act of 2010. The Maine Center for Disease Control and Prevention received a \$1.3 million dollar Community Transformation Grant in September 2011. The Community Transformation Grant money was distributed between the eight public health districts and the tribal district.

The grant requires a committee to oversee the work of the grant in each district. The Oversight Sub-committee formed in late 2011 and met in January, February, March, and April. The Oversight Sub-committee consists of the all of the Executive Committee of the Council plus additional individuals interested in the work. The process of developing the structure for collaborative design and oversight has been labor-intensive but valuable for the Council's development.

The Oversight Sub-committee approved Shane Gallagher as the Community Transformation Grant Coordinator. The Coordinator is primarily responsible for communication among the district, local level work and the state level work. Shane Gallagher began to transition into the Coordinator role in mid-March 2012.

Two work groups formed to draft a district work plan. The first work group focused on the physical activity and nutrition objectives, and the second work group focused on the active community environment objectives. Both work groups submitted draft work plans, budgets, and staffing plans for year one (ending September 29, 2012) to the Oversight Sub-committee in April.

Shane Gallagher, Joan Ingram, Jennifer Thibodeau, and Zoe Miller attended the Community Transformation Grant Action Institute in Augusta. Over the course of two days, the attendees learned about the expectations of the grant and had questions answered by the state-level Community Transformation Grant team.

Community Access to Child Health Grant

The Community Access to Child Health Grant (CATCH) from the American Academy of Pediatrics looks at increasing child immunization rates in Cumberland County. The grant required an environmental scan to identify potential “alternative” vaccination sites. MaineHealth contracted with the Council to have Shane Gallagher develop the assessment using a modified “community asset map” model. The final product contained over 17,000 data points.

County Health Rankings

The collaborative efforts of the member organizations of the Council are paying off. The results of these efforts are reflected in the County Health Rankings & Roadmaps. Cumberland ranked in the top five for health outcomes and health factors in both 2011 and 2012. The 2011 and 2012 County Health Rankings & Roadmaps can be found in Appendices B and C.

Financial Report

The Council received funding from several organizations, as well as the Community Transformation Grant. The main expense of the Council remained salary for staff support. A detailed report can be found in Appendix D.

Meeting Locations

Over the past year, the Council held meetings in various locations in order to reach various parts of the District. Meeting locations included Bridgton Hospital, MaineHealth, Portland Water District, VNA Home Health & Hospice, and University of New England’s Portland Campus.

Membership

The Council’s membership represented a variety of organizations and diverse regions of the Cumberland Public Health District. Members from the past year are listed below.

Neal Allen— Greater Portland Council of Governments

Faye Daley—Bridgton/Harrison Local Health Officer

Anita Anderson—Chebeague Island Local Health Officer

Deb Deatrick—MaineHealth/Maine Medical Center

Denise Bisailon—University of New England Public Health Graduate Program

Stephen Fox—South Portland Fire Department/Local Health Officer

Lynn Browne—St. Joseph’s College

Sandra Hale—Westbrook School System

Jim Budway—Cumberland County Emergency Management Agency

Megan Hannan—Planned Parenthood of Northern New England

Colleen Hilton—Mercy Health System of
Maine/VNA Home Health and Hospice

Paul Hunt—Portland Water District

Valerie Landry—Mercy Health System of
Maine

Becca Matusovich—Maine CDC Cumberland
District DHHS Office

Bernice Mills—University of New England
Dental Hygiene Program

Dianne North—Cumberland County Jail

Karen O’Rourke—University of New
England Center for Community and Public
Health

Cathy Patnaude—Home Health Visiting
Nurses

Helen Peake-Godin—University of Southern
Maine School of Nursing

Lois Reckitt—Family Crisis Services

Emily Rines—United Way of Greater
Portland

Lucie Rioux—Opportunity Alliance

Erica Schmitz—Medical Care Development

Pamela Smith—Bridgton Hospital

Toho Soma—City of Portland Public Health
Division

Ashley Soule—Maine Medical Center
Cancer Institute

Peter Stuckey—Maine State Legislature
(Portland Area Representative)

Julie Sullivan—City of Portland Public Health
Division

Meredith Tipton—Tipton Enterprises, Inc.

Ted Trainer—Southern Maine Area Agency
on Aging

Anne Tricomi—City of Portland Public
Health Division, Healthy Casco Bay

Steve Trockman—Midcoast Hospital

Helen Twombly—Sebago Local Health
Officer

Eileen Wyatt—
Cumberland/Yarmouth/North Yarmouth
Local Health Officer

Carol Zechman—CarePartners,
MaineHealth

Next Steps

Looking forward there is much work for the Council in the coming year. Some examples of the Councils work include:

- Continue work on DPHIP priorities through continuing workgroups, including those convened following the Cumberland Community Health Needs Assessment Forums
- Healthy Cumberland will be working on strengthening their role as Advisory Board to the four Healthy Maine Partnerships, including a need to guide the HMPs in adapting to the potential for significantly reduced budgets
- Continue significant focus on the Community Transformation Grant
- Strengthen and re-vitalize the membership committee in order to ensure an active membership that represents the full breadth of public health partners in the district.

Cumberland District Public Health Improvement Plan Mid-Term Report Card

District Priorities

Health status focus areas (Call to Action):

• Flu & Pneumococcal vaccination



- Well-functioning workgroup with collaborative leadership by key partners
- Designed and implemented three strands of work for 2011 flu season and continuing to build on this work for the 2012 flu season: school flu clinics, adult public clinics and coordinated communications
- Overall, demand for flu vaccine in the 2011 season was much lower than in past seasons and attendance at public flu season was at its lowest point in years, which is forcing district partners to consider cutting back on the number of adult public clinics they offer next season.

• High Blood Pressure & High Cholesterol



- The CDPHC's focus on this priority to date has been on the prevention end of the spectrum, with the CDPHC's participation in the Community Transformation Grant, as well as ongoing collaborative work on physical activity and nutrition by the four Healthy Maine Partnerships, MaineHealth's Health Index initiative, Let's Go, and other partners in the district.
- A Cardiovascular Health workgroup has just formed as a follow-up activity after the Community Health Needs Assessment Forums sponsored by MaineHealth in January 2012. This workgroup is just beginning to consider options for collaborative activity to improve blood pressure and cholesterol control.

• Tobacco



- Ongoing collaborative work in the district includes partnerships across the four Healthy Maine Partnerships, the Center for Tobacco Independence and Maine Tobacco Quitline, the Breathe Easy Coalition, and other partners such as hospitals, colleges, housing authorities, municipalities, schools, etc.
- A Tobacco workgroup has just formed as a follow-up activity after the Community Health Needs Assessment Forums sponsored by MaineHealth in January 2012. This workgroup is just beginning to consider options for collaborative activity at the district level that would add to the impact of the existing efforts.

• Access to care



- The Greater Portland Refugee and Immigrant Healthcare Collaborative was formed in May 2011, with leadership from the Maine CDC District Public Health Unit and Portland Public Health. The focus of this very active collaborative effort is on access to care among the refugee and immigrant communities who face many barriers to accessing needed services. Five workgroups have been formed to address priority areas identified by the collaborative: mental health, dental care, vision care, primary care/initial health screenings, and nutrition education. Each workgroup has identified strategies to streamline and coordinate available services and reduce barriers to access.
- Through the Community Health Needs Assessment Forums in January 2012, access to care in the Lakes Region section of Cumberland County was identified as an area of particular concern in addition to access among refugee & immigrant communities in Greater Portland. A workgroup is being formed to examine the access issues in the Lakes Region and develop collaborative strategies to increase access to primary care and preventive health services.

• Public Health Preparedness



- Planning efforts for a Cumberland County Medical Reserve Corps initiated, with leadership provided by the Cumberland County Emergency Management Agency in partnership with Maine CDC, Portland Public Health, American Red Cross, Southern Maine Regional Resource Center, and other CDPHC members. Goal is for MRC startup in the fall of 2012. Core missions include support for special health-related needs at regional shelters during emergencies, alternative care sites to mitigate hospital surge events, Strategic National Stockpile points of dispensing, and routine mass immunization clinics.
- Ongoing collaboration of many CDPHC members through the Advisory Committee for the Cities Readiness Initiative (CRI), led by Portland Public Health with support from Maine CDC.

Strategies

- **Flu & Pneumococcal Vaccination: Support & expand school flu clinics, coordinate planning & promotion of public flu clinics to ensure access for vulnerable populations, develop a communications campaign. ***
 - Flu & Pneumococcal Workgroup has implemented action steps successfully on all three strands of work.
 - Maintained participation of all school districts in 2011 who had conducted flu clinics in 2010, and supported the addition of one new school district who had not offered flu clinics the previous year. Created “School Flu Clinics Issue Brief” to educate administrators, school boards, and other decision-makers about the rationale for school flu clinics and offer the workgroup’s support.
 - Developed a coordinated schedule of adult public flu clinics across all five clinic providers in the county, and worked with 211 to develop a mechanism for promoting county-wide listing of all flu clinics rather than each provider individually promoting only their own clinics.
 - Worked with partners to collaborate on joint newspaper ads strategically promoting specific clinics (by location rather than by provider).
 - Developed a poster campaign to remind people to get a flu shot and advertise 211 as a source for information on where to find flu clinics.

- **Communication: establish a Communications Plan for the council, including a process and tools for coordinating communications across district partners on priority health topics. ↑**
 - Drafted components of a Communications Plan, including
 - Guiding principles for the Council’s Communications efforts
 - A framework for developing a “coordinated communications strategy” on selected topic
 - A strategic planning tool for identifying key messages and audiences on a selected topic
 - An “Implementation Guide” template to use with each coordinated communications strategy
 - Piloted the process and tools with two topics: mold in rental housing, and flu vaccination.

- **Create workgroups on the other priorities to implement the Communications Plan and replicate the most successful aspects of the Flu & Pneumococcal Vaccination Workgroup’s process. ↑**
 - Workgroups have been on all of the DPHIP priorities, either initiated by the CDPHC or led by partners who are members of the CDPHC and who can report back to the CDPHC on the workgroup’s activities. The CDPHC is in the process of establishing a mechanism to track these collaborative efforts and receive periodic updates on their progress.
 - The CDPHC also created a Health Equity Workgroup to increase capacity of the district partners to address health equity, as well as to examine ways that the Council can impact health equity and reduce disparities across all of its efforts.

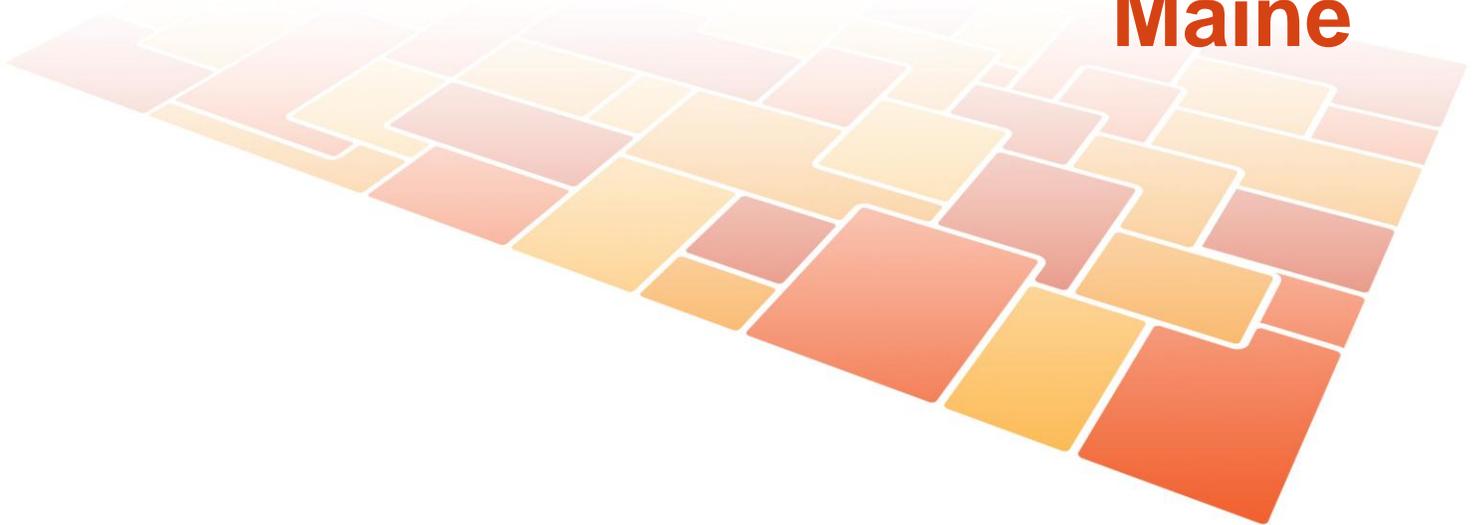


County Health Rankings

Mobilizing Action Toward Community Health

2011

Maine



Robert Wood Johnson Foundation



UNIVERSITY OF WISCONSIN

Population Health Institute

Translating Research into Policy and Practice

Introduction

Where we live matters to our health. The health of a community depends on many different factors, including quality of health care, individual behavior, education and jobs, and the environment. We can improve a community's health through programs and policies. For example, people who live in communities with ample park and recreation space are more likely to exercise, which reduces heart disease risk. People who live in communities with smoke-free laws are less likely to smoke or to be exposed to second-hand smoke, which reduces lung cancer risk.

The problem is that there are big differences in health across communities, with some places being much healthier than others. And up to now, it has been hard to get a standard way to measure how healthy a county is and see where they can improve.

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute are pleased to present the 2011 *County Health Rankings*, a collection of 50 reports that reflect the overall health of counties in every state across the country. For the second year in a row, counties can get a snapshot of how healthy their residents are by comparing their overall health and the factors that influence their health with other counties in their state. This allows communities to see county-to-county where they are doing well and where they need to improve.

Everyone has a stake in community health. We all need to work together to find solutions. The *County Health Rankings* serve as both a call to action and a needed tool in this effort.

All of the *County Health Rankings* are based upon this model of population health improvement:



In this model, health outcomes are measures that describe the current health status of a county. These health outcomes are influenced by a set of health factors. These health factors and their outcomes may also be affected by community-based programs and policies designed to alter their distribution in the community. Counties can improve health outcomes by addressing all health factors with effective, evidence-based programs and policies.

To compile the *Rankings*, we built on our prior work in Wisconsin, obtained input from a team of expert advisors, and worked closely with staff from the National Center for Health Statistics. Together we selected a number of population health measures based on scientific relevance, importance, and availability of data at the county level.

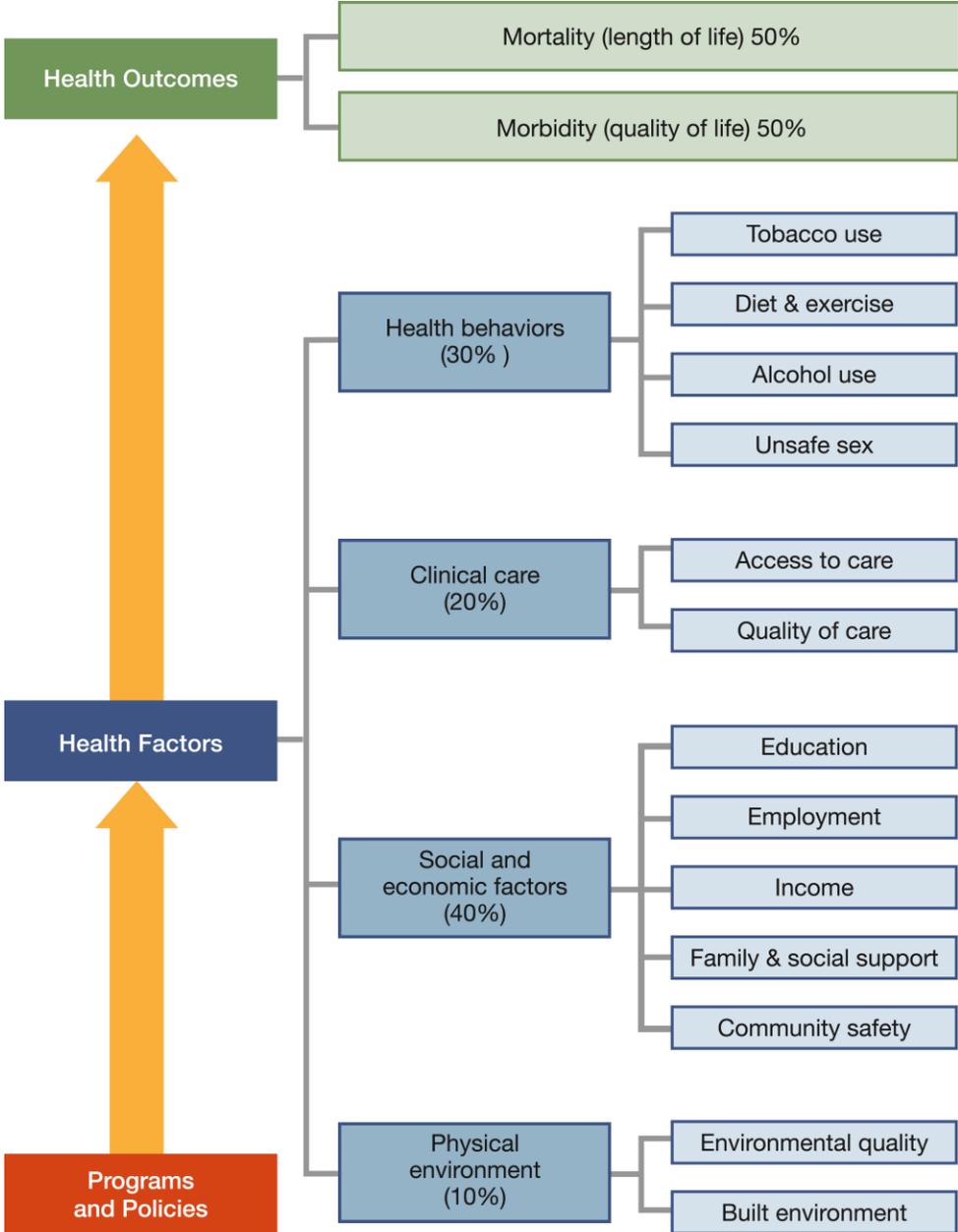
For a more detailed explanation of our approach, the methods used to compile the *Rankings*, information on the action steps communities can take to improve their health, and examples of communities in action, see www.countyhealthrankings.org



The Rankings

This report ranks Maine counties according to their summary measures of **health outcomes** and **health factors**, as well as the components used to create each summary measure. The figure below depicts the structure of the *Rankings* model. Counties receive a rank for each population health component; those having high ranks (e.g., 1 or 2) are estimated to be the “healthiest.”

Our summary **health outcomes** rankings are based on an equal weighting of mortality and morbidity measures. The summary **health factors** rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input, but represent just one way of combining these factors.

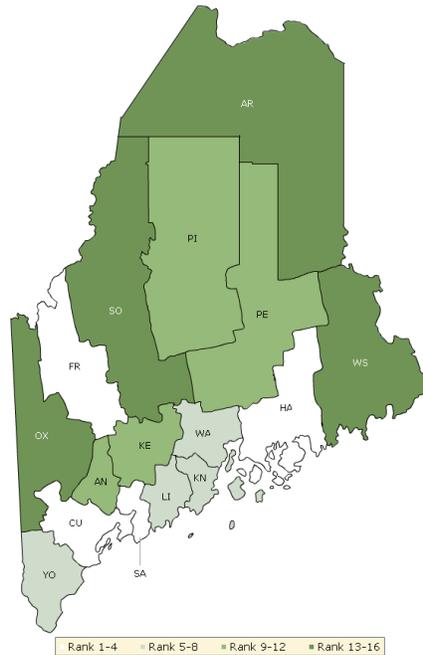


County Health Rankings model ©2010 UWPHI

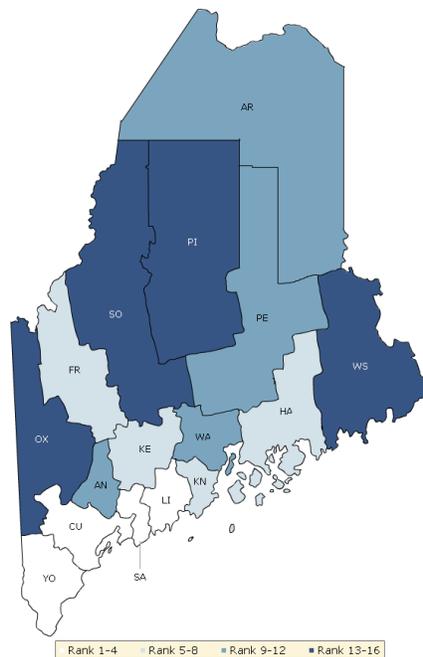
The maps on this page display Maine's counties divided into groups by health rank. The lighter colors indicate better performance in the respective summary rankings. The green map shows the distribution of summary health outcomes. The blue displays the distribution of the summary rank for health factors.

Maps help locate the healthiest and least healthy counties in the state. The health factors map appears similar to the health outcomes map, showing how health factors and health outcomes are closely related.

HEALTH OUTCOMES



HEALTH FACTORS



Summary Health Outcomes & Health Factors Rankings

Counties receive two summary ranks:

- Health Outcomes
- Health Factors

Each of these ranks represents a weighted summary of a number of measures.

Health outcomes represent how healthy a county is while health factors are what influences the health of the county.

Rank	Health Outcomes	Rank	Health Factors
1	Hancock	1	Cumberland
2	Franklin	2	York
3	Cumberland	3	Sagadahoc
4	Sagadahoc	4	Lincoln
5	Lincoln	5	Kennebec
6	York	6	Hancock
7	Knox	7	Knox
8	Waldo	8	Franklin
9	Kennebec	9	Penobscot
10	Piscataquis	10	Waldo
11	Penobscot	11	Aroostook
12	Androscoggin	12	Androscoggin
13	Aroostook	13	Oxford
14	Somerset	14	Piscataquis
15	Washington	15	Washington
16	Oxford	16	Somerset

Health Outcomes Rankings

The summary health outcomes ranking is based on measures of mortality and morbidity. Each county's ranks for mortality and morbidity are displayed here. The mortality rank, representing length of life, is based on a measure of premature death: the years of potential life lost prior to age 75.

The morbidity rank is based on measures that represent health-related quality of life and birth outcomes. We combine four morbidity measures: self-reported fair or poor health, poor physical health days, poor mental health days, and the percent of births with low birthweight.

Rank	Mortality	Morbidity
1	Franklin	Hancock
2	Sagadahoc	Knox
3	Cumberland	Franklin
4	Lincoln	Cumberland
5	Hancock	York
6	York	Sagadahoc
7	Knox	Lincoln
8	Piscataquis	Waldo
9	Waldo	Washington
10	Kennebec	Kennebec
11	Aroostook	Penobscot
12	Penobscot	Piscataquis
13	Somerset	Androscoggin
14	Androscoggin	Aroostook
15	Oxford	Oxford
16	Washington	Somerset

Health Factors Rankings

The summary health factors ranking is based on four factors: health behaviors, clinical care, social and economic, and physical environment factors. In turn, each of these factors is based on several measures. Health behaviors include measures of smoking, diet and exercise, alcohol use, and risky sex behavior. Clinical

care includes measures of access to care and quality of care. Social and economic factors include measures of education, employment, income, family and social support, and community safety. The physical environment includes measures of environmental quality and the built environment.

Rank	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
1	Cumberland	Kennebec	Cumberland	Cumberland
2	Lincoln	Cumberland	Sagadahoc	Knox
3	Franklin	Franklin	York	York
4	Knox	Androscoggin	Hancock	Piscataquis
5	Hancock	Piscataquis	Penobscot	Sagadahoc
6	Sagadahoc	Lincoln	Kennebec	Franklin
7	York	York	Lincoln	Aroostook
8	Waldo	Sagadahoc	Knox	Somerset
9	Aroostook	Penobscot	Waldo	Waldo
10	Kennebec	Knox	Aroostook	Washington
11	Penobscot	Oxford	Androscoggin	Penobscot
12	Oxford	Aroostook	Franklin	Kennebec
13	Androscoggin	Hancock	Oxford	Oxford
14	Piscataquis	Washington	Washington	Androscoggin
15	Washington	Somerset	Somerset	Hancock
16	Somerset	Waldo	Piscataquis	Lincoln

2011 County Health Rankings: Measures, Data Sources, and Years of Data

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Mortality	Premature death	National Center for Health Statistics	2005-2007
Morbidity	Poor or fair health	Behavioral Risk Factor Surveillance System	2003-2009
	Poor physical health days	Behavioral Risk Factor Surveillance System	2003-2009
	Poor mental health days	Behavioral Risk Factor Surveillance System	2003-2009
	Low birthweight	National Center for Health Statistics	2001-2007
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco	Adult smoking	Behavioral Risk Factor Surveillance System	2003-2009
Diet and Exercise	Adult obesity	National Center for Chronic Disease Prevention and Health Promotion	2008
Alcohol Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2003-2009
	Motor vehicle crash death rate	National Center for Health Statistics	2001-2007
High Risk Sexual Behavior	Sexually transmitted infections	National Center for Hepatitis, HIV, STD and TB Prevention	2008
	Teen birth rate	National Center for Health Statistics	2001-2007
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates, U.S. Census	2007
	Primary care providers	Health Resources & Services Administration	2008
Quality of Care	Preventable hospital stays	Medicare/Dartmouth Institute	2006-2007
	Diabetic screening	Medicare/Dartmouth Institute	2006-2007
	Mammography screening	Medicare/Dartmouth Institute	2006-2007
SOCIOECONOMIC FACTORS			
Education	High school graduation	National Center for Education Statistics ¹	2006-2007
	Some college	American Community Survey	2005-2009
Employment	Unemployment	Bureau of Labor Statistics	2009
Income	Children in poverty	Small Area Income and Poverty Estimates, U.S. Census	2008
Family and Social Support	Inadequate social support	Behavioral Risk Factor Surveillance System	2005-2009
	Single-parent households	American Community Survey	2005-2009
Community Safety	Violent crime ²	Uniform Crime Reporting, Federal Bureau of Investigation	2006-2008
PHYSICAL ENVIRONMENT			
Air Quality ³	Air pollution-particulate matter days	U.S. Environmental Protection Agency / Centers for Disease Control and Prevention	2006
	Air pollution-ozone days	U.S. Environmental Protection Agency / Centers for Disease Control and Prevention	2006
Built Environment	Access to healthy foods	Census Zip Code Business Patterns	2008
	Access to recreational facilities	Census County Business Patterns	2008

¹ State data sources for KY, NH, NC, PA, SC, and UT (2008-2009).

² Homicide rate (2001-2007) from National Center for Health Statistics for AK, AZ, AR, CO, CT, GA, ID, IN, IA, KS, KY, LA, MN, MS, MT, NE, NH, NM, NC, ND, OH, SD, UT, and WV. State data source for IL.

³ Not available for AK and HI.

CREDITS

Report Authors

University of Wisconsin-Madison
School of Medicine and Public Health
Department of Population Health Sciences
Population Health Institute

Bridget Booske, PhD, MHSA
Jessica Athens, MS
Patrick Remington, MD, MPH

This publication would not have been possible without the following contributions:

Technical Advisors

Amy Bernstein, ScD, Centers for Disease Control and Prevention
Michele Bohm, MPH, Centers for Disease Control and Prevention

Research Assistance

Jennifer Buechner
Hyojun Park, MA
Seth Prins, MPH
Jennifer Robinson
Matthew Rodock
Anne Roubal

Communications and Outreach

Burness Communications
Ivan Cherniack
Nathan Jones, PhD
Kate Konkle, MPH
Angela Russell
Julie Willems Van Dijk, PhD, RN

Design

Forum One, Alexandria, VA
Media Solutions, UW School of Medicine and Public Health

Robert Wood Johnson Foundation

Brenda L. Henry, PhD, MPH – Program Officer
Michelle Larkin, JD, MS, RN – Team Director and Senior Program Officer
James S. Marks, MD, MPH – Senior Vice President and Group Director, Health Group
Joe Marx – Senior Communications Officer

Suggested citation: University of Wisconsin Population Health Institute. *County Health Rankings 2011*.



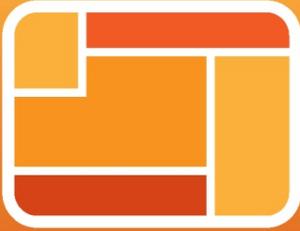
County Health Rankings

Mobilizing Action Toward Community Health

countyhealthrankings.org



University of Wisconsin Population Health Institute
610 Walnut St, #524, Madison, WI 53726
(608) 265-6370 / info@countyhealthrankings.org



County Health Rankings & Roadmaps

A Healthier Nation, County by County

2012 *Rankings* **Maine**



Robert Wood Johnson Foundation



UNIVERSITY OF WISCONSIN

Population Health Institute

Translating Research into Policy and Practice

Introduction

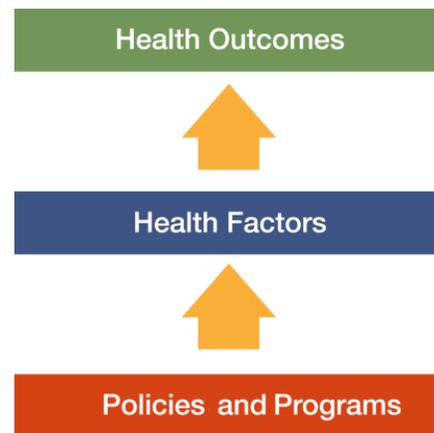
Where we live matters to our health. The health of a community depends on many different factors, including the environment, education and jobs, access to and quality of healthcare, and individual behaviors. We can improve a community's health by implementing effective policies and programs. For example, people who live in communities with smoke-free laws are less likely to smoke or to be exposed to second-hand smoke, which reduces lung cancer risk. In addition, people who live in communities with safe and accessible park and recreation space are more likely to exercise, which reduces heart disease risk.

However, health varies greatly across communities, with some places being much healthier than others. And, until now, there has been no standard method to illustrate what we know about what makes people sick or healthy or a central resource to identify what we can do to create healthier places to live, learn, work and play.

We know that much of what influences our health happens outside of the doctor's office – in our schools, workplaces and neighborhoods. The *County Health Rankings & Roadmaps* program provides information on the overall health of your community and provides the tools necessary to create community-based, evidence-informed solutions. Ranking the health of nearly every county across the nation, the *County Health Rankings* illustrate **what we know** when it comes to what is making communities sick or healthy. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin

Population Health Institute to bring this groundbreaking program to counties and states across the nation.

The *County Health Rankings & Roadmaps* program includes the *County Health Rankings* project, launched in 2010, and the newer *Roadmaps* project that mobilizes local communities, national partners and leaders across all sectors to improve health. The program is based on this model of population health improvement:



In this model, health outcomes are measures that describe the current health status of a county. These health outcomes are influenced by a set of health factors. Counties can improve health outcomes by addressing all health factors with effective, evidence-informed policies and programs.

Everyone has a stake in community health. We all need to work together to find solutions. The *County Health Rankings & Roadmaps* serve as both a call to action and a needed tool in this effort.

Guide to Our Web Site

To compile the *Rankings*, we selected measures that reflect important aspects of population health that can be improved and are available at the county level across the nation. Visit www.countyhealthrankings.org to learn more.

To get started and see data, enter your county or state name in the search box. Click on the name of a county or measure to see more details. You can: Compare Counties; Download data for your state; Print one or more county

snapshots; or Share information with others via Facebook, Twitter, or Google+. To understand our methods, click on Learn about the Data and Methods. To learn about steps that you can take to improve health in your community, click on the *Roadmaps* tab. The *Roadmaps to Health Action Center* provides tools and resources to help groups working together to create healthier places. The Opportunities section provides information on funding, recognition, and partnership opportunities. The Connections section helps you learn what others are doing.

County Health Roadmaps

The *Rankings* illustrate **what we know** when it comes to making people sick or healthy. The *County Health Rankings* confirm the critical role that factors such as education, jobs, income and the environment play in how healthy people are and how long we live.

This report introduces the *County Health Roadmaps*, a new partnership that mobilizes local communities, national partners and leaders across all sectors to improve health. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this groundbreaking project to cities, counties and states across the nation.

The *Roadmaps* project includes grants to local coalitions and partnerships among policymakers, business, education, public health, health care, and community organizations; grants to national organizations working to improve health; recognition of communities whose promising efforts have led to better health; and customized technical assistance on strategies to improve health.

Roadmaps to Health Community Grants

The *Roadmaps to Health Community Grants* provide funding for 2 years to state and local efforts among policymakers, business, education, healthcare, public health and community organizations working to create positive policy or systems changes that address the social and economic factors that influence the health of people in their community.

Roadmaps to Health Partner Grants

The Robert Wood Johnson Foundation is awarding *Roadmaps to Health Partner Grants* to national organizations that are experienced at engaging local partners and leaders and are able to deliver high-quality training and technical assistance, and committed to making communities healthier places to live, learn, work and play. Partner grantees increase awareness about the *County Health Rankings & Roadmaps* to their members, affiliates and allies. The first Partner Grant was awarded to United Way Worldwide (UWW) in July 2011.

Roadmaps to Health Prize

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute will award *Roadmaps to Health Prizes* of \$25,000 to up to six communities that are working to become healthier places to live, learn, work and play. The *Roadmaps to Health Prize* is intended not only to honor successful efforts, but also to inspire and stimulate similar activities in other U.S. communities.



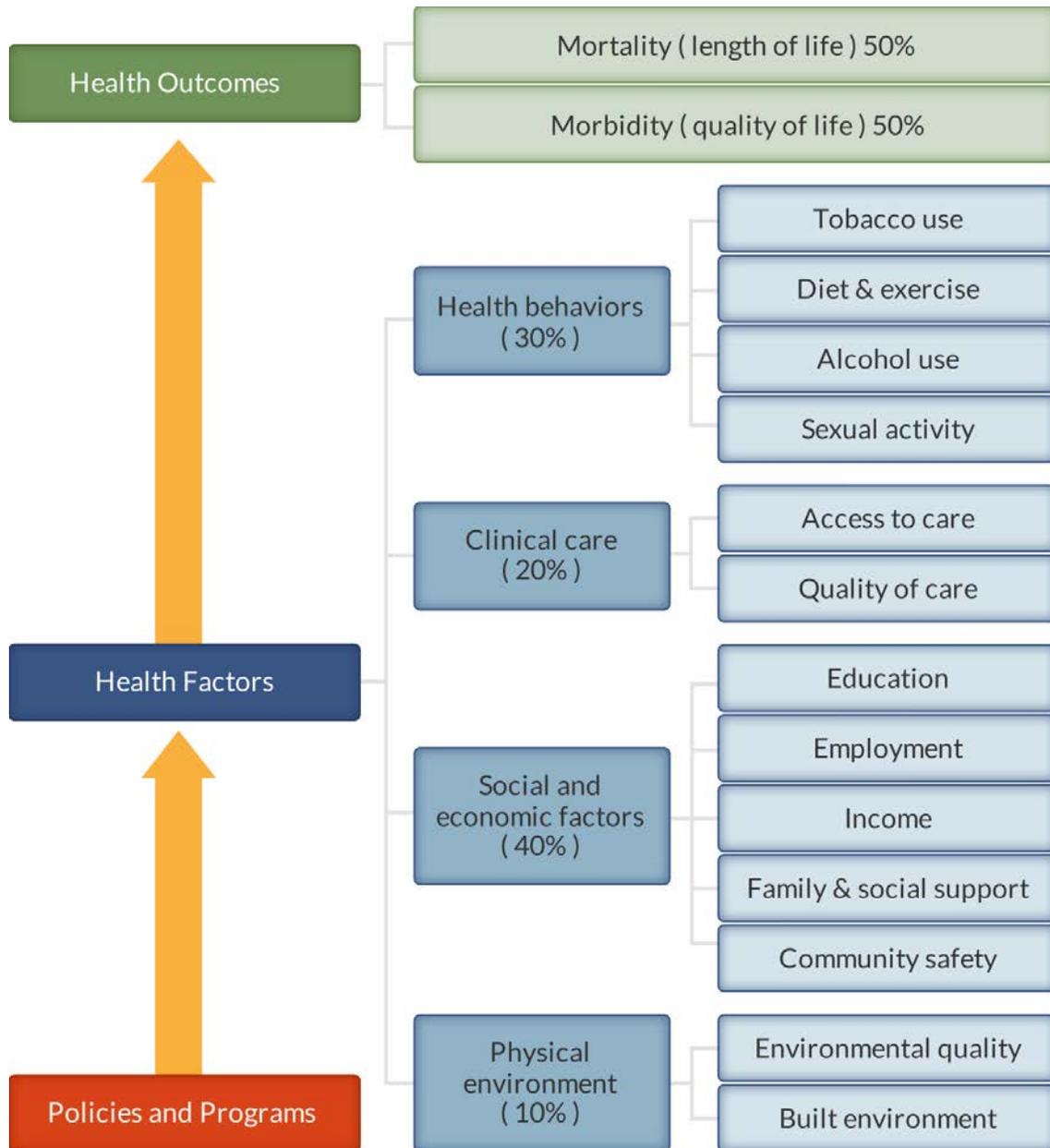
Roadmaps to Health Action Center

The *Roadmaps to Health Action Center*, based at the University of Wisconsin Population Health Institute, provides tools and resources to help groups working to make their communities healthier places. The new Action Center will provide guidance on developing strategies and advocacy efforts to advance pro-health policies, offer opportunities for ongoing learning, and in the summer of 2012, host a searchable database of evidence-informed policies and programs focused on health improvement. Experts provide customized consultation to local communities who have demonstrated the willingness and capacity to address factors that we know influence how healthy a person is, such as education, income and family connectedness.

County Health Rankings

The 2012 *County Health Rankings* report ranks Maine counties according to their summary measures of **health outcomes** and **health factors**. Counties also receive a rank for mortality, morbidity, health behaviors, clinical care, social and economic factors, and the physical environment. The figure below depicts the structure of the *Rankings* model; those having high ranks (e.g., 1 or 2) are estimated to be the “healthiest.”

Our summary **health outcomes** rankings are based on an equal weighting of mortality and morbidity measures. The summary **health factors** rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input, but represent just one way of combining these factors.

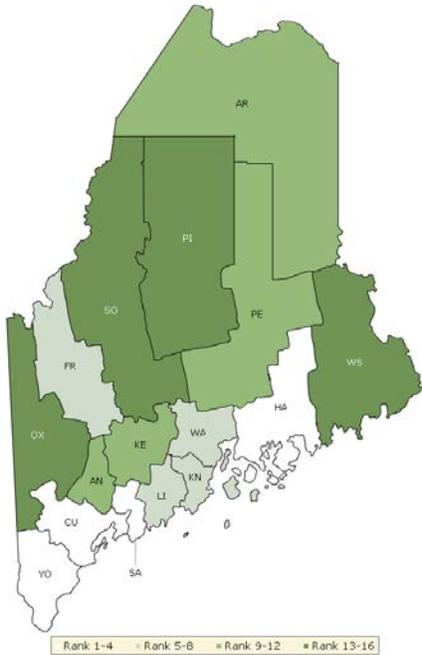


County Health Rankings model ©2012 UWPHI

The maps on this page and the next display Maine’s counties divided into groups by health rank. Maps help locate the healthiest and least healthy counties in the state. The lighter colors indicate better

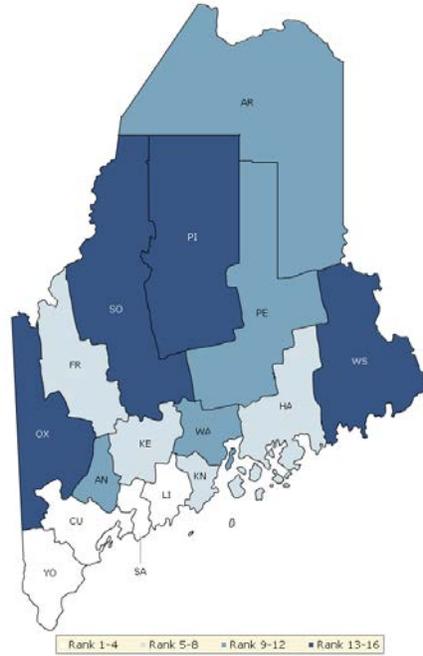
performance in the respective summary rankings. The green map shows the distribution of summary health outcomes. The blue displays the distribution of the summary rank for health factors.

HEALTH OUTCOMES



County	Rank	County	Rank	County	Rank	County	Rank
Androscoggin	11	Hancock	2	Oxford	15	Somerset	14
Aroostook	12	Kennebec	9	Penobscot	10	Waldo	6
Cumberland	3	Knox	5	Piscataquis	13	Washington	16
Franklin	8	Lincoln	7	Sagadahoc	1	York	4

HEALTH FACTORS



County	Rank	County	Rank	County	Rank	County	Rank
Androscoggin	12	Hancock	5	Oxford	13	Somerset	15
Aroostook	11	Kennebec	7	Penobscot	9	Waldo	10
Cumberland	1	Knox	6	Piscataquis	14	Washington	16
Franklin	8	Lincoln	4	Sagadahoc	2	York	3

Summary Health Outcomes & Health Factors Rankings

Counties receive two summary ranks:

- Health Outcomes
- Health Factors

Each of these ranks represents a weighted summary of a number of measures.

Health outcomes represent how healthy a county is while health factors represent what influences the health of the county.

Rank	Health Outcomes	Rank	Health Factors
1	Sagadahoc	1	Cumberland
2	Hancock	2	Sagadahoc
3	Cumberland	3	York
4	York	4	Lincoln
5	Knox	5	Hancock
6	Waldo	6	Knox
7	Lincoln	7	Kennebec
8	Franklin	8	Franklin
9	Kennebec	9	Penobscot
10	Penobscot	10	Waldo
11	Androscoggin	11	Aroostook
12	Aroostook	12	Androscoggin
13	Piscataquis	13	Oxford
14	Somerset	14	Piscataquis
15	Oxford	15	Somerset
16	Washington	16	Washington

2012 County Health Rankings: Measures, Data Sources, and Years of Data

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Mortality	Premature death	National Center for Health Statistics	2006-2008
Morbidity	Poor or fair health	Behavioral Risk Factor Surveillance System	2004-2010
	Poor physical health days	Behavioral Risk Factor Surveillance System	2004-2010
	Poor mental health days	Behavioral Risk Factor Surveillance System	2004-2010
	Low birthweight	National Center for Health Statistics	2002-2008
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2004-2010
Diet and Exercise	Adult obesity	National Center for Chronic Disease Prevention and Health Promotion	2009
	Physical inactivity	National Center for Chronic Disease Prevention and Health Promotion	2009
Alcohol Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2004-2010
	Motor vehicle crash death rate	National Center for Health Statistics	2002-2008
Sexual Activity	Sexually transmitted infections	National Center for Hepatitis, HIV, STD and TB Prevention	2009
	Teen birth rate	National Center for Health Statistics	2002-2008
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2009
	Primary care physicians	Health Resources & Services Administration	2009
Quality of Care	Preventable hospital stays	Medicare/Dartmouth Institute	2009
	Diabetic screening	Medicare/Dartmouth Institute	2009
	Mammography screening	Medicare/Dartmouth Institute	2009
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	National Center for Education Statistics and state-specific sources ¹	2008-2010
	Some college	American Community Survey	2006-2010
Employment	Unemployment	Bureau of Labor Statistics	2010
Income	Children in poverty	Small Area Income and Poverty Estimates	2010
Family and Social Support	Inadequate social support	Behavioral Risk Factor Surveillance System	2006-2010
	Children in single-parent households	American Community Survey	2006-2010
Community Safety	Violent crime rate ²	Federal Bureau of Investigation	2007-2009
PHYSICAL ENVIRONMENT			
Environmental Quality ³	Air pollution-particulate matter days	U.S. Environmental Protection Agency	2007
	Air pollution-ozone days	U.S. Environmental Protection Agency	2007
Built Environment	Access to recreational facilities	Census County Business Patterns	2009
	Limited access to healthy foods ⁴	U.S. Department of Agriculture	2006
	Fast food restaurants	Census County Business Patterns	2009

¹ NCES used for AK, AL, AR, CA, CT, FL, HI, ID, KY, MT, ND, NJ, OK, SD and TN

² State data source for IL.

³ Not available for AK and HI.

⁴ Access to Healthy Foods (2009) from Census Zip Code Business Patterns for AK and HI.

CREDITS

Report Authors

University of Wisconsin-Madison
School of Medicine and Public Health
Department of Population Health Sciences
Population Health Institute

Bridget Booske Catlin, PhD, MHSA
Amanda Jovaag, MS
Patrick Remington, MD, MPH

This publication would not have been possible without the following contributions:

Technical Advisor

Amy Bernstein, ScD, Centers for Disease Control and Prevention

Research Assistance

Jennifer Buechner
Hyojun Park, MA
Jennifer Robinson
Matthew Rodock, MPH
Anne Roubal

Communications and Outreach

Burness Communications
Anna Grilley
Anna Graupner, MPH
Kate Konkle, MPH
Angela Russell, MS
Julie Willems Van Dijk, PhD, RN

Design

Forum One, Alexandria, VA
Media Solutions, UW School of Medicine and Public Health

Robert Wood Johnson Foundation

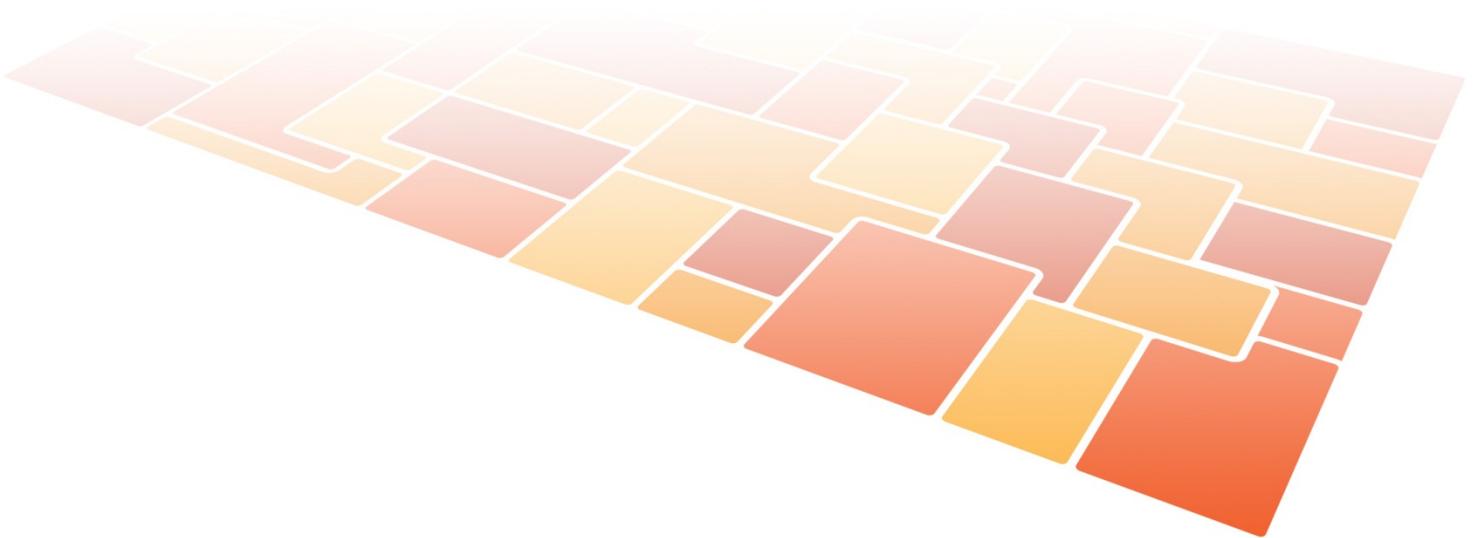
Brenda L. Henry, PhD, MPH – Senior Program Officer
Abbey Cofsky, MPH – Program Officer
Michelle Larkin, JD, MS, RN – Assistant Vice-President and Deputy Director, Health Group
James S. Marks, MD, MPH – Senior Vice-President and Group Director, Health Group
Joe Marx – Senior Communications Officer

Suggested citation: University of Wisconsin Population Health Institute. *County Health Rankings 2012*.



**County Health
Rankings & Roadmaps**
A Healthier Nation, County by County

countyhealthrankings.org



University of Wisconsin Population Health Institute
610 Walnut St, #524, Madison, WI 53726
(608) 265-6370 / info@countyhealthrankings.org



FY12 Cumberland District Public Health Council Finances (as of 5/7/12)

Code	Line Item	FY12 Budget	FY12 Contrib.	FY12 Need
01 10	Salaries	\$36,267	\$36,267	\$0
02 10	Fringe	\$10,303	\$10,303	\$0
20 00	Administrative Services	\$0		\$0
20 10	Postage	\$0		\$0
20 20	Travel/training/meetings	\$500	\$500	\$0
20 25	Goodwill Meals	\$0		\$0
20 30	Indirect Costs	\$4,346	\$4,346	\$0
35 00	Contractual Services	\$0		\$0
35 10	Advertising	\$0		\$0
35 30	Mileage	\$500	\$500	\$0
35 50	Lab Medical	\$0		\$0
35 60	Printing/Binding	\$500	\$500	\$0
35 76	Transportation expense	\$0		\$0
45 10	Land and Building	\$0		\$0
55 20	Supplies all other	\$11,887	\$11,887	\$0
55 25	Event Supplies	\$0		\$0
55 50	Medical Supplies	\$0		\$0
55 60	Minor Equipment	\$0		\$0
55 70	Office Supplies	\$1,000	\$1,000	\$0
63 41	Cell Phones	\$0		\$0
	Total	\$65,303	\$65,303	\$0

FY12 Contributions to Date

FY11 Carryover	\$12,547
Cumberland County	\$15,000
City of Portland	\$10,303
HMPs	\$9,453
MaineHealth	\$7,500
Mercy	\$5,000
CATCH	\$3,000
VNA	\$2,500
Total	\$65,303



Slate

May 18, 2012

10:00 a.m. — 12:00 p.m.

Planned Parenthood of Northern New England
443 Congress Street, Portland

Officer Positions

- ❖ **Council Chair**-Toho Soma
 - ❖ **Vice Chair**- Colleen Hilton
 - ❖ **Secretary**-Julie Sullivan
-

New Members

- ❖ **None**
-

Current Contacts/Leads for collaborative work on district priorities

5/18/12 CDPHC

~Work in progress~

DPHIP/CHIP/ CHNA Priority	Contacts/Leads	
<p>Access to Care</p>	<p>Access to primary care in the Lakes Region (DPHIP, CHNA)</p>	<p><i>Becca Matusovich</i></p>
	<p>Greater Portland Refugee & Immigrant Health Care Collaborative (vision, dental care, mental health, initial health screenings/primary care)</p>	<p><i>Becca Matusovich</i></p>
	<p>Public Health & Transportation Connection (PHiT)</p>	<p><i>Zoe Miller, Elizabeth Trice, Val Landry</i></p>
	<p>PCMH Community Care Team</p>	<p><i>Carol Zechman, Care Partners</i></p>
	<p>Portland Public Health, Community-Clinical Partnerships & Community Health Outreach/Minority Health</p>	<p><i>Toho Soma, Dr. Bankole</i></p>
<p>Mental health and Substance Abuse</p>	<p>CHNA Follow-up Conversation on MH & SA</p>	<p><i>Emily Rines & Liz Blackwell-Moore</i></p>
	<p>Substance Abuse prevention, underage drinking, Prescription Monitoring Program outreach/promotion</p>	<p><i>HMPs, 21 Reasons</i></p>
	<p>Depression & chronic disease (see 1/27 CDPHC minutes)</p>	<p><i>Liz Blackwell-Moore</i></p>
<p>Immunization</p>	<p>Flu & Pneumococcal Vaccination Workgroup</p>	<p><i>Becca Matusovich, Cathy Patnaude</i></p>
	<p>Childhood Immunizations</p>	<p><i>Cassie Grantham, Deb Deatrick</i></p>
<p>Sexual health</p>	<p>Sexual Health - Healthy Lakes & Healthy Rivers CHIPs</p> <p><i>Jenn Thibodeau & Zoe Miller</i></p>	
<p>Cardiovascular Health/ High Blood Pressure/ Cholesterol</p>	<p>CHNA Follow-upon Cardiovascular Health</p>	<p><i>Jaclyn Morrill, Anne Tricomi</i></p>
	<p>Chronic Disease Self-Management Program/ Living Well</p>	<p><i>HMPs, Liz Weaver, Ted Trainer</i></p>

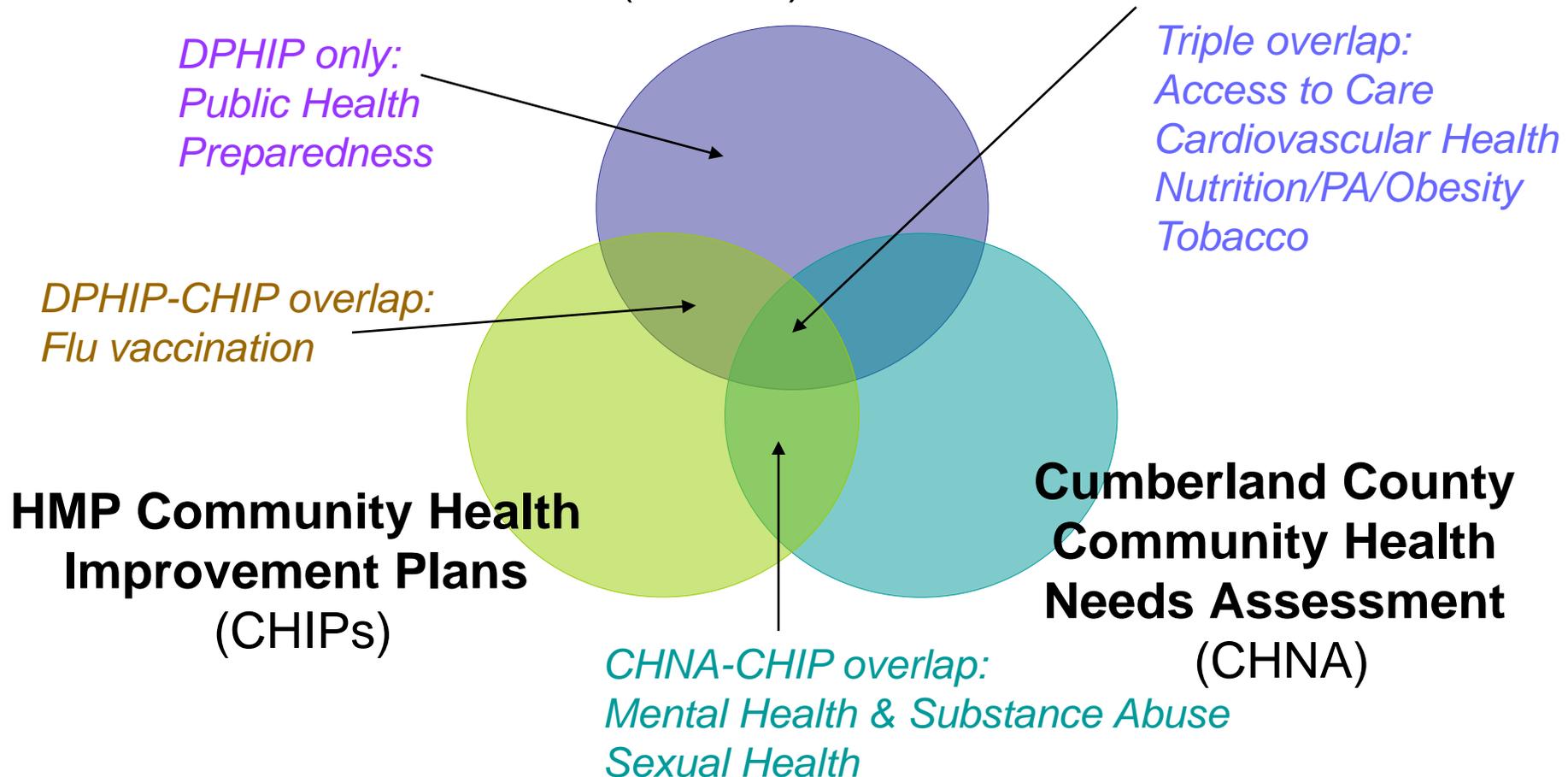
Current Contacts/Leads for collaborative work on district priorities

***5/18/12 CDPHC
~Work in progress~***

DPHIP/ CHIP/ CHNA Priority	Contacts/Leads	
Obesity/PA/ Nutrition	<p>HMP work on obesity/PA/Nutrition</p> <p>Let's Go!/5210 – Schools, childcare, healthcare sector</p> <p>CHNA Follow-up on Physical Activity & Nutrition</p> <p>CDPHC Community Transformation Grant (CTG)</p>	<p><i>Healthy Portland – Joan Ingram Healthy Casco Bay – Anne Tricomi Healthy Rivers – Jenn Thibodeau Healthy Lakes – Zoe Miller</i></p> <p><i>Deb Deatrack, Tory Rogers, Emily Rines, HMPs</i></p> <p>Anne Tricomi</p> <p><i>Shane Gallagher, Becca Matusovich</i></p>
Tobacco	<p>HMP work on tobacco (incl. Healthy Homes campaign- Healthy Portland & Healthy Casco Bay)</p> <p>CHNA Follow-up on Tobacco</p> <p>Breath Easy Coalition (tobacco-free hospitals, colleges, smokefree housing)</p>	<p><i>HMPs (see above)</i></p> <p><i>Claire Schroeder, Fred Wolff</i></p> <p><i>Sarah Mayberry</i></p>
Public health preparedness	<p>Medical Reserve Corps</p> <p>Cities Readiness Initiative</p> <p>Southern Maine Regional Resource Center (hospital preparedness)</p> <p>Cumberland County Regional Sheltering Initiative</p> <p><i>?Need for alignment of pandemic/all-hazards plans</i></p>	<p><i>Jim Budway, Ron Jones</i></p> <p><i>Caity Hager</i></p> <p><i>Paul Weiss</i></p> <p><i>Jim Budway</i></p> <p><i>?no current initiative, but potential local/county/state partnership in the future</i></p>
Health Equity	<p>CDPHC Health Equity Workgroup</p> <p>United Way Cultural Diversity Cabinet</p> <p>Collection of Racial/Ethnic/Language data</p> <p>Hanley Disparities Ambassadors Tobacco & R/E/L data project</p>	<p><i>Toho Soma</i></p> <p><i>Dolly Hersom, United Way</i></p> <p><i>Jessica Loney, Dr. Bankole</i></p> <p><i>Jessica Loney, Dr. Bankole, Becca Matusovich</i></p>

Public Health Collaborations on Cumberland district priorities

District Public Health Improvement Plan (DPHIP) + CTG



Greater Portland Refugee/Immigrant Health Care Collaborative

Overview as of October 2011

Summary of emerging issues moving forward

The group convened in May 2011, providing an opportunity to engage providers in Portland who have a special focus on the needs of immigrant/refugee people living in Maine in a conversation about the barriers this population faces in accessing needed health-related services and opportunities to strengthen the system to better meet the needs.

The group quickly agreed we needed a more comprehensive understanding of the “gateways” to health care access, i.e. those organizations whose role in working with refugees/immigrants includes helping them to access whole clusters of health and social services. We have begun to try to understand the role of these gateway organizations by examining:

- Who they serve - Eligibility/priority populations
- What they provide - Scope of services
- How people can access their services, referral options, etc
- Capacity & limitations
- Opportunities to strengthen, support, & maximize this gateway’s capacity
- Opportunities to expand referral options this gateway could use to better meet the needs of the individuals/families they serve

Some of the challenges identified so far during our meetings are:

- ✓ Interpreter services – cost, availability, consistency
- ✓ Understanding the easiest way to refer patients to a particular service so the referral is successful
- ✓ Different categories of immigrants are eligible for different services and through different access routes. Primary refugees have access to more resettlement resources than secondary refugees, asylum seekers, and undocumented immigrants.
- ✓ There are sliding fee scales and/or co-pays for many health care services, which may still be a major barrier for many patients. False assumptions about fees may also be a barrier.
- ✓ Need clarity about what providers take MaineCare and uninsured
- ✓ Dental access is a major challenge throughout Maine. They seek dental and health care much later, and health problems are advanced
- ✓ Mental health services available are insufficient to meet the need
- ✓ Waiting lists
- ✓ Ability to get “basic needs” met – where to go for things like heat, rent, warm clothes, eyeglasses, etc.
- ✓ Getting needed testing/treatment/prophylaxis for family members of someone seen at ER when whole families don’t have medical homes
- ✓ Too many forms, probing questions, can be too complex for many families who don’t speak English and don’t have the background knowledge about how our health care system works
- ✓ Transportation to appointments (particularly for children who need car seats since RTP does not provide car seats)
- ✓ Inconsistency across different providers of initial screenings and immunizations

GOALS FOR ON-GOING WORK MAY INCLUDE:

1. Understand the role of “gateway” organizations (i.e. organizations who provide case management-type services and help connect families to whole clusters of services) in improving refugee health and strengthening the “system” of services. Support the gateways in strengthening their effectiveness and increasing their capacity as needed.
2. Develop communication mechanisms for sharing information about:
 - Resources for helping refugee/immigrant families with basic needs and health/social services (examples: car seats, bus passes, winter clothes & blankets, furniture, eyeglasses, etc)
 - Changes in services (particularly evolving limitations on capacity), and initiate proactive planning when services are maxed out and alternative referrals are needed, population patterns/needs are shifting, etc.
 - Complex eligibility questions/situations
3. Create collaborative strategies to ensure access to health care services among refugees/immigrants
 - Consistency in initial health screenings & immunizations for newly arrived immigrants
 - Access to civil surgeon (capacity & affordability)
 - Getting everyone set up with a medical home
 - Mental health services
 - Dental care (preventive, restorative, emergency)
 - Vision care

Greater Portland Refugee & Immigrant Health Care Collaborative
~ Workgroup updates March 2012 ~

Questions? Contact Becca Matusovich
797-3424 or Becca.matusovich@maine.gov



Mental Health

- 2 meetings, next meeting April 10th (2:30)
- Participants: Jane Hubley, MaryEllen Jaeger, Robbie Lawson, Becca Matusovich, Molly McMahon, Regina Philips, Sue Steele, Susan Stiker, Grace Valenzuela, Katherine Wihry, Lori Wolanski, Catherine Yomoah, Lauren Grousd, Paul Revier (joining next time)
- Brainstormed gaps & challenges
- Current focus: referral profiles, Lori interviewing each provider
- Next steps:
 - Complete referral profiles, decide how to disseminate & system/timeline for updating them
 - Aggregate profile results into a basic inventory of MH services for refugees & immigrants in Portland/Westbrook, refine gaps & challenges list
 - Identify any other potential strategies to address gaps & challenges?

Primary Care/Initial Health Assessment

- 1 meeting, next meeting April 26th (1:00)
- Participants: Becca Matusovich, Dr. Stephen Sears, Dr. Bankole Kolawole, Dr. Carrie Frost, Maureen Clancy, Kate Colby, Luanne Crinion, Deqa Ahmed, Dalit Gulak, Katherine Wihry, Laura Gottfried, Leslie Brancato, Heidi Mallis, Dr. Nat James, Peggy Akers, Dr. Deb Rothenberg, Dr. Shuli Bonham, Susan Bell, Susan Stiker, Dr. Susan Talbot, Lori Wolanski, Dr. Sarah Alvarez
- Examined existing “Initial Health Assessment Recommendations” from 2008 and brainstormed potential revisions needed
- Discussed methods for dissemination & follow-up support, and need for local “community resources” addendum to accompany the recommendations document
- Next steps:
 - Dr. James leading small committee to draft revisions to the recommendations document
 - Becca leading small committee to develop the community resources “addendum”
 - Dissemination plans will be a focus of the next meeting

Dental Care

- 1 meeting, next meeting May 22nd (3:00)
- Participants: Martha Barnes, Kate Herrick, Dr. Demi Kouzounas, Becca Matusovich, Kathy Martin, Bunny Mills, Pam Pride, Susan Stiker, Lori Wolanski, Vaneesa Woodward, Carol Zechman
- Brainstormed assets & challenges (list?)
- Identified 4 potential strategies to explore (insurance pilot project, volunteer adult clinic, design UNE student project for oral health prevention & education tailored for refugee & immigrant adults, expand donated dental day- “Dentists Who Care for ME”)
- Next steps
 - Exploring potential for insurance pilot with Northeast Delta Dental
 - Lori & Dr. Demi gathering info on volunteer adult dental clinics in Lincoln & Kennebec counties
 - Lori to work on framing a UNE student project (joint project for dental hygiene & MPH students?) for summer or fall semester

Vision/Eyeglasses

- 2 meetings, next meeting April 25th (2:30)
- Participants: Laura Gottfried, Becca Matusovich, Jen Morton, Amanda Rowe, Lori Wolanski, Caroline Teschke, Jean Hall, Janice Jaffe, John Shipee, Kate Herrick, Pam Pride
- Brainstormed challenges & assets
- Lori developing resource guide with info about sources for low-cost/free eyeglasses for adults
- Identified primary strategy: develop optician services at Portland Community Health Center
- Next steps:
 - Laura Gottfried interviewing Sacopee Valley, working out logistics for PCHC re serving people who aren't patients, billing MaineCare for children, space, scheduling, etc.
 - Identify training options (Jen Morton interviewing New England College of Optometry, Amanda Rowe discussing potential partnership with Casco Bay EyeCare)
 - Lori exploring options for working with MaineCare vendor to buy eyeglasses at MaineCare rate for uninsured patients
 - Identify start-up funding budget and sources (Becca exploring MeHaf discretionary grant, Lori to check with Lions Club)

Nutrition Education

- 1st meeting scheduled for April 13th
- Invited: Lynn McGrath, Kolawole Bankole; Deqa Ahmed; Joan Ingram; Kathy Savoie; Jean Hall, Mary Ellen Jaeger; Julie Greene; Susan Talbot; Ingrid Hagberg; Katie Leary; Chris Sady; Emily Rines
- Two UNE RN-to-BSN students to design inventory/assessment project for workgroup this spring

Greater Portland Refugee & Immigrant HealthCare Collaborative

This list represents people who have attended meetings between Nov 2011 and May 2012 (others are also on the email list)

NAME	TITLE	ORGANIZATION
Deqa Ahmed	CHOW	Portland Public Health, Minority Health Program
Dr. Kolawole Bankole	Director	PPH, Minority Health Program
Susan Bell	Prof. of Sociology	Bowdoin College
Leslie Brancato	CEO	Portland Community Health Center
Maureen Clancy	Community Relations	Mercy Hospital
Kate Colby	ID Epidemiologist	MECDC
Luanne Crinion	PHN Supervisor	MECDC
Carrie Frost	Medical Director	Portland Community Health Center
Laura Gottfried	Program Manager	Portland Community Health Center
Jean Hall	Public Hlth Nurse	MECDC
Kate Herrick	Program Coordinator	Care Partners, MMC
Dolly Hersom	Project Director, Language Access for New Americans (LANA)	United Way of Greater Ptld
Lucky Hollander	Policy Analyst/Facilitator	
MaryEllen Jaeger	Public Hlth Nurse	MECDC
Janice Jaffe	Assoc. Dir./McKeen Center & teaches interpreters	Bowdoin College
Nat James	Director, International Clinic	ME Medical Center
Robbie Lawson	Public Hlth Nurse	MECDC
Byron Marshall	Public Hlth Nurse	MECDC
Becca Matusovich	Cumberland District PH Liaison	MECDC
Molly McMahon	Social Worker	Portland Community Health Center
Robyn Merrill	Policy Analyst	ME Equal Justice Partners
Regina Philips	Program Coordinator	City of Portland, Refugee Services
Roxanne Peterson	Case Manager	CCME/DHHS
Meghan Rouselle	Public Hlth Nurse	MECDC
Amanda Rowe	School Nurse Coordinator	Portland Public Schools
John Shippee	Sr. Human Services Counselor	City of Portland, Family Shelter
Sue Steele		Portland Public Schools
Susan Stiker	Refugee PH Liaison	Catholic Charities ME
Rachel Talbot Ross	Director, Multicultural Affairs	City of Portland
Caroline Teschke	Program Director, Infectious Disease	PPH
Donna Travaglini	Public Hlth Nurse	MECDC
Katherine Wihry	PhD Student Intern	Catholic Charities ME
Catherine Yomoah	State Refugee Coordinator	DHHS
Dalit Gulak	MECDC TB Control Coordinator	MECDC

Additional participants in workgroups (spring 2012):	
Dr. Shuli Bonham	Health Care for the Homeless/Portland Community Health Center
Heidi Mallis	Maine CDC, Infectious Disease Epidemiology
Peggy Akers	Portland School Based Health Centers
Dr. Deb Rothenberg	MMC Family Medicine
Dr. Stephen Sears	Maine CDC, Infectious Disease Epidemiology
Dr. Susan Talbot	MMC International Clinic/Pediatric Clinic
Jennifer Morton	University of New England, Nursing, Cross-cultural health initiatives
Pam Pride	CarePartners
Tina Veilleux	Portland Public Schools, school nurse
Asha Suldan	City of Portland, Children's Oral Health Program
Bunny Mills	University of New England, Dental Hygiene
Carol Zechman	CarePartners
Susan Cote	MaineHealth, From the First Tooth
Dr. Demi Kouzounas	Dunstan Dental Center
Martha Barnes	Healthcare for the Homeless Dental Clinic
Vaneesa Woodward	City of Portland, Children's Oral Health Program
Lauren Grousd	Planned Parenthood
Jane Hubley	Portland Public Schools
Paul Revier	Community Counseling
Lynn McGrath	Opportunity Alliance, WIC, HeadStart
Joan Ingram	Healthy Portland
Kathy Savoie	Cooperative Extension, EatWell program
Chris Sady	Maine Nutrition Network

	Goals/Purpose	Strategies
School clinics Key players: - School nurses - School Health Coordinators - VNAs - MRC - MCDC - Portland & Westbrook schools	<ul style="list-style-type: none"> - Help schools maintain existing clinics - Help schools increase uptake at school clinics - Add one new school district? 	<ul style="list-style-type: none"> - Support school nurses - Identify/encourage factors that increase uptake rates - Support minority outreach - Billing?/ ImmPact training
Adult public clinics Key players: - VNAs - PPH - Bridgton Hospital - MRC/CRI/EMA	<ul style="list-style-type: none"> - Ensure that CC residents have access to a flu shot, especially those who lack access at a PCP or workplace - Help non-profit clinic providers develop a sustainable business model that <ul style="list-style-type: none"> a) provides a mechanism for free/low-cost vaccinations for populations who lack other access, and b) ensures capacity for public flu clinics will be sustained for emergencies when rapid mass vaccination may be needed 	<ul style="list-style-type: none"> - Identify & encourage factors that increase uptake rates at public clinics - Identify core set of clinics to support in order to increase utilization - Assessment of Lakes Region access for adults (is there a need for public clinics? If so, what would increase utilization of them?) - Help develop Medical Reserve Corps
Communication Key players: - CDPHC members - 211 - HMPs?	<ul style="list-style-type: none"> - Coordinate a common message to promote flu vaccine and times/locations of community-based flu clinics 	<ul style="list-style-type: none"> - Refine 2011 campaign, start earlier, target promotion of specific clinics? - Minority outreach? (See below) - Add pneumo reminder to flu messages?
Minority Outreach Key players: -CDPHC Health Equity Workgroup - City of Portland Minority Health and CRI (and Immunization program) -211 -UNE -Portland Housing Authority - MCDC Schools	<p>Ensure multicultural communities have equal</p> <ul style="list-style-type: none"> - access to flu vaccination - access to info they need about flu vaccination - encouragement to get vaccinated <p>Create a model for how the CDPHC can better reach multicultural communities without relying too heavily on the same key players – draw on their leadership without exhausting their capacity</p> <p>Assist in strengthening and testing methods/plans for communicating with multicultural communities in an emergency situation</p>	<p>Tie promotion of adult flu vaccination with school outreach to parents (flu shots not just for kids?)</p> <p>Work with UNE students on health fairs (and town hall community meetings) at Portland Housing Authority sites in the fall</p> <p>Consider ways to use flu outreach as a “drill” for emergency planning/CRI communications</p>

Site/Clinic name	Town	Date	Weekday/ weekend	day or evening or overlap	# served	Agency:VNA-Home Health & Hospice (VNAHHH), Home Health Visiting Nurses (HHVN), CHANS, PPH	Region:Lakes region LR, Rivers region RR, Portland, Casco bay CB, Brunswick-Harpswell BH.	
BRUNSWICK/HARPSWELL								
Brunswick Visitors Center, Fall Festival	Brunswick	10/1/11	sat	day	103	CHANS	BH	
St. Charles Church	Brunswick	10/8/11	sat	day	32	CHANS	BH	
Community Wellness Fair, FHC	Brunswick	10/13/11	weekday	overlap	81	CHANS	BH	
Mid Coast Hunger Prevention	Brunswick	10/19/11	weekday	day	53	CHANS	BH	
People Plus	Brunswick	10/20/11	weekday	day	37	CHANS	BH	
Pejepscot Terrace	Brunswick	10/21/11	weekday	day		CHANS	BH	
Harpswell Town Office	Harpswell	10/6/11	weekday	day	79	CHANS	BH	
Harpswell Town Office	Harpswell	10/6/11	weekday	evening	47	CHANS	BH	
Midcoast Rise Expo		11/5/11			50	CHANS	BH	
Family Focus		11/11/11			20	CHANS	BH	
Mid Coast Senior Health Center - Flu Fridays (9 clinics 9/30-11/25) avg	Brunswick		weekday	day	630	CHANS	BH	
Total adult >18 pop	20,404				Total 2011:	1132	Goal for clinic access:	816
CASCO BAY (Falmouth, Gray, New Gloucester, Pownal, Freeport, Yarmouth, North Yarmouth, Cumberland, Chebeague, Long Island)								
Freeport Town Hall	Freeport	10/31/11	weekday	day	30	CHANS	CB	
Tuttle Rd Church UMC	Cumberland C	11/1/11	weekday	day	18	HHVN	CB	
Falmouth Congregational Church	Falmouth	10/24/11	weekday	day	13	HHVN	CB	
Yarmouth Amvets	Yarmouth	10/5/11	weekday	day	158	HHVN	CB	
Maine Centers for Deafness	Falmouth	10/1/11	sat	day	45	VNAHHH	CB	
Sacred Heart Parish	Yarmouth	10/23/11	sun	day	42	VNAHHH	CB	
Bay Square at Yarmouth	Yarmouth	10/24/11	weekday	day	2	VNAHHH	CB	
Yarmouth Mealsite	Yarmouth	11/1/11	weekday	day	2	VNAHHH	CB	
Total adult >18 pop	40,623				Total 2011:	310	Goal for clinic access:	1,625
LAKES REGION (Baldwin, Bridgton, Casco, Frye Island, Harrison, Naples, Sebago, Standish, Raymond, Windham)								
Bridgton Community Center	Bridgton	10/31/11	weekday	day	12	HHVN	LR	
Casco Senior Mealsite	Casco	10/17/11	weekday	day	0	HHVN	LR	
Harrison Fire Station	Harrison	11/8/11	weekday	day	8	HHVN	LR	
Naples Town Hall	Naples	10/31/11	weekday	day	17	VNAHHH	LR	
Standish Fire Dept	Standish	11/9/12	weekday	day	6	VNAHHH	LR	
Total adult >18 pop	39,257				Total 2011:	43	Goal for clinic access:	1,570
PORTLAND								
Iris Network	Portland	9/23/11	weekday	day	28	VNAHHH	Portland	
Jewish Community Center Temple Beth	Portland	10/11/11	weekday	day	7	VNAHHH	Portland	
The Root Cellar	Portland	10/28/11	weekday	day	23	VNAHHH	Portland	
West End Neighborhood	Portland	11/9/11	weekday	evening	15	VNAHHH	Portland	
Woodfords Congregational Church	Portland	10/4/11	weekday	day	30	HHVN	Portland	
Salvation Army	Portland	9/27/11	weekday	day	25	HHVN	Portland	
First Baptist Church	Portland	9/28/11	weekday	day	20	HHVN	Portland	
Sagamore Comm. Center	Portland	10/4/11	weekday	evening	51	PPH	Portland	
City Hall-State of Me. Room	Portland	10/5/11	weekday	day	159	PPH	Portland	
St. Pius X Parish Hall	Portland	10/7/11	weekday	overlap	112	PPH	Portland	
St. Pius X Parish Hall	Portland	10/18/11	weekday	overlap	162	PPH	Portland	
First Lutheran Church	Portland	10/22/11	sat	day	67	PPH	Portland	
City Hall Basement Rm #24	Portland	10/26/11	weekday	day	166	PPH	Portland	
Cliff Island Comm. Center	Cliff Island	10/2/11	sun	day	31	PPH	Portland-islands	
V.A. Building	Long Island	10/2/11	sun	day	49	PPH	Portland-islands	
Peaks Island	Peaks Island	10/6/11	weekday	day	58	PPH	Portland-islands	
Total adult >18 pop	54,865				Total 2011:	1003	Goal for clinic access:	2,195
RIVERS REGION (South Portland, Cape Elizabeth, Scarborough, Gorham, Westbrook)								
St. Anne's Church	Gorham	10/19/11	weekday	day	13	HHVN	RR	
Scarboro Town Hall	Scarborough	9/27/11	weekday	day	10	HHVN	RR	
Cape Elizabeth Middle School	Cape Elizabeth	11/8/11	weekday	day	71	HHVN	RR	
St. Bartholomew Catholic Parish	Cape Elizabeth	10/16/11	sun	day	33	VNAHHH	RR	
St. Maximilian Kolbe	Scarborough	10/2/11	sun	day	49	VNAHHH	RR	
St. John the Evangelist Church	South Portland	10/8/11	sat	evening	10	VNAHHH	RR	
Holy Cross	South Portland	10/9/11	sun	day	15	VNAHHH	RR	
Cumberland County Marketing Expo	South Portland	11/13/11	sun	day	27	VNAHHH	RR	
Vineyard Church	Westbrook	9/30/11	weekday	evening	24	VNAHHH	RR	
Springbrook Center	Westbrook	9/30/11	weekday	day	23	VNAHHH	RR	
St. Anthony's Parish	Westbrook	10/1/11	sat	day	8	VNAHHH	RR	
Westbrook Pointe	Westbrook	10/3/11	weekday	day	10	VNAHHH	RR	
Mercy - Westbrook	Westbrook	10/5/11	weekday	day	21	VNAHHH	RR	
Pride's Corner Church	Westbrook	10/11/11	weekday	day	12	VNAHHH	RR	
Vineyard Church	Westbrook	10/21/11	weekday	evening	10	VNAHHH	RR	
Mercy - Westbrook	Westbrook	10/25/11	weekday	day	25	VNAHHH	RR	
clinics 9 clinics (9/19-11/28) - avg 6/clinic	South Portland	11/28/11	weekday	day	54	VNAHHH	RR	
Total adult >18 pop	67,631				Total 2011:	415	Goal for clinic access:	2,705
Countywide						Goal for clinic access: (4% of adult population)		
Total adult >18 population	222,780				Total 2011:	2,903		8,911

Cumberland County Community Health Forum: Tobacco Focus Group

Conveners:

Claire Schroeder, Tobacco Prevention Coordinator, Opportunity Alliance/Communities Promoting Health Coalition

Fred Wolff, Manager: Education and Training Program, MaineHealth Center for Tobacco Independence

Contact information

Number of people contacted: 180

Number of people contacted who had indicated an interest in tobacco: 21

Number of people who attended the Tobacco Focus Group: 14

Number of people unable to attend but wishing to remain on mailing list: 14

Meeting information

In Attendance:

Claire Schroeder and Fred Wolff (conveners), Ashley Soule, Anne Tricomi, Donna Levi, Mattie Fowler, Leigh Kirschner, Alex Hughes, Sarah Mayberry, Jackie Rogers, Courtney Kennedy, Jo Linder, Ashley Edmondson, Becca Matusovich

The meeting was conducted on March 28, 2012 from 9:00 a.m. – 10:30 a.m. at the MaineHealth building in Portland, Maine.

All participants introduced themselves to the group, stating their name, organization and their role as it pertains to tobacco.

Given existing statewide and local efforts related to tobacco treatment and control it was agreed that an appropriate starting place would be to generate a list of current programs and initiatives. The intention was to establish the baseline we were building upon as well as ensure that everyone was on the same page. This was accomplished by listing these items under four broad categories: Treatment, Prevention/Education, Enforcement/Advocacy and Policy. Though this cannot be taken as the definitive comprehensive list of tobacco treatment and control activities in Maine, it was agreed that it was nevertheless representative of the local and statewide efforts that exist.

Discussion:

There is still much work to be done, especially in the area of addressing tobacco use in populations for whom there continue to be disparities with regard to prevalence of tobacco use - and resources and opportunities for resolving these issues. Nevertheless, it was agreed that much meaningful work has been done on the state and local level to address this threat to public health. Three key areas of concern were noted.

1. Communication

Even amongst this very well informed group of professionals it was notable that all present had significant gaps in their awareness and knowledge about tobacco treatment and control efforts. It highlighted the need for a central clearinghouse of information – from treatment opportunities, to tobacco-related laws and legislation, to education and training programs. The Partnership For A Tobacco-Free Maine has an existing strong website; it was felt however that

this could be improved in providing a more user-friendly and comprehensive clearinghouse of all tobacco-related initiatives, programs, collaborations and services.

2. Health Disparities

Though strong efforts continue to provide services to populations that suffer from health disparities, this was identified as an ongoing need. Tobacco use takes its greatest toll on populations that suffer the greatest disparity in economic and health opportunities. It should continue as a strong priority to identify these needs related to tobacco and to identify population-specific strategies to provide the most effective tobacco prevention and treatment services.

3. Funding Impacts

It was noted that the Healthy Maine Partnerships (HMP) have had a strong role in provision of current tobacco control and treatment efforts. There was concern stated with regard to current reports around the insecurity of the HMP's funding. The Tobacco Focus group felt that it would be important to reconvene this group upon resolution of the status of the HMP's to take stock of any emergent gaps in services and programs relative to any such legislative action.

Recommendation:

The Tobacco Focus Group should reconvene post any legislative action relative to the disposition of the HMP's to assess its impact on tobacco control and treatment efforts. At such time it would also be essential to make recommendations based on that assessment, with particular attention paid to the needs of populations suffering from tobacco-related health disparities.

Also, at that time, the Tobacco Focus Group shall devise a plan for making recommendations to PTM regarding some possible additional features for the PTM website.

Addendum

The following list was generated for discussion purposes only and is not intended as a comprehensive list of tobacco treatment and control programs in Maine.

Treatment

Maine Tobacco Helpline

1-800-NEW-CHOICE (dedicated HelpLine number for teens)

Tobacco Treatment Services Guide (PTM)

- Cessation Support Groups (for example Martins Point)

Brief Interventions

*Project Integrate (Mental Health & Substance Abuse)

School Based Health Centers

Not On Tobacco (NOT) Program

*Tribal Health Centers

Prevention/Education

Media Campaigns

Tabling at local events with resources

National Awareness Days

- Kick Butts & Great American Smoke-out

Trainings (for teachers, clinicians and others)

- Basic Skills (clinical based)
- *Helpers Training (non-clinical approach)
- Annual Intensive Tobacco Treatment Training and Conference

Employee Health Programs (site specific)

Comprehensive Health Education Programs (In schools throughout the district)

Winter Kids Program

Partnership for Tobacco Free Maine

- Resources & brochures at PTM online store

Webinars (CTI/PTM)

Clinical Outreach (CTI/PTM)

Drug Free Community Grants

- Substance Abuse Action Teams in various regions

Enforcement/Advocacy

School disciplinary action plans

Star stores from Attorney Generals office

No Butts program

Tobacco Laws

MPHA Tobacco Policy committee

American Lung Association

MYAN

School Health Clubs

Friends of the Fund for Healthy Maine

Policy

Partnership for Tobacco-Free Maine policy manuals

Tobacco-Free policies @ Hospitals, Colleges, Municipalities, *Housing, Recreation Areas, Hotels

Maine Tobacco-Free Awards for Colleges & Hospitals

Fund for a Healthy Maine

Work site policies

Other

*District Public Health Improvement Plan

*Community Health Improvement Plan (HMP's)

*Disparities data project

PTM

CTI

HMP's

Breathe Easy Coalition

211

Year 1 Budget Amounts

CTG Coordinator (15hr/wk)	\$ 15,201
PAN Schools	\$ 23,413
PAN Childcare	\$ 23,414
ACE Teams	\$ 22,972
Communications	\$ 5,000
Total	<u>\$ 90,000</u>

Community Transformation Grant Update

Cumberland District Public Health
Council

May 18, 2012

Shane Gallagher

Accomplishments since March

- Monthly technical assistance calls.
- Lead organizations selected.
- 1st quarterly report submitted.
- Draft work plans, budgets, and staffing plans for year one submitted to Oversight Sub-committee.
- Oversight Sub-committee endorsed plans and budgets.
- Action Institute.

Current Tasks

- Monthly technical assistance calls.
- Budget and work plan revisions.
- Submit 2nd Quarterly Report.
- Formal assessment of District Capacity.
- Schedule site visit (June or July) with Dawn Littlefield and Pat Hart.
- Implementation of milestones and objectives.

Timeline of key CTG Dates

- 06/05/12 CTG technical assistance call
- 06/25/12 Oversight Sub-committee meeting
- 06/30/12 Final work plans, budgets and staffing plans due
- 07/03/12 CTG technical assistance call
- 07/20/12 Oversight Sub-committee meeting
- 07/29/12 2nd Quarterly Report due
- 07/31/12 Formal assessment of District Capacity due
- 09/29/12 First grant year ends

OBJECTIVE: By September 29, 2014, increase the number of licensed early care and education sites that have implemented the NAPSACC/Let's goes to Childcare, and are in compliance with the state's new licensing rules.					
Milestone/Activity	Timeframe	Short-term Outcome/ Measure (product/deliverable?)	Lead	Partners –	Potential Partners w/ CTG funding
				In-kind	
Develop Y1 workplan	Q3	Copy of workplan	City of Portland/HMP	PAN Sub-group	
Send representative to CTG Action Institute	Q3	Attend Action Institute	City of Portland/HMP		
Review recent combination of NAPSACC and Let's Go to Childcare	Q3	Staff understands new combined tool	City of Portland/HMP	Let's Go	
Identify partners who can assist in efforts to reach childcare providers (such as Childcare Connections)	Q3	Partners contacted	City of Portland/HMP		
Create inventory of all childcare sites in Cumberland County, how many have been approached about NAPSACC and/or Let's Go!, how many participating, and how many refused participation	Q3	List of childcare sites and NAPSACC status	City of Portland/HMP	HMP Directors, Let's Go Childcare Staff	
Conduct survey to determine barriers to participation among those approached who decline participation	Q4	Assessment of barriers to participating in NAPSACC	City of Portland/HMP	HMP Directors	
Create interest survey to administer to all other childcare care providers to gauge interest in working on NAPSACC	Q3	List of interested childcare providers in Cumberland County	City of Portland/HMP		
Conduct assessment to determine which sites serve disparate populations	Q4	Excel spreadsheet with demographics for Childcare centers/surrounding neighborhood	City of Portland/HMP	City's Research and Data Management	
Develop criteria for prioritizing which sites to work with in Year 2 to propose to PAN Sub-group	Q4	List of criteria	City of Portland/HMP		
Develop methodology and process for working with childcare sites in Year 2	Q4	Written process for working with childcare sites in Year 2 - how do we prioritize sites, what will be asked of them, what should we provide	City of Portland/HMP	PAN Sub-group	
Obtain commitments from sites to work with in Year Two	Q4	Signed commitments from sites	City of Portland/HMP		

OBJECTIVE: By September 29, 2014, increase the number of licensed early care and education sites that have implemented the NAPSACC/Let's goes to Childcare, and are in compliance with the state's new licensing rules.					
Milestone/Activity	Timeframe	Short-term Outcome/ Measure (product/deliverable?)	Lead	Partners –	Potential Partners w/ CTG funding
				In-kind	
Develop plan for Let's Go/HMP and CTG work to ensure that existing grants are being supplemented, not supplanted, by the CTG work	Q4	List of deliverables for Let's Go, HMPs, CTG and any other relevant partners specific to funding streams	City of Portland/HMP	HMP Directors, UWGP, Let's Go	
Outline Year 2 workplan, including the budget and staffing plan	Q4	Workplan, budget, staffing plan	City of Portland/HMP	PAN Sub-group	

OBJECTIVE: By September 29, 2014, increase the number of schools who have achieved a bronze or silver award under the Helatier US Schools Challenge (HUSSC)					
Milestone/Activity	Timeframe	Short-term Outcome/ Measure (product/deliverable?)	Lead	Partners –	Potential Partners w/ CTG funding
				In-kind	
Develop Y1 workplan	Q3	Copy of workplan	City of Portland/HMP	PAN Sub-group	
Send representative to CTG Action Institute	Q3	Attend Action Institute	City of Portland/HMP		
Create inventory of all public schools Cumberland County, how many have applied for the HUSSC, and how many have been awarded a bronze, silver or gold HUSSC status	Q3	List of all CC public schools, if they've applied and if they've received and award	City of Portland/HMP	HMP Directors	Let's Go
Create inventory of all Cumberland County public schools that have a policy for a minimum of 30 minutes of daily physical activity	Q4	List of all CC schools and status of policy for PA	City of Portland/HMP	HMP Directors, Let's Go, SHC's	
Gather baseline data for free and reduced lunch rates and other demographics	Q4	Excel spreadsheet with baseline data	City of Portland/HMP		
Obtain information on the HUSSC process from food service directors and staff from schools that have applied and/or been awarded.	Q4	Lessons learned from past applicants	City of Portland/HMP		Let's Go
Conduct survey to determine barriers to applying among those schools that haven't applied	Q4	Assessment of barriers to participating in HUSSC	City of Portland/HMP	HMP Directors	Let's Go
Create interest survey to administer to all other schools to gauge interest in working on HUSSC and meet with representative from each school	Q4	Contacts at each non-participating school	City of Portland/HMP		
Develop methodology and process for working with schools in Year 2	Q4	Written process for working with schools in Year 2 - what will be asked of them, what should we provide	City of Portland/HMP	PAN Sub-group	
Assess barriers and opportunities to implementing a policy requiring 30 minutes of physical activity per day	Q4	Barrier and opportunities to PA identified	City of Portland/HMP		
Develop mentoring process to pair new schools with schools that have successfully applied for HUSSC	Q4	Roles of each parties outlined	City of Portland/HMP		Let's Go
Develop criteria for prioritizing which sites to work with in Year 2	Q4	List of criteria	City of Portland/HMP	PAN Sub-group	
Obtain commitments from sites to work with in Year Two, both new schools and mentoring schools	Q4	Signed commitments from sites	City of Portland/HMP		Let's Go

OBJECTIVE: By September 29, 2014, increase the number of schools who have achieved a bronze or silver award under the Helatier US Schools Challenge (HUSSC)					
Milestone/Activity	Timeframe	Short-term Outcome/ Measure (product/deliverable?)	Lead	Partners –	Potential Partners w/ CTG funding
				In-kind	
Outline Year 2 workplan, including the budget and staffing plan	Q4		City of Portland/HMP	PAN Sub-group	
Develop plan for Let's Go/ HMP and CTG work to ensure that existing grants are being supplemented, not supplanted, by the CTG work	Q4	List of deliverables for Let's Go, HMPs, CTG and any other relevant partners by funding stream	City of Portland/HMP	HMP Directors, UWGP, Let's Go	
Host kick off meeting with incoming schools - include existing HUSSC schools for peer to peer conversations	Q4		City of Portland/HMP	HMP Directors, Let's Go, SHC's	

Cumberland CTG Workplan draft - Active Community Environments

Milestone/Activity	Timeline	Short-term Outcome/ Measure (product/deliverable?)	Lead	Partners – In-kind	Partners w/ CTG funding
Assessment completed identifying existing ACE, Bike/Ped, capacity, assets, infrastructure/ existing groups and champions, gaps, and needs	Q3	Completed gap analysis/ needs assessment for Active Community work	HMP 70 hours	PHiT, PACTS, meet-up, existing bike/ped advisory entities	BCM 20 hours
Develop criteria and process for prioritizing which communities to work with in Year Two (using gap analysis/ needs assessment)	Q4	Criteria developed, Communities identified	BCM 30 hours	PHiT	HMP 19 hours
Select and get commitments from sites to work with in Year Two	Q4	4-6 communities identified and committed to forming ACE teams	BCM 60 hours	PHiT, PACTS, existing bike/ped	HMP 30 hours
Best practices, toolkits, and applicable trainings assessed and gathered (to be used by coordinators, advocates, and ACE teams going forward)	Q4	ACET toolkit/ manual to be shared with new and existing ACE teams	BCM 50 hours	PHiT, CDC (training), PACTS, DOT	HMP 40 hours
Create presentation for municipal and county officials, ACE teams, get PHiT & CTGOC review	Q4	ACE presentation and materials created.	HMP 20 hours	PHiT, PACTS, municipal partners	BCM, 10 hours + marketing consultant
Recruit ACET members from low income, racial/ethnic/language minorities, seniors, children, people with disabilities.	Q4	Strategies included in ACET recruitment, presentations, and all best practices products	HMP 40 hours	PHiT	BCM 10 hours
Create logic model with measurable goal indicators for years 2-5	Q4	Project evaluation plan. Report of baseline data.	BCM 20 hours	PHiT	HMP 30 hours
Draft monitoring and evaluation (M&E) plan for entire 5-year grant period, including interim M&E benchmarks that allow for adjustments in the	Q4	Develop report schedule, specific process and desired	HMP 60 hours	PHiT	BCM 10 hours

Cumberland CTG Workplan draft - Active Community Environments

workplan and reporting system to Oversight Committee.		outcome goals			
Propose (and implement as approved) and one time funding/purchases investment plan for region to jumpstart activity (i.e., training resources, materials for presentations, marketing and communications materials/ plans, possibly temp staff position, capital investments.), create Grants calendar and other funding sources (local government TIFs, bonds etc)	Q4	RFP/ award process defined for jump-start funding (to be disbursed in year two)	HMP 60 hours	PHiT	BCM, Marketing firm TBD? possible purchase of Alliance Winning Campaigns training session?
Create Year Two workplan, budget, and staffing plan	Q4	Year two workplan, budget, and staffing plan complete	BCM & HMP 60 hours	PHiT	BCM 20 hours
Agent(s) from ACE lead and/or partner orgs completes training in Health Impact Assessments for Active Communities: CDC sponsors an online Health Impact Assessment self-directed study course free of charge until mid-September. Planning for Healthy Places with Health Impact Assessments is available online	Q4	Key staff/ partners trained in Health Impact Assessments	BCM	PHiT	HMP 20 hours (?), CDC
YEAR 2: Create communications plan market “Complete Streets” and “ACE” concepts district-wide		** YEAR 2**	BCM & HMP	PHiT, PACTS	

Milestones drafted collaboratively by HMP and BCM staff. Lead on each milestone/objective must work with the PAN subgroup and Oversight Sub-Committee to ensure broad collaborative engagement in design, implementation, and evaluation. Total BCM hours: approx 230 hours, Total HMP hours: 320