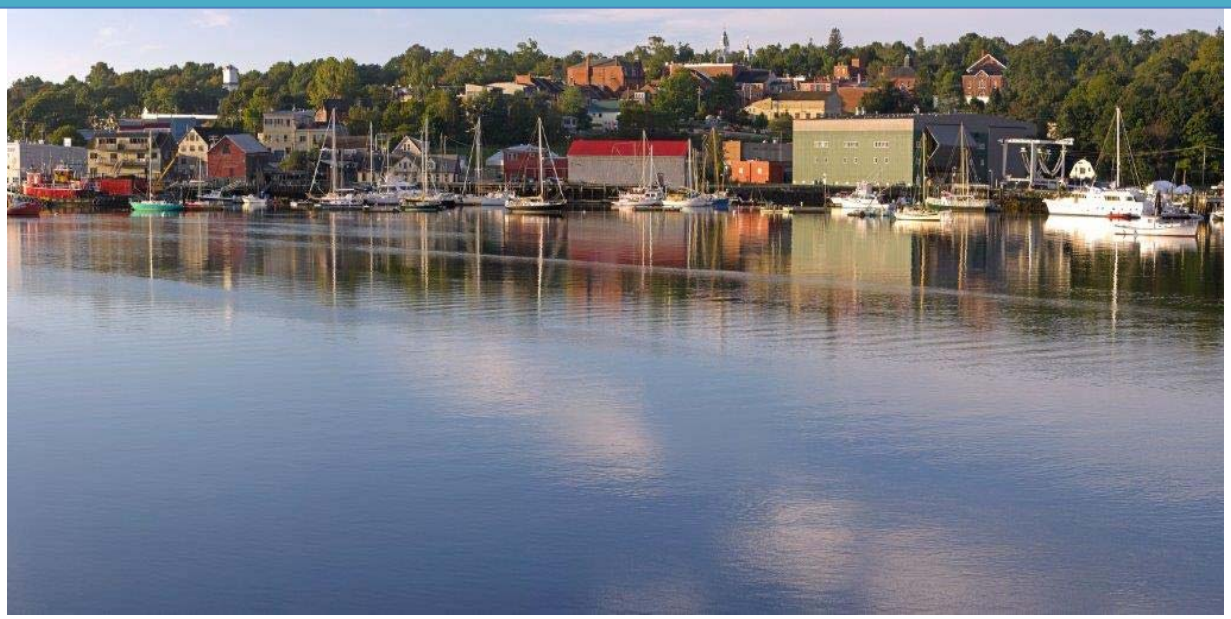
# Midcoast Public Health District

# District Public Health Improvement Plan

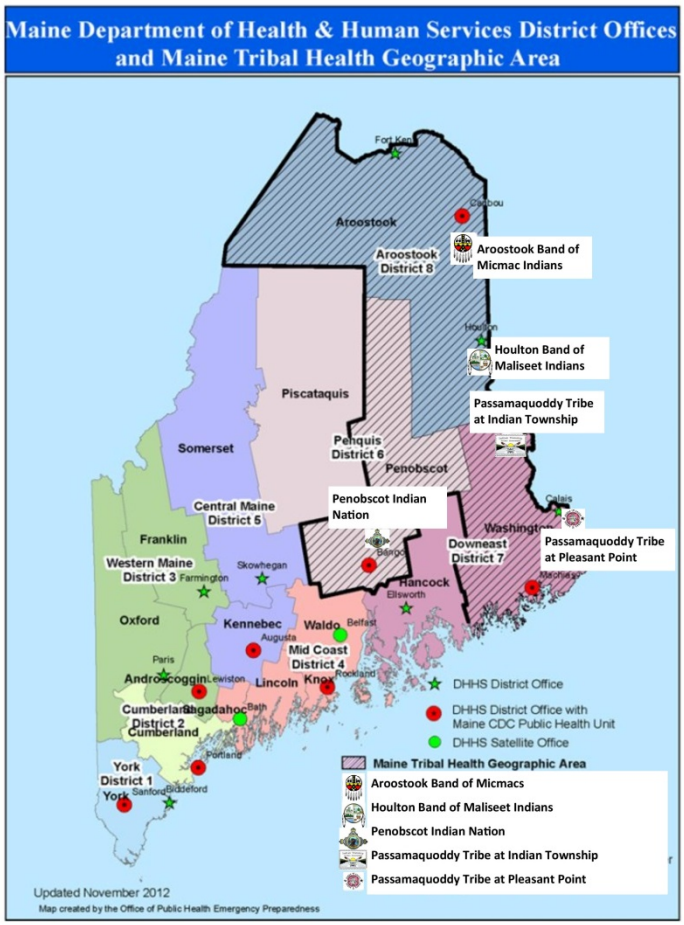
# 2017 – 2019

Revised October 19, 2018



## Midcoast District Coordinating Council for Public Health

# Maine's Public Health Districts




## Midcoast Public Health District

The Midcoast Public Health District includes Sagadahoc, Lincoln, Knox, and Waldo Counties. The district covers 1805 square miles, with a population of 148,272, giving a population density of 82.14 people per square mile. (US Census 2010 data) Midcoast District's largest municipalities by population include Brunswick, Bath, Belfast, Rockland, and Wiscasset. Midcoast District is a coastal district and a portion of its area is composed of peninsulas and small islands where there are limited services, lack of transportation, and seasonal populations.

The Midcoast District Coordinating Council (DCC) has, historically, included Brunswick and Harpswell due to Brunswick's close proximity to and its role as a service center for Sagadahoc County municipalities. Brunswick and Harpswell cover 71 square miles, with a population of 25,018, giving a population density of 352.36 people per square mile. (US Census 2010 data)

# Midcoast District Coordinating Council Members Who Contributed to This Plan

| Leadership: Steering Committee for 2016 - 2017 | | |
|---|---|---|
| **Name** | **Leadership** | **Organization** |
| Pinny Beebe-Center | Chair | Municipal Government |
| Melissa Fochesato | Vice Chair | Access Health |
| Cathy Cole | Steering Committee Member | Lincoln County Healthcare, MaineHealth |
| Jaki Ellis | SCC Representative | Community Member |
| Nancy Laite | Steering Committee Member | Knox County Community Health Coalition |
| Cindy Look | Steering Committee Member | Public Health Nursing, Maine CDC |
| Kate Marone | Steering Committee Member | Healthy Lincoln County |
| Marianne Pinkham | Steering Committee Member | Spectrum Generations |
| Connie Putnam | Steering Committee Member | Knox County Community Health Coalition |
| Vyvyenne Ritchie | Steering Committee Member | Healthy Waldo County |
| Al May / Drexell White | District Liaisons | Maine CDC |

| Council Members as of 2016 | |
|---|---|
| Name | Organization |
| Kate Marone | Healthy Lincoln County |
| Melissa Fochesato | Access Health |
| Pinny Beebe-Center | State Legislator |
| Cathy Cole | Lincoln Health |
| Connie Putnam | Knox County Community Health Coalition |
| Al May | District Liaison, Maine CDC |
| Drexell White | District Liaison, Maine CDC |
| Cindy Look | Maine CDC |
| Joy Osterhout | Pen Bay Medical Center/Waldo County General Hospital |
| Ray Sisk | Knox EMA |
| Paul Weiss | Southern Maine RRC |
| Kathy Knight | Northern Maine RRC |
| Vyvyenne Ritchie | Healthy Waldo County |
| Betty Johnson | Waldo County Commissioner |
| Paul Dumdey | LHO |
| Jenna Schmitz | Planned Parenthood of Northern New England |
| Marianne Pinkham | Spectrum Generations |
| Patrick Walsh | Broadreach |
| Jim Peavey | Midcoast United Way |
| Jeanne Dooley | Out As I Wanna Be |
| Becky Dinces | Penquis CAP |
| Jaki Ellis | SCC Representative |
| Candice Carpenter | Midcoast CAP, WIC |
| | NAMI |

| Interested Parties and Stakeholders Who Contributed to This Plan | |
|---|---|
| **Name** | **Organization** |
| Kate Perkins | Healthy Lincoln County |
| Karyn Butts | ME CDC |
| Jennah Godo | Access Health |
| Andrea Saniuk-Gove | Access Health |
| Jen Kellerman | Access Health |
| Chris Lyman | Community Member |
| Patricia Buck-Welton | Healthy Lincoln County |
| Elizabeth Munsey | Access Health |
| Terry Sherman | Access Health |
| Ira Mandel | Physician |
| Linda Christie | Access Health |
| Sarah Hicks | Sagadahoc EMA |
| Sarah Lash | Midcoast WIC Office |
| Kristina Verney | Lincoln Health |

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# Maine's District Public Health Infrastructure

## Public Health Districts and District Coordinating Councils

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

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

The statutory language further states:

"A district coordinating council for public health shall:

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

## District Public Health Planning Process

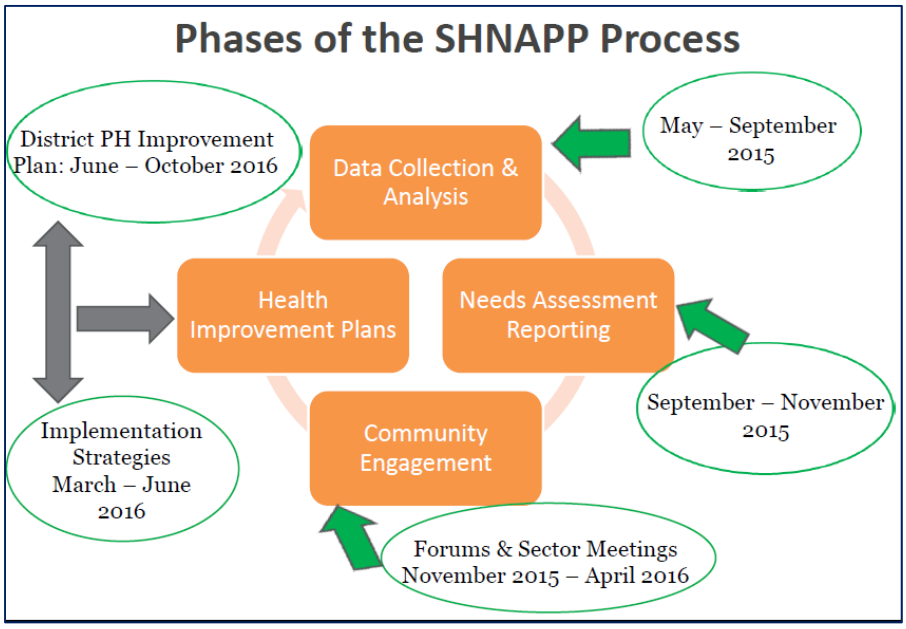
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health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

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

The Maine CDC is required to create and implement a State Health Improvement Plan (SHIP), designed to improve the health of all Maine people. The previous versions of the DPHIPs and SHIP were developed simultaneously, and partially aligned. In 2017, a new SHIP will be developed. In order to better coordinate health improvement efforts and resources between the state, districts, and Maine's people, priorities selected for the DPHIPs will inform this new SHIP. This is the third Midcoast District Public Health Improvement Plan with previous versions created in 2010 and 2013.

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

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




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

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

A community engagement process was used to bring the numbers to life. Thirty-four community forums and fifty-two smaller events with more narrow audiences such as business leaders, or healthcare providers were held across the state, with over 3,000 attendees. A selection of the data from the SHNAPP was presented at each event, and participants discussed their priorities, assets and resources to address the issues, community needs and barriers, and next steps and solutions. The discussions were captured by facilitators and recorders and compiled for each district. Summaries from the community engagement events provided support for the next planning steps.

### Midcoast District Planning Process

In the Midcoast District, an Ad Hoc DPHIP Committee formed and reviewed community and stakeholder input from the SHNAPP community forum and the Midcoast District Data Summary to identify five priorities that were voiced as community concerns – obesity, substance abuse, tobacco use, mental health, and elevated blood lead levels.

At their September 2016 DCC meeting, stakeholders identified attainable results in one to three years, data sources, and evidence based strategies to be implemented for each of the five health areas of concern. In October 2016, the District Liaisons and District Coordinator held a series of conference calls, each focused on one of the health areas of concern, to solicit stakeholder input regarding goals, objectives, and strategies.

The Steering Committee, at their October 2016 meeting, reviewed and refined the preliminary goals, objectives, and strategies. Three, of the initial five, priorities were selected and finalized at the November 2016 DCC meeting. Work groups met in November 2016 to further refine goals, objectives, and strategies for the three health priorities. Meeting minutes documenting this process are available and can be obtained by contacting Phoebe Downer, Council Coordinator, at phoebe.downer@maine.gov or Drexell White, District Liaison, at drexell.r.white@maine.gov .

This process allowed the Midcoast DCC to reduce five priorities to three final priorities for this plan. The remaining two health areas of concern were retained in the appendices as health areas of concern.

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

- **Maximize impact and optimize limited resources**: District partners should first assess existing work being done in the district and determine how best to enhance and

not duplicate these efforts. This criterion also speaks to collaboration across district partners, bringing the priority home to the specific organization, and leveraging existing resources.

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

- **Best addressed at the district level**: In Maine, many community actions are local. However, some issues may be better addressed at a district level. The district should consider whether it can provide a platform for collaboration of non-typical partners; or be an avenue for policy and environmental change that ismore difficult to achieve at the local community level.

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

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

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

- **Focus on Prevention**: While some issues may be addressed with treatment in the health care system, the Public Health Improvement plans focus on outcomes that can be prevented. This may include primary prevention (focus on the entire population), secondary prevention (focus on those at highest risk), or tertiary prevention (focus on

those with existing conditions). Social determinants of health (social and physical environmental factors impacting health) are also considered.

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

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

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

## Midcoast District Public Health Improvement Plan

## Community Health Improvement Priorities

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

- Mental Health
- Elevated Blood Lead Levels
- Obesity

Substance Abuse and Tobacco Use are considered health areas of concern and are included in Appendix 1.

The remainder of this plan provides in-depth information about each of the public health priority areas listed above and plans for improvement. Through district and community based workgroups, council partners have identified goals, objectives and strategies, and will develop detailed work plans to meet their outcomes.

## Implementation Plan Design

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

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

Strategies or action steps were identified and designed to meet the outcomes of the objective. They may lead to short term impacts or intermediate outcomes that are clearly linked to the objectives. Not all possible strategies are able to be addressed within the DPHIP. The DCC considered possible strategies and selected one that met criteria such as those used in selecting the priority areas:

- Does it maximize impact and use of limited resources?
- Is it evidence-based?
- Is it population-based?
- Is it feasible at the district level?
- Does it involve multiple sectors and partners?
- Does it address district disparities?
- Can the DCC hold itself accountable for achieving the impact or outcome?
- Is it prevention-focused?
- Does the data support the use of the strategy?
- Is there adequate community support, or can this be built?
- Is there an organization that is willing to take the lead?
- Does it fill a gap?

# Priority Area 1: Mental Health

| **Priority: Mental Health** | | | |
|---|---|---|---|
| Description/Rationale/Criteria: Mental health is a growing concern in the Midcoast District. Challenges include adverse childhood experiences (ACEs), youth interventions, substance abuse, and increasing rates of youth suicidal ideation and feelings of hopelessness. Older adult focused community partner organizations have expressed a need for increasing access to mental health services for older adults and their families and non-professional caregivers. In addition, mental health has been included in the implementation strategies for both Lincoln Health and Mid Coast Hospitals. | | | |
| Goals | Objectives | Strategies | District Partners |
| 1. Improve the mental health of youth in the Midcoast District | 1.1 Increase the number of depression and/or suicide prevention programs in communities by one in each county. | 1.1.A (Yr. 1) Conduct assessment with 75% of district schools and youth serving organizations to determine existing informal and formal supports to youth:<br>• Who is providing services?<br>• Where and what are the gaps?<br>• What is their capacity?<br>• Use of existing tools | District school departments<br>District schools<br>Parent groups<br>National Alliance on Mental Illness (NAMI)<br>Sweetser<br>ME Behavioral Healthcare<br>Mid Coast Hospital<br>Lincoln Health |
| | | 1.1.B (Yr. 1) Establish communication with and engage school administration to build support and interest for implementation of peer social network programs | District school departments<br>District schools<br>Parent groups |
| | | 1.1.C (Yr. 2) Provide resources for school staff training for implementation of Sources of Strength (peer social network) in priority schools | |
| | | 1.1.D (Yr. 3) Expand Sources of Strength implementation to additional schools in the district | |
| | 1.2 Increase prevention messaging PSAs on local media outlets. | 1.2 Implement media campaigns. | Sexual Assault Support Services of Midcoast Maine (SASSMM)<br>New Hope for Women<br>Community Health Coalitions |

| **Priority: Mental Health (continued)** | | | |
|---|---|---|---|
| Goals | Objectives | Strategies | District Partners |
| 1. Improve the mental health of youth in the Midcoast District | 1.3 By December 31, 2021, increase the number of youth who, when experiencing signs of depression, report receiving help from an adult by three percentage points. | 1.3 Provide the Mental Health First Aid Training course in each of the four counties in the District. | NAMI |
| 2. Improve the mental health of adults in the Midcoast District | 2.1 By June 30, 2017, assess mental health services for older adults and their caregivers in the district. | 2.1 (Yr. 1) Perform gap assessment to identify suicide and depression prevention/reduction mental health services and current outreach and mental health education for older adults and their caregivers in the district<br>• Conduct focus groups with providers<br>• Community forums to engage the District's older adults, caregivers, and stakeholders to identify mental health services status, barriers, and opportunities in the Midcoast District<br>• Mapping services<br>• What is needed?<br>• Gap in understanding | |
| | 2.2 By September 30, 2017, DCC will use the gap analysis results to develop an action plan to respond to the needs identified in the gap analysis. | 2.2.A Based on the gap analysis results, DCC will create partnerships and build network to support implementation of CDSM program at district level<br>2.2.B (Yr. 2) Facilitate education process, i.e. conference or workshop, about mental health for DCC members and interested partners/stakeholders<br>2.2.C Convene stakeholders and service providers | Spectrum Generations<br>NAMI<br>People Plus<br>United Way<br>SAGE Maine<br>AARP Age Friendly Community<br>Tri State Learning<br>WISE Program<br>Municipalities<br>Local Health Officers<br>MaineHealth<br>District Hospitals<br>Emergency Medical Services<br>Code Enforcement Officers<br>Churches<br>Maine Alzheimer's Association<br>Office Adult Disability & Aging |

| **Priority: Mental Health (continued)** | | | |
|---|---|---|---|
| Goals | Objectives | Strategies | District Partners |
| | 2.3 By June 30, 2019, implement, through district partners, at least 1 evidence based strategy across the district. | 2.3.A – Implement educational campaign for older adults and their families and non-professional caregivers, for example early identification of warning signs of Alzheimer's/dementia | Spectrum Generations<br>NAMI<br>Senior Housing People Plus<br>United Way<br>SAGE Maine<br>AARP Age Friendly Community Initiative<br>Aging in Place Initiatives<br>Maine Health Access Foundation (MEHAF)<br>Tri State Learning<br>WISE Program<br>Municipalities<br>Local Health Officers<br>MaineHealth<br>District Hospitals<br>Emergency Medical Services<br>Code Enforcement Officers<br>Churches<br>TRIAD<br>Maine Alzheimer's Association<br>Island Institute<br>ME Seacoast Mission<br>Office of Adult Disability and Aging<br>211 |
| | | 2.3.B -Research and identify evidence based strategies for year 3 implementation | |
| | | 2.3.C - Monitor and assure existing programs | |
| | | 2.3.D Implement evidence based pilot program | |
| | | 2.3.E (Yr. 3) – Assure implementation of at least one evidence based program for older adults, such as *Senior Reach, Age Well Pittsburg, Final Acts Healthy Ideas* | |

## Priority Area 2: Elevated Blood Lead Levels

<table>
<tr><th colspan="4">Priority: Elevated Blood Lead Levels</th></tr>
<tr><td colspan="4">Description/Rationale/Criteria: The Midcoast District has significantly lower lead screening rates among one to two year olds than the state of Maine. The district screening rate for 2009-2013 for one year olds is 34% compared to the statewide rate of 49.2%. The district rate for two year olds is 15% compared to the statewide rate of 27.6%. Increasing lead screening rates is a priority and implementation strategy for district hospitals, Pen Bay Medical Center/Waldo County General Hospital and Mid Coast Hospital, and is also a priority for the United Way of Midcoast Maine.</td></tr>
<tr><td>Goals</td><td>Objectives</td><td>Strategies</td><td>District Partners</td></tr>
<tr><td rowspan="2">1. Reduce Lead Exposure in Children</td><td rowspan="2">1.1 By June 30, 2019, increase the rate of blood lead screening in 1 year olds from 34% to the State average of 49% and increase the rate of blood lead screening in 2 year olds from 15 to 27%.</td><td>1.1.A Conduct a root-cause-analysis regarding clinical sites' barriers to in-office testing, commitment to screening, number of MaineCare children seen at practice, to include:<br>• Use of 4 question risk assessment by physicians<br>• Success rate of referrals<br>• Pediatric, family physician, & GP offices – what are their approaches & commitment to screening?<br>• Identify number of MaineCare children under age of 3 in their practices and the number of those kids who have had screening test<br>• Understanding of barriers at physicians' offices<br>• Determine the baseline of non-clinical sites i.e. Head Start, WIC offices, offering lead screening</td><td rowspan="2">Pen Bay Medical Center<br>Waldo County Hospital<br>Mid Coast Hospital<br>Lincoln Health<br>Martins Point Health Care<br>Belfast Pediatrics<br>Pen Bay Medical Center<br>Waldo County Hospital<br>Mid Coast Hospital<br>Lincoln Health<br>Martins Point Health Care<br>Belfast Pediatrics<br>Head Start<br>CAP agencies<br>Head Start<br>Lead program<br>Pediatric champion<br>Parent organizations</td></tr>
<tr><td>1.1..B (Yr. 1-3) Establish and convene district lead taskforce, including pediatric physician champion, parents & other stakeholders to identify barriers to widespread testing and parents getting their children tested, and to increase screening opportunities</td></tr>
</table>

| **Priority: Elevated Blood Lead Levels (continued)** | | | |
|---|---|---|---|
| Goals | Objectives | Strategies | District Partners |
| 1. Reduce Lead Exposure in Children | | 1.1.C (Yr. 2 & 3) Develop home lead assessment tool for home care visitors, Maine Families, & case management workers | |
| | | 1.1.D (Yr. 2 & 3) Convene task force and engage pediatric patient providers to increase their capacity to provide in office screening, including training staff on screening, obtaining mobile testing units, distributing education materials to parents | |
| | | 1.1.E Create partnerships between non-clinical sites and hospitals/providers with mobile screening units for expansion of mobile testing, by clinicians, at non-clinical sites | United Way of Midcoast Maine<br>Bath Head Start<br>District hospitals<br>Pediatrics & family physicians |
| | 1.2. By June 30, 2019, decrease elevated blood lead levels in one and two year olds from 3.3% to 2.5%, the 2015 state average. | 1.2.A.Determine a pilot program for targeting municipalities in the Midcoast based on estimated children with blood lead levels | Maine Families of Mid coast area |
| | | 1.2.B. Engage and conduct outreach with municipalities, code enforcement, fire department, & LHOs | District Municipalities<br>Local Health Officers (LHOs)<br>Code Enforcement<br>Fire Department |

## Priority Area 3: Obesity

<table>
<tr><td colspan="4">Priority: Obesity</td></tr>
<tr><td colspan="4">Description/Rationale/Criteria: The District levels for obesity and overweight are not significantly higher than the state rates, obesity remains a priority of the Midcoast District. Current obesity prevention funding focuses solely on youth populations. In order to compliment this youth focused work, strategies that incorporate adults and families need to be implemented. Obesity was selected as a hospital implementation strategy for Mid Coast Hospital and Lincoln Health Care and was included in the cardiovascular health priority for Pen Bay Medical Center/Waldo County General Hospital.</td></tr>
<tr><td>Goals</td><td>Objectives</td><td>Strategies/</td><td>District Partners</td></tr>
<tr><td rowspan="4">1. Decrease the impact of Chronic Disease in the Midcoast District</td><td>1.1 By June 30, 2019, Increase the number of chronic disease self-management (CDSM) programs in the Midcoast District</td><td>1.1.A (Yr. 1) - Conduct a District assessment to Identify those organizations providing Chronic Disease Self-Management programs, to include:<br>• Programs, by organization<br>• Program costs<br>• Delivery Method<br>• Participant eligibility requirements<br>• Fees charged to participants in CDSMP programs<br>• Target audience<br>• Whether program is evidence based</td><td>Mid Coast Hospital<br>Bath Iron Works<br>YMCAs (Lincoln, Pen Bay, Bath)<br>Coastal Health Care Alliance</td></tr>
<tr><td rowspan="3">1.2 By June 30, 2019, assure implementation of community education and lifestyle coach mentoring programs in the district.</td><td>1.2.A (Yr. 2 & 3) Amplify awareness campaigns about Diabetes Prevention Program (DPP) and CDSM for primary care providers</td><td rowspan="3">District primary care and general physicians<br>District hospitals<br>DPP Lifestyle coaches</td></tr>
<tr><td>1.2.B (Yr. 2 & 3) Host two learning sessions on successes in the district for lifestyle health coach mentoring systems</td></tr>
<tr><td>1.2.C (Yr. 2 & 3) Adapt Swan’s Island media success story model and implement in Midcoast</td></tr>
</table>

| **Priority: Obesity (continued)** | | | |
|---|---|---|---|
| Goals | Objectives | Strategies/ | District Partners |
| 2. Increase public use of existing low or no cost physical activity resources | 2.1 By June 30, 2019, implement a Midcoast Moves campaign and/or mobile app. | 2.1.A (Yr. 1-3)<br>• Assess readiness for technology options<br>• Develop and implement technology options to promote use of existing free or low-cost physical activity resources such as outdoor trails, indoor walking routes, playgrounds<br><br>2.1.B (Yr. 1-3) Convene and collaborate with district land trusts and conservation groups to assess partnerships and work plans, how to increase public use of their resources | Bowdoin College<br>Land Trusts<br>Conservation Groups<br>Mid Coast Hospital<br>Pen Bay Medical Center<br>Waldo County Hospital<br>Lincoln Health<br>YMCAs<br>Pemaquid Watershed Association<br>Midcoast Conservancy<br>Damariscotta River Assoc.<br>WinterKids<br>Realtors<br>Municipalities<br>Non-Governmental Organizations |
| | 2.2 By June 30, 2019, increase the use of existing low to no cost physical activity in each county | 2.2.A. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will increase the use of existing physical activity resources by providing physical changes to create increased use of a current program/resource or developing a new resource.<br><br>2.2.B. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will increase the use of existing physical activity resources by providing sustainable plans and/or policies to increase public participation in an existing physical activity program. | |
| | 2.3 By June 30, 2019, increase the usability of existing low to no cost physical activity in each county | 2.3.A. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will improve the usability of existing physical activity resources through sustainable modifications, policies or agreements. | |
| | 2.4 By June 30, 2019, increase awareness of low to no cost opportunities for physical activity in each county | 2.4.A. Engage community, government, nonprofit organizations and businesses to promote awareness of low to no cost physical activity resources. | |

## Appendices and Contact Information

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

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

**For more information on the Midcoast District Coordinating Council**, please contact Drexell White, District Liaison, at Drexell.R.White@maine.gov, Phoebe Downer, Council Coordinator, at phoebe.downer@maine.gov , or Cathy Cole, Chair, at cathy.cole@lchcare.org

## Appendix 1: Additional Public Health Areas of Concern

The Midcoast District Coordinating Council considered, but did not select, tobacco use and substance abuse as priorities for focus on the DPHIP. However, tobacco use and substance abuse remain public health areas of concern for the Midcoast District.

Tobacco use and substance abuse are two domains funded through State of Maine prevention funding. Sub recipients of these funds are member organizations of the Midcoast District Coordinating Council. Through these partner organizations, the council will continue to monitor and indirectly work on these areas.

At this time, the Midcoast District Coordinating Council has not created specific plans for addressing tobacco use and substance abuse. The council may decide in the future to create detailed plans to supplement the work of the prevention funding sub recipients.

# Maine Shared Community Health Needs Assessment
# District Summary: 2015

## Midcoast District

Updated: October 2015

## Qualitative Stakeholder Input

A survey of 158 health professionals and community stakeholders in the Midcoast Public Health District provided insight into the most critical health issues and determinants impacting the lives of those living in the area. According to these stakeholders, the following five health issues and health factors have the most impact on the District resulting in poor health outcomes for residents.

**Top five health issues**

- Drug and alcohol abuse
- Obesity
- Mental health
- Depression
- Physical activity and nutrition

**Top five health factors**

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

| Maine Shared CHNA Health Indicators | Year | Midcoast | Knox | Lincoln | Sagadahoc | Waldo | Maine | U.S. |
|---|---|---|---|---|---|---|---|---|
| Demographics | | | | | | | | |
| Total Population | 2013 | 147,591 | 39,550 | 34,088 | 35,013 | 38,940 | 1,328,302 | 319 Mil |
| Population – % ages 0-17 | 2013 | 19.1% | 18.6% | 17.7% | 19.9% | 20.0% | 19.7% | 23.3% |
| Population – % ages 18-64 | 2013 | 60.1% | 59.7% | 57.7% | 61.3% | 61.4% | 62.6% | 62.6% |
| Population – % ages 65+ | 2013 | 20.8% | 21.7% | 24.6% | 18.8% | 18.6% | 17.7% | 14.1% |
| Population – % White | 2013 | 96.9% | 97.0% | 97.4% | 96.3% | 97.0% | 95.2% | 77.7% |
| Population – % Black or African American | 2013 | 0.6% | 0.6% | 0.4% | 0.8% | 0.5% | 1.4% | 13.2% |
| Population – % American Indian and Alaska Native | 2013 | 0.4% | 0.4% | 0.3% | 0.4% | 0.5% | 0.7% | 1.2% |
| Population – % Asian | 2013 | 0.6% | 0.5% | 0.6% | 0.8% | 0.5% | 1.1% | 5.3% |
| Population – % Hispanic | 2013 | 1.1% | 1.1% | 0.9% | 1.5% | 1.1% | 1.4% | 17.1% |
| Population – % with a disability | 2013 | 15.4% | 16.1% | 14.1% | 15.6% | 15.7% | 15.9% | 12.1% |
| Population density (per square mile) | 2013 | NA | 108.8 | 75.6 | 139.1 | 53.1 | 43.1 | 87.4 |
| Socioeconomic Status Measures | | | | | | | | |
| Adults living in poverty | 2009-2013 | 12.5% | *10.8%* | 11.7% | *11.1%* | *16.4%* | 13.6% | 15.4% |
| Children living in poverty | 2009-2013 | 18.5% | 14.6% | 19.8% | 17.2% | 22.2% | 18.5% | 21.6% |
| High school graduation rate | 2013-2014 | 84.3% | 86.2% | 88.9% | 77.9% | 85.4% | 86.5% | 81.0% |
| Median household income | 2009-2013 | NA | $49,755 | $50,181 | *$56,733* | *$42,221* | $48,453 | $53,046 |
| Percentage of people living in rural areas | 2013 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.4% | NA |
| Single-parent families | 2009-2013 | 34.9% | 39.0% | 36.0% | 27.5% | 37.1% | 34.0% | 33.2% |
| Unemployment rate | 2014 | 5.5% | 5.2% | 5.9% | 4.6% | 6.1% | 5.7% | 6.2% |
| 65+ living alone | 2009-2013 | 38.9% | 41.5% | 34.3% | 37.3% | 42.3% | 41.2% | 37.7% |
| General Health Status | | | | | | | | |
| Adults who rate their health fair to poor | 2011-2013 | 14.1% | 14.5% | *12.5%* | 13.6% | 15.9% | 15.6% | 16.7% |
| Adults with 14+ days lost due to poor mental health | 2011-2013 | 11.3% | 12.3% | 11.8% | 11.3% | 9.7% | 12.4% | NA |
| Adults with 14+ days lost due to poor physical health | 2011-2013 | 12.3% | 11.8% | 11.3% | 11.1% | 14.8% | 13.1% | NA |
| Adults with three or more chronic conditions | 2011, 2013 | 27.2% | 24.9% | 26.1% | 29.4% | 28.7% | 27.6% | NA |
| Mortality | | | | | | | | |
| Life expectancy (Female) | 2012 | NA | 82.7 | 82.6 | 81.8 | 81.2 | 81.5 | 81.2 |
| Life expectancy (Male) | 2012 | NA | 77.2 | 77.0 | 78.3 | 77.6 | 76.7 | 76.4 |
| Overall mortality rate per 100,000 population | 2009-2013 | *708.1* | *672.3* | 714.3 | 713.1 | 752.3 | 745.8 | 731.9 |

| Maine Shared CHNA Health Indicators | Year | Midcoast | Knox | Lincoln | Sagadahoc | Waldo | Maine | U.S. |
|---|---|---|---|---|---|---|---|---|
| Access | | | | | | | | |
| Adults with a usual primary care provider | 2011-2013 | *89.9%* | 88.5% | *93.6%* | 90.6% | 87.1% | 87.7% | 76.6% |
| Individuals who are unable to obtain or delay obtaining necessary medical care due to cost | 2011-2013 | 10.9% | 12.1% | 10.4% | 10.2% | 10.9% | 11.0% | 15.3% |
| MaineCare enrollment | 2015 | 25.4% | 25.5% | 23.6% | 21.0% | 30.7% | 27.0% | 23.0% |
| Percent of children ages 0-19 enrolled in MaineCare | 2015 | 43.8% | 45.8% | 43.2% | 37.2% | 48.2% | 41.8% | 48.0% |
| Percent uninsured | 2009-2013 | 11.2% | *13.0%* | 11.9% | *8.0%* | *12.3%* | 10.4% | 11.7% |
| Health Care Quality | | | | | | | | |
| Ambulatory care-sensitive condition hospital admission rate per 100,000 population | 2011 | 1,504.7 | 1,609.9 | 1,353.7 | 1,530.0 | 1,509.1 | 1,499.3 | 1458 |
| Ambulatory care-sensitive condition emergency department rate per 100,000 population | 2011 | *3,776.0* | *3,387.6* | *3,925.3* | *3,374.7* | 4,410.3 | 4,258.8 | NA |
| Oral Health | | | | | | | | |
| Adults with visits to a dentist in the past 12 months | 2012 | 65.2% | 67.4% | 66.8% | 64.8% | 62.2% | 65.3% | 67.2% |
| MaineCare members under 18 with a visit to the dentist in the past year | 2014 | 51.5% | 53.6% | 50.4% | 50.7% | 50.9% | 55.1% | NA |
| Respiratory | | | | | | | | |
| Asthma emergency department visits per 10,000 population | 2009-2011 | *53.1* | *60.8* | *49.3* | *50.5* | *50.9* | 67.3 | NA |
| COPD diagnosed | 2011-2013 | 6.6% | 6.5% | 7.1% | 6.6% | 6.5% | 7.6% | 6.5% |
| COPD hospitalizations per 100,000 population | 2011 | *183.0* | *153.7* | 175.5 | 238.0 | 180.7 | 216.3 | NA |
| Current asthma (Adults) | 2011-2013 | 10.8% | 11.2% | *8.3%* | 12.6% | 11.2% | 11.7% | 9.0% |
| Current asthma (Youth 0-17) | 2011-2013 | 6.5%† | 9.6%† | *3.1%†* | 6.7%† | 5.7%† | 9.1% | NA |
| Pneumonia emergency department rate per 100,000 population | 2011 | *614.1* | *516.9* | *581.1* | *458.8* | *919.2* | 719.9 | NA |
| Pneumonia hospitalizations per 100,000 population | 2011 | *270.5* | 294.7 | *209.1* | *236.5* | 357.9 | 329.4 | NA |
| Cancer | | | | | | | | |
| Mortality – all cancers per 100,000 population | 2007-2011 | *174.2* | 173.8 | 167.8 | 166.8 | 189.2 | 185.5 | 169 |
| Incidence – all cancers per 100,000 population | 2007-2011 | 486.3 | 523.5 | *449.5* | *453.8* | 513.8 | 500.1 | 453 |
| Bladder cancer incidence per 100,000 population | 2007-2011 | 27.2 | 28.3 | 28.8 | 28.8 | 22.9 | 28.3 | 20.2 |
| Female breast cancer mortality per 100,000 population | 2007-2011 | 20.1 | 24.1 | 14.2 | 19.1 | 22.0 | 20.0 | 21.5 |
| Breast cancer late-stage incidence (females only) per 100,000 population | 2007-2011 | 40.7 | 49.6 | 31.7 | 38.3 | 42.8 | 41.6 | 43.7 |
| Female breast cancer incidence per 100,000 population | 2007-2011 | 123.6 | 129.5 | 112.2 | 115.2 | 136.8 | 126.3 | 124 |
| Mammograms females age 50+ in past two years | 2012 | 78.2% | 78.4% | 78.9% | 84.9% | 71.7% | 82.1% | 77.0% |
| Colorectal cancer mortality per 100,000 population | 2007-2011 | 13.9 | 11.7 | 13.1 | 13.1 | 18.2 | 16.1 | 15.1 |
| Colorectal late-stage incidence per 100,000 population | 2007-2011 | 20.7 | 21.7 | 16.2 | 18.5 | 26.4 | 22.7 | 22.9 |
| Colorectal cancer incidence per 100,000 population | 2007-2011 | 38.9 | 36.6 | 34.5 | 36.2 | 48.4 | 43.5 | 42.0 |
| Colorectal screening | 2012 | 69.6% | 70.1% | 75.0% | 73.0% | *61.2%* | 72.2% | NA |
| Lung cancer mortality per 100,000 population | 2007-2011 | 49.9 | 48.4 | 45.0 | 52.6 | 54.1 | 54.3 | 46.0 |
| Lung cancer incidence per 100,000 population | 2007-2011 | *65.9* | 70.0 | *54.0* | *55.3* | 83.6 | 75.5 | 58.6 |
| Melanoma incidence per 100,000 population | 2007-2011 | 25.4 | *34.5* | 24.5 | 24.1 | 17.6 | 22.2 | 21.3 |
| Pap smears females ages 21-65 in past three years | 2012 | 88.7% | 89.6% | 88.9% | 90.6% | 85.8% | 88.0% | 78.0% |
| Prostate cancer mortality per 100,000 population | 2007-2011 | 21.4 | 22.0 | 18.7 | 23.8 | 21.2 | 22.1 | 20.8 |
| Prostate cancer incidence per 100,000 population | 2007-2011 | 141.9 | *162.1* | 123.6 | 141.8 | 141.6 | 133.8 | 141 |
| Tobacco-related neoplasms, mortality per 100,000 population | 2007-2011 | 33.8 | 38.4 | 32.6 | 30.6 | 32.5 | 37.4 | 34.3 |
| Tobacco-related neoplasms, incidence per 100,000 population | 2007-2011 | 87.5 | 93.2 | 87.0 | 82.8 | 85.7 | 91.9 | 81.7 |
| Cardiovascular Disease | | | | | | | | |
| Acute myocardial infarction hospitalizations per 10,000 population | 2010-2012 | *21.6* | *18.4* | *18.8* | 23.6 | *26.7* | 23.5 | NA |
| Acute myocardial infarction mortality per 100,000 population | 2009-2013 | 27.7 | 30.5 | *23.7* | 25.1 | 30.0 | 32.2 | 32.4 |
| Cholesterol checked every five years | 2011. 2013 | 81.2% | 81.1% | 79.3% | 83.4% | 81.0% | 81.0% | 76.4% |
| Coronary heart disease mortality per 100,000 population | 2009-2013 | *78.6* | *65.6* | 85.2 | 76.1 | 90.2 | 89.8 | 103 |

| Maine Shared CHNA Health Indicators | Year | Midcoast | Knox | Lincoln | Sagadahoc | Waldo | Maine | U.S. |
|---|---|---|---|---|---|---|---|---|
| Heart failure hospitalizations per 10,000 population | 2010-2012 | *19.4* | 19.7 | 23.0 | *17.5* | *16.6* | 21.9 | NA |
| Hypertension prevalence | 2011, 2013 | 35.9% | 29.6% | 37.9% | *42.3%* | 34.9% | 32.8% | 31.4% |
| High cholesterol | 2011, 2013 | 39.3% | 37.6% | 41.3% | 39.8% | 38.4% | 40.3% | 38.4% |
| Hypertension hospitalizations per 100,000 population | 2011 | 29.6 | 19.8 | 28.4 | 35.8 | 36.5 | 28.0 | NA |
| Stroke hospitalizations per 10,000 population | 2010-2012 | 20.5 | 22.4 | *18.0* | 21.8 | 19.5 | 20.8 | NA |
| Stroke mortality per 100,000 population | 2009-2013 | *40.2* | 34.3 | 37.8 | *50.7* | 42.8 | 35.0 | 36.2 |
| Diabetes | | | | | | | | |
| Diabetes prevalence (ever been told) | 2011-2013 | 9.0% | 8.0% | 9.1% | 9.5% | 9.4% | 9.6% | 9.7% |
| Pre-diabetes prevalence | 2011-2013 | 7.4% | 8.0% | 9.2% | 6.6%† | 5.9%† | 6.9% | NA |
| Adults with diabetes who have eye exam annually | 2011-2013 | 72.2% | NA | NA | NA | NA | 71.2% | NA |
| Adults with diabetes who have foot exam annually | 2011-2013 | NA | NA | NA | NA | 84.9% | 83.3% | NA |
| Adults with diabetes who have had an A1C test twice per year | 2011-2013 | 74.6% | NA | NA | NA | NA | 73.2% | NA |
| Adults with diabetes who have received formal diabetes education | 2011-2013 | 66.3% | NA | NA | NA | NA | 60.0% | 55.8% |
| Diabetes emergency department visits (principal diagnosis) per 100,000 population | 2011 | *197.6* | *161.7* | *168.2* | 233.4 | 236.4 | 235.9 | NA |
| Diabetes hospitalizations (principal diagnosis) per 10,000 population | 2010-2012 | 12.1 | 12.3 | 10.3 | *14.5* | 11.6 | 11.7 | NA |
| Diabetes long-term complication hospitalizations | 2011 | 68.7 | 67.0 | 64.0 | *90.8* | 52.7 | 59.1 | NA |
| Diabetes mortality (underlying cause) per 100,000 population | 2009-2013 | *15.8* | 16.9 | *12.4* | *12.6* | 21.4 | 20.8 | 21.2 |
| Environmental Health | | | | | | | | |
| Children with confirmed elevated blood lead levels (% among those screened) | 2009-2013 | *3.3%* | *5.0%* | *4.5%* | 3.3% | *1.3%* | 2.5% | NA |
| Children with unconfirmed elevated blood lead levels (% among those screened) | 2009-2013 | *2.8%* | *2.0%* | *2.0%* | *1.4%* | 5.0% | 4.2% | NA |
| Homes with private wells tested for arsenic | 2009, 2012 | 39.6% | 47.4% | *31.8%* | 38.9% | 41.9% | 43.3% | NA |
| Lead screening among children age 12-23 months | 2009-2013 | *34.0%* | *32.8%* | *31.4%* | *33.3%* | *37.5%* | 49.2% | NA |
| Lead screening among children age 24-35 months | 2009-2013 | *15.0%* | *14.4%* | *10.2%* | *12.3%* | *21.4%* | 27.6% | NA |
| Immunization | | | | | | | | |
| Adults immunized annually for influenza | 2011-2013 | 43.6% | 41.9% | *47.0%* | *47.0%* | 39.0% | 41.5% | NA |
| Adults immunized for pneumococcal pneumonia (ages 65 and older) | 2011-2013 | 70.8% | 69.3% | 69.8% | 74.4% | 70.2% | 72.4% | 69.5% |
| Immunization exemptions among kindergarteners for philosophical reasons | 2015 | 4.7% | 5.7% | 2.5% | 3.0% | 6.5% | 3.7% | NA |
| Two-year-olds up to date with “Series of Seven Immunizations” 4-3-1-3-3-1-4 | 2015 | NA | 74.0% | 63.0% | NA | NA | 75.0% | NA |
| Infectious Disease | | | | | | | | |
| Hepatitis A (acute) incidence per 100,000 population | 2014 | 2.7† | 0.0† | 0.0† | 0.0† | 10.2† | 0.6 | 0.4 |
| Hepatitis B (acute) incidence per 100,000 population | 2014 | 0.0† | 0.0† | 0.0† | 0.0† | 0.0† | 0.9 | 0.9 |
| Hepatitis C (acute) incidence per 100,000 population | 2014 | 2.7† | 5.0† | 5.9† | 0.0† | 0.0† | 2.3 | 0.7 |
| Incidence of past or present hepatitis C virus (HCV) per 100,000 population | 2014 | 99.4 | 221.8 | 73.2 | 28.5† | 61.5 | 107.1 | NA |
| Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population | 2014 | 2.7† | 2.5† | 2.9† | 0.0† | 5.1† | 8.1 | NA |
| Lyme disease incidence per 100,000 population | 2014 | 203.5 | 267.2 | 240.0 | 182.6 | 125.5 | 105.3 | 10.5 |
| Pertussis incidence per 100,000 population | 2014 | 66.9 | 45.4† | 58.5 | 25.7† | 133.2 | 41.9 | 10.3 |
| Tuberculosis incidence per 100,000 population | 2014 | 0.0† | 0.0† | 0.0† | 0.0† | 0.0† | 1.1 | 3.0 |
| STD/HIV | | | | | | | | |
| AIDS incidence per 100,000 population | 2014 | 0.0† | 0.0† | 0.0† | 0.0† | 0.0† | 2.1 | 8.4 |
| Chlamydia incidence per 100,000 population | 2014 | 197.4 | 128.5 | 187.3 | 219.7 | 256.1 | 265.5 | 452 |
| Gonorrhea incidence per 100,000 population | 2014 | 9.5† | 7.6† | 8.8† | 11.4† | 10.2† | 17.8 | 110 |
| HIV incidence per 100,000 population | 2014 | 2.0† | 2.5† | 0.0† | 0.0† | 5.1† | 4.4 | 11.2 |
| HIV/AIDS hospitalization rate per 100,000 population | 2011 | 20.9 | 13.3 | 23.1 | 17.0 | 29.8 | 21.4 | NA |
| Syphilis incidence per 100,000 population | 2014 | 1.4† | 0.0† | 0.0† | 2.9† | 2.6† | 1.6 | 19.9 |

| Maine Shared CHNA Health Indicators | Year | Midcoast | Knox | Lincoln | Sagadahoc | Waldo | Maine | U.S. |
|---|---|---|---|---|---|---|---|---|
| Intentional Injury | | | | | | | | |
| Domestic assaults reports to police per 100,000 population | 2013 | 292.4 | 330.9 | 351.2 | 185.5 | 297.6 | 413.0 | NA |
| Firearm deaths per 100,000 population | 2009-2013 | 9.7 | 9.7† | 13.2 | 6.5† | 9.9 | 9.2 | 10.4 |
| Intentional self-injury (Youth) | 2013 | NA | NA | NA | NA | NA | 17.9% | NA |
| Lifetime rape/non-consensual sex (among females) | 2013 | NA | NA | NA | NA | NA | 11.3% | NA |
| Nonfatal child maltreatment per 1,000 population | 2013 | NA | NA | NA | NA | NA | 14.6 | 9.1 |
| Reported rape per 100,000 population | 2013 | 24.4 | 10.1† | 67.3 | 20.0† | 5.1† | 27.0 | 25.2 |
| Suicide deaths per 100,000 population | 2009-2013 | 16.3 | 15.2 | 20.3 | 15.2 | 15.5 | 15.2 | 12.6 |
| Violence by current or former intimate partners in past 12 months (among females) | 2013 | NA | NA | NA | NA | NA | 0.8% | NA |
| Violent crime rate per 100,000 population | 2013 | 75.1 | 63.2 | 122.9 | 59.9 | 59.0 | 125.0 | 368 |
| Unintentional Injury | | | | | | | | |
| Always wear seatbelt (Adults) | 2013 | 85.2% | 83.8% | 84.4% | 86.5% | 86.5% | 85.2% | NA |
| Always wear seatbelt (High School Students) | 2013 | 62.0% | NA | 63.8% | 62.5% | NA | 61.6% | 54.7% |
| Traumatic brain injury related emergency department visits (all intents) per 10,000 population | 2011 | *88.3* | *64.5* | *110.7* | *96.7* | 85.5 | 81.4 | NA |
| Unintentional and undetermined intent poisoning deaths per 100,000 population | 2009-2013 | 10.8 | 12.3 | 9.4† | 7.1† | 13.6 | 11.1 | 13.2 |
| Unintentional fall related deaths per 100,000 population | 2009-2013 | 5.3 | 6.0 | 5.7† | 5.4† | 4.0† | 6.8 | 8.5 |
| Unintentional fall related injury emergency department visits per 10,000 population | 2011 | *390.3* | *416.5* | *396.5* | 360.2 | 383.9 | 361.3 | NA |
| Unintentional motor vehicle traffic crash related deaths per 100,000 population | 2009-2013 | 12.3 | 14.8 | 10.3 | 9.1† | 14.6 | 10.8 | 10.5 |
| Occupational Health | | | | | | | | |
| Deaths from work-related injuries (number) | 2013 | NA | NA | NA | NA | NA | 19.0 | 4,585 |
| Nonfatal occupational injuries (number) | 2013 | 1,423.0 | 382.0 | 255.0 | 545.0 | 241.0 | 13,205.0 | NA |
| Mental Health | | | | | | | | |
| Adults who have ever had anxiety | 2011-2013 | 17.1% | 18.3% | 16.0% | 17.7% | 16.5% | 19.4% | NA |
| Adults who have ever had depression | 2011-2013 | 23.0% | 24.0% | 23.0% | 24.2% | 20.8% | 23.5% | 18.7% |
| Adults with current symptoms of depression | 2011-2013 | 9.9% | 10.6% | 8.1% | 11.0% | 9.8% | 10.0% | NA |
| Adults currently receiving outpatient mental health treatment | 2011-2013 | 16.0% | 15.5% | 15.6% | 18.7% | *14.3%* | 17.7% | NA |
| Co-morbidity for persons with mental illness | 2011, 2013 | 32.9% | 26.2% | NA | NA | NA | 35.2% | NA |
| Mental health emergency department rates per 100,000 population | 2011 | *1,822.0* | 1,908.1 | *1,461.0* | 1,854.1 | 2,008.3 | 1,972.1 | NA |
| Sad/hopeless for two weeks in a row (High School Students) | 2013 | 26.8% | NA | 25.9% | *29.6%* | NA | 24.3% | 29.9% |
| Seriously considered suicide (High School Students) | 2013 | 16.6% | NA | 14.6% | *19.7%* | NA | 14.6% | 17.0% |
| Physical Activity, Nutrition and Weight | | | | | | | | |
| Fewer than two hours combined screen time (High School Students) | 2013 | NA | NA | NA | NA | NA | 33.9% | NA |
| Fruit and vegetable consumption (High School Students) | 2013 | *20.0%* | NA | 18.4% | *21.3%* | NA | 16.8% | NA |
| Fruit consumption among Adults 18+ (less than one serving per day) | 2013 | 32.0% | 27.9% | 30.0% | 33.7% | 37.1% | 34.0% | 39.2% |
| Met physical activity recommendations (Adults) | 2013 | 56.0% | 59.0% | 55.5% | 59.0% | 50.0% | 53.4% | 50.8% |
| Physical activity for at least 60 minutes per day on five of the past seven days (High School Students) | 2013 | 44.0% | NA | 46.6% | 44.5% | NA | 43.7% | 47.3% |
| Sedentary lifestyle – no leisure-time physical activity in past month (Adults) | 2011-2013 | 21.8% | 19.5% | 23.7% | 19.1% | 24.8% | 22.4% | 25.3% |
| Soda/sports drink consumption (High School Students) | 2013 | 25.6% | NA | 29.8% | 23.7% | NA | 26.2% | 27.0% |
| Vegetable consumption among Adults 18+ (less than one serving per day) | 2013 | 15.1% | 14.9% | 11.6%† | 16.6%† | 17.7% | 17.9% | 22.9% |
| Obesity (Adults) | 2013 | 25.0% | 24.3% | 22.4% | 24.4% | 29.2% | 28.9% | 29.4% |
| Obesity (High School Students) | 2013 | 13.2% | NA | 13.4% | 12.8% | NA | 12.7% | 13.7% |
| Overweight (Adults) | 2013 | 40.1% | 33.8% | 40.8% | *46.7%* | 40.1% | 36.0% | 35.4% |

| Maine Shared CHNA Health Indicators | Year | Midcoast | Knox | Lincoln | Sagadahoc | Waldo | Maine | U.S. |
|---|---|---|---|---|---|---|---|---|
| Overweight (High School Students) | 2013 | 17.8% | NA | *20.7%* | 15.7% | NA | 16.0% | 16.6% |
| Pregnancy and Birth Outcomes | | | | | | | | |
| Children with special health care needs | 2009-2010 | NA | NA | NA | NA | NA | 23.6% | 19.8% |
| Infant deaths per 1,000 live births | 2003-2012 | 5.6 | 6.2 | 3.4 | 5.2 | 7.2 | 6.0 | 6.0 |
| Live births for which the mother received early and adequate prenatal care | 2010-2012 | 86.8% | 88.5% | 90.5% | 90.5% | *79.5%* | 86.4% | 84.8% |
| Live births to 15-19 year olds per 1,000 population | 2010-2012 | *24.2* | 24.5 | 20.0 | 22.5 | *28.4* | 20.5 | 26.5 |
| Low birth weight (<2500 grams) | 2010-2012 | 6.1% | 6.6% | 5.7% | 5.2% | 6.6% | 6.6% | 8.0% |
| Substance and Alcohol Abuse | | | | | | | | |
| Alcohol-induced mortality per 100,000 population | 2009-2013 | 7.3 | 6.8† | 10.8 | 7.1† | 5.0† | 8.0 | 8.2 |
| Binge drinking of alcoholic beverages (High School Students) | 2013 | 14.7% | NA | 12.5% | 15.9% | NA | 14.8% | 20.8% |
| Binge drinking of alcoholic beverages (Adults) | 2011-2013 | 15.6% | 15.3% | 16.9% | 17.0% | *13.3%* | 17.4% | 16.8% |
| Chronic heavy drinking (Adults) | 2011-2013 | 7.7% | 8.3% | 8.6% | 7.2% | 6.9% | 7.3% | 6.2% |
| Drug-affected baby referrals received as a percentage of all live births | 2014 | 6.8% | 5.7% | 10.7% | 2.2% | 9.6% | 7.8% | NA |
| Drug-induced mortality per 100,000 population | 2009-2013 | NA | 12.8 | 13.4 | NA | 16.9 | 12.4 | 14.6 |
| Emergency medical service overdose response per 100,000 population | 2014 | 237.9 | 259.6 | 263.4 | 254.0 | 179.3 | 391.5 | NA |
| Opiate poisoning (ED visits) per 100,000 population | 2009-2011 | 23.2 | 31.4 | 16.5 | 23.9 | 20.3 | 25.1 | NA |
| Opiate poisoning (hospitalizations) per 100,000 population | 2009-2011 | 16.4 | *26.2* | 9.4 | 11.6 | 17.3 | 13.2 | NA |
| Past-30-day alcohol use (High School Students) | 2013 | 26.9% | NA | 24.9% | *29.0%* | NA | 26.0% | 34.9% |
| Past-30-day inhalant use (High School Students) | 2013 | 3.1% | NA | 2.9% | 3.7% | NA | 3.2% | NA |
| Past-30-day marijuana use (Adults) | 2011-2013 | 8.5% | 10.4%† | 9.4%† | 8.9%† | 5.4%† | 8.2% | NA |
| Past-30-day marijuana use (High School Students) | 2013 | 25.1% | NA | 22.8% | 28.0% | NA | 21.6% | 23.4% |
| Past-30-day nonmedical use of prescription drugs (Adult) | 2011-2013 | 1.7%† | 2.4%† | 1.6%† | 1.8%† | 1.0%† | 1.1% | NA |
| Past-30-day nonmedical use of prescription drugs (High School Students) | 2013 | 5.7% | NA | *4.1%* | *7.9%* | NA | 5.6% | NA |
| Prescription Monitoring Program opioid prescriptions (days supply/pop) | 2014-2015 | 7.2 | 6.7 | 8.2 | 6.1 | 7.8 | 6.8 | NA |
| Substance-abuse hospital admissions per 100,000 population | 2011 | 325.8 | *518.0* | 308.8 | *208.2* | *260.3* | 328.1 | NA |
| Tobacco Use | | | | | | | | |
| Current smoking (Adults) | 2011-2013 | 17.7% | 24.5% | *12.5%†* | 17.2%† | 15.4%† | 20.2% | 19.0% |
| Current smoking (High School Students) | 2013 | 15.4% | NA | 13.4% | 18.7% | NA | 12.9% | 15.7% |
| Current tobacco use (High School Students) | 2013 | 19.7% | NA | 16.7% | *24.0%* | NA | 18.2% | 22.4% |
| Secondhand smoke exposure (Youth) | 2013 | 40.3% | NA | 41.9% | 42.6% | NA | 38.3% | NA |

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

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

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

## Appendix 3 - DHPHIP Revisions & Corrections

| Revision Date | Section | Original Language | Revision | Comments |
|---|---|---|---|---|
| 02/08/2017 | Mental Health Priority | Goal 1 - Increase the percentage number of youth who report feeling sad or hopeless who seek help from an adult | Goal 1 - Improve the Mental Health of youth in the Midcoast District | Revision made as part of CDC Funding Review |
| 02/08/2017 | Mental Health Priority | Objective 1.1 Increase the number of depression and/or suicide prevention or skill building programs in communities by one in each county | 1.1 Increase the number of depression and/or suicide prevention programs in communities by one in each county. | Revision made as part of CDC Funding Review |
| 02/08/2017 | Mental Health Priority | Strategy 1.1.B - Establish communication with and engage school administration to gain a commitment to implementation of peer social network/skill building programs | 1.1.B (Yr. 1) Establish communication with and engage school administration to build support and interest for implementation of peer social network programs | Revision made as part of CDC Funding Review |
| 02/08/2017 | Mental Health Priority | Goal 2 - Improve availability and access to depression and suicide prevention services for adults | Goal 2 - Improve the Mental Health of adults in the Midcoast District | Revision made as part of CDC Funding Review |
| 02/08/2017 | Mental Health Priority | 2.1.A (Yr. 1) Perform gap assessment to identify suicide and depression prevention/reduction mental health services for older adults and their caregivers in the district<br>• Conduct focus groups with providers<br>• Community forums<br>• Mapping services<br>• What is needed?<br>Gap in understanding | 2.1.A (Yr. 1) Perform gap assessment to identify suicide and depression prevention/reduction mental health services and current outreach and mental health education for older adults and their caregivers in the district<br>• Conduct focus groups with providers<br>• Community forums to engage the District's older adults, caregivers and stakeholders to identify mental health services status, barriers and opportunities in the Midcoast District<br>• Mapping services | Revision made as part of CDC Funding Review |

| Revision Date | Section | Original Language | Revision | Comments |
|---|---|---|---|---|
| | | | • What is needed?<br>Gap in understanding | |
| 02/08/2017 | Elevated Lead Levels Priority | Status - The Midcoast District has significantly lower lead screening rates among one to two year olds than the state of Maine. District screening rates for one to two year olds are 34% compared to the state's rate of 49.2%. Increasing lead screening rates is a priority and implementation strategy for district hospitals, Pen Bay Medical Center/Waldo County General Hospital and Mid Coast Hospital, and is also a priority for the United Way of Midcoast Maine. | Description/Rationale/Criteria: The Midcoast District has significantly lower lead screening rates among one to two year olds than the state of Maine. The district screening rate for 2009-2013 for one year olds is 34% compared to the statewide rate of 49.2%. The district rate for two year olds is 15% compared to the statewide rate of 27.6%. Increasing lead screening rates is a priority and implementation strategy for district hospitals, Pen Bay Medical Center/Waldo County General Hospital and Mid Coast Hospital, and is also a priority for the United Way of Midcoast Maine. | Revision made as part of CDC Funding Review |
| 02/08/2017 | Elevated Lead Levels Priority | Goal 1. Increase blood lead level screening rates for one and two year olds | Goal 1 - Reduce Lead Exposure in Children | Revision made as part of CDC Funding Review |
| 02/08/2017 | Elevated Lead Levels Priority | 1.1 By June 30, 2017, conduct assessment regarding clinical sites' barriers to in-office testing, commitment to screening, number of MaineCare children seen at practice, etc. | 1.1. By June 30, 2019, increase rate of blood lead screening in 1 year olds from 34% to the State average of 49%.and increase rate of blood lead screening in 2 year olds from 15% to 27%. | Revision made as part of CDC Funding Review |
| 02/08/2017 | Elevated Lead Levels Priority | 1.1.A (Yr. 1) Gap analysis to assess:<br>• Use of 4 question risk assessment by<br>• physicians<br>• Success rate of referrals<br>• Pediatric, family physician, & GP<br>• offices – what are their approaches &<br>• Commitment to screening? | 1.1.A Conduct a root-cause-analysis regarding clinical sites' barriers to in-office testing, commitment to screening, number of MaineCare children seen at practice, to include:<br>• Use of 4 question risk<br>• assessment by physicians<br>• Success rate of referrals<br>• Pediatric, family physician, &<br>• GP offices – what are their | Revision made as part of CDC Funding Review |

| Revision Date | Section | Original Language | Revision | Comments |
|---|---|---|---|---|
| | | • Identify number of MaineCare<br>• children under age of 3 in their<br>• practices and the number of those<br>• kids who have had screening test<br>• Understanding of barriers at<br>• physicians' offices<br>• Determine the baseline of non-clinical<br>• sites i.e. Head Start, WIC offices,<br>• offering lead screening | • approaches & commitment to<br>• screening?<br>• Identify number of MaineCare<br>• children under age of 3 in<br>• their practices and the<br>• number of those kids who<br>• have had screening test<br>• Understanding of barriers at<br>• physicians' offices<br>• Determine the baseline of<br>• non-clinical sites i.e. Head<br>• Start, WIC offices, offering<br>• lead screening | |
| 02/08/2017 | Elevated Lead Levels Priority | 1.1.A (Yr. 1-3) Establish and convene district lead taskforce, including pediatric physician champion, parents & other stakeholders | 1.1.B (Yr. 1-3) Establish and convene district lead taskforce, including pediatric physician champion, parents & other stakeholders to identify barriers to widespread testing and parents getting their children tested, and to increase screening opportunities | Revision made as part of CDC Funding Review |
| 02/08/2017 | Obesity Priority | Goal 1. Improve utilization of chronic disease self-management (CDSM) programs | Goal 1 Decrease the impact of Chronic Disease in the Midcoast District | Revision made as part of CDC Funding Review |
| 02/08/2017 | Obesity Priority | 1.1 By June 30, 2017, assess community readiness for Diabetic Prevention Programs (DPP). | 1.1 By June 30, 2019, Increase the number of chronic disease self-management (CDSM) programs in the Midcoast District | Revision made as part of CDC Funding Review |
| 02/08/2017 | Obesity Priority | 1.1.A (Yr. 1) Conduct an assessment to determine the following:<br>• Community readiness<br>• Worksite readiness<br>• Stage of change | 1.1.A (Yr. 1) - Conduct a District assessment to Identify those organizations providing Chronic Disease Self-Management programs, to include:<br>• Programs, by organization<br>• Program costs<br>• Delivery Method | Revision made as part of CDC Funding Review |

| Revision Date | Section | Original Language | Revision | Comments |
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| | | Potential models:<br>- *Fishermen's Forum in March as outreach potential*<br>*MEHAF community readiness model* | • Participant eligibility requirements<br>• Fees charged to participants in CDSMP programs<br>• Target audience<br>• Whether program is evidence based | |
| 2/8/2017 | Main | Colleen Fuller, District Coordinator | Ruth Lawson-Stopps, District Coordinator | Change of District Coordinators in January 2017 |

| Revision Date | Section | Original Language | Revision | Comments |
|---|---|---|---|---|
| 4/17/2017 | Obesity Priority | 2.1.C (Yr. 1-3) Expand or implement initiatives and/or programs that promote use of walking trails and paths such as the Midcoast Summer Trail Challenge<br><br>2.1.D (Yr. 1-3) Update/maintain and promote existing resources such as Healthy Maine Walks, Maine Trail Finder | 2.2 By June 30, 2019, increase the use of existing low to no cost physical activity in each county<br>2.2.A. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will increase the use of existing physical activity resources by providing physical changes to create increased use of a current program/resource or developing a new resource.<br>2.2.B. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will increase the use of existing physical activity resources by providing sustainable plans and/or policies to increase public participation in an existing physical activity program.<br>2.3 By June 30, 2019, increase the usability of existing low to no cost physical activity in each county<br>2.3.A. Engage community, government, nonprofit organizations and businesses to perform at least one activity in each county that will improve the usability of existing physical activity resources through sustainable modifications, policies or agreements.<br>2.4 By June 30, 2019, increase awareness of low to no cost opportunities for physical activity in each county<br>2.4.A. Engage community, government, nonprofit organizations and businesses to promote awareness of low to no cost physical activity resources | Original strategies reworked as part of Mini Grant process. Additional objectives and strategies added to clarify and strengthen goal. |

| Revision Date | Section | Original Language | Revision | Comments |
|---|---|---|---|---|
| 10/19/2018 | Mental Health Priority | N/A | 1.3 By December 31, 2021, increase the number of youth who, when experiencing signs of depression, report receiving help from an adult by three percentage points.<br>1.3 Provide the Mental Health First Aid Training course in each of the four counties in the District. | Objective and Strategy added to enable funding to be used for Mental Health First Aid Trainings. |
| 10/19/2018 | Housekeeping | | For more information on the Midcoast District Coordinating Council, please contact Drexell White, District Liaison, at Drexell.R.White@maine.gov, Phoebe Downer, Council Coordinator, at phoebe.downer@maine.gov , or Cathy Cole, Chair, at cathy.cole@lchcare.org | Updated Council Chair and Council Coordinator Contact Information |