Welcome/Introductions
We went around the room and did quick introductions.
Deeper Dive: Partnership for Improving Community Health (PICH)

Jessica Shaffer, Director of Community Healthy Partnerships, Eastern Maine Healthcare Systems.

Jessica was explaining the results of the three-year Partnership to Improve Community Health (PICH) grant results which were finalized in Sept 2017. Jessica was talking about how to keep the positive steps going in the future even though the grant is no longer running. The PICH grant focused on food insecurities in the Northern part of Maine. The results showed the Food Insecurity in Maine is slightly higher than the counties average. The focus of the presentation was places where the grant was most successful and sustainable.

Strengthening Maine’s food pantry network was one successful goal of the PICH grant. There has been a mindset change of people, specifically the directors, of food pantries towards wanting to get healthier options to the people, not just food. Some food pantry’s have developed some guidelines for donations. In one year they saw a 9% growth of pantry’s sourcing local farms for vegetables. Collaboration not competition was fostered among pantry’s.

Making Healthier Hospital Food was another successful focus of the PICH grant. Hospitals employ so many people in our communities it was a natural place get healthier food options. Often the directors of the cafeterias were worried about losing money. They equated healthy to a loss of profit, when in fact data proved to be just the opposite. A question arose as to why the nutritional information was not readily available in hospitals like at many fast food chains. Getting the nutritional information displayed or at least in a binder was something that the PICH grant encouraged. As well as placing healthier foods at eye level and other esthetic changes. It seems that if hospitals are willing to work together, sustainability is conceivable.

PICH was also interested in Food Insecurity Screening and Intervention. It’s a two-step process. First you screen individuals for food insecurities with a two-question survey, then if they say that they do feel they have food insecurity problems, address them. Addressing the matter was harder then screening the people. However, getting people to admit to food insecurity took a level of trust and familiarity, relationship building is vitally important in this process. When it was possible to talk directly to clinicians and clinical staff regarding food insecurities, through programs like Lunch and Learn, was an effective way to reach organizations. Without funding, finding clinicians to champion the efforts will be most effective. Often the clinicians or medical staff asked the two-question survey. A frustration arose once they identified at risk patients – what could they do? Once we normalize the questions regarding food insecurity (like we do seat-belt use) it is more likely to get the statistical data back up to “what we know to be true”. Some sites created lists of pantry’s or emergency boxes to be given out to patients, but there was helplessness felt on the part of the providers once patients had been identified.
Overall, the PICH grant found that when people worked together there was power. It is also important to build lasting relationships BEFORE trying to change things. Especially in our rural areas, the people are worried of outsiders. Overall, there was really no right way to do a screening (in person, clipboard etc.) what was important was that the screening got done and in a sustainable way.

Discussion: Now that the grant is over and there is no money how do we keep the good work going. Re-engaging with collaborative partners as a network was suggested. Also, recruiting from not traditional sources. Thinking outside the box to get more local farms and vegetables. Most importantly getting clinicians and staff to ‘buy in’ and want these changes to happen. There was a question as to whether the Doctors thought this was a hassle, and seemingly they did not. Often the MAs would help do the screening and just inform the doctors. It was also talked about home visitors, such as the Public Health Nurses that may be able to do the screening. Often when home visitors enter homes they can see that there is no food in the home, however, it takes time to build the relationship where someone will willingly tell you they are in need. The grant did its best to create collaboratives and sustainable procedures that could were maintainable after the grant was over. Jessica would enjoy any other suggestions on how to sustain the PICH project.

Exercise Break

After the break, instead of following the agenda, the group was open and preferred to move around from topic to topic. Attempting to allow current information and reports to be better discussed.

District Council Consent

Al May, District Liaison, Maine CDC

The option of having a consent section on the agenda was discussed. It is a place in a meeting where all regular meeting items are voted in one motion to accept. For our purposes, our consent agenda would primarily be for accepting minutes. The minutes would be placed on the Downeast Public Health website for members to read before the meeting. At the meeting, it will first be asked if any member opposes an item on the agenda. If an item is up for debate, that item is taken off the agenda. All items remaining on the consent would be accepted in one motion. The downfall to consent is that prior to the meeting members must look over the minutes. It is important that people know what they are voting on.

Al will send out the link to the Downeast Public Health Website.
District Public Health Priorities: Eco-Mapping
Is being moved to committee work at the suggestion of members.

District Public Health Priorities: Infectious Disease Report
The Maine CDC Infectious Disease Program Quarterly Case Count: Quarter 4, 2017 came out as of 3/5/17 and a copy was given to members. This report is a view of the entire year. Significant changes and stable public health issues were discussed.

- Tick borne disease like Lyme, Anaplasmosis are on the rise (some tick-borne training will be happening this spring with local health officers and a panel discussion is being planned for May on Mount Desert Island)
- Hepatitis C==typically associated with 1970s drug users, there is now a growing incidence of Hepatitis C showing up in a younger population.
- Latent TB is always a concern as public health nurses must monitor a person with it on a daily basis. We see more of it due to folks coming here from countries where it is not monitored or there is a lack of education and awareness about it.
- Rabies was mostly found in animals.

District Council Work: SCC Meeting 15 March 2018

Maria Donahue, SCC Member, Health Acadia Hancock

It was noted the Helen Burlock has stepped down at the SCC Member and Maria, who was the alternate has taken her place on the SCC Council.

Adverse Childhood Experiences (ACEs) was a presentation at the SCC that Maria felt was very important to bring back to the council and discuss. Adverse Childhood Experiences has been declared a Public Health Problem. ACEs are major life events or situations that traumatically impact childhood and beyond. Many problems faced by adolescence and adults are being directly linked to higher ACEs risk factors. Issues like substance abuse, suicide and mental illness are often found in grown-ups that had a higher number of adverse childhood experiences. Something important to note is that once you ask adolescence or adults about past traumas, they may then need extra supports. We must be mindful of how, when and when we screen as the mental health of the person being screened is of utmost importance.

A possible refresher course of ACEs and the newest information available was floated and many liked that idea.
District Public Health Priorities: County Health Ranking
We took a look at the county health rankings from 2010 to the present. We looked at them along two styles of ranking, Health Outcomes and Health Factors.

- **Health Outcomes** – Health Outcomes measures how healthy a county is in each year. It is based on mortality and morbidity. Hancock county is ranked fifth this year whereas Washington is ranked 16th. This is a great disparity between our two counties.
- **Health Factors** – Health Factors measures how healthy the county will be in the future based on its infrastructure and social factors. Hancock is ranked seventh and Washington is ranked 15th. This is a great disparity between our two counties.
- If we look back over the years we see very little has changed. If we want to really help people we need to make bigger changes. Fundamental, structural changes.

*This is another possible topic to be discussed further.*

District Public Health Priorities: Preventative Services – Substance Abuse Prevention
It is accepted that there is a major drug/alcohol/opioid and other substance abuse problem in our districts. What was presented to us was a program that HAS FUNDING to train people.

- **Prime For Life** – This program is highly adaptable to the needs of whatever style classroom or learning environment. It is generally a 4.5-hour program. For high schools it can be broken down in the 30-minute blocks, it could be done as a half day training or even break it up over a few classes. It specifically targets Adults and At-Risk youth.

Discussion: Where could we see this tool used in our districts. Next Step Domestic Violence Project, Jails, at the new Families First Community Centers, Food Panty’s, the Lobstermen and people in the Restaurant industry. People were quick to come up with places Prime For Life could make a real difference. Maria asked anyone with ideas or places they want to see this program to her.

Thank you all for attending, hope to see you at the next meeting.

Meeting adjourned at 11:30