

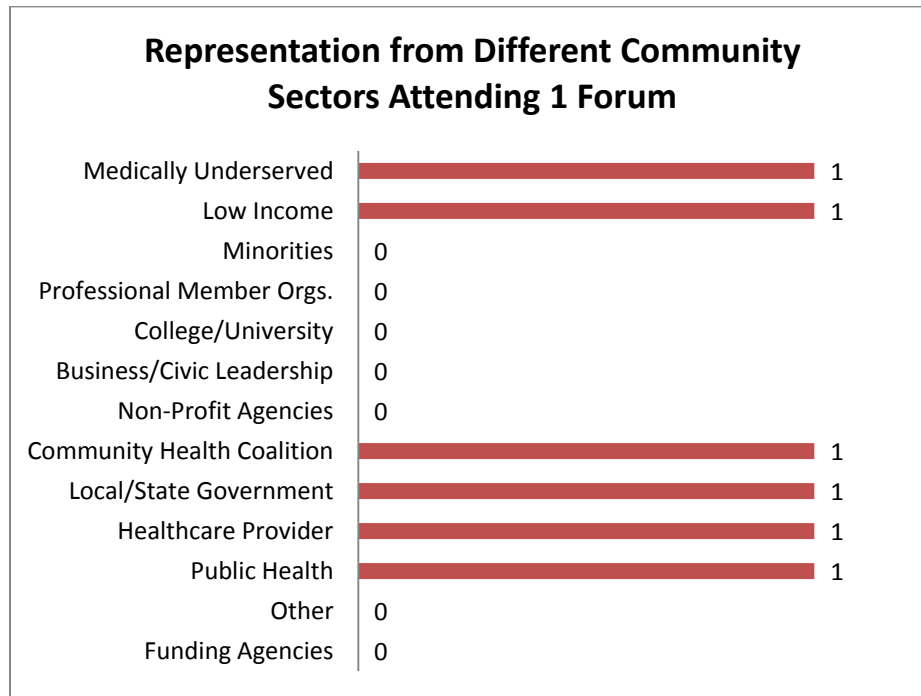
Maine SHNAPP Community Engagement Phase Summary Report of Forum & Event Input Hancock County April 2016

This serves as a brief summary report of the input provided by community members attending the 1 community forum that took place between November 2015 and March 2016.

Community Forum

Meeting	Date	Location
Hancock County Forum	11/10/2015	Ellsworth, ME
Total Attending Forum:		55

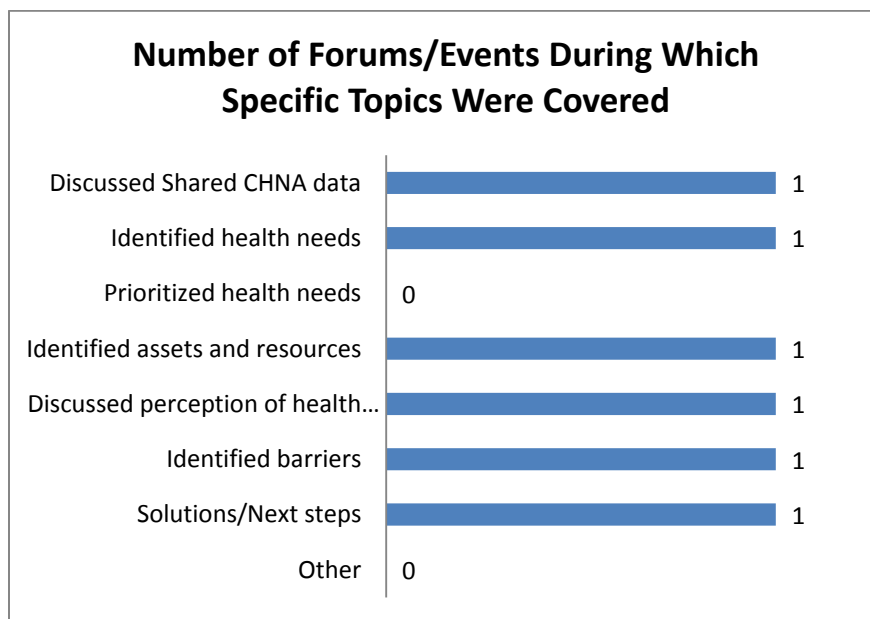
Community Sectors Represented During Forums and Events



“Medically underserved,” “low income,” and “racial/ethnic minorities” are sub-populations named specifically by the Department of Treasury/IRS regulations.

Other: n/a

Type of Input Obtained During Forums and Events



“Other” included: n/a

Community Forums

These forums, organized and co-led by Maine CDC District Liaisons and SHNAPP hospital community benefit representatives, typically consisted of a prepared Power Point presentation followed by breakout sessions on health topics. In general, breakout sessions obtained input about:

- Summary statements about the issue and/or its effect on the community
- Identification of local assets and resources to address the issue
- Identification of barriers to addressing the health issue or needs of the community before more adequately addressing the issue
- Ideas for next steps, how to solve the health issue, who to include, and what the community should look like in the future

Themes Identified During Hancock County Forums

Health Issue: **Obesity**

Summary of assets to resources to address issue: Hiking/walking trails; apps, maps, and websites show us where we can hike/walk; exercise/health clubs; school sports; nutrition education and outreach by community organizations and health care providers; access to healthy local foods including community gardens, schools, stores and food pantries; businesses employee wellness policies/programs. (See list of specific programs in appendix on page 5.)

Summary of barriers or community needs (if reported): Some barriers have to do with infrastructure such as lack of walkable sidewalks and safe places to exercise or transportation access to get to grocery stores with affordable healthy food or to places to be physically active. Other barriers have to do with health factors: poverty; ACEs; culture (learned cooking/eating habits from family, stigma of exercising among thin or fit people, healthy eating is expensive/organic, isolation due to less group activity and/or busy work lives); health literacy (need to physical activity even if work is “physical”, not seeking health care for overweight/obesity, fast food marketing is confusing); health insurance access. Education about portion sizes and how to cook along with PE in schools is lacking. Underlying mental health and oral health issues affect many individuals’ ability to address obesity.

Summary of next steps, solutions, and future ideal: The group reported on improving worksite and school wellness policies and recommended many different programming options to reduce or prevent obesity through better nutrition and improved physical activity.

Health Issue: **Drug and Alcohol Abuse**

Summary of assets to resources to address issue: Private practices and counseling services; substance abuse counselors; substance treatment network to assess the gaps in treatment; health care providers and hospitals; tele-psychiatry; medicated assisted treatment (MAT); prevention information and education; Drug Free Communities (DFC) grants; youth-serving organizations; Drug Court; support groups; youth intervention programming; law enforcement; programs addressing ACEs; HMPs and community organizations; youth diversion; youth correction officers; tertiary hospital availability for pregnant women with substance abuse issues and drug effected babies. (See list of specific programs in appendix on page 6.)

Summary of barriers or community needs (if reported): Highest level barriers include no cohesive state-level strategy to address substance use disorders and no Medicaid expansion. At the next level, health factors that need to be addressed include: transportation; housing; jobs/training; affordable childcare; access to health insurance and reimbursement reform; addressing stigma. Additionally, there needs to be funding to expand services (residential treatment, detox, additional law enforcement, constructive

activities/opportunities for youth), provide education (specific targets and topics), and ensure increases in access to medication assisted treatment and physicians treating substance use disorders.

Summary of next steps, solutions, future ideal: Address underlying health factors such as housing, jobs, and transportation and seek funding for additional treatment and providers. Expand treatment options and space available, provide education for healthcare providers (PCPs, support staff, ED staff), law enforcement, alternative healing providers, and schools (students, teachers, staff), and ensure collaboration among prevention programs, early childhood service providers, social services, healthcare and behavioral healthcare providers.

Health Issue: **Diabetes**

Summary of assets to resources to address issue: Outreach and intact- making referrals to diabetes management treatment programs; coaching for pre-diabetes; each hospital has a diabetes education program; nutrition and cooking classes/education programs; Tele-health outreach (focus on some chronic disease); many the same as obesity (blue group, theater); Farm to School, Farm to Pantry; walking and physical activities; home health care; ACO coordinated care; population health management through hospital using electronic capability; currently working harder to identify pre-diabetics; Dialysis Center; community organizations; medical practices- PCPS & staff; mental health for LGBT – work on underlying social issues. (See list of specific programs in appendix on page 7.)

Summary of barriers or community needs (if reported): Health factors impeding access to diabetes screening, treatment, and management include: financial obstacles/poverty; health literacy (about diabetes and/or managing/avoiding complications); transportation; culture (“people choose to not be healthy,” making the annual physical the norm, healthcare providers screening for diabetes and taking time to educate patients); access to mental health and/or substance use services. Additionally there is a lack of coordination (screening among PCPs, referral system, screening at non-traditional locations such as food pantries or free clinics), education (eating on a budget, eating out healthfully, home economics in schools), and resources (screening tool for pre-diabetes, community organization focused on diabetes).

Summary of next steps, solutions, future ideal: Address poverty (increase minimum wage) and improve health care coverage in addition to enhancing collaboration (stakeholders conduct spot analysis, work with hospitals to deliver programming, improve provider referrals to community programs) and expanding services (identify what end-users want, address behavioral/mental health needs, telemedicine, incentives for providers and patients).

Additional identified concerns: People who have/or not, advanced directives and proxy for health care.

Appendix: Specific local resources identified

Obesity:

- Maine Coast Heritage Trust new trails and walkways
- Sunrise Trail
- Acadia National Park
- Ellsworth sidewalks
- Schoodic Woods, public trails
- YMCA in Ellsworth and MDI; other local sites
- School sports
- Healthy Acadia
- Primary care physician: nagging health care professionals who focus on nutrition and exercise
- Community gardens
- Health food store
- Holistic health providers
- Farmers markets in various locations
- School greenhouses/gardens: Blue Hill School as example, schools and communities can get funding for raised beds and greenhouses
- Farm to School is an active program in Hancock County
- School diet/food service: there have been trainings in some of the schools about utilizing fresh local foods in the school food service
- National School Lunch Program is being implanted with new direction of lean protein and understanding of portions
- Food pantries are big asset: utilize and serve local fruits and produce, gleaning initiative, and nutrition policies
- Ellsworth American Quarterly Health Digest is good but could provide more information on obesity, physical activity, and nutrition
- Nutrition Education Program (SNAP-Ed)
- Cooperative Extension (including Food Corp, Gleaning & Master Gardener)
- Magic Food Bus
- Businesses employee wellness policies/programs
- Hannaford educator/dietician: shopping on limited income; what items to buy that you can stretch; nutrition differences in foods
- Schools and community centers
- WHCA Back to School Backpack program
- Health coaching (Coastal Care Team)
- Health education in hospitals

Appendix: Specific local resources identified (continued)

Drug & Alcohol Abuse

- Drug Free Community (DFC) grants
- Private practices and counseling services
- Hospitals
- Open Door
- Acadia Family Center
- Drug Court
- Support groups
- Youth intervention programming
- Intensive Outpatient services
- School resource officers
- Youth diversion program
- Youth corrections officers/corrections officers
- Parole system/probation
- EMHC
- Maine Resiliency Building Network
- YMCA
- Childcare and childcare providers
- Camps
- Sports programs
- Enrichment programming
- DARE/Keeping it Real
- Local churches/pastors
- 12 step support programs -AA/NA/Al-Anon
- Coordination between EDs to prevent drug seekers/prescription monitoring
- AMHC
- All primary care have embedded mental health services
- Tele-psychiatry at BMMH
- BMMH has one provider with medicated assisted treatment certification and training, as well as a physician at MDIH
- HMPs and community organizations
- A lot of federal dollars
- Substance treatment network to assess the gaps in treatment
- Tertiary hospital availability for pregnant women with substance abuse issues and drug effected babies

Appendix: specific local resources identified (continued)

Diabetes

- Outreach and intact- making referrals to diabetes management treatment programs (Dixon Clinic and Maine Coast itself)
- Community Care teams through local hospitals (coaching for pre-diabetes)
- Health coaching (including in home)
- Minorities LGBT kids – Gay, Lesbian, Straight Educators Network (GLSEN)- works on underlying social issues)
- Each hospital has a diabetes education program
- Nutrition and cooking classes/education programs
- EMHS MDI- Tele-health outreach (focus on some chronic disease)
- Nutrition education various settings (SNAP-ed, Cooperative Extensions, hospital settings); many the same as obesity (blue group, theater)
- Farm to school
- Farm to pantry
- Walking and physical activities
- Home health care
- ACO coordinated care/ Capital Care CCT
- Population health management through hospital (management of diabetes patients) using electronic capability
- Currently working harder to identify pre-diabetics
- Hospitals (Diabetes Center in Ellsworth)
- Dialysis center
- Community organizations
- Medical practices- PCPS & staff
- Mental health

If you are interested in reviewing individual reporting forms represented in this summary, please contact communitybenefits@emhs.org