“The healthcare system alone can’t solve big problems like obesity or cancer—it takes partners in our communities, business, education, government and families—all working together, hand in hand.”

— Sara Burns, President and CEO, Central Maine Power Company, and Chair, MaineHealth Board of Trustees, 2010–2012
Partnerships—The Key to Improving Community Health

This year marks the third annual publication of MaineHealth’s Health Index Report. The progress on MaineHealth’s seven health improvement priorities highlighted in the 2012 Report represents only the tip of the iceberg. In words, graphs and photos, the Report provides a glimpse of a much bigger body of work that includes thousands of individuals (clinicians, educators, administrators, data analysts, researchers, employees, home health nurses, community health outreach workers, school superintendents and many others) who comprise a virtual team of skilled and committed individuals and organizations. Working to improve the health of Maine communities, the team focuses on seven high priority determinants and outcomes that are known to have a major impact on overall health status.

The contributions of many individuals and organizations across the region and the state are critical to our collective success in making improvements on these issues. When the healthcare and public health sectors join hands and work collaboratively to address widespread, complex problems like obesity, diabetes or cancer, progress is not only possible, it is almost predictable.

Maine has a unique and vibrant approach to community health improvement, building coalitions of diverse organizations that work collaboratively to get the job done. MaineHealth’s 2012 Health Index Report presents examples of some of these partnerships and their successes, such as:

- The Maine Immunization Coalition, an informal alliance hosted by the Maine Primary Care Association, the Maine Immunization Program within the Maine Centers for Disease Prevention and Control, the Maine Vaccine Board, MaineHealth, physicians, hospitals and others collaboratively connected the new Maine Universal Vaccine Program with clinicians, families, children, information systems experts, payers and public health agencies to increase Maine’s up-to-date rate for childhood immunizations and thereby prevent dangerous diseases like whooping cough.
- Primary care practice teams are collaborating with schools, child care centers, after school programs and businesses to promote the 5-2-1-0 messages of Let’s Go!, Maine’s nationally recognized childhood obesity prevention initiative.
- Community organizations are partnering with healthcare providers to assure that seniors with chronic conditions get the home care and medications they need to stay out of the hospital.
- Partnerships between clinical care, community and public policy organizations are striving to ensure patients and families have access to a network of cancer prevention, treatment and survivorship programs.

Creating and sustaining partnerships across the healthcare and public health systems is hard work. Too often these sectors fail to connect the “upstream” and “downstream” strategies, resulting in a needless expenditure of valuable resources. Dr. Reed Tuckson, executive vice president of United Health Foundation and a nationally recognized public health advocate, notes, “We need to break down the silos of medicine and public health and get people working together on the problems that we all share.”

Partnerships are the key ingredient to successfully improve population health. MaineHealth is committed to help strengthen and expand the many important partnerships with organizations throughout Maine who are equally committed to making our communities the healthiest in America.
2012 Health Index Report

The 2012 Health Index Report provides a high-level overview of progress on the seven high priority issues organized by three major focus areas: clinical, community and policy. These three domains encompass work accomplished by MaineHealth members, affiliates and many external partners. Overall, the Index has sharpened the system’s strategic priorities and has helped inform the allocation of resources by the Board of Trustees and other decision makers. Due to space limitations, the Report provides only a summary of actions and outcomes. While considerable progress toward achieving long-term outcomes was made in 2012, much more remains to be done, as highlighted in the “Getting to The Next Level” sections found on the bottom right page of each section of the Report.

The initial six priority issues were selected in 2009 through a consensus-driven process that involved stakeholders from MaineHealth and our external partners. The list of priorities was re-examined in 2012 by the system’s Community Health Improvement Council, whose members include physicians, public health experts, researchers, funders and representatives of state and local government. In addition to recommitting to the existing six priorities, the Council voted unanimously to add a new priority: decrease prescription drug abuse and addiction.

Maine has the highest opioid addiction treatment rate in the U.S. and the state’s mortality rate from prescription drug abuse has more than tripled over the last decade. The summary on pages 20-21 provides more details regarding the status of the problem in Maine, work currently underway to address the problem and selected strategies to be launched in 2013.

Publication of this year’s Health Index Report coincides with the release of America’s Health Rankings® 2012 edition, the yardstick against which progress in improving Maine’s overall health status is measured. Maine’s 2012 rankings are presented on pages 4-5.

External Advisory Panel Meets for the First Time

On October 15th and 16th, 2012, four nationally recognized public health experts met with more than 40 individuals in Portland to seek feedback on the Health Index initiative, including the overall purpose and methods, engagement of internal and external partners and overall impact.

In general, the experts gave the Health Index initiative and annual report high marks as “an ambitious program that embraces the aim of improving community health.”

Select feedback from the panel included the following:

- Clarify goals and purpose of the report as a “call to action.”
- Move to MaineHealth-specific targets and data.
- Maintain broad population-based measures and targets.
- Strengthen and expand internal and external partnerships.
## Health Index Priorities: 2012 in Review

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase Childhood Immunizations</strong></td>
<td>Up-to-date rate increased above national rate.</td>
<td>8</td>
</tr>
<tr>
<td><strong>Decrease Tobacco Use</strong></td>
<td>Half of tobacco users made quit attempts, but more progress is needed.</td>
<td>10</td>
</tr>
<tr>
<td><strong>Decrease Obesity</strong></td>
<td>Healthy behaviors among youth have increased, but more progress is needed.</td>
<td>12</td>
</tr>
<tr>
<td><strong>Decrease Preventable Hospitalizations</strong></td>
<td>Home health and primary care management decreased hospitalizations.</td>
<td>14</td>
</tr>
<tr>
<td><strong>Decrease Cardiovascular Deaths</strong></td>
<td>Mortality rates decreased. Maine rate significantly lower than U.S. rate.</td>
<td>16</td>
</tr>
<tr>
<td><strong>Decrease Cancer Deaths</strong></td>
<td>Mortality rates decreased, but still among the highest in the nation.</td>
<td>18</td>
</tr>
<tr>
<td><strong>Decrease Prescription Drug Abuse and Addiction</strong></td>
<td>Added priority in June 2012. Targets and strategies will be determined in FY 2013.</td>
<td>20</td>
</tr>
</tbody>
</table>
The Benchmark: America’s Health Rankings®
How Maine Compares

Strengths
• Lowest violent crime rate
• Low rate of uninsured population
• Low prevalence of low birthweight

Challenges
• High prevalence of smoking
• High rate of cancer deaths
• High prevalence of obesity

Changes in America’s Health Rankings® Methodology Impacted Maine’s Rankings in 2011 and 2012

For America’s Health Rankings® (AHR) 2012 edition, two changes were made to measures used in the AHR model:

1. Sedentary lifestyle, from the Behavioral Risk Factor Surveillance System (BRFSS), was added. In the ranking calculations, sedentary lifestyle has a weight of 2.5%, which was subtracted from the obesity metric’s weight of 7.5%.

2. Low birthweight replaced prenatal care. Abstracted from birth certificates, prenatal care data is difficult to compare across states because the two certificate formats used in the U.S. are not directly comparable.

To report on changes between 2011 and 2012 rankings, AHR re-ranked the 2011 edition with the new components and weights. Maine’s revised 2011 ranks and 2012 ranks are presented in Figure 1.

In addition, states’ rankings in the 2012 AHR edition could be influenced by two major methodological improvements implemented in the 2011 BRFSS. First, a more rigorous method to adjust for response rates in different demographic groups was adopted. Second, households that only use cell phones (i.e., do not have a landline) were included in the survey for the first time.
# Maine Summary 2012 Edition of AHR

## Determinants: 75% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of smoking (Percent of adult population)*</td>
<td>22.8</td>
<td>33</td>
<td>11.8</td>
</tr>
<tr>
<td>Prevalence of binge drinking (Percent of adult population)*</td>
<td>17.3</td>
<td>18</td>
<td>10.0</td>
</tr>
<tr>
<td>Prevalence of obesity (Percent of adult population)*</td>
<td>27.8</td>
<td>25</td>
<td>20.7</td>
</tr>
<tr>
<td>Sedentary lifestyle (Percent of adult population)*</td>
<td>23.0</td>
<td>13</td>
<td>16.5</td>
</tr>
<tr>
<td>Percent of 9th graders graduating high school</td>
<td>79.9</td>
<td>17</td>
<td>90.7</td>
</tr>
</tbody>
</table>

## Behaviors: 25% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of smoking (Percent of adult population)*</td>
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<td>79.9</td>
<td>17</td>
<td>90.7</td>
</tr>
</tbody>
</table>

## Community & Environment: 22.5% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent crime (Offenses per 100,000 population)</td>
<td>122</td>
<td>1</td>
<td>122</td>
</tr>
<tr>
<td>Occupational fatalities (Deaths per 100,000 workers)</td>
<td>3.2</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td>Infectious disease (Cases per 100,000 population)</td>
<td>6.7</td>
<td>9</td>
<td>2.8</td>
</tr>
<tr>
<td>Percent of children in poverty (Under age 18)</td>
<td>17.7</td>
<td>19</td>
<td>8.6</td>
</tr>
<tr>
<td>Air pollution (Micrograms of fine particulates per cubic meter)</td>
<td>7.8</td>
<td>12</td>
<td>5.1</td>
</tr>
</tbody>
</table>

## Public & Health Policies: 12.5% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of health insurance (Percent without health insurance)</td>
<td>9.7</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Public health funding (Dollars per person)</td>
<td>$83</td>
<td>23</td>
<td>$236</td>
</tr>
<tr>
<td>Immunization coverage (Percent of children ages 19 to 35 months)</td>
<td>90.4</td>
<td>24</td>
<td>94.2</td>
</tr>
</tbody>
</table>

## Clinical Care: 15% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birthweight (Percent of live births)</td>
<td>6.3</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td>Primary care physicians (Number per 100,000 population)</td>
<td>130</td>
<td>12</td>
<td>194.5</td>
</tr>
<tr>
<td>Preventable hospitalizations (Number per 1,000 Medicare enrollees)</td>
<td>59.3</td>
<td>20</td>
<td>25.0</td>
</tr>
</tbody>
</table>

## All Determinants Ranking

<table>
<thead>
<tr>
<th>No. 1 State</th>
</tr>
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<tbody>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

## Outcomes: 25% weight in overall rank

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Rank</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (Percent of adult population)*</td>
<td>9.6</td>
<td>26</td>
<td>6.7</td>
</tr>
<tr>
<td>Poor mental health days in previous 30 (Adults self-report)*</td>
<td>4.1</td>
<td>34</td>
<td>2.8</td>
</tr>
<tr>
<td>Poor physical health days in previous 30 (Adults self-report)*</td>
<td>4.3</td>
<td>38</td>
<td>2.9</td>
</tr>
<tr>
<td>Geographic disparity (Relative standard deviation)</td>
<td>8.2</td>
<td>9</td>
<td>5.6</td>
</tr>
<tr>
<td>Infant mortality (Deaths per 1,000 live births)</td>
<td>5.6</td>
<td>14</td>
<td>4.4</td>
</tr>
<tr>
<td>Cardiovascular deaths (Deaths per 100,000 population)</td>
<td>239.2</td>
<td>17</td>
<td>195.9</td>
</tr>
<tr>
<td>Cancer deaths (Deaths per 100,000 population)</td>
<td>196.3</td>
<td>40</td>
<td>128.6</td>
</tr>
<tr>
<td>Premature death (Years of potential life lost before 75)</td>
<td>6,724</td>
<td>16</td>
<td>5,621</td>
</tr>
</tbody>
</table>

## All Outcomes Ranking

<table>
<thead>
<tr>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
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</tbody>
</table>

## Overall Ranking

<table>
<thead>
<tr>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

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*Line items in red indicate a MaineHealth Health Index Priority*

*Indicates measures from the BRFSS*

America’s Health Rankings® is produced by the United Health Foundation, the American Public Health Association and Partnership for Prevention.
Differences Across Maine: County Health Rankings©

Measures used in 2012 County Health Rankings©

<table>
<thead>
<tr>
<th>Health Outcomes Ranking</th>
<th>2012 County Health Rankings©</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality: (50% weight in outcomes ranking)</td>
<td></td>
</tr>
<tr>
<td>Premature death (Years of potential life lost before 75)</td>
<td></td>
</tr>
<tr>
<td>Morbidity: (50% weight in outcomes ranking)</td>
<td></td>
</tr>
<tr>
<td>Poor or fair health (Percent of adult population)</td>
<td></td>
</tr>
<tr>
<td>Poor physical health days in previous 30 (Adults self-report)</td>
<td></td>
</tr>
<tr>
<td>Poor mental health days in previous 30 (Adults self-report)</td>
<td></td>
</tr>
<tr>
<td>Live births with low birthweight (Percent &lt;2500 grams)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Factors Ranking</th>
<th>2012 County Health Rankings©</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Behaviors: (30% weight in factors ranking)</td>
<td></td>
</tr>
<tr>
<td>Prevalence of smoking (Percent of adult population)</td>
<td></td>
</tr>
<tr>
<td>Prevalence of obesity (Percent of adult population with BMI ≥30)</td>
<td></td>
</tr>
<tr>
<td>No leisure-time physical activity (Percent of adult population)</td>
<td></td>
</tr>
<tr>
<td>Alcohol use</td>
<td></td>
</tr>
<tr>
<td>Excessive drinking in past 30 days (Percent of adult population)</td>
<td></td>
</tr>
<tr>
<td>Motor vehicle crash death rate (Per 1,000 population)</td>
<td></td>
</tr>
<tr>
<td>High-risk sexual behavior</td>
<td></td>
</tr>
<tr>
<td>Adults with chlamydia (Per 100,000 population)</td>
<td></td>
</tr>
<tr>
<td>Teen births (Per 1,000 females age 15-19)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Care: (20% weight in factors ranking)</th>
<th>2012 County Health Rankings©</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to care</td>
<td></td>
</tr>
<tr>
<td>Percent of ages 0-64 years without health insurance</td>
<td></td>
</tr>
<tr>
<td>Ratio of population-to-primary care providers</td>
<td></td>
</tr>
</tbody>
</table>

| Quality of care among Medicare enrollees |  |
| Preventable hospitalizations (Per 1,000 enrollees) |  |
| Diabetic screening (Percent tested for hemoglobin A1c) |  |
| Mammography (Percent females screened) |  |

<table>
<thead>
<tr>
<th>Socio-Economic Factors: (40% weight in factors ranking)</th>
<th>2012 County Health Rankings©</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Percent of 9th graders graduating high school in 4 years</td>
<td></td>
</tr>
<tr>
<td>Percent of 25-44 yr-olds with some post-secondary education</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Unemployment: Percent among aged 16+ seeking work</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Income: Percent of children in poverty (Under age 18)</th>
<th></th>
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</thead>
</table>

| Family and social support |  |
| Percent of adults reporting no social-emotional support |  |
| Single-parent households |  |

<table>
<thead>
<tr>
<th>Community safety: Violent crimes (Per 100,000 population)</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Physical Environment: (10% weight in factors ranking)</th>
<th></th>
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<table>
<thead>
<tr>
<th>Number days per year with unhealthy air quality</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Due to ozone levels</th>
<th></th>
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<tbody>
<tr>
<td>Due to fine particulate matter</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Built environment</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Limited access to health foods (Percent of population)</td>
<td></td>
</tr>
<tr>
<td>Fast food restaurants (Percent of all restaurants)</td>
<td></td>
</tr>
<tr>
<td>Access to recreational facilities with fees (Per 100,000 population)</td>
<td></td>
</tr>
</tbody>
</table>

2012 County Health Rankings©

The County Health Rankings© is a national program that uses two sets of measures to compare and rank counties within each of the 50 states. Health outcomes represent how healthy a county is currently, while health factors influence the future health of a county. These measures are similar, but not identical, to those used in America’s Health Rankings®.

Among Maine’s eight healthiest counties in the 2012 Rankings (health outcomes ranks), seven were in the MaineHealth service area (Cumberland, Franklin, Sagadahoc, Knox, Waldo, Lincoln and York).

Results of the County Health Rankings© highlight that health status is impacted by disparities across Maine such as household income, level of education and access to medical care.

<table>
<thead>
<tr>
<th>2012 Rankings for Maine</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rank</td>
<td>Health Outcomes</td>
</tr>
<tr>
<td>1</td>
<td>Sagadahoc</td>
</tr>
<tr>
<td>2</td>
<td>Hancock</td>
</tr>
<tr>
<td>3</td>
<td>Cumberland</td>
</tr>
<tr>
<td>4</td>
<td>York</td>
</tr>
<tr>
<td>5</td>
<td>Knox</td>
</tr>
<tr>
<td>6</td>
<td>Waldo</td>
</tr>
<tr>
<td>7</td>
<td>Lincoln</td>
</tr>
<tr>
<td>8</td>
<td>Franklin</td>
</tr>
<tr>
<td>9</td>
<td>Kennebec</td>
</tr>
<tr>
<td>10</td>
<td>Penobscot</td>
</tr>
<tr>
<td>11</td>
<td>Androscoggin</td>
</tr>
<tr>
<td>12</td>
<td>Aroostook</td>
</tr>
<tr>
<td>13</td>
<td>Piscataquis</td>
</tr>
<tr>
<td>14</td>
<td>Somerset</td>
</tr>
<tr>
<td>15</td>
<td>Oxford</td>
</tr>
<tr>
<td>16</td>
<td>Washington</td>
</tr>
</tbody>
</table>

Counties in red are in the MaineHealth Service Area.
MaineHealth Service Area

75% of Maine’s 1.3 million residents live in the eleven counties that constitute the MaineHealth Service Area.
Maine's rate of children up-to-date² on recommended immunizations increased from 67% in 2010 to 77% in 2011, and now exceeds the national average (Figure 3).

A shortage of Haemophilus Influenza B vaccine caused Maine's low rate in 2009 (Figure 3).

In 2011, there was significant variation within Maine's 16 counties for two-year-olds who were up-to-date on the series of seven immunizations.

- County rates ranged from 37% to 89% (Figure 4).
- Oxford and Kennebec counties had the highest up-to-date rates in the MaineHealth service area.
- Lincoln, Sagadahoc and Waldo counties had the lowest up-to-date rates in the MaineHealth service area.

In 2012, Maine implemented the Universal Childhood Immunization Program. The goal of the program is to improve the health of Maine children by improving immunization rates. The Maine Vaccine Board, created under the program, sets an annual assessment on health insurance providers to cover the cost of childhood immunizations provided to privately insured children through the program.
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

MaineHealth practices increased rates of children up-to-date on series of recommended immunizations.
- 12 of 14 practices increased their rates (Figure 5).
- Seven of 14 practices had rates above Maine’s 2011 rate of 77%.

First STEPS Learning Initiative
- Coached care teams in 24 primary care practices as they implemented strategies.
- Child immunization up-to-date rates increased three percentage points in only seven months.

Created and tested a website (vaxcheck.org) for clinical support staff to provide evidence-based answers to parents’ vaccine questions.

Pen Bay Pediatrics piloted text reminders of scheduled visits as a strategy for keeping children up-to-date with immunizations. Preliminary results:
- Parents were enthusiastic about text reminders.
- 6% no-show rate for those texted a reminder, compared to 14% for other types of reminders.

COMMUNITY STRATEGIES

Created social media program, Vax Maine Kids, to provide parents with vaccine information.
- It includes a website, Facebook and Twitter pages and a YouTube site.
- 767 Facebook “Likes” (Number of subscribers between August 1 and October 10, 2012).
- 486,335 total reach (Potential audience in and outside of Maine if all Facebook subscribers and their friends view a post).

POLICY STRATEGIES

Collaborators revised tools and policies that increase accurate data sharing and communication between providers, patients and the Maine Department of Health and Human Services.
- Ultimate goal of tools and policies is to improve care and increase immunization rates.
- Collaborators included the Improving Health Outcomes for Children Project, Maine Immunization Program, Maine Immunization Coalition, MaineCare Services and members of the MaineHealth Childhood Immunizations Task Force.

GETTING TO THE NEXT LEVEL

CLINICAL
Increase adherence to evidence-based standards of care for childhood vaccination by training clinical support staff across the MaineHealth system.

COMMUNITY
Make Vax Maine Kids one of Maine’s best sources for accurate, timely information on childhood vaccination and, in turn, increase immunization rates.

POLICY
Implement data sharing between the Maine Immunization Program’s registry and MaineHealth’s Shared Electronic Health Record to eliminate practices manually entering data into the registry.
Decrease Tobacco Use

MaineHealth is expanding access to effective programs and therapies for helping tobacco users become tobacco-free, and partnering with community organizations to prevent youth from ever using tobacco.

Due to improvements in the methodology for the Behavioral Risk Factor Surveillance System (BRFSS)⁴, 2011 estimates of adult smoking rates are more accurate across the U.S. These estimates are higher than in previous years: one in five adults in Maine currently smoke some days or every day (Figure 7).

Adult smoking rates varied across Maine’s socio-economic groups. Rates were higher among:
- 18-49 year-olds (26%)
- those with household incomes under $25,000 (35%)
- adults with just a high school education/GED or who did not finish high school (over 30%)
- uninsured adults or those with MaineCare (over 35%)

In contrast, there was little variability in the percent of smokers within socio-economic groups who made a serious quit attempt in the 12 months prior to being surveyed (Figure 6).

The percent of smokers who seriously attempted to quit did vary by county (Figure 8).
**MAINEHEALTH AND PARTNERS RESPOND**

**CLINICAL STRATEGIES**

Maine’s healthcare providers see most smokers annually and are advising them to quit

- Studies have established that physicians advising patients to quit increases patients’ success becoming tobacco-free.\(^{11}\)
- 73% of adult smokers reported that they had visited a doctor for a routine checkup in the 12 months prior to being surveyed (approximately 175,000 adults). Of these smokers, 83% reported that a health professional advised them to quit during the same period.\(^{10}\)
- County rates are presented in Figure 9.

**MaineHealth members expanded capacity for treating tobacco dependence**

- All member hospitals implemented systems to provide inpatient tobacco treatment and proactively refer them to the Maine Tobacco HelpLine.
- 10 MaineHealth member employees attended two-day training for intensive counseling interventions for tobacco dependence, funded by the Partnership For A Tobacco-Free Maine.
- 11 training interventions were completed in outpatient practices owned by MaineHealth member hospitals.
- 916 referrals to the Maine Tobacco HelpLine from MaineHealth member hospitals and outpatient practices.\(^{12}\)

**MMC PHO practices increased routine screening for tobacco use and cessation counseling when a patient reported using tobacco**

- 75% at baseline (January-December 2011)
- 80% latest measurement period (October 2011-September 2012)
- Fiscal year 2013 target = 85%\(^{13}\)

**POLICY STRATEGIES**

The Maine Tobacco Free Hospital Network uses 10 standards of excellence to rate hospitals; meeting all 10 standards earns a gold status, 8-9 earns silver and 6-7 earns bronze.\(^{14}\) In 2012, seven MaineHealth hospitals were awarded gold, three earned silver, and one earned bronze for being tobacco-free environments.

**GETTING TO THE NEXT LEVEL**

**CLINICAL**

All tobacco users identified in MaineHealth’s Shared Electronic Record are offered support at each medical visit, as recommended by the U.S. Public Health Service Guidelines for treating tobacco dependence.

**COMMUNITY**

Increase the percent of tobacco users using Maine Tobacco HelpLine services annually from 3% to 6%.

**POLICY**

Ensure all MaineHealth hospitals are awarded gold status for being tobacco-free environments.
Decrease Obesity

MaineHealth remains focused on working with many partners to make clinical, community and policy changes that will help prevent children and youth from becoming obese.

Maine’s adult obesity rate of 28% remains close to the national average (Figure 11). Statewide obesity rates have increased among Maine students, particularly in younger age groups (Figure 10). However, obesity among high school students remained unchanged in five of Maine’s 16 counties.

Physical activity and fruit/vegetable consumption by Maine students increased from 2009 to 2011 (Figure 10).

- Proportions of high school students getting recommended levels of physical activity increased by at least 10% in eight counties. Oxford County, which had the lowest percent in 2009, improved from 33% to 38%.
- Consumption of five or more servings of fruits and vegetables daily by high school students increased at least 10% in eight counties; highest in Cumberland County (19%); lowest in Aroostook (13%).

How Maine Compares to the U.S.

<table>
<thead>
<tr>
<th>Year</th>
<th>Maine</th>
<th>U.S.</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>13%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>2010</td>
<td>28%</td>
<td>27%</td>
<td>21%</td>
</tr>
<tr>
<td>2016</td>
<td>MaineHealth target: 30% or less</td>
<td>28% Maine</td>
<td>27% U.S.</td>
</tr>
</tbody>
</table>

The 2011 data presented in this graph are not directly comparable to prior years.1
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Let’s Go! Healthcare partners with physicians to prevent and treat childhood obesity in MaineHealth region

- 94% of 67 practices report that all or most providers routinely determine BMI percentile for their pediatric patients.
- 81% of 67 practices report that all or most providers routinely counsel patients and families on healthy eating and active living using the 5-2-1-0 Healthy Habits Questionnaire.17

Maine childhood obesity treatment clinics collaborating to standardize pediatric weight management

- Countdown to a Healthy ME—Barbara Bush Children’s Hospital at Maine Medical Center, Portland
- WOW! (Way to Optimal Weight)—Cutler Clinic, University of Maine, Orono
- Zing!— Pen Bay Healthcare, Rockport

COMMUNITY STRATEGIES

MaineHealth has provided grants to all member hospitals to implement regional Let’s Go! initiatives in multiple Let’s Go! sectors (Figure 13)

Let’s Go! school nutrition initiative resulted in healthier food choices

School nutrition directors in the MaineHealth region report that, because of Let’s Go!, more students are choosing healthy foods:
- 82% of 130 schools increased their purchase of produce.
- 66% of 130 schools increased their purchase of whole grains.18
- 62 of the 67 schools in Maine that achieved the USDA’s HealthierUS School Challenge were involved in the Let’s Go! school nutrition initiative. Only 2% of the schools in the nation achieved this award.19

POLICY STRATEGIES

Wellness policies support Let’s Go! 5-2-1-0 message in MaineHealth region

Due to involvement with Let’s Go! in the past year:
- 73% of 110 participating schools reported their school did more to implement the district wellness policy and its recommendations.
- 56% of 110 schools reported their district strengthened its wellness policy.20
- 67% of 105 early childhood programs participating reported they created, implemented or strengthened an existing wellness policy.21

GETTING TO THE NEXT LEVEL

CLINICAL

Expand reach of Let’s Go! by engaging 155 healthcare practices by 2016 with funding from the Harvard Pilgrim Health Care Foundation.

COMMUNITY

Complete sustainability plans with MaineHealth Let’s Go! sites to assure ongoing implementation of regional Let’s Go! programs.

POLICY

All MaineHealth hospitals will meet nutrition standards used in the Partnership for a Healthier America’s national Hospital Healthy Food Commitment initiative.
Decrease Preventable Hospitalizations

MaineHealth remains focused on high-quality outpatient care for chronic illnesses and on improving care coordination as patients transition from one setting to another.

From 1999-2010, Maine’s rate of hospitalizations for ambulatory care-sensitive conditions (ACSC) decreased by 16 hospitalizations per 1,000 Medicare enrollees (Figure 15).

Overall, the 2010 rates of ACSC hospitalizations per 1,000 Medicare enrollees were lower in the MaineHealth hospital service areas (HSAs).

- The combined ACSC rate across all MaineHealth HSAs was 42, compared to 59 across all non-MaineHealth HSAs.
- All 12 MaineHealth HSAs had rates under 50, and seven had rates under 45 (Figure 16).

Half of the ACSC hospitalizations in MaineHealth HSAs were for congestive heart failure or bacterial pneumonia (Figure 14).

### How Maine Compares to the U.S.

#### Hospitalizations for Ambulatory Care-Sensitive Conditions Per 1,000 Medicare Enrollees

- **2016 MaineHealth target:** 58 or less
- **83**
- **75**
- **67 U.S.**
- **59 Maine**
- **36**
- **25 Hawaii** (best state)

- **1999**
- **2010**

- **Figure 15**

### From 1999-2010, Maine’s rate of hospitalizations for ambulatory care-sensitive conditions (ACSC)

decreased by 16 hospitalizations per 1,000 Medicare enrollees (Figure 15).

Overall, the 2010 rates of ACSC hospitalizations per 1,000 Medicare enrollees were lower in the MaineHealth hospital service areas (HSAs).

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Half of the ACSC hospitalizations in MaineHealth HSAs were for congestive heart failure or bacterial pneumonia (Figure 14).
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Managing patients with diabetes
- 112 MMC PHO primary care practices are close to meeting 2012 targets for three key quality care standards (Figure 17).
- 91 of 183 participating providers were recognized in the National Committee for Quality Assurance Diabetes Recognition Program.25

MMC PHO Nurse Care Management Program
- Supported 74 primary care practices and empowered 2,805 patients to manage their health more independently.
- Reduced 30-day readmissions for high-risk population to 14%, compared to 18-20% for similar patients, system-wide.27

Nine MaineHealth hospitals reduced 30-day readmission rate by using the Transition of Care Bundle28 and strengthening collaboration with community organizations, such as home health and palliative care agencies.
- Goal: reduce system-wide 30-day readmission rate to 14.6% by September 2013. This represents a 10% reduction from the baseline rate of 16.2%.
- 15% 30-day readmission rate for April 2011–March 2012.29

COMMUNITY STRATEGIES

Community Care Teams: Across five patient-centered medical home practices, teams assisted 712 patients having difficulty managing care at home from January-September 2012.30

MMC PHO collaborated with Southern Maine Agency on Aging in the Community-based Care Transitions Program (CCTP)31
- CCTP is a demonstration program funded by the Centers for Medicare and Medicaid Services (CMS).
- Maine CCTP team was one of the first seven sites selected across the U.S. to participate.
- CMS formally recognized Maine CCTP for its rapid success and is using it as a national case study.

Caring for heart failure patients from hospitals to home (see page 17).

GETTING TO THE NEXT LEVEL

CLINICAL
Increase primary care providers’ use of guidelines on diagnosing and staging asthma and COPD, in order to improve timely management of symptoms.

COMMUNITY
Continue expanding home-based services for heart failure patients across MaineHealth system.

POLICY
Expand use of Physician Orders for Life Sustaining Treatment (POLST) policies in MaineHealth hospitals.
Decrease Cardiovascular Deaths

MaineHealth remains focused on managing risk factors to prevent heart disease and on maximizing the quality of care for patients who have heart disease.

Maine improved from 28th in 1990 to 17th lowest cardiovascular mortality in the 2012 edition of America’s Health Rankings® (Figure 19).

From 2000-2009, Maine’s cardiovascular mortality decreased 33%. In 2009, Maine’s rates for overall cardiovascular mortality, as well as for heart attack, coronary heart disease and heart disease sub-classes, were significantly lower than the U.S. rates (Figure 18).

In 2007-2009, cardiovascular mortality was lower in the 11-county MaineHealth Service Area.
- The overall rate, adjusted for age and gender differences, was 205/100,000 people in the 11 counties compared to 253/100,000 in Northern and Downeast Maine.
- Regarding heart attacks, four counties had rates 27 to 35/100,000 and five counties had rates between 42 and 50/100,000 (Figure 20).

### How Maine Compares to the U.S.

**Cardiovascular Mortality Rates: 3-yr averages of age-adjusted 1-yr death rates per 100,000 population**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>264 U.S.</td>
<td>391</td>
<td>383</td>
</tr>
<tr>
<td>239 Maine</td>
<td>332</td>
<td>264 Maine</td>
</tr>
<tr>
<td>196 Minnesota (best state)</td>
<td>196</td>
<td>196</td>
</tr>
</tbody>
</table>

*Maine rate was significantly lower than the U.S. rate.

### Cardiovascular Mortality in Maine

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2009</th>
<th>% Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall cardiovascular disease</td>
<td>308 *</td>
<td>208 *</td>
<td>33%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>231 *</td>
<td>156 *</td>
<td>32%</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>164 *</td>
<td>96</td>
<td>41%</td>
</tr>
<tr>
<td>Heart attack</td>
<td>61</td>
<td>33</td>
<td>45%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>19</td>
<td>17</td>
<td>14%</td>
</tr>
<tr>
<td>Stroke</td>
<td>56</td>
<td>38</td>
<td>33%</td>
</tr>
</tbody>
</table>

Rates are calculated per 100,000 population and age-adjusted to the year 2000 U.S. standard population.

*Maine rate was significantly lower than the U.S. rate.
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

MaineHealth’s AMI PERFUSE Network
- The Program remains focused on increasing the percent of heart attack patients provided evidence-based treatment within recommended timeframes at local hospitals.
- Need to focus future resources on community education to both shorten the time to recognize symptoms of heart attacks and to increase calls to 911 for initial care and transport to the hospital (Figure 21).

Managed patients with cardiovascular disease (CVD)
- 112 MMC PHO primary care practices nearly met or surpassed three of four key quality care standards (Figure 22).
- 55 of 183 participating providers were recognized by the National Committee for Quality Assurance Heart/Stroke Recognition Program.37

COMMUNITY STRATEGIES

Caring for heart failure patients from hospital to home
MaineHealth member and affiliate hospitals and seven home health agencies collaborated to improve the care for heart failure patients in MaineHealth service area.
- Piloted a new diuretic protocol that empowered home health nurses to manage fluid retention more quickly in order to avoid hospitalizations and increase patients’ quality of life.
- The agencies using telehealth technology expanded monitoring from 40% of patients in 2010 to 60% in 2012.
- From October 2011 through September 2012, over 95% of heart failure patients in home health care improved or stabilized their symptoms of being short of breath.36

GETTING TO THE NEXT LEVEL

CLINICAL
Expand participation in the Million Hearts™ initiative38 across entire MaineHealth system. Maine Medical Partners and Pen Bay Healthcare both started in fiscal year 2012.

COMMUNITY
Efforts to reduce tobacco use and obesity will help Mainers reduce their risk of cardiovascular disease, particularly reducing the risk of heart problems at younger ages.

POLICY
Advocate for increasing state tobacco taxes on all types of tobacco to fund evidence-based tobacco treatment programs.
Maine’s 2008 death rates for all malignant cancers combined, and for lung/bronchus cancers were significantly higher than national rates (Figure 23). At least 30% of all cancer deaths and 80% of all lung cancer deaths are associated with smoking.39 The best strategy for reducing these deaths is to eradicate tobacco use.

An additional one-third of cancer deaths are associated with poor nutrition, being physically inactive and obesity.39 More Mainers are getting screenings for colon, breast and cervical cancers than in the U.S. overall.41 Similarly, more cancers are being diagnosed before the tumors have spread beyond the site/organ of origin (Figure 24). When diagnosed in this localized stage, five-year survival rates are greater than 90% for all three cancers.42

How Maine Compares to the U.S.  

**Figure 25**

**Cancer Mortality Rates: 3-yr averages of age-adjusted 1-yr rates of deaths per 100,000 population**

<table>
<thead>
<tr>
<th>Year</th>
<th>Maine</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-2009</td>
<td>196</td>
<td>182</td>
</tr>
<tr>
<td>2000-2002</td>
<td>218</td>
<td>201</td>
</tr>
<tr>
<td>1997-1999</td>
<td>145</td>
<td>129</td>
</tr>
<tr>
<td>1995-1997</td>
<td>182</td>
<td>179</td>
</tr>
<tr>
<td>1993-1995</td>
<td>145</td>
<td>138</td>
</tr>
</tbody>
</table>

MaineHealth is striving to lower the incidence of cancers by reducing tobacco use and obesity rates, while increasing survivorship by maximizing cancer screening and expanding access to community-based treatment.

**Maine Cancer Death Rates and Five-Year Survival Rates**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All malignant cancers</td>
<td>186*</td>
</tr>
<tr>
<td>Lung and bronchus</td>
<td>56* 16%</td>
</tr>
<tr>
<td>Other tobacco-related</td>
<td>33  6-78%</td>
</tr>
<tr>
<td>Prostate</td>
<td>24  99%</td>
</tr>
<tr>
<td>Breast (females only)</td>
<td>22  89%</td>
</tr>
<tr>
<td>Cervix uteri</td>
<td>2   69%</td>
</tr>
<tr>
<td>Colon and rectum</td>
<td>16  64%</td>
</tr>
</tbody>
</table>

---

* Rates are per 100,000 population and age-adjusted to the year 2000 U.S. standard population.
◆ Survival rates are for all diagnosed from 2001-2007, adjusted for normal life expectancy.
* Maine 2008 death rate was significantly higher than the rate for U.S. whites.
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES
Treating tobacco dependence (see page 11)

Colorectal cancer screening has increased across the state
• In 2010, 74% of Mainers 50+ years of age reported ever having had a sigmoidoscopy or colonoscopy; up from 47% in 2002.43
• The 2010 median rate for U.S. states was only 65%.43
• Over half of 50+ year-olds in every Maine county had received a sigmoidoscopy or colonoscopy between 2006-2010 (Figure 27).

Maine Colorectal Cancer Control Program (MCRCCP)44
• MaineHealth is one of four health systems partnering with the Maine CDC.
• Provides screening to low-income, underinsured and uninsured Mainers.

Between July 1, 2011-June 30, 2012:
• 317 screened statewide.
• MaineHealth’s MCRCCP assisted 68 individuals in getting a colonoscopy.
• 26 of these 68 (38%) had precancerous polyps removed during the screening, which prevented cancer from occurring.45

COMMUNITY STRATEGIES
Traffic to the MaineHealth Cancer Resource web portal, www.mainehealthcancer.org, increased significantly in the past fiscal year
• 12,422 hits were recorded in the first ten months after the site’s launch (January-October 2011).
• From October 2011-September 2012, there were 51,833 hits.
• Most of this increase was attributed to more aggressive, targeted marketing of the website via Google Adwords. Viral marketing also was an important contributor to this growth.46

MaineHealth employees getting cancer screenings
• 84% of 50-75 yr-old females across all MaineHealth organizations had a mammogram; the Healthy People 2020 goal is 81%.
• 76% of 50-75 yr-old employees at Western Maine Health had a colon cancer screening (based on only 5 yrs of data, 2007-2011); the Healthy People 2020 goal is 71%.47

GETTING TO THE NEXT LEVEL

CLINICAL
Implement additional components of MaineHealth’s Regional Oncology Plan.

COMMUNITY
Increase colorectal cancer screening rates among 50+ yr-olds through use of colonoscopy and fecal immunoassay tests.

POLICY
Advocate for increasing state tobacco taxes on all types of tobacco to fund evidence-based treatment programs.
Decrease Prescription Drug Abuse and Addiction

In June 2012, MaineHealth added this seventh priority issue to the Health Index program. In the year ahead, targets and strategies will be determined.

Maine has the highest opioid addiction treatment rate in the U.S. — more than eight times the national average (Figure 28).

Sales of prescription painkillers tripled in Maine in the last decade.49
- The rate of opioids sold in 2010 was higher than the national average; only five states had higher rates.49
- From 2000 to 2010, the number of drug overdose deaths more than doubled and exceeded the number of motor vehicle related deaths in five of the past six years (Figure 29).

Opioid abusers have direct health care costs more than eight times those of non-abusers.51
- Outpatient hospital visits related to opioid abuse increased from 19,739 in 2006 to 35,950 in 2009; twice the number of alcohol-related hospital visits in 2009.50
- 18% of Maine’s high school seniors report having misused prescription drugs in their lifetime.52
- Prescription drug abuse is highest among Mainers age 18 to 25.50

Maine’s Prescription Monitoring Program (PMP) is a tool to prevent and detect drug misuse and diversion as well as enable a better coordination of care.
- PMP maintains a database of all transactions for schedule II, III, and IV controlled substances dispensed in Maine.
- PMP is a free service of the Office of Substance Abuse and Mental Health in the Maine Department Health and Human Services.
- As of October 2012, approximately 47% of all licensed medical prescribers in Maine were registered to use PMP.53

More than 1,400 Mainers have died from prescription drug overdoses in the past decade.50
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Provide evidence-based guidelines and educate prescribers of controlled medications
- MaineHealth implemented emergency department (ED) protocol for prescription refills of controlled medications in 2011.
- Lincoln County Healthcare (LCHC) ED physicians prescribed 35-40% less opioid painkillers by using injections of local anesthetic to treat dental pain.
- LCHC developed a controlled substance abuse agreement for use by all primary care practices.
- MaineGeneral established the Drug Overdose Prevention Task Force in 2005 and created medical staff workgroups to address physician and patient education and develop standard guidelines for pain management.
- MaineGeneral’s pain clinic implemented Compassionate Limits Prescription Program (CLIPP) guidelines that assess a patient’s risk of opioid addition and use of the CAGE-AID questionnaire to screen for alcohol or drug problems.

COMMUNITY STRATEGIES

Promote proper disposal and safe storage of unused prescription drugs
Maine hospitals and local public health organizations promoted disposal at drop-off locations around the state and on National Drug Take Back Day collections of expired and unwanted medications. MaineHealth hospitals included:
- Lincoln County Healthcare
- Maine Medical Center
- Pen Bay Healthcare
- Southern Maine Medical Center

Healthy Maine Partnerships and local health departments have supported disposal events across Maine and there are currently 60 drop-off locations at law enforcement agencies statewide.

Community education on safe and secure medication storage
MaineGeneral implemented a MED Smart medication safety campaign to engage patients on safe and secure management of medications to prevent diversion and accidental overdose.

GETTING TO THE NEXT LEVEL (Proposed)

CLINICAL
- Enroll all MaineHealth physicians in Maine’s PMP.
- Implement CLIPP guidelines that emphasize screening for addiction and overdose risk.
- Stop use of opiates for clinical diagnoses where there is no evidence to support their use. (headaches, chronic back pain).
- Routine screening for overdose risk, prescribing of naloxone kits and education for preventing overdose.

COMMUNITY
- Community education and outreach about pain management therapies and alternatives.

POLICY
- Support enhancements of Maine’s Prescription Monitoring Program to change pharmacy reporting to real-time and enable interstate data sharing.
- Support passage of Good Samaritan Law, protecting bystanders who call and provide emergency assistance to individuals who overdose.
- Expand access to naloxone for at-risk patients.
Introduction

1. “The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. BRFSS was established in 1984 by the Centers for Disease Control and Prevention (CDC). More than 500,000 adults were interviewed in 2011, making the BRFSS the largest telephone health survey in the world.

BRFSS introduced two changes to their telephone survey this year that affected data presented in this report. The first change is a revised method of analysis. Survey data is always adjusted to reflect who completes a survey in comparison to the population being surveyed. Previously, BRFSS had used a process called post-stratification that allowed them to correct for about half a dozen differences among the completed surveys and the population. Starting with this edition, a process called raking has been adopted which allows them to now adjust for over a dozen differences. This becomes increasingly important as you get more diverse segments within the population and improves the accuracy of the survey estimates.

The second change is to survey households that use a cell phone as their primary residential phone and do not have a landline. This portion of the population is increasing rapidly, and the prior, landline only surveys were not reaching these households. The CDC conducted a study and found four demographic groups in which the majority live in households without landlines: adults aged 25 to 34, adults living with only unrelated roommates, adults renting their home, and adults living in poverty. The survey still does not capture responses from those without a phone, and the CDC, similar to all phone surveys, faces increasing difficulty reaching those who screen all calls.”

Retrieved from http://www.americashealthrankings.org

The Health Index Report uses two metrics that rely on BRFSS data: prevalences of smoking and obesity. The changes in the BRFSS methodology do not allow comparisons to be made between 2011 values of these metrics and prior values.

Increase Childhood Immunizations

2. Up-to-date means a child has received the recommended number of immunizations (initial + boosters) within the timeframe established in the U.S. Centers for Disease Control and Prevention’s immunization schedule.


4. Maine Immunization Program Regional Training Presentation, August 9, 2012, Portland, ME.


6. First STEPS is the practice improvement effort of the Improving Health Outcomes for Children Program, a collaborative effort in Maine and Vermont supported by a federal Children’s Health Insurance Program Reauthorization Act grant to MaineCare Services. First STEPS is a three-year learning initiative based on the AAP Bright Futures Curriculum that aims to increase the rate of EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) services in practices serving high volumes of children receiving MaineCare.


Decrease Tobacco Use


13. Provided by Center for Quality & Safety, October 2012.

14. Details about the 10 Point Policy Plan/Standards of Excellence can be found at the Maine Tobacco-Free Hospital Network website: http://www.mainetobaccofreehospitals.org/gold_stars/

Decrease Obesity

ACSC data presented in this report include the following?


Let’s Go!

18. Decrease Cardiovascular Deaths

22. Ambulatory care-sensitive conditions (ACSC) are those “for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided.” Agency for Healthcare Research and Quality. Prevention Quality Indicators. Retrieved from http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx ACSC data presented in this report include the following 10 conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension, dehydration, bacterial pneumonia, urinary tract infection, angina (no procedure), adult asthma, and perforated appendix.


25. “NCQA developed the Diabetes Recognition Program (DRP) to provide clinicians with tools to support the delivery and recognition of consistent high quality care. This voluntary program is designed to recognize clinicians who use evidence-based measures and provide excellent care to their patients with diabetes. The DRP Program has 11 measures which cover areas such as: HbA1c control, blood pressure control, LDL control, eye examinations, nephropathy assessment, smoking and tobacco use and cessation advice or treatment. Eligible clinicians will abstract data from the charts of diabetes patients (25 patients for a single applicant) and submit this information to NCQA for review.” Retrieved from http://www.ncqa.org/Programs/Recognition/DiabetesRecognitionProgramDRP.aspx


28. The Transition of Care Bundle includes risk stratification, use of a discharge checklist, medication reconciliation, timely communication between hospital and outpatient providers, and a timely follow-up visit with the regular care provider.


31. Community-based Care Transitions Program (CCTP) information provided by MMC PHO, October 2012.

Decrease Preventable Hospitalizations

22. Ambulatory care-sensitive conditions (ACSC) are those “for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided.” Agency for Healthcare Research and Quality. Prevention Quality Indicators. Retrieved from http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx ACSC data presented in this report include the following 10 conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension, dehydration, bacterial pneumonia, urinary tract infection, angina (no procedure), adult asthma, and perforated appendix.


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31. Community-based Care Transitions Program (CCTP) information provided by MMC PHO, October 2012.

Decrease Cardiovascular Deaths


35. MaineHealth AMI PERFUSE (Patients Emergently Reperfused by Facilities United for STEMI Excellence) Program. Provided by MaineHealth Clinical Integration, October 2012. Data presented for time-to-treatment in the hospital (solid lines in graph) are the proportions among those patients who did not have unavoidable circumstances that delayed treatment beyond the strived-for timeframe. Timeframes are set by American College of Cardiology and the American Heart Association.


37. “The Heart/Stroke Recognition Program was launched in 2003. This voluntary program is designed to recognize clinicians who use evidence-based measures and provide excellent care to persons with cardiovascular disease (CVD) or who have had a stroke. The Heart Stroke Recognition Program (HSRP) assesses key quality performance measures that are based on national evidence-based guidelines for secondary prevention of cardiovascular disease and stroke. Program measures include: Blood pressure control, complete lipid profile, cholesterol control, use of aspirin or another antiplatelet, smoking status and cessation advice or treatment. HSRP Recognition provides assurance that clinicians are providing high quality, evidence-based care for their CVD and stroke patients. Eligible clinicians will abstract data from the charts of CVD/stroke patients (35 patients for a single applicant) and submit this information to NCQA for review.” Retrieved from http://www.ncqa.org/tabid/140/default.aspx
38. “Million Hearts™ is a national initiative to prevent 1 million heart attacks and strokes in the U.S. over the next 5 years. Launched by the Department of Health and Human Services (HHS) in September 2011, it aligns existing efforts, as well as creates new programs, to improve health across communities and help Americans live longer, more productive lives. The Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS), co-leaders of Million Hearts™ within HHS, are working alongside other federal agencies and private-sector organizations to make a long-lasting impact against cardiovascular disease.” Retrieved from http://millionhearts.hhs.gov/index.html

Decrease Cancer Deaths
44. “[Maine Colorectal Cancer Control Program] is offered by the Maine Comprehensive Cancer Control Program, Maine CDC, in partnership with Medical Care Development, the American Cancer Society, Central Maine HealthCare Corporation, Eastern Maine Health System, the Healthy Maine Partnership, the Maine Cancer Consortium, the Maine Cancer Registry, MaineGeneral Medical Center, MaineHealth, Maine Primary Care Association, Maine’s tribal communities, and other Maine CDC programs, among numerous other organizations statewide.” Retrieved from http://www.maine.gov/dhhs/mecdc/population-health/ccc/colorectal.shtml
47. MaineHealth Employee Health Improvement. Reported October 2012.

Decrease Prescription Drug Abuse and Addiction
53. Provided by Anne Rogers, Data & Research Manager, Substance Abuse and Mental Health Services/DHHS.

Recommended Resources
- www.mainehealth.org
- www.americashealthrankings.org
- www.countyhealthrankings.org
- www.cdc.gov
- www.cdc.gov/nchs/nis.htm
- www.maine.gov/youthhealthsurvey/main.cgi
- www.dartmouthatlas.org
- www.maine.gov/dhhs/boh/index.shtml
Notable Health Index Accomplishments in 2012

**Targets established for six priorities:** After workgroups and experts identified potential targets for each of the six original Health Index priorities, MaineHealth’s Community Health Improvement Council (CHIC) reviewed and unanimously approved them in June 2012.

**Decrease Prescription Drug Abuse and Addiction approved as seventh priority:** After Lincoln County Healthcare and MaineGeneral Health identified the issue as one of their two population health priorities for FY2012, the Health Index team researched it and recommended it as a priority. The Community Health Improvement Council unanimously approved this motion in June 2012.

**New funds leveraged for Index priorities:** During 2012, approximately $6 million in new or expanded grants and contracts directed at Health Index priorities (obesity, tobacco, and immunizations) were awarded to MaineHealth. These funds are being deployed to hospitals, community organizations, after school programs, and others to advance new programs and fill gaps in local and state funding.

**Invited presentation at APHA:** Health Index staff and Dr. Andy Coburn, consultant from USM’s Cutler Institute in the Muskie School at the University of Southern Maine, collaborated with staff from United Health Foundation, the University of North Carolina’s School of Public Health, Arundel Street Consulting, Rockfish Interactive, and the Glover Park Group (all contractors who work on America’s Health Rankings®) on a four-part presentation at the annual meeting of the American Public Health Association in San Francisco.

**Invited presentation at MPHA:** Health Index staff presented a 2-hour workshop on the Index and the County Health Rankings®, and how to access, interpret, and use data from these and other sources at the Annual Meeting of the Maine Public Health Association.

**Article published in Trustee magazine:** Article highlighted the role of MaineHealth’s Board of Trustees in developing the Health Index: the conceptual framework, the report, and the process to inform resource allocation and strategic initiatives across the health system.

**Invited participation on national expert panel on implementing community health strategies:** The Association of State and Territorial Health Officials (ASTHO) and the United Health Foundation are hosting an expert panel to guide the work of a new learning collaborative intended to strengthen individual state public health activities by learning from identified best practices. The Health Index initiative was selected for our use of the America’s Health Rankings® to prioritize population health issues for MaineHealth organizations and external partners to work on.

**The first site visit of an external advisory panel for the Health Index initiative was convened in October 2012.** Summary of meeting and panel’s findings/recommendations are presented on page 2.

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