City of Portland, Maine
Public Safety/Health & Human Services Committee

June 9, 2015
5:30 PM
Room 209, City Hall

1. Review And Accept Minutes From May 15, 2015 Meeting

   Documents: MAY 12 2015 MEETING MINUTES.PDF

2. Quarterly Public Health Updates
   Toho Soma, Director of Public Health

   Documents: PUBLIC HEALTH DIVISION QUARTERLY REPORT 6-8-15.PDF, COUNTY HEALTH RANKINGS_MAINE_2015_CUMBERLAND.PDF, MHINDEX_FINAL_2014.PDF

3. Staff Report And Recommendations On Fire/Code Task Force
   Committee Action to follow Public Comment on this item

   Documents: FIRE CODE TASK FORCE BACKUP FOR 6.9.15 MEETING.PDF

4. Adjourn

Portland, Maine Yes. Life's good here.

Portland Police Department

City of Portland, Maine
Public Safety / Health & Human Services Committee
May 12, 2015

Meeting Minutes

Committee Attendance: Chair Councilor Suslovic, Councilor Costa, Councilor Brenerman; Councilor Duson

City Staff Attendance: Michael Sauschuck, Acting City Manager; Anita LaChance, Acting Deputy City Manager, Dawn Stiles, Director of Health and Human Services; Adam Lee, Associate Corporation Counsel; Julie Sullivan, Acting Chief of Staff; Brendan O'Connell, Finance Director; Keith Gautreau, Acting Assistant Fire Chief; Mayor Michael Brennan; Councilor Jon Hinck

AGENDA ITEM 1 - Meeting Called to Order at 5:33pm

Chair Suslovic moved to accept minutes from the March 10, 2015 meeting. The motion was seconded with all in favor.

AGENDA ITEM 2 – Public Hearing on the Fire/Code Task Force: Includes Ordinance Change Proposals and a committee vote on recommendations to the full council.

Julie Sullivan provided an overview of her memo (see back-up material) with regard to landlord registration process and fees. Julie introduced Acting Assistant Fire Chief, Keith Gautreau to illustrate impacts on the fire department (see back-up material) should the City elect to fund the task force's recommendation from the fire department budget or utilize current fire department staff to perform the suggested work by the task force. Adam Lee spoke regarding the recommended ordinance changes (see back-up material) noting the fee for registration is higher than the task force recommended and the newer number came from the finance committee. Adam also said that chapters 6 and 10 would need changes should the task force recommendations fall to an existing city department or if a new department was created.
Julie commented on the registration portion of her memo saying there are suggested exemptions of 2,840 units due to current federal inspection requirements for those properties. Adam is working on additional language for those exemptions.

Councilor Suslovic asked for the points of the ordinance changes. Adam responded that the ordinance changes apply to any rental unit to be registered at $35 per unit annually. Violation fines were priced high at $100 per day and a failure to pay fine was imposed as well. A false information fine was proposed at $1000.

Public Comment on this item opened at 5:51pm:

1) Mark Adelson, Executive Director of the Portland Housing Authority agrees with the task force recommendation of the housing office being established and supports the exemption from fees for those properties already inspected by the feds and HUD.

2) Saiid Neelan (?) of 29 Emerson Street has a 3 family unit and suggests suspending $300k on the shelter instead

3) Dana Totman of 32 Kenwood Street and representing Avesta Housing echoed Mark Adelson's comments. Avesta has 600 affordable housing options already heavily inspected. Additional inspections would cause a hardship for residents to include translation services and pet arrangements. He suggested the MSHA HUD inspection be equal to Portland's proposed inspection.

4) Cullen Ryan, Executive Director of Community Housing of Maine, said they have 277 units in Portland and echoes both Mark and Dana's comments. They have quarterly inspections and the fees proposed are cumbersome for small non-profits.

5) Robert Hanes, a home advocate, does not support any exemptions unless that group meets the City's expectations for inspections and suggested a re-organization of the current building code office to support multi unit inspections.

6) Carlton Winslow, an Auburn Street landlord, supports the program but not the fees or exemptions.

7) Jim Harmon, a Portland landlord has subsidized units and is subject to the same inspections as Avesta, etc and would like the same exemptions to apply to his units. He also said this should be a function of the existing code department.

8) Carol Schiller of 7 Longfellow street witnessed the Noyes street fire and urged the committee to support the recommendations of the task force to include registration fees and supports fully staffing the fire and police departments to respond to tragedies such as these.

9) Mr. Vitalias of the southern Maine landlord association expressed disappointment with the increase in the proposed fee and reminded folks that this fee is paying for the highest risk properties in Portland. He also suggested that the proposed ordinance changes read, "…knowingly provide false information…" when imposing fines on false information provided.

10) Stephen Sharp from High Street supports the concept but thinks the code enforcement office should be incorporated to handle these code issues. He does not support the exemption and thinks condos should be added.

Public Comment closed at 6:17pm

Chair Suslovic was inclined to provide staff with questions (from each councilor) and postpone any action to the June meeting.

Councilor Brennerman asked if there was any law about tenants disabling smoke alarms. Adam said the current ordinances gives the City room on this but there is always a challenge to proving who disabled a smoke alarm. Councilor Suslovic asked what ever happened to the form previously discussed with regard to a checklist that a landlord and tenant would go over together. Julie said a form is in the works and

Adam pointed out that this item may be better suited for a landlord and tenant to work out instead of the City requiring it.
Councilor Brenerman questioned whether or not a single family home was subject to fees and if condos were included in the proposal. Adam clarified the terminology in the ordinance proposal does intent to include condos. Julie clarified that owner occupied units were not included in the registration requirements. Councilor Brenerman asked why the fee was set at $35/unit. Julie responded a 70% collection rate was assumed and the city would need $420k to implement the task force's recommendations.
Councilor Brenerman supported the change to "..Knowingly providing false information…" and Adam understood that enforceability was the goal in drafting the ordinance changes so he doesn't support adding the word knowingly.
Councilor Brenerman questioned the current level of training and the fire department. Acting Assistant Chief Keith Gautreau said all firefighters are trained in the NFPA life safety code which is different from the code enforcement officer training. In addition all Captains and Lieutenants were trained in chapter 31 codes in April 2015. The fire department currently inspects units that are 3 units or more.

AGENDA ITEM 3 – Public Comment on the Overflow Shelter Closure Proposal

Acting City Manager Sauschuck gave a brief update to provide context for the discussion noting the state's partnership has changed and forced the City to re-consider its funding commitments and address the potential significant loss of funding from the state. In the FY15 budget, then Acting City Manager Sheila Hill-Christian put measures in place to lessen the impact by imposing a hiring freeze, a spending freeze and did not stop providing services. 22.7 positions, 13 of which were actual people were proposed to offset projected loss in funding. We are laying off people to deal with this reality. The City's finance director, Brendan O'Connell is available to outline decisions made publicly and Dawn Stiles, Director of Health and Human Services is available as subject matter expert.

Dawn Stiles described the January 2015 state audit that reviewed 91 files and found zero errors and noted the City's 2014 audit appeal has been met with no response to date. At the shelter there were 5 findings in the audit regarding the use of assumptive eligibility and subsequent eligibility not done correctly. The City has filed a plan of compliance but the state has not paid the City since June of 2014. Three shelter staff have been eliminated and the overflow shelter is proposed to close. The City plans to comply with the findings.

Brendan O'Connell Described two standing charts in the committee room showing the geographic distribution of shelter users: 32% Portland residents, 28% Maine residents, 20% from this nation and 20% from the entire world. The second chart illustrated shelter costs and Brendan described the projected $6.6 million dollar shortfall. Brendan also went over a handout provided at the meeting.

Dawn described efforts to place long term stayers and had asked area agencies to help, mentioning that there were some vouchers available for long term stayers.

Councilor Suslovic wanted to clarify the $6.6 million dollar shortfall and impacts on the City. Brendan said the fund balance is 12.5% of operating expenses, which would drop to 9% with the projected shortfall. Anything below 8% equates to a bad credit rating. Any general downgrade increases the City's cost of doing business. The City is prepared to absorb the $6.6 million this year, but needs a plan to replenish the fund balance moving forward. Brendan said a plan to do that was in place.

Public Comment opened on this item at 7:15pm.

The following individuals spoke in opposition of the proposed closure:

1) Kevin Andrew McGuire, self-identified transient
2) Bob Bergeron of Deering Oaks Park
3) Dr. Tom McLaughlin (UNE social work) of Oakwood Avenue
4) Jason Blanchard of Maple Street
5) Jim Devine of Homeless voices for Justice
6) Charles Lang, homeless for 5 years
7) Chris Muse, currently homeless
8) Tyler (no last name given)
9) Reverend Don from HopeGateway at 185 High Street
10) Matthew Coffee of 5 Portland Street
11) Megan Connolly of Montreal Street
12) Bob Fowler, Exec Director of Milestone
13) Evan Prosper, homeless
14) Andrew Rice, OOB Milestone client
15) Mike Tarpinian, Opportunity Alliance
16) Melanie McGinnis, former client of services
17) Dana Totman, Avesta representative
18) Micky Kline, oxford shelter resident
19) Kelly (no last name) of oxford shelter
20) Liz Cotter Shlax, President and CEO, United Way of Greater Portland
21) Norman Mays of the Shalom House
22) Cullen Ryan, Community housing of Maine
23) Donald Drake, service member
24) Renea (last name unavailable), Medical professional
25) Jenny Stasio, Residential Services Director at Family Crisis in Portland
26) Steve Hirschon of Hanover Street
27) Kelly from Family Crisis
28) Bill Higgins, currently homeless
29) Lewellin Ingerton, teen shelter
30) Renea Walberg, President, Preble Street Board (along with 7 board members) and they announced they would forego collecting rent from the City for a period of time in order to keep the overflow shelter open
31) Lucky Hollander of Ludlow Street
32) Robert Densmore, shelter occupant
33) Mark Swann, Exec Dir, Preble street
34) Elizabeth Marshall, Opportunity Alliance
35) Don Harden, Douglas Street
36) Sumner Sweatt, Oxford Shelter
37) Shawn Kirwin, Paris Street
38) Raymond Dalberts, shelter resident
39) Jess McBrewer, high school student
40) James Fletcher, Pastor at Woodfords representing area clergy
41) Sheryl Holmberg, shelter resident
42) Hannan Hanhouser, Preble street caseworker
43) Mr. Hanes, no location given

44) Lou Savado of Cumberland Ave

The following individual spoke in favor of the proposal:

1) Steven S of high street

Public Comment ended at 8:59pm.

The committee and staff discussed options to keep the shelter open for the immediate future and identified the possibility of a $350k funding option and reviewed timing and availability of funding, then deferred to staff to put a proposal in motion. Chair Suslovic requested an update on section 8 housing vouchers and a progress report for the homeless task force at the June meeting. A short discussion was had about how much of this change is being driven by the state's audit vs. the pending lawsuit or budget processes. Councilor Brenerman asked if the committee was going to make a recommendation to the full council on this item. Chair Suslovic recognized the majority of council members were present (4 committee members and two councilors sat in on the meeting: Councilor Hinck and Mayor Brennan) so the committee didn't need to make a recommendation. Mayor Brennan went over the options to fund the overflow shelter and showed support to use some funding from the City to cover the cost and maintained optimism that the council would support that notion as well. The Chair asked finance staff why the budget is crafted to recommend closure of the overflow shelter. Brendan O'Connell replied that the 2016 budget was crafted in response to the GA audit and reimbursement status noting it was a risk based budget. Councilor Costa agreed it makes more sense to budget in accordance with the statute and suggested this item be taken up with the full council on Monday citing minimal consensus on issues at this level concerning whether or not the City intends to fund this item and if so, for how long.

AGENDA ITEM 4 – Committee Discussion of the Framework for an FY16 Emergency Support Fund; Request for Staff to propose options for program design, eligibility, scope of service and fiscal management for the next committee meeting in June

Councilor Duson presented the idea that staff come back with a framework for an emergency support fund for this purpose noting that the potential closure of the overflow shelter is in fact an emergency. Councilor Duson and Chair Suslovic were not ready to say they supported using an available $350k allotment for this purpose while understanding future fiscal challenges the City faces. The committee generally agreed to review what an emergency fund looked like.

With no further business to attend to the meeting adjourned at 9:55pm

Public Health Division Quarterly Report

Public Safety, Health and Human Services Committee

June 4, 2015

Toho Soma

Acting Public Health Director

Public Health
Prevent. Promote. Protect.
Portland Public Health Division
City of Portland, Health and Human Services Department

Recent Achievements

- Provisional restoration of the Children's Oral Health Program
- Expansion of the tobacco ordinance to include electronic nicotine delivery systems (e.g., e-cigarettes)
- Tightening up restaurant inspection ordinances
- Extensive media coverage (43 stories since January)
- Involvement in various meetings and conferences
  - Maine Harm Reduction Conference
  - Maine Minority Health Conference
  - Invited to speak at national meetings on smoke-free housing and violence prevention

Concerns

- Heroin epidemic
  - Closure of Mercy Recovery Services
  - Organizing Community Forum on Opiates on June 16, 3 to 5, at UNE's Portland campus
- State budget
  - $800,000 from the Fund for Healthy Maine still on the chopping block (funds Healthy Maine Partnerships and 2/3 of School Health Centers)
  - Concern about State shutdown if no budget by end of June
- Loss of grants for Minority Health
  - Loss of 2.2 FTE of Community Health Outreach Workers starting July 1

Plans for the next quarter

- Revising tobacco ordinance to include all parks and public grounds where a permit is required to hold an event
  - Sec. 17-96 currently lists each place by name
  - Prefer generic language to easily include new places (e.g., Thompson's Point, pop-up parks)
- Implementing Electronic Medical Records at medical clinics
  - Must complete by October 1 in order to submit for insurance reimbursements
- Developing an Action Plan for Local Public Health Accreditation
- Health on the Move Event on June 27, 10 to 3, at Deering High
- Strategizing with Finance and other City departments on grants to pursue

County Health Rankings – 2015 – Summary for Cumberland County

Rankings produced by Robert Wood Johnson Foundation and University of Wisconsin

Measure				Comparisons		
	Rank (1-16)[¥]	Rate	Error Margin	Maine	Best ME County	Top U.S. Performers
Health Outcomes	***2***					
Length of Life: 50% weight in health outcomes ranking	***2***					
Premature Death (Years of potential life lost before age 75 per 100,000 pop, 2010-2012)		5178	4867 – 5490	6199	4780	5200
Quality of Life: 50% weight in health outcomes ranking	***2***					
Poor or Fair Health (% adults self-rating, 2006-2012)		10%	9 – 11%	13%	10%	10%
Poor Physical Health Days (Mean number days, 2006-2012)		2.9	2.7 – 3.1	3.5	2.9	2.5
Poor Mental Health Days (Mean number days, 2006-2012)		3.3	3.1 – 3.6	3.6	3.3	2.3
Live Births with Low Birth weight (% <2500 grams, 2006-2012)		6.5%	6.1 – 6.8%	6.5%	5.7%	6%
Health Factors	***1***					
Health Behaviors: 30% weight in health factors ranking	***1***					
Current Smokers (% adults self-reporting, 2006-2012)		14%	13 – 15%	19%	14%	14%
Diet and Exercise:						
Obesity (% adults report Body Mass Index>=30, 2011)		22%	20 – 23%	28%	22%	25%
Healthy Food Environment Index (range 0-10, 10=best, 2012)		7.6		7.5	8.2	8.4
No Leisure-Time Physical Activity (% age 20+ self-reporting, 2011)		16%	15 – 17%	21%	16%	20%
% with Access to Exercise Opportunities (2010 & 2013)		86%		72%	86%	92%
Alcohol and Drug Use:						
Excessive Drinking in Past 30 Days (% adults, self-reporting, 2006-2012)		19%	18 – 20%	17%	14%	10%
Alcohol-Impaired Driving Deaths (% deaths, 2009-2013)		30%		34%	24%	14%
High Risk Sexual Behavior:						
Chlamydia Rate (per 100,000 pop, 2012)		263		257	142	138.2
Teen Birth Rate (per 1,000 females ages 15-19, 2006-2012)		14	13 – 15	23	14	19.5
Clinical Care: 20% weight in health factors ranking	***1***					
Access to Care:						
Uninsured 0-64 yrs. (%, 2012)		11%	10 – 12%	12%	11%	11%
Ratio of Population to Primary Care Physicians (2012)		641:1		935:1	641:1	1045:1
Ratio of Population to Dentists (2013)		1236:1		1773:1	1236:1	1377:1
Ratio of Population to Mental Health Providers (2014)		167:1		250:1	167:1	386:1
Quality of Care: (for Medicare Enrollees, 2012)						
Preventable Hospital Stays (per 1,000 enrollees, 2012)		41	39 – 43	55	41	41.2
Diabetic Monitoring (% diabetics who had HbA1c tested, 2012)		89%	85 – 92%	88%	91%	90%
Mammography (% female Medicare enrollees, 2012)		69	65 – 72%	70%	80%	71%
Socio Economic Factors: 40% weight in factors ranking	***1***					
Education:						
% Ninth Grade Cohort Graduating in 4 Years (2011-2012)		88%		85%	88%	93%
Age 25-44 with Some Post-Secondary Education (2009-2013)		74%	71 – 76%	63%	74%	71%
Unemployment: (% ages 16+, 2013)		5.3		6.7%	5.3%	4%
Income:						
Children in Poverty (% age <18, 2013)		14%	11 – 17%	18%	12%	13%
Income Inequality (gap between lower and upper income, 2009-2013)†		4.6		4.5	3.7	3.7
Family & Social Support:						
Children in Single-Parent Households (2009-2013)		31%	28 – 34%	32%	27%	20%
Social associations (2012)†		13.2		11.3	14.8	22.0
Community Safety:						
Violent Crimes per 100,000 pop (2010-2012)		145		123	39	59
Injury Deaths per 100,000 pop (2008-2012)		56	52 – 60	63	44	50.1
Physical Environment: 10% weight in factors ranking	***12***					
Air and Water Quality:						
Air Pollution – Average Daily Fine Particulate Matter (2011)		10.3		10.3	10.0	9.5
Drinking Water Safety (FY 2013-2014)		0%		2%	0%	0%
Housing and Transit:						
Severe Housing Problems (% households, 2007-2011)†		17%	16 – 18%	15%	12%	9%
Driving Alone to Work (% workforce, 2009-2013)		78%	77 – 78%	78%	71%	71%
Commute 30+ Minutes (% of those who drive alone, 2009-2013)		27%	26 – 28%	30%	17%	15%

[¥] Ranking amongst Maine counties (1 = Highest, 16 = Lowest) † New measure in the 2015 *Only 10% of counties throughout the US had better rates.

Health Index

2014 REPORT

MaineHealth

Health Index

www.mainehealthindex.org

MaineHealth

is a not-for-profit family of leading, high-quality providers and other healthcare organizations, working together so our communities are the healthiest in America.

– MaineHealth's Vision

ABOUT THE REPORT

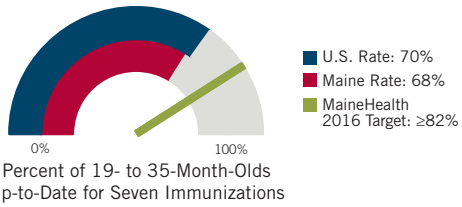
This report includes the following sections:

The Priorities At-a-Glance: How Are We Doing?

Increase childhood immunizations

page 8

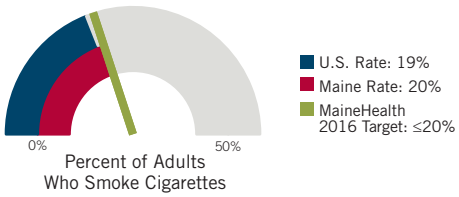
The rate of toddlers up-to-date for immunizations in 2013 was not statistically different from the rate in 2012 and remained below the 2016 target.



Decrease tobacco use

page 10

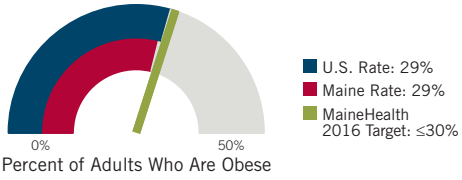
The rate of adults smoking in 2013 was unchanged from 2012 and met the 2016 target.



Decrease obesity

page 12

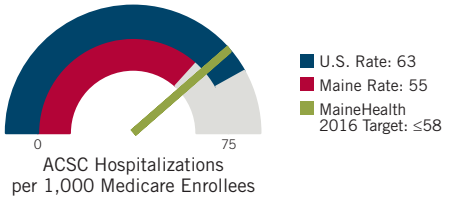
The rate of adults with obesity in 2013 was unchanged from 2012 and met the 2016 target.



Decrease preventable hospitalizations

page 14

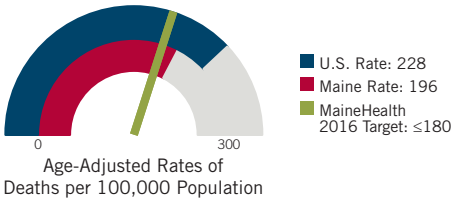
The rate of ACSC hospitalizations in 2012 decreased from 2011 and met the 2016 target.



Decrease cardiovascular deaths

page 16

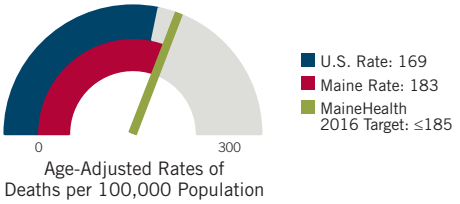
The rate of cardiovascular deaths continued to decrease in 2010-2012 but remained above the 2016 target.



Decrease cancer deaths

page 18

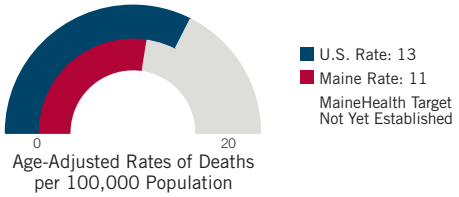
The rate of cancer deaths continued to decrease in 2010-2012 and met the 2016 target.



Decrease prescription drug abuse and addiction

page 20

The rate of deaths from drug overdose in 2010-2012 was unchanged from the 2009-2011 rate. The MaineHealth target has not yet been established.



2014 Health Index Report

Welcome to the 2014 Health Index Report!

The 2014 report marks the fifth edition of MaineHealth's Health Index Report. The Health Index initiative was launched in 2009 as a unique strategy to monitor progress on Maine's most pressing health priorities, spur collective action, and improve the health status of people and communities. While the 2014 report highlights activities in the MaineHealth region (11 counties in Maine and adjacent Carroll County, New Hampshire), data for all Maine counties is included. Data for Carroll County, N.H. is included where available. A special section on health disparities describes the impact of factors such as income and education on health status.

On pages 4-5 you will find the most recent results for two national population health assessments, the 2014 America's Health Rankings® (AHR) and the 2015 County Health Rankings© (CHR). These rankings enable easy comparisons, either state to state (AHR) or county to county (CHR). Both also provide benchmarks that are helpful for measuring Maine's progress (and challenges) in improving population health over time.

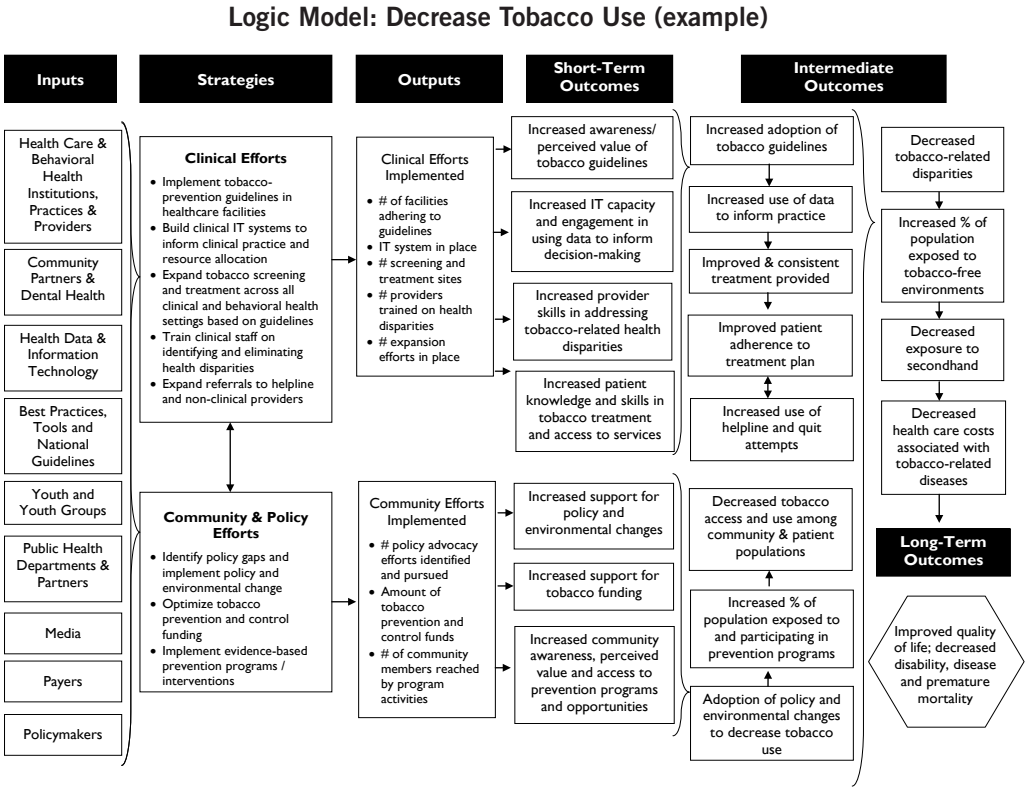
How the Report is Organized

The Report features an "At-a-Glance" page providing a summary of each priority's status, and comparing current Maine and national data to MaineHealth's targets. All MaineHealth targets have a goal of being met by 2016. Pages 8 to 21 contain two-page spreads for the seven priorities. Left-hand pages include a narrative overview of progress, a table that compares national, Maine and "best state" results, and maps or tables that show details of county-level data. Right-hand pages highlight actions on the priority during the previous year in three domains:

- **Clinical** – clinical settings include hospital, health centers, physician practices, school-based health centers, and rural clinics.
- **Community** – community settings include schools, child care centers, community organizations, and businesses.
- **Policy** – policy strategies include local, state, and federal legislation or organizational policies.

Health Index Logic Models Updated

Logic models are a widely accepted method of graphically depicting major relationships between desired health outcomes and the science- and evidence-based steps that are involved in achieving those outcomes. Typically, logic models link inputs to processes and outcomes and are useful guides to choosing strategies and allocating resources. During the summer and fall of 2014, Health Index staff convened seven work groups comprised of more than 100 researchers, clinicians, public health experts, and others to revise and update the logic models for each of the seven Health Index priorities. Brenda Joly MPH, Ph.D., professor of Public Health at the University of Southern Maine's Muskie School, led each of the groups through a process of assessment and consensus-building that resulted in new and improved logic models. They can be found on the Health Index website under "Strategies" within each priority section at www.mainehealthindex.org.

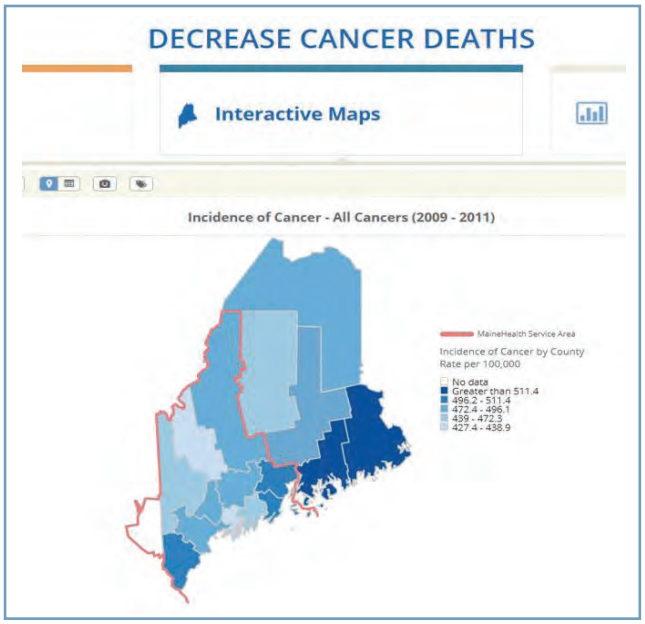


The Health Index Website

www.mainehealthindex.org

The Health Index is Online.

Due to space limitations, the annual Health Index Report provides a high-level summary of data, actions and outcomes. The website provides more detailed data and resources in an interactive format.



What Kind of Information Can Users Find?

Browse Data

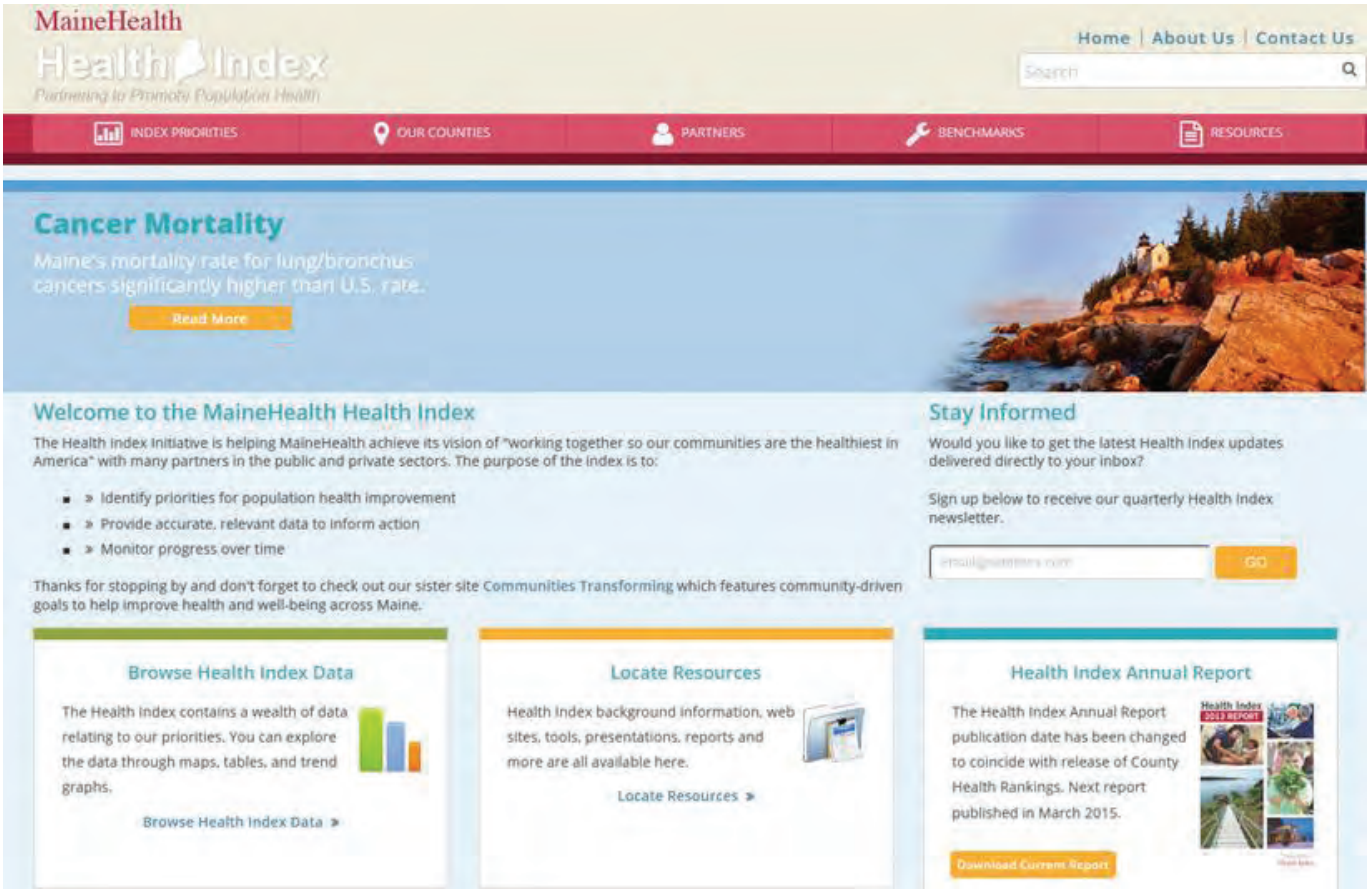
- Interactive maps that illustrate differences among counties
- Trend graphs that highlight changes over time
- In-depth information about priority issues

Locate Resources

- Links to national and county-level comparisons
- Strategies and success stories
- Access to current and past Health Index Reports

Quarterly Health Index e-Newsletter

- A great way to keep up with new features, timely reports, people and projects
- It's easy to sign up on the website home page: www.mainehealthindex.org



AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION
www.americashealthrankings.org

Maine Summary from America's Health Rankings® 2014 Edition

Maine's overall rank decreased from the 16th healthiest state in the nation in the 2013 edition to the 20th healthiest in the 2014 edition.

Determinants: 75% weight in overall rank	Rate of No. 1 State	Maine Rate	Maine Rank
Behaviors: 25% weight in overall rank			
Prevalence of smoking (Percent of adult population)	10.3	20.2	32
Prevalence of binge drinking (Percent of adult population)	9.6	17.2	31
Drug overdose deaths (Deaths per 100,000 population)	3.0	11.0	12
Prevalence of obesity (Percent of adult population)	21.3	28.9	24
Physical inactivity (Percent of adult population)	16.2	21.9	14
Percent of 9th graders graduating high school within four years	93.0	87.0	9
Community & Environment: 22.5% weight in overall rank			
Violent crime (Offenses per 100,000 population)	123	123	1
Occupational fatalities (Deaths per 100,000 workers)	2.2	3.7	11
Infectious disease (Combined score Chlamydia, Pertussis, Salmonella)	-0.9	-0.28	17
Chlamydia (Cases per 100,000 population)	233.0	257.0	2
Pertussis (Cases per 100,000 population)	1.6	55.5	44
Salmonella (Cases per 100,000 population)	6.8	12.1	15
Percent of children in poverty (Under age 18)	9.2	20.9	35
Air pollution (Micrograms of fine particles per cubic meter)	4.9	7.6	12
Public & Health Policies: 12.5% weight in overall rank			
Lack of health insurance (Percent of population)	3.8	10.7	12
Public health funding (Dollars per person)	$219	$83	22
Immunization–children (Percent ages 19 to 35 months)	82.1	68.0	35
Immunization–adolescents (Percent ages 13 to 17 years)	81.3	66.7	21
Clinical Care: 15% weight in overall rank			
Low birthweight (Percent of live births)	5.7	6.6	8
Primary care physicians (Number per 100,000 population)	324.6	130.2	14
Dentists (Number per 100,000 population)	107.6	51.1	35
Preventable hospitalizations (Number per 1,000 Medicare enrollees)	28.2	55.1	21
All Determinants Ranking	**0.71**	**0.29**	**18**

Outcomes: 25% weight in overall rank	Rate of No. 1 State	Maine Rate	Maine Rank
Diabetes (Percent of adult population)	6.5	9.6	22
Poor mental health days in previous 30 days (Adults self-report)	2.5	3.8	30
Poor physical health days in previous 30 days (Adults self-report)	2.8	4.0	30
Disparity in health status (By educational attainment)	15.5	26.1	15
Infant mortality (Deaths per 1,000 live births)	4.2	6.6	31
Cardiovascular deaths (Deaths per 100,000 population)	184.7	215.4	9
Cancer deaths (Deaths per 100,000 population)	145.7	205.4	40
Premature death (Years lost before age 75 per 100,000 population)	5,345	6,645	20
All Outcomes Ranking	**0.34**	**0.01**	**29**
Overall Ranking	**0.91**	**0.30**	**20**

Line items in red indicate a MaineHealth Health Index Priority.

America's Health Rankings® is produced by the United Health Foundation, the American Public Health Association and Partnership for Prevention.

HOW MAINE DIFFERS ACROSS COUNTIES

Where we live matters to our health, and one of the greatest disparities in the U.S. is the variation of health between communities. Health status is impacted across Maine by disparities such as household income, level of education and access to medical care. County Health Rankings© is intended to provide a tool for each state to identify where disparities exist and where there are opportunities for action.

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

www.countyhealthrankings.org

Health Outcome Ranking over Time (Lower number = healthier population)

Maine Counties (N=16)	2010	2011	2012	2013	2014	2015
MaineHealth Service Area						
Androscoggin	11	12	11	6	7	13
Cumberland	3	3	3	2	3	2
Franklin	1	2	8	8	8	9
Kennebec	8	9	9	7	5	8
Knox	6	7	5	5	6	6
Lincoln	4	5	7	11	9	5
Oxford	16	16	15	12	10	7
Sagadahoc	7	4	1	3	2	1
Somerset	14	14	14	15	15	16
Waldo	9	8	6	10	12	12
York	5	6	4	4	4	4
Northern Maine Counties						
Aroostook	13	13	12	13	13	14
Hancock	2	1	2	1	1	3
Penobscot	10	11	10	9	11	11
Piscataquis	12	10	13	16	16	15
Washington	15	15	16	14	14	10
New Hampshire Counties (N=10)						
Carroll County	8	7	6	6	7	7

METRICS IN HEALTH OUTCOMES RANKING
MORTALITY (50% weight in outcomes ranking)
Premature death (Years lost before age 75)
MORBIDITY (50% weight in outcomes ranking)
Poor or fair health (Percent of adults; self-report)
Poor physical health days in previous 30 days (Adults; self-report)
Poor mental health days in previous 30 days (Adults; self-report)
Live births with low birthweight (Percent <2500 grams)

County Health Rankings© is produced collaboratively by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Health Disparities and Health Equity – What Is the Effect on Health?[1]

Health disparities and health equity are important considerations in any efforts to improve population health. Health disparities include risk factors and health outcomes where differences exist among various populations.

Across the country and in Maine, communities, policymakers, healthcare providers, and others are becoming increasingly aware of how factors such as ethnicity or income impact the overall health status of the population.

Health equity relates to differences in population health that result from unequal economic and social conditions. They are pervasive and avoidable, unjust and unfair. Effectively addressing concerns about health equity means that ALL voices, regardless of race, economic status, education and geography, are included in finding and implementing solutions to health issues like cancer or asthma.

Common demographic and socioeconomic factors that result in health disparities include the following:

- Gender
- Age
- Race and ethnicity
- Sexual orientation
- Income
- Education
- Health insurance status
- Immigration status
- Veteran status
- Disability status
- Geographic location

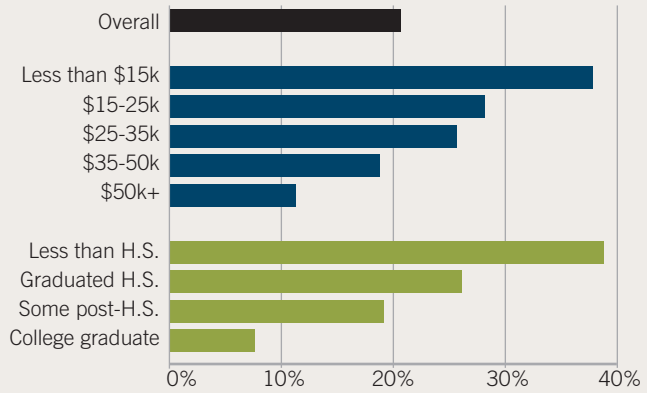
These factors alone cannot account for health disparities, but can serve as a starting point for further exploration. For instance, race alone might not account for different rates of mortality, but racial biases in the healthcare setting that delay screening and treatment have been shown to be a factor that affects health status.

Historically in Maine, health disparities have centered on income, education and geographic location (urban vs. rural).

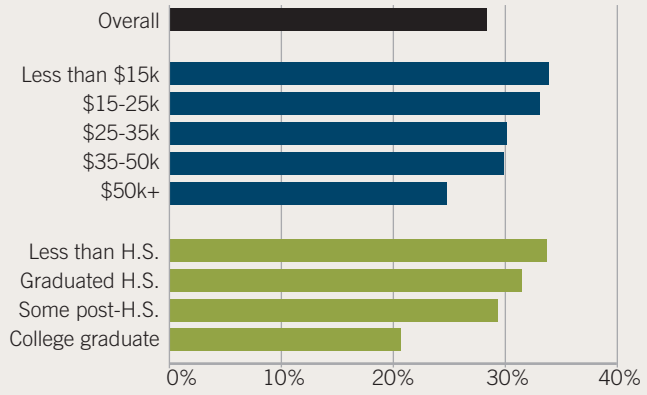
Examples of disparities in Maine include:[2]

- 39% of adults with less than a high school diploma smoke, compared to 8% of college graduates (Figure 1).
- The obesity rate among those that earn more than $50,000 annually is 25% while the rate is 34% for those that earn less than $15,000 (Figure 2).

Adults in Maine Who Smoke by Income and Education (2011-2013) Figure 1



Adults in Maine With Obesity by Income and Education (2011-2013) Figure 2



In recent years the increasing number of immigrants, asylees and racial/ethnic minorities in the state has yielded enough data to examine health disparities along these lines. For example, among Maine high school students, 63% of Hispanic students are at a healthy weight, compared with 70% of White students.[3]

LOCAL, STATE AND NATIONAL RESOURCES

Maine has several initiatives focusing on achieving health equity. As part of the Maine Center for Disease Control and Prevention's (CDC) State Innovation Model award, four agencies are implementing Community Health Worker initiatives to help underserved patients with health education and care navigation in order to produce better health outcomes. Specific subpopulations targeted include the uninsured, the elderly, and the disabled.[4]

Other resources include:

Office of Health Equity at the Maine CDC
- The statewide office devoted to health equity issues
- www.maine.gov/dhhs/mecdc/health-equity

Minority Health Program at the City of Portland's Public Health Division
- Maine's largest municipal health department houses staff and resources addressing health disparities
- www.portlandmaine.gov/467/Minority-Health-Program

Maine Migrant Health Program
- A statewide organization focused on improving the health of Maine's migrant and seasonal farmworkers
- www.mainemigrant.org

Daniel Hanley Center for Health Leadership Health Equity Council
- Maine's health leadership training institute has produced a video and facilitator's guide highlighting health disparities in Maine.
- www.hanleyleadership.org/events/#In-All-Fairness

Unnatural Causes
- A groundbreaking documentary series focusing on health disparities and health equity in the United States
- www.unnaturalcauses.org

Equity Indicators

PolicyLink, a national organization devoted to advancing economic and social equity, developed the Equity Indicators Framework to help communities define and track the state of equity in their regions. The Framework includes four sets of indicators:

Demographics — Who lives in the region and how is this changing?

Economic vitality — How is the region doing on measures of economic growth and well-being?

Readiness — How ready are the region's residents for the 21st-century economy?

Connectedness — Are the region's residents and neighborhoods connected to one another and to the region's assets and opportunities?[5]

Looking Ahead – What's Needed?

One major gap related to health disparities is the lack of robust, timely data that will help researchers and evaluators identify and understand other health disparities, as there are subgroups within groups in Maine (e.g., not all African immigrants come from the same country, and not all rural Mainers are in the same income bracket).

More training on health disparities and health equity is needed to help health students and practicing health care providers remain culturally competent and practice from a holistic viewpoint.

Another strategy is to create more opportunities for vulnerable and marginalized populations to participate in efforts to address health priorities. For example, public health and healthcare organizations might consider paid internships or leadership training for community members to gain needed knowledge and skills.

Increase Childhood Immunizations

MaineHealth continues to collaborate with organizations to implement clinical, community, and policy strategies to increase on-time childhood immunization rates in Maine.

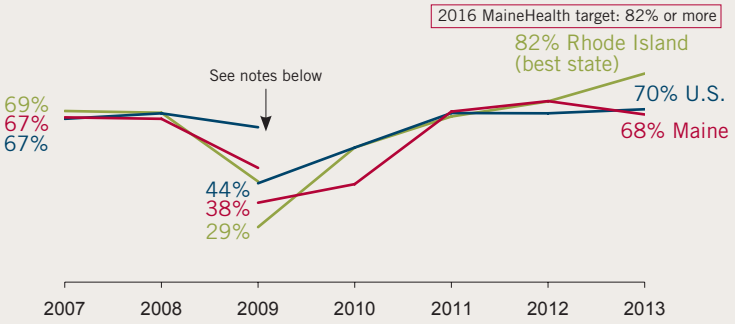
Maine's estimated up-to-date[6] rates among all 19- to 35-month-olds in Maine for 2011, 2012 and 2013 were statistically similar (Figure 3), suggesting the actual rate in Maine has not changed over the three years. Figure 4 presents Maine's estimated up-to-date rates for individual vaccines in 2013; those in red text are the seven in the series presented in Figure 3. The estimates presented in Figures 3 and 4 are from the National Immunization Survey.[7]

In January 2015, there was substantial variation across Maine's 16 counties in the percent of two-year-olds up-to-date on the series of seven immunizations (Figure 5). County rates were calculated from data submitted to ImmPact, Maine's Immunization Information System.[8]

How Maine Compares to the U.S.

Figure 3

Percent of 19- to 35-Month-Olds Up-to-Date for a Series of Seven Immunizations



In response to a national shortage of Haemophilus Influenza B vaccine in 2009, clinicians were encouraged to delay booster shots. These delays reduced up-to-date rates for the series graphed above.

In 2009, the National Immunization Survey began reporting a measure that more accurately estimated the true up-to-date rate in each state. These more accurate estimates (lines from 2009-2013) are not directly comparable to the older measure's rates in 2007-2009.

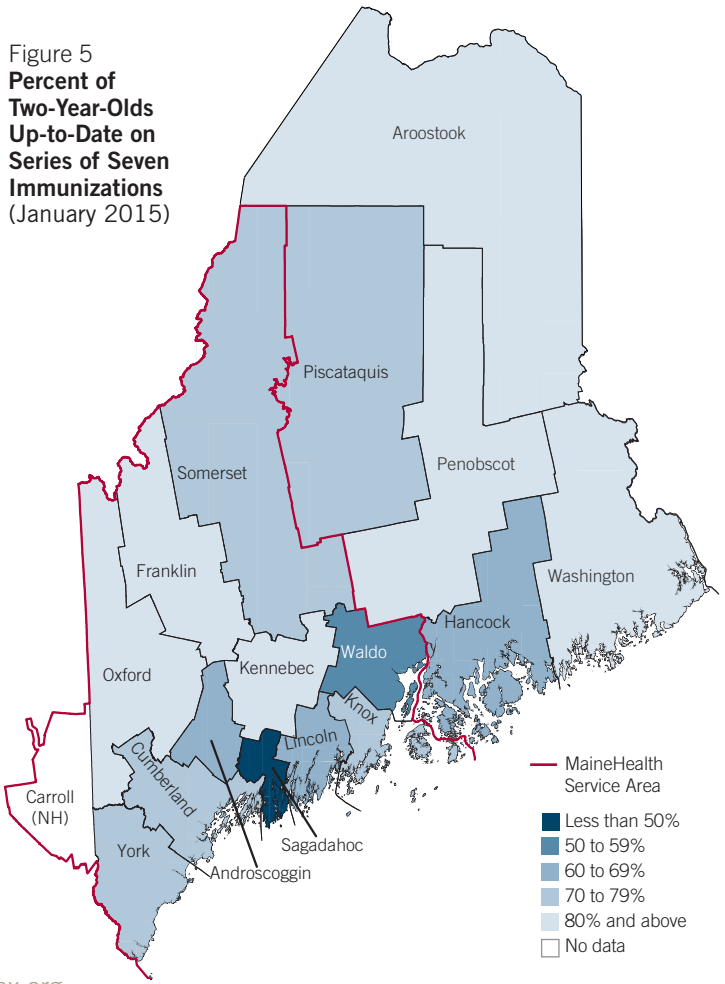
Percent Up-to-Date for Recommended Immunizations (2013) Figure 4

Vaccine	Estimated Percent Up-to-Date*	95% Confidence Interval*
19- to 35-month-olds		
4+ DTaP	88	82-94
3+ Polio	94	90-98
1+ MMR	91	87-96
HIB-FS	80	74-87
3+ HepB	85	79-90
1+ Var	91	86-95
4+ PCV	85	79-91
1+ HepA	80	74-86
Rotavirus	72**	65-79
13- to 17-year-olds		
1+ Td/Tdap	86**	81-90
1+ MCV	71	66-77
1+ HPV Female	60	51-69
1+ HPV Male	42	34-51

* Data is based on a sample of parents randomly selected to be interviewed. The values in the estimated percent of up-to-date column are the values for all children included in the sample. The confidence interval is a range of values that you can be 95% certain contains the true percent up-to-date for the total population.

** 2013 rate is significantly higher than the 2011 rate.

Figure 5
Percent of Two-Year-Olds Up-to-Date on Series of Seven Immunizations (January 2015)



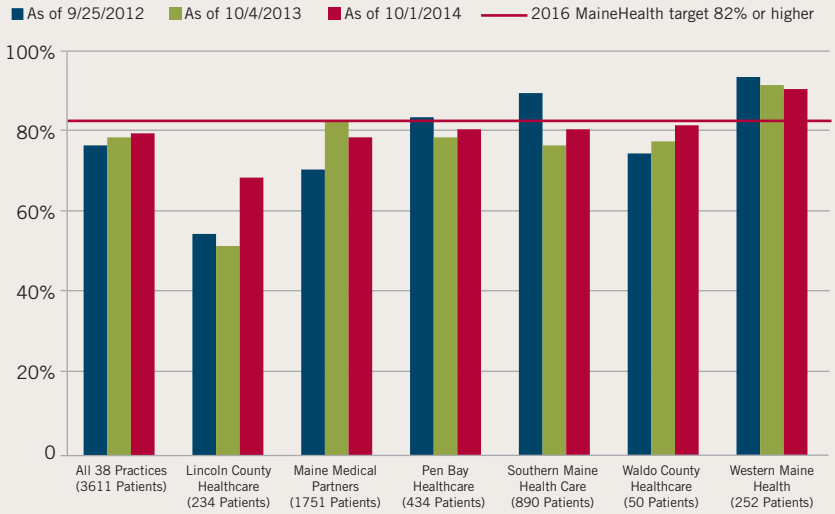
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Through the **First STEPS learning initiative,**[9] 20 pediatric and family medicine practices collaborated to increase child immunization rates. The up-to-date rate for 2-year-olds thorughout all 20 practices increased from 74% to 85% over 22 months.[10]

In January 2014, the Maine Center for Disease Control and Prevention, the Maine Office of Information Technology, and MaineHealth launched **Maine's first interface to transfer vaccination data directly from electronic medical records to ImmPact,** eliminating the need to manually enter data in both systems. MaineHealth sent 76,500 records in one year.[11]

Rates for 41 MaineHealth Practices: Percent of 19- to 35-Month-Olds Up-to-Date with Complete Series of Seven Immunizations[13] Figure 6



The 41 practices represented above are affiliated with MaineHealth member organizations. The first two rates for Southern Maine Health Care (as of 9/25/2012 and 10/4/2013) include data from five practices affiliated with SMHC's Medical Center in Biddeford. Data from practices affiliated with SMHC's Medical Center in Sanford were added into the 10/1/2014 rate. Data from practices affiliated with Franklin Community Health Network are not included in any of the rates presented.

MaineHealth's Childhood Immunizations Education and Training Program ensures clinical support staff are up to date on current evidence-based guidelines and competencies to vaccinate children safely and skilled to communicate with families about immunizations. In 2014 the program trained 126 clinical staff in 37 primary care practices; 97% of participants passed a comprehensive written test and a hands-on competency skills evaluation.[12]

COMMUNITY STRATEGIES

Developed by the Maine Immunization Coalition and the MH Childhood Immunizations Taskforce, the **Vax Maine Kids website and social media platforms** provide science-based information to families and the general public in clinical and community settings. In 2014:[14]

- The website had 7,730 new and returning visitors.
- Both Facebook likes and Twitter followers increased by 145%.

Kohl's Vax Kids,[15] a collaboration of the Barbara Bush Children's Hospital at Maine Medical Center and MH, targeted vaccine-hesitant parents in Cumberland and York counties. The community education media campaign was funded by Kohl's Cares; more than 22,000 people in 15 communities were reached.[14]

POLICY STRATEGIES

Through a partnership of private insurers, KidsVax and the Maine Vaccine Board, the **universal childhood vaccine purchasing program** saved Maine over $34 per child per year in 2013-2014. The state's total cost saving per year was over $4.21 million.[16]

GETTING TO THE NEXT LEVEL

CLINICAL

Implement a strategy to share local childhood immunization best practices across MaineHealth's service area.

COMMUNITY

Use the Vax Maine Kids website to increase awareness among Maine families about the importance of on-time childhood immunizations.

POLICY

Implement evidence-based policies that result in improved childhood immunization rates.

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.

Smoking rates among both Maine's adults and youth decreased significantly from 2011 to 2013.

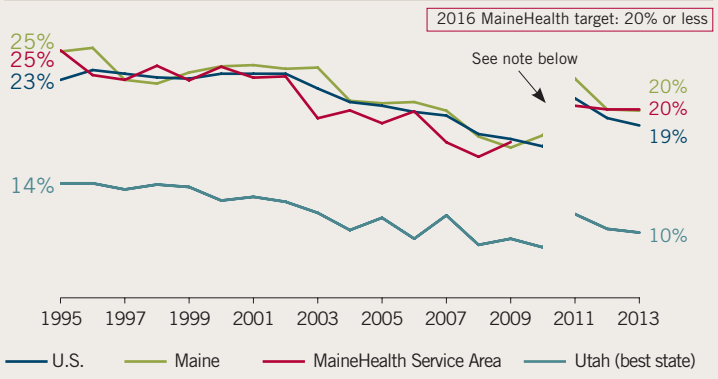
- While Maine's youth smoking rate in 1997 (39%) was one of the highest rates in the nation, rates have been below the national youth rates since 2001.[17] In 2013, Maine's youth smoking rate was 13%, statistically lower than Maine's rate in 2011 (15.5%).[18]
- The 2013 smoking rate among Maine's adults (20%) was statistically lower than the 2011 and 2000 rates (23% and 24%, respectively[19]) (Figure 7).

Recent adult smoking rates varied across socioeconomic groups, health status and county of residence[2] (Figures 8 and 9).

The majority (58%) of Maine's adults smokers made a serious attempt to quit in the 12 months prior to being interviewed (in 2011-2013). The percentages of adults trying to quit were similar across age, education and income groups. However, quit attempts were higher among smokers who had 3+ poor mental health days in the past month (63%).[2]

How Maine Compares to the U.S. Figure 7

Percent of Adults Who Smoke Daily or Some Days



Due to improvements in survey methods, the 2011, 2012 and 2013 estimates are considered more accurate than those made in previous years, particularly data from 2004-2010.[20]

Adult Smokers in Maine by Gender, Age, Income, Education and Poor Mental Health Days (2011-2013) Figure 8

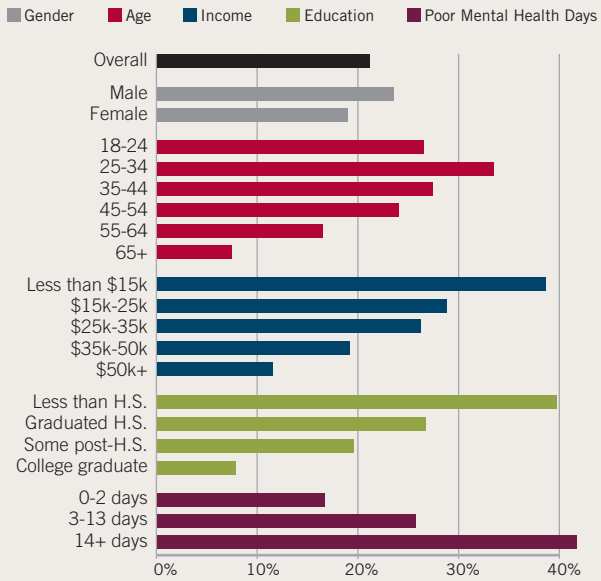
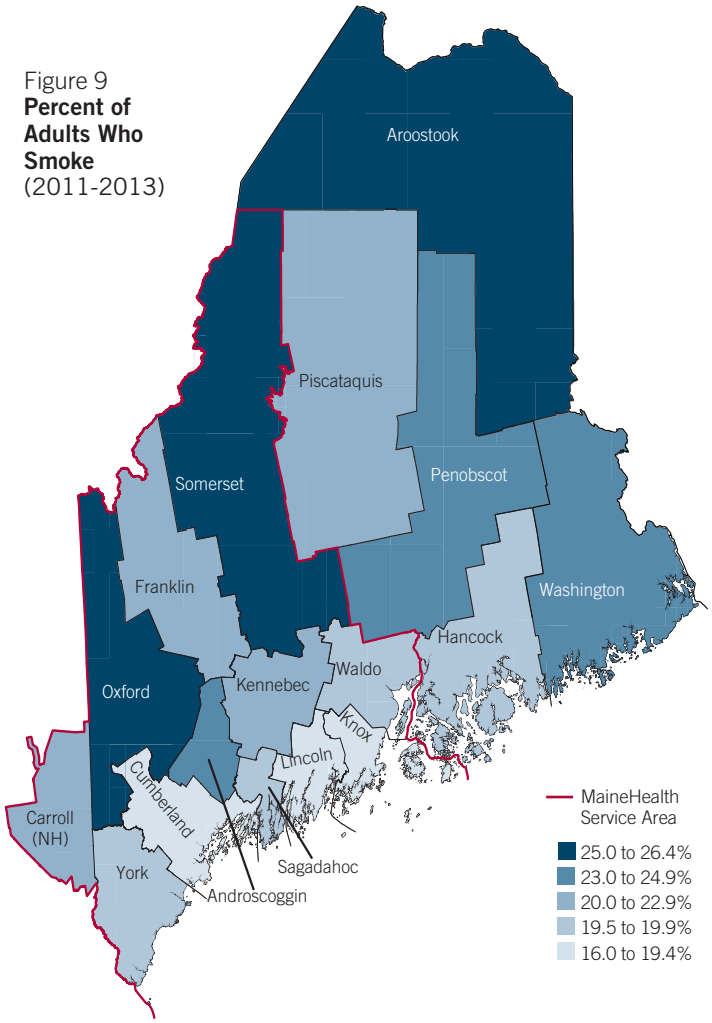


Figure 9
Percent of Adults Who Smoke
(2011-2013)



MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

From October 2013 through September 2014, **MaineHealth member hospitals provided counseling at bedside** to 4,542 inpatients with tobacco use. Of those counseled, 984 (22%) had a referral to the Maine Tobacco HelpLine.[21]

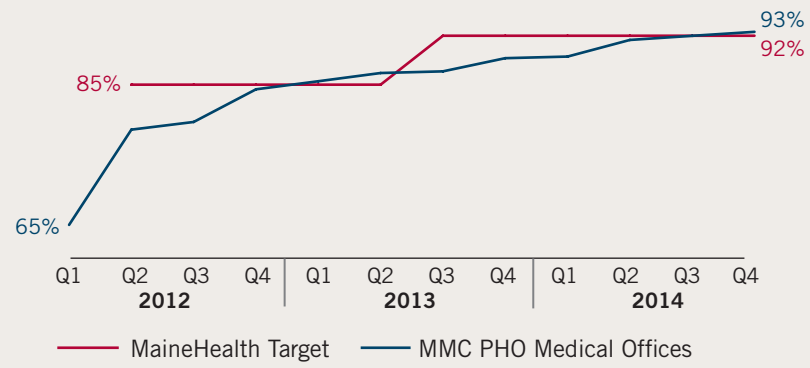
MMC Physician-Hospital Organization medical offices have steadily increased the percent of all adult patients (18+ years old) screened for tobacco use and, if identified as a tobacco user, provided cessation counseling[22] (Figure 10).

In 2012-2014, as part of the tobacco prevention and treatment programs funded by the **Partnership For A Tobacco-Free Maine,** the Center for Tobacco Independence worked with providers to increase referrals to the Maine Tobacco HelpLine (MTHL)[23] (Figure 11).

- Trainings that highlighted the benefits of referring patients were conducted in 441 health practices across the state.[24]
- MTHL collaborated with numerous healthcare systems statewide to implement electronic referral processes. Many systems send referrals directly from their electronic medical record (EMR); regular faxing is also used.
- Referrals from EPIC© EMR began in mid-February, 2014.

Patients Screened for Tobacco Use, and Counseled If Identified as a Tobacco User*
Rolling 12-month rates, ending in denoted quarter

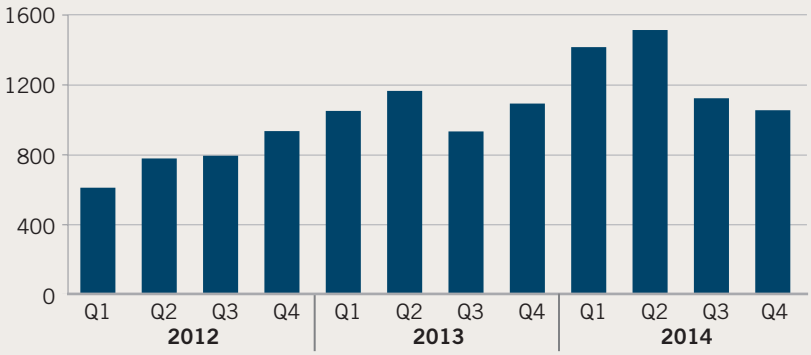
Figure 10



* Percent of all adults (18+-years old) with an office visit within the last 24 months who were screened at least once for tobacco use AND who received tobacco cessation counseling if identified as a tobacco user.

Referrals* to the Maine Tobacco HelpLine by Healthcare Providers Statewide

Figure 11



* Referrals include both messages sent directly from electronic medical record systems and faxes.

COMMUNITY STRATEGIES

Sidekicks,[25] an innovative tobacco risk reduction initiative for youth, was successfully pilot-tested in Lincoln County. Sixty-nine high school students were trained to have respectful, helpful conversations with their peers about tobacco use.[26]

POLICY STRATEGIES

The **Breathe Easy Coalition of Maine** administers two Gold Star Standards of Excellence programs to encourage Maine's hospitals and colleges/universities to implement tobacco-free policies.[27]

- In 2014, 31 of 38 Maine hospitals were recognized: 18 earned gold (met all 10 standards), 10 silver and 3 bronze.[28]
- All MaineHealth member hospitals received Gold or Silver recognition.[28]
- In 2014, 7 colleges/universities were recognized: 4 earned gold status, 4 silver and 1 bronze.[29]

GETTING TO THE NEXT LEVEL

CLINICAL

Increase use of performance feedback reports, including comparisons with other providers and practices, to improve care for tobacco dependence.

COMMUNITY

Maximize use of community-based programs to prevent youth from using tobacco products and to help those addicted to tobacco to quit.

POLICY

Implement evidence-based tobacco treatment processes and tobacco-free policies at all behavioral health organizations in Maine.

Decrease Obesity

MaineHealth remains focused on partnering with organizations to make clinical, policy and environmental changes that will help prevent children, youth and adults from becoming obese and treat those who are obese.

Recent trends of obesity in Maine are encouraging. Though the estimated percent of adults with obesity has increased slightly in 2011-2013, the amount of increase per year was smaller than the annual increases during 2002-2010[19] (Figure 12). Even more encouraging is that obesity rates among Maine's students in grades 5 and 9-12 have remained statistically steady from 2009-2013[18] (Figure 13). "Slowing the rise" of obesity rates is an intermediate point toward the ultimate goal of decreasing the prevalence of obesity.

Increasing healthy eating is a key strategy for decreasing obesity in Maine.

- In 2011-2013, the percent of Maine's adults who reported eating five or more fruits and vegetables per day varied across demographic groups and by self-reported poor health status[2] (Figure 14).
- The percent of Maine's students who reported eating five or more fruits and vegetables daily, and who reported drinking zero sugary beverages per day increased significantly from 2009 to 2013[18] (Figure 13).

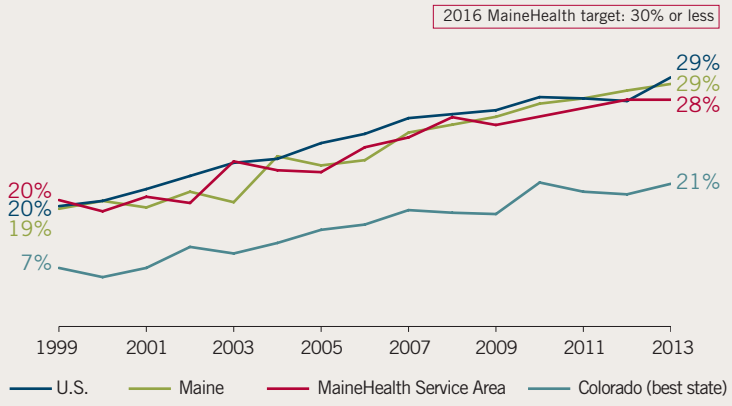
Obesity and Healthy Eating Among Maine Students Figure 13

	2009	2013
Obesity		
Grade 5	23%	22%
Grades 7 - 8	10%	14%*
Grades 9 - 12	12%	13%
Eat 5+ Fruits and Vegetables Daily		
Grade 5	28%	33%*
Grades 7 - 8	19%	19%
Grades 9 - 12	15%	17%*
Drink Zero Sugary Beverages Daily		
Grade 5	69%	78%*
Grades 7 - 8	69%	77%*
Grades 9 - 12	72%	74%*

* Percent in 2013 is significantly higher, statistically than the percent in 2009.

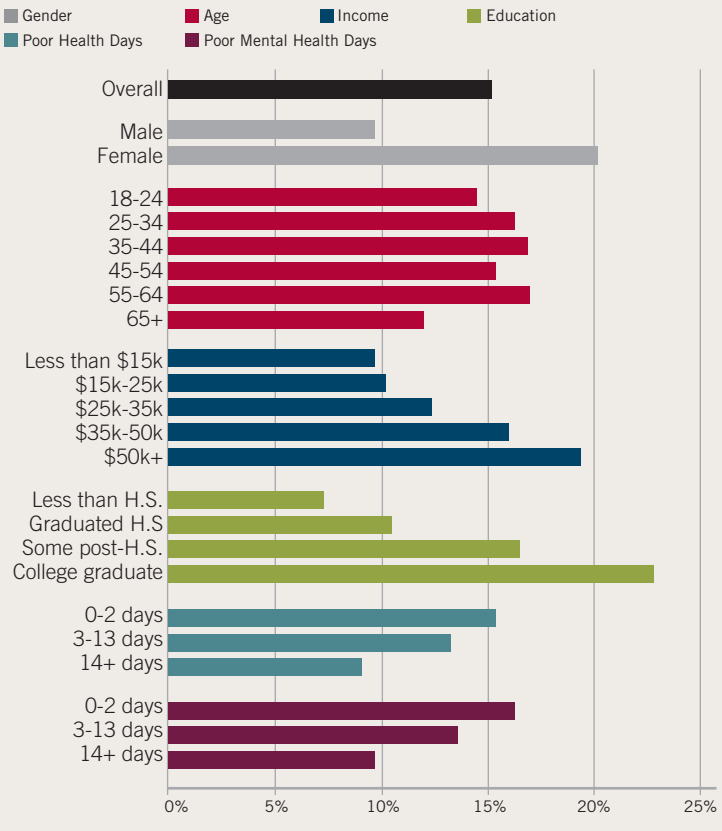
How Maine Compares to the U.S. Figure 12

Percent of Adults Who Are Obese — Body Mass Index ≥ 30



Adults Who Eat 5+ Fruits and Vegetables Per Day Figure 14

by Gender, Age, Income, Education, and Poor Mental and Physical Health Days (2011-2013)



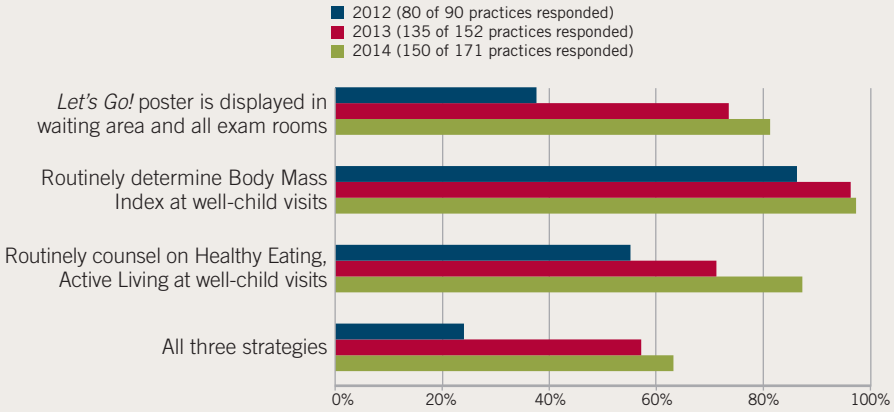
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

A Harvard Pilgrim Health Care Foundation grant helped *Let's Go!* Healthcare[30] **continue to expand** its reach in Maine, New Hampshire and Massachusetts.[31]

- **The number of participating** primary care providers increased to 725 in 2014.
- Pediatric patients totaled 349,881.
- **Figure 15 shows** the increase in percent of healthcare practices that implemented all three of the recommended *Let's Go!* strategies for healthcare settings.

Healthcare Practices Implementing *Let's Go!* Strategies Figure 15

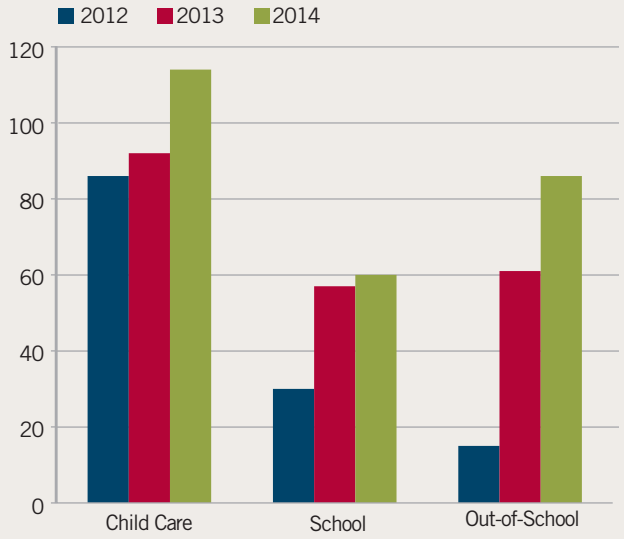


COMMUNITY STRATEGIES

Let's Go![32] **also expanded in schools, out-of-school and child care programs** (Figure 16).[31]

- All MaineHealth (MH) member hospitals[33] implementing *Let's Go!* programs met 100% of their annual targets in all sectors (child care, schools, out-of-school and healthcare).

Number of *Let's Go!* Sites Achieving Recognition Figure 16



The two-year HOMEtowns Partnership program[25] concluded in September 2014, having implemented evidence-based activities to promote healthy eating and physical activity that reached more than 300,000 people in seven rural counties in Maine.

- The work was funded by a $2.4 million Community Transformation Grant from the U.S. Centers for Disease Control and Prevention.
- The partnership's success was featured in a national study of 12 notable collaborations among hospitals, public health and community organizations. The study was funded by the Robert Wood Johnson Foundation and others.[34]

POLICY STRATEGIES

MaineHealth, *Let's Go!* and its partners, including the Maine Public Health Association, advocated for passage of a strong **Child Nutrition and WIC Reauthorization Act of 2015.**[35]

The Partnership for a Healthier America's Hospital Healthy Food Initiative (HHFI) continues to guide the work of 10 MH hospitals[36] as they create healthier cafeteria environments and more nutritious patient meals: increasing access to fruits, vegetables and healthier beverages, lowering the cost of healthy meals, labeling food with nutrition information, using healthier cooking techniques and making the healthy choice the easy choice.[37]

GETTING TO THE NEXT LEVEL

CLINICAL

Increase provider knowledge and adherence to recommended management and treatment guidelines for childhood obesity. Pilot an approach to address adult obesity in primary care practices.

COMMUNITY

Communicate and disseminate HOMEtowns Partnership activities and other successful programs via www.DiscoverTransformShare.org.

POLICY

Continue to increase access to healthy foods and beverages by strengthening partnerships with vendors and distributors. Expand the HHFI work to Memorial Hospital and Franklin Memorial Hospital.

Decrease Preventable Hospitalizations

MaineHealth remains focused on high-quality community-based primary care to manage chronic illnesses and improve care coordination as patients transition from one setting to another.

Ambulatory care-sensitive conditions (ACSC) are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.[38] About half of Maine's ACSC hospitalizations can be attributed to heart failure and chronic obstructive pulmonary disease/asthma.[39] Other conditions in the ACSC rates presented in Figures 17 and 18 include diabetes, hypertension (when it is the primary reason for the hospitalization), angina (when no procedure is completed), convulsions, bacterial pneumonia, kidney/urinary tract infection, gastroenteritis, cellulitis and dehydration.

Maine's rate of ACSC hospitalizations decreased more from 2011 to 2012 than in any other one-year period since 1999 (Figure 17).[40] ACSC rates were lowest in southern, central and mid-coast Maine counties (Figure 18).[41]

While not included in the ACSC rates, injuries due to falls are a major cause of hospitalizations that can often be prevented. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.[42] In 2011, falls among Maine residents age 65 and older resulted in 3,032 hospitalizations and 13,076 emergency department visits that did not end in a hospitalization.[43] Maine's rate of hospitalization for hip fracture was 5.7 per 1,000 Medicare beneficiaries. This rate was slightly lower than the national average of 6.2 per 1,000 beneficiaries.[44]

How Maine Compares to the U.S.

Figure 17

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

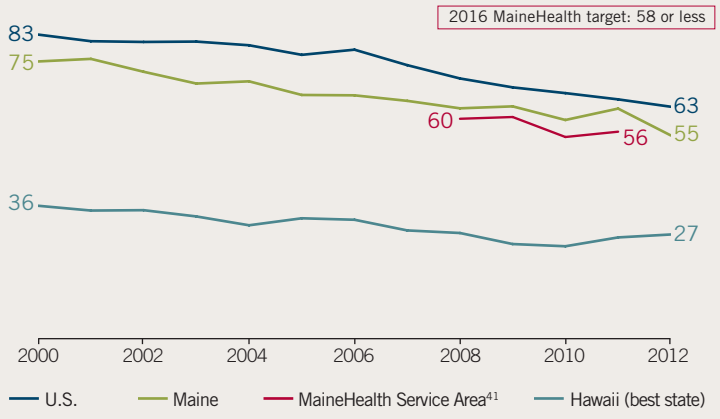
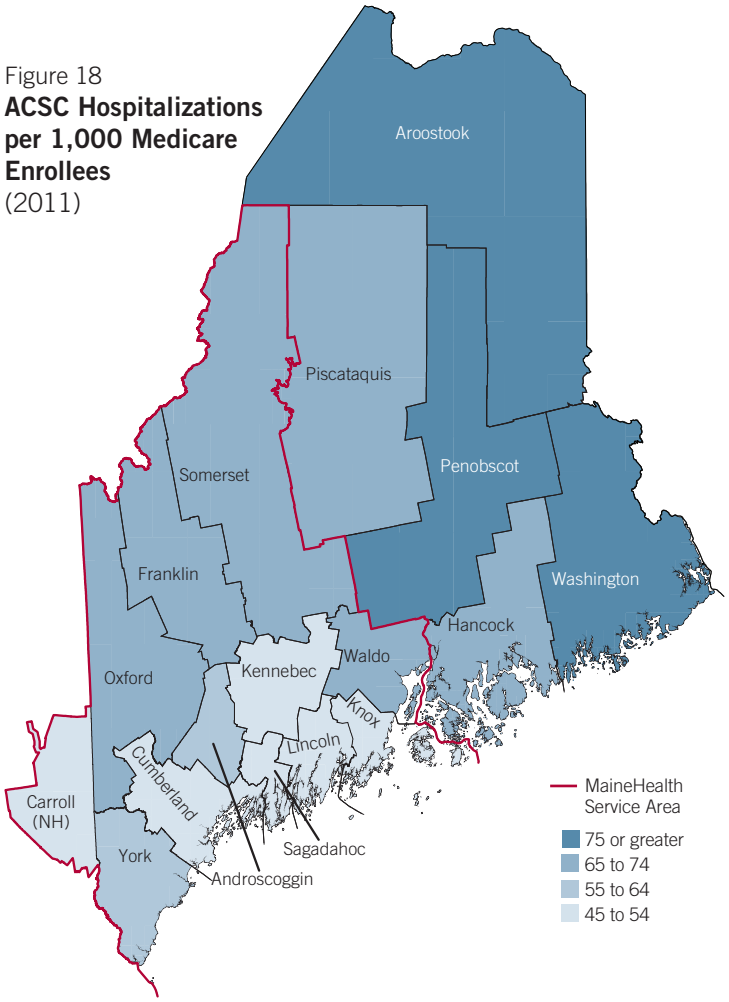


Figure 18
ACSC Hospitalizations per 1,000 Medicare Enrollees
(2011)



MAINEHEALTH AND PARTNERS RESPOND

CLINICAL AND COMMUNITY STRATEGIES

Preventing unnecessary hospitalizations requires close alignment and coordination of both clinical and community strategies to provide care that is evidence-based, provided by integrated care teams and patient- and family-centered. Examples of activities are listed below:

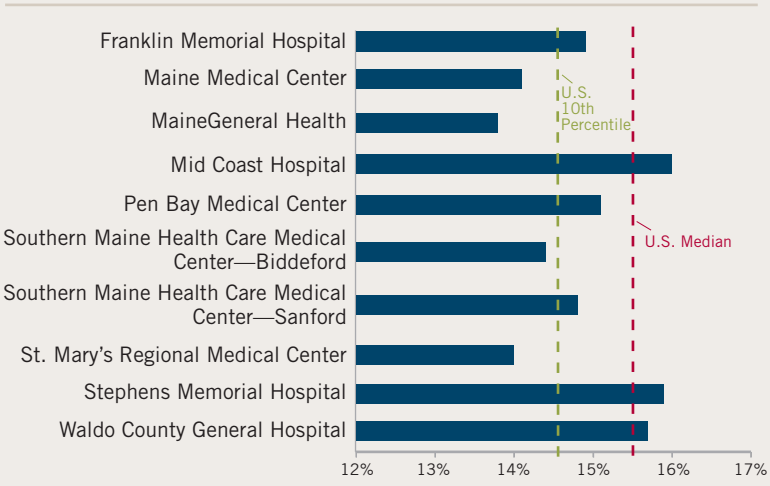
A MaineHealth strategic goal is that all 55 practices employed by MaineHealth members are eligible to attain the highest Patient Centered Medical Home[45] (PCMH) recognition by 2017. As of December 2014, 35 (64%) practices had attained this level.[46]

Within MaineHealth practices 79% of patients age 65 or older who had visited the office within the last year were screened for risk of falling. This was up from 25% screened in 2013.[47]

MaineHealth continued using its Home Diuretic Protocol (HDP) with heart failure (HF) patients who were receiving home health and telehealth monitoring services. This protocol empowers home health nurses to respond quickly to signs of worsening fluid retention using predetermined orders for treatment, often enabling patients to stay in their homes, where they want to be. Over the past two years, use of the HDP has resulted in a readmission rate of only 17%, compared to 21% among all HF patients across the MaineHealth system.[48]

Risk Standardized All-cause 30-Day Readmission Rates per 100 Admissions of Medicare Beneficiaries
July 2012-June 2013

Figure 19



NOTE: rates are not available for LincolnHealth because the sample size was too small.

MaineHealth hospitals continued efforts to reduce 30-day readmission rates.

- All MaineHealth hospitals strive to utilize the **Transitions of Care Bundle** for all patients being discharged. The Bundle includes addressing risk, medication reconciliation, timely communication between hospital and outpatient providers, a timely follow-up visit with the regular care provider, and patient education with Teach-back.[49]
- **Maine's Community-based Care Transitions Program (CCTP)**[50] provided clinical support and nonclinical resources to 2,971 patients discharged from four MH hospitals, from October 2013 through September 2014.[51] A description of CCTP (organizations involved and services provided) is provided in the endnotes section.[49]
- Seven MaineHealth hospitals had all-cause 30-day readmission rates,[52] adjusted to account for types and severity of illness, that were below the median rate for hospitals across the U.S.[53] (Figure 19). Four of these hospitals had rates that were below the 10th percentile.

POLICY STRATEGIES

Increasing patients' use of End-of-life planning and Advance Directives is a key priority for the MH system. To help achieve this objective, clinicians systemwide surpassed a goal of having 50% complete the "Critical Conversations: Engaging Patients in Advanced Care Planning" training by October 1, 2014. As of December 2014, 82% of over 2,200 physicians and mid-level providers, 89% of 2,900 nurses and 76% of 1,500 general clinical staff were trained.[54]

GETTING TO THE NEXT LEVEL

CLINICAL

Increase patients participation with healthcare teams, by helping them: engage in self-care, understand choices, help others, improve healthcare systems, and improve the community.

COMMUNITY

Ensure all long-term care facilities serving MaineHealth organizations are fully engaged in the quality improvement activities of the Senior Living Collaborative.

POLICY

Continue implementing the EPIC© electronic medical record system across MaineHealth care providers, to optimize care coordination.

Decrease Cardiovascular Deaths

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

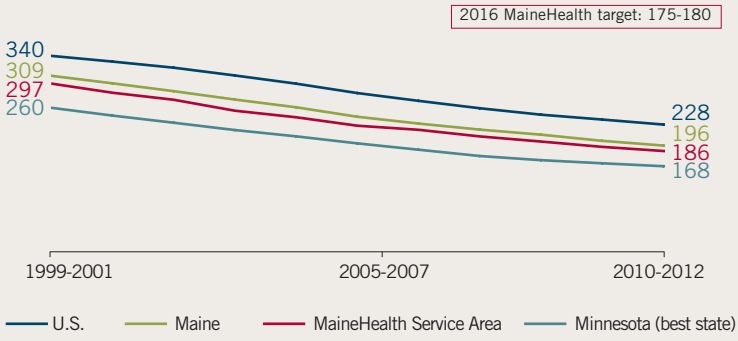
Maine's age-adjusted rates for deaths due to cardiovascular disease were consistently lower than the U.S. rates from 1999 to 2012. Likewise, the death rates in the MaineHealth Service Area were consistently lower than Maine's statewide rates (Figure 20). Examining change over time, the age-adjusted rates for the U.S., Maine and the MaineHealth Service Area decreased by similar levels from 1999 to 2012.[55]

Maine's death rates decreased for all categories of cardiovascular disease from 2000-2002 to 2010-2012 (Figure 21). The largest percent decreases were for heart attack and coronary heart disease. In 2010-2012, Maine's rates for overall cardiovascular death, as well as rates for heart disease, coronary heart disease and heart attack, were significantly lower than the U.S. rates.[55]

In 2010-2012, deaths due to heart attack varied widely across Maine. Counties in the 12-county service area had lower rates than counties in Northern and Eastern Maine[55] (Figure 22).

How Maine Compares to the U.S. Figure 20

Cardiovascular Death Rate: 3-Year Rolling Averages
Age-Adjusted Rates per 100,000 Population



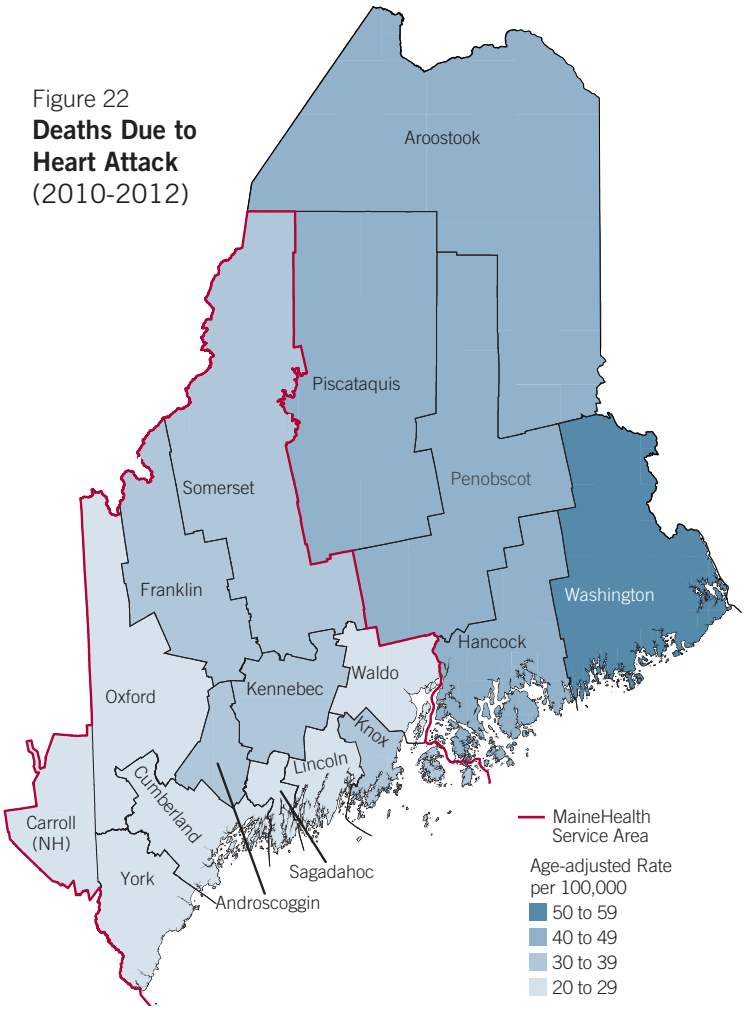
Cardiovascular Death Rates in Maine Figure 21

	2000-2002	2010-2012	Percent decrease
Cardiovascular Disease, Total	298	196*	34%
Heart Disease	222	149*	33%
Coronary Heart Disease	156	88*	44%
Heart Attack	57	31*	45%
Heart Failure	18	17	7%
Stroke	56	35	37%

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

* Maine rates are significantly lower than U.S. rates.

Figure 22
Deaths Due to Heart Attack
(2010-2012)



MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

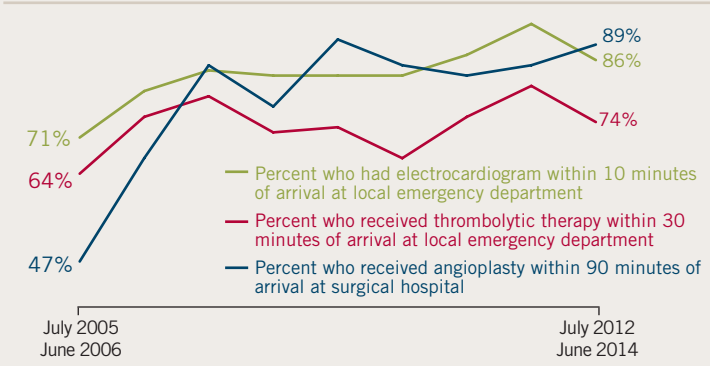
Million Hearts® [56] is a public-private initiative co-led by the U.S. Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services to prevent one million heart attacks and strokes by 2017. Strategies focus on empowering people to make healthy choices, and improving care for people with high blood pressure, high cholesterol and tobacco dependence. Examples of accomplishments by MaineHealth organizations in 2014:

- Trained 228 clinicians in evidence-based techniques for measuring blood pressure; over 1,000 clinicians have been trained since 2009.[57]
- Among the 33,207 patients with a diagnosis of hypertension who are cared for at practices in the MMC Physician-Hospital Organization, 65%[58] had blood pressure in control at the time of their last measurement; the Million Hearts® national target is 70% by 2017.[56]
- MaineHealth organizations began implementing changes to cholesterol care management processes, to align with revised guidelines that were released in November 2013 by the American College of Cardiology and the American Heart Association.[59]

Maine Medical Partners (MMP) implemented a blood pressure (BP) management program in all family and internal medicine practices from April to September 2014. MMP reached out to 2,100 patients who either did not have a BP reading in the past two years or had elevated BP levels. Of these, 900 got a BP screening and an additional 650 were treated for high BP.[60]

MaineHealth's AMI PERFUSE Network[61] continued efforts to increase the percent of patients having a heart attack who are provided evidence-based treatment within the nationally recommended time frames[62] (Figure 23).

Percent Patients* with Acute Myocardial Infarction Receiving Treatment within Recommended Timeframes**
(MaineHealth's AMI PERFUSE Network) Figure 23



* Data presented does not include patients with unavoidable circumstances that delayed treatment beyond the strived-for timeframe.

** Timeframes are set by American College of Cardiology and the American Hospital Association.

COMMUNITY STRATEGIES

The American Heart Association (AHA) partnered with WMTW to air "Heart Health 8," a television and online series that focuses on specific heart-related health topics each month and includes interviews with medical experts and local survivors of heart disease and stroke.[63]

In 2014, AHA trained over 1,000 people across Maine to use Hands-Only CPR — a simple two-step lifesaving technique.[63]

Oxford County Moves,[25] a community-based initiative of Oxford County Wellness Collaborative, Healthy Oxford Hills and Stephens Memorial Hospital, made it easier for residents to be physically active.[26]

- Mapped routes for walking, running and cycling, with input from over 240 residents and community stakeholders.
- Formed free indoor walking groups that meet weekly.

GETTING TO THE NEXT LEVEL

CLINICAL

Promote utilization of cardiac rehabilitation for patients with advanced heart failure, accessed through the new Medicare benefit.

COMMUNITY

Increase public awareness of the symptoms of heart attacks and strokes, and the fact that obtaining treatment quickly can improve outcomes.

POLICY

Engage employees in cardiovascular disease reduction with employee wellness programs.

Decrease Cancer Deaths

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.

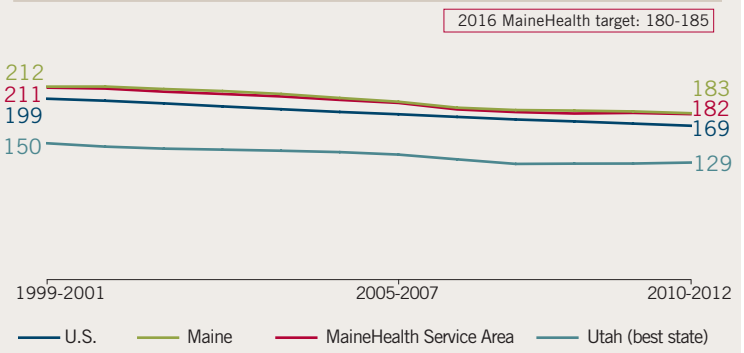
Although Maine's age-adjusted death rates for all malignant cancers combined have decreased over time (Figure 24), the state's rates remain higher than national rates.[55] These higher rates are primarily due to Maine's historically high prevalence of tobacco use. Cancers that scientific studies have proven can be caused by tobacco use are listed in a footnote of Figure 25. Examining 2011 cancer data (the most recent available), Maine's incidence and death rates for tobacco-related cancers were significantly higher than national rates (Figure 25).[64] In 2011, 50% of all cancer deaths in Maine were linked to tobacco use.[64]

For many of the cancers where tobacco use is a risk factor, the 5-year survival rates are very low (e.g. less than 20% for lung/bronchus and esophagus cancers). Lung/bronchus cancer is the leading cause of cancer death for both men and women — in Maine and the U.S.[65] The best long-term strategy for reducing these deaths is to eradicate tobacco use. Improvements in screening and treatment have resulted in improved outcomes for those diagnosed with these cancers.

How Maine Compares to the U.S.

Figure 24

Cancer Death Rates: 3-Year Rolling Averages
Age-Adjusted Rates per 100,000 Population



Maine Cancer Incidence and Death Rates

Figure 25

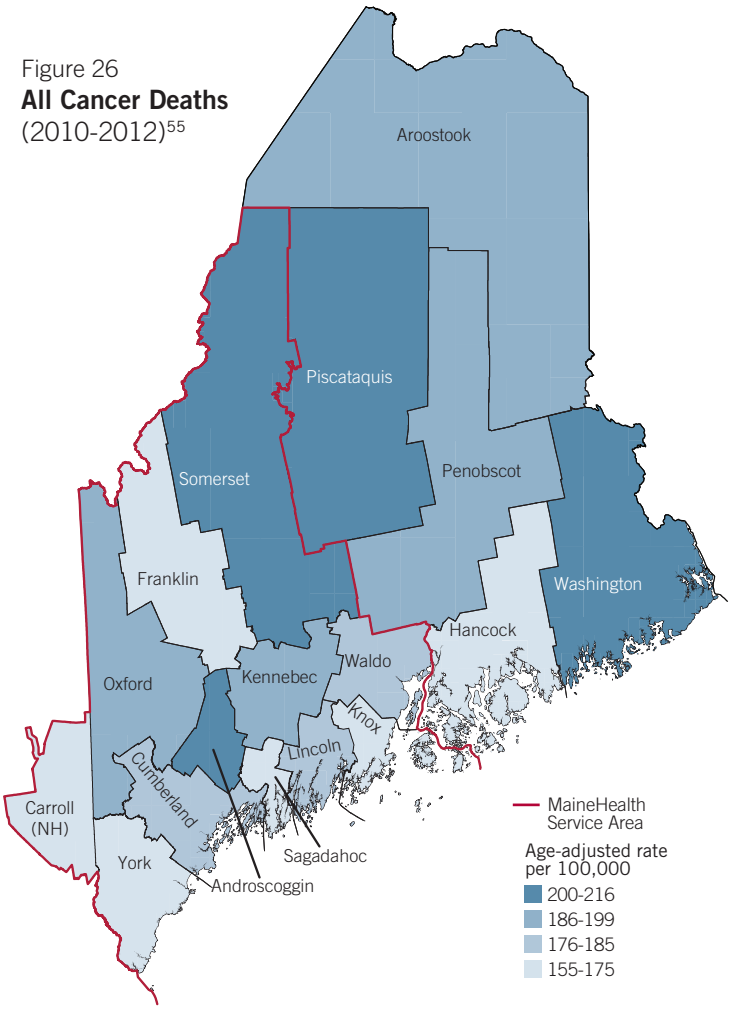
	Incidence Rates		Death Rates	
	2006	2011	2006	2011
All malignant cancers	536*	478*	194*	182*
Lung and bronchus	80*	69*	62*	52*
Other tobacco-related	95*	93*	38	38*
Esophagus	7*	6*	6*	6*
Urinary bladder	30*	30*	6*	6*
Colon and Rectum	50*	39	17	15
Prostate	171*	115**	24	20
Breast (female only)	128	127	21	17
Cervix Uteri	6	7	2	***

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

* Maine rate is significantly higher than the rate among U.S. Whites.
** Maine rate is significantly lower than the rate among U.S. Whites.
*** Rates and counts are suppressed due to fewer than 10 cases within time period.

Tobacco-related cancers include: lung and bronchus, laryngeal, oropharyngeai, esophageal, stomach, pancreatic, kidney and renal pelvis, urinary bladder, cervical cancers, and acute myeloid leukemia.

Figure 26
All Cancer Deaths
(2010-2012)[55]



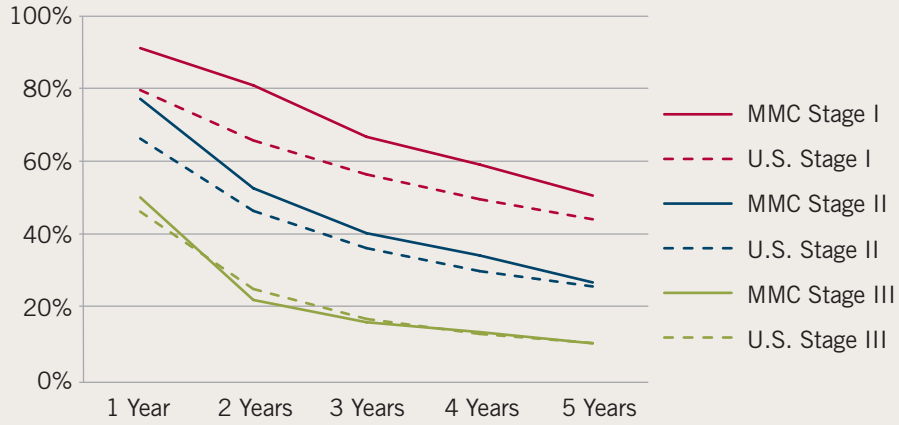
MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Regional cancer plan developed. MaineHealth members, affiliates and partners completed a regional strategic plan to develop an integrated, patient-centered and subspecialized model for cancer care across the system.[66]

Survival rates for patients treated for early-stage lung cancer at the Maine Medical Center (MMC) Cancer Institute are higher than U.S. benchmarks[67] (Figure 27).

Observed Survival for Lung Cancer Cases Diagnosed in 2003-2006
Maine Medical Center (MMC) vs. 1489 Facilities Across U.S. Figure 27



Feasibility of the Comprehensive Lung Cancer Screening Program Piloted.[66]

- The MMC Cancer Institute, Chest Medicine Associates, Spectrum Medical Group, and the MMC Center for Outcomes Research and Evaluation piloted a screening program in FY2014 through funding from the Maine Cancer Foundation (MCF). The program is based on screening guidelines that the U.S. Preventive Services Task Force adopted in December 2013, and includes shared decision-making counseling by a physician, to ensure that patients understand the risks and benefits of a computed tomography (CT) scan to screen for lung cancer.
- Based on early success, the program is continuing in FY2015, with additional funding from the MCF.

Expanded Access to Cancer Genetics Services through Telemedicine.[66]

- Through a grant from the MCF, the MMC Cancer Risk and Prevention program and MaineGeneral Medical Center implemented a second telemedicine site in July 2014. The MCF also funded implementation of the first telemedicine site with Waldo County Hospital in 2012.
- From January-December 2014, 58 patients received telegenetic services at the Waldo and MaineGeneral sites.

COMMUNITY STRATEGIES

Launched in January 2011, the **MaineHealth Cancer Resource web portal, www.mainehealthcancer.org,** continued to provide people throughout Maine access to up-to-date educational information about cancers, as well as information about events that are taking place across the state. There were nearly 170,000 visits to the site from January 2013 to December 2014.[68]

POLICY STRATEGIES

In 2014, the Maine legislature passed a law requiring health insurance policies that cover chemotherapy to include coverage for orally administered anticancer medications equivalent to the coverage for chemotherapy administered intravenously or injected. In addition to being more cost-effective than IV or injected chemotherapy, patients can self-administer oral medications at home.[69]

GETTING TO THE NEXT LEVEL

CLINICAL

Implement all components of the new MaineHealth Oncology Plan, including tumor-specific care guidelines.

COMMUNITY

Increase public awareness that lung cancer is the leading cause of cancer death for both men and women, and about screening choices.

POLICY

Finalize Maine's Comprehensive Cancer Control Plan for 2015-2020, and then implement components.

Decrease Prescription Drug Abuse and Addiction

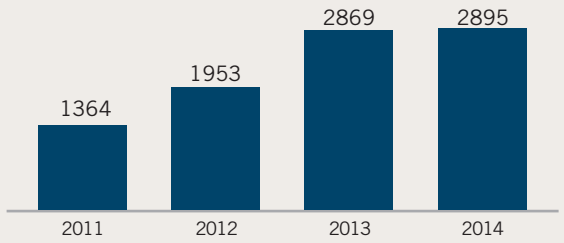
Prescription drug abuse and addiction continue to be major health problems in Maine and the nation.

Since 2000 the number of deaths related to drug overdose has doubled — both nationally and in Maine — surpassing that of motor vehicle accidents. In 2013, there were 142 deaths attributed to motor vehicle accidents and 157 to drug overdose in Maine (Figure 31).[70]

In 2006, when Maine began tracking the number of drug-affected babies, there were 200 reports statewide, 1.4% of all births. By 2014, the number of reports was almost 1,000, or about 8% of total births. There is substantial variation across Maine, ranging from 3% in Franklin and Sagadahoc counties to 16% in Penobscot County.[71]

The number of Emergency Medical Services (EMS) calls related to drug and medication overdose plateaued between 2013 and 2014. Of the almost 3,000 calls related to overdose, EMS administered naloxone, a drug that blocks opiate receptors and therefore prevents overdose, to 829 patients.[72]

Emergency Medical Service (EMS) Drug and Medication Overdose Calls Figure 29



Maine's Prescription Monitoring Program (PMP) was created to detect and prevent prescription drug misuse and diversion. In 2014, enrollment in the PMP became mandatory for prescribers of controlled substances. The "days supply"[73] of a medication is defined as the number of days a prescription will last if taken as prescribed and enables comparison between medications of varying strengths and doses.

Statewide, Kennebec and Somerset counties had the highest per person days supply of opiates in 2014. Cumberland, Franklin and Sagadahoc counties had the lowest rates[74] (Figure 30).

How Maine Compares to the U.S. Figure 28

Deaths Due to Drug Overdose: Age-Adjusted Rates of Deaths per 100,000[55]

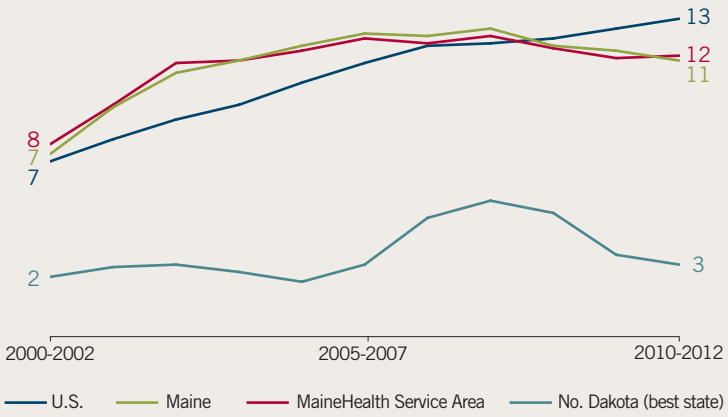
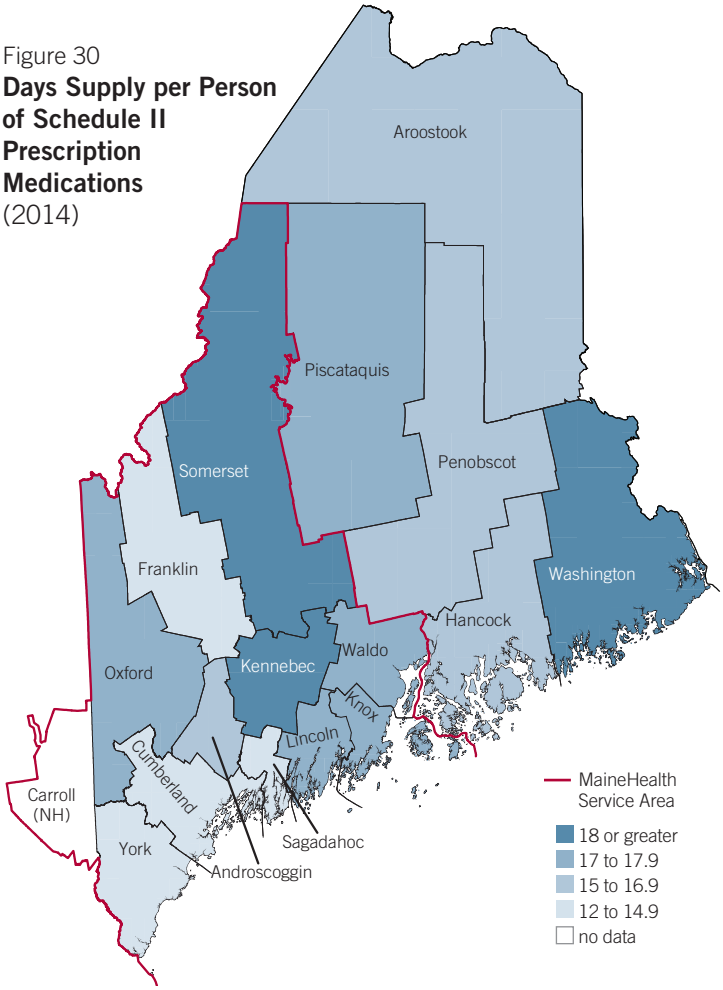


Figure 30
Days Supply per Person of Schedule II Prescription Medications
(2014)



MAINEHEALTH AND PARTNERS RESPOND

CLINICAL STRATEGIES

Maine Medical Partners implemented guidelines for opioid prescribing for chronic pain. These guidelines incorporate use of the Prescription Monitoring Program, assessment of substance abuse risk, ceiling dose amount, behavioral health referrals and it details diagnoses for which the medical literature does not suggest a benefit from opioids.[75]

Quality Counts, an independent, multi-stakeholder regional healthcare collaborative dedicated to transforming healthcare in Maine, established a group in 2014 to address the issue of chronic pain. The Maine Chronic Pain Collaborative seeks to improve patient-provider partnerships, improve the capacity of primary care practice teams, and increase their confidence and competence in dealing with chronic pain.[76]

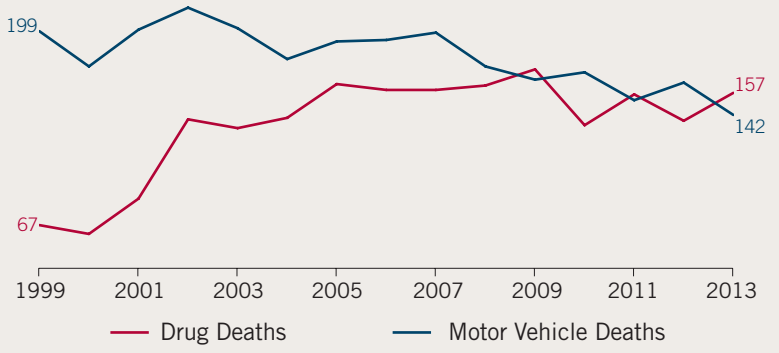
Maine Medical Center held its second conference presenting transdisciplinary approaches for caring for drug-affected mother and baby dyads to more than 100 health professionals. Topics included treatment of neonatal abstinence syndrome, intrapartum and postpartum pain management, and caring for babies experiencing withdrawal.[77]

COMMUNITY STRATEGIES

Secure, Monitor and Dispose of Medications.

- A recent statewide collection in Maine amassed over 19,000 pounds of medications, the largest amount gathered during any fall collection. This brought the total for nine Maine collections to over 150,000 pounds.[78]
- Disposing of unused medications reduces the chance of drug diversion. In a 2013 survey, 12% of high school students reported taking a prescription medication without a prescription.[18]
- In 2015, the Kennebec County Sherriff's Office was the first law enforcement agency in Maine trained to carry naloxone, also known as Narcan, to prevent overdose.[79]

Drug and Motor Vehicle Deaths in Maine, 1999-2013 Figure 31



POLICY STRATEGIES

As part of an overall **Harm Reduction Program,** MaineGeneral Health, an affiliate of MaineHealth, implemented the state's first large-scale program to provide Emergency Opiate Overdose Kits (EOOK) to at-risk patients and family members. In a 4-month period in 2014, over 500 EOOKs were distributed. In addition to providing education to kit recipients, MaineGeneral conducted community-based seminars in Augusta and Waterville.[80]

GETTING TO THE NEXT LEVEL

CLINICAL

Expand Prescription Monitoring Program to:

- Include morphine equivalent for prescriptions.
- Integrate data with existing Electronic Medical Records.
- Increase data interoperability with other states.

COMMUNITY

- Educate public on risk factors for overdose.
- Continue to expand use of naloxone by law enforcement and first responders.

POLICY

- Support continued dissemination of Guidelines for Opioid Prescribing for Chronic Pain and systemwide training on pain management strategies.
- Support development and expansion of drug disposal options in Maine.
- Expand distribution and implementation of EOOK toolkit by other health systems in Maine.

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5. PolicyLink is a national research and action organization institute advancing economic and social equity by Lifting Up What Works®. Details about PolicyLink can be found at their website www.policylink.org.
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    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 organizations conducting phone surveys, faces increasing difficulty reaching those who screen all calls. UnitedHealth Foundation. America's Health Rankings® – 2012 Edition, p. 29.
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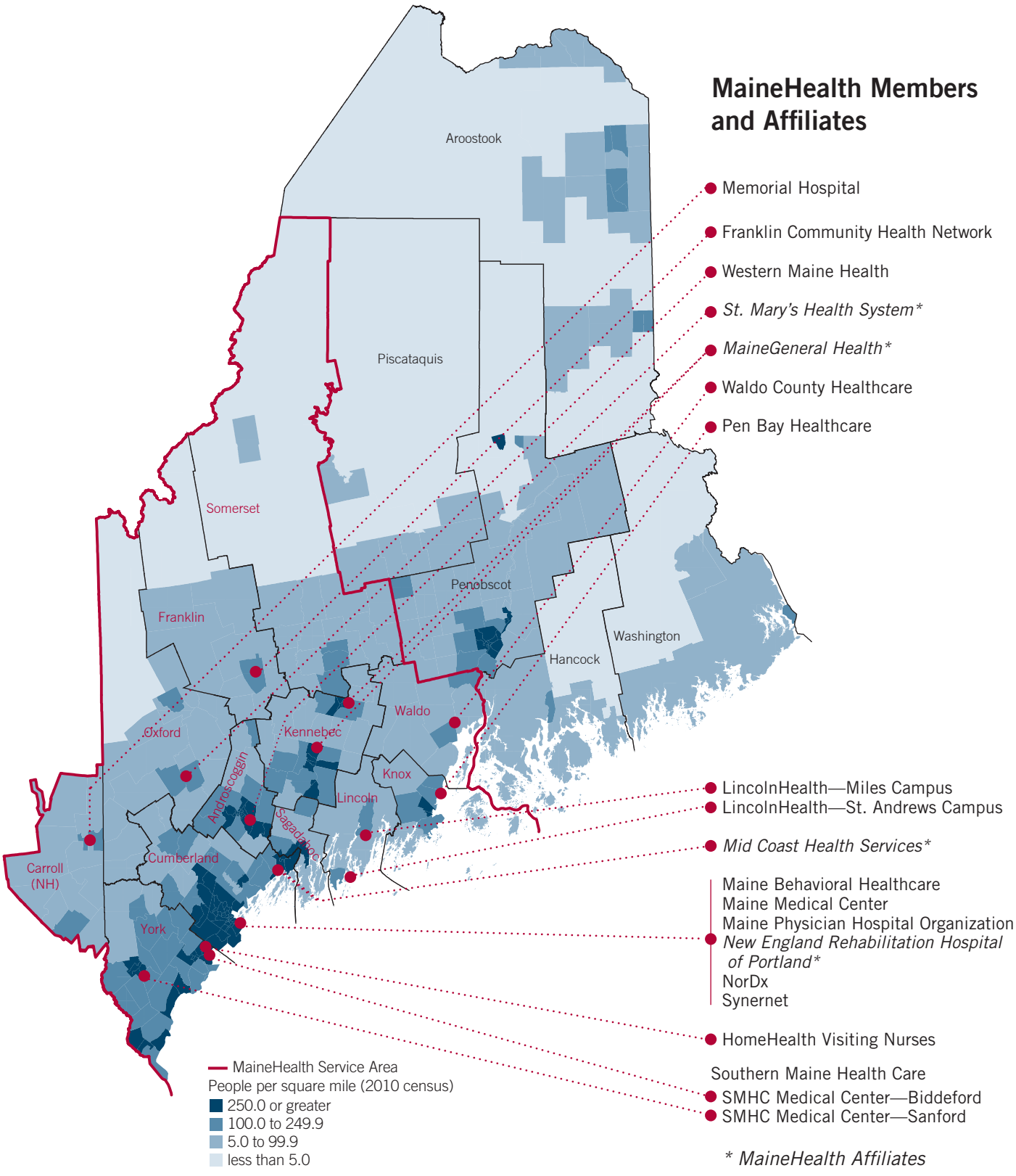
MaineHealth Service Area

Just over 1 million people live in the 12 counties that constitute the MaineHealth Service Area.



MaineHealth Members and Affiliates

- Memorial Hospital
- Franklin Community Health Network
- Western Maine Health
- *St. Mary's Health System**
- *MaineGeneral Health**
- Waldo County Healthcare
- Pen Bay Healthcare
- LincolnHealth—Miles Campus
- LincolnHealth—St. Andrews Campus
- *Mid Coast Health Services**
- Maine Behavioral Healthcare
  Maine Medical Center
  Maine Physician Hospital Organization
  *New England Rehabilitation Hospital of Portland**
  NorDx
  Synernet
- HomeHealth Visiting Nurses

Southern Maine Health Care

- SMHC Medical Center—Biddeford
- SMHC Medical Center—Sanford

** MaineHealth Affiliates*

Franklin Community Health Network

LincolnHealth

Maine Medical Center

Maine Behavioral Healthcare

Memorial Hospital

Pen Bay Healthcare

Southern Maine Health Care

Waldo County Healthcare

Western Maine Health

HomeHealth Visiting Nurses

Maine Physician Hospital Organization

NorDx

Synernet

MaineHealth

110 Free Street, Portland, ME 04101
www.mainehealth.org

Executive Department
Julie Sullivan, Acting Chief of Staff

M E M O R A N D U M

TO: Public Safety, Health & Human Services Committee, City Council
FROM: Julie Sullivan, Acting Chief of Staff
DATE: June 9, 2015
RE: Fire/Code Task Force Recommendations/Proposed Housing Safety Office

I am pleased to present for your consideration and action the following Staff recommendations and responses regarding the Fire/Code Task Force's proposed Housing Safety Office.

Former Acting City Manager Sheila Hill-Christian convened the Task Force in November 2014 following the tragic Noyes Street fire. The Task Force was charged *"…to recommend improvements to better ensure the safety of the city's rental housing stock."* The Task Force presented recommendations to this Committee in February 2015 and returned to the Committee in March to answer questions posed by the Committee. Since then, Staff have been researching and gathering additional data to provide greater insight into the implementation questions Councilors have had regarding the Task Force's recommendations.

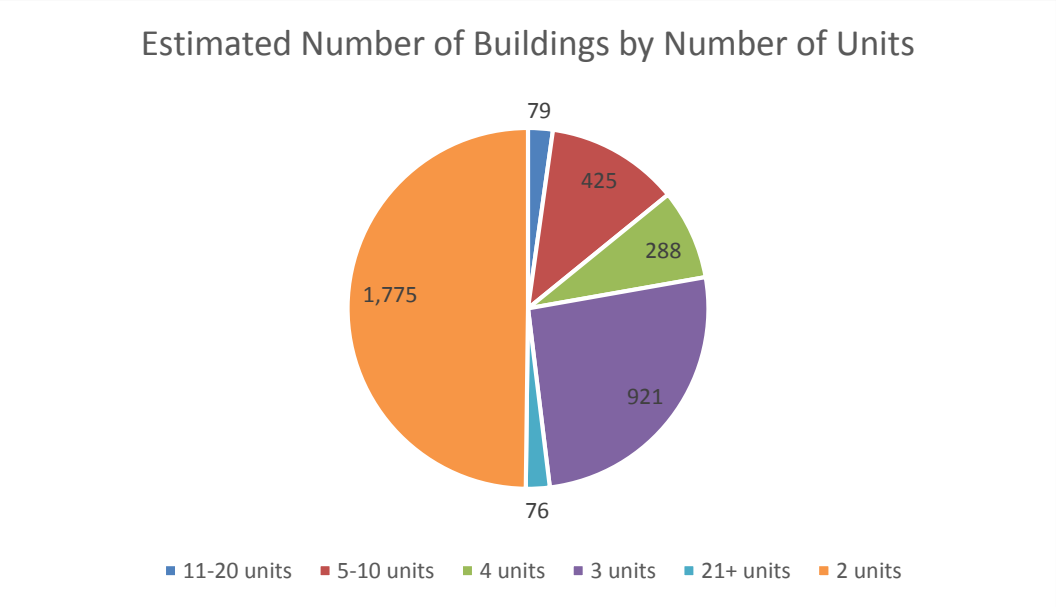
To that end, this table details Staff recommendations, responses to outstanding questions, an action plan and timeline including points of communication with the Committee.

Area	General Issue(s)	Staff Recommendation	Time Frame
Ordinance changes	Authority	Add to Chs. 6 and 10; please see Attachment A.	June 9 PSHHS meeting
	Landlord registration – fee, possible discounts, required data, fine schedule	Add to Ch. 6 (please see Att. A)	June 9 PSHHS
		Housing Safety Officer (*please note – not hired until 9/1 or later*) will develop specific criteria for discounted fees	Present proposed discount schedule to PSHHS Nov. 10
	Definition of rental unit – condos, single-family, Air BnB	Add to Ch. 6 (please see Att. A)	June 9 PSHHS
	Tenant accountability, especially re disabling smoke alarms	We currently have the statutory authority to hold tenants accountable and the Housing Safety Office will assign responsibility based on what they find during inspections.	HSO to develop operating policies and procedures for City Manager approval by November.

Area	General Issue(s)	Staff Recommendation	Time Frame
	Other – add "knowingly" re provision of false information; not require list of every member with ownership interest	Change made (Att. A); ability to utilize a registered agent for multi-owner properties: §6-152(a)(3) already provides that for multi-owner properties, all names must be listed, but only one must provide contact information; §6-152(a)(5) provides for designation of a registered agent.	June 9 PSHHS
	Allowing the Fire Department to inspect one- and two-unit buildings as well as three-plus	Change made (Att. A)	June 9 PSHHS
Organization	Should the Housing Safety Office report to the City Manager's Office; report to the Planning & Urban Development Department Head; or be part of a new, combined Inspections Department	Staff recommends allowing this important, new endeavor to incubate during its first year without tying it to a significant and complex restructuring, or adding it to an already overburdened department. Thus, Staff recommends that the Committee uphold the Task Force's intention that the Housing Safety Office report to the City Manager's Office.	June 9 PSHHS
		Staff suggests that the Housing Safety Officer and the Planning & Urban Development Director engage in a thoughtful, collaborative process to evaluate inspections functions and recommend possible restructuring, also considering any other restructuring initiatives put forth by the new City Manager.	January 2016
	Performance standards, evaluation, frequency of inspections, roles of Fire companies and Fire Prevention, flow charts and decision trees	The Housing Safety Office should use their experience and expertise to research, define and propose specific performance standards, policies and procedures, and a rigorous annual evaluation of the program. The HSO will collaborate with the Fire Department to create and set measurable goals.	Ongoing; to City Manager with regular updates to PSHHS
	Other organizational and functional questions regarding	Please see Attachment B	

Area	General Issue(s)	Staff Recommendation	Time Frame
	Fire and Inspections		

The pie chart below is in response to a Councilor question regarding the number and type of rental housing units. Please note that this data is at best an estimate; it is one of the reasons the Task Force emphasized the landlord registration, so that the City can have accurate data regarding the number of type of rental housing.



In response to questions regarding who does what (please also see Attachment B):

- Fire Dept Line Companies proactively inspect buildings with a basic Life Safety review.
- Fire Prevention responds to life safety-related complaints.
- Inspections Division responds to housing complaints.
- Proposed Housing Safety Office will begin with risk-based prioritization of all rental housing and work toward a regular, proactive inspection cycle. Complaints regarding housing safety will go to this office once it is fully staffed.

ATTACHMENT A

In order to carry out the Task Force's recommendations and the Council's goal of increased and more effective housing inspections, Staff recommends two sets of Ordinance changes.

The first set of Ordinance changes will accommodate the existence of a Housing Safety Office and provide officials in that office the authority to do inspections under both the Housing Code, in Chapter 6 and the Life Safety and Fire Codes in Chapter 10. This authority will not replace the authority of the Building Authority or the Fire Department to do inspections, but be supplemental to it.

Specifically:

- Chapter 6 will be amended in several places to add "or a housing safety official authorized by the City Manager" to the building authority as officials entitled to do inspections and enforce Chapter 6;
- Chapter 10 would also require that "or a housing safety official authorized by the City Manager" to the "authority having jurisdiction" section of Chapter 10 again to permit that official to do inspections and enforce Chapter 10;
- Given that the official would be cross-trained and expected to enforce provisions of the Life Safety Code to all rental units, § 10-3 will be amended to apply the Life Safety Code to all rental units.

The second set of Ordinance changes will substantially augment the presently existing but not enforced Registration Ordinance. It will be administered by the Housing Safety Office and will provide an effective means of acquiring an accurate census of rental properties in the City, provide information that will make enforcement of the housing and life safety codes more efficient, and through rental fees will help defray the cost of adding the Housing Safety Office.

Specifically, the Staff's recommended amendments:

- Establish a definition of *rental unit* which encompasses all rented portions of residential structures rented for any period of time;
- Require that the owner or owners of buildings with 1 or more rental units register their ownership interest, address, telephone number, e-mail address, as well as information regarding their property manager by January 1, 2016. For multiple ownership situations, only one owner is required to provide this information. And in all circumstances a registered agent shall be designated for service of process;
- Establish a $35 annual fee for registration and obligation for owners to update their information annually;
- Provide that the City Manager or designee shall promulgate regulations providing for discounts to the $35 fee for those situations where such practices as alternative inspections or certain lease conditions mitigate public safety risks and the costs to the City;
- Provide a $100 per day fine for failure to register, renew or pay the per unit fee;
- Provide a $1000 fine for knowingly providing false information;

Finally, staff has considered issues expressed by landlords with the provision of insurance information and is recommending that, instead of requiring such information of all owners, only owners in violation of either Chapter 6 or Chapter 10 be required to provide their insurance information.

ATTACHMENT A

ARTICLE VI. DISCLOSURE OF BUILDING OWNERSHIP

Sec. 6-150. Purpose.

The proliferation of real estate proprietorships, partnerships, and trusts having undisclosed, anonymous or otherwise unidentifiable principals, owning large numbers of multiunit residential properties, sometimes managed through unresponsive property management companies, has impeded the proper enforcement of this chapter, chapter 12 and other ordinances of the city. This article is intended to require the disclosure of the ownership of such property and to make owners and persons responsible for the maintenance of property more accessible and accountable with respect to the premises.
(Ord. No. 443-89, 6-7-89; Ord. No. 53-89, 7-17-89)

Sec. 6-151. Registration required.

(a) For purposes of this Article, a *rental unit* is a portion of any residential structure that is rented or available for rent to any individual or individuals for any length of time. A Single-Family Home, Condominium, or Apartment that is occupied by the owner or owners, and of which no portion is rented or available for rent, is not a *rental unit*. Any portion of a Single-Family Home, Condominium, or Apartment that is rented to or available to be rented to an individual or individuals who are not the owner or owners is a rental unit. *Dwelling units* and *rooming units* as defined in § 6-106 are, without limitation, *rental units*.

(b) ~~(a)~~ *Registration of ownership.* The owner or owners of all buildings containing one (1) or more rental units ~~three (3) or more dwelling units, rooming units, or any combination thereof within the city~~ shall register their ownership interest, address, ~~and~~ telephone number, e-mail address, ~~and the~~ as well as the name, address and telephone number of the person or entity responsible for managing the property~~, or cause such interest to be registered,~~ with a housing safety official designated by the City Manager~~the building~~

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~~authority~~ as provided in section 6-152 ~~by October 1, 2015~~by January 1, 2016~~within ninety (90) days of the effective date of this article~~ or within thirty (30) days of purchase of the property and/or building, whichever occurs later.

(c) *Fee for registration.* The owner or owners shall pay to a housing safety official designated by the City Manager a fee of $35 per rental unit at the time of registration. Failure to pay this fee by ~~October 1, 2015~~January 1, 2016 shall constitute a violation pursuant to section 6-153.

(d) *Annual Renewal and Fee.* The owner or owners shall renew their registration annually by updating the information provided in their initial registration and by payment to a housing safety official designated by the City Manager of a fee of $35 per rental unit. Failure to update information or pay the annual renewal fee by ~~October~~January 1 shall constitute a violation pursuant to section 6-153.

(e) *Discounts.* The City Manager or his or her designee shall promulgate and administer regulations to provide discounted registration and renewal fees based on and corresponding to the public safety risks and financial costs mitigated by such practices as alternative inspections and lease conditions.

~~The registration required hereunder shall be updated or withdrawn within thirty (30) days of transfer of ownership, change in management or change in registered agent as provided in section 6-152. Each and every owner of the property shall be responsible for the filing of the registration and for updating prior filings as required.~~

(d~~b~~) *Registration of management companies.* Any individual, firm, corporation or purchaser under a land installment contract pursuant to Title 13 M.R.S.A. § 481 et seq. as may be amended from time to time, managing property subject to the registration requirements of subsection (a) shall register with the building authority its management responsibility ~~within thirty (30) days of the effective date of this article~~by ~~October~~January 1, 201~~5~~6 or within thirty (30) days of assuming management responsibility. Any filing shall be updated, at least annually, if there are any changes whatsoever with regard to the information supplied. Failure to register management responsibility or update the information supplied regarding such

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management responsibility shall constitute a violation pursuant to section 6-153.

(Ord. No. 443-89, 6-7-89; Ord. No. 53-89, 7-17-89; Ord. No. 246-97, 4-9-97)

Sec. 6-152. Registration form; information.

A housing safety official designated by the City Manager~~The building authority~~ shall provide forms to be completed by the owners and managers of properties subject to registration under this article and shall maintain a file containing all registrations made under this article.

(a) The registration form for owners shall include, at a minimum, the following:

1. The street address of the building;

2. The assessor's chart, block and lot of the property on which the building is located;

3. The names, addresses, ~~and~~ telephone numbers, and e-mail addresses, of all individual persons having any ownership interest in the property including, without limitation, all partners, all officers or trustees of any real estate trusts; and including the residential street address, e-mail address and home phone number of at least one (1) such individual person;

4. The name, address and telephone number of the manager of the property or the person or persons responsible for its regular maintenance or repair;

5. The name, ~~e and~~ address, telephone number and e-mail address of a person designated as the agent of the owner or owners for the service of notices and civil process by the city. Service of notice and process upon the person so designated shall be deemed conclusive service upon the owner or owners designating that person in any litigation pertaining to the premises.

(b) The registration form for managers of property shall include, at a minimum, the following:

1. The name, address, e-mail address and local telephone number of the management company and of at least one (1) such individual, including the residential street address, e-mail address and home telephone number of that individual; and

2. A list of all buildings for which the person or firm is responsible, including the street address and chart, block and lot description of the property and the name of the owner of that building.

(Ord. No. 443-89, 6-7-89; Ord. No. 53-89, 7-17-89)

Sec. 6-153. Violations.

(a) Any person failing to timely file the required registration or failing to timely pay, in full, the registration fee or annual renewal fee, or failing to timely file any required update to the registration ~~or filing a false statement on any registration shall be guilty of an offense~~shall be in violation of this Article for which a fine of $100 per day each day the violation continues shall be assessed.

(b) Any person knowingly providing false information with respect to registration shall be in violation of this article for which a fine of $1000 shall be assessed.

(c) It shall ~~also~~ be a violation of this article for which a fine of $100 per day each day the violation continues shall be assessed ~~,~~ for any owner or manager to rent any apartment or other portion of any building subject to registration, not registered under this article, or to permit the occupancy of such premises.

(d) ~~.~~

No certificate of occupancy shall be issued for property subject to the registration requirements which is not registered in accordance with this article. ~~Each day's continuing failure to file such a registration, to update such registration or permitting the continued occupancy of such premises shall be a separate offense.~~

(Ord. No. 443-89, 6-7-89; Ord. No. 53-89, 7-17-89)

Sec. 6-154. Reserved.
Sec. 6-155. Reserved.
Sec. 6-156. Reserved.

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Sec. 6-164. Reserved.

ATTACHMENT G

Question	Fire Dept Line Companies	Fire Dept Prevention Bureau	Inspections Division, Planning Dept
What types of inspections are conducted?	• Life Safety (refers to specific NFPA code and Ch. 10 of City code) inspections on apartment buildings with 3 or more units • Monthly school inspections • Fire permit inspections • Inspect SSRs (System Shut Down Reports) for compliance and document findings	• Final Certificate of Occupancy (CO) inspections • Fire permit inspections • Fire alarm systems • Sprinkler system inspections • Life Safety-related complaint inspections • Legalization (of a previously nonconforming unit) inspections • Business Licensing inspections • Correspond w/ owners • Inspect public property for mass gatherings	• Foundation inspections including setbacks, footings, rebar, backfill • Framing inspections • Plumbing inspections • Electrical Inspections • Final Certificate of Occupancy (CO) inspections • Complaint inspections • Outdoor dining inspections • Street artist compliance inspections • Vacant building inspections • Inspect public property for mass gatherings • Monitor cruise ship area activities • Legalization inspections of nonconforming dwelling units • Trash, junk vehicles on private property • Zoning violations (such as illegal businesses, illegal dwelling units, etc.) • Respond to referrals from Police, Fire, Public Services, Public Health, and General Assistance when necessary • Inspect ice/snow-related hazards over public property • Demolition inspections • On call 24 hours to respond to emergency calls from Police and/or Fire such as multifamily fires, severe structural fires, building collapses, etc.

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Question	Fire Dept Line Companies	Fire Dept Prevention Bureau	Inspections Division, Planning Dept
What are the roles/expectations and performance standards?	• Make initial contact and set appointment for inspection • Research property prior to inspection • Conduct Life Safety inspection of said property • Document and record inspection results in Urban Insight software program • Follow-up may be requested from Fire Prevention	• Coordinate, schedule and work closely with Inspections Division for final CO inspections • Support the Fire Companies with training, coordination, documentation, resources, etc. • Respond to complaints within 24-48 hours, depending upon severity of risk • Work with other City Departments as needed • Conduct plans review and approve building permits • Development review with Planning Dept • Post unfit housing units against occupancy • Appear in court when necessary	• Perform intake and process all applications for the Planning and Historic Preservation Divisions and process all building, plumbing, HVAC, subsurface, internal plumbing , electrical, sprinkler, fire alarm, and fire suppression permit applications • Process all Zoning Board of Appeals applications for the Department; staff the Board of Appeals • Enter all applications into Urban Insight and create and upload all applications into E-Plan • Enter complaints received via email or phone • Assist the public in performing records research • Schedule inspections • Conduct building plan review for all permits • Conduct zoning reviews • Issue all permits • Issue stop work orders • Post unfit housing units against occupancy • Maintain SeeClickFix database • Issue summons when necessary • Appear in court when necessary • Maintain the no-rent list for G/A • Maintain the vacant building list • Code Enforcement Officers are

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			expected to obtain training and certifications within 1 year of hire and maintain those certifications • Acts as the lead agency in coordinating with all other City departments on building permit inspections, Certificates of Occupancy, legalizations, complaints, etc. • Responds to over **10,000** incoming administrative phone calls per year
What is the level of training?	• Basic understanding of Life Safety code and practices • Line Company Officers received advanced training in April 2015 in Apartment Building chapter from National Fire Protection Agency • Line Company Officers trained in Urban Insight software April 2015	• More advanced training in the Life Safety Code NFPA 101 & 1 • MIS provides additional training and support to FPB staff • Additional seminars in Fire Alarms, Sprinkler Systems, Fire Investigations, Burn Prevention, Juvenile Fire Setters when money is available	All Code Enforcement Officers, Plan Reviewers and Directors are required by law to have the following State certifications: • Legal Issues in Code Enforcement • Commercial Building Code • Residential Building Code • Energy Code for Residential Construction • Energy Code for Commercial Construction • Ventilation Code for Residential Construction • Ventilation Code for Commercial Construction • Residential Radon Code • Internal Plumbing Code • External Plumbing Code • Shoreland Zoning (plan reviewers) • Land Use (plan reviewers) • 80K Legal Certification (Directors)

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Question	Fire Dept Line Companies	Fire Dept Prevention Bureau	Inspections Division, Planning Dept
			• CEOs and Plan Reviewers must maintain 11 to 13 areas of certification over a 5-year period by earning continuing education units in each discipline.
What is the scheduled cycle or frequency for inspections?	• Depending on the risk level and occupancy, every 1-3 years • Monthly school inspections • Annual fire permit inspections • Apartment buildings every 1-3 years	• Monthly business renewal inspections • New business licensing as they come in • Life safety-related complaints as they come in – 24-48 hours depending on severity of risk • Annual fire permits • Final CO inspections on new projects as they are completed • Legalization inspections on request	• Building inspections (setback, electrical, plumbing, backfill, close-ins, final, etc.) are performed when ready for all issued permits (building, plumbing, etc.) • Complaints are scheduled after being reported; high-risk are 24 hours, others can be over a week due to volume of complaints • Outdoor dining permits are inspected one day per week during the summer season or by complaint • Street artists issues are inspected one day per week or by complaint • Vacant buildings are inspected once a month or per complaint • When requested by Fire, Police, Public Services, General Assistance, Public Health, Elder Services, etc.
How many Inspections are done?	<u>Proactive Inspections Totals for Dept:</u> • CY 2011 **3,402** • CY 2012 **2,949** • CY 2013 **2,067** • CY 2014 **510** (suspension of inspection program for	<u>Total Inspections for FP Bureau</u> • CY 2012 **161** • CY 2013 **461** • CY 2014 **570**	<u>Totals for Inspection Division</u> • CY 2012 **2,405** • CY 2013 **4,312** • CY 2014 **4,954**

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Question	Fire Dept Line Companies	Fire Dept Prevention Bureau	Inspections Division, Planning Dept
In addition to Inspection duties:	upgrades and improvements) Calls for Service: • CY 2013 **15,929** • CY 2014 **15,916** Dept-wide training 2015: • Jan. **601** hrs • Feb. **402** hrs • Mar. **1,092** hrs • Apr. **921** hrs • May. **645** hrs Station Maintenance: • Avg. 1.5 hrs per person per day Vehicle Checks & Maintenance: • Avg. 1.0 hrs per person per day Equipment Maintenance: • Avg. 1.0 hrs per person per day		
When do the Fire Dept and Inspections Division inspect together?	• Not applicable to Line Companies	• Scheduled final CO Inspections • Legalization inspections • After significant fire in a structure • When there are both life safety and building code issues • Inspecting public property for mass gatherings	
What is the compensation?	• Firefighter EMT-B new hire: Union Pay Plan **$14.83 hr** • Firefighter EMT-B 1yr: Union Pay	• Fire Prevention Lieutenant: Union Pay Plan **$25.17 hr** • Fire Prevention Captain: Union Pay	• Code Enforcement Officer new hire: CEBA Pay Plan **$19.09 hr** • Certified Code Enforcement Officer 1yr:

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Question	Fire Dept Line Companies	Fire Dept Prevention Bureau	Inspections Division, Planning Dept
	Plan **$16.25 hr**	Plan **$27.14 hr** • Includes $50 weekly stipend for being assigned to Fire Prevention	CEBA Pay Plan **$21.91 hr**