TESTIMONY IN SUPPORT
L.D. 1693
An Act to Advance Equity, Improve the Well-being of All Maine People and Create a Health Trust
Rep. Rachel Talbot Ross of Portland
AND
LD 1523
An Act To Establish the Trust for a Healthy Maine
Rep. Rebecca Millett of Cape Elizabeth

Dear Senator Claxton, Representative Meyer and Distinguished Members of the Joint Standing Legislative Committee on Health and Human Services,

I am Sue Mackey Andrews and have resided in Piscataquis County since 1979. I currently serve as the volunteer Facilitator for our local county coalition, Helping Hands with Heart (HHH) and our economic partnership effort, the Maine Highlands Investment Partnership (MHIP). We are recent awardees of one of five three-year grants from the Boston FED Working Communities Challenge, working to better understand and address the challenges of poverty in this region. Our 75 members represent our public-school districts, post-secondary education, and a variety of social service agencies including workforce development, domestic violence, child abuse and neglect and other important efforts.

I have represented HHH and MHIP on the Public Health Reimagined Group over these past years, even prior to the Pandemic. In many ways, HHH is the public health advocate for our rural region and we certainly have risen to this responsibility over the pandemic through coalition efforts to ensure food and fuel for all area residents in need and address some of the youth and older resident needs specific to social isolation, the increase in vaping, child abuse and neglect, and the further degradation of our housing health and availability, as well as further limiting transportation options in what is still considered a rural "Frontier County."

I write today to reflect our members' strong support for LDs 1693 and 1523 to promote the establishment of the Trust for a Healthy Maine to receive money paid to the State from the tobacco settlement and other sources. The Trust will distribute these funds across state agencies or designated agents of the State to fund tobacco use prevention and control, ensure adequate resources for other disease prevention efforts, promote public health, plan and deliver public health and prevention programs and services, support accreditation of the Department of Health and Human Services/Maine Center for Disease Control and Prevention and - perhaps most importantly - support our public health workforce development and capacity building at the state AND local levels.

Over the past 10 years, Maine watched on the sidelines as our public health system was systematically destroyed. Then, the Covid-19 pandemic struck. Maine was caught basically flat-footed without the essential public health structure needed to create, implement, and sustain a robust response to protect all Mainers.

Nowhere has this impact been more felt than in our rural Maine counties. Over the years, the erosion of any public health presence in our region has resulted in intermittent and unreliable prevention programs across a variety of public health issues (hypertension, diabetes, cancer, obesity, lack of access to dental care, etc.) as well as programs intended to address tobacco use, alcohol and other substances, and the retraction of a variety of programs responding to treatment and recovery.

The result has been not only an escalation of need, but also a growing sense amongst residents of being "forgotten" and not important. Most services provided in Piscataquis County travel up Route 15 from Bangor and often are not culturally consistent with the unique challenges of this very rural region. The pandemic has only made this situation worse. *I am attaching a comparison of several Maine rural counties created by the Robert Wood Johnson Foundation, illustrating the high needs of these regions across a variety of health parameters.*

The pandemic has ripped bare the substantial needs of our region, which has chronically been one of (if not THE) poorest, least healthy counties in Maine. Nearly all of our health metrics have gotten worse, including the reported incidence of youth vaping – which has sky-rocketed during this pandemic.

Our members believe that the Trust for a Healthy Maine will restore public health services to meaningful and responsive levels as determined by residents informed by data and lived experiences. The Trust will bring consistency to essential public health programs through reliable and consistent funding, thus avoiding our too-often experience of recruiting and on-boarding talented staff only to be defunded the following year. Importantly, the Trust for a Healthy Maine will protect these federal funds and preserve them for their intended purpose. This is essential.

The Trust for a Healthy Maine is imperative for our State, especially for regions such as ours, with different needs and priorities, as well as cultural differences that demand unique approaches to service planning and delivery. The Trust will recognize that public health is essential – all its facets – to not only the health and well-being of our residents but also to our communities and to our economy.

We urge your support and appreciate, as always, your dedication to the people of Maine and to the service you provide by serving in the Maine Legislature.

Respectfully submitted,

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Enclosure (2 pages)

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Robert Wood Johnson Foundation

| | Maine | Piscataquis (PI), ME X | Washington (WS), ME X | Aroostook (AR), ME X | Somerset (SO), ME X | Franklin (FR), ME X | Penobscot (PE), ME X |
|---|---|---|---|---|---|---|---|
| Length of Life | | | | | | | |
| Premature age-adjusted mortality | 330 | 390 | 440 | 380 | 400 | 310 | 360 |
| Child mortality | 50 | 100 | 50 | 80 | 60 | 50 | 60 |
| Infant mortality | 6 | | | 8 | 9 | | 7 |
| Quality of Life | | | | | | | |
| Frequent physical distress | 13% | 12% | 11% | 13% | 12% | 11% | 12% |
| Frequent mental distress | 14% | 13% | 14% | 13% | 13% | 13% | 13% |
| Diabetes prevalence** | 10% | 12% | 13% | 12% | 11% | 10% | 10% |
| HIV prevalence | 129 | | 106 | 57 | 63 | | 82 |
| Health Behaviors | | | | | | | |
| Food insecurity** | 15% | 17% | 17% | 17% | 16% | 14% | 16% |
| Limited access to healthy foods | 4% | 2% | 5% | 5% | 7% | 1% | 5% |
| Drug overdose deaths | 21 | 20 | 40 | 15 | 20 | 11 | 21 |
| Drug overdose deaths - modeled | 28.7 | 18-19.9 | 24-25.9 | 8-11.9 | 14-15.9 | 12-13.9 | 18-19.9 |
| Motor vehicle crash deaths | 11 | 16 | 20 | 12 | 16 | 17 | 12 |
| Insufficient sleep | 33% | 34% | 34% | 34% | 35% | 33% | 33% |
| Clinical Care | | | | | | | |
| Uninsured adults | 12% | 13% | 18% | 14% | 13% | 12% | 13% |
| Uninsured children | 6% | 7% | 8% | 7% | 5% | 7% | 6% |
| Health care costs** | $8,818 | $9,667 | $9,381 | $9,151 | $9,790 | $8,043 | $9,641 |
| Other primary care providers | 814:1 | 1,053:1 | 953:1 | 918:1 | 1,306:1 | 1,200:1 | 493:1 |
| Social & Economic Factors | | | | | | | |
| Disconnected youth | 11% | 19% | | 12% | 16% | | 11% |
| Median household income | $52,900 | $35,900 | $37,700 | $39,700 | $42,100 | $43,500 | $47,100 |
| Children eligible for free or reduced price lunch | 46% | 65% | 63% | 53% | 68% | 55% | 47% |
| Residential segregation - black/white** | 71 | | | 80 | 71 | | 64 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Residential segregation - non-white/white** | 42 | 24 | 56 | 40 | 31 | 43 | 43 |
| Homicides | 2 | | | 2 | | | 3 |
| Firearm fatalities | 10 | 15 | 16 | 14 | 13 | 13 | 11 |
| Physical Environment | | | | | | | |
| Demographics | | | | | | | |
| Population | 1,331,479 | 16,843 | 31,450 | 67,959 | 50,915 | 30,001 | 151,806 |
| % below 18 years of age | 19.1% | 17.0% | 19.0% | 18.4% | 19.4% | 18.1% | 18.3% |
| % 65 and older | 19.4% | 25.0% | 23.2% | 22.5% | 20.2% | 20.5% | 17.7% |
| % Non-Hispanic African American | 1.4% | 0.5% | 0.6% | 0.9% | 0.5% | 0.6% | 0.9% |
| % American Indian and Alaskan Native | 0.7% | 0.6% | 5.4% | 1.9% | 0.5% | 0.5% | 1.2% |
| % Asian | 1.2% | 0.8% | 0.5% | 0.5% | 0.7% | 0.5% | 1.1% |
| % Native Hawaiian/Other Pacific Islander | 0.0% | 0.1% | 0.0% | 0.0% | 0.1% | 0.0% | 0.0% |
| % Hispanic | 1.6% | 1.4% | 2.0% | 1.1% | 1.1% | 1.3% | 1.3% |
| % Non-Hispanic white | 93.5% | 95.4% | 89.9% | 94.4% | 95.8% | 95.7% | 94.0% |
| % not proficient in English | 1% | 0% | 0% | 1% | 0% | 0% | 0% |
| % Females | 51.0% | 50.4% | 50.8% | 50.6% | 50.4% | 50.9% | 50.5% |
| % Rural | 61.3% | 100.0% | 92.4% | 80.3% | 80.5% | 83.0% | 57.7% |

** Compare across states with caution

Note: Blank values reflect unreliable or missing data