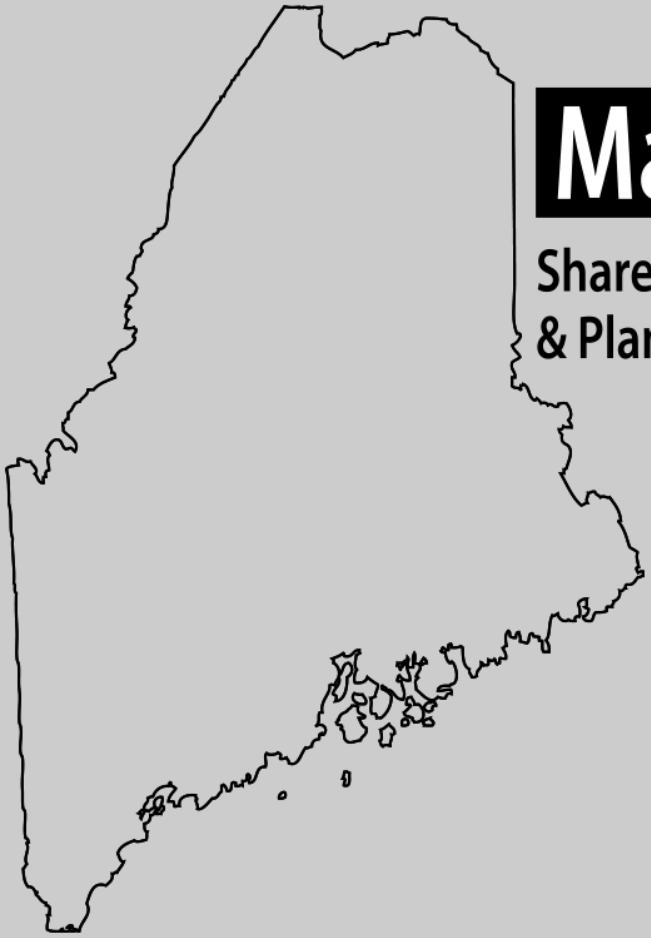

Maine SHNAPP

Shared Health Needs Assessment & Planning Process

2016 Shared Community Health Needs Assessment

Cumberland County

Prepared by: Market Decisions Research and Hart Consulting, Inc., November 3, 2015 [updated 2/29/16]

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MARKET DECISIONS RESEARCH

HART CONSULTING

See end of the report for a list of contributors and collaborating organizations.

Note: Originally, this report was dated 2015 on the cover. However, it has been changed to 2016 to reflect the fiscal years of the organizations that have been involved.

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How to Use This Report

This report contains findings for Cumberland County from the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) conducted in 2015. It is divided into ten sections to provide the reader with an easy-to-use reference to the data-rich assessment. It starts with the highest level of data, followed by summaries and synthesis of the data. The last sections include the detailed findings from assessments as well as the sources.

The report has several features that are important to keep in mind:

- The document provides a reference for more than 160 indicators and more than 30 qualitative survey questions covering many topics. It does not explore any individual topic in-depth.
- The definitions, sources and year(s) for each indicator discussed in the report are found at the end in the data sources section.
- Wherever the term, "statistically significant" is used to describe differences between data estimates, it means that the 95 percent confidence intervals for the given point estimates do not overlap.
- Unless otherwise noted, all rates presented in this report are age-adjusted and calculated per 100,000 population to facilitate comparisons between counties, Maine and the U.S.

The following is a brief description of each section.

Executive Summary
The summary provides the highest level overview of data for the county.

Background
This section explains the purpose and background of the SHNAPP and the Shared CHNA. It includes a description of the methodology and data sources used in the assessment.

County Demographics
The demographic section compares the population and socioeconomic characteristics of the county to the overall state of Maine.

Summary of Findings
This section provides a summary of the assessment data by health issue; it compares the county to the state and U.S. on key indicators and explains the importance of the health issues.

Stakeholder Feedback
High-level findings from the stakeholder survey are included in this section. It explores the top five health issues and factors identified as local priorities or concerns by stakeholders. It shares respondent concern for populations experiencing disparities in health status for these issues.

Priority Health Issues and Challenges

Priority health issues and challenges appear in this section. This section categorizes the key findings from the quantitative and stakeholder (qualitative) datasets as strengths and challenges. The analysis includes health issue indicators from the quantitative datasets sorted into challenges and strengths, stakeholder responses for challenges and resources to address the challenges.

County Health Rankings

The *2015 County Health Ranking & Roadmaps* model for the county is shown in this section. The model, from the University of Wisconsin Population Health Institute, shows how the individual health behaviors lead to health outcomes, which then determines the overall health status for a population. The graphic illustration includes the associated measures for each health indicator and the county rank among all 16 counties in the state of Maine. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to the time period for the data or use of different indicators.

Stakeholder Survey Findings

This section displays the full set of responses to each question asked in the stakeholder survey (excluding open-ended responses, which are available upon request). It compares the county to the statewide responses.

Health Indicator Results from Secondary Data Sources

The results and sources section details the data for each of the 160 indicators for the county. It includes a table that compares data for the county, the state and the U.S. (where available). Statistically significant differences (at 95 percent confidence) are noted in this table where available and applicable.

Health Indicator Data Sources

This section lists the data source, year and additional notes for each indicator. In addition to the stakeholder survey conducted as a primary data source for this project, the secondary data sources used in this assessment include:

- Child Maltreatment Report, Administration on Children Youth and Families
- Maine Cancer Registry (MCR)
- MaineCare
- Maine Behavioral Risk Factor Surveillance System (BRFSS)
- Maine CDC Drinking Water Program
- Maine CDC HIV Program
- Maine CDC Lead Program
- Maine CDC National Electronic Disease Surveillance System (NEDSS)
- Maine CDC Public Health Emergency Preparedness (PHEP)
- Maine CDC STD Program
- Maine CDC Vital Records
- Maine Department of Education
- Maine Department of Public Safety
- Maine Department of Labor
- Maine Health Data Organization (MHDO)
- Maine Integrated Youth Health Survey (MIYHS)
- Maine Office of Data Research and Vital Records
- National Immunization Survey (NIS)
- National Survey of Children w/ Special Health Care Needs
- National Center for Health Statistics
- U.S. Bureau of Labor Statistics
- U.S. CDC WONDER & WISQARS
- U.S. Census

Executive Summary

Public health and health care organizations share the goal of improving the lives of Maine people. Health organizations, along with business, government, community organizations, faith communities and individuals, have a responsibility to shape health improvement efforts based on sound data, personal or professional experience and community need.

This summary provides high-level findings from the Maine Shared Community Health Needs Assessment (CHNA), a comprehensive review of health data and community stakeholder input on a broad set of health issues in Maine. The Shared CHNA was conducted through a collaborative effort among Maine's four largest health-care systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention an office of the Maine Department of Health and Human Services (DHHS).

While it covers a broad range of topics, the Shared CHNA is not an exhaustive analysis of all available data on any single health issue. These data help identify priorities and should lead the reader to conduct a deeper investigation of the most pressing health issues.

Data are important and a solid starting point, but the numbers represent people who live in Maine. The overall goal of the Maine SHNAPP is to "turn data into action." Community engagement is therefore a critical next step, assuring shared ownership and commitment to collective action. The perspectives of those who live in our communities will bring these numbers to life and, together, we can set priorities to achieve measurable community health improvement. We invite all readers to use the information in this report as part of the solution to develop healthier communities in Maine.

Demographics and Socioeconomic Factors

Cumberland County was home to 285,456 people in 2013. It is considered a metro or urban county, according to the urban and rural classifications defined by the New England Rural Health RoundTable.[1] It is better off than the state as a whole in many demographic and socioeconomic characteristics, including income, poverty rates and education. Key demographic features for the 2009-2013 time period include:

- Median household income of $57,461.
- 15.7 percent of children and 11.4 percent of all individuals live in poverty.

[1] Rural Data for Action, New England Rural Health RoundTable, 2014. Available from: http://www.newenglandruralhealth.org/rural_data

Access to Health Care/Quality

Access to care in Cumberland County is slightly above the state; specifically, a higher percentage of residents have health insurance and fewer report a lack of care due to cost. The ambulatory care sensitive-conditions[2] hospital admission rate in Cumberland County was also significantly below the state. Key features for Cumberland County include:

- 8.9 percent of residents did not have health insurance (2009-2013); 9.5 percent experienced cost-related barriers to getting healthcare in the last year (2011-2013).
- 89.5 percent of adults reported having a personal doctor or other health care provider (2011-2013).
- The hospitalization rate for ambulatory care-sensitive conditions was 1,167.5 per 100,000 population (2011).

General Health and Mortality

The general health of people in Cumberland County is better than the state as a whole, including a lower overall mortality rate. Key features for Cumberland County include:

- 11.5 percent of adults reported their health as fair or poor (2011-2013).
- Similar to the state overall, the top three leading causes of death are cancer, heart disease and lower respiratory diseases (2013).
- The overall mortality rate per 100,000 population was 687.2 in Cumberland County compared with 745.8 for the state (2009-2013).

Disease Incidence and Prevalence

Cancer is the leading cause of death in Cumberland County. While the overall cancer mortality rates are significantly lower, the incidence of melanoma is significantly higher than the state, and other cancer rates are similar. Cardiovascular health is a leading cause of disease and death in Cumberland County, but the rates are lower than the state for coronary heart disease mortality, acute myocardial infarction mortality, stroke mortality and prevalence of high cholesterol. Diabetes prevalence is significantly lower than the state. Asthma rates among adults and youth are similar to the state. AIDS incidence is higher than other parts of the state. Key features for Cumberland County include:

- Mortality from all cancers per 100,000 population was 174.9. The number of new cases of all cancer sites per 100,000 population in Cumberland County was 494.8. Melanoma incidence per 100,000 population in Cumberland County (27.9) was significantly higher than the state, at 22.2 (2007-2011).

[2] Ambulatory care-sensitive conditions (ACSC) are Prevention Quality Indicators from the Agency for Healthcare Research and Quality and is intended to measure whether these conditions are being treated appropriately in the outpatient setting before hospitalization is required.

- When it comes to cardiovascular health:
  - Coronary heart disease mortality per 100,000 population was 68.0 (2009-2013).
  - 36.7 percent of adults had high cholesterol (2011, 2013).
  - The rate for heart attack mortality per 100,000 population was 22.4 (2009-2013).
  - Stroke mortality rate was 29.1 per 100,000 per population (2009-2013).
- Diabetes prevalence for Cumberland County was significantly lower than the state: 7.6 percent of adults (2011-2013).
- Asthma prevalence among adults was 10.8 percent; rates among youth 0-17 were 8.6 percent (2011-2013).
- AIDS incidence was 4.2 per 100,000 population (2014).
- Lyme disease incidence was 117.4 per 100,000 population (2014).
- 43.4 percent of adults reported being immunized annually for influenza, which is similar to the state at 41.5 percent (2011-2013).

Health Behaviors and Risk Factors

Cumberland County's rates are worse than the state for some health behaviors and risk factors and better on others. Lead screening is significantly lower than the state. Mental health emergency room visits, opiate poisoning rates, substance abuse, and violent crime rates are significantly higher than the state. Obesity rates are lower, and tobacco use is similar. Key health behavior and risk factor indicators for Cumberland County include:

- Lead screening rates among 24-35 months old children were 17.6 percent compared to 27.6 percent for the state (2009-2013).
- Mental health emergency department rates per 100,000 population were significantly higher than the state (2,152.3 compared to 1,972.1) (2011).
- Obesity rates for adults and high school youth were significantly lower than the state, 23.7 percent and 9.3 percent, respectively (2013).
- Opiate poisoning rates for emergency department visits per 100,000 population were significantly higher than the state: 35.3 compared to 25.1 (2009-2011).
- Substance abuse hospital admissions per 100,000 population were significantly higher than the state: 477.8 compared to 328.1 (2011).
- Violent crime rate was higher than the state, 139.2 compared to 125 per 100,000 population (2013).
- Current smoking among adults was 17 percent (2011-2013); and high school youth current tobacco use was 16.4 percent (2013).

Stakeholder Priorities of Health Issues

Stakeholders who work in Cumberland County listed the following health issues as their top five concerns:

- Mental health
- Drug and alcohol abuse
- Obesity
- Diabetes
- Depression

Stakeholders identified the following populations as being disproportionately affected by the top health issues in Cumberland County:

- Low-income people, including those with incomes below the federal poverty level
- People with less than a high school education and/or low literacy (low reading or math skills)
- People who are medically underserved, including the uninsured and underinsured
- People with disabilities: physical, mental, or intellectual
- People in very rural and/or geographically isolated locations

Stakeholders prioritized the following factors as having a great influence on health in Cumberland County, resulting in poor health outcomes for residents:

- Access to behavioral care/mental health care
- Poverty
- Health care insurance
- Health literacy
- Access to oral health

Background

Purpose

The Maine Shared Health Needs Assessment and Planning Process (SHNAPP) Project is a collaborative effort among Maine's four largest healthcare systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention an office of the Maine Department of Health and Human Services (DHHS). The current collaboration expands upon the OneMaine Health Collaborative created in 2007 as a partnership among EMHS, MGH and MaineHealth. The Maine CDC and other partners joined these entities to develop a public-private partnership in 2012. The four hospital systems and the Maine CDC signed a memorandum of understanding in effect between June 2014 and December 2019 committing resources to the Maine SHNAPP Project.

The overall goal of the Maine SHNAPP is to "turn data into action" by conducting a shared community health improvement planning process for stakeholders across the state. The collaborative assessment and planning effort will ultimately lead to the implementation of comprehensive strategies for community health improvement. As part of the larger project, the Maine SHNAPP has pooled its resources to conduct this Shared Community Health Needs Assessment (Shared CHNA) to address community benefit reporting needs of hospitals, support state and local public health accreditation efforts, and provide valuable population health assessment data for use in prioritizing and planning for community health improvement.

This assessment builds on the earlier *OneMaine 2011 CHNA* that was developed by the University of New England and the University of Southern Maine, as well as the 2012 Maine State Health Assessment that was developed by the Maine DHHS. This Shared CHNA includes a large set of statistics on health status and risk factors from existing surveillance and health datasets. It differs from earlier assessments in two ways. Firstly, it includes input from a broad set of stakeholders from across the state from the 2015 SHNAPP Stakeholders' Survey. Secondly, it does not include the household telephone survey conducted for the OneMaine effort.

Quantitative Data

This report contains both quantitative health data and qualitative stakeholder survey data on health issues and determinants affecting those living in Maine. The quantitative data come from numerous sources including surveillance surveys, inpatient and outpatient health data and disease registries. These data consist of 160 quantitative indicators within 18 groupings (domains) for reporting at the state level and, where possible, at the county and select urban levels. Please note that the data are taken from the most current year(s) available. Since the indicators come from a variety of sources, the data are measured over different time periods. In some cases, where there were not enough data in a single year to produce a statistically valid result, multiple years were combined to compute an indicator. Table 28 contains the complete list of the data sources.

Qualitative Data

Qualitative data were collected through a statewide stakeholder survey conducted in May and June 2015 with 1,639 people representing more than 80 organizations and businesses in Maine. The survey was developed using a collaborative process that included Maine SHNAPP partners, Market Decisions Research and Hart Consulting, and a number of other stakeholders and health experts. In Cumberland County, a total of 176 stakeholders responded to the survey.

The objective of the survey was to produce qualitative data of the opinions of health professionals and community stakeholders on the health issues and needs of communities across the state. Given this purpose, the survey used a snowball sampling approach by inviting leaders of member organizations and agencies to invite their members and employees to participate. A concerted effort was made to recruit participants from a number of different industries and backgrounds across all communities in the state. Survey respondents represented public health and health care organizations as well as behavioral health, business, municipalities, education, public safety, and nongovernmental organizations. More than 80 organizations agreed to send the survey to their members or stakeholders.

The online survey was approximately 25 minutes in length and contained a number of questions about important health issues and determinants in the state, including a rating of most critical issues, the ability of Maine's health system (including public health) to respond to issues, availability of resources and assets to address specific health issues, impact on disparate populations, and identification of the entities primarily responsible for addressing issues and determinants. The survey asked all respondents a basic set of questions to rate the importance of health issues and impact of health factors. It then allowed respondents to provide answers to probing questions on the three issues and factors that they were most interested in or had the most knowledge about. Respondents provided over 12,000 open-ended comments to these in-depth probing questions in the survey. The Market Decisions Research/Hart Consulting team reviewed, coded and cleaned all open-ended comments for similar and recurrent themes. Not all respondents shared comments for the probing questions.

Limitations

While a number of precautions were taken to ensure that the results and findings presented in this report are sound and based upon statistically valid methods and analyses, there are some limitations to note. While the quantitative analysis used the most recent data sources available as of July 1, 2015, some of these sources contain data that are several years old. The most recent BRFSS and mortality data available at the time of analysis were from 2013, while the most recent hospitalization and cancer data were from 2011. This presents a particular challenge in trying to capture recent trends in health in the state, such as with opioid use. The data presented in this report may not necessarily represent the current situation in Maine, but are the best data available at the time of publication.

Given the qualitative nature of the survey questions and the sampling methodology, it is important to note that the results of the stakeholder survey are not necessarily representative of the population of Maine or a county at a given level of statistical precision. The findings reflect the informed opinions of health experts and community leaders from all areas of the state. However, it is important to use some caution when interpreting results, especially at the county level due to smaller sample sizes, as the results represent the opinions of only those who completed the survey.

Reports

The Shared CHNA has several reports and datasets for public use that are available on the Maine CDC website and may be downloaded at www.maine.gov/SHNAPP/.

- County-Level Maine Shared Community Health Needs Assessment Reports summarize the data and provide insights into regional findings. These reports explore the priorities, challenges, and resources for each county and contain both summary and detailed tables.
- State-Level Maine Shared Community Health Needs Assessment Report includes information on each health issue, including analysis of sub-populations. The report includes state summaries and detailed tables.
- Summary tables are available for each public health district[3], each county, and the cities of Portland and Bangor and the combined cities of Lewiston/Auburn.
- Detailed Tables contain each indicator, by subpopulation, region, and year.

[3] To improve coordinated delivery of essential public health services, Department of Health and Human Services (DHHS) and the Maine Legislature approved the establishment of eight public health districts. District boundaries were established using population size, geographic areas, hospital service areas, and county borders. A District Liaison coordinates a Public Health Unit with co-located Maine CDC staff in one DHHS regional office for every District.

County Demographics

Cumberland County has a total population of 285,456, and is younger and more diverse than the state of Maine. The demographic and socioeconomic characteristics of the county are improved compared with the state on many measures including income, poverty rates, education and general health status.

Figure 1. Population by Age Categories (U.S. Census 2013)[4]

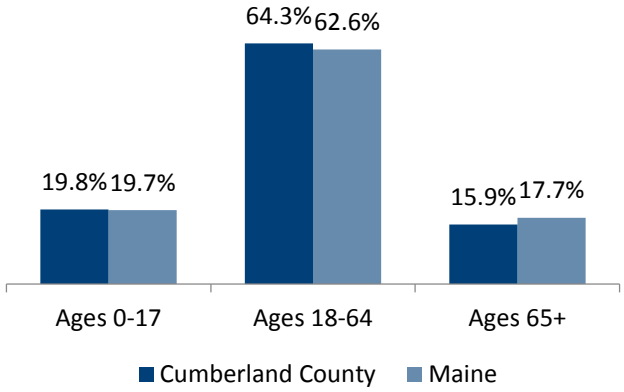
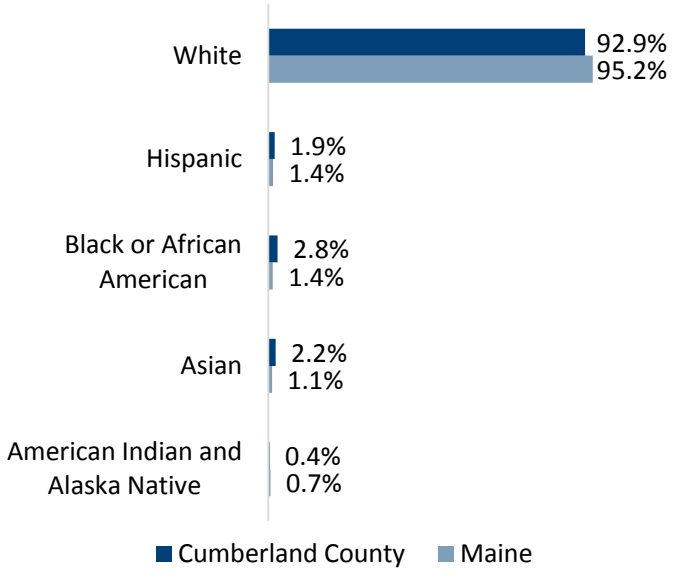


Figure 2. Population by Race/Ethnicity (U.S. Census 2013)



[4] Numbers may not add up to 100% due to rounding

Cumberland County

Cumberland County also makes up the Cumberland Public Health District. It is the most populous county in Maine and economic center of the state. Cumberland is home to Maine's largest urban area, the city of Portland, where the Portland Public Health Division is located. Several hospitals are sited in Cumberland County including:

- Bridgton Hospital.
- Maine Medical Center.
- Mercy Hospital.
- Mid Coast Hospital.
- New England Rehabilitation Hospital.
- Parkview Adventist Medical Center.
- Spring Harbor Hospital.

Key Demographics

Population	Cumberland County	Maine
Overall Population	285,456	1.33 mil
Population density (per sq. mile)	337.2	43.1
Percentage living in rural areas	33.2%	66.4%
Single parent families	31.2%	34.0%
65+ living alone	43.1%	41.2%
Population living with a disability	12.2%	15.9%
Economic Status		
Median household income	$57,461	$48,453
Unemployment rate	4.4%	5.7%
Adults and children living in poverty	11.4%	13.6%
Children living in poverty	15.7%	18.5%
Education		
HS graduation rate	88.2%	86.5%

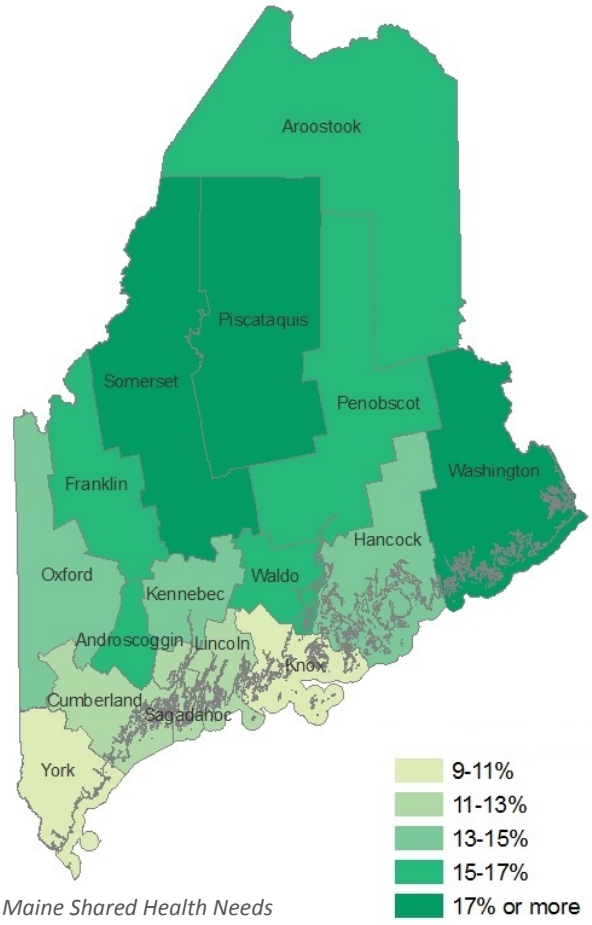
Cumberland County Summary of Findings

Socioeconomic Status

Economic opportunity and stability, including factors such as income, employment, food security and housing stability, have a significant impact on the health of individuals and communities. The 2013 Maine Behavioral Risk Factor Surveillance System (BRFSS) found the percentage of adults in Maine rating their health as excellent, very good or good was 94.8 percent among adults with household incomes of $50,000 or more, but 53.8 percent among those with incomes under $15,000.

In addition to income, there are many other social determinants of health, which have been defined as "conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[5] The conditions in which we live explain in part why some are healthier than others and why many generally are not as healthy as they could be. The Maine Shared CHNA takes into account a number of socioeconomic factors and other health determinants, including income and poverty, employment, education and household structure.

Percentage of adults and children living in poverty



Maine Shared Health Needs Assessment, 2015

[5] The Institute of Medicine. Disparities in Health Care: Methods for Studying the Effects of Race, Ethnicity, and SES on Access, Use, and Quality of Health Care, 2002. Available from: www.iom.edu/~/media/Files/Activity%20Files/Quality/NHDRGuidance/DisparitiesGornick.pdf

Table 1. Key Socioeconomic Indicators for Cumberland County

	Cumberland	Maine	U.S.
Adults and children living in poverty (2009-2013)	*11.4%**	13.6%	15.4%
Children living in poverty (2009-2013)	*15.7%**	18.5%	21.6%
Median household income (2009-2013)	*$57,461**	$48,453	$53,046
Single-parent families (2009-2013)	31.2%	34.0%	33.2%
65+ living alone (2009-2013)	43.1%	41.2%	37.7%

Asterisk (*) and italics indicate a statistically significant difference between Cumberland County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

General Health and Mortality

While it is essential to understand the causes, risk factors and other determinants of a population's health status, broad measures of health and mortality can also help explain the overall status and needs of the population in general and show in which populations there are disparities. General health status can be measured by self-reported data, as well as by mortality-related data such as life expectancy, leading causes of death and years of potential life lost.

Table 2. Key Health and Mortality Indicators for Cumberland County

	Cumberland	Maine	U.S.
Adults who rate their health fair to poor (2011-2013)	*11.5%**	15.6%	16.7%
Adults with 14+ days lost due to poor mental health (2011-2013)	11.4%	12.4%	NA
Adults with 14+ days lost due to poor physical health (2011-2013)	*10.6%**	13.1%	NA
Adults with three or more chronic conditions (2011, 2013)	*23.2%**	27.6%	NA
Overall mortality rate per 100,000 population (2009-2013)	*687.2**	745.8	731.9

Asterisk (*) and italics indicate a statistically significant difference between Cumberland County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

The life expectancy in Cumberland County is 78.1 years for males and 82.3 years for females.

Access to Health/Health Care Quality

Access to timely, appropriate, high-quality and regular health care and preventive health services is a key component of maintaining health. Good access to health care can be limited by financial, structural, and personal barriers. Access to health care is affected by location of and distance to health services, availability of transportation and the cost of obtaining the services – including the availability of insurance, the ability to understand and act upon information regarding

services, the cultural competency of health care providers and a host of other characteristics of the system and its clients. *Healthy People 2020* has identified four major components of access to health services: coverage, services, timeliness and workforce.[6]

In Cumberland County, 8.9 percent of residents did not have health insurance over the period from 2009-2013. However, access to health insurance does not necessarily guarantee access to care: among adults with health insurance, 5.8 percent in Cumberland County reported that they had experienced cost-related barriers to getting health care during the previous year (compared to 9.5 percent of all adults in the county).

Table 3. Key Access to Health/Health Care Quality Indicators for Cumberland County

	Cumberland	Maine	U.S.
Adults with a usual primary care provider (2011-2013)	89.5%	87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost (2011-2013)	9.5%	11.0%	15.3%
Percent uninsured (2009-2013)	*8.9%**	10.4%	11.7%
Ambulatory care-sensitive condition hospital admission rate per 100,000 population (2011)	*1,167.5**	1,499.3	1,457.5
Adults with visits to a dentist in the past 12 months (2012)	*72.8%**	65.3%	67.2%

Asterisk (*) and italics indicate a statistically significant difference between Cumberland County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

Ambulatory care-sensitive hospital discharges is a Prevention Quality Indicator defined by the Agency for Healthcare Research and Quality (AHRQ) and is intended to measure whether conditions are being treated appropriately in the outpatient setting before hospitalization is required. AHRQ provides nationwide rates based on lower acuity and cost analysis of 44 states from the 2010 Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project State Inpatient Databases.[7]

Chronic Disease

It is estimated that treatment for chronic diseases accounts for 86 percent of our nation's health care costs.[8] Chronic diseases include cancer, cardiovascular disease, diabetes and respiratory diseases like asthma and COPD, among other conditions. They are long-lasting health conditions and are responsible for seven out of ten deaths each year. Many chronic diseases can be

[6] Healthy People 2020, Office of Disease Prevention and Health Promotion. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[7] Agency for Healthcare Research and Quality, Prevention Quality Indicators Technical Specifications - Version 5.0, March 2015, available at: http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
[8] National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/chronicdisease/

prevented or controlled by reducing risk factors such as tobacco use, physical inactivity, poor nutrition and obesity.

Asthma is the most common childhood chronic condition in the United States and the leading chronic cause of children being absent from school.

Table 4. Key Asthma and COPD Indicators for Cumberland County

	Cumberland	Maine	U.S.
Asthma emergency department visits per 10,000 population (2009-2011)	*57.3**	67.3	NA
COPD diagnosed (2011-2013)	*5.1%**	7.6%	6.5%
COPD hospitalizations per 100,000 population (2011)	*159.1**	216.3	NA
Current asthma (Adults) (2011-2013)	10.8%	11.7%	9.0%
Current asthma (Youth 0-17) (2011-2013)	8.6%	9.1%	NA
Pneumonia emergency department rate per 100,000 population (2011)	*558.7**	719.9	NA
Pneumonia hospitalizations per 100,000 population (2011)	*229.9**	329.4	NA

Asterisk (*) and italics indicate a statistically significant difference between Cumberland County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

While the age-adjusted all-cancer incidence and mortality rates in Maine decreased significantly over the past ten years, cancer remains the leading cause of death among people in Maine. Cancer was also the leading cause of death in Cumberland County in 2013.

Table 5. Key Cancer Indicators for Cumberland County

	Cumberland	Maine	U.S.
Mortality – all cancers per 100,000 population (2007-2011)	*174.9**	185.5	168.7
Incidence – all cancers per 100,000 population (2007-2011)	494.8	500.1	453.4
Mammograms females age 50+ in past two years (2012)	83.1%	82.1%	77.0%
Colorectal screening (2012)	72.5%	72.2%	NA
Melanoma incidence per 100,000 population (2007-2011)	*27.9**	22.2	21.3

Asterisk (*) and italics indicate a statistically significant difference between Cumberland County and Maine;
NA = Not Available - data are not available for this indicator
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

More than one in three adults lives with some type of cardiovascular disease. Heart disease and stroke can cause serious illness and disability with associated decreased quality of life and high economic costs. Cardiovascular disease conditions are among the most preventable health problems through the modification of common risk factors.

Table 6. Key Cardiovascular Disease Indicators for Cumberland County

	Cumberland	Maine	U.S.
Acute myocardial infarction hospitalizations per 10,000 population (2010-2012)	*14.8**	23.5	NA
Acute myocardial infarction mortality per 100,000 population (2009-2013)	*22.4**	32.2	32.4
Cholesterol checked every five years (2011, 2013)	83.3%	81.0%	76.4%
Coronary heart disease mortality per 100,000 population (2009-2013)	*68.0**	89.8	102.6
Heart failure hospitalizations per 10,000 population (2010-2012)	*19.0**	21.9	NA
Hypertension prevalence (2011, 2013)	29.5%	32.8%	31.4%
High cholesterol (2011, 2013)	*36.7%**	40.3%	38.4%
Stroke hospitalizations per 10,000 population (2010-2012)	*17.6**	20.8	NA
Stroke mortality per 100,000 population (2009-2013)	*29.1**	35.0	36.2

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Diabetes mellitus is a complex health condition that lowers life expectancy, increases the risk of heart disease and is the leading cause of adult-onset blindness, lower-limb amputations and kidney failure. Lifestyle changes, effective self-management and treatment can delay or prevent diabetes and complications of diabetes.

Table 7. Key Diabetes Indicators for Cumberland County

	Cumberland	Maine	U.S.
Diabetes prevalence (ever been told) (2011-2013)	*7.6%**	9.6%	9.7%
Pre-diabetes prevalence (2011-2013)	6.9%	6.9%	NA
Adults with diabetes who have received formal diabetes education (2011-2013)	62.9%	60.0%	55.8%
Diabetes hospitalizations (principal diagnosis) per 10,000 population (2010-2012)	*9.3**	11.7	NA
Diabetes long-term complication hospitalizations (2011)	53.4	59.1	NA
Diabetes mortality (underlying cause) per 100,000 population (2009-2013)	*16.3**	20.8	21.2

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Environmental Health

Environmental health includes the natural and built environments. Within these environments, there is risk of exposure to toxic substances and other physical hazards that exist in the air we breathe, the food we eat, the water we drink and the places where we live, play and work.[9]

Water quality issues in Maine include hazards such as disinfection byproducts, arsenic and nitrates/nitrites as well as bacteria contamination. Among households who get their drinking water from private wells, naturally occurring arsenic is a risk. Regular water quality testing can indicate the need for mitigation. In Cumberland County, 53.1 percent of households with private wells have tested their water for arsenic, compared with 43.3 percent of households statewide.

Childhood lead poisoning rates are of particular concern in areas with older housing. It can disproportionately affect people who live in older rental units and those who have less income.

Table 8. Key Environmental Health Indicators for Cumberland County

	Cumberland	Maine	U.S.
Children with confirmed elevated blood lead levels (% among those screened) (2009-2013)	*3.2%**	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened) (2009-2013)	*2.5%**	4.2%	NA
Homes with private wells tested for arsenic (2009, 2012)	*53.1%**	43.3%	NA
Lead screening among children age 12-23 months (2009-2013)	*42.3%**	49.2%	NA
Lead screening among children age 24-35 months (2009-2013)	*17.6%**	27.6%	NA

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NA = Not Available - data are not available for an indicator

Immunization

Immunization has accounted for significant decreases in morbidity and mortality of infectious diseases and an overall increase in life expectancy. However, many infectious diseases that can be prevented through vaccination continue to cause significant burdens on the health of Maine residents. The U.S. CDC has recommendations for a number of vaccines for young children, adolescents and older adults. Among its other recommendations, the U.S. CDC recommends yearly influenza vaccinations for people over six months of age.

[9] Maine Center for Disease Control and Prevention. Healthy Maine 2020. Available from: http://www.maine.gov/dhhs/mecdc/healthy-maine/index.shtml

Table 9. Key Immunization Indicators for Cumberland County

	Cumberland	Maine	U.S.
Adults immunized annually for influenza (2011-2013)	43.4%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older) (2011-2013)	73.2%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons (2015)	4.7%	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4 (2015)	NA	75.0%	NA

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Infectious Disease/Sexually Transmitted Disease

There are 71 infectious diseases and conditions reportable in Maine. Surveillance data assist in monitoring trends in disease and identifying immediate threats to public health. However, there are limitations in surveillance data, specifically pertaining to underreporting. Available data reflects a subset of the disease burden in Maine.

Advances in sanitation, personal hygiene and immunizations have provided control over some diseases, but others continue to thrive despite best efforts. Lyme disease, if left untreated, can cause severe headaches, severe joint pain and swelling, inflammation of the brain and short-term memory problems[10]. Incidence has increased from 224 reported cases statewide in 2004 to 1,400 in 2014, a growth of more than 500 percent in a decade.

Table 10. Key Infectious Disease Indicators for Cumberland County

	Cumberland	Maine	U.S.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population (2014)	99.4	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population (2014)	19.5	8.1	NA
Lyme disease incidence per 100,000 population (2014)	117.4	105.3	10.5

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[10] Signs and Symptoms of Untreated Lyme Disease, Centers for Disease Control and Prevention (CDC), Available from: http://www.cdc.gov/lyme/signs_symptoms/

While the rates of sexually transmitted diseases like chlamydia, gonorrhea and HIV are significantly lower in Maine than the U.S., it is an issue that disproportionately affects specific segments of the population, including young adults and men who have sex with men.

Table 11. Key Sexually Transmitted Disease Indicators for Cumberland County

	Cumberland	Maine	U.S.
Chlamydia incidence per 100,000 population (2014)	287.4	265.5	452.2
Gonorrhea incidence per 100,000 population (2014)	20.8	17.8	109.8
HIV incidence per 100,000 population (2014)	11.1	4.4	11.2

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Injuries

Intentional or violence-related injury is an important public health problem that affects people of all ages. Violence prevention activities include changing societal norms regarding the acceptability of violence, improving conflict resolution and other problem-solving skills and developing policies to address economic and social conditions that can lead to violence.

Suicide is the second leading cause of death among 15- to 34-year-olds in Maine and the tenth leading cause of death among all ages combined. In Cumberland County, the age-adjusted rate of suicide deaths was 13.4 per 100,000 population, compared to 15.2 for the state over the same time period.

Table 12. Key Intentional Injury Indicators for Cumberland County

	Cumberland	Maine	U.S.
Domestic assault reports to police per 100,000 population (2013)	327.1	413.0	NA
Firearm deaths per 100,000 population (2009-2013)	*6.3**	9.2	10.4
Intentional self-injury (Youth) (2013)	NA	17.9%	NA
Nonfatal child maltreatment per 1,000 population (2013)	NA	14.6	9.1
Suicide deaths per 100,000 population (2009-2013)	13.4	15.2	12.6
Violent crime rate per 100,000 population (2013)	139.2	125.0	367.9

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Unintentional injuries are a leading cause of death and disability. While many people think of unintentional injuries as a result of accidents, most are predictable and preventable. Unintentional injury was the leading cause of death among 1- to 44-year-olds in Maine and the fifth-leading cause of death among all ages combined in 2013. Motor vehicle crashes, unintentional poisonings, traumatic brain injuries and falls lead to millions of dollars in medical and lost work costs.

Table 13. Key Unintentional Injury Indicators for Cumberland County

	Cumberland	Maine	U.S.
Always wear seatbelt (Adults) (2013)	*89.7%**	85.2%	NA
Always wear seatbelt (High School Students) (2013)	*67.3%**	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population (2011)	*75.7**	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population (2009-2013)	11.7	11.1	13.2
Unintentional fall related injury emergency department visits per 10,000 population (2011)	*306.0**	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population (2009-2013)	*6.4**	10.8	10.5

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Mental Health

Mental health is a complex issue that can affect many facets of a person's daily life. In the U.S., about one in four adults and one in five children have diagnosable mental disorders and they are the leading cause of disability among people ages 15-44.[11] In Cumberland County, 18.3 percent of adults reported currently receiving outpatient mental health treatment (taking medicine or receiving treatment from a doctor) in 2011-2013, compared to 17.7 percent of adults statewide.

Mental well-being can also affect a person's physical health in many ways, including chronic pain, a weakened immune system and increased risk for cardiovascular problems. In addition, mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors.[12]

Stigma, additional health issues, access to services and complexities of treatment delivery also prevent many from receiving adequate treatment for their mental health issues.

Percentage of Adults with Current Depression

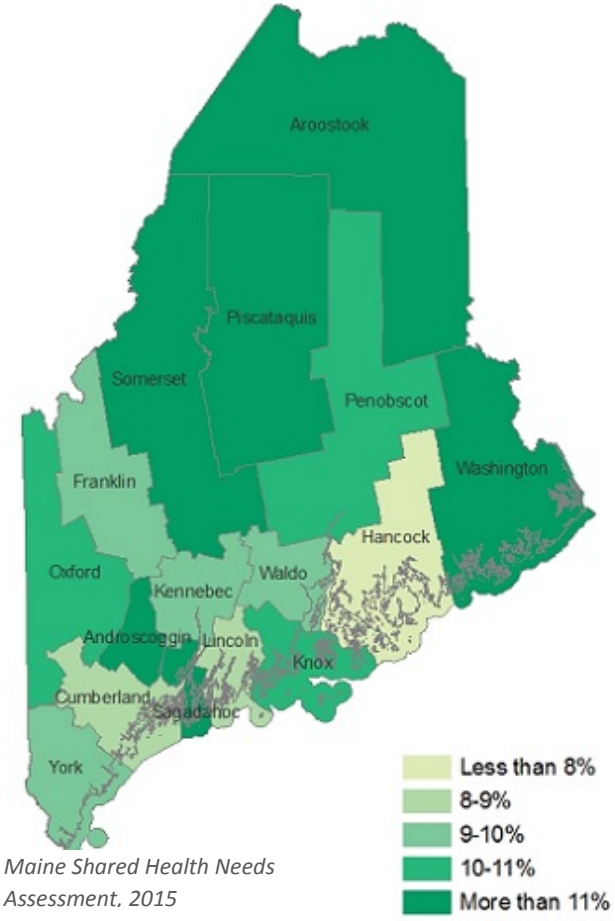

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Table 14. Key Mental Health Indicators for Cumberland County

	Cumberland	Maine	U.S.
Adults who have ever had depression (2011-2013)	23.1%	23.5%	18.7%
Adults with current symptoms of depression (2011-2013)	8.4%	10.0%	NA
Adults currently receiving outpatient mental health treatment (2011-2013)	18.3%	17.7%	NA
Mental health emergency department rates per 100,000 population (2011)	*2,152.3**	1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students) (2013)	22.6%	24.3%	29.9%
Seriously considered suicide (High School Students) (2013)	13.5%	14.6%	17.0%

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[11] Guide to Community Preventive Services. Improving mental health and addressing mental illness. www.thecommunityguide.org/mentalhealth/index.html.
[12] US Department of Health and Human Services. Health People 2020: Mental Health and Mental Disorders. 2012 Available from: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28.

Physical Activity, Nutrition and Weight

Eating a healthy diet, being physically active and maintaining a healthy weight are essential for an individual's overall health. These three factors can help lower the risk of developing numerous health conditions, including high cholesterol, high blood pressure, heart disease, stroke, diabetes and cancer. They also can help prevent existing health conditions from worsening over time.

Sugar-sweetened beverages, such as non-diet soda, sports drinks and energy drinks, provide little to no nutritional value, but their calories can lead to obesity and being overweight, along with health risks including tooth decay, heart disease and type 2 diabetes.

The 2008 *Physical Activity Guidelines for Americans* recommends that adults, age 18-64, get a minimum of 150 minutes of moderate-intensity physical activity a week and that children, age 6-17, get 60 or more minutes of physical activity each day.[13] Among adults in Cumberland County from 2011-2013, 16.9 percent led a sedentary lifestyle, meaning they did not participate in any leisure-time (non-work) physical activity or exercise in the previous month.

Percentage of Obese Adults

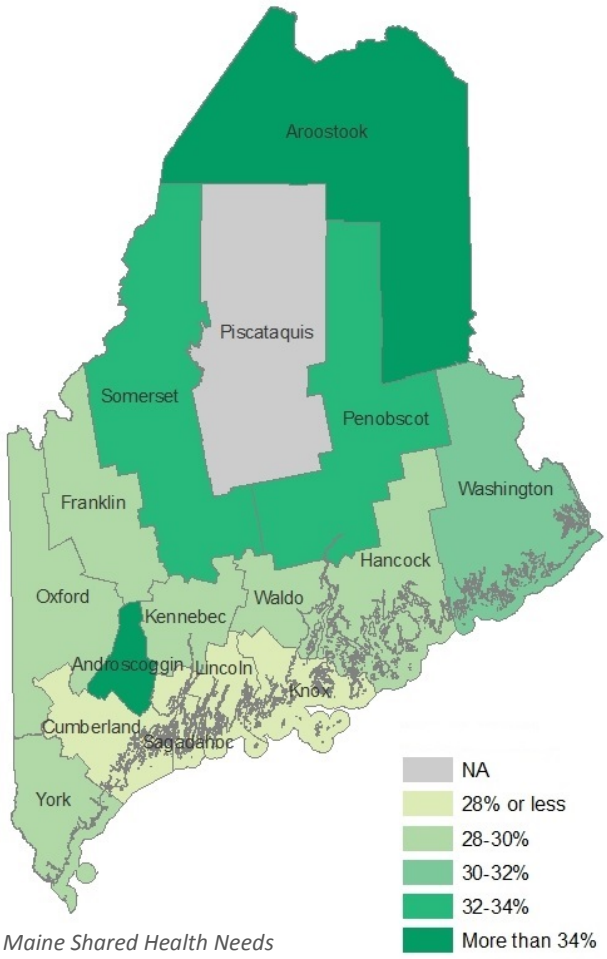

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Table 15. Key Nutrition and Physical Activity Indicators for Cumberland County

	Cumberland	Maine	U.S.
Fruit and vegetable consumption (High School Students) (2013)	*19.7%**	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day) (2013)	*28.8%**	34.0%	39.2%
Met physical activity recommendations (Adults) (2013)	57.8%	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students) (2013)	45.9%	43.7%	47.3%

[13] Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services, 2008, http://health.gov/Paguidelines/guidelines/

	Cumberland	Maine	U.S.
Sedentary lifestyle – no leisure-time physical activity in past month (Adults) (2011-2013)	*16.9%**	22.4%	25.3%
Soda/sports drink consumption (High School Students) (2013)	*21.9%**	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day) (2013)	17.1%	17.9%	22.9%

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In 2013, 58.8 percent of adults 18 years and older in Cumberland County were overweight or obese (35.1 percent were overweight and 23.7 percent were obese). Overall in Maine, 64.8 percent of adults were overweight or obese.

Table 16. Key Weight Indicators for Cumberland County

	Cumberland	Maine	U.S.
Obesity (Adults) (2013)	*23.7%**	28.9%	29.4%
Obesity (High School Students) (2013)	*9.3%**	12.7%	13.7%

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Pregnancy and Birth Outcomes

Addressing health risks during a woman's pregnancy can help prevent future health issues for women and their children. Increasing access to quality care both before pregnancy and between pregnancies can reduce the risk of pregnancy-related complications and maternal and infant mortality. Early identification and treatment of health issues among babies can help prevent disability or death.[14]

Table 17. Key Pregnancy and Birth Outcomes for Cumberland County

	Cumberland	Maine	U.S.
Infant deaths per 1,000 live births (2003-2012)	5.7	6.0	6.0
Live births for which the mother received early and adequate prenatal care (2010-2012)	85.9%	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population (2010-2012)	*12.2**	20.5	26.5
Low birth weight (<2500 grams) (2010-2012)	6.5%	6.6%	8.0%

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[14] Healthy People 2020. Maternal, infant, and child health: overview. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

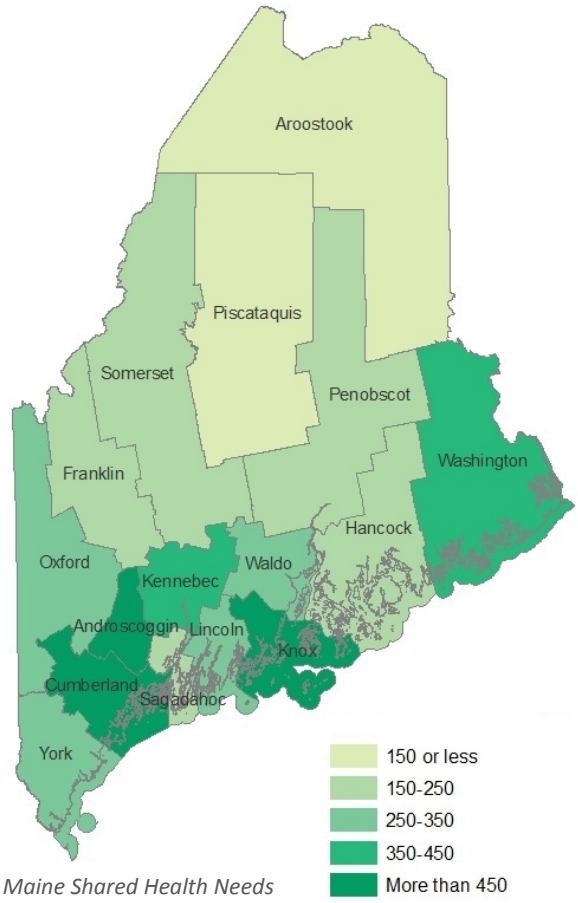
Substance and Alcohol Abuse

Substance abuse and dependence are preventable health risks that lead to increased medical costs, injuries, related diseases, cancer and even death. Substance abuse also adversely affects productivity and increases rates of crime and violence.[15] In Maine in 2010, approximately $300 million was spent on medical care where substance use was a factor.[16]

Of particular note is the recent increase in heroin and prescription opioid dependence and mortality, both nationally and in the state. From 2002 to 2013, heroin overdose death rates nearly quadrupled in the U.S., from 0.7 deaths to 2.7 deaths per 100,000 population. The rates nearly doubled from 2011 to 2013.[17] In addition, data from the National Survey on Drug Use and Health (NSDUH) indicate that heroin use, abuse and dependence have increased in recent years.[11]

The heroin problem in Maine has become a focus of national attention.[18] Deaths from heroin overdoses in Maine rose from seven in 2010 to 57 in 2014[19] and that number continues to climb in 2015.[20]

Substance Abuse Hospitalizations



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[15] National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse. NIH publication No. 11-5316, revised 2012. Available at www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations

[16] The Cost of Alcohol and Drug Abuse in Maine, 2010. Office of Substance Abuse and Mental Health Services, Department of Health and Human Services, 2013. Available at: http://www.maine.gov/dhhs/samhs/osa/pubs/data/2013/Cost2010-final%20Apr%2010%2013.pdf

[17] Jones CM, Logan J, Gladden M, Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013, Morbidity and Mortality Weekly Report (MMWR), 2015. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm

[18] Heroin in New England, More Abundant and Deadly. The New York Times. July 18, 2013. http://www.nytimes.com/2013/07/19/us/heroin-in-new-england-more-abundant-and-deadly.html

[19] Heroin Deaths in Maine Jump – Record Level of Overdose Deaths in 2014. May 15, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=644190

[20] First half of 2015 shows pace of drug deaths has not slowed – Heroin, Fentanyl deaths continue to surge. August 20, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=653671

Table 18. Key Substance Abuse Indicators for Cumberland County

	Cumberland	Maine	U.S.
Alcohol-induced mortality per 100,000 population (2009-2013)	7.0	8.0	8.2
Chronic heavy drinking (Adults) (2011-2013)	*9.0%**	7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births (2014)	3.9%	7.8%	NA
Drug-induced mortality per 100,000 population (2009-2013)	12.7	12.4	14.6
Emergency medical service overdose response per 100,000 population (2014)	467.0	391.5	NA
Opiate poisoning (ED visits) per 100,000 population (2009-2011)	*35.3**	25.1	NA
Past-30-day alcohol use (High School Students) (2013)	25.6%	26.0%	34.9%
Past-30-day marijuana use (High School Students) (2013)	22.0%	21.6%	23.4%
Prescription Monitoring Program opioid prescriptions (days supply/pop) (2014-2015)	4.7	6.8	NA
Substance-abuse hospital admissions per 100,000 population (2011)	*477.8**	328.1	NA

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Tobacco Use

Use of tobacco is the most preventable cause of disease, death and disability in the United States. Despite this, more than 480,000 deaths in the United States are attributable to tobacco use every year [21] (more than from alcohol use, illegal drug use, HIV, motor vehicle injuries and suicides combined). In addition, exposure to secondhand tobacco smoke has been causally linked to cancer and to respiratory and cardiovascular diseases in adults, and to adverse effects on the health of infants and children, such as respiratory and ear infections.[22] While the percentage of Maine adults who smoke cigarettes has declined significantly over time, one-fifth of the state's population still smokes cigarettes, including 17.0 percent of adults in Cumberland County.

[21] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

[22] U.S. Department of Health and Human Services. Healthy People 2020. Leading health indicators: tobacco overview and impact. Available from: http://www.healthypeople.gov/2020/LHI/tobacco.aspx

Table 19. Key Tobacco Use Indicators for Cumberland County

	Cumberland	Maine	U.S.
Current smoking (Adults) (2011-2013)	17.0%	20.2%	19.0%
Current smoking (High School Students) (2013)	10.8%	12.9%	15.7%
Current tobacco use (High School Students) (2013)	16.4%	18.2%	22.4%
Secondhand smoke exposure (Youth) (2013)	*30.6%**	38.3%	NA

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Stakeholder Feedback

In June 2015, the Maine Shared CHNA research team conducted a survey among stakeholders to identify and prioritize significant health issues in communities across the state. The purpose of the survey was to include the voices and broad interests of local stakeholders about community health needs in their areas. The survey instrument was designed in collaboration with the Maine Shared CHNA Steering Committee and its work groups; it covered four domains of questions:

- Stakeholder demographic information
- Health issues with the greatest impact
- Determinants of health
- Health priorities and challenges

The survey was administered using a snowball approach, where stakeholder agencies agreed to send the surveys to their members and stakeholders for participation. Statewide, 1,639 people completed the survey; 176 of the total respondents indicated that they worked in Cumberland County. Respondents represented health care agencies, public health agencies, law enforcement, municipalities, schools, businesses, social service agencies and non-governmental organizations.

There were 403 respondents who indicated they worked at the state-level (e.g., Maine CDC, businesses that spanned the state, etc.). These respondents were included in the overall results, but were not included in any of the county-level results. Respondents could indicate that they represent more than one county in the survey, therefore the total of completed surveys by county will add up to more than 1,639.

Stakeholder Ratings of Health Issues

How much of a problem is __ in Cumberland County? (Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes percent reporting 4-Major or 5-Critical problem).

Health Issue	Cumberland	Maine
Family Health	n=176	n=1,639
Childhood obesity	60%	58%
Elder health	57%	55%
Child developmental issues	29%	34%
Adolescent health	24%	25%
Maternal and child health	22%	23%
Infant mortality	8%	4%
Chronic Diseases		
Obesity	74%	78%
Diabetes	66%	63%
Depression	64%	67%
Cardiovascular diseases	61%	63%
Respiratory diseases	59%	60%
Cancer	49%	50%
Neurological diseases	41%	35%
Musculoskeletal diseases	28%	28%
Infectious Diseases		
Infectious diseases	24%	22%
Sexually transmitted diseases/HIV/AIDS	20%	13%
Healthy Behaviors		
Drug and alcohol abuse	75%	80%
Physical activity and nutrition	62%	69%
Tobacco use	59%	63%
Other Health Issues		
Mental health	77%	71%
Oral health	59%	53%
Violence	41%	38%
Unintentional injury	37%	34%
Suicide and self-harm	35%	37%
Lead poisoning and other environmental health issues	16%	17%

Top Health Issues

Cumberland County stakeholders ranked a set of 25 health issues on "how you feel they impact overall health of residents" on a five-point scale, where 1 is "not at all a problem" and 5 is "critical problem." The top five issues of concern reported for the county were:

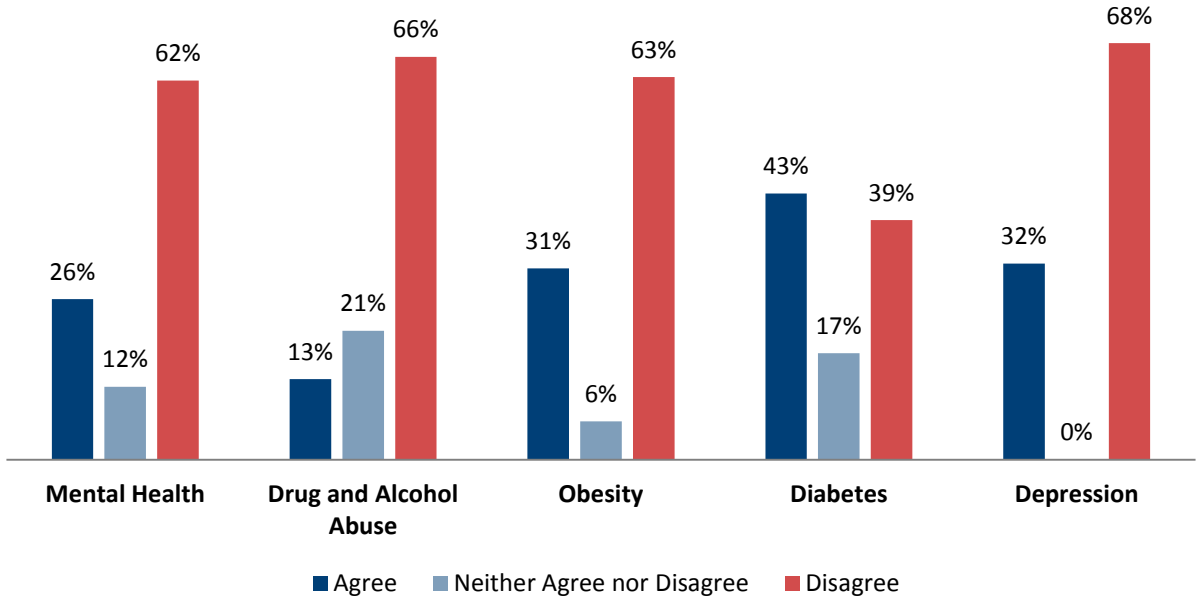
- Mental Health
- Drug and Alcohol Abuse
- Obesity
- Diabetes
- Depression

Respondents were asked probing statements about the three issues they knew the most about. The question was worded as follows:

"The health system (including public health) in Cumberland County has the ability to significantly improve [ ] health issue."

Stakeholder responses on the probing question for the top five health issues appear in Figure 3.

Figure 3. The health system (including public health) in Cumberland County has the ability to significantly improve these health issues.



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Stakeholders were also asked to share their thoughts on the populations experiencing health disparities for the health issues that they selected. Results for the top five health issues in Cumberland County are presented in Table 20.

Table 20. Percentage of Stakeholders who agreed that Significant Disparities Exist Among Specific Groups for a Specific Health Issue.

Populations Experiencing Health Disparities	Mental health	Drug and alcohol abuse	Obesity	Diabetes	Depression
Low- income, including those below the federal poverty limit	79%	85%	87%	89%	76%
Medically-underserved - including uninsured and under-insured	74%	63%	70%	78%	68%
Less than a high school education and/ or low literacy	56%	67%	61%	66%	52%
Very rural and/or geographically isolated people	56%	49%	44%	47%	53%
People with disabilities - physical, mental, or intellectual	63%	41%	47%	46%	61%
Limited or no English proficiency	21%	14%	12%	25%	20%
Military veterans	43%	34%	4%	9%	43%
Gay, lesbian, bisexual or transgendered people	36%	30%	4%	3%	34%
Women	20%	17%	15%	5%	22%
Members of any Federally-recognized Tribe	19%	21%	12%	13%	17%
Refugees/immigrants	20%	8%	4%	9%	18%
Specific age group	12%	12%	10%	11%	10%
Racial/ethnic minority populations	11%	9%	4%	13%	10%
Deaf and hard of hearing people	11%	3%	3%	7%	9%
Adolescents/Teens (13-17)	6%	8%	3%	1%	6%
Seniors/Elderly (65+)	3%	-	3%	6%	4%
Youth/Children (0-12)	4%	-	4%	2%	2%
Adults (21-64)	-	3%	1%	6%	-
Young adults (18-21)	2%	7%	1%	1%	1%
All ages	-	-	-	1%	1%
Other	12%	12%	6%	6%	11%

Stakeholder input also pointed out the key social or environmental drivers in Maine that lead to these health issues. The key drivers for the top five health issues in Cumberland County are presented in Table 21.

Table 21. Percentage of Stakeholders who identified Certain Factors as Key Drivers that lead to a Specific Health Condition

Key Drivers	Mental health	Drug and alcohol abuse	Obesity	Diabetes	Depression
Poverty/low income/low socio-economic status	27%	30%	40%	46%	37%
Lack of education	15%	11%	31%	26%	12%
Lack of access to healthy foods	1%	-	28%	21%	-
Bad eating habits	1%	-	26%	24%	1%
Lack of access to physical activity opportunities	-	-	25%	13%	1%
Lack of access to behavioral care/mental health care	44%	3%	-	1%	34%
Isolated and rural areas	14%	11%	9%	15%	26%
Inadequate health literacy	-	8%	9%	13%	1%
Cultural or social norms/acceptance/role modeling	4%	22%	9%	9%	7%
Lack of transportation	11%	6%	8%	13%	18%
Lack of access to treatment	2%	33%	2%	5%	1%
Lack of employment opportunities	6%	17%	2%	1%	6%
Social attitudes such as discrimination, stigma, etc.	34%	14%	2%	3%	29%
Lack of health care insurance	10%	5%	2%	5%	9%
Adverse childhood experiences	5%	3%	2%	-	4%
Substance use/addiction	5%	2%	2%	2%	9%
Lack of access to primary care	3%	-	2%	10%	1%
Personal responsibility	3%	4%	8%	9%	1%
Apathy/depression/hopelessness	2%	11%	5%	3%	5%
Food insecurity	1%	-	4%	4%	1%
Co-morbidity-physical or behavioral	4%	-	3%	8%	3%
Lack of exercise		-	3%	6%	-
Lack of social support and interactions-positive	1%	14%	2%	2%	7%
Mental illness	2%	2%	2%	-	3%
Lack of civic participation	1%	-	2%	-	1%
Abuse/trauma	3%	3%	1%	-	4%
Lack of funding-programs/low reimbursement to providers	8%	2%	1%	2%	5%

The next section of this report has a list of the community resources and assets that are available in the area to address these health issues and drivers, along with a summary of the additional resources that are needed. See **Table 23. Priority Health Issues** in the following section of this report.

Top Health Factors

Health factors are those conditions, such as health behaviors, socioeconomic status, or physical environment features that can affect the health of individuals and communities. Stakeholders prioritized 26 health factors in five categories that can play a significant role in the incidence and prevalence of health problems in their communities.

Stakeholders responded to the following question: "For the factors listed below, please indicate how much of a problem each is in your area and leads to poor health outcomes for residents." They responded using a scale of 1 to 5, where 1 means "not a problem at all," and 5 means "critical problem." Respondents selected the following five factors as greatest problems that lead to poor health outcomes in Cumberland County:

- Access to Behavioral care/mental health Care
- Poverty
- Health Care Insurance
- Health Literacy
- Access to Oral Health

As with health issues, stakeholders were asked further probing questions on the three factors that they believe have the greatest impact on the health of their county.

To understand the capacity available in the county to address the most significant health factors identified by stakeholders, respondents were asked additional probing statements about the issues they knew the most about. "The health system (including public health) in Cumberland County has the ability to significantly improve these health factors with the current investment of time and resources."

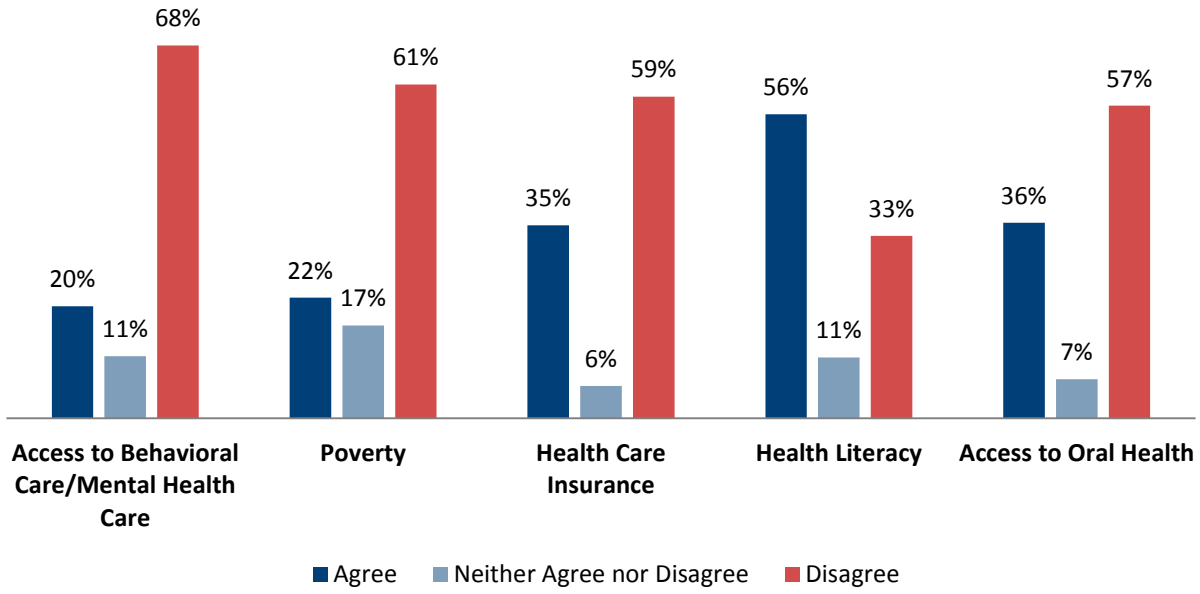
Stakeholder Ratings of Health Factors

How much of a problem is __ in Cumberland County? (Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes percent reporting 4-Major or 5-Critical problem).

Health Factor	Cumberland	Maine
Economic Stability	n=176	n=1,639
Poverty	74%	78%
Housing stability	63%	57%
Food security	58%	58%
Employment	52%	64%
Education		
Early Childhood Education/Development	40%	43%
Language and literacy	38%	34%
Enrollment in higher education	31%	35%
High school graduation	28%	31%
Social and Community Context		
Social support and interactions	52%	50%
Adverse childhood experiences	52%	56%
Caregiver support	40%	46%
Incarceration or Institutionalization	37%	35%
Social Attitudes (such as Discrimination)	35%	38%
Civic participation	27%	30%
Health and Health Care		
Access to behavioral care/mental health care	80%	67%
Health care insurance	69%	64%
Health literacy	67%	62%
Access to oral health	64%	56%
Access to other health care	48%	41%
Access to primary care	48%	39%
Neighborhood and Built Environment		
Transportation	59%	67%
Access to healthy foods	56%	53%
Access to physical activity opportunities	38%	42%
Quality of housing	36%	34%
Crime and violence	29%	27%
Environmental Conditions (Air quality, water quality, pollution, etc.)	14%	12%

Stakeholder responses on the probing question for the top five health issues appear in Figure 4.

Figure 4. The health system in Cumberland County (including public health) has the ability to significantly improve these health factors with the current investment of time and resources.



Maine Shared Community Health Needs Assessment, 2015

The next section of this report has a list of the community resources and assets that are available in the area to address these health factors, along with a summary of the additional resources that are needed. See **Table 25. Priority Health Factors** in the next section.

Cumberland County Priority Health Issues and Factors

Table 22 presents a summary of the health issues - successes and challenges - experienced by residents of Cumberland County. Data come from a comprehensive analysis of available surveillance data (see Table 28 for a full list of the health indicators and factors included in this project). Two criteria were used to select the issues in this table: statistically significant and relative differences between the county and state. **Statistically significant differences**, using a 95 percent confidence level, are noted with an asterisk (*) after the indicator. A **rate ratio** was also calculated to compare the relative difference between the county and state. Indicators where the county was 10 percent or more above or below the state average are included in this table.

Table 22. Priority Health Issue Successes and Challenges for Cumberland County-Surveillance Data

Health Issues - Surveillance Data	
Health Successes	**Health Challenges**

• Cumberland County has less adults who rate their health fair to poor [CUMB=11.5%; ME=15.6%]*, less adults with 14+ days lost due to poor physical health [CUMB=10.6%; ME=13.1%]* as well as less adults with three or more chronic conditions [CUMB=23.2%; ME=27.6%]*
• Low overall mortality rate per 100,000 population [CUMB=687.2; ME=745.8]*
• Low ambulatory care-sensitive condition hospital admission rate per 100,000 population [CUMB=1,167.5; ME=1,499.3]*
• Cumberland County fares better than the state on a number of respiratory health indicators, including:
  • Low asthma emergency department visits per 10,000 population [CUMB=57.3; ME=67.3]*
  • Lower COPD diagnosed [CUMB=5.1%; ME=7.6%]*
  • Low COPD hospitalizations per 100,000 population [CUMB=159.1; ME=216.3]*
  • Low pneumonia emergency department rate per 100,000 population [CUMB=558.7; ME=719.9]*
  • Low pneumonia hospitalizations per 100,000 population [CUMB=229.9; ME=329.4]*
	• Cumberland has high incidence rates for bladder cancer [CUMB=27.6; U.S.=20.2] as well melanoma [CUMB=27.9; ME=22.2]*
	• More children with confirmed elevated blood lead levels (% among those screened) [CUMB=3.2%; ME=2.5%]*
	• Cumberland County also has higher incidence rates than the state for:
	  • Newly reported chronic hepatitis B virus (HBV) [CUMB=19.5; ME=8.1]
	  • HIV [CUMB=11.1; ME=4.4]
	• High mental health ED visits rate [CUMB=2,152.3; ME=1,972.1]*
	• Cumberland has more binge drinking of alcoholic beverages [CUMB=20.7%; ME=17.4%]* as well as more chronic heavy drinking [CUMB=9.0%; ME=7.3%]* among adults
	• High emergency medical service overdose response per 100,000 population [CUMB=467.0; ME=391.5]
	• In addition, Cumberland County has a high opiate poisoning ED visits rate [CUMB=35.3; ME=25.1]* as well as a high substance-abuse hospital admissions rate

Health Issues - Surveillance Data

Health Successes	Health Challenges

• Low mortality – all cancers per 100,000 population [CUMB=174.9; ME=185.5]*
• Cumberland County fares better than the state on several cardiovascular health indicators, including:
  • Low acute myocardial infarction hospitalizations per 10,000 population [CUMB=14.8; ME=23.5]*
  • Low acute myocardial infarction mortality per 100,000 population [CUMB=22.4; ME=32.2]*
  • Low coronary heart disease mortality per 100,000 population [CUMB=68.0; ME=89.8]*
  • Low heart failure hospitalizations per 10,000 population [CUMB=19.0; ME=21.9]*
  • Lower high cholesterol [CUMB=36.7%; ME=40.3%]*
  • Low hypertension hospitalizations per 100,000 population [CUMB=23.2; ME=28.0]
  • Low stroke hospitalizations per 10,000 population [CUMB=17.6; ME=20.8]*
  • Low stroke mortality per 100,000 population [CUMB=29.1; ME=35.0]*
• Lower diabetes prevalence (ever been told) [CUMB=7.6%; ME=9.6%]*
• Low diabetes hospitalizations (principal diagnosis) per 10,000 population [CUMB=9.3; ME=11.7]*
• Low diabetes mortality (underlying cause) per 100,000 population [CUMB=16.3; ME=20.8]*
• Fewer children with unconfirmed elevated blood lead levels (% among those screened) [CUMB=2.5%; ME=4.2%]*
• Low pertussis incidence per 100,000 population [CUMB=10.4; ME=41.9]
• Low HIV/AIDS hospitalization rate per 100,000 population [CUMB=16.3; ME=21.4]
	[CUMB=477.8; ME=328.1]*

Health Issues - Surveillance Data	
Health Successes	**Health Challenges**

• Cumberland County has lower rates than the state for:
  • Domestic assaults reports to police [CUMB=327.1; ME=413.0]
  • Firearm deaths [CUMB=6.3; ME=9.2]*
  • Reported rape [CUMB=21.3; ME=27.0] and
• Low traumatic brain injury related emergency department visits (all intents) per 10,000 population [CUMB=75.7; ME=81.4]*
• Low unintentional fall related injury emergency department visits per 10,000 population [CUMB=306.0; ME=361.3]*
• Low unintentional motor vehicle traffic crash related deaths per 100,000 population [CUMB=6.4; ME=10.8]*
• Fewer adults with current symptoms of depression [CUMB=8.4%; ME=10.0%]
• Lower co-morbidity for persons with mental illness [CUMB=29.2%; ME=35.2%]
• Low live births to 15-19 year olds per 1,000 population [CUMB=12.2; ME=20.5]*
• Lower drug-affected baby referrals received as a percentage of all live births [CUMB=3.9%; ME=7.8%]
• Low prescription Monitoring Program opioid prescriptions (days supply/pop) [CUMB=4.7; ME=6.8]	

Asterisk (*) indicates a statistically significant difference between Cumberland County and Maine
All rates are per 100,000 population unless otherwise noted

Table 23 summarizes the results of the health issues questions in the stakeholder survey for Cumberland County. It includes a summary of the biggest health challenges from the perspective of stakeholders who work in and represent communities in the county. The table also shares stakeholders' knowledge of the assets and resources available and those that are lacking but needed in the county to address the biggest health challenges.

Table 23. Priority Health Issue Challenges and Resources for Cumberland County-Stakeholder Survey Responses

Stakeholder Input - Stakeholder Survey Responses[23]	
Community Challenges	**Community Resources**
Biggest health issues in Cumberland County according to stakeholders *(% of those rating issue as a major or critical problem in their area*). • Mental health (77%) • Drug and alcohol abuse (75%) • Obesity (74%) • Diabetes (72%) • Depression (71%)	**Assets Needed to Address Challenges:** • **Mental health/depression:** More mental health professionals; more community-based services; better funding and support; greater access to inpatient care; readily available information about resources; transitional programs • **Drug and alcohol abuse:** Greater access to drug/alcohol treatments; greater access to substance abuse prevention programs; free or low-cost treatments for the uninsured; more substance abuse treatment providers; additional therapeutic programs • **Obesity:** Greater access to affordable and healthy food; more programs that support low income families • **Diabetes:** More funding **Assets Available in County/State:** • **Mental health/depression:** Mental health/counseling providers and programs • **Drug and alcohol abuse:** Maine Alcoholics Anonymous; Substance Abuse Hotlines; Office of Substance Abuse and Mental Health Services • **Obesity:** Public gyms; farmers markets; Maine SNAP-ED Program; school nutrition programs; public walking and biking trails; Healthy Maine Partnerships; Let's Go! 5-2-1-0 • **Diabetes:** National Diabetes Prevention Program; Free screenings; YMCA's (Public gyms); Education programs; School nutrition programs; Diabetes and Nutrition Center; Maine CDC DPCP

[23] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015, n=220.

Table 24 presents a summary of the major health strengths and challenges that affect the health of Cumberland County residents. Data come from a comprehensive analysis of available surveillance data (see Table 28 for a full list of the health indicators and factors included in this project). Two criteria were used to select the factors presented in this table. **Statistically significant differences**, using a 95 percent confidence level, between the county and state are noted with an asterisk (*) after the indicator. A **rate ratio** was also calculated to compare the relative difference between the county and state. Indicators where the county was 10 percent or more above or below the state average are included in this table.

Table 24. Priority Health Factor Strengths and Challenges for Cumberland County-Surveillance Data

Health Factors – Surveillance Data	
Health Factor Strengths	**Health Factor Challenges**
• Cumberland County has fewer individuals living in poverty [CUMB=11.4%; ME=13.6%]* as well as fewer children living in poverty [CUMB=15.7%; ME=18.5%]* • High median household income [CUMB=$57,461; ME=$48,453]* • Lower unemployment rate [CUMB=4.4%; ME=5.7%] • Fewer individuals who are unable to obtain or delay obtaining necessary medical care due to cost [CUMB=9.5%; U.S.=15.3%] • Lower percent of uninsured [CUMB=8.9%; ME=10.4%]* • More adults with visits to a dentist in the past 12 months [CUMB=72.8%; ME=65.3%]* • More homes with private wells tested for arsenic [CUMB=53.1%; ME=43.3%]* • More adults who always wear seatbelt [CUMB=89.7%; ME=85.2%]* • More high school students who always wear seatbelt [CUMB=67.3%; ME=61.6%]* • More fruit and vegetable consumption among high school students [CUMB=19.7%; ME=16.8%]* • Fewer adults aged 18+ with less than one serving of fruit per day [CUMB=28.8%; ME=34.0%]* • Lower sedentary lifestyle – no leisure-time physical activity in past month (Adults) [CUMB=16.9%; ME=22.4%]*	• Lower percent of lead screening among children age 12-23 months [CUMB=42.3%; ME=49.2%]* • Lower percent of lead screening among children age 24-35 months [CUMB=17.6%; ME=27.6%]* • More immunization exemptions among kindergarteners for philosophical reasons [CUMB=4.7%; ME=3.7%]

Health Factors – Surveillance Data	
Health Factor Strengths	**Health Factor Challenges**
• Lower soda/sports drink consumption (High School Students) [CUMB=21.9%; ME=26.2%]* • Less obesity among adults [CUMB=23.7%; ME=28.9%]* and high school students [CUMB=9.3%; ME=12.7%]* • Lower current cigarette smoking rate among adults [CUMB=17.0%; ME=20.2%] and high school students [CUMB=10.8%; ME=12.9%] • Less secondhand smoke exposure (Youth) [CUMB=30.6%; ME=38.3%]*	

Asterisk (*) indicates a statistically significant difference between Cumberland County and Maine
All rates are per 100,000 population unless otherwise noted

Table 25 summarizes the results of the health factor questions in the stakeholder survey for Cumberland County. It includes a summary of the health factors that cause the biggest challenges from the perspective of stakeholders who work in and represent communities in the county. The table also shares stakeholders' knowledge of the assets and resources available and those that are lacking but needed in the county to address the biggest health challenges.

Table 25. Priority Health Factor Challenges and Resources for Cumberland County- Stakeholder Responses

Stakeholder Input- Stakeholder Survey Responses [24]	
Community Challenges	**Community Resources**
Biggest health factors leading to poor health outcomes in Cumberland County according to stakeholders *(% of those rating factor as a major or critical problem in their area*). • Access to behavioral care/mental health Care (80%) • Poverty (74%) • Health care insurance (69%) • Health literacy (67%) • Access to oral health (64%)	**Assets Needed to Address Challenges:** • **Access to behavioral care/mental health care:** Better access to behavioral/mental health care for the uninsured; full behavioral/mental health integration at hospital and primary care levels; expand behavioral/mental health agencies to more rural areas; more hospital beds for mentally ill patients • **Poverty:** Greater economic development; increased mentoring services; more skills trainings; more employment opportunities at livable wages; better transportation; better education • **Health care insurance:** Expansion of Medicaid; making insurance more affordable; universal health care; more stable health care system **Assets Available in County/State:** • **Poverty:** General Assistance; other federal, state and local programs • **Access to behavioral care/mental health care:** Behavioral/mental health agencies • **Health care insurance:** MaineCare; ObamaCare (Affordable Care Act); Free care • **Health literacy:** Hospital systems; primary care providers; social service agencies.

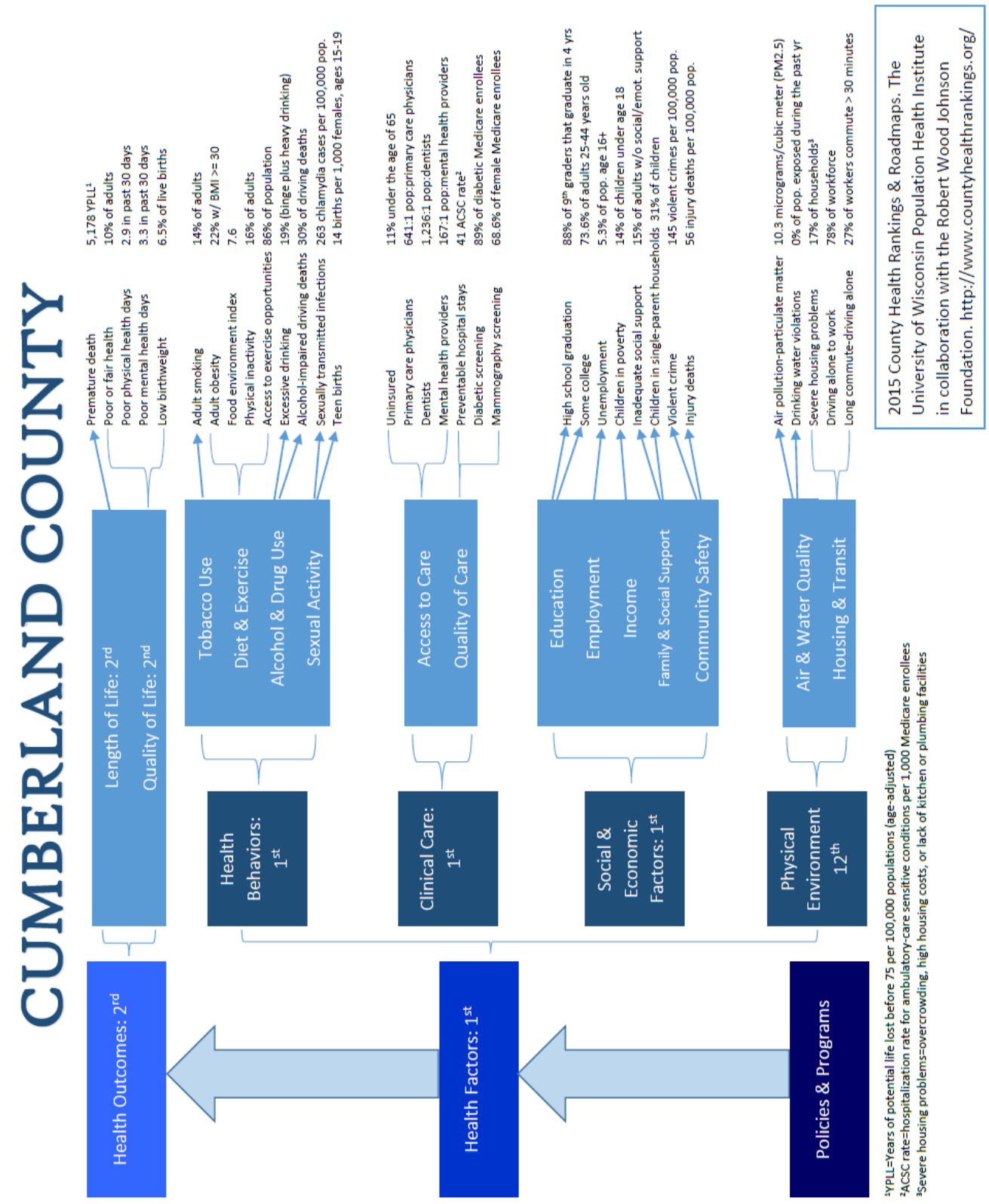
[24] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015.

County Health Rankings & Roadmaps

Each year, the University of Wisconsin Health Institute and Robert Wood Johnson Foundation produce *The County Health Rankings & Roadmaps* for every county in the U.S. The annual reports measure the social, economic, environmental and behavioral factors that influence health. These factors are quantified using indicators such as high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income and teen births, to name a few. The rankings weight and score the sets of indicators to provide county comparisons within each state. For more information: www.countyhealthrankings.org

For this analysis, the 2015 rankings data for each of Maine's 16 counties is displayed in the graphic used by the University of Wisconsin to show how all of the factors ultimately affect community health. The comparison across counties provides insight into county health status. In Maine, the county ranked as "#1" on a particular health issue, is the healthiest in that measure, "#16" is the least healthy. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to timing or use of different indicators.

In interpreting the rankings for each county, it is important to keep in mind the underlying health measures. Because of the forced ranking, one county is always the "healthiest" and one is always the "least healthy." The comparisons are helpful in understanding differences, but it is important to look past the assignment of rank to understand the underlying issues and opportunities and their relative importance in the region.


CUMBERLAND COUNTY
Health Outcomes: 2nd
Length of Life: 2nd
Quality of Life: 2nd
Premature death 5,178 YPLL¹
Poor or fair health 10% of adults
Poor physical health days 2.9 in past 30 days
Poor mental health days 3.3 in past 30 days
Low birthweight 6.5% of live births
Health Factors: 1st
Health Behaviors: 1st
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Adult smoking 14% of adults
Adult obesity 22% w/ BMI >= 30
Food environment index 7.6
Physical inactivity 16% of adults
Access to exercise opportunities 86% of population
Excessive drinking 19% (binge plus heavy drinking)
Alcohol-impaired driving deaths 30% of driving deaths
Sexually transmitted infections 263 chlamydia cases per 100,000 pop.
Teen births 14 births per 1,000 females, ages 15-19
Clinical Care: 1st
Access to Care
Quality of Care
Uninsured 11% under the age of 65
Primary care physicians 641:1 pop:primary care physicians
Dentists 1,236:1 pop:dentists
Mental health providers 167:1 pop:mental health providers
Preventable hospital stays 41 ACSC rate²
Diabetic screening 89% of diabetic Medicare enrollees
Mammography screening 68.6% of female Medicare enrollees
Social & Economic Factors: 1st
Education
Employment
Income
Family & Social Support
Community Safety
High school graduation 88% of 9th graders that graduate in 4 yrs
Some college 73.6% of adults 25-44 years old
Unemployment 5.3% of pop. age 16+
Children in poverty 14% of children under age 18
Inadequate social support 15% of adults w/o social/emot. support
Children in single-parent households 31% of children
Violent crime 145 violent crimes per 100,000 pop.
Injury deaths 56 injury deaths per 100,000 pop.
Physical Environment 12th
Air & Water Quality
Housing & Transit
Air pollution-particulate matter 10.3 micrograms/cubic meter (PM2.5)
Drinking water violations 0% of pop. exposed during the past yr
Severe housing problems 17% of households³
Driving alone to work 78% of workforce
Long commute-driving alone 27% of workers commute > 30 minutes
Policies & Programs
¹YPLL=Years of potential life lost before 75 per 100,000 populations (age-adjusted)
²ACSC rate=hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
³Severe housing problems=overcrowding, high housing costs, or lack of kitchen or plumbing facilities
2015 County Health Rankings & Roadmaps. The University of Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation. http://www.countyhealthrankings.org/

Stakeholder Survey Findings

Table 26. Stakeholder Survey Results for Cumberland County and Maine

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Cumberland County	**Maine**
Demographics		
Which of the following sectors best describes your role or organization? (12 choices, picked 1)		
Number of Respondents	n=176	n=1639
Medical care provider	23%	22%
Other non-profit or social service agency	14%	14%
Other	7%	13%
Public health	14%	11%
Business owner or employee	4%	9%
Educator	9%	8%
Other type of health care organization	10%	8%
Behavioral/mental health provider	12%	6%
Local government	2%	4%
Other governmental agency	1%	3%
Youth-serving organization	1%	2%
Faith-based organization	3%	1%
Do you work for or represent: (5 choices, picked 1)		
None of the above	38%	49%
Hospital/Health-care system	43%	38%
Local public health agency	18%	10%
Maine CDC	0%	3%
Tribal health	0%	<1%
Please identify the type of geographical area that you primarily serve? (6 choices, picked 1)		
Town or region	31%	27%
Hospital/Health service area	27%	26%
Statewide	14%	22%
County	18%	18%
Other area	9%	4%
Public health district	2%	3%
Does your organization work with specific groups of people or populations recognized as being at risk of, or experiencing, higher rates of health risk or poorer health outcomes than the general population within your area?		
Yes	36%	24%
Somewhat	49%	47%
No	14%	29%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Cumberland County	**Maine**
If "Yes" or "Somewhat" to Q4: To which of the following populations does your organization directly provide resources to address their needs? (select all that apply)		
Number of Respondents	n=151	n=1159
Don't know	2%	5%
Low-income, including those below the federal poverty limit, or defined as low-income by some other definition	81%	77%
Medically-underserved - including uninsured and under-insured	75%	63%
People with disabilities - physical, mental, or intellectual	64%	58%
Very rural and/or geographically isolated people	29%	47%
Less than a high school education and/ or low literacy (low reading or math skills)	58%	47%
Women	49%	44%
Limited or no English proficiency	60%	38%
Gay, lesbian, bisexual or transgendered people	50%	36%
Deaf and hard of hearing people	44%	35%
Military veterans	35%	34%
Refugees/immigrants	61%	28%
Racial/ethnic minority populations	44%	27%
Members of any federally recognized tribe	23%	25%
Specific age group	24%	21%
Other	16%	15%
Overall, to what degree to you feel the health needs of your area are being addressed?		
Number of Respondents	n=176	n=1639
Not addressed at all	0%	<1%
Mostly unaddressed	7%	10%
Somewhat addressed	61%	55%
Mostly addressed	30%	30%
Completely addressed	1%	2%
Don't know	2%	2%
Health Issues and Factors		
Please rate the following health issues based on how you feel they impact the overall health of residents in your area. (*Percentage of stakeholders in county who rated issue as a major or critical problem in their area*)		
Number of Respondents	n=176	n=1639
Family Health		
Adolescent health	24%	25%
Child developmental issues	29%	34%
Childhood obesity	60%	58%
Elder health	57%	55%
Infant mortality	8%	4%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Cumberland County	**Maine**
Maternal and child health	22%	23%
Chronic Diseases		
Cancer	49%	50%
Cardiovascular disease	61%	63%
Depression	64%	67%
Diabetes	66%	63%
Musculoskeletal diseases	28%	28%
Neurological diseases	41%	35%
Obesity	74%	78%
Respiratory disease	59%	60%
Infectious Diseases		
Infectious diseases	24%	22%
Sexually transmitted diseases/HIV/AIDS	20%	13%
Health Behaviors		
Drug and alcohol abuse	75%	80%
Physical activity and nutrition	62%	69%
Tobacco use	59%	63%
Other Health Issues		
Lead poisoning and other environmental health issues	16%	17%
Mental health	77%	71%
Oral health	59%	53%
Suicide and self-harm	35%	37%
Unintentional injury	37%	34%
Violence	41%	38%
"Don't know" responses not included		
Please indicate how much of a problem each of the following health factors is in your area and leads to poor health outcomes for residents. *(Percentage of stakeholders in county who rated factor as a major or critical problem in their area)*		
Number of Respondents	n=176	n=1639
Economic Stability		
Employment	52%	64%
Food security	58%	58%
Housing stability	63%	57%
Poverty	74%	78%
Education		
Enrollment in higher education	31%	35%
Early childhood education/development	40%	43%
High school graduation	28%	31%
Language and literacy	38%	34%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Cumberland County	**Maine**
Social and Community Context		
Adverse childhood experiences	52%	56%
Civic participation	27%	30%
Incarceration or institutionalization	37%	35%
Social attitudes such as discrimination	35%	38%
Social support and interactions	52%	50%
Caregiver support	40%	46%
Health and Health Care		
Access to behavioral care/mental health care	80%	67%
Access to primary care	48%	39%
Access to other health care	48%	41%
Access to oral health	64%	56%
Health care insurance	69%	64%
Health literacy	67%	62%
Neighborhood and Built Environment		
Access to healthy foods	56%	53%
Access to physical activity opportunities	38%	42%
Crime and violence	29%	27%
Environmental conditions	14%	12%
Quality of housing	36%	34%
Transportation	59%	67%
"Don't know" responses not included		
Please rank each health issue according to how you think resources in your area should be allocated. (1=highest priority and 8=lowest priority) *(mean)*		
Number of Respondents	n=130	n=1168
Risk factors that lead to poor health	3.17	3.08
Mental health - conditions that impact how people think, feel and act as they cope with life	3.30	3.49
Substance abuse behaviors, including excessive drinking, smoking, and other drug use	3.71	3.71
Community capacity - ability to sustain a high quality of life, including access to employment, education and housing	3.97	3.93
Chronic diseases, such as heart disease, cancer, diabetes, and asthma	4.07	4.05
Family health, including teen pregnancy, prenatal care, and healthy behaviors during pregnancy	5.12	4.81
Environmental issues - access to healthy foods, access to recreation, clean air, water, lead exposure, etc.	5.26	5.36
Injuries, intentional and unintentional	6.54	6.52

Health Indicators Results from Secondary Data Sources

The county level summary of health indicators analyzed from secondary data sources is presented in the table below. Results are displayed for the county, state and U.S. (where available). County trends are presented in the column after the county data when available. Results are organized by health issue or category. Please note that age-adjusted rates are presented for all applicable indicators, with the exception of ambulatory care-sensitive conditions and infectious and sexually transmitted diseases (which are presented as crude rates). A detailed list of all data sources, years and notes for all indicators is presented in Table 28.

Indicates county is significantly better than state average (using a 95% confidence level).
Indicates county is significantly worse than state average (using a 95% confidence level).
+ Indicates an improvement in the indicator over time at the county level (using a 95% confidence level)
− Indicates a worsening in the indicator over time at the county level (using a 95% confidence level)
† Results may be statistically unreliable due to small numerator, use caution when interpreting.
NA = Data not available.

Table 27. Quantitative Health Indicators for Cumberland County, Maine and the U.S.

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Demographics					
Total Population	2013	285,456		1,328,302	319 Mil
Population – % ages 0-17	2013	19.8%		19.7%	23.3%
Population – % ages 18-64	2013	64.3%		62.6%	62.6%
Population – % ages 65+	2013	15.9%		17.7%	14.1%
Population – % White	2013	92.9%		95.2%	77.7%
Population – % Black or African American	2013	2.8%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.4%		0.7%	1.2%
Population – % Asian	2013	2.2%		1.1%	5.3%
Population – % Hispanic	2013	1.9%		1.4%	17.1%
Population – % with a disability	2013	12.2%		15.9%	12.1%
Population density (per square mile)	2013	337.2		43.1	87.4
Socioeconomic Status Measures					
Adults and children living in poverty	2009-2013	*11.4%*	NA	13.6%	15.4%
Children living in poverty	2009-2013	*15.7%*	NA	18.5%	21.6%
High school graduation rate	2013-2014	88.2%	NA	86.5%	81.0%
Median household income	2009-2013	*$57,461*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	33.2%	NA	66.4%	NA
Single-parent families	2009-2013	31.2%	NA	34.0%	33.2%
Unemployment rate	2014	4.4%	NA	5.7%	6.2%
65+ living alone	2009-2013	43.1%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	*11.5%*		15.6%	16.7%

Indicates county is significantly better than state average (using a 95% confidence level).
Indicates county is significantly worse than state average (using a 95% confidence level).

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Adults with 14+ days lost due to poor mental health	2011-2013	11.4%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	*10.6%*		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	*23.2%*		27.6%	NA
Mortality					
Life expectancy (Female)	2012	82.3	NA	81.5	81.2
Life expectancy (Male)	2012	78.1	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*687.2*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	89.5%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	9.5%		11.0%	15.3%
MaineCare enrollment	2015	19.0%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	30.0%	NA	41.8%	48.0%
Percent uninsured	2009-2013	*8.9%*	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,167.5*		1,499.3	1457.5
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*3,509.6*	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	*72.8%*	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	52.9%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	*57.3*		67.3	NA
COPD diagnosed	2011-2013	*5.1%*		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	*159.1*	-	216.3	NA
Current asthma (Adults)	2011-2013	10.8%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	8.6%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	*558.7*	-	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	*229.9*	-	329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	*174.9*	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	494.8	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	27.6	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	19.7	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	43.5	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	136.4	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	83.1%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	15.3	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	23.0	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	41.2	NA	43.5	42.0

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Indicates county is significantly worse than state average (using a 95% confidence level).

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Colorectal screening	2012	72.5%	NA	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	50.7	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	69.5	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*27.9*	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	91.6%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	23.2	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	127.6	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	35.4	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	88.2	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*14.8*		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*22.4*	NA	32.2	32.4
Cholesterol checked every five years	2011. 2013	83.3%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*68.0*	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	*19.0*		21.9	NA
Hypertension prevalence	2011, 2013	29.5%		32.8%	31.4%
High cholesterol	2011, 2013	*36.7%*		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	23.2		28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	*17.6*		20.8	NA
Stroke mortality per 100,000 population	2009-2013	*29.1*	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	*7.6%*		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	6.9%		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	74.1%	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	90.2%	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	78.3%	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	62.9%	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	238.8	-	235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	*9.3*		11.7	NA
Diabetes long-term complication hospitalizations	2011	53.4		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	*16.3*	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	*3.2%*	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	*2.5%*	NA	4.2%	NA

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Indicates county is significantly worse than state average (using a 95% confidence level).

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Homes with private wells tested for arsenic	2009, 2012	*53.1%*	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*42.3%*	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	*17.6%*	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	43.4%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	73.2%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	4.7%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.7†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.3†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	1.4†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	99.4	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	19.5	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	117.4	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	10.4	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.7†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	4.2†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	287.4	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	20.8	NA	17.8	109.8
HIV incidence per 100,000 population	2014	11.1	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	16.3		21.4	NA
Syphilis incidence per 100,000 population	2014	2.1†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	327.1	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	*6.3*	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	21.3	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	13.4	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	139.2	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	*89.7%*		85.2%	NA
Always wear seatbelt (High School Students)	2013	*67.3%*		61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*75.7*	NA	81.4	NA

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Indicates county is significantly worse than state average (using a 95% confidence level).

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	11.7	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	6.9	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*306.0*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	*6.4*	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	3,750.0	NA	13,205.0	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	18.8%		19.4%	NA
Adults who have ever had depression	2011-2013	23.1%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	8.4%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	18.3%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	29.2%		35.2%	NA
Mental health emergency department rates per 100,000 population	2011	*2,152.3*	-	1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	22.6%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	13.5%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	*19.7%*	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	*28.8%*	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	57.8%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	45.9%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	*16.9%*		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	*21.9%*	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	17.1%	NA	17.9%	22.9%
Obesity (Adults)	2013	*23.7%*		28.9%	29.4%
Obesity (High School Students)	2013	*9.3%*		12.7%	13.7%
Overweight (Adults)	2013	35.1%		36.0%	35.4%
Overweight (High School Students)	2013	13.9%		16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	5.7	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	85.9%	NA	86.4%	84.8%

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Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Live births to 15-19 year olds per 1,000 population	2010-2012	*12.2*	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.5%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	7.0	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	14.5%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	*20.7%*		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	*9.0%*		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	3.9%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	12.7	NA	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	467.0	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	*35.3*		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	12.0		13.2	NA
Past-30-day alcohol use (High School Students)	2013	25.6%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.2%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	7.1%		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	22.0%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	1.0%†		1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	5.5%		5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	4.7	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*477.8*		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	17.0%		20.2%	19.0%
Current smoking (High School Students)	2013	10.8%		12.9%	15.7%
Current tobacco use (High School Students)	2013	16.4%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	*30.6%*		38.3%	NA

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Indicates county is significantly worse than state average (using a 95% confidence level).

Table 28. List of Data Sources and Years for Quantitative Health Indicators

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Demographics			
Population	U.S. Census	2013	2013 data was used for all age, racial and ethnic groups.
Population with a disability	U.S. Census	2011-2013	Adults reporting any one of the six disability types are considered to have a disability: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, independent living difficulty.
Population density	U.S. Census	2010	Based on 2010 U.S. Census population.
Socioeconomic Status Measures			
Adults and children living in poverty	U.S. Census	2009-2013	The poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. The American Community Survey measures poverty in the previous 12 months instead of the previous calendar year.
Children living in poverty	U.S. Census	2009-2013	The poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. The American Community Survey measures poverty in the previous 12 months instead of the previous calendar year.
High school graduation rate	Maine Dept. of Education	2013-14 School Year	Proportion of students who graduate with a regular diploma four years after starting ninth grade. Graduation rates include all public schools and all private schools that have 60% or more publicly funded students.
Median household income	U.S. Census	2009-2013	In 2013 inflation-adjusted dollars. This includes the income of the householder and all other individuals 15 years old and older in the household, whether they are related to the householder or not.
Percentage of people living in rural areas	U.S. Census	2012	The urban/rural categories used in this analysis were defined by the New England Rural Health Roundtable available in Rural Data For Action 2nd Edition: http://www.newenglandruralhealth.org/rural_data
Single-parent families	U.S. Census	2009-2013	Families consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. "Householder without a spouse present" is defined as a male householder without a wife present or a female householder without a husband present.
Unemployment rate	Bureau of Labor Statistics	2014	Unemployment rate of the civilian noninstitutionalized population averaged for the full year of 2014.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
65+ living alone	U.S. Census	2009-2013	Estimated number of one-person households with a person 65 years and older.
General Health Status			
Adults who rate their health fair to poor	BRFSS	2011-2013	Adults rating their health as fair or poor vs. excellent, very good or good.
Adults with 14+ days lost due to poor mental health	BRFSS	2011-2013	Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?
Adults with 14+ days lost due to poor physical health	BRFSS	2011-2013	Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
Adults with three or more chronic conditions	BRFSS	2011, 2013	Chronic conditions available in 2013 BRFSS: arthritis, asthma, cancer, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, hypertension, high cholesterol, obesity.
Mortality			
Life expectancy (Female)	National Center for Health Statistics	2012	Life expectancy at birth.
Life expectancy (Male)	National Center for Health Statistics	2012	Life expectancy at birth.
Overall mortality rate per 100,000 population	DRVS	2009-2013	All deaths are defined as deaths in which the underlyin g cause of death was coded as ICD-10 any listed.
Access			
Adults with a usual primary care provider	BRFSS	2011-2013	Adults that have one or more person they think of as their personal doctor or health care provider.
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	BRFSS	2011-2013	Adults reporting that there was a time during the last 12 months when they needed to see a doctor but could not because of the cost.
MaineCare enrollment	MaineCare	2015	The number and percent of individuals participating in MaineCare. These data are reported as of April 2015. Percentages calculated based on the 2014 US Census population estimates. Individuals are reported by county of residence at the end of the SFY or the end of participation in the program. Figures exclude individuals who were nonresidents or who were out of state.
Percent of children ages 0-19 enrolled in MaineCare	MaineCare	2015	The number and percent of individuals participating in MaineCare. These data are reported as of April 2015. Individuals are reported by county of residence at the end of the SFY or the end of participation in the program. Figures exclude individuals who were nonresidents or who were out of state.
Percent uninsured	U.S. Census	2009-2013	Estimated number of Maine people who do not currently have health insurance.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Health Care Quality			
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	MHDO	2011	PQI = Prevention Quality Indicators, a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care-sensitive conditions. Additional information at: AHRQ Quality Indicators, Version 4.4, Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services. http://www.qualityindicators.ahrq.gov.
Ambulatory care-sensitive condition emergency department rate per 100,000 population	MHDO	2011	PQI = Prevention Quality Indicators, a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care-sensitive conditions. Additional information at: AHRQ Quality Indicators, Version 4.4, Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services. http://www.qualityindicators.ahrq.gov.
Oral Health			
Adults with visits to a dentist in the past 12 months	BRFSS	2012	Adults who last visited the dentist or a dental clinic for any reason in the past 12 months.
MaineCare members under 18 with a visit to the dentist in the past year	Maine Care	2014	Total members younger than 18 with dental claims during calendar year 2014 was 67,871. Of those, only 61,948 had eligibility as of April 2015. Members were younger than 18 on date of service, but some turned 18 by April 2015.
Respiratory			
Asthma emergency department visits per 10,000 population	MHDO	2009-2011	ICD-9 CM - 493
COPD diagnosed	BRFSS	2011-2013	Adults that have been told by a doctor, nurse or health professional that they have COPD chronic obstructive pulmonary disease, emphysema, or chronic bronchitis.
COPD hospitalizations per 100,000 population	MHDO	2011	ICD-9 CM - 490, 491, 492, 494, 496
Current asthma (Adults)	BRFSS	2011-2013	Adults that have been told by a doctor, nurse or health professional that they had asthma and that they still have asthma.
Current asthma (Youth 0-17)	BRFSS	2011-2013	Children that have been told by a doctor, nurse or health professional that they had asthma and that they still have asthma.
Pneumonia emergency department rate per 100,000 population	MHDO	2011	ICD-9 CM - 480-486
Pneumonia hospitalizations per 100,000 population	MHDO	2011	ICD-9 CM - 480-486
Cancer			
Mortality – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Cause of Death Recode: 20010-37000 (which include ICD-10 codes: C00-C97).
Incidence – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Site Recode: 20010-37000 (which include ICD-O-3 codes: C00-C797).

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Bladder cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Female breast cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Breast cancer late-stage incidence (females only) per 100,000 population	Maine Cancer Registry (MCR)	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Female breast cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Mammograms females age 50+ in past two years	BRFSS	2012	Females ages 50 years and older who reported they had a mammogram within the past 2 years.
Colorectal cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Colorectal late-stage incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Colorectal cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Colorectal screening	BRFSS	2012	Adults ages 50 years and older who reported that they had a home blood stool test (e.g., FOBT or FIT) within the past year OR sigmoidoscopy within the past 5 years and home blood stool test within the past 3 years OR a colonoscopy within the past 10 years.
Lung cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Lung cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Melanoma incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Pap smears females ages 21-65 in past three years	BRFSS	2012	Females with intact cervix, that have received a pap smear within the past three years.
Prostate cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Prostate cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Tobacco-related neoplasms, mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Tobacco-related neoplasms, incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Cardiovascular Disease			
Acute myocardial infarction hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 410
Acute myocardial infarction mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I21-I22
Cholesterol checked every five years	BRFSS	2011. 2013	Adults reporting that they last had their blood cholesterol checked within the past 5 years.
Coronary heart disease mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I20-I25
Heart failure hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 428
Hypertension prevalence	BRFSS	2011, 2013	Adults who have ever been told by a doctor, nurse, or other health professional that they have high blood pressure.
High cholesterol	BRFSS	2011, 2013	Adults who have been told by a doctor or other health professional that their blood cholesterol is high.
Hypertension hospitalizations per 100,000 population	MHDO	2011	ICD-9 CM - 401, 402, 403, 404
Stroke hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 430-438
Stroke mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I60-I69
Diabetes			
Diabetes prevalence (ever been told)	BRFSS	2011-2013	Adults that have ever been told by a doctor or other health professional that they have diabetes.
Pre-diabetes prevalence	BRFSS	2011-2013	Adults that have ever been told by a doctor or other health professional that they have pre-diabetes or borderline diabetes.
Adults with diabetes who have eye exam annually	BRFSS	2011-2013	Adults with diabetes who report having an eye exam in which the pupils were dilated within the past year.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Adults with diabetes who have foot exam annually	BRFSS	2011-2013	Adults with diabetes who report having a health professional check their feet for any sores or irritations within the past year.
Adults with diabetes who have had an A1C test twice per year	BRFSS	2011-2013	Adults who have had a doctor, nurse, or other health professional checked them for "A one C" in the past 12 months.
Adults with diabetes who have received formal diabetes education	BRFSS	2011-2013	Adults with diabetes who have ever taken a course or class in how to manage your diabetes themselves.
Diabetes emergency department visits (principal diagnosis) per 100,000 population	MHDO	2011	ICD-9 CM - 250
Diabetes hospitalizations (principal diagnosis) per 10,000 population	MHDO	2010-2012	ICD-9 CM - 250
Diabetes long-term complication hospitalizations	MHDO	2011	Diabetes long-term complication hospitalizations are defined as hospitalizations of Maine residents for which diabetes long-term complication was the primary diagnosis, coded as ICD 9 - 25040, 25070, 25041, 25071, 25042, 25072, 25043, 25073, 25050, 25051, 25052, 25053, 25080, 25081, 25082, 25083, 25060, 25061, 25062, 25063, 25090, 25091, 25092.
Diabetes mortality (underlying cause) per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 E10-E14
Environmental Health			
Children with confirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2009-2013	In 2012, CDC defined a reference level of 5 micrograms per deciliter (µg/dL) to identify children with elevated blood lead levels. These children are exposed to more lead than most children. For more information, visit: www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm(http://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
Children with unconfirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2009-2013	In 2012, CDC defined a reference level of 5 micrograms per deciliter (µg/dL) to identify children with elevated blood lead levels. These children are exposed to more lead than most children. For more information, visit: www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm(http://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
Homes with private wells tested for arsenic	BRFSS	2009, 2012	Data are weighted to the household. At the county level, 9.7%-32.2% of those surveyed did not know whether they had tested their well water for arsenic.
Lead screening among children age 12-23 months	Maine CDC Lead Program	2009-2013	A blood lead test is considered a “screening test” only when a child has no prior history of a confirmed elevated blood lead level.
Lead screening among children age 24-35 months	Maine CDC Lead Program	2009-2013	A blood lead test is considered a “screening test” only when a child has no prior history of a confirmed elevated blood lead level.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Immunization			
Adults immunized annually for influenza	BRFSS	2011-2013	Adults who have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose during the past 12 months.
Adults immunized for pneumococcal pneumonia (ages 65 and older)	BRFSS	2011-2013	Risk factor for adults aged 65 or older that have ever had a pneumonia shot.
Immunization exemptions among kindergarteners for philosophical reasons	Maine Immunization Program	2015	Available from: http://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/publications/index.shtml
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	Maine Immunization Program	2015	The Maine Immunization Program conducts an annual immunization assessment on January 1 of each calendar year that includes all 2-year-olds in the State of Maine immunization registry, ImmPact, associated to a practice that enters client specific data. These assessments follow the standard Centers for Disease Control and Prevention childhood assessment criteria of 24-35 months of age immunized as of 24 months for the 4 DTaP (Diphtheria, Tetanus, Polio): 3 IPV (Polio): 1 MMR (Measles, Mumps, Rubella): 3 Hib (Haemophilus influenza type B): 3 HepB (Hepatitis B):1 Var (Varicella):4 PCV (Pneumococcal Conjugate) schedule.
Infectious Disease			
Hepatitis A (acute) incidence per 100,000 population	Maine Infectious Disease Surveillance System (MIDSS)	2014	Defined as the number of new infections during 2014.
Hepatitis B (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Hepatitis C (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	MIDSS	2014	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	MIDSS	2014	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
Lyme disease incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Pertussis incidence per 100,000 population	MIDSS	2014	Incidence is defined as the number of new infections during 2014.
Tuberculosis incidence per 100,000 population	MIDSS	2014	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
STD/HIV			
AIDS incidence per 100,000 population	Maine CDC HIV Program	2014	Incidence is defined as the number of new infections during 2014.
Chlamydia incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Gonorrhea incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.
HIV incidence per 100,000 population	Maine CDC HIV Program	2014	Incidence is defined as the number of new infections during 2014.
HIV/AIDS hospitalization rate per 100,000 population	MHDO	2011	DRG-MDC 25
Syphilis incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.
Intentional Injury			
Domestic assaults reports to police per 100,000 population	Maine Dept. of Public Safety	2013	All offenses of assault between family or household members are reported as domestic assault.
Firearm deaths per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 W32-W34 ,X72-X74, X93-X95, Y22-Y24, Y350 or U014.
Intentional self-injury (Youth)	MIYHS	2013	High school students who have ever done something to purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose.
Lifetime rape/non-consensual sex (among females)	BRFSS	2012	Females who have ever had sex with someone after they said or showed that they didn't want them to or without their consent.
Nonfatal child maltreatment per 1,000 population	Child Maltreatment Report ACYF	2013	Rates are unique child victims per 1,000 population under age 18.
Reported rape per 100,000 population	Maine Dept. of Public Safety	2013	Includes rape by force and attempted forcible rape. Excludes carnal abuse without force (statutory rape) and other sex offenses.
Suicide deaths per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 U03 X60-X84 or Y87.0
Violence by current or former intimate partners in past 12 months (among females)	BRFSS	2012	Females who have experienced physical violence or had unwanted sex with a current or former intimate partner within the past 12 months.
Violent crime rate per 100,000 population	Maine Dept. of Public Safety	2013	Reported violent crime offenses. Violent crime includes murder, rape, robbery and aggravated assault.
Unintentional Injury			
Always wear seatbelt (Adults)	BRFSS	2013	Adults reporting they always use seatbelts when they drive or ride in a car.
Always wear seatbelt (High School Students)	MIYHS	2013	High School students who report they always wear a seatbelt when riding in a vehicle.
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	MHDO	2011	Emergency department visits by Maine residents at Maine acute care hospitals that did not end with the patient being admitted to that hospital as an inpatient, for which the principal diagnosis is an injury (ICD 9 CM 800–909.2, 909.4, 909.9–994.9, 995.5–995.59 or 995.80–995.85) or any external cause of injury code is ICD 9 CM E800-E869, E880-E929 or E950-E999, and the principal or any other diagnosis is ICD-9-CM 800.00–801.99, 803.00–804.99, 850.0–850.9, 851.00–854.19, 950.1–950.3, 959.01 or 995.55.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Unintentional and undetermined intent poisoning deaths per 100,000 population	Maine CDC Vital Records	2009-2013	Deaths of Maine residents for which the underlying cause of death is ICD-10 X40-X49 or Y10-Y19.
Unintentional fall related deaths per 100,000 population	Maine CDC Vital Records	2009-2013	Deaths of Maine residents for which the underlying cause of death is ICD-10 W00-W19.
Unintentional fall related injury emergency department visits per 10,000 population	MHDO	2011	Unintentional fall-related injury ED Visits are defined as ED Visits in which external cause of injury was coded as ICD--9CM E880-E886 or E888.
Unintentional motor vehicle traffic crash related deaths per 100,000 population	Maine CDC Vital Records	2009-2013	Deaths of Maine residents for which the underlying cause of death is ICD-10 V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29 (.4-.9), V30-V39 (.4-.9), V40-V49 (.4-.9), V50-V59 (.4-.9) ,V60-V69 (.4-.9), V70-V79 (.4-.9) ,V80 (.3-.5), V81.1 ,V82.1, V83-V86 (.0-.3) ,V87 (.0-.8) or V89.2."
Occupational Health			
Deaths from work-related injuries (number)	Maine Dept. of Labor	2013	Includes self-employed workers, owners of unincorporated businesses and farms, paid and unpaid family workers, members of partnerships and may include owners of incorporated businesses.
Nonfatal occupational injuries (number)	U.S. Bureau of Labor Statistics	2013	Includes both injuries that required days away from work and those that required job transfer or restriction. Data do not reflect the relative FTEs worked by the various groups of employees.
Mental Health			
Adults who have ever had anxiety	BRFSS	2011-2013	Adults who have ever been told by a doctor or other healthcare provider that they have an anxiety disorder?
Adults who have ever had depression	BRFSS	2011-2013	Adults who have ever been told by a doctor or other healthcare provider that they have a depressive disorder.
Adults with current symptoms of depression	BRFSS	2011-2013	Indicator of current depression coded using two items from the PHQ-2 depression screener.
Adults currently receiving outpatient mental health treatment	BRFSS	2011-2013	Adults now taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.
Co-morbidity for persons with mental illness	BRFSS	2011, 2013	Adults with current symptoms of depression from the PHQ-2 depression screener with 3 or more chronic conditions.
Mental health emergency department rates per 100,000 population	MHDO	2011	ICD-9 CM- 209-302, 306-319, which exclude substance use related disorders.
Sad/hopeless for two weeks in a row (High School Students)	MIYHS	2013	During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities? Percentage of students who answered "Yes".
Seriously considered suicide (High School Students)	MIYHS	2013	During the past 12 months, did you ever seriously consider attempting suicide? Percentage of students who answered "Yes".

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Physical Activity, Nutrition and Weight			
Fewer than two hours combined screen time (High School Students)	MIYHS	2013	Percentage of students watching 2 or fewer hours of combined screen time (tv, video games, computer) per day on an average school day.
Fruit and vegetable consumption (High School Students)	MIYHS	2013	Percentage of students who drank 100% fruit juice, ate fruit and/or ate vegetables five or more times per day during the past seven days.
Fruit consumption among Adults 18+ (less than one serving per day)	BRFSS	2013	Adults with less than one serving per day of fruits or fruit juice.
Met physical activity recommendations (Adults)	BRFSS	2013	Adults who reported doing enough physical activity to meet the aerobic and strengthening recommendations.
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	MIYHS	2013	Percentage of students who were physically active for a total of at least 60 minutes per day on five of the past seven days.
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	BRFSS	2011-2013	Adults reporting that during the past month, other than their regular job, they did not participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise.
Soda/sports drink consumption (High School Students)	MIYHS	2013	Percentage of students who drank at least one can, bottle, or glass of soda, sports drink, energy drink, or other sugar-sweetened beverage such as Gatorade, Red Bull, lemonade, sweetened tea or coffee drinks, flavored milk, Snapple, or Sunny Delight (Not counting diet soda, other diet drinks, or 100% fruit juice.) per day during the past week.
Vegetable consumption among Adults 18+ (less than one serving per day)	BRFSS	2013	Adults with less than one serving per day of vegetables.
Obesity (Adults)	BRFSS	2013	Adults with a BMI of 30 or more.
Obesity (High School Students)	MIYHS	2013	Percentage of students who were obese (i.e., at or above the 95th percentile for body mass index, by age and sex) -- SELF-REPORTED HEIGHT/WEIGHT.
Overweight (Adults)	BRFSS	2013	Adults with a BMI between 25.0 and 29.9.
Overweight (High School Students)	MIYHS	2013	Percentage of students who were overweight (i.e., at or above the 85th percentile but below the 95th percentile for body mass index, by age and sex) -- SELF-REPORTED HEIGHT/WEIGHT.
Pregnancy and Birth Outcomes			
Children with special health care needs	National Survey of Children with Special Health Care Needs	2011-2012	Survey respondents who reported that their child has a special health care need.
Infant deaths per 1,000 live births	Maine CDC Vital Records	2003-2012	Number of babies who died before their first birthday per 1,000 live births. Average annual number of infant deaths and infant mortality rate might be slightly underestimated due to possible missing out-of-state deaths of Maine infants in 2010.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Live births for which the mother received early and adequate prenatal care	Maine CDC Vital Records	2010-2012	Defined as an adequate or adequate-plus rating on the Kotelchuck Adequacy of Prenatal Care Utilization Index.
Live births to 15-19 year olds per 1,000 population	Maine CDC Vital Records	2010-2012	Defined as the number of live births among 15- to 19-year-old Maine women per 1,000 population.
Low birth weight (<2500 grams)	Maine CDC Vital Records	2010-2012	Low birth weight defined as less than 2500 grams.
Substance and Alcohol Abuse			
Alcohol-induced mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 - E24.4 , F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, R78.0, X45, X65 or Y15
Binge drinking of alcoholic beverages (High School Students)	MIYHS	2013	During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours? Percentage of students who answered at least 1 day.
Binge drinking of alcoholic beverages (Adults)	BRFSS	2011-2013	Risk factor for binge drinking where binge drinking is defined as having 5 or more drinks on 1 occasion for men and 4 or more drinks on 1 occasion for women.
Chronic heavy drinking (Adults)	BRFSS	2011-2013	At risk for heavy alcohol consumption (greater than two drinks per day for men and greater than one drink per day for women).
Drug-affected baby referrals received as a percentage of all live births	OCFS Maine Automated Child Welfare Information System	2014	This measure reflects the number of infants born in Maine where a healthcare provider reported to OCFS that there was reasonable cause to suspect the baby may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure or who have fetal alcohol spectrum disorders.
Drug-induced mortality per 100,000 population	CDC Wonder	2009-2013	The population figures for year 2013 are bridged-race estimates of the July 1 resident population, from the Vintage 2013 postcensal series released by NCHS on June 26, 2014.
Emergency medical service overdose response per 100,000 population	Maine Emergency Medical Services	2014	Includes overdoses from drugs/medication, alcohol and inhalants.
Opiate poisoning (ED visits) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Opiate poisoning (hospitalizations) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Past-30-day alcohol use (High School Students)	MIYHS	2013	During the past 30 days, on how many days did you have at least one drink of alcohol? Percentage of students who answered at least 1 day.
Past-30-day inhalant use (High School Students)	MIYHS	2013	During the past 30 days, how many times did you sniff glue, breathe the contents of aerosol spray cans, or inhale any paints or sprays to get high? Percentage of students who answered at least 1 time.
Past-30-day marijuana use (Adults)	BRFSS	2011-2013	During the past 30 days, have you used marijuana?
Past-30-day marijuana use (High School Students)	MIYHS	2013	During the past 30 days, how many times did you use marijuana? Percentage of students who answered at least 1 time.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Past-30-day nonmedical use of prescription drugs (Adult)	BRFSS	2011-2013	Adults who used prescription drugs that were either not prescribed and/or not used as prescribed in order to get high at least once within the past 30 days.
Past-30-day nonmedical use of prescription drugs (High School Students)	MIYHS	2013	During the past 30 days, how many times did you take a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription? Percentage of students who answered at least 1 time.
Prescription Monitoring Program opioid prescriptions (days supply/pop)	Prescription Monitoring Program	2014-2015	Presented as Days Supply/Population, which is the total days of supply of medication divided by the overall population.
Substance-abuse hospital admissions per 100,000 population	MHDO	2011	DRG-MDC 20
Tobacco Use			
Current smoking (Adults)	BRFSS	2011-2013	Adults that reported having smoked at least 100 cigarettes in their lifetime and currently smoke.
Current smoking (High School Students)	MIYHS	2013	During the past 30 days, on how many days did you smoke cigarettes? Percentage of students who answered at least 1 day.
Current tobacco use (High School Students)	MIYHS	2013	Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days. (Note: Reports read "Percentage of students who smoked cigarettes and/or cigars and/or used chewing tobacco, snuff, or dip on one or more of the past 30 days").
Secondhand smoke exposure (Youth)	MIYHS	2013	Percentage of students who were in the same room with someone who was smoking cigarettes at least 1 day during the past 7 days.

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Peter E. Chalke, Central Maine HealthCare, President and CEO
M. Michelle Hood, FACHE, EMHS President and CEO
Chuck Hays, MaineGeneral Health, CEO and President
William L. Caron, Jr., MaineHealth, President
Mary C. Mayhew, Maine DHHS, Commissioner

Market Decisions/Hart Consulting, Inc. Research Team:
Patrick Madden, MBA
Patricia Hart, MS, GC-PH
John Charles
Jennifer MacBride
Bethany Porter
Kelly MacGuirl, MSc

University of Southern Maine, Muskie School of Public Service, Epidemiologist Team:
Crystal Cushman
Zachariah Croll
Kathy Decker
Pamela Foster Albert
Alison Green-Parsons
Sara Huston
Jennifer Lenardson
Erika Lichter
Cindy Mervis
Alexandra Nesbitt
Donald Szlosek
Finn Teach
Denise Yob
Erika Ziller

Maine SHNAPP Steering Committee:
Nancy Birkhimer - Director, Performance Improvement, Maine CDC, Maine DHHS
Deborah Deatrick - Senior Vice President, Community Health Improvement, MaineHealth
Doug Michael - Chief Community Health & Grants Officer, Eastern Maine Healthcare Systems
Natalie Morse - Director of the Center for Prevention and Healthy Living, MaineGeneral
Cindie Rice - Director of Community Health, Wellness and Cardiopulmonary Rehab, Central Maine Medical Center

Maine SHNAPP Metrics Subcommittee:

Nancy Birkhimer, Maine CDC, Maine DHHS
Sean Cheetham, Central Maine Medical Center
Tim Cowan, MaineHealth
Ron Deprez, University of New England
Brent Dubois, Eastern Maine Healthcare Systems
Charles Dwyer, Maine Health Access Foundation
Jayne Harper, SHNAPP Staff (MaineGeneral Health)
Rebecca Kingsbury, MaineGeneral Health
Jean Mellett, Eastern Maine Healthcare Systems
Natalie Morse, MaineGeneral Health
Jeb Murphy, Maine Primary Care Association
Lisa Nolan, Maine Health Management Coalition
Rebecca Parent, Eastern Maine Healthcare Systems
Sandra Parker, Maine Hospital Association
Cindie Rice, Central Maine Medical Center
Toho Soma, Portland Public Health Division
Jenn Yurges, MaineGeneral Health

Maine SHNAPP Community Engagement Subcommittee:

Nancy Birkhimer, Maine CDC, Maine DHHS
Andy Coburn, University of Southern Maine, Muskie School
Charles Dwyer, Maine Health Access Foundation
Deb Erickson-Irons, York Hospital
Joanne Fortin, Northern Maine Medical Center
Nicole Hammar, Eastern Maine Healthcare Systems
Jayne Harper, SHNAPP Staff (MaineGeneral Health)
Elizabeth Keene, St. Mary's Regional Medical Center
Celine Kuhn, MaineHealth
Joy Leach, MaineGeneral Health
Christine Lyman, Maine CDC, Maine DHHS
Becca Matusovich, formerly Maine CDC, Maine DHHS
Doug Michael, Eastern Maine Healthcare Systems
Natalie Morse, MaineGeneral Health
Jeb Murphy, Maine Primary Care Association
Cindie Rice, Central Maine Medical Center
Toho Soma, Portland Public Health Division
Paula Thomson, Maine CDC, Maine DHHS

Collaborating Organizations for SHNAPP Implementation:

Bangor Public Health and Community Services
Maine Health Access Foundation
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Portland Public Health Division
St. Mary's Regional Medical Center
Statewide Coordinating Council for Public Health
University of New England
University of Southern Maine, Maine Public Health Institute at the Muskie School

Maine Department of Health and Human Services Review Team:
Ken Albert, Maine CDC Director and Chief Operating Officer
Sheryl Peavey, DHHS, Strategic Reform Coordinator
Jay Yoe, Director, DHHS Office of Continuous Quality Improvement

District Public Health Liaisons:
Aroostook: Stacy Boucher
Central: Paula Thomson
Cumberland: Becca Matusovich, formerly Maine CDC, Maine DHHS
Cumberland: Adam Hartwig, acting
Downeast: Alfred May
MidCoast: Carrie McFadden
Penquis: Jessica Fogg
Wabanaki: Kristi Ricker and Sandra Yarmal
Western: Jamie Paul
York: Adam Hartwig