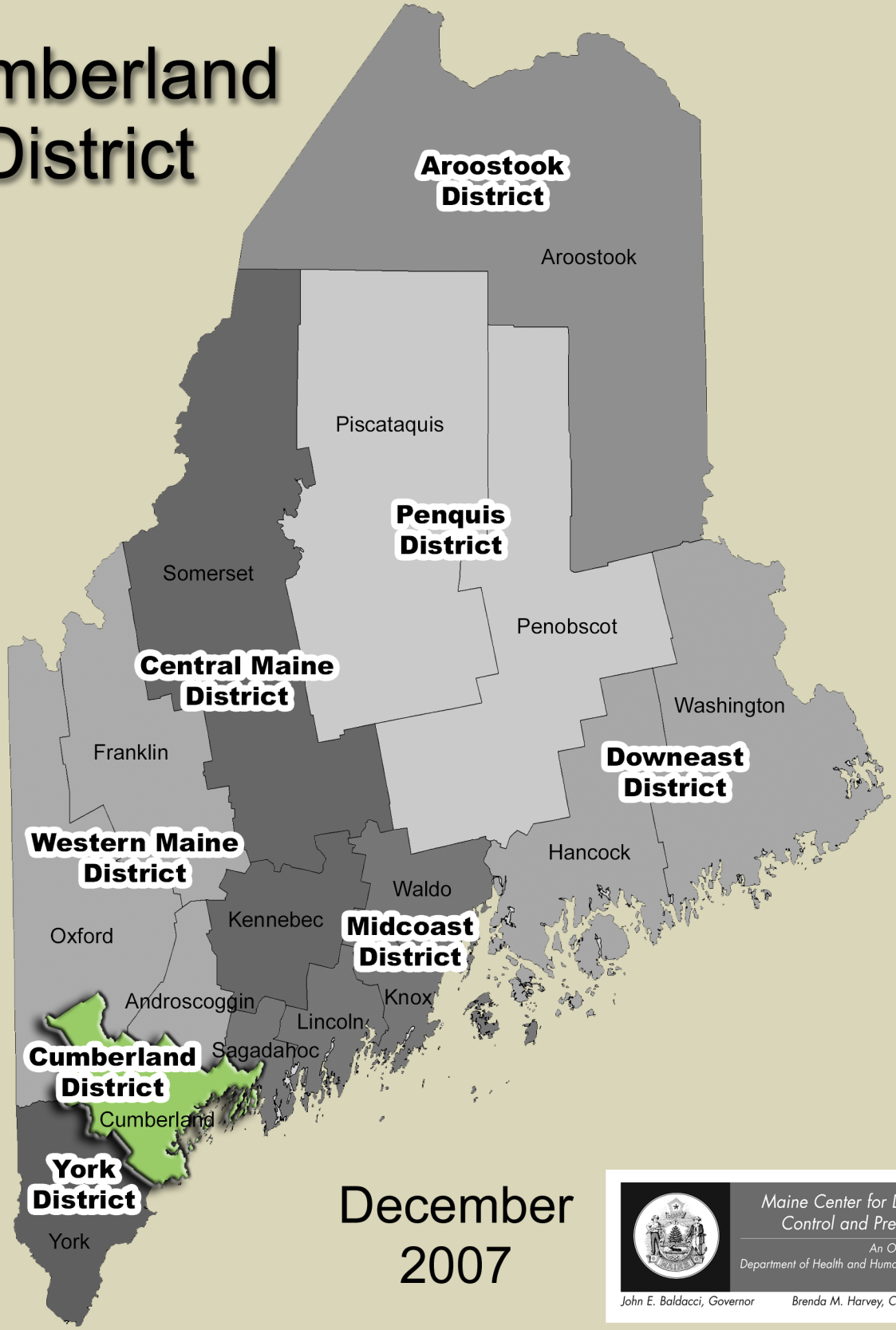
Maine DHHS District Health Profile

Cumberland District



December
2007

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

John Elias Baldacci
Governor

Maine Department of Health and Human Services

Maine Center for Disease Control and Prevention
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Brenda M. Harvey
Commissioner

Dora Anne Mills, MD, MPH
Public Health Director
Maine CDC Director

December 2007

Dear Colleague:

The Maine Department of Health and Human Services has adopted for the purposes of coordinating services eight Health and Human Services Districts. Their boundaries take in account population, geographical spread, hospital service areas, and county borders.

These Districts are:

Aroostook District	(Aroostook County)
Penquis District	(Penobscot and Piscataquis Counties)
Downeast District	(Washington and Hancock Counties)
Central Maine District	(Somerset and Kennebec Counties)
Midcoast District	(Waldo, Lincoln, Knox, Sagadahoc Counties)
Western District	(Androscoggin, Franklin, and Oxford Counties)
Cumberland District	(Cumberland County)
York District	(York County)

We have quickly compiled these District Health Profiles as a way to show some key health indicators for each district with some state comparisons. We welcome your feedback about how these profiles can be redesigned and improved for the future. Meanwhile, we hope these are helpful as a discussion starter on the potential priorities for the next State Health Plan issued by the Governor's Office of Health Policy and Finance and part of the Dirigo Health Initiative. Please use these Profiles to raise questions about public health issues in your area.

All Profiles are available for downloading at www.mainepublichealth.gov. Please note a limited number of paper copies have been made available to your closest Healthy Maine Partnership, whose contact information can also be located at the link above. If you have comments or questions about the Profiles, please email me, Dora.A.Mills@maine.gov and use "Profiles" in the subject line.

In the future we hope that greater alignment of state and each district's public and private resources will better support local efforts to protect and improve community health, and reduce disparities in health status among groups within your district.

Thank you for your interest in the health of Maine people.

Sincerely,

Dora Anne Mills, MD, MPH
State Health Officer
Director, Maine Center for Disease Control and Prevention
Maine Department of Health and Human Services

Acknowledgements and Process Notes

An inventory of health statistics can serve a number of purposes. The District Health Profiles were developed to support the debut of the new DHHS Districts, and to reflect the range of issues a public health system must address in order to protect and improve the health of all Maine people. They are considered preliminary as they were created exclusively by Maine CDC's epidemiologists and program specialists (including the DHHS Office of Substance Abuse and DHHS Adult Mental Health Services). They should not be considered the State's final word on priority health indicators. Profiles will hopefully start conversations, raise questions and concerns, and serve as a stepping stone for more robust Profiles in the future.

Criteria for data selection was established by consensus. Programs were asked to sift through the mountains of data they work with routinely to select a very few key indicators. These had to offer a high level picture of a topic or issue, be potentially actionable at local or district levels, and be comparable across all Districts. Selections had to align with the scientific evidence to date on determinants and factors relevant to how population health is protected, maintained or improved.

It was a fast-paced collaborative effort on the part of many people on top of existing workloads and scheduled federal or state contract deliverables. It included everyone from those with public health and epidemiological expertise to clerical and technical staff. The three largest funding sources for staff time and printing costs came from Maine's share of the federal Preventive Health Block Grant, federal Maternal/Child Health Block Grant, and Maine CDC's Administrative Fund. For further information, please contact Christine Lyman, Maine CDC at christine.b.lyman@maine.gov and put Profiles in the subject line.

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TABLE OF CONTENTS

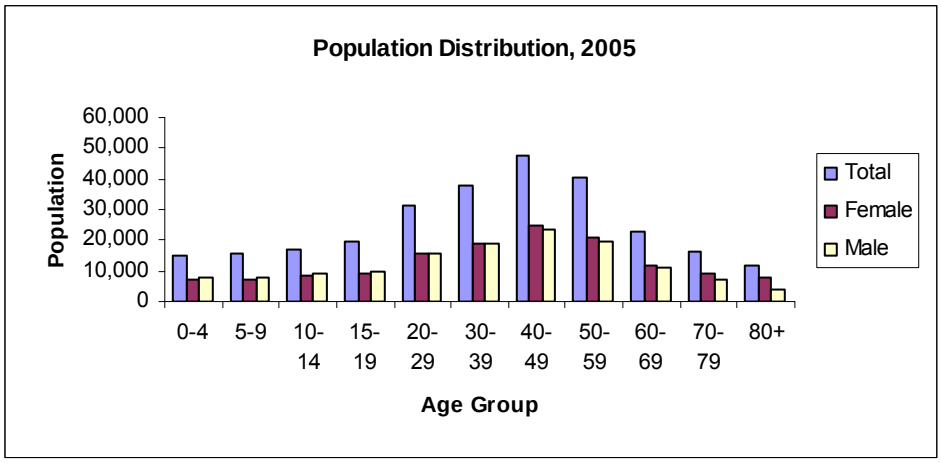
CUMBERLAND DISTRICT: Demographics

Population

The distribution of age, race, and gender in a population is a basic consideration in defining public health priorities, as many health behaviors and outcomes differ by these factors.

	Cumberland District	Cumberland District: % of Maine	Maine State
Total Population	274,598	20.8%	1,321,574
Population Density (People/Square Mile)	328.7	N/A	42.8

Source: 2006 U.S. Census



Source: 2005 U.S. Census

Population Distribution By Age Group in District and State

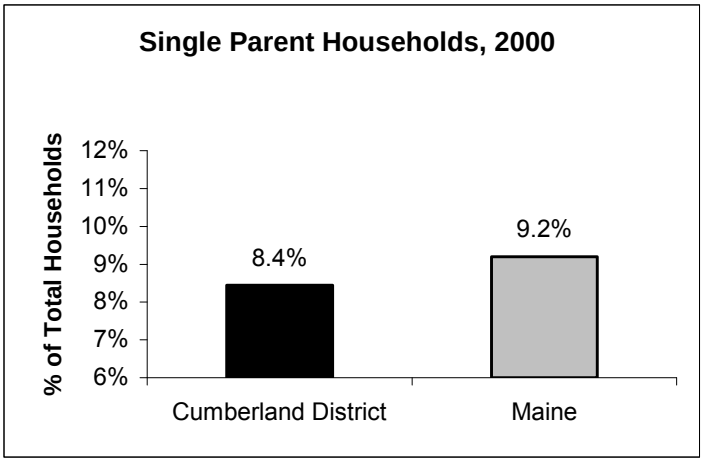
Age Group:	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
District	5.4%	5.6%	6.3%	7.0%	11.4%	13.7%	17.4%	14.8%	8.3%	5.9%	4.2%
State	5.1%	5.4%	6.3%	7.1%	11.9%	12.5%	16.8%	15.0%	9.1%	6.5%	4.2%
District	14,858	15,340	17,269	19,295	31,284	37,734	47,861	40,597	22,740	16,311	11,661
State	67,660	70,765	82,808	93,788	157,810	165,590	222,643	198,710	119,780	86,241	55,710

Source: 2005 U.S. Census

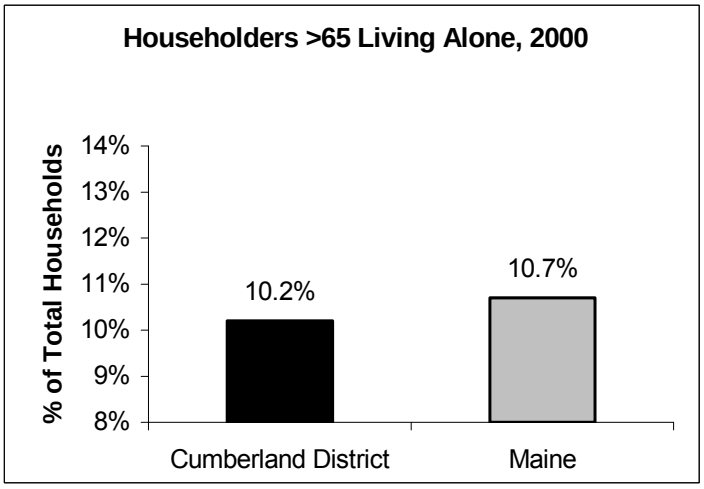
Race & Ethnic Distribution in District and State

	White	Black	American Indian & Alaskan Native	Asian	Native Hawaiian & Pacific Islander	Two or More Races	Non-Hispanic	Hispanic	Franco-American*
District	95.3%	1.5%	0.3%	1.6%	0.1%	1.2%	98.6%	1.4%	21.8%
State	96.9%	0.8%	0.6%	0.8%	0.0%	0.9%	99.0%	1.0%	22.8%
District	262,126	4,056	821	4,376	150	3,421	271,200	3,750	47,185
State	1,280,776	9,946	7,293	10,893	455	12,142	1,308,460	13,045	291,272

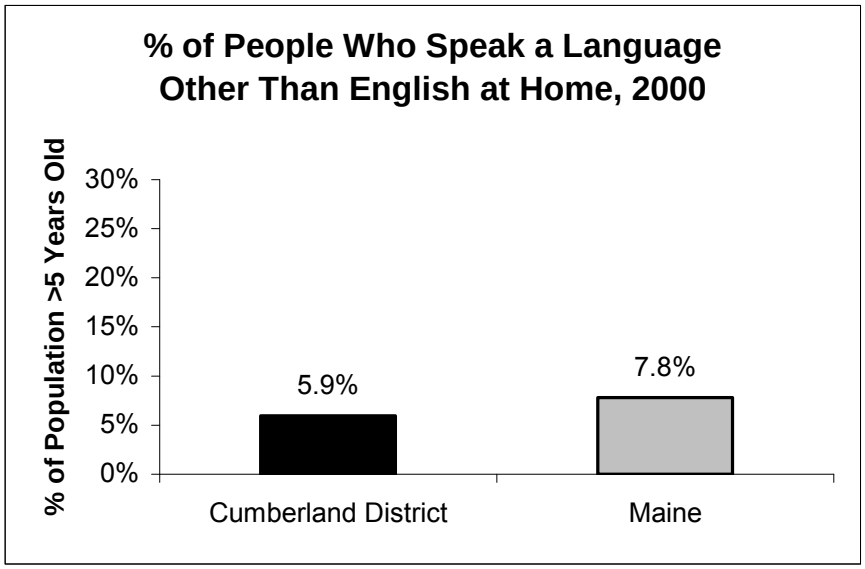
Source: 2005 U.S. Census, *2000 U.S. Census



Source:2000 U.S. Census



Source:2000 U.S. Census



Source: 2000 U.S. Census; % among people >5years

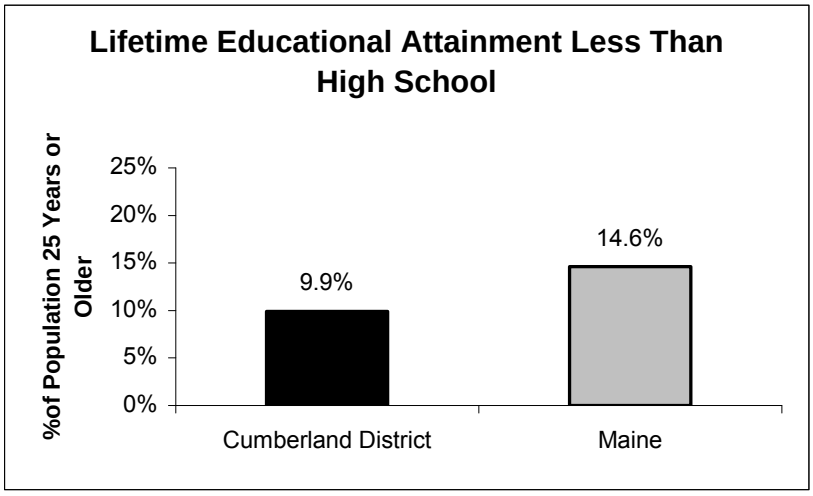
	Cumberland District Number	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Total Households	107,989		
Single-Parent Households (With Children <18)	9,117	8.4 (±0.2)	9.2 (±0.1)
Householder >65 Living Alone	11,015	10.2 (±0.2)	10.7 (±0.1)
People Who Speak a Language Other Than English At Home (>5 Years Old)	14,888	5.9 (±0.1)	7.8 (±0.1)

Source:2000 U.S. Census

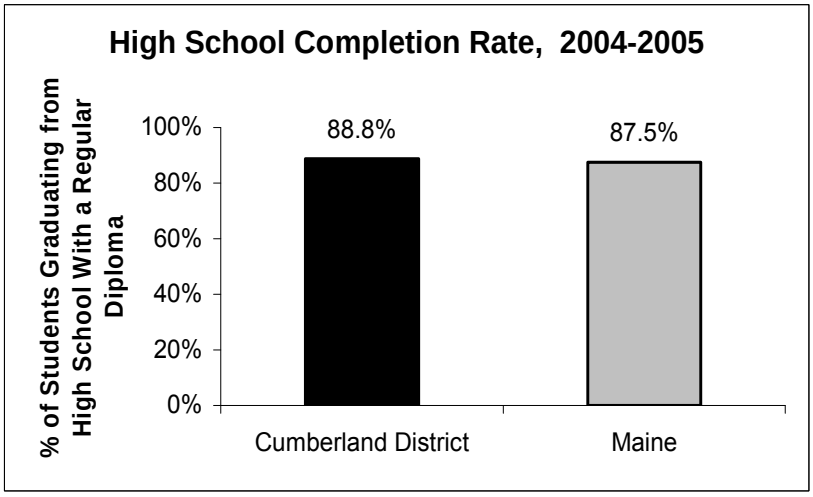
Socio-Economic Status

Socio-economic status (SES), as measured by factors such as income and educational attainment, is highly related to health status. Numerous health disparities are linked to inequalities in SES.

Mechanisms by which SES contributes to health status include barriers to access of quality health care and prevention, environmental and behavioral factors, and generally high levels of stress. Data on educational attainment and income status, as presented below, are obtained through the Maine Department of Education and the U.S. Census.



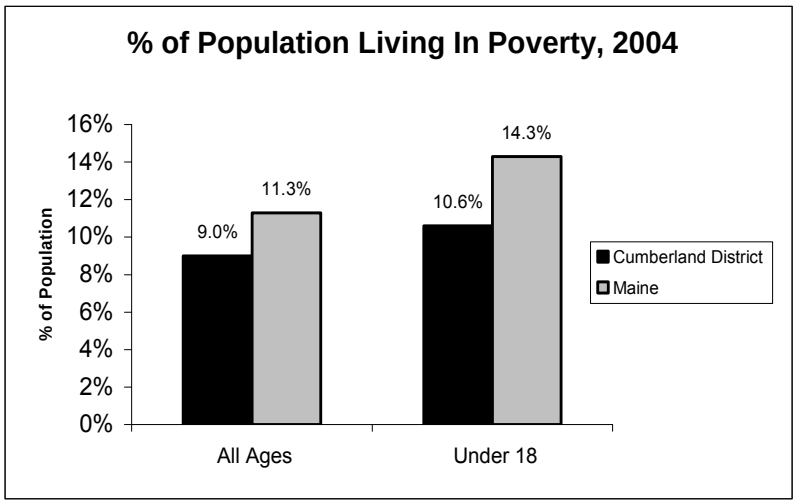
Source: 2000 Census; % of population 25 and older with < high school education



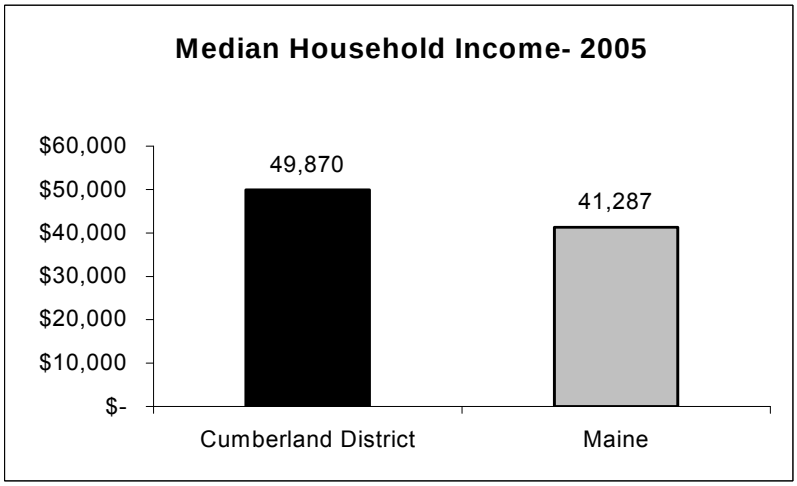
Source: 2004-2005 Maine Department of Education

	Cumberland District Number	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Lifetime Educational Attainment Less Than High School[1]	17,946	9.9 (±0.1)	14.6 (±0.1)
High School Completion[2]	2,678	88.8 (±3.4)	87.5 (±1.5)

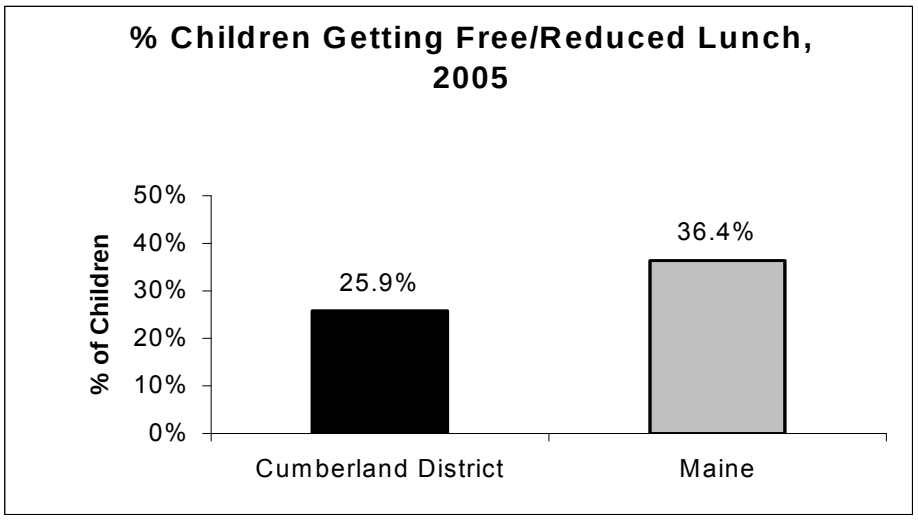
1. Source: 2000 Census; Less than high school education among those 25 years and older,
2. Source: Maine Department of Education; 2004-2005; percent of students graduating high school with a regular diploma; based on county location of school



Source: 2004 Poverty Estimates; U.S. Census Small Areas Estimates Branch



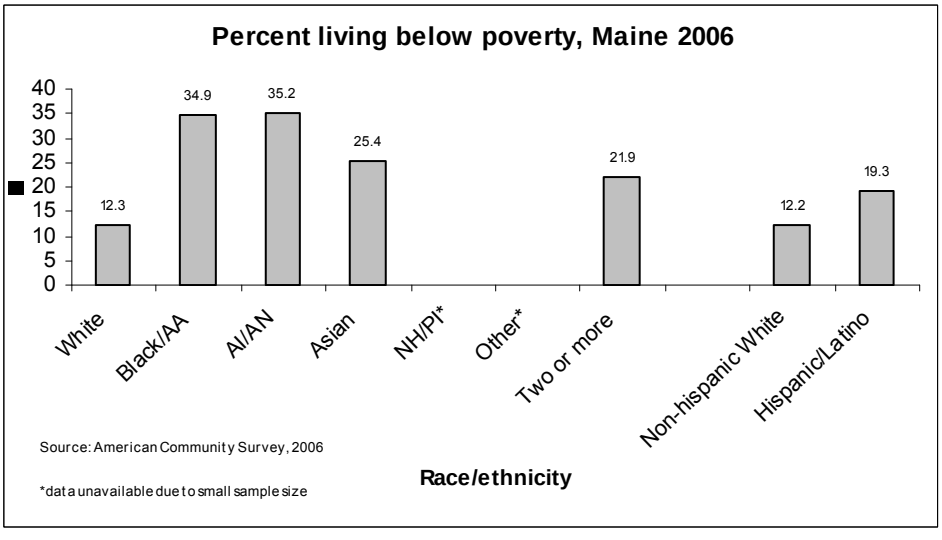
Source: 2004 Median Income Estimates; U.S. Census Small Areas Estimates Branch

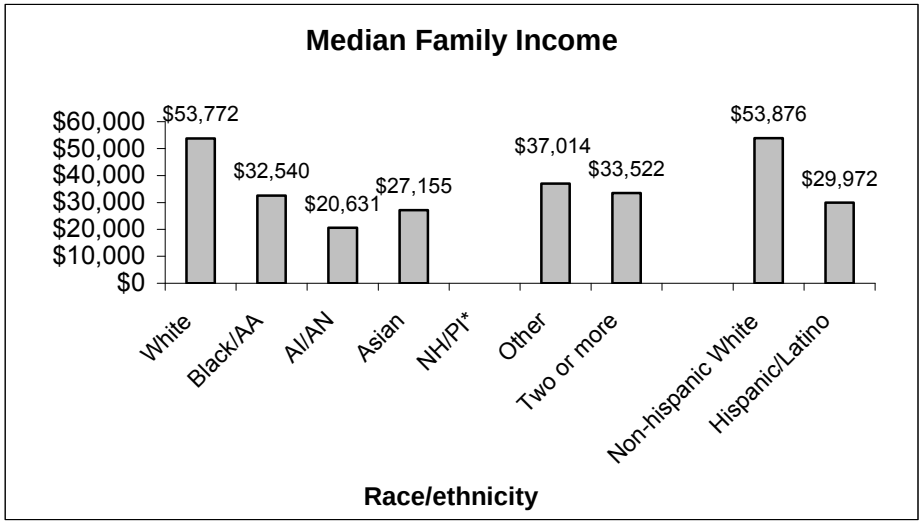


Source: Maine Department of Education: 2005 data

	Cumberland District Number	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Poverty, All Ages[1]	24,708	9.0 (±0.1)	11.3 (±0.1)
Poverty, Under 18[1]	6,188	10.6 (±0.3)	14.3 (±0.1)
Median Household Income[1]	$49,870	N/A	$41,287
Children On Free/Reduced Lunch Program[2]	10,483	25.9 (±0.5)	36.4 (±0.3)

1. Source: 2004 Poverty Estimates; U.S. Census Small Areas Estimates Branch
2. Source: Maine Department of Education: 2005 data





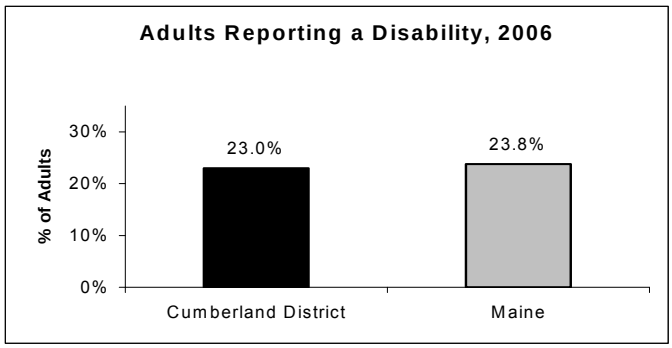
Source: American Community Survey, 2006
*Data unavailable due to small sample size

Disability

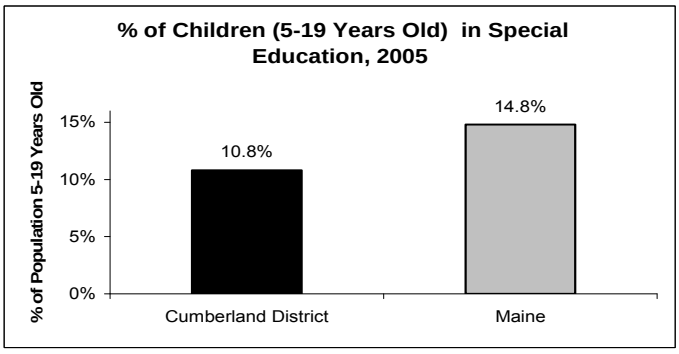
Having a disability is associated with higher rates of poverty, unemployment, physical inactivity, obesity, pain, sleeplessness, depression and anxiety. Many people with disabilities have inadequate medical access and care, and experience social isolation.

Defining disability is difficult. In this document, we have defined an adult with disabilities as someone who has an activity limitation or a health problem requiring special equipment. For children, we present information on children in special education as a proxy for disability status.

For more information about adults with disability in Maine, contact the Office of Adults with Cognitive and Physical Disability Services www.maine.gov/dhhs/OACPDS/DS/. For information about children, please contact the Children with Special Health Needs program at the Maine Center for Disease Control and Prevention: www.maine.gov/dhhs/boh/cshn/.



Source: 2006 BRFSS; Reported either having a health problem requiring special equipment or having activity limitation due to a physical, mental, or emotional health problem.



Source: 2005 Maine Department of Education, 2005 Census: % of 5-19 year olds who are in special education

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Percent of Adults Who Report Having a Disability[1]	23.0 (± 3.9)	23.8 (±1.6)
Children (5-19 Years Old) Who Are in Special Education[2]	10.8 (±0.3)	14.8 (±0.2)

1. Source: 2006 BRFSS; Reported either having a health problem requiring special equipment or having activity limitation due to a physical, mental, or emotional health problem.
2. Source: 2005 Maine Department of Education, 2005 Census: % of 5-19 year olds who are in special education; Based on county of residence of child

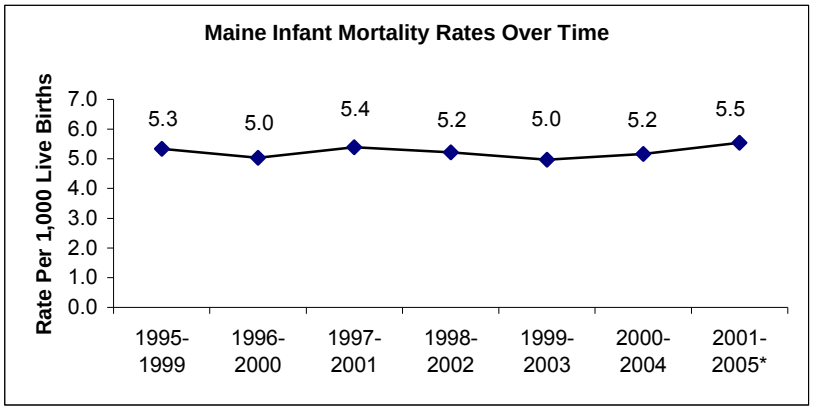
CUMBERLAND DISTRICT: Maternal/Child Health

Perinatal Health

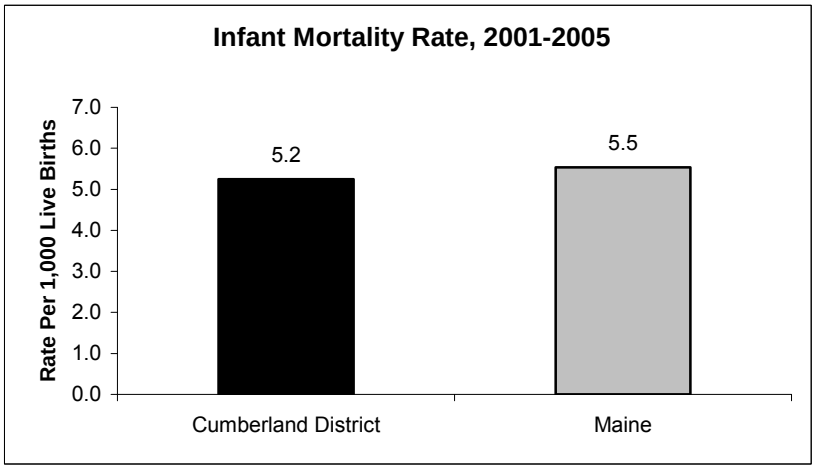
The health of infants often reflects the social, economic, and environmental conditions of a society and the systems of care available to support children and families.

By improving preconception and prenatal care and by enhancing systems of support for women and children, we can help improve birth outcomes and children's long-term health.

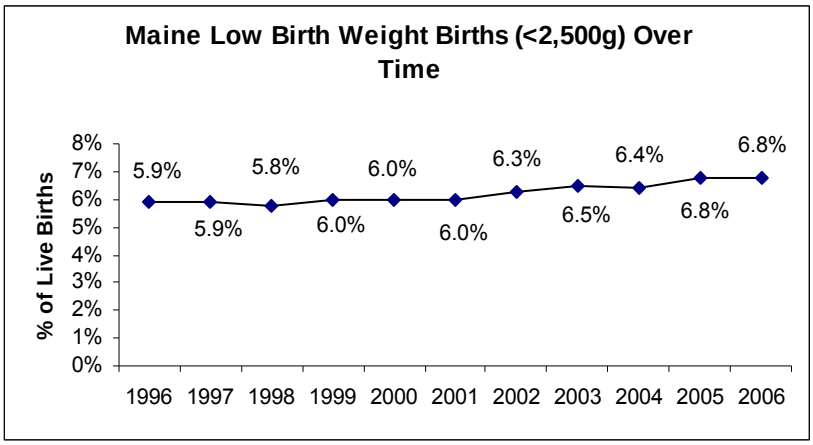
For more information about maternal and child health in Maine, contact Maine CDC's Division of Family Health, www.maine.gov/dhhs/bohdcfh/FamilyHealth/family.html and for more state-level data on maternal and child health in Maine, please visit: https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp.



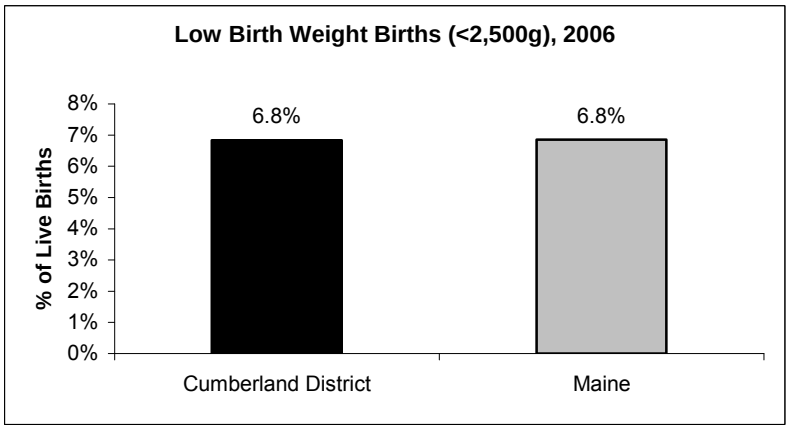
Source: 1995-2005 Maine Vital Records Data; 5-year rolling rates



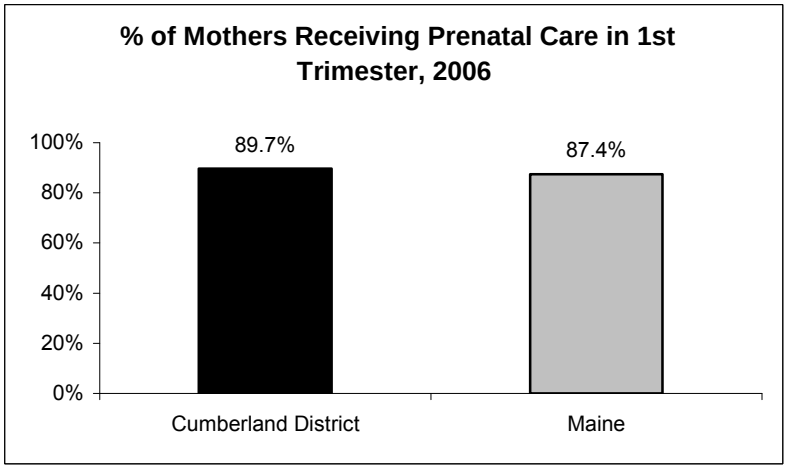
Source: 2001-2005 Maine Vital Records Data



Source: 1996-2006 Maine Vital Records Data



Source: 2006 Maine Vital Records Data



Source: 2006 Maine Vital Records

	Cumberland District Number	Cumberland District Rate or Percent (± Margin of Error)	Maine State Rate or Percent (± Margin of Error)
Infant Mortality[1]	15.8 (avg. per yr)	5.2 (± 1.2) (per 1,000 live births)	5.5 (± 0.5) (per 1,000 live births)
Live Births That Were Low Birth Weight (<2,500 grams)[2]	211	6.8% (± 0.8)	6.8% (±0.4)
Infants Born to Women Receiving Prenatal Care Beginning in the First Trimester[2]	2,768	89.7% (±1.1)	87.4% (±0.6)

1. Source: 2001-2005 Maine Vital Records Data
2. Source: 2006 Maine Vital Records Data

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Mothers Who Ever Breastfed	84.6 (± 6.1)	76.3 (± 6.7)

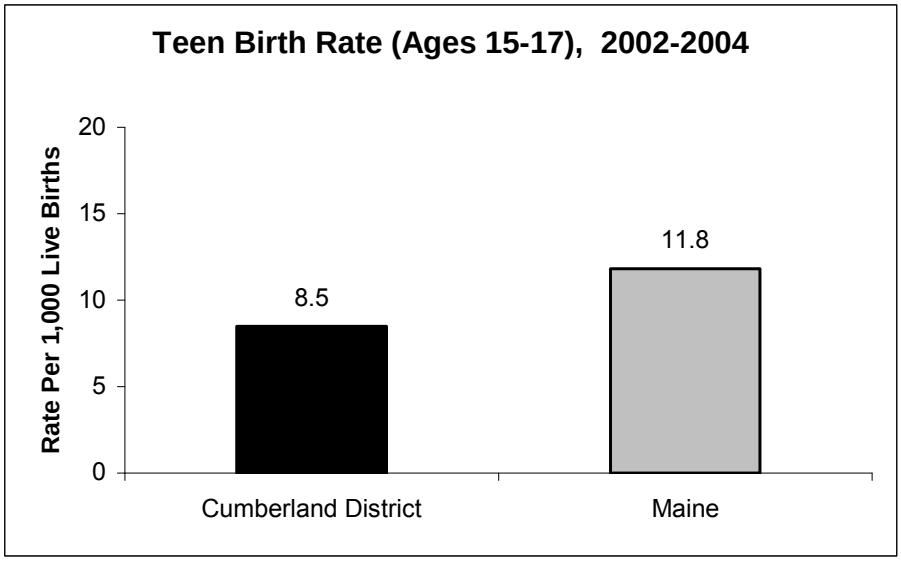
Source: Maine Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

Teen Birth Rate

Teen pregnancy is a physical, mental, and social health concern for both teens and their newborn children. Almost 88% of teen births are unintended. Teen mothers are less likely to complete high school, more likely to live in poverty, and are typically single parents. They have higher rates of pre-term labor and frequently deliver low birth-weight babies who are at increased risk for developmental delays.

Teen pregnancy rates are much lower in Maine compared to the United States, due to effective public health interventions and Maine political will and leadership over time. Maine strives to reduce our teen birth rates even further through the provision of family planning services and support for comprehensive sexual education in schools and communities.

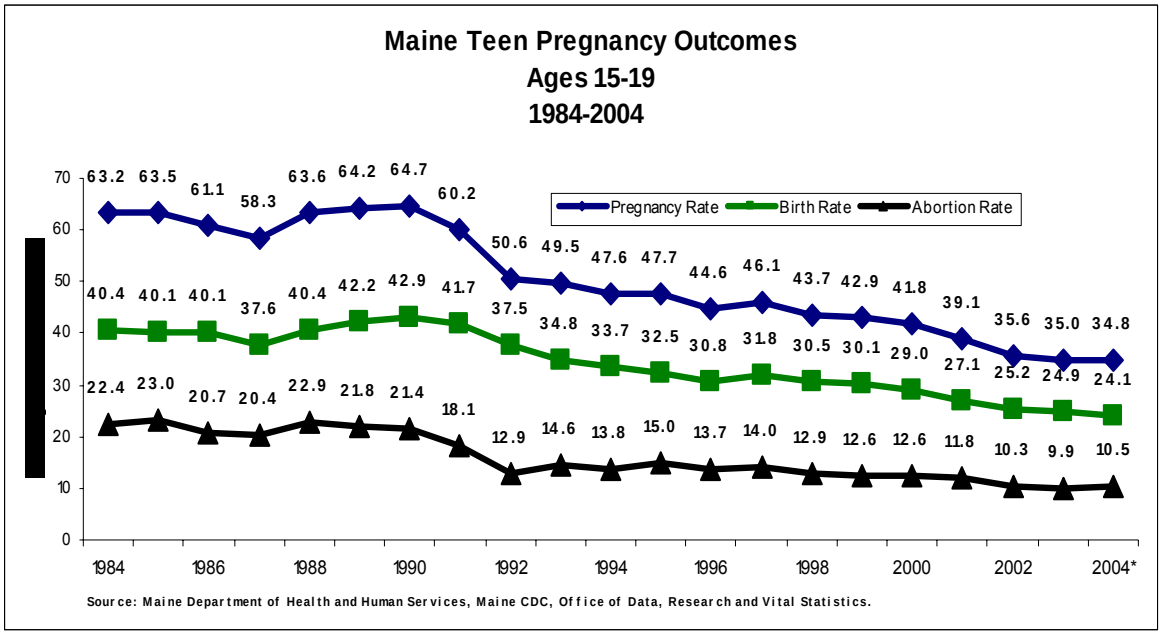
Contact Maine's Teen and Young Adult Health program for more information at www.maine.gov/dhhs/bohdcfh/tya/index.html.



Source: 2002-2004 Maine Vital Records Data

	Cumberland District Number	Cumberland District Rate (± Margin of Error)	Maine State Rate (± Margin of Error)
Teen Births; (Ages 15-17)	42.7 (avg. per yr.)	8.5 (± 1.5) (per 1,000 female population)	11.8 (± 0.7) (per 1,000 female population)

Source: 2002-2004 Maine Vital Records Data


Maine Teen Pregnancy Outcomes
Ages 15-19
1984-2004
Pregnancy Rate
Birth Rate
Abortion Rate
63.2 63.5 61.1 58.3 63.6 64.2 64.7 60.2 50.6 49.5 47.6 47.7 44.6 46.1 43.7 42.9 41.8 39.1 35.6 35.0 34.8
40.4 40.1 40.1 37.6 40.4 42.2 42.9 41.7 37.5 34.8 33.7 32.5 30.8 31.8 30.5 30.1 29.0 27.1 25.2 24.9 24.1
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2004*
Source: Maine Department of Health and Human Services, Maine CDC, Office of Data, Research and Vital Statistics.

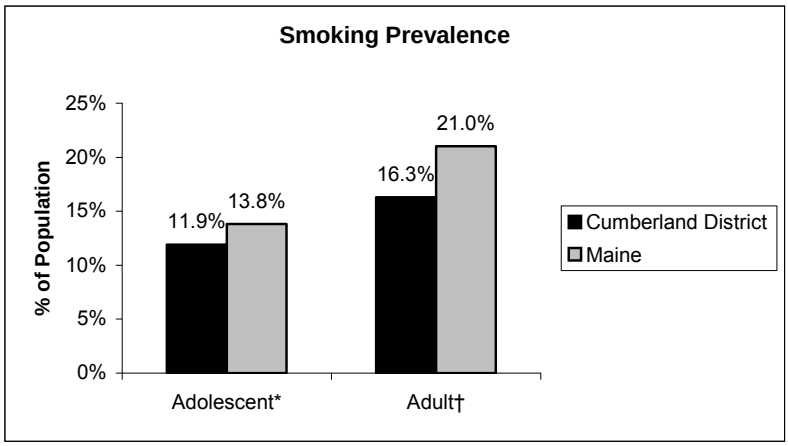
CUMBERLAND DISTRICT: Health & Wellness

Health Behavior Risk Factors

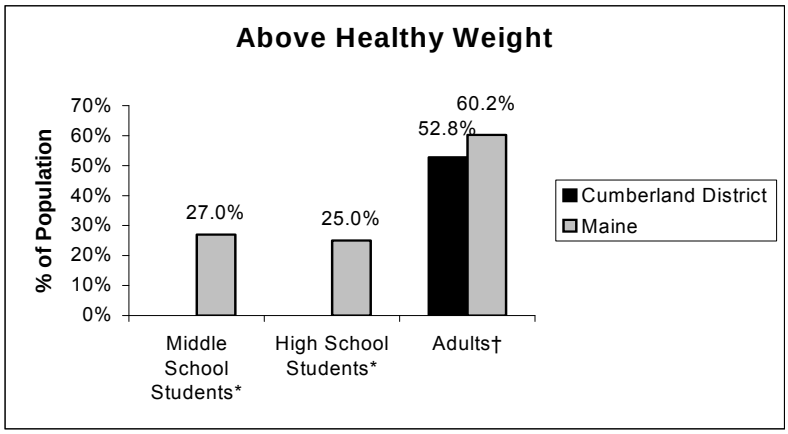
Public health evidence indicates that tobacco use and exposure, sedentary lifestyle and poor nutrition are the top three health behavior risk factors affecting the greatest number of people in terms of the impact on quality and length of life for all Mainers.

Health behavior risks in combination with a lack of environment and policy supports for making healthier choices can result in premature death and disability from cardiovascular disease, diabetes, cancer, chronic lung disease, along with many other health problems.

For more information, the Maine CDC's Partnership for a Tobacco-Free Maine, the Maine Physical Activity and Nutrition program, and the Healthy Maine Partnership address these issues. For more information visit: www.mainepublichealth.gov.



*Source: MYDAUS/YTS; % 6-12 graders who smoked at all during the past 30 days
† Source: 2006 BRFSS; % of adults who are current smokers--defined as those who have smoked at least 100 cigarettes in their lifetime and report currently smoking every day or some days.



*Source: 2005 YRBS; "Overweight": ≥ 95th%ile of self-reported BMI or "At risk of becoming overweight": ≥ 85th%ile but below 95th%ile of self-reported BMI; (Note: District-level data not available in YRBS)
†Source: BRFSS: "Overweight": self-reported BMI 25.0-29.9 or "Obese": self-reported BMI ≥ 30.0

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Adolescent smoking prevalence[1]	11.9% (±0.3)	13.8% (±0.2)
Adult smoking prevalence[2]	16.3% (±3.7)	21.0% (±1.6)
Overweight or At Risk of Becoming Overweight- Middle School Students[3]	N/A	27%
Overweight or At Risk of Becoming Overweight - High School Students[3]	N/A	25%
Overweight or Obese- Adults[4]	52.8% (± 5.1)	60.2% (±2.0)

1. Source: 2006 MYDAUS/YTS; % 6-12 graders who smoked at all during past 30 days
2. Source: 2006 BRFSS; % of adults who are current smokers--defined as those who have smoked at least 100 cigarettes in their lifetime and report currently smoking every day or some days.
3. Source: 2005 YRBS; "Overweight": ≥ 95th%ile of self-reported BMI, "At risk of becoming overweight": ≥ 85th%ile but below 95th%ile of self-reported BMI; (Note: District-level data not available in YRBS)
4. Source: BRFSS: "Overweight": self-reported BMI 25.0-29.9, "Obese": self-reported BMI ≥ 30.0

CUMBERLAND DISTRICT: Health Disparities

This DHHS District Health Profile contains key health measures reflecting the health status of groups who share one or more characteristics in common – what is called population health status. Public health has two overarching goals: to protect and improve population health *and* to reduce disparities in health status among different populations.

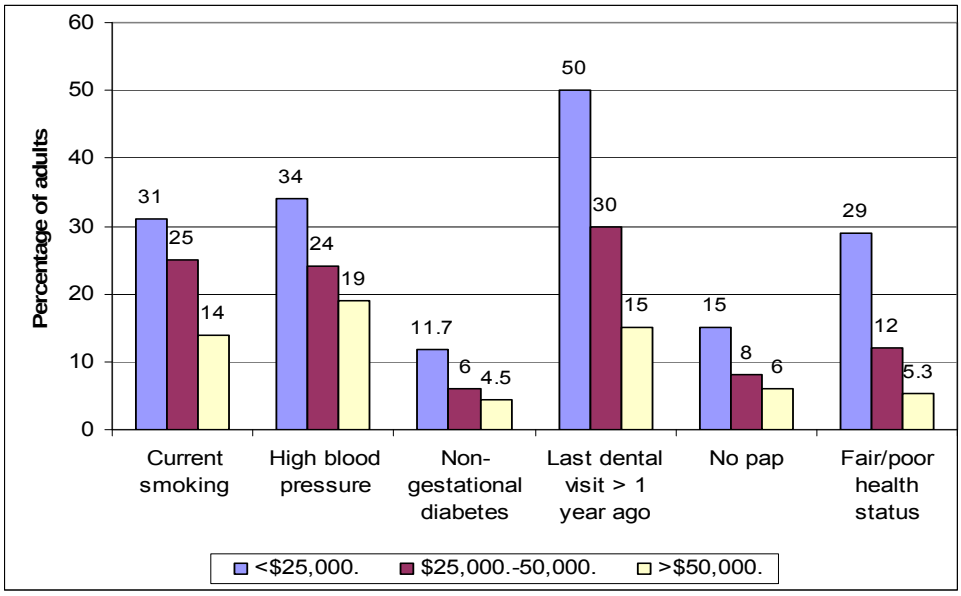
From a bird's eye view, there are multiple pathways contributing to health status. These include health risk behaviors, access to health care, genes, and the environments where people live, work, learn and play. When examined at a population level, age, race/ethnicity, gender, income and lifetime education, disability, sexual orientation are factors in our country and state that result in disparities in health status. Research continues to reveal additional factors: social determinants such as transportation, housing, and social exclusion play key roles. In fact, emerging global health research indicates that every group on a society's social status ladder experiences better overall health than other groups below it.

Epidemiological analysis and our own eyes and experiences offer information about how to improve health here in Maine. Whether it is the presence of Native American tribal nations, Franco-American or new refugee communities, our range of ages, incomes, and lifetime education, or gender, we need to monitor and address disparities in health here in Maine.

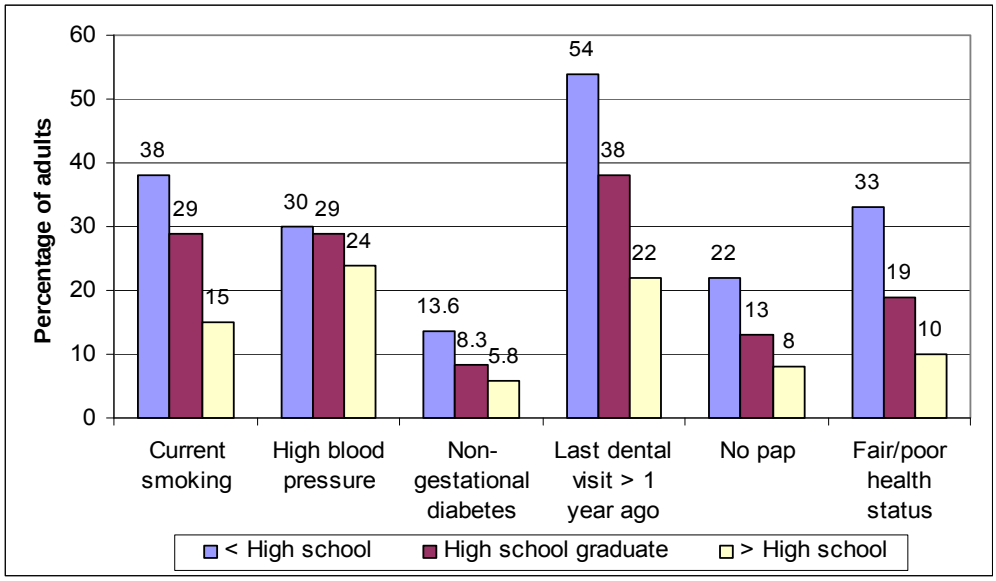
However, statistical analysis is a challenge in a relatively sparsely populated state, and we are often unable to provide data on disparate populations. In addition to small numbers, it is critical that race and ethnicity data be reported accurately and with culturally competent methods to collect it. Together, these limitations in Maine's data require that we sometimes rely on national profiles for disadvantaged populations in lieu of state, regional or local data. The following tables are offered to consider in our vision, inclusiveness, strategies and values in improving health for all in Maine.

Maine's dialogue about setting priorities to make Maine the healthiest state in the nation for all Maine people can be based on an understanding of "how health happens" *and* that disparities in health status exist in Maine.

Percentage: Select Chronic Disease Indicators by Income, Maine Adults, 2002-2006



Percentage: Select Chronic Disease Indicators by Educational Attainment, Maine 2002-2006

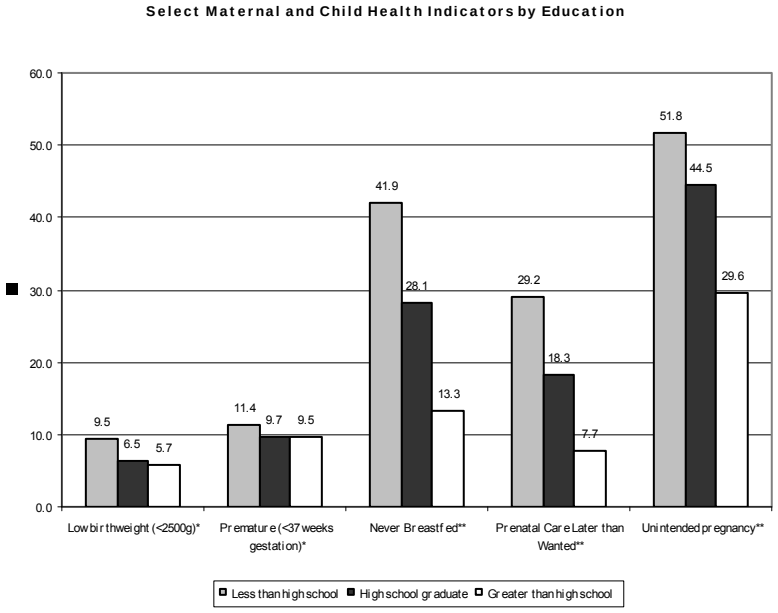


BRFSS

Percentage: Chronic Disease Indicators by Educational Attainment and Income, Maine Adults, 2002-2006

EDUCATIONAL ATTAINMENT	Current smoking	High blood pressure	Non-gestational diabetes	Last dental visit > 1 year ago	No pap test in past 3 years	Fair/poor health status
< High school	**38**	**30**	**13.6**	**54**	**22**	**33**
High school graduate	**29**	**29**	**8.3**	**38**	**13**	**19**
> High school	**15**	**24**	**5.8**	**22**	**8**	**10**
Income						
<$25,000.	**31**	**34**	**11.7**	**50**	**15**	**29**
$25,000.-50,000.	**25**	**24**	**6**	**30**	**8**	**12**
>$50,000.	**14**	**19**	**4.5**	**15**	**6**	**5.3**

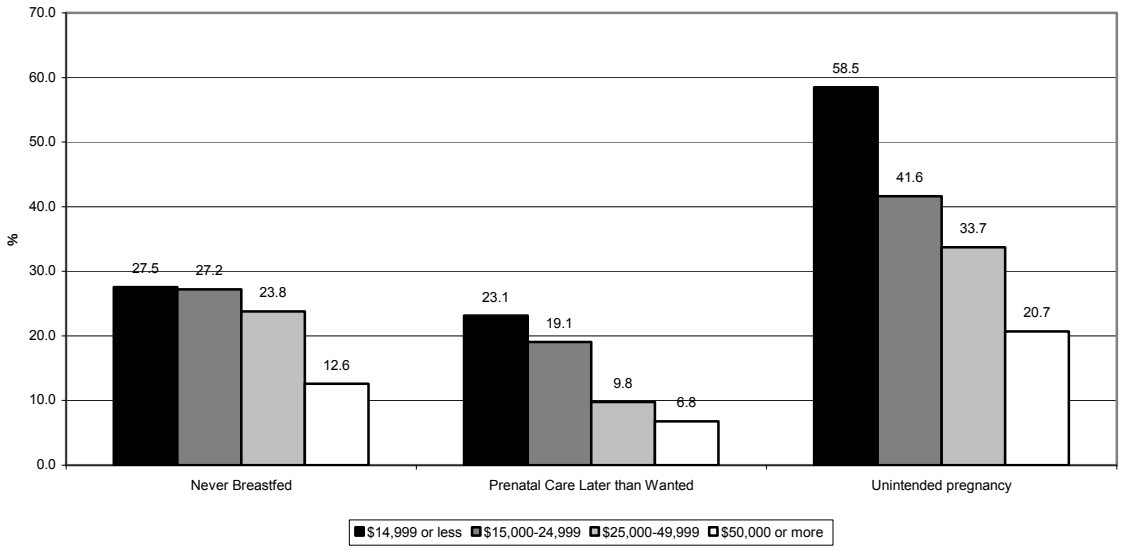
BRFSS



*Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2003-2004, on CDC WONDER Online Database, September 2007. Accessed at http://wonder.cdc.gov/natality-v2004.html on Nov 6, 2007 1:49:33 PM

**Source: Maine Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

Breastfeeding, Prenatal Care and Unintended Pregnancy by Income, 2005



**Source: Maine Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

Select Maternal and Child Health Risk Factors by Education and Income

EDUCATIONAL ATTAINMENT	Low Birthweight* (<2500g)	Premature birth* (<37 wk gestation)	Never breastfed most recent child**	Received prenatal care later than wanted**	Unintended pregnancy
Less than High school	**9.5%**	**11.4%**	**41.9%**	**29.2%**	**51.8%**
High school graduate	**6.5%**	**9.7%**	**28.1%**	**18.3%**	**44.5%**
Greater than High school	**5.7%**	**9.5%**	**13.3%**	**7.7%**	**29.6%**
INCOME					
$14,999 or less	**n/a*** **	**n/a*** **	**27.5%**	**23.1%**	**58.5%**
$15,000-$24,999	**n/a*** **	**n/a*** **	**27.2%**	**19.1%**	**41.6%**
$25,000-$49,999	**n/a*** **	**n/a*** **	**23.8%**	**9.8%**	**33.7%**
$50,000 or more	**n/a*** **	**n/a*** **	**12.6%**	**6.8%**	**20.7%**

*Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2003-2004, on CDC WONDER Online Database, September 2007. Accessed at http://wonder.cdc.gov/natality-v2004.html on Nov 6, 2007 1:49:33 PM
**Source: Maine Pregnancy Risk Assessment Monitoring System (PRAMS), 2005
***data on income are not available for these indicators

Use of Prenatal Care in 1st Trimester, Maine, 2004

	Received prenatal care in 1st Trimester		Total births
Race	Number	Percent	Number
Total	12182	87.4	13944
White	11724	87.6	13381
Black	181	80.4	225
American Indian	87	75.0	116
Asian or Pacific Islander	190	85.6	222
Non-Hispanic total	11992	87.6	13694
Hispanic total	140	77.8	180

Maine CDC Office on Research, Data and Vital Statistics

2000-2004 Aggregated Teen Pregnancies by Teen Mother's Race and Ethnicity, Ages 15-19		
Race	**Rate** per 1,000 Females	**Counts**
White	35.7	1538
Black	65.3	27
American Indian	96.1	35
Asian/Pacific Islander	34.7	17
Total	37.2	1672
Ethnicity	**Rate** per 1,000 Females	**Counts**
Hispanic	44.0	23
Non-Hispanic	34.5	1532
Total	37.2	1672

Source: Maine DHHS/Maine CDC, Office of Data, Research, and Vital Statistics.

NATIONAL BURDEN OF DISEASE RELATED TO RACE/ETHNICITY: KEY PRIORITY AREAS	
Cancer	African American women: more than twice as likely to die of cervical cancer than white women. More likely to die of breast cancer than women of any other racial or ethnic group.
Cardiovascular Disease	2000: rates of death from heart diseases: 29 % higher among African American adults than among white adults. Death rates from stroke: 40% higher.
Diabetes	2000: American Indians, Alaska Natives: 2.6 times more likely to have diagnosed diabetes compared w/non-Hispanic Whites. African Americans: 2.0 times more likely, Hispanics were 1.9 times more likely
HIV/AIDS	2001: African Americans + Hispanics = 26 % of U.S. population but are 66% of adult AIDS cases. 82% of pediatric AIDS cases in the first half of that year
Immunizations	2001: Hispanics and African Americans aged 65 and older: less likely than Non-Hispanic Whites to report having received influenza and pneumococcal vaccines.
Infant Mortality	African American, American Indian, Puerto Rican infants: higher death rates than white infants. Yr. 2000: black-to-white ratio in infant mortality = 2.5 (up from 2.4 in 1998). This is a widening trend persisting over the last two decades.

US CDC Office of Minority Health/ Health Disparities see www.cdc.gov/omhd/AMH/dbrf.htm for citations.

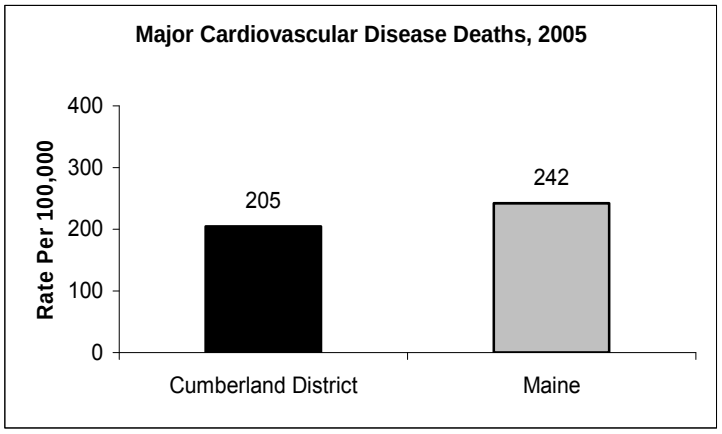
CUMBERLAND DISTRICT: Chronic Diseases

Cardiovascular Disease

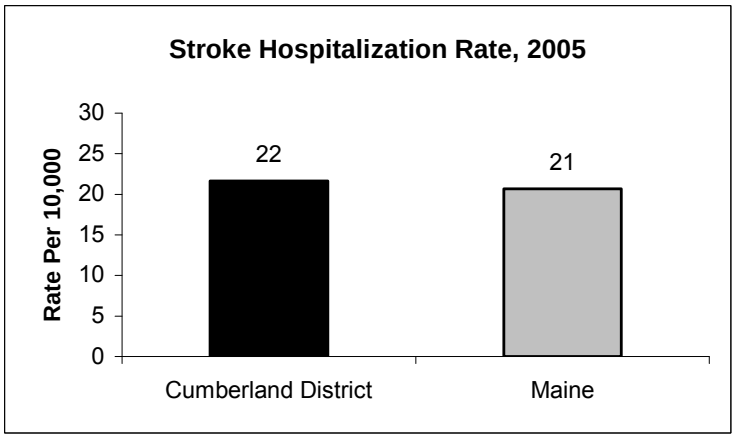
Cardiovascular disease refers to a group of diseases and conditions affecting the heart and blood vessels, and is the leading killer of adults in Maine. Heart disease, stroke and hypertension, among other conditions, also create a vast burden of illness and need for health care in Maine.

Cardiovascular disease is not an inevitable consequence of life. Many cardiovascular diseases can be prevented or modified through basic healthy lifestyle choices. Screening and early identification of disease and those at risk of disease, and monitoring of blood pressure and cholesterol, changes in health care delivery, and policies and environments that support healthy choices can make a difference.

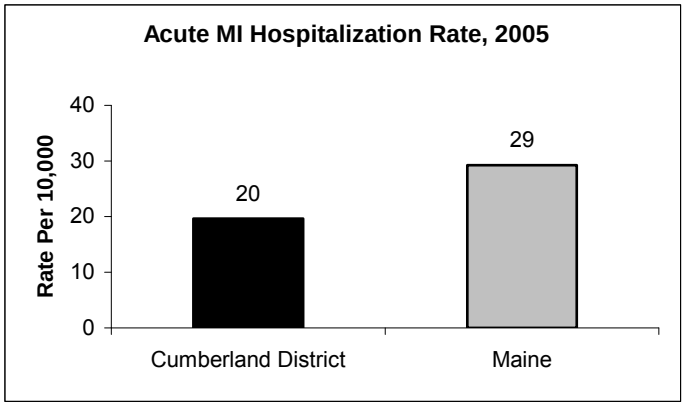
The Maine CDC's Cardiovascular Health Program and links to many partners can be found at www.maine.gov/dhhs/boh/hmp/mcvhp/.



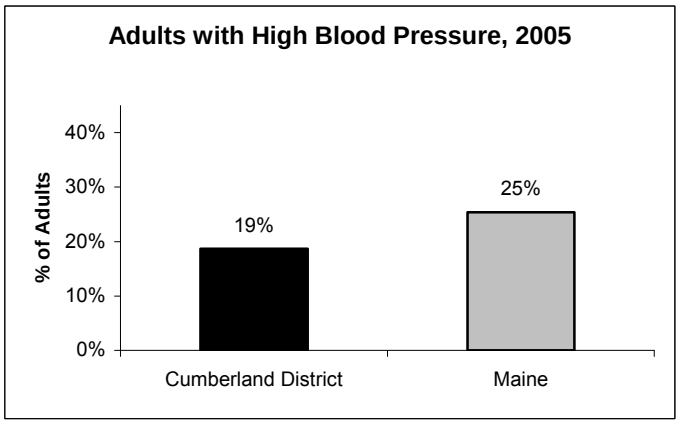
Source: 2005 Maine Office of Data, Research and Vital Statistics; Age-adjusted to 2000 U.S. Standard Population



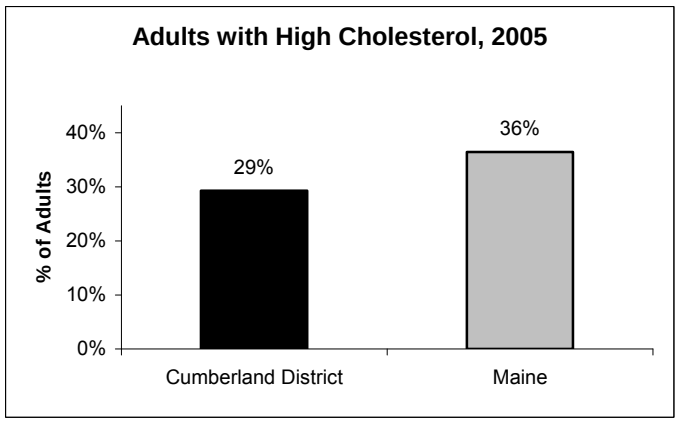
Source: 2005 Maine Hospital Discharge Datasets; Age-adjusted to 2000 U.S. Standard Population



Source: 2005 Maine Hospital Discharge Datasets; Age-adjusted to 2000 U.S. standard population



Source: 2005 BRFSS



Source: 2005 BRFSS

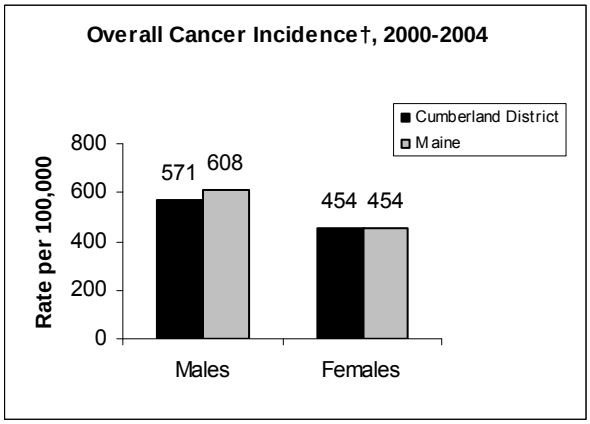
	Cumberland District Number	Cumberland District Rate or Percent (± Margin of Error)	Maine State Rate or Percent (± Margin of Error)
Major CVD Deaths[1]	672	204.6 (± 15.5) (per 100,000)	242.0 (±7.6) (per 100,000)
Stroke Hospitalizations[2]	684	21.7 (±1.6) (per 10,000)	20.7 (±0.7) (per 10,000)
Acute Myocardial Infarction Hospitalizations[2]	624	19.6 (± 1.5) (per 10,000)	29.2 (±0.8) (per 10,000)
High Blood Pressure Among Adults[3]	N/A	18.7% (± 3.1)	25.4% (±1.6)
High Cholesterol Among Adults[3]	N/A	29.3% (± 4.1)	36.4% (±2.0)

1) Source: 2005 Maine Office of Data, Research and Vital Statistics; Age-adjusted to 2000 U.S. standard population
2) Source: 2005 Maine Hospital Discharge Datasets; Age-adjusted to 2000 U.S. standard population
3) Source: 2005 BRFSS: Ever told by a doctor

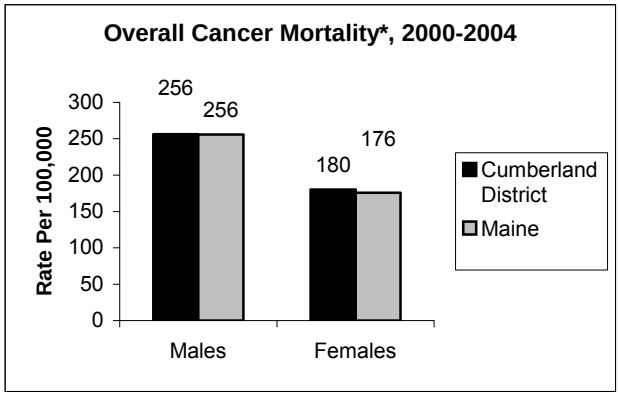
Cancer

Cancers are caused by modifiable risk factors, by genes, and influenced by environmental factors. Four cancers account for the majority of new cancer diagnoses: lung, colorectal, female breast, and in men, prostate. It is the second leading cause of death in Maine.

Data are collected and analyzed by the Maine CDC's certified Maine Cancer Registry to monitor trends and investigate possible cancer clusters. The Maine Comprehensive Cancer Program supports strategic planning in partnership with its nonprofit partners and provides targeted prevention activities if there are gaps as identified in the Maine Cancer Plan. The Maine Breast and Cervical Cancer Program reduces disparities in health by supporting outreach and screening for breast and cervical cancer in women at risk who cannot afford them. For more information see www.mainepublichealth.org



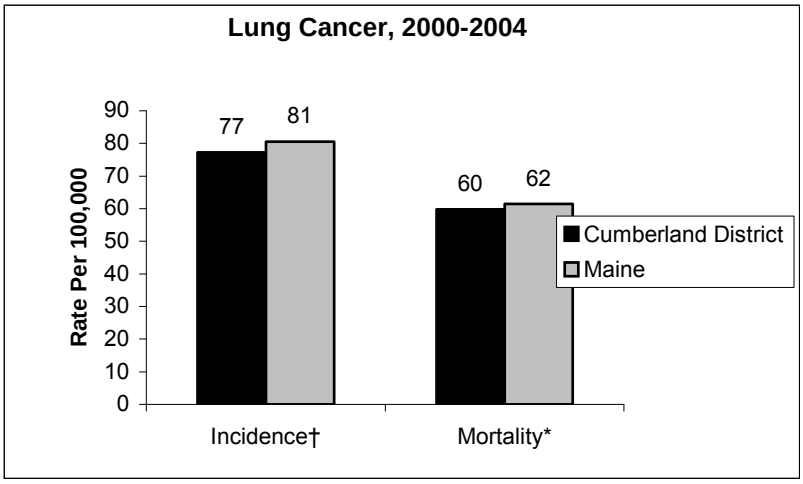
Source: 2000-2004 National Center for Health Statistics data



† Source: 2000-2004 Maine Cancer Registry, Maine CDC *

	Cumberland District Rate (± Margin of Error) Male	Cumberland District Rate (± Margin of Error) Female	Maine State Rate (± Margin of Error) Male	Maine State Rate (± Margin of Error) Female
Overall Cancer Incidence† Rate (Per 100,000)	571.4 (±19.2)	453.9 (±15.0)	608.3 (±8.6)	454.2 (±6.7)
Overall Cancer Mortality* Rate (Per 100,000)	256.0 (±13.1)	180.1 (±9.2)	255.6 (±5.7)	175.6 (±4.1)

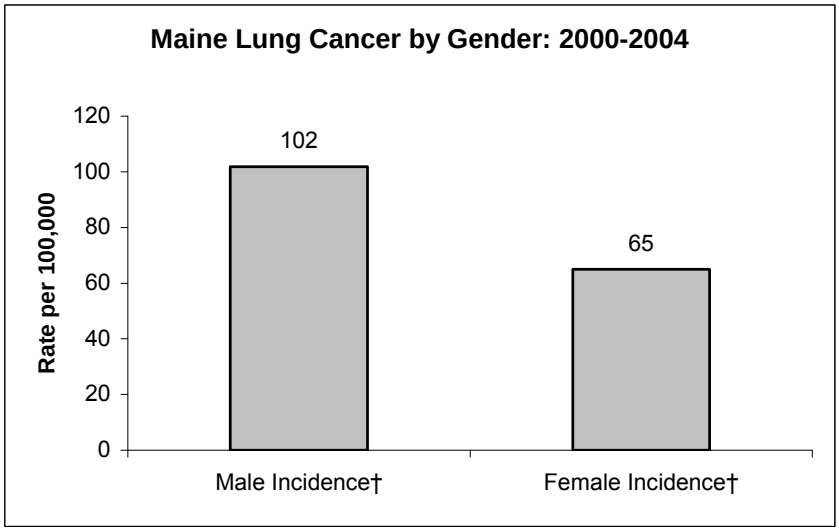
† Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS
* Source: 2000-2004 National Center for Health Statistics data



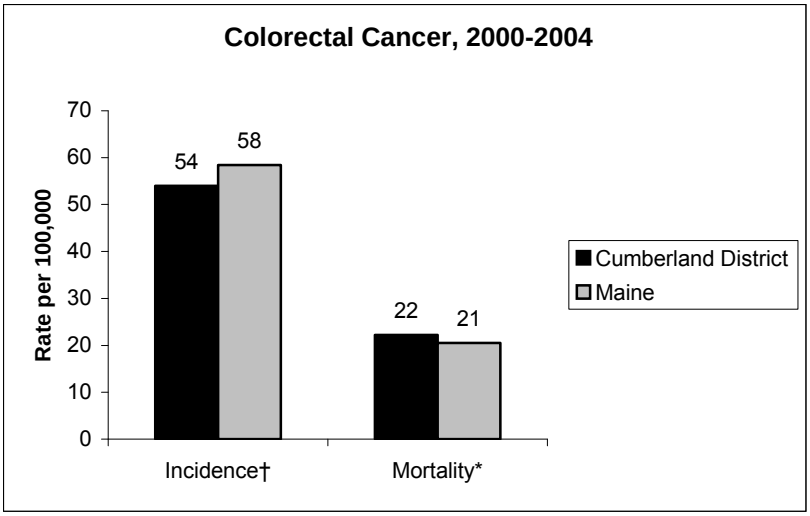
†Incidence Source: Maine Cancer Registry, Maine CDC, DHHS
*Mortality Source: 2000-2004 National Center for Health Statistics data

	Cumberland District Rate (± Margin of Error)	Maine State Rate (± Margin of Error)
Lung Cancer Incidence† Rate (Per 100,000)	77.3 (± 4.6)	80.6 (±2.1)
Lung Cancer Mortality* Rate (Per 100,000)	59.8 (±4.1)	61.5 (±1.8)

† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS
* Mortality Source: 2000-2004 National Center for Health Statistics data



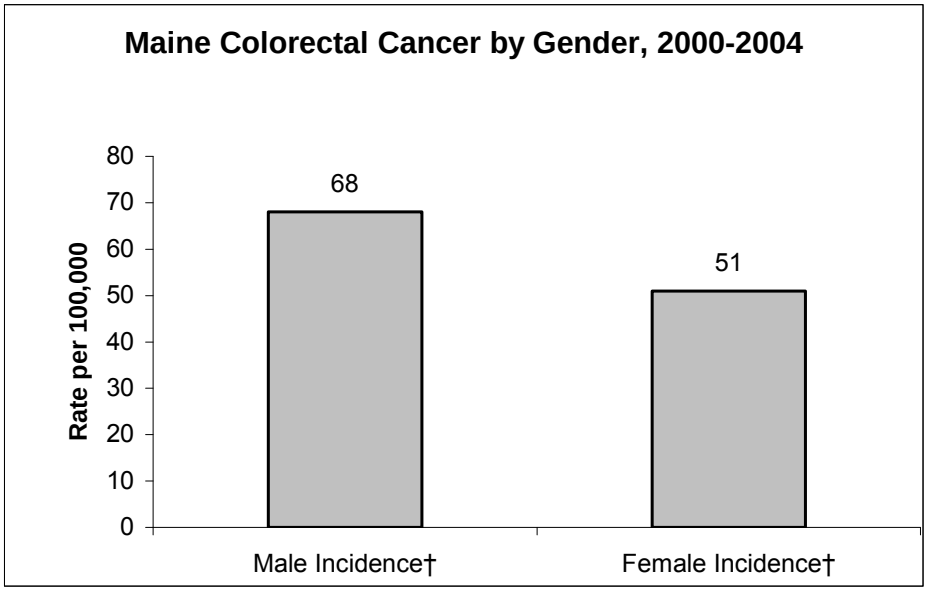
† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS



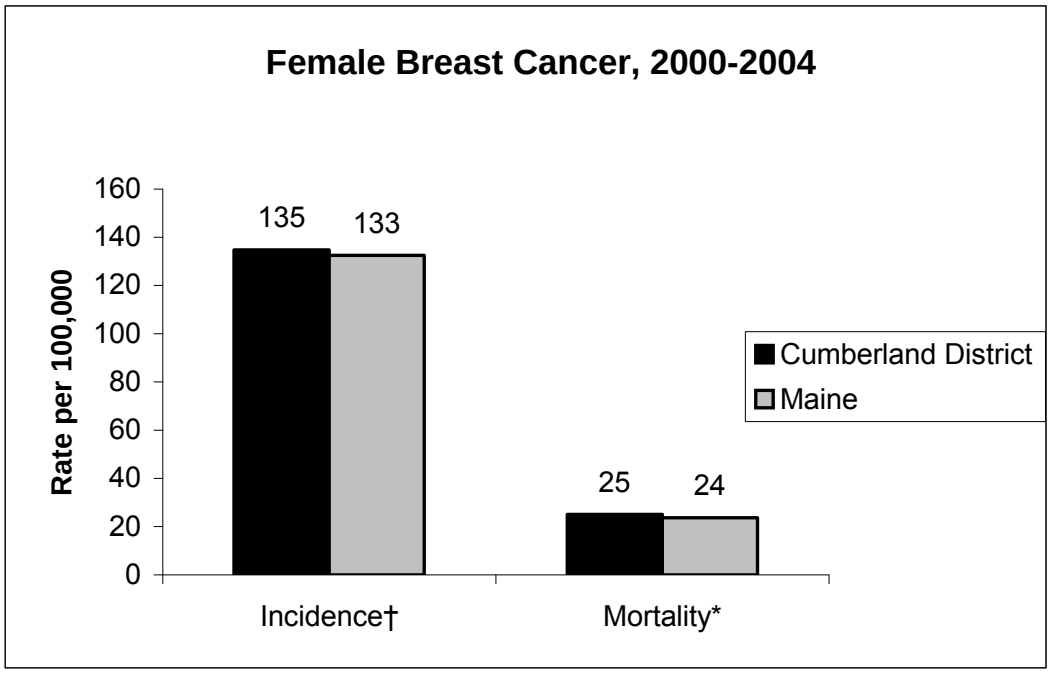
† Incidence Source: Maine Cancer Registry, Maine CDC, DHHS
* Mortality Source: 2000-2004 National Center for Health Statistics data

	Cumberland District Rate (± Margin of Error)	Maine State Rate (± Margin of Error)
Colorectal Cancer Incidence† Rate (Per 100,000)	54.0 (± 3.8)	58.4 (±1.8)
Colorectal Cancer Mortality* Rate (Per 100,000)	22.2 (± 2.5)	20.5 (±1.1)

† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS
* Mortality Source: 2000-2004 National Center for Health Statistics data



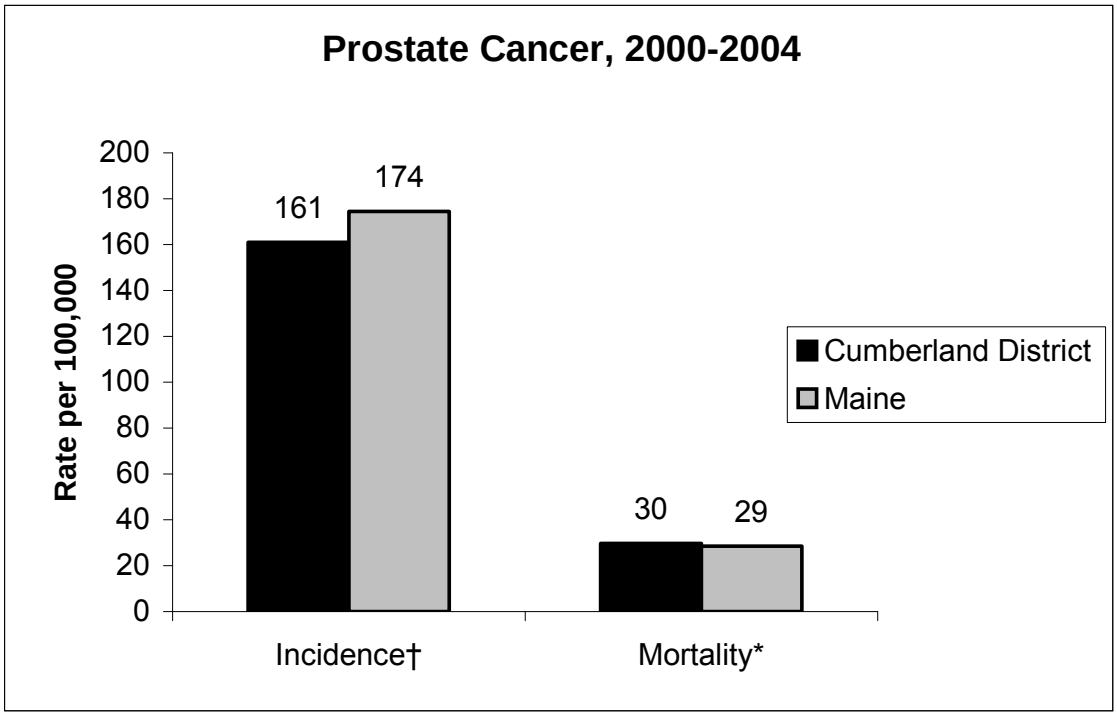
† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS



† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS
*Source: 2000-2004 National Center for Health Statistics data

	Cumberland District Rate (± Margin of Error)	**Maine State Rate** (± Margin of Error)
Female Breast Cancer Incidence† Rate (Per 100,000)	134.8 (± 8.2)	132.5 (±3.6)
Female Breast Cancer Mortality* Rate (Per 100,000)	25.1 (± 3.5)	23.7 (±1.5)

† Incidence Source:2000-2004 Maine Cancer Registry, Maine CDC, DHHS
* Mortality Source: 2000-2004 National Center for Health Statistics data



† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS
* Source: 2000-2004 National Center for Health Statistics data

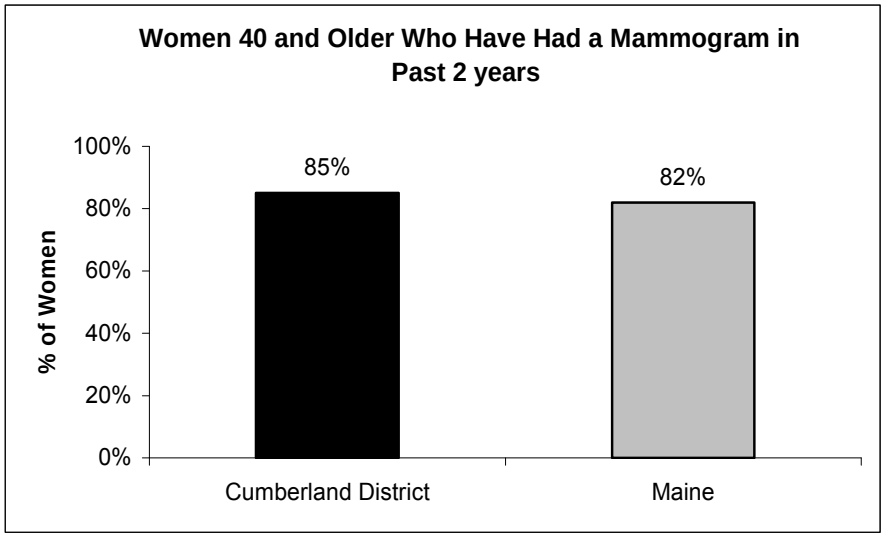
	Cumberland District Rate (± Margin of Error)	**Maine State Rate** (± Margin of Error)
Prostate Cancer Incidence† Rate (Per 100,000)	161.1 (±10.2)	174.5 (± 4.6)
Prostate Cancer Mortality* Rate (Per 100,000)	29.8 (± 4.8)	28.5 (±2.1)

† Incidence Source: 2000-2004 Maine Cancer Registry, Maine CDC, DHHS*Mortality Source: 2000-2004 National Center for Health Statistics data

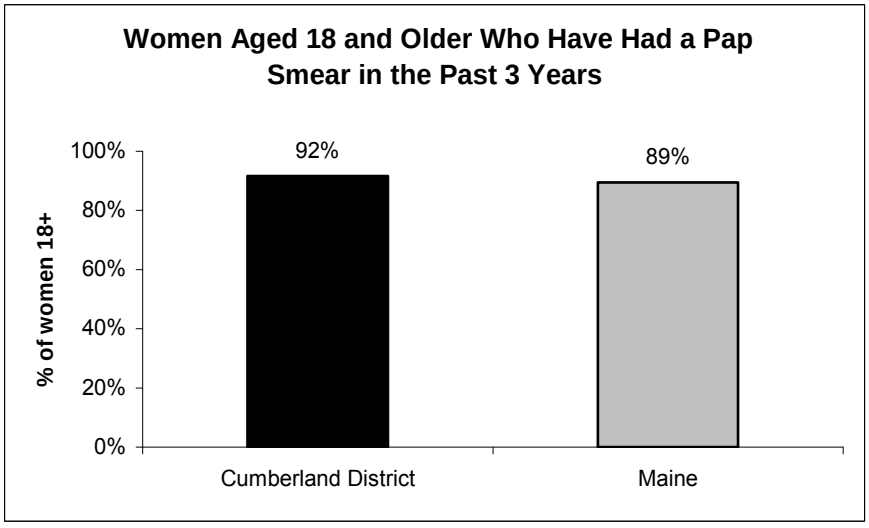
Cancer Screening

Screening tests for breast, colorectal, and cervical cancer have contributed to declines in death due to these cancers. Colonoscopies and pap smears have preventive aspects critical to early detection and treatment.

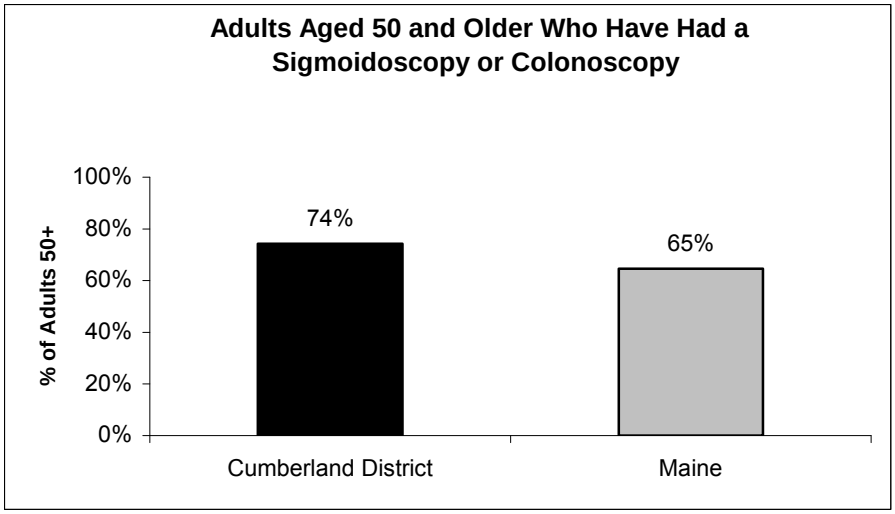
The early detection of cancer is the most effective way to improve the chances of a positive outcome through treatment. Additional information on cancer screening can be obtained from Maine CDC's Comprehensive Cancer Control Program at: www.maine.gov/dhhs/boh/ccc.html.



Source: 2006 BRFSS



Source: 2006 BRFSS



Source: 2006 BRFSS

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Mammogram Among Women 40 and Older (Past 2 years)[1]	85.1 (±4.3)	82.0 (±2.0)
Pap Smear Among Women 18 and Older (Past 3 Years)[2]	91.6 (±3.3)	89.4 (±1.6)
Sigmoidoscopy/colonoscopy Among Adults 50 and Older[3]	74.3 (±5.1)	64.6 (±2.4)

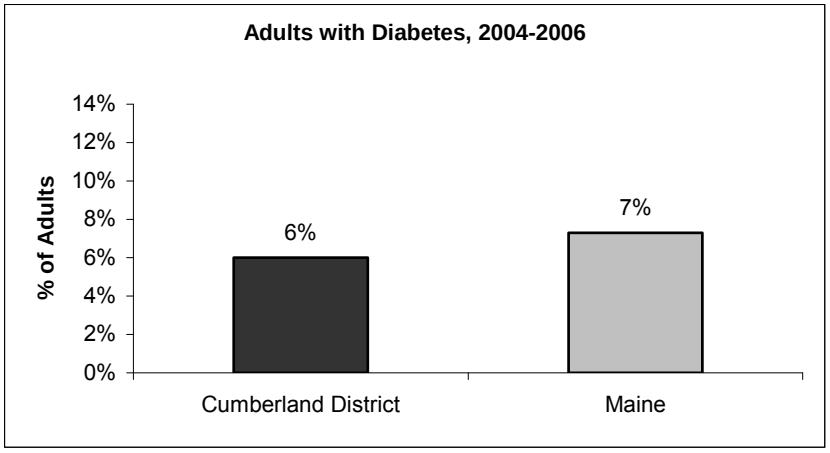
1) Source: 2006 BRFSS: % of women 40 years and older who have had a mammogram in the past 2 years
2) Source: 2006 BRFSS: % of women 18 years and older who have had a pap smear within the past 3 years
3) Source: 2006 BRFSS: % of adults 50 years and older who have had a sigmoidoscopy or colonoscopy

Diabetes

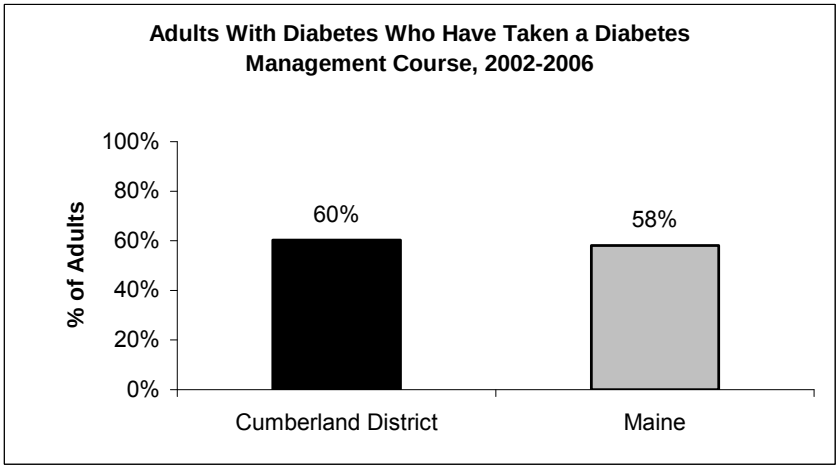
Diabetes mellitus, if left unidentified or managed poorly, can lead to problems that include urgent emergency department visits and hospitalizations, a higher risk of heart attack, blindness, kidney disease, or amputation. Many cases of diabetes are preventable or lead to a chronic condition that can be managed if adequate supports are available and used.

Many Mainers are currently at risk for or have diabetes but are unaware of it Once diagnosed, diabetes is a challenging disease with which to live, and creates costs for families, employers, communities, and the State's health care safety net system.

For more information, contact the Maine Diabetes Prevention and Control Program at www.maine.gov/dhhs/bohdcfh/dcp/.



Source: 2004-2006 BRFSS: Non-Gestational Diabetes Prevalence



Source: 2002-2006 BRFSS; among those with diabetes

	Cumberland District Number	Cumberland District Rate or Percent (± Margin of Error)	Maine State Rate or Percent (± Margin of Error)
Diabetes Mortality[1]	64 (avg. per year)	21.2 (±2.3) (per 100,000)	25.8 (±1.1) (per 100,000)
Diabetes Hospitalizations[2]	281	9.6 (±1.1) (per 10,000)	10.5 (±0.5) (per 10,000)
Non-Gestational Diabetes Prevalence (%) Among Adults[3]	N/A	6.0% (±1.2)	7.3% (±0.6)
Adults With Diabetes Who Have Taken a Diabetes Management Course[3]	N/A	60.3% (±8.2)	58.1% (±3.1)
Hemoglobin A1c Test at Least Once a Year[3]	N/A	93.1% (±4.3)	91.9% (±2.0)

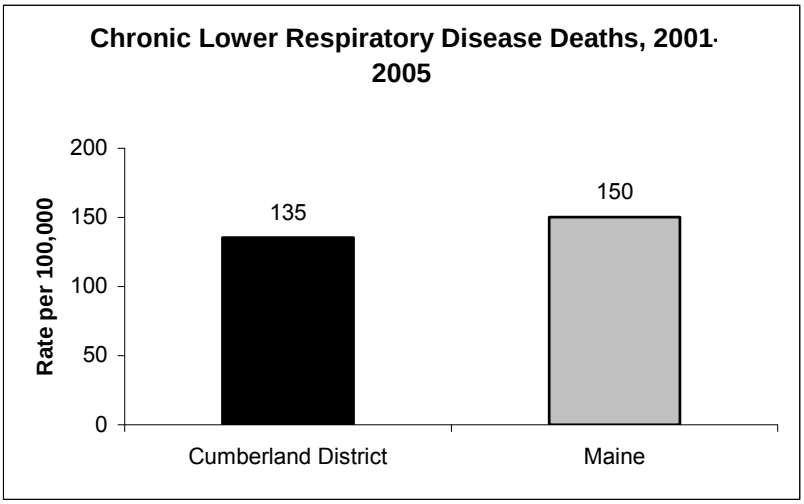
1) Source: 2001-2005 Maine Office of Data, Research and Vital Statistics; (ICD)-10 codes E10–E14
2) Source: 2005 Maine Hospital Discharge Datasets, (ICD)-10 codes E10–E14; Age-adjusted to 2000 U.S. Standard Population
3) Source: 2002-2006 BRFSS

Respiratory Health

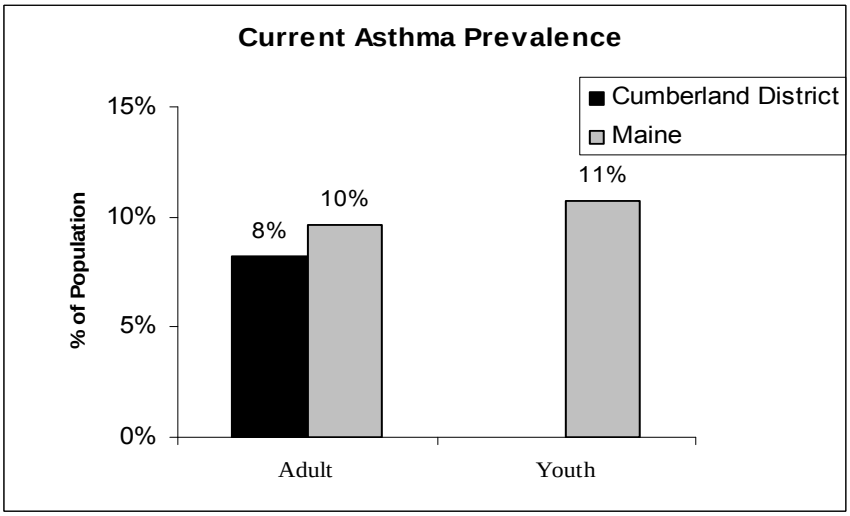
Chronic respiratory diseases include chronic obstructive pulmonary disease (COPD) and asthma, and affect approximately one in eight people in Maine. COPD is largely a result of tobacco smoke and primarily affects older adults. Asthma affects people of all ages and is increasing in Maine at a dramatic rate.

Data on chronic lower respiratory disease [includes COPD] and on asthma are collected through Maine vital records, hospital data, and state surveys.

Information on asthma can be found at Maine Asthma Control and Prevention Program at: www.maine.gov/dhhs/bohdcfh/mat/index.html and its links to its many state and local partners.



Source: 2001-2005 Maine Office of Data, Research and Vital Statistics



Source: 2006 BRFSS, 2003 NCHS
*District level data for youth not available from NCHS

	Cumberland District Number	Cumberland District Rate or Percent (± Margin of Error)	Maine State Rate or Percent (± Margin of Error)
Chronic Lower Respiratory Disease Deaths Among Adults 45 and Older[1]	136.6 (avg. per year)	135.4 (± 10.1) (per 100,000)	150.2 (±4.6) (per 100,000)
Adult Asthma Prevalence[2]	N/A	8.2% (± 2.5)	9.6% (±1.2)
Child & Youth Asthma Prevalence (17 and Younger)[3]	N/A	N/A	10.7% (±1.5)
Asthma Emergency Department Visits[4]	1,345	51.6 (±1.7) (per 10,000)	66.1 (±1.4) (per 10,000)

1. Source: 2001-2005 Maine Office of Data, Research and Vital Statistics; ICD-10: J40-J47; Age-adjusted to 2000 U.S. standard population (45 and Older)
2. Source: 2006 BRFSS: % of adults with current asthma
3. Source: 2003 NCHS; Note: NCHS data not available at district level
4. Source: 2004 Maine Hospital Discharge Datasets; Age-adjusted to 2000 U.S. Standard Population

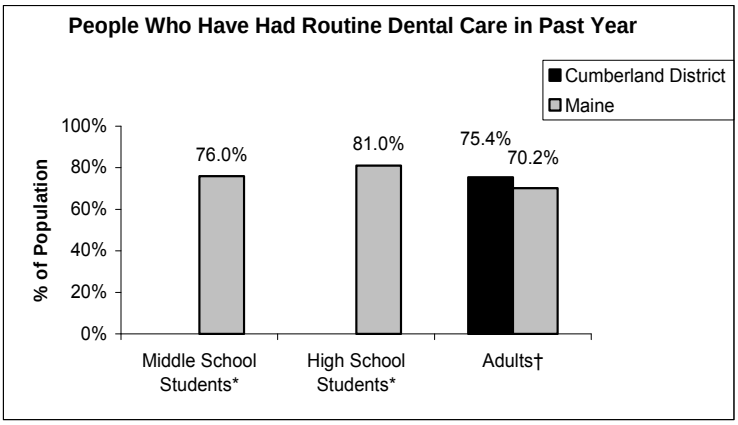
CUMBERLAND DISTRICT: Oral Health

Oral Health Status and Access to Care

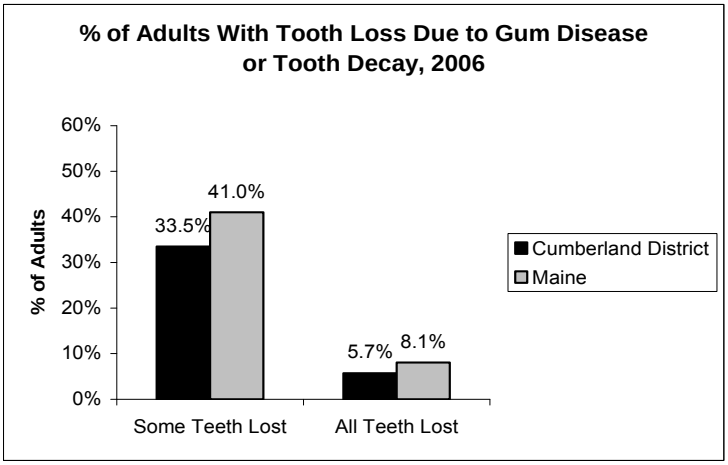
Oral health is an important part of the overall health of our bodies. Poor dental hygiene and lack of preventive care can lead to dental disease, which can have serious adverse effects on physical health, contribute to other health problems and even to social exclusion. Most oral health problems can be prevented through proper dental hygiene, routine oral health care visits, oral health education, school based dental sealant programs, and fluoridation of community water systems.

Access to oral health care is of particular concern across Maine as many Maine dentists are near retirement age, and not all dentists accept Medicaid patients including children. The aging of Maine's population in a retirement state will create more need for oral health care services so that seniors can resolve oral health problems and continue to eat properly. Medicare does not cover dental care services.

Contact the Maine Oral Health Program at www.maine.gov/dhhs/bohdcfh/odh.



*Source: 2005 YRBS; Note: district-level data not available
†Source: 2006 BRFSS



Source: 2006 BRFSS: # of permanent teeth lost due to tooth decay or gum disease

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Middle School Students Who Have Had a Routine Dental Visit in Past Year[1]	N/A	76
High School Students Who Have Had a Routine Dental Visit in Past Year[1]	N/A	81
Adults Who Have Had a Routine Dental Visit in Past Year[2]	75.4 (±5.1)	70.2 (±1.8)
Adults Who Have Lost Teeth Due to Gum Disease or Tooth Decay[2]		
Some teeth lost	35.2 (± 4.3)	41 (±1.8)
All teeth lost	5.7 (± 2.0)	8.1 (±1.0)

1. Source: 2005 YRBS: Note: district-level data not available
2. Source: 2006 BRFSS

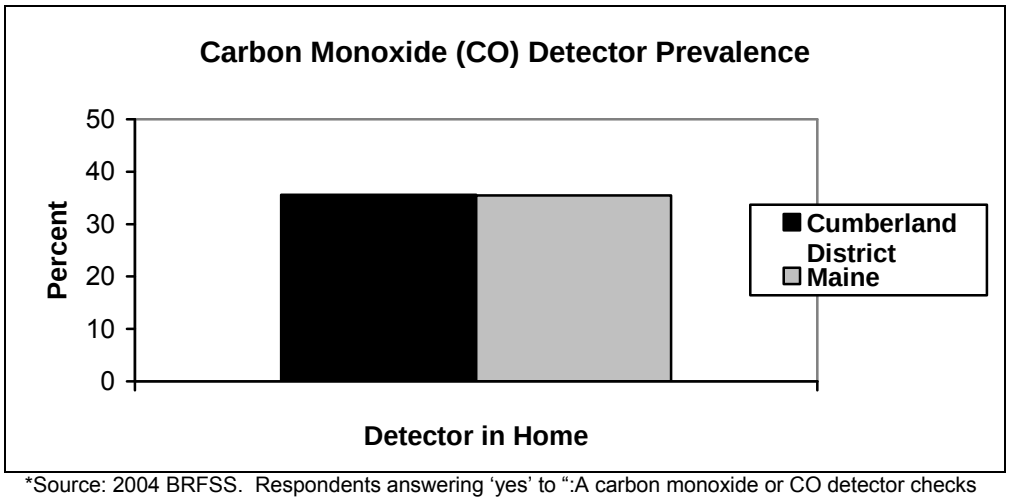
CUMBERLAND DISTRICT: Environmental Health

Carbon Monoxide Detector in Home

In Maine there are about 150 Emergency Room visits for carbon monoxide poisoning each year.

Having a carbon monoxide (CO) detector in the home can prevent injury and death from exposure to carbon monoxide.

Improved monitoring of exposures to carbon monoxide is a national objective in *Healthy People 2010*. Data is tracked by Maine CDC's Environmental Health program. More information about carbon monoxide exposures in Maine can be found at www.maine.gov/dhhs/eohp/air/co.htm.



*Source: 2004 BRFSS. Respondents answering 'yes' to ":A carbon monoxide or CO detector checks the level of carbon monoxide in your home. It is not a smoke detector. Do you have a carbon monoxide detector in your home?

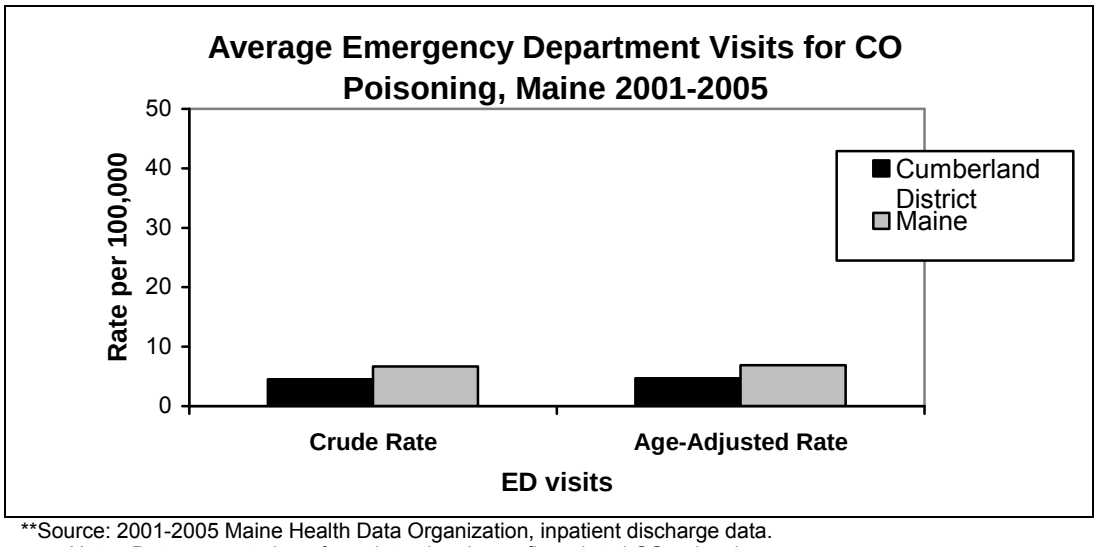
	Cumberland District Percent (±Margin of Error)	Maine State Percent (±Margin of Error)
Percent of homes with carbon monoxide detector*	35.6 (± 4.1)	35.5 (±1.7)

*Source: 2004 BRFSS. Respondents answering 'yes' to ":A carbon monoxide or CO detector checks the level of carbon monoxide in your home. It is not a smoke detector. Do you have a carbon monoxide detector in your home?

Emergency Department Visits for Carbon Monoxide (CO) Poisoning

In Maine there are about 150 Emergency Room visits for carbon monoxide poisoning each year. Carbon monoxide poisoning is almost entirely preventable.

Improved monitoring of exposures to carbon monoxide is a national objective in *Healthy People 2010*. More information about carbon monoxide may be found at www.maine.gov/dhhs/boh.



**Source: 2001-2005 Maine Health Data Organization, inpatient discharge data.
Note: Data presented are for unintentional, non-fire related CO poisonings

	Cumberland District Age-Adjusted Rate (± Margin of Error)	Maine State Age-Adjusted Rate (± Margin of Error)
ED visit rate for CO poisoning*	4.7 (± 1.2)	6.9 (± 0.7)

Source: 2001-2005 Maine Health Data Organization, inpatient discharge data.
Note: Data presented are for unintentional, non-fire related CO poisonings.

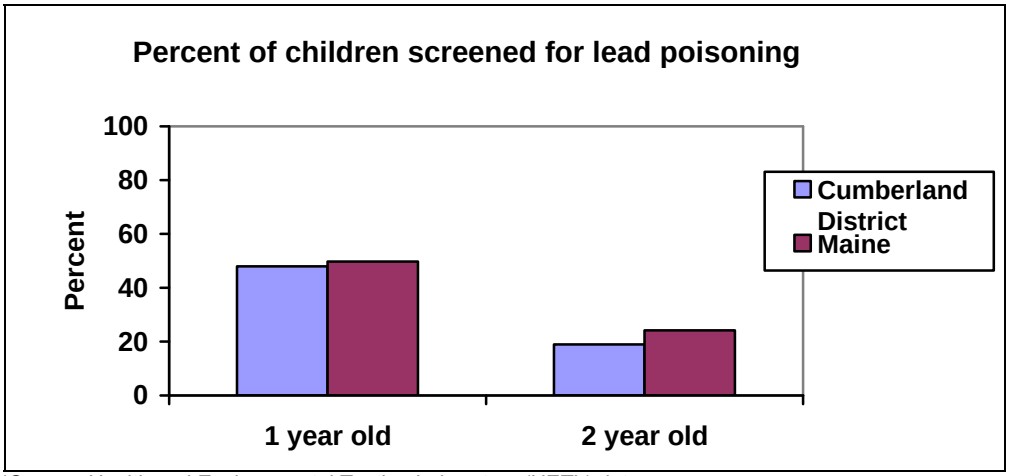
Children Screened for Lead Poisoning

Children at risk of lead poisoning are mandated by Maine legislation to be screened at 1 and 2 years of age.

Children enrolled in MaineCare as well as all children potentially exposed to lead in their home or elsewhere are considered at risk for lead poisoning and must be screened.

The goal of screening is to identify children with lead poisoning who need interventions to reduce the level of blood in their system.

To find out more about Childhood Lead Poisoning go to: www.mainepublichealth.gov



*Source: Health and Environmental Testing Laboratory (HETL) data.
Note: Screening defined as blood lead tests of children who have not previously been identified as having lead poisoning.

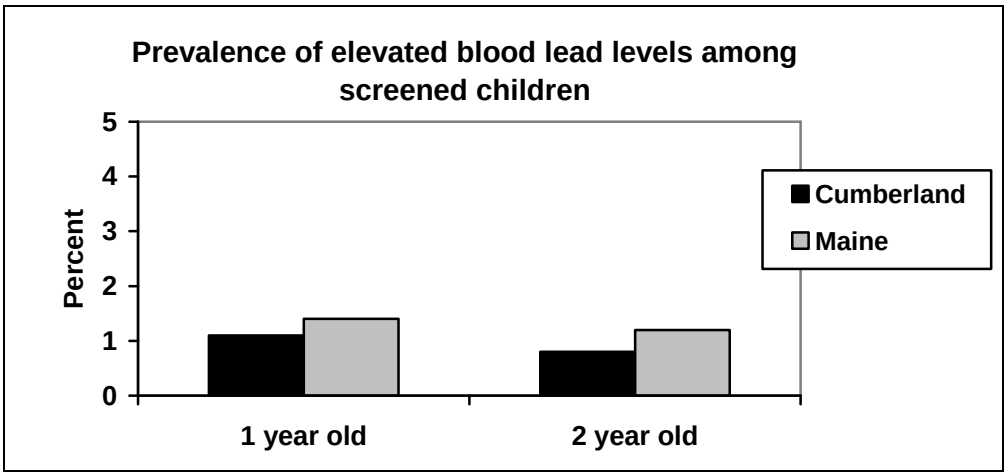
	Cumberland District Percentage (± Margin of Error)	Maine State Percentage (± Margin of Error)
Percent of 1 year old children screened	48.0 (±1.8)	49.8 (±0.8)
Percent of 2 year old children screened	18.9 (±1.4)	24.2 (±0.7)

Source: Health and Environmental Testing Laboratory (HETL) data.
Note: Screening defined as blood lead tests of children who have not previously been identified as having lead poisoning.

Children with Elevated Blood Lead Levels

Blood lead levels (BLLs) as low as 10 µg/dl are associated with harmful effects on children's learning and behavior. It is estimated that statewide, there are 1,200 children age 1 to 5 years that have BLLs ≥ 10 µg/dl.

Children at 1 and 2 years of age are at greatest risk for elevated BLLs because of their increasing mobility and normal hand-to-mouth activity. To see more about Childhood Lead Poisoning go to: www.maine.gov/dhhs/boh/eohp.



*Source: 2005-2006 data combined, Maine Childhood Lead Poisoning Prevention Program.
Note: Percent based on the number of children screened with confirmed elevated blood lead levels.
Elevated blood lead level defined as having a blood lead level of ≥ 10 µg/dl .

	Cumberland District Percent (± Margin of Error)	**Maine State Percent** (± Margin of Error)
Prevalence of elevated blls among screened 1 year old children*	1.1 (±0.4)	1.4 (±0.2)
Prevalence of elevated blls among screened 2 year old children*	0.8 (±0.6)	1.2 (±0.3)

* Source: 2005-2006 data combined, Maine Childhood Lead Poisoning Prevention Program.
Note: Percent based on the number of children screened with confirmed elevated blood lead levels.
Elevated blood lead level defined as having a blood lead level of ≥ 10 µg/dl

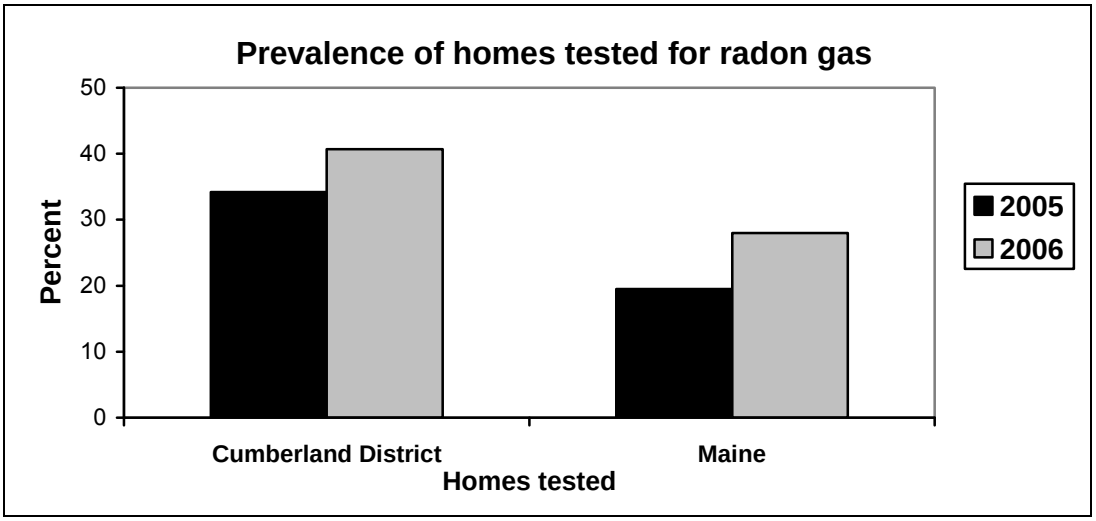
Homes Tested for Presence of Radon Gas

Radon is an odorless and colorless gas and exists in varying concentrations in geographic areas of Maine. Radon is the leading cause of lung cancer among nonsmokers.

Seventy-six (76%) percent of homes in Cumberland District had levels of radon (>2pCI/L) in their home where actions should be considered to reduce radon. Radon levels in forty-five (45%) percent of homes in the same district were high enough (4pCI/L or higher) where action should be taken to reduce radon levels.

Increasing the number of Maine homes tested for radon is an objective of Healthy Maine 2010.

To find out more information about radon in the home go to:
www.maine.gov/dhhs/eng/rad/Radon/hp_radon.htm



*Source: 2005-2006 BRFSS. Respondents answering 'yes' to ":Has your household air been tested for the presence of radon gas?"

	Cumberland District Percentage (± Margin of Error)	Maine State Percentage (± Margin of Error)
Prevalence of homes tested for radon gas*		
2005	34.2 (± 4.1)	19.5. (±1.4)
2006	40.7 (± 4.1)	28.0 (±1.6)

*Source: 2005-2006 BRFSS. Respondents answering 'yes' to "Has your household air been tested for the presence of radon gas?"
Note: Data for Aroostook District in 2005 considered unreliable due to the small number of survey respondents, therefore, no data presented.

Health Inspection Program

Public eateries and lodging places are required to address food safety and security, and environmental sanitation to prevent food borne illness and the spread of infectious disease. Body artists working in tattoo parlors must provide proper facilities, equipment, and procedures to assure compliance with health regulations to prevent the transmission of certain infectious diseases. Such services have a wide impact in protecting the health of individuals and the health of the community's businesses and environment.

Establishments are required to apply for licenses and approvals and submit to periodic inspections. Applicants need to be educated to identify risks and take the right action to prevent or correct problems. The public needs education and information about licensing and inspection information.

The Health Inspection Program in the Maine CDC assists licensees with technical and administrative assistance, and provides licensing and inspection data to the public and stakeholders upon request. FMI contact: www.mainepublichealth.gov

Cumberland District				
Total Number of Eating and Lodging Place Licenses Issued per Year	**Total Number of Body Artist Licenses Issued per Year**	**Total Number of Eating and Lodging Place Inspections per Year**	**Total Number of Body Artist Inspections per Year**	**Total Number of Failed Inspections per Year**
2,050	86	381	25	78

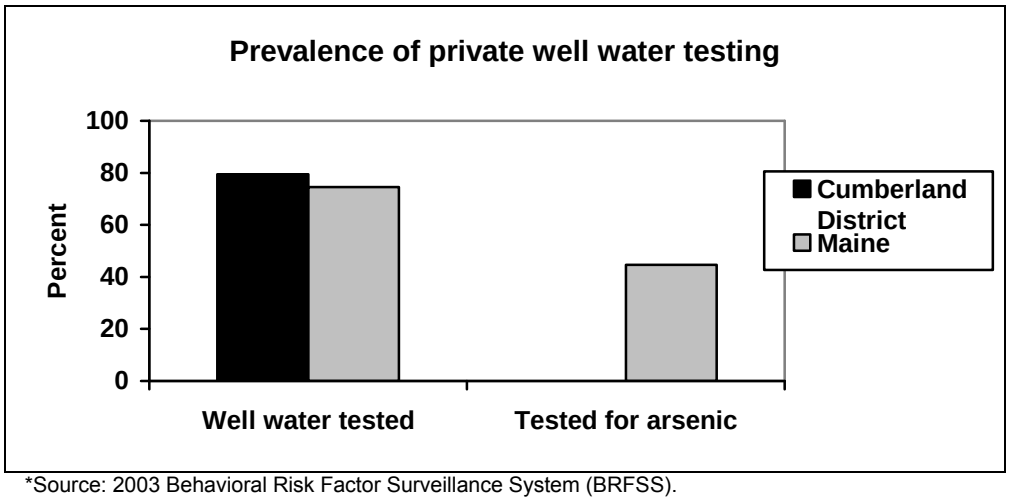
Source: Maine CDC Health Inspection Program 2005.

Private Well Water Testing

More than half of Maine's population relies on a private well for their drinking water. Many Maine wells have unsafe levels of arsenic, radon, and uranium - chemicals that can cause cancer or other health effects.

Testing is the only way to know if the well water is safe to drink.

To find out more about drinking water and where to get water test kits in Maine go to: www.wellwater.maine.gov/



*Source: 2003 Behavioral Risk Factor Surveillance System (BRFSS).
Note: Arsenic test data for Cumberland District considered unreliable due to small number of respondents, therefore, no data presented.

	Cumberland District Percent (± Margin of Error)	**Maine State Percent** (± Margin of Error)
Homes with private well water tested*	79.4 (± 7.2)	74.6 (±2.7)
Homes with private well water tested for arsenic*		44.6 (±3.9)

*Source: 2003 Behavioral Risk Factor Surveillance System (BRFSS).

Public Drinking Water Systems

Safe drinking water is essential to protecting good human health. Maine citizens and visitors enjoy access to excellent quality drinking water from many lakes, rivers and underground aquifers. More than 2,000 public water systems provide drinking water to over half of Maine's population and many guests.

Local public water systems must comply with the federal Safe Drinking Water Act and state regulations, including protecting source water areas and maintaining or improving local water system infrastructure. Communities can take charge by working together to protect shared drinking water sources.

The Maine Drinking Water Program in the Maine CDC assists communities with technical assistance, grants and funding. FMI contact: www.mainepublichealth.gov

Total Number of DISTRICT Community Water Systems	Total DISTRICT Population Served by Community Drinking Water Systems
31	171,172

Total Number of DISTRICT Water Quality Violations Documented in 2006	Total Number of DISTRICT Systems in Which Violations Occurred	Total DISTRICT Population Served by Community Water Systems with a Violation(s)
10	4	248

Percent of DISTRICT Community Water Systems Meeting all Health Based Standards	Percent of MAINE Community Water Systems Meeting all Health Based Standards
87.10%	79.84%

Percent of DISTRICT Population Served by Community Water Systems Meeting all Health Based Standards	Percent of MAINE Population Served by Community Water Systems Meeting all Health Based Standards
99.86%	86.74%

Total Number of DISTRICT Community Water Systems with a Wellhead Protection Plan	Total Population Served by DISTRICT Community Water Systems with Wellhead Protection
31	170,868

Percent of DISTRICT Community Water Systems with Source Water Protection in Place	Percent of MAINE Community Water Systems with Source Water Protection in Place	Percent of MAINE Population served by Community Water Systems with Source Water Protection in Place
83.87%	83.72%	78.49%

Subsurface Wastewater Disposal Systems

(Septic Systems)

Proper handling and disposal of domestic sanitary wastewater is critical to prevent the spread of bacterial and viral diseases to individuals and entire communities.

Septic systems must be installed correctly and work properly over time. But maintenance is costly, and system repair or replacement may be postponed for too long. All Maine municipalities are required by statute to have a local plumbing inspector and code enforcement officer. Not all towns have full time code enforcement officers; and code enforcement may vary from town to town.

Persons or organizations who need to install a new (or replace an existing) subsurface wastewater disposal system must hire a licensed site evaluator and get a permit from the municipal local plumbing inspector who will perform construction inspections.

Maine CDC's Subsurface Wastewater Program assists communities with technical and administrative assistance. It licenses people who design subsurface wastewater disposal systems. It conducts a voluntary certification program for system installers and people who conduct real estate transfer inspections. FMI contact: www.mainepublichealth.gov

Total Number of Subsurface Wastewater System Permits issued per year	Total Number of Internal Plumbing Permits Issued per Year	Total Number of Licensed Site Evaluators Currently Residing in District	Total Number of Real Estate Transfer System Inspections Performed per Year	Total Number of Voluntarily Certified Inspectors Working in District
2,590	3,060	42	604	32

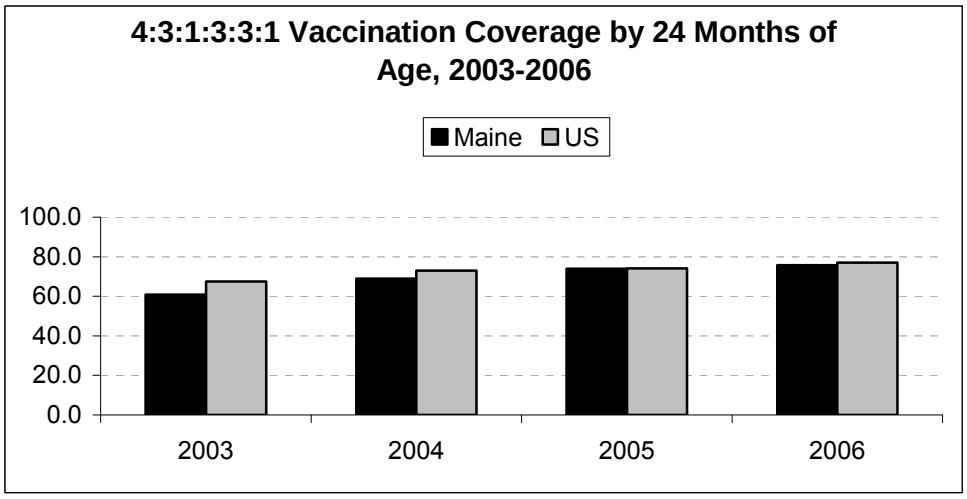
CUMBERLAND DISTRICT: Infectious Diseases

Child Vaccinations
Immunization Rates by 24 Months of Age

Immunization has been one of the safest and most effective public health tools in the prevention and control of infectious diseases. Achieving higher vaccination rates prevents and reduces immediate risk of disease and death in individuals and the community as a whole. Groups of people, whose immune systems are more vulnerable, such as children, have particular need for protection.

The Maine Immunization Program works with the federal CDC, local providers and community partners to educate, promote and provide oversight of local vaccination rates for **4:3:1:3:3:1**, the optimal vaccination sequence for kids in this age group.

Through support of local community action and outreach and provider education, communities can choose to protect their own, and in the process, everyone is protected. Learn more about the Maine Immunization Program at www.maine.gov/dhhs/boh/ddc/_immunization/



4:3:1:3:3:1 represents 4 DTaP, 3 Polio, 1 MMR, 3 Hepatitis B, 3 Hib and 1 Varicella; US National Immunization Survey

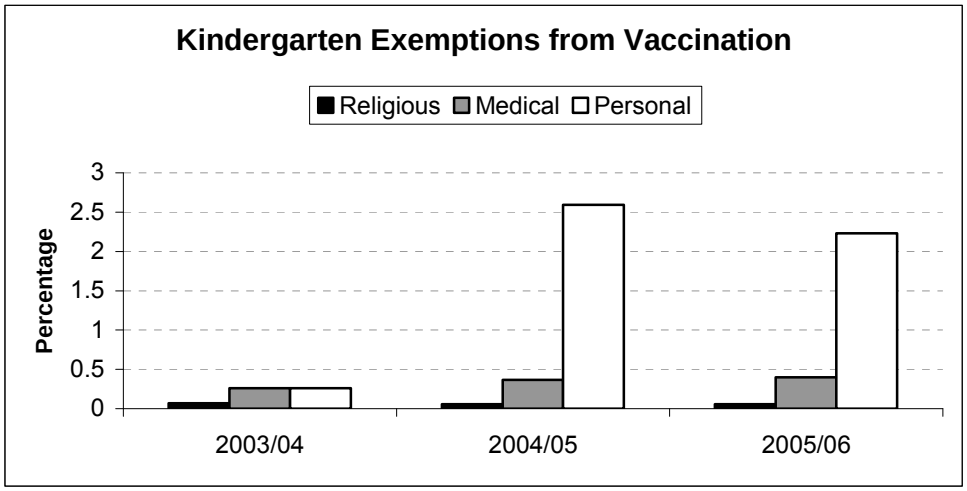
	Maine State Percent	US Percent
2003	60.8	67.4
2004	68.9	72.9
2005	73.9	74.1
2006	75.7	77.0

Kindergarten Exemptions from Vaccination

Although today's vaccines are extremely safe and effective, misinformation exists that may lead some well intentioned parents to question the value of child immunizations related to that safety. The Maine CDC monitors the scientific evidence for safety at all times, and balances that research against the alternative: to not vaccinate children. The long experience of using this public health tool to protect children's health wins out every time.

Maine CDC's Maine Immunization Program tracks rates of vaccinations, and funds education outreach in partnership with communities. It builds partnerships with school nurses to allow for an open dialogue with parents to counter the myths and misinformation pushed through the internet and in other popular media.

To learn more: www.maine.gov/dhhs/boh/ddc/_immunization/school_requirements.html



	Religious Number	**Medical** Number	**Philosophical** Number	**Total Surveyed**
2003/04	10	38	38	14,701
2004/05	8	53	375	14,452
2005/06	8	57	319	14,298

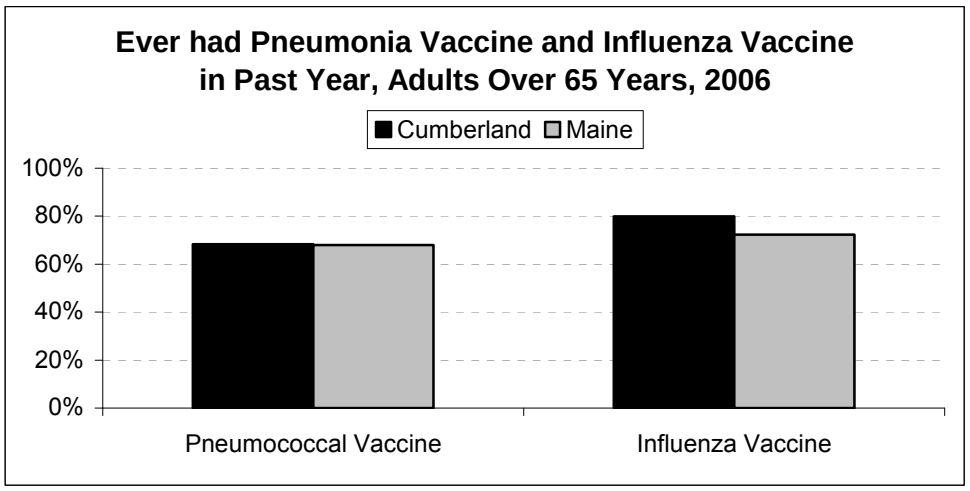
*Maine CDC Immunization Program (MIP) School Survey

Immunization for Adults: Pneumococcal and Influenza Vaccination 65 years of age or older

Research data indicate on average, 226,000 people are hospitalized every year because of influenza [flu] and 36,000 die – especially vulnerable seniors. Pneumococcal disease, another infectious disease that is particularly lethal for those over 65, kills more people in the United States each year than all other vaccine preventable diseases combined.

This is preventable when our communities and health systems work together.

The Maine CDC's Maine Immunization Program funds educational campaigns and free flu vaccine to high risk populations and free pneumococcal vaccine for Maine residents in long-term care facilities. See www.maine.gov/dhhs/boh/Influenza_2007-2008.htm and www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm.



	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Pneumococcal Vaccine Ever	68.3 (± 8.6)	67.9 (± 3.5)
Influenza Vaccine Past Year	79.9 (± 6.7)	72.3 (± 3.1)

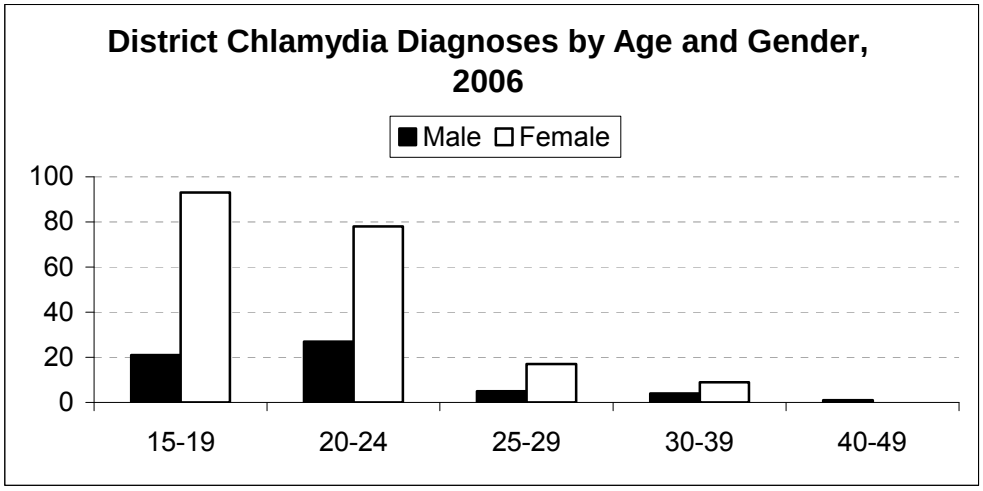
*2006 Behavioral Risk Factor Surveillance System (BRFSS) data

Chlamydia

Chlamydia is a sexually transmitted infection in men and women. In women, symptoms may be mild or absent, and can result in pelvic inflammatory disease and infertility. It is more frequently diagnosed in younger adults and adolescents; and is preventable.

Reducing the number of chlamydia cases and related illnesses is a *Healthy Maine 2010* objective. Communities can work to assure that there is access to prevention education, prevention supports and screening for residents.

Maine CDC's Maine Infertility Prevention Project is supported by the Maine HIV/STD program, and includes support for education outreach campaigns, public STD testing and treatment clinics. For more information, contact the program at www.mainepublichealth.gov



Diagnoses	Cumberland District Number Males	Cumberland District Number Females	Maine State Number Males	Maine State Number Females
0-14	0	3	1	18
15-19	37	140	134	647
20-24	93	191	277	698
25-29	45	63	114	190
30-39	25	32	74	94
40-49	13	5	27	19
50+	2	2	4	5
Unknown	1	0	1	1
Total	216	436	632	1672

*Maine CDC HIV, STD & Viral Hepatitis Program

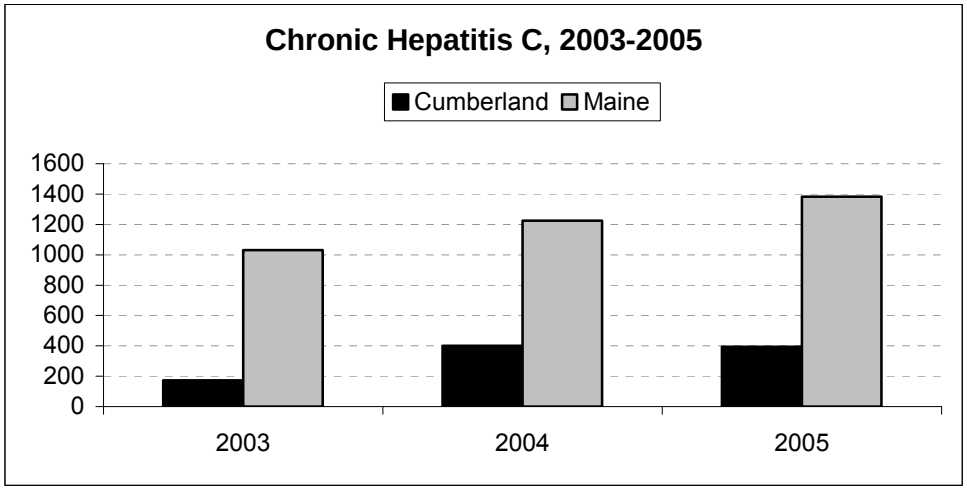
Chronic Hepatitis C

Hepatitis C is a virus that can damage the liver, cause cirrhosis, liver cancer or even death. It is the most common bloodborne infection in the U.S.

An estimated 20,000 Maine people have been infected with hepatitis C; however, less than half may be aware of their infection. A reliable test for this virus only became available in the last fifteen years and many people have never been screened.

Identifying people infected with hepatitis C is an objective of *Healthy Maine 2010*.

To find out more about Hepatitis C prevention activities in Maine: see the HIV/STD Program at www.mainepublichealth.gov



	Central Maine District Number	Maine State Number
Chronic Hepatitis C 2003	172	1030
Chronic Hepatitis C 2004	400	1224
Chronic Hepatitis C 2005	394	1382

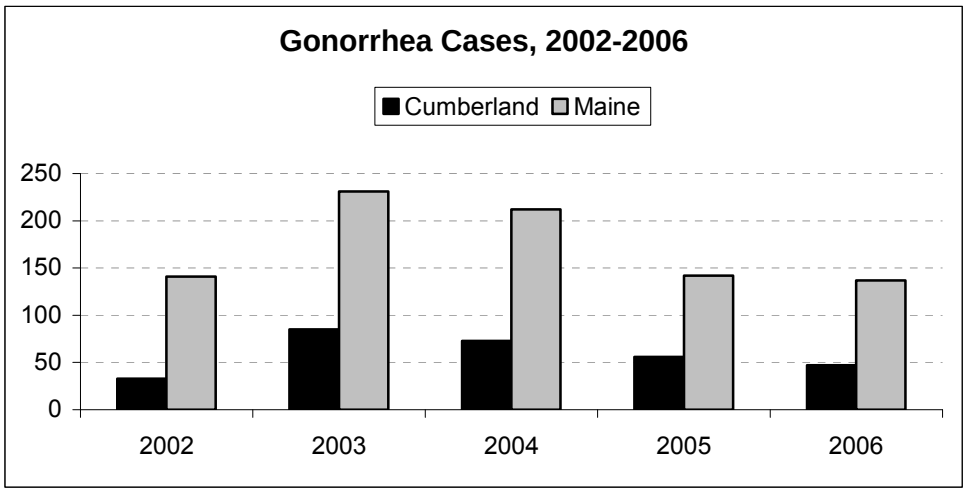
*Maine CDC HIV, STD & Viral Hepatitis Program

Gonorrhea

Gonorrhea is a sexually transmitted infection that can cause serious and permanent health problems in both women and men. However while it can cause notable and painful symptoms in men, there may be no symptoms in women. Gonorrhea can cause pelvic inflammatory disease and infertility.

Communities need to assure that there is access to prevention education, prevention supports and screening for their residents. Gonorrhea prevention, testing and treatment is promoted in Maine through health education programs, information campaigns, and public STD testing and treatment clinics.

Maine CDC's Maine HIV/STD program supports for education outreach campaigns, public STD testing and treatment clinics. For more information, see www.mainepublichealth.gov



Diagnoses	**Cumberland District** Number	**Maine State** Number
Gonorrhea Cases 2002	33	141
Gonorrhea Cases 2003	85	231
Gonorrhea Cases 2004	73	212
Gonorrhea Cases 2005	56	142
Gonorrhea Cases 2006	47	137

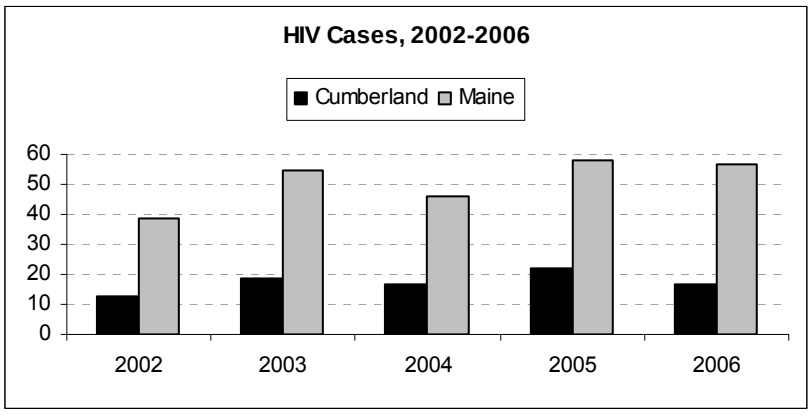
*Maine CDC HIV, STD & Viral Hepatitis Program

HIV

HIV is a virus that can weaken a person's immune system, leading to AIDS, a potentially fatal condition characterized by illnesses such as cancers, respiratory infections and uncontrolled weight loss.

HIV infection continues to be a risk in Maine. While medications, medical, financial and social supports can lead some people to experience HIV more as a long term chronic illness, it remains a challenging and costly condition. Nationally, up to a third of people with HIV don't know they're infected. HIV leads to a vulnerable health status and years of life lost; and it is preventable. As a result, reducing illness and death caused by HIV is an objective of Healthy Maine 2010.

Maine CDC's HIV/STD Program tracks data on HIV and offers technical assistance, training and funds to Maine's community HIV prevention and care providers. To find out more see the Program and its resources at www.maine.gov/dhhs/boh/ddc/hiv_std_vh.htm



Maine State HIV Characteristics	2002-2006 N=255
Male	217
Female	38
Under 13	2
13-19	2
20-29	59
30-39	66
40-49	91
Over 49	35
Men Who Have Sex with Men [MSM]	163
Injection Drug Use [IDU]	17
MSM/IDU	2
Heterosexual Contact	30
Pediatric	2
Unknown	41**

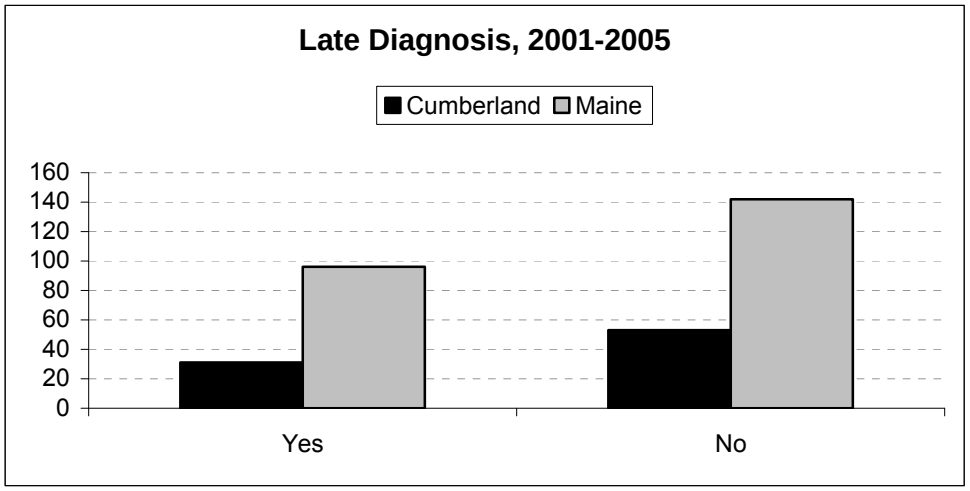
Includes people who did not disclose transmission risk or who disclosed heterosexual contact with partner of unknown risk status; Maine CDC HIV, STD & Viral Hepatitis Program

Late Diagnosis
(AIDS diagnosis within 12 months of first HIV diagnosis)

During the past 5 years, 40% of people diagnosed with HIV were ill enough to be classified with AIDS within 12 months of their initial HIV+ test. This likely means they had been infected with HIV for a long while. As many as 500 people in Maine may have HIV and not know it.

Reducing late HIV diagnoses is an objective of *Healthy Maine 2010*, and is the goal of numerous HIV testing initiatives targeting at-risk persons throughout the state.

To find out more about HIV testing and prevention in Maine: www.mainepublichealth.gov



	Cumberland District Number	Maine State Number
Late Diagnosis	31	96
Not a Late Diagnosis	53	142

*Maine CDC HIV, STD & Viral Hepatitis Program

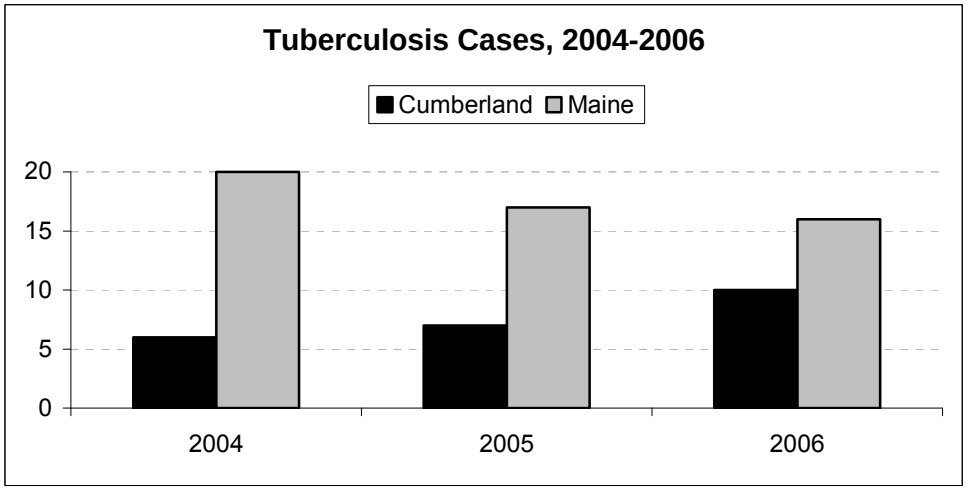
Tuberculosis

Controlling tuberculosis (an airborne bacterial infection) is a priority for public health systems across the U.S. Because it is contagious a diagnosis must be immediately reported to the Maine CDC.

Tuberculosis control may only be achieved through aggressive statewide efforts to identify, diagnose and treat active tuberculosis disease and by preventing new infections. Tuberculosis control is an objective of *Healthy Maine 2010* and the Maine State Health Plan.

The Maine CDC's Tuberculosis Control Program provides oversight, tracking, technical assistance and support for health care providers and communities. It follows U.S. CDC standards for prevention, treatment and control, up to and including using the Maine CDC's authority to power to require isolation of patients.

To learn more, see www.maine.gov/dhhs/boh/ddc/tuberculosis_control.htm



	Cumberland District number	**Maine State** number
Tuberculosis Cases 2004	6	20
Tuberculosis Cases 2005	7	17
Tuberculosis Cases 2006	10	16

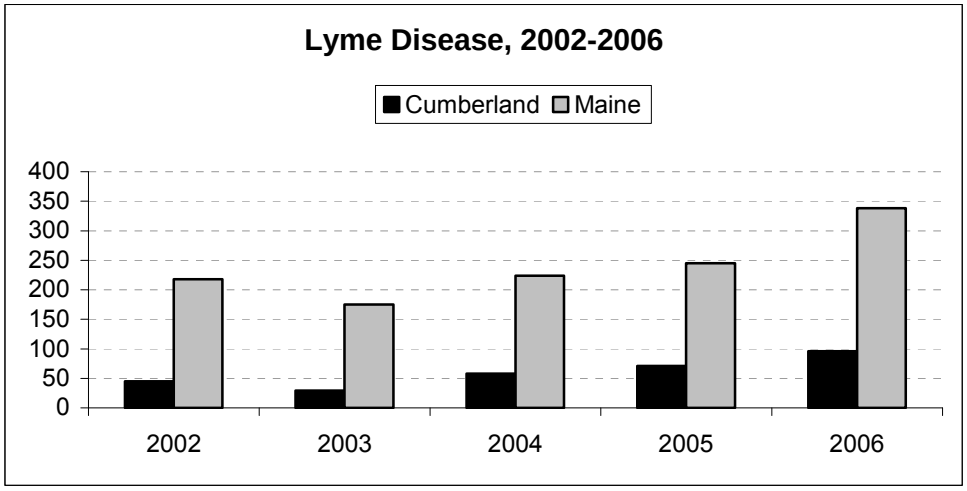
*Maine CDC Tuberculosis Program

Lyme Disease

Lyme disease is a tick-borne illness that is a growing threat in Maine, with an average of about 240 reported cases per year in the last five years and the growth in cases is of increasing concern. People who get it most often are those who are outdoors in areas where ticks are found, children under 15, or adults over 50, and people who have other illnesses that make it hard for them to fight off diseases.

A *Healthy People 2010* objective is to reduce the annual incidence of Lyme disease.

Maine is working toward achieving this objective through general and targeted educational activities and technical assistance to local communities. For more information on Lyme disease, contact the Maine CDC at www.maine.gov/dhhs/boh/ddc/_lyme/lyme_1.htm



	Cumberland District Number	Maine State Number
Lyme Disease Cases 2002	45	218
Lyme Disease Cases 2003	29	175
Lyme Disease Cases 2004	58	224
Lyme Disease Cases 2005	71	245
Lyme Disease Cases 2006	96	338

*Maine CDC Infectious Disease Epidemiology Program

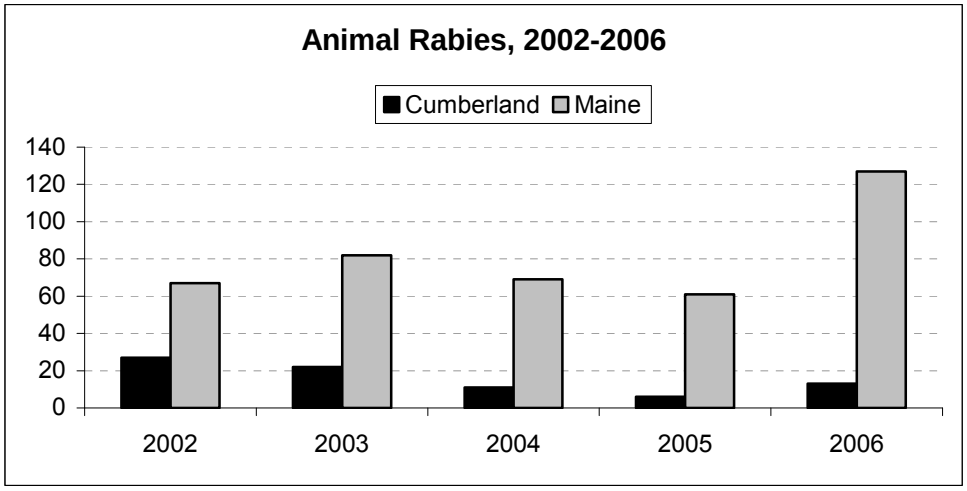
Rabies in Animals

Animals that are infected with rabies can spread this fatal disease to people and other animals through a bite, scratch, or other exposure to saliva.

Rabies can be prevented in domestic animals through vaccination and in people through prompt medical care once an exposure occurs. Communities can take action to assure awareness and education about rabies.

The Maine CDC's Rabies Program tracks cases, provides outreach education, and technical assistance if an exposure occurs.

To learn more about rabies: see www.maine.gov/dhhs/boh/ddc/rabies_surveillance.htm



	Cumberland District Number	Maine State Number
Animal Rabies Cases 2002	27	67
Animal Rabies Cases 2003	22	82
Animal Rabies Cases 2004	11	69
Animal Rabies Cases 2005	6	61
Animal Rabies Cases 2006	13	127

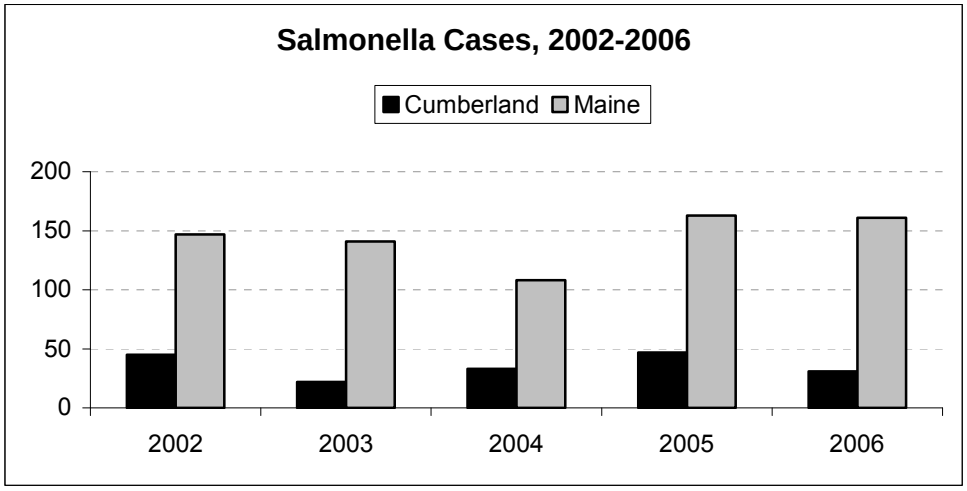
*Maine CDC Infectious Disease Epidemiology Program

Salmonella

Salmonellosis is one of the most frequent foodborne illnesses reported in Maine and the US. While most people recover without treatment. The highest incidence occurs among children under five years of age; the elderly, infants, and those with impaired immune systems are more likely to have a severe illness and/or require hospitalization..

A *Healthy Maine 2010* objective is to decrease the incidence of salmonellosis. The Division of Infectious Disease tracks and monitors cases, provides education and technical assistance. In addition, Maine CDC's infectious disease field staff can provide technical assistance in tracking down the source of the salmonella.

See www.maine.gov/dhhs/boh/salmonella%20information.htm and www.cdc.gov/salmonella.



	Cumberland District Number	Maine State Number
Salmonella Cases 2002	45	147
Salmonella Cases 2003	22	141
Salmonella Cases 2004	33	108
Salmonella Cases 2005	47	163
Salmonella Cases 2006	31	161

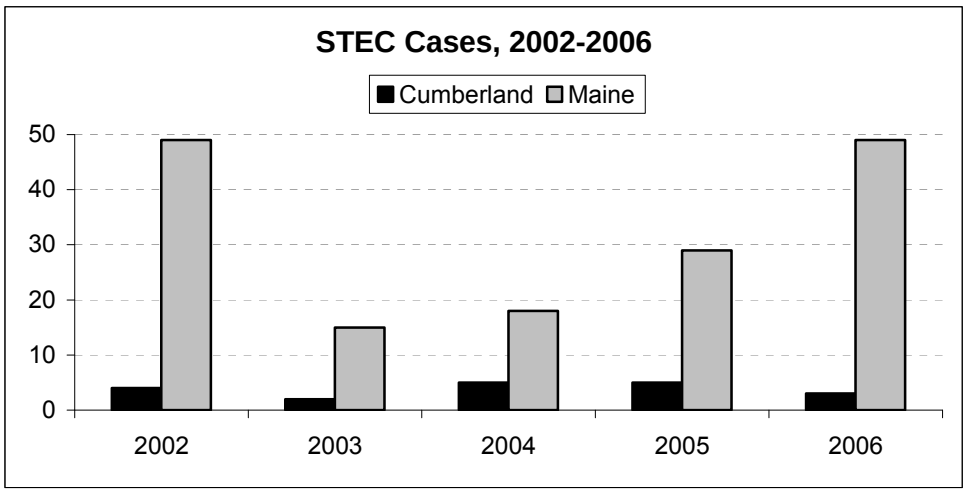
*Maine CDC Infectious Disease Epidemiology Program

Shiga Toxin Producing E. coli (STEC)

STEC is a leading cause of foodborne illness in Maine. It is a source of the food-borne illness associated with the life-threatening hemolytic uremic syndrome (HUS), particularly in children under five years of age. It can result in death; and it causes fear and disruption for communities and businesses.

Decreasing STEC infections is an objective of *Healthy Maine 2010.* The Infectious Disease Epidemiology Program tracks and monitors cases and provides education and technical assistance to clinical providers and communities.

For more information on STEC: www.cdc.gov/ecoli/



	Cumberland District Number	**Maine State** Number
STEC Cases 2002	4	49
STEC Cases 2003	2	15
STEC Cases 2004	5	18
STEC Cases 2005	5	29
STEC Cases 2006	3	49

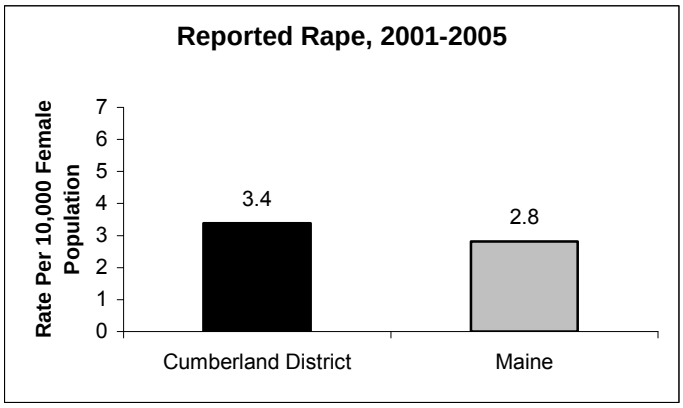
*Maine CDC Infectious Disease Epidemiology Program

CUMBERLAND DISTRICT: Injury and Violence

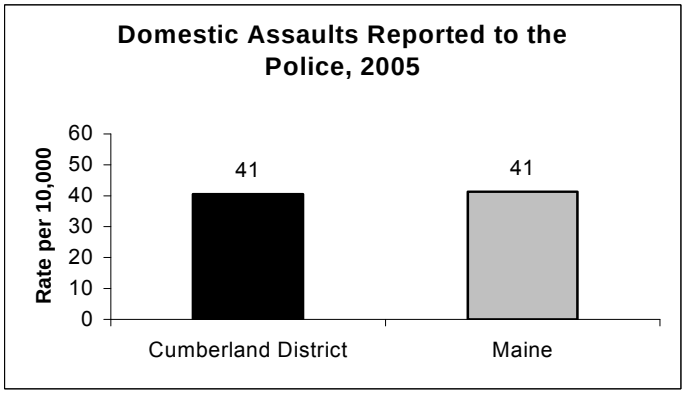
Interpersonal Violence

Physical and sexual assault pose a serious threat to the public's health and safety, affecting not only individuals but families, employers and neighborhoods. While men experience more physical assaults overall, women are disproportionately victims and survivors of sexual assault and interpersonal violence. This can have long-term implications on health and well-being. Those who have been raped or experience domestic violence may have increased risk for further injury, chronic illness, and poor mental health, and often have trouble in accessing and experiencing medical care. Addressing violence across the lifespan is critical to improve health in Maine.

DHHS' Office of Child and Family Services at www.maine.gov/dhhs/bcfs/ and the Safe Families Partnership Initiative coordinated by the Division of Family Health at the Maine CDC at www.maine.gov/dhhs/bcfs are two key programs that are part of the State's efforts to apply a public health approach to prevent interpersonal violence.



Source: Maine Sheriff's Association; Department of Public Safety: County Crime Analysis 2001-2005



Source: Maine Sheriff's Association; Department of Public Safety: County Crime Analysis 2005

	Cumberland District Number	Cumberland District Rate (± Margin of Error)	Maine State Rate (± Margin of Error)
Reported Rapes[1]	85 (avg. per yr)	3.4 (±0.3) (per 10,000 female population)	2.8 (±0.1) (per 10,000 female population)
Domestic Assaults Reported to the Police[2]	1,115	40.6 (±2.4) (per 10,000)	41.3 (±1.1) (per 10,000)

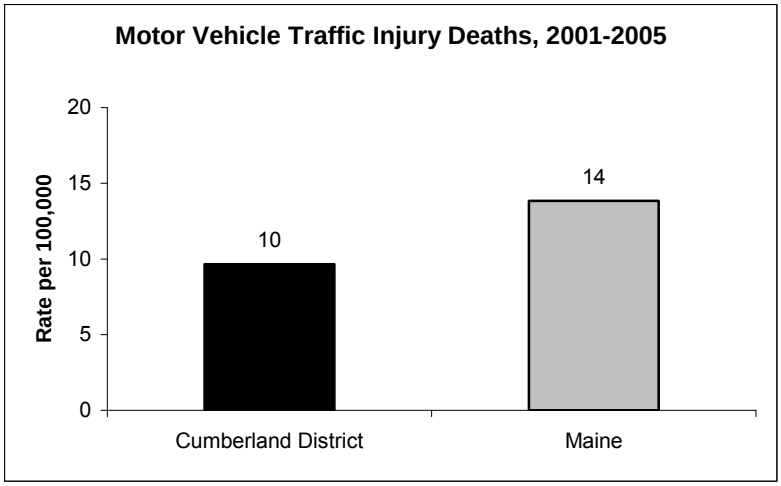
1. Source: Department of Public Safety: County Crime Analysis 2001-2005
2. Source: Department of Public Safety: County Crime Analysis 2005

Unintentional Injury

Unintentional injuries were the leading cause of death among 1-44 year olds in Maine in 2000-2004, and the 6th leading cause of death among all ages combined. Motor vehicle crashes are the most common cause of unintentional injury deaths in the state.

Unintentional falls were the leading cause of injury hospitalization among Mainers aged 65 and older in 2001-2005. Hip fractures in this age group are usually caused by falls and can result in reduced quality of life or premature death. Hip fracture hospitalizations are a key measure of the problem, and falls can be reduced or prevented.

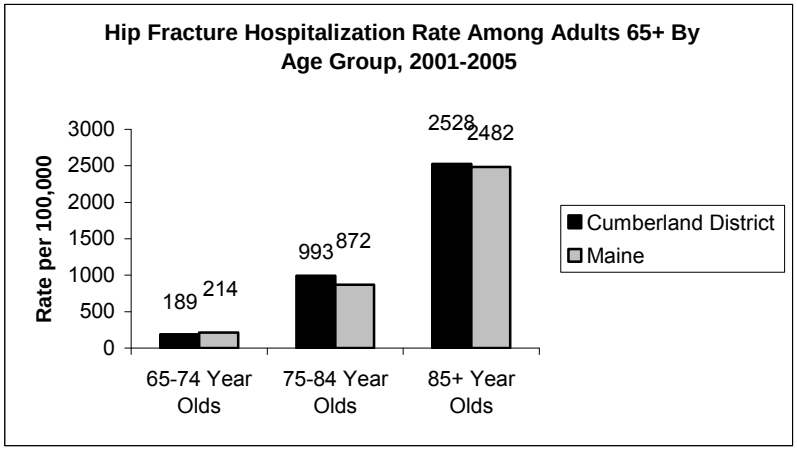
The Maine CDC's Injury Prevention Program tracks and analyzes injury data and has recently revised the Maine Injury Prevention Plan. Contact the program at www.maine.gov/dhhs/bohdcfh/inj/ .



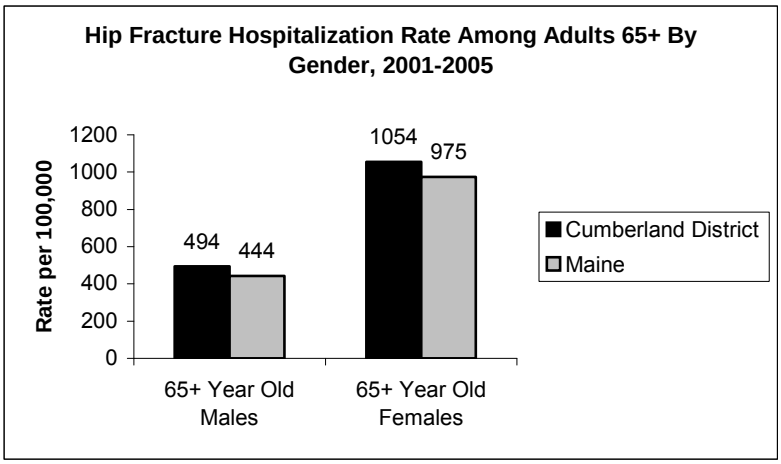
Source: 2001-2005 Maine Office of Data, Research and Vital Statistics; Age-adjusted to 2000 U.S. Standard Population

	Cumberland District Number	Cumberland District Rate (± Margin of Error)	Maine State Rate (± Margin of Error)
Deaths for Unintentional Injuries Due to Motor Vehicle Traffic Crashes	27 (avg. per year)	9.7 (± 1.6) (per 100,000)	13.8 (±0.9) (per 100,000)

Source: 2001-2005 Maine Office of Data, Research and Vital Statistics; Age-adjusted to 2000 U.S. Standard Population
ICD-10 Codes:V30-V39 (.4-.9), V40-V49 (.4-.9), V50-V59 (.4-.9), V60-V69 (.4-.9), V70-V79 (.4-.9), V81.1 V82.1, V83-V86 (.0-.3), V20-V28 (.3-.9), V29 (.4-.9), V12-V14 (.3-.9) , V19 (.4-.6), V02-V04 (.1, .9) V09.2, V80 (.3-.5), V87(.0-.8), V89.2



Source: 2001-2005 Maine Hospital Discharge Datasets



Source: 2001-2005 Maine Hospital Discharge Datasets

	Cumberland District Number	Cumberland District Rate (± Margin of Error) Rate per 100,000	Maine State Rate (± Margin of Error) Rate per 100,000
Hip Fracture Hospitalizations Among 65+ Year Olds – Overall	1497	827.7 (±41.9)	751.3 (± 17.5)
65-74 Year Olds	166	188.9 (± 28.7)	214.1 (± 13.1)
75-84 Year Olds	660	993.2 (±75.8)	872.2 (± 31.8)
85+ Year Olds	671	2528.4 (±191.3)	2482.3 (± 86.9)
Males	361	493.7 (±50.9)	443.5 (± 20.8)
Females	1136	1054.4 (±61.3)	974.6 (± 26.2)

Source: 2001-2005 Maine Hospital Discharge Datasets;
Definition: Discharges from Maine acute care hospitals for which the principal diagnosis is an injury (ICD-9 code 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, or 995.80-995.85) and the principal or secondary diagnosis is a hip fracture (ICD-9 code 820.x).

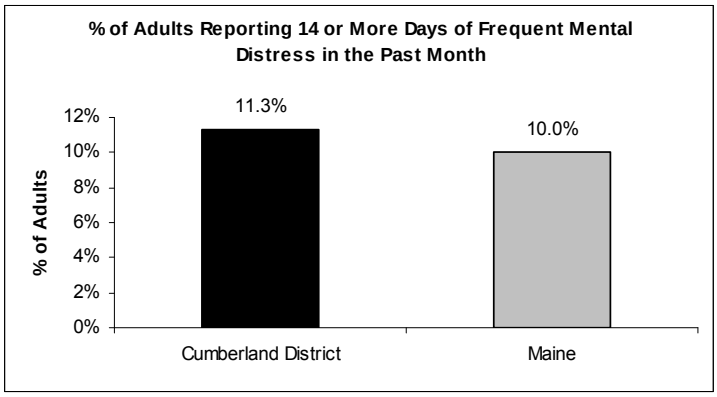
CUMBERLAND DISTRICT: Mental Health

Depression and Suicide

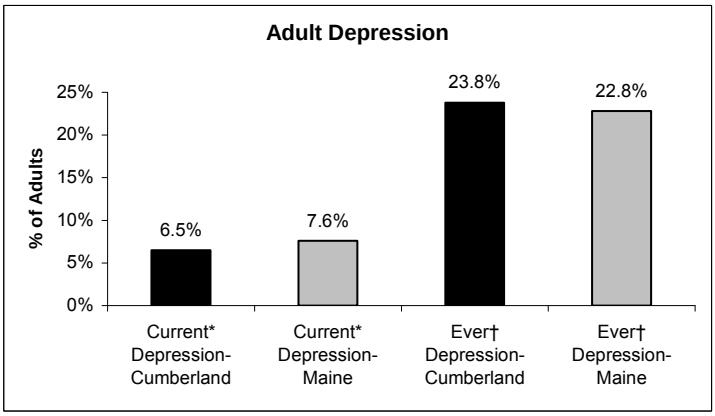
Mental disorders burden a large proportion of people from all age, race, and ethnic groups. Major depression is the leading cause of disability among adults in the United States and is diagnosed in women twice as often as men. However, proper intervention and treatment can be highly effective.

Recent Maine data has demonstrated an inter-relationship between mental illness, health risk, chronic disease and poor self care. Prevention, early screening and diagnosis, and access to care is essential for those who suffer from mental illness to maintain healthy and productive lives.

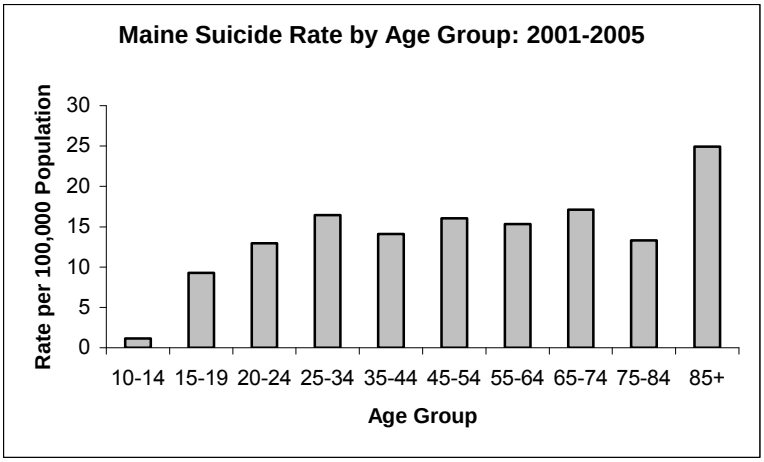
Data on mental health are collected through public health surveillance systems, hospital records, and vital records. For more information on adult mental health in Maine, contact the Office of Adult Mental Health Services at: www.maine.gov/dhhs/mh/. For information on suicide prevention in Maine youth, see www.maine.gov/suicide/ and/or contact Maine CDC's Injury Prevention Program at www.mainepublichealth.gov



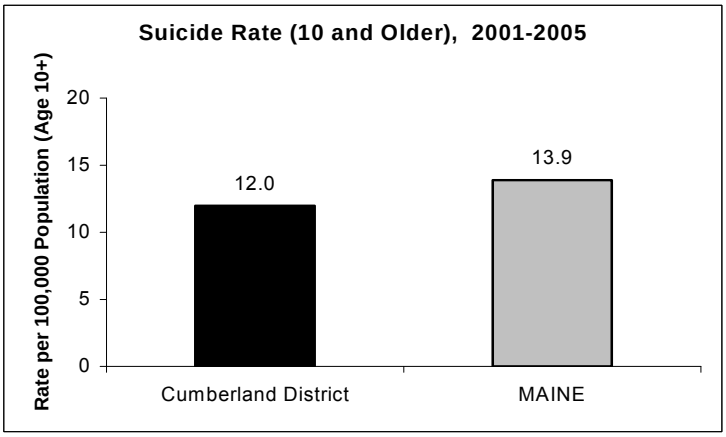
Source:2006 BRFSS



*Source: 2004-2006 BRFSS; Based on responses on PHQ-8
†Source: 2006 BRFSS; Combined Depression: Ever diagnosed with depression or reporting current symptoms



Source: 2001-2005 Maine Vital Records



Source: 2001-2005 Maine Vital Records

	Cumberland District Number	Cumberland District Percent or Rate (± Margin of Error)	Maine State Percent or Rate (± Margin of Error)
Adults Who Report Experiencing 14 or More Days of Frequent Mental Distress in the Past Month[1]		11.3% (± 3.2)	10.0% (± 1.2)
Adults Who Report Current Symptoms of Moderate or Severe Depression[2]		6.5% (±2.7)	7.6% (±1.0)
Adults Who Have Ever Had Depression[3]		23.8% (±4.1)	22.8% (±1.6)
Youth Who Report Symptoms of Depression in the Past Year; 2005[4]		*Not available*	20.6% (± 3.2)
Suicide Deaths; Age 10 and Older[5]	29 (avg per yr)	12.0 (± 2.0) (per 100,000)	13.9 (± 1.0) (per 100,000)

1. Source: BRFSS 2006. "Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days in the past 30 days was your mental health not good?"
2. Source: 2004-2006 BRFSS: based on responses on PHQ-8
3. Source: 2006 BRFSS: Combined: Ever diagnosed with depression or reporting current symptoms
4. Source: 2005 Youth Risk Behavior Survey: Youth who reported feeling "so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months." YRBS data are not available at the district level
5. Source: 2001-2005 Maine Vital Record

CUMBERLAND DISTRICT: Substance Abuse

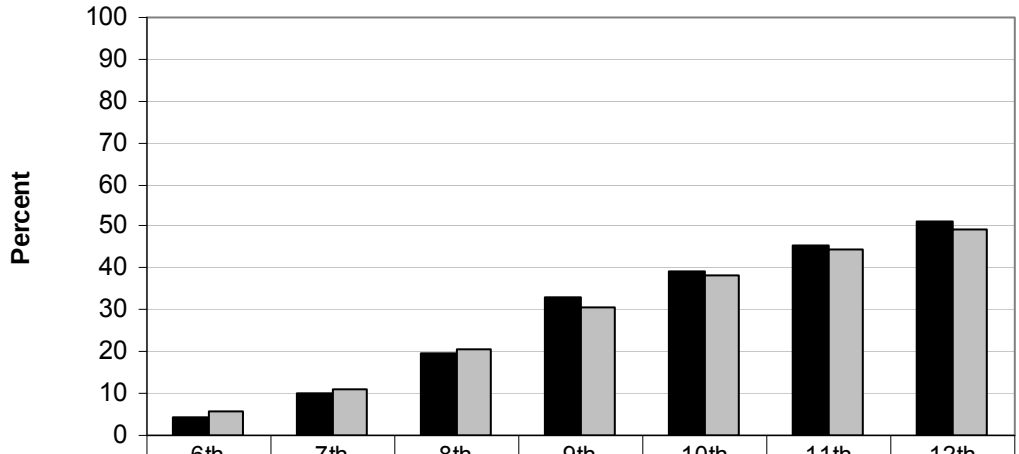
Underage Alcohol Use

Recent studies show that underage alcohol consumption has the potential to trigger long-term biological changes that may have detrimental effects on the developing adolescent brain. Und erage alcohol use is Maine's most prevalent substance abuse problem.

Decreasing alcohol use among Maine youth is an objective of the Maine Office of Substance Abuse [OSA] as identified in the Maine Substance Abuse Prevention Strategic Prevention Framework Plan 2006 – 2010. Such use is targeted through collaboration with state and local agencies using environmental evidence based strategies.

To find out more about substance abuse prevention activities in Maine: www.maine.gov/dhhs/osa/prevention/index.htm.

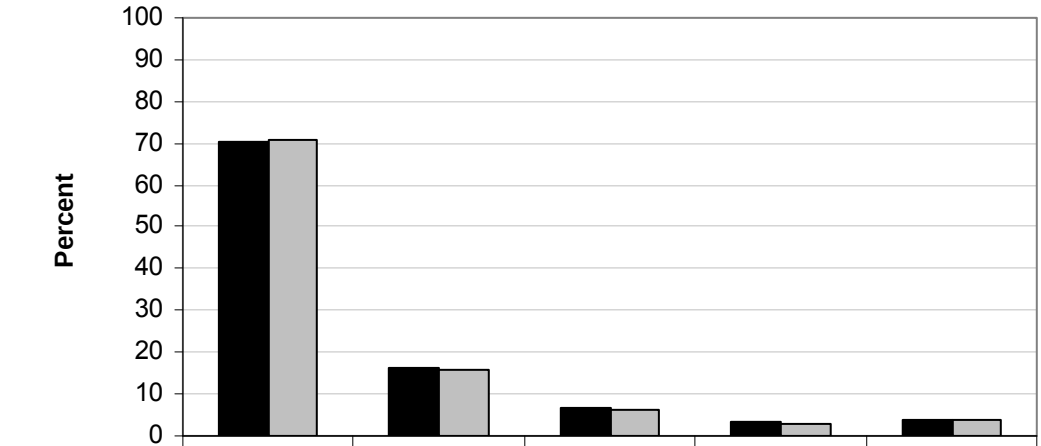
Previous 30-day alcohol use, by grade: Cumberland District and Maine, 2006



	6th	7th	8th	9th	10th	11th	12th
Cumberland	4.5	9.9	19.8	33.2	39.2	45.6	51.2
Maine	5.9	11.2	20.5	30.8	38.2	44.6	49.1

Source: Maine Youth Drug and Alcohol Use Survey/Youth Tobacco Survey, 2006

Previous 30-day use of alcohol among 6th through 12th graders: Cumberland District and Maine, 2006



	No Use	1-2 times	3-5 times	6-9 times	10 or more
Cumberland	70.3	16.3	6.7	3.1	3.6
Maine	71.0	16.0	6.4	2.8	3.7

Source: Maine Youth Drug and Alcohol Use Survey/Youth Tobacco Survey, 2006

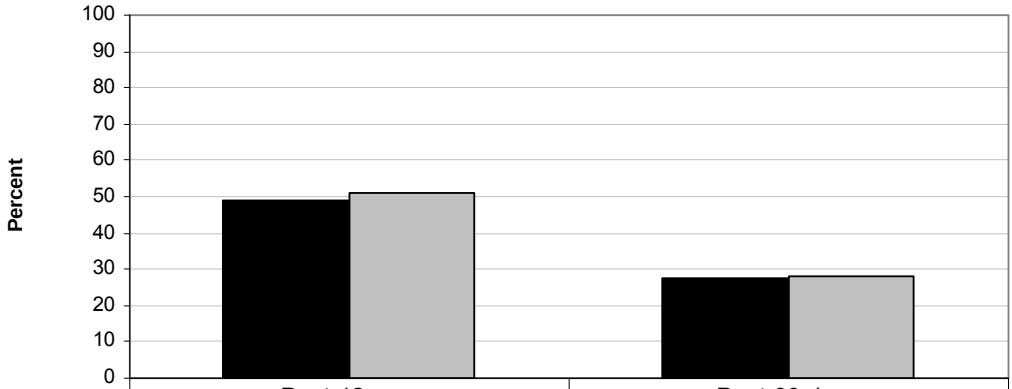
High Risk or Binge Drinking

The range of consequences for high risk drinking ranges from health to criminal and economic concerns. Young adults (age 18-25) have the greatest prevalence of high risk drinking compared to other age groups. Approximately five percent of middle-school students reported binge-drinking.

Decreasing high risk or binge drinking among Maine youth and young adults is an objective of OSA as identified in the Maine Substance Abuse Prevention Strategic Prevention Framework Plan 2006 – 2010. Such use is targeted through collaboration with state and local agencies using environmental evidence based strategies.

To find out more about substance abuse prevention activities in Maine: www.maine.gov/dhhs/osa/prevention/index.html.

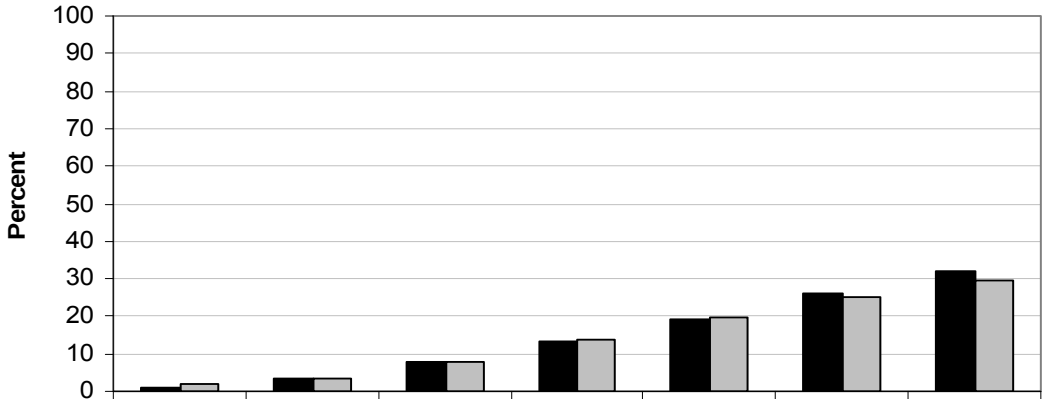
Adults age 18 and older who have particpated in binge drinking*: Cumberland District and Maine, 2004



	Past 12 mos	Past 30 days
■ Cumberland	48.8	27.3
□ Maine	50.8	27.8

*Binge drinking is defined as 5 or more alcoholic beverages for men in one occasion and 4 or more alcoholic beverages for women in one occasion.
Source: Maine General Population Survey, 2004.

Percentage of students who participated in binge drinking* within the last 2 weeks, by grade: Cumberland District and Maine, 2006



	6th	7th	8th	9th	10th	11th	12th
Cumberland	1.1	3.6	7.7	13.5	19.3	26.1	31.9
Maine	1.8	3.5	7.7	13.7	19.7	25.2	29.4

*Binge drinking is defined as 5 or more alcoholic beverages in one occasion.
Source: Maine Youth Drug and Alcohol Youth Survey/Youth Tobacco Survey, 2006

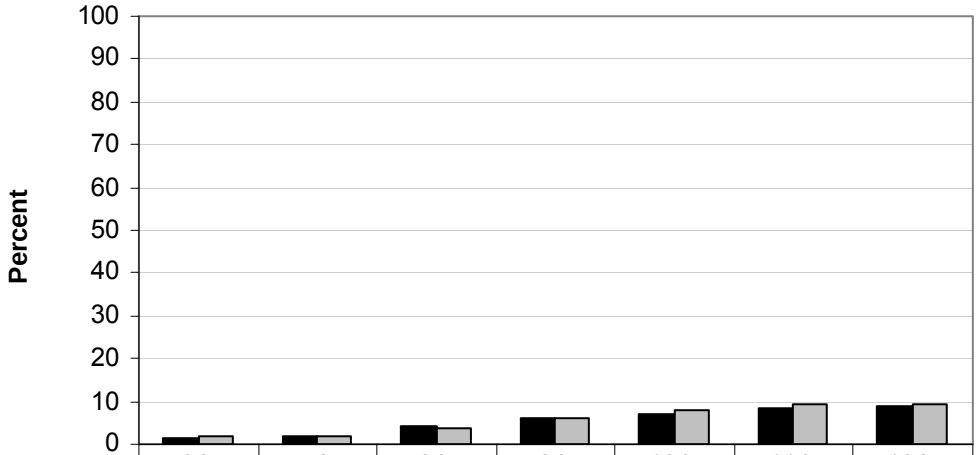
Prescription Drug Misuse

Maine data for middle and high school students indicate that prescription drug abuse is also a high priority.

Decreasing prescription drug misuse among Maine youth and young adults is an objective of the Maine Office of Substance Abuse identified in the Maine Substance Abuse Prevention Strategic Prevention Framework Plan 2006 – 2010. It is targeted through collaboration with state and local agencies using environmental evidence based strategies.

To find out more about substance abuse prevention activities in Maine contact OSA at www.maine.gov/dhhs/osa/prevention/index.htm

Previous 30-day prescription drug misuse, by grade: Cumberland District and Maine, 2006



	6th	7th	8th	9th	10th	11th	12th
Cumberland	1.6	1.8	4.1	6.2	7.1	8.6	9.1
Maine	1.8	2.0	3.8	6.2	8.1	9.5	9.4

Source: Maine Youth Drug and Alcohol Use Survey/Youth Tobacco Survey, 2006

Substance Use Consequences

Information below is compiled from admission and discharge data collected from public agencies receiving funds from the Office of Substance Abuse. It represents clients who enter treatment as a result of an OUI, and/or are Medicaid eligible, and/or are in methadone programs.

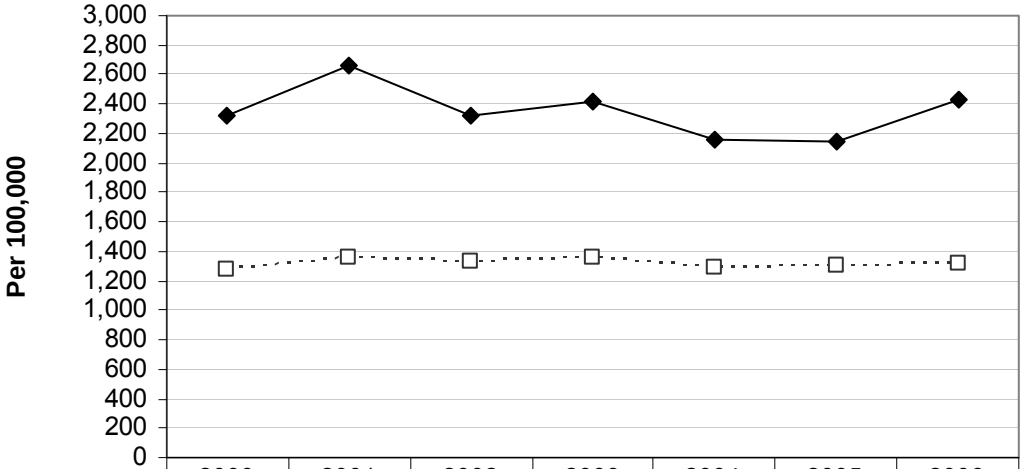
Admissions for treatment remained relatively consistent over the past three years, yet Maine has been identified by the National Survey on Drug Use and Health as having one of the highest unmet drug treatment needs for adolescents in the county.

This data is used to monitor and track trends in substance use for new or changing trends and used for needs assessment planning and workforce development. The Office of Substance Abuse is working across systems to provide a comprehensive, integrated approach to treatment services. To find out more about the Treatment Data System: www.maine.gov/dhhs/osa/data/tds/index.htm

Substance abuse* treatment admissions (all ages)

*Substance abuse treatment includes all admissions for those whose lives are directly impacted by the use and abuse of alcohol and other drugs.

Substance abuse admissions (all ages) per 100,000: Cumberland District and Maine, 2000-2006



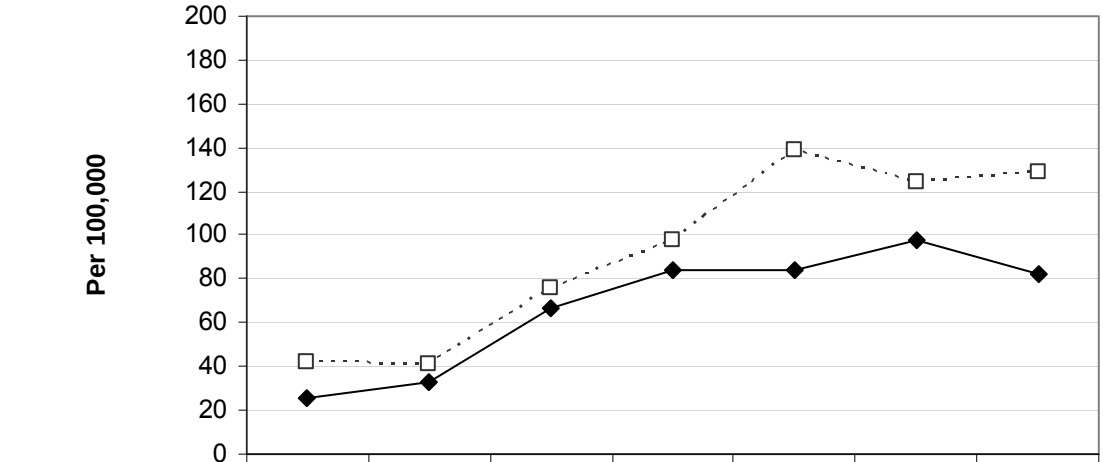
	2000	2001	2002	2003	2004	2005	2006
Cumberland	2316	2655	2320	2413	2153	2143	2426
Maine	1270	1353	1327	1359	1286	1297	1320

Source: Treatment Data System (TDS), 2000-2006 and U.S. Census Bureau.

Evaluation only admissions (all ages) per 100,000*

*Evaluation only clients are those who are referred to substance abuse services for the purpose of determining their need for treatment. Referrals originate from, but are not exclusive to, the Driver Education and Evaluation Program (DEEP), child welfare services, and probation.

Evaluation only admissions (all ages) per 100,000: Cumberland District and Maine, 2000-2006



	2000	2001	2002	2003	2004	2005	2006
Cumberland	26	33	67	84	84	98	82
Maine	42	41	76	98	138	124	129

Source: Treatment Data System (TDS), 2000-2006 and U.S. Census Bureau.

CUMBERLAND DISTRICT: Quality of Life

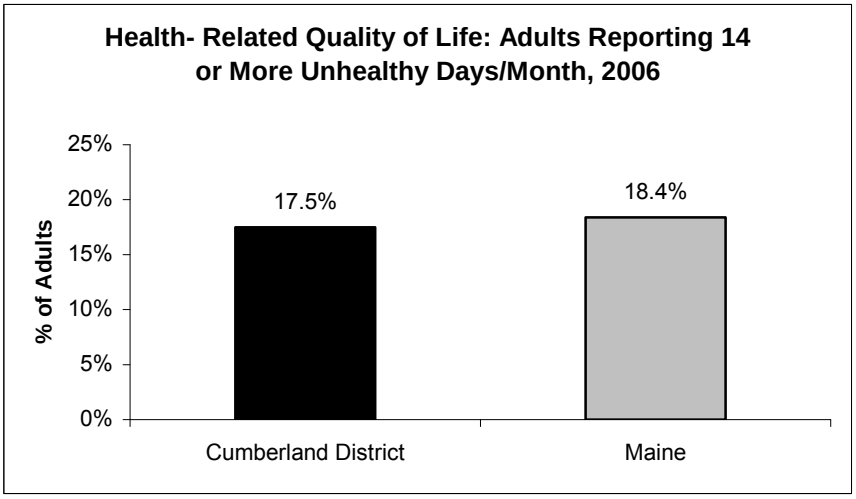
Healthy Days

The concept of health-related quality of life refers to a person or group's perceived physical and mental health. Survey data in BRFSS include a set of questions related to health-related quality of life entitled "Healthy Days", which ask a core set of questions related to how individuals have reported feeling in terms of their physical and mental health over the last 30 days. This provides an over-time measure of perceptions of well-being. Evidence suggests this can be used not only a measure of individual health but as a proxy for measuring community level health.

Healthy Days measures have been found useful for (1) identifying health disparities in different populations and subgroups and (2) tracking population trends. They can also be used to build broad coalitions around a measure of population health compatible with the World Health Organization's 1948 definition of health: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity".

At the state and local level, Healthy Days data can be used for tracking overall progress on achieving the two major goals of *Healthy People 2010*: (1) Increase quality and years of healthy life and (2) eliminate health disparities. Below, one indicator selected from this set of questions, "Unhealthy Days" reflects an estimate of the overall number of days during the previous 30 days when the survey respondent felt that either his or her physical or mental health was not good.

For more information on Healthy Days, contact the BRFSS Program, the Community Health Promotion Program or Maine CDC's epidemiology services at www.mainepublichealth.gov and see the US CDC's webpage at www.cdc.gov/hrqol/findings.htm.



Source: 2006 BRFSS; Adults reporting poor physical and/or mental health on 14 or more days/month

	Cumberland District Percent (± Margin of Error)	Maine State Percent (± Margin of Error)
Adults Who Report ≥ 14 Unhealthy Days per Month	17.5 (±3.9)	18.4 (±1.4)

Source: 2006 BRFSS; Adults reporting poor physical and/or mental health on 14 or more days/month

CUMBERLAND DISTRICT: Access to Care

Health Care Provider Shortage Areas & federally supported Health Care Centers

One of the public health system's two main goals is to reduce identified disparities in population health status between different groups. In Maine, this includes improving access to care for vulnerable populations, among them people with low socio-economic status, the very young and very old, and those who best served by trained culturally competent health care providers.

Maine residents can learn if their community falls within a federal designation indicating access to care is a problem locally. The Maine CDC's Office of Primary Care and Rural Health tracks where in the state communities are underserved. It offers technical assistance to communities for applying for federally sponsored health care providers to serve locally, or to receive funding to establish community health centers to serve people with low incomes who otherwise would go without care altogether and/or use costly emergency departments as their "medical home".

Native American people qualifying as Tribal members may access limited health care services provided by Tribal Health Centers (a separate federal health care delivery system flat funded by the U.S. Indian Health Service [IHS]). However, about half to two thirds of Native Americans in Maine live off reservation, with many living outside the service area for IHS centers.

Transportation, literacy and health literacy levels, lack of trained culturally competent providers are just a few of the numerous barriers to full access to care for all Maine people.

District	Health Professional Shortage Areas	Community Health Centers	Tribal Health Departments
York	1	1	-
Cumberland	**1**	**1**	**-**
Western	10	10	-
Midcoast	5	4	-
Central Maine	13	10	-
Penquis	12	9	1
Downeast	14	9	2
Aroostook	13	5	2

Health Professional Shortage Areas (HPSA) are areas in which the State has identify a shortage of providers of (1) primary care, (2) dental care or (3) mental health providers, using federal criteria for defining a shortage. These HPSAs do *not* include the eleven additional HPSAs that cover multiple districts.

Community Health Centers are federally funded centers that provide access to care. Satellite sites serve additional locations, and CHCs are a core strategy to reduce barriers to access to care.

Tribal Health Departments are dedicated to the needs of members of Tribal Nations. There are five Tribal health centers in Maine that receive some funding from IHS.

Access to Primary Care Physicians

Maine is a rural state with a widely scattered population. Primary dental, and mental health care services in rural and certain urban areas are limited by a lack of providers, health care facilities and by a lack of services which complement and supplement health care services. Geographic, financial, transportation and other barriers prevent access to health care services.

Medical care providers are more difficult to recruit and retain in rural areas. Small populations limit their practices. They may be long distances from hospitals where they can treat patients and consult with colleagues. They may find it difficult to keep up with changing knowledge and to know about changes in resources for patients.

The Maine CDC's Office of Rural Health and Primary Care gathers and analyzes data to assess both resources and makes recommendations for filling gaps and increasing access to primary care, mental health and dental health care services for underserved areas. It provides technical assistance to communities, health care providers and health care facilities. It also supports communication links among stakeholders in rural health issues. For more information contact the ORHPC at www.maine.gov/dhhs/boh/orhpc.

ACTIVE PHYSICIANS* IN MAINE WHO SPECIFIED PRIMARY CARE AS A FIRST SPECIALTY

Selected Statistics by District of Employment: December 31, 2004

District	2003 Population	Total PC Physicians	Avg Pt Care Hrs per week	Pop to Physician Ratio
York	198,026	156	41.3	1,269:1
Cumberland	**270,923**	**357**	**39.9**	**759:1**
Midcoast	149,838	126	41.9	1,189:1
Western	192,029	176	39.5	1,091:1
Central	170,837	176	41.3	971:1
Penquis	164,376	175	44.1	939:1
Aroostook	73,428	71	47.7	1,034:1
Downeast	86,271	98	42.2	880:1
State Total	**1,305,728**	**1,335**	**42.2**	**978:1**

*Licensed, active professionals working in Maine who responded to the survey.
Sources: Maine Cooperative Health Manpower Resource Inventory, ODRVS, ORHPC, and US Census Bureau.
Maine CDC/DHHS, Office of Data, Research and Vital Statistics [ODRVS] and Office of Rural Health and Primary Care [ORHPC].
Prepared by ORHPC, October 2007.
Notes: The calculation of average patient care hours per week excludes 83 physicians with unknown patient care hours.
Some physicians report more than one specialty. Average patient care hours per week in this table represents the average of all patient care hours reported by physicians with primary care as a first specialty. Some of these hours may represent time spent in another specialty area.

State Public Health Nursing Services

Public Health Nurses [PHNs], registered professional nurses, are employed directly by the Maine CDC and deliver public health nursing services, expertise and leadership to individuals, families, and organizations across Maine. The State's Public Health Nursing Program assures public health nursing services are available for Maine people – critical in a state where only a few local governments employ public health nurses. Through State agreements with regional agencies, Maternal and Child Health (MCH) nursing services are contracted to provide additional MCH nursing capacity.

PHNs help assess and assure the State's delivery of Essential Public Health Service #7: "assess people's access to quality, affordable and accessible personal health services and assure the provision of health care when otherwise unavailable." Public health nurses identify local needs and availability of resources through a community nursing assessment and diagnosis process.

A few examples of State funded PHN services include outreach and case management, immunization clinics, participation in all-hazard preparedness planning and disaster response, technical assistance to comprehensive community health coalitions, and disease outbreak response. PHNs provide consultation when municipal officials or health care providers aren't sure what resources exist for a local health need or problem. Public health nurses provide broad and flexible services, filling gaps in those areas of the state lacking sufficient public health infrastructure.

Maine CDC PHNs serve in districts as well as out of a central office in Augusta. PHNs are or will be co-located in DHHS District Public Health Units along with other regionally based State public health staff in future. More information on the Public Health Nursing Program can be found at www.mainepublichealth.gov.

State Public Health Nursing Services in Cumberland District

Office Location	Co-located In DHHS District PH Unit	Maine CDC PHN staff positions	Maine CDC PHN Visits for Individual Services 2006	Maine CDC PHN Visits: Population-Based Services 2006	District's Maine CDC's contracted MCH nursing services	State Contracted Agency District MCH visits 2006
Portland	Co-located w/municipal staff PHNs	6	3570	259	City of Portland	1395
Cumberland District excluding City of Portland					Home Health Visiting Nurses of Southern Maine, Inc.	2275
TOTAL		6	3570	259		3670

CUMBERLAND DISTRICT: Public Health Preparedness

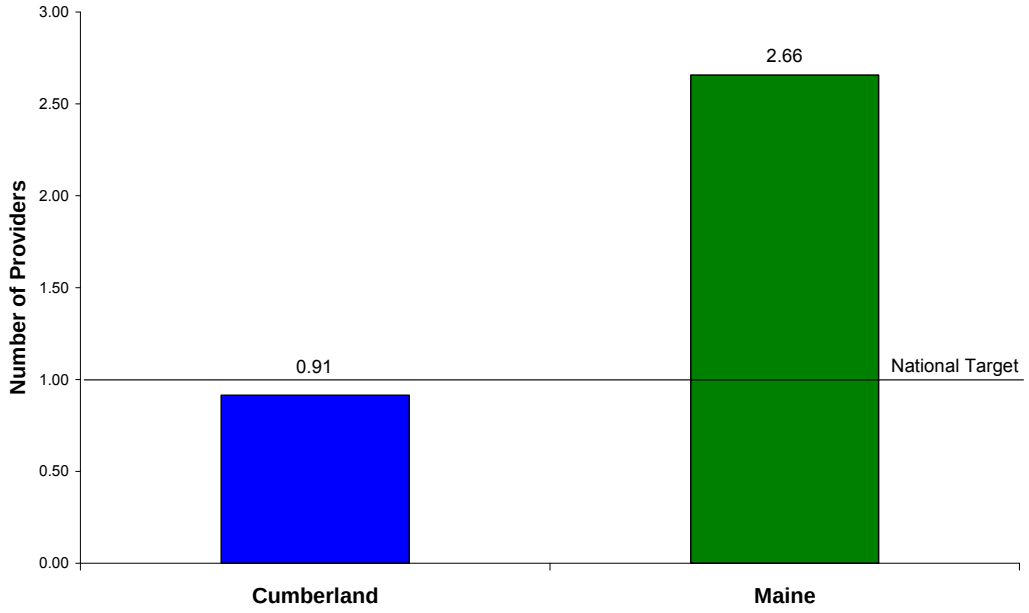
Sentinel Provider Influenza Surveillance Program

The Maine Center for Disease Control and Prevention and a group of primary care providers statewide participate in the federal CDC's Sentinel Provider Influenza Surveillance Program. That program was implemented to meet several objectives. Influenza viruses are constantly evolving and cause substantial morbidity and mortality ever winter. Data from sentinel providers are critical for monitoring the impact of influenza. In combination with other influenza surveillance data, this information can be used to guide prevention and control activities, vaccine strain selection, patient care, and detection of new pathogenic organisms, such as the A:H5N1 avian strain. Sentinel providers receive feedback on the data submitted, summaries of regional and national influenza data, and a free subscription to CDC's *Morbidity and Mortality Weekly Report* and *Emerging Infectious Diseases Journal*. The most important consideration is that the date providers are critical for protecting the public's health.

Sentinel providers report the total number of patient visits each week and number of patient visits for influenza-like illness by age group (0-4 years, 5-24 years, 25-64 years ≥65 years). These data are transmitted once a week via the internet or fax to a central data repository at the federal CDC. In addition, sentinel providers can submit specimens from a subset of patients to the State Health and Environmental Testing Laboratory for virus isolation free of charge.

The federal CDC has a target of 1 sentinel provider for every 250,000 population. In addition, Maine has a target of 1 sentinel provider per county and 1 for each Metropolitan Standard Statistical Area (MSMA).

Number of Sentinel Influenza Providers, per 250,000 Population



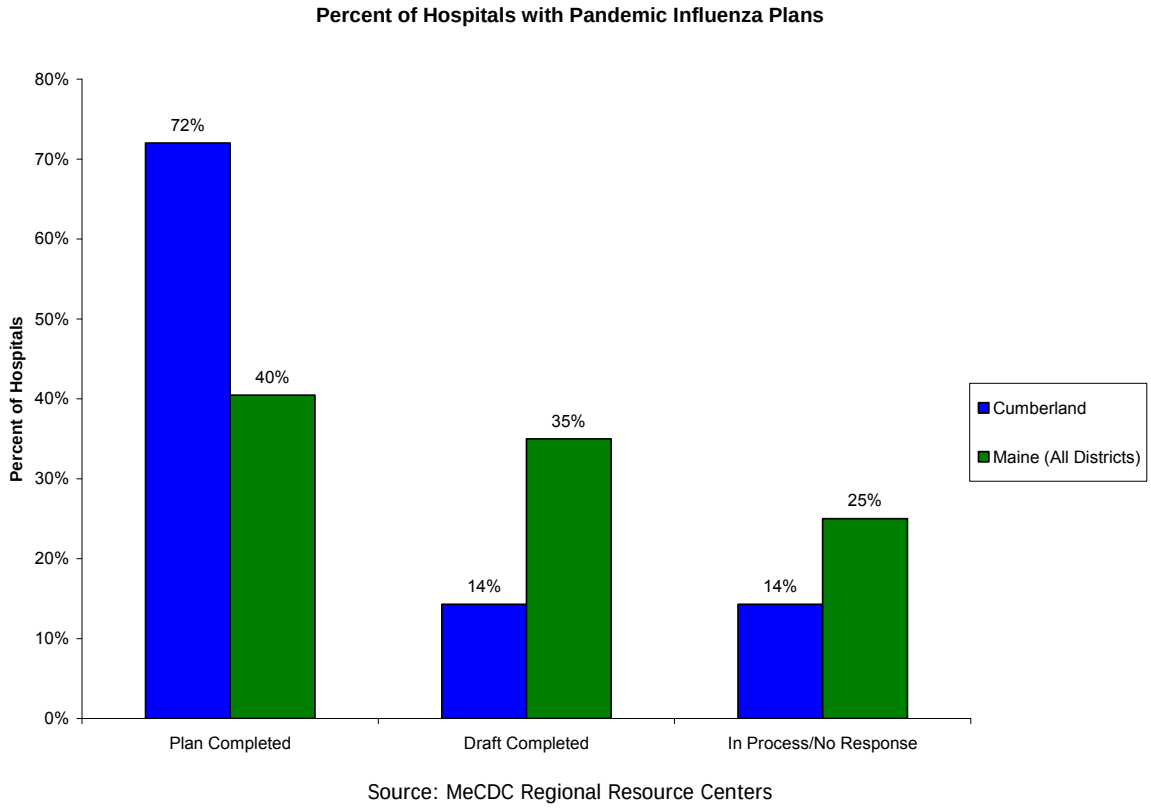
Source: Infectious Disease Epidemiology Program

Number of Maine Hospitals with Pandemic Influenza Response Plans

The Maine Center for Disease Control and Prevention (Maine CDC) has established a Pandemic Influenza preparedness planning process for Maine in coordination with key partners at the federal, state, and local level. The focus is on practical, statewide and community-based procedures that could prevent or delay the spread of pandemic influenza, and help to reduce the burden of illness communities would contend with during an outbreak.

The Maine CDC Regional Resource Centers, representing Maine hospitals have facilitated the development of Pandemic Influenza response plans for all hospitals. A critical component of Pandemic Influenza response in Maine is assuring hospitals have effective Pandemic Influenza plans which are integrated with county level and State plans and define their ability to manage such a crisis.

There are a variety of indicators with which to assess Maine's capacity to respond to an influenza pandemic including the number of hospitals who have completed plans. This measurement defines the percent of hospitals within any district that have completed part of a pandemic planning process.



Source: MeCDC Regional Resource Centers

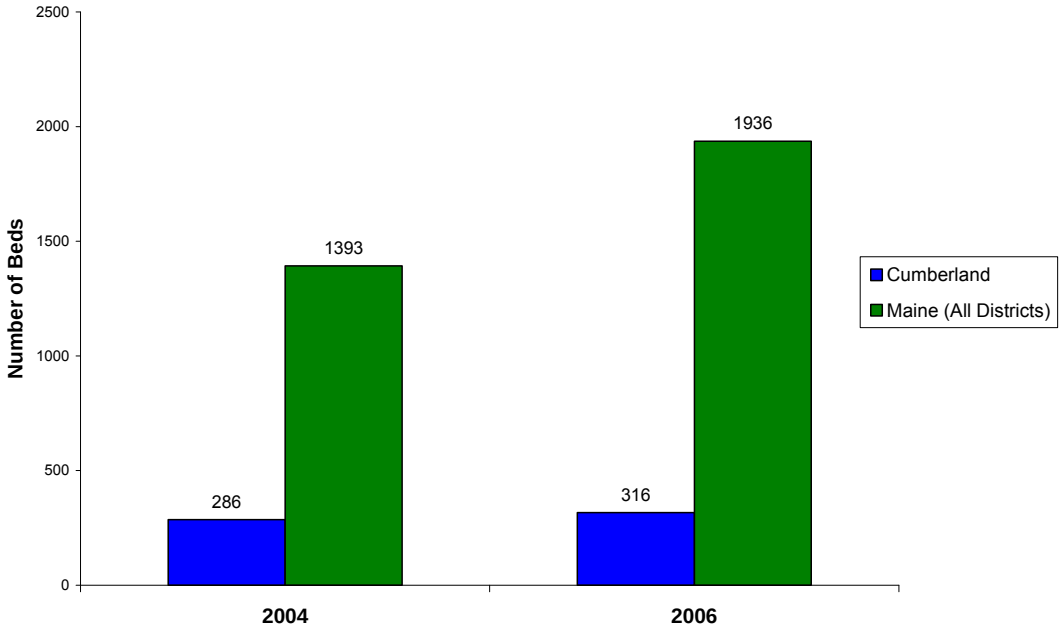
Source: Regional Resource Centers

Healthcare System Surge Capacity: Average Number of Emergency Department Beds

The term surge capacity may be generally defined as the relative ability of any organization or entity to continue to provide services when challenged by demands for those services that are significantly beyond ongoing capacity. Surge demands are often immediate in nature and may offer little warning. Integration of public and private medical capabilities with public health and other first responder systems is required to assure that Maine's healthcare and public health systems are capable of responding well to events that demand surge capacity in response to extreme public health emergencies, or high-impact events, such as a hurricane, severe ice storm or widespread biological or chemical attack.

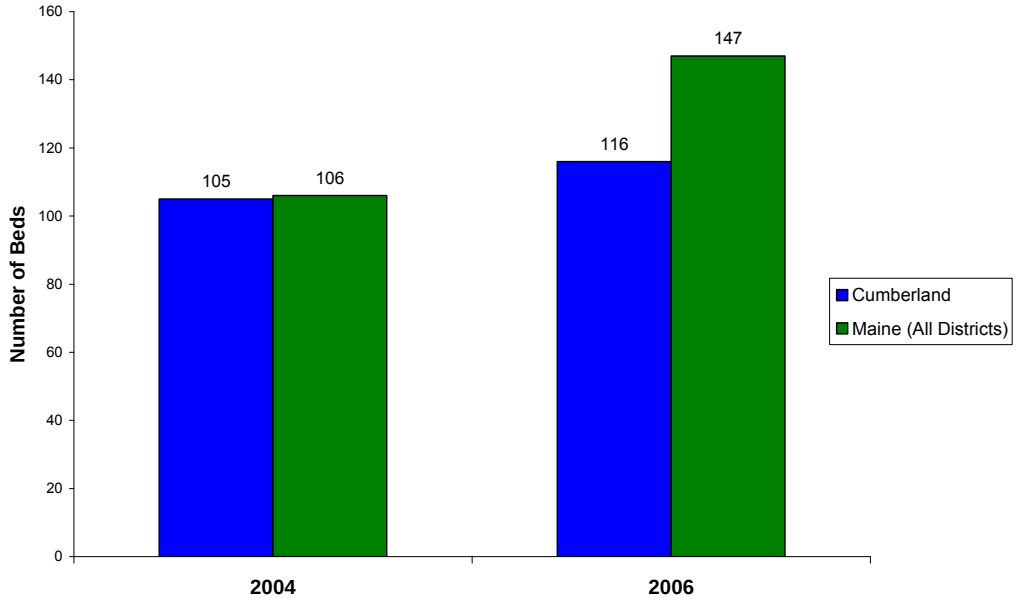
The Maine CDC, Office of Public Health Emergency Preparedness works with partners statewide to develop operational healthcare system surge plans for the medical response to public health emergencies. Assessment of medical surge capacity in the State provides evidence of its current status and recent contributions to its improvement. There are a variety of indicators with which to assess surge capacity including the number of available hospital emergency department beds. This measurement defines the average number of emergency department beds available on any day, for a specific district and for the state.

Average Daily Number of Available Emergency Department Beds



Source: 2004/2006 MeCDC Hospital Assessment Report

Average Daily Number of Available Emergency Department Beds, per 100,000 Population



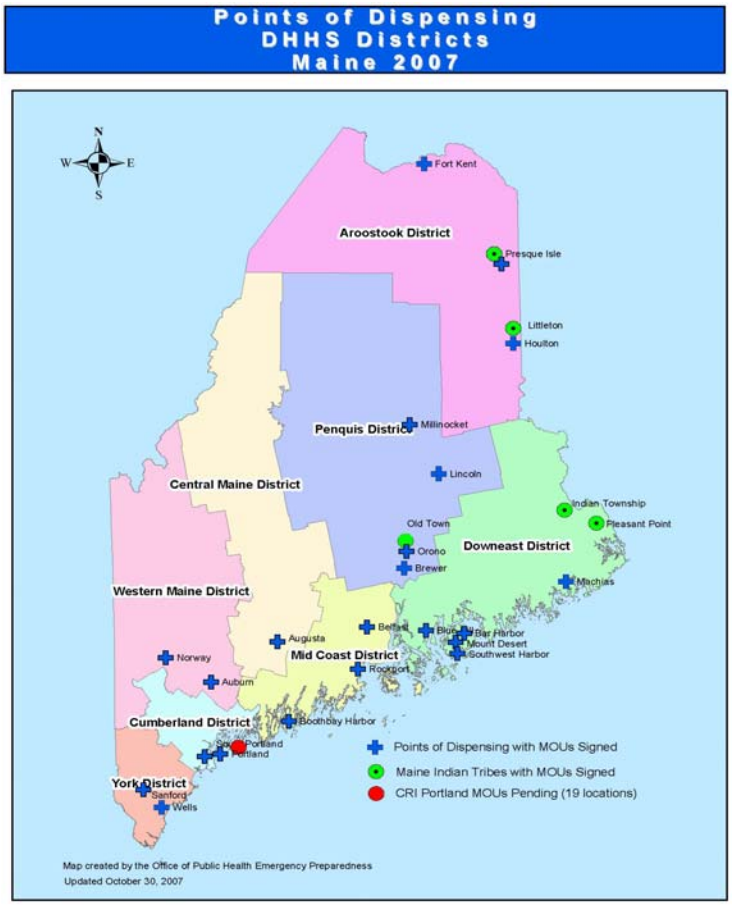
Source: 2004/2006 MeCDC Hospital Assessment Report

The Strategic National Stockpile: Emergency Mass Medication Dispensing

The Strategic National Stockpile (SNS) is a national program that provides large quantities of medicine and medical supplies to protect the American public if there is a public health emergency (terrorist attack, flu outbreak, earthquake) severe enough to exhaust local supplies. Once Federal and local authorities agree that the SNS is needed, assets will be delivered to any state in the U.S. within 12 hours. Every state has plans to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible. Medications are provided at Points of Dispensing (POD); public dispensing centers that are located in pre-determined sites throughout the state. Maine CDC, community leaders and local emergency management have defined sites that will be announced to the public at the time they are opened.

The Cities Readiness Initiative (CRI) is a key SNS activity that focuses on mass-dispensing of emergency medications in each state's most populated cities. In Maine, CRI is centered in Portland and will expand to two other locations within the next year.

The Maine CDC, Office of Public Health Emergency Preparedness manages the SNS program for Maine.



Technical Notes/Glossary

Age-Adjusted Rate – Age-adjustment is a method used to better ensure comparability of estimates (e.g., rates) with respect to age. The age distribution of a population may change over time and differ from place to place. Because some health conditions or diseases are more common in certain age groups of people, it can be misleading to compare rate or prevalence estimates of populations if the age distributions of the populations compared are different. A rate is age-adjusted by applying age-specific rates in the population of interest to the U.S. 2000 Census standard population. Age-adjusted rates are relative, and should not be considered exact rates that necessarily represent the true underlying burden of disease in the population. Additional information on age-adjustment is available at: www.cdc.gov/nchs/data/statnt/statnt06rv.pdf or www.cdc.gov/nchs/data/statnt/statnt20.pdf.

Body Mass Index (BMI) – Body mass index (BMI) is a measure of body fat based on height and weight. The formula for BMI is weight in kilograms divided by height in meters squared. Healthy body mass index (BMI) for the adult population is defined as 18.5 – 24.9 kilogram/meter^2 (kg/m^2). Overweight is defined as BMI 25.0 – 29.9 kg/m^2. Obese is defined as BMI greater than or equal 30.0 kg/m^2. Underweight (not reported) includes those under a BMI of 18.5. Both weight and height measurements are self-reported.

Estimate—We believe that there are true underlying prevalences and disease rates. However, the best we can do is to obtain an estimate of this true underlying value. Every number reported is an estimate. We include margin of errors to remind us that we are engaged in an estimation process.

Incidence—The rate with which new cases of disease have developed, over a defined period of time, from within a previously disease-free population.

Infant mortality rate – The number of children in a population who die before their first birthday divided by the number of live births in that population during the same time period.

Margin of error (ME)—The margin of error is a measure of the degree of uncertainty in an estimate, such as prevalence or rate, often due to the estimate stemming from a sampled portion of the population. Consider this, a survey finds that 25 percent of adults in Maine have high blood pressure and the survey's margin of sampling error is plus or minus 1.6 percentage points. The estimate, 25 percent, is considered the most likely value, but we consider a range of plausible values between 23.4 and 26.6 percent (25-1.6 and 25+1.6). This range is sometimes referred to as the 95 percent confidence interval. In 95 out of 100 samples, we expect the 95 percent confidence interval to expect the true value. If the range of estimates based on the margin of error between the state and the district overlap, then it is unlikely that there is a statistically significant difference between the district and the state on that indicator.

Median—The median is the number in the middle of a listing of all values by magnitude. This differs from the mean (sometimes called the average), which is a sum of all values divided by the number of values. For example, if a sample of 5 individuals report that their daily fruit & vegetable consumption is 3, 5, 8, 9, and 10 servings, we calculate a median of 8 and a mean of 7.

Mortality – A fatal outcome, death.

Poverty—Poverty is defined by a cross-classification of family size (taking into account the number of individuals under age 18) by combined family income. Thresholds for poverty (2006) can be found at: www.census.gov/hhes/www/poverty/threshld/thresh06.html.

Percentage—A ratio where the value for the numerator is included in the total denominator. Prevalence is a percentage. The prevalence of diabetes is the number of people with diabetes divided by the entire population, with and without diabetes.

Prevalence – The percent of the population with a particular condition or characteristic. It is calculated as the number of people in a population who have a health condition divided by the total number of people in the population.

Rate—A measure of new events or occurrences in a population. The crude rate is calculated as the number of events per time period divided by the total number of people in the population in the same time period. The crude rate represents the actual burden of disease in the population.

Data Sources

American Community Survey (ACS) –The ACS is a mail survey that provides demographic, socio-economic, and housing information about communities in between the 10-year census. The ACS is conducted by the U.S. Census Bureau. The survey is sent to a sample of households in the United States. Households that receive the survey are required by law to complete it. Additional information about the ACS is available at: www.census.gov/acs/www/.

Behavioral Risk Factor Surveillance System (BRFSS) – The BRFSS is an annual, statewide telephone survey conducted it's conducted by the states, coordinated and even largely coordinated by the states, and supported by the federal Centers for Disease Control and Prevention (CDC) that was designed to collect uniform, state-specific data on preventive health behaviors and risk factors that are associated with the leading causes of morbidity and mortality (Link et al. 2006). Randomly selected, residential, non-institutionalized adults aged 18 and older are interviewed. Survey data for estimates are weighted to be a representative sample of the state adult population. One aspect of the weighting is the expected response rate by sex and age of the participant. For example, if 1 in 150 female residents between the ages of 18 and 24 were surveyed, then each female participant within this age group is weighted to represent 150 people. It should be noted that responses are voluntary and based on self-report. Documented errors exist in the ability of the BRFSS to accurately reflect certain population indicators. For example, the prevalence of overweight/obesity obtained from the BRFSS through self-report is an underestimate when compared to national data based on direct measurement of individuals by trained survey staff. Additional details regarding the design and analysis of the BRFSS data are available at www.cdc.gov/brfss.

Hospital discharge datasets—The hospital discharge datasets include all hospitalizations and emergency department visits in Maine facilities. Analyses for this report were restricted to Maine residents. The datasets are maintained by the Maine Health Data Organization (MHDO), legislatively-established in 1996 to collect and maintain "clinical and financial health care information and to exercise stewardship in making this information accessible to the public" (MHDO).

Maine Cancer Registry—Program within the Division of Chronic Disease, Maine CDC, charged with collecting data on cancer incidence and deaths within the state of Maine and among Maine residents.

Maine Department of Education - Maine's Department of Education (DOE) collects and disseminates information on its student population on an annual basis. For more information, please visit DOE's data center: www.maine.gov/education/datalist.htm

Maine Department of Public Safety – Provides criminal justice, law enforcement, fire safety, and emergency response services. For more information, go to www.maine.gov/dps/.

Maine General Population Drug and Alcohol Survey – 2004 – The Maine Office of Substance Abuse's (OSA) statewide quantitative research study on drug and alcohol use and abuse issues. Principles of this study were to: Evaluate the prevalence of alcohol and drug use and abuse among Maine residents aged 18 to 64; and Measure the impacts of the use and abuse of alcohol and drugs on workplace performance. For more information, go to: www.maine.gov/dhhs/osa/data/pubrpts.htm

Maine Youth Drug and Alcohol Use Survey/Maine Youth Tobacco Survey (MYDAUS/YTS)—The MYDAUS/YTS represents a collaborative effort between the Office of Substance Abuse (OSA) and the Partnership for a Tobacco-Free Maine (PTM), and provides comprehensive data on substance use among Maine's 6th-12th graders. Fully private schools are not included in the MYDAUS/YTS sampling frame. Further information on MYDAUS is available at http://www.maine.gov/dhhs/osa/data/mydaus/index.htm.

Maine Vital Records—A unit within Maine CDC charged with collecting data on births and deaths within the state and among Maine residents. Raw data from Vital Records are processed by the statistical service unit to produce analysis-ready datasets.

National Center for Health Statistics (NCHS)—Within the federal CDC, the NCHS provides national birth and death data through various print and online sources. These statistics are compiled from data submitted by individual states.

Pregnancy Risk Assessment Monitoring System (PRAMS) – Funded by the CDC, PRAMS is a state-wide representative survey of new mothers that is currently conducted in 37 states. It has been conducted on an ongoing basis in Maine since 1987. The survey collects data on maternal experiences and attitudes before, during, and shortly after pregnancy. The estimates derived from PRAMS are weighted to be representative of women who have recently delivered live-born infants in the state. For more information about the national PRAMS project, please visit: www.cdc.gov/prams/. For information about PRAMS in Maine, visit us at www.maine.gov/dhhs/bohodr/prams.htm.

Small Area Income & Poverty Estimates – A U.S. Census Bureau program that provides more recent income and poverty measures than are available through the 10-year census. Information is available at the state, county, and school district levels. For more information, visit www.census.gov/hhes/www/saipe/index.html.

U.S. Census Bureau – The Census Bureau provides data on the people and economy of the United States. Further information about the bureau's activities can be found at: www.census.gov/.

Youth Risk Behavior Survey (YRBS) –The YRBS is a biennial survey supported by the federal CDC, but conducted at the state level. The YRBS was designed to collect uniform data on health risk behaviors among youth. The sampling frame include publicly-funded Maine middle and high schools and the students attending those schools. Survey data for estimates are weighted to be a representative sample of the state youth population. Additional details about the YRBS, including design and analysis features, are available at www.cdc.gov/HealthyYouth/yrbs/.

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