York Public Health District

District Public Health Improvement Plan

2017 – 2019

York District Coordinating Council for Public Health

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

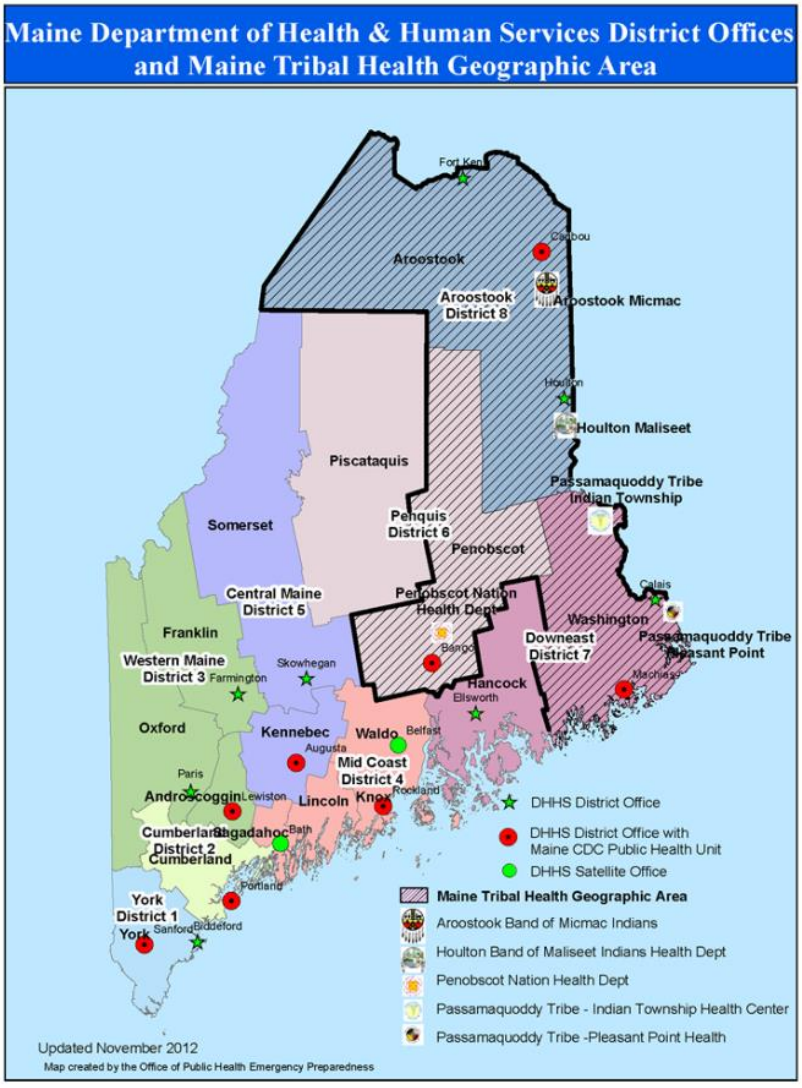
Vision

We envision a comprehensive, well-coordinated, accessible, and equitable public health system for all in York County.

Mission

Our mission is to promote, improve, sustain, and advocate for the delivery of the essential public health services in York County. We strive to: collaborate, communicate, and advance partnerships at all levels of the public health system; engage York District partners in public health planning, assessment, evaluation, and quality improvement.

Maine's Public Health Districts



York Public Health District

York Public Health District includes York County, the most south western county in Maine. The district covers 1,271 square miles, with a population of 201,169 (United States Census Bureau, estimated 2015). The district encompasses 29 cities and towns, with its largest municipalities being Biddeford, Saco, and Sanford. 52.8% of residents in the district live in areas classified as rural.

York District Coordinating Council

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Leadership: Executive Committee for 2016 - 2017		
Name	**Leadership**	**Organization**
Clay Graybeal	Chair	University of New England
Sarah Breul	Vice Char	University of New England/Coastal Healthy Communities Coalition
Betsy Kelly	State Coordinating Council Representative	Southern Maine Health Care
Jackie Tselikis	Member	N/A
Ted Trainer	Member	Kennebunkport Rotary
Meaghan Arzberger	Member	York County Community Action Council
Sue Patterson	Member	York Hospital
Diane Gerry	Member	York County Shelter Program
Adam Hartwig	District Liaison	Maine State CDC

Council Members as of 2016 who contributed to this plan		
Greg Zinser	Laurie Trenholm	Tessa Mazza
Amber Harrison	Gretchen Litchfield	Dawn Gray
Donna DeBlois	Renee Longarini	Barbara Wentworth
Deb Erickson-Irons	Kate Meredith	Kristen Garvin
Paul Weiss	Nik Charov	John Leighton

Table of Contents

Maine's District Public Health Infrastructure

Public Health Districts and District Coordinating Councils

The Public Health Districts were formed in 2008 as part of Maine's Statewide Public Health System Development Initiative called for in the 2007 Public Health Work Group Recommendations (22 MRSA §412). The Tribal Public Health District was established as Maine's ninth Public Health District in 2011, with the Act to Amend the Laws Regarding Public Health Infrastructure (22 MRSA §411). The establishment of the nine Districts was designed to ensure the effectiveness and efficiency of public health services and resources.

According to Maine law, the Maine Center for Disease Control and Prevention "shall maintain a district coordinating council for public health (DCC) in each of the nine districts as resources permit (22 MRSA §412). This is a representative district wide body of local public health stakeholders working toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system." (22 MRSA §411)

The statutory language further states:

"A district coordinating council for public health shall:

(1) participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and
(2) ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible." (22 MRSA §412)

District Public Health Planning Process

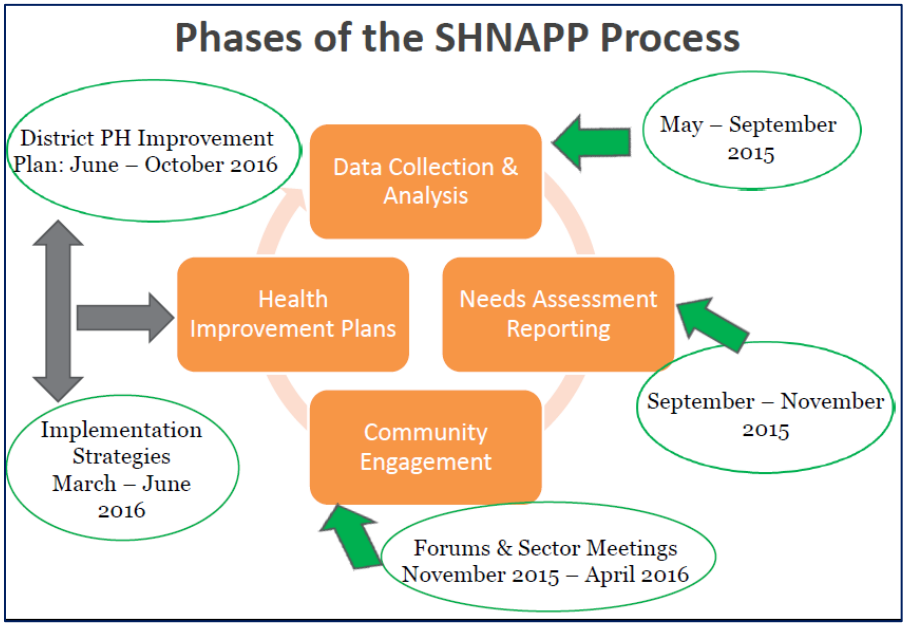
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health Improvement Plan (SHIP).

The purpose and importance of creating and implementing a DPHIP is based on the ten essential public health services through assessment, policy development, and assurance. Through the DPHIP, the DCC is working locally and regionally to meet public health accreditation and national public health standards through a community-based, multi-sector partnership to improve the public's health.

The Maine CDC is required to create and implement a State Health Improvement Plan (SHIP), designed to improve the health of all Maine people. The previous versions of the DPHIPs and SHIP were developed simultaneously, and partially aligned. In 2017, a new SHIP will be developed. In order to better coordinate health improvement efforts and resources between the state, districts, and Maine's people, priorities selected for the DPHIPs will inform this new SHIP. This is the third York District Public Health Improvement Plan with previous versions created in 2008 and 2012.

In 2015-2016, a collaborative process called the Shared Health Needs Assessment and Planning Process (SHNAPP) was created by Maine's four largest health-care systems – Central Maine Healthcare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, MaineHealth – and Maine CDC to integrate public health and health care needs assessment and community engagement. The SHNAPP serves as a platform for developing the current DPHIPs.

The graphic below shows the planning process over the past year portraying a four phase approach—collection of quantitative (health indicator statistics) and qualitative (survey of professionals and community organizations of field knowledge) data, creating a "Shared Community Health Needs Assessment (Shared CHNA)" for each district, partnering with hospitals to facilitate community input, and then creating implementation strategies (hospital community plans) and district public health improvement plans (public health districts).



The data in the Shared CHNA (see Appendix 1 for district data summary) provides a starting point for discussing the health issues that face Maine people. The indicators chosen for the Shared CHNA cover a broad range of topics, but are not intended to be an exhaustive analysis of all available data on any single health issue. District-shared CHNAs can be used to compare a health indicator in the district, in the counties making up the district, in the State of Maine, and to the national values.

Qualitative data were collected through a statewide stakeholder survey conducted in May and June 2015 with 1,639 people representing more than 80 organizations and businesses in Maine. The survey was developed using a collaborative process that included Maine SHNAPP partners, Market Decisions Research and Hart Consulting, and a number of other stakeholders and health experts. In York County, a total of 86 stakeholders responded to the survey.

During 2015-2016, a community engagement process was used to bring the numbers to life. Thirty-four community forums and fifty-two smaller events with more narrow audiences such as business leaders, or healthcare providers were held across the state, with over 3,000 attendees. A selection of the data from the SHNAPP was presented at each event, and participants discussed their priorities, assets and resources to address the issues, community needs and barriers, and next steps and solutions. The discussions were captured by facilitators and recorders and compiled for each district. Summaries from the community engagement events provided support for the next planning steps.

On September 12, 2016, the York District Coordinating Council met to vote on the top health priorities for the district. Prior to voting, the Council was presented with information on the top five health disparities in the district, data from the SHNAPP, and data from MYIHS to inform the decision making process. Council members were given four stickers to vote on the priorities that Executive Committee had categorized based on a list of approved topics from the Maine State CDC. Council members who were not present were given an electronic survey, and a week to complete their votes. The voting process led to three final proprities for this plan: Nutrition and Obesity, Oral Health, and Substance Abuse.

York District used the following criteria from the Collective Impact Framework:

- **Maximize impact and optimize limited resources**: District partners should first assess existing work being done in the district and determine how best to enhance and not duplicate these efforts. This criterion also speaks to collaboration across district partners, bringing the priority home to the specific organization, and leveraging existing resources.

- **Use evidence-based strategies and population-based interventions**: Districts should invest time in doing research on evidence-based strategies used successfully for

a specific disease area. For example, the Guide to Community Preventive Services (http://www.thecommunityguide.org/) provides recommendations for best practices for prevention services by a national task force of subject matter experts at the federal CDC.

- **Best addressed at the district level**: In Maine, many community actions are very local. However, some issues may be better addressed at a district level. The district should consider whether it can provide a platform for collaboration of non-typical partners; or be an avenue for policy and environmental change that ismore difficult to achieve at the local community level.

- **Involve multiple sectors**: District coordinating councils require active recruitment of multiple sectors across the public health continuum. Districts need to actively engage all partners that have the value of health as their mission. Districts should consider those health issues that can best be addressed by involving multiple sectors.

- **Address district health disparities**: The district should consider whether they can reduce health disparities between their district and the state or within their population by addressing a specific issue. Populations to consider as having potential health disparities include racial and ethnic minorities, immigrants, migrant farm workers, lesbian, gay, bisexual, and transgender people, people at low income levels, people with veteran's status, people with lower levels of educational attainment, people with physical impairments (including deafness, blindness and other physical disabilities), people with mental impairments (including those with developmental disabilities and mental illness), people over sixty years old, and youth.

- **Strengthen/Assure Accountability**: The district should consider whether change can be meaningfully measured and whether they can hold themselves accountable for changes in outcomes.

- **Focus on Prevention**: While some issues may be addressed through treatment in the health care system, for the Public Health Improvement plans districts should focus on whether outcomes can be prevented. This may include primary prevention (focus on the entire population), secondary prevention (focus on those at highest risk), or tertiary prevention (focus on those with existing conditions). Social determinants of health (social and physical environmental factors impacting health) should also be considered.

- **Data driven**: Based on the planned three-year cycle for health improvement plans, districts should be able to track short-term and long-term changes using data indicators. Although some data indicators may not change substantially in a short time

frame, being able to consistently use these data to measure change is important. However, shorter-term impacts and intermediate outcomes may also provide important information on determining if specific actions will lead to population health improvement.

- **Community Support**: Districts should be aware of the local priorities within the district, and seek common ground across the community, as well as in different sectors in the districts. Even when communities within the same county may not necessarily agree on specific strategies, there may be agreement on what the priorities are.

- **Gaps in prevention services:** The district should consider if a health issue has not been adequately addressed across the district or in some parts of the district. An appropriate discussion on root causes, barriers to services, or gap analysis may be an appropriate way to address this.

York District Public Health Improvement Plan

Community Health Improvement Priories

The top public health priority areas chosen by the York District Coordinating Council for focused district wide community health improvement efforts over the next three years (2017 – 2019) include:

- Nutrition and Obesity
- Oral Health
- Substance Abuse

The remainder of this plan provides more in-depth information about each of the public health priority areas listed above and plans for improvement. Through district and community based workgroups, council partners have identified goals, objectives and strategies, and will develop detailed work plans to meet their outcomes.

Implementation Plan Design

Once priority areas were identified, objectives were created and strategies selected.

Objectives are based on the SMART model: Specific, Measureable, Achievable, Realistic or Relevant, and Time-limited. SMART objectives are used to provide a structured approach to systematically monitor progress toward a target and to succinctly communicate intended impact and current progress to stakeholders.

Strategies or action steps were identified and designed to meet the outcomes of the objective. They may lead to short term impacts or intermediate outcomes that are clearly linked to the objectives. Not all possible strategies are able to be addressed within the DPHIP. The DCC considered possible strategies and selected one that met criteria such as those used in selecting the priority areas:

- Does it maximize impact and use of limited resources?
- Is it evidence-based?
- Is it population-based?
- Is it feasible at the district level?
- Does it involve multiple sectors and partners?
- Does it address district disparities?
- Can the DCC hold itself accountable for achieving the impact or outcome?
- Is it prevention-focused?
- Does the data support the use of the strategy?
- Is there adequate community support, or can this be built?
- Is there an organization that is willing to take the lead?
- Does it fill a gap?

Priority Area 1: Nutrition and Obesity

Priority: **Nutrition and Obesity**			
Description/Rationale/Criteria: Eating a healthy diet, being physically active and maintaining a healthy weight are essential for an individual's overall health. These three factors can help lower the risk of developing numerous health conditions, including high cholesterol, high blood pressure, heart disease, stroke, diabetes and cancer. They also can help prevent existing health conditions from worsening over time. According to the 2015 SHNAPP, high schoolers in York County are eating fewer fruits and vegetables as compared to the state average, and adult obesity rates in York County are 28.4%			
Goal	Objectives	Strategies	District Partners
1. Promote health and reduce chronic disease risk through the consumption of healthful diets	1.1 By 2020, increase fruit and vegetable consumption for all by implementing Fruit and Vegetable Prescription Program	1.1.A Engage Wholesome Wave for technical assistance 1.1.B. Build capacity by creating partnership with one large super market in York County to accept FVRx vouchers 1.1.C. Build capacity by engaging health care providers and encouraging them to give FVRx vouchers to patients	TBD
	Increase proportion of physician office visits that include education related to nutrition or weight by 2020	1.2.A. Providers will educate patients by distributing nutrition education information at visit, targeting only dentists and OBGYNs to broaden Let's Go Strategies. 1.2.B Providers will refer patients to community based nutrition resources (SNAP-ED Classes, WIC workshops, UMaine: Eat Well Nutrition Program)	
	1.3 Increase participation in WIC by 2020	1.3.A. Collaborate with WIC to increase enrollment in program.	
	1.4 Increase participation in Market Bucks by 2020	1.4.A. Participating health care providers will include information on how to use Market Bucks with their FVRx vouchers	

Priority Area 2: Oral Health

Priority: **Oral Health**			
Description/Rationale/Criteria: Access to timely, appropriate, high-quality and regular oral health care and preventive oral health services is a key component of maintaining health. Good access to oral health care can be limited by financial, structural, and personal barriers. Access to oral health care is affected by location of and distance to dental clinics, limited number of providers, availability of transportation and the cost of obtaining the services – including the availability of insurance, the ability to understand and act upon information regarding services, the cultural competency of oral health care providers and a host of other characteristics of the system and its clients. According to the 2015 SHNAPP, 51.5% of MaineCare members in York County under 18 visited the dentist in the past year, compared to the state rate of 55.1%.			
Goal	Objectives	Strategies	District Partners
1. Increase availability of treatment options available to residents	1.1 By 2020, increase percent of low income children and adolescents in York County who received any preventative oral health or dental services in the past year to align with state averages	1.1.A Expand school based oral health care partnership with the University of New England from one school to four schools 1.1.B Increase the number elementary schools to offer oral health education at schools, including preventative oral health services, such as dental screenings, to children and adolescents	TBD
	1.2 Increase awareness for parents about the importance of oral health by 2020	1.2.A. Develop and implement a comprehensive public education/parent education campaign on the benefits of good oral health	
	1.3 Increase the number of schools that have oral health education included in health policies that include oral health screenings to ensure that all students have access to at least one screening per year by 2020	1.3.A. Conduct gap analysis to understand which schools in York County need comprehensive oral health care policies 1.3.B. Work with PTO/PTA and school nurses to help schools develop policies that do not already have them in place	

Priority Area 3: Substance Misuse

Priority: **Substance Misuse**			
Description/Rationale/Criteria: Substance misuse and dependence are preventable health risks that lead to increased medical costs, injuries, related diseases, cancer and even death. Substance misuse also adversely affects productivity and increases rates of crime and violence. According to the 2015 SHNAPP, in York County, past-30-day marijuana use for high school students in York county is at 22.7%, as compared with the state rate of 21.6%. Past 30-day-day marijuana use for adults is at 8.8%. Drug induced mortality rates are slightly higher in York County than the State rates, similarly with emergency medical service overdose response rates.			
Goal	Objectives	Strategies	District Partners
1. Reduce substance use rates to protect the health, safety, and quality of life for all	1.1 Increase awareness of available community resources for prevention, treatment, and recovery by 2020	1.1.A. Complete inventory of existing community resources and gap analysis of community resources (211, asset map, SAMHS, etc.) 1.1.B. Increase public awareness and use of community resources by compiling information and developing an electronic resource guide	TBD

Appendices

1. **York District** 2015-2016 Health Profile: this is a health profile of the district using a set of quantitative indicators established by the Maine CDC Data Work Group and qualitative input. The quantitative indicators come from sources that Maine CDC uses to report disease incidence and prevalence data, including the Behavioral Risk Factor Surveillance System, Maine Health Data Organization (hospitalization data), US Census, and other health surveillance systems. The qualitative stakeholder input on the first page is a summary of the top five health issues and top five health factors in the district determined from a survey instrument that was distributed electronically to partners in each district.

For more information on Maine's Public Health Districts, please visit the Maine CDC website at http://www.maine.gov/dhhs/mecdc/ and choose *District Public Health* from the menu.

For more information on the Aroostook District Coordinating Council, please contact Adam Hartwig, District Liaison, at Adam.Hartwig@maine.gov or Clay Graybeal, Chair, at cgraybeal@une.edu

Appendix 1: York District Health Profile 2015-2016

Maine Shared Community Health Needs Assessment
County Summary: 2015

York County

Updated: October 2015

Qualitative Stakeholder Input

A survey of 86 health professionals and community stakeholders in York County provided insight into the most critical health issues and determinants impacting the lives of those living in the area. According to these stakeholders, the following five health issues and health factors have the most impact on York County resulting in poor health outcomes for residents.

Top five health issues

- Mental health
- Drug and alcohol abuse
- Obesity
- Physical activity and nutrition
- Tobacco use

Top five health factors

- Poverty
- Transportation
- Access to behavioral care/mental health care
- Health literacy
- Housing stability

Maine Shared CHNA Health Indicators	Year	York	Trend	Maine	U.S.
Demographics					
Total Population	2013	199,431		1,328,302	319 Mil
Population – % ages 0-17	2013	20.1%		19.7%	23.3%
Population – % ages 18-64	2013	62.6%		62.6%	62.6%
Population – % ages 65+	2013	17.3%		17.7%	14.1%
Population – % White	2013	96.3%		95.2%	77.7%
Population – % Black or African American	2013	0.7%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.3%		0.7%	1.2%
Population – % Asian	2013	1.2%		1.1%	5.3%
Population – % Hispanic	2013	1.5%		1.4%	17.1%
Population – % with a disability	2013	13.8%		15.9%	12.1%
Population density (per square mile)	2013	199.0		43.1	87.4
Socioeconomic Status Measures					
Adults living in poverty	2009-2013	*9.5%*	NA	13.6%	15.4%
Children living in poverty	2009-2013	*11.5%*	NA	18.5%	21.6%
High school graduation rate	2013-2014	89.0%	NA	86.5%	81.0%
Median household income	2009-2013	*$57,348*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	52.8%	NA	66.4%	NA
Single-parent families	2009-2013	30.1%	NA	34.0%	33.2%
Unemployment rate	2014	5.3%	NA	5.7%	6.2%
65+ living alone	2009-2013	41.1%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	*13.4%*		15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	11.7%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	12.2%		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	27.2%		27.6%	NA
Mortality					
Life expectancy (Female)	2012	82.3	NA	81.5	81.2
Life expectancy (Male)	2012	77.8	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*683.9*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	*89.9%*		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	11.3%		11.0%	15.3%
MaineCare enrollment	2015	21.2%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	33.8%	NA	41.8%	48.0%
Percent uninsured	2009-2013	*9.1%*	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,261.0*	+	1,499.3	1457.5

Maine Shared CHNA Health Indicators	Year	York	Trend	Maine	U.S.
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	3,989.3	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	58.9%	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	51.5%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	61.1		67.3	NA
COPD diagnosed	2011-2013	8.0%		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	166.2	-	216.3	NA
Current asthma (Adults)	2011-2013	11.2%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	10.2%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	723.4	-	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	272.0		320.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	178.9	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	510.4	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	31.1	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	19.0	NA	20.0	21.5
Breast cancer late stage incidence (females only) per 100,000 population	2007-2011	44.0	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	132.0	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	82.0%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	15.8	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	23.3	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	43.6	NA	43.5	42.0
Colorectal screening	2012	71.9%	NA	77.7%	NA
Lung cancer mortality per 100,000 population	2007-2011	49.4	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	69.4	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	27.8	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	86.4%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	19.8	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	142.7	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	37.0	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	95.9	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	18.9		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	25.3	NA	32.2	32.4
Cholesterol checked every five years	2011, 2013	82.4%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	74.5	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	21.5		21.9	NA
Hypertension prevalence	2011, 2013	33.6%		32.8%	31.4%
High cholesterol	2011, 2013	41.0%		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	16.8		28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	19.3		20.8	NA
Stroke mortality per 100,000 population	2009-2013	32.3	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	9.4%		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	8.5%		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	67.5%	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	82.5%	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	81.9%	NA	73.2%	NA

Maine Shared CHNA Health Indicators	Year	York	Trend	Maine	U.S.
Acults with diabetes who have received formal diabetes education	2011-2013	65.7%	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	146.2		235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	9.0		11.7	NA
Diabetes long-term complication hospitalizations	2011	47.2	-	59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	18.0	NA	20.8	21.2
Environmental Health					
Ch ldren with confirmed elevated blood lead levels (% among those screened)	2009-2013	2.1%	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	4.5%	NA	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	44.5%	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	53.9%	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	31.4%	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	41.7%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	73.8%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	2.0%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.5†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.5†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	1.0†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	76.2	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	4.0†	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	134.0	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	11.5	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.5†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	3.0†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	198.8	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	17.4	NA	17.8	109.8
HIV incidence per 100,000 population	2014	3.0†	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	17.7		21.4	NA
Syphilis incidence per 100,000 population	2014	1.0†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	554.0	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	9.7	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child ma treatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	37.1	NA	27.0	25.2
Suicide deaths per 100,000 popu ation	2009-2013	17.1	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	169.0	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	88.7%		85.2%	NA
Always wear seatbelt (High School Students)	2013	69.5%		61.6%	54.7%

Maine Shared CHNA Health Indicators	Year	York	Trend	Maine	U.S.
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	75.7	NA	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	10.3	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	8.9	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	326.5	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	9.6	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	1,271.0	NA	13,205.0	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	19.2%		19.4%	NA
Adults who have ever had depression	2011-2013	22.1%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	9.2%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	18.0%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	36.1%		35.2%	NA
Mental health emergency department rates per 100,000 population	2011	1,782.0		1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	25.1%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	15.7%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	14.8%	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	31.3%	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	53.2%	-	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	42.2%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	20.7%		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	25.5%	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	16.7%	NA	17.9%	22.9%
Obesity (Adults)	2013	28.4%		28.9%	29.4%
Obesity (High School Students)	2013	11.6%		12.7%	13.7%
Overweight (Adults)	2013	35.7%		36.0%	35.4%
Overweight (High School Students)	2013	16.3%		16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2008-2012	5.3	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	87.0%	NA	80.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	18.1	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.2%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	6.9	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	15.1%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	18.3%		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	8.5%		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	5.2%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	13.2	NA	12.4	14.6

Maine Shared CHNA Health Indicators	Year	York	Trend	Maine	U.S.
Emergency medical service overdose response per 100,000 population	2014	444.9	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	26.5		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	12.5		15.2	NA
Past-30-day alcohol use (High School Students)	2013	26.6%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.2%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	8.8%		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	22.7%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	1.0%+	NA	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	7.4%		5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	6.8	NA	6.8	NA
Substance abuse hospital admissions per 100,000 population	2011	316.1		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	20.1%		20.2%	19.0%
Current smoking (High School Students)	2013	12.4%		12.9%	15.7%
Current tobacco use (High School Students)	2013	18.5%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	36.3%		38.3%	NA

Indicates county is significantly better than state average (using a 95% confidence level).
Indicates county is significantly worse than state average (using a 95% confidence level).
+ Indicates a positive trend over time at the county level (using a 95% confidence level)
- Indicates a negative trend over time at the county level (using a 95% confidence level)
† Results may be statistically unreliable due to small numerator, use caution when interpreting.
NA = No data available