Cumberland District Public Health Council

Public Health
Prevent. Promote. Protect.

May 17

2013

Annual Report

Introduction

The Cumberland District Public Health Council (Council) continues to work toward its vision of making communities in Cumberland District among the healthiest in the state. Over the past year, the Council formed work groups to address issues such as influenza, coordinated communication, and health equity. The Council received a Community Transformation Grant to improve physical activity, nutrition, and active communities across the district. This annual report contains information on the Council's activities, the Council's fiscal health, committees and workgroups, and all members who were active over the past fiscal year.

History

The Council convened in December 2006 immediately following the statewide Public Health Work Group's decision to create eight public health districts, each with a district coordinating council (DCC). The Council built the initial membership from participants in the Portland Public Health Division's Local Public Health System Assessment in January and February 2005, and the Cumberland County Strategic Planning Committee's Public Health and Human Services Subcommittee in July 2006. In November 2008, the Council restructured with the adoption of official bylaws. In March 2013, the Council voted to accept a series of bylaws amendments designed to make the Council's bylaws consistent with the recommendations of the State Coordinating Council for Public Health.

Council Officers

At the May 2012 Annual Meeting, the Membership voted on three officer positions. The Membership elected Toho Soma as the Council Chair (replacing Colleen Hilton), Colleen Hilton as the Council Vice Chair (interim for one year), and Julie Sullivan as the Council Secretary. The current officers of the Council are:

Council Chair—Toho Soma (term ending May 2014)
Council Vice Chair—Colleen Hilton (term ending May 2013)
Council Secretary—Julie Sullivan (term ending May 2014)
Council Treasurer—Deb Deatrick (term ending May 2013)
Council Representative to the State Coordinating Council—Steve Fox (term ending May 2013)
Maine CDC District Liaison—Becca Matusovich

Committees and Workgroups

The Council maintained six standing committees, as set forth in the Council bylaws. The standing committees include the Advocacy Committee, Communications Committee, Finance &

Fundraising Committee, Health Data Committee, Healthy Cumberland Committee, and Membership Committee. These committees had varying level of activity over the past year.

One ad-hoc committee operated over the past year (see Oversight Sub-committee under the Community Transformation Grant), serving as Council oversight for the Community Transformation Grant. In addition, the Executive Committee continued meeting every other month to discuss and administer Council business.

The Council also maintained several work groups that addressed District Public Health Improvement Plan priorities (see below).

Progress on the Cumberland 2011-13 District Public Health Improvement Plan Priorities

With leadership provided by the Maine CDC Cumberland District Liaison, as well as many other Council members and district partners, the Council made progress this year on all of the priorities set forth in the 2011-2013 District Public Health Improvement Plan.

- **Flu & Pneumococcal Vaccination**

The Flu & Pneumococcal Workgroup met from March through September, implementing a 3-pronged work plan. The work plan focused on supporting and encouraging school flu clinics, coordinating adult public clinics to ensure access for vulnerable populations, and a marketing strategy to promote flu vaccination for everyone and 2-1-1 as an easy point of contact for all public flu clinics.

- **Access to Care**

Although the Cumberland District has a reputation for robust health care infrastructure, concerns about disparities in access to care for vulnerable populations drove the selection of "Access to Care" as one of Cumberland's District Public Health Improvement Plan priorities. There are three aspects of "access to care" that were the focus of this year's activities.

1) **Health on the Move**

The Council's Health Equity Workgroup developed a concept named "Health on the Move," a mobile health access project that brings health resources into community settings to break down barriers that limit access to preventive health services and screenings for vulnerable populations. The primary goal is to reduce health disparities by bringing health resources to the communities where the target population lives. Health on the Move events are planned by a team including Council members, local organizations that know and serve the target population, and members of the community themselves. The team uses tools that draw on emergency preparedness approaches, so that in the process of planning these events we are

building the capacity of the district public health system to quickly plan similar events that might be needed to address specific health needs in an emergency situation.

The Council decided to support four Health on the Move pilot events during 2012-13. The first two pilots were held in the fall of 2012, at Riverton Park in Portland and at the Crooked River Community Center in Casco. The third pilot event is May 19, 2013 in Brunswick in conjunction with MidCoast Hospital's Women's Wellness Day, and the fourth pilot is scheduled for July 27, 2013 in Portland in conjunction with the Parkside Neighborhood's Annual Block Party.

2) Access to Care in the Lakes Region

A small workgroup began meeting in 2012 to follow up on the breakout session discussion about access to care in the Lakes Region that began at the Community Health Needs Assessment Forum hosted by MaineHealth in January 2012. A core group of key players met several times and identified some initial issues to explore, and then focused their attention on the December 2012 Health on the Move event in Casco, through which several excellent partnerships were formed and momentum established. In the spring of 2013, a core group reconvened under the leadership of the Healthy Lakes Director and designed an internship for a graduate student who will complete an assessment of access challenges in the region during the summer of 2013.

3) The Greater Portland Refugee and Immigrant Healthcare Collaborative

One of district partners' greatest concerns focuses on the barriers to care experienced by refugees and immigrants, who are an increasing proportion of the Cumberland County population and a group with particularly complex health needs. 2012 was the second year of existence for the "Greater Portland Refugee & Immigrant Healthcare Collaborative," an informal network of partners in the Greater Portland area who serve refugees and immigrants and who all share a role in ensuring access to culturally appropriate health care services. The Collaborative is facilitated by Becca Matusovich, the Cumberland District Public Health Liaison, with over 60 partners participating in its quarterly meetings and/or workgroups in the past year.

In the last year great progress was made on several of the Collaborative's priorities. With *leadership provided by the University of New England, in partnership with Portland Community* Health Center, the City of Portland, Maine CDC, and others, the "CHANNELS" project was awarded a grant from the U.S. Health Resources and Services Administration (HRSA) to implement an innovative project that weaves together nurse leadership, inter-professional education and inter-professional practice, community health outreach workers, and community partnerships to increase access to care and improve health outcomes among Greater Portland's refugee and immigrant communities. This project was also integrated strategically with a

successful grant application to the DentaQuest Foundation to fund "SmilePartners," a demonstration project grounded in MaineHealth's CarePartners Program, designed to test methods for maintaining good oral health, building culturally appropriate oral health literacy education tools, and establishing access to effective preventive dental care services among Portland's newly arriving refugees and immigrants.

In the fall of 2012, the Collaborative's primary care workgroup revised a set of "Initial Health Assessment Recommendations" promoted by the Maine CDC to provide guidance for primary care providers who see newly arriving refugees and immigrants for their first health care in the U.S. This document is now available to practices across the state that may not be experienced in serving this population. The primary care workgroup has also been exploring the need for increased access to Civil Surgeons in the Portland area, and several members of the workgroup have been working together on ways to improve the referral and intake process to ensure that these mechanisms work for this population.

Finally, the Collaborative worked with a summer intern from Bowdoin College to build a wiki, which has become a valuable communication tool that allows partners in the Collaborative to share the communal knowledge and resources. This helps meet the goal of the Collaborative to maximize the capacity of all of the partners to meet the health needs of the refugee and immigrant community more effectively and efficiently.

A team from the Collaborative presented a workshop at the Maine Public Health Association conference in October 2012, and as a result was offered the pro bono services of a team of experienced evaluators who are now assisting with the development of an evaluation of the Collaborative's use of the "Collective Impact" model to work together and achieve progress on common goals.

- **Public Health Preparedness**

The Council's Public Health Preparedness priority was addressed through several initiatives, including those of other workgroups such as the Flu Workgroup and the Health Equity Workgroup as described above. The most substantive work on the public health preparedness priority area was the development of a Cumberland County Medical Reserve Corps, with leadership provided by Cumberland County Emergency Management Agency, along with Maine CDC, the City of Portland's Cities Readiness Initiative, the Southern Maine Regional Resource Center, and several other Council members and district partners. After a year of intensive planning and design work, the Medical Reserve Corps is ready to be launched in the summer and fall of 2013.

- **Tobacco**

An active Tobacco Workgroup was established in March of 2012 and continues to meet bi-monthly. The group operates from a strong core of 7 individuals with approximately another dozen who remain engaged. It has become an important mechanism for sharing information about tobacco control efforts and coordinating resources and communication. An identified core value is to seek to improve access to tobacco treatment resources for vulnerable populations. This group designed outreach approaches related to tobacco prevention, intervention, and treatment for inclusion in Health on the Move events. This workgroup continues to meet regularly and anyone interested in contributing to reducing the impact of tobacco in Cumberland County is encouraged to get involved.

- **Blood Pressure**

A Blood Pressure workgroup formed at the Community Health Needs Assessment forum in January 2012 and continued meeting through the rest of the year. The group identified several focus areas: expanding and improving blood pressure screening to ensure that populations who face barriers to ongoing care are able to access blood pressure checks regularly; and working with small employers to support wellness activities that can help employees monitor and reduce their blood pressure. This workgroup assisted with the design of blood pressure screening stations for the Health on the Move model.

Selection of the 2013-14 Cumberland District Public Health Improvement Plan Priorities

Between November 2012 and May 2013, the Council worked on selecting new District Public Health Improvement Plan priorities for the next two year period. The process included the following steps led by the Executive Committee and the District Liaison over the course of three CDPHC meetings:

- Review of the district health profile, with district-level data produced by the Maine CDC as part of the State Health Assessment
- Nomination of potential priorities, consensus on criteria for the prioritization process
- A survey to gather the additional information needed to score the potential priorities on the agreed upon criteria
- A formal weighting and scoring process to rank the potential priorities
- Decision about how many of the top-ranked priorities to select

At the end of this process, 8 priorities were selected for 2013-14. See Appendix A.

Community Transformation Grant

The Community Transformation Grants are Federal grants authorized under the Affordable Care Act of 2010. The Maine Center for Disease Control and Prevention received a $1.3 million dollar Community Transformation Grant in September 2011. The majority of the Community Transformation Grant funds were distributed to the eight public health districts and the tribal district.

The grant requires a committee to oversee the work of the grant in each district. The Oversight Sub-committee (OSC) met in May, June, August, September, October, and November 2012. The OSC changed to a quarterly meeting schedule after the November 2012 meeting. The Oversight Sub-committee consists of the all of the Executive Committee of the Council plus additional individuals interested in the work. Over the past year, the OSC developed a communication and operational protocol, approved the Year 2 work plans, approved the revisions made to the Year 2 work plans (based on feedback from the Maine CDC), and approved the Year 2 CTG budget.

Shane Gallagher continues to serve as the Community Transformation Grant Coordinator. The Coordinator is primarily responsible for communication among the district, local level work and the state level work, the maintenance of the wiki page, grant management, and maintenance of the performance monitoring data.

Two work groups continue to serve as advisory bodies for the grant objectives. The first work group focused on the physical activity and nutrition objectives, and the second work group focused on the active community environment objectives.

As of May 8, 2013, the Early Childhood Education (ECE) implementation staff have recruited and enrolled 29 childcare sites, which is 83% of the work plan goal of 35 sites for Year 2, and 41% of the Community Transformation Implementation Plan (CTIP) Annual objective of 70 sites. Twenty four of the enrolled sites (83%) have completed the Let's Go! baseline assessment and twenty three sites (79%) completed their action plan.

School nutrition implementation staff have recruited and enrolled 10 schools, which is 125% of the work plan goal of 8 sites in Year 2, and 71% of the CTIP Annual Objective of 14 sites.

Physical Activity implementation staff have recruited and enrolled 7 schools, which is 88% of the work plan goal of 8 sites in Year 2, and 50% of the CTIP annual Objective of 14 sites.

Active Community Environment (ACE) implementation staff worked closely with several communities. Currently there are three communities (Freeport, Scarborough, and South Portland) working to become ACE teams and several additional towns that are expressing interest in beginning work.

County Health Rankings

The collaborative efforts of the member organizations of the Council continue to pay off. The results of these efforts are reflected in the County Health Rankings & Roadmaps. Cumberland County continues to rank very well amongst Maine's 16 counties—second for health outcomes (how healthy a county is) and first for health factors (what influences the health of a county). The 2013 County Health Rankings & Roadmaps can be found in Appendix B.

Financial Report

The Council received funding from several organizations, as well as the Community Transformation Grant. The main expense of the Council remained salary for staff support. A detailed report can be found in Appendix C.

Meeting Locations

Over the past year, the Council held meetings in various locations. Meeting locations included MaineHealth, Planned Parenthood of Northern New England, Portland Public Library, Portland Water District, and the South Portland Community Center.

Membership

The Council's membership represented a variety of organizations and diverse regions of the Cumberland Public Health District. Members from the past year are listed below.

Neal Allen— Greater Portland Council of Governments

Anita Anderson—Chebeague Island Local Health Officer

Denise Bisaillon—University of New England Public Health Graduate Program

Leslie Brancato—Portland Community Health Center

Jim Budway—Cumberland County Emergency Management Agency

Faye Daley—Bridgton/Harrison Local Health Officer

Deb Deatrick—MaineHealth/Maine Medical Center

Kristen Dow—City of Portland Public Health Division, Healthy Portland HMP

Dennis Fitzgibbons—AlphaOne

Stephen Fox—South Portland Fire Department/Local Health Officer

Mark Grover—Cumberland County Commissioner, District 3

Sandra Hale—Westbrook School System

Megan Hannan—Planned Parenthood of Northern New England

Colleen Hilton—Mercy Health System of Maine/VNA Home Health and Hospice

Liz Horton—Westbrook Local Health Officer

Paul Hunt—Portland Water District

Valerie Landry—Mercy Health System of Maine

Anne Lang—City of Portland Public Health Division, Healthy Casco Bay

Jessica Loney—Midcoast Hospital

Becca Matusovich—Maine CDC Cumberland District DHHS Office

Zoe Miller—Opportunity Alliance, Healthy Lakes

Bernice Mills—University of New England Dental Hygiene Program

Paul Niehoff— Portland Area Comprehensive Transportation System

Dianne North—Cumberland County Jail

Karen O'Rourke—University of New England Center for Community and Public Health

Cathy Patnaude—VNA Home Health & Hospice

Helen Peake-Godin—University of Southern Maine School of Nursing

Linda Putnam—Portland Public Library

Emily Rines—United Way of Greater Portland

Lucie Rioux—Opportunity Alliance, Healthy Rivers

Erica Schmitz—Medical Care Development

Amanda Sears—Environmental Health Strategy Center

Pamela Smith—Bridgton Hospital

Toho Soma—City of Portland Public Health Division

Ashley Soule—Maine Medical Center Neuroscience Institute

Peter Stuckey—Maine State Legislature, District 114 (part of Portland)

Julie Sullivan—City of Portland Public Health Division

Ted Trainer—Southern Maine Area Agency on Aging

Helen Twombly—Sebago Local Health Officer

Eileen Wyatt—Cumberland/Yarmouth/ North Yarmouth Local Health Officer

Carol Zechman—CarePartners, MaineHealth

Next Steps

Looking forward there is much work for the Council in the coming year. Some examples of the Council's current work include:

- Continuing work on DPHIP priorities, such as developing new workgroups and strengthening existing groups.
- Continue significant focus on the Community Transformation Grant.
- Continue to strengthen the Membership Subcommittee in order to ensure an active membership that represents the full breadth of public health partners in the district.

Cumberland District Coordinating Council
2013-14 District Public Health Improvement Plan Priorities

Priority Area	To get involved contact:	Current Strategies and Focus Areas
Flu Vaccination	Becca Matusovich Cathy Patnaude	1. School clinics 2. Adult public flu clinics 3. Coordinated communications, joint campaign to promote 2-1-1 and flu clinics
Health Equity	Toho Soma Shane Gallagher Becca Matusovich	1. Health on the Move 2. Greater Portland Refugee & Immigrant Healthcare Collaborative 3. Lakes Region Access to Care 4. Disparities data
Healthy Homes	Alex Hughes	1. Initiative to educate families of children aged 0 to 5 2. Create district Healthy Homes Resource Inventory
Obesity/ Nutrition/ Physical Activity	Kristen Dow Karen O'Rourke Shane Gallagher	1. Create an overall plan covering the long-term vision for work relating to physical activity, nutrition, and active community environments.
Public Health Preparedness	Becca Matusovich Caity Hager Ron Jones	1. Medical Reserve Corps 2. Cities Readiness Initiative 3. Communications plan to ensure language access for public health emergency communications 4. Public health Hazard Vulnerability Analysis
STDs/ Reproductive Health	Alex Hughes Bridget Nevers Rauscher	1. Joint campaign to promote STD testing 2. Provider education related to testing recommendations and increasing access to treatment 3. Targeted effort in Rivers Region
Substance Abuse/ Mental Health	Elizabeth Trice Mark Grover	1. Re-establish workgroup 2. Agree upon strategies and focus areas
Tobacco	Claire Schroeder Fred Wolff	1. Share resources and information 2. Engage broader network of partners, coordinating publicity and public messaging 3. Focus on hard-to-reach populations

What Does Being a DPHIP Priority Mean?

Council Commitment:

- ✓ Contribute core leadership and backbone support
- ✓ Engage in priority work
- ✓ Monitor progress

Workgroup Commitment:

- ✓ Plan
- ✓ Implement
- ✓ Report

County Health Rankings & Roadmaps

A Healthier Nation, County by County

2013 *Rankings*

Maine

Robert Wood Johnson Foundation

UNIVERSITY OF WISCONSIN
Population Health Institute
Translating Research for Policy and Practice

Introduction

Where we live matters to our health. The health of a community depends on many different factors, including the environment, education and jobs, access to and quality of healthcare, and individual behaviors. We can improve a community's health by implementing effective policies and programs. For example, people who live in communities with smoke-free laws are less likely to smoke or to be exposed to second-hand smoke, which reduces lung cancer risk. In addition, people who live in communities with safe and accessible park and recreation space are more likely to exercise, which reduces heart disease risk.

However, health varies greatly across communities, with some places being much healthier than others. And, until now, there has been no standard method to illustrate what we know about what makes people sick or healthy or a central resource to identify what we can do to create healthier places to live, learn, work and play.

We know that much of what influences our health happens outside of the doctor's office – in our schools, workplaces and neighborhoods. The *County Health Rankings & Roadmaps* program provides information on the overall health of your community and provides the tools necessary to create community-based, evidence-informed solutions. Ranking the health of nearly every county across the nation, the *County Health Rankings* illustrate **what we know** when it comes to what is making communities sick or healthy. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this groundbreaking program to counties and states across the nation.

The *County Health Rankings & Roadmaps* program includes the *County Health Rankings* project, launched in 2010, and the newer *Roadmaps* project that mobilizes local communities, national partners and leaders across all sectors to improve health. The program is based on this model of population health improvement:

In this model, health outcomes are measures that describe the current health status of a county. These health outcomes are influenced by a set of health factors. Counties can improve health outcomes by addressing all health factors with effective, evidence-informed policies and programs.

Everyone has a stake in community health. We all need to work together to find solutions. The *County Health Rankings & Roadmaps* serve as both a call to action and a needed tool in this effort.

Guide to Our Web Site

To compile the *Rankings*, we selected measures that reflect important aspects of population health that can be improved and are available at the county level across the nation. Visit www.countyhealthrankings.org to learn more.

To get started and see data, enter your county or state name in the search box. Click on the name of a county or measure to see more details. You can: Compare Counties; Download data for your state; Print one or more county snapshots; or Share information with others via Facebook, Twitter, or Google+. To understand our methods, click on Learn about the Data and Methods. You can also take advantage of the Using the *Rankings* Data guide to help you explore the data and figure out more about what is driving your community's health. To learn about what you can do to improve health in your community, visit the *Roadmaps to Health* Action Center. Finally, you can learn what others are doing by reading Communities Stories and visiting the Project Showcase.

County Health Roadmaps

The *Rankings* illustrate **what we know** when it comes to making people sick or healthy. The *County Health Rankings* confirm the critical role that factors such as education, jobs, income and the environment play in how healthy people are and how long we live.

The *County Health Roadmaps* mobilizes local communities, national partners and leaders across all sectors to improve health. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this groundbreaking project to cities, counties and states across the nation.

The *Roadmaps* project includes grants to local coalitions and partnerships among policymakers, business, education, public health, health care, and community organizations; grants to national organizations working to improve health; recognition of communities whose promising efforts have led to better health; and customized guidance on strategies to improve health.

***Roadmaps to Health* Community Grants**
The *Roadmaps to Health* Community Grants provide funding for 2 years to thirty state and local efforts among policymakers, business, education, healthcare, public health and community organizations working to create positive policy or systems changes that address the social and economic factors that influence the health of people in their community.

***Roadmaps to Health* Partner Grants**
RWJF is awarding *Roadmaps to Health* Partner Grants to national organizations that are experienced at engaging local partners and leaders and are able to deliver high-quality training and technical assistance, and committed to making communities healthier places to live, learn, work and play. Partner grantees increase awareness about the *County Health Rankings & Roadmaps* to their members, affiliates and allies. As of February 2013, RWJF has awarded partner grants to United Way Worldwide, National Business Coalition on Health, and National Association of Counties.

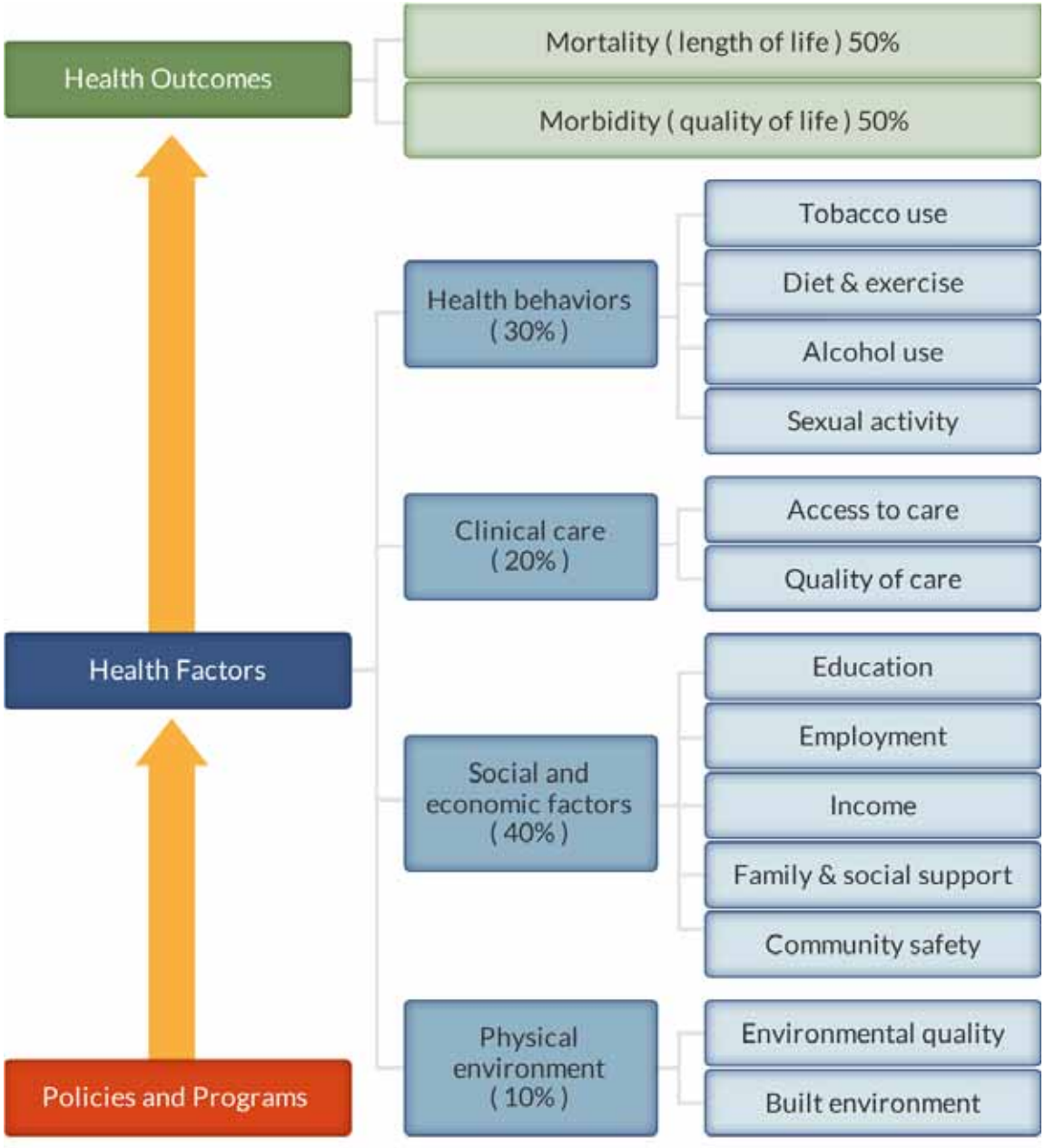
RWJF Roadmaps to Health Prize
In February 2013, RWJF awarded the first *RWJF Roadmaps to Health* Prizes of $25,000 to six communities that are working to become healthier places to live, learn, work and play. The *RWJF Roadmaps to Health* Prize is intended not only to honor successful efforts, but also to inspire and stimulate similar activities in other U.S. communities.

***Roadmaps to Health* Action Center**
The *Roadmaps to Health* Action Center, based at UWPHI, provides tools and guidance to help groups working to make their communities healthier places. The Action Center website provides guidance on developing strategies and advocacy efforts to advance pro-health policies, opportunities for ongoing learning, and a searchable database of evidence-informed policies and programs focused on health improvement: *What Works for Health*. Action Center staff provide customized consultation via email and telephone to those seeking more information about how to improve health. Coaching, including possible on-site visits, is also available for communities who have demonstrated the willingness and capacity to address factors that we know influence how healthy a person is, such as education, income and family connectedness.

County Health Rankings

The 2013 *County Health Rankings* report ranks Maine counties according to their summary measures of **health outcomes** and **health factors**. Counties also receive a rank for mortality, morbidity, health behaviors, clinical care, social and economic factors, and the physical environment. The figure below depicts the structure of the *Rankings* model; those having high ranks (e.g., 1 or 2) are estimated to be the "healthiest."

Our summary **health outcomes** rankings are based on an equal weighting of mortality and morbidity measures. The summary **health factors** rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input, but represent just one way of combining these factors.



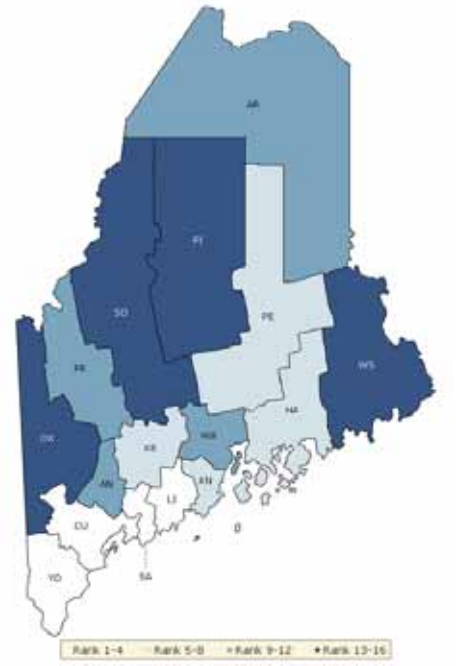
County Health Rankings model ©2012 UWPHI

The maps on this page and the next display Maine's counties divided into groups by health rank. Maps help locate the healthiest and least healthy counties in the state. The lighter colors indicate better performance in the respective summary rankings. The green map shows the distribution of summary health outcomes. The blue displays the distribution of the summary rank for health factors.

HEALTH OUTCOMES

County	Rank	County	Rank	County	Rank	County	Rank
Androscoggin	6	Hancock	1	Oxford	12	Somerset	15
Aroostook	13	Kennebec	7	Penobscot	9	Waldo	10
Cumberland	2	Knox	5	Piscataquis	16	Washington	14
Franklin	8	Lincoln	11	Sagadahoc	3	York	4

HEALTH FACTORS



County	Rank	County	Rank	County	Rank	County	Rank
Androscoggin	11	Hancock	6	Oxford	13	Somerset	15
Aroostook	12	Kennebec	7	Penobscot	8	Waldo	9
Cumberland	1	Knox	5	Piscataquis	14	Washington	16
Franklin	10	Lincoln	4	Sagadahoc	2	York	3

Summary Health Outcomes & Health Factors Rankings

Counties receive two summary ranks:

- Health Outcomes
- Health Factors

Each of these ranks represents a weighted summary of a number of measures.

Health outcomes represent how healthy a county is while health factors represent what influences the health of the county.

Rank	Health Outcomes	Rank	Health Factors
1	Hancock	1	Cumberland
2	Cumberland	2	Sagadahoc
3	Sagadahoc	3	York
4	York	4	Lincoln
5	Knox	5	Knox
6	Androscoggin	6	Hancock
7	Kennebec	7	Kennebec
8	Franklin	8	Penobscot
9	Penobscot	9	Waldo
10	Waldo	10	Franklin
11	Lincoln	11	Androscoggin
12	Oxford	12	Aroostook
13	Aroostook	13	Oxford
14	Washington	14	Piscataquis
15	Somerset	15	Somerset
16	Piscataquis	16	Washington

2013 *County Health Rankings*: Measures, Data Sources, and Years of Data

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Mortality	Premature death	National Center for Health Statistics	2008-2010
Morbidity	Poor or fair health	Behavioral Risk Factor Surveillance System	2005-2011
	Poor physical health days	Behavioral Risk Factor Surveillance System	2005-2011
	Poor mental health days	Behavioral Risk Factor Surveillance System	2005-2011
	Low birthweight	National Center for Health Statistics	2004-2010
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2005-2011
Diet and Exercise	Adult obesity	National Center for Chronic Disease Prevention and Health Promotion	2009
	Physical inactivity	National Center for Chronic Disease Prevention and Health Promotion	2009
Alcohol Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2005-2011
	Motor vehicle crash death rate	National Center for Health Statistics	2004-2010
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention	2010
	Teen birth rate	National Center for Health Statistics	2004-2010
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2010
	Primary care physicians	HRSA Area Resource File	2011-2012
	Dentists	HRSA Area Resource File	2011-2012
Quality of Care	Preventable hospital stays	Medicare/Dartmouth Institute	2010
	Diabetic screening	Medicare/Dartmouth Institute	2010
	Mammography screening	Medicare/Dartmouth Institute	2010
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	Primarily state-specific sources, supplemented with National Center for Education Statistics	State-specific
	Some college	American Community Survey	2007-2011
Employment	Unemployment	Bureau of Labor Statistics	2011
Income	Children in poverty	Small Area Income and Poverty Estimates	2011
Family and Social Support	Inadequate social support	Behavioral Risk Factor Surveillance System	2005-2010
	Children in single-parent households	American Community Survey	2007-2011
Community Safety	Violent crime rate	Federal Bureau of Investigation	2008-2010
PHYSICAL ENVIRONMENT			
Environmental Quality	Daily fine particulate matter [1]	CDC WONDER Environmental data	2008
	Drinking water safety	Safe Drinking Water Information System	FY 2012
Built Environment	Access to recreational facilities	Census County Business Patterns	2010
	Limited access to healthy foods	USDA Food Environment Atlas	2012
	Fast food restaurants	Census County Business Patterns	2010

[1] Not available for AK and HI.

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FY13 Cumberland District Public Health Council Finances
(as of 5/16/13)

Code	Line Item		Budget	Spent	Balance
01 10	Salaries		$32,305	$21,078	$11,227
02 10	Fringe		$9,249	$6,035	$3,214
20 00	Administrative Services		$500	$0	$500
20 20	Travel/training/meetings		$1,000	$117	$883
20 30	Indirect Costs		$5,940	$4,950	$990
35 00	Contractual		$1,000	$200	$800
35 30	Mileage		$546	-$54	$600
35 60	Printing and binding		$100	$6	$94
55 20	Supplies all other		$14,705	$3,040	$11,665
	Total		**$65,345**	**$35,372**	**$29,973**

FY13 Contributions to Date

FY12 Carryover		$15,038
Cumberland County		$33,307
Healthy Maine Partnerships		$8,000
Mercy		$5,000
CarePartners/MaineHealth		$4,000
Total		**$65,345**