Western Public Health District

District Public Health Improvement Plan

2017 – 2019

Western District Coordinating Council for Public Health

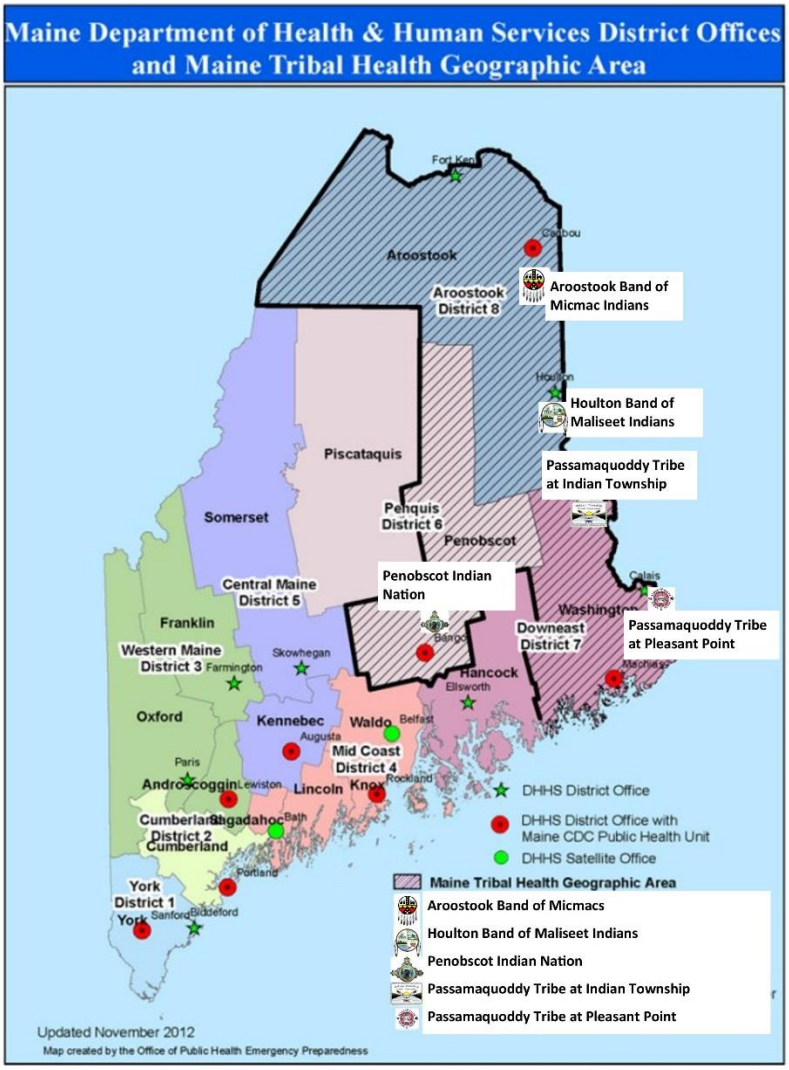
Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Maine's Public Health Districts



Western Public Health District

The Western Maine Public Health District includes three counties, Androscoggin, Franklin and Oxford, all located in western Maine, with Oxford county bordering New Hampshire. The district population is 195,376 people spread over 4,271 square miles, which results in a population density of 46 people per square mile (Maine Shared Community Health Needs Assessment, 2015; U.S. Census Bureau, 2010 Census). Of the three counties Androscoggin is smallest geographically with 459 square miles but the largest in population, 107,604 people. Oxford county is larger in size with 2,023 square miles than

Androscoggin but has a much smaller population, 57, 277 people. Oxford county is larger in both aspects compared to Franklin county. Franklin county has a population of 30,495 people and an area of 1,789 square miles (Maine Shared Community Health Needs Assessment, 2015; U.S. Census Bureau, 2010 Census). There are 71 municipalities within the district including cities, towns, and unincorporated townships (http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district3/index.shtml, 2013). The largest municipalities, in terms of population, in each county are Lewiston, Paris and Farmington in Androscoggin, Oxford and Franklin county, respectively (U.S. Census Bureau, 2010 Census). Clearly the Western District has a range of metropolitan areas including the larger cities of Lewiston and Auburn in Androscoggin county to rural areas consisting of small towns and townships throughout Oxford and Franklin County. This variety of communities spread across the district bring many health issues that can require unique health improvement strategies.

Western District Coordinating Council

Mission Statement: *Through collaborative assessment and coordinated planning, the Western Maine District Coordinating Council will maximize Oxford, Franklin, and Androscoggin County resources to advance the delivery of the 10 essential public health services.*

Leadership: Steering Committee for 2016 - 2017		
Name	**Leadership**	**Organization**
James Douglas	Chair	Healthy Oxford Hills
Michele McCormick	Vice Chair	Franklin Community Health Network
Jennifer McCormack	Committee Member	Healthy Community Coalition of Greater Franklin County
Patricia Duguay	Committee Member	River Valley Healthy Communities Coalition
Erin Guay	Committee Member	Healthy Androscoggin
Jamie Paul	District Liaison	Maine Centers for Disease Control and Prevention

Council Members as of 2016 who contributed to this plan		
James Douglas	Michele McCormick	
Patricia Duguay	Kim Preble	
Erin Guay		
Steven Johndro		
Cynthia Rice		
Kenneth Albert		

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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

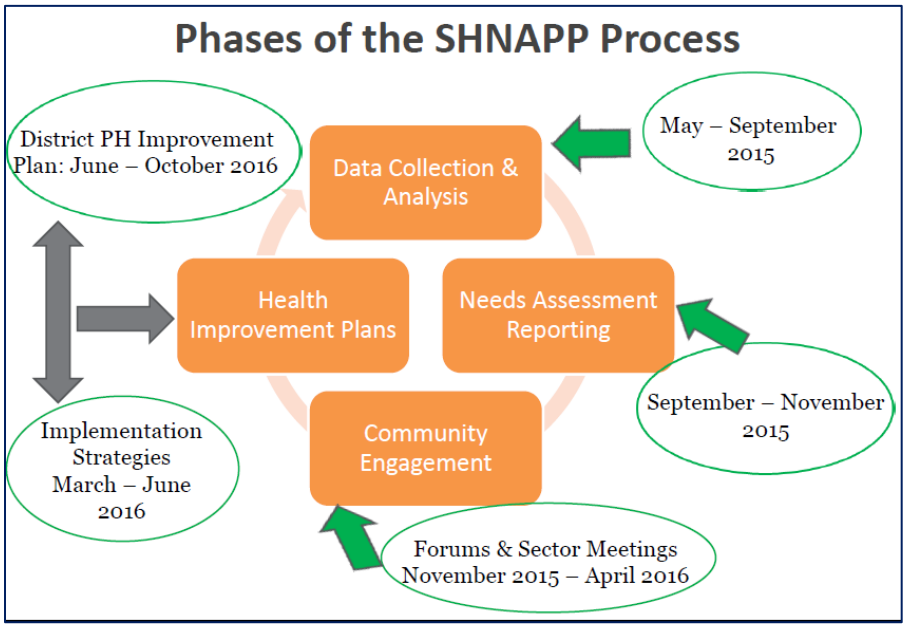
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health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

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.

Within the Western District the community engagement process consisted of seven community forums. Two in Androscoggin county, two in Franklin county and three in Oxford county. The total attendance of all seven forums was 270 people. There were nineteen smaller community events with a total attendance of 606. For the entire Western district, the total number of participants for all community engagement proceedings was 876. Based on the SHNAPP data presented throughout the community engagement process thirteen health issues were identified as priorities. Most priorities were consistent across all three countries, but some were significant only to one or two counties. The complete list:

1. Substance Use Disorder*
2. Mental Health/Depression*
3. Obesity/Physical Activity/Nutrition*
4. Access to Healthcare
5. Aging
6. Child Abuse/Neglect/Exposure to Parental Drug Use *
7. Chronic Diseases *
8. Diabetes
9. Drug Affected Babies
10. Lead Poisoning *
11. Oral Health/Dental Care *
12. Physical Disabilities
13. Poverty
14. STDs
15. Suicide

In addition to the priorities recognized in the community engagement summaries the DPHIP subcommittee, a small planning group formed from Western DCC members,

included priorities from district hospital implementation strategies. The * next to seven priorities indicate the aforementioned priorities. These priorities complemented health issues identified in the community engagement process. The use of this additional information supported trends from the community engagement summaries.

Of the 13 only three issues were unanimously identified as priorities in all three counties (the entire district) and the majority of district hospitals. Those three were Substance Use Disorder, Mental Health/Depression, and Obesity/Physical Activity/Nutrition. Undoubtedly, these three health issues are clear priorities across the whole Western district

The Western District Coordinating Council used the community engagement summaries and district hospital implementation strategies to select three final priorities for this plan. The priorities selection process started at the District Coordinating Council meeting held on Friday September 16, 2016. Over the following month the DPHIP subcommittee met regularly to continue refining the selection process starting with a conference call on Tuesday September 6, 2016. That meeting necessitated a smaller group meeting to develop the specifics of the selection process. The smaller subset met in Norway at Healthy Oxford Hills on Tuesday September 20, 2016. The conclusions of that meeting were reported back to the DPHIP subcommittee conference call the next week, Wednesday September 28th. The small subset had agreed that three health issues were clearly priorities throughout the entire district, Substance Use Disorder, Mental Health/Depression, and Obesity/Physical Activity/Nutrition. All three county's community engagement activities selected these three issues as well as the majority of district hospitals in their implementation strategies. Before the October 14th DCC meeting the DPHIP subcommittee met once more to finalize the selection process. The DPHIP subcommittee decided to present the top three health issues to the District Coordinating Council and suggest these should be the DPHIP priorities.

On the October 14th DCC meeting the DPHIP committee presented the proposal to select the top three district wide health issues as priorities for the DPHIP. The DCC seemed in favor of this idea. There were two suggestions regarding the entire list of district priorities. One being the list should include two additional priorities that are not directly viewed as health issues but can have significant impacts on population health, those two priorities are poverty and access to health care. The DCC agreed to include those two additional health topics. The other suggestion was to include the total priorities list in the DPHIP. Mentioning that these issues are seen as priorities within in the Western District will assist partner organizations in demonstrating the importance of their work towards any of these priorities because it is an issue recognized in the District Public Health Improvement Plan. The DPHIP will not designate objectives and strategies towards these additional health issues, simply recognize that they are issues within the Western District for Public Health.

In addition to selecting the three health priorities for the DPHIP, strategic approaches was discussed at the October DCC meeting. The DPHIP committee suggested using one unifying approach to address all three health priorities. One topic that was brought up was Adverse Child Experiences (ACEs). Many DCC members have been working with this idea for some time, within the Western DCC there is substantial experience and knowledge. Many other members voiced their support of addressing ACEs as a preventative effort to reduce negative health outcomes in adults, specifically substance use disorder, mental illness and obesity.

The DPHIP subcommittee continued meeting regularly, once on October 19th and after the November DCC meeting on November 20, 2016. The entire DCC met on November 18, 2016 to discuss goals, objectives and strategies. The direction of the discussion was led by the DPHIP committee. The criteria below were presented during this meeting and used to guide the development of DPHIP goals, objectives and strategies.

All the districts were presented with a set of criteria based on the Collective Impact framework. The Western District used the following criteria

- **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.
- **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 is more 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 (include 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.

  Notes from the November DCC meeting were collected by the District Coordinator. Based on the notes a draft of goals, objectives and strategies was created and presented to the DPHIP committee. This committee discussed and refined the draft during a conference call on November 29, 2016. The finalized draft was presented to the whole DCC on December 9, 2016 for approval.

Western District Public Health Improvement Plan

Community Health Improvement Priorities

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

- Substance Use Disorder
- Mental Health/Depression
- Obesity/Physical Activity/Nutrition

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.

Western District Health Secondary Priorities

The following health issues were identified as priorities during the community engagement activities across the Western District. The Western District Coordinating Council recognizes the issues are priorities but did not select them as the top three priorities of this plan.

- Access to Healthcare
- Aging
- Child Abuse/Neglect/Exposure to Parental Drug Use
- Chronic Diseases
- Diabetes
- Drug Affected Babies
- Lead Poisoning
- Oral Health/Dental Care
- Physical Disabilities
- Poverty
- STDs
- Suicide

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: Substance Use Disorder

Priority: Substance Use Disorder			
Description/Rationale/Criteria: Substance Use Disorder was selected as a priority area because it was identified as important across several sectors of the Western District. All three county's community engagement activities (forums and events) as well as the majority of the district hospital's highlighted Substance Use Disorder as a top priority. Additionally, Western District community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 identified alcohol and drug use as one of the top five health issues. Substance Use Disorder is a complex health issue, the DCC has recognized a need to focus on the underlying cause. The DCC sees value in taking a proactive approach to prevent Substance Use Disorder and expand the view of Substance Use Disorder.			
Goals	Objectives	Strategies	District Partners
1. Promote education and reduce substance use disorder by addressing root causes of substance use disorder.	1.1 By 2018 increase awareness of existing and needed resources for the general public and providers throughout the district.	1.1.A Complete an inventory and gap analysis. 1.1.B Distribute district-wide inventory to district partners by 2019.	Mental Health services providers Healthy Community Coalitions ACEs trainers Maine Resilience Building Network School Districts Hospitals Community Service Agencies Oxford County Wellness Collaborative United Way Child Abuse and Neglect Councils
	1.2 Increase number of DCC members, organizations, providers and community members educated about root causes of substance use disorder by 2019.	1.2.A Increase number of trainings and educational opportunities offered in district on a root cause of substance use disorder.	
	1.3 By 2019 increase education of ACEs screenings for Substance use disorder.	1.3.A Assess substance use disorder providers who are currently using an evidence based tool to screen for ACEs by 2018. 1.3.B Increase the number of substance use disorder providers using evidence based tool by 2019.	
	1.4 By 2019 increase awareness of social service providers regarding tools and strategies that build resiliency.	1.4.A Increase number of opportunities for social service provider's education in becoming trauma informed (ACEs) and building resiliency by 2019.	

Priority Area 1: Substance Use Disorder (continued)

Priority: Substance Use Disorder			
Description/Rationale/Criteria: Substance Use Disorder was selected as a priority area because it was identified as important across several sectors of the Western District. All three county's community engagement activities (forums and events) as well as the majority of the district hospital's highlighted Substance Use Disorder as a top priority. Additionally, Western District community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 identified alcohol and drug use as one of the top five health issues. Substance Use Disorder is a complex health issue, the DCC has recognized a need to focus on the underlying cause. The DCC sees value in taking a proactive approach to prevent Substance Use Disorder and expand the view of Substance Use Disorder.			
Goals	Objectives	Strategies	District Partners
1. Promote education and reduce substance use disorder by addressing root causes of substance use disorder.	1.5 Support alignment and collaboration of existing and developing resources that address a root cause of substance use disorder by 2019.	1.5.A Conduct district-wide inventory of identified best practices, emerging and evidence informed strategies by 2019. 1.5.B Develop a district wide plan to address district wide resource gaps. 1.5.C Distribute district wide resource directory to district partners by 2019.	Mental Health services providers Healthy Community Coalitions ACEs trainers Maine Resilience Building Network School Districts Hospitals Community Service Agencies Oxford County Wellness Collaborative United Way Child Abuse and Neglect Councils

Priority Area 2: Mental Health/Depression

<table>
<tr><td colspan="4">Priority: Mental Health/Depression</td></tr>
<tr><td colspan="4">Description/Rationale/Criteria: Mental Health and Depression are a priority area because both were identified as important across several sectors of the Western District. All three county's community engagement activities (forums and events) as well as the majority of the district hospital's listed Mental Health and/or Depression as top priorities. Additionally, Western District community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 identified both Mental Health and Depression as two of the top five health issues. Since Mental Health is clearly a large and important issue across the District the DCC has recognized a need to focus on the underlying cause of mental illness. The DCC sees value in taking a proactive approach to prevent poor mental health outcomes.</td></tr>
<tr><td>Goals</td><td>Objectives</td><td>Strategies</td><td>District Partners</td></tr>
<tr><td rowspan="2">1. Reduce the impact of mental illness and depression.</td><td>1.1 Enhance coordination of district-wide mental health and depression services.</td><td>1.1.A Increase collaboration between behavioral health and primary care providers through the adoption of integration models such as Behavioral Health Homes and Community Care Teams by 2019.</td><td rowspan="2">Mental Health

Services providers

School Districts

Hospitals

Community Service Agencies

Federally Qualified Health Centers

United Way

Agencies on Aging

NAMI Maine

Employee Assistance Programs

ACEs trainers

Child Abuse and Neglect Councils</td></tr>
<tr><td>1.2 Increase awareness of mental illness and depression throughout Western District as a means to reduce stigma.</td><td>1.2.A Convene community forums throughout all three counties in district to educate the public on key issues contributing to the stigma of mental illness such as negative stereotypes, social distancing, and exclusionary behaviors of persons with mental illness by 2019.</td></tr>
</table>

Priority Area 3: Healthy Weight, Physical Activity and Nutrition

Priority: Obesity/Physical Activity/Nutrition			
Description/Rationale/Criteria: Healthy Weight, Physical Activity and Nutrition were selected as a priority area because all three were identified as important across several sectors of the Western District. All three county's community engagement activities (forums and events) as well as the majority of the district hospitals listed either obesity, physical activity, nutrition or all three as top priorities. Additionally, Western District Community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 list obesity and physical activity with nutrition as two of the top five health issues. Since obesity is clearly a large and important issue across the District the DCC has recognized a need to focus on the underlying cause of unhealthy weight and obesity. The DCC sees value in taking a proactive approach to prevent poor health outcomes.			
Goals	Objectives	Strategies	District Partners
1. Reduce obesity among Western District residents by addressing root causes of obesity, physical inactivity and poor nutrition.	1.1 Increase regular physical activity among Western District residents by 2019.	1.1.A Increase the opportunities for low cost/no cost physical activity throughout district by 2019. 1.1.B Increase awareness of physical activity opportunities throughout district by 2019.	Hospitals Healthy Community Coalitions School Districts Community Service Agencies Oxford County Wellness Collaborative United Way University of New England Hospitals Employee Assistance Programs Western Maine Community Action (WIC)
	1.2 Increase the awareness of social service professionals on the potential of ACEs to impact unhealthy weight and obesity.	1.2.A Assess current educational opportunities on ACEs as a root cause of obesity for professionals by 2018. 1.2.B Provide educational opportunities for professionals on the adverse health effects of ACEs with a focus on obesity and unhealthy weight.	
	1.3 Increase participation in WIC by 2019.	1.3.A Collaborate with WIC to increase enrollment in program.	

Priority Area 3: Healthy Weight, Physical Activity and Nutrition (continued)

Priority: Obesity/Physical Activity/Nutrition			
Description/Rationale/Criteria: Healthy Weight, Physical Activity and Nutrition were selected as a priority area because all three were identified as important across several sectors of the Western District. All three county's community engagement activities (forums and events) as well as the majority of the district hospitals listed either obesity, physical activity, nutrition or all three as top priorities. Additionally, Western District Community stakeholders and health professionals surveyed as part of the Maine Shared Community Health Needs Assessment in 2015 list obesity and physical activity with nutrition as two of the top five health issues. Since obesity is clearly a large and important issue across the District the DCC has recognized a need to focus on the underlying cause of unhealthy weight and obesity. The DCC sees value in taking a proactive approach to prevent poor health outcomes.			
Goals	Objectives	Strategies	District Partners
1. Reduce obesity among Western District residents by addressing root causes of obesity, physical inactivity and poor nutrition.	1.4 Increase awareness and participation in Farmer's Market Harvest Bucks Program by 25% by 2019.	1.4.A Increase collaboration and communication among all participating farmers in the Western District by 2018. 1.4.B Convene an annual gathering of farmers' market participants and stakeholders, looking for efficiencies, cost savings and capacity building.	Hospitals Healthy Community Coalitions School Districts Community Service Agencies Oxford County Wellness Collaborative United Way University of New England Hospitals Employee Assistance Programs Western Maine Community Action (WIC)
	1.5 Increase healthy lifestyle choices made by college aged students in the Western District by 2019.	1.5.A Offer education on college campuses on the potential of ACEs to affect unhealthy weight/body image by 2019. 1.5.B Provide opportunities for college students to participate in Cooking Matters/Healthy Cooking on a Budget Classes.	

Appendices

1. **Western 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 Western District Coordinating Council, please contact Jamie Paul, District Liaison, at jamie.l.paul@maine.gov or Council Chair James Douglas at jim@healthyoxfordhills.org.

Appendix 1: Western District Health Profile 2015-2016

Maine Shared Community Health Needs Assessment
District Summary: 2015

Western District

Updated: October 2015

Qualitative Stakeholder Input

A survey of 185 health professionals and community stakeholders in the Western Public Health District 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 the District resulting in poor health outcomes for residents.

Top five health issues

- Drug and alcohol abuse
- Mental health
- Obesity
- Physical activity and nutrition
- Depression

Top five health factors

- Poverty
- Transportation
- Employment
- Health care insurance
- Access to behavioral care/mental health care

Maine Shared CHNA Health Indicators	Year	Western	Androscoggin	Franklin	Oxford	Maine	U.S.
Demographics							
Total Population	2013	195,376	107,604	30,495	57,277	1,328,302	319 Mil
Population – % ages 0-17	2013	20.9%	22.2%	18.7%	19.8%	19.7%	23.3%
Population – % ages 18-64	2013	62.1%	62.4%	62.6%	61.4%	62.6%	62.6%
Population – % ages 65+	2013	16.9%	15.5%	18.7%	18.8%	17.7%	14.1%
Population – % White	2013	94.8%	93.0%	97.2%	97.0%	95.2%	77.7%
Population – % Black or African American	2013	2.3%	3.8%	0.4%	0.4%	1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.4%	0.4%	0.4%	0.4%	0.7%	1.2%
Population – % Asian	2013	0.7%	0.7%	0.6%	0.6%	1.1%	5.3%
Population – % Hispanic	2013	1.5%	1.7%	1.2%	1.2%	1.4%	17.1%
Population – % with a disability	2013	16.6%	15.8%	17.9%	17.5%	15.9%	12.1%
Population density (per square mile)	2013	NA	230.2	18.1	27.8	43.1	87.4
Socioeconomic Status Measures							
Adults living in poverty	2009-2013	15.4%	*15.6%*	15.6%	14.9%	13.6%	15.4%
Children living in poverty	2009-2013	22.3%	*23.8%*	19.9%	20.4%	18.5%	21.6%
High school graduation rate	2013-2014	84.0%	80.6%	89.6%	86.5%	86.5%	81.0%
Median household income	2009-2013	NA	*$44,921*	*$41,626*	*$40,674*	$48,453	$53,046
Percentage of people living in rural areas	2013	61.8%	30.4%	100.0%	100.0%	66.4%	NA
Single-parent families	2009-2013	39.8%	41.5%	39.4%	36.0%	34.0%	33.2%
Unemployment rate	2014	6.1%	5.5%	6.6%	7.0%	5.7%	6.2%
65+ living alone	2009-2013	39.0%	42.2%	31.8%	37.3%	41.2%	37.7%
General Health Status							
Adults who rate their health fair to poor	2011-2013	16.8%	16.8%	15.9%	17.3%	15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	12.7%	13.5%	11.9%	11.8%	12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	13.6%	13.2%	14.1%	13.9%	13.1%	NA
Adults with three or more chronic conditions	2011, 2013	*30.9%*	31.5%	29.9%	30.5%	27.6%	NA
Mortality							
Life expectancy (Female)	2012	NA	80.4	80.7	81.1	81.5	81.2
Life expectancy (Male)	2012	NA	75.7	77.2	76.4	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*785.2*	*789.0*	758.0	*794.2*	745.8	731.9

Maine Shared CHNA Health Indicators	Year	Western	Androscoggin	Franklin	Oxford	Maine	U.S.
Access							
Adults with a usual primary care provider	2011-2013	88.0%	89.7%	87.8%	85.4%	87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	11.9%	10.9%	12.8%	13.0%	11.0%	15.3%
MaineCare enrollment	2015	32.7%	32.9%	27.8%	34.7%	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	49.6%	49.7%	42.8%	53.2%	41.8%	48.0%
Percent uninsured	2009-2013	10.4%	*9.5%*	11.6%	*11.8%*	10.4%	11.7%
Health Care Quality							
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,611.6*	1,466.0	*1,741.7*	*1,807.0*	1,499.3	1458
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*4,567.9*	*4,060.6*	4,301.9	*5,639.7*	4,258.8	NA
Oral Health							
Adults with visits to a dentist in the past 12 months	2012	61.7%	61.9%	58.5%	63.0%	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	51.9%	51.0%	56.2%	51.8%	55.1%	NA
Respiratory							
Asthma emergency department visits per 10,000 population	2009-2011	*75.9*	*81.8*	*58.0*	*73.9*	67.3	NA
COPD diagnosed	2011-2013	*9.0%*	9.1%	9.0%	8.8%	7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	*254.8*	237.1	264.8	*277.3*	216.3	NA
Current asthma (Adults)	2011-2013	11.8%	13.0%	12.7%	9.3%	11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	6.6%†	5.3%†	9.8%†	7.0%†	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	*829.4*	692.4	*611.1*	*1,166.0*	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	*372.2*	338.1	*420.5*	*404.4*	329.4	NA
Cancer							
Mortality – all cancers per 100,000 population	2007-2011	193.4	195.5	182.9	196.4	185.5	169
Incidence – all cancers per 100,000 population	2007-2011	492.9	501.3	*452.9*	500.9	500.1	453
Bladder cancer incidence per 100,000 population	2007-2011	30.0	30.9	31.2	27.8	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	20.0	19.4	18.0	22.4	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	36.4	34.4	35.9	40.7	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	114.6	111.8	118.4	117.9	126.3	124
Mammograms females age 50+ in past two years	2012	81.8%	82.3%	81.4%	81.1%	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	16.7	15.0	*24.8*	15.7	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	20.9	19.0	21.4	24.0	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	42.1	40.9	45.6	43.0	43.5	42.0
Colorectal screening	2012	73.3%	71.5%	69.6%	77.7%	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	59.3	61.1	55.6	59.2	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	79.0	83.9	67.6	78.0	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*17.7*	*15.3*	16.1	22.8	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	89.0%	*94.3%*	NA	81.4%	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	19.1	20.7	18.6	17.4	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	133.8	139.3	133.8	126.1	133.8	141
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	41.7	42.8	31.9	44.9	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	94.6	97.0	82.3	96.6	91.9	81.7
Cardiovascular Disease							
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*21.7*	22.8	20.6	*20.3*	23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	30.5	30.2	36.4	27.8	32.2	32.4
Cholesterol checked every five years	2011. 2013	82.6%	*85.0%*	79.3%	80.5%	81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	97.2	*101.0*	82.0	98.5	89.8	103
Heart failure hospitalizations per 10,000 population	2010-2012	22.4	23.1	24.4	20.2	21.9	NA

Maine Shared CHNA Health Indicators	Year	Western	Androscoggin	Franklin	Oxford	Maine	U.S.
Hypertension prevalence	2011, 2013	34.9%	37.0%	30.6%	33.8%	32.8%	31.4%
High cholesterol	2011, 2013	42.3%	41.0%	44.6%	43.2%	40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	24.0	33.1	*15.3*	*13.0*	28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	19.5	20.4	22.7	*16.7*	20.8	NA
Stroke mortality per 100,000 population	2009-2013	33.3	34.0	38.0	30.0	35.0	36.2
Diabetes							
Diabetes prevalence (ever been told)	2011-2013	10.6%	11.5%	9.1%	10.0%	9.6%	9.7%
Pre-diabetes prevalence	2011-2013	5.9%	5.4%	4.7%†	7.2%	6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	69.4%	69.9%	NA	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	87.8%	87.6%	NA	89.3%	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	70.4%	74.0%	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	57.6%	NA	NA	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	262.3	236.2	236.8	*327.1*	235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	*14.3*	*13.7*	*18.1*	13.6	11.7	NA
Diabetes long-term complication hospitalizations	2011	*72.9*	*77.2*	*80.3*	60.9	59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	*24.6*	24.2	23.9	25.6	20.8	21.2
Environmental Health							
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	*3.7%*	*4.7%*	2.3%	2.3%	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	*5.6%*	*5.4%*	4.7%	*6.5%*	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	38.5%	44.5%	*26.7%*	37.5%	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*57.0%*	*51.1%*	*70.9%*	*63.9%*	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	*37.0%*	*29.1%*	*52.8%*	*47.6%*	27.6%	NA
Immunization							
Adults immunized annually for influenza	2011-2013	40.1%	42.8%	37.0%	37.5%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	73.1%	75.8%	74.5%	68.6%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	3.9%	3.4%	4.2%	5.3%	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	NA	81.0%	NA	75.0%	NA
Infectious Disease							
Hepatitis A (acute) incidence per 100,000 population	2014	0.0†	0.0†	0.0†	0.0†	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	1.0†	0.9†	3.3†	0.0†	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	2.6†	3.7†	0.0†	1.7†	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	87.7	90.3	82.5	85.6	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	10.8	16.8†	9.9†	0.0†	8.1	NA
Lyme disease incidence per 100,000 population	2014	74.9	87.5	33.0†	73.4	105.3	10.5
Pertussis incidence per 100,000 population	2014	52.8	34.4	165.0	28.0†	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	2.1†	3.7†	0.0†	0.0†	1.1	3.0
STD/HIV							
AIDS incidence per 100,000 population	2014	1.0†	1.9†	0.0†	0.0†	2.1	8.4
Chlamydia incidence per 100,000 population	2014	365.2	485.9	214.5	218.4	265.5	452
Gonorrhea incidence per 100,000 population	2014	38.0	63.3	16.5†	1.7†	17.8	110
HIV incidence per 100,000 population	2014	1.5†	2.8†	0.0†	0.0†	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	23.8	24.3	21.6	23.9	21.4	NA
Syphilis incidence per 100,000 population	2014	2.1†	3.7†	0.0†	0.0†	1.6	19.9
Intentional Injury							
Domestic assaults reports to police per 100,000 population	2013	545.1	608.1	540.6	429.4	413.0	NA
Firearm deaths per 100,000 population	2009-2013	8.3	7.2	8.9†	10.1	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	NA	NA	11.3%	NA

Maine Shared CHNA Health Indicators	Year	Western	Androscoggin	Franklin	Oxford	Maine	U.S.
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	34.8	33.5	19.7†	45.4	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	13.1	13.5	9.9†	14.0	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	138.3	161.1	131.1	99.5	125.0	368
Unintentional Injury							
Always wear seatbelt (Adults)	2013	83.0%	85.1%	81.9%	80.1%	85.2%	NA
Always wear seatbelt (High School Students)	2013	59.6%	61.3%	NA	*56.9%*	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*70.4*	76.5	71.5	*58.4*	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	9.8	11.9	6.9†	7.5	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	7.1	6.3	7.2†	8.3	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*431.1*	*436.4*	*431.0*	*421.9*	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	13.4	11.2	17.7	15.4	10.8	10.5
Occupational Health							
Deaths from work-related injuries (number)	2013	NA	NA	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	1,605.0	1,059.0	145.0	401.0	13,205.0	NA
Mental Health							
Adults who have ever had anxiety	2011-2013	18.9%	20.9%	17.4%	16.7%	19.4%	NA
Adults who have ever had depression	2011-2013	24.8%	*27.0%*	22.5%	22.3%	23.5%	18.7%
Adults with current symptoms of depression	2011-2013	10.7%	11.4%	9.8%	10.2%	10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	17.3%	20.8%	14.0%	*13.8%*	17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	*45.6%*	44.4%	NA	43.4%	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	*2,210.7*	*2,523.6*	*1,568.5*	1,948.9	1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	26.6%	25.6%	NA	27.2%	24.3%	29.9%
Seriously considered suicide (High School Students)	2013	15.3%	14.7%	NA	15.9%	14.6%	17.0%
Physical Activity, Nutrition and Weight							
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	*14.9%*	15.9%	NA	*13.8%*	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	37.9%	38.9%	37.8%	36.3%	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	51.1%	50.3%	55.5%	49.9%	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	39.9%	*38.7%*	NA	41.4%	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	24.0%	24.2%	23.8%	23.9%	22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	28.2%	28.2%	NA	*28.4%*	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	18.6%	19.8%	21.0%	15.3%†	17.9%	22.9%
Obesity (Adults)	2013	33.5%	*37.9%*	29.0%	28.4%	28.9%	29.4%
Obesity (High School Students)	2013	*16.0%*	16.0%	NA	15.7%	12.7%	13.7%
Overweight (Adults)	2013	35.3%	33.4%	35.0%	39.0%	36.0%	35.4%
Overweight (High School Students)	2013	17.0%	17.0%	NA	16.7%	16.0%	16.6%
Pregnancy and Birth Outcomes							
Children with special health care needs	2009-2010	NA	NA	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	6.8	7.1	6.9	6.0	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	88.5%	89.2%	84.4%	88.7%	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	*27.3*	*31.7*	21.8	22.8	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	7.5%	7.7%	7.7%	6.8%	6.6%	8.0%

Maine Shared CHNA Health Indicators	Year	Western	Androscoggin	Franklin	Oxford	Maine	U.S.
Substance and Alcohol Abuse							
Alcohol-induced mortality per 100,000 population	2009-2013	8.6	10.0	7.5†	6.8	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	14.5%	13.2%	NA	16.6%	14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	16.2%	15.4%	18.0%	16.6%	17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	6.2%	5.4%	7.5%	6.8%	7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	7.5%	8.5%	2.8%	7.5%	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	NA	12.6	NA	8.0	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	264.1	243.9	217.9	326.7	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	*18.8*	20.0	18.7	16.7	25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	10.8	10.5	8.8	12.5	13.2	NA
Past-30-day alcohol use (High School Students)	2013	25.6%	23.6%	NA	28.5%	26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.0%	2.7%	NA	3.2%	3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	7.8%	8.9%†	4.9%†	8.0%†	8.2%	NA
Past-30-day marijuana use (High School Students)	2013	22.5%	18.9%	NA	*26.8%*	21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	0.8%†	0.6%†	NA	1.7%†	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	5.5%	4.7%	NA	6.3%	5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	7.3	7.0	6.8	8.0	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*399.8*	*516.4*	*205.9*	279.6	328.1	NA
Tobacco Use							
Current smoking (Adults)	2011-2013	24.4%	24.4%	20.3%†	26.8%	20.2%	19.0%
Current smoking (High School Students)	2013	12.6%	10.7%	NA	14.3%	12.9%	15.7%
Current tobacco use (High School Students)	2013	18.3%	16.1%	NA	21.1%	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	*45.0%*	42.1%	NA	*48.1%*	38.3%	NA

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

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

† Results may be statistically unreliable due to small numerator, use caution when interpreting.