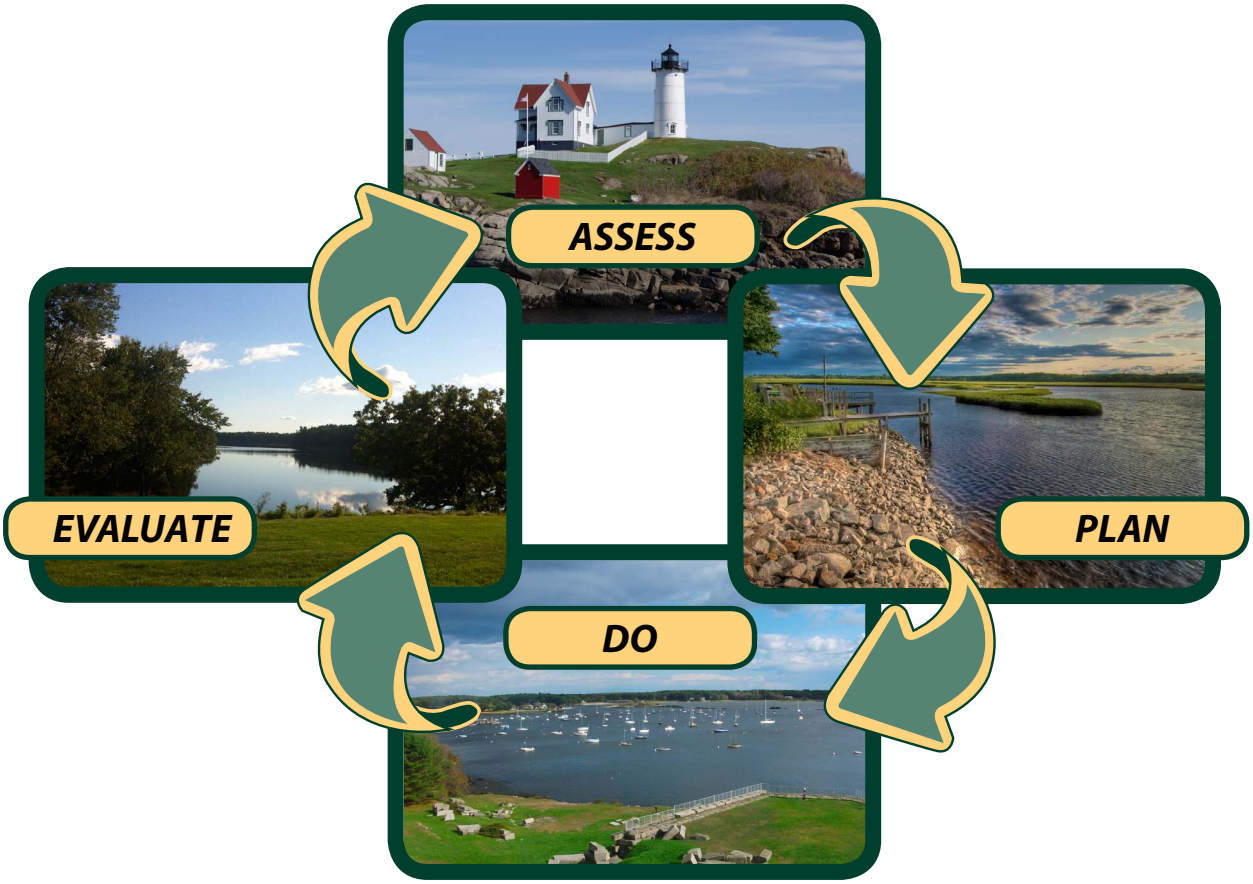
York Hospital

Community Health Needs Assessment and Action Plan

December 2015



COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

AND ACTION PLAN

December 2015

Contents

Executive Summary

York Hospital continues our long history of caring about the health of those living in Southern York County Maine by conducting and publishing our 2015 Community Health Needs Assessment Report and Action Plan. As a nonprofit hospital we maintain a dual purpose - to provide high quality health services to care for all, and to improve the health of those living in our service area community. We have gathered both health data and community member input about local health issues. We have then used this information to identify priority health issues and to propose and plan activities to address them. Our 2015 Community Health Improvement Action Plan reflects this dual purpose, proposing 2 levels of interventions to address identified priorities – the treatment level and the community/population health level.

We want to thank the Maine Shared Health Needs Assessment & Planning Process partners - Central Maine Healthcare, Eastern Maine Healthcare, Maine General Health, MaineHealth, and the Maine Center for Disease Control and Prevention, for providing their county and statewide data and findings for use by York Hospital in our assessment and planning process. Additionally, we thank our partner, the Choose to Be Healthy Coalition, for helping us to engage diverse community stakeholders in this process.

Process

Between October and December 2015, York Hospital undertook a community health needs assessment (CHNA) to identify the health needs of those living in the hospital's entire service area. The assessment updated one completed in June of 2013 and included the Southern Maine towns of Berwick, Eliot, Kittery, Lebanon, North Berwick, Ogunquit, South Berwick, Wells, and York. The hospital partnered with the Choose to Be Healthy Coalition (CTBH), a comprehensive community health coalition. CTBH has a membership purposefully comprised of those representing diverse community sectors such as education, law enforcement, behavioral health care, social service agencies, municipalities, business, etc. We have found that the involvement of these diverse perspectives is necessary to engage in successful health improvement initiatives.

Guiding the process was the perspective articulated by the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps initiative, that much of what influences health outcomes happens outside of the health care system. These influential factors include poverty, level of education, behavioral health status, age, and social connectedness, among others. Members of CTBH represent populations in our service area with disparate health outcomes including those with low-incomes, the elderly, and the mentally ill. Additionally, elements of the

National Association of City and County Health Officials' community health planning process were used. Specifically, community stakeholders identified a Vision for a Healthy Community and a list of Community Values, and a Community Themes & Strengths Survey was conducted.

Data

Most quantitative data was sourced from the 2015 Maine Shared Health Needs Assessment & Planning Process, which gathered data from multiple secondary sources including the US Census, the Maine Behavioral Risk Factor Surveillance System, the Maine Integrated Youth Health Survey, and several State of Maine departments, among others. Demographic and socio-economic data was sourced from the 2014 American Community Survey. A chart of data sources may be found in the appendices. The following quantitative data was gathered:

- Demographic and socio-economic factors
- Health care access
- Health status
- Disease incidence and prevalence
- Health behaviors and risk factors

Qualitative data came from:

- Two focus groups
- Community Themes & Strengths online survey
- A Community Engagement Forum

Community Engagement

The CTBH Advisory Board provided community guidance of the process within its regular bi-monthly meetings. This group reviewed and amended both the *Community Vision for a Healthy Southern York County* and a list of *Community Values*. Additionally the group reviewed and considered demographic, socioeconomic, disease incidence, and health behavior data to identify priority health issues.

Two focus groups were held with representatives of health-disparate populations. One group was of those 65+ years of age and the other was of those who are uninsured or underinsured. In addition, a Community Engagement Forum was held on December 14, 2015 to discuss three identified priorities, Substance Abuse, Mental Health, and Obesity.

To coordinate health planning activities, the York Hospital Director of Community Health participated on the statewide Community Engagement sub-committee of the Maine Shared

Health Needs Assessment & Planning Process. Needs Assessment activities were further coordinated with the York District Public Health Council that is responsible for drafting and implementing the York District Public Health Improvement Plan.

Recommendations

The Community Health Needs Assessment process identified and prioritized three health issues for action in the York Hospital service area: the rate of overweight & obesity, the number of opiate poisonings, and the percentage of current smokers. The following goals for action were set:

1. Lower the % of overweight and obese community members in the service area (from 64%) by the end of 2018. (This priority is continued from 2013 assessment report.)
2. Decrease the number of opiate poisoning (ED visits) per 100,000 population by 25% before the end of 2019; from 26.5% to 20%.
3. Reduce the percentage of York Hospital Primary Care patients who are current smokers by 5% by the end of 2019; from 20 % to 15%.

Choose To Be Healthy Coalition Advisory Board Members

Rev. Sudie Blanchard
Karen Boardman
Barb Bourgoine
Erin Dickson
Pat Endsley
Deborah Erickson-Irons
Ginger Lauritis
Maggie Norbert
Jack Moran
Michelle Surdoval
Linda White

More Thanks

York Hospital wishes to also thank Sue Patterson, Sally Manninen and Michelle Mason of the Choose To Be Healthy Coalition, and Sarah Trafton, FNP, for their assistance with this report.

Vision and Values

We envision a healthy Southern York County where:

- People's housing and food security needs are met.
- People's health care needs are met, including mental health services.
- People have access to affordable, quality education across the lifespan.
- There is a sense of belonging and community connectedness.
- People can attend to their spiritual needs .
- People have jobs with livable wages.
- The air, water, and land are clean and people take an active approach in sustaining them.
- Diverse neighborhoods exist.
- Recreational programs and spaces are accessible and supported by the community.
- There is a low crime rate and people feel safe.
- The social service safety net resources are available, accessible, and people are aware of them.
- Public transportation is in place and is utilized.
- Strong families exist and are well-supported.
- Across the age span, people feel secure and are part of the community.
- There are low rates of preventable disease.
- We have an active and engaged citizenry.
- Arts and culture are supported, thrive and are an integral part of community life.
- People are happy, fulfilled, and peaceful in their dealings with each other.

Community Values

Commitment to health
Diversity within communities
Equality
Integrity
Lifelong learning
Mutual respect
Peaceful negotiations
Personal self-determination
Supported families
Wellness

Population & Demographics

Demographic and socio-economic information shows how people in our service area live - for example income and education level, and housing and employment status. Since the census is conducted only once every ten years, we used the most recent (2014) American Community Survey (ACS) for much of the demographic and socio-economic data. The ACS is an estimated projection, conducted every year.

York County		
Total Population	200, 170	
Median Annual Household Income	$57,348	+
% Labor Force Unemployed	3.5%	=
% Population Not Attaining HS Diploma	8%	+
% Population on Medicaid	21.2%	>
% Population Under 19 Years	22.9%	+
% Population Between 20-44	28.9%	+
% Population Between 45-64	31.5%	+
% Population 65+	16.6%	+
Population By Race		
White	96.2%	+
Hispanic or Latino	1.5%	+
Asian	1.1%	+
American Indian and Alaska Native	0.3%	+
Black or African American	0.6%	+
Two or More Races	1.6%	+
% Uninsured	9.1%	+
% Uninsured Non-Elderly Adults (18-64)	12.8%	+
Veterans	18, 399	+

+ American Community Survey 2014, = US Bureau of Labor Statistics 2015, > Maine SHNAPP

Berwick	03901
Total Population	7,408
Median Annual Household Income	$64,309
% Not Attaining HS Diploma >25	7.5%
% Population HS Graduate	31.9%
% Population Bachelor's Degree+	28.2%
% Population Under 19 Years	24.4%
% Population Between 20-44	34.7%
% Population Between 45-64	29.1%
% Population 65+	11.7%
% 65+ and Living Alone	7.4%
% of Families Living in Poverty/ Below Poverty Level	4.6%
% Uninsured	8.9%
% of 65+ Living Below Poverty Level	6.7%

Eliot	03903
Total Population	6,234
Median Annual Household Income	$79,403
% Not Attaining HS Diploma >25	5.6%
% Population HS Graduate	28.7%
% Population Bachelor's Degree+	34.3%
% Population Under 19 Years	23.1%
% Population Between 20-44	28.3%
% Population Between 45-64	33.7%
% Population 65+	14.9%
% 65+ and Living Alone	11.7%
% of Families Living in Poverty/ Below Poverty Level	4.6%
% Uninsured	11.3%
% of 65+ Living Below Poverty Level	8.0%

Kittery	03904
Total Population	8,023
Median Annual Household Income	$59, 521
% Not Attaining HS Diploma >25	6.6%
% Population HS Graduate	27.7%
% Population Bachelor's Degree+	34.0%
% Population Under 19 Years	18.6%
% Population Between 20-44	31.6%
% Population Between 45-64	31.8%
% Population 65+	18.1%
% 65+ and Living Alone	13.4%
% of Families Living in Poverty/ Below Poverty Level	1.3%
% Uninsured	8.0%
% of 65+ Living Below Poverty Level	6.2%

Lebanon	04027
Total Population	6, 077
Median Annual Household Income	$62, 870
% Not Attaining HS Diploma >25	13.3%
% Population HS Graduate	41.6%
% Population Bachelor's Degree+	11%
% Population Under 19 Years	28%
% Population Between 20-44	28.3%
% Population Between 45-64	32.5%
% Population 65+	11%
% 65+ and Living Alone	6.6%
% of Families Living in Poverty/ Below Poverty Level	8.9%
% Uninsured	11.4%
% of 65+ Living Below Poverty Level	10.7%

North Berwick	03906
Total Population	4, 643
Median Annual Household Income	$72, 991
% Not Attaining HS Diploma >25	10.4%
% Population HS Graduate	34.8%
% Population Bachelor's Degree+	24.7%
% Population Under 19 Years	22.9%
% Population Between 20-44	30.7%
% Population Between 45-64	30.1%
% Population 65+	16.4%
% 65+ and Living Alone	7.2%
% of Families Living in Poverty/ Below Poverty Level	4.2%
% Uninsured	13.3%
% of 65+ Living Below Poverty Level	5.7%

Ogunquit	03907
Total Population	1, 141
Median Annual Household Income	$61, 750
% Not Attaining HS Diploma >25	1.3%
% Population HS Graduate	19%
% Population Bachelor's Degree+	54.8%
% Population Under 19 Years	10.2%
% Population Between 20-44	12.5%
% Population Between 45-64	37.6%
% Population 65+	40%
% 65+ and Living Alone	19.4%
% of Families Living in Poverty/ Below Poverty Level	4.4%
% Uninsured	4.6%
% of 65+ Living Below Poverty Level	3.5%

South Berwick	03908
Total Population	7, 276
Median Annual Household Income	$75, 341
% Not Attaining HS Diploma >25	4.6%
% Population HS Graduate	26.2%
% Population Bachelor's Degree+	39.8%
% Population Under 19 Years	28.8%
% Population Between 20-44	29.6%
% Population Between 45-64	30.7%
% Population 65+	10.9%
% 65+ and Living Alone	12.1%
% of Families Living in Poverty/ Below Poverty Level	5.7%
% Uninsured	7.5%
% of 65+ Living Below Poverty Level	17.0%

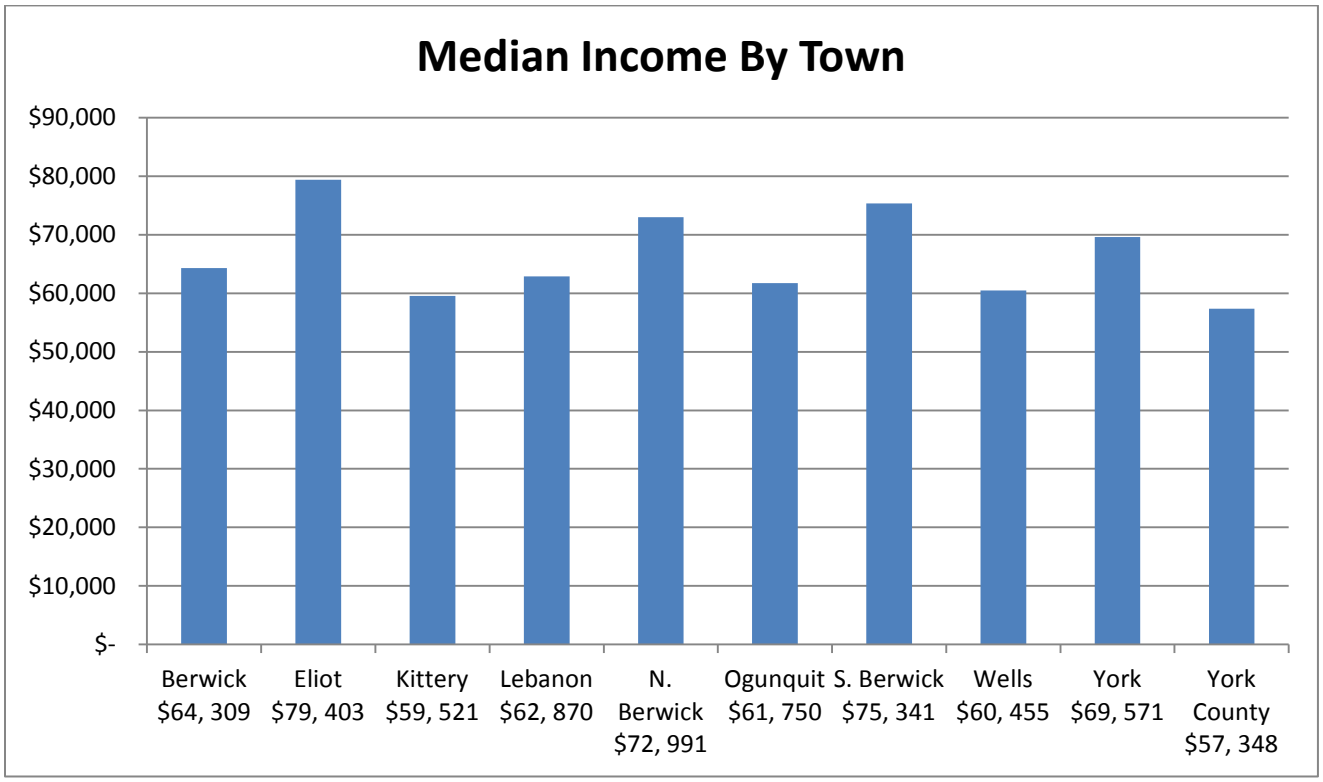
Wells	04090
Total Population	9,783
Median Annual Household Income	$60, 455
% Not Attaining HS Diploma >25	6.9%
% Population HS Graduate	27.4%
% Population Bachelor's Degree+	30.3%
% Population Under 19 Years	21.3%
% Population Between 20-44	19.7%
% Population Between 45-64	33.6%
% Population 65+	25.5%
% 65+ and Living Alone	15.7%
% of Families Living in Poverty/ Below Poverty Level	2.1%
% Uninsured	9.2%
% of 65+ Living Below Poverty Level	5.5%

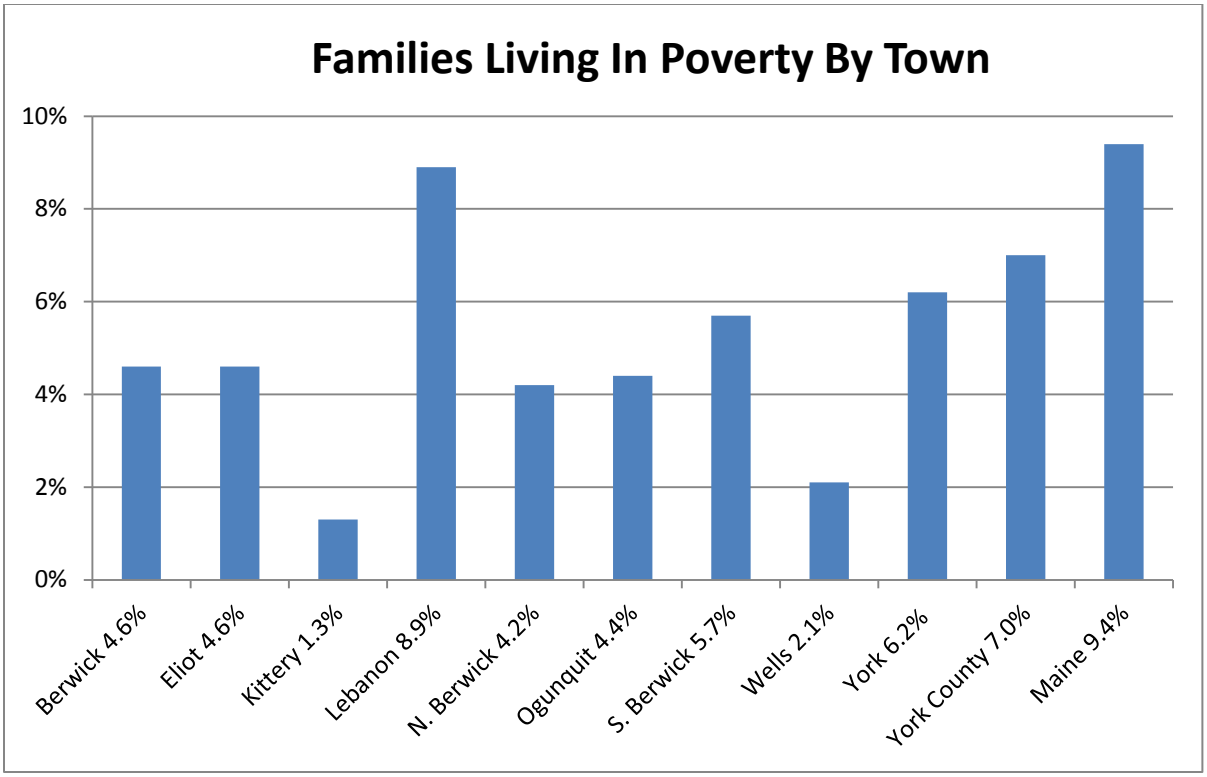
York	03909
Total Population	9, 792
Median Annual Household Income	$69, 571
% Not Attaining HS Diploma >25	2.4%
% Population HS Graduate	21%
% Population Bachelor's Degree+	48.7%
% Population Under 19 Years	18.9%
% Population Between 20-44	23%
% Population Between 45-64	35.8%
% Population 65+	22.3%
% 65+ and Living Alone	16.4%
% of Families Living in Poverty/ Below Poverty Level	6.2%
% Uninsured	6.3%
% of 65+ Living Below Poverty Level	5.8%

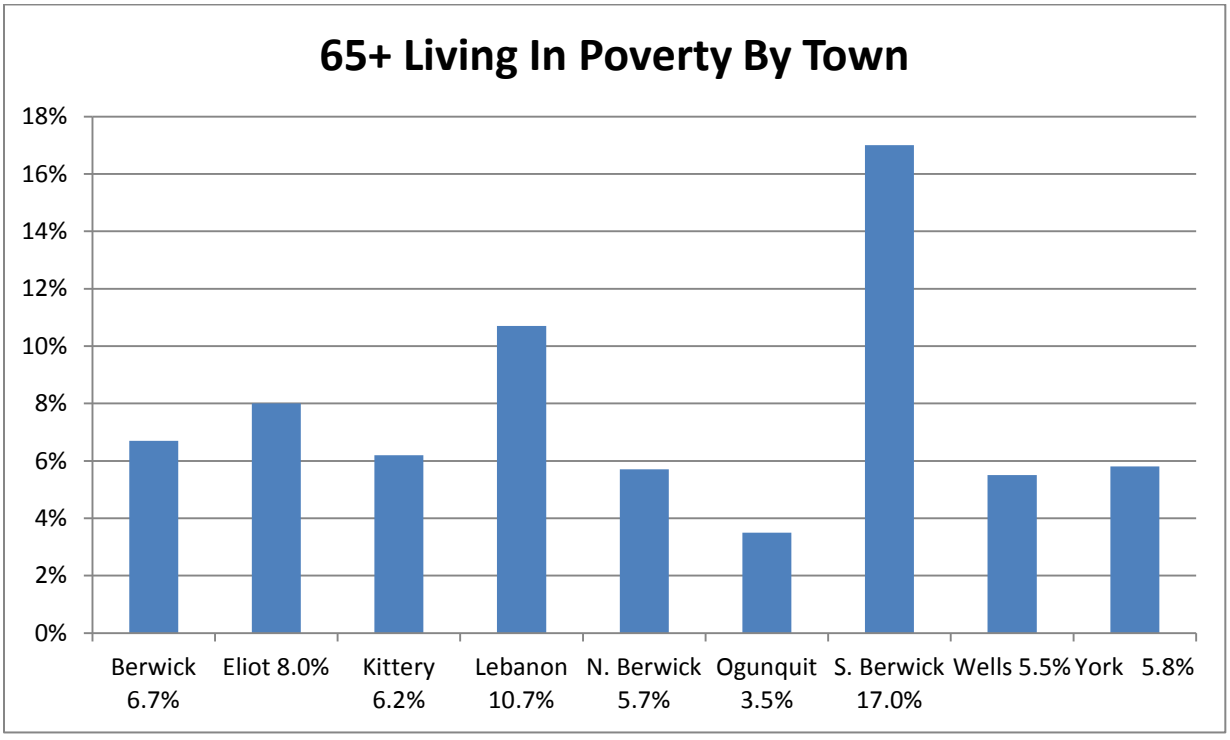
Socio-Economic Characteristics

"We know that much of what influences our health happens outside of the doctor's office – in our schools, workplaces, and neighborhoods…Having health insurance and quality health care are important to our health, but we need leadership and action beyond heath care." *Robert Wood Johnson Foundation: County Health Rankings & Roadmaps*

	York County	Maine
Unemployment rate	5.3%	5.7%
Median household income	$57,348	$48,453
Adults and Children living in poverty	9.5%	13.6%
Children living in poverty	11.5%	18.5%
Single parent families	30.1%	34%
Population living with a disability	13.8%	15.9%
65+ living alone	41.1%	41.2%
Inadequate social support	20%	17%
% Population on Medicaid	21.2%	27%
% uninsured	9.1%	10.4%
High School graduation rate	89%	86.5%




Families Living In Poverty By Town
10%
8%
6%
4%
2%
0%
Berwick 4.6%
Eliot 4.6%
Kittery 1.3%
Lebanon 8.9%
N. Berwick 4.2%
Ogunquit 4.4%
S. Berwick 5.7%
Wells 2.1%
York 6.2%
York County 7.0%
Maine 9.4%


65+ Living In Poverty By Town
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Berwick 6.7%
Eliot 8.0%
Kittery 6.2%
Lebanon 10.7%
N. Berwick 5.7%
Ogunquit 3.5%
S. Berwick 17.0%
Wells 5.5%
York 5.8%

Access To Care

Access to health care is influenced by many factors, such as coverage by health insurance, ability to pay for care, and having a relationship with a primary care provider.

	York County	Maine
Adults with a usual primary care provider (2011-2013)	89.9%	87.7%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost (2011-2013)	11.3%	11%
MaineCare enrollment 2015	21.2%	27%
% of children ages 0-19 enrolled in MaineCare (2015)	33.8%	41.8%
Percent uninsured (2009-2013)	9.1%	10.4%
Adults with visit to dentist in past year (2012)	68.9%	65.3%
Adults currently receiving outpatient mental health treatment (2011-2013)	18%	17.7%

Health Status

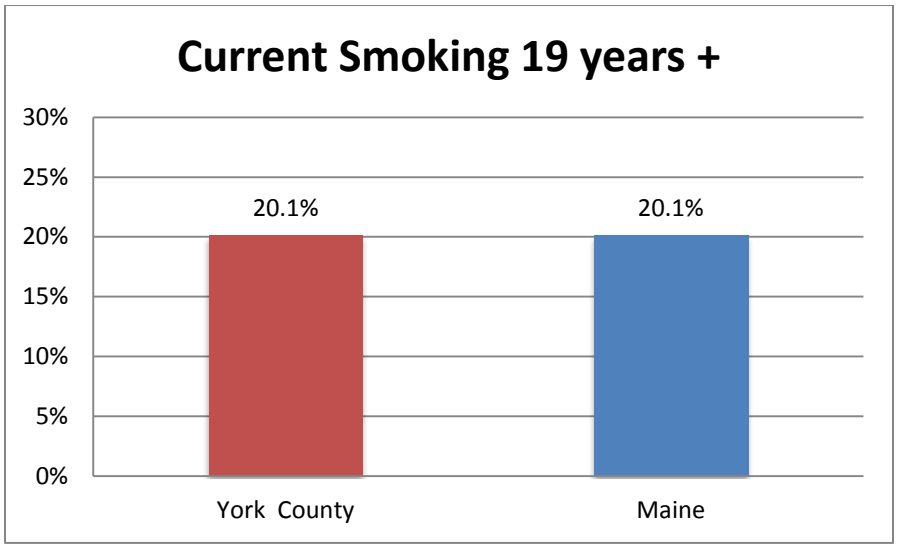
	York County	Maine
Adults who rate their health fair to poor (2011-2013)	13.4%	15.6%
Adults with 14+ days lost due to poor mental health (2011-2013)	11.7%	12.4%
Adults with 14+ days lost due to poor physical health (2011-2013)	12.2%	13.1%
Adults with 3+ chronic conditions (2011-2013)	27.2%	27.6%
Adults immunized annually for influenza (2011-2013)	41.7%	41.5%
Adults immunized for pneumococcal pneumonia (ages 65+, 2011-2013)	73.8%	72.4%

Cardiovascular Heath

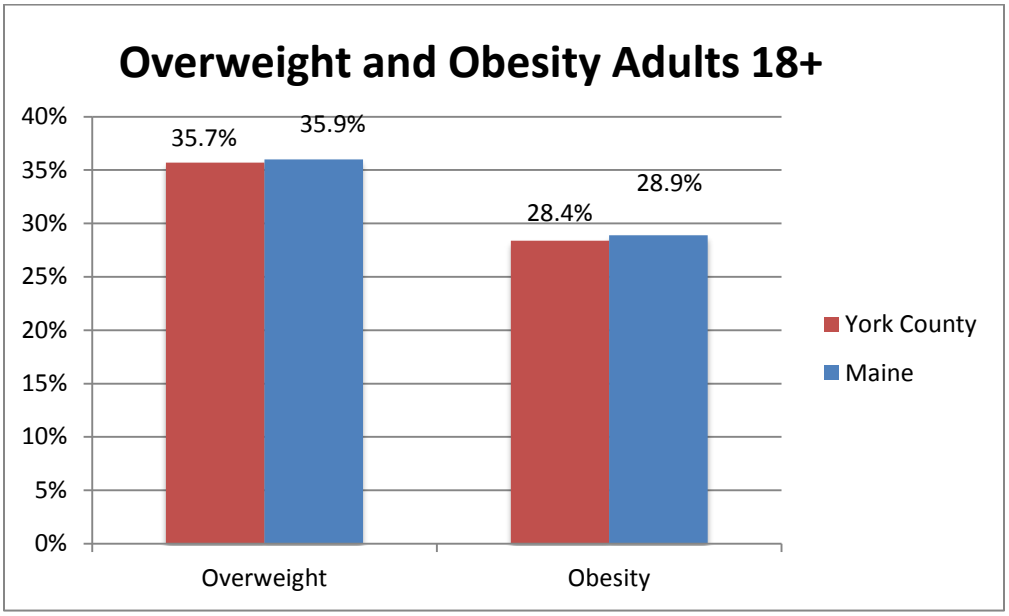
According to the Maine Cardiovascular Health and Diabetes Strategic Plan (2011-2020) "Chronic diseases are among the most common, costly, and preventable of health problems, and in Maine, they account for 28% of all spending for commercial insurance populations, 30% for Department of Health and Human Services' MaineCare populations, and 63% of spending for Medicare." Health behaviors such as not smoking, being physically active, having a healthy diet and maintaining a healthy weight positively impact our overall health and help to prevent cardiovascular health conditions such as heart attacks and strokes. York County has statistically significant lower rates of heart attacks, strokes, and coronary heart disease deaths than Maine rates for these cardiovascular health indicators.

	York County	Maine
Heart attack hospitalizations per 10.000 population (2010-2012)	18.3	23.5
Heart attack deaths per 100,000 population (2009-2013)	25.3	32.2
Stroke hospitalizations per 10,000 population (2010 – 2012)	19.3	20.8
Stroke deaths per 100,000 population (2009-2013)	32.3	35
Coronary Heart Disease deaths per 100,000 population (2009-2013)	74.5	89.8
High Blood Pressure prevalence per 100,000 population (2011-2013)	33.6	23.8
Cholesterol checked every 5 years (2011, 2013)	82.4%	81%
Adult current smokers (2011-2013)	20.1%	20.2%
Met physical activity recommendations (Adults, 2013)	53.2%	53.4%
Sedentary lifestyle – no leisure time physical activity in past month (Adults, 2011-2013)	20.7%	22.4%
Obesity (Adults, 2013)	28.4%	28.9%
Overweight (Adults, 2013)	35.7%	35.9%

Current Smoking – Adults



Overweight and Obesity - Adults



In York County nearly 36% of adults are overweight and another 28% are obese. For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). BMI is used because, for most people, it correlates with their amount of body fat. An adult who has a BMI of between 25 and 29.9 is considered overweight. An adult is obese if their BMI is 30 or higher.

Diabetes Health

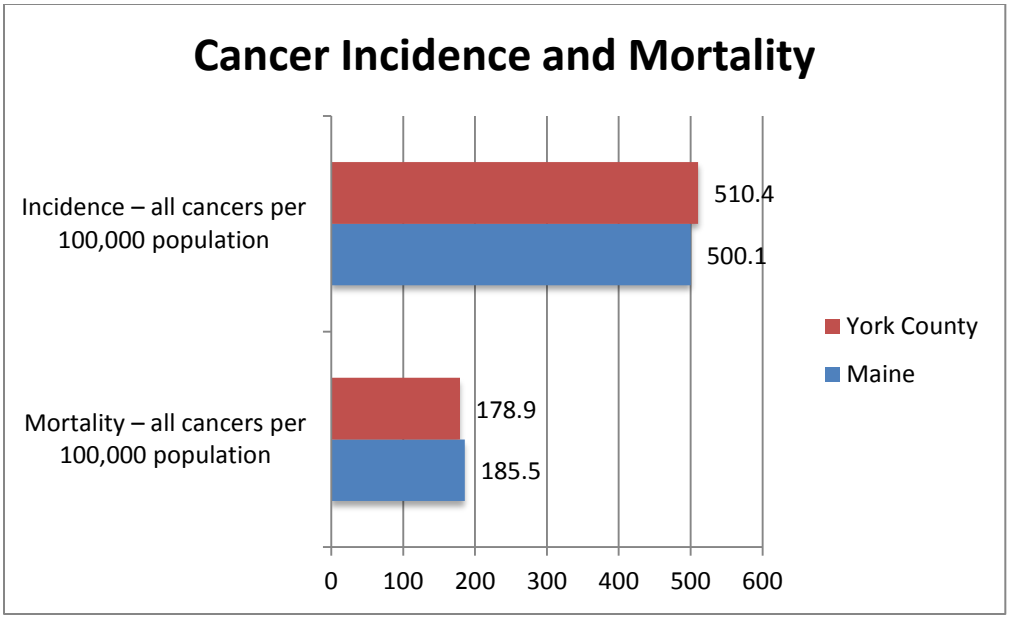
On average, diabetes diagnosed in middle age reduces a person's life expectancy by 10 years. An estimated 18,816 people in York County have diabetes, which is marked by high levels of glucose in the blood. Type 2 diabetes can be prevented with lifestyle interventions such as maintaining a healthy weight. Effective treatment and self-management of the disease can reduce the onset of complications such as blindness and kidney failure.

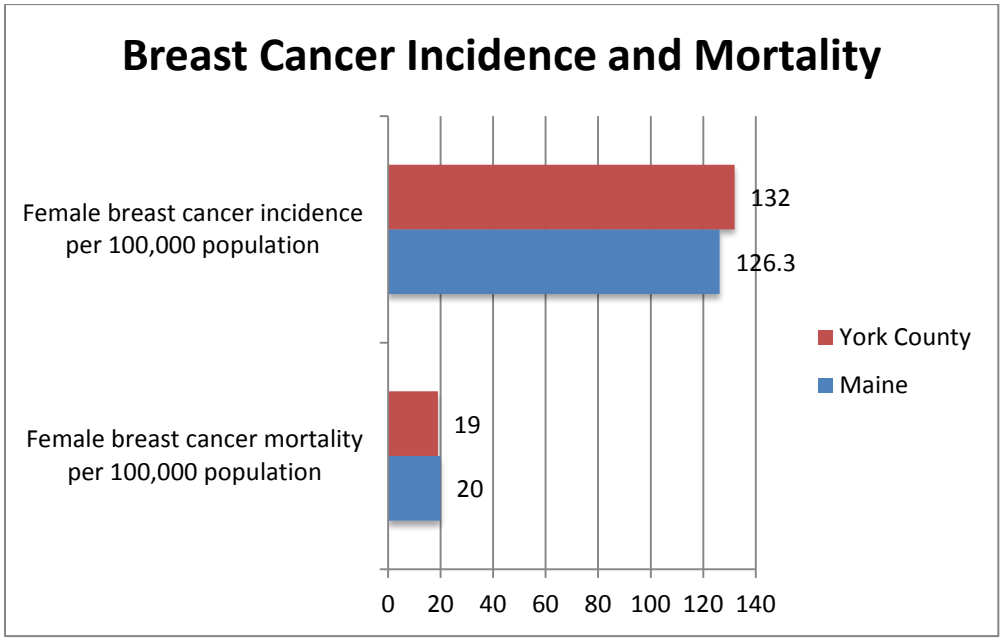
	York County	Maine
Adults diagnosed with diabetes (Adults, 2011-2013)	9.4%	9.6%
Pre-diabetes prevalence (2011-2013)	8.5%	6.9%
Adults with diabetes who have received formal diabetes education (2011-2013)	65.7%	60%
Diabetes emergency department visits (principal diagnosis) per 100,000 population (2011)	146.1	235.9
Diabetes hospitalizations (principal diagnosis) per 10,000 population (2010-2012)	9	11.7
Diabetes long-term complication hospitalizations (2011)	47.2	59.1

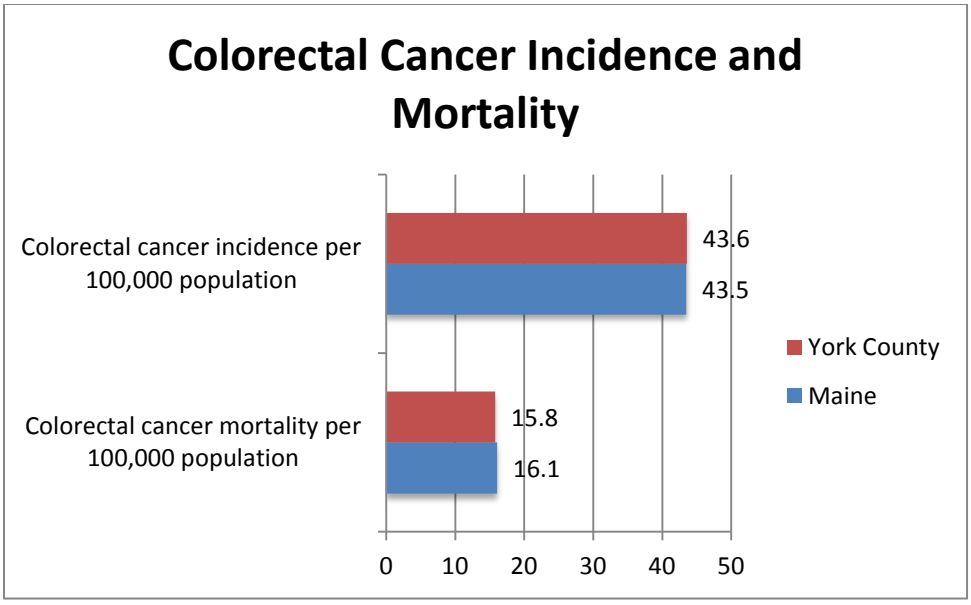
Cancer

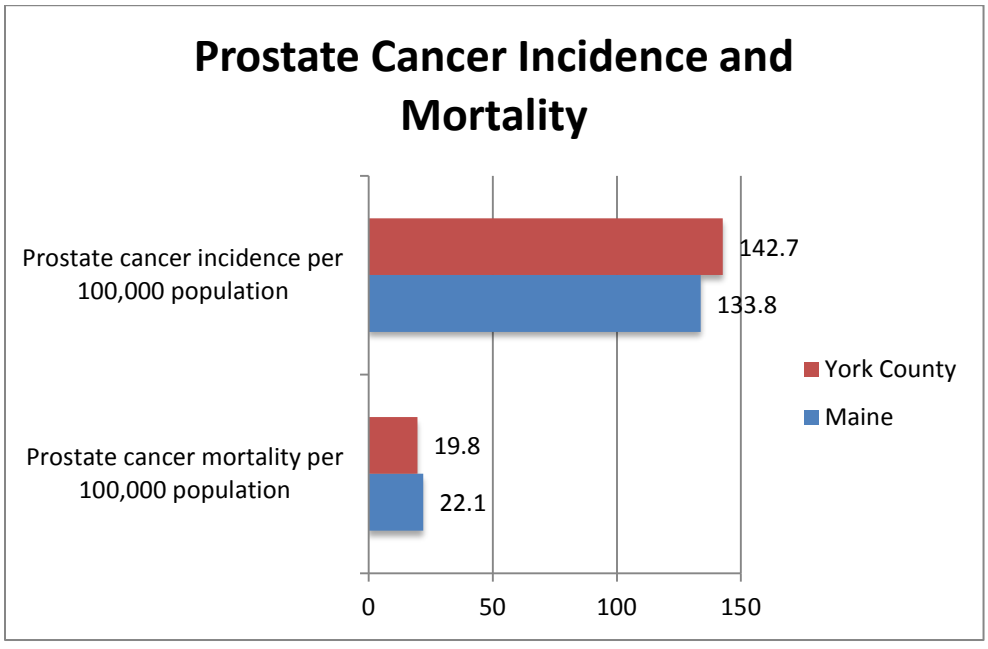
Cancer is the leading cause of death in York County and in Maine. Healthy behaviors such as maintaining body weight and eating fruits and vegetables as well as early detection remain our greatest tools to fight cancer. Early detection screening includes mammography for breast cancer, pap smears for cervical cancer, colorectal screening for colorectal cancer and prostate and skin cancer exams.

	York County	Maine
Lung cancer incidence, per 100,000 population, 2012	69.7	72.9
Lung cancer mortality, per 100,000 population, 2012	48.4	53.8
Prostate cancer incidence, per 100,000 population, 2012	116.4	111.1
Prostate cancer mortality, per 100,000 population, 2012	17.7	21.1
Breast cancer Incidence per 100,000 population, 2012,	141.4	123.8
Breast cancer mortality, per 100,000 population, 2012	18.1	19.4
Have had a mammogram within past 2 years	82%	82.1%
Colorectal cancer incidence per 100,000 population, 2012,	39.2	38.8
Colorectal cancer mortality per 100,000 population, 2012,	14.8	15.2
Have had a colonoscopy or sigmoidoscopy, within last 2 years (adults 50+), 2012	71.9%	72.2%
Had pap smear within past 2 years, 2012	86.4%	88%


Cancer Incidence and Mortality
Incidence – all cancers per 100,000 population
510.4
500.1
Mortality – all cancers per 100,000 population
178.9
185.5
York County
Maine
0
100
200
300
400
500
600


Breast Cancer Incidence and Mortality
Female breast cancer incidence per 100,000 population
132
126.3
Female breast cancer mortality per 100,000 population
19
20
York County
Maine
0
20
40
60
80
100
120
140

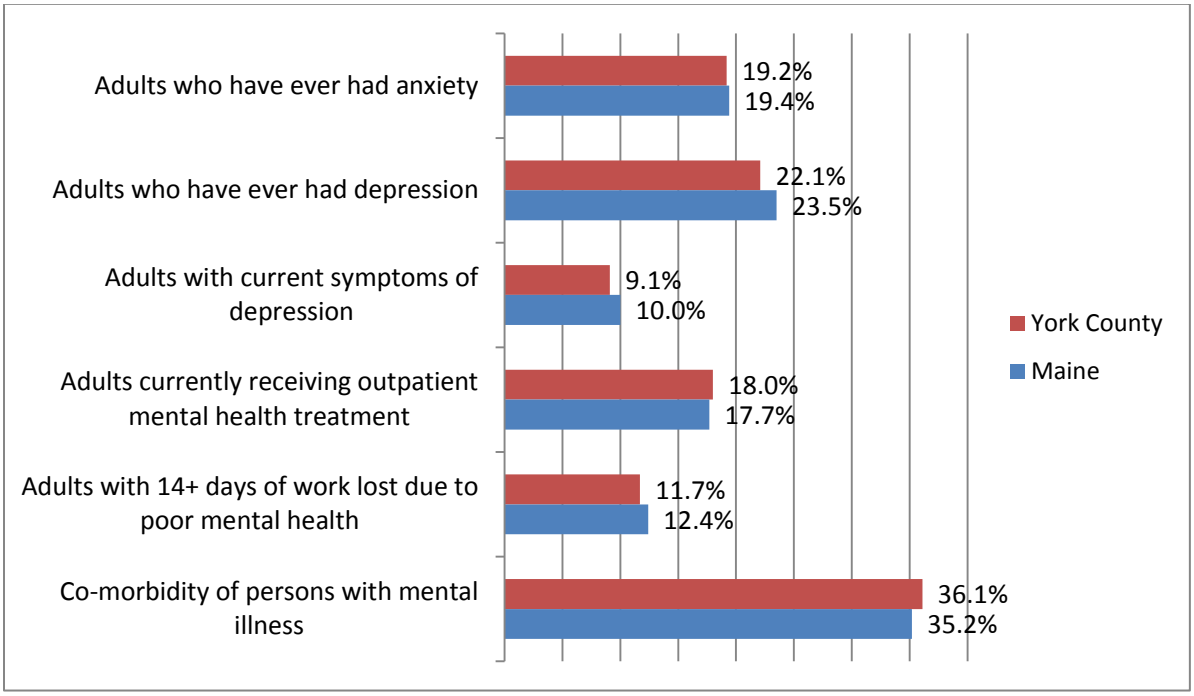

Colorectal Cancer Incidence and Mortality
Colorectal cancer incidence per 100,000 population
43.6
43.5
Colorectal cancer mortality per 100,000 population
15.8
16.1
0
10
20
30
40
50
York County
Maine


Prostate Cancer Incidence and Mortality
Prostate cancer incidence per 100,000 population
142.7
133.8
Prostate cancer mortality per 100,000 population
19.8
22.1
0
50
100
150
York County
Maine

Respiratory Health

	York County	Maine
Current asthma (Adults 2011-2013)	11.2%	11.7%
Chronic Obstructive Pulmonary Disease - COPD (Adults 2011-2013)	8%	7.6%
Asthma emergency room visits per 10,000 population (2009-2011)	61.1	67.3
COPD emergency room visits per 10,000 population (2011)	166.2	216.3
Pneumonia hospitalizations per 100,000 population (2011)	272	329.4

Mental Health

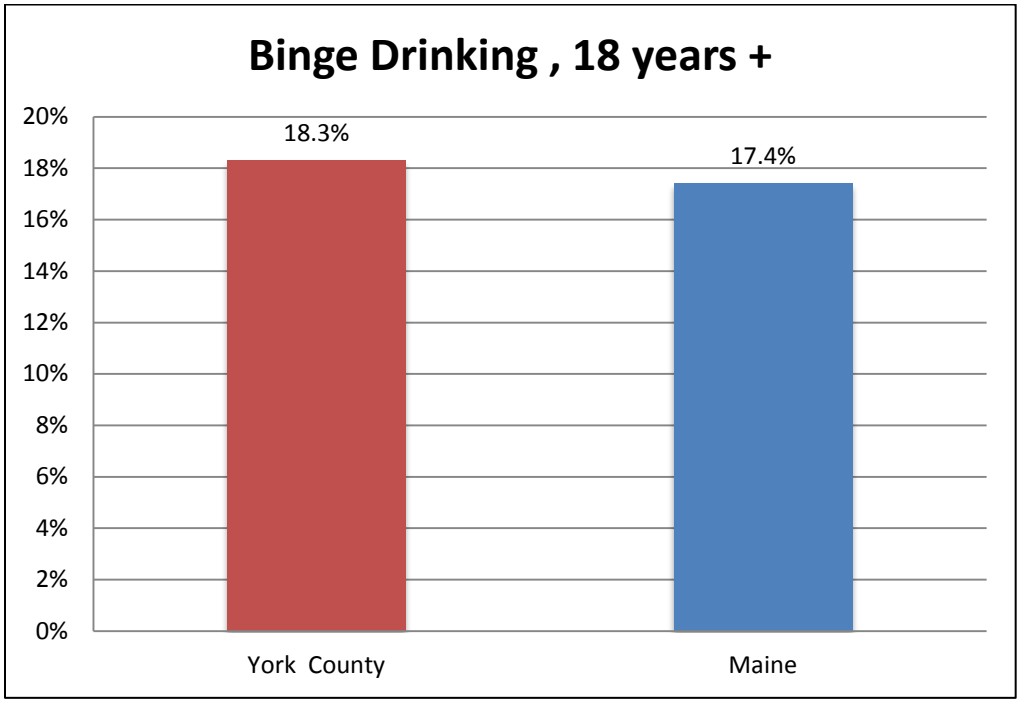


The relationship between our mental health and physical health is experienced by everyone. We know that when we are under stress, often times our physical health suffers. Conversely, if we are in poor physical health we often experience depression or sadness. In York County 12% of people report losing 14 or more days of work due to poor mental health. One optimistic linkage is that it has been shown that physical activity can improve both our physical and our mental health.

Access to mental health services is often a problem due to stigma. In addition, access to community mental health services has been limited due to the closing of a community mental health clinic in Kittery. York Hospital does offer limited mental health services within its primary care practices.

Substance Abuse

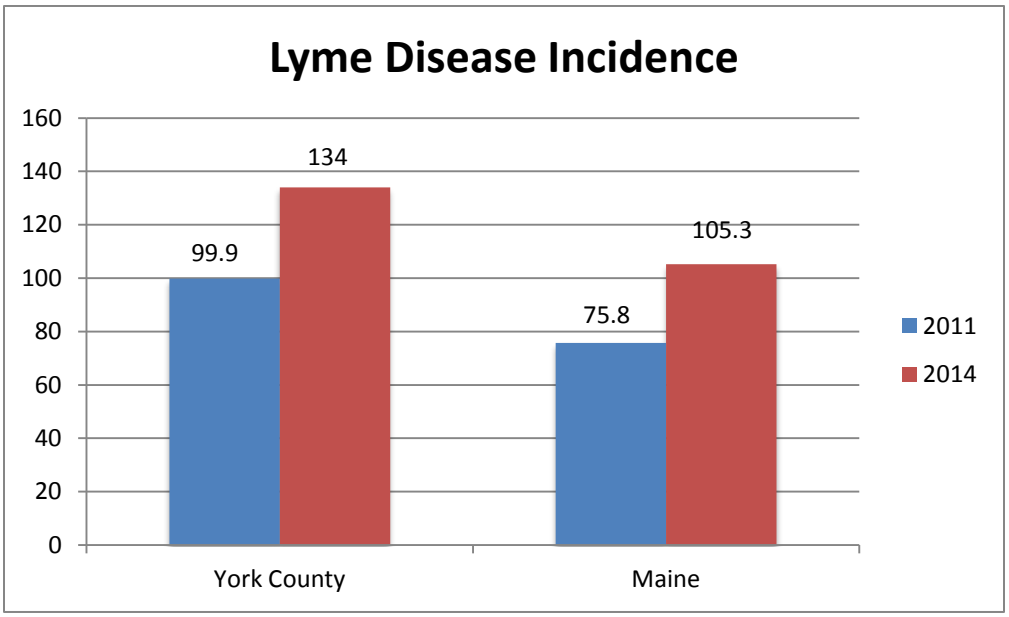
	York County	Maine
Chronic heavy drinking - past month, 2011-2013	8.7%	7.2%
Binge drinking past month, 2013	14.1%	16%
Emergency medical services overdose response per 100,000 population,	444.9	391.5
Opiate poisoning (ED visits) per 100,000 population, 2009-2011	26.5	25.1
Substance abuse hospital admission rate per 100,000 population, 2011	316.1	328.1
Have used prescription drugs for non- prescribed purpose, 30 days,	1%	1.1%
Alcohol-induced mortality per 100,000	6.9	8
Drug-affected baby referrals received as % of all live births, 2014	5.2%	7.8%
Drug-induced mortality per 100,000 population, 2009-2013	13.2	12.4
Prescription Monitoring Program opioid prescriptions (days supply/pop)	6.8	6.8



Environmental Health

	York County	Maine
Lead screening for children age 12-23 months old, 2009-2013	53.9%	49.2%
Children 12-23 months old with elevated blood lead levels (% among those screened) 2009-2013	2.1%	2.5%
Homes with carbon monoxide detectors, 2013	71.6%	54.3%
Rate of unintentional carbon monoxide poisoning ED visits per 100,000 population, 2007-2011	6.3%	8.7%

Lyme Disease



The rate of Lyme disease in York County has risen from a rate of 99.9 per 100,000 population in 2011 to a rate of 134 per 100,000 in 2014. According to the Maine Center for Disease Control and Prevention, "The number of new cases of Lyme disease in Maine has increased dramatically over the past two decades. Lyme disease became Maine's second-most reported infectious disease in 2013, putting all residents and visitors at risk for the disease."

Youth Health

	York County	Maine
Felt sad, hopeless 2 weeks in a row (9-12 grades)	25.3%	25.9%
Seriously considered suicide (9-12 grades)	15.2%	14.8%
Current smoker, past month (9-12 grades)	10.4%	10.7%
Current smokeless tobacco user (9-12 grades)	5.7%	5.8%
Alcohol use, past month (9-12 grades)	24.5%	23.8%
Binge drinking, 5 drinks in a row, past month, (9-12 grades)	12.1%	12.2%
Marijuana use, past month (9-12 grades)	21.4%	19.6%
Sniffed glue or other inhalant, ever (9-12 grades)	7.4%	7.5%
Used prescription drug without prescription, past month (9-12 grades)	6.0%	4.8%
Regular physical activity, 60 mins. 5 of last 7 days (9-12 grades)	41.4%	42.1%
At least one day of physical education at school (9-12 grades)	31.6%	39.0%
Consume fruits/vegs 5 or more times/day (9-12 grades)	15.7%	16.1%
Drank sugar sweetened beverage, in past week (9-12 grades)	22.2%	26.2%
Teen birth rate per 1,000 female population (15-19 years)	18.1	20.5
Current asthma ages 0-17, 2011-2013	11.2%	11.7%
Overweight (9-12 grades)	16.3%	16.5%
Obese (9-12 grades)	13.1%	14.1%
Ate at least 7 meals with family in the past week (9-12 grades)	37.6%	36.6%
Rarely or never use a seat belt (9-12 grades)	4.9%	6.4%
1+ times in vehicle driven by someone drinking alcohol, past 30 days (9-12 grades)	14.4%	13.7%
1+ times drove vehicle when drinking alcohol, past 30 days (9-12 grades)	5.3%	4.7%

Community Themes & Strengths

A Community Themes & Strength Assessment was conducted via a survey that was posted online at the York Hospital and the Choose To Be Healthy Coalition websites. The survey was completed by 383 residents of the nine towns comprising the York Hospital and Choose To Be Healthy service area: Berwick, Eliot, Kittery, Lebanon, North Berwick, Ogunquit, South Berwick, Wells, York. An ad in the Weekly Sentinel newspaper ran for 4 weeks promoting the link to the survey. In addition, hard copy surveys were distributed to 27 community sites including food pantries, housing complexes, social service agencies, libraries, town halls, and York Hospital locations. There were 91 hard copy surveys of the 383 completed surveys. After providing a description of the survey respondents, the following charts highlight top findings regarding health issues, contributing health behaviors, and factors for a healthy community.

Survey Respondents

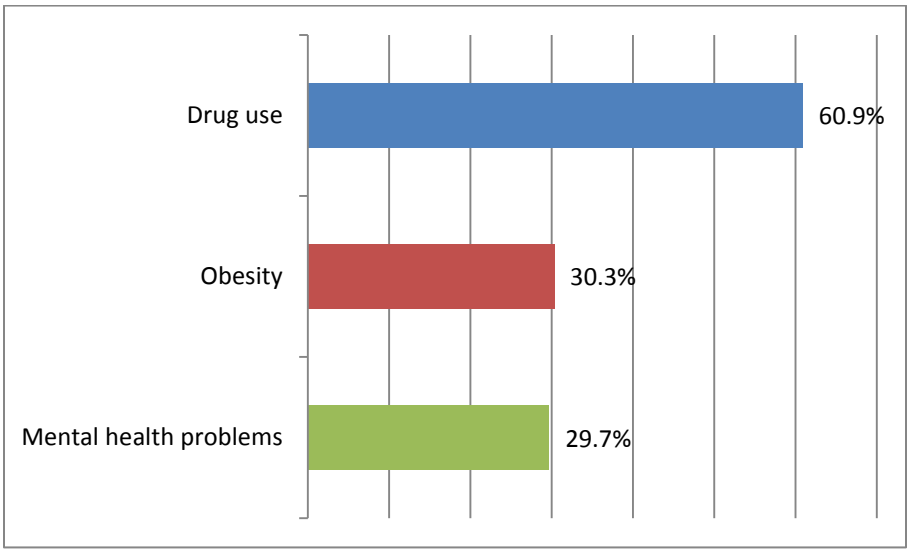
In what town do you currently live?		
Answer Options	**Response Percent**	**Response Count**
Berwick 03901	9.4%	36
Eliot 03903	7.3%	28
Kittery 03905, 03904	7.8%	30
Lebanon 04027	1.0%	4
North Berwick 03906	4.7%	18
Ogunquit 03907	2.1%	8
South Berwick 03908	5.7%	22
Wells 04909	13.3%	51
York 03902, 03909, 03910, 03911	46.0%	176
Other (please specify)	2.6%	10
	answered question	**383**
	skipped question	**0**

80% Female respondents
20% Male respondents

Age range of respondents: 18 years - 85+ years
20%, Age 18 – 39 years
55%, Age 40 – 64
26%, Age 65+

Top 3 Health Problems

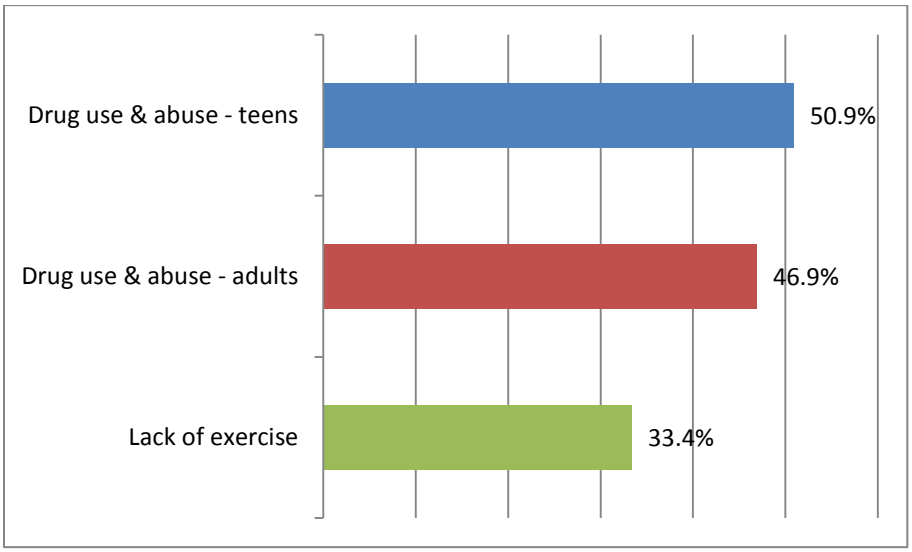
In your opinion, what are the top 3 health problems/issues in the following list in your community?



Aging and alcohol abuse followed closely, both at 25%

Top 3 Risk Behaviors Affecting Community

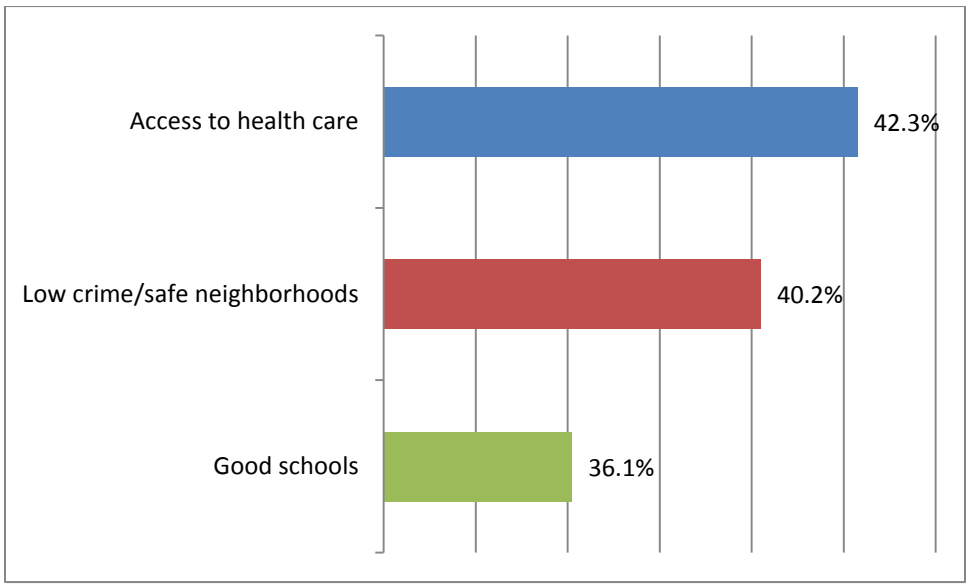
In your opinion, what are the 3 risky behaviors from the following list that have the greatest impact on your community's overall health?



Poor weight management and alcohol abuse by adults were virtually tied with lack of exercise for third most risky behavior at 33%.

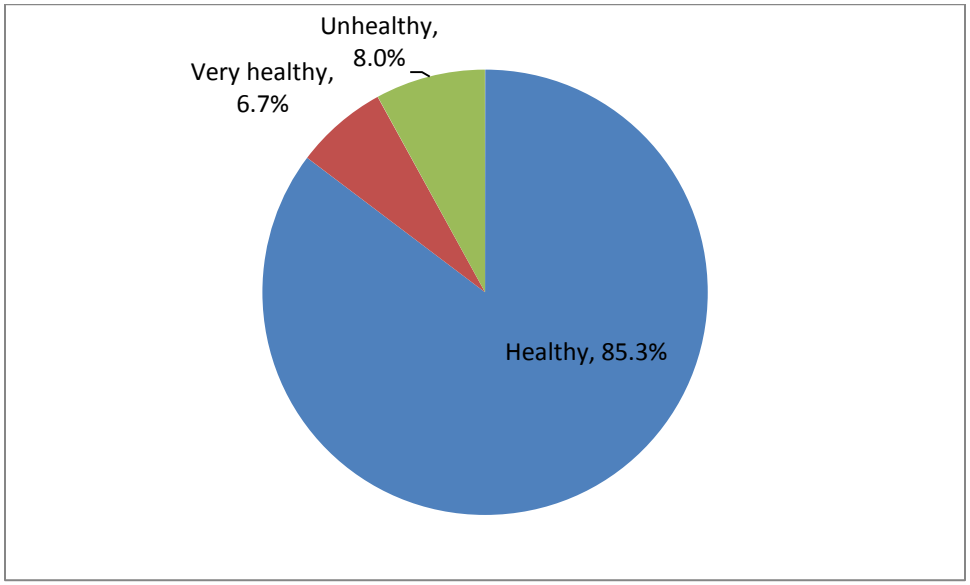
Top 3 Factors for a Healthy Community

In your opinion, what are the 3 most important factors in the following list for a "healthy community?" (Those factors that most improve the quality of life in a community.)



Healthy Community

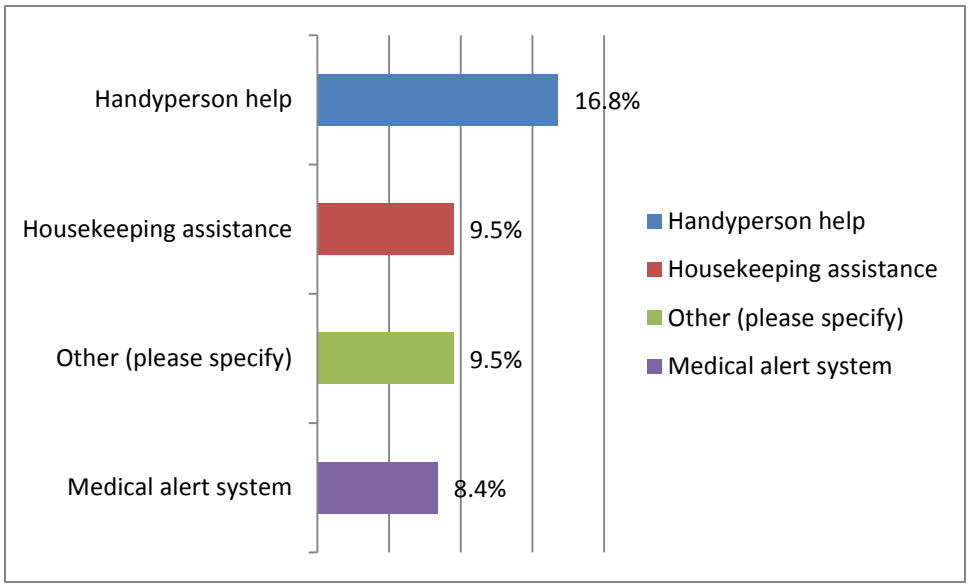
Overall, how would you rate your community as a "healthy community?"



In addition, respondents who answered that they were 65 years old and older were invited to answer additional questions regarding their needs in order to be able to live and thrive in their home.

Needed Supports

Of the following supports that allow you to live and thrive in your home, please check the top 3 you currently do NOT have but need.



- 95 People 65 and older responded to this question
- 67% said there were no supports that they needed
- Medical alert system was the 3rd need named
- Other included: quality physicians, free access to town recreational activities, free cleaning in spring and fall, winter exercise opportunities, and massage therapy

Focus Group Summaries

Focus groups were held to get the perspective of representatives of two health-disparate populations - those 65+ years of age, and those who are uninsured or underinsured.

Focus Group One: Those 65+ Years of Age

This population was chosen to speak with because each of the towns in the hospital service area has at least 11% of their population in this age group. It is notable that 40% of the population of the town of Ogunquit is 65+, with Wells having 25% and York having 22% of their populations 65+. Further, area housing authorities and recreation departments are creating new programs to address the needs of this population and it was thought that the information gathered here would be useful in these efforts.

Date of Focus Group	**October 20, 2015**
Location of Focus Group	**York Housing Authority**
Number of Participants	**17 total—4 men and 13 women**
Category of Group	**65+, participants ages ranged from 71-95**
Moderator Name	**Deborah Erickson-Irons**
Asst. Moderator Name	**Michelle Mason**

York Hospital has a long history of partnering with the York Housing Authority. Recruitment of focus group participants was easily accomplished by placing a flyer about the group in the Baldwin Center community room. This group of 17 men and women ages 71-95 engaged the facilitators in a lively discussion regarding what health is, access to health care and health information, and what is needed to "Thrive in Place."

When asked what the definition of "health" is, answers included "quality of life," "feeling good," and "being able to do what you like to do and to stay active." It was mentioned that health is both physical and emotional and that happiness is a key to health.

The group shared that health information is gleaned from a variety of sources including:

- Coffee Klatch group (offered at the Baldwin Center)
- Friends and relatives

- Internet
- Doctor who I have a long relationship with
- Media: magazines, newsletters, Reader's Digest

When asked what might be helpful to find this information, participants offered the idea of a 24 hour call line that would be available to get information or a referral any time of the day from knowledgeable medical professional (nurse/mental health provider/etc).

Participants then discussed access to health care. When asked how easy it is for them to get needed health care, most said that access to health care was easy due to the close proximity of the hospital and several healthcare providers to York Village. However participants reported several frustrations with access to care. These included getting someone to answer the phone at the family practice that they go to, and concerns were expressed regarding turnover in the medical staff. Several voiced a sense that just as a relationship is built with a provider they leave and a relationship with a new provider has to be established. ("Why is there so much turnover? It used to be that a doctor would stay for years.") Discussion also focused on wanting to see "my own doctor" in the hospital. One participant shared that she was impressed and thankful that "my doctor from York Hospital called to check on me when she was on vacation." There were questions regarding how the hospital decides to recruit specialists or not – one person mentioned pulmonary. Participants talked about needing to go outside of the community for certain services, such as breast radiation. All in the room agreed that transportation to local health care was available from the hospital. However, several mentioned having difficulty getting to services outside of the immediate area, including travel to Boston, MA, and cancer care at Wentworth Douglass Hospital in Dover, NH as examples. "Doctors have no business sending people to a specialist in another state if they are not willing to organize transportation to help people get to the appointments." There was a lot of agreement in the room when one participant said that they were impressed that York Hospital encourages visitors to visit and bring by food/coffee/pets. "Makes it all feel more enjoyable when you need to stay in the hospital."

Participants were asked whether information regarding paying for health care was clear, and where do they, and those in their age group, get this type of information? Responses included:

- I would call the hospital and ask if I had a question about billing.
- The Alzheimer's Association is a good resource and will help you go through your medical bills.

The discussion then turned to the concept of "Thriving in Place." A large majority of participants were positively inclined to the this concept stating that it is positive sounding and that it means not stagnating, but "living life to the fullest." During this part of the conversation participants spontaneously shared what they perceived as the positive aspects of aging:

- "Thriving means to 'step out of the box.' When I turned 68, I started doing things I had never done before, like skydiving. I think there is something we can all do if we think about it. Maybe you never had time before, but I think this is a good age because responsibilities have lessened."
- "I feel more comfortable and confident in my own skin now, more than I ever have before."
- "A person may make the decision to move out and live in a senior living facility. If they don't make an effort to assimilate, they may not thrive, making them just as alone as they were before."

Regarding the question of whether or not their community was a good place to grow old, most felt that it was. The issue of needing public transportation came up as a notable exception. One person made the suggestion of the community keeping a list of volunteers who are willing to drive others to medical appointments. Participants felt safe in their community and mentioned that "Well Checks" were important to those living alone.

Discussion turned to what services would help them "Thrive in Place." Helping services that participants were aware of included York Community Service Association, Southern Maine Area Agency on Aging, local churches, and the Lions Club for glasses. Since all of the participants live in senior housing, maintenance and repair work for the home was not a problem for them. Participants mentioned that they rely on visiting nurses and go to the York Hospital Living Well Center, which is nearby, for physical activity. It was mentioned that York Village was difficult to walk in.

Several agreed that more support is needed for caregivers. Someone mentioned that there is a support group in York for care givers. The Alzheimer's Association was mentioned as a resource for tips and support. Visiting nurses can also be support for caregivers.

The group discussion ended with issues of mental health being raised, such as grief and loss. There was mention of a hospice group. Some participants spoke openly about having been depressed and there appeared to be a general acceptance that emotional help is important to Thriving in Place. "Touch is important; everyone can benefit from a hug."

Focus Group Two: Those Who Are Under or Uninsured

Date of Focus Group	**Saturday, November 14, 2015**
Location of Focus Group	**16 Hospital Dr, York ME**
Number of Participants	**7 total—3 men and 4 women**
Category of Group	**No insurance; using hospital Rx Assistance Program**
Moderator Name	**Deborah Erickson-Irons**
Asst. Moderator Name	**Sarah Trafton**

This group was chosen to speak with due to the fact that those who are uninsured often have poorer health outcomes than those who have insurance. All participants receive help through the hospital's Caring For all and Prescription Assistance programs.

When asked how they define health, participants were quick to draw the relationship between physical and mental health. They discussed how being "down" or depressed can have a negative effect on overall well-being. This group also spoke about the importance of having access to dental health and spoke about how dental health is linked to one's physical appearance and the ability to be employed.

Regarding where these participants got health information that they could trust, most agreed that they call their family doctor or specialist. They also said that asking questions of the nurses at their doctor's office was also helpful regarding specific concerns/ailments. All participants said that they read articles in magazines and newspapers as well. There was much discussion about whether or not television commercials for medications were an accurate source of information, with some in the group finding them helpful, and others not.

Regarding access to healthcare, the group all agreed that having health insurance (free care from the hospital) has allowed them satisfactory access to the care that they need. Most spoke about a reluctance to see a healthcare provider while being uninsured. The participants expressed that not having insurance meant that getting health care was not possible financially. When asked what might be helpful for people seeking free healthcare and programs like the Prescription Assistance Program, all said advertising in the local newspapers.

Participants were asked to think about a friend, family member or acquaintance who has had a mental health diagnosis, and were asked how easy it was for them to find health care for this concern. The participants felt that services for addiction problems were readily available, such as 12-step programs. Two of the participants shared that they had been to The Cottage Program (addiction care services at York Hospital) and were now sober and participating in AA. One person felt that many mental health issues were dealt primarily with medication. The group was in agreement that having a counselor or other support was as important to good mental health. Access to the addiction services had been easy, however most in the group spoke at length about the difficulty a family member had in finding accessible mental health services.

The group then turned to the topic of obtaining health insurance and understanding how to pay for health services. All participants were too young to obtain Medicare and had not purchased healthcare from the Affordable Care Act Marketplace because it was too expensive. Four of the participants had had health insurance at some point in their adult lives.

When asked if health care bills were understandable and clear, the general consensus was that occasionally bills have been received that were difficult to understand. The participants felt that health bills were somewhat confusing. They would like bills to be clearer and specify dates and services provided. Some spoke about receiving a bill for a specific service/health care device that they didn't know they'd be charged for (an arm sling was one example) All participants said that if they were unsure about a charge, they contacted the office or hospital but that they sometimes were still confused after the call.

When the participants discussed preventive ways to stay healthy, attending 12 step meetings was mentioned, as was eating healthy. There was discussion regarding how difficult it is to buy healthy food because it costs more and that cooking for one is a challenge.

As a conclusion, participants were asked about what we had not discussed that they would like to comment on. Participants spoke about a specific issue regarding parking in front of York Hospital and the difficulty of parking close to the pharmacy. Also, some had an issue related to the number of non-handicapped parking spaces in that area of the hospital.

One participant mentioned how helpful the Medicare seminar was in discussing health coverage and that the Southern Maine Agency on Aging was very helpful in explaining benefits and how to obtain them.

Community Forum Summary

On December 14, 2015 a community forum was held at York County Community College in Wells, Maine. The forum was planned together with the York District Public Health Council. Nancy Birkhimer, from MeCDC presented quantitative data from the Shared Health Needs Assessment Planning Process and Deborah Erickson-Irons from York Hospital presented qualitative findings from the Community Themes and Strengths survey. Participants represented diverse community sectors including the medically underserved and low income population, higher education, health care, law enforcement, public health, local and state government, funding agencies, and community health coalitions. Participants then broke into small discussion groups according to their own interest in 3 topic areas: obesity, substance abuse, and mental health. Plans to have a group to discuss the topic of tobacco were changed when there were few participants that wished to discuss the topic. The decision was made to discuss the topic of tobacco use, when applicable, within the other discussion groups.

There were 3 objectives for the small group discussions. They were:

1. Identify local assets and resources available to address the health issue
2. Identiy local barriers to and needs of addressing the health issue
3. Identify next steps for solving the heath issue, keeping in mind a vision for the future of the community regarding the health issue

Obesity

Resources: community health coalitions, health care providers, land trust properties and the Eastern Trail, SNAP-Ed program, local food security programs including Partners for Hunger-free York County, WIC, and the summer meals program.

Barriers: Food assistance is hard to stretch for a family when purchasing healthy food, lack of funding for effective programs, lack of healthy food polices at schools and workplaces, lack of transportation, a sense that areas might be unsafe to be physically active in, sugar is cheap.

Ideas: identify key intervention points and intervention strategies including in health care providers' offices, coordinate stakeholders to work together.

Substance Abuse

Resources: Drug take-back events and boxes; people in recovery; treatment programs like the Cottage Program at York Hospital, Maine Behavioral Healthcare, Nasson Community Health

Center, and the York County Shelter; Public Health Task Force on Opiate Abuse; Drug Free Communities coalitions in county.

Barriers: Attitudes/perceptions/stigma; lack of suboxone providers, lack of funding for treatment including insurance coverage; lack of treatment availability without insurance coverage, lack of transportation.

Ideas: Take a comprehensive approach; address social determinants and increase youth protective factors; better utilize people in recovery, recovery centers and recovery coaches; "Angel" access programs with police departments; treatment providers work together to fill gaps in care.

Mental Health

Resources: Sweetser; Me Behavioral Healthcare; psychiatrists and other providers; emergency rooms; NAMI; behavioral health providers in primary care practices.

Barriers: Lack of coordination; lack of a system of care; lack of types of treatment and treatment capacity; no community mental health center in Southern York County; not enough awareness regarding mental health topics; too much stigma still.

Ideas: A comprehensive model that provides a continuity of care and includes community health workers or navigators; more treatment access including short-term stay care and follow-up.

Recommendations for Action

1. Lower the % of overweight and obese community members in the service area by the end of 2018.

Rationale

i. This goal is a continuation of the goal set during the 2013 Community Health Needs Assessment planning process .
ii. Nearly two thirds of people in York County are either overweight or obese.
iii. The Robert Wood Johnson Foundation's County Health Rankings highlights obesity as a health issue of concern in York County.
iv. In the community engagement process of the needs assessment, obesity, lack of exercise and poor weight management were identifed as a top priority health issue or health behavior.

2. Decrease the number of Opiate Poisoning (ED visits) per 100,000 population by 25% by December 2019

Rationale

i. Maine has had a significant increase in opiate overdose deaths to nearly 300 in one year.
ii. Multiple community members from all sectors have expressed a concern for this issue and a willingness to work together in a coordinated way to reduce opiate deaths and opiate use.

3. Reduce the number of York Hospital Primary Care Practice patients who are current smokers.

Rationale

i. This goal is a continuation of the goal set during the 2013 Community Health Needs Assessment planning process .
ii. Twenty percent of adults in York County smoke, a behavior that contributes to preventable chronic disease.

Action Plan

Community Health Needs Assessment Action Plan

December 2015

Goal 1: Lower the % of overweight and obese community members in the service area by the end of 2018.

Treatment Strategy	Due Date	Reporting
Continue to offer a Healthy Weight Management Program at least 5 times per year.	Continuous, January 2016-December 2018	Hospital website reporting; York Hospital newsletter
Develop an evaluation plan that tracks participants at 6 months and one year after participation.	January 2017	Hospital website reporting; York Hospital newsletter

Population Health Strategy	Due Date	Reporting
Support the expansion of the Eastern Trail through the towns of Wells, North Berwick, South Berwick, Eliot and Kittery	Continuous, January 2016-December 2018	Hospital website reporting; York Hospital newsletter
Sponsor a series of six "Walk With the Doc" community walks with York Hospital Family Practice physicians, on local Land Trust properties	June and September, 2016, 2017, 2018	Hospital website reporting; York Hospital newsletter

Goal 2: **Decrease the number of Opiate poisoning (ED visits) per 100,000 population by 25% by December 2019**

Treatment Strategy	Due Date	Reporting
Expand outpatient addiction treatment services to include Medication Assisted Treatment including buprenorphine and naltrexone.	December 2016	Marketing of services
Expand obstetrical services to include Medication Assisted Treatment (buprenorphine) for pregnant women who abuse opiates.	June 2017	Policies and Procedures are in place

Population Health Strategy	Due Date	Reporting
Enact a Responsible Opioid Prescribing Policy throughout the York Hospital system including physician practices, emergency department and inpatient care.	June 2016	Policies and Procedures are in place
Continue to implement Student Intervention and Reintegration Program (SIRP) in partnership with area high schools and Sweetser, Inc. at least quarterly.	December 2016 December 2017 December 2018	Written program evaluations.
Partner with Choose To Be Healthy Coalition to support youth substance abuse prevention activities. This will include in-kind support for the Drug Free Communities grant such as rent, bookkeeping and HR department support, etc.	On going	Hospital and Choose To Be Healthy websites, DFC coalition contractual reports, and CTBH Coalition Annual Report

Goal 3: Reduce the number of York Hospital Primary Care Practice patients who are current smokers by 5% by December 2019.

Treatment Strategy	Due Date	Reporting
Work with the Center for Tobacco Independence to allow for electronic referrals of patients who smoke directly to CTI from our EMRs.	June 2016	Protocols in place
Implement EMR changes to help support the use of brief interventions and referrals for tobacco users	December 2016	EMR menus in place
Promote resources on Choose To Be Healthy Coalition and hospital websites	Continuous	Website

Population Health Strategy	Due Date	Reporting
Promote tobacco addiction treatment resources on Choose To Be Healthy Coalition and hospital websites	Continuous	Website
Make Tobacco Helpline materials available in all York Hospital physician practice offices	Continuous	Hospital newsletter

Appendices

Maine Shared CHNA County Summary, 2015, York County

Maine Data Sources Table

Maine Shared Community Health Needs Assessment County Summary: 2015			York County Updated: October 2015	
Maine Shared CHNA Health Indicators	**Year**	**York**	**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%*	13.6%	15.4%
Children living in poverty	2009-2013	*11.5%*	18.5%	21.6%
High school graduation rate	2013-2014	89.0%	86.5%	81.0%
Median household income	2009-2013	*$57,348*	$48,453	$53,046
Percentage of people living in rural areas	2013	52.8%	66.4%	NA
Single-parent families	2009-2013	30.1%	34.0%	33.2%
Unemployment rate	2014	5.3%	5.7%	6.2%
65+ living alone	2009-2013	41.1%	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	81.5	81.2
Life expectancy (Male)	2012	77.8	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*683.9*	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%	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	33.8%	41.8%	48.0%
Percent uninsured	2009-2013	*9.1%*	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
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*3,589.3*	4,258.8	NA
Oral Health				
Adults with visits to a dentist in the past 12 months	2012	68.9%	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	51.5%	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%†	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*	329.4	NA
Cancer				
Mortality – all cancers per 100,000 population	2007-2011	178.9	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	510.4	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	31.1	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	19.0	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	44.0	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	132.0	126.3	124.1
Mammograms females age 50+ in past two years	2012	82.0%	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	15.8	16.1	15.1

Cancer				
Colorectal late-stage incidence per 100,000 population	2007-2011	23.3	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	43.6	43.5	42.0
Colorectal screening	2012	71.9%	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	49.4	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	69.4	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*27.8*	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	86.4%	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	19.8	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	142.7	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	37.0	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	95.9	91.9	81.7
Cardiovascular Disease				
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*18.3*	23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*25.3*	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*	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	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%	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	82.5%	83.3%	NA
Diabetes				
Adults with diabetes who have had an A1C test twice per year	2011-2013	81.9%	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	65.7%	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	*146.1*	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	20.8	21.2
Environmental Health				
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	2.1%	2.5%	NA

Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	4.5%	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	44.6%	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*53.9%*	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	*31.4%*	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%	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	75.0%	NA
Infectious Disease				
Hepatitis A (acute) incidence per 100,000 population	2014	0.5†	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.5†	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	1.0†	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	76.2	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	4.0†	8.1	NA
Lyme disease incidence per 100,000 population	2014	134.0	105.3	10.5
Pertussis incidence per 100,000 population	2014	11.5	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.5†	1.1	3.0
STD/HIV				
AIDS incidence per 100,000 population	2014	3.0†	2.1	8.4
Chlamydia incidence per 100,000 population	2014	198.8	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	17.4	17.8	109.8
HIV incidence per 100,000 population	2014	3.0†	4.4	11.2
STD/HIV				
HIV/AIDS hospitalization rate per 100,000 population	2011	17.7	21.4	NA
Syphilis incidence per 100,000 population	2014	1.0†	1.6	19.9
Intentional Injury				
Domestic assaults reports to police per 100,000 population	2013	554.0	413.0	NA
Firearm deaths per 100,000 population	2009-2013	9.7	9.2	10.4
Intentional self-injury (Youth)	2013	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	14.6	9.1
Reported rape per 100,000 population	2013	37.1	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	17.1	15.2	12.6

Violence by current or former intimate partners in past 12 months (among females)	2013	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	169.0	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%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*75.1*	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	10.3	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	8.9	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*326.5*	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	9.6	10.8	10.5
Occupational Health				
Deaths from work-related injuries (number)	2013	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	1,271.0	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	9.1%	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	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	*14.8%*	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	31.3%	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%	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%	26.2%	27.0%

Vegetable consumption among Adults 18+ (less than one serving per day)	2013	16.7%	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	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	5.3	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	87.0%	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	18.1	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.2%	6.6%	8.0%
Substance and Alcohol Abuse				
Alcohol-induced mortality per 100,000 population	2009-2013	6.9	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%	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	13.2	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	444.9	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	13.2	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
Substance and Alcohol Abuse				
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%†	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	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%	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).
† Results may be statistically unreliable due to small numerator, use caution when interpreting.

Maine Shared Community Health Needs Assessment Data Sources				
Indicator	**Data Source**	**Year(s)**	**Comparison Year for Trends**	**Other Notes**
Demographics				
Population	U.S. Census	2014	NA	2013 data was used for all age, racial and ethnic groups.
Population with a disability	U.S. Census	2013	NA	Adults reporting any one of the six disability types are considered to have a disability: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, independent living difficulty.
Population density	U.S. Census	2010	NA	Based on 2010 U.S. Census population.
Socioeconomic Status Measures				
Individuals living in poverty	U.S. Census	2009-2013	2008	The poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. The American Community Survey measures poverty in the previous 12 months instead of the previous calendar year.
Children living in poverty	U.S. Census	2009-2013	2008	The poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. The American Community Survey measures poverty in the previous 12 months instead of the previous calendar year.
High school graduation rate	Maine Dept of Education	2013-14 School Year	2009-10 School Year	Proportion of students who graduate with a regular diploma four years after starting ninth grade. Graduation rates include all public schools and all private schools that have 60% or more publicly funded students.
Median household income	U.S. Census	2009-2013	2008	In 2013 inflation-adjusted dollars. This includes the income of the householder and all other individuals 15 years old and older in the household, whether they are related to the householder or not.
Percentage of people living in rural areas	U.S. Census	2012	NA	The urban/rural categories used in this analysis were defined by the New England Rural Health Roundtable available in Rural Data For Action 2nd Edition: http://www.newenglandruralhealth.org/rural_data
Single-parent families	U.S. Census	2013	NA	Families consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. "Householder without a spouse present" is defined as a male householder without a wife present or a female householder without a husband present.
Unemployment rate	Bureau of Labor Statistics	2014	2009	Unemployment rate of the civilian noninstitutionalized population averaged for the full year of 2014.
65+ living alone	U.S. Census	2013	2009	Estimated number of one-person households with a person 65 years and older.
General Health Status				
Adults who rate their health fair to poor	BRFSS	2013	2011	Adults rating their health as fair or poor vs. excellent, very good or good.
Adults with 14+ days lost due to poor mental health	BRFSS	2013	2011	Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?

Adults with 14+ days lost due to poor physical health	BRFSS	2013	2011	Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
Adults with three or more chronic conditions	BRFSS	2013	2011	Chronic conditions available in 2013 BRFSS: arthritis, asthma, cancer, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, hypertension, high cholesterol, obesity.
Mortality				
Life expectancy (Female)	National Center for Health Statistics	2012	NA	Life expectancy at birth.
Life expectancy (Male)	National Center for Health Statistics	2012	NA	Life expectancy at birth.
Overall mortality rate per 100,000 population	DRVS	2013	NA	All deaths are defined as deaths in which the underlying cau se of death was coded as ICD-10 any listed.
Access				
Adults with a usual primary care provider	BRFSS	2013	2011	Adults that have one or more person they think of as their personal doctor or health care provider.
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	BRFSS	2013	2011	Adults reporting that there was a time during the last 12 months when they needed to see a doctor but could not because of the cost.
MaineCare enrollment	MaineCare	2015	NA	The number and percent of individuals participating in MaineCare. These data are reported as of April 2015. Percentages calculated based on the 2014 US Census population estimates. Individuals are reported by county of residence at the end of the SFY or the end of participation in the program. Figures exclude individuals who were nonresidents or who were out of state.
Percent of children ages 0-19 enrolled in MaineCare	MaineCare	2015	NA	The number and percent of individuals participating in MaineCare. These data are reported as of April 2015. Individuals are reported by county of residence at the end of the SFY or the end of participation in the program. Figures exclude individuals who were nonresidents or who were out of state.
Percent uninsured	U.S. Census	2014	2009	Estimated number of Maine people who do not currently have health insurance.
Health Care Quality				
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	MHDO	2011	2008	PQI = Prevention Quality Indicators, a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care-sensitive conditions. Additional information at: AHRQ Quality Indicators, Version 4.4, Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services. http://www.qualityindicators.ahrq.gov.
Ambulatory care-sensitive condition emergency department rate per 100,000 population	MHDO	2011	NA	PQI = Prevention Quality Indicators, a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care-sensitive conditions. Additional information at: AHRQ Quality Indicators, Version 4.4, Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services. http://www.qualityindicators.ahrq.gov.
Oral Health				
Adults with visits to a dentist in the past 12 months	BRFSS	2012	NA	Adults who last visited the dentist or a dental clinic for any reason in the past 12 months.

MaineCare members under 18 with a visit to the dentist in the past year	Maine Care	2014	NA	Total members younger than 18 with dental claims during calendar year 2014 was 67,871. Of those, only 61,948 had eligibility as of April 2015. Members were younger than 18 on date of service, but some turned 18 by April 2015.
Respiratory				
Asthma emergency department visits per 10,000 population	MHDO	2011	NA	ICD-9 CM - 493
COPD diagnosed	BRFSS	2013	2011	Adults that have been told by a doctor, nurse or health professional that they have COPD chronic obstructive pulmonary disease, emphysema, or chronic bronchitis.
COPD hospitalizations per 100,000 population	MHDO	2011	2007	ICD-9 CM - 490, 491, 492, 494, 496
Current asthma (Adults)	BRFSS	2013	2011	Adults that have been told by a doctor, nurse or health professional that they had asthma and that they still have asthma.
Current asthma (Youth 0-17)	BRFSS	2011-2013	NA	Children that have been told by a doctor, nurse or health professional that they had asthma and that they still have asthma.
Pneumonia emergency department rate per 100,000 population	MHDO	2011	2007	ICD-9 CM - 480-486
Pneumonia hospitalizations per 100,000 population	MHDO	2011	2007	ICD-9 CM - 480-486
Cancer				
Mortality – all cancers per 100,000 population	MCR	2011	2006	All cancer: SEER Cause of Death Recode: 20010-37000 (which include ICD-10 codes: C00-C97).
Incidence – all cancers per 100,000 population	MCR	2009-2011	2004-2006	All cancer: SEER Site Recode: 20010-37000 (which include ICD-O-3 codes: C00-C797).
Bladder cancer incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Female breast cancer mortality per 100,000 population	MCR	2011	2006	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Breast cancer late-stage incidence (females only) per 100,000 population	Maine Cancer Registry (MCR)	2009-2011	NA	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Female breast cancer incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Mammograms females age 50+ in past two years	BRFSS	2012	NA	Females ages 50 years and older who reported they had a mammogram within the past 2 years.
Colorectal cancer mortality per 100,000 population	MCR	2011	2006	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Colorectal late-stage incidence per 100,000 population	MCR	2009-2011	NA	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Colorectal cancer incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.

Colorectal screening	BRFSS	2012	NA	Adults ages 50 years and older who reported that they had a home blood stool test (e.g., FOBT or FIT) within the past year OR sigmoidoscopy within the past 5 years and home blood stool test within the past 3 years OR a colonoscopy within the past 10 years.
Lung cancer mortality per 100,000 population	MCR	2011	2006	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Lung cancer incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Melanoma incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Pap smears females ages 21-65 in past three years	BRFSS	2012	NA	Females with intact cervix, that have received a pap smear within the past three years.
Prostate cancer mortality per 100,000 population	MCR	2011	2006	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Prostate cancer incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Tobacco-related neoplasms, mortality per 100,000 population	MCR	2011	2006	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Tobacco-related neoplasms, incidence per 100,000 population	MCR	2009-2011	2004-2006	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Cardiovascular Disease				
Acute myocardial infarction hospitalizations per 10,000 population	MHDO	2012	2007	ICD-9 CM - 410
Acute myocardial infarction mortality per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 I21-I22
Cholesterol checked every five years	BRFSS	2013	2011	Adults reporting that they last had their blood cholesterol checked within the past 5 years.
Coronary heart disease mortality per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 I20-I25
Heart failure hospitalizations per 10,000 population	MHDO	2012	NA	ICD-9 CM - 428
Hypertension prevalence	BRFSS	2013	2011	Adults who have ever been told by a doctor, nurse, or other health professional that they have high blood pressure.
High cholesterol	BRFSS	2013	2011	Adults who have been told by a doctor or other health professional that their blood cholesterol is high.
Hypertension hospitalizations per 100,000 population	MHDO	2011	2007	ICD-9 CM - 401, 402, 403, 404
Stroke hospitalizations per 10,000 population	MHDO	2012	2007	ICD-9 CM - 430-438
Stroke mortality per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 I60-I69

Diabetes				
Diabetes prevalence (ever been told)	BRFSS	2013	2011	Adults that have ever been told by a doctor or other health professional that they have diabetes.
Pre-diabetes prevalence	BRFSS	2013	NA	Adults that have ever been told by a doctor or other health professional that they have pre-diabetes or borderline diabetes.
Adults with diabetes who have eye exam annually	BRFSS	2011-2013	NA	Adults with diabetes who report having an eye exam in which the pupils were dilated within the past year.
Adults with diabetes who have foot exam annually	BRFSS	2011-2013	NA	Adults with diabetes who report having a health professional check their feet for any sores or irritations within the past year.
Adults with diabetes who have had an A1C test twice per year	BRFSS	2011-2013	NA	Adults who have had a doctor, nurse, or other health professional checked them for "A one C" in the past 12 months.
Adults with diabetes who have received formal diabetes education	BRFSS	2013	NA	Adults with diabetes who have ever taken a course or class in how to manage your diabetes themselves.
Diabetes emergency department visits (principal diagnosis) per 100,000 population	MHDO	2011	2006	ICD-9 CM - 250
Diabetes hospitalizations (principal diagnosis) per 10,000 population	MHDO	2012	2007	ICD-9 CM - 250
Diabetes long-term complication hospitalizations	MHDO	2011	2007	Diabetes long-term complication hospitalizations are defined as hospitalizations of Maine residents for which diabetes long-term complication was the primary diagnosis, coded as ICD 9 - 25040, 25070, 25041, 25071, 25042, 25072, 25043, 25073, 25050, 25051, 25052, 25053, 25080, 25081, 25082, 25083, 25060, 25061, 25062, 25063, 25090, 25091, 25092.
Diabetes mortality (underlying cause) per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 E10-E14
Environmental Health				
Children with confirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2013	2008	In 2012, CDC defined a reference level of 5 micrograms per deciliter (µg/dL) to identify children with elevated blood lead levels. These children are exposed to more lead than most children. For more information, visit: www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm(http://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
Children with unconfirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2013	2008	In 2012, CDC defined a reference level of 5 micrograms per deciliter (µg/dL) to identify children with elevated blood lead levels. These children are exposed to more lead than most children. For more information, visit: www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm(http://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
Homes with private wells tested for arsenic	BRFSS	2009, 2012	NA	Data are weighted to the household. At the county level, 9.7%-32.2% of those surveyed did not know whether they had tested their well water for arsenic.
Lead screening among children age 12-23 months	Maine CDC Lead Program	2009-2013	NA	A blood lead test is considered a "screening test" only when a child has no prior history of a confirmed elevated blood lead level.
Lead screening among children age 24-35 months	Maine CDC Lead Program	2009-2013	NA	A blood lead test is considered a "screening test" only when a child has no prior history of a confirmed elevated blood lead level.
Immunization				
Adults immunized annually for influenza	BRFSS	2013	2011	Adults who have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose during the past 12 months.

Adults immunized for pneumococcal pneumonia (ages 65 and older)	BRFSS	2013	2011	Risk factor for adults aged 65 or older that have ever had a pneumonia shot.
Immunization exemptions among kindergarteners for philosophical reasons	Maine Immunization Program	2015	NA	Available from: http://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/publications/index.shtml
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	Maine Immunization Program	2015	2012	The Maine Immunization Program conducts an annual immunization assessment on January 1 of each calendar year that includes all 2-year-olds in the State of Maine immunization registry, ImmPact, associated to a practice that enters client specific data. These assessments follow the standard Centers for Disease Control and Prevention childhood assessment criteria of 24-35 months of age immunized as of 24 months for the 4 DTaP (Diphtheria, Tetanus, Polio): 3 IPV (Polio): 1 MMR (Measles, Mumps, Rubella): 3 Hib (Haemophilus influenza type B): 3 HepB (Hepatitis B):1 Var (Varicella):4 PCV (Pneumococcal Conjugate) schedule.
Infectious Disease				
Hepatitis A (acute) incidence per 100,000 population	Maine Infectious Disease Surveillance System (MIDSS)	2014	NA	Defined as the number of new infections during 2014.
Hepatitis B (acute) incidence per 100,000 population	MIDSS	2014	NA	Defined as the number of new infections during 2014.
Hepatitis C (acute) incidence per 100,000 population	MIDSS	2014	NA	Defined as the number of new infections during 2014.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	MIDSS	2014	NA	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	MIDSS	2014	NA	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
Lyme disease incidence per 100,000 population	MIDSS	2014	2009	Defined as the number of new infections during 2014.
Pertussis incidence per 100,000 population	MIDSS	2014	2009	Incidence is defined as the number of new infections during 2014.
Tuberculosis incidence per 100,000 population	MIDSS	2014	2008	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
STD/HIV				
AIDS incidence per 100,000 population	Maine CDC HIV Program	2014	2008	Incidence is defined as the number of new infections during 2014.
Chlamydia incidence per 100,000 population	Maine CDC STD Program	2014	NA	Incidence is defined as the number of new infections during 2014.
Gonorrhea incidence per 100,000 population	Maine CDC STD Program	2014	NA	Incidence is defined as the number of new infections during 2014.
HIV incidence per 100,000 population	Maine CDC HIV Program	2014	2009	Incidence is defined as the number of new infections during 2014.
HIV/AIDS hospitalization rate per 100,000 population	MHDO	2011	2007	DRG-MDC 25
Syphilis incidence per 100,000 population	Maine CDC STD Program	2014	2009	Incidence is defined as the number of new infections during 2014.
Intentional Injury				
Domestic assaults reports to police per 100,000 population	Maine Dept of Public Safety	2013	2009	All offenses of assault between family or household members are reported as domestic assault.
Firearm deaths per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 W32-W34 ,X72-X74, X93-X95, Y22-Y24, Y350 or U014.
Intentional self-injury (Youth)	MIYHS	2013	2009	High school students who have ever done something to purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose.
Lifetime rape/non-consensual sex (among females)	BRFSS	2012	2011	Females who have ever had sex with someone after they said or showed that they didn't want them to or without their consent.

Nonfatal child maltreatment per 1,000 population	Child Maltreatment Report ACYF	2013	2008	Rates are unique child victims per 1,000 population under age 18.
Reported rape per 100,000 population	Maine Dept of Public Safety	2013	2009	Includes rape by force and attempted forcible rape. Excludes carnal abuse without force (statutory rape) and other sex offenses.
Suicide deaths per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 U03 X60-X84 or Y87.0
Violence by current or former intimate partners in past 12 months (among females)	BRFSS	2012	2011	Females who have experienced physical violence or had unwanted sex with a current or former intimate partner within the past 12 months.
Violent crime rate per 100,000 population	Maine Dept of Public Safety	2013	2008	Reported violent crime offenses. Violent crime includes murder, rape, robbery and aggravated assault.
Unintentional Injury				
Always wear seatbelt (Adults)	BRFSS	2013	NA	Adults reporting they always use seatbelts when they drive or ride in a car.
Always wear seatbelt (High School Students)	MIYHS	2013	NA	High School students who report they always wear a seatbelt when riding in a vehicle.
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	MHDO	2011	2006	Emergency department visits by Maine residents at Maine acute care hospitals that did not end with the patient being admitted to that hospital as an inpatient, for which the principal diagnosis is an injury (ICD 9 CM 800–909.2, 909.4, 909.9–994.9, 995.5–995.59 or 995.80–995.85) or any external cause of injury code is ICD 9 CM E800-E869, E880-E929 or E950-E999, and the principal or any other diagnosis is ICD-9-CM 800.00–801.99, 803.00–804.99, 850.0–850.9, 851.00–854.19, 950.1–950.3, 959.01 or 995.55.
Unintentional and undetermined intent poisoning deaths per 100,000 population	Maine CDC Vital Records	2013	2008	Deaths of Maine residents for which the underlying cause of death is ICD-10 X40-X49 or Y10-Y19.
Unintentional fall related deaths per 100,000 population	Maine CDC Vital Records	2013	2008	Deaths of Maine residents for which the underlying cause of death is ICD-10 W00-W19.
Unintentional fall related injury emergency department visits per 10,000 population	MHDO	2011	NA	Unintentional fall-related injury ED Visits are defined as ED Visits in which external cause of injury was coded as ICD--9CM E880-E886 or E888.
Unintentional motor vehicle traffic crash related deaths per 100,000 population	Maine CDC Vital Records	2013	2008	Deaths of Maine residents for which the underlying cause of death is ICD-10 V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29 (.4-.9), V30-V39 (.4-.9), V40-V49 (.4-.9), V50-V59 (.4-.9) ,V60-V69 (.4-.9), V70-V79 (.4-.9) ,V80 (.3-.5), V81.1 ,V82.1, V83-V86 (.0-.3) ,V87 (.0-.8) or V89.2."
Occupational Health				
Deaths from work-related injuries (number)	Maine Dept. of Labor	2013	2009	Includes self-employed workers, owners of unincorporated businesses and farms, paid and unpaid family workers, members of partnerships and may include owners of incorporated businesses.
Nonfatal occupational injuries (number)	U.S. Bureau of Labor Statistics	2013	2009	Includes both injuries that required days away from work and those that required job transfer or restriction. Data do not reflect the relative FTEs worked by the various groups of employees.
Mental Health				
Adults who have ever had anxiety	BRFSS	2013	2011	Adults who have ever been told by a doctor or other healthcare provider that they have an anxiety disorder?
Adults who have ever had depression	BRFSS	2013	2011	Adults who have ever been told by a doctor or other healthcare provider that they have a depressive disorder.
Adults with current symptoms of depression	BRFSS	2013	2011	Indicator of current depression coded using two items from the PHQ-2 depression screener.
Adults currently receiving outpatient mental health treatment	BRFSS	2013	2011	Adults now taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.
Co-morbidity for persons with mental illness	BRFSS	2013	2011	Adults with current symptoms of depression from the PHQ-2 depression screener with 3 or more chronic conditions.

Mental health emergency department rates per 100,000 population	MHDO	2011	2007	ICD-9 CM- 209-302, 306-319, which exclude substance use related disorders.
Sad/hopeless for two weeks in a row (High School Students)	MIYHS	2013	2011	During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities? Percentage of students who answered "Yes".
Seriously considered suicide (High School Students)	MIYHS	2013	2011	During the past 12 months, did you ever seriously consider attempting suicide? Percentage of students who answered "Yes".
Physical Activity, Nutrition and Weight				
Fewer than two hours combined screen time (High School Students)	MIYHS	2013	NA	Percentage of students watching 2 or fewer hours of combined screen time (tv, video games, computer) per day on an average school day.
Fruit and vegetable consumption (High School Students)	MIYHS	2013	2009	Percentage of students who drank 100% fruit juice, ate fruit and/or ate vegetables five or more times per day during the past seven days.
Fruit consumption among Adults 18+ (less than one serving per day)	BRFSS	2013	NA	Adults with less than one serving per day of fruits or fruit juice.
Met physical activity recommendations (Adults)	BRFSS	2013	NA	Adults who reported doing enough physical activity to meet the aerobic and strengthening recommendations.
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	MIYHS	2013	2009	Percentage of students who were physically active for a total of at least 60 minutes per day on five of the past seven days.
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	BRFSS	2013	2011	Adults reporting that during the past month, other than their regular job, they did not participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise.
Soda/sports drink consumption (High School Students)	MIYHS	2013	NA	Percentage of students who drank at least one can, bottle, or glass of soda, sports drink, energy drink, or other sugar-sweetened beverage such as Gatorade, Red Bull, lemonade, sweetened tea or coffee drinks, flavored milk, Snapple, or Sunny Delight (Not counting diet soda, other diet drinks, or 100% fruit juice.) per day during the past week.
Vegetable consumption among Adults 18+ (less than one serving per day)	BRFSS	2013	NA	Adults with less than one serving per day of vegetables.
Obesity (Adults)	BRFSS	2013	2011	Adults with a BMI of 30 or more.
Obesity (High School Students)	MIYHS	2013	2009	Percentage of students who were obese (i.e., at or above the 95th percentile for body mass index, by age and sex) -- SELF-REPORTED HEIGHT/WEIGHT.
Overweight (Adults)	BRFSS	2013	2011	Adults with a BMI between 25.0 and 29.9.
Overweight (High School Students)	MIYHS	2013	2009	Percentage of students who were overweight (i.e., at or above the 85th percentile but below the 95th percentile for body mass index, by age and sex) -- SELF-REPORTED HEIGHT/WEIGHT.
Pregnancy and Birth Outcomes				
Children with special health care needs	National Survey of Children with Special Health Care Needs	2011-2012	2009-2010	Survey respondents who reported that their child has a special health care need.
Infant deaths per 1,000 live births	Maine CDC Vital Records	2008-2012	2006	Number of babies who died before their first birthday per 1,000 live births. Average annual number of infant deaths and infant mortality rate might be slightly underestimated due to possible missing out-of-state deaths of Maine infants in 2010.
Live births for which the mother received early and adequate prenatal care	Maine CDC Vital Records	2010-2012	2007	Defined as an adequate or adequate-plus rating on the Kotelchuck Adequacy of Prenatal Care Utilization Index.
Live births to 15-19 year olds per 1,000 population	Maine CDC Vital Records	2012	2007	Defined as the number of live births among 15- to 19-year-old Maine women per 1,000 population.

Low birth weight (<2500 grams)	Maine CDC Vital Records	2010-2012	2007	Low birth weight defined as less than 2500 grams.
Substance and Alcohol Abuse				
Alcohol-induced mortality per 100,000 population	Maine CDC Vital Records	2013	2008	ICD-10 - E24.4 , F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, R78.0, X45, X65 or Y15
Binge drinking of alcoholic beverages (High School Students)	MIYHS	2013	2011	During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours? Percentage of students who answered at least 1 day.
Binge drinking of alcoholic beverages (Adults)	BRFSS	2013	2011	Risk factor for binge drinking where binge drinking is defined as having 5 or more drinks on 1 occasion for men and 4 or more drinks on 1 occasion for women.
Chronic heavy drinking (Adults)	BRFSS	2013	2011	At risk for heavy alcohol consumption (greater than two drinks per day for men and greater than one drink per day for women).
Drug-affected baby referrals received as a percentage of all live births	OCFS Maine Automated Child Welfare Information System	2014	NA	This measure reflects the number of infants born in Maine where a healthcare provider reported to OCFS that there was reasonable cause to suspect the baby may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure or who have fetal alcohol spectrum disorders.
Drug-induced mortality per 100,000 population	CDC Wonder	2013	2009	The population figures for year 2013 are bridged-race estimates of the July 1 resident population, from the Vintage 2013 postcensal series released by NCHS on June 26, 2014.
Emergency medical service overdose response per 100,000 population	Maine Emergency Medical Services	2014	NA	Includes overdoses from drugs/medication, alcohol and inhalants.
Opiate poisoning (ED visits) per 100,000 population	MHDO	2011	2007	Primary diagnoses of: ICD-9 - 9650, 96500, 96501, 96502, 96509
Opiate poisoning (hospitalizations) per 100,000 population	MHDO	2011	2007	Primary diagnoses of: ICD-9 - 9650, 96500, 96501, 96502, 96509
Past-30-day alcohol use (High School Students)	MIYHS	2013	2009	During the past 30 days, on how many days did you have at least one drink of alcohol? Percentage of students who answered at least 1 day.
Past-30-day inhalant use (High School Students)	MIYHS	2013	2011	During the past 30 days, how many times did you sniff glue, breathe the contents of aerosol spray cans, or inhale any paints or sprays to get high? Percentage of students who answered at least 1 time.
Past-30-day marijuana use (Adults)	BRFSS	2013	2011	During the past 30 days, have you used marijuana?
Past-30-day marijuana use (High School Students)	MIYHS	2013	2009	During the past 30 days, how many times did you use marijuana? Percentage of students who answered at least 1 time.
Past-30-day nonmedical use of prescription drugs (Adult)	BRFSS	2013	2011	Adults who used prescription drugs that were either not prescribed and/or not used as prescribed in order to get high at least once within the past 30 days.
Past-30-day nonmedical use of prescription drugs (High School Students)	MIYHS	2013	2009	During the past 30 days, how many times did you take a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription? Percentage of students who answered at least 1 time.
Prescription Monitoring Program opioid prescriptions (days supply/pop)	Prescription Monitoring Program	2014-2015	NA	Presented as Days Supply/Population, which is the total days of supply of medication divided by the overall population.
Substance-abuse hospital admissions per 100,000 population	MHDO	2011	2007	Primary diagnoses of DRG-MDC 20
Tobacco Use				
Current smoking (Adults)	BRFSS	2013	2011	Adults that reported having smoked at least 100 cigarettes in their lifetime and currently smoke.

Current smoking (High School Students)	MIYHS	2013	2009	During the past 30 days, on how many days did you smoke cigarettes? Percentage of students who answered at least 1 day.
Current tobacco use (High School Students)	MIYHS	2013	2011	Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days. (Note: Reports read "Percentage of students who smoked cigarettes and/or cigars and/or used chewing tobacco, snuff, or dip on one or more of the past 30 days").
Secondhand smoke exposure (Youth)	MIYHS	2013	2011	Percentage of students who were in the same room with someone who was smoking cigarettes at least 1 day during the past 7 days.