Community Health Needs Assessment Report

July 2016

MaineGeneral Health

- Community Health Needs Assessment
- Community Engagement Summary
- 3-Year Implementation Strategy

MaineGeneral Health

Table of Contents

MaineGeneral Health Overview

MaineGeneral Health is an integrated, not-for-profit health care system which provides a wide range of services throughout central Maine's Kennebec Valley. In November 2013, MaineGeneral opened a 192-bed, state-of-the-art hospital in Augusta — the Alfond Center for Health. Renovations to transform its Waterville Campus into a comprehensive outpatient center — the Thayer Center for Health—were completed in October 2014.

The health care system also includes a regional cancer center; primary care and specialty physician practices; long term care facilities; rehabilitation; mental health and substance abuse services; home health care and hospice services; specialized care for people with memory loss; community outreach programs and retirement living options.

The health system employs more than 4,300 people and is the largest private employer in the region. Gross patient revenue for Fiscal Year 2015 was $843 million.

In Fiscal Year 2015, the health system provided more than 400 community health events — free education sessions, support group meetings and screenings — to 14,652 participants. It provided 3,978 flu vaccinations to students, faculty and staff at area schools.

If you have questions about this report, please call MaineGeneral's Center for Prevention and Healthy Living at (207) 872-4102.

Shared Health Needs Assessment and Planning Process

MaineGeneral Health

About the Collaborative

The Maine Shared Health Needs Assessment & Planning Process (SHNAPP) was borne out of a series of planning events and conversations among healthcare and public health leaders in response to emerging state and federal mandates to improve the health of Maine communities. A memorandum of understanding (MOU) was developed and signed in June 2014 by CEO's from Central Maine Healthcare, Eastern Maine Healthcare Systems, MaineGeneral Health, and MaineHealth in addition to the Commissioner of Maine Department of Health and Human Services. Tangible products include shared community health needs assessment (CHNA) reports created from secondary quantitative data and primary qualitative data analyses, community engagement activities, and health improvement plans.

About the Shared Community Health Needs Assessment

The Shared Community Health Needs Assessment (CHNA) was conducted by Maine SHNAPP members. The series of reports produced as a result support MaineHealth member organizations' and community partners' efforts to make Maine's communities the healthiest in America.

The CHNA report (See Appendix for full County report) presents both quantitative and qualitative findings. The quantitative data came from 25 sources (surveys such as the Behavioral Risk Factor Surveillance System, the Maine Integrated Youth Health Survey; patient claims data from the Maine Health Data Organization; and disease registries such as the Cancer Registry) for over 160 indicators within 18 domains or health categories. The qualitative data was gleaned from an online stakeholder survey meant to capture opinions of health professionals and community stakeholders on the health issues and needs of communities across the state. The data gathered from these sources allowed MaineHealth member and affiliate organizations to identify the top health issues or priorities for their county and local communities.

Community Engagement

Community engagement using shared CHNA reports for local and regional planning is a critical part of the needs assessment and health improvement planning process. For some, working with a community means engaging community partners at the organizational or agency level, and for others it entails working with individual community members or working with community leaders who represent specific populations. Both types of engagement satisfy the IRS and Public Health Accreditation Board. Community feedback was used to collaboratively create 3-year implementation strategies, also called implementation plans.

The process, co-led by Maine CDC District Liaisons and representatives from Maine SHNAPP not-for-profit hospitals, achieved the following:

- Ensured broad interests of the local community were represented;
- Obtained stakeholder input on identifying significant health needs based on review of data;
- Solicited stakeholder feedback on prioritizing significant health needs; and
- Identified local assets and resources that could address local health priorities.

Preparing for Community Engagement
September 2014-September 2015

The planning process included the District Liaison from the Maine CDC and representatives from participating Maine SHNAPP hospitals in the region. The leaders reached out to community benefit leadership among other local not-for-profit hospitals, local public health departments, and other organizations and community sectors whose work impacts the health of the communities in the district and/or county. The committees established for this purpose or a current body may carry out the commitments. This outreach resulted in the formation of committees which reflected the populations that need to be engaged, and included individuals with diverse expertise or community roles, including representatives from the following sectors:

- Public health
- Community health coalitions
- Healthcare providers, including oral and behavioral health care providers
- Minority populations (e.g. Maine NAACP members, Latino student club, immigrant services)
- Business and civic leadership (e.g. local employers, civic organizations, community leaders)
- Funding agencies (e.g. local philanthropic organizations, bank and credit union services)
- Local and state governmentNon-profit organizations, including hospitals
- Colleges and Universities
- Low-income and/or medically underserved people

Obtaining Local Community Engagement Input
October 2015-March 2016

The SHNAPP Committee collected input as resources allowed through the best methods determined locally. Suggestions for obtaining feedback from organizations and groups included, but were not limited to:

- Additional Community Forums
- Key Informant Interviews: Interviews are focused conversations. They are used to learn about assumptions and perceptions in our communities about health issues, resources, and actions.
- Focus Groups: Focus groups are discussions led by a trained facilitator among a small group of people. Members of the group share opinions about the topic at hand and offer suggestions.
- Written or Electronic Surveys: Surveys provide a consistent and structured method for asking questions among a selected group of people. People responding to surveys share their experience or feedback at their convenience without the potential influence of responding to a person.
- Group Presentations with Structured Feedback: Instead of a forum or focus group, a presentation of an issue using prepared slides or handouts can be planned during a regularly scheduled meeting of a group such as a Rotary Club, school booster club, public health nursing staff meeting, or patient advisory board, etc. with the goal of gaining input through nominal group process or a variation to obtain individual votes and recommendations.

Disseminating Local Community Engagement Input
October 2015 - March 2016

Community input was made available for any interested party to review and use. Dissemination activities occurred concurrently with collection of community input. This provided an opportunity to share information collected among stakeholders responsible for creating District Public Health Improvement Plans and Implementation Strategies for their respective agencies, and created a transparent process through which organizations and community members could be involved. There was a standard online method for sharing information from reporting forms with SHNAPP Community Engagement Committees. This ensured collected feedback was readily available to organizations drafting District Public Health Improvement Plans and Implementation Strategies, and to communities at-large.

Implementation Planning Group

MaineGeneral Health created an implementation planning group to help review forum results and input and prioritize results.

The following individuals contributed to the CHNA process on the Implementation Planning Group:

Monica Beaulieu, Administrative Director, Quality Care Management & Safety, MGMC
Nona Boyink, Senior Vice President, MaineGeneral Health and President, MaineGeneral Community Care and MaineGeneral Rehabilitation & Long Term Care
Barbara Covey, MD, Emergency Services, MGMC
Vicki Foster, Health Educator Supervisor, Center for Prevention & Healthy Living
LeeAnna Lavoie, Manager, Community Health Education, MGH
Barbara Mayer, MaineGeneral Board of Directors
Natalie Morse, Director, Center for Prevention and Healthy Living
Barbara Moss, DO, Maine-Dartmouth Family Medicine Residency
Laura Mrazik, Program Leader, Accountable Care and Population Health Management, MGH
Laura Robbins, Grant Program Manager, Center for Prevention & Healthy Living
Malindi Thompson, Project Director, MaineGeneral Harm Reduction Program
Melanie Thompson, MD, Medical Director, Primary Care, MGMC
Emilie van Eeghen, Vice President, Mental Health & Substance Abuse Services, MGMC

Community Engagement Summary

MaineGeneral Health

Summary of Community Engagement

Priorities Selected: Central Public Health District

Access to care, chronic disease, obesity, tobacco and substance misuse

Process

MaineGeneral representatives participated in 12 of 16 community engagement forums and events held in the Central Public Health District between Sept. 11, 2015 and March 23, 2016. These forums and events involved individuals who represent the broad interest of the community.
Sectors attending included: public health, medical staff leadership, nurses, social workers, health care administration, local and state government, low income community representatives, community health coalitions, non-profit agencies, behavioral health service providers, public schools, local police and the faith community. Appendix A includes the 16 completed community engagement reporting forms that list those attending and additional details regarding the sharing of data, and the input provided by those attending. Appendix B outlines the summary of these 16 community engagement reporting forms within the Central Public Health District (Kennebec and Somerset counties).

These community engagement forums and events were an essential component of the Maine Shared Health Needs Assessment Planning Process (SHNAPP) Community Health Needs Assessment (CHNA), allowing for community members to review state and local health data and identify the next steps required to address the identified community health priorities. Participants in some of the forums met in small, focused groups to discuss opportunities for collaboration on specific priority issues. Other engagement events involved questions, suggestions and discussion about possible implementation strategies that a hospital system could lead or contribute to in some way. In addition, MaineGeneral convened its Community Health Improvement Committee (CHIC) board of directors committee and invited key stakeholders with expertise in mental health and substance use disorders, chronic disease, obesity, tobacco use and access to care. The CHIC scheduled a series of meetings which were attended by representatives from MaineGeneral Community Care, MaineGeneral Quality Department, Emergency Department medical staff, Family Medicine Residency staff, MaineGeneral leadership, MaineGeneral Health Board of Directors, and the Center for Prevention and Healthy Living. The CHIC then developed MaineGeneral's Community Health Implementation Plan based on the results of the series of meetings. The Community Health Implementation Plan includes goals, strategies, outcomes and resources committed and needed for each of the five priority areas identified.

- Chronic disease
- Obesity
- Tobacco use and exposure
- Access to care
- Substance use disorders

The CHIC selected strategies the health care system is uniquely positioned to address. In addition it identified the community partners MaineGeneral will be working with to address the priority areas.

Priorities Not Selected

All of the priorities identified by the community forums and events were included in the CHIP. The following health issues were identified by surveillance data but not selected for the CHIP:

- Falls
- Traumatic brain Injury
- Overall mortality rates

In addition to the strategy of focusing current resources on the top five priorities listed above, there is a lack of detailed data, evidence-based programs, expertise within the system and financial resources to address these priorities.

Community Health Implementation Committee

Monica Beaulieu, Administrative Director, Quality Care Management & Safety, MGMC

Nona Boyink, Senior Vice President, MaineGeneral Health and President, MaineGeneral Community Care and MaineGeneral Rehabilitation & Long Term Care

Barbara Covey, MD, Emergency Services, MGMC

Vicki Foster, Health Educator Supervisor, Center for Prevention & Healthy Living

LeeAnna Lavoie, Manager, Community Health Education, MGH

Barbara Mayer, MaineGeneral Board of Directors

Natalie Morse, Director, Center for Prevention and Healthy Living

Barbara Moss, DO, Maine Dartmouth Family Medicine Residency

Laura Mrazik, Program Leader, Accountable Care and Population Health Management, MGH

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Malindi Thompson, Project Director, MaineGeneral Harm Reduction Program

Melanie Thompson, MD, Medical Director, Primary Care, MGMC

Emilie van Eeghen, Vice President, Mental Health & Substance Abuse Services, MGMC

Impact of the 2013-2015 Community Health Needs Assessment Impelmentation Plan

MaineGeneral Medical Center addressed its tobacco, chronic disease prevention, substance misuse, infectious disease, access to care and data and indicator goals over the three-year period of the implementation plan.

Leadership to oversee the implementation of the plan, management of staff and grant funding was support by MGMC's operational budget. In addition, the board allocated $52,000 per year along with three other health systems to oversee the implementation of an ongoing statewide community health needs assessment process. MaineGeneral's Prevention Center has served as the home for the program manager of this statewide project which coordinated the assessment process and contacts - resulting in the 2016 Community Health Needs Assessment (CHNA) used to inform this 2016 - 2018 implementation plan.

The Prevention Center director secured approximately $2.5 million in grant funds and use $750,000 of the MaineGeneral Community Health fund to implement the strategies included in the CHIP. Securing these funds supported carrying out all of the implementation plan goals including tobacco, chronic disease, access to care and substance use prevention.

A network of evidence based prevention programs was built and in 2015 the Healthy Living programs were integrated to provide all patients access to mind-body, physical movement and healthy eating educational programs as well as disease management programs. Most of these programs to support healthy living are provided at low cost or are free.

Patients now with chronic disease risk are screened and routinely referred via the EHR to evidence-based chronic disease programs and services offered in more than 30 communities in MaineGeneral's service area. Referrals for smoking cessation counseling locally or to the Maine Tobacco Helpline are standard workflows in primary care.

The Prevention Center HUB serves as the information and referral center for programs and services and links patients without access to primary care to open primary care practices, Care Partners and oral health care. With primary care staffing challenges, the HUB staff helps patients find a PCP when they are in need, even when many practices are closed. HUB staff work with leadership of primary care to deal with the challenges of limited access.

Two community health workers spend time in the community working closely with primary care to link patients who need cancer screenings, diabetes diagnostic tests, and health education. They address barriers such as food insecurity, transportation and health literacy, to name a few barriers to better health.

One oral health community health worker now assists families with young children. She educates families about prevention of caries, helps with them gain access to fluoride supplements and links them to local dentists for prevention screening by age one and needed oral health care for children up to age nine.

An integrated harm reduction program was built, by braiding grant funds from five different sources. This program provides outreach targeting adults about how to reduce harm, if they are actively using substances. The service links patients to primary care or to substance use treatment services when they are ready.

In addition the staff provides harm reduction education to patients via the Needle Exchange Program at Green Street in Augusta. The program started distributing naloxone to patients at risk for opiate overdose in clinical settings, and naloxone use education was provided to local sheriff departments, that now can save lives of people they find who have overdosed, while waiting for the ambulance.

In addition staff provides training to primary care providers on how to use the Maine PMP program, to monitor controlled substance prescriptions among patients they see to support safe prescribing practices and prevent diversion. A program identifying patients at risk of opiate overdose by using EHR data has been developed that will assist providers in implementing the new opiate prescribing guidelines. Staff have coordinated four suboxone waiver trainings for primary care providers to provide office based opioid treatment.

SHNAPP Community Engagement Committee Reporting Form

Name of Mtg/Group:
Name:
Phone:
Date of Event:
Location of Event:
Geographic area of group:
Population served:
County or District:
people present:

Format of Event (highlight or circle one):

Community Forum	Key Informant Interview	Focus Group
Survey	Group Presentation	Other:

Representation From (highlight or circle all that apply):

Public Health	Community Health Coalition	Business/Civic Leadership
Healthcare Providers	Funding Agencies	College/University
Local/State Government	Non-Profit Agencies	Professional Member Orgs.
Medically Underserved	Low Income	Minorities (Racial/Ethnic)

Other:

Details About Organizations (explain medically underserved, low income, minorities and "other"):

Type of Input (highlight or circle all that apply):

Shared CHNA Presented & Discussed	Identified Significant Health Needs
Selected Priorities among Needs	Named Local Assets/Resources

Perception of health & social/environmental factors affecting health outcomes

Other:

Details to Summarize Input (use more pages as needed or copy/paste notes/minutes):

Important: Your name and phone number will be confidential.

Implementation Strategy (3 Year)

MaineGeneral Health

MaineGeneral Medical Center Implementation Strategy

Member / Affiliate Hospital	MaineGeneral Medical Center
County	Kennebec and Somerset
Priority	Chronic Disease
Goal	Prevention and Management of Chronic Disease (Diabetes, Cardiovascular Disease and Cancer) via health system strategies.

Strategies/ Activities:
Implement Primary Care Demonstration Project Team Based Care pilot project within MaineGeneral Primary Care.
Implement Care Management Platform by Kennebec Regional Health Alliance, and implement standardization of care management to improve population health.
Utilize MaineGeneral Outpatient Staff Education *Center* to develop outpatient clinical staff education plan to assure competent workforce to implement population health strategies.
Expand PICH Clinical Community Linkages Project to include screening for social determinants of health and chronic disease risk and referral to new evidence based services and resources to improve health.
Expand and sustain the use of Community Health Workers in linking patients and practices to chronic disease management prevention and treatment resources in the MGH service area.
Resources Committed:
MG Primary Care budgets for Team Based Care, Care Management Platform and Staff Education Center
PICH Clinical Community Linkages work funded by Center for Disease Control from July 1, 2016 to September 30, 2017
Center for Prevention and Healthy Living funding from Peter Alfond Endowment, MaineGeneral Community Health Fund
SIM grant from July 1, 2016 to Sept 30, 2016
Additional resources committed by Spectrum Generation, KV YMCA, Alfond Youth Center, and Greater Somerset Public Health for chronic disease support services

Resources Needed:
Grant funding to expand primary care, care management, and community linkages activities and evaluate expansion of these strategies
Additional funds needed to support community health workers, and evidence based programs and service ($200,000/ year).
Leadership engagement with business leaders, insurers, governmental leadership (local and state), social service agencies
Outcomes/ what will be measured:
Increased patient panels per practice and provider
Improved patients experience scores in outpatient practices
Improved chronic disease indicators (Blood pressure, Pre-diabetes, Diabetes, Depression, COPD)
Maintain readmission rates for AMI, CHF, PN, COPD
Increased referral to evidence based prevention services and social determinants of health resources in the community
Increased enrollment and utilization of evidence based prevention intervention and health education services delivered by MGMC
Increased screening rates for breast, cervical, colon and lung cancer

MaineGeneral Medical Center Implementation Strategy

Member / Affiliate Hospital	MaineGeneral Medical Center
County	Kennebec
Priority	Obesity
Goal	Prevention and Management obesity via physical movement and healthy eating policies, programs and services.

Strategies/ Activities:
Expand and sustain evidence based health cooking and physical movement programs.
Develop and implement 3 year communication plan targeting providers, business, insurers, governmental leadership, social service agencies and the public re the benefits of local physical movement and healthy eating polices programs and services.
Primary care practices will develop proactive outreach plan and implement work flow and electronic health system changes to better serve populations of patients with obesity risk.
Expand obesity prevention activities via WIC (Women Infant and Children program) and primary care.
Increase collaboration with community agencies such as Alfond Youth Center, YMCA and Spectrum Generation to assure obesity prevention programs are sustained in the community.
Resources Committed:
Peter Alfond Endowment
Alfond Communication Funds
WIC Resources
Clinical community linkages work to be funded by PICH grant funding from the Center for Disease Control from July 1, 2016 to September 30, 2017
Resources Needed:
Grant funding for program expansion ($200,000/year)

Leadership engagement with business leaders, insurers, governmental leadership (local and state), social service agencies
Outcomes/ what will be measured:
Improved obesity and physical activity indicators of adults and children (overweight, obesity, sedentary lifestyle)
Increased obesity prevention policy, program and service participation indicators
Improved WIC prevention indicators

MaineGeneral Medical Center Implementation Strategy

Member / Affiliate Hospital	MaineGeneral Medical Center
County	Kennebec
Priority	Tobacco Use and Exposure
Goal	Reduce lung disease mortality, by reducing disease risk factors for COPD and Lung cancer via primary care and community based strategies.

Strategies/ Activities:
Expand tobacco exposure screening and referrals to lung disease risk reduction and screening services via primary care.
Implement use of community health workers “CHWs” to educate low income communities about lung cancer risk and link them to cessation, primary care, prevention services and lung cancer screening.
Expand access and referral to cessation services via WIC, and MG counseling.
Resources Committed:
MaineGeneral Community Health Fund
Bristol Meyer Squibb Foundation Lung Cancer Prevention and Screening contract
Free ME from Lung Cancer Foundation funds
Clinical community linkages work to be funded by PICH grant funding from the Center for Disease Control from July 1, 2016 to September 30, 2017
WIC Contract funds
Resources Needed:
Grant funding or payment of Community Health worker staff time ($100,000)
IT technical support for report writing assuring accurate data re tobacco exposure and referral to services for quality improvement and program evaluation

Outcomes/ what will be measured:
Increased % of patients screened and referred to lung disease risk reduction services
Increased % of patients age 55 + patients receiving Low Dose CT Lung cancer screening
% of MaineGeneral Primary Care practices and providers implementing lung disease screening and referral interventions

MaineGeneral Medical Center Implementation Strategy

Member / Affiliate Hospital	MaineGeneral Medical Center
County	Kennebec
Priority	Substance Use Disorder
Goal	Reduction in overdose mortality, by implementation of health systems strategies reducing number of pain prescriptions per capita, substance use risk screening , and provision of treatment in primary care.

Strategies/ Activities:
Establish a comprehensive medical staff plan for opiate prescribing, pain management, risk reduction and opiate treatment of patients.
Implement outreach plan for provider education on guidelines for safe opioid prescribing, use of Maine Prescription Drug Monitoring (PMP) system, screening and referral for opiate dependence services.
Implement public education campaign on MG standards of care for pain management, and commitment to prevention and treatment.
Implement overdose prevention and naloxone education in all MaineGeneral clinical settings targeting patients and families at increased risk.
Expand medication assisted treatment capacity by providing provider and primary care office staff training.
Complete feasibility study to expand integrated harm reduction services to Waterville area.
Resources Committed:
ROOR HRSA Grant(July 1 to October 1, 2016)
Maine General Community Health Fund
Resources Needed:
Grant funding to coordinate implementation of Community Education Campaign,($200,000)

Funds to coordinate implementation of comprehensive plan of medical staff education, including waiver training, new guidelines for safe opioid prescribing, PMP updates, and treatment resources($200,000)
Outcomes/ what will be measured:
Increased # of providers utilizing PMP, new prescribing guidelines for safe opioid prescribing, and community education materials.
Increased % MGH practices where office based opioid treatment services are provided.

MaineGeneral Medical Center Implementation Strategy

Member / Affiliate Hospital	MaineGeneral Medical Center
County	Kennebec
Priority	Access to Care
Goal	**Increasing access to primary care, oral health and mental health services.**

Strategies/ Activities:
Expand use of Community Health Workers to address access to care barriers related to medical care and oral health.
Expand Center for Prevention and Health living HUB staffing to support linking Emergency Department, Express Care, and Care Management Platform patients with no PCPs to appropriate follow up and primary care.
Expand the integration of mental health services in primary care settings.
Implement stigma education for medical staff and primary care regarding mental illness and barriers to access to care.
Implement collaboration strategies and referrals between oral health service providers and primary care to assure dental health service access to children up to age 9, and pregnant women.
Participate in public transportation planning process to address transportation barriers to assure access prevention and medical care services.
Resources Committed:
SIM grant from July 1, 2016 to Sept 30, 2016.
Maine Oral Health Funders Children's Oral Health Program Grant July 1, 2016 to June 30, 2017.
From The First Tooth Oral Health grant, January 1, 2016 to Dec 31, 2016.
MaineGeneral Community Health Fund.
Medical Staff and Behavioral Health Leadership education budgets .
Resources Needed:

Additional Funds to support community health workers, and HUB navigation staff ($100,000/ year).
Grant to support oral health service access for uninsured pregnant women ($100,000)
Local matching funds to support enhancements to public transit services to areas outside of Kennebec Explorer current routes.
Outcomes/ what will be measured:
Increased # of patients linked to services by Community Health Workers and HUB staff.
Increased# of practices offering mental health services.
# of providers and practice staff completing training on addressing stigma.
Increased # of children up to age 9 and pregnant mothers who are linked to a dental health for oral health services.
# of new transit routes and service times established to support access to prevention and care.

Appendix A

Community Health
Needs Assessment:

Kennebec and Somerset
Counties

SHNAPP Community Engagement Committee Reporting Form

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

*** Name of Meeting or Group:**	**Community Health Issues**
*** Date of Event:**	**9/11/2015**
*** Location of Event:**	**Redington Fairview General Hospital**
*** Geographic area of group:**	**Somerset County**
*** Population served:**	**Residents of Somerset County**
*** County or District:**	**Somerset**
*** # people present:**	**316**
*** Format of Event:**	**Survey**

*** Representation from (check all that apply):**

Healthcare Providers | Medically Underserved | Low Income

Details about organizations (provide any additional information here):

Healthcare: This survey was provided at RFGH sponsored support groups; the participants of these support groups are at risk of not receiveing medical care. RFGH serves a low income population.

Type of Input (check all that apply):

√ Identified Significant Health Needs
√ Selected Priorities among Needs

*** Details to summarize input:**

Surveys were offered to and completed by 316 participants of community programs:
-Support groups (cardiac, pulmonary, cancer, tobacco, and diabetes)
-Worksite meetings

Members and caregivers were asked to rate health issues (family health, chronic diseases, infectious diseases, healthy behaviors or other health issues) based on how they felt the health issues might impact their overall health.

Greater than 50% of those responding indicated the following were moderate or major problems:
-Cardiovascular health
-Elder health
-Obesity

Greater than 33% of those responding indicated the following were moderate or major problems:
-Physical activity
-Musculoskeletal health
-Diabetes Mellitus
-Cancer
-Respiratory health
-Depression

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**Somerset Public Health Annual Meeting**
Date of Event:	**9/14/2015**
Location of Event:	**Skowhegan Maine**
Geographic area of group:	**Skowhegan to Jackman**
Population served:	**Residents of Somerset County**
County or District:	**Somerset**
# people present:	**89**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Funding Agencies
Non-Profit Agencies	Low Income	Business/Civic Leadership
College/University		
Other: Law Enforcement & Clergy		

Details about organizations (provide any additional information here):
A snapshot of organizations/individuals represented during the meeting: Greater Somerset Public Health Collaborative, Healthy Northern Kennebec, Redington Fairview Hospital, MaineGeneral, United Way,Somerset Sheriff's Office, Skowhegan Police department, Spectrum Generations, Kennebec Behavioral Health, Hospice Volunteers of Somerset County, Maine St. Skowhegan, economic development corporation and local business owners, KVCAP, DHHS in Skowhegan, legislator, and community members.

The voice of low income people was represented by healthcare and behavioral health providers and hospitals serving patients with MaineCare and/or Medicare insurance. Medically underserved patients were represented by healthcare providers and hospitals that provide low-cost or free care to qualifying patients. In addition, Skowhegan DHHS, United Way, KVCAP, and Healthy Maine Partnerships serve low income and medically underserved community members.

Type of Input (check all that apply):
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**
Presentation by Tim Cowan of Maine Med. of 2015 County Health Ranking data and some early available SHNAPP data to our broad based coalition and community members. Community members and some of our senior committee members in attendence.

Issues for follow up action: Data should be age adjusted, youth smoking obesity and nutrition, obesity rates and inactivity of adults, Substance abuse prevention and treatment at all levels (marijuana), reproductive health issues especially of teens, mental health (isolation and depression), poverty and access (transportation).
Steps to take to address health issues: More access to tobacco cessation, creative ways to evolve public transportation, more youth involvement in their own solutions to health issues, connect youth and seniors together more, create a culture of healthy eating, identify high risk youth early and create ways to reach them, increase funding support for rural counties to implement evidence-based programs,
work to address shortages of health care professionals to patient ratios, promote health screenings, annual checkups and knowing your numbers (incentivize these), get businesses more involved in employee health.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**DCC SHNAPP Waterville Forum – Topic OBESITY**
Date of Event:	**12/10/2015**
Location of Event:	**WTVL Elks Club**
Geographic area of group:	**Towns in Kennebec/Somerset Counties**
Population served:	**Citizens within Kennebec and Somerset Counties**
County or District:	**Central- Kennebec & Somerset Counties**
# people present:	**52**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Low Income	Other: Clergy
Other: School administration		

Details about organizations (provide any additional information here):

Sample of organizations – KVCAP, Waterville Main Street, Kennebec Messalonskee Trails, Maine Children's Home, NAMI Maine, American Lung Assn., Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley, MaineGeneral (MG), Inland Hospital, Redington Fairview General Hospital, EMHS, HealthReach Community Health Centers, Kennebec Behavioral Health, MG Community Care, Assistance Plus, MSAD 59, Waterville/Vassalboro Before/After School Programs, MG Board of Directors, Maine CDC.

Hospitals (MaineGeneral, Inland, EMHS, Redington Fairview), health care providers (HealthReach Community Health Centers), and behavioral health care providers (Kennebec Behavioral Health, MG Community Care) serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services (Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley), non-profit agencies (KVCAP, Maine Children's Home, NAMI Maine), and local/state government agencies (Maine CDC) specifically serve low-income and medically underserved residents.

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

Details to summarize input:

Obesity - 3 measures of Success:
[1] Decrease in obesity rates/BMI
[2] Increase in physical activity/weight loss programs
[3] Access to programs (offerings/transportation)

3 Identified gaps:
[1] Access to affordable food
[2] Poverty
[3] Lack of knowledge/lack of desire change of lifestyle

Top 3 Roles for Hospitals: [1] Links to programs
[2] Collaboration with community organizations
[3] Referrals for programs from primary care, etc.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**DCC SHNAPP Waterville Forum – Topic DRUG & ALCOHOL ABUSE**
Date of Event:	**12/10/2015**
Location of Event:	**WTVL Elks Club**
Geographic area of group:	**Towns in Kennebec/Somerset Counties**
Population served:	**Citizens within Kennebec and Somerset Counties**
County or District:	**Central- Kennebec & Somerset Counties**
# people present:	**52**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Low Income	Other: Clergy
Other: School administration		

Details about organizations (provide any additional information here):

Sample of organizations – KVCAP, Waterville Main Street, Kennebec Messalonskee Trails, Maine Children's Home, NAMI Maine, American Lung Assn., Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley, MaineGeneral (MG), Inland Hospital, Redington Fairview General Hospital, EMHS, HealthReach Community Health Centers, Kennebec Behavioral Health, MG Community Care, Assistance Plus, MSAD 59, Waterville/Vassalboro Before/After School Programs, MG Board of Directors, Maine CDC.

Hospitals (MaineGeneral, Inland, EMHS, Redington Fairview), health care providers (HealthReach Community Health Centers), and behavioral health care providers (Kennebec Behavioral Health, MG Community Care) serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services (Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley), non-profit agencies (KVCAP, Maine Children's Home, NAMI Maine), and local/state government agencies (Maine CDC) specifically serve low-income and medically underserved residents.

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

Details to summarize input:

Drug & Alcohol Abuse - 3 measures of Success:
[1] Reduce hospital and ER visits
[2] Fewer 911 calls

[3] Reductions in A/D related mortalities

3 Identified gaps:
[1] Education/prevention in schools
[2] Access/Funding
[3] Cultural change
[4] Treat SA as a health issue and not a legal issue

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**DCC SHNAPP Waterville Forum – Topic OTHER PRIORITIES**
Date of Event:	**12/10/2015**
Location of Event:	**WTVL Elks Club**
Geographic area of group:	Towns in **Kennebec/Somerset Counties**
Population served:	**Citizens within Kennebec and Somerset Counties**
County or District:	**Central- Kennebec & Somerset Counties**
# people present:	**52**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Low Income	Other: Clergy
Other: School administration		

Details about organizations (provide any additional information here):
Sample of organizations – KVCAP, Waterville Main Street, Kennebec Messalonskee Trails, Maine Children's Home, NAMI Maine, American Lung Assn., Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley, MaineGeneral (MG), Inland Hospital, Redington Fairview General Hospital, EMHS, HealthReach Community Health Centers, Kennebec Behavioral Health, MG Community Care, Assistance Plus, MSAD 59, Waterville/Vassalboro Before/After School Programs, MG Board of Directors, Maine CDC.

Hospitals (MaineGeneral, Inland, EMHS, Redington Fairview), health care providers (HealthReach Community Health Centers), and behavioral health care providers (Kennebec Behavioral Health, MG Community Care) serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services (Healthy Northern Kennebec, Somerset Public Health, Healthy Sebasticook Valley), non-profit agencies (KVCAP, Maine Children's Home, NAMI Maine), and local/state government agencies (Maine CDC) specifically serve low-income and medically underserved residents.

Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

Details to summarize input:
What are three other top priority issues:
[1] Poverty
[2] Mental health
[3] Domestic violence

Other priority issues:

- Transportation
- Access to services

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**Central DCC Augusta SHNAPP Forum – Topic: Obesity**
Date of Event:	**12/11/2015**
Location of Event:	**Alfond Center for Health, Augusta**
Geographic area of group:	**WTVL/Augusta**
Population served:	**Central District**
County or District:	**Central-Kennebec & Somerset Counties**
# people present:	**37**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Professional Member Orgs.	Low Income
Other: Law Enforcement		

Details about organizations (provide any additional information here):
Sample of organizations – KVCAP, Somerset Public Health, Healthy Northern Kennebec, Healthy Communities of the Capital Area, MaineGeneral, Redington Fairview, Inland, EMHS, Quality Counts, United Way, Southern Kennebec Child Development Corp., Spurwink, Crisis & Counseling, Sexual Assault Crisis & Support, Gardiner Food Co-op, Hallowell Bicycle/Pedestrian Committee, ME Oral Health Coalition, Discovery House, Hart Consulting, Maine CDC, Augusta Police Dept.

Hospitals, health care providers, substance abuse treatment programs, and behavioral health providers serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services, non-profit agencies, and local/state government agencies specifically serve low-income and medically underserved residents.

Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Health Issue #1 Obesity -- 3 measures for success in addressing obesity:
[1] Access to healthy foods along with access to grocery stores, food banks, and farmers markets
[2] Social networking groups for physical activity, i.e., walking clubs, and
[3] Transportation to physical activity services

3 gaps in addressing obesity:
[1] Transportation

[2] Awareness of the problem
[3] Nutrition education in schools and among adults

Top 3 roles for hospitals: [1] Fund Let's Go in schools
[2] Have Standards of care for obesity

How can other organizations take a lead:
[1] Schools offer use of facilities and promote through adult education
[2] Employers offering gym memberships
[3] Communities initiate food policy councils with HMP support

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**Central DCC Augusta SHNAPP Forum – Topic: Drugs & Alcohol**
Date of Event:	**12/11/2015**
Location of Event:	**Alfond Center for Health in Augusta**
Geographic area of group:	**WTVL/Augusta**
Population served:	**Central District-Residents of Kennebec & Somerset Counties**
County or District:	**Central**
# people present:	**37**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Professional Member Orgs.	Low Income
Other: Law Enforcement		

Details about organizations (provide any additional information here):
Sample of organizations – KVCAP, Somerset Public Health, Healthy Northern Kennebec, Healthy Communities of the Capital Area, MaineGeneral, Redington Fairview, Inland, EMHS, Quality Counts, United Way, Southern Kennebec Child Development Corp., Spurwink, Crisis & Counseling, Sexual Assault Crisis & Support, Gardiner Food Co-op, Hallowell Bicycle/Pedestrian Committee, ME Oral Health Coalition, Discovery House, Hart Consulting, Maine CDC, Augusta Police Dept.

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Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Health Issue #2 Drug & Alcohol Abuse -- 3 measures for success:
[1] Increase prevention education for all ages to remove the stigma
[2] Stronger partnership with law enforcement and public safety
[3] ACE's root causes identified early on
[4] Reduced overdoses (deaths, ED visits and hospitalizations)

3 gaps in addressing drug & alcohol abuse:
[1] Access to treatment (wait lists, score at ER not high enough to refer for treatment)
[2] Lack of education-all ages to remove cultural stigma
[3] Affordable and accessible mental/behavioral health prevention, treatment and recovery services

Top 3 roles for hospitals:
[1] Navigators eligibility for treatment
[2] Prescribing and monitoring - use PMP
[3] Address ACE to address substance abuse

What can other organizations do: [1] More state government funding

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

Name of Meeting or Group:	**Central DCC Augusta SHNAPP Forum – Topic: Other**
Date of Event:	**12/11/2015**
Location of Event:	**Alfond Center for Health, Augusta**
Geographic area of group:	**WTVL/Augusta**
Population served:	**Central District**
County or District:	**Residents of Kennebec & Somerset Counties**
# people present:	**37**
Format of Event:	**Community Forum**

Representation from (check all that apply):

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Non-Profit Agencies
Business/Civic Leadership	Professional Member Orgs.	Low Income
Other: Law Enforcement		

Details about organizations (provide any additional information here):
Sample of organizations – KVCAP, Somerset Public Health, Healthy Northern Kennebec, Healthy Communities of the Capital Area, MaineGeneral, Redington Fairview, Inland, EMHS, Quality Counts, United Way, Southern Kennebec Child Development Corp., Spurwink, Crisis & Counseling, Sexual Assault Crisis & Support, Gardiner Food Co-op, Hallowell Bicycle/Pedestrian Committee, ME Oral Health Coalition, Discovery House, Hart Consulting, Maine CDC, Augusta Police Dept.

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Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
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*** Details to summarize input:**

Other health issues - Three additional priorities:
Issue 1. Increase utilization of primary care vs. ED/Express Care visits; Increase awareness & provide transportation
Issue 2. Transportation: access, reliable , cost
Issue 3. Oral health; school based prevention, funding; care for un/under insured

Other issues listed: Poverty, Violence prevention, and Mental health services

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**MaineGeneral Board of Directors Meeting**
* Date of Event:	**1/4/2016**
* Location of Event:	**Alfond Center for Health in Augusta, ME**
* Geographic area of group:	**Kennebec Valley**
* Population served:	**Residents of Kennebec Valley**
* County or District:	**Kennebec**
* # people present:	**21**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Healthcare Provider
Business/Civic Leadership
Low Income
Medically Underserved

*** Details about organizations (provide any additional information here):**

The Board of Directors is comprised of medical/healthcare providers, hospital administrators and leadership, and prominent local business leaders. As a healthcare system, MaineGeneral provides low-cost and free care to low-income and medically underserved citizens of the Kennebec Valley.

*** Type of Input (check all that apply):**

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

The group learned about the Maine SHNAPP/Shared CHNA and reviewed summary data tables while seeing highlights of select data trends on indicators within the 2013-16 Implementation Strategy [Overweight/Obesity (adult); Sedentary Adults; Diabetes Prevalence; HTN Prevalence; Stroke Mortality; Smkoing Prevalence (adult); All Cancer Mortality; Lung CA Incidence; Lung CA Mortality; Breast CA Mortality; CRC Screening; Adults with Usual Provider; Opioid stats/trends].
-One Board member noted the relationship between income and health outcomes; poorer people have worse health outcomes.
-There was a question about whether diabetes incidence has been increasing or we do a better job of screening and diagnosing? One presenter with many years experience felt this is due to improved screening and availability of evidence-based programs.
-A question arose about the “usual source of care” metric – does it include ED and Express Care? Probably not, the item is worded about perception of a person doctor or health care provider.
-Another question arose about wanting to know the number of MG practices that offer Suboxone treatment.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**MaineGeneral Medical Directors Meeting**
* Date of Event:	**1/11/2016**
* Location of Event:	**Alfond Center for Health in Augusta, ME**
* Geographic area of group:	**Kennebec Valley**
* Population served:	**Residents of Kennebec Valley**
* County or District:	**Kennebec**
* # people present:	**15**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Healthcare Provider Low Income Medically Underserved

*** Details about organizations (provide any additional information here):**

The medical directors meeting is comprised of medical/healthcare administrators and leadership. As a healthcare system, MaineGeneral provides low-cost and free care to low-income and medically underserved citizens of the Kennebec Valley.

*** Type of Input (check all that apply):**

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

The group learned about the Maine SHNAPP/Shared CHNA and reviewed summary data tables while seeing highlights of select data trends on indicators within the 2013-16 Implementation Strategy [Overweight/Obesity (adult); Sedentary Adults; Diabetes Prevalence; HTN Prevalence; Stroke Mortality; Smkoing Prevalence (adult); All Cancer Mortality; Lung CA Incidence; Lung CA Mortality; Breast CA Mortality; CRC Screening; Adults with Usual Provider; Opioid stats/trends].

Significant needs include:
-Multi-pronged approach to substance abuse & unified prescribing practices; Use of PMP as a standard
-Mental health resources
-Coordinate communication among primary care/mental health/substance abuse for better pt outcomes
-Aging population
-Spaces for safe &/or indoor physical activity [let patients/public know about them]

Information needed:
-Overall mortality trends (have mortality by diagnosis)
-PCPs per capita; Try to explain drop in people not reporting a regular health care provider
-Are residents not going into primary care? What percentage remain in central ME (MDFP, FMI)?

Although hospitals cannot necessarily address poverty or other social determinants of health, it is understood these issues lie at the root of many of the health outcomes noted in the Kennebec Valley, and throughout Maine.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**Primary Care Transformation (PCT) Leadership Team**
* Date of Event:	**1/19/2016**
* Location of Event:	**MaineGeneral Alfond Center for Health**
* Geographic area of group:	**Kennebec County region**
* Population served:	**Primary Care: practices, providers & patients**
* County or District:	**Kennebec**
* # people present:	**25**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Medically Underserved
Non-Profit Agencies	Low Income	

Details about organizations (provide any additional information here):
PCT is primarily representatives from the primary care practices in Kennebec Region Health Alliance. There are some other MaineGeneral departments that are members but no outside organizations unless they are guests.

Medically underserved pop represented by primary care providers who have a number of patients with financial barriers affecting access care. Low income are represented by patients with MaineCare and Medicare as payor.

Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Named Local Assets/Resources

*** Details to summarize input:**
TOP HEALTH NEEDS IDENTIFIED

1. **Mental Health, Behavioral Health & Substance Abuse**
   - Better access to services, including expanding insurance coverage to address financial barriers
   - Med management & support
   - Opiates: addiction & prescribing
   - Drug counseling
2. **Obesity - needs**
   - Treatment
   - The stigma of having obesity as the primary reason for a healthcare visit
   - Having difficult conversations about obesity, both by patients talking to providers AND providers talking to patients
   - Dietary/nutrition education, especially how this is related to many different chronic diseases
3. **Chronic conditions -needs**
   - Chronic disease
   - Barriers to accessing diabetic eye exams, including payment

• Tobacco
• Chronic pain management
• Poly-pharmacy (elderly patients)

RESOURCES & NEED FOR MORE
1. Ongoing education/training for providers
• Health coaching & motivational interviewing
• Early risk identification
• Guidance & recommendations, especially on safe prescribing, for example CDC guidelines, Beers List, PMP
2. Partnerships
• Identifying resources that are part of a care management platform or based in the community
• Connecting patients (recommending or referring) to these community resources & programs through partnerships
• Shared medical appointments: developing the "team" model, engaging the team, co-management within the team
• Utilizing services already available in the practice (e.g., social services, CHWs, dietitians): sharing
these resources and expanding their already existing roles
• Expand care teams/practice support to include health educators, CHWs, leaders, community care workers, pharmacy help, social workers, and med management/prescribing team (especially for mental health needs)
3. Direction of healthcare
• Aligning healthcare priorities/direction toward population health
▪ Federal solution to disparate records

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**Sebasticook Valley Hospital Community Engagement Forum-Drug & Alcohol Abuse Breakout Session**
* Date of Event:	**1/20/2016**
* Location of Event:	**Sebasticook Valley Hospital, Pittsfield**
* Geographic area of group:	Somerset **County**
* Population served:	**Residents of Sebasticook Valley**
* County or District:	**Somerset County**
* # people present:	**43**
* Format of Event:	**Community Forum**

*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Funding Agencies
Non-Profit Agencies	Low Income	Business/Civic Leadership
College/University	Professional Member Orgs.	Minorities

Details about organizations (provide any additional information here):
Sample of organizations – United Way, ME Health Access Foundation, Southern ME Area Agency on Aging, Preble St. Resource Center, legislator, Somali commnity members, USM/UNE/SMCC/Tufts medical School, ME Health Mgt Coalition, MaineMedical Center (hospital facility), Spring Harbor Hospital, Mercy Hospital, Bridgton Hospital, HMP, & Portland Public Health.

Hospitals and health care providers serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services, social service agencies, funding agencies, and non-profit agencies specifically serve racial/ethnic minorities, low-income, and medically underserved residents. Somali community members attended the forum.

Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

1. What resources currently exist in our region to address <u>DRUG AND ALCOHOL ABUSE</u>?

Support groups such as AA, NA, etc.	Substance abuse treatment, both individual and group treatment
Kennebec Behavioral Health	Somerset county psych provider (only 1 in the county)
School education in middle and high school classrooms	Northeast Occupational Exchange
Emergency Department	HealthySV Coalition

Disaster teams at schools	Project Graduation
EAP	Law enforcement

Certain programs like Angel Program, Project Hope (report use without penalty)
NAMI – will be offering 20 min. classes in Somerset County on Mental
Health First Aid Training. Goal of reaching 20 adults.

2. What resources are needed in our region to address DRUG AND ALCOHOL ABUSE?

Transportation to existing services	VERY limited support groups such as AA in our region
Limited education in schools	VERY limited crisis care and management
Lack of education level for general population	Lack of education on root causes for use/abuse
Limited first responders	Limited acute treatment, one day or short term only
Family outreach	Psych providers
Communication of available resources	Information and visibility of agencies/resources

Intake – first come, first serve and may review, may take/not take/may refer or not Emergency Department – call crisis and could take HOURS
Inappropriate care/location, housed in Emergency Department but not able to provide appropriate services. The patient stays in the ED until too tired and go home (not treated) while taking up resources (inefficient). Then, police are called for safety check.

3. Where do we go from here?

- Increase access to treatment
- Increase visibility of services
- Multiple providers are needed: behavior health, intake, direct services, PCP, direct substance abuse treatment
- START in schools and at younger age than middle school
- Provide education for parents of youth age 0 to 5
- PCP needs to be part of the strategy
- Involve Boy Scouts/Girl Guides
- Offer after school programs
- Region needs a youth center (possibly use an empty elementary school)
- Expose children and FAMILY to fun activities at an earlier age
- Community based teams to address substance abuse and change cultural norms as a community
- Address poverty
- Address stigma of substance abuse (3)*
- Break the cycle...poverty, low education
- Start more support groups in the region
- Youth lead message to change culture (2)
- Word of mouth best advertising
- Use real Life stories, testimonials at forums

- Agencies identified: SVH, Healthy SV Coalition, KBH, NOE, EMS, DHHS, Law Enforcement, Child Protection Services, Current Providers, Community Leaders, Crisis Center, Schools, EAP

4. What are some of the barriers that exist in our region that we should be aware of, as we determine what strategies to focus on over the next 3 year period?

- Stigma (3)
- Lack of resources
- Rural and poor
- Transportation (3)
- Not seeing substance abuse as a problem – socially acceptable
- Lack of education opportunities (no post-secondary)
- PCP screenings – question self-reporting/honesty
- Parents apathetic
- Protection of job/status

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

*** Name of Meeting or Group:** **Sebasticook Valley Hospital Community Engagement Forum-Mental Health Breakout Session**
*** Date of Event:** **1/20/2016**
*** Location of Event:** **Sebasticook Valley Hospital, Pittsfield**
*** Geographic area of group:** **Somerset County**
*** Population served:** **Residents of Sebasticook Valley**
*** County or District:** **Somerset County**
*** # people present:** **43**
*** Format of Event:** **Community Forum**
*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Funding Agencies
Non-Profit Agencies	Low Income	Business/Civic Leadership
College/University	Professional Member Orgs.	Minorities

Details about organizations (provide any additional information here):
Sample of organizations – United Way, ME Health Access Foundation, Southern ME Area Agency on Aging, Preble St. Resource Center, legislator, Somali commnity members, USM/UNE/SMCC/Tufts medical School, ME Health Mgt Coalition, MaineMedical Center (hospital facility), Spring Harbor Hospital, Mercy Hospital, Bridgton Hospital, HMP, & Portland Public Health.

Hospitals and health care providers serve low income patients through Medicare/MaineCare and provide low-cost/no-cost services to medically underserved residents. Many public health programs and services, social service agencies, funding agencies, and non-profit agencies specifically serve racial/ethnic minorities, low-income, and medically underserved residents. Somali community members attended the forum.

Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

1. What resources currently exist in our region to address MENTAL HEALTH?

211 (2)	Acadia Hospital (3)
Alcoholics Anonymous (2)	Assistance Plus (3)
Assisted Living Centers	Charlotte White
Church Ministry (2)	Crisis and Counseling (3)

GEAR Parent Network
Imbedded mental health services in family practice (3)
Independent practitioners (3)
Kennebec Behavioral Health (3)
Kid's Connection
Law enforcement
Maine Behavioral Health (2)
Maine.gov
ME DHHS Warm Line (2)
NAMI (3)
NAMI Respite program
National Alliance Mental Illness
Northeast Occupational Exchange (3)
Skills, Inc. (2)
Support groups (2)
Tele-health (3)
Women Care
Worksite EAP
School guidance counselors, school nurses, school social workers (3)
Somerset County Hospice House, Pine Tree Hospice, Hospice Volunteers of Somerset County (2)

2. What resources are needed in our region to address MENTAL HEALTH?
Ability to move patients to/from different settings(2)
Access to psychiatrists (2)
Access to services (2)
Acute care beds
Additional inpatient beds (2)
Care plans linking physical and mental health needs (2)
Collaboration with law enforcement, health care and schools
Create a shared database between providers and law enforcement to increase awareness of those with mental illness
Directory of resources
Educate healthcare providers on mental health conditions
Emergency psychiatric services
Funding to support services not covered by insurance (2)
Improve access to resources to connect providers
Improved tele-health services to coordinate services in the ED and inpatient
Increase capacity for inpatient adult and adolescent treatment
Increase funding for services
Increase home-based mental health services
Increase number of service providers
Increase public support for education, funding, and incentives
Programs to increase awareness about mental health and educate providers and the public to improve attitudes surrounding mental health
Standardized process
Streamlined/coordinated access
Timely access to services
Transportation to services (3)

3. Where do we go from here?

- Increase collaboration between service providers; primary care providers identify and referrals from school personnel
- Improve the laws pertaining to reimbursement and access to services.
- Provide incentive to discuss issues.
- Provide training to primary care providers and staff on early recognition (using assessment tools) of mental health illnesses.
- Define a protocol for schools to assist with early recognition and referral to provider
- Create a comprehensive resource list of services providers, locations, contact information, etc.
- Legislators-Increase knowledge of mental health issues and laws so as to effectively update legislation to improve access to care.
- Bring groups together to educate and inform community members and providers about mental health.
- Increase number of peer navigators (i.e. Assistance Plus, behavioral health homes)
- Engage businesses to help fund the cost through increased employee mental health services

4. What are some of the barriers that exist in our region that we should be aware of, as we determine what strategies to focus on over the next 3 year period?

- Lack of recognition of mental illness within the community (2)
- Limited funding of mental health services (2)
- Stigma surrounding mental health illness
- Who will take the lead?
- Poverty, lack of employment opportunities
- Laws limiting options to share information, perceptions and reimbursement

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**Sebasticook Valley Hospital Community Engagement Forum-Obesity Breakout Session**
* Date of Event:	**1/20/2016**
* Location of Event:	**Sebasticook Valley Hospital, Pittsfield**
* Geographic area of group:	**Somerset County**
* Population served:	**Residents of Sebasticook Valley**
* County or District:	**Somerset County**
* # people present:	**43**
* Format of Event:	**Community Forum**

*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Local/State Government
Medically Underserved	Community Health Coalition	Funding Agencies
Non-Profit Agencies	Low Income	Business/Civic Leadership
College/University	Professional Member Orgs.	Minorities

Details about organizations (provide any additional information here):
Sample of organizations – United Way, ME Health Access Foundation, Southern ME Area Agency on Aging, Preble St. Resource Center, legislator, Somali commnity members, USM/UNE/SMCC/Tufts medical School, ME Health Mgt Coalition, MaineMedical Center (hospital facility), Spring Harbor Hospital, Mercy Hospital, Bridgton Hospital, HMP, & Portland Public Health.

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Type of Input (check all that apply):
√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

1. What resources currently exist in our region to address <u>OBESITY</u>?

Winter Walking (3)	SVH/Diabetes & Nutrition Services (3)
Food Pantries (3)	SNAP-Ed (3)
Pittsfield Welcome Table and other free community meals (2)	Adult Education (2)
Worksites/Worksite Wellness Programs (2)	Kohl's Cares About ME (2)

Bone Builders (2)
Summer Meals Program (2)
Senior Farm Share
Maine Federation of Farmers' Markets
In-school food bank
Youth groups / Boy Scouts / 4H
Primary Care Providers
Churches
Meals on Wheels
Fresh Fruit and Veggie Program
Parks (2)
Co-operative Extension (2)
Maine Organic Farmers and Growers Association (MOFGA)
MCI – Culinary club
Adult Softball and Baseball leagues
Pittsfield Library
Overeaters Anonymous /Weight Watchers /TOPS
Recreation Departments
Alliance Club in Hartland and St. Albans
Back Pack Program

2. What resources are needed in our region to address OBESITY?

Community Gardens (2)
Increased physical education in schools (2)
Fitness Facilities
Community Center
More support groups
Adult Nutrition Education
Nutrition Education and gardening in public schools (2)
Transportation (2)
Funding to address food insecurity
Health Food Stores
Increased utilization of farmers' markets
Schools to obtain Community Eligibility status for free breakfast and lunch Ameri-Corp & Food Corp

3. Where do we go from here?

- Better communication of resources available (3)
- PCP referrals to community resources (3)
- Referrals to Living Well for Better Health (chronic disease self-management program) and Cooking Matters (cooking/nutrition education class)
- Coordinate youth programming utilizing local parks and Summer Meals Program
- Have in-store nutrition educators/dieticians at Buds
- Youth and Adult Physical Activity programming
- Have our local farmers' markets accept SNAP benefits
- Consistent Fresh Fruit and Veggies program
- Utilize town grange halls for programming
- Increased DHHS presence in the community

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**HCCA HealthReach Community Health Center Board Of Directors**
* Date of Event:	**1/27/2016**
* Location of Event:	**Waterville**
* Geographic area of group:	**Multi-county Central Maine** (Kennebec, Somerset, Franklin, Oxford)
* Population served:	**Rural, underserved, & low SES individuals, families & older adults within counties identified**
* County or District:	**Central**
* # people present:	**11**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Medically Underserved
Community Health Coalition	Non-Profit Agencies	Low Income

Details about organizations (provide any additional information here):

HealthReach Health Centers (HRCHC)provide primary care practice services including acute, chronic and preventive medical services to 28,000 Maine residents and visitors each year at 11 sites that include two dental centers and the integration of behavioral health services across our sites. With the integration of primary care, dental and behavioral health services, HRCHC health care team are able to more fully address the needs of their patients.

Since FQHCs must be at least 50% patients from the health centers, at least 50% are medically underserved due to geography or low-income and they also represent the other patients at the FQHC who do not have insurance, use sliding fee scales

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

The Board members were provided data one week prior to the meeting on four of the counties in which Health Reach has FQHC sites: Franklin, Kennebec, Oxford and Somerset. These included the Executive Summary for each county report and the longer data sets as well as summaries from the Robert Wood Johnson County Health Rankings. (Note: the district chosen was Central because most input was regarding Kennebec and Somerset Counties.)

The presentation of health data was a new experience for a Board whose primary responsibilities are financial and policy related. However, in the past several years there has been a greater focus by the Board on learning about the various health services provided. The Medical Directors provide medical updates and presentations have including education that have included measures of success, and the

tracking of core health criteria related to chronic conditions such treatment of opiate addiction, diabetes care and tobacco use and exposure as well as how the tracking process ultimately helps the practices to best serve the patients.

The presentation consisted primarily of comparisons among the data for each of the 4 counties. The presenter helped the participants to note the demographics including income as well as the health data. All understood that

- Lower-income often translates into health disparities and less access as the FQHC Health Centers must serve medically underserved
- Locations of health centers also serve more rural areas
- There are providers who prescribe Suboxone, but not at all health centers. Since the need is high for MAT, this is also an area of concern at this time.
- HRCHC also should be noted for the many providers who do provide Suboxone and for their leadership on this issue.

General:

- Most health conditions continue to be linked to obesity such as diabetes, tobacco use and exposure and substance abuse, although at different rates. And these continue to be priorities.
- It is good that all centers are Patient Centered Medical Homes, have behavioral health providers on site.
- The SNAPP information can be used in applying for grants. Consistent data collection across hospital services areas makes it much easier to describe conditions in different geographic locations served by HRCHC.
- HRCHC has integrated tobacco referrals into EMR and continues to increase screening and referral for tobacco treatment.

Franklin County – No representative on the board. Did not discuss in detail.
Oxford County - Did not discuss in detail.

Kennebec County significant discussion:

- Highest median income of the 4 counties.
- Dental care continues to be a significant need.
- Future Asset: Belgrade Health Center is in the planning stages of adding at least one dentist, and is working on the funding options for a 2nd dentist.
- Concern: MaineCare for children's dental care is available, but under used so promoting availability and need will be important to make a 2nd dentist financially viable
- Concern: Travel to Belgrade is not currently a KVCAP bus route
- Unknown if dental appointments can be covered for travel reimbursements through MaineCare

Somerset County:

- Poverty is clearly an issue here. There are more sliding fee scale patients.
- Adults are sicker than in other counties.
- People go to emergency departments more than in other counties, but the distance between providers is a factor.
- More concerns with lead and children as the housing stock is very old. Would like more resources about this in the community.

MaineCare expansion would greatly increase ability to provide services and for patients to afford their prescriptions.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**MaineGeneral Leadership Council Meeting**
* Date of Event:	**2/9/2016**
* Location of Event:	**Thayer Center for Health in Waterville, ME**
* Geographic area of group:	**Kennebec Valley**
* Population served:	**MG Patients & Residents of Kennebec Valley**
* County or District:	**Kennebec**
* # people present:	**200**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Healthcare Provider | Low Income | Medically Underserved
Business/Civic Leadership

*** Details about organizations (provide any additional information here):**

The MG Leadership Council is comprised of medical/healthcare providers, hospital and practice administrators, and leadership within MG departments. As a healthcare system and accountable care organization (ACO), MaineGeneral provides low-cost and free care to low-income and medically underserved citizens of the Kennebec Valley.

*** Type of Input (check all that apply):**

√ Shared CHNA Presented & Discussed

*** Details to summarize input:**

The group learned about the MaineGeneral 2013-2015 CHNA/Implementation Plan in addition to the Maine SHNAPP/Shared CHNA. Approximately 30% of attendees were familiar with the current documents.

We reviewed highlights of select data trends on indicators within the 2013-16 Implementation Strategy. Print resources from the 2015-2016 Shared CHNA were available as well as copies of the power point with embedded URLs for data and resources. Some of the people attending will be selected to participate in updating the MaineGeneral CHNA/Implementation Plan for 2016-2018.

There were no questions or comments posed during the presnetation.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**HCCA-MeHAF Healthy Communities Planning Team**
* Date of Event:	**2/18/2016**
* Location of Event:	**Augusta, KBH Conference Room**
* Geographic area of group:	**Gardiner to Augusta on both sides of river**
* Population served:	**Residents of Southern Kennebec County**
* County or District:	**Kennebec**
* # people present:	**11**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Public Health	Healthcare Providers	Medically Underserved
Community Health Coalition	Non-Profit Agencies	Low Income
Other: Law Enforcement		

Details about organizations (provide any additional information here):

HCCA received a Healthy Communities Grant from Maine Health Access Foundation. This is a Phase II planning process to align multiple organizations and sectors to combine efforts to reduce the impact of substance abuse on the whole community. This issue was identified 2-1 over housing and adequate food for our communities as the biggest health issue. 22 Organizations have committed representatives to collaboratively define the strategies and partner roles to implement over a 3-5 year period. Member organizations that serve medically underserved and low income include: MaineGeneral Behavioral Health Services, Family Violence Project, Spurwink Services, Head Start, Kennebec Sherriff's Office

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

The presentation provided added treatment data over the past year, needle exchange data over the past three years, and the 2015 Maine Integrate Youth Health Survey past 30 day use for tobacco, alcohol, marijuana, prescriptions not their own, parent attitudes and perception of harm.

The group already had prioritized substance abuse as the primary driver of health related concern in southern Kennebec County in a prior 18 month process, so focused on these issues.

Areas of concern:

- The use of tobacco, alcohol, marijuana, prescription and illegal drugs are strongly connected to all the other issues of the most concern in our communities
- We need to double down on prevention for all of these substances because of the number of people reporting multiple use
- The legislation rather than clinical trials that make marijuana use legal are a great concern, not because there might not be good medical reasons for use as tinctures, etc., but because now marijuana seems 'healthy' and without risk which is not true with links to mental illness and other concerns especially for developing brains.
- Police are by necessity more focused on the crimes related to illegal drugs then on enforcement of other violations to the same extent as in previous times like OUI, underage drinking violations, etc. also reducing the idea that there will be consequences
- Schools, parents, etc. are saying about substance use – it's just tobacco, it's only alcohol, marijuana is better than heroin, comments and ideas that will no help with prevention or recovery from a wide range of substances.
- Children are not being nurtured adequately when parents are using nor being fed, clothed, housed adequately.

Unmet needs:

- Not adequate supports for affected families, children, teens
- Isolation needs to be reduced and community connections need to be increased at all levels
- Recovery needs to be supported, people in recovery need to feel safe and not always exposed to drugs, alcohol, tobacco. People in recovery also may not have healthcare or safe housing, transportation, jobs, food or a place to cook.
  - ♦ Identify location for recovery center to branch out from
- Reduce stigma for the individual and families
- Schools should have consequences for substance policy violations, but they should focus on keeping youth in school, engaged and expecting more not less from them
- SIRP classes should increase
- Increase mental health and substance abuse screening at all primary care practice
- Assessment of need for opiates by surgeons including dental surgeons, assessment of prior problems with drugs, recommendations for other pain control becomes standard
- Longer term support systems.

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**RFGH Better Breathers (pulmonary support)**
* Date of Event:	**2/18/2016**
* Location of Event:	**Redington-Fairview General Hospital**
* Geographic area of group:	**Skowhegan Maine**
* Population served:	**community members with breathing problems**
* County or District:	**Somerset**
* # people present:	**25**
* Format of Event:	**Survey**

*** Representation from (check all that apply):**

Public Health | Healthcare Providers | Low Income
Medically Underserved

Details about organizations (provide any additional information here):

1 out of every 5 adults in Somerset County live in poverty. Redington Fairview General Hospital provides care to low income patients (covered by MaineCare) and medically underserved patients (who qualify for sliding fees and free care).

Type of Input (check all that apply):

√ Selected Priorities among Needs
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Biggest Problems:
-Obesity
-Addiction
-Transportation
-Smoking

Why is it a problem here?
-No places or resources to be healthy
-Nothing to do, no alternatives to unhealthy behaviors
-Lack of people to run programs
-Lack of ambition

What needs to change?
-Places to get help
-Sidewalks needed
-Places to walk

-Senior centers
-Free transportation
-Accountability
-Addition education
-Leadership

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**RFGH Cancer Support Group**
* Date of Event:	**2/23/2016**
* Location of Event:	**Redington-Fairview General Hospital**
* Geographic area of group:	**Skowhegan, Maine**
* Population served:	**Cancer survivors, community members in greater Somerset County**
* County or District:	**Somerset**
* # people present:	**15**
* Format of Event:	**Focus Group**

*** Representation from (check all that apply):**

Public Health | Healthcare Providers | Low Income
Medically Underserved

Details about organizations (provide any additional information here):

Redington Fairview General Hospital provides care to low income patients (covered by MaineCare) and medically underserved patients (who qualify for sliding fees and free care).

Type of Input (check all that apply):

√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Biggest issues: Drug abuse; Smoking; Obesity

Why a problem?
Drugs--dependency, lack of education, breakdown of relationships
Smoking--people are getting sick
Obesity--food system provides unhealthy foods (added sugars)

Why a problem here?
Drugs--social acceptance, society treating it as an offense rather than a disease. Nobody helps. No socially acceptable treatment. Lots of social isolation. Poor role-modeling.
Obesity--economics--fattening foods are cheaper, no home economics (for teaching food resource management).

What needs to change?
Drugs--Parents who use need to be taken from their kids. Provide education and assistance without stigma.

Smoking--shock ads to prevent them from starting smoking when they are young; increase price to $20 per pack; enforce smoking distances, "50 foot rule."

Obesity--use sugary beverage displays; feed kids better food at school; It begins at home, if it doesn't happen there, at school won't help. Parents need to be parents (i.e. act responsible).

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

* Name of Meeting or Group:	**Southern Kennebec Social Services Meeting**
* Date of Event:	**3/1/2016**
* Location of Event:	**Family Violence Project**
* Geographic area of group:	**Southern Kennebec County**
* Population served:	**Youth, low income families, community members**
* County or District:	**Kennebec**
* # people present:	**7**
* Format of Event:	**Group Presentation**

*** Representation from (check all that apply):**

Public Health | Medically Underserved | Non-Profit Agencies
Low Income

Details about organizations (provide any additional information here):

Maine Children's Services, YMCA, SKCDC, Private psychology practice. Southern Kennebec Child Development Corporation serves low income families; all provide services for community members who are medically underserved.

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Top priorities identified by the group for Kennebec county:
-Cancer
-Sexual Assault
-Substance Use
-Child Oral Health
-Lead Screenings

Reasons for Health Outcomes:
-Lack of Maine State Learning Requirement for substance/alcohol education
-Lack of transportation
-Lack of insurance coverage
-Need for health system redesign

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

*** Name of Meeting or Group:**	**HCCA Capital Area Food Council**
*** Date of Event:**	**3/10/2016**
*** Location of Event:**	**Healthy Communities of the Capital Area, Gardiner**
*** Geographic area of group:**	**Capital Area**
*** Population served:**	**Residents of the Capital area**
*** County or District:**	**Kennebec**
*** # people present:**	**3**
*** Format of Event:**	**Group Presentation**

*** Representation from (check all that apply):**

Public Health | Healthcare Providers | Other: Farmer

Details about organizations (provide any additional information here):

Type of Input (check all that apply):

√ Shared CHNA Presented & Discussed
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Named Local Assets/Resources
√ Perception of health & social/environmental factors affecting health outcomes

*** Details to summarize input:**

Surprised at high obesity rates.

What can HCCA & CAFC do: Need to increase education opportunities at the ground level (grocery store, MD offices, nutrition information provided with SNAP benefits). Public health efforts need to be a two-way street with feedback from the recipients. Utilize local level public health intervention data and outcomes (SNAP-Ed, Cooking Matters, Farm to School, FoodCorps, etc.) to address obesity prevention.

What can others do: Legislature should prohibit any item hit by the snack tax to be purchased by SNAP recipients. Need to focus less on the individual and more on policy, systems, and environmental change. Focus on healthy food as a public health prevention strategy. Need to match readiness for behavior change with prevention strategies.

Who else needs to partner: Health care, Hannaford, RDs

Outstanding questions: What is currently going on throughout the state's public health sector to address social determinants, as related to prevention?

Maine Shared Health Needs Assessment & Planning Process Project
SHNAPP Community Engagement Committee Reporting Form

*** Name of Meeting or Group:**	**Healthy People of the Kennebec Valley Event**
*** Date of Event:**	**3/23/2016**
*** Location of Event:**	**Alfond Center for Health, Augusta**
*** Geographic area of group:**	**Greater Kennebec Valley**
*** Population served:**	**Employers/Employees**
*** County or District:**	**Central District**
*** # people present:**	**15**
*** Format of Event:**	**Group Presentation**

*** Representation from (check all that apply):**

Business/Civic Leadership	Non-Profit Agencies	Healthcare Providers
Colleges/Universities	Medically Underserved	Low Income

Details about organizations (provide any additional information here):

Some of the businesses/agencies represented include: State of Maine, Anthem, Kennebec Technologies, KV YMCA, Kennebec Behavioral Health, Thomas College, Cigaret Shopper, Northeast Outreach Associates, and MaineGeneral Medical Center.

Many local businesses and social service organizations employ low income/medically underserved individuals. Healthcare providers serve low income people covered by MaineCare and Medicare and medically underserved people without insurance by providing sliding fees and/or free care.

Type of Input (check all that apply):

√ Discussed Shared CHNA
√ Identified Significant Health Needs
√ Selected Priorities among Needs
√ Perception of health & social/environmental factors affecting health outcomes
√ Other: Identified gaps in resources and role of employers

*** Details to summarize input:**

Top priorities

1. Obesity-Physical, Activity, Nutrition and Tobacco
2. Mental Health and Substance Abuse
3. Chronic Disease Management (cancer, diabetes, CVD)
4. Health Literacy

Top roles for employers

1. Education (resources, health care consumerism, etc)
2. Prevention (physical activity, weight loss, health coaching, behavior change)
3. Policy development, education and enforcement (develop a culture of health)
4. Connect employees/families to community resources

Top gaps:

1. Mental health and substance abuse resources
2. Community support for managing chronic disease

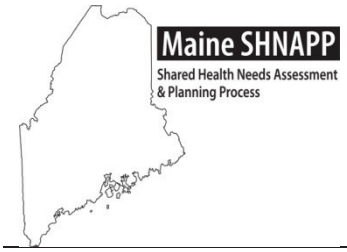
3. Education on where to get help for employee wellness
4. Leadership from all businesses

Other comments:

- How do we get more employers engaged and realize that "healthy employees" is a priority and should be part of the business strategy?
- How do we demonstrate the benefits for small employers – is there a way to incent and reward them for improving the health of our community?
- How do we build sustainability?

Appendix B

Summary Report of
Forums & Event Input



Maine SHNAPP Community Engagement Phase Summary Report of Forum & Event Input Central Public Health District

May 2016

This serves as a brief summary report of the input provided by community members attending the 4 community forums and 12 community events that took place in Kennebec and Somerset Counties between September 2015 and March 2016. Maine SHNAPP held community engagement events starting in November 2015 although events that took place in Skowhegan during September have been included since the community representing Somerset County participated and provided pertinent input. Copies of individual reporting forms (pdf) can be viewed using the link below by looking under the Community Engagement header and clicking on the forum or event of interest:
https://www.mainegeneral.org/Pages/District-5-Central-Maine.aspx

Community Forums

Meeting	Date	Location
Somerset Public Health Annual Meeting-Forum	9/14/2015	Skowhegan, ME
Central DCC Waterville Forum	12/10/2015	Waterville Elks Club
Central DCC Augusta Forum	12/11/2015	Alfond Center for Health, Augusta
Somerset County Forum	1/20/2016	Sebasticook Valley Hospital, Pittsfield
Total Attending Forums:		**221**

Community Events

Meeting	Date	Location
Community Health Issues Survey	9/11/2015	Redington Fairview General Hospital, Skowhegan
MaineGeneral Board of Directors Meeting	1/4/2016	Alfond Center for Health, Augusta
MaineGeneral Medical Directors Meeting	1/11/2016	Alfond Center for Health, Augusta
Primary Care Transformation (PCT) Leadership Team	1/19/2016	Alfond Center for Health, Augusta
HCCA HealthReach Community Health Center Board Of Directors	1/27/2016	Waterville
MaineGeneral Leadership Council	2/9/2016	Thayer Center for Health, Waterville
RFGH Better Breathers (pulmonary support)	2/18/2016	Redington-Fairview General Hospital, Skowhegan
HCCA-MeHAF Healthy Communities Planning Team	2/18/2016	Augusta, KBH Conference Room
RFGH Cancer Support Group	2/23/2016	Redington-Fairview General Hospital, Skowhegan
Southern Kennebec Social Services Meeting	3/1/2016	Family Violence Project in Augusta
HCCA-Capital Area Food Council	3/10/16	Gardiner
Healthy People of the Kennebec Valley Event	3/23/2016	Alfond Center for Health in Augusta
Total Attending Events:		**664**

Total Attending Forums & Events 885

Attendance numbers may contain duplicates if one person attended more than one forum/event.

Community Sectors Represented During Forums and Events

Representation from Different Community Sectors Attending 16 Forums/Events

Medically Underserved	15
Low Income	15
Minorities	1
Professional Member Orgs.	2
College/University	3
Business/Civic Leadership	7
Non-Profit Agencies	9
Community Health Coalition	6
Local/State Government	4
Healthcare Provider	15
Public Health	11
Other	5
Funding Agencies	2

"Medically underserved," "low income," and "racial/ethnic minorities" are sub-populations named specifically by the Department of Treasury/IRS regulations.

Other: Law enforcement, clergy, public schools, farmer

Type of Input Obtained During Forums and Events

Number of Forums/Events During Which Specific Topics Were Covered

Discussed Shared CHNA data12

Identified health needs	14
Prioritized health needs	11
Identified assets and resources	7
Discussed perception of health	13
Identified barriers	5
Solutions/Next steps	4
Other	1

"Other" included: Role of employers in addressing health needs

Community Forums

These forums, organized and co-led by Maine CDC District Liaisons and SHNAPP hospital community benefit representatives, typically consisted of a prepared Power Point presentation followed by breakout sessions on health topics. In general, breakout sessions obtained input about:

- Summary statements about the issue and/or its effect on the community
- Identification of local assets and resources to address the issue
- Identification of barriers to addressing the health issue or needs of the community before more adequately addressing the issue
- Ideas for next steps, how to solve the health issue, who to include, and what the community should look like in the future

Themes Identified During Central District Forums

Health Issue: Obesity

Summary of assets to resources to address issue: Let's Go!, school facilities, and adult education offerings as well as opportunities for organized and unorganized physical activity, meal supports in the community and schools, education in schools, community settings, and health care, worksite wellness programs. (See list of specific programs in appendix on page 7.)

Summary of barriers or community needs (if reported): Transportation and poverty are two of the largest barriers recognized in the district leading to remarks about lack of access to care for a number of medical issues. There is also an awareness from the community about a lack of providers/practitioners to support the need of various health issues (a lack of telehealth services, lack of behavioral health professionals). Within this there is also a concern for lack of "medical homes," locations that provide behavioral, primary care and even sometimes dental services. Much of the response was more systems- based, both of the needs of the providers to build better care times as well addressing the issues of health needs on a statewide level, from a policy perspective. Lack of employment opportunities and funding to address issues across the district, as well as education were also mentioned.

Summary of next steps, solutions, future ideal: Success in reducing obesity means increased programming for and access to physical activity and weight loss (includes transportation to activities and programs), access to healthy foods at grocery stores, farmer's markets (i.e. accept SNAP), and food banks, and overall decrease in body mass index (BMI) and obesity rates. Hospitals play a role in reducing obesity by funding evidence-based programs (Let's Go!, Living Well for Better Health) in the community and having standards of care that include linkages/collaboration and referrals to community programs. Other organizations can play a role in reducing obesity by offering space for activities (schools, grange halls), gym memberships (employers), cooperation or collaboration in bringing education and programs to the community (local parks and summer meals program for youth, in-store nutrition educators or Cooking Matters). Communities can initiate food policy councils. There needs to be increased funding for rural counties to implement evidence-based programs and improved health care provider ratios.

Health Issue: Drug and Alcohol Abuse

Summary of assets to resources to address issue: Prescription Monitoring System (PMP), Screening, Brief Interventions and Referral to Treatment (SBIRT), treatment providers, support groups, school- based education and supports, employer-based supports, health care, law enforcement, and mental health assets. (See list of specific programs in appendix on page 7.)

Summary of barriers or community needs (if reported): Transportation and poverty are two of the largest barriers recognized in the district leading to remarks about lack of access to care for a number of medical issues. There is also an awareness from the community about a lack of providers/practitioners to support the need of various health issues (a lack of telehealth services, lack of behavioral health professionals). Within this there is also a concern for lack of "medical homes," locations that provide behavioral, primary care and even sometimes dental services. Much of the response was more systems- based, both of the needs of the providers to build better care times as well addressing the issues of health needs on a statewide level, from a policy perspective. Lack of employment opportunities and funding to address issues across the district, as well as education were also mentioned. Stigma around substance use issues and limited social support for those issues were mentioned as well.

Summary of next steps, solutions, future ideal:
Success in addressing drug and alcohol abuse means reduced hospital/ED visits and 911 calls along with reductions in mortality associated with drugs and alcohol. This will be achieved by addressing ACEs (Adverse Childhood Experiences), increasing prevention education for all ages, and improving partnerships among law enforcement and public safety. Hospitals support success on this issue by providing resources (navigators for people seeking treatment, increasing outpatient treatment capacity), creating standards of care that include the PMP, SBIRT, and addressing ACEs, and collaborating with other organizations to provide education and evidence-based programs. Other organizations play a role by providing funding (government, philanthropic agencies), legislative change, and collaboration. A cultural shift needs to take place to reduce stigma, treat the disease (instead of treating people with addictions as criminals), and involve youth in their prevention/treatment programming.

Health Issue: Mental Health (Somerset County only)
Summary of assets to resources to address issue: Behavioral health care providers, NAMI, support groups, assisted living and hospice providers, school support staff, health care, Acadia hospital, 211. (See list of specific programs in appendix on page 7.)

Summary of barriers or community needs (if reported): Transportation and poverty are two of the largest barriers recognized in Somerset County, leading to remarks about lack of access to care for a number of medical issues. Lack of employment opportunities and funding to address issues across the county, as well as education were also mentioned. As in other counties, specific system-based asks were also brought up, such as a lack of telehealth services and lack of behavioral health professionals were cited. Stigma around substance use issues and limited social support for those issues were mentioned as well.

Summary of next steps, solutions, future ideal: Next steps and solutions fall into four categories: Policy changes, collaboration, education, and provider protocols. Access to services will improve when laws related to reimbursement change and privacy laws allow information sharing among mental health providers and primary care. Agencies and providers need to collaborate to improve referral processes (especially from schools), create a comprehensive community resource list, support peer navigators, develop creative transportation solutions, and engage local businesses (help fund through increased employee mental health services). Educate primary care providers and their staff, school personnel, and community members about recognizing and responding to mental health issues. Encourage primary care providers, school personal, and mental health providers to implement protocols that consistently identify and refer people in need of services to the correct resource.

Health Issue: Tobacco Use and Cessation (Somerset County only)

Summary of assets to resources to address issue: Youth, seniors, parents, businesses (no specifics included)

Summary of barriers or community needs (if reported): Transportation and poverty are two of the largest barriers recognized in Somerset County, leading to remarks about lack of access to care for a number of medical issues. Lack of employment opportunities and funding to address issues across the county, as well as education were also mentioned. As in other counties, specific system-based asks were also brought up, such as a lack of telehealth services and lack of behavioral health professionals were cited. Stigma around substance use issues and limited social support for those issues were mentioned as well.

Summary of next steps, solutions, future ideal: Youth need to be involved in solutions to their health issues, including tobacco prevention programming and cessation efforts. There needs to be increased access to tobacco cessation including creative ways to evolve public transportation for people to access services. Finally, the shortage of health care professionals who can screen and refer for services needs to be addressed and people should attend existing groups/Quit Line.

Health Issue: Name three additional health issues or health factor priorities (December 2016 Forums)

- Transportation, Poverty, Mental Health, and Access to Services identified at both forums
- Increase utilization of primary care over ED/Express Care, Oral Health, and Violence Prevention identified during one forum.

Summary of assets to resources to address issue: n/a

Summary of barriers or community needs (if reported): n/a

Summary of next steps, solutions, future ideal: n/a

Community Events
These events were organized and carried out by community stakeholders (including Maine CDC District Liaisons, SHNAPP hospital employees, or others who sat on local SHNAPP Community Engagement Committees). Typically already formed groups agreed to hold a presentation about the Shared CHNA data and discuss their reactions based on the group leader's questions. In general, input from events consisted of brief summary statements or questions about health issues and health factors affecting the geographic area.

Priorities Identified During Central District Events:
- Obesity (in 6 of 12 district events)
- Drug abuse/addiction (8 of 12 district events)
- Smoking/Tobacco (5 of 12 district events)
- Poverty and social determinants of health (4 of 12 district events)
- Mental health, oral health, chronic conditions, lead, and older adults (2 of 12 district events, each)
- Physical activity, rural populations, cancer, sexual assault, health literacy, transportation, cardiovascular health, elder health (1 of 12 district events, each)

Additional Themes Identified During Central District Events:

- Roles for employers
- Transportation barriers
- Suboxone treatment as both a resource and a need
- Patient centered medical homes as a resource
- Need to align healthcare priorities and direction with population health
- Partnerships and communication for better team care of patients as both solutions and needs
- Lack of resources and alternatives to unhealthy behaviors
- Leadership is needed

Appendix: Specific resources listed by priority area [Somerset County]

OBESITY

- Winter Walking (3)
- SVH/Diabetes & Nutrition Services (3)
- Food Pantries (3)
- SNAP-Ed (3)
- Pittsfield Welcome Table and other free community meals (2)
- Adult Education (2)
- Worksites/WorksiteWellness Programs (2)
- Kohl's Cares About ME (2)
- Bone Builders (2); Parks (2)
- Summer Meals Program (2)
- Co-operative Extension(2)
- Senior Farm Share
- Maine Organic Farmers and Growers Association (MOFGA)
- Maine Federation of Farmers' Markets
- MCI – Culinary club
- In-school food bank
- Adult Softball and Baseball leagues
- Youth groups/Boy Scouts/4H
- Pittsfield Library
- Primary Care Providers
- Overeaters Anonymous/Weight Watchers/TOPS
- Churches
- Recreation Departments
- Meals on Wheels
- Alliance Club in Hartland and St. Albans
- Fresh Fruit and Veggie Program
- Back Pack Program

DRUG AND ALCOHOL ABUSE

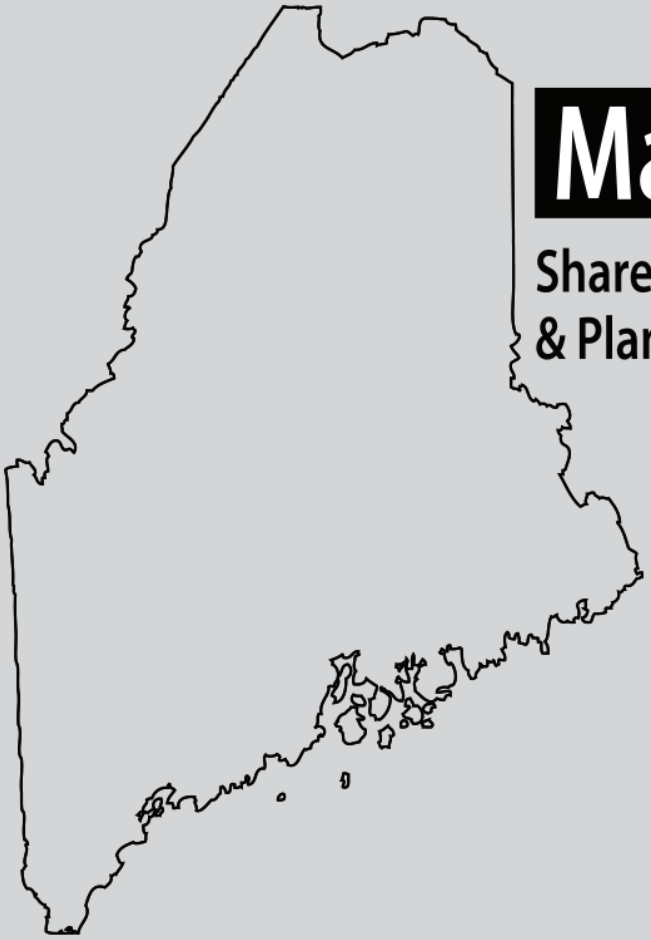
- Support groups such as AA, NA, etc.
- Substance abuse treatment, both individual and group treatment
- Kennebec BehavioralHealth
- Somerset county psych provider (only 1 in the county)
- School education in middle and high school classrooms
- Northeast Occupational Exchange
- Emergency Department
- Healthy SV Coalition
- Disaster teams at schools
- Project Graduation
- EAP
- Law enforcement Certain programs like Angel Program, Project Hope (report use without penalty)
- NAMI – will be offering 20 min. classes in Somerset County on Mental Health First Aid Training (Goal of reaching 20 adults)

MENTAL HEALTH

- 211 [2]
- Acadia Hospital [3]
- Alcoholics Anonymous [2]
- Assistance Plus [3]
- Assisted Living Centers
- Charlotte White; Church Ministry [2]
- Crisis and Counseling [3]
- GEAR Parent Network
- Imbedded mental health services in family practice [3]
- Independent practitioners [3]
- Kennebec Behavioral Health [3]
- Kid's Connection
- Law enforcement
- Maine Behavioral Health [2]
- Maine gov ME DHHS
- Warm Line [2]
- NAMI [3]
- NAMI Respite program
- National Alliance Mental Illness
- Northeast Occupational Exchange [3]
- School guidance counselors, school nurses, school social workers [3]
- Skills, Inc [2]
- Somerset County Hospice House,
- Pine Tree Hospice,
- Hospice Volunteers of Somerset County [2]
- Support groups [2]
- Tele-health [3]
- Women Care
- Worksite EAP

Appendix C

Kennebec County and Somerset County Reports



Maine SHNAPP

Shared Health Needs Assessment & Planning Process

2016 Shared Community Health Needs Assessment

Kennebec County

Prepared by: Market Decisions Research and Hart Consulting, Inc., November 3, 2015 [updated 2/29/2016]

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MARKET DECISIONS RESEARCH

HART CONSULTING

See end of the report for a list of contributors and collaborating organizations.

Note: Originally, this report was dated 2015 on the cover. However, it has been changed to 2016 to reflect the fiscal years of the organizations that have been involved.

Table of Contents

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Table of Tables

How to Use This Report

This report contains findings for Kennebec County from the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) conducted in 2015. It is divided into ten sections to provide the reader with an easy-to-use reference to the data-rich assessment. It starts with the highest level of data, followed by summaries and synthesis of the data. The last sections include the detailed findings from assessments as well as the sources.

The report has several features that are important to keep in mind:

- The document provides a reference for more than 160 indicators and more than 30 qualitative survey questions covering many topics. It does not explore any individual topic in-depth.
- The definitions, sources and year(s) for each indicator discussed in the report are found at the end in the data sources section.
- Wherever the term, "statistically significant" is used to describe differences between data estimates, it means that the 95 percent confidence intervals for the given point estimates do not overlap.
- Unless otherwise noted, all rates presented in this report are age-adjusted and calculated per 100,000 population to facilitate comparisons between counties, Maine and the U.S.

The following is a brief description of each section.

Executive Summary
The summary provides the highest level overview of data for the county.

Background
This section explains the purpose and background of the SHNAPP and the Shared CHNA. It includes a description of the methodology and data sources used in the assessment.

County Demographics
The demographic section compares the population and socioeconomic characteristics of the county to the overall state of Maine.

Summary of Findings
This section provides a summary of the assessment data by health issue; it compares the county to the state and U.S. on key indicators and explains the importance of the health issues.

Stakeholder Feedback
High-level findings from the stakeholder survey are included in this section. It explores the top five health issues and factors identified as local priorities or concerns by stakeholders. It shares respondent concern for populations experiencing disparities in health status for these issues.

Priority Health Issues and Challenges

Priority health issues and challenges appear in this section. This section categorizes the key findings from the quantitative and stakeholder (qualitative) datasets as strengths and challenges. The analysis includes health issue indicators from the quantitative datasets sorted into challenges and strengths, stakeholder responses for challenges and resources to address the challenges.

County Health Rankings

The *2015 County Health Ranking & Roadmaps* model for the county is shown in this section. The model, from the University of Wisconsin Population Health Institute, shows how the individual health behaviors lead to health outcomes, which then determines the overall health status for a population. The graphic illustration includes the associated measures for each health indicator and the county rank among all 16 counties in the state of Maine. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to the time period for the data or use of different indicators.

Stakeholder Survey Findings

This section displays the full set of responses to each question asked in the stakeholder survey (excluding open-ended responses, which are available upon request). It compares the county to the statewide responses.

Health Indicator Results from Secondary Data Sources

The results and sources section details the data for each of the 160 indicators for the county. It includes a table that compares data for the county, the state and the U.S. (where available). Statistically significant differences (at 95 percent confidence) are noted in this table where available and applicable.

Health Indicator Data Sources

This section lists the data source, year and additional notes for each indicator. In addition to the stakeholder survey conducted as a primary data source for this project, the secondary data sources used in this assessment include:

Child Maltreatment Report, Administration on Children Youth and Families
Maine Cancer Registry (MCR)
MaineCare
Maine Behavioral Risk Factor Surveillance System (BRFSS)
Maine CDC Drinking Water Program
Maine CDC HIV Program
Maine CDC Lead Program
Maine CDC National Electronic Disease Surveillance System (NEDSS)
Maine CDC Public Health Emergency Preparedness (PHEP)
Maine CDC STD Program
Maine CDC Vital Records
Maine Department of Education
Maine Department of Public Safety
Maine Department of Labor
Maine Health Data Organization (MHDO)
Maine Integrated Youth Health Survey (MIYHS)
Maine Office of Data Research and Vital Records
National Immunization Survey (NIS)
National Survey of Children w/ Special Health Care Needs
National Center for Health Statistics
U.S. Bureau of Labor Statistics
U.S. CDC WONDER & WISQARS
U.S. Census

Executive Summary

Public health and health care organizations share the goal of improving the lives of Maine people. Health organizations, along with business, government, community organizations, faith communities and individuals, have a responsibility to shape health improvement efforts based on sound data, personal or professional experience and community need.

This summary provides high-level findings from the Maine Shared Community Health Needs Assessment (CHNA), a comprehensive review of health data and community stakeholder input on a broad set of health issues in Maine. The Shared CHNA was conducted through a collaborative effort among Maine's four largest health-care systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention an office of the Maine Department of Health and Human Services (DHHS).

While it covers a broad range of topics, the Shared CHNA is not an exhaustive analysis of all available data on any single health issue. These data help identify priorities and should lead the reader to conduct a deeper investigation of the most pressing health issues.

Data are important and a solid starting point, but the numbers represent people who live in Maine. The overall goal of the Maine SHNAPP is to "turn data into action." Community engagement is therefore a critical next step, assuring shared ownership and commitment to collective action. The perspectives of those who live in our communities will bring these numbers to life and, together, we can set priorities to achieve measurable community health improvement. We invite all readers to use the information in this report as part of the solution to develop healthier communities in Maine.

Demographics and Socioeconomic Factors

Kennebec County was home to 121,164 people in 2013. It is considered a rural county, according to the urban and rural classifications defined by the New England Rural Health RoundTable.[1] It is similar to the state in many demographic and socioeconomic characteristics, including income, poverty rates and education. Key demographic features for the 2009-2013 time period include:

- Median household income of $46,808.
- 17% of children and 13.4% of all individuals live in poverty.

[1] Rural Data for Action, New England Rural Health RoundTable, 2014. Available from: http://www.newenglandruralhealth.org/rural_data

Access to Health Care/Quality

Access to care in Kennebec County is slightly above the state; specifically, a higher percentage of Kennebec County residents have health insurance and fewer report a lack of care due to cost. The ambulatory care sensitive-conditions[2] hospital admission rate in Kennebec County was also significantly below the state. Key features for Kennebec County include:

- 9.6 percent of residents did not have health insurance (2009-2013); 10.4 percent experienced cost-related barriers to getting healthcare in the last year (2011-2013).
- 88 percent of adults reported having a personal doctor or other health care provider (2011-2013).
- In 2011, the hospitalization rate for ambulatory care-sensitive conditions was 1,390.4 per 100,000 population.

General Health and Mortality

The general health of Kennebec County tracks very closely to the state, with the exception of a high overall mortality rate. Key features for Kennebec County include:

- 16.1 percent of adults reported their health as fair or poor (2011-2013).
- Similar to the state overall, the top three leading causes of death are cancer, heart disease and lower respiratory diseases (2013).
- The overall mortality rate per 100,000 population is significantly higher in Kennebec County (805.1) compared with the state (745.8) (2009-2013).

Disease Incidence and Prevalence

Cancer is the leading cause of death in Kennebec County, with a significantly high all-cancers mortality rate. Cardiovascular diseases and diabetes are also issues of concern for the county. Key features for Kennebec County include:

- Rate of hospitalizations for acute myocardial infarction per 10,000 population were significantly higher in Kennebec County, 27.8 compared with the state at 23.5 (2010-2012). In addition, Kennebec County had significantly higher coronary heart disease mortality rates per 100,000 population: 100.7 compared to 89.8 for the state (2009-2013).
- While diabetes prevalence for Kennebec County was similar to the state, diabetes mortality per 100,000 population was significantly higher: 25.8 compared to 20.8 (2009-2013). The rate of long-term diabetes complication hospitalizations was also significantly higher than the state: 72.3 per 100,000 population compared to 59.1 (2011).
- Chlamydia incidence rate was 295.6 per 100,000 population (2014). Lyme disease incidence was 113.9 per 100,000 population (2014).

[2] Ambulatory care-sensitive conditions (ACSC) are Prevention Quality Indicators from the Agency for Healthcare Research and Quality and is intended to measure whether these conditions are being treated appropriately in the outpatient setting before hospitalization is required.

- 43.4 percent of adults report being immunized annually for influenza, which is similar to the state at 41.5 percent (2011-2013).

Risk Factors and Social Determinants

Kennebec County has lower alcohol use risk factors among adults, including lower rates of binge drinking of alcoholic beverages and fewer adults who report chronic heavy drinking. The county has significantly higher rates of crime and violence outcomes than the state. This includes a higher violent crime rate, more domestic assault reports to police and more reported rapes per 100,000 population.

Stakeholder Priorities of Health Issues

Stakeholders who work in Kennebec County listed the following health issues as their top five concerns:

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

Stakeholders identified the following populations as being disproportionately affected by the top health issues in Kennebec County:

- Low-income people, including those with incomes below the federal poverty level
- People with less than a high school education and/or low literacy (low reading or math skills)
- People who are medically underserved, including the uninsured and underinsured
- People with disabilities: physical, mental, or intellectual
- People in very rural and/or geographically isolated locations

Stakeholders prioritized the following factors as having a great influence on health in Kennebec County, resulting in poor health outcomes for residents:

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

Background

Purpose

The Maine Shared Health Needs Assessment and Planning Process (SHNAPP) Project is a collaborative effort among Maine's four largest healthcare systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health (MGH), and MaineHealth – as well as the Maine Center for Disease Control and Prevention (Maine CDC), an office of the Maine Department of Health and Human Services (Maine DHHS). The current collaboration expands upon the OneMaine Health Collaborative created in 2007 as a partnership among EMHS, MGH and MaineHealth. The Maine CDC and other partners joined these entities to develop a public-private partnership in 2012. The four hospital systems and the Maine CDC signed a memorandum of understanding in effect between June 2014 and December 2019 committing resources to the Maine SHNAPP Project.

The overall goal of the Maine SHNAPP is to "turn data into action" by conducting a shared community health improvement planning process for stakeholders across the state. The collaborative assessment and planning effort will ultimately lead to the implementation of comprehensive strategies for community health improvement. As part of the larger project, the Maine SHNAPP has pooled its resources to conduct this Shared Community Health Needs Assessment (Shared CHNA) to address community benefit reporting needs of hospitals, support state and local public health accreditation efforts, and provide valuable population health assessment data for use in prioritizing and planning for community health improvement.

This assessment builds on the earlier *OneMaine 2011 CHNA* that was developed by the University of New England and the University of Southern Maine, as well as the 2012 Maine State Health Assessment that was developed by the Maine DHHS. This Shared CHNA includes a large set of statistics on health status and risk factors from existing surveillance and health datasets. It differs from earlier assessments in two ways. Firstly, it includes input from a broad set of stakeholders from across the state from the 2015 SHNAPP Stakeholders' Survey. Secondly, it does not include the household telephone survey conducted for the OneMaine effort.

Quantitative Data

This report contains both quantitative health data and qualitative stakeholder survey data on health issues and determinants affecting those living in Maine. The quantitative data come from numerous sources including surveillance surveys, inpatient and outpatient health data and disease registries. These data consist of 160 quantitative indicators within 18 groupings (domains) for reporting at the state level and, where possible, at the county and select urban levels. Please note that the data are taken from the most current year(s) available. Since the indicators come from a variety of sources, the data are measured over different time periods. In some cases, where there were not enough data in a single year to produce a statistically valid result, multiple years were combined to compute an indicator. Table 28 contains the complete list of the data sources.

Qualitative Data

Qualitative data were collected through a statewide stakeholder survey conducted in May and June 2015 with 1,639 people representing more than 80 organizations and businesses in Maine. The survey was developed using a collaborative process that included Maine SHNAPP partners, Market Decisions Research and Hart Consulting, and a number of other stakeholders and health experts. In Kennebec County, a total of 220 stakeholders responded to the survey.

The objective of the survey was to produce qualitative data of the opinions of health professionals and community stakeholders on the health issues and needs of communities across the state. Given this purpose, the survey used a snowball sampling approach by inviting leaders of member organizations and agencies to invite their members and employees to participate. A concerted effort was made to recruit participants from a number of different industries and backgrounds across all communities in the state. Survey respondents represented public health and health care organizations as well as behavioral health, business, municipalities, education, public safety, and nongovernmental organizations. More than 80 organizations agreed to send the survey to their members or stakeholders.

The online survey was approximately 25 minutes in length and contained a number of questions about important health issues and determinants in the state, including a rating of most critical issues, the ability of Maine's health system (including public health) to respond to issues, availability of resources and assets to address specific health issues, impact on disparate populations, and identification of the entities primarily responsible for addressing issues and determinants. The survey asked all respondents a basic set of questions to rate the importance of health issues and impact of health factors. It then allowed respondents to provide answers to probing questions on the three issues and factors that they were most interested in or had the most knowledge about. Respondents provided over 12,000 open-ended comments to these in-depth probing questions in the survey. The Market Decisions Research/Hart Consulting team reviewed, coded and cleaned all open-ended comments for similar and recurrent themes. Not all respondents shared comments for the probing questions.

Limitations

While a number of precautions were taken to ensure that the results and findings presented in this report are sound and based upon statistically valid methods and analyses, there are some limitations to note. While the quantitative analysis used the most recent data sources available as of July 1, 2015, some of these sources contain data that are several years old. The most recent BRFSS and mortality data available at the time of analysis were from 2013, while the most recent hospitalization and cancer data were from 2011. This presents a particular challenge in trying to capture recent trends in health in the state, such as with opioid use. The data presented in this report may not necessarily represent the current situation in Maine, but are the best data available at the time of publication.

Given the qualitative nature of the survey questions and the sampling methodology, it is important to note that the results of the stakeholder survey are not necessarily representative of the population of Maine or a county at a given level of statistical precision. The findings reflect the informed opinions of health experts and community leaders from all areas of the state. However, it is important to use some caution when interpreting results, especially at the county level due to smaller sample sizes, as the results represent the opinions of only those who completed the survey.

Reports

The Shared CHNA has several reports and datasets for public use that are available on the Maine CDC website and may be downloaded at www.maine.gov/SHNAPP/.

- County-Level Maine Shared Community Health Needs Assessment Reports summarize the data and provide insights into regional findings. These reports explore the priorities, challenges, and resources for each county and contain both summary and detailed tables.
- State-Level Maine Shared Community Health Needs Assessment Report includes information on each health issue, including analysis of sub-populations. The report includes state summaries and detailed tables.
- Summary tables are available for each public health district[3], each county, and the cities of Portland and Bangor and the combined cities of Lewiston/Auburn.
- Detailed Tables contain each indicator, by subpopulation, region, and year.

[3] To improve coordinated delivery of essential public health services, Department of Health and Human Services (DHHS) and the Maine Legislature approved the establishment of eight public health districts. District boundaries were established using population size, geographic areas, hospital service areas, and county borders. A District Liaison coordinates a Public Health Unit with co-located Maine CDC staff in one DHHS regional office for every District.

County Demographics

Kennebec County has a total population of 121,164, with age and race/ethnicity breakdowns that closely match that of the state of Maine. The demographic and socioeconomic characteristics of the county are consistent with the state on many measures, including income, poverty rates, education and general health status. Based on the Urban and Rural Classifications defined by the New England Rural Health RoundTable[4], Kennebec County is considered a rural area.

Figure 1. Population by Age Categories (U.S. Census 2013)

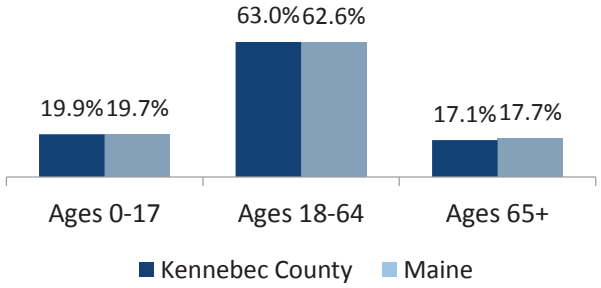
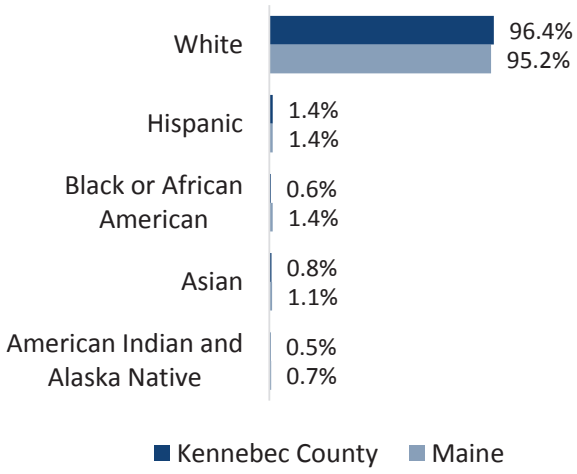


Figure 2. Population by Race/Ethnicity (U.S. Census 2013)



[4] Rural Data for Action, New England Rural Health RoundTable, 2014. Available from: http://www.newenglandruralhealth.org/rural_data

Kennebec County

Kennebec County is part of the Central Public Health District. Located in central Maine, it is home to the state's capital and many state government functions. A number of hospitals are sited in Kennebec:

- Inland Hospital.
- MaineGeneral Medical Center-Augusta and Waterville.
- Riverview Psychiatric Center.
- Maine VA Medical Center.

Key Demographics

Population	Kennebec County	Maine
Overall Population	121,164	1.33 mil
Population density (per sq. mile)	140.8	43.1
Percentage living in rural areas	100.0%	66.4%
Single-parent families	36.7%	34.0%
65+ living alone	42.7%	41.2%
Population living with a disability	17.6%	15.9%
Economic Status		
Median household income	$46,808	$48,453
Unemployment rate	5.4%	5.7%
Adults and children living in poverty	13.4%	13.6%
Children living in poverty	17.7%	18.5%
Education		
HS graduation rate	85.5%	86.5%

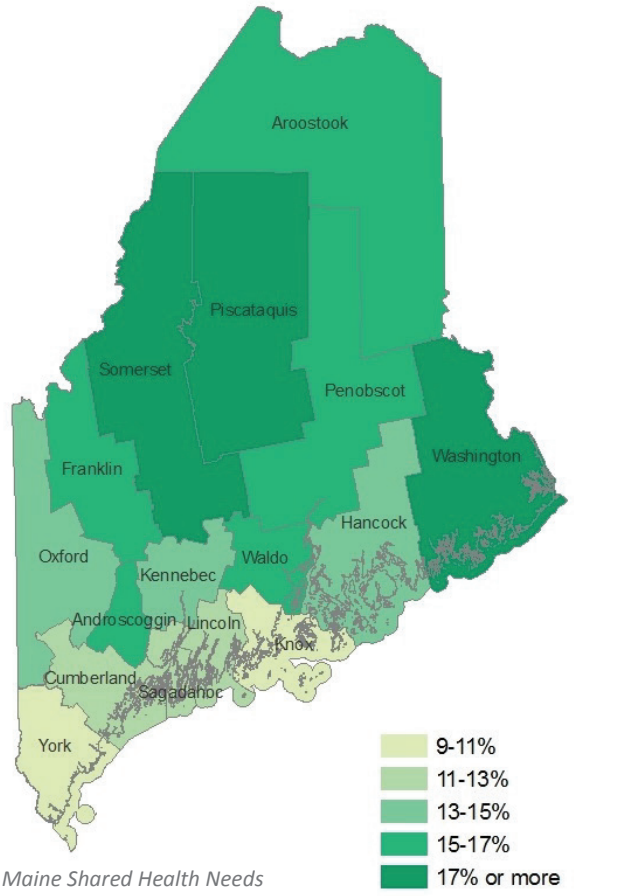
Kennebec County Summary of Findings

Socioeconomic Status

Economic opportunity and stability, including factors such as income, employment, food security and housing stability, have a significant impact on the health of individuals and communities. The 2013 Maine Behavioral Risk Factor Surveillance System (BRFSS) found the percentage of adults in Maine rating their health as excellent, very good or good was 94.8 percent among adults with household incomes of $50,000 or more, but 53.8 percent among those with incomes under $15,000.

In addition to income, there are many other social determinants of health, which have been defined as "conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[5] The conditions in which we live explain in part why some are healthier than others and why many generally are not as healthy as they could be. The Maine Shared CHNA takes into account a number of socioeconomic factors and other health determinants, including income and poverty, employment, education and household structure.

Percentage of adults and children living in poverty



Maine Shared Health Needs Assessment, 2015

[5] The Institute of Medicine. Disparities in Health Care: Methods for Studying the Effects of Race, Ethnicity, and SES on Access, Use, and Quality of Health Care, 2002. Available from: www.iom.edu/~/media/Files/Activity%20Files/Quality/NHDRGuidance/DisparitiesGornick.pdf

Table 1. Key Socioeconomic Indicators for Kennebec County

	Kennebec	Maine	U.S.
Adults and children living in poverty (2009-2013)	13.4%	13.6%	15.4%
Children living in poverty (2009-2013)	17.7%	18.5%	21.6%
Median household income (2009-2013)	*$46,808**	$48,453	$53,046
Single-parent families (2009-2013)	36.7%	34.0%	33.2%
65+ living alone (2009-2013)	42.7%	41.2%	37.7%

Asterisk (*) and italics indicate a statistically significant difference between Kennebec County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

General Health and Mortality

While it is essential to understand the causes, risk factors and other determinants of a population's health status, broad measures of health and mortality can also help explain the overall status and needs of the population in general and show in which populations there are disparities. General health status can be measured by self-reported data, as well as by mortality-related data such as life expectancy, leading causes of death and years of potential life lost.

Table 2. Key Health and Mortality Indicators for Kennebec County

	Kennebec	Maine	U.S.
Adults who rate their health fair to poor (2011-2013)	16.1%	15.6%	16.7%
Adults with 14+ days lost due to poor mental health (2011-2013)	14.0%	12.4%	NA
Adults with 14+ days lost due to poor physical health (2011-2013)	14.1%	13.1%	NA
Adults with three or more chronic conditions (2011, 2013)	27.7%	27.6%	NA
Overall mortality rate per 100,000 population (2009-2013)	*805.1**	745.8	731.9

Asterisk (*) and italics indicate a statistically significant difference between Kennebec County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

The life expectancy in Kennebec County is 75.6 years for males and 80.9 years for females.

Access to Health/Health Care Quality

Access to timely, appropriate, high-quality and regular health care and preventive health services is a key component of maintaining health. Good access to health care can be limited by financial, structural, and personal barriers. Access to health care is affected by location of and distance to health services, availability of transportation and the cost of obtaining the services – including the availability of insurance, the ability to understand and act upon information regarding

services, the cultural competency of health care providers and a host of other characteristics of the system and its clients. *Healthy People 2020* has identified four major components of access to health services: coverage, services, timeliness and workforce.[6]

In Kennebec County, 9.6 percent of residents did not have health insurance over the period from 2009-2013. However, access to health insurance does not necessarily guarantee access to care: among adults with health insurance, 5.5 percent in Kennebec County reported that they had experienced cost-related barriers to getting health care during the previous year (compared to 10.4 percent of all adults in the county).

Table 3. Key Access to Health/Health Care Quality Indicators for Kennebec County

	Kennebec	Maine	U.S.
Adults with a usual primary care provider (2011-2013)	88.0%	87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost (2011-2013)	10.4%	11.0%	15.3%
Percent uninsured (2009-2013)	9.6%	10.4%	11.7%
Ambulatory care-sensitive condition hospital admission rate per 100,000 population (2011)	*1,390.4**	1,499.3	1,457.5
Adults with visits to a dentist in the past 12 months (2012)	67.4%	65.3%	67.2%

Asterisk (*) and italics indicate a statistically significant difference between Kennebec County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

Ambulatory care-sensitive hospital discharges is a Prevention Quality Indicator defined by the Agency for Healthcare Research and Quality (AHRQ) and is intended to measure whether conditions are being treated appropriately in the outpatient setting before hospitalization is required. AHRQ provides nationwide rates based on lower acuity and cost analysis of 44 states from the 2010 Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project State Inpatient Databases.[7]

Chronic Disease

It is estimated that treatment for chronic diseases accounts for 86 percent of our nation's health care costs.[8] Chronic diseases include cancer, cardiovascular disease, diabetes and respiratory diseases like asthma and COPD, among other conditions. They are long-lasting health conditions and are responsible for seven out of ten deaths each year. Many chronic diseases can be

[6] Healthy People 2020, Office of Disease Prevention and Health Promotion. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[7] Agency for Healthcare Research and Quality, Prevention Quality Indicators Technical Specifications - Version 5.0, March 2015, available at: http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
[8] National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/chronicdisease/

prevented or controlled by reducing risk factors such as tobacco use, physical inactivity, poor nutrition and obesity.

Asthma is the most common childhood chronic condition in the United States and the leading chronic cause of children being absent from school.

Table 4. Key Asthma and COPD Indicators for Kennebec County

	Kennebec	Maine	U.S.
COPD diagnosed (2011-2013)	7.7%	7.6%	6.5%
COPD hospitalizations per 100,000 population (2011)	*166.5**	216.3	NA
Current asthma (Adults) (2011-2013)	12.6%	11.7%	9.0%
Current asthma (Youth 0-17) (2011-2013)	10.7%	9.1%	NA

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While the age-adjusted all-cancer incidence and mortality rates in Maine decreased significantly over the past ten years, cancer remains the leading cause of death among people in Maine. Cancer was also the leading cause of death in Kennebec County in 2013.

Table 5. Key Cancer Indicators for Kennebec County

	Kennebec	Maine	U.S.
Mortality – all cancers per 100,000 population (2007-2011)	*199.4**	185.5	168.7
Incidence – all cancers per 100,000 population (2007-2011)	493.5	500.1	453.4
Mammograms females age 50+ in past two years (2012)	82.9%	82.1%	77.0%
Colorectal screening (2012)	77.7%	72.2%	NA
Melanoma incidence per 100,000 population (2007-2011)	*15.6**	22.2	21.3

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More than one in three adults lives with some type of cardiovascular disease. Heart disease and stroke can cause serious illness and disability with associated decreased quality of life and high economic costs. Cardiovascular disease conditions are among the most preventable health problems through the modification of common risk factors.

Table 6. Key Cardiovascular Disease Indicators for Kennebec County

	Kennebec	Maine	U.S.
Acute myocardial infarction hospitalizations per 10,000 population (2010-2012)	*27.8**	23.5	NA
Acute myocardial infarction mortality per 100,000 population (2009-2013)	36.1	32.2	32.4

	Kennebec	Maine	U.S.
Cholesterol checked every five years (2011, 2013)	82.2%	81.0%	76.4%
Coronary heart disease mortality per 100,000 population (2009-2013)	*100.7**	89.8	102.6
Hypertension prevalence (2011, 2013)	32.4%	32.8%	31.4%
Hypertension hospitalizations per 100,000 population (2011)	*18.4**	28.0	NA
Stroke mortality per 100,000 population (2009-2013)	36.1	35.0	36.2

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Diabetes mellitus is a complex health condition that lowers life expectancy, increases the risk of heart disease and is the leading cause of adult-onset blindness, lower-limb amputations and kidney failure. Lifestyle changes, effective self-management and treatment can delay or prevent diabetes and complications of diabetes.

Table 7. Key Diabetes Indicators for Kennebec County

	Kennebec	Maine	U.S.
Diabetes prevalence (ever been told) (2011-2013)	9.5%	9.6%	9.7%
Pre-diabetes prevalence (2011-2013)	5.0%	6.9%	NA
Adults with diabetes who have received formal diabetes education (2011-2013)	65.1%	60.0%	55.8%
Diabetes long-term complication hospitalizations (2011)	*72.3**	59.1	NA
Diabetes mortality (underlying cause) per 100,000 population (2009-2013)	*25.8**	20.8	21.2

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Environmental Health

Environmental health includes the natural and built environments. Within these environments, there is risk of exposure to toxic substances and other physical hazards that exist in the air we breathe, the food we eat, the water we drink and the places where we live, play and work.[9]

Water quality issues in Maine include hazards such as disinfection byproducts, arsenic and nitrates/nitrites as well as bacteria contamination. Among households who get their drinking water from private wells, naturally occurring arsenic is a risk. Regular water quality testing can

[9] Maine Center for Disease Control and Prevention. Healthy Maine 2020. Available from: http://www.maine.gov/dhhs/mecdc/healthy-maine/index.shtml

indicate the need for mitigation. In Kennebec County, 56.5 percent of households with private wells have tested their water for arsenic, compared with 43.3 percent of households statewide.

Childhood lead poisoning rates are of particular concern in areas with older housing. It can disproportionately affect people who live in older rental units and those who have less income.

Table 8. Key Environmental Health Indicators for Kennebec County

	Kennebec	Maine	U.S.
Children with confirmed elevated blood lead levels (% among those screened) (2009-2013)	2.3%	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened) (2009-2013)	*5.7%**	4.2%	NA
Homes with private wells tested for arsenic (2009, 2012)	*56.5%**	43.3%	NA
Lead screening among children age 12-23 months (2009-2013)	*37.9%**	49.2%	NA
Lead screening among children age 24-35 months (2009-2013)	27.3%	27.6%	NA

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Immunization

Immunization has accounted for significant decreases in morbidity and mortality of infectious diseases and an overall increase in life expectancy. However, many infectious diseases that can be prevented through vaccination continue to cause significant burdens on the health of Maine residents. The U.S. CDC has recommendations for a number of vaccines for young children, adolescents and older adults. Among its other recommendations, the U.S. CDC recommends yearly influenza vaccinations for people over six months of age.

Table 9. Key Immunization Indicators for Kennebec County

	Kennebec	Maine	U.S.
Adults immunized annually for influenza (2011-2013)	43.4%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older) (2011-2013)	74.0%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons (2015)	3.1%	3.7%	NA
Two-year-olds up to date with “Series of Seven Immunizations” 4-3-1-3-3-1-4 (2015)	81.0%	75.0%	NA

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Infectious Disease/Sexually Transmitted Disease

There are 71 infectious diseases and conditions reportable in Maine. Surveillance data assist in monitoring trends in disease and identifying immediate threats to public health. However, there are limitations in surveillance data, specifically pertaining to underreporting. Available data reflects a subset of the disease burden in Maine.

Advances in sanitation, personal hygiene and immunizations have provided control over some diseases, but others continue to thrive despite best efforts. Lyme disease, if left untreated, can cause severe headaches, severe joint pain and swelling, inflammation of the brain and short-term memory problems[10]. Incidence has increased from 224 reported cases statewide in 2004 to 1,400 in 2014, a growth of more than 500 percent in a decade.

Table 10. Key Infectious Disease Indicators for Kennebec County

	Kennebec	Maine	U.S.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population (2014)	39.6	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population (2014)	3.3	8.1	NA
Lyme disease incidence per 100,000 population (2014)	113.9	105.3	10.5

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While the rates of sexually transmitted diseases like chlamydia, gonorrhea and HIV are significantly lower in Maine than the U.S., it is an issue that disproportionately affects specific segments of the population, including young adults and men who have sex with men.

Table 11. Key Sexually Transmitted Disease Indicators for Kennebec County

	Kennebec	Maine	U.S.
Chlamydia incidence per 100,000 population (2014)	295.6	265.5	452.2
Gonorrhea incidence per 100,000 population (2014)	19.0	17.8	109.8
HIV incidence per 100,000 population (2014)	3.3	4.4	11.2

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Injuries

Intentional or violence-related injury is an important public health problem that affects people of all ages. Violence prevention activities include changing societal norms regarding the

[10] Signs and Symptoms of Untreated Lyme Disease, Centers for Disease Control and Prevention (CDC), Available from: http://www.cdc.gov/lyme/signs_symptoms/

acceptability of violence, improving conflict resolution and other problem-solving skills and developing policies to address economic and social conditions that can lead to violence.

Suicide is the second leading cause of death among 15- to 34-year-olds in Maine and the tenth leading cause of death among all ages combined. In Kennebec County, the age-adjusted rate of suicide deaths was 14.7 per 100,000 population, compared to 15.2 for the state over the same time period.

Table 12. Key Intentional Injury Indicators for Kennebec County

	Kennebec	Maine	U.S.
Domestic assault reports to police per 100,000 population (2013)	478.3	413.0	NA
Firearm deaths per 100,000 population (2009-2013)	9.0	9.2	10.4
Suicide deaths per 100,000 population (2009-2013)	14.7	15.2	12.6
Violent crime rate per 100,000 population (2013)	146.2	125.0	367.9

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Unintentional injuries are a leading cause of death and disability. While many people think of unintentional injuries as a result of accidents, most are predictable and preventable. Unintentional injury was the leading cause of death among 1- to 44-year-olds in Maine and the fifth-leading cause of death among all ages combined in 2013. Motor vehicle crashes, unintentional poisonings, traumatic brain injuries and falls lead to millions of dollars in medical and lost work costs.

Table 13. Key Unintentional Injury Indicators for Kennebec County

	Kennebec	Maine	U.S.
Always wear seatbelt (Adults) (2013)	86.5%	85.2%	NA
Always wear seatbelt (High School Students) (2013)	61.8%	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population (2011)	*100.0**	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population (2009-2013)	13.6	11.1	13.2
Unintentional fall related injury emergency department visits per 10,000 population (2011)	*400.1**	361.3	NA

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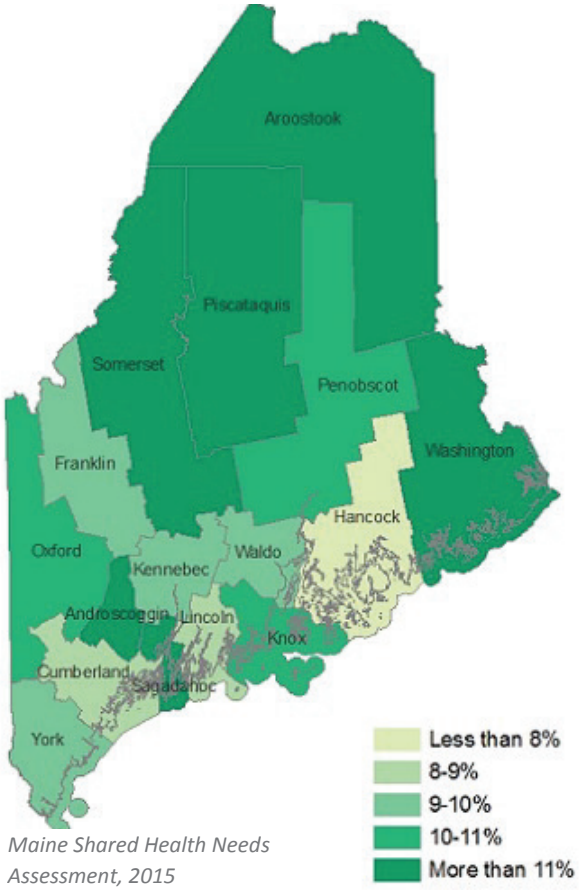
Mental Health

Mental health is a complex issue that can affect many facets of a person's daily life. In the U.S., about one in four adults and one in five children have diagnosable mental disorders and they are the leading cause of disability among people ages 15-44.[11] In Kennebec County, 18.7 percent of adults reported currently receiving outpatient mental health treatment (taking medicine or receiving treatment from a doctor) in 2011-2013, compared to 17.7 percent of adults statewide.

Mental well-being can also affect a person's physical health in many ways, including chronic pain, a weakened immune system and increased risk for cardiovascular problems. In addition, mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors.[12]

Stigma, additional health issues, access to services and complexities of treatment delivery also prevent many from receiving adequate treatment for their mental health issues.

Percentage of Adults with Current Depression



Maine Shared Health Needs Assessment, 2015

Table 14. Key Mental Health Indicators for Kennebec County

	Kennebec	Maine	U.S.
Adults who have ever had depression (2011-2013)	24.1%	23.5%	18.7%
Adults with current symptoms of depression (2011-2013)	9.6%	10.0%	NA
Adults currently receiving outpatient mental health treatment (2011-2013)	18.7%	17.7%	NA
Sad/hopeless for two weeks in a row (High School Students) (2013)	24.5%	24.3%	29.9%
Seriously considered suicide (High School Students) (2013)	15.3%	14.6%	17.0%

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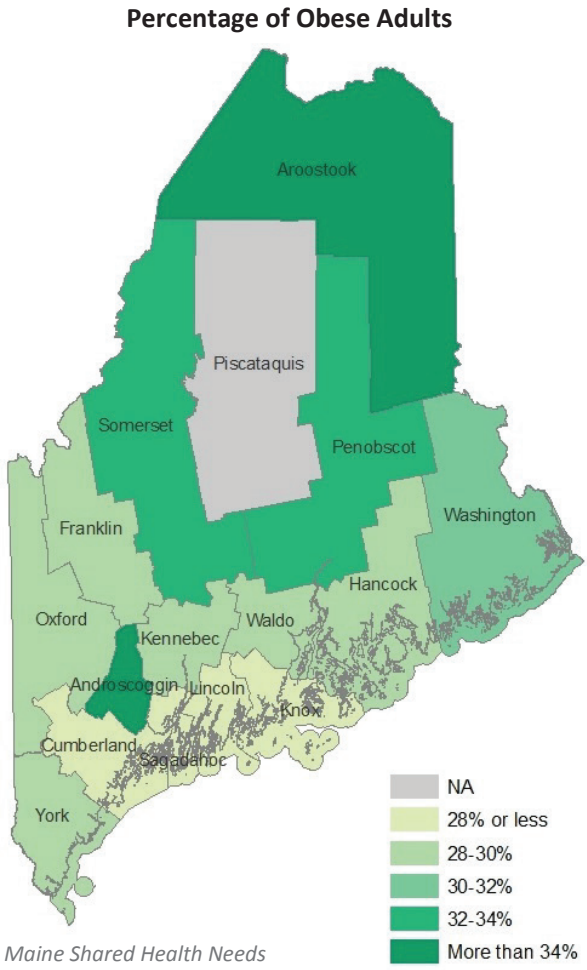
[11] Guide to Community Preventive Services. Improving mental health and addressing mental illness. www.thecommunityguide.org/mentalhealth/index.html.
[12] US Department of Health and Human Services. Health People 2020: Mental Health and Mental Disorders. 2012 Available from: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28.

Physical Activity, Nutrition and Weight

Eating a healthy diet, being physically active and maintaining a healthy weight are essential for an individual's overall health. These three factors can help lower the risk of developing numerous health conditions, including high cholesterol, high blood pressure, heart disease, stroke, diabetes and cancer. They also can help prevent existing health conditions from worsening over time.

Sugar-sweetened beverages, such as non-diet soda, sports drinks and energy drinks, provide little to no nutritional value, but their calories can lead to obesity and being overweight, along with health risks including tooth decay, heart disease and type 2 diabetes

The 2008 *Physical Activity Guidelines for Americans* recommends that adults, age 18-64, get a minimum of 150 minutes of moderate-intensity physical activity a week and that children, age 6-17, get 60 or more minutes of physical activity each day.[13] Among adults in Kennebec County from 2011-2013, 22.6 percent led a sedentary lifestyle, meaning they did not participate in any leisure-time (non-work) physical activity or exercise in the previous month.



Maine Shared Health Needs Assessment, 2015

Table 15. Key Nutrition and Physical Activity Indicators for Kennebec County

	Kennebec	Maine	U.S.
Fruit and vegetable consumption (High School Students) (2013)	16.7%	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day) (2013)	36.1%	34.0%	39.2%
Met physical activity recommendations (Adults) (2013)	57.1%	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students) (2013)	44.4%	43.7%	47.3%

[13] Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services, 2008, http://health.gov/Paguidelines/guidelines/

	Kennebec	Maine	U.S.
Sedentary lifestyle – no leisure-time physical activity in past month (Adults) (2011-2013)	22.6%	22.4%	25.3%
Soda/sports drink consumption (High School Students) (2013)	27.5%	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day) (2013)	20.3%	17.9%	22.9%

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In 2013, 67.1 percent of adults 18 years and older in Kennebec County were overweight or obese (38.8 percent were overweight and 28.3 percent were obese). Overall in Maine, 64.8 percent of adults were overweight or obese.

Table 16. Key Weight Indicators for Kennebec County

	Kennebec	Maine	U.S.
Obesity (Adults) (2013)	28.3%	28.9%	29.4%
Obesity (High School Students) (2013)	14.3%	12.7%	13.7%

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Pregnancy and Birth Outcomes

Addressing health risks during a woman's pregnancy can help prevent future health issues for women and their children. Increasing access to quality care both before pregnancy and between pregnancies can reduce the risk of pregnancy-related complications and maternal and infant mortality. Early identification and treatment of health issues among babies can help prevent disability or death.[14]

Table 17. Key Pregnancy and Birth Outcomes for Kennebec County

	Kennebec	Maine	U.S.
Infant deaths per 1,000 live births (2003-2012)	5.7	6.0	6.0
Live births for which the mother received early and adequate prenatal care (2010-2012)	*81.3%**	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population (2010-2012)	23.7	20.5	26.5
Low birth weight (<2500 grams) (2010-2012)	6.9%	6.6%	8.0%

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[14] Healthy People 2020. Maternal, infant, and child health: overview. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

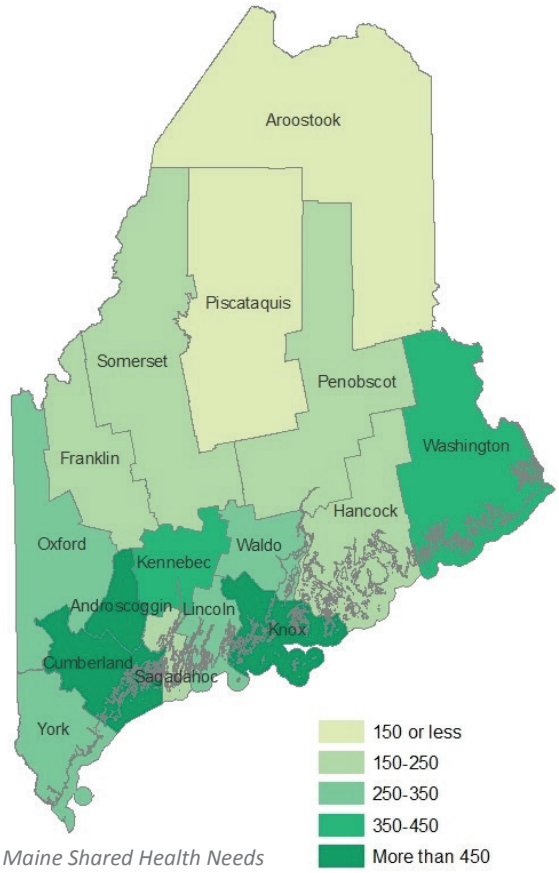
Substance and Alcohol Abuse

Substance abuse and dependence are preventable health risks that lead to increased medical costs, injuries, related diseases, cancer and even death. Substance abuse also adversely affects productivity and increases rates of crime and violence.[15] In Maine in 2010, approximately $300 million was spent on medical care where substance use was a factor.[16]

Of particular note is the recent increase in heroin and prescription opioid dependence and mortality, both nationally and in the state. From 2002 to 2013, heroin overdose death rates nearly quadrupled in the U.S., from 0.7 deaths to 2.7 deaths per 100,000 population. The rates nearly doubled from 2011 to 2013.[17] In addition, data from the National Survey on Drug Use and Health (NSDUH) indicate that heroin use, abuse and dependence have increased in recent years.[11]

The heroin problem in Maine has become a focus of national attention.[18] Deaths from heroin overdoses in Maine rose from seven in 2010 to 57 in 2014[19] and that number continues to climb in 2015.[20]

Substance Abuse Hospitalizations



Maine Shared Health Needs Assessment, 2015

[15] National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse. NIH publication No. 11-5316, revised 2012. Available at www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations

[16] The Cost of Alcohol and Drug Abuse in Maine, 2010. Office of Substance Abuse and Mental Health Services, Department of Health and Human Services, 2013. Available at: http://www.maine.gov/dhhs/samhs/osa/pubs/data/2013/Cost2010-final%20Apr%2010%2013.pdf

[17] Jones CM, Logan J, Gladden M, Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013, Morbidity and Mortality Weekly Report (MMWR), 2015. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm

[18] Heroin in New England, More Abundant and Deadly. The New York Times. July 18, 2013. http://www.nytimes.com/2013/07/19/us/heroin-in-new-england-more-abundant-and-deadly.html

[19] Heroin Deaths in Maine Jump – Record Level of Overdose Deaths in 2014. May 15, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=644190

[20] First half of 2015 shows pace of drug deaths has not slowed – Heroin, Fentanyl deaths continue to surge. August 20, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=653671

Table 18. Key Substance Abuse Indicators for Kennebec County

	Kennebec	Maine	U.S.
Alcohol-induced mortality per 100,000 population (2009-2013)	8.0	8.0	8.2
Chronic heavy drinking (Adults) (2011-2013)	*5.5%**	7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births (2014)	8.3%	7.8%	NA
Drug-induced mortality per 100,000 population (2009-2013)	13.0	12.4	14.6
Emergency medical service overdose response per 100,000 population (2014)	416.1	391.5	NA
Opiate poisoning (ED visits) per 100,000 population (2009-2011)	19.6	25.1	NA
Past-30-day alcohol use (High School Students) (2013)	24.0%	26.0%	34.9%
Past-30-day marijuana use (High School Students) (2013)	20.0%	21.6%	23.4%
Prescription Monitoring Program opioid prescriptions (days supply/pop) (2014-2015)	9.5	6.8	NA
Substance-abuse hospital admissions per 100,000 population (2011)	351.2	328.1	NA

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Tobacco Use

Use of tobacco is the most preventable cause of disease, death and disability in the United States. Despite this, more than 480,000 deaths in the United States are attributable to tobacco use every year [21] (more than from alcohol use, illegal drug use, HIV, motor vehicle injuries and suicides combined). In addition, exposure to secondhand tobacco smoke has been causally linked to cancer and to respiratory and cardiovascular diseases in adults, and to adverse effects on the health of infants and children, such as respiratory and ear infections.[22] While the percentage of Maine adults who smoke cigarettes has declined significantly over time, one-fifth of the state's population still smokes cigarettes, including 17.9 percent of adults in Kennebec County.

[21] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

[22] U.S. Department of Health and Human Services. Healthy People 2020. Leading health indicators: tobacco overview and impact. Available from: http://www.healthypeople.gov/2020/LHI/tobacco.aspx

Table 19. Key Tobacco Use Indicators for Kennebec County

	Kennebec	Maine	U.S.
Current smoking (Adults) (2011-2013)	17.9%	20.2%	19.0%
Current smoking (High School Students) (2013)	13.6%	12.9%	15.7%
Current tobacco use (High School Students) (2013)	18.6%	18.2%	22.4%

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Stakeholder Feedback

In June 2015, the Maine Shared CHNA research team conducted a survey among stakeholders to identify and prioritize significant health issues in communities across the state. The purpose of the survey was to include the voices and broad interests of local stakeholders about community health needs in their areas. The survey instrument was designed in collaboration with the Maine Shared CHNA Steering Committee and its work groups; it covered four domains of questions:

- Stakeholder demographic information
- Health issues with the greatest impact
- Determinants of health
- Health priorities and challenges

The survey was administered using a snowball approach, where stakeholder agencies agreed to send the surveys to their members and stakeholders for participation. Statewide, 1,639 people completed the survey; 220 of the total respondents indicated that they worked in Kennebec County or the Central Public Health District. Respondents represented health care agencies, public health agencies, law enforcement, municipalities, schools, businesses, social service agencies and non-governmental organizations.

There were 403 respondents who indicated they worked at the state-level (e.g., Maine CDC, businesses that spanned the state, etc.). These respondents were included in the overall results, but were not included in any of the county-level results. Respondents could indicate that they represent more than one county in the survey, therefore the total of completed surveys by county will add up to more than 1,639.

Stakeholder Ratings of Health Issues

How much of a problem is __ in Kennebec County?(Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes % reporting 4-Major or 5-Critical problem)

Health Issue	Kennebec	Maine
Family Health	n=220	n=1,639
Elder health	63%	55%
Childhood obesity	61%	58%
Child developmental issues	31%	34%
Adolescent health	29%	25%
Maternal and child health	17%	23%
Infant mortality	8%	4%
Chronic Diseases		
Obesity	80%	78%
Depression	72%	67%
Diabetes	64%	63%
Cardiovascular disease	63%	63%
Respiratory disease	59%	60%
Cancer	48%	50%
Neurological diseases	37%	35%
Musculoskeletal diseases	28%	28%
Infectious Diseases		
Infectious diseases	21%	22%
Sexually transmitted diseases/HIV/AIDS	13%	13%
Health Risk Behaviors		
Drug and alcohol abuse	80%	80%
Physical activity and nutrition	71%	69%
Tobacco use	64%	63%
Other Health Issues		
Mental health	76%	71%
Oral health	54%	53%
Violence	44%	38%
Suicide and self-harm	40%	37%
Unintentional injury	33%	34%
Lead poisoning and other environmental health issues	13%	17%

Top Health Issues

Kennebec County stakeholders ranked a set of 25 health issues on "how you feel they impact overall health of residents" on a five-point scale, where 1 is "not at all a problem" and 5 is "critical problem." The top five issues of concern reported for the county were:

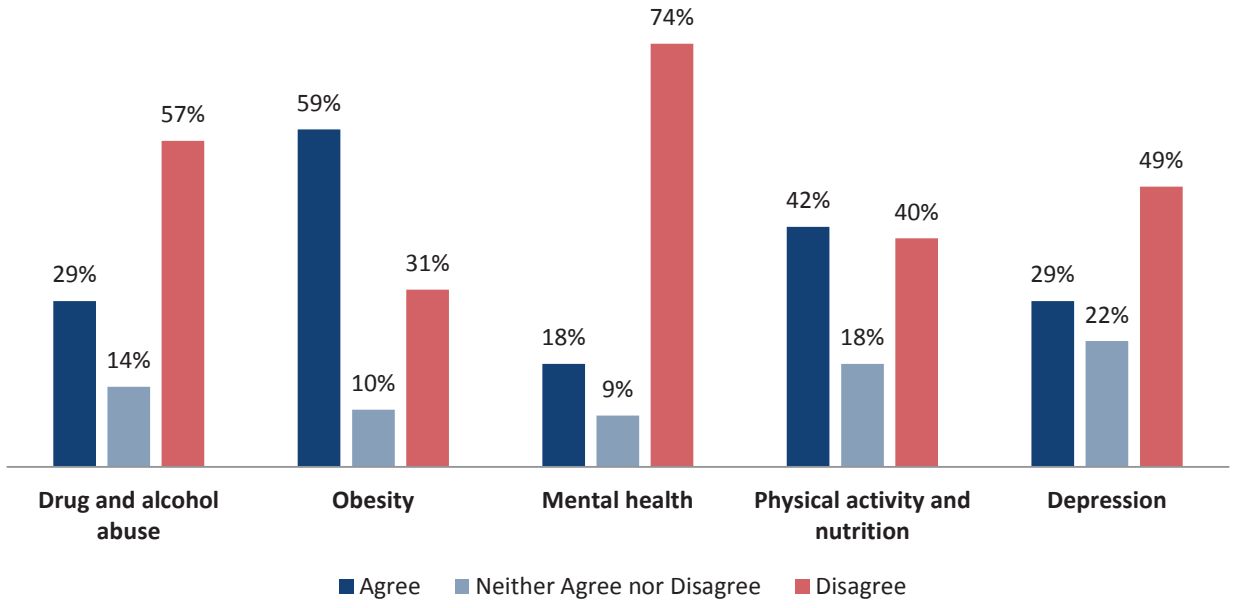
- Obesity
- Drug and alcohol abuse
- Mental health
- Depression
- Physical activity and nutrition

Respondents were asked probing statements about the three issues they knew the most about. The question was worded as follows:

"The health system (including public health) in Kennebec County has the ability to significantly improve [ ] health issue."

Stakeholder responses on the probing question for the top five health issues appear in Figure 3.

Figure 3. The health system (including public health) in Kennebec County has the ability to significantly improve these health issues.



Maine Shared Community Health Needs Assessment, 2015

Stakeholders were also asked to share their thoughts on the populations experiencing health disparities for the health issues that they selected. Results for the top five health issues in Kennebec County are presented in Table 20.

Table 20. Percentage of Stakeholders who agreed that Significant Disparities Exist Among Specific Groups for a Specific Health Issue.

Populations Experiencing Health Disparities	Drug and alcohol abuse	Obesity	Mental health	Physical activity and nutrition	Depression
Low-income, including those below the federal poverty level	85%	87%	79%	90%	76%
Medically underserved – including uninsured and under-insured	63%	70%	74%	59%	68%
Less than a high school education and/or low literacy	67%	61%	56%	65%	52%
Very rural and/or geographically isolated people	49%	44%	56%	58%	53%
People with disabilities – physical, mental, or intellectual	41%	47%	63%	56%	61%
Limited or no English proficiency	14%	12%	21%	17%	20%
Military veterans	34%	4%	43%	4%	43%
Gay, lesbian, bisexual, or transgendered people	30%	4%	36%	2%	34%
Women	17%	15%	20%	11%	22%
Members of any federally recognized Native American Tribe	21%	12%	19%	13%	17%
Refugees/immigrants	8%	4%	20%	6%	18%
Specific age group	12%	10%	12%	9%	10%
Racial/ethnic minority populations	9%	4%	11%	6%	10%
Deaf and hard of hearing people	3%	3%	11%	4%	9%
Adolescents/Teens (13-17)	8%	3%	6%	2%	6%
Seniors/Elderly (65+)	-	3%	3%	5%	4%
Youth/Children (0-12)	-	4%	4%	4%	2%
Adults (21-64)	3%	1%	-	1%	-
Young adults (18-21)	7%	1%	2%	-	1%
All ages	-	-	-	-	1%
Other	12%	6%	12%	5%	11%

Stakeholder input also pointed out that there are key social or environmental drivers in Maine that lead to these health issues. The key drivers for the top five health issues in Kennebec County are presented in Table 21.

Table 21. Percentage of Stakeholders who identified Certain Factors as Key Drivers that lead to a Specific Health Condition

Key Drivers	Drug and alcohol abuse	Obesity	Mental health	Physical activity and nutrition	Depression
Poverty/low income/low socio-economic status	30%	40%	27%	37%	37%
Lack of education	11%	31%	15%	22%	12%
Lack of access to healthy foods	-	28%	1%	29%	-
Bad eating habits	-	26%	1%	13%	1%
Lack of access to physical activity opportunities	-	25%	-	47%	1%
Lack of access to behavioral care/mental health care	3%	-	44%	-	34%
Isolated and rural areas	11%	9%	14%	16%	26%
Inadequate health literacy	8%	9%	-	9%	1%
Cultural or social norms/acceptance/role modeling	22%	9%	4%	8%	7%
Lack of transportation	6%	8%	11%	12%	18%
Lack of access to treatment	33%	2%	2%	6%	1%
Lack of employment opportunities	17%	2%	6%	1%	6%
Social attitudes such as discrimination, stigma, etc.	14%	2%	34%	-	29%
Lack of health care insurance	5%	2%	10%	1%	9%
Adverse childhood experiences	3%	2%	5%	1%	4%
Substance use/addiction	2%	2%	5%	2%	9%
Lack of access to primary care	-	2%	3%	1%	1%
Personal responsibility	4%	8%	3%	6%	1%
Apathy/depression/hopelessness	11%	5%	2%	6%	5%
Food insecurity	-	4%	1%	1%	1%
Co-morbidity--physical or behavioral	-	3%	4%	1%	3%
Lack of exercise	-	3%	-	1%	-
Lack of social support and interactions--positive	14%	2%	1%	4%	7%
Mental illness	2%	2%	2%	1%	3%
Lack of civic participation	-	2%	1%	-	1%
Abuse/trauma	3%	1%	3%	-	4%
Lack of funding-programs/low reimbursement to providers	2%	1%	8%	3%	5%

The next section of this report has a list of the community resources and assets that are available in the area to address these health issues, along with a summary of the additional resources that are needed. See **Table 23. Priority Health Issues** in the following section of this report.

Top Health Factors

Health factors are those conditions, such as health behaviors, socioeconomic status, or physical environment features that can affect the health of individuals and communities. Stakeholders prioritized 26 health factors in five categories that can play a significant role in the incidence and prevalence of health problems in their communities.

Stakeholders responded to the following question: "For the factors listed below, please indicate how much of a problem each is in your area and leads to poor health outcomes for residents." They responded using a scale of 1 to 5, where 1 means "not a problem at all," and 5 means "critical problem." Respondents selected the following five factors as greatest problems that lead to poor health outcomes in Kennebec County:

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

As with health issues, stakeholders were asked further probing questions on the three factors that they believe have the greatest impact on the health of their county.

To understand the capacity available in the county to address the most significant health factors identified by stakeholders, respondents were asked additional probing statements about the issues they knew the most about. "The health system (including public health) in Kennebec County has the ability to significantly improve these health factors with the current investment of time

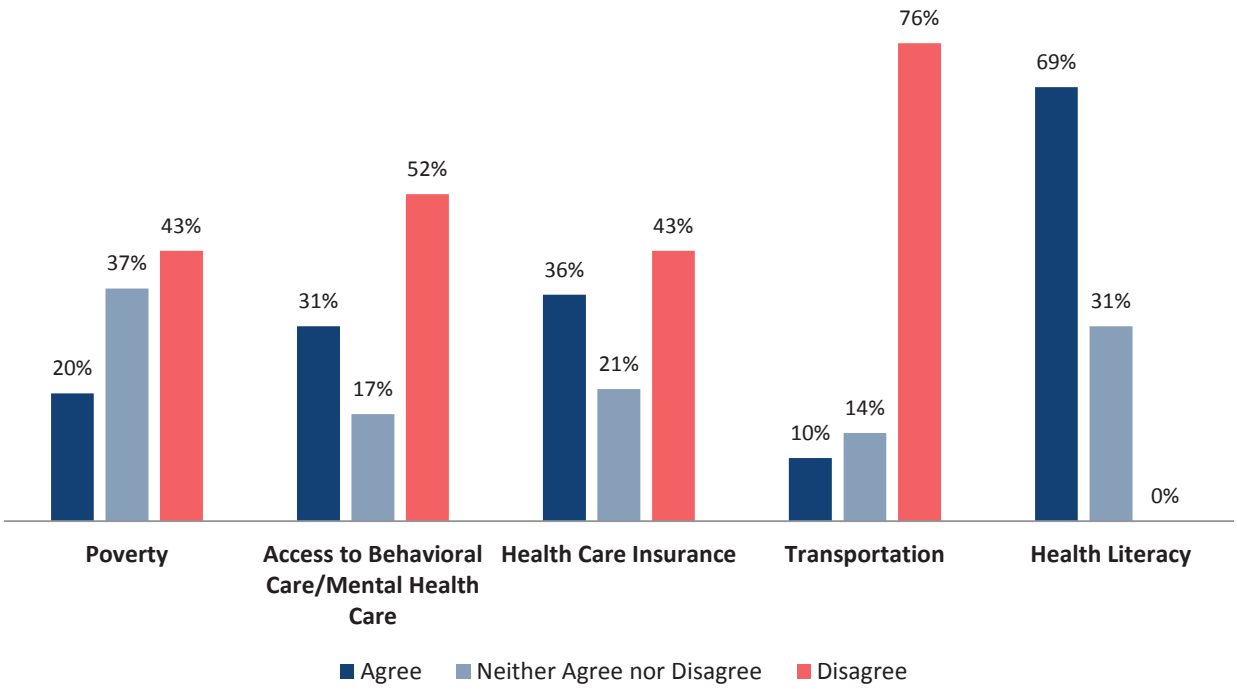
Stakeholder Ratings of Health Factors

How much of a problem is __ in Kennebec County? (Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes % reporting 4-Major or 5-Critical problem)

Health Factors	Kennebec	Maine
Economic Stability	n=220	n=1,639
Poverty	75%	78%
Employment	59%	64%
Housing stability	55%	57%
Food security	52%	58%
Education		
Early childhood education/development	42%	43%
Enrollment in higher education	34%	35%
High school graduation	32%	31%
Language and literacy	27%	34%
Social and Community Context		
Adverse childhood experiences	56%	56%
Social support and interactions	52%	50%
Caregiver support	51%	46%
Incarceration or Institutionalization	39%	35%
Civic participation	30%	30%
Social attitudes (such as discrimination)	30%	38%
Health and Health Care		
Access to behavioral care/mental health care	68%	67%
Health care insurance	65%	64%
Health literacy	60%	62%
Access to oral health	56%	56%
Access to primary care	40%	39%
Access to other health care	36%	41%
Neighborhood and Built Environment		
Transportation	61%	67%
Access to healthy foods	49%	53%
Quality of housing	40%	34%
Access to physical activity opportunities	39%	42%
Crime and violence	28%	27%
Environmental conditions	10%	12%

and resources." Stakeholder responses on the probing question for the top five health issues appear in Figure 4.

Figure 4. The health system in Kennebec County (including public health) has the ability to significantly improve these health factors with the current investment of time and resources.



Maine Shared Community Health Needs Assessment, 2015

The next section of this report has a list of the community resources and assets that are available in the area to address these health factors, along with a summary of the additional resources that are needed. See **Table 25. Priority Health Factors** in the next section.

Kennebec County Priority Health Issues and Factors

Table 22 presents a summary of the health issues - successes and challenges - experienced by residents of Kennebec County. Data come from a comprehensive analysis of available surveillance data (see Table 26 for a full list of the health indicators and factors included in this project). Two criteria were used to select the issues and challenges in this table: statistically significant and relative differences between the county, state and U.S. **Statistically significant differences**, at the 95 percent confidence level, are noted with an asterisk (*) after the indicator. A **rate ratio** was calculated to compare the county, state and U.S. indicators where the county was 10 percent or more above or below the state and U.S. figures were included in this table.

Table 22. Priority Health Issue Successes and Challenges for Kennebec County-Surveillance Data

Health Issues - Surveillance Data	
Health Successes	**Health Challenges**

• Kennebec County has a lower ambulatory care-sensitive condition hospital admission rate per 100,000 population than the state [KEN=1,390.4; ME=1,499.3]*
• Low COPD hospitalizations per 100,000 population [KEN=166.5; ME=216.3]*
• Low melanoma incidence per 100,000 population [KEN=15.6; ME=22.2]*
• Low hypertension hospitalizations per 100,000 population [KEN=18.4; ME=28.0]*
• Lower pre-diabetes prevalence [KEN=5.0%; ME=6.9%]
• Kennebec has low incidence rates for:
  • Past or present hepatitis C virus (HCV) [KEN=39.6; ME=107.1]
  • Newly reported chronic hepatitis B virus (HBV) [KEN=3.3; ME=8.1]
  • Pertussis [KEN=14.0; ME=41.9]
  • Chlamydia [KEN=295.6; US=452.2] and
  • HIV [KEN=3.3; ME=4.4]
• Low unintentional fall related deaths per 100,000 population [KEN=6.3; US=8.5]
	• Kennebec has a high overall mortality rate than the state [KEN=805.1; ME=745.8]*
	• More adults with current asthma [KEN=12.6%; US=9.0%] as well as more youth (ages 0-17) with current asthma [KEN=10.7%; ME=9.1%]
	• Kennebec faces a number of cancer related challenges, including:
	  • High all cancers mortality rate [KEN=199.4; ME=185.5]*
	  • High bladder cancer incidence per 100,000 population [KEN=25.4; US=20.2]
	  • High lung cancer incidence per 100,000 population [KEN=78.8; US=58.6]
	  • High prostate cancer mortality per 100,000 population [KEN=27.0; ME=22.1]
	• High acute myocardial infarction hospitalizations per 10,000 population [KEN=27.8; ME=23.5]*
	• High coronary heart disease mortality per 100,000 population [KEN=100.7; ME=89.8]*
	• High diabetes long-term complication hospitalization rate [KEN=72.3; ME=59.1]*
	• High diabetes mortality (underlying cause) per 100,000 population [KEN=25.8; ME=20.8]*

Health Issues - Surveillance Data

- Low binge drinking of alcoholic beverages among high school students [KEN=14.3%; U.S.=20.8%]
- In addition, Kennebec fares better than the state on a number of alcohol and substance use related indicators, including:
  - Lower chronic heavy drinking (Adults) [KEN=5.5%; ME=7.3%]*
  - Low opiate poisoning (ED visits) per 100,000 population [KEN=19.6; ME=25.1]
  - Lower past-30-day alcohol use (High School Students) [KEN=24.0%; US=34.9%]
  - Lower past-30-day nonmedical use of prescription drugs (Adult) [KEN=0.1%; ME=1.1%]*
  - Lower past-30-day nonmedical use of prescription drugs (High School Students) [KEN=4.5%; ME=5.6%]
- More children with unconfirmed elevated blood lead levels (% among those screened) [KEN=5.7%; ME=4.2%]*
- High Lyme disease incidence per 100,000 population [KEN=113.9; U.S.=10.5]
- Kennebec also has high rates for:
  - Domestic assaults reports to police [KEN=478.3; ME=413.0]
  - Reported rape [KEN=52.0; ME=27.0] and
  - Violent crime [KEN=146.2; ME=125.0]
- High traumatic brain injury related emergency department visits (all intents) per 10,000 population [KEN=100.0; ME=81.4]*
- High unintentional and undetermined intent poisoning deaths per 100,000 population [KEN=13.6; ME=11.1]
- High unintentional fall related injury emergency department visits per 10,000 population [KEN=400.1; ME=361.3]*
- More adults who have ever had depression [KEN=24.1%; U.S.=18.7%]
- Fewer live births for which the mother received early and adequate prenatal care [KEN=81.3%; ME=86.4%]*
- High live births to 15-19 year olds per 1,000 population [KEN=23.7; ME=20.5]
- High prescription Monitoring Program opioid prescriptions (days supply/pop) [KEN=9.5; ME=6.8]

Asterisk (*) indicates a statistically significant difference between Kennebec County and Maine
All rates are per 100,000 population unless otherwise noted.

Table 23 summarizes the results of the health issues questions in the stakeholder survey for Kennebec County. It includes a summary of the biggest health challenges from the perspective of stakeholders who work in and represent communities in the county. The table also shares stakeholder's knowledge of the assets and resources available and those that are needed to address the biggest health challenges.

Table 23. Priority Health Issue Challenges and Resources for Kennebec County-Stakeholder Survey Responses

Stakeholder Input - Stakeholder Survey Responses[23]	
Community Challenges	**Community Resources**
Biggest health issues in Kennebec County according to stakeholders *(% of those rating issue as a major or critical problem in their area*). • Drug and alcohol abuse (80%) • Obesity (80%) • Mental health (76%) • Depression (72%) • Physical activity and nutrition (71%)	**Assets Needed to Address Challenges:** • **Drug and alcohol abuse:** Greater access to drug/alcohol treatments; greater access to substance abuse prevention programs; free or low-cost treatments for the uninsured; more substance abuse treatment providers; additional therapeutic programs • **Obesity/Physical activity and nutrition:** Greater access to affordable and healthy food; more programs that support low-income families • **Mental health/Depression:** More mental health professionals; more community-based services; better funding and support; greater access to inpatient care; readily available information about resources; transitional programs **Assets Available in County/State:** • **Drug and alcohol abuse:** Maine Alcoholics Anonymous; Substance Abuse Hotlines; Office of Substance Abuse and Mental Health Services • **Obesity/Physical activity and nutrition:** Public gyms; farmers markets; Maine SNAP-ED Program; school nutrition programs; public walking and biking trails; Healthy Maine Partnerships; Let's Go! 5-2-1-0 • **Mental health/Depression:** Mental health/counseling providers and programs

[23] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015, n=220.

Table 24 presents a summary of the major health strengths and challenges that affect the health of Kennebec County residents. Data come from a comprehensive analysis of available surveillance data (see Table 26 for a full list of the health indicators and factors included in this project). Two criteria were used to select the factors and challenges presented in this table. **Statistically significant differences** (at 95 percent confidence) between the county and state are noted with an asterisk (*) after the indicator. In addition, a **rate ratio** was calculated comparing the county results to the state and U.S. (where available). Indicators where the county was 10 percent or more above or below the state and U.S. figures were noted for inclusion in this table.

Table 24. Priority Health Factor Strengths and Challenges for Kennebec County-Surveillance Data

Health Factors – Surveillance Data	
Health Factor Strengths	**Health Factor Challenges**
• Fewer individuals who are unable to obtain or delay obtaining necessary medical care due to cost [KEN=10.4%; U.S.=15.3%] • More homes with private wells tested for arsenic [KEN=56.5%; ME=43.3%]* • Fewer immunization exemptions among kindergarteners for philosophical reasons [KEN=3.1%; ME=3.7%]	• Low median household income [KEN=$46,808; ME=$48,453]* • Lower lead screening among children age 12-23 months [KEN=37.9%; ME=49.2%]*

Asterisk (*) indicates a statistically significant difference between Kennebec County and Maine.
All rates are per 100,000 population unless otherwise noted.

Table 25 summarizes the results of the health factor questions in the stakeholder survey for Kennebec County. It includes a summary of the health factors that cause the biggest challenges from the perspective of stakeholders who work in and represent communities in the county. A description of the assets and resources available and those that are needed at the county and state level to address these health factors is also included.

Table 25. Priority Health Factor Challenges and Resources for Kennebec County-Stakeholder Responses

Stakeholder Input- Stakeholder Survey Responses [24]	
Community Challenges	**Community Resources**
Biggest health factors leading to poor health outcomes in Kennebec County according to stakeholders *(% of those rating factor as a major or critical problem in their area*). • Poverty (75%) • Access to behavioral care/mental health care (68%) • Health care insurance (65%) • Transportation (61%) • Health literacy (60%)	**Assets Needed to Address Challenges:** • **Poverty:** Greater economic development; increased mentoring services; more skills trainings; more employment opportunities at livable wages; better transportation; better education • **Access to behavioral care/mental health Care:** Better access to behavioral/mental health care for the uninsured; full behavioral/mental health integration at hospital and primary care levels; expand behavioral/mental health agencies to more rural areas; more hospital beds for mentally ill patients • **Health care insurance:** Expansion of Medicaid; making insurance more affordable; universal health care; more stable health care system • **Transportation:** More/better transportation systems; better access to public transportation; additional funding for organizations that help with rides to medical appointments; additional resources for transportation for the elderly and disabled **Assets Available in County/State:** • **Poverty:** General Assistance; other federal, state and local programs • **Access to behavioral care/mental health care:** Behavioral/mental health agencies • **Health care insurance:** MaineCare; free care • **Health literacy:** Hospital systems; primary care providers; social service agencies

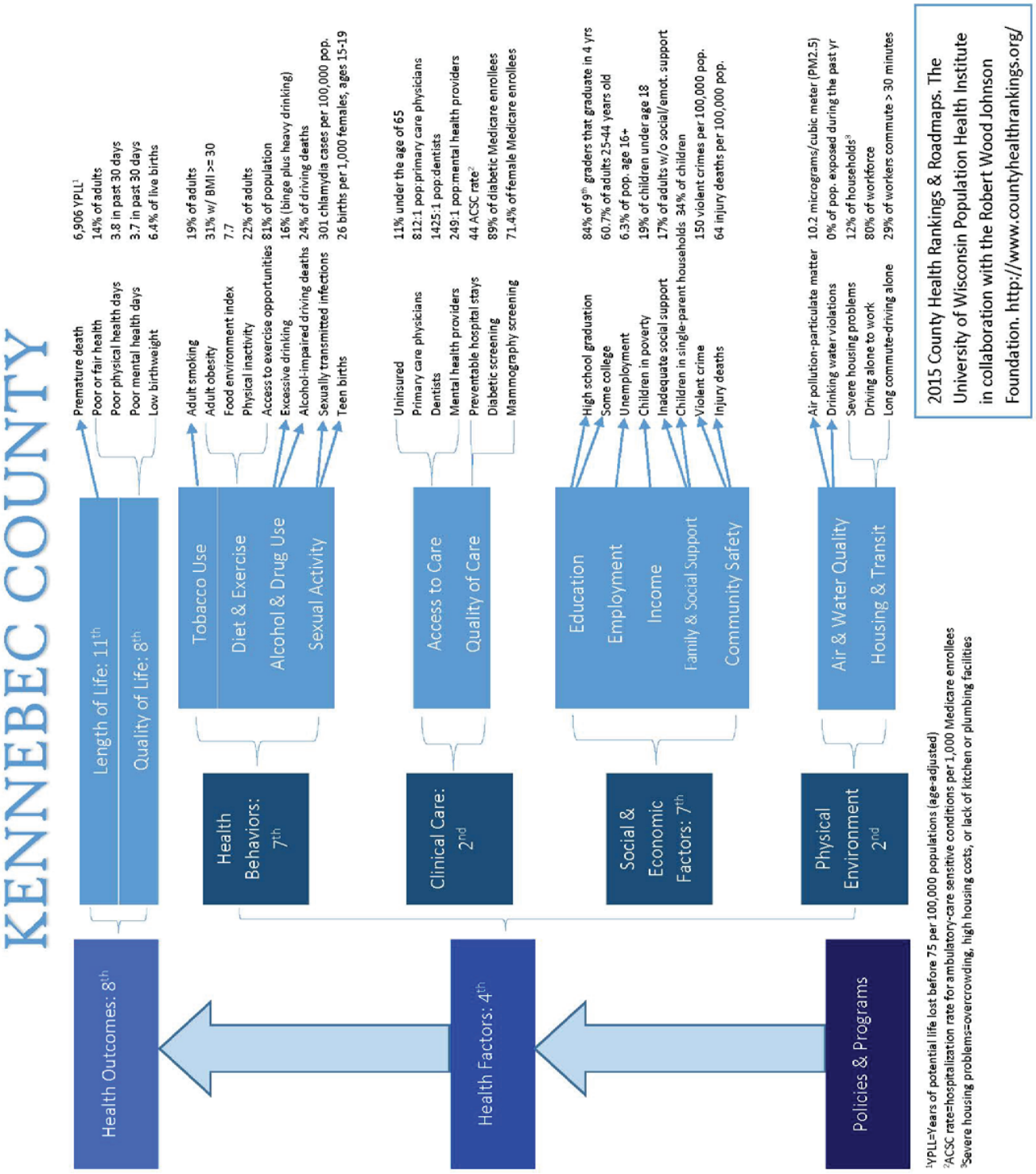
[24] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015.

County Health Rankings & Roadmaps

Each year, the University of Wisconsin Health Institute and Robert Wood Johnson Foundation produce *The County Health Rankings & Roadmaps* for every county in the U.S. The annual reports measure the social, economic, environmental and behavioral factors that influence health. These factors are quantified using indicators such as high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income and teen births, to name a few. The rankings weight and score the sets of indicators to provide county comparisons within each state. For more information: www.countyhealthrankings.org

For this analysis, the 2015 rankings data for each of Maine's 16 counties is displayed in the graphic used by the University of Wisconsin to show how all of the factors ultimately affect community health. The comparison across counties provides insight into county health status. In Maine, the county ranked as "#1" on a particular health issue, is the healthiest in that measure, "#16" is the least healthy. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to timing or use of different indicators.

In interpreting the rankings for each county, it is important to keep in mind the underlying health measures. Because of the forced ranking, one county is always the "healthiest" and one is always the "least healthy." The comparisons are helpful in understanding differences, but it is important to look past the assignment of rank to understand the underlying issues and opportunities and their relative importance in the region.


KENNEBEC COUNTY
Health Outcomes: 8th
Length of Life: 11th
Quality of Life: 8th
Premature death 6,906 YPLL1
Poor or fair health 14% of adults
Poor physical health days 3.8 in past 30 days
Poor mental health days 3.7 in past 30 days
Low birthweight 6.4% of live births
Health Factors: 4th
Health Behaviors: 7th
Tobacco Use
Adult smoking 19% of adults
Diet & Exercise
Adult obesity 31% w/ BMI >= 30
Food environment index 7.7
Physical inactivity 22% of adults
Alcohol & Drug Use
Access to exercise opportunities 81% of population
Excessive drinking 16% (binge plus heavy drinking)
Alcohol-impaired driving deaths 24% of driving deaths
Sexual Activity
Sexually transmitted infections 301 chlamydia cases per 100,000 pop.
Teen births 26 births per 1,000 females, ages 15-19
Clinical Care: 2nd
Access to Care
Uninsured 11% under the age of 65
Primary care physicians 812:1 pop:primary care physicians
Dentists 1425:1 pop:dentists
Quality of Care
Mental health providers 249:1 pop:mental health providers
Preventable hospital stays 44 ACSC rate2
Diabetic screening 89% of diabetic Medicare enrollees
Mammography screening 71.4% of female Medicare enrollees
Social & Economic Factors: 7th
Education
High school graduation 84% of 9th graders that graduate in 4 yrs
Some college 60.7% of adults 25-44 years old
Employment
Unemployment 6.3% of pop. age 16+
Income
Children in poverty 19% of children under age 18
Family & Social Support
Inadequate social support 17% of adults w/o social/emot. support
Children in single-parent households 34% of children
Community Safety
Violent crime 150 violent crimes per 100,000 pop.
Injury deaths 64 injury deaths per 100,000 pop.
Physical Environment 2nd
Air & Water Quality
Air pollution-particulate matter 10.2 micrograms/cubic meter (PM2.5)
Drinking water violations 0% of pop. exposed during the past yr
Housing & Transit
Severe housing problems 12% of households3
Driving alone to work 80% of workforce
Long commute-driving alone 29% of workers commute > 30 minutes
Policies & Programs
2015 County Health Rankings & Roadmaps. The University of Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation. http://www.countyhealthrankings.org/
1YPLL=Years of potential life lost before 75 per 100,000 populations (age-adjusted)
2ACSC rate=hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
3Severe housing problems=overcrowding, high housing costs, or lack of kitchen or plumbing facilities

Stakeholder Survey Findings

Table 26. Stakeholder Survey Results for Kennebec County and Maine

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Kennebec County	**Maine**
Demographics		
Which of the following sectors best describes your role or organization? (12 choices, picked 1)		
Number of Respondents	n=220	n=1639
Medical care provider	34%	22%
Other non-profit or social service agency	12%	14%
Other	9%	13%
Public health	12%	11%
Business owner or employee	10%	9%
Educator	5%	8%
Other type of health care organization	10%	8%
Behavioral/mental health provider	4%	6%
Local government	1%	4%
Other governmental agency	<1%	3%
Youth-serving organization	2%	2%
Faith-based organization	<1%	1%
Do you work for or represent: (5 choices, picked 1)		
None of the above	30%	49%
Hospital/Health-care system	61%	38%
Local public health agency	7%	10%
Maine CDC	1%	3%
Tribal health	<1%	<1%
Please identify the type of geographical area that you primarily serve? (6 choices, picked 1)		
Town or region	20%	27%
Hospital/Health service area	49%	26%
Statewide	7%	22%
County	10%	18%
Other area	6%	4%
Public health district	8%	3%
Does your organization work with specific groups of people or populations recognized as being at risk of, or experiencing, higher rates of health risk or poorer health outcomes than the general population within your area?		
Yes	24%	24%
Somewhat	60%	47%
No	16%	29%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
If "Yes" or "Somewhat" to Q4: To which of the following populations does your organization directly provide resources to address their needs? (select all that apply)		
Number of Respondents	n=184	n=1159
Don't know	8%	5%
Low-income, including those below the federal poverty limit, or defined as low-income by some other definition	79%	77%
Medically underserved – including uninsured and underinsured	66%	63%
People with disabilities – physical, mental, or intellectual	62%	58%
Very rural and/or geographically isolated people	41%	47%
Less than a high school education and/ or low literacy (low reading or math skills)	51%	47%
Women	45%	44%
Limited or no English proficiency	36%	38%
Gay, lesbian, bisexual or transgendered people	33%	36%
Deaf and hard of hearing people	42%	35%
Military veterans	38%	34%
Refugees/immigrants	20%	28%
Racial/ethnic minority populations	21%	27%
Members of any federally recognized tribe	23%	25%
Specific age group	20%	21%
Other	14%	15%
Overall, to what degree to you feel the health needs of your area are being addressed?		
Number of Respondents	n=220	n=1639
Not addressed at all	<1%	<1%
Mostly unaddressed	6%	10%
Somewhat addressed	51%	55%
Mostly addressed	37%	30%
Completely addressed	2%	2%
Don't know	3%	2%
Health Issues and Factors		
Please rate the following health issues based on how you feel they impact the overall health of residents in your area. (*Percentage of stakeholders in county who rated issue as a major or critical problem in their area*)		
Number of Respondents	n=220	n=1639
Family Health		
Adolescent health	29%	25%
Child developmental issues	31%	34%
Childhood obesity	61%	58%
Elder health	63%	55%
Infant mortality	8%	4%
Maternal and child health	17%	23%
Chronic Diseases		
Cancer	48%	50%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Cardiovascular disease	63%	63%
Depression	72%	67%
Diabetes	64%	63%
Musculoskeletal diseases	28%	28%
Neurological diseases	37%	35%
Obesity	80%	78%
Respiratory disease	59%	60%
Infectious Diseases		
Infectious diseases	21%	22%
Sexually transmitted diseases/HIV/AIDS	13%	13%
Health Behaviors		
Drug and alcohol abuse	80%	80%
Physical activity and nutrition	71%	69%
Tobacco use	64%	63%
Other Health Issues		
Lead poisoning and other environmental health issues	13%	17%
Mental health	76%	71%
Oral health	54%	53%
Suicide and self-harm	40%	37%
Unintentional injury	33%	34%
Violence	44%	38%
"Don't know" responses not included		
Please indicate how much of a problem each of the following health factors is in your area and leads to poor health outcomes for residents. *(Percentage of stakeholders who rated factor as a 4-major or 5-critical problem in their area, on 5-point scale)*		
Number of Respondents	n=220	n=1639
Economic Stability		
Employment	59%	64%
Food security	52%	58%
Housing stability	55%	57%
Poverty	75%	78%
Education		
Enrollment in higher education	34%	35%
Early childhood education/development	42%	43%
High school graduation	32%	31%
Language and literacy	27%	34%
Social and Community Context		
Adverse childhood experiences	56%	56%
Civic participation	30%	30%
Incarceration or institutionalization	39%	35%
Social attitudes such as discrimination	30%	38%
Social support and interactions	52%	50%
Caregiver support	51%	46%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Health and Health Care		
Access to behavioral care/mental health care	68%	67%
Access to primary care	40%	39%
Access to other health care	36%	41%
Access to oral health	56%	56%
Health care insurance	65%	64%
Health literacy	60%	62%
Neighborhood and Built Environment		
Access to healthy foods	49%	53%
Access to physical activity opportunities	39%	42%
Crime and violence	28%	27%
Environmental conditions	10%	12%
Quality of housing	40%	34%
Transportation	61%	67%
"Don't know" responses not included		
Please rank each health issue according to how you think resources in your area should be allocated. (1=highest priority and 8=lowest priority) *(mean)*		
Number of Respondents	n=164	n=1168
Risk factors that lead to poor health	3.10	3.08
Mental health - conditions that impact how people think, feel and act as they cope with life	3.27	3.49
Substance abuse behaviors, including excessive drinking, smoking and other drug use	3.68	3.71
Community capacity - ability to sustain a high quality of life, including access to employment, education and housing	3.84	3.93
Chronic diseases, such as heart disease, cancer, diabetes and asthma	3.92	4.05
Family health, including teen pregnancy, prenatal care and healthy behaviors during pregnancy	4.90	4.81
Environmental issues - access to healthy foods, access to recreation, clean air, water, lead exposure, etc.	5.50	5.36
Injuries, intentional and unintentional	6.55	6.52

Health Indicators Results from Secondary Data Sources

The county level summary of health indicators analyzed from secondary data sources is presented in the table below. Results are displayed for the county, state and U.S. (where available). County trends are presented in the column after the county data when available. Results are organized by health issue or category. Please note that age-adjusted rates are presented for all applicable indicators, with the exception of ambulatory care-sensitive conditions and infectious and sexually transmitted diseases (which are presented as crude rates). A detailed list of all data sources, years and notes for all indicators is presented in Table 28.

Indicates county is significantly better than state average (using a 95% confidence level).
Indicates county is significantly worse than state average (using a 95% confidence level).
+ Indicates an improvement in the indicator over time at the county level (using a 95% confidence level)
− Indicates a worsening in the indicator over time at the county level (using a 95% confidence level)
† Results may be statistically unreliable due to small numerator, use caution when interpreting.
NA = Data not available.

Table 27. Quantitative Health Indicators for Kennebec County, Maine and the U.S.

Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Demographics					
Total Population	2013	121,164		1,328,302	319 Mil
Population – % ages 0-17	2013	19.9%		19.7%	23.3%
Population – % ages 18-64	2013	63.0%		62.6%	62.6%
Population – % ages 65+	2013	17.1%		17.7%	14.1%
Population – % White	2013	96.4%		95.2%	77.7%
Population – % Black or African American	2013	0.6%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.5%		0.7%	1.2%
Population – % Asian	2013	0.8%		1.1%	5.3%
Population – % Hispanic	2013	1.4%		1.4%	17.1%
Population – % with a disability	2013	17.6%		15.9%	12.1%
Population density (per square mile)	2013	140.8		43.1	87.4
Socioeconomic Status Measures					
Adults and children living in poverty	2009-2013	13.4%	NA	13.6%	15.4%
Children living in poverty	2009-2013	17.7%	NA	18.5%	21.6%
High school graduation rate	2013-2014	85.5%	NA	86.5%	81.0%
Median household income	2009-2013	*$46,808*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	100.0%	NA	66.4%	NA
Single-parent families	2009-2013	36.7%	NA	34.0%	33.2%
Unemployment rate	2014	5.4%	NA	5.7%	6.2%
65+ living alone	2009-2013	42.7%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	16.1%		15.6%	16.7%

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).

Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Adults with 14+ days lost due to poor mental health	2011-2013	14.0%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	14.1%		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	27.7%		27.6%	NA
Mortality					
Life expectancy (Female)	2012	80.9	NA	81.5	81.2
Life expectancy (Male)	2012	75.6	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*805.1*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	88.0%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	10.4%		11.0%	15.3%
MaineCare enrollment	2015	29.0%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	44.8%	NA	41.8%	48.0%
Percent uninsured	2009-2013	9.6%	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,390.4*		1,499.3	1457.5
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*3,892.4*	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	67.4%	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	54.4%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	67.6	+	67.3	NA
COPD diagnosed	2011-2013	7.7%		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	*166.5*		216.3	NA
Current asthma (Adults)	2011-2013	12.6%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	10.7%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	754.2		719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	299.7		329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	*199.4*	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	493.5	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	25.4	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	22.1	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	44.5	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	138.0	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	82.9%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	18.1	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	21.0	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	40.2	NA	43.5	42.0

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

Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Colorectal screening	2012	77.7%	NA	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	56.6	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	78.8	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*15.6*	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	85.7%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	27.0	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	138.3	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	41.1	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	89.3	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*27.8*	+	23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	36.1	NA	32.2	32.4
Cholesterol checked every five years	2011. 2013	82.2%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*100.7*	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	20.3		21.9	NA
Hypertension prevalence	2011, 2013	32.4%		32.8%	31.4%
High cholesterol	2011, 2013	40.0%		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	*18.4*	+	28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	22.4		20.8	NA
Stroke mortality per 100,000 population	2009-2013	36.1	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	9.5%		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	5.0%		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	74.5%	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	79.8%	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	65.1%	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	233.9		235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	12.5		11.7	NA
Diabetes long-term complication hospitalizations	2011	*72.3*		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	*25.8*	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	2.3%	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	*5.7%*	NA	4.2%	NA

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

Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Homes with private wells tested for arsenic	2009, 2012	*56.5%*	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*37.9%*	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	27.3%	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	43.4%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	74.0%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	3.1%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	81.0%	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.0†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	4.1†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	3.3†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	39.6	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	3.3†	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	113.9	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	14.0†	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	0.8†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	0.0†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	295.6	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	19.0	NA	17.8	109.8
HIV incidence per 100,000 population	2014	3.3†	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	22.0		21.4	NA
Syphilis incidence per 100,000 population	2014	0.0†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	478.3	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	9.0	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	52.0	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	14.7	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	146.2	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	86.5%		85.2%	NA
Always wear seatbelt (High School Students)	2013	61.8%		61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*100.0*	NA	81.4	NA

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Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	13.6	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	6.3	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*400.1*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	12.0	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19	4,585
Nonfatal occupational injuries (number)	2013	1,539	NA	13,205	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	20.5%		19.4%	NA
Adults who have ever had depression	2011-2013	24.1%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	9.6%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	18.7%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	36.0%	NA	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	2,008.8		1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	24.5%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	15.3%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	16.7%	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	36.1%	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	57.1%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	44.4%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	22.6%		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	27.5%	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	20.3%	NA	17.9%	22.9%
Obesity (Adults)	2013	28.3%		28.9%	29.4%
Obesity (High School Students)	2013	14.3%		12.7%	13.7%
Overweight (Adults)	2013	38.8%		36.0%	35.4%
Overweight (High School Students)	2013	16.7%		16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	5.7	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	*81.3%*	NA	86.4%	84.8%

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Maine Shared CHNA Health Indicators	Year	Kennebec	Trend	Maine	U.S.
Live births to 15-19 year olds per 1,000 population	2010-2012	23.7	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.9%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	8.0	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	14.3%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	15.5%		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	*5.5%*		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	8.3%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	13.0	NA	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	416.1	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	19.6		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	14.0		13.2	NA
Past-30-day alcohol use (High School Students)	2013	24.0%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.0%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	8.4%		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	20.0%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	*0.1%†*	NA	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	4.5%		5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	9.5	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	351.2	+	328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	17.9%		20.2%	19.0%
Current smoking (High School Students)	2013	13.6%		12.9%	15.7%
Current tobacco use (High School Students)	2013	18.6%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	39.4%		38.3%	NA

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

Table 28. List of Data Sources and Years for Quantitative Health Indicators

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Demographics			
Population	U.S. Census	2013	2013 data was used for all age, racial and ethnic groups.
Population with a disability	U.S. Census	2011-2013	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	Based on 2010 U.S. Census population.
Socioeconomic Status Measures			
Adults and children living in poverty	U.S. Census	2009-2013	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	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	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	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	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	2009-2013	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	Unemployment rate of the civilian noninstitutionalized population averaged for the full year of 2014.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
65+ living alone	U.S. Census	2009-2013	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	2011-2013	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	2011-2013	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	2011-2013	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	2011, 2013	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	Life expectancy at birth.
Life expectancy (Male)	National Center for Health Statistics	2012	Life expectancy at birth.
Overall mortality rate per 100,000 population	DRVS	2009-2013	All deaths are defined as deaths in which the underlyin g cause of death was coded as ICD-10 any listed.
Access			
Adults with a usual primary care provider	BRFSS	2011-2013	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	2011-2013	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	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	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	2009-2013	Estimated number of Maine people who do not currently have health insurance.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Health Care Quality			
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	MHDO	2011	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	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	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	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	2009-2011	ICD-9 CM - 493
COPD diagnosed	BRFSS	2011-2013	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	ICD-9 CM - 490, 491, 492, 494, 496
Current asthma (Adults)	BRFSS	2011-2013	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	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	ICD-9 CM - 480-486
Pneumonia hospitalizations per 100,000 population	MHDO	2011	ICD-9 CM - 480-486
Cancer			
Mortality – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Cause of Death Recode: 20010-37000 (which include ICD-10 codes: C00-C97).
Incidence – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Site Recode: 20010-37000 (which include ICD-O-3 codes: C00-C797).

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Bladder cancer incidence per 100,000 population	MCR	2007-2011	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	2007-2011	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)	2007-2011	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	2007-2011	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	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Colorectal late-stage incidence per 100,000 population	MCR	2007-2011	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	2007-2011	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	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Lung cancer incidence per 100,000 population	MCR	2007-2011	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	2007-2011	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.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Pap smears females ages 21-65 in past three years	BRFSS	2012	Females with intact cervix, that have received a pap smear within the past three years.
Prostate cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Prostate cancer incidence per 100,000 population	MCR	2007-2011	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Tobacco-related neoplasms, incidence per 100,000 population	MCR	2007-2011	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	2010-2012	ICD-9 CM - 410
Acute myocardial infarction mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I21-I22
Cholesterol checked every five years	BRFSS	2011. 2013	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	2009-2013	ICD-10 I20-I25
Heart failure hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 428
Hypertension prevalence	BRFSS	2011, 2013	Adults who have ever been told by a doctor, nurse, or other health professional that they have high blood pressure.
High cholesterol	BRFSS	2011, 2013	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	ICD-9 CM - 401, 402, 403, 404
Stroke hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 430-438
Stroke mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I60-I69
Diabetes			
Diabetes prevalence (ever been told)	BRFSS	2011-2013	Adults that have ever been told by a doctor or other health professional that they have diabetes.
Pre-diabetes prevalence	BRFSS	2011-2013	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	Adults with diabetes who report having an eye exam in which the pupils were dilated within the past year.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Adults with diabetes who have foot exam annually	BRFSS	2011-2013	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	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	2011-2013	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	ICD-9 CM - 250
Diabetes hospitalizations (principal diagnosis) per 10,000 population	MHDO	2010-2012	ICD-9 CM - 250
Diabetes long-term complication hospitalizations	MHDO	2011	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	2009-2013	ICD-10 E10-E14
Environmental Health			
Children with confirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2009-2013	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	2009-2013	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	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	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	A blood lead test is considered a “screening test” only when a child has no prior history of a confirmed elevated blood lead level.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Immunization			
Adults immunized annually for influenza	BRFSS	2011-2013	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	2011-2013	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	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	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	Defined as the number of new infections during 2014.
Hepatitis B (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Hepatitis C (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	MIDSS	2014	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	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.
Lyme disease incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Pertussis incidence per 100,000 population	MIDSS	2014	Incidence is defined as the number of new infections during 2014.
Tuberculosis incidence per 100,000 population	MIDSS	2014	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	Incidence is defined as the number of new infections during 2014.
Chlamydia incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Gonorrhea incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.
HIV incidence per 100,000 population	Maine CDC HIV Program	2014	Incidence is defined as the number of new infections during 2014.
HIV/AIDS hospitalization rate per 100,000 population	MHDO	2011	DRG-MDC 25
Syphilis incidence per 100,000 population	Maine CDC STD Program	2014	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	All offenses of assault between family or household members are reported as domestic assault.
Firearm deaths per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 W32-W34 ,X72-X74, X93-X95, Y22-Y24, Y350 or U014.
Intentional self-injury (Youth)	MIYHS	2013	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	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	Rates are unique child victims per 1,000 population under age 18.
Reported rape per 100,000 population	Maine Dept. of Public Safety	2013	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	2009-2013	ICD-10 U03 X60-X84 or Y87.0
Violence by current or former intimate partners in past 12 months (among females)	BRFSS	2012	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	Reported violent crime offenses. Violent crime includes murder, rape, robbery and aggravated assault.
Unintentional Injury			
Always wear seatbelt (Adults)	BRFSS	2013	Adults reporting they always use seatbelts when they drive or ride in a car.
Always wear seatbelt (High School Students)	MIYHS	2013	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	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.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Unintentional and undetermined intent poisoning deaths per 100,000 population	Maine CDC Vital Records	2009-2013	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	2009-2013	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	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	2009-2013	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	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	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	2011-2013	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	2011-2013	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	2011-2013	Indicator of current depression coded using two items from the PHQ-2 depression screener.
Adults currently receiving outpatient mental health treatment	BRFSS	2011-2013	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	2011, 2013	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	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	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	During the past 12 months, did you ever seriously consider attempting suicide? Percentage of students who answered "Yes".

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Physical Activity, Nutrition and Weight			
Fewer than two hours combined screen time (High School Students)	MIYHS	2013	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	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	Adults with less than one serving per day of fruits or fruit juice.
Met physical activity recommendations (Adults)	BRFSS	2013	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	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	2011-2013	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	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	Adults with less than one serving per day of vegetables.
Obesity (Adults)	BRFSS	2013	Adults with a BMI of 30 or more.
Obesity (High School Students)	MIYHS	2013	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	Adults with a BMI between 25.0 and 29.9.
Overweight (High School Students)	MIYHS	2013	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	Survey respondents who reported that their child has a special health care need.
Infant deaths per 1,000 live births	Maine CDC Vital Records	2003-2012	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.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Live births for which the mother received early and adequate prenatal care	Maine CDC Vital Records	2010-2012	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	2010-2012	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	Low birth weight defined as less than 2500 grams.
Substance and Alcohol Abuse			
Alcohol-induced mortality per 100,000 population	Maine CDC Vital Records	2009-2013	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	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	2011-2013	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	2011-2013	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	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	2009-2013	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	Includes overdoses from drugs/medication, alcohol and inhalants.
Opiate poisoning (ED visits) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Opiate poisoning (hospitalizations) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Past-30-day alcohol use (High School Students)	MIYHS	2013	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	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	2011-2013	During the past 30 days, have you used marijuana?
Past-30-day marijuana use (High School Students)	MIYHS	2013	During the past 30 days, how many times did you use marijuana? Percentage of students who answered at least 1 time.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Past-30-day nonmedical use of prescription drugs (Adult)	BRFSS	2011-2013	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	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	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	DRG-MDC 20
Tobacco Use			
Current smoking (Adults)	BRFSS	2011-2013	Adults that reported having smoked at least 100 cigarettes in their lifetime and currently smoke.
Current smoking (High School Students)	MIYHS	2013	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	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	Percentage of students who were in the same room with someone who was smoking cigarettes at least 1 day during the past 7 days.

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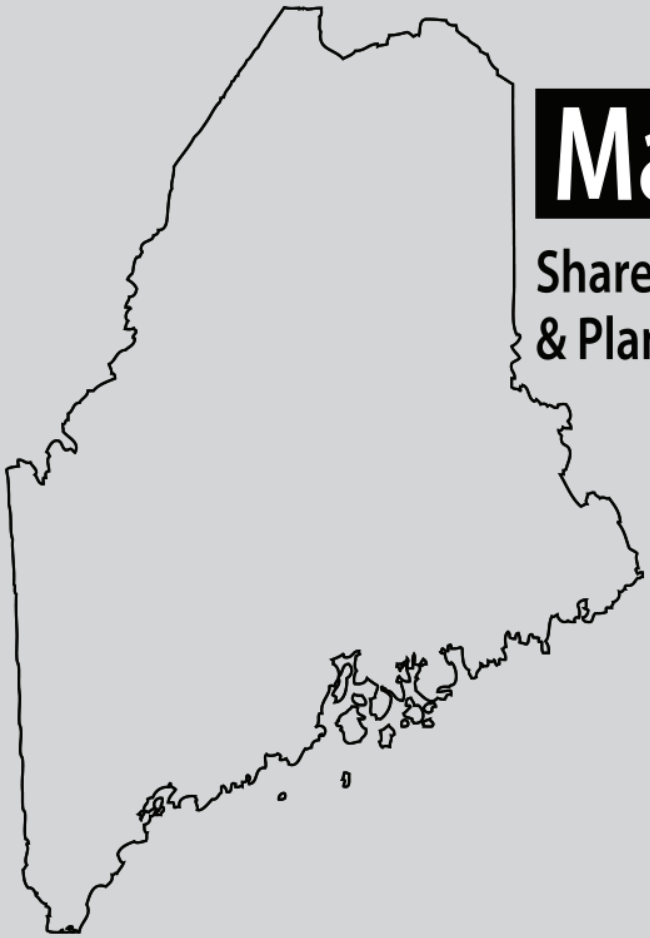

Maine SHNAPP

Shared Health Needs Assessment & Planning Process

2016 Shared Community Health Needs Assessment

Somerset County

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MaineGeneral Health

MaineHealth

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
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The report was prepared by the research teams at Market Decisions Research of Portland, Maine, Hart Consulting Inc. of Gardiner, Maine, and the Maine Center for Disease Control and Prevention. Substantial segments of the narrative sections were adapted from the 2012 Maine State Health Assessment and significant analysis and research was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service.

MARKET DECISIONS RESEARCH

HART CONSULTING

See end of the report for a list of contributors and collaborating organizations.

Note: Originally, this report was dated 2015 on the cover. However, it has been changed to 2016 to reflect the fiscal years of the organizations that have been involved.

Table of Contents

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Table of Tables

How to Use This Report

This report contains findings for Somerset County from the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) conducted in 2015. It is divided into ten sections to provide the reader with an easy-to-use reference to the data-rich assessment. It starts with the highest level of data, followed by summaries and synthesis of the data. The last sections include the detailed findings from assessments as well as the sources.

The report has several features that are important to keep in mind:

- The document provides a reference for more than 160 indicators and more than 30 qualitative survey questions covering many topics. It does not explore any individual topic in-depth.
- The definitions, sources and year(s) for each indicator discussed in the report are found at the end in the data sources section.
- Wherever the term, "statistically significant" is used to describe differences between data estimates, it means that the 95 percent confidence intervals for the given point estimates do not overlap.
- Unless otherwise noted, all rates presented in this report are age-adjusted and calculated per 100,000 population to facilitate comparisons between counties, Maine and the U.S.

The following is a brief description of each section.

Executive Summary
The summary provides the highest level overview of data for the county.

Background
This section explains the purpose and background of the SHNAPP and the Shared CHNA. It includes a description of the methodology and data sources used in the assessment.

County Demographics
The demographic section compares the population and socioeconomic characteristics of the county to the overall state of Maine.

Summary of Findings
This section provides a summary of the assessment data by health issue; it compares the county to the state and U.S. on key indicators and explains the importance of the health issues.

Stakeholder Feedback
High-level findings from the stakeholder survey are included in this section. It explores the top five health issues and factors identified as local priorities or concerns by stakeholders. It shares respondent concern for populations experiencing disparities in health status for these issues.

Priority Health Issues and Challenges

Priority health issues and challenges appear in this section. This section categorizes the key findings from the quantitative and stakeholder (qualitative) datasets as strengths and challenges. The analysis includes health issue indicators from the quantitative datasets sorted into challenges and strengths, stakeholder responses for challenges and resources to address the challenges.

County Health Rankings

The *2015 County Health Ranking & Roadmaps* model for the county is shown in this section. The model, from the University of Wisconsin Population Health Institute, shows how the individual health behaviors lead to health outcomes, which then determines the overall health status for a population. The graphic illustration includes the associated measures for each health indicator and the county rank among all 16 counties in the state of Maine. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to the time period for the data or use of different indicators.

Stakeholder Survey Findings

This section displays the full set of responses to each question asked in the stakeholder survey (excluding open-ended responses, which are available upon request). It compares the county to the statewide responses.

Health Indicator Results from Secondary Data Sources

The results and sources section details the data for each of the 160 indicators for the county. It includes a table that compares data for the county, the state and the U.S. (where available). Statistically significant differences (at 95 percent confidence) are noted in this table where available and applicable.

Health Indicator Data Sources

This section lists the data source, year and additional notes for each indicator. In addition to the stakeholder survey conducted as a primary data source for this project, the secondary data sources used in this assessment include:

Child Maltreatment Report, Administration on Children Youth and Families
Maine Cancer Registry (MCR)
MaineCare
Maine Behavioral Risk Factor Surveillance System (BRFSS)
Maine CDC Drinking Water Program
Maine CDC HIV Program
Maine CDC Lead Program
Maine CDC National Electronic Disease Surveillance System (NEDSS)
Maine CDC Public Health Emergency Preparedness (PHEP)
Maine CDC STD Program
Maine CDC Vital Records
Maine Department of Education
Maine Department of Public Safety
Maine Department of Labor
Maine Health Data Organization (MHDO)
Maine Integrated Youth Health Survey (MIYHS)
Maine Office of Data Research and Vital Records
National Immunization Survey (NIS)
National Survey of Children w/ Special Health Care Needs
National Center for Health Statistics
U.S. Bureau of Labor Statistics
U.S. CDC WONDER & WISQARS
U.S. Census

Executive Summary

Public health and health care organizations share the goal of improving the lives of Maine people. Health organizations, along with business, government, community organizations, faith communities and individuals, have a responsibility to shape health improvement efforts based on sound data, personal or professional experience and community need.

This summary provides high-level findings from the Maine Shared Community Health Needs Assessment (CHNA), a comprehensive review of health data and community stakeholder input on a broad set of health issues in Maine. The Shared CHNA was conducted through a collaborative effort among Maine's four largest health-care systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention an office of the Maine Department of Health and Human Services (DHHS).

While it covers a broad range of topics, the Shared CHNA is not an exhaustive analysis of all available data on any single health issue. These data help identify priorities and should lead the reader to conduct a deeper investigation of the most pressing health issues.

Data are important and a solid starting point, but the numbers represent people who live in Maine. The overall goal of the Maine SHNAPP is to "turn data into action." Community engagement is therefore a critical next step, assuring shared ownership and commitment to collective action. The perspectives of those who live in our communities will bring these numbers to life and, together, we can set priorities to achieve measurable community health improvement. We invite all readers to use the information in this report as part of the solution to develop healthier communities in Maine.

Demographics and Socioeconomic Factors

Somerset County was home to 51,706 people in 2013. It is considered a rural county, according to the urban and rural classifications defined by the New England Rural Health RoundTable.[1] It is worse off than the state in many demographic and socioeconomic characteristics, including income, poverty rates and education. A significantly greater percentage of adults and children are living in poverty compared to the state. The county has a greater proportion of families with one parent. Key demographic features for the 2009-2013 time period include:

- Median household income of $38,642.
- 24.9 percent of children and 17.8 percent of all individuals live in poverty.
- 37.7 percent of families are single parent families.

[1] Rural Data for Action, New England Rural Health RoundTable, 2014. Available from: http://www.newenglandruralhealth.org/rural_data

Access to Health Care/Quality

Access to care in Somerset County is slightly lower than the state; specifically, a lower percentage of Somerset County residents have health insurance and more report a lack of care due to cost. The ambulatory care sensitive-conditions[2] hospital admission rate in Somerset County is also significantly above the state. Key features for Somerset County include:

- 12.2 percent of residents did not have health insurance (2009-2013); 12.6 percent experienced cost-related barriers to getting healthcare in the last year (2011-2013).
- 85.5 percent of adults reported having a personal doctor or other health care provider (2011-2013).
- The hospitalization rate for ambulatory care-sensitive conditions was 1,665.2 per 100,000 population (2011).

General Health and Mortality

The general health of people in Somerset County is poor compared to the state. Key features for Somerset County include:

- 22.1 percent of adults reported their health as fair or poor, which is significantly higher than the state at 15.6 percent (2011-2013).
- Similar to the state overall, the top three leading causes of death were heart disease, cancer and lower respiratory diseases (2013).
- The overall mortality rate per 100,000 population was 826.3 in Somerset County compared with 745.8 for the state (2009-2013).

Disease Incidence and Prevalence

Cardiovascular health is a major issue in Somerset County. Many cardiovascular disease health measures are significantly worse than the state. Coronary heart disease mortality, heart failure hospitalization rate, acute myocardial infarction hospitalization and mortality rates are all significantly higher than the state. Cancer mortality rates are also higher than the state, with the exception of female breast cancer mortality. In addition, asthma and pneumonia emergency department visits are significantly higher in Somerset County. Among infectious diseases, pertussis incidence rates were higher in the county, while Lyme disease rates were lower. Key features for Somerset County include:

- The acute myocardial infarction hospitalization rate per 10,000 population was significantly higher than the state, 30.4 compared to 23.5. As well as heart failure hospitalizations, 28.5 compared to 21.9 (2010-2012).

[2] Ambulatory care-sensitive conditions (ACSC) are Prevention Quality Indicators from the Agency for Healthcare Research and Quality and is intended to measure whether these conditions are being treated appropriately in the outpatient setting before hospitalization is required.

- In addition, the acute myocardial infarction mortality rate was also significantly higher than the state, 40.1 per 100,000 population for Somerset County compared to 32.2 for the state. As well as coronary heart disease mortality, 117.4 per 100,000 population compared to 89.8 (2009-2013).
- Diabetes prevalence for Somerset County was comparable to the state (11.8 percent of adults).
- Mortality from all cancers was 204.9 per 100,000 population compared to the state at 185.5 (2007-2011). The number of new cases of all cancer sites per 100,000 population in Somerset County was 472. Lung cancer mortality rate was slightly higher than the state, 57.6 compared to 54.3 per 100,000 population (2007-2011).
- Asthma emergency department visits per 10,000 population were 101.2 compared to 67.3 for the state (2009-2011).
- The pertussis incidence rate of 86 per 100,000 population was higher than the state and nation at 41.9 and 10.3 respectively. Lyme disease incidence was 33.2 per 100,000 population (2014).
- 37.6 percent of adults reported being immunized annually for influenza, which is below the state at 41.5 percent (2011-2013).

Health Behaviors and Risk Factors

Somerset County residents experience high rates of unhealthy behaviors. A significantly greater proportion of adults are sedentary and more high school youth are obese. Moreover, a significantly lower proportion of pregnant women are receiving adequate prenatal care, and a significantly higher proportion of teens are having babies compared to the state. Binge drinking for adults and high school youth are similar to the state. Current cigarette smoking rates are higher for both adults and youth compared to the state. Key health behavior and risk factor indicators include:

- The proportion of adults reporting sedentary lifestyles was 29.3 percent (2011-2013).
- The proportion of high school youth reporting obesity was 16.9 percent (2013).
- Live births for which mothers received early and adequate care was 75.5 percent. Teen birth rate per 1,000 live births (age 15-19) was 27.8 percent compared to 20.5 for the state (2010-2012).
- Binge drinking of alcoholic beverages by adults was 17.3 percent (2011-2013); and by high school youth was 14.2 percent (2013).
- Current cigarette smoking among adults was 26.1 percent (2011-2013); and by high school youth was 14.9 percent (2013). Youth exposure to secondhand smoke was significantly higher in Somerset County than the state, 46.6 percent compared to 38.3 percent (2013).

Stakeholder Priorities of Health Issues

Stakeholders who work in Somerset County listed the following health issues as their top five concerns:

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

Stakeholders identified the following populations as being disproportionately affected by the top health issues in Somerset County:

- Low-income people, including those with incomes below the federal poverty level
- People with less than a high school education and/or low literacy (low reading or math skills)
- People who are medically underserved, including the uninsured and underinsured
- People with disabilities: physical, mental, or intellectual
- People in very rural and/or geographically isolated locations

Stakeholders prioritized the following factors as having a great influence on health in Somerset County, resulting in poor health outcomes for residents:

- Poverty
- Employment
- Access to oral health
- Transportation
- Health literacy

Background

Purpose

The Maine Shared Health Needs Assessment and Planning Process (SHNAPP) Project is a collaborative effort among Maine's four largest healthcare systems – Central Maine HealthCare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health (MGH), and MaineHealth – as well as the Maine Center for Disease Control and Prevention (Maine CDC), an office of the Maine Department of Health and Human Services (Maine DHHS). The current collaboration expands upon the OneMaine Health Collaborative created in 2007 as a partnership among EMHS, MGH and MaineHealth. The Maine CDC and other partners joined these entities to develop a public-private partnership in 2012. The four hospital systems and the Maine CDC signed a memorandum of understanding in effect between June 2014 and December 2019 committing resources to the Maine SHNAPP Project.

The overall goal of the Maine SHNAPP is to "turn data into action" by conducting a shared community health improvement planning process for stakeholders across the state. The collaborative assessment and planning effort will ultimately lead to the implementation of comprehensive strategies for community health improvement. As part of the larger project, the Maine SHNAPP has pooled its resources to conduct this Shared Community Health Needs Assessment (Shared CHNA) to address community benefit reporting needs of hospitals, support state and local public health accreditation efforts, and provide valuable population health assessment data for use in prioritizing and planning for community health improvement.

This assessment builds on the earlier *OneMaine 2011 CHNA* that was developed by the University of New England and the University of Southern Maine, as well as the 2012 Maine State Health Assessment that was developed by the Maine DHHS. This Shared CHNA includes a large set of statistics on health status and risk factors from existing surveillance and health datasets. It differs from earlier assessments in two ways. Firstly, it includes input from a broad set of stakeholders from across the state from the 2015 SHNAPP Stakeholders' Survey. Secondly, it does not include the household telephone survey conducted for the OneMaine effort.

Quantitative Data

This report contains both quantitative health data and qualitative stakeholder survey data on health issues and determinants affecting those living in Maine. The quantitative data come from numerous sources including surveillance surveys, inpatient and outpatient health data and disease registries. These data consist of 160 quantitative indicators within 18 groupings (domains) for reporting at the state level and, where possible, at the county and select urban levels. Please note that the data are taken from the most current year(s) available. Since the indicators come from a variety of sources, the data are measured over different time periods. In some cases, where there were not enough data in a single year to produce a statistically valid result, multiple years were combined to compute an indicator. Table 28 contains the complete list of the data sources.

Qualitative Data

Qualitative data were collected through a statewide stakeholder survey conducted in May and June 2015 with 1,639 people representing more than 80 organizations and businesses in Maine. The survey was developed using a collaborative process that included Maine SHNAPP partners, Market Decisions Research and Hart Consulting, and a number of other stakeholders and health experts. In Somerset County, a total of 102 stakeholders responded to the survey.

The objective of the survey was to produce qualitative data of the opinions of health professionals and community stakeholders on the health issues and needs of communities across the state. Given this purpose, the survey used a snowball sampling approach by inviting leaders of member organizations and agencies to invite their members and employees to participate. A concerted effort was made to recruit participants from a number of different industries and backgrounds across all communities in the state. Survey respondents represented public health and health care organizations as well as behavioral health, business, municipalities, education, public safety, and nongovernmental organizations. More than 80 organizations agreed to send the survey to their members or stakeholders.

The online survey was approximately 25 minutes in length and contained a number of questions about important health issues and determinants in the state, including a rating of most critical issues, the ability of Maine's health system (including public health) to respond to issues, availability of resources and assets to address specific health issues, impact on disparate populations, and identification of the entities primarily responsible for addressing issues and determinants. The survey asked all respondents a basic set of questions to rate the importance of health issues and impact of health factors. It then allowed respondents to provide answers to probing questions on the three issues and factors that they were most interested in or had the most knowledge about. Respondents provided over 12,000 open-ended comments to these in-depth probing questions in the survey. The Market Decisions Research/Hart Consulting team reviewed, coded and cleaned all open-ended comments for similar and recurrent themes. Not all respondents shared comments for the probing questions.

Limitations

While a number of precautions were taken to ensure that the results and findings presented in this report are sound and based upon statistically valid methods and analyses, there are some limitations to note. While the quantitative analysis used the most recent data sources available as of July 1, 2015, some of these sources contain data that are several years old. The most recent BRFSS and mortality data available at the time of analysis were from 2013, while the most recent hospitalization and cancer data were from 2011. This presents a particular challenge in trying to capture recent trends in health in the state, such as with opioid use. The data presented in this report may not necessarily represent the current situation in Maine, but are the best data available at the time of publication.

Given the qualitative nature of the survey questions and the sampling methodology, it is important to note that the results of the stakeholder survey are not necessarily representative of the population of Maine or a county at a given level of statistical precision. The findings reflect the informed opinions of health experts and community leaders from all areas of the state. However, it is important to use some caution when interpreting results, especially at the county level due to smaller sample sizes, as the results represent the opinions of only those who completed the survey.

Reports

The Shared CHNA has several reports and datasets for public use that are available on the Maine CDC website and may be downloaded at www.maine.gov/SHNAPP/.

- County-Level Maine Shared Community Health Needs Assessment Reports summarize the data and provide insights into regional findings. These reports explore the priorities, challenges, and resources for each county and contain both summary and detailed tables.
- State-Level Maine Shared Community Health Needs Assessment Report includes information on each health issue, including analysis of sub-populations. The report includes state summaries and detailed tables.
- Summary tables are available for each public health district[3], each county, and the cities of Portland and Bangor and the combined cities of Lewiston/Auburn.
- Detailed Tables contain each indicator, by subpopulation, region, and year.

[3] To improve coordinated delivery of essential public health services, Department of Health and Human Services (DHHS) and the Maine Legislature approved the establishment of eight public health districts. District boundaries were established using population size, geographic areas, hospital service areas, and county borders. A District Liaison coordinates a Public Health Unit with co-located Maine CDC staff in one DHHS regional office for every District.

County Demographics

Somerset County has a total population of 51,706, with age and race/ethnicity breakdowns that closely match that of the state of Maine. The demographic and socioeconomic characteristics of the county are below the state on many measures including income, poverty rates, education, and general health status.

Figure 1. Population by Age Categories (U.S. Census 2013)[4]

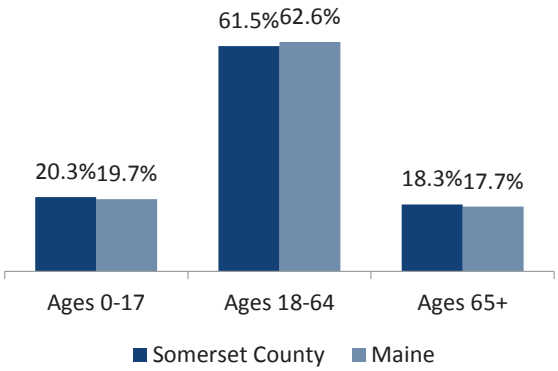
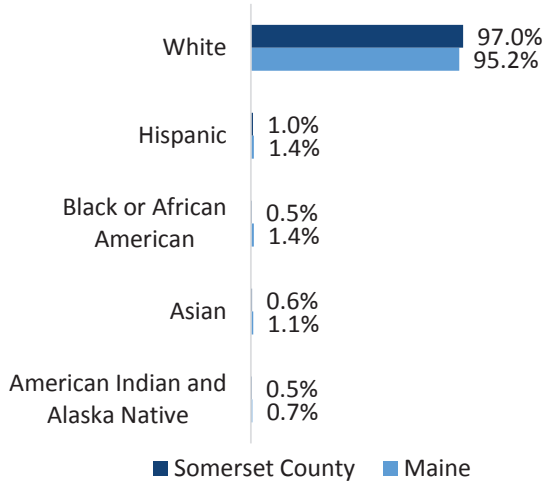


Figure 2. Population by Race/Ethnicity (U.S. Census 2013)



[4] Numbers may not add up to 100% due to rounding

Somerset County

Somerset County is part of the Central Public Health District. Located in northwestern Maine, it is the third-largest county in the state by size, but contains the ninth largest population. There are two hospitals located in Somerset:

- Redington-Fairview General Hospital.
- Sebasticook Valley Health.

Key Demographics

Population	Somerset County	Maine
Overall Population	51,706	1.33 mil
Population density (per sq. mile)	13.3	43.1
Percentage living in rural areas	100%	66.4%
Single parent families	37.7%	34.0%
65+ living alone	36.3%	41.2%
Population living with a disability	18.5%	15.9%
Economic Status		
Median household income	$38,642	$48,453
Unemployment rate	7.9%	5.7%
Adults and children living in poverty	17.8%	13.6%
Children living in poverty	24.9%	18.5%
Education		
HS graduation rate	83.9%	86.5%

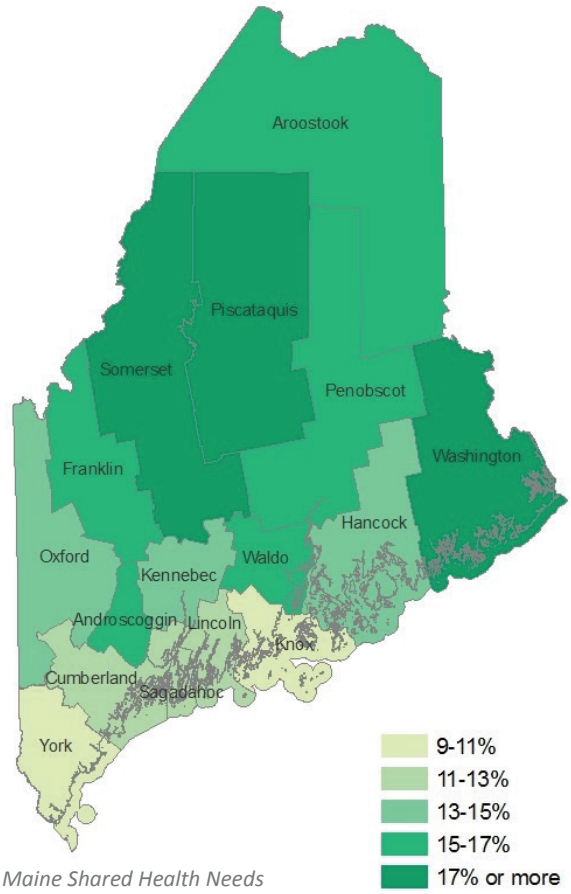
Somerset County Summary of Findings

Socioeconomic Status

Economic opportunity and stability, including factors such as income, employment, food security and housing stability, have a significant impact on the health of individuals and communities. The 2013 Maine Behavioral Risk Factor Surveillance System (BRFSS) found the percentage of adults in Maine rating their health as excellent, very good or good was 94.8 percent among adults with household incomes of $50,000 or more, but 53.8 percent among those with incomes under $15,000.

In addition to income, there are many other social determinants of health, which have been defined as "conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[5] The conditions in which we live explain in part why some are healthier than others and why many generally are not as healthy as they could be. The Maine Shared CHNA takes into account a number of socioeconomic factors and other health determinants, including income and poverty, employment, education and household structure.

Percentage of adults and children living in poverty



Maine Shared Health Needs Assessment, 2015

[5] The Institute of Medicine. Disparities in Health Care: Methods for Studying the Effects of Race, Ethnicity, and SES on Access, Use, and Quality of Health Care, 2002. Available from: www.iom.edu/~/media/Files/Activity%20Files/Quality/NHDRGuidance/DisparitiesGornick.pdf

Table 1. Key Socioeconomic Indicators for Somerset County

	Somerset	Maine	U.S.
Adults and children living in poverty (2009-2013)	*17.8%**	13.6%	15.4%
Children living in poverty (2009-2013)	*24.9%**	18.5%	21.6%
Median household income (2009-2013)	*$38,642**	$48,453	$53,046
Single-parent families (2009-2013)	37.7%	34.0%	33.2%
65+ living alone (2009-2013)	36.3%	41.2%	37.7%

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

General Health and Mortality

While it is essential to understand the causes, risk factors and other determinants of a population's health status, broad measures of health and mortality can also help explain the overall status and needs of the population in general and show in which populations there are disparities. General health status can be measured by self-reported data, as well as by mortality-related data such as life expectancy, leading causes of death and years of potential life lost.

Table 2. Key Health and Mortality Indicators for Somerset County

	Somerset	Maine	U.S.
Adults who rate their health fair to poor (2011-2013)	*22.1%**	15.6%	16.7%
Adults with 14+ days lost due to poor mental health (2011-2013)	14.9%	12.4%	NA
Adults with 14+ days lost due to poor physical health (2011-2013)	*17.1%**	13.1%	NA
Adults with three or more chronic conditions (2011, 2013)	*32.5%**	27.6%	NA
Overall mortality rate per 100,000 population (2009-2013)	*826.3**	745.8	731.9

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

The life expectancy in Somerset County is 75.4 years for males and 80.2 years for females.

Access to Health/Health Care Quality

Access to timely, appropriate, high-quality and regular health care and preventive health services is a key component of maintaining health. Good access to health care can be limited by financial, structural, and personal barriers. Access to health care is affected by location of and distance to health services, availability of transportation and the cost of obtaining the services – including the availability of insurance, the ability to understand and act upon information regarding

services, the cultural competency of health care providers and a host of other characteristics of the system and its clients. *Healthy People 2020* has identified four major components of access to health services: coverage, services, timeliness and workforce.[6]

In Somerset County, 12.2 percent of residents did not have health insurance over the period from 2009-2013. However, access to health insurance does not necessarily guarantee access to care: among adults with health insurance, 7.1 percent in Somerset County reported that they had experienced cost-related barriers to getting health care during the previous year (compared to 12.6 percent of all adults in the county).

Table 3. Key Access to Health/Health Care Quality Indicators for Somerset County

	Somerset	Maine	U.S.
Adults with a usual primary care provider (2011-2013)	85.5%	87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost (2011-2013)	12.6%	11.0%	15.3%
Percent uninsured (2009-2013)	*12.2%**	10.4%	11.7%
Ambulatory care-sensitive condition hospital admission rate per 100,000 population (2011)	*1,665.2**	1,499.3	1,457.5
Adults with visits to a dentist in the past 12 months (2012)	59.1%	65.3%	67.2%

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: U.S. results are from the most recently available year which may be different than county and state figures.

Ambulatory care-sensitive hospital discharges is a Prevention Quality Indicator defined by the Agency for Healthcare Research and Quality (AHRQ) and is intended to measure whether conditions are being treated appropriately in the outpatient setting before hospitalization is required. AHRQ provides nationwide rates based on lower acuity and cost analysis of 44 states from the 2010 Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project State Inpatient Databases.[7]

Chronic Disease

It is estimated that treatment for chronic diseases accounts for 86 percent of our nation's health care costs.[8] Chronic diseases include cancer, cardiovascular disease, diabetes and respiratory diseases like asthma and COPD, among other conditions. They are long-lasting health conditions and are responsible for seven out of ten deaths each year. Many chronic diseases can be

[6] Healthy People 2020, Office of Disease Prevention and Health Promotion. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[7] Agency for Healthcare Research and Quality, Prevention Quality Indicators Technical Specifications - Version 5.0, March 2015, available at: http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
[8] National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/chronicdisease/

prevented or controlled by reducing risk factors such as tobacco use, physical inactivity, poor nutrition and obesity.

Asthma is the most common childhood chronic condition in the United States and the leading chronic cause of children being absent from school.

Table 4. Key Asthma and COPD Indicators for Somerset County

	Somerset	Maine	U.S.
Asthma emergency department visits per 10,000 population (2009-2011)	*101.2**	67.3	NA
COPD diagnosed (2011-2013)	9.1%	7.6%	6.5%
Current asthma (Adults) (2011-2013)	14.4%	11.7%	9.0%
Current asthma (Youth 0-17) (2011-2013)	12.1%	9.1%	NA
Pneumonia emergency department rate per 100,000 population (2011)	*1,379.2**	719.9	NA

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

While the age-adjusted all-cancer incidence and mortality rates in Maine decreased significantly over the past ten years, cancer remains the leading cause of death among people in Maine.

Table 5. Key Cancer Indicators for Somerset County

	Somerset	Maine	U.S.
Mortality – all cancers per 100,000 population (2007-2011)	*204.9**	185.5	168.7
Incidence – all cancers per 100,000 population (2007-2011)	472.0	500.1	453.4
Mammograms females age 50+ in past two years (2012)	82.8%	82.1%	77.0%
Colorectal screening (2012)	70.1%	72.2%	NA

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

More than one in three adults lives with some type of cardiovascular disease. Heart disease and stroke can cause serious illness and disability with associated decreased quality of life and high economic costs. Cardiovascular disease conditions are among the most preventable health problems through the modification of common risk factors. Heart disease was the leading cause of death in Somerset County in 2013.

Table 6. Key Cardiovascular Disease Indicators for Somerset County

	Somerset	Maine	U.S.
Acute myocardial infarction hospitalizations per 10,000 population (2010-2012)	*30.4**	23.5	NA
Acute myocardial infarction mortality per 100,000 population (2009-2013)	*40.1**	32.2	32.4
Cholesterol checked every five years (2011, 2013)	79.2%	81.0%	76.4%
Coronary heart disease mortality per 100,000 population (2009-2013)	*117.4**	89.8	102.6
Heart failure hospitalizations per 10,000 population (2010-2012)	*28.5**	21.9	NA
Hypertension prevalence (2011, 2013)	39.6%	32.8%	31.4%
Stroke mortality per 100,000 population (2009-2013)	40.3	35.0	36.2

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

Diabetes mellitus is a complex health condition that lowers life expectancy, increases the risk of heart disease and is the leading cause of adult-onset blindness, lower-limb amputations and kidney failure. Lifestyle changes, effective self-management and treatment can delay or prevent diabetes and complications of diabetes.

Table 7. Key Diabetes Indicators for Somerset County

	Somerset	Maine	U.S.
Diabetes prevalence (ever been told) (2011-2013)	11.8%	9.6%	9.7%
Adults with diabetes who have received formal diabetes education (2011-2013)	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population (2011)	*364.7**	235.9	NA
Diabetes long-term complication hospitalizations (2011)	47.2	59.1	NA

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.
Note: Age-adjusted rates presented in table; U.S. results are from the most recently available year which may be different than county and state figures.

Environmental Health

Environmental health includes the natural and built environments. Within these environments, there is risk of exposure to toxic substances and other physical hazards that exist in the air we breathe, the food we eat, the water we drink and the places where we live, play and work.[9]

[9] Maine Center for Disease Control and Prevention. Healthy Maine 2020. Available from: http://www.maine.gov/dhhs/mecdc/healthy-maine/index.shtml

Water quality issues in Maine include hazards such as disinfection byproducts, arsenic and nitrates/nitrites as well as bacteria contamination. Among households who get their drinking water from private wells, naturally occurring arsenic is a risk. Regular water quality testing can indicate the need for mitigation. In Somerset County, 45.4 percent of households with private wells have tested their water for arsenic, compared with 43.3 percent of households statewide. Childhood lead poisoning rates are of particular concern in areas with older housing. It can disproportionately affect people who live in older rental units and those who have less income.

Table 8. Key Environmental Health Indicators for Somerset County

	Somerset	Maine	U.S.
Children with confirmed elevated blood lead levels (% among those screened) (2009-2013)	2.4%	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened) (2009-2013)	*9.1%**	4.2%	NA
Homes with private wells tested for arsenic (2009, 2012)	45.4%	43.3%	NA
Lead screening among children age 12-23 months (2009-2013)	*41.1%**	49.2%	NA
Lead screening among children age 24-35 months (2009-2013)	*40.7%**	27.6%	NA

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
NA = Not Available - data are not available for this indicator.

Immunization

Immunization has accounted for significant decreases in morbidity and mortality of infectious diseases and an overall increase in life expectancy. However, many infectious diseases that can be prevented through vaccination continue to cause significant burdens on the health of Maine residents. The U.S. CDC has recommendations for a number of vaccines for young children, adolescents and older adults. Among its other recommendations, the U.S. CDC recommends yearly influenza vaccinations for people over six months of age.

Table 9. Key Immunization Indicators for Somerset County

	Somerset	Maine	U.S.
Adults immunized annually for influenza (2011-2013)	37.6%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older) (2011-2013)	73.1%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons (2015)	3.9%	3.7%	NA

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
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Infectious Disease/Sexually Transmitted Disease

There are 71 infectious diseases and conditions reportable in Maine. Surveillance data assist in monitoring trends in disease and identifying immediate threats to public health. However, there are limitations in surveillance data, specifically pertaining to underreporting. Available data reflects a subset of the disease burden in Maine.

Advances in sanitation, personal hygiene and immunizations have provided control over some diseases, but others continue to thrive despite best efforts. Lyme disease, if left untreated, can cause severe headaches, severe joint pain and swelling, inflammation of the brain and short-term memory problems[10]. Incidence has increased from 224 reported cases statewide in 2004 to 1,400 in 2014, a growth of more than 500 percent in a decade.

Table 10. Key Infectious Disease Indicators for Somerset County

	Somerset	Maine	U.S.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population (2014)	35.2	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population (2014)	2.0	8.1	NA
Lyme disease incidence per 100,000 population (2014)	33.2	105.3	10.5

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While the rates of sexually transmitted diseases like chlamydia, gonorrhea and HIV are significantly lower in Maine than the U.S., it is an issue that disproportionately affects specific segments of the population, including young adults and men who have sex with men.

Table 11. Key Sexually Transmitted Disease Indicators for Somerset County

	Somerset	Maine	U.S.
Chlamydia incidence per 100,000 population (2014)	230.6	265.5	452.2
Gonorrhea incidence per 100,000 population (2014)	9.8	17.8	109.8
HIV incidence per 100,000 population (2014)	5.9	4.4	11.2

Asterisk (*) and italics indicate a statistically significant difference between Somerset County and Maine;
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Injuries

Intentional or violence-related injury is an important public health problem that affects people of all ages. Violence prevention activities include changing societal norms regarding the

[10] Signs and Symptoms of Untreated Lyme Disease, Centers for Disease Control and Prevention (CDC), Available from: http://www.cdc.gov/lyme/signs_symptoms/

acceptability of violence, improving conflict resolution and other problem-solving skills and developing policies to address economic and social conditions that can lead to violence.

Suicide is the second leading cause of death among 15- to 34-year-olds in Maine and the tenth leading cause of death among all ages combined. In Somerset County, the age-adjusted rate of suicide deaths was 17.7 per 100,000 population, compared to 15.2 for the state over the same time period.

Table 12. Key Intentional Injury Indicators for Somerset County

	Somerset	Maine	U.S.
Domestic assault reports to police per 100,000 population (2013)	774.0	413.0	NA
Firearm deaths per 100,000 population (2009-2013)	11.6	9.2	10.4
Intentional self-injury (Youth) (2013)	NA	17.9%	NA
Nonfatal child maltreatment per 1,000 population (2013)	NA	14.6	9.1
Suicide deaths per 100,000 population (2009-2013)	17.7	15.2	12.6
Violent crime rate per 100,000 population (2013)	108.4	125.0	367.9

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Unintentional injuries are a leading cause of death and disability. While many people think of unintentional injuries as a result of accidents, most are predictable and preventable. Unintentional injury was the leading cause of death among 1- to 44-year-olds in Maine and the fifth-leading cause of death among all ages combined in 2013. Motor vehicle crashes, unintentional poisonings, traumatic brain injuries and falls lead to millions of dollars in medical and lost work costs.

Table 13. Key Unintentional Injury Indicators for Somerset County

	Somerset	Maine	U.S.
Always wear seatbelt (Adults) (2013)	79.8%	85.2%	NA
Always wear seatbelt (High School Students) (2013)	*52.4%**	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population (2011)	*115.9**	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population (2009-2013)	10.4	11.1	13.2
Unintentional fall related injury emergency department visits per 10,000 population (2011)	*470.7**	361.3	NA

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Mental Health

Mental health is a complex issue that can affect many facets of a person's daily life. In the U.S., about one in four adults and one in five children have diagnosable mental disorders and they are the leading cause of disability among people ages 15-44.[11] In Somerset County, 18.2 percent of adults reported currently receiving outpatient mental health treatment (taking medicine or receiving treatment from a doctor) in 2011-2013, compared to 17.7 percent of adults statewide.

Mental well-being can also affect a person's physical health in many ways, including chronic pain, a weakened immune system and increased risk for cardiovascular problems. In addition, mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors.[12]

Stigma, additional health issues, access to services and complexities of treatment delivery also prevent many from receiving adequate treatment for their mental health issues.

Percentage of Adults with Current Depression

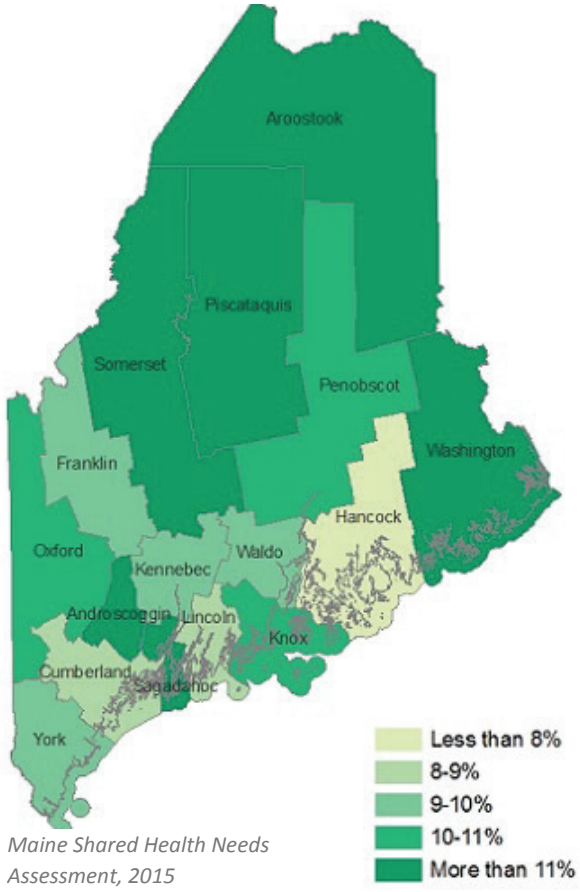

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Table 14. Key Mental Health Indicators for Somerset County

	Somerset	Maine	U.S.
Adults who have ever had depression (2011-2013)	26.5%	23.5%	18.7%
Adults with current symptoms of depression (2011-2013)	13.3%	10.0%	NA
Adults currently receiving outpatient mental health treatment (2011-2013)	18.2%	17.7%	NA
Sad/hopeless for two weeks in a row (High School Students) (2013)	22.1%	24.3%	29.9%
Seriously considered suicide (High School Students) (2013)	14.4%	14.6%	17.0%

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[11] Guide to Community Preventive Services. Improving mental health and addressing mental illness. www.thecommunityguide.org/mentalhealth/index.html.
[12] US Department of Health and Human Services. Health People 2020: Mental Health and Mental Disorders. 2012 Available from: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28.

Physical Activity, Nutrition and Weight

Eating a healthy diet, being physically active and maintaining a healthy weight are essential for an individual's overall health. These three factors can help lower the risk of developing numerous health conditions, including high cholesterol, high blood pressure, heart disease, stroke, diabetes and cancer. They also can help prevent existing health conditions from worsening over time.

Sugar-sweetened beverages, such as non-diet soda, sports drinks and energy drinks, provide little to no nutritional value, but their calories can lead to obesity and being overweight, along with health risks including tooth decay, heart disease and type 2 diabetes.

The 2008 *Physical Activity Guidelines for Americans* recommends that adults, age 18-64, get a minimum of 150 minutes of moderate-intensity physical activity a week and that children, age 6-17, get 60 or more minutes of physical activity each day.[13] Among adults in Somerset County from 2011-2013, 29.3 percent led a sedentary lifestyle, meaning they did not participate in any leisure-time (non-work) physical activity or exercise in the previous month.

Percentage of Obese Adults

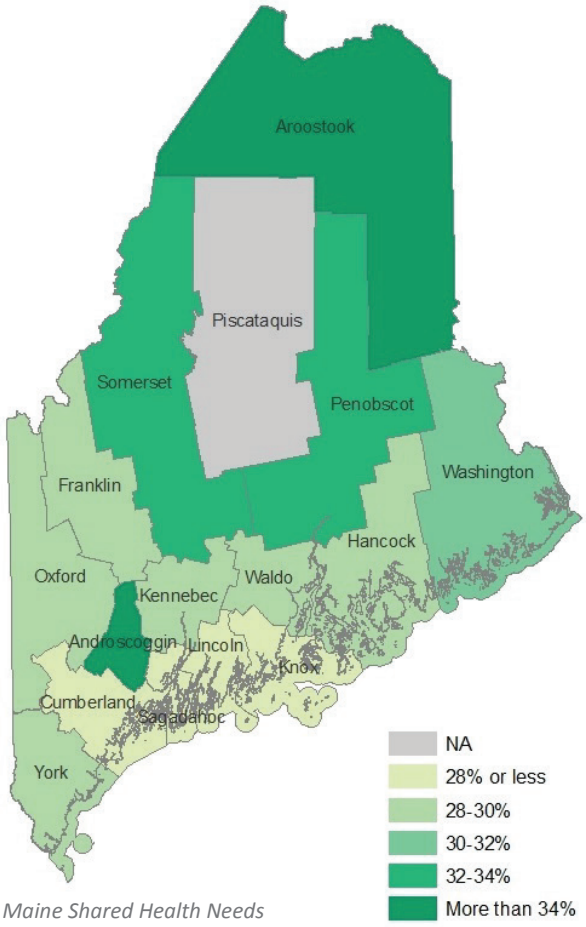

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Table 15. Key Nutrition and Physical Activity Indicators for Somerset County

	Somerset	Maine	U.S.
Fruit and vegetable consumption (High School Students) (2013)	16.2%	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day) (2013)	*44.4%**	34.0%	39.2%
Met physical activity recommendations (Adults) (2013)	45.9%	53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students) (2013)	41.6%	43.7%	47.3%

[13] Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services, 2008, http://health.gov/Paguidelines/guidelines/

	Somerset	Maine	U.S.
Sedentary lifestyle – no leisure-time physical activity in past month (Adults) (2011-2013)	*29.3%**	22.4%	25.3%
Soda/sports drink consumption (High School Students) (2013)	28.7%	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day) (2013)	20.1%	17.9%	22.9%

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In 2013, 72.8 percent of adults 18 years and older in Somerset County were overweight or obese (39.0 percent were overweight and 33.8 percent were obese). Overall in Maine, 64.8 percent of adults were overweight or obese.

Table 16. Key Weight Indicators for Somerset County

	Somerset	Maine	U.S.
Obesity (Adults) (2013)	33.8%	28.9%	29.4%
Obesity (High School Students) (2013)	*16.9%**	12.7%	13.7%

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Pregnancy and Birth Outcomes

Addressing health risks during a woman's pregnancy can help prevent future health issues for women and their children. Increasing access to quality care both before pregnancy and between pregnancies can reduce the risk of pregnancy-related complications and maternal and infant mortality. Early identification and treatment of health issues among babies can help prevent disability or death.[14]

Table 17. Key Pregnancy and Birth Outcomes for Somerset County

	Somerset	Maine	U.S.
Infant deaths per 1,000 live births (2003-2012)	7.5	6.0	6.0
Live births for which the mother received early and adequate prenatal care (2010-2012)	*75.5%**	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population (2010-2012)	*27.8**	20.5	26.5
Low birth weight (<2500 grams) (2010-2012)	6.1%	6.6%	8.0%

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[14] Healthy People 2020. Maternal, infant, and child health: overview. Available from: http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

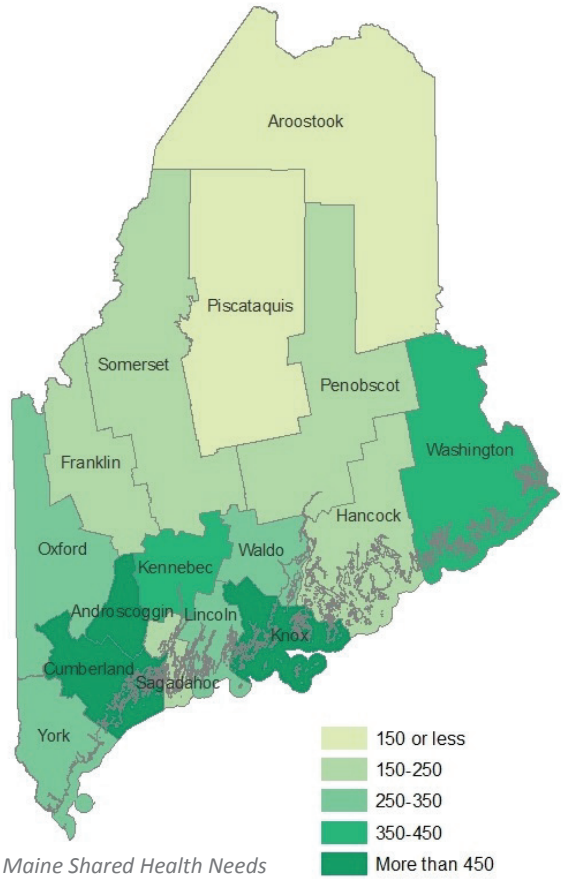
Substance and Alcohol Abuse

Substance abuse and dependence are preventable health risks that lead to increased medical costs, injuries, related diseases, cancer and even death. Substance abuse also adversely affects productivity and increases rates of crime and violence.[15] In Maine in 2010, approximately $300 million was spent on medical care where substance use was a factor.[16]

Of particular note is the recent increase in heroin and prescription opioid dependence and mortality, both nationally and in the state. From 2002 to 2013, heroin overdose death rates nearly quadrupled in the U.S., from 0.7 deaths to 2.7 deaths per 100,000 population. The rates nearly doubled from 2011 to 2013.[17] In addition, data from the National Survey on Drug Use and Health (NSDUH) indicate that heroin use, abuse and dependence have increased in recent years.[11]

The heroin problem in Maine has become a focus of national attention.[18] Deaths from heroin overdoses in Maine rose from seven in 2010 to 57 in 2014[19] and that number continues to climb in 2015.[20]

Substance Abuse Hospitalizations



Maine Shared Health Needs Assessment, 2015

[15] National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse. NIH publication No. 11-5316, revised 2012. Available at www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations

[16] The Cost of Alcohol and Drug Abuse in Maine, 2010. Office of Substance Abuse and Mental Health Services, Department of Health and Human Services, 2013. Available at: http://www.maine.gov/dhhs/samhs/osa/pubs/data/2013/Cost2010-final%20Apr%2010%2013.pdf

[17] Jones CM, Logan J, Gladden M, Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013, Morbidity and Mortality Weekly Report (MMWR), 2015. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm

[18] Heroin in New England, More Abundant and Deadly. The New York Times. July 18, 2013. http://www.nytimes.com/2013/07/19/us/heroin-in-new-england-more-abundant-and-deadly.html

[19] Heroin Deaths in Maine Jump – Record Level of Overdose Deaths in 2014. May 15, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=644190

[20] First half of 2015 shows pace of drug deaths has not slowed – Heroin, Fentanyl deaths continue to surge. August 20, 2015. Office of the Chief Medical Examiner (OCME) of the Office of the Maine Attorney General. Available at: http://www.maine.gov/ag/news/article.shtml?id=653671

Table 18. Key Substance Abuse Indicators for Somerset County

	Somerset	Maine	U.S.
Alcohol-induced mortality per 100,000 population (2009-2013)	9.1	8.0	8.2
Chronic heavy drinking (Adults) (2011-2013)	5.7%	7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births (2014)	12.3%	7.8%	NA
Drug-induced mortality per 100,000 population (2009-2013)	12.2	12.4	14.6
Emergency medical service overdose response per 100,000 population (2014)	281.5	391.5	NA
Opiate poisoning (ED visits) per 100,000 population (2009-2011)	22.7	25.1	NA
Past-30-day alcohol use (High School Students) (2013)	25.1%	26.0%	34.9%
Past-30-day marijuana use (High School Students) (2013)	21.6%	21.6%	23.4%
Prescription Monitoring Program opioid prescriptions (days supply/pop) (2014-2015)	9.6	6.8	NA
Substance-abuse hospital admissions per 100,000 population (2011)	*240.6**	328.1	NA

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Tobacco Use

Use of tobacco is the most preventable cause of disease, death and disability in the United States. Despite this, more than 480,000 deaths in the United States are attributable to tobacco use every year [21] (more than from alcohol use, illegal drug use, HIV, motor vehicle injuries and suicides combined). In addition, exposure to secondhand tobacco smoke has been causally linked to cancer and to respiratory and cardiovascular diseases in adults, and to adverse effects on the health of infants and children, such as respiratory and ear infections.[22] While the percentage of Maine adults who smoke cigarettes has declined significantly over time, one-fifth of the state's population still smokes cigarettes, including 26.1 percent of adults in Somerset County.

[21] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

[22] U.S. Department of Health and Human Services. Healthy People 2020. Leading health indicators: tobacco overview and impact. Available from: http://www.healthypeople.gov/2020/LHI/tobacco.aspx

Table 19. Key Tobacco Use Indicators for Somerset County

	Somerset	Maine	U.S.
Current smoking (Adults) (2011-2013)	26.1%	20.2%	19.0%
Current smoking (High School Students) (2013)	14.9%	12.9%	15.7%
Current tobacco use (High School Students) (2013)	19.6%	18.2%	22.4%
Secondhand smoke exposure (Youth) (2013)	*46.6%**	38.3%	NA

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Stakeholder Feedback

In June 2015, the Maine Shared CHNA research team conducted a survey among stakeholders to identify and prioritize significant health issues in communities across the state. The purpose of the survey was to include the voices and broad interests of local stakeholders about community health needs in their areas. The survey instrument was designed in collaboration with the Maine Shared CHNA Steering Committee and its work groups; it covered four domains of questions:

- Stakeholder demographic information
- Health issues with the greatest impact
- Determinants of health
- Health priorities and challenges

The survey was administered using a snowball approach, where stakeholder agencies agreed to send the surveys to their members and stakeholders for participation. Statewide, 1,639 people completed the survey; 102 of the total respondents indicated that they worked in Somerset County or the Central Public Health District. Respondents represented health care agencies, public health agencies, law enforcement, municipalities, schools, businesses, social service agencies and non-governmental organizations.

There were 403 respondents who indicated they worked at the state-level (e.g., Maine CDC, businesses that spanned the state, etc.). These respondents were included in the overall results, but were not included in any of the county-level results. Respondents could indicate that they represent more than one county in the survey, therefore the total of completed surveys by county will add up to more than 1,639.

Stakeholder Ratings of Health Issues

How much of a problem is __ in Somerset County? (Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes % reporting 4-Major or 5-Critical problem).

Health Issue	Somerset	Maine
Family Health	n=102	n=1,639
Childhood obesity	67%	58%
Elder health	60%	55%
Adolescent health	30%	25%
Child developmental issues	28%	34%
Maternal and child health	20%	23%
Infant mortality	6%	4%
Chronic Diseases		
Obesity	84%	78%
Depression	73%	67%
Respiratory diseases	65%	60%
Diabetes	65%	63%
Cardiovascular diseases	64%	63%
Cancer	46%	50%
Neurological diseases	28%	35%
Musculoskeletal diseases	27%	28%
Infectious Diseases		
Infectious diseases	20%	22%
Sexually transmitted diseases/HIV/AIDS	13%	13%
Healthy Behaviors		
Drug and alcohol abuse	80%	80%
Tobacco use	68%	63%
Physical activity and nutrition	75%	69%
Other Health Issues		
Mental health	69%	71%
Oral health	69%	53%
Violence	39%	38%
Unintentional injury	33%	34%
Suicide and self-harm	31%	37%
Lead poisoning and other environmental health issues	14%	17%

Top Health Issues

Somerset County stakeholders ranked a set of 25 health issues on "how you feel they impact overall health of residents" on a five-point scale, where 1 is "not at all a problem" and 5 is "critical problem." The top five issues of concern reported for the county were:

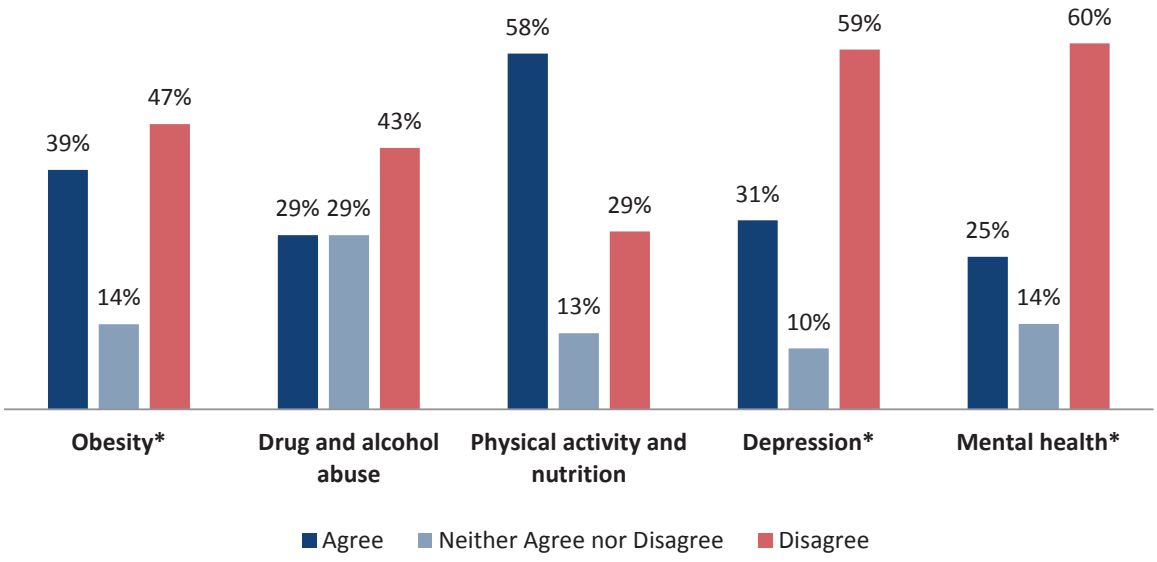
- Obesity
- Drug and Alcohol Abuse
- Physical Activity and Nutrition
- Depression
- Mental Health

Respondents were asked probing statements about the three issues they knew the most about. The question was worded as follows:

"The health system (including public health) in Somerset County has the ability to significantly improve [ ] health issue."

Stakeholder responses on the probing question for the top five health issues appear in Figure 3.

Figure 3. The health system (including public health) has the ability to significantly improve these health issues.



Maine Shared Community Health Needs Assessment, 2015

** Results presented for Maine due to small sample size at the county level*

Stakeholders were also asked to share their thoughts on the populations experiencing health disparities for the health issues that they selected. Results for the top five health issues in Somerset County are presented in Table 20.

Table 20. Percentage of Stakeholders who agreed that Significant Disparities Exist Among Specific Groups for a Specific Health Issue.

Populations Experiencing Health Disparities	Obesity	Drug and alcohol abuse	Physical activity and nutrition	Mental health	Depression
Low- income, including those below the federal poverty limit	87%	85%	90%	79%	76%
Medically-underserved - including uninsured and under-insured	70%	63%	59%	74%	68%
Less than a high school education and/ or low literacy	61%	67%	65%	56%	52%
Very rural and/or geographically isolated people	44%	49%	58%	56%	53%
People with disabilities - physical, mental, or intellectual	47%	41%	56%	63%	61%
Limited or no English proficiency	12%	14%	17%	21%	20%
Military veterans	4%	34%	4%	43%	43%
Gay, lesbian, bisexual or transgendered people	4%	30%	2%	36%	34%
Women	15%	17%	11%	20%	22%
Members of any Federally-recognized Tribe	12%	21%	13%	19%	17%
Refugees/immigrants	4%	8%	6%	20%	18%
Specific age group	10%	12%	9%	12%	10%
Racial/ethnic minority populations	4%	9%	6%	11%	10%
Deaf and hard of hearing people	3%	3%	4%	11%	9%
Adolescents/Teens (13-17)	3%	8%	2%	6%	6%
Seniors/Elderly (65+)	3%	-	5%	3%	4%
Youth/Children (0-12)	4%	-	4%	4%	2%
Adults (21-64)	1%	3%	1%	-	-
Young adults (18-21)	1%	7%	-	2%	1%
All ages	-	-	-	-	1%
Other	6%	12%	5%	12%	11%

Stakeholder input also pointed out the key social or environmental drivers in Maine that lead to these health issues. The key drivers for the top five health issues in Somerset County are presented in Table 21.

Table 21. Percentage of Stakeholders who identified Certain Factors as Key Drivers that lead to a Specific Health Condition

Key Drivers	Obesity	Drug and alcohol abuse	Physical activity and nutrition	Mental health	Depression
Poverty/low income/low socio-economic status	40%	30%	37%	27%	37%
Lack of education	31%	11%	22%	15%	12%
Lack of access to healthy foods	28%	-	29%	1%	-
Bad eating habits	26%	-	13%	1%	1%
Lack of access to physical activity opportunities	25%	-	47%	-	1%
Lack of access to behavioral care/mental health care	-	3%	-	44%	34%
Isolated and rural areas	9%	11%	16%	14%	26%
Inadequate health literacy	9%	8%	9%	-	1%
Cultural or social norms/acceptance/role modeling	9%	22%	8%	4%	7%
Lack of transportation	8%	6%	12%	11%	18%
Lack of access to treatment	2%	33%	6%	2%	1%
Lack of employment opportunities	2%	17%	1%	6%	6%
Social attitudes such as discrimination, stigma, etc.	2%	14%	-	34%	29%
Lack of health care insurance	2%	5%	1%	10%	9%
Adverse childhood experiences	2%	3%	1%	5%	4%
Substance use/addiction	2%	2%	2%	5%	9%
Lack of access to primary care	2%	-	1%	3%	1%
Personal responsibility	8%	4%	6%	3%	1%
Apathy/depression/hopelessness	5%	11%	6%	2%	5%
Food insecurity	4%	-	1%	1%	1%
Co-morbidity-physical or behavioral	3%	-	1%	4%	3%
Lack of exercise	3%	-	1%	-	-
Lack of social support and interactions-positive	2%	14%	4%	1%	7%
Mental illness	2%	2%	1%	2%	3%
Lack of civic participation	2%	-	-	1%	1%
Abuse/trauma	1%	3%	-	3%	4%
Lack of funding-programs/low reimbursement to providers	1%	2%	3%	8%	5%

The next section of this report has a list of the community resources and assets that are available in the area to address these health issues and drivers, along with a summary of the additional resources that are needed. See **Table 23. Priority Health Issues** in the following section of this report.

Top Health Factors

Health factors are those conditions, such as health behaviors, socioeconomic status, or physical environment features that can affect the health of individuals and communities. Stakeholders prioritized 26 health factors in five categories that can play a significant role in the incidence and prevalence of health problems in their communities.

Stakeholders responded to the following question: "For the factors listed below, please indicate how much of a problem each is in your area and leads to poor health outcomes for residents." They responded using a scale of 1 to 5, where 1 means "not a problem at all," and 5 means "critical problem." Respondents selected the following five factors as greatest problems that lead to poor health outcomes in Somerset County:

- Poverty
- Employment
- Access to oral health
- Transportation
- Health literacy

As with health issues, stakeholders were asked further probing questions on the three factors that they believe have the greatest impact on the health of their county.

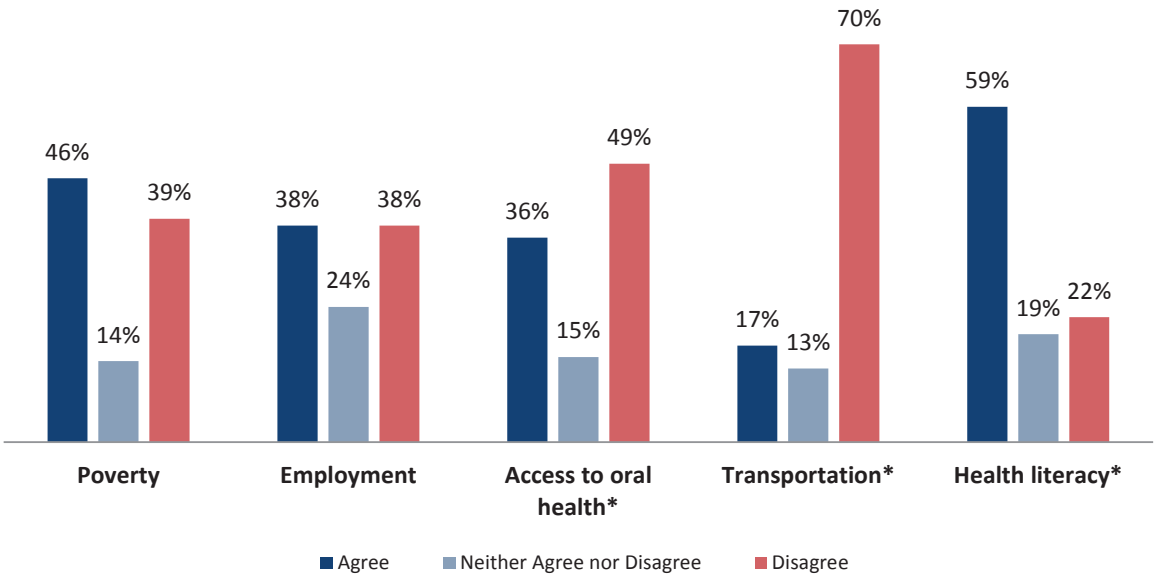
To understand the capacity available in the county to address the most significant health factors identified by stakeholders, respondents were asked additional probing statements about the issues they knew the most about. "The health system (including public health) in Somerset County has the ability to significantly improve these health factors with the current investment of time and resources." Stakeholder responses on the probing question for the top five health issues appear in Figure 4.

Stakeholder Ratings of Health Issues

How much of a problem is __ in Somerset County? (Responses were provided on a 5 point scale where 1-Not at all a problem, 2-Minor problem, 3-Moderate problem, 4-Major problem, 5-Critical problem (This table includes % reporting 4-Major or 5-Critical problem).

Health Factor	Somerset	Maine
Economic Stability	n=102	n=1,639
Poverty	81%	78%
Employment	71%	64%
Food security	60%	58%
Housing stability	55%	57%
Education		
Early Childhood Education/Development	47%	43%
Language and literacy	42%	34%
Enrollment in higher education	41%	35%
High school graduation	39%	31%
Social and Community Context		
Adverse childhood experiences	54%	56%
Social support and interactions	54%	50%
Caregiver support	51%	46%
Civic participation	42%	30%
Social Attitudes (such as Discrimination)	40%	38%
Incarceration or Institutionalization	36%	35%
Health and Health Care		
Access to oral health	69%	56%
Health literacy	67%	62%
Access to behavioral care/mental health care	65%	67%
Health care insurance	65%	64%
Access to other health care	42%	41%
Access to primary care	37%	39%
Neighborhood and Built Environment		
Transportation	68%	67%
Access to healthy foods	55%	53%
Access to physical activity opportunities	49%	42%
Quality of housing	36%	34%
Crime and violence	28%	27%
Environmental Conditions (Air quality, water quality, pollution, etc.)	15%	12%

Figure 4. The health system (including public health) has the ability to significantly improve these health factors with the current investment of time and resources.



Maine Shared Community Health Needs Assessment, 2015

** Results presented for Maine due to small sample size at the county level*

The next section of this report has a list of the community resources and assets that are available in the area to address these health factors, along with a summary of the additional resources that are needed. See **Table 25. Priority Health Factors** in the next section.

Somerset County Priority Health Issues and Factors

Table 22 presents a summary of the health issues - successes and challenges - experienced by residents of Somerset County. Data come from a comprehensive analysis of available surveillance data (see Table 28 for a full list of the health indicators and factors included in this project). Two criteria were used to select the issues in this table: statistically significant and relative differences between the county and state. **Statistically significant differences**, using a 95 percent confidence level, are noted with an asterisk (*) after the indicator. A **rate ratio** was also calculated to compare the relative difference between the county and state. Indicators where the county was 15 percent or more above or below the state average are included in this table.

Table 22. Priority Health Issue Successes and Challenges for Somerset County-Surveillance Data

Health Issues - Surveillance Data	
Health Successes	**Health Challenges**

• Somerset has low rates of incidence of female breast cancer [SOM=105.9; ME=126.3] and melanoma per 100,000 population [SOM=17.1; ME=22.2]
• Low diabetes long-term complication hospitalizations [SOM=47.2; ME=59.1]
• Lower incidence of past or present hepatitis C virus (HCV) [SOM=35.2; ME=107.1], newly reported chronic hepatitis B virus (HBV) [SOM=2.0; ME=8.1] and Lyme disease per 100,000 population [SOM=33.2; ME=105.3]
• Low chlamydia incidence per 100,000 population [SOM=230.6; U.S.=452.2]
• Low violent crime rate per 100,000 population [SOM=108.4; U.S.=367.9]
• Lower percentage of high school students reporting feeling sad/hopeless for two weeks in a row [SOM=22.1%; U.S.=29.9%]
• Somerset County fairs better than the state on a number of substance and alcohol use indicators, including:
  • Lower chronic heavy drinking among adults [SOM=5.7%; ME=7.3%]
	• Somerset County fares worse than the state on general health/mental health indicators:
	  • More adults who rate their health fair to poor [SOM=22.1%; ME=15.6%]*
	  • More adults with 14+ days lost due to poor mental health [SOM=14.9%; ME=12.4%] or poor physical health [SOM=17.1%; ME=13.1%]*
	  • More adults with three or more chronic conditions [SOM=32.5%; ME=27.6%]*
	• High age-adjusted mortality rate per 100,000 population [SOM=826.3; ME=745.8]*
	• High ambulatory care-sensitive condition hospital admission rate per 100,000 population [SOM=1,665.2; ME=1,499.3]*
	• Higher percentage of adults with current asthma ([SOM=14.4%; ME=11.7%] and children with current asthma [SOM=12.1%; ME=9.1%], along with high asthma emergency department visits per 10,000 population [SOM=101.2; ME=67.3]*
	• More COPD diagnosed among adults [SOM=9.1%; ME=7.6%], high pneumonia emergency department rate [SOM=1,379.2; ME=719.9]*and high pneumonia hospitalizations per 100,000 population [SOM=380.4; ME=329.4]
	• High mortality for all cancer sites per 100,000 population [SOM=204.9; ME=185.5]*

Health Issues - Surveillance Data

Health Successes	Health Challenges

• Low emergency medical service overdose response per 100,000 population [SOM=281.5; ME=391.5]
• Lower percentage of past-30-day alcohol use [SOM=25.1%; US=34.9%], past-30-day inhalant use [SOM=2.5%; ME=3.2%], and past-30-day nonmedical use of prescription drugs [SOM=4.1%; ME=5.6%] among high school students
• Low substance-abuse hospital admissions per 100,000 population [SOM=240.6; ME=328.1]*
	• Also, high levels of colorectal cancer mortality [SOM=18.8; ME=16.1], lung cancer mortality [SOM=57.6; U.S.=46.0]] and tobacco-related neoplasms mortality per 100,000 population [SOM=44.5; ME=37.4]
	• Somerset fares worse than the state on a number of cardiovascular indicators, including:
	  • High acute myocardial infarction hospitalizations per 10,000 population [SOM=30.4; ME=23.5]*
	  • High acute myocardial infarction mortality per 100,000 population [SOM=40.1; ME=32.2]*
	  • High coronary heart disease mortality per 100,000 population [SOM=117.4; ME=89.8]*
	  • High heart failure hospitalizations per 10,000 population [SOM=28.5; ME=21.9]*
	  • More hypertension prevalence [SOM=39.6%; ME=32.8%]
	  • High hypertension hospitalizations per 100,000 population [SOM=36.8; ME=28.0]
	• Higher percentage of diabetes prevalence (ever been told) [SOM=11.8%; ME=9.6%] and more diabetes emergency department visits (principal diagnosis) per 100,000 population [SOM=364.7; ME=235.9]*
	• High pertussis incidence per 100,000 population [SOM=86.0; ME=41.9]
	• Despite a low violent crime rate, Somerset has more domestic assaults reports to police [SOM=774.0; ME=413.0], reported rape [SOM=46.4; ME=27.0] and suicide deaths per 100,000 population [SOM=17.7; ME=15.2] than the state
	• High traumatic brain injury related emergency department visits (all intents) [SOM=115.9; ME=81.4]* and unintentional fall related injury emergency department visits per 10,000 population [SOM=470.7; ME=361.3]*
	• Higher rates of unintentional motor vehicle traffic crash related deaths per 100,000 population [SOM=13.8; ME=10.8]
	• Higher percentage of adults who have ever had depression [SOM=26.5%; U.S.=18.7%] than the nation and more adults with current symptoms of depression

Health Issues - Surveillance Data	
Health Successes	**Health Challenges**
	than the state [SOM=13.3%; ME=10.0%] • Higher rate of infant deaths per 1,000 live births [SOM=7.5; ME=6.0] and fewer live births for which the mother received early and adequate prenatal care [SOM=75.5%; ME=86.4%]* Also, more live births to 15-19 year olds per 1,000 population [SOM=27.8; ME=20.5]* • More drug-affected baby referrals received as a percentage of all live births [SOM=12.3%; ME=7.8%] • High prescription Monitoring Program opioid prescriptions (days supply/pop) [SOM=9.6; ME=6.8]

Asterisk (*) indicates a statistically significant difference between Somerset County and Maine
All rates are per 100,000 population unless otherwise noted

Table 23 summarizes the results of the health issues questions in the stakeholder survey for Somerset County. It includes a summary of the biggest health challenges from the perspective of stakeholders who work in and represent communities in the county. The table also shares stakeholders' knowledge of the assets and resources available and those that are lacking but needed in the county to address the biggest health challenges.

Table 23. Priority Health Issue Challenges and Resources for Somerset County-Stakeholder Survey Responses

Stakeholder Input - Stakeholder Survey Responses[23]	
Community Challenges	**Community Resources**
Biggest health issues in Somerset County according to stakeholders *(% of those rating issue as a major or critical problem in their area*). • Obesity (84%) • Drug and alcohol abuse (80%) • Physical activity and nutrition (75%) • Depression (73%) • Mental health (69%)	**Assets Needed to Address Challenges:** • **Obesity/ Physical activity and nutrition:** Greater access to affordable and healthy food; more programs that support low income families • **Drug and alcohol abuse:** Greater access to drug/alcohol treatments; greater access to substance abuse prevention programs; free or low-cost treatments for the uninsured; more substance abuse treatment providers; additional therapeutic programs • **Depression/ Mental health:** More mental health professionals; more community-based services; better funding and support; greater access to inpatient care; readily available information about resources; transitional programs **Assets Available in County/State:** • **Obesity/ Physical activity and nutrition:** Public gyms; farmers markets; Maine SNAP-ED Program; school nutrition programs; public walking and biking trails; Healthy Maine Partnerships; Let's Go! 5-2-1-0 • **Drug and alcohol abuse:** Maine Alcoholics Anonymous; Substance Abuse Hotlines; Office of Substance Abuse and Mental Health Services • **Depression/ Mental health:** Mental health/counseling providers and programs

[23] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015.

Table 24 presents a summary of the major health strengths and challenges that affect the health of Somerset County residents. Data come from a comprehensive analysis of available surveillance data (see Table 28 for a full list of the health indicators and factors included in this project). Two criteria were used to select the factors presented in this table. **Statistically significant differences**, using a 95 percent confidence level, between the county and state are noted with an asterisk (*) after the indicator. A **rate ratio** was also calculated to compare the relative difference between the county and state. Indicators where the county was 15 percent or more above or below the state average are included in this table.

Table 24. Priority Health Factor Strengths and Challenges for Somerset County-Surveillance Data

Health Factors – Surveillance Data	
Health Factor Strengths	**Health Factor Challenges**

• More lead screening among children age 24-35 months [SOM=40.7%; ME=27.6%]*	• Somerset has a number of socioeconomic factors that are worse than state average, including:
	  • More individuals [SOM=17.8%; ME=13.6%]* and children living in poverty [SOM=24.9%; ME=18.5%]*
	  • Lower median household income [SOM=$38,642; ME=$48,453]*
	  • Higher unemployment rate [SOM=7.9%; ME=5.7%]
	  • Higher percentage of individuals who are unable to obtain or delay obtaining necessary medical care due to cost [SOM=12.6%; ME=11.0%]
	• Higher percentage uninsured [SOM=12.2%; ME=10.4%]*
	• Lower rates of lead screening among children age 12-23 months [SOM=41.1%; ME=49.2%]*
	• Fewer high school students always wear seatbelts [SOM=52.4%; ME=61.6%]*
	• Higher percentage of adults eat less than one serving of fruit per day [SOM=44.4%; ME=34.0%]*
	• Higher percentage of adults live a sedentary lifestyle – no leisure-time physical activity in past month [SOM=29.3%; ME=22.4%]*
	• Higher levels of obesity among both adults [SOM=33.8%; ME=28.9%] and high school students [SOM=16.9%; ME=12.7%]*
	• Higher percentage of current smoking among adults [SOM=26.1%; ME=20.2%] and high school students [SOM=14.9%; ME=12.9%] and more secondhand smoke exposure for high school students [SOM=46.6%; ME=38.3%]*

Asterisk (*) indicates a statistically significant difference between Somerset County and Maine
All rates are per 100,000 population unless otherwise noted

Table 25 summarizes the results of the health factor questions in the stakeholder survey for Somerset County. It includes a summary of the health factors that cause the biggest challenges from the perspective of stakeholders who work in and represent communities in the county. The table also shares stakeholders' knowledge of the assets and resources available and those that are lacking but needed in the county to address the biggest health challenges.

Table 25. Priority Health Factor Challenges and Resources for Somerset County-Stakeholder Responses

Stakeholder Input- Stakeholder Survey Responses [24]	
Community Challenges	**Community Resources**
Biggest health factors leading to poor health outcomes in Somerset County according to stakeholders *(% of those rating factor as a major or critical problem in their area*). • Poverty (81%) • Employment (71%) • Access to Oral Health (69%) • Transportation (68%) • Health literacy (67%)	**Assets Needed to Address Challenges:** • **Poverty:** Greater economic development; increased mentoring services; more skills trainings; more employment opportunities at livable wages; better transportation; better education • **Employment:** More job creations; more training; more employment opportunities at livable wages; greater economic development; more funding for education • **Transportation:** More/better transportation systems; better access to public transportation; additional funding for organizations that help with rides to medical appointments; additional resources for transportation for the elderly and disabled **Assets Available in County/State:** • **Poverty:** General Assistance; other federal, state and local programs • **Employment:** Adult education centers; career centers • **Health literacy:** Hospital systems; primary care providers; social service agencies.

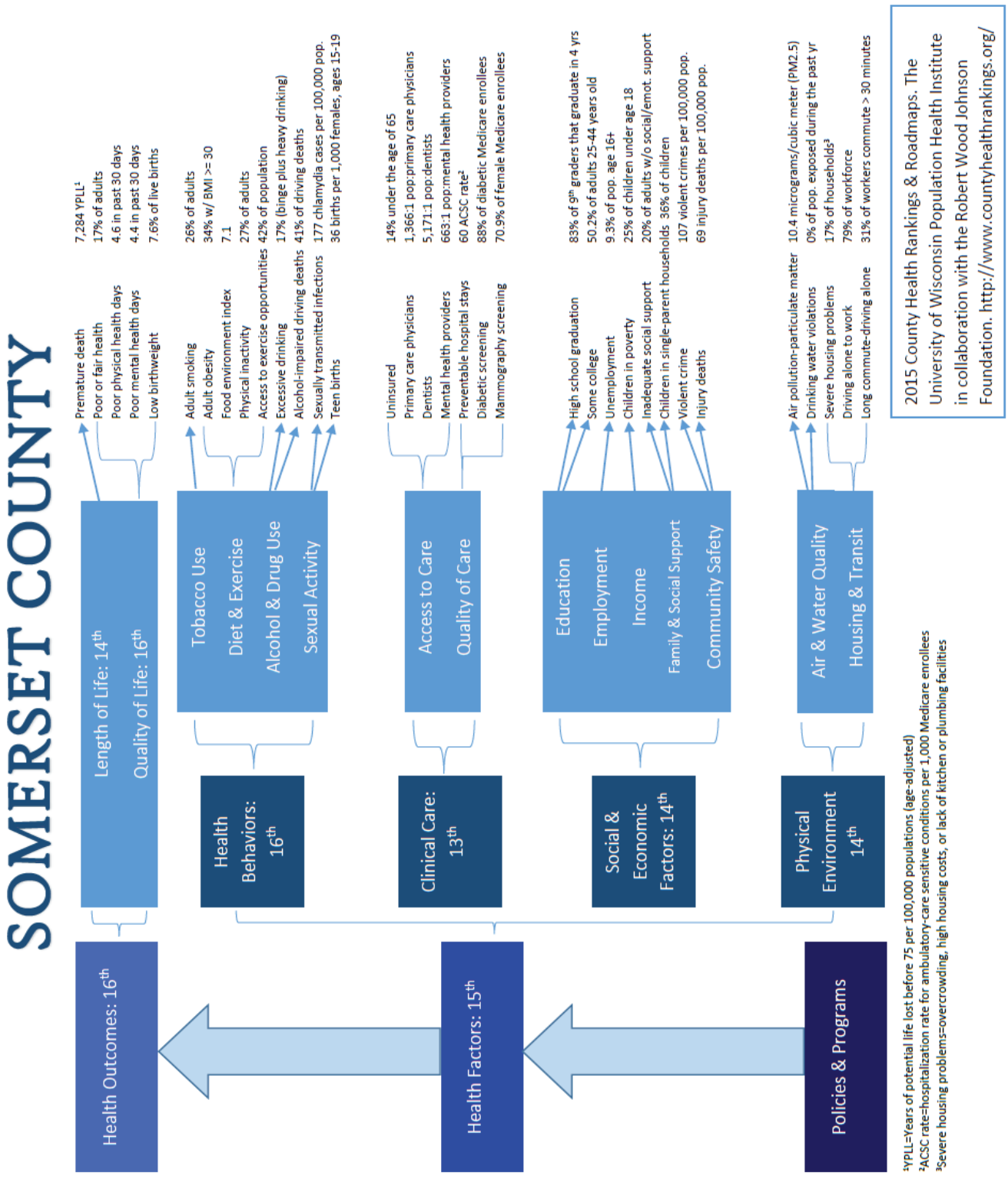
[24] Results are from the Maine Shared Community Health Needs Assessment Stakeholder Survey, conducted in May-June, 2015.

County Health Rankings & Roadmaps

Each year, the University of Wisconsin Health Institute and Robert Wood Johnson Foundation produce *The County Health Rankings & Roadmaps* for every county in the U.S. The annual reports measure the social, economic, environmental and behavioral factors that influence health. These factors are quantified using indicators such as high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income and teen births, to name a few. The rankings weight and score the sets of indicators to provide county comparisons within each state. For more information: www.countyhealthrankings.org

For this analysis, the 2015 rankings data for each of Maine's 16 counties is displayed in the graphic used by the University of Wisconsin to show how all of the factors ultimately affect community health. The comparison across counties provides insight into county health status. In Maine, the county ranked as "#1" on a particular health issue, is the healthiest in that measure, "#16" is the least healthy. The data for the underlying health measures are those used by the University of Wisconsin in its 2015 report and may not always match the data shown in other sections of this report due to timing or use of different indicators.

In interpreting the rankings for each county, it is important to keep in mind the underlying health measures. Because of the forced ranking, one county is always the "healthiest" and one is always the "least healthy." The comparisons are helpful in understanding differences, but it is important to look past the assignment of rank to understand the underlying issues and opportunities and their relative importance in the region.


SOMERSET COUNTY
Health Outcomes: 16th
Length of Life: 14th
Quality of Life: 16th
Premature death
Poor or fair health
Poor physical health days
Poor mental health days
Low birthweight
7,284 YPLL¹
17% of adults
4.6 in past 30 days
4.4 in past 30 days
7.6% of live births
Health Factors: 15th
Health Behaviors: 16th
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Adult smoking
Adult obesity
Food environment index
Physical inactivity
Access to exercise opportunities
Excessive drinking
Alcohol-impaired driving deaths
Sexually transmitted infections
Teen births
26% of adults
34% w/ BMI >= 30
7.1
27% of adults
42% of population
17% (binge plus heavy drinking)
41% of driving deaths
177 chlamydia cases per 100,000 pop.
36 births per 1,000 females, ages 15-19
Clinical Care: 13th
Access to Care
Quality of Care
Uninsured
Primary care physicians
Dentists
Mental health providers
Preventable hospital stays
Diabetic screening
Mammography screening
14% under the age of 65
1,366:1 pop:primary care physicians
5,171:1 pop:dentists
663:1 pop:mental health providers
60 ACSC rate²
88% of diabetic Medicare enrollees
70.9% of female Medicare enrollees
Social & Economic Factors: 14th
Education
Employment
Income
Family & Social Support
Community Safety
High school graduation
Some college
Unemployment
Children in poverty
Inadequate social support
Children in single-parent households
Violent crime
Injury deaths
83% of 9th graders that graduate in 4 yrs
50.2% of adults 25-44 years old
9.3% of pop. age 16+
25% of children under age 18
20% of adults w/o social/emot. support
36% of children
107 violent crimes per 100,000 pop.
69 injury deaths per 100,000 pop.
Physical Environment 14th
Air & Water Quality
Housing & Transit
Air pollution-particulate matter
Drinking water violations
Severe housing problems
Driving alone to work
Long commute-driving alone
10.4 micrograms/cubic meter (PM2.5)
0% of pop. exposed during the past yr
17% of households³
79% of workforce
31% of workers commute > 30 minutes
Policies & Programs
¹YPLL=Years of potential life lost before 75 per 100,000 populations (age-adjusted)
²ACSC rate=hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
³Severe housing problems=overcrowding, high housing costs, or lack of kitchen or plumbing facilities
2015 County Health Rankings & Roadmaps. The University of Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation. http://www.countyhealthrankings.org/

Stakeholder Survey Findings

Table 26. Stakeholder Survey Results for Somerset County and Maine

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Somerset County	**Maine**
Demographics		
Which of the following sectors best describes your role or organization? (12 choices, picked 1)		
Number of Respondents	n=102	n=1639
Medical care provider	30%	22%
Other non-profit or social service agency	8%	14%
Other	15%	13%
Public health	15%	11%
Business owner or employee	7%	9%
Educator	7%	8%
Other type of health care organization	7%	8%
Behavioral/mental health provider	5%	6%
Local government	6%	4%
Other governmental agency	0%	3%
Youth-serving organization	1%	2%
Faith-based organization	0%	1%
Do you work for or represent: (5 choices, picked 1)		
None of the above	34%	49%
Hospital/Health-care system	50%	38%
Local public health agency	13%	10%
Maine CDC	3%	3%
Tribal health	0%	<1%
Please identify the type of geographical area that you primarily serve? (6 choices, picked 1)		
Town or region	33%	27%
Hospital/Health service area	33%	26%
Statewide	3%	22%
County	7%	18%
Other area	6%	4%
Public health district	18%	3%
Does your organization work with specific groups of people or populations recognized as being at risk of, or experiencing, higher rates of health risk or poorer health outcomes than the general population within your area?		
Yes	26%	24%
Somewhat	54%	47%
No	20%	29%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Somerset County	**Maine**
If "Yes" or "Somewhat" to Q4: To which of the following populations does your organization directly provide resources to address their needs? (select all that apply)		
Number of Respondents	n=82	n=1159
Low-income, including those below the federal poverty limit, or defined as low-income by some other definition	82%	77%
Medically-underserved - including uninsured and under-insured	60%	63%
People with disabilities - physical, mental, or intellectual	65%	58%
Very rural and/or geographically isolated people	57%	47%
Less than a high school education and/ or low literacy (low reading or math skills)	50%	47%
Women	41%	44%
Limited or no English proficiency	29%	38%
Gay, lesbian, bisexual or transgendered people	26%	36%
Deaf and hard of hearing people	28%	35%
Military veterans	33%	34%
Refugees/immigrants	11%	28%
Racial/ethnic minority populations	22%	27%
Members of any federally recognized tribe	18%	25%
Specific age group	27%	21%
Other	11%	15%
Don't know	9%	5%
Overall, to what degree to you feel the health needs of your area are being addressed?		
Number of Respondents	n=102	n=1639
Not addressed at all	1%	<1%
Mostly unaddressed	7%	10%
Somewhat addressed	54%	55%
Mostly addressed	34%	30%
Completely addressed	3%	2%
Don't know	1%	2%
Health Issues and Factors		
Please rate the following health issues based on how you feel they impact the overall health of residents in your area. (*Percentage of stakeholders in county who rated issue as a major or critical problem in their area*)		
Number of Respondents	n=102	n=1639
Family Health		
Adolescent health	30%	25%
Child developmental issues	28%	34%
Childhood obesity	67%	58%
Elder health	60%	55%
Infant mortality	6%	4%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Somerset County	**Maine**
Maternal and child health	20%	23%
Chronic Diseases		
Cancer	46%	50%
Cardiovascular disease	64%	63%
Depression	73%	67%
Diabetes	65%	63%
Musculoskeletal diseases	27%	28%
Neurological diseases	28%	35%
Obesity	84%	78%
Respiratory disease	65%	60%
Infectious Diseases		
Infectious diseases	20%	22%
Sexually transmitted diseases/HIV/AIDS	13%	13%
Health Behaviors		
Drug and alcohol abuse	80%	80%
Physical activity and nutrition	75%	69%
Tobacco use	68%	63%
Other Health Issues		
Lead poisoning and other environmental health issues	14%	17%
Mental health	69%	71%
Oral health	69%	53%
Suicide and self-harm	31%	37%
Unintentional injury	33%	34%
Violence	39%	38%
"Don't know" responses not included		
Please indicate how much of a problem each of the following health factors is in your area and leads to poor health outcomes for residents. *(Percentage of stakeholders in county who rated factor as a major or critical problem in their area)*		
Number of Respondents	n=102	n=1639
Economic Stability		
Employment	71%	64%
Food security	60%	58%
Housing stability	55%	57%
Poverty	81%	78%
Education		
Enrollment in higher education	41%	35%
Early childhood education/development	47%	43%
High school graduation	39%	31%
Language and literacy	42%	34%

Detailed Findings from SHNAPP Stakeholder Survey, June 2015		
Survey Questions and Top Responses		
	Somerset County	**Maine**
Social and Community Context		
Adverse childhood experiences	54%	56%
Civic participation	42%	30%
Incarceration or institutionalization	36%	35%
Social attitudes such as discrimination	40%	38%
Social support and interactions	54%	50%
Caregiver support	51%	46%
Health and Health Care		
Access to behavioral care/mental health care	65%	67%
Access to primary care	37%	39%
Access to other health care	42%	41%
Access to oral health	69%	56%
Health care insurance	65%	64%
Health literacy	67%	62%
Neighborhood and Built Environment		
Access to healthy foods	55%	53%
Access to physical activity opportunities	49%	42%
Crime and violence	28%	27%
Environmental conditions	15%	12%
Quality of housing	36%	34%
Transportation	68%	67%
"Don't know" responses not included		
Please rank each health issue according to how you think resources in your area should be allocated. (1=highest priority and 8=lowest priority) *(mean)*		
Number of Respondents	n=74	n=1168
Risk factors that lead to poor health	2.66	3.08
Mental health - conditions that impact how people think, feel and act as they cope with life	3.50	3.49
Substance abuse behaviors, including excessive drinking, smoking, and other drug use	3.54	3.71
Community capacity - ability to sustain a high quality of life, including access to employment, education and housing	3.26	3.93
Chronic diseases, such as heart disease, cancer, diabetes, and asthma	4.26	4.05
Family health, including teen pregnancy, prenatal care, and healthy behaviors during pregnancy	4.61	4.81
Environmental issues - access to healthy foods, access to recreation, clean air, water, lead exposure, etc.	5.43	5.36
Injuries, intentional and unintentional	6.72	6.52

Health Indicators Results from Secondary Data Sources

The county level summary of health indicators analyzed from secondary data sources is presented in the table below. Results are displayed for the county, state and U.S. (where available). County trends are presented in the column after the county data when available. Results are organized by health issue or category. Please note that age-adjusted rates are presented for all applicable indicators, with the exception of ambulatory care-sensitive conditions and infectious and sexually transmitted diseases (which are presented as crude rates). A detailed list of all data sources, years and notes for all indicators is presented in Table 28.

Indicates county is significantly better than state average (using a 95% confidence level).
Indicates county is significantly worse than state average (using a 95% confidence level).
+ Indicates an improvement in the indicator over time at the county level (using a 95% confidence level)
− Indicates a worsening in the indicator over time at the county level (using a 95% confidence level)
† Results may be statistically unreliable due to small numerator, use caution when interpreting.
NA = Data not available.

Table 27. Quantitative Health Indicators for Somerset County, Maine and the U.S.

Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Demographics					
Total Population	2013	51,706		1,328,302	319 Mil
Population – % ages 0-17	2013	20.3%		19.7%	23.3%
Population – % ages 18-64	2013	61.5%		62.6%	62.6%
Population – % ages 65+	2013	18.3%		17.7%	14.1%
Population – % White	2013	97.0%		95.2%	77.7%
Population – % Black or African American	2013	0.5%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.5%		0.7%	1.2%
Population – % Asian	2013	0.6%		1.1%	5.3%
Population – % Hispanic	2013	1.0%		1.4%	17.1%
Population – % with a disability	2013	18.5%		15.9%	12.1%
Population density (per square mile)	2013	13.3		43.1	87.4
Socioeconomic Status Measures					
Adults and children living in poverty	2009-2013	*17.8%*	NA	13.6%	15.4%
Children living in poverty	2009-2013	*24.9%*	NA	18.5%	21.6%
High school graduation rate	2013-2014	83.9%	NA	86.5%	81.0%
Median household income	2009-2013	*$38,642*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	100.0%	NA	66.4%	NA
Single-parent families	2009-2013	37.7%	NA	34.0%	33.2%
Unemployment rate	2014	7.9%	NA	5.7%	6.2%
65+ living alone	2009-2013	36.3%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	*22.1%*		15.6%	16.7%

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).

Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Adults with 14+ days lost due to poor mental health	2011-2013	14.9%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	*17.1%*		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	*32.5%*		27.6%	NA
Mortality					
Life expectancy (Female)	2012	80.2	NA	81.5	81.2
Life expectancy (Male)	2012	75.4	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*826.3*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	85.5%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	12.6%		11.0%	15.3%
MaineCare enrollment	2015	35.5%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	52.3%	NA	41.8%	48.0%
Percent uninsured	2009-2013	*12.2%*	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,665.2*		1,499.3	1457.5
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*7,478.6*	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	59.1%	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	54.1%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	*101.2*	+	67.3	NA
COPD diagnosed	2011-2013	9.1%		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	246.8		216.3	NA
Current asthma (Adults)	2011-2013	14.4%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	12.1%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	*1,379.2*	+	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	380.4		329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	*204.9*	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	472.0	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	31.2	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	18.5	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	36.2	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	105.9	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	82.8%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	18.8	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	25.1	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	41.2	NA	43.5	42.0
Colorectal screening	2012	70.1%	NA	72.2%	NA

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

Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Lung cancer mortality per 100,000 population	2007-2011	57.6	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	74.3	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	17.1	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	86.7%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	23.6	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	126.6	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	44.5	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	99.8	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*30.4*		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*40.1*	NA	32.2	32.4
Cholesterol checked every five years	2011. 2013	79.2%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*117.4*	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	*28.5*		21.9	NA
Hypertension prevalence	2011, 2013	39.6%		32.8%	31.4%
High cholesterol	2011, 2013	43.3%		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	36.8		28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	22.3		20.8	NA
Stroke mortality per 100,000 population	2009-2013	40.3	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	11.8%		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	8.1%†		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	NA	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	NA	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	NA	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	*364.7*		235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	11.4		11.7	NA
Diabetes long-term complication hospitalizations	2011	47.2		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	20.8	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	2.4%	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	*9.1%*	NA	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	45.4%	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*41.1%*	NA	49.2%	NA

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Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Lead screening among children age 24-35 months	2009-2013	*40.7%*	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	37.6%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	73.1%	NA	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	3.9%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	NA	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.0†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.0†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	2.0†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	35.2†	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	2.0†	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	33.2†	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	86.0	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	0.0†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	7.8†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	230.6	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	9.8†	NA	17.8	109.8
HIV incidence per 100,000 population	2014	5.9†	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	30.0		21.4	NA
Syphilis incidence per 100,000 population	2014	0.0†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	774.0	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	11.6	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	46.4	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	17.7	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	108.4	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	79.8%		85.2%	NA
Always wear seatbelt (High School Students)	2013	*52.4%*		61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*115.9*	NA	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	10.4	NA	11.1	13.2

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Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Unintentional fall related deaths per 100,000 population	2009-2013	5.8†	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*470.7*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	13.8	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	370.0	NA	13,205.0	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	21.8%		19.4%	NA
Adults who have ever had depression	2011-2013	26.5%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	13.3%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	18.2%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	NA	NA	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	2,073.6		1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	22.1%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	14.4%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	16.2%	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	*44.4%*	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	45.9%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	41.6%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	*29.3%*		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	28.7%	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	20.1%†	NA	17.9%	22.9%
Obesity (Adults)	2013	33.8%		28.9%	29.4%
Obesity (High School Students)	2013	*16.9%*		12.7%	13.7%
Overweight (Adults)	2013	39.0%		36.0%	35.4%
Overweight (High School Students)	2013	17.4%		16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	7.5	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	*75.5%*	NA	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	*27.8*	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.1%	NA	6.6%	8.0%
Substance and Alcohol Abuse					

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Maine Shared CHNA Health Indicators	Year	Somerset	Trend	Maine	U.S.
Alcohol-induced mortality per 100,000 population	2009-2013	9.1	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	14.2%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	17.3%		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	5.7%		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	12.3%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	12.2	NA	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	281.5	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	22.7		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	13.7		13.2	NA
Past-30-day alcohol use (High School Students)	2013	25.1%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	2.5%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	9.0%†	NA	8.2%	NA
Past-30-day marijuana use (High School Students)	2013	21.6%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	2.5%†	NA	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	4.1%	+	5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	9.6	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*240.6*		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	26.1%		20.2%	19.0%
Current smoking (High School Students)	2013	14.9%		12.9%	15.7%
Current tobacco use (High School Students)	2013	19.6%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	*46.6%*		38.3%	NA

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

Table 28. List of Data Sources and Years for Quantitative Health Indicators

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Demographics			
Population	U.S. Census	2013	2013 data was used for all age, racial and ethnic groups.
Population with a disability	U.S. Census	2011-2013	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	Based on 2010 U.S. Census population.
Socioeconomic Status Measures			
Adults and children living in poverty	U.S. Census	2009-2013	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	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	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	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	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	2009-2013	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	Unemployment rate of the civilian noninstitutionalized population averaged for the full year of 2014.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
65+ living alone	U.S. Census	2009-2013	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	2011-2013	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	2011-2013	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	2011-2013	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	2011, 2013	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	Life expectancy at birth.
Life expectancy (Male)	National Center for Health Statistics	2012	Life expectancy at birth.
Overall mortality rate per 100,000 population	DRVS	2009-2013	All deaths are defined as deaths in which the underlyin g cause of death was coded as ICD-10 any listed.
Access			
Adults with a usual primary care provider	BRFSS	2011-2013	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	2011-2013	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	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	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.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Percent uninsured	U.S. Census	2009-2013	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	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	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	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	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	2009-2011	ICD-9 CM - 493
COPD diagnosed	BRFSS	2011-2013	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	ICD-9 CM - 490, 491, 492, 494, 496
Current asthma (Adults)	BRFSS	2011-2013	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	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	ICD-9 CM - 480-486

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Pneumonia hospitalizations per 100,000 population	MHDO	2011	ICD-9 CM - 480-486
Cancer			
Mortality – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Cause of Death Recode: 20010-37000 (which include ICD-10 codes: C00-C97).
Incidence – all cancers per 100,000 population	MCR	2007-2011	All cancer: SEER Site Recode: 20010-37000 (which include ICD-O-3 codes: C00-C797).
Bladder cancer incidence per 100,000 population	MCR	2007-2011	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	2007-2011	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)	2007-2011	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	2007-2011	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	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Colorectal late-stage incidence per 100,000 population	MCR	2007-2011	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	2007-2011	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	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Lung cancer incidence per 100,000 population	MCR	2007-2011	Cancer Incidence: The number of people who develop cancer (new cancer cases) during a specified period of time in a specified population. Incidence case

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
			definitions exclude histologies consistent with Kaposi sarcoma and mesothelioma, where applicable.
Melanoma incidence per 100,000 population	MCR	2007-2011	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	Females with intact cervix, that have received a pap smear within the past three years.
Prostate cancer mortality per 100,000 population	MCR	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Prostate cancer incidence per 100,000 population	MCR	2007-2011	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	2007-2011	Cancer Deaths: Deaths with malignant cancer as the underlying cause of death.
Tobacco-related neoplasms, incidence per 100,000 population	MCR	2007-2011	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	2010-2012	ICD-9 CM - 410
Acute myocardial infarction mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I21-I22
Cholesterol checked every five years	BRFSS	2011. 2013	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	2009-2013	ICD-10 I20-I25
Heart failure hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 428
Hypertension prevalence	BRFSS	2011, 2013	Adults who have ever been told by a doctor, nurse, or other health professional that they have high blood pressure.
High cholesterol	BRFSS	2011, 2013	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	ICD-9 CM - 401, 402, 403, 404
Stroke hospitalizations per 10,000 population	MHDO	2010-2012	ICD-9 CM - 430-438
Stroke mortality per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 I60-I69

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Diabetes			
Diabetes prevalence (ever been told)	BRFSS	2011-2013	Adults that have ever been told by a doctor or other health professional that they have diabetes.
Pre-diabetes prevalence	BRFSS	2011-2013	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	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	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	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	2011-2013	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	ICD-9 CM - 250
Diabetes hospitalizations (principal diagnosis) per 10,000 population	MHDO	2010-2012	ICD-9 CM - 250
Diabetes long-term complication hospitalizations	MHDO	2011	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	2009-2013	ICD-10 E10-E14
Environmental Health			
Children with confirmed elevated blood lead levels (% among those screened)	Maine CDC Lead Program	2009-2013	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	2009-2013	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_

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
			levels.htm
Homes with private wells tested for arsenic	BRFSS	2009, 2012	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	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	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	2011-2013	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	2011-2013	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	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	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	Defined as the number of new infections during 2014.
Hepatitis B (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Hepatitis C (acute) incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	MIDSS	2014	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	New diagnoses, regardless of when infection occurred or stage of disease at diagnosis.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Lyme disease incidence per 100,000 population	MIDSS	2014	Defined as the number of new infections during 2014.
Pertussis incidence per 100,000 population	MIDSS	2014	Incidence is defined as the number of new infections during 2014.
Tuberculosis incidence per 100,000 population	MIDSS	2014	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	Incidence is defined as the number of new infections during 2014.
Chlamydia incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.
Gonorrhea incidence per 100,000 population	Maine CDC STD Program	2014	Incidence is defined as the number of new infections during 2014.
HIV incidence per 100,000 population	Maine CDC HIV Program	2014	Incidence is defined as the number of new infections during 2014.
HIV/AIDS hospitalization rate per 100,000 population	MHDO	2011	DRG-MDC 25
Syphilis incidence per 100,000 population	Maine CDC STD Program	2014	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	All offenses of assault between family or household members are reported as domestic assault.
Firearm deaths per 100,000 population	Maine CDC Vital Records	2009-2013	ICD-10 W32-W34 ,X72-X74, X93-X95, Y22-Y24, Y350 or U014.
Intentional self-injury (Youth)	MIYHS	2013	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	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	Rates are unique child victims per 1,000 population under age 18.
Reported rape per 100,000 population	Maine Dept. of Public Safety	2013	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	2009-2013	ICD-10 U03 X60-X84 or Y87.0
Violence by current or former intimate partners in past 12 months (among females)	BRFSS	2012	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	Reported violent crime offenses. Violent crime includes murder, rape, robbery and aggravated assault.
Unintentional Injury			
Always wear seatbelt (Adults)	BRFSS	2013	Adults reporting they always use seatbelts when they drive or ride in a car.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Always wear seatbelt (High School Students)	MIYHS	2013	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	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	2009-2013	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	2009-2013	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	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	2009-2013	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	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	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	2011-2013	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	2011-2013	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	2011-2013	Indicator of current depression coded using two items from the PHQ-2 depression screener.
Adults currently receiving outpatient mental health treatment	BRFSS	2011-2013	Adults now taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Co-morbidity for persons with mental illness	BRFSS	2011, 2013	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	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	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	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	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	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	Adults with less than one serving per day of fruits or fruit juice.
Met physical activity recommendations (Adults)	BRFSS	2013	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	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	2011-2013	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	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	Adults with less than one serving per day of vegetables.
Obesity (Adults)	BRFSS	2013	Adults with a BMI of 30 or more.
Obesity (High School Students)	MIYHS	2013	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	Adults with a BMI between 25.0 and 29.9.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Overweight (High School Students)	MIYHS	2013	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	Survey respondents who reported that their child has a special health care need.
Infant deaths per 1,000 live births	Maine CDC Vital Records	2003-2012	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	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	2010-2012	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	Low birth weight defined as less than 2500 grams.
Substance and Alcohol Abuse			
Alcohol-induced mortality per 100,000 population	Maine CDC Vital Records	2009-2013	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	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	2011-2013	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	2011-2013	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	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	2009-2013	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	Includes overdoses from drugs/medication, alcohol and inhalants.

Maine Shared Community Health Needs Assessment Data Sources 2015			
Indicator	**Data Source**	**Year(s)**	**Other Notes**
Opiate poisoning (ED visits) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Opiate poisoning (hospitalizations) per 100,000 population	MHDO	2009-2011	ICD-9 - 9650, 96500, 96501, 96502, 96509
Past-30-day alcohol use (High School Students)	MIYHS	2013	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	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	2011-2013	During the past 30 days, have you used marijuana?
Past-30-day marijuana use (High School Students)	MIYHS	2013	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	2011-2013	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	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	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	DRG-MDC 20
Tobacco Use			
Current smoking (Adults)	BRFSS	2011-2013	Adults that reported having smoked at least 100 cigarettes in their lifetime and currently smoke.
Current smoking (High School Students)	MIYHS	2013	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	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	Percentage of students who were in the same room with someone who was smoking cigarettes at least 1 day during the past 7 days.

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