PAUL R. LEPAGE
GOVERNOR

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
286 Water Street
Augusta, Maine 04333-0011

BETHANY L. HAMM
ACTING COMMISSIONER

STATEWIDE COORDINATING COUNCIL FOR PUBLIC HEALTH

DECEMBER 13, 2018, 10:00 am – 1:00 pm

DRAFT AGENDA

Call number: 877-455-0244; Passcode: 879 303 3495

10:00 **Welcome, Introductions –** *Patty Hamilton*

10:05 **Review of Agenda, Meeting Materials** – *Patty Hamilton*

10:10 **Administrative Issues** – *Dr. Bates, Patty Hamilton*

- Annual Election of Chair and Co-Chair
- Announcing Steering Committee Member-Elect Kalie Hess
- Membership Committee Update Announcement– reappointment of Carol Zechman and Peter Michaud
- Second reading of the SCC governance document amendments to Section 6(1)
- SCC Annual Report 2018
- SCC Annual Reporting
- Website refresh update

10:30 **A Scaled Rural Prevention Network: *Addressing Food Insecurity in Northern Maine* –** *Doug Michael*

Healthy Androscoggin *Reach Partnership* – *Holly Lasagna, with Erin Guay*

11:30 **Break**

11:45 **SCHNAP/SHIP/PHHSBG Updates –** *Nancy Birkhimer*

12:15 **Obesity Presentation –***Dawn Littlefield and Tory Rogers*

12:45 **District Reports –** *All/Around the Table*

1:00 **Next Steps, Evaluation -** *Patty Hamilton*

Adjourn

The Statewide Coordinating Council for Public Health, established under Title 5, section 12004-G, subsection 14-G, is a representative statewide body of public health stakeholders for collaborative public health planning and coordination.

Statewide Coordinating Council for Public Health

(December 2018)

Seat 01 – York District
Betsy Kelly (Exp. 6/24/21)
Partners for Healthier Communities
Southern Maine Health Care
25 June Street
Sanford, ME 04073
490-7853
blkelly@smhc.org

Seat 02 – Cumberland District
Courtney Kennedy (Exp. 9/29/20)
Nutrition and Education Manager
Good Shepherd Food Bank
3121 Hotel Road | PO Box 1807
Auburn, Maine 04211
577-4847
ckennedy@gsfb.org

Seat 03 – Western District
Erin Guay (Exp. 9/24/19)
Executive Director
Healthy Androscoggin
300 Main Street
Lewiston, Maine 04240
795-5990
guayer@cmhc.org

Seat 04 – Midcoast District
Caer Hallundbaek, EdD (Exp. 6/24/19)
University of Maine at Orono-Hutchinson Center
PO Box 218
Lincolnville Center, Maine 04850
230-9929
caer.hallundbaek@maine.edu

Seat 05 – Central District
Joanne Joy – (Exp. 6/24/19)
Healthy Communities of the Capital Area
11 Mechanic Street
Gardiner, Maine 04345
588-5350
j.joy@hccame.org

Seat 06 – Penquis District
Patty Hamilton (Exp. 6/24/19)
Bangor Health and Community Services
103 Texas Avenue
Bangor, Maine 04401
992-4550
patty.hamilton@bangormaine.gov

Seat 07 – Downeast District
Maria C. Donahue, MPH, MSW (Exp. 6/24/21)
Community Health Director, Healthy Acadia
140 State Street, Suite 1
Ellsworth, Maine 04605
207-667-7171
maria@healthyacadia.org

Seat 08 – Aroostook District
Joy Barresi Saucier (Exp. 9/24/21)
Executive Director
Aroostook Agency on Aging
PO Box 1288
Presque Isle, Maine 04769
207-764-3396
joy.b.saucier@aroostookaging.org

Seat 09 – Maine CDC – State Government
Bruce Bates, D.O.
Director, Maine Center for Disease Control and Prevention
286 Water Street, 11 SHS
Augusta, ME 04333
287-3270
bruce.bates@maine.gov

Seat 10 – Behavioral Health – State Gov't
Victor Dumais (Exp. 6/24/21)
Office of Substance Abuse & Mental Health Services
41 Anthony Avenue, 11 SHS
Augusta, ME 04333
287-3707
victor.dumais@maine.gov

Seat 11 – Education
Emily Poland (Exp. 9/24/21)
School Nurse Consultant
Maine Department of Education
23 State House Station
Augusta, ME 04333
624-6688
emily.poland@maine.gov

Seat 12 – Environmental Protection
Kerri Malinowski (Exp. 9/22/19)
Maine Department of Environmental Protection
28 Tyson Drive, Ray Building
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kerri.malinowski@maine.gov

Statewide Coordinating Council for Public Health

(December 2018)

Seat 13 – 10 EPHS
Kenney Miller (Exp.6/24/21)
Maine AIDS Education and Training Center
The Health Equity Alliance
295 Water Street, Suite 105
Augusta, Maine 04330
Email: kenney@mainehealthequity.org

Seat 14 – 10 EPHS
Kalie Hess (Exp. 9/24/20)
Maine Primary Care Association
73 Winthrop Street
Augusta, Maine 04330
Email: khess@mepca.org

Seat 15 – 10 EPHS
Doug Michael (Exp. 9/24/20)
Chief Community Health and Grants Officer
Northern Light Health
43 Whiting Hill Road, Suite 200
Brewer, Maine 04412
973-6602
dmichael@emhs.org

Seat 16 – 10 EPHS
Peter Michaud (Exp. 9/24/21)
Maine Medical Association
PO Box 190
Manchester, ME 04351
622-3374 x 211
pmichaud@mainemed.com

Seat 17 – 10 EPHS
Meg Callaway (Exp. 9/24/20)
Penquis
262 Harlow Street
Bangor, Maine 04401
270-2778 (C) 937-3500x3640 (O)
mcallaway@penquis.org

Seat 18 – 10 EPHS
Erika Ziller (Exp. 9/24/20)
University of Southern Maine
PO Box 9300
Portland, Maine 04104
780-4615
Erika.ziller@maine.edu

Seat 19 – 10 EPHS
Heather Shattuck-Heidorn, Ph.D. (Exp. 6/24/21)
Catholic Charities Maine
307 Congress Street
Portland, Maine 04101
207-805-4010
hshattuckheidorn@ccmaine.org

Seat 20 – 10 EPHS
Joanne LeBrun (Exp. 9/24/20)
Tri-County EMS
300 Main Street
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795-2880
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Seat 21 – 10 EPHS
Abdulkerim Said (Exp. 9/24/20)
New Mainers Public Health Initiative
PO Box 541
Lewiston, ME 04240
asaid@nmphi.org

Seat 22 – Tribal District
Kristi Ricker (Exp. 9/24/20)
88 Bell Road
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Seat 23 – 10 EPHS
Carol Zechman (1/9/22)
MaineHealth
241 Oxford Street
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State Coordinating Council for Public Health Governance Structure
State Coordinating Council for Public Health
September 2018

Article I. Legislative Purpose and Mission

The State Coordinating Council for Public Health, established under Title 22, section 12004-G, subsection 14-G, is a representative statewide body of public health stakeholders for collaborative public health planning and coordination.

The State Coordinating Council for Public Health shall:

(1) Participate as appropriate to help ensure the state public health system is ready and maintained for accreditation;

(2) Assist the Maine Center for Disease Control and Prevention in planning for the essential public health services and resources to be provided in each district and across the State in the most efficient, effective and evidence-based manner possible;

(3) Receive reports from the Tribal District Coordinating Council for public health regarding readiness for tribal public health systems for accreditation if offered; and

(4) Participate as appropriate and as resources permit to help support tribal public health systems to prepare for and maintain accreditation if assistance is requested from any tribe.

Article II. Role and Structure of the Council

Section 1. Council Role

The Council is responsible for providing assistance and support to the Maine CDC in fulfillment of the directives established by legislation. In addition, the Council may:

a. Review and comment on reports from entities within and outside the public health infrastructure including the State Health Improvement Plan, and assist in identifying districtwide and statewide streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of essential public health services throughout the public health infrastructure.

b. Develop reports and summaries for the purposes of fulfilling their role annually and as determined necessary.

Section 2. Council Size

The Council is comprised of twenty-three (23) members.

Section 3. Council Members

Members of the Statewide Coordinating Council for Public Health are appointed as follows:

(1) Each district coordinating council for public health, including the tribal district coordinating council, shall appoint one member.

(2) The Director of the Maine Center for Disease Control and Prevention or designee shall serve as a member.

(3) The DHHS Commissioner shall appoint an expert in behavioral health from the Department to serve as a member.

(4) The Commissioner of Education shall appoint a health expert from the Department of Education to serve as a member.

(5) The Commissioner of Environmental Protection shall appoint an environmental health expert from the Department of Environmental Protection to serve as a member.

An additional ten (10) members, selected from the following sectors, according to the process described in Section 4:

a. county governments
b. municipal governments
c. tribal governments/health departments
d. city health departments
e. local health officers
f. hospitals
g. health systems
h. emergency management agencies
i. emergency medical services
j. comprehensive community health coalitions
k. school districts
l. institutions of higher education
m. physicians and other health care providers
n. clinics and community health centers
o. voluntary health organizations
p. family planning organizations
q. area agencies on aging
r. mental health services
s. substance use prevention, treatment, and recovery services
t. organizations seeking to improve environmental health
u. other community-based organizations

Section 4. Selection of Council Members

The Director of the Maine Center for Disease Control and Prevention, in collaboration with the Chair of the Statewide Coordinating Council for Public Health shall convene a Membership Committee.

After evaluation of the appointments to the Statewide Coordinating Council for Public Health, the Membership Committee shall appoint no more than 10 additional members and ensure that the total membership has at least one member who is a recognized content expert in each of the essential public health services and has representation from populations in the state facing health disparities.

The Membership Committee shall also strive to ensure diverse representation on the Statewide Coordinating Council for Public Health from county governments, municipal governments, tribal governments, tribal health departments or health clinics, city health departments, local health officers, hospitals, health systems, emergency management agencies, emergency medical services, community health coalitions, school districts, institutions of higher education, physicians and other health care providers, clinics and community health centers, voluntary health organizations, family planning organizations, area agencies on aging, mental health services, substance abuse services, organizations seeking to improve environmental health and other community-based organizations.

Section 5. Council Terms

The term of office for each member is three (3) years. A non-state agency member may serve up to two terms. All vacancies must be filled for the balance of the unexpired term in the same manner as the original appointment. A partial term shall not count toward term limits. Terms are not linked to Seat; terms apply to individuals regardless of Seat or role.

A Council member may resign from the Council by written notice to the Steering Committee.

Section 6. Council Meetings and Operations

A simple majority of the current Council membership shall constitute a quorum. In the absence of a quorum, a Council meeting may continue discussion; however, no formal actions shall be taken, except a vote to adjourn the meeting to a subsequent date.

(1) The Council shall

~~a. Elect two co-chairs to serve on the Steering Committee~~

a) Elect a chair and a co-chair annually from among SCC members in good standing at the time of nomination;

b) The Chair and Co-Chair positions will be nominated by current members of the Council at the last regularly-scheduled meeting of the calendar year;

c) The Chair and Co-Chair will be elected from the nominees by simple majority of eligible members by electronic ballot, to assume their positions in January of the subsequent calendar year;

d) The Chair shall serve to determine the agenda for each meeting, serve on the Membership Committee and the Steering Committee, and be the primary point liaison for members and the Maine CDC leadership;

e) *The Co-Chair will serve on the Membership Committee and the Steering Committee and assume the functions of Chair in the absence of the Chair.*

(2) Time and Place of Meetings

The Statewide Coordinating Council for Public Health shall meet at least quarterly, and will be staffed by the Department as resources permit. Maine CDC will set place of meetings.

(3) Agenda

The Steering Committee shall prepare an agenda of items requiring Council action, and add items of business as may be requested by Council members.

(4) Notice

Council members shall be sent electronic mail notice of the time and date of the meetings at least three business days before a regular Council meeting. In the event of an emergency, the Steering Committee may call a meeting and shall give as much notice as possible.

(5) Rules of Order

Robert's Rules of Order or another agreed-upon system of operation shall govern regular Council meetings unless the Council adopts other rules of order.

(6) Council Meeting Minutes

The Maine Center for Disease Control and Prevention is responsible for minutes and Council records as resources permit. Minutes recording attendance, all motions and subsequent action including the number of yea, nay, or abstentions shall be recorded.

(7) Voting

Formal Council actions are limited to the legislatively established responsibilities of the Council defined in Article II, Section 1 of this document. Council actions must be subject to vote by the Council when a quorum is present. Once a quorum is established, each Council member shall have one vote.

Electronic voting on a specific issue may be conducted with prior agreement of the Council.

(8) Council Member Responsibilities

Members shall demonstrate an interest in and commitment to public health; have the capacity for district-level decision-making, and the ability to share critical information with their sector/district peers.

Members shall regularly attend meetings of the Council, and meetings of committees to which they are appointed.

Membership in good standing requires minimal annual attendance at 75% of full SCC meetings and meetings to which they are appointed.

As representatives to the Council, each Council member shall routinely communicate decisions, discussions, and business of the Council to the member's sector/district, and likewise communicate sector/district information back to the Council.

As the Council has membership drawn from across the public health infrastructure, it is anticipated that at times some members may find themselves in a position where there exists the potential for a conflict of interest or the appearance thereof as defined in Article VI.

Council members are expected to maintain vigilance for this event, and to recuse themselves from any voting or actions that present a conflict of interest. Failure to do so may be grounds for dismissal from the Council.

(9) Operations Calendar

The operations calendar of the Council is the calendar year.

Article III. Steering Committee

Section 1. Steering Committee Responsibilities

The Steering Committee will provide leadership through convening regularly scheduled Council meetings, facilitation of meetings, agenda setting for the Council meetings, and identifying ad-hoc committees as needed. The Steering Committee members and staff appointed by Maine Center for Disease Control and Prevention shall ensure that accurate records are maintained of Council actions, adequate notice is sent regarding Council meetings, and maintain records of active membership for purposes of establishing quorum. Steering Committee members shall regularly attend meetings of the Council and meetings of the Steering Committee.

The Maine Center for Disease Control and Prevention shall be responsible for Council communications.

Section 2. Steering Committee Members

The Steering Committee is composed of five members, including the chair, the co-chair, two elected members at large and the CDC Director or designee. Nominations will be taken from the floor for the non-state positions.

Section 3. Steering Committee Terms

Elected members serve two-year terms and may serve up to a maximum of three, two-year terms. However, their total SCC membership term cannot exceed terms outlined in Article II, Section 5.

Section 4. Steering Committee Meetings

The Steering Committee shall meet on a regular schedule that it deems necessary and appropriate in order to fulfill its responsibilities as set forth in the Governance Structure. Notice of all regular Steering Committee meetings shall be communicated via electronic mail at least five days prior to the meeting.

Special or emergency meetings of the Steering Committee may be called as needed. Notice of special or emergency meetings shall be sent via electronic mail with as much notice as possible.

Article IV. Committees/Workgroups

Section 1. Creation of Committees

The Steering Committee shall have the power to create standing and ad-hoc committees and workgroups. The Steering Committee shall appoint and charge each committee with its responsibilities and shall appoint the committee chair.

Section 2. Committee Membership

Membership on a committee or workgroup, with the exception of the Steering Committee, is not limited to (voting) members of the Council. The Steering Committee and other committees may call on non-Council members as advisors to provide information and guidance.

Section 3. Committee Operations

Committee chairs shall bring proposed activities to the Council for discussion and approval. The Council may accept recommendations of committees/workgroups as part of a consent agenda; however, if any Council member finds that he/she has a significant issue with a committee/workgroup recommendation, he/she shall raise said issue at the Council meeting and bring it for further discussion and separate vote at the Council level.

Section 4. Committee Chair

The Committee Chair shall be responsible for scheduling meetings, assigning specific tasks within the mandate of the committee, and reporting to the Steering Committee and the Council concerning the work of the committee.

ARTICLE V. Non-partisan Activities

The Council shall be non-partisan. No part of the activities of the Council shall consist of the publication or distribution of materials or statements with the purposes of attempting to influence or intervene in any political campaign on behalf of or in opposition to any candidate for public office.

ARTICLE VI. Conflict of Interest

A conflict of interest is defined as any personal or organizational financial or other interest which prevents or appears to prevent an impartial action or decision on the part of a Council member. A conflict occurs when a financial or other interest could:

a. Significantly impair the individual's objectivity.
b. Create an unfair competitive advantage for any person or organization.
c. Provide a direct or indirect fiduciary interest of financial gain for that individual or organization.

Should a matter before the Council present a known, or a potential conflict of interest, Council members are required to disclose such potential conflict to the Steering Committee at the earliest point possible. Once a conflict or potential conflict is disclosed, the steering shall lead the rest of the members in deciding how the member with the conflict or potential conflict may participate in discussions or voting.

ARTICLE VII . Process for Governance Structure Review and Revision

The Steering Committee shall review the Governance Structure every two years.

1. Any current Council member may propose an amendment to the Governance Document.
2. The Steering Committee, upon majority vote, may advance proposed amendment to the full SCC for a first reading at the next regularly scheduled Council meeting.
3. The SCC will schedule the amendment for a first reading at a scheduled quarterly meeting, and refer for a second reading at the next regularly scheduled meeting.
4. Upon a second reading, the proposed amendment will be considered a proper motion without need for a second. The amendment will be considered adopted if 2/3 of those present at the regularly scheduled meeting vote in favor of the amendment.

ARTICLE VIII. Reporting

The Maine Center for Disease Control and Prevention shall prepare and draft an annual report on behalf of the State Coordinating Council to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the Governor's office on progress made toward achieving and maintaining accreditation of the state public health system and on districtwide and statewide streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of essential public health services.

Adopted September 2018.

State Coordinating Council Chair, acting on behalf of
State Coordinating Council for Public Health:

Signed,

Chair

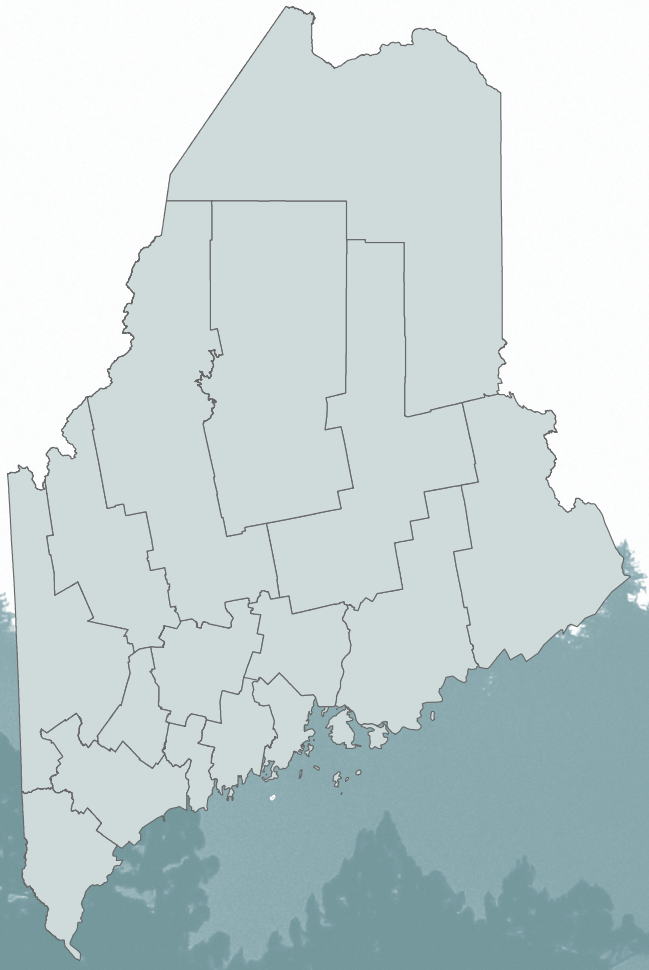
Director, Maine Center for Disease Control and Prevention, acting on behalf of the Maine Center for Disease Control and Prevention:

Signed,

Director

2018 District Public Health Report Card

From the Maine Shared Community Health Needs Assessment



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INTRODUCTION

The Maine Center for Disease Control and Prevention (Maine CDC), in consultation with the Statewide Coordinating Council for Public Health (SCC), is mandated to develop, distribute and publicize an annual brief report card on health status statewide and for each district, based on MRS 22 Chapter 152 §413.

For 2018, the Maine CDC coordinated these reports with the Maine Shared Community Health Needs Assessment (CHNA). The Maine Shared CHNA is a collaborative effort between the Maine CDC and Central Maine Healthcare, Maine General Health, MaineHealth, and Northern Light Health. The Maine Shared CHNA is a partnership with the vision to turn health data into actions to improve the health of all Maine people. This is the third Maine Shared CHNA and the second conducted on a triennial basis.

The mission of the Maine Shared CHNA is to:

- Create Shared CHNA Reports,
- Engage and activate communities, and
- Support data-driven health improvements for Maine people.

In 2018, the Maine Shared CHNA developed Health Profiles for each county, each public health district and the State. These reports present over 2000 indicators on health status, health behaviors, access to health and factors regarding where people live, work, learn and play that affect their health. The Health Profiles, as the data in an interactive format, can be found on the webpage for the Maine Shared CHNA (www.mainechna.org).

In this report card, demographics and data on 33 key indicators are presented for each public health district. These key indicators show a broad sample of health topics, including health behaviors, outcomes, and conditions.

HOW TO READ THIS DOCUMENT

The data in this report card represent the most recent data available as of March 2018. Data from several years is often combined to ensure there is enough data to draw conclusions. County comparisons are made in several ways: between two time periods, to the state, and to the U.S. The two time periods being compared can be found within the tables under columns marked, "Point 1" and "Point 2." All comparisons are based on 95% confidence intervals. A **95% confidence interval** is a way to say that if this indicator were measured over and over for the same population, we are 95% confident that the true value among the total population falls within the given range/interval. When the confidence intervals of two measurements do not overlap, the difference between them is statistically significant. Where confidence intervals were not available, no indication of significant difference has been made.

The tables use symbols to show whether there are important changes in each indicator over time, and to show if local data is notably better or worse than the state or the nation. See the box below for a key to the symbols:

CHANGE shows **statistically significant changes** in the indicator over time, based on 95% confidence interval (see description above).

★	means the health issue or problem is **getting better** over time.
!	means the health issue of problem is **getting worse** over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.

BENCHMARK compares the District data to state and national data, based on 95% confidence interval (see description above).

★	means the District is doing **significantly better** than the state or national average.
!	means the District is doing **significantly worse** than the state or national average.
○	means there is no statistically significant difference between the data points
N/A	means there is not enough data to make a comparison.

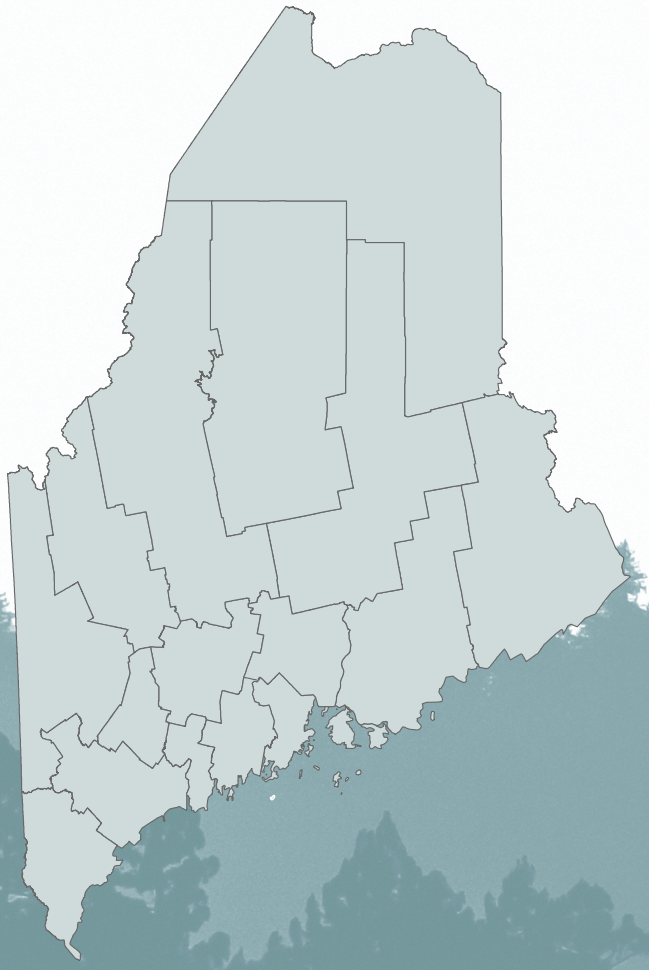
ADDITIONAL SYMBOLS

*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

Data in this report are presented as both rates and percentages.

- For data that is presented as a percentage, the "%" symbol appears with the data point. The most common conditions and behaviors are presented as percentages.
- When the health condition, behavior, or outcome is less common, the numbers are presented as rates per 1,000, 10,000, or 100,000 people. For indicators that are a rate, look below the indicator name to see the rate denominator (per 1,000 or per 10,000, etc.). The less common the health condition, behavior, or outcome is, the larger the denominator.

STATE OVERVIEW



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

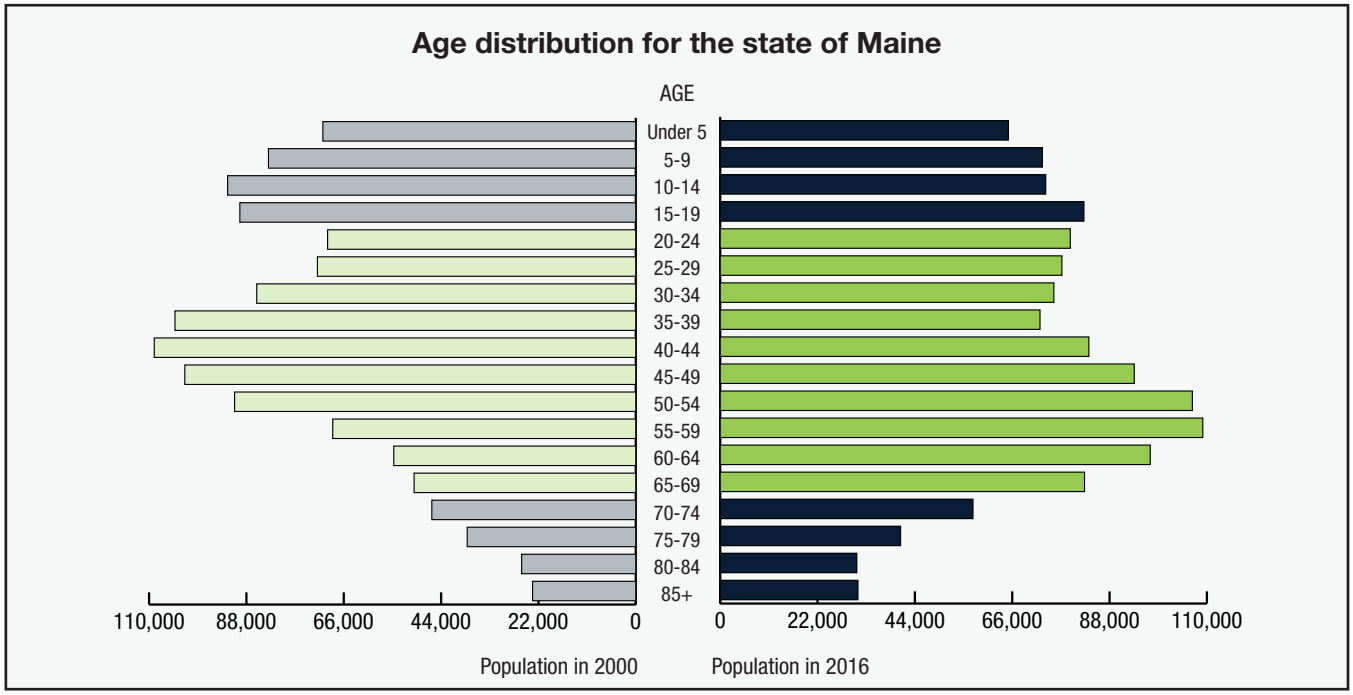
STATE OF MAINE POPULATION

1,329,923

	MAINE
Median household income	**$50,826**
Unemployment rate	**3.8%**
Individuals living in poverty	**13.5%**
Children living in poverty	**17.2%**
65+ living alone	**45.3%**

	MAINE	
	PERCENT	**NUMBER**
American Indian/Alaskan Native	**0.6%**	**8,013**
Asian	**1.1%**	**14,643**
Black/African American	**1.2%**	**16,303**
Hispanic	**1.5%**	**19,772**
Some other race	**0.2%**	**3,151**
Two or more races	**2.0%**	**27,126**
White	**94.8%**	**1,260,476**

The chart below shows the shift in the age of the population. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



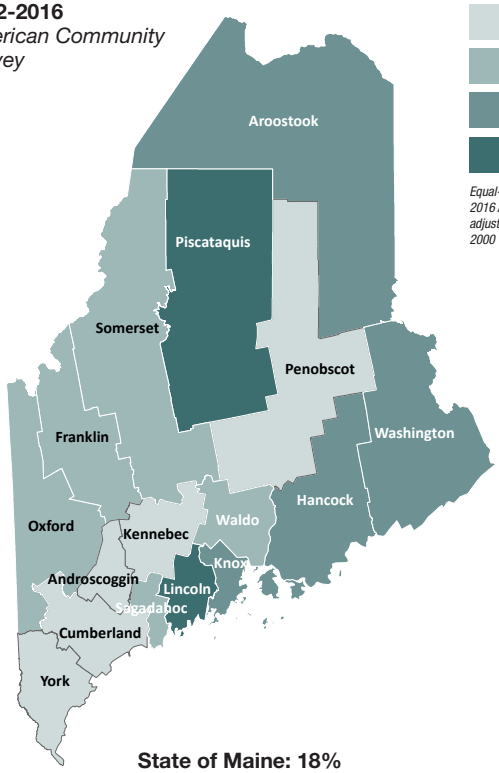
All data on this page is from the U.S. Census Bureau, American Community Survey 2012-2016, with the exception of the unemployment rate, for which the source is the U.S. Bureau of Labor Statistics, 2015-2017.

Percent of population over age 65

2000
U.S. Census

State of Maine: 14%

2012-2016
American Community Survey



12% to 18%
19% to 20%
21% to 23%
24% to 25%

Equal-interval scale based on 2012-2016 American Community Survey adjusted to be inclusive of all Census 2000 values

State of Maine: 18%

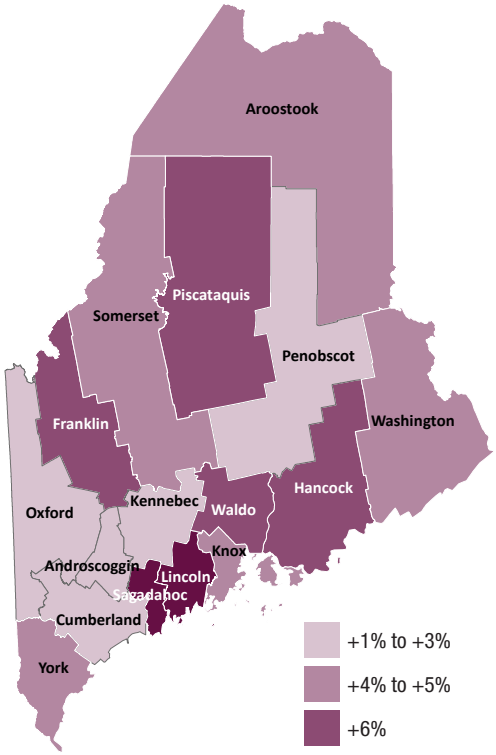
The maps on this page reflect a further breakdown in the population for those over age 65. The two maps at the top of this page show the percentage of population over age 65 by county during two time periods. The map on the top left shows the population over age 65 in 2000 as measured by the U.S. Census. The map on the top right shows the population over age 65 from years 2012 through 2016 as estimated by the American Community Survey.

The darker the shade on the maps, the greater the percentage of those over age 65. Lincoln County has the largest proportion of people over age 65 in 2000 and 2016.

The map to the right shows the change in percent of population over age 65 by county. The darker shades on the map indicate a greater increase. Lincoln and Sagadahoc are the two counties with the greatest increase in the percentage of those over age 65.

Change in percent of population over age 65

2000-2016



+1% to +3%
+4% to +5%
+6%
+7%

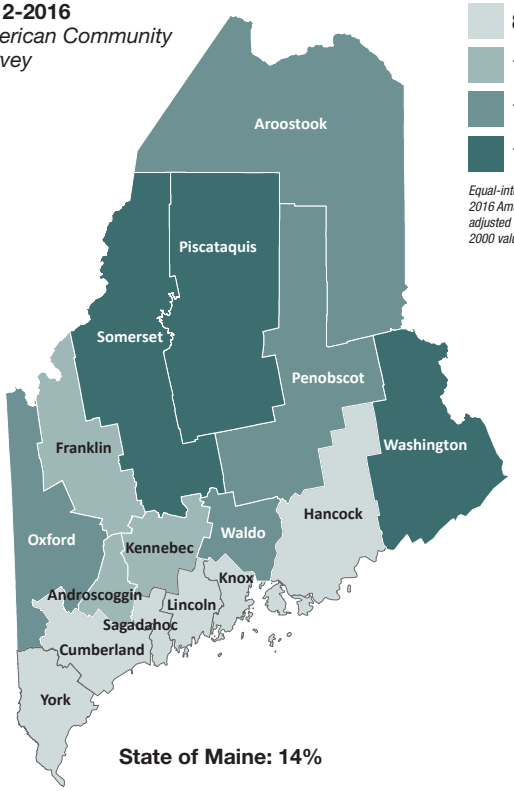
State of Maine: +4%

Percent of population in poverty

2000
U.S. Census

State of Maine: 11%

2012-2016
American Community Survey



State of Maine: 14%

8% to 12%
13% to 15%
16% to 18%
19% to 21%

Equal-interval scale based on 2012-2016 American Community Survey adjusted to be inclusive of all Census 2000 values

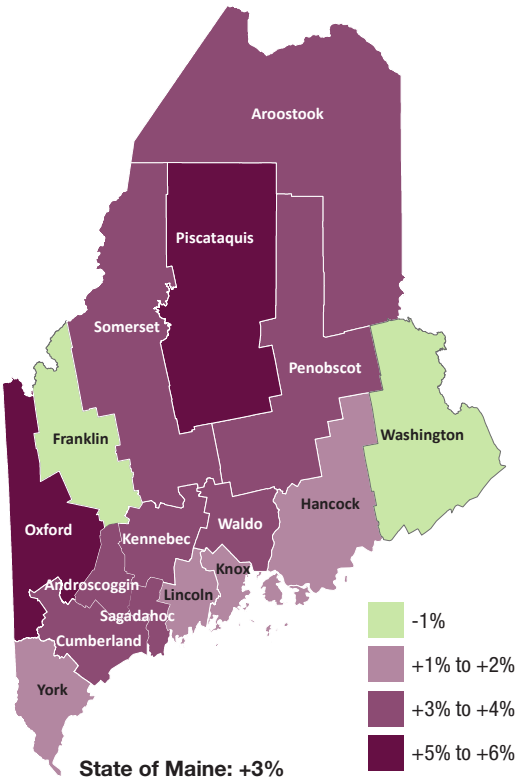
The two maps at the top of this page show the percentage of population in poverty by county during two time periods. The map on the top left shows the population in poverty in 2000 as measured by the U.S. Census. The map on the top right shows the population in poverty from years 2012 through 2016 as estimated by the American Community Survey.

The darker the shade is on the top two maps, the greater the percentage of those in poverty. Washington County has the greatest percentage in both maps. In the 2012-2016, Washington County is joined by Somerset and Piscataquis Counties.

The map to the right shows the change in percent of population in poverty by county. The darker the shade is on the map, the larger the increase. Interestingly, while Washington County has maintained one of the highest rates of poverty, there was a slight decrease, shown in the light shade of green. Likewise, in Franklin County, while there was not enough decrease of population living in poverty to change shade used in the 2012-2016 map below, there was a 1% decrease of population in poverty, shown in the light shade of green on the map to the right. This may indicate some leveling off of those rates.

Change in percent of population in poverty

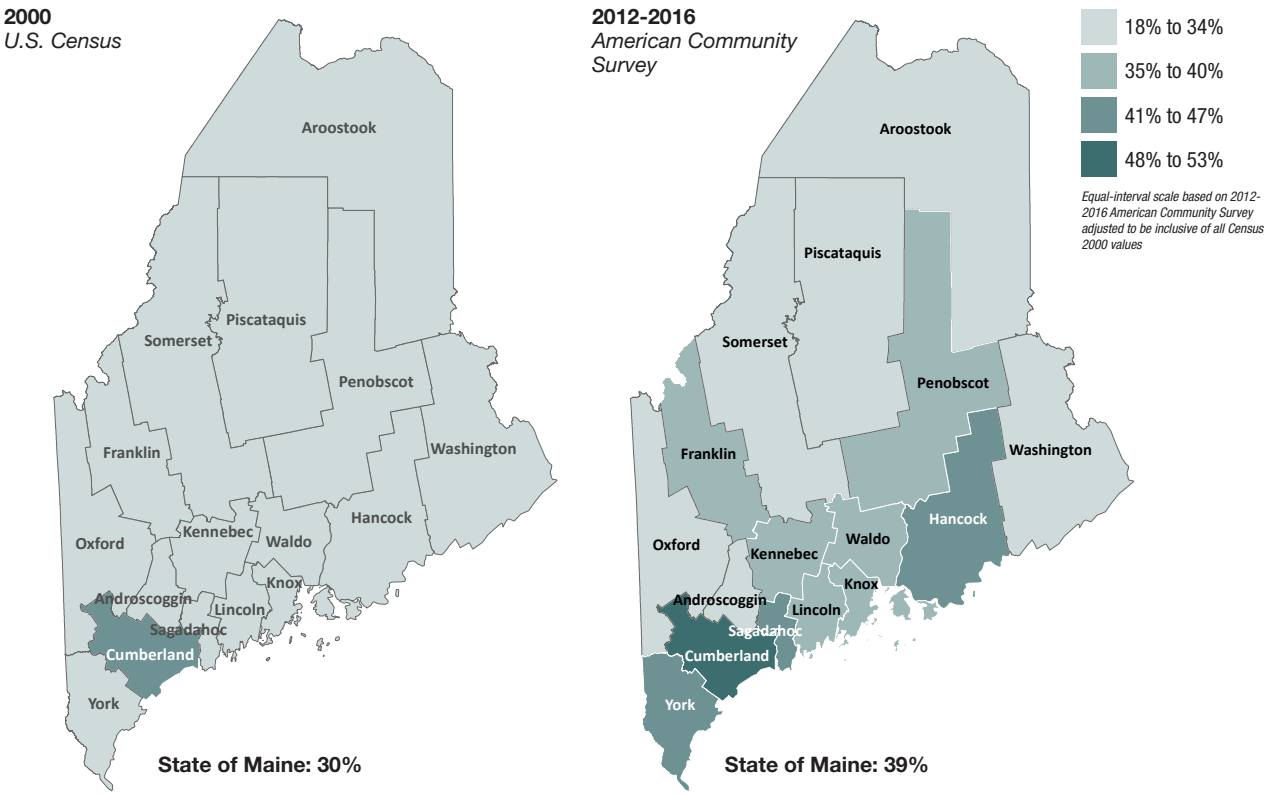
2000-2016



State of Maine: +3%

-1%
+1% to +2%
+3% to +4%
+5% to +6%

Percent of population over age 25 with an associates degree or higher



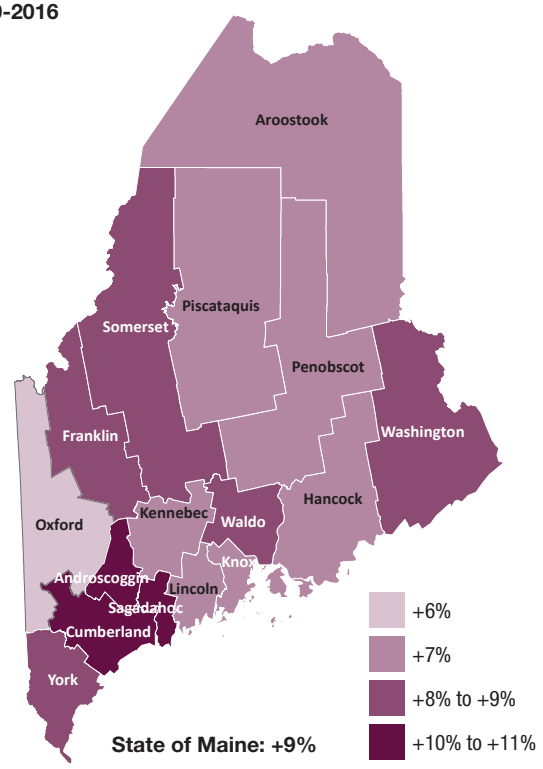
The two maps at the top of this page show the percentage of population over age 25 with an associate's degree or higher by county during two time periods. The map on the top left shows the population over age 25 with an associate's degree or higher in 2000 as measured by the U.S. Census. The map on the top right shows the population over age 25 with an associate's degree or higher from years 2012 through 2016 as estimated by the American Community Survey.

The darker the shade on the map, the larger the percentage of those with an associate's degree or higher. Cumberland County has the largest percentage of those in both maps.

The map to the right shows the change in percent of population over age 25 with an associate's degree or higher by county. The darker the shade, the larger the increase of those over age 25 with an associate's degree or higher. Cumberland, Androscoggin, and Sagadahoc counties show the largest increases of population over age 25 with an associate's degree or higher.

Change in percent of population over age 25 with an associates degree or higher

2000-2016



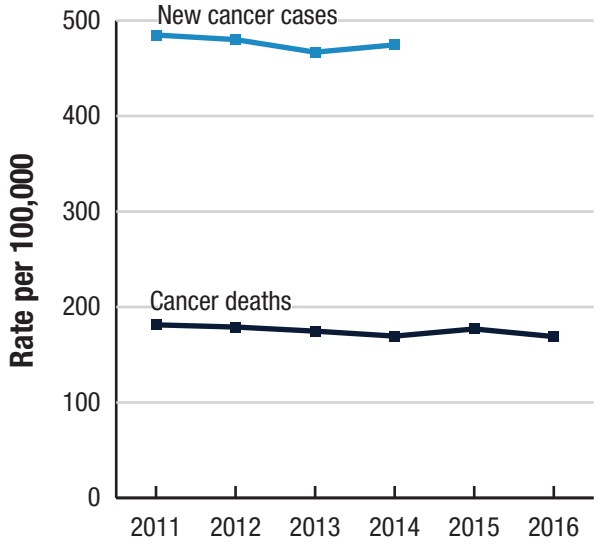
PAST MAINE STATEWIDE PRIORITIES

The following six topics have been priorities in Maine since 2016. They were addressed in one or more of the following planning documents based on the 2016 Maine Shared CHNA: the State Health Improvement Plan, District Public Health Improvement Plans, and/or Hospital Implementation Strategies.

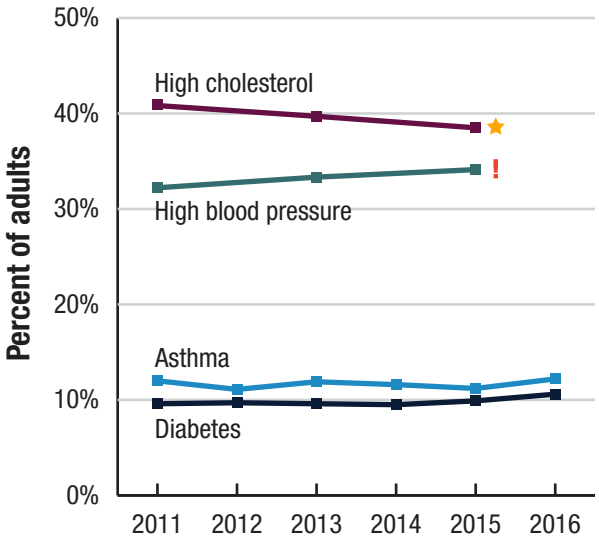
1. Cancer
2. Chronic disease
3. Mental health
4. Obesity and physical activity
5. Nutrition
6. Substance use, including tobacco

The following charts show trends in the data for these areas.

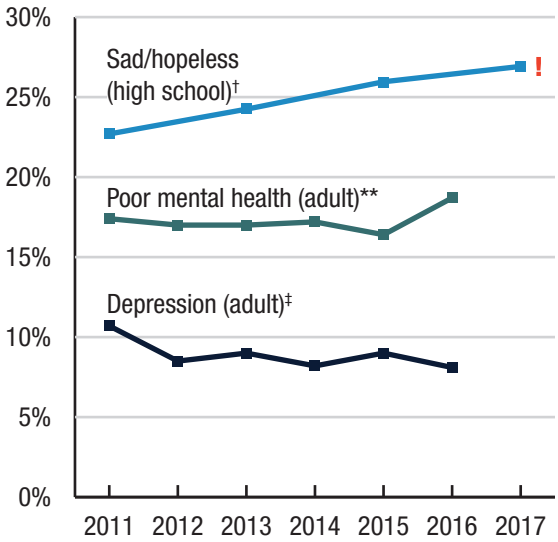
CANCER



CHRONIC DISEASE



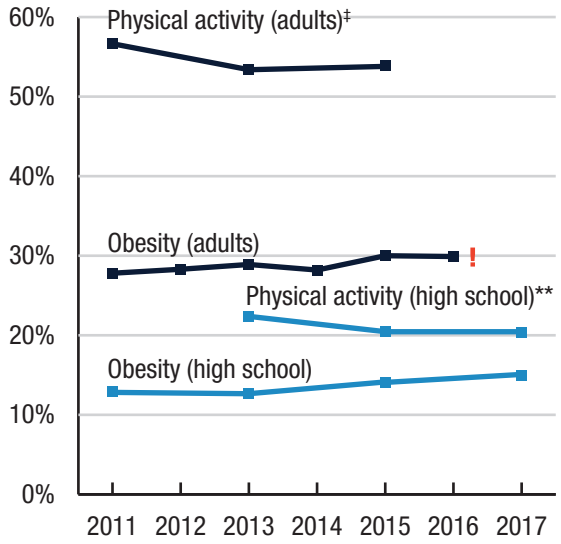
MENTAL HEALTH



† Sad/hopeless for two weeks in a row (high school)
**14+ days lost due to poor mental health (adult)
‡ Current symptoms of depression (adult)

OBESITY AND PHYSICAL ACTIVITY

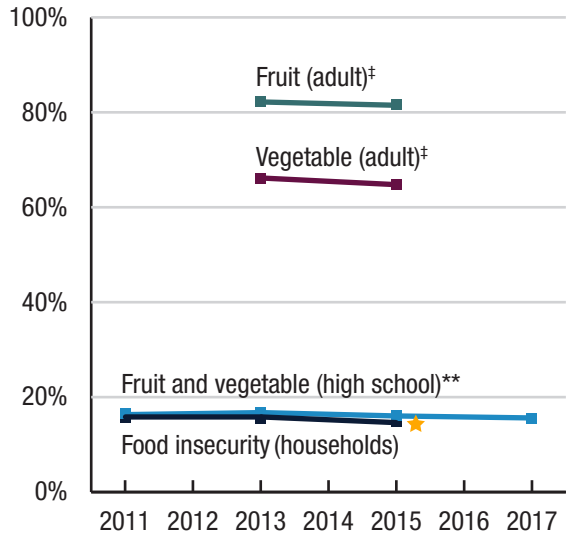
Physical activity and obesity levels for adults and high school students



‡ Met aerobic physical activity recommendations (adults)
** Physical activity for at least 60 minutes per day on seven of the past seven days (high school)

NUTRITION

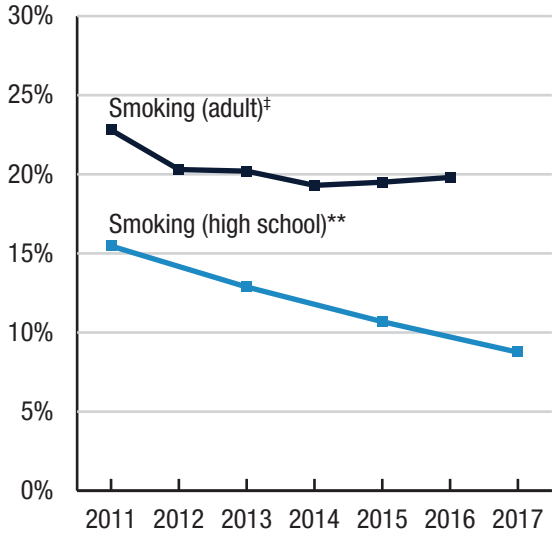
Nutrition indicators for adults, high school students, and households



‡Adults reporting more than one serving of fruits/vegetables per day
** High school students reporting five or more servings of fruits and vegetables a day

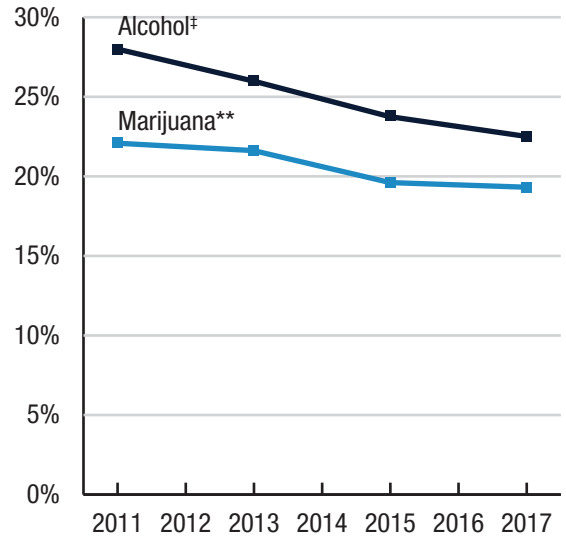
SUBSTANCE USE, INCLUDING TOBACCO

Current cigarette smoking



‡Adults who report cigarette smoking every day or some days
**High school students who report past 30 day cigarette smoking

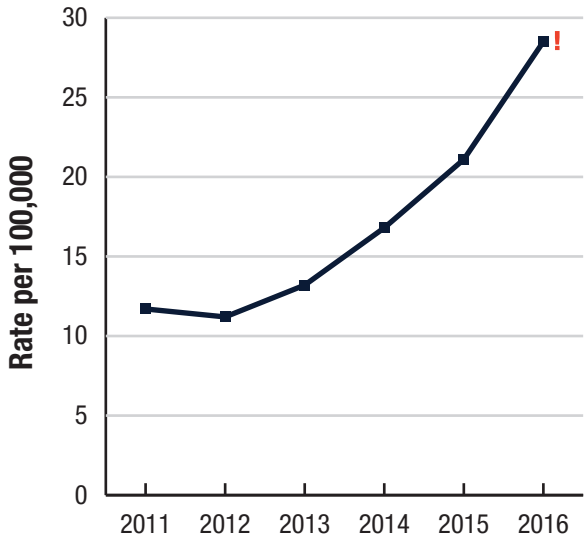
High school alcohol and marijuana use



‡High school students who report past 30 day alcohol use
**High school students who report past 30 day marijuana use

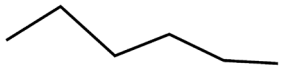
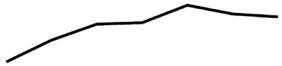
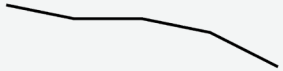
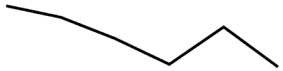
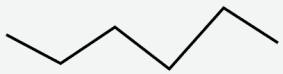
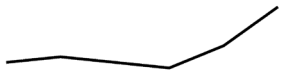
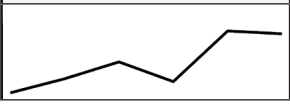
SUBSTANCE USE, INCLUDING TOBACCO

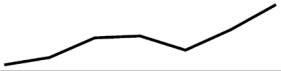
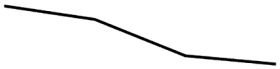
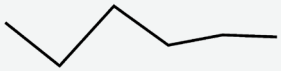
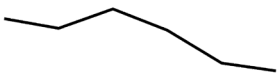
Overdose deaths

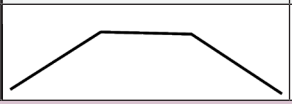
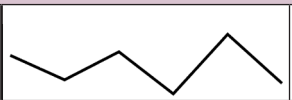
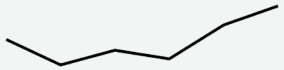
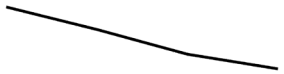
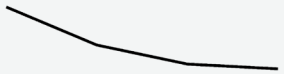
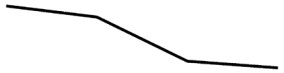
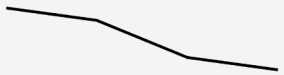
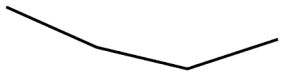


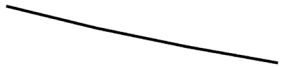
YEAR	NUMBER OF DEATHS
2011	155
2012	146
2013	174
2014	216
2015	268
2016	351

6

	MAINE STATEWIDE DATA									BENCHMARK	
INDICATOR	**STATEWIDE TREND**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**CHANGE**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT											
Children living in poverty		18.7%	20.9%	17.7%	19.1%	17.4%	17.2%	–	○	2016 21.1%	○
Median household income		$46,033	$46,709	$46,974	$49,462	$51,494	$53,079	–	★	2016 $57,617	!
Estimated high school student graduation rate		83.8%	85.3%	86.4%	86.5%	87.7%	87.1%	86.9%	★	–	N/A
Food insecurity		15.7%	15.5%	15.5%	15.3%	14.8%	–	–	★	2015 13.4%	N/A
HEALTH OUTCOMES											
14 or more days lost due to poor physical health		20.8%	21.2%	20.5%	20.3%	19.2%	22.4%	–	○	2016 11.4%	N/A
14 or more days lost due to poor mental health		17.4%	17.0%	17.0%	17.2%	16.4%	18.7%	–	○	2016 11.2%	N/A
Years of potential life lost per 100,000 population		–	2010-2012 6,198.7	2011-2013 6,314.1	2012-2014 6,378.5	–	2014-2016 6,529.2	–	○	2014-2016 6,658.0	N/A
All cancer deaths per 100,000 population		181.3	179.0	174.7	169.5	177.0	169.0	–	○	2016 155.8	!
Cardiovascular disease deaths per 100,000 population		196.8	192.6	197.9	191.8	200.7	195.6	–	○	2016 218.2	★
Diabetes		9.6%	9.7%	9.6%	9.5%	9.9%	10.6%	–	○	2016 10.5%	○
Chronic obstructive pulmonary disease (COPD) (adults who had ever been told)		7.8%	7.8%	7.0%	7.7%	8.1%	7.4%	–	○	2016 6.3%	○
Obesity (adults)		27.8%	28.3%	28.9%	28.2%	30.0%	29.9%	–	!	2016 29.9%	N/A

INDICATOR	STATEWIDE TREND	MAINE STATEWIDE DATA 2011	2012	2013	2014	2015	2016	2017	CHANGE	BENCHMARK U.S.	+/–
HEALTH OUTCOMES (CONTINUED)											
Obesity (high school students)		12.9%	–	12.7%	–	14.1%	–	15.0%	○	–	N/A
Obesity (middle school students)		15.5%	–	14.2%	–	14.3%	–	15.3%	○	–	N/A
Infant deaths per 1,000 live births		2007-2011 5.8	–	–	–	–	2012-2016 6.5	–	N/A	2012-2016 5.9	○
Cognitive decline		–	14.2%	–	–	–	10.3%	–	N/A	2016 10.6%	○
Lyme disease new cases per 100,000 population		76.3	83.8	104.1	106.0	91.4	112.4	138.3	!	2016 11.3	N/A
Chlamydia new cases per 100,000 population		233.5	256.8	258.8	262.3	289.7	311.8	340.9	!	2016 494.7	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population		361.3	354.5	336.1	331.9	–	–	–	★	–	N/A
Suicide deaths per 100,000 population		16.6	14.5	17.4	15.5	16.0	15.9	–	○	2016 13.5	!
Overdose deaths per 100,000 population		11.7	11.2	13.2	16.8	21.1	28.5	–	!	2016 19.8	!
HEALTH CARE ACCESS AND QUALITY											
Uninsured		10.7%	10.2%	11.2%	10.1%	8.4%	8.0%	–	★	2016 8.6%	○
Ratio of primary care physicians to 100,000 population		–	–	–	–	–	–	67.3	N/A	–	N/A

	MAINE STATEWIDE DATA									BENCHMARK	
INDICATOR	**STATEWIDE TREND**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**CHANGE**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY (CONTINUED)											
Ratio of psychiatrists to 100,000 population		–	–	–	–	–	–	8.4	N/A	–	N/A
Ratio of practicing dentists to 100,000 population		–	–	–	–	–	–	32.1	N/A	–	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population		–	–	–	–	–	74.6	–	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations		–	–	–	73.9%	76.6%	76.5%	73.7%	○	–	N/A
HEALTH BEHAVIORS											
Sedentary lifestyle – no leisure-time physical activity in past month (adults)		23.0%	20.9%	23.3%	19.7%	24.8%	20.6%	–	○	2016 **23.2%**	N/A
Chronic heavy drinking (adults)		7.3%	6.6%	7.0%	6.8%	7.7%	8.3%	–	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)		28.0%	–	26.0%	–	23.8%	–	22.5%	★	–	N/A
Past-30-day alcohol use (middle school students)		6.3%	–	4.7%	–	3.9%	–	3.7%	○	–	N/A
Past-30-day marijuana use (high school students)		22.1%	–	21.6%	–	19.6%	–	19.3%	★	–	N/A
Past-30-day marijuana use (middle school students)		4.6%	–	4.4%	–	3.8%	–	3.6%	★	–	N/A
Past-30-day misuse of prescription drugs (high school students)		7.1%	–	5.6%	–	4.8%	–	5.9%	○	–	N/A

		MAINE STATEWIDE DATA								BENCHMARK	
INDICATOR	STATEWIDE TREND	2011	2012	2013	2014	2015	2016	2017	CHANGE	U.S.	+/–
HEALTH BEHAVIORS (CONTINUED)											
Past-30-day misuse of prescription drugs (middle school students)		3.2%	–	2.6%	–	2.2%	–	1.5%	★	–	N/A
Current (every day or some days) smoking (adults)		22.8%	20.3%	20.2%	19.3%	19.5%	19.8%	–	○	2016 17.0%	N/A
Past-30-day cigarette smoking (high school students)		15.5%	–	12.9%	–	10.7%	–	8.8%	★	–	N/A
Past-30-day cigarette smoking (middle school students)		4.2%	–	3.2%	–	2.7%	–	1.9%	★	–	N/A

Leading Causes of Death

The following chart shows the leading causes of death for the state of Maine and the U.S.

MAINE			U.S.		
CAUSE OF DEATH	NUMBER OF DEATHS	AGE-ADJUSTED RATE PER 100,000	CAUSE OF DEATH	NUMBER OF DEATHS	AGE-ADJUSTED RATE PER 100,000
Cancer	3,275	168.9	Heart disease	635,260	165.5
Heart disease	2,907	149.5	Cancer	598,038	155.8
Chronic lower respiratory disease	928	47.4	Unintentional injury	161,374	47.4
Unintentional injury	909	62.4	Chronic lower respiratory disease	154,596	40.6
Cerebrovascular disease	663	34.4	Cerebrovascular disease	142,142	37.3
Alzheimer's disease	577	29.6	Alzheimer's disease	116,103	30.3
Diabetes	463	23.9	Diabetes	80,058	21
Liver disease	239	12.4	Influenza and pneumonia	51,537	13.5
Influenza and pneumonia	231	12.0	Liver disease	50,046	13.1
Suicide	226	15.9	Suicide	44,965	13.5

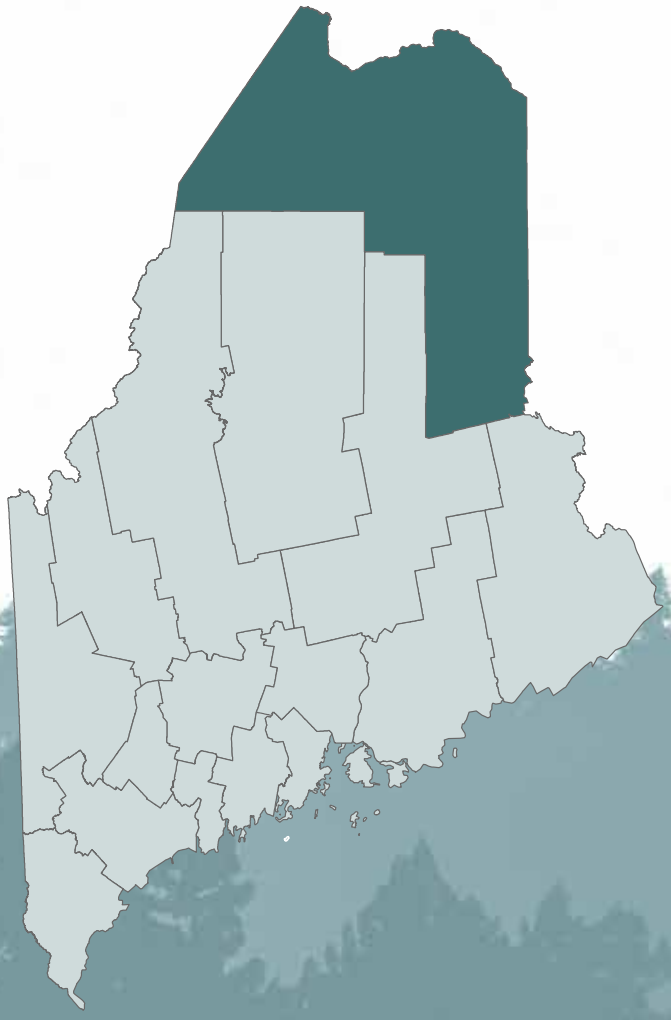
Years of Potential Life Lost

The following chart shows the causes of death with the highest values of years of potential life lost for the state of Maine and the U.S.

	MAINE		U.S.	
RANK	CAUSE OF YEARS OF POTENTIAL LIFE LOST	NUMBER OF YEARS	CAUSE OF YEARS OF POTENTIAL LIFE LOST	NUMBER OF YEARS
1	Cancer	21,529	Cancer	4,362,037
2	Unintentional injury	20,003	Unintentional injury	3,901,259
3	Heart disease	12,332	Heart disease	3,225,740
4	Suicide	6,185	Suicide	1,289,181
5	Chronic lower respiratory disease	3,602	Perinatal period*	860,014
6	Liver disease	2,887	Homicide	795,211
7	Diabetes	2,868	Chronic lower respiratory disease	622,866
8	Perinatal period*	2,700	Liver disease	61,0807
9	Cerebrovascular disease	1,941	Diabetes	596,730
10	Congenital anomalies	1,663	Cerebrovascular disease	543,414

**The deaths during the perinatal period include fetal death (stillbirth) or an early neonatal death before 28 days after birth. They exclude deaths due to congenital anomalies, metabolic injuries, poisonings, cancer, and tetanus.*

AROOSTOOK DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

AROOSTOOK COUNTY POPULATION

69,405

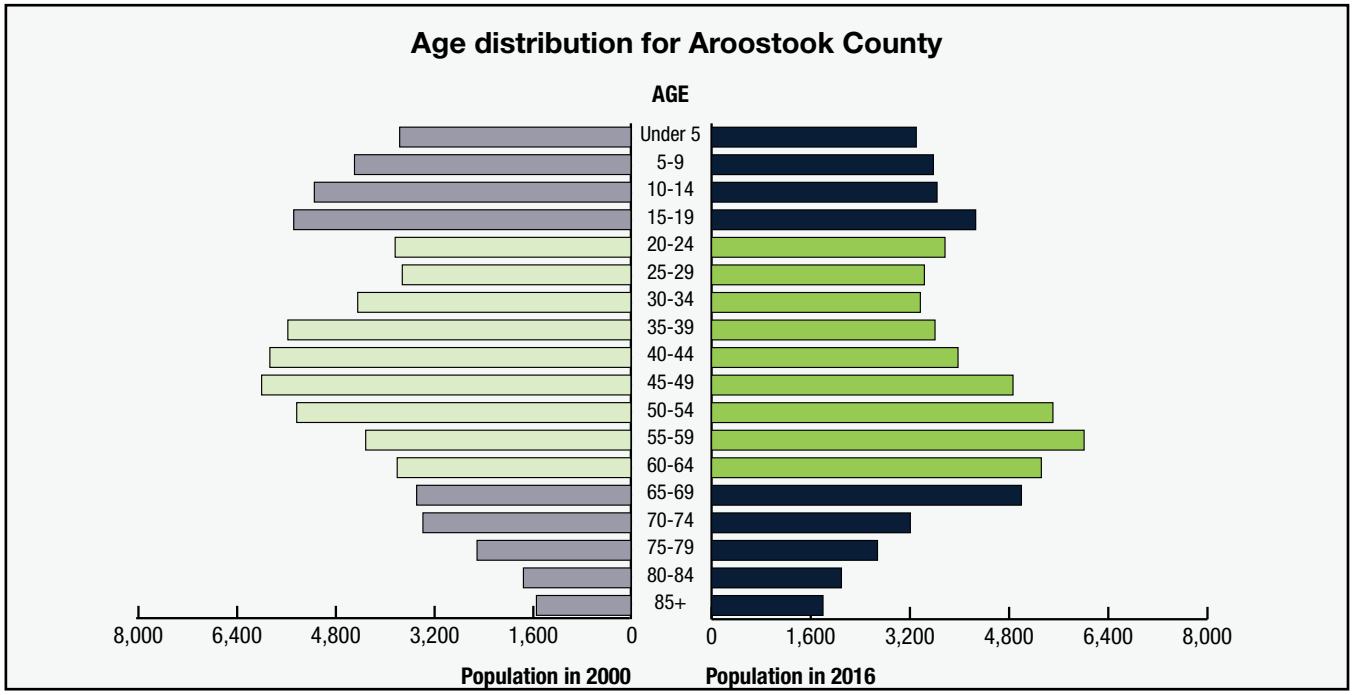
STATE OF MAINE POPULATION

1,329,923

	AROOSTOOK	MAINE
Median household income	$38,087	$50,826
Unemployment rate	5.5%	3.8%
Individuals living in poverty	17.7%	13.5%
Children living in poverty	23.6%	17.2%
65+ living alone	47.7%	45.3%

	AROOSTOOK COUNTY	
	PERCENT	NUMBER
American Indian/Alaskan Native	1.6%	1,144
Asian	0.5%	320
Black/African American	0.9%	597
Hispanic	1.1%	736
Some other race	0.2%	161
Two or more races	1.6%	1,122
White	95.2%	66,055

The chart below shows the shift in the age of the population. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.

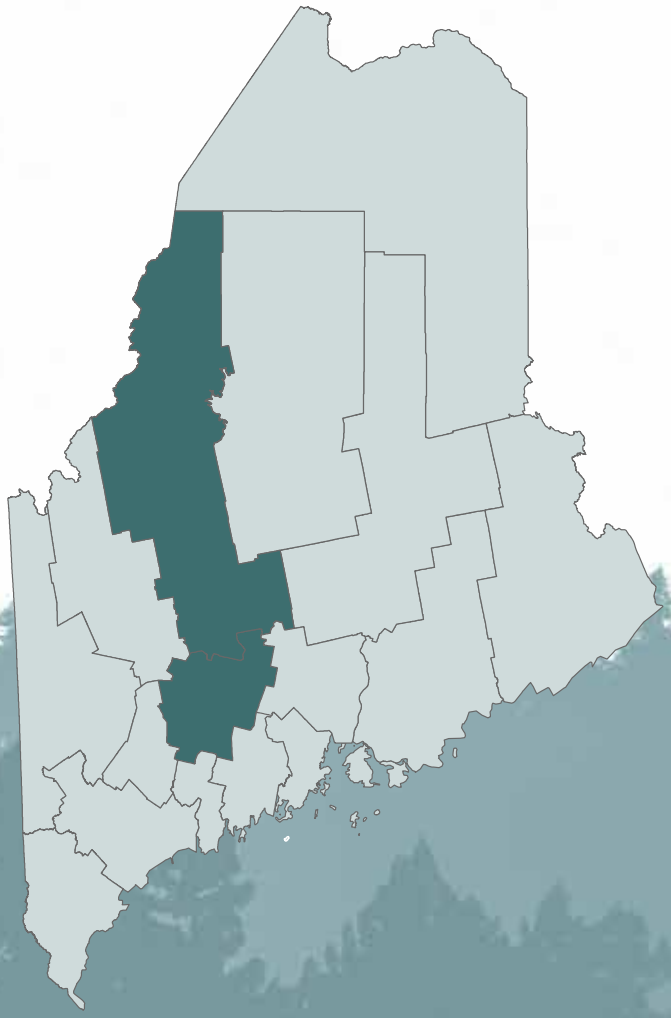


All data on this page is from the U.S. Census Bureau, American Community Survey 2012-2016, with the exception of the unemployment rate, for which the source is the U.S. Bureau of Labor Statistics, 2015-2017.

	AROOSTOOK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2007-2011 **21.6%**	2012-2016 **23.6%**	N/A	2012-2016 **17.2%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$37,138**	2012-2016 **$38,087**	N/A	2012-2016 **$50,826**	N/A	2016 **$57,617**	N/A
Estimated high school student graduation rate	2014 **88.1%**	2017 **89.5%**	N/A	2017 **86.9%**	N/A	—	N/A
Food insecurity	2012-2013 **16.9%**	2014-2015 **16.9%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2011-2013 **27.3%**	2014-2016 **26.5%**	○	2014-2016 **19.6%**	!	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **22.1%**	2014-2016 **24.3%**	○	2014-2016 **16.7%**	!	2016 **11.2%**	N/A
Years of potential life lost per 100,000 population	2010-2012 **7,400.7**	2014-2016 **7,808.6**	○	2014-2016 **6,529.2**	!	2014-2016 **6,658.0**	N/A
All cancer deaths per 100,000 population	2007-2011 **199.6**	2012-2016 **174.7**	★	2012-2016 **173.8**	○	2011-2015 **163.5**	○
Cardiovascular disease deaths per 100,000 population	2007-2011 **239.6**	2012-2016 **221.5**	○	2012-2016 **195.8**	!	2016 **218.2**	○
Diabetes	2011-2013 **14.2%**	2014-2016 **13.0%**	○	2014-2016 **10.0%**	!	2016 **10.5%**	○
Chronic obstructive pulmonary disease (COPD)	2011-2013 **10.5%**	2014-2016 **11.1%**	○	2014-2016 **7.8%**	!	2016 **6.3%**	!
Obesity (adults)	2011 **34.2%**	2016 **35.6%**	○	2016 **29.9%**	○	2016 **29.6%**	○
Obesity (high school students)	2011 **14.7%**	2017 **20.9%**	!	2017 **15.0%**	!	—	N/A
Obesity (middle school students)	2015 **17.9%**	2017 **15.8%**	○	2017 **15.3%**	○	—	N/A
Infant deaths per 1,000 live births	2007-2011 **5.5***	2012-2016 **9.0**	○	2012-2016 **6.5**	○	2012-2016 **5.9**	!
Cognitive decline	2012 **19.2*%**	2016 **11.1*%**	○	2016 **10.3%**	○	2016 **10.6%**	○
Lyme disease new cases per 100,000 population	2008-2012 **12.5**	2013-2017 **8.4**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **141.5**	2013-2017 **182.7**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **419.4**	2012-2014 **472.6**	!	2012-2014 **340.9**	!	—	N/A
Suicide deaths per 100,000 population	2007-2011 **13.7**	2012-2016 **21.4**	○	2012-2016 **15.9**	○	2016 **13.5**	!
Overdose deaths per 100,000 population	2007-2011 **9.9**	2012-2016 **14.7**	○	2012-2016 **18.1**	○	2016 **19.8**	○

	AROOSTOOK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2009-2011 **10.5%**	2012-2016 **9.5%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ratio of primary care physicians to 100,000 population	—	2017 **45.6**	N/A	2017 **67.3**	N/A	—	N/A
Ratio of psychiatrists to 100,000 population	—	2017 **3.5**	N/A	2017 **8.4**	N/A	—	N/A
Ratio of practicing dentists to 100,000 population	—	2017 **24.8**	N/A	2017 **32.1**	N/A	—	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	—	2016 **95.3**	N/A	2016 **74.6**	N/A	—	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **84.9%**	2017 **86.0%**	N/A	2017 **73.7%**	N/A	—	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **27.0%**	2016 **30.1%**	○	2016 **20.6%**	!	2016 **23.2%**	N/A
Chronic heavy drinking (adults)	2011-2013 **4.7%**	2014-2016 **5.8%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)	2011 **26.9%**	2017 **23.1%**	○	2017 **22.5%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2011 **5.2%**	2017 **5.6%**	○	2017 **3.7%**	○	—	N/A
Past-30-day marijuana use (high school students)	2011 **16.7%**	2017 **14.5%**	○	2017 **19.3%**	★	—	N/A
Past-30-day marijuana use (middle school students)	2011 **4.0%**	2017 **4.5%**	○	2017 **3.6%**	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **5.2%**	2017 **5.4%**	○	2017 **5.9%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2011 **2.2%**	2017 **1.7%**	○	2017 **1.5%**	○	—	N/A
Current (every day or some days) smoking (adults)	2011-2012 **26.2%**	2016 **26.6%**	○	2016 **19.8%**	!	2016 **17.0%**	N/A
Past-30-day cigarette smoking (high school students)	2011 **16.8%**	2017 **13.4%**	○	2017 **8.8%**	!	—	N/A
Past-30-day cigarette smoking (middle school students)	2011 **4.8%**	2017 **3.5%**	○	2017 **1.9%**	○	—	N/A

CENTRAL DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

CENTRAL DISTRICT POPULATION

172,316

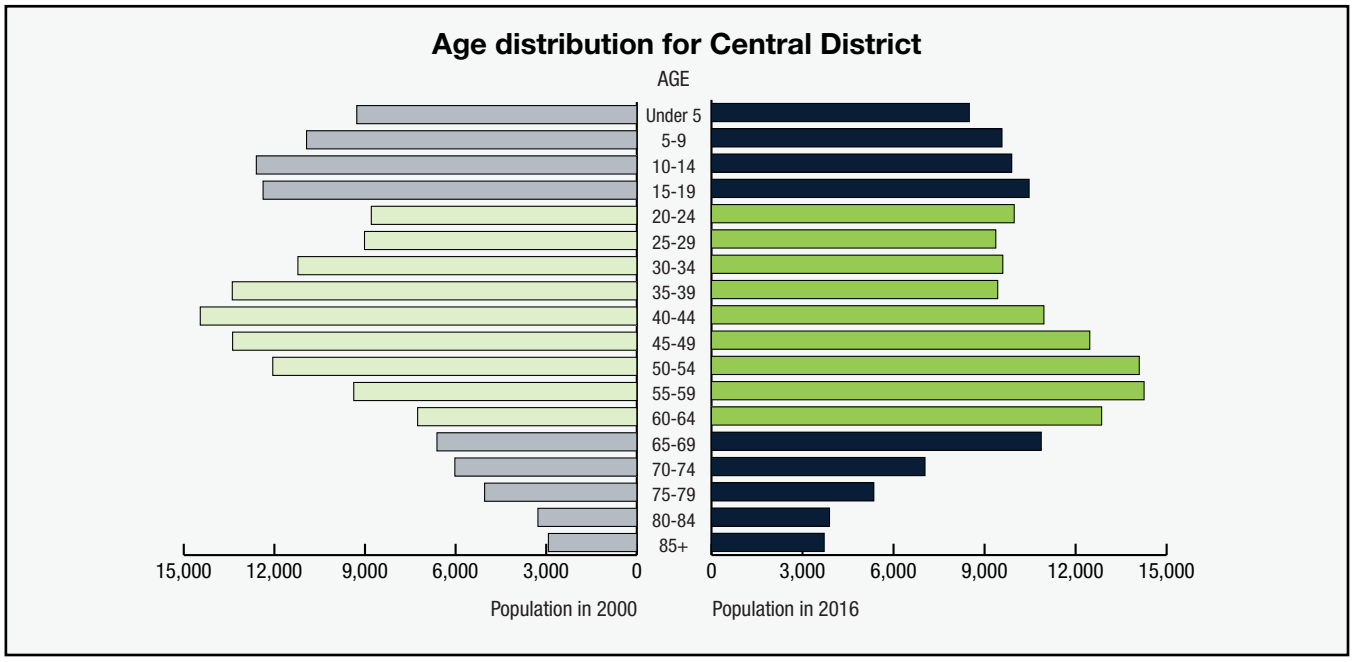
STATE OF MAINE POPULATION

1,329,923

	CENTRAL DISTRICT	
	PERCENT	NUMBER
American Indian/Alaskan Native	0.5%	900
Asian	0.7%	1,167
Black/African American	0.8%	1,413
Hispanic	1.3%	2,237
Some other race	0.3%	499
Two or more races	1.5%	2,579
White	96.1%	165,681

	KENNEBEC	SOMERSET	MAINE
Median household income	$48,570	$40,484	$50,826
Unemployment rate	3.7%	5.7%	3.8%
Individuals living in poverty	14.6%	18.0%	13.5%
Children living in poverty	20.3%	26.2%	17.2%
65+ living alone	46.1%	46.7%	45.3%

The chart below shows the shift in the age of the population for the district. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



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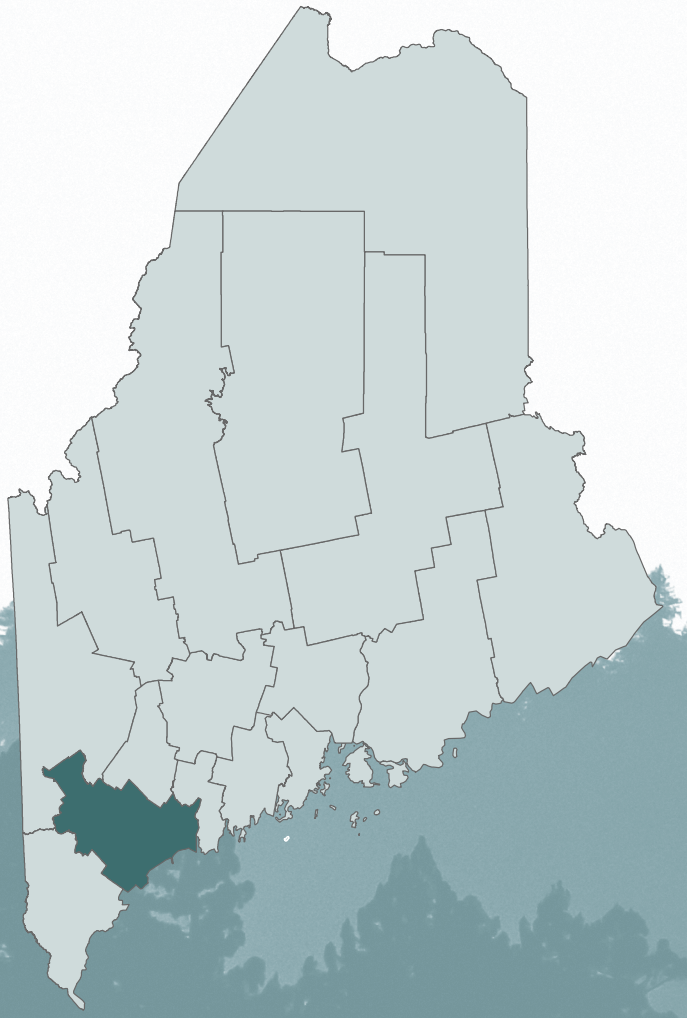
	BENCHMARK	CENTRAL DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**KENNEBEC**	**+/–**	**SOMERSET**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2012-2016 **17.2%**	2012-2016 **22.1%**	N/A	2012-2016 **20.3%**	N/A	2012-2016 **26.2%**	N/A
Median household income	2012-2016 **$50,826**	**–**	N/A	2012-2016 **$48,570**	N/A	2012-2016 **$40,484**	N/A
Estimated high school student graduation rate	2017 **86.9%**	2017 **84.8%**	N/A	2017 **84.0%**	N/A	2017 **86.4%**	N/A
Food insecurity	2014-2015 **15.1%**	**–**	N/A	2014-2015 **14.7%**	N/A	2014-2015 **16.2%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2014-2016 **19.6%**	2014-2016 **19.9%**	○	2014-2016 **21.5%**	○	2014-2016 **19.0%**	○
14 or more days lost due to poor mental health	2014-2016 **16.7%**	2014-2016 **18.5%**	○	2014-2016 **18.6%**	○	2014-2016 **20.6%**	○
Years of potential life lost per 100,000 population	2014-2016 **6,529.2**	**–**	N/A	2014-2016 **7,151.2**	○	2014-2016 **7,889.5**	!
All cancer deaths per 100,000 population	2012-2016 **173.8**	2012-2016 **184.9**	!	2012-2016 **181.7**	○	2012-2016 **192.7**	!
Cardiovascular disease deaths per 100,000 population	2012-2016 **195.8**	2012-2016 **230.4**	!	2012-2016 **219.3**	!	2012-2016 **256.7**	!
Diabetes	2014-2016 **10.0%**	2014-2016 **10.7%**	○	2014-2016 **10.2%**	○	2014-2016 **11.7%**	○
Chronic obstructive pulmonary disease (COPD)	2014-2016 **7.8%**	2014-2016 **8.0%**	○	2014-2016 **6.2%**	○	2014-2016 **12.4%**	!
Obesity (adults)	2016 **29.9%**	2016 **29.9%**	○	2016 **27.0%**	○	2016 **36.5%**	○
Obesity (high school students)	2017 **15.0%**	2017 **16.9%**	○	2017 **16.4%**	○	2017 **18.0%**	○
Obesity (middle school students)	2017 **15.3%**	2017 **19.8%**	!	2017 **17.9%**	○	2017 **22.7%**	!
Infant deaths per 1,000 live births	2012-2016 **6.5**	2012-2016 **8.1**	○	2012-2016 **7.1**	○	2012-2016 **7.7***	○
Cognitive decline	2016 **10.3%**	2016 **12.4%**	○	2016 **13.2*%**	○	2016 **10.8%**	○
Lyme disease new cases per 100,000 population	2013-2017 **96.5**	2013-2017 **113.7**	N/A	2013-2017 **132.8**	N/A	2013-2017 **68.5**	N/A

	BENCHMARK	CENTRAL DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**KENNEBEC**	**+/–**	**SOMERSET**	**+/–**
HEALTH OUTCOMES (CONTINUED)							
Chlamydia new cases per 100,000 population	2013-2017 **293.4**	2013-2017 **300.9**	N/A	2013-2017 **305.0**	N/A	2013-2017 **291.2**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2012-2014 **340.9**	2012-2014 **390.2**	!	2012-2014 **365.6**	!	2012-2014 **448.8**	!
Suicide deaths per 100,000 population	2012-2016 **15.9**	2012-2016 **17.4**	○	2012-2016 **16.9**	○	2012-2016 **18.2**	○
Overdose deaths per 100,000 population	2012-2016 **18.1**	2012-2016 **19.3**	○	2012-2016 **20.7**	○	2012-2016 **15.9**	○
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2012-2016 **9.5%**	2012-2016 **9.3%**	N/A	2012-2016 **8.5%**	N/A	2012-2016 **11.3%**	N/A
Ratio of primary care physicians to 100,000 population	2017 **67.3**	2017 **63.8**	N/A	2017 **73.2**	N/A	2017 **41.9**	N/A
Ratio of psychiatrists to 100,000 population	2017 **8.4**	2017 **5.5**	N/A	2017 **7.0**	N/A	2017 **1.9**	N/A
Ratio of practicing dentists to 100,000 population	2017 **32.1**	2017 **30.3**	N/A	2017 **39.0**	N/A	2017 **10.0**	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	2016 **74.6**	2016 **78.4**	N/A	2016 **70.4**	N/A	2016 **97.8**	N/A
Two-year-olds up-to-date with recommended immunizations	2017 **73.7%**	2017 **81.4%**	N/A	2017 **83.3%**	N/A	2017 **73.9%**	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2016 **20.6%**	2016 **22.4%**	○	2016 **22.1%**	○	2016 **23.0%**	○
Chronic heavy drinking (adults)	2014-2016 **7.6%**	2014-2016 **7.4%**	○	2014-2016 **7.9%**	○	2014-2016 **6.2%**	○
Past-30-day alcohol use (high school students)	2017 **22.5%**	2017 **20.6%**	○	2017 **21.2%**	○	2017 **19.6%**	○
Past-30-day alcohol use (middle school students)	2017 **3.7%**	2017 **3.9%**	○	2017 **3.8%**	○	2017 **4.3%**	○
Past-30-day marijuana use (high school students)	2017 **19.3%**	2017 **19.3%**	○	2017 **19.3%**	○	2017 **19.2%**	○
Past-30-day marijuana use (middle school students)	2017 **3.6%**	2017 **4.3%**	○	2017 **3.8%**	○	2017 **5.3%**	○

	BENCHMARK	CENTRAL DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**KENNEBEC**	**+/–**	**SOMERSET**	**+/–**
HEALTH BEHAVIORS (CONTINUED)							
Past-30-day misuse of prescription drugs (high school students)	2017 **5.9%**	2017 **4.9%**	○	2017 **5.2%**	○	2017 **4.4%**	★
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.5%**	2017 **1.8%**	○	2017 **1.5%**	○	2017 **2.5%**	○
Current (every day or some days) smoking (adults)	2016 **19.8%**	2016 **21.5%**	○	2016 **20.3%**	○	2016 **24.1%**	○
Past-30-day cigarette smoking (high school students)	2017 **8.8%**	2017 **9.1%**	○	2017 **8.9%**	○	2017 **9.8%**	○
Past-30-day cigarette smoking (middle school students)	2017 **1.9%**	2017 **2.1%**	○	2017 **2.1%**	○	2017 **2.3%**	○

CUMBERLAND DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

CUMBERLAND COUNTY POPULATION

288,204

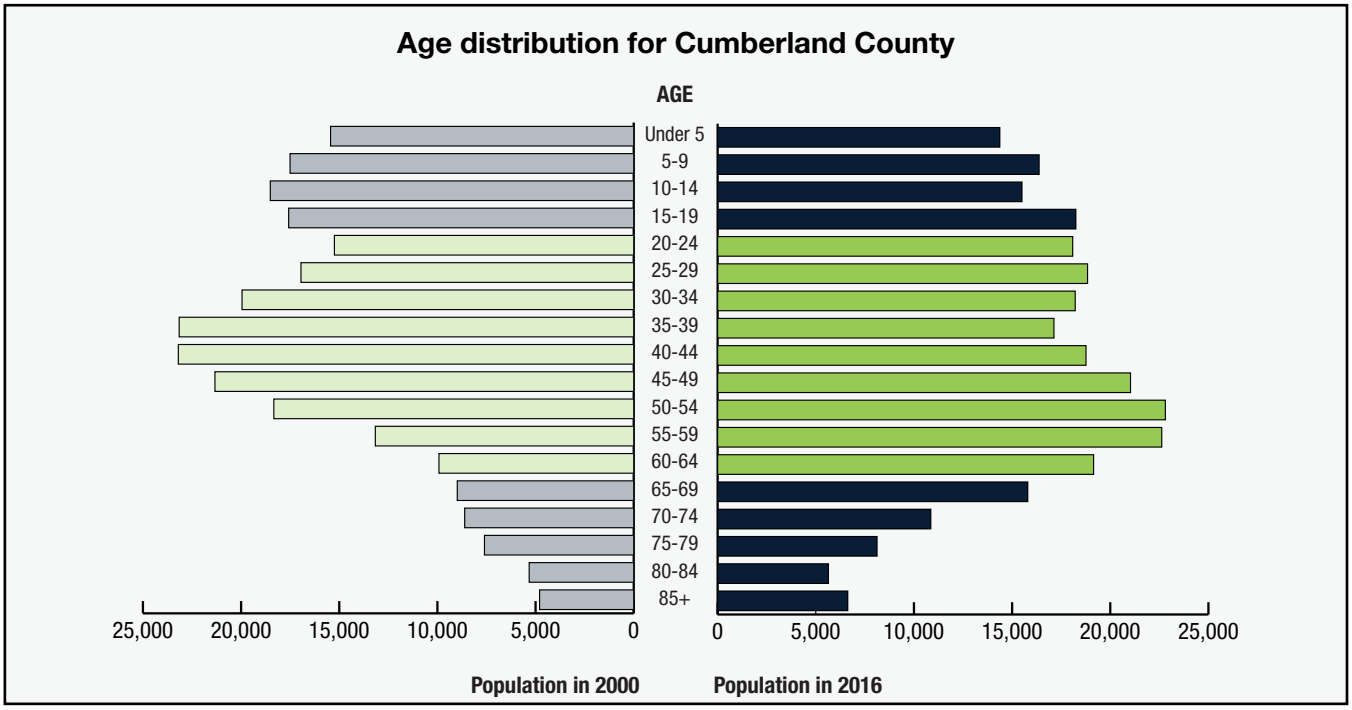
STATE OF MAINE POPULATION

1,329,923

	CUMBERLAND	MAINE
Median household income	$61,902	$50,826
Unemployment rate	2.9%	3.8%
Individuals living in poverty	11.1%	13.5%
Children living in poverty	13.3%	17.2%
65+ living alone	46.4%	45.3%

	CUMBERLAND COUNTY	
	PERCENT	NUMBER
American Indian/Alaskan Native	0.2%	650
Asian	2.0%	5,899
Black/African American	2.7%	7,833
Hispanic	1.9%	5,538
Some other race	0.4%	1,132
Two or more races	2.3%	6,768
White	92.3%	265,918

The chart below shows the shift in the age of the population. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



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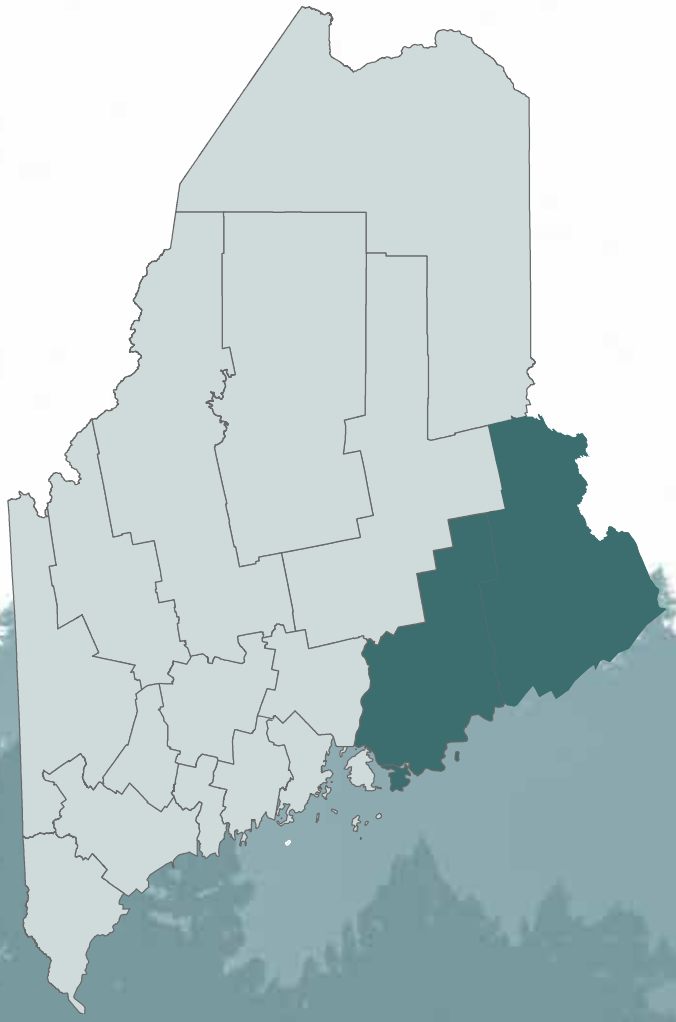
	CUMBERLAND COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2007-2011 **14.8%**	2012-2016 **13.3%**	N/A	2012-2016 **17.2%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$57,267**	2012-2016 **$61,902**	N/A	2012-2016 **$50,826**	N/A	2016 **$57,617**	N/A
Estimated high school student graduation rate	2014 **88.2%**	2017 **87.7%**	N/A	2017 **86.9%**	N/A	–	N/A
Food insecurity	2012-2013 **14.2%**	2014-2015 **14.0%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2011-2013 **17.1%**	2014-2016 **15.5%**	○	2014-2016 **19.6%**	★	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **13.5%**	2014-2016 **12.9%**	○	2014-2016 **16.7%**	★	2016 **11.2%**	N/A
Years of potential life lost per 100,000 population	2010-2012 **5,178.5**	2014-2016 **5,354.3**	○	2014-2016 **6,529.2**	★	2014-2016 **6,658.0**	N/A
All cancer deaths per 100,000 population	2007-2011 **174.6**	2012-2016 **161.5**	★	2012-2016 **173.8**	★	2011-2015 **163.5**	○
Cardiovascular disease deaths per 100,000 population	2007-2011 **173.9**	2012-2016 **164.3**	○	2012-2016 **195.8**	★	2016 **218.2**	★
Diabetes	2011-2013 **7.6%**	2014-2016 **9.7%**	!	2014-2016 **10.0%**	○	2016 **10.5%**	○
Chronic obstructive pulmonary disease (COPD)	2011-2013 **5.1%**	2014-2016 **6.2%**	○	2014-2016 **7.8%**	★	2016 **6.3%**	○
Obesity (adults)	2011 **21.8%**	2016 **27.0%**	○	2016 **29.9%**	○	2016 **29.6%**	○
Obesity (high school students)	2011 **9.6%**	2017 **11.9%**	○	2017 **15.0%**	○	–	N/A
Obesity (middle school students)	2015 **11.9%**	2017 **10.8%**	○	2017 **15.3%**	★	–	N/A
Infant deaths per 1,000 live births	2007-2011 **5.7**	2012-2016 **5.5**	○	2012-2016 **6.5**	○	2012-2016 **5.9**	○
Cognitive decline	2012 **9.7*%**	2016 **8.9*%**	○	2016 **10.3%**	○	2016 **10.6%**	○
Lyme disease new cases per 100,000 population	2008-2012 **46.4**	2013-2017 **93.1**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **236.8**	2013-2017 **327.9**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **307.4**	2012-2014 **272.1**	★	2012-2014 **340.9**	★	–	N/A
Suicide deaths per 100,000 population	2007-2011 **12.6**	2012-2016 **12.6**	○	2012-2016 **15.9**	★	2016 **13.5**	○
Overdose deaths per 100,000 population	2007-2011 **12.2**	2012-2016 **18.1**	!	2012-2016 **18.1**	○	2016 **19.8**	○

	CUMBERLAND COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2009-2011 **9.1%**	2012-2016 **7.5%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ratio of primary care physicians to 100,000 population	–	2017 **94.3**	N/A	2017 **67.3**	N/A	–	N/A
Ratio of psychiatrists to 100,000 population	–	2017 **18.8**	N/A	2017 **8.4**	N/A	–	N/A
Ratio of practicing dentists to 100,000 population	–	2017 **49.7**	N/A	2017 **32.1**	N/A	–	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	–	2016 **49.9**	N/A	2016 **74.6**	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **67.2%**	2017 **71.3%**	N/A	2017 **73.7%**	N/A	–	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **17.5%**	2016 **17.9%**	○	2016 **20.6%**	○	2016 **23.2%**	N/A
Chronic heavy drinking (adults)	2011-2013 **8.7%**	2014-2016 **8.2%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)	2011 **28.6%**	2017 **24.1%**	★	2017 **22.5%**	○	–	N/A
Past-30-day alcohol use (middle school students)	2011 **5.5%**	2017 **3.1%**	★	2017 **3.7%**	○	–	N/A
Past-30-day marijuana use (high school students)	2011 **22.9%**	2017 **19.4%**	○	2017 **19.3%**	○	–	N/A
Past-30-day marijuana use (middle school students)	2011 **3.8%**	2017 **2.7%**	○	2017 **3.6%**	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **7.1%**	2017 **6.1%**	○	2017 **5.9%**	○	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	2011 **3.0%**	2017 **1.4%**	★	2017 **1.5%**	○	–	N/A
Current (every day or some days) smoking (adults)	2011-2012 **16.9%**	2016 **13.9%**	○	2016 **19.8%**	★	2016 **17.0%**	N/A
Past-30-day cigarette smoking (high school students)	2011 **13.2%**	2017 **6.6%**	★	2017 **8.8%**	★	– –	N/A
Past-30-day cigarette smoking (middle school students)	2011 **3.5%**	2017 **1.2%**	★	2017 **1.9%**	★	– –	N/A

DOWNEAST DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

DOWNEAST DISTRICT POPULATION

86,408

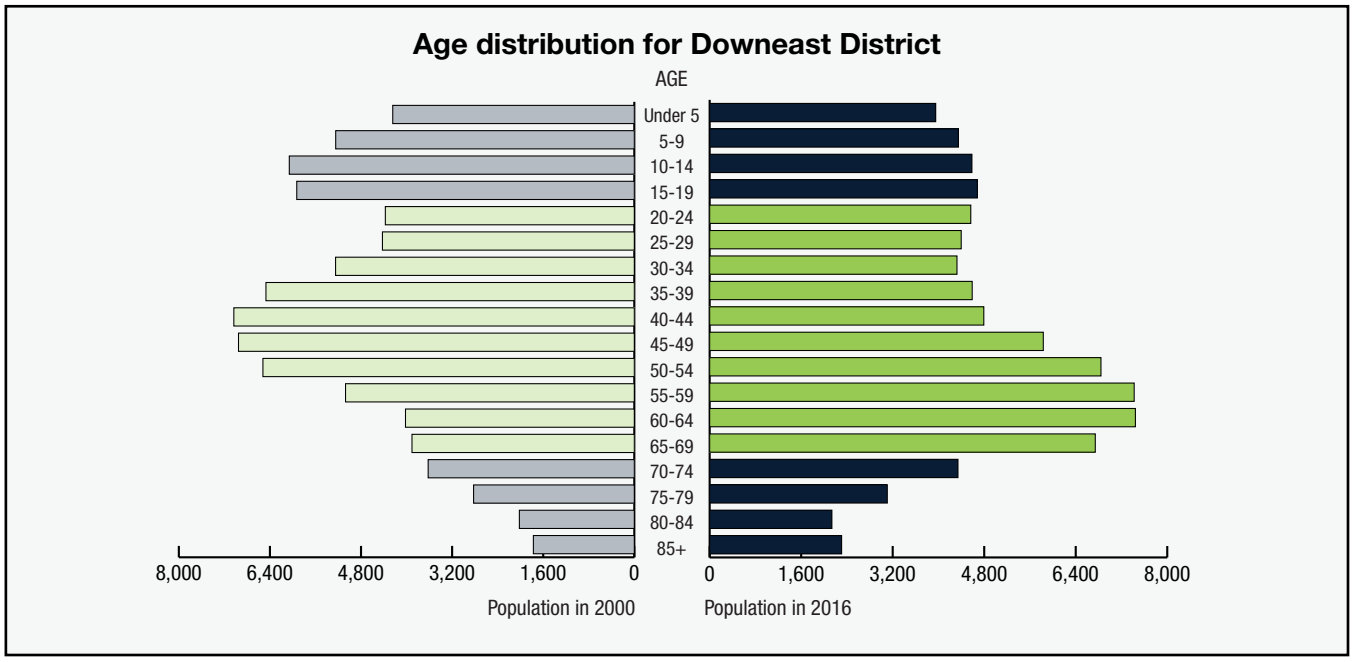
STATE OF MAINE POPULATION

1,329,923

	DOWNEAST DISTRICT	
	PERCENT	NUMBER
American Indian/Alaskan Native	1.9%	1,649
Asian	0.8%	672
Black/African American	0.5%	457
Hispanic	1.5%	1,292
Some other race	0.2%	191
Two or more races	2.1%	1,781
White	94.5%	81,629

	HANCOCK	WASHINGTON	MAINE
Median household income	$50,037	$39,469	$50,826
Unemployment rate	4.7%	6.0%	3.8%
Individuals living in poverty	12.1%	18.0%	13.5%
Children living in poverty	15.5%	22.1%	17.2%
65+ living alone	46.2%	—	45.3%

The chart below shows the shift in the age of the population for the district. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.

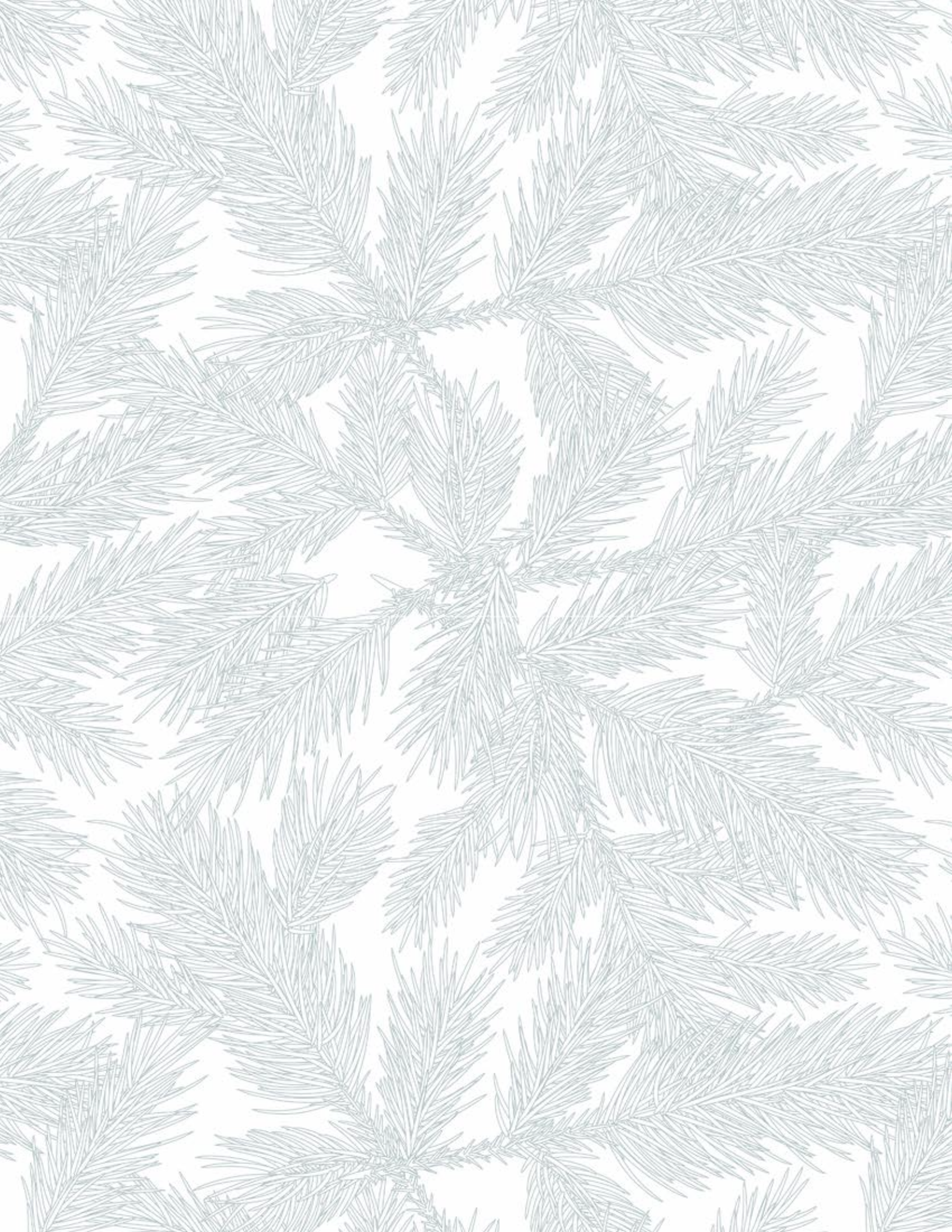


All data on this page is from the U.S. Census Bureau, American Community Survey 2012-2016, with the exception of the unemployment rate, for which the source is the U.S. Bureau of Labor Statistics, 2015-2017.

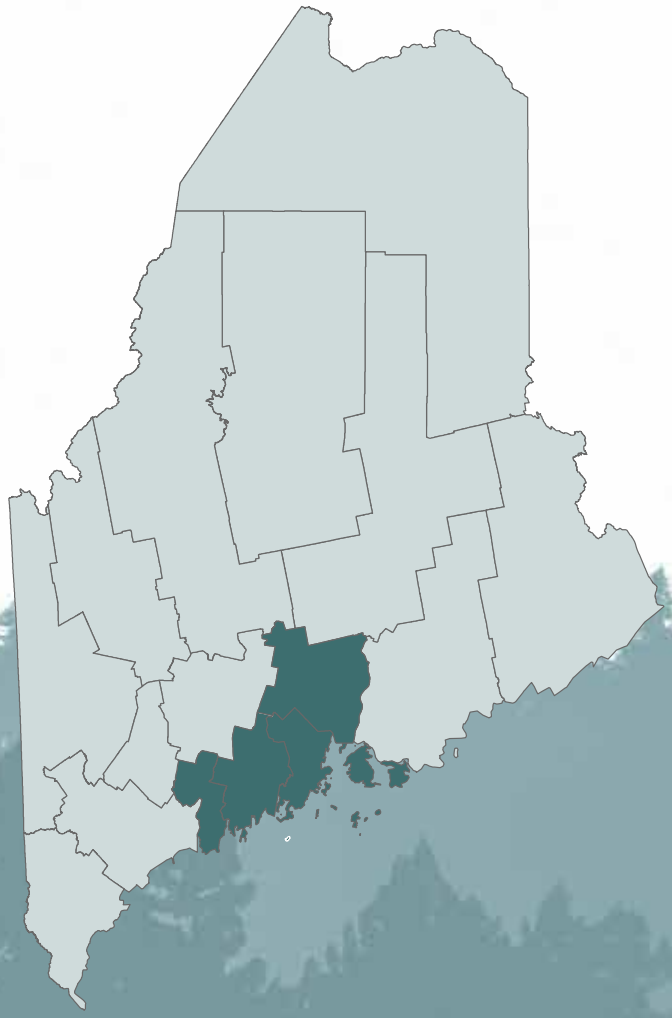
	BENCHMARK	DOWNEAST DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**HANCOCK**	**+/–**	**WASHINGTON**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2012-2016 **17.2%**	2012-2016 **18.0%**	N/A	2012-2016 **15.5%**	N/A	2012-2016 **22.1%**	N/A
Median household income	2012-2016 **$50,826**	**–**	N/A	2012-2016 **$50,037**	N/A	2012-2016 **$39,469**	N/A
Estimated high school student graduation rate	2017 **86.9%**	2017 **88.1%**	N/A	2017 **88.3%**	N/A	2017 **87.7%**	N/A
Food insecurity	2014-2015 **15.1%**	**–**	N/A	2014-2015 **15.3%**	N/A	2014-2015 **16.9%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2014-2016 **19.6%**	2014-2016 **18.5%**	○	2014-2016 **16.9%**	○	2014-2016 **22.8%**	○
14 or more days lost due to poor mental health	2014-2016 **16.7%**	2014-2016 **14.8%**	○	2014-2016 **12.2%**	○	2014-2016 **20.1%**	○
Years of potential life lost per 100,000 population	2014-2016 **6,529.2**	**–**	○	2014-2016 **6,912.1**	○	2014-2016 **9,152.7**	!
All cancer deaths per 100,000 population	2012-2016 **173.8**	2012-2016 **177.5**	○	2012-2016 **160.2**	○	2012-2016 **207.3**	!
Cardiovascular disease deaths per 100,000 population	2012-2016 **195.8**	2012-2016 **203.0**	○	2012-2016 **191.3**	○	2012-2016 **222.3**	!
Diabetes	2014-2016 **10.0%**	2014-2016 **9.7%**	○	2014-2016 **7.8%**	★	2014-2016 **12.8%**	!
Chronic obstructive pulmonary disease (COPD)	2014-2016 **7.8%**	2014-2016 **7.1%**	○	2014-2016 **5.5%**	★	2014-2016 **9.7%**	○
Obesity (adults)	2016 **29.9%**	2016 **29.2%**	○	2016 **25.8%**	○	2016 **35.4%**	○
Obesity (high school students)	2017 **15.0%**	2017 **15.6%**	○	2017 **13.5%**	○	2017 **20.4%**	○
Obesity (middle school students)	2017 **15.3%**	2017 **15.3%**	○	2017 **12.0%**	○	2017 **24.1%**	!
Infant deaths per 1,000 live births	2012-2016 **6.5**	2012-2016 **6.0**	○	2012-2016 **6.0***	○	2012-2016 **5.3***	○
Cognitive decline	2016 **10.3%**	2016 **11.5%**	○	2016 **8.9*%**	○	2016 **15.5*%**	○
Lyme disease new cases per 100,000 population	2013-2017 **96.5**	2013-2017 **153.8**	N/A	2013-2017 **213.8**	N/A	2013-2017 **50.4**	N/A

	BENCHMARK	DOWNEAST DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**HANCOCK**	**+/–**	**WASHINGTON**	**+/–**
HEALTH OUTCOMES (CONTINUED)							
Chlamydia new cases per 100,000 population	2013-2017 **293.4**	2013-2017 **192.7**	N/A	2013-2017 **173.6**	N/A	2013-2017 **225.6**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2012-2014 **340.9**	2012-2014 **364.8**	!	2012-2014 **314.9**	★	2012-2014 **449.8**	!
Suicide deaths per 100,000 population	2012-2016 **15.9**	2012-2016 **18.0**	○	2012-2016 **16.9**	○	2012-2016 **20.0**	○
Overdose deaths per 100,000 population	2012-2016 **18.1**	2012-2016 **25.0**	!	2012-2016 **19.1**	○	2012-2016 **35.4**	!
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2012-2016 **9.5%**	2012-2016 **12.8%**	N/A	2012-2016 **12.9%**	N/A	2012-2016 **12.7%**	N/A
Ratio of primary care physicians to 100,000 population	2017 **67.3**	2017 **52.6**	N/A	2017 **64.5**	N/A	2017 **30.0**	N/A
Ratio of psychiatrists to 100,000 population	2017 **8.4**	2017 **3.7**	N/A	2017 **5.0**	N/A	2017 **1.5**	N/A
Ratio of practicing dentists to 100,000 population	2017 **32.1**	2017 **27.6**	N/A	2017 **26.1**	N/A	2017 **30.0**	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	2016 **74.6**	2016 **96.6**	N/A	2016 **82.8**	N/A	2016 **119.9**	N/A
Two-year-olds up-to-date with recommended immunizations	2017 **73.7%**	2017 **77.5%**	N/A	2017 **72.0%**	N/A	2017 **87.2%**	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2016 **20.6%**	2016 **18.0%**	○	2016 **14.0%**	★	2016 **25.3%**	○
Chronic heavy drinking (adults)	2014-2016 **7.6%**	2014-2016 **8.9%**	○	2014-2016 **9.9%**	○	2014-2016 **7.3%**	○
Past-30-day alcohol use (high school students)	2017 **22.5%**	2017 **24.3%**	○	2017 **24.9%**	○	2017 **23.4%**	○
Past-30-day alcohol use (middle school students)	2017 **3.7%**	2017 **3.4%**	○	2017 **3.8%**	○	2017 **2.5%**	○
Past-30-day marijuana use (high school students)	2017 **19.3%**	2017 **18.8%**	○	2017 **18.6%**	○	2017 **19.8%**	○
Past-30-day marijuana use (middle school students)	2017 **3.6%**	2017 **3.0%**	○	2017 **2.2%**	○	2017 **4.9%**	○

	BENCHMARK	DOWNEAST DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**HANCOCK**	**+/–**	**WASHINGTON**	**+/–**
HEALTH BEHAVIORS (CONTINUED)							
Past-30-day misuse of prescription drugs (high school students)	2017 **5.9%**	2017 **4.2%**	★	2017 **3.7%**	★	2017 **5.0%**	○
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.5%**	2017 **1.1%**	○	2017 **0.9%**	○	2017 **1.6%**	○
Current (every day or some days) smoking (adults)	2016 **19.8%**	2016 **22.1%**	○	2016 **21.3%**	○	2016 **23.6%**	○
Past-30-day cigarette smoking (high school students)	2017 **8.8%**	2017 **8.8%**	○	2017 **7.0%**	○	2017 **12.3%**	!
Past-30-day cigarette smoking (middle school students)	2017 **1.9%**	2017 **1.7%**	○	2017 **1.3%**	○	2017 **2.5%**	○



MIDCOAST DISTRICT



DEMOGRAPHICS

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MIDCOAST DISTRICT POPULATION

148,087

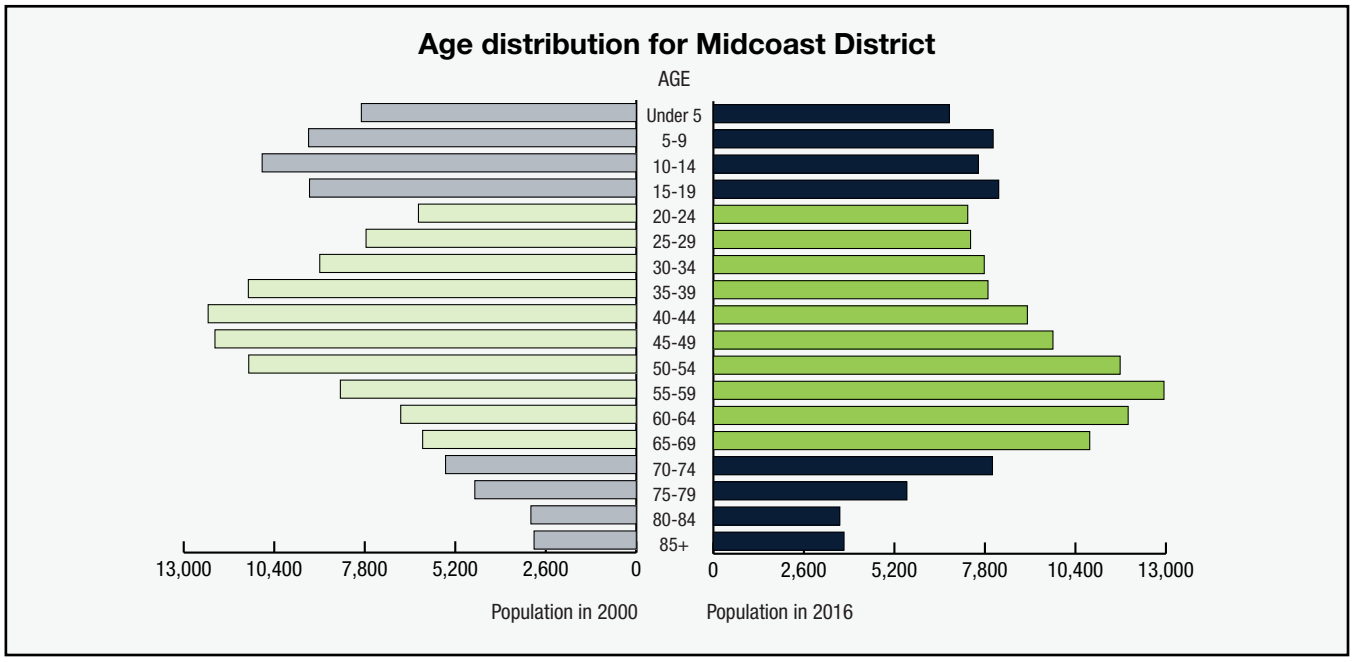
STATE OF MAINE POPULATION

1,329,923

	MIDCOAST DISTRICT	
	PERCENT	NUMBER
American Indian/Alaskan Native	0.4%	572
Asian	0.9%	1,298
Black/African American	0.5%	785
Hispanic	1.2%	1,809
Some other race	0.1%	168
Two or more races	1.6%	2,371
White	96.5%	142,891

	KNOX	LINCOLN	SAGADAHOC	WALDO	MAINE
Median household income	$52,239	$53,515	$55,766	$45,480	$50,826
Unemployment rate	3.6%	3.8%	3.1%	4.3%	3.8%
Individuals living in poverty	11.9%	12.1%	10.7%	16.0%	13.5%
Children living in poverty	15.5%	18.5%	17.2%	20.2%	17.2%
65+ living alone	47.1%	41.5%	—	42.5%	45.3%

The chart below shows the shift in the age of the population for the district. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



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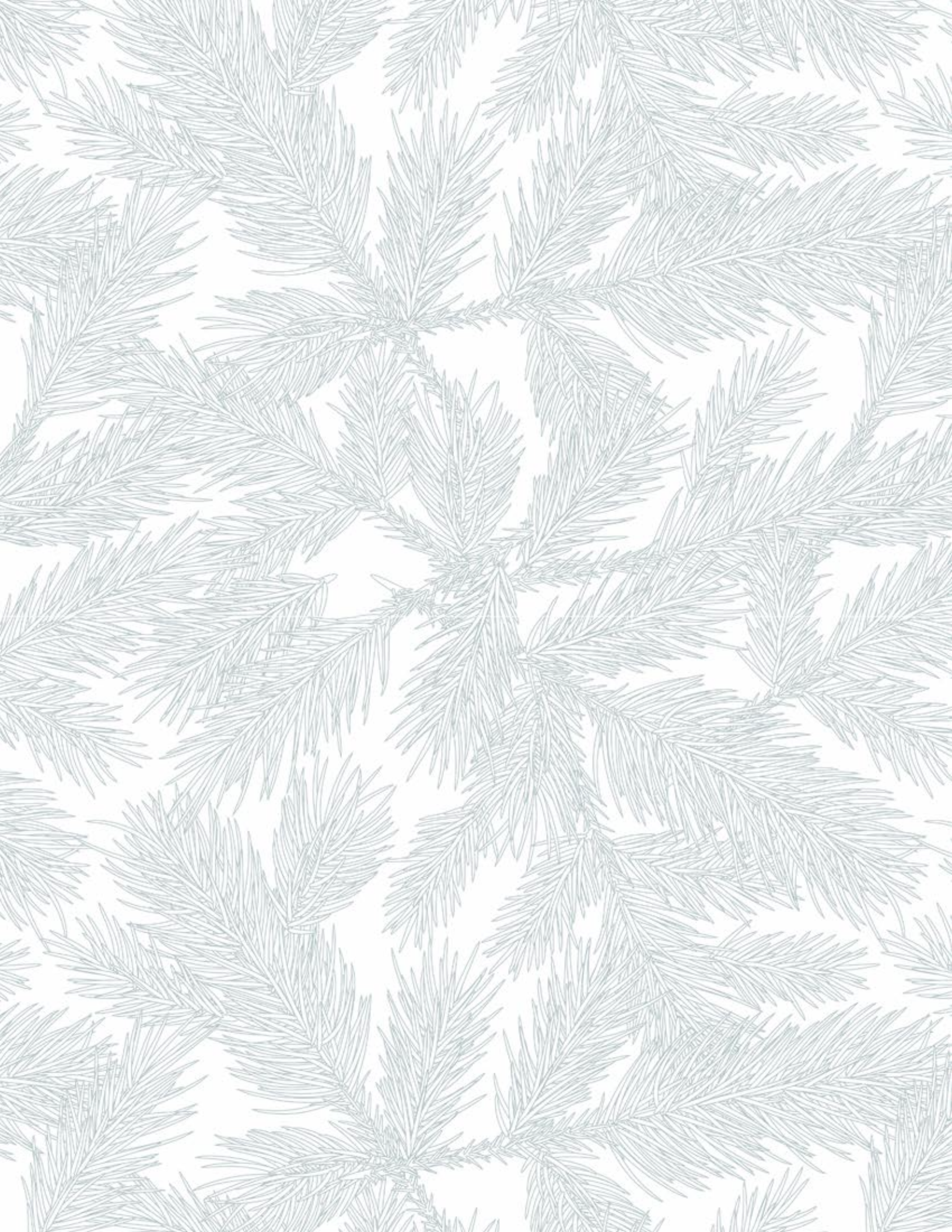
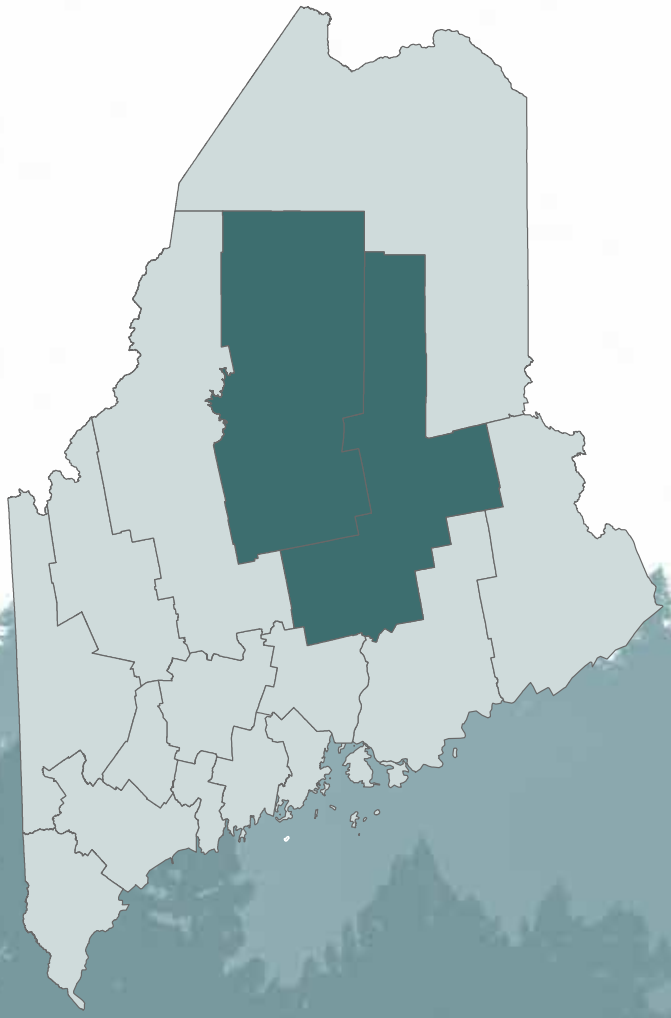
	BENCHMARK	MIDCOAST DISTRICT									
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**KNOX**	**+/–**	**LINCOLN**	**+/–**	**SAG.**	**+/–**	**WALDO**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT											
Children living in poverty	2012-2016 **17.2%**	2012-2016 **17.8%**	N/A	2012-2016 **15.5%**	N/A	2012-2016 **18.5%**	N/A	–	N/A	2012-2016 **20.2%**	N/A
Median household income	2012-2016 **$50,826**	–	N/A	2012-2016 **$52,239**	N/A	2012-2016 **$53,515**	N/A	2012-2016 **$55,766**	N/A	2012-2016 **$45,480**	N/A
Estimated high school student graduation rate	2017 **86.9%**	2017 **87.5%**	N/A	2017 **91.8%**	N/A	2017 **88.0%**	N/A	2017 **84.8%**	N/A	2017 **86.1%**	N/A
Food insecurity	2014-2015 **15.1%**	–	N/A	2014-2015 **13.4%**	N/A	2014-2015 **13.4%**	N/A	2014-2015 **13.2%**	N/A	2014-2015 **15.1%**	N/A
HEALTH OUTCOMES											
14 or more days lost due to poor physical health	2014-2016 **19.6%**	2014-2016 **17.9%**	○	2014-2016 **15.5%**	○	2014-2016 **17.3%**	○	2014-2016 **24.1%**	○	2014-2016 **19.0%**	○
14 or more days lost due to poor mental health	2014-2016 **16.7%**	2014-2016 **13.0%**	★	2014-2016 **10.1%**	★	2014-2016 **11.8%**	★	2014-2016 **15.8%**	○	2014-2016 **16.8%**	○
Years of potential life lost per 100,000 population	2014-2016 **6,529.2**	–	N/A	2014-2016 **6,260.2**	○	2014-2016 **6,887.6**	○	2014-2016 **5,724.0**	○	2014-2016 **6,870.4**	○
All cancer deaths per 100,000 population	2012-2016 **173.8**	2012-2016 **169.0**	○	2012-2016 **166.7**	○	2012-2016 **164.4**	○	2012-2016 **183.4**	○	2012-2016 **165.5**	○
Cardiovascular disease deaths per 100,000 population	2012-2016 **195.8**	2012-2016 **190.9**	○	2012-2016 **177.8**	★	2012-2016 **187.0**	○	2012-2016 **194.3**	○	2012-2016 **208.8**	○
Diabetes	2014-2016 **10.0%**	2014-2016 **8.9%**	○	2014-2016 **7.9%**	○	2014-2016 **8.6%**	○	2014-2016 **9.8%**	○	2014-2016 **9.5%**	○
Chronic obstructive pulmonary disease (COPD)	2014-2016 **7.8%**	2014-2016 **6.8%**	○	2014-2016 **6.0%**	○	2014-2016 **6.6%**	○	2014-2016 **7.7%**	○	2014-2016 **7.3%**	○
Obesity (adults)	2016 **29.9%**	2016 **27.3%**	○	2016 **28.8%**	○	2016 **23.8%**	○	2016 **25.2%**	○	2016 **30.5%**	○
Obesity (high school students)	2017 **15.0%**	2017 **14.8%**	○	2017 **14.0%**	○	2017 **13.5%**	○	2017 **14.2%**	○	2017 **21.7%**	!
Obesity (middle school students)	2017 **15.3%**	2017 **14.3%**	○	2017 **11.4%**	○	2017 **18.7%**	○	2017 **13.5%**	○	2017 **13.1%**	○
Infant deaths per 1,000 live births	2012-2016 **6.5**	2012-2016 **6.4**	○	2012-2016 **5.2***	○	2012-2016 **6.6***	○	2012-2016 **5.4**	○	2012-2016 **8.5***	○
Cognitive decline	2016 **10.3%**	2016 **8.3%**	○	2016 **6.4*%**	○	2016 **8.2*%**	○	2016 **11.6*%**	○	2016 **7.3*%**	○
Lyme disease new cases per 100,000 population	2013-2017 **96.5**	2013-2017 **200.1**	N/A	2013-2017 **233.6**	N/A	2013-2017 **193.4**	N/A	2013-2017 **156.9**	N/A	2013-2017 **210.9**	N/A

INDICATOR	BENCHMARK MAINE	MIDCOAST DISTRICT DISTRICT	+/–	KNOX	+/–	LINCOLN	+/–	SAG.	+/–	WALDO	+/–
HEALTH OUTCOMES (CONTINUED)											
Chlamydia new cases per 100,000 population	2013-2017 **293.4**	2013-2017 **225.5**	N/A	2013-2017 **226.1**	N/A	2013-2017 **189.9**	N/A	2013-2017 **260.4**	N/A	2013-2017 **224.6**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2012-2014 **340.9**	2012-2014 **360.3**	!	2012-2014 **411.5**	!	2012-2014 **294.4**	★	2012-2014 **335.0**	○	2012-2014 **387.6**	!
Suicide deaths per 100,000 population	2012-2016 **15.9**	2012-2016 **16.8**	○	2012-2016 **15.1**	○	2012-2016 **16.8**	○	2012-2016 **15.7**	○	2012-2016 **19.4**	○
Overdose deaths per 100,000 population	2012-2016 **18.1**	2012-2016 **15.8**	○	2012-2016 **15.8**	○	2012-2016 **19.2**	○	2012-2016 **10.3**	★	2012-2016 **18.2**	○
HEALTH CARE ACCESS AND QUALITY											
Uninsured	2012-2016 **9.5%**	2012-2016 **10.9%**	N/A	2012-2016 **12.4%**	N/A	2012-2016 **11.4%**	N/A	2012-2016 **7.8%**	N/A	2012-2016 **11.9%**	N/A
Ratio of primary care physicians to 100,000 population	2017 **67.3**	2017 **56.3**	N/A	2017 **62.5**	N/A	2017 **60.2**	N/A	2017 **36.3**	N/A	2017 **64.8**	N/A
Ratio of psychiatrists to 100,000 population	2017 **8.4**	2017 **6.7**	N/A	2017 **16.3**	N/A	2017 **0.0**	N/A	2017 **1.7**	N/A	2017 **7.2**	N/A
Ratio of practicing dentists to 100,000 population	2017 **32.1**	2017 **29.0**	N/A	2017 **39.8**	N/A	2017 **20.8**	N/A	2017 **37.1**	N/A	2017 **17.8**	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	2016 **74.6**	2016 **75.1**	N/A	2016 **59.7**	N/A	2016 **86.8**	N/A	2016 **66.0**	N/A	2016 **92.8**	N/A
Two-year-olds up-to-date with recommended immunizations	2017 **73.7%**	2017 **68.4%**	N/A	2017 **73.1%**	N/A	2017 **73.1%**	N/A	2017 **50.9%**	N/A	2017 **59.9%**	N/A
HEALTH BEHAVIORS											
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2016 **20.6%**	2016 **18.1%**	○	2016 **17.4%**	○	2016 **17.2%**	○	2016 **13.9%**	○	2016 **23.4%**	○
Chronic heavy drinking (adults)	2014-2016 **7.6%**	2014-2016 **8.3%**	○	2014-2016 **8.9%**	○	2014-2016 **9.0%**	○	2014-2016 **8.5%**	○	2014-2016 **6.6%**	○
Past-30-day alcohol use (high school students)	2017 **22.5%**	2017 **21.2%**	○	2017 **25.2%**	!	2017 **19.3%**	○	2017 **19.5%**	○	2017 **21.9%**	○
Past-30-day alcohol use (middle school students)	2017 **3.7%**	2017 **4.3%**	○	2017 **5.9%**	○	2017 **3.4%**	○	2017 **4.3%**	○	2017 **4.3%**	○
Past-30-day marijuana use (high school students)	2017 **19.3%**	2017 **22.1%**	○	2017 **25.8%**	○	2017 **21.9%**	○	2017 **19.4%**	○	2017 **21.5%**	!
Past-30-day marijuana use (middle school students)	2017 **3.6%**	2017 **3.9%**	○	2017 **5.6%**	○	2017 **2.9%**	○	2017 **4.9%**	○	2017 **3.0%**	○

INDICATOR	BENCHMARK MAINE	MIDCOAST DISTRICT DISTRICT	+/–	KNOX	+/–	LINCOLN	+/–	SAG.	+/–	WALDO	+/–
HEALTH BEHAVIORS (CONTINUED)											
Past-30-day misuse of prescription drugs (high school students)	2017 **5.9%**	2017 **5.7%**	○	2017 **4.7%**	★	2017 **5.3%**	○	2017 **7.1%**	○	2017 **5.3%**	○
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.5%**	2017 **1.3%**	○	2017 **1.5%**	○	–	N/A	2017 **1.2%**	○	2017 **2.1%**	○
Current (every day or some days) smoking (adults)	2016 **19.8%**	2016 **18.1%**	○	2016 **14.2%**	○	2016 **19.9%**	○	2016 **17.0*%**	○	2016 **21.5%**	○
Past-30-day cigarette smoking (high school students)	2017 **8.8%**	2017 **10.1%**	○	2017 **9.5%**	○	2017 **9.6%**	○	2017 **9.5%**	○	2017 **13.7%**	!
Past-30-day cigarette smoking (middle school students)	2017 **1.9%**	2017 **2.2%**	○	2017 **3.3%**	!	2017 **1.8%**	○	2017 **2.6%**	○	2017 **1.6%**	○



PENQUIS DISTRICT



DEMOGRAPHICS

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PENQUIS DISTRICT POPULATION

170,022

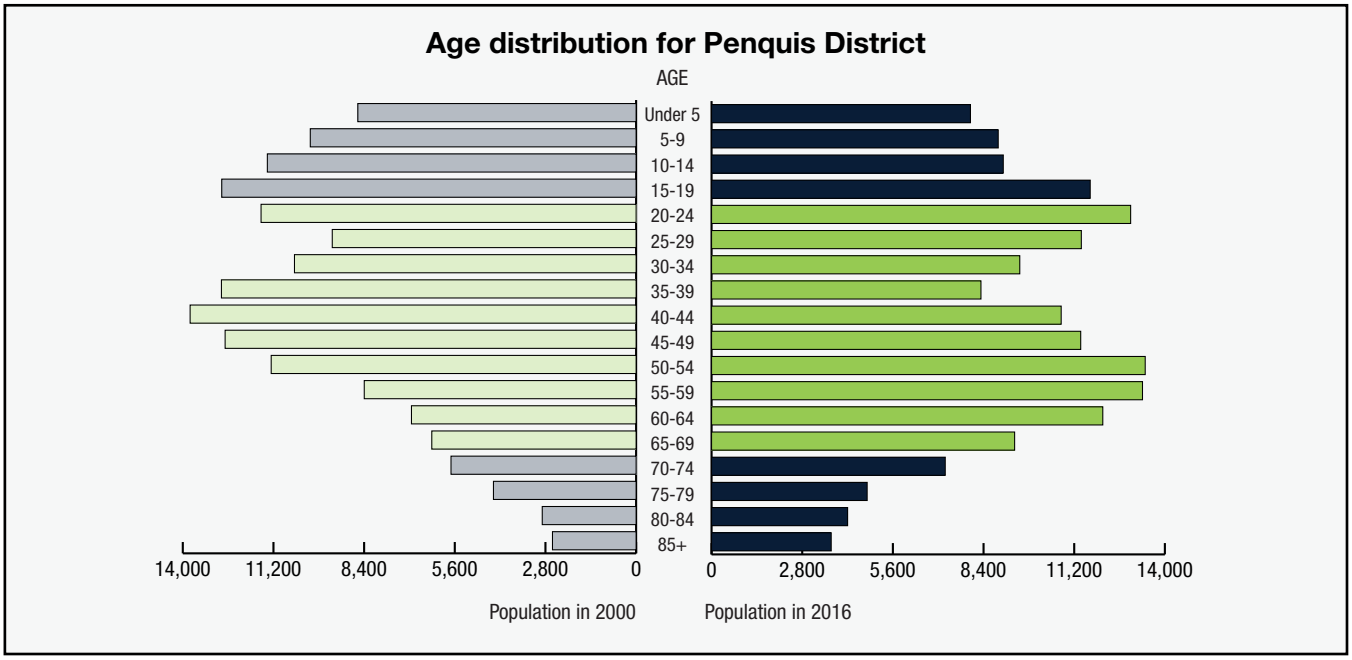
STATE OF MAINE POPULATION

1,329,923

	PENQUIS DISTRICT	
	PERCENT	NUMBER
American Indian/Alaskan Native	1.1%	1,845
Asian	1.1%	1,788
Black/African American	0.7%	1,262
Hispanic	1.2%	2,105
Some other race	0.2%	327
Two or more races	1.7%	2,899
White	95.2%	161,873

	PENOBSCOT	PISCATAQUIS	MAINE
Median household income	$45,302	$36,938	$50,826
Unemployment rate	4.3%	5.1%	3.8%
Individuals living in poverty	16.3%	20.6%	13.5%
Children living in poverty	18.3%	31.4%	17.2%
65+ living alone	44.5%	—	45.3%

The chart below shows the shift in the age of the population for the district. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



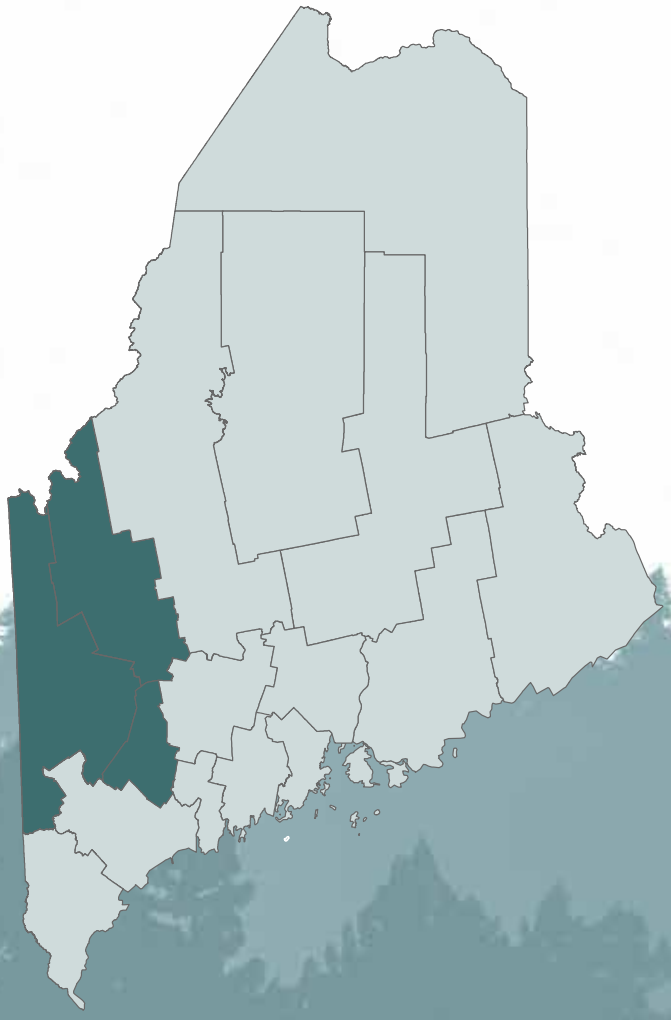
All data on this page is from the U.S. Census Bureau, American Community Survey 2012-2016, with the exception of the unemployment rate, for which the source is the U.S. Bureau of Labor Statistics, 2015-2017.

	BENCHMARK	PENQUIS DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**PENOBSCOT**	**+/–**	**PISCATAQUIS**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2012-2016 **17.2%**	2012-2016 **19.5%**	N/A	2012-2016 **18.3%**	N/A	2012-2016 **31.4%**	N/A
Median household income	2012-2016 **$50,826**	–	N/A	2012-2016 **$45,302**	N/A	2012-2016 **$36,938**	N/A
Estimated high school student graduation rate	2017 **86.9%**	2017 **87.7%**	N/A	2017 **88.3%**	N/A	2017 **83.3%**	N/A
Food insecurity	2014-2015 **15.1%**	–	N/A	2014-2015 **16.2%**	N/A	2014-2015 **16.8%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2014-2016 **19.6%**	2014-2016 **26.3%**	!	2014-2016 **27.0%**	!	2014-2016 **29.7%**	!
14 or more days lost due to poor mental health	2014-2016 **16.7%**	2014-2016 **23.3%**	!	2014-2016 **23.9%**	!	2014-2016 **24.2%**	○
Years of potential life lost per 100,000 population	2014-2016 **6,529.2**	–	N/A	2014-2016 **6,931.3**	○	2014-2016 **8,138.9**	○
All cancer deaths per 100,000 population	2012-2016 **173.8**	2012-2016 **180.6**	○	2012-2016 **176.7**	○	2012-2016 **206.6**	!
Cardiovascular disease deaths per 100,000 population	2012-2016 **195.8**	2012-2016 **219.1**	!	2012-2016 **216.7**	!	2012-2016 **238.2**	!
Diabetes	2014-2016 **10.0%**	2014-2016 **10.3%**	○	2014-2016 **10.3%**	○	2014-2016 **9.8%**	○
Chronic obstructive pulmonary disease (COPD)	2014-2016 **7.8%**	2014-2016 **8.3%**	○	2014-2016 **8.1%**	○	2014-2016 **10.5%**	○
Obesity (adults)	2016 **29.9%**	2016 **35.1%**	○	2016 **35.1%**	○	2016 **35.1%**	○
Obesity (high school students)	2017 **15.0%**	2017 **17.4%**	○	2017 **16.8%**	○	2017 **23.0%**	!
Obesity (middle school students)	2017 **15.3%**	2017 **17.4%**	○	2017 **17.5%**	○	2017 **18.0%**	○
Infant deaths per 1,000 live births	2012-2016 **6.5**	2012-2016 **7.9**	○	2012-2016 **8.1**	○	2012-2016 **8.3***	N/A
Cognitive decline	2016 **10.3%**	2016 **10.3%**	○	2016 **10.2*%**	○	2016 **11.2*%**	○
Lyme disease new cases per 100,000 population	2013-2017 **96.5**	2013-2017 **39.5**	N/A	2013-2017 **42.2**	N/A	2013-2017 **15.3**	N/A

INDICATOR	BENCHMARK MAINE	PENQUIS DISTRICT DISTRICT	+/–	PENOBSCOT	+/–	PISCATAQUIS	+/–
HEALTH OUTCOMES (CONTINUED)							
Chlamydia new cases per 100,000 population	2013-2017 **293.4**	2013-2017 **322.7**	N/A	2013-2017 **339.2**	N/A	2013-2017 **173.6**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2012-2014 **340.9**	2012-2014 **296.4**	★	2012-2014 **283.7**	★	2012-2014 **420.6**	!
Suicide deaths per 100,000 population	2012-2016 **15.9**	2012-2016 **15.0**	○	2012-2016 **14.8**	○	2012-2016 **16.3*%**	○
Overdose deaths per 100,000 population	2012-2016 **18.1**	2012-2016 **16.9**	○	2012-2016 **17.0**	○	2012-2016 **17.7**	○
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2012-2016 **9.5%**	2012-2016 **10.7%**	N/A	2012-2016 **10.5%**	N/A	2012-2016 **12.8%**	N/A
Ratio of primary care physicians to 100,000 population	2017 **67.3**	2017 **55.2**	N/A	2017 **59.5**	N/A	2017 **18.3**	N/A
Ratio of psychiatrists to 100,000 population	2017 **8.4**	2017 **5.7**	N/A	2017 **5.7**	N/A	2017 **5.7**	N/A
Ratio of practicing dentists to 100,000 population	2017 **32.1**	2017 **32.9**	N/A	2017 **35.0**	N/A	2017 **14.8**	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	2016 **74.6**	2016 **97.0**	N/A	2016 **96.6**	N/A	2016 **99.3**	N/A
Two-year-olds up-to-date with recommended immunizations	2017 **73.7%**	2017 **77.5%**	N/A	2017 **78.6%**	N/A	2017 **62.5%**	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2016 **20.6%**	2016 **22.8%**	○	2016 **22.7%**	○	2016 **23.5%**	○
Chronic heavy drinking (adults)	2014-2016 **7.6%**	2014-2016 **6.5%**	○	2014-2016 **6.6%**	○	2014-2016 **5.6%**	○
Past-30-day alcohol use (high school students)	2017 **22.5%**	2017 **19.9%**	○	2017 **19.9%**	○	2017 **21.4%**	○
Past-30-day alcohol use (middle school students)	2017 **3.7%**	2017 **3.3%**	○	2017 **3.6%**	○	2017 **2.5%**	○
Past-30-day marijuana use (high school students)	2017 **19.3%**	2017 **16.6%**	○	2017 **16.5%**	○	2017 **19.4%**	○
Past-30-day marijuana use (middle school students)	2017 **3.6%**	2017 **2.9%**	○	2017 **2.7%**	○	2017 **3.6%**	○

	BENCHMARK	PENQUIS DISTRICT					
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**PENOBSCOT**	**+/–**	**PISCATAQUIS**	**+/–**
HEALTH BEHAVIORS (CONTINUED)							
Past-30-day misuse of prescription drugs (high school students)	2017 **5.9%**	2017 **4.9%**	○	2017 **5.0%**	○	2017 **3.6%**	★
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.5%**	2017 **1.6%**	○	2017 **1.7%**	○	2017 **3.6%**	!
Current (every day or some days) smoking (adults)	2016 **19.8%**	2016 **24.2%**	○	2016 **24.6%**	○	2016 **20.8%**	○
Past-30-day cigarette smoking (high school students)	2017 **8.8%**	2017 **9.2%**	○	2017 **8.8%**	○	2017 **14.5%**	!
Past-30-day cigarette smoking (middle school students)	2017 **1.9%**	2017 **1.4%**	○	2017 **1.4%**	○	–	N/A

WESTERN DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

WESTERN DISTRICT POPULATION

194,945

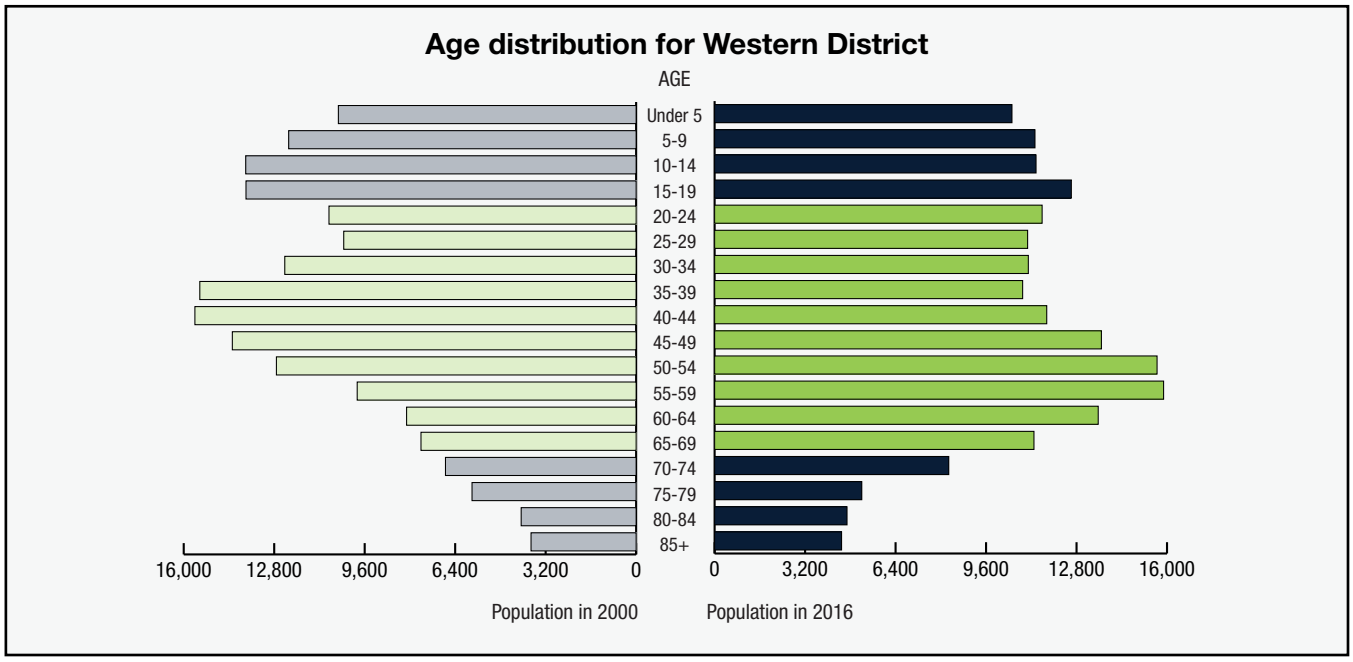
STATE OF MAINE POPULATION

1,329,923

	WESTERN DISTRICT	
	PERCENT	NUMBER
American Indian/Alaskan Native	0.3%	556
Asian	0.7%	1,320
Black/African American	1.1%	2,211
Hispanic	1.5%	2,933
Some other race	0.2%	406
Two or more races	3.4%	6,634
White	94.3%	183,777

	ANDROSCOGGIN	FRANKLIN	OXFORD	MAINE
Median household income	$48,728	$43,007	$42,197	$50,826
Unemployment rate	3.6%	4.3%	4.7%	3.8%
Individuals living in poverty	14.8%	14.1%	16.7%	13.5%
Children living in poverty	21.3%	16.2%	22.6%	17.2%
65+ living alone	47.5%	–	43.1%	45.3%

The chart below shows the shift in the age of the population for the district. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



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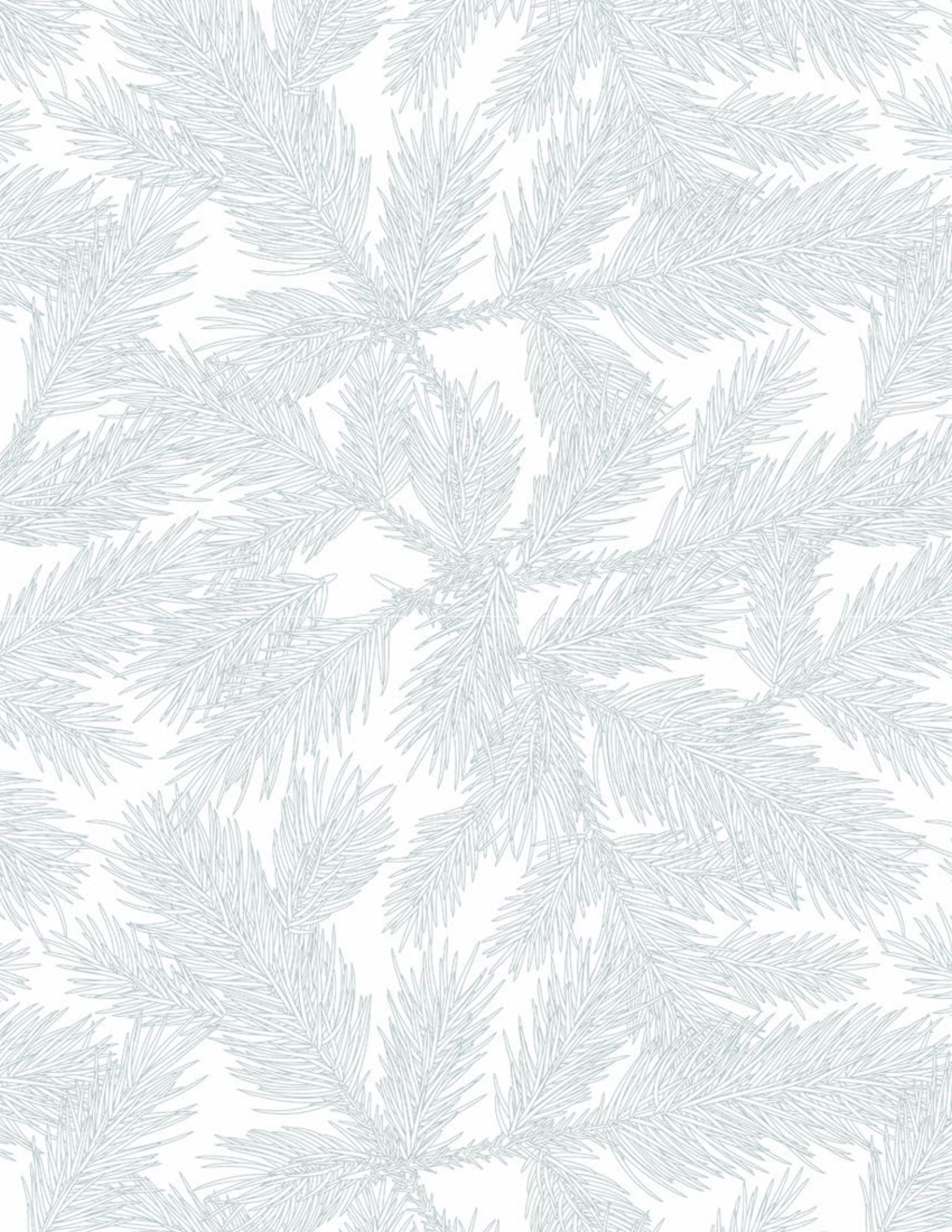
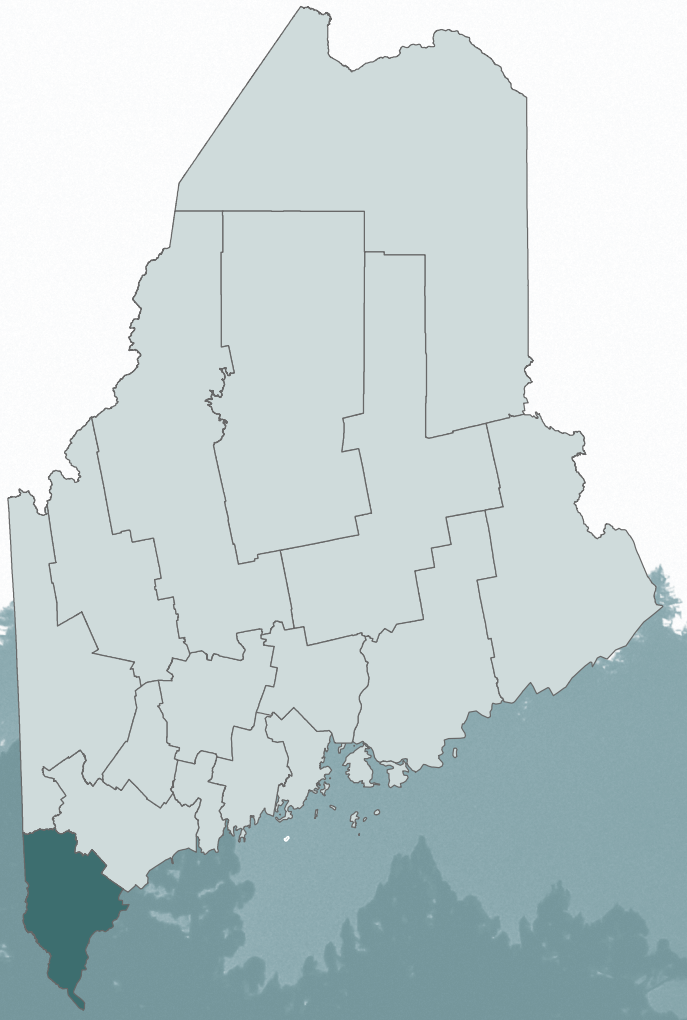
	BENCHMARK	WESTERN DISTRICT							
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**ANDRO.**	**+/–**	**FRANKLIN**	**+/–**	**OXFORD**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT									
Children living in poverty	2012-2016 **17.2%**	2012-2016 **21.0%**	N/A	2012-2016 **21.3%**	N/A	2012-2016 **16.2%**	N/A	2012-2016 **23.4%**	N/A
Median household income	2012-2016 **$50,826**	–	N/A	2012-2016 **$48,728**	N/A	2012-2016 **$43,007**	N/A	2012-2016 **$42,197**	N/A
Estimated high school student graduation rate	2017 **86.9%**	2017 **83.5%**	N/A	2017 **80.9%**	N/A	2017 **89.5%**	N/A	2017 **84.5%**	N/A
Food insecurity	2014-2015 **15.1%**	–	N/A	2014-2015 **16.0%**	N/A	2014-2015 **14.7%**	N/A	2014-2015 **15.4%**	N/A
HEALTH OUTCOMES									
14 or more days lost due to poor physical health	2014-2016 **19.6%**	2014-2016 **20.6%**	○	2014-2016 **20.9%**	○	2014-2016 **27.6%**	!	2014-2016 **19.6%**	○
14 or more days lost due to poor mental health	2014-2016 **16.7%**	2014-2016 **19.2%**	○	2014-2016 **19.6%**	○	2014-2016 **27.4%**	!	2014-2016 **17.5%**	○
Years of potential life lost per 100,000 population	2014-2016 **6,529.2**	–	N/A	2014-2016 **7,253.8**	○	2014-2016 **6,341.6**	○	2014-2016 **6,345.2**	○
All cancer deaths per 100,000 population	2012-2016 **173.8**	2012-2016 **178.2**	○	2012-2016 **178.0**	○	2012-2016 **164.0**	○	2012-2016 **186.1**	○
Cardiovascular disease deaths per 100,000 population	2012-2016 **195.8**	2012-2016 **208.4**	!	2012-2016 **218.0**	!	2012-2016 **218.8**	!	2012-2016 **187.2**	○
Diabetes	2014-2016 **10.0%**	2014-2016 **10.4%**	○	2014-2016 **10.9%**	○	2014-2016 **9.9%**	○	2014-2016 **9.8%**	○
Chronic obstructive pulmonary disease (COPD)	2014-2016 **7.8%**	2014-2016 **10.2%**	!	2014-2016 **10.3%**	!	2014-2016 **10.3%**	○	2014-2016 **9.9%**	○
Obesity (adults)	2016 **29.9%**	2016 **30.9%**	○	2016 **28.0%**	○	2016 **32.0%**	○	2016 **35.7%**	○
Obesity (high school students)	2017 **15.0%**	2017 **17.2%**	○	2017 **17.4%**	○	2017 **17.7%**	○	2017 **16.9%**	○
Obesity (middle school students)	2017 **15.3%**	2017 **19.1%**	!	2017 **18.4%**	!	2017 **21.5%**	○	2017 **18.6%**	○
Infant deaths per 1,000 live births	2012-2016 **6.5**	2012-2016 **6.3**	○	2012-2016 **7.3**	○	2012-2016 **5.5***	N/A	2012-2016 **4.7***	○
Cognitive decline	2016 **10.3%**	2016 **10.1%**	○	2016 **8.9*%**	○	2016 **14.0*%**	○	2016 **9.3*%**	○
Lyme disease new cases per 100,000 population	2013-2017 **96.5**	2013-2017 **69.3**	N/A	2013-2017 **67.6**	N/A	2013-2017 **71.0**	N/A	2013-2017 **71.6**	N/A

INDICATOR	BENCHMARK MAINE	WESTERN DISTRICT DISTRICT	+/–	ANDRO.	+/–	FRANKLIN	+/–	OXFORD	+/–
HEALTH OUTCOMES (CONTINUED)									
Chlamydia new cases per 100,000 population	2013-2017 293.4	2013-2017 393.1	N/A	2013-2017 495.9	N/A	2013-2017 246.1	N/A	2013-2017 277.6	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2012-2014 340.9	2012-2014 413.3	!	2012-2014 435.4	!	2012-2014 356.9	!	2012-2014 403.0	!
Suicide deaths per 100,000 population	2012-2016 15.9	2012-2016 15.9	○	2012-2016 17.4	○	2012-2016 13.8	○	2012-2016 14.0	○
Overdose deaths per 100,000 population	2012-2016 18.1	2012-2016 15.2	○	2012-2016 18.3	○	2012-2016 8.8	★	2012-2016 12.2	○
HEALTH CARE ACCESS AND QUALITY									
Uninsured	2012-2016 9.5%	2012-2016 9.7%	N/A	2012-2016 8.6%	N/A	2012-2016 10.9%	N/A	2012-2016 11.0%	N/A
Ratio of primary care physicians to 100,000 population	2017 67.3	2017 71.3	N/A	2017 86.3	N/A	2017 47.6	N/A	2017 56.1	N/A
Ratio of psychiatrists to 100,000 population	2017 8.4	2017 6.0	N/A	2017 10.0	N/A	2017 3.3	N/A	2017 0.0	N/A
Ratio of practicing dentists to 100,000 population	2017 32.1	2017 25.3	N/A	2017 28.1	N/A	2017 14.3	N/A	2017 25.9	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	2016 74.6	2016 80.8	N/A	2016 83.9	N/A	2016 90.8	N/A	2016 71.8	N/A
Two-year-olds up-to-date with recommended immunizations	2017 73.7%	2017 72.0%	N/A	2017 65.8%	N/A	2017 86.1%	N/A	2017 78.1%	N/A
HEALTH BEHAVIORS									
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2016 20.6%	2016 23.8%	○	2016 22.2%	○	2016 25.0%	○	2016 26.1	○
Chronic heavy drinking (adults)	2014-2016 7.6%	2014-2016 6.8%	○	2014-2016 6.6%	○	2014-2016 8.6%	○	2014-2016 6.2%	○
Past-30-day alcohol use (high school students)	2017 22.5%	2017 22.6%	○	2017 20.4%	○	2017 26.4%	○	2017 23.2%	○
Past-30-day alcohol use (middle school students)	2017 3.7%	2017 4.3%	○	2017 3.6%	○	2017 8.8%	○	2017 2.8%	○
Past-30-day marijuana use (high school students)	2017 19.3%	2017 21.6%	○	2017 20.2%	○	2017 22.5%	!	2017 22.7%	○
Past-30-day marijuana use (middle school students)	2017 3.6%	2017 5.2%	○	2017 4.7%	○	2017 7.7%	○	2017 4.5%	○

	BENCHMARK	WESTERN DISTRICT							
INDICATOR	**MAINE**	**DISTRICT**	**+/–**	**ANDRO.**	**+/–**	**FRANKLIN**	**+/–**	**OXFORD**	**+/–**
HEALTH BEHAVIORS (CONTINUED)									
Past-30-day misuse of prescription drugs (high school students)	2017 **5.9%**	2017 **6.7%**	○	2017 **7.5%**	○	2017 **6.0%**	○	2017 **6.4%**	○
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.5%**	2017 **1.5%**	○	2017 **1.6%**	○	2017 **1.6%**	○	2017 **1.2%**	○
Current (every day or some days) smoking (adults)	2016 **19.8%**	2016 **22.7%**	○	2016 **25.0%**	○	2016 **18.4%**	○	2016 **21.0%**	○
Past-30-day cigarette smoking (high school students)	2017 **8.8%**	2017 **9.9%**	○	2017 **7.7%**	○	2017 **13.1%**	!	2017 **10.6%**	!
Past-30-day cigarette smoking (middle school students)	2017 **1.9%**	2017 **2.9%**	○	2017 **3.1%**	○	2017 **3.5%**	○	2017 **2.0%**	○



YORK DISTRICT



DEMOGRAPHICS

The graphs and charts—as well as the maps on the following pages—show information about the make-up of Maine's counties. The differences in age, education, and poverty affect a wide range of health risks and outcomes.

YORK COUNTY POPULATION

200,536

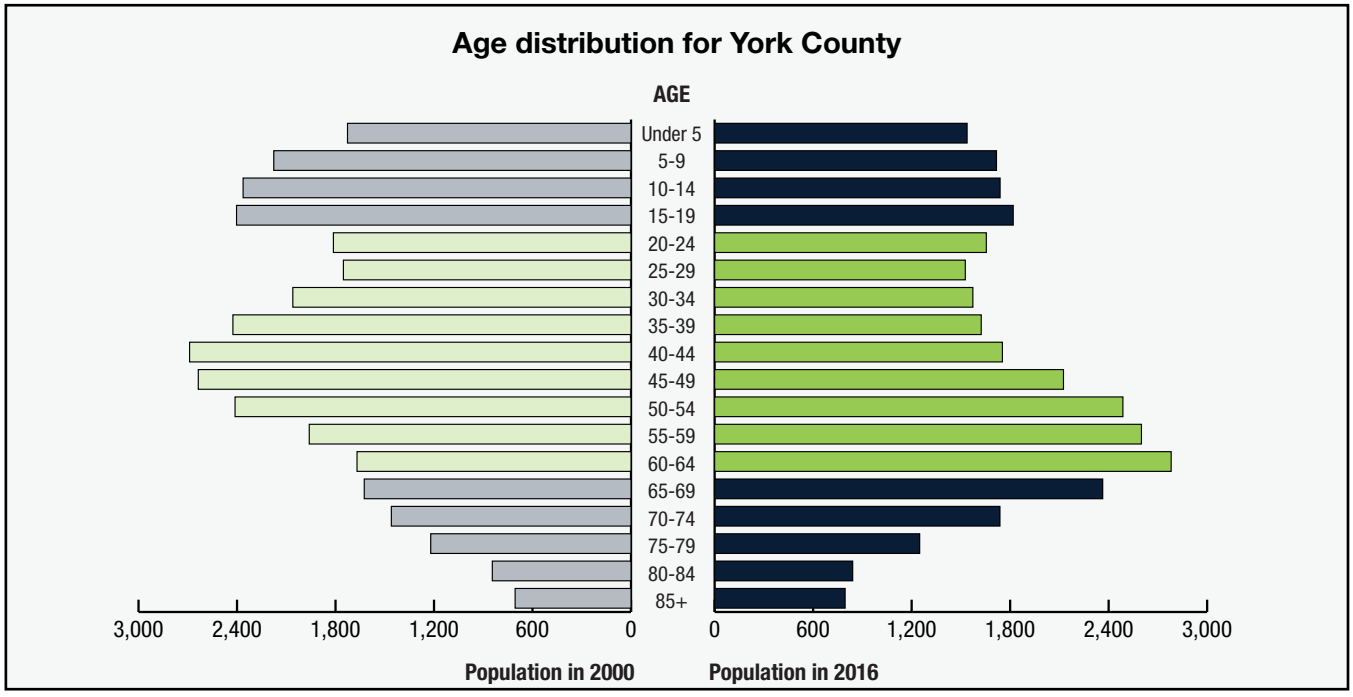
STATE OF MAINE POPULATION

1,329,923

	YORK	MAINE
Median household income	$59,132	$50,826
Unemployment rate	3.4%	3.8%
Individuals living in poverty	9.4%	13.5%
Children living in poverty	10.5%	17.2%
65+ living alone	43.6%	45.3%

	YORK COUNTY	
	PERCENT	NUMBER
American Indian/Alaskan Native	0.3%	697
Asian	1.1%	2,179
Black/African American	0.9%	1,745
Hispanic	1.6%	3,122
Some other race	0.1%	267
Two or more races	1.5%	2,972
White	96.1%	192,652

The chart below shows the shift in the age of the population. As Maine's population grows older, there is an impact on things such as increases in healthcare costs, decreases in number of caregivers, and a shortage in the supply of employees in the workforce, to name a few.



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	YORK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2007-2011 **10.5%**	2012-2016 **10.5%**	N/A	2012-2016 **17.2%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$56,552**	2012-2016 **$59,132**	N/A	2012-2016 **$50,826**	N/A	2016 **$57,617**	N/A
Estimated high school student graduation rate	2014 **89.0%**	2017 **89.0%**	N/A	2017 **86.9%**	N/A	–	N/A
Food insecurity	2012-2013 **13.6%**	2014-2015 **13.4%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2011-2013 **17.7%**	2014-2016 **20.9%**	○	2014-2016 **19.6%**	○	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **13.9%**	2014-2016 **16.9%**	○	2014-2016 **16.7%**	○	2016 **11.2%**	N/A
Years of potential life lost per 100,000 population	2010-2012 **5,473.7**	2014-2016 **6,010.5**	○	2014-2016 **6,529.2**	○	2014-2016 **6,658.0**	N/A
All cancer deaths per 100,000 population	2007-2011 **174.9**	2012-2016 **173.5**	○	2012-2016 **173.8**	○	2011-2015 **163.5**	!
Cardiovascular disease deaths per 100,000 population	2007-2011 **188.9**	2012-2016 **168.9**	★	2012-2016 **195.8**	★	2016 **218.2**	★
Diabetes	2011-2013 **9.4%**	2014-2016 **10.1%**	○	2014-2016 **10.0%**	○	2016 **10.5%**	○
Chronic obstructive pulmonary disease (COPD)	2011-2013 **8.0%**	2014-2016 **7.2%**	○	2014-2016 **7.8%**	○	2016 **6.3%**	○
Obesity (adults)	2011 **26.5%**	2016 **32.5%**	○	2016 **29.9%**	○	2016 **29.6%**	○
Obesity (high school students)	2011 **11.6%**	2017 **13.4%**	○	2017 **15.0%**	○	–	N/A
Obesity (middle school students)	2015 **10.8%**	2017 **14.6%**	○	2017 **15.3%**	○	–	N/A
Infant deaths per 1,000 live births	2007-2011 **4.9**	2012-2016 **5.4**	○	2012-2016 **6.5**	○	2012-2016 **5.9**	○
Cognitive decline	2012 **12.3*%**	2016 **10.0*%**	○	2016 **10.3%**	○	2016 **10.6%**	○
Lyme disease new cases per 100,000 population	2008-2012 **42.9**	2013-2017 **90.1**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **192.4**	2013-2017 **247.5**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **324.7**	2012-2014 **298.2**	★	2012-2014 **340.9**	★	–	N/A
Suicide deaths per 100,000 population	2007-2011 **16.2**	2012-2016 **16.7**	○	2012-2016 **15.9**	○	2016 **13.5**	!
Overdose deaths per 100,000 population	2007-2011 **12.4**	2012-2016 **21.3**	!	2012-2016 **18.1**	○	2016 **19.8**	○

	YORK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2009-2011 **9.1%**	2012-2016 **8.7%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ratio of primary care physicians rate to 100,000 population	–	2017 **62.4**	N/A	2017 **67.3**	N/A	–	N/A
Ratio of psychiatrists to 100,000 population	–	2017 **6.1**	N/A	2017 **8.4**	N/A	–	N/A
Ratio of practicing dentists to 100,000 population	2012 **68.9%**	2016 **63.6%**	○	2016 **63.3%**	○	–	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	–	2016 **62.1**	N/A	2016 **74.6**	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **78.6%**	2017 **64.0%**	N/A	2017 **73.7%**	N/A	–	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **19.9%**	2016 **19.2%**	○	2016 **20.6%**	○	2016 **23.2%**	N/A
Chronic heavy drinking (adults)	2011-2013 **8.2%**	2014-2016 **8.1%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)	2011 **29.3%**	2017 **23.4%**	○	2017 **22.5%**	○	–	N/A
Past-30-day alcohol use (middle school students)	2011 **6.0%**	2017 **3.3%**	★	2017 **3.7%**	○	–	N/A
Past-30-day marijuana use (high school students)	2011 **23.9%**	2017 **18.4%**	★	2017 **19.3%**	○	–	N/A
Past-30-day marijuana use (middle school students)	2011 **4.7%**	2017 **3.1%**	○	2017 **3.6%**	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **7.8%**	2017 **6.1%**	○	2017 **5.9%**	○	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	2011 **3.6%**	2017 **1.4%**	★	2017 **1.5%**	○	–	N/A
Current (every day or some days) smoking (adults)	2011-2012 **19.2%**	2016 **18.4%**	○	2016 **19.8%**	○	2016 **17.0%**	N/A
Past-30-day cigarette smoking (high school students)	2011 **15.5%**	2017 **8.5%**	★	2017 **8.8%**	○	–	N/A
Past-30-day cigarette smoking (middle school students)	2011 **4.3%**	2017 **2.5%**	○	2017 **1.9%**	○	–	N/A

ACKNOWLEDGMENTS

The **Maine Shared CHNA** is a collaboration between the Maine Center for Disease Control and Prevention (Maine CDC), Central Maine Healthcare, Northern Light Health, MaineGeneral Health, and MaineHealth.

Funding for the Maine Shared CHNA is provided by the partnering healthcare systems with generous in-kind support from the Maine CDC and countless community partners and stakeholder groups. These stakeholder groups include the Metrics Committee, Data Analysis Team, Community Engagement Committee, and of course the Steering Committee. Special thanks to the Maine Health Data Organization. John Snow, Inc. served as the contractor for this project www.jsi.com. For a complete listing please visit www.mainechna.org.

Significant analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. John Snow, Inc. provided analysis, methodology, and design support.

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Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
286 Water Street
Augusta, Maine 04333-0011

Statewide Coordinating Council for Public Health

Annual Report

2018

The Statewide Coordinating Council for Public Health (SCC) is required under Title 2, Section 104, to report annually to the Joint Standing Committee of Health and Human Services on progress made toward achieving and maintaining accreditation of the state public health system. The report also focuses on streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of public health services.

The Statewide Coordinating Council is a representative statewide body of public health stakeholders that engages in collaborative planning and coordination. Its members provide several key functions, including advising the Maine Center for Disease Control and Prevention on activities and expenditures related to the Public Health and Health Services Block Grant; collaborating in the development and implementation of the State Health Improvement Plan, and helping to determine how best to deliver essential public health services across the State in the most efficient, effective and evidence-based manner possible.

The Statewide Coordinating Council has been integrally involved in the planning and implementation of the improved local public health system that now exists in Maine. This document highlights key activities and successes of the infrastructure at both the state and local levels in 2018.

Accreditation

Maine CDC was accredited by the Public Health Accreditation Board (PHAB) in May of 2016. Annually, thereafter, Maine CDC is required to report to PHAB on activities that might influence continued accreditation, on the on-going work related to key public health planning documents, on performance management and quality improvement activities and on emerging issues. The Maine CDC shared these annual reports with the SCC, as well as collaborating on Maine Shared Community Health Needs Assessment (CHNA) and the State Health Improvement Plan (SHIP), two documents required by PHAB.

In late 2017, the SCC assisted the Maine CDC is selecting the current priorities for the SHIP:

- Cancer
- Chronic Disease
- Healthy Weight
- Mental Health
- Substance Use, including Tobacco

At the beginning of 2018, SCC member contributed the strategies included in the SHIP. In December, SCC members provided input to progress reporting and received updates on implementation.

The SCC also received regular reports on the progress on the most recent Maine Shared CHNA. This collaboration between Maine CDC, Central Maine Healthcare, Maine General Health, Maine Health, and Northern Light Health, begun as an initiative

of SCC. Two hundred indicators were analyzed and included in County, District and State Health Profiles. The indicators included four general types:

1. health status, such as deaths, hospitalizations, and diagnoses of chronic health conditions
2. health behaviors such as physical activity and nutrition,
3. access to health care such as provider ratios and health screening, and
4. factors regarding where people live, work, play and learn that influence health.

The SCC reviewed the data in the State Health Profile in September, and many members also attended community forums held across the state in the fall.

The data from the Shared CHNA health profiles, along with input from the community forums and key informant interviews scheduled for early 2019, will be used by the SCC to consider updates to the SHIP as well as by non-profit hospitals in Maine for the development of implementation strategies for their community benefit programs.

Effectiveness and Efficiencies

The Statewide Coordinating Council, Maine CDC, and many partners have worked over the past several years to streamline Maine's public health infrastructure. In 2018, the SCC continued oversight of district public health infrastructure by reviewing the activities of District Coordinating Councils (DCC) on a quarterly basis. In addition, the SCC has received updates on the implementation of a contract for four District Council Coordinators to staff DCC meetings and activities. This contract was put in place to streamline DCC support based on the available funding in 2018, and is funded through the Preventive Health and Health Services Block Grant (PHHS BG).

The SCC received regular updates on the PHHS BG as part of their advisory role. In March, it voted to approve Maine CDC's plan for this funding, based on preliminary information on the federal allocation. In June, they voted on a revised plan that accounted for a 10% increase in the funding, based on the actual allocation that was announced in early June. This funding includes support for:

1. Accreditation activities.
2. Community-based prevention activities reflected in the District Public Health Improvement Plans.
3. Epidemiological services, to support the collections and analysis of public health data, such as that used in the Maine Shared CHNA.
4. Social Media to help connect substance using pregnant women with treatment services.
5. Sexual violence prevention education.

Other topics that the SCC considered during the year included:

- Adverse Childhood Experiences
- High Intensity Drug Trafficking Areas (HIDTA) Heroin Response Strategy
- Prescription Monitoring Program
- Maine CDC's prevention services, addressing substance use prevention, tobacco use prevention, and physical activity and nutrition promotion

Northern Light Health

A Scaled Rural Prevention Network:
Addressing Food Insecurity in Northern Maine

Contributors	Doug Michael, MPH	Northern Light Health
	Jessica Shaffer, MS	Northern Light Health
	Anush Hansen, MS, MA	University of Southern Maine
	Brenda Joly, PhD, MPH	University of Southern Maine

12.13.2018 | *Maine Statewide Coordinating Council for Public Health*

CDC Partnerships to Improve Community Health

National Prevention Strategy

1. Healthy & Safe Community Environments
2. Expand Quality Preventive Services
3. Empempower People to Make Healthy Choices
4. Eliminate Health Disparities

Overview

- **Network Partners** – Northern Maine Rural Collaborative (NMRC)
- **Regional Context**
- **Health Factors**
- **Food Security Interventions**
- **Results** - Reach, Adoption and Network Engagement

Northern Maine Rural Collaborative Network Partners & Regional Context

Northern Light Health – Serving Maine

Northern
1. Home Care & Hospice
2. A. R. Gould Hospital
3. Homecare & Hospice

Maine Highlands
4. Charles A. Dean Hospital
5. Eastern Maine Medical Center
   Foundation
   Acadia Hospital
   Home Care & Hospice
   Rosscare
   Affiliated
6. Eastern Maine Medical Center
   Home Office
   Beacon Health
   Affiliated

Downeast Acadia
7. Maine Coast Hospital
   Home Care & Hospice
8. Blue Hill Hospital

Kennebec Valley
9. Sebasticook Valley Health
10. Inland Hospital
    Lakewood
    Home Care & Hospice

Southern
11. Mercy Hospital
    Home Care & Hospice
    Affiliated

Northern Maine Rural Collaborative Network Partners

Aroostook County Action Program

Power of Prevention

Mayo Community Outreach

Millinocket Regional Hospital

Healthy Acadia

Good Shepherd Food Bank

EMMC Clinical Research Center

415,000 Lives

Coastal Healthcare Alliance

Bangor Public Health

Healthy Sebasticook Valley

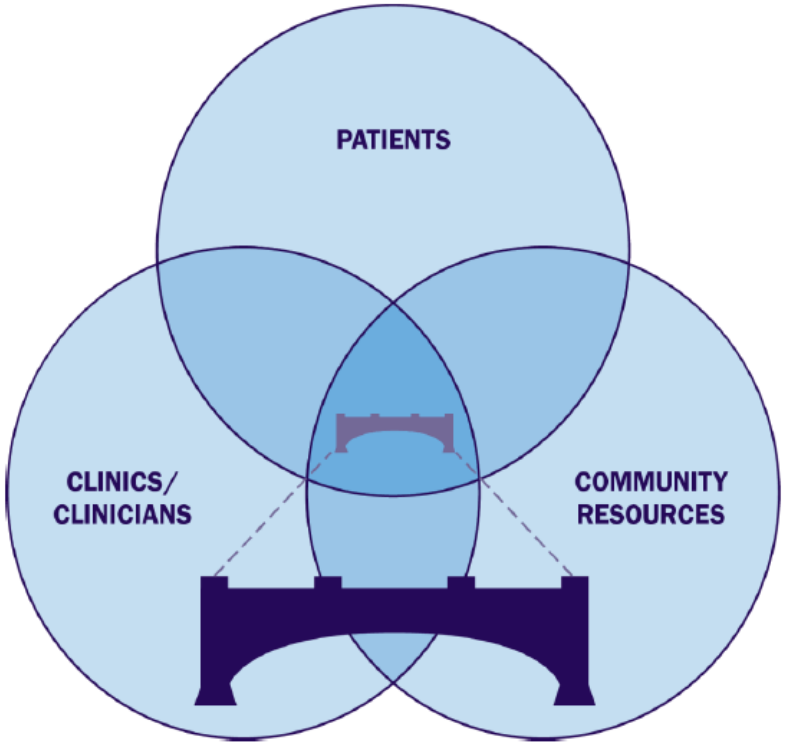
Somerset Public Health

VNA Home Health Hospice

United Way of Eastern Maine

USM Muskie School of Public Service

Northern Maine Rural Collaborative



Shared Network Goals

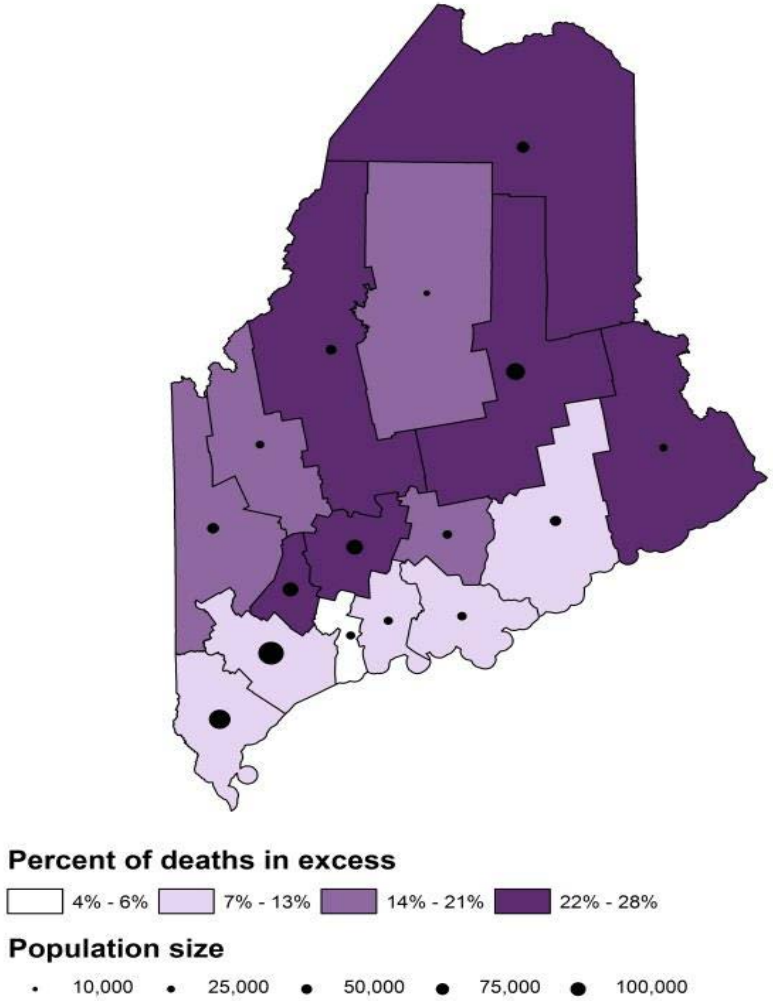
1. **Prevent Chronic Disease** using evidence-based population level strategies
2. **Link Community & Clinical Partners** to better connect patients with community supports
3. **Foster a Prevention Network** that could rapidly scale rural community health improvement

Population Health Factors & Disparities

Why Northern Maine?
Health Gaps – Excess Chronic Disease

Excess Chronic Disease Morbidity & Mortality
Demographic, Environmental & Behavioral Risk

- Aging
- Poverty/Household Income
- Cancer
- Food Insecurity



University of Wisconsin, Population Health Institutes Health Gaps Report 2015

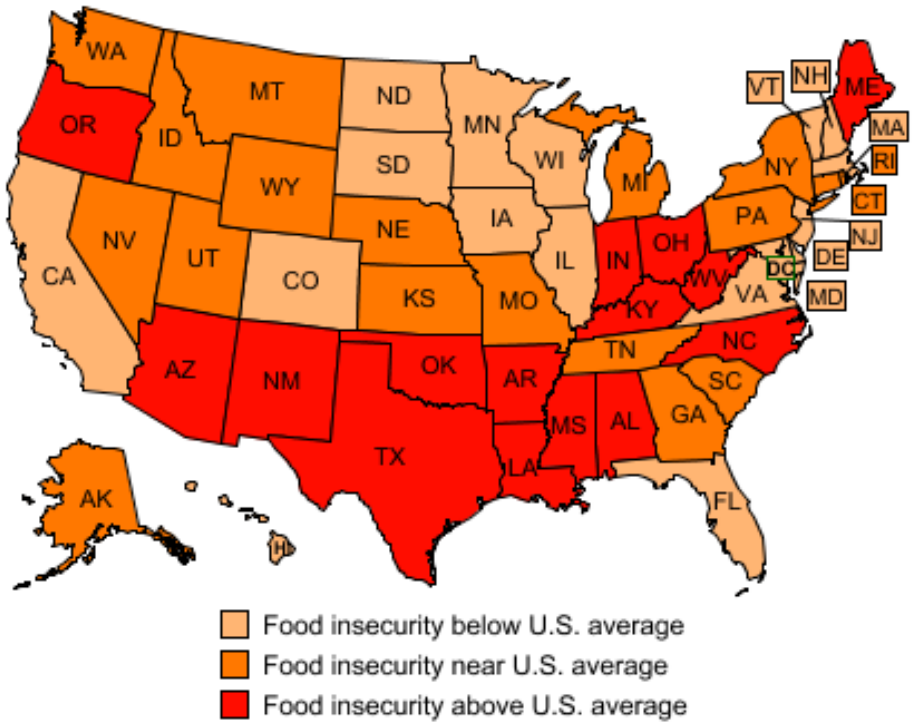
Health Gaps – Food Insecurity in the Maine

Low or Very Low Food Security

Prevalence Rates:

	(2004-2006)	(2014-2016)
USA:	**11.3%**	**13.0%**
Maine:	**12.9%**	**16.4%**

Prevalence of food insecurity, average 2014-16



Source: USDA, Economic Research Service, using data from the December 2014, 2015, and 2016 Current Population Survey Food Security Supplements.

Food Security Interventions

Intervention Strategy

Changing the Context for Health (PSE)

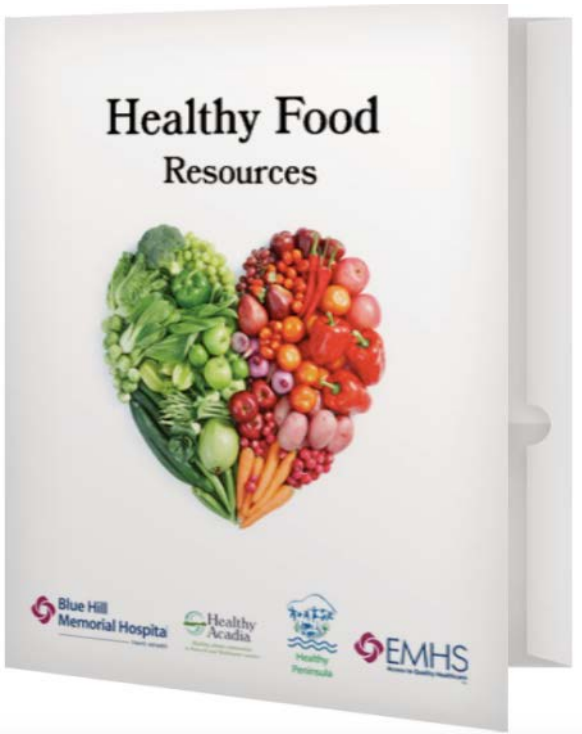
1. **Food Pantry System**
   Strengthen the rural food security network
2. **Healthier Hospital Food Service**
   Source & serve healthier foods
3. **Hunger Screening & Referral**
   Clinical-community connections

Food Insecurity Screening & Referral
Community Food & Nutrition Resources

Community partner outreach - laying the groundwork, building relationships, educating & assisting providers

Eastern Area Agency on Aging

Good Shepherd Food Bank



County Resource Guides

Food Insecurity Screening
Hunger Vital Sign: Validated 2-Question Screen

The Hunger Vital Sign™ identifies individuals and families as being at risk if they answer that either of the following two statements is 'often true' or 'sometimes true':

1. **"Within the past 12 months we worried whether our food would run out before we got money to buy more."**

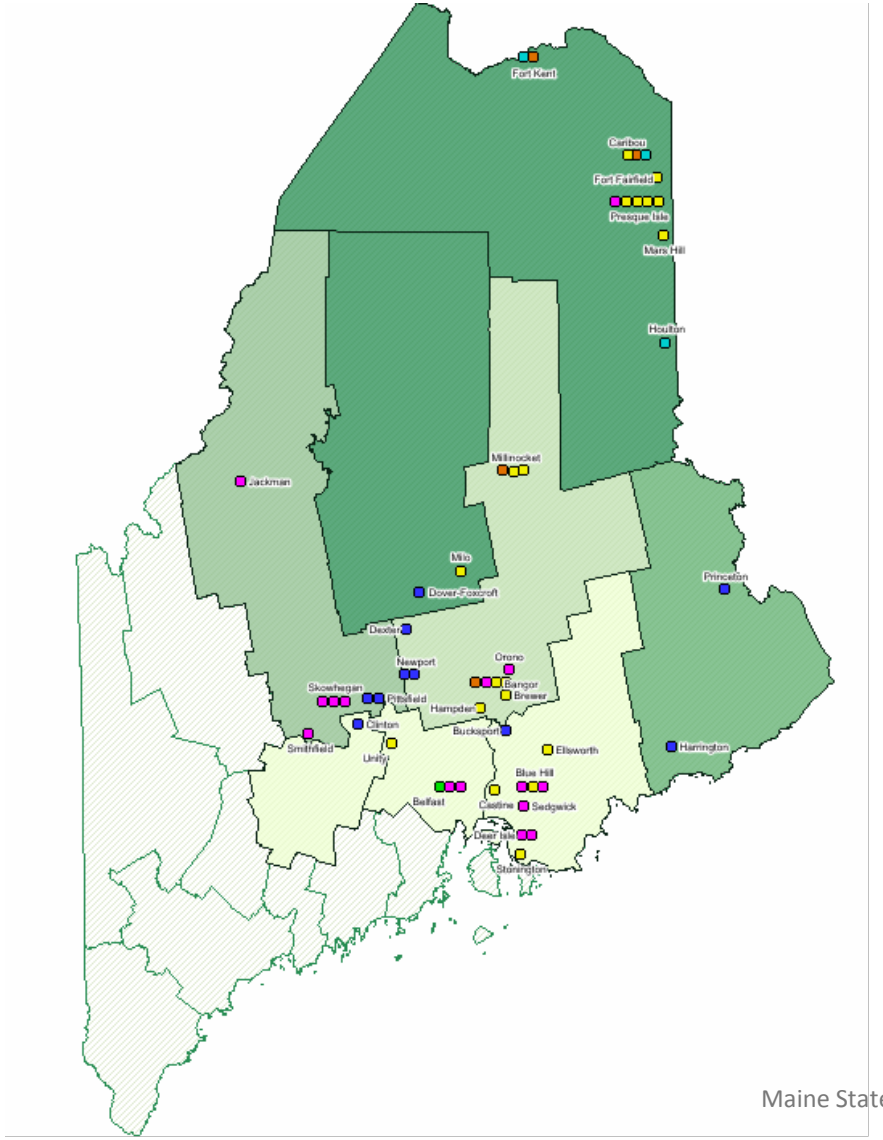
2. **"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."**

Results
Reach, Adoption and Network Engagement

REACH - Food Insecurity Screening and Referral
52 Screening Sites, 7 Counties

Screening Sites

Community Organization	(15)
Dental Clinic	(1)
FQHC	(10)
Hospital	(4)
Primary Care Practice	(19)
VNA	(3)

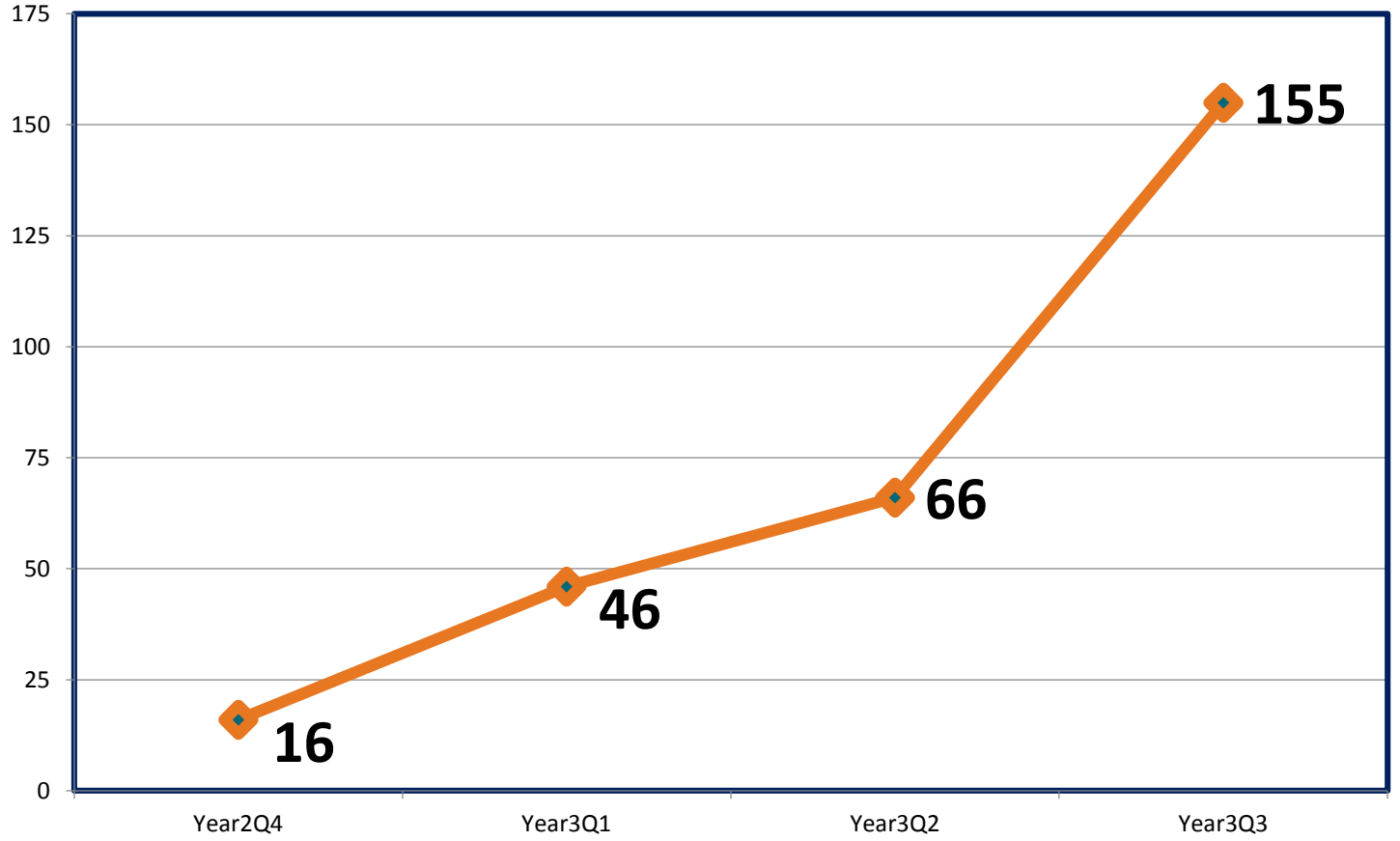


Counties by Food Insecurity Rate (2015)

	16.6% to 16.8%
	16.5% to 16.6%
	16.0% to 16.5%
	15.8% to 16.0%
	14.4% to 15.8%

ADOPTION - Healthcare Providers Activated

Total Providers by Quarter (12 mos)



Food Insecurity Screening & Referral
FINDINGS

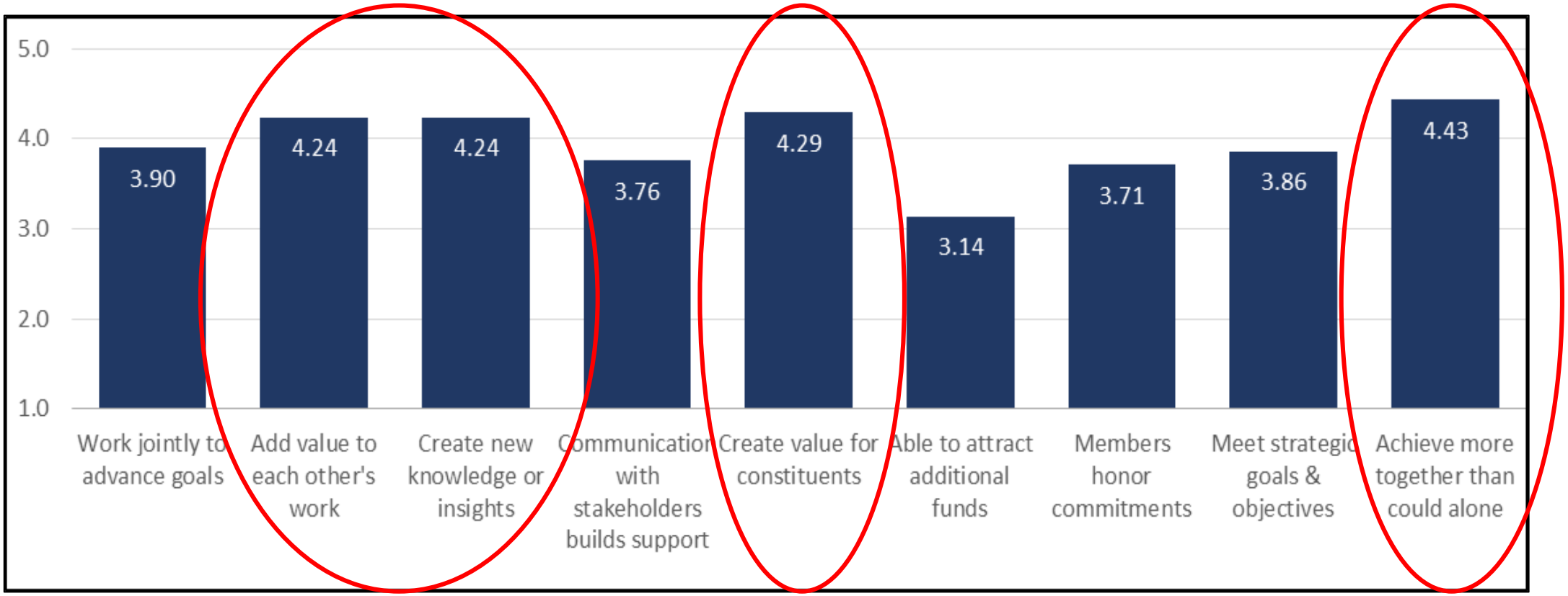
	# Sites	# Screenings	# Positive	% Positive
Clinical sites	37	59,720	4,049	6.8
Community sites	15	1,531	450	29.4
TOTAL	**52**	**61,254**	**4,499**	**7.4**

Effectiveness

- Patients screening positive were provided referrals 97% of the time.
- 75.3% of patients with positive screens connected with food resources

ENGAGEMENT - Northern Maine Rural Collaborative Network Analysis – Network Performance Mean Scores

Foster a Prevention Network that could rapidly scale rural community health improvement

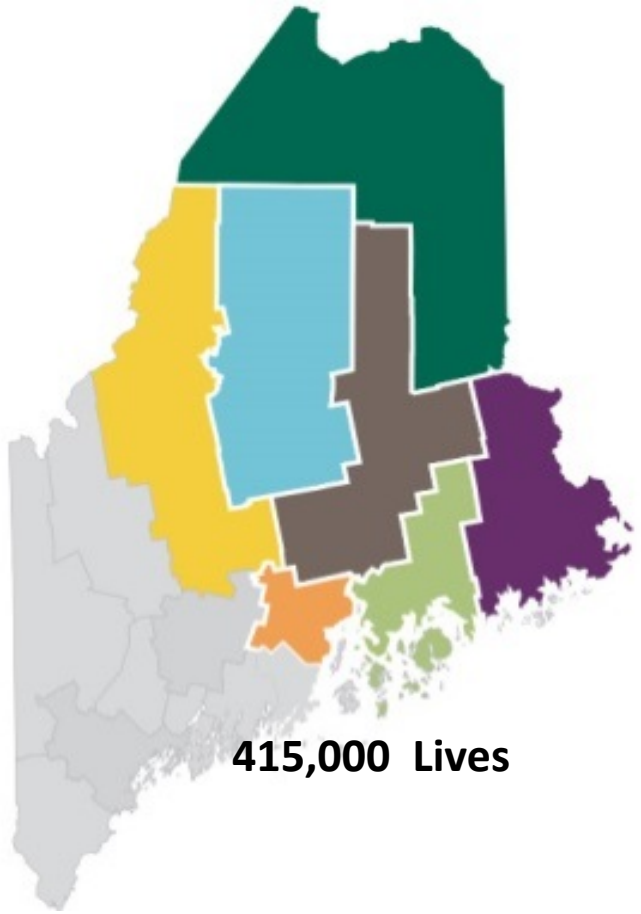


Network Engagement Implementation Factors

Peer Leadership & Practice Sharing

"Sharing summits have had really good content. Some of the best information comes from within."

Scale - Cumulative Prevention Network Reach (3 years)
All Sites, All Interventions



275 Organizations

305,000 Lives

73% of Northern Maine Population

Conclusions

1. Healthcare providers and delivery systems can play a vital role in addressing Food Insecurity and other SDOH (Social Determinants of Health)

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2. Real-time peer practice sharing can accelerate best practice implementation and site adoption

Conclusions

1. Healthcare providers and delivery systems can play a vital role in addressing Food Insecurity and other SDOH (Social Determinants of Health)

2. Real-time peer practice sharing can accelerate best practice implementation and site adoption

3. Accountable rural prevention networks can create scaled value for patients and communities

Northern Light Health

Thank You

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dmichael@northernlight.org

Contributors

Jessica Shaffer, MS	Northern Light Health
Anush Hansen, MS, MA	University of Southern Maine
Brenda Joly, PhD, MPH	University of Southern Maine

Healthy Androscoggin

October 2014 – October 2018

The REACH Partnership Model

- In 2014, Healthy Androscoggin was awarded a four-year Racial and Ethnic Approaches to Community Health (REACH) Grant from the U.S. Centers for Disease Control. This grant was designed to help Healthy Androscoggin and their partner health care and wellness organizations assess their practices and make changes to ensure they are providing culturally and linguistically competent services while addressing the issue of chronic disease in immigrant and refugee adults.
- We partnered with the following health and wellness organizations:
  - The YWCA of Central Maine
  - Androscoggin Home Healthcare and Hospice
  - St. Mary's Medical Center
  - Community Clinical Services B Street Health Center
  - Bedard Pharmacy
  - United Ambulance
  - Seniors Plus

Assessing Assets and Gaps in Culturally Competent Care

REACH staff:

- Implemented CLAS Assessments (Culturally and Linguistically Appropriate Services) for each partner.
- Developed projects, programs and activities to address gaps in culturally and linguistically appropriate programming and healthcare delivery.
- Implemented projects and programs which addressed health education, creation of materials, evaluation, and convening of conversations about health equity.
- Reported on program success through marketing, monthly success stories and grant reporting.
- Created a Peer to Peer learning network to education partners about resources and information to address gaps in culturally competent services.
- Developed sustainability plans to continue culturally competent projects, programs and procedures.

Examples of Success

- YWCA single gender swim and walking programs
- United Ambulance intake forms include country of origin and preferred language
- Culturally appropriate safe medication storage and disposal project for Bedard Pharmacy
- Online cultural competency video trainings for providers and those accessing the system currently accessed by approximately 7,000
- Over 230 people trained in cultural competency and implicit bias in healthcare
- Development of a culturally appropriate Diabetes Prevention Program

Sustainability of Programs and Projects

- Cultural Competency and Implicit Bias training for healthcare providers is still offered by Healthy Androscoggin staff. 28 Dempsey Center staff recently completed training.
- A robust “Neighbor To Neighbor” (N2N) program was developed out of REACH community health education work and continues to be embedded in HA community-based health programming.
- Maine Cancer Foundation funded a two-year “Colon Health RX” grant to HA based on the success of the REACH programming.
- HA is involved in addressing issues of health equity locally and in the state through engagement in research, planning and program implementation, helping to fill gaps due to the lack of a State Office of Minority Health.

Statewide Coordinating Council for Public Health
District Coordinating Council Update

District: Aroostook District	Date: December 13, 2018

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district's website at: http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district8/council-main.shtml

- Healthy Aging presentation by the Aroostook Agency on Aging followed by Healthy Aging Committee planning for Aroostook.
- Aroostook DCC Sub-Committee membership overview and self-assessment project reviewed.
- Dates of note in Aroostook District:
  - Next DCC Meeting: February 6, 2019
  - Next Steering Committee Meeting: January 2, 2019
  - Next Access to Care Committee Meeting: January 24, 2019
  - Next Healthy Aging Committee Meeting: February 6, 2019
  - Next Shared (CHNA) Community Engagement planning meeting: January 9, 2019

Ongoing or upcoming projects or priority issues:

- *Improving Cardiovascular Health Among Seniors* application by ACAP was awarded November 26, 2018. Currently creating reliable outcomes and measures that are aligned with the stated goals.

Progress with District Public Health Improvement Plan:

- Access to Care & Healthy Aging Committee in process identifying current gaps and barriers and creating objectives to translate into the new DPHIP.

Structural and Operational changes, including updates in membership.

- Five SOPs are going to an electronic vote by the members.
- Minutes will now reflect absent Sub-Committee members.
- LeRae Kinney has been nominated to fill school sector vacancy.
- Nathan DeFelice, Child Abuse & Neglect Council Community Coordinator, replacing Lola P., as primary representative for the Aroostook Council for Healthy Families.

In-district or multi-district collaborations:

- Actively involved with post-forum Maine State CHNA Community Engagement Committee.
- Ad Hoc Protocol Committee (DL &Council Coordinators) to reconvene January 2018

Other topics of interest for SCC members: MDOT transportation survey disseminated to DCC Members and Stakeholders.

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22 M.R.S.§412 (2011).

A. A district coordinating council for public health shall:

(1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and

(4) Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible.

A-1. The tribal district coordinating council shall:

(1) Participate as appropriate in department district-level activities to help ensure the tribal public health system in the tribal district is ready and maintained for tribal public health accreditation; and

(2) Ensure that the national goals and strategies for health in tribal lands and the tribal district health goals and strategies are aligned and that tribal district health goals and strategies are appropriately tailored for each tribe and tribal health department or health clinic

Statewide Coordinating Council for Public Health
District Coordinating Council Update

District: Central	Date: December 13, 2018

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting. For agendas and copies of minutes, please see district's website at: http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml At the October 17 and 18 Central District Shared Community Health Needs Assessment (SCHNA) forums, we had 57 attendees in Skowhegan and 80 in Waterville. JSI, Inc. presented county and district data, and participants discussed the data, identified gaps, and identified priorities for health improvement. They reconvened and voted for the following top priorities: Mental Health, Substance Use, Social Determinants of Health, Aging/Older Adults, Physical Activity/Nutrition, Food Insecurity, and other priorities, including Youth/ACEs (adverse childhood experiences), Access to Care, Chronic Disease, Oral Health, Intentional Injury, and Infectious Disease.

Ongoing or upcoming projects or priority issues: coordination with hospital Implementation Strategies and the new round of Shared CHNA; District-Wide Prevention Messaging to priority populations, MGMC/District Oral Health Implementation Grant Community Health Worker (CHW) support and increasing/sustaining resources for community health workers; transportation services and volunteer efforts; recruiting/maintaining sector membership; coordinating with recipients of the Maine Prevention Services contracts; vulnerable populations HAN; ongoing sustainability of successful initiatives

Progress with District Public Health Improvement Plan (DPHIP): *Activities planned for completion during the quarter and whether activities are able to be completed on schedule*

- Use Central District Public Health Unit updates and DCC website to communicate important information to DCC, LHOs, and partners – ongoing task with updates going out weekly as needed
- Establish and implement DCC Vaccination Workgroup and communication network – ongoing
- The Adverse Childhood Experiences (ACEs) Workgroup was asked to re-convene and assist with district Drug-Free Communities (DFC) grantees' school and community efforts to build resiliency
- DCC Leadership continues to review workgroup charges and possible partnering alternatives to determine how to proceed with funding changes

Successes achieved

- District Oral Health Grant Community Health Worker services to connect low SES children to dental appointments, parent education, and outreach to/referrals from district pediatric practices, school nurses, Maine Families, KVCAP, WIC, and the Children's Center – over 400 dental appointments for children and families made so far!
- ACEs Workgroup completed an environmental scan of community and school efforts in the district and RPF for DPHIP implementation funding
- District-Wide Prevention Messaging Workgroup created a new fall playlist for the KVCAP buses and identified additional settings to share prevention messages
- Development of DCC role as Advisory Committee for district HRSA Substance Abuse Treatment grant

Barriers encountered

- Volunteers for DCC initiatives are reporting that they are increasingly being asked to serve beyond the scope of their funding sources
- Ongoing funding for Oral Health Community Health Worker past year 5
- The Substance Use/Mental Health Workgroup has identified creating recovery supports as a priority yet does not have resources or grassroots engagement to advance the priority

Structural and Operational changes, including updates in membership: updating Workgroup charges and membership; ongoing review of membership and adjusting to turnover/filling gaps in sector representation
In-district or multi-district collaborations: Oral Health Grant; District-Wide Prevention Messaging/PICH Communications Sustainability, MaineGeneral HRSA application; Senior Transportation and Neighbors Driving Neighbors pilot; Poverty Action Coalition; UWMM and Drug-Free Communities Grant recipients collaboration on ACEs/resiliency; Flu vaccination in schools
Other topics of interest for SCC members: Steadily building participation in and awareness of the DCC has led to more interest in using the DCC to recruit partners and 'asks' to take on work as a district – a good success, but one that highlights our lack of resources to complete some work identified by the DCC.

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Statewide Coordinating Council for Public Health

District Coordinating Council Update

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor — Ricker Hamilton, Commissioner

District: Cumberland	**Date: 12/10/2018**

For agendas and copies of minutes, please see district's website at:
http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district2/council-main.shtml

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:

Thirty-five people participated in the full Council meeting on September 21st, 2018. Robin Hetzler of Maine CDC's Suicide Prevention Program presented on suicide trends in the state and Cumberland District. Additionally, this meeting focused on work carried out under Maine Prevention Services Program substance use work, with participation by UNE, South Portland Unite, Opportunity Alliance, City of Portland, Westbrook Communities that Care, Access Health (Brunswick/Harpswell), Be the Influence (Windham/Raymond), and Casco Bay Can.

The group discussed progress on the proposal to use the CDPHC's discretionary funding to hire a consultant to develop the Council's capacity for advocacy, and to create an advocacy communications plan. It was agreed that the EC would develop a Scope of Work (SOW) for the Consultant. The Maine CDC micro-grant related to DPHIP strategies was also announced and discussed. A committee was formed to develop a call for proposals.

The Full Council meeting that was scheduled for November 16th was cancelled due to weather, and will meet again on January 18th, from 10am – 12 noon at the Baxter Memorial Public Library in Gorham. There will be a presentation of data about accidental overdose deaths and those that may be considered intentional with Tim Cowan of MaineHealth, and a presentation from one community-based effort to build awareness and reduce stigma around mental illness, Bring Change 2 Mind (Bridgton/Lakes Region), as the Council continues to make connections between discussions and actions in the District.

Ongoing or upcoming projects or priority issues:

The Chair developed an SOW for the Consultant position that was discussed and approved by the EC and the full Council. The EC met on October 12th and reviewed the 5 applications from for the position, and a sub-committee of 3 EC members was appointed to interview 3 of the applicants. Interviews were conducted and a recommendation was made to the EC regarding the top candidate. The EC will meet with the successful candidate on December 14th to review and finalize the consultant's workplan.

An ad-hoc committee prepared the announcement for funding opportunity from Maine CDC for implementation of district-level strategies related to the DPHIP. Two applications were received and reviewed by a sub-committee comprised of 4 EC members. The call was for proposals that will address opioid substance use, using strategies taken directly from the 2017-2019 DPHIP, and that also support the recently re-visited priority-setting goals of the Council.

Progress with District Public Health Improvement Plan:
Structural and Operational changes, including updates in membership:
N/A
In-district or multi-district collaborations:
The Cumberland District Community Health Needs Assessment Public Forums took place on October 4th (Portland) and October 11th (Naples) Priorities included: Substance Use/Opioids, Mental Health, Access to Care, Social Determinants of Health and Elder Care. Follow-up meetings are being scheduled with groups that were under-represented at the forums.
Other topics of interest for SCC members:

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Statewide Coordinating Council for Public Health
District Coordinating Council Update

Public Health
Prevent. Promote. Protect.

Template updated 03/2015 (CTG section removed)

District: Downeast	**Date: December 13, 2018**

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting.

District Public Health Council Meetings

September 21, 2018: Women's Health Research Library in Milbridge (attendance: twenty-seven with twenty-three in person and four by Adobe Connect)

- Deeper Dive: **High Intensity Drug Trafficking Area**: ***Monica St. Clair***, *Public Health Analyst and* ***Jim Minkowsky,*** *Drug Intelligence Officer, New England HIDTA and Maine Information and Analysis Center (MIAC).*
- Committee Work: Using public health standards, established the objectives for the communication and emergency preparedness committees.

November 16, 2018: No Site—Virtual Meeting (attendance: nineteen participants)

- Deeper Dive: **District Cancer Elimination Plan**: ***Al May***, *District Liaison, Maine CDC.*
- Committee Work: The Emergency Preparedness committee met and created next steps by discussing the use of a quality improvement process for meeting objectives.

Executive Committee Meetings

October 24, 2018 by conference call

- DEPHC 2019 meetings: determine day/time/dates of meetings; discuss possible topics for presentations; discuss increasing member involvement.

Ongoing or upcoming district projects or priority issues:

- *Cancer Navigation* project was awarded the 2018-2019 DPHIP funding.

Progress with District Public Health Improvement Plan:

- Ongoing discussions of connecting Prevention Services work to DPHIP.
- Cancer: working with healthcare partners at county level to assess current services; will be looking for avenues like cancer navigation to bring county level groups together.

Structural and Operational changes, including updates in membership:

- Communication Committee being formed.
- Develop quality improvement projects for council work.

In-district or multi-district collaborations:

- Diabetes Prevention Programs
- Chronic Disease and Chronic Pain Management Programs
- Food Security Networks

SCC meeting materials and general information can be found at http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district7/council-main.shtml.

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[1]**Section 5. 22 MRSA c. 152**

A district coordinating council for public health shall:

1. Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation;
2. Provide a mechanism for district-wide input to the state health plan under Title 2, section 103;
3. Ensure that the goals and strategies of the state health plan are addressed in the district; and
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- Connecting Youth Policy and Engagement Projects to District Council
- Cancer Patient Navigators
- Multiple partners across the district continue to collaborate on substance use prevention and treatment, including a new treatment facility in Ellsworth, the newly launched Maine RecoveryCorps program through AmeriCorps to expand support services among individuals in six northern Maine counties (9/2018), and a new SAMHSA MAT Expansion Grant (10/2018) to increase treatment services for people struggling with substance use disorders, particularly opioid use disorders.

SCC meeting materials and general information can be found at http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district7/council-main.shtml**.**

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Statewide Coordinating Council for Public Health
District Coordinating Council Update

District: Midcoast	Date: December 13, 2018

Brief review of decisions and outcomes from Steering Committee and DCC meetings held since last SCC meeting.

- The Steering Committee continues to monitor the Shared Community Health Needs Assessment (SCHNA) process within the District.
- Staff is working with the Steering Committee on its annual membership gap analysis and identification of potential Council members.
- At the November 13, 2018, Council meeting we heard from Scott Gagnon about the changes to Maine's legislation concerning medical and adult use marijuana. Our Priority Oversight Committees met to continue work on the Council's District Public Health Improvement Plan (DPHIP) priorities.

Ongoing or upcoming projects or priority issues:

- The Steering Committee called for applications to provide Youth Mental Health First Aid trainings with District funding. The Selection Committee chose the National Alliance on Mental Illness – Maine (NAMI Maine) to provide one training in each county over the next year.

Progress with District Public Health Improvement Plan:

- The Elevated Lead Levels Oversight Committee continues to work with a pediatrician in Knox to begin capillary testing at checkups rather than referring patients to a lab for a blood draw, cutting down on the steps that patients need to take to get test results. The pilot work in Knox County shows that this change has increased blood-lead-level testing numbers.
- The Obesity Oversight Committee is researching applications that track health data (exercise, nutrition, sleep, etc.) as an aid for weight and chronic disease self-management
- The Mental Health Oversight Committee is taking a lead role in coordinating the Youth Mental Health First Aid Trainings.

Structural and operational changes, including updates in membership:

- No changes in structure or membership since the last SCC report.

In-district or multi-district collaborations:

- Midcoast is finishing up its Shared Community Health Needs Assessment (CHNA) forums, held in each of the District's four counties. District Council members, community partners, hospital system representatives, and Maine CDC collaborated to make the forums a success. Small forums targeting remote geographic regions and medically underserved communities will continue through December.

22 M.R.S. §412 (2011). A. A district coordinating council for public health shall: (1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and (4) Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible.

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Statewide Coordinating Council for Public Health
District Coordinating Council Update

District: Penquis	Date: December 13, 2018

Brief review of decisions and outcomes from Steering Committee and DCC meetings held since last SCC meeting.

- The Steering Committee is staying up to date with the Shared Community Health Needs Assessment (CHNA) process and has decided to target the poverty priority from the DPHIP with the funding.
- The December DCC meeting will feature a presentation from Becca Matusovich, the Executive Director of Partnership for Children's Oral Health. She will present an overview of her organization's work and discuss oral health in the Penquis district.

Ongoing or upcoming projects or priority issues:

- The Council Coordinator and District Liaison continue work on Council governance, membership, communications plan, and policies/procedures.

Progress with District Public Health Improvement Plan:

- The Steering Committee asked community partners to propose work to be done with $3700 to address the DPHIP priority of poverty. The Selection Committee chose to fund work that will be done by the Piscataquis Regional Food Center. They will train volunteers to help people sign up for SNAP, then host application clinics to carry out that work.

Structural and operational changes, including updates in membership:

- N/A

In-district or multi-district collaborations:

- Bangor Livable Communities
- Prevention Service Grant: Maine CDC
- Community Health Leadership Board, Greater Bangor
- Thriving in Place (MeHAF Grant Initiative), Millinocket, Old Town, Orono, Veazie, Dover-Foxcroft
- Health Communities (MeHAF Grant Initiative), Dover-Foxcroft, Bangor
- Save-a-Life Coalition in the greater Lincoln Region
- Substance abuse HRSA Planning Grant: Health Access Network, Lincoln
- Helping Hands with Heart
- Piscataquis Regional Food Center

Other topics of interest for SCC members:

- Oral health and access to oral health care, especially in the youth population.
- Poverty and its various intersections with health outcomes (i.e. food insecurity, as addressed by the Piscataquis Regional Food Center's work)

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District Coordinating Council Update

District: Western	**December 13, 2018**

For agendas and copies of minutes, please see district's website at:
http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:

11/09/2018 Executive Committee Meeting

Developed agenda for upcoming 12/14/2018 DCC Meeting

Administrative topics to be covered at this meeting include:

- Discussing DCC operations for the upcoming year
- DCC meeting dates for 2019
- Steering Committee terms ending (Chair, Jim Douglass ends 12/2018, Treasurer, Ken Albert ends 1/2019)
- Protocol timelines for DCC Communication Plan

Discussion of recent CHNA forums

Youth Conference presentation by Sabrina LoPizzo, Healthy Community Coalition of Greater Franklin County

Electronic Cigarettes and Juuls presentation by Kristen McAuley, MaineHealth

Ongoing or upcoming projects or priority issues:

The Community Health Needs Assessments have involved many DCC partners' collaboration as part of planning committees over the past months.

Western District held the following CHNA forums:

10/3/2018	10-12pm	(JSI)	Gendron Frano Center	(Androscoggin)
10/10/2018	5:30-7:30pm	(JSI)	Telstar High School Library	(Oxford)
10/11/2018	6-8pm	(Tim Cowan)	St. Mary's Lepage Conference Center	(Androscoggin)
10/16/2018	5:30-7:30pm	(Carl Costanzi)	Mountain Valley High School	(Oxford)
10/22/2018	5:30-7:30pm	(JSI)	Paris Fire Station	(Oxford)
10/25/2018	4:30-7:30pm	(JSI)	Mt. Blue High School	(Franklin)

Progress with District Public Health Improvement Plan:

Ongoing discussions have been difficult due to loss of funding.

Structural and Operational changes, including updates in membership:

Shawn Yardley from Community Concepts is new Androscoggin County representative to the Executive Committee.

In-district or multi-district collaborations:

Other topics of interest for SCC members:

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District: York District	Date: 12/13/2018

For agendas and copies of minutes, please see district's website at:
http://www.maine.gov/dhhs/boh/olph/lphd/index.shtml

Brief review of decisions and outcomes from Executive Committee and DCC meetings held since last SCC meeting:

The Executive Committee continues to meet regularly.

The last public health council meeting focused on recognizing volunteers who work in the community for different agencies. The purpose of this meeting was twofold to raise the awareness of those who are making meaningful contributions to public health, and to help expand the understanding of who encompassing public health is.

Recognition of Volunteers: **Clay presented certificates and mugs to the following:**

- **Ericka Sanborn, York County Community Action Corporation: Recognized YCCAC volunteer network as a whole and in particular member of the** Knitting Circle
- **Peter Baker, Alzheimer's Association: Recognized** Barbara Alberda **for years of running caregiver support groups in Biddeford**
- **Amanda Ouellette, Southern Maine Agency on Aging: Recognized** Tammy Cole **for delivering meals and going above and beyond to support clients' needs**
- **Michelle Surdoval, York Community Service Association: Recognized** Nancy Daigle **for her work in the food pantry and other areas at St Georges**
- **Laura Overton, Coastal Health Communities Coalition: Recognized** Carl Walsh **for contributions to the youth substance use prevention coalition Project Alliance and building strong youth programming**
- **Ted Trainer on behalf of the YDPHC: Recognized and thanked** Jackie Tselikis **for years of service on the public health council**

MPS Updates**: Betsy Kelly provided updates on Maine Prevention Services Contracts, sharing copies of Jul-Sept quarterly reports and noting the York County agencies and individual contacts for each area of work: Substance Use Prevention, Youth Engagement, Tobacco, and Let's Go**

YDPHC Updates**: Sarah Breul, in place of Adam Hartwig, gave overview of the Council's current DPHIP, which focusses on substance use prevention, nutrition and oral health. Funding from MaineCDC was just bid out and awarded to Opportunity Alliance to support the Oral Health initiative which was launched last year and links local schools to the UNE dental school**

Ongoing or upcoming projects or priority issues:

The council is awarded the Oral Health funding to the Opportunity Alliance. Updates on progress will follow in the next report.

Progress with District Public Health Improvement Plan:

Substance Misuse:

- Working group for Drug Free Community grantees and recipients of Manie Prevention Services funding continues to talk about workplans and goals for 2018 to try an align efforts.

Physical Nutrition and Obesity:

- The York County Physical Activity Guide is continuing to be updated and should be uploaded to the ME CDC York webpage in the next few weeks.

Oral Health:

- Opportunity Alliance was awarded the DCC DPHIP funding. Progress on their work will follow in future reports.

Structural and Operational changes, including updates in membership:

In-district or multi-district collaborations:

Other topics of interest for SCC members:

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PAUL R. LEPAGE
GOVERNOR

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BETHANY L. HAMM
ACTING COMMISSIONER

STATEWIDE COORDINATING COUNCIL FOR PUBLIC HEALTH

2019 MEETING SCHEDULE

All meetings to be held at Maine State Library, 10 am to 1 pm

Statewide Coordinating Council Meetings

March 21, 2019
June 20, 2019
September 19, 2019
December 19, 2019

Steering Committee Calls
Dates TBD by Consensus of Participants

February
May
August
November

Membership Committee Calls
Dates TBD by Consensus of Participants

April 2019 (2 June expirations, Hamilton and Hallundbake)
June 2019 (2 September expirations, Guay and Malinowski)