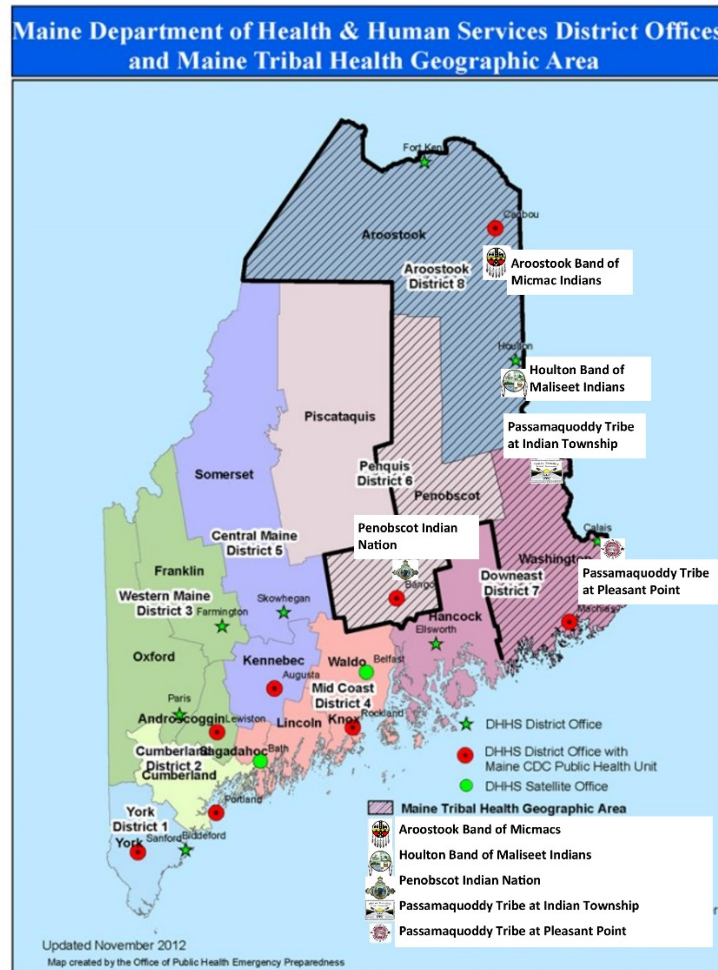
Cumberland Public Health District

District Public Health Improvement Plan

2017 – 2019

Cumberland District Coordinating Council for Public Health

Maine's Public Health Districts



Cumberland Public Health District

Cumberland Public Health District includes Cumberland County, the most populous county in Maine. The district covers 835.4 square miles with a population of 281,674, giving a population density of 337.2 people per square mile. (2010 Census) There are 28 municipalities (incorporated local governments) including cities and towns. Cumberland's largest municipalities by population include the cities of Portland, South Portland and Westbrook. Cumberland District covers both urban and rural areas, and provides ample access to lakes, rivers and the ocean. Several towns and villages are ocean island communities.

Cumberland District Coordinating Council

Mission: To promote the health of all our communities by providing information, coordination, collaboration, and advocacy.

Vision: Communities in the Cumberland District are among the healthiest in the state.

Leadership: Executive Committee for 2016 - 2017		
Name	**Leadership**	**Organization**
Kristen Dow	Chair	City of Portland, Public Health
Zoe Miller	Vice Chair	Consultant
Naomi Schucker	Treasurer	MaineHealth
Liz Blackwell-Moore	Secretary	Consultant
Carol Zechman	Advocacy Committee Chair	MaineHealth
Joanna Morrissey	SCC Representative	Consultant
Kristine Jenkins	District Liaison	Maine CDC

Council Members as of 2016 who contributed to this plan		
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Maine's District Public Health Infrastructure

Public Health Districts and District Coordinating Councils

The Public Health Districts were formed in 2008 as part of Maine's Statewide Public Health System Development Initiative called for in the 2007 Public Health Work Group Recommendations (22 MRSA §412). The Tribal Public Health District was established as Maine's ninth Public Health District in 2011, with the Act to Amend the Laws Regarding Public Health Infrastructure (22 MRSA §411). The establishment of the nine Districts was designed to ensure the effectiveness and efficiency of public health services and resources.

According to Maine law, the Maine Center for Disease Control and Prevention "shall maintain a district coordinating council for public health (DCC) in each of the nine districts as resources permit (22 MRSA §412). This is a representative district wide body of local public health stakeholders working toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system." (22 MRSA §411)

The statutory language further states:

"A district coordinating council for public health shall:

(1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and
(2) Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible." (22 MRSA §412)

District Public Health Planning Process

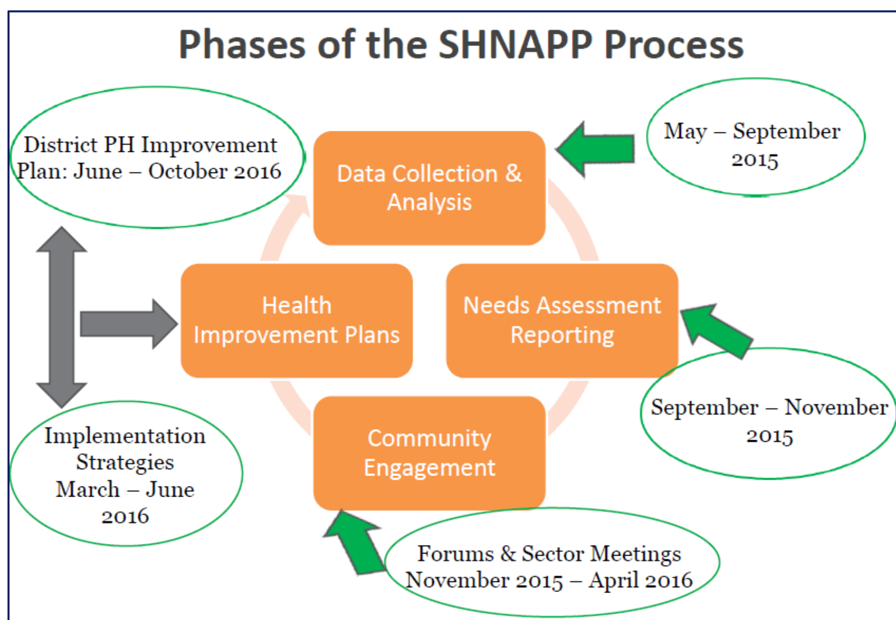
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health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

The purpose and importance of creating and implementing a DPHIP is based on the ten essential public health services through assessment, policy development, and assurance. Through the DPHIP, the DCC is working locally and regionally to meet public health accreditation and national public health standards through a community-based, multi-sector partnership to improve the public's health.

The Maine CDC is required to create and implement a State Health Improvement Plan (SHIP), designed to improve the health of all Maine people. The previous versions of the DPHIPs and SHIP were developed simultaneously, and partially aligned. In 2017, a new SHIP will be developed. In order to better coordinate health improvement efforts and resources between the state, districts, and Maine's people, priorities selected for the DPHIPs will inform this new SHIP. This is the third Cumberland District Public Health Improvement Plan with previous versions created in 2008 and 2012.

In 2015-2016, a collaborative process called the Shared Health Needs Assessment and Planning Process (SHNAPP) was created by Maine's four largest health-care systems – Central Maine Healthcare, Eastern Maine Healthcare Systems (EMHS), MaineGeneral Health, MaineHealth – and Maine CDC to integrate public health and health care needs assessment and community engagement. The SHNAPP serves as a platform for developing the current DPHIPs.

The graphic below shows the planning process over the past year portraying a four phase approach—collection of quantitative (health indicator statistics) and qualitative (survey of professionals and community organizations of field knowledge) data, creating a "Shared Community Health Needs Assessment (Shared CHNA)" for each district, partnering with hospitals to facilitate community input, and then creating implementation strategies (hospital community plans) and district public health improvement plans (public health districts).



The data in the Shared CHNA (see Appendix 1 for district data summary) provides a starting point for discussing the health issues that face Maine people. The indicators chosen for the Shared CHNA cover a broad range of topics, but are not intended to be an exhaustive analysis of all available data on any single health issue. District-shared CHNAs can be used to compare a health indicator in the district, in the counties making up the district, in the State of Maine, and to the national values.

A community engagement process was used to bring the numbers to life. Thirty-four community forums and fifty-two smaller events with more narrow audiences such as business leaders, or healthcare providers were held across the state, with over 3,000 attendees. A selection of the data from the SHNAPP was presented at each event, and participants discussed their priorities, assets and resources to address the issues, community needs and barriers, and next steps and solutions. The discussions were captured by facilitators and recorders and compiled for each district. Summaries from the community engagement events provided support for the next planning steps.

DPHIP priorities were chosen as a result of several community processes including the seven Cumberland District CHNA and SHNAPP forums that occurred throughout winter into early spring 2016. [January 11, 2016, January 26, 2016, February 2, 2016, February 23, 2016, March 29, 2016, April 8, 2016 and April 15, 2016] The Cumberland DCC held a DPHIP priority-setting discussion at the September 16, 2016 full council meeting, followed up with an online survey to DCC members and interested parties who were not able to attend the meeting in person. An additional survey was sent to stakeholders on October 5, 2016 requesting input about the district's current assets and resources related to the priority areas chosen. DPHIP priorities weighed against priorities chosen by the United Way of Greater Portland's Thrive 2027 process and implementation strategies chosen by hospitals in Cumberland County. (See table below)

Cumberland County FY 17 Health Improvement Priorities Matrix						
DPHIP (# votes)	Thrive 2027	CHNA Priorities	Bridgton Hospital	Maine Medical Center	Mercy Hospital	Spring Harbor Hospital
SA Prevention/Treatment–All Ages (36)	SA prevention/Treatment-All Ages	Substance/Opioid Misuse				
Comp school health/nutrition, SBHCs (31)						
Child Care up to 15yo and after school (25)						
Dental/Oral Health Care for Low-Income/Underinsured (23)	Dental Services					
Obesity-All Ages (21)	Obesity-Youth	Obesity				
Prenatal/Young Children's Care (20)						
Tobacco-All Ages (16)		Tobacco				
Health Care for Children/Adults (13)	Provide Basic Health Care Access	Access to Care				
Rx for seniors and disabled (4)	Senior Safety/Independence	Elder/Senior Health				
Mental Health-All Ages (2)	Mental Health-All Ages	Mental Health and Health-Youth				
Transportation (1)						
	Mental Health-All Ages	Mental Health				
	Housing	Affordable Housing				
	Food Insecurity	Food Insecurity				
	Home Nursing Care					
	Domestic Violence					
		Adverse Childhood Experiences (ACEs)				
		Mental Health (Early ID)				
		Preventive Care				
		Enrollment Activities				

A work group was developed for each priority, and one or two point people were chosen from the Executive Committee to lead each priority work group. The point people and District Coordinator (DC) brainstormed content experts, both Council members and non-members. Content expert focus work group began meeting on November 2, 2016. Point people discussed draft workplans with content experts, and asked them to provide feedback on the goals that were chosen and provide suggestions for objectives for each goal. The DC received and compiled feedback in a Word document, and met with point people to discuss how best to add the feedback as appropriate. Much of the feedback consisted of ideas for strategies and measures, which was saved for later discussion.

The DC updated the draft workplans, and sent them back to the content experts for additional review. The DC developed power point presentation (PPT) consisting of proposed priority areas, goals and objectives. The PPT was presented at the November 18, 2016 DCC meeting along with a request for help in developing strategies and measures. Individuals interested in helping in the strategy and measure development process were asked to reach out to priority point people, whose contact information was listed on a slide in the PPT. Point people and the DC met with individuals interested in helping to develop the strategies and measures. The draft workplans were finalized on December 19, 2016, and sent to Maine CDC for review and approval.

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

- **Maximize impact and optimize limited resources**: District partners should first assess existing work being done in the district and determine how best to enhance and not duplicate these efforts. This criterion also speaks to collaboration across district partners, bringing the priority home to the specific organization, and leveraging existing resources.

- **Use evidence-based strategies and population-based interventions**: Districts should invest time in doing research on evidence-based strategies used successfully for a specific disease area. For example, the Guide to Community Preventive Services (http://www.thecommunityguide.org/) provides recommendations for best practices for prevention services by a national task force of subject matter experts at the federal CDC.

- **Best addressed at the district level/Good faith effort to ensure the entire county is served**: In Maine, many community actions are very local. However, some issues may be better addressed at a district level. The district should consider whether it can provide a platform for collaboration of non-typical partners; or be an avenue for policy and environmental change that is more difficult to achieve at the local community level.

- **Involve multiple sectors**: District coordinating councils require active recruitment of multiple sectors across the public health continuum. Districts need to actively engage all partners that

have the value of health as their mission. Districts should consider those health issues that can best be addressed by involving multiple sectors.

- **Address district health disparities/Seeking to ensure health equity**: The district should consider whether they can reduce health disparities between their district and the state or within their population by addressing a specific issue. Populations to consider as having potential health disparities include racial and ethnic minorities, immigrants, migrant farm workers, lesbian, gay, bisexual, and transgender people, people at low income levels, people with veteran's status, people with lower levels of educational attainment, people with physical impairments (include deafness, blindness and other physical disabilities), people with mental impairments (including those with developmental disabilities and mental illness), people over sixty years old, and youth.
- **Strengthen/Assure Accountability/Ensure Measureable Outcomes**: The district should consider whether change can be meaningfully measured and whether they can hold themselves accountable for changes in outcomes.

- **Focus on Prevention**: While some issues may be addressed through treatment in the health care system, for the Public Health Improvement plans districts should focus on whether outcomes can be prevented. This may include primary prevention (focus on the entire population), secondary prevention (focus on those at highest risk), or tertiary prevention (focus on those with existing conditions). Social determinants of health (social and physical environmental factors impacting health) should also be considered.

- **Data driven**: Based on the planned three-year cycle for health improvement plans, districts should be able to track short-term and long-term changes using data indicators. Although some data indicators may not change substantially in a short time frame, being able to consistently use these data to measure change is important. However, shorter-term impacts and intermediate outcomes may also provide important information on determining if specific actions will lead to population health improvement.

- **Community Support**: Districts should be aware of the local priorities within the district, and seek common ground across the community, as well as in different sectors in the districts. Even when communities within the same county may not necessarily agree on specific strategies, there may be agreement on what the priorities are.

- **Gaps in prevention services:** The district should consider if a health issue has not been adequately addressed across the district or in some parts of the district. An appropriate discussion on root causes, barriers to services, or gap analysis may be an appropriate way to address this.

Cumberland District Public Health Improvement Plan

Community Health Improvement Priorities

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

- Substance Use Prevention
- Oral Health
- Healthy Weight
- Care for Children 0-6 Years of Age

The remainder of this plan provides more in-depth information about each of the public health priority areas listed above and plans for improvement. Through district and community based workgroups, council partners have identified goals, objectives and strategies, and will develop detailed work plans to meet their outcomes.

Implementation Plan Design

Once priority areas were identified, objectives were created and strategies selected.

Objectives are based on the SMART model: Specific, Measureable, Achievable, Realistic or Relevant, and Time-limited. SMART objectives are used to provide a structured approach to systematically monitor progress toward a target and to succinctly communicate intended impact and current progress to stakeholders.

Strategies or action steps were identified and designed to meet the outcomes of the objective. They may lead to short term impacts or intermediate outcomes that are clearly linked to the objectives. Not all possible strategies are able to be addressed within the DPHIP. The DCC considered possible strategies and selected one that met criteria such as those used in selecting the priority areas:

- Does it maximize impact and use of limited resources?
- Is it evidence-based?
- Is it population-based?
- Is it feasible at the district level?
- Does it involve multiple sectors and partners?
- Does it seek to ensure health equity?
- Does it address district disparities?
- Can the DCC hold itself accountable for achieving the impact or outcome?
- Is it prevention-focused?
- Does the data support the use of the strategy?
- Is there adequate community support, or can this be built?
- Is there an organization that is willing to take the lead?
- Does it fill a gap?

Priority 1: Substance Use Prevention

Description/Rationale/Criteria: Substance Use Prevention was chosen because it was identified by multiple stakeholders and partners that it was of top priority. It was selected by 100% of Cumberland District hospitals as an implementation strategy through their community health needs assessments; was identified as a community goal through United Way of Greater Portland's Thrive 2027 initiative; and received the most votes among Cumberland DCC members and interested parties. According to the 2015 Cumberland County CHNA Summary (CHNA), binge drinking of alcoholic beverages was much higher for adults in Cumberland County (20.7%) than in Maine (17.4%) and the U.S. (16.8%). Chronic heavy drinking in adults was also found to be higher in Cumberland County (9.0%) than in Maine (7.3%) and the U.S. (6.2%).

Goals	Objectives	Strategies	District Partners
Goal 1: Reduce substance use rates in populations aged 25 years and older.	1.1. Enhance coordination of district-wide substance use prevention efforts	1.1.A. Conduct a community scan to identify which stakeholders should be invited to district-wide forums of substance use prevention stakeholders, taking into account communities experiencing health disparities. (Community-based Process)	Prevention services grantees, hospitals, Drug-free Communities grantees, municipalities, community-based organizations, community members, law enforcement
		1.1.B By June 30, 2019, convene at least 3 District-wide forums of substance use prevention stakeholders with the goal of identifying and coordinating the various activities, as well as to exchange ideas and network. (must be quantifiable)	
	1.2. Increase awareness of substance use prevention, intervention, treatment and recovery resources.	1.2.A Update local service directories on substance use prevention, intervention, treatment and recovery services.	Prevention services grantees, hospitals, Drug-free Communities grantees, municipalities, community-based organizations, community members, law enforcement
		1.2.B. Disseminate local service directories on substance use prevention, intervention, treatment and recovery services to substance use prevention stakeholders	
	1.3 By June 30, 2019, 10 municipal ordinances will be passed that address responsible marijuana vending practices.	1.3.A. Provide information to municipal officials on their authority to enact ordinances related to retail marijuana. (Education)	Municipal officials, law enforcement, marijuana growers and vendors, community partners.
		1.3.B. Provide ongoing technical assistance on best practice marijuana ordinances to 10 municipal officials and local vendors. (Education)	
	1.4 By June 30, 2019, 10 municipalities will pass policies increasing the availability of naloxone in municipal buildings.	1.4.A. Assess which municipalities are interested in having naloxone available in their municipal buildings. (Community-based Process)	Municipal officials and employees, community partners
		1.4.B. Provide technical assistance to 10 municipalities in crafting a policy around naloxone availability in municipal buildings. (Education)	

Priority 1: Substance Use Prevention (cont'd)

Goals	Objectives	Strategies	District Partners
Goal 2: Reduce prescription drug misuse rates in populations aged 25 years and older.	2.1 By June 30, 2019, increase the availability for safe disposal of unused prescription drugs	2.1.A. Identify appropriate sites (secure, interested partners)	Municipal officials and employees, community partners
		2.1.B. Enlist five (5) sites for safe disposal	
		2.1.C. Ensure proper training of safe disposal	
		2.1.D. Provide TA around proper policies and procedures around safe disposal.	
		2.1.E. Promotion of safe disposal	
	2.2. By June 30, 2019, 100% of local service directories will contain accurate information on alternative pain management.	2.2.A. Conduct a community scan of updated resources related to alternative pain management in the Cumberland District. (Community-based Process)	Mercy Hospital, 2-1-1, prevention services grantees, other hospitals, Drug-free Communities grantees, municipalities, community-based organizations, community members
		2.2.B. Work with those agencies overseeing local service directories (e.g., 211) to update their directory of alternative pain management resources. (Information Dissemination)	
		2.2.C. Publicize these updated service directories to all audiences, taking CLAS Standards into account, and message in a way that reduces stigma around substance use (Information Dissemination)	
		2.2.D Provide this information and TA to providers	

Priority 2: Healthy Weight			
Description/Rationale/Criteria: Obesity prevention was determined to be a top DPHIP priority as a result of several community processes including the Cumberland District CHNA and SHNAPP forums, the United Way of Greater Portland's Thrive 2017 process and most recently, the Cumberland DCC's DPHIP priority-setting discussion, stakeholder survey and content expert focus groups. The DPHIP Goals outlined below seek to prevent obesity and promote health weight by increasing physical activity and consumption of fruits and vegetables by children and adults in Cumberland District. Objectives and strategies include a focus on health equity. According to Maine Kids Count 2015-2016, the percentage of Maine children aged 0-17 who are overweight (17.0%) is up from the previous percent calculated (15.3%), and is greater than the national percentage (15.6%).			
Goals	**Objectives**	**Strategies**	**District Partners**
1. Increase physical activity among children and adults in Cumberland District	1.1 Increase use of active transportation (walking, biking, wheeling, and transit use for daily travel) by June 30, 2019.	1.1.A Provide technical assistance to at least two towns to help them adopt Complete Streets policies and/or utilizing CS approaches. https://www.thecommunityguide.org/findings/physical-activity-street-scale-urban-design-land-use-policies	Municipalities, PACTs, ACETs
		1.1.B Increase number of major employers and educational institutions that support active transportation by implementing travel policies and practices such as employer incentives for walking, biking, ride-sharing and transit use, as well as participation in bike share programs. http://www.cdc.gov/obesity/downloads/pa_2011_web.pdf	Major employers and educational institutions, PACTs, ACETs
		1.1.C Implement a plan for district-wide community-based social marketing campaign to promote and increase use of active transportation. http://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/exec-summary.html	PACTs, ACETs, UMaine Cooperative Extension
2. Increase fruit and vegetable consumption among children and adults in Cumberland District	2.1. Reduce transportation barriers to accessing grocery stores, food pantries and community gardens in underserved communities by 2019.	2.1.A. Assess needs and feasibility of emerging solutions including "grocery shuttles" and mobile markets in rural locations https://www.cdc.gov/obesity/downloads/fandv_2011_web_tag508.pdf) http://www.policylink.org/sites/default/files/HEALTHYFOOD.pdf	Municipalities, Transportation, Food retailers, UMaine Cooperative Extension
	2.2 Increase consumer variety of fruits and vegetables at places they purchase or receive food including emergency food programs, retail locations, farmer's markets and farm share programs.	2.2.A. Support pilot to help food producers to disseminate un-used/sold produce to those in need.	Emergency food programs, retailers, Cumberland County Food Security Council, UMaine Cooperative Extension

Priority 3: Oral Health

Description/Rationale/Criteria: Oral health is an integral part of overall health, and many individuals face barriers to accessing oral health care. Some of the barriers include individuals' low oral health literacy and an unfamiliarity with Maine's oral health system and resources; no dental insurance (or underinsured) with high out-of-pocket cost for services; difficulty finding dentists that accept MaineCare and subsequent long waiting periods, and transportation issues. According to the 2015 Cumberland County CHNA Summary (CHNA), health professionals and community stakeholders reported that access to oral health care was one of the top five health factors resulting in poor health outcomes for Cumberland County residents. Further, the 2015 CHNA indicated that 52.9% of MaineCare members in Cumberland County under the age of 18 visited the dentist in the past year, compared to the state rate of 55.1%.

Goal	**Objectives**	**Strategies**	**District Partners**
Increase the use of preventative oral health services.	1.1 Increase access to oral health services for vulnerable populations, including but not limited to new Americans, children, parents, seniors.	1.1 Update 2-1-1's oral health resources by June 30, 2017	Dental health providers United Way
		1.2 Promote and market 2-1-1 among vulnerable populations and individuals or groups who serve those populations http://www.astdd.org/health-communications-committee/ http://www.cdc.gov/oralhealth/oral_health_disparities/index.htm https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health	Dental health providers, medical offices, health departments, community centers
		1.3 Assess existing resources to identify potential additional untapped resources and underutilized capacity and ongoing gapshttp://www.astdd.org/docs/access-to-care-and-sohp-tip-sheet-nov-2011.pdf http://www.nidr.nih.gov/sgr/nationalcalltoaction.htm	Dental health providers, medical offices, health departments, community centers, oral health program partners and stakeholders
	1.2Increase vulnerable populations Patient Activation Measures (PAM) scores on their understanding of how to access dental care and making financial plans in order to do so. https://www.researchgate.net/profile/Judith_Hibbard/publication/7432282_Development_Testing_of_a_Short_Form_of_the_Patient_Activation_Measure/links/53f350950cf2dd48950ca51a.pdf	2.1.A Engage Community Health Outreach Workers (CHOWs) and Community Financial Literacy to assist vulnerable populations in health savings planning.	CHOWs, CFL
		2.1.B Work with dental providers to enhance patient outreach and education such as alternative methods of appointment reminders.	Dental health providers, oral health program partners and stakeholders
	1.3. Increase awareness about oral health hygiene best practices, including the effect of diet on oral health	1.3.A Develop materials that provides information about oral health hygiene best practices, taking CLAS Standards into account https://www.aacdp.com/docs/Framework.pdf	Dental health providers, oral health program partners and stakeholders
		1.3.C Disseminate newly developed and increase dissemination of existing education materials (ex. From the First Tooth, Smile Partners resources) http://www.astdd.org/health-communications-committee/	Dental health providers, medical offices, health departments, community centers, oral health program partners and stakeholders

Priority 4: Care for children 0-6 years of age			
Description/Rationale/Criteria: Care for Children 0-6 Years of Age was determined to be a top DPHIP priority as a result of several community processes including the Cumberland District CHNA and SHNAPP forums, the United Way of Greater Portland's Thrive 2017 process and most recently, the Cumberland DCC's DPHIP priority-setting discussion, stakeholder survey and content expert focus groups. The DPHIP Goals outlined below seek to improve the health of young children by ensuring screenings are conducted and caretakers have access to health resources and education that lead them to attain the knowledge, abilities and behaviors to provide optimal care for children in the Cumberland District. According to Maine Kids Count 2015-2016, the current percentage of Maine children aged 0-17 who have experienced two or more adverse experiences is greater than the national average, 25.1% and 22.6%, respectively.			
Goal	**Objectives**	**Strategies**	**District Partners**
Improve the health and wellbeing of children aged 0-6 years of age.	1. Improve accessibility of resources related to health and wellbeing for caregivers of 0-6 year olds.	1.1 Conduct assessment and analysis of available health and behavioral health resources specific to young children and caregivers in the Cumberland District.	Health and Behavioral Health service providers
		1.2 Provide opportunities for district-wide collaboration, idea sharing and communication between young children and caregiver health and behavioral health service providers.	Health and Behavioral Health service providers
	2. Enhance pre and post-natal care for caregivers and newborns.	2.1 Ensure all MCH nurses are trained in best practices for screening and universal education for parents to be and new parents/caregivers by 2019.	MCH nurses
	3. Increase breastfeeding rates at 6 months by 5%.http://www.maine.gov/dhhs/mecdc/population-health/hmp/panp/breastfeeding.html	3.1 Provide technical assistance to health care providers around cultural competency for vulnerable populations http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps	OB/GYN, pediatricians, family practitioners
		3.2 Increase availability of culturally competent materials around benefits of breastfeeding	Medical offices, health departments, community centers
		3.3 Increase number of worksites that receive TA to ensure compliance with Maine state law around breastfeeding mothers / lactation support in the workplace	Worksites

Appendices

1. **Cumberland District** 2015-2016 Health Profile: this is a health profile of the district using a set of quantitative indicators established by the Maine CDC Data Work Group and qualitative input. The quantitative indicators come from sources that Maine CDC uses to report disease incidence and prevalence data, including the Behavioral Risk Factor Surveillance System, Maine Health Data Organization (hospitalization data), US Census, and other health surveillance systems. The qualitative stakeholder input on the first page is a summary of the top five health issues and top five health factors in the district determined from a survey instrument that was distributed electronically to partners in each district.

For more information on Maine's Public Health Districts, please visit the Maine CDC website at http://www.maine.gov/dhhs/mecdc/ and choose *District Public Health* from the menu.

For more information on the Cumberland District Coordinating Council, please contact Kristine Jenkins, District Liaison, at Kristine.L.Jenkins@maine.gov or Kristen Dow, Chair, at kjd@portlandmaine.gov

Cumberland District Coordinating Council's website is at http://portlandmaine.gov/218/Cumberland-District-Public-Health-Counci

Appendix 1: Cumberland District Health Profile 2015-2016

Maine Shared Community Health Needs Assessment County Summary: 2015

Cumberland County

Updated: October 2015

Qualitative Stakeholder Input

A survey of 176 health professionals and community stakeholders in Cumberland County provided insight into the most critical health issues and determinants impacting the lives of those living in the area. According to these stakeholders, the following five health issues and health factors have the most impact on Cumberland County resulting in poor health outcomes for residents.

Top five health issues
- Mental health
- Drug and alcohol abuse
- Obesity
- Diabetes
- Depression

Top five health factors
- Access to behavioral care/mental health care
- Poverty
- Health care insurance
- Health literacy
- Access to oral health

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Demographics					
Total Population	2013	285,456		1,328,302	319 Mil
Population – % ages 0-17	2013	19.8%		19.7%	23.3%
Population – % ages 18-64	2013	64.3%		62.6%	62.6%
Population – % ages 65+	2013	15.9%		17.7%	14.1%
Population – % White	2013	92.9%		95.2%	77.7%
Population – % Black or African American	2013	2.8%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.4%		0.7%	1.2%
Population – % Asian	2013	2.2%		1.1%	5.3%
Population – % Hispanic	2013	1.9%		1.4%	17.1%
Population – % with a disability	2013	12.2%		15.9%	12.1%
Population density (per square mile)	2013	337.2		43.1	87.4
Socioeconomic Status Measures					
Adults living in poverty	2009-2013	*11.4%*	NA	13.6%	15.4%
Children living in poverty	2009-2013	*15.7%*	NA	18.5%	21.6%
High school graduation rate	2013-2014	88.2%	NA	86.5%	81.0%
Median household income	2009-2013	*$57,461*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	33.2%	NA	66.4%	NA
Single-parent families	2009-2013	31.2%	NA	34.0%	33.2%
Unemployment rate	2014	4.4%	NA	5.7%	6.2%
65+ living alone	2009-2013	43.1%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	*11.5%*		15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	11.4%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	*10.6%*		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	*23.2%*		27.6%	NA
Mortality					
Life expectancy (Female)	2012	82.3	NA	81.5	81.2
Life expectancy (Male)	2012	78.1	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*687.2*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	89.5%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	9.5%		11.0%	15.3%
MaineCare enrollment	2015	19.0%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	30.0%	NA	41.8%	48.0%
Percent uninsured	2009-2013	*8.9%*	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,167.5*		1,499.3	1457.5

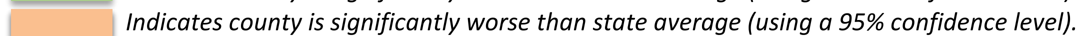
Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*3,509.6*	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	*72.8%*	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	52.9%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	*57.3*		67.3	NA
COPD diagnosed	2011-2013	*5.1%*		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	*159.1*	-	216.3	NA
Current asthma (Adults)	2011-2013	10.8%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	8.6%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	*558.7*	-	719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	*229.9*	-	329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	*174.9*	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	494.8	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	27.6	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	19.7	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	43.5	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	136.4	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	83.1%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	15.3	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	23.0	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	41.2	NA	43.5	42.0
Colorectal screening	2012	72.5%	NA	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	50.7	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	69.5	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*27.9*	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	91.6%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	23.2	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	127.6	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	35.4	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	88.2	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*14.8*		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*22.4*	NA	32.2	32.4
Cholesterol checked every five years	2011. 2013	83.3%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*68.0*	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	*19.0*		21.9	NA
Hypertension prevalence	2011, 2013	29.5%		32.8%	31.4%
High cholesterol	2011, 2013	*36.7%*		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	23.2		28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	*17.6*		20.8	NA
Stroke mortality per 100,000 population	2009-2013	*29.1*	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	*7.6%*		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	6.9%		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	74.1%	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	90.2%	NA	83.3%	NA

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Adults with diabetes who have had an A1C test twice per year	2011-2013	78.3%	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	62.9%	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	238.8	-	235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	*9.3*		11.7	NA
Diabetes long-term complication hospitalizations	2011	53.4		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	*16.3*	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	*3.2%*	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	*2.5%*	NA	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	*53.1%*	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*42.3%*	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	*17.6%*	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	43.4%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	73.2%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	4.7%	NA	3.7%	NA
Two-year-olds up to date with “Series of Seven Immunizations” 4-3-1-3-3-1-4	2015	NA	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.7†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.3†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	1.4†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	99.4	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	19.5	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	117.4	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	10.4	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.7†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	4.2†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	287.4	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	20.8	NA	17.8	109.8
HIV incidence per 100,000 population	2014	11.1	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	16.3		21.4	NA
Syphilis incidence per 100,000 population	2014	2.1†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	327.1	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	*6.3*	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	21.3	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	13.4	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	139.2	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	*89.7%*		85.2%	NA

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Always wear seatbelt (High School Students)	2013	*67.3%*		61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	*75.7*	NA	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	11.7	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	6.9	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*306.0*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	*6.4*	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19.0	4,585
Nonfatal occupational injuries (number)	2013	3,750.0	NA	13,205.0	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	18.8%		19.4%	NA
Adults who have ever had depression	2011-2013	23.1%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	8.4%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	18.3%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	29.2%		35.2%	NA
Mental health emergency department rates per 100,000 population	2011	*2,152.3*	-	1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	22.6%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	13.5%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	*19.7%*	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	*28.8%*	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	57.8%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	45.9%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	*16.9%*		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	*21.9%*	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	17.1%	NA	17.9%	22.9%
Obesity (Adults)	2013	*23.7%*		28.9%	29.4%
Obesity (High School Students)	2013	*9.3%*		12.7%	13.7%
Overweight (Adults)	2013	35.1%		36.0%	35.4%
Overweight (High School Students)	2013	13.9%		16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%
Infant deaths per 1,000 live births	2003-2012	5.7	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	85.9%	NA	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	*12.2*	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.5%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	7.0	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	14.5%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	*20.7%*		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	*9.0%*		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	3.9%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	12.7	NA	12.4	14.6

Maine Shared CHNA Health Indicators	Year	Cumberland	Trend	Maine	U.S.
Emergency medical service overdose response per 100,000 population	2014	467.0	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	*35.3*		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	12.0		13.2	NA
Past-30-day alcohol use (High School Students)	2013	25.6%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.2%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	7.1%		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	22.0%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	1.0%†		1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	5.5%		5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	4.7	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*477.8*		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	17.0%		20.2%	19.0%
Current smoking (High School Students)	2013	10.8%		12.9%	15.7%
Current tobacco use (High School Students)	2013	16.4%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	*30.6%*		38.3%	NA

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


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

+ Indicates a positive trend over time at the county level (using a 95% confidence level)

- Indicates a negative trend over time at the county level (using a 95% confidence level)

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

NA = No data available