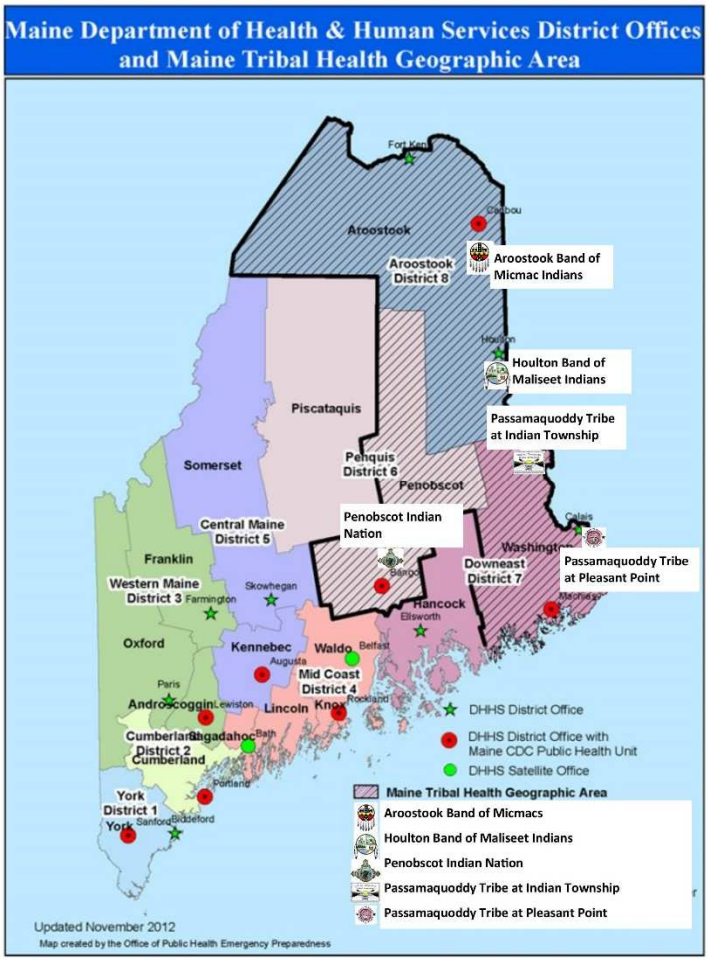
Penquis Public Health District

District Public Health Improvement Plan

2017 – 2019

Penquis District Coordinating Council for Public Health

Maine's Public Health Districts



Penquis Public Health District

Penquis Public Health District includes Penobscot and Piscataquis Counties. The district covers 7,934 square miles with a population of 170,488, giving a population density of 21 people per square mile. Penquis' largest municipalities by population include Dover-Foxcroft, Milo, Greenville, and Guilford. Penobscot's largest municipalities by population include Bangor, Orono, Brewer, and Old Town.

Penquis District Coordinating Council

Leadership: Steering Committee for 2016 - 2017		
Name	**Leadership**	**Organization**
Kathryn Yerxa	Chair	University of Maine Cooperative Extension
Nicole Hammar	Vice Chair	EMHS
Patty Hamilton	SCC Representative	Bangor Public Health and Community Services
Shirar Patterson	Member	United Way of Eastern Maine
Jane Danforth	Member	Millinocket Regional Hospital
Jessica Fogg	Non-voting member	Maine Center for Disease Control and Prevention
Jamie Comstock	Ex-officio member	Bangor Public Health and Community Services

Council Members as of 2016 who contributed to this plan	
Alyssa Coffey	Health Equity Alliance
Bill Shook	Public Health Advisory Board
Boyd Kronholm	Bangor Area Homeless Shelter
Brianna Bryant	Bangor Public Health and Community Services
Caroline King	American Red Cross
Christina Pratley	Mayo Regional Hospital
Dale Hamilton	Community Health Advisory Board
Dyan Walsh	Eastern Area Agency on Aging
Elaine Beaulieu	Bangor Public Health and Community Services
Erin Callaway	Piscataquis Healthy Community/Piscataquis Regional YMCA
Hillary Starbird	Mayo Community Outreach
Kristi Ricker	Wabanaki Public Health
Kristie Libby	Penobscot Valley Hospital
Larry Clifford	Penobscot Community Health Care
Laura Morris	Healthy Sebasticook Valley
Laura Sidelko	University of Maine
LeighAnn Howard	VNA Home Health Hospice/Bangor Area Visiting Nurses
Marie Vienneau	Mayo Regional Hospital
Nelson Durgin	City of Bangor
Nikki Chadwick	Mayo Regional Hospital
Patrick McFarlane	Eastern Maine Medical Center Family Medicine Center

Reid Plimpton	Maine Center for Disease Control and Prevention/Maine Integrated Youth Health Survey
Renae Muscatell	Penquis Community Action Program
Robin Carr	Bangor Public Health and Community Services
Rodney Larson	Bangor Public Health Advisory Board
Roxane Dubay	Wellness Council of Maine
Sara Yasner	Bangor Public Health and Community Services
Shawna Melanson	Healthy Sebasticook Valley
Sherry Tardy	Sebasticook Valley Health
Sue Mackey Andrews	Helping Hands with Heart/Maine Resilience Building Network
Susan Russell	Center for Community Inclusion & Disability Studies
Thomas M Capraro	Piscataquis County Emergency Management Agency
Thomas Malcolm	Millinocket Fire Department
Vicki Rea	Maine Center for Disease Control and Prevention
William Shook	City of Bangor

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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

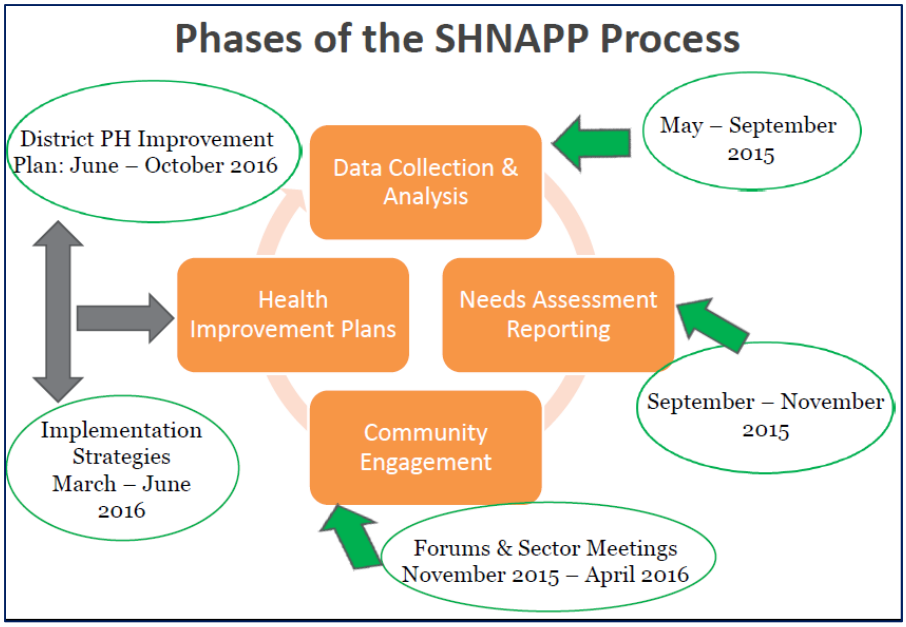
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health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

All the districts were presented with a set of criteria based on the Collective Impact framework. Penquis 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**: 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 ismore difficult to achieve at the local community level.

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

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

- **Address district health disparities**: The district should consider whether they can reduce health disparities between their district and the state or within their population by addressing a specific issue. Populations to consider as having potential health disparities include racial and ethnic minorities, immigrants, migrant farm workers, lesbian, gay, bisexual, and transgender people, people at low income levels, people with veteran's status, people with lower levels of educational attainment, people with physical impairments (include deafness, blindness and other physical disabilities), people with mental impairments (including those with developmental disabilities and mental illness), people over sixty years old, and youth.

- **Strengthen/Assure Accountability**: The district should consider whether change can be meaningfully measured and whether they can hold themselves accountable for changes in outcomes.

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

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

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

- **Gaps in prevention services:** The district should consider if a health issue has not been adequately addressed across the district or in some parts of the district. An

appropriate discussion on root causes, barriers to services, or gap analysis may be an appropriate way to address this.

Penquis District Public Health Improvement Plan

Community Health Improvement Priories

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

- Drug & Alcohol Abuse, Tobacco Use
- Food Security, Obesity, Physical Activity, & Nutrition
- Access to Behavioral Health/Mental Healthcare
- Poverty

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 meetings and online surveys, 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 address district disparities?
- Can the DCC hold itself accountable for achieving the impact or outcome?
- Is it prevention-focused?
- Does the data support the use of the strategy?
- Is there adequate community support, or can this be built?
- Is there an organization that is willing to take the lead?
- Does it fill a gap?

Priority Area 1: Drug & Alcohol Abuse and Tobacco Use

Priority: Drug & Alcohol Abuse and Tobacco Use			
Description/Rationale/Criteria: Data shows that substance abuse continues to be the most significant health issue in Penobscot and Piscataquis counties. Partners from around Penquis Public Health District are engaged in focused efforts to decrease its impact, and substance abuse strategies are included in the Department of Health and Human Services Strategic Plan, many local hospital implementation strategies, and it is a priority for local community collaborations such as the Bangor Public Health Advisory Board and the Community Health Leadership Board.			
Goals	Objectives	Strategies	District Partners
1. Reduce drug and alcohol abuse and tobacco use.	1.1 Increase awareness among adults of the impacts of drug and alcohol abuse and tobacco use.	1.1A Implement harm reduction media campaign targeting adults.	Acadia Hospital, Bangor Area Recovery Network, Blue Sky Counseling, Charles A. Dean Memorial Hospital, City of Bangor, Community Health Leadership Board, Eastern Maine Medical Center, Health Access Network, Health Equity Alliance, Helping Hands with Heart, Maine Opiate Collaborative, Maine Quality Counts Mayo Regional Hospital, Maine Health Access Foundation Healthy Communities Grantees, Millinocket Regional Hospital, Penobscot Community Health Care, Penobscot Valley Hospital, Penquis, Public Health Advisory Board, Sebasticook Valley Health, St. Joseph's Hospital, Wabanaki Health and Wellness
		1.1 B Connect worksites to drug free workplace education and resources.	Organizations listed above, regional Chambers of Commerce, and the Wellness Council of Maine
		1.1.C . Increase opportunities for education around substance use disorder treatment and recovery.	Organizations listed above.

Priority Area 2: Food Security, Obesity, Physical Activity, & Nutrition

Priority: Food Security, Obesity, Physical Activity, & Nutrition			
Description/Rationale/Criteria: According to the Maine Shared CHNA data, obesity, and physical activity and nutrition, rank as two of the top five health issues in the Penquis Public Health District. District partners, including those organizations listed below, have developed strategies and are dedicating resources to address these issues. Strategies below were chosen to address existing gaps and underserved populations.			
Goals	Objectives	Strategies/	District Partners
2. Improve nutrition and increase physical activity in the Penquis Public Health District.	2.1 Increase access to nutrient rich foods among the food insecure.	2.1.A Partner with food insecurity and hunger relief organizations to achieve or make measurable progress on organizational goals identified in self-assessment.	City of Bangor, Eastern Area Agency on Aging, Eastern Maine Healthcare Systems-Partnerships to Improve Community Health Grant, Good Shepherd Food Band, Helping Hands with Heart, local food pantries, Mayo Regional Hospital, Millinocket Regional Hospital, Penobscot Community Health Care, Penobscot Nation, Penquis, Piscataquis Healthy Community, Piscataquis Regional YMCA, Sebasticook Valley Health, St. Joseph Healthcare, United Way of Eastern Maine, University of Maine Cooperative Extension
	2.2 Increase access to physical activity opportunities and nutrition resources.	2.2.A Partner with worksites to identify gaps and implement policies and programs.	Health Access Network, Millinocket Regional Hospital, Penobscot Valley Hospital, regional Chambers of Commerce, Wellness Council of Maine
	2.3 Increase access to physical activity opportunities.	2.3.A Engage existing Active Community Environment Teams to solicit a plan for a project to increase access to physical activity.	Active Community Environment Teams, Organizations listed above.

Priority Area 3: Access to behavioral care/mental healthcare

Priority: Access to behavioral care/mental healthcare			
Description/Rationale/Criteria: According to the Maine Shared CHNA data, mental health ranks as one of the top five health issues in Penquis Public Health District and access to behavioral care/mental health care as one of the top five health factors. A number of partner organizations have included mental health and access to mental healthcare/behavioral care as a priority of focus.			
Goals	Objectives	Strategies/	District Partners
3. Decrease stigma around mental health issues.	3.1. Increase public awareness around mental health disorders and available resources.	3.1A Provide education to the community about disorders and available resources.	Acadia, Blue Sky Counseling, Charles A. Dean Memorial Hospital, Charlotte White Center, City of Bangor, Community-based organizations, Community Health and Counseling Services, Health Access Network, Helping Hands with Heart, Maine Resilience Building Network, Mayo Regional Hospital, Millinocket Regional Hospital, National Alliance on Mental Illness Bangor, Pathways of Maine, Penobscot Community Health Care, Penobscot Valley Hospital, Schools, Sebasticook Valley Health, St. Joseph Healthcare. Wabanaki Health and Wellness

Priority Area 4: Poverty

Priority: Poverty			
Description/Rationale/Criteria: According to Maine Shared CHNA data, poverty is the number one health factor in both Piscataquis and Penobscot counties. As the number one health factor, it has the greatest impact and results in poor health outcomes for residents.			
Goals	Objectives	Strategies/	District Partners
4. Reduce the impacts of poverty.	4.1 Increase the number of organizations that adopt poverty best practices.	4.1.A Affect organizational change though implementation of Poverty Competencies for Leaders, particularly in social services agencies.	Adoptive and Foster Families of Maine, Bangor Area Homeless Shelter, Charlotte White Center, City of Bangor, Department of Health and Human Services, Eastern Area Agency on Aging, Families and Children Together, Food Pantries, Federally Qualified Health Centers, Helping Hands with Heart, Millinocket Regional Hospital, Municipalities, Penobscot Nation, Schools, St. Joseph Healthcare, Penquis, Thriving in Place Grantees, United Way of Mid-Maine, University of Maine, Wabanaki Health and Wellness
		4.1B Partner with social services organizations to apply the two-generational approach to systems, polices, and programs.	Organizations listed above
		4.1.C Increase cultural competencies around poverty.	Organizations listed above

Appendices

1. **Penquis 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 Penquis District Coordinating Council, please contact Jessica Fogg, District Liaison, at jessica.fogg@maine.gov or Kathryn Yerxa, Penquis District Coordinating Council Chair, at kate.yerxa@maine.edu

Appendix 1: Penquis District Health Profile 2015-2016

Maine Shared Community Health Needs Assessment District Summary: 2015				Penquis District Updated: October 2015	
Maine Shared CHNA Health Indicators	**Penquis**	**Penobscot**	**Piscataquis**	**Maine**	**U.S.**
Demographics					
Total Population	170,488	153,364	17,124	1,328,302	319 Mil
Population – % ages 0-17	18.7%	18.8%	17.9%	19.7%	23.3%
Population – % ages 18-64	64.6%	65.2%	59.2%	62.6%	62.6%
Population – % ages 65+	16.7%	16.0%	22.9%	17.7%	14.1%
Population – % White	95.5%	95.4%	96.8%	95.2%	77.7%
Population – % Black or African American	0.8%	0.9%	0.5%	1.4%	13.2%
Population – % American Indian and Alaska Native	1.1%	1.2%	0.6%	0.7%	1.2%
Population – % Asian	1.0%	1.0%	0.8%	1.1%	5.3%
Population – % Hispanic	1.2%	1.2%	1.1%	1.4%	17.1%
Socioeconomic Status Measures					
Adults living in poverty	17.2%	*17.0%*	*18.5%*	13.6%	15.4%
Children living in poverty	21.6%	20.8%	*28.9%*	18.5%	21.6%
High school graduation rate	86.6%	86.9%	83.3%	86.5%	81.0%
Unemployment rate	6.3%	6.2%	7.5%	5.7%	6.2%
65+ living alone	40.5%	40.5%	40.0%	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	*18.1%*	*18.3%*	17.1%	15.6%	16.7%
Adults with 14+ days lost due to poor mental health	13.7%	13.8%	13.2%	12.4%	NA
Adults with 14+ days lost due to poor physical health	13.9%	14.0%	13.3%	13.1%	NA
Adults with three or more chronic conditions	29.6%	29.7%	29.0%	27.6%	NA
Access					
Adults with a usual primary care provider	86.4%	86.4%	86.8%	87.7%	76.6%
MaineCare enrollment	29.9%	29.2%	35.8%	27.0%	23.0%
Percent uninsured	10.8%	10.6%	*14.4%*	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	*1,993.4*	*1,981.9*	*2,095.3*	1,499.3	1458
Oral Health					
Adults with visits to a dentist in the past 12 months	64.2%	63.8%	66.5%	65.3%	67.2%
Respiratory					
Asthma emergency department visits per 10,000 population	*56.3*	*55.5*	67.6	67.3	NA
COPD hospitalizations per 100,000 population	*307.2*	*307.1*	*312.4*	216.3	NA

Appendix 1: Penquis District Health Profile 2015-2016

Current asthma (Adults)	13.1%	13.4%	11.0%	11.7%	9.0%
Current asthma (Youth 0-17)	10.4%†	10.9%†	7.4%†	9.1%	NA
Cancer					
Mortality – all cancers per 100,000 population	190.4	189.4	197.4	185.5	169
Mammograms females age 50+ in past two years	85.3%	85.4%	84.8%	82.1%	77.0%
Colorectal screening	72.9%	72.7%	73.7%	72.2%	NA
Pap smears females ages 21-65 in past three years	89.3%	89.0%	91.4%	88.0%	78.0%
Maine Shared CHNA Health Indicators	**Penquis**	**Penobscot**	**Piscataquis**	**Maine**	**U.S.**
Cardiovascular Disease					
Hypertension prevalence	33.9%	33.5%	36.9%	32.8%	31.4%
High cholesterol	41.7%	42.1%	39.5%	40.3%	38.4%
Diabetes					
Diabetes prevalence (ever been told)	10.6%	10.3%	12.1%	9.6%	9.7%
Pre-diabetes prevalence	7.1%	7.1%	6.8%†	6.9%	NA
Adults with diabetes who have had an A1C test twice per year	76.6%	78.1%	NA	73.2%	NA
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	*1.9%*	*1.6%*	*5.5%*	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	*2.0%*	*2.1%*	*1.4%*	4.2%	NA
Homes with private wells tested for arsenic	*35.2%*	*35.5%*	33.7%	43.3%	NA
Immunization					
Adults immunized annually for influenza	43.3%	44.2%	37.6%	41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	*76.8%*	77.0%	76.2%	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	3.1%	2.9%	4.8%	3.7%	NA
Infectious Disease					
Hepatitis B (acute) incidence per 100,000 population	0.6†	0.7†	0.0†	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	4.1†	4.6†	0.0†	2.3	0.7
Lyme disease incidence per 100,000 population	30.5	32.6	11.7†	105.3	10.5
Pertussis incidence per 100,000 population	73.3	63.2	164.5	41.9	10.3
STD/HIV					
Chlamydia incidence per 100,000 population	336.2	350.0	211.4	265.5	452
Gonorrhea incidence per 100,000 population	10.6†	11.7†	0.0†	17.8	110
Intentional Injury					
Nonfatal child maltreatment per 1,000 population	NA	NA	NA	14.6	9.1
Suicide deaths per 100,000 population	15.9	15.3	21.8†	15.2	12.6
Unintentional Injury					
Unintentional and undetermined intent poisoning deaths per 100,000 population	11.1	11.1	11.1†	11.1	13.2
Unintentional fall related injury emergency department visits per 10,000 population	*311.5*	*303.3*	392.3	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	9.8	10.0	8.2†	10.8	10.5

Appendix 1: Penquis District Health Profile 2015-2016

Mental Health					
Adults who have ever had anxiety	21.5%	21.8%	19.7%	19.4%	NA
Adults who have ever had depression	25.2%	25.8%	21.8%	23.5%	18.7%
Co-morbidity for persons with mental illness	32.9%	33.6%	NA	35.2%	NA
Physical Activity, Nutrition and Weight					
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	*26.1%*	*25.8%*	*28.2%*	22.4%	25.3%
Obesity (Adults)	33.5%	32.4%	NA	28.9%	29.4%
Obesity (High School Students)	14.6%	14.8%	14.1%	12.7%	13.7%
Overweight (Adults)	35.9%	36.7%	30.2%	36.0%	35.4%
Overweight (High School Students)	15.8%	15.9%	15.5%	16.0%	16.6%
Pregnancy and Birth Outcomes					
Infant deaths per 1,000 live births	6.5	6.6	6.5	6.0	6.0

Maine Shared CHNA Health Indicators	Penquis	Penobscot	Piscataquis	Maine	U.S.
Live births for which the mother received early and adequate prenatal care	90.0%	*90.9%*	80.6%	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	18.7	18.2	24.4	20.5	26.5
Low birth weight (<2500 grams)	6.2%	6.3%	4.7%	6.6%	8.0%
Substance and Alcohol Abuse					
Binge drinking of alcoholic beverages (Adults)	16.2%	16.2%	16.0%	17.4%	16.8%
Drug-affected baby referrals received as a percentage of all live births	15.6%	16.0%	11.9%	7.8%	NA
Past-30-day alcohol use (High School Students)	27.7%	28.1%	27.0%	26.0%	34.9%
Past-30-day marijuana use (High School Students)	20.0%	21.0%	15.8%	21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	1.1%†	1.4%†	NA	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	5.8%	6.3%	*3.9%*	5.6%	NA
Tobacco Use					
Current smoking (Adults)	22.8%	22.5%	24.5%†	20.2%	19.0%
Current tobacco use (High School Students)	19.3%	19.6%	18.2%	18.2%	22.4%

Indicates district/county is significantly better than state average (using a 95% confidence level). Indicates district/county is significantly worse than state average (using a 95% confidence level).
† Results may be statistically unreliable due to small numerator, use caution when interpreting.