Maine SHNAPP
Frequently Asked Questions (FAQs) on
Shared Community Health Needs Assessment Reports
2015-2016

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How can this data be useful?

This data can be used for a variety of situations. It is supporting public health organizations and non-profit hospitals in creating Community Health Needs Assessments (CHNAs) at the state, district, county, and (selected) urban levels. It may also be useful for other organizations and agencies who are tracking health behaviors and outcomes to evaluate progress toward goals and work plans. This data may help some organizations complete requests for funding by showing the need for programs or interventions.

What is the difference between a health issue and a health factor?

The Maine SHNAPP Stakeholders Survey asked people responding to it to rate health issues and health factors. Health issues fall under the categories of family health, chronic diseases, infectious diseases, health risk behaviors, and other health issues (such as oral health, violence, injury, etc.), and describe actual health status (how many people have a disease; or health behaviors, i.e. how many people eat a healthy diet). Health factors are conditions such as socioeconomic status, access to health care, or environmental features that can affect the health of individuals and communities. Health factors fall under the categories of economic stability, education, social and community context, health and health care, and neighborhood and built environment. These are the things that affect where we live, work, learn, and play that can play a role in health outcomes.

How do you explain the differences between numbers on the County Health Rankings chart and information outlined in the priority health issues (in the State and County-level Reports) – an example:

> **Rates of binge drinking of alcoholic beverages among adults = 13.7% (p 27 success column)**
> **Excessive drinking = 16% (p 32 right column)**

While the County Health Rankings (CHR) indicators were considered for inclusion in the Maine Shared CHNA, is some cases, the Metrics Subcommittee chose to include slightly different indicators based in part on the criteria listed in a previous question, "How were all the indicators selected?" In other cases, more recent data was used in the Shared CHNA. Since our analyses did not include the ranking or the weighting that the CHR did, we chose to not "recreate" this using SHNAPP data. New data from the County Health Rankings will be released early in 2016.

Why are data sources from such a variety of years? Why do the different indicators have data from different years?

The quantitative data come from numerous sources including surveillance surveys, inpatient and outpatient health data, and disease registries. The data are taken from the most current year(s) available for each source as of July 1, 2015. Since the indicators come from a variety of sources, the data are measured in different time periods. In some cases, where there were not enough data in a single year to produce a statistically valid result, multiple years were combined to compute an indicator.

Why are the data so old? Why don't we have 2014/2015 data?

While analyses were conducted using the most recent data sources available as of July 1, 2015, some of these data sources contain data that are several years old. The most recent Behavioral Risk Factor Surveillance System (BRFSS) and mortality data available at the time of analysis were from 2013, and the most recent hospitalizations and emergency visit data and cancer data were from 2011. This presents a particular challenge in trying to capture recent trends in health in the state, such as with opioid use. The data presented in the reports may not necessarily represent the current situation in Maine, but are the best data available at the time of publication [p 10-11 State Report]. In addition, while there are some indicators that change considerably in a short period of time, for most indicators, such changes are typically small. If a particular indicator indicates a problem in 2013, it will still likely be a problem in 2014 or 2016.

It is surprising the data is so old! (MHDO) What year(s) were used for the 2010/2011 OneMaine Health Collaborative CHNA? [11/13/15]

2007, 2008

Questions Related to the Data Analysis Plan

Why don't we have data at a community level or stratified for every demographic subgroup?

Data from surveys are gathered by sampling a portion of the population instead of from every member of the population. Expanding the sample sizes to provide town level data or data for every demographic subgroup (e.g., African refugees, people with disabilities, people who are uninsured) for every indicator is beyond the resources of these surveys, although attempts to have better county-level data continue. Even so, depending on the number of responses for a certain indicator, more than one year of data may need to be combined to show data at the county-level or for a demographic subgroup.

Data from disease registries or inpatient and outpatient hospitalizations and emergency room visits capture each person in that population. However, the amount of data (responses) for a specific indicator may be too small for an area smaller than a county or a specific subgroup, and too many years of data would need to be combined (If too many years of data are combined, we cannot tell if any trends are happening in 3 or 5 years.).   In addition, in order to protect the privacy of individuals, it is important to not get too specific about these data.

Can we get Brunswick/Harpswell data to add to the Sagadahoc data? [12/8/15]

Not easily. There are not sufficient resources in the SHNAPP project to do these additional analyses at this time. This can be considered for future SHNAPP data/reports.

How were all the indicators selected? What criteria were used? Why isn't [insert topic] included?

Indicators were selected by the Maine SHNAPP Metrics Subcommittee and submitted to the Steering Committee for approval. The Metrics Subcommittee is made of data experts and data consumers from many organizations representing public health, healthcare, professional organizations, and social service

interests. The group took approximately 18 months to complete a process to identify the over 160 indicators included in the 2015 Shared CHNA.

Indicators were selected based on what has been used in the past for similar reports, what Maine CDC is required to report to the US CDC on, what organizations have historically found to be the most useful, what other national health assessments such as Healthy People 2020, the County Health Rankings and America's Health Rankings use, what reliable data is available at a county level, and what stakeholders believed to be the most important to include.

The Metrics Subcommittee and Steering Committee struck a balance between adequately describing multiple facets of population health and delving deeply into any one or multiple health domains. Both groups made a decision to use data sources already easily available that could provide state-level and county-level data. If a topic does not have a readily available state- or county-level data set, it was not considered for inclusion.

If our community organization wants additional data and indicators to be included in future reports what is the process to make this happen?

People or organizations seeking to have indicators included in future Shared CHNA Reports should put their request in writing and share it with Jayne Harper at jayne.harper@mainegeneral.org. Depending on how familiar members of the Metrics Subcommittee are with a particular indicator(s), the person making the submission may be invited to present background information to educate the group prior to decision-making.

What does it really mean to use a rate ratio of 10% when selecting priorities among health issues? (Table 22 in County-Level reports) How is this different than statistically significant?

A rate ratio is a way of calculating differences between groups such as the data for Maine and the USA, or data for a county and the state of Maine. When the difference in the rate between the groups being compared was 10% or more, it was reported as notable. This difference of 10% was used to identify notable differences for the 2010 OneMaine Health Collaborative Health Needs Assessment and was also applied for the 2015 Shared CHNA. This is not the same as statistically significant. It is a difference agreed upon by the researchers as worthy of attention.

Statistical significance means the difference between numbers most likely did not happen by chance. It is a way of calculating differences between groups such as the data for Maine and the US, or data for a county and the state of Maine. When we read the results are statistically significant at the 95% confidence interval, we are saying that 95% percent of the time we would get the same results from a different sample.

Why do some data not include confidence intervals?

For some types of data, such as infectious disease data, standard practice does not include the calculation of confidence intervals. This is true of some data sources that are not based on a sample, but include all reported cases. In some cases, it is known that there are missing cases that may not be randomly distributed, making the use of confidence intervals less useful.

How are the emergency department numbers attributed (in the MHDO)? Is this tied to access? [11/20/15]

The data is from Maine Health Data Organization (MHDO). It includes all people who are treated in the Emergency Department regardless of whether they are admitted to an inpatient unit or not. *If someone is registered in the ED, they are included, even if they leave without being treated.* The data is based on the residence of the patient not the location of the ED.

Is there a cross correlation between major categories for the analysis through the reports? For example, poverty rates + oral health + tobacco use? Does the work with the data look at a leverage point? [12/1/15]

No, we do not have the resources to run these types of analyses. We do analyze single indicators by income and insurance status, which should be on the web by the end of 2015.

Using the BRFSS as the source, is there an analysis of people who rate their health as poor and also have chronic conditions such as diabetes? [12/11/15]

No, not within the scope of the current project. There will be cross tabulations of indicators by age, gender, county, race/ethnicity, sexual orientation, income, education level, health insurance status, and rurality, but not by other health conditions.

Could you clarify some of the definitions for the Maine Health Data Organization (MHDO) indicators? [11/4/15]

- **First, what address is used for the patient? (If the person is an out-of-state student living in Maine for school or someone visiting for the summer, which address is used for them? Maine address? Insurance billing address from out-of-state?)**

   The MHDO collects patient city, state and zip. The rule does not specify whether this is mailing or billing, the 837 form locator indicates that 2010 N4 is "to specify the geographic place of the named party"

- **Second, if someone is counted for inpatient hospitalization, have they stayed in the hospital for a period of time such as 24 hours? How are they counted in this data if they are transferred to another facility after being admitted to the first hospital?)**

Chapter 241 says the following about inpatient data: "F. Hospital Inpatient Data.   "Hospital inpatient data" pertains to the information generated at the time of discharge which is associated with patients who are provided with room, board, and continuous nursing service based on a physician's written order in an area of the hospital where patients generally stay more than twenty-four hours."

Questions Related to How Data are Reported

Why are there so many reports and how are they different?

There is a single state-level report that describes the assessment of health needs among the population of Maine as compared to the nation. There are 16 county-level reports to describe the health needs of the county. There are a series of summary data reports. Each county has a longer summary report outlining each of the quantitative indicators comparing the county to Maine and the US (where data are available) and a shorter summary report containing a smaller number of indicators (subset) with the same comparisons. Both sets of summary reports show trends of movement in indicators where the

data are available. For Maine Public Health Districts with more than one county, reports have been created showing tables of data for the multiple counties in the district. Finally, there are summary data tables for the urban areas of Bangor, Portland, and Lewiston/Auburn. We have provided the results of the analyses done for the Maine CHNA in these different formats so that people can select the format and data that is most useful to them.

Is the information on the Maine CDC website different than the reports? How?
All of the reports are located on the Maine CDC website (www.maine.gov/SHNAPP/). In addition the Maine CDC website contains all of the data tables created for the Shared CHNA – there are cross tabulation data tables on the website that are not included in the reports. All tables on the website are in Microsoft Excel format so people can create their own graphs, charts, and infographics from the data as needed for presentations, reports, or funding applications. Maine CDC does produce other reports with health data in them, as does the Maine Office of Substance Abuse and Mental Health Services. These reports may have data from different years, and additional related indicators.

Clarify the yellow highlight from the State Summary Table [12/18/15]
The yellow highlights indicate a rate ratio of 10% or more. This means there is 10% greater difference in the two rates (ME and US), which could be 10% better or 10% worse.

How do I know something is meaningful – do I only look at the statistically significant differences on the quantitative indicator list?
While it is useful to look for statistical significance, there are other things to consider:
- How much is the difference? Is it a small or large difference? This is what the rate ratio tells us.
- Is the indicator moving in the direction of improved community health or in the opposite direction?
- Do differences vary between the county and state or nation?
- Do related indicators also show similar differences? For example if one is interested in looking at adult obesity, it helps to look at obesity, fruit and vegetable consumption, and physical activity and sedentary lifestyle – as well as some cardiovascular disease and diabetes indicators that show long-term outcomes of obesity.

Is comparing to the state the only measure by which we are determining priorities? [12/14/15]
Just because a county is not significantly different from the state does not mean that it is not an issue in that county. The significant differences are provided to add additional information, not to be the sole determinant of priorities. [See bulleted items listed in response to the previous question.]

Based on this data, what would you say the priorities should be? [3/2016]
There are a lot of different criteria that can be used to select priorities, and we think this is a decision that starts with community conversations about the data. In using data to drive priority selection, there may be different ways of looking at it.
- A community may look at what is a common problem, affecting many people or more people than other issues, or at what issues effect more people than others (such as leading causes of death).
- Community members may look at the severity of an issue, such as whether it causes deaths versus lesser outcomes, or if it cuts lives short at earlier ages.

- Community may want to focus on root causes that cause a number of different poor health outcomes, such as obesity, tobacco or community factors such as poverty, poor housing, or education.
- Looking at economic burden or health care costs caused by an issue go beyond the most of data in the Shared CHNA, but is another way of selecting priorities.
- Another criteria may be by looking at disparities, whether an issues causes more illness or death for one community or one part of the population.

In addition, there may be criteria that are not based on the Shared CHNA data, such as the feasibility of solutions, the evidence of effective interventions, the cost of solutions and interventions, and the political will in the community to address an issue.

Can we get information on the statistically significant differences between County level and available U.S. data? [1/20/16] One participant made the point that national grants often look for supporting data comparing local regions with the nation.

There was no way to portray the US comparisons and the Maine comparisons on the data summaries. In some cases the detailed tables will have this data, while in other cases comparisons cannot be made, or the years of the data analyses are different, and therefore comparisons cannot be made across different tables.

How should we determine what goals to set? (What number should we pick?) [12/14/15]
This is the call of the people implementing strategies to address the issue. Analyses of past trends People often look for benchmarks (such as state or national rates, or the "best state/county" in the state/nation). Healthy People 2020 used a 10% change for the better in 10 years when no other good benchmark was available. Analyses of past trends can also be helpful. Sometimes when an issue is getting worse, the goal may be to just reverse the trend.

Why do the standardized presentations lead with the top 3 health issues and data from the Stakeholders Survey (if we are supposed to be identifying the issues that are important to this group)?
The Maine SHNAPP Stakeholders Survey took place in May-June 2015. While it used a sample of convenience (snowball method), there were 1,639 responses from across the state with representation from every county. Among counties, there was a low of 37 surveys (Sagadahoc) and a high of 220 surveys (Kennebec). Only 2 counties had fewer than 50 surveys and 7 counties had more than 100 surveys. The responses to the Stakeholders Surveys do a good job of describing top health issues and health factors noted by stakeholders from within the counties. These issues were fairly similar across the state, and echo conclusions drawn from previous discussions of priorities.

There are 18 domains or data categories within the Shared CHNA and the researchers purposefully did not provide guidance on which issues should be addressed or how they should be addressed. The top issues from the Stakeholders Survey provide a great starting point for getting the dialogue going about identifying significant health needs and setting priorities, but are not intended to limit discussion on other issues. Community Forums and group presentations are to foster an on-going conversation about improving the health of the community, and we encourage groups to discuss other issues that they find notable or important.

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Research shows that it is difficult for most people to absorb a lot of data at once. Therefore, we decided to limit the data presented, in favor of better discussion.

In the summary tables, NA is represented a number of times, what does that mean? [11/10/15]

NA means "not available." This may mean that the data elements collected in the data source did not include the demographic group in question, that the number of responses for a category were too small to be able to report, that there is not equivalent United States data, or that data from previous years is not comparable.

On the summary tables, where there is a blank or NA in the trend column, do you anticipate having trends available from this 2015 iteration to the 2018 iteration? [12/1/15]

Where there is a blank in the trend column, it means there was no (statistically) significant difference in the indicator over time. If the same indicator is used in future Shared CHNA reports, yes, the trend will be tracked.

Where there is an NA in the trend column, it means the trend was not computed. This may be for a variety of reasons [response to another question in the Data FAQs]. It will depend on the reason and which indicators are selected for future Shared CHNA reports whether these trends may be tracked.

Is there any correlation data between this report and previous iterations? Very little trend data. [11/10/16]

Some comparisons are limited, due to changes in questions and the methodology of surveys over time. In addition, for some indicators, it was necessary to aggregate responses over multiple years, which expands the timeframe needed for comparison data.

The data summaries present available trend directions, typically using a 5-year time frame. When a trend is not indicated and there is no "NA" indicating that trend data is not available, there was no statistically significant trend found.

Trending data would be helpful, prior to 2010. Trends should the big picture. [1/20/16]

Some additional trends will be available in detailed tables on the Maine.gov/SHNAPP/ webpages. Additional trends were beyond the resources of the current project. This need will be considered for the 2018-2019 Shared CHNA, where possible.

For example, see details about changes in BRFSS data weighting methodology; this explains why trends prior to 2011 were not calculated for the 2015-2016 Shared CHNA.

If you compare county reports and the state report data tables, the numbers for Maine differ sometimes by a tenth of a percent. Why is this?

The State-Level Shared CHNA uses a single year of data to report on each indicator and the County-Level Reports relied upon multiple years of data for many indicators.

Questions about Survey Data

How do we know that self-reported survey data is valid? Don't people lie?

Both the adult survey data (BRFSS) and the youth survey data (MIYHS) come from surveys that have gone through extensive testing for validity. While not every question has been thoroughly tested, we do know in general, based on survey research that respondents tend to answer consistently over time, and are for the most part, answer accurately. Because the confidentiality procedures in both surveys, respondents can be assured that their answers are not linked with their identities, reducing the possibility of negative consequences for any particular answer.

How do you screen out lack of objectivity in the responses? [11/18/15]
We have three sources of data that are dependent on individual responses. The Stakeholder Survey asked about perceptions, so there is no attempt to screen out subjectivity. For the MIYHS and BRFSS, individuals are asked specific behavior questions that have been tested over time for reliability and are worded to minimize subjectivity. Self-reported data has limitations in this area.

How do we know that the people who responded to these surveys are like all people in Maine?
Once all responses are collected, calculations are done to "weight" or "rake" the data, so that the pool of people surveyed reflects the actual people of Maine in key characteristics, such as race, gender, age, and county of residence. As a simple example, if 34 women and 66 men are surveyed, their answers are weighted so that the rates reflect the 50/50 gender split in the population. In this case, the answers from each woman would get counted twice as if 68 women and 66 men answered the questions.

Are the survey data age-adjusted? Are the data weighted? [11/4/15]
Plain language explanation of age-adjustment and weighting:
Briefly, age-adjustment means that the rates reported were modified to minimize differences that are caused by having a population that is older or younger than the general population. Since older people tend to die of chronic diseases and Maine has the highest median age in the country, Maine rates of chronic disease mortality are higher than U.S. rates. Age adjusting eliminates this by adjusting the rates to a standard population. Maine's older population is adjusted downward, along with the number of deaths from those age groups. Counties with younger populations, such as Cumberland have less change between the "crude" and "age-adjusted" rates than older counties such as Aroostook. Death, hospitalization, and emergency department visits use age-adjusted rates.

Weighting means that survey responses have been adjusted to reflect the population from which the survey was taken. For example, if a population has equal numbers of men and women, but more women were surveyed, the responses or the men are given more "weight" so that the combined results reflect equal numbers. BRFSS presents both the actual number of survey responses, and the "weighted number," which is adjusted to reflect the total population including reflecting the proportions of people of different races, ethnicities, genders and ages. BRFSS and MIYHS also use this technique to make the survey results representative of the population.

Examples using Maine data
BRFSS – Diabetes Prevalence (weighted to be representative of the population) data is weighted so that the survey responses reflect the population. When a population is older, the responses reflect this. 8,088 people responded to the survey question about diabetes prevalence. 940 of these people say

they had been told they had diabetes. This number was adjusted to reflect the entire population of Maine, resulting in an estimate of 102,784 people in Maine with diabetes. For females, 519 out of 4,758 women said yes to the question, and this was adjusted to a total that is proportionate to the number of women in Maine. For males, 421 out of 3,330 men said yes, and was adjusted to be proportionate to the number of men in Maine.

Diabetes prevalence among adults by demographics, Maine, 2013

	Total Respondents	n	N	%	95% CI
Maine Total	8,088	940	102784	**9.6**	8.9 - 10.4
Female	4,758	519	49,055	**8.9**	8.0 - 9.9
Male	3,330	421	53,729	**10.4**	9.2 - 11.7

Maine Health Data Organization (MHDO)(non-survey data) – Cancer (all types) mortality has been age-adjusted from the crude rate (every case); this makes it more comparable to a population that may have a different age structure.

Cancer Mortality - all types, rates per 100,000 population

		average annual number	crude rate	age adjusted rate
2007-2011	Aroostook	208	288.4	**197.5**
2007-2011	Cumberland	586	208.3	**174.9**
2007-2011	Maine	3,157	237.6	**185.5**

The age-adjusted rates are all lower than the crude rate, since Maine and all of its counties are "older" than the standard US age structure. Aroostook's rates have the biggest difference, since it is the "oldest" of the three populations shown. The age-adjusted rates, however, show that the differences between these rates are NOT due to age.

Clarify the changes in BRFSS data weighting methodologies in 2011. During the 1/11/16 presentation data trends from 2000 to the most recent year were presented for Overweight/Obesity (adult), Sedentary Adults, Diabetes Prevalence, HTN Prevalence, Stroke Mortality, Smkoing Prevalence (adult), All Cancer Mortality, Lung CA Incidence, Lung CA Mortality, Breast CA Mortality, CRC Screening, Adults with Usual Provider, & Opioid stats/trends. Afterward, one of the presenters recalled a change in weighting methodologies for the BRFSS.
Prior to 2011, a simple weighting methodology was used based on the population estimates for the region or state by age, race, and gender groups. For 2011 and beyond, a more complex "raking" methodology was used that also included additional characteristics such as marital status, race or ethnicity, education, etc. **Because of the changes in the methodology, researchers are advised to avoid comparing data collected before the changes (up to 2010) with data collected from 2011 and onward.** Further details and an example of a how trends across these years might be shown are included below.

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The following is directly from the US CDC BRFSS documentation: http://www.cdc.gov/brfss/annual_data/2014/pdf/compare_2014.pdf and http://www.cdc.gov/brfss/annual_data/2011/pdf/compare_11_20121212.pdf .

Since 2011, the BRFSS has used the weighting methodology called iterative proportional fitting (IPF) or raking to weight data. Raking allows incorporation of cellular telephone survey data, and it permits the introduction of additional demographic characteristics that more accurately match sample distributions to known demographic characteristics of populations at the state level. …. Raking adjusts the estimates within each state using the margins (raking control variables). The raking method applies a proportional adjustment to the weights of the cases that belong to the same category of the margin. The iteration (up to 100 times) continues until a convergence to within a target percentage difference is achieved. In 2014, there were up to 16 raking margins used in the following order— county by gender, county by age, county by race or ethnicity, county, region by race or ethnicity, region by gender, region by age, region, telephone service (landline, cellular telephone or dual user), age by race or ethnicity, gender by race or ethnicity, tenure (rent or own), marital status, education, race or ethnicity, and gender by age. *(from the 2014 document)*

Previously, BRFSS processed weighting using post-stratification to estimate how non-respondents may have answered survey questions. The final weight is achieved by multiplying design weight (stratum weight * 1 / number of phone lines * number of adults) by post-stratification adjustment. Post-stratification forces the sum of weighted frequencies to equal the population estimates for the region or state by age, race, and gender groups. One big limitation is that it was not possible to control for the full distribution of other important demographic information such as marital status, race or ethnicity, education, etc. *(from the 2011 document)*

Because of the changes in the methodology, researchers are advised to avoid comparing data collected before the changes (up to 2010) with data collected from 2011 and onward. *(from the 2014 document)*

Below, the BRFSS trend data on rape illustrates how our Epidemiologists are showing the data from the two sets of years.

	Females					Males				
Year	Total Respondents	n	N	%	95% CI	Total Respondents	n	N	%	95% CI
2001	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2002	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2003	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2004	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2005	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2006	2,196	264	55,480	11.4	9.9 - 13.0	1,395	18	4,580	1.0[†]	0.5 - 1.5[†]
2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2008	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2009	2,319	257	60,026	11.9	10.0 - 13.8	1,422	25	8,138	1.8[†]	0.9 - 2.6[†]
2010	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Change in BRFSS methods										
2011	2,216	239	62,137	12.9	10.7 - 15.1	1,380	24	10,230	2.2[†]	1.1 - 3.4[†]
2012	2,287	224	59,045	11.3	9.2 - 13.4	1,516	34	14,497	3.0[†]	1.6 - 4.4[†]

Adults who have ever been raped by sex, Maine, 2001-2012

Data Source: Maine Behavioral Risk Factor Surveillance System.

Definition: Percent of female respondents who have ever had sex with after they said or showed they didn't want or without their consent.

n: Number of female respondents who have ever had sex with after they said or showed they didn't want or without their consent.

N: Estimated number of female respondents who have ever had sex with after they said or showed they didn't want or without their consent.

†: Use caution in interpreting rates based upon a numerator < 50.

95% CI: 95% confidence interval.

NA: Data not available in that year.

In a good presentation, not all the information can be included in print on the slides. Nancy from the Maine CDC has been adding that to what is said during presentations – either on the "interpretation" slide or when the slide with BRFSS data is being shown. This detail is also in the "data sources" section of the reports.

Where can I get more information about the BRFSS? [12/14/15]

The methodology and other information can be found at: http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/brfss/index.shtml. The "data dictionary" provides technical survey methodology, as well as the lists of included questions by year.

Did Bangor High School participate in the MIYHS survey? [11/18/15]

No, this was a local decision and a consideration to take into account when reviewing data. Throughout the state, there is the potential that other schools did not participate in the survey. Again, it was a local decision, but worth keeping into account.

Where is the student data from – providers or students? [12/11/15]

Data sources are included in the State and County reports, and are in a stand-alone document on the www.maine.gov/SHNAPP / with the data summaries. It is from the MIYHS among students in participating schools.

When can we get the new MIYHS data? [12/8/15]

Detailed and comparison reports from the 2015 Maine Integrated Youth Health Survey (MIYHS) are now available. State, public health district, and county level reports on public school students in

kindergarten, grade 3, and grades 5 through 12 are available on the MIYHS website
http://data.mainepublichealth.gov/miyhs/2015_report_fact_sheets.

Questions about Health Topics
Substance Abuse

Why wasn't the middle school data on substance abuse from the Maine Integrated Youth Health Survey (MIYHS) included in the County Report? Why wasn't data about substance treatment programs included in the County Report? [11/4/15]

As noted above, the Metrics Subcommittee and Steering Committee struck a balance between adequately describing multiple facets of population health and delving deeply into any one or multiple health domains. Both groups made a decision to use data sources already easily available that could provide state-level and county-level data. If a topic does not have a readily available state- or county-level data set, it was not considered for inclusion.

There are some data available at www.maine.gov/SHNAPP/ in tables that were not included in the County Reports (to keep their length manageable). Since the 2013 MIYHS was used within the Shared CHNA, one can find middle school student substance abuse data online. Data about substance use disorder treatment programs are not readily available at the state and county level. To obtain more detailed data about substance use disorder treatment in Maine, visit the Maine Substance Abuse & Mental Health Services data dashboard at http://www.maineseow.com/#/home.

How do we access more substance abuse data? [12/8/15]
Maine SAMHS has created the following dashboard: http://www.maineseow.com/#/home.

Other than admissions data, are there other indicators that exist to show there is/is not a substance abuse problem? Admissions data may reflect better the population's willingness to seek help or the severity of the addiction. [1/20/16]
Yes. There are additional indicators in the summary table, and SAMHS produced more in-depth substance abuse data report (http://www.maineseow.com/#/home).

Is the substance and alcohol abuse data (and mental health indicators) available by age and gender? [11/17/15]
It will be available once the data tables are posted to the Maine CDC website. Also look to the recently released reports by the Maine SAMHS for detailed substance abuse and mental health data. MIYHS reports at https://data.mainepublichealth.gov/miyhs/ have youth data by age and grade level.

Why do the Substance Abuse Hospitalization rates and drug affected baby referrals show different results? [11/18/15]
Hospitalization rates are from 2011 and the drug affected baby numbers are more recent. The upward trend for this issue may explain some difference. Also substance abuse hospitalizations only reflect those receiving in-patient treatment, and many people with substance abuse issues do not seek treatment, or receive out-patient treatment. On the other hand, most babies are born in hospitals and receive screening for drug effects. Also, this data includes both moms in treatment with replacement therapies and moms not in treatment.

Why is there no national comparison for drug-affected baby referrals? [1/20/16]

This is Maine-specific data, for which we did not have a corresponding national source. (Maine law requires hospital to report this information to DHHS. Such laws, as well as definitions for reporting may vary by state, and have not been aggregated by a federal agency.)

Are the Substance Abuse Hospitalization rates in northern Maine affected by the lack of access (limited or no beds for SA detoxification)? [12/10/15]

It was beyond the scope of the Maine Shared CHNAs to analyze data for causes, and this is why community conversations about data are important. This is likely true. While the patient's address is used to track these data, patients may not travel to hospitals to other areas of the state. Also note, insurers do not pay for opioid detoxification as it is not life-threatening. Many people with substance use disorder access outpatient treatment or cannot access treatment. Hospitalization data are from 2011 and regional issues with illicit and pharmaceutical drugs have been changing quickly – more recent data may reflect these trends.

Are substance abuse hospitalizations overnight? Are all hospitals included in the MHDO data (specifically Acadia and Spring Harbor)? [12/11/15]

From MHDO staff--Chapter 241 says the following about inpatient data: "F. Hospital Inpatient Data. "Hospital inpatient data" pertains to the information generated at the time of discharge which is associated with patients who are provided with room, board, and continuous nursing service based on a physician's written order in an area of the hospital where patients generally stay more than twenty-four hours." People who present at the Emergency Department and not admitted to an Inpatient room are not included, but are include in ED visit indicators.

Spring Harbor and Acadia as hospitals report to the MHDO.

On the summary table for opiate poisoning, was this a primary diagnosis or secondary diagnosis used for the two opiate items (ED visits and hospitalizations) under Substance and Alcohol Abuse? [11/10/15]

Detailed definitions of all indicators will be available in a data sources document (appended to all of the state and county reports and posted on the www.maine.gov/SHNAPP/) for opiate poisoning, both hospitalizations and emergency visits, this is a primary diagnoses only.

Mental Health/Depression

What is the difference between mental health and depression? [11/13/15]

For the Stakeholders Survey, depression was listed separately from mental health, since the Steering Committee and other experts within the hospitals felt it was important to include depression as a chronic disease (listed among obesity, cardiovascular disease, diabetes, respiratory disease, cancer, neurological diseases, and musculoskeletal diseases) and mental health as a health issue (listed among oral health, violence, suicide/self-harm, unintentional injury, and lead poisoning/other environmental health issues).

In the quantitative data, depression indicators fall under the mental health category, but these indicators also include some other mental health diagnoses such as anxiety. For all of the Power Points

we used the slide of the state map with current depression followed by a slide with "ever had depression" and "ever had anxiety." (Piscataquis County was the only one with depression in the top three while seven counties had mental health in the top three. Mental health was #3 at the state level and depression #5).

Why is there "NA" for Aroostook County and trend for the "Co-morbidity for persons with mental illness" indicator? [1/7/16]; **Under the Mental Health indicator, NA is listed for Somerset County for co-morbidity for persons with a mental illness. Do we know why BRFSS captured this for Penobscot County and not Somerset?** [1/20/16]
Co-morbidity is based on numbers of people that answer yes to current depression AND a (physical) chronic disease. Because this, the numbers of people answering yes to both are smaller than other indicators. For Aroostook and Somerset Counties, the numbers are too small to report, whereas for Penobscot, the numbers are higher due in part to a higher underlying number of people surveyed.

Emergency visits for mental health compared to the number of open beds for mental health emergencies would be an interesting comparison as well as a comparison with number of telepsych beds. [1/20/16]
Additional data and analysis on these issues is beyond the scope of this analysis.

Tobacco

Under tobacco use, does this account for e-cigarette use?
The data from the 2013 Maine Integrated Youth Health Survey (MIYHS) does not include e-cigarette use in the items for smoking or tobacco use. It will in the future.

The data from the 2013 Behavioral Risk Factor Surveillance System (BRFSS) does not include e-cigarette use in the items for smoking or tobacco use. E-cigarette use has been added to more recent BRFSS surveys.

We are not seeing the data on adults that chew tobacco and we see it a lot in Washington County. [11/20/15]
According to the Maine CDC, there are not any stand-alone data regarding tobacco chewing in adults. However, sometime in this coming year, the Partnership for a Tobacco-free Maine will release data for any tobacco use.

Is there data available for third-hand smoke? (response to PPT slide about secondhand smoke exposure among students in grades 9-12 MIYHS) [11/20/15]
At this time, the Maine CDC does not know of any data being collected regarding third-hand smoke exposure either at the state or national level.

Obesity

What is the significant difference in rural and urban areas in Maine, specific to obesity? [11/10/15]

This level of detailed analyses will be made available in detailed tables on the Maine CDC SHNAPP website (www.maine.gov/SHNAPP/) at some time in the near future. The data is below, and shows that regarding obesity, there are no statistically significant differences between the four levels of urban/rural used in the SHNAPP analyses:

Obesity among adults by demographics, Maine, 2013

Rurality					
Metro	1,932	520	83,294	**27.7**	25.1-30.3
Large Rural	2,638	760	111,039	**29.6**	27.3-31.9
Small Rural	2,241	675	74,527	**30.7**	28.2-33.2
Isolated Rural	688	190	18,852	**29.0**	24.2-33.8

Do we consider access to healthy food? As it seems the poorer you are the heavier you are. [12/18/15] Access to healthy food and food security are two of the health factors listed and rated for the Stakeholders Survey but the Maine SHNAPP did not have any secondary quantitative data about these topics.

Children with Special Health Care Needs

How come there is not county level data for Children With Special Health Care Needs?
[11/17/15]
The data come from a national survey (National Survey of Children with Special Health Needs) and county-level data are not collected/available.

Births

How come there is not data showing all live births in Maine to compare to Live Births to 15-19 Year Olds per 1,000 Population? [11/17/15]
The leadership of the Shared CHNA had to balance the number and types of indicators included. The "Live Births to 15-19 Year Olds per 1,000 Population" metric was included in the report because scientific evidence indicates that teen pregnancy is a marker for current and future sexual risk behavior and adverse health outcomes for both mothers and babies.*(Reference: County Health Rankings website-http://www.countyhealthrankings.org/app/#!/maine/2015/measure/factors/14/description, accessed, November 21, 2015)*

The rate of all live births in Maine is readily available in another place. Including this additional measure in future Shared CHNA reports can be reviewed by the SHNAPP Metrics Committee.

Regarding immunizations of children, the rate shows 75% for 2 year olds and under. Why are these rates so low? [11/18/15]
Slightly older data might not reflect the most recent trend, but the more recent rates we have for Maine from the National Immunization Survey (parent self-report)(2014) do not provide county-level estimates.

County-level estimates are from ImmPact (2015), Maine's immunization registry, which still does not include every provider participating. Some parents opt to not immunize, based on medical reasons, religious reasons, and philosophical reasons. These are all allowed for exemptions from school requirements in Maine, and we have included an indicator on Kindergarten philosophical exemptions.

Also note other possible reasons that contribute to the rather low percent of for 2-year olds who were fully up-to-date for seven recommended vaccines.

- The percentage up-to-date for the series of seven vaccines is a stringent measure. A child is only considered "up-to-date" if they have received ALL doses for all seven vaccines by age two years. Five of the seven vaccines require more than one shot- an initial dose and then booster doses administered at subsequent visits. A child may need to get 19 shots to be up-to-date for these seven vaccines.
- An important reason why the up-to-date rate is so low is that the delivery of one or more vaccine (initial shot or boosters shots) gets delayed. While all doses of the vaccine are ultimately given to the child, they often happen after a child's 2nd birthday. In these cases, the child is considered NOT up-to-date because the age selection criteria used in ImmPact to determine immunization status is age 2 years old. If a 2-year old child has received 18 out of 19 required doses, they are considered NOT up-to-date. Reasons for the vaccine delivery getting behind schedule range from missed wellness visits, to practices not having the vaccine in stock, to parents making a conscious choice to postpone a shot until a later visit due to concerns about their child getting too many shots in one visit.

Diabetes

Deaths due to diabetes seems very small (20 out of 100,000 slide) based on data from 2009-2013, a five year combination provided. What is the source of this number? [11/20/15]
Death data is from Maine Vital Records. Data sources are provided in the full reports and on the website with the summary tables.

Are these deaths due to diabetes as a primary or secondary cause? [11/20/15] **Do diabetes deaths include those that are caused by complications of Diabetes?** [12/1/15]
Yes, these are deaths that include diabetes as an underlying cause.

Do you think that diabetes incidence has been increasing or are we doing a better job of identifying and diagnosing it? (Group was looking at a trend graph of diabetes prevalence, 2000-2013) [1/4/16]
While the answer to this question is not part of the analysis of the Shared CHNA, the person presenting the trend data feels this is due to system-wide improvements in screening and availability of evidence-based programs to address pre-diabetes and diabetes in central Maine. In general, the analysis done for

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the Shared CHNA does not include root causes analyses. This type of interpretation is intended to be part of the community engagement process.

Infectious Disease

Did you include Lyme under infectious diseases? [12/18/15]
Yes.

Health Care Access

Graph titled "Adults who named usual source of care" for "Adults with a usual primary care provider" from indicator list. Comment: This doesn't clarify if the respondent is talking about a PCP or the ED. *(Note this was from supplementary slides added for a particular presentation)* [1/4/16]
The source document shows this indicator is from the 2013 BRFSS and called "Adults with a usual primary care provider." The notes section explains BRFSS respondents are asked if they have one or more persons they think of as their personal doctor or health care provider.

Hypertension

Is it true that in rate of hypertension hospitalizations per 100,000 population for Aroostook County is really 70.1 (compared to ME at 28.0)? Why is this number so high? [1/7/16]
Probably. The trend data was calculated and was not shown to be significantly different over time. We are 95% confident that the actual rate is between 60.8 And 79.5. Also, it is important to look at similar indicators (those related to HTN and CVD) and these rates and percentages are also significantly higher for Aroostook than for the state. To answer why this number is so high, it is best to speak with clinicians and local experts as this type of analysis was beyond the scope and resources of the Shared CHNA.

Lead Screening

For Lead Screening Rates among children, is this based on all children or is it only for those who screen that lead may be an issue? [4/22/16]
The denominator for lead screening rates is all children from the age cohort.

Pneumonia

For ED Rates for Pneumonia, is it provider diagnosis or diagnosis via confirmed x-ray/scan? [4/22/16]
ED rates for pneumonia are based on all diagnoses, based on ICD-9 CM codes - 480-486. This includes both provider diagnoses and diagnoses via confirmed x-ray/scans among de-duplicated visits. MHDO hospital inpatient/outpatient database is the data source.

What topics were included within the Stakeholders Survey?

There were a number of questions about important health issues and health factors , including a rating of most critical issues, the ability of Maine's health system (including public health) to respond to issues, availability of resources and assets for specific health issues, impact on disparate populations, and identification of the entities primarily responsible for addressing issues and determinants. The survey asked all respondents a basic set of questions to rate importance of health issues and impact of health factors. It then allowed respondents to provide answers to probing questions on the three issues and factors that they were most interested in.

Who responded to the Stakeholders Survey?

Survey respondents represented public health and health care organizations as well as behavioral health, business, municipalities, education, public safety, and nongovernmental organizations. More than 80 organizations agreed to send the survey to their members or stakeholders. Some of the organizations included:

- Maine Public Health Association,
- Maine Medical Association,
- Maine Area Agencies on Aging,
- Maine State Chamber of Commerce,
- Maine Development Foundation,
- Maine Municipal Association,
- Maine Drug Court/Court System,
- Maine Police Chiefs,
- Maine Sheriffs and
- Maine Department of Public Safety.

Do you know the breakdown (by community sector) of Stakeholder Survey respondents?
[11/17/15] and **Who answered the Stakeholder survey, did it include health care providers?** [12/1/15]

The objective of the survey was to produce qualitative data of the opinions of health experts and community stakeholders on the health issues and needs of communities in the state. Given this purpose, the survey used a snowball sampling method by inviting leaders of member organizations and agencies to invite their members and employees to participate. A concerted effort was made to recruit participants from a number of different industries and backgrounds across all communities in the state. Survey respondents represented public health and health care organizations as well as behavioral health, business, municipalities, education, public safety, and nongovernmental organizations. [Below is Table 27, p 67 of State-level Report] To answer this question at the county-level, refer to Table 26 of county-level reports under the Demographics section.

Sectors that Best Describe Respondents' Role or Organization	Percentage
Medical care provider/hospital	22%
Other nonprofit or social service agency	14%
Public health	11%
Business owner or employee	9%

Educator	8%
Other type of health care organization	8%
Behavioral/mental health provider	6%
Local government	4%
Other governmental agency	3%
Youth-serving organization	2%
Faith-based organization	1%
Other	13%

Percentage of respondents in corresponding sector

How was qualitative data analyzed from the Stakeholders Survey?

Respondents provided over 12,000 open ended comments in the survey. The Market Decisions/Hart Consulting team reviewed, coded and cleaned all open ended comments for similar and recurrent themes. This was first done by hand, with researchers reviewing all comments and grouping and coding similar comments by theme. As a second step, Wordstat text mining software by Provalis was used to scan all comments and identify patterns and themes in the data. The final, coded groups of comments were developed using a combination of these two approaches and reflect the actual verbatim comments provided by stakeholders (no editing was done to the comments). The coded comments are used throughout the report to provide more detailed information on the health issues and factors identified by stakeholders as most important to their communities and to support the results of the quantitative analysis. Not all respondents shared comments for the open-ended, probing questions.

When people responded to the online Stakeholders Survey, were they responding personally (for themselves) or for the people in the geographic area in which they live/work? [11/12/15]

Geographic area.

On the stakeholder survey, did the respondents have access to the data prior to taking the survey? [12/18/15]

No. The quantitative data analyses were finished after the stakeholder survey was completed. Stakeholders may have had access to other data, but they were not given quantitative data from us with the survey.