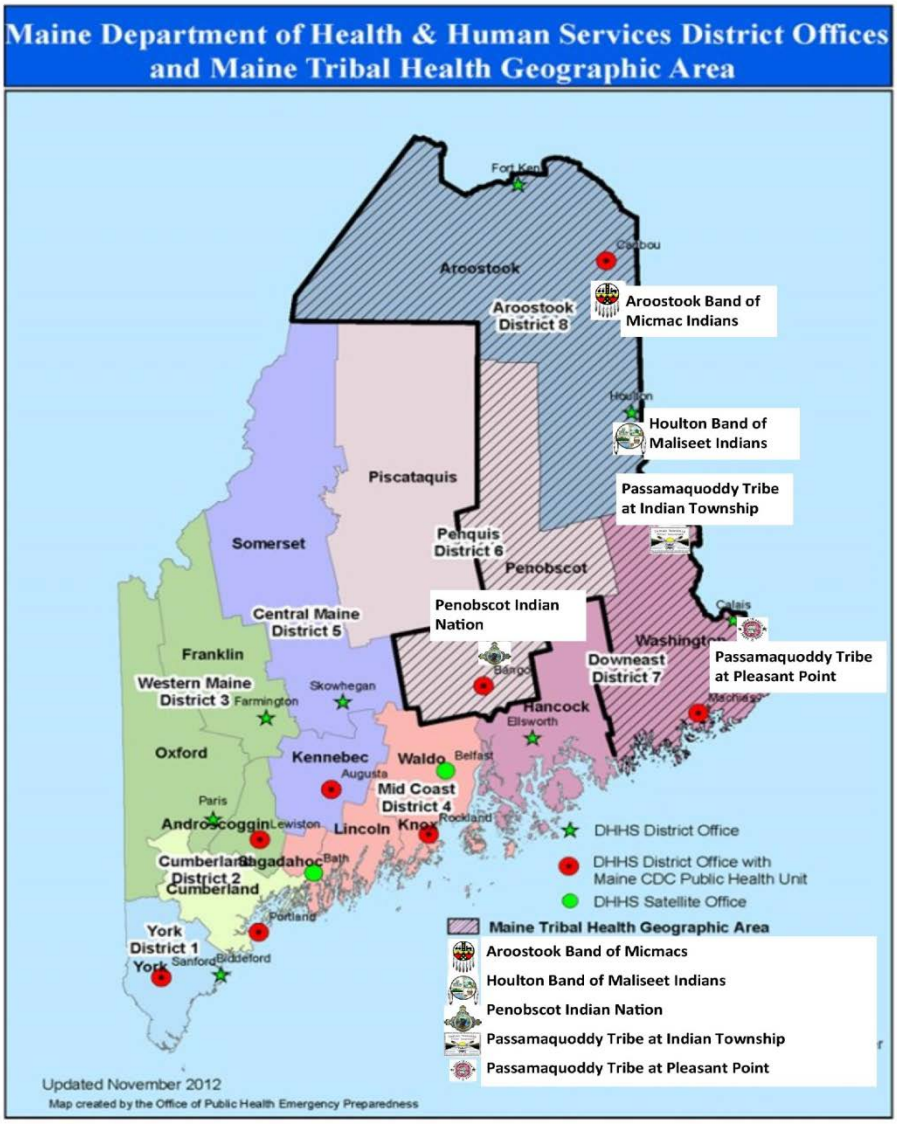
Aroostook Public Health District

District Public Health Improvement Plan

2017 – 2019

Aroostook District Coordinating Council for Public Health

Maine's Public Health Districts



Aroostook Public Health District

Aroostook Public Health District includes Aroostook County, the northern most county in Maine. The district covers 6,828 square miles with a population of 70,055, giving a population density of 11 people per square mile. Aroostook's largest municipalities by population include Presque Isle, Caribou, Fort Kent, and Houlton. Aroostook has a large amount of its area composed of unorganized townships and plantations where there are limited services and seasonal populations.

Aroostook District Coordinating Council

The mission of the Aroostook DCC is to be the district-wide representative body for collaborative public health infrastructure development in Aroostook County by:

- ensuring the effective and efficient delivery of the 10 Essential Public Health Services in Aroostook County
- creating and sustaining partnerships and shared public health resources
- promoting county-wide collaboration in public health assessment, planning, implementation, and evaluation;
- continually enhancing the quality of public health services provided

Leadership: Steering Committee for 2016 - 2017

Name		**Organization**
Dr. Rachel Albert	Chair	University of Maine at Fort Kent
Stacy Boucher	District Liaison	Maine CDC
Greg Disy	Steering Committee	Aroostook Mental Health Center
Heather Pelletier	Steering Committee	Fish River Rural Health
Jim Davis	Vice Chair, Aroostook District Representative to the Statewide Coordinating Council	Pines Health Services
Joy Barresi Saucier	Steering Committee	The Aroostook Medical Center
Carol Bell	Steering Committee	Healthy Aroostook / Community Stakeholder
Alain Bois	Steering Committee	Northern Maine Medical Center
Victoria Moody	Steering Committee	Houlton Regional Hospital

Members and *Agency Ad Hoc Contributors 2016		
Laura Turner	Nutrition and Physical Activity/Cardiovascular Health/Alcohol and Substance Abuse	***The Aroostook Medical Center**
Gary Michaud	Member	Caribou CBOC & Fort Kent Access Point Veterans' Administration
Leah Buck	Member	Northern Maine Community College
Ralph McPherson	Access to Care (standing committee)	***Eastern Maine Health Systems – Community Care Team**
Danielle Langley	Member	Healthy Families
Jason Parent	Member/Nutrition and Physical Activity/Drug and Alcohol Abuse	***Aroostook County Action Program**
Ben Zetterman	Member	Aroostook EMS
George Howe	Member	City of Presque Isle
Victoria Moody	Nutrition and Physical Activity	***Houlton Regional Hospital**
Lisa Fishman	Nutrition and Physical Activity	***University of Maine Cooperative Extension**
Kristi Ricker	Member/Nutrition and Physical Activity/Drug and Alcohol Abuse	***Tribal Public Health District**
Michelle Plourde-Chasse	Drug and Alcohol Abuse	***Community Voices**
Peter McCorison	Drug and Alcohol Abuse	***Aroostook Mental Health Center**
Mark Shea	Drug and Alcohol Abuse	***Aroostook Substance Abuse Prevention Coalition/Power of Prevention Coalition**
Darren Woods	Member	Aroostook EMS
Jay Kamm	Member	Northern Maine Development Commission
Jessica St. Peter	Cardiovascular Health	***Visiting Nurses of Aroostook**
Jim Davis	Cardiovascular Health	***Pines Health Services**
Bill Flagg	Member/Drug and Alcohol Abuse/Cardiovascular Health	***Cary Medical Center**

Members and *Agency Ad Hoc Contributors 2016 Continued		
Linda Mastro	Member	***Northern Maine Community College, University of Maine at Presque Isle**
Carol Bell	Drug and Alcohol Abuse/Cardiovascular Health	***Community Stakeholder**
Mike Gahagan	Member	Caribou Police Department
Norman Fournier	Member	County Commissioner
Pat Smith	Member	Hope and Justice Project
Patty Carson	Member	Maine CDC
Sherry Locke	Member	United Way of Aroostook
Stephen James	Member	Homeless Services of Aroostook
Steve Farnham	Member	Aroostook Agency on Aging
Tanya Sleeper	Member	Aroostook Home Health Services

***Agency Ad Hoc Contributors:** Agency Ad Hoc Contributors are those agencies who may or may not be voting members of the District Coordinating Council but directly contributed to the development of the 2017-2019 District Health Improvement Plan. Some agency's contributed through representatives of the organization listed that have specialized skills. Steering Members contributed throughout the process but are not denoted.

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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

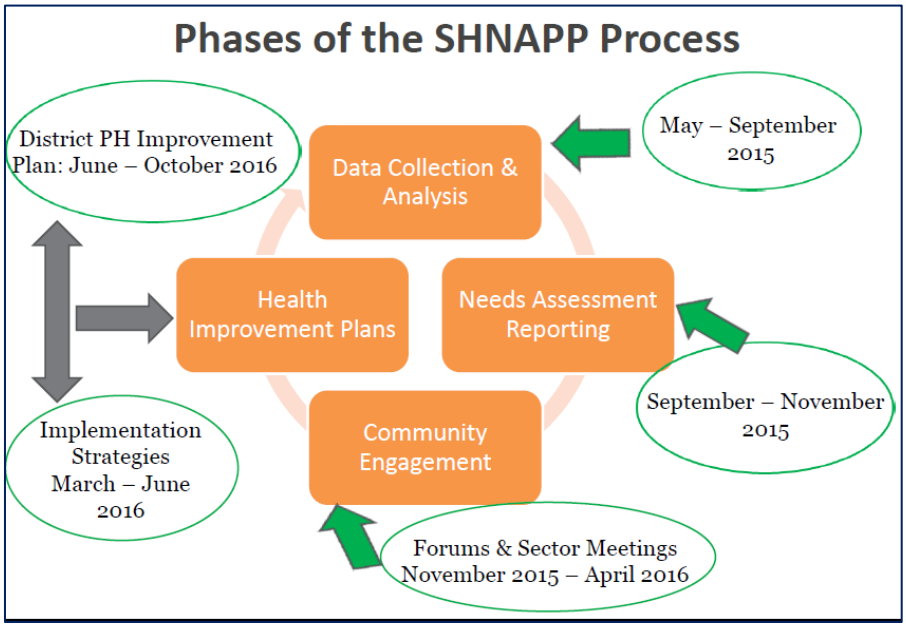
The District Public Health Improvement Plan (DPHIP) identifies the individual district's public health priorities in order to create a multi-year plan of objectives, strategies, and outcomes for district action. The DPHIP also informs partners of the district work and is used to inform the State Health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

Many members and stakeholders of the Aroostook District Coordinating Council participated in one or more of the three (3) regional Shared Community Health Needs Assessment forums. Consequently, as a Council they were very familiar with the data and methodology for interpreting the findings.

Furthermore, Aroostook DCC interested party response to the stakeholder survey disseminated by the SHNAPP committee was robust. The resulting ranking of priority health indicators by respondants was consistent with the statistical presentation of disease in Aroostook District.

The Aroostook DCC Steering Committee reviewed summary community engagement feedback as well as two (2) parking lot conditions proposed for consideration. This information was then shared with the full Aroostook District Coordinating Council. On February 3, 2016 the Council chose to focus on three (3) priorities that would be addressed during the 2017-2019 timeframe.

Once priority areas had been formally selected, members and stakeholders convened for ad hoc committee meetings. Each ad hoc committee was charged with one priority and met 3 to 4 times to create priority, objective, and strategy statements. Meetings were held beginning in October 2016 and ended in November of 2016.

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

- Maximize impact and optimize limited resources
- Use evidence-based strategies and population-based interventions
- Use population-based interventions (dependent on initiative)
- Best addressed at no larger than the district level
- Address district health disparities
- Strengthen/Assure Accountability
- Reduce duplication of other DHHS funded activities
- Gaps in prevention services

Aroostook District Public Health Improvement Plan

Community Health Improvement Priories

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

- Drug and Alcohol Abuse
- Cardiovascular Health
- Nutrition and Physical Activity

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 stepswere 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 and Alcohol Abuse

Priority Statement: Increase resources needed to meet the challenge posed by drug and alcohol abuse.			
Description/Rationale/Criteria: According to 2015 Shared Community Health Needs Assessment data, 80% of 110 Aroostook District stakeholders rated drug and alcohol abuse as a major or critical health challenge in the County. Those stakeholders also identified that greater access to drug/alcohol treatments; greater access to substance abuse prevention programs; more substance abuse treatment providers were among the community resources necessary to address the health challenge. These sentiments were echoed by participants at each of 3 regional Community Engagement forums conducted throughout the District. The recommendations are consistent with the fact that 65% also felt that the health system (including public health) did not have the ability to significantly improve access to behavioral care/mental health care with the current investment of time and resources. This suggests that coordination, collective effort, and additional resources should be directed to addressing Drug and Alcohol Use as a district-wide public health priority.			
Goals	Objectives	Strategies	District Partners
1.Reduce the impact of drug and alcohol abuse by supporting and enhancing the behavioral health of Aroostook County residents.	**1.1 Access to Intervention and Treatment Resources:** Enhance the continuum of care for Aroostook County residents who struggle with substance abuse issues.	1.1.A.Increase behavioral health service capacity in Aroostook District by increasing the number of individuals who enter the profession by 20 professionals by June 2019.	Aroostook Mental Health Center (AMHC) University of Maine at Fort Kent Pines Health Services Cary Medical Center Northern Maine Community College The Aroostook Medical Center (TAMC)
		1.1.B. Increase the collaboration between behavioral health and primary care providers, through adoption of integration models such as Behavioral Health Homes or Community Care Teams.	
		1.1.C Increase the number of primary care providers that perform substance abuse screening as a regular practice by implementing SBIRT or other evidence-based screening tools.	
		1.1.D. Increase the availability of resources for Aroostook District residents to provide support for individuals with substance abuse issues.	

Priority Area 1: Drug and Alcohol Abuse Continued:

Priority Statement: Increase resources needed to meet the challenge posed by drug and alcohol abuse.			
Goals	Objectives	Strategies	District Partners
1. Reduce the impact of drug and alcohol abuse by supporting and enhancing the behavioral health of Aroostook County residents.	**1.2 Public Education:** Increase awareness of substance abuse issues (for prevention resources, etc.) for adult populations in Aroostook District.	1.2.A. Increase awareness of the impact of substance abuse in Aroostook District	
		1.2.B. Increase awareness of resources for Aroostook District residents to support individuals with substance abuse issues.	

PriorityArea2: Cardiovascular Health

Priority Statement: Reduce the incidence of morbidity and mortality of chronic cardiovascular disease so Aroostook residents live longer, healthier lives.

Description/Rationale/Criteria:
Aroostook District has a number of statistically significant cardiovascular related health indicators that rank us highest among all public health districts in the State of Maine. These include:

- Acute myocardial infarction hospitalizations per 100,000[Aro=39.5;ME=23.5]*
- Acute myocardial infarction mortality per 100,000[Aro=40.0;ME32.3]*
- Coronary heart disease mortality per 100,000[Aro=111.8;ME=89.8]*
- Hypertension prevalence [Aro=40.7%;ME=32.8%]*
- Hypertension hospitalizations per 100,000[Aro=70.1;ME=28.0]*
- Diabetes mortality (underlying cause)per 100,000[Aro=24.3;ME=20.8]
- Current smoking (adults)[Aro=22.8%;ME=20.2%;US=19.0%]
- Current smoking(high school students)[Aro=16.4%;ME=12.9%;US=15.7%]

Goals	Objectives	Strategies	District Partners
2.Reduce the health impacts of cardiovascular disease on Aroostook residents.	**2.1. Leadership and Collaboration:** Build capacity of communities in Aroostook County to work together to optimize population-based cardiovascular health at the individual and community level by engaging the business community.	2.1.A. Increase the number of employers offering evidence-based wellness programming such as Healthy US to their employees.	Pines Health Services Cary Medical Center Aroostook County Action Program ,Inc.(ACAP) Visiting Nurses of Aroostook University of Maine at FortKent TAMC
	2.2 Promote Evidence-based Preventive Services, Resources and Secondary Prevention Practices: Increase the use of evidence-based preventative services, resources, and secondary prevention practices to reduce the incidence and impact of cardiovascular disease.	2.2.A. Increase the number of policies that facilitate low cost/no cost hypertension screening opportunities for Aroostook District residents.	
		2.2.B. By December 31,2018, increase the percentage of worksites that offer a wellness program which includes blood pressure screening for all employees.	

Priority Area 2: Cardiovascular Health Continued

Priority Statement: Reduce the incidence of morbidity and mortality of chronic cardiovascular disease so Aroostook residents live longer, healthier lives.			
Goals	Objectives	Strategies	Partners
		2.2.C. By June, 2018 increase the number of healthcare providers utilizing the National Diabetes Prevention Program or other evidence-based diabetes prevention guidelines to 100%.	
		2.2.D. By December 2019, increase access to evidence based tobacco cessation programming.	
	2.3 Nutrition: Decrease the number of Aroostook District residents that eat a diet that places them at increased risk of cardiovascular disease.	2.3.A. By December 2017, increase access to nutritionally sound foods by vulnerable populations at increased risk of diet related cardiovascular/diabetic complications.	
	2.4 Public and Professional Education: Increase awareness of evidence based strategies for improving cardiovascular health	2.4.A. Increase cardiovascular health promotion and disease prevention education activities to enhance behavior and lifestyle changes at the community level.	
		2.4.B. Increase the number of health organizations that utilize emerging technology, such as tele-health for the management of cardiovascular disease in Aroostook District from 1 to 3 by 2019.	

PriorityArea3: Nutrition and Physical Activity

Priority Statement: Increase opportunities for Aroostook County residents to be active and eat healthier foods.			
Description/Rationale/Criteria: According to the 2015 Shared Health Needs Assessment stakeholder survey, "Obesity" was rated as the "biggest health issue in Aroostook County". This assertion is evidenced by statistical data as well. In 2013, 38.3% of adults in Aroostook we are obese(BMI of 30 or more)compared to 28.9% for the State of Maine and the national average of 29.4%. Statistics also suggest that as a population, Aroostook residents are more sedentary, eat less fruits and vegetables and drink more sports drinks and sodas. These factors are complicated by economics in Aroostook District. There are more people living in poverty[Aro=16.3%;ME=13.6%] and a lower median household income [Aro=$37,855;ME=$48,453;US=$53,046] in the County. Since Physical Activity, Nutrition and Weight indicators can also be linked to cardiovascular disease prevention, making obesity and overweight a priority has a cumulative effect in the overall mission to improve health outcomes for residents of Aroostook District.			
Goals	Objectives	Strategies	District Partners
3.Reduce the impact of obesity and unhealthy weight in Aroostook District	**3.1 Food Insecurity:** Decrease food insecurities among Aroostook District residents by increasing access to food sources such as food pantries and meal centers.	3.1.A. Complete a baseline assessment of Aroostook District food pantries and meal site in order to determine access issues.	ACAP University of Maine Cooperative Extension Northern Maine Recreation Directors Houlton Regional Hospital TAMC
		3.1.B. Assist Aroostook District food pantries and meal sites in recruitment of volunteers to expand hours of operation by 20%.	
	3.2 Physical Activity: Increase the percentage of adults who have met physical activity recommendations.	3.2.A. Increase the number of sites that offer low cost or free access to physical activity through collaboration with organizations that focus on physical activity.	
		3.2.B. Promote what is available in the community to increase physical activity for families where childcare could be an issue.	
	3.3 Healthy Foods: Increase the number of Aroostook County residents consuming a healthy diet.	3.3.A.Increase the number of Aroostook District residents with access to nutrition education.	

Priority Area 3: Nutrition and Physical Activity Continued

Priority Statement: Increase opportunities for Aroostook County residents to be active and eat healthier foods.			
Goals	Objectives	Strategies	Partners
		3.3.B. Increase awareness of the opportunities to learn healthy food preparation and consumption.	

Appendices

1. **Aroostook 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 Aroostook District Coordinating Council, please contact Stacy Boucher, District Liaison, at stacy.boucher@maine.gov or Rachel E. Albert, PhD, RN, realbert@maine.edu.

Appendix 1:Aroostook District Health Profile 2015

Maine Shared Community Health Needs Assessment
County Summary: 2015

Aroostook County

November 2015

Qualitative Stakeholder Input

A survey of 110 health professionals and community stakeholders in Aroostook 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 Aroostook County resulting in poor health outcomes for residents.

Top five health issues

- Obesity
- Drug and alcohol abuse
- Cardiovascular diseases
- Diabetes
- Respiratory diseases

Top five health factors

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

Maine Shared CHNA Health Indicators	Year	Aroostook	Trend	Maine	U.S.
Demographics					
Total Population	2013	70,055		1,328,302	319 Mil
Population – % ages 0-17	2013	19.1%		19.7%	23.3%
Population – % ages 18-64	2013	60.4%		62.6%	62.6%
Population – % ages 65+	2013	20.6%		17.7%	14.1%
Population – % White	2013	95.5%		95.2%	77.7%
Population – % Black or African American	2013	0.8%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	1.8%		0.7%	1.2%
Population – % Asian	2013	0.5%		1.1%	5.3%
Population – % Hispanic	2013	1.1%		1.4%	17.1%
Population – % with a disability	2013	21.6%		15.9%	12.1%
Population density (per square mile)	2013	10.8		43.1	87.4
Socioeconomic Status Measures					
Individuals living in poverty	2009-2013	*16.3%*	NA	13.6%	15.4%
Children living in poverty	2009-2013	*23.7%*	NA	18.5%	21.6%
High school graduation rate	2013-2014	88.1%	NA	86.5%	81.0%
Median household income	2009-2013	*$37,855*	NA	$48,453	$53,046
Percentage of people living in rural areas	2013	100.0%	NA	66.4%	NA
Single-parent families	2009-2013	33.0%	NA	34.0%	33.2%
Unemployment rate	2014	7.6%	NA	5.7%	6.2%
65+ living alone	2009-2013	45.5%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	*21.0%*		15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	11.5%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	*17.2%*		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	*35.1%*		27.6%	NA
Mortality					
Life expectancy (Female)	2012	81.3	NA	81.5	81.2
Life expectancy (Male)	2012	75.1	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	*800.8*	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	87.0%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	11.1%		11.0%	15.3%
MaineCare enrollment	2015	37.4%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	52.3%	NA	41.8%	48.0%

Maine Shared CHNA Health Indicators	Year	Aroostook	Trend	Maine	U.S.
Percent uninsured	2009-2013	10.9%	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	*1,791.9*	+	1,499.3	1457.5
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	*6,147.5*	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	*51.9%*	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	58.4%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	*113.5*	–	67.3	NA
COPD diagnosed	2011-2013	*10.6%*		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	*380.7*	–	216.3	NA
Current asthma (Adults)	2011-2013	13.2%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	13.6%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	736.3		719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	*445.0*	–	329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	197.5	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	487.6	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	26.9	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	24.2	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	34.7	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	*100.2*	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	85.3%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	20.0	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	24.4	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	*56.2*	NA	43.5	42.0
Colorectal screening	2012	72.2%	NA	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	60.6	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	*87.8*	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	*13.1*	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	89.4%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	17.4	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	*104.3*	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	38.6	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	95.9	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	*39.5*		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	*40.0*	NA	32.2	32.4
Cholesterol checked every five years	2011. 2013	82.3%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	*111.8*	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	22.2		21.9	NA
Hypertension prevalence	2011, 2013	*40.7%*		32.8%	31.4%
High cholesterol	2011, 2013	*47.7%*		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	*70.1*		28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	20.7		20.8	NA

Maine Shared CHNA Health Indicators	Year	Aroostook	Trend	Maine	U.S.
Stroke mortality per 100,000 population	2009-2013	39.9	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	*14.2%*		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	9.5%		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	NA	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	77.0%	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	NA	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	*352.0*		235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	*13.8*		11.7	NA
Diabetes long-term complication hospitalizations	2011	66.8		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	24.3	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	*0.7%*	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	3.8%	NA	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	*30.2%*	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	*71.1%*	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	27.5%	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	*36.5%*		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	69.5%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	0.6%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	86.0%	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	0.0†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	0.0†	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	64.8	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	7.2†	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	7.2†	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	97.9	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	0.0†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	2.9†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	161.3	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	1.4†	NA	17.8	109.8
HIV incidence per 100,000 population	2014	0.0†	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	18.6		21.4	NA
Syphilis incidence per 100,000 population	2014	0.0†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	284.1	NA	413.0	NA

Maine Shared CHNA Health Indicators	Year	Aroostook	Trend	Maine	U.S.
Firearm deaths per 100,000 population	2009-2013	8.6	NA	9.2	10.4
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	10.0†	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	14.5	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	70.0	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	*76.2%*		85.2%	NA
Always wear seatbelt (High School Students)	2013	*47.1%*		61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	86.6	NA	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	9.9	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	4.1	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	*427.9*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	14.2	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19	4,585
Nonfatal occupational injuries (number)	2013	637	NA	13,205	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	21.5%		19.4%	NA
Adults who have ever had depression	2011-2013	23.2%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	11.2%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	15.5%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	NA	NA	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	1,867.8		1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	23.6%		24.3%	29.9%
Seriously considered suicide (High School Students)	2013	14.0%		14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	16.5%	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	35.1%	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	50.0%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	45.6%	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	*27.7%*		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	30.1%	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	20.4%	NA	17.9%	22.9%
Obesity (Adults)	2013	*38.3%*		28.9%	29.4%
Obesity (High School Students)	2013	11.5%		12.7%	13.7%
Overweight (Adults)	2013	31.1%		36.0%	35.4%
Overweight (High School Students)	2013	18.1%		16.0%	16.6%

Maine Shared CHNA Health Indicators	Year	Aroostook	Trend	Maine	U.S.
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	6.4	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	85.1%	NA	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	*25.5*	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	7.6%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	10.7	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	15.0%		14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	*13.9%*		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	*4.9%*		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	8.9%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	11.7	NA	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	305.3	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	21.2		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	10.8		13.2	NA
Past-30-day alcohol use (High School Students)	2013	26.5%		26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	3.4%		3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	6.8%†		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	*16.5%*		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	1.8%†	NA	1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	5.0%		5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	7.0	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	*125.7*		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	22.8%		20.2%	19.0%
Current smoking (High School Students)	2013	16.4%		12.9%	15.7%
Current tobacco use (High School Students)	2013	18.4%	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	*46.0%*		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 an improvement in the indicator over time at the county level (using a 95% confidence level)

– Indicates a worsening in the indicator over time at the county level (using a 95% confidence level)

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

NA = No data available