LIVE UNITED

United Way
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of Greater Portland

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Health White Paper

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INTRODUCTION

Health matters. Health impacts individual experience as well as families, communities and schools. And health impacts the economy profoundly, both in financial and productivity costs. Health is not solely about individual health factors and the lack or presence of disease - in fact "long before we need medical care, our foundation for health begins in our homes, schools, jobs and neighborhoods."[1] The wide-reaching impact of health status reminds us of the importance of looking at all factors that contribute to health, especially when attempting to evaluate the health status of a population, such as Cumberland County. According to The Institute of Medicine: "the health of a nation's population is determined by the conditions it creates for living, the equity in opportunity that it affords, and the access to and quality of its medical care delivery system."[2]

The consequences of not systematically addressing the issue of health can be significant. The economic costs alone are staggering:

- "Medical bankruptcy is the number-one cause of personal bankruptcy in the United States.
- Americans pay three times more for medical debt than they do for bank and credit-card debt combined.
- Nearly a fifth of [Americans] will hear from medical-debt collectors this year, and they'll gather $21 billion from [them], collectively." [3]

Examining health data allows a glimpse into what is driving this intense economic impact: chronic disease, which is incredibly costly, includes cancer, heart disease, stroke, chronic lower respiratory disease, and diabetes. Chronic disease is the leading cause of death for Maine residents; in 2008 it accounted for more than 60% of deaths among Maine residents.[4] Chronic disease, and the conditions and health risk behaviors related to it, account for most health care costs. In the United States, 86% of all health care spending in 2010 was for people with one or more chronic medical conditions.[5]

The impacts of chronic disease are widespread, such as an adult's ability to work and maintain employment and a child's ability to get an education. Asthma is the leading cause of school absences from chronic illness for children aged 5 to 17, accounting for an annual loss of more than 14 million school days per year nationally (approximately eight days annually for each

[1] http://www.rwjf.org/en/our-topics/topics/social-determinants-of-health.html.
[2] "For the Public's Health: Investing in a Healthier Future" from Institute of Medicine, 2012. See more at: http://iom.nationalacademies.org/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx#sthash.rtRzHXBC.dpuf.
[3] http://www.theatlantic.com/health/archive/2014/10/why-americans-are-drowning-in-medical-debt/381163/ Direct reference: http://www.nerdwallet.com/blog/health/2014/03/26/medical-bankruptcy/.
[4] "Healthy Maine 2020 Report," from Maine Center for Disease Control and Prevention. http://www.maine.gov/dhhs/mecdc/healthy-maine/documents/HealthyMaine2020_2-25.pdf.
[5] Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf.

student with asthma).[6] When a population is healthy, children do better in school, employees are more productive, families have more money to spend, and businesses can add jobs because health costs are lower.[7,8,9] It is also important to note that Maine adults with lower levels of education are significantly more likely to have asthma, high blood pressure, diabetes, and other chronic diseases, and are significantly less likely to have received certain cancer screenings compared to those with more education.[10]

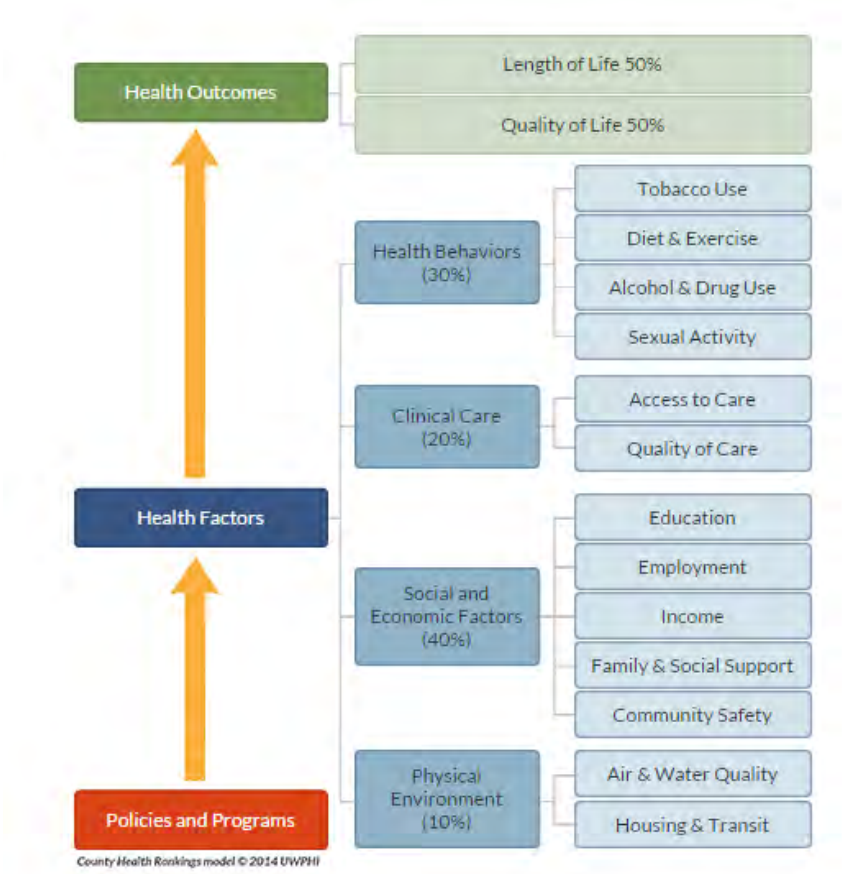
Examining the individual and community impact of chronic disease is a tangible way to illustrate the importance of health status and its widespread impact. To understand the health status of a community one must look not only at health outcomes, but also the factors that facilitate and support a healthy, or unhealthy, community. The evidence recommends that a comprehensive approach is necessary to help people and communities achieve and sustain a healthy life. A healthy population needs access to health care services, safe environments, and health promotion and wellness supports.

SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

Social determinants of health are the circumstances in which people are born, grow up, live, work, play and age as well as the systems in place to deal with illness. These determinants, which individually and collectively impact health outcomes, recognize that health status is driven by more than genetics. Indeed, the circumstances associated with the social determinants are shaped by a wider set of economic, social and political forces and there is little personal control over the majority of the determinants.[11] The Social Determinants of Health Framework also clearly depicts the interconnectedness across the areas of education, financial stability and health.

The Social Determinants of Health Framework is pictured below:[12]

[6] "Healthy Maine 2020 Report," Maine Center for Disease Control and Prevention. http://www.maine.gov/dhhs/mecdc/healthy-maine/documents/HealthyMaine2020_2-25.pdf.
[7] "Leading by Example", Partnership for Prevention and U.S. Chamber of Commerce, 2007 http://www.prevent.org/downloadStart.aspx?id=26.
[8] "National Prevention Strategy", National Prevention Council, Office of the Surgeon General, June 2011, http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf.
[9] "National Prevention Strategy: America's Plan for Better Health and Wellness", Centers for Disease Control and Prevention, January 2014, http://www.cdc.gov/features/preventionstrategy/.
[10] Maine Behavioral Risk factor Surveillance System, Maine Center for Disease Control and Prevention, 2010.
[11] "United Way of Greater Portland Health Report" from University of New England Center for Community and Public Health, August 2012.
[12] The Social Determinants of Health framework was created by University of Wisconsin for the County Health Rankings Project and funded by Robert Wood Johnson Foundation (RWJF). United Way Worldwide has worked with the RWJ to distribute this model through the United Way Network.



This framework is powerful in understanding, and improving, population-based health status. The framework is based in the evidence as to what impacts health outcomes, with the ultimate definition and measurements being both how long and how well someone lives. It groups health factors into four categories of focus areas: Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment. Each health factor is supported by multiple measures. For example, health behaviors are broken down into tobacco use, diet and exercise, alcohol and drug use, and sexual activity. These factors can be mitigated and addressed by the implementation of evidence-based programs and state and local policies (specific programs are linked on the County Rankings website). The presence or absence of these evidence-based interventions in a community can impact health outcomes.

This framework is not intended to be owned by any one organization. Because health and all its related factors are so complex, it would be difficult for any one organization to have a mission in complete alignment. For example, social and human service agencies like United Way would likely not have a substantial role in implementing program or policies in the Physical Environment realm, but would likely be a key partner in the other areas. Similarly, a substance abuse organization cannot solve the problem of substance abuse alone; prevention and access

to care issues must be tackled together. Successfully addressing the social determinants of health requires alignment of organizations and their resources in a mutually reinforcing way.

This framework suggests percentages for each of the health factors to articulate what, and to what degree, each contributes to health outcomes for individuals and families. It recognizes that individuals and their biology do not have complete control over their current health or health status. For example, the focus area of health behaviors represents only 30% of what ultimately determines health outcomes and is driven by tobacco use, diet and exercise, alcohol and drug use and sexual activity.

What is powerful and transformative in this model is the notion that clinical care, as measured by examining access to care and quality of care, has a relatively small impact (20%) on an individual's health.

The factors that individuals have the least amount of control over are Social and Economic Factors and Physical Environment, yet they make up 40% and 10%, respectively, of what ultimately impacts health outcomes. The Physical Environment measures are air and water quality and housing and transit. Social and Economic Factors tracks indicators that measure education, employment, income, family and social support, and community safety. Although Physical Environment is likely outside the scope of most social service providers' mission, with the exception of housing and transit, the intersection of Social and Economic Factors is significant: the single largest collection of factors impacting an individual's health outcomes are directly related to education and financial stability issues. Indeed, there is an opportunity to apply a multi-disciplinary perspective on community issues.

It is important to recognize that the areas in which individuals have very little control over the factors can lead to the presence of health disparities and inequities. This must be further explored and demonstrates why communities must look beyond individual health behavior and disease prevalence data to fully evaluate and understand health status.

The Social Determinants of Health model is not only useful as a framework because of the reasons articulated above, it is useful because of the data and tools that have been associated with it as a framework for examining population level health outcomes. This model is also particularly useful because of the data and tools that accompany it. County Health Rankings created the action model[13] below to provide community members with direction on how to define factors and their scope, and utilize the data in a meaningful way to impact health. The County Health Rankings also delineates roles and potential responsibilities for specific stakeholders, demonstrating the importance of partnership and alignment across organizations.

[13] http://www.countyhealthrankings.org/roadmaps/action-center.

HIGH-LEVEL SNAPSHOT AND SOCIAL DETERMINANTS OF HEALTH DATA: THE INTERCONNECTION OF EDUCATION, FINANCIAL STABILITY AND HEALTH

From a health and well-being perspective, Cumberland County residents are healthier than residents in other parts of the state, but there is significant progress to be made.[14] According to the County Health Rankings Cumberland County Report, Cumberland County is ranked second in the state for overall health outcomes and first for health behaviors, clinical care, and socioeconomic factors. However, Cumberland County ranked twelfth for physical environment factors– this includes air and water quality and housing and transit measures.[15]

Cumberland County represents one of two medical hubs in Maine and residents enjoy the benefits of two teaching hospitals in Portland that focus on primary care. It also includes two major health care systems: MaineHealth and EMHS. Dental and oral health clinics exist in Portland and Westbrook. And a robust mental health and substance abuse network of service providers also exists. However, even with these resources, the needs of Cumberland County are immense and available resources do not always meet needs. This is in part due to insufficient resources to meet demand, lack of emphasis on prevention, and a complex interplay of social and economic factors.

[14] The Maine Shared Health Needs Assessment and Planning Process Project (SHNAPP) is a joint project of the four major hospital systems (Central Maine Healthcare, EMHS, MaineGeneral Health, MaineHealth) and the Maine Centers for Disease Control and Prevention with a mission to create a "framework and approach for a shared community health needs assessment (shared CHNA) that can: addresses community benefit reporting needs of hospitals, supports state and local public health accreditation efforts, and provides valuable population health assessment data for a wide variety of organizations concerned with the health of Maine's communities and citizens." Updated SHNAPP reports will be available every three years. This coordinated effort translates to the availability of local, high quality data that will be readily available to benchmark community goals and outcomes.

[15] http://www.countyhealthrankings.org/app/maine/2015/rankings/cumberland/county/outcomes/overall/snapshot.

Indeed, as mentioned earlier, it is necessary to have data that describes the social determinants of health factors as well as data specific to health behavior and disease in order to understand the health status of the population. The Social Determinants of Health model has confirmed that an individual and community's health status is impacted by a number of factors. A smaller percentage of those factors, about 30% are health behaviors that a person has some control over.[16] The other factors - access to care, social and economic, and the physical environment are ones that people have much less control over, yet they significantly impact health outcomes. For this reason it is important to consider Cumberland County demographics when looking at health status.

A look at various data sources indicates that despite the second overall ranking above and the presence of a high quality medical hub, there are wide disparities and inequities. For example, individuals with higher annual household income (over $50,000) report their health as excellent, very good or good (94.8%), as compared to 53.8% of individuals with incomes under $15,000. This is significant for two reasons. **Research has demonstrated that those living at lower socio-economic levels as well as those with less education are more apt to experience health disparities.**[17,18] They tend to have higher levels of chronic disease, higher levels of smoking, and suffer from higher rates of mental illness and heavy drinking.[19] They also tend to live lives which are typically unhealthy compared with the richest 5% of income strata. This is important to Cumberland County because almost 16% of children and 11% of adults are living in poverty.[20] The table below provides an overview of the negative implications to health as it relates to poverty levels.

Other statistics are representative of the complex interplay between health, education, and financial stability:

- Individuals with lower income ranges (an annual income of less than $25,000) have health status of poor/fair which is 23% higher than individuals who have incomes of over $50,000 annually. [21]
- Individuals experiencing poverty are more likely to live in substandard housing.
- According to Kids Count 2013 report, 19.3% of Maine's children under the age of 18 are living in poverty.[22]
- In Cumberland County, 15% of one and two year old children are screened for lead (as compared to 23% in Maine) with 3.2% of these children having elevated levels (as compared to 2.5% in Maine).[23]

[16] http://www.countyhealthrankings.org/our-approach/health-factors.
[17] http://content.healthaffairs.org/content/21/2/60.full.
[18] http://www.cdc.gov/healthyyouth/disparities/.
[19] http://content.healthaffairs.org/content/21/2/60.full.
[20] http://www.countyhealthrankings.org/app/maine/2015/rankings/cumberland/county/outcomes/overall/snapshot.
[21] BRFSS (Behavioral Risk Factor Surveillance System), Maine Centers for Disease Control.
[22] Kids Count 2013 Report. http://www.mekids.org/assets/files/kidscount/2013KidsCount_lores.pdf.
[23] Maine Shared Community Health Needs Assessment Cumberland County Summary Report, 2015.

Analysis of United Way of Greater Portland partner agency application data from prior years suggests the number of people in poverty who are helped by health-related, United Way funded programs has increased nearly 15% in the last five years. Partner agencies also report providing more substance abuse and mental health services in the past 12 months than in prior years.[24]

FY15 United Way of Greater Portland Partner Agency Demographic Data by Goal Areas

By funded program	Substance Abuse	Basic Health Care Access	Mental Health	Senior Independence	Violence and Abuse
Male	51%	46%	46%	28%	23%
Female	49%	54%	54%	72%	77%
Below poverty	80%	85%	29%	13%	19%
Low income	14%	3%	65%	86%	59%
Above low income	6%	12%	6%	0%	22%
UWGP Investment	$192,963	$218,860	$512,476	$204,588	$274,395

HEALTH DATA HIGHLIGHTS AND EVIDENCE-BASED PUBLIC HEALTH APPROACHES & COMMUNITY STRATEGIES

To support and promote healthy communities it is imperative that data is systematically reviewed, gaps are identified and best available evidence is utilized to address needs comprehensively. The health assessment data for Cumberland County clearly demonstrates that there are significant needs. It is important that both health issues and preventative factors are addressed and attended to. A community that is solely focused on the health or disease status, but not on supporting prevention efforts, will not be successful in being the healthiest community possible. Cumberland County must address access to care and connect patients to health care services (both physical and mental health); support the development and maintenance of safe homes and communities; and promote health and wellness.

For the purposes of examining data and considering promising strategies, this paper focuses on the first three factors in the Social Determinants of Health Framework: healthy behavior, clinical care, and social and economic factors.

[24] UWGP investment process and partner agency data 2013.

FOCUS AREA #1
HEALTH BEHAVIOR: SUPPORT HEALTH PROMOTION AND WELLNESS
Overview and Promising Strategies

In the health behavior category, the framework identifies four factors: tobacco use, diet and exercise, alcohol and drug use, and sexual activity. Obesity, as part of diet and exercise, and substance abuse behaviors are the two primary considerations.

Obesity

Obesity is a staggering problem for Cumberland County, the State of Maine and the entire country. Like tobacco use, it is linked to the leading causes of death and disease. In 2013, 24% of adult Cumberland County residents, as compared to 29% of adult Mainers, were reported to be obese. In addition to this, almost 35% of adult Cumberland County residents and 36% of Mainers are overweight.[25]

This is an issue with teens in Maine as well. In 2013, 9% of Cumberland County high school students and 13% of Maine high school students were reported to be obese. In addition to this, 14% Cumberland County high school students and 16% of Maine high school students are overweight.[26]

This equates to **59% of the adult Cumberland County population and 23% of the youth population being either overweight or obese.**

The protective factors for obesity are increasing healthy food choices and exercise, reducing recreational screen time and limiting or restricting sugar sweetened beverages. Less than half of Maine high school students reported they were active for 60 minutes a day and fruit and vegetable consumption of both Maine high school students and adults is lower than U. S. averages.[43] Roughly one out of four (26.2%)[43] of Maine high school students are drinking sugar sweetened beverages daily. In all cases there is opportunity for improvement.

For a community to be healthy, it must support preventive health and wellness efforts for individual behaviors and the entire health care systems. The Community Guide to Preventative Services recommends the following promising obesity prevention and control intervention strategies:

- Provider-level interventions that use methods or techniques that directly engage a health care professional or a team of professionals to address overweight and obesity.[27]
- Programs designed to reduce screen time, technology-based strategies, and interventions specific to worksite and school settings.[28]

[25] Maine Shared Community Health Needs Assessment Cumberland County Summary Report, 2015.
[26] Ibid.
[27] http://www.thecommunityguide.org/obesity/provider.html.
[28] http://www.thecommunityguide.org/obesity/communitysettings.html.

Let's Go! recommends implementation of the following five evidence-based strategies to address childhood obesity. These strategies are used in concert with a consistent message across multiple settings.

Let's Go! has also identified priority evidence-based strategies including:[29]

1. Provide healthy choices for snacks and celebrations; limit unhealthy choices.
2. Provide water and low fat milk; limit or eliminate sugary beverages.
3. Provide non-food rewards.
4. Provide opportunities for children to get physical activity every day.
5. Limit recreational screen time.

Substance Abuse: Alcohol & Drug Use

Data demonstrates that substance abuse is an alarming issue in Cumberland County. Currently, significant attention is being given to the use of opiates, the lack of local residential detox and treatment options, and the lives lost due to overdose. Deaths from heroin overdoses have been steadily increasing since 2010, but the issue of substance abuse, and mortality directly related to use and abuse, is much broader.

As reported by the National Centers for Disease Control and Prevention, in 2013 there were 83 drug-induced deaths and 144 alcohol-induced deaths.[30] Nineteen percent of Cumberland County adults self report excessive drinking in the past 30 days and 30% of driving deaths involve alcohol.[31] These rates are relatively similar to the rest of the state, but significantly higher compared to other states.[32] The rate of opiate poisoned Emergency Department visits in Maine is 25 per 100,000 people and in 2014 the number of drug affected babies born in Maine was almost 8% of all live births.[33] Youth substance abuse rates are alarming as well. Twenty-six percent of high school students report using alcohol in the past 30 days and 22% report using marijuana during the same timeframe.[34]

Addiction to tobacco must also be considered. Tobacco is the most preventable cause of death and disease. In Cumberland County 17% of adults and 16.4% of high school seniors are self-reported cigarette smokers.[35] While these rates are slightly lower than the rest of the state, there is significant room for improvement and opportunity to impact health status.

[29] http://www.letsgo.org/programs.
[30] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html.
[31] County Health Rankings, 2015 data summary.
[32] County Health Rankings, 2015 data summary.
[33] DRAFT State SHNAPP report, 2015.
[34] MIYHS, 2014 Data.
[35] Maine Shared Community Health Needs Assessment County Summary Report, 2015.

In addition to an incredible impact on health status, substance abuse has a significant economic impact. A new study published in American Journal of Preventative Medicine found that excessive drinking costs the US $249 billion in 2010, or $2.05 a per drink – a significant increase from $223.5 billion or $1.90 per a drink in 2006.[36] Substance abuse data reveals that this issue impacts all ages and demographics and requires action.

Addiction is a cycle and interventions and treatment goals vary depending on the substance of choice (alcohol, opiates, marijuana and tobacco, for example) and the progression of the disease. Promising and evidence-based strategies to comprehensively address substance use, abuse and addiction in a community must include the following components: prevention programs; harm reduction initiatives (when appropriate) and evidence–based treatment services available for the entire age span regardless of ability to pay. Increasing excise taxes on alcohol and tobacco is an important strategy to explore.

Rhode Island experienced a spike in opiate overdoses similar to Cumberland County's. In response it has developed and implemented a ten-point strategic plan to curb overdoses and death, which includes[37]:

1. Establish statewide overdose surveillance mechanisms.
2. Increase usage and effectiveness of the Prescription Monitoring Program (PMP).
3. Increase access to naloxone training and distribution programs.
4. Increase licensed healthcare worker and institutional responsibility.
5. Implement and expand disposal units throughout the state.
6. Support prevention policies that work.
7. Increase general public awareness of drug overdose as a preventable public health problem.
8. Support and affirm people at risk for drug overdose.
9. Increase access to substance abuse treatment.
10. Build state capacity to implement drug overdose prevention and rescue programs.

FOCUS AREA #2

CLINICAL CARE: CONNECTION TO NECESSARY HEALTH SERVICES

Overview and Promising Strategies

In identifying clinical care, the framework is acknowledging access to care as an important element. Although Maine's rates of uninsured have decreased from 16% in 2013 to 9.4% in 2015,[38] there is still a sizable segment of the population that does not have access to insurance coverage or consequently necessary health care services. This is in large part because of the

[36] The American Journal of Preventative Medicine, http://www.ajpmonline.org/content/infoformedia.
[37] Rhode Island Medical Journal, (Bowman, Engelman, Koziol, Mahoney, Maxwell, & abd MKenzie, 2014) October 2014.
[38] http://www.pressherald.com/2015/08/10/health-insurance-rate-maine-improves-many-still-go-without-polls-shows/.

decision not to expand MaineCare which would provide coverage for approximately 22,000 people.[39] The SHNAPP State Draft report states that basic health care access in Cumberland County is slightly above the state average and that individuals are getting care in the appropriate setting with the majority reporting they have a primary care doctor. Having coverage does not equate to affordable care and does not predetermine the health status of a community or individual. An estimated 11% of Cumberland County residents lack access to preventative health care due to a lack of insurance.[40]

In considering access to health care, there are two main health issues that surface: access to mental health and substance abuse services. Data clearly indicates that connecting communities to necessary health care services in these areas is an issue of significance in Southern Maine. Community members need access to comprehensive services including physical health, substance abuse, mental health and oral health care services. This access is aligned with what is discussed in the Social Determinants to Health Framework as Clinical Care and is measured by examining and tracking access to care and quality of care.

Access to Care: Mental Health

Mental illness has a profound effect on health outcomes. A 2006 study determined that **Americans with major mental illness die 14 to 32 years earlier than the general population** and are dying from natural causes attributed to chronic disease.[41] This population also experiences higher rates of tobacco use and obesity. Life expectancy in the referenced study ranged from 49 to 60 as compared to average U.S. life expectancy of 77.9 years.[42] Maine data also depicts higher rates for mental health indicators for women and girls.

Data shows that mental health is a significant issue in Maine and Cumberland County. In the United States about one in four adults and one in five children have diagnosed mental health disorders. Mental health disorders are the leading cause of disability for 15-44 year olds.[43] In Cumberland County, 23% of adults are reported as having ever had depression and 9% as currently experiencing symptoms.[44] Twenty-three percent of high school students reported feeling sad or helpless for two weeks in a row.[45] In the past year almost 20% of Cumberland County residents receive outpatient mental health treatment.[46]

[39] KFF report: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.
[40] 2015 County Health Rankings Summary for Cumberland County.
[41] Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prevention Chronic Disease 2006 Apr Vol 3: No.2.
[42] Ibid.
[43] National Institutes of Mental Health - http://www.nimh.nih.gov/health/statistics/prevalence/index.shtml.
[44] BRFSS Data, 2014.
[45] MIYHS Data, 2013.
[46] BRFSS Data, 2014.

Mental disorders are among the most common causes of disability,[47] so evidence-based services for the chronically and persistently mentally ill, regardless of ability to pay, are needed to protect and promote a healthy community. Examples of promising strategies from comprehensive services include cognitive and medication-based treatments, case and care management services, housing and employment supports.[48]

In addition to having appropriate community supports and programs in place there is also an important role for public policy when ensuring communities have access to health care services.

Access to Care: Substance Abuse

Substance abuse is a significant issue in Cumberland County; left unaddressed, it can undermine having a healthy community in which people can live and work. Lack of access to substance abuse services and treatment adversely impact one's health, as well as their education attainment and financial stability. In this paper, substance abuse behaviors, as opposed to access to substance abuse services, are addressed in the Health Behaviors section above.

FOCUS AREA #3
SOCIAL AND ECONOMIC FACTORS: SUPPORT DEVELOPMENT AND MAINTAIN SAFE HOMES AND COMMUNITIES

Overview and Promising Strategies

Social and economic factors include education, employment, income, family and social support, and community safety. Many of these factors are addressed in the education and financial stability white papers and therefore this paper addresses senior independence as an issue of family and social supports and domestic violence as a community safety issue.

Senior Independence

When the Social Determinants of Health Framework identifies family and social supports, perhaps the most significant issue in a state like Maine, with a rapidly growing senior population, is senior independence. Providing seniors with social supports can reduce isolation and increase community engagement, increase quality of life, and keep seniors in their homes. "Aging in place" may reduce the impact of isolation and mental health issues, thereby allowing individuals to live longer and healthier lives.

The rapid aging of the population of Maine is something to consider when examining the health status of Cumberland County. Individuals aged 65 and older comprise almost 16% of the Cumberland County population.[49] Forty-three percent of those adults are living alone, as

[47] http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders.
[48] http://www.thecommunityguide.org/mentalhealth/index.html.
[49] Maine Shared Community Health Needs Assessment Cumberland County Summary: 2015.

compared to 41% statewide.[50] An important indicator to examine while thinking about older adults is emergency department visits due to falls; in Cumberland County, this was 306 per 100,000[51]. Community supports are needed to keep seniors safe in their preferred, and most appropriate, housing situation.

Seniors are an example of a target population that needs special accommodations to be safe in their homes and communities. Maine is the oldest State in the nation, which poses significant demographic issues. The availability of services that allow them to safely age in place (if that is their desire) is necessary. The appropriate type and amount of home health services is both a safety and cost effective way to keep seniors in the most appropriate housing situation for their individual scenario. This is also a financial stability issue that must be addressed in that not all seniors can afford the costs of services to remain at home. Nevertheless, supporting seniors to age in place with home care services is much more cost effective than moving seniors into skilled nursing facilities, especially when that level of care is not absolutely necessary.

Domestic Violence

Community safety and domestic violence in particular, is an important issue when examining the health status of a community. No one adult or child can thrive and reach his full potential when living in an unsafe environment. Accidents and violence affect health and quality of life in the short and long term, for those directly and indirectly affected.[52]

When reviewing domestic violence prevalence and corresponding injury data, it is important to acknowledge that it is often under-reported due to social stigma. 2013 Federal Bureau of Investigation data ranked **Maine as number nine in the country for women killed by men**.[53] The rate for domestic assaults in Cumberland County (reported to police per a 100,000 population) is 327.[54] While accurate domestic violence data is hard to attain, it is also hard to provide it with context that makes it easier to understand. For this reason, it is noteworthy that the above rate of 327 cases (per 100,000 people) in Cumberland County is not statistically different than the number of cases recorded statewide.[55]

For Cumberland County to be a healthy place to live, work and play, it is imperative that safe homes and communities are supported. For communities and homes to be safe, those impacted by domestic violence need to have access to immediate and safe shelter for themselves and their families, and access to court advocacy services to get speedy and effective protection from abuse orders in place.[56] Comprehensive approaches also include policy strategies that include

[50] Maine Shared Community Health Needs Assessment Cumberland County Summary: 2015.
[51] Ibid.
[52] http://www.countyhealthrankings.org/our-approach/health-factors/community-safety.
[53] Maine Domestic Violence Homicide Review Panel Recommendations, 2014. http://www.maine.gov/ag/dynld/documents/10th%20Biennnial%20Report%20-FINAL%204-23-14.pdf.
[54] BRFSS Data, 2012.
[55] Ibid.
[56] Maine Domestic Violence Homicide Review Panel Recommendations, 2014. http://www.maine.gov/ag/dynld/documents/10th%20Biennnial%20Report%20-FINAL%204-23-14.pdf.

stricter gun control and better coordination among law enforcement and the judicial systems.[57] These strategies can de-escalate dangerous situations and provide both short and long term housing solutions, reduce the impact of trauma on children and families' mental health, and keep community members safe.

GENERAL SUMMARY

In summary, the data demonstrates that Maine and Cumberland County residents need access to supportive clinical services and healthy behaviors to prevent and combat obesity. Community members need access to services to meet both their physical and mental health needs. Access to substance abuse treatment services is critical as well. And social and economic issues impacting health must be addressed as well. Health and health status is a complex issue that is impacted by multiple factors. If communities are to reach their maximum health potential they must assess needs and resources and comprehensively address the social determinants of health.

[57] Maine Domestic Violence Homicide Review Panel Recommendations, 2014. http://www.maine.gov/ag/dynld/documents/10th%20Biennnial%20Report%20-FINAL%204-23-14.pdf.

Appendix A: Maine Shared Community Health Needs Assessment Cumberland County Summary: 2015

Provided by: The Maine Shared Health Needs Assessment & Planning Process (SHNAPP) Project - a collaborative of Central Maine Healthcare, Eastern Maine Healthcare Systems, MaineGeneral Health, MaineHealth and the Maine Center for Disease Control and Prevention.

Available at:
http://www.maine.gov/dhhs/mecdc/phdata/SHNAPP/documents/Cumberland%20County%20-%202%20page%20Summary%20Report.pdf

Full Cumberland County Report will be available in November 2015.

Maine Shared Community Health Needs Assessment County Summary: 2015

Cumberland County

November 2015

Maine Shared CHNA Health Indicators	Cumberland	Trend	Maine	U.S.
Demographics				
Total Population	285,456		1,328,302	319 Mil
Population – % ages 0-17	19.8%		19.7%	23.3%
Population – % ages 18-64	64.3%		62.6%	62.6%
Population – % ages 65+	15.9%		17.7%	14.1%
Population – % White	92.9%		95.2%	77.7%
Population – % Black or African American	2.8%		1.4%	13.2%
Population – % American Indian and Alaska Native	0.4%		0.7%	1.2%
Population – % Asian	2.2%		1.1%	5.3%
Population – % Hispanic	1.9%		1.4%	17.1%
Socioeconomic Status Measures				
Individuals living in poverty	*11.4%*	NA	13.6%	15.4%
Children living in poverty	*15.7%*	NA	18.5%	21.6%
High school graduation rate	88.2%	NA	86.5%	81.0%
Unemployment rate	4.4%	NA	5.7%	6.2%
65+ living alone	43.1%	NA	41.2%	37.7%
General Health Status				
Adults who rate their health fair to poor	*11.5%*		15.6%	16.7%
Adults with 14+ days lost due to poor mental health	11.4%		12.4%	NA
Adults with 14+ days lost due to poor physical health	*10.6%*		13.1%	NA
Adults with three or more chronic conditions	*23.2%*		27.6%	NA
Access				
Adults with a usual primary care provider	89.5%		87.7%	76.6%
MaineCare enrollment	19.0%	NA	27.0%	23.0%
Percent uninsured	*8.9%*	NA	10.4%	11.7%
Health Care Quality				
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	*1,167.5*		1,499.3	1457.5
Oral Health				
Adults with visits to a dentist in the past 12 months	*72.8%*	NA	65.3%	67.2%
Respiratory				
Asthma emergency department visits per 10,000 population	*57.3*		67.3	NA
COPD hospitalizations per 100,000 population	*159.1*	–	216.3	NA
Current asthma (Adults)	10.8%		11.7%	9.0%
Current asthma (Youth 0-17)	8.6%†	NA	9.1%	NA
Cancer				
Mortality – all cancers per 100,000 population	*174.9*	NA	185.5	168.7
Mammograms females age 50+ in past two years	83.1%	NA	82.1%	77.0%
Colorectal screening	72.5%	NA	72.2%	NA
Pap smears females ages 21-65 in past three years	91.6%	NA	88.0%	78.0%
Cardiovascular Disease				
Hypertension prevalence	29.5%		32.8%	31.4%
High cholesterol	*36.7%*		40.3%	38.4%
Diabetes				
Diabetes prevalence (ever been told)	*7.6%*		9.6%	9.7%
Pre-diabetes prevalence	6.9%		6.9%	NA
Adults with diabetes who have had an A1C test twice per year	78.3%	NA	73.2%	NA
Environmental Health				
Children with confirmed elevated blood lead levels (% among those screened)	*3.2%*	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	*2.5%*	NA	4.2%	NA
Homes with private wells tested for arsenic	*53.1%*	NA	43.3%	NA

Prepared by: Market Decisions Research and Hart Consulting, Inc., November 3, 2015

Maine Shared CHNA Health Indicators	Cumberland	Trend	Maine	U.S.
Immunization				
Adults immunized annually for influenza	43.4%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	73.2%		72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	4.7%	NA	3.7%	NA
Infectious Disease				
Hepatitis B (acute) incidence per 100,000 population	0.3†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	1.4†	NA	2.3	0.7
Lyme disease incidence per 100,000 population	117.4	NA	105.3	10.5
Pertussis incidence per 100,000 population	10.4	NA	41.9	10.3
STD/HIV				
Chlamydia incidence per 100,000 population	287.4	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	20.8	NA	17.8	109.8
Intentional Injury				
Nonfatal child maltreatment per 1,000 population	NA	NA	14.6	9.1
Suicide deaths per 100,000 population	13.4	NA	15.2	12.6
Unintentional Injury				
Unintentional and undetermined intent poisoning deaths per 100,000 population	11.7	NA	11.1	13.2
Unintentional fall related injury emergency department visits per 10,000 population	*306.0*	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	*6.4*	NA	10.8	10.5
Mental Health				
Adults who have ever had anxiety	18.8%		19.4%	NA
Adults who have ever had depression	23.1%		23.5%	18.7%
Co-morbidity for persons with mental illness	29.2%		35.2%	NA
Physical Activity, Nutrition and Weight				
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	*16.9%*		22.4%	25.3%
Obesity (Adults)	*23.7%*		28.9%	29.4%
Obesity (High School Students)	*9.3%*		12.7%	13.7%
Overweight (Adults)	35.1%		36.0%	35.4%
Overweight (High School Students)	13.9%		16.0%	16.6%
Pregnancy and Birth Outcomes				
Infant deaths per 1,000 live births	5.7	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	85.9%	NA	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	*12.2*	NA	20.5	26.5
Low birth weight (<2500 grams)	6.5%	NA	6.6%	8.0%
Substance and Alcohol Abuse				
Binge drinking of alcoholic beverages (Adults)	*20.7%*		17.4%	16.8%
Drug-affected baby referrals received as a percentage of all live births	3.9%	NA	7.8%	NA
Past-30-day alcohol use (High School Students)	25.6%		26.0%	34.9%
Past-30-day marijuana use (High School Students)	22.0%		21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	1.0%†		1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	5.5%		5.6%	NA
Tobacco Use				
Current smoking (Adults)	17.0%		20.2%	19.0%
Current tobacco use (High School Students)	16.4%	NA	18.2%	22.4%

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