

**Community Health Assessment 2000
A Snapshot**

Healthy Community Coalition

Table of Contents

Introduction	1
HCC Report Cards	
<i>How Franklin County is doing compared to Maine</i>	3
<i>How Franklin County is doing compared to Peer Counties</i>	4
Indicators	
<i>Summary of Indicators</i>	5
<i>Demographics</i>	7
<i>Access to Care</i>	10
<i>Wellness</i>	13
<i>Disease Prevention</i>	21
<i>Maternal and Child Health</i>	26
Appendix	28

Introduction

A Snapshot, A Visioning

This report is one snapshot of the health of Franklin County, looking at the data available to us on the health, well-being, and lifestyle choices of the people who live in our community. We are publishing it for the Health Visioning 2000, the conference that sets priorities for policies and programs addressing the health of West Central Maine. We hope that this data will help residents understand the health issues facing our community and make informed decisions about actions we need to undertake to improve the health of our neighbors and families.

The Limitations of Snapshots

Like any snapshot, this report cannot tell the whole story: it is dependent on the angle of our vision and can never account for all of the dimensions of our real experience as individuals and as a community. The first limitation in our report is geographical: because most available data carves the state by county, this report can only evaluate Franklin County, not the full service area of Healthy Community Coalition and the network we belong to, the Franklin Community Health Network. Thus, for instance, we cannot evaluate the health of Livermore Falls or Vienna. For some important indicators, we cannot even offer information on Franklin County because data is only available for the State as a whole.

Nor can we depict the richness of the lives and experience surrounding the one-dimensional numbers in these pages, another limitation of snapshots. There are many very sad stories that we cannot truly depict with a series of numbers on a page, from the families torn by suicides to the people recovering from stroke or heart disease. And there are triumphant, very positive stories here as well that numbers cannot fully depict because they did *not* happen. Those are the people whose lives were saved through prevention. There are many mothers and fathers in Franklin County who quit smoking and as a result are living to experience the joy of the birth of grandchildren. There are children playing in playgrounds today who wore a bike helmet or sat in a secure carseat when an accident happened that might have claimed their lives.

The Limitations of Numbers

Snapshots depict one image at one place in time, and leave out the rest of the world existing outside the scope of the camera lens. Similarly, this report can only depict one view of the health of our community at one point in time, and leaves out many angles and facts and experiences that are also important to a full understanding. The third limitation is the limitation of resources and time that prevent us from examining every possible indicator of health and prevent the State and federal governments from gathering data on every possible component of health.

Our final limitation is the difficulty inherent in statistics. As Mark Twain once said, “there are lies, d—m lies, and statistics.” In our report, we are subject to the whims and difficulties of statistics. Within our limits of resources and time, we have tried to avoid data problems, statistical variations, and methodological barriers, mostly by reporting published data from reliable sources. We have attempted to uncover the most recent data available. We have tried to compile these numbers with thoroughness and goodwill, though the notorious challenge of statistics may have thwarted us in some cases.

How We Chose Our Indicators




Recognizing all of these limitations, we constructed our list of indicators very carefully. We began with the data currently available, then selected from that body of information the key indicators that could best comprise a good snapshot. Two reports helped us choose the indicators to make our good snapshot. First and foremost, we considered indicators important to our community. For this list, we relied on the results of the Health Visioning 1998, a conference and research project conducted in 1998 sponsored by health leaders in Franklin County, which built community consensus around ten main health priorities. Our report looks at data, when available, that responds to those priorities. Second, we considered indicators rated important in *Healthy People 2000*, the document produced by the U.S. Department of Health & Human Services reflecting the consensus of national public health leaders on the key indicators of the health status of Americans. Surprisingly, the health issues considered important to people in our community were often very different from the issues considered important by federal public health officials. In our Health Assessment, we have tried to represent indicators that address local as well as national priorities.

Our Report Cards

To aid our community in evaluating the significance of key features of this report, we are including two Report Cards. The first Report Card points out how Franklin County compares with the rest of the State on key indicators for which such data is available. The second Report Card shows how Franklin County compares with “peer counties” in the nation—counties with similar demographic compositions. The latter Report Card is taken from a Community Health Status Report prepared for Franklin County by the U.S. Department of Health & Human Services’ Health Resources and Service Administration and available on the web at www.communityhealth.hrsa.gov. All the limitations that apply to the Report as a whole apply to the Report Cards: they are one-dimensional and rely on available statistics. The Report Cards are not meant as a definitive guide to the priority health issues in Franklin County. Instead, the Report Cards are meant as one source among many we may use in our community to set an agenda for action.

Despite all the limitations inherent in any snapshot, we believe we have taken a very interesting and rich photograph of our community and hope that our report will help the community make good decisions for our future. Whatever limitations are inherent in this report are not inherent in our ability to envision the future. We urge the community to use this report—and their own values and common sense—to create a bold new future for Franklin County and build a healthier community for future generations.



**HOW FRANKLIN COUNTY
IS DOING COMPARED TO MAINE**

 FAVORABLE	<ul style="list-style-type: none"> ❖ Primary Care Physicians ❖ Smoking Rate ❖ Unintentional Injury Death ❖ Motor Vehicle Deaths ❖ Occupational Injury ❖ Bicycle accident injuries ❖ Prostate Cancer mortality ❖ Cervical Cancer mortality ❖ Skin Cancer mortality ❖ Heart Disease mortality ❖ Chronic Obstructive Pulmonary Disease ❖ Immunization rates ❖ Infant Mortality ❖ Low Birth Weight ❖ Prenatal Care ❖ Teen Births
 UNFAVORABLE	<ul style="list-style-type: none"> ❖ Unemployment ❖ Median Household Income ❖ Percent of population in poverty ❖ Mental Health Workers ❖ Dentists ❖ Uninsured Population ❖ Overweight Population ❖ Domestic Assault ❖ Physical Activity ❖ Suicide ❖ Youth Suicide ❖ Colorectal Cancer mortality ❖ Breast Cancer mortality ❖ Lung Cancer mortality ❖ Stroke mortality
 NEUTRAL	<ul style="list-style-type: none"> ❖ Educational Attainment ❖ Long Term Care Beds





**HOW FRANKLIN COUNTY
COMPARES TO PEER COUNTIES***

 FAVORABLE	<ul style="list-style-type: none"> ❖ Low Birth Weight (<2500g) ❖ Very Low Birth Weight (<1500g) ❖ Premature Births (<37 weeks) ❖ Teen Mothers, ❖ No Care in First Trimester ❖ Infant Mortality ❖ White Infant Mortality ❖ Neonatal Infant Mortality ❖ Post-Neonatal Infant Mortality ❖ Colon Cancer ❖ Coronary Heart Disease ❖ Unintentional Injury ❖ Motor vehicle injuries
 UNFAVORABLE	<ul style="list-style-type: none"> ❖ Breast cancer mortality ❖ Lung cancer mortality ❖ Stroke ❖ Suicide

❖ **Source: Department of Health and Human Services,
Health Resource and Service Administration**
A full study is available at www.communityhealth.hrsa.gov

*Peer counties are defined as U.S. counties similar to Franklin County in terms of frontier status, population size, poverty and age structure.



SUMMARY OF INDICATORS

AREA	INDICATORS	GRADE*	TABLE	PAGE
DEMOGRAPHICS:	• □ Land Area of Maine and Maine Counties	N/A	1	7
	• □ Maine County Populations	N/A	2	7
	• □ Municipality Populations for the HCC service area	N/A	3	7
	• □ Franklin County Age Distribution	N/A	4	8
	• □ Racial Distribution	N/A	5	8
	• □ Educational Attainment	↔	6	8
	• □ Unemployment	↓	7	9
	• □ Median Household Income	↓	8	9
	• □ Percent in Poverty	↓	9	9
	ACCESS TO CARE:			
➤ Local Providers	• □ Primary Care Physicians	↑	10	10
	• □ Mental Health Workers	↓	11	11
	• □ Licensed Dentists	↓	12	11
➤ Health Insurance	• □ Uninsured	↓	13	11
➤ Prescription Drugs	• □ Cost of Prescription Drugs	N/A	14	12
	• □ Prescription Insurance Options	N/A	15	12
	• □ Rate of Long Term Care Beds	↔	16	12
WELLNESS:				
➤ Public Health Info.	• □ Excess Deaths in Maine	N/A	17	13
	• □ Smoking Rates	↑	18	14
	• □ Adult Alcohol Use	N/A	19	14
	• □ Youth Alcohol Use	N/A	20	14
	• □ Youth Smoking	N/A	21	15
	• □ Overweight Population	↓	22	15
➤ Injury Prevention	• □ Unintentional Injury deaths	↑	23	15
	• □ Seatbelts	N/A	24	16
	• □ Motor Vehicle Deaths	↑	25	16
	• □ Occupational Injury	↑	26	16
	• □ Poison Control Knowledge	N/A	27	17
	• □ Smoke Detectors	N/A	28	17
	• □ Motorcycle Helmets	N/A	29	17
	• □ Bicycle Helmets	N/A	30	17
	• □ Bicycle Accident Injuries	↑	31	18
➤ Violence Prevention	• □ Firearm Injury Deaths	N/A	32	18
	• □ Domestic Assault	↓	33	18
	• □ Incarceration Rate	N/A	34	19
	• □ Physical Activity	↓	35	19
	• □ Suicide	↓	36	19
	• □ Youth Suicide	↓	37	20
DISEASE PREVENTION:				
➤ Chronic Disease	• □ Cancer mortality (Colorectal, Breast, Lung)	↓	38	21

SUMMARY OF INDICATORS

> Infectious Disease > Oral Health MATERNAL AND CHILD HEALTH:	• ☐ Cancer mortality (Prostate, Cervical, Skin)	↑	39	21
	• ☐ Stroke death rate	↓	40	22
	• ☐ Mammogram Utilization	N/A	41	22
	• ☐ Coronary Heart Disease death rates	↑	42	22
	• ☐ Chronic Obstructive Pulmonary Deaths	↑	43	23
	• ☐ High Blood Pressure	N/A	44	23
	• ☐ High Cholesterol	N/A	45	23
	• ☐ Eye Disorders	N/A	46	24
	• ☐ Positive HIV tests	N/A	47	24
	• ☐ Infectious Disease Occurrence	N/A	48	24
	• ☐ Immunization	↑	49	25
	• ☐ Fifth Graders with Cavities	N/A	50	25
• ☐ Infant Mortality	↑	51	26	
• ☐ Low Birth Weight	↑	52	26	
• ☐ Prenatal Care	↑	53	27	
• ☐ Teen Pregnancy	↑	54	27	

***GRADE symbols identify indicators as:**

↔ practically even compared to the state or nation

↑ doing better than the state or nation

↓ doing worse than the state or nation

N/A the data is not applicable to the grading system



DEMOGRAPHICS

The region is classified as “very rural” with a population density of only 17 people per square mile, with some regions so sparsely populated they are referred to as “frontier.” Farmington is the largest town, with 7709 people, with Wilton and Livermore Falls close seconds with 3858 and 3196 respectively. Educational attainment of residents compares favorably with the Statewide average and national average, yet our economic indicators lag well behind, with high unemployment and poverty and a median income lower than the rest of the state.

(Table 1)
Land Area of Maine and Maine Counties in Square Miles

State/County	Land Area
Maine	31,904.78
Androscoggin	498.81
Aroostook	6,735.82
Cumberland	875.19
Franklin	1,707.68
Hancock	1,692.86
Kennebec	939.90
Knox	375.00
Lincoln	468.43
Oxford	2,138.30
Penobscot	3,468.20
Piscataquis	4,015.20
Sagadahoc	262.04
Somerset	4,015.71
Waldo	753.97
Washington	2,770.09
York	1,018.86

❖ Source: Maine State Planning Office

(Table 2)
Maine County Population Estimates, 1999

State/County	Population
State of Maine	1,253,040
Androscoggin	101,337
Aroostook	75,836
Cumberland	256,437
Franklin	28,797
Hancock	49,670
Kennebec	115,224
Knox	38,193
Lincoln	31,947
Oxford	54,288
Penobscot	144,432
Piscataquis	18,077
Sagadahoc	36,267
Somerset	52,630
Waldo	36,965
Washington	35,352
York	177,588

❖ Source: US Census Bureau

(Table 3)
Municipality Populations for the Healthy Community Coalition Service Area, 1998

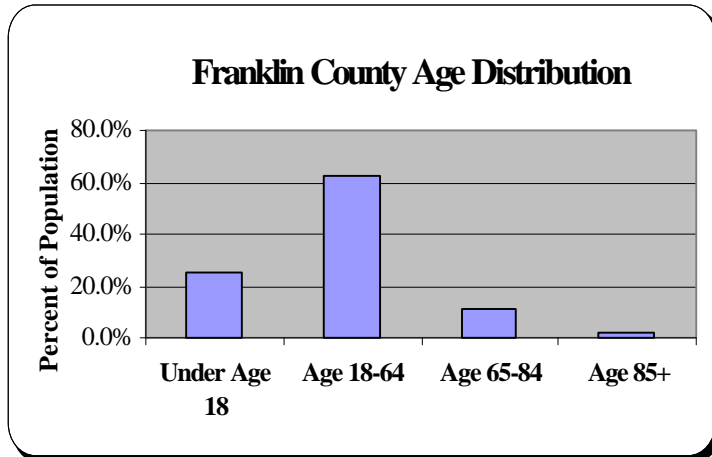
Municipality	Population	Municipality	Population	Municipality	Population
<i>Avon</i>	616	<i>Industry</i>	623	<i>Rangeley Plan.</i>	101
<i>Carrabasset</i>	291	<i>Jay</i>	5,586	<i>Rangeley</i>	958
<i>Carthage</i>	502	<i>Kingfield</i>	1,012	<i>Sandy River</i>	67
<i>Chesterville</i>	961	<i>Livermore*</i>	1,916	<i>Plantation</i>	
<i>Coplin Plan.</i>	127	<i>Livermore Falls*</i>	3,196	<i>Starks*</i>	587
<i>Dallas Plan.</i>	171	<i>Madrid</i>	159	<i>Strong</i>	1,332
<i>Dixfield*</i>	2,546	<i>New Portland*</i>	896	<i>Temple</i>	497
<i>Eustis</i>	586	<i>New Sharon</i>	1,150	<i>Weld</i>	372
<i>Farmington</i>	7,709	<i>New Vineyard</i>	584	<i>Wilton</i>	3,858
<i>Fayette*</i>	915	<i>Phillips</i>	1,023	<i>Vienna*</i>	434

*Indicates towns outside of Franklin County

❖ Source: US Census Bureau

DEMOGRAPHICS

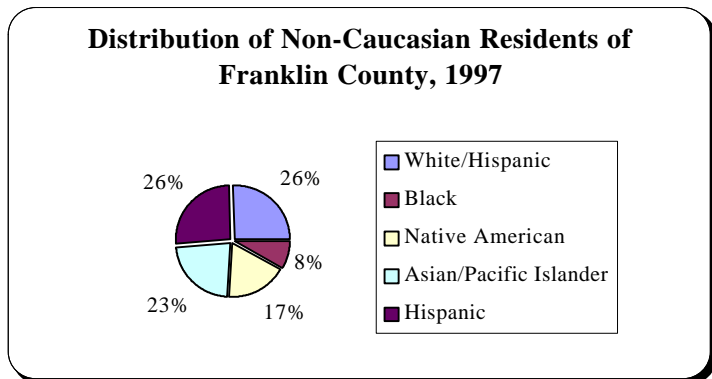
Table 4



The bulk of Franklin County's population is found between the ages of 18 and 64 years old, and the smallest age group is over age 85.

❖ Source: US Census Bureau, 1997

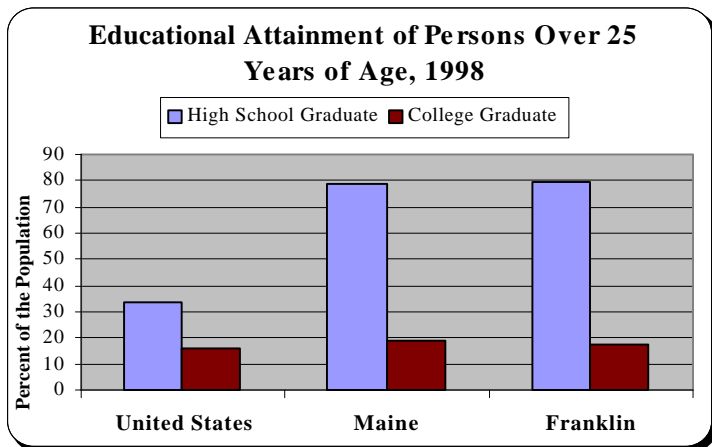
Table 5



The overwhelming majority of Franklin County residents are classified as Caucasian. Only 1.59% of residents are Non-Caucasian.

❖ Source: US Census Bureau, 1998

Table 6

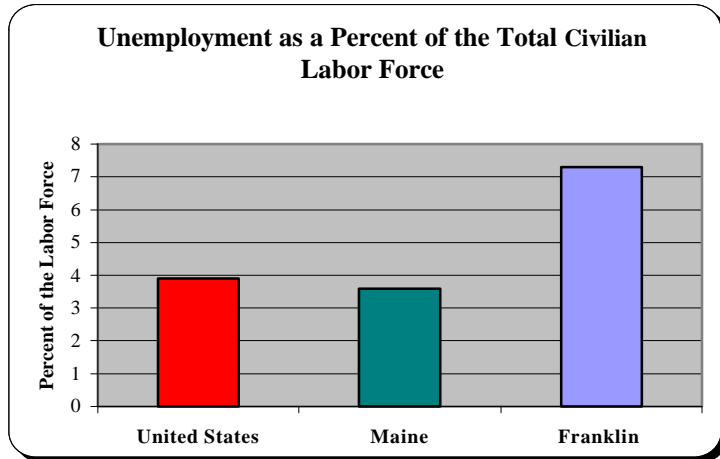


The educational attainment of Maine and Franklin County residents is well above the national percent for high school, and almost even for college education.

❖ Source: US Census Bureau, 1998

DEMOGRAPHICS

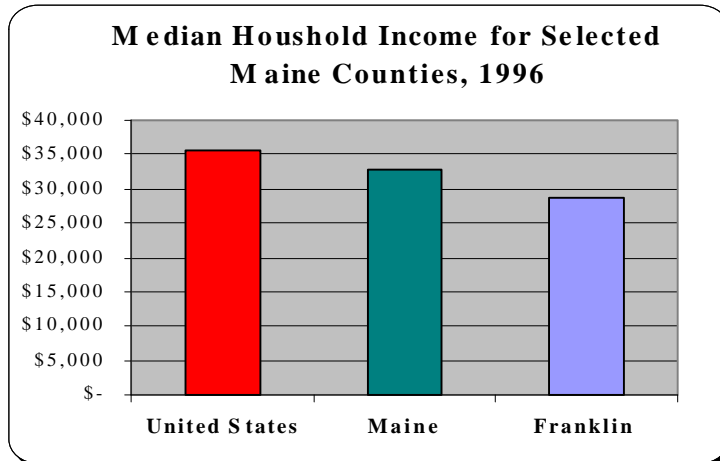
Table 7



The percent of the employable population that remains unemployed in Franklin County is almost double the state and well above the national average.

❖ Source: US Census Bureau, 1998, and Maine Department of Labor, 2000

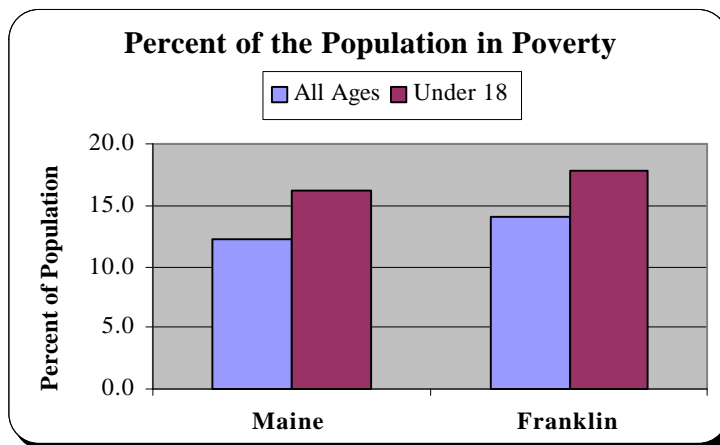
Table 8



Franklin County's income level is slightly below the state level, but there is a difference of over \$6,000 between Franklin and the national average.

❖ Source: US Census Bureau, 1998

Table 9



The percent of Franklin County residents living in poverty is only slightly higher than the state average for all age groups.

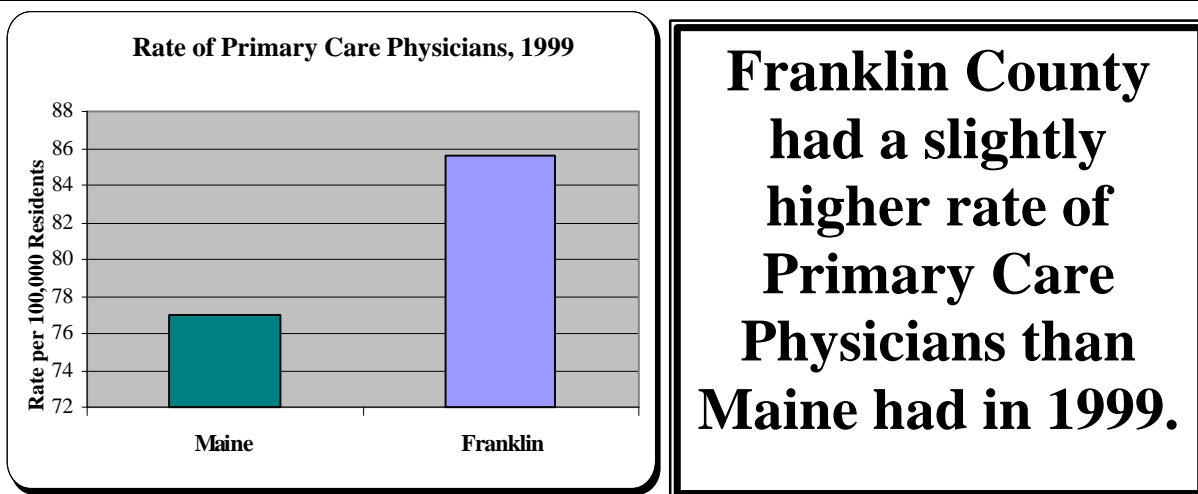
❖ Source: US Census Bureau, 1999

ACCESS TO CARE

When people cannot see a doctor or nurse when they need care, their health suffers and the health status of the entire community declines. Unfortunately, access to care is a major problem for people in Greater Franklin County expressed by the community in the Visioning Process and reflected in the available data here.

There are two kinds of challenges people face when access is a problem: availability of providers and finding the financial resources to afford to see them. The data suggests that compared with the rest of the State, Franklin County has a higher proportion of primary care physicians serving our population, but fewer mental health workers and dentists. There is also evidence that supports many testimonials from the Visioning Process that affording needed care is a problem. The data available here suggests that people in Franklin County are more likely to be uninsured, meaning they do not have private insurance or a publicly financed form of coverage such as Medicaid and pay out of pocket for all their health care. A major concern of the community has been affording prescription drugs, and our data reveals that the cost of some of the most commonly prescribed drugs is very high, especially when compared with our lower median income.

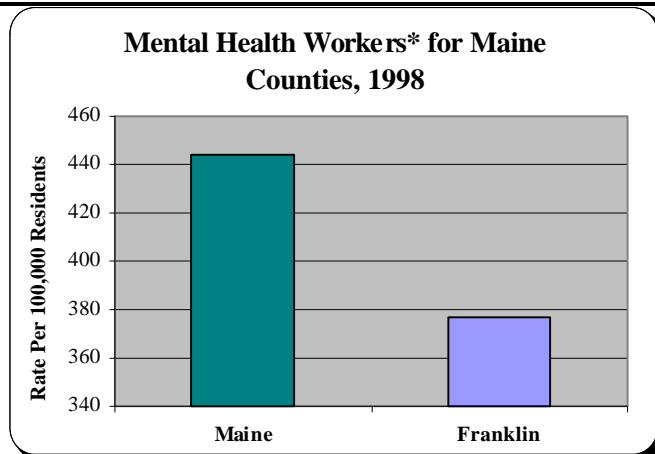
Table 10



❖ Source: Maine Department of Human Services, Bureau of Health, 1999

ACCESS TO CARE

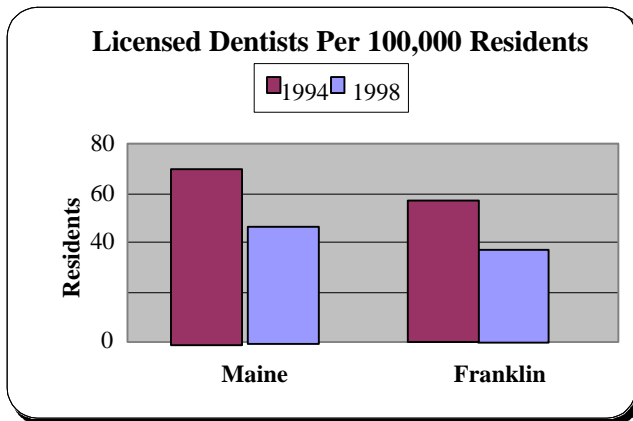
Table 11



Franklin County is considerably below the state average for mental health workers per 100,000 residents.

❖ Source: Maine Department of Human Services, Bureau of Health, 1999
 *Psychologists, Counselors, Licensed Social Workers, and Alcohol and Drug Counselors

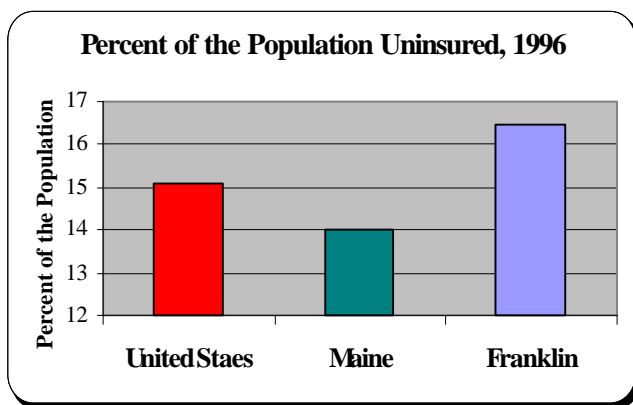
Table 12



Franklin is one of the lowest ranking counties for access to dental care. Between 1994 and 1998, there was a significant reduction in the availability of Dentists.

❖ Source: Maine Department of Human Services, Bureau of Health, 1999, 1997

Table 13



Although Maine falls below the national average, Franklin County itself is above the nation and state for uninsured residents.

❖ **Maine and US data:** Source: Maine Department of Human Services, Bureau of Health, 1996
 ❖ **Franklin data:** Source: Department of Health and Human Services, 1997

ACCESS TO CARE

Table 14

Three Most Commonly Prescribed Drugs in the United States	
Drug Names:	30 Day Prescription Cost:
Amoxicilin (10 Day Prescription)	\$19.69
Premarin (Most Common Strength)	\$23.69
Prilosec	\$155.98

This table presents the local cost for the three most commonly prescribed drugs and dosage in the nation, as well as the cost under Medicaid.

❖ Source: Farmington Rite Aid Pharmacy

Table 15

Maine Prescription

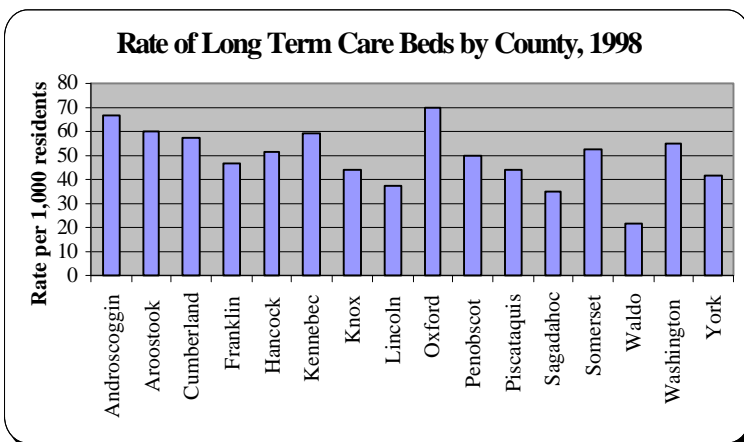
Drug Programs:

- Medicaid
- Cub Care
- Elderly Low-Cost Drug Program
- Maine Resident Low-Cost Prescription Drug Program
- Medicaid Waiver Drug Program



❖ Source: Augusta, ME: Office of Policy and Legal Analysis, 1999

Table 16



Franklin County seems to be in the middle to high range for Maine's availability of long term care beds.

❖ Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics, 1999

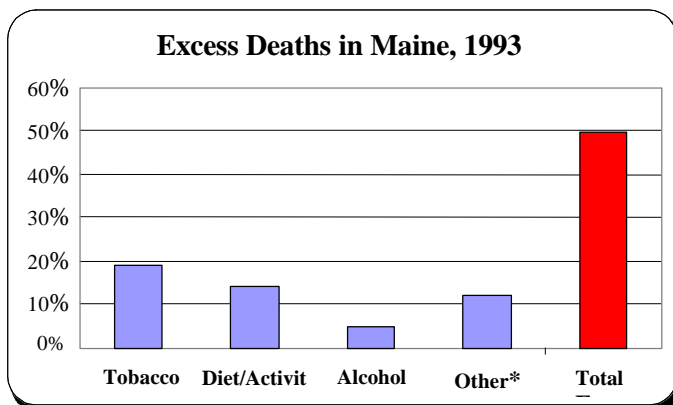
ACCESS TO CARE

While it is natural for us to think of hospitals or doctors when trying to preserve our health, often the solution is closer to home, in our own daily choices about how we live our life. These choices seem simple, but have a colossal impact: About half of all deaths in Maine could have been prevented through personal lifestyle changes, from quitting smoking to wearing a bike helmet. In this section, we took a look at some of the available data on the behaviors contributing to the health status of Franklin County and Maine, although we were forced to rely heavily on statewide statistics due to the scarcity of Franklin County data.

Compared to the rest of the State Franklin County has a lower rate of smoking, a lower rate of motor vehicle deaths, fewer occupational injuries per worker, fewer unintentional injuries, and fewer bicycle accidents. Areas of concern for residents include the rate of obesity, alcohol use, and firearm injuries.

Franklin County has a higher rate of reported domestic assault than the rest of the State—a major preventable cause of injury and sometimes death. And tragedy stalks residents in the form of an exceptionally high suicide rate. The suicide rate for Franklin County remains higher than the rate for Maine, which in turn is much higher than the national rate in all age categories.

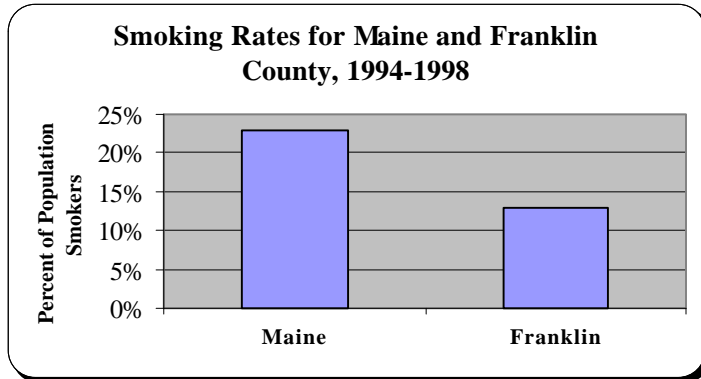
Table 17



Half of the annual deaths in Maine are attributable to lifestyle choices, where the death may have been prevented by a change in lifestyle.

❖ Source: Department of Health and Human Services, 2000

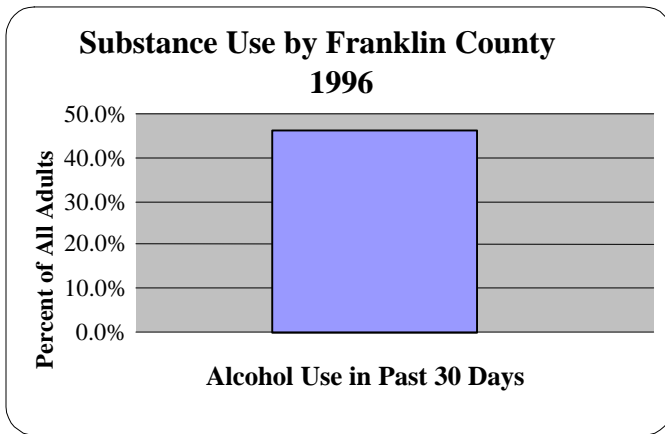
Table 18



12.3% of Franklin residents smoke, while 23% of all Maine residents report themselves as smokers.

❖ Source:

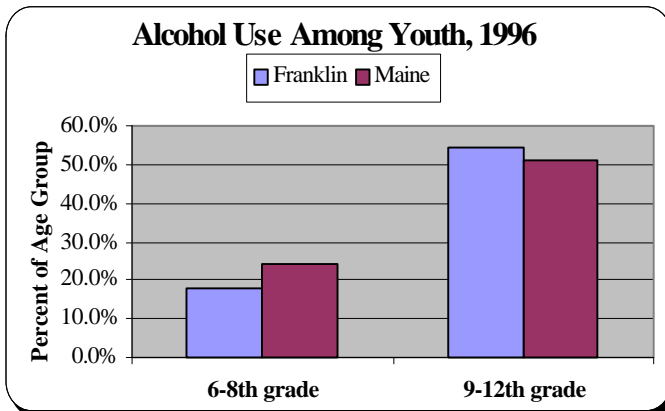
Table 19



Almost half of all Franklin County adults have used alcohol in the last 30 days, almost 20% use tobacco, and 3.4% of adults report using Marijuana.

❖ Source: Maine Office of Substance Abuse, 2000

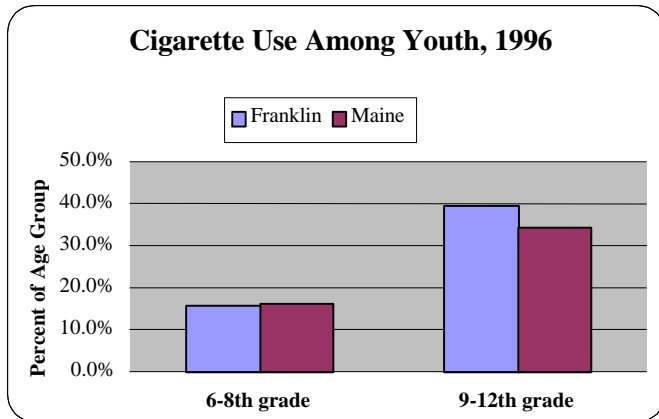
Table 20



About 20% of 6-8th grade, and over half of 9-12th grade students in Franklin report using alcohol in the last 30 days.

❖ Source: Maine Office of Substance Abuse, 2000

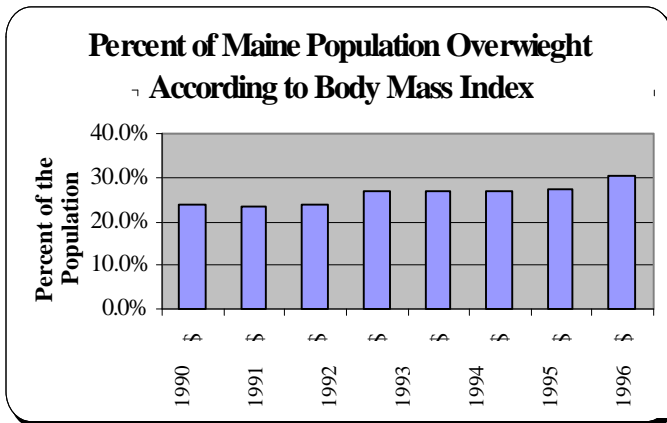
Table 21



More 9-12th grade students in Franklin County smoke, than 9-12th grade students in Maine. The same amount of 6-8th grade students smoke in Maine and Franklin.

❖ Source: Maine Office Of Substance Abuse, 1998

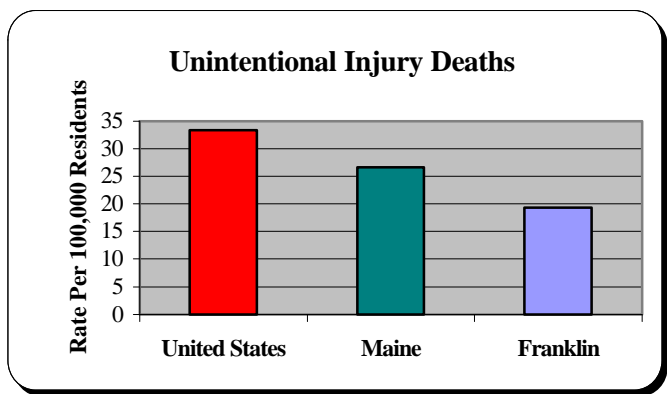
Table 22



The overweight population of Maine has been gradually increasing over the past eight years.

❖ Source: Department of Health and Human Services, 2000

Table 23



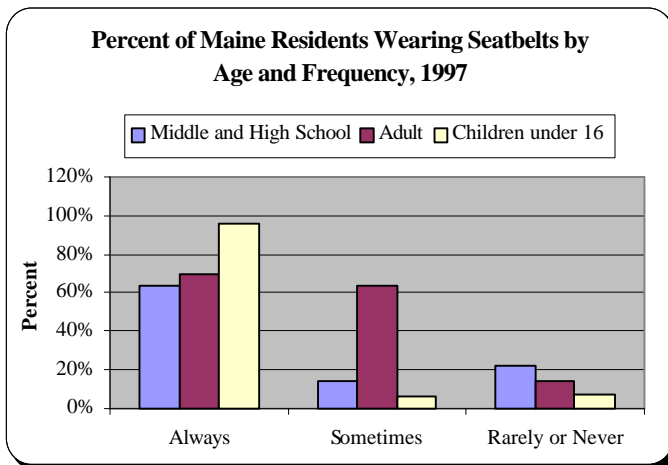
Franklin County has an unintentional injury rate that is about 8% lower than Maine, and about 15% lower than the national average.

❖ **Maine data:** Source: Maine Department of Human Services, Bureau of Health, 1999

❖ **US and Franklin data:** Source: Department of Health and Human Services, 2000

WELLNESS

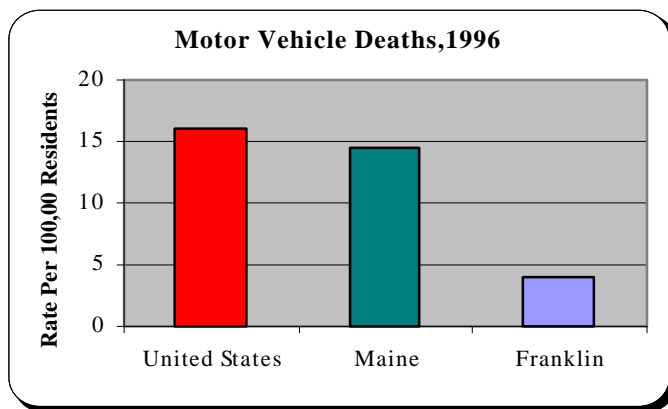
Table 24



Over 60% of all age groups in Maine report always wearing a seat belt, but over 60% of adults report only using them sometimes.

❖ Source: Maine Behavioral Risk Factor Surveillance System, 1997

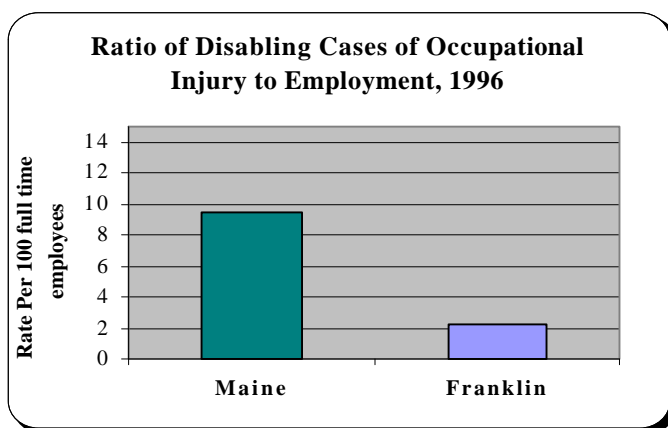
Table 25



Franklin County has a lower rate of motor vehicle deaths than the state or nation.

❖ Source: Maine Department of Human Services, Bureau of Health, 1999 and Maine Behavioral Risk Factor Surveillance System, 2000

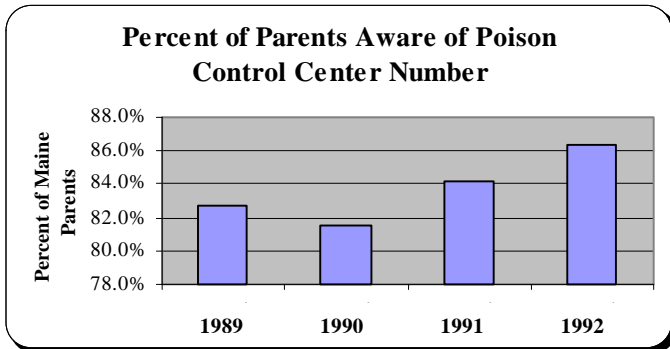
Table 26



Maine's Occupational Injury rate is about 10 injuries for every 100 employees, a big difference from Franklin, which has about 2 injuries for every 100 employees.

❖ Source: Maine Department of Labor, 1998

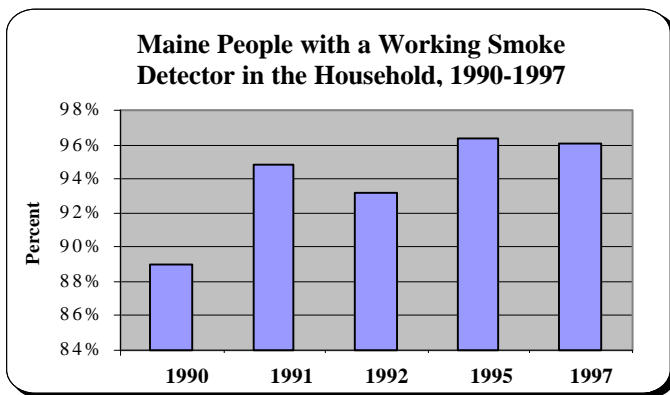
Table 27



The Percent of Maine Parents who are aware of the Poison Control phone number rose between 1990 and 1992.

❖ Source: Maine Behavioral Risk Factor Surveillance System, 1987-1992

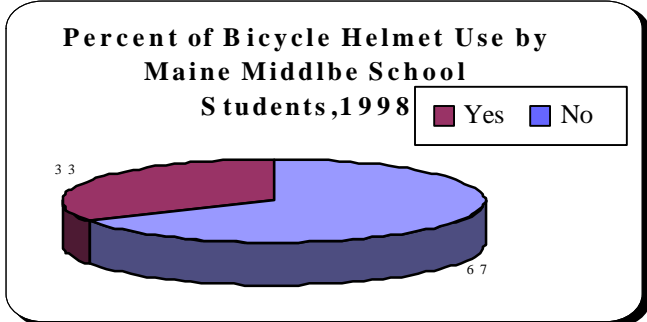
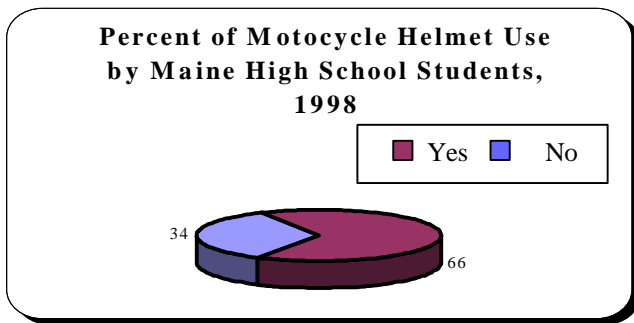
Table 28



The seven-year period between 1990 and 1997 saw a jagged rise in smoke detectors, leveling to about 96% of homes in 1997.

❖ Source: Maine Behavioral Risk Factor Surveillance System, 1997

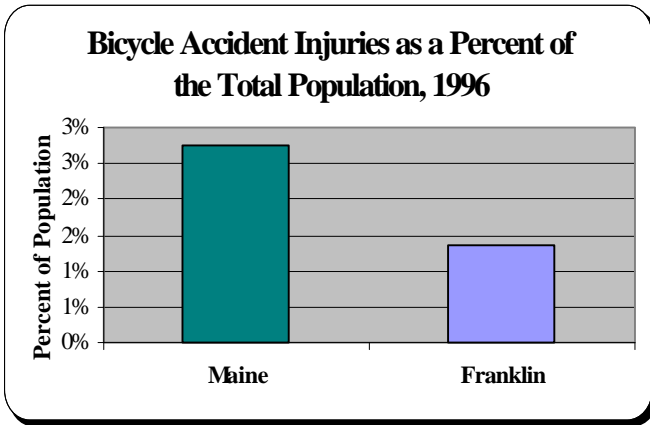
Table 29 and 30



In 1998 about 66% of Maine high school students reported wearing motorcycle helmets, and only 33% of middle school students reported wearing bike helmets when riding.

❖ Source: Maine Behavioral Risk Factor Surveillance System, 1998

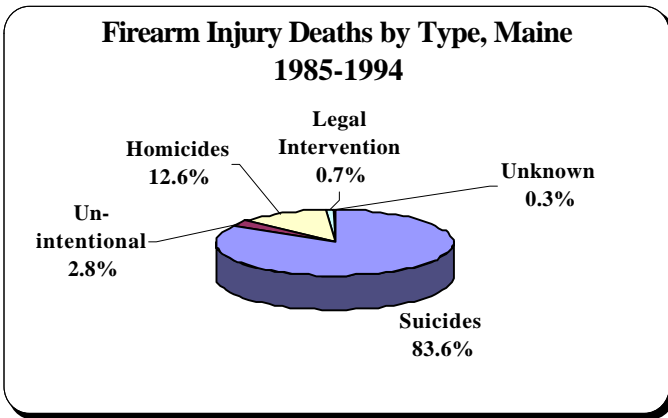
Table 31



About 2% of the Franklin County population experienced a bicycle accident of varying severity. There were no fatalities due to bicycles for Franklin County for the previous 7 years.

❖ Source: Maine Department of Transportation, Bureau of Maintenance and Operations, Traffic Engineering Division, Accident Records Section, 1988-1996

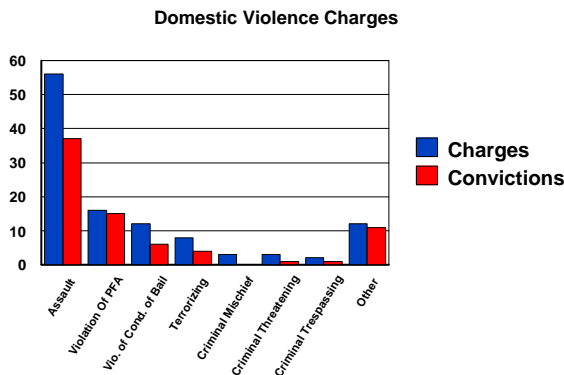
Table 32



Most of the 1,170 firearm-related fatalities between 1985 and 1994 were the result of completed suicides in Maine.

❖ Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics, 1999

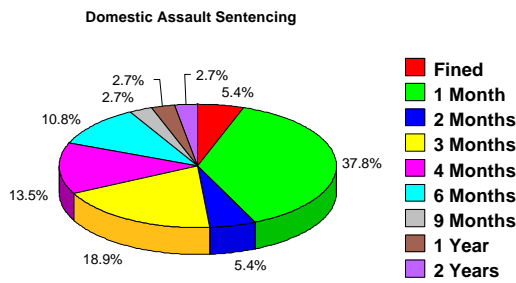
Table 33



Less than 40 convictions resulted from over 50 charges of domestic violence in Franklin County.

❖ Source: Healthy Community Coalition, A Local Perspective on Violence, 2000

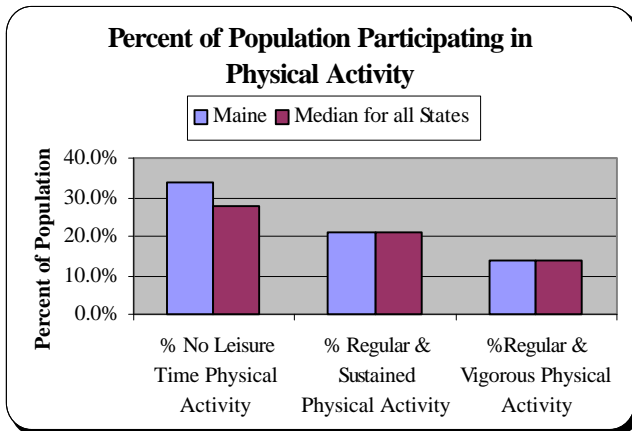
Table 34



More than one-third of offenders convicted of domestic assault were sentenced to serve no time in prison.

❖ Source: Healthy Community Coalition, A Local Perspective on Violence, 2000

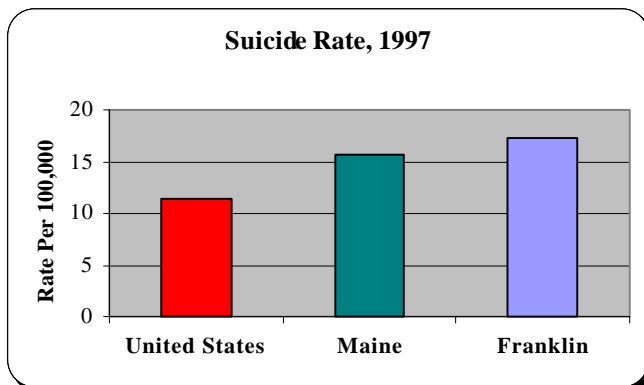
Table 35



About 34% of Maine residents, and about 27% of US residents report participating in no leisure time physical activity.

❖ Source: American Cancer Society, 1996

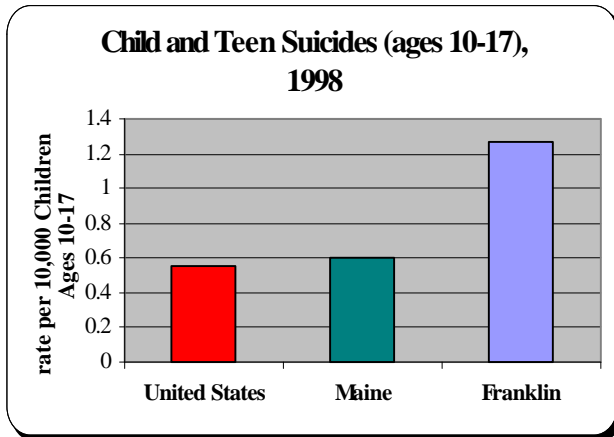
Table 36



The rate of suicide in Franklin County is higher than both the state and the national rate.

❖ Source: Maine Department of Human Services, Bureau of Health, and National Center for Health

Table 37



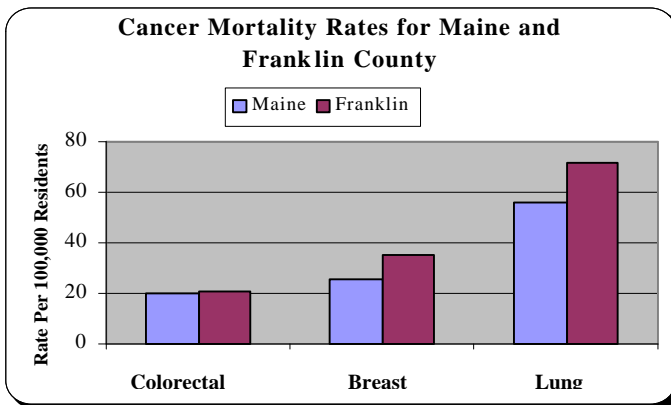
The incidence of young adult and teen suicide has tripled in the past 40 years. While Maine and the US seem fairly even, Franklin County's teen suicide rate is more than double that of Maine or the US.

❖ Source: Maine Children's Alliance, 2000

DISEASE PREVENTION

There is good news and bad news about the incidence of deadly disease in Franklin County. We have a higher rate of mortality from breast cancer, lung cancer, and stroke than the rest of the State, although for other diseases Franklin does not have a higher rate of death. Franklin has made substantial progress in combating heart disease through prevention and screenings, particularly as a result of screening and case management interventions by the Western Maine Center for Heart Health. Franklin's rate of heart disease mortality is lower than the rest of the state, a very encouraging finding especially in light of Franklin's relatively low median income. Nonetheless, hypertension and/or high cholesterol appear to be a problem for more than a quarter of all adults in Maine. Childhood illnesses are on the decline but danger signs are apparent: While the occurrence of vaccine-related disease is currently the lowest in Maine's history, one out of ten of Maine's 2-year-old children have not been properly immunized.

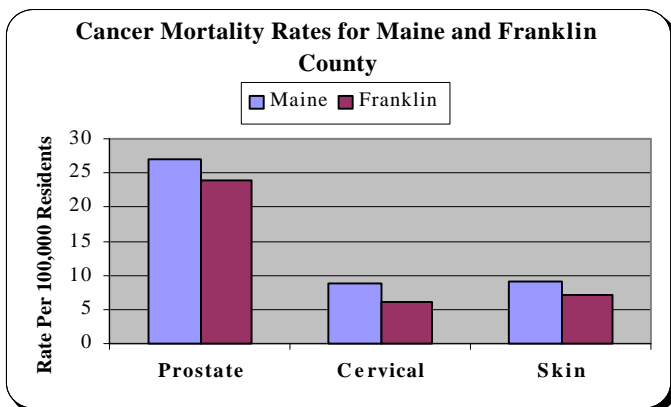
Table 38



Franklin is well above the state and national average for breast and lung cancer mortality. The highest mortality rate for all populations is due to lung cancer.

❖ Source: Department of Health and Human Services, 2000

Table 39

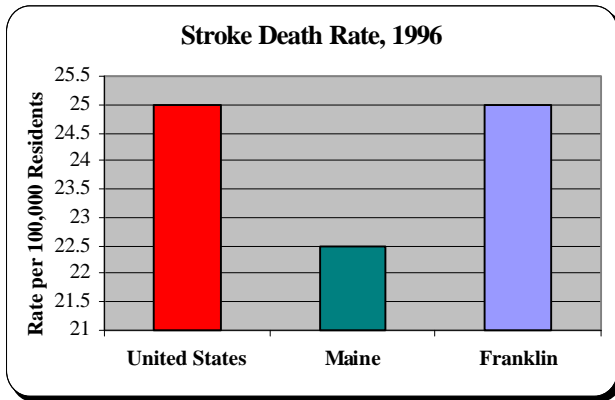


Franklin is below the state and average for prostate, cervical and skin cancers, with prostate cancer as the highest mortality rate.

❖ Source: Maine Department of Human Services, Bureau of Health, Department of Community and Family Health, 1983-1994

DISEASE PREVENTION

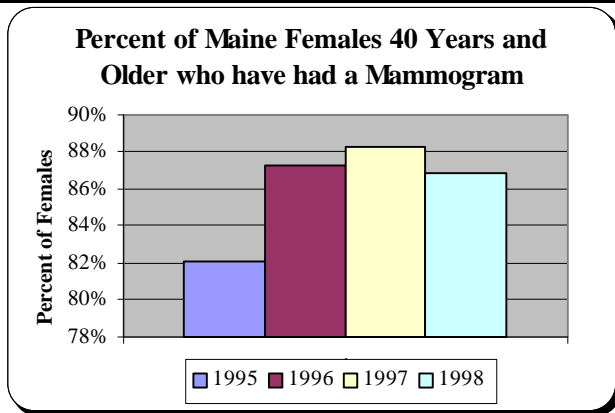
Table 40



Franklin County appears to be almost exactly at the national average for stroke deaths, but about 2.5 points above the state's average rate.

❖ Maine Department of Human Services, Bureau of Health, 1999

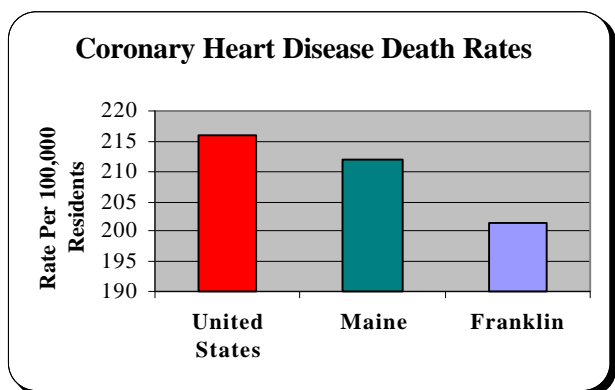
Table 41



Although utilization has been increasing, Maine did take a slight drop in the percentage of women over 40 who have had a recent mammogram in 1998.

❖ Source: Maine Behavioral Risk Factor Surveillance System, 1999

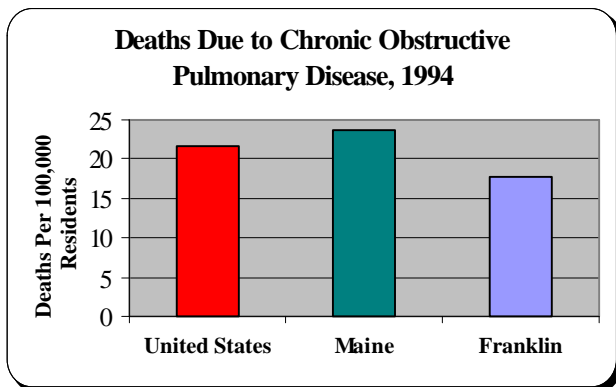
Table 42



Franklin's rate of heart disease mortality is lower than the state or nation, despite our relatively low median income.

❖ Source: Department of Health and Human Services, 2000, and Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics, 1999

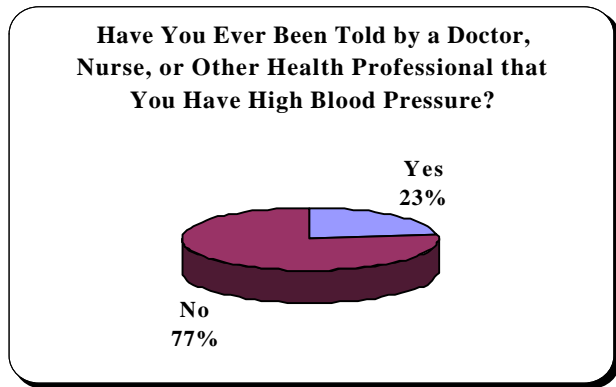
Table 43



Among Maine counties, Franklin has the fourth lowest death rate for COPD.

❖ Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics, 1999

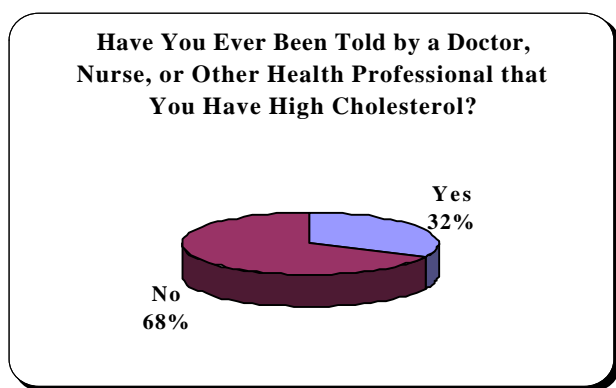
Table 44



About 23% of Maine residents surveyed claimed to have been told by a professional that they have high blood pressure.

❖ Source: National Center for Health Statistics, 1997

Table 45



About 32% of surveyed Maine residents reported being told they had high cholesterol by a health professional.

❖ Source: National Center for Health Statistics, 1997

DISEASE PREVENTION

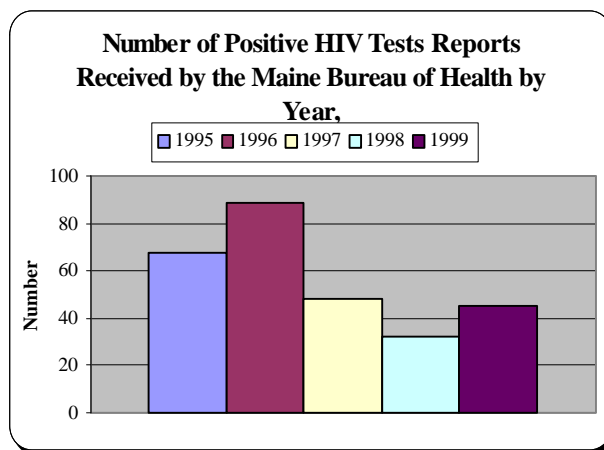
Table 46

Eye Disorders in the United States	
Disorder	# Affected
Macular Degeneration	13 million
Macular Degeneration in the vision-threatening stage	1.2 million
Glaucoma	2-3 million

Millions of Americans are being affected by age-related eye disorders that could potentially cause blindness.

❖ Source: Association of Vision Science Libraries, 1994

Table 47



Over the past 5 years, there has been a slow decline in the number of HIV diagnosed individuals in Maine, although there was a slight increase in 1999.

❖ Source: Maine Bureau of Health HIV?STD Program, 2000

Table 48

Infectious Disease Occurrence for Franklin County, Maine, 1994-1998	
Disease	Cases
Hepatitis A	3
Hepatitis B	1
Measles	0
Pertussis	5
Congenital Rubella Syndrome	0
Syphilis	rna
Tuberculosis	rna
E. coli	2
Salmonella	57
Shigella	1

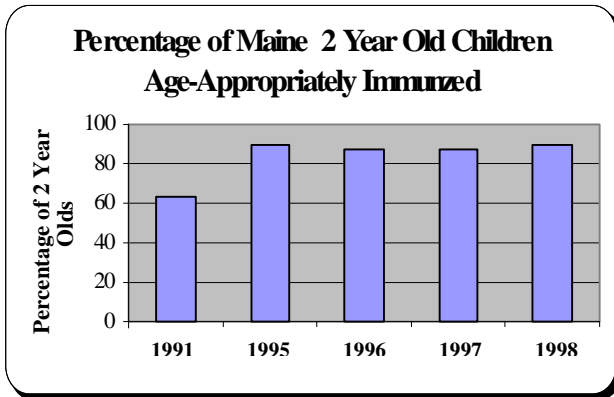
*rna—Data for all counties has not been authorized for release
Source: Department of Health and Human Service

In the period of time between 1994 and 1998, Franklin County had varying occurrences of infectious diseases, with salmonella the one most frequently occurring.

❖ Source: Department of Health and Human Services, 2000

DISEASE PREVENTION

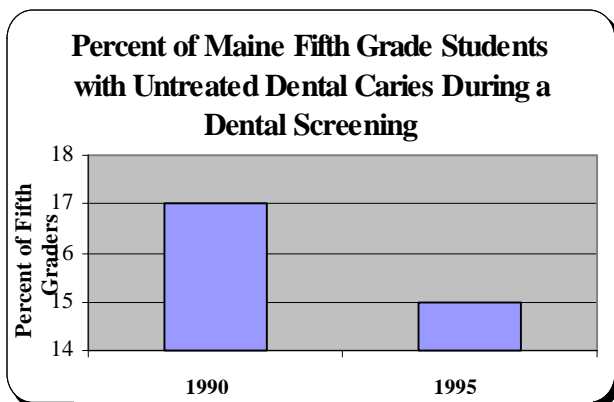
Table 49



About 89% of Maine 2-year-old children were immunized in 1998. The occurrence of vaccine preventable diseases is currently the lowest in Maine's history.

❖ Source: Maine Department of Human Services, Bureau of Health, 1999

Table 50

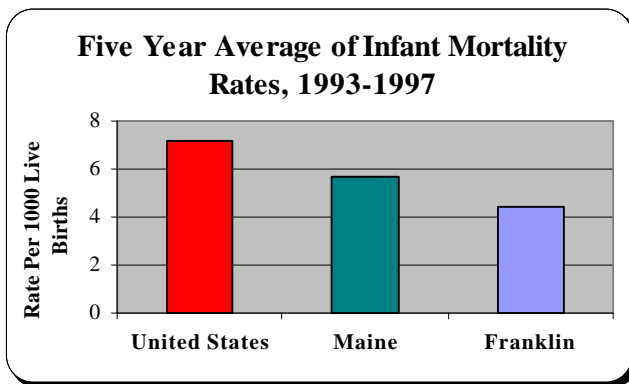


Maine's percent of fifth grade students with tooth decay dropped by 2% between 1990 and 1995.

❖ Source: Maine Department of Human Services, Bureau of Health, 1997

One gauge of the success of our health system is its ability to maintain the health status of particularly vulnerable populations, such as newborns and pregnant women. In this area, Franklin County’s health system appears to excel. Infant mortality and the incidence of low birth weight births are far lower in Franklin than the rest of the State or nation, and our teen pregnancy rate is half that of the national rate.

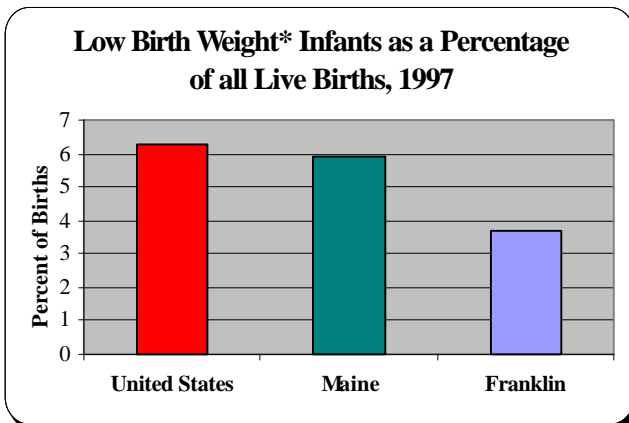
Table 51



Although there is not a large difference between the national, state, and county measures, Franklin has managed to stay below the state and national rates.

❖ Source: Maine Children’s Alliance, 2000

Table 52

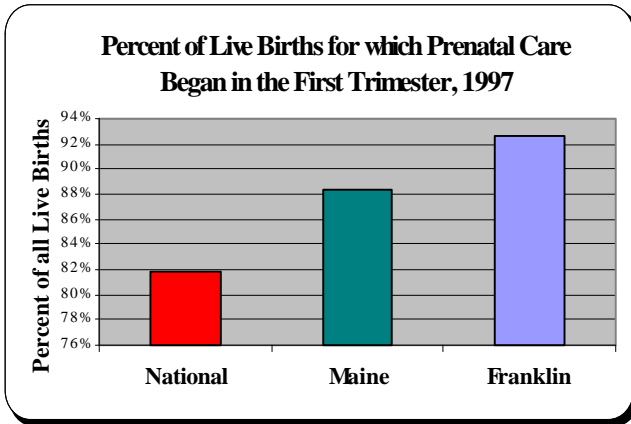


Like the infant mortality measure, Franklin’s rate has stayed below both the state and national measures of low birth weight babies.

*Low Birth Weight: Under 2500g

❖ Source: Maine Children’s Alliance, 2000

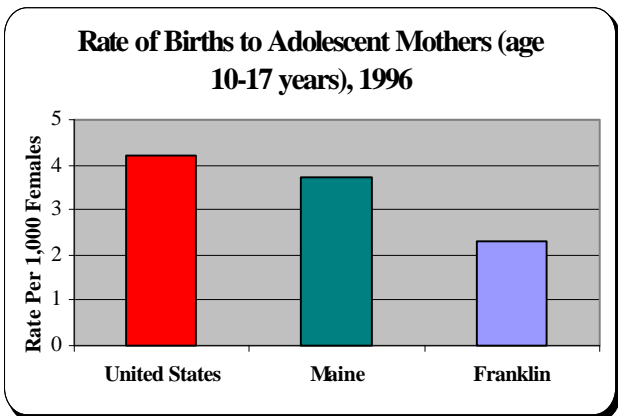
Table 53



90% of pregnant women in Franklin County receive prenatal care, while Maine and the US are in the 80% range, and not too far behind.

❖ Source: Maine Children’s Alliance, 2000

Table 54



Franklin County has a teen pregnancy rate half that of the national rate, and below Maine’s rate as well.

❖ Source: Maine Children’s Alliance, 2000

Health Visioning Process 2000

Final Report

Introduction

The Visioning Process is a biennial event in Greater Franklin County, Maine, aimed at bringing the communities together to build consensus on health priorities. Visioning 2000 was co-sponsored by the Franklin Community Health Network, HealthReach Community Health Centers, United Way of Tri-Valley Area and the Health Leaders Forum. Visioning 2000 was the fourth such process, and many new concerns that did not emerge in earlier processes came forward this year. Community health leaders take the results of the visioning very seriously, frequently building key elements of their strategic plans around the priorities from the Visioning. For example, in 1998, one priority was Public Health Information/Resource Directory. The Healthy Community Coalition and the United Way collaborated to establish One Call, an information and referral line. Specialty Care was another priority identified in the 1998 Visioning and Franklin Memorial Hospital has initiated the Dermatology clinic, Oncology clinic and kidney dialysis services.

The Visioning Process began with Focus Groups that were held in communities throughout Franklin County. Key Informant interviews were also conducted with health leaders and others throughout the area. The Visioning Process concluded with the Visioning Conference held on October 5th. To inform this year's process we used the health indicators found in this volume, *Community Health Assessment 2000: A Snapshot*. We included some of the indicators in the Focus Group discussions and the *Assessment* was distributed at the Visioning Conference. Indicators work indirectly – we don't achieve our goals through indicators but through the steps the community takes in response to them. We also use indicators to measure our progress from year to year.

Focus Groups and Key Informant Interviews

Six focus groups were held in five different towns throughout Franklin County – in Jay, Phillips, Farmington (2), Kingfield and Rangeley. Participants for these groups were randomly solicited from shoppers at Wal-Mart. The issues addressed by these groups varied somewhat by area but there were many common issues as well. For example, two of the top issues in Phillips were access to vision care and dental care, with the final consensus that access to vision care was more important. In Jay, on the other hand, access to mental health and the stigma attached to mental health issues were a top priority.

Key informant interviews were completed with a variety of community members including health care providers, business owners, a school nurse, senior citizen, an adolescent and uninsured and under-insured people. Topping the list were access to mental health services and access to dental care. Other access issues included access to eye care, prescription medications, after-school and mentoring programs for youth and transportation.

Expanding health education and communication about existing resources were also strongly cited. Many people mentioned that knowledge of existing resources, including programs already in existence, is lacking for many in our communities. Wellness issues that the focus groups and key informants would like to see addressed include healthy diet, physical activity/exercise, and reducing tobacco use. Community members also wanted to see prevention efforts focused on suicide, substance abuse and injuries.

Breast cancer, stroke, colorectal cancer and heart disease were also identified as issues that continue to require attention. Last, but not least, people raised the issue of jobs that pay a livable wage with affordable health insurance as a major issue for this area.

Visioning Conference

At the Visioning Conference, participants were given a voter guide to help them think about the issues that emerged for focus groups and key informant interviews. A silent voting process was used for determining the top five priorities. Each participant was given five stickers that they placed on their top five priorities. The votes were then tallied and the top priorities (in descending order) were access to mental health; jobs with affordable health insurance that pay a livable wage; expansion of health education and communication about existing resources; suicide prevention; and access to dental care. The participants then broke into groups and recommended strategies and a lead organization for implementation.

The number one priority is Access to Mental Health. The discussion in this group focused on recruitment and education. Recruitment of professionals is a top priority and this group recommended looking for funding to provide incentives for new providers. Increasing educational programs and awareness around mental health issues was another recommendation from this group. Educating physicians on identifying depression; increasing outreach through the Safe Visitors program; and addressing the stigma of mental health were also addressed. The lead organizations recommended for recruitment were the Franklin Community Health Network (FCHN), HealthReach Community Health Centers, Tri-County Mental Health (TCMH) and the University of Maine at Farmington (UMF). The Healthy Community Coalition (HCC) was recommended to implement the education and awareness recommendation.

The second priority is for jobs with affordable health insurance that pay a livable wage. The recommendations from the group addressing this issue included researching what we want in our area, identifying the needs of potential employers and then providing training for the identified skill sets. The Greater Franklin Development Corporation was recommended for implementation.

The third priority is expansion of health education and communication about resources for improving health. The recommendations for achieving this were to build a strong infrastructure of health educators who collaborate with one another to organize the delivery of health education. Using the successful program, Growing Healthy Families as a model was also recommended. Spending more time on health education in grades K-6 was also discussed. FCHN, including the HCC, and the Health Leaders Forum (HLF) were identified to implement this priority.

The fourth priority is suicide prevention. The recommendation from this group was to build a network of community-based lay services and model it on the successful Peace in Our Families initiative. Other suggestions included having the Hope Book (a resource for teachers and others on suicide prevention) in all schools; promoting the Yellow Ribbon Campaign; expanding the Senior Companion program and overcoming the stigma of depression/mental illness. The HCC, with community and agency collaboration, was recommended for implementation. Employer EAP programs should also be addressing the issue.

The fifth priority is access to dental care. The first recommendation was for increased education – of parents, at daycare, in schools and of medical/health care community. Recruitment of more dentists, and of dental students and interns, was also considered important. Other issues discussed in this group were the lack of understanding of the importance of dental health; the limitations of the hygienists' role (vs. NPs and PAs in health care); and the education, awareness and use of the fluoride programs in the schools. The group recommended that the HCC, UMF, the schools and social services be responsible for the education recommendation and that FCHN, HealthReach, Community Action, the Center for Community Dental Health and local dentists be responsible for recruitment.

VISIONING 2000 PRIORITIES

Below are the issues brought up in community focus groups and interviews with individuals and the Health Leaders Forum in August and September 2000 and the number of votes garnered at the Visioning Conference. Page numbers that appear next to many of the issues refer to related data in the Healthy Community Coalition's *Community Health Assessment 2000: A Snapshot*.

ISSUE	VOTES AT VISIONING 2000
Access to Mental Health (p. 11)	50
Access to Eye Care (p. 24)	0
Access to Dental Care (pp. 11, 25)	33
Prescription Medications (p. 12)	27
Day Care	21
After-School programs for youth	14
Mentoring programs for youth	22
Transportation	10
Expand health education & communication about resources for improving health	38
Healthy diet (p.15)	9
Physical Activity/Exercise (p. 19)	19
Suicide Prevention (pp. 18, 19, 20)	37
Substance Abuse Prevention (pp. 14, 15)	6
Domestic Violence Prevention (pp. 18, 19)	27
Reducing tobacco use (pp. 14, 15)	12
Injury prevention (i.e. fire safety, car seats, helmet use) (pp. 15, 16, 17, 18)	1
Breast Cancer Prevention (p. 21)	8
Stroke prevention (p. 22)	2
Colorectal cancer prevention (p. 21)	0
Heart disease prevention (pp. 13, 14, 15, 22, 23)	4
Jobs that pay a livable wage with affordable health insurance (pp. 9, 11)	41
Health Insurance Cost	7
Home Heating	1
Case Management Support for Young Fathers	2
Affordable Rents	1
Eating Disorders (support for teens)	2
Raising self-esteem of all, especially women	1

VISIONING 2000

Priorities

Below are the issues brought up in community focus groups and interviews with individuals and the Health Leaders Forum in August and September 2000 and the number of votes garnered at the Visioning Conference. Page numbers that appear next to many of the issues refer to related data in the Healthy Community Coalition's *Community Health Assessment 2000: A Snapshot*.

ISSUE	VOTES AT VISIONING 2000
Access to Mental Health (p. 5)	50
Access to Eye Care (p. 18)	0
Access to Dental Care (pp. 5, 19)	33
Prescription Medications (p. 6)	27
Day Care	21
After-School programs for youth	14
Mentoring programs for youth	22
Transportation	10
Expand health education & communication about resources for improving health	38
Healthy diet (p. 9)	9
Physical Activity/exercise (p. 13)	19
Suicide Prevention (pp. 12, 13, 14)	37
Substance Abuse Prevention (pp. 8, 9)	6
Domestic Violence Prevention (pp. 12, 13)	27
Reducing tobacco use (pp. 8, 9)	12
Injury prevention (i.e. fire safety, car seats, helmet use) (pp. 9, 10, 11, 12)	1
Breast Cancer prevention (p. 15)	8
Stroke prevention (p. 16)	2
Colorectal cancer prevention/screening (p. 15)	0
Heart disease prevention (pp. 7, 8, 9, 16, 17)	4
Jobs that pay a livable wage with affordable health insurance (pp. 3, 5)	41
Health Insurance Cost	7
Home Heating	1
Case Management Support for Young Fathers	2
Affordable Rents	1
Eating Disorders (support for teens)	2
Raising self-esteem of all, especially women	1

Acknowledgements

This report comes from the Healthy Community Coalition in collaboration with some partners that we wish to thank for their time and consideration. We thank our “sibling” affiliates in the Franklin Community Health Network, especially Evergreen Behavioral Health Services and Franklin Memorial Hospital’s Western Maine Center for Heart Health. We also wish to thank task force members and volunteers, especially *Peace in our Families*. Angela Cassidy, a University of Maine at Farmington student and Joan Orr, Program Manager at the Healthy Community Coalition shared with us Domestic Violence statistics and their original research. Thanks as well to Dr. Connie Adler for reviewing data and offering suggestions. We thank the University of Maine at Farmington for donating student research as well as their ongoing support for HCC, and we are grateful to the Maine Bureau of Health for their data and time reviewing our statistics.

This project was funded in part by grants from the Maine Community Foundation, the Health Research & Educational Trust, Community Care Network Demonstration Project (funded by the Kellogg Foundation), and UMF’s Work Initiative Program.

Two individuals deserve commendation for their leadership in producing this report. First, the main research and design was completed by Jaime D’Errico, a student at UMF/Psychology Dept. and a summer Work Initiative student with the HCC. Project oversight was provided by Judy Rawlings, MPH, HCC’s evaluator.

