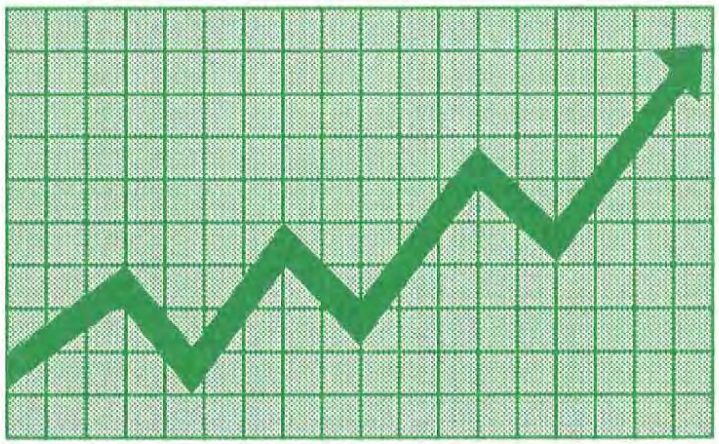
HEALTHY MAINE

2000



Progress Toward The 13 Lead Objectives

HEALTHY MAINE 2000

PROGRESS TOWARDS THE LEAD OBJECTIVES

This report was prepared by the staff of the Bureau of Health's Year 2000 Assessment Project using data and information provided by:

Maine Bureau of Health
- Office of Data, Research, and Vital Statistics
- Division of Disease Control
- Division of Health Promotion and Education
- Division of Health Engineering
- Division of Maternal and Child Health
- Division of Dental Health

Maine Department of Labor
- Bureau of Labor Standards

Maine Department of Public Safety
- Bureau of Highway Safety

Maine Department of Mental Health and Mental Retardation
- Division of Mental Health

Maine Executive Department
- Office of Substance Abuse

Questions regarding this publication should be directed to:

Linda J. Huff or Edward B. Hayes
Year 2000 Assessment Project
Bureau of Health
11 State House Station
Augusta, Maine 04333-0033

Telephone (207)287-6652

Acknowledgment: Kimberly Nelson, a student at the University of Massachusetts, contributed significantly to the development of this report while serving a student internship with the Year 2000 Assessment Project. Richard Smith, Division of Disease Control, provided assistance with graphics.

SEPTEMBER 1995

Table of Contents

Introduction ---------- 3

Maternal and Child Health ---------- 5

Injury Prevention and Control ---------- 7

Chronic Disease Prevention and Control ---------- 9

Human Immunodeficiency Virus (HIV/AIDS) ---------- 11

Teen and Young Adult Health ---------- 13

Immunization and Infectious Diseases ---------- 15

Tobacco Prevention and Control ---------- 17

Oral Health ---------- 19

Cancer Prevention and Control ---------- 21

Mental Health ---------- 23

Substance Abuse ---------- 25

Occupational Health and Safety ---------- 27

Environmental Health ---------- 29

HEALTHY MAINE 2000

Progress Toward The Lead Objectives

Introduction

Healthy Maine 2000 is a statewide strategic plan for improving the health of Maine citizens over the decade and into the 21st century. The plan is the result of a collaborative effort between state health agencies, community organizations, and concerned citizens brought together by the Bureau of Health late in 1989. Healthy Maine 2000 is modeled after the national plan for disease prevention and health promotion called Healthy People 2000 and provides specific public health objectives for the state.

Healthy Maine 2000 targets 13 priority areas for improving the public's health.

Maternal & Child Health

Chronic Disease Prevention & Control

Teen & Young Adult Health

Tobacco Prevention & Control

Cancer Prevention & Control

Substance Abuse

Environmental Health

Injury Prevention & Control

Human Immunodeficiency Virus(HIV/AIDS)

Immunization & Infectious Disease

Oral Health

Mental Health

Occupational Health & Safety

General goals and specific objectives were developed for each priority area. In addition a lead objective has been highlighted for each priority area. This report reviews the 13 priority areas, identifies the general goals and the lead objective for each area, and charts the progress made toward meeting these objectives.

As we approach the 21st century, we must envision a better society and a healthier Maine. By setting and measuring specific public health objectives we can track our progress towards a healthier Maine by the year 2000. Halfway through the decade it is time to evaluate our progress and take the necessary steps to achieve our goals.

Maternal and Child Health

Goal
Improve the health status of women, infants, and children.

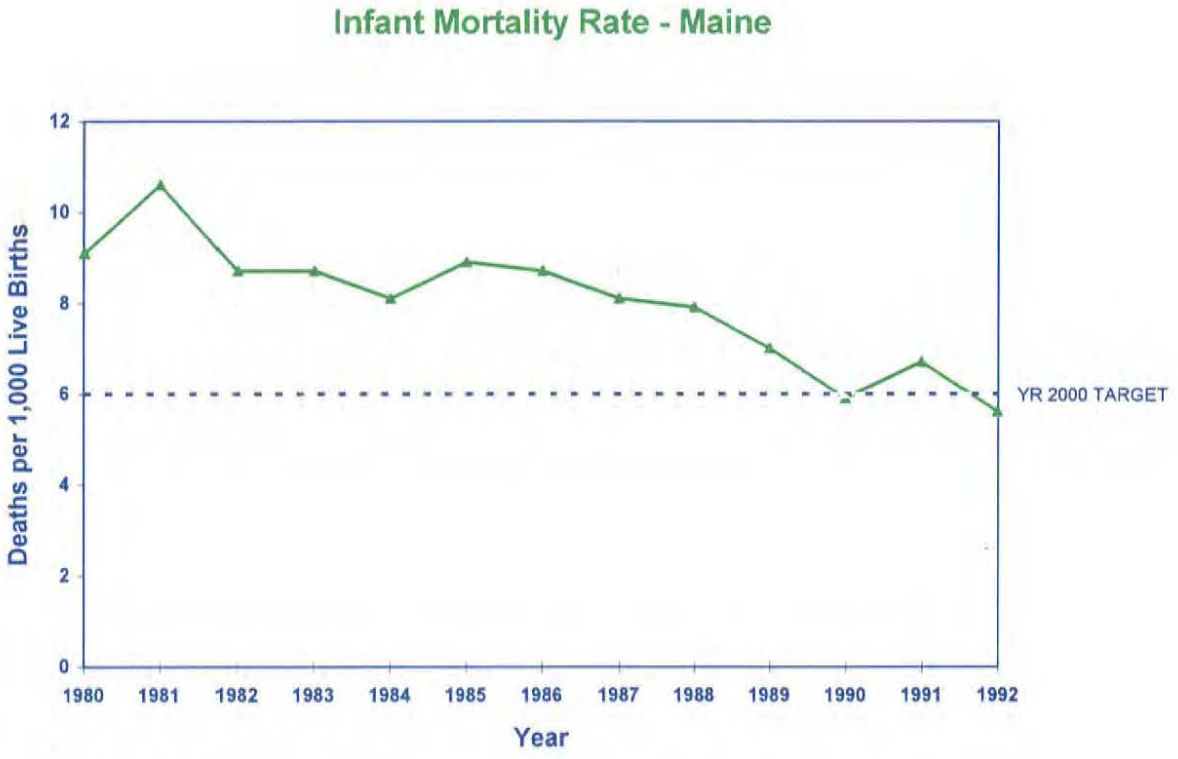
Lead Objective
Reduce the infant mortality rate to 6 deaths per 1,000 live births.

Contact: Rachel Curtis, Division of Maternal & Health

Improving the health of mothers, infants, and children is an important task for Maine. Current public health efforts to reduce infant mortality and improve the health of pregnant women in Maine include programs to improve nutrition and access to care, and to reduce smoking, substance abuse, and pre-term labor.

The Pregnancy Risk Assessment Monitoring System (PRAMS) and the Women, Infants, and Children Program (WIC) are currently being used to monitor and evaluate the health status of pregnant women in Maine. Data from (PRAMS) indicates that 40 percent of all mothers smoked before pregnancy and 57 percent of all mothers delivering low birthweight infants smoked before pregnancy.[1] WIC program data indicates that 30 percent of mothers receiving services were outside normal weight parameters and 51 percent were inadequately nourished.[2]

Over a twenty year period Maine succeeded in reducing its infant mortality rate from 20.9 deaths per 1,000 live births in 1970 to 6 deaths per 1,000 live births in 1990. Maine's infant mortality rate for 1990-1992 of 6.2 was the lowest in the United States.[3]



Data Source: Office of Data, Research and Vital Statistics

Injury Prevention and Control

Goal
Reduce the rate of injuries to Maine residents

Lead Objective
Reduce unintentional injury mortality by 15% to 34 deaths per 100,000

Contact: Cheryl DiCara, Division of Maternal and Child Health

The majority of injuries are both predictable and preventable: they are not chance occurrences. The task of injury control is to limit the opportunities for injuries to occur, to reduce the extent of injuries, and to minimize the consequences when they do occur.

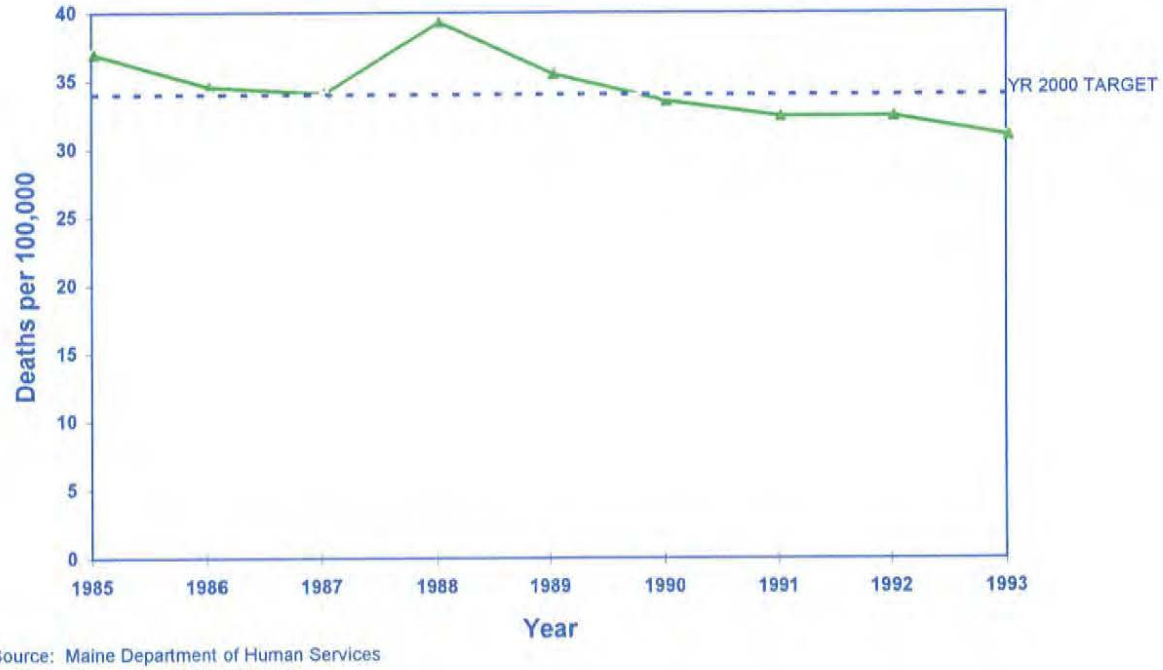
From 1987 to 1990, injury deaths accounted for 5.6 percent of all the deaths in Maine.[4] Unlike other leading causes of death, injuries disproportionately strike the young. Nearly 71% of all deaths between the ages of 1-19 result from injuries.[5]

Approximately two thirds of injury deaths are unintentional. Unintentional injuries are the leading cause of death for Maine residents between the ages of 1-34 and the fifth leading cause of death for all age groups.[4]

For 1990-1992, the three leading causes of fatal injuries in Maine were motor vehicle crashes, suicide, and falls.[6]

In recent years, a number of services and prevention initiatives have been implemented with the aim of reducing the number of fatal injuries. Factors such as reductions in drunk driving, as well as increases in the use of safety belts, child safety seats, and motorcycle and bicycle helmets can aid in the continued reduction of this leading cause of death among Maine residents.

Unintentional Injury Death Rate - Maine



Data Source: Maine Department of Human Services
Office of Data, Research and Vital Statistics

Chronic Disease Prevention and Control

Goal

Reduce morbidity and mortality among Maine citizens from heart disease, stroke, diabetes, asthma and other chronic conditions.

Lead Objective

Reduce the mortality from cardiac and cerebrovascular disease by reducing coronary heart disease deaths to no more than 100 per 100,000 and stroke deaths to no more than 20 per 100,000.

Contact: Pat Jones, Division of Health Promotion and Education

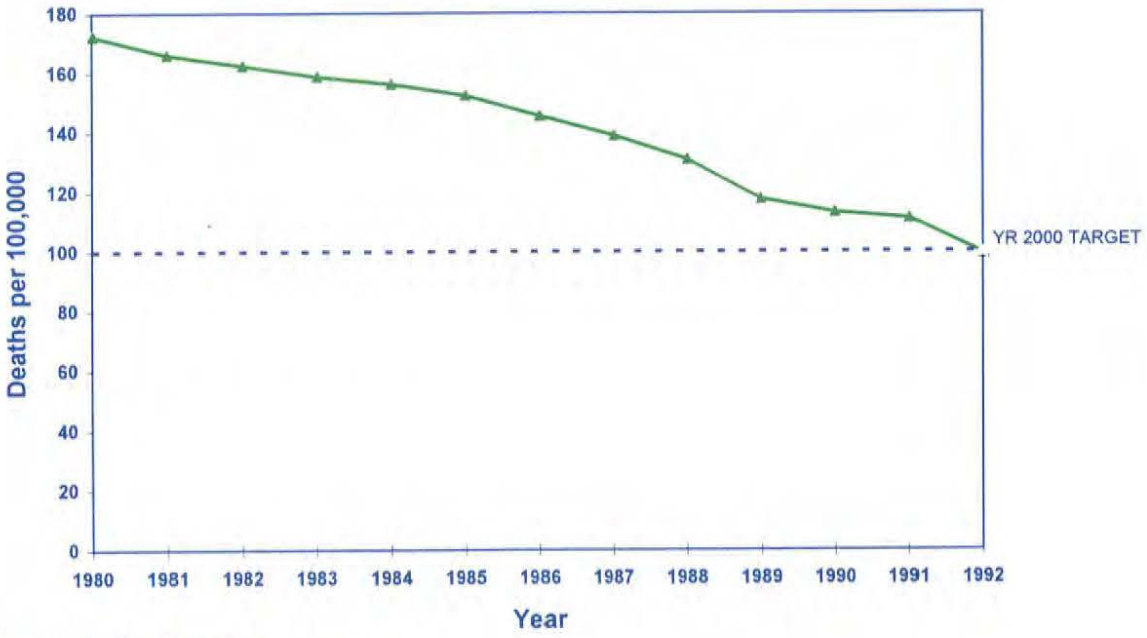
Cardiovascular disease continues to be the number one cause of death in Maine and the United States, accounting for 49% of all Maine deaths in 1990. The primary modifiable risk factors for this disease include high cholesterol, high blood pressure, smoking and physical inactivity. Obesity and diabetes are additional risk factors.

Cardiovascular disease also imposes a heavy financial burden on Maine. According to the Maine Health Care Finance Commission, inpatient charges for heart disease in 1990 totaled over $201 million, one fourth of all hospital costs, and the charges for stroke totaled another $21 million. These figures do not include costs for treatment outside of a hospital, or due to lost productivity.

As with the rest of the nation, Maine has experienced a decline in heart disease and stroke mortality rates. The rate for coronary

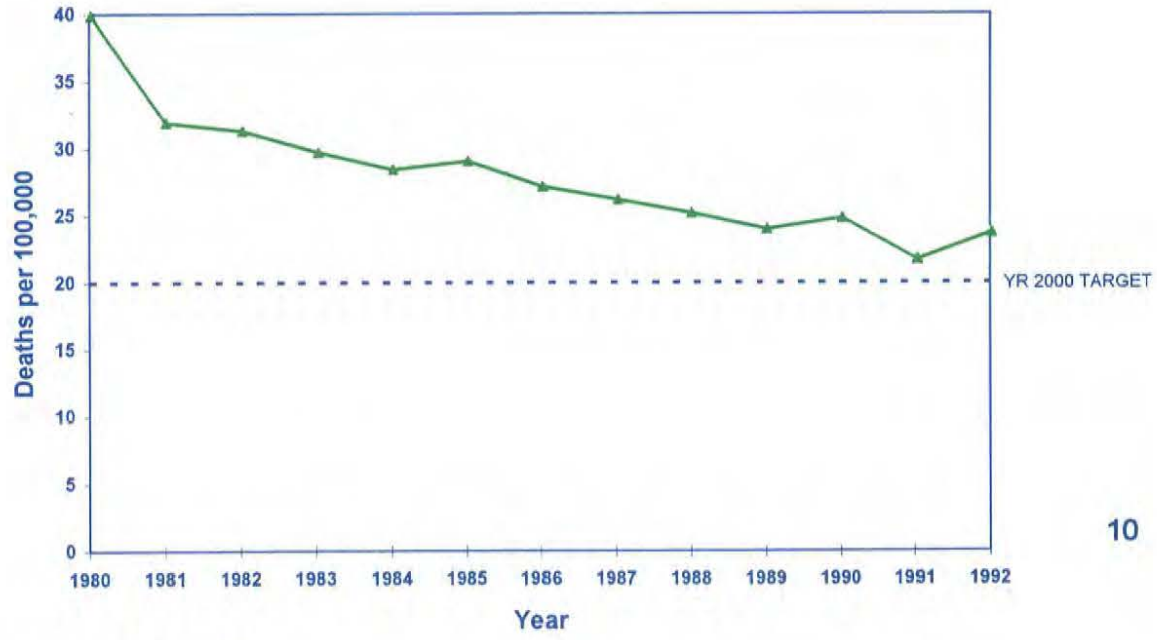
heart disease has declined steadily to reach the Healthy Maine 2000 goal in 1992. The rate of stroke has shown a slower decline in recent years and even increased slightly in 1992.

Coronary Heart Disease Death Rate - Maine



Age Adjusted to the US 1940 Population
Data Source: Office of Data, Research and Vital Statistics

Stroke Death Rate - Maine



Age Adjusted to the US 1940 Population
Data Source: Office of Data, Research and Vital Statistics

Human Immunodeficiency Virus (HIV/AIDS)

Goal
Prevent HIV infection and reduce associated morbidity and mortality.

Lead Objective
Decrease the incidence of AIDS cases to no more than 3.0 per 100,000

Contact: Steve Fleming, Division of Disease Control

Through 1994, 592 Maine residents had been diagnosed with AIDS. An estimated 1200-1800 persons in the state are believed to be living with HIV infection. The majority (73%) of recently-diagnosed cases of AIDS continue to be seen among gay and bisexual men, as is true in most non-urbanized areas of the U.S., where levels of injection drug use are relatively low. The proportion of AIDS cases who are women has increased since 1988. In 1993, females represented 11% of AIDS cases in Maine and over 15% of persons testing HIV-positive were female. Although the greatest number of AIDS cases have been reported from areas of urban southern Maine, case reports from the more rural central and northern areas of the state have recently increased.

In January 1993, the Centers for Disease Control and Prevention adopted an expanded case definition of AIDS. The new

definition encompassed a greater number of AIDS cases by broadening the criteria used to make a diagnosis of AIDS in patients with HIV infection. The expanded definition resulted in dramatic increases in the number of cases reported in 1993. Many of these cases met the new diagnostic criteria in earlier years, and those that did were retrospectively assigned to the year of diagnosis. Approximately 30% of cases diagnosed in 1992 and 50% of cases diagnosed in 1993 would not have been included under the old definition.

AIDS Incidence Rate - Maine

Data Source: Maine Department of Human Services
AIDS Surveillance System, DDC

* On 1/1/93, the CDC adopted an expanded AIDS definition

Teen and Young Adult Health

Goal

Improve the health of teens and young adults and improve access to preventive and primary health care services.

Lead Objective

***Reduce the pregnancy rate of 10-14 year olds to 0 per 1000 females, the pregnancy rate of 15-17 to 30 per 1000 females and the pregnancy rate of 18 and 19 year olds to a rate of 80 per 1000 females.**

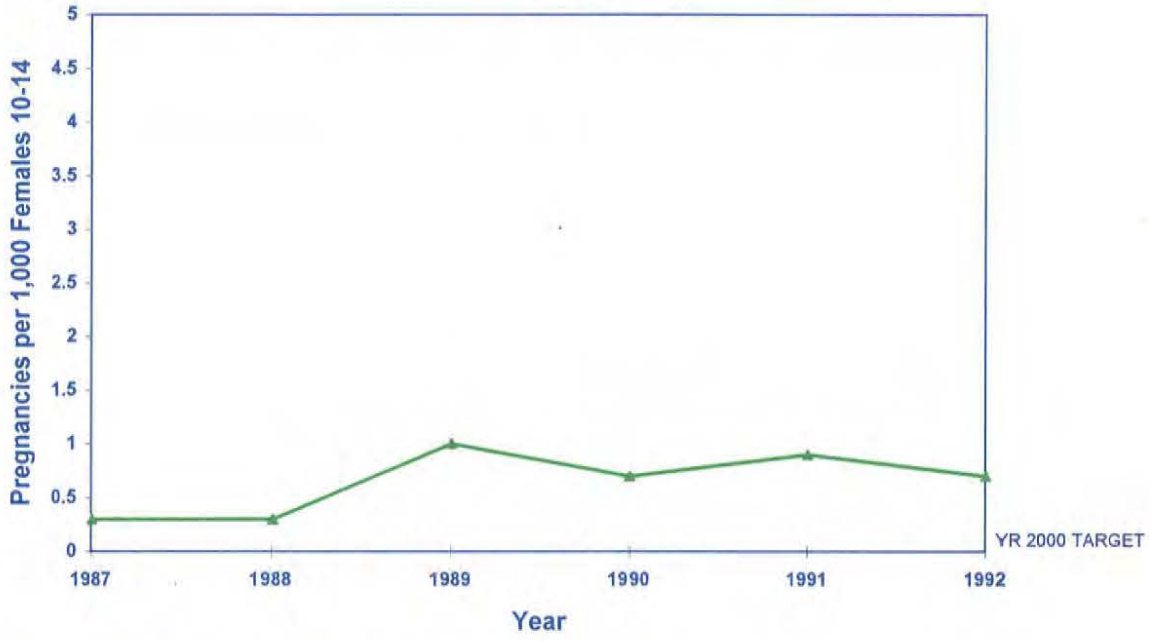
Contact: DeEtte Hall, Division of Maternal and Child Health

Some of the negative consequences which can result from adolescent pregnancy include reduced educational achievement, lower economic status, and increased risk of adverse health effects for both mother and child.

Maine's teen birth rate is lower than the national average. In 1992 the birth rate for girls aged 15-19 in Maine was 39 per 1000,[7] compared with a national rate of 60.7 for all girls aged 15-19, and 51.8 for white girls in this age group.[9]

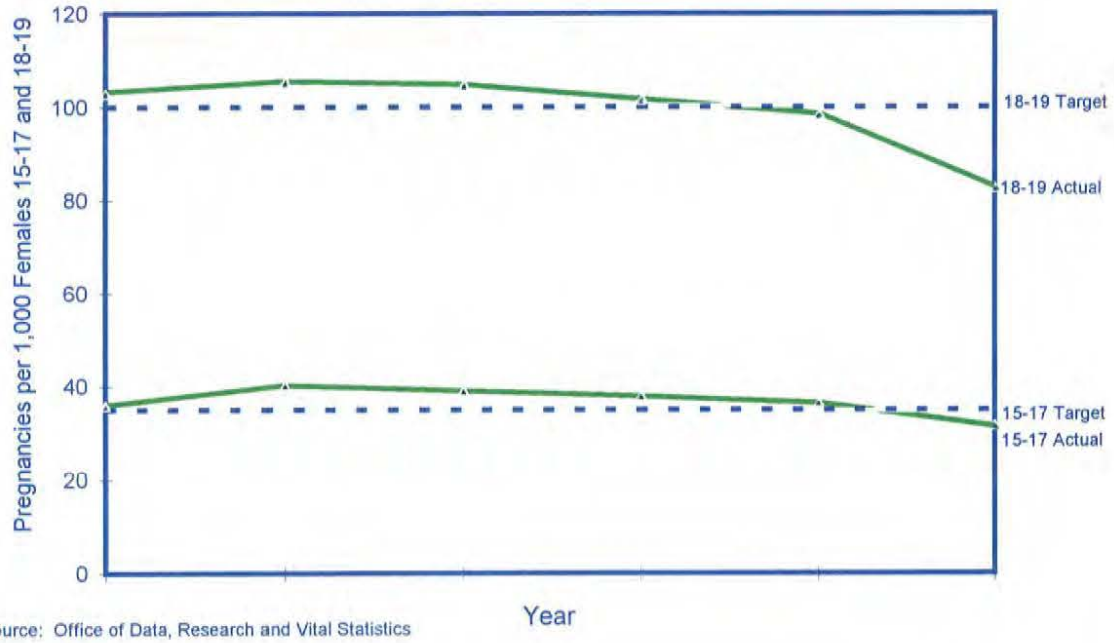
**This objective has been revised from the original in Healthy Maine 2000.*

Teen Pregnancy Rate - Maine
Age 10-14



Data Source: Office of Data, Research and Vital Statistics

Teen Pregnancy Rate- Maine
15-17 and 18-19



Data Source: Office of Data, Research and Vital Statistics

Immunization and Infectious Diseases

Goal
Reduce the incidence of infectious diseases in Maine.

Lead Objective
***Increase to 90% the percentage of two year old children who are age-appropriately immunized.**

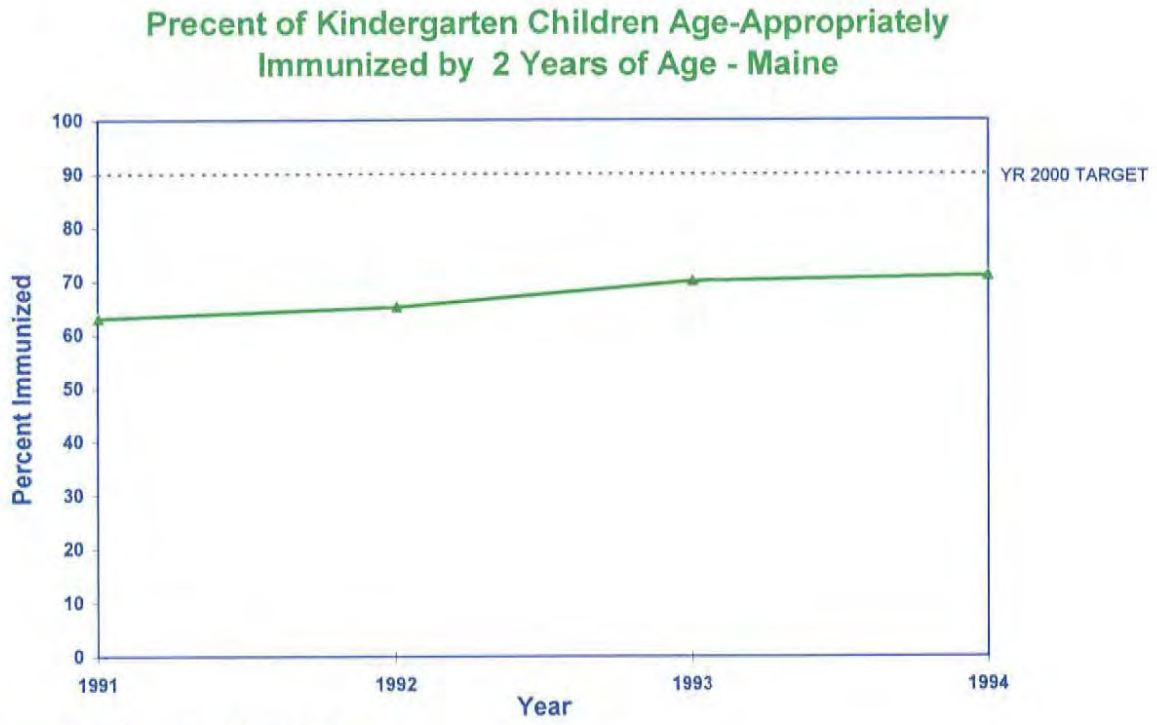
Contact: Jude Walsh, Division of Disease Control

Each year field staff from the Immunization Program conduct a retrospective survey of entering kindergarten students to assess immunization rates for the state. In 1991, 63% of kindergarten students had received the basic immunization series by their second birthday. In 1994, this percentage had increased to 74%. By the time children in Maine enter school at age 4-6, 98% are adequately immunized. Healthy Maine 2000 seeks to close the gap in immunization coverage by increasing the percentage of two year olds who are age-appropriately immunized.

The Immunization Program is in the process of implementing assessment activities using software developed by the Centers for Disease Control and Prevention (CDC). This will provide current

**This objective has been revised from the original in Healthy Maine 2000.*

immunization information instead of retrospective data, allowing the Immunization Program to target resources to those areas of the state in greatest need of intervention.



Data Source: Maine Department of Human Services
Dividion of Disease Control

Tobacco Prevention and Control

Goal

Reduce death and disability due to tobacco use among Maine citizens and eliminate involuntary public exposure to environmental tobacco smoke.

Lead Objective

***Reduce the prevalence of cigarette smoking to no more than 15 % among Maine citizens age 18 and older, and totally eliminate public involuntary exposure to environmental tobacco smoke.**

Contact: Sandra Hoover, Division of Health Promotion and Education

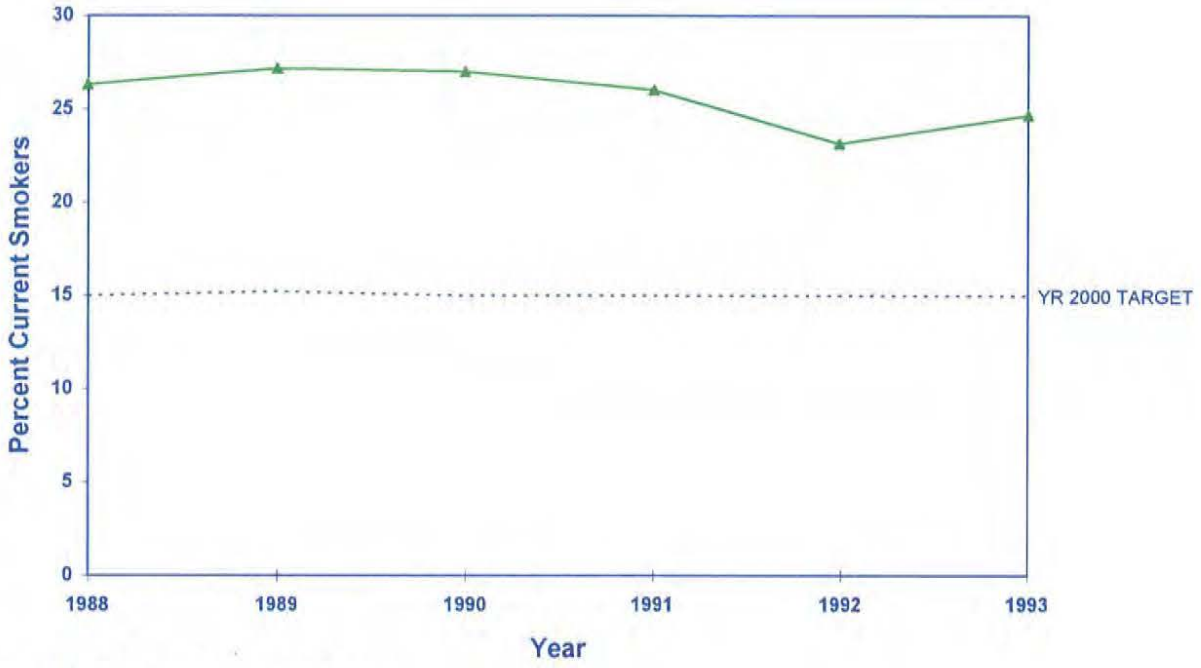
Tobacco use is the single most preventable cause of death and disease in the United States and in Maine, accounting for one of every six deaths in the US.[8] Tobacco use is a known cause of heart disease, chronic bronchitis and emphysema, and cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder. The adverse health effects from tobacco extend past the user to non-smokers. Involuntary smoking is a cause of lung cancer in non-smokers, severe respiratory problems in young children, and growth retardation of unborn infants.

Over the past 25 years, there has been a significant reduction in tobacco use in this country due to changes in societal norms and

**This objective has been revised from the original in Healthy Maine 2000.*

heightened health awareness. However, according to the 1993 Maine Behavioral Risk Factor Survey, 24% of Maine adults aged 18 and older smoke cigarettes. In order to reduce the prevalence of smoking, Maine's health programs are committed to preventing young people from starting to smoke, and to increasing the number of smokers who quit; with emphasis given to high risk groups such as women of child bearing age, children, adolescents, and blue collar workers.

Prevalence of Cigarette Smoking - Maine
Age 18 and Older



Data Source: Maine Behavioral Risk Factor Survey
Maine Department of Human Services

Oral Health

Goal
Improve the oral health of Maine citizens.

Lead Objective
***Decrease, to 10 percent, the proportion of Maine citizens who have lost 6 or more of their natural teeth because of tooth decay or gum disease by the age of 25.**

Contact: Debra Andrews, Division of Dental Health

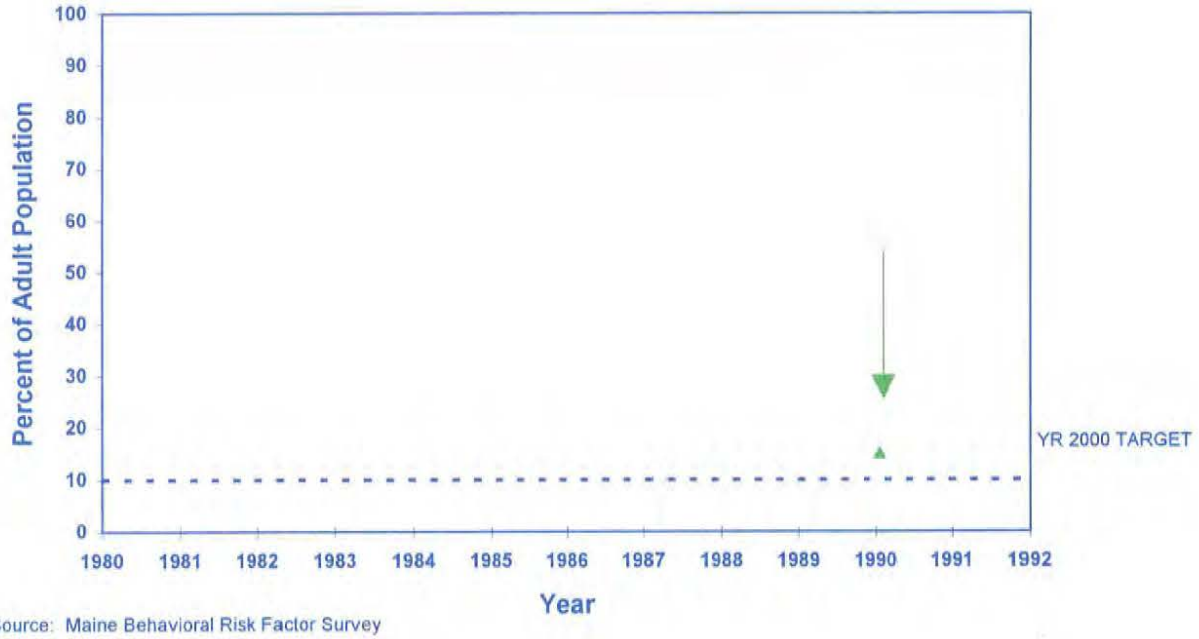
The degree of tooth loss in adults due to tooth decay or gum disease is a marker of the oral health status of an entire community. A high rate may be an indicator of lack of access to dental care, insufficient exposure to fluorides, or poor oral hygiene and irregular visits to a dentist. Poor oral health in adults may result not only in eventual tooth loss, but also in impaired general health, compromised nutrition, days lost from work, and inability to advance in employment.

Strategies to decrease tooth loss include the promotion of daily tooth brushing with fluoridated toothpaste, flossing, good nutrition, and assuring access to regular dental care including the placement of dental sealants and hygienic cleaning.

** This objective has been revised from the original in Healthy Maine 2000.*

The data point shown in the graph is based on the oral health questions asked as part of the 1990 Maine Behavioral Risk Factor Surveillance Survey (BRFSS). Additional data will be collected periodically from the state and national BRFSS surveys; both surveys are asking oral health questions during 1995.

Proportion of Maine Citizens Who Have Lost Most or All of Their Natural Teeth by Age 25



Data Source: Maine Behavioral Risk Factor Survey
Maine Department of Human Services

Cancer Prevention and Control

Goal
Reduce Cancer morbidity and mortality.

Lead Objective
Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000.

Contact: Barbara Leonard, Division of Health Promotion and Education

The Maine Cancer Registry has collected cancer incidence data on Maine residents since 1983. According to the Registry, the most frequently diagnosed cancers from 1983 -1992 among men were lung, prostate, and colorectal cancer, and among women were breast, colorectal and lung cancer. The leading causes of cancer deaths among males were lung, colorectal, and prostate. The leading causes of cancer death among women were lung, breast and colorectal.

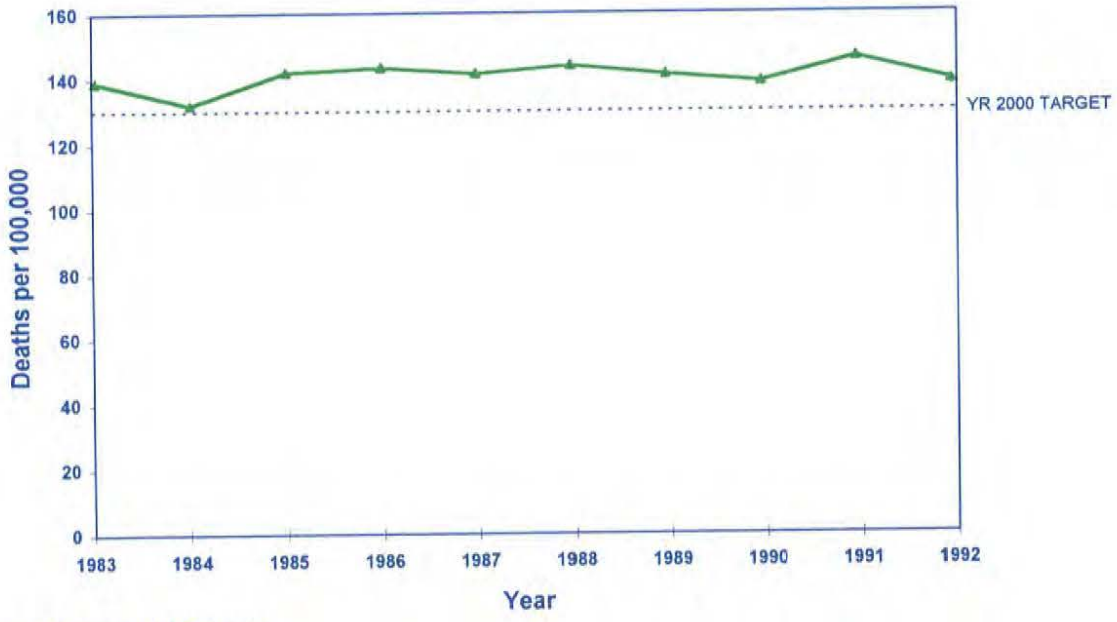
The age distribution of patients with newly diagnosed cancers peaks in the 65-74 age group for both men and women; however, a greater number of women than men are diagnosed between the ages of 25 and 55, due primarily to breast cancer diagnosed in women in this age group.

Early detection and intervention can significantly reduce cancer mortality for some cancers. Studies have demonstrated that screening

mammography and clinical breast examination are effective in reducing breast cancer mortality.[9,10,11] More than 30 percent of cancer deaths are due to smoking [12] and an estimated 35 percent of cancer deaths may be related to diet.[13]

As indicated on the following graph, Maine's cancer death rate remains above the Healthy Maine 2000 objective. Promoting healthy nutrition, reducing tobacco use and increasing clinical screening associated with early detection are important factors in efforts to reduce the cancer mortality rate.

Cancer Death Rate - Maine



Age Adjusted to the US 1940 Population

Data Source: Office of Data, Research and Vital Statistics

Mental Health

Goal

Reduce the disruptive and debilitating effects of serious emotional disturbances in youth and serious mental illness and mental disorders in adults in Maine.

Lead Objective

***Increase the access of community mental health services by adults with serious mental illness to at least 90 percent, and by youth with serious emotional disturbances to 33 percent.**

Contact: Julita Klavins, Department of Mental Health and Mental Retardation

According to national studies, approximately 1 out of 5 people have a mental disorder serious enough to warrant mental health intervention.[14] This represents about 230,000 individuals in Maine. An estimated 10,000 adults in Maine have severe and prolonged mental illness with significant functional impairments.[15] Mental health problems affect approximately 30,000 children in Maine. Of these, about 14,000 children ages 6-20 have serious emotional disturbances, while an additional 8,000 children from birth to 5 years of age have developmental or emotional/behavioral disabilities.[16]

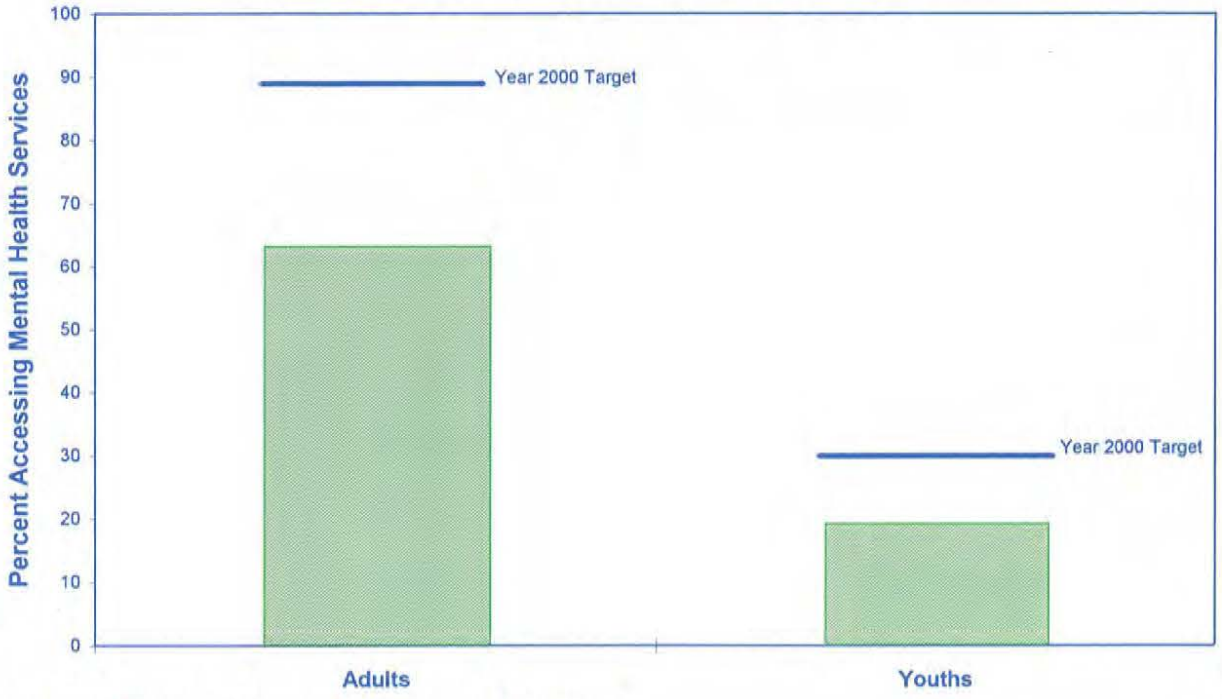
Mental illness can be successfully treated and managed in most instances with a variety of treatment services to reduce symptoms and prevent relapse, and supportive rehabilitative services to improve social, vocational. and other daily living functioning. An effective mental

**This objective has been revised from the original in Healthy Maine 2000.*

health system makes individualized services and supports accessible to individuals and their families in settings most appropriate to their needs, while promoting personal independence and an improved quality of life.

In fiscal year 1994, 6315 adults using community support services funded by the Division of Mental Health were reported as having serious mental illness. Thus roughly 63% of the 10,000 Maine adults with serious mental illness accessed these community services. In fiscal year 1991, 2677 youths with serious emotional disturbances accessed services funded by the Bureau of Children With Special Needs. Thus roughly 19% of the 14,000 Maine youths with serious emotional disturbances accessed such services.

Estimated Proportion of Individuals With Serious Mental Illness Who Access Community Mental Health Services



Data Source: State of Maine Department of Mental Health and Retardation

Substance Abuse

Goal

Reduce morbidity and mortality related to alcohol and drug use through change in the social and cultural climate.

Lead Objective

*** Reduce the number of alcohol-related motor vehicle fatalities to no more than 72 by the year 2000.**

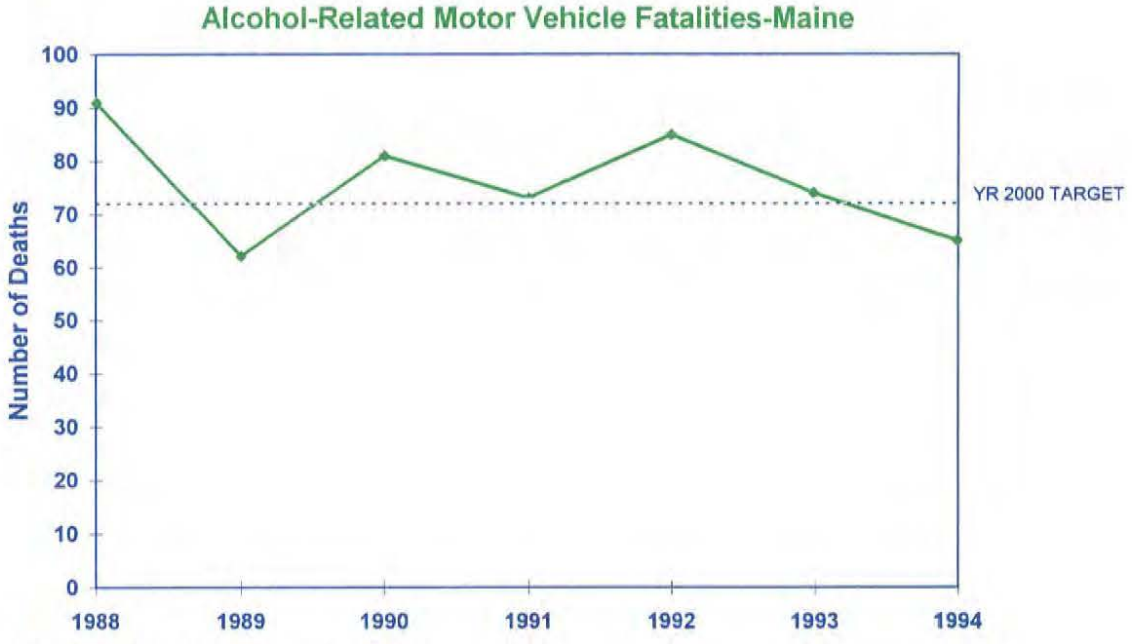
Contact: Joanne Medwid, Office of Substance Abuse, Executive Department

This objective is critical since it represents a major avoidable cause of death in Maine as well as across the country. From 30 to 40% of all traffic crash deaths are alcohol-related.[17] These crashes affect all age groups and are the leading cause of death among America's youth.[17] In Maine, alcohol was involved in an average of 80 highway deaths per year from 1990 through 1992.[18] The data for 1993 and 1994 show an encouraging improvement.[18] However, prevention, intervention and treatment activities must be continued and enhanced if this trend is to be maintained.

The most significant factor affecting alcohol and drug use is the social and cultural climate. In recent years, public attitudes toward drinking and driving have changed dramatically. These attitude changes have led to legislative and policy changes at all levels of

**This objective has been revised from the original in Healthy Maine 2000.*

government. Changes in the legal blood alcohol level for drivers, driver education and evaluation programs, drinking age, number of outlets for the sale of alcohol, "server" training and public information campaigns have all been shown to reduce the alcohol-related fatal crash rate. The combination of increased public resolve and improved understanding of issues related to substance abuse, will assist efforts to make further advancements by the Year 2000.



Data Source: Maine Department of Public Sagety
Bureau of Highway Safety

Data Source: Maine Bureau of Highway Safety

Occupational Health and Safety

Goal
Reduce morbidity and mortality among Maine's citizens from work-related injuries and illnesses.

Lead Objective
Reduce work-related injuries and illnesses by 50% to 7.2 per 100 full-time workers per year.

Contact: Beth Carvette, Division of Disease Control

Occupational safety and health is a major concern in Maine. According to the US Occupational Safety and Health Administration, Maine's rate of work-related injuries and illnesses have consistently exceeded national rates - even after adjusting for Maine's more hazardous industry mix.[19] In 1993, the adjusted injury and illness incidence rate in Maine was 18.6% higher than the United States rate (10.08 cases versus 8.5 cases per 100 full-time workers).[19]

Although occupational injury rates are declining, Maine's occupational illness rates continue to rise. This increase is largely due to disorders associated with repeated trauma (tendonitis, carpal tunnel syndrome and noise-induced hearing loss) which accounted for 77% of all occupational illnesses in 1993.[19]

Many new programs have been instituted to increase awareness of occupational hazards and assist businesses in developing comprehensive health and safety programs. Nevertheless, occupational conditions are under-reported, in part due to difficulties in recognizing the link between occupational exposures and illnesses.

Reaching this Healthy Maine 2000 objective will help promote a healthier work force, make Maine businesses more competitive, and make Maine a healthier place to live, work, and do business.

Occupational Injury and Illness Rate - Maine

Data Source: Maine Department of Labor, Bureau of Labor Standards

Environmental Health

Goal
Enhance the safety of the environment and reduce adverse impacts on the health of Maine citizens.

Lead Objective
***Increase to at least 50 percent the proportion of homes in Maine that have been tested for radon.**

Contact: Clough Toppan, Division of Health Engineering

Radon, a naturally occurring radioactive gas proven to cause lung cancer, is the leading source of ionizing radiation exposure to the public.[20] Approximately 30% of Maine homes and schools have radon levels over the U.S. EPA recommended action level of 4.0 picocuries per liter (pCi/L).

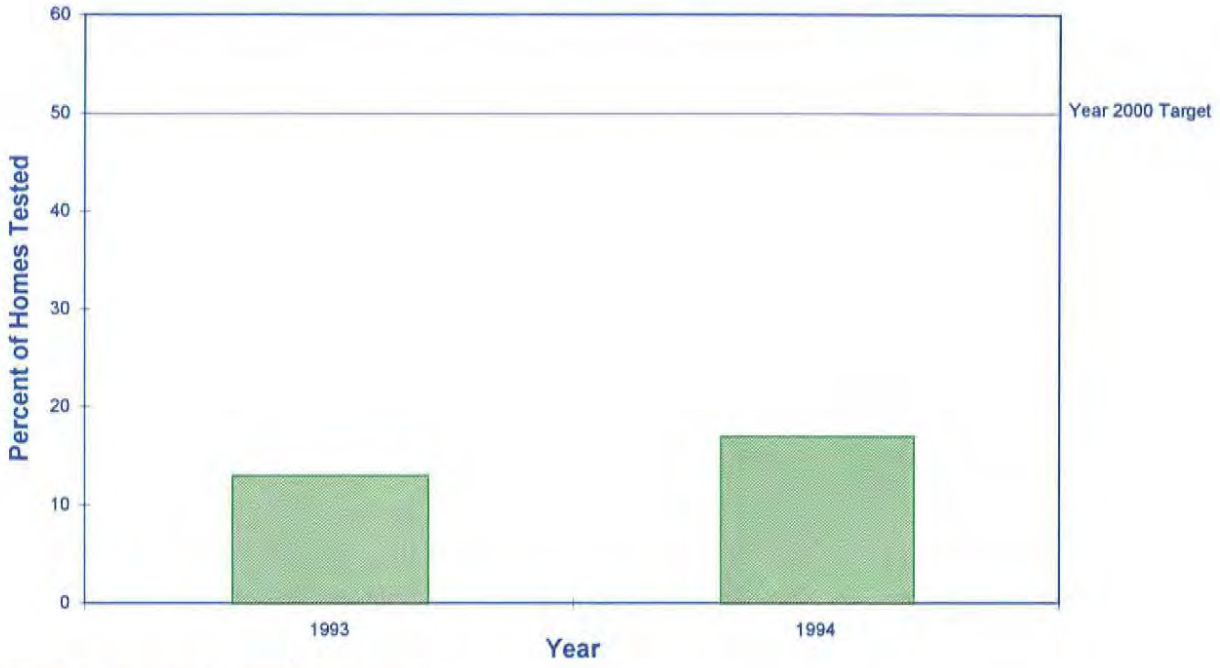
The effort to reduce radon exposures in Maine was expanded by EPA's State Indoor Radon Grant program, begun in 1990, and the Maine Radon Registration Act which took effect in 1993. The grant provides funds for State radon activities, and the Act requires providers of radon services to prove they meet training requirements and follow performance standards.

A 1993 nationwide survey to determine radon awareness and percentages of homes tested and mitigated showed 13% of Maine

**This objective has been revised from the original Healthy Maine 2000.*

homes had been tested.[21] A repeat survey in 1994 showed 17% had been tested, an increase of 4% in one year. Both surveys found Maine has the highest radon awareness in the country. Another survey is planned in 1996.

Percent of Homes in Maine Tested for Radon



Data Source: Maine Department of Human Services
Division of Health Engineering

REFERENCES

1. Office of Data Research and Vital Statistics, Pregnancy Risk Assessment Monitoring System (PRAMS) Survey Data 1989.

2. Maine Bureau of Health, Division of Maternal and Child Health. WIC Gelco Report. Augusta, Maine, June 1990.

3. National Center Health Statistics. Health , United States, 1994. Hyattsville, Maryland: Public Health Service. 1995.

4. Maine Office of Data, Research, and Vital Statistics. Maine Vital Statistics, mortality data, 1987-1990. Augusta, Maine, 1990

5. Maine Office of Data, Research, and Vital Statistics. Maine Vital Statistics, mortality data, 1979-1988. Augusta, Maine, 1988.

6. EpiGram Software 1995

7. Maine Office of Data, Research, and Vital Statistics. Maine Vital Statistics, Fact Sheet on Adolescent Pregnancy in Maine, 1988-1992 (preliminary)

8. Office on Smoking and Health. Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General. DHHS Pub. No. (CDC) 89-8411. Washington, DC. U.S. Department of Health and Human Services, 1989.

9. Shapiro S, Venet W, Strax L, and Roeser R. Selection, Followup, and Analysis in the Health Insurance Plan Study: A Randomized Trial with Breast Cancer Screening. National Cancer Institute Monograph 67:65-74,1985.

10. Tabar L, Gad A, Homberg LH, Ljungquist V, Eklund G, Fagorberg CJG, Baldetorp L, Grontoft O, Lundstrom B, Manson JC, Day NE, and Peherson F. Reduction in mortality from breast cancer after mass screening with mammography. Lancet 1:829-832,1985.

11. Verbeek ALM, Hendricks JHCL, Holland R, Mravunac M, Sturmans F, and Day NE. Reduction of breast cancer mortality through mass screening with modern mammography: first results of the Nijmegan Project, 1975-1981. Lancet 1:1222-1224, 1984.

12. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. DHHS Publication No. (PHS) 91-50212, 1990.

13. Centers fro Disease Control. Black-White Differences in Cervical Cancer Mortality-United States, 1980-1987. Morbidity and Mortality Weekly Report 39:245-248, 1989.

14. National Institute of Mental Health. Epidemiologic Catchment Area Study. Rockville, Maryland: U.S. Department of Health and Human Services, 1984

15. Maine Department of Mental Health and Mental Retardation. Mental Health Client Census. Augusta, Maine, 1990.

16. Maine Department of Mental Health and Mental Retardation, Bureau of children with special needs. Biennial Plan: 1991-1992. Augusta, Maine 1991.

17. National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Drunk Driving Facts. Washington, DC, 1988.

18. Maine Highway Facts, Bureau of Highway Safety, Department of public Safety, Augusta, Maine, 1994.

19. Maine Department of Labor. Bureau of Labor Standards. Research and Statistics Division. 1993 Occupational Injuries and Illnesses, Augusta, Maine. January, 1995

20. National Council on Radiation Protection and Measurements. Ionizing Radiation Exposure of the Population of the United States. Report # 93, Bethesda, Maryland. September, 1987

21. Conference of Radiation Control Program Inc., Radon Risk Communication and Results Study. February 1993.

Maine Department of Human Services
Bureau of Health
11 State House Station
Augusta, ME 04333

Angus S. King, Jr.
Governor

Kevin Concannon
Commissioner

Lani Graham
Bureau Director

In accordance with Federal laws, the Maine Department of Human Services does not discriminate on the basis of sex, age, color, or national origin or disability in admission of access to or treatment or employment in its programs and activities. The Department Affirmative Action Coordinator has been designated to coordinate our efforts to comply with and implement these federal laws and can be contacted for further information at 221 State Street, Augusta, Maine 04333, (207) 287-3488 (voice), or 1-800-332-1003.

Printed under appropriation # 013-10A-2554-032