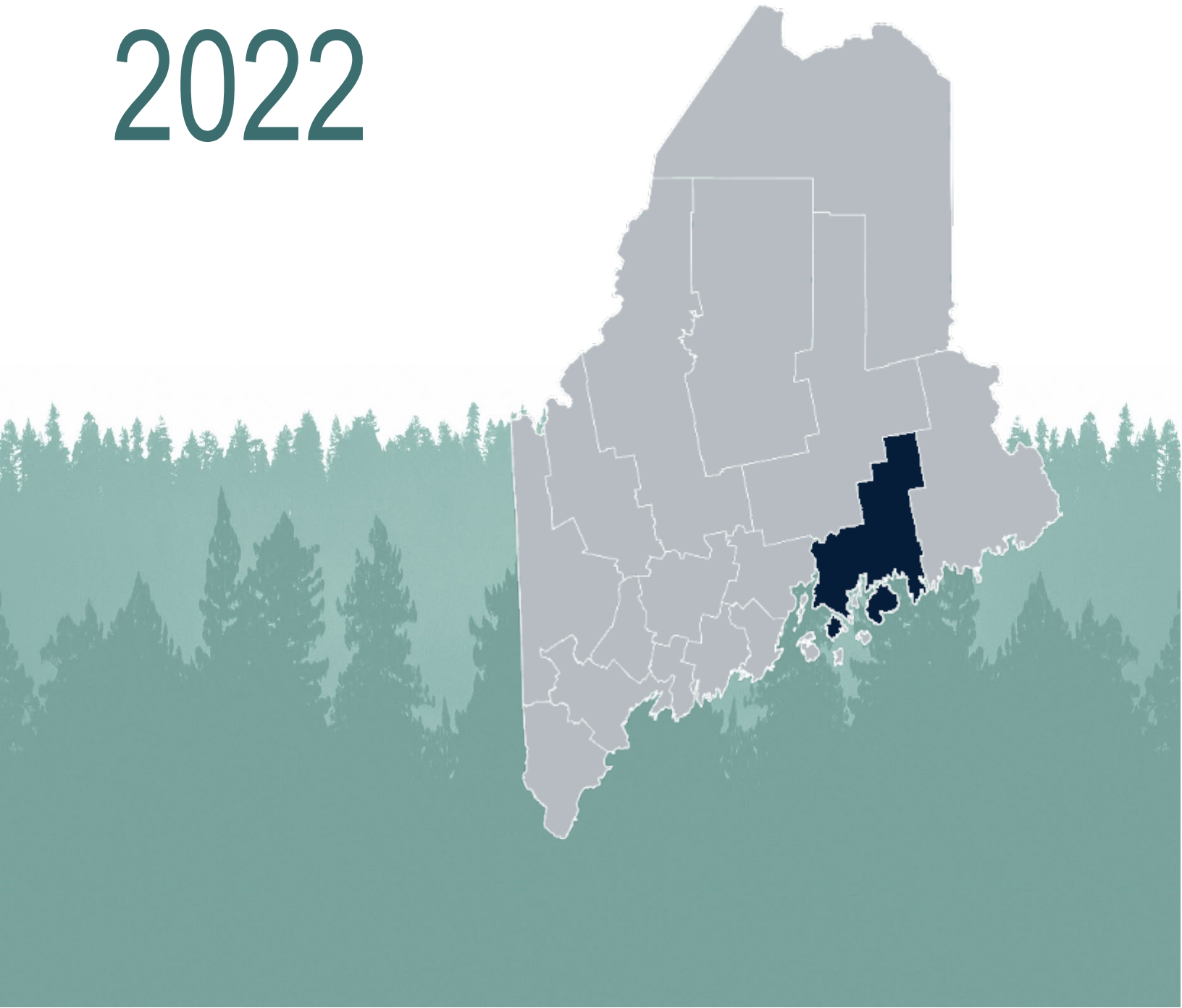
HANCOCK COUNTY

Maine Shared Community Health Needs Assessment Report

2022



COVID-19 AND OUR HEALTH

While our quantitative data pre-dates the COVID-19 pandemic, the 2021 community health needs assessment outreach took place during the pandemic, and participants noted its impacts in deep and meaningful ways. It was impossible not to recognize the pandemic's impacts on healthcare, health outcomes, behavioral health, and social support systems, especially for those who experience systemic disadvantages.

Challenges in accessing care have impacted chronic disease management and caused delays in non-emergency procedures. Rates of those seeking medical care for even acute health events such as heart attack, stroke, and uncontrolled high blood sugar were low during the early phase of the pandemic due to COVID-19 concerns. This occurred even while the use of telemedicine increased (Kendzerska, et al., 2021). Later in the pandemic, health care usage data from July 2020 through July 2021 show that increases in ICU bed occupancy were followed weeks later by a higher number of deaths not caused by COVID than typically seen before the pandemic. ICU bed occupancy had exceeded 75% of capacity nationwide for at least 12 weeks as of October 25, 2021 (French G., et al., 2021).

Previous disasters have shown that the secondary impacts on population health are long-lasting. For instance, 10 years after Hurricane Katrina, Tulane University Health Sciences Center saw a significant increase in heart disease and related risk factors such as increases in A1C levels, blood pressure, and LDL cholesterol (Fonseca, et al., 2009). The after-effects of disasters such as the Iraqi occupation in Kuwait in 1990, the London bombings in 2005, and the tidal waves and the nuclear meltdown in Fukushima, Japan in 2011 have revealed the need for immediate as well as long-term mental health care (McFarlane & Williams, 2012).

Emerging concerns on the lasting impacts of this pandemic also include the long-term effects of COVID infection as our newest chronic disease. A recent systematic review estimates that more than half of COVID-19 survivors worldwide continue to have COVID-related health problems six months after recovery from acute COVID-19 infection (Groff, et al., 2021). New evidence shows increases in adult diagnoses of diabetes, the risk for diabetes among children, and worsening diabetes among those who already had diabetes after COVID-19 infection (Barrett, et al, 2022).

There are some concerns that the pandemic has had negative impacts on health behaviors. However, the evidence is not yet clear. In Maine, newly available 2020 Maine Behavioral Risk Factors Surveillance System (BRFSS) data on a few key measures give us an early snapshot of the health of Maine adults in the first year of the pandemic. These data do not show any evidence of adverse impacts on trends in smoking, alcohol use, overweight, obesity, or physical activity. Self-reported alcohol use, binge drinking, and current smoking in 2020 were at the lowest levels since 2011 (Maine CDC, unpublished analysis). Drug overdose deaths increased by 33% in 2020 and by another estimated 23% in 2021 according to preliminary findings (Maine Attorney General's Office); it is not clear whether this is a continuation of previous trends, other factors, or due to the pandemic.

The pandemic is affecting different segments of the population more than others. The August 2021/COVID Resilience Survey showed that younger people, people of color, and those with lower incomes all had elevated stress (American Psychological Association). In Maine, Black or African Americans experience a disproportionate share of the COVID-19 burden as they are only 1.4% of Maine's total population yet, as of January 19, 2022, makeup 3.1% of cases and hospitalizations (Maine DHHS).

Thus, the findings in the 2022 Maine Shared CHNA Reports which show the most often identified priorities such as mental health, substance and alcohol use, access to care, and social determinants of health take on new meaning and an increased sense of urgency.

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INTRODUCTION

The **Maine Shared Community Health Needs Assessment (Maine Shared CHNA)** is a collaboration between Central Maine Healthcare (CMHC), Maine Center for Disease Control and Prevention (Maine CDC), MaineGeneral Health (MGH), MaineHealth (MH), and Northern Light Health (NLH). The vision of the Maine Shared CHNA is to turn health data into action so that Maine will become the healthiest state in the U.S.

The mission of the Maine Shared CHNA is to:

- Create Shared CHNA Reports,
- Engage and activate communities, and
- Support data-driven health improvements for Maine people.

This is the fourth Maine Shared CHNA and the third conducted on a triennial basis. The Collaboration began with the One Maine initiative published in 2010. The project was renamed to the Shared Health Needs Assessment and Planning Process in 2015 which informed the 2016 final reports, and renamed to the Maine Shared CHNA in 2018, which informed the 2019 final reports. The 2021 community engagement cycle has informed the 2022 final reports.

New this cycle is an expanded effort to reach those who may experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted in this effort. One effort included nine community sponsored events hosted by organizations representing the following communities: Black or African Americans; people who are deaf or hard of hearing; people with a mental health diagnosis; people with a disability; people who define themselves or identify as lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ+); people with low income; older adults; people who are homeless or formerly homeless; and youth. In addition to these events, 1,000 oral surveys were conducted in collaboration with eight ethnic-based community organizations' community health workers to better reach Maine's immigrant population. A complete description of how these efforts were deployed and a listing of those who provided input is provided in the Methodology section on page 18.

All of the County, District, and State reports and additional information and data can be found on our webpage: www.mainechna.org.

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

One way to view the top health priorities is to consider their contributions to Maine's morbidity, mortality, and overall quality of life issues. It is important to note Maine's leading causes of death to put the community-identified health priorities into perspective. This includes underlying causes of death such as tobacco use, substance and alcohol use, and obesity.

Table 1. Leading Causes of Death

RANK	MAINE	HANCOCK COUNTY
1	Cancer	Cancer
2	Heart Disease	Heart Disease
3	Unintentional Injury	Chronic Lower Respiratory Disease
4	Chronic Lower Respiratory Disease	Unintentional Injury
5	Stroke	Stroke

TOP HEALTH PRIORITIES

The participants at the Hancock County forum have identified the following health priorities.

Table 2. Top Health Priorities for Hancock County

PRIORITIES	% OF VOTES
Mental Health	51%
Access to Care	46%
Social Determinants of Health	34%
Substance and Alcohol Use	28%

Statewide, participants identified similar top four priorities in the 2021 engagement process as was in 2018.

Table 3. Top Health Priorities for County/State

PRIORITIES	2018	2021
Mental Health	✓ ●	✓ ●
Access to Care	✓ ●	✓ ●
Social Determinants of Health	✓ ●	✓ ●
Substance Use	✓ ●	✓ ●
Older Adult Health	✓ ●	
Physical Activity, Nutrition, and Weight	●	

✓ *County Priority* ● *State Priority*

Common themes identified by participants in 2021 include an emerging mental health crisis; challenges in access to healthcare, including mental health providers; issues related to poverty, transportation, and other social determinants of health in a rural state; and increasing rates of substance and alcohol use. The following pages describe each of these priorities in more detail including the **major health concerns** identified by participants in the community engagement process. There is a description of community-identified resources available to address those concerns as well as any related gaps or needs. Where available, there is also information for certain groups that are at higher risk due to systemic disadvantages. Finally, following the sections that discuss each of the health priorities is a listing of other health issues that were raised by community members but were not identified as priorities.

DEMOGRAPHICS

Hancock is a rural county, with similar median income, educational attainment, and unemployment rates to Maine overall. Rates of those living in poverty or with a disability are also similar. Much of the population is at or near retirement age.

Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	54,601	1.34M
Median household income	$57,178	$57,918
Unemployment rate	5.7%	5.4%
Individuals living in poverty	10.8%	11.8%
Children living in poverty	14.2%	13.8%

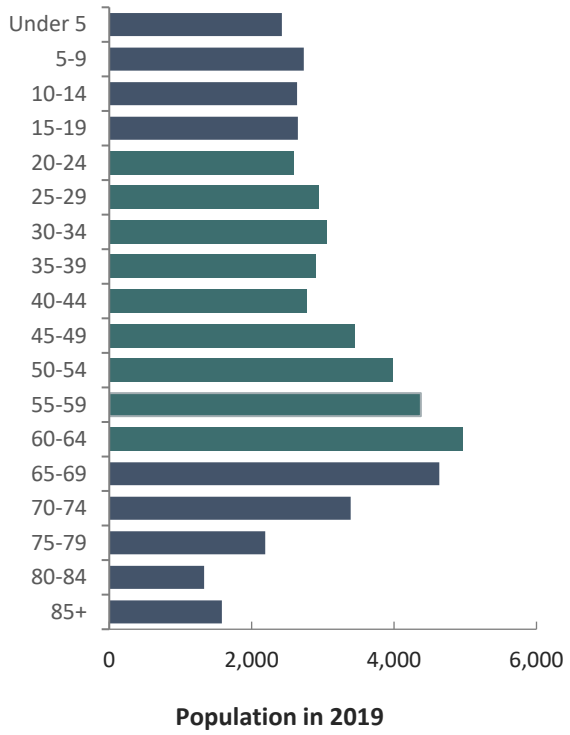
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	27.3%	29.0%
Associate's degree or higher (age 25+)	43.2%	41.9%
Gay, lesbian, and bisexual (adults)	3.0%	3.5%
Persons with a disability	14.6%	16.0%
Veterans	10.1%	9.6%

Table 5. Race/Ethnicity in Hancock County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.5%	254
Asian	1.1%	624
Black/African American	0.9%	469
Native Hawaiian or other Pacific Islander	-	-
White	95.9%	52,344
Some other race	0.1%	65
Two or more races	1.4%	770
Hispanic	1.5%	794
Non-Hispanic	98.5%	53,807

Figure 1. Age distribution for Hancock County



HEALTH EQUITY

There is significant agreement between the priorities chosen during county forums and those identified through community-sponsored events and oral surveys. The underlying root causes for those who may experience systemic disadvantages differ depending on local resources and unique characteristics and cultural norms for each sub-population. These differences are best identified through further collaboration at the community level.

For a detailed look at what each community identified as priority health topics, as well as any gaps or barriers and resources or assets, please see the State Report, found on the Maine Shared CHNA website, www.mainechna.org.

For a quantitative look at how these differences affect health outcomes, see the Health Equity Data Sheets, also found on the Maine Shared CHNA website, www.mainechna.org.

NEXT STEPS

This assessment report will be used to fulfill the Internal Revenue Service (IRS) requirements for non-profit hospitals as well as the Public Health Accreditation Board (PHAB) requirements for state and local public health departments. The next steps include:

- For hospitals, create an informed implementation strategy designed to address the identified needs.
- For District Coordinating Councils, create District Health Improvement Plans.
- For the Maine CDC, create an informed State Health Improvement Plan.

This report will also be used by policymakers, non-profits, businesses, academics, and countless community partners to support strategic planning, coalition building, and grant writing. Taken together, these steps can lead to Maine becoming the healthiest state in the nation.

PRIORITY: MENTAL HEALTH

KEY TAKEAWAYS FOR HANCOCK COUNTY

Mental health was the top priority identified in Hancock County. It was also identified as a top health concern in all other counties and underserved communities in the state. Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.[1]

Participants at an event hosted for those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services. Participants also suggested the need for more case management, supportive, and wrap-around services, as those with a mental health diagnosis required varied and nuanced care and treatment.

"Youth mental health has alarming statistics- I see a correlation between a lot of youth indicators."

Availability of mental health providers in Hancock County was the most frequently mentioned indicator related to mental health. Community members noted the low availability of mental health providers in the area, both for inpatient and outpatient care. They also noted long waitlists to access mental health care services. More than one-third (37%) of community forum participants identified the use of the **emergency department** to address mental health needs in Hancock County as a concern. The rate of those seeking mental health care in the emergency department is significantly lower in Hancock County (116.7) than in Maine overall (181.5) per 10,000 population.

During the 2015-2017 time period, the percentage of **adults with current symptoms of depression** in Hancock County was 7.6%. This is lower than Maine overall (9.5%). Those who experienced a depression in their lifetime were 21.9% among Hancock County residents between 2015-2017. This is similar to Maine overall (23.7%). Rates of those who had ever experienced **anxiety** in their lifetime were significantly lower in Hancock County (16.2%) when compared to the state (21.4%) between 2015 and 2017.

Outpatient mental health treatment has decreased among Hancock County residents. Rates dropped from 15.3% in 2012-2014 to 13.1% in 2015-2017, which is also lower than the state (18.0%).

Mental health issues among youth were concerning to those in the community, particularly the rate at which youth experience **suicidal ideation** and feeling **sad and hopeless**. In 2019, 31.7% of high school students and 23.0% of middle school students in Hancock County reported feeling sad or hopeless for two or more weeks in a row. During this same time period, 17.1% of high school students and 18.6% of middle school students seriously considered suicide.

There were concerns about the impact of the COVID-19 pandemic on youth, including potential increases in adverse childhood experiences (ACEs) resulting from the pandemic which forced homeschooling in potentially unsafe situations while decreasing access to school-based supports.

Youth with disabilities who experience mental health issues are a particularly vulnerable population. They require access to providers who can connect and communicate in ways to meet their unique needs.

Community resources that were mentioned to address mental health issues include Healthy Acadia, 211 Maine, The Yellow Tulip Project, and Acadia Cares.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[1] Centers for Disease Control and Prevention. Available from: https://www.cdc.gov/mentalhealth/index.htm

MAJOR HEALTH CONCERNS FOR HANCOCK COUNTY

	HANCOCK COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
Mental health emergency department rate per 10,000 population	—	2016-2018 **116.7**	N/A	2016-2018 **181.5**	★	—	N/A
Depression, current symptoms (adults)	2012-2014 **7.9%**	2015-2017 **7.6%**	○	2015-2017 **9.5%**	○	—	N/A
Depression, lifetime	2012-2014 **21.2%**	2015-2017 **21.9%**	○	2015-2017 **23.7%**	○	2017 **19.1%**	N/A
Anxiety, lifetime	2012-2014 **16.5%**	2015-2017 **16.2%**	○	2015-2017 **21.4%**	★	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 **26.4%**	2019 **31.7%**	○	2019 **32.1%**	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 **19.4%**	2019 **23.0%**	○	2019 **24.8%**	○	—	N/A
Seriously considered suicide (high school students)	2017 **13.9%**	2019 **17.1%**	○	2019 **16.4%**	○	—	N/A
Seriously considered suicide (middle school students)	2017 **15.8%**	2019 **18.6%**	○	2019 **19.8%**	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 **31.0%**	N/A	2011-2017 **30.8%**	○	—	N/A
Ratio of population to psychiatrists	—	2019 **9,144.0**	N/A	2019 **12,985.0**	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 **15.3%**	2015-2017 **13.1%**	N/A	2015-2017 **18.0%**	N/A	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
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ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified multiple available treatment options and the presence of youth mental health resources as assets available for the Hancock County community. The community also identified barriers to care, including a lack of mental health providers, a need for additional youth mental health services, a lack of focus on prevention, and the potentially serious consequences of untreated mental health issues as ongoing challenges Hancock County will need to overcome.

The following information was gathered from participants during a group activity. Participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities regarding the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 6. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Healthy Acadia programs (3) Collaborative providers (4) Low competition **Treatment** Telehealth (10) Healthy Acadia Emergency Room **Awareness/stigma** Northern Light Acadia Hospital's CARES (Child-Adolescent Resource and Educational Series) (3) Yellow Tulip project **Law Enforcement** Better public safety/law enforcement training	**Barriers to Care** Navigating system of care (4) Structural racism (3) Distance to treatment (3) Screenings are vague/ineffective (2) Need more inpatient care (7) Not enough beds for patients (6) Need more outpatient care (4) Support groups (3) Stigma (12) Transportation (3) Distrust caused by political strife/media (2) Lack of health literacy (2) **Providers/workforce** Lack of providers (19) Provider burnout (2) Students don't enroll in mental health professions (4) Provider recruitment (3) **Youth** Youth lacking resources (2) Alarming needs among youth (4) Not enough youth counselors (3) **Community Cohesion** Lack of family support systems **Funding** Lack of funding **Law Enforcement** Police need social workers for mental health calls (2)

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR HANCOCK COUNTY

Access to care was identified as the second top priority in Hancock County. It was also identified as a top health concern in all other counties and underserved communities in the state. Access to care means having the timely use of health services to achieve the best possible health outcomes. It consists of four main components: availability of insurance coverage, availability of services, timeliness of access, and the health care workforce.[2]

Participants in the community forums noted barriers exist that are difficult to address, including attracting and keeping health care providers, staff shortages and burnout, a lack of providers for youth services, long travel distances, and a lack of broadband access that makes telehealth more difficult to implement. Overuse or misuse of the emergency department for preventative or routine care was also noted as a challenge for the community.

Cost barriers to care were the most frequently identified health indicator related to access to care. In 2015-2017, 11.1% of adults reported that there was a time during the last 12 months when they needed to see a doctor but could not because of the cost. This is similar to Maine overall (10.6%).

"Telehealth has been a good resource during COVID but it's not available to everyone because of broadband issues."

From 2015-2019, the rate of **uninsured** people in Hancock County was 10.2%, a concern among community members. This rate has improved significantly within the county since 2009-2011 when the rate was 15.0%, however, the current rate remains significantly higher than the state (7.9%).

The **lack of providers** in the area risks establishing a relationship with a usual primary care provider. The **rural** nature of the county also creates long travel distances to see a doctor. More than thirty-seven (37.6%) percent of **primary care visits in Hancock County were more than 30 miles from the patient's home** in 2019. Given these long travel distances, **transportation** was identified as a top need in Hancock County to help improve access.

The percentage of adults who were seen by **any primary care provider** between 2015 and 2017 was 70.3%. This means 29.7% (almost 1 in 3) of Hancock County residents were at risk for not receiving routine preventative care from a primary care provider.

"Across the board, there are issues with provider recruitment and retention."

Disparate communities experience barriers related to access differently. Black or African American community members expressed concerns about representation and culturally competent care, as well as issues with health literacy. Similarly, individuals with disabilities noted a lack of provider training in care and communication with the population. Additionally, the LGBTQ+ community identified a need for primary care, behavioral health, and other providers who offer affirming care for the LGBTQ+ population.

Despite the challenges that Hancock County faces with access to care, community forum participants noted the resources such as Peninsula Free Health, Friends in Action, and Island Connections.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[2] Chartbook on Access to Health Care, Agency for Healthcare Research and Quality. Available from: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html

MAJOR HEALTH CONCERNS FOR HANCOCK COUNTY

	HANCOCK COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
ACCESS							
Uninsured	2009-2011 **15.0%**	2015-2019 **10.2%**	★	2015-2019 **7.9%**	!	2019 **9.2%**	N/A
MaineCare enrollment (all ages)	2019 **21.8%**	2020 **26.2%**	N/A	2020 **29.1%**	N/A	**2020** **24.1%**	N/A
MaineCare enrollment (ages 0-19)	2019 **38.1%**	2020 **43.9%**	N/A	2020 **43.8%**	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 **1,280.0**	N/A	2019 **1,332.0**	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 **87.7%**	2015-2017 **85.0%**	○	2015-2017 **87.9%**	○	2017 **76.8%**	N/A
Primary care visit to any primary care provider in the past year	2012-2014 **70.7%**	2015-2017 **70.3%**	○	2015-2017 **72.0%**	○	2017 **70.4%**	N/A
Cost barriers to health care	2011-2013 **9.9%**	2015-2017 **11.1%**	○	2015-2017 **10.6%**	○	2016 **12.0%**	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 **37.6%**	N/A	2019 **20.0%**	N/A	—	N/A

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COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Available resources in Hancock County to address issues related to access include cohesion of the community, the presence of community organizations that increase access to care, emerging technologies, alternatives to in-office care, health care education, and a development plan for the health care workforce. Community members were also able to identify potential barriers to care. These included limited numbers of healthcare providers, a lack of specialist services, the need for transportation resources in an extremely rural area, and a lack of resources for youth healthcare.

The following information was gathered from participants during a group activity. Participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities regarding the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 7. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Strong collaboration (3) Good communication with schools (2) Resources for diverse populations (2) Many nonprofits working to improve access (2) **Community Organizations** Three hospitals (6) Services at Togus Veteran's Administration Medical Center Peninsula Free Health **Technology** Telehealth **Access alternatives** Hospitals provide palliative care/hospital (3) Home health agencies (2) Long term care facilities (2) MaineCare Growth of primary care practices	**Barriers to Care** Long wait times (9) COVID added new barriers (5) Emergency Department utilization for preventive care (3) Transportation to services (16) Lack of health literacy (2) Stigma (8) Lack of knowledge about resources (2) **Cost of Care** Need access to insurance (8) Cost of care (8) Financial support is hard to find (2) Gaps in Accountable Care Act coverage Lack of affordable health insurance (3) **Providers/workforce** Healthcare workforce (7) Need better Provider recruitment/retention (6) **Missing Services** Oral health (2) Vision care (2) Specialty care Need advancements in heart/stroke care (2) **Coordination** Centralized referral process (2) **Funding/resources** More funding for navigators (3) Funding/resources for palliative/hospice care More telehealth resources for rural populations **Racism** Structural racism (3)

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR HANCOCK COUNTY

Social determinants of health were selected as a top priority in Hancock County. It was also identified as one of the top health concerns in 14 other counties and among underserved communities in the state.

Social determinants of health are the conditions in which people live, learn, work, play, worship, and age. Domains include education, economic stability, health care access and quality, the environment, and social connectedness. Examples include access to healthy food, housing, water, air, and relationships. Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Hancock County.

Poverty was the most frequently mentioned health indicator in Hancock County. According to recent estimates, 10.8% of individuals and 14.2% of children in Hancock County live in poverty. This is similar to the state overall for individuals (11.8%) and children (13.8%). The rate has improved significantly for individuals but remain similar for children within the county.

"I wonder whether the seasonal increase of affluent folks overshadows the true poverty in the county."

Broadband access was the second most frequently identified concern related to social determinants of health. The percentage of residents with access to broadband internet was 79.6% in Hancock County in 2017. This is lower than the percentage of Maine residents overall (88.6%). This means 21.4% of Hancock County residents are at risk for not being unable to take advantage of telehealth services or have limited ability to participate in the global economy.

Older adults living alone was the third most frequently mentioned health indicator. Over one-quarter (27.3%) of adults 65 and older in Hancock County were living alone between 2015 and 2019. The county rate is similar to Maine overall (29.0%).

Lack of transportation was the fourth most frequently mentioned health indicator. Almost two percent (1.8%) of Hancock County households do not own a vehicle and there is a lack of community transportation in the area.

Housing Insecurity was mentioned by 22% (15 of the 67) of forum participants. Recent data shows 3.8% of Hancock County high school students regularly sleep somewhere other than in their parents or guardians homes, while 11.9% of residents spent more than **half their income on housing**. The **cost of housing** was the fifth most identified health indicator.

Community members facing systemic disadvantages can be especially impacted by social determinants of health. Individuals with disabilities are impacted by a lack of transportation and face issues of discrimination. Black or African Americans noted poverty, unemployment, and food insecurity issues. Older adults often live on limited incomes on must rely on the support of others as well as face barriers related to transportation and food insecurity.

Resources mentioned by participants to address issues related to social determinants of health in Hancock include Island Workforce Housing Project, locally grown food and farm programs, Friends in Action, and Island Connections.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

MAJOR HEALTH CONCERNS FOR HANCOCK COUNTY

	HANCOCK COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 **13.8%**	2015-2019 **10.8%**	★	2015-2019 **11.8%**	○	2019 **12.3%**	N/A
Children living in poverty	2018 **15.9%**	2019 **14.2%**	○	2019 **13.8%**	○	2019 **16.8%**	○
Children eligible for free or reduced lunch	2020 **41.1%**	2021 **32.8%**	N/A	2021 **38.2%**	N/A	2017 **15.6%**	N/A
Median household income	2007-2011 **$47,421**	2015-2019 **$57,178**	★	2015-2019 **$57,918**	○	2019 **$65,712**	N/A
Unemployment	2018 **3.8%**	2020 **5.7%**	N/A	2020 **5.4%**	N/A	2020 **8.1%**	N/A
High school student graduation	2019 **89.2%**	2020 **89.0%**	N/A	2020 **87.4%**	N/A	2019 **87.1%**	N/A
People living in rural areas	—	2019 **100.0%**	N/A	2019 **66.2%**	N/A	—	N/A
Access to broadband	2015 **81.1%**	2017 **79.6%**	N/A	2017 **88.6%**	N/A	2017 **90.4%**	N/A
No vehicle for the household	2007-2011 **1.9%**	2015-2019 **1.8%**	○	2015-2019 **2.1%**	○	2019 **4.3%**	N/A
Persons 65 years and older living alone	2011-2015 **30.8%**	2015-2019 **27.3%**	N/A	2015-2019 **29.0%**	N/A	2019 **26.6%**	N/A
Households that spend more than 50% of income toward housing	—	2015-2019 **11.9%**	N/A	2015-2019 **12.0%**	○	—	N/A
Housing insecure (high school students)	2017 **3.9%**	2019 **3.8%**	○	2019 **3.3%**	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 **19.3%**	N/A	2019 **21.3%**	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 **39.0%**	2015-2019 **43.2%**	N/A	2015-2019 **41.9%**	N/A	2019 **41.7%**	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 **35.4%**	N/A	2015-2019 **32.9%**	N/A	2019 **37.9%**	N/A

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○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Hancock County community members point to several resources available that improve social determinants of health. These include many resources available to assist residents with accessing healthy foods, community cohesion, health screenings, and new revenue streams becoming available. However, community members also identified several challenges related to social determinants of health, including high levels of poverty, lack of resources for housing and transportation, high levels of food insecurity, isolation and rurality, and a lack of childcare resources.

The following information was gathered from participants during a group activity. Participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities regarding the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 8. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Strong collaboration (6) Island Connections (3) Friends in Action (3) Nonprofits offering free programs/resources Decrease in poverty **Food** Food access programs (11) Locally grown food/farm programs (4) **Housing** Safe and affordable low-income housing Island Workforce Housing Project (2) **Transportation** Western Maine Transportation Transportation agencies/resources (3) Telehealth **Child Development/schools** School Administration and Staff Early childhood consultants **Jobs** A plethora of job opportunities	**Housing** Not enough affordable housing (18) Lack of homeless shelters (3) **Poverty** Percent living in poverty (3) Increase in cost of living (2) Low wages (3) Disparities in income - seasonal affluence (3) **Transportation** Transportation (14) Lack of health literacy (2) **Isolation** Lack of community engagement **Equity** Structural racism (3) **Food** Food insecurity **Access to Services** No financial support for follow up (2) Lack of broadband (6) Closed-loop referrals **Youth** Lack of support for young children (2) **Workforce** Education around Social Determinants of Health (2)

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR HANCOCK COUNTY

Substance and alcohol use was selected as a top priority in Hancock County. It was also identified as one of the top health concerns in all other counties and underserved communities among the state. Recurring use of alcohol and/or drugs can have significant negative impacts, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance and alcohol use has also been linked to co-occurring mental health issues such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), among others.[3]

Overdose deaths were mentioned by 49% of forum participants and was the most frequently mentioned health indicator for substance use in Hancock County. In 2020, the rate of overdose deaths per 100,000 population in Hancock County was 23.6, an increase from 16.4 in 2019. The rate in Maine overall was 37.3% in 2020, higher than Hancock County but not to a significant degree.

Overdose emergency medical service response per 10,000 increased significantly between 2019 and 2020 from 39.1 to 51.4. This is still significantly lower than the state rate of 76.7.

"Significant concerns for youth substance use. The increase in electronic cigarette use was concerning."

The **misuse of prescription drugs** was mentioned by 40% of forum participants. In 2019, 6.1% of Hancock County high school students had misused prescription drugs, an increase from 3.7% in 2019 and higher than the state (5.0%).

Drug-affected infants were the third most frequently mentioned health indicator related to substance use. The rate of drug-affected infant reports per 1,000 births in Hancock County was 59.8 in 2018-2019. The rate is lower than that of the state overall (73.7%).

Youth binge drinking was the fourth most frequently mentioned health indicator. The percentage of high school students who engaged in binge drinking behavior increased from 7.5% in 2017 to 8.8% in 2019. This is similar to Maine (8.2%).

Past-30 day **adult marijuana use** showed a significant increase from 9.8% in 2013-2016 to 17.8% in 2017. This was similar to the state rate of 16.3% in 2017.

Hospital utilization was the fifth most frequently mentioned health indicator for substance use. In 2016-2018, the rate of opiate poisoning emergency department rate per 10,000 population in Hancock County was 16.7%. This is significantly lower than the state rate (9.9%).

Community members facing systemic disadvantages, including the formerly homeless or homeless, low-income adults, and the LGBTQ+ community mentioned a lack of treatment and recovery resources in the state. They noted a lack of harm-reduction programming, a need for supportive living environments, and skill-building programs for independent living.

Participants mentioned a common barrier to addressing substance and alcohol use is a lack of treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Resources mentioned include Downeast Treatment Center, Healthy Acadia, Project Hope, the availability of recovery centers and peer support, and youth education and prevention services.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[3] Mental Health and Substance Use Disorders. Substance Abuse and Mental Health Services Administration (SAMHSA). Available from: https://www.samhsa.gov/find-help/disorders

MAJOR HEALTH CONCERNS FOR HANCOCK COUNTY

	HANCOCK COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 **16.4**	2020 **23.6**	○	2020 **37.3**	○	2019 **21.5**	N/A
Drug-induced deaths per 100,000 population	2007-2011 **12.3**	2015-2019 **21.4**	○	2015-2019 **29.5**	○	2019 **22.8**	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 **8.6**	2015-2019 **12.3**	○	2015-2019 **11.6**	○	2019 **10.4**	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 **5.5**	2019 **10.9**	N/A	2019 **3.8**	N/A	2019 **3.1**	N/A
Drug-affected infant reports per 1,000 births	2017 **61.5**	2018-2019 **59.8**	○	2018-2019 **73.7**	○	—	N/A
Chronic heavy drinking (adults)	2012-2014 **8.7%**	2015-2017 **10.2%**	○	2015-2017 **8.5%**	○	2017 **6.2%**	N/A
Binge drinking (adults)	2012-2014 **16.3%**	2015-2017 **17.5%**	○	2015-2017 **17.9%**	○	2017 **17.4%**	N/A
Past-30-day marijuana use (adults)	2013-2016 **9.8%**	2017 **17.8%**	!	2017 **16.3%**	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	—	2013-2017 **0.5%***	N/A	2013-2017 **1.0%**	○	—	N/A
Past-30-day alcohol use (high school students)	2017 **24.9%**	2019 **26.0%**	○	2019 **22.9%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 **3.8%**	2019 **4.1%**	○	2019 **4.0%**	○	—	N/A
Binge drinking (high school students)	2017 **7.5%**	2019 **8.8%**	○	2019 **8.2%**	○	—	N/A
Binge drinking (middle school students)	2017 **1.6%**	2019 **0.6%**	○	2019 **1.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2017 **18.6%**	2019 **21.5%**	○	2019 **22.1%**	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 **2.2%**	2019 **2.4%**	○	2019 **4.1%**	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 **3.7%**	2019 **6.1%**	○	2019 **5.0%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 **0.9%**	2019 **2.5%**	○	2019 **3.0%**	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 **12.2**	2020 **12.2**	N/A	2020 **12.1**	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 **39.1**	2020 **51.4**	!	2020 **76.7**	★	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 **6.7**	N/A	2016-2018 **9.9**	★	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 **1.2**	N/A	2016-2018 **1.4**	○	—	N/A

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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Community members in Hancock County identified peer recovery and treatment resources available as potential strengths to address substance and alcohol use in their county, along with harm reduction strategies and funding sources. Additionally, barriers to substance use issues were identified by community members, including a lack of available treatment programs, a need for additional recovery coaches, widely available addictive substances, and a lack of youth resources.

The following information was gathered from participants during a group activity. Participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities regarding the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 9. Gaps/Needs and Available Resources (Substance & Alcohol Use)

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Good track record for service providers working together, especially nonprofits (3) **Prevention** Healthy Acadia Prevention programs (3) **Recovery** Healthy Acadia coaches (3) Alcoholics Anonymous meeting helpful for alcohol New Recovery Center in Ellsworth Recovery centers New recovery resources are being created in the County **Treatment** Project Hope (Heroin Opiate Prevention Effort) Downeast Treatment Center (2) New treatment resources being created in the County No wrong door at local hospitals to gain access to treatment Ongoing training for Medication-Assisted Treatment (MAT) programs for providers (3) New emergency medical services protocols allow for starting treatment at home with medication without the need for transport or hospitalization **Harm Reduction** Availability of Naloxone **Youth** Can partner with school administration staff to improve communication about youth substance use (2) Resources for middle school students	**Stigma** Stigma (6) **Ease of Access/attitudes** Increasing access/acceptance of marijuana Resistance in reaching out for help (2) Availability of prescription drugs (2) **Treatment** Outpatient detox (2) More access to Medication-Assisted Treatment (3) Not enough Primary Care Providers for screening (3) **Recovery** Shortage of recovery programs/funding **Youth** Increase in youth use (3) Lack of residential youth beds (2) Resources for middle schoolers (2) **Other Services** Transportation (3) **Workforce** Provider recruitment (2) **Other Barriers** Lack of health literacy (2) **Equity** Structural racism (3)

OTHER IDENTIFIED NEEDS

The following is a list of all health priorities identified in the Hancock County forum. Each participant was allowed to vote for up to 4 priorities from a list of twenty-four priorities. The first column is the name of the priority, the second column is the total number of votes that priority received, and the final column is the percentage of participants who voted for that priority.

Table 10. All Priority Health Topic Areas for Hancock County

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	34	51%
Access to Care	31	46%
Social Determinants of Health	23	34%
Substance and Alcohol Use	19	28%
Cancer	14	21%
Physical Activity, Nutrition, and Weight	11	16%
Older Adult Health	7	10%
Intentional Injury	5	7%
Health Care Quality	4	6%
Unintentional Injury	4	6%
Oral Health	4	6%
Cardiovascular Disease	3	4%
Diabetes	3	4%
Environmental Health	3	4%
Children with Special Needs	2	3%
Immunizations	2	3%
Pregnancy and Birth Outcomes	2	3%
Tobacco	2	3%
Infectious Disease	1	1%

APPENDIX: METHODOLOGY

The Maine Shared CHNA is a public-private collaboration governed by a Steering Committee, which is made up of representatives of each member organization (CMHC, MGH, MH, NLH, and Maine CDC). The Steering Committee sets fiscal and operational goals that are then implemented by the Maine Shared CHNA Program Manager. Input is provided by key stakeholder groups including the Metrics Committee and the Health Equity/Community Engagement Committee.

The **Metrics Committee** is charged with creating and reviewing a common set of population/community health indicators and measures every three years. Before the 2018-2019 Maine Shared CHNA, the Metrics Committee conducted an extensive review of the data using the following criteria as a guide: 1.] describes an emerging health issue; 2.] describes one or more social determinants of health; 3.] measures an actionable issue; 4.] the issue is known to have high health and social costs; 5.] rounds out our description of population health; 6.] aligns with national health assessments (e.g.: County Health Rankings, American Health Rankings, Healthy People); 7.] data is less than 2 years old; 8.] data was included in the previous data set, or 9.] the Maine CDC analyzes the indicator in a current program. This review process was carried into the 2021-2022 Maine Shared CHNA, where the Metrics Committee also reviewed the previous data set to check for changes in data sources, potential new sources of data to round out certain topics, and to deepen Social Determinants of Health data which many of our partners have included in their work.

The **Health Equity/Community Engagement Committee** is charged with updating outreach methodology to ensure a collection of broad, diverse, and representative qualitative data from groups that are more likely to experience health disparities. To ensure these methods reflect the needs and cultural expectations this committee included representatives from a variety of Maine's ethnic-based and community-based organizations, along with representatives from public health and healthcare, and a variety of additional partners.

The 2021-2022 Maine Shared CHNA process involved three phases.

Data Analysis

The first phase of the project involved the analysis of more than 220 health indicators for the state, counties, public health districts, selected cities, and by specific demographics when available.

Data analysis was conducted by the Maine CDC and its epidemiology contractor, the University of Southern Maine with additional support from the contracted vendor, Market Decisions Research.

Community Outreach and Engagement

Community outreach and engagement for the Maine Shared CHNA included the following efforts:

- 17 County Forums (Maine)
- 9 Community Sponsored Events
- 1,000 Oral Surveys

County Forums were held in each of Maine's 16 counties, with one county, Cumberland, hosting one event in western Cumberland and one in eastern Cumberland in recognition of the differences between Greater Portland (Maine's most densely populated area) and the Lakes Region, (a more rural area). Local planning teams led by local healthcare and public health district liaisons organized and promoted these events. Participants were shown a PowerPoint presentation with relevant county data and were led through guided discussions to identify indicators of concern. Participants then voted to identify their top four health priorities. They were then asked to share their knowledge on gaps and assets available in their communities to address each of the top priorities identified.

New this cycle was an expanded effort to reach those who experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted. One effort included nine community-sponsored events. The hosts were chosen for their statewide reach.

The communities included:

- Black or African American
- Homeless or formerly homeless
- LGBTQ+ community
- Older adults
- People who are deaf or hard of hearing
- People who live with a disability
- People with low income
- People with a mental health diagnosis
- Youth

These events followed the same methodology as county forums with hosts providing input on the data presentation and leading the effort to recruit participants

Oral surveys were conducted in collaboration with eight ethnic-based community organizations' (ECBO's) community health workers to better reach Maine's immigrant population. There were 1,000 surveys were conducted in either English (32%), Somali, (24%), Arabic (23%), French (8%), Spanish (5%), Lingala (3%), and other languages including Swahili, Maay Maay, Portuguese, Oromo, Eretria, Kirundi, and Amara. When asked for their countries of origin, respondents most commonly cited the United States (212), Iraq (205), Somalia (157), The Democratic Republic of Congo (81), Djibouti (70), Kenya (30), and Mexico (29).

Other countries of origin mentioned included Rwanda, Ethiopia, Angola, Syria, Guatemala, South Africa, Palestine, Puerto Rico, Morocco, Afghanistan, El Salvador, Nigeria, Canada, Burundi, Eritrea, France, Honduras, Uganda, Jamaica, Mali, Gabon, Sudan, Nicaragua, Peru, and Brazil

The survey was an adaptation of the City of Portland's Minority Health Program Survey conducted in 2009, 2011, 2014, and 2018. In 2021, a small group of stakeholders convened to adapt this survey to meet the needs of the Maine Shared CHNA. This group included those who deployed the survey as well as other interested parties.

Groups that piloted these new outreach methods were offered stipends for their time.

Due to concerns related to COVID-19, community engagements efforts were conducted virtually except the event for the deaf or hard of hearing, which was held in a gymnasium at the Governor Baxter School for the Deaf on Mackworth Island. Oral surveys were conducted telephonically or by following current U.S. CDC COVID-19 protocols.

Community engagement was supported by John Snow, Inc. (JSI), who also conducted the initial qualitative analysis. All support materials including Data Profiles and PowerPoints were produced by Market Decisions Research.

Reporting

Initial analysis for each event and the oral surveys were reviewed by local hosts for accuracy and to ensure the information the community may find sensitive was flagged. Final CHNA reports for the state, each county, and districts were developed in the spring of 2022. Final Reports were written and produced by Market Decisions Research.

In addition to Urban, County, and Health District reports, the County, District, and State level data are also available on an Interactive Data Portal. The data in the portal is arranged by health topic and provides demographic comparisons, trends over time, definitions, and information on the data sources. Visit www.mainechna.org and click on **Interactive Data** in the menu to the left. The Maine Shared CHNA website is hosted by the Maine DHHS. (www.mainechna.org).

One virtual community forum was held in Hancock County on September 30, 2021, with 68 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Aroostook Mental Health Center
Bar Harbor Bank & Trust
Beth C. Wright Cancer Resource Center
Blue Hill Heritage Trust
City of Ellsworth
Community Health & Counseling Services
Department of Health and Human Services/Office of Child and Family Services: Children's Behavioral Health Services
Downeast Community Partners
Downeast Horizons
Downeast Public Health Council - Maine Center for Disease Control and Prevention
First Congregational Church of Blue Hill
Friends in Action
Hancock County Emergency Management Agency
Healthy Acadia
Healthy Peninsula-Community Health
Hospice Council of Maine
Hospice Volunteers of Hancock County
Maine Community Foundation
Maine Hospice Council
Maine State Senate
Mount Desert Island Hospital
New Ventures Maine
Northern Light Blue Hill Hospital
Northern Light Maine Coast Hospital
Northern Light Health
State of Maine Department of Health and Human Services, Maine CDC Downeast District
Surry Neighbors Helping Neighbors
Town of Bar Harbor
United Way of Eastern Maine
University of Maine Augusta

For a complete listing of organizations consulted for each of the 10 health equity outreach efforts, please see the Acknowledgements, page 21. The State Report, found on the Maine Shared CHNA website, www.mainechna.org, provides a full description of findings by each community-sponsored event.

ACKNOWLEDGMENTS

Funding for the Maine Shared CHNA is provided by the partnering healthcare systems with generous support from the Maine CDC and countless community partners and stakeholder groups. Additional funding was provided by the Maine Health Access Foundation and the Maine CDC to conduct additional outreach to engage those whose voices would not otherwise be distinctly heard. The Maine Shared CHNA is also supported in part by the U.S. Centers for Disease Control and Prevention (U.S. CDC) of the U.S. Department of Health and Human Services (U.S. DHHS) as part of the Preventive Health and Health Services Block Grant (awards NB01OT009343-01 & NB01OT009413-01). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by the U.S. CDC/HHS, or the U.S. Government.

The infrastructure for community-led efforts is gaining strength. We are grateful to those who put their trust in the Maine Shared Community Health Needs Assessment process. Together, the MSCHNA and each of our community hosts have strived to ensure their voices are reflected herein.

Oral Survey Sponsors

Capital Area New Mainers Project
City of Portland's Minority Health Program
Gateway Community Services
Maine Access Immigrant Network
Maine Community Integration
Maine Department of Health and Human Services*
Maine Immigrant and Refugee Services
Mano en Mano
New England Arab American Organization
New Mainers Public Health Initiative

Community Event Sponsors

Consumer Council System of Maine
Disability Rights Maine
Green A.M.E. Zion Church
Health Equity Alliance
Maine Continuum of Care
Maine Council on Aging
Maine Primary Care Association
Maine Youth Action Network

*Includes the Manager of Diversity, Equity, and Inclusion and the Maine CDC.

Months of planning were conducted by stakeholder groups including the Metrics Committee, Data Analysis Team, Community Engagement Committee, Health Equity Committee, and Local Planning teams. For a complete listing please visit the Maine Shared CHNA website About Us page. Significant analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. Market Decisions Research provided quantitative and qualitative analysis and design and production support. John Snow, Inc. (JSI) provided methodology, community engagement, and qualitative analysis expertise and support. The oral survey was adapted from the City of Portland's Minority Health Program's survey. Special thanks to the Partnership for Children's Oral Health for their data contribution.