STATE OF MAINE

Maine Shared Community Health Needs Assessment Report

2022

Rev 7.12.2022

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 of 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, make up 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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McFarlane, A.C., Williams., R. (2012). Mental Health Services Required after Disasters, *Depression Research and Treatment.* Volume 2012, Article ID 970194, DOI: 10.1155/2012/970194 10.1155/2012/970194. Last accessed 4/5/2022: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3395273/pdf/DRT2012-970194.pdf

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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 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 and Hard of Hearing; people with a mental health diagnosis; people with a disability; people who define themselves or identify as lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ+); people with low income; older adults; people experiencing homelessness; and youth. In addition to these events, 1,000 oral surveys were conducted in collaboration with 10 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 are provided in the Methodology section on page 69.

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

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

Noting Maine's leading causes of death helps to put community-identified health priorities, related health data, and public health initiatives into perspective. In only two years, COVID-19 deaths have overtaken unintentional injury, chronic lower respiratory disease, and stroke to become the 3rd leading cause of death in Maine .

Table 1. Leading Causes of Death: 2021

RANK	MAINE
1	Cancer
2	Heart Disease
3	COVID-19
4	Unintentional Injury
5	Chronic Lower Respiratory Disease

DEMOGRAPHICS

Maine is the most rural state in the nation and the least populated state east of the Mississippi. In 2019, Maine had the largest proportion of adults over 65 (21.2%), a lower median household income, and a higher percentage of individuals who have a disability, yet fewer children and adults who live in poverty. Maine's birth rate has been among the lowest in the nation and has been decreasing.[1]

Table 2. Race/Ethnicity in Maine.

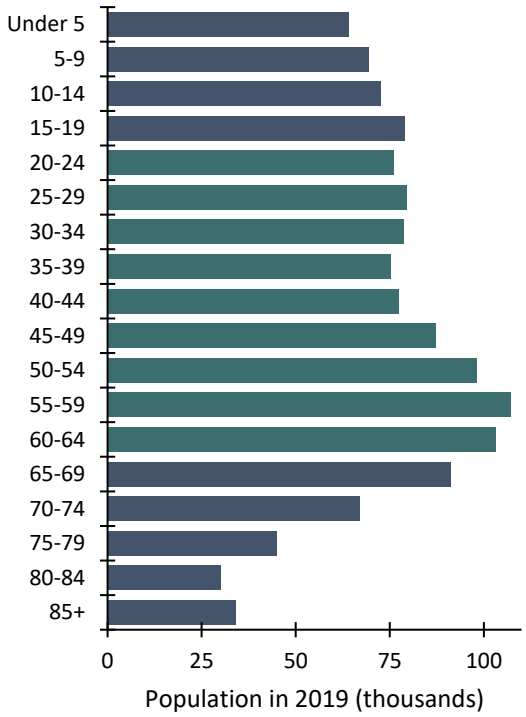
	PERCENT	NUMBER
American Indian/Alaskan Native	0.7%	9,419
Asian	1.1%	15,323
Black/African American	1.6%	21,983
Native Hawaiian or other Pacific Islander	<0.1%	222
White	94.0%	1,263,287
Some other race	0.4%	5,442
Two or more races	2.1%	28,536
Hispanic	1.7%	23,067
Non-Hispanic	98.3%	1,321,145

1,372,247
Maine Population, 2021

Table 3. Selected Demographics.

	MAINE	U.S.
Median household income	$57,918	$65,712
Unemployment rate	5.4%	8.1%
Persons with a disability	16.0%	12.7%
Individuals living in poverty	10.9%	12.3%
Children living in poverty	13.8%	16.8%
MaineCare enrollment	29.1%	24.1%
65+ living alone	29.9%	26.6%
Associate's degree or higher (age 25+)	43.2%	41.7%
Gay, lesbian, and bisexual (adults)	4.4%	-
Persons with a disability	16.2%	12.7%
Veterans	8.9%	6.9%

Figure 1. Age Distribution in Maine, 2019.



[1] Centers for Disease Control and Prevention. National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Last accessed 5/25/2022. http://wonder.cdc.gov/mcd-icd10-provisional.html.

TOP HEALTH PRIORITIES

Common concerns identified by participants in 2021 include an ongoing mental health crisis; challenges in accessing health care - especially mental health providers - and increasing rates of substance use. Participants also noted social risk factors such as poverty and lack of transportation as barriers to getting and staying healthy. A list of all the health priorities identified by various communities is included on the next page in Table 4. This is then followed by a series of bar graphs depicting priorities for the statewide county forums and the 9 community events that can be traced to each participant's vote. Note the Youth event chose priorities by consensus, not by each participant's vote.

ABOUT THIS REPORT

There are two major sections to this report. The first section provides an overview of each of the four statewide priorities including their related health indicators and participant's key takeaways identified through the community engagement process. There is also a description of community-identified resources available to address those concerns and any related gaps or needs, and a table of related health indicators.

The second section provides a full description of the results from focused outreach among 10 diverse communities. These communities included:

- Black or African Americans
- People who are Deaf and Hard of Hearing
- People who live with a disability
- People with low income
- People Experiencing Homelessness
- Immigrants
- LGBTQ+ community
- People with a mental health diagnosis
- Older adults
- Youth

For a more quantitative look at how these populations experience different 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.

This report can also be used as a catalyst for deeper collaboration to improve the health outcomes of those currently experiencing health disparities within our state.

Taken together, these steps can lead to Maine becoming the healthiest state in the nation.

The following table provides a summary of the top health priorities selected by participants during the community engagement process. The total number of participants in each set of events (or oral survey in the case of the immigrant population) is provided in the column labeled 'N'. The percentages reflect the percentage of participants who selected the issue as a top health priority. The darker the cells are shaded, the higher percentage of participants who selected it as a top health priority. The exception is for the youth event where no formal voting took place. Instead, checkmarks are used to indicate recurring themes in those discussions.

Table 4. State of Maine Health Priorities.

Population	N	Mental Health	Social Determinants of Health	Access to Care	Substance and Alcohol Use	Older Adult Health	Diabetes	Oral Health	Cancer	Communi-cation
County Forums	1,029	54%	41%	40%	39%	17%	6%	6%	8%	-
Black or African American	8	50%	50%	75%	25%	-	-	13%	38%	-
People who are Deaf and Hard of Hearing	20	20%	20%	30%	15%	30%	15%	5%	-	55%
People who live with a disability	35	40%	37%	17%	7%	6%	-	31%	3%	-
People Experiencing Homelessness	31	52%	16%	35%	42%	3%	10%	10%	3%	-
Immigrant	1,000	69%	-	19%	-	28%	65%	61%	20%	-
LGBTQ+ community	13	69%	69%	62%	38%	15%	-	-	-	-
People with low income	21	38%	48%	19%	29%	19%	10%	19%	5%	-
People with a mental health diagnosis	15	53%	40%	44%	20%	20%	-	13%	-	-
Older adults	75	32%	37%	43%	4%	32%	1%	9%	1%	-
Youth	30	✓	✓	✓	-	-	-	✓	-	-

Figure 2-1. Priority areas by population.

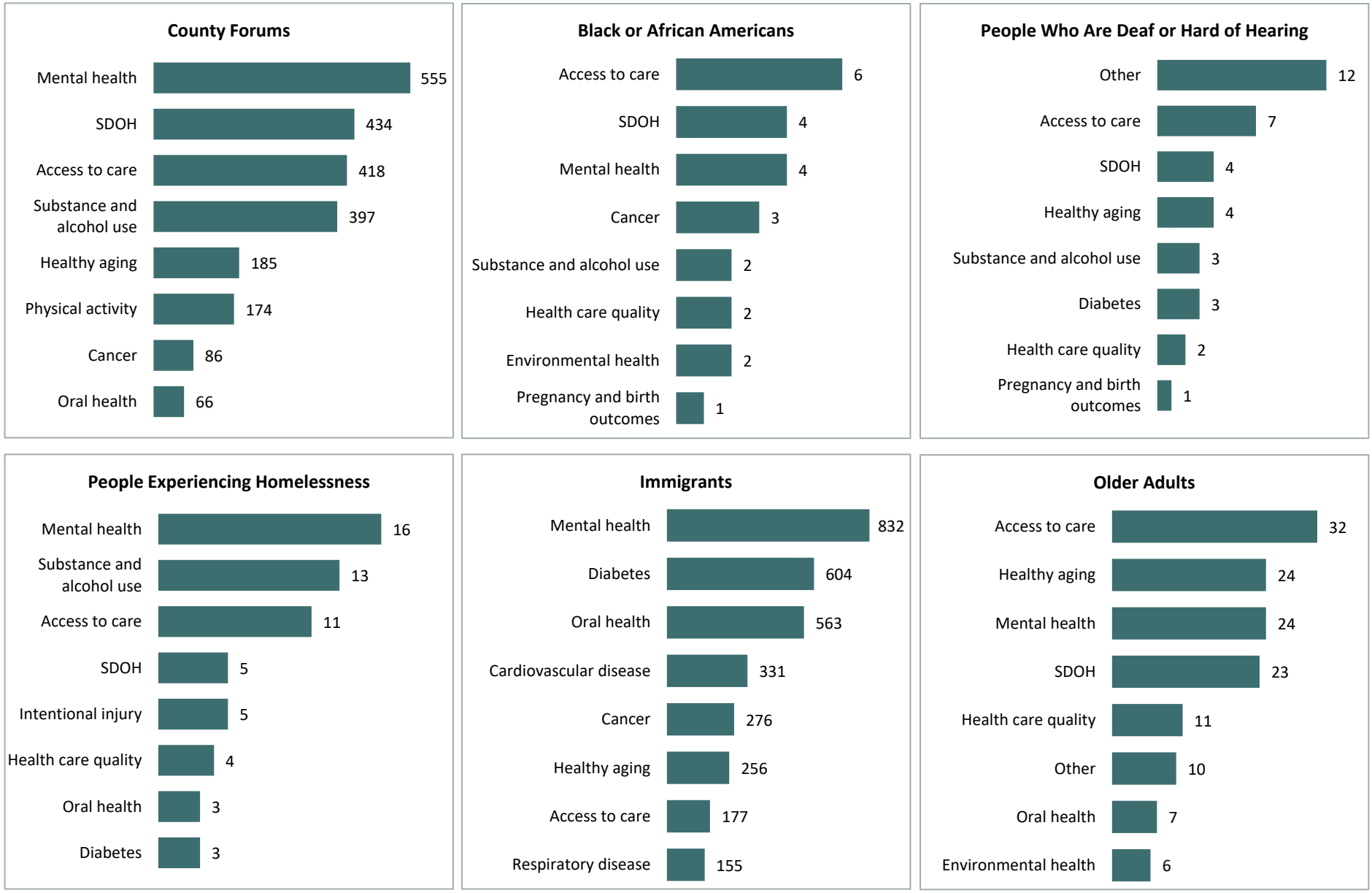
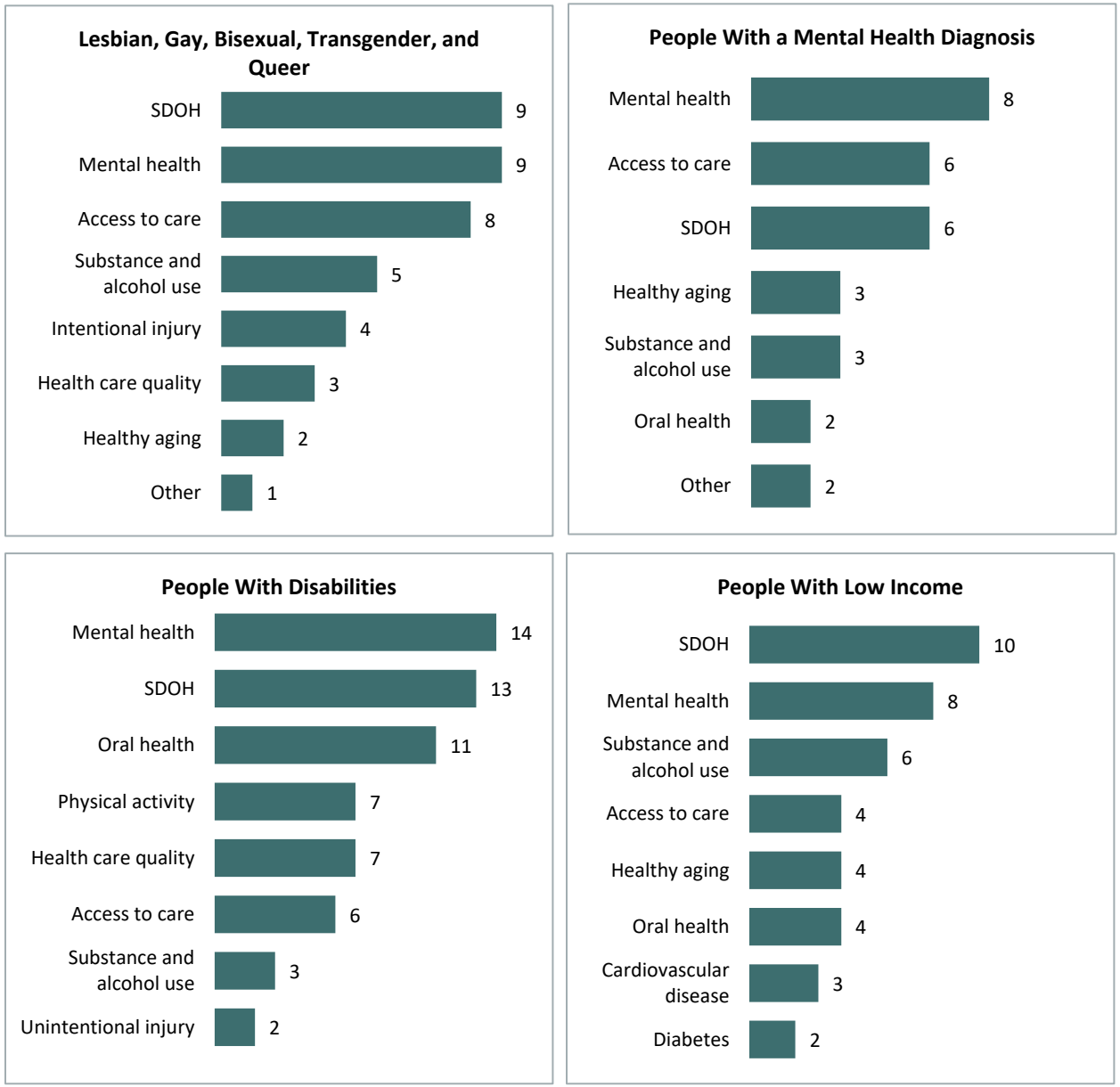


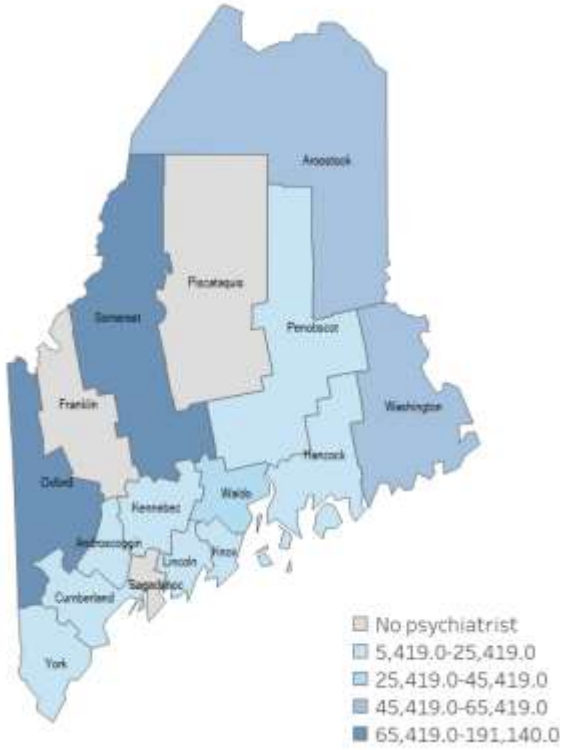
Figure 2-2. Priority areas by population (continued).



STATEWIDE PRIORITY: MENTAL HEALTH

KEY TAKEAWAYS FOR MENTAL HEALTH

Figure 3. Ratio of population to psychiatrists, 2019.



Mental Health was a top priority identified across all counties and community-sponsored events. Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also determines how we handle stress, relate to others, and make healthy choices.[2]

There is a lack of African American mental health workers. Someone who can relate to their lived experiences and feel safe to open up to."
-Black/AA Event Participant

The availability of providers was the most frequently mentioned indicator related to mental health. There is concern that the current health care workforce cannot meet mental health needs. This shortage of providers increases mental health emergencies and the use of the emergency department for care.

A second key theme is a concern for youth mental health - depression, suicide ideation, stress/anxiety, and mental health impacts of adverse childhood experiences. In 2019, 32.1% of high school students and 24.8% of middle school students reported feeling sad or hopeless for two or more weeks in a row, while 16.4% of high school students and 19.8% of county middle school students seriously considered suicide.

Community members were concerned that the pandemic exacerbated mental health issues across the state, leading to increased isolation, trauma, and stress.

"There is a stigma around mental health, it plays a factor with people trying to reach out to get help and seek resources. People struggling financially would be less likely to seek help due to reimbursement with these programs. Everything ties together." - Lincoln County Forum Participant

Those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services.

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

STATEWIDE DATA: MENTAL HEALTH

	MAINE			BENCHMARKS	
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**U.S.**	**+/-**
MENTAL HEALTH					
Mental health emergency department rate per 10,000 population	2016 **186.7**	2018 **170.6**	★	—	N/A
Depression, current symptoms (adults)	2013 **9.9%**	2017 **9.6%**	○	—	N/A
Depression, lifetime	2013 **23.4%**	2017 **26.0%**	○	2017 **19.1%**	!
Anxiety, lifetime	2013 **18.8%**	2017 **21.8%**	!	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2015 **25.9%**	2019 **32.1%**	!	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2015 **21.2%**	2019 **24.8%**	!	—	N/A
Seriously considered suicide (high school students)	2015 **14.8%**	2019 **16.4%**	○	—	N/A
Seriously considered suicide (middle school students)	2015 **15.7%**	2019 **19.8%**	!	—	N/A
Chronic disease among persons with depression	2013 **27.8%**	2017 **34.0%**	○	—	N/A
Ratio of population to psychiatrists	—	2019 **12,985.0**	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2013 **17.4%**	2017 **18.6%**	○	—	N/A

CHANGE columns show statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
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COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times a type of resource or gap/need was mentioned in one of the mainstream forums or community-sponsored events.

Resources that Maine has to address mental health include various treatment options, community-based collaboration and cohesion, school-based services focusing on youth, and a shift away from punitive approaches toward community efforts that raise awareness, reduce stigma, and build resilience. Common gaps related to mental health care in the state include barriers to getting treatment or medication, a lack of mental health providers, the need for more community collaboration, a lack of additional youth mental health services, and a need to improve services relative to the needs of this population.

Table 5. Gaps/Needs and Available Resources (Mental Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Treatment Options Treatment, including community-based and trauma, informed treatment (24) **Collaboration and Community Cohesion** Collaboration & Community cohesion (14) **Youth Services** Supports provided for youth through school-based services and programs (11) **Prevention** Prevention, awareness, stigma reduction, and resilience-building efforts (9) Other Services (9) **Law Enforcement** Public safety policy shifts away from incarceration towards providing community-based interventions (law enforcement, first responders) (4) Training in mental health first aid or best practices for those on the front lines (3)	**Barriers to Treatment** Barriers to treatment, including medications (24) **Providers** Lack of mental health treatment providers (21) Collaboration, coordination & community cohesion (10) Schools, youth, and families (15) **Culturally Competent Care** Inadequate services, including lack of culturally competent care, care integration across co-occurring or continuum of care, & poor quality (8) **Adverse Childhood Events** Need to address underlying causes, including adverse childhood experiences (ACEs), trauma stress, isolation, & equity (9) **Lack of Prevention** Need more prevention, awareness, & advocacy (5) Need to decrease poor health consequences such as intentional injury (1) **Law Enforcement** Need more law enforcement training in de-escalation and community-based intervention (6) Lack of data on the impact of COVID-19 on mental health (1)

STATEWIDE PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR SOCIAL DETERMINANTS OF HEALTH

Figure 4. Individuals living in poverty, 2015-2019.

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, environment, and social connectedness. Examples include access to healthy food, housing, water, and relationships[3]. These social determinants can create disparities that impact vulnerable populations.

Social determinants of health were a top priority identified across 15 counties and seven community-sponsored events. Poverty was the most mentioned health indicator of social determinants of health. Recent data shows that 10.9% of individuals and 13.8% of children in Maine live in poverty.

"So much relates to trauma and poverty – lack of education, food, and housing. Without a good set of baseline assets, it's hard to navigate."
-Cumberland (Lakes Region) Forum Participant

Community members identified Adverse Childhood Experiences (ACEs) as the second most frequently mentioned concern. ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. In 2019, 21.3% of Maine high school students reported experiencing four or more ACEs.

Housing insecurity was the third most frequently mentioned indicator. Recent data show that 3.3% of Maine high school students have insecure housing. In many cases, housing insecurity is linked to housing costs. In 2019, 12.0% of residents spent more than half of their income on housing. The cost of housing was the fourth most identified health indicator.

Health care may be low on the list of [people's] priorities – [they are] busy dealing with their immediate needs."
-Somerset Forum Participant

[3] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

STATEWIDE DATA: SOCIAL DETERMINANTS OF HEALTH

	MAINE			BENCHMARKS	
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**U.S.**	**+/-**
SOCIAL DETERMINANTS OF HEALTH					
Individuals living in poverty	2015 **13.4%**	2019 **10.9%**	★	2019 **12.3%**	N/A
Children living in poverty	2016 **16.7%**	2019 **13.8%**	★	2019 **16.8%**	★
Children eligible for free or reduced lunch	2017 **47.3%**	2021 **38.2%**	N/A	2017 **15.6%**	N/A
Median household income	2015 **$51,494**	2019 **$58,924**	★	2019 **$65,712**	!
Unemployment	2016 **3.8%**	2020 **5.4%**	N/A	2020 **8.1%**	N/A
High school student graduation	2018 **86.7%**	2020 **87.4%**	N/A	2019 **87.1%**	N/A
People living in rural areas	—	2019 **66.2%**	N/A	—	N/A
Access to broadband	—	2017 **88.6%**	N/A	2017 **90.4%**	N/A
No vehicle for the household	2015 **2.5%**	2019 **1.8%**	○	2019 **4.3%**	★
Persons 65 years and older living alone	2015 **29.5%**	2019 **29.9%**	N/A	2019 **26.6%**	N/A
Households that spend more than 50% of income on housing	2013-2017 **13.0%**	2015-2019 **12.0%**	★	—	N/A
Housing insecure (high school students)	2017 **3.6%**	2019 **3.3%**	○	—	N/A
Adverse childhood experiences (high school students)	2017 **23.4%**	2019 **21.3%**	○	—	N/A
Associate's degree or higher among those age 25 and older	2015 **39.8%**	2019 **43.2%**	N/A	2019 **41.7%**	N/A
Commute of greater than 30 minutes driving alone	2015 **31.0%**	2019 **33.6%**	N/A	2019 **37.9%**	N/A

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COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

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Resources that Maine has to address social determinants of health include various treatment options, community-based collaboration and cohesion, school-based services focusing on youth, and a shift away from punitive approaches toward community efforts that raise awareness, reduce stigma, and build resilience. Common gaps related to mental health care in the state include barriers to getting treatment or medication, a lack of mental health providers, the need for more community collaboration, a lack of additional youth mental health services, and a need to improve services relative to the needs of this population.

Table 6. Gaps/Needs and Available Resources (Social Determinants of Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Community cohesion (19) Technology (1) **Food** Food safety net programs (17) **Child and Family Services** Child development, youth, family supports & schools (13) **Housing and Transportation** Housing supports (9) Transportation (6) **Adverse Childhood Events** ACEs/Trauma/Resiliency (6) **Funding** Funding (4) **Employment Opportunities** Jobs (4) **Law Enforcement** Public safety's support for alternative policing models (2) **Prevention** Health services & screening (13) Physical activity (7) Prevention services (1) **Awareness and Options for Services** Awareness (1) Substance Use Disorder Recovery options (2) Older adult supports (2)	**Barriers to Treatment** Barriers to Treatment, including medications (24) **Lack of Providers** Lack of mental health treatment providers (21) **Collaboration, Coordination & Community Cohesion** Collaboration, Coordination & Community cohesion (10) Lack of data on the impact of COVID-19 on mental health (1) **Child and Family Services** Schools, youth, and families (15) **Culturally Competent Care** Inadequate services, including lack of culturally competent care, care integration across co-occurring or continuum of care, & poor quality (8) **Prevention** Need to address underlying causes, including adverse childhood experiences (ACEs), trauma stress, isolation, & equity (9) Need to decrease poor health consequences such as intentional injury (1) Need more prevention, awareness, & advocacy (5) **Law Enforcement** Need more law enforcement training in de-escalation and community-based intervention (6)

STATEWIDE PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR ACCESS TO CARE

Figure 5. Cost barriers to health care, 2015-2017.

Access to care means having the timely use of health services to achieve the best possible health outcomes. It consists of four main components: insurance coverage, availability of services, timeliness of access, and the provider workforce.[4]

Access to care was a top priority identified across all counties in Maine. 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 coverage, services, timeliness, and workforce.[5]

Cost barriers to care and a lack of health insurance were identified as concerns by the majority of participants. Between 2015 and 2017, 10.6% of adults reported there was a time in the last 12 months when they needed to see a doctor but could not due to the cost. In 2019, 8.0% of Mainers were uninsured. Members highlighted the challenges in getting health insurance, notably among those with disabilities.

There's a lack of health insurance for people with disabilities. For many the only option is MaineCare. Many offices don't accept MaineCare. There are co-pays and what you have to pay out of pocket is the difference between buying food, medicine, or health care." - Deaf/HOH Event Participant

Another key theme emerged regarding access to care and workforce issues. Almost half (48%) of community members identified the number of primary care providers throughout the state as a key indicator of concern. In 2019, 20.0% of primary care visits across the state were more than 30 miles from the patient's home. In some counties, particularly in the more rural parts of the state, participants shared that it is difficult to recruit and retain providers. Members also mentioned the need for culturally competent and educated providers.

"It's a challenge to get PCPs to come to the area. Some PCPs stay for a few years, others come and leave. It's all over the place."

-Piscataquis County Forum Participant

[4] 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
[5] Chartbook on Access to Health Care. Agency for Healthcare Research. Available from: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html.

STATEWIDE DATA: ACCESS TO CARE

	MAINE			BENCHMARKS	
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**U.S.**	**+/-**
ACCESS TO CARE					
Uninsured	2015 **8.4%**	2019 **8.0%**	○	2019 **9.2%**	★
MaineCare enrollment (all ages)	2016 **25.0%**	2020 **29.1%**	N/A	2020 **24.1%**	N/A
MaineCare enrollment (ages 0-19)	2016 **40.0%**	2020 **43.8%**	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 **1332.0**	N/A	—	N/A
Usual primary care provider (adults)	2013 **87.4%**	2017 **87.2%**	○	2017 **76.8%**	N/A
Primary care visit to any primary care provider in the past year	2013 **72.1%**	2017 **72.8%**	○	2017 **70.4%**	N/A
Cost barriers to health care	2013 **10.1%**	2017 **11.7%**	○	2017 **13.5%**	★
Primary care visits that were more than 30 miles from the patient's home	—	2019 **20.0%**	N/A	—	N/A

CHANGE columns show 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 state data to national data.	
★	means the state is doing significantly better than the national average.
!	means the state is doing significantly worse than the 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 ACCESS TO CARE

Resources that Maine has to address access to care include community organizations and programs, workforce development programs, and housing options. Common gaps related to access to care in the state include a lack of sufficient numbers of providers, culturally competent care, and offerings for specific services including oral health, medications, long-term care, and home care.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times a type of resource or gap/need was mentioned in one of the mainstream forums or community-sponsored events.

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

AVAILABLE RESOURCES	GAPS/NEEDS
Alternative Services Access with alternatives (22) Other services (3) **Coordination and Community Cohesion** Community organizations & programs (20) Community cohesion (18) **Technology** Technology (12) **Education** Education (8) **Employment Opportunities** Workforce development (7) **Housing** Housing options (1) **Health Care Equity** Equity (1) **Funding** Funding (1)	**Barriers to Care** Barriers to care & access (21) Cost of care (9) Measuring access to care (1) **Lack of Providers and Services** Providers and workforce issue (17) Specific services, including oral health, medications, long-term care, home care, and others (14) **Housing and Transportation** Transportation (14) Stable, affordable, and safe housing (3) **Culturally Competent Care** Culturally competent care, that is inclusive of diverse populations, ages, languages, and literacy levels (9) **Coordination and Community Cohesion** Coordination collaboration, & community organizations (9) **Youth Services** Youth, schools, health education (6) **Education** Education (5) **Funding** Need for stable and reliable funding and resources (3)

STATEWIDE PRIORITY: SUBSTANCE AND ALCOHOL USE

KEY TAKEAWAYS FOR SUBSTANCE AND ALCOHOL USE

Figure 6. Overdose deaths per 100,000, 2020.

Substance and alcohol use was identified as a top priority among all counties across the state. Recurring use of alcohol and/or drugs can cause clinically significant impairment, 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.[6]

Drug overdose deaths were identified by the majority of participants (79%) as a top health indicator of concern. Indeed in 2020, the rate of overdose deaths in Maine per 100,000 residents was 37.3, which is much higher than the 2019 rate of 21.5 in the U.S. overall.

Furthermore, there was a recognition that these deaths do not occur in isolation, and that substance use disorder has rippling effects across families and communities across the state.

"Substance abuse is hurting communities and families and needs to be treated as a condition." - Aroostook County Forum Participant

Participants also perceived an overall lack of preventive services and treatment options across the state, such as psychiatrists, counselors/social workers, and harm reduction and prevention outreach. Due in part to this lack of preventive services, the majority of participants (52%) indicated that hospital utilization for overdoses was a top health indicator of concern.

However, there was an acknowledgment from participants that recent efforts to support individuals with substance use issues have been working and have had a real impact on their communities.

"The decrease in the amount of use in this county has shown that the work that has been done has had an impact" - Washington County Forum Participant

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

STATEWIDE DATA: SUBSTANCE AND ALCOHOL USE

	MAINE			BENCHMARKS	
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**U.S.**	**+/-**
SUBSTANCE AND ALCOHOL USE					
Overdose deaths per 100,000 population	2016 **28.2**	2020 **37.3**	!	2019 **21.5**	!
Drug-induced deaths per 100,000 population	2015 **21.8**	2019 **31.3**	!	2019 **22.8**	!
Alcohol-induced deaths per 100,000 population	2015 **11.6**	2019 **11.3**	○	2019 **10.4**	○
Alcohol-impaired driving deaths per 100,000 population	2015 **3.8**	2019 **3.8**	○	2019 **3.1**	○
Drug-affected infant reports per 1,000 births	2015 **80.5**	2019 **72.9**	○	—	N/A
Chronic heavy drinking (adults)	2013 **7.2%**	2017 **8.9%**	!	2017 **6.2%**	!
Binge drinking (adults)	2013 **17.2%**	2017 **17.9%**	○	2017 **17.4%**	○
Past-30-day marijuana use (adults)	2013 **7.8%**	2017 **16.3%**	!	—	N/A
Past-30-day misuse of prescription drugs (adult)	2013 **1.0%**	2017 **1.3%**	○	—	N/A
Past-30-day alcohol use (high school students)	2015 **23.8%**	2019 **22.9%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2015 **3.9%**	2019 **4.0%**	○	—	N/A
Binge drinking (high school students)	2015 **12.2%**	2019 **8.2%**	★	—	N/A
Binge drinking (middle school students)	2015 **1.5%**	2019 **1.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2015 **19.6%**	2019 **22.1%**	!	—	N/A
Past-30-day marijuana use (middle school students)	2015 **3.8%**	2019 **4.1%**	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2015 **4.8%**	2019 **5.0%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2015 **2.2%**	2019 **3.0%**	!	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2018 **13.1**	2020 **12.1**	★	—	N/A
Overdose emergency medical service responses per 10,000 population	2018 **65.9**	2020 **76.7**	○	—	N/A
Opiate poisoning emergency department rate per 10,000 population	2016 **9.6**	2018 **8.6**	★	—	N/A
Opiate poisoning hospitalizations per 10,000 population	2016 **1.4**	2018 **1.2**	○	—	N/A

CHANGE columns show statistically significant changes in the indicator over time.	
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BENCHMARK columns compare the county data to the state and national data.	
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ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE AND ALCOHOL USE

Resources that Maine has to address substance and alcohol use include community organizations, treatment programs, and recovery communities. Common gaps related to substance and alcohol use in the state include feelings of stigma among community members asking for help, a lack of harm reduction initiatives, and a need for more prevention, awareness, and education regarding substance use.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times a type of resource or gap/need was mentioned in one of the mainstream forums or community-sponsored events.

Table 8. Gaps/Needs and Available Resources (Substance and Alcohol Use).

AVAILABLE RESOURCES	GAPS/NEEDS
Coordination and Community Cohesion Collaboration & Organizations (22) **Treatment Options** Treatment options (17) Pre/post-natal care (2) Recovery community & other supports (17) **Prevention and Awareness** Prevention and awareness (13) Harm reduction programs (13) Improved focus on stimulant misuse (1) **Funding** Federal and state grant funding (10) **Youth Services** Youth camps, groups, and supports (7) **Law Enforcement** Alternative approaches in law enforcement (4)	**Lack of Treatment Options** Need more treatment options (18) Harm reduction initiatives - needle exchanges, access to Naloxone, and disposal options (10) Other services, including transportation, or treatment for specific substances (6) Workforce (4) **Stigma** Fear of stigma when asking for help (14) **Coordination and Community Cohesion** Community support for people in recovery - Recovery homes and hiring practices (13) Ease of access and community norms (9) Collaboration, coordination & community engagement (7) **Youth Services** Need more screening, brief intervention, and referrals to treatment options geared toward youth and their families (11) **Prevention** Prevention, awareness, & education (8) **Funding** Funding and other community resources (5) **Health Care Equity** Equity (4) Poverty, housing supports (3) **Culturally Competent Care** Other barriers such as lack of linguistically appropriate resources (1)

HEALTH EQUITY IN MAINE

Healthy People 2030 defines **health equity** as, "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Healthy People 2030 defines a **health disparity** as, "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[7]

THE PEOPLE OF MAINE

There are approximately 81,000 people of color in Maine. This includes Latino/a/x communities, Asian American/Pacific Islanders, Native Americans, and Black or African Americans. Many are from families who have been in Maine or other areas of the U.S. for generations, while others have more recently immigrated from outside the U.S. Many Mainers also identify as more than one race. When added together, there are more people of color in Maine than the populations of Piscataquis, Franklin, and Washington Counties combined.

There are five Native American Tribes whose ancestors have lived on the land we call Maine for centuries. The relationship between these sovereign Nations and the State of Maine reflects a problematic history that continues today. The ongoing justified lack of trust in historical White institutions limits the inclusion of their perspective in this assessment.

Maine's diversity is also enriched by individuals who identify as lesbian, gay, bisexual, transgender, and/or those who may have gender diverse or gender-expansive identities or sexual identities. Maine is also home to those who possess a wide range of intellectual, physical, and psychological abilities. While group labels can be a convenient way to quantify those who share certain characteristics, it is important to note one individual can identify as a member of several groups. As just one example, Maine has the highest percentage of individuals who identify as White and the highest percentage of people aged 65 and over in the nation. Statistically then a portion of these individuals must also identify either as someone with low income, live in a rural setting, or identify as lesbian, gay, bisexual, transgender, or among those who possess a range of intellectual, physical, and psychological characteristics.

While Maine's diversity is a source of strength and pride, for some, their identities also predict a disproportionate share of health disparities. These disparities have complex causes but are often driven by inequitable access to good jobs, quality education, safe housing, ample healthy food, and other basic needs. Achieving health equity requires close collaboration with those who experience disparities to identify the best strategies, policies, or programs that work for them.

COMMUNITY ENGAGEMENT

The Maine Shared CHNA 2021 community engagement effort, launched in 2020, sought to gain a better understanding of these disparities. To do so, the MSCHNA partnered with just a few of the many non-profit organizations that provide support to Maine's under-resourced communities. These partnerships resulted in outreach guided by, hosted for, and facilitated with community members. For nine of these communities, this consisted of a single two-hour event attended by a small portion of their communities. For Maine's immigrant

[7] Health Equity in Health People 2030, last accessed 4/19/2022: Health Equity in Healthy People 2030 - Healthy People 2030 | health.gov

population, this consisted of 1,000 seven-question oral surveys.

There were three goals in this effort. The first goal was to establish and strengthen relationships across Maine to foster collaboration in removing health disparities. The second goal was to provide a space and empower those who experience health disparities to own and tell their stories. The third goal was to build the skills, experience, and capacity of those who have limited opportunities to conduct this type of assessment so that they may lead their public health initiatives.

The relationships that have been built, the stories that have been collected, and the knowledge that has been gained are only the beginning. While there is significant agreement between the top health priorities chosen during county forums and those identified with Maine's diverse communities, the underlying root causes differ depending on local resources and unique characteristics and cultural norms across the state. We intend that public health, healthcare, advocacy groups, and policymakers use these reports as conversation starters to explore these differences and form collaborations to address these findings.

Since the Maine Shared CHNA equity outreach effort began, Maine has established an Office of Population Health Equity. In the coming months and years, this office is charged with advancing health equity in Maine. One of their initiatives will be community-led health needs assessments. The Maine Shared CHNA looks forward to supporting these efforts.

ABOUT THE QUANTITATIVE DATA

For a quantitative look at how these differences affect health outcomes, see the Health Equity Data Sheets, found on the Maine Shared CHNA website, www.mainechna.org. The MSCHNA collects and analyzes data on health outcomes, health behaviors, social determinants of health, and demographics wherever those data are available.

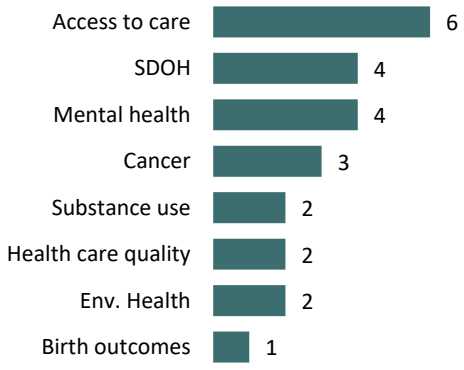
Not all data sources collect a full set of social or demographic data. In addition, some sub-populations experiencing health disparities are small, resulting in data that is less reliable due to low numbers or unavailable due to privacy concerns. These limitations have reduced the number of data points available for publication of county state-level data. This is another area where the Maine Shared CHNA looks forward to supporting the efforts of Maine's Office of Population Health Equity to enhance data collection practices.

BLACK OR AFRICAN AMERICANS

Black or African American is a term often used to describe residents who can trace their ancestry in Maine from pre-colonial times up to, and including, today's immigrants from predominately Black nations. Regardless of genealogy or country of origin, Black or African Americans face similar racial barriers and discrimination while at the same time, the differences in their history create unique cultural identities. In 2019, 21,983 people identified as Black or African American in Maine, 1.6% of the population.

The first record of a Black or African American in Maine dates back to 1608 when Mathieu da Costa served as a translator between Native Americans and the French and Dutch. In the seminal work *Maine's Visible Black History*[8], Maine has a mixed history of both participating in the slave trade during the colonial era through its connections to the shipbuilding industry and opposing slavery, supporting abolitionism, and embracing vibrant Black communities. Despite facing systematic disadvantages, Maine has a long history of Black or African American journalists, scientists, US patent holders, doctors, lawyers, professors, and artists.

Figure 7. Priority Areas – Black or African Americans.



Yet still, Black and African Americans in Maine, and across the U.S., face segregation, racism, and injustices creating social, economic, and environmental disadvantages. Many of these injustices are systemic, created and sustained by institutional systems that were created by those seeking advantage over others based on race, and not yet transformed to eliminate these systemic biases. These disadvantages have created avoidable health disparities due to a lack of timely and quality care, undue stress, and a general lack of similar opportunities to those who identify as White.

The Maine Shared CHNA partnered with the Green Memorial A.M.E. Zion Church to host a community event to gain a deeper understanding of the unique health priorities, gaps, and assets of Black or African Americans. Built in 1914, the Green Memorial A.M.E. Zion Church houses one of Maine's oldest African American congregations. The church is named for Moses Green, an escaped slave. The event was held on November 4, 2021, and attended by nine community members. The four priorities identified during this event were:

- Access to Care (66%)
- Social Determinants of Health (44%)
- Mental Health (44%)
- Cancer (33%)

Due to limited time during this one 2-hour event, participants were unable to explore the topic of Mental Health and Cancer more deeply. Concerns raised about these priorities are mentioned in the Access to Care section. Many of the identified health needs during this event are linked to access to healthcare, in particular, the impact this has on health outcomes and quality of care.

It should be noted that not all data sources collect a full set of social or demographic data. In addition, some sub-populations experiencing health disparities are small, resulting in data that is less reliable due to low numbers or unavailable due to privacy concerns. These limitations have reduced the number of data points available for publication of county or state-level data.

[8] Price, H.H., Talbot, G.E. (2006). Maine's Visible Black History, Tilbury House Publishers, Gardiner, ME. ISBN: 0884482758.

ACCESS TO CARE

KEY TAKEAWAYS

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.

MaineCare enrollment was the most frequently mentioned health indicator among event participants. Of those who identify as Black or African American in Maine, 57.3% are enrolled in MaineCare. This is more than twice the rate of those who identify as White (21.7%) in 2020. As mentioned by other communities who experience health disparities, it can be difficult to find a provider who accepts MaineCare, making it challenging to access preventative screenings and ongoing medical monitoring of chronic conditions.

Participants also mentioned the difficulty in understanding the MaineCare application forms. It was noted that the reading level is too high, especially for those who do not speak English as their primary language. They also noted a lack of sustained effort to get those who qualify for MaineCare to enroll in the program.

Cost barriers to care were the second most frequently identified health indicator related to access to care. Between the years 2011-2017, 24.7% of the Black or African American residents 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 a significantly higher rate than White residents (10.4%). This rate was also higher than residents of more than one race (18.3%), and Asians (15.5%), but not significantly.

The third health indicator mentioned by participants as a concern was the rate of uninsured. In Maine, 12.8% of Black or African Americans do not have any form of health insurance. This is higher than Whites (8.8%) and lower than those who identified as some other race (15.5%). The uninsured rate includes those who do not have any form of health insurance, whether purchased individually, through an employer, or provided through the government. These data are from 2017.

Of particular concern was the link between a lack of access to care and Cancer. Collectively, those who identify as Black or African American have the highest death rates and shortest survival rates of any racial/ethnic group in the US for most cancers.[9] Cancer is the second leading cause of death for Black or African American Mainers. Participants noted the challenges in accessing healthcare to obtain regular, early, preventative screenings to avoid detecting late-stage cancers.

"[There is a] lack of African American mental health workers. Someone who can relate."

Additional barriers to accessing care included limited paid time off to go see a doctor. Participants also mentioned a desire for being able to choose from a diverse pool of providers as well as the need for multicultural training. This was a particular concern for those who identified **Mental Health** as a priority concerning the quality of care.

[9] American Cancer Society. Cancer Facts and Figures for African American/Black People, 2022-2024. Atlanta; American Cancer Society, 2022.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Participants identified MaineCare enrollment, cost barriers, rates of the uninsured, location of primary care providers, and the number of providers and specialists as ongoing challenges or needs that impact individuals who are Black or African American.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about 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 (Access to Care).

AVAILABLE RESOURCES	GAPS/NEEDS
Access Alternatives Expansion of MaineCare to include more adults New Marketplace available **Community Organizations** Maine Immigrant and Refugee Services (MEIRS)	**Culturally Competent Care** Lack of diversity among providers (3) **Need multicultural training for providers** Barriers to Care Underinsurance High deductible insurance plans **Lack of available vacation/sick time to see a doctor** Forms are not accessible/easily understood (3) Youth Lack of school-based health centers/services (2) **Mental Health** African American providers who can relate **Cancer** Access to regular screenings

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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 economic and health disparities.

Economic stability was the top concern among participants, in particular, the rate of Black or African Americans who live in poverty. During the 2015-2019 time period, the rate of Black or African Americans living in poverty (34.8%) was more than three times the rate of Whites (11.1%). During the same period, Black or African American median household income ($42,901) also lagged behind those of Whites ($58,459).

According to the U.S. Bureau of Labor Statistics, the Black unemployment rate has been and continues to be higher than the national average. There is also a lower rate of high school students who graduate with a regular diploma four years after starting ninth grade for Black or African Americans (82%) than Whites (94.8%). According to the 2016-2020 five-year estimates,

the percentage of adults age 25 and older with a bachelor's degree or higher in Maine was 32.5%. Ninety-four percent of those were white compared to 1.7% who identify as Black or African American. The persistently lower socioeconomic stability was mentioned by participants as a leading cause of challenges in breaking the cycle of poverty.

Youth well-being was also raised as a concern. Participants noted that Black or African American high school students are significantly more likely to report experiencing housing insecurity (9.1%) compared to Whites (2.6%). High school housing insecurity is defined as those who report they usually do not sleep in their parent's or guardian's home. These data are from 2019. Participants particularly noted the lack of transitional housing for young people who experience homelessness.

Adverse Childhood Experiences (ACEs) were also discussed as a concern by participants. ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. In 2019, roughly 1 in 5 Maine high school students report having experienced 4 or more ACEs in their lifetimes. These rates are similar for Black and African American high school students (20.1%), Whites (21%), and Maine overall (21.3%). It should be noted that students who identify as White, Black or African American, or Asian have significantly lower rates than students who identify as from more than one race (29.4%), or Native Hawaiian or other Pacific Islander (32%).

Participants also mentioned intentional injury as a concern. These rates are lowest among Black or African American high school students (17.3%) in comparison to all other race categories and the state overall (18.7%) in 2019.

Housing was also mentioned as a concern. In Maine, 12% of households spend more than 50% of their income on housing costs between 2015-2019. Beyond affordability were the health and safety levels of Maine's homes. During the 2012-2016 timeframe, 3.8% of Portland and Lewiston - Auburn and 1.8% of Bangor children who were screened had confirmed elevated lead blood levels. The state rate was 2.2% during this same period.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Participants identified poverty, unemployment, limited transportation, and education as ongoing challenges or needs that impact individuals who are Black or African American.

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

Table 10. Gaps/Needs and Available Resources (Social Determinants of Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Religious institutions Community-based organizations School facilities **Substance Use Recovery** R.E.S.T. Center (Recovery, Employment, Support, Training)	**Poverty** Underemployment (2) **Transportation** Lack of transportation (2) **Housing** Lack of transitional housing for young people who are homeless Lack of safe housing **Education** Lack of health education/community outreach (2) Lack of education - general (2) Families Lack of childcare

PEOPLE WHO ARE DEAF AND HARD OF HEARING

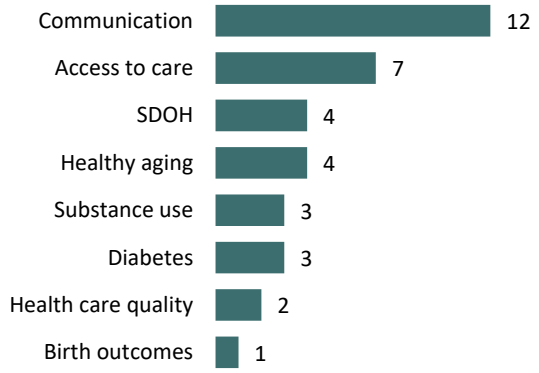
The Deaf and Hard of Hearing population is richly diverse. Individuals who were born deaf and use sign language typically do not see themselves as having lost their hearing, but rather as members of a Deaf cultural and linguistic minority. This centers their identity in a way that may be different from someone who became deaf later in life or who uses spoken languages. People who are Hard of Hearing may fall into several cultural groups depending on their desired affiliation with the Deaf community.

During 2015-2019, 5.1% of Mainers of all ages had hearing difficulty. Nationally, according to the U.S. CDC, about 2-3 out of every 1,000 children in the U.S. are born with a detectable level of hearing loss in one or both ears.[10]

Many people who are Deaf and Hard of Hearing experience health disparities. Examples include higher rates of fair to poor health, psychological distress, diabetes, and high blood pressure. In addition, smoking rates, binge drinking, not engaging in leisure-time physical activity, getting less than 6 hours of sleep, and being obese were also found to be more prevalent among people who are Deaf and Hard of Hearing.[11] There are also socioeconomic disparities. This includes lower educational attainment rates and higher rates of poverty and unemployment compared with hearing adults.[12]

The Maine Shared CHNA collaborated with Disability Rights Maine to host a health needs assessment event for people who are Deaf and Hard of Hearing. Disability Rights Maine advocates for the legal rights of people with disabilities. The most common theme was the desire to be able to get the same quality of healthcare, services, information, and resources as hearing people get. Put another way: people who are Deaf and Hard of Hearing want equity.

Figure 8. Priority Areas – People who are Deaf or Hard of Hearing.



The event was held at Baxter School for the Deaf on Mackworth Island, on September 9, 2021. There were 19 community members in attendance. The four priorities identified during this event were:

- Communication Access (57%)
- Access to Care (37%)
- Older Adult Health/Healthy Aging (32%)
- Physical Activity, Nutrition, and Weight (32%)

It should be noted that not all data sources collect a full set of social or demographic data. In addition, some sub-populations experiencing health disparities are small, resulting in data that is less reliable due to low numbers or unavailable due to privacy concerns. These limitations have reduced the number of data points available for publication of county or state-level data.

[10] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5908a2.htm.
[11] Schoenborn, C., Heyman, K. (2008). Health Disparities Among Adults with Hearing Loss: United States, 2000-2006. U.S. CDC national Center for Health Statistics. Last accessed 4/27/2022: https://www.cdc.gov/nchs/data/hestat/hearing00-06/hearing00-06.htm.
[12] Emmet, S., Francis, H., (2015). The Socioeconomic Impact of hearing Loss in US Adults. Otol Neurotol. 2015 March; 36(3): 545–550. doi:10.1097/MAO.0000000000000562

COMMUNICATION ACCESS

KEY TAKEAWAYS

Communication access is a top issue for the Deaf and Hard of Hearing community. Participants' overarching concern was that providers generally lack awareness of the unique communication needs of Deaf and Hard of Hearing patients. In the healthcare setting, participants noted that a lack of successful patient-provider communication limits their ability to understand their diagnosis and make informed decisions regarding options. Lack of understanding also impacts a patient's ability to understand or follow provider instructions.

In particular, participants noted the challenges of accessing care through provider networks or healthcare systems that are not well-trained or equipped to meet the needs of a patient who is Deaf and Hard of Hearing. The provision and effective use of American Sign Language interpreters was a top concern. There is a need for professional training on communication aids and services, as well as how to communicate with a patient through an interpreter.

"Some interpreters are not a good fit for me. They don't understand me; I don't understand them. But they don't get that. To them, an interpreter is an interpreter."

Some common experiences included providers who question the need for sign language interpreters or ask patients to pay for their interpreters, as well as providers who address the interpreter or a family member instead of the patient when speaking. In addition, there is a preference for local interpreters, as American Sign Language (ASL), like any other language, has many different dialects that are not always understood across states or regions.

Some communication technologies and tools can also come with challenges if misused or not used under the right conditions. For instance, the use of Video Remote Interpreters (VRI), when used appropriately, can help facilitate communication quickly. However, when a patient is in distress or pain, it can be difficult to keep an eye on the screen or to hold a tablet and sign at the same time. Other participants expressed frustration with common VRI problems, like freezing screens.

It is a common assumption that those who are Deaf and Hard of Hearing can read and write in English or lip-read. In reality, Deaf and Hard of Hearing adults are at high risk for low literacy and reading comprehension skills. In addition, lip reading is not a universal or common skill, and is an unreliable tool for accurate understanding.[13]

Participants also expressed a desire for access to health education. Deaf American Sign Language users are at high risk of inadequate health literacy. Communication and language barriers isolate them from mass media, healthcare messages, and healthcare communication.[14] To fill this gap, there is a desire for health education via videos with captioning and sign language or live workshops held in collaboration with Deaf community organizations and clubs.

"For five weeks, a hard of hearing man sat in the hospital before he got communication access. He had no accessible phone. He couldn't contact a loved one."

In-patient hospital stays pose unique challenges. One participant noted they were told to bring their hard of hearing family member's hearing aids home from the hospital so they would not get lost. This left the patient unable to hear or understand

[13] Altieri, N., Pino, D., Townsend, J. (2011). Some Normative data on lip-reading skills. Journal of the Acoustical Society of America; July; 130(1) doi: 10.1121/1.3593376
[14] McKee, M., Paasche-Orlow, M., Winters, P. et al. (2015). Assessing Health Literacy in Deaf American Sign Language Users. Journal of Health Communication. doi: 10.1080/10810730.2015.1066468

conversations during their stay. This meant the patient could not understand what the doctors, nurses, or other care providers were saying and therefore unable to understand their treatment options or participate in decision making.

Participants did express their appreciation for providers who are aware of the need to bridge the communication gap. This included longer appointment times to accommodate the extra time needed to work with interpreters or captioning. Telehealth and video remote care were also mentioned as options. Other strengths or assets mentioned were interpretation and accommodation coordinators who can help providers and patients bridge the communication gap.

COMMUNITY RESOURCES TO ADDRESS COMMUNICATION

Participants identified interpretation/miscommunication, provider competency and Deaf awareness, mistrust/disrespect, and patient education and support as ongoing challenges or needs that impact the Deaf and Hard of Hearing community.

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 about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 11. Gaps/Needs and Available Resources (Communication).

AVAILABLE RESOURCES	GAPS/NEEDS
Interpretation Local American Sign Language (ASL) interpreters and agencies (2) Interpretation/accommodation coordinators Hospitals with staff interpreters or contracts with interpreters MaineCare reimbursement for interpreters **Providers** Providers who try and are sincere Providers who schedule longer appointment times **Telehealth** Virtual appointments/telehealth (2) **Training/Advocacy** Maine Medical Center's Deaf & Hard of Hearing Patient Advisory Board Deaf awareness training (2)	**Interpretation/Miscommunication** Being asked to provide/pay for own interpreter (2) MaineCare reimbursement for interpreters is widely misunderstood Communication access in hospitals (2) Miscommunications/misunderstanding of body language (3) Looking at the interpreter instead of the patient Masks impede communication Video Remote Interpreters (VRI) introduce information errors and detract from interpersonal communication -- there is a lot of misinformation while using this service-- and therefore could be dangerous if misinformation is relayed (2) **Provider Competency** Lack of provider training and awareness on how to work with Deaf and Hard of Hearing individuals (8) Overall lack of understanding on how to communicate with Deaf patients Limited appointment times (interpretation is time-consuming) **Mistrust/Respect** Need for bias training Lack of respect for individual needs Avoidance of physician care due to mistrust or a history of bad experiences **Patient Education and Support** Need workshops on health topics in American Sign Language (ASL) for the Deaf community to increase health literacy via on-site or in-person; can also include education delivered via video Lack of funding/resources geared at Deaf and Hard of Hearing people Language deprivation among Deaf children with hearing parents People unaware/unable to advocate for themselves

ACCESS TO CARE

KEY TAKEAWAYS

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.[15]

One of the top concerns in accessing care for People who are Deaf and Hard of Hearing was insurance coverage. MaineCare is often the only insurance option due to the large percentage of People who are Deaf and Hard of Hearing who live in poverty. MaineCare recipients can experience challenges in finding providers who accept MaineCare. This can compound the challenges in finding a provider, especially in rural areas where there are a limited number of providers.

"I had that [lack of health care services] experience when I lived up north. I did not have all the services I needed. Everything was harder."

MaineCare only covers one hearing aid every five years and participants with private insurance noted their experiences with insurers denying claims for hearing aids despite the recent changes in coverage laws. Medicare does not provide coverage for hearing aids. Hearing aids are expensive, and without insurance, the personal cost for hearing aids can conservatively range from $1,500-$6,000 per aid. Even with insurance, the out-of-pocket cost can vary widely and remain a barrier, depending on an individual's insurance deductible or cost-share obligations.

Participants also noted when healthcare requires co-pays or when certain services are not covered at all, they often need to choose between buying food, fuel, or medicine.

"There's a lack of health insurance for people with disabilities. For many the only option is MaineCare. You have to go to suboptimal care if you have MaineCare. It's sad. It's not right."

Another challenge in access to care is the advances in, and reliance on, technology.

Participants also noted the lack of patient education materials delivered in a way that is accessible for individuals who use sign language or have limited English literacy. Without this type of support, it can compound the challenges of navigating an already complex health care system. As noted in the Communication priority section, traditional appointment time slots often do not have enough time to use interpretation services.

"Many people don't know how to download apps or use technology that's supposed to help with hearing loss."

Participants also noted their challenges in not having a usual primary care provider. Having at least one person that a patient considers as their healthcare provider is the gateway to preventative care, screenings, and ongoing monitoring for chronic conditions. Without access to these services, community members are at risk of not detecting preventable or treatable health conditions or keeping chronic diseases from worsening.

[15] 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

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Participants identified culturally competent care, cost of care, and lack of screening as ongoing challenges or needs that impact the Deaf and Hard of Hearing community. Available resources include community organizations, access alternatives, and culturally competent workforce development.

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 about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 12. Gaps/Needs and Available Resources (Access to Care).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Organizations Disability Rights Maine **Access Alternatives** Some culturally competent (strong) providers/audiologists (2) Some providers allow for longer appointments **Workforce Development** Deaf and Hard of Hearing awareness training for providers (2)	**Culturally Competent Care** Confusion on how to navigate the health care system Need longer appointment times Oppression of the Deaf and Hard of Hearing community **Cost of Care** Insurers skirting Hearing Aid Mandate (3) Lack of health insurance/insurance issues/high copays (3) Hearing aids are expensive (1) Cost of preventative care **Screening** Lack of screening from birth onward

OLDER ADULT HEALTH

KEY TAKEAWAYS

Older adult health was mentioned as a top concern for Deaf and Hard of Hearing community members. Age-related hearing loss (presbycusis) is the loss of hearing that gradually occurs in most of us as we grow older. It is one of the most common conditions affecting older adults. Approximately one in three people in the United States between the ages of 65 and 74 has hearing loss, and nearly half of those older than 75 have difficulty hearing. Having trouble hearing can make it hard to understand and follow a doctor's advice, respond to warnings, and hear phones, doorbells, and smoke alarms. Hearing loss can also make it hard to enjoy talking with family and friends, leading to feelings of isolation.

Age-related hearing loss most often occurs in both ears, affecting them equally. Because the loss is gradual, many do not notice the loss in the ability to hear. There are many causes of age-related hearing loss. It commonly arises from changes in the inner ear as we age, but it can also result from changes in the middle ear or complex changes along the nerve pathways from the ear to the brain. Certain medical conditions and medications may also play a role.[16]

[16] National Institute on Deafness and Other Hearing Disorders. Last accessed on 4/727/2022: https://www.nidcd.nih.gov/health/age-related-hearing-loss

Participants noted the added complexity of meeting the needs of older adults who are also Deaf and Hard of Hearing.

One example is the connection between hearing loss and cognitive decline.[17] In 2016, 10.3% of adults in Maine ages 45 and over had cognitive decline, defined as experiencing confusion or memory loss that happened more often or got worse within the past 12 months. Participants expressed concern for the number of Older Adults who may be exhibiting cognitive decline due to undetected and untreated hearing loss. With Maine's aging population, participants noted screening for hearing loss should be considered a routine procedure.

"Their doctor kept talking about therapy, but we helped them get a hearing evaluation and hearing aids. It made such a difference."

Communication was also mentioned in the context of meeting the unique health needs of older adults. Specific examples included a lack of long-term care or nursing homes with staff or residents who can sign. Community members indicated that the nearest facility that offers this is located in Massachusetts and there are excessively long wait times. It was also noted that the lack of advanced directives or do not resuscitate orders among the Deaf and Hard of Hearing older adult population makes it impossible to meet a patient's end-of-life expectations.

Participants also noted the additional challenges for Deaf and Hard of Hearing older adults to age in place. This included a lack of support or services for hearing family members who are often the primary caregivers. For those living in rural areas, difficulty accessing transportation services and social opportunities can compound feelings of isolation and loneliness. Rurality can also mean a lack of access to broadband, which is necessary to access technology such as telehealth visits and support apps.

COMMUNITY RESOURCES TO ADDRESS OLDER ADULT HEALTH

Participants identified health care access, a lack of providers/staff/workforce, long-term care, awareness around navigating resources, and a lack of community support as ongoing challenges or needs that impact the Deaf and Hard of Hearing community.

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

Table 13. Gaps/Needs and Available Resources (Older Adult Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Programs New England Home for the Deaf (Danvers, MA) Maine Deaf Senior Citizens Group (Senior citizen social group through Maine Association for the Deaf, Inc.) Hearing loss support groups Adult hearing screenings Local interpreting agencies	**Health Care Access** Cost of care Untreated hearing loss can lead to mental health and cognitive decline Deaf people don't have Advance directives/DNRs **Workforce** Not enough providers/staff/workforce for our older adult population

[17] Yuan, J., Sun, Y., Sang, S. et al. The risk of cognitive impairment associated with hearing function in older adults: a pooled analysis of data from eleven studies. Sci Rep 8, 2137 (2018). https://doi.org/10.1038/s41598-018-20496-w

Table 13. Gaps/Needs and Available Resources (Older Adult Health) (Continued).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Community involvement The Deaf community supports one another Senior citizen social group through Maine Association for the Deaf, Inc. Disability Rights Maine **Alternative Care Options** Relay services for phone access **Training** Deaf culture training for long-term care	**Long-Term Care** No nursing homes or rehabilitation providers with professional interpretation services (3) No Deaf-friendly places **Navigating Resources** Providers unaware of hearing loss resources **Lack of Support** Viewing older people as "less" Isolation among Deaf seniors Memory loss/cognitive decline Support for hearing family members who help Deaf family members Lack of services to support aging in place

PHYSICAL ACTIVITY, NUTRITION, AND WEIGHT

KEY TAKEAWAYS

Physical activity, nutrition, and weight are top health concerns for Deaf and Hard of Hearing community members. Participants expressed a desire for health education on physical activity, nutrition, and weight formatted to be more accessible to them. Communication and language barriers isolate them from mass media, healthcare messages, and healthcare communication.[18] Participants also mentioned their experience with obesity and their lack of leisure-time physical activity to help address this. In addition, higher poverty levels among this population may also result in less access to nutritious foods like fruits and vegetables which are more expensive than processed foods.

Many participants expressed a desire for outdoor adventure. While there are a few resources to assist in this, such as the Maine Deaf Senior Citizens Group and the Maine Association for the Deaf, participants noted the need for more outdoor instructors who can sign.

The list of gaps also includes a lack of workshops and educational opportunities provided with American Sign Language (ASL) interpretation services or with closed captioning. Examples include dieticians and health education classes. There was a recognition of the need to understand communication access and the unique needs and challenges of the community for these opportunities to be accessible and engaging.

Participants noted they were not even sure where to go to get referrals for health education or more information. Not unlike the hearing community, there was also the recognition of a lack of encouragement and willpower necessary to make healthy food choices.

[18] McKee, M., Paasche-Orlow, M., Winters, P. et al. (2015). Assessing Health Literacy in Deaf American Sign Language Users. Journal of Health Communication. doi: 10.1080/10810730.2015.1066468

COMMUNITY RESOURCES TO ADDRESS PHYSICAL ACTIVITY, NUTRITION, AND WEIGHT

Participants identified health care gaps, health education, and a lack of resources/support as ongoing challenges or needs that impact the Deaf and Hard of Hearing community. Resources include community organizations and outdoor programs for people who are Deaf and Hard of Hearing.

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

Table 14. Gaps/Needs and Available Resources (Physical Activity and Weight).

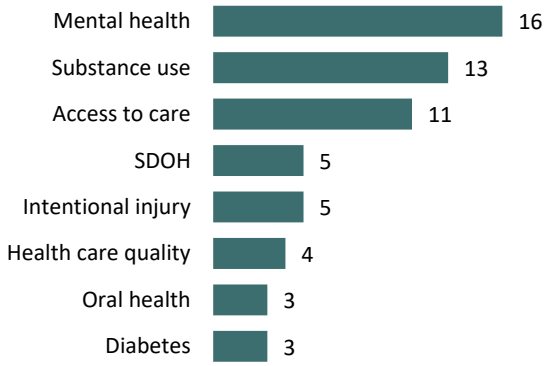
AVAILABLE RESOURCES	GAPS/NEEDS
Programs Outdoor education for people who are Deaf and Hard of Hearing **Organizations** Maine Deaf Senior Citizen Group Maine Association for the Deaf	**Health Care Gaps** Lack of Deaf-friendly, culturally competent dieticians **Health Care Gaps - Continued** Bifurcated approach to physical/mental health **Health Education** Expensive healthy foods Lack of health education for Deaf people (3) Unsure of where to get referrals for health education/info **Resources/Support** Lack of encouragement/willpower (2) Lack of funding/resources No instructors who are Deaf and Hard of Hearing or can sign

PEOPLE WHO EXPERIENCE HOMELESSNESS

Homeless is defined by the U.S. Department of Housing and Urban Development (HUD) as individuals and families who lack a fixed, regular, and adequate nighttime residence; including those who will imminently lose their nighttime residence; homeless under other federal statutes, or those fleeing domestic violence, assault, stalking, or other violence against an individual or family member.[19]

Maine's 2020 Point in Time (PiT) count identified 2,097 individuals experiencing homelessness, as reported by the Maine Continuum of Care (MCoC) to the U.S. Department of Housing and Urban Development (HUD).

Figure 9. Priority Areas – People experiencing homelessness.



The Continuum of Care (CoC) Program is a federal program designed to promote communitywide commitment to the goal of ending homelessness. Maine's CoC covers the entire state. Local agencies wishing to submit applications to the U.S. Department of Housing and Urban Development's McKinney-Vento homeless assistance funding opportunities must do so through the Maine CoC (MCoC). The MCoC's mission is to plan and coordinate an inclusive system that helps Maine people avoid or exit quickly from homelessness, and to address the underlying causes of homelessness.[20]

HUD expects all CoCs across the country to conduct the PiT count annually to quantify homelessness on one night in January. Of the total counted in 2020, 260 were family households, 103 were Veterans, 139 were unaccompanied young adults (aged 18-24), and 248 were individuals experiencing chronic homelessness.

Maine public school data reported to the U.S. Department of Education during the 2018-2019 school year shows that an estimated 2,552 public school students experienced homelessness over the year. Of that total, 105 students were unsheltered, 535 were in shelters, 284 were in hotels/motels, and 1,628 were doubled up, meaning households that cannot afford the cost of housing share housing with others.[21]

"Data isn't accurate and [true] numbers aren't portrayed; there are subpopulations of individuals who are housing insecure (not necessarily homeless) that likely aren't included in the data."

Participants recognized the challenges of a lack of robust data on homelessness and that for many of the reported health indicators, there was likely a higher incidence for those in this population.

Participants also noted that those utilizing emergency housing are often not included in any of the data sets. Because housing status is often not collected in health surveys and questionnaires, the Maine Shared CHNA is unable to obtain health outcome data based on housing status. Participants also noted a lack of data regarding the time spent

[19] HUD Exchange, Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Homeless Final Rule. Last accessed 4/15/2022: https://www.hudexchange.info/resource/1928/hearth-defining-homeless-final-rule/ United States Interagency Council on Homelessness, Maine Homeless Statistics. Last accessed 4/15/2022: https://www.usich.gov/homelessness-statistics/me/
[20] Maine Continuum of Care. Last accessed 4/15/2022: https://www.mainehomelessplanning.org/maine-coc/
[21] United States Interagency Council on Homelessness, Maine Homeless Statistics. Last accessed 4/15/2022: https://www.usich.gov/homelessness-statistics/me/

on waitlists for family housing, which they report can be very long.

The lack of permanent shelter can lead to a complex set of challenges, many of which can impact an individual's ability to secure a fixed residence. This cycle can be difficult to break given a lack of a fixed address to receive mail, store and prepare food, or securely store belongings and medications. The inability to meet even these primary needs makes meeting daily social, emotional, and physical needs challenging.

The Maine Continuum of Care hosted a community event on December 14, 2021, to share insights on the health priorities, as well as the gaps and resources experienced by this population. The event was attended by 31 individuals who either have experienced homelessness and housing insecurity or provide support and services to those who do. The top three health priorities identified by participants included:

- Mental health (52%)
- Substance and alcohol use (42%)
- Access to care (35%)

There was a tie for fourth place**: Intentional Injury** and **Social Determinants of Health**. There was not enough time during this event to explore these topics more deeply. However, what limited data was gathered via discussion notes, and any identified indicators of concern are discussed in their abbreviated sections.

MENTAL HEALTH

KEY TAKEAWAYS

Mental health was the number one concern among those who experience housing insecurity. This was also a top concern for every group across 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.[22]

The majority (58%) of participants identified the availability of mental health care providers as a top health indicator. Over half (52%) identified the use of the emergency department for mental health issues. Statewide, the mental health emergency department rate per 10,000 had decreased from 186.7 in 2016 to 170.6 in 2018. As of 2017 in Maine, 18.6% of adults in Maine were receiving outpatient mental health treatment. These numbers do not reflect the impact of the pandemic.

Participants noted the need for an increase in Assertive Community Treatment (ACT) models for those with a mental health diagnosis to retain stable housing. ACT teams provide wrap-around services from multiple disciplines to coordinate the complex needs of this population. Participants mentioned Portland's Shalom House as a valued community resource and an example of how delivering these services could work. Shalom House supports those with severe mental illness through various programs, housing, and housing supports.

Youth mental health was identified as a concern among participants. In 2019, approximately one-third (32.1%) of Maine's high school students and one-quarter (24.8%) of Maine's middle school students **felt sad or hopeless** for two weeks in a row. Across Maine, 16.4% of high school students and 19.8% of middle school students **seriously considered suicide** during the same year (2019).

"Mental health is health care."

Depression and anxiety were also identified as top health indicators. In Maine, 26% of adults reported having depression and 21.8% reported having anxiety within their lifetimes.

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

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Participants identified the Shalom House, community organizations, and outreach services, particularly Project for Assistance in Transition from Homelessness (PATH), as resources available to those experiencing homelessness. The community also identified a lack of access to care and health care quality issues as ongoing challenges the state will need to overcome.

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

Table 15. Gaps/Needs and Available Resources (Mental Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Community-based organizations (3) **Treatment** Shalom House (6) Learning Collaborative and Greater Portland Health in Portland-targeted at providing mental health Community-based organizations (3) **Other Services** Projects for Assistance in Transition from Homelessness (PATH) for those with mental health conditions	**Barrier to Treatment** Lack of access to MH care (4) Not enough rehab (inpatient) beds (4) Need for more rehab facilities (3) Limited education for dealing with mental health personally or in the family (6) **Providers** Not enough mental health providers (3) Not enough ACT teams in Maine for people unable to retain stable housing due to behavioral health issues (3)

SUBSTANCE AND ALCOHOL USE

KEY TAKEAWAYS

Substance and alcohol use was identified as a health priority among the homeless or formerly homeless event participants.

Drug overdose deaths are a top priority health indicator of concern by 61% of participants. In 2020, the rate of overdose deaths per 100,000 population in Maine was 37.3, a significant increase from 28.2 in 2016. These numbers are not available by housing status.

The rate of **drug-induced deaths** in Maine per 1000,000 population was 29.5 from 2015 to 2019. This is higher than the rate in the U.S. in 2019 of 22.8 drug-induced deaths per 100,000 population. This rate in the homeless and formerly homeless population is unknown, but of concern according to community members.

Table 16. Overdose Deaths by Year, Maine.

YEAR	NUMBER
2016	378
2017	417
2018	354
2019	380
2020	502
2021	633*

*Preliminary number from the Office of the Chief Medical Examiner

The second indicator of concern identified by 45% of participants was the rate of alcohol-induced deaths in Maine. Between 2015 to 2019, the rate of alcohol-induced deaths per 100,000 population was 11.6. This is again higher than the rate in the U.S. rate of 10.4 in 2019. The rate of alcohol-induced

deaths specifically in the homeless and the formerly homeless population is also unknown but was identified as a top health indicator.

Approximately one-third of participants also identified misuse of prescription drugs (36%), drug-affected infants (36%), and alcohol-impaired driving (32%) as top health indicators.

Participants expressed their perception that a lack of housing options was hindering individuals struggling with opioid use from recovering.

"Opioid users need housing, substance, and mental health. If we had housing, we could support and give people recovery."

Participants noted a series of barriers to recovery that were especially acute for those experiencing homelessness. These barriers were all related to the instability of being homeless while in recovery. This included a lack of stable housing, Medication-Assisted Treatment, housing support programs, and supported living environments that offer opportunities for skill-building before independent living. There was a recognition of the limited amount of education and skill-building available to those from multi-generational substance use settings.

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Participants identified a lack of treatment options, housing support systems, and educational opportunities as ongoing challenges or needs that impact the homeless and formerly homeless community.

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

Table 17. Gaps/Needs and Available Resources (Substance and Alcohol Use).

AVAILABLE RESOURCES	GAPS/NEEDS
Prevention Great local community health coalitions working on prevention (2) **Recovery/Maintenance** Increased access to vouchers (3) The Farm (3) Limestone Maine (3) **Treatment** Medication-Assisted Treatment (MAT) (3) **Harm Reduction** Harm reduction (2) Milestone Recovery Shelter allows people using substances to have a place to stay (4)	**Treatment** Not enough inpatient treatment (7) Need for more detox centers (3) Lack of Medication Assisted Treatment and housing support programs (3) **Harm Reduction** Lack of fentanyl testing (3) **Housing Supports** Lack of housing for the recovery community (3) Lack of supported living environments that offer opportunities for skill-building before independent living (4) **Awareness/Education** Limited education for dealing with substance use disorders personally or in the family (6)

ACCESS TO CARE

KEY TAKEAWAYS

Access to care was identified as a health priority by 35% of participants. 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.[23]

Almost half (45%) of participants identified cost as a barrier to accessing care. Between 2015 and 2017, 10.6% of adults across Maine reported that there was a time in the last 12 months when they needed to see a doctor but could not because of the cost.

Cost of care is related to one's health insurance status. In Maine, 8% of adults report they were uninsured in 2019. This percentage can vary from county to county. For instance, 12.1% of Washington County residents reported they do not currently have any form of health insurance, compared to 5.8% of Cumberland County residents. In addition, while the statewide percentage is lower than the percentage of uninsured across the U.S. in 2019 (9.2%), this was still noted as a concern within the homeless and formerly homeless community where the percentage of those uninsured is likely to be much higher than the general population.

There are other unique challenges in accessing care for those who are homeless. As one participant noted, visiting a doctor puts them at risk of losing everything they may own.

"Homeless people risk losing belongings to go to appointments and therefore only go when they are very sick."

The association between homelessness and lack of other resources such as transportation was also discussed. While transportation is often considered a social determinant of health, lack of transportation can be a barrier to accessing care. Approximately one-quarter (26%) of participants identified long commutes to see primary care providers as a top health indicator. In Maine, 20% of adults report they needed to travel over 30 miles for a primary care visit. Further investigation is warranted to document the link between this indicator and the percentage of people living in rural areas and those who report there is no vehicle for the household.

"There may be providers, but people are scattered all over the county."

About a quarter (23%) of participants indicated the number of primary care providers as a top health indicator. Participants noted long waitlists to see providers.

The ability to see a primary care provider is vital to disease prevention and management such as cancer screenings and diabetes management. If left unmanaged, Type I diabetes can be fatal. The lack of a secure place to store the insulin necessary to manage this disease is a risk factor for this population. This was also noted as a chief concern for deaf clients and those who have language barriers that complicate access to care, insulin, and diabetes management.

[23] 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

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Participants identified housing, transportation, and the limited number of providers as ongoing challenges or needs that impact the homeless and formerly homeless community.

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

Table 18. Gaps/Needs and Available Resources (Access to Care).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Caring and determined people are doing their best in all levels of care (2) **Community Organizations** Federally Qualified Healthcare Center in Portland - Greater Portland Healthcare (3) Office of Child and Family Services (Maine DHHS) CFS does have a program for youth transitioning from foster care (3) Portland-area partners have teams that outreach to homelessness (2) Mercy Hospital in Portland (2) Caseworkers from Frannie Peabody Center and outreach from Spurwink can navigate health care for members of this community (2) City of Portland providing harm reduction supplies to community members (2) **Access Alternatives** More express/urgent care facilities (2) South Portland Community Paramedics team provides great support to people experiencing homelessness who are sheltered at hotels in South Portland (3) **Housing Options** Emergency housing in hotels (4) Hotels willing to partner during COVID (4) Financial rental assistance like the Bridging Rental Assistance Program (BRAP) (2) Maine State Housing Authority (MSHA)/ MaineHousing Emergency Rental Assistance Program (2)	**Housing** Emergency hotel housing programs ending soon (4) Long waitlists (3) Lack of affordable/subsidized housing (5) Background checks limit access to housing (3) Lack of housing for formerly incarcerated (3) Lack of day housing spaces, especially during winter months (2) Lack of safe places for people fleeing Domestic Violence situations (2) Lack of transitional housing support services (2) Only one homeless center in Aroostook (2) Lack of isolation areas when there are infectious disease outbreaks (2) **Workforce** Health care staff shortage (5) **Youth** Lack of Transition programs for youth (2) Inconsistency around the availability of child welfare services for older minors who are not in DHHS custody (1) **Barriers to Care** Lack of medical services to those unhoused (4) Long waitlists (3) Homeless people risk losing belongings to go appointments-only when very sick (2) Lack of education regarding accessing care (4) Need for more Mobile Clinics (3) Poor medication management (2) **Transportation** Limited transportation resources (6)

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

Social determinants of health (SDOH) were tied for the fourth health priority during the event hosted for those who experience homelessness. There was not an opportunity to explore this topic more deeply due to lack of time. However, given the close relationship between housing and the other social determinants of health, what limited data was gathered via discussion notes and indicators of concern are discussed in this section.

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[24] Differences in social determinants can create disparities that impact vulnerable populations. These disparities in SDOH are often referred to as social risks.

Participants from the state's homeless and formerly homeless population identified several social risk factors that affect their health. The top four SDOH health indicators of concern were all related to income or housing. More than half (52%) of participants identified **poverty** as a top health indicator. Between 2015 and 2019, 11.8% of Maine residents reported living in poverty. While this is lower than the number of people reporting living in poverty across the U.S. (12.3% in 2019), the proportion among the homeless and formerly homeless population is likely much higher given their lack of participation and representation in most data sources. Another indicator that almost half (48%) of all participants mentioned related to economic security was **Unemployment**. A similar number of participants also identified **median household income** (45%).

Housing costs as a percentage of income were also mentioned by almost half of all participants (45%). During the 2015-2019 time period, 12% of Maine's households spent 50% or more of their household income on housing. This exceeds the recommended 30% of income for housing expenditures to allow for other living expenses such as food, clothing, and transportation.

The reasons for homelessness are complex and impact people from a wide variety of backgrounds and life experiences. Of note are those who lack housing opportunities due to their status as **formerly incarcerated**. Limited options for safe places for those **fleeing domestic violence** were also mentioned. Comments were also made about the rise in homelessness for **people with disabilities**. People with disabilities are often in poverty and heavily reliant on scarce resources for affordable housing. A lack of accessible housing further shrinks their housing options. For all these groups, there is also the challenge of overcoming discrimination or stigma.

"[Securing] housing is especially hard for the Deaf and Hard of Hearing community."

Participants also **identified housing insecure youth** as a concern. According to the Maine Youth Integrated Health Survey, 3% or 1,256 high school students, reported they usually do not sleep in their parent's or guardian's home in 2019.

[24] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

INTENTIONAL INJURY

KEY TAKEAWAYS

Intentional injury was also identified as a health priority and was tied for fourth place during the event. There was limited time to explore this topic more deeply. However, there were three top indicators of concern related to intentional injury identified by participants.

In addition to noting the high rates of youth suicide ideation, **suicide** was mentioned by 58% of participants. There were 19.4 suicides per 100,000 population in Maine in 2019. This is higher than the national rate of 13.9.

Using combined data over 5 years, the percentage of **rape/non-consensual sex** among females over their lifetime was 14.9%. Using combined data over 4 years, the percentage of reported **violence by current or former intimate partners** in the past 12 months was 1.5% in Maine. Given the lack of data on homeless or formerly homeless populations and the fact that 45% of participants also identified these last two indicators as concerning, further exploration is warranted to determine the extent of the abuse and its relation to housing security.

IMMIGRANTS

As of 2019, 52,421 people in Maine were born outside of the U.S., including 31,039 immigrants who have become U.S. citizens.[25] Forty-one percent (41%) of foreign-born Mainers came to the U.S. before 1990, while 29% came after 2010.[26] These numbers do not reflect the children of immigrants who are born in the U.S. and grow up in households where the dominant culture is that of their parent's country of origin. Native-born U.S. children under age 18, with at least one immigrant parent, make up a total of 7.5% of Maine's under-age 18 population.[27]

These numbers include naturalized U.S. citizens, refugees, asylees, permanent resident immigrants, those here on student, work, or other temporary visas, and undocumented immigrants, including those who have stayed beyond a temporary visa time frame. These designations can dictate the level of access to services and employment opportunities.

A **refugee** is any person who is outside his or her country of nationality or habitual residence and is unable or unwilling to return to or seek the protection of that country due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion. They are deemed refugees and granted refugee status overseas by the U.S. Department of Homeland Security, and then come to the United States for resettlement by the U.S. Department of State.[28] Refugees in Maine include primary refugees and secondary migrants who originally resettled in another state and then moved to Maine. There were 2,181 primary refugees and 287 secondary migrants served by Catholic Charities Maine Refugee and Immigration Services from 2013 to 2018.[29]

An **asylee** is also any person who is outside his or her country of nationality or habitual residence and is unable or unwilling to return to or seek the protection of that country due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion individuals.[30] However, an asylee enters the United States differently than a refugee. They may enter as students, tourists, businessmen, or even in an undocumented status. Once in the U.S., or at a land border or port of entry, they apply to the Department of Homeland Security (DHS) for asylum.[31] Catholic Charities Maine Refugee and Immigration Services served 396 asylees between 2013-2018.[32]

Permanent resident immigrants are issued immigrant visas by the Department of State overseas or adjusted to permanent resident status by Homeland Security in the U.S.[33] Refugees and resident aliens are eligible for public assistance and may work, while asylum seekers with pending asylum applications are not.

Undocumented residents are the most difficult to count. The Migration Policy center assigns legal status based on U.S. Census data and estimates that Maine is home to less than 5,000 undocumented immigrants.[34] Fifty are Deferred Action for Childhood Arrivals (DACA) recipients.[35]

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[25] Migration Policy Institute tabulations of the U.S. Census Bureau American Community Survey (ACS) 2019 one-year estimate State Demographics Data | migrationpolicy.org
[26] Migration Policy Institute
[27] Migration Policy Institute
[28] U.S. Department of Homeland Security, Definition of Terms, https://www.dhs.gov/immigration-statistics/data-standards-and-definitions/definition-terms
[29] Catholic Charities Maine Refugee Immigration Services FAQs | Catholic Charities of Maine (ccmaine.org)
[30] U.S. Department of Homeland Security, Definition of Terms
[31] U.S. Department of Health and Human Services, Office of Refugee Resettlement, https://www.acf.hhs.gov/orr/policy-guidance/who-we-serve-refugees
[32] Catholic Charities
[33] U.S. Department of Homeland Security, Definition of Terms
[34] Migration Policy Institute Program: Unauthorized Immigrant Population Profiles | migrationpolicy.org
[35] U.S. Citizenship and Immigration Services Approximate Active DACA Recipients (uscis.gov)

Immigrants are a diverse group. In Maine, immigrants have come from more than 122 countries,[36] with the greatest proportion coming from Asia followed by Europe, North America, and Africa. The top countries of origin are Canada, the United Kingdom, China, Germany, the Philippines, India, Somalia, Korea, and Vietnam.[37] Between 2014-2019, the majority of intakes served by Catholic Charities' Refugee and Immigrant Services (RIS) include Iraq, Congo, Somalia, Sudan, Burundi, Rwanda, and others. The number of intakes served by RIS in 2018 has been greatest in Portland (107), followed by Lewiston (26), and Augusta (4).

Three out of four foreign-born Mainers (76%) report speaking only English or speaking English "very well."[38] There are 77,312 people ages 5 and over in Maine who speak a language other than English, 62,592 of whom also speak English very well. Of those with limited English proficiency, the most common languages spoken at home are[39]:

- French, including Cajun
- Spanish
- Chinese
- Amharic, Somali, or other Afro-Asiatic languages
- Arabic
- Portuguese
- Swahili or other languages of Central, Eastern, or Southern Africa
- Russian, Polish, or other Slavic languages
- Khmer
- Vietnamese
- Portuguese
- German
- Tagalog or Filipino
- Thai

Most immigrants in Maine have pursued an education at the college level or above, with only 15% of those ages 25 and older with less than a high school diploma, and 41% with a bachelor's degree or higher.[40] Despite this, they are often under-employed outside of their training area leading to disparities in income and other social determinants of health. While Portland and Cumberland County have the greatest number of immigrants, there are also significant numbers of immigrants in Androscoggin, Aroostook, Kennebec, Penobscot, and York Counties.[41] Some migrant workers reside seasonally or year-round in more rural counties such as Aroostook, Washington, and Hancock Counties.

An oral survey was the primary assessment method used to engage with Maine's immigrant community for the 2021 Maine Shared CHNA effort. There were several reasons for this. First was the recognition that Maine's linguistically and culturally diverse immigrant community would make holding forums a complex effort. Another reason is the lack of representative data on which to base feedback and conversation. Traditional data sources are not nuanced enough to reflect the diversity within the immigrant community and are typically restricted to the five race and two ethnicity categories from the Office of Management and Budget. Those race categories are White; Black or African American; American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander. Ethnicity is captured only as i) Hispanic or Latino/a/x or ii) non-Hispanic or Latino/a/x. Many immigrants do not identify with these narrowly defined options. Finally, the City of Portland's Minority Health Program had success in meeting the challenges of assessing the health needs of their immigrant population using an oral survey. It was this survey instrument that was adapted and used.

Despite the lack of nuanced data, such as by country of origin, the report does include health data collected by race and ethnicity if there is relevant health data available. Please note

[36] American Immigration Council https://www.americanimmigrationcouncil.org/research/immigrants-in-maine#:~:text=Four%20percent%20of%20Maine%20residents, 5%2C399%20children%20who%20were%20immigrants

[37] U.S. Census American Community Survey, five-year estimates 2016-2020

[38] Migration Policy Institute tabulations of the U.S. Census Bureau American Community Survey (ACS) 2019 one-year estimate U.S. Immigrant Population by State and County | migrationpolicy.org.

[39] Migration Policy Institute

[40] Migration Policy Institute

[41] Migration Policy Institute

American Indian and Alaska Native data are not included here because they are not immigrants. Data for his racial group can be found on the Interactive Portal.

Oral surveys were conducted in collaboration with seven ethnic-based community organizations' (ECBOs) and one municipality's (City of Portland) community health worker (CHWs). The CHWs used their networks to recruit respondents. This method was designed to assist in respondent recruitment, culturally competent interviewing techniques, and to increase respondents' comfort level. The demographic information on respondents is as follows:

Table 21. Top languages in which the survey was conducted (1000 responses).

	PERCENT (number)
English	31% (312)
Somali	24% (244)
Arabic	23% (232)
French	9% (85)
Spanish	5% (54)
Lingala	3% (33)
Other	3% (24)
Swahili	2% (15)

Other languages in which the survey was conducted include Portuguese (5), Maay Maay (2), Amharic (2), Amara (1), Creole/Haitian (1), Oromo (1), Pashto (1), Tigrinya (1), and Kirundi (1).

Of the total surveys that were conducted in English, the majority of respondents were between the ages of 18-29, (63% or 197 responses); and 28% were born outside the U.S. For those surveys conducted in Somali, the majority of respondents were between the ages of 30-44 (31% or 76 responses); and 81% were born outside the U.S. Of the total surveys conducted in Arabic, the majority of respondents were also between the ages of 30-44 (52% or 121 responses), and 100% were born outside the U.S. Not all respondents provided their age range.

Table 22. Top countries of origin (890 responses).

	PERCENT
United States	24%
Iraq	24%
Somalia	17%
Democratic Republic of Congo	7%
Djibouti	8%
Kenya	3%
Mexico	3%

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

Of note, the distribution of languages, countries of origin, and age groups may not mirror the makeup of Maine's total immigrant population, and the survey data was not weighted to make it representative.

Respondents were asked to identify their top 4 priorities. Due to a tie for 4th, the top five health priorities identified by the 926 respondents who answered this question were:

- Mental health (69%)
- Diabetes (65%)
- Oral Health (61%)
- Heart Disease (30%)
- Cancer (30%)

The following table depicts how the priority votes are broken down by global region of origin. The darker the cell, the higher the priority.

Table 23. Priority Votes by Region.

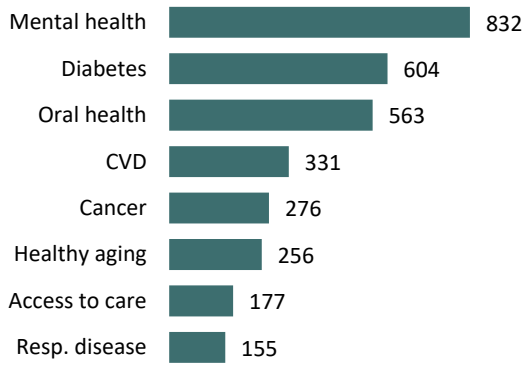
Global Region	Number of Votes	Health Priority				
		Mental Health	Diabetes	Oral Health	Cancer	Heart Disease
Central Africa	83	61%	65%	54%	40%	33%
East Africa	290	68%	66%	66%	18%	28%
Mexico, Central America, & the Caribbean	47	43%	30%	51%	13%	13%
The Middle East and West/Central Asia	230	74%	76%	65%	18%	36%
The U.S.	213	73%	60%	53%	59%	30%

Table 24. All Priority Health Topic Areas (926 responses).

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	832	90%
Diabetes	604	65%
Oral Health	563	61%
Heart Disease	276	30%
Cancer	276	30%
Older Adult Health	256	28%
Access to healthcare	177	19%
Lung disease/respiratory health	155	17%
Other	127	14%
Domestic Violence	112	12%
Motor vehicle crash	55	6%
Blood pressure	43	5%
COVID-19	34	4%
Stroke	12	1%

Respondents were also asked to describe any gaps or barriers or assets and resources related to their chosen priorities. What follows is a summary of what was shared. In many instances, a number of those responses apply not only to specific health priorities but describe more universal community conditions as well.

Figure 10. Priority Areas – Immigrants.



Responses that can be attributed to specific health priorities are included in the following sections on **Mental Health**, **Diabetes**, **Oral Health**, **Cancer**, and **Heart Disease**. Responses which are more generally related to universal community conditions are described in the **Overall Wellbeing** section.

Like all communities, the underlying root causes for those who may experience systemic disadvantages differ depending on local resources, unique community characteristics, and cultural norms. These differences are best identified through further collaboration at the community level. For some of the ECBOs who participated in this project, the health survey results have helped them become aware of the concerns of their communities and will assist them in planning the types of support they can provide. For other public health, healthcare, and policy stakeholders, these results can be used as a starting point for future collaboration.

OVERALL WELLBEING

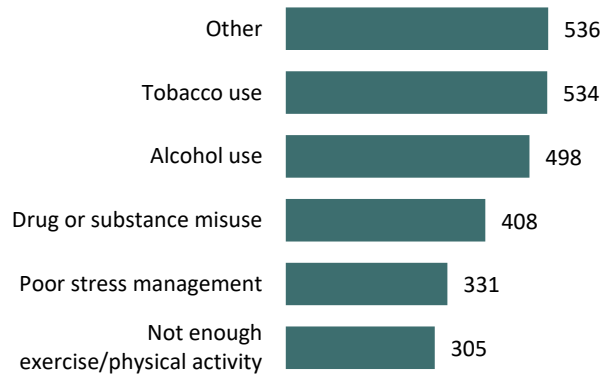
KEY TAKEAWAYS

Respondents were asked to rate the overall health of their community, 30% chose neither unhealthy nor healthy, 31% chose unhealthy or very unhealthy, and 35% chose healthy or very healthy.

According to Maine CDC Vital Records, the overall death rate per 100,000 population during the 2010-2019 time period, adjusted for age, is significantly lower for those who identify as Black or African American (494.4) and Asian (329.4) than for those who identify as White (757.6). There are significantly lower rates for Hispanic or Latino/a/x (289.3) compared to non-Hispanic or Latino/a/x (754.5) during the same period.

When asked for the four most common barriers or challenges that contribute to their chosen health priority, several responses related to more than one health priority and generally focused on health behaviors. The top responses included the following:

Figure 11. Barriers Contributing to Health Priorities.



Barriers related to language accessibility and cultural sensitivity, including cultural awareness, community norms, isolation, and stigma, also make up 58% of the responses when combined (see 'Other' category).

When asked what trusted services were missing or what they might like to have available, 86 responses mentioned affordable healthcare, affordable insurance, or free care; 75 responses mentioned the need for more affordable and accessible dental care; 47 responses mentioned case management, and 24 responses included interpreters and language support.

"When I was new, I did not know where to go for healthcare, and then I found someone to help me out and understood what I needed even if my English was little."

Other types of health services that were mentioned as missing were providers, including mental health providers, drug use prevention, and counseling.

When asked what were the strengths or resources that help to keep members of the respondents' community healthy, the number one response (51%) was a strong sense of community and sense of belonging. Another 39% of responses mentioned a safe and welcoming environment. Other strengths listed included churches (25), a friendly environment (13), a safe place to live (12), a sense of community (11), and mosques (9).

When asked about trusted services available in the community, there were 63 responses related to local clinics, free clinics, pop-ups, and mobile clinics, an additional 50 responses for doctors or doctor's offices, and 26 mentioned healthcare. There were 51 responses related to not being able to find trusted services.

Trusted sources for healthcare included doctor's office (68%), emergency department (42%), urgent care (34%), mental health counseling (25%), and free clinics (24%).

"[We need] access to proper health care and it should be affordable. It makes them feel like you won't survive in America if you don't have money to pay for healthcare."

When asked if someone in the family received assistance from someone that speaks their language or understands their culture, or is from

their community to access healthcare, 98% of responses were, “Yes.”

The types of assistance and number of responses included interpreters (106), Community Health Outreach Workers (CHWs) or cultural brokers (32), and translated materials (31).

Examples of the types of assistance varied widely and included meeting several daily living requirements. One top example was the challenge in accessing healthcare such as trying to find a doctor, scheduling appointments, and providing translation during the appointment. Respondents also mentioned the need for extra time during appointments to ensure patients understood care instructions, such as the need for follow-up appointments, diagnosis, and treatment regimens.

“[We need] well-educated translators that would explain the exact words that the doctor said.”

Other examples of assistance included finding healthy, culturally appropriate, and affordable food or food pantries; translating letters from employers or the Department of Health and Human Services; assistance in finding employment, transportation, and applying for MaineCare. An important theme was being able to fully communicate with someone in a preferred language and who was familiar with the culture to avoid mistakes.

COMMUNITY RESOURCES FOR OVERALL WELLBEING

Respondents identified transportation, access to community health workers/interpreters, and culturally and linguistically appropriate services as ongoing challenges or needs that impact the immigrant community.

The following information was gathered from survey participants who were asked to share their knowledge of the gaps and needs or resources and assets in their communities about their identified health priorities.

Table 25. Gaps/Needs and Available Resources (Overall Wellbeing).

TRUSTED RESOURCES	GAPS/NEEDS
B Street Health Clinic at St. Mary's Career Centers Catholic Charities Church Community Home Health Care ConvenientMD Cultivating Community Down East Community Hospital Downeast Clinic Downeast Coastal Conservancy Eastern Maine Medical Center Eastport Machias Clinic Free clinics Gateway Community Services Machias Bank Maine Immigrant and Refugee Services (MEIRS) Maine Medical Center Maine Mobile Health Program Mano en Mano Mosques MYAN New England Arab American Organization Passamaquoddy Health Center Tree Street Youth Tribal Fitness Center Wabanaki Public Health Walgreen's Pharmacy	Transportation (6) Timely access to CHWs, interpreters (3) Local, immigrant-owned businesses (3) Culturally and linguistically appropriate assistance (speaks client's dialect, understands their culture) (2) Interpreters who understand the American medical system (1)

MENTAL HEALTH

KEY TAKEAWAYS

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.[42]

The majority (653 or 71%) of survey participants identified mental health issues as their number one health priority.

In addition to votes for mental health as a priority, the 6th health priority mentioned by respondents was trauma-related health concerns (179 or 19%). Those who report an East African nation as their global region of origin were more likely to identify trauma-related health concerns as a top priority. While this was identified as a distinct health priority among participants, it is important to note trauma's impact on mental health and other long-term impacts on overall health and wellbeing.

The availability of mental health providers was one of the top concerns, in particular, the need for trauma health counselors. One common response to those who live in the Downeast region of the state was that providers or specialists were too far away.

During the period between 2011-2017, about one-fifth of all adults reported experiencing anxiety (21.4%) sometime throughout their lifetime. This rate is significantly higher for those who identify as from more than one race (33.8%) and similar to those who identify as White (19.9%), Hispanic or Latino/a/x (21.8%), and non-Hispanic or Latino/a/x (20.2%). These data are not available by Asian, Black or African American, Native Hawaiian or other Pacific Islander, or another identity.

Data show significantly different rates for mental health emergency department rate per 10,000 population by race and ethnicity, with those who identify as Asian (105.6) and Hispanic or Latino/a/x (105.9) significantly lowest. Significantly higher rates were among those who identify as Native Hawaiian or Other Pacific Islander (325.6), and Black or African American (262.2).

When asked about what types of services or healthcare were missing that could be used to get or stay healthy that could relate to Mental Health, responses included access to health care, stress management, and acceptance of mental health as a part of overall health.

"The only problem is that there are limited providers, you have to drive long distances to get what you want and the help you need."

Another challenge was the length of time it can take to see a mental health provider.

"Seeing the specialist for the first time is scheduled too far, by that time the problem is already too bad physically and mentally."

The idea of poor stress management being a significant barrier to overcome was mentioned by more than one-third (36%) of participants. A common cause of stress mentioned included references to economic and job security.

"There is a career center in the area that helps people find a job. When you have a job, you have less stress and you focus on building yourself."

Respondents also mentioned a preference for culturally and linguistically appropriate care. Responses included the desire for therapists who shared the same ethnicity and language. Others mentioned resources for spiritual needs. One example was the desire for local leaders of mosques to express support for mental health conditions and include the topic in their discussions.

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

When asked what were the strengths or resources that help to keep members of your community healthy, the number one response (51%) was a strong sense of community and sense of belonging. Another 39% of responses mentioned a welcoming environment. Examples provided included churches (25), friendly environment (13), safe (12), sense of community (11), mosques (9), and socializing (3).

"We support each other as co-workers and friends."

Other responses regarding assets or resources to help with mental health included opportunities for exercise and opportunities for socialization. One participant shared that community activities help you to feel better.

When asked about the types of trusted services available that could be related to mental health, top responses included doctor's offices (68%). Other responses specifically mentioned therapist, family doctors, case management, and their local ECBOs.

Further collaboration with each community is necessary to determine how these topics relate to Mental Health since local resources and cultural preferences can vary.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Respondents identified a lack of providers with whom they could feel comfortable as ongoing challenges or needs that impact the immigrant community.

The following information was gathered from survey participants who were asked to share their knowledge of the gaps and needs or resources and assets in their communities about their identified health priorities.

Table 26. Gaps/Needs and Available Resources (Mental Health).

AVAILABLE RESOURCES	GAPS/NEEDS
ARISE drug treatment and rehabilitation	Culturally and linguistically appropriate mental health providers
Atlantic Mental Health Center	Lack of trauma counselors
B Street Health Clinic at St. Mary's	Somali or Arabic psychiatrists and therapists
Churches	Online counseling
Cultivating Community	Limited providers in the area
DLTC Healthcare	Long distances to travel to see a provider
Downeast Coastal Conservancy	Walk through mental health clinics
Eastport Healthcare	
Gateway Community Services	
Machias Bank (3)	
Maine Seacoast Mission	
Mano en Mano (9)	
MAS Community Health	
Mental health counseling	
Mosques	
Maine Youth Action Network (MYAN)	
New Mainers Public Health Initiative	
Passamaquoddy Health Center	
Pleasant Point Health Center	
Wabanaki Public Health	

DIABETES

KEY TAKEAWAYS

Diabetes was the second most mentioned health priority, identified by 604 or 65% of respondents.

Diabetes can be a chronic (long-lasting) health condition that affects how your body turns food into energy. Diabetics are unable to efficiently process the sugars in the food they eat. This can lead to long-term health problems such as heart disease, vision loss, and kidney disease. If left untreated, diabetes can be fatal and is the 7th leading cause of death in the United States.[43]

There are three types of diabetes. Type 1 diabetes is usually diagnosed in children and requires lifelong treatment with insulin. Type 2 diabetes can be prevented or delayed with healthy lifestyle changes, such as losing weight, eating healthy food, and being active. Gestational diabetes develops in pregnant women who have never had diabetes. It usually goes away after childbirth.[44]

Addressing diabetes requires prevention programs that emphasize healthy lifestyles, including exercise and eating habits and disease management strategies that involve good primary health care. When asked about what types of services or healthcare were missing that could be used to get or stay healthy that could relate to Diabetes, responses included topics such as access to health care and healthy lifestyle choices.

Access to healthcare was mentioned in 22% of the responses. 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 coverage, services, timeliness, and workforce.[45] Regular doctor's visits can help to identify and monitor diabetes with regular blood glucose testing and lifestyle coaching from a trusted doctor.

A lack of exercise or physical activity was also mentioned as one of the top five challenges or barriers that contribute to their identified health priority by 33% of those surveyed. Between 2011 and 2017, between 1/4 to 1/5 (from 24.7% to 20.9%) of adults reported a lack of leisure-time physical activity in Maine. This includes all adults from all races or ethnicities. There are also similarities in obesity rates among adults by race between 2011 and 2017, with 29% of Whites reporting a BMI greater than 30 compared to 28.6% of those from more than one race, and 25.6% of Black or African Americans. While only 13.2% of those who identify as Asian report a BMI greater than 30, the difference is not statistically significant. The overall rate for the state of Maine during the same period was 28.9%.

When asked what kind of trusted services the community might like to have, responses included free personal trainers, more exercise programs, and affordable facilities. Several responses included the desire for women-only facilities. Other barriers related to physical activity included lack of time and the expense of gym memberships, especially during the cold winter months. Several responses noted the difficulty in getting outdoors during cold weather. Respondents also commented on the need for women-only gyms.

Other exercise resources respondents mentioned included parks and other options for walking.

"[Need] nutrition center for all ages and cultures, … nutrition specialists that can help people to make better eating choices and what is better for the body to stay healthy."

Access to healthy foods was another common response when asked what types of services are

[43] U.S. CDC Diabetes. Last accessed 5/3/2022: https://www.cdc.gov/diabetes/basics/diabetes.html
[44] Ibid
[45] 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.

used to get and stay healthy or resources that help to keep community members healthy. Examples included the ability to afford nutritional, organic food and the value of food pantries and food clubs sponsored by ethnic-based community organizations and churches. Respondents expressed a desire for more food stamps (called SNAP), and more nutritional and lifestyle education.

"[We need] more training about processed food, and advice on what's healthy and what's not."

Further collaboration with each community is necessary to determine how these topics relate to Diabetes since local resources and cultural preferences can vary.

COMMUNITY RESOURCES TO ADDRESS DIABETES

Respondents identified affordability of healthy options**,** culturally appropriate services, and education/information as a few of the ongoing challenges or needs that impact the immigrant community.

The following information was gathered from survey participants who were asked to share their knowledge of the gaps and needs or resources and assets in their communities about their identified health priorities.

Table 27. Gaps/Needs and Available Resources (Diabetes).

AVAILABLE RESOURCES	GAPS/NEEDS
B-Street Nutrition Center Catholic Charities Cultivating Community Farmers markets First Assembly of God food donations Food pantries with fresh food General Assistance Good Shepherd Food Bank Hannaford Lewiston Nutrition Center Maine Mobile Health Program Mano en Mano MEIRS food pantry New Mainers Public Health Initiative New Roots Farm Passamaquoddy Health Center Portland Farmers Market on Saturday Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Temporary Assistance for Needy Families (TANF) Tribal Government Services Trinity Jubilee Center Wabanaki Public Health Washington County Food and Fuel Alliance	Affordable gyms Women-only gyms Culturally appropriate, affordable healthy food Easier access to healthy food Affordable gym memberships during cold weather months Nutrition and lifestyle education/information

ORAL HEALTH

KEY TAKEAWAYS

Oral health was the third most important priority health issue identified by 563 or 61% of respondents.

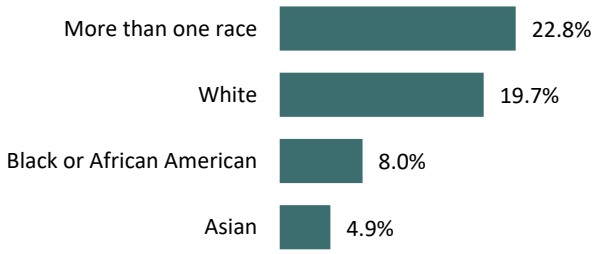
Oral health refers to the health of the teeth, gums, and the entire oral-facial system that allows us to smile, speak and chew. Oral conditions are frequently considered separate from other chronic conditions, but these are interrelated. Poor oral health is associated with other chronic diseases such as diabetes and heart disease. Oral diseases are also associated with risk behaviors such as using tobacco and consuming sugary foods and beverages. Due to several social risk factors, some groups experience a greater rate of oral disease than others. These social risk factors include the inability to pay for co-pays or other out-of-pocket expenses, lack of dental insurance whether public or private, and the inability to take time off from work to see a dentist. Environmental inequities include lack of fluoridated water, school sealant programs, healthy non-sugary foods, or public transportation to get to the dentists.

When asked about what types of services or healthcare were missing that could be used to get or stay healthy that could relate to Oral Health, responses included topics such as cost of care and lack of insurance.

The quantitative data does show differences in oral health. For instance, during the years 2012, 2014, and 2016 combined, there were 64.8% of White adults who reported having had a dental visit in the last year compared to 49.1% of those from more than one race. There were no differences in the percentage of adults who reported having a dental visit in the last year between those who identify as Hispanic or Latino/a/x (62.7%) and non-Hispanic or Latino/a/x (64.3%).

For adults without access to preventative dental care, this can mean an increase in rates for dental emergency care. Unfortunately, options for dental care in the emergency departments are often limited to pain management or extraction. During the years 2012, 2014, and 2016 combined, almost 1 in 5 Maine adults (19.8%) have lost 6 or more teeth due to decay or gum disease. The percentage of adults who report having lost 6 or more teeth varies by race.

Figure 12. Percentage of Adults Experiencing Tooth Loss by Race.



In 2019, 80.3% of children were covered by dental insurance. There were 62.6% of insured children with at least one preventative dental visit that same year. During the 2016-2018 time period, the rate per 10,000 Black or African American children who visited the emergency department for dental-related reasons (42.8) was significantly higher compared to those who identify as White (16.7) or Asian (11). During the same period, the rate among Hispanic or Latino/a/x children was not significantly different than the rate among non-Hispanic or Latino/a/x children (13 vs 17 per 10,000, respectively).

When asked about some of the trusted services most often used to keep the community healthy, responses related to oral health included several dental clinics around the state including those sponsored by Mano en Mano, Maine Mobile Health, CCS Dental, and Community Dental. A common theme for barriers or challenges included obtaining dental insurance, and distance to clinics.

Further collaboration with each community is necessary to better understand the relationship between these topics and Oral Health since local resources and cultural preferences can vary.

COMMUNITY RESOURCES TO ADDRESS ORAL HEALTH

Respondents identified a lack of treatment options and the cost of dental insurance as ongoing challenges or needs that impact the immigrant community.

The following information was gathered from survey participants who were asked to share their knowledge of the gaps and needs or resources and assets in their communities about their identified health priorities.

Table 28. Gaps/Needs and Available Resources (Oral Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Mano en Mano dental clinics Maine Mobile dental clinics CCS Dental Clinic of St. Mary's Community Dental in Portland	**Lack of Treatment Options** Lack of dental clinics in general Dental clinics that were located nearby **Cost** Difficulty in finding and affording dental insurance

CANCER

KEY TAKEAWAYS

Cancer was tied for 4th place, along with Heart Disease, as a priority health concern with 276 or 30% of responses. It should be noted that Cancer and Heart Disease are the top two causes of death in Maine.

The leading risk factors for known preventable cancers are smoking, getting too much UV radiation from the sun or tanning beds, being overweight or obese, and drinking too much alcohol. Some kinds of cancers (like breast, cervical, and colorectal) can be caught early through screening. Other kinds of cancers can be prevented. Examples of cancer prevention include vaccination to protect from cervical cancer or the removal of abnormal growths in the colon.[46]

Between 2010 and 2019, the data show there were significantly greater rates of cancer deaths for those who identify as White or non-Hispanic or Latino/a/x than for all other races and ethnicities. Cancer deaths for those who identify as Black or African American were, in turn, greater than for all other races other than White. These rates are age-adjusted meaning that age is not a factor in these numbers.

Table 29. All cancer deaths per 100,000 population by race and ethnicity, 2010-2019.

	PERCENT
White	174.1
Black/African American	134.2
Asian	77.6
Two or more races	59.4
Native Hawaiian or other Pacific Islander	40.8
Some other race	—
Non-Hispanic or Latino/a/x	173.6
Hispanic or Latino/a/x	59.8

When asked about what types of services or healthcare were missing that could be used to get or stay healthy that could relate to Cancer, responses included topics such as tobacco use, access to healthcare, alcohol use, and obesity.

Tobacco use was identified by 58% of respondents as a common barrier or challenge that contributes to poor health. During the 2013-2017 time period, adult self-reported tobacco use among

[46] U.S. CDC Cancer Fast Facts. Last accessed 5/4/2022: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/cancer.htm

those who identified with more than one race was 30% compared to Black or African Americans (22.6%), Whites (18.8%), and Asians (13.4%). Among those who identified as Hispanic or Latino/a/x, 25.2% reported smoking every day or some days compared with 19.1% of those who identified as non-Hispanic or Latino/a/x. These differences are not statistically significant.

Many noted that tobacco use in public places was often observed, despite policies that ban this. Respondents also noted the addictive nature of tobacco as a challenge.

Alcohol use was also mentioned by 54% of respondents. Data show no significant differences in chronic heavy drinking, as defined as more than two drinks a day for men and one a day for women, by race. The rate in Maine overall is 8.5% during the 2015-2017 time period.

When asked what type of health care services were missing, responses included a lack of AA meetings, drug rehabilitation, and counseling.

A lack of exercise or physical activity was also mentioned as one of the top five challenges or barriers that contribute to their identified health priority by 33% of those surveyed. The resources and challenges regarding physical activity and nutrition are discussed in the Diabetes section above.

Cancer screenings play a key role in cancer prevention. The MSCHNA data set does not include Cancer screening rates by race or ethnicity. During the years 2012, 2014, and 2016 combined, Maine's overall screening rates were 82.5% for breast cancer, 74.1% for colorectal cancer, and 84.9% for cervical cancer.

Primary care visits are often another indication of how often a population is monitored for several health outcomes, including cancers. During the 2011-2017 time period, 71.9% of Whites report having visited a primary care provider in the past year compared to 67.4% of Asians, 66.4% of Black or African Americans, and 65% of those who identify as being from more than one race. This rate is 66% for those who identify as Hispanic or Latino/a/x and 72% for those who identify as non-Hispanic or Latino/a/x during the same period.

"There are not a lot of health resources and accessing them is hard. They are either too far away or don't have hours after work."

Barriers and challenges related to seeing a doctor included a limited number of providers, long commutes to get to the doctor's office, not following up on checkups, and missing appointments. When asked what type of trusted services the community might like to have, responses included trusted providers, translation services, and case management.

Vaccinations also play a key role in cancer prevention. In Maine, 36% of 13-year-olds were up-to-date on HPV Immunization. This data is not available by race or ethnicity. The rate of HPV-associated new cancer cases per 100,000 is significantly higher among Whites (13.1) than those who identified as from some other race (7.6), or Hispanic or Latino/a/x (5.8), and higher than for Black or African Americans (7) during the 2009-2018 time period.

Further collaboration with each community is necessary to better understand the relationship between these topics and Cancer since local resources and cultural preferences can vary.

COMMUNITY RESOURCES TO ADDRESS CANCER

Respondents identified the lack of affordable healthcare, and culturally and linguistically appropriate health education materials as ongoing challenges or needs that impact the immigrant community.

The following information was gathered from survey participants who were asked to share their knowledge of the gaps and needs or resources and assets in their communities about their identified health priorities.

Table 30. Gaps/Needs and Available Resources (Cancer).

AVAILABLE RESOURCES	GAPS/NEEDS
Mano en Mano	Affordable healthcare
Maine Mobile Health	Having a man as an interpreter when I am a woman
Alcohol and tobacco trainings to get healthy	Drug and alcohol addiction treatment
Pleasant Point Health Center	Lack of enforcement for tobacco-free zones
Indian Health Services	Smoking
Tribal Government services	Transportation
Passamaquoddy Health Center	Playgrounds and sports centers with lots of activities
Wabanaki Public Health	Affordable gyms
Avoiding smoking; breathing fresh air	Laboratory and diagnostic care
Campus gyms	
Down East Community Hospital	
Maine Medical Center	
Portland Health & Human Services	
Tribal Fitness Center	
Down East Machias Hospital	
Eastport Machias Hospital	
MaineCare	
Access to free clinics and free care	
Case managers	
Med-management	

HEART DISEASE

KEY TAKEAWAYS

Heart Disease was tied for 4th as a priority health concern along with Cancer by 276 or 30% of responses. It should be noted that Cancer and Heart Disease are the top two causes of death in Maine overall.

Table 31. Heart Disease % of votes by global regions of origin.

	PERCENT
Middle East and West/Central Asia	35.7%
Central Africa	32.5%
U.S.	30.0%
East Africa	28.3%
Mexico, Central America, & the Caribbean	12.8%

"[There are] too many requirements to access health resources."

Heart disease, also called cardiovascular disease, refers to a group of diseases that affect the heart and blood flow throughout your body. These diseases include high blood pressure, high cholesterol, heart attacks, coronary artery disease, and stroke. Risk factors for developing heart disease are similar to diabetes and cancer, including tobacco use, obesity, excessive alcohol use, unhealthy diet, and lack of exercise.

The quantitative data does show some key disparities in heart disease by race and ethnicity.

The hospitalization rate per 10,000 for heart attacks is higher for those who identify as Native Hawaiian or Other Pacific Islander (78.9) compared to Black or African American (18.9) and is significantly higher than those who identify as White (22.5) or Asian (7.8). High blood pressure hospitalizations were significantly higher for Black or African Americans (30.6) compared to Whites (13.6). The rate was also higher for Native Hawaiian or other Pacific Islanders (21.5), but not significantly so. Hospitalizations for stroke were also significantly higher for Native Hawaiian or other Pacific Islanders (137) than any other group including Black or African Americans (25.2), White (20.8), and Asian (14.1).

When asked about what types of services or healthcare were missing that could be used to get or stay healthy that could relate to heart disease, responses included the same risk factors and resources as those for Diabetes and Cancer. See those sections for more discussion on tobacco and alcohol use, access to healthcare, and healthy lifestyle needs.

Further collaboration with each community is necessary to better understand the relationship between these topics and Cancer since local resources and cultural preferences can vary.

COMMUNITY RESOURCES TO ADDRESS HEART DISEASE

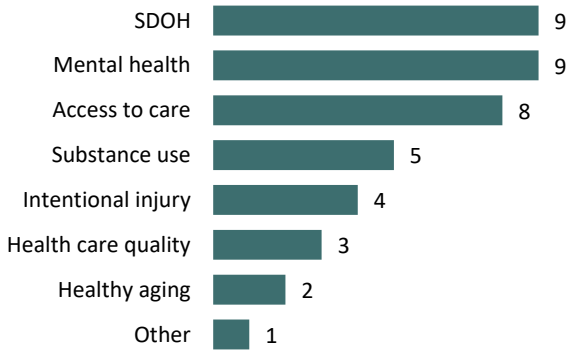
See Gaps/Needs and Available Resource Tables for Diabetes and Cancer

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER

Individuals who identify as lesbian, gay, bisexual, transgender, and/or queer, and those who may have gender diverse, gender expansive, or diverse sexual identities (often referred to as LGBTQ+), experience significant health disparities compared to individuals who are cisgender and/ or heterosexual.

However, a single label does not do justice to the diverse backgrounds and identities this grouping of five letters may suggest. Sexual orientation, gender identity, and expression (SOGIE) is diverse, exists on a spectrum, and spans cultures across the world. Those who identify as LGBTQ+ can include anyone of any age, income level, race, ethnicity, or educational attainment, and can be from a rural small town, or a large metropolitan area, and may have intersectional identities that can present more challenges and barriers.[47] It's important to note that while the term "queer" has historically had harmful impacts on the community, and may still be offensive to some, it is increasingly a reclaimed term used to include various gender and sexual identities and embraced by many in this community.

Figure 13. Priority Areas – Lesbian, Gay, Bisexual, Transgender, and Queer.



Historically LGBTQ+ people have had to fight against their identities being both pathologized and criminalized. While in much of the world different sexual orientations are no longer considered an illness, this acceptance is more recent for those with different gender identities and expressions. At the same time, the stigma associated with LGBTQ+ identities has often made data collection for this population difficult and sparse. While great strides have been made towards equity, much work is yet unfinished to dispel the systematic discrimination and health disparities that still exist today.

Globally, those who identify as LGBTQ+ are more likely to experience stigma and discrimination due to structural and interpersonal experiences and barriers that make it more difficult for LGBTQ+ individuals to access and advocate for care. In some instances, stigma can cause a person to not advocate for their needs. In other instances, healthcare providers are not well prepared to provide the needed care.

"We are not necessarily one (LGBTQ+) community in how we experience health. Different genders have different experiences, comparing lesbian women to gay men is not an accurate picture."

Health Equity Alliance (HEAL) is a non-profit which provides medical case management services to people with HIV, harm reduction programs, and sexual health and wellness services. HEAL's work with the LGBTQ+ community is deeply rooted. Formally as Down East AIDS Network, HEAL was founded in response to the HIV epidemic in 1987, and began work with the LGBTQ+ community due to the disproportionate impacts of HIV among gay men or men who have sex with men. HEAL continues to support and advocate for LGBTQ+ communities to combat stigma and help individuals access health equity. On December 9, 2021, HEAL hosted an event to support data collection on the

[47] World Health Organization, Improving the health and well-being of LGBTQI+ people. Last accessed 4/19/2022: https://www.who.int/activities/improving-the-health-and-well-being-of-lgbtqi-people

impacts of health disparities among the LGBTQ+ community in Maine. HEAL hosted an event on December 9, 2021, which was attended by 13 people. The top four health priorities identified by participants during this event included:

- Mental Health (69%)
- Social Determinants of Health (69%)
- Access to Care (62%)
- Substance and Alcohol Use (38%)

There is limited health data collected on LGBTQ+ Mainers, especially so for those who are transgender or who are gender diverse. Sexual orientation data is slightly more available, and therefore the quantitative data presented here is presented by lesbian, gay, or bisexual (LGB) identity. While there may be gender-based differences, data is generally not reliable when disaggregated by gender. However, it is possible to separate lesbian and gay responses from those of bisexual individuals.

MENTAL HEALTH

KEY TAKEAWAYS

Event participants were divided in naming their top health priority between mental health and Social Determinants of Health (SDOH). 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.[48]

Participants reported the **availability of mental health providers** is of particular concern. They further emphasized the need for not only enough providers, but enough providers that are capable of creating and facilitating safe and affirming spaces and experiences for LGBTQ+ patients.

"We need to have providers who are 'affirming' and have 'competency' in recognizing issues that are unique to the LGBTQ+ community."

The second reported indicator of concern was **depression**. There is a significant difference in the percentage of those with current depression who identify as gay or lesbian (13.9%), or bisexual (22.3%), than those who identify as straight or heterosexual (9.4%). The same is true for those who have ever been told by a healthcare provider that they have a depression disorder for those who identify as gay or lesbian (37.3%), or bisexual (58.1%), compared to those who identify as straight or heterosexual (23.3%). This is also a significant difference between those who identify as gay or lesbian compared to those who identify as bisexual. These same significant disparities also exist for the percentage of adults who have ever been told by their healthcare provider that they have an **anxiety** disorder.

Suicide ideation among high school students was the third indicator identified as a concern. In 2019, 16.4% of all high school students reported they had seriously considered suicide. The rate for those who identify as gay or lesbian was 35.1%, or bisexual (43.3%), which is significantly higher compared to those who identify as straight or heterosexual (12.3%).

What's more, 2 out of every 3 (66.6%) students who identify as bisexual and over half (57.6%) of students who identify as gay or lesbian report feeling so sad or hopeless for two weeks in a row that they stopped doing usual activities. There is not only a significant difference between these two groups but between these two groups and students who identify as straight or heterosexual (26.8%).

Participants noted the data was collected before COVID-19 pandemic policies decreased access to social networks and support. Participants expressed concern for the impact on mental health from the isolation, social distancing, and working and learning from home on those who were already feeling marginalized and excluded.

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

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Participants identified a lack of providers trained on or specializing in LGBTQ+ issues, stigma, and isolation as ongoing challenges or needs that impact the LGBTQ+ community.

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

Table 32. Gaps/Needs and Available Resources (Mental Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Treatment Use of more evidence-based practices (5) Creation of online safe spaces to prevent self-harm (5) **Youth** Teachers who are out or affirming	**Providers** Lack of awareness, affirming, competent providers for LGBTQ (7) **Barriers to Treatment** Stigma (4) **Community Cohesion** Isolation during COVID Fear outing, lack of community connections, and lack of support in rural communities

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

Event participants were divided in naming their top health priority between Mental Health and Social Determinants of Health (SDOH). 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[49]. Differences in social determinants can create disparities that impact vulnerable populations.

The top health indicator identified as a concern was for those **living in poverty**. While the Maine CHNA data set does not include data on poverty by SOGIE, research has shown that those who identify as LGBT have higher rates of poverty compared to those who identify as straight or heterosexual[50].

Participants noted concern for those living in rural areas. In Maine, the percentage of adults who identify as LGB live in greater concentrations in metropolitan areas (4.5%), compared to isolated rural (3%). Participants noted the lack of social support and networks, mentors for youth and families, and difficulty in finding affirming churches that provide safe community spaces. The link between rurality and these concerns can widely depend on local resources, unique characteristics, and cultural norms across the state and are best explored through further collaboration at the community level. The Maine Shared CHNA data set does not include health outcome data on **rurality** by SOGIE.

[49] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[50] University of Wisconsin, Madison. (2021). The Complexity of LGBT Poverty in the United States, Fast Focus Policy Brief, No. 53-2021. Last accessed 4/25/2022: https://www.irp.wisc.edu/resource/the-complexity-of-lgbt-poverty-in-the-united-states/

The concern for youth's social risks was also mentioned by participants. In 2019, the percentage of high school students reporting they usually do not sleep in their parent's or guardian's homes was significantly higher for those who identify as bisexual (5.2%), than gay or lesbian (8.4%), and both were significantly higher than those who identify as straight or heterosexual (2.4%).

The impact of adverse childhood experiences (ACEs) on the LBGTQ+ community was identified as a concern. ACEs increase the likelihood of negative health and behavioral outcomes later in life. The most commonly used list contains 10 events. Individuals who experience 4 or more of these events by age 17 double their risk of heart disease and cancer, increase the likelihood of becoming an alcoholic by 700 percent, and the risk of attempting suicide by 1200 percent. Events can include experiencing violence, abuse, or neglect. Participants expressed concern for youth may not have a nurturing supportive environment as they explore their sexual orientation, gender identity, and gender expression. In particular, participants reported concern with the lack of policies in place to protect children who express their gender outside of the traditional, binary gender they were assigned at birth.

Here the data show a similar pattern with the percentage of high school students who report experiencing 4 or more ACEs. In 2019, those who report experiencing 4 or more ACEs were greater for those who identify as bisexual (46%) and for those who identify as gay or lesbian (37.8%). This difference is not significant between these two groups, but both of these percentages are significantly higher than those who identify as straight or heterosexual (17.7%).

There was also a concern for older adults who are LGBTQ+. As such, participants mentioned the need to provide care to the diverse LGBTQ+ population that recognizes those who may live alone without strong networks or connections due to stigma or marginalization.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Participants identified a lack of mentorship for LGBTQ+ youths, policies to protect children questioning their gender or orientation, and social support as ongoing challenges or needs that impact the LGBTQ+ community.

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

Table 33. Gaps/Needs and Available Resources (Social Determinants of Health).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Increased support and recognition of LGBTQ+ inclusion and identities from within "mainstream" organizations (4) Committed community partners (3) **Support for Youth** OUT Maine Youth Art groups support (2) Teachers who are out or affirming	**Barriers to Services** Need a nuanced understanding of barriers for LGBT populations (7) **Youth/Families** Lack of LGBT mentors for youth and family (3) Lack of policies to protect children from affirming gender and orientation Schools that do not allow GSTA or other organizations (2) **Safety and Support** Lack of social support and networks for Q+(2) Difficulty finding affirming churches that provide safe places Safe community spaces

ACCESS TO CARE

KEY TAKEAWAYS

Access to care was the third most identified health priority. 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.[51]

Participants identified the rate of those without insurance as a top concern in accessing care. The percentage of those reporting there was a time in the last year when they needed to see a doctor but could not due to cost was twice as high for those who identify as bisexual (23.1%) than for those who identify as straight or heterosexual (9.8%) and significantly higher than for those who identify as gay or lesbian (11.3%). The Maine Shared CHNA data set does not include data on **insurance status** by SOGIE.

There is also a disparity in the percentage of adults who report having seen a primary care provider in the past year. Of those who identify as bisexual, gay, or lesbian, 64.8% and 66% percent respectively have seen a primary care provider in the past year. These percentages are significantly lower compared to those who identify as straight or heterosexual (71.2%). There is not a disparity by identity in the percentage of adults who report they have a usual primary care provider.

When discussing the types of care they would like to receive, community members frequently emphasized the need for health care providers trained specifically in how to work with and care for individuals identifying as LGBTQ+. Participants reported that not all providers have had cultural competency training around LGBTQ+ topics to promote access to gender-affirming care or specific needs they may have that relate to their gender identity and/or sexual orientation. Some of the specific concerns range from being misgendered to not having processes to collect legal or administrative names as well as name in use, in addition to gender identity, sexual orientation, and pronouns. If this information is not collected, or if providers are not trained, many times clients are stigmatized, face micro-aggressions, or are left educating their providers on their identity as well as their needs. This ultimately decreases confidence in the provider's ability to support their needs and can be a deterrent from wanting to access care. It's important to note that many providers may have never learned this information and may not choose to seek this information out

"We need to have providers who are 'affirming' and have 'competency' in recognizing issues that are unique to the LGBTQ+ community."

Health care services for older adults were also mentioned as a concern. In particular, participants noted the need to understand the support system older LGBTQ+ individuals may have in place. Older LGBTQ+ individuals may have made great sacrifices to live their lives authentically – and this may have caused families to disown them. This is a particular concern for those living in assisted living, nursing homes, or in other care settings where there is often a need to have next of kin or emergency contact on record, or in aftercare planning.

[51] 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

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Participants identified a lack of access to providers specializing in LGBTQ+ issues, transportation, and housing in rural areas as ongoing challenges or needs that impact the LGBTQ+ community.

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

Table 34. Gaps/Needs and Available Resources (Access to Care).

AVAILABLE RESOURCES	GAPS/NEEDS
Community Organizations Maine Family Planning Open Door for transgender health (2) **Access Alternatives** COVID funding opportunities for organizations to embrace and extend access related to DEI	**Culturally Competent Care** Lack of access to affirming and competent providers (3) Lack of clear methodology to assess and judge a care provider's level of competency (3) Lack of provider training re: LGBT/inclusion (5) Lack of trauma-informed care provision (2) **Barriers to Care** Lack of access to Wi-Fi for telehealth (3) Discrepancies between the name used and the name on legal documents Youth on parents' insurance being worried about being 'outed' Lack of providers and surgeons providing gender-affirming care **Transportation** Gaps in transportation in rural areas (2) Access to transportation in general (2) Far distance of providers for LGBT folks to travel to appointments **Housing** Gender requirements and recommendations specific to single-sex facilities. Need to promote inclusion in signage, intake forms, and policies that reflect inclusivity (2)

SUBSTANCE AND ALCOHOL USE

KEY TAKEAWAYS

Substance and alcohol use was identified as a top health priority. Recurring use of alcohol and/or drugs can cause clinically significant impairment, 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.[52]

For the LGBTQ+ community, social marketing and history with gay spaces only being in bars have contributed to disparities in substance use rates. Another common cause for these disparities is to find relief from social or personal rejection and stigma.

The majority of forum participants noted **drug overdose deaths** as a top priority health indicator of concern in regards to substance and alcohol use. In 2020, the rate of overdose deaths per 100,000 population in Maine was 37.3, a significant increase from 28.2 in 2016. This data is unavailable by sexual orientation, gender identity, or expression.

Table 35. Overdose Deaths by Year.

YEAR	NUMBER
2016	378
2017	417
2018	354
2019	380
2020	502
2021	633*

*Preliminary number from the Office of the Chief Medical Examiner.

More than half of the participants (54%) also identified alcohol-induced deaths and binge drinking among youth as top health priority indicators of concern across the state.

While alcohol-induced deaths were identified as an indicator of concern, the MSCHNA data set does not contain this data by SOGIE. The data on adult binge drinking in Maine shows a health disparity by gender expression. Twenty-five percent (25.1%) of adults who identify as bisexual report binge drinking, compared to those who identify as straight or heterosexual (17%). Eighteen percent (17.7%) of those who identify as gay or lesbian report binge drinking during the years 2011-2015 & 2017.

In 2019 in Maine, the rate of self-reported binge drinking was higher among gay or lesbian high school students (9.1%) than straight or heterosexual students (8.2%), but it was not significantly so. There were disparities reported for past-30-day alcohol use among bisexual high school students (27%) in comparison to straight or heterosexual students (22.6%). The rate was 26% for gay or lesbian high school students, which was not a significant difference between either of these two other groups.

The percentage of adults who report past-30-day use of marijuana is 22.2% and 21.3% for those who identify as bisexual or gay or lesbian respectively, compared to 9.7% of those who identify as straight or heterosexual. These differences are significant.

"There is a need for promotion of LGBTQ+ care and services so [the] community knows this is available and can feel safe connecting to care."

Participants mentioned concern for the need to provide harm reduction services in spaces that were safe for the LGBTQ+ community. This can include space for families as well as prevent self-harm. Complex barriers exist to overcoming the stigma of both sexual orientation, identity, and expressions that differ from the cultural norms and addiction.

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

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Participants identified a lack of LGBTQ+ affirming care, LGBTQ+ harm reduction programming, and stigma as ongoing challenges or needs that impact the LGBTQ+ community.

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

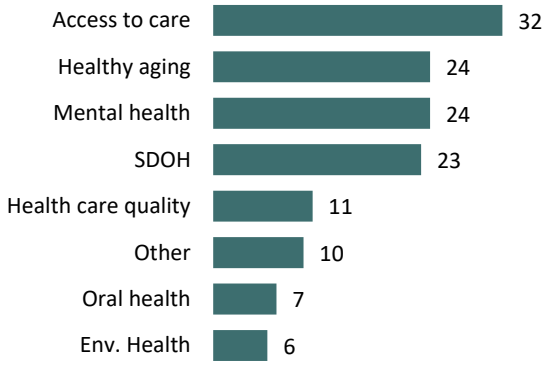
Table 36. Gaps/Needs and Available Resources (Substance and Alcohol Use).

AVAILABLE RESOURCES	GAPS/NEEDS
Prevention Specific safe places for youth and families of LGBT to prevent self-harm and addiction and promote wellness (2)	**Treatment** Lack of LGBTQ+ affirming care **Harm Reduction** Lack of LGBTQ+ harm reduction programming **Cultural Norms** Stigma (4)

OLDER ADULTS

Adults aged 65 and older make up a growing percentage of the population in Maine. Maine also has the largest percentage of those 65 and older of all U.S. states at 21% or 1 in 5 Mainers, compared to 16% in the U.S. overall. This is expected to increase to 1 in 4 by the year 2030. Maine's rural counties are home to a greater proportion of older adults.

Figure 14. Priority Areas – Older adults.



Of those 75 and older, 48.3% report having any one of the six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty.

The three leading causes of death among Maine adults 65 and over are heart disease, cancer, and chronic lower respiratory disease. The risk of having these conditions increases with age. Many of these conditions are preceded by high blood pressure, cholesterol, Type II Diabetes, and being overweight or obese and can be mitigated with behavioral health support and resources.

As with other populations that experience health disparities, participants noted that other than having age in common, this is a diverse group.

The MSCHNA partnered with the Maine Council on Aging to host an event on October 4, 2021, that was attended by 75 individuals. The top four health priorities identified during this event were:

- Access to Care (43%)
- Older Adult Health (32%)
- Mental Health (32%)
- Social Determinants of Health (31%)

ACCESS TO CARE

KEY TAKEAWAYS

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.[53]

Participants in the event held with older adults identified access to care as their number one priority health area of concern. Given the prevalence of chronic conditions among older adults, ensuring timely access to preventative services such as screenings and chronic disease monitoring, accessing care can have a profound impact on the quality of life and longevity.

There was a concern about the lack of insurance among the older population. While Maine overall has a lower percentage of **uninsured** individuals (8.0%) compared to the nation (9.2%) in 2019, this is still almost 1 in 10 people at risk of financial strain should they require urgent or chronic healthcare.

While people 65 and older have access to Medicare, there are limits to that coverage that

[53] 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

amount to out-of-pocket costs for those without supplemental insurance. For those that are retired, these costs can have a significant impact on household budgets. There was also recognition of the overall complexity of the healthcare/health insurance system and its level of difficulty for some to navigate alone.

Participants also expressed concern over the need to travel over 30 miles to see a doctor. In Maine, one-fifth (20%) of all **primary care visits were 30 miles or more** from the patient's residence in 2019. While access to transportation is often considered a social determinant of health, participants noted the effects of not being able to understand or access the transportation resources available to them was a risk factor in being able to see a doctor.

Access to telehealth services was mentioned as a promising innovation. Challenges in access to broadband and the need for technical savvy to utilize these new resources were also discussed. On average, 88.6% of Mainers have **broadband access**. However, this can vary widely across the state, with only 41.8% having access in Franklin County and 99.9% having access in Cumberland in 2017.

Participants noted workforce shortages of all types and levels. This included specialists in neurology, hearing, ophthalmology, mental health, geriatrics, and home health care providers. They also pointed out a lack of incentives and resources to build a workforce that is well-trained to treat older adults, specifically in neuro diseases and home health care.

"The lack of home care workers is the biggest threat to the health of my patients."

Other types of care that were mentioned as a gap were resources or services for individuals with disabilities such as loss of hearing or visual impairment.

While having a usual primary care provider was mentioned as a concern, 95.9% of adults aged 65-74 and 96.8% of adults 75 and older report they have at least one person they think of as their doctor or healthcare provider. This puts roughly 4% of older adults without a primary care provider at risk for lack of preventative healthcare screening and ongoing support for chronic disease management.

In 2017, 2.6% of adults 65-74 and 1.9% of adults 75 and over 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 significantly lower than the state overall (11.7%).

Participants also expressed concern over the length of time it took to access the care they needed. There was also recognition of the overall complexity of the health care and health insurance system which made it difficult to get timely care or any care at all.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Community members identified a lack of health care services and providers, long waitlists, and transportation issues as ongoing challenges that impact Maine's older adults.

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

Table 37. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Neighbors Driving Neighbors Age-Friendly Communities efforts Volunteer transportation **Community Organizations** Small community-based orgs **Technology** Telehealth/technology (7) Online support groups Online social groups **Access Alternatives** Non-traditional models of care Mobile med practices In-home OT, PT, speech services **Workforce Development** Free CNA training at tech schools	**Barriers to Care** Access/understanding of technology Health insurance/cost of care Long waitlists (4) Some specialists do not accept Medicare Timely access to care Complexity of system Better communication about medications **Providers/Workforce** Workforce shortages **Age-Friendly Services** Providers not trained to work with older adults (2) More funding for age-friendly communities (2) **Transportation** Walkable communities Transportation problems (4) Rurality **Missing Services** Lack of home care (2) Lack of dentists Lack of specialists (neuro, hearing, visual, geriatrics) (4) Caregiver support MH access Respite access

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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[54]. Differences in social determinants can create disparities that impact vulnerable populations and rural residents alike.

Maine is the most rural state in the nation and the least populated state east of the Mississippi. These distinctions are a source of local pride as well as a source of challenge in meeting the needs of daily living.

"[There is a lack of] understanding for what transportation resources are available and how to access them."

Isolation can lead to a lack of social connections and feelings of loneliness. And for those with limited or no access to transportation or internet access, these risk factors can become exacerbated. In 2019, 29.9%, or 1 in 3, adults 65 and older were **living alone**, higher than the national rate of 26.6%. There are only two counties in Maine that are below the national average for adults 65 and older living alone during the four years between 2015-2019: Waldo and Oxford Counties.

Participants also expressed concerns about the challenges of living on retirement savings with limited alternatives for additional income. One example is the cost of housing. While there are "affordable" housing options, participants noted those options are not always in good condition. There was also a concern for limited housing options for caregivers, an important component for those wishing to remain living independently and in need of affordable care.

During four years between 2015-2019, 12.0% of Maine households spent **more than 50% of their income on housing**. There is no available data on this by age. However, 21% of households over 60 are renters, and in 2019, 45% of renters 60+ (or 15,917 people), were "rent-burdened," spending 30% or more of household income on rent.[55]

Access to affordable **healthy food** was also mentioned as a challenge. While some indicated that they had been able to identify and use local food programs, those options did not always offer healthy foods.

As with many other events held with those who experience health disparities, there was a desire for more data specific to their experiences, as well as a desire for more local data that could be used to take local action.

[54] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

[55] Census ACS B25007 ACS 2020 5-year estimates and Census ACS B25072 ACS 2020 5-year estimates

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community members identified a lack of social connections, food insecurity, and a lack of affordable housing as ongoing challenges that impact Maine's older adults.

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

Table 38. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Health Services Pathfinder in Aroostook County Mobile medical practices COVID clinics in senior centers **Food** Local food banks/gleaning programs SNAP benefits **Older Adult Supports** Age-Friendly Communities (2) Saco Aging program **Technology** National Digital Equity Center Telehealth **Housing** Home repair services **Awareness** More recent interest in SDOH More people understand the impacts of isolation/loneliness	**Poverty** Poverty **Transportation** Transportation (2) Lack of transportation **Housing** Lack of affordable housing (2) **Food** Food insecurity (2) Lack of healthy options at food pantries Healthy food is too expensive **Barriers to Services** Cumbersome systems Don't know about resources/programs Wrap-around care Lack of funding for programs Broadband access/equipment/support **Isolation** Lack of social connections and isolation (3) Coordination Better communication/coordination across providers **Workforce/Systems** Lack of workforce

OLDER ADULT HEALTH

KEY TAKEAWAYS

Forum participants noted the difference between this health priority area and the others. While many health priorities were concrete health conditions, Older Adult Health is based solely on a single inevitable factor: growing older. Participants also noted that as a health priority, older adult health was as complex and diverse as the population itself.

While data does show that with age comes a greater risk for poor health outcomes, with the right support, anyone can lead a full and engaging life. Research shows that people with a positive view towards aging live 7.5 years longer with fewer chronic conditions and less anxiety than those living with a negative view.[56]

Supports mentioned include caregivers, transportation, home health supports, and social opportunities. Also identified was a need for more education and resources around improving cognitive health, including programs that specifically addressed Alzheimer's disease and dementia. In Maine, 10.8% of adults age 45 and over report having experienced **confusion or memory loss** that happened more often or got worse within the past 12 months. This is the same as the national average.

Caregiving to support aging adults, including but not limited to those with cognitive decline, was also highlighted as a challenge.

In Maine, 4.8% of the population provides regular care or assistance to a friend or family member who has a health problem or disability for at least 20 hours a week during the past 30 days. Participants noted this data point may not reflect all those caring for an older adult family member, perhaps because the number of hours spent is under 20 per week or is underestimated. Recent data by AARP estimates nearly 1 in 5 Americans provide caregiving to a family member.[57]

"[There are] many age-friendly groups but need to bring younger people along."

Arthritis is one health issue that is also affected by age. According to the data, the percentage of adults who have been told by a healthcare provider that they have arthritis shows a steady increase with 5.5% among 18-24-year-olds to 55.5% for those 75 and older reporting they have been told they have arthritis.

Ageism was also mentioned as a barrier to older adult health. According to the World Health Organization, ageism is defined as the stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others or oneself based on age.[58] Ageism can affect anyone at any age and can erode the connectedness across generations.

Participants expressed a desire for policies and municipal planning that would support age-positive cultures and age-friendly communities. Age-friendly communities require community-wide coordination of existing resources to meet the challenges that can come with decreased mobility and increasingly complex health needs. As with any group, those needs and resources can vary widely based on local conditions. These differences are best identified through further collaboration at the community level.

[56] Levy, B. R., Slade, M. D., Kunkel, S. R., & Kasl, S. V. (2002). Longevity is increased by positive self-perceptions of aging. Journal of personality and social psychology, 83(2), 261–270. https://doi.org/10.1037//0022-3514.83.2.261
[57] AARP, Caregiving in the U.S. Last accessed 5/17/2022, https://www.caregiving.org/caregiving-in-the-us-2020/
[58] https://www.who.int/news-room/questions-and-answers/item/ageing-ageism#:~:text=Ageism%20refers%20to%20the%20stereotypes,of%20their%20culture's%20age%20stereotypes.

COMMUNITY RESOURCES TO ADDRESS OLDER ADULT HEALTH

Community members identified access to food, transportation, and appropriate home care as ongoing challenges that impact Maine's older adults.

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

Table 39. Gaps/Needs and Available Resources (Older Adult Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Neighbors/ community cohesion/ volunteers (3) Age-friendly communities Outdoor environment **Alternative Care Options** Mobile medical practices Telehealth Home health support Programs to get people into housing **Training** Increased understanding/education of impacts of falls (2)	**Workforce** Lack of workforce **Basic Needs** Food Transportation Medication Fuel assistance Poverty/lack of financial resources **Long-Term Care** Lack of home care **Navigating Resources** Technology barriers **Lack of Support** Social isolation (3) Ageism

MENTAL HEALTH

KEY TAKEAWAYS

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.[59]

The top health indicator identified as a concern among participants was chronic disease among adults with depression. This is defined as the percentage of adults who have reported current symptoms of depression and have three or more chronic conditions. Chronic conditions include skin cancer, other types of cancer, cardiovascular disease [such as stroke], coronary heart disease [such as heart attack], arthritis, COPD and asthma, obesity, and chronic kidney disease. As with other health indicators, the rates increase with age. For those aged 18-24, the rate is 6.5% compared to 50.9% of those aged 75 and older.

Participants also noted the rate at which the emergency department is used to address those with a mental health condition. In Maine, the highest rate of those discharged from the emergency room with a mental health diagnosis is those aged 15-24,

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

at 281.9 per 10,000. This rate declines with age with 75.2 per 10,000 for those aged 65-74 except those 85 and older (141.8).

Many participants expressed concern over feeling isolated, anxious, depressed, sad, or hopeless. According to recent data, nearly one-quarter (23.7%) of adults across Maine reported having experienced depression. Isolation has a significant impact on the health of older adults. This is even more pronounced for those in rural areas, those without caregivers, and those who live alone.

“I’m concerned about suicide, isolation, and mental health in older adults."

In 2019, the suicide rate per 100,000 people was 19.4 in Maine. This is significantly higher than the national rate of 13.9 during the same period. In Maine, these rates were the highest among those aged 45-54 (33.8) and 85 or older (26.6), and 75-85 (24.3) and 65-74 (21.9).

Participants expressed a need for more mental health specialists trained to treat older adult mental health issues. Participants expressed a desire for more health care providers that understood these additional needs of older adults that go beyond physical needs. They acknowledged the promise of emerging telehealth capabilities along with the challenge of mastering and accessing these new technologies.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified a general lack of providers, resources, and community support as ongoing challenges that impact Maine's older adults.

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

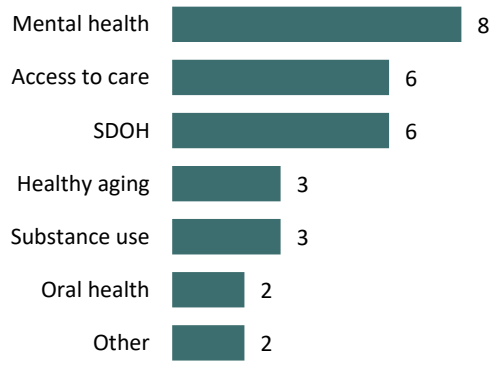
Table 40. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Good neighbors Volunteer programs Ability to make connections **Treatment** Licensed Clinical Social Workers Peer support programs and support groups **Law Enforcement** Local law enforcement check-ins **Resilience** Resilience	**Barriers to Treatment** Long wait times Research not translated into practice Not covered by Medicare Diagnosis of underlying conditions Isolation Interconnection with SDOH issues Rural state COVID Not enough support in the community Stigma **Providers** Lack of providers, generally (2) Lack of providers with training in older adult mental health (2) Not enough resources for older adult medication needs Medication misuse **Coordination** Fragmented system **Law Enforcement** Law enforcement needs training for mental health crisis

PEOPLE WITH A MENTAL HEALTH DIAGNOSIS

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.[60] Mental illness can affect anyone regardless of racial or ethnic identity; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or any other characteristic. Mental illnesses include many different conditions that vary in degree of severity. Severe Mental Illness is a subset of mental illness that affects fewer people but may be disabling and general requires more intensive professional care and case management.[61]

Figure 15. Priority Areas – People with a mental health diagnosis.



Depression and anxiety have been used as proxies for the general prevalence of mental health disorders, even though they are only a subset of these disorders. According to the results from the Maine Behavioral Risk Factor Surveillance Survey, in 2017, almost 1 in 10 adults in Maine (9.6%) reported having current symptoms of depression and 1 in 5 (21.8%) experienced anxiety in their lifetimes. Nationally, nearly 1 in 5 adults live with a mental illness.[62] Globally, depression is one of the leading causes of disability.

Mental illness is associated with increased premature death, including by suicide, which is the second leading cause of death among 15-29-year-olds. People with severe mental health conditions die prematurely – as much as two decades early – due to preventable physical conditions.

Due to the diverse nature of conditions and those who are affected, the diagnoses and treatment of mental illness require a nuanced, skilled, and individually tailored approach. Many mental health conditions can be effectively treated at a relatively low cost, yet the gap between people needing care and those with access to care remains substantial. People with mental health conditions often experience human rights violations, discrimination, and stigma, which can further impede treatment.[63]

The Consumer Council System of Maine (CCSM) is responsible for bringing an independent and effective consumer voice into mental health public policy, services, and funding decisions. CCSM consists entirely of past/present recipients of mental health services. To assist in engaging with those who have lived experience, MSCHNA partnered with the CCSM to host an event on October 14, 2021. The event was attended by 16 participants.

The three priorities that were identified and discussed at this event included:

- Mental Health (53%)
- Access to Care (40%)
- Social Determinants of Health (40%)

[60] Centers for Disease Control and Prevention, last accessed 4/19/2022: https://www.cdc.gov/mentalhealth/index.htm
[61] National Institute of Mental Health, last accessed 4/21/2022: https://www.nimh.nih.gov/health/statistics/mental-illness#:~:text=Mental%20illnesses%20are%20common%20in,(52.9%20million%20in%202020).
[62] Ibid (NIH)
[63] World Health Organization, Mental Health, last accessed 4/19/2022: https://www.who.int/health-topics/mental-health#tab=tab_1

Three other priorities tied for fourth place. These included **Older Adult Health**, **Health Care Quality**, and **Substance and Alcohol Use**. Due to the limited amount of time during this one 2-hour event, participants were unable to explore these priorities more deeply.

Participants also noted the lack of data specific to those with a mental health diagnosis. The lack of integration of mental and physical health data, and incomplete social or demographic data in some data sets limits the ability to cross-reference health outcomes by subpopulations or health conditions. Additional steps are needed to enhance the data available for this population.

MENTAL HEALTH

KEY TAKEAWAYS

Mental health was identified as a top priority in every outreach effort and is one of the four top statewide priorities. Participants expressed concern that COVID-19 has created a new mental health crisis even as it has been an area of high concern for many years, and a priority in previous MSCHNA cycles. We await updated data that reflects new trends during the pandemic.

Individuals with a mental health diagnosis identified barriers that have prevented them from receiving the care they needed to address their mental health. Almost half (47%) of all participants indicated the usage of the **emergency room for mental health issues** as an indicator of concern. In 2018, the rate of visits to the emergency room related to mental health issues was 170.6 per 10,000 population in Maine.

Participants also noted concern for **youth mental health**. For instance, the rate of visits to the emergency room related to mental health issues was 281.9 for 15-24-year-olds in 2018. This is a significantly higher rate – almost twice as high – than the overall population. In 2017, 26.9% of high school students and 21.6% of middle school students reported feeling sad or hopeless for more than two weeks in a row. Additionally, 14.7% of high school and 16.1% of middle school students reported they had seriously considered attempting suicide during that same period.

Approximately one-fifth (18.0%) of Maine residents received outpatient mental health treatment between 2015 and 2017, while about a quarter (23.7%) reported having depression at some point throughout their lifetime. Participants commonly mentioned that wait times for mental health care providers were excessively long.

Participants conveyed the perception that traditional methods of addressing those with a mental health diagnosis in the community were not working. For example, one participant noted police involvement as a gap or barrier, and that people do not always know their rights. Others noted a general lack of options to address acute situations within both the community and clinical settings.

"A lot of traditional mental health services are not working, so let's look at alternatives. Let's look at social factors instead of pumping money into pharmaceuticals."

Compounding these issues was a feeling that not only is there a scarcity of available, highly skilled mental health care providers, but that it was difficult to find the right care and that the cost of the care is too high.

"[Increased services like case management and supportive/wrap-around services are] so important to people's health care."

Other challenges included lack of transportation and the prevalence of the chronic disease among people with depression. In Maine, 34% percent of adults who have reported current symptoms of depression also have three or more chronic conditions. This has shown an increase from 29% in 2011, although not significantly.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified accessing treatment, quality of treatment, and a lack of peer support as ongoing challenges or needs that impact individuals with a mental health diagnosis.

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

Table 41. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community-based Treatment Peer recovery community (vastly underutilized) Alternatives to crisis services/hospitalizations	**Barriers to Care** Treatment for children (2) Long wait times for services (2) Cost of care Lack of options Mental health facilities are cold/sterile Daily Living Supports no longer exists - barrier to becoming more independent Lack of peer support/peer centers (2) Transportation **Providers** Losing counselors to the private sector Highly trained/qualified psychiatrists **Awareness/Advocacy** Knowing how to find programs People not aware of rights/Knowing your rights Lack of advocacy opportunities **Law Enforcement** Police involvement

ACCESS TO CARE

KEY TAKEAWAYS

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.[64]

One of the top concerns noted by participants was the lack of people covered by insurance. The rate of uninsured in Maine was 8% in 2019, which

[64] 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

was lower than the national rate of 9.2% that same year. MaineCare enrollment for all ages was 29.1% of adults and 43.8% of children ages 0-19 in 2020. Nationally, Medicaid (MaineCare's federal name) enrollment rate is 24.1% in 2020.

The rate of insured, as well as the type of insurance (MaineCare, Medicare, private, or other), can greatly impact the types of services that are covered by insurance and a patient's out-of-pocket expenses.

Cost of care was identified by 40% of participants as a priority health indicator and a major barrier to accessing care. Across the state, 11.7% of individuals reported that there was a time in the last 12 months when they needed to see a doctor, but could not due to cost in 2017.

The connection between physical health and mental health was highlighted during discussions. Indicators that concerned participants included adults with a usual primary care provider (87.2%) and adults who saw a primary care provider within the last year (71.3%) in 2017.

Another concern was the distance needed to travel for care. In Maine, 1 in 5 people (20%) needed to travel over 30 miles from home for a primary care visit. These long distances were mentioned as particularly challenging for those with limited options for transportation.

Participants commented on the wait times associated with receiving mental health care in the state. Participants stated that these waitlists are often very long and prevent them from receiving the care they need promptly. Participants also noted the need for highly skilled, trained, and qualified psychiatrists. Overall in Maine, there is one psychiatrist for every 12,985 people. In some rural counties like Aroostook, this number climbs to 64,856, reflecting even less availability, and more people a single provider could potentially need to serve. Higher ratios potentially impact wait times and timeliness of care.

"Let's look at alternatives. Let's look at social factors instead of pumping money into pharmaceuticals."

Community members with a mental health diagnosis also perceived that traditional means of addressing health care needs may not be sufficient and encouraged the use of alternatives such as increased case management, supportive services, and wrap-around services.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Community members identified affordability of care, lack of access to technology, and a lack of offered services as ongoing challenges or needs that impact individuals with a mental health diagnosis.

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

Table 42. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
Access Alternatives Self-referrals for services Peer support groups	**Barriers to Care** Lack of universal healthcare Transportation barriers (2) Lack of broadband/smartphone for telehealth Location **Missing Services** Lack of vision care Lack of dental Lack of nutrition services

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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[65]. Differences in social determinants can create disparities that impact vulnerable populations and rural residents alike.

Forum participants identified a variety of factors in their day-to-day lives that are affecting both their health and their ability to access the care they need. This includes a multitude of issues such as poverty, unemployment, housing insecurity, and access to broadband internet and a vehicle.

"[Social determinants of health are] so important to people's health care."

In Maine, 10.9% of adults and 13.8% of children live in poverty in 2019. In some of Maine's more rural counties, the rate of adults living in poverty can be higher. For instance, 20.4% of adults in 2015-2019 and 64% of children in 2021 in Somerset County lived in poverty.

Participants identified both access to broadband internet and a vehicle as priority health indicators (40% of votes, each). In Maine, 88.6% of residents have access to broadband internet in 2017. This is lower than the national rate of 90.4% and can vary widely across the state, such as 99.9% of Androscoggin County residents compared to 41.8% of Piscataquis County residents who have broadband access.

According to recent data, Maine also has a lower proportion of households where no one owns a vehicle compared to the U.S. (2.1% vs 4.3%, respectively). However, several participants still noted transportation as a need. This could indicate several other barriers including reliability, affordability for repairs, insurance, and fuel, as well as the possibility of a limited number of vehicles to meet household needs. Maine also lacks a coordinated and well-connected public transportation system.

Other social risks noted by participants included people 65 and over living alone, housing insecure youth, and adverse childhood experiences (ACEs).

[65] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community members identified housing affordability, access to education, and food security as ongoing challenges or needs that impact individuals with a mental health diagnosis.

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

Table 43. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Dedicated providers working with little resources Organizations trying to provide grants, education **Community Cohesion - Continued** Organizations teaching against discrimination Peer supporters **Substance Use Recovery** Recovery/reintegration coaches	**Housing** Lack of affordable/stable housing (2) **Education** Access to affordable colleges **Food** Lack of healthy food/food security **Equity** Sexism Discrimination Racism Homophobia **Environment** Pollution **Poverty** Lack of level wage **Public Safety** The prison model is based on punishment, not rehabilitation Violence

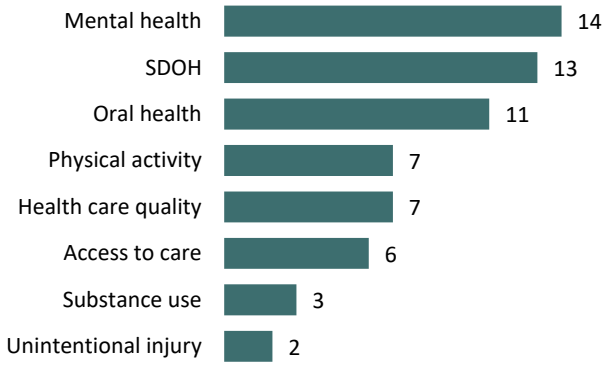
PEOPLE WITH DISABILITIES

People are not defined by their disability. Like gender and ethnicity, disability is merely a human characteristic; a natural part of the human experience. A disability does not imply a lack of ability or contribution.

"Disability is not a brave struggle or 'courage in the face of adversity.' Disability is an art. It's an ingenious way to live." - Neil Marcus

One of the world's leading physicists published the record-breaking bestseller, *A Brief History of Time*, while paralyzed from ALS. Stephen Hawking offers just one example of the rich contributions made by members of our community who also happen to live with a disability.

Figure 16. Priority Areas – People with disabilities.



In Maine, it is estimated that 340,215 adults, or 1 in 3 adults, have some form of disability. As defined by the U.S. CDC, there are six disability types. **Mobility** is defined as having serious difficulty walking or climbing stairs. It is estimated that 13% of adults have mobility difficulties. **Cognition** disability is defined as having serious difficulty concentrating, remembering, or making decisions. It is estimated that 14% of adults in Maine have cognition difficulties. **Independent living** disability is defined as having serious difficulty doing errands alone, such as visiting a doctor's office. It is estimated that 9% of adults experience independent living difficulties. **Hearing** disability includes deafness or serious difficulty hearing. Eight percent (8%) of adults experience hearing difficulty. **Vision** disability includes blindness or serious difficulty seeing, even when wearing glasses. An estimated 5% of the adult population has vision difficulty. **Self-Care** disability type is defined as having difficulty dressing or bathing. It is estimated that 4% of adults in Maine have a self-care disability type.[66]

One of the challenges for anyone living with any one of these types of disabilities is that our society is often not designed in a way to accommodate their unique needs. This includes the need for inclusionary policies that take into account transportation and mobility, language accessibility, physical and programmatic access, and living supports.

It can be harder for disabled populations to maintain good health due to facing additional barriers that the general population does not. According to the U.S. CDC, 38% of adults in Maine with a disability are obese, compared to 28% of adults without a disability. Similarly, 31% of Maine adults with a disability smoke, compared to 14% of those without a disability. Rates of diabetes and heart disease are also higher among those with a disability (14% and 11%, respectively).[67]

The Maine Shared CHNA worked with Disability Rights Maine to engage with members of the disability community to help us better understand the health priorities and the related gaps and barriers which drive these disparities. Disability Rights Maine advocates for people with disabilities. The event was held on September 16, 2021, and was attended by 20 people. The five priorities identified during this event were:

- Mental Health (70%)
- Social Determinants of Health (65%)
- Oral Health (55%)

[66] https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/maine.html.
[67] Ibid.

- Health Care Quality (35%)
- Physical Activity, Nutrition, and Weight (35%)

Due to limited time during this one 2-hour event, participants were unable to explore the topic of Physical Activity, Nutrition, and Weight more deeply. Any comments on this topic are included in the Social Determinants of Health section.

It should be noted that not all data sources collect a full set of social or demographic data. In addition, some sub-populations experiencing health disparities are small, resulting in data that is less reliable due to low numbers or unavailable due to privacy concerns. These limitations have reduced the number of data points available for publication of county or state-level data.

MENTAL HEALTH

KEY TAKEAWAYS

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.[68]

Participants noted several barriers to accessing mental health care. The first was the number of providers who do not accept MaineCare. MaineCare is a means-tested program that provides safety-net services for vulnerable populations. MaineCare also has additional options for coverage for people with disabilities and certain health conditions. Due to these provisions, MaineCare is often a primary source of insurance coverage for community members. MaineCare does cover behavioral health services, however, with a lack of providers and an increasing demand for service, many providers can choose between clients with private or employer-sponsored insurance that have higher reimbursement rates for services than clients with MaineCare.

Another barrier noted by participants is the irony of having to prove their disability to receive services, while their disability itself created challenges in being able to follow the process to do so. Participants expressed concern about provider bias, discrimination, and overall lack of training in providing care for those with a disability.

"People need to be more comfortable talking to people with different disabilities - with different ways of feeling and communicating."

Suicidality was also mentioned by participants as a concern. While there is no specific data by disability status, we do know that in Maine overall there were 19.4 **suicides** per 100,000 population in 2019. This is higher than the national rate of 13.9. The other intentional injury discussed was **domestic violence**. Again, referencing data from Maine overall using combined data over 4 years, the percentage of violence by current or former intimate partners was 1.5% per year in Maine.

Telehealth was identified as a potential solution by participants. It was also noted that to access services using telehealth, individuals need broadband access, and a certain level of technical savvy to understand how to use the equipment. For some people with disabilities this may also require special adaptive devices.

Participants noted positive experiences with the Behavioral Health Home (BHH) model. Health homes help patients manage their physical and behavioral health needs such as securing housing and helping clients reach their goals.

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

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified a lack of providers and specialists, waitlists, and discrimination as ongoing challenges or needs that impact individuals with disabilities.

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

Table 44. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Treatment Telehealth Behavioral health home model Case management for adults	**Providers** Providers don't accept MaineCare Lack of providers & specialists (4) Undertrained case managers **Barriers to Treatment** Waitlists (4) Lack of care coordination (2) Social isolation **Poor Quality Care** Individuals with disabilities are dismissed/not well cared for Shaming people/Victim blaming Having to prove disabilities/difficulties Discrimination A one-size-fits-all approach to care Some specialists do not accept Medicare

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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[69]. Differences in social determinants can create health disparities that impact vulnerable populations and rural residents alike. The challenges in finding safe, affordable, and accessible housing, employment, and living in poverty were among the social determinants of health mentioned by participants.

Adverse Childhood Experiences (ACEs) were one of the top concerns among participants. ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. Participants noted the association between children with disabilities and a heightened risk of experiencing ACEs. This association could be related to the social isolation and stigma

[69] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

experienced by children with special healthcare needs.

Maine is a rural state which lacks a robust public **transportation** system. Participants also noted that for many, their disability prevents them from driving a car. This immobility prevents physical access to the community to meet the demands of everyday living. This included employment, access to healthy food, making appointments, and socialization.

Housing and **homelessness** were also concerns expressed by participants As of January 2020, Maine had an estimated 2,097 experiencing homelessness on any given day.[70] Almost one-third of participants (28.6% or 6 out of 21) identified **housing costs** as the second priority health indicator. Between 2015-2019, 12.0% of Mainers paid more than 50% of their income toward housing. In addition to housing stability and affordability, participants also mentioned a statewide lack of safe, affordable, and accessible housing.

"Concerned with care moving to telehealth. It can be challenging with broadband access and use of the technology."

Among the gaps or needs of SDOH, participants noted concerns related to care moving towards a **telehealth delivery model**. In particular, participants noted challenges in using the technology and a lack of broadband access.

Another health priority area mentioned was **Physical Activity, Nutrition, and Weight**. There was a lack of time to explore this topic more deeply. As mentioned earlier, according to the U.S. CDC, 38% of adults in Maine with a disability are obese, compared to 28% of adults without a disability. Similarly, rates of diabetes and heart disease are also higher among those with a disability (14% and 11%, respectively).[71]

Participants did express frustration with the lack of data for those living with a disability and the rate at which they experience food insecurity. **Food insecurity** is associated with being overweight or obese. This aligns with participants' concerns about housing, employment, and living in poverty. Eating on a budget often means purchasing pasta and highly processed foods which are cheaper than fresh fruits, vegetables, and fresh, lean protein. Participants also noted the connection offered by local churches and community organizations. These community assets often provide or distribute resources such as food and clothing.

[70] United States Interagency Council on Homelessness, Maine Homeless Statistics. Last accessed 4/15/2022: https://www.usich.gov/homelessness-statistics/me/
[71] Ibid.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community members identified poverty, discrimination, and language barriers as ongoing challenges or needs that impact individuals with disabilities.

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

Table 45. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Local community orgs/churches distribute resources Informal help	**Poverty** Poverty Unemployment **Transportation** Transportation for people with disabilities (11) **Housing** Affordable/accessible housing & rising costs Homelessness **Equity** Discrimination Racism Language barriers Physical access within the community **Barriers to Services** Access to legal intervention and the judicial system to address violence and domestic violence Telehealth access (broadband issues, rurality, poverty) **Violence** Violence/domestic violence prevention and intervention

ORAL HEALTH

KEY TAKEAWAYS

Oral health was identified as a top health priority by event participants.

Oral health refers to the health of the teeth, gums, and the entire oral-facial system that allows us to smile, speak and chew. Some of the most common diseases that impact our oral health include cavities (tooth decay), gum (periodontal) disease, and oral cancer. Oral conditions are frequently considered separate from other chronic conditions, despite being connected. For instance, poor oral health is associated with other chronic diseases such as diabetes and heart disease.

Tooth decay is one of the most common and preventable chronic diseases.[72]

Participants noted the overuse or misuse of the emergency department for oral health care. Unfortunately, options for dental care in the emergency departments are often limited to pain management or extraction. In 2016, almost 1 in 5 Maine adults (19.5%) have lost 6 or more teeth due to decay or gum disease. In 2019, 80.3% of children were covered by dental insurance. There were 62.6% of insured children with at least one preventative dental visit that same year. These data are unavailable by ability status.

"There's a long history of people with disabilities having poor oral health. ... Sensory issues can make receiving oral health care more difficult. It can be done, but it takes more effort."

Participants acknowledged the obstacles facing those with disabilities when it comes to oral health care. This includes mobility and transportation barriers to getting to appointments and into dental chairs. It also includes finding a provider who is willing to treat them or is trained and experienced in treating them.

COMMUNITY RESOURCES TO ADDRESS ORAL HEALTH

Community members identified oral healthcare quality and access as ongoing challenges or needs that impact individuals with disabilities.

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

Table 46. Gaps/Needs and Available Resources (Oral Health)

AVAILABLE RESOURCES	GAPS/NEEDS
	Healthcare Quality Better training for providers **Access** Dental care is too expensive (2) MaineCare does not cover adults (2) Lack of providers even for people with insurance Discrimination Educating providers regarding: communication and care for individuals with disabilities

[72] U.S. CDC Oral Health. Last accessed 4/26/2022: https://www.cdc.gov/oralhealth/conditions/index.html

HEALTH CARE QUALITY

KEY TAKEAWAYS

The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Quality measurements include effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness.[73]

The top concerns regarding healthcare quality expressed by participants related to patient-centeredness. Participants noted a need for training and discussion on best practices in communicating with individuals that may have intellectual or developmental disabilities, communication, or sensory barriers. This includes not only facility accessibility, but the use of other equipment necessary to provide equitable care like the ability to weigh a patient who uses a wheelchair. There is also a need for longer appointment times to meet the physical and intellectual needs of this population.

Participants noted the use of the emergency department to treat conditions that are usually addressed in a primary care physician's office. In Maine, the rate of those seeking treatment in the emergency department for ambulatory care sensitive conditions between 2016-2018 was 282.5 per 10,000 people. There are significant differences between counties. For instance, in Washington County, the rate is 592.8, while in Cumberland County the rate is 191.0 during the same period. These data are unavailable by ability status.

This rate can be affected by many factors including lack of insurance, access to preventative care, or putting off seeing a doctor due to cost. For those who live with a disability, this could also indicate the limited number of providers providing the type of patient-centered care they need. In addition, while more of an Access to Care measurement, participants also noted the challenges in accessing specialty care such as pediatrics and mental health providers.

"One barrier is not accepting the family as part of the individual's care team. The family is a resource - they certainly have information that can be useful."

Participants shared their experiences of being dismissed by the provider when trying to communicate their needs or the provider speaking to the guardian or family member present, instead of to them.

Assets or resources that were working or could work included medical providers accepting supported decision-making agreements, shared decision-making models, medical home models, and reimbursements for transportation through MaineCare.

[73] Agency for Healthcare Research and Quality. Last accessed 4/26/2022: https://www.ahrq.gov/patient-safety/quality-resources/tools/chtoolbx/understand/index.html

COMMUNITY RESOURCES TO ADDRESS HEALTH CARE QUALITY

Community members identified a lack of trusting relationships with providers, overuse of the emergency room, and lack of quality time with providers as to ongoing challenges or needs that impact individuals with disabilities.

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

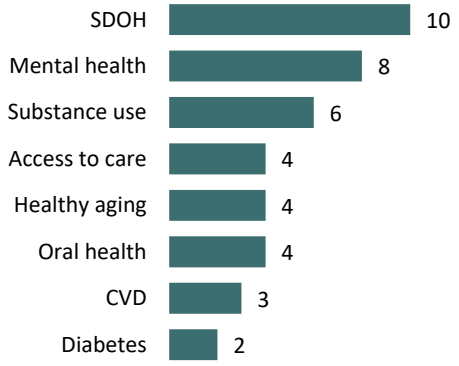
Table 47. Gaps/Needs and Available Resources (Health Care Quality).

AVAILABLE RESOURCES	GAPS/NEEDS
Providers Good relationships/ dialogue with providers Shared decision making (program by Pat Deegan) Supported Decision-Making agreements **Access Issues** Reimbursement for transportation through MaineCare	**Providers** Lack of trusting relationships w/ providers Lack of education for providers to understand disabilities (5) No team/family approach No medical home Providers that rush **Access Issues** Inaccessible medical equipment Emergency department overuse

PEOPLE WITH LOW-INCOME

Individuals with low income, including those who live in poverty, exist in every community. Low income and living in poverty are social risk factors that affects the ability for people to eat healthy foods, access healthcare, and live in safe, stable housing. More generally it is associated with poor health and are two of several social risk factors.

Figure 17. Priority Areas – People with low income.



There are a number of ways to measure poverty and economic security. One way people are characterized as living in poverty is when the total income of the householder's family is below the established federal poverty level. For a family of four, that would be $25,926 a year or $498 a week.[74] Income data is also available that describes the percentage of individuals living in poverty (11.8%) as well as the percentage of children ages 0-17 living in poverty (13.8%) in Maine. These data are from between 2015-2019.

Another way to view economic capacity is to consider the median household income. This is defined as the dollar amount that splits all households into two equal groups, using the median, or middle number when all income is listed in order, as the dividing line. In 2019, that number was $57,918 in Maine compared to $65,712 across the U.S.

Both poverty rates and median household income can vary widely from county to county and town to town, and even neighborhood to neighborhood. These differences in income are associated with an increase in health disparities. Those with low income experience higher rates of poor health outcomes such as diabetes, obesity, and poor mental health.

To better understand the health priorities for those with low income, the Maine Shared CHNA partnered with the Maine Primary Care Association (MPCA) to host a community event. MPCA is the statewide champion for Maine's Federally Qualified Healthcare Centers (FQHC's). FQHC's primary mission is to provide care to medically underserved in high need communities, regardless of ability to pay. Governing Boards are made up of no less than 51% of their consumers. Of the 206,211 patients served by 19 MPCA health centers in 2018, 68% were low income, 9% identify as an ethnic or racial minority, 5% were veterans, and 3% were homeless. Learn more about MPCA's impacts here. MPCA recruited leaders and staff from their member healthcare centers to discuss the health priorities, gaps and barriers experienced by their clients. The event was held on September 23, 2021. The event was attended by 22 participants. There were three clear top priorities chosen during this event:

- Social Determinants of Health (45%)
- Mental Health (36%)
- Substance and Alcohol Use (27%)

There were three priorities that tied for fourth place: Access to Care, Older Adult Health, and Oral Health with 18% of participants voting for each. Given their relevance to those served by Maine's FQHCs, these priorities are discussed together as, "Other Identified Priorities."

[74] U.S. Census Poverty Thresholds, last accessed 4/19/22: https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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[75]. Differences in social determinants, or social risk factors, can create disparities that impact vulnerable populations and rural residents alike.

Participants from the state's low-income population identified several social risk factors in their daily lives that affect both their health and ability to meet the needs of daily living.

"There is a lack of transportation in rural areas and a lack of access to healthy food resources."

Nearly one-third (28.6%) of participants identified poverty as a concerning health indicator.

The same number of participants (28.6% or 6 out of 21) identified **housing costs** as the second priority health indicator. Between 2015-2019, 12.0% of Mainers paid more than 50% of their income toward housing. Housing costs can vary widely from county to county. For instance, in 2015-2019, the Somerset County median household income was $44,256 and 13.3% of households spent more than 50% of their income on housing. In Cumberland County, the median household income was $73,072 and 12.8% of households spent more than 50% of their income on housing. In this example, while there is a similar percentage of those who spend more than 50% or more of their household income on housing, there is a large difference in the amount of funds left over for daily living expenses.

Another third (28.6%) of participants identified adverse childhood events (ACEs) as a concern. While typically considered a risk factor for mental health, participants noted ACE's impacts on other factors. ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. In 2019, 21.3%, or 1 in 5, high school students reported having experienced four or more ACEs.

Other indicators of concern included the percentage people living in rural areas (66% in 2019) and adults 65 and living alone (29.9% in 2019%).

[75] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community members identified access to food, poverty, and transportation as ongoing challenges or needs that impact the low-income community.

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

Table 48. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Food Food shelf at FQHCs for patients to have healthy foods Good Shepherd Food Bank **Screening** PREPARE screening tool	**Poverty** Poverty (3) **Transportation** Lack of public transportation, especially in rural areas. (7) **Food** Lack of reimbursement to increase access to food Food insecurity (3) **Economic Security** Lack of staff/unemployment

MENTAL HEALTH

KEY TAKEAWAYS

Mental health was the second priority identified among the low-income group. It was also identified as a top health concern in every county in the state and among other underserved community groups. 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.[76]

The availability of mental health providers was the most frequently mentioned indicator related to mental health. Nearly one-third (28.6%) of community members noted the low availability of mental health providers across the state both for inpatient and outpatient care. They also shared their experiences with long waitlists to access mental health care services.

The stigma associated with receiving mental health services was mentioned as a barrier to accessing these services. Participants also noted the need for mechanisms for improving communication between primary care and behavioral health providers.

Emergency Department usage to address mental health needs was identified by 28.6% of community event participants as a concern. The rate of those seeking **mental health care in the emergency department** in Maine overall is 170.6 per 10,000 population in 2018.

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

Participants also noted concern for **youth mental health**. For instance, the rate of visits to the emergency room related to mental health issues was 281.9 for 15-24 year olds in 2018. This is a significantly higher rate – almost twice as high – than the overall population. In 2017, 26.9% of high school students and 21.6% of middle school students reported feeling sad or hopeless for more than two weeks in a row. Additionally, 14.7% of high school and 16.1% of middle school students reported they had seriously considered attempting suicide during that same time period. These data are not available by income level.

"Teen hopelessness travels into adulthood and tools are lacking for parents and kids."

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

The data show a health disparity for those reporting 14 or more days lost due to poor mental health by income. For those earning under $15,000, the percentage was 34.8% in 2017. These percentages decrease with each increasing income bracket. For those earning $75,000 or more, the percentage is 6.1% in 2017. This pattern is similar for the percentage of adults with current symptoms of depression, having ever had an anxiety diagnosis, and currently receiving outpatient mental health treatment. As with any population experiencing a health disparity, 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.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified a lack of providers, stigma surrounding mental health, and lack of communication between providers as to ongoing challenges that impact the low-income community.

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

Table 49. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Telehealth	**Providers** Lack of providers (4) **Barriers to Treatment** Stigma to access services Lack of education Recordkeeping barriers b/w primary care/behavioral health

SUBSTANCE AND ALCOHOL USE

KEY TAKEAWAYS

Substance and alcohol use was selected as a top priority in the low-income community. It was also identified as one of the top health concerns in all the counties in the state and among other underserved communities. Recurring use of alcohol and/or drugs can cause clinically significant impairment, 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.[77]

"The number of overdoses that weren't fatal is going up. The problem is increasing but there is value in the tool (Narcan) that is being utilized."

Community event participants expressed concerns about multiple drug and alcohol use health indicators. Overdose deaths were mentioned by 33.3% of event participants as a health indicator of concern. In 2020, the rate of overdose deaths per 100,000 population in Maine was 37.3, a significant increase from 28.2 in 2016. These numbers are not available by income.

Table 50: Overdose Deaths by Year.

YEAR	NUMBER
2016	378
2017	417
2018	354
2019	380
2020	502
2021	633*

*Preliminary number from the Office of the Chief Medical Examiner

Participants noted changing societal norms around drug use and increased access, especially for marijuana and alcohol, coupled with a lack of early intervention and education. The data show a significant difference in past-30-day marijuana use between lower and higher income brackets. In 2017, 27% of those earning less than $15,000 reported using marijuana in the past 30 days, compared to 11.1% of those earning $75,000 or more. The differences in use correspond with each subsequent increase in income brackets. In short, those who earn less report higher rates of marijuana use.

Alcohol consumption follows a different pattern by income. In 2017, 21.3% of those earning $75,000 or more reported binge drinking, a significant difference from the 11.3% of those earning less than $15,000 who reported binge drinking. These differences in use correspond with each subsequent decrease in income brackets. In short, those who earn more report higher rates of binge drinking. The percentage of adults who report chronic heavy drinking also show differences by income bracket, with higher wage earners reporting more chronic heavy drinking, but the pattern is not as clear.

There is no data on alcohol-induced deaths, alcohol-impaired driving deaths, nor drug-affected infants by income. The data shows no significant difference in past-30-day misuse of prescription drugs by income, with 1.3% of adults who misused prescription drugs in 2017.

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

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Community members identified lack of treatment options and long waitlists for services as ongoing challenges or needs that impact the low-income community.

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

Table 51. Gaps/Needs and Available Resources (Substance and Alcohol Use)

AVAILABLE RESOURCES	GAPS/NEEDS
Low barrier services Sacopee has a strong focus on Medication-Assisted Treatment	**Treatment** Lack of providers (2) Long wait lists for case managers

OTHER IDENTIFIED PRIORITIES

KEY TAKEAWAYS

Participants noted with equal concern Access to Care, Oral Health, and Older Adult Health as their fourth priority. Given that many low income Mainer's are impacted by all three of these areas, below is a snapshot of these health priority areas.

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 coverage, services, timeliness, and workforce.[78] It should be noted many FQHC's in Maine provide dental care, hence access to Oral Health is also considered as an Access to Care issue for these participants.

Adults aged 65 and older make up a growing percentage of the population in Maine. In 2019, 21% or 1 in 5 Mainers were 65 or older. This is expected to increase to 1 in 4 by the year 2030. Maine's rural counties are home to a greater proportion of older adults.

Cost barriers to care were the most frequently identified health indicator related to access to care, mentioned by 28.6% of community participants. In 2015-2017, 10.6% 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.

Unsurprisingly, there is a significant difference among those who report **cost barriers to care by income level**. In 2017, 18.1% of those earning less than $15,000 compared to 4.7% of those earning $75,000 or more reported this barrier.

A **lack of health insurance** was the third most frequently identified health indicator mentioned by low-income community members. The percentage of those reporting they currently have **no insurance** was 8% in Maine and 9.2% nationally in 2019.

There are four primary means of obtaining health insurance: Medicaid (known and MaineCare in Maine), Medicare, employer sponsored private insurance, or non-group coverage, typically

[78] 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.

obtained through the Affordable Care Act's Marketplace.

One in three (29.1%) Maine adults were enrolled in **MaineCare** in 2020 compared to 24.1% nationally. MaineCare is a means tested safety net program, meaning to be eligible, you must show proof of limited income and resources. As a federal and state funded program, enrollment eligibility and services can differ between states.

While people 65 and older have access to **Medicare**, there are limits to that coverage. Those coverage limits can create out-of-pocket costs. For those that are retired these costs can have a significant impact on household budgets. There was also recognition of the overall complexity of the healthcare/health insurance system and it is difficult for some to navigate alone.

"There's a lack of providers across the board. People are utilizing the emergency room for primary care needs."

Participants also noted concern over access to primary care. In Maine, there is a significant difference between the percentage of adults who had a regular physical exam in the past year based on insurance status. This ranges from 85.5% of those who report 'Other' type of insurance, 83.5% covered by Medicare, 71.7% with private insurance, 70% with MaineCare, to only 35.7% for those who are uninsured.

For adults without access to preventative dental care, this can mean higher rates for dental emergency care. Unfortunately, options for dental care in the emergency departments is often limited to pain management or extraction. In 2016, almost 1 in 5 Maine adults (19.5%) have lost 6 or more teeth due to decay or gum disease.

In 2019, 80.3% of children were covered by dental insurance. There were 62.6% of insured children with at least one preventative dental visit that same year.

"People's healthcare is focused on emergency services, rather than preventative care."

There is also disparity between adults who report they have a usual primary care provider based on income. In 2017, 84.7% of those who earn $35,000-$49,000 compared to 92.4% of those who earn over $75,000 report they have a usual primary care provider. There is a similar disparity for primary care visits in the past year. In 2017, 67.5% of those who earn $35,000-$49,000 compared to 76.7% of those who earn over $75,000 report they have had a primary care visit in the last year.

Participants noted barriers 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 and other online services more difficult to implement. Participants also noted the overuse or misuse of the emergency department for preventative or routine care.

Long-distance travel to see a provider was identified as a top priority among the low-income community. While transportation is typically discussed as a social determinant of health, lack of transportation is a real barrier to all modes of care.

In 2019, 20.0% (1 in 5) Maine residents had to travel more than 30 miles to be seen by a primary care provider. According to recent data, Maine also has a lower proportion of households where no one owns a vehicle compared to the U.S. (2.1% vs 4.3%, respectively). However, a number of participants still noted transportation as a need. This could indicate a number of other barriers including reliability, affordability for repairs, insurance, and fuel, as well as the possibility of a limited number of vehicles to meet household needs. Maine also lacks coordinated and well connected public transportation system. For older adults who rely on family or caretakers for transportation, this is also particularly challenging to coordinate transportation and appointments. These data are not available by income.

COMMUNITY RESOURCES TO OTHER IDENTIFIED PRIORITIES

Community members identified a lack of providers as an ongoing challenge or need that impacts the low-income community.

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

Table 52. Gaps/Needs and Available Resources (Other Identified Priorities)

AVAILABLE RESOURCES	GAPS/NEEDS
Access to Care None listed **Oral Health** Dental program at UNE **Older Adult Health** Area Agencies on Aging	**Access to Care** Lack of providers (3) Lack of social workers **Oral Health** Lack of providers Not enough people covered by dental insurance **Older Adult Health** Lack of staff/unemployment Lack of long term care Lack of home care Stigma around cognitive impairment/aging Lack of community support No Program for All-inclusive Care for the Elderly (PACE) programs

YOUTH

There are approximately 146,519 young people aged 10-24 in Maine, which is 10.9% of the total population during the 2015-2019 time period. This is approximately the same number of people who live in all of Franklin, Lincoln, Piscataquis, Sagadahoc, and Washington Counties combined. One of the overarching themes from participant's input was that despite making up 10.8% of Maine's population, young people are under-represented in leadership roles and in decision-making processes that affect them.

The other piece participants wanted people to understand is that 'youth' is not a homogenous group just due to age. "Youth" or young people reflect the full spectrum of diversity present in Maine's overall population. The one commonality is that for young people, this is a time of rapid developmental transition to adulthood that includes changes in the brain and body, and is a time for healthy exploration of identity and learning independence.[79] It can also be a stressful or challenging time for teens because of these rapid changes. Young people also seek supportive environments and people who understand their journey towards growing independence and gaining power over their agency.

To gain insight into young people's views on health and healthcare, the Maine Youth Action Network (MYAN) hosted an event on November 18, 2021. MYAN's vision is for communities throughout Maine to foster the healthy development of youth and create a thriving network of engaged leaders. This out-of-school event had 30 participants. The top four health priorities identified during this event included:

- Access to Care
- Mental Health
- Social Determinants of Health
- Oral Health
- Health Education

ACCESS TO CARE

KEY TAKEAWAYS

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.[80]

Participating youth indicated that access was a key barrier they had to overcome to receive the care they required. They often indicated that they didn't know where to find care or even where/who to ask for additional information on available resources.

In Maine, 57.2% of children ages 0-17 had **access to a medical home** during the 2018-2019 time period. This is significantly higher than the national rate of 47.7% during the same period. The medical home model helps to coordinate a patient's care across specialties, services, and supports.

Furthermore, youths indicated that health care was generally unaffordable and too time-consuming as most doctor offices were not geographically close enough to them.

An idea that found broad support was offering health services in school settings. This appears especially salient given that participating youth

[79] Youth.Gov, last accessed 4/20/2022: https://youth.gov/youth-topics/adolescent-health/adolescent-development
[80] 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

indicated they often have busy schedules, and that time was a frequent barrier to receiving the care they required.

There were 43.8% of Maine **children aged 0-19 enrolled in MaineCare** in 2020. Overall, 1 in 5 or 20% of all **primary care visits were more than 30 miles from a patient's home**, regardless of age.

When asked what they needed to be healthy, participants noted they needed trusted community members with whom to share their thoughts and opinions without fear of being judged. This appears to extend into the health care setting where they indicated a desire for providers that would actively listen and not be dismissive. This includes providing care that is tailored to the unique needs of young people in a trusted, confidential manner.

"People in the positions of power need to become aware of the power they have so they can make students feel more comfortable."

Participants also noted a desire to access healthcare without the need for parental consent.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Community members identified health care costs, long commutes to providers, social stigma, and a lack of education concerning mental health issues as ongoing challenges or needs that impact youth.

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

Table 53. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
School-based health clinics	**Cost Barriers** More affordable health care (2) Resources being too expensive Resources that are available to everyone, regardless of income Orthodontics not affordable **Transportation/Distance** Distance/transportation: Hospitals/ health services are far away Geographically closer doctor offices **Barriers to Care** Stigma and shame (2) Not knowing about services Time; busy schedules **Providers** Caring doctors who listen and are not dismissive **Medications** Need affordable and accessible medications

MENTAL HEALTH

KEY TAKEAWAYS

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.[81]

Concern for youth's mental health was expressed during every one of Maine Shared CHNA's outreach events. This was in response to data that shows 16.4% of high school and 19.8% of middle school students reported they had **seriously considered suicide** in 2019. Data also show that 32.1% of high school and 24.8% of middle school students reported feeling so **sad or hopeless for two weeks or more** in a row during the past 12 months that they stopped doing some usual activities.

When participating youth were asked to identify what they need to be healthy, many mentioned aspects related to mental health. This included a supportive community of people where they could share their thoughts, feelings, and emotions without judgment. Youth highlighted the connection between mental and physical health and the need to support both, especially through time spent outdoors.

When asked what was holding them back from achieving health, many indicated a lack of mental health services. In particular, the need for additional therapy options was broadly supported by participating youth. Many expressed the understanding that needing to work through trauma and daily life experiences through therapy and other mental health care services were or should be considered normal, and accessible to everyone regardless of cost. Given the busy lives of youths across Maine, many indicated that offering mental health services through school would be a good way to reach youth in most need of these services.

> *"A lot of people can't handle all their emotions and need someone to talk to, especially anyone who has had trauma in their past."*

Participants in the event hosted for and by the LGTBQ+ community expressed concern for youth who wish to explore their sexual orientation or gender identity in environments that are not supportive.

Stigma was also perceived as a significant barrier that they needed to overcome to receive the mental health care they required. They expressed feeling that asking for help is seen as shameful and a weakness.

> *"[We experience] stigma against the things we are feeling and being told we are too young to feel that way."*

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

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified the cost of therapy, access to medications and treatment options, and a lack of awareness of ongoing challenges or needs impacting youth.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities.

Table 54. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Spending time outdoors Letting things out, not holding things in	**Barriers to Treatment** Prioritize mental health. Free therapy! Lack of mental health resources A good, affordable therapist Eating disorder recovery/treatment Access to antidepressants, antipsychotics **Trauma** People have past trauma that needs to be addressed **Awareness** Speaking more about mental health Need to feel connected to people you are excited to be with

SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

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[82]. Differences in social determinants can create disparities that impact vulnerable populations and rural residents alike.

Participants expressed their perception that healthy living is multifaceted and extends beyond simply eating well and working out. They placed a particularly strong emphasis on the physical and mental connection of health and a high priority on one's ability to live within a community where they can openly discuss their issues.

As an example, the Search Institute has identified 40 positive supports and strengths that young people need to succeed. Half of the assets focus on the relationships and opportunities they need in their families, schools, and communities (external assets). The remaining assets focus on the social-emotional strengths, values, and commitments that are nurtured within young people (internal assets).[83]

[82] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

[83] Search Institute, last accessed 4/20/2022: https://www.search-institute.org/our-research/development-assets/developmental-assets-framework/

For those who work with young people, this is complimentary to preventing children and adolescents' exposure to adverse childhood experiences (ACEs). In Maine, 21.3%, or one in five, high school students report having experienced at least four out of nine **adverse childhood experiences** (ACEs). ACEs are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. The most commonly used list contains 10 events. Individuals who experience 4 or more of these events by age 17 double their risk of heart disease and cancer, increase the likelihood of becoming an alcoholic by 700 percent, and the risk of attempting suicide by 1200 percent. Events can include experiencing violence, abuse, or neglect.

Building on Developmental Assets provides opportunities for youth to engage in positive experiences, feel they are cared for and supported. As one example, for those who are encouraged to participate in decision making are more likely to thrive later in life.[84]

When asked what resources are currently lacking, the participating youth indicated that healthy foods should be made more available, especially to homeless individuals. They also recognized the stigma and shame to get 'handouts' and that it was embarrassing to ask for help. Yet, in 2021, more than 1 in 3 students (38.2%) enrolled in all grades were **eligible for free and reduced lunch**. Over 1 in 10 (13.2%) children ages 0-17 were **living in poverty** in 2019.

In Maine, 3.3% of high school students reported being **housing insecure**, meaning they usually do not sleep in their parent's or guardian's home in 2019.

School culture and learning opportunities were discussed. Participants recognized that different students may have different needs to have equitable access to resources and learning opportunities. For instance, allowing students with ADHD to use headphones to stay focused.

As for educational attainment, **Maine's high school graduation rate** is 87.4% in 2020, similar to the national average of 87.1% in 2019. Those who go on to attain an **associate's degree or higher** by age 25 or older were 41.9% in Maine during the 2015-2019 time period. This is similar to the national average of 41.7% in 2019.

[84] Search Institute (2020). The Intersection of Developmental Relationships, Equitable Environments, and SEL [Insights & Evidence Series]. Minneapolis, MN: https://www.search-institute.org/wp-content/uploads/2020/10/Insights-Evidence-DRs-DEI.SEL-FINAL.pdf

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community members identified the availability of food, education about minority populations, and accommodations for individuals with unique health needs as ongoing challenges or needs that impact youth.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities.

Table 55. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
	Food Food should be more available Homeless people can't get the food they need **Poverty/Income** Resources that are available to everyone, regardless of income **Equity** Accommodations in schools that acknowledge and account for individual health needs Hearing voices of those who are non-binary, gender-fluid

ORAL HEALTH

KEY TAKEAWAYS

Participants noted a lack of access to timely and affordable dental care. It was noted that when health services are promoted through school, like the dental clinics at Deering and Portland High School, youth are more likely to gain access. It was also noted that once students leave school, not everyone can get what they need elsewhere.

According to the Children's Oral Health Network of Maine, oral health is closely connected to overall health and well-being. Lack of oral health care in childhood contributes to serious and costly complications for health and economic stability later in life.[85]

In Maine, 80.3% of children and young people under the age of 21 are **covered by dental insurance**. Regardless of insurance status, whether MaineCare or commercial insurance, only 65.7% of children and young people had at least **one preventative dental visit in the past year** in 2019. The percentage of children and young people who had **at least one dental claim** in 2019 was 70.9%.

"Orthodontic [services] are not affordable. I need braces, but it costs too much money."

[85] https://www.mainecohn.org/

Much attention is paid to general physical and mental wellbeing, with the recognition that dental health is an integral part of overall health.

COMMUNITY RESOURCES TO ADDRESS ORAL HEALTH

Community members identified the cost of oral health care as an ongoing challenge or need that impacts youth.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities.

Table 56. Gaps/Needs and Available Resources (Oral Health)

AVAILABLE RESOURCES	GAPS/NEEDS
	Orthodontics not affordable

HEALTH EDUCATION

KEY TAKEAWAYS

Participants noted the need for more information on a much broader set of health topics than what is currently being taught in schools. Participants felt the health class curriculum was not providing deep enough information on topics that affect them such as overall wellness, mental health, diversity, and sexuality.

"Being healthy means more than just eating well and exercising, and we should talk about that."

Participants expressed frustration in being made to take quizzes from the state about how many vegetables they eat or what their weight is in an acknowledgment that health encompasses so much more. There was also discussion on the desire to know more about how to get and stay healthy.

"[I] don't' know where to go to find resources without having to talk to strangers or adults."

They also expressed a desire for comprehensive mental health education that included perspectives from commonly marginalized populations.

"It's important we have all voices and bodies represented so everyone can feel included in these conversations."

Another health education topic was the need for sex education that was destigmatized and taught more broadly. Participants felt the health curriculum as it is, is very restrictive and heteronormative and focused on cis white males. Hearing the voices of those who are non-binary, or gender-fluid, was important to participants.

"There was a lack of health class education that covers reproductive health and anatomy. Instead, we learned how to meditate."

COMMUNITY RESOURCES TO ADDRESS HEALTH EDUCATION

Community members identified the need for education on diverse health topics as an ongoing challenge or need that impacts youth.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities.

Table 57. Gaps/Needs and Available Resources (Health Education)

AVAILABLE RESOURCES	GAPS/NEEDS
Things promoted through school are more accessible	**Awareness** Speaking more about mental health Not knowing about services **Equity** LGBTQ education Traditional ideas of health taught in today's curriculums are exclusive and don't account for diverse experiences The health curriculum as it is very restrictive and heteronormative. We must have all voices and bodies represented so everyone can feel included in these conversations. **Health Education/Schools** Health classes that go deep into the issues that affect young people (i.e., mental health and sexual education) (2) Healthy relationships

APPENDIX: METHODOLOGY

The Maine Shared CHNA is a 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 (i.e.: 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 those who experience systematic disadvantages. 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 health care, 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 health care 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 is an expanded effort to reach those who experience systematic 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 and communities were chosen for their statewide reach. The communities included:

- Black or African American
- People who are Deaf and Hard of Hearing
- People who live with a disability
- People with a mental health diagnosis
- People Experiencing Homelessness
- LGBTQ+ community
- People with low income
- Older adults
- Youth

These events followed the same methodology as county forums.

Oral surveys were conducted in collaboration with 10 ethnic-based community organizations' (ECBOs) 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 engagement efforts were conducted virtually except for the event for the Deaf and 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), which also conducted the initial qualitative analysis. All support materials including Data Profiles and PowerPoints produced by Market Decisions Research.

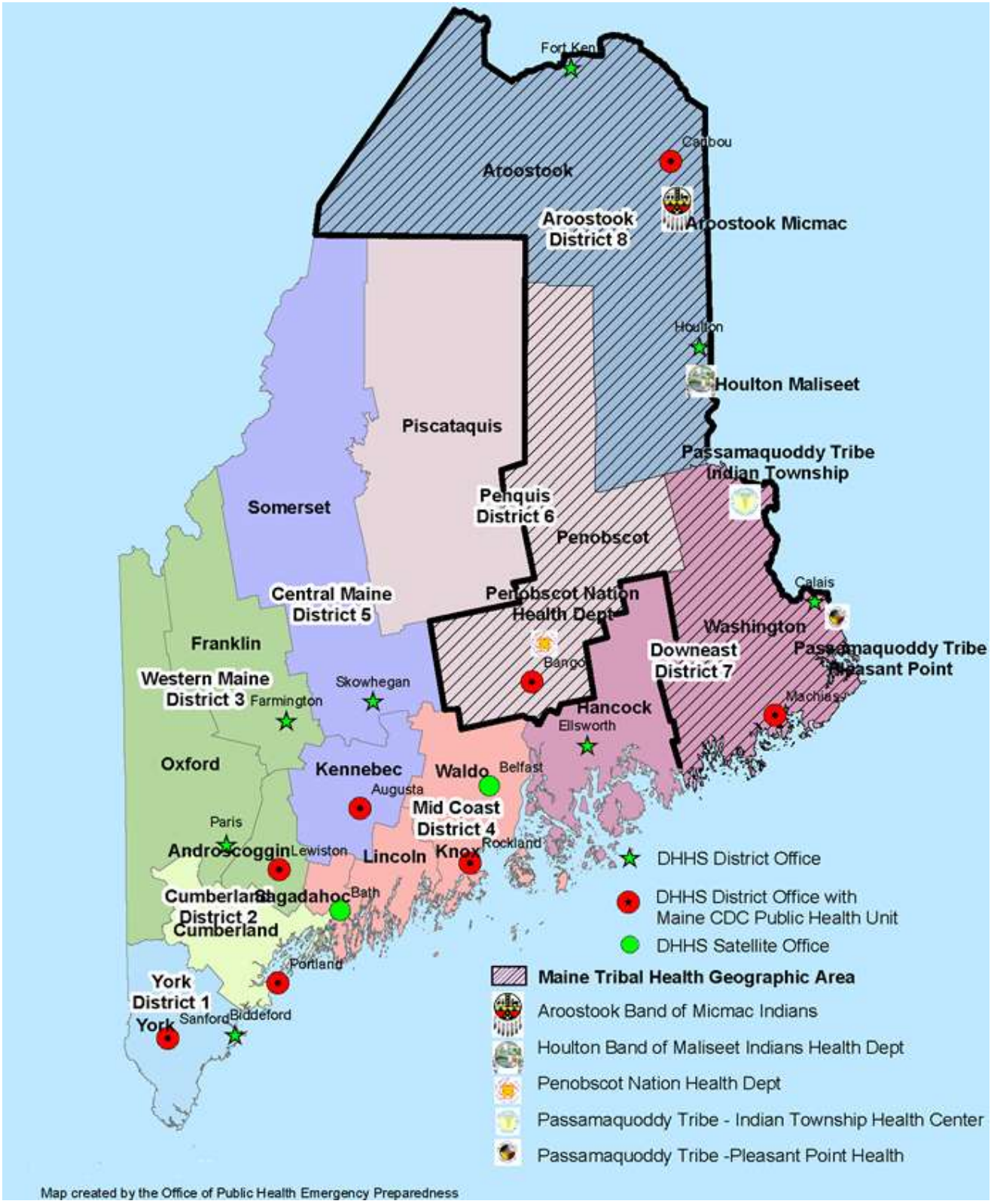
Reporting

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 data is also available on an Interactive Data Portal. The data in the portal is arranged by health topic and provides county and state-level data, as well as 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).

For a complete listing of organizations consulted please see the Acknowledgements found on the Maine Shared CHNA website, www.mainechna.org.

APPENDIX: PUBLIC HEALTH DISTRICTS*



*Map courtesy of Maine Department of Health and Human Services. Last accessed 7/5/2022: https://www.maine.gov/dhhs/mecdc/public-health-systems/scc/images/dhhs-districts_020618.jpg

Table 58. Public Health Districts and Hospitals (*Critical Access Hospitals, **Behavioral Health Hospitals)

PUBLIC HEALTH DISTRICTS	HOSPITALS
District 1, York	
York County	• Southern Maine Health Care, MaineHealth, Biddeford & Sanford • York Hospital, York
District 2: Cumberland	
Cumberland County	• Barbara Bush Children's Hospital, MaineHealth, Portland • Bridgton Hospital, Central Maine Healthcare, Bridgton* • Maine Medical Center, MaineHealth, Portland • Northern Light Mercy Hospital, Portland • New England Rehabilitation, MaineHealth, Portland • Spring Harbor Hospital, MaineHealth, Westbrook**
District 3, Western	
Androscoggin County	• Central Maine Medical Center, Central Maine Healthcare, Lewiston • St. Mary's Regional Medical Center, Lewiston
Oxford County	• Rumford Hospital, Central Maine Healthcare, Rumford* • Stephens Memorial Hospital, MaineHealth, Norway*
Franklin County	• Franklin Memorial Hospital, MaineHealth, Farmington
District 4, Midcoast	
Sagadahoc County	• Mid Coast Hospital, MaineHealth, Brunswick
Lincoln County	• LincolnHealth, MaineHealth, Damariscotta*
Waldo County	• Waldo County General Hospital, MaineHealth, Belfast*
Knox County	• Pen Bay Medical Center, MaineHealth, Rockport
District 5, Central	
Kennebec County	• MaineGeneral Health, Augusta • Northern Light Inland Hospital, Waterville • Riverview Psychiatric Center, Augusta**
Somerset County	• Redington-Fairview General Hospital, Skowhegan* • Northern Light Sebasticook Valley Hospital, Pittsfield*
District 6, Penquis	
Penobscot County	• Millinocket Regional Hospital, Millinocket* • Northern Light Eastern Maine Medical Center, Bangor • Northern Light Acadia Hospital, Bangor** • Dorothea Dix Psychiatric Center, Bangor** • Penobscot Valley Hospital, Lincoln* • St. Joseph Hospital, Bangor
Piscataquis County	• Northern Light Mayo Hospital, Dover-Foxcroft* • Northern Light CA Dean Hospital, Greenville*
District 7, Down East	
Washington	• Calais Community Hospital, Calais* • Down East Community Hospital, Machias*
Hancock County	• Mount Desert Island Hospital, Bar Harbor* • Northern Light Blue Hill Hospital, Blue Hill* • Northern Light Maine Coast Hospital, Ellsworth
Aroostook County	• Cary Medical Center, Caribou • Houlton Regional Hospital, Houlton* • Northern Light AR Gould Hospital, Presque Isle • Northern Maine Medical Center, Fort Kent
District 9, Tribal	
Aroostook, Penobscot, and Washington Counties	• This is a population-based district. There are five tribal health facilities located in Aroostook, Penobscot, and Washington Counties.

ACKNOWLEDGMENTS

Funding for the Maine Shared CHNA is provided by the partnering health care 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 pilot the additional outreach methods to reach those whose voices would not be distinctly heard otherwise. 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	Community Event Sponsors
Capital Area New Mainers Project	Consumer Council System of Maine
City of Portland's Minority Health Program	Disability Rights Maine
Gateway Community Services	Green A.M.E. Zion Church
Maine Access Immigrant Network	Health Equity Alliance
Maine Community Integration	Maine Continuum of Care
Maine Department of Health and Human Services*	Maine Council on Aging
Maine Immigrant and Refugee Services	Maine Primary Care Association
Mano en Mano	Maine Youth Action Network
New England Arab American Organization	
New Mainers Public Health Initiative	

*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, as well as 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

Funding for the Maine Shared CHNA is provided by the partnering health care systems with generous in-kind support from the Maine CDC and countless community partners and stakeholder groups. These stakeholder groups include the Metrics Committee, Data Analysis Team, Community Engagement Committee, and of coursethe Steering Committee. Special thanks to the Maine Health Data Organization. Market Decisions Research (MDR) of Portland, Maine, and JSI served as the contractors for this project. For a complete listing please visit www.mainechna.org.

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 analysis, methodology, and design support.