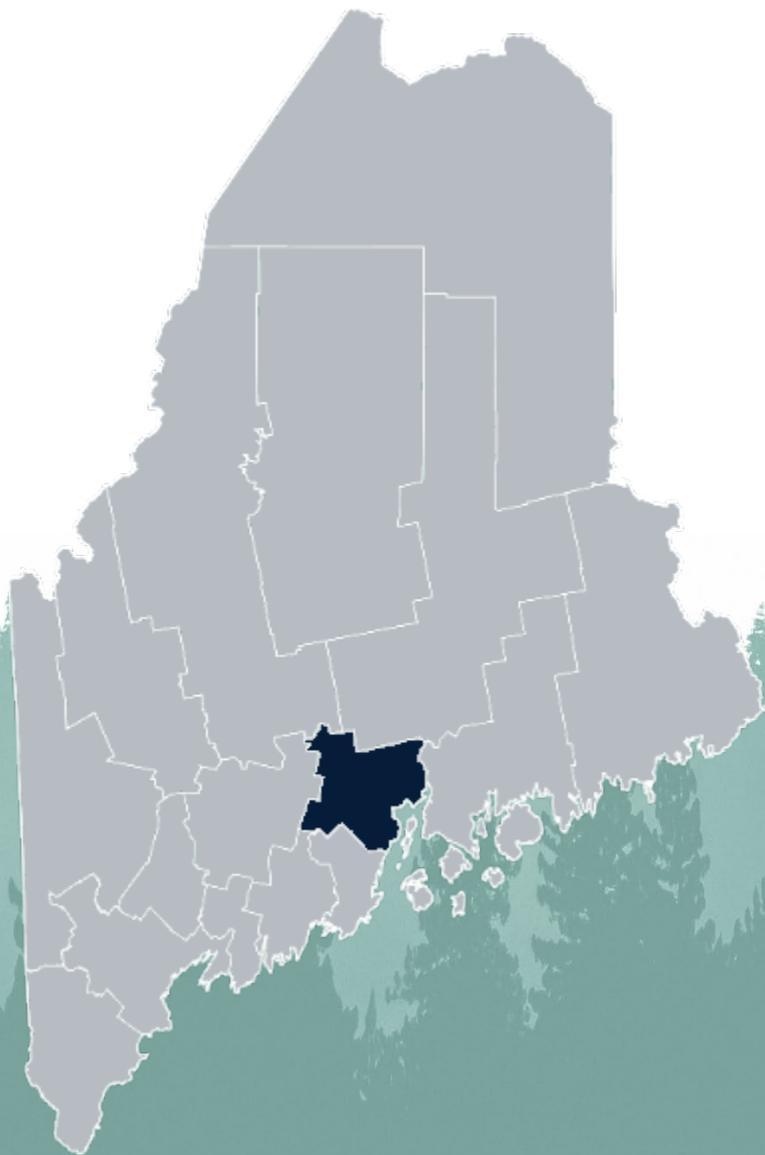


# WALDO COUNTY

Maine Shared Community Health  
Needs Assessment Report

# 2022



# COVID-19 AND OUR HEALTH

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

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

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

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

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

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

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

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## INTRODUCTION

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

The mission of the Maine Shared CHNA is to:

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

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

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

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

# EXECUTIVE SUMMARY

## LEADING CAUSES OF DEATH

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

Table 1. Leading Causes of Death

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

## TOP HEALTH PRIORITIES

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

Table 2. Top Health Priorities for Waldo County

PRIORITIES	% OF VOTES
Mental Health	59%
Social Determinants of Health	50%
Access to Care	35%
Substance and Alcohol Use	28%

Statewide, participants in all 16 counties identified similar top four priorities in the 2021 engagement process as was in 2018.

Table 3. Top Health Priorities for County/State

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

✓ County Priority ● State Priority

Common themes identified by participants in 2021 include an emerging mental health crisis; challenges in access to healthcare, including mental health providers; issues related to poverty, transportation,

and other social determinants of health in a rural state; and increasing rates of substance and alcohol use.

The following pages describe each of these priorities in more detail including the **major health concerns** identified by participants in the community engagement process. There is a description of community-identified resources available to address those concerns as well as any related gaps or needs. Where available, there is also information for certain groups that are at higher risk due to systemic disadvantages. Finally, following the sections that discuss each of the health priorities is a listing of other health issues that were raised by community members but were not identified as priorities.

## DEMOGRAPHICS

Waldo is a rural county, with lower income and educational attainment and higher rates of those living in poverty or with a disability. Much of the population is at or near retirement age.

Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	39,539	1.34M
Median household income	\$51,931	\$57,918
Unemployment rate	5.2%	5.4%
Individuals living in poverty	13.5%	11.8%
Children living in poverty	18.6%	13.8%

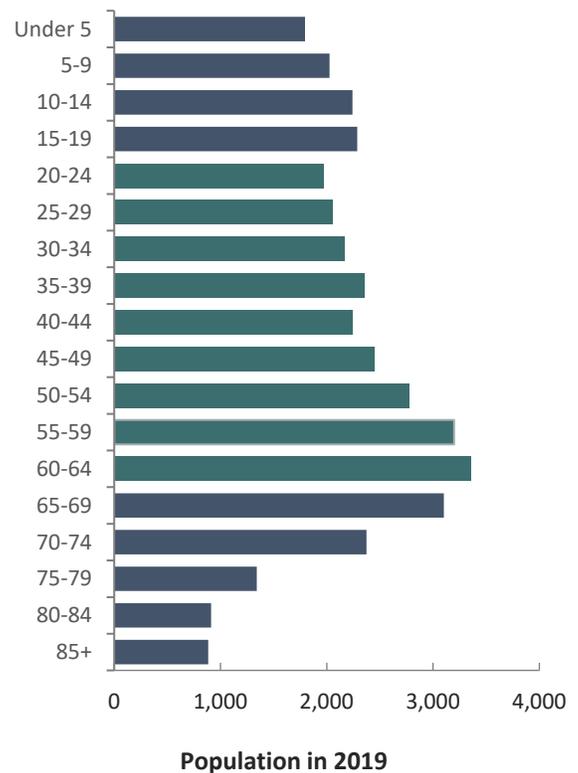
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	23.3%	29.0%
Associate's degree or higher (age 25+)	39.9%	41.9%
Gay, lesbian, and bisexual (adults)	2.5%	3.5%
Persons with a disability	16.8%	16.0%
Veterans	10.3%	9.6%

Table 5. Race/Ethnicity in Waldo County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.4%	176
Asian	0.5%	182
Black/African American	0.6%	234
Native Hawaiian or other Pacific Islander	-	-
White	96.2%	38,044
Some other race	0.4%	155
Two or more races	1.9%	748
Hispanic	1.5%	586
Non-Hispanic	98.5%	38,953

Figure 1. Age distribution for Waldo County



## HEALTH EQUITY

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

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

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

## NEXT STEPS

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

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

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

# PRIORITY: MENTAL HEALTH

## KEY TAKEAWAYS FOR WALDO COUNTY

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

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

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*“There’s a lack of care specifically for youth and for the LGBTQ+ population, both youth, and adults.”*

---

**Availability of mental health providers** in Waldo County was the most frequently mentioned indicator related to mental health. Community members noted the low availability of mental health providers in the area, both for inpatient and outpatient care. They also noted long waitlists to access mental health care services. **Emergency Department services** to address mental health needs was a concern by 37% of Waldo County forum participants. The rate of those seeking mental health care in the emergency department in Waldo County is significantly lower than in Maine overall (165.1 vs 181.5 per 10,000 population, respectively).

**Mental health issues among youth** were concerning to those in the community, particularly the rate at which youth experience **suicidal ideation** and feeling **sad and hopeless**. In 2019, 38.4% of high school students and 26.4% of middle school students in Waldo County reported feeling sad or hopeless for two or more weeks in a row. Data

shows that 15.7% of high school students and 19.5% of middle school students seriously considered suicide during the same period. These rates are similar to Maine overall. There were concerns about the impact of the COVID-19 pandemic on youth, including potential increases in adverse childhood experiences (ACEs) resulting from the pandemic that forced homeschooling in potentially unsafe situations while decreasing access to school-based supports.

According to recent estimates, the percentage of **adults with depression** in Waldo County was 8.9%. Similarly, almost a tenth (9.5%) of all Maine adults had current symptoms of depression. Those who experienced a depressive episode in their lifetime were 23.3% among Waldo County residents between 2015-2017. This is similar to Maine overall (23.7%). Rates of **anxiety** were lower in Waldo County (18.7%) when compared to the state (21.4%), but not significantly.

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*“A lack of mental health providers and treatment options mean people utilize the emergency department.”*

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

Community resources mentioned by participants to address mental health issues include Maine Behavioral Healthcare groups for Cognitive Behavioral Therapy, 211 Maine, Waldo County Recovery Group, and licensed social workers.

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

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<sup>1</sup> Centers for Disease Control and Prevention. Available from: <https://www.cdc.gov/mentalhealth/index.htm>

## MAJOR HEALTH CONCERNS FOR WALDO COUNTY

INDICATOR	WALDO COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
<b>MENTAL HEALTH</b>							
Mental health emergency department rate per 10,000 population	—	2016-2018 <b>165.1</b>	N/A	2016-2018 <b>181.5</b>	★	—	N/A
Depression, current symptoms (adults)	2012-2014 <b>7.7%</b>	2015-2017 <b>8.9%</b>	○	2015-2017 <b>9.5%</b>	○	—	N/A
Depression, lifetime	2012-2014 <b>20.6%</b>	2015-2017 <b>23.3%</b>	○	2015-2017 <b>23.7%</b>	○	2017 <b>19.1%</b>	N/A
Anxiety, lifetime	2012-2014 <b>15.7%</b>	2015-2017 <b>18.7%</b>	○	2015-2017 <b>21.4%</b>	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 <b>32.1%</b>	2019 <b>38.4%</b>	○	2019 <b>32.1%</b>	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 <b>23.5%</b>	2019 <b>26.4%</b>	○	2019 <b>24.8%</b>	○	—	N/A
Seriously considered suicide (high school students)	2017 <b>19.2%</b>	2019 <b>15.7%</b>	○	2019 <b>16.4%</b>	○	—	N/A
Seriously considered suicide (middle school students)	2017 <b>16.9%</b>	2019 <b>19.5%</b>	○	2019 <b>19.8%</b>	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 <b>34.0%</b>	N/A	2011-2017 <b>30.8%</b>	○	—	N/A
Ratio of population to psychiatrists	—	2019 <b>27,319.0</b>	N/A	2019 <b>12,985.0</b>	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 <b>15.2%</b>	2015-2017 <b>16.4%</b>	N/A	2015-2017 <b>18.0%</b>	N/A	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.

★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.

BENCHMARK columns compare the county data to the state and national data.

★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.

ADDITIONAL SYMBOLS

*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

## COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified multiple available treatment options and the presence of youth mental health resources as assets available for the Waldo County community. The community also identified barriers to care, including a lack of mental health providers, a need for additional youth mental health services, a lack of focus on prevention, and the potentially serious consequences of untreated mental health issues as ongoing challenges Waldo County 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 6. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
<p><b>Collaboration</b>                      Waldo County Building Communities for Children (BCC) (3)                      Dedicated organizations/community members (4)</p> <p><b>Treatment</b>                      Maine Behavioral Healthcare groups for Cognitive Behavioral Therapy (CBT) Anxiety/Depression (3)                      Use of telehealth (2)                      Michael Bowe, Licensed Clinical Social Worker (LCSW)</p> <p><b>ACEs</b>                      Adverse Childhood Experience (ACEs) screening tool (3)</p> <p><b>Other Services</b>                      Groups at YMCA (5)                      Waldo County Recovery Group (3)                      Restorative justice programs (2)                      findhelp (previously known as Aunt Bertha) (2)</p>	<p><b>Providers/workforce</b>                      Providers not taking new patients (3)                      Not enough providers (18)                      Providers leaving the field (3)                      Lack of trauma-informed providers</p> <p><b>Barriers to Care</b>                      Lack of MaineCare reimbursement (3)                      Services for those uninsured                      Limited insurance coverage for services (4)                      Lack of inpatient facilities                      Stigma/shame (13)</p> <p><b>Youth</b>                      Prevention/intervention for young people (3)</p> <p><b>Other Services</b>                      Limited social groups/social isolation (6)                      Need more safety net programs</p> <p><b>Culturally Competent Services</b>                      Need resources for LGBTQ+ youth &amp; adults (5)</p>

# PRIORITY: SOCIAL DETERMINANTS OF HEALTH

## KEY TAKEAWAYS FOR WALDO COUNTY

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

Social determinants of health are the conditions in which people live, learn, work, play, worship, and age. Domains include education, economic stability, health care access and quality, the environment, and social connectedness. Examples include access to healthy food, housing, water, air, and relationships.<sup>2</sup> Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Waldo County.

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*“Access to internet and broadband is important for people to take advantage of telehealth and other programs.”*

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**Poverty** was the most frequently mentioned priority health indicator in Waldo County. According to recent estimates, 13.5% of individuals and 18.6% of children in Waldo County live in poverty. This is higher than the state overall for individuals (11.8%) and children (13.8%) but is not considered significant.

**Median household income** increased between 2007-2011 (\$41,728) and 2015-2019 (\$51,931). However, this was still lower than the statewide median household income of \$57,919.

**The cost of housing** was the second most frequently mentioned priority health indicator. Approximately eleven percent (11.1%) of Waldo County residents spent more than **half of their income on housing** from 2015 to 2019.

**Older Adults living alone** was also a concern for Waldo County community members. According to recent estimates, 23.3% of adults 65 years and older were living alone in Waldo County. This compares to 29.0% of older adults in Maine who live alone.

**Housing Insecurity** was mentioned by 41% (19 of 46) of participants. Recent data shows 4.5% of Waldo County high school students reported they experienced housing insecurity, which is similar to Maine (3.3%). For high school students, housing insecurity is defined as those who report they usually do not sleep in their parent’s or guardian’s home.

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*“This provides recognition of issues related to poverty, housing, transportation, which underlie many of the poor health outcomes”*

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

Community resources mentioned by participants to address issues related to social determinants of health include Housing development in Belfast for families, Improved Social Determinants of Health (SDOH) screening, and Supplemental Nutrition Assistance Program (SNAP).

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

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<sup>2</sup> 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>

# MAJOR HEALTH CONCERNS FOR WALDO COUNTY

INDICATOR	WALDO COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
<b>SOCIAL DETERMINANTS OF HEALTH</b>							
Individuals living in poverty	2009-2011 15.0%	2015-2019 13.5%	○	2015-2019 11.8%	○	2019 12.3%	N/A
Children living in poverty	2018 20.2%	2019 18.6%	○	2019 13.8%	○	2019 16.8%	○
Children eligible for free or reduced lunch	2020 50.1%	2021 49.1%	N/A	2021 38.2%	N/A	2017 15.6%	N/A
Median household income	2007-2011 \$41,728	2015-2019 \$51,931	★	2015-2019 \$57,918	!	2019 \$65,712	N/A
Unemployment	2018 3.5%	2020 5.2%	N/A	2020 5.4%	N/A	2020 8.1%	N/A
High school student graduation	2019 86.7%	2020 83.2%	N/A	2020 87.4%	N/A	2019 87.1%	N/A
People living in rural areas	—	2019 100.0%	N/A	2019 66.2%	N/A	—	N/A
Access to broadband	2015 58.5%	2017 61.7%	N/A	2017 88.6%	N/A	2017 90.4%	N/A
No vehicle for the household	2007-2011 1.9%	2015-2019 2.3%	○	2015-2019 2.1%	○	2019 4.3%	N/A
Persons 65 years and older living alone	2011-2015 28.3%	2015-2019 23.3%	N/A	2015-2019 29.0%	N/A	2019 26.6%	N/A
Households that spend more than 50% of income toward housing	—	2015-2019 11.1%	N/A	2015-2019 12.0%	○	—	N/A
Housing insecure (high school students)	2017 5.2%	2019 4.5%	○	2019 3.3%	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 31.9%	N/A	2019 21.3%	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 32.1%	2015-2019 39.9%	N/A	2015-2019 41.9%	N/A	2019 41.7%	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 41.0%	N/A	2015-2019 32.9%	N/A	2019 37.9%	N/A

**CHANGE** columns shows statistically significant changes in the indicator over time.

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**ADDITIONAL SYMBOLS**

*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

# COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

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

The following information was gathered from participants during a group activity, 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 7. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
<p><b>Community Cohesion</b>            Dedicated organizations and community members (2)            Strong cultural identity in the county            Waldo County Community Action Partnership (CAP) (2)</p> <p><b>Food</b>            Programs addressing food insecurity (11)            Bread of Life (2)            Supplemental Nutrition Assistance Program (SNAP) Benefits (2)            Free school lunch</p> <p><b>Housing</b>            Housing development in Belfast for families (4)            Low-income housing (4)</p> <p><b>Physical Activity</b>            Walking trails (2)            Adverse Childhood Events (ACEs)/Resiliency ACEs screening (3)</p> <p><b>Screening</b>            Improved Social Determinants of Health (SDOH) screenings (2)</p> <p><b>Health Services</b>            Belfast public health nurse (2)</p>	<p><b>Housing</b>            Housing issues (24)</p> <p><b>Isolation</b>            Older adults living alone (5)            Lack of internet/broadband (7)</p> <p><b>Poverty</b>            Poverty (4)            Lack of employment opportunities (2)</p> <p><b>Education</b>            Need more educational institutions</p> <p><b>Youth/families</b>            ACEs (7)            Grandparents responsible for grandkids (4)            Children are taken out of school in bad home situations (3)            More social work services in schools (3)</p> <p><b>Barriers to services</b>            The stigma of asking for help (3)            Siloed programs to address SDOH            People don't know about resources and how to access them (3)</p>

# PRIORITY: ACCESS TO CARE

## KEY TAKEAWAYS FOR WALDO COUNTY

Access to care was identified as the third top priority in Waldo County. It was also identified as a top health concern in all other counties and among underserved communities in the state. Access to care means having the timely use of health services to achieve the best possible health outcomes. It consists of four main components: availability of insurance coverage, availability of services, timeliness of access, and the health care workforce<sup>3</sup>

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*“There is a lack of providers in Waldo, PCPs, and of behavioral health clinicians. Transportation is a significant barrier, especially for those on islands and in the most rural areas.”*

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**Cost barriers to care** were the most frequently identified health indicator related to access to care. In 2015-2017, 12.3% of adults in Waldo County reported there was a time during the last 12 months when they needed to see a doctor but could not because of cost. This is similar to Maine (10.6%).

A lack of health insurance was mentioned by 37% (17 of 46) of forum participants. From 2015-2019, the rate of **uninsured** in Waldo County was 11.1%. This is significantly higher than the state uninsured rate of 7.9% over the same period.

A lack of **available primary care providers** in Waldo County was the third most frequently mentioned health indicator related to access to care. It was also identified as the largest gap/barrier to access by community forum participants (mentioned by 30% of forum participants)

The lack of providers in the area and the rural nature of the county create long travel distances to receive care as well as lengthy delays to establish care. Almost one-third (29.5%) of **primary care visits in Waldo County were more than 30 miles from the patient's home** in 2019. This compares to 20.0% of primary care visits in Maine.

The percentage of adults in Waldo County who report they were seen by **any primary care provider** within the past year was 67.1% in 2015-2017. This is significantly lower than the state (72.0%) during the same time period. According to recent data, the percentage of adults who reported they have a usual primary care provider in Waldo County (87.2%) is similar to Maine overall (87.9%).

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*“There is a negative 'culture' in Waldo County. It affects people's attitudes towards healthcare and their willingness to seek care. People{often} feel judged in a doctors' offices - what are they doing right instead of wrong?”*

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

Despite the challenges that Waldo County faces with access to care, community forum participants noted the area has Waldo County General Hospital Dental Clinic, 340B programs, lower medication costs at Penn Bay Medical Center and Waldo County as resources to help with access to healthcare.

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

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<sup>3</sup> Chartbook on Access to Health Care, Agency for Healthcare Research and Quality. Available from: <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html>

## MAJOR HEALTH CONCERNS FOR WALDO COUNTY

INDICATOR	WALDO COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
<b>ACCESS</b>							
Uninsured	2009-2011 13.4%	2015-2019 11.1%	○	2015-2019 7.9%	!	2019 9.2%	N/A
MaineCare enrollment (all ages)	2019 28.7%	2020 33.0%	N/A	2020 29.1%	N/A	2020 24.1%	N/A
MaineCare enrollment (ages 0-19)	2019 45.6%	2020 50.3%	N/A	2020 43.8%	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 1,775.0	N/A	2019 1,332.0	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 87.8%	2015-2017 87.2%	○	2015-2017 87.9%	○	2017 76.8%	N/A
Primary care visit to any primary care provider in the past year	2012-2014 67.8%	2015-2017 67.1%	○	2015-2017 72.0%	!	2017 70.4%	N/A
Cost barriers to health care	2011-2013 10.9%	2015-2017 12.3%	○	2015-2017 10.6%	○	2016 12.0%	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 29.5%	N/A	2019 20.0%	N/A	—	N/A

**CHANGE** columns shows statistically significant changes in the indicator over time.

★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.

**BENCHMARK** columns compare the county data to the state and national data.

★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.

**ADDITIONAL SYMBOLS**

*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

# COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

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

The following information was gathered from participants during a group activity, 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 8. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
<p><b>Community Cohesion</b>                      Waldo County Building Communities for Children (BCC)                      Collaborative community providers (7)                      A strong network of clinics</p> <p><b>Community Organizations</b>                      Waldo Community Action (4)                      Waldo County General Hospital Dental Clinic (3)                      Care partners (3)                      Waldo County General Hospital (3)                      Penn Bay Medical Center</p> <p><b>Access Alternatives</b>                      Walk-in clinics (3)                      Expansion of MaineCare (3)                      Waldo County General Hospital Dental Clinic (3)                      Care partners (3)                      Behavioral Health Intervention Clinicians in Primary Care Physician’s offices (3)                      340B programs for lower cost meds @ Pen Bay Medical Center and Waldo County</p> <p><b>Other Support</b>                      Community health/wellness education in schools (2)                      Findhelp (previously known as Aunt Bertha) (2)</p>	<p><b>Transportation</b>                      Transportation (23)</p> <p><b>Cost of Care</b>                      Lack of clarity over costs (2)                      The population that does not qualify for MaineCare but can't afford copay (2)                      High rate of uninsured                      Cost of care (2)</p> <p><b>Providers</b>                      Lack of providers - general (5)                      Lack of access to primary care providers (PCP) (3)</p> <p><b>Barriers to Care</b>                      Fear of judgmental providers (2)                      Long wait in the emergency department (ED) (2)                      Examine barriers for oral health (2)                      No urgent care                      Lack of support for caregivers</p> <p><b>Culturally Competent Care</b>                      Lack of LGBT+ friendly care</p> <p><b>Coordination</b>                      Lack of coordination among nonprofits (2)                      Residents in Winterport are challenged because they live on County lines</p>

# PRIORITY: SUBSTANCE & ALCOHOL USE

## KEY TAKEAWAYS FOR WALDO COUNTY

Substance and alcohol use was selected as a top priority in Waldo County. It was also identified as one of the top health concerns in all other counties and among underserved communities in the state. Recurring use of alcohol and/or drugs can have significant negative impacts, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use has also been linked to co-occurring mental health issues such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), among others.<sup>4</sup>

Waldo County community members noted that the area has good collaboration to help address this issue, but there are still gaps in the service continuum. There is a need for more options for long-term care and recovery as well as detox facilities. Stigma can also affect an individual's willingness to come forward about their struggles.

**Overdose deaths** were the most frequently mentioned health concern for substance use in Waldo County. In 2020, the rate of overdose deaths per 100,000 population in Waldo County was 22.5, while the rate in Maine was 37.3.

**Drug-affected infants** were the second most frequently mentioned health concern for substance and alcohol use. The rate of drug-affected infant reports per 1,000 births in Waldo County was 107.1 in 2018-2019. This is significantly higher than Maine overall (73.7).

The percentage of adults who are **chronic heavy drinkers** was 6.5% in 2015-2017, similar to 6.7% in 2012-2014. In Waldo County, **alcohol-induced deaths** per 100,000 were 10.2 in 2015-2019. This is similar to Maine overall (11.6).

The misuse of prescription drugs was mentioned by 28% (13 of 46) of forum participants. According to recent estimates, 0.9% of adults in Waldo County had misused prescription medication. This is similar to the state overall (1.0%).

**Hospital utilization** was also a frequently mentioned priority health indicator for substance and alcohol use. In 2016-2018, the rate of opiate poisoning hospitalizations per 10,000 population in Waldo County was 1.3. Similar to the state (1.4).

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

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*“There are still gaps in the service continuum – I would like to see more options for long-term care/recovery, detox facilities.”*

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A common barrier to addressing substance and alcohol use in Waldo County is a lack of substance and alcohol use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Community resources mentioned by participants include Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS), Waldo County Recovery Committee, and Collaborative for people with substance use disorder (SUD).

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

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<sup>4</sup> Mental Health and Substance Use Disorders. Substance Abuse and Mental Health Services Administration (SAMHSA). Available from: <https://www.samhsa.gov/find-help/disorders>

## MAJOR HEALTH CONCERNS FOR WALDO COUNTY

INDICATOR	WALDO COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
<b>SUBSTANCE USE</b>							
Overdose deaths per 100,000 population	2019 —	2020 22.5*	N/A	2020 37.3	○	2019 21.5	N/A
Drug-induced deaths per 100,000 population	2007-2011 12.8	2015-2019 20.4	○	2015-2019 29.5	○	2019 22.8	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 6.8	2015-2019 10.2	○	2015-2019 11.6	○	2019 10.4	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 5.0	2019 0.0	N/A	2019 3.8	N/A	2019 3.1	N/A
Drug-affected infant reports per 1,000 births	2017 107.1	2018-2019 107.1	○	2018-2019 73.7	!	—	N/A
Chronic heavy drinking (adults)	2012-2014 6.7%	2015-2017 6.5%	○	2015-2017 8.5%	○	2017 6.2%	N/A
Binge drinking (adults)	2012-2014 13.0%	2015-2017 15.5%	○	2015-2017 17.9%	○	2017 17.4%	N/A
Past-30-day marijuana use (adults)	2013-2016 8.3%	2017 19.2%	!	2017 16.3%	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	2012-2016 0.6%	2013-2017 0.9%*	N/A	2013-2017 1.0%	○	—	N/A
Past-30-day alcohol use (high school students)	2017 21.9%	2019 25.2%	○	2019 22.9%	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 4.3%	2019 4.1%	○	2019 4.0%	○	—	N/A
Binge drinking (high school students)	2017 9.3%	2019 12.3%	○	2019 8.2%	!	—	N/A
Binge drinking (middle school students)	2017 1.3%	2019 2.3%	○	2019 1.3%	○	—	N/A
Past-30-day marijuana use (high school students)	2017 21.5%	2019 23.3%	○	2019 22.1%	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 3.0%	2019 4.1%	○	2019 4.1%	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 5.3%	2019 6.0%	○	2019 5.0%	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 2.1%	2019 2.3%	○	2019 3.0%	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 13.9	2020 13.5	N/A	2020 12.1	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 45.3	2020 50.3	○	2020 76.7	★	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 6.4	N/A	2016-2018 9.9	★	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 1.3*	N/A	2016-2018 1.4	○	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
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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 & ALCOHOL USE

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

The following information was gathered from participants during a group activity, 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 (Substance Use)

AVAILABLE RESOURCES	GAPS/NEEDS
<p><b>Collaboration</b> A partnership among organizations (4) findhelp (previously known as Aunt Bertha) (2)</p> <p><b>Prevention</b> Prevention programs</p> <p><b>Recovery/ Maintenance</b> Recovery programs/support groups (4) Waldo County Recovery Committee (11) Collaborative for people with substance use disorder (SUD) (2)</p> <p><b>Treatment</b> Medication-Assisted Treatment programs (9) Stigma reduction training with providers (2)</p> <p><b>Harm Reduction</b> Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative</p> <p><b>Organizations</b> Volunteers of America Health Equity Alliance</p> <p><b>Funding</b> Increased funding through state government (2)</p>	<p><b>Treatment</b> Lack of trauma-informed services (2) Abstinence-only providers (2) Lack of long-term treatment (3) Lack of treatment facilities - general (3) Lack of detox options (3)</p> <p><b>Recovery</b> Lack of supportive/recovery housing resources (6)</p> <p><b>Stigma</b> Stigma (6)</p> <p><b>Specific substances</b> Presence of Fentanyl Use of painkillers among those in physical jobs Vaping</p> <p><b>Prevention</b> Not enough education</p>

# OTHER IDENTIFIED NEEDS

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

Table 10. All Priority Health Topic Areas for Waldo County

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	27%	59%
Social Determinants of Health	23	50%
Access to Care	16	35%
Substance and Alcohol Use	13	28%
Oral Health	11	24%
Older Adult Health	10	22%
Physical Activity, Nutrition, and Weight	10	22%
Infectious Disease	5	11%
Intentional Injury	5	11%
Environmental Health	4	9%
Diabetes	4	9%
Cardiovascular Disease	2	4%
Children with Special Needs	2	4%
Health Care Quality	2	4%
Pregnancy and Birth Outcomes	2	4%
Respiratory Disease	2	4%
Other- the quality of life for youth 9+	2	4%
Unintentional Injury	1	2%
Tobacco	1	2%
Immunizations	1	2%
Cancer	1	2%

# APPENDIX: METHODOLOGY

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

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

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

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

## Data Analysis

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

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

## Community Outreach and Engagement

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

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

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

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

The communities included:

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

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

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

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

The survey was an adaptation of the City of Portland's Minority Health Program Survey conducted in 2009, 2011, 2014, and 2018. In 2021, a small group of stakeholders convened to adapt

this survey to meet the needs of the Maine Shared CHNA. This group included those who deployed the survey as well as other interested parties.

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

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

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

## Reporting

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

In addition to Urban, County, and Health District reports, the County, District, and State level data are also available on an [Interactive Data Portal](#). The data in the portal is arranged by health topic and provides demographic comparisons, trends over time, definitions, and information on the data sources. Visit [www.mainechna.org](http://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](http://www.mainechna.org)).

One virtual community forum was held in Waldo County on November 4, 2021, with 51 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Belfast Climate Crisis Committee  
Belfast Soup Kitchen  
Coastal Healthcare Alliance  
Downeast Public Health District  
Islands Community Medical Services, Inc.  
Maine Behavioral HealthCare – MaineHealth  
Maine Center for Disease Control and Prevention  
Maine Community Foundation  
Maine State Legislature  
MaineHealth  
MaineHealth-Maine Medical Center Research Institute  
Midcoast District Public Health Council  
Midcoast Maine Community Action  
Northern Light Health  
Office of Child and Family Services Children's Behavioral Health Services  
OPTIONS / Sweetser  
OUT Maine  
Pen Bay Medical Center  
Waldo Community Health Care  
Restorative Justice Project Maine  
Sweetser  
Waldo Community Action Partners  
Waldo Community Action Partners Early Childhood Program  
Waldo County General Hospital  
Waldo County YMCA  
Winterport Community Health Center/Waldo Community Health Center

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

# ACKNOWLEDGMENTS

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

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

## Oral Survey Sponsors

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

## Community Event Sponsors

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

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

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



