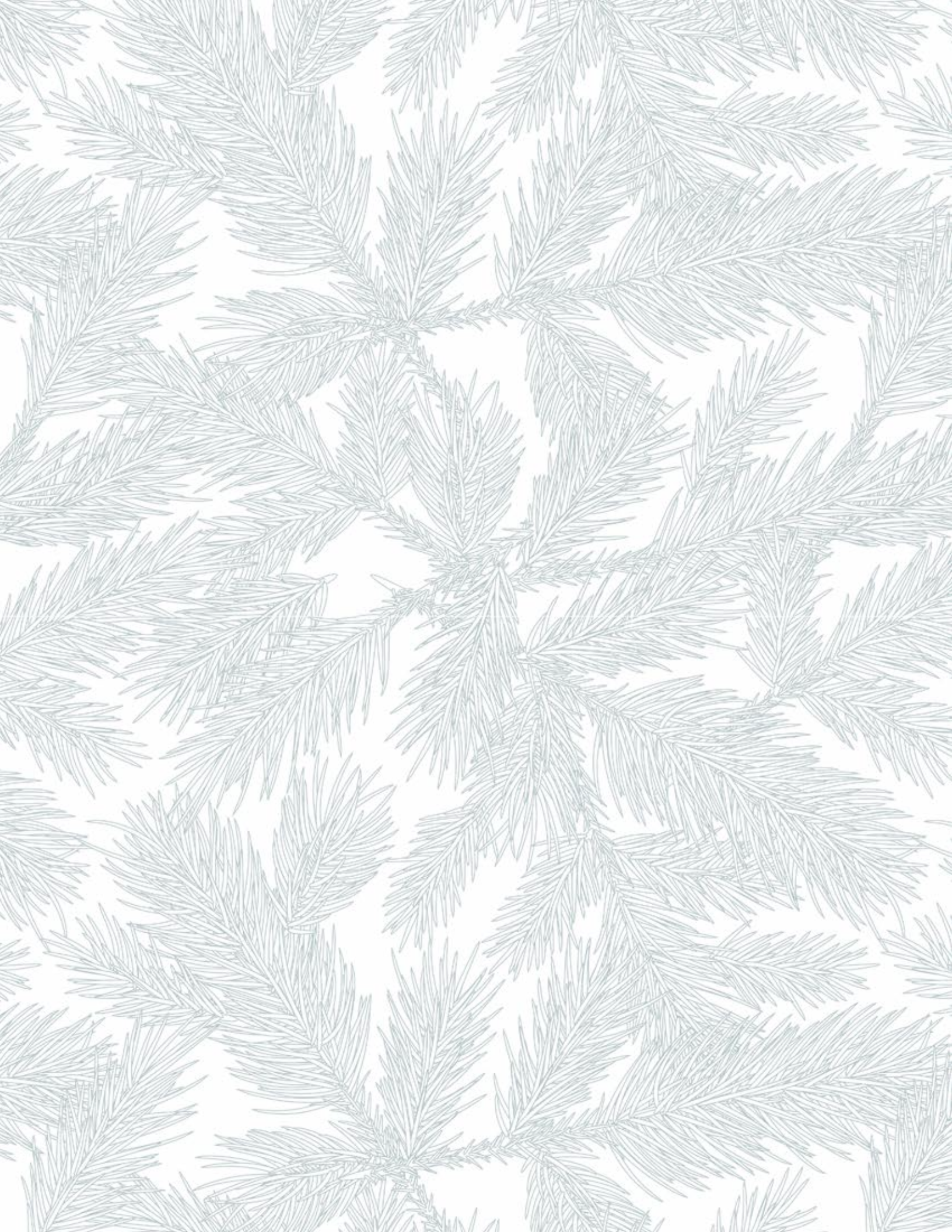
2019 Maine Shared
Community Health Needs Assessment

Hancock County

Northern Light Health℠



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Key companion documents available at www.mainechna.org:

- Hancock County Health Profile
- Downeast District Health Profile
- Health Equity Data Summaries, including state level data by sex, race, Hispanic ethnicity, sexual orientation, educational attainment, and income

EXECUTIVE SUMMARY

PURPOSE

The Maine Shared Community Health Needs Assessment (Maine CHNA) is a collaborative effort amongst Central Maine Healthcare (CMHC), Northern Light Health (NLH), MaineGeneral Health (MGH), MaineHealth (MH), and the Maine Center for Disease Control and Prevention (Maine CDC). This unique public-private partnership is intended to assess the health needs of all who call Maine home.

- **Mission:** The Maine Shared CHNA is a dynamic public-private partnership that creates shared Community Health Needs Assessment reports, engages and activates communities, and supports data-driven health improvements for Maine people.
- **Vision:** The Maine Shared CHNA helps to turn data into action so that Maine will become the healthiest state in the US.

DEMOGRAPHICS

Hancock County is one of two counties that make up the Downeast Public Health District. The population of Hancock County is 54,483 and 21.4% of the population is 65 years or older. The population is predominantly white (96.3%). The average household income is $50,037. Educational attainment measures for high school graduation (88.3%) and associates' degree or higher (40.9%) are higher than the state average.

TOP HEALTH PRIORITIES

The Hancock County Community Forum identified a list of health issues in that community through a voting methodology outlined in the Methods section. See Appendix C for a description of how priorities were chosen.

Table 1: Hancock County Health Priorities

PRIORITY AREA	% OF VOTES
Mental Health*	18%
Substance Use*	18%
Social Determinants of Health*	16%
Access to Care*	15%
Older Adult Health/Healthy Aging*	15%

Also a statewide priority. For a complete list of statewide priorities, see state health profile on our 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. Required activities include:

- Obtaining input from the community, including providers and communities served, on leading health issues and unmet needs
- Evaluating previous actions taken to address needs identified in previous assessments
- Choosing (with justification) which health needs should be addressed
- For hospitals, creating an informed implementation strategy designed to address the identified needs
- For District Coordinating Councils, creating District Health Improvement Plans
- For the Maine CDC, creating an informed State Health Improvement Plan

In the coming months and years, policymakers, non-profits, businesses, academics, and other community partners may also use these reports for their own strategic planning purposes.

ACKNOWLEDGEMENTS

Funding for the Maine Shared CHNA is provided by Central Maine Healthcare, Northern Light Health, MaineGeneral Health, and MaineHealth, with generous in-kind support from the Maine Center for Disease Control and Prevention, an office of the Department of Health and Human Services and countless community partners and stakeholder groups. These stakeholder groups include the Metrics Committee, Data Analysis Workgroup, Community Engagement Committee, Local Planning Committees, and the Steering Committee. Special thanks to the Maine Health Data Organization for working with us to access their data. For a listing of committee members please visit **www.mainechna.org** and click on "About Maine CHNA."

Significant analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. John Snow, Inc. provided analysis, methodology, and design support.

In addition, the Steering Committee gratefully acknowledges the countless community volunteers who gave their time and passionately committed to hosting, facilitating, attending, and engaging in this effort. From Aroostook to York, Oxford to Washington County, almost 2,000 Mainers gave their time and talent to this effort. Thank you.

HEALTH PRIORITIES

Health priorities for the county, public health district, and the state were developed through community participation and voting at a community forum. The forum was an opportunity for review of the County Health Profile, discussion of community needs, and prioritization in small break-out sessions followed by a forum session vote. Table 2 lists all nine priorities which arose from group break-out sessions at the forum held in Hancock County. The priorities shaded are the five priorities which rose to the top. See Appendix C for full description of the methodology used in identifying priorities.

This section provides a synthesis of findings for each of the shaded top priorities. The discussion of each priority draws from several sources including: the data in the county health data profiles, the information gathered through community engagement discussions at the community forum, and key informant interviews. See Appendix C for the complete methodology for all of these activities.

Table 2: Hancock County Forum Voting Results

PRIORITY AREA	% OF VOTES
Mental Health*	**18%**
Substance Use*	**18%**
Social Determinants of Health*	**16%**
Access to Care*	**15%**
Older Adult Health/ Healthy Aging*	**15%**
Physical Activity, Nutrition, and Weight*	10%
Healthcare Quality	6%
Cardiovascular Disease	1%
Cancer	1%

Also a statewide priority. For a complete list of statewide priorities, see state health profile on our website,* **www.mainechna.org

MENTAL HEALTH

Mental health affects all segments of the population, regardless of age, socioeconomic status, race/ethnicity, or gender. Poor mental health contributes to a number of issues that affect both individuals and communities. Mental health disorders, when left unmanaged, may affect an individual's ability to form and maintain relationships with others, cope with challenges, and lead a healthy and productive life. Individuals with serious mental illness (e.g., major depression or schizophrenia) are at a higher risk of developing other medical conditions, including cardiovascular disease, diabetes, stroke, and Alzheimer's disease. While the reason for this link is unclear, research suggests that those with mental illness may experience more barriers to medical care and prevention strategies may find it harder to care for themselves.[1]

More than 25% of adults with a mental health disorder also have a substance use disorder; this comorbidity occurs more among adults with depression, anxiety disorders, schizophrenia, and personality disorders. While mental health conditions may lead to drug or alcohol use, the reverse can also be true—the use of certain substances may cause individuals to experience symptoms of a mental health disorder.[2]

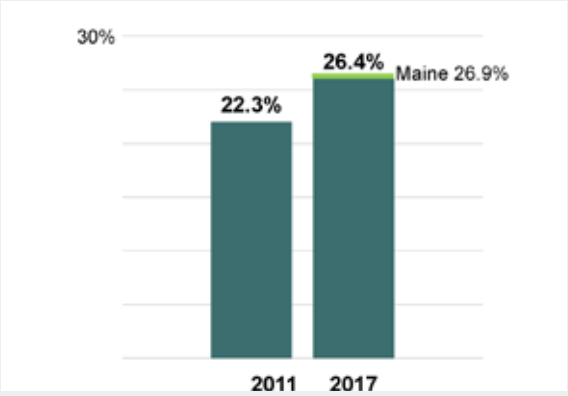
QUALITATIVE EVIDENCE

Forum participants cited depression/hopelessness, stress, isolation, trauma, family separation, and suicidality as issues and conditions of note. Community members discussed the need for individual mental wellness supports and the opportunity to support one another in mental wellness at the community level. While many said there was a need for behavioral health services in general, they identified counseling, screening for Adverse Childhood Experiences (ACEs), pediatric providers, inpatient services, and psychiatry as specific gaps in the spectrum of care.

Though mental health issues affect all individuals, community forum participants identified youth as a population of particular concern both in terms of risk, and the need to ensure access to appropriate resources. Rising rates of depression among high school youth was a concern, and there were questions about the contribution of technology and social media to isolation and bullying. For youth, forum participants discussed the need for increased education, training, and resources around the mental health effects of Adverse Childhood Experiences (ACEs). ACEs are stressful or traumatic events, such as abuse, neglect, and substance use or mental illness within the household, that are correlated to the development of physical and mental health issues for those exposed.[3] The community discussed the following ACEs of concern: housing insecurity, sexual assault, food insecurity, parental substance use, and child welfare removals. Forum participants suggested that schools would be an ideal setting for behavioral health screening, education, and intervention, and that such activities should begin in pre-kindergarten and kindergarten.

A final key theme from discussions on mental health was lack of community cohesion. Several forum participants identified social isolation as a critical determinant of mental health issues, which some related to the increased use of technology and how that limits personal interaction. There were several needs identified in this area, including the need for free recreational opportunities, free community building and social events, increased community resilience, and more faith-based community support services.

Figure 1: Sad/Hopeless for Two or More Weeks in a Row (High School)



QUANTITATIVE EVIDENCE

In Hancock County:

- The percentage of adults who had ever been told by a healthcare provider that they had a depressive disorder was lower than the Maine average in 2014–2016 (20.8% vs. 22.8%).
- The percentage of adults who had ever been told by a healthcare provider that they had an anxiety disorder was significantly lower than Maine overall in 2014–2016 (16.4% vs. 20.7%).
- The percentage of adults with chronic disease among those with mental illness was significantly lower than the state overall in 2014–2016 (15.4%* vs 32%). *Note that due to small numbers the rate for Hancock County should be interpreted with caution.
- The percentage of adults receiving outpatient mental health treatment was significantly lower than Maine overall in 2014–2016 (12.8% vs. 17.6%).
- The percentage of high school youth who reported being sad or hopeless for two weeks or more in a row was similar to the state overall (26.4% vs 26.9%).

See Key Indicators on page 18 as well as companion Health Profiles on our website **www.mainechna.org**. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Table 3 is a summary of the assets and needs identified through the community engagement process including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 3: Assets and Gaps/Needs (Mental Health)

ASSETS	GAPS/NEEDS
• Northern Light Acadia Hospital • Aroostook Mental Health Center • Local counselors • Behavioral Health and Primary Care Provider Integration • Depression Screening • Many medications are affordable • Downeast Treatment center • Sweetser outreach • Crisis Response • School resiliency training • Education in schools • Tele-psychiatry • Hub and Spoke Model	• Lack of resources • Stigma • Poor internet • Lack of counseling centers • More Primary Care Providers/mental health/ substance use providers • More inpatient options • Adverse Childhood Experiences (ACEs) screening • Breaks in insurance • More treatment slots/inpatient beds • Support groups/rehabilitation options • Counseling/education in schools • Pediatric providers • Motivational interviewing • Reduction of stigma • Transportation • Better tobacco education • Medication-Assisted Treatment availability • More suboxone providers

SUBSTANCE USE

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 8% of adults in the United States have had a substance use disorder in the past year.[4] Tobacco, alcohol, marijuana, and nonmedical use of prescription pain relievers (e.g., OxyContin, Vicodin) are the leading health issues for adults.[5] Tobacco, alcohol, and marijuana are the most common substances misused by adolescents, followed by amphetamines (e.g., Adderall) and nonmedical use of prescription pain relievers.[6] Those with substance use disorders often face a number of barriers that limit access and hinder engagement in care; one study estimates that more than 50% of individuals with mental health and substance use issues are not engaged in needed services.[7]

Barriers to care include a lack of education, awareness, and understanding around the signs, symptoms, risk factors, and consequences associated with substance use; social stigma; and workforce shortages. Statewide, many forum participants and key informant interviewees identified gaps in access to substance use treatment and recovery services. Finally, those who are uninsured or underinsured are more likely to face barriers to care, and historically, coverage for substance use services has been less comprehensive than for physical health services. This is further complicated by the cost of co-pays, transportation, and medications, even for those who are eligible for free or discounted services or those with commercial insurance, as many private substance use treatment providers to not accept insurance and require cash payments.

QUALITATIVE EVIDENCE

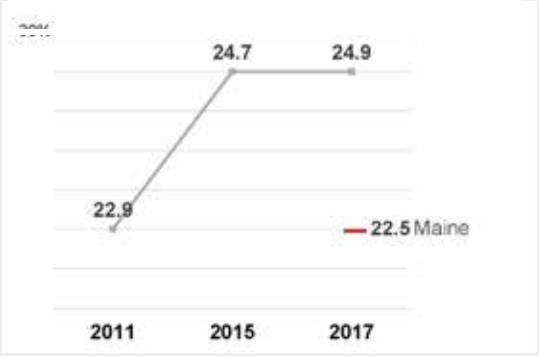
Opioid use was the leading substance use issue discussed in the community forum. Forum participants discussed the need for more comprehensive, accessible, and affordable services to help those in need. The need for harm-reduction services (e.g., needle exchange), medication-assisted treatment (MAT) (e.g., methadone, Suboxone), inpatient services, supportive housing for recovery, and substance use disorder specialists were identified. The criminalization of substance use was seen as problematic for engaging people in treatment, as well as a challenge when offering a continuity of treatment services while people are in jail and after they are released.

Forum participants were also concerned about the link between un-addressed mental health needs and substance use, particularly marijuana and prescription drugs among youth. Additionally, they discussed the risk of prescription drug misuse among youth who are accessing medications from family members, and the need for more education on the risks of marijuana use for developing teens. Given the prevalence of adult drug use in the community, there are increasing numbers of grandparents raising grandchildren, and the group discussed how to create resilient kids and communities to prevent another generation impacted by substance use disorders.

Key informants identified many priority health issues for those who misuse substances and those in treatment/recovery: education and outreach around how to access healthcare and treatment options, routine basic health care (primary care, dental care), and care that addresses co-occurring mental health and substance use issues. Informants also identified needs specific to youth, including information on where and how to access treatment and better access to confidential services. Another key theme was the need to provide better access to many of the resources that make up the social determinants of health: affordable, safe, and supportive housing; transportation; and nutritious foods.

QUANTITATIVE EVIDENCE

Figure 2: Past-30-Day Alcohol Use (High School)



In Hancock County:

- Substance use hospitalizations were lower than the state overall (16.4 vs. 18.1 per 10,000 population) in 2016.
- The rate of overdose deaths increased between 2007–2011 and 2012–2016, from 12.0 to 19.1 per 100,000.
- The rate of overdose emergency medical service responses decreased between 2013–2014 and 2016–2017, from 64.3 to 57.3 per 10,000 population. The rate was significantly lower than the state overall (93 per 10,000 population).
- Past-30-day alcohol use among high school students was higher than the state overall (24.9% vs. 22.5%) in 2017.

See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE USE

Table 4 is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 4: Assets and Gaps/Needs (Substance Use)

ASSETS	GAPS/NEEDS
• Northern Light Acadia Hospital • Aroostook Mental Health Center • Local counselors • Behavioral Health and Primary Care Provider Integration • Depression Screening • Many medications are affordable • Downeast Treatment center • Sweetser outreach • Crisis Response • School resiliency training • Education in schools • Tele-psychiatry • Hub and Spoke Model	• Lack of resources • Stigma • Poor internet • Lack of counseling centers • More Primary Care Providers/mental health/ substance use providers • More inpatient options • Adverse Childhood Experiences (ACES) screening • Breaks in insurance • More treatment slots/inpatient beds • Support groups/rehabilitation options • Counseling/education in schools • Pediatric providers • Motivational interviewing • Reduction of stigma • Transportation • Better tobacco education • Medication-Assisted-Treatment availability • More suboxone providers

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people live, work, learn, and play; factors include socioeconomic status (e.g., education, income, poverty), housing, transportation, social norms and attitudes (e.g., racism and discrimination), crime and violence, literacy, and availability of resources (e.g., food, health care). These conditions influence an individuals' health and define quality of life for many segments of the population, but specifically those that are most vulnerable. According to the Kaiser Family Foundation, social factors like education, racism, and poverty accounted for over a third of total deaths in the United States.[8]

QUALITATIVE EVIDENCE

A dominant theme from key informant interviews and community forum was the tremendous impact that the underlying social determinants, particularly food insecurity, transportation, housing, and social interaction/community cohesion have on residents in Hancock County. Forum participants felt that there were cultural issues amongst some older adults that stopped them from seeking or accepting services (e.g., stigma associated with assistance, belief that others need more support than they do).

Food insecurity was a primary concern. Food pantries support immediate access to food but there was a need for long-term solutions for individuals and families. Supplemental Nutrition Assistance Program (SNAP) benefits were identified as an asset; however, transportation issues challenge families' ability to access stores and markets.

The availability and affordability of housing and transportation was a need identified in all Hancock engagement activities. Multiple generations of a family are living together due to housing costs, and there is a need for affordable temporary and permanent housing. For older adults in particular, there is a need for affordable home maintenance support to allow them to remain in their homes.

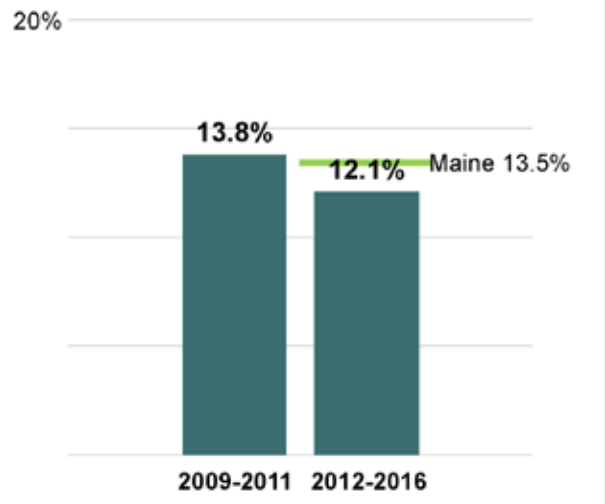
Transportation was a major barrier to accessing health care and a contributing factor to patients not showing up for appointments. Lack of access to the use of a personal vehicle may be due to any number of factors including affording the vehicle itself, or the insurance, repairs, or even perhaps a license suspension or revocation. This is can be especially challenging in areas without reliable public transportation, like in rural Maine. This results in difficulty accessing health services, employment, and basic necessities (e.g., food, clothing, medication). This issue is further complicated for older adults with mobility impairments and individuals with disabilities who require specialized forms of transportation or extra assistance. Forum participants discussed how access could be improved by coordination of multiple health appointments in one day to reduce trips when possible. Further, with some planning there are some sources of transportation assistance, but some individuals may need assistance with the planning process.

QUANTITATIVE EVIDENCE

In Hancock County:

- The unemployment rate in Hancock County was higher than the state overall (4.7% vs. 3.8%) in 2012-2016.
- The percentage of individuals living in poverty was lower than the state overall (12.1% vs. 13.5%).

Figure 3: Individuals Living in Poverty



- The estimated high school graduation rate was higher than the state overall (88.3% vs. 86.9%) in 2017.
- The percentage of the population with an associates' degree or higher among those over 25 was higher than the state overall (40.9% vs. 37.3%) in 2017.
- The percent of households that were food insecure was higher than the state overall (15.3% vs. 15.1%) in 2012–2016.
- The percentage of high school students who reported having experienced at least 3 adverse child experiences was lower than the state overall (20.7% vs. 23.4%) in 2017.

See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Table 5 is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 5: Assets and Gaps/Needs (Social Determinants of Health)

ASSETS	GAPS/NEEDS
• Food and clothing drives • Health food options • Community events • Healthy Acadia • Healthy Peninsula • Integrated screenings • Mount Desert Island Hospital integrated care team • Care coordinators • Telemonitoring program • Aroostook Mental Health Center clinic • Community Health and Counseling Services provider clinics	• User friendly transportation • Telehealth • Cost of services/insurance • Lack of providers • Child care • Food pantries/access to healthy shopping • Community health workers/nurses/social workers • Education on services available • Referrals • Lack of mental health • Housing options/affordability • Social service systems • Community resources for connection

ACCESS TO CARE

Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely, and accessible preventive and disease management or follow-up services—is critical to overall health and well-being. Access to a usual source of primary care is particularly important, since it greatly affects an individual's ability to receive regular preventive, routine, and urgent care and to manage chronic conditions. Though the percentage of uninsured individuals in Hancock County has declined over time lack of insurance and underinsurance remains a leading barrier to care in the region, and the rate of uninsured is higher than the state average. Medicaid expansion, which holds the promise of providing health insurance coverage for an additional 70,000 Mainers, was signed into law on January 3, 2019.

Barriers to accessing care also include the availability and affordability of care. Low-income individuals, people of color, those with less than a high school diploma, and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) populations face even greater disparities in health insurance coverage compared to those who are heterosexual, white, and well-educated. For example, in Maine, over 20% of American Indian/Alaska Natives and Black/African American adults report they are unable to receive or have delayed medical care due to cost, compared to 10% of white adults. Compared to heterosexual residents (11.6%), 19.3% of bisexual residents, and 22.5% of residents who identified as something other than heterosexual, gay or lesbian, or bisexual, were uninsured. More information on health disparities by race, ethnicity, education, sex, and sexual orientation can be found in the Health Equity Data Summaries.

QUALITATIVE EVIDENCE

Many forum participants and key informants identified the social determinants of health—particularly inability to access reliable and affordable forms of transportation, safe and affordable housing, and poverty/low wages—as significant barriers to care. The "Social Determinants of Health" priority area discusses this in more detail.

Factors contributing to timely access to care included access to insurance and coordination of health care services. Another factor forum participants discussed is how relationships with primary care teams have changed, as people may no longer have continuity in relationship with a provider and as a result the primary care office may need a more proactive approach to engage patients.

To address rural health access, the community discussed the potential uses of telemedicine and the challenges in making it a reality, such as broadband connection, equipment needs, and knowledge of patients and providers on how to use the tool effectively. There was also concern that use of telemedicine, while improving access, does not address the isolation of individuals.

Beyond the need for Medicaid expansion, forum participants discussed the need for several specific services including palliative care, collaborative care, and pediatrics.

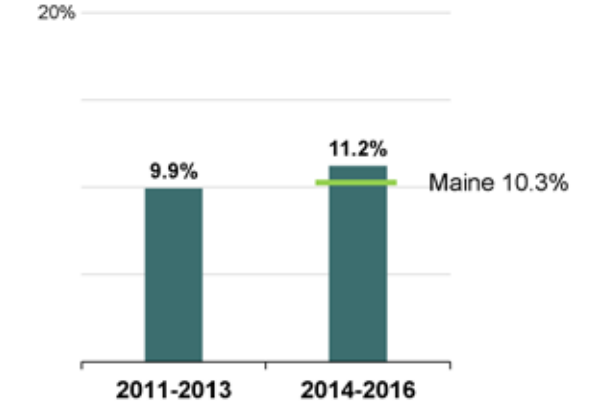
Key informants identified treatment biases that impact access for medically underserved populations, including those with physical disabilities, mental health conditions, and substance use disorders. An additional barrier to care was provider capacity to serve unique populations. Unique needs include accommodating patients with physical or developmental disabilities when healthcare sites experience limitations in specific services (e.g., accessible equipment and capacity to provide dental and gynecology services.)

QUANTITATIVE EVIDENCE

In Hancock County:

- The percentage of the population without health insurance was higher than the state overall (12.9% vs. 9.5%) in 2012-2016.
- The percentage of the population who made a primary care visit to any primary care provider in the past year was lower than the state overall (70.9% vs. 71.8%) in 2014-2016.
- The percentage of the population who experienced cost barriers to care increased between 2011-2013 and 2014-2016, from 9.9% to 11.2%. The percentage is higher than the state average (10.3%).

Figure 4: Individuals Unable to Afford Healthcare Due to Cost



See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Table 6 is a summary of the assets and needs identified through the community engagement process including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 6: Assets and Gaps/Needs (Access to Care)

ASSETS	GAPS/NEEDS
• Downeast Community Partners, Connector, Transportation • Faith in Action • Food pantries • Transportation Services, Friends in Action • Island Connections • Home Health and Hospice • MaineCare • Community Paramedicine Professionals • Eastern Area Agency on Aging • Neighbor for Neighbor • Deer Isle Stonington	• Medicaid expansion • Funding • Transportation • Insurance • Lack of providers • Telemedicine/broadband • In home visits • Collaborative care • Lack of providers • Cost of care • Walkable communities • Palliative care • Early childhood healthcare • Better health/development education

OLDER ADULT HEALTH/HEALTHY AGING

The World Health Organization's definition of active aging and support services are those that "optimize opportunities for health, participation and security in order to enhance quality of life as people age." Maine's older population is growing in all parts of the state, and it remains the "oldest state in the nation" as defined by median population of 44.7 in 2017 compared to the national median age of 38. Gains in human longevity create an opportunity for active lives well after age 65. As this population grows in size, there is growing interest in wellness in addition to the infrastructure of health services for the older population.

QUALITATIVE EVIDENCE

The community discussed the increasing size of the aging population and the need to focus on a range of supports for healthy aging and care services, including care, housing, food, transportation and social needs, technology support, and guides to aging in place. Falls were a primary concern that came up, and the group discussed the need for better data to track and understand the rate of falls among aging adults, and needing to educate adults early (in their 40s) on the importance of exercise for health and to support health as they age. These interventions would improve physical activity amongst older adults and improve mental health and mobility.

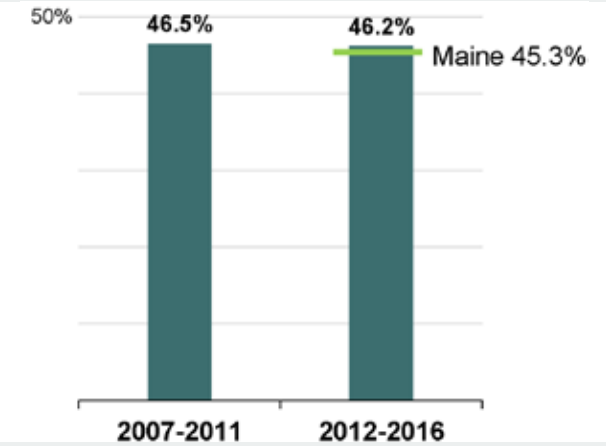
Home care, nursing homes, and long-term care were discussed in the context of improving access to care for older adults. Aging in place was a popular concept, and recognized as one that reduces the need for nursing homes and specially designed senior housing; nevertheless, the group acknowledged that it is financially out of reach for some seniors. There is a need for more resources on aging in place and advocacy. With aging in place being a preferred lifestyle, there is a tandem concern of isolation of seniors, the impact of isolation on health, and mental health and physical risks for seniors.

QUANTITATIVE EVIDENCE

In Hancock County:

- The percent of the population age 65 and older living alone was higher than the state overall (46.2% vs. 45.3%) in 2014-2016.
- The percent of adults age 45 or older with cognitive decline was lower than the state overall (8.9%* vs. 10.3%) in 2016. *Note that due to small numbers the county rate should be interpreted with caution.
- The percentage of adults providing regular caregiving for at least 20 hours a week was lower than the state overall (2.2%* vs. 4.4%) in 2015. *Note that due to small numbers the county rate should be interpreted with caution)
- The percent of adults with arthritis was lower than the state overall (31.3% vs. 32.0%) in 2014-2016.

Figure 5: 65+ Living Alone



See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS OLDER ADULT HEALTH/HEALTHY AGING

Table 7 is a summary of the assets and needs identified through the community engagement process including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 7: Assets and Gaps/Needs (Older Adult Health/Healthy Aging)

ASSETS	GAPS/NEEDS
• Changing culture/reducing stigma • Programs that allow people to age in place/age friendly communities • Friends in Action • Strong community networks/volunteers • Friendship Cottage • Food programs like magic food bus • Eastern Area Agency on Aging • Falls prevention assessment/services • Supplemental Nutrition Assistance Program Education (SNAP-Ed) • Healthy Acadia • Healthy Peninsula • Moose Senior Center • Church/Community Groups	• Local initiatives/networks/centers • Social networking/involvement • Transportation • Access to cheap and healthy food • Isolation • Lack of income/insurance/affordable services • More in home help for aging, Alzheimer's • Lack of funding for family caregivers • Communication/broadband • Resources for families to support elderly care • Lack of volunteers and supports for older adults • Lack of promotion of fall prevention training

COMMUNITY CHARACTERISTICS

AGE DISTRIBUTION

Age is a fundamental factor to consider when assessing individual and community health status; older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.[9] With an aging population comes increased pressure on the healthcare system and shortages in the healthcare workforce, especially geriatricians, nurses, social workers, and direct care workers like home health aides and certified nursing assistants, to meet the needs of older adults.[10]

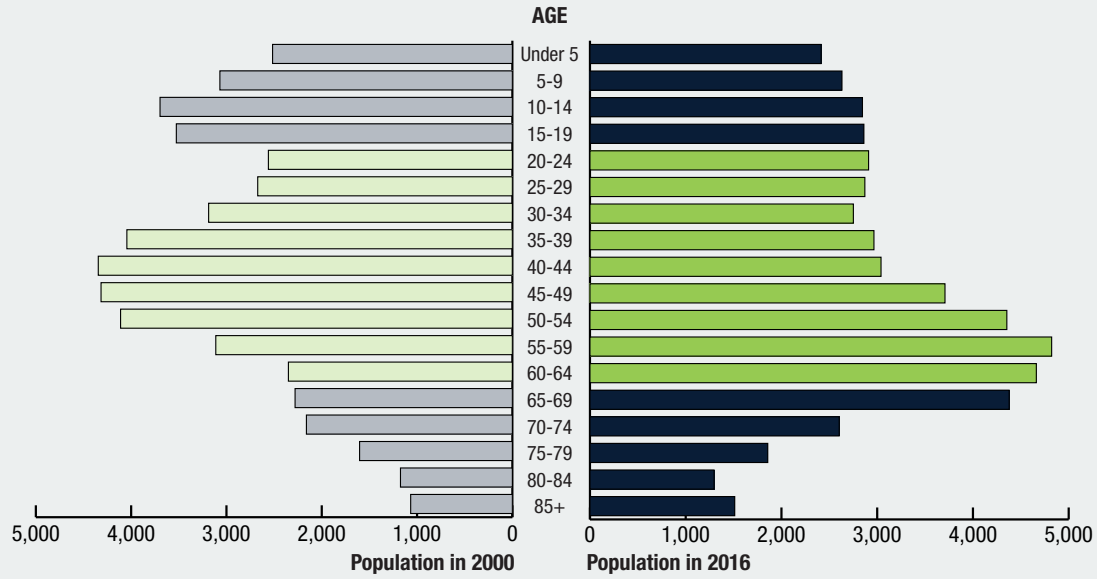
- Over one fifth of Hancock County's population is 65 years or older (21.4%)—among the highest percentages in the state.

The following is a summary of findings related to community characteristics for Hancock County. Conclusions were drawn from quantitative data and qualitative information collected through the forum and key informant interviews.

For Hancock County, the following reports can also be found at www.mainechna.org:

- Hancock County Health Profile
- Downeast District Health Profile
- Health Equity Data Summaries

Figure 6: Age Histogram of Hancock County



RACE/ETHNICITY

An extensive body of research illustrates the health disparities that exist for racial/ethnic minorities, non-English speakers, and foreign-born populations. According to the US CDC, non-Hispanic Blacks have higher rates of premature death, infant mortality, and preventable hospitalization than non-Hispanic Whites.[11] Individuals with limited English proficiency (LEP), defined as the ability to read, speak, write, or understand English "less than very well," have lower levels of medical comprehension. This leads to higher rates of medical issues and complications, such as adverse reactions to medication.[12,13]

Cultural differences, such as but not limited to, the expectations of who is involved in medical decisions can also impact access to health care health information. These disparities show the

disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.

In Hancock County:

- The population was predominantly White (96.3%); 1.7% of the population was two or more races, 1.3% were Hispanic, and 1.0% were Asian in 2012-2016.

Table 8: Race/Ethnicity in Hancock County 2012-2016

	PERCENT/NUMBER
American Indian/Alaskan Native	0.4% / 211
Asian	1.0% / 518
Black/African American	0.6% / 320
Hispanic	1.3% / 711
Some other race	0.0% / 19
Two or more races	1.7% / 938
White	96.3% / 52,462

SOCIOECONOMIC STATUS

Socioeconomic status (SES) is measured by such things as income, poverty, employment, education, and neighborhood characteristics. Individuals with low SES are more likely to have chronic health issues, die prematurely, and have overall poor health. Low income status is highly correlated to a lower than average life expectancy. Lack of gainful employment is linked to several barriers to care, such as lack of health insurance, inability to pay for health care services, and inability to pay for transportation to receive services. Higher education is associated with improved health outcomes and social development at individual and community levels.[14] The health benefits of higher education typically include better access to resources, safer and more stable housing, and better engagement with providers. Factors associated with low education impact an individual's ability to navigate the healthcare system, disparities in personal health behaviors, and exposure to chronic stress. It is important to note that, while education affects health, poor health status may also be a barrier to education. Table 9 includes a number of data points comparing Hancock County to the state overall.

Additionally, in Hancock County:

- The estimated high school graduation rate was higher than the state overall (88.3% vs. 86.9%) in 2017.
- The percent of the population over 25 with an associates' degree or higher was higher than the state overall (40.9% vs. 37.3%) in 2017.

Table 9: Socioeconomic Status in Hancock County, 2012-2016

	HANCOCK/MAINE
Median household income	$50,037 / $50,826
Unemployment rate	4.7% / 3.8%
Individuals living in poverty	12.1% / 13.5%
Children living in poverty	15.5% / 17.2%
65+ living alone	46.2% / 45.3%

SPECIAL POPULATIONS

Through community engagement activities, several populations in Hancock County were identified as being particularly vulnerable or at-risk for poor health or health inequities.

Youth

Youth were identified as a priority population in the community forum. Specific issues of concern were youth mental health issues (specifically stress, depression, and anxiety); substance use (specifically opioids, marijuana, and vaping/Juuling), lack of education and promotion around nutrition and physical activity, and unsupervised youth. One key informant who works with youth identified a need for them to be able to access low-cost and anonymous health services, specifically reproductive and substance use services, without parent permission.

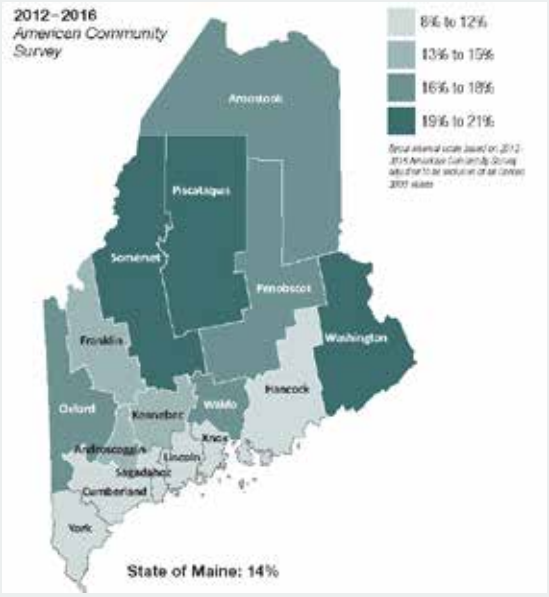
Older Adults

As noted in the priority section on Older Adult Health/ Healthy Aging, older adults are a key community concern with the growth of the aging population. See the histogram (Table 10) for the demographics of aging in the county.

Low-Income/Rural

Nationally, an ever-evolving economic structure has placed extra strain on individuals and families living in large rural areas with low population density; some of the most well-known causes and conditions of hardship include a lack of and outsourcing of jobs, limited long-term employment opportunities, barriers to accessing health care services, and the need for a personal vehicle. Generational poverty—when a family has lived in poverty for at least two generations—differs from situational poverty in that it typically includes the constant presence of hopelessness. This lack of hope and a near-constant state of perpetual crisis creates a cycle of poverty that persists from one generation to the next.

Figure 7: Poverty in the State of Maine



In addition to the data collected and analyzed for the County Health Profiles, the Maine CDC created Health Equity Data Summaries (available at www.mainechna.org) which provides selected data analyzed by sex, race, ethnicity, sexual orientation, education, and income. These data are at the state level, as much of the county level data would be suppressed due to small numbers and privacy concerns, and the previous analyses have shown that health disparities found at the state level are generally similar in individual counties.

It should also be noted that during the summer months, Maine's population increases due to temporary and part-time residents with those who seek the beauty of the rocky coast, mountains, lakes, camps, and islands. For many communities, this poses unique opportunities – and challenges.

KEY INDICATORS

The Key Indicators provide an overview of the health of each county. They are a broad sampling of health topics, including health behaviors, outcomes, living conditions, and health care quality and access. See the Hancock County Health Profile for a full set of data. The table uses symbols to show whether there are important changes in each indicator over time and to show if local data is notably better or worse than the state or the nation. See the box below for a key to the symbols:

CHANGE shows **statistically significant changes** in the indicator over time, based on 95% confidence interval (see description above).

- ★ 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 compares Hancock County data to state and national data, based on 95% confidence interval (see description above).

- ★ means Hancock County is doing **significantly better** than the state or national average.
- ! means Hancock 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.

	HANCOCK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2007-2011 **18.9%**	2012-2016 **15.5%**	N/A	2012-2016 **17.2%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$47,421**	2012-2016 **$50,037**	N/A	2012-2016 **$50,826**	N/A	2016 **$57,617**	N/A
Estimated high school student graduation rate	2014 **84.3%**	2017 **88.3%**	N/A	2017 **86.9%**	N/A	–	N/A
Food insecurity	2012-2013 **15.4%**	2014-2015 **15.3%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2011-2013 **15.8%**	2014-2016 **16.9%**	○	2014-2016 **19.6%**	○	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **13.1%**	2014-2016 **12.2%**	○	2014-2016 **16.7%**	○	2016 **11.2%**	N/A
Years of potential life lost per 100,000 population	2010-2012 **5,593.9**	2014-2016 **6,912.1**	○	2014-2016 **6,529.2**	○	2014-2016 **6,658.0**	N/A
All cancer deaths per 100,000 population	2007-2011 **176.3**	2012-2016 **160.2**	○	2012-2016 **173.8**	○	2011-2015 **163.5**	○
Cardiovascular disease deaths per 100,000 population	2007-2011 **223.6**	2012-2016 **191.3**	★	2012-2016 **195.8**	○	2016 **218.2**	★
Diabetes	2011-2013 **8.9%**	2014-2016 **7.8%**	○	2014-2016 **10.0%**	★	2016 **10.5%**	★
Chronic obstructive pulmonary disease (COPD)	2011-2013 **7.0%**	2014-2016 **5.5%**	○	2014-2016 **7.8%**	★	2016 **6.3%**	○
Obesity (adults)	2011 **26.2%**	2016 **25.8%**	○	2016 **29.9%**	○	2016 **29.6%**	○
Obesity (high school students)	2011 **12.9%**	2017 **13.5%**	○	2017 **15.0%**	○	–	N/A
Obesity (middle school students)	–	2017 **12.0%**	N/A	2017 **15.3%**	○	–	N/A
Infant deaths per 1,000 live births	2007-2011 **5.3***	2012-2016 **6.0***	○	2012-2016 **6.5**	○	2012-2016 **5.9**	○
Cognitive decline	2012 **15.3*%**	2016 **8.9*%**	○	2016 **10.3%**	○	2016 **10.6%**	○
Lyme disease new cases per 100,000 population	2008-2012 **25.0**	2013-2017 **213.8**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **167.0**	2013-2017 **173.6**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **305.2**	2012-2014 **314.9**	○	2012-2014 **340.9**	★	–	N/A
Suicide deaths per 100,000 population	2007-2011 **12.7**	2012-2016 **16.9**	○	2012-2016 **15.9**	○	2016 **13.5**	○
Overdose deaths per 100,000 population	2007-2011 **12.0**	2012-2016 **19.1**	○	2012-2016 **18.1**	○	2016 **19.8**	○

	HANCOCK COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2009-2011 **15.0%**	2012-2016 **12.9%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ratio of primary care physicians to 100,000 population	–	2017 **64.5**	N/A	2017 **67.3**	N/A	–	N/A
Ratio of psychiatrists to 100,000 population	–	2017 **5.0**	N/A	2017 **8.4**	N/A	–	N/A
Ratio of practicing dentists to 100,000 population	–	2017 **26.1**	N/A	2017 **32.1**	N/A	–	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	–	2016 **82.8**	N/A	2016 **74.6**	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **68.4%**	2017 **72.0%**	N/A	2017 **73.7%**	N/A	–	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **20.8%**	2016 **14.0%**	○	2016 **20.6%**	★	2016 **23.2%**	N/A
Chronic heavy drinking (adults)	2011-2013 **8.4%**	2014-2016 **9.9%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)	2011 **22.9%**	2017 **24.9%**	○	2017 **22.5%**	○	–	N/A
Past-30-day alcohol use (middle school students)	2011 **5.6%**	2017 **3.8%**	○	2017 **3.7%**	○	–	N/A
Past-30-day marijuana use (high school students)	2011 **20.3%**	2017 **18.6%**	○	2017 **19.3%**	○	–	N/A
Past-30-day marijuana use (middle school students)	2011 **2.9%**	2017 **2.2%**	○	2017 **3.6%**	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **4.6%**	2017 **3.7%**	○	2017 **5.9%**	★	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	2011 **2.2%**	2017 **0.9%**	○	2017 **1.5%**	○	–	N/A
Current (every day or some days) smoking (adults)	2011-2012 **22.6%**	2016 **21.3%**	○	2016 **19.8%**	○	2016 **17.0%**	N/A
Past-30-day cigarette smoking (high school students)	2011 **14.2%**	2017 **7.0%**	★	2017 **8.8%**	○	–	N/A
Past-30-day cigarette smoking (middle school students)	2011 **2.6%**	2017 **1.3%**	○	2017 **1.9%**	○	–	N/A

Leading Causes of Death

The following chart compares the leading causes of death for the state of Maine and Hancock County.

RANK	STATE OF MAINE	HANCOCK COUNTY
1	Cancer	Cancer
2	Heart disease	Heart disease
3	Chronic lower respiratory diseases	Chronic lower respiratory diseases
4	Unintentional injuries	Unintentional injuries
5	Stroke	Stroke

APPENDIX A: REFERENCES

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APPENDIX B: HISTORY AND GOVERNANCE

Maine is one of the few states in the nation that conducts a shared public-private statewide community health needs assessment—the Maine Shared CHNA—which was born out of a unique public-private partnership. The partnership began as the OneMaine Health Collaborative in 2007, involving Northern Light Health (formerly Eastern Maine Healthcare Systems), MaineGeneral Health, and MaineHealth. After conversations with the Statewide Coordinating Council for Public Health, the Maine Center for Disease Control and Prevention, an office of the Department of Health and Human Services joined in 2012. In 2013, Central Maine Healthcare (CMHC) joined the group and in 2014, leadership from the signatory partners signed a formal Memorandum of Understanding outlining mutual goals and expectations. A charter was drafted by all five partners to guide a statewide assessment process.

The Maine Shared CHNA is intended to coordinate state and county needs assessments to meet the needs of hospitals, to support state and local public health accreditation efforts, and to provide valuable population health assessment data for a wide variety of organizations across Maine. Our vision is to turn data into action so that Maine will become the healthiest state in the nation.

The Metrics Committee drafted the list of data indicators, and the Community Engagement Committee drafted a method to ensure a robust community engagement process – both of which were approved by the Steering Committee. Each committee was led by the Program Manager, who was the primary point of contact for all entities and partners and was responsible for drafting and implementing the work plans which drove this process. A more detailed outline of these efforts follows. For more information about the committee structure and our partners, please visit the, "About Us," page on our website www.mainechna.org.

The Metrics Committee is charged with updating the common set of health indicators; developing the preliminary data analysis plan reviewing that indicators on emerging health issues; making recommendations for annual data-related activities; and estimating projected costs associated with these recommendations. Members of the Metrics Committee create processes and deliverables for the Steering Committee to review and approve. Members of the Metrics Committee include representatives of the Steering Committee, public health system partners, Federally Qualified Health Centers, academia, non-profits, and others with experience in epidemiology.

Figure 8: Maine Shared CHNA Governance Structure, 2018–2019

The Community Engagement Committee is charged with making recommendations for approval by the Steering Committee outlining a consistent and robust community engagement process. This process should identify priorities among significant health issues and identify local, regional, or statewide assets and resources that may potentially address the significant health needs identified. Members of the Community Engagement Committee share their expertise create processes and deliverables for the Steering Committee to review and approve. Members of the Community Engagement committee include representatives of the Steering Committee, public health system partners, Federally Qualified Health Centers, academia, and Maine non-profits such as United Ways, Community Action Programs, and others with an interest in broad community representation and input.

APPENDIX C: METHODOLOGY

Per the Maine Shared CHNA charter, the effort was conducted by the Steering Committee, Metrics Committee, and Community Engagement Committee. The Community Engagement Committee was led by the program manager who was the point of contact for all entities and partners and was responsible for meeting planning and facilitation. These committees worked in partnership with the Maine CDC and the contracted vendor, JSI. Maine CDC and its epidemiology contractor, University of Southern Maine, provided a significant amount of data analyses, technical support, and website development. JSI was contracted to support forum facilitation, a subset of data analysis, profile development, and report writing.

The Maine Shared CHNA process was rolled out in three stages:

Data Analysis

- **County Health Profiles** were released in September 2018. Two hundred indicators were selected to describe health outcomes, health behaviors, healthcare access and quality, and the social, community, and physical environments that affect health and wellness. See Hancock County Health Profile at www.mainechna.org.
- **District Health Profiles** were released in November 2018.
- **City Health Profiles** for Lewiston/Auburn, Bangor, and Portland were released in January 2019.

Outreach and Engagement

- **Community outreach** was conducted between September 2018 and January 2019. Community forums with residents and service providers were held in all 16 counties. All forms of engagement included forums and key informant interviews. Some local planning teams also conducted additional targeted outreach, focus groups, and surveys. The purpose of this outreach was to gather feedback on data and to identify health priorities, community assets, and gaps in resources to be used in health improvement planning.

Final Reports

- **Final CHNA reports** for the state, each county, and districts were released in April 2019. These reports included information from the health data profiles, summaries of qualitative information gathered from engagement activities, and a presentation of community health priorities.

DATA ANALYSIS

The Metrics committee identified the approximately 200 health indicators from over 30 sources to be used for the Maine Shared CHNA. The initial list was based on the indicators from the 2016 effort. This list was first scored against the following set of criteria:

- Was it already analyzed for a MeCDC program?
- Is the data from this indicator collected within the last few years?
- Does it “round out” the description of population health?
- Does it address one or more social determinants of health?
- Describe an emerging health issue?
- Does it measure something “actionable” or “impactful”?
- Does the indicator measure an issue that is known to have high health and social costs?

Further refinement included ensuring a mix of Outcomes, Behaviors, Healthcare Access and Quality, as well as Social, Community, and Physical Environment Measures. The final list was then arranged under the current 24 health topics as outlined in the Data Health Profiles.

The Metrics Committee, led by Maine CDC staff, then drafted a data analysis plan that included which indicator was to be analyzed by which demographic characteristics (i.e. gender, race/ethnicity, sexual orientation, income, educational attainment, and insurance status), and geographic stratification (state, public health district, county, and city). This analysis plan was then approved by the Steering Committee.

The **Data Analysis Workgroup** used the set of indicators and the data analysis plan, as laid out by the Metrics Committee, and collected and analyzed the data. Members of the Data Analysis Workgroup shared their years of epidemiological and data analysis experience and knowledge of best practices to inform all aspects of the final health profiles at the county, public health district, city, and state level. This included not only the data analysis but recommendations on best practices for data presentation and visualization.

The Data Analysis Workgroup met weekly from March through August 2018 to discuss and coordinate an approach for analysis and data sharing between the University of Southern Maine (USM), Maine CDC, and John Snow, Inc. (JSI). The group developed rules regarding time frame (e.g., comparisons across time were to be of periods of equal duration; the most recent data used was from 2010 to present), handling complexity (e.g., how to combine years of data when an indicator's data definition changed over time, such as ICD9/ICD10 coding or BRFSS question changes), benchmarking, map and graph formats, and iconography to be used in profile tables. Some of the methodologies are documented in the Data Definitions section of each health profile. More is provided in the "2018 Maine Shared CHNA Data Analysis Technical Definitions" posted on the Maine Shared CHNA website.

Data Health Profiles include:

- 1 State Health Profile
- 16 County Health Profiles
- 5 Public Health District Profiles (One for each of the geographically-based multi-county district. A Tribal District Profile as not possible at this time.)
- 3 City Health Profiles (Bangor, Lewiston/ Auburn, and Portland)
- 6 Health Equity Data Sheets, one for each of the following demographic characteristics:
  - Sex
  - Race
  - Hispanic ethnicity
  - Sexual orientation
  - Educational attainment
  - Income

*These reports, along with an interactive data form, can be found under the Health Profiles tab at **www.mainechna.org**.*

OUTREACH AND ENGAGEMENT

Community outreach and engagement for the Maine Shared CHNA included coordination at both the statewide, public health district, and county level. The statewide Community Engagement Committee met monthly from March 2018 through January 2019 to review and provide input on every aspect of engagement process.

In addition to the state-level Community Engagement Committee, a **Local Community Engagement Planning Committee** in each of Maine's 16 counties planned and implemented the logistics of community forums and events within each district. These committees were comprised of hospitals, public health district liaisons, and a variety of additional partners.

The 2018 Community Engagement Toolkit was designed to assist the Local Community Engagement Planning Committees in this effort.

Forums and Health Priorities

Criteria for visualizing data included areas identified as a health priority in the last CHNA, significant changes in the data over time, or where a county's data was notably better or worse than the state or the nation. Forum agenda items included remarks from health leaders; a review of previous health improvement efforts; a review of county-level data, discussion, and prioritization in small groups; and an overall forum-wide voting process. The Community Engagement and Steering Committees created and approved a rubric to guide the selection criteria for the subset of data to be presented in each forum's PowerPoint presentations.

Small groups had 35-45 minutes to discuss the data in the presentation and the full county profile, and to share their own experiences in order to identify their top county health priorities. Table facilitators guided these discussions using key questions and worksheets for reporting purposes. Health priorities identified during these small groups were collated and presented to the larger plenary session, where each attendee voted for their top four priorities. Votes were tallied and a hierarchy emerged.

The summary votes for each forum were used to develop the county level priorities. If multiple forums were held in a county, the forum results for forums held with the general community were included in the total votes for the county. In cases where a forum was held with a specific population, for example, LGBTQ youth or older adults, then the results of their voting and discussion were included in the section describing the needs of that particular population. To arrive at the top countywide community health issues, votes from the broad community forums were combined for each of the priority areas to identify priority areas which fell within 70% of the combined voting total.

The community forum participants also shared knowledge on gaps and assets available in their communities to address each of the top four priorities identified. The information gathered in this report is a start for further asset and gap mapping for each priority selected by the county.

Hancock County Forums

One community engagement activity was held in Hancock County.

Table 10: Community engagement activites in Hancock County, 2018

TYPE OF ENGAGEMENT	LOCATION & DATE	FACILITATOR	ATTENDEES
Community Forum	Ellsworth October 30, 2018	JSI	53

COMMUNITY ENGAGEMENT

Persons representing broad interests of the community who were consulted during the engagement process:

- Amyotrophic Lateral Sclerosis (ALS) Maine Collaborative
- Mount Desert Island Regional School District AOS 91
- Deer Isle-Stonington Central School District (CSD 13)
- Downeast Community Partners
- Downeast Public Health District
- Eastern Area Agency on Aging
- Friends in Action
- George Stevens Academy
- Hancock County Emergency Management Agency
- Healthy Acadia
- Healthy Island Project
- Healthy Peninsula
- Hospice Volunteers of Hancock County
- Island Health & Wellness Foundation
- Maine CDC
- Maine Community Foundation
- Mount Desert Island Hospital
- Next Step Domestic Violence Project
- Northern Light Acadia Healthcare
- Northern Light Acadia Hospital
- Northern Light Blue Hill Hospital
- Northern Light Health
- Northern Light Home Health & Hospice
- Northern Light Maine Coast Hospital
- Parker Ridge Retirement Community
- Peninsula Ambulance
- School Union 76 (Brooklin and Sedgwick Schools)
- State of Maine DHHS, Maine CDC
- Town of Deer Isle

Key informant interviews

The Steering Committee identified ten categories of medically underserved and vulnerable populations to ensure their input was heard and captured. A list of 80 potential interview subjects was created with statewide input. Selected key informants either had lived experience in or worked for an organization that focused on providing services or advocacy for the identified population. No Tribal representatives were able to be interviewed. In the future, we hope to include this important group in the CHNA process. The populations identified included:

- Veterans
- Tribal communities
- Adults ages 65 and older who are isolated or have multiple chronic conditions
- Non-English speakers, undocumented individuals, immigrants, and refugees
- Deaf individuals and those with other physical disabilities
- Adolescents/youth
- LGBTQ
- People with mental health conditions and developmental disabilities
- Rural individuals
- Individuals in substance use disorder recovery/substance use disorder prevention and treatment professionals

The following is a list of organizations who participated in Key Informant Interviews conducted both by JSI and local planning committee members:

- Alpha One
- Androscoggin Home Healthcare + Hospice
- Bingham Foundation
- Cary Medical Center
- Catholic Charities of Maine
- Community Concepts
- Community Caring Collaborative
- Edmund Ervin Pediatric Center, MaineGeneral Health
- EqualityMaine
- Family Medicine Institute
- Frannie Peabody Center
- Greater Portland Council of Governments
- Healthy Acadia
- Healthy Androscoggin
- Healthy Communities of the Capitol Area
- Kennebec Valley Council of Governments
- Long Creek Youth Development Center
- Maine Access Immigrant Network
- Maine Alliance for Addiction and Recovery
- Maine Alliance to Prevent Substance Abuse
- Maine Chapter Multiple Sclerosis Society
- Maine Council on Aging
- Maine Migrant Health
- Maine Seacoast Mission
- Millinocket Chamber of Commerce
- National Alliance on Mental Illness
- Nautilus Public Health
- Northern Light Maine Coast Hospital
- Office of Aging and Disability Services
- Penquis Community Action Agency
- Portland Public Health
- Seniors Plus
- Sunrise Opportunities
- Tri-County Mental Health Services
- United Ambulance Service
- Veterans Administration Maine Healthcare System
- York County Community Action Corporation

The key informant interview guide was developed with input from the Community Engagement and Steering Committee members and consisted of the following five questions.

- We are interested in learning more about the priority health needs for this population (reference population(s) of expertise of interviewee). How would you characterize the health needs for this population? How are they different than for the general population?
- From where you sit and the work you do, what do you feel are the most important health needs to address? Why?
- What do you see as the major resource gaps with respect to health and wellness for this population?
- Are you currently working on anything that contributes to community health and wellness for this population? Are there any areas of health you would like to work on in partnership with others?
- Are there any particular assets or resources to address the needs of this population that can be leveraged?

Thirty-one interviews were conducted by JSI and 11 by members of Local Community Engagement Planning Committees. Information gathered from the key informant interviews is included in discussions where applicable in the county level report within each of the county priorities. For example, when discussing substance use, a discussion of the needs of vulnerable populations within this priority was also included. The state level report provides a summary of key findings from these interviews for each of the ten vulnerable populations.

Data collection

All outcomes from these efforts were collected via the Community Outreach Reporting Tool or the Key Informant Reporting tool. Both of these collection tools were online surveys within Survey Monkey. Other data collection tools included Table Facilitators notes, forum registrations, and sign-ins.

FINAL REPORTS

Integrated analysis of all quantitative and qualitative activities and findings was conducted between December 2018 and January 2019. These were used to develop a full description of the risk factors underlying the health priorities for each county.

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