

2022 Maine Shared
Community Health Needs Assessment

Androscoggin County



Northern Light HealthSM

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, as well as a listing of those who provided input, is provided in the Methodology section on page 18.

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

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

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

Table 1. Leading Causes of Death

RANK	MAINE	ANDROSCOGGIN COUNTY
1	Cancer	Heart Disease
2	Heart Disease	Cancer
3	Unintentional Injury	Chronic Lower Respiratory Disease
4	Chronic Lower Respiratory Disease	Unintentional Injury
5	Stroke	Alzheimer's Disease

TOP HEALTH PRIORITIES

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

Table 2. Top Health Priorities for Androscoggin County

PRIORITIES	% OF VOTES
Mental Health	97%
Social Determinants of Health	62%
Substance & Alcohol Use	51%
Access to Care	45%

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

Table 3. Top Health Priorities for County/State

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

✓ 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 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

Androscoggin is the state's fifth-most populous county, with lower income and educational attainment. It has a slightly younger population than the state overall.

Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	105,604	1.34M
Median household income	\$53,509	\$57,918
Unemployment rate	5.5%	5.4%
Individuals living in poverty	11.8%	11.8%
Children living in poverty	15.3%	13.8%

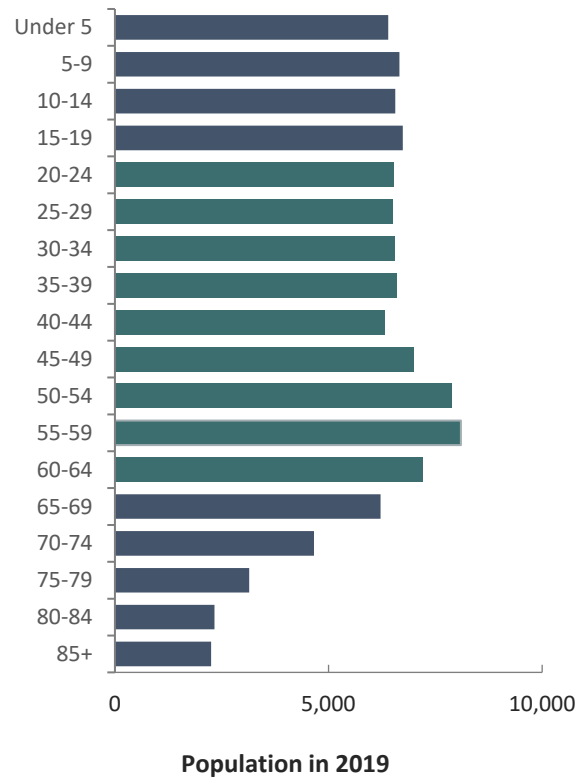
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	31.0%	29.0%
Associate's degree or higher (age 25+)	34.3%	41.9%
Gay, lesbian, and bisexual (adults)	4.2%	3.5%
Persons with a disability	15.9%	16.0%
Veterans	10.1%	9.6%

Table 5. Race/Ethnicity in Androscoggin County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.2%	162
Asian	0.8%	839
Black/African American	2.4%	2,562
Native Hawaiian or other Pacific Islander	-	-
White	91.4%	98,386
Some other race	0.2%	267
Two or more races	5.0%	5,386
Hispanic	1.9%	1,998
Non-Hispanic	98.1%	103,606

Figure 1. Age distribution for Androscoggin County



HEALTH EQUITY

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

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

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

NEXT STEPS

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

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

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.

The availability of mental health providers in Androscoggin 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. Nearly two-thirds (60%) of community forum participants identified the use of the **emergency department** to address mental health needs in Androscoggin County as a concern. The rate of those seeking mental health care in the emergency department was 278.8 per 10,000 in 2106-2018, significantly higher than in Maine overall (181.5).

“Would like more education and resources available in the schools.”

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, 34.1% of

high school students and 30.2% of middle school students reported feeling sad or hopeless for two or more weeks in a row. This was a significant increase of high school from 26.7% in 2017. There were also increases in the percentage of high school students, (from 16.5% to 18.7%) and of middle school students (from 18.8% to 22.3%) who seriously considered suicide between 2017 and 2019. These rates are not a significant increase and are similar to the state 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 which forced homeschooling in potentially unsafe situations while decreasing access to school-based supports.

The percentage of adults diagnosed with anxiety in their lifetime is during the 2015-2017 period was 26.3%. This is a significantly greater rate than the state overall (21.4%).

“Long wait lists, lack of providers, this must be a priority. We need to get more creative/innovative.”

Community resources mentioned by participants to address mental health issues include St. Mary’s Regional Medical Centers’ newly renovated adult and adolescent psychiatric units, the Lewiston Police Department Project Support You, the Maine Resilience Building Network, and Tri-County Mental Health.

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

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

MAJOR HEALTH CONCERNS FOR ANDROSCOGGIN COUNTY

INDICATOR	ANDROSCOGGIN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 278.8	N/A	2016-2018 181.5	!	—	N/A
Depression, current symptoms (adults)	2012-2014 10.5%	2015-2017 11.2%	○	2015-2017 9.5%	○	—	N/A
Depression, lifetime	2012-2014 28.4%	2015-2017 26.5%	○	2015-2017 23.7%	○	2017 19.1%	N/A
Anxiety, lifetime	2012-2014 22.0%	2015-2017 26.3%	○	2015-2017 21.4%	!	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 26.7%	2019 34.1%	!	2019 32.1%	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 23.9%	2019 30.2%	○	2019 24.8%	○	—	N/A
Seriously considered suicide (high school students)	2017 16.5%	2019 18.7%	○	2019 16.4%	○	—	N/A
Seriously considered suicide (middle school students)	2017 18.8%	2019 22.3%	○	2019 19.8%	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 30.7%	N/A	2011-2017 30.8%	○	—	N/A
Ratio of population to psychiatrists	—	2019 19,079.0	N/A	2019 12,985.0	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 21.4%	2015-2017 20.0%	N/A	2015-2017 18.0%	N/A	—	N/A

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

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

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

★	means the county is doing significantly better than the state or national average.
!	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 Androscoggin County community. The community also identified barriers to care, including a lack of mental health providers, a need for additional youth mental health services, the need for law enforcement training, and the potentially serious consequences of untreated mental health issues as ongoing challenges Androscoggin County will need to overcome.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Collaboration Collaboration across organizations</p> <p>Treatment St. Mary's new adult psychiatric unit (3) Mobile crisis unit Experience of provider communities (2) Expansion of telehealth (5) Dedicated staff (3) Tri-County Mental Health (4) Common Ties</p> <p>Schools/Youth New child/adolescent unit (2) Education in schools MaineCare covers support for children Lewiston High School Yellow Tulip Project</p> <p>ACEs/trauma Maine Resiliency Building Network</p> <p>Law Enforcement Provider ride-alongs with police (4) Lewiston PD Project Support You (3)</p> <p>Other Services State providing agencies funding for growing homeless population</p>	<p>Collaboration Need better coordination (3)</p> <p>Providers Not enough providers/long waitlists (19) Lack of providers for youth Providers available limited hours</p> <p>Barriers to Treatment Not everyone wants help Stigma (5) Lack of access to in-home services Lack of prescribers (3) Overuse of Emergency Department (3) Patients cannot self-refer to services (2) Access to case management/counseling for people without MaineCare (2) Waitlists (2)</p> <p>Schools/Youth Teachers leaving due to student behaviors Lack of access to services in schools (5) Bullying</p> <p>Law Enforcement Law enforcement training (2)</p> <p>Funding Inadequate reimbursements for providers (2) Inadequate funding Not enough resources to pay for gaps/barriers</p>

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR ANDROSCOGGIN COUNTY

Social determinants of health were selected as a top priority in Androscoggin County. It was also identified as one of the top health concerns in 14 other counties and among the 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.² Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Androscoggin County.

Androscoggin County community forum participants noted challenges that included high housing costs, unreliable transportation for those needing services, and a lack of cultural competency in an area with a large immigrant population.

“Would like to see services-healthcare and other services-provided in a way that addresses language barriers and issues of cultural competency”

Adverse childhood experiences (ACEs) are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. This was the most frequently mentioned health indicator. In 2019, 22.5% of high school students in Androscoggin County reported having experienced four or more adverse childhood experiences.

Poverty was the second most frequently mentioned health indicator in Androscoggin County. According to recent estimates, 11.8% of individuals and 15.3% of children in Androscoggin County live in

poverty. This is the same as the state overall for individuals (11.8%) and a significant decline from 15.5% in 2009-2011. It is a similar rate to Maine overall for children (13.8%). While the median household income significantly increased from \$45,699 in 2007-2011 to \$53,509 in 2015-2019, it is still significantly lower than the state (\$57,918).

Housing Insecurity was the third most frequently mentioned health indicator. Recent data shows 4.4% of high school students report sleeping somewhere other than in their parents or guardians homes, while 10.9% of residents spent more than **half their income on housing**. The **cost of housing** was the fourth most identified health indicator. This was also a major concern highlighted among Maine’s immigrant population.

Lack of transportation was the fifth most frequently mentioned health indicator. Recent data show 2.6% of residents do not own a vehicle. Participants noted a lack of public transportation.

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. Older adults often live on limited incomes and must rely on the support of others as well as face barriers related to transportation and food insecurity.

Resources mentioned by participants include the Good Food Bus, the CHOICE Neighborhoods Initiative Grant, the Lewiston Area Public Housing Committee, and the Maine Resiliency Building Network.

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

² 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 ANDROSCOGGIN COUNTY

INDICATOR	ANDROSCOGGIN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 15.5%	2015-2019 11.8%	★	2015-2019 11.8%	○	2019 12.3%	○
Children living in poverty	2018 17.3%	2019 15.3%	○	2019 13.8%	○	2019 16.8%	○
Children eligible for free or reduced lunch	2020 62.6%	2021 60.9%	N/A	2021 38.2%	N/A	—	N/A
Median household income	2007-2011 \$45,699	2015-2019 \$53,509	★	2015-2019 \$57,918	!	2019 \$65,712	N/A
Unemployment	2018 3.3%	2020 5.5%	N/A	2020 5.4%	N/A	2020 8.1%	N/A
High school student graduation	2019 80.3%	2020 80.5%	N/A	2020 87.4%	N/A	2019 87.1%	N/A
People living in rural areas	—	2019 31.1%	N/A	2019 66.2%	N/A	—	N/A
Access to broadband	2015 99.6%	2017 99.9%	N/A	2017 88.6%	N/A	2017 90.4%	N/A
No vehicle for the household	2007-2011 2.5%	2015-2019 2.6%	○	2015-2019 2.1%	○	2019 4.3%	N/A
Persons 65 years and older living alone	2011-2015 31.2%	2015-2019 31.0%	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 10.9%	N/A	2015-2019 12.0%	○	—	N/A
Housing insecure (high school students)	2017 3.5%	2019 4.4%	○	2019 3.3%	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 22.5%	N/A	2019 21.3%	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 27.4%	2015-2019 34.3%	N/A	2015-2019 41.9%	N/A	2019 41.7%	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 33.8%	N/A	2015-2019 32.9%	N/A	2019 37.9%	N/A

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COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Androscoggin County community members point to several resources available that improve social determinants of health. These include several resources available to assist residents with accessing healthy foods, public safety groups, support groups, and strong community cohesion. 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 concerning 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>Community Cohesion Androscoggin Community Stakeholder Group (4) Lewiston Area Public Health Committee Residents friendly, willing to help neighbors Nonprofit willingness to meet needs (2) Collaboration across orgs Bates volunteers</p> <p>Food St. Mary's Nutrition Center programming (2) Good Food Bus (2) WIC</p> <p>Housing Choice Neighborhoods Initiative Grant from U.S. Department of Housing and Urban Development (HUD) Lewiston Housing Committee</p> <p>ACEs/Trauma/Resiliency Maine Resiliency Building Network (4) Knowledge of ACEs</p> <p>Public Safety Auburn Police Activities League Center School Resource Officers</p>	<p>Poverty Ability to afford medications (2) Poverty (4) Unemployment (4)</p> <p>Food Food crisis for youth</p> <p>Housing Housing/homelessness issues (13)</p> <p>Transportation Transportation issues (13)</p> <p>Isolation 65+ living alone (2)</p> <p>Children/youth No childcare (3)</p> <p>Equity Lack of health equity/cultural competence (5) Language barriers (3) Bias in healthcare (2) Need programs explicitly tackling racism/discrimination</p> <p>ACEs Lack of awareness of the effects of adverse childhood experiences (ACEs) (4)</p> <p>Access to Resources Lack of health literacy (3) Lack of knowledge of available resources The disconnect between resources (2)</p> <p>Workforce Staff burnout (3)</p>

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR ANDROSCOGGIN COUNTY

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

Overdose deaths were the most frequently mentioned health indicator for substance and alcohol use (by 84% of forum participants). In 2020, the rate of overdose deaths per 100,000 population in Androscoggin County was 47.9, an increase from 30.5 in 2019. The rate in Maine overall was 37.3 in 2020, lower than Androscoggin County but not to a significant degree.

“The drug use rates in our community are very alarming. This ties into ACEs.”

Community forum participants expressed concerns about multiple drug and alcohol use health indicators, including, **chronic heavy drinking, alcohol-induced deaths, and alcohol-impaired driving deaths.** Participants noted changing societal norms around drug use and increased access, especially for marijuana and alcohol, coupled with a lack of early intervention and education. The rate of alcohol-induced deaths in Androscoggin County was 14.9 per 100,000 residents between 2015 and 2019. This is significantly higher increase from 8.8 during the 2007-2011 time period. Drug induced deaths include those from chronic drug use due to a medical condition.

Drug-affected infants were the third most frequently mentioned health indicator. The rate of drug-affected infant reports per 1,000 births in Androscoggin County was 113.5 in 2018-2019. This is significantly higher than the state overall (73.7).

Drug-induced deaths have increased substantially and are out of control

Hospital utilization was the fourth most frequently mentioned health indicator for substance and alcohol use. In 2016-2018, the rate of opiate poisoning hospitalizations per 10,000 population in Androscoggin County was 1.5. This is similar to the state overall (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

A common barrier mentioned by participants is a lack of substance use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Participants also mentioned resources such as the OPTIONS Recovery Connection of Maine, Tri-County Mental Health Services, and Healthy Androscoggin.

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

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

MAJOR HEALTH CONCERNS FOR ANDROSCOGGIN COUNTY

INDICATOR	ANDROSCOGGIN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 30.5	2020 47.9	○	2020 37.3	○	2019 21.5	N/A
Drug-induced deaths per 100,000 population	2007-2011 12.7	2015-2019 28.4	!	2015-2019 29.5	○	2019 22.8	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 8.8	2015-2019 14.9	!	2015-2019 11.6	○	2019 10.4	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 1.9	2019 3.7	N/A	2019 3.8	N/A	2019 3.1	N/A
Drug-affected infant reports per 1,000 births	2017 95.1	2018-2019 113.5	○	2018-2019 73.7	!	—	N/A
Chronic heavy drinking (adults)	2012-2014 6.1%	2015-2017 6.5%	○	2015-2017 8.5%	○	2017 6.2%	N/A
Binge drinking (adults)	2012-2014 16.4%	2015-2017 17.2%	○	2015-2017 17.9%	○	2017 17.4%	N/A
Past-30-day marijuana use (adults)	2013-2016 10.0%	2017 15.9%	○	2017 16.3%	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	—	2013-2017 0.9%*	N/A	2013-2017 1.0%	○	—	N/A
Past-30-day alcohol use (high school students)	2017 20.4%	2019 18.2%	○	2019 22.9%	★	—	N/A
Past-30-day alcohol use (middle school students)	2017 3.6%	2019 2.8%	○	2019 4.0%	★	—	N/A
Binge drinking (high school students)	2017 7.0%	2019 6.2%	○	2019 8.2%	○	—	N/A
Binge drinking (middle school students)	2017 1.8%	2019 0.6%	★	2019 1.3%	★	—	N/A
Past-30-day marijuana use (high school students)	2017 20.2%	2019 21.5%	○	2019 22.1%	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 4.7%	2019 4.1%	○	2019 4.1%	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 7.5%	2019 5.5%	★	2019 5.0%	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 1.6%	2019 4.1%	!	2019 3.0%	!	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 13.3	2020 12.4	N/A	2020 12.1	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 96.2	2020 108.1	○	2020 76.7	!	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 9.7	N/A	2016-2018 9.9	○	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 1.5	○	2016-2018 1.4	○	—	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 SUBSTANCE & ALCOHOL USE

Community members in Androscoggin 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 care coordination, stigma, limited inpatient treatment options, widely available addictive substances, and long waitlists to access care.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Collaboration Collaboration across orgs</p> <p>Prevention Drug take-back events (4)</p> <p>Recovery Vocal/growing recovery community (3) Many recovery organizations in Lewiston/Auburn (3) Recovery Connection of Maine (2)</p> <p>Treatment Telehealth</p> <p>Harm Reduction Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) program (4) Harm reduction/syringe exchange (9)</p> <p>Law Enforcement Law enforcement shifting focus to provide help Law enforcement (3)</p> <p>Organizations Healthy Androscoggin (3) Seniors Plus (3) Community Concepts (3)</p> <p>Youth National Recreation and Park Association (NRPA) grants in Lewiston/Auburn recreation for opioid impacted youth Counselor in Auburn Schools</p>	<p>Collaboration Need better coordination (4)</p> <p>Stigma Not everyone wants help – stigma</p> <p>Ease of Access/attitudes The abundance of cannabis storefronts Alcohol not considered a drug of concern (4) Criminalization (2)</p> <p>Treatment Limited inpatient treatment options (5) Lack of treatment programs/providers - general (4) Long wait lists (3)</p> <p>Funding Inadequate funding</p> <p>Youth Need early intervention in schools (3)</p>

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR ANDROSCOGGIN COUNTY

Access to care was identified as the fourth top priority in Androscoggin County. It was also identified as a top health concern in all other counties and underserved communities across 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.⁴

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

“All priority areas have severe staffing shortages, and this relates to staff burnout”

Cost barriers to care were the most frequently identified health indicator related to access to care. In 2015-2017, 14.2% of adults reported that there was a time during the last 12 months when they needed to see a doctor but could not because of the cost. This is significantly higher than Maine overall (10.6%).

A lack of **easy access to primary care providers** was the second most frequently mentioned health indicator related to access to care. In 2019, 8.6% of residents needed to travel 30 miles or more to be seen by a primary care provider. It was also identified as a common gap/need in the area (mentioned by 30% of forum participants).

A lack of health insurance was the third most frequently mentioned health indicator by community

members. From 2015-2019, the rate of **uninsured** in Androscoggin County was 8.0%. This is similar to the state uninsured rate of 7.9% over that same period. In 2020, 53.8% of children ages 0-19 were enrolled in MaineCare. This is an increase from 49.7% in 2019, and higher than the state rate of 43.8%.

“Telehealth has been a way to overcome some access barriers.”

The percentage of adults who were seen by **any primary care provider** between 2015 and 2019 was 75.7%, an increase from 72.9% between 2012 and 2014. This still equates to 24.3% of residents at risk of not having received routine preventative care.

Disparate communities experience barriers related to access differently. Maine’s immigrant population noted the need for culturally and linguistically appropriate care and support and more free clinics. 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 Androscoggin County faces with access to care, community forum participants noted the area has St. Mary’s Behavioral Emergency Department, the Central Maine Heart and Vascular Institute, increased telehealth services and the City of Auburn’s new Public Health Manager position.

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.

⁴ Chartbook on Access to Health Care, Agency for Healthcare Research and Quality. Available from: <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html>

MAJOR HEALTH CONCERNS FOR ANDROSCOGGIN COUNTY

INDICATOR	ANDROSCOGGIN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
ACCESS							
Uninsured	2009-2011 9.5%	2015-2019 8.0%	○	2015-2019 7.9%	○	2019 9.2%	N/A
MaineCare enrollment (all ages)	2019 31.9%	2020 35.7%	N/A	2020 29.1%	N/A	2020 24.1%	N/A
MaineCare enrollment (ages 0-19)	2019 49.7%	2020 53.8%	N/A	2020 43.8%	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 1,038.0	N/A	2019 1,332.0	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 88.4%	2015-2017 90.1%	○	2015-2017 87.9%	○	2017 76.8%	N/A
Primary care visit to any primary care provider in the past year	2012-2014 72.9%	2015-2017 75.7%	○	2015-2017 72.0%	○	2017 70.4%	N/A
Cost barriers to health care	2011-2013 10.9%	2015-2017 14.2%	○	2015-2017 10.6%	!	2016 12.0%	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 8.6%	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.
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○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.

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

★	means the county is doing significantly better than the state or national average.
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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 ACCESS TO CARE

Resources available in Androscoggin 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, 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, a lack of culturally competent care, and a lack of education around prevention and primary care.

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

Table 9. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Community Cohesion Collaboration across organizations (2)</p> <p>Community Organizations & Programs Many organizations working to connect residents with resources (2) Auburn Public Health Manager position just added Number of Primary Care Providers in the community Life Flight St. Mary's Behavioral Emergency Department (BED) (3) Central Maine Heart and Vascular Institute (2) Local hospitals (3)</p> <p>Technology Telehealth</p> <p>Access with alternatives Central Maine Medical Center Family Medicine Residents providing walk-in at New Beginnings</p> <p>Workforce Development Dedicated staff (3) Maine College of Health Professions University of New England College of Osteopathic Medicine (2)</p>	<p>Culturally Competent Care Lack of culturally appropriate care (10)</p> <p>Barrier to Access LogistiCare Transportation Services is challenging to access (4)</p> <p>Providers/workforce Shortage of specialists (3) Lack of Primary Care Providers (2) Need nursing level care beds (2) Workforce shortages/long waitlists (6) Not enough trained staff (2) Primary Care Provider turnover Provider burnout</p> <p>Coordination Need better coordination/breakdown of silos (5)</p> <p>Education Need prevention/education Lack of understanding/value of primary care (2)</p>

OTHER IDENTIFIED NEEDS

The following is a list of all health priorities identified in the Androscoggin 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 Androscoggin County

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	36	97%
Social Determinants to Health	23	62%
Substance and Alcohol Use	19	51%
Access to Care	17	46%
Older Adults	10	27%
Physical Activities, Nutrition, and Weight	7	19%
Health Care Quality	4	11%
Oral Health	4	11%
Tobacco	4	11%
Children with Special Needs	3	8%
Environmental Health	3	8%
Diabetes	3	8%
Pregnancy and Birth Outcomes	3	8%
Other- Housing and Homelessness	3	8%
Cancer	2	5%
Cardiovascular Disease	2	5%
Intentional Injury	2	5%
Immunizations	1	3%
Respiratory Disease	1	3%
Unintentional Injury	1	3%

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

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

Reporting

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

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

One virtual community forum was held in Androscoggin County on November 10, 2021, with 42 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Androscoggin Collaborative
Androscoggin Home Healthcare & Hospice
Ascentria Community Services
Bates College
Central Maine HealthcareCommunity Concepts
Community Concepts
Community Credit Union
Healthy Androscoggin/Central Maine Healthcare
Maine Center for Disease Control and Prevention
Maine Immigrant Rights Coalition
New Beginnings
Promise Early Education Center
Safe Voices
Sandcastle Clinical & Educational Services
SeniorsPlus
St. Mary's Health System
Sweetser
Tri-County Mental Health Services
Western Maine Community Action WIC
YWCA Central Maine

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

ACKNOWLEDGMENTS

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

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

Oral Survey Sponsors

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

Community Event Sponsors

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

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

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



