2022 Maine Shared
Community Health Needs Assessment

Oxford County

Northern Light Health SM

COVID-19 AND OUR HEALTH

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

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

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

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

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

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

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

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INTRODUCTION

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

The mission of the Maine Shared CHNA is to:

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

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

New this cycle is an expanded effort to reach those who may experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted in this effort. One effort included nine community sponsored events hosted by organizations representing the following communities: Black or African Americans; people who are deaf or hard of hearing; people with a mental health diagnosis; people with a disability; people who define themselves or identify as lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ+); people with low income; older adults; people who are homeless or formerly homeless; and youth. In addition to these events, 1,000 oral surveys were conducted in collaboration with eight ethnic-based community organizations' community health workers to better reach Maine's immigrant population. A complete description of how these efforts were deployed and a listing of those who provided input is provided in the Methodology section on page 20.

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

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

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	OXFORD COUNTY
1	Cancer	Cancer
2	Heart Disease	Heart Disease
3	Unintentional Injury	Chronic Lower Respiratory Disease
4	Chronic Lower Respiratory Disease	Unintentional Injury
5	Stroke	Stroke

TOP HEALTH PRIORITIES

The participants at the Oxford County forums have identified the following health priorities.

Table 2. Top Health Priorities for Oxford County	
PRIORITIES	% OF VOTES
Mental Health	58%
Access to Care	49%
Substance and Alcohol Use	42%
Social Determinants of Health	38%

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

Table 3. Top Health Priorities for County/State				
PRIORITIES	2018		2021	
Mental Health	✓	●	✓	●
Access to Care	✓	●	✓	●
Substance and Alcohol Use	✓	●	✓	●
Social Determinants of Health	✓	●	✓	●
Older Adult Health		●		
Physical Activity, Nutrition, and Weight		●		

✓ *County Priority*   ● *State Priority*

Common themes identified by participants in 2021 include an emerging mental health crisis; challenges in access to healthcare, including mental health providers; issues related to poverty, transportation, and other social determinants of health in a rural state; and increasing rates of substance and alcohol use.

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

DEMOGRAPHICS

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

Table 4. Selected Demographics		
	COUNTY	MAINE
Population numbers	57,550	1.34M
Median household income	$49,204	$57,918
Unemployment rate	6.7%	5.4%
Individuals living in poverty	15.1%	11.8%
Children living in poverty	17.6%	13.8%

Table 4. Selected Demographics (Continued)		
	COUNTY	MAINE
65+ living alone	24.0%	29.0%
Associate's degree or higher (age 25+)	30.5%	41.9%
Gay, lesbian and, or bisexual (adults)	2.6%	3.5%
Persons with a disability	18.5%	16.0%
Veterans	10.2%	9.6%

Table 5. Race/Ethnicity in Oxford County		
	PERCENT	NUMBER
American Indian/Alaskan Native	0.3%	182
Asian	0.4%	217
Black/African American	0.4%	212
Native Hawaiian or other Pacific Islander	-	-
White	96.2%	57,550
Some other race	0.2%	88
Two or more races	2.5%	1,453
Hispanic	1.4%	793
Non-Hispanic	98.6%	56,757

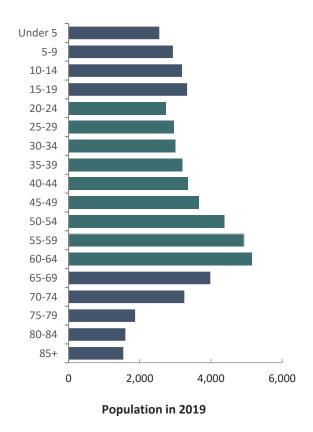Figure 1. Age distribution for Oxford County

Population in 2019

HEALTH EQUITY

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

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

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

NEXT STEPS

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

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

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

PRIORITY: MENTAL HEALTH

KEY TAKEAWAYS FOR OXFORD COUNTY

Mental health was the top priority identified in Oxford 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 from an event held with those who have 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.

"I see lots of mental health issues, concerns around suicide and self-injurious behaviors, lots of students feeling lonely."

Availability of mental health providers in Oxford 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. Community forum participants (15%) identified the use of the **Emergency Department** to address mental health needs in Oxford County as a concern.

The mental health emergency department rate per 10,000 population in Oxford County during the time period of 2016-2018 was 199.3. This is significantly higher than in Maine overall (181.5). During the 2015-2017 time period, one in five adults reported they had experienced **depression** in their lifetime, while a similar proportion has experienced **anxiety** (19.7%) over the same time period.

Mental health issues among youth was also noted as a concern by participants, particularly the rate at which youth experience **suicidal ideation** and feeling **sad and hopeless**. In 2019, 35.0% (1 in 3) of high school students and 25.3% (1 in 4) of middle school students in Oxford County reported feeling sad or hopeless for two or more weeks in a row. During the same period, 19.1% of high school students and 20.8% of middle school students, (1 in 5 each), seriously considered suicide. These rates have all increased since 2017. They are also are similar to Maine overall.

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

"I'm concerned about the mental health impacts of adverse childhood events (ACEs)."

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

Participants mentioned community resources in Oxford to address mental health issues such as Tri-County Mental Health, 211 Maine, Common Grounds Counseling, the availability of telehealth services, and Oxford 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.

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

MAJOR HEALTH CONCERNS FOR OXFORD COUNTY

| INDICATOR | OXFORD COUNTY | | | BENCHMARKS | | | |
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 **199.3**	N/A	2016-2018 **181.5**	**!**	—	N/A
Depression, current symptoms (adults)	2012-2014 **9.4%**	2015-2017 **10.4%**	○	2015-2017 **9.5%**	○	—	N/A
Depression, lifetime	2012-2014 **23.7%**	2015-2017 **22.7%**	○	2015-2017 **23.7%**	○	2017 **19.1%**	N/A
Anxiety, lifetime	2012-2014 **18.2%**	2015-2017 **19.7%**	○	2015-2017 **21.4%**	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 **28.2%**	2019 **35.0%**	○	2019 **32.1%**	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 **20.4%**	2019 **25.3%**	○	2019 **24.8%**	○	—	N/A
Seriously considered suicide (high school students)	2017 **16.2%**	2019 **19.1%**	○	2019 **16.4%**	○	—	N/A
Seriously considered suicide (middle school students)	2017 **15.8%**	2019 **20.8%**	○	2019 **19.8%**	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 **30.5%**	N/A	2011-2017 **30.8%**	○	—	N/A
Ratio of population to psychiatrists	—	2019 **173,148.0**	N/A	2019 **12,985.0**	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 **15.7%**	2015-2017 **18.4%**	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 Oxford County community. The community also identified barriers to care, including a lack of mental health providers, a need for additional youth mental health services, a lack of focus on prevention, and the potentially serious consequences of untreated mental health issues as ongoing challenges Oxford County will need to overcome.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Collaborations **Treatment** Oxford County Mental Health (8) Tri-County Mental Health (3) Common Ground Counseling (2) Telehealth **Awareness/stigma** Work towards reducing stigma **Schools/Youth** Trauma-informed education in schools (5) Improvement in diagnosis/referral for youth **Other Services** Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) Program (7) Organizations collaborating on substance use disorder prevention	**Barriers to Treatment** Stigma (6) Isolation/limitations due to COVID (3) Lack of specialized care (2) Lack of inpatient treatment (2) Lack of intermediate care (2) Waitlists **Youth Mental Health** Lack of child specialists (2) **ACEs/Trauma** Adverse Childhood Events (ACEs) **Providers** Not enough providers - general and waitlists (11)

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR OXFORD COUNTY

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

A lack of **availability of primary care providers** in Oxford County was the most frequently mentioned health indicator related to access to care. The lack of providers in the area and the rural nature of the county creates long travel distances to receive care as well as lengthy delays to establish care. Data shows 42.2% of **primary care visits in Oxford County were more than 30 miles from the patient's home** in 2019. This compares to 20.0% of primary care visits in Maine. Given these long travel distances, **transportation** was identified as a top need in Oxford County to help improve access (mentioned by 57% of the forum participants).

"As with mental health and substance use disorder, there is a lack of providers and waitlists for medical services."

Cost barriers to care were the second most frequently identified health indicator related to access to care. In 2015-2017, 11.6% of adults reported that there was a time during the last 12 months when they needed to see a doctor but could not because of the cost. This is similar to Maine overall (10.6%).

The percentage of adults with a **usual primary care provider** increased from 86.8% in 2012-2014 to 89.1% in 2015-2017, however, this increase is not statistically significant. Overall, 87.9% of Mainers had a usual primary care provider in 2015-2017.

The percentage of adults who were seen by **any primary care provider** between 2015 and 2017 was 73.2%, an increase from 70.8% between 2012 and 2014. This means 26.8% of Oxford County residents did not receive any preventative care from a primary care provider.

A lack of health insurance was another health indicator frequently mentioned by community members. From 2015-2019, the rate of **uninsured** in Oxford County was 8.8%. This is similar to the state uninsured rate of 7.9% over the same period.

According to 2020 data, 36.4% of Oxford County residents were enrolled in **MaineCare**. This rate of enrollment is higher than the previous year (32.0), the state (29.1%), and the nation (24.1).

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

Despite the challenges that Oxford County faces with access to care, community forum participants noted the area has Cancer Resource Center of Western Maine, Stephen's Memorial Hospital, Rumford Hospital, Western Maine Transportation Services, and Rumford Group Homes.

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

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

MAJOR HEALTH CONCERNS FOR OXFORD COUNTY

INDICATOR	OXFORD COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
ACCESS							
Uninsured	2009-2011 **11.6%**	2015-2019 **8.8%**	★	2015-2019 **7.9%**	○	2019 **9.2%**	N/A
MaineCare enrollment (all ages)	2019 **32.0%**	2020 **36.4%**	N/A	2020 **29.1%**	N/A	2020 **24.1%**	N/A
MaineCare enrollment (ages 0-19)	2019 **50.2%**	2020 **56.3%**	N/A	2020 **43.8%**	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 **1,742.0**	N/A	2019 **1,332.0**	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 **86.8%**	2015-2017 **89.1%**	○	2015-2017 **87.9%**	○	2017 **76.8%**	N/A
Primary care visit to any primary care provider in the past year	2012-2014 **70.8%**	2015-2017 **73.2%**	○	2015-2017 **72.0%**	○	2017 **70.4%**	N/A
Cost barriers to health care	2011-2013 **13.0%**	2015-2017 **11.6%**	○	2015-2017 **10.6%**	○	2016 **12.0%**	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 **42.2%**	N/A	2019 **20.0%**	N/A	—	N/A

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COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

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

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Organizations collaborating on substance use disorder prevention **Community Organizations** Rumford Hospital (5) Cancer Resource Center of Western Maine (2) Stephens Memorial Hospital (2) Western Maine Transportation Services Western Maine Addiction Recovery Initiative (WMARI) Project Save ME (2) **Access alternatives** Telehealth MaineCare increased the pay rate Rumford Group Homes **Education** Social-Emotional Learning in schools	**Barriers to Care** Long waitlists/lack of providers (7) No internet devices/education for telehealth (4) Outpatient clinics (2) Need to work toward reducing stigma (3) Isolation/limitations due to COVID (2) **Cost of Care** Insurance issues (3) Limited treatment for uninsured (2) Transportation (14) Limited medical facilitates outside of Rumford **Other SDOH** Lack of access to affordable healthy food (3) Poverty Housing issues

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR OXFORD COUNTY

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

Drug-affected infants were the most frequently mentioned health indicator related to substance use in Oxford County. The rate of drug-affected infant reports per 1,000 births in Oxford County was 121.1 in 2018-2019. This rate is significantly higher than the state overall (73.7).

"I'd like to see harm reduction programs, earlier education and intervention in schools, and a reduction of stigma."

Overdose deaths were mentioned by 84% of forum participants and was the second most frequently mentioned priority health indicator for substance use in Oxford County. The rate of overdose deaths per 100,000 population in Oxford County In 2020 was 25.8, an increase from 15.5 in 2019. This is a similar rate compared to Maine (37.3) in 2020.

The need for medical intervention was the third most frequently mentioned area of concern for substance use. In 2016-2018, the rate of overdose emergency medical service responses per 10,000 in 2020 was 59.7. This is a significantly improved rate when compared to the state in 2020 (76.7) and is similar to the rate in 2019 (56.6).

The **misuse of prescription drugs** was mentioned by 10% of forum participants. During the time period of 2013-2017, 1.5% of Oxford County adults from and 5.5% of high school students in 2019 reported they misused prescription medication. Narcotic does dispensed per capita in 2020 was 14.6, higher than the state rate of 12.1.

Community forum participants expressed concerns about multiple health indicators, including, **chronic heavy drinking, alcohol-induced deaths, and alcohol-impaired driving deaths.** Participants noted changing societal norms and increased access, especially for marijuana and alcohol, and a lack of early intervention and education. The rate of alcohol-induced deaths in Oxford County was 13.6 per 100,000 residents between 2015 and 2019. This is higher than Maine overall (11.6).

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

Participants mentioned common barrier to addressing substance and alcohol use is a lack of substance and alcohol use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Participants also mentioned resources to address the issue in the area include River Valley Healthy Community Coalition, Western Maine Addiction Recovery Initiative (WMARI), Larry Labonte Recovery Center, Beacon House, and Common Ties.

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

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[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 OXFORD COUNTY

	OXFORD COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 **15.5**	2020 **25.8**	◯	2020 **37.3**	◯	2019 **21.5**	N/A
Drug-induced deaths per 100,000 population	2007-2011 **10.8**	2015-2019 **22.1**	❗	2015-2019 **29.5**	◯	2019 **22.8**	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 **8.4**	2015-2019 **13.6**	◯	2015-2019 **11.6**	◯	2019 **10.4**	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 **6.9**	2019 **10.3**	N/A	2019 **3.8**	N/A	2019 **3.1**	N/A
Drug-affected infant reports per 1,000 births	2017 **143.2**	2018-2019 **121.1**	◯	2018-2019 **73.7**	❗	—	N/A
Chronic heavy drinking (adults)	2012-2014 **5.8%**	2015-2017 **7.1%**	◯	2015-2017 **8.5%**	◯	2017 **6.2%**	N/A
Binge drinking (adults)	2012-2014 **14.6%**	2015-2017 **14.8%**	◯	2015-2017 **17.9%**	◯	2017 **17.4%**	N/A
Past-30-day marijuana use (adults)	2013-2016 **11.4%**	2017 **17.8%**	◯	2017 **16.3%**	◯	—	N/A
Past-30-day misuse of prescription drugs (adult)	2012-2016 **1.5%**	2013-2017 **1.5%***	N/A	2013-2017 **1.0%**	N/A	—	N/A
Past-30-day alcohol use (high school students)	2017 **23.2%**	2019 **23.9%**	◯	2019 **22.9%**	◯	—	N/A
Past-30-day alcohol use (middle school students)	2017 **2.8%**	2019 **5.2%**	◯	2019 **4.0%**	◯	—	N/A
Binge drinking (high school students)	2017 **7.9%**	2019 **8.1%**	◯	2019 **8.2%**	◯	—	N/A
Binge drinking (middle school students)	2017 **0.5%**	2019 **1.4%**	◯	2019 **1.3%**	◯	—	N/A
Past-30-day marijuana use (high school students)	2017 **22.7%**	2019 **24.1%**	◯	2019 **22.1%**	◯	—	N/A
Past-30-day marijuana use (middle school students)	2017 **4.5%**	2019 **5.1%**	◯	2019 **4.1%**	◯	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 **6.4%**	2019 **5.5%**	◯	2019 **5.0%**	◯	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.2%**	2019 **2.4%**	◯	2019 **3.0%**	◯	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 **15.2**	2020 **14.6**	N/A	2020 **12.1**	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 **56.6**	2020 **59.7**	◯	2020 **76.7**	★	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 **7.8**	N/A	2016-2018 **9.9**	★	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 **0.7***	N/A	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 Oxford County identified peer recovery and treatment resources available as potential strengths to address substance and alcohol use in their county, along with harm reduction strategies and funding sources. Additionally, barriers to substance and alcohol use issues were identified by community members, including a lack of available treatment programs, a need for additional recovery residences, widely available addictive substances, and a lack of youth resources.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration River Valley Healthy Communities (6) Healthy Oxford Hills (3) Organizations collaborating on substance use disorder prevention (3) **Prevention** Organizations collaborating on substance use disorder prevention (3) **Recovery/ Maintenance** Larry Labonte Recovery Center (10) Western Maine Addiction Recovery Initiative (WMARI) (3) **Treatment** Integrated Medication-Assisted Treatment (MAT) prescribers (2) **Harm Reduction** Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative **Organizations** Common Ties **Youth** Beacon House	**Treatment** Lack of treatment/providers/long waitlists (7) Lack of prescribers (3) Lack of counselors (3) Limited treatment for uninsured (3) Lack of detox programs (2) Lack of inpatient treatment (2) Lack of long-term treatment options (2) Waitlists **Recovery** Lack of recovery center (3) Isolation/limitations due to COVID (2) Need recovery residence/sober living (2) **Harm Reduction** Need syringe programs/needle exchange **Stigma** Need to work to reduce stigma (5) **Youth** Need adolescent treatment (3) Need earlier education/intervention in schools

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR OXFORD COUNTY

Social determinants of health were selected as a top priority in Oxford County. It was also identified as one of the top health concerns in 14 other counties and among underserved communities across 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.[4] Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Oxford County.

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 related to social determinants of health by participants. In 2019, 24.8% (1 in 4) of high school students in Oxford County reported experiencing four or more adverse childhood experiences.

"Key issues are the price of fresh foods, housing issues, lack of transportation, and generational poverty."

Poverty was the second most frequently mentioned health indicator in Oxford County. According to recent estimates, 15.1% of individuals and 17.6% of children in Oxford County live in poverty. This is significantly higher than the state overall for individuals (11.8%), although not significantly different for children (13.8%).

In 2021 over half (52.8%) of students 18 years old and younger were eligible to receive **free or reduced lunch**. This rate is down from 56.8% in 2020 but remains a significant concern in the county. Access to free school lunch was extended to all students in 2020 in response to the COVID-19 pandemic.

Broadband access was the third most frequently mentioned health indicator. In 2017, 87.6% of residents in Oxford County had broadband access, meaning 12.4% of residents were without access, limiting their ability to participate in telehealth or access the global marketplace.

Ten percent of forum participants said **education** was a concern. Oxford County's **graduation** rate was 87.1% in 2020, similar to Maine overall (87.4%). Recent data shows 30.5% of those 25 and older in Oxford County hold an **associate degree**. This is lower than Maine overall (41.9%), but the difference is not significant.

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

Resources mentioned by participants include River Valley Healthy Communities Coalition, Oxford Hills Trauma-Informed Training, and Healthy Oxford Hills and Oxford County Wellness Collaborative.

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

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[4] 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 OXFORD COUNTY

INDICATOR	OXFORD COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 **14.4%**	2015-2019 **15.1%**	◯	2015-2019 **11.8%**	❗	2019 **12.3%**	N/A
Children living in poverty	2018 **26.3%**	2019 **17.6%**	◯	2019 **13.8%**	◯	2019 **16.8%**	◯
Children eligible for free or reduced lunch	2020 **56.8%**	2021 **52.8%**	N/A	2021 **38.2%**	N/A	2017 **15.6%**	N/A
Median household income	2007-2011 **$40,889**	2015-2019 **$49,204**	★	2015-2019 **$57,918**	❗	2019 **$65,712**	N/A
Unemployment	2018 **4.0%**	2020 **6.7%**	N/A	2020 **5.4%**	N/A	2020 **8.1%**	N/A
High school student graduation	2019 **85.7%**	2020 **87.1%**	N/A	2020 **87.4%**	N/A	**2019** **87.1%**	N/A
People living in rural areas	—	2019 **100.0%**	N/A	2019 **66.2%**	N/A	—	N/A
Access to broadband	2015 **86.6%**	2017 **87.6%**	N/A	2017 **88.6%**	N/A	2017 **90.4%**	N/A
No vehicle for the household	2007-2011 **1.6%**	2015-2019 **1.4%**	◯	2015-2019 **2.1%**	◯	2019 **4.3%**	N/A
Persons 65 years and older living alone	2011-2015 **24.9%**	2015-2019 **24.0%**	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 **10.7%**	N/A	2015-2019 **12.0%**	◯	—	N/A
Housing insecure (high school students)	2017 **5.8%**	2019 **4.4%**	◯	2019 **3.3%**	◯	—	N/A
Adverse childhood experiences (high school students)	—	2019 **24.8%**	N/A	2019 **21.3%**	◯	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 **25.9%**	2015-2019 **30.5%**	N/A	2015-2019 **41.9%**	N/A	2019 **41.7%**	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 **41.9%**	N/A	2015-2019 **32.9%**	N/A	2019 **37.9%**	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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BENCHMARK columns compare the county data to the state and national data.		
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COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

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

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

Table 9. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Collaborations Oxford County Wellness Collaborative Healthy Oxford Hills (2) River Valley Healthy Communities Coalition (5) Community Concepts (5) Greater Rumford Community Center (4) FedCap (2) findhelp.org (Aunt Bertha) (2) Oxford Hills Trauma-Informed Training **Food** Food pantries (4) Nutrition education/SNAP-educators (2) Region 9 Culinary Arts (2) Cooperative Extension office & programs Robert's Farm **Physical Activity** River Valley Recreation Black Mountain (2) Trails (3) Community rec depts (3) Mountain View High School (MVHS) Fitness Center (2) MVHS Lifetime Pursuits Class (2) Disc golf at MVHS Outdoor Educational program @ Meroby Elementary (2) Swift River (2) Snowmobile club (2) Greater Lovell Land Trust Trails Western Foothills Land Trust Alan Day Community Garden American Youth Football	**Poverty** Generational poverty (2) Need access to jobs **Transportation** Transportation issues (5) **Housing** Housing issues (2) **Food** Hard to get fresh produce (2) Nutritious foods are expensive **Youth** Need school resource officer for RSU56 **Physical Activity** Some recreational trails are not safe for youth/families (2) Limited PE in elementary/middle schools **Barriers to Care** Isolation/limitations due to COVID (2) Need to work to reduce stigma (3)

Table 9. Gaps/Needs and Available Resources (Social Determinants of Health, Continued)

AVAILABLE RESOURCES	GAPS/NEEDS
Youth and Schools Schools offer many extra and co-curricular After school programs Western Foothills Kids Association (2) **ACEs/Trauma/Resiliency** Oxford Hills Trauma-Informed Training/Social Emotional Learning Curriculum (3) **Family Support** Safe Voices Domestic Violence Resource Center	

OTHER IDENTIFIED NEEDS

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

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	41	58%
Access to Care	35	49%
Substance and Alcohol Use	30	42%
Social Determinants of Health	27	38%
Physical Activity, Nutrition, and Weight	15	21%
Health Care Quality	6	8%
Cancer	4	6%
Pregnancy and Birth Outcomes	4	6%
Children with Special Needs	4	6%
Tobacco	4	6%
Older Adult Health	3	4%
Intentional Injury	2	3%
Environmental Health	1	1%
Diabetes	1	1%
Immunizations	1	1%

APPENDIX: METHODOLOGY

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

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

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

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

Data Analysis

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

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

Community Outreach and Engagement

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

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

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

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

The communities included:

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

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

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

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

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

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

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

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

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

Reporting

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

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

One virtual community forum was held in Oxford County on November 3, 2021, November 9, 2021, and November 23, 2021, with 71 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

A Family for ME
Bethel Family Health Center
Central Maine Healthcare/Rumford Hospital
Common Ground Counseling
Community Concepts
Community member
Healthy Oxford Hills
Hope Association
Jared Golden's office
Larry Labonte Recovery Center
Let's Go!
Maine Behavioral Health
Maine Center for Disease Control and Prevention
Maine Medical Center
Maine Medical Center Research Institute
Maine Prisoner Reentry Network
MaineHealth
MSAD17
New Balance Foundation
Oxford and Oxford County DA's Office
Oxford County Mental Health Services
Oxford County Wellness Collaborative
Portland Recovery Community Center
River Valley Healthy Community Coalition
RSU 10
RSU 56
Safe Voices
Stephens Memorial Hospital
Western Foothill Kids Association
Western Foothills Land Trust
Western Maine Community Action
Western Maine Health

For a complete listing of organizations consulted for each of the 10 health equity outreach efforts, please see the Acknowledgements, page 23. 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

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

Oral Survey Sponsors	Community Event Sponsors
Capital Area New Mainers Project	Consumer Council System of Maine
City of Portland's Minority Health Program	Disability Rights Maine
Gateway Community Services	Green A.M.E. Zion Church
Maine Access Immigrant Network	Health Equity Alliance
Maine Community Integration	Maine Continuum of Care
Maine Department of Health and Human Services*	Maine Council on Aging
Maine Immigrant and Refugee Services	Maine Primary Care Association
Mano en Mano	Maine Youth Action Network
New England Arab American Organization	
New Mainers Public Health Initiative	

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