

2022 Maine Shared
Community Health Needs Assessment

Piscataquis 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 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	PISCATAQUIS COUNTY
1	Cancer	Cancer
2	Heart Disease	Heart Disease
3	Unintentional Injury	Diabetes
4	Chronic Lower Respiratory Disease	Unintentional Injury
5	Stroke	Stroke

TOP HEALTH PRIORITIES

The participants of the Piscataquis County forum have identified the following health priorities.

Table 2. Top Health Priorities for Piscataquis County

PRIORITIES	% OF VOTES
Mental Health	49%
Access to Care	45%
Social Determinants of Health	37%
Substance & Alcohol Use	37%

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

Table 3. Top Health Priorities for County/State

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

✓ County Priority ● State Priority

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

providers; issues related to poverty, transportation, and other social determinants of health in a rural state; and increasing rates of substance and alcohol use.

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

DEMOGRAPHICS

Piscataquis 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	16,836	1.34M
Median household income	\$40,890	\$57,918
Unemployment rate	5.5%	5.4%
Individuals living in poverty	18.5%	11.8%
Children living in poverty	23.8%	13.8%

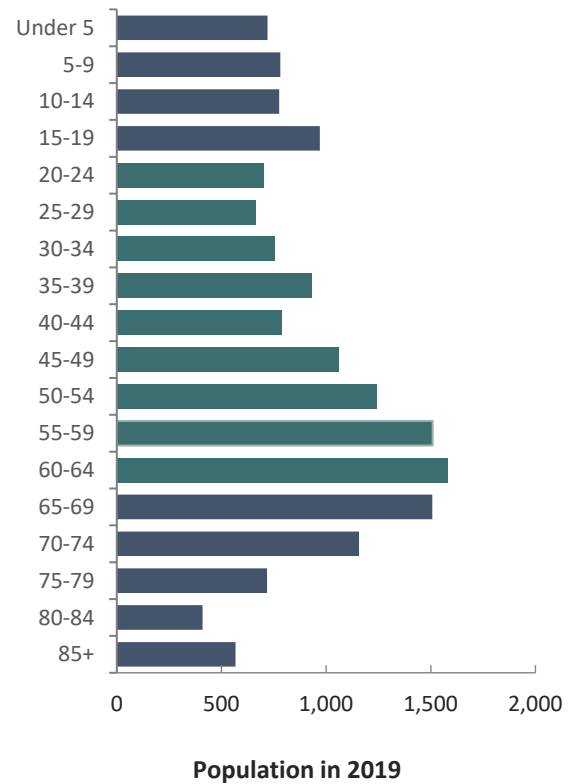
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	27.4%	29.0%
Associate's degree or higher (age 25+)	31.3%	41.9%
Gay, lesbian, and bisexual (adults)	3.2%	3.5%
Persons with a disability	26.3%	16.0%
Veterans	12.6%	9.6%

Table 5. Race/Ethnicity in Piscataquis County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.8%	135
Asian	0.8%	131
Black/African American	0.6%	96
Native Hawaiian or other Pacific Islander	-	-
White	95.8%	16,128
Some other race	0.7%	119
Two or more races	1.3%	227
Hispanic	1.5%	245
Non-Hispanic	98.5%	16,583

Figure 1. Age distribution for Piscataquis 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. 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 PISCATAQUIS COUNTY

Mental health was the top priority identified in Piscataquis County. It was also identified as a top health priority 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 the community sponsored event for individuals living with a mental health diagnosis noted extremely long waitlists for services, and the need for more high-quality, personally tailored mental health services. Participants also suggested the need for more case management, supportive, and wrap-around services, as a mental health diagnoses can vary widely and require individualized care and treatment.

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

Availability of mental health providers in Piscataquis County was the most frequently mentioned concern related to mental health. Community members noted the low availability of providers in the area and the long distances people must travel to receive care. Additional **telehealth services** were identified as the top need in Piscataquis County to help address mental health issues (mentioned by 14% of forum participants).

Mental health issues among youth were concerning to those in the community, particularly the rate at which youth feel sad or hopeless and thoughts of suicide. In 2019, 30.0% of middle school students in Piscataquis County reported feeling sad or hopeless for two or more weeks in a row, while 24.5% seriously considered suicide. Both of these

rates are significantly higher than 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.

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.

Mental health emergency department usage was the fourth most frequently identified health concern related to mental health. The mental health emergency department rate per 10,000 population from 2016-2018 was 188.2. This rate was similar to the state (181.5) over that same period.

Nearly one in five adults (19.8%) in the county has experienced **depression** in their lifetime, while a similar proportion (20.7%) has experienced **anxiety**.

“Anxiety and depression are especially high right now. Mental health ends up being provided by law enforcement and hospital personnel. It’s hard to address other issues if you can’t get beyond mental health issues.”

Community members also expressed concerns about **MaineCare’s mental health treatment options** - especially for first-time moms. Participants mentioned MaineCare recipients’ ability to get the medication needed for anxiety and/or postpartum depression.

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.

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

MAJOR HEALTH CONCERNS FOR PISCATAQUIS COUNTY

INDICATOR	PISCATAQUIS			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 188.2	N/A	2016-2018 181.5	○	—	N/A
Depression, current symptoms (adults)	2012-2014 13.4%	2015-2017 10.6%	○	2015-2017 9.5%	○	—	N/A
Depression, lifetime	2012-2014 24.3%	2015-2017 19.8%	○	2015-2017 23.7%	○	2017 19.1%	N/A
Anxiety, lifetime	2012-2014 21.0%	2015-2017 20.7%	○	2015-2017 21.4%	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 32.5%	2019 37.0%	○	2019 32.1%	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 20.7%	2019 30.0%	○	2019 24.8%	!	—	N/A
Seriously considered suicide (high school students)	2017 17.4%	2019 18.9%	○	2019 16.4%	○	—	N/A
Seriously considered suicide (middle school students)	2017 19.4%	2019 24.5%	○	2019 19.8%	!	—	N/A
Chronic disease among persons with depression	—	2011-2017 —	N/A	2011-2017 30.8%	N/A	—	N/A
Ratio of population to psychiatrists	—	2019 —	N/A	2019 12,985.0	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 17.3%	2015-2017 17.8%	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 Piscataquis 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 Piscataquis 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>Treatment Increased use of telehealth (3) Northern Light Mayo Outreach Program Northern Light Acadia Hospital Child-Adolescent Resource and Educational Series (CARES) (5) Behavioral Health (2) Patient participation increased through virtual sessions with Northern Light Behavioral Health – Dover-Foxcroft (2)</p> <p>Youth Guidance counselors Motivational interviewing through programs such as SideKicks Positive action teams for youth (2)</p>	<p>Barriers to Care Telehealth services (7) Long delays to establish care (2) Long wait lists for services leads people to Emergency Department (ED) for services that should be outpatient Emergency services outside of the emergency departments and police Not enough facilities Lack of motivation Zoom fatigue Lack of transportation (5) Stigma (2) Lack of broadband</p> <p>Providers Lost a Psychiatric Mental Health Nurse Practitioner Inadequate availability of providers – Licensed Clinical Social Workers (LCSWS), counselors, psych specialties (5)</p> <p>Youth Mental Health Not enough focus on youth issues/needs (4) Children in emergency departments waiting for placements Lack of youth mental health providers No access in schools Lack of family support</p> <p>Prevention Lack of education/prevention services (4) Not enough mentoring/recreation for youth Lack of resources for online bullying</p> <p>Consequences Intentional injury/self-harm</p>

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR PISCATAQUIS COUNTY

Access to care was identified as the second top priority in Piscataquis County. It was also identified as a top health priority 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.²

Participants in the community forums noted that the rurality of the county creates barriers that are difficult to address, including attracting and keeping health care providers, long travel distances, and a lack of broadband access that makes telehealth and other online services more difficult to implement.

A lack of **availability of primary care providers** in Piscataquis County was the most frequently mentioned health concern related to access to care. It was also identified as the largest gap/barrier to access by community forum participants (mentioned by 27% of forum participants).

“This is a concern. It’s a challenge to get PCPs to come to the area. Some PCPs stay for a few years, others come and leave. It’s all over the place.”

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. One-third (33.1%) of **primary care visits in Piscataquis County were more than 30 miles from the patient’s home** in 2019. This compares to 20.0% of all primary care visits in Maine. Given these long travel distances, **transportation** was identified as a top need in Piscataquis County to help improve access (mentioned by 22% of forum participants).

Cost barriers were the third most frequently identified health concern related to access to care. In 2015-2017, 11.2% 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 similar to the state overall (10.6%).

A lack of health insurance was another health concern mentioned by community members. From 2015-2019, 10.2% of Piscataquis County residents were **uninsured**. This is significantly higher than the state uninsured rate of 7.9% over that same period.

The percentage of adults with a **usual primary care provider** declined from 88.1% in 2012-2014 to 84.9% in 2015-2017, however this decline is not statistically significant. Overall, 87.9% of Mainers had a usual primary care provider in 2015-2017.

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 Piscataquis County faces, community forum participants noted the area has two community hospitals as well as active community organizations committed to providing residents with education, assessments, and other program and services to help fill in the provider gap.

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 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 PISCATAQUIS COUNTY

INDICATOR	PISCATAQUIS COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
ACCESS							
Uninsured	2009-2011 —	2015-2019 10.2%	N/A	2015-2019 7.9%	!	2019 9.2%	N/A
MaineCare enrollment (all ages)	2019 33.5%	2020 38.2%	N/A	2020 29.1%	N/A	2020 24.1%	N/A
MaineCare enrollment (ages 0-19)	2019 53.3%	2020 61.0%	N/A	2020 43.8%	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 3,562.0	N/A	2019 1,332.0	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 88.1%	2015-2017 84.9%	○	2015-2017 87.9%	○	2017 76.8%	N/A
Primary care visit to any primary care provider in the past year	2012-2014 74.3%	2015-2017 71.8%	○	2015-2017 72.0%	○	2017 70.4%	N/A
Cost barriers to health care	2011-2013 10.9%	2015-2017 11.2%	○	2015-2017 10.6%	○	2016 12.0%	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 33.1%	N/A	2019 20.0%	N/A	—	N/A

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COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Available resources in Piscataquis 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
<p>Community Cohesion Strong health system despite rural areas (4) Good communication between Northern Light Mayo & CA Dean Hospitals</p> <p>Community Organizations Alzheimer's Association Northern Light Mayo Outreach Program Existing providers are committed Good hospitals Lots of community organizations</p> <p>Technology Telehealth options (3)</p> <p>Access Alternatives Programs offering home care assessments to older adults (2) Social partners like YMCA have integrated wellness programs Prevention programs such as YMCA integrated wellness Registered dietician at CA Dean & Mayo</p> <p>Education Healthcare organizations offering education/prevention work Diabetes education</p> <p>Workforce Development Actively recruiting primary care resources</p>	<p>Barriers to Care Long wait times Low reimbursement rates from home health, palliative, and hospice care Need healthcare insurance Limited availability of Primary Care, using the emergency department instead of a primary care provider Physicians and dental providers</p> <p>Specific Services Lack of screenings and subsequent earlier identification Low immunization rates Need diabetes education, nurse educators. Need better women's healthcare Lack of walk-in clinics and specialists</p> <p>Transportation Transportation</p> <p>Youth/children Lack of resources for children</p>

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR PISCATAQUIS COUNTY

Social determinants of health were selected as a top priority in Piscataquis County. It was also identified as one of the top health priorities in 14 other counties 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.³ Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Piscataquis County.

Piscataquis County community forum participants noted challenges related to social determinants of health that included a decrease in the number of childcare and daycare providers available, unreliable transportation for those needing services, and the fact that older adults need to rely on others to get the care and services they need.

Poverty was the most frequently mentioned health concern related to social determinants of health in Piscataquis County. According to recent estimates, 18.5% of individuals and 23.8% of children in Piscataquis County live in poverty. This is significantly higher than the state overall for both individuals (11.8%) and children (13.8%). Forum participants noted several local programs available that provide food and meals to those experiencing food insecurity.

Broadband access was the second most frequently identified concern related to social determinants of health. The percentage of residents with access to broadband internet was 41.8% in Piscataquis County in 2017. This is less than half the percentage of Maine residents overall (88.6%).

Rurality and lack of vehicles for households are the third most frequently identified social determinant of health concern. All of Piscataquis County is classified as rural and a lack of a personal vehicle creates a need for better transportation services in the area.

Adverse childhood experiences (ACEs) are a list of traumatic events that when occur during childhood increase the likelihood of negative health and behavioral outcomes later in life. In 2019, the percentage of high school students in Piscataquis County who had experienced four or more ACEs (19.7%) was similar to the state overall (21.3%).

Education was also identified as a concern related to social determinants of health. The percentage of adults aged 25 and older in Piscataquis County with an associate degree or higher increased from 26.1% in 2007-2011 to 31.3% in 2015-2019. This is lower than the state rate (41.9%) over that same time.

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

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 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 PISCATAQUIS COUNTY

INDICATOR	PISCATAQUIS COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 —	2015-2019 18.5%	N/A	2015-2019 11.8%	!	2019 12.3%	N/A
Children living in poverty	2018 23.8%	2019 23.8%	○	2019 13.8%	!	2019 16.8%	○
Children eligible for free or reduced lunch	2020 61.8%	2021 54.4%	N/A	2021 38.2%	N/A	2017 15.6%	N/A
Median household income	2007-2011 \$35,123	2015-2019 \$40,890	★	2015-2019 \$57,918	!	2019 \$65,712	N/A
Unemployment	2018 4.2%	2020 5.5%	N/A	2020 5.4%	N/A	2020 8.1%	N/A
High school student graduation	2019 86.8%	2020 85.9%	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 41.9%	2017 41.8%	N/A	2017 88.6%	N/A	2017 90.4%	N/A
No vehicle for the household	2007-2011 1.0%	2015-2019 1.5%	○	2015-2019 2.1%	○	2019 4.3%	N/A
Persons 65 years and older living alone	2011-2015 30.6%	2015-2019 27.4%	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 12.6%	N/A	2015-2019 12.0%	○	—	N/A
Housing insecure (high school students)	2017 3.7%	2019 3.5%	○	2019 3.3%	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 19.7%	N/A	2019 21.3%	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 26.1%	2015-2019 31.3%	N/A	2015-2019 41.9%	N/A	2019 41.7%	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 34.3%	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.
!	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 SOCIAL DETERMINANTS OF HEALTH

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

The following information was gathered from participants during a group activity. 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 (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Community Cohesion Helping Hands with Heart (2) United Way Furry Friends helps older adults get food for pets (2)</p> <p>Food Meals on Wheels (4) Backpacks for students through Good Shepherd (3) Piscataquis Regional Food Center (3) WIC (2) Food pantries (2) Summer Meals programs (3) Food bags in primary care provider offices Pineland Farms</p> <p>ACEs/Resiliency Knowledge of adverse childhood events (ACEs) has increased (2)</p> <p>Screening Northern Light Mayo Outreach Program Screening patients for food insecurity</p> <p>Funding: Money coming in through American Rescue Plan for broadband</p>	<p>Poverty Poverty (3)</p> <p>Housing Housing insecurity (7) No homeless shelters Education around environmental health (lead exposure, radon, air quality, indoor smoking) (3) Lack of housing for professionals wanting to move to the area (2)</p> <p>Transportation Transportation (7)</p> <p>Food Access to healthy food (2) Food insecurity (3) Winter activities expensive (2)</p> <p>Isolation Limited broadband/internet (7) Access to social support in winter</p> <p>Barriers to Services Computer literacy The rural area makes it difficult to recruit workforce (2) No Department of Health and Human Services (DHHS) Center No career center</p> <p>Youth/families Lack of childcare providers (2)</p>

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR PISCATAQUIS COUNTY

Substance and alcohol use was selected as a top priority in Piscataquis County. It was also identified as one of the top health priorities 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 use has also been linked to co-occurring mental health issues such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), among others.⁴

Overdose deaths were the most frequently mentioned health indicator for substance use in Piscataquis County. In 2020, the rate of overdose deaths per 100,000 population in Piscataquis County was 58.8. The rate in Maine overall was 37.3 in 2020.

Hospital utilization was the second most frequently mentioned health indicator for substance use. In 2016-2018, the rate of opiate poisoning hospitalizations per 10,000 population in Piscataquis County was 1.2. This is similar to the state overall (1.4).

Drug-affected infants were the third most frequently mentioned health indicator for substance use. The rate of drug-affected infant reports per 1,000 births in Piscataquis County was 132.2 in 2017 and declined to 99.6 during the 2018-2019 time period. The rate overall in the state was 73.7 during the 2018-2019 time period.

Community forum participants expressed concerns about multiple drug and alcohol use health indicators, including **adult chronic heavy drinking, alcohol-induced deaths, misuse of prescription drugs, and marijuana use.**

The percentage of adults who used marijuana in the past 30 days in Piscataquis County increased significantly from 6.6% in 2013-2016 to 14.9% in 2017. This rate similar to the state (16.3%) in 2017. Past 30-day use of marijuana among middle school students also increased significantly from 2017 (3.6%) to 2019 (5.1%). This rate for all middle school students in Maine was 4.1% in 2019.

Rates of other alcohol and drug health indicators in Piscataquis County were not significantly different from that of the state overall.

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.

“Opioid users need housing, substance, and mental health treatment and support. If we had housing, we could support people recovery.”

A common barrier to addressing substance use in Piscataquis County is a lack of substance and alcohol use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Community resources mentioned by participants include peer recovery coaches and centers, Northern Light Mayo Hospital Community Outreach Program, and group Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs.

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 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 PISCATAQUIS COUNTY

INDICATOR	PISCATAQUIS COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 —	2020 58.8*	N/A	2020 37.3	○	2019 21.5	N/A
Drug-induced deaths per 100,000 population	2007-2011 20.8	2015-2019 21.8*	○	2015-2019 29.5	○	2019 22.8	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 11.2	2015-2019 10.1*	○	2015-2019 11.6	○	2019 10.4	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 6.0	2019 0.0	N/A	2019 3.8	N/A	2019 3.1	N/A
Drug-affected infant reports per 1,000 births	2017 132.2*	2018-2019 99.6	○	2018-2019 73.7	○	—	N/A
Chronic heavy drinking (adults)	2012-2014 6.5%*	2015-2017 7.0%	○	2015-2017 8.5%	○	2017 6.2%	N/A
Binge drinking (adults)	2012-2014 15.1%	2015-2017 14.4%	○	2015-2017 17.9%	○	2017 17.4%	N/A
Past-30-day marijuana use (adults)	2013-2016 6.6%	2017 14.9%	!	2017 16.3%	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	2012-2016 0.5%	2013-2017 0.7%*	○	2013-2017 1.0%	○	—	N/A
Past-30-day alcohol use (high school students)	2017 21.4%	2019 20.8%	○	2019 22.9%	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 2.5%	2019 3.2%	○	2019 4.0%	★	—	N/A
Binge drinking (high school students)	2017 7.3%	2019 9.5%	○	2019 8.2%	○	—	N/A
Binge drinking (middle school students)	2017 —	2019 —	N/A	2019 1.3%	N/A	—	N/A
Past-30-day marijuana use (high school students)	2017 19.4%	2019 20.5%	○	2019 22.1%	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 3.6%	2019 5.1%	!	2019 4.1%	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 3.6%	2019 3.2%	○	2019 5.0%	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 3.6%	2019 4.1%	○	2019 3.0%	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 12.6	2020 10.9	N/A	2020 12.1	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 62.6	2020 73.0	○	2020 76.7	○	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 9.5	N/A	2016-2018 9.9	○	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 1.2*	N/A	2016-2018 1.4	○	—	N/A

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ADDITIONAL SYMBOLS	
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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

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

The following information was gathered from participants during a group activity. 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 (Substance & Alcohol Use)

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Recovery Peer Recovery Centers Peer Recovery Coaches (2) Group NA and AA programs</p> <p>Treatment Northern Light Mayo's Outreach Program Telehealth (2)</p> <p>Harm Reduction Education regarding the administration of Narcan (2)</p> <p>Funding Building resources for substance use disorder (SUD) Tobacco and substance use prevention funds</p>	<p>Barriers to Treatment Transportation (4) Lack of providers (2) e.g., Medication-Assisted Treatment (MAT) (4) Not enough detox programs (3) Not enough rehab programs (2)</p> <p>Recovery Need recovery coaches (2)</p> <p>Ease of access to substances Substance use has skyrocketed and can't keep up with new drugs Substance and alcohol use during pandemic Culture of acceptance around substance use</p> <p>Youth In-person tobacco education in school</p>

OTHER IDENTIFIED NEEDS

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

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	24	49%
Access to Care	22	45%
Social Determinants of Health	18	37%
Substance and Alcohol Use	18	37%
Physical Activity, Nutrition, and Weight	10	20%
Older Adult Health	7	14%
Tobacco	5	10%
Intentional Injury	5	10%
Immunizations	5	10%
Health Care Quality	5	10%
Children with Special Health Needs	5	10%
Unintentional Injury	3	6%
Pregnancy and Birth Outcomes	3	6%
Diabetes	3	6%
Cardiovascular Disease	3	6%
Cancer	3	6%
Environmental Health	2	4%
Infectious Disease	1	2%

APPENDIX: METHODOLOGY

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

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

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

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

Data Analysis

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

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

Community Outreach and Engagement

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

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

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

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

The communities included:

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

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

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

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

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

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

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

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

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

Reporting

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

In addition to Urban, County, and Health District reports, the County, District, and State level data are also available on an [Interactive Data Portal](#). The data in the portal is arranged by health topic and provides demographic comparisons, trends over time, definitions, and information on the data sources. Visit www.mainechna.org 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 Piscataquis County on September 7, 2021, with 51 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Bangor Public Health and Community Services
Bangor Public Health Department
Child Behavioral Health Services
Downeast Public Health District
Eastern Area Agency on Aging
Healthy Acadia
Helping Hands with Heart /Maine Highlands Investment Partnership
Northeastern Workforce Development Board
Northern Light Acadia Hospital
Northern Light CA Dean Hospital
Northern Light Health Systems
Northern Light Mayo Hospital
Office of Child and Family Services, Maine Department of Health and Human Services
Partners for Peace
Penquis
Penquis Public Health District
Piscataquis Regional Food Center
Public Health Care
Public Health Nursing, Maine Center for Disease Control and Prevention
State of Maine
United Way of Eastern Maine
WIC Nutrition Program

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.



