2022 Maine Shared
Community Health Needs Assessment

Sagadahoc County

Northern Light Health℠

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 19.

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-ident 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	SAGADAHOC COUNTY
1	Cancer	Heart Disease
2	Heart Disease	Cancer
3	Unintentional Injury	Chronic Lower Respiratory Disease
4	Chronic Lower Respiratory Disease	Stroke
5	Stroke	Unintentional Injury

TOP HEALTH PRIORITIES

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

Table 2. Top Health Priorities for Sagadahoc County

PRIORITIES	% OF VOTES
Mental Health	57%
Social Determinants of Health	48%
Access to Care	43%
Substance & Alcohol Use	40%

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

Table 3. Top Health Priorities for County/State

PRIORITIES	2018		2021	
Mental Health	✓	●	✓	●
Social Determinants of Health	✓	●	✓	●
Access to Care	✓	●	✓	●
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

Sagadahoc is a rural county, with higher income and educational attainment and lower rates of those living in poverty or with a disability. Sagadahoc is the only county in Maine without a hospital facility within its borders, often relying on services located in Brunswick.

Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	35,452	1.34M
Median household income	$63,694	$57,918
Unemployment rate	4.7%	5.4%
Individuals living in poverty	9.6%	11.8%
Children living in poverty	11.4%	13.8%

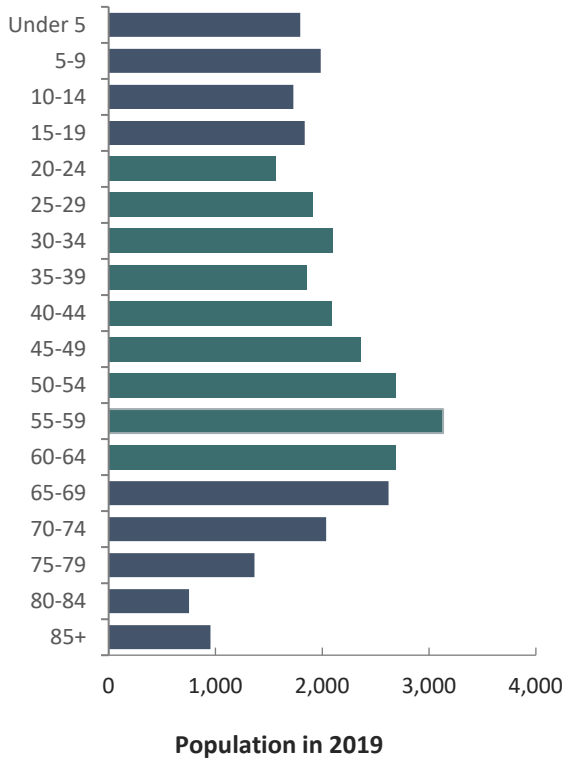
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	28.7%	29.0%
Associate's degree or higher (age 25+)	46.0%	41.9%
Gay, lesbian, and bisexual (adults)	3.2%	3.5%
Persons with a disability	11.8%	16.0%
Veterans	12.9%	9.6%

Table 5. Race/Ethnicity in Sagadahoc County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.4%	127
Asian	0.8%	271
Black/African American	0.8%	278
Native Hawaiian or other Pacific Islander	-	-
White	95.7%	33,941
Some other race	0.2%	58
Two or more races	2.2%	777
Hispanic	1.7%	609
Non-Hispanic	98.3%	34,843

Figure 1. Age distribution for Sagadahoc County



HEALTH EQUITY

There is significant agreement between the priorities chosen during county forums and those identified through community 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.

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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

Mental health was the top priority identified by Sagadahoc County area participants. 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 event hosted for those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services. Participants also suggested the need for more case management, supportive, and wrap-around services, as those with a mental health diagnosis required varied and nuanced care and treatment.

Forum participants were particularly concerned about various issues related to youth mental health including supporting parents, bullying, self-harm, and lack of early childhood interventions.

Availability of mental health providers was the most frequently mentioned concern related to mental health. Community members noted the low availability of providers in the area and the social isolation of the pandemic. A lack of providers and long waitlists for services was identified as the top gap/need related to mental health issues.

"People are very stressed and that impacts their health…stress is becoming a significant issue. The pace of society is impacting our stress, and the pace of society is not going to become slower. It reinforces the importance of helping people address stress."

Outpatient mental health treatment another frequently identified mental health concern. Between 2015 and 2017, 17.3% of adults in Sagadahoc County received outpatient mental health treatment. This is similar to the state overall (18.0%).

Mental health issues among youth were concerning to those in the community, particularly the rate at which youth expressed feelings of hopelessness and thoughts of suicide. In 2019, 35.7% of high school students and 26.3% of middle school students in Sagadahoc County reported feeling sad or hopeless for two or more weeks in a row. In 2019, data shows 19.3% of Sagadahoc County high school students and 24.1% of middle school students seriously considered suicide. These rates are similar to Maine overall. There were concerns about the impact of the COVID-19 pandemic on youth, including potential increases in adverse childhood experiences (ACEs) resulting from the pandemic which forced homeschooling in potentially unsafe situations while decreasing access to school-based supports.

Mental health emergency department usage was also frequently identified as a health concern related to mental health. The mental health emergency department rate per 10,000 population in Sagadahoc County from 2016-2018 was 196.8. This rate is significantly higher than the state (181.5) over that same period.

Community resources mentioned by participants to address mental health issues include area crisis and treatment services, Midcoast Youth Center, Brunswick Teen Center, and Mid Coast Hospital's Mental Health Awareness Training Grant.

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

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

MAJOR HEALTH CONCERNS FOR SAGADAHOC COUNTY

	SAGADAHOC COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 **196.8**	N/A	2016-2018 **181.5**	!	—	N/A
Depression, current symptoms (adults)	2012-2014 **9.6%**	2015-2017 **6.9%**	○	2015-2017 **9.5%**	○	—	N/A
Depression, lifetime	2012-2014 **22.5%**	2015-2017 **23.0%**	○	2015-2017 **23.7%**	○	2017 **19.1%**	N/A
Anxiety, lifetime	2012-2014 **16.4%**	2015-2017 **18.3%**	○	2015-2017 **21.4%**	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 **30.2%**	2019 **35.7%**	○	2019 **32.1%**	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 **23.3%**	2019 **26.3%**	○	2019 **24.8%**	○	—	N/A
Seriously considered suicide (high school students)	2017 **17.6%**	2019 **19.3%**	○	2019 **16.4%**	○	—	N/A
Seriously considered suicide (middle school students)	2017 **20.7%**	2019 **24.1%**	○	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 **16.6%**	2015-2017 **17.3%**	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.
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○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
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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 Sagadahoc County area. The community also identified barriers to care, including a lack of mental health providers, a need for coordination among providers, a lack of childcare and support for parents, and the potentially serious consequences of untreated mental health issues as ongoing challenges that will need to be 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
Treatment Crisis services Caring physicians **Awareness** Mental Health Awareness Training Grant **Youth** Midcoast Youth Center (4) Brunswick Teen Center (3) Youth Mental Health First Aid (NAMI)	**Coordination** Lack of coordination (3) Fragmented system **Providers** Not enough providers / long waitlists (8) Lack of providers who take MaineCare (2) **Funding** No funding for programs **Barriers to Care** Cost of care Overuse of emergency department The emergency department is overcrowded Capacity to respond after community emergencies Holistic treatment (lack of) Fear of stigma (4) Social isolation (3) Youth/Families Bullying (8) Self-harm (8) Interventions in early childhood (4) Need focus on social-emotional health in schools (4) Support for parents of young children (3)

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS

Social determinants of health were selected as a top priority by forum participants. 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[2]. Differences in social determinants can create disparities that impact vulnerable populations and rural areas like Sagadahoc County.

Forum participants echoed the concerns identified by community-sponsored event participants, including generational poverty, lack of childcare, housing costs, and limited transportation options.

Poverty was the most frequently mentioned health concern related to social determinants of health. According to recent estimates, 9.6% of individuals and 11.4% of children in Sagadahoc County live in poverty. This is significantly lower than the state overall for individuals (11.8%) and similar to Maine for children (13.8%). Forum participants noted several local programs available that provide food and meals to those experiencing food insecurity.

"If you can't stabilize someone's resources- money or benefits-you can't hope to stabilize many of the other things. If you don't have enough money for subsidized housing, it's really hard to move those other pieces."

Housing Insecurity was the second most frequently mentioned health concern. Recent data shows 3.6% of Sagadahoc County high school students report they do not usually sleep in their parents or guardians home, while 12.4% of households spent more than **half their income on housing**.

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. In 2019, 22.2% of high school students in Sagadahoc County reported having experienced four or more ACEs. This was the third most frequently mentioned indicator.

Older Adults living alone was the fourth most frequently mentioned health concern by forum participants. From 2015-2019, 28.7% of adults 65 years and older were living alone. Statewide, 29.0% of older adults lived alone over that same period.

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.

Despite the challenges, community members mentioned the area has good partnerships and collaborations to address issues related to social determinants of health, including the Gathering Place, Age-Friendly Communities of the Lower Kennebec, Tedford Housing and several food security organizations and 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.

[2] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

MAJOR HEALTH CONCERNS FOR SAGADAHOC COUNTY

	SAGADAHOC COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 **10.1%**	2015-2019 **9.6%**	○	2015-2019 **11.8%**	★	2019 **12.3%**	N/A
Children living in poverty	2018 **13.0%**	2019 **11.4%**	○	2019 **13.8%**	○	2019 **16.8%**	★
Children eligible for free or reduced lunch	2020 **35.6%**	2021 **25.2%**	N/A	2021 **38.2%**	N/A	2017 **15.6%**	N/A
Median household income	2007-2011 **$56,865**	2015-2019 **$63,694**	★	2015-2019 **$57,918**	★	2019 **$65,712**	N/A
Unemployment	2018 **2.7%**	2020 **4.7%**	N/A	2020 **5.4%**	N/A	2020 **8.1%**	N/A
High school student graduation	2019 **86.6%**	2020 **83.7%**	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 **95.1%**	2017 **95.3%**	N/A	2017 **88.6%**	N/A	2017 **90.4%**	N/A
No vehicle for the household	2007-2011 **1.4%**	2015-2019 **2.3%**	○	2015-2019 **2.1%**	○	2019 **4.3%**	N/A
Persons 65 years and older living alone	2011-2015 **26.6%**	2015-2019 **28.7%**	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 **12.4%**	N/A	2015-2019 **12.0%**	○	—	N/A
Housing insecure (high school students)	2017 **3.5%**	2019 **3.6%**	○	2019 **3.3%**	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 **22.2%**	N/A	2019 **21.3%**	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 **39.1%**	2015-2019 **46.0%**	N/A	2015-2019 **41.9%**	N/A	2019 **41.7%**	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 **30.7%**	N/A	2015-2019 **32.9%**	N/A	2019 **37.9%**	N/A

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COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Sagadahoc County area participants 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, transportation, and housing resources. However, community members also identified several challenges related to social determinants of health, including high levels of poverty, lack of resources for transportation, high levels of food insecurity, isolation and rurality, and a lack of broadband access.

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 (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Good communication/partnerships (3) Age-Friendly Communities of Lower Kennebec Midcoast Maine Community Action (2) **Food** Midcoast Hunger Prevention Program (3) Good Food for Bath Merrymeeting Gleaners Backpack Program School lunch/breakfast program (5) Let's Go! (2) **Transportation** People Plus Transportation Network (2) Bowdoinham Ride Share Program **Housing** Southern Midcoast Housing Collaborative (4) Bath Housing Brunswick Housing Authority Tedford Housing The Gathering Place Lead/water testing **Physical Activity** Topsham Dome (2) Bath Area YMCA (6) Recreation programs Local trails **Child Development/Schools** Head Start/childcare (3) **ACEs/Resiliency** Maine Resilience Building Network	**Poverty** High cost of living (5) Poverty/generational poverty (4) Unpredictable working hours (2) Low wages (2) **Food** Food deserts/food insecurity (6) Housing Housing issues (8) Not enough resources for homeless individuals (3) **Youth/families** Childcare issues (8) Need family medical leave (2) Families are stressed Lack of parenting skills **Transportation** Transportation issues (16) **Barriers to Services** Stigma (2) Need to consider those with low literacy/non-English speakers in communications **Isolation** Internet/broadband issues Isolation **ACEs** Adverse Childhood Experiences (ACEs) (2) Education Access to education

Table 7. Gaps/Needs and Available Resources (Social Determinants of Health - Continued)

AVAILABLE RESOURCES	GAPS/NEEDS
Screening Hunger Vital Signs Social Determinants of Health screening **Jobs** Access to jobs **Public Safety** Law enforcement as a partner (4) Maine Youth Court	**Physical Activity** Sedentary lifestyle (4) **Environmental Health** Tech support to help municipalities plan for climate emergencies

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS

Access to care was identified as the second top priority by participants. 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.[3]

Forum participants and those who attended community-sponsored events voiced the same concerns, including long wait times to access services, a lack of providers, and limited providers who accept MaineCare.

Cost barriers to care were the most frequently identified health concern related to access to care. In 2015-2017, 8.3% 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%).

"There are issues related to workforce shortages. We need incentives to draw people to the area. Workforce shortages lead to long wait times, especially for mental health."

A lack of **availability of primary care providers** was the second 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 48% of forum participants).

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. In 2019, 25.5% of **primary care visits in Sagadahoc County were more than 30 miles from the patient's home**. This compares to 20.0% of all primary care visits in Maine.

The percentage of adults who saw a **primary care provider in the past year** declined slightly from 72.2% in 2012-2014 to 70.3% in 2015-2017, however, this decline is not statistically significant. Overall, 72.0% of Mainers were seen by a primary care provider in 2015-2017.

A lack of health insurance was another concern mentioned by community members. From 2015-2019, 6.5% of Sagadahoc County residents were **uninsured.** This is similar to Maine overall (7.9%).

MaineCare enrollment increased from 17.7% in 2019 to 21.5% in 2020. This is lower than the state overall (29.1%), although it is not known if this difference is significant. Forum members were concerned about how few providers accept MaineCare.

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 their community faces with access to care, community forum participants noted the area has Mid Coast Parkview Health, located in Cumberland County, Oasis Free Clinics, Mid Coast Hospital's Maternal Opioid Misuse (MaineMOM) Program, as well as community organizations offering alternative types of access.

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] 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 SAGADAHOC COUNTY

	SAGADAHOC COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
ACCESS							
Uninsured	2009-2011 **8.2%**	2015-2019 **6.5%**	○	2015-2019 **7.9%**	○	2019 **9.2%**	N/A
MaineCare enrollment (all ages)	2019 **17.7%**	2020 **21.5%**	N/A	2020 **29.1%**	N/A	**2020** **24.1%**	N/A
MaineCare enrollment (ages 0-19)	2019 **30.8%**	2020 **35.3%**	N/A	2020 **43.8%**	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 **1,368.0**	N/A	2019 **1,332.0**	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 **90.3%**	2015-2017 **87.8%**	○	2015-2017 **87.9%**	○	2017 **76.8%**	N/A
Primary care visit to any primary care provider in the past year	2012-2014 **72.2%**	2015-2017 **70.3%**	○	2015-2017 **72.0%**	○	2017 **70.4%**	N/A
Cost barriers to health care	2011-2013 **10.2%**	2015-2017 **8.3%**	○	2015-2017 **10.6%**	○	2016 **12.0%**	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 **25.5%**	N/A	2019 **20.0%**	N/A	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
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○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Available resources noted by participants to address issues related to access include cohesion of the community, the presence of community organizations that increase access to care, emerging technologies, alternatives to in-office care, and health care education. 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 coordination among providers, 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 8. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Leadership (4) Good communication/partnerships (2) **Community Organizations** Community hospitals (4), Mid Coast-Parkview Health, Mid Coast Medical Group, Sagadahoc Health, Oasis Free Clinics Bath 18+ **Technology** Telehealth (3) Findhelp (previously Aunt Bertha (4) 211 Maine (4) **Access alternatives** Navigators/interpreters for New Mainers Home visiting programs for families with young children Maine Maternal Opioid Misuse (MaineMOM) Program **Education** Nutrition programs	**Providers/workforce** Need incentives for professionals to work in the area (2) The labor shortage in early childhood services Wait times due to provider shortages (general) (3) **Coordination** Lack of formal public health infrastructure **Education** Health literacy issues Understanding how to navigate the health system Knowing how to get to the provider **Barriers to care** Issues for those in towns far from Route 1 Federal programs cumbersome to access (2) Dentists not accepting MaineCare (2) Cost barriers Insurance with high deductibles (4) **Data** Measuring access to care **Specific Services** Childhood development Early and Periodic Screening, Diagnostic and Treatment (EPSDT) High cancer rates (5) Lack of support for caregivers (2)

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS

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

Both forum participants and those involved in community-sponsored events noted a lack of funding for programs and limited community involvement as a concern when addressing substance and alcohol use. Community members noted that stigma is a barrier to people seeking care and discussing issues.

Overdose deaths were the most frequently mentioned health concern for substance use in Sagadahoc County. In 2020, the rate of overdose deaths per 100,000 population in Sagadahoc County was 22.2. The rate in Maine overall was 37.3 in 2020.

"It is a community issue that does not have a community response."

Drug-affected infants were the second most frequently mentioned health concern for substance use. The rate of drug-affected infant reports per 1,000 births in was 42.7 in 2018-2019. This is significantly lower than Maine overall (73.7).

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 are chronic heavy drinkers was 8.7% in 2015-2017, a slight increase from 7.2 in 2012-2014. The rate of **alcohol-induced deaths** per 100,000 residents was 10.9 in 2015-2019. This is similar to Maine overall (11.6).

Marijuana use in adults increased from 10.9% in 2013-2016 to 18.3% in 2017. The rates of alcohol and drug health indicators in Sagadahoc County were similar to the state overall.

"I'm concerned about changing community norms around marijuana use."

Community members facing systemic disadvantages mentioned a lack of treatment and recovery resources in the state. They noted a lack of harm-reduction programming, a need for supportive living environments, and skill-building programs for independent living.

A common barrier cited by participants to addressing substance and alcohol use in the area is a lack of access to substance and alcohol use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Resources mentioned by forum participants to address substance and alcohol use in the area include Mid Coast Hospital Addiction Resource Center, including the MaineMOM Program, Southern Midcoast Communities for Prevention's Drug-Free Communities Grant, and Maine's Medication Take-Back Program.

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 SAGADAHOC COUNTY

	SAGADAHOC COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 **22.3**	2020 **22.2***	○	2020 **37.3**	○	2019 **21.5**	N/A
Drug-induced deaths per 100,000 population	2007-2011 **6.2**	2015-2019 **14.6**	○	2015-2019 **29.5**	★	2019 **22.8**	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 **6.2**	2015-2019 **10.9**	○	2015-2019 **11.6**	○	2019 **10.4**	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 **2.8**	2019 **0.0**	N/A	2019 **3.8**	N/A	2019 **3.1**	N/A
Drug-affected infant reports per 1,000 births	2017 **38.1***	2018-2019 **42.7**	○	2018-2019 **73.7**	★	—	N/A
Chronic heavy drinking (adults)	2012-2014 **7.2%**	2015-2017 **8.7%**	○	2015-2017 **8.5%**	○	2017 **6.2%**	N/A
Binge drinking (adults)	2012-2014 **16.5%**	2015-2017 **16.7%**	○	2015-2017 **17.9%**	○	2017 **17.4%**	N/A
Past-30-day marijuana use (adults)	2013-2016 **10.9%**	2017 **18.3%***	○	2017 **16.3%**	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	2012-2016 **0.8%**	2013-2017 **0.6%***	N/A	2013-2017 **1.0%**	○	—	N/A
Past-30-day alcohol use (high school students)	2017 **19.5%**	2019 **20.8%**	○	2019 **22.9%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 **4.3%**	2019 **4.2%**	○	2019 **4.0%**	○	—	N/A
Binge drinking (high school students)	2017 **7.4%**	2019 **7.4%**	○	2019 **8.2%**	○	—	N/A
Binge drinking (middle school students)	2017 **1.7%**	2019 **0.9%**	○	2019 **1.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2017 **19.4%**	2019 **19.2%**	○	2019 **22.1%**	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 **4.9%**	2019 **4.9%**	○	2019 **4.1%**	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 **7.1%**	2019 **5.7%**	○	2019 **5.0%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.2%**	2019 **3.0%**	○	2019 **3.0%**	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 **11.8**	2020 **11.1**	N/A	2020 **12.1**	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 **45.5**	2020 **45.8**	○	2020 **76.7**	★	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 **8.9**	N/A	2016-2018 **9.9**	○	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 **1.6***	N/A	2016-2018 **1.4**	○	—	N/A

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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Community members identified strong collaboration and available grant funding as potential strengths to address substance and alcohol use, along with harm reduction strategies. Lack of substance and alcohol use intervention and treatment resources for youth, ease of access and permissive community norms surrounding marijuana were issues identified by community members.

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
Collaboration Strong community programs (2) Drug take back days **Funding** Drug Free Communities Grant Prevention work/grants (3) **Treatment** Medication Assisted Treatment **Recovery/Community Supports** Addiction Resource Center (2) **Harm Reduction** Narcan availability **Prevention** Prevention programs – Southern Midcoast Communities for Prevention State and Federal Grants Teen Centers in Brunswick and Bath	**Ease of access/attitudes** Community norms around marijuana (3) **Stigma (3)** **Youth** Need focus on social-emotional health in schools (2) **Treatment** Lack of Medication-Assisted Treatment for youth (2) **Community resources** Limited community involvement (2) No funding for programs The capacity of the mental health/substance use system to respond after community emergencies

OTHER IDENTIFIED NEEDS

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

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	24	57%
Social Determinants of Care	20	48%
Access to Care	18	43%
Substance & Alcohol Use	17	40%
Older Adult Health	8	19%
Physical Activity, Nutrition, and Weight	5	12%
Cancer	4	10%
Environmental Health	4	10%
Intentional Injury	4	10%
Oral Health	3	7%
Pregnancy and Birth Outcomes	3	7%
Children with Special Needs	2	5%
Diabetes	2	5%
Immunizations	2	5%
Health Care Quality	1	2%
Tobacco	1	2%
Unintentional Injury	1	2%
Other - Early Childhood Development	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
- 1000 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 1000 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 Sagadahoc County on November 16, 2021, with 46 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Bath Area Family YMCA
Brunswick Police Department
Brunswick Topsham Land Trust
Sagadahoc County Board of Health
Maine Association of School Nurses
Maine Center for Disease Control and Prevention
Maine Coast Fishermen's Association
MaineHealth
Merrymeeting Adult Education/MSAD75
Mid Coast Hospital
Mid Coast-Parkview Health
Midcoast District Public Health Council
Midcoast Maine Community Action
Midcoast Youth Center
Office of U.S. Senator Angus King
Sagadahoc County Emergency Management Agency
Sagadahoc County Sheriff's Office
Southern Midcoast Communities for Prevention
Tedford Housing
Topsham Family Medicine
United Way of Mid Coast Maine

For a complete listing of organizations consulted for each of the 10 health equity outreach efforts, please see the Acknowledgements, page 22. 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.