

FAQ's 2021 Maine Shared CHNA Quantitative Data Set

How has COVID-19 affected our health?

As we emerge from the pandemic, the overall impact on health is becoming apparent, but not well measured in many of our standard data sources. For instance, drug overdose deaths have risen from 380 in 2019 to 504 in 2020. Over the first three months of 2021, there have been 152 confirmed drug deaths in Maine. The source for these data is Maine's Office of Chief Medical Examiner and are frequently updated. However, many of our sources for data are published up to a year or more after the data has been collected. In fact, as of 2021, many of our data were collected two or three years prior to the pandemic. Therefore, data on those who experience mental health conditions due to anxiety of getting infected by COVID-19, the isolation, job loss, and other stressors of managing day-to-day routines during a pandemic may not be evident in the currently available data. We do know many had to put off getting care for health conditions, such as treatment for cardiovascular disease or getting screened for cancers. We may well see the effects of the pandemic from exposure, deferred care, stress, and interruptions in education for years to come, but many of the impacts will not be evident in any data collected and reported even in 2021.

Why is there no COVID-19 infection and vaccination data in the Maine Shared CHNA data set?

The [COVID-19: Maine Data](#) dashboard provides comprehensive and up-to-date data, relieving the need to duplicate this data in the Maine Shared CHNA data set. Inclusion of COVID-19 data in future Health Profiles will be considered by the Metrics Committee in the next triennial MSCHNA cycle when there may be multiyear trend data.

What criteria do you use when choosing which data to include in the Maine Shared CHNA data?

The Metrics Committee is charged with creating and reviewing a common set of population/community health indicators and measures every three years. Previously, in 2016-2017, 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 issue that is actionable; 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 (i.e.: 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. The 2020 Metrics Committee 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.

What is new in the 2021 Maine Shared CHNA data set?

We've added the following population, condition, or health outcome data:

- 1.) Transgender youth
- 2.) Children eligible for free or reduced lunch
- 3.) Access to broadband
- 4.) Housing costs as a percentage of income
- 5.) Life expectancy
- 6.) Percentage of people living beyond 35 miles for usual source of care
- 7.) Lung cancer screening rate among eligible adults
- 8.) Lung cancer late-stage incidence
- 9.) HPV-associated cancer incidence
- 10.) Obesity-associated cancer incidence (excluding colon)

- 11.) Homes tested for radon
- 12.) Adult tooth loss
- 13.) Those under 21 covered by dental insurance
- 14.) Dental claims for those under 21
- 15.) Emergency department visits for tooth pain
- 16.) Preventive dental visits past year (adult)

The following indicators were retired:

- 1.) Children with mental health disorders – this data is not available at the county level.
- 2.) Dental visits in last year for those using MaineCare under the age of 18 was replaced by dental claims for those under 21 for all claims types (MaineCare and private pay).

The following indicators were renamed:

- 1.) Tobacco-related cancer deaths (excluding lung cancer) was renamed to Tobacco-related cancer deaths, excluding lung and bronchus.
- 2.) Tobacco-related cancer new cases was renamed to Tobacco-related cancer, excluding lung and bronchus.
- 3.) Chronic disease among people with mental illness was renamed to chronic disease among people with depression to more accurately reflect the data definition.

Why is the Behavior Risk Surveillance System's data from 2017?

As of July 1, 2021, the data collector is in the process of addressing anomalies discovered in the 2018 and 2019 data sets. Once these anomalies

have been addressed, the data will be sent to the US CDC for review then sent back to Maine for final analysis. Once this process is complete, it is expected that the Maine Shared CHNA will publish the updated data in the [interactive data portal](#). There is no given timeframe for when this will happen.

How well do the quantitative data represent Maine's diversity?

Standard responses in the majority of our data sets follow Federal Reporting guidelines. Age options typically include Children 0-17, Adults 18-64, and Older Adults 65+. Ethnicity options often include Hispanic or Non-Hispanic. Standard race categories include White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaskan Native, or more than one race. Standard gender identity choices include only male, female, or transgender. Standard sexual orientation choices typically include lesbian, gay, heterosexual, bisexual, something else, or don't know. Language choice is often English or primary language other than English. These response options may not resonate with everyone. For an individual who identifies as, Sudanese, or gender fluid, or questioning their sexual orientation, there are no options for them to choose from.¹ Even with the data we do have, the numbers tend to be too small to have data disaggregated at the city or county level. The small sample sizes make the data unreliable or risk identifying respondents. So instead we report this data at the State level, which provides more reliable data analysis and (often) eliminates the need to suppress data to protect confidentiality.