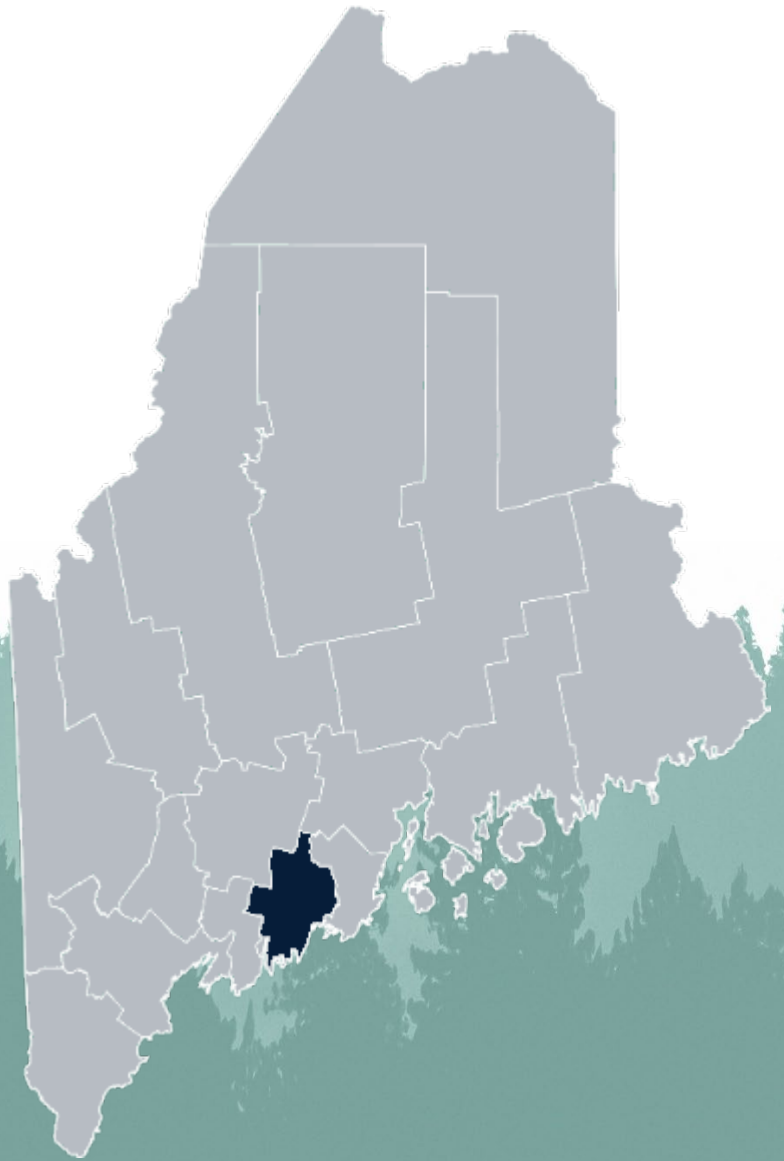


LINCOLN COUNTY

Maine Shared Community Health
Needs Assessment Report

2022



COVID-19 AND OUR HEALTH

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

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

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

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

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

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

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

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INTRODUCTION

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

The mission of the Maine Shared CHNA is to:

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

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

New this cycle is an expanded effort to reach those who may experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted in this effort. One effort included nine community sponsored events hosted by organizations representing the following communities: Black or African Americans; people who are deaf or hard of hearing; people with a mental health diagnosis; people with a disability; people who define themselves or identify as lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ+); people with low income; older adults; people who are homeless or formerly homeless; and youth. In addition to these events, 1,000 oral surveys were conducted in collaboration with eight ethnic-based community organizations’ community health workers to better reach Maine’s immigrant population. A complete description of how these efforts were deployed, as well as a listing of those who provided input, is provided in the Methodology section on page 18.

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

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

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

Table 1. Leading Causes of Death

RANK	MAINE	LINCOLN COUNTY
1	Cancer	Cancer
2	Heart Disease	Heart Disease
3	Unintentional Injury	Unintentional Injury
4	Chronic Lower Respiratory Disease	Stroke
5	Stroke	Chronic Lower Respiratory Disease

TOP HEALTH PRIORITIES

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

Table 2. Top Health Priorities for Lincoln County

PRIORITIES	% OF VOTES
Mental Health	47%
Access to Care	47%
Social Determinants of Health	40%
Substance & Alcohol Use	36%

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

Table 3. Top Health Priorities for County/State

PRIORITIES	2018		2021	
Mental Health	✓	●	✓	●
Access to Care	✓	●	✓	●
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

Lincoln is the state's fourth-smallest populous county, with a similar median income and educational attainment as the state overall. Much of the population is near retirement age.

Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	34,201	1.34M
Median household income	\$57,720	\$57,918
Unemployment rate	5.3%	5.4%
Individuals living in poverty	12.3%	11.8%
Children living in poverty	16.4%	13.8%

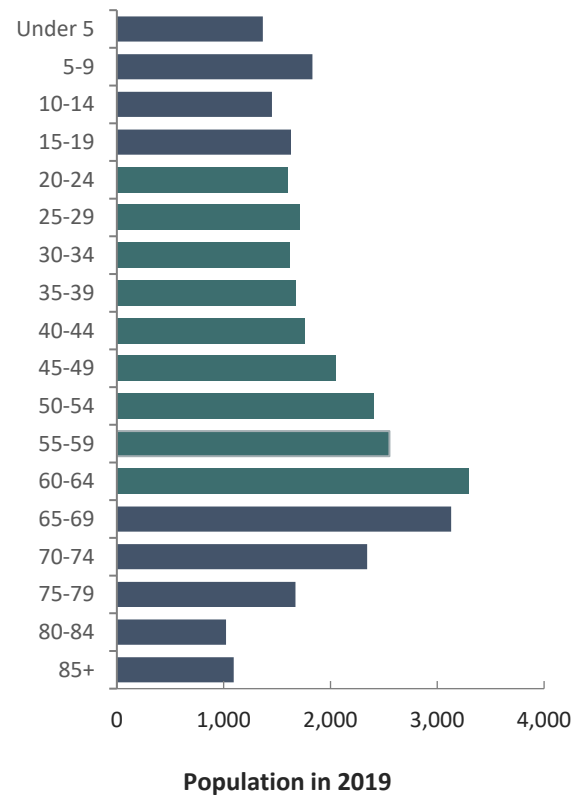
Table 4. Selected Demographics (continued)

	COUNTY	MAINE
65+ living alone	28.6%	29.0%
Associate's degree or higher (age 25+)	41.0%	41.9%
Gay, lesbian, and bisexual (adults)	3.0%	3.5 %
Persons with a disability	16.9%	16.0%
Veterans	11.5%	9.6%

Table 5. Race/Ethnicity in Lincoln County

	PERCENT	NUMBER
American Indian/Alaskan Native	0.4%	148
Asian	1.0%	340
Black/African American	0.4%	129
Native Hawaiian or other Pacific Islander	-	-
White	96.9%	33,143
Some other race	0.2%	74
Two or more races	1.1%	367
Hispanic	1.2%	426
Non-Hispanic	98.8%	33,775

Figure 1. Age distribution for Lincoln County



HEALTH EQUITY

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

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

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

NEXT STEPS

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

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

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

PRIORITY: MENTAL HEALTH

KEY TAKEAWAYS FOR LINCOLN COUNTY

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

Participants in an event hosted for those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services. Participants also suggested the need for more case management, supportive, and wrap-around services, as those with a mental health diagnosis required varied and nuanced care and treatment.

“There is a stigma around mental health which plays a factor with people trying to reach out to get help and seek resources. People who are struggling financially would be less likely to seek help due to reimbursement with these programs. Everything ties together.”

Availability of mental health providers in Lincoln County was the most frequently mentioned indicator related to mental health. Community members noted the low availability of mental health providers in the area, both for inpatient and outpatient care. They also noted long waitlists to access mental health care services. The use of the **Emergency Department** to address mental health needs in Lincoln County was identified by 30% of community forum participants as a concern. During the 2016-2018 time period, the mental health emergency room discharges per 10,000 is significantly higher in Lincoln County (181.5) compared to the state of Maine (151.1).

Mental health issues among youth were concerning to those in the community, particularly the rate at which youth experience **suicidal ideation** and feeling **sad and hopeless**. In 2019, 33.0% of high school students and 29.5% of middle school students reported feeling sad or hopeless for two or more weeks in a row. This is a significant increase from 2017 (24.3%) for high school students. The data show 16.8% of high school students and 19.0% of middle school students seriously considered suicide during the 2019 period. 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.

The percentage of adults receiving **outpatient mental health treatment** in Lincoln County remained stable with 15.6% in 2012-2014 and 15.4% in 2015-2017. In 2015-2017, 18.0% (almost 1 in 5) of all Maine adults were receiving outpatient mental health treatment.

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.

Resources mentioned by participants included National Alliance on Mental Illness (NAMI) Maine, National Mental Health First Aid Training Course, the Midcoast Public Health District and Central Lincoln County YMCA.

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 LINCOLN COUNTY

INDICATOR	LINCOLN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 151.1	N/A	2016-2018 181.5	★	—	N/A
Depression, current symptoms (adults)	2012-2014 7.5%	2015-2017 8.4%	○	2015-2017 9.5%	○	—	N/A
Depression, lifetime	2012-2014 20.9%	2015-2017 21.5%	○	2015-2017 23.7%	○	2017 19.1%	N/A
Anxiety, lifetime	2012-2014 15.4%	2015-2017 18.1%	○	2015-2017 21.4%	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 24.3%	2019 33.0%	!	2019 32.1%	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 23.7%	2019 29.5%	○	2019 24.8%	○	—	N/A
Seriously considered suicide (high school students)	2017 14.4%	2019 16.8%	○	2019 16.4%	○	—	N/A
Seriously considered suicide (middle school students)	2017 12.6%	2019 19.0%	○	2019 19.8%	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 22.7%	N/A	2011-2017 30.8%	○	—	N/A
Ratio of population to psychiatrists	—	2019 24,211.0	N/A	2019 12,985.0	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 15.6%	2015-2017 15.4%	N/A	2015-2017 18.0%	N/A	—	N/A

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

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified multiple available treatment options and the presence of youth mental health resources as assets available for the Lincoln 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 broadband access, and the potentially serious consequences of untreated mental health issues as ongoing challenges Lincoln County will need to overcome.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Collaboration Midcoast Public Health District Orgs working in collaboration (4)</p> <p>Training National Mental Health First Aid Training Course (2) National Alliance on Mental Illness (NAMI) Maine</p> <p>Schools/Youth School based health center (4)</p> <p>Other Services Central Lincoln County (CLC) YMCA</p>	<p>Barriers to Treatment Cost of care (3) Telehealth visits need to be reimbursed as office visits Stigma (8) Impacts of pandemic (2) Generational differences in addressing mental health issues Emergency Department utilization Lack of privacy/broadband for telehealth (2)</p> <p>Coordination Fragmented system (2) Silos (2)</p> <p>Providers/workforce No pipeline for clinicians Lack of providers/long waitlists (12) Low pay, no benefits for workers</p> <p>Funding/resources Limited number of resources – general</p> <p>Youth Youth mental health Limited number of providers for youth</p>

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR LINCOLN COUNTY

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

A lack of health insurance was the most frequently mentioned health indicator among community participants. During the years 2015-2019, the rate of **uninsured** in Lincoln County was 10.0%. This is significantly higher than the state uninsured rate of 7.9% over that same period.

Cost barriers to care were the second most frequently identified health indicator related to access to care. In 2015-2017, 9.3% of adults in Lincoln County 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%).

“Healthcare practitioners- since so many people are leaving the industry due to burnout- are becoming a much-needed resource.”

The lack of providers in the area and the rural nature of the county can both contribute to long travel distances to receive care. In 2019, 30.7% (1 in 3) of **primary care visits in Lincoln County were more than 30 miles from the patient's home** in 2019. This compares to 20.0% (1 in 5) of all primary care visits in Maine.

A lack of **availability of primary care providers** in Lincoln County was the fifth most frequently mentioned health indicator related to access to care. It was also identified as the largest gap/barrier to access by community forum participants (mentioned by 43% of forum participants).

The percentage of adults in Lincoln County who were seen by **any primary care provider** declined from 69.5% in 2012-2014 to 66.0% in 2015-2017. This is significantly lower than the 72.0% of Mainers were seen by a primary care provider in 2015-2017

Disparate communities across the state 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 Lincoln County faces with access to care, community forum participants noted the area has community navigators, MaineHealt CarePartners, the Elder Care Network, and LincolnHealth among other community organizations and related services.

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/nhqdr/chartbooks/access/elements.html>

MAJOR HEALTH CONCERNS FOR LINCOLN COUNTY

INDICATOR	LINCOLN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
ACCESS							
Uninsured	2009-2011 11.4%	2015-2019 10.0%	○	2015-2019 7.9%	!	2019 9.2%	N/A
MaineCare enrollment (all ages)	2019 21.6%	2020 25.9%	N/A	2020 29.1%	N/A	2020 24.1%	N/A
MaineCare enrollment (ages 0-19)	2019 40.3%	2020 46.6%	N/A	2020 43.8%	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 1,493.0	N/A	2019 1,332.0	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 92.9%	2015-2017 90.4%	○	2015-2017 87.9%	○	2017 76.8%	N/A
Primary care visit to any primary care provider in the past year	2012-2014 69.5%	2015-2017 66.0%	○	2015-2017 72.0%	!	2017 70.4%	N/A
Cost barriers to health care	2011-2013 10.4%	2015-2017 9.3%	○	2015-2017 10.6%	○	2016 12.0%	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 30.7%	N/A	2019 20.0%	N/A	—	N/A

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

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!	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.
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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.
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COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Available resources in Lincoln County to address issues related to access include cohesion of the community, the presence of community organizations that increase access to care, emerging technologies, and an expanded elder care network. Community members were also able to identify potential barriers to care. These included limited numbers of healthcare providers, a lack of dental care, the need for behavioral health services, and a lack of cultural competence.

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

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

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Community Cohesion Organizations working in collaboration (3) Midcoast Public Health District</p> <p>Community Organizations LincolnHealth (3) Dental providers (2) MaineHealth CarePartners Community Health Clinic</p> <p>Access alternatives School based health clinics (3) Innovative models of preventive dental care (2) Lively retired health professionals (2) Community navigators in Boothbay Area/Waldoboro (3) Elder Care Network</p> <p>Other Services FISH transport Strong schools Good Shepherd Food Bank</p>	<p>Barriers to Care Impacts of pandemic (2) Lack of access to primary care (5) Lack of access to dental care (6) Work/schedule conflicts (2) Need communications designed for those with low literacy Lack of access to behavioral health care (2)</p> <p>Cost and Income Cost of care (3) Low pay, no benefits Access to MaineCare</p> <p>Providers/workforce Lack of providers/long waitlists (general) (5) Hard to recruit providers (3) Lack of cultural competence among providers (2)</p> <p>Coordination Silos (2)</p>

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR LINCOLN COUNTY

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

“Work is happening in silos with multiple organizations working on the same issues.”

Adverse childhood experiences (ACEs) are a list potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. This was the most frequently mentioned health indicator related to social determinants of health. In 2019, 26.4% of high school students in Lincoln County reported having experienced four or more ACEs. This is higher than the state rate of 21.3%.

Older Adults living alone was the second most frequently mentioned priority health indicator in Lincoln County. According to recent estimates, 28.6% of Lincoln County adults 65 years and older were living alone. This is similar to older adults in the state who live alone (29.0%).

The cost of housing was the third most frequently mentioned health indicator. In 2015-2019

13.2% of Lincoln County residents spent more than **half their income on housing**. Recent data shows 12.3% of Lincoln County residents and 16.4% of children reported living in **poverty**. This is an increase from the 2009-2011 rate of 10% for individuals and similar to the state overall for individuals (11.8%) and children (13.8%).

Lack of transportation was the fifth most frequently mentioned health indicator. During the 2015-2019 timeframe, 1.3% of Lincoln County residents reported they do not own a vehicle. This is a significant increase from 2007-2011 (0.5%), but significantly lower than the state overall during 2015-2019 (2.1%).

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 issues related to poverty, unemployment, and food insecurity. 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.

Resources mentioned by participants include the Community Resource Council, Healthy Lincoln County, Lincoln County YMCAs, food security programs, Midcoast Regional Planning Agency, and 211 Maine.

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.

MAJOR HEALTH CONCERNS FOR LINCOLN COUNTY

INDICATOR	LINCOLN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 10.0%	2015-2019 12.3%	○	2015-2019 11.8%	○	2019 12.3%	N/A
Children living in poverty	2018 16.8%	2019 16.4%	○	2019 13.8%	○	2019 16.8%	○
Children eligible for free or reduced lunch	2020 40.4%	2021 31.4%	N/A	2021 38.2%	N/A	2017 15.6%	N/A
Median household income	2007-2011 \$48,862	2015-2019 \$57,720	★	2015-2019 \$57,918	○	2019 \$65,712	N/A
Unemployment	2018 3.3%	2020 5.3%	N/A	2020 5.4%	N/A	2020 8.1%	N/A
High school student graduation	2019 86.8%	2020 85.4%	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 96.1%	2017 96.1%	N/A	2017 88.6%	N/A	2017 90.4%	N/A
No vehicle for the household	2007-2011 0.5%	2015-2019 1.3%	!	2015-2019 2.1%	★	2019 4.3%	N/A
Persons 65 years and older living alone	2011-2015 26.1%	2015-2019 28.6%	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 13.2%	N/A	2015-2019 12.0%	○	—	N/A
Housing insecure (high school students)	2017 4.5%	2019 3.7%	○	2019 3.3%	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 26.4%	N/A	2019 21.3%	○	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 40.7%	2015-2019 41.0%	N/A	2015-2019 41.9%	N/A	2019 41.7%	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 36.7%	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

Lincoln County community members point to several resources available that improve social determinants of health. These include many resources available to assist residents with accessing healthy foods, community cohesion, and a strong school system. 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, lack of coordination among providers, isolation, and rurality, and a lack of childcare resources.

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

Table 8. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Community Cohesion Collaboration among orgs/individuals (10) 211 Maine Age Friendly Communities Midcoast Public Health District Boothbay Harbor Memorial Library Community Resource Council (CRC) Healthy Lincoln County (2) Coulombe Center (2) Midcoast Regional Planning Agency YMCA (3) Maine Climate Change Plan</p> <p>Food Food security programs (7) Free meals for students in public school (5) Twin Villages Food Bank (2) Lincoln County Gleaners (2) School backpack program (2) Community Supported Agriculture (CSA) programs (2) Access to food at LincolnHealth provider practices</p> <p>Schools Strong schools (2)</p>	<p>Poverty Poverty (4) Low pay, no benefits</p> <p>Housing Housing issues (5)</p> <p>Transportation Transportation (16)</p> <p>Coordination Silos (5) Need more multi-sector partnerships</p> <p>Youth/families Struggles with childcare (3) Stress in families (2)</p> <p>Awareness Lack of awareness of issues (2)</p> <p>Access to Services Lack of health literacy Stigma accessing services (3)</p> <p>Isolation Impacts of pandemic (2) Social isolation</p> <p>Equity “Isms” and “othering” (2) Need diverse planning committees/boards</p>

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR LINCOLN COUNTY

Substance and alcohol use was selected as a top priority in Lincoln County. It was also identified as one of the top health concerns in all other counties and in community events with special populations in 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 depression, and attention-deficit/hyperactivity disorder were (ADHD), among others.³

Overdose deaths was a top concern among forum participants. In 2020, the rate of overdose deaths per 100,000 population in Lincoln County was 25.9, a decrease from 31.8 in 2019. The rate in Maine overall was 37.3 in 2020, similar to Lincoln County. **Drug-induced deaths** per 100,000 significantly increased between the 2007-2011 and 2015-2019 time periods from 9.3 to 32.1. Drug-induced deaths include chronic use of drugs due to a medical condition.

“We have a lot of access to Narcan but not the funding or bandwidth to educate or provide resources about why carrying Narcan is so beneficial to everyone.”

Drug-affected infants were the second most frequently mentioned health indicator of concern. The rate of drug-affected infant reports per 1,000 births in Lincoln County was 92.3 in 2018-2019. This was higher than the state overall (73.7).

Hospital utilization for substance and alcohol use is also a concern. In 2016-2018, the rate of opiate poisoning hospitalizations per 10,000 population in Lincoln County was 2.2. This is similar to the state overall (1.4).

The misuse of prescription drugs was mentioned by 26% of the forum participants. The rate of **narcotics dispensed per capita** by retail pharmacies was significantly higher in Lincoln County (14.8) compared to the state rate of 12.1. In 2019, 5.7% of high school students reported the misuse of prescription drugs.

Community forum participants expressed concerns about multiple drug and alcohol use health indicators, including, **chronic heavy drinking, alcohol-induced deaths, and alcohol-impaired driving deaths**. Participants noted changing societal norms around drug use and increased access, coupled with a lack of early intervention and education. High school students reporting **past-30 day alcohol use** increased from 19.3% in 2017 to 25.8% in 2019.

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

A common barrier to addressing substance and alcohol use in Lincoln County is a perception of a lack of substance and alcohol use treatment providers and programs. Resources mentioned by participants include Integrated Medication-Assisted Treatment (IMAT), Mid Coast Hospital Addiction Resource Center, Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS), and Amistad.

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

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

MAJOR HEALTH CONCERNS FOR LINCOLN COUNTY

INDICATOR	LINCOLN COUNTY			BENCHMARKS			
	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 31.8	2020 25.9	○	2020 37.3	○	2019 21.5	N/A
Drug-induced deaths per 100,000 population	2007-2011 9.3	2015-2019 32.1	!	2015-2019 29.5	○	2019 22.8	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 9.4	2015-2019 10.4	○	2015-2019 11.6	○	2019 10.4	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 2.9	2019 5.8	N/A	2019 3.8	N/A	2019 3.1	N/A
Drug-affected infant reports per 1,000 births	2017 47.2*	2018-2019 92.3	○	2018-2019 73.7	○	—	N/A
Chronic heavy drinking (adults)	2012-2014 8.4%	2015-2017 10.2%	○	2015-2017 8.5%	○	2017 6.2%	N/A
Binge drinking (adults)	2012-2014 16.3%	2015-2017 16.5%	○	2015-2017 17.9%	○	2017 17.4%	N/A
Past-30-day marijuana use (adults)	2013-2016 10.6%	2017 16.3%	○	2017 16.3%	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	2012-2016 0.7%	2013-2017 0.3%*	○	2013-2017 1.0%	★	—	N/A
Past-30-day alcohol use (high school students)	2017 19.3%	2019 25.8%	○	2019 22.9%	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 3.4%	2019 2.9%	○	2019 4.0%	○	—	N/A
Binge drinking (high school students)	2017 8.3%	2019 9.4%	○	2019 8.2%	○	—	N/A
Binge drinking (middle school students)	2017 1.6%	2019 —	N/A	2019 1.3%	N/A	—	N/A
Past-30-day marijuana use (high school students)	2017 21.9%	2019 24.9%	○	2019 22.1%	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 2.9%	2019 3.9%	○	2019 4.1%	○	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 5.3%	2019 5.7%	○	2019 5.0%	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 —	2019 2.6%	N/A	2019 3.0%	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 14.8	2020 14.8	○	2020 12.1	!	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 64.1	2020 48.6	○	2020 76.7	★	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 7.9	N/A	2016-2018 9.9	○	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 2.2	N/A	2016-2018 1.4	○	—	N/A

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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Community members in Lincoln 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 a strong youth program. 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 positive role models.

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

Table 9. Gaps/Needs and Available Resources (Substance & Alcohol Use)

AVAILABLE RESOURCES	GAPS/NEEDS
<p>Collaboration Collaboration among individuals/organizations (4) Midcoast Public Health District/Council</p> <p>Recovery Recovery collaborative (2) AA and Al-Anon</p> <p>Treatment Integrated Medication-Assisted Treatment (IMAT) (3) SUD treatment at primary care and Mid Coast Hospital Addiction Resource Center (3)</p> <p>Harm Reduction Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative Free Narcan</p> <p>Youth Strong schools/educators</p> <p>Organizations Amistad Maine</p>	<p>Coordination Silos (2)</p> <p>Treatment Access to clinical resources and behavioral health supports Mobile units for rural communities (3) Impacts of pandemic include an uptick in use and disruption in access to treatment (2)</p> <p>Recovery No supportive services for people in recovery Community Supports Impacts of pandemic including disruption in access to recovery support (2)</p> <p>Harm Reduction Funding for more harm reduction programming</p> <p>Stigma Stigma (2)</p> <p>Equity Tailored services for different pop segments (by race/ethnicity, LGBTQ, new Mainers, etc.) (3)</p> <p>Prevention Lack of positive role models</p> <p>Poverty Low pay, no benefits</p>

OTHER IDENTIFIED NEEDS

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

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	22	47%
Access to Care	22	47%
Social Determinants of Health	19	40%
Substance and Alcohol Use	17	36%
Oral Health	10	21%
Older Adult Health	7	15%
Physical Activity, Nutrition, and Weight	5	11%
Children with Special Needs	4	9%
Cardiovascular Disease	3	6%
Intentional Injury	3	6%
Pregnancy and Birth Outcomes	3	6%
Unintentional Injury	2	4%
Diabetes	2	4%
Tobacco	1	2%
Infectious Disease	1	2%
Immunizations	1	2%
Environmental Health	1	2%
Other (early childhood development, climate change)	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 Lincoln County on November 17, 2021, with 51 attendees. Persons from the following organizations representing broad interests of the community who were consulted during the engagement process:

Boothbay Harbor Memorial Library
Boothbay Region Health Care, Inc.
Central Lincoln County YMCA
Coastal Kids Preschool
Coastal Rivers Conservation Trust
Community Housing Improvement Project
Head Start
Healthy Kids
Healthy Lincoln County
Lincoln County Regional Planning Commission
LincolnHealth
LincolnHealth Board of Trustees
Maine Center for Disease Control and Prevention
MaineHealth
Medical Care Development
Midcoast Public Health District
Mobius, Inc.
Office of U.S. Senator Angus King
Pen Bay Medical Center
Skidompha Public Library
Town of Alna
Town of Nobleboro
United Way of Mid Coast Maine
Waldo County General Hospital

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.



