

Community Health Needs Assessment and Action Plan

2016

For the Mount Desert Island Region Local Service Area

Including Bar Harbor, Cranberry Isles, Frenchboro, Lamoine, Mount Desert,
Southwest Harbor, Swan's Island, Tremont, and Trenton

Prepared by Mount Desert Island Hospital and Healthy Acadia



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Below we have listed the Community Health Needs Assessment team members. Your commitment to the health of our communities is invaluable.

The 382 survey respondents are not listed here out of respect for confidentiality. These contributions have been paramount to the success of this report.

Thanks also to Maria Donahue, Shoshona Smith, and Rebecca Reisman for editorial support.

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Introduction

The Community Health Needs Assessment and Action Plan for Mount Desert Island Service Area serves as a framework and guide for Mount Desert Island Hospital and Healthy Acadia in developing and strengthening our programming to fulfill community needs. This report is also available to all local organizations and citizens to support their efforts to address and coordinate community health improvement.

Mount Desert Island Hospital (MDIH), a 501(c)(3) non-profit, state-of-the-art rural healthcare organization, serves the close-knit island and surrounding communities. Formed in 1897, MDIH has grown to offer a continuum of care through a 25-bed critical access facility, a retirement facility, and nine regional health centers, including a full-service behavioral health center and a dental clinic.

Mount Desert Island Hospital's mission is to provide compassionate care and strengthen the health of the community by embracing tomorrow's methods and respecting time-honored values. MDIH is committed to providing the care that community members need, close to their homes.

Healthy Acadia (HA) is a 501(c)(3) non-profit organization dedicated to empowering people and organizations to build healthy communities and make it possible for all people to lead healthier lives. HA is a community health coalition, working since 2001 with hundreds of partners and thousands of community members in Maine's Washington and Hancock counties to address a wide range of local health needs. The coalition works to build partnerships, coordinate education and prevention services, and improve policies and environments to create lasting positive changes to the health of our communities.

HA relies on both private and public funding sources to address critical locally-defined health priorities throughout the two counties, including the nine-town service area of MDIH. These towns include Bar Harbor, Cranberry Isles, Frenchboro, Lamoine, Mount Desert, Southwest Harbor, Swans Island, Tremont, and Trenton. This nine-town area is the focus of this report. It is referred to here as the "Local Service Area" (LSA).

In 2010, the population of these 9 towns totaled 14,232, according to the U.S. census data. The LSA area includes three municipalities on unbridged islands: Cranberry Isles, Frenchboro, and Swans Island. The LSA has high numbers of older adults, as well as seasonal visitors. There are significant numbers of self-employed individuals, contributing in part to significantly higher than average levels of uninsured people. In Hancock County, 16% of adults are uninsured, compared with 13% statewide (County Health Rankings, 2016).

Hancock County has slightly below average rates of educational attainment, with 84.3% graduating from high school, compared to the state rate of 86.5%. We are also slightly below average in terms of college attendance; 61% of residents in Hancock County attend at least some college, and 64% of people have

attended at least some college statewide (County Health Rankings, 2016). Our unemployment levels are slightly higher than the statewide average, (7% unemployment in Hancock County, compared with 5.7% statewide) (SHNAPP, 2015). However, seasonal fluctuations in employment are significant because a substantial part of our economy is based on seasonal tourism.

Healthy Acadia and Mount Desert Island Hospital have worked from the Summer of 2015 through the Spring of 2016 to develop the community health action plan for this nine-town service area. The process has been conducted through collaborative efforts with community partners and has involved a broad base of community members every step of the way.

Through the Community Health Needs Assessment (CHNA) process, partners have used a process entitled Mobilizing for Action through Planning and Partnerships (MAPP), which provides the framework for convening the variety of organizations, groups, and individuals that comprise the local public health system in order to create and implement our community health action plan. We have built off of and worked to complement other community health planning processes, from those conducted at regional hospitals, to strategic plans of our partner organizations.

Community Vision

Our area is home to vibrant communities where people thrive and healthful resources are easily accessible.

Process for Development of Vision

Healthy Acadia Advisory Council members, who served as MAPP Advisory Team members during the previous needs assessment process, worked from the Fall of 2008 to the Spring of 2009 to develop a vision statement that would reflect the ideal future for the region in terms of broad-based community health. In 2015, at the onset of this Community Health Needs Assessment Process, our Core MAPP Planning Team decided to uphold this vision statement for the 2015-2016 process.

CHNA and Action Plan Timeline

Task	Timeline
Form Community Health Needs Assessment Core Planning Team	May 2015
Define community	May 2015
Conduct Community Themes and Strengths Assessment through interviews, group dialogues, & surveys (both print & online)	May 15, 2015 – January 15, 2016
Conduct Health Status Assessment (gather, collate, analyze external data)	May 30 – November 30, 2015
Conduct Forces of Change Assessment	September 2015
Conduct Local Public Health System Assessment	January 2016
Organize community data into Themes, summarizing strengths and issues (to finalize Community Themes and Strengths Assessment)	January 15 – February 1, 2016
Hold Theme Team meetings	February 2016
Share draft goals and strategies with Theme Teams and solicit feedback	March 2016
Building on all assessments and data gathered, complete written "Community Health Assessment and Action Plan"	March 2016

Strategic Issues, Goals and Strategies

The MAPP process, which was used to guide this Community Health Needs Assessment, includes four distinct assessment processes: the Community Themes and Strengths Assessment, Community Health Status Assessment, Local Public Health Systems Assessment, and Forces of Change Assessment. Documentation of these assessments begins on page 30 of this report.

Six strategic issues emerged through the Community Themes and Strengths Assessment. Subsequently, Theme Teams were developed around each of these strategic issues to develop corresponding goals and strategies based on data from all four assessments. The Strategic Issues, Goals, and Strategies presented below are the culmination of the Community Health Needs Assessment and constitute this Action Plan.

Data included under Strategic Issues headings was primarily sourced from the 2015 Maine Shared Community Health Needs Assessment (SHNAPP, 2015), unless otherwise noted in citations. The SHNAPP data summaries include “top issues” as reported by Hancock County stakeholders through a statewide 2015 survey, and quantitative demographic and health data from 25 sources.

Strategic Issue #1:

How can we ensure that all community members have access to high quality affordable health care, including health and wellness education?

Strategic Issue #2:

How can we ensure that all community members have access to healthy affordable food and an environment that encourages healthy eating?

Strategic Issue #3:

How can we ensure that all community members have access to safe, affordable opportunities for physical activity and an environment that encourages physical activity?

Strategic Issue #4:

How can we ensure that all community members have access to quality substance use disorder prevention and treatment?

Strategic Issue #5:

How can we ensure that all community members have access to high quality social and mental health services and resources, and benefit from positive social environments?

Strategic Issue #6:

How can we ensure that all community members benefit from healthy indoor and outdoor environments today and for future generations?

Strategic Issue #1:

How can we ensure that all community members have access to high quality affordable health care, including health and wellness education?

Key Findings:

- Numerous assets exist in the region that support our vision of high quality, affordable health care and health and wellness education for all, including:
 - Mount Desert Island Hospital (MDIH) and Maine Coast Memorial Hospital (MCMH), which provide high quality care to our region and continue to expand services including dental and flu clinics, specialty MDs, and expanded services and hours during the summer.
 - Mount Desert Nursing Association, which provides care for Mount Desert residents at low cost.
 - Maine Seacoast Mission and Mount Desert Island Hospital, which provide telemedicine, clinics, behavioral health services, and elder care programs on outer islands.
 - Positive communication and collaboration between service providers to increase problem solving and reduce service gaps.
 - Acadia National Park, which provides an environment that encourages health.
 - Strong, healthy role modeling within the community and community engagement in supporting health programming.
 - Life flight air ambulance service, connecting our rural and island communities with advanced life support and tertiary care facilities in Bangor and Boston.
 - Health education resources in the public schools, at College of the Atlantic (COA), through large employers such as the Jackson Laboratory, and through community group efforts.
 - Private dentists, which occasionally conduct clinics on outer islands.
 - A newly established Good Morning Program, supporting seniors in safely aging at home with a Monday through Friday well-being call offered by the police departments of Bar Harbor and Mount Desert..
 - Prevention programming offered through Healthy Acadia and other area organizations including YMCA, YWCA, Harbor House, Health Equity Alliance and others.
 - Transportation services including the Island Explorer, Downeast Transportation, Island Connections, and Friends in Action, all of which support community members' ability to access health care resources and services.
- 16% of adults in Hancock County are uninsured, compared to 13% statewide (County Health Rankings, 2016).

- Only 23.6% of Hancock County residents are enrolled in MaineCare, compared to 27% of all Mainers. And, 40.4% of children in Hancock County ages 0-19 are enrolled in MaineCare, which is slightly less than the state rate of 41.8% (SHNAPP, 2015).
- Many additional Hancock County residents are underinsured.
- When people are uninsured or underinsured, they often do not get needed primary care, such as yearly check-ups, and they wait to get needed care because of the cost. This leads to preventable illness, more acute illness, more emergency rooms visits, and higher healthcare costs.
- A lack of dental care providers in the Downeast region has led to limited access to dental care, particularly for MaineCare members. 32.4% of adults in Hancock County did not have a visit to a dentist in the past 12 months. Nearly 44% of MaineCare members under the age of 18 did not have a visit to the dentist in the past year (SHNAPP, 2015). This may not reflect children who received free dental services at school or through a community dental clinic.
- Many community members are unaware of healthcare resources available in our communities.
- Nearly 10% of Hancock County residents are unable to obtain or delay obtaining necessary medical care due to cost (SHNAPP, 2015)..
- Obstacles such as transportation, cost, awareness, stigma, and others exist for community members to access resources available in our communities.
- Access to healthcare is a distinct concern for outer island residents, who have unique transportation challenges.
- Lack of data for Hancock County limits our ability to understand the health status of our immediate region.
- With the implementation of the Affordable Care Act, our communities and state have opportunities to improve access to high quality, affordable healthcare for all, but lack of Medicaid expansion in Maine continues to limit healthcare for many.
- Health concerns for the area include substance use disorder, depression, and overweight and obesity and associated issues such as diabetes and cardiovascular diseases. Additionally, a number of seniors who access healthcare are underweight.
- The area has an increasing aging population. Hancock County is one of the older counties in Maine, with a high percentage of population who are seniors. This group has unique transportation, socialization, and healthcare needs including palliative care.

Goal:

Increase awareness about available healthcare resources, including prevention and wellness.

Strategies:

- Use traditional and social media, including press releases, newsletters, flyers, Facebook, Twitter, and Instagram to increase awareness.
- Use healthcare resources such as pamphlets, information sheets, magnets, and electronic health bulletins.
- Use existing community resource sharing tools and community events calendars.
- Use existing community infrastructure such as community organizations, municipal entities, schools, hospitals, clinics, and others to disseminate printed materials.
- Use television and radio to spotlight health programs and services.

- Engage with key groups including youth and young families, seniors, veterans, migrant and seasonal workers, community members with disabilities, LGBTQ community members, business owners, and seasonal visitors.

Goal:

Make healthcare more affordable.

Strategies:

- Educate legislators and key stakeholders about the importance of Medicaid expansion in Maine for increasing access to healthcare.
- Continue to promote the Maine Health Insurance Exchange and increase awareness of available navigators to support utilization of this resource.
- Continue to develop Patient-Centered Medical Homes, community health teams, and other innovative care models to insure quality affordable care.
- Develop more opportunities for collaboration and coordination of resources; coordinate meetings for providers to share resources.
- Continue to work to obtain grants to improve affordability of healthcare resources.
- Increase prevention efforts to reduce long-term healthcare costs.

Goal:

Overcome obstacles to accessing healthcare resources, including prevention and wellness.

Strategies:

- Improve transportation support for home healthcare and to help community members access health resources.
- Expand and promote evening and weekend hours of health services.
- Further develop telemedicine on outer islands – expand to new areas and enhance services that already exist, and seek funding to develop additional mobile health opportunities.
- Use personal interactions and the business community to connect people to resources in order to diffuse fear, uncertainty, and stigma associated with accessing resources.
- Engage community in recruitment and retention of providers to increase community buy-in to their healthcare system.
- Increase promotion and availability of translator services.
- Offer gender and sexuality sensitivity training to first responders and healthcare providers.
- Reduce shortages in healthcare resources such as, but not limited to, palliative care.

Strategic Issue #2:

How can we ensure that all community members have access to healthy, affordable food and an environment that encourages healthy eating?

Key Findings:

- Numerous assets exist in the region to support access to healthy and affordable food for all and an environment that encourages healthy eating, including:
 - Food Pantries and meal sites (Bar Harbor Food Pantry; Westside Food Pantry, Food For All, and Common Good Cafe)
 - Share the Harvest Program through College of the Atlantic (COA)
 - Meals for ME
 - Healthy food options in major grocery stores and at a variety of health food stores
 - Innovative school cooks and school lunch programs
 - Gardening programs in pre-k through 8 schools
 - COA (providing community gardening spaces; students interested and involved in food and farms; faculty expertise in food and sustainability)
 - University of Maine Cooperative Extension, providing resources and expertise
 - Community and Victory Gardens (Saint John's, COA, Malvern-Belmont)
 - Farmers Markets, farm stands, and Community Supported Agriculture (CSA) shares available throughout the area, some accepting payment via the Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infant (WIC)
 - An increasing cultural shift towards valuing nutritious and local foods
 - Maine Coast Heritage Trust's Kids Can Grow program in partnership with Cooperative Extension's Master Gardeners
 - Culture of fishing and clamming
 - Healthy Acadia's Gleaning Initiative, Food For All, Healthy General Stores, and Farm to School programs
- Diet-related disease occurs in our region at high rates, representing important health concerns connected directly to food:
 - The percentage of adults with high blood pressure is 37.3% compared to 32.8% in the state (SHNAPP, 2015).
 - The percentage of high cholesterol in Hancock County rate is 40.7%, which is comparable to the state rate of 40.3% (SHNAPP, 2015).

- The diabetes prevalence among adults is slightly below the state average, at 8.9% compared with 9.6%% statewide. The number of diabetes hospitalizations per 10,000 is significantly below the state at 181.1 compared to 235.9 (SHNAPP, 2015).
- The percentage of adults who are overweight or obese is 67.1%. This is slightly above the state average of 64.9% (SHNAPP, 2015).
- Hancock County has high rates of children eligible for free and reduced lunch, at 43.13% of children (Maine Department of Education, 2015).
- More than half of the region's population earns less than a livable wage, making food insecurity high (Poverty in ME, 2010).
- Consumers face limited access to good, healthy food because of high price, limited number of food venues, and the isolation that some people, especially elders, face.
- Increasing numbers of seniors are presenting underweight. Anecdotal evidence also shows that many seniors must make difficult decisions between paying for food and medication.

Goal:

Increase awareness of available food systems resources for consumers, home gardeners, producers, institutions, grocery and general stores, and food service businesses.

Strategies:

- Use traditional and social media, including press releases, newsletters, flyers, Facebook, Twitter, and Instagram.
- Use existing community resource sharing tools and community events calendars.
- Use existing infrastructure such as community organizations, municipal entities, schools, hospitals, clinics, and others to disseminate printed materials.
- Use television and radio to spotlight food programs and systems.

Goal:

Create more opportunities for community members to access healthy food.

Strategies:

- Support expansion of area farmers' markets.
- Work with area institutions, including schools and hospitals, to create policies and practices so that they are able to serve healthy, whole foods.
- Expand the number of community & school gardens and greenhouses and complementary educational opportunities.
- Continue to develop and promote food recovery efforts such as gleaning.
- Increase availability of healthy cooking, shopping and nutrition classes.
- Support the use of Electronic Benefits Transfer (EBT) technology at farmers' markets and other food retailers.
- Promote transportation resources to improve access to farmers' markets, farm stands, grocery stores and restaurants.

Goal:

Improve the affordability of healthy food options.

Strategies:

- Increase participation in federal programs, such as SNAP, WIC, Fresh Fruit and Vegetable Program (FFVP) for schools, Senior Farm Share, and Free and Reduced Price Lunch and Breakfast.
- Support the development of garden beds at community housing locations.

Goal:

Create better policy and environments for local food producers to grow and succeed.

Strategies:

- Coordinate with local supermarkets to sell more local produce.
- Create a Food Policy Council that engages leaders from all sectors of the food system, in order to develop a plan for a stronger local food system.
- Improve local ordinances to better support and encourage local producers, including fishermen.
- Support increased marketing opportunities for local fisheries.
- Educate and promote big-picture benefits of eating local to community health.

Strategic Issue #3:

How can we ensure that all community members have access to safe, affordable opportunities for physical activity and an environment that encourages physical activity?

Key Findings:

- Numerous assets exist in our region to support physical activity and healthy transportation, including:
 - Sidewalks and walkable village centers
 - Acadia National Park, town parks and green spaces
 - Organizations providing opportunity for physical activity, such as: Mount Desert Island YMCA, Ellsworth YMCA, Harbor House, Neighborhood House, Camp Beech Cliff, Destination Health, Acadia Fire, golf courses, and Friends in Action
 - Mount Desert Island Hospital – walking courses, weight management courses, post-discharge patient care
 - Jackson Lab, Mount Desert Island Hospital, Maine Coast Memorial Hospital, and other large employer’s worksite wellness programs.
 - School programs, such as gym, recess, walking clubs, after-school sports
 - Public tennis courts, sports fields, and playgrounds
 - Bicycle, kayak and canoe rentals and outfitters
 - Hancock County Planning Commission
 - Walkability and bikeability audits have been conducted in various towns.
- Diseases related to lack of physical activity occur at high rates. Diet, as mentioned above, as well as lack of physical activity are both significant contributors to these diseases:
 - The percentage of adults in Hancock County with high blood pressure is 37.3% compared to 32.8% in the state (SHNAPP, 2015).
 - The percentage of high cholesterol in Hancock County rate is 40.7%, which is comparable to the state rate of 40.3% (SHNAPP, 2015).
 - The diabetes prevalence among adults in Hancock County is slightly below the state average, at 8.9% compared with 9.6%% statewide. The number of diabetes hospitalizations per 10,000 is significantly below the state at 181.1 compared to 235.9 (SHNAPP, 2015).
- The percentage of adults who are overweight or obese is 67.1%. This is slightly above the state average of 64.9% (SHNAPP, 2015).
- Lack of physical activity contributes directly to obesity. 44.1% of adults in Hancock County are not meeting the physical activity recommendations, and 20% are reporting no leisure-time

physical activity in the past month. These rates are comparable to state rates of 44.6% and 22.4%, respectively (SHNAPP, 2015).

- According to the 2015 *Maine Integrated Youth Health Survey* (MIYHS), 40.9% of high school students in Hancock County reported being physically active for 60 minutes a day on five or more days of the week. The percentage of students who are physically active steadily declines throughout high school, with 50.2% of 9th graders reporting being physically active for 60 minutes a day on five or more days of the week, compared to only 36% of 12th graders (Maine Integrated Youth Health Survey (MIYHS), 2015).
- Limited bikeability and walkability are major concerns for area residents.

Goal:

Increase awareness about available physical activity opportunities.

Strategies:

- Use traditional and social media, including press releases, newsletters, flyers, Facebook, Twitter, and Instagram to increase awareness.
- Use existing community resource sharing tools and community events calendars.
- Use existing infrastructure such as community organizations, municipal entities, schools, hospitals, clinics, and others to disseminate printed materials.
- Use television and radio to spotlight physical activity programs and resources.

Goal:

Ensure greater opportunities for physical activity, making exercise the easy choice.

Strategies:

- Increase 5-2-1-0 Let's Go! messaging and programming in schools, healthcare practices, and other community locations.
- Create free, safe and convenient places for indoor physical activity.
- Develop infrastructure such as playground and exercise equipment, water fountains, and warming huts to encourage physical activity in outdoor areas.
- Create student drop-off points away from schools with volunteer adult walkers for the students.
- Increase physical activity opportunities for working community members, including daytime worksite wellness programs.
- Provide education on safe and simple ways to be physically active at all ages and wherever you are.
- Promote transportation resources to improve access to physical activity programs and resources.

Goal:

Support policy and infrastructure changes to increase safety and appeal of physical activity opportunities.

Strategies:

- Improve sidewalks and bikeways for walking and bicycling.
- Support development of new locations for physical activity such as indoor tennis courts, swimming pools, skate parks and pickleball courts.
- Support and increase town and village walkability assessment efforts.
- Develop branding of the area as a healthy, active community.
- Develop more opportunities for collaboration and coordination of resources.

Strategic Issue #4:

How can we ensure that all community members have access to quality substance use disorder prevention and treatment?

Key Findings:

- Numerous assets exist in our communities to support efforts to reduce and prevent substance use disorder:
 - Acadia Family Center
 - Mount Desert Island Hospital Behavioral Health Center
 - Contracted substance counselor at Mount Desert Island High School
 - Private substance use disorder counselors
 - Drug Court
 - Open Door Recovery
 - Maine Sea Coast Mission facilitates substance use disorder services and other behavioral health counselling appointments on outer islands through telemedicine
 - Strong positive engagement of police and county sheriff's department
 - Healthy Acadia's substance prevention programs, including the Drug Free Communities Program
 - Strong recovery community including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)
 - Downeast Substance Treatment Network
 - Community social and recreation centers and other programs that provide healthy opportunities
 - Many tobacco-free community locations
 - Spiritual organizations and leaders; youth groups
 - Political will and availability of federal funding
 - Public recognition of growing opioid epidemic
 - Acadia National Park has adopted tobacco-free policies for certain outdoor areas.
 - Numerous prevention education and activities are available through the schools.
- Smoking rates among Hancock County high school students have been on the decline, with 9% of high school students reporting past month use in 2015, compared to 19% in 2009. The statewide average was 11% in 2015. Unfortunately, use of electronic vaping devices is on the rise among youth, with 26.9% of Hancock County high school students reporting ever having used a vaping device (MIYHS, 2015).
- Hancock County has the second lowest rate of current adult smoking at 14.2%, second only to Lincoln County at 12.5%. The statewide average is 20.2%, with a range of 12.5% to 28.8% (SHNAPP, 2015).

- According to the 2015 *MIYHS*, lifetime youth alcohol use among 9th to 12th graders is statistically higher in Hancock County than the state average (55% compared with 51% statewide). Past 30-day alcohol use is more similar to the state average, with 25% of Hancock County 9th to 12th graders having consumed alcohol in the past 30 days compared to 24% statewide. Binge drinking within the previous 2 weeks among 9th to 12th graders is 12% both in Hancock County and statewide. Use of alcohol increases dramatically from 11th to 12th grade students, with 45% of 12th graders reporting past month use compared to 21% of 11th graders (*MIYHS*, 2015).
- Marijuana use among Hancock County youth is slightly lower than the state average, but not statistically significant. 17% of Hancock County youth reported using marijuana in the past month, compared to 20% of Maine youth. Marijuana use is trending downward, with 31% reporting ever having used marijuana in 2015, down from 36% in 2009. The 2015 state rate was 35%. As with alcohol, use of marijuana increases dramatically from 11th to 12th grades, with 18% of 11th graders and 30% of 12th graders reporting past month use. Despite the favorable downward trends in marijuana use, perception of harm is decreasing; 63% of high school students believe marijuana use poses little risk of harm (*MIYHS*, 2015).
- Misuse of prescription drugs in the last 30 days by 9th to 12th graders is the same as the state rate of 5% (*MIYHS*, 2015).
- Among students who indicated that they were gay, lesbian or bisexual we see much higher rates of substance use disorder compared to the rates among all students who do not identify that way.

Goal:

Increase awareness about available substance use disorder prevention and treatment resources.

Strategies:

- Use traditional and social media, including press releases, newsletters, flyers, Facebook, Twitter, and Instagram.
- Use existing community resource sharing tools and community events calendars.
- Use existing infrastructure such as community organizations, municipal entities, schools, hospitals, clinics, and others to disseminate printed materials.
- Use television and radio to deliver substance use disorder prevention and treatment programs and resources.
- Hold regular community forums to engage community members in discussions about substance issues.

Goal:

Create more opportunities for people to get the support they need to free themselves from addiction.

Strategies:

- Develop programming, including medication assisted treatment options, to support treatment and recovery.

- Develop an opioid treatment hub and spokes model to provide coordinated care to community members across the region.
- Create more affordable and accessible individual and group recovery counseling options.
- Strengthen ER services, walk-in services, and inpatient services for treatment.
- Promote transportation resources to improve access to substance use disorder prevention and treatment programs and resources.
- Increase and promote amount and diversity of opportunities for substance-free social engagement, especially among youth and young adults.
- Expand on resiliency trainings sponsored by Acadia Family Center and Healthy Acadia, focusing on strengths-based approaches.
- Strengthen relationships of local law enforcement with schools and broader community.

Goal:

Remove the stigma around addiction.

Strategies:

- Provide education and advocacy around substance use disorder across all sectors of the community including state and local policy makers, the business community, schools, and others.
- Use personal interactions and the business community to connect people to resources in order to diffuse fear, uncertainty, and stigma associated with accessing resources.
- Build a network of employers and landlords who will hire and rent to those in recovery.

Goal:

Reduce alcohol and prescription and illegal drug risks in the community.

Strategies:

- Continue to support careful medication prescribing practices to reduce excess unused medication at home and/or excessive prescribing and use of pain medication.
- Provide prescription medication disposal guidance and awareness of drop-off locations.
- Provide sharps disposal units in public locations.
- Increase availability and use of overdose reversal medication, such as naloxone, by first responders.
- Continue offering Responsible Beverage Service trainings with an added sexual assault prevention component.
- Provide education to parents and teachers on signs of teen marijuana, huffing, alcohol, and prescription drug abuse, and the dangers presented to their growing minds from these activities.

Goal:

Improve policies and environments to reduce tobacco use and tobacco exposure.

Strategies:

- Create smoke-free public areas in all parts of the community.
- Provide education on the hazards of e-cigarettes and vaping.
- Provide tobacco cessation opportunities.

Strategic Issue #5:

How can we ensure that all community members have access to high quality social and mental health services and resources, and benefit from positive social environments?

Key Findings:

- Numerous assets exist in our community to support a healthy environment, including:
 - Supportive and close-knit communities
 - Low crime
 - Many positive social environments and opportunities, including
 - Both indoor and outdoor physical activity resources
 - Local faith-based organization, libraries and community-based third places
 - Cultural events
 - Growing year-round business community
 - Smaller year-round communities, with residents striving to ensure a vibrant, year-round, socially engaging, quality of life
 - Strong perception of community members' willingness to help one another out
 - Culture of volunteerism and civic engagement
 - Many multigenerational events
 - Schools working to address mental health needs of youth
 - Private counselors such as the Counseling Collaborative
 - Collaborative nonprofits and social service agencies
- An overall highly seasonal economy with seasonal tourism, businesses, and population changes
- Concerns about lack of safe and healthy social opportunities for youth
- Mental health data is slightly more favorable for Hancock County adults compared to statewide rates: 9.9% of adults in Hancock County had 14 or more days lost due to poor mental health, compared with 12.4% statewide; 11.6% of adults had 14 or more days lost due to poor physical health, compared to 13.1% statewide (SHNAPP, 2015).
- In Hancock County, 15.7% of adults have ever had anxiety compared to 19.4% of Mainers (SHNAPP, 2015).
- 21.1% of adults have ever had depression, compared to 23.5% of Mainers (SHNAPP, 2015).
- Only 7.6% of Hancock County residents report current symptoms of depression, compared to 10% of Mainers (SHNAPP, 2015).
- Hancock County has significantly fewer mental health emergency department visits at 1,564.4 per 100,000 compared to 1,972.1 per 100,000 statewide (SHNAPP, 2015).
- According to *MIYHS*, one quarter (25.7%) of Hancock County high school students reported feeling so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. This is very comparable to the state rate of 25.9%. It should be noted that 18% of high school males in Hancock County report this, compared to 34.1% of females (MIYHS, 2015).

- 13.8% of Hancock County high school students seriously considered attempting suicide in the past 12 months, compared to 14.8% statewide. For students who indicated that they were gay, lesbian, bisexual, 63% reported feeling sad or hopeless for two weeks, and just under half (47%) seriously contemplated suicide (MIYHS, 2015).
- While 93.2% of high school students in Hancock report feeling safe at school (compared to 88.6% statewide), nearly 20% (19.8%) report having ever been bullied on school property (compared to 24% statewide). 90% of middle school students report feeling safe at school, yet 57% report having been bullied on school property, compared to 47% statewide (MIYHS, 2015).
- 85.5% of high school students feel that at least one of their teachers really cares and gives help and support when they need it, which is significantly higher than the statewide rate of 80.4%
- 58% of high school students (compared to 51% statewide) and 56% of middle school students (compared to 55.8% statewide) feel like, in their community, they matter to people (MIYHS, 2015).

Goal:

Increase awareness about available social opportunities and social/mental health resources.

Strategies:

- Use traditional and social media, including press releases, newsletters, flyers, Facebook, Twitter, and Instagram to increase awareness.
- Use pamphlets, information sheets, magnets, and electronic health bulletins, etc., to promote mental health resources.
- Use existing community resource sharing tools and community events calendars.
- Use existing community infrastructure such as community organizations, municipal entities, schools, businesses, hospitals, clinics, and others to disseminate printed materials.
- Use television and radio to spotlight both social opportunities and mental health programs.
- Engage with key groups including youth and young families, seniors, veterans, migrant and seasonal workers, community members with disabilities, and LGBTQ community members.

Goal:

Promote positive social environments for all.

Strategies:

- Create more Third Places; safe hangout locations that aren't home or school for youth, or home or work for adults.
- Support existing community hubs, including schools, libraries, churches, and more.
- Support care providers at childcare centers, schools, community service organizations, and mental and physical health facilities to offer good working environments and strong professional development for staff.
- Support increased recess and physical activity opportunities for K-12 students throughout the school day.
- Offer behavioral support for youth through individually tailored, team-based management techniques and careful medication prescribing practices if necessary.

- Increase support services for seniors aging at home.
- Foster tolerance and diversity throughout our communities.
- Provide gender-neutral bathrooms in public buildings.

Goal:

Increase opportunities for positive social engagement for all.

Strategies:

- Increase multi-generational social opportunities.
- Work with existing organizations to increase opportunities for afterschool and summer activities for youth.
- Work with existing organizations to increase social offerings for seniors.
- Increase availability of evening and weekend social events for working parents, with affordable childcare offerings.
- Promote transportation resources to improve access to social opportunities.

Goal:

Increase volunteerism and civic engagement.

Strategies:

- Work with area partners to promote and facilitate volunteerism throughout the area, such as through a volunteer fair or clearinghouse to match skills and interests with volunteer needs.
- Embed service learning into the school system at every level.
- Educate public on the workings of our municipal governance structure, what it means to be involved, and how to be involved.

Goal:

Make mental healthcare more affordable.

Strategies:

- Increase access to free and reduced cost clinics and counseling services.
- Increase access to health insurance coverage for mental health services.
- Develop more opportunities for collaboration and coordination of resources; coordinate meetings for providers to share resources.
- Continue to embed mental health services in primary care settings, such as through Patient Centered Medical Homes.

Goal:

Overcome obstacles to accessing mental health resources.

Strategies:

- Improve and promote transportation support to help community members access mental health resources.
- Expand and promote evening and weekend hours of mental health services.
- Further develop telemedicine on outer islands – expand to new areas and enhance services that already exist, and seek funding to develop additional mobile mental health opportunities.
- Offer gender and sexuality sensitivity training to first responders and mental health providers.
- Support existing mental health providers with their large caseloads through recruitment of more mental health providers to the area.
- Offer crisis intervention training for law enforcement, first responders, and emergency department personnel.
- Develop safe, “blinded” access to care the high school to increase the anonymity of accessing services

Goal:

Remove the stigma around mental health.

Strategies:

- Provide education and advocacy around mental health issues across all sectors of the community including state and local policy makers, the business community, schools, and others.
- Use personal interactions and the business community to connect people to resources in order to diffuse fear, uncertainty, and stigma associated with accessing resources.

Strategic Issue #6:

How can we ensure that all community members benefit from healthy indoor and outdoor environments today and for future generations?

Key Findings:

- Numerous assets exist in our community to support a healthy environment, including:
 - Town recycling and compost opportunities
 - Town Conservation and Waste Prevention Committees
 - Friends of Acadia; Maine Coast Heritage Trust
 - Town Chamber “Greening Initiatives”
 - Overall respect and appreciation for the environment in the community
 - Natural beauty – ocean, lakes, forests, mountains
 - Acadia National Park; Lamoine State Park; town parks
 - Transportation services, such as: Island Explorer, Friends in Action, Downeast Transportation, Island Connections, Acadia Gateway Center (potential for more future use of the latter)
 - School – environment-related curricula; sustainability initiatives
 - Community Health Lab at MDI Biological Laboratory
 - College of the Atlantic (COA)
- Air pollution in our region is one of the worst in the nation largely because of the wind currents from heavy emissions-producing mid-western states.
- In 2007, Hancock County had 5 days with heavy ozone air pollution days in comparison with Maine’s statewide average of less than 1 day (County Health Rankings, 2012).
- Hancock County has a high rate of cancer incidence: 521.4 per 100,000 for all cancers, compared to the state average of 500.1 per 100,000. However, our cancer mortality rate is lower than the state, with 171.4 deaths per 100,000 compared to 185.5 per 100,000 statewide. It should be noted that despite the differences between Hancock and the state, these numbers are not significant (SNHAPP, 2015).
- We have significantly higher rates of lead screening among 1-year old children, at 56.3% in Hancock County, compared with 49.2% statewide. However, lead screening among 2-year old children in Hancock County decreases to only 26.5%, compared to 27.6% statewide (SNHAPP, 2015).
- We also have significantly fewer children with confirmed elevated blood levels among those screened, at 1.5%, compared with 2.5% statewide (SNHAPP, 2015).
- Summer ridership of the propane-powered shuttle, the Island Explorer, continues to increase annually. In 2015, more than a half million passengers used the bus system (Island Explorer, 2015). (<http://www.mdislander.com/featured/island-explorer-tops-ridership-record>).

Goal:

Increase awareness and expand opportunities for community members to make environmentally healthy choices at home.

Strategies:

- Increase awareness of potential home health hazards including lead, arsenic, radon, pesticides, and mold.
- Promote and increase availability of low-cost testing and remediation for lead, arsenic, and radon, and other contaminants.
- Provide education on and resources for low-cost home energy audits and winterization.

Goal:

Increase awareness and expand opportunities for communities to make environmentally healthy choices to protect our natural resources.

Strategies:

- Create easier recycling and composting opportunities with consistent standards region-wide.
- Support development of shared alternative energy projects.
- Support environmentally friendly policies, such as an region-wide plastic bag charge at stores.
- Offer community and school-based education on environmental sustainability.
- Continue and increase water-quality monitoring and air quality monitoring, making this information publically accessible.
- Promote pet waste management through signage, free waste bags and public trash cans.
- Consider deer management methods, including educating residents about not feeding wildlife, and controlled hunting, particularly on bridged and outer islands.
- Continue to support and maintain public greenspace.

Goal:

Improve planning and infrastructure to encourage healthy transportation.

Strategies:

- Improve roads, sidewalks, and pathways to improve safety and appeal of biking and walking.
- Increase awareness of public transportation options and year-round availability of public transportation.
- Promote existing ride-share and volunteer driving resources.
- Increase public will for development and use of environmentally friendly transportation options.

Assessment Process

The Community Health Needs Assessment (CHNA), culminating in the Strategic Issues, Goals, and Strategies listed in this report from pages 12-29, has followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework.

As previously mentioned, MAPP includes four distinct assessment processes:

- The Community Themes and Strengths Assessment
- The Community Health Status Assessment
- The Local Public Health Systems Assessment
- The Forces of Change Assessment

Data from these assessments collectively provide a detailed picture of the current community health landscape in the Local Service Area (LSA).

This data was shared with small community stakeholder groups, called “Theme Teams”, to utilize in developing the Strategic Issues, Goals, and Strategies, which now make up this Action Plan.

The four MAPP assessments processes and outcomes are documented in the following pages.

Community Themes and Strengths Assessment

Process for Conducting Assessment:

MAPP Core Planning Team members spent four months collecting community input through an electronic and paper survey, phone calls, and group dialogues from late 2015 into early 2016. We reached out to thousands of community members in the Local Service Area (LSA) and asked them broad-based questions about “community health.” Participants were asked about area community health assets, concerns regarding community health, and what they would like to see happen to build greater community health (see Appendix for the survey). We received 382 surveys from community members living, working, and receiving services in the MDI Service Region.

We worked to ensure that survey participants constitute a broad spectrum of our community, representing wide-ranging sectors, geographic areas, genders, age groups, and economic backgrounds proportionate to the population as much as possible. This was fulfilled through a diverse survey dissemination effort and frequent evaluation of respondent demographics. Community area, work and community affiliations, gender and age all were data collected through the survey process and we were therefore able to evaluate the success of the assessment’s reach based on this data. We chose not to collect the income levels of survey respondents out of respect for privacy, and therefore can only make anecdotal determinations on the economic diversity of our reach.

While greater representation is always to be strived for as part of every needs assessment, we feel confident that we have heard from a large representative group of community members with a range of interests and opinions regarding the health of their communities and the efforts needed to increase community health.

The interview data was collected using a SurveyMonkey survey and then downloaded as an Excel document for coding and analysis. In early winter of 2016, MAPP Core Planning Team members worked together to review the data. All efforts were made to maintain the breadth and depth of survey responses while collating data into community health topic areas. Of the ten topic areas initially determined to encompass the data, six were deemed to be unique themes and appropriate for response from the community health system. The remaining four are systematic elements relevant across all of the six “themes”.

The six themes are listed here, with the summary of each one below. Topics of Economy, Jobs and Housing, Infrastructure and Transportation, Youth, and Aging are integrated throughout each theme.

STRATEGIC ISSUES

Also referred to as Themes, developed through the Community Themes and Strengths Assessment:

1. *Healthcare*
2. *Food*
3. *Physical Activity*
4. *Substance Use*
5. *Social/Mental Health*
6. *Healthy Environments*

HEALTH CARE

STRENGTHS:

- Healthy social and physical environments and a culture valuing healthy lifestyles
- Healthcare facilities and resources, including
 - Mount Desert Island Hospital
 - Maine Coast Memorial Hospital
 - Community health centers
 - Mount Desert Nursing Association
 - Maine Seacoast Mission
- Law enforcement, fire department, and medical first responders
- Good dental care

CHALLENGES:

- High insurance rates - limits access to affordable, quality health care
- Limited weekend and evening clinic hours as well as off-season access
- Limited healthcare options on outer islands and transportation resources from outer islands for residents to make medical appointments on MDI or beyond
- Increasing senior population numbers and shortage of palliative care resources
- Limited affordable dental care access
- Limited midwifery access and no birthing center
- Limited general wellness and prevention programs, and/or awareness of existing resources
- High levels of obesity in schools
- Many seniors presenting underweight
- Unclear consistency in quality and availability of services across the disparate geographic LSA
- Income disparities
- Health literacy inconsistent across communities
- Underserved seasonal workers
- Shortage of specialist MDs and young MDs
- Concern about people not taking advantage of resources that exist

FOOD

STRENGTHS:

- A culture of local food, including
 - Many small-scale local farms
 - Home and community gardens
 - Farm stands, farmers' markets
 - Grocery stores selling local products
 - Restaurants and food service selling meals made with locally derived ingredients
 - Gardening education for youth in schools and through local non-profit programs
 - A fishing culture and economy
- Food access and food security resources, including
 - Locally run free community meal sites, food pantries, and school backpack programs
 - National School Lunch and School Breakfast programs, the Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infant (WIC)
 - School and community-based classes around shopping, cooking, and eating healthy on a budget
 - EBT and WIC accepting farmers' markets and farm stands
 - Share the Harvest program through COA's Beech Hill Farm
 - Food waste reduction and food recovery partnerships between farms, grocery stores, non-profits, and meal sites and food pantries
- A growing trend to prioritize consumption of healthy food

CHALLENGES:

- Limited access to and affordability of healthy foods
- Hunger/food insecurity
- Limited education opportunities in healthy food options, preparation
- Limited access to garden spaces
- Healthy food in local institution cafeterias (e.g. schools, hospitals)
- Limited Farmers' Markets (especially in winter)

PHYSICAL ACTIVITY

STRENGTHS:

- An outdoor environment that provides opportunities to engage in outdoor physical activity, including
 - Acadia National Park
 - Lamoine State Park
 - Town green spaces
 - Walking paths
 - The ocean

- Area ponds
 - The Sunrise Trail
- Indoor physical activity resources, including
 - The YMCA
 - Harbor House
 - Neighborhood House
 - Camp Beech Cliff
 - Destination Health
 - Acadia Fire
 - Atlantic Oceanside
- Non-profit efforts to organize and promote physical activity opportunities
- Social media groups forming to get people active
- Culture of physical activity in some areas

CHALLENGES:

- Limited access and affordability of physical activity opportunities (e.g. programs/facilities/membership/classes)
 - Especially for the winter season, and for youth, seniors, and working adults
- Limited information about affordable options for physical activity
- Limited bikeability – poor roads, lack of bike lanes, unsafe conditions
- Limited walkability – poor sidewalks; lack of sidewalks, limited paths
- Limited connector trails between towns
- Significant electronic use/screen time
- Limited awareness of bikers/pedestrians by auto drivers and vice versa

SUBSTANCE USE

STRENGTHS:

- Treatment and recovery resources, including
 - Acadia Family Center
 - Open Door Recovery
 - AA and NA support systems
 - Various recovery houses
- Collaboration between service providers, law enforcement and first responders, such as
 - The Downeast Substance Treatment Network
 - Drug Court
 - Drug Free Communities
 - Health Equity Alliance (formerly the Downeast AIDS Network)
- Law enforcement resources and prioritization, including

- Dedicated drug enforcement officer
- Crisis intervention training to be offered March, 2016
- Drug Recognition Expert trainings
- RIDE Teams and highway safety efforts
- Federal prioritization and funding allocation, including
 - Drug Free Communities Grant
- Tobacco free public areas and a low-rate of tobacco use
- Public recognition of a growing opioid epidemic
- Many positive environments and social opportunities for youth and adults

CHALLENGES:

- Increasing medication dependency, opioid addiction and related substance addiction
- A budget driven medical system, resulting in many treatment facilities closing due to debt
- Shortage of medication assisted treatment options for those seeking recovery
- Limited emergency room and walk-in treatment services
- Availability of ‘gateway drugs’ to youth, such as alcohol, tobacco, marijuana, and aerosol huffing
- Alcohol abuse – youth peer pressure; drunk driving; health dangers; negative impacts in community
- Resistance to free School Resource Officer/positive law enforcement presence by some schools

SOCIAL/MENTAL HEALTH

STRENGTHS:

- Supportive and close-knit communities
- Low crime
- Many positive social environments and opportunities, including
 - Both indoor and outdoor activity physical activity resources
 - Local faith-based organization, libraries and community-based third places
 - Cultural events
- Growing year-round business community
- Strong perception of community members’ willingness to help one another out
- Culture of volunteerism and civic engagement
- Many multigenerational events
- Schools working to address mental health needs of youth
- Collaborative nonprofits and social service agencies

CHALLENGES:

- Shortage of year-round third places, especially for youth
- Shortage of year-round businesses and affordable housing
- Many community members are not engaged in volunteerism or local or state politics, especially youth and young adults
- Difficulty of winter depression
- Single parents (and many young parents) lack time or opportunities for themselves, which may lead to feelings of isolation
- Limitations on year-round transportation
- Many seniors lack transportation to social events, which may lead to feelings of isolation
- Social and mental health services are needed for large and growing senior population
- Mental health issues in youth, related in part to reduced opportunities for physical activity in the school system and greater emphasis on diagnosis
- Need more mental health care access for all ages--and/or awareness of availability
- Lack of diversity can lead to judgmental attitudes

HEALTHY ENVIRONMENTS

STRENGTHS:

- Outdoor environments and the resulting benefits, including
 - Acadia National Park, Village greens, and open spaces
 - Oceans, lakes and water access
 - Fresh air
 - Natural beauty
- Culture of environmental awareness and engagement, including
 - Organizations and community initiatives supporting environmental stewardship
 - Groups and individuals promoting sustainable energy
- Public transportation and volunteer-powered ride sharing, including
 - Island Explorer
 - Downeast Transportation Bus
 - The College of the Atlantic van
 - Island Connections
 - Friends in Action
- Bar Harbor Walkability Assessment
- Plans for increasing walk and bikeability in some areas

CHALLENGES:

- Limited testing for water and air contaminants both indoor and out, private and public, including radon, arsenic, mold, e-coli, pesticides, and more
- Some waste management issues in public areas, including pet waste, needles, and plastic waste
- High cancer rates – concern about environmental impacts
- Water quality and water resource protection concerns
- Limited sustainable energy
- Limited recycling/composting (good there is some, would like to see more)
- Need for road repairs – concerns about road safety for cars, bikes, pedestrians
- Year round public transportation
- Need for improved public transportation system; year-round
- Limitations of transportation system to outer islands (ferries) – cost, limited schedule, etc

Community Health Status Assessment

Process for Conducting Assessment:

The Community Health Status report provides quantitative data on demographics and health indicators that is significant in clarifying the landscape of community health needs initially presented through the Community Themes and Strengths Assessment and broadened by the Local Public Health System Assessment and the Forces of Change Assessment. The six Theme Teams used this data to consider each strategic issue and develop goals and strategies.

Data for the Community Health Status report was primarily sourced from the 2015 Maine Shared Community Health Needs Assessment with supplementary data from other federal, state, and regional sources, as seen in citations. Data is used to illustrate significant trends impacting community health in the LSA.

Below is a summary of key health indicators:

- **Demographic Characteristics**
 - Hancock County is rural, with 100% of residents living in rural areas, compared to 66.4% of all Mainers living in rural areas. The population density of Hancock County is 34.3 people per square mile compared to the state average of 43.1 people per square mile (SHNAPP, 2015).
 - We also have a disproportionately elderly population, and few young people. Hancock County is one of the older counties in Maine, with 20.7%% of our population aged 65 years old and older. Statewide, 17.7% of the population is 65 years old and older. We have the lowest percentage of young people under the age of 18, at 17.6%, compared to 19.7% of Mainers under the age of 18 (SHNAPP, 2015).
- **Socioeconomic Characteristics**
 - We have high rates of children eligible for free lunch, although we are not the highest in the state. In Hancock County, 43.13% of children are eligible for the free and reduced lunch program (Maine Department of Education, 2015).
 - We have a slightly higher percentage of individuals living in poverty, at 14.0% compared to the state average of 13.6%. 21.5% of Hancock County children are living in poverty compared to 18.5% of children statewide (SHNAPP, 2015).
 - The unemployment rate in Hancock County is 7.0% compared to the state average of 5.7% (SHNAPP, 2015).
 - The high school graduation rate is 84.3%, which is slightly below the state rate of 86.5% (SHNAPP, 2015).

- Among other socioeconomic indicators, we are relatively close to the state average. The percent of single-parent households is only slightly higher at 34.7 % compared to 34%; the percent of seniors 65 years and older who live alone is 41.4% compared to a state rate of 41.2%; and the median household income is just slightly below the state average (SHNAPP, 2015).
- Health Resource Availability
 - Within the category of health resource availability, Hancock County has high rates of uninsurance, with 16% of residents having no insurance compared to 13% statewide (County Health Rankings, 2016). Hancock County is among the bottom four ranking counties in Maine with fewer residents enrolled in MaineCare (23.6% vs. 27.0% statewide) (SHNAPP, 2015). Additionally, a smaller percentage of Hancock County children ages 0-19 are enrolled in MaineCare compared to the rest of the state (40.4% vs. 41.8%).
 - Hancock County fares better on our ratio of population to physicians; there is one physician for every 660 people, which is better than the state average of one physician for every 910 people. Hancock County has the second lowest ratio in the state, next to Cumberland County, which has 640 people per physician. For mental health providers, however, Hancock County falls behind the state, with a ratio of 1 provider for every 300 people. The state average is 1 mental health provider for every 240 people (County Health Rankings, 2016).
- Quality of Life
 - Hancock County ranks relatively well in quality of life. We have a relatively low percentage of adults with greater than or equal to 14 unhealthy days per month. 9.9% of adults in Hancock County had 14 or more days lost due to poor mental health, compared with 12.4% statewide; 11.6% of adults had 14 or more days lost due to poor physical health, compared to 13.1% statewide (SHNAPP, 2015).
 - We have close to the average percentage of adults reporting fair or poor health status: 15.2% in Hancock County compared to 15.6% statewide (SHNAPP, 2015).
 - The percentage of adults with three or more chronic conditions is 26.6% in Hancock County compared to 27.6 % statewide (SHNAPP, 2015).
- Behavioral Risk Factors
 - Youth smoking rates have been on the decline in Hancock County, with 9% of high school students reporting past month use in 2015, compared to 19% in 2009. The statewide average was 11% in 2015. There is a big jump in smoking rates between 11th and 12th grades, with only 8.3% of 11th graders reporting past 30 day use of cigarettes, but 17.5% of 12th graders reporting past 30 day use. While not surprising that use increases as youth age, the jump between 11th and 12th graders is cause for concern (MIYHS, 2015).
 - Also of concern are rates of youth use of electronic vapor products, which exceed use of traditional cigarettes, following national trends. In Hancock County, 26.9% of high

school students report ever having used an electronic vapor product. However, this is lower than the state rate of 33.5% (MIYHS, 2015).

- Hancock County has the second lowest rate of current adult smoking at 14.2%, second only to Lincoln County at 12.5%. The statewide average is 20.2%, with a range of 12.5% to 28.8% (SHNAPP, 2015).
- The percentage of adults who are overweight or obese is 67.1%, which is higher than the statewide average of 64.9% (SHNAPP, 2015).

- Environmental Health Indicators

- The data shows a number of positive indicators for environmental health in Hancock County.
- We have significantly higher rates of lead screening among 1-year children, at 56.3% in Hancock County, compared with 49.2%% statewide. However, lead screening among 2-year old children in Hancock County decreases to only 26.5%, compared to 27.6% statewide (SHNAPP, 2015).
- We also have significantly fewer children with confirmed elevated blood levels among those screened), at 1.5%, compared with 2.5% statewide (SHNAPP, 2015).
- A less favorable indicator is the percentage of carbon monoxide detectors in homes in our area. Whereas in 2004, the Downeast District (Hancock and Washington counties) had the highest percentage (41.7%) of carbon monoxide detectors in homes, as of 2013, we now have the lowest percentage (55.5%) of homes with carbon monoxide detectors (Maine Tracking Network Data Portal, 2015). Other districts have nearly doubled their rates, while the Downeast District has seen much lower increases. Hancock County has seen the smallest increase of all counties during this time period and now ranks as the county with the lowest percentage of carbon monoxide detectors in homes (51.6%).
- Hancock County has the 3rd highest percentage of wells with arsenic above guidelines, with 20.4% of all wells testing high (Maine Tracking Network Data Portal, 2015). 80.4% of homes with private well water have ever had the well water tested.

- Social & Mental Health

- The indicators relating to adult mental health in Hancock County are slightly more favorable than state rates. The percentage of adults who have ever had anxiety is 15.7% compared to 19.4% in the state; 21.1% of Hancock County adults have ever had depression, compared to 23.5% statewide; 7.6% of adults have current symptoms of depression, compared to 10% statewide; 14.9% of adults are currently receiving outpatient mental health treatment compared to 17.7% statewide (SHNAPP, 2015).
- Among high school students, 26% reported feeling so sad or hopeless for a period of at least two weeks that it impacted their daily functioning, which is nearly equal to the statewide rate of 25.9% (MIYHS, 2015).
- 9.9% of adults in Hancock County had 14 or more days lost due to poor mental health, compared with 12.4% statewide; 11.6% of adults had 14 or more days lost due to poor physical health, compared to 13.1% statewide (SHNAPP, 2015).

- In Hancock County, 15.7% of adults have ever had anxiety compared to 19.4% of Mainers (SHNAPP, 2015).
- 21.1% of adults have ever had depression, compared to 23.5% of Mainers (SHNAPP, 2015).
- Only 7.6% of Hancock County residents report current symptoms of depression, compared to 10% of Mainers (SHNAPP, 2015).
- Hancock County has significantly fewer mental health emergency department visits at 1,564.4 per 100,000 compared to 1,972.1 per 100,000 statewide (SHNAPP, 2015).
- One quarter (25.7%) of Hancock County high school students reported feeling so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. This is very comparable to the state rate of 25.9%. It should be noted that 18% of high school males in Hancock County report this, compared to 34.1% of females. For students who indicated that they were gay, lesbian, or bisexual, 63% reported feeling sad or hopeless for two weeks (MIYHS, 2015).
- 13.8% of Hancock County high school students seriously considered attempting suicide in the past 12 months, compared to 14.8% statewide. For students who indicated that they were gay, lesbian, bisexual, just under two thirds reported feeling sad or hopeless for two weeks, and just under half (47%) seriously contemplated suicide (MIYHS, 2015).
- While 93.2% of high school students in Hancock report feeling safe at school (compared to 88.6% statewide), nearly 20% (19.8%) report having ever been bullied on school property (compared to 24% statewide). 90% of middle school students report feeling safe at school, yet 57% report having been bullied on school property (compared to 47% statewide) (MIYHS, 2015).
- 85.5% of high school students feel that at least one of their teachers really cares and gives help and support when they need it, which is significantly higher than the statewide rate of 80.4% (MIYHS, 2015).
- 58% of high school students (compared to 51% statewide) and 56% of middle school students (compared to 55.8% statewide) feel like, in their community, they matter to people (MIYHS, 2015).
- Substance Use Disorder Including Drugs and Alcohol
 - Indicators relating to substance and alcohol use are mixed for Hancock County. The alcohol-induced mortality rate per 100,000 is 8.7 compared to 8.0 statewide. Chronic heavy drinking is higher among Hancock County adults at 8.7% compared to 7.3% statewide, while binge drinking of alcoholic beverages is lower among Hancock County adults at 15.7% compared to 17.4% statewide. These differences are not significant (SHNAPP, 2015).
 - Lifetime youth alcohol use among 9th to 12th graders is statistically higher in Hancock County than the state average (55% compared with 51% statewide). Past 30-day alcohol use is more similar with 25% of Hancock County 9th to 12th graders having consumed alcohol in the past 30 days compared to 24% statewide. Binge drinking within the previous 2 weeks among 9th to 12th graders is 12% both in Hancock County and statewide. Of particular concern, however, is an increase in past 30-day use and binge

drinking among Hancock County 12th grade students, which are significantly higher than in other grade levels. Among 12th graders in Hancock County, 45% consumed alcohol in the past 30 days compared to only 21% of 11th graders; 24% of 12th graders reported binge drinking compared to 13% of 11th graders (MIYHS, 2015).

- Among students with self-reported mental health needs (feeling sad or hopeless, as reported in the Social & Mental Health section above), use of cigarettes, alcohol, marijuana, and prescription drugs are notably higher than for students who do not struggle with mental health needs.
- Past 30-day marijuana use among adults is 10.9% in Hancock County compared to 8.2% statewide, though results may be statistically unreliable due to small numbers (SHNAPP, 2015). Past 30-day marijuana use is 17% among Hancock County 9th–12th graders, compared to 20% statewide (MIYHS, 2015).
- Past 30-day nonmedical use of prescription drugs is 1% among Hancock County adults, compared to 1.1% statewide (SHNAPP, 2015). Again, these rates may be statistically unreliable due to small numbers. Misuse of prescription drugs in the last 30 days by 9th to 12th graders is the same as the state rate of 5% (MIYHS, 2015).
- Substance use disorder hospital admissions per 100,000 population is statistically significantly less in Hancock County with only 184.4 per 100,000 compared to 328.1 per 100,000 statewide. However, this may be due to lack of hospital-based treatment options in Hancock County, so substance-related visits may not result in actual admissions (SHNAPP, 2015).

- **Maternal & Child Health**

- Several indicators around births reflect positively for maternal and child health in Hancock County. The rate of infant mortality is 3.8 per 1000 live births in our county compared to 6 per 1000 statewide (SHNAPP, 2015).
- The percentage of live births with low birth weight is just slightly lower in Hancock County; 6.4% of births in our county have low birth weights, compared to 6.6% statewide (SHNAPP, 2015).
- The percentage of infants born to women receiving early and adequate prenatal care is 90.9% in Hancock County, compared to the state average of 86.4% (SHNAPP, 2015).
- The rate of teen births, ages 15 to 19 is 19.2% in Hancock County compared with 20.5% statewide (SHNAPP, 2015).

- **Death & Illness**

- Incidence of all cancers per 100,000 is higher in Hancock County at 521.4 per 100,000, compared to 500.1 statewide; however, mortality is lower at 171.4 per 100,000 in Hancock and 185.5 per 100,000 statewide (SHNAPP, 2015). Though cancer incidence and mortality has decreased significantly over the past 10 years, it remains the leading cause of death among Mainers.
- The rates of cancer screening in Hancock County are inconsistent. The rate of colorectal screening is 73% in Hancock County, compared to 72.2% statewide (SHNAPP, 2015).

- The percentage of women 50 and older who have had a mammogram in the past two years is 82.9% compared to 82.1% statewide (SHNAPP, 2015).
- Among females ages 21-65, only 79% have had pap smears in the past three years compared to 88% statewide (SHNAPP, 2015).
- Several cardiovascular disease indicators are concerning for our region. Hancock County's rate of acute myocardial infarction hospitalizations is 33.2 per 10,000, which is significantly higher than the state rate of 23.5 per 10,000. Acute myocardial infarction mortality per 100,000 is also significantly higher at 40.3 per 100,000 compared to 32.2 per 100,000 statewide. Coronary heart disease mortality per 100,000 is also significantly higher in Hancock County with 102.1 deaths per 100,000 compared to 89.8 per 100,000 (SHNAPP, 2015).
- The percentage of adults with high blood pressure in Hancock County is 37.3% compared to 32.8% statewide (SHNAPP, 2015).
- The percentage of adults with high cholesterol is similar to the state average at 40.7% in Hancock County and 40.3% statewide. Our cholesterol screening rate is lower than the state average with 76.6% of Hancock County adults having checked their cholesterol every five years compared to 81% statewide. The difference, however, is not significant (SHNAPP, 2015).
- The diabetes prevalence among Hancock County adults is slightly below the state average, at 8.9% compared with 9.6% statewide. Pre-diabetes prevalence, diabetes hospitalizations (as a principal diagnosis) per 10,000, diabetes long-term complication hospitalizations, and diabetes mortality (as an underlying cause) per 100,000 are all below statewide rates. Diabetes emergency department visits (as a principal diagnosis) per 100,00 are significantly lower in Hancock County at 181.1 per 100,000 compared to 235.9 statewide (SHNAPP, 2015).
- Injury
 - Domestic assault reports to police are 177 per 100,000 in Hancock County, compared to 413 per 100,000 statewide. Though this is a big difference, it is not significant (SHNAPP, 2015).
 - Firearm deaths per 100,000 in Hancock County are slightly higher at 11.2 compared to 9.2 statewide. This is also not significant (SHNAPP, 2015).
 - Suicide deaths are also slightly higher in Hancock County with 16.1 per 100,000, compared to 15.2 per 100,000 statewide (SHNAPP, 2015).
 - The violent crime rate per 100,000 is quite a bit lower (though not significantly) than the state rate with 56.6 crimes per 100,000 compared to 125 per 100,000 statewide (SHNAPP, 2015).
- Infectious Disease
 - Overall, the indicators for infectious disease are mixed for Hancock County. The percentage of adults who have had the influenza vaccine in the past year is 38.4% compared to a state rate of 41.5% (SHNAPP, 2015).

- Those 65 years or older who have ever had the pneumococcal vaccine is only 62.3%, which is significantly lower than the state rate of 72.4% (SHNAPP, 2015).
- The rate of reported cases of Lyme disease has been increasing in recent years, and Hancock County had the 3rd highest rate in 2015. We experienced 219.4 cases per 100,000 people, much higher (though not statistically significant) than the state rate of 105.3 per 100,000 people (SHNAPP, 2015).
- Incidence of Hepatitis A, B, and C (acute) is 1.8 cases per 100,000, slightly higher than the state rate, while the incidence of past or present hepatitis C virus (HCV), incidence of newly reported chronic hepatitis B virus (HBV), and pertussis incidence are lower than the state-level incidences (SHNAPP, 2015).
- There are more immunization exemptions among kindergarteners for philosophical reasons (10%) compared to the rest of Maine (3.7%). Additionally, fewer two-year olds are up to date with their “Series of Seven Immunizations”, with 68% being up to date in Hancock County compared to a state rate of 75% (SHNAPP, 2015).
- Our rates of STD/HIV are generally all better than state averages. In Hancock County, the chlamydia incidence is 164.5 per 100,00 compared to 265.5 statewide. The gonorrhea incidence per 100,000 is 3.7 in Hancock County compared to 17.8 statewide, but that may be statistically unreliable due to small numerators and should be interpreted with caution (SHNAPP, 2015).

Local Public Health Systems Assessment

Process for Conducting Assessment:

A local public health system is commonly defined as encompassing all public, private, and voluntary entities that contribute to the local community health and public health infrastructure. An assessment of the delivery of the 10 Essential Public Health Services (10 EPHS), listed below, is one way to comprehensively view the services and infrastructure that are in place, as the 10 EPHS enumerate all that a successful public health system will include.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

A state level Local Public Health Systems Assessment is anticipated to be conducted in the next few years. For local analysis, the 10 EPHS were reviewed and six were determined to be priority areas for assessment as part of this Community Health Needs Assessment process. These include the following:

2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.
8. Assure competent public and personal health care workforce.

The Healthy Acadia Advisory Council, which served throughout this Community Health Needs Assessment as the CHNA Advisory Team, is a coalition of community health providers and stakeholders from across Hancock County. For the purposes of the Local Public Health System Assessment, the CHNA Advisory Team and the CHNA Core Planning Team assessed Essential Public Health Services

numbers 3, 4, 7, and 8, and 2 and 5, respectively, based on group expertise. The CHNA Advisory Team LPHSA covered the geographic area of Hancock County, while the CHNA Core Planning Team focused primarily on the Mount Desert Island Region Local Service Area (LSA). For the purpose of this report, the following assessment summary pertains specifically to the LSA.

Overwhelmingly, team members were able to list many groups and organizations participating in and propelling each, of the EPHS that were assessed. What follows is a list of needs as determined through this assessment process.

2. Diagnose and investigate health problems and health hazards in the community.

EPHS #2 encompasses activities such as identification and surveillance, responding to threats and emergencies, and laboratory support for investigations.

- Needs include:
 - Increased coordination of efforts
 - Increased number of trained professionals, such as epidemiologists, code enforcement officers, plumbing inspectors
 - Increased training for public health professionals
 - Increased consistency of funding for local public health

3. Inform, educate, and empower people about health issues.

EPHS number three encompasses activities such as education and empowerment, health communication, and risk communication.

- Needs include:
 - Increased coordination of efforts
 - Continue development of creative efforts to find the right times, methods, and places to deliver information to community members
 - Increased efforts around certain issues, including but not limited to, teens, seniors, community members affected by mental health issues, and community members affected by substance use disorder
 - Increased relationships with, and communication of issues to, municipal, state, and national policy leaders

4. Mobilize community partnerships and action to identify and solve health problems.

EPHS number four encompasses activities such as developing constituency and community partnerships.

- Needs include:
 - Identify and map out existing work of local entities doing similar work
 - Increase communication and coordination between partners
 - Continue to develop partner meeting opportunities, both in person and through electronic tools such as social media

5. Develop policies and plans that support individual and community health efforts.

EPHS number five encompasses activities such as government presence, health policy development, community health improvement process and strategic planning, and emergency preparedness and response.

- Needs include:
 - Consistent and collaborative assessment processes and decision making on key priorities
 - Focused implementation plans
 - Increased consistency of funding for local public health
 - Pooling of assets towards defined objectives

7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

EPHS number seven encompasses activities such as identifying personal health service needs and linking people to personal health services.

- Needs include:
 - Increased communication of free and reduced price programs
 - An improved referral system
 - Increased access to health, housing, and other basic needs advocates/navigators
 - The addition of physical or electronic community health centers in locations without a central health service information hub

8. Assure competent public and personal health care workforce.

EPHS number eight encompasses activities such as workforce assessment, planning, and development, workforce standards, lifelong workforce learning opportunities, and leadership development.

- Needs include:
 - Increased consistency of funding for local public health
 - Increased training opportunities for public health professionals
 - Additional public health professionals in some specialties, such as having Dedicated Health Officials in each town
 - Involve business and community in public health staff recruitment and retention efforts

This information is to inform our work as local public health system partners. Building from the current foundation of diverse assets, targeted efforts to develop areas of demonstrated gaps in systems and services will strengthen our ability to ensure healthy and vibrant policies, environments, and individuals across the LSA.

Forces of Change Assessment

There are ‘forces of change’, events, trends, and factors in the broader environment, that are occurring or might occur and affect the health of our community. These forces are beyond local control but may require local awareness and response. The Forces of Change Assessment explores these forces and possible threats or opportunities generated as a result of these forces.

The CHNA Advisory Team gathered for a Forces of Change Assessment meeting, where members broke into small groups to explore forces, threats, and opportunities in the community. The team then shared their results and the CHNA Core Planning Team compiled the chart included below.

In summary, the participants identified numerous different forces, as well as the various threats and opportunities they posed. Overall, various *demographic indicators* came up often such as “an aging population” and “social disparities”; broad *healthcare dynamics* were raised, such as “healthcare costs” and “development of public health infrastructure”; and other *general outside forces* were identified and found to have linkages with community health, ranging from “changes in the drug landscape” to “climate change” to the “increasing access to and use of technology.” The results of the Forces of Change Assessment were dynamic, with many forces identified as potentially bringing both threats and opportunities to our community.

<i>Forces</i>	<i>Threats</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> Changes in drug landscape 	<ul style="list-style-type: none"> Vapor tobacco Lack of drug prevention/drug treatment Limited resources for treatment and recovery Life threatening substances Social breakdown Drug Use Easy access to prescription and street drugs Push towards legalization of marijuana Drug trafficking into area Opiate use 	<ul style="list-style-type: none"> Reduced overall tobacco use Opens up opportunities for community coming together Increasing community awareness
<ul style="list-style-type: none"> Rural nature of the area 	<ul style="list-style-type: none"> Transportation difficulties Unable to set up appointments 	<ul style="list-style-type: none"> Taxi, public transportations Island Connection

and distance between service areas	<ul style="list-style-type: none"> ● Access to health care, jobs, and training ● Local increase in traffic on too small roads/grids ● Lack of good public transportation ● Disintegrating infrastructure 	
<ul style="list-style-type: none"> ● Trend in Physical Activity 	<ul style="list-style-type: none"> ● Ped./Pedal Infrastructure ● Acadia National Park ● Obstacles to pedestrian and bike-ways for local community ● Children less active ● Lack of sidewalks/road shoulders ● Disintegrating infrastructure 	<ul style="list-style-type: none"> ● Walking school bus—walking and biking considered “cool” ● Increased bike paths ● Centennial ANP next year ● Fit bits/health apps
<ul style="list-style-type: none"> ● Technology taking greater role 	<ul style="list-style-type: none"> ● Access to technology (esp. for youth) ● Children less active—obesity a growing issue ● Poor internet connectivity 	<ul style="list-style-type: none"> ● Telehealth in rural settings ● Telehealth for speech, etc. ● Access to technology ● Access to internet ● Fit bits/ health apps ● Tech. education opportunities/job training
<ul style="list-style-type: none"> ● Climate change as well as seasonal weather changes 	<ul style="list-style-type: none"> ● Sea level rise ● Impact economies ● Healthy Acadia infectious disease ● Refugees moving north ● Inactive Winter Culture ● Lack of vibrant central community spaces during fall through spring ● Weather/power outagesà Isolation, health, fire, heat, home damage, transportation, communication ● Disintegrating infrastructure 	<ul style="list-style-type: none"> ● Refugees moving north ● Park, year round asset
<ul style="list-style-type: none"> ● Food system shifts 	<ul style="list-style-type: none"> ● Culture of high=-fructose, highly processed food ● Food insecurity ● High rate of poverty 	<ul style="list-style-type: none"> ● Strong local food systems ● Increased nutrition ed. in schools ● Local farm to table

	<ul style="list-style-type: none"> Locally grown food 	<ul style="list-style-type: none"> Increased interest in healthy eating—especially children
<ul style="list-style-type: none"> Trends in local employment and economies 	<ul style="list-style-type: none"> Inadequate pool of workers Lack of job opportunities Cost of living and recreational activities Seasonal work/lack of year round employment Aging workforce Low wages Economic hourglass Income inequality High rate of poverty Bucksport Mill closure Globalization of the economy Diverse employment opportunities—but large seasonal employment tied to tourism Continued trend of aging population—aging workforce 	<ul style="list-style-type: none"> Maternity leave plans (small businesses) Jobs Importance of supporting and maintaining local business Tech. education opportunities/ Job training Young people/young families leave area Business growth Flexible home health jobs available with aging population
<ul style="list-style-type: none"> Aging Population 	<ul style="list-style-type: none"> Increased health needs Disproportionate revenues Increased taxes Continued trend of aging population—aging workforce 	<ul style="list-style-type: none"> Healthier aging and engagement Beacon Hospice presence in community Home health agencies
<ul style="list-style-type: none"> Policy and other shifts in health care 	<ul style="list-style-type: none"> Rural Setting Merger of MCMH with EMHS ACO Hospital Requirements ACO expansion and commercial carriers. Access Drug resistant pathogens State of Maine lack of expansion of Medicaid Lack of systematic patient engagement process Cut-backs in all areas of healthcare-especially for low-income 	<ul style="list-style-type: none"> Telehealth Increased health care access Increased relationships between community health organizations and health care facilities Health service integration and networking—change in services. Flexible home health jobs available with aging population Home health agencies

	<ul style="list-style-type: none"> • Increased health care access • Changes to programs/education and support required due to ACA • Lack of money for public health initiatives, gaps/restrictions 	<ul style="list-style-type: none"> • Affordable Care Act • More people have health insurance • Quality based reimbursement • Allocation of limited health services—in flux tourists and migrant workers • More people obtaining preventative care/chronic disease management • Increased health policies in schools • Wellness policy regulations • Lack of mental health services
<ul style="list-style-type: none"> • Housing availability 	<ul style="list-style-type: none"> • Quality affordable and year round housing is limited 	<ul style="list-style-type: none"> • Housing Study-Ellsworth/Hancock County
<ul style="list-style-type: none"> • State and federal politics 	<ul style="list-style-type: none"> • State political climate not supportive of public health • Political stalemate at state level • Money spent on defense/war nationally • LePage 	<ul style="list-style-type: none"> • Upcoming national elections • National school lunch regulations
<ul style="list-style-type: none"> • Racism 	<ul style="list-style-type: none"> • Increase in racism 	
<ul style="list-style-type: none"> • Gun law shift 	<ul style="list-style-type: none"> • Change in gun laws (carrying allowed permit) 	
<ul style="list-style-type: none"> • Community Awareness of Health Initiatives 		<ul style="list-style-type: none"> • Increasing engagement and awareness around building healthy communities • Increasing awareness of importance of health and wellness—community prevention • Increased level of participation • Community health implementation plan

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Appendix

**Community Themes and Strengths ‘Community Health Assessment’ Survey
Maine Shared Community Health Needs Assessment Hancock County Summary 2015**



Community Health Assessment

Healthy Acadia and Mount Desert Island Hospital are seeking input from community members across Hancock County to assess the health needs of our communities. The information will be used to create a community health plan to improve our overall health. This survey should only take about 10 minutes to complete; it is also available electronically at: <https://www.surveymonkey.com/r/HancockCHNA>

1. **Today's Date:** _____ **Name (optional):** _____

2. **What is "your community" in Hancock County?** For this survey, "your community" could be a town (e.g. Bass Harbor, Orland, Brooksville, Frenchboro) or a region (e.g. Bucksport Bay, Blue Hill Peninsula, Mt. Desert Island). It could be your community of residence, work or other involvement.

3. **With which organizations are you affiliated, either through work, volunteer efforts, or other community involvement (e.g. where do you work and/or volunteer)?**

4. **What do you like most about "your community"?**

5. **What would you say are some of the characteristics of a "healthy community"?**

6. What are the assets or strengths of “your community”, things that contribute most to your idea of a healthy community?
7. Are there some things that get in the way of “your community” living up to your idea of a healthy community? What concerns do you have, or concerns that you hear others express?
8. Are there specific ideas or projects that you would like to see accomplished, to make us a healthier community?
9. Age:
- | | |
|---|--|
| <input type="checkbox"/> Under 18 years | <input type="checkbox"/> 45-54 years |
| <input type="checkbox"/> 18-24 years | <input type="checkbox"/> 55-64 years |
| <input type="checkbox"/> 25-34 years | <input type="checkbox"/> Age 65 or older |
| <input type="checkbox"/> 35-44 years | |
10. Gender:
- | | |
|--|-------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male |
| <input type="checkbox"/> Other (please specify): _____ | |
11. Where do you receive most of your health care services?
- | | |
|--|---|
| <input type="checkbox"/> Mount Desert Island/Trenton | <input type="checkbox"/> Bucksport Bay |
| <input type="checkbox"/> Ellsworth Area | <input type="checkbox"/> Schoodic Peninsula |
| <input type="checkbox"/> Blue Hill Peninsula | <input type="checkbox"/> Washington County |
| <input type="checkbox"/> Other (please specify): _____ | |
12. What is your residential zip code? _____

Surveys can be returned to: Maria Donahue, Healthy Acadia, 140 State Street, Ellsworth, ME 04605

Maine Shared Community Health Needs Assessment County Summary: 2015

Hancock County

November 2015

Qualitative Stakeholder Input

A survey of 81 health professionals and community stakeholders in Hancock County provided insight into the most critical health issues and determinants impacting the lives of those living in the area. According to these stakeholders, the following five health issues and health factors have the most impact on Hancock County resulting in poor health outcomes for residents.

Top five health issues

- Obesity
- Drug and alcohol abuse
- Diabetes
- Physical activity and nutrition
- Depression

Top five health factors

- Transportation
- Health care insurance
- Health literacy
- Poverty
- Employment


Maine Shared CHNA Health Indicators	Year	Hancock	Trend	Maine	U.S.
Demographics					
Total Population	2013	54,845		1,328,302	319 Mil
Population – % ages 0-17	2013	17.6%		19.7%	23.3%
Population – % ages 18-64	2013	61.7%		62.6%	62.6%
Population – % ages 65+	2013	20.7%		17.7%	14.1%
Population – % White	2013	96.7%		95.2%	77.7%
Population – % Black or African American	2013	0.6%		1.4%	13.2%
Population – % American Indian and Alaska Native	2013	0.5%		0.7%	1.2%
Population – % Asian	2013	1.0%		1.1%	5.3%
Population – % Hispanic	2013	1.3%		1.4%	17.1%
Population – % with a disability	2013	15.7%		15.9%	12.1%
Population density (per square mile)	2013	34.3		43.1	87.4
Socioeconomic Status Measures					
Individuals living in poverty	2009-2013	14.0%	NA	13.6%	15.4%
Children living in poverty	2009-2013	21.5%	NA	18.5%	21.6%
High school graduation rate	2013-2014	84.3%	NA	86.5%	81.0%
Median household income	2009-2013	\$47,460	NA	\$48,453	\$53,046
Percentage of people living in rural areas	2013	100.0%	NA	66.4%	NA
Single-parent families	2009-2013	34.7%	NA	34.0%	33.2%
Unemployment rate	2014	7.0%	NA	5.7%	6.2%
65+ living alone	2009-2013	41.4%	NA	41.2%	37.7%
General Health Status					
Adults who rate their health fair to poor	2011-2013	15.2%		15.6%	16.7%
Adults with 14+ days lost due to poor mental health	2011-2013	9.9%		12.4%	NA
Adults with 14+ days lost due to poor physical health	2011-2013	11.6%		13.1%	NA
Adults with three or more chronic conditions	2011, 2013	26.6%		27.6%	NA
Mortality					
Life expectancy (Female)	2012	82.4	NA	81.5	81.2
Life expectancy (Male)	2012	77.7	NA	76.7	76.4
Overall mortality rate per 100,000 population	2009-2013	702.2	NA	745.8	731.9
Access					
Adults with a usual primary care provider	2011-2013	85.7%		87.7%	76.6%
Individuals who are unable to obtain or delay obtaining necessary medical care due to cost	2011-2013	9.9%		11.0%	15.3%
MaineCare enrollment	2015	23.6%	NA	27.0%	23.0%
Percent of children ages 0-19 enrolled in MaineCare	2015	40.4%	NA	41.8%	48.0%

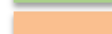
Maine Shared CHNA Health Indicators	Year	Hancock	Trend	Maine	U.S.
Percent uninsured	2009-2013	14.7%	NA	10.4%	11.7%
Health Care Quality					
Ambulatory care-sensitive condition hospital admission rate per 100,000 population	2011	1,600.0	–	1,499.3	1457.5
Ambulatory care-sensitive condition emergency department rate per 100,000 population	2011	4,321.8	NA	4,258.8	NA
Oral Health					
Adults with visits to a dentist in the past 12 months	2012	67.6%	NA	65.3%	67.2%
MaineCare members under 18 with a visit to the dentist in the past year	2014	55.8%	NA	55.1%	NA
Respiratory					
Asthma emergency department visits per 10,000 population	2009-2011	62.5		67.3	NA
COPD diagnosed	2011-2013	7.0%		7.6%	6.5%
COPD hospitalizations per 100,000 population	2011	220.8	–	216.3	NA
Current asthma (Adults)	2011-2013	10.5%		11.7%	9.0%
Current asthma (Youth 0-17)	2011-2013	4.4%†	NA	9.1%	NA
Pneumonia emergency department rate per 100,000 population	2011	558.4		719.9	NA
Pneumonia hospitalizations per 100,000 population	2011	347.7		329.4	NA
Cancer					
Mortality – all cancers per 100,000 population	2007-2011	171.4	NA	185.5	168.7
Incidence – all cancers per 100,000 population	2007-2011	521.4	NA	500.1	453.4
Bladder cancer incidence per 100,000 population	2007-2011	35.0	NA	28.3	20.2
Female breast cancer mortality per 100,000 population	2007-2011	19.9	NA	20.0	21.5
Breast cancer late-stage incidence (females only) per 100,000 population	2007-2011	40.7	NA	41.6	43.7
Female breast cancer incidence per 100,000 population	2007-2011	125.6	NA	126.3	124.1
Mammograms females age 50+ in past two years	2012	82.9%	NA	82.1%	77.0%
Colorectal cancer mortality per 100,000 population	2007-2011	13.0	NA	16.1	15.1
Colorectal late-stage incidence per 100,000 population	2007-2011	24.2	NA	22.7	22.9
Colorectal cancer incidence per 100,000 population	2007-2011	47.8	NA	43.5	42.0
Colorectal screening	2012	73.0%	NA	72.2%	NA
Lung cancer mortality per 100,000 population	2007-2011	48.0	NA	54.3	46.0
Lung cancer incidence per 100,000 population	2007-2011	70.1	NA	75.5	58.6
Melanoma incidence per 100,000 population	2007-2011	24.0	NA	22.2	21.3
Pap smears females ages 21-65 in past three years	2012	79.0%	NA	88.0%	78.0%
Prostate cancer mortality per 100,000 population	2007-2011	30.7	NA	22.1	20.8
Prostate cancer incidence per 100,000 population	2007-2011	149.8	NA	133.8	140.8
Tobacco-related neoplasms, mortality per 100,000 population	2007-2011	31.0	NA	37.4	34.3
Tobacco-related neoplasms, incidence per 100,000 population	2007-2011	93.8	NA	91.9	81.7
Cardiovascular Disease					
Acute myocardial infarction hospitalizations per 10,000 population	2010-2012	33.2		23.5	NA
Acute myocardial infarction mortality per 100,000 population	2009-2013	40.3	NA	32.2	32.4
Cholesterol checked every five years	2011, 2013	76.6%		81.0%	76.4%
Coronary heart disease mortality per 100,000 population	2009-2013	102.1	NA	89.8	102.6
Heart failure hospitalizations per 10,000 population	2010-2012	21.9		21.9	NA
Hypertension prevalence	2011, 2013	37.3%		32.8%	31.4%
High cholesterol	2011, 2013	40.7%		40.3%	38.4%
Hypertension hospitalizations per 100,000 population	2011	27.5	+	28.0	NA
Stroke hospitalizations per 10,000 population	2010-2012	23.0		20.8	NA

Maine Shared CHNA Health Indicators	Year	Hancock	Trend	Maine	U.S.
Stroke mortality per 100,000 population	2009-2013	42.0	NA	35.0	36.2
Diabetes					
Diabetes prevalence (ever been told)	2011-2013	8.9%		9.6%	9.7%
Pre-diabetes prevalence	2011-2013	6.5%†		6.9%	NA
Adults with diabetes who have eye exam annually	2011-2013	NA	NA	71.2%	NA
Adults with diabetes who have foot exam annually	2011-2013	NA	NA	83.3%	NA
Adults with diabetes who have had an A1C test twice per year	2011-2013	NA	NA	73.2%	NA
Adults with diabetes who have received formal diabetes education	2011-2013	NA	NA	60.0%	55.8%
Diabetes emergency department visits (principal diagnosis) per 100,000 population	2011	181.1		235.9	NA
Diabetes hospitalizations (principal diagnosis) per 10,000 population	2010-2012	11.0		11.7	NA
Diabetes long-term complication hospitalizations	2011	53.8		59.1	NA
Diabetes mortality (underlying cause) per 100,000 population	2009-2013	16.6	NA	20.8	21.2
Environmental Health					
Children with confirmed elevated blood lead levels (% among those screened)	2009-2013	1.5%	NA	2.5%	NA
Children with unconfirmed elevated blood lead levels (% among those screened)	2009-2013	3.3%	NA	4.2%	NA
Homes with private wells tested for arsenic	2009, 2012	54.9%	NA	43.3%	NA
Lead screening among children age 12-23 months	2009-2013	56.3%	NA	49.2%	NA
Lead screening among children age 24-35 months	2009-2013	26.5%	NA	27.6%	NA
Immunization					
Adults immunized annually for influenza	2011-2013	38.4%		41.5%	NA
Adults immunized for pneumococcal pneumonia (ages 65 and older)	2011-2013	62.3%	NA	72.4%	69.5%
Immunization exemptions among kindergarteners for philosophical reasons	2015	10.0%	NA	3.7%	NA
Two-year-olds up to date with "Series of Seven Immunizations" 4-3-1-3-3-1-4	2015	68.0%	NA	75.0%	NA
Infectious Disease					
Hepatitis A (acute) incidence per 100,000 population	2014	1.8†	NA	0.6	0.4
Hepatitis B (acute) incidence per 100,000 population	2014	1.8†	NA	0.9	0.9
Hepatitis C (acute) incidence per 100,000 population	2014	1.8†	NA	2.3	0.7
Incidence of past or present hepatitis C virus (HCV) per 100,000 population	2014	91.4	NA	107.1	NA
Incidence of newly reported chronic hepatitis B virus (HBV) per 100,000 population	2014	1.8†	NA	8.1	NA
Lyme disease incidence per 100,000 population	2014	219.4	NA	105.3	10.5
Pertussis incidence per 100,000 population	2014	14.6†	NA	41.9	10.3
Tuberculosis incidence per 100,000 population	2014	1.8†	NA	1.1	3.0
STD/HIV					
AIDS incidence per 100,000 population	2014	0.0†	NA	2.1	8.4
Chlamydia incidence per 100,000 population	2014	164.5	NA	265.5	452.2
Gonorrhea incidence per 100,000 population	2014	3.7†	NA	17.8	109.8
HIV incidence per 100,000 population	2014	1.8†	NA	4.4	11.2
HIV/AIDS hospitalization rate per 100,000 population	2011	25.5		21.4	NA
Syphilis incidence per 100,000 population	2014	0.0†	NA	1.6	19.9
Intentional Injury					
Domestic assaults reports to police per 100,000 population	2013	177.0	NA	413.0	NA
Firearm deaths per 100,000 population	2009-2013	11.2	NA	9.2	10.4

Maine Shared CHNA Health Indicators	Year	Hancock	Trend	Maine	U.S.
Intentional self-injury (Youth)	2013	NA	NA	17.9%	NA
Lifetime rape/non-consensual sex (among females)	2013	NA	NA	11.3%	NA
Nonfatal child maltreatment per 1,000 population	2013	NA	NA	14.6	9.1
Reported rape per 100,000 population	2013	0.0†	NA	27.0	25.2
Suicide deaths per 100,000 population	2009-2013	16.1	NA	15.2	12.6
Violence by current or former intimate partners in past 12 months (among females)	2013	NA	NA	0.8%	NA
Violent crime rate per 100,000 population	2013	56.6	NA	125.0	368
Unintentional Injury					
Always wear seatbelt (Adults)	2013	82.9%		85.2%	NA
Always wear seatbelt (High School Students)	2013	NA	NA	61.6%	54.7%
Traumatic brain injury related emergency department visits (all intents) per 10,000 population	2011	64.5	NA	81.4	NA
Unintentional and undetermined intent poisoning deaths per 100,000 population	2009-2013	10.0	NA	11.1	13.2
Unintentional fall related deaths per 100,000 population	2009-2013	6.4	NA	6.8	8.5
Unintentional fall related injury emergency department visits per 10,000 population	2011	309.8	NA	361.3	NA
Unintentional motor vehicle traffic crash related deaths per 100,000 population	2009-2013	14.5	NA	10.8	10.5
Occupational Health					
Deaths from work-related injuries (number)	2013	NA	NA	19	4,585
Nonfatal occupational injuries (number)	2013	446	NA	13,205	NA
Mental Health					
Adults who have ever had anxiety	2011-2013	15.7%		19.4%	NA
Adults who have ever had depression	2011-2013	21.1%		23.5%	18.7%
Adults with current symptoms of depression	2011-2013	7.6%		10.0%	NA
Adults currently receiving outpatient mental health treatment	2011-2013	14.9%		17.7%	NA
Co-morbidity for persons with mental illness	2011, 2013	NA	NA	35.2%	NA
Mental health emergency department rates per 100,000 population	2011	1,564.4		1,972.1	NA
Sad/hopeless for two weeks in a row (High School Students)	2013	NA	NA	24.3%	29.9%
Seriously considered suicide (High School Students)	2013	NA	NA	14.6%	17.0%
Physical Activity, Nutrition and Weight					
Fewer than two hours combined screen time (High School Students)	2013	NA	NA	33.9%	NA
Fruit and vegetable consumption (High School Students)	2013	NA	NA	16.8%	NA
Fruit consumption among Adults 18+ (less than one serving per day)	2013	33.2%	NA	34.0%	39.2%
Met physical activity recommendations (Adults)	2013	55.9%		53.4%	50.8%
Physical activity for at least 60 minutes per day on five of the past seven days (High School Students)	2013	NA	NA	43.7%	47.3%
Sedentary lifestyle – no leisure-time physical activity in past month (Adults)	2011-2013	20.1%		22.4%	25.3%
Soda/sports drink consumption (High School Students)	2013	NA	NA	26.2%	27.0%
Vegetable consumption among Adults 18+ (less than one serving per day)	2013	14.7%†	NA	17.9%	22.9%
Obesity (Adults)	2013	29.8%		28.9%	29.4%
Obesity (High School Students)	2013	NA	NA	12.7%	13.7%
Overweight (Adults)	2013	37.3%		36.0%	35.4%
Overweight (High School Students)	2013	NA	NA	16.0%	16.6%
Pregnancy and Birth Outcomes					
Children with special health care needs	2009-2010	NA	NA	23.6%	19.8%

Maine Shared CHNA Health Indicators	Year	Hancock	Trend	Maine	U.S.
Infant deaths per 1,000 live births	2003-2012	3.8	NA	6.0	6.0
Live births for which the mother received early and adequate prenatal care	2010-2012	90.9%	NA	86.4%	84.8%
Live births to 15-19 year olds per 1,000 population	2010-2012	19.2	NA	20.5	26.5
Low birth weight (<2500 grams)	2010-2012	6.4%	NA	6.6%	8.0%
Substance and Alcohol Abuse					
Alcohol-induced mortality per 100,000 population	2009-2013	8.7	NA	8.0	8.2
Binge drinking of alcoholic beverages (High School Students)	2013	NA	NA	14.8%	20.8%
Binge drinking of alcoholic beverages (Adults)	2011-2013	15.7%		17.4%	16.8%
Chronic heavy drinking (Adults)	2011-2013	8.7%		7.3%	6.2%
Drug-affected baby referrals received as a percentage of all live births	2014	7.6%	NA	7.8%	NA
Drug-induced mortality per 100,000 population	2009-2013	11.6	NA	12.4	14.6
Emergency medical service overdose response per 100,000 population	2014	301.7	NA	391.5	NA
Opiate poisoning (ED visits) per 100,000 population	2009-2011	21.5		25.1	NA
Opiate poisoning (hospitalizations) per 100,000 population	2009-2011	11.6		13.2	NA
Past-30-day alcohol use (High School Students)	2013	NA	NA	26.0%	34.9%
Past-30-day inhalant use (High School Students)	2013	NA	NA	3.2%	NA
Past-30-day marijuana use (Adults)	2011-2013	10.9%†		8.2%	NA
Past-30-day marijuana use (High School Students)	2013	NA	NA	21.6%	23.4%
Past-30-day nonmedical use of prescription drugs (Adult)	2011-2013	1.0%†		1.1%	NA
Past-30-day nonmedical use of prescription drugs (High School Students)	2013	NA	NA	5.6%	NA
Prescription Monitoring Program opioid prescriptions (days supply/pop)	2014-2015	6.0	NA	6.8	NA
Substance-abuse hospital admissions per 100,000 population	2011	184.4		328.1	NA
Tobacco Use					
Current smoking (Adults)	2011-2013	14.2%†	+	20.2%	19.0%
Current smoking (High School Students)	2013	NA	NA	12.9%	15.7%
Current tobacco use (High School Students)	2013	NA	NA	18.2%	22.4%
Secondhand smoke exposure (Youth)	2013	NA	NA	38.3%	NA

 Indicates county is significantly better than state average (using a 95% confidence level).

 Indicates county is significantly worse than state average (using a 95% confidence level).

+ Indicates an improvement in the indicator over time at the county level (using a 95% confidence level)

– Indicates a worsening in the indicator over time at the county level (using a 95% confidence level)

† Results may be statistically unreliable due to small numerator, use caution when interpreting.

NA = No data available