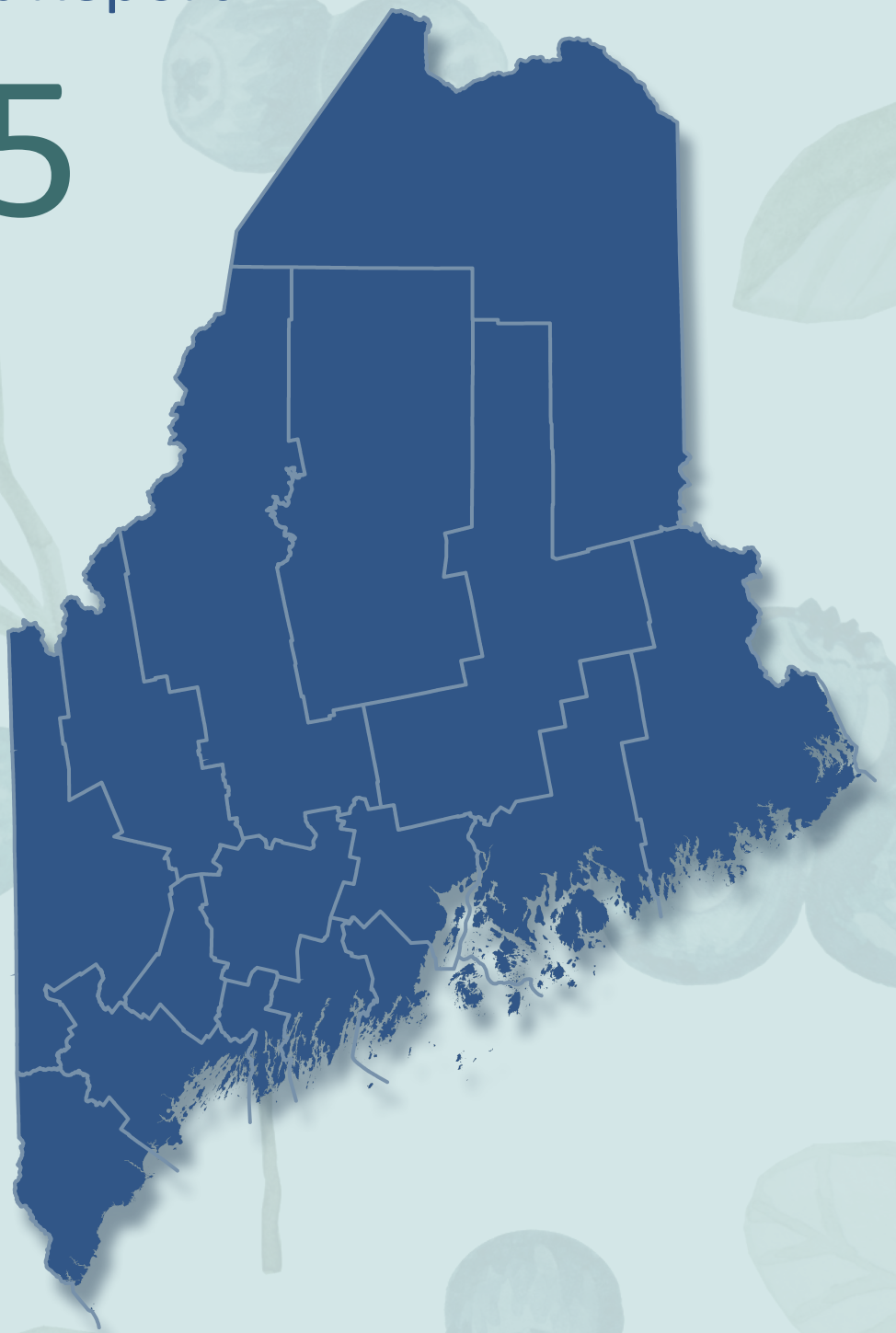
State of Maine

Maine Shared Community Health Needs Assessment Report

2025



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Introduction

The Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is a collaborative partnership between Central Maine Healthcare (CMHC), Northern Light Health (NLH), MaineGeneral Health (MGH), MaineHealth (MH), the Maine Center for Disease Control and Prevention (Maine CDC), and the Maine Community Action Partnership (MeCAP). By engaging and learning from people and communities and through data analysis, the partnership aims to improve the health and well-being of all people living in Maine.

The mission of the Maine Shared CHNA is to:

- Create shared CHNA reports,
- Engage and activate communities, and
- Support data-driven improvements in health and well-being for all people living in Maine.

This is the fifth collaborative Maine Shared CHNA and the fourth conducted on a triennial basis. The Maine Shared CHNA began with the One Maine Collaborative, a partnership between MaineGeneral Health, MaineHealth, and Northern Light Health, which published its first community health assessment in 2010. Community Action Agencies (CAAs) have a long history of community needs assessments (CNA), most recently as a collective system conducting a statewide assessment in Maine. The Maine Community Action Partnership, which represents the CAAs in Maine, and the Maine Shared CHNA partners most recently joined together in recognition that the partners' missions cut across the multitude of factors that influence a person's health and well-being and the overlap in service areas, patient populations, and services and programs. Additionally, common elements run through each partner's federal and accreditation reporting requirements leading to efficiencies and effectiveness in conducting a health and well-being assessment.

This assessment cycle, the Maine Shared CHNA has continued its collection and analysis of data covering community conditions and social drivers of health, protective and risk factors, and health conditions and outcomes at the urban, county, state, and national level. This cycle saw expanded efforts to engage communities across Maine, conducting statewide focus groups with specific populations, county level focus groups, key informant interviews, and a statewide community survey. Both the quantitative and qualitative data were used to inform a health and well-being prioritization process held with stakeholders at 17 forums, one in each county and two in Cumberland County. The resulting priorities for Maine are outlined in the following report, along with a summary of related and contributing data, community engagement findings, and forum discussions. A more detailed explanation of the Maine Shared CHNA methodology can be found in Appendix 1.

Executive Summary

The Maine Shared Community Health Needs Assessment engages in a community health and well-being assessment every three years resulting in the selection of top health and well-being priorities for each county and the State of Maine to be addressed by the Maine Shared CHNA collaborative members and its partners. This report includes the health and well-being priorities for Maine and a summary of the assessment findings related to those priorities.

State of Maine Health and Well-Being Priorities

The following table includes the top health and well-being priorities confirmed by the Maine Shared Community Health Needs Assessment Steering Committee based on quantitative and qualitative data, the county stakeholder forum prioritization process, and their own knowledge, expertise, and experience. Priorities that were chosen at the stakeholder forums, but were not selected by the Steering Committee are listed in Appendix 2.

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Housing	Substance Use*	Mental Health
Transportation	Adverse Childhood Experiences	Chronic Conditions**
Poverty	Nutrition	
Provider Availability		

*Substance use includes but is not limited to alcohol, cannabis, illicit drugs, and tobacco

**Chronic conditions include but are not limited to cancer, cardiovascular disease, multiple chronic conditions, and obesity and weight status

Next Steps

The Maine Shared CHNA assessment reports will be used to fulfill the Internal Revenue Service (IRS) requirements for non-profit hospitals, the Public Health Accreditation Board (PHAB) requirements for state and local public health departments, and the Community Services Block Grant (CSBG) requirements for Community Action Agencies (CAAs). The next steps include:

- For hospitals, create an informed implementation strategy designed to address identified health and well-being priorities.
- For the Maine CDC and local public health departments, create an informed State Health Improvement Plan and Community Health Improvement Plans.
- For Maine CDC convened District Coordinating Councils, inform stakeholder discussions and planning at the local level, as relevant and applicable.
- For Community Action Agencies, develop informed strategic and programmatic plans to address the identified health and well-being priorities and their impact on those in poverty.

The use of these reports is also encouraged and welcomed by non-profits, community partners, academics, policymakers, businesses, and countless others to support their strategic planning, coalition building, and grant writing. The Maine Shared CHNA sought to learn who is currently working on the priorities outlined within this report and hopes the report can serve as a catalyst for deeper collaboration to improve the health and well-being of people living in Maine.

Report Outline

This report is broken into three sections.

1. Select demographics, including socioeconomic indicators, race and ethnicity, age, and the leading causes of death for Maine are presented to give a broad view of the make-up of people living in Maine and to provide context for which health and well-being conditions and outcomes may or may not prevail.
2. A section is devoted to discussing health equity and disparities in Maine. This section outlines efforts made during this Maine Shared CHNA assessment to engage and learn from specific populations and the resulting qualitative data.
3. The remainder of the report provides an in-depth discussion of each of the health and well-being priorities, grouped by the categories of community conditions, protective and risk factors, and health conditions and outcomes. Each discussion includes findings from the statewide focus groups, key informant interviews, statewide community survey, summary discussions from the county stakeholder forums, and quantitative data from the State Health Profile, as relevant and applicable.

Additional reports highlighting the results of the health and well-being assessment, including data profiles and community engagement overviews, as well as reports for each county and the state, are available online at www.mainechna.org.

Select Data

Demographics

The following tables and chart show information about the population of Maine. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

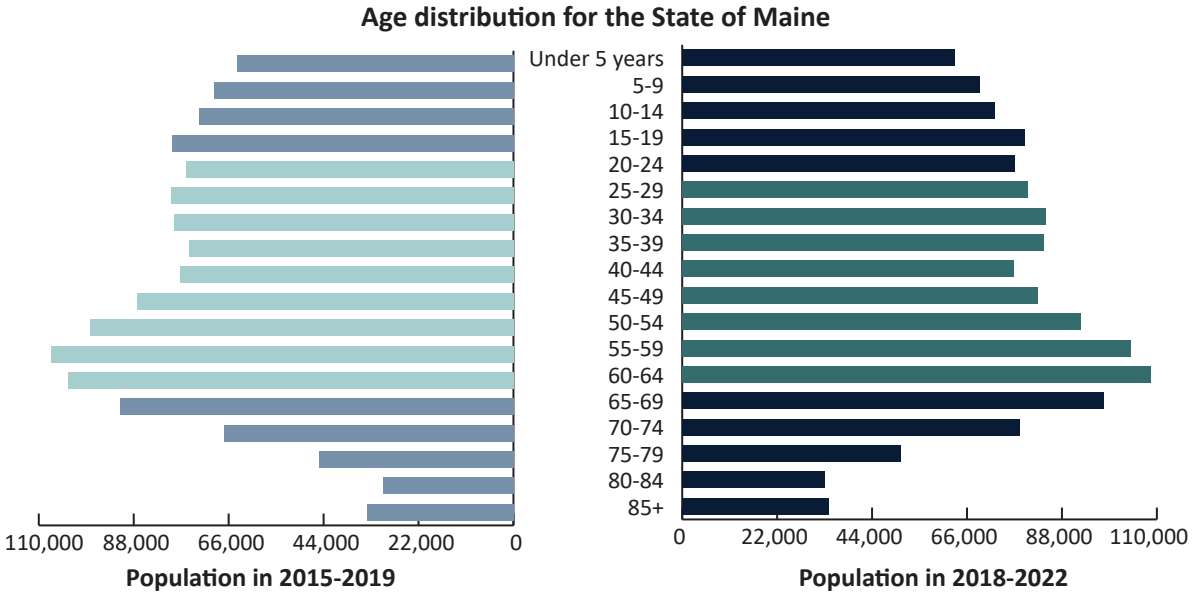
State of Maine Population

1,366,949

	Maine (2018-2022)
Median household income	**$68,251**
Unemployment rate (2023)	**3.1%**
Individuals living in poverty	**10.9%**
Children living in poverty	**13.4%**
65+ living alone	**29.5%**

	Maine (2018-2022)	
	Percent	Number
American Indian/Alaskan Native	**0.5%**	**6,722**
Asian	**1.1%**	**15,071**
Black/African American	**1.6%**	**21,775**
Native Hawaiian or other Pacific Islander	**0.02%**	**265**
Some other race	**0.6%**	**8,128**
Two or more races	**3.9%**	**53,704**
White	**92.3%**	**1,261,284**
Hispanic	**1.9%**	**25,898**
Non-Hispanic	**98.1%**	**1,341,051**

The chart below shows the shift in the age of the population between 2015-2019 and 2018-2022. As Maine's population grows older, there may be impacts on health care costs, caregivers, and workforce capacity, while on the other end, increases in children may cause impacts on child care availability and educational institutions.



Leading Causes of Death

When reviewing the top health and well-being priorities it is important to consider how they may fit into the leading causes of death for the county and Maine. In some instances, they may overlap, in others they may contribute to or cause a leading cause of death, and in others they may be distantly related. The priorities identified demonstrate the continuum of health and well-being and the impact of other factors, such as social, institutional, and community conditions, and protective and risk factors on health and well-being outcomes.

Leading Causes of Death, 2022

The following chart contains the leading causes of death for the State of Maine.

Maine		U.S.	
Cause of Death	Number of Deaths	Cause of Death	Number of Deaths
Diseases of heart	**3,592**	Diseases of heart	**702,880**
Cancer	**3,428**	Cancer	**608,371**
Accidents (unintentional injuries)	**1,391**	Accidents (unintentional injuries)	**227,039**
Chronic lower respiratory diseases	**901**	COVID-19	**186,552**
COVID-19	**798**	Cerebrovascular diseases (e.g. stroke)	**165,393**
Cerebrovascular diseases (e.g. stroke)	**639**	Chronic lower respiratory diseases	**147,382**
Diabetes mellitus	**603**	Alzheimer disease	**120,122**
Alzheimer disease	**543**	Diabetes mellitus	**101,209**
Chronic liver disease and cirrhosis	**304**	Kidney disease (nephritis, nephrotic syndrome & nephrosis)	**57,937**
Influenza and pneumonia	**281**	Chronic liver disease and cirrhosis	**54,803**
Intentional self-harm (suicide)	**268**	Intentional self-harm (suicide)	**49,476**
Kidney disease (nephritis, nephrotic syndrome & nephrosis)	**243**	Influenza and pneumonia	**47,052**

Health Equity

Definitions

Healthy People 2030 defines **health equity** as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[i] In order to achieve health equity, actions must be taken to improve access to conditions that influence health and well-being, specifically for those who lack access or have worse health. This in turn should impact everyone's outcomes positively. "Equity" means focusing on those who have been excluded or marginalized.[ii]

Healthy People 2030 defines a **health disparity** as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systemically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristic historically linked to discrimination or exclusion."[iii] Disparities in health and well-being are how progress is measured toward health equity and are the preventable differences in health and well-being.[iv]

Social drivers of health (SDOH) are conditions in the environments where people are born, live, work, play, worship, and age – the community-level factors – that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social drivers of health are sometimes used interchangeably with social determinants of health; however, "determinants" can be interpreted to suggest nothing can be done; that our health and well-being is determined. Whereas "drivers" reframes the conversation with a focus on health and demonstrate changes can be made to improve health and well-being outcomes.[v]

Health-related social needs (HRSNs) is another term often used. These are the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They refer to individual-level factors, such as financial instability, lack of access to healthy food, lack of access to housing, and lack of access to health care and social services, that put people at risk for worse health and well-being outcomes and increased health care use.[vi]

Health Equity and Community Engagement

The Maine Shared CHNA takes a broad approach to assessing health and well-being throughout the state. While we attempted to reach many populations in our assessment process who have disparate health and well-being experiences and outcomes, some choices about which groups to include were necessary based on available resources. We ultimately engaged directly with people who are LGBTQ+, multigenerational Black/African Americans, veterans, women, young adults, and youth through statewide focus groups. Focus groups were also held within each county with people with low income. Key informant interviews were also conducted

with stakeholders representing various populations and sectors and a statewide survey was administered and open to all people living in Maine. (See Appendix 1: Methodology, for more information on the focus groups, key informant interviews, and survey.) The Maine Shared CHNA also used findings from the Maine State Plan on Aging Needs Assessment (SPOA) for the older adult population and Disability Rights Maine (DRM) for the disability community.

It should be noted the voices we heard in focus groups and interviews are not meant to be representative of their entire identified population or community. Despite efforts to recruit for the focus groups, several had low attendance, and resources limited the engagement to one focus group for each identified population or community, resulting in limited perspectives shared. Furthermore, we recognize that for many people, their lives and their health are affected by multiple aspects of their identity and lived experiences or their "intersectionality." We attempted to recognize participants' intersectionality by asking them to voluntarily share any other identities they may have. The totality of focus group participants also identify as: a Tribal member, older adults, non-English speaker, immigrant, asylee, migrant, Latino/Latine/Latinx, residents of rural, urban, and suburban areas, people with substance use disorder, people with mental health disorder, members of the disability community, people who are deaf or hard of hearing, people who are incarcerated or formerly incarcerated, people who are unhoused or experiencing homelessness, and caregivers.

This report is not meant to replace in-depth assessments that focus on disproportionately impacted populations. We recognize many people have past experiences with public and private institutions that include, but are not limited to, oppression, discrimination, and exclusion, which results in a hesitancy to engage without more intentional relationship and trust building. In addition, potential community engagement participants may be unable to participate due to barriers

Quantitative Data

The experiences shared in the Maine Shared CHNA community engagement process are augmented through the Maine Shared CHNA quantitative data analysis. Quantitative data for Maine and specific populations are embedded within the report as they relate to health equity and the state priorities. The State Data Profile and Health Equity Profiles can be accessed at www.mainechna.org.

Assessment Findings

Systemic Racism and Discrimination

Discrimination was a prominent throughout the statewide focus groups. Systemic racism and discrimination, with historical and present-day impacts, reverberated through the discussions with multigenerational Black/African Americans, people who are LGBTQ+, migrants, and the disability community. Health equity was also a top concern in the findings of the SPOA and DRM assessments. Among the Maine Shared CHNA survey respondents, 12% of people said racism impacted them, 19% a loved one, and 77% their community, and 9% said discrimination impacted them, 15% a loved one, and 58% their community.

Research demonstrates that systemic racism sets in motion complex causal chains resulting in experiences and exposures that contribute to racial and ethnic disparities in health and well-being.[vii] Systemic racism can harm health by disenfranchising and disempowering people, placing people at an economic disadvantage, exposing people to health-harming conditions and limiting their access to health promoting resources and opportunities, and exposing people to race-based unfair treatment.[viii] Respondents discussed how the systems that have been in place have impacted public health funding, promotion, and interventions, leading to underinvestment and an increasing need for targeted funding and interventions to decrease disparities. These disparities were specifically discussed as they relate to:

- The wage gap, specifically with Black women.
- Lack of representation of people of color in state departments and positions.
- State programs and policies that lack intentionality in addressing gaps and barriers.
- An inability to receive high-quality health care experienced by the Black community in the form of inequitable treatment and lack of cultural competence, by older adults through ageism, and by the LGBTQ+ community with regard to receiving culturally competent, non-stigmatizing, and trauma-informed care.
- Structural barriers impacting care for people with disabilities including healthcare system navigation, specifically for the deaf community, and transportation and physical spaces that are accessible to people with disabilities. Three-quarters of the Maine Shared CHNA survey respondents said the “availability of transportation that meets a variety of specific needs” impacted their community.

The migrant population, including immigrants, refugees, asylees, seasonal workers and those who work with these populations, also frequently cited the stigma they experience when attempting to access healthcare and basic needs. Related barriers that rose to the top were language differences and minimal access to translation services or providers that speak languages other than English, which can lead to receiving inadequate care and a difficult time accessing services. Additionally, this community faces hurdles when it comes to seeking employment, maintaining an adequate income, and receiving social services, which may be due to how they are paid, citizenship status, and access to services such as MaineCare.

Socioeconomic Empowerment

The Maine Shared CHNA recognizes the impact poverty and low incomes have on health and well-being. Community Action Agencies are funded through the Community Services Block Grant to administer support services that alleviate the causes and conditions of poverty in under resourced communities[ix] and identify those causes and conditions through the community needs assessment process. In an effort to reach this aim, the Maine Shared CHNA survey asked respondents to rate the top five items that are "very necessary" steps to help move people out of poverty and to a place of housing stability and financial stability. The table below represents the ratings for the county and Maine and when applicable, are referenced in each priority discussion.

Top 5 "Very Necessary" Steps to Move from Poverty to Stability
1) Jobs that pay enough to support a living wage
2) Affordable and safe housing
3) Mental health care and treatment
4) Affordable & available health care
5) Affordable & quality childcare

Health and Well-Being Priorities

Section Overview

The following section contains the top health and well-being priorities for each category – community conditions, protective and risk factors, and health conditions and outcomes. The categories are derived from the Bay Area Regional Health Inequities Initiative (BARHII) framework. More information on the framework is in Appendix 1: Methodology.

Each priority contains a discussion of the related quantitative and qualitative data and stakeholder forum takeaways. Within each priority the following sections are also included, as applicable:

Socioeconomic Empowerment

- This provides the step or steps rated by Maine Shared CHNA survey respondents that help move a person from poverty to stability that relate to the priority. The complete list of the top five rated steps is outlined in the health equity section of this report.

Crosscutting Priorities

- This section includes a list of the other health and well-being priorities for Maine that are related or connected to the priority of discussion. Readers are encouraged to reference these to gain more insight into the interconnectivity of the priorities and overall health and well-being.

Strengths

The Maine Shared CHNA survey asked respondents to identify the top five strengths of their communities. For Maine, respondents highlighted:

- Safe opportunities to be active outside;
- Locally owned businesses;
- Safe neighborhoods;
- Schools and education for all ages; and
- Low crime.

Focus group respondents, representing populations and communities with disparate health outcomes, were also asked to identify strengths of their communities. At the state level, the top themes identified were:

- Strong sense of community;
- Increased use of telehealth and telehealth accommodations; and
- Creative public health initiatives.

The Maine Shared CHNA survey demonstrates people living in Maine have a positive outlook on their health and well-being – 64.1% respondents believe their community is healthy or very healthy; 69.5% rate their own physical health as good or excellent; and 70.4% say their mental health is good or excellent.

Community Conditions

Community conditions include the physical environment (environmental exposures, housing, transportation, etc.), economic and work environment (employment, income, etc.), social environment (discrimination, crime, community safety, etc.), and service environment (health care and social service access, education, etc.). Social drivers of health (SDOH), which are the policies, systems, structures, life experiences, and social supports that influence a person's health, most often fit into the context of community conditions. The following section outlines the top community conditions priorities for Maine, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Maine Community Conditions			
Housing	Transporatation	Poverty	Provider Availability

Housing

Housing was the top priority for the community conditions category for Maine. It was identified as a top community conditions priority in all 17 county stakeholder forums. For the purposes of the prioritization process, housing includes such topics as housing availability and affordability, costs associated with home ownership or renting, and costs of utilities.

Assessment Findings

Respondents to the Maine Shared CHNA survey said "housing insecurity" is the fourth of top five social concerns negatively impacting their community and 68.5% said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, respondents highlighted several that impact their community, including:

- availability of affordable housing (82.4%),
- housing costs (80%),
- availability of housing for older adults or those with special needs (77.5%),
- cost of utilities (74.4%), and
- weatherization (75.6%), which also directly impacted respondents (55.4%) and their loved ones (48.5%).

"Housing and housing support" was one of the top common needs across the state discussed in the Maine Shared CHNA statewide focus groups and key informant interviews. Housing was also identified as a primary need or priority in the Maine State Plan on Aging Needs Assessment (SPOA assessment) and the Disability Rights Maine health access assessment (DRM assessment).

Housing Availability

In the Maine Shared CHNA veterans focus group, a lack of available housing specific to their population was raised as a need. Participants note there are programs, such as "Cabin in the

Woods" which offer permanent housing, but availability is limited and there are long wait lists. Many veterans would like to see more housing programs like this. One veteran said:

"I would only leave [Cabin in the Woods] for two reasons: to go to a nursing home or to die. I could not afford somewhere else."

Availability of housing was a theme in the Maine Shared CHNA county stakeholder forums, with participants noting a general lack of housing. As of 2022, 80.5% of housing was occupied in Maine and 1.6% of housing units were vacant and for sale or rent. In combination with a lack of supply, another common theme was the age of the housing stock and quality of homes. Over half (56%) of housing in Maine was built before 1979 and only 6.4% has been built since 2010 (2018-2022).

Housing Affordability

Older adults discussed the current lack of affordable housing in Maine as well as concern over being able to maintain the quality of their home. Participants in the SPOA assessment said they are unable to afford home repairs and unable to find people to assist with their repairs. Close to one-quarter of adults aged 65-74 (18.2%) and 75 or older (20.5%) in Maine live in poverty (2018-2022).

One SPOA assessment participant said:

"[There is a need for] building more available housing for the aging or elderly as they are having to sell their homes due to the increase in property taxes."

Specific to maintenance, one SPOA assessment participant shared:

"[My] roof is rotting, and even more damage is happening. But there's nothing I can do about the process. And I do follow up phone calls. And it's quite exhausting."

Young adults also discussed affordable, quality housing in their focus group. Many feel they cannot afford to purchase a home due to their limited financial assets as they pursue education or are early in their career. This leads many young people to rent, which can sometimes be more expensive than home ownership.

Housing affordability was discussed in almost every county stakeholder forum. Increasing home prices and rental costs were mentioned in several forums, including rising home valuations and security deposits. In Maine, 11% of households spend more than 50% of their income toward housing, which data shows is significantly better than the U.S. (15%, 2022) and the median gross rent in Maine is $1,033, significantly better than the U.S. ($1,300, 2022). Forum participants noted the costs associated with interest rates, taxes, and insurance as barriers to housing. Costs were also discussed related to utilities, heating, maintenance and repair, and weatherization, both in terms of rising costs and the inability to afford these costs with fixed or limited incomes. For those who qualify for housing vouchers or Section 8 Housing, there is often a lack of

landlords who accept them, challenges with their funding mechanisms, or a stigma associated with using them.

Housing Insecurity

Several forums also discussed people experiencing homelessness, noting a lack of safe and supportive shelter options throughout the state. A few forums specifically mentioned the need for shelters in the winter and for older adults. As of 2022, Maine had 4,657 available shelter beds. From the period 2021-2022 there were 3,087 children experiencing homelessness across the state and as of 2023, 2.6% of high school students were housing insecure. Housing insecurity among high school students varies by demographic as shown in Table1: Housing Insecure Maine High School Students by Demographic.

Table 1: Housing Insecure Maine High School Students by Demographic, 2023

Demographic	Housing Insecure (High School Students)
Maine	2.6%
Hispanic	10.7%
Non-Hispanic	2.3%
American Indian or Alaska Native	9.3%
Asian	6.2%
Black or African American	8.7%
Native Hawaiian or Other Pacific Islander	24.1%
Two or More Races	7.7%
White	2.0%
Heterosexual	1.7%
Gay or Lesbian	7.2%
Bisexual	3.1%
Something Else	3.1%
Not Sure	3.6%

Contributing Factors & Root Causes of Housing

Butting up against a lack of housing, are regulations that prohibit building homes, coupled with increasing construction costs. Forum participants noted municipal ordinances, density, building regulations, zoning limits, and land use limitations as challenges to building more housing. In several forums a preference for single family homes and a “not in my backyard” attitude toward building housing was discussed, specifically with regard to building low-income housing.

Another common theme in the stakeholder forums was with regard to seasonal housing and short-term rentals, which compete with and limit opportunities for those seeking to reside in Maine year-round.

Socioeconomic Empowerment

When asked to rate the top five “very necessary” steps to help move someone from a place of poverty to stability, Maine Shared CHNA survey respondents rated “affordable and safe housing” number two.

Transportation

Transportation was the second priority for the community conditions category for Maine. It was identified as a top community conditions priority in 11 of the 17 county stakeholder forums. For the purposes of the prioritization process, transportation includes such topics as access to transportation, availability of transportation, and transportation that meets a variety of specific needs.

Assessment Findings

"Transportation" was one of the top common needs across the state discussed by Maine Shared CHNA focus group participants and interview respondents. Transportation was also identified as a primary need or priority in the Maine State Plan on Aging Needs Assessment and the Disability Rights Maine health access assessment.

In the Maine Shared CHNA statewide survey, 60.9% of respondents said "transportation needs" negatively impact them, a loved one, and/or their community. More than three-quarters of respondents said their community is negatively impacted by:

- "availability of public transportation" (78.6%),
- "access to transportation" (78%), and
- "availability of transportation that meets a variety of specific needs" (76%).

Of the 53.7% of survey respondents who said "public safety needs" negatively impact them, a loved one, and/or their community, 44.6% said "pedestrian or bicycle safety" negatively impacts their community, 22.3% a loved one, and 25.4% themselves.

Transportation & Rurality

Participants in the veterans focus group discussed how living in rural areas can make it difficult to travel to access healthcare, sharing:

"At Togus, it is easy. For others, it is not so easy. Especially for older people who can't drive"

"…Some people can't travel all over to get the care they need."

Older adults in general share the concerns discussed by the veterans. In the SPOA assessment many older adults report they are no longer able or willing to drive. Specifically in rural areas, this can limit older adults' ability to reach healthcare services, access food, and socialize. Participants in the SPOA assessment shared this leads to a dependency on public transportation or volunteer organizations, both of which come with their own challenges. One SPOA assessment focus group participant shared:

"People who don't drive in rural areas rely on volunteer transportation programs. If there's a hiccup in those programs, and they become unavailable, then suddenly people are not able to get where they need to go. If there's a downturn in volunteerism, or if there isn't good recruitment in certain corners of the service area, people just try once to get it or try a couple times, and then they give up and don't try anymore."

Public Transportation

In the county stakeholder forums, a lack of transportation options and transportation infrastructure was a common theme. Forum participants noted a lack of public transportation in general, and specifically a lack of on-demand transportation, transportation for last minute requests, and taxis.

For public transportation that does exist, forum participants discussed schedules that are often complex, long wait times, requirements for advance scheduling, specifically with Modivcare, and eligibility requirements, specifically for those on MaineCare. In the DRM assessment, people with disabilities discussed structural barriers to care including a lack of transportation to health care facilities. One participant said:

"[There are] lots of public transportation problems for disabled people. It's not right. They don't understand that if you don't get the care you need, it could be serious"

Forum participants did note some of the challenges with public transportation are related to workforce shortages, which may be due to low pay, low reimbursement rates and a lack of funding. The lack of public transportation is reflected by commuting patterns. As of 2022, 35.8% of people in Maine had a commute of greater than 30 minutes driving alone and only 3.8% of those 16 years and older use public transportation to commute to work (2018-2022).

Transportation Costs

The cost of transportation was also raised in several stakeholder forums. This was discussed with regard to the cost of vehicle ownership, noting gas, repairs, registration, and insurance. Vehicle ownership and maintenance negatively impacted Maine Shared CHNA survey respondents (48.9%), their loved ones (43.7%), and their communities (70.3%). A few forums also noted the expense of participating in driver's education, specifically for high school students, and costs associated with reinstating a license. In Maine 6.8% of households do not have a vehicle, significantly better than the U.S. (8.3%, 2022).

Poverty

Poverty was the third priority for the community conditions category for Maine. It was identified as a top community conditions priority in 11 of the 17 county stakeholder forums. For the purposes of the prioritization process, poverty includes such topics as individuals and children

living in poverty, unemployment, asset poverty, Head Start eligibility, Asset Limited, Income Constrained, Employed (ALICE) thresholds.

Assessment Findings

From a quantitative standpoint, Maine is doing significantly better than the U.S. when it comes to poverty levels:

- 10.8% of individuals live in poverty (U.S. 12.6%, 2022).
- 6.2% of households live below the federal poverty level (U.S., 8.9%, 2022).
- 11.7% of children live in poverty (U.S. 16.3%, 2022).

However, poverty rates vary considerably by demographic, as shown in Table 2: Maine Individual Poverty Levels by Demographics.

Table 2: Maine Individual Poverty Levels by Demographics, 2018-2022

Demographic	Individuals Living in Poverty
Maine	10.9%
Hispanic	13.4%
Non-Hispanic	10.5%
American Indian or Alaska Native	19.7%
Asian	10.7%
Black or African American	24.2%
Native Hawaiian or Other Pacific Islander	12.5%
Two or More Races	14.7%
White	10.5%
Male	9.8%
Female	11.7%
Less than high school diploma or equivalent	28.9%
High school diploma or equivalent	14.4%
Some college or associate's degree	9.3%
Bachelor's degree or higher	4.1%

In Maine, 30.2% of households live above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold of financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy. In addition, 18% of Maine people are asset poor, meaning they have insufficient net worth to live without income at or above the federal poverty level for three months (2021).

In the Maine Shared CHNA survey, "low incomes and poverty" were identified by respondents as the third of five social concerns negatively impacting their community and 76.1% of respondents said "economic needs" negatively impact them, a loved one, and/or their community. Of those respondents, the "ability to contribute to savings, retirement" impacted respondents (54.5%), their loved ones (46.6%), and their community (63.3%).

Poverty, Employment, & Income

Participants in the county stakeholder forums discussed the impacts of unemployment, a lack of jobs, and a lack of employment training and skills development opportunities as contributing to poverty. As of 2022, 3.5% of people in Maine were unemployed. In Maine, 46.8% of those 25 and older had an Associate's degree or higher, significantly better than the U.S. (44.4%, 2022).

Forum participants discussed a lack of broadband access and transportation as impacting a person's ability to gain employment. As of 2022, 90.7% of households in Maine had a broadband subscription.

Related to a lack of employment, several forums noted a lack of income and livable wages, citing a mismatch between incomes and expenses leading to an inability to save. The median household income in Maine as of 2022 was $69,543, significantly worse than the U.S. ($74,755) (Census data for 1-year estimates). Incomes in Maine vary by race as indicated in Table 3: Maine Household Income by Race.

Table 3: Maine Household Income by Race, 2018-2022

Demographic	Median Household Income
Maine	$68,251
American Indian or Alaska Native	$61,365
Asian	$81,581
Black or African American	$54,996
Native Hawaiian or Other Pacific Islander	$103,629
Two or More Races	$59,540
White	$70,228

Participants in the migrant focus group discussed challenges they face seeking employment and maintaining an adequate income, and the unique impact a migrant worker's income can have on receiving social services. A varying income may impact their eligibility, with one focus group participant noting:

"Some farm workers may make a lot of money in a short period of time but annually is not a lot. They can't include dependents who live outside the area even though they financially support them […] some people don't get paystubs or get paid in different ways."

Regarding inadequacies with income, a key informant interviewee who works with migrant communities said:

"Access to food and basic items, people don't know how cold it is and all they have are sandals. Where do people get cold weather clothes? Migrants use last paycheck to get to the right place."

Forum participants also highlighted the gender pay gap and a lack of generational wealth.

Further, some noted that more employers are no longer offering benefits. For those who qualify for public benefits, forum participants expressed concern about funding for social services like the Women, Infants and Children (WIC) program and the Supplemental Nutrition Assistance Program (SNAP). In addition, some people may be victim to the public benefits cliff, which occurs when a small increase in income causes ineligibility for public benefits while still being unable to maintain day to day expenses.

Poverty & Child Care

Of the Maine Shared CHNA survey respondents who cited economic needs as negatively impacting them, a loved one, and/or their community (76.1%), 72.9% said their community is negatively impacted by the "availability of quality, affordable child care." When child care is unaffordable or nonexistent it may prevent parents from working and earning an income. For parents who work low paying jobs, their wages may barely cover the cost of child care, leaving them with less for other expenses and necessities. These costs may be offset by social programs but may become inaccessible if a parent begins to earn higher incomes that make them ineligible; however, this does not necessarily mean they are able to afford child care or day to day expenses.

County stakeholder forum participants discussed access to child care, with child care expenses sometimes outweighing obtaining and maintaining employment. As of 2022, 47.5% of children in Maine were served in publicly funded state and local preschools and there were 823 licensed child care centers across the state.

Child care was a topic of discussion in the focus group with women, specifically its impact on women entering the workforce. If child care isn't available women tend to have to stay home as the primary caregiver or because their income may not be enough to offset the expense of child care. One focus group participant said:

"Child care is really expensive. My sister stopped working for two years because it was cheaper for her to stop working than for her to use daycare."

Regarding child care availability, another focus group participant said:

"There are some nice and affordable options, but long wait lists, like two years. A lot of people choose to say home or use relatives to watch kids; child care is very much needed."

Participants in the young adult focus group also discussed child care noting adequate and flexible child care as a prominent concern. They reported the number of child care providers is inadequate to serve the needs of their community.

These barriers are compounded for those whose first language isn't English. One participant said:

"Child care is hard to find. Language plays a big piece for kids who don't speak or understand English. Hard to even b3 placed on a wait list – they won't get a translator."

Poverty & Health

Health conditions and outcomes were also discussed as factors that either lead to poverty or are caused by the repercussions of being in poverty. These include health conditions such as substance use disorder, mental health disorder, and special health care needs. The lack of health care was also discussed by forum participants, including both a lack of providers and facilities and also an inability to afford care.

Socioeconomic Empowerment

Maine Shared CHNA survey respondents rated "jobs that pay enough to support a living wage" as the number one and "affordable and quality child care" as the fifth of five "very necessary" steps to help move someone from a place of poverty to stability.

Crosscutting Priorities

Housing **Transportation** **Substance Use** **Mental Health**

Chronic Conditions

Provider Availability

Provider availability was the fourth priority for the community conditions category for Maine. It was identified as a top community conditions priority in ten of the 17 county stakeholder forums. For the purposes of the prioritization process, provider availability includes such topics as availability of primary care physicians, dentists, psychiatrists, and mental health providers; access to mental health treatment; access to drug and alcohol treatment; access to caregiving; and access to prenatal care.

Assessment Findings

"Healthcare access" was one of the top common needs across the state identified by Maine Shared CHNA focus group participants and interview respondents. Healthcare access was also identified as a primary need or priority in the Maine State Plan on Aging Needs Assessment and the Disability Rights Maine health access assessment and in all of the Maine Shared CHNA focus groups – multigenerational Black/African American, veterans, LGBTQ+, women, youth, young adult, and migrant.

Provider Access

Quantitative data shows 90.3% of adults in Maine had a usual primary care provider and

81.4% had been to a primary care provider in the past year, both significantly better than the U.S. (76.9% and 74.7%, 2022, respectively). While this is a positive outcome for Maine in the aggregate, the percentage of adults who have a usual primary care provider and who have seen a primary care provider in the past year vary by ethnicity and race within Maine. This variation is shown in Table 4: Primary Care Provider and Visits by Ethnicity and Race. Additionally, those who are uninsured are less likely to have a usual primary care provider (49.5%, 2021) and to have had a primary care visit in the past year (34.7%, 2021).

Table 4: Primary Care Provider and Visits by Ethnicity and Race, 2012-2021

Demographic	Usual Primary Care Provider	Primary Care Visit in the Past Year
Maine	87.5%	74.3%
Hispanic	81.1%	70.1%
Non-Hispanic	87.6%	74.4%
American Indian or Alaska Native	78.5%	68.9%
Asian	75.0%	68.3%
Black or African American	74.6%	73.4%
Native Hawaiian or Other Pacific Islander	–	–
Two or More Races	80.5%	66.9%
White	88.0%	74.6%

In the Maine Shared CHNA survey 47.9% respondents said they or a loved one could not or chose not to get health care in the past year. Reasons for forgoing care include: "long wait times to see a provider," "had health insurance, could not afford care," and "no evenings or weekend hours to get care."

County stakeholder forum participants discussed a general lack of providers throughout Maine, specifically mental health providers, specialists, and dentists. As of 2022 in Maine,

- There were 675 people for every primary care provider.
- There were 11,372 people for every psychiatrist.
- There were 1,614 people for every dentist.

Veterans also discussed difficulty accessing providers:

"Too many veterans don't reach out to get help, so lack of awareness of available support. Even if they do reach out, there are too few practitioners."

Participants in the focus group with women noted difficulties finding adequate women-focused health care. One participant said:

"I was seeing a provider last month, she wasn't working or listening to me […] so I was transferred to new provider, and I'd have to wait five months to see a new OB-GYN. But I was dealing with women's health issues at the time and needed to see someone and it took me six phone calls before someone got me in to see an interim doctor."

Availability of dental providers was specifically discussed among youth related focus group participants and key informant interviewees and in the SPOA assessment of older adults. As of 2020, 66.7% of adults in Maine had been to a dentist in the past year. Maine Shared CHNA focus group participants said finding dental providers who see children, specifically children with MaineCare is hard to find in the more rural areas of Maine. Participants in youth centric conversations said:

"Dentists don't get enough [pediatrics] training. We need more hygienists to do cleanings for prevention. Even if there were enough, providers aren't accessible. We should integrate into primary care more; some primary care providers are doing dental screenings."

"[We need an] army of hygienists out in communities: public health hygienists to work in territories, with at least one covering each county or region. They could train primary care providers and others on dental care."

In the SPOA assessment, one survey respondent said:

"Dental and hearing aid assistance. Too expensive to even consider seeking help to resolve. Eating problems due to missing and rotten teeth. Need dentures but cannot afford."

Participants in the county stakeholder forums discussed what they believe are the contributing factors to provider availability. Overall, forum participants discussed that areas are struggling to find and retain medical providers. They believe there is a lack of training and career development for medical professionals and that they aren't compensated fairly. Providers seem to be leaving many areas, particularly rural areas and also may not be able to move to some areas of the state because of a lack of housing.

Provider Cultural Competency

Participants in the multigenerational Black and African American focus group discussed a lack of culturally competent providers. One focus group participant said:

"[It is important medical providers] have cultural fluency and medical knowledge to understand how black women's bodies and health issues are different than white women."

Participants would like to see more cultural competency training and more Black healthcare providers. One participant said:

"The long game is to reduce unnecessary barriers that prevent more people of color from going into these professions in the first instance. When you are in the process of being trained, having cultural competency be prioritized and included from day one is really important. If issues of race and ethnicity are included in training and education from day one, it gives multiple opportunities for individuals to be sensitive to issues and aware of how it may manifest in different areas of practice."

Participants in the LGBTQ+ focus group also discussed the need for more providers with knowledge and awareness of LGBTQ+ people and providers who are trauma informed. Focus group participants said:

"People don't understand non-binary or what it means even about sexual health or sexual violence."

"The healthcare system is not adequate or trauma-informed through race, class, cultural-socioeconomic lens especially for severely radicalized and violent incidents."

Participants in the Disability Rights Maine assessment reported providers often lack knowledge about their disability and how to accommodate patients with different disabilities. A DRM focus group participant said:

"I've faced such chronic shame that if I go to a medical professional and feel like they are shaming me in any way, I will not return. As a trans person, I have to find care that is trauma-informed and competent."

Older adults share similar concerns, noting their concerns in the SPOA assessment of a lack of providers, experiences of ageism when seeking care, and a lack of trauma informed care.

Stakeholders who work closely with migrant families discussed the disparity in access to care that marginalized women face. One stakeholder noted:

"Some services have been closed. Some practices aren't willing to see patients who won't be there throughout their pregnancy […] never mind if providers understand the language and culture."

Maine Shared CHNA stakeholder forum participants also noted there are a lack of providers who are culturally competent and those who work with youth and older populations. For those providers who do work with older adults, forum participants believe they may be overwhelmed due to a more complex patient panel, appointments that warrant more time, and that they may be taking on patients who would be better served by specialists, but these providers are inaccessible. In general, forum participants believe many primary care providers are overwhelmed and facing burnout.

Health Insurance Access

LGBTQ+ focus group participants also discussed health insurance as it relates to provider availability noting it appears providers are more willing to accept patients with private insurance as opposed to MaineCare. Forum participants also noted difficulty accessing care because of insurance barriers, specifically a lack of providers who accept MaineCare. Forum participants noted the challenges with reimbursement rates, specifically for MaineCare and are aware of the financial struggles Maine's health systems and hospitals are in. As of 2022, 6.6% of people in Maine were uninsured, significantly better than the U.S. (8.0%) and as of 2023, 27.6% of people were enrolled in MaineCare. Table 5: Health Insurance Status by Demographic shows the variation in uninsured rates and MaineCare enrollment based on demographics.

Table 5: Health Insurance Status by Demographic

Demographic	Uninsured (2018-2022)	MaineCare Enrollment (all ages) (2023)	MaineCare Enrollment (ages 0-19) (2023)
Maine	7.1%	27.6%	48.5%
Hispanic	17.6%	32.3%	43.8%
Non-Hispanic	5.9%	23.7%	38.6%
American Indian or Alaska Native	12.7%	39.2%	54.6%
Asian	7.8%	20.4%	23.1%
Black or African American	11.1%	74.2%	73.9%
Native Hawaiian or Other Pacific Islander	14.2%	59.7%	70.1%
Two or More Races	7.7%	45.3%	—
White	7.0%	22.1%	39.8%
Male	8.3%	26.2%	49.0%
Female	6.0%	28.3%	48.9%
Less than high school diploma or equivalent	13.9%	—	—
High school diploma or equivalent	10.3%	—	—
Some college or associate's degree	7.1%	—	—
Bachelor's degree or higher	3.4%	—	—

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to help move a person from poverty to stability, Maine Shared CHNA survey respondents rated "affordable and available health care" as number four.

Crosscutting Priorities

Housing

Protective & Risk Factors

Protective and risk factors are aspects of a person or environment that make it less likely (protective) or more likely (risk) that someone will achieve a desired outcome or experience a given problem. The more protective factors a person experiences, the more likely they are to have positive health and well-being outcomes, whereas the more risk factors, the greater the likelihood of experiencing negative health and well-being outcomes. Protective and risk factors can occur at both the individual and the environmental level, often overlapping with topics that fall within community conditions. The following section outlines the top protective and risk factor priorities for Maine, findings from the assessment process, steps necessary to move from poverty to stability, and crosscutting priorities.

Maine Protective & Risk Factors		
Substance Use	**Adverse Childhood Experiences**	**Nutrition**

Substance Use (including, but not limited to alcohol, cannabis, illicit drugs, and tobacco)

Substance use was the top-rated priority for the protective and risk factors category for Maine. Substance use or a specific substance was identified as a top protective and risk factor priority in 15 of the 17 county stakeholder forums – 11 prioritized illicit drug use, 3 alcohol use, 3 substance use, and 1 cannabis use (three forums prioritized two substances for a total of 18 substance use related priorities). Substance use includes but is not limited to priorities identified in the county stakeholder forums: alcohol, cannabis, and illicit drugs and given tobacco's impact on the people and communities of Maine, the Steering Committee chose to emphasize tobacco.

Assessment Findings

In the Maine Shared CHNA survey, respondents listed "substance use" as the second of five social concerns negatively impacting their community and 68.5% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances the following negatively impact respondents' communities:

- opioid misuse (75.1%),
- other illicit drug use (74.5%),
- alcohol misuse or binge drinking (73.4%),
- tobacco use (71.4%), and
- youth substance use (70.2%).

Table 6: Substance Use Indicators shows statewide substance use indicators in Maine.

Table 6: Substance Use Indicators

Indicator	Maine Statewide Data								Benchmark	
	2016	2017	2018	2019	2020	2021	2022	2023	U.S.	+/-
Substance Use										
Overdose deaths per 100,000 population	28.2	31.2	26.4	28.2	36.9	45.8	51.9	—	2019 21.5	N/A
Drug-induced deaths per 100,000 population	29.7	35.5	29.3	31.3	36.4	44.3	55.6	—	2019 22.8	N/A
Alcohol-induced deaths per 100,000 population	11.8	11.1	12.1	11.3	—	—	18.6	—	2019 10.4	N/A
Alcohol-impaired driving deaths per 100,000 population	4.1	3.8	2.9	3.8	4.7	3.3	4.5	—	2022 4.1	N/A
Drug-affected infant reports per 1,000 births	80.6	77.5	73.4	72.9	—	—	—	—	—	N/A
Chronic heavy drinking (adults)	8.6%	8.9%	7.9%	8.9%	8.1%	8.2%	7.9%	—	2021 6.3%	!
Past-30-day alcohol use (high school students)	—	22.5%	—	22.9%	—	22.3%	—	20.5%	—	N/A
Past-30-day alcohol use (middle school students)	—	3.7%	—	4.0%	—	3.2%	—	4.8%	—	N/A
Binge drinking (adults)	18.3%	17.9%	16.9%	17.0%	14.4%	15.3%	15.4%	—	2021 15.4%	○
Binge drinking (high school students)	—	8.2%	—	8.2%	—	—	—	9.6%	—	N/A
Binge drinking (middle school students)	—	1.2%	—	1.3%	—	1.0%	—	1.8%	—	N/A
Past-30-day marijuana use (adults)	14.4%	16.3%	16.7%	18.2%	19.0%	21.3%	—	—	—	N/A
Past-30-day marijuana use (high school students)	—	19.3%	—	22.1%	—	17.9%	—	18.7%	—	N/A
Past-30-day marijuana use (middle school students)	—	3.6%	—	4.1%	—	3.2%	—	5.0%	—	N/A
Past-30-day misuse of prescription drugs (adults)	2012-16 1.0%	—	—	—	—	0.4%	—	—	—	N/A
Past-30-day misuse of prescription drugs (high school students)	—	5.9%	—	5.0%	—	4.1%	—	5.2%	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	—	1.5%	—	3.0%	—	2.9%	—	4.9%	—	N/A
Lifetime illicit drug use (high school students)	—	18.0%	—	14.3%	—	9.6%	—	3.6%	—	N/A

The County Health Profile contains more information on data interpretation and additional indicators.

★ means the health issue or problem is getting statistically significantly better over time.

! means the health issue or problem is getting statistically significantly worse over time.

○ means the change was not statistically significant.

N/A means there is not enough data to make a comparison.

— means data is unavailable.

Youth Substance Use & Prevention

Substance use was identified as a concern by both youth focus group participants and key informant interviewees. The youth in the focus group specifically discussed tobacco use, marijuana use, and prescription opioid use. They mentioned vaping as a serious health issue noting its impacts on the developing brain. Forum participants worry about early initiation of use and low perceptions of use, specifically with regard to alcohol and cannabis. Forum participants would like to see more community activities to act as a protective factor and education on coping skills. The lack of activities for alternatives to substance use and the need for prevention programming to stop use before it starts, which would both serve as protective factors was also discussed in the youth focus group and by interviewees.

Substance Use Access

Forum participants discussed the ease of access to substances, regardless of the substance. With regard to illicit drug use, several forums discussed the impact of prescribing practices, believing prescription drugs are being overprescribed, leading to self-medication and misuse, especially for those who have chronic conditions. As of 2020, there were 12.1 narcotic doses dispensed in Maine for every 1,000 people. When discussing alcohol and cannabis, forum participants noted social acceptance of use, which has been increasing through cannabis legalization and the ease of access to alcohol. Participants note generational use, social media acceptance, and peer pressure as impacts on use rates.

Substance Use Intervention, Treatment & Recovery

Key informant interviewees noted a lack of accessible treatment centers for youth with severe substance use and forum participants noted a lack of substance use prevention education and screening programs. Interviewees discussed the positive impacts of the Screening, Brief Intervention, Referral to Treatment (SBIRT) program, but noted there are waiting periods for treatment, sometimes six months or more.

The majority of county stakeholder forums identified a lack of treatment and recovery services, including clinics, with regard to illicit drug use. Forums specifically mentioned a lack of Naloxone and medication assisted treatment programs. Forum participants noted insurance does not always cover treatment and recovery services, and in general there are a lack of providers. In Maine, 20.7% of adults needed substance use treatment in the past year and 70.6% of adults who needed treatment did not receive it (2021-2022).

Contributing Factors & Root Causes to Substance Use

Forum participants discussed the impact of mental health and poverty on substance use, which may contribute to one's use or be made worse by one's use. Forum participants note a lack of mental health providers and social workers and mental health resources. Mental health in general was discussed and specifically adverse childhood experiences, mattering, social connections, isolation, trauma, and generational trauma. In 2021, 24.5% of Maine high school students had at least four of nine adverse childhood experiences. In the migrant focus group, the impact of COVID-19 on substance use was noted, specifically alcohol.

Stigma was also discussed, specifically with illicit drug use and when socially acceptable use becomes a substance use disorder. Stigma may be felt by people because of their use and when seeking care. In the focus group with women, there is concern about the ability to access substance use treatment because of a lack of child care, societal stigma, and the fear of child protective interventions.

Poverty, income disparities, a lack of safety nets, and lack of employment were also discussed as contributing factors to substance use. Forum participants noted some jobs may be more susceptible to substance use, such as those requiring physical labor and for those that don't provide benefits which may make it more difficult for people to access treatment.

Crosscutting Priorities

Provider Availability **Poverty** **Chronic Conditions** **Mental Health**

Adverse Childhood Experiences

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the second priority for the protective and risk factors category for Maine. It was identified as a top protective and risk factor priority in 15 of the 17 county stakeholder forums. ACEs are potentially traumatic events that occur in childhood, such as experiencing abuse or neglect; witnessing violence; or the death of a family member by suicide and aspects of a child's environment, such as substance use, mental health problems, and instability in the home due to parental separation or an incarcerated family member.[x]

Assessment Findings

In the Maine Shared CHNA survey, the top four social concerns that negatively impact the community could be associated with ACEs – mental health, substance use, low incomes and poverty, and housing insecurity. Three-quarters of survey respondents said economic needs (76.1%) and mental health needs (73.6%), potential root causes of ACEs, impact them, a loved one, and/or their community. Of those respondents who said mental health needs, 56.1% said youth mental health negatively impacts their community.

In 2023, 36.7% of high school students in Maine had at least four of nine adverse childhood experiences. Table 7: Adverse Childhood Experiences by Demographic show how the percentage of high school students with ACEs varies by demographic. County stakeholder forum participants discussed adverse childhood experiences primarily with regard to young people; however, at least one forum did note segments of the adult population may have ACEs that are going unaddressed.

Table 7: Adverse Childhood Experiences by Demographic, 2023

Demographic	Adverse Childhood Experiences
Maine	36.7%
Hispanic	37.6%
Non-Hispanic	26.3%
American Indian or Alaska Native	42.9%
Asian	14.9%
Black or African American	22.2%
Native Hawaiian or Other Pacific Islander	36.4%
Two or More Races	40.5%
White	26.4%
Male	20.2%
Female	33.4%
Heterosexual	20.8%
Gay or Lesbian	45.6%
Bisexual	45.0%
Something Else	46.9%
Not Sure	33.5%

Systemic Contributing Factors & Root Causes for ACEs

In the multigenerational Black and African American focus group, participants discussed how systemic cycles of racism have negatively impacted their community. Migrant focus group participants discussed that many people who have moved to Maine from other countries have experienced xenophobia and some shared their experiences with hate crimes and bias.

In the county stakeholder forms, community conditions were also discussed as contributing factors to ACEs, such as poverty, a lack of safety nets, housing insecurity, and food insecurity

Mental Health & ACEs

In the youth focus group and in interviews with stakeholders who work with the youth population there was a shared concern about the mental health of young people. Concerns included public safety within communities and the implications of climate change on the future health and well-being of people living in Maine. In the Disability Rights Maine assessment, a parent of a child with a mental health disability reflected on the need for more treatment options:

"Children with mental health conditions and their families are a neglected, underfunded, and underserved component of health care. The wait time to see a psychiatrist, therapist, HCT (Homecare team) and occupational therapist (OT) is totally unacceptable and dangerous."

Several forums discussed the lack of mental health services and providers, which may lead to unaddressed mental health conditions, specifically those that address ACEs. In 2022 in Maine, for every psychiatrist there were 11,372 people. One LGBTQ+ focus group participant said

providers are not addressing the root causes of mental health issues. When mental health care services do exist, forum participants noted people may not be aware of where to go to access care.

Regardless of mental health diagnosis, forum participants noted a lack of support for parents and would like to see more education and support for all types of caregivers. Forum participants discussed the mental health of parents, specifically when unaddressed, which may contribute to generational impacts on their children.

Trauma was a dominant theme in the discussions with the migrant community and the stakeholders who work with them. One interviewee said:

"Childhood trauma, generational trauma, depressive disorder, anxiety, PTSD and a few others tend to be most common, but it's hard to talk with them about it due to stigma. We need to talk about symptoms rather than diagnosis."

Forum participants also discussed trauma, domestic violence, sexual assault, substance use, and medical diagnoses, all potential causes of ACEs.

Addressing ACEs

To combat ACEs, forum participants would like to see more supports and protective factors for young people, such as community involvement, transportation to access activities, positive role models, feelings of belonging and connection, after school programs, and more community assets.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move someone from a place of poverty to stability, "mental health care and treatment" was rated number three by Maine Shared CHNA survey respondents.

Crosscutting Priorities

Housing **Transportation** **Substance Use** **Mental Health**

Provider Availability **Poverty**

Nutrition

Nutrition was the third rated priority for the protective and risk factors category for Maine. It was identified as a top protective and risk factor priority in nine of the 17 county stakeholder forums. For the purposes of the prioritization process, nutrition was defined by topics such as fruit and vegetable consumption and soda/sports drink consumption.

Assessment Findings

Of the 76.1% of Maine Shared CHNA survey respondents who said "economic issues" negatively impacted them, a loved one, and/or their community, "access to affordable, quality foods" negatively impacted respondents' communities (72.9%), their loved ones (35.1%), and themselves (37.4%). "Food and nutrition access" was a top need or priority identified in the Maine State Plan on Aging Needs Assessment (SPOA assessment).

Quantitative data shows that in 2021:

- 35% of adults consumed less than one serving of fruit per day, significantly better than the U.S. (39.7%).
- 13.1% of adults consumed less than one vegetable serving per day, significantly better than the U.S. (20.4%).
- 13.6% of high school and 18.1% of middle school students consumed five or more servings of fruits and vegetables per day.
- 23% of high school and 19.5% of middle school students consumed one or more soda/sports drinks per day.

Food Access

In the SPOA assessment participants discussed the difficulty accessing nutrient dense food due to transportation barriers, cost, and lack of availability especially in rural areas of the state. The availability and affordability of food were dominant themes in the county stakeholder forums. In several forums participants noted the presence of food deserts, coupled with a lack of transportation to get to food sources. Forum participants specifically mentioned a lack of access to nutritious food. The perceived lack of support for community gardens and local food and the impact of climate change on food availability, seasonality and access to fruits and vegetables, and environmental contaminants such as PFAS were discussed by forum participants. One forum specifically mentioned a lack of access to potable water. In 2022, 13% of adults and 18.7% of youth in Maine were food insecure.

In the Maine Shared CHNA focus group with the migrant community, one participant noted a particular concern for food insecurity among aging immigrant men, noting:

"Not having a woman to cook for them is culturally not something they've done and so often they are trying to find somebody to have dinner with to go over somebody's house. And they are often food insecure."

Food Affordability

When food is available, forum participants noted the associated costs and the impact of poverty. Forum participants discussed that some people may need to prioritize other necessities over nutritious foods. While social service programs do exist to help people access food, there may be challenges or a lack of funding. In addition, some people may feel a stigma attached to using benefits or be susceptible to the benefits cliff, which occurs when a small increase in income causes ineligibility for public benefits while still being unable to maintain day to day expenses. SPOA assessment focus group participants also discussed the challenges with their Supplemental Nutrition Assistance Program (SNAP) benefits not being adequate to meet older adult needs, with one person sharing it's hard to get by on $23 a month.

Food Preparation

Another barrier that was discussed in a majority of forums was with regard to food preparation. There is a belief people do not have the skills or knowledge of how to prepare nutritious meals. In addition, people may also not have the time or the right equipment or space to prepare meals. Forum participants would like to see nutrition information in plain language and more culturally appropriate foods in their communities.

Forum participants also noted outside influences on food access and preparation, specifically the impact of corporations and marketing of convenient and processed foods, misinformation regarding food nutrition and health, and the "American diet."

Crosscutting Priorities

Poverty **Transportation**

Health Conditions & Outcomes

Health conditions and outcomes are the state of a person's health and well-being either as a current disease state, one that has been experienced, or the category of injury and death. These are at the downstream of the Bay Area Regional Health Inequities Initiative (BARHII) continuum (Appendix 1) and those that we ultimately hope to reduce and/or prevent through earlier changes in policies and systems, programs, and interventions at the upper stream levels. The following section outlines the top health conditions and outcomes priorities for Maine, findings from the assessment process, steps necessary to move from poverty to stability, and crosscutting priorities.

Maine Health Conditions & Outcomes	
Mental Health	**Chronic Conditions**

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Maine. It was identified as a top health conditions and outcomes priority in all 17 county stakeholder forums. For the purposes of the prioritization process, this includes topics such as: depression, anxiety, sad/hopeless, suicide, depression during pregnancy, and post-partum depression.

Assessment Findings

"Mental health issues" were the number one social concern negatively impacting Maine Shared CHNA survey respondents' communities and 73.6% of respondents said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about specific mental health needs, "anxiety or panic disorder," "depression," and "general stress of day-to-

day life" impacted respondents, their loved ones, and their communities, as detailed in Table 8: Mental Health Needs along with other mental health needs.

Table 8: Mental Health, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder	52.0%	58.9%	47.3%	1.9%	5.4%	2.1%
Depression	45.7%	58.1%	52.8%	2.0%	4.5%	2.4%
Bipolar disorder	7.8%	28.1%	39.6%	7.2%	21.2%	12.7%
Trauma or post-traumatic stress disorder (PTSD)	33.1%	39.2%	48.7%	4.5%	11.3%	6.5%
General stress of day-to-day life	63.9%	57.7%	55.8%	2.3%	5.0%	2.4%
Social isolation or loneliness	27.3%	37.5%	55.9%	4.2%	8.6%	5.7%
Stigma associated with seeking care for mental health or substance use disorders	17.5%	30.2%	54.9%	8.7%	13.7%	8.4%
Suicidal thoughts and/or behaviors	10.9%	27.2%	51.1%	6.4%	16.8%	11.0%
Youth mental health	13.8%	32.7%	56.1%	4.9%	11.2%	9.1%

Data shows as of 2021, 10.8% of adults in Maine reported current symptoms of depression and as of 2022, 26.3% reported depression in their lifetime. In Maine, 23.8% of adults reported ever having anxiety in their lifetime (2021). Table 9 shows these indicators by demographic. In the Maine Shared CHNA survey, 70.4% of survey respondents rate their own mental health as "good or excellent."

Table 9: Mental Health Indicators by Demographic (various years)

Demographic	Year(s)	Depression, current	Depression, lifetime	Anxiety, lifetime
American Indian or Alaskan Native	2012-2021	21.6%	33.7%	35.0%
Asian	2012-2021	12.3%	18.3%	16.2%
Black or African American	2012-2021	15.6%	17.2%	14.0%
Native Hawaiian or Other Pacific Islander	2012-2021	–	–	–
Two or More Races	2012-2021	19.8%	35.8%	34.1%
White	2012-2021	9.5%	23.1%	21.6%
Male	2021	10.0%	16.8%	16.4%
Female	2021	11.5%	30.0%	30.5%
Heterosexual	2011-15 & 2017-2021	9.5%	22.6%	20.5%
Gay or Lesbian	2011-15 & 2017-2021	17.2%	37.2%	32.3%
Bisexual	2011-15 & 2017-2021	23.6%	54.3%	51.7%
Something Else	2011-15 & 2017-2021	25.1%	44.5%	36.4%
Not Sure	2011-15 & 2017-2021	–	–	–
Less than high school diploma or equivalent	2021	20.5%	36.1%	33.1%
High school diplomate or equivalent	2021	13.3%	24.2%	24.5%
Some college or Associate's degree	2021	10.7%	25.0%	25.0%
Bachelor's degree or higher	2021	6.1%	18.6%	18.6%

Socialization & Isolation

"Social and community networks" was one of the top common needs identified in statewide focus groups and by interviewees across the state. Social and community networks were also identified as a primary need or priority in the Maine State Plan on Aging Needs Assessment (SPOA assessment). Older adults in the SPOA assessment specifically discussed socialization, saying they would like more designated areas, such as senior centers, in their communities to socialize, but noted these need to come with transportation options. Stakeholder forum participants also noted that a lack of transportation impacts a person's ability to access mental health care when resources exist. A Maine Shared CHNA focus group participant discussed the ways socialization is changing to be more on-line and through social media, which may mean older adults or those without broadband access miss important information. Forum participants believe loneliness, isolation, feelings of belonging and mattering, and a lack of community connections and support are contributing to mental health outcomes.

Stigma

In the veterans focus group and in key informant interviews there was a theme of internalized stigma which often prevents people from reaching for the services they may need including mental and behavioral healthcare. Participants in the veterans focus group shared mental and behavioral health concerns have a significant impact on their community and accessible care is essential for well-being. They discussed the difficulty in opening up to mental health providers who don't have the same experiences of having been in the military and that they would like to see more mental health providers who are veterans or understand the specific needs and experiences of veterans. Similar to the sentiments shared by veterans, forum participants also noted a particular stoicism and help yourself mentality that exists in Maine. Stigma was also discussed at the forums with regard to the general population, both as it relates to seeking mental health care and being diagnosed with a mental health disorder. Veterans did cite the positive work being done at Togus Veterans Affairs and the opening of a new residential treatment facility in Chelsea.

Youth Mental Health

In the youth focus group and in interviews with stakeholders who work with the youth population there was a shared concern about the mental health of young people. Concerns included public safety within communities and the implications of climate change on the future health and well-being of people living in Maine. As of 2023, 32.7% of middle school students felt sad or hopeless for two weeks in a row and 21.8% had seriously considered suicide, while 35% of high school students felt sad or hopeless for two weeks in arow and 17.8% of high school students had seriously considered suicide. These percentages vary by demographics as detailed in Table 10: Youth Mental Health by Demographic.

Table 10: Youth Mental Health by Demographic, 2023

	Middle School Students		High School Students	
Demographic	**Sad/Hopeless**	**Suicide**	**Sad/Hopeless**	**Suicide**
Maine	32.7%	21.8%	35.0%	17.8%
Hispanic	43.8%	34.2%	45.3%	26.1%
Non-Hispanic	32.8%	21.6%	34.7%	17.4%
American Indian or Alaskan Native	42.8%	35.4%	48.4%	24.1%
Asian	33.2%	25.7%	31.9%	17.5%
Black or African American	32.1%	22.1%	31.0%	16.1%
Native Hawaiian or Other Pacific Islander	28.1%	19.4%	44.6%	32.3%
Two or More Races	39.6%	30.7%	45.0%	26.7%
White	32.3%	21.1%	34.7%	17.4%
Male	20.7%	14.3%	24.2%	13.0%
Female	44.9%	29.0%	46.0%	22.6%
Heterosexual	25.7%	15.0%	26.2%	11.5%
Gay or Lesbian	67.0%	52.2%	59.2%	35.9%
Bisexual	62.6%	52.0%	62.8%	37.8%
Something Else	64.0%	50.4%	63.1%	38.7%

Forum participants specifically cited a lack of pediatric mental health care, resources that teach young people coping skills, and mental health resources for parents. A lack of pediatric supports may lead to the sentiments discussed by those in the young adult focus group – a particular concern about a lack of education or communication around mental health for their age group. One participant noted:

"I feel like growing up in the school systems, you're told you can get help with mental health, but they don't say where."

Mental Health Care Access

Participants in the county stakeholder forums discussed the lack of mental health providers and resources, and inaccessibility due to costs and insurance barriers. In 2022, for every psychiatrist there were 11,372 people. Some forum participants noted hospitals have had to take a larger role in mental health care, serving as stopgaps when other resources aren't available. Due to provider shortages and a lack of care, there are wait lists and waiting times to schedule appointments. In the Maine Shared CHNA survey, 39.4% of survey respondents say they or a loved one could not or chose not to get mental health care services in the past year, citing "long wait times to see a provider," "had health insurance, could not afford care," and "no evenings or weekend hours to receive care" as reasons why.

Contributing Factors & Root Causes to Mental Health

Several forums highlighted the impact of trauma, including generational trauma, adverse childhood experiences, and domestic violence on mental health, and the long-standing impacts of the COVID-19 pandemic. Community conditions were discussed as contributing to mental

health. These include poverty, low incomes, housing challenges, and food insecurity, all of which may mean people must choose between necessities and their mental health.

Socioeconomic Empowerment

Maine Shared CHNA survey respondents rated "mental health care and treatment" as the fourth of five "very necessary" steps to move someone from poverty to stability.

Crosscutting Priorities

Housing **Transportation** **Mental Health** **Poverty**

Provider Availability **Adverse Childhood Experiences**

Chronic Conditions (including, but not limited to cancer, cardiovascular disease, multiple chronic conditions, and obesity/weight status)

Chronic conditions were the second rated priority for the health conditions and outcomes category for Maine. A chronic condition was identified as a top health conditions and outcomes priority in 16 of the 17 county stakeholder forums – 6 prioritized cardiovascular disease, 5 obesity and weight status, 3 cancer, and 3 multiple chronic conditions (one forum prioritized two chronic conditions for a total of 17 priorities related to chronic conditions). For the purposes of the prioritization process, this includes but is not limited to priorities identified in the county stakeholder forums: cancer, cardiovascular disease, multiple chronic conditions, and obesity and weight status.

Assessment Findings

In the Maine Shared CHNA survey, three-quarters (75.7%) of survey respondents said "chronic health conditions" negatively impact them, a loved one, and/or their community. When asked about specific chronic health conditions, no one condition was dominant, but several impacted people, their loved ones, and their communities as detailed in Table 11: Chronic Health Conditions.

Table 11: Chronic Health Conditions, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Asthma, COPD, or Emphysema	21.0%	37.7%	33.7%	5.7%	11.2%	13.6%
Arthritis	33.9%	45.2%	27.8%	4.1%	11.1%	8.7%
Cancer	10.9%	44.1%	43.2%	4.3%	9.1%	12.1%
Diabetes or high blood sugar	17.2%	44.9%	40.0%	4.2%	8.1%	9.9%
Heart disease or heart attack	10.1%	39.9%	37.6%	5.3%	12.6%	12.9%
High cholesterol	26.3%	43.6%	29.8%	5.1%	12.2%	10.1%
High blood pressure or hypertension	28.9%	52.0%	33.1%	3.4%	8.4%	7.2%
Overweight/obesity	44.3%	46.8%	47.4%	3.2%	4.4%	6.3%
Stroke	3.6%	21.4%	29.5%	9.5%	20.8%	21.7%
Chronic liver disease/cirrhosis	3.6%	12.7%	25.5%	11.2%	27.1%	24.6%

Related to the conditions identified in the Maine Shared CHNA survey, quantitative data shows:

- In 2022, 33.1% of adults in Maine were obese.
- In 2022, there were 211.1 cardiovascular disease deaths for every 100,000 people, significantly better than the U.S. (231.8 per 100,000, 2021).
- In 2022, there were 23.6 heart attack deaths for every 100,000 people.
- As of 2019, 35.4% of people in Maine had high cholesterol, significantly worse than the U.S. (33.1%).
- In 2022 there were 153.8 cancer deaths for every 100,000 people.
- In 2021 there were 483.2 new cancer cases for every 100,000 people.
- As of 2021, 16.7% of Maine people had three or more chronic conditions.

The same indicators are broken down by ethnicity and race in Table 12: Chronic Conditions by Ethnicity and Race, demonstrating the variability of chronic conditions within these populations.

Table 12: Chronic Conditions by Ethnicity and Race

Demographic	Cardiovascular Deaths per 100,000 (2014-2022)	Heart Attack Deaths per 100,000 (2014-2022)	High Cholesterol (2011, '13, '15, '17, '19)	Cancer Deaths per 100,000 (2014-2022)	New Cancer Cases per 100,000 (2012-2021)	Three or More Chronic Conditions (2012-2021)
Maine	197.9	25.3	38.3%	164.6	478.4	15.5%
Hispanic	55.5	8.5	31.3%	67.9	260.5	10.4%
Non-Hispanic	199.0	25.4	38.3%	165.3	480.2	15.5%
American Indian or Alaska Native	181.3	33.9	38.3%	186.1	435.3	28.7%
Asian	84.1	11.9	__	69.8	__	2.6%
Black or African American	159.5	14.9	29.5%	127.1	341.1	7.1%
Native Hawaiian or Other Pacific Islander	762.3	42.9	__	581.9	__	__
Two or More Races	71.5	11.3	40.8%	79.4	477.4	23.8%
White	199.2	25.5	38.4%	165.6	477.4	15.4%

Additionally, as of 2021, people with less than a high school diploma were twice as likely (33.5%) to have three or more chronic conditions compared to the general population (16.7%), as were those making $0-$15,000 (41.1%) and $15,000-$24,999 (33.5%) and those on MaineCare (27.1%) and Medicare (30.0%)

Health Care Costs

In the Disability Rights Maine assessment (DRM assessment), one survey respondent noted how the cost of treatment could dissuade individuals from seeking care:

"I wish it was more affordable to all in this country, as many people, me included, are hesitant to use these services as they cost so much, even for a simple visit to answer a question or get a diagnosis."

The impact of poverty, low incomes, and insurance access were also discussed as barriers to receiving preventative care and managing conditions when diagnosed with a chronic condition by forum participants.

Provider Access & Communication

Forum participants discussed a lack of primary care providers leading to a decrease in prevention and early detection. Forum participants do not believe there is enough time at primary care visits, offices are not always accessible to people with disabilities, nor are they always trained in cultural and linguistic care or offer a diverse workforce. When care does exist, the distance to care, especially for the rural areas of the state and those areas that lack specialists, and a lack of transportation impact a person's ability to access both preventative visits and care after a diagnosis.

Another DRM assessment participant noted how important communication between healthcare providers and patients is, noting it is essential for a mutual understanding of health concerns, diagnoses, and treatments, specifically for those who are deaf or hard of hearing. In addition, a lack of accommodating medical equipment and accessible waiting and exam rooms can impede or prevent adequate care.

Obesity & Weight Status

In the Maine Shared CHNA survey, "obesity" was identified by survey respondents as the fifth of five social concerns negatively impacting their community. Access to nutritious foods and physical activity were dominant themes in the county stakeholder forums who prioritized cardiovascular disease and obesity and weight status. They discussed the impacts of diets and a lack of nutrition, food deserts, the cost of food, a lack of nutrition education, cooking skills, and time constraints. With regard to physical activity, forum participants noted a general lack in physical activity and sedentary lifestyles, the impact of social media and screens, impacts of the built environment and accessibility of outdoor activities, including a lack of public parks, a decrease in participation in youth sports, and the cost of engaging in physical activity. In 2021, 26.5% of adults in Maine reported a sedentary lifestyle, significantly worse than the U.S. (23.7%). In 2021, 50.1% of high school and 56.6% of middle school students met physical activity recommendations. Table 13: Adult Obesity by Ethnicity and Race show the variation in obesity rates by ethnicity and race.

Table 13: Adult Obesity by Ethnicity and Race

Demographic	Obesity (2012-2021)
Maine	29.9%
Hispanic	28.7%
Non-Hispanic	29.9%
American Indian or Alaskan Native	35.5%
Asian	11.6%
Black or African American	29.4%
Native Hawaiian or Other Pacific Islander	–
Two or More Races	32.8%
White	30.0%

Contributing Factors & Root Causes to Chronic Conditions

Forum participants also discussed substance use as a contributing factor to chronic conditions, specifically tobacco and alcohol use, both for cardiovascular disease and cancer. As of 2022, 15% of adults in Maine currently smoked cigarettes. In Maine, 7.9% of Maine adults engaged in chronic heavy drinking (2022), significantly worse than the U.S. (6.3%, 2021) and 15.4% of adults reported binge drinking (2022). Stress was also highlighted as a factor, specifically for cardiovascular disease.

Crosscutting Priorities

Nutrition **Transportation** **Substance Use** **Mental Health**

Poverty

Appendices

Appendix 1: Methodology

The Maine Shared Community Health Needs Assessment conducted a multiprong health and well-being assessment, including the collection and analysis of quantitative and qualitative data. The following methodology section outlines this effort.

Data Commitments

The Maine Shared CHNA uses a set of data stewardship guidelines to ensure data is collected, analyzed, shared, published, and stored in a transparent and responsible manner. Included in these guidelines is a commitment to promote data equity in data collection, analyses, and reporting. These guidelines include a commitment to:

- Correctly assign the systemic factors that compound and contribute to health behaviors and health outcomes rather than implying that social or demographic categories are "causes" of disparities. We will use a systems-level approach when discussing inequities to avoid judging, blaming, and/or marginalizing populations.
- Lead with and uplift the assets, strengths, and resources when discussing populations and communities, specifically with qualitative data collection.
- Acknowledge missing data and data biases and limitations.
- Identify and address important issues for which we lack data.
- Share data with communities affected by challenges, including sharing analysis, reporting and ownership of findings.

Quantitative Data

Data Criteria

The Metrics Committee, one of two standing committees of the Maine Shared CHNA, is charged with reviewing and revising a common set of population and community health and well-being indicators and measures every three years. Each cycle, the following criteria are used to guide an extensive review of the data:

- Describes an existing or emerging health issue;
- Describes one or more social drivers of health (SDOH);
- Describes the people in Maine;
- Measures an issue that is actionable;
- Describes issues that are known to have high health and/or social costs;
- Collectively provide for a comprehensive description of population health;
- Aligns with national health assessments (i.e.: County Health Rankings, American Health Rankings, Healthy People);
- Aligns with data previously included in Maine Community Health Partnership Assessments;
- Aligns with data routinely analyzed by the Maine CDC for program planning, monitoring, and evaluation;
- Have recent data less than two years old or have updates coming; and/or
- Were previously included, allowing for trends to be presented.

Additionally, the Metrics Committee, Maine CDC, and Crescendo Consulting Group (the 2024

Maine Shared CHNA vendor) reviewed the data to check for changes in data sources and definitions, potential new sources of data, and any discrepancies or errors in the data.

Data Profiles & Interpretation

The data profiles provide more than 250 health and well-being indicators that describe demographics, health outcomes and behaviors, and conditions that influence our health and well-being. The number of indicators available vary between counties, urban areas, and health equity profiles based on data availability and other data limitations, discussed below. The data come from more than 30 sources and represent the most recent information available and analyzed as of November 2024. Data from several years is often combined to ensure the data is reliable enough to draw conclusions. County comparisons are made in several ways: between two time periods; to the state; and to the U.S. The two time periods can be found within the tables under columns marked, "Point 1" and "Point 2." The majority of comparisons are based on 95% confidence intervals. In some instances, a 90% confidence interval is calculated from a Margin of Error and is noted with a "#" symbol. Confidence intervals may be determined using various methodologies (e.g. using weighting in calculations), resulting in a more narrow or wide margin of error and impacting the frequency of statistically significant differences. A 95% confidence interval is a way to say that if this indicator were measured over and over for the same population, we are 95% confident that the true value among the total population falls within the given range/interval. When the confidence intervals of two measurements do not overlap, the difference between them is statistically significant. Where confidence intervals were not available, no indicator of significant difference is included. A list of indicators, data sources, and definitions can be found in the appendix of each County Health Profile and is available on the Maine Shared CHNA website.

Data Limitations, Gaps, & Considerations

Quantitative data collection and analysis has several benefits, including the ability to see health and well-being trends over time. The Maine Shared CHNA draws on many data sets at the state and national level. Some of these include self-reported surveys while others are reports of health and well-being care and utilization rates. Each methodology has its own advantages and disadvantages, and both have limitations in response options and sample sizes. Additionally, some quantitative data representing the same indicators may be slightly different due to the source of the data and the methods used for interpretation. For example, this occurs with death data from the Maine's Data, Research, and Vital Statistics database versus the U.S. CDC's WONDER database.

The data sets used by the Maine Shared CHNA generally follow federal reporting guidelines and responses for race, ethnicity, sexual orientation, and gender identity, which may not encompass nor resonate with everyone and leave them without an option that represents their identity. Additionally, for some demographics, the numbers may be too small to have data disaggregated at certain levels, specifically the city and county level. Small sample sizes may pose the risk of unreliable or identifiable data. Both a lack of comprehensive response options and small sample sizes can lead to a gap in data analysis and reporting and leave some populations and communities underrepresented or missing entirely. The Maine Shared CHNA generally relies on state-level data and aggregation of multiple years of data for more reliable estimates with less

suppression. This implies an assumption that disparities found at the state level have similar patterns for smaller geographical areas, which does not account for the unique characteristics of populations throughout the state.

These data limitations may result in programming and policies that do not meet the needs of certain populations. To try to account for some of these gaps and complement the quantitative data, the Maine Shared CHNA engaged in an extensive community engagement process. That process and the results are outlined in the Community Engagement Overviews.

Specific data changes and limitations relevant to the 2024 Maine Shared CHNA data analysis are further described below.

Data Changes

This cycle brought a number of new indicators to the data set with the addition of the Maine Community Action Partnership to the Maine Shared CHNA collaborative, specifically related to social drivers of health. Social drivers of health (SDOH) are conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Previous versions of the Maine Shared CHNA have used the term social determinants of health to capture that same type of data. These and other changes were made based on currently available data and reviews by the Metrics Committee, Maine CDC, and Crescendo Consulting Group (the Maine Shared CHNA vendor). New, retired, and paused indicators are listed at the end of each County Health Profile.

Data Discrepancies

COVID's Impact

The COVID-19 pandemic impacted health and well-being behaviors, utilization of health care, and health and well-being outcomes, among other things that have created long-lasting impacts across Maine. These impacts are now being reflected in a multitude of data sets from roughly 2020 through 2023. In most cases, more recent, post-pandemic data is not yet available. Rather than exclude data collected during the pandemic, unless advised by the data source, we encourage readers to interpret data collected during the pandemic with this context in mind and that it may not be representative of a non-pandemic year.

Health Equity Profiles

The Maine Shared CHNA highlights populations and geographies that experience disparate health and well-being outcomes due to social, institutional, and environmental inequities through a community engagement process and health equity data profiles. Due to limitations in data availability and capacity of Maine Shared CHNA partners, health equity profiles on rurality and disability status will not be ready until early 2025. Additionally, some health equity profiles may include fewer indicators than others given data availability, suppressed data rates, and what is and is not collected at the state and national level. As noted above, disparities are generally only analyzed at the state level. The Maine Shared CHNA website and dashboard will be updated as data is available and analyzed.

Qualitative Data

In order to begin to understand how people interact in their communities and with the systems, policies, and programs they encounter we must build relationships and engage in ways that are mutually beneficial. By drawing on narrative and lived experience we are better positioned to identify the root causes of health and well-being behaviors and outcomes. Qualitative data, resulting from community engagement, provides an important context for the health and well-being outcomes and trends contained in the numbers. In combination, qualitative and quantitative data produce a broader picture of what a community is experiencing and enable a more thorough and well-rounded approach to program and policy development. The Maine Shared CHNA recognizes the need to collaborate with communities to build relationships and trust to more respectfully, transparently, and meaningfully work together in an effort to continuously improve upon our community engagement processes.

The Community Engagement Committee, one of two standing Committees of the Maine Shared CHNA, is charged with developing a framework for engaging and building relationships with populations and communities to gain a better understanding of their health and well-being strengths, needs and underlying causes of health and well-being behaviors and outcomes. The Maine Shared CHNA's community engagement included: focus groups, key informant interviews, and a statewide community survey.

Considerations for Identifying Populations to Engage With

The Maine Shared CHNA takes a broad approach to assessing health and well-being throughout the state. While we have attempted to reach many populations who have disparate health and well-being experiences and outcomes, some choices about which groups to include were necessary. We recognize that for many people, their lives and their health is affected by multiple aspects of their identity and lived experiences or their "intersectionality." We attempted to recognize participants' intersectionality by asking them to voluntarily share any other identities they may have. The totality of focus group participants also identify as: a Tribal member, older adults, Non-English speaker, immigrant, asylee, migrant, Latino/Latine/Latinx, residents of rural, urban, and suburban areas, people with substance use disorder, people with mental health disorder, members of the disability community, people who are deaf or hard of hearing, people who are incarcerated or formerly incarcerated, people who are unhoused or experiencing homelessness, and caregivers, in addition to the targeted populations listed below. It should be noted the voices we hear in focus groups are not meant to be representatives of their entire identified population or community.

This cycle, the Community Engagement Committee developed considerations to use to identify populations for focus group engagement. The considerations included whether each population:

- Is medically underserved;
- Is historically not involved in CHNA processes;
- Is negatively impacted by structural determinants of health – "the written and unwritten rules that create, maintain, or eliminate…patterns of advantage among socially constructed groups in the conditions that affect health, and the manifestation of power relations in that people and groups with more power based on current social structures

work to maintain their advantage by reinforcing or modifying these rules;"[xi]
- Experiences intersectionality (the interconnection and impact of multiple identities on a person's life); and/or
- Includes participants ability to gather in-person or virtually.

The Community Engagement Committee also considered the willingness and ability of potential partner organizations to assist with recruitment; whether potential partner organizations represent multiple populations and sectors; and the ability to recruit a minimum number of participants for each focus group.

Considerations for the Use of Other Assessments

The Maine Shared CHNA recognizes communities are often overburdened by outside organizations as those organizations seek to learn about health and well-being strengths, resources, and needs. Additionally, with multiple organizations conducting assessments, the Maine Shared CHNA seeks to reduce duplicative work and partner with other organizations to learn from their assessments as opposed to assessing the same Maine communities multiple times. As such, the following criteria were established to identify potential organizations to collaborate with and use aspects of their research:

- The outside organization is agreeable to sharing their needs assessment information, both published reports and any additional data collected.
- For assessments in process or results that will not be completed on time, the outside organization is agreeable to sharing their work in progress.
- The needs assessment is less than two years old.
- The content of the assessment is similar enough to the Maine Shared CHNA for integration of results into Maine Shared CHNA reports.
- All reports/assessments used will be given attribution and referenced in the Maine Shared CHNA reports.
- The organization that conducted the needs assessment is willing to engage to share their assessment process/methodology, outcomes, and any updates from when the original assessment occurred.

Using these criteria, the Maine Shared CHNA identified two other assessments to use as part of our assessment. The assessments enabled us to learn about the assets, resources, needs and challenges of the older adult population and the disability community. These assessments are the Maine State Plan on Aging Needs Assessment, prepared by the Catherine Cutler Institute University of Southern Maine for the Office of Aging and Disability Services in January 2024 and Disability Rights Maine's "I Don't Get the Care I Need:" Equitable Access to Health Care for Mainers with Disabilities published in Spring 2023.

Focus Groups

Using the criteria listed above, the Maine Shared CHNA ultimately identified the following populations for community engagement through state level focus groups. The listing also includes the number of participants for each focus group:

- Statewide Focus Group Participants: 31 (total)

- Multigenerational Black / African American: 12
- Veterans: 7
- LGBTQ+: 5
- Women: 1
- Youth: 3
- Young Adults: 3

As part of the Community Services Block Grant reporting, the Community Action Agencies are required to engage directly with the communities they serve, namely those of lower income. To meet this requirement, the Maine Shared CHNA hosted local focus groups with people with low-income in each Maine County, conducting two focus groups in Aroostook, Cumberland and Penobscot Counties to account for variation in the population and geography of these counites. These focus groups also provide important information and insights to the experiences of people at the county level. The following is a list of counties with the number of participants for each of the counties' focus groups.

- County Focus Group Participants: 93 (total)
  - Androscoggin: 5
  - Aroostook: 12
  - Cumberland: 19
  - Franklin: 4
  - Hancock: 3
  - Kennebec: 3
  - Knox: 6
  - Lincoln: 2
  - Oxford: 10
  - Penobscot: 10
  - Piscataquis: 1
  - Sagadahoc: 0
  - Somerset: 7
  - Waldo: 3
  - Washington: 3
  - York: 5

Key Informant Interviews

The Maine Shared CHNA completed 25 key informant interviews to gather in-depth insights from individuals with specialized knowledge or experience relevant to community health and well-being issues. These interviews involved engaging stakeholders, including health care providers, community leaders, and community-based organization representatives, to discuss their perspectives on local health and well-being needs, barriers to achieving optimal health and well-being, and potential solutions. The findings from key informant interviews may be combined when similar themes exist.

Key informant interviews help identify priority health and well-being concerns, assess the effectiveness of existing services, and uncover gaps in resources. This information is crucial for developing targeted interventions and strategies that address the unique needs of the community, ensuring that any resulting action plans are informed by local expertise and grounded in real-world experiences.

The following is a list of organizations that participated in the key informant interviews.

- Alliance for Addiction and Mental Health Services
- Children's Oral Health Network
- Community Caring Collaborative
- Disability Rights Maine
- Governor's Office of Policy Innovation and the Future
- Leadership Education in Neurodevelopmental & Related Disabilities
- Maine Center for Disease Control and Prevention
- Maine Children's Alliance
- Maine Conservation Alliance
- Maine Council on Aging
- Maine Emergency Management Agency
- Maine Housing
- Maine Mobile Health Program
- Maine Prisoner Re-Entry Network
- Mid-Coast Veterans Council
- Moving Maine
- Unified Asian Communities
- Volunteers of America Northern New England

Statewide Community Survey

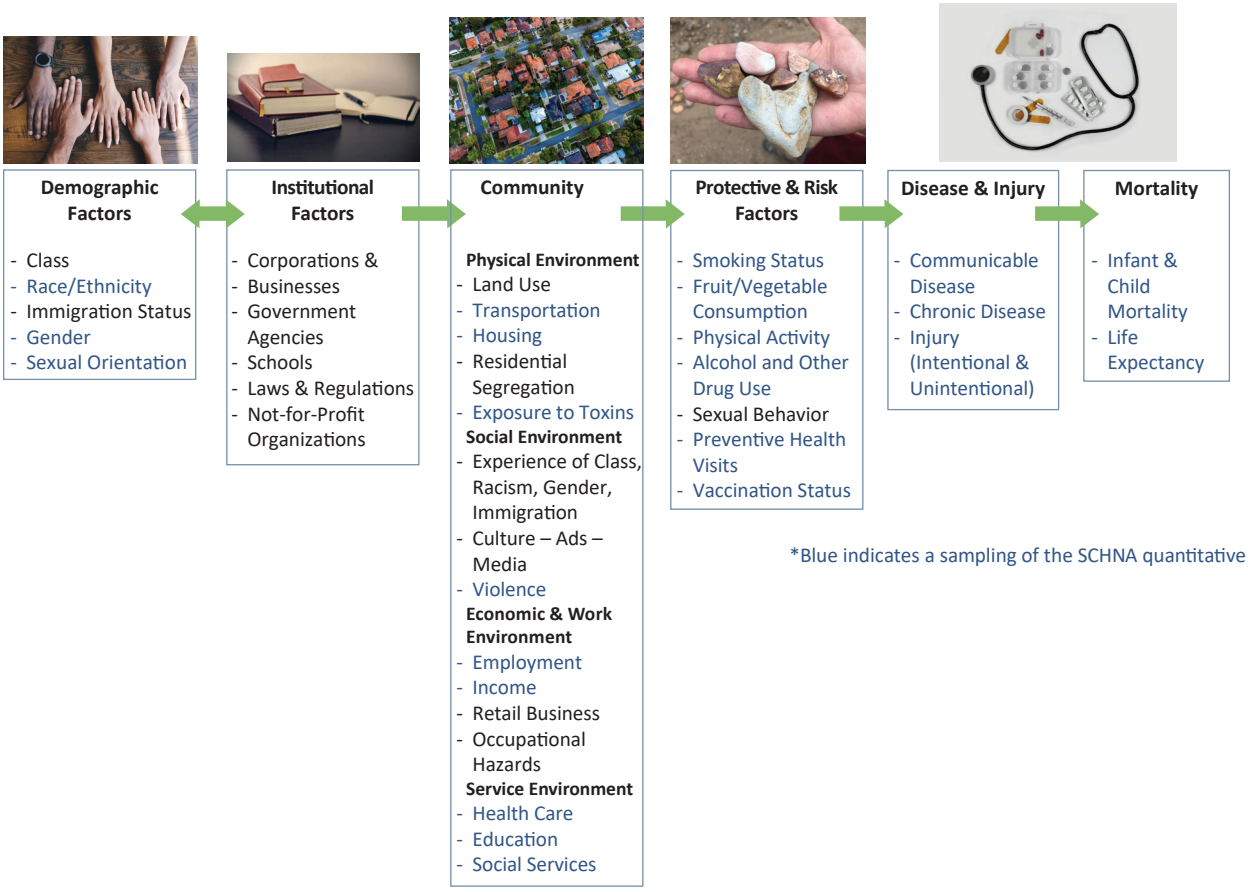
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, with final approval by the Steering Committee. The survey was translated and made available in eight languages: Arabic, Chinese, English, French, Lingala, Portuguese, Somali, and Spanish. It was distributed statewide with assistance from Maine Shared CHNA partners via multiple methods including newsletters, flyers, listservs, announcements, and social media (materials were available in formats compatible with Facebook and Instagram). Flyers and social media content were available in the eight languages of the survey. The survey was available electronically via SurveyMonkey and in paper format. The survey was open to anyone living in Maine and respondents were asked to complete 40 questions related to the local resources and strengths of their communities and their own health and well-being and that of those who live in their community. The survey was not weighted and should not be considered a representative sample of the Maine Population or of sub-populations within Maine.

3,967 people completed the survey providing their insights on the health and well-being status, community assets, and social concerns. The majority of surveys were completed in English (98%), 1% were in Chinese and less than .5% were completed in French, Spanish, Arabic, Lingala, Portuguese, and Somali.

Bay Area Regional Health Inequities Initiative (BARHII) Framework

The impact of upstream factors on health and well-being continues to draw awareness and be incorporated into assessments and improvement planning as critical components of a person's ultimate health and well-being. Upstream factors of health are the social, institutional and community conditions that impact health and well-being and can be used to promote quality of life and prevent poor health and well-being outcomes – the downstream factors of health. The Maine Shared Community Health Needs Assessment based this cycle's assessment and health and well-being prioritization process on an adapted version of the Bay Area Regional Health Inequities Initiative (BARHII) Framework[xii] (Figure 1). The BARHII Framework explains the connections between upstream factors on health and well-being outcomes and focuses attention on measures which have not characteristically been within the scope of public health epidemiology.[xiii] Use of this framework enables a greater connection to the work of the Maine Shared CHNA's newest partner, the Maine Community Action Partnership, and the varying levels within which all of the collaborative and community partners of the Maine Shared CHNA can potentially have an impact. Additionally, it provides a framework with which to group the myriad health and well-being topics our community members and stakeholders are asked to share insight on and prioritize within their counties. Instead of comparing all of the health and well-being topics against each other, this Maine Shared CHNA aimed to prioritize topics within their best fit categories, while recognizing the interconnections upstream and downstream factors have with each other. In this way, the Maine Shared CHNA hopes to convey how the health and well-being priorities are related and influence one another, shedding light on potential opportunities for collaboration and cross sector work.

Figure 1: Bay Area Regional Health Inequities Initiative Framework (adapted)



Stakeholder Forums

Seventeen forums were conducted in each of Maine's Counties, with two held in Cumberland County. These forums were organized by Local Planning Teams, including the development of invitation lists. The aim of the invitation method was to include a broad and equal array of diverse sectors and voices, specifically those who are required as part of the signatory partners reporting and accreditation standards. Community members were not necessarily included in the forums this cycle as their voices were captured through other community engagement methods. Five of the forums were conducted virtually and 12 were conducted in-person. Each forum used the same methodology, including pre-forum voting on the top 15 health and well-being priorities for their county – five in each category: community conditions, protective & risk factors, and health conditions & outcomes -; a presentation of key findings and voting results and accompanying breakout to discuss those findings; a second round of prioritization voting to narrow the priorities to the top 3 in each category; and iterative breakout discussions to dive deeper into each priority – it's causes, collaborations, populations impacted, and assets and resources. Crescendo Consulting Group summarized the voting results and discussions in key forum findings documents for use in developing each county's Maine Shared CHNA report. The key findings are from a point in time discussion based on the expertise and opinions of those who participated in the forum, which is not necessarily representative of any county, community, or sector as a whole.

Reporting

The Maine Shared CHNA assessment reports will be used to fulfill the Internal Revenue Service (IRS) requirements for non-profit hospitals, the Public Health Accreditation Board (PHAB) requirements for state and local public health departments, and the Community Services Block Grant (CSBG) requirements for Community Action Agencies (CAAs). The next steps include:

- For hospitals, create an informed implementation strategy designed to address identified health and well-being priorities.
- For the Maine CDC and local public health departments, create an informed State Health Improvement Plan and Community Health Improvement Plans.
- For Maine CDC convened District Coordinating Councils, inform stakeholder discussions and planning at the local level, as relevant and applicable.
- For Community Action Agencies, develop informed strategic and programmatic plans to address the identified health and well-being priorities and their impact on those in poverty.

The use of these reports is also encouraged and welcomed by non-profits, community partners, academics, policymakers, businesses, and countless others to support their strategic planning, coalition building, and grant writing. The Maine Shared CHNA sought to learn who is currently working on the priorities outlined within this report and hopes the report can serve as a catalyst for deeper collaboration to improve the health and well-being of people living in Maine.

Appendix 2: Other Identified Health and Well-Being Topics

The Maine Shared Community Health Needs Assessment Steering Committee chose the health and well-being priorities for Maine based on quantitative and qualitative data, the county stakeholder forum prioritization process, and their own knowledge, expertise and experience. The following table depicts the priorities that were identified in the county forums but were not selected by the Steering Committee. Although Substance Use Related Injury and Death was a top priority among counties, the Steering Committee chose to prioritize Substance Use under the Protective and Risk Factors category as a catchall for all substance use related priorities.

Table 1: Other Identified Health and Well-Being Priorities

Community Conditions	Total Number of Counties
Aging Related Services	**2**
Child Care	**2**

Protective and Risk Factors	Total Number of Counties
Youth Mattering	**4**
Physical Activity	**2**
Adult Screening & Preventive Visits	**2**
Cancer Prevention	**1**
Community Mattering	**1**
Preventive Oral Care	**1**
Patient Education	**1**

Health Conditions and Outcomes	Total Number of Counties
Substance Use Injury and Death	**15**
Access to Long Term Care	**1**
Special Health Care Needs	**1**

Appendix 3: Maine Shared CHNA Partners & Service Areas

Maine Shared CHNA Partner Missions

Central Maine Healthcare

Central Maine Healthcare is an integrated healthcare delivery system serving 400,000 people living in central, western, and mid-coast Maine. CMH's hospital facilities include Central Maine Medical Center in Lewiston, Bridgton Hospital, and Rumford Hospital. CMH also supports Central Maine Medical Group, a primary and specialty care practice organization with a presence in 17 Maine communities. Other system services include the Central Maine Heart and Vascular Institute, a regional trauma program, LifeFlight of Maine's southern Maine base, the Central Maine Comprehensive Cancer Center, and other high quality clinical services.

MaineGeneral Health

MaineGeneral Health is an integrated, nonprofit health care system serving the Kennebec Valley community. MaineGeneral is the third largest health system in Maine and largest non-government employer in the Kennebec Valley with a mission to enhance, every day, the health of our patients, our families and our communities. MaineGeneral operates a 198-bed, state-of-the-art hospital: the Alfond Center for Health in Augusta; and the largest comprehensive outpatient center in the state: the Thayer Center for Health in Waterville. MaineGeneral includes a regional cancer center, primary care and specialty physician practices, long-term care facilities, rehabilitation, home health care and hospice services, specialized care for people with memory loss and community outreach programs.

MaineHealth

MaineHealth is a not-for-profit, integrated health system whose vision is, "Working together so our communities are the healthiest in America," and is committed to a mission of providing high-quality affordable care, educating tomorrow's caregivers and researching better ways to provide care. MaineHealth includes a Level 1 trauma medical center, eight additional licensed hospitals, comprehensive pediatric care services, an extensive behavioral health care network, diagnostic services as well as home health, hospice and senior care services. With more than 2,000 employed providers and approximately 24,000 care team members, MaineHealth provides preventive care, diagnosis and treatment to 1.1 million residents in Maine and New Hampshire.

The MaineHealth system includes MaineHealth Behavioral Health at Spring Harbor, MaineHealth Franklin Hospital, MaineHealth Lincoln Hospital, MaineHealth Maine Medical Center, MaineHealth Memorial Hospital, MaineHealth Mid Coast Hospital, MaineHealth Pen Bay Hospital, MaineHealth Stephens Hospital, MaineHealth Waldo Hospital, MaineHealth Barbara Bush Children's Hospital, MaineHealth Care at Home, the MaineHealth Institute for Research, the MaineHealth Medical Group and MaineHealth NorDx. MaineHealth affiliates include Maine General Health and St. Mary's Health System. Joint venture partners include New England Rehabilitation Hospital of Portland. MaineHealth is also a significant stakeholder in the MaineHealth Accountable Care Organization. The Leapfrog Group has recognized several of MaineHealth's community hospitals as Top Rural Hospitals and consistently awarded strong Hospital Safety Grades to its larger hospitals, contributing to Leapfrog's naming Maine as the Leapfrog Top State of the Decade for Patient Safety. The Maine hospitals are all Breathe Easy Gold Star Standard of Excellence recipients at the Platinum level. The quality of MaineHealth's care is also reflected in accreditations from the Joint Commission and recognitions in Becker's Healthcare and U.S. News and World Report.

Northern Light Health

At Northern Light Health, we're building a better approach to healthcare because we believe people deserve access to care that works for them. As an integrated health delivery system serving Maine, we're raising the bar with no-nonsense solutions that are leading the way to a healthier future for our state. Our care team—in hospitals, primary and specialty care practices, long-term and home healthcare, behavioral healthcare, and ground and air medical transport and emergency care—are committed to making healthcare work for you: our patients, communities, and employees. Northern Light Health member hospitals include: Northern Light Acadia, Northern Light AR Gould, Northern Light Blue Hill, Northern Light CA Dean, Northern Light Eastern Maine Medical Center (EMMC), Northern Light Inland, Northern Light Maine Coast, Northern Light Mercy, Northern Light Mayo, and Northern Light Sebasticook Valley.

Maine Center for Disease Control and Prevention

Maine Center for Disease Control and Prevention (Maine CDC) is an office of the Maine Department of Health and Human Services, whose mission is to protest and promote the health and well-being of the people of Maine. Accredited by the Public Health Accreditation Board (PHAB), Maine CDC, in partnership with public health institutions in the state, participated in the development of the Maine Shared Community Health Needs Assessment. Maine CDC led the development of the Maine 2024–2029 State Health Improvement Plan, a collaborative framework for ensuring all people in Maine have a fair and just opportunity to attain their highest level of health, which is informed by the Maine Shared CHNA.

Maine Community Action Partnership

Maine Community Action Partnership (MeCAP) is a statewide organization dedicated to improving the quality of life of Maine citizens by advocating for, enhancing and supporting the work of Maine CAAs. Each of Maine's ten CAAs is rooted in the communities within which it serves, collectively touching the lives of approximately 140,000 clients. Each individual CAA has developed a mission statement and program focus areas specific to its organization and service area through community needs assessments. The unifying thread weaving the CAAs together is the strategic effort to improve the quality of life, health, and social and economic mobility of Maine's most vulnerable people -- specifically targeting Maine's low and very low-income people.

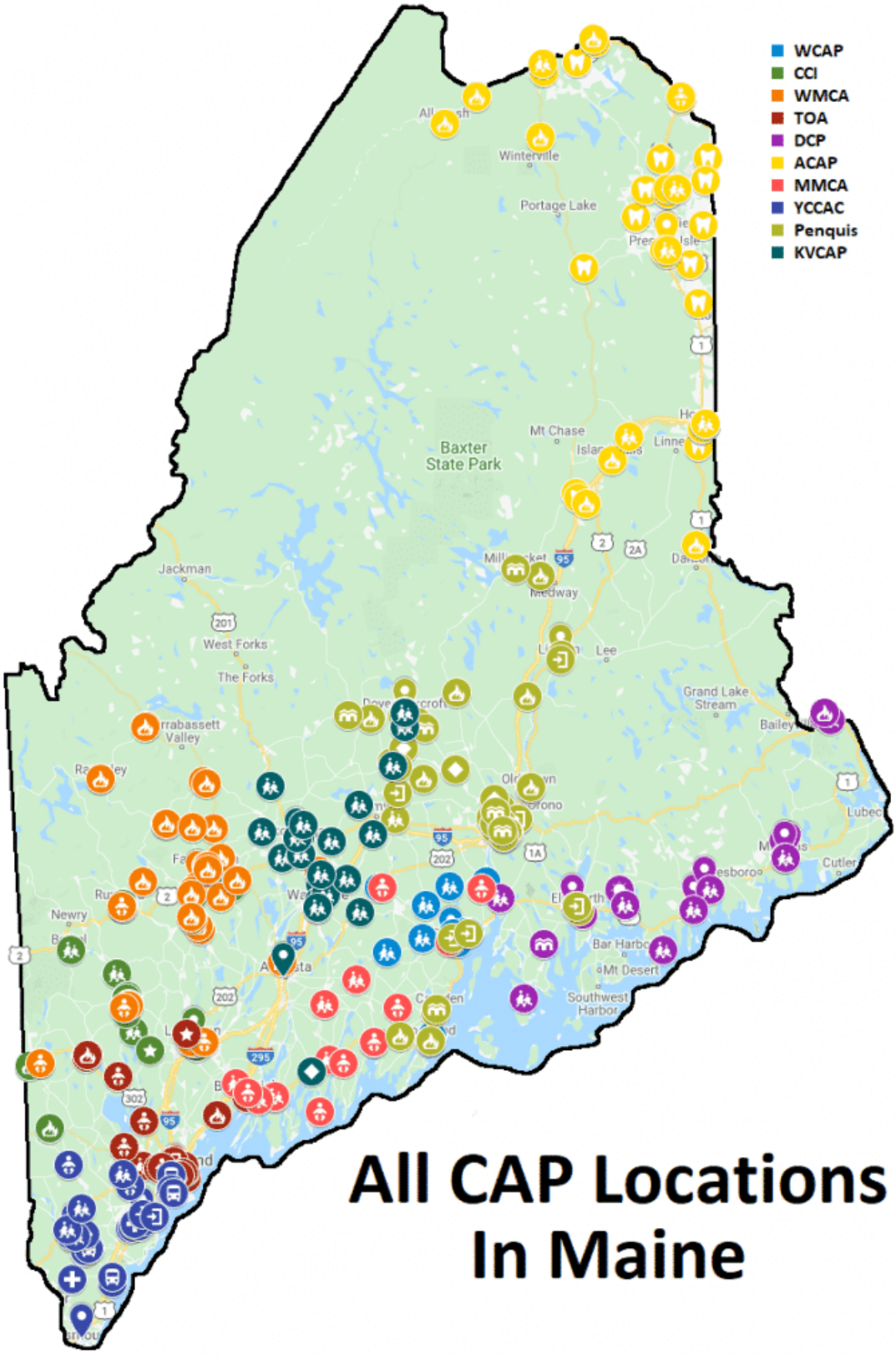
Maine Shared CHNA Partner Reporting Requirements

The community needs assessment fulfills federal Accountable Care Act (ACA)/Internal Revenue Service (IRS) reporting requirements for health systems, Community Services Block Grant (CSBG) reporting requirements for the Community Action Programs (CAPs), and public health accreditation requirements for the MeCDC through the Public Health Accreditation Board (PHAB). Below is a list of common requirements that inform the Maine Shared CHNA:

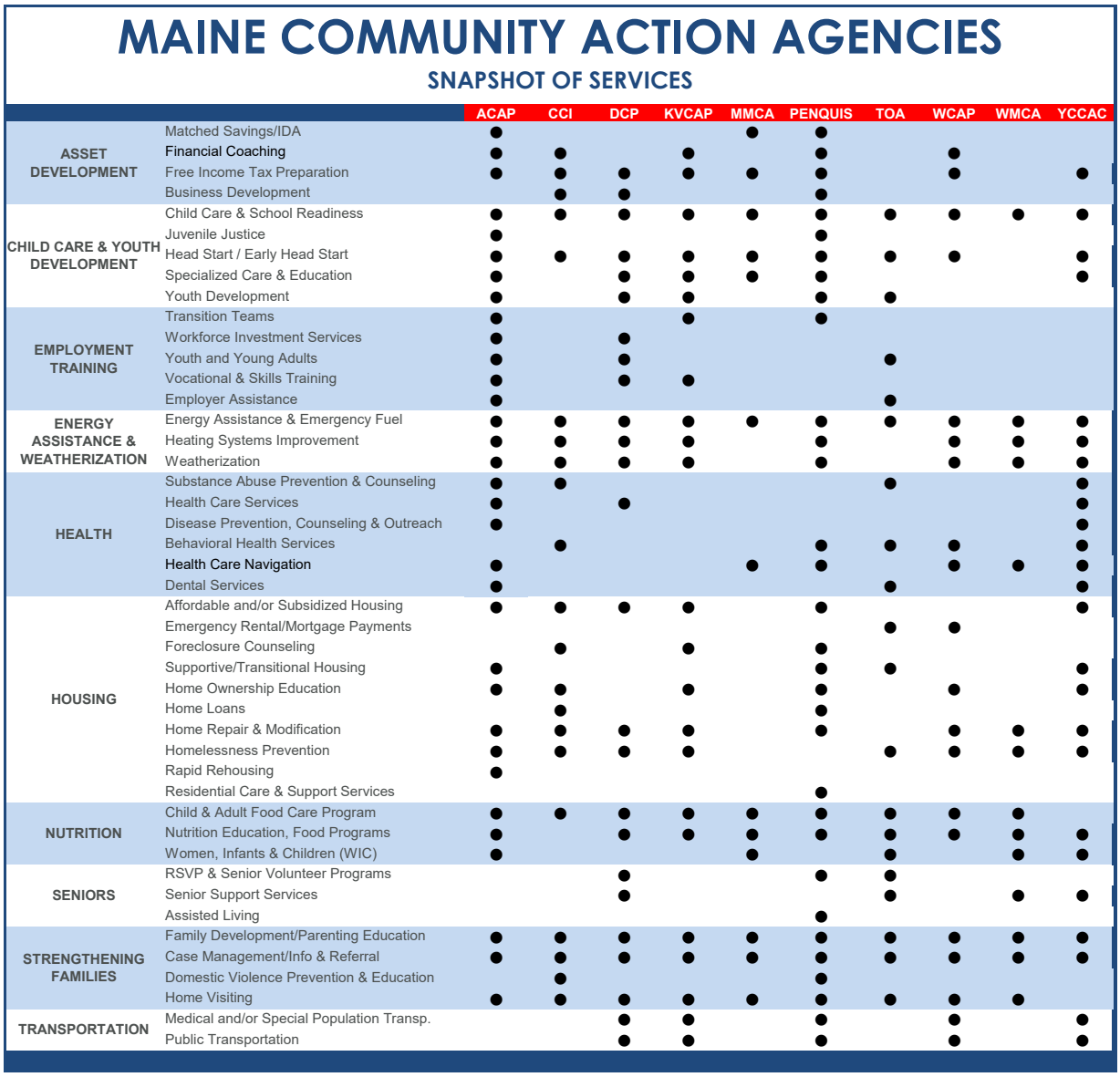
Timing	At least every 3 years. This is the 5th triennial effort (2010, 2015-2016, 2018-2019, 2021-2022, and now 2024-2025).
Collaboration	For PHAB and CSBG: collaboration required For ACA/IRS: collaboration highly encouraged
Service Area	This combined effort involves the entire state. This includes hospital service areas, Public Health Districts, and the Community Action Partnership network. The service areas are outlined below this table.
Partners	Must include input from: • Public Health professionals • Government • Public Health department staff • Medically underserved or organizations who serve them • Low income population and organizations who serve them • Minority populations or organizations who serve them • Faith based organizations • Educational institutions • Community based organizations • Private sector • Public sector
Requirements	• Assess and prioritize top health issues • Compile potential community resources to address health priorities • Lists gaps and or barriers to overcoming identified health priorities • Describe the local challenges in the social determinants of health • Describe the health surveillance system (PHAB) • Include description and examples of how data is being used (PHAB) • Collect comments of previously adopted health improvement plans
Process	The assessment process and criteria used to identify health needs must be outlined.
Documentation	• Meeting minutes, emails, website or other documentation used to collect data and information • Description of criteria used to identify health priorities and resources • Description of which model or framework was used • List of organizations representing board interest of the community who were consulted during the engagement process
Data	• Describe process of identifying data sources, methodology and analysis

Data	• Must include 'context for the population' such as census, employment, income, education, voter registration, transportation, parks, housing stock, home values, etc. • Must include primary data collection through either surveys, focus groups, interviews, or talking circles, for example • Must include agency data and customer satisfaction data (CSBG)
Final Product	• For ACA/IRS: written report adopted by a hospital board • For PHAB: Description of how results are to be shared and used; ongoing monitoring and updating of data • For CSBG: written report approved by the Board of Directors
Follow-up	• Hospitals use final reports to develop Community Health Improvement Plans • The State of Maine and other health departments use final reports to develop the State Health Improvement Plan. • Community Action Partnerships use the final report to develop their strategic plans.

Community Action Agency Service Areas



Community Action Agency Service Areas

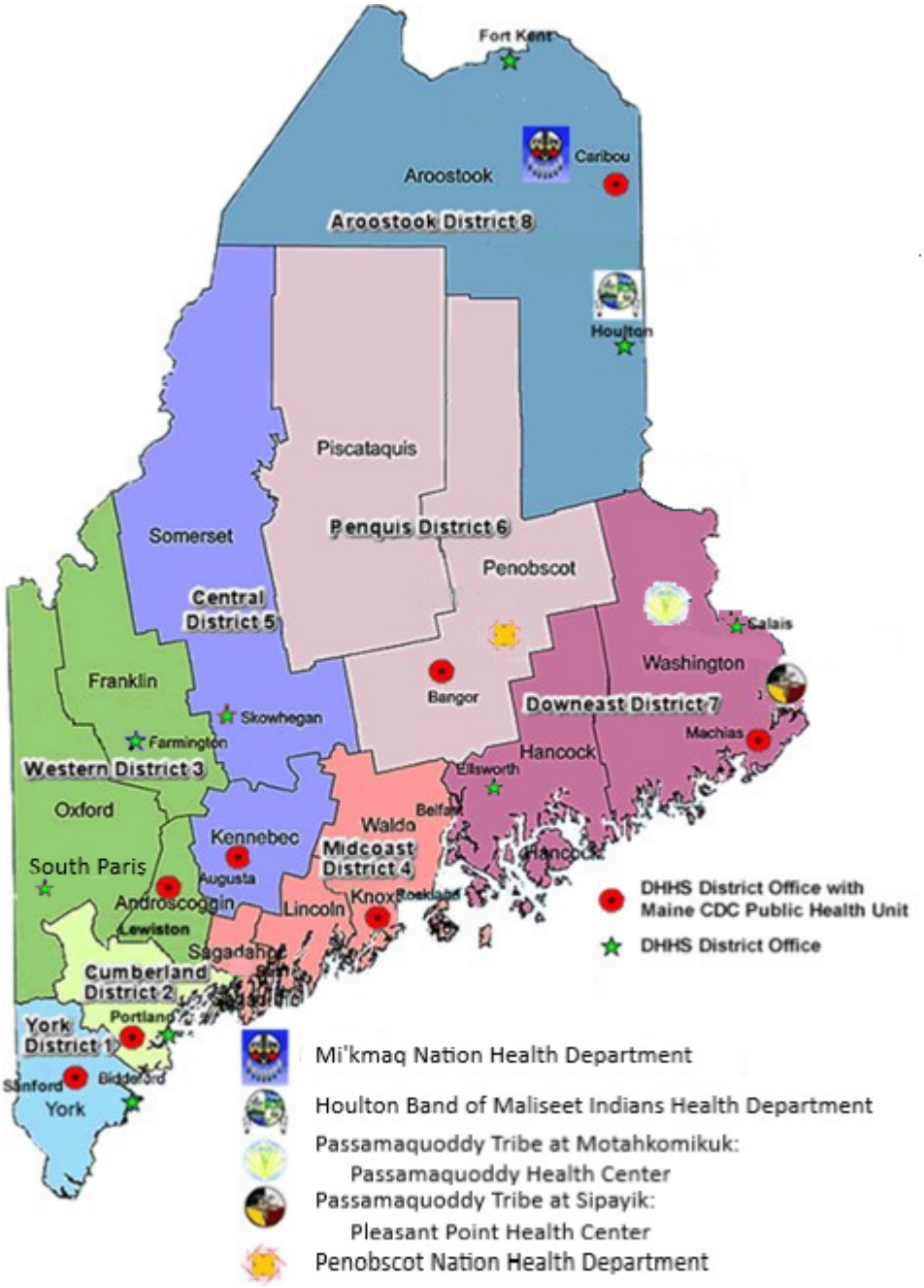


MAINE COMMUNITY ACTION AGENCIES

SNAPSHOT OF SERVICES

		ACAP	CCI	DCP	KVCAP	MMCA	PENQUIS	TOA	WCAP	WMCA	YCCAC
ASSET DEVELOPMENT	Matched Savings/IDA	●				●	●				
	Financial Coaching	●	●		●		●		●		
	Free Income Tax Preparation	●	●	●	●	●	●		●		●
	Business Development		●	●			●				
CHILD CARE & YOUTH DEVELOPMENT	Child Care & School Readiness	●	●	●	●	●	●	●	●	●	●
	Juvenile Justice	●					●				
	Head Start / Early Head Start	●	●	●	●	●	●	●	●		●
	Specialized Care & Education	●		●	●	●	●				●
	Youth Development	●		●	●		●	●			
EMPLOYMENT TRAINING	Transition Teams	●			●		●				
	Workforce Investment Services	●		●							
	Youth and Young Adults	●		●				●			
	Vocational & Skills Training	●		●	●						
	Employer Assistance	●						●			
ENERGY ASSISTANCE & WEATHERIZATION	Energy Assistance & Emergency Fuel	●	●	●	●	●	●	●	●	●	●
	Heating Systems Improvement	●	●	●	●		●		●	●	●
	Weatherization	●	●	●	●		●		●	●	●
HEALTH	Substance Abuse Prevention & Counseling	●	●					●			●
	Health Care Services	●		●							●
	Disease Prevention, Counseling & Outreach	●									●
	Behavioral Health Services		●				●	●	●		●
	Health Care Navigation	●				●	●		●	●	●
	Dental Services	●						●			●
HOUSING	Affordable and/or Subsidized Housing	●	●	●	●		●				●
	Emergency Rental/Mortgage Payments							●	●		
	Foreclosure Counseling		●		●		●				
	Supportive/Transitional Housing	●					●	●			●
	Home Ownership Education	●	●		●		●		●		●
	Home Loans		●				●				
	Home Repair & Modification	●	●	●	●		●		●	●	●
	Homelessness Prevention	●	●	●	●			●	●	●	●
	Rapid Rehousing	●									
	Residential Care & Support Services						●				
NUTRITION	Child & Adult Food Care Program	●	●	●	●	●	●	●	●	●	
	Nutrition Education, Food Programs	●		●	●	●	●	●	●	●	●
	Women, Infants & Children (WIC)	●				●		●		●	●
SENIORS	RSVP & Senior Volunteer Programs			●			●	●			
	Senior Support Services			●				●		●	●
	Assisted Living						●				
STRENGTHENING FAMILIES	Family Development/Parenting Education	●	●	●	●	●	●	●	●	●	●
	Case Management/Info & Referral	●	●	●	●	●	●	●	●	●	●
	Domestic Violence Prevention & Education		●				●				
	Home Visiting	●	●	●	●	●	●	●	●	●	
TRANSPORTATION	Medical and/or Special Population Transp.			●	●		●		●		●
	Public Transportation			●	●		●		●		●

Public Health District Map



Health System Service Areas (with corresponding Public Health District and Community Action Agency)

Public Health Districts	Community Action Agencies	Hospitals
District 1: York		
York County	• York County Community Action Corporation	• MaineHealth Medical Center, Biddeford and Sanford • York Hospital, York
District 2: Cumberland		
Cumberland County	• The Opportunity Alliance • Midcoast Maine Community Action	• Bridgton Hospital, Central Maine HealthCare, Bridgton* • MaineHealth Medical Center, Portland • Northern Light Mercy Hospital, Portland • New England Rehabilitation, Portland • MaineHealth Behavioral Health, Westbrook
District 3: Western		
Androscoggin County	• Community Concepts, Inc. • Western Maine Community Action	• Central Maine Medical Center, Central Maine HealthCare, Lewiston • St. Mary's Regional Medical Center, Lewiston
Oxford County	• Community Concepts, Inc. • Western Maine Community Action	• Rumford Hospital, Central Maine HealthCare, Rumford • MaineHealth Stephens Memorial, Norway
Franklin County	• Community Concepts, Inc. • Western Maine Community Action	• MaineHealth Franklin Hospital, Farmington
District 4: Midcoast		
Sagadahoc County	• Kennebec Valley Community Action Program • Midcoast Maine Community Action	• MaineHealth Mid Coast Hospital, Brunswick
Lincoln County	• Kennebec Valley Community Action Program • Midcoast Maine Community Action	• MaineHealth Lincoln Hospital, Damariscotta and Boothbay Harbor
Waldo County	• Waldo Community Action Partners • Midcoast Maine Community Action	• MaineHealth Waldo Hospital, Belfast
Knox County	• Penquis • Midcoast Maine Community Action	• MaineHealth Pen Bay Hospital, Rockport
District 5: Central		
Kennebec County	• Kennebec Valley Community Action Program	• MaineGeneral Health, Augusta • Northern Light Inland Hospital, Waterville
Somerset County	• Kennebec Valley Community Action Program	• Redington-Fairview General Hospital, Skowhegan • Northern Light Sebasticook Valley Hospital, Pittsfield

Public Health Districts	Community Action Agencies	Hospitals
District 6: Penquis		
Penobscot County	• Penquis	• Millinocket Regional Hospital • Northern Light Eastern Maine Medical Center, Bangor • Northern Light Acadia Hospital, Bangor • Penobscot Valley Hospital, Lincoln • St. Joseph Hospital, Bangor
Piscataquis County	• Penquis	• Northern Light Mayo Hospital, Dover-Foxcroft • Northern Light CA Dean Hospital, Greenville
District 7: Downeast		
Washington County	• Downeast Community Partners	• Calais Regional Hospital, Calais • Down East Community Hospital, Machias
Hancock County	• Downeast Community Partners	• Mount Desert Island Hospital, Bar Harbor • Northern Light Blue Hill Hospital, Blue Hill • Northern Light Maine Coast Hospital, Ellsworth
District 8: Aroostook		
Aroostook County	• Aroostook Community Action Program, Inc.	• Cary Medical Center, Caribou • Houlton Regional Hospital, Houlton • Northern Light AR Gould Hospital, Presque Isle • Northern Maine Medical Center, Ft. Kent
District 9: Tribal		
Aroostook, Penobscot, and Washington Counties		• This is a population-based district. See individual counties for hospital listings.

Appendix 4: Focus Group Guide

Maine Shared CHNA Focus Group Moderator's Guide

[As participants arrive] Welcome! While we're waiting to begin, please complete the Pre-Focus Group Questionnaire *[provide paper copies if in person; provide link in Zoom chat if virtual]*.

Good morning [or afternoon]. My name is [Name] from Crescendo Consulting Group. We are working with partners across Maine to conduct a statewide community health needs assessment. The Maine Shared Community Health Needs Assessment is a collaborative between Maine's health systems, Maine Center for Disease Control and Prevention, and the Maine Community Action Partnership that:

- Creates Shared Community Health Needs Assessment Reports;
- Engages and activates communities; and
- Supports data-driven health improvements for Maine people.

The purpose of this focus group discussion is to learn more about the strengths and resources in the community. We will also gather your insights about health and related social needs. We are interested in learning about how you and people you know interact with the health and social service systems. We would also like to hear about access to health care and social services in your community.

Your input is important because the information you and others share will be used to identify and describe important health needs in Maine. Maine's health systems, MeCDC, Maine's Community Action Programs, and partners will use this information to work to address these challenges.

We will describe our discussion and will include a list of populations and communities represented by focus group participants in a written report. Specific quotes may be reported by the geographic area or population of the focus group. Quotes will not be associated with individuals by name or by other characteristics that, in combination, could be used to identify you. **Please consider what you say in our conversation to be confidential and voluntary.**

We have some group agreements to consider before we start our conversation today. It is essential that this is a safe place, free from abusive words and actions, threats, and disrespectful behaviors. That includes words and behaviors directed towards us, your facilitators, or anyone else. It is really important that we have a rich conversation that is respectful and that we use language that does not put down other people or cause them to feel unsafe. It's also important to allow all people to speak.

As a facilitator, I will sometimes interject so I want you to know that up front. Due to time constraints, I may also need to move the conversation along.

I will sometimes come into the conversation to make sure we are allowing for all voices and to ensure that the conversation stays respectful. I recognize that I am interrupting at times, but it's an important part of my job as the facilitator, so I want you to know to expect that from me.

Do you have any questions for me before we start?

Introductory Questions

1. To start, please briefly introduce yourself and share something about how you belong or feel part of your community.

2. What does a "healthy" community look like to you?

3. What are the two or three most important health needs in your community?
   [PROBE: mental health, substance and alcohol use, cancer, heart disease, COVID-19, unintentional injury, chronic lower respiratory disease]

4. In the past three years, what has changed about the health and well-being of your community?

Access to Care and Delivery of Services

5. What services and resources for becoming and staying healthy are difficult to find? What services and resources are difficult to access? Why?

   PROBE: Arthritis
   Cancer
   Cardiovascular disease
   Children with Special Health Care Needs
   Cognitive health
   Community-based supports
   Diabetes
   Early intervention programs
   Immunizations
   Infectious disease
   Mental health
   Oral health
   Physical activity, nutrition, and wellness
   Pregnancy and birth outcomes
   Prevention programs
   Respiratory health
   Substance use
   Tobacco treatment

6. What health resources or services are easier to find? Why?

Social Determinants, Neighborhood & Physical Environment

7. What are the top three social or environmental health needs or challenges in the community? Why?

   PROBE: Affordable housing
   Air/water pollution
   Childcare
   Employment and job training opportunities
   Extreme weather events
   Food insecurity and access to healthy food

Internet and technology access
Power and internet outages
Services for people experiencing homelessness
Social isolation; loneliness
Transportation
Others

8. What resources and services are <u>available</u> in your community to help people with *[needs or challenges identified in Question 7]*?

9. What resources and services are <u>missing</u> from your community to help people with *[needs or challenges identified in Question 7]*?

Health Equity and Vulnerable Populations

NOTE: Different approach for Statewide and County discussions. For Statewide groups, inquire directly about demographic sub-population from which group is drawn (e.g., veterans, LGBTQ+, etc.).

10. [STATEWIDE GROUPS] Do you consider your community/population to be one that experiences more challenges than others?

    [STATEWIDE & COUNTY GROUPS] What (other) populations in your community experience more challenges than others? *PROBE: veterans, youth, immigrants, LGBTQ+ populations, people of color, older adults, people living with disabilities, people with lower income*

    What are the two or three biggest needs or challenges faced by these groups/your group?

11. What health or social services are not equally available to everyone in your community regardless of gender, race, age, income, or ability? Why?

Protective and Risk Factors

12. In your community, what factors or lifestyle choices help people stay healthier and happier?

    PROBE: Cancer prevention
    Economic opportunity
    Family/parental resilience
    Health status
    Immunizations and vaccinations
    Nutrition
    Oral care
    Physical activity
    Public policy protections
    Safety
    Screening and preventative visits
    Social connections

13. What factors or lifestyle choices contribute the most to the health problems people in your community face?

    PROBE: Cannabis Use (adults)
    Tobacco Use (adults)
    Alcohol Use (adults)
    Opioid Use (adults)
    Substance Use (youth)
    Health Status
    Pregnancy & Birth Outcomes
    Overweight

Magic Wand

14. If you had all the money and resources in the world and could do any one thing to make your community healthier, what would it be?

Thank you for your time and participation!

MODERATOR FOOTNOTES

Not all topics may be covered in all interviews. Discussion content will be modified to respond to the interviewees' professional background and availability of time during the interview.

During the discussion, these are tools that can be used to help redirect participants:

Validation. "I appreciate you sharing this. Sometimes getting deep into the details can be retraumatizing, so I want you to know that we've recorded what you are saying and it's very meaningful. Thank you."

Assurance. "We've noted your thought/opinion/concern" "You've been really clear in your statement and we've got it written down." "I see this is important to you, I've got it captured in the notes."

Space. "I'm going to create some space for another voice here. Does anyone else have a thought on this matter?"

Movement. "Moving on to the next question…" "I'm bringing us back to the questions at hand now."

Respond. "A reminder that this group is a place for us to talk respectfully" "Each person deserves dignity and respect, so let's be mindful of our language here in this group." "I'm asking you to refrain from that language in this group."

Maine Shared Community Health Needs Assessment

Statewide Survey

2024

The Maine Shared Community Health Needs Assessment is a collaboration between Central Maine Healthcare, MaineGeneral, MaineHealth, Northern Light Health, the Maine Center for Disease Control and Prevention, and the Maine Community Action Partnership.

About the Survey

Please help us by taking this short survey. There are 40 survey questions and it will take about 10 minutes to complete. Our goal is to learn about the local resources and strengths in your community, as well as the health and well-being of the people who live in your community.

Your survey responses will be kept anonymous and will not be shared with anyone outside of our research team.

Raffle Prizes

To thank you for taking the time to do this survey, you will have the option to enter a raffle. Ten (10) randomly selected people will each win a $100 gift card. The contact information you share to enter the raffle will be kept separate from your survey answers.

Note: Employees and Board members of the community action organizations, health system partners, and MeCDC are not eligible to win a gift card. Gift cards will only be sent through the mail and not as an e-card.

Timeline to Complete the Survey

The survey will close at 5:00 pm EST on Friday, June 28th, 2024.

Questions?

Please send your questions to info@mainechna.org.

Survey Starts Here

1. What county do you live in?
   - ☐ Androscoggin
   - ☐ Aroostook
   - ☐ Cumberland
   - ☐ Franklin
   - ☐ Hancock
   - ☐ Kennebec
   - ☐ Knox
   - ☐ Lincoln
   - ☐ Oxford
   - ☐ Penobscot
   - ☐ Piscataquis
   - ☐ Sagadahoc
   - ☐ Somerset
   - ☐ Waldo
   - ☐ Washington
   - ☐ York

2. What town/city do you live in?

   _____

Community Health

3. How would you rate **the overall health and well-being of the community where you live**?
   - ☐ Very healthy (almost everyone around you seems very healthy)
   - ☐ Healthy (most people around you seem healthy)
   - ☐ Unhealthy (some people around you seem sick or unhealthy)
   - ☐ Very unhealthy (mostly everyone around you seems sick or unhealthy)

4. When you **think of the community where you live,** which of the following **strengths** come to mind? (select all that apply.)
   - ☐ Access to quality & affordable food
   - ☐ A healthy environment
   - ☐ Clean sidewalks and walkways free from litter
   - ☐ Diverse population including people of all abilities
   - ☐ Safe opportunities to be active outside
   - ☐ Safe neighborhoods
   - ☐ Low crime
   - ☐ Strong sense of community
   - ☐ Variety of languages spoken
   - ☐ Availability of affordable & quality housing
   - ☐ Availability of affordable & quality childcare
   - ☐ Banks & financial institutions
   - ☐ Locally owned businesses
   - ☐ Community behavioral and/or mental health clinics
   - ☐ Faith organizations
   - ☐ Human & social service agencies
   - ☐ Hospitals
   - ☐ Health clinics & doctors' offices
   - ☐ Job availability
   - ☐ A healthy economy
   - ☐ Schools & education for all ages
   - ☐ Other (please specify):

     _____

5. Which of the following do you think are important **social concerns** that negatively impact the community where you live? (choose up to 5)
    - ☐ Access to primary care providers
    - ☐ Childcare
    - ☐ Discrimination (based on race, ethnicity, language, gender, sexual orientation, ability, etc.)
    - ☐ Educational opportunities
    - ☐ Employment opportunities
    - ☐ Environmental (public spaces and parks, water and air quality, sidewalk conditions, litter, etc.)
    - ☐ Homelessness
    - ☐ Housing insecurity
    - ☐ Isolation or lack of social connections
    - ☐ Lack of community engagement (participation in local organizations or government, voting, etc.)
    - ☐ Low incomes and poverty
    - ☐ School absences
    - ☐ Social and emotional learning delays
    - ☐ Lack of transportation
    - ☐ Violence and crime rates
    - ☐ Quality & affordable food
    - ☐ Other (please specify):

      _____

6. Which of the following do you think are important **health issues** that negatively impact the community where you live? (choose up to 5)
   - ☐ Aging health concerns (arthritis, osteoporosis, dementia, Alzheimer's, etc.)
   - ☐ Cancer
   - ☐ Children's health
   - ☐ Dental and oral health
   - ☐ Diabetes
   - ☐ Physical disabilities
   - ☐ Cognitive disabilities
   - ☐ Substance use (alcohol, cannabis, prescription drugs, illicit drugs, etc.)
   - ☐ Heart disease (high blood pressure, high cholesterol, etc.)
   - ☐ Immunization rates (measles, polio, tetanus, etc.)
   - ☐ Infectious disease (pneumonia, flu, Hepatitis C, COVID, etc.)
   - ☐ Injuries (car accidents, falls, concussions, etc.)
   - ☐ Mental health issues (anxiety, depression, suicide, etc.)
   - ☐ Obesity
   - ☐ Breathing issues (asthma, COPD, emphysema, etc.)
   - ☐ Sexually transmitted infections (HIV/AIDS, chlamydia, etc.)
   - ☐ Tobacco or nicotine use (cigarettes, cigars, vapes, dip, nicotine pouches, etc.)
   - ☐ Health issues for people who identify as women (prenatal/maternal health, reproductive health, etc.)
   - ☐ Other (please specify):

     _____

Health Issues

7. How would you rate your own **physical** health?
   - ☐ Excellent (I feel healthy almost every day)
   - ☐ Good (I feel healthy most days)
   - ☐ Fair (I have some health concerns, but I feel healthy some days)
   - ☐ Poor (I don't feel healthy most of the time)

8. Within the past year (365 days), have there been 1 or more times when you or a loved one needed **health care** services but **could not** or **chose not** to get it?
   - ☐ Yes (answer question 9)
   - ☐ No (skip to next page)

9. If yes, what stopped you from getting care when you needed it? (select all that apply)
   - ☐ Did not have health insurance
   - ☐ Had health insurance, could not afford care
   - ☐ Providers/hospitals did not take my health insurance
   - ☐ No childcare
   - ☐ Not sure where to go for help
   - ☐ Hard to get time off from work
   - ☐ No evenings or weekend hours to get care
   - ☐ Did not feel comfortable with available providers
   - ☐ Providers did not speak my language
   - ☐ Concern about my immigration status
   - ☐ No transportation
   - ☐ Did not feel comfortable seeking help
   - ☐ Worried that others would find out about it
   - ☐ Long wait times to see a provider
   - ☐ Other (please specify):

     _____

Mental Health Issues

10. How would you rate your own **mental** health?
    - ☐ Excellent (Almost every day is good)
    - ☐ Good (I have mostly good days)
    - ☐ Fair (I have good days and hard days)
    - ☐ Poor (Most days are hard)

11. Within the past year (365 days), have there been 1 or more times when you or a loved one needed **mental health care** services but **could not** or **chose not** to get it?
    - ☐ Yes (answer question 12)
    - ☐ No (skip to next page)

12. If yes, what stopped you from getting **mental health care** when you needed it? (select all that apply)
    - ☐ Did not have health insurance
    - ☐ Had health insurance, could not afford care
    - ☐ Providers/hospitals did not take my insurance
    - ☐ No childcare
    - ☐ Not sure where to go for help
    - ☐ Hard to get time off from work
    - ☐ No evenings or weekend hours to receive care
    - ☐ Did not feel comfortable with available providers
    - ☐ Providers did not speak my language
    - ☐ Concern about my immigration status
    - ☐ No transportation
    - ☐ Did not feel comfortable seeking help
    - ☐ Worried that others would find out about it
    - ☐ Long wait times to see a provider
    - ☐ Other (please specify):

      _____

Each of the following pages focuses on a topic that may negatively impact you, a loved one, and/or your community.

13. In the chart below, please put a check mark if there are **chronic health conditions (cancer, high blood pressure, heart disease, high cholesterol, etc.)** that **negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 14 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Chronic health conditions						
	CONTINUE TO QUESTION 14	CONTINUE TO QUESTION 14	CONTINUE TO QUESTION 14	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 14	SKIP TO THE NEXT PAGE

14. Please put a check mark in the box if any of the following **chronic health conditions (cancer, high blood pressure, heart disease, high cholesterol, etc.)** negatively impact you, a loved one, and/or the community where you live (select all that apply).

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Asthma, COPD, or Emphysema						
Arthritis						
Cancer						
Diabetes or high blood sugar						
Heart disease or heart attack						
High cholesterol						
High blood pressure or hypertension						
Overweight/obesity						
Stroke						
Chronic liver disease/cirrhosis						

15. In the chart below, please put a check mark in the box if there are **mental health needs** that **negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 16 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Mental health needs						
	CONTINUE TO QUESTION 16	CONTINUE TO QUESTION 16	CONTINUE TO QUESTION 16	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 16	SKIP TO THE NEXT PAGE

16. Please put a check mark in the box if any of the following **mental health needs** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder						
Bipolar disorder						
Depression						
Trauma or post-traumatic stress disorder (PTSD)						
General stress of day-to-day life						
Social isolation or loneliness						
Stigma associated with seeking care for mental health or substance use disorders						
Suicidal thoughts and/or behaviors						
Youth mental health						

17. In the chart below please put a check mark in the box if **substance use negatively impacts you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 18 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Substance use						
	CONTINUE TO QUESTION 18	CONTINUE TO QUESTION 18	CONTINUE TO QUESTION 18	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 18	SKIP TO THE NEXT PAGE

18. Please put a check mark in the box if **substance use** negatively impacts you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Alcohol misuse or binge drinking						
Opioid misuse						
Tobacco use (cigarettes, cigars, dip, etc.)						
Vaping (also called e-cigarettes)						
Adult cannabis (marijuana) use						
Other illicit drug use						
Youth substance use						

19. In the chart below please put a check mark in the box if **housing needs negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 20 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Housing needs						
	CONTINUE TO QUESTION 20	CONTINUE TO QUESTION 20	CONTINUE TO QUESTION 20	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 20	SKIP TO THE NEXT PAGE

20. Please put a check mark in the box if any of the following **housing needs** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Housing costs						
Availability of affordable, quality homes/rentals						
Availability of affordable, quality housing for older adults or those with special needs						
Issues associated with home ownership or renting (mortgage/rent payments, taxes, evictions, etc.)						
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold, etc.)						
Homelessness and/or availability of shelter beds						
Cost of utilities (heat, electricity, water, etc.)						
Costs associated with weatherization (insulation, energy efficiency, etc.)						

21. In the chart below please put a check mark in the box if **transportation needs negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 22 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Transportation needs						
	CONTINUE TO QUESTION 22	CONTINUE TO QUESTION 22	CONTINUE TO QUESTION 22	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 22	SKIP TO THE NEXT PAGE

22. Please put a check mark in the box if any of the following **transportation needs** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Access to transportation (for medical appointments, work, basic needs, childcare, etc.)						
Availability of public transportation (buses, trains, ride shares, taxis, etc.)						
Availability of transportation that meets a variety of specific needs (older adults, physical or cognitive needs)						
Costs associated with owning and maintain a vehicle (insurance, registration, repairs, etc.)						

23. In the chart below please put a check mark in the box if **economic needs negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 24 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Economic needs						
	CONTINUE TO QUESTION 24	CONTINUE TO QUESTION 24	CONTINUE TO QUESTION 24	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 24	SKIP TO THE NEXT PAGE

24. Please put a check mark in the box if any of the following **economic needs** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Availability of quality educational opportunities						
Availability of jobs and employment opportunities						
Availability of high-speed internet						
Availability of quality, affordable childcare						
Ability to contribute to savings, retirement, etc.						
Access to affordable, quality foods						

25. In the chart below please put a check mark in the box if **environmental concerns negatively impact you, a loved one, and/or the community where you live** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 26 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Environmental concerns						
	CONTINUE TO QUESTION 26	CONTINUE TO QUESTION 26	CONTINUE TO QUESTION 26	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 26	SKIP TO THE NEXT PAGE

26. Please put a check mark in the box if any of the following **environmental concerns** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Air quality						
Water quality						
PFAS ("forever chemicals") contamination						
Extreme weather events (hurricane, flooding, etc.)						
Access to parks and green spaces for recreation						

27. In the chart below please put a check mark in the box if **public safety needs negatively impact you, a loved one, and/or your community** (select all that apply).

    If you select 1 or more or 'I don't know' please complete question 28 below.

    If you select 'Doesn't have any impact' or 'Not applicable' please skip to the next page.

TOPIC	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Public safety needs						
	CONTINUE TO QUESTION 28	CONTINUE TO QUESTION 28	CONTINUE TO QUESTION 28	SKIP TO THE NEXT PAGE	CONTINUE TO QUESTION 28	SKIP TO THE NEXT PAGE

28. Please put a check mark in the box if any of the following **public safety needs** negatively impact you, a loved one, and/or the community where you live. (select all that apply)

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Pedestrian (walking) or bicycle safety						
Property crime						
Community violence (gangs, guns, street crime)						
Violence between people (domestic, sexual, bullying)						
Racism						
Discrimination based on race, ethnicity, gender, LGBTQIA2S+, age, ability, etc.						

29. What other health or social issues, not listed previously, impact you, a loved one and/or the community where you live? Please list examples.

Socioeconomic Empowerment

30. Using a check mark in the boxes, please rate the following items based on what you think is a necessary step to help move people out of poverty and to a place of housing stability & financial stability.

	1 Not necessary	2 Somewhat necessary	3 Necessary	4 Very necessary	I don't know
Jobs that pay enough to support a living wage					
Reduction in substance use (drugs, alcohol)					
Affordable and safe housing					
Parenting supports (family support, parenting classes, etc.)					
Mental health care and treatment					
Reduction in racism or discrimination					
Reliable transportation					
Affordable & available health care					
Availability of dentists					
Affordable & quality childcare					
Reduction in teen pregnancy rates					
Quality educational opportunities (college, trade, or technical school)					
Public assistance reform					
Low crime rates					
Other: _____					

Demographic Information

This section asks questions about your demographic characteristics. This information helps us understand the people who completed the survey All questions are optional and will not be used to identify a respondent.

31. What is your age?
    - ☐ Under 18
    - ☐ 18 to 24
    - ☐ 25 to 34
    - ☐ 35 to 44
    - ☐ 45 to 54
    - ☐ 55 to 64
    - ☐ 65 to 74
    - ☐ 75 to 84
    - ☐ 85 or older
    - ☐ I prefer not to say

32. Including yourself, how many people live in your household?
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5

33. What is your annual household income?
    - ☐ Under $15,000
    - ☐ $15,000 to $24,999
    - ☐ $25,000 to $34,999
    - ☐ $35,000 to $44,999
    - ☐ $45,000 to $54,999
    - ☐ $55,000 to $64,999
    - ☐ $65,000 to $74,999
    - ☐ $75,000 to $84,999
    - ☐ $85,000 to $99,999
    - ☐ $100,000 to $149,999
    - ☐ $150,000 to $199,999
    - ☐ $200,000 or more
    - ☐ I prefer not to say

34. Which best identifies you? (select all that apply)
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Hispanic or Latino/a/x
    - ☐ Middle Eastern or North African
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ White
    - ☐ I identify as: _____
    - ☐ I prefer not to say

35. Do you identify yourself as:
    - ☐ Genderqueer/gender nonconforming
    - ☐ Man
    - ☐ Nonbinary
    - ☐ Transgender man
    - ☐ Transgender woman
    - ☐ Woman
    - ☐ I identify as: _____
    - ☐ I prefer not to say

36. Do you identify as a member of the LGBTQIA2s+ community?
    - ☐ Yes
    - ☐ No
    - ☐ I prefer not to say

37. What is your highest level of education?
    - ☐ Did not attend school
    - ☐ Some high school, no diploma
    - ☐ High school diploma or equivalent
    - ☐ Some college, no degree
    - ☐ Technical or trade school/Professional certification program
    - ☐ Associate's degree
    - ☐ Bachelor's degree
    - ☐ Graduate or professional degree (Masters, PhD, MD, etc.)
    - ☐ I prefer not to say

38. Are you a veteran?
    - ☐ Yes
    - ☐ No
    - ☐ I prefer not to say

39. Please select all that apply to you (select all that apply):
    - ☐ I am blind or I have trouble seeing even when wearing glasses
    - ☐ I am deaf or hard of hearing
    - ☐ I have difficulty doing errands alone such as visiting a doctor's office or shopping
    - ☐ I have serious difficulty in my daily life caused by: mood, intense feelings, controlling my impulses, or hearing, seeing, sensing something that others around me are not
    - ☐ I have a really hard time learning how to do things most people my age can learn
    - ☐ I have trouble concentrating, remembering, or making decisions because of a physical, mental, or emotional condition
    - ☐ I have trouble getting dressed, taking a bath, or showering
    - ☐ I have trouble walking or climbing stairs
    - ☐ I have a disability or medical condition not described by any of the conditions above (please specify): _____
    - ☐ I prefer not to say
    - ☐ None of the above

40. What is your housing status?
    - ☐ Renter
    - ☐ Homeowner
    - ☐ Live with family or loved ones
    - ☐ Experiencing homelessness or housing instability
    - ☐ Other (please specify): _____
    - ☐ I prefer not to say

End of Survey

Thank you for completing the Maine Shared Community Health Needs Assessment community survey. We really appreciate your time and we value the insights that you shared with us. For completing the survey, you may enter into a raffle to win a $100 gift card. If you would like to enter the raffle, please enter your contact information below. Your contact information will be kept separate from your survey responses.

Please email us if you have any questions: info@mainechna.org

Name: _____

Email: _____

Phone: _____

Acknowledgements

Funding for the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is provided by the partnering healthcare systems and the Maine Community Action Partnership with support from the Maine Center for Disease Control and Prevention (Maine CDC). The Maine Shared CHNA is also supported in part by the U.S. Centers for Disease Control and Prevention (U.S. CDC) of the U.S. Department of Health and Human Services (U.S. DHHS) as part of the Preventive Health and Health Services Block Grant (awards NB01TO000018 & NB01PW000031). The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, the U.S. CDC/DHHS, or the U.S. Government.

We are grateful for the time, expertise, and commitment of numerous community partners and stakeholder groups, including: the Metrics Committee, the Community Engagement Committee, Local Planning Teams, and several Ad-Hoc Committees. Crescendo Consulting Group provided quantitative and qualitative expertise, design and production support, and analysis.

We are grateful to our community partners and stakeholders who took the time to help advertise and recruit for our focus groups, both at the state and county level, and for our statewide community survey. Our utmost thanks also goes to all of the individuals who took part in our key informant interviews. Each of you enabled us to learn more about populations, communities and sectors in Maine. Without all of these efforts we would not have been able to conduct the community engagement aspect of our assessment. A special thank you also goes to the Catherine Cutler Institute at the University of Southern Maine and Maine DHHS' Office of Aging and Disability Services and John Snow, Inc. and Disability Rights Maine for use of their assessments and ability to include their findings in ours.

Significant quantitative data analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. Crescendo Consulting Group provided quantitative and qualitative expertise, design and production support, and analysis. A special thank you to the Children's Oral Health Network for its data contribution, the Maine Integrated Youth Health Survey for use of its LGBTQ+ Student Health fact sheet, and for volunteers from the Aroostook County Action Agency, Central Maine Healthcare, Northern Light Health, MaineHealth and the Roux Institute's Data Analytics for Social Good student group, who helped with our data quality control and assurance process.

Endnotes

i Health Equity in Healthy People 2030 - Healthy People 2030 | odphp.health.gov

ii Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

iii Health Equity in Healthy People 2030 - Healthy People 2030 | odphp.health.gov

iv Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

v Using Clear Terms to Advance Health Equity – "Social Drivers" vs "Social Determinants" | PRAPARE

vi Social Drivers of Health and Health-Related Social Needs | CMS

vii Braveman, P, Arkin E, Proctor D, Kauh T, and Holm N. Systemic Racism and Health Equity. Executive Summary. Robert Wood Johnson Foundation, 2022.

viii Braveman, P, Arkin E, Proctor D, Kauh T, and Holm N. Systemic Racism and Health Equity. Executive Summary. Robert Wood Johnson Foundation, 2022.

ix Community Services Block Grant (CSBG) | The Administration for Children and Families

x About Adverse Childhood Experiences | Adverse Childhood Experiences (ACEs) | CDC

xi Heller, J.C., Givens, M.L., Johnson, S.P. and Kindig, D.A. (2024), Keeping It Political and Powerful: Defining the Structural Determinants of Health. Milbank Quarterly., 102: 351-366. https://doi.org/10.1111/1468-0009.12695

xii BARHII: FRAMEWORK — BARHII - Bay Area Regional Health Inequities Initiative

xiii 3 key upstream factors that drive health inequities | American Medical Association

www.mainechna.org