2025 Maine Shared Community Health Needs Assessment

Northern Light Health

Androscoggin County

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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 Androscoggin County 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

Androscoggin County Health and Well-Being Priorities

The following table includes the top health and well-being priorities identified by Androscoggin County stakeholder forum participants based on quantitative and qualitative data, and their own knowledge, expertise, and experience in the community. Those followed by "(ME)" indicate they are also state priorities. A complete list of results from the county stakeholder forum health and well-being prioritization process are listed in Appendix 2.

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Housing (ME)	Adverse Childhood Experiences (ME)	Mental Health (ME)
Provider Availability (ME)	Nutrition (ME)	Substance Use Related Injury & Death
Poverty (ME)	Illicit Drug Use	Cardiovascular Disease
	Adult Screening & Preventative Visits	

In addition, the following are state priorities that were not selected by Androscoggin County:

Transportation Substance Use Chronic Conditions

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. Data on Androscoggin County's select demographics, including socioeconomic indicators, race and ethnicity, age, and leading cause of death are presented to give a broad view of the make-up of people living in Androscoggin County 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 related terms and the Maine Shared CHNA's approach to community engagement.
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 county focus group representing people with low-income, county specific results from the statewide community survey, summary discussions from the county stakeholder forum, and county specific quantitative data from the County 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

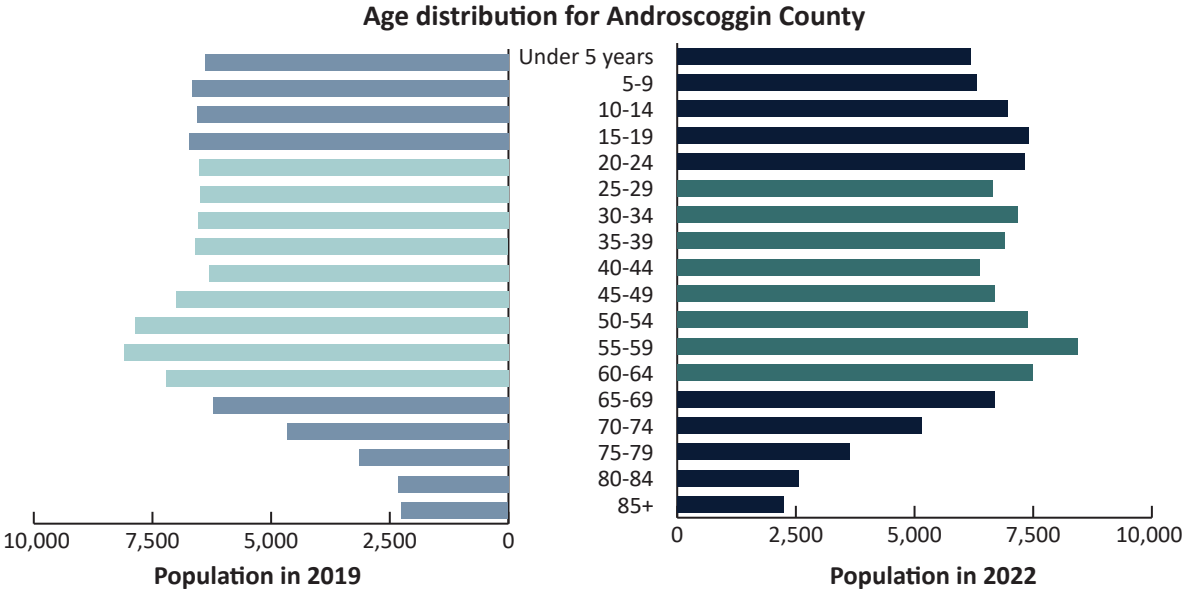
The following tables and chart show information about the population of Androscoggin County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Androscoggin County Population	State of Maine Population
111,532	**1,366,949**

	Androscoggin	Maine
Median household income	**$64,500**	**$68,251**
Unemployment rate	**2.9%**	**3.1%**
Individuals living in poverty	**12.4%**	**10.9%**
Children living in poverty	**17.8%**	**13.4%**
65+ living alone	**30.8%**	**29.5%**

	Androscoggin County	
	Percent	Number
American Indian/Alaskan Native	**0.1%**	**78**
Asian	**1.0%**	**1,141**
Black/African American	**4.4%**	**4,863**
Native Hawaiian or other Pacific Islander	**0.0%**	**18**
Some other race	**0.4%**	**456**
Two or more races	**4.4%**	**4,876**
White	**89.8%**	**100,100**
Hispanic	**2.0%**	**2,259**
Non-Hispanic	**98.0%**	**109,273**

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 compares leading causes of death for the state of Maine and Androscoggin County.

Cause of Death	Maine	Androscoggin County
Heart disease	**27.2%**	**27.1%**
Cancer	**25.9%**	**22.4%**
Accidents	**10.5%**	**10.1%**
COVID 19	**6.0%**	**8.5%**
Chronic lower respiratory disease	**6.8%**	**7.6%**
Alzheimer's disease	**4.1%**	**7.2%**
Diabetes	**4.6%**	**6.6%**
Cerebrovascular disease	**4.8%**	**3.4%**
Chronic liver disease and cirrhosis	**2.3%**	**2.1%**
Suicide	**2.0%**	**1.9%**
Influenza & pneumonia	**2.1%**	**1.7%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**1.4%**
Parkinson's disease	**1.7%**	**0.8%**

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. We ultimately engaged directly with LGBTQ+ people, multigenerational black/African Americans, people with low-income, veterans, women, young adults, and youth through focus groups and several other populations and sectors through interviews. Additionally, we heard from a diverse audience through a statewide survey.

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. 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.

Community Engagement Findings

The Maine Shared CHNA recognizes the findings of our assessment do not encompass all populations and communities in Maine, nor the diverse experiences of those within the populations and communities we have engaged with. Maine is a diverse state with approximately 51,696 people who identify as American Indian/Alaskan Native (6,722), Asian (15,071), Black/African American (21,775), or some other race (8,128). An additional 53,704 people identify as two or more races. The Maine Shared CHNA will continue to develop meaningful and transparent relationships with these populations and others, in an effort to continuously improve our assessment process and ultimately drive improvement in health and well-being outcomes. Additional information on the qualitative data process can be found in Appendix 1: Methodology and the complete community engagement findings can be found at www.mainechna.org.

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[vii] 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.

Androscoggin County	Maine
1) Affordable and safe housing	1) Jobs that pay enough to support a living wage
2) Jobs that pay enough to support a living wage	2) Affordable and safe housing
3) Mental health care and treatment	3) Mental health care and treatment
4) Affordable & available health care	4) Affordable & available health care
5) Reduction in substance use (drugs, alcohol)	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.

Populations and Communities

- This includes populations and communities impacted by the priority as identified in a pre-forum survey and at the forum.

Community Resources

- This includes a list of assets and resources to address the priority as identified in a pre-forum survey and at the forum.

Crosscutting Priorities

- This section includes a list of the other health and well-being priorities for Androscoggin County 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.

Androscoggin County Strengths

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

- Schools and education for all ages;
- Locally owned businesses;
- Diverse population including people of all abilities;
- Safe opportunities to be active outside; and
- Hospitals.

People living in Androscoggin County have a positive outlook on their health and well-being – 52.2% of survey respondents believe their community is healthy or very healthy; 76.1% rate their own physical health as good or excellent and 69.5% 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 Androscoggin County, 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.

Androscoggin County Community Conditions		
Housing	Provider Availability	Poverty

Housing

Housing was the top priority for the community conditions category for Androscoggin County. 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

In the Androscoggin County focus group, "affordable housing" was a key theme. One focus group participant said:

> **"Housing needs to be reformed. It looks like they are doing a lot of housing in the community but not a lot of employment options – people need to travel elsewhere."**

Androscoggin County stakeholder forum participants also discussed the affordability of housing. They noted housing is expensive for everyone – smaller houses are not more affordable; renting can cost more than buying and may not be supplanted by general assistance or vouchers; and maintenance costs are increasing, which can be exacerbated through renter and landlord relationships. Forum participants expanded on rental properties and landlord relationships, citing a lack of protections for both renters and landlords when disputes arise, but that the City of Lewiston is working to address some of these issues. In Androscoggin County, 11.5% of households spend more than 50% of their income on housing (2018-2022). The median gross rent for Androscoggin County was $916 as of 2018-2022, significantly worse than rent in 2015-2022 ($771). However, rent in Androscoggin County is significantly better than median gross rents in Maine ($1,009) and the U.S. ($1,268).

In a Maine Shared CHNA survey, respondents noted "homelessness" and "housing insecurity" as the top fourth and fifth of five social concerns that negatively impact their communities. In the survey, 67% reported "housing needs" impacted them, a loved one, and/or their community. When asked about more specific housing needs, "availability of affordable, quality homes/ rentals" was the top issue that impacted respondents' community (85%), followed closely by "homelessness or availability of shelter beds" (84.4%). See Table 1: Housing Needs for a complete listing of how housing impacts people in Androscoggin County.

A lack of housing inventory and poor quality of existing stock were cited as root causes for housing issues by forum participants. As of 2022, 1.2% of housing units were either vacant and for sale or rent in Androscoggin County and 91.8% of housing was occupied (2018-2022). Regarding homelessness, as of 2023, 306 children were experiencing homelessness in Androscoggin County.

Table 1: Housing Needs, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Housing costs	50.3%	52.0%	80.9%	1.2%	4.0%	0.6%
Availability of affordable, quality homes/rentals	31.2%	43.9%	85.0%	0.6%	2.3%	0.6%
Availability of affordable, quality housing for older adults or those with special needs	13.3%	24.9%	77.5%	3.5%	8.7%	2.3%
Issues associated with home ownership or renting	40.5%	44.5%	75.7%	1.2%	5.8%	1.2%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	20.2%	21.4%	67.6%	2.3%	13.9%	5.8%
Homelessness or availability of shelter beds	3.5%	13.3%	84.4%	1.2%	6.9%	1.7%
Cost of utilities	55.5%	46.8%	76.3%	2.3%	5.2%	0.0%
Costs associated with weatherization	36.4%	31.8%	64.7%	4.6%	12.7%	4.0%

Socioeconomic Empowerment

"Affordable and safe housing" was the top-rated step of five that Maine Shard CHNA survey respondents believe is "very necessary" to help move people out of poverty and to a place of stability.

Populations and Communities Impacted by Housing

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For housing, respondents cited: adults, New Mainers/immigrants, unhoused/housing insecure, older adults, and young adults (18-25).

Community Resources to Address Housing

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities, as were those at the forum. For housing, respondents identified:

- 211
- Auburn Housing Authority
- Community Concepts
- Community Providers/Case Management
- Department of Health and Human Services
- General Assistance
- Healthy Homeworks
- Immigrant Resource Center of Maine
- Lewiston Housing Authority
- Low Income Home Energy Assistance Program
- Pine Tree Legal Services
- Preble Street
- Resettlement Agencies
- Schools
- Section 8 Housing
- Shelters, including New Beginnings, Safe Voices, Trinity Jubilee, Hope Haven
- Sophia's House

Crosscutting Priorities

Poverty

Provider Availability

Provider availability was the second priority for the community conditions category for Androscoggin County. 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

In the county-wide focus group, "accessibility of care" was a top theme. Focus group participants said:

"Access to mental health services…[you] can't get a live person on the phone. Some people don't have access or don't feel comfortable with [virtual options] or telehealth."

"It's hard to find a good doctor that talks with you. Insurance is a barrier, [you may be able to] find a good provider, but [they might not] take your insurance."

In Androscoggin County 7.4% of people are uninsured (2018-2022) and 12.1% have experienced cost barriers to health care (2019-2021). As of 2024 in Androscoggin County, there was one primary care provider for every 855 people; one psychiatrist for every 11,625 people; and one mental health provider for every 190 people. Forum participants noted the gaps and high deductibles that affect healthcare coverage. They also discussed insurance related stipulations on what topics can be covered during preventative care visits.

In the past year, 42.9% of survey respondents said there have been one or more times when they or a loved one needed care but could not or chose not to get it. "Long wait times to see a

provider" and "have health insurance, could not afford care" were two of the top three reasons for not getting care. These reasons were also cited when asked about not seeking mental health services when they were needed. Almost 40% of survey respondents or their loved ones have not sought mental health care one or more times in the past year.

In addition to what people pay for care, forum participants also cited gaps in reimbursement rates, specifically for ambulances, and report hospitals are struggling financially. It is also challenging to attract and retain providers, which is exacerbated by a lack of housing options. The providers that are in the region are reported to be overwhelmed by patient caseloads and its suggested case managers would benefit from additional training. Forum participants would like to see case managers taking on more of a role getting patients on waitlists and helping them remember appointments.

Forum participants also cited issues accessing dentists and physicians, but did highlight a new space for adult and pediatric dental care. As of 2024, there were 2,482 people for every dentist in Androscoggin County.

Despite challenges finding providers and accessing care, a majority of adults are receiving some level of care according to quantitative data. In Androscoggin County, 87.6% of adults have a usual primary care provider (2019-2021) and 80.2% of adults have visited their primary care provider in the past year during the same time period.

Socioeconomic Empowerment

In the statewide survey, when asked which steps are "very necessary" to move a person out of poverty to a place of stability, Maine Shared survey respondents rated "mental health care and treatment" and "affordable and available health care" as numbers three and four respectively out of five.

Populations and Communities Impacted by Provider Availability

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For provider availability, respondents cited: adults, New Mainers/immigrants, refugees/asylees, older adults, and young adults (18-25).

Community Resources to Address Provider Availability

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. For provider availability, respondents identified:

- B Street Community Clinic
- Community organizations
- Free Care/MaineCare
- Healthcare training programs
- Hospitals – Central Maine Medical Center, St. Mary's Health System
- Schools/School based services
- Spurwink
- Telehealth options
- Tri-County Avalon
- Trinity Jubilee Center
- Waterville Housing Authority

Crosscutting Priorities

Housing **Adult Screening & Preventative Visits** **Mental Health**

Poverty

Poverty was the third priority for the community conditions category for Androscoggin County. 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

In the statewide survey, "low incomes and poverty" was the third ranked social concern out of five negatively impacting the community and 72.5% of survey respondents said "economic needs" negatively impacted themselves, a loved one, and/or their community. In Androscoggin County during the period 2018-2022, 12.4% of individuals lived in poverty, 7.4% of families lived below the federal poverty level, and 17.8% of children lived in poverty.

When asked about more specific economic needs, survey respondents cited,

- "availability of quality, affordable childcare" (74.2%),
- "access to affordable, quality foods" (70.6%), and
- "availability of jobs and employment opportunities" (69.1%) as top impacts on their communities.
- 52.6% of people said the "ability to contribute to savings, retirement" impacted them personally.

As of 2023, 65.8% of children in Androscoggin County were served in publicly funded state and local preschools and in 2024 there were 70 child care centers. As of 2022, 13.8% of adults and 23% of youth were food insecure and in 2023, 2.9% of people in Androscoggin County were unemployed.

The responses from the survey were similar to discussions at the Androscoggin County stakeholder forum. Forum participants credited poverty to the lack of employment and underemployment, along with the lack of job opportunities and companies that have relocated out of the area. A lack of skills and training was also listed as a root cause, but participants noted some training programs do exist allowing people to earn while they learn such as St. Mary's Nursing Assistance Training Program and the Progressive Employment Program at the state level, which focuses on people with substance use disorder and those in the criminal justice system.

Forum participants also discussed that people lack emergency savings and opportunities to create savings. In 2022, 30.6% of households were living above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold of financial survival. The ALICE household survival budget is the bare minimum cost of household basics necessary

to live and work in the current economy. In 2021, 20% of people were asset poor, meaning they have insufficient net worth to live without income at or above the poverty level for three months. Regarding child care, forum participants believe child care accessibility is critical to open up resources, but the costs are prohibitive. Forum participants also discussed the impact of inflation on seniors with limited or fixed incomes.

Socioeconomic Empowerment

When asked to rate the top five items to move someone out of poverty to a place of stability, "jobs that pay enough to support a living wage" was ranked second as "very necessary" by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Poverty

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For poverty, respondents cited: older adults, children, youth, teens, and young adults.

Community Resources to Address Poverty

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities, as were those at the forum. For poverty, respondents identified:

- 211
- Bridges Out of Poverty
- B-Street Clinic
- Churches
- Citylink
- Community Clinical Services
- Community Concepts
- Department of Health and Human Services
- Fedcap
- Food Pantries
- General Assistance Program
- Kaydenz Kitchen
- L/A CA$H Coalition
- Lewiston Housing Authority
- Libraries
- Maine CareerCenters
- Maine Immigrant and Refugee Services
- New Beginnings
- New Ventures
- Pine Tree Legal
- Recovery Friendly Workplaces
- Safe Voices
- Schools
- Small Business Administration
- Strengthen L-A
- Supplemental Nutrition Assistance Program
- Temporary Assistance for Needy Families
- Trinity Jubilee Center
- United Way
- Vocational Rehabilitation
- Women, Infants and Children Program
- Working Fields
- WorxLink program

Crosscutting Priorities

Adverse Childhood Experiences

Nutrition

Adult Screening & Preventative Visits

Illicit Drug Use

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 Androscoggin County, 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.

Androscoggin County Protective & Risk Factors			
Adverse Childhood Experiences	Nutrition	Illicit Drug Use	Adult Screening & Preventative Visits

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the top-rated priority for the protective and risk factors category for Androscoggin County. 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.[viii]

Assessment Findings

In 2021, 29.6% of high school students in Androscoggin County had adverse childhood experiences. In the Maine Shared CHNA survey, the top five social concerns that negatively impact the community could be associated with ACEs – mental health issues, substance use, low incomes and poverty, homelessness, and housing insecurity. Three-quarters of survey respondents said mental health needs (75.2%) and economic needs (72.5%), potential root causes of ACEs, impact them, a loved one, and/or their community.

Androscoggin County stakeholder forum participants discussed contributing factors to ACEs. These include community conditions such as poverty, unstable or poor housing conditions, and single parent households. Forum participants also discussed the impact of bullying on young people. In Androscoggin County, 25.1% of high school (2019) and 49.6% of middle school students (2023) were bullied on school property and 18.7% of high school (2021) and 39.4% of middle school students (2023) experienced electronic bullying.

Of the 75.2% of Maine Shared CHNA survey respondents who said mental health needs negatively impact them, a loved one, and/or their community, 52.3% said "youth mental health" impacts their community. As of 2019, 34.1% of high school students had felt sad/hopeless for two weeks in a row and 18.7% had seriously considered suicide. As of 2023, 34.9% of middle school students reported the feeling of being sad/hopeless for two weeks in a row and 21.2% had seriously considered suicide.

Stakeholder forum participants noted youth mattering and ACEs are recognized in the Androscoggin County community and are being addressed by such organizations as Androscoggin Community Health Stakeholders Coalition, Community Concepts, Inc., the Boys and Girls Club, Central Maine Healthcare, and Maine Family Planning. Participants noted schools as an area of potential improvement to work on ACEs

Populations and Communities Impacted by Adverse Childhood Experiences

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For ACEs, respondents cited: children, youth, teens, young adults, and New Mainers/immigrants.

Community Resources to Address Adverse Childhood Experiences

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. For ACEs, respondents identified:

- After school programs
- Child Protective Services
- Community conversations and trainings on ACEs and Positive Childhood Experiences (PCEs)
- Community reading opportunities of the book "What Happened to You?"
- Department of Health and Human Services
- Foster Care
- LA Youth Network
- Maine Resilience Building Network
- Promise Head Start
- Provider awareness and training
- Root Cellar
- Tree Street Youth

Crosscutting Priorities

Housing **Poverty**

Nutrition

Nutrition was the second rated priority for the protective and risk factors category for Androscoggin County. 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

In the Androscoggin County focus group, one participant said:

"Access to food, healthy foods. There are pantries but not everyone has transportation to places."

Participants at the Androscoggin County stakeholder forum also discussed the lack of transportation and its impact on whether someone is able to get to a food pantry, along with the impact of food pantry hours on access.

In the statewide survey, of the 72.5% who said "economic needs" negatively impacts them, a loved one, and/or their community, 34% of people living in Androscoggin County said "access to affordable, quality foods" impacts them, 33.5% said it impacts a loved one, and 70.6% said it impacts their community. As of 2022, 13.8% of adults and 23% of youth were food insecure. Access to affordable, quality foods was also discussed at the Androscoggin County stakeholder forum, with participants noting the cost of food, the need to prioritize other purchases over nutritional food, and a lack of access to culturally appropriate food.

In Androscoggin County:

- 37.5% of adults reported less than one serving a day of fruit (2021).
- 15.2% reported less than one serving a day of vegetables (2021), significantly better than the U.S. (20.4%).
- 12.9% of high school students reported five or more servings of fruits and vegetables per day and 19.9% reported drinking one or more soda/sports drinks per day (2019).
- 16% of middle school students reported five or more servings of fruits and vegetables per day and 26.4% reported drinking one or more soda/sports drinks per day (2023).

Forum participants cited the provision of free school meals as an asset to addressing nutrition and food insecurity. Opportunities to address nutrition include money management training to make cost-effective food choices at the grocery store and cooking classes, specifically those that are oriented toward people with limited time to cook.

Populations and Communities Impacted by Nutrition

In a pre-forum survey to identify initial priority topics, forum registrants were also asked to identify populations impacted by their identified priorities. For nutrition, respondents cited: children, adults, older adults, youth, and teens.

Community Resources to Address Nutrition

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities, as were those at the forum. For nutrition, respondents identified:

- Department of Health and Human Services
- Employer-based food pantries
- Gleaners
- Go NAPSACC
- Good Food Council LA
- Good Shepard Food Bank
- Hope Haven Gospel Mission
- Hunger Vital Signs Program at Central Maine Medical Center
- Kaydenz Kitchen
- Let's Go 5210
- Lewiston Housing Food Insecurity
- Local food pantries
- Lots to Gardens
- Maine Harvest Bucks
- School-based food pantries and lunch programs
- Soup Kitchens
- St. Mary's Nutrition Center
- Supplemental Nutrition Assistance Program and SNAP-Ed
- Trinity Jubilee Center
- Women, Infants and Children Program

Crosscutting Priorities

Poverty

Illicit Drug Use

Illicit drug use was the third rated priority for the protective and risk factors category for Androscoggin County.

Assessment Findings

Survey respondents said, "substance use," which includes illicit drug use, was the second of five social concerns that negatively impacts their community and 68.3% of survey respondents said substance use negatively impacts themselves, a loved one, and/or their community. Specifically, 73.6% of respondents said "other illicit drug use" impacts their community, 18.1% said it impacts a loved one, and 2.2% said it impacts themselves. In Androscoggin County,

- There were 68 overdose deaths per 100,000 people (2023).
- There were 49.4 drug-induced deaths per 100,000 for 2018-2022, a significant increase from 2015-2019 (28.4 per 100,000).
- Lifetime illicit drug use among high school students was 3.4% (2024).

Androscoggin County stakeholder forum participants cited the impact of the medical system on illicit drug use, specifically prescribing practices and care protocols that may lead to addiction. In 2020 there were 12.4 narcotic doses dispensed for every 1,000 people. Forum participants noted a lack of detox facilities for those who are actively using. With regard to youth use and initiation, participants believe there are a lack of activities for youth and a lack of adult supervision. Overall, there is the perception substances are easy to access in the community. Forum participants also discussed the impact of mental health and ACEs on illicit drug use.

Socioeconomic Empowerment

A reduction in substance use was rated the fifth of five "very necessary" steps to help move someone out of poverty and to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Illicit Drug Use

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For illicit drug use, respondents cited: adults, people with mental health disorders, people with substance use disorder, young adults, and teens.

Community Resources to Address Illicit Drug Use

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities, as were those at the forum. For illicit drug use, respondents identified:

- An Angel's Wing
- Avalon Counseling Services
- Better Life Partners
- Church of Safe Injection
- City of Lewiston Recreation Department
- Community Concepts
- Community organizations
- Groups Recover Together
- Healthy Androscoggin
- Hospitals
- Lewiston Auburn Area Recovery Collaborative
- Maine Re-Entry Network
- Milestone
- OPTIONS program
- Police Activities League
- Recovery Connections of Maine
- Recovery friendly workplaces
- Root Cellar
- Schools
- Sophia's House
- Spurwink
- St. Francis House
- St. Mary's
- Tree Street
- YMCA/YWCA
- Youth serving organizations

Crosscutting Priorities

Adverse Childhood Experiences | **Mental Health** | **Substance Use Related Injury & Death**

Adult Screening & Preventative Visits

Adult screening and preventative visits was also the third rated priority for the protective and risk factors category for Androscoggin County. For the purposes of the prioritization process, this includes topics such as: annual well visits, cholesterol checked, A1c checked, and eye exams.

Assessment Findings

Androscoggin County focus group participants cited "accessibility of care" as a top theme. One participant said:

"It's hard to find a good doctor that talks with you. Insurance is a barrier, [you may be able to] find a good provider, but [they might not] take your insurance."

In the Maine Shared CHNA survey 43% of survey respondents said they could not or chose not to get health care services in the past year due to "long wait times to see a provider," "hard to get time off from work," and "had health insurance, could not afford care." Androscoggin County stakeholder forum participants also discussed access to care, noting there is a lack of providers in the area, and many are susceptible to burnout, are carrying large panel sizes, or are not reimbursed adequately. In 2024, there were 855 people in Androscoggin County for every primary care provider.

Forum participants also discussed the lack of access to insurance and transparency related to screening costs. In Androscoggin County, 7.4% of people are uninsured (2018-2022) and 12.1%

have experienced cost barriers to health care (2019-2021). Transportation may also be a barrier for some in accessing medical appointments and others may experience language or cultural barriers.

Despite barriers to care, in Androscoggin County quantitative data shows:

- 80.2% of adults had seen their primary care provider in the past year (2019-2021).
- 89% of people had their cholesterol checked in the past five years (2017 & 2019).
- 75.7% of adults with diabetes had their A1c test at least twice a year (2014-2021).
- 55.8% of adults in Androscoggin County had a dentist visit in the past year, which is significantly worse than Maine (66.7%) and the U.S. (66.7%, 2020).

Socioeconomic Empowerment

Maine Shared CHNA survey respondents rated "affordable and available health care" as the fourth of five steps to move someone out of a place of poverty and to a place of stability.

Populations and Communities Impacted by Adult Screening and Preventative Visits

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For adult screening and preventative visits, respondents cited: adults, older adults, New Mainers/immigrants, people with low-income, and veterans.

Community Resources to Address Adult Screening and Preventative Visits

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. For adult screening and preventative visits, respondents cited:

- B Street Community Clinic
- Central Maine Medical Center
- Community Clinical Services
- Healthy Androscoggin's HPV and Cancer Screening
- Maine Breast and Cervical Health
- Maine Family Planning
- New Mainers Public Health Initiative
- St. Mary's Health Center

Crosscutting Priorities

Provider Availability

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 Androscoggin County, 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.

Androscoggin County Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Cardiovascular Disease**

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Androscoggin County. 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

One participant in the Androscoggin County focus group said:

> **"Access to mental health services…[you] can't get a live person on the phone. Some people don't have the access or don't feel comfortable with [virtual options] or telehealth."**

Androscoggin County stakeholder forum participants note the lack of care in the community, specifically with regard to primary care providers and psychiatric care as providers retire. In 2024 in Androscoggin County there were 855 people for every primary care provider and 11,625 people for every psychiatrist. Forum participants noted challenges with insurance and accessing care and a general lack of mental health resources, specifically for people who are unhoused. In the Maine Shared CHNA survey 39.8% of respondents say they could not or chose not to get mental health care services in the past year due to "long wait times to see a provider," "had health insurance, could not afford care," and "hard to get time off from work."

Forum participants discussed the systemic health inequities that exacerbate mental health and how people often address their hierarchy of needs, putting other needs before their mental health. As people try to address their needs, forum participants note the impacts of poverty and access to nutritional food.

In the Maine Shared CHNA survey, "mental health issues'' was the top social concern out of five that negatively impact the Androscoggin County community and 75.2% of people said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about more specific topics of mental health, people responded mental health impacts them in one way or another across topics, depicted in Table 2: Mental Health Needs.

In Androscoggin County, 12.3% of adults reported current symptoms of depression; 26.7% reported depression at any point in their life; and 27.7% have experienced anxiety in their lifetime (2019-2021). Overall, 71.3% of Maine Shared CHNA survey respondents rate their own mental health as "good or excellent."

Several sectors in Androscoggin County are addressing mental health. Examples of these efforts include homing systems which connect people to each other to understand systems in place; the community resource hub; and partnering with substance use treatment facilities to connect and provide wraparound services.

Table 2: 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	53.3%	57.8%	59.8%	2.0%	4.0%	2.0%
Depression	46.2%	59.3%	60.3%	1.0%	5.5%	2.0%
Bipolar disorder	5.5%	30.2%	48.2%	4.5%	18.6%	12.6%
Trauma or post-traumatic stress disorder (PTSD)	31.7%	39.2%	61.8%	3.0%	10.6%	5.5%
General stress of day-to-day life	62.8%	64.8%	63.8%	0.5%	6.0%	2.0%
Social isolation or loneliness	25.6%	40.2%	64.8%	2.5%	9.5%	3.5%
Stigma associated with seeking care for mental health or substance use disorders	17.1%	34.2%	56.8%	8.0%	15.1%	5.5%
Suicidal thoughts and/or behaviors	16.1%	31.7%	57.8%	5.0%	14.6%	6.5%
Youth mental health	11.6%	29.6%	62.3%	5.5%	10.1%	9.0%

Socioeconomic Empowerment

Mental health was the third of five "very necessary" steps Maine Shared CHNA survey respondents believe will help move people from poverty to a place of stability.

Populations and Communities Impacted by Mental Health

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For mental health, respondents cited: young adults, youth, teens, adults, and older adults.

Community Resources to Address Mental Heath

Participants in the pre-forum survey and at the forum were also asked to identify assets and resources related to their identified priorities. For mental health, respondents cited:

- Alternative Services
- Andwell Health Partners
- Auburn Resource Hub
- Blue Willow Counseling
- Central Maine Medical Center
- Community organizations
- Kennebec Behavioral Health
- Lewiston Resource Hub
- Lewiston VA Clinic
- Lifeline
- Maine Resilience Building Network
- Primary care physicians
- Recovery Homes
- Schools and school-based providers
- Spurwink
- St. Mary's Hospital
- Sweetser
- The Warming Center
- Youth organizations

Crosscutting Priorities

Poverty **Provider Availability**

Substance Use Related Injury & Death

Substance use related injury and death was the second rated priority for the health conditions and outcomes category for Androscoggin County. For the purposes of the prioritization process, this includes topics such as: drug affected infants, overdose, and opiate poisoning.

Assessment Findings

Statewide survey respondents listed "substance use" as the second of five social concerns negatively impacting Androscoggin County and 68.3% said "substance use" negatively impacts themselves, a loved one, and/or their community. Three-quarters of survey respondents said, "alcohol misuse or binge drinking" (75.8%), "opioid misuse" (75.3%), and "illicit drug use" (73.6%) impacts their community and 34.6% say "alcohol misuse or binge drinking" impacts a loved one. In Androscoggin County,

- There were 68 overdose deaths per 100,000 people (2023).
- There were 49.4 drug-induced deaths per 100,000 people (2018-2022), significantly higher than Androscoggin County in 2015-2019 (28.4).
- There were 19.6 alcohol-induced deaths per 100,000 people (2018-2022).

Participants at the Androscoggin County stakeholder forum believe there is a lack of access for substance use treatment in general, and more specifically a lack of funding for stimulant use disorder. Many cited the connection between mental health and substance use and lack of access for treatment when both conditions are involved. Narcan training and its use is increasing, with required trainings for both those in Emergency Medical Services and providers. Stakeholder respondents noted similar root causes and contributing factors for substance use as mental health – challenges with insurance and accessing care and a general lack of mental health resources, specifically for people who are unhoused. They also discussed the systemic health inequities that exacerbate mental health and how people often address their hierarchy of needs, putting other needs before their health.

Androscoggin County is addressing substance use related injury and death, as noted by forum participants, through such efforts as: street medicine outreach.

Socioeconomic Empowerment

Maine Shared CHNA survey respondents rated substance use as the fifth of five steps that are "very necessary" to move people out of poverty and to a place of stability.

Populations and Communities Impacted by Substance Use Related Injury and Death

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For substance use related injury and death, respondents cited: young adults, adults, people with substance use disorder, teens, and older adults.

Community Resources to Address Substance Use Related Injury and Death

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. For substance use related injury and death, respondents cited:

- An Angel's Wing Recovery Resource Center
- Blue Sky Counseling
- Blue Willow Counseling
- Central Maine Medical Center
- Church of Safe Injection
- Community organizations
- EMS Leave Behind Program
- Generational Noor
- Health Affiliates Maine
- Healthy Androscoggin
- Kaydenz Kitchen
- Lewiston Auburn Area Recovery Collaborative
- Maine Community Integration
- Naloxone Distribution Sites
- OPTIONS
- Outreach workers
- Peer Recovery Support
- Police Department
- Recovery Connections of Maine
- Recovery Friendly Workplaces
- Schools
- Spurwink
- St. Mary's Regional Medical Center
- Winter Warming Center
- Working Fields

Crosscutting Priorities

Poverty **Provider Availability** **Mental Health**

Cardiovascular Disease

Cardiovascular disease was the third rated priority for the health conditions and outcomes category for Androscoggin County. For the purposes of the prioritization process, this includes topics such as: high blood pressure, high cholesterol, heart attack, and stroke.

Assessment Findings

In the Maine Shared CHNA survey, 71.3% of respondents said, "chronic health conditions," which includes cardiovascular disease, impacted themselves, a loved one, and/or their community. More specifically,

- 42.6% and 43.1% said "heart disease or heart attack" impacted a loved one or their community.
- 48% said high cholesterol impacted a loved one.
- 52.8% said high blood pressure or hypertension impacted a loved one.

There are several cardiovascular indicators for which Androscoggin County is doing significantly worse than Maine, with one exception of heart failure hospitalizations, where Androscoggin County has seen significant improvements between 2016-2018 (11.9 per 10,000) and 2019-2021 (3.4 per 10,000) and better than Maine (4.5 per 10,000 in 2019-2021). These data are outlined in Table 3: Cardiovascular Disease

Participants at the Androscoggin stakeholder forum identified food deserts, obesity, and diabetes as contributing factors of cardiovascular disease. In 2022, 13.8% of adults and 23% of youth were food insecure. In 2021, 36.2% of adults were obese and 11.2% of adults had diabetes (2019-2021). Public transportation and health insurance were also cited as factors to accessing care. In Androscoggin County 7.4% of people are uninsured (2018-2022). Healthy Androscoggin, specifically their food resource guide, nutrition center, and food kits, was identified as an organization addressing cardiovascular disease.

Table 3: Cardiovascular Disease	Androscoggin County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cardiovascular Disease							
Cardiovascular disease deaths per 100,000 population	2015-2019 **221.1**	2018-2022 **229.1**	○	2018-2022 **200.4**	!	2021 **231.8**	N/A
Coronary heart disease deaths per 100,000 population	2015-2019 **90.0**	2018-2022 **112.5**	!	2018-2022 **82.0**	!	2021 **92.8**	N/A
Heart attack deaths per 100,000 population	2015-2019 **20.9**	2018-2022 **24.9**	○	2018-2022 **24.6**	○	2021 **26.8**	N/A
Stroke deaths per 100,000 population	2015-2019 **40.3**	2018-2022 **34.1**	○	2022 **29.4**	○	2021 **41.1**	N/A
High blood pressure hospitalizations per 10,000 population	2016-2018 **18.0**	2019-2021 **24.8**	!	2019-2021 **19.4**	!	—	N/A
Heart failure hospitalizations per 10,000 population	2016-2018 **11.9**	2019-2021 **3.4**	★	2019-2021 **4.5**	★	—	N/A
Heart attack hospitalizations per 10,000 population	2016-2018 **23.5**	2019-2021 **20.7**	○	2019-2021 **18.9**	!	—	N/A

Table 3: Cardiovascular Disease	Androscoggin County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Stroke hospitalizations per 10,000 population	2016-2018 **22.1**	2019-2021 **21.5**	○	2019-2021 **19.2**	!	—	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.

Populations and Communities Impacted by Cardiovascular Disease

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For cardiovascular disease, respondents cited: adults, older adults, people with low-income, New Mainers/immigrants, and refugees/asylees.

Community Resources to Address Cardiovascular Disease

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities, as were those at the forum. For cardiovascular disease, respondents identified:

- B Street Community Clinic
- Central Maine Medical Center
- Food pantries
- Healthy Androscoggin
- Let's Go 5210
- Seniors Plus (chronic disease self-management programs)
- SNAP-Ed
- St. Mary's

Crosscutting Priorities

Nutrition

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;"[ix]
- 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

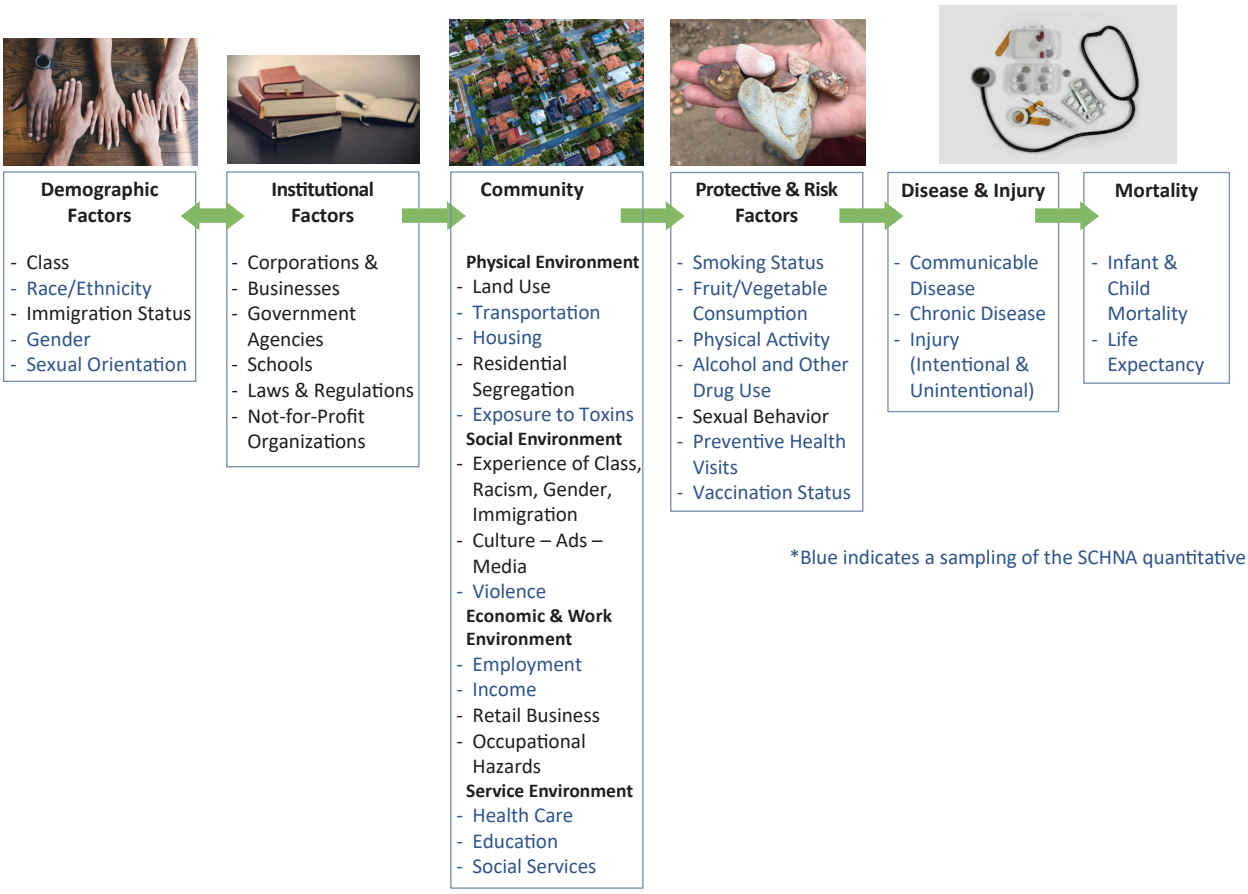
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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[x] (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.[xi] 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.

One in-person stakeholder forum was held in Androscoggin County on October 24, 2024, with 26 attendees. People from the following organizations participated in the forum process:

- Alfond Youth & Community Center
- Augusta Police Department
- Community Health & Counseling Services
- Consumers for Affordable Health Care
- Corrections
- Healthy Communities of the Capital Area
- Healthy Living for ME
- Kennebec Behavioral Health
- Kennebec Valley Community Action Program
- Maine Center for Disease Control and Prevention
- MaineGeneral
- MaineGeneral Health - Peter Alfond Prevention and Healthy Living Center
- MaineGeneral Medical Center
- Northern Light Inland Hospital
- OPTIONS/Sweetser
- United Way of Kennebec Valley
- Wellness Mobile Foundation

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

Prior to the stakeholder forums, registrants were asked to take part in a review of quantitative and qualitative data, in the form of data health profiles and community engagement overviews. Based on their interpretation of this information and their own knowledge, expertise, and experience, registrants were asked to vote on their top five health and well-being priorities in each of the following categories: community conditions, protective and risk factors, and health conditions and outcomes. This priority identification was the first step in the overall Maine Shared CHNA health and well-being prioritization process. The complete results are depicted in the table below.

Table 1: Complete Results of the First Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	27	84.4%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	21	65.6%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	18	56.3%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	16	50.0%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	8	25.0%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	8	25.0%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	7	21.9%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	7	21.9%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	5	15.6%
Employment Opportunities	5	15.6%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	5	15.6%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	4	12.5%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	3	9.4%
Bullying	3	9.4%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	3	9.4%
Climate Impacts (such as extreme weather events)	2	6.3%
Isolation	2	6.3%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	2	6.3%
Wage Gaps and Income Disparities	2	6.3%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	6.3%

Community Conditions	# Votes	% of Participants
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	2	6.3%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	2	6.3%
Education (such as pre-K through post-secondary and technical/trade opportunities)	1	3.1%
Systemic Discrimination	1	3.1%
Other (please specify): Drug-related deaths	1	3.1%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	20	62.5%
Illicit Drug Use	19	59.4%
Adverse Childhood Experiences	14	43.8%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	11	34.4%
Youth Mattering (such as positive role models, community connections, etc.)	10	31.3%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	8	25.0%
Cancer Prevention (such as cancer screenings, sunscreen use)	8	25.0%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	8	25.0%
Alcohol Use (including binge drinking)	8	25.0%
Vaping Use (including tobacco and cannabis)	8	25.0%
Preventive Oral Health Care	7	21.9%
Cannabis Use	7	21.9%
Injury Prevention (such as fall prevention, always wear a seat belt)	6	18.8%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	6	18.8%
Immunizations & Vaccinations	4	12.5%
Access to Child and Family Home Visiting	4	12.5%
Prescription Drug Misuse	4	12.5%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	2	6.3%
Foster Care	1	3.1%
Indoor Air Quality	1	3.1%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	2	6.3%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	2	6.3%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	24	75.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	20	62.5%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	18	56.3%
Obesity/Weight Status	15	46.9%
Diabetes	14	43.8%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	24	75.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	20	62.5%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	18	56.3%
Obesity/Weight Status	15	46.9%
Diabetes	14	43.8%
Cancer	11	34.4%
Intentional Injury & Death (self-injury)	8	25.0%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	7	21.9%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	7	21.9%
Multiple Chronic Conditions	6	18.8%
Dental Disease	5	15.6%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	4	12.5%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	3	9.4%
Cognitive Decline, Alzheimer's disease and other dementias	3	9.4%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	2	6.3%
Non-Infectious Respiratory Disease (such as asthma, COPD)	2	6.3%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	2	6.3%

After a presentation of key quantitative and qualitative findings and breakout discussions, participants were asked to take part in a second round of voting to narrow the health and well-being priorities for their county to the top three in each category of community conditions, protective & risk factors, and health conditions & outcomes. The complete results are depicted in the table below.

Table 2: Complete Results of the Second Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	73.7%	28
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	63.2%	24
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	60.5%	23
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	36.8%	14
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	26.3%	10
Bullying	26.3%	10
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	10.5%	4

Protective and Risk Factors	# Votes	% of Participants
Adverse Childhood Experiences	24	63.2%
Nutrition (such as fruit & veg consumption, soda/sports drink consumption)	20	52.6%
Illicit Drug Use	20	52.6%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	20	52.6%
Youth Mattering (such as positive role models, community connections, etc.)	17	44.7%
Cannabis Use	13	34.2%
Cancer Prevention (such as cancer screenings, sunscreen use)	8	25.0%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	8	25.0%
Alcohol Use (including binge drinking)	8	25.0%
Vaping Use (including tobacco and cannabis)	8	25.0%
Preventive Oral Health Care	7	21.9%
Cannabis Use	7	21.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	38	100.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning), Vascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	35	92.1%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	32	84.2%
Obesity/Weight Status	5	13.2%
Diabetes	2	5.3%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	2	6.3%

Appendix 3: Community Action Agency Profile

About Community Concepts Inc.

Community Concepts is a community-based 501(c)3 non-profit organization in Maine that has been supporting residents in Androscoggin, Oxford, and Franklin Counties to strengthen families since 1965. CCI helps more than 14,000 people every year with a dynamic range of services. Community Concepts fosters economic development in Maine through its wholly owned subsidiary, Community Concepts Finance Corporation (CCFC). CCFC provides home and business loans, financial coaching, and education to help people and businesses realize their financial goals.

Our Mission: "To provide pathways to a healthy life for and with those most impacted by inequities in Western Maine through programs, partnerships, and advocacy."

Our Vision: "To provide pathways to a healthy life for and with those most impacted by inequities in Western Maine through programs, partnerships, and advocacy."

Our Values:

- WHOLE FAMILIES We connect families with services to meet basic needs and work to correct the root causes of poverty to support current and future generations.
- PEOPLE AND RELATIONSHIPS matter. We work to build trust and create stronger connections that support everyone's journey toward hope, financial stability, and success.
- COMMUNITY THAT COOPERATES We cooperate with community partners by sharing our strengths and resources to build a stronger community.
- DIVERSITY & EQUITY: We welcome and create paths for people from diverse backgrounds to be leaders, decision-makers, and innovators. We value the wisdom and ideas that diverse experiences bring to create lasting solutions for everyone.

Services Offered by Community Concepts Inc.

Home Programs and Renovation:

- **Home Building and Renovating:** Our Self-Help program helps income-eligible families build their own homes with the help of other families or get support to purchase or rehab an existing home.
- **Evaluation and Maintenance:** Testing for lead paint (removal), home energy efficiency, and grant-funded maintenance work, including home repair.

Home Energy and Heating Assistance

- **Heating Assistance and Home Repair:** Energy and fuel assistance programs support residents in danger of having no heating oil or having utilities cut. The Central Heating Improvement Program (CHIP) provides grants to repair or replace heating systems or unsafe furnaces. We also offer weatherization services like insulation and repairs for safety and energy efficiency.

Children and Family Services

Works with a variety of partners to develop affordable housing options within communities. Current properties include:

- **Head Start and Childcare:** 13 licensed centers in Oxford and Franklin Counties provide center- and home-based Head Start services to income-eligible families, serving pregnant women and children from newborns through entering kindergarten. We have 7 centers that offer childcare services for children 6 weeks to kindergarten age.
- **Food Program:** We administer the USDA Child and Adult Care Food Program, which reimburses independent, licensed childcare homes for providing nutritious meals and snacks to enrolled children.
- **Maine Families Program:** Using the Parents as Teachers model, Family Visitors explore healthy pregnancies, child development, parenting topics, questions, and concerns with parents. Enrollment is open to anyone expecting or with a newborn residing in Androscoggin, Oxford, and Northern Cumberland Counties.
- **Parenting Support and Coaching:** We offer Parenting classes, support, playgroups, training on safe sleep, mandated reporting, and the Front Porch Project. We also offer Whole-Family Coaching services for families in Androscoggin and Oxford Counties to help them work toward their life goals.

Community Concepts Finance Corporation

- **Business Advisory Services:** Advisors work with clients one-on-one to help them start, expand, or buy a business. Free services include marketing and financing support.
- **Business Loans:** Loans to start or buy a business, provide working capital, or meet other business needs.
- **Homebuyer Counseling and Education:** Comprehensive group classes and personalized counseling services provide the skills and knowledge needed for successful homeownership and help participants meet requirements for most homebuyer assistance programs.
- **Credit and Foreclosure Counseling:** Free confidential assistance for individuals with credit difficulties to prevent foreclosure.

Oxford County Mental Health Services

- **OCMHS:** Provides comprehensive behavioral health services.
- **Crisis Intervention:** 24/7 community-based crisis assessment, intervention, and aftercare support.
- **Crisis Residential Unit:** Located in Rumford, a short-term residential care program offering emotion regulation skills development and case management to provide a safe return to the community.
- **Options Program:** Clinicians support treatment, harm reduction, and recovery for those seeking change in their substance use or supporting a loved one.
- **Behavioral Health Homes and Community Integration Services:** These services provide physical and behavioral health care coordination, community integration, wellness, education, and support.
- **Outpatient Therapy:** Mental Health Counseling, Substance Use treatment, Dialectical Behavior Therapy (DBT), and specialized groups.
- **Beacon House (Rumford):** A peer Recovery center offering peer support, structured groups, and self-help activities to encourage independence and self-reliance.
- **Andy's Place (Rumford)** is a community Residence and Rehabilitation program for adults suffering from mental illness. This program supports independent living, community integration, and wellness.

Maine Resiliency Center

The Maine Resiliency Canter was created in response to the mass shooting tragedy that happened on October 25, 2023, in Lewiston. The MRC offers a safe space for our guests to find connection, support and resources.

- **One-on-one Support and Advocacy:** Advocates provide one-on-one and family support to assist in navigating available resources and services.
- **Groups:** Provides various group support to affected community members. Groups are facilitated by trauma-informed providers and are available for both youth and adults.
- **Wellness Activities:** Staff organize and facilitate various restorative wellness activities, including yoga, meditation, and retreats to parks and camps, to help foster resiliency and connection.
- **Community Events:** Staff host events at the MRC or other venues to offer resources and connect with the community.
- **Education and Training:** Offering practice training and education resources to the community.

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

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

ix 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

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

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