2025 Maine Shared Community Health Needs Assessment

Northern Light Health

Franklin 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 Franklin 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

Franklin County Health and Well-Being Priorities

The following table includes the top health and well-being priorities identified by Franklin 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)	Alcohol Use	Mental Health (ME)
Poverty (ME)	Adverse Childhood Experiences (ME)	Substance Use Related Injury & Death
Transportation (ME)	Illicit Drug Use	Cancer

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

Provider Availability Nutrition 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 Franklin 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 Franklin 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

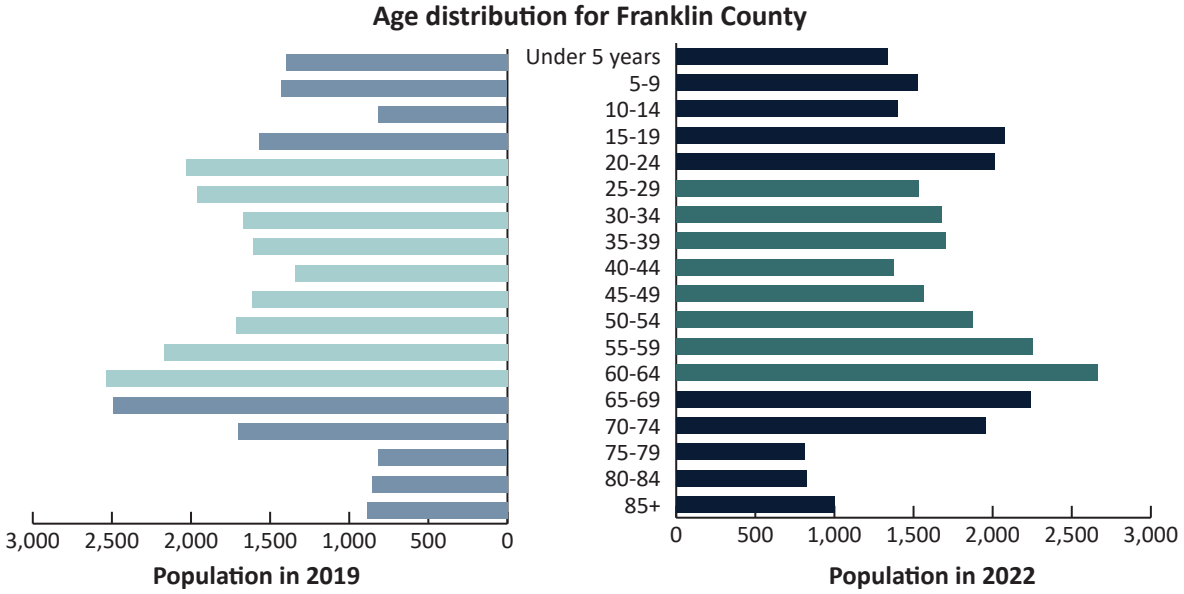
The following tables and chart show information about the population of Franklin County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Franklin County Population	State of Maine Population
29,839	**1,366,949**

	Franklin	Maine
Median household income	**$56,890**	**$68,251**
Unemployment rate	**3.4%**	**3.1%**
Individuals living in poverty	**12.1%**	**10.9%**
Children living in poverty	**16.2%**	**13.4%**
65+ living alone	**26.4%**	**29.5%**

	Franklin County	
	Percent	Number
American Indian/Alaskan Native	**0.1%**	**38**
Asian	**0.5%**	**155**
Black/African American	**0.4%**	**120**
Native Hawaiian or other Pacific Islander	**0.0%**	**3**
Some other race	**0.4%**	**121**
Two or more races	**3.3%**	**989**
White	**95.2%**	**28,413**
Hispanic	**1.5%**	**462**
Non-Hispanic	**98.5%**	**29,377**

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 Franklin County.

Cause of Death	Maine	Franklin County
Cancer	**25.9%**	**26.6%**
Heart disease	**27.2%**	**25.0%**
Accidents	**10.5%**	**9.4%**
Chronic lower respiratory disease	**6.8%**	**8.8%**
COVID 19	**6.0%**	**6.5%**
Alzheimer's disease	**4.1%**	**5.5%**
Diabetes	**4.6%**	**4.9%**
Cerebrovascular disease	**4.8%**	**3.9%**
Chronic liver disease and cirrhosis	**2.3%**	**2.9%**
Influenza & pneumonia	**2.1%**	**2.6%**
Suicide	**2.0%**	**1.9%**
Parkinson's disease	**1.7%**	**1.3%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**0.6%**

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.

Franklin County	Maine
1) Affordable and safe housing	1) Jobs that pay enough to support a living wage
2) Mental health care and treatment	2) Affordable and safe housing
3) Affordable & quality childcare	3) Mental health care and treatment
4) Affordable & available health care	4) Affordable & available health care
5) Jobs that pay enough to support a living wage	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 Franklin 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.

Franklin County Strengths

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

- Safe opportunities to be active outside;
- Safe neighborhoods;
- Locally owned businesses;
- Schools and education for all ages; and
- Strong sense of community.

People living in Franklin County have a positive outlook on their health and well-being – 72% of survey respondents believe their community is healthy or very healthy; 81% rate their own physical health as good or excellent and 81% 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 Franklin 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.

Franklin County Community Conditions		
Housing	Poverty	Transportation

Housing

Housing was the top priority for the community conditions category for Franklin 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 Franklin County focus group top themes included "affordable housing" and "emergency and transitional housing." One focus group participant said:

"There is definitely a housing crisis. Who can afford first, last and security deposit?"

Franklin County stakeholder forum participants reiterated the costs of rising rent. In Franklin County 7.5% of households spend more than 50% of their income toward housing (2018-2022), significantly better than Maine (11.3%) and the U.S. (14.1%). The median gross rent is $752, also significantly better than Maine ($1,009) and the U.S. ($1,268).

Other focus group participants said:

"I got MaineHousing while working with a navigator. I was able to go to the top of the list by doing what they wanted me to do. Now they are putting people in hotels because the waiting lists are so long."

"Homeless shelters are a need. There used to be one, but it shut down during COVID."

Franklin County stakeholder forum participants also noted the lack of temporary and emergency housing, including a lack of sober living homes. Forum participants highlighted formerly incarcerated individuals who face barriers due to a lack of transitional housing beds for men and women, and people with criminal records face significant hurdles. In 2023, there were 63 children experiencing homelessness in Franklin County and 3.7% of high school students were housing insecure, significantly worse than 2021 (2.8%), but better than Maine (2.6%).

In the Maine Shared CHNA survey, respondents in Franklin County listed "housing insecurity" as one of the top five social concerns that negatively impact their community and 74.7% of respondents say "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, a majority cited several needs that impact their community, with lower percentages, but still noteworthy, impacting a loved one or themselves, as indicated in Table 1: Housing Needs.

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	37.0%	39.7%	84.9%	2.7%	4.1%	0.0%
Availability of affordable, quality homes/rentals	26.0%	37.0%	89.0%	2.7%	2.7%	1.4%
Availability of affordable, quality housing for older adults or those with special needs	15.1%	17.8%	84.9%	5.5%	6.8%	2.7%
Issues associated with home ownership or renting	37.0%	41.1%	87.7%	2.7%	5.5%	0.0%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	20.5%	31.5%	67.1%	9.6%	17.8%	0.0%
Homelessness or availability of shelter beds	13.7%	19.2%	75.3%	9.6%	12.3%	1.4%
Cost of utilities	39.7%	39.7%	86.3%	2.7%	4.1%	1.4%
Costs associated with weatherization	30.1%	26.0%	75.3%	2.7%	13.7%	1.4%

Socioeconomic Empowerment

When asked to rate the top five steps that are "very necessary" to move people out of poverty and to a place of stability Maine Shared CHNA survey respondents rated "affordable and safe housing" as the number one step.

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, older adults, unhoused/housing insecure, young adults, and people living in rural areas.

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:

- Community Concepts
- Community Health Workers
- Grant funded vouchers
- Healthy Community Coalition of Franklin County
- Housing and Urban Development
- Landlords
- LEAP Inc.
- Maine State Housing Authority
- Mission at the Eastwood
- Rangely Health and Wellness
- Salvation Army
- United Methodist Economic Ministry
- USDA Rural Development
- Veterans' Affairs
- Western Maine Community Action

Poverty

Poverty was the second rated priority for the community conditions category for Franklin 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, and ALICE (Asset Limited, Income Constrained, Employed) thresholds.

Assessment Findings

In the Maine Shared CHNA survey, respondents in Franklin County listed "low incomes and poverty" as the third of five social concerns negatively impacting their community and 78.2% of respondents said "economic needs" negatively impact them, a loved one, and/or their community. When asked about specific economic needs,

- 76.3% of respondents said, "availability of quality, affordable childcare" impact their communities.
- 76.3% said "access to affordable, quality foods" impact their communities.
- Almost half of people (47.5%) said the "ability to contribute to savings, retirement" impact a loved one and themselves.

In 2023, 53.9% of children in Franklin County were served in publicly funded state and local preschools and in 2024 there were 17 child care centers. In 2022, 13.6% of adults and 20.8% of youth were food insecure.

Participants at the Franklin County stakeholder forum discussed the root causes and contributing factors to poverty. These included broader topics of generational poverty and systemic injustices. Forum participants discussed economic related causes of poverty, such as low wages and a lack of jobs, specifically manufacturing. As of 2023, 3.4% of people in Franklin County were unemployed. Related to employment, forum participants noted there is a lack of a skilled workforce, and at the same time, a lack of educational opportunities to advance skills. In Franklin County, 38.6% of people have an Associate's degree or higher (2018-2022), significantly worse than Maine (44.4%) and the U.S. (43%). There is also a lack of child care in the region which may impact some people's ability to work, even when jobs do exist.

Forum participants noted the number of people in Franklin County who fall into the Asset Limited, Income Constrained and Employed (ALICE) status (36.3%, 2022), which means despite

working they face financial challenges and do not qualify for the majority of financial assistance. Forum participants recognize that this group of people are working hard and giving back, but don't know if they can put food on the table for their family. The ALICE household survival budget is the bare minimum cost of household basics necessary to live and work in the current economy.

In Franklin County,

- 16% of people are asset poor, meaning they have insufficient net worth to live without income at or above the poverty level for three months (2021).
- 12.1% of individuals live in poverty (2018-2022).
- 4.8% of families live below the federal poverty level, significantly better than Maine (6.4%) and the U.S. (8.8%, 2018-2022).
- 16.2% of children live in poverty (2018-2022).

Socioeconomic Empowerment

When asked about the top five "very necessary" steps to move someone from poverty to a place of stability, "affordable and quality child care" was ranked number three and "jobs that pay enough to support a living wage" was ranked number five 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:

- Adult Education
- Career Center
- Community Concepts
- Community Health Workers
- Department of Health and Human Services
- Farmington Ecumenical Ministry
- Food banks and pantries, specifically the Care and Share Food Closet
- Franklin County Children's Task Force
- Healthy Community Coalition
- MaineHealth's Access to Care Program
- Town General Assistance
- United Way
- Warming Centers
- Western Maine Community Action
- Western Maine Economic Council

Transportation

Transportation was the third rated priority for the community conditions category for Franklin County. For the purposes of the prioritization process, transportation includes such topics as access to transportation, availability of public transportation, and transportation that meets a variety of specific needs.

Assessment Findings

In the Franklin County focus group, one participant said:

> **"Transportation is a huge barrier. People know where the resources are, they just can't get to them."**

In the Maine Shared CHNA survey, 74.1% of respondents said "transportation needs" negatively impact them, a loved one, and/or their community. When asked about specific transportation needs, "availability of transportation" (80.3%), "availability of transportation that meets a variety of specific needs" (77.6%), and "access to transportation" (77.6%) were listed as top impacts on the community, while "costs associated with owning and maintaining a vehicle" were most likely to impact a loved one. Table 2: Transportation Needs shows these and other specific needs.

Participants at the Franklin County stakeholder forum discussed an overall lack of infrastructure and bikeable/walkable areas. Of the 51.6% of survey respondents who said "public safety needs" negatively impact them, a loved one, and/or their community, 59.3% said "pedestrian or bicycle safety" negatively impacts their community. Forum participants also discussed a lack of dependable public transportation, specifically when impacted by weather.

Participants highlighted Modivcare as a resource and noted there are restrictions to accessing it. Western Maine Transportation Services is available, but underutilized due to limited awareness and difficulties in navigating services. In addition, Franklin County is one of the more rural counties in Maine, impacting the effectiveness of public transportation. Community Health Workers and Recovery Coaches are teaching individuals to access these resources and providing transportation vouchers.

The costs of transportation were also widely discussed, spanning the costs of fuel, car insurance, driver's education and participating in the Driver Education and Evaluation Programs (DEEP). The costs associated with driver's education, reported at over $600, may be contributing to young people not getting their licenses. In Franklin County 9.2% of households do not have a vehicle (2018-2022).

Forum participants would like to see efforts focus on ongoing education, supporting community members, and securing funding for low-cost transportation options.

Table 2: Transportation Needs, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Access to transportation (for medical appointments, work, childcare)	18.4%	28.9%	77.6%	3.9%	6.6%	1.3%
Availability of public transportation (buses, trains, ride shares, taxis)	22.4%	27.6%	80.3%	6.6%	7.9%	2.6%
Availability of transportation that meets a variety of specific needs (older adults, physical or cognitive needs)	14.5%	25.0%	77.6%	2.6%	9.2%	0.0%
Costs associated with owning and maintaining a vehicle (insurance, registration, repairs)	35.5%	40.8%	69.7%	5.3%	9.2%	2.6%

Populations and Communities Impacted by Transportation

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For transportation, respondents cited: adults, older adults, people living in rural areas, people with low-income, and young adults.

Community Resources to Address Transportation

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

- Community Health Workers
- Healthy Community Coalition
- Modivcare
- MOMs Taxi
- Rangeley Health & Ride
- United Way of the Tri-Valley Area
- Western Maine Community Action Program
- Western Maine Transportation Services

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 Franklin 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

Franklin County Protective & Risk Factors		
Alcohol Use	**Adverse Childhood Experiences**	**Illicit Drug Use**

Alcohol Use

Alcohol use was the top priority for the protective and risk factors category for Franklin County.

Assessment Findings

In the Franklin County focus group, "substance use services, including detox" was a top theme. In the Maine Shared CHNA survey, respondents said "substance use," which includes alcohol, is a top social concern in their community. Of the 74.7% of survey respondents who said substance use impacts them, a loved one, and/or their community, 68.4% said alcohol misuse or binge drinking impacts their community, 39.2% said it impacts a loved one, and 15.2% said it impacts them.

Franklin County stakeholder forum participants discussed the impacts of mental health on alcohol use, specifically with regard to unresolved trauma, social isolation, and feeling unvalued, specifically for youth. Forum participants also believe people use alcohol to self-medicate. In Franklin County, there is a shortage of treatment facilities and limited options for detox. During the period 2019-2021, 10.8% of adults reported chronic heavy drinking and 18.2% reported binge drinking.

Forum participants discussed the culture of social drinking, such as breweries promoting socialization with family and friends. Forum participants shared that youth report the normalization of drinking, peer pressure, and increased access directly impacts their likelihood to use. In 2023, 20.2% of high school and 6% of middle school students report past 30-day alcohol use and 9.3% of high school and 2.3% of middle school students report binge drinking.

In addition, forum participants note there is the impact of generational poverty which may increase alcohol use rates.

Populations and Communities Impacted by Alcohol Use

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

Community Resources to Address Alcohol 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 alcohol, respondents identified:

- Alcoholics Anonymous
- Faith-based organizations
- Franklin County Children's Task Force
- Franklin County Recovery Center
- Groups Recover Together
- Healthy Community Coalition
- HealthReach
- Kennebec Behavioral Health
- Law enforcement
- Local healthcare providers
- MaineHealth Behavioral Health
- MaineHealth Franklin Hospital
- OPTIONS
- Recovery Centers
- Schools
- Substance disorder therapists
- Sweetser

Crosscutting Priorities

Mental Health

Adverse Childhood Experiences

Adverse childhood experiences was the second rated priority for the protective and risk factors category for Franklin 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 the Franklin County focus group, "mental health services, especially crisis services" was a top theme. In the Maine Shared CHNA survey, the four of the five top social concerns that negatively impact the community could be associated with ACEs – mental health issues, substance use, low incomes and poverty, and housing insecurity.

Approximately three-quarters of survey respondents said economic needs (78.2%), mental health needs (77.3%), substance use (74.7%), and housing needs (74.7%), potential root causes of ACEs, impact them, a loved one, and/or their community. Of the survey respondents who said mental health needs, 63.9%, 34.9%, and 20.5% said "youth mental health" negatively impacts their community, a loved one, and themselves, respectively.

In Franklin County,

- 31.5% of high school students had at least four of nine adverse childhood experiences (2023).
- 37.4% of high school and 36.3% of middle school students had been sad/hopeless for two weeks in a row, with middle school percentages significantly worse than Maine (32.7%, 2023).
- 18.7% of high school and 23.6% of middle school students had seriously considered suicide (2023).

At the Franklin County stakeholder forum, participants discussed the impact of generational poverty and family conditions, including a lack of family support and social isolation, on ACEs. Forum participants noted there is a lack of resources and treatment options and inadequate funding for programs. In 2024, there was one mental health provider for every 310 people. When resources are available, transportation may be a barrier to accessing them and people may not know they exist or how to access them. In addition, people may experience real or perceived stigma in accessing services.

There are ongoing efforts in Franklin County to provide more positive childhood experiences and opportunities for protective factors such as creating opportunities for positive youth experiences and building positive community relationships.

Socioeconomic Empowerment

"Mental health care and treatment" were rated the second of five "very necessary" steps to move someone from poverty to a place of stability by Maine Shared CHNA survey respondents.

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: youth, teens, young adults, children, and adults.

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
- Community Concepts
- Franklin County Children's Task Force
- Head Start
- HealthReach
- Healthy Community Coalition
- Kennebec Behavioral Health
- Local Department of Health and Human Services
- MaineHealth Franklin Hospital
- Recreation Department
- Schools
- Western Maine Behavioral Health
- Youth mattering initiatives (through Healthy Community Coalition and local schools)
- Youth sports

Crosscutting Priorities

Transportation **Poverty** **Housing** **Alcohol Use**

Illicit Drug Use **Mental Health** **Substance Use Related Injury & Death**

Illicit Drug Use

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

Assessment Findings

In the Franklin County focus group, participants noted "substance use services, including detox" as a top theme and in the Maine Shared CHNA survey, respondents said "substance use," which includes illicit drug use, is a top social concern in their community. Of the 74.7% of survey respondents who said substance use impacts them, a loved one, and/or their community, 69.6% said "opioid misuse" impacts their community, 19% said it impacts a loved one, and 7.6% said it impacts them. "Other illicit drug use" impacts 67.1% of respondents' communities, 22.8% of their loved ones, and 10.1% are impacted themselves.

In Franklin County,

- There were 20 overdose deaths for every 100,000 people (2023).
- 35.6 drug induced deaths per every 100,000 people (2018-2022), significantly better

than Maine (55.6 per 100,000).
- 4.8% of high school and 4.4% of middle school students reported past 30-day misuse of prescription drugs (2023).
- 4.9% of high school students reported lifetime illicit drug use (2024).

Franklin County stakeholder forum participants discussed the impacts of mental health on illicit drug use, specifically with regard to unresolved trauma, social isolation, and feeling unvalued, specifically for youth. Forum participants believe people may use substances to self-medicate. In Franklin County, there is a shortage of treatment facilities and limited options for detox. In addition, forum participants note there is the impact of generational poverty which may increase illicit drug use rates.

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, young adults, teens, older adults, and people with substance use disorder.

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:

- Faith-based organizations
- Franklin County Recovery Center
- Groups Recover Together
- Healthy Community Coalition
- Law enforcement
- MaineHealth Behavioral Health
- MaineHealth Franklin Hospital
- Medication Assisted Treatment
- Narcotics Anonymous
- Prevention education through Healthy Community Coalition and local schools
- Recreation Department
- Schools
- Town Offices
- University of Maine Farmington
- Western Maine Community Action
- Youth Leadership Board

Crosscutting Priorities

Poverty **Mental Health** **Substance Use Related Injury & Death**

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 Franklin 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.

Franklin County Health Conditions & Outcomes		
Mental Health	Substance Use Related Injury & Death	Cancer

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Franklin County. For the purposes of the prioritization process, mental health includes such topics as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, and post-partum depression.

Assessment Findings

In the Franklin County focus group, "mental health services, especially crisis services" was a top theme. Maine Shared CHNA survey respondents cited "mental health issues" as the first of five social concerns for the community and 77.3% said "mental health needs" impact them, a loved one, and/or their community. When asked about specific mental health needs, "anxiety or panic disorder," "depression," and the "general stress of day-to-day life" impacts approximately half of individuals, their loved ones, and/or their communities as indicated in Table 3: Mental Health Needs, along with other specific mental health needs. In Franklin County, 9.8% of adults have current symptoms of depression, 25% have experienced depression in their lifetime, and 24.2% of adults have had anxiety (2019-2021).

At the Franklin County stakeholder forum several themes emerged around social media and the internet, violence, and systemic factors. Regarding social media and the internet, participants cited online bullying and digital literacy and online safety risks. In 2023, 20.1% of high school and 39.6% of middle school students were electronically bullied, with the middle school percentage significantly worse than Maine (35.1%). Social media can also create a false sense of reality, which may contribute to anxiety, depression, and other mental health concerns.

There is a concern by forum participants that people, especially children, are exposed to domestic violence and gun violence and that child abuse and neglect is occurring in the community. There is also an increase in the ease of access and acceptability of cannabis use and

increasing use among young people. In 2023, 19.6% of high school and 7.5% of middle school students reported past 30-day marijuana use.

Forum participants noted systems level factors contributing to mental health such as a lack of a social infrastructure and isolation, generational poverty, and adverse childhood experiences. Overarching all of these factors is a lack of education and coping skills to address one's own mental health and that of their loved ones and community and a lack of support for the aging population. One-quarter (26.4%) of adults 65 and older live alone in Franklin County (2018-2022).

In Franklin County, 80.9% of Maine Shared CHNA survey respondents rated their own mental health as "good or excellent" and 44.5% of survey respondents said they or a loved one could not or chose not to get mental health care services in the past year. They cited "long wait times to see a provider," "not sure where to go for help," and "did not feel comfortable with available providers" as reasons why. In Franklin County, there are 310 people for every mental health provider.

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	44.6%	51.8%	47.0%	4.8%	6.0%	2.4%
Depression	43.4%	42.2%	57.8%	6.0%	3.6%	2.4%
Bipolar disorder	13.3%	32.5%	31.3%	8.4%	22.9%	9.6%
Trauma or post-traumatic stress disorder (PTSD)	30.1%	32.5%	49.4%	8.4%	13.3%	2.4%
General stress of day-to-day life	56.6%	48.2%	61.4%	6.0%	4.8%	6.0%
Social isolation or loneliness	26.5%	31.3%	59.0%	2.4%	9.6%	3.6%
Stigma associated with seeking care for mental health or substance use disorders	19.3%	27.7%	49.4%	8.4%	19.3%	3.6%
Suicidal thoughts and/or behaviors	18.1%	32.5%	47.0%	6.0%	16.9%	4.8%
Youth mental health	20.5%	34.9%	63.9%	6.0%	9.6%	3.6%

Socioeconomic Empowerment

"Mental health care and treatment" was rated the second of five "very necessary" steps to move someone from poverty to a place of stability by Maine Shared CHNA survey respondents.

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: adults, teens, young adults, youth, 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:

- Adult education
- Business with youth helpers
- Community members
- Community-based organizations
- Faith-based organizations
- Healthy Community Coalition
- In-home services
- Kennebec Behavioral Health
- Law enforcement, including the Sheriff's Office well-being checks
- Local counseling agencies
- Local schools
- Low-income housing partnering with seniors
- MaineHealth Behavioral Health
- MaineHealth Franklin Hospital
- Meals on Wheels
- NAMI
- Recreation Departments
- School-based health centers
- Seniors Plus
- Sweetser
- Teen text line
- Town offices
- Tri-County Mental Health
- United Way of the Tri Valley
- University of Maine Farmington
- Western Maine Behavioral Health
- Western Maine Community Action

Crosscutting Priorities

Poverty **Adverse Childhood Experiences**

Substance Use Related Injury & Death

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

Assessment Findings

In the Franklin County focus group, participants noted "substance use services, including detox" as a top theme and in the Maine Shared CHNA survey, respondents said "substance use" is a top social concern in their community. Of the 74.7% of survey respondents who said substance use impacts them, a loved one, and/or their community, 69.6% said "opioid misuse" impacts their community, 19% said it impacts a loved one, and 7.6% said it impacts them. "Other illicit drug use" impacts 67.1% of respondents' communities, 22.8% of their loved ones, and 10.1% are impacted themselves.

In Franklin County, there were:

- 20 overdose deaths for every 100,000 people (2023).
- 35.6 drug induced deaths for every 100,000 people (2018-2022), significantly better than Maine (55.6 per 100,000)
- 24.4 alcohol-induced deaths for every 100,000 people (2018-2022), significantly worse than 2015-2019 (7.2 per 100,000).

At the Franklin County stakeholder forum, participants discussed the mix of challenges their communities face contributing to substance use related injury and death. Generational poverty and a lack of job opportunities create financial hardships. Feelings of social isolation and not being valued deepen emotional struggles, while unresolved trauma often pushes people toward self-medicating. High rates of adverse childhood experiences (ACEs) may contribute to hopelessness, self-medicating, and substance use disorder. Additionally, untreated chronic pain, often from injuries, adds to the problem. In 2020, there were 12.8 narcotic doses dispensed for every 1,000 people. The ease of access to substances, youth being influenced by peers, unrestricted technology use and a shortage of treatment facilities are all causes identified by forum participants.

Forum participants highlighted positive work within the community to address substance use related injury and death. The Maine DHHS' Office of Behavioral Health is partnering with Franklin County to provide funding for a community recovery center. This center works with individuals to provide a social network, offering access to resources such as recovery coaches, workforce development, addressing social drivers of health, and assisting with accessing other treatment, recovery, and healthcare services. The University of Maine Farmington offers incentives to graduates to stay in the area, higher education and local community career fairs, adult education, and behavioral health. The Healthy Community Coalition receives funding from the Maine CDC to support primary prevention efforts targeting tobacco, alcohol, cannabis, and other substances. These efforts include collaborating with all schools in Franklin County to implement policies and evidence-based programs. To enhance this work, additional resources are needed, including funding to expand primary prevention initiatives for school-aged children impacted by substance use, community education based on collected data, and stronger provider collaboration between the healthcare and education systems.

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: adults, young adults, teens, older adults, and people with substance use disorder.

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:

- Adult Education
- Alcoholics Anonymous
- Franklin County Recovery Center
- Groups Recover Together
- Healthy Community Coalition
- Law enforcement
- Maine Area Health Education Center (AHEC)
- MaineHealth Behavioral Health
- MaineHealth Franklin Hospital
- Medicated Assisted Treatment
- Office of Behavioral Health
- OPTIONS
- University of Maine Farmington

Crosscutting Priorities

Poverty **Alcohol Use** **Mental Health** **Illicit Drug Use**

Adverse Childhood Experiences

Cancer

Cancer was the third rated priority for the health conditions and outcomes category for Franklin County.

Assessment Findings

In the Maine Shared CHNA survey, 78.1% of respondents said, "chronic health conditions," which includes cancer, impacts them, a loved one, and/or their community. Of those respondents, 54.3% said cancer impacts their community, 29.3% said a loved one, and 16.3% said it impacts them.

During the period 2018-2022, there were 162.4 cancer deaths for every 100,000 people in Franklin County and from 2019-2021, there were 442.3 new cancer cases for every 100,000 people. Franklin County has seen shifts in their rates of cancer deaths and new cancer cases, but data shows none are significant, with the exception of new cases of female breast cancer – 100.6 cases for every 100,000 people (2019-2021), which is significantly better than Maine (135.4 per 100,000).

At the Franklin County stakeholder forum, participants discussed the impacts of individual behaviors, environmental exposures, and genetics on cancer. On the individual level, risk factors include vaping and the use of tobacco and nicotine and low levels of or no physical activity. Related to these risk factors,

- 14.5% of adults currently smoke cigarettes (2021).
- 31.9% of adults report a sedentary lifestyle, significantly worse than the U.S. (23.7%, 2021).
- 54% of adults met physical activity recommendations (2017 & 2019).

Forum participants also note there are low cancer screening rates in Franklin County. Challenges exist with accessing cancer screenings, especially with regard to provider access, which may be exacerbated by long wait times for appointments, health literacy, a lack of health insurance, or transportation barriers. Despite this, data shows that in Franklin County,

- 82.6% of people are up to date on breast cancer screening (2018 & 2020).
- 79.8% are up to date on cervical cancer screening (2018 & 2020).
- 72% are up to date on colorectal cancer screening (2020), significantly worse than Maine (81.2%).
- For those eligible, 18.7% of adults have had lung cancer screenings (2018-2021).

Populations and Communities Impacted by Cancer

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

Community Resources to Address Cancer

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

- American Cancer Society
- Colonoscopy services
- Community health
- Community Health Workers
- Community partners
- Dempsey Center
- HealthReach
- Healthy Community Coalition
- MaineHealth Franklin Hospital
- Primary care practices
- Rangeley Health and Wellness

Crosscutting Priorities

Transportation

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

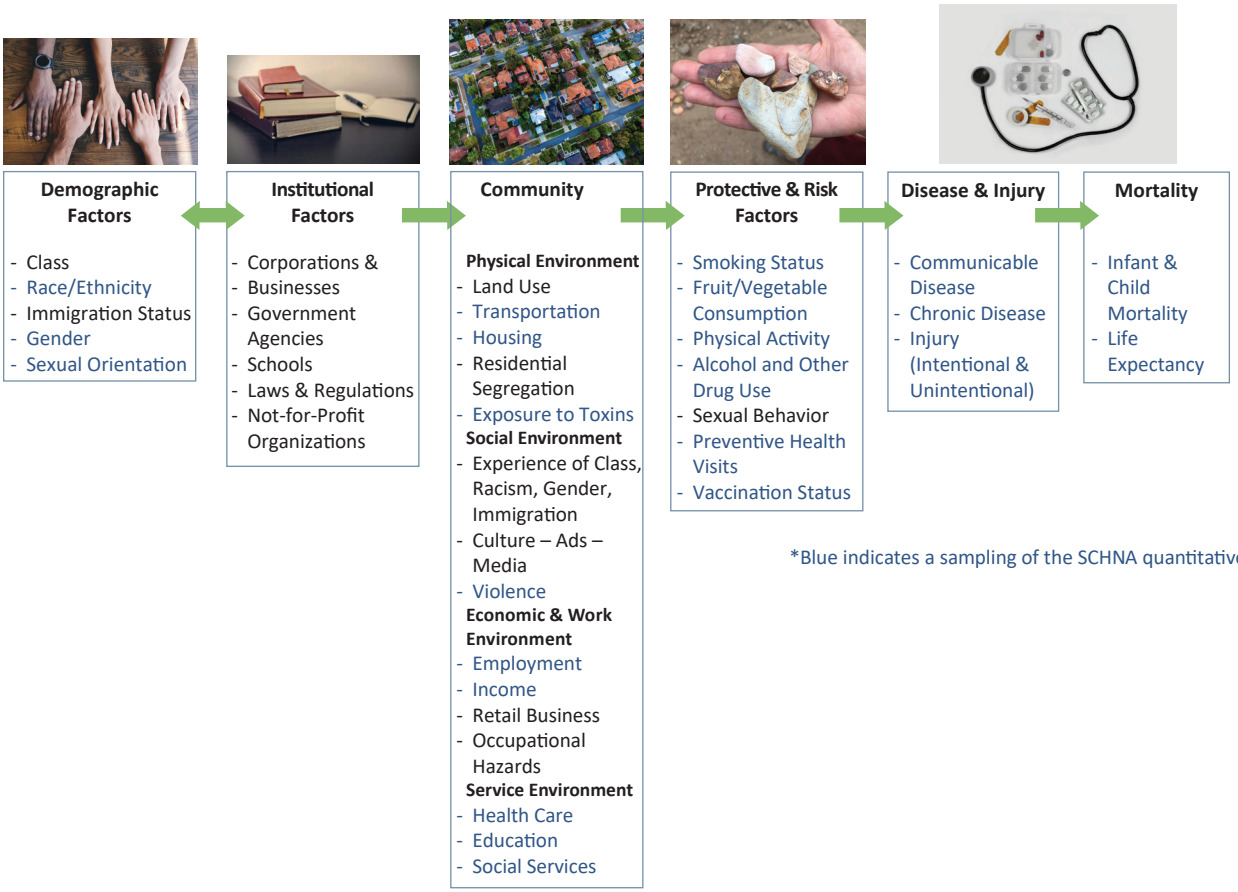
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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 Franklin County on September 18, 2024, with 50 attendees. People from the following organizations participated in the forum process:

- Avalon Counseling Services
- Better Life Partners
- Community Concepts
- Franklin County
- Franklin County Children's Task Force
- Franklin County Emergency Management Agency
- Franklin County Sheriff's Office
- Greater Franklin Economic and Community Development
- Greater Franklin Food Council
- Join Groups
- Kennebec Behavioral Health
- Lifeline for ME
- Literacy Volunteers of Franklin and Somerset Counties
- MaineHealth Franklin Hospital
- MaineHealth
- MaineHealth/Franklin Healthy Community Coalition
- MSAD 58
- Mt. Blue Regional School District (RSU9)
- OPTIONS
- PQC4ME
- Sexual Assault Prevention and Response Services (SAPARS)
- Spruce Mountain Adult Education
- University of Maine at Farmington
- Western Maine Community Action

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)	29	85.3%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	24	70.6%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	23	67.7%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	14	41.2%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	12	35.3%
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)	12	35.3%
Isolation	8	23.5%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	7	20.6%
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.)	6	17.7%
Climate Impacts (such as extreme weather events)	5	14.7%
Employment Opportunities	5	14.7%
Technology (such as access to high-speed internet and phone services)	4	11.8%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	4	11.8%
Wage Gaps and Income Disparities	3	8.8%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	2	5.9%
Education (such as pre-K through post-secondary and technical/trade opportunities)	2	5.9%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	5.9%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	2	5.9%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	2	5.9%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	1	2.9%

Community Conditions	# Votes	% of Participants
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	1	2.9%
Systemic Discrimination	1	2.9%

Protective and Risk Factors	# Votes	% of Participants
Alcohol Use (including binge drinking)	16	47.1%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	15	44.1%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	15	44.1%
Adverse Childhood Experiences	15	44.1%
Illicit Drug Use	14	41.2%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	13	38.2%
Youth Mattering (such as positive role models, community connections, etc.)	13	38.2%
Preventive Oral Health Care	11	32.4%
Immunizations & Vaccinations	7	20.6%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	7	20.6%
Prescription Drug Misuse	7	20.6%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	6	17.7%
Vaping Use (including tobacco and cannabis)	6	17.7%
Cancer Prevention (such as cancer screenings, sunscreen use)	4	11.8%
Cannabis Use	4	11.8%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	3	8.8%
Safe Drinking Water	3	8.8%
Injury Prevention (such as fall prevention, always wear a seat belt)	1	2.9%
Foster Care	1	2.9%
Access to Child and Family Home Visiting	1	2.9%
Indoor Air Quality	1	2.9%
Other (please specify): Isolation as people age	1	2.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	30	88.2%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	22	64.7%
Obesity/Weight Status	19	55.9%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	18	52.9%
Cancer	17	50.0%
Diabetes	15	44.1%
Cognitive Decline, Alzheimer's disease and other dementias	7	20.6%
Multiple Chronic Conditions	7	20.6%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	6	17.7%
Dental Disease	5	14.7%

Health Conditions and Outcomes	# Votes	% of Participants
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)	5	14.7%
Intentional Injury & Death (self-injury)	4	11.8%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	4	11.8%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	3	8.8%
Non-Infectious Respiratory Disease (such as asthma, COPD)	1	2.9%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	1	2.9%

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)	37	80.4%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	36	78.3%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	24	52.2%
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)	22	47.8%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	17	37.0%

Protective and Risk Factors	# Votes	% of Participants
Alcohol Use (including binge drinking)	37	80.4%
Adverse Childhood Experiences	36	78.3%
Illicit Drug Use	30	65.2%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	24	52.2%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	9	19.6%

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%

Appendix 3: Community Action Agency Profile

About Western Maine Community Action

Established in 1965, Western Maine Community Action (WMCA) is a social service agency that has been providing assistance to low- and mid-income families living in the western mountain region of Maine for over 50 years. WMCA is funded with private, local, state and federal money.

Our Mission: It is Western Maine Community Action's mission to advocate for, strengthen, and coordinate all resources – private, local, state, and federal – that will assist us in promoting the self-sufficiency of people.

A belief in basic human dignity and the exercise of free choice motivates the agency to approach this goal in two ways: by providing services to alleviate the conditions of economic uncertainty and by advocating for changes to eliminate the causes of poverty.

Services Offered by WMCA

- **Nutrition Services –** Women Infants & Children (WIC), Adult and Childcare Food Program
- **Community Services –** LIHEAP (Fuel Assistance), Emergency Fuel, Senior Food Program
- **Family & Health Services –** Whole Families Coaching, Homelessness, Homeless Targeted Case Management, Childcare, Diaper Program, Health Navigator, Opioid Harm Reduction Services
- **Housing Services –** Weatherization, Central Heating Improvement, Home Repair

Acknowledgements

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

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

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

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

Endnotes

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

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

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

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

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

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

vii 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

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

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

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