2025 Maine Shared Community Health Needs Assessment

Northern Light Health

Somerset 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 Somerset 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

Somerset County Health and Well-Being Priorities

The following table includes the top health and well-being priorities identified by Somerset 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
Provider Availability (ME)	Adverse Childhood Experiences (ME)	Mental Health (ME)
Transportation (ME)	Illicit Drug Use	Substance Use Related Injury & Death
Housing (ME)	Alcohol Use	Chronic Conditions
	Adult Screening & Preventative Visits	

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

Poverty Substance Use Nutrition

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 Somerset 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 Somerset 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

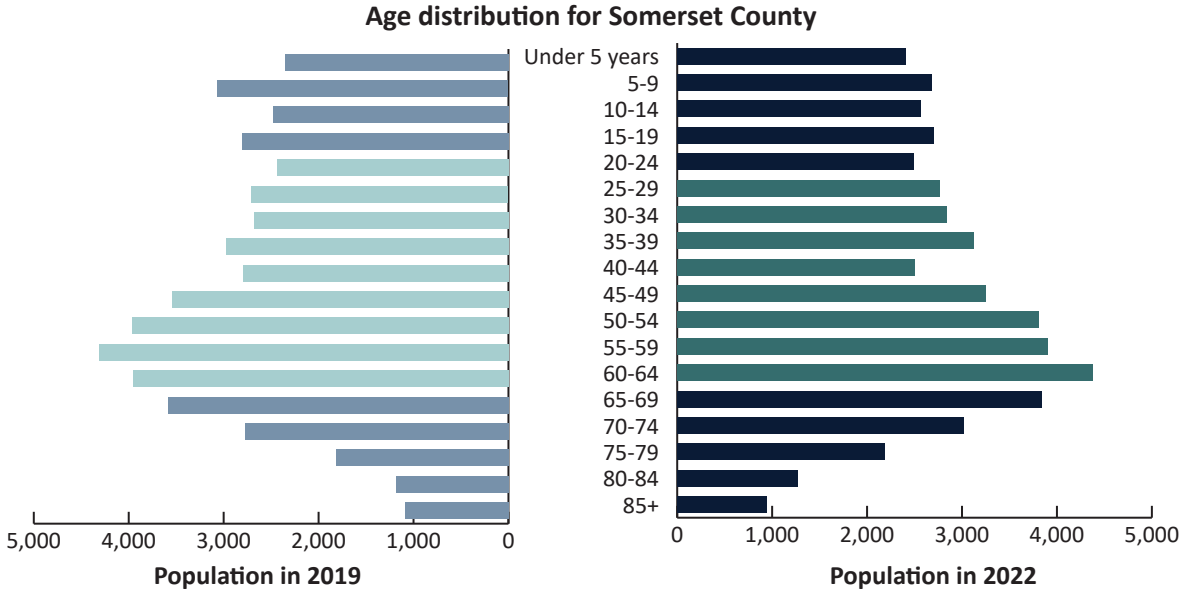
The following tables and chart show information about the population of Somerset County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Somerset County Population	State of Maine Population
50,656	**1,366,949**

	Somerset	Maine
Median household income	**$53,527**	**$68,251**
Unemployment rate	**4.0%**	**3.1%**
Individuals living in poverty	**16.8%**	**10.9%**
Children living in poverty	**19.4%**	**13.4%**
65+ living alone	**31.4%**	**29.5%**

	Somerset County	
	Percent	Number
American Indian/Alaskan Native	**0.2%**	**91**
Asian	**0.4%**	**213**
Black/African American	**0.5%**	**235**
Native Hawaiian or other Pacific Islander	**0.0%**	**19**
Some other race	**0.3%**	**127**
Two or more races	**3.0%**	**1,530**
White	**95.6%**	**48,441**
Hispanic	**1.3%**	**648**
Non-Hispanic	**98.7%**	**50,008**

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 Somerset County.

Cause of Death	Maine	Somerset County
Heart Disease	**27.2%**	**28.6%**
Cancer	**25.9%**	**25.7%**
Accidents	**10.5%**	**10.4%**
Chronic Lower Respiratory Disease	**6.8%**	**8.1%**
COVID 19	**6.0%**	**5.8%**
Diabetes	**4.6%**	**4.4%**
Alzheimer's Disease	**4.1%**	**4.3%**
Cerebrovascular Disease	**4.8%**	**3.5%**
Influenza & Pneumonia	**2.1%**	**2.5%**
Suicide	**2.0%**	**2.3%**
Chronic Liver Disease and Cirrhosis	**2.3%**	**1.8%**
Nephritis, Nephrotic Syndrome & Nephrosis	**1.8%**	**1.5%**
Parkinson's Disease	**1.7%**	**1.3%**

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.

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

Health and Well-Being Priorities

Section Overview

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

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

Socioeconomic Empowerment

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

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 Somerset 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.

Somerset County Strengths

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

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

People living in Somerset County have a positive outlook on their health and well-being – 65% of survey respondents believe their community is healthy or very healthy; 76% rate their own physical health as good or excellent and 69.4% say their mental health is good or excellent.

Community Conditions

Community conditions include the physical environment (environmental exposures, housing, transportation, etc.), economic and work environment (employment, income, etc.), social environment (discrimination, crime, community safety, etc.), and service environment (health care and social service access, education, etc.). Social drivers of health (SDOH), which are the policies, systems, structures, life experiences, and social supports that influence a person's health, most often fit into the context of community conditions. The following section outlines the top community conditions priorities for Somerset 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.

Somerset County Community Conditions		
Provider Availability	Transportation	Housing

Provider Availability

Provider availability was the top priority for the community conditions category for Somerset County. For the purposes of the prioritization process, provider availability includes such topics as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care.

Assessment Findings

In the Somerset County focus group, "physician shortage" was a top theme. Focus group participants said:

"Accessibility – wait times have gotten worse. Less doctors, less nurses, more patients."

"We don't have access to behavioral evaluations because there are no providers."

In 2024 there were 1,143 people for every primary care physician in Somerset County. Half (54.5%) of Maine Shared CHNA survey respondents said they or a loved one could not or chose not to get health care in the past year, citing reasons as: "long wait times to see a provider" and "no evenings or weekend hours to get care." With regard to mental health care, 33.9% of survey respondents said they or a loved one could not or chose not to get mental health care in the past year with the top reason as "long wait times to see a provider." These sentiments were echoed at the Somerset County stakeholder forum. Participants discussed the difficulty in finding and retaining physicians. Despite this, data shows 87.3% of adults have a usual primary care provider and 79.4% have visited a primary care provider in the past year (2019-2021).

Dental care was specifically discussed at the forum, with participants noting funding is not put toward recruiting dentists and there are challenges with obtaining a dental license in Maine through the Maine Dental Board. In 2024 there were 4,989 people for every dentist. In Somerset County, 60.3% of adults have visited the dentist in the past year (2020), 46.8% of insured children had at least one preventative dental visit in the past year (2022), and 50% of MaineCare members under age 21 had been to the dentist in the past year (2021).

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty and to a place of stability, "affordable and available health care" was rated number five by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Provider Availability

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

Community Resources to Address Provider Availability

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

- Blue Sky
- Bridge Clinic
- Certified Community Behavioral Health Clinics
- Kennebec Behavioral Health
- Opioid Health Home
- OPTIONS
- Penobscot Community Health Center
- Primary care providers
- Recovery Coaching Center
- Somerset Public Health
- Telehealth

Transportation

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

Assessment Findings

In the Somerset County focus group, "transportation" was a top theme. In the Maine Shared CHNA survey, "lack of transportation" was the fourth of five social concerns that negatively impact respondents' community. Participants in the Somerset County stakeholder forum also discussed a lack of transportation options, specifically walkable communities given the nature of the towns in Somerset County and no on-demand public transportation options. For the public transportation that is available, forum participants said it does not serve many people. From 2018-2022, 0.1% of those aged 16 and older used public transportation to commute to work. Forum participants also noted the poor conditions of the roads which are exacerbated by weather challenges.

Approximately half of Maine Shared CHNA survey respondents (56.5%) said "transportation needs" negatively impact them, a loved one, and/or their community. When asked about specific transportation needs, "costs associated with owning and maintaining a vehicle" impacted respondents (53.6%), their loved ones (53.6%), and their communities (78.6%) with several other topics impacting respondents' community as detailed in Table 1: Transportation Needs. In Somerset County,

- 6.2% of people do not have a vehicle in the household (2018-2022), significantly better than 2015-2019 (9%) and the U.S. (8.3%, 2021).
- During the period 2018-2022, 41.7% of people had a commute greater than 30 minutes alone, significantly worse than 2015-2019 (35.9%), Maine (33.9%) and the U.S. (36.5%).

Forum participants would like to see a more organized approach to address transportation by town governments with a focus on planning.

Table 1: 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)	4.8%	25.0%	84.5%	1.2%	8.3%	4.8%
Availability of public transportation (buses, trains, ride shares, taxis)	17.9%	23.8%	86.9%	0.0%	4.8%	3.6%
Availability of transportation that meets a variety of specific needs (older adults, physical or cognitive needs)	3.6%	15.5%	81.0%	2.4%	13.1%	2.4%
Costs associated with owning and maintaining a vehicle (insurance, registration, repairs)	53.6%	53.6%	78.6%	0.0%	3.6%	0.0%

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: people with substance use disorder, people with low-income, caregivers, young adults, and unhoused/housing insecure.

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:

- Kennebec Valley Community Action Program
- Opportunities Driving Schools
- Sebasticook Valley Van
- Taxi company
- Volunteer drivers and organizations

Housing

Housing was the third priority for the community conditions category for Somerset 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 Somerset County focus group, "housing for all" was a top theme. In the Maine Shared CHNA survey, 62.1% of respondents said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, several topics impacted respondents, their loved ones, and their community, such as "housing costs," "issues associated with home ownership or renting," "cost of utilities," and "costs associated with weatherization." These details and other responses are in Table 2: Housing Needs.

Somerset County stakeholder forum participants also noted the affordability of homes, specifically for people earning between 60% to 100% of the area median income and those who qualify for Section 8 Housing. Data shows during the period 2018-2022, 10.6% of households spent more than 50% of their income toward housing, significantly better than the U.S. (14.1%). Median gross rent in Somerset County was $849, significantly worse than 2015-2019 ($728), but significantly better than Maine ($1,009) and the U.S. ($1,268).

Forum participants discussed low housing stock, specifically housing that was built in the last 15 years, which may attribute to reports by survey respondents of issues with home ownership or renting and costs of weatherization. Over 50% (54.6%) of housing in Somerset County was built before 1979 and only 5.7% of housing has been built since 2010. In 2022, 1.5% of housing units were vacant and for sale or rent and 73.8% of houses were occupied (2018-2022). Forum participants discussed many people in the community prefer to age in place which may be due to a negative perception of assisted living. In Somerset County 31.4% of people 65 and older live alone (2018-2022). Forum participants believe resources that address housing could be better coordinated.

Table 2: 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	42.9%	56.0%	84.6%	1.1%	1.1%	0.0%
Availability of affordable, quality homes/rentals	26.4%	38.5%	80.2%	1.1%	6.6%	2.2%
Availability of affordable, quality housing for older adults or those with special needs	8.8%	24.2%	74.7%	6.6%	9.9%	3.3%
Issues associated with home ownership or renting	37.4%	45.1%	73.6%	1.1%	2.2%	1.1%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	16.5%	19.8%	63.7%	3.3%	15.4%	5.5%
Homelessness or availability of shelter beds	2.2%	3.3%	72.5%	6.6%	13.2%	5.5%
Cost of utilities	54.9%	52.7%	74.7%	4.4%	3.3%	0.0%
Costs associated with weatherization	33.0%	37.4%	72.5%	2.2%	11.0%	2.2%

Socioeconomic Empowerment

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: veterans, people with low-income, adults, people with substance use disorder, and young adults.

Populations and Communities Impacted by Housing

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

Community Resources to Address Housing

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

- General Assistance
- Goodwill
- Homeless shelters
- Kennebec Behavioral Health
- Kennebec Valley Community Action Program Housing
- Low-income housing units
- Maine Housing Authority
- Projects for Assistance with Transition from Homelessness (PATH)
- SKILLS, Inc.

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 Somerset 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.

Somerset County Protective & Risk Factors			
Adverse Childhood Experiences	**Illicit Drug Use**	**Alcohol Use**	**Adult Screening & Preventative Visits**

Adverse Childhood Experiences

Adverse childhood experiences was the top priority for the protective and risk factors category for Somerset 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 Somerset County focus group, one participant said:

> **"We don't have access to behavioral evaluations because there are no providers"**

This was echoed at the Somerset County stakeholder forum by participants who discussed a lack of mental health resources and a general lack of knowledge regarding what resources are available to address mental health. There is also a stigma associated with mental health. In the Maine Shared CHNA survey, three of the five top social concerns that negatively impact the community could be associated with ACEs – substance use, low incomes and poverty, and mental health issues. Over three-quarters of survey respondents said, "economic needs" (80%) and "mental health needs" (76.3%), potential root causes of ACEs, impact them, a loved one, and/or their community. Of those who said mental health needs, 53% said youth mental health negatively impacts their community, 34% said a loved one and 15% said them.

In Somerset County,

- 35.2% of Somerset County high school students had at least four of nine adverse childhood experiences (2023).
- 37.2% of high school and 32.1% of middle school students were sad/hopeless for two weeks in a row (2023), with the percentage of middle school students significantly worse than 2019 (23.2%).
- 19.1% of high school and 19.5% of middle school students seriously considered suicide (2023).

Forum participants discussed risk factors for ACEs, including feelings of a lack of belonging and community connectedness, trauma, and bullying. In 2023, 23.3% of high school and 47.7% of middle school students reported bullying on school property and 21.5% of high school and 33.4% of middle school students experienced electronic bullying. Discrimination and poverty are institutional factors and community conditions within Somerset County that also impact ACEs.

Populations and Communities Impacted by Adverse Childhood Experiences

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For ACEs, respondents cited: veterans, unhoused/housing insecure, women, justice-involved people, people with substance use disorder, people with mental health disorder, caregivers, people who are low-income, children, people living in rural areas, older adults, youth, teens, young adults, 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:

- Adult education
- Community Reinforcement and Family Training
- GEAR Parent Network
- Head Start
- Kennebec Valley Community Action Program
- MaineMOM
- Maine Parent Federation
- Maine Resilience Building Network
- NAMI Maine
- Northern Light Sebasticook Valley Hospital
- OPTIONS
- Parents of Addicted Loved Ones
- Schools
- Somerset County Jail

Crosscutting Priorities

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

Illicit Drug Use

Illicit drug use was the second priority for the protective and risk factors category for Somerset County.

Assessment Findings

In the Somerset County focus group, "substance use services" was a top theme. In the Maine Shared CHNA survey, "substance use," which includes illicit drug use, was the number one social concern negatively impacting the community and 68.6% of survey respondents said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances, 71.7% said "opioid misuse" and 75% said "other illicit drug use" negatively impacts their community, with 20.7% saying "other illicit drug use" negatively impacts a loved one. In 2023 there were 51 overdose deaths for every 100,000 people and 48.4 drug-induced deaths for every 100,000 people (2018-2022).

Somerset County stakeholder forum participants discussed the early initiation of substance use as a contributing factor to illicit drug use, which may be related to a lack of prevention education and coping skills. In 2024, 2.9% of high school students had used illicit drugs in their lifetime.

Forum participants discussed the medical systems role in illicit drug use, specifically with regard to prescribing practices and treatment protocols for certain injuries such as traumatic brain injury. In 2020, there were 18.2 narcotic doses dispensed for every 1,000 people in Somerset County. In 2023, 5.6% of high school and 4.6% of middle school students had misused prescription drugs in the past 30 days.

Another potential risk factor for illicit drug use discussed at the forum is domestic violence. Forum participants also noted there is a lack of employment opportunities, which if available, could act as a protective factor. In Somerset County 4% of adults were unemployed in 2023.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty to a place of stability, "reduction in substance use" was rated number four by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Illicit Drug Use

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For illicit drug use, respondents cited: veterans, unhoused/housing insecure, women, justice-involved people, people with substance use disorder, people with mental health disorder, caregivers, people who are low-income, children, people living in rural areas, older adults, adults, teens, young adults, and LGBTQIA2S+.

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:

- Adult education
- Alcoholics Anonymous
- Blue SKY
- Bridge Clinic
- Community Reinforcement and Family Training
- GEAR Parent Network
- Head Start
- Kennebec Behavioral Health, specifically ROAR
- Kennebec Valley Community Action Program
- Maine Parent Federation
- Maine Resilience Building Network
- MaineMOM
- NAMI Maine
- Northern Light Sebasticook Valley Hospital
- Office of Behavioral Health
- OPTIONS
- Parents of Addicted Loved Ones
- Recovery Coaching Center
- Skowhegan treatment programs
- Somerset County Jail
- Somerset Public Health
- Support groups

Crosscutting Priorities

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

Alcohol Use

Alcohol use was the third priority for the protective and risk factors category for Somerset County.

Assessment Findings

In the Somerset County focus group, "substance use services" was a top theme. In the Maine Shared CHNA survey, "substance use," which includes alcohol use, was the number one social concern negatively impacting the community and 68.6% of survey respondents said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances, 69.6% and 38% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one, respectively.

Quantitative data for alcohol use for adults and youth are detailed in Table 3: Alcohol Indicators. Participants at the Somerset County forum discussed how the social acceptance and availability of alcohol may contribute to a low perception of its risks, which is further exacerbated by a lack of education on the dangers of alcohol use.

Table 3: Substance Use Indicators	Somerset County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Substance Use							
Chronic heavy drinking (adults)	2015-2017 **7.1%**	2019-2021 **6.1%**	○	2019-2021 **8.4%**	○	2021 **6.3%**	N/A
Past-30-day alcohol use (high school students)	2019 **22.1%**	2023 **20.3%**	○	2023 **20.5%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2019 **4.0%**	2023 **5.2%**	○	2023 **4.8%**	○	—	N/A
Binge drinking (adults)	2015-2017 **15.0%**	2019-2021 **13.4%**	○	2019-2021 **15.5%**	○	2021 **15.4%**	N/A
Binge drinking (high school students)	2019 **8.6%**	2023 **9.1%**	○	2023 **9.6%**	?	—	N/A
Binge drinking (middle school students)	2019 **1.5%**	2023 **2.5%**	N/A	2023 **1.8%**	?	—	N/A

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

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

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

○ means the change was not statistically significant.

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

— means data is unavailable.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty to a place of stability, "reduction in substance use" was rated number four by Maine Shared CHNA survey respondents.

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, as were those at the forum. For alcohol use, respondents cited: veterans, unhoused/housing insecure, women, justice-involved people, people with substance use disorder, people with mental health disorder, caregivers, people with low-income, children, people living in rural areas, older adults, adults, young adults, and teens.

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 use, respondents identified:

- Adult education
- Alcoholics Anonymous
- Community Reinforcement and Family Training
- GEAR Parent Network
- Head Start
- Kennebec Behavioral Health
- Kennebec Valley Community Action Program
- Maine Parent Federation
- Maine Resilience Building Network
- MaineMOM
- NAMI Maine
- Northern Light Sebasticook Valley Hospital
- OPTIONS
- Parents of Addicted Loved Ones
- Recovery Coaching Center
- Somerset Public Health

Crosscutting Priorities

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

Adult Screening & Preventative Visits

Adult screening and preventative visits was the fourth priority for the protective and risk factors category for Somerset County. For the purposes of the prioritization process, adult screening and preventative visits includes such topics as annual well visits, cholesterol checked, a1c checked, and eye exams.

Assessment Findings

In the Somerset County focus group, “physician shortage” and “accessible prescriptions” were top themes. One focus group participant said:

“Accessibility – wait times have gotten worse. Less doctors, less nurses, more patients.”

Participants at the Somerset County stakeholder forum discussed the lack of primary care providers. In 2024 there were 1,143 people for every primary care physician. In addition to there not being enough providers, forum participants noted a lack of child care and transportation to enable people to get to their medical appointments. Of the 56.5% of Maine Shared CHNA survey respondents who said, “transportation needs” negatively impact them, a loved one, and/or their community, “access to transportation,” which includes for medical appointments, impacts 84.5% of respondents’ community and 25% of loved ones.

In the Maine Shared CHNA 73.1% of respondents said, “chronic health conditions,” which include conditions diagnosed or monitored via screening and preventative visits, negatively impact them, a loved one, and/or their community. When asked about the impacts of specific chronic health conditions several were cited that may be diagnosed or monitored via screening including,

- 49.5% said “diabetes or high blood sugar” impacts a loved one.
- 47.5% said “high cholesterol impacts a loved one, with one-quarter saying it impacts their community (26.7%) and them (23.8%).
- 63.4% said “high blood pressure or hypertension” impacts a loved one, with just over one-quarter saying it impacts their community (29.7%) and them (27.7%).

Forum participants believe there needs to be more education and awareness about the importance of prevention and screenings.

In Somerset County,

- 12.5% of people have diabetes and there were 17.2 diabetes hospitalizations per 10,000 people, significantly worse than Maine (13.1, 2019-2021).
- 40.8% of people had high cholesterol (2021).
- 42.7% of people had high blood pressure, significantly worse than Maine (35.5%, 2017 & 2019).

About half (54.5) of Maine Shared CHNA survey respondents said they or a loved one could not or chose not to get health care in the past year. Of those, barriers included: “long wait times to see a provider,” “had health insurance, could not afford care,” and “no evenings or weekend hours to get care.” While survey respondents note they have health insurance, a lack of health insurance coupled with poverty was noted as a contributing factor to obtaining preventative care and screening by forum participants. In Somerset County 8% of people are uninsured (2018-2022) and 39.4% are enrolled in MaineCare (2020).

Three-quarters (76%) of Maine Shared CHNA survey respondents rate their own physical health as “good or excellent.” Quantitative data shows in Somerset County 87.3% of adults have a usual primary care provider and 79.4% have visited a primary care provider in the past year (2019-2021).

Socioeconomic Empowerment

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

Populations and Communities Impacted by Adult Screening and Preventative Visits

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For adult screening and preventative visits, respondents cited: veterans, unhoused/housing insecure, women, justice-involved people, people with substance use disorder, people with mental health disorder, caregivers, people with low-income, children, people living in rural areas, older adults, adults, and young adults.

Community Resources to Address Adult Screening and Preventative Visits

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

- American College of Physicians
- Federally Qualified Health Centers
- Maine Academy of Family Physicians
- Maine Medical Association
- Medical providers

Crosscutting Priorities

Transportation **Provider Availability**

Health Conditions & Outcomes

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

Somerset County Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Chronic Conditions**

Mental Health

Mental health was the top priority for the health conditions and outcomes category for Somerset 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 Maine Shared CHNA survey, respondents said "mental health issues" were the third of five social concerns negatively impacting the community and 76.3% said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about specific mental health needs, impacts were felt across respondents, their loved ones, and their community on a variety of topics, specifically, "anxiety or panic disorder," "depression," and "general stress of day-to-day life." These details and other topics are outlined in Table 4: Mental Health Needs. In Somerset County 13% of adults have current symptoms of depression, 23.7% have had depression in their lifetime, and 24.7% have had anxiety in their lifetime (2019-2021).

Somerset County stakeholder forum participants noted isolation and a lack of connection to community as risk factors for mental health, in addition to adverse childhood experiences. The impact of the COVID-19 pandemic has been a contributing factor, specifically for young people. Forum participants discussed community conditions, such as poverty and education level as contributing to mental health outcomes. Protective factors, such as physical activity and nutrition, were noted as missing in the region.

In the Maine Shared CHNA survey 69.4% of respondents rate their own mental health as "good or excellent" and 33.9% of respondents say they or a loved one could not or chose not to get mental health care in the past year citing "long wait times to see a provider," "hard to get time off from work," and "not sure where to go for help" as reasons why. In 2024 in Somerset County, there were 198,568 people for every psychiatric provider and 530 people for every mental health provider. Stakeholder forum participants discussed a lack of resources and an inability to easily access providers when needed. They also noted the barrier of stigma associated with seeking care and being diagnosed with a mental health disorder.

Table 4: 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	49.0%	63.0%	42.0%	3.0%	6.0%	2.0%
Depression	42.0%	64.0%	51.0%	1.0%	3.0%	5.0%
Bipolar disorder	3.0%	29.0%	37.0%	8.0%	22.0%	14.0%
Trauma or post-traumatic stress disorder (PTSD)	30.0%	43.0%	47.0%	6.0%	9.0%	7.0%
General stress of day-to-day life	61.0%	66.0%	56.0%	4.0%	4.0%	2.0%
Social isolation or loneliness	24.0%	38.0%	56.0%	8.0%	11.0%	1.0%
Stigma associated with seeking care for mental health or substance use disorders	16.0%	35.0%	56.0%	7.0%	13.0%	8.0%
Suicidal thoughts and/or behaviors	7.0%	22.0%	51.0%	4.0%	17.0%	14.0%
Youth mental health	15.0%	34.0%	53.0%	6.0%	13.0%	9.0%

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty and to a place of stability, "mental health care and treatment" was rated number two 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, as were those at the forum. For mental health, respondents cited: people involved with the criminal justice system, youth, children, older adults, caregivers, unhoused/housing insecure, people with low income, women, LGBTQ people, veterans, agricultural workers, teens, young adults, adults, and people with substance use disorder.

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:

- 988
- Certified Community Behavioral Health Clinics
- Emergency Management System
- Employee Assistance Programs
- Faith-based organizations
- Farmers' markets
- Federally Qualified Health Centers
- Kennebec Behavioral Health
- Kennebec Valley Community Action Program
- Law enforcement
- MaineMOM
- Medical providers
- Parks
- Public supports
- Recovery Coaching Center
- Schools, specifically RSU/MSAD #54
- Somerset County Jail
- Somerset Public Health
- Telehealth

Crosscutting Priorities

Provider Availability **Adverse Childhood Experiences**

Substance Use Related Injury & Death

Substance use related injury and death was the second priority for the health conditions and outcomes category for Somerset 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 Somerset County focus group, "substance use services" was a top theme. Participants in the Somerset County stakeholder forum noted a lack of substance use related resources and an inability to easily access providers when needed. Forum participants discussed the stigma associated with seeking help for substance use disorder.

In the Maine Shared CHNA survey, "substance use" was the number one social concern negatively impacting the community and 68.6% of survey respondents said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 75% said "other illicit drug use" negatively impacts their community, with 20.7% saying "other illicit drug use" negatively impacts a loved one.
- 71.7% said "opioid misuse" negatively impacts their community.
- 69.6% and 38% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one, respectively.

In Somerset County,

- There were 51 overdose deaths for every 100,000 people (2023).
- There were 48.4 drug-induced deaths for every 100,000 people (2018-2022).
- There were 17.6 alcohol-induced deaths for every 100,000 people (2018-2022).
- 2.9% of high school students had used illicit drugs in their lifetime (2024).
- 5.6% of high school and 4.6% of middle school students had misused prescription drugs in the past 30 days (2023).

Forum participants discussed community conditions, such as poverty and education levels, which may impact substance use. They also discussed the impacts of isolation and connection to the community, ACEs, and lack of access to physical activity and nutritious foods as contributing factors. Also discussed were the generational impacts of using substances and the impacts of substance use disorder on other people.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty to a place of stability, "reduction in substance use" was rated number four by Maine Shared CHNA respondents.

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, as were those at the forum. For substance use related injury and death, respondents cited: people involved with the criminal justice system, youth, children, older adults, caregivers, unhoused/housing insecure, people with low income, women, LGBTQ people, veterans, agricultural workers, teens, young adults, 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:

- Bridge Clinic
- Certified Community Behavioral Health Clinics
- Court system
- Emergency Management Systems
- Faith-based organizations
- Farmers' markets
- Federally Qualified Health Centers
- Kennebec Valley Community Action Program
- Law enforcement
- MaineMOM
- Medical providers
- OPTIONS
- Recovery Coaching Center
- Schools, specifically RSU/MSAD #54
- Sober House
- Somerset County Jail
- Somerset Public Health
- Telehealth

Crosscutting Priorities

Provider Availability **Illicit Drug Use** **Alcohol Use**

Adverse Childhood Experiences **Mental Health**

Chronic Conditions

Chronic conditions was the third priority for the health conditions and outcomes category for Somerset County.

Assessment Findings

In the Maine Shared CHNA survey, 73.1% of survey respondents said "chronic health conditions" negatively impact them, a loved one, and/or their community. When asked about specific chronic health conditions, no one chronic condition had resounding impacts, but several impacted respondents, their loved ones, and their communities as detailed in Table 5: Chronic Health Conditions.

Table 5: Chronic Health Conditions, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Asthma, COPD, or Emphysema	22.8%	48.5%	30.7%	1.0%	9.9%	14.9%
Arthritis	31.7%	47.5%	19.8%	3.0%	14.9%	9.9%
Cancer	5.0%	50.5%	38.6%	2.0%	11.9%	10.9%
Diabetes or high blood sugar	16.8%	49.5%	32.7%	4.0%	9.9%	8.9%
Heart disease or heart attack	8.9%	34.7%	35.6%	4.0%	18.8%	14.9%
High cholesterol	23.8%	47.5%	26.7%	6.9%	10.9%	11.9%
High blood pressure or hypertension	27.7%	63.4%	29.7%	3.0%	5.9%	6.9%
Overweight/obesity	51.5%	51.5%	42.6%	1.0%	3.0%	5.0%
Stroke	2.0%	27.7%	27.7%	7.9%	13.9%	22.8%
Chronic liver disease/cirrhosis	3.0%	10.9%	21.8%	12.9%	25.7%	30.7%

Related to the survey responses, in Somerset County,

- 14.6% of adults and 4.2% of youth currently have asthma (2019-2021), with youth percentages significantly better than Maine (8.2%, 2019-2021).
- There were 478.8 new cancer cases for every 100,000 people (2019-2021).
- 36.4% of adults have arthritis, significantly higher than Maine (30.7%, 2019-2021).
- 37.8% of adults are obese (2021).
- 21.6% of high school students are obese, significantly higher than Maine (15.7%, 2023).
- 19.8% of middle school students are obese (2023).

Populations and Communities Impacted by Chronic Conditions

Chronic conditions were added as a priority at the forum and was not addressed in the pre-forum survey; however, cancer, obesity/weight status, and diabetes were. For chronic conditions at the forum, respondents cited: older adults, children, youth, caregivers, unhoused/housing insecure, women, people with low income, veterans and agricultural workers. For cancer, obesity/weight status, and diabetes, respondents cited: adults, youth, teens, young adults, people with substance use disorder, LGBTQIA2S+, New Mainers/immigrants, and caregivers.

Community Resources to Address Chronic Conditions

Chronic conditions were added as a priority at the forum and not addressed in the pre-forum survey; however, cancer, obesity/weight status, and diabetes were. Those specific to cancer, obesity/weight, and diabetes are marked with an asterisk and may be applicable to chronic conditions in general. For chronic conditions, respondents identified:

- Beacon*
- Certified Community Behavioral Health Clinics
- Care Management*
- Cooperative extension*
- Diabetes Prevention Programs*
- Emergency Management Services
- Faith-based organizations
- Farmers' markets*
- Federally Qualified Health Centers*
- Health care*
- Kennebec Valley Community Action Program
- Law enforcement
- MaineGeneral Homecare and Hospice*
- MaineMOM
- Medical providers
- Northern Light*
- Nutrition educators*
- Jackman Community Health Center/PCHC*
- Recovery Coaching Center
- Schools, specifically RSU/MSAD #54
- Somerset Public Health*
- Telehealth

Crosscutting Priorities

Adult Screening & Preventative Visits

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

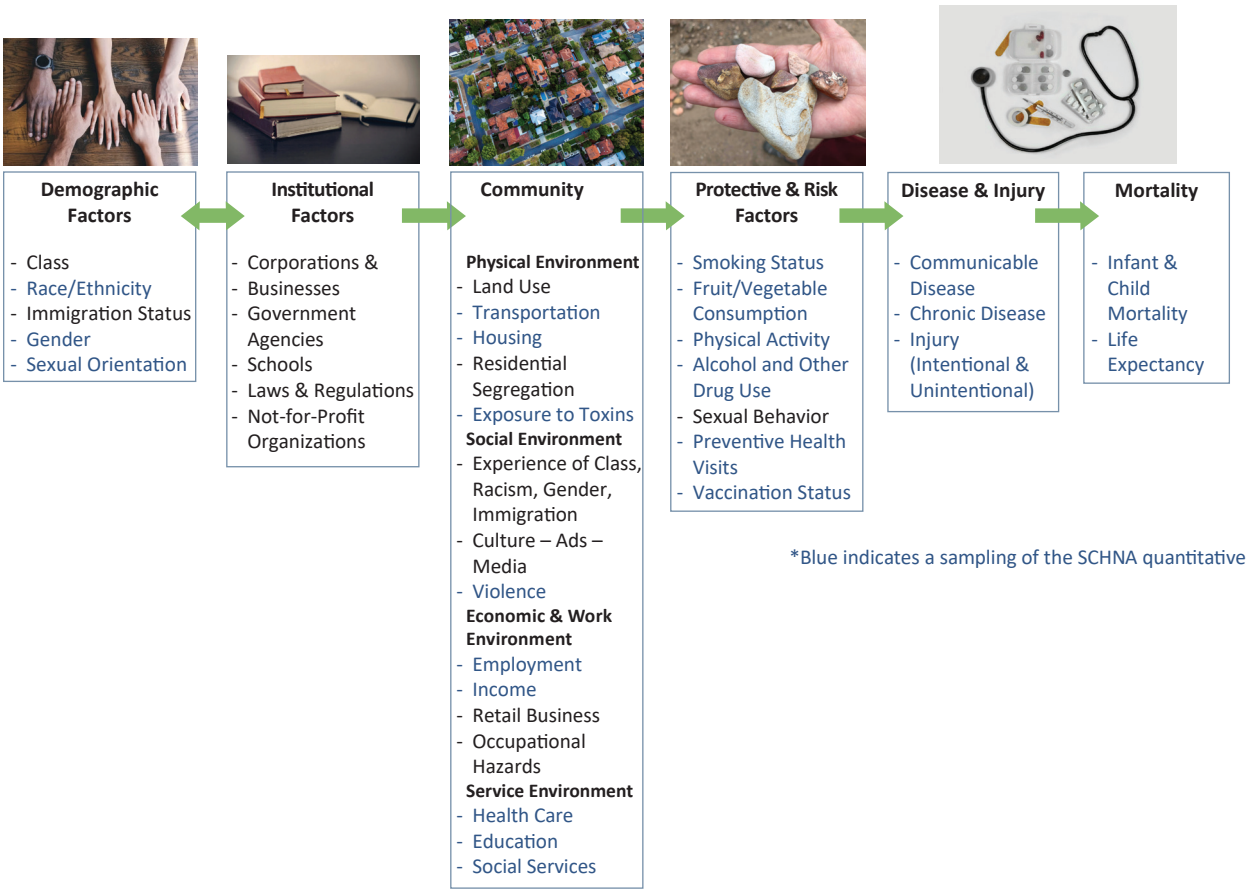
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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 Somerset County on October 9, 2024, with 36 attendees. People from the following organizations participated in the forum process:

- Healthy Living for ME
- Hospice Volunteers of Somerset County
- Jackman Community Health Center (PCHC)
- Kennebec Behavioral Health (KBH)
- Kennebec Valley Community Action Program (KVCAP)
- Main Street Skowhegan
- Maine Center for Disease Control and Prevention
- Maine Central Institute
- Maine Mobile Health Programs
- Northern Light Inland Hospital
- Northern Light Sebasticook Valley Hospital
- OPTIONS-Sweetser
- Penobscot Community Health Care
- Redington Fairview General Hospital
- SKILLS, Inc.
- Skowhegan Family Medicine/ Redington-Fairview General Hospital
- Somerset County
- Somerset Public Health

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
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)	17	73.9%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	16	69.6%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	14	60.9%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	12	52.2%
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.)	8	34.8%
Isolation	6	26.1%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	5	21.7%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	4	17.4%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	4	17.4%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	3	13.0%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	3	13.0%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	3	13.0%
Education (such as pre-K through post-secondary and technical/trade opportunities)	3	13.0%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	2	8.7%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	2	8.7%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	2	8.7%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	8.7%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	2	8.7%
Climate Impacts (such as extreme weather events)	1	4.4%
Civic Engagement	1	4.4%

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

Community Conditions	# Votes	% of Participants
Wage Gaps and Income Disparities	1	4.4%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	1	4.4%
Ambulatory Care Sensitive Conditions	1	4.4%
Other (please specify): Domestic violence	1	4.4%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	15	65.2%
Adverse Childhood Experiences	11	47.8%
Alcohol Use (including binge drinking)	10	43.5%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	9	39.1%
Youth Mattering (such as positive role models, community connections, etc.)	9	39.1%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	8	34.8%
Preventive Oral Health Care	7	30.4%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	6	26.1%
Prescription Drug Misuse	6	26.1%
Cancer Prevention (such as cancer screenings, sunscreen use)	5	21.7%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	5	21.7%
Access to Child and Family Home Visiting	5	21.7%
Cannabis Use	4	17.4%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	4	17.4%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	2	8.7%
Vaping Use (including tobacco and cannabis)	2	8.7%
Injury Prevention (such as fall prevention, always wear a seat belt)	1	4.4%
Immunizations & Vaccinations	1	4.4%
Other (please specify): Unhoused youth and families	1	4.4%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	19	82.6%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	13	56.5%
Obesity/Weight Status	10	43.5%
Cancer	9	39.1%
Diabetes	8	34.8%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	7	30.4%
Cognitive Decline, Alzheimer's disease and other dementias	6	26.1%
Dental Disease	6	26.1%

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)	6	26.1%
Multiple Chronic Conditions	6	26.1%
Intentional Injury & Death (self-injury)	5	21.7%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	4	17.4%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	4	17.4%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	3	13.0%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	2	8.7%
Non-Infectious Respiratory Disease (such as asthma, COPD)	1	4.4%

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
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)	24	77.4%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	20	64.5%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	17	54.8%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	16	51.6%
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.)	16	51.6%

Protective and Risk Factors	# Votes	% of Participants
Adverse Childhood Experiences	30	96.8%
Illicit Drug Use	18	58.1%
Alcohol Use (including binge drinking)	17	54.8%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	17	54.8%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	10	32.3%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	26	83.9%

Health Conditions and Outcomes	# Votes	% of Participants
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	**20**	**64.5%**
Chronic conditions	**14**	**45.2%**
Tobacco related diseases	**11**	**35.5%**
Adverse childhood experiences	**11**	**35.5%**
Obesity/Weight Status	**7**	**22.6%**
Cancer	**3**	**9.7%**
Diabetes	**1**	**3.2%**

Appendix 3: Community Action Agency Profile

About KVCAP

KVCAP is a private, non-profit community action program which has been providing services to the people of Kennebec and Somerset counties for over 56 years. We offer a variety of services geared toward helping individuals and families achieve economic and social self-sufficiency. Each year, thousands of residents access KVCAP services to assist them in their struggle to overcome the barriers of poverty. Many of our services
are available to people of all income levels.

Our Mission: We strengthen individuals, families and communities by providing direct services and by partnering with others to create sustainable solutions to poverty in an ever-changing environment.

Our Vision: Our vision for the Kennebec Valley Region is thriving communities made up of individuals and families who are healthy, financially secure, and able to reach their fullest potential.

Services Offered by KVCAP

Energy and Housing Services:

- **Home Energy Assistance Program (HEAP):** Provides assistance to low-income homeowners and renters to help pay heating costs. Program is intended as a supplement to assist with heating costs for one season. Income eligibility applies.
- **Emergency Crisis Intervention Program (ECIP):** For those who are HEAP eligible, provides emergency heating assistance one time per heating season.
- **Low-income Assistance Program:** For those who are HEAP eligible, provides assistance to low-income homeowners and renters with electricity bills.
- **Weatherization:** For those who are HEAP eligible, provides energy Saving measures such as insulation, weather stripping and air sealant measures.
- **Central Heating Improvement Program (CHIP):** For those who are HEAP eligible, provides heating system repair and replacement of non-working or condemned heating systems to homeowners.
- **Home Heating Oil Tank Program:** Provides heating oil tank repair or replacement for tanks that meet criteria. Income eligibility applies.
- **Home Repair Services:** Provides assistance to make essential home repairs or improvements, such as roofing, siding or windows or for health, safety and/or accessibility repairs/improvements. Income eligibility applies.
- **CMP Pole Assistance Program:** Provides a credit up to $2,800 on the installation of electrical pole lines to a new residence. Income eligibility applies.

Community Initiatives

- **South End Teen Center (SETC):** Provides a safe, after-school environment for teens in grades 6-12, including meals, a computer lab, field trips and more, including special summer programming. The SETC is a collaborative project with the Alfond Youth and Community Center and functions as a Boys and Girls Club unit.
- **Resource Navigators:** Provides information and referral services, linking people to community resources. Also provides ongoing case management services, helping people navigate the health and social services system and develop goal plans to help enhance self-sufficiency.
- **Financial Capability and Counseling Services:** Provides personal financial coaching, homebuyer education classes, pre and post purchase counseling and foreclosure intervention for individuals and families. No income restrictions.
- **Central Maine CA$H/Volunteer Income Tax Assistance (VITA) program:** Oversees this coalition of organizations, businesses and community members that work together to help empower Maine individuals and families to achieve long-term financial stability. We offer free tax preparation to qualified filers during tax season and educate families and individuals about programs in their community that can increase their income, reduce debt and build savings.

Real Estate Development

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

- **Cony Village** – providing affordable homes for purchase in a purposefully designed neighborhood in Augusta.
- **Gerald Senior Residences** – a 55+ affordable housing residence in Fairfield.
- **Mary St. Residences** – affordable housing residence in Skowhegan
- **Hartland Senior Residences** – two 55+ affordable housing residences in Hartland.
- **Projects currently under development in the South End neighborhood of Waterville:**
  - An affordable housing project for individuals and families.
  - Renovation of a single family residence that will be sold to a family eligible for MaineHousing's first time homebuyers' program.

Social Services

- **Maine Families:** Offers home visiting services for all expectant parents or new parents in Kennebec and Somerset Counties, including information on child development, health and safety, parent education, and links to other community resources. Participation is voluntary and free of charge, with no income restrictions.
- **Family Enrichment Councils:** These Child Abuse and Neglect Prevention Councils facilitate parenting education, parenting support groups, playgroups, and concrete supports (e.g., diapers and wipes) free of charge to families throughout Kennebec and Somerset Counties. They also offer training opportunities in Protective Factors; Mandated Reporting; Infant Safe Sleep; and Front Porch Project free of charge to professionals and community members, and coordinate family friendly events and activities throughout the year.

Transportation Services

- **KV Van – Public transit:** Provides curb-to- curb demand response public transportation within designated zones in Augusta, greater Waterville/Winslow, Skowhegan and Intercity service between Augusta/Waterville. Riders make appointments by noon on the business day prior to their requests. All service is open to the public. Single ride fares and monthly passes are available.
- **KV Van – Non-emergency transportation and other contracted transportation:** Provides door –to-door transportation for medical and social service appointments. Income eligibility applies.

Child and Family Services:

Early Head Start, Head Start, Child Care and Preschool

- **Child Care:** Through Early Head Start and Head Start partnerships, our child care options provide full-day, full-year care and early childhood education. Options at both child care centers and family child care locations are available to families who qualify for child care subsidies, based on a sliding fee scale. (Birth to age 5)
- **Preschool:** Children participate in learning experiences that promote school readiness and support holistic development.
  - Free preschool classrooms are offered in partnership with public schools in MSAD 54, RSU 19, and Waterville. Part-day and/or school-day options available depending on location. (Ages 3-5)
- **Before and After School Care:** KVCAP, through a partnership with MSAD 54, provides high-quality before and after school programming for children aged three to six in Skowhegan and Canaan.
- **Homestart:** KVCAP partners with family day care providers throughout Kennebec and Somerset counties. Partners receive training in Head Start and early Childhood care practices from highly trained KVCAP staff, and children receive the benefits of Head Start programming, including a variety of behavioral and health screenings.
- **Family Coaching:** Family Coaching is provided to all families with a child attending KVCAP's Child Care and/or Preschool programming. Families receive assistance in setting and achieving goals, navigating resources, parenting skills, and solving challenges. (Birth to age 5)
- **Whole Family Services:** KVCAP provides Whole Family Services to eligible families through a TANF grant. Families receive intensive services via a Family Coach, who assists in setting and achieving family and individual goals, resource navigation, and general life skills coaching.

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Endnotes

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

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

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

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

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

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

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

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

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

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

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