2025 Maine Shared Community Health Needs Assessment

Northern Light Health

Washington 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 Washington 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

Washington County Health and Well-Being Priorities

The following table includes the top health and well-being priorities identified by Washington 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
Transportation (ME)	Illicit Drug Use	Mental Health (ME)
Poverty (ME)	Adverse Childhood Experiences (ME)	Substance Use Disorder
Housing (ME)	Nutrition (ME)	Cancer
Provider Availability (ME)		

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

Substance Use Chronic Conditions

Next Steps

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

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

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

Report Outline

This report is broken into three sections.

1. Data on Washington 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 Washington 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

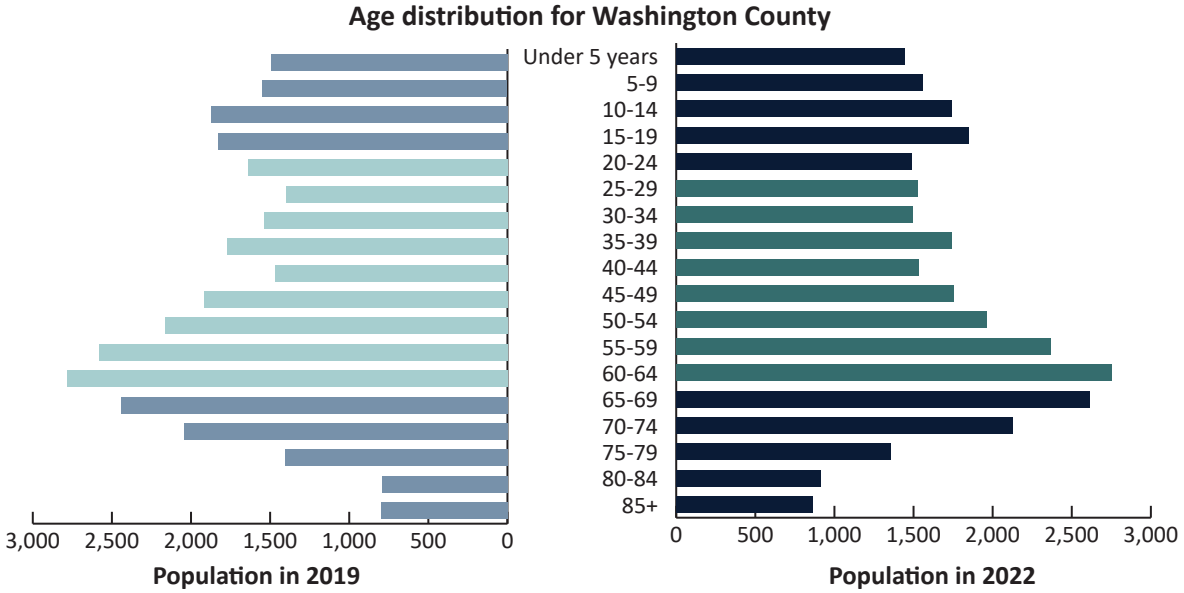
The following tables and chart show information about the population of Washington County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Washington County Population	State of Maine Population
31,096	**1,366,949**

	Washington	Maine
Median household income	**$51,669**	**$68,251**
Unemployment rate	**4.0%**	**3.1%**
Individuals living in poverty	**17.5%**	**10.9%**
Children living in poverty	**22.6%**	**13.4%**
65+ living alone	**31.4%**	**29.5%**

	Washington County	
	Percent	Number
American Indian/Alaskan Native	**4.9%**	**1,522**
Asian	**0.4%**	**129**
Black/African American	**1.0%**	**315**
Native Hawaiian or other Pacific Islander	**0.0%**	**12**
Some other race	**0.5%**	**169**
Two or more races	**4.4%**	**1,358**
White	**88.7%**	**27,591**
Hispanic	**2.8%**	**869**
Non-Hispanic	**97.2%**	**30,227**

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 Washington County.

Cause of Death	Maine	Washington County
Heart Disease	**27.2%**	**31.7%**
Cancer	**25.9%**	**22.0%**
Accidents	**10.5%**	**12.0%**
Chronic Lower Respiratory Disease	**6.8%**	**8.5%**
Diabetes	**4.6%**	**6.1%**
Cerebrovascular Diseases	**4.8%**	**4.8%**
COVID 19	**6.0%**	**3.5%**
Suicide	**2.0%**	**2.8%**
Chronic Liver Disease and Cirrhosis	**2.3%**	**2.8%**
Influenza & Pneumonia	**2.1%**	**2.2%**
Parkinson's Disease	**1.7%**	**1.5%**
Nephritis, Nephrotic Syndrome & Nephrosis	**1.8%**	**1.3%**
Alzheimer's Disease	**4.1%**	**0.9%**

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.

Washington 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 & available health care	3) Mental health care and treatment
4) Affordable and safe housing	4) Affordable & available health care
5) Reduction in substance use (drugs, alcohol)	5) Affordable & quality childcare

Health and Well-Being Priorities

Section Overview

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

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

Socioeconomic Empowerment

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

Populations and Communities

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

Community Resources

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

Crosscutting Priorities

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

Washington County Strengths

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

- Safe neighborhoods;
- Safe opportunities to be active outside;
- Locally owned businesses;
- Strong sense of community; and
- Low crime.

People living in Washington County have a positive outlook on their health and well-being – 69.6% of survey respondents rate their own physical health as good or excellent and 75% 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 Washington 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.

Washington County Community Conditions			
Transportation	Poverty	Housing	Provider Availability

Transportation

Transportation was the top priority for the community conditions category for Washington 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 Washington County focus group "transportation" was a top theme. In the Maine Shared CHNA survey, "lack of transportation" was the fifth of five top social concerns negatively impacting the community. In Washington County, 7.4% of households do not have a vehicle and 26.4% of people commute more than 30 minutes driving alone (2018-2022).

Almost three-quarters (72.6%) of Maine Shared CHNA survey respondents said "transportation needs" negatively impact them, a loved one, and/or their community. When asked about specific transportation needs,

- "access to transportation" (82.9%);
- "availability of public transportation" (82.2%);
- "availability of transportation that meets a variety of specific needs" (79.5%); and
- "costs associated with owning and maintaining a vehicle" (69.2%) were cited by respondents as negatively impacting their communities.
- 44.5% of survey respondents said costs associated with vehicles negatively impacts a loved one and 44.5% said it impacts themselves.

The focus group and survey findings were echoed at the Washington County stakeholder forum. Participants at the forum noted a lack of transportation infrastructure, specifically with regard to public transit options and transportation that accommodates last minute requests, which

may be attributable to workforce shortages and low driver reimbursement rates. Where public transportation options exist, forum participants noted there has been an increase in wait times.

Forum participants discussed costs associated with vehicles and driving, similar to those indicated in the survey responses. Forum participants specifically talked about costs associated with driver's education and cost barriers to reinstating a license. For those with a license, there are also barriers to vehicle ownership due to costs associated with registration and insurance and barriers purchasing vehicles for people with poor credit scores. Table 1 demonstrates the types of transportation people in Washington County use to commute work.

Table 1: Commute by Transportation Type, 2018-2022

The following chart compares commute by transportation type for the state of Maine and Washington County.

Commute Type	Maine	Washington County
Car, truck, or van – drove alone	**73.5%**	**76.3%**
Worked from home	**12.3%**	**8.4%**
Car, truck, or van – carpooled	**8.7%**	**11.5%**
Walked	**3.6%**	**3.3%**
Other means	**1.4%**	**0.5%**
Public transportation (excluding taxicab)	**0.4%**	**0.1%**

Populations and Communities Impacted by Transportation

IIn 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 transportation, respondents cited: teens, adults, older adults, people with low-income, people living in rural areas, and young adults.

Community Resources to Address Transportation

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

- AMHC
- Beth C. Wright Cancer Resource Center
- Community Health & Counseling Services
- Downeast Community Partners
- Maine Seacoast Mission
- Modivcare
- Taxi
- Telehealth
- The Connection Initiative
- Uber
- Volunteer driver networks
- West Bus
- Woodland High School (Baileyville), specifically extended learning opportunities for driver's education

Poverty

Poverty was the second priority for the community conditions category for Washington County. For the purposes of the prioritization process, poverty includes such topics as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, and ALICE (Asset Limited, Income Constrained, Employed) thresholds.

Assessment Findings

In Washington County,

- 17.5% of individuals live in poverty, significantly worse than Maine (10.9%) and the U.S. (12.5%, 2018-2022).
- 6.9% of families live below the federal poverty level, significantly better than the U.S. (8.8%, 2018-2022).
- 22.6% of children live in poverty (2018-2022), significantly worse than Maine (13.4%) and the U.S. (16.7%, 2018-2022).
- 30.6% of households were living above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold of financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy.
- 18% of people were asset poor, meaning they have insufficient net worth to live without income at or above the poverty level for three months (2021).

In the Washington County focus group, "child care" and "food deserts and access to affordable, healthy food" were top themes. Focus group participants said:

"I have heard many people say, 'I can't go back to work because they would spend so much on child care'."

"Once you have kids who are school age, what do you do when school is out? School is child care for so many people."

The availability and increasing costs of child care was also discussed during the Washington County stakeholder forum. In 2023, 87.1% of children were served in publicly funded state and local preschools and there were 14 child care centers in Washington County (2024).

In the Maine Shared CHNA survey, "low incomes and poverty" was the second of five top social concerns negatively impacting the community and 81.4% said "economic needs" negatively impact them, a loved one, and/or their community. When asked about specific economic needs, the following impacted respondents' communities:

- "access to affordable, quality foods" (75.8%);
- "availability of quality, affordable child care" (75.2%); and
- "availability of jobs and employment opportunities" (73.3%).

In 2022, 17.1% of adults and 25.9% of youth in Washington County were food insecure. Survey respondents identified the "ability to contribute to savings, retirement" as negatively impacting communities (65.2%), loved ones (46.6%), and respondents (49.1%).

The economic concerns highlighted in the Maine Shared CHNA survey were also discussed at the stakeholder forum. Forum participants noted factors related to employment and wages, citing employers shifting away from providing benefits, such as retirement; a decrease in jobs; specifically those that pay livable wages; the gender wage gap; and a lack of job training and education. In Washington County 4% of people are unemployed (2023) and the median household income is $51,669, significantly better than 2015-2019 ($41,347), but significantly worse than Maine ($68,251) and the U.S. ($75,149, 2018-2022).

Stakeholder forum participants noted other contributors to poverty including the cyclical nature of poverty and impacts of generational trauma, as well as mental health challenges, housing insecurity, homelessness, and seasonal work.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people from a place of poverty to stability "jobs that pay enough to support a living wage" was rated number one by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Poverty

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

Community Resources to Address Poverty

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

- Backpack programs
- Community Caring Collaborative
- Downeast Community Partners
- Faith-based organizations
- Food pantries and meal sites
- Fresh Start
- Machias Savings Bank
- Maine Seacoast Mission's EDGE program
- MaineCare
- Post-secondary institutions
- Private sector employers
- Public assistance programs
- Recovery centers
- School Meals for All
- SNAP-Ed
- Student loan repayment programs
- Sunrise County Economic Council
- The Connection Initiative
- Workforce programs
- Wyman's

Crosscutting Priorities

Housing **Nutrition** **Mental Health**

Housing

Housing was tied for the third priority for the community conditions category for Washington 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 Washington County focus group, "affordable housing" was a top theme. One focus group participant said:

> **"Last winter there was so much damage [from the storms]. FEMA was here to provide relief, but a lot of people didn't know that. People were choosing between fixing their roof or buying food."**

While storm damage may have highlighted the problem, housing stock is in poor condition in Washington County. This is a result of deferred maintenance, a lack of funds for making the fixes, a lack of dependable contractors, and people either not knowing about resources for housing maintenance assistance or having a sense of pride that prohibits them from asking for help.

The theme of affordable housing was also evident at the Washington County stakeholder forum. Participants noted there are rising costs associated with home ownership and renting, with increases in security deposits, taxes, and insurance. Quantitative data shows in Washington County, 11.5% of households spend more than 50% of their income toward housing, significantly better than the U.S. (14.1%, 2018-2022). The median gross rent is $687, significantly better than Maine ($1,009) and the U.S. ($1,268, 2018-2022). Participants discussed that rising costs are coinciding with decreases in funding and grants.

In the Maine Shared CHNA survey, 73.1% of respondents said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, several topics negatively impacted respondents, their loved ones, and their communities as detailed in Table 2: Housing Needs and discussed below.

"Availability of affordable, quality homes/rentals" was cited by 79.7% of respondents as impacting their communities. Washington County stakeholder forum participants also discussed the availability of housing, noting a general lack of housing stock. Forum participants discussed how availability is further impacted by a decrease in housing repair and building options and a decrease in an infrastructure to oversee or complete housing projects. In addition, there has been a decrease in Section 8 Housing. Other factors impacting housing include the increase of short-term rentals, resulting in a decrease in long term rentals and a lack of pet friendly rental options. As of 2018-2022, 62.5% of houses in Washington County were occupied and 1.6% of housing units were vacant and for rent or sale as of 2022.

"Availability of affordable, quality housing options for older adults or those with special needs" was cited as negatively impacting communities by 78.4% of survey respondents. This was also discussed at the Washinton County stakeholder forum, with participants noting a lack of options for older adults, specifically nursing home options, and a decrease in housing for veterans. While not necessarily a population with special needs, forum participants also noted there is a decrease in housing options for young people.

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	34.5%	37.8%	73.6%	1.4%	4.7%	0.7%
Availability of affordable, quality homes/rentals	23.6%	35.8%	79.7%	1.4%	4.1%	0.0%
Availability of affordable, quality housing for older adults or those with special needs	12.2%	29.7%	78.4%	3.4%	2.7%	2.7%
Issues associated with home ownership or renting	25.7%	36.5%	73.6%	1.4%	8.1%	2.0%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	20.3%	25.0%	67.6%	2.0%	15.5%	4.1%
Homelessness or availability of shelter beds	5.4%	12.2%	62.2%	4.7%	23.0%	4.1%
Cost of utilities	33.1%	46.6%	75.7%	3.4%	3.4%	0.0%
Costs associated with weatherization	33.1%	40.5%	70.9%	3.4%	5.4%	0.7%

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people from a place of poverty to stability Maine Shared CHNA survey respondents rated "affordable and safe housing" number four.

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, young adults, people with low income, and unhoused/housing insecure.

Community Resources to Address Housing

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

- Community Caring Collaborative
- Community Health & Counseling Services
- Department of Health and Human Services, PATH (Projects for Assistance in Transition from Homelessness)
- Downeast Community Partners
- Healthy Acadia
- Jobs for Maine Graduates
- Joy Fund
- Maine Housing Authority
- Maine Seacoast Mission
- Neighbors Helping Neighbors
- Next Step Domestic Violence Project
- Safe Harbor
- Section 8 Housing
- Sunrise County Economic Council
- Sunrise Opportunities
- The Connection Initiative

Crosscutting Priorities

Poverty

Provider Availability

Provider availability was tied for the third rated priority for the community conditions category for Washington County. Due to the logistics of the forum, provider availability was not discussed; findings from the community engagement and quantitative data processes are presented. 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

IIn the Washington County focus group, participants discussed provider retention and recruitment in the area:

"Many [providers] are retiring. There are many older providers who have been around for years and it's hard to replace them. No one wants to move here when they find out how rural it is."

Quantitative data shows in Washington County there were 1,757 people for every primary care physician (2024). During the period 2019-2021, 86% of adults in Washington County had a usual primary care provider and 80.7% had been to a primary care provider in the past year, significantly better than 2015-2017 (67.5%).

Over half (56.9%) of Maine Shared CHNA survey respondents said they or a loved one could not or chose not to get health care services in the past year, with "long wait times to see a provider" and "no evenings or weekend hours to get care." As of 2024, there were 150 people for every mental health provider and 60,174 people for every psychiatrist in Washington County. Less than half (41%) of Maine Shared CHNA survey respondents said they or a loved one could not or chose not to get mental health care services in the past year, with "long wait times to see a provider" and "not sure where to go for help" as reasons why.

In the Washington County focus group, "dental care" was a top theme. In 2024 there were 3,468 people for every dentist in Washington County. As of 2020, 56.3% of adults had been to a dentist in the past year, significantly worse than Maine (66.7%) and the U.S. (66.7%).

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 three 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, older adults, young adults, children, and youth.

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:

- Calais Community Hospital
- Downeast Community Health Center
- Downeast Community Hospital
- Eastport Healthcare/Lubec Regional
- Federally Qualified Health Centers
- Harrington Family Health Center
- Hospitals and emergency rooms
- Local clinics
- Local health centers
- St. Croix Regional Family Health Center
- Telehealth

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 Washington 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.

Washington County Protective & Risk Factors		
Illicit Drug Use	Adverse Childhood Experiences	Nutrition

Illicit Drug Use

Illicit drug use was the top priority for the protective and risk factors category for Washington County.

Assessment Findings

In the Washington County focus group one respondent said:

> **"Stigma around substance use disorder – they're 'bad people' or have some moral failing. Even medical providers have some beliefs like this. Treatment is vastly different than any other mental health disorders."**

Washington County stakeholder forum participants discussed the lack of access to care, specifically with prevention and screening for substance use. Forum participants noted people with chronic health conditions may be particularly susceptible to illicit drug use if their treatment protocol involves prescription drugs with addictive properties. As of 2020, there were 17.7 narcotic doses dispensed per 1,000 people in Washington County.

Forum participants highlighted that while stigma may exist for those with substance use disorder, there is also a social acceptance to substance use. This is evident in the legalization of certain substances which forum participants believe may lead to early initiation and use.
In the Maine Shared CHNA survey, respondents said "substance use," which includes illicit drug use, was the top social concern negatively impacting their community and 77% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 84.6% and 24.8% of survey respondents said "opioid misuse" negatively impacts their community and a loved one.
- 81.2% and 27.5% of survey respondents said "other illicit drug use" negatively impacts their community and a loved one.
- Quantitative data for Washington County shows:
- There were 79 overdose deaths for every 100,000 people (2023).
- There were 69.2 drug-induced deaths for every 100,000 people (2018-2022).
- 4.8% of high school students misused prescription drugs in the past 30 days (2023).
- 6% of high school students have used illicit drugs in their lifetime (2024).

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to help move people from a place of poverty to stability, "reduction in substance use" was rated number five 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, indigenous community members, unhoused/housing insecure, people who are justice involved, people with dual diagnoses, young parents, people who are pregnant, cancer patients, infants, LGBTQ people, people with low-income, adults, young adults, teens, older adults, and people with substance use disorder.

Community Resources to Address Illicit Drug Use

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

- Acupuncture
- AMHC
- ARISE
- Beth C. Wright Cancer Resource Center
- Better Life Partners
- Community Caring Collaborative
- Community Health & Counseling Services
- Downeast Correctional Facility
- Downeast Recovery Support Centers
- Faith-based organizations
- Federally Qualified Health Centers
- Health clinics and providers
- Healthy Acadia
- Hub and Spoke Network
- Local counselors
- Prevention and Recovery Services
- Recovery Resource Guide
- Safe Harbor
- Substance Use Response Collaborative
- Substance use treatment programs
- Support groups
- The Connection Initiative
- Yoga

Crosscutting Priorities

Adverse Childhood Experiences | **Mental Health** | **Substance Use Disorder**

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the second priority for the protective and risk factors category for Washington 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 2023, 33.4% of high school students in Washington County had at least four of nine childhood adverse experiences. In the Maine Shared CHNA survey, three of the five top social concerns that negatively impact the Washington County community could be associated with ACEs – substance use, low incomes and poverty, and mental health issues.

Three-quarters or more of survey respondents said potential root causes of ACEs impact them, a loved one, and/or their community, including:

- "economic needs" (81.4%),
- "substance use" (77%),
- "mental health needs" (73.1%), and
- "housing needs" (73.1%).

When asked about specific mental health needs, 62.3% and 32.5% said "youth mental health" negatively impacts their community and a loved one, respectively. In 2023, 36.4% of high school students were sad/hopeless for two weeks in a row and 16.5% of high school students had seriously considered suicide. In 2019, 35.2% of middle school students were sad/hopeless for

two weeks in a row and 22.6% of middle school students had seriously considered suicide. In the Washington County stakeholder forum, participants discussed root causes and contributing factors to adverse childhood experiences. Several factors were related to parenting. These include parents with mental health disorders, incarcerated parents, a lack of parenting skills and knowledge, and the death of parents or other parental loss. ACEs may also be caused by difficult experiences with health conditions or medical events, such as a cancer diagnosis, suicide, or overdose.

Intergenerational trauma, abuse, neglect, domestic violence, sexual assault, and bullying were also discussed as contributing factors to ACEs. In Washington County, 23.6% of high school (2023) and 50.5% of middle school students (2019) had been bullied on school property and 20.4% of high school students had experienced electronic bullying (2023). Community conditions such as the housing crisis and a lack of community assets were also noted as potential contributors to 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: older adults, caregivers, parents, healthcare providers, teachers, people involved with the foster care system, educators, people who have experienced sexual abuse or domestic violence, adults, young adults, youth, teens, and children.

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:

- AMHC
- Child care sites
- Cobscook Institute
- Community Health & Counseling Services
- Community volunteer organizations
- Department of Health and Human Services, Child Protective Services
- Department of Health and Human Services, Office of Child and Family Services
- Faith-based organizations
- Families Future Downeast
- Foster Families of Maine
- Healthy Acadia
- Local recreation departments
- Maine Families
- Maine Seacoast Mission
- Prevention Council
- Safe Families for Children
- Schools, specifically guidance counselors, nurses, and after school programs
- Tribal home visiting

Crosscutting Priorities

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

Illicit Drug Use **Poverty** **Cancer**

Nutrition

Nutrition was the third priority for the protective and risk factors category for Washington County. For the purposes of the prioritization process, nutrition includes such topics as fruit and vegetable consumption and soda/sports drink consumption.

Assessment Findings

In the Washington County focus group, "food deserts and access to affordable, healthy food" was a top theme. In the Maine Shared CHNA survey, 81.4% of survey respondents said "economic needs" negatively impact them, a loved one, and/or their community. When asked about specific economic needs, 75.8% said "access to affordable, quality foods" negatively impacts their community, 37.9% a loved one, and 39.1% themselves.

Access to food was also discussed at the Washington County stakeholder forum, with participants citing the cost of and access to food. In 2022, 17.1% of adults and 25.9% of youth were food insecure. The influence of corporations on nutrition was discussed at the forum, specifically the way food is marketed and messaged which may promote the purchase of processed foods and a culture of convenience. Forum participants believe there is a lack of support for local foods and community gardens and difficulty accessing nutritious foods. In Washington County,

- 43.6% of adults report less than one serving per day of fruit, significantly worse than Maine (35%, 2021).
- 13.8% of adults report less than one serving per day of vegetables, significantly better than the U.S. (20.4%, 2021).
- 8.5% of high school students report five or more servings of fruits and vegetables per day, significantly worse than Maine (14.2%, 2023).
- 16.1% of middle school students report five or more servings of fruits and vegetables per day (2019).
- 34.3% of high school students consumed one or more soda/sports drinks per day, significantly worse than Maine (25.3%, 2023).
- 27.2% of middle school students report drinking one or more soda/sports drinks per day (2019).

For those who need assistance with purchasing food, forum participants noted there may be resistance to ask for help due to feelings of shame and stigma. Lifestyle barriers were also discussed at the forum including a lack of time to prepare foods, which may be particularly felt among single-parent households.

Populations and Communities Impacted by Nutrition

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 nutrition, respondents cited: older adults, people with diabetes, people living in isolation, people with substance use disorder, people with mental health disorders, people with cancer, people with transportation issues, Asset Limited, Income Constrained, Employed (ALICE) populations, people with low income, Tribal communities, refugees/immigrants, adults, older adults, children, youth, and teens.

Community Resources to Address Nutrition

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

- Backpack Program
- Behavioral Health Homes
- Beth C. Wright Cancer Resource Center
- Blakes Meats
- Child and Adult Care Food Program
- Community gardens
- Culinary arts program
- Eastern Area Agency on Aging
- Food pantries
- Good Shepherd Food Bank
- Hunter for the Hungry
- Private food sector donations
- Recovery Centers
- Schools
- Senior Farm Share
- SNAP-Ed
- The Emergency Food Assistance Program
- University of Maine
- Women, Infants and Children Program

Crosscutting Priorities

Transportation **Poverty**

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 Washington 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.

Washington County Health Conditions & Outcomes		
Mental Health	**Substance Use Disorder**	**Cancer**

Mental Health

Mental health was the top priority for the health conditions and outcomes category for Washington 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 Washington County focus group one participant said:

"For the population I work with [LGBT kids], having a consistent provider is important because you build trust with them. If you don't have this, you might not go to the doctor. There are about 20% of teens in Washington County that identify as LGBTQ, and many have wanted mental health care but are unable to access it. There are elevated levels of suicidality among this population."

In the Washington County stakeholder forum participants discussed a range of factors contributing to mental health including a lack of services and a lack of transportation to get to services that do exist. In the Maine Shared CHNA survey, 41% of respondents say they or a loved one could not or chose not to get mental health care in the past year, with "long wait times to see a provider," "not sure where to go for help," and "did not feel comfortable seeking help" as reasons why. As of 2024, there were 60,174 people in Washington County for every psychiatrist and 150 people for every mental health provider. During the period 2019-2021, 19.7% of adults were currently receiving outpatient mental health care. Stakeholder forum participants discussed the mental health infrastructure, with factors such as a lack of community-based education and training, workforce shortages, and challenges with reimbursement for mental health services.

In the Maine Shared CHNA survey, "mental health issues" was rated the third of five top social concerns negatively impacting the community and 76% said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about specific mental health needs, several needs negatively impact respondents, their loved ones, and their communities, specifically "anxiety or panic disorder," "depression," and "general stress of day-to-day life." These details and other needs are in Table 3: Mental Health Needs. In Washington County, 11.5% of adults have current symptoms of depression, 24.7% have experienced depression in their lifetime, and 26.5% of adults have had anxiety in their lifetime (2019-2021).

Stakeholder forum participants discussed ACEs, trauma, and isolation as contributing to mental health outcomes. Forum participants noted that mental health can also be impacted by changes as people age, specifically with regard to menopause. Additional factors discussed include stigma and the influence of social media.

Three quarters of Maine Shared CHNA survey respondents rate their own mental health as "good or excellent."

Table 3: 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	50.0%	54.5%	48.1%	1.3%	5.2%	1.3%
Depression	40.9%	63.0%	56.5%	2.6%	2.6%	1.3%
Bipolar disorder	7.1%	22.1%	46.8%	7.1%	20.1%	8.4%
Trauma or post-traumatic stress disorder (PTSD)	27.9%	39.6%	51.9%	5.8%	12.3%	4.5%
General stress of day-to-day life	57.8%	53.9%	55.2%	3.2%	2.6%	2.6%
Social isolation or loneliness	26.6%	39.6%	63.6%	3.2%	5.8%	3.2%
Stigma associated with seeking care for mental health or substance use disorders	18.8%	27.9%	66.2%	7.8%	11.0%	5.2%
Suicidal thoughts and/or behaviors	9.1%	24.0%	61.0%	4.5%	15.6%	8.4%
Youth mental health	13.0%	32.5%	62.3%	3.9%	8.4%	4.5%

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to help move people from a place of poverty to 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: LGBTQ people, people with low income, minorities, people who are incarcerated, children, people who are unhoused, people who have experienced abuse, case managers, single parents, people with cancer, veterans, people who are post-partum, adults, older adults, teens, young adults, and youth.

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:

- AMHC
- Beth C. Wright Cancer Resource Center
- Calais Community Hospital
- Community Caring Collaborative
- Community Health and Counseling Services
- Crisis services
- Down East Community Hospital
- Downeast Public Health District
- Eastern Area Agency on Aging
- Eastport Health Care
- Emergency medical services
- Federally Qualified Health Centers
- Harrington Family Health Center
- Healthy Acadia
- Higher education
- Law enforcement
- Local counselors
- Local health care organizations
- Medical providers
- NAMI Maine
- Northern Light Acadia Hospital
- Regional Medical Center at Lubec
- Schools
- St. Croix Regional Family Health Center
- Sunrise Opportunities
- Tribal health centers

Crosscutting Priorities

Transportation | **Illicit Drug Use** | **Provider Availability** | **Adverse Childhood Experiences**

Substance Use Disorder

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

Assessment Findings

In the Washington County focus group one participant said:

"Stigma around substance use disorder – they're 'bad people' or have some moral failing. Even medical providers have some beliefs like this. Treatment is vastly different than any other mental health disorders."

Washington County stakeholder forum participants also discussed the impact of the medical system on substance use citing the way chronic pain may be treated could create opportunities for prescription drug misuse and a lack of health insurance may impede the ability to get care. In 2020, there were 17.7 narcotic doses dispensed for every 1,000 people. In Washington County, 10.5% of people are uninsured, significantly worse than Maine (7.1%) and the U.S. (8.7%, 2018-2022). While there is a stigma to having a substance use disorder, forum participants note there is a culture that promotes substance use and peer pressure to use. Stakeholder forum participants also noted trauma and workforce stress can impact substance use disorder.

In the Maine Shared CHNA survey, respondents said "substance use" was the top social concern negatively impacting their community and 77% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 84.6% and 24.8% said "opioid misuse" negatively impacts their community and a loved one, respectively.
- 81.2% and 27.5% said "other illicit drug use" negatively impacts their community and a loved one, respectively.
- "Alcohol misuse or binge drinking" negatively impacts respondents' community (79.2%) and a loved one (40.9%).

In Washington County,

- There were 79 overdose deaths for every 100,000 people (2023).
- There were 69.2 drug-induced deaths for every 100,000 people (2018-2022).
- There were 22.3 alcohol-induced deaths for every 100,000 people (2018-2022).
- 7.7% of adults report chronic heavy drinking (2019-2021).
- 15% of adults report binge drinking (2019-2021).

Socioeconomic Empowerment

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

Populations and Communities Impacted by Substance Use Disorder

Substance use disorder was established as a priority at the forum and not addressed as part of the pre-forum survey. At the forum, for populations impacted by substance use disorder, respondents cited: infants, LGBTQ people, people with low income, minorities, and people who are incarcerated.

Community Resources to Address Substance Use Disorder

Substance use disorder was established as a priority at the forum and not addressed as part of the pre-forum survey. Participants did not identify assets and resources at the forum.

Cancer

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

Assessment Findings

In the Maine Shared CHNA survey, 81.5% of respondents said, "chronic health conditions," which includes cancer, negatively impacts them, a loved one, and/or their community. When asked about specific chronic health conditions, 60.2% of respondents said cancer impacts their community, 46.2% said it impacts a loved one and 12.3% said it impacts them. Table 4: Cancer Indicators shows the overall cancer death rates and new cancer cases, as well as the cancers with the highest rates of death and new cases in Washington County.

Table 3: Cancer Indicators	Washington County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cancer							
All cancer deaths per 100,000 population	2015-2019 **190.9**	2018-2022 **190.4**	○	2018-2022 **159.9**	!	2020 **144.1**	N/A
Lung cancer deaths per 100,000 population	2015-2019 **56.6**	2018-2022 **46.2**	○	2018-2022 **40.2**	○	2020 **31.8**	N/A
Prostate cancer deaths per 100,000 population	2015-2019 **29.1**	2018-2022 **34.4**	○	2022 **19.9**	!	2020 **18.5**	N/A
Tobacco-related cancer deaths per 100,000 population	2015-2019 **56.3**	2018-2022 **66.0**	○	2018-2022 **52.8**	!	2020 **42.1**	N/A
All cancer new cases per 100,000 population	2015-2019 **502.0**	2018-2022 **588.7**	!	2018-2022 **476.0**	!	2019 **438.6**	N/A
Female breast cancer new cases per 100,000 population	2016-2018 **123.8**	2019-2021 **169.0**	○	2019-2021 **135.4**	○	2019 **129.7**	N/A
Prostate cancer new cases per 100,000 population	2016-2018 **104.3**	2019-2021 **141.8**	○	2019-2021 **106.2**	!	2019 **111.6**	N/A

Table 3: Cancer Indicators	Washington County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Tobacco-related cancer (excluding lung cancer) new cases per 100,000 population	2016-2018 **134.2**	2019-2021 **175.8**	○	2019-2021 **137.2**	!	2019 **125.0**	N/A
Obesity-associated cancer (excluding colon cancer) new cases per 100,000 population	2016-2018 **143.0**	2019-2021 **171.6**	○	2019-2021 **138.3**	!	2019 **133.2**	N/A
Alcohol-associated new cancer cases per 100,000 population	2017-2019 **148.0**	2019-2021 **174.7**	○	2019-2021 **135.4**	!	—	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.

Participants at the Washington County stakeholder forum discussed risk factors for cancer including environmental factors, such as water contamination; substance use, specifically alcohol and tobacco; obesity; and untreated illnesses. As it relates to these root causes, in Washington County,

- Approximately half (46.8%) of households have had their private wells tested for arsenic (2016-2019 & 2021), significantly lower than Maine (52.7%).
- 40% of adults (2021), 20.2% of high school students (2023), and 17.5% of middle school students were obese (2019).
- 7.7% of adults engage in chronic heavy drinking and 15% engaged in binge drinking (2019-2021).
- 23.3% of adults currently smoke cigarettes, significantly worse than Maine (15.6%) and the U.S. (14.4%, 2021) and 8% of high school students (2023), and 1.7% of middle school students (2019) had smoked cigarettes in the past 30 days.

Forum participants highlighted access to care challenges, specifically the impacts of not having insurance, a lack of transportation, and challenges with health literacy which may all impact the ability to access cancer screenings. In Washington County, 10.5% of people are uninsured, significantly worse than Maine (7.1%) and the U.S. (8.7%, 2018-2022).

Populations and Communities Impacted by Cancer

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For cancer, respondents cited: children, women, men, people with low income, industrial workers, those exposed to radon and/or PFAS, people who use tobacco and/or are exposed to tobacco, adults, older adults, people living in rural areas, young adults, and veterans.

Community Resources to Address Cancer

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 cancer, respondents identified:

- Beth C. Wright Cancer Resource Center
- Cancer Patient Navigation Program
- Community Health & Counseling Services
- Down East Community Hospital
- Durable Medical Equipment
- Eastern Area Agency on Aging
- Federally Qualified Health Centers
- Health centers
- Healthy Acadia
- Hospice
- Local cancer centers
- Local hospitals
- Local providers
- Maine Cancer Foundation
- Make A Wish
- Northern Light Cancer Care
- Northern Light Health
- Sarah's House
- The Connection Initiative

Crosscutting Priorities

Transportation **Housing** **Nutrition** **Substance Use Disorder**

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)

Demographic Factors
- Class
- Race/Ethnicity
- Immigration Status
- Gender
- Sexual Orientation

Institutional Factors
- Corporations & Businesses
- Government Agencies
- Schools
- Laws & Regulations
- Not-for-Profit Organizations

Community

Physical Environment
- Land Use
- Transportation
- Housing
- Residential Segregation
- Exposure to Toxins

Social Environment
- Experience of Class, Racism, Gender, Immigration
- Culture – Ads – Media
- Violence

Economic & Work Environment
- Employment
- Income
- Retail Business
- Occupational Hazards

Service Environment
- Health Care
- Education
- Social Services

Protective & Risk Factors
- Smoking Status
- Fruit/Vegetable Consumption
- Physical Activity
- Alcohol and Other Drug Use
- Sexual Behavior
- Preventive Health Visits
- Vaccination Status

Disease & Injury
- Communicable Disease
- Chronic Disease
- Injury (Intentional & Unintentional)

Mortality
- Infant & Child Mortality
- Life Expectancy

*Blue indicates a sampling of the SCHNA quantitative

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 Washington County on September 26, 2024, with 50 attendees. People from the following organizations participated in the forum process:

- AMHC
- Beth C. Wright Cancer Resource Center
- Calais Community Hospital
- Community Caring Collaborative
- Community Health & Counseling Services
- Department of Health and Human Services Office of Aging and Disability Services
- Down East Community Hospital
- Downeast Community Partners
- Eastport Health Care
- Family Futures Downeast
- Harrington Family Health Center
- Healthy Acadia
- Maine Center for Disease Control and Prevention
- Maine Center for Disease Control and Prevention Division of Public Health Nursing
- Maine Seacoast Mission
- Maine State Senate
- MCD Public Health
- Next Step Domestic Violence Project
- Northern Light Health
- Regional Medical Center at Lubec
- St. Croix Regional Family Health Center
- University of Maine at Machias
- Wabanaki Public Health and Wellness
- Washington County Consortium
- Washington County Emergency Management

Reporting

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

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

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

Appendix 2: Other Identified Health and Well-Being Topics

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

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

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	23	65.7%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	22	62.9%
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)	21	60.0%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	14	40.0%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	14	40.0%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	13	37.1%
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.)	11	31.4%
Isolation	9	25.7%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	8	22.9%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	6	17.1%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	6	17.1%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	5	14.3%
Employment Opportunities	4	11.4%
Stigma Around Accessing/Accepting Help, Services, or Treatment	3	8.6%
Bullying	2	5.7%
Wage Gaps and Income Disparities	2	5.7%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	2	5.7%
Climate Impacts (such as extreme weather events)	1	2.9%
Technology (such as access to high-speed internet and phone services)	1	2.9%
Civic Engagement	1	2.9%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	1	2.9%

Community Conditions	# Votes	% of Participants
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	2.9%
Education (such as pre-K through post-secondary and technical/trade opportunities)	1	2.9%
Other (please specify): Substance use prevention and treatment	1	2.9%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	23	65.7%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	18	51.4%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	15	42.9%
Adverse Childhood Experiences	15	42.9%
Alcohol Use (including binge drinking)	15	42.9%
Preventive Oral Health Care	13	37.1%
Cancer Prevention (such as cancer screenings, sunscreen use)	13	37.1%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	12	34.3%
Youth Mattering (such as positive role models, community connections, etc.)	8	22.9%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	8	22.9%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	7	20.0%
Prescription Drug Misuse	6	17.1%
Cannabis Use	4	11.4%
Vaping Use (including tobacco and cannabis)	4	11.4%
Safe Drinking Water	4	11.4%
Indoor Air Quality	3	8.6%
Immunizations & Vaccinations	2	5.7%
Injury Prevention (such as fall prevention, always wear a seat belt)	1	2.9%
Access to Child and Family Home Visiting	1	2.9%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	1	2.9%
Other (please specify): Culture and community	1	2.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	28	80.0%
Cancer	24	68.6%
Diabetes	24	68.6%
Obesity/Weight Status	21	60.0%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	19	54.3%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	18	51.4%
Cognitive Decline, Alzheimer's disease and other dementias	8	22.9%
Dental Disease	8	22.9%
Multiple Chronic Conditions	7	20.0%
Non-Infectious Respiratory Disease (such as asthma, COPD)	5	14.3%

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)	4	11.4%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	2	5.7%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	2	5.7%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	2	5.7%
Arthritis	1	2.9%

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

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

Community Conditions	# Votes	% of Participants
Transportation (such as access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	31	66.0%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	29	61.7%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	25	53.2%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	25	53.2%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	9	19.2%
Age-related services, lack of adult day centers	9	19.2%
Domestic abuse, elder abuse, IPV / DV	5	10.6%
Isolation	3	6.4%
Opportunities for community engagement - all ages	3	6.4%
Environmental Impacts	3	6.4%
Lack of emergency shelters	1	2.1%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	27	57.5%
Adverse Childhood Experiences	24	51.1%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	17	36.2%
Alcohol Use (including binge drinking)	16	34.0%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	15	31.9%
Education & training	14	29.8%
Transportation	13	27.7%
Social connectedness	10	21.3%

Protective and Risk Factors	# Votes	% of Participants
Oral health	8	17.0%
Vaping Use (including tobacco and cannabis)	8	25.0%
Preventive Oral Health Care	7	21.9%
Cannabis Use	7	21.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	44	93.6%
Substance use disorder	27	57.5%
Cancer	26	55.3%
Metabolic - diabetes, obesity, chronic kidney disease	17	36.2%
Cardiopulmonary - COPD, asthma, CAD, CHF	10	21.3%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	9	19.2%
Obesity/Weight Status	7	14.9%
Diabetes	3	6.4%

Appendix 3: Community Action Agency Profile

About Downeast Community Partners

Downeast Community Partners (DCP) was formed in 2017 with the merging of two of the most venerable organizations in the region, Child and Family Opportunities and the Washington Hancock Community Agency. With a mission to improve the quality of life and reduce the impact of poverty in Downeast communities, DCP is committed to creating and delivering services and programs that treat community members with dignity and compassion and offer them the possibility of achieving their goals and dreams.

Our Mission: Downeast Community Partners' mission is to improve the quality of life and reduce the impact of poverty in Downeast communities.
Our Vision: Downeast Community Partners is a catalyst for improving life in Downeast Maine.
Our Values: Dignity. Compassion. Possibility.

Services Offered by Downeast Community Partners

Children's Education

- Early Care and education programs such as Head Start, Early Head Start, and Family Futures Downeast help provide childcare, meals, education, and more to children and families in Hancock and Washington County.

Elder Services

- Our day program, called Friendship Cottage, provides a place for elders to spend time during the day and where they can still feel integrated into our community. At Home provides support for seniors wanting to maintain independent living in their current home by installing safety railings, delivering meals and medications, and more.

Energy and Housing Services

- We have multiple programs that help people pay for heating services during the winter, as well as provide home repairs and weatherization services.

Transportation

- Transportation assistance is offered for doctors' appointments, grocery shopping, and more. Downeast Community Partners has a fleet of vans and cars dedicated to transporting people in our community to and from vital destinations.

Supportive Services

- We also have programs that are based more on coaching and providing knowledge to people or families in need. Our Whole Family Coaching program aims to help families succeed and reach their goals. We also have nursing services as well as maternal and child health services. We also provide pantry food boxes to people and families in need.

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

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Endnotes

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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

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