Knox County

Maine Shared Community Health Needs Assessment Report

2025

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Introduction

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

The mission of the Maine Shared CHNA is to:

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

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

This assessment cycle, the Maine Shared CHNA has continued its collection and analysis of data covering community conditions and social drivers of health, protective and risk factors, and health conditions and outcomes at the urban, county, state, and national level. This cycle saw expanded efforts to engage communities across Maine, conducting statewide focus groups with specific populations, county level focus groups, key informant interviews, and a statewide community survey. Both the quantitative and qualitative data were used to inform a health and well-being prioritization process held with stakeholders at 17 forums, one in each county and two in Cumberland County. The resulting priorities for Knox 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

Knox County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Housing (ME)	Adverse Childhood Experiences (ME)	Mental Health (ME)
Transportation (ME)	Illicit Drug Use	Substance Use Related Injury & Death
Provider Availability (ME)	Youth Mattering	Special Health Care Needs

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

Poverty Substance Use Nutrition 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 Knox 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 Knox 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

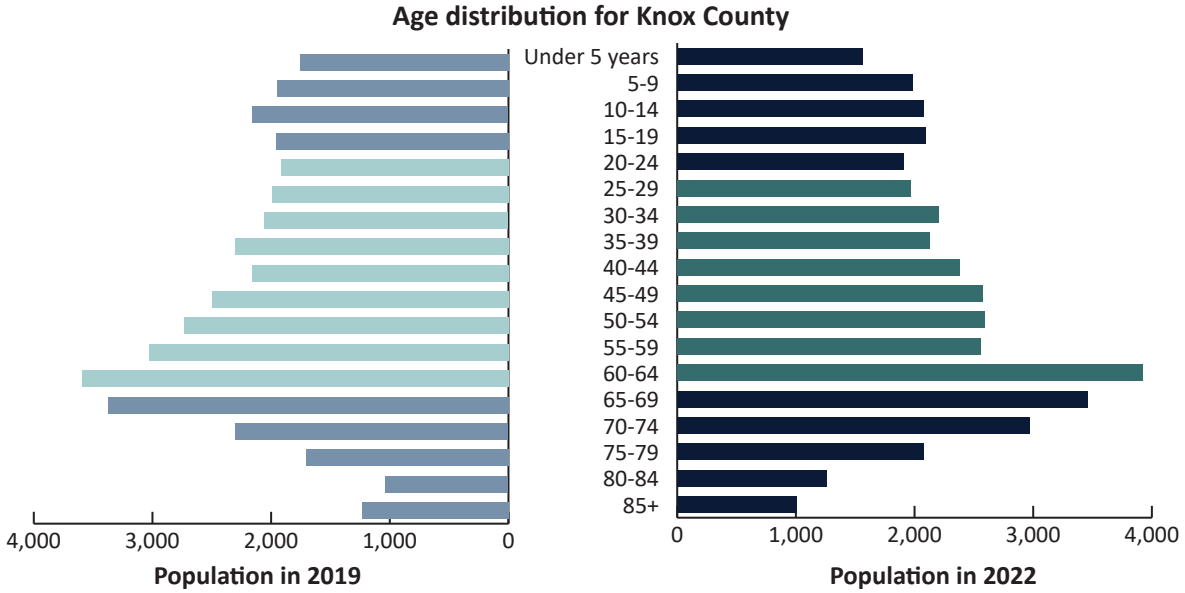
The following tables and chart show information about the population of Knox County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Knox County Population	State of Maine Population
40,729	**1,366,949**

	Knox	Maine
Median household income	**$68,904**	**$68,251**
Unemployment rate	**2.8%**	**3.1%**
Individuals living in poverty	**10.0%**	**10.9%**
Children living in poverty	**12.9%**	**13.4%**
65+ living alone	**28.6%**	**29.5%**

	Knox County	
	Percent	Number
American Indian/Alaskan Native	**0.2%**	**98**
Asian	**0.4%**	**146**
Black/African American	**0.4%**	**157**
Native Hawaiian or other Pacific Islander	**0.0%**	**4**
Some other race	**0.8%**	**314**
Two or more races	**3.3%**	**1,328**
White	**95.0%**	**38,682**
Hispanic	**1.7%**	**680**
Non-Hispanic	**98.3%**	**40,049**

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 Knox County.

Cause of Death	Maine	Knox County
Cancer	**25.9%**	**29.8%**
Heart disease	**27.2%**	**26.3%**
Accidents	**10.5%**	**7.8%**
Chronic lower respiratory disease	**6.8%**	**6.8%**
COVID 19	**6.0%**	**6.0%**
Alzheimer's disease	**4.1%**	**5.8%**
Cerebrovascular disease	**4.8%**	**5.3%**
Diabetes	**4.6%**	**3.3%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**3.0%**
Suicide	**2.0%**	**2.3%**
Chronic liver disease and cirrhosis	**2.3%**	**2.0%**
Parkinson's disease	**1.7%**	**1.3%**
Influenza & pneumonia	**2.1%**	**0.8%**

Health Equity

Definitions

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

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

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

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

Health Equity and Community Engagement

The Maine Shared CHNA takes a broad approach to assessing health and well-being throughout the state. While we attempted to reach many populations in our assessment process who have disparate health and well-being experiences and outcomes, some choices about which groups to include were necessary. We ultimately engaged directly with LGBTQ+ people, multigenerational black/African Americans, people with low-income, veterans, women, young adults, and youth through focus groups and several other populations and sectors through interviews. Additionally, we heard from a diverse audience through a statewide survey.

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

Community Engagement Findings

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

Socioeconomic Empowerment

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

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

Health and Well-Being Priorities

Section Overview

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

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

Socioeconomic Empowerment

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

Populations and Communities

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

Community Resources

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

Crosscutting Priorities

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

Knox County Strengths

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

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

People living in Knox County have a positive outlook on their health and well-being – 67.1% of survey respondents believe their community is healthy or very healthy; 52.8% rate their own physical health as good or excellent and 61.5% say their mental health is good or excellent.

Community Conditions

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

Knox County Community Conditions		
Housing	Transportation	Provider Availability

Housing

Housing was the top priority for the community conditions category for Knox 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 Knox County focus group, "affordable housing" was a key theme. Focus group respondents said:

"Services in the wintertime – no warming shelters. There is one that is sometimes open on Saturdays. No immediate thing to bridge that gap."

"Housing affordability – issues with zoning, gentrification. You almost have to have two jobs to afford housing locally. About $2,500 if you have a family."

Related to these comments, data shows in Knox County,

- 58 children were experiencing homelessness and 2.6% of high school students were housing insecure (2023).
- 12.2% of households spend more than 50% of their income toward housing (2018-2022).
- The median gross rent is $1,027 (2018-2022), significantly worse than 2015-2019 ($856), but significantly better than the U.S. ($1,268).

In the Maine Shared CHNA survey, respondents said "housing insecurity" was the third of five top social concerns negatively impacting their community and 72.7% said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, respondents, whether themselves, a loved one, or their community, were impacted in several ways. These are outlined in Table 1: Housing Needs.

At the Knox County stakeholder forum, participants discussed how housing is impacted by an interconnection of issues and specifically cited the availability of housing including the supply and type of housing. The seasonal nature of Knox County also impacts housing. As of 2022, 2% of housing units in Knox County were vacant and for sale or rent and 73.1% of housing was occupied (2018-2022). In Knox County, 5% of houses were built before 2010, with over half built before 1979 (58.1%, 2018-2020).

Forum participants discussed potential opportunities to collaborate on housing citing the need for a regional approach, specifically to address the impact of cold weather on the unhoused; a team approach to grant seeking and implementation between community-based organizations; the development and use of universal intake forms to be used among community based organizations; and updating FindHelp, an on-line directory that lists free or reduced costs services.

Table 1: Housing Needs, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Housing costs	62.0%	59.5%	84.3%	0.8%	0.8%	0.0%
Availability of affordable, quality homes/rentals	43.0%	47.1%	83.5%	1.7%	1.7%	1.7%
Availability of affordable, quality housing for older adults or those with special needs	22.3%	34.7%	75.2%	1.7%	9.1%	1.7%
Issues associated with home ownership or renting	56.2%	50.4%	76.9%	0.8%	5.0%	2.5%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	33.1%	32.2%	55.4%	4.1%	19.0%	5.0%
Homelessness or availability of shelter beds	6.6%	19.8%	73.6%	3.3%	13.2%	3.3%
Cost of utilities	66.1%	55.4%	79.3%	0.8%	1.7%	0.0%
Costs associated with weatherization	48.8%	41.3%	71.9%	5.0%	5.0%	3.3%

Socioeconomic Empowerment

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

Populations and Communities Impacted by Housing

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For housing, respondents cited: youth, children, formerly incarcerated people, LGBTQ youth, people with substance use disorder, people involved with the criminal justice system, people with disabilities, Black, Indigenous and People of Color (BIPOC), fishing community, adults, older adults, unhoused/housing insecure, people with mental health disorders, and people living in rural areas.

Community Resources to Address Housing

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

- Community development corporation
- Community Health Workers and case managers
- Department of Health and Human Services, specifically supportive housing
- Faith-based organizations
- General Assistance
- Habitat for Humanity
- Homeworth/The Landing Place
- Low income and affordable housing development
- MaineHousing
- New Hope
- Penquis
- Rockland Emergency Warming Center
- Volunteers of America
- Waldo County Action Corporation

Transportation

Transportation was the second rated priority for the community conditions category for Knox 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 Knox County focus group, "transportation" was a top theme. One focus group participant said:

"Transportation – most of us use the Dash or Mid-Coast Connector – but they are not reliable. They will call and change your time – you might have to go an hour early to your appointment or stay there an extra hour."

In the Maine Shared CHNA survey, 67.7% of survey respondents said "transportation needs" negatively impact them, a loved one, and/or their community. When asked about specific transportation needs, several topics impacted people, their loved ones, and their community; outlined in Table 2: Transportation Needs.

In Knox County 5.8% of households do not have a vehicle (2018-2022). During the period 2018-2022, 23.8% of people had a commute of greater than 30 minutes driving alone, significantly worse than 2015-2019 (18.8%), but significantly better than Maine (33.9%) and the U.S. (36.5%).

Participants at the Knox County stakeholder forum discussed availability of and costs associated with transportation. There is an overall lack of public transportation and drivers, along with concerns about the types of transportation available, including the safety of bikes and scooters and having vehicles that match the needs of people with disabilities. Regarding costs, low wages and the high costs of vehicles and insurance were cited as contributing factors and for those with vehicles, the costs of gas and car repairs are factors. Participants discussed possible collaborations to work on transportation, such as regional collaborations beyond Knox County and including rural and suburban communities not just urban areas.

Table 2: Transportation Needs, 2024	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Access to transportation (for medical appointments, work, childcare)	26.5%	42.7%	73.5%	0.9%	4.3%	3.4%
Availability of public transportation (buses, trains, ride shares, taxis)	36.8%	40.2%	77.8%	0.9%	3.4%	3.4%
Availability of transportation that meets a variety of specific needs (older adults, physical or cognitive needs)	16.2%	29.9%	69.2%	3.4%	11.1%	5.1%
Costs associated with owning and maintaining a vehicle (insurance, registration, repairs)	63.2%	57.3%	64.1%	0.9%	1.7%	2.6%

Socioeconomic Empowerment

When asked to rate the five "very necessary" steps to move people out of poverty and to a place of stability, "reliable transportation" was rated number four by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Transportation

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For transportation, respondents cited: Black, Indigenous and People of Color (BIPOC), households with shared vehicles, immigrants, island communities, older adults, young adults, people living in rural areas, adults, and people with low income.

Community Resources to Address Transportation

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

- Community support workers
- Dash Bus
- Faith-based organizations
- Homeworthy
- MaineCare transportation
- Midcoast Connector
- Moving Maine Network
- Neighbor to Neighbor
- Penquis
- Taxis
- Volunteers of America
- Waldo Community Action Program

Provider Availability

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

Assessment Findings

In the Knox County focus group, "access to healthcare" and "timely mental health care" were top themes. Focus group participants said:

"Most specialties [are hard to find]. They are available but far away and few accept MaineCare."

"A lot [of providers] won't take Medicare or Medicaid because they have to wait to get paid. It takes about 120 days, not just a couple of weeks."

In Knox County, 27.8% of adults are enrolled in MaineCare and 45.6% of people ages 0 to 19 are enrolled in MaineCare (2020).

Approximately half (53.4%) of survey respondents said they or a loved one could not or chose not to get health care services in the past year and 61.5% said the same about mental health care services. With relation to provider availability, barriers for receiving health care include "long wait times to see a provider," and "no evenings or weekend hours to get care." Barriers related to provider availability for mental health care include "long wait times to see a provider" and "did not feel comfortable with available providers."

In Knox County,

- There were 1,361 people for every primary care physician (2024).
- 89.3% of adults have a usual primary care provider.
- 78% of adults have had a primary care visit in the past year (2019-2021), significantly better than 2015-2017 (65.4%).
- There were 5,802 people for every psychiatrist and 190 people for every mental health provider (2024).
- 18.9% of adults were currently receiving outpatient mental health services (2019-2021).

Participants at the Knox County stakeholder forum discussed workforce challenges contributing to provider availability. Forum participants see an inability to recruit and retain providers and challenges in provider education and medical school residency programs. They believe there is a lack of infrastructure and that reimbursement issues exist for certain levels of healthcare providers. In addition, there is a perception health care could be better provided by matching the level of patient need to a provider with the appropriate skill set. Patients may also be lacking the appropriate literacy levels to seek the care they need. There is a lack of trust with the health care system and financial discrimination, specifically with dental care. Forum participants see a potential to expand telehealth and to collaborate with community paramedics, Fish Ability, and the Maine Seacoast Mission.

Socioeconomic Empowerment

Participants in the Maine Shared CHNA survey said "affordable and available health care" is the fifth of five top "very necessary" steps to move people out of poverty to a place of stability.

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, as were those at the forum. For provider availability, respondents cited: people with disabilities, people who are self-employed, caretakers, fishing community, island communities, adults, older adults, children, youth, and teens.

Community Resources to Address Provider Availability

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

- Children's Oral Health Network
- Community Development Corporation
- Community Health Workers
- Finding Our Voices
- Independent and private providers
- Knox Clinic
- MaineCare
- Maine Coast Fisherman's Trust for Mental Health
- MaineHealth
- MaineHealth Behavioral Health
- Mainely Teeth
- Public health nurses
- Tooth Protectors
- Town government

Crosscutting Priorities

Adverse Childhood Experiences **Mental Health**

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 Knox 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.

Knox County Protective & Risk Factors		
Adverse Childhood Experiences	**Illicit Drug Use**	**Youth Mattering**

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the top-rated priority for the protective and risk factors category for Knox 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, 24% of high school students in Knox County had at least four of nine adverse childhood experiences. In the Maine Shared CHNA survey, four of the five top social concerns that negatively impact the community could be associated with ACEs – substance use, mental health issues, housing insecurity, and low incomes and poverty. Approximately three-quarters of survey respondents said economic needs (79.1%) and housing needs (72.7%), potential root causes of ACEs, impact them, a loved one, and/or their community.

Seventy percent (70.2%) of Maine Shared CHNA survey respondents said "mental health needs" negatively impact them, a loved one, and/or their community. In the Knox County focus group, "timely mental health care" was a top theme. Of those who said mental health needs, half (50.4%) said "youth mental health" negatively impacts their community and 38.6% said it impacts a loved one. In Knox County,

- 31.2% of high school students reported being sad/hopeless for two weeks in a row and 13.6% had seriously considered suicide (2023).
- 25.1% of middle school students reported being sad/hopeless for two weeks in a row and 21.1% had seriously considered suicide (2019).

Forum participants discussed mental and behavioral health as contributing factors to ACEs, specifically when it is untreated and the impacts of parental mental health on children. Root causes identified also included generational trauma, domestic violence, and sexual abuse. Participants noted the impact of community conditions on ACEs, such as housing insecurity, lack of social services, food insecurity, lack of child care, and lack of community involvement. Related to these factors, 11.9% of adults and 17.6% of youth were food insecure (2022), 44.8% of children were served in publicly funded state and local preschools (2023), and there were 29 child care centers (2024) in Knox County.

Populations and Communities Impacted by Adverse Childhood Experiences

Adverse childhood experiences was a priority added at the forum and was not included in population identification during the pre-forum survey. Those at the forum cited: children, youth, teens, grandparents, parents, people with disabilities, and LGBTQ people.

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:

- Faith-based organizations
- Finding Our Voices
- Healthy Kids
- Homeworthy
- Knox Clinic
- Law enforcement
- Maine Center for Disease Control and Prevention Public Health Nursing
- Maine Department of Health and Human Services
- Maine Families
- MaineHealth Behavioral Health
- Midcoast Collaborative
- New Hope
- OUT Maine
- Penquis
- School nurses
- Social workers
- Spectrum Generations
- Sweetser
- The Landing Place
- Trekkers
- Trevor Project
- Volunteers of America
- Welcome Little Dragons
- Women, Infants and Children Program
- YMCA

Crosscutting Priorities

Housing **Illicit Drug Use** **Youth Mattering**

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

Illicit Drug Use

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

Assessment Findings

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 62.5% said “substance use” negatively impacts them, a loved one, and/or their community. When asked about specific substances, 73.7% and 21.9% said “opioid misuse” negatively impacts their community and a loved one respectively and 69.3% and 28.1% said “other illicit drug use” negatively impacts their community and a loved one respectively. In Knox County,

- There were 35 overdose deaths per 100,000 people (2023).
- There were 35.5 drug-induced deaths per 100,000 people (2018-2022), significantly better than Maine (55.6 per 100,000).
- 5.5% of high school students engaged in past 30-day prescription drug misuse (2023).
- 2.5% of middle school students engaged in past 30-day prescription drug misuse (2019).
- 6.1% of high school students reported using illicit drugs in their lifetime, significantly worse than Maine (3.6%, 2024).

Knox County stakeholder forum participants cited mental health factors, such as mental health status in general, and specifically ACEs, isolation, and generational and active trauma as contributing factors to illicit drug use. Forum participants discussed a lack of substance use prevention services as a contributing factor and specifically education on alternatives to substance use. There is a belief some may be treating chronic or untreated pain with illicit drugs. Forum participants highlighted the cultural acceptance that exists around some types of drug use and peer pressure for youth to use.

Populations and Communities Impacted by Illicit Drug Use

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

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:

- Better Life Partners
- Coastal Recovery Community Center
- Counseling services
- Emergency Medical Services
- Groups Recover Together
- Hospitals
- Knox Clinic
- Law enforcement
- Maine Behavioral Health
- Medication Assisted Treatment
- Methadone clinic
- Midcoast Recovery Coalition
- Narcotics Anonymous
- OPTIONS
- Penbay Medical Center
- Penobscot Bay Community Health Partnerships
- Primary care providers
- Public health organizations
- Recovery coaches and peer support
- Safe disposal sites
- Safeline
- Schools
- Smart recovery
- Substance use disorder treatment centers
- Volunteers of America

Crosscutting Priorities

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

Youth Mattering

Youth mattering was the third rated priority for the protective and risk factors category for Knox County. For the purposes of the prioritization process, youth mattering includes such topics as positive role models and community connections.

Assessment Findings

In the Maine Shared CHNA survey, respondents listed community strengths related to youth mattering as “safe opportunities to be outside,” “safe neighborhoods,” and “schools and education for all ages.”

In the Maine Shared CHNA survey, of the:

- 70.2% of respondents who said, “mental health needs” negatively impact them, a loved one, and/or their community, 50.4% and 38.6% said “youth mental health” negatively impacts their community and a loved one.
- 62.5% that said, “substance use” negatively impacts them, a loved one, and/or their community, 69.3% said “youth substance use” negatively impacts their community.
- 45.9% of respondents that said, “public safety needs” negatively impact them, a loved one, and/or their community, specific negative impacts on community include “violence between people” (76.5%), “discrimination based on race, ethnicity, gender, LGBTQIA2S+, age, ability, etc.” (54.9%), and “racism” (53.9%).

In Knox County,

- 24% of high school students had at least four of nine adverse childhood experiences (2023).
- 17.9% of high school students reported bullying on school property, significantly better than Maine (21.9%, 2023).
- 16.6% of high school students were bullied electronically, significantly better than 2021 (19.7%) and Maine (20%, 2023).
- 46.8% of middle school students reported bullying on school property and 28.7% were bullied electronically (2019).

Knox County stakeholder forum participants noted the impact of connections, specifically isolation, loneliness, a lack of role models, and a lack of opportunity and activities for recreating. Other factors include the impacts of social media, politics, and climate change, as well as those who are exposed to or experiencing addiction and substance use disorder. Participants would like to see more programming for young adults and services that assist with life transitions, along with more apprentice programs and multigenerational programming.

Populations and Communities Impacted by Youth Mattering

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 youth mattering, respondents cited: youth, teens, young adults, LGBTQIA2S+, and people with substance use disorder.

Community Resources to Address Youth Mattering

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

- Big Brothers Big Sisters
- Child Protective Services
- Civic groups
- Center for Maine Contemporary Art's youth education programs
- Community mental health workers
- Faith-based organizations
- Flanagan Center
- Healthy Kids
- Law enforcement
- Maine Youth Thriving
- New Hope Midcoast
- OUT Maine
- Penbay Medical Center
- Restorative Justice Project
- School resource fairs
- School social worker departments
- Sports and coaches
- The Landing Place
- Trekkers
- Wayfinder
- YMCA
- Youth Alliance
- Youth mentorship programs

Crosscutting Priorities

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

Health Conditions & Outcomes

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

Knox County Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Special Health Care Needs**

Mental Health

Mental health was the top priority for the health conditions and outcomes category for Knox 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 Knox County focus group, "timely mental health care" was a top theme. In the Maine Shared CHNA survey, "mental health issues" was listed as the second of five social concerns negatively impacting the community by survey respondents and 70.2% said "mental health needs" negatively impacts them, a loved one, and/or their community. When asked about specific mental health needs, several topics negatively impacted respondents, their loved ones, and their community as outlined in Table 3: Mental Health Needs.

In Knox County, data shows 9% of adults have current symptoms of depression; 22.6% have had depression in their lifetime; and 22.8% have had anxiety in their lifetime (2019-2021). In the Maine Shared CHNA survey, 61.5% of respondents rate their own mental health as "good or excellent" and 46% of respondents said they or a loved one could not or chose not to get mental health care services in the past year. They cited barriers as: "long wait times to see a provider," "did not feel comfortable with available providers," and "did not feel comfortable seeking help." In 2024, there were 5,802 people for every psychiatrist and 190 people for every mental health provider. During the period 2019-2021,18.9% of adults were receiving outpatient mental health services.

At the Knox County stakeholder forum, participants discussed several systemic and structural factors impacting mental health, including cultural norms, specifically stoicism, generational and societal stigma, and the need to address the hierarchy of needs before all else. Community conditions were also cited, such as isolation, poverty, and housing instability. Additional factors contributing to mental health that were discussed included ACEs, domestic violence, and trauma. Forum participants noted some people may have negative experiences with healthcare systems specifically related to their concerns being appropriately addressed, which may make them hesitant to seek care.

Forum participants would like to see more collaboration in the health system to address mental health and funding for programming. They believe there should be more supports in place for caregivers and school employees, specifically education on local resources.

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	57.5%	64.6%	41.7%	1.6%	4.7%	1.6%
Depression	55.1%	65.4%	44.1%	3.9%	1.6%	2.4%
Bipolar disorder	13.4%	36.2%	39.4%	6.3%	18.1%	8.7%
Trauma or post-traumatic stress disorder (PTSD)	44.1%	48.0%	46.5%	3.1%	7.1%	6.3%
General stress of day-to-day life	63.0%	64.6%	55.9%	3.1%	2.4%	1.6%
Social isolation or loneliness	41.7%	40.2%	48.0%	2.4%	10.2%	6.3%
Stigma associated with seeking care for mental health or substance use disorders	21.3%	26.8%	43.3%	12.6%	16.5%	10.2%
Suicidal thoughts and/or behaviors	10.2%	26.8%	48.8%	9.4%	13.4%	13.4%
Youth mental health	16.5%	38.6%	50.4%	5.5%	10.2%	11.0%

Populations and Communities Impacted by Mental Health

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For mental health, respondents cited: people with disabilities, the fishing community, unhoused/housing insecure, people in early recovery, Black, Indigenous, and People of Color (BIPOC), LGBTQ people, people living in isolation, island communities, older adults, teens, young adults, adults, youth, and the formerly incarcerated.

Community Resources to Address Mental Heath

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 mental health, respondents identified:

- Case managers
- Community Health Workers
- Coastal Recovery Community Center
- Employee Assistance Programs
- Family Peer Support Specialists
- Knox Clinic
- Local counselors
- Maine Coast Fisherman's Association
- Maine Seacoast Mission
- Maine Trans Net
- MaineHealth
- MaineHealth Behavioral Health
- NAMI Maine
- New Hope Midcoast
- OUT Maine
- Penbay Medical Center
- Penquis
- Private practices
- Sweetser
- The Landing Place
- Trevor Project
- Wabanaki Alliance

Crosscutting Priorities

Housing **Provider Availability** **Youth Mattering**

Illicit Drug Use **Mental Health** **Adverse Childhood Experiences**

Substance Use Related Injury & Death

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

Assessment Findings

In the Maine Shared CHNA survey, respondents said "substance use" was the top social concern negatively impacting their community and 62.5% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 64% and 44.7% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one.
- 73.6% said "opioid misuse" negatively impacts their community.
- 69.3% said "other illicit drug use" negatively impacts their community.

In Knox County,

- There were 14.3 alcohol-induced deaths per 100,000 people (2018-2022).
- 9.9% of adults engage in chronic heavy drinking (2019-2021).
- 14.3% of adults engage in binge drinking (2019-2021).
- There were 35 overdose deaths per 100,000 people (2023).
- There were 35.5 drug-induced deaths per 100,000 people (2018-2022), significantly better than Maine (55.6 per 100,000).

Knox County stakeholder forum participants discussed the cultural acceptance of substance use, coupled with a lack of recreation activities without substances and the ease of accessing them. Boredom and isolation were also noted as potential contributing factors.

Participants discussed the health care system, including a lack of providers and provider education on substance use, in addition to pain management practices that may lead to self-management. Forum participants believe there is a stigma and resistance to using harm reduction strategies. They also noted mental health and related factors including domestic violence and trauma. Community conditions such as homelessness and poverty were also raised as contributing factors.

Forum participants would like to see more resources in the community including places like The Landing Place and youth appropriate substance use centers. Additionally, they would like a more robust re-entry system for the formerly incarcerated and continued engagement between providers and law enforcement. Participants believe there should be more education in schools around harm reduction and overdose response.

Populations and Communities Impacted by Substance Use Related Injury and Death

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For substance use related injury and death, respondents cited: people with disabilities, LGBTQ people, Black, Indigenous and People of Color (BIPOC), fishing community, people with chronic pain, island populations, formerly incarcerated, people in early recovery, unhoused/housing insecure, adults, older adults, teens, young adults, and veterans.

Community Resources to Address Substance Use Related Injury and Death

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

- Better Life Partners
- Coastal Recovery Community Center
- Community Health Workers
- Fishing Partnership Support Services
- Knox Clinic
- Maine Coast Fisherman's Association
- Maine Seacoast Mission
- MaineGeneral
- MaineHealth
- MaineHealth Behavioral Health
- Medication Assisted Treatment
- Midcoast Maine Recovery Coalition
- Narcotics Anonymous
- OPTIONS
- OUT Maine
- Penbay Community Health Partnerships
- Primary care providers
- Recovery services and peer support
- Schools
- Smart Recovery
- Student Intervention and Reintegration Program (SIRP)
- Substance use counselors
- Treatment and Recovery Court
- Volunteers of America

Crosscutting Priorities

Housing **Provider Availability** **Youth Mattering**

Illicit Drug Use **Mental Health** **Adverse Childhood Experiences**

Special Health Care Needs

Special health care needs was the third rated priority for the health conditions and outcomes category for Knox County. For the purposes of the prioritization process, special health care needs are 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.

Assessment Findings

At the Knox County stakeholder forum there was a theme about the intricacies of special health care needs and how they are handled within the health care system. These included a lack of access to screening, waitlists and providers not accepting new patients, a lack of specialists, limited ability to access services or programs for people with conflicting diagnoses, care communication between providers, lack of preventive care, and a lack of acute needs being addressed that turn into chronic disease. In the Knox County focus group, "access to healthcare" was also a top theme. One participant said:

"Most specialties [are hard to find]. They are available but far away and few accept MaineCare."

Related to the forum and focus group discussions, in Knox County,

- 32.6% of MaineCare members had developmental screening (2023).
- There were 1,361 people for every primary care physician (2024).
- 89.3% of adults have a usual primary care provider (2019-2021).
- 78% of adults have had a primary care visit in the past year (2019-2021), significantly better than 2015-2017 (65.4%).
- There were 5,802 people for every psychiatrist (2024).
- There were 190 people for every mental health provider (2024).
- 18.9% of adults were currently receiving outpatient mental health services (2019-2021).
- 27.8% of adults are enrolled in MaineCare and 45.6% of people ages 0 to 19 are enrolled in MaineCare (2023).
- 6.1% of people have cognitive decline (2018 & 2020), significantly better than Maine (9.2%).

Forum participants discussed community conditions such as a lack of transportation and poverty as impacting special health care needs. Domestic violence, physical labor, mental health, and substance use were all potential risk factors discussed by participants. Forum participants noted the current definitions used for disability status may limit access to needed services depending on the definition used or if an official diagnosis is not given.

Socioeconomic Empowerment

In the Maine Shared CHNA survey, respondents rated "affordable and available health care" as the fifth "very necessary" step of five to help move people out of poverty and to a place of stability.

Populations and Communities Impacted by Special Health Care Needs

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 special health care needs, respondents cited: people with disabilities, fishing community, unhoused/housing insecure, children, women, people in early recovery, Black, Indigenous and People of Color (BIPOC), LGBTQ people, older adults, youth, teens, young adults, and people with substance use disorder.

Community Resources to Address Special Health Care Needs

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 special health care needs, respondents identified:

- Care coordinators
- Community Health Workers
- Department of Health and Human Services
- Knox Clinic
- Lend a Hand
- Maine AgrAbility/FishAbility
- Maine Center for Integrated Rehabilitation
- Maine Coast Fisherman's Association
- MaineHealth
- MaineHealth Behavioral Health
- Penbay Medical Center

Crosscutting Priorities

Transportation **Provider Availability** **Youth Mattering**

Illicit Drug Use **Adverse Childhood Experiences** **Mental Health**

Substance Use Related Injury & Death

Appendices

Appendix 1: Methodology

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

Data Commitments

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

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

Quantitative Data

Data Criteria

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

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

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

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

Data Profiles & Interpretation

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

Data Limitations, Gaps, & Considerations

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

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

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

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

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

Data Changes

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

Data Discrepancies

COVID's Impact

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

Health Equity Profiles

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

Qualitative Data

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

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

Considerations for Identifying Populations to Engage With

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

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

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

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

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

Considerations for the Use of Other Assessments

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

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

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

Focus Groups

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

- Statewide Focus Group Participants: 31 (total)

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

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

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

Key Informant Interviews

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

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

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

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

Statewide Community Survey

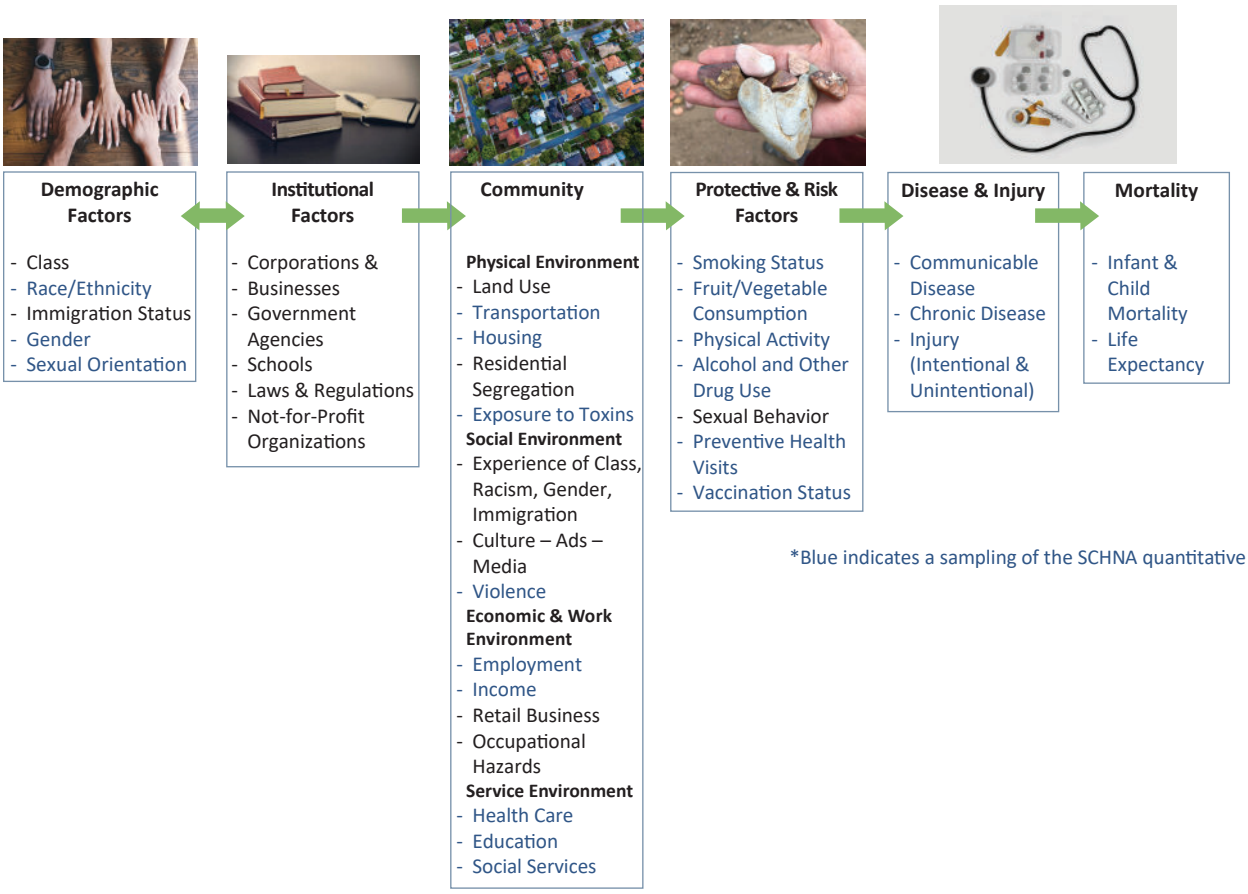
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group,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

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

Bay Area Regional Health Inequities Initiative (BARHII) Framework

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

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



Stakeholder Forums

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

One in-person stakeholder forum was held in Knox County on November 13, 2024, with 33 attendees. People from the following organizations participated in the forum process:

- Beach Hill Research
- CRCC
- First National Bank
- Homeworthy
- Knox Clinic
- Maine CDC Midcoast District Public Health
- Maine Center for Disease Control & Prevention
- Maine Senator District 12
- MaineHealth
- MaineHealth Behavioral Health
- MaineHealth Pen Bay Hospital
- MaineHealth Pen Bay and Waldo Hospitals
- MCD Global Health
- MCH Inc.-Knox County Meals on Wheels
- Mid-Coast Health Net, dba Knox Clinic
- New Season
- Penobscot Bay Community Health Partnerships
- Penquis
- Penquis Rockland
- RSU 40
- Second Congregational Church of Warren
- University of Maine
- Volunteers of America - Northern New England

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)	16	88.9%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	12	66.7%
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)	9	50.0%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	8	44.4%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	8	44.4%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	8	44.4%
Wage Gaps and Income Disparities	5	27.8%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	5	27.8%
Employment Opportunities	4	22.2%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	3	16.7%
Isolation	2	11.1%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	11.1%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	1	5.6%
Climate Impacts (such as extreme weather events)	1	5.6%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	1	5.6%
Technology (such as access to high-speed internet and phone services)	1	5.6%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	1	5.6%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	5.6%
Systemic Discrimination	1	5.6%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	1	5.6%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	13	72.2%
Alcohol Use (including binge drinking)	11	61.1%
Youth Mattering (such as positive role models, community connections, etc.)	8	44.4%
Preventive Oral Health Care	7	38.9%
Adverse Childhood Experiences	7	38.9%
Prescription Drug Misuse	7	38.9%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	6	33.3%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	5	27.8%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	5	27.8%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	3	16.7%
Vaping Use (including tobacco and cannabis)	3	16.7%
Injury Prevention (such as fall prevention, always wear a seat belt)	2	11.1%
Foster Care	2	11.1%
Cannabis Use	2	11.1%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	2	11.1%
Immunizations & Vaccinations	1	5.6%
Access to Child and Family Home Visiting	1	5.6%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	1	5.6%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	17	94.4%
Obesity/Weight Status	10	55.6%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	9	50.0%
Dental Disease	6	33.3%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	6	33.3%
Multiple Chronic Conditions	6	33.3%
Intentional Injury & Death (self-injury)	5	27.8%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	5	27.8%
Cognitive Decline, Alzheimer's disease and other dementias	5	27.8%
Cancer	4	22.2%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	4	22.2%
Diabetes	4	22.2%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	1	5.6%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	1	5.6%
Non-Infectious Respiratory Disease (such as asthma, COPD)	1	5.6%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	1	5.6%
Other (please specify): Physical activity, nutrition and weight	1	5.6%

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

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

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	25	96.2%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	17	65.4%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	17	65.4%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	7	26.9%
Literacy, including digital literacy	5	19.2%
Isolation	4	15.4%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	3	11.5%
Protective and Risk Factors	**# Votes**	**% of Participants**
ACEs	18	69.2%
Illicit Drug Use	17	65.4%
Youth Mattering (such as positive role models, community connections, etc.)	16	61.5%
Preventive Oral Health Care	14	53.9%
Physical activity	7	26.9%
Alcohol Use (including binge drinking)	3	11.5%
Prescription Drug Misuse	3	11.5%
Health Conditions and Outcomes	**# Votes**	**% of Participants**
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	22	84.6%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning), Vascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	20	76.9%
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)	13	50.0%
Multiple Chronic Conditions	12	46.2%
Chronic pain & pain management	4	15.4%
Obesity/Weight Status	3	11.5%
Intentional Injury & Death (self-injury)	3	11.5%
Neurodevelopmental disabilities for all populations	2	7.7%

Appendix 3: Community Action Agency Profile

PENQUIS

Helping Today • Building Tomorrow

About Penquis

Penquis is a nonprofit organization dedicated to helping Maine people improve their financial stability and wellbeing. It is a community action agency, a licensed mental health agency, a community development corporation, and a community housing development organization. Its subsidiaries include a community development financial institution, a sexual assault services agency, and housing development organizations.

Penquis primarily serves individuals and families in Penobscot, Piscataquis and Knox counties. It has an even broader impact across all of Maine's sixteen counties through its programs, subsidiaries and community partnerships. Penquis touches the lives of up to 5,000 people on any given day and more than 30,000 each year.

Penquis is a chartered member of NeighborWorks® America and a member of the Housing Partnership Network. Penquis has consistently earned an "exemplary" rating from NeighborWorks America for attaining the highest level of performance and impact. Other recognition includes a 2024 Maryann Hartman award from the University of Maine, a 2023 National Lyndon Baines Johnson Leadership Award from the National Community Action Partnership, a 2022 Catalyst in Financial Stability award from the Internal Revenue Service, and a 2020 Stephen B. Mooers Award from MaineHousing.

Services Offered by Penquis

- **Housing Stability:** Services increase housing access, affordability, and availability to enable families and individuals to improve their health, safety, and stability. Services include homebuyer education and housing counseling; asset development opportunities through financial coaching, matched savings, business counseling, and lending; home improvement programs, including repair, replacement, and testing; affordable housing support, including housing development and rent-to-own properties, housing navigation, and heating and utilities assistance; and energy safety and efficiency measures, including above ground tank replacement, heating system repair, heat pumps, and weatherization.
- **Access to High-Quality Transportation:** Penquis transportation programs support health, independence, and access to resources through safe, reliable transportation options. These include the arrangement of non-emergency transportation for MaineCare-covered appointments, general public transportation to meet everyday

needs, and transportation reimbursement options.

- **Low-income Assistance Program:** For those who are HEAP eligible, provides assistance to low-income homeowners and renters with electricity bills.
- **School Readiness:** Services and supports help children enter kindergarten ready to be successful in school and in life. Children receive high-quality early childhood education and childcare services, healthy nutrition, and the benefits of home visiting, which supports families in providing care that promotes healthy development.
- **Healthy Lives:** Programs in this area help individuals achieve optimal health and development in safe, nurturing environments. They include support services such as assisted living, case management, parenting education, supervised visitation, whole family services, and behavioral health and disability supports; victim services, including services for sexual assault survivors and child victims of sexual abuse, housing navigation for victims of human trafficking, and education for male perpetrators of domestic violence; volunteering for older adults; and youth programs, including youth engagement, restorative justice, housing and supportive services for youth experiencing homelessness, programming for substance-affected youth, and services to support employment and financial security.

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Endnotes

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

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

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

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

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

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

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