Penobscot County

Maine Shared Community Health Needs Assessment Report

2025

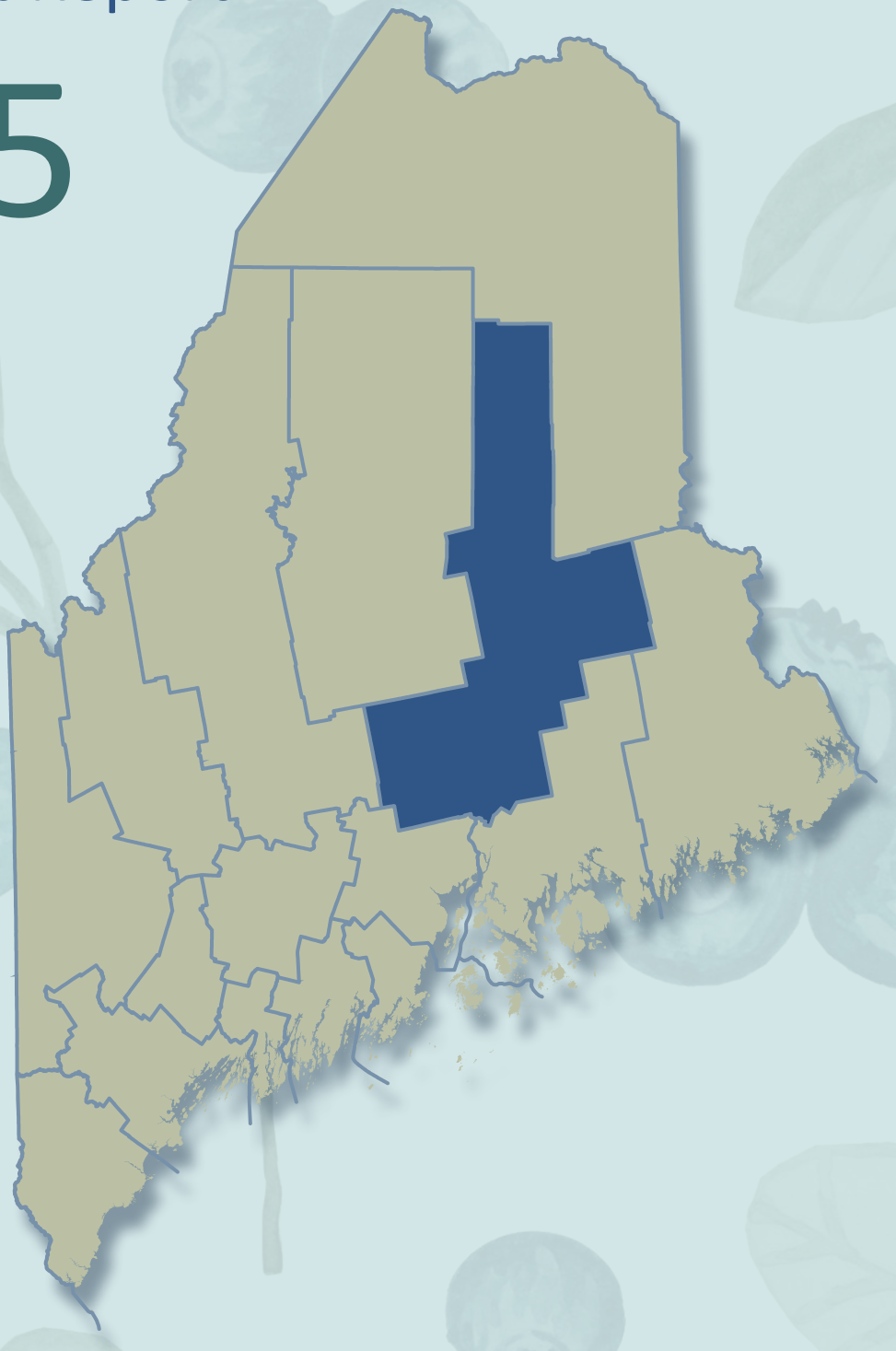


Table of Contents

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 Penobscot 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

Penobscot County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Provider Availability (ME)	Illicit Drug Use	Mental Health (ME)
Aging-Related Services	Alcohol Use	Substance Use Related Injury & Death
Housing (ME)	Adverse Childhood Experiences (ME)	Cancer

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

- Transportation
- Poverty
- Chronic Conditions
- Substance Use
- Nutrition

Next Steps

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

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

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

Report Outline

This report is broken into three sections.

1. Data on Penobscot 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 Penobscot 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

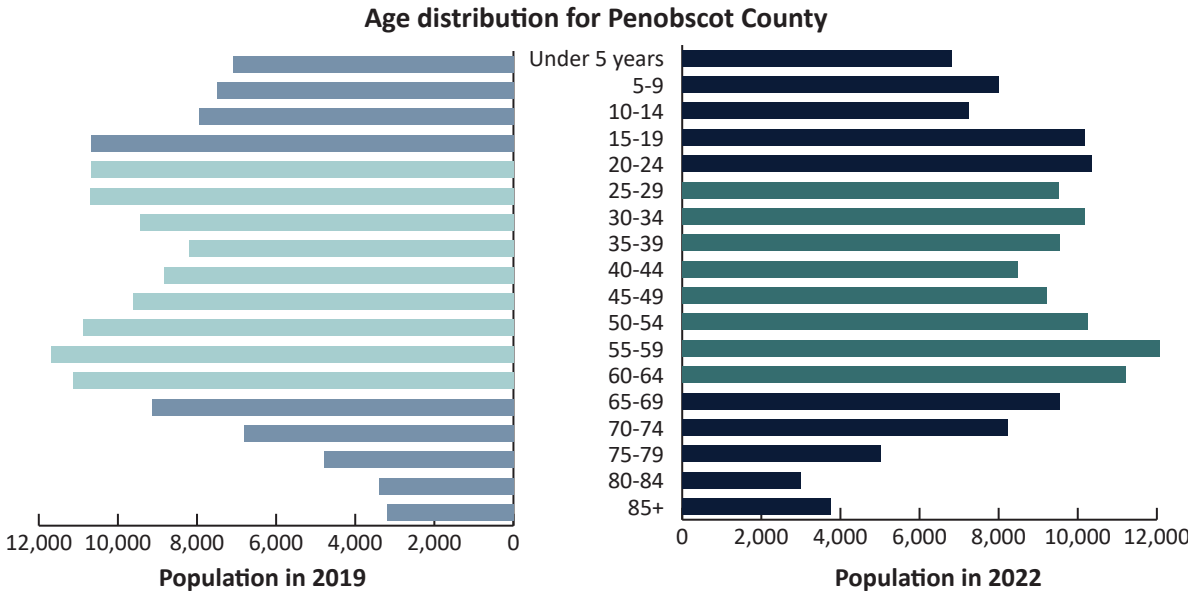
The following tables and chart show information about the population of Penobscot County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Penobscot County Population	State of Maine Population
152,640	**1,366,949**

	Penobscot	Maine
Median household income	**$59,438**	**$68,251**
Unemployment rate	**2.9%**	**3.1%**
Individuals living in poverty	**13.4%**	**10.9%**
Children living in poverty	**14.8%**	**13.4%**
65+ living alone	**31.2%**	**29.5%**

	Penobscot County	
	Percent	Number
American Indian/Alaskan Native	**1.1%**	**1,697**
Asian	**1.0%**	**1,486**
Black/African American	**1.0%**	**1,504**
Native Hawaiian or other Pacific Islander	**0.0%**	**34**
Some other race	**0.7%**	**1,038**
Two or more races	**3.3%**	**5,101**
White	**92.9%**	**141,780**
Hispanic	1.6%	2,498
Non-Hispanic	98.4%	150,142

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 Penobscot County.

Cause of Death	Maine	Penobscot County
Heart disease	**27.2%**	**29.1%**
Cancer	**25.9%**	**23.3%**
Accidents	**10.5%**	**12.0%**
COVID 19	**6.0%**	**7.0%**
Chronic lower respiratory disease	**6.8%**	**6.9%**
Diabetes	**4.6%**	**4.4%**
Cerebrovascular disease	**4.8%**	**4.4%**
Alzheimer's disease	**4.1%**	**2.5%**
Influenza & pneumonia	**2.1%**	**2.5%**
Suicide	**2.0%**	**2.2%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**2.0%**
Parkinson's disease	**1.7%**	**2.0%**
Chronic liver disease and cirrhosis	**2.3%**	**1.7%**

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.

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

Health and Well-Being Priorities

Section Overview

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

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

Socioeconomic Empowerment

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

Populations and Communities

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

Community Resources

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

Crosscutting Priorities

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

Penobscot County Strengths

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

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

People living in Penobscot County have a positive outlook on their health and well-being – 64.7% of survey respondents believe their community is healthy or very healthy; 55.3% rate their own physical health as good or excellent and 58.3% 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 Penobscot 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.

Penobscot County Community Conditions		
Provider Availability	Aging-Related Services	Housing

Provider Availability

Provider availability was the top priority for the community conditions category for Penobscot County. For the purposes of the prioritization process, provider availability includes topics 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.

Assessment Findings

Participants at the Penobscot County stakeholder forum discussed several contributing factors that have resulted in health care provider shortages and have impacted the ability to obtain care, with primary care wait lists specifically mentioned. In general, stakeholder participants noted providers are leaving the area, some due to retirement, and an inability to recruit providers. This was attributed to a lack of competitive provider compensation in the area; a lack of resources to attract providers such as cultural resources and housing, and high burnout rates for specific providers, notably primary care providers who may be taking on more complex cases due to the lack of specialists. Participants in the Penobscot County focus group experience these sentiments as well, with "high turnover rates of providers" as a top theme and saying:

"Specialists are difficult to access this far north. I needed to travel south to get tests done. I was told if I needed anything further, I would need to go to Boston. I find that very common here. If you need surgeries, your best bet is to go to Boston. I don't have the ability to just hop in a car and rent a motel."

In addition to a lack of providers, health care facilities also continue to experience financial repercussions from the COVID-19 pandemic resulting in a reduction or elimination of services. Stakeholder participants did note Penobscot Community Health Center is working to recruit and

retain providers, as is Northern Light Health, specifically through collaborations with nursing schools to recruit nurses and pay for their training.

Participants in both the Penobscot County focus group and the Penobscot County stakeholder forum discussed challenges with MaineCare, specifically with regard to finding providers who accept MaineCare and MaineCare reimbursement rates. Stakeholder participants noted reimbursements are very low, which means many medical facilities can only take so many MaineCare clients. In Penobscot County, 8% of people are uninsured (2018-2022) and 32.1% are enrolled in MaineCare (2020), with 44.7% of those aged 0-19 enrolled in MaineCare (2020). This is echoed with what people, specifically those with low-income, are experiencing. A key theme in the Penobscot County focus group was "dentists who accept MaineCare." In Penobscot County 8.7% of people have experienced cost barriers to health care (2019-2021). Focus group participants were quoted as saying:

"My son hasn't seen a dentist in 6+ years. Nobody has an answer for dentists that take MaineCare."

"Mental or behavioral health and definitely dental. All have waiting lists that are nine months or none at all for MaineCare.."

Just over half (57.4%) of adults in Penobscot County have seen a dentist in the past year (2020), which is significantly worse than Maine (66.7%) and the U.S. (66.7%). Despite difficulties accessing general providers, 87.1% of adults in Penobscot County have a "usual primary care provider" (2019-2021) and 79.9% of adults have visited their primary care provider in the past year (2019-2021), which is significantly better than 2015-2017 (72.1%).

Socioeconomic Empowerment

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

Populations and Communities Impacted by Provider Availability

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

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:

- Northern Light Health
- Penobscot Community Health Center

Crosscutting Priorities

Housing

Aging-Related Services

Aging related services was the second priority for the community conditions category for Penobscot County. For the purposes of the prioritization process, aging related services includes such topics as long-term care, assisted living access, and in-home care support services.

Assessment Findings

In their discussion of aging related services, participants at the Penobscot County stakeholder forum highlighted several contributing factors related to provider shortages for older adults. Forum participants noted 16 nursing homes and extended care facilities have closed since the COVID-19 pandemic. For those that are still in operation, there are staffing shortages at the administrative, clinical, and support levels. These shortages may be due to low reimbursement rates and low salaries. The shortages are leading to wait lists and an inability to provide an appropriate level of care.

Forum participants believe there is a lack of communication between federal and state agencies who may be providing funding and services. In addition to this, forum participants believe coordination of care appears to be non-existent, with no one place to help find information and resources for the aging population. This is impacting the continuum of care and pushing some care onto family members. In Penobscot County 5.4% of adults are providing regular care or assistance to a friend or family member who has a health problem or disability for at least 20 hours week (2017, 2019, 2021). Some older adults are also choosing to age in place. In Penobscot County 31.2% of people 65 and older are living alone (2018-2022). There is a concern among forum participants older adults may not ask for help, due to the self-sufficient ethos of people who live in Maine, or know where to find it, leaving them without supports set up such as advanced care directives.

Other older adults who are seeking care may need to spend down their assets to qualify for services, such as housing. Forum participants did note some facilities are moving to private pay models. These sentiments were echoed by the Penobscot County respondents to the Maine Shared CHNA survey. Of the 64.8% of survey respondents who said “housing needs” negatively impacted them, a loved one, and/or their community, 70.9% said “availability of affordable, quality housing for older adults or those with special needs” negatively impacted their community, 31.7% said a loved one, and 26.2% said it impacted them. Transportation needs also negatively impacted survey respondents, their loved ones, and/or their community (55.3%), with 65.2% of survey respondents saying, “availability of transportation that meets a variety of specific needs,” which includes older adults, physical or cognitive needs, impacting their community.

Populations and Communities Impacted by Aging-Related Services

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

Community Resources to Address Aging-Related Services

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 aging-related services, respondents identified:

- Eastern Area Agency on Aging
- Long-term care facilities
- YMCA

Crosscutting Priorities

Provider Availability

Housing

Housing was the third priority for the community conditions category for Penobscot 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

Participants at the Penobscot County stakeholder forum discussed several factors impacting housing. Penobscot County has an aging housing stock, with many rundown properties. Only 6.8% of houses in Penobscot County were built in 2010 or later. Forum participants discussed that there is a general lack of housing, and zoning issues prohibit additional housing from being built, specifically low-income housing and housing in smaller, more rural towns. Stakeholder participants believe there is an attitude of "not in my backyard" regarding housing construction and the costs of construction are also noted as "skyrocketing." In 2022, 2.5% of housing was vacant and for rent or sale in Penobscot County and 84.8% of houses were occupied (2018-2022).

In the Maine Shared CHNA survey, 64.8% of Penobscot County respondents said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, "housing costs," "availability of affordable, quality homes/rentals," "issues associated with home ownership or renting" and "cost of utilities" impacted respondents, their loved ones, and their communities as detailed in Table 1: Housing Needs, along with other housing needs.

Stakeholder participants also discussed the increasing costs of rent and housing prices. Data shows in Penobscot County 11% of households spend more than 50% of their income toward housing, significantly better than the U.S. (14.1%, 2018-2022). The most recent data for median gross rent (2018-2022) is $932 per month, significantly worse than 2015-2019 ($799), but significantly better than Maine ($1,009) and the U.S. ($1,268).

In the Penobscot County focus group, "affordable housing" was a top theme. Penobscot County Maine Shared CHNA survey participants said "housing insecurity" is the fourth of five top social concerns negatively impacting their community. Penobscot County focus group participants said:

"Affordable housing has definitely been a huge barrier in our community.."

"It seems to me that poverty is so hard to get out of. We can't afford a house…."

Bangor was described as a service center by forum participants, which has resulted in an increase in people from the northern part of Penobscot County and rural areas moving there. Bangor offers more services and better-equipped services than other areas of Penobscot County, which attract people who are in need of those services. Homelessness was rated as the fifth of five top social concerns negatively impacting the community by Maine Shared CHNA survey respondents. In Penobscot County 2.4% of high school students were housing insecure in 2023 and 216 children were experiencing homelessness (2023).

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	59.2%	52.1%	76.0%	0.9%	3.2%	1.3%
Availability of affordable, quality homes/rentals	46.0%	47.9%	75.8%	1.3%	4.0%	1.3%
Availability of affordable, quality housing for older adults or those with special needs	26.2%	31.7%	70.9%	2.1%	10.8%	4.7%
Issues associated with home ownership or renting	51.9%	46.4%	67.0%	1.3%	7.9%	1.9%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	27.5%	27.9%	56.4%	6.2%	16.8%	7.4%
Homelessness or availability of shelter beds	8.1%	15.7%	71.3%	4.5%	10.6%	8.3%
Cost of utilities	68.9%	56.8%	71.7%	1.3%	3.4%	2.3%
Costs associated with weatherization	44.3%	38.7%	65.3%	4.0%	8.9%	4.2%

Socioeconomic Empowerment

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

Populations and Communities Impacted by Housing

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

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:

- Bangor Area Homeless Shelter
- Community Health and Counseling Services
- General Assistance
- Hope House
- Housing navigators
- Housing vouchers
- Landlord Liaison
- Low-income housing opportunities, such as area apartment complexes
- Penquis
- Projects for Assistance with Transition from Homelessness (PATH)

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 Penobscot 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.

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

Illicit Drug Use

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

Assessment Findings

In the Penobscot County focus group, “substance use services” was a top theme. Penobscot County stakeholder forum participants cited a lack of interventions and treatment for substance use as a contributing factor to illicit drug use in the community. Participants at the forum would like to see more support and services, specifically for people who are pregnant and parents, citing family support as another contributing factor to use.

In the Maine Shared CHNA survey, respondents said “substance use,” which includes illicit drug use, was the second of five social concerns negatively impacting their community and 62.8% said substance use negatively impacts them, a loved one, and/or their community. When asked about specific substances, 70.7% and 22.6% said “opioid misuse” negatively impacts their community and a loved one, respectively and 73.5% and 25.9% said “other illicit drug use” negatively impacts their community and a loved one. In Penobscot County,

- 5.6% of high school students and 4.8% of middle school students had misused prescription drugs in the past 30 days (2023).
- 3.7% of high school students had used illicit drugs in their lifetime (2024).
- There were 62 overdose deaths per 100,000 people (2023).
- There were 55 drug-induced deaths per 100,000 people (2018-2022), significantly worse than 2015-2019 (33.9 per 100,000).

Participants at the stakeholder forum also discussed the role of mental health, isolation, and community conditions, such as poverty on illicit drug use. Approximately one-quarter (23.6%) of adults in Penobscot County have experienced depression in their lifetime and 11% of adults have current depression symptoms (2019-2021). In Penobscot County 13.4% of individuals live in poverty which is significantly worse than Maine (10.9%, 2018-2022).

Socioeconomic Empowerment

"Reduction in substance use" was the fifth of five top rated "very necessary" steps to move someone from a place of poverty to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Illicit Drug Use

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

Community Resources to Address Illicit Drug Use

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

- Bangor Area Recovery Network
- Bangor Community Action Team
- Bangor Public Health and Wellness
- Breaking the Cycle
- Community Health and Counseling Services
- Community Treatment Center
- FindHelp
- Health Equity Alliance
- Hope House
- Local hospitals
- Maine Center for Disease Control and Prevention
- Maine Resilience Building Network
- Medication Assisted Treatment clinics
- OPTIONS
- Penobscot Community Health Center, specifically case management
- Recovery programs, specifically group homes
- SaVida Health
- St. Joseph's Hospital
- True Connections
- Wabanaki Public Health and Wellness
- Wellspring Fresh Start

Crosscutting Priorities

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

Alcohol Use

Alcohol use was the second priority for the protective and risk factors category for Penobscot County.

Assessment Findings

In the Penobscot County focus group, "substance use services" was a top theme. Penobscot County stakeholder forum participants cited a lack of interventions and treatment for substance use as a contributing factor to alcohol use in the community. Participants at the forum would like to see more support and services, specifically for people who are pregnant and parents, citing family support as another contributing factor.

Alcohol use impacts communities, and forum participants noted the multigenerational impacts it has. In the Maine Shared CHNA survey, respondents said "substance use," which includes alcohol use, was the second of five social concerns negatively impacting their community and 62.8% said substance use negatively impacts them, a loved one, and/or their community. When asked about specific substances, 69.3% and 40.5% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one, respectively. In Penobscot County,

- 7.2% of adults engaged in chronic heavy drinking (2019-2021).
- 14.2% of adults engaged in binge drinking (2019-2021), which is significantly better than 2015-2017 (19.9%).
- 8.6% of high school and 1.6% of middle school students had engaged in binge drinking (2023).
- 18.8% of high school and 4.7% of middle school students had used alcohol in the past 30 days (2023).

Participants at the stakeholder forum also discussed the role of mental health and isolation on alcohol use, the influences of advertising and social media, and community conditions, such as poverty. Approximately one-quarter (23.6%) of adults in Penobscot County have experienced depression in their lifetime and 11% of adults have current depression symptoms (2019-2021). In Penobscot County 13.4% of individuals live in poverty which is significantly worse than Maine (10.9%, 2018-2022).

Socioeconomic Empowerment

"Reduction in substance use" was the fifth of five top rated "very necessary" steps to move someone from a place of poverty to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Alcohol Use

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

Community Resources to Address Alcohol Use

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

- Alcoholics Anonymous
- Bangor Area Recovery Network
- Bangor Community Action Team
- Bangor Public Health and Wellness
- Breaking the Cycle
- Community Health and Counseling Services
- Community Treatment Center
- FindHelp
- Health Equity Alliance
- Hope House
- Maine Center for Disease Control and Prevention
- Maine Resilience Building Network
- OPTIONS
- Penobscot Community Health Center, specifically case management
- SaVida Health
- St. Joseph's Hospital
- True Connections
- Wabanaki Public Health and Wellness
- Wellspring Fresh Start

Crosscutting Priorities

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

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the third priority for the protective and risk factors category for Penobscot 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, 28.8% of high school students had experienced at least four of the nine adverse childhood experiences. Penobscot County stakeholder forum participants noted that ACEs can be part of a generational cycle when not addressed. In the Maine Shared CHNA survey, all five top social concerns that negatively impact the community could be associated with ACEs – mental health issues, substance use, low incomes and poverty, housing insecurity, and homelessness. Approximately three-quarters of survey respondents said economic needs (75.6%) and mental health needs (72.9%), potential root causes of ACEs, impact them, a loved one, and/or their community.

When discussing specific mental health needs, 45.8% said youth mental health negatively impacts their community and 38.8% said it negatively impacts a loved one. In Penobscot County,

- 34.1% of high school students and 34% of middle school students felt sad or hopeless for two weeks in a row (2023), with middle school percentages significantly worse than 2019 (21.1%).
- 18.2% of high school students and 23.7% of middle school students had seriously considered suicide (2023).

At the stakeholder forum, a theme of support emerged, including the need for more support for parents, guardians, and caregivers, including foster parents and more support for the school system, specifically resources and funding to provide that support. In the Penobscot County focus group, "mental health services for youth and adults" was a top theme. One focus group participant said:

"Mental or behavioral health…All have waiting lists that are nine months or none at all for MaineCare."

Forum participants would like to see more cross sector communication to better address ACEs, including communities, municipalities, recreation departments, youth workers, and child care providers.

Socioeconomic Empowerment

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

Populations and Communities Impacted by Adverse Childhood Experiences

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

Community Resources to Address Adverse Childhood Experiences

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

- Community Health and Counseling Services
- KidsPeace
- Penobscot Community Health Center
- Penquis
- School based health centers
- School Meals for All

Crosscutting Priorities

Housing **Alcohol Use** **Illicit Drug Use**

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 Penobscot 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.

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

Mental Health

Mental health was the top priority for the health conditions and outcomes category for Penobscot 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

IIn the Penobscot County focus group, "mental health services for youth and adults" was a top theme. One focus group participant said:

> **"Mental or behavioral health…All have waiting lists that are nine months or none at all for MaineCare."**

In Penobscot County, 32.3% of people are enrolled in MaineCare (2023), with 49.5% of those aged 0-19 enrolled in MaineCare (2023).

Participants in the Penobscot County stakeholder forum discussed that there are not enough providers in the area to care for people with mental health disorders and it often takes months to get into medical management or counseling. In the Maine Shared CHNA survey 38.7% of respondents said they or a loved one could not or chose not to get mental health services in the past year, citing "long wait times to see a provider," "no evenings or weekend hours to receive care," and "did not feel comfortable seeking help" as reasons why. In 2024 there were 11,599 people for every psychiatrist and 150 people for every mental health provider in Penobscot County.

Stakeholder forum participants discussed mental health and the pediatric population, echoing the focus group theme of limited pediatric services and long wait lists for providers who are not taking referrals. School based health centers are being used to help identify mental health disorders earlier and provide treatment for better outcomes. Stakeholder forum participants believe there is a crisis for parents with children who have a mental health concern. Participants at the forum would like to see more services for children to learn healthy coping skills to potentially avoid later impacts of stress and anxiety.

In the Maine Shared CHNA survey, "mental health issues" was the number one of five social concerns negatively impacting the community and 72.9% said "mental health needs" negatively impact them, a loved one, and/or their community. Participants at the stakeholder forum believe there has been an increase in mental health disorders that started with the COVID-19 pandemic and isolation. It has been further exacerbated by low incomes and housing challenges. Forum participants noted specific increases in diagnoses of anxiety, depression, schizophrenia, and suicidal ideation. In Penobscot County,

- 23.6% of adults have experienced depression in their lifetime (2019-2021).
- 11% of adults have current symptoms of depression (2019-2021).
- 25.2% of adults have experienced anxiety in their lifetime (2019-2021).
- 34.1% of high school students and 34% of middle school students felt sad or hopeless

for two weeks in a row (2023), with middle school percentages significantly worse than 2019 (21.1%).
- 18.2% of high school students and 23.7% of middle school students have seriously considered suicide.

When discussing specific mental health needs, survey respondents identified some of these topics and others as negatively impacting them, their loved ones, and their communities as detailed in Table 3: Mental Health Needs.

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	64.1%	61.5%	40.4%	0.7%	4.2%	2.8%
Depression	58.2%	60.5%	42.6%	1.2%	4.0%	3.1%
Bipolar disorder	15.8%	35.9%	32.1%	6.2%	15.3%	17.5%
Trauma or post-traumatic stress disorder (PTSD)	49.6%	45.4%	40.6%	2.8%	8.0%	7.8%
General stress of day-to-day life	72.4%	59.1%	49.4%	1.4%	3.5%	1.9%
Social isolation or loneliness	40.0%	41.9%	45.9%	4.3%	7.6%	6.6%
Stigma associated with seeking care for mental health or substance use disorders	23.7%	32.8%	46.4%	10.2%	12.7%	11.6%
Suicidal thoughts and/or behaviors	12.0%	30.0%	41.9%	6.1%	16.6%	16.6%
Youth mental health	17.7%	38.8%	45.8%	4.7%	11.3%	13.2%

Socioeconomic Empowerment

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

Populations and Communities Impacted by Mental Health

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

Community Resources to Address Mental Heath

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

- Bangor Community Action Team
- Community Health and Counseling Services
- Counselors
- Federally Qualified Health Centers
- FindHelp
- Local hospitals
- Penobscot Community Health Center
- School based health centers
- Telehealth
- Workplace Employee Assistance Programs

Crosscutting Priorities

Provider Availability **Housing**

Substance Use Related Injury & Death

Substance use related injury and death was the second rated priority for the health conditions and outcomes category for Penobscot 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 Penobscot County focus group, "substance use services" was a top theme. Participants in the Penobscot County stakeholder forum discussed the lack of substance use services in the area, but did highlight some organizations addressing substance use related injury and death. Forum participants noted Millinocket Regional Hospital provides substance use treatment and is collaborating with SaVida for treatment and peer recovery. St. Joseph's Hospital has medication management to prescribe suboxone. Telepsych services are also collaborating with St. Mary's in Lewiston to offer services on the weekends.

In the Maine Shared CHNA survey, respondents said "substance use" was the second of five social concerns negatively impacting their community and 62.8% said substance use negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 69.3% and 40.5% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one.
- 70.7% and 22.6% said "opioid misuse" negatively impacts their community and a loved one.
- 73.5% and 25.9% said "other illicit drug use" negatively impacts their community and a loved one.

In Penobscot County,

- 5.6% of high school students and 4.8% of middle school students had misused prescription drugs in the past 30 days (2023).
- 3.7% of high school students had used illicit drugs in their lifetime (2024).
- There were 62 overdose deaths per 100,000 people (2023).
- There were 55 drug-induced deaths per 100,000 people (2018-2022), significantly worse than 2015-2019 (33.9 per 100,000).

Socioeconomic Empowerment

"Reduction in substance use" was the fifth of five top rated "very necessary" steps to move someone from a place of poverty to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Substance Use Related Injury and Death

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For substance use related injury and death, respondents cited: adults, teens, young adults, older adults, and LGBTQIA2S+.

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:

- Community Health Workers
- Harm reduction programs, specifically Narcan
- Medication Assisted Treatment clinics
- Millinocket Regional Hospital Emergency Room
- Peer recovery programs
- Penobscot Community Health Center
- Telehealth
- Treatment centers

Crosscutting Priorities

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

Cancer

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

Assessment Findings

In the Penobscot County focus group, one participant noted:

"Specialists are difficult to access this far north. I needed to travel south to get tests done. I was told if I needed anything further, I would need to go to Boston. I find that very common here. If you need surgeries, your best bet is to go to Boston. I don't have the ability to just hop in a car and rent a motel."

Cancer patients in Penobscot County reiterated the issue of access and long wait times, specifically noting the length of time to be seen for an initial diagnosis and the length of time for a provider to get them on surgical schedules and start other treatments. In addition, cancer patients note their medical records are not shared seamlessly between providers, resulting in disjointed care.

In the Maine Shared CHNA survey, 74.6% of respondents said, "chronic health conditions," of which cancer is one, negatively impacts them, a loved one, and/or their community. When asked specifically about cancer, 34.3% said it impacted their community, 44.1% said a loved one, and 12.2% said it impacts them. Table 3: Cancer Indicators shows the overall cancer death and new case rates, as well as the cancers with the highest rates of death and new cases and those with significant differences in Penobscot County.

Table 3: Cancer Indicators	Penobscot County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cancer							
All cancer deaths per 100,000 population	2015-2019 **175.0**	2018-2022 **169.5**	○	2018-2022 **159.9**	○	2020 **144.1**	N/A
Lung cancer deaths per 100,000 population	2015-2019 **49.0**	2018-2022 **45.9**	○	2018-2022 **40.2**	!	2020 **31.8**	N/A
Tobacco-related cancer deaths per 100,000 population	2015-2019 **52.1**	2018-2022 **54.1**	○	2018-2022 **52.8**	○	2020 **42.1**	N/A
All cancer new cases per 100,000 population	2015-2019 **528.9**	2018-2022 **523.8**	○	2018-2022 **476.0**	!	2019 **438.6**	N/A
Bladder cancer new cases per 100,000 population	2016-2018 **27.6**	2019-2021 **28.4**	○	2019-2021 **26.4**	○	2019 **18.3**	N/A
Female breast cancer new cases per 100,000 population	2016-2018 **125.8**	2019-2021 **138.2**	○	2019-2021 **135.4**	○	2019 **129.7**	N/A
Lung cancer new cases per 100,000 population	2016-2018 **82.7**	2019-2021 **84.4**	○	2019-2021 **65.3**	!	2019 **52.9**	N/A
Prostate cancer new cases per 100,000 population	2016-2018 **112.6**	2019-2021 **98.4**	○	2019-2021 **106.2**	○	2019 **111.6**	N/A
Tobacco-related cancer (excluding lung cancer) new cases per 100,000 population	2016-2018 **149.0**	2019-2021 **145.5**	○	2019-2021 **137.2**	○	2019 **125.0**	N/A
Obesity-associated cancer (excluding colon cancer) new cases per 100,000 population	2016-2018 **140.9**	2019-2021 **156.7**	○	2019-2021 **138.3**	!	2019 **133.2**	N/A
Alcohol-associated new cancer cases per 100,000 population	2017-2019 **134.5**	2019-2021 **136.2**	○	2019-2021 **135.4**	○	—	N/A
Lung cancer late-stage new cases per 100,000 population	2016-2018 **54.5**	2019-2021 **54.9**	○	2019-2021 **42.2**	!	2019 **34.3**	N/A

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

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

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

○ means the change was not statistically significant.

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

— means data is unavailable.

Populations and Communities Impacted by Cancer

Cancer was an added priority at the forum and not addressed in the pre-forum survey, nor did forum participants identify specific populations or communities impacted by cancer at the forum.

Community Resources to Address Cancer

Cancer was an added priority at the forum and not addressed in the pre-forum survey, nor did forum participants identify assets and resources at the forum.

Crosscutting Priorities

Provider Availability

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

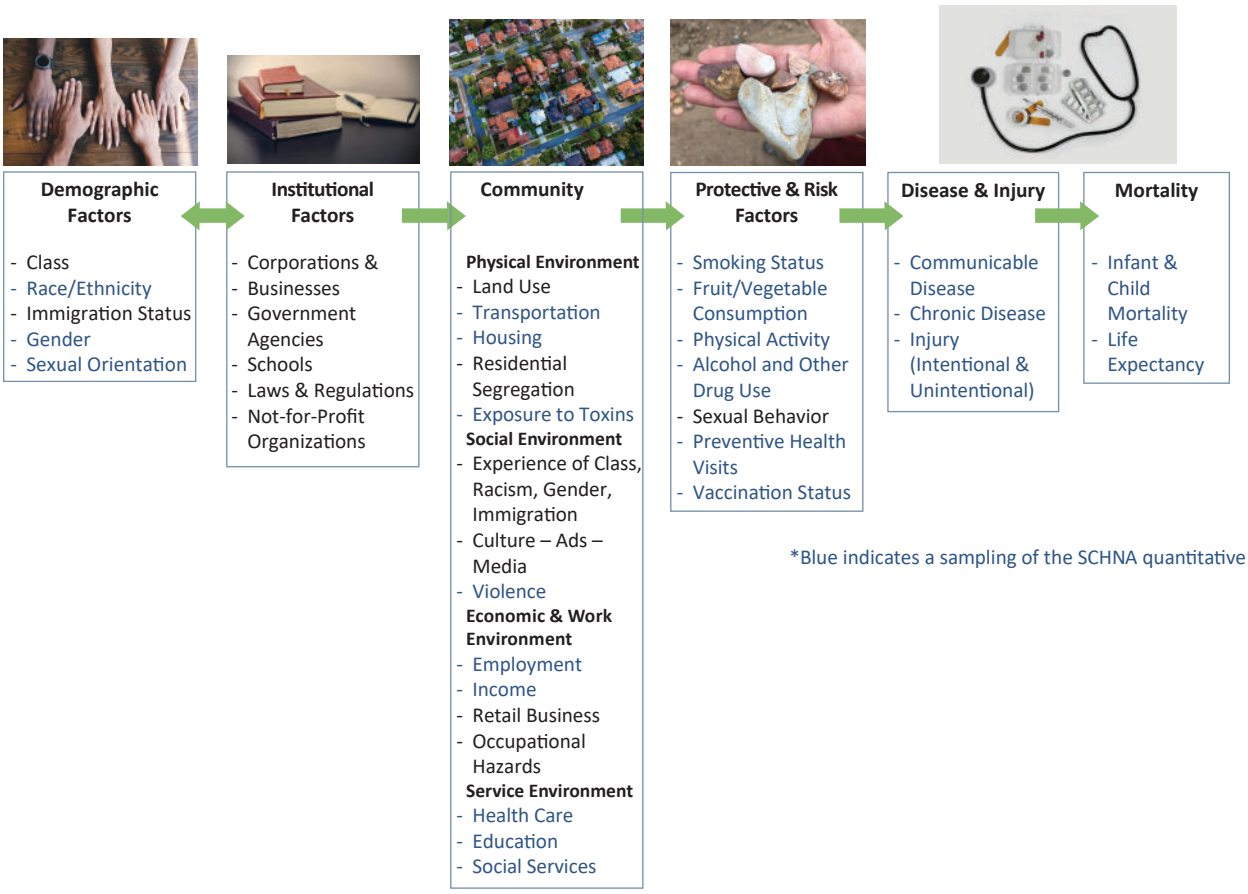
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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 virtual stakeholder forum was held in Penobscot County on September 19, 2024, with 36 attendees. People from the following organizations participated in the forum process:

- Bangor Area Comprehensive Transportation System
- Bangor Public Health and Community Services
- Bangor Public Health Department
- Health Access Network
- Heart of Maine United Way
- Maine Center for Disease Control and Prevention
- Maine Multicultural Center
- Millinocket Regional Hospital
- Northern Light Health
- Penobscot Community Health Care - Hope House
- Penobscot Community Health Center
- Penobscot Valley Hospital
- Penquis
- St. Joseph Healthcare
- Wabanaki Public Health

Reporting

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

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

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

Appendix 2: Other Identified Health and Well-Being Topics

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

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

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	13	65.0%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	12	60.0%
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.)	10	50.0%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	9	45.0%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	9	45.0%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	7	35.0%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	7	35.0%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	6	30.0%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	5	25.0%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	4	20.0%
Stigma Around Accessing/Accepting Help, Services, or Treatment	3	15.0%
Other (please specify): Substance use; Widescale impacts of significant disaster events (isolation, school closures, limited healthcare availability, mass care, sheltering, etc.) and community resilience; Autism supports	3	15.0%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	2	10.0%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	2	10.0%
Bullying	2	10.0%
Systemic Discrimination	2	10.0%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	5.0%
Wage Gaps and Income Disparities	1	5.0%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	1	5.0%
Ambulatory Care Sensitive Conditions	1	5.0%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	13	65.0%
Illicit Drug Use	12	60.0%
Adverse Childhood Experiences	9	45.0%
Alcohol Use (including binge drinking)	8	40.0%
Preventive Oral Health Care	7	35.0%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	6	30.0%
Vaping Use (including tobacco and cannabis)	6	30.0%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	5	25.0%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	5	25.0%
Youth Mattering (such as positive role models, community connections, etc.)	4	20.0%
Immunizations & Vaccinations	3	15.0%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	3	15.0%
Foster Care	3	15.0%
Cannabis Use	3	15.0%
Prescription Drug Misuse	3	15.0%
Safe Drinking Water	3	15.0%
Cancer Prevention (such as cancer screenings, sunscreen use)	2	10.0%
Indoor Air Quality	1	5.0%
Other (please specify): Culture	1	5.0%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	17	85.0%
Obesity/Weight Status	13	65.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	12	60.0%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	11	55.0%
Cancer	7	35.0%
Cognitive Decline, Alzheimer's disease and other dementias	7	35.0%
Diabetes	6	30.0%
Multiple Chronic Conditions	6	30.0%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	5	25.0%
Non-Infectious Respiratory Disease (such as asthma, COPD)	4	20.0%
Intentional Injury & Death (self-injury)	3	15.0%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	3	15.0%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	2	10.0%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	1	5.0%
Dental Disease	1	5.0%

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

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

Community Conditions	# Votes	% of Participants
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	25	92.6%
Aging related services (such as long term care, assisted living access, and in-home care support services)	16	59.3%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	15	55.6%
Timeliness of healthcare and social services (such as wait ones for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	10	37.0%
Transportation	8	29.6%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	5	18.5%
Dental services	2	7.4%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	20	74.1%
Alcohol Use (including binge drinking)	15	55.6%
Adverse Childhood Experiences	13	48.2%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	12	44.4%
Culture and community	12	44.4%
Preventive Oral Health Care	9	33.3%
Cancer Prevention (such as cancer screenings, sunscreen use)	8	25.0%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	8	25.0%
Alcohol Use (including binge drinking)	8	25.0%
Vaping Use (including tobacco and cannabis)	8	25.0%
Preventive Oral Health Care	7	21.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	26	96.3%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	16	59.3%
Cancer	13	48.2%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	12	44.4%
Cognitive Decline, Alzheimer's disease and other dementia	10	37.0%
Obesity/Weight Status	4	14.8%

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

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