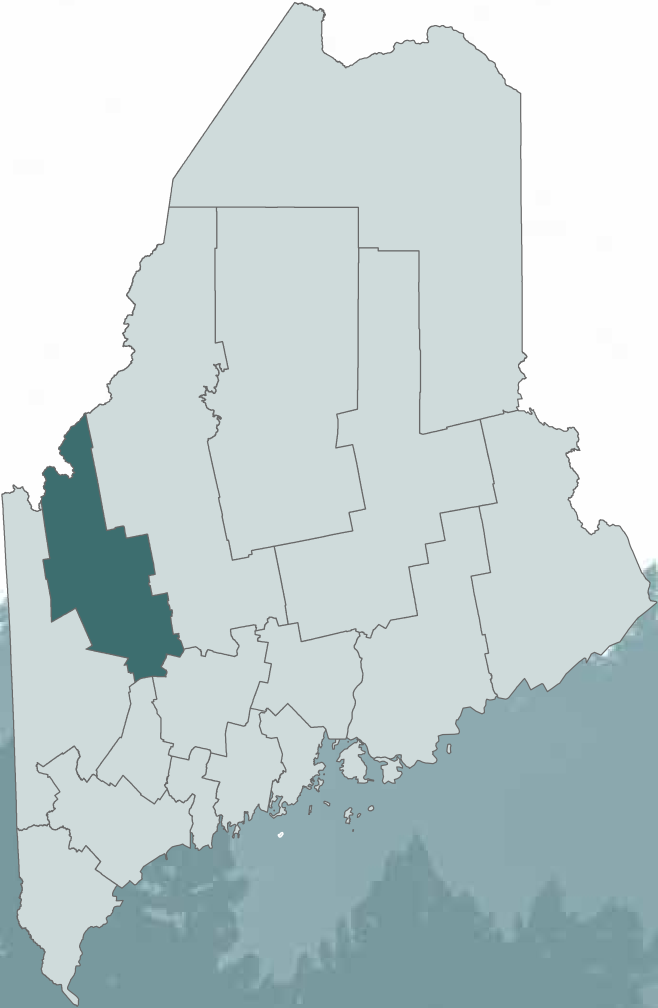
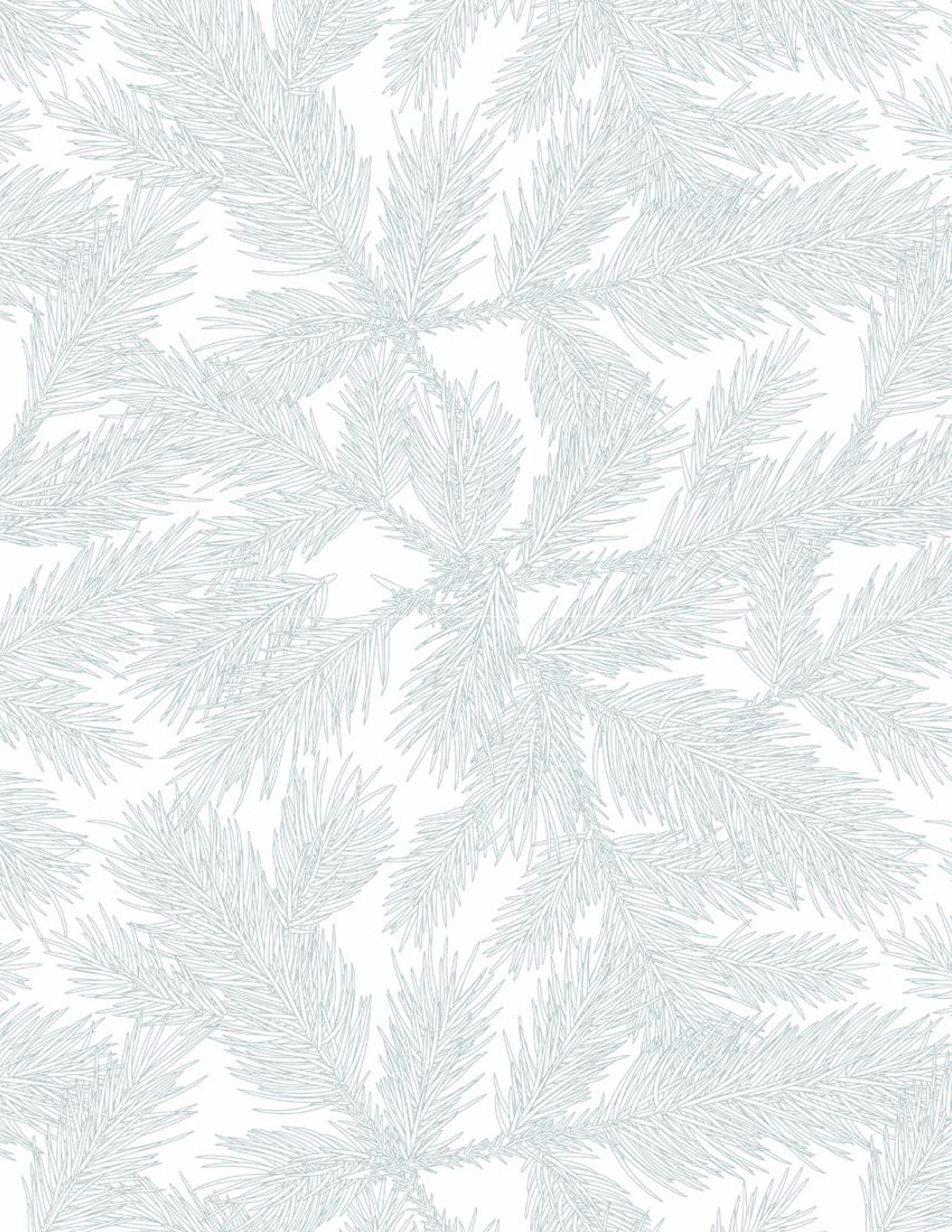
FRANKLIN COUNTY

2019 Maine Shared Community Health Needs Assessment Report





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Key companion documents available at www.mainechna.org:

- Franklin County Health Profile
- Western District Health Profile
- Maine State Health Profile
- Health Equity Data Summaries, including state-level data by race, Hispanic ethnicity, sex, sexual orientation, educational attainment, and income

EXECUTIVE SUMMARY

PURPOSE

The Maine Shared Community Health Needs Assessment (Maine CHNA) is a collaborative effort amongst Central Maine Healthcare (CMHC), Northern Light Health (NLH), MaineGeneral Health (MGH), MaineHealth (MH), and the Maine Center for Disease Control and Prevention (Maine CDC). This unique public-private partnership is intended to assess the health needs of all who call Maine home.

- **Mission:** The Maine Shared CHNA is a dynamic public-private partnership that creates shared Community Health Needs Assessment reports, engages and activates communities, and supports data-driven health improvements for Maine people.
- **Vision:** The Maine Shared CHNA helps to turn data into action so that Maine will become the healthiest state in the US.

DEMOGRAPHICS

Franklin is one of three counties that make up the Western Public Health District. Franklin County's population is 30,270 and 20.2% of the population is 65 years of age or older. The County is predominantly white (96.7%) and the average household income is $43,007. The high school graduation rate (89.5%) is higher than the state average, while the percentage of the population with an associate's' degree or higher (35.4%) is lower than the state average.

TOP HEALTH PRIORITIES

The forums held in Franklin County identified a list of health issues in that community through a voting methodology outlined in Appendix C of this report. Table 1 is a list of the top five health priorities for Franklin County.

Table 1: Franklin County Health Priorities

PRIORITY AREA	% OF VOTES
Access to Care*	21%
Social Determinants of Health*	16%
Mental Health*	14%
Physical Activity, Nutrition, and Weight*	14%
Substance Use	13%

Also a statewide priority. For a complete list of statewide priorities, see state health profile on our website,* ***www.mainechna.org*

NEXT STEPS

This assessment report will be used to fulfill the Internal Revenue Service (IRS) requirements for non-profit hospitals as well as the Public Health Accreditation Board (PHAB) requirements for state and local public health departments. Required activities include:

- Obtaining input from the community, including providers and communities served, on leading health issues and unmet needs
- Evaluating previous actions taken to address needs identified in previous assessments
- Choosing (with justification) which health needs should be addressed
- For hospitals, creating an informed implementation strategy designed to address the identified needs
- For District Coordinating Councils, creating District Health Improvement Plans
- For the Maine CDC, creating an informed State Health Improvement Plan

In the coming months and years, policymakers, non-profits, businesses, academics, and other community partners may also use these reports for their own strategic planning purposes.

ACKNOWLEDGEMENTS

Funding for the Maine Shared CHNA is provided by Central Maine Healthcare, Northern Light Health, MaineGeneral Health, and MaineHealth, with generous in-kind support from the Maine Center for Disease Control and Prevention, an office of the Department of Health and Human Services and countless community partners and stakeholder groups. These stakeholder groups include the Metrics Committee, Data Analysis Workgroup, Community Engagement Committee, Local Planning Committees, and the Steering Committee. Special thanks to the Maine Health Data Organization for working with us to access their data. For a listing of committee members please visit www.mainechna.org and click on "About Maine CHNA."

Significant analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. John Snow, Inc. provided analysis, methodology, and design support.

In addition, the Steering Committee gratefully acknowledges the countless community volunteers who gave their time and passionately committed to hosting, facilitating, attending, and engaging in this effort. From Aroostook to York, Oxford to Washington County, almost 2,000 Mainers gave their time and talent to this effort. Thank you.

HEALTH PRIORITIES

Health priorities for the county, public health district, and the state were developed through community participation and voting at community forums. The forums were an opportunity for review of the Franklin County Health Profile, discussion of community needs, and prioritization in small break-out sessions followed by a forum session vote. Table 2 lists all ten priorities which arose from group break-out sessions at forums held in Franklin County. The priorities shaded are those that that rose to the top.

This section provides a synthesis of findings for each of the bolded top priorities. The following discussion of each priority are from several sources including the data in the county health data profiles, the information gathered at community engagement discussions at the community forums, and key informant interviews. See Appendix C for the complete methodology for all of these activities.

Table 2: Franklin County Forum Voting Results

PRIORITY AREA	% OF VOTES
Access to Care*	**21%**
Social Determinants of Health*	**16%**
Mental Health*	**14%**
Physical Activity, Nutrition, and Weight*	**14%**
Substance Use*	**13%**
Diabetes	9%
Cancer	4%
Tobacco	4%
Intentional Injury	2%
Older Adult Health/Healthy Aging	2%

**Also a statewide priority. For a complete list of statewide priorities, see state health profile on our website,* www.mainechna.org

ACCESS TO CARE

Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely, and accessible preventive and disease management or follow-up services—is critical to overall health and well-being. Access to a usual source of primary care is particularly important, since it greatly affects the individual's ability to receive regular preventive, routine, and urgent care, and to manage chronic conditions. Though the percentage of uninsured individuals in Franklin County has slightly declined over time (from 11.2% in 2009–2011 to 10.9% in 2012–2016), uninsuance and underinsurance remains a leading barrier to care in the region. Medicaid expansion, which holds the promise of providing health insurance coverage for an additional 70,000 Mainers, was signed into law on January 3, 2019.

Barriers to accessing care also include the availability and affordability of care. Low-income individuals, people of color, those with less than a high school diploma, rural residents, and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) populations face even greater disparities in health insurance coverage compared to those who are heterosexual, white, and well-educated. For example, in Maine, over 20% of American Indian/Alaska Natives and Black/African American adults report they are unable to receive or have delayed medical care due to cost, compared to 10% of white adults. Compared to heterosexual residents (11.6%), 19.3% of bisexual residents, and 22.5% of residents who identified as something other than heterosexual, gay or lesbian, or bisexual, were uninsured. Finally, a greater percentage of those earning less than $25,000 a year were uninsured compared to the state overall (8%). More information on health disparities by race, ethnicity, education, sex, and sexual orientation can be found in the Health Equity Data Summaries on our website at www.mainechna.org.

QUALITATIVE EVIDENCE

Many forum participants and key informants identified the social determinants of health—particularly poverty, low wages, unemployment, inability to access reliable and affordable forms of transportation, and lack of affordable and safe housing—as significant barriers to care. These are discussed in more detail in the "Social Determinants of Health" priority area.

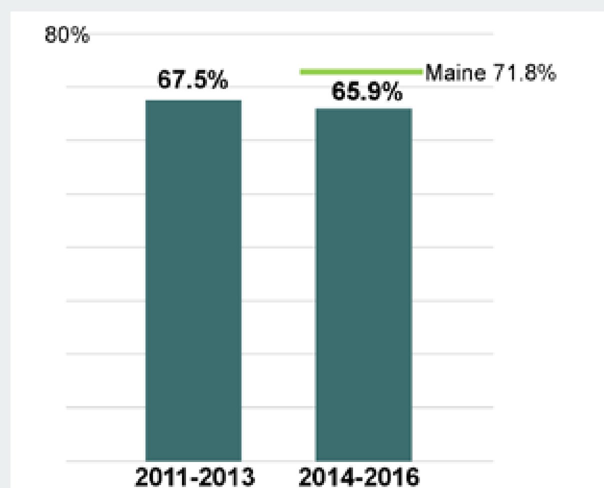
Participants discussed the need for comprehensive and affordable health services for low-income individuals, specifically dental care and behavioral health services. Free care programs and MaineCare do not cover preventative oral health services for adults. Even for those with insurance, deductibles, co-pays, and prescription medications may be unaffordable and prevent people from seeking care.

QUANTITATIVE EVIDENCE

In Franklin County:

- The percentage of the population that is uninsured was higher than the state overall (10.9% vs. 9.5%) in 2012–2016.
- The percentage of individuals who reported being unable to obtain healthcare due to cost was slightly lower than the state overall (9.4% vs. 10.3%) in 2014–2016.

Figure 1: Population Who Reported a Visit to Any Primary Care Provider in the Past Year



- The percentage of the population who reported a primary care visit to any primary care provider in the past year was significantly lower than the state overall (65.9% vs. 71.8%) in 2014–2016.
- The ratio of practicing dentists to 100,000 population was lower compared to the state overall (14.3 vs. 32.1) in 2017.
- The ratio of psychiatrists to 100,000 population was lower compared to the state overall (3.3 vs. 8.4) in 2017.

See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

The table below is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 3: Assets and Gaps/Needs (Access to Care)

ASSETS	GAPS/NEEDS
• Western Maine Transportation • Franklin Healthy Communities Network • Private Practices • Healthy Community Coalition of Greater Franklin County • United Way of the Tri-Valley Area • Community Para-medicine	• Increase use of nurse practitioners and physician assistants for acute care • Education/outreach to connect people with existing resources • Transportation (rural) • Case managers/coaches • Free care and reduced costs for preventive services before urgent needs arise • Access to specialty care • Better broadband • Access to care providers • Parenting support/education • Wellness coaches • Increased health literacy • Health navigators • Communication specialists • Telemedicine • Patient education (not just computer printouts) • More capacity for primary care providers • Community care teams • More mental health workers

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people live, work, learn, and play that affect their health; factors include socioeconomic status (e.g., education, income, poverty), housing, transportation, social norms and attitudes (e.g., racism and discrimination), crime and violence, literacy, and availability of resources (e.g., food, health care). These conditions influence and define quality of life for many segments of the population, but specifically those that are most vulnerable. According to the Kaiser Family Foundation, social factors like education, poverty, and racism accounted for over a third of total deaths in the United States.[1]

For example, lack of access to the use of a personal vehicle may be due to any number of factors including affording the vehicle itself, or the insurance, repairs, or even perhaps a license suspension or revocation. This is can be especially challenging in areas without reliable public transportation, like in rural Maine. This results in difficulty accessing health services, employment, and basic necessities (e.g., food, clothing, medication). This issue is further complicated for older adults with mobility impairments and individuals with disabilities who require specialized forms of transportation or extra assistance.

QUALITATIVE EVIDENCE

A leading theme from key informant interviews and community forums was the tremendous impact that the underlying social determinants, particularly poverty, transportation, housing, and Adverse Childhood Experiences (ACEs) have on residents in Franklin County.

The impacts of poverty were a dominant theme in engagement activities—food insecurity, housing/heat insecurity, generational poverty and trauma (especially for youth), and lack of basic life skills (e.g., parenting skills, accessing local resources, money management/budgeting). Some forum participants suggested economic development, education and job training, and more support for parents and families as ways to address some of these issues. Several participants also identified homelessness, including youth homelessness, as an issue of concern in the county.

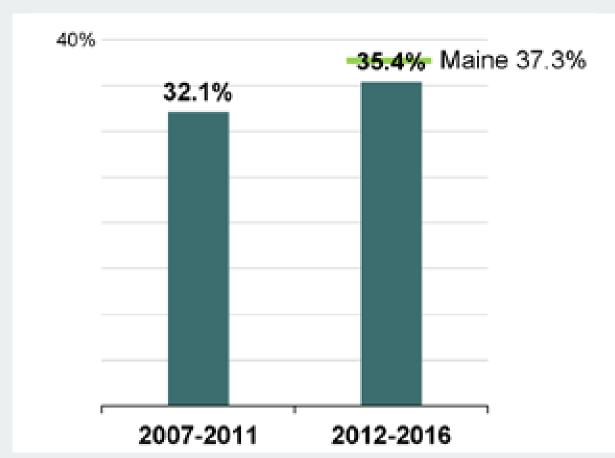
The availability of transportation to get to and from health and social services was a need identified in many Franklin engagement activities—particularly for those that live outside of Farmington.

QUANTITATIVE EVIDENCE

In Franklin County:

- The unemployment rate in Franklin County was 4.3% in 2015–2017.
- The percentage of individuals living in poverty was higher than the state overall (14.1% vs. 13.5%) in 2012–2016.
- The percentage of children living in poverty was lower than the state overall (16.2% vs. 17.2%) in 2012–2016.
- The percentage of the population with an associates' degree or higher among those over 25 was lower than the state overall (35.4% vs. 37.3%) in 2012–2016.
- The percentage of high school students who were housing insecure was higher than the state overall (4.1% vs. 3.6%) in 2017.

Figure 2: Percentage of the Population with an Associates Degree or Higher



- The percentage of high school students who reported having experienced at least 3 adverse child experiences was similar to the state overall (23.1% vs. 23.4%) in 2017.

See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO SOCIAL DETERMINANTS OF HEALTH

The table below is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 4: Assets and Gaps/Needs (Social Determinants of Health)

ASSETS	GAPS/NEEDS
• School food pantry • Western Maine Community Action • Community support figures • Healthy Community Coalition of Greater Franklin County • United Way of the Tri-Valley Area • Franklin County Children's Task Force • Western Maine Transporation • Western Maine Homeless Outreach • Adult Education • Community Concepts	• More heat funding • Community agencies collaboration • Neighbors helping neighbors • Screening for insecurities • Volunteer drivers • Workforce development including: education about work ethics, skills training, professionals to come into schools and talk to kids about job opportunities, student success, post-secondary education and training • Innovation center and funding • Adult role models • Instability in the home • Lack of vehicles and transportation

MENTAL HEALTH

Mental health affects all segments of the population, regardless of age, socioeconomic status, race/ethnicity, or gender. Mental health disorders, when left unmanaged, may affect an individual's ability to form and maintain relationships with others, cope with challenges, and lead a healthy and productive life. Individuals with serious mental illness (e.g., major depression or schizophrenia) are at a higher risk of developing other medical conditions, including cardiovascular disease, diabetes, stroke, and Alzheimer's disease. While the reason for this link is unclear, research suggests that those with mental illness may experience more barriers to medical care and prevention strategies may find it harder to care for themselves.[2]

More than 25% of adults with a mental health disorder also have a substance use disorder; this comorbidity occurs more among adults with depression, anxiety disorders, schizophrenia, and personality disorders. While mental health conditions may lead to drug or alcohol use, the reverse can also be true—the use of certain substances may cause individuals to experience symptoms of a mental health disorder.[3]

QUALITATIVE EVIDENCE

Forum participants cited depression, suicidality, isolation, trauma, and breakdowns in the family unit as key mental health concerns. While many participants said there was a need for behavioral health services in general, they specifically mentioned resources for parents, youth, and isolated older adults as well as psychiatry.

For youth, participants discussed the need for increased resources around the mental health effects of Adverse Child Experiences (ACEs). ACEs are strongly correlated to the development of physical and mental health issues for those exposed to them.[4] There was also discussion about the impacts of ACEs and the need for behavioral health interventions across multiple settings (e.g., schools, at home, healthcare).

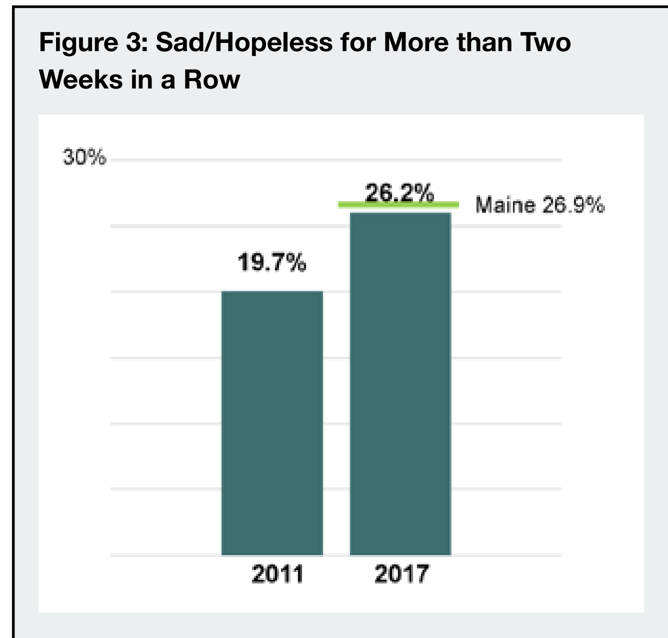
Several forum participants identified social isolation as a critical determinant of mental health issues, which some related to the increased use of technology and how that limits personal interaction. Social isolation was a concern for older adults, especially those outside of Farmington. Participants cited a need for senior centers and social events.

QUANTITATIVE EVIDENCE

In Franklin County:

- The percentage of high school students who reported being sad or hopeless for more than two weeks in a row increased significantly (19.7% to 26.2%) between 2011 and 2017.
- The percentage of adults with current symptoms of depression was higher than the state overall 11.3% vs. 8.4%) in 2014–2016.
- The percentage of high school students who seriously considered suicide increased between 2011 and 2017, from 11.8% to 14.6%.

Figure 3: Sad/Hopeless for More than Two Weeks in a Row



See Key Indicators on page 18 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

The table below is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 5: Assets and Gaps/Needs (Mental Health)

ASSETS	GAPS/NEEDS
• Mt. Blue Success and Innovation Center (youth) • Multiple community mental health agencies (Tri-County, Evergreen, online support) • Sexual Assault Prevention and Response Services • Guidance counselors/social workers in schools • Social workers in office practices • Community para-medicine	• Peer support advocacy, earlier interventions, parents support, network social groups (child mental health) • Mentors for families, for students who don't have good network at home • Childhood mental health care, especially related to Adverse Childhood Experiences • Isolation relief—rideshare network, safe gathering places • Generational trauma—substance use prevention/treatment, poverty, dedicated learning for social emotional needs, teacher/parent education • More behavioral health home teams • Copings skills education • Teaching compassion • More screening and education • Bullying education • Role model—youth/older adult pairing • More mental health workers • Insurance • Family supports • Addressing root causes • Respite opportunities • Educational/stigma awareness

PHYSICAL ACTIVITY, NUTRITION, AND WEIGHT

Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues. Adequate nutrition helps prevent disease and is essential for the healthy growth and development of children and adolescents, while overall fitness and the extent to which people are physically active reduce the risk for many chronic conditions and are linked to good emotional health. Over the past two decades, obesity rates in the United States have doubled for adults and tripled for children. Overall, these trends have spanned all segments of the population, regardless of age, sex, race, ethnicity, education, income, or geographic region.

QUALITATIVE EVIDENCE

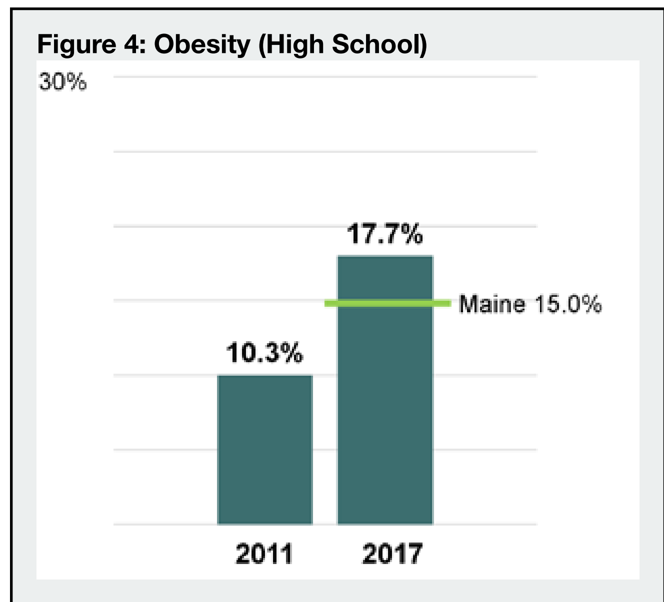
In the community forum, obesity was identified as an issue for the population in general, but especially for youth. Key informants, including school nurses, suggested several reasons for the increase in obesity among youth people, including poor eating habits (unhealthy and not enough food) and increased use of technology and sedentary activities. Several people identified a need to address these issues in families to ensure that good habits are developed and maintained in schools and within the home.

QUANTITATIVE EVIDENCE

In Franklin County:

- The percentage of adults who reported less than one serving of vegetables a day increased between 2013 and 2015, from 21% to 24.2%. The percentage was higher than the state overall (18.3%) in 2015.
- The percentage of adults who lived a sedentary lifestyle, with no leisure-time physical activity in the past month, was higher than the state overall (25% vs. 20.6%) in 2016.
- The percentage of high school students that were obese increased significantly between 2011 and 2017, from 10.3% to 17.7 %.

Figure 4: Obesity (High School)



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COMMUNITY RESOURCES TO ADDRESS PHYSICAL ACTIVITY, NUTRITION, AND WEIGHT

The table below is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 6: Assets and Gaps/Needs (Physical Activity, Nutrition, and Weight)

ASSETS	GAPS/NEEDS
• Let's Go! Franklin • Supplemental Nutrition Assistance Program Education (SNAP-Ed) • Maine Harvest Bucks • Nutrition education in schools • Access to healthy affordable foods • Farmers market • Town recreation departments • Environment	• Adult activities and recreation (like pickleball) • Better school lunches • Family-wide education and efforts with home life—supporting working families with 9 am–5 pm working schedules • Access to exercise opportunities and healthy foods • Improved access to physical activity (addressing proximity, finances, lack of child care) • Exercise curriculum • Access to free programs that get kids active

SUBSTANCE USE

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 8% of adults in the United States have had a substance use disorder in the past year.[5] Tobacco, alcohol, marijuana, and nonmedical use of prescription pain relievers (e.g., OxyContin, Vicodin) are the leading substance use health issues for adults.[6] Tobacco, alcohol, and marijuana are the most common substances misused by adolescents, followed by amphetamines (e.g., Adderall) and nonmedical use of prescription pain relievers.[7]

Those with substance use disorders often face a number of barriers that limit access and hinder engagement in care; one study estimates that more than 50% of individuals with both mental health and substance use issues are not engaged in needed services.[8] Barriers to care include a lack of education, awareness, and understanding around the signs, symptoms, risk factors, and consequences associated with substance use, social stigma, and workforce shortages. Statewide, many forum participants and key informant interviewees identified gaps in access to substance use treatment and recovery services. Finally, those who are uninsured or underinsured are more likely to face barriers to care, and historically, coverage for substance use services has been less comprehensive than for physical health services. This is further complicated by the cost of co-pays, transportation, and medications, even for those who are eligible for free or discounted services, or for those with commercial insurance, as many private substance use treatment providers do not accept insurance and require cash payments.

QUALITATIVE EVIDENCE

Forum participants identified a need for services and support for children whose parents were affected by substance use disorder.

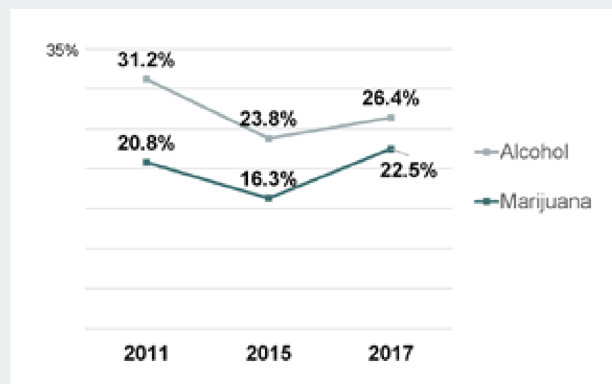
Several participants also identified a need for more education and prevention around the use of electronic cigarettes (also referred to as "vaping" or "Juuling") and policy changes to limit marketing aimed at youth and adolescents.

QUANTITATIVE EVIDENCE

In Franklin County:

- The rate of overdose deaths decreased between 2007–2011 and 2012–2016, from 11 to 8.8 per 100,000 population. Franklin is the only county in the state with an overdose death rate significantly lower than the state average (18.1).
- Past-30-day marijuana use among high school students was significantly higher than the state overall (22.5% vs. 19.3%) in 2017.
- The percentage of high school students who reported past-30-day alcohol use declined between 2011 and 2017, from 31.2% to 26.4%.
- The percentage of high school students who reported binge drinking declined between 2011 and 2015, from 19.6% to 13.0%. The percentage was higher than the state overall (12.2%) in 2015.

Figure 5: Past Thirty Day Alcohol and Marijuana Usage (High School)



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COMMUNITY RESOURCES TO ADDRESS SUBSTANCE USE

The table below is a summary of the assets and needs identified through the community engagement process, including review by local teams. It is important to note that this is not a complete list of available resources or existing needs in the community; other resources, like 211 Maine, and local/county resource guides should be referenced as a more comprehensive inventory.

Table 7: Assets and Gaps/Needs (Substance Use)

ASSETS	GAPS/NEEDS
• Intensive outpatient program • Evergreen Behavioral Health Services • Tri-County Health • Hospital doctors/Medical assisted • Healthy Community Coalition (substance use related initiatives) • Multiple independent counselors • Kennebec Behavioral Health • Self-help/Support programs	• Limited access to care/health insurance • Bias/stigma training • Treatment match person • Understanding how to treat disease vs. crime • More community support • More education • Educate students about dangers of vaping • Education and rehab • Peer-to-peer programs • Access to Juul, and limiting Juul marketing • One central number to call for emergency services • Harm reduction program • Support for new moms with substance use disorder

COMMUNITY CHARACTERISTICS

AGE DISTRIBUTION

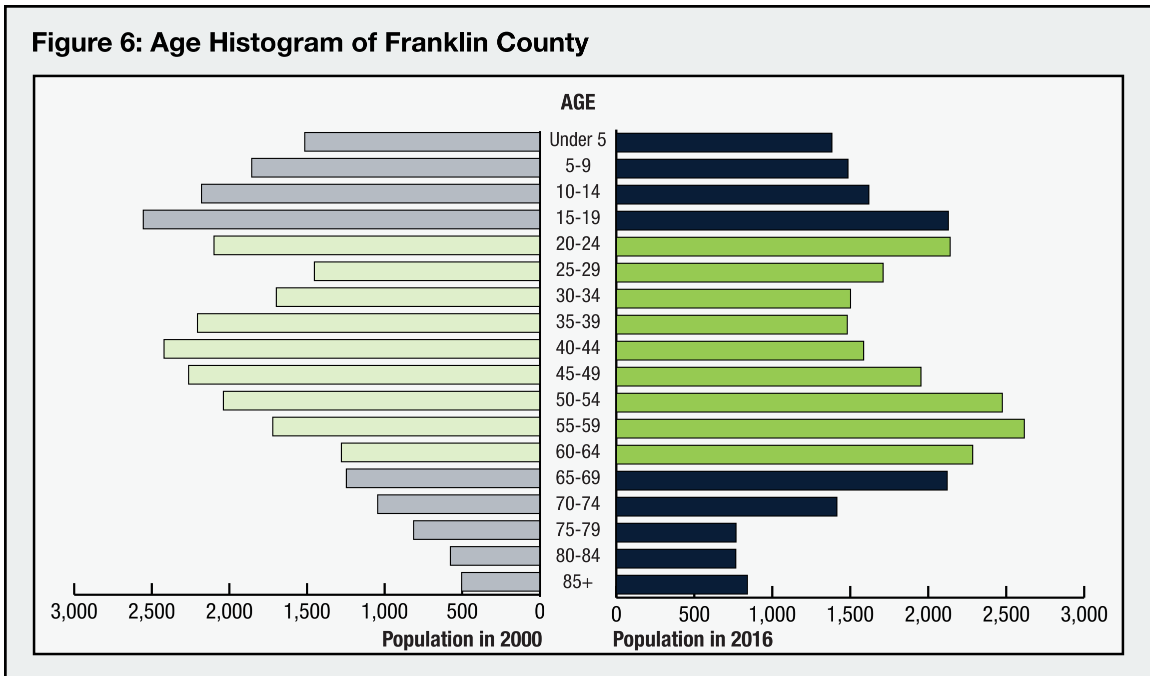
Age is a fundamental factor to consider when assessing individual and community health status. In particular, older individuals typically have more physical and mental health vulnerabilities, and are more likely to rely on immediate community resources for support compared to young people.[9] An aging population leads to increased pressure on the healthcare system and shortages in the healthcare workforce, especially geriatricians, nurses, social workers, and direct care workers like home health aides and certified nursing assistants, to meet the needs of older adults.[10]

The following is a summary of findings related to community characteristics for Franklin County. Conclusions were drawn from quantitative data and qualitative information collected through forums and key informant interviews.

For key companion documents visit www.mainechna.org and click on "Health Profiles."

- In Franklin County, 20.2% of the population is 65 years of age or older.

Figure 6: Age Histogram of Franklin County



RACE/ETHNICITY

An extensive body of research illustrates the health disparities that exist for racial/ethnic minorities, non-English speakers, and foreign-born populations. According to the US CDC, non-Hispanic Blacks have higher rates of premature death, infant mortality, and preventable hospitalization than non-Hispanic Whites.[11] Individuals with limited English proficiency (LEP), defined as the ability to read, speak, write, or understand English "less than very well," have lower levels of health literacy or comprehension of medical information. This leads to higher rates of medical issues and complications, such as adverse reactions to medication.[12,13] Cultural differences such as but not limited to the expectations of who is involved in medical decisions can also impact access to health care and to health information. These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.

In Franklin County:

- The population is predominantly White (96.7%), 1.5% are two or more races, and 1.3% are Hispanic.

Table 8: Race/Ethnicity in Franklin County 2012–2016

	PERCENT/NUMBER
American Indian/Alaskan Native	0.4% / 126
Asian	0.5% / 145
Black/African American	0.4% / 131
Hispanic	1.3% / 384
Some other race	0.3% / 85
Two or more races	1.5% / 463
White	96.7% / 29,281

SOCIOECONOMIC STATUS

Socioeconomic status (SES) is measured by such things as income, poverty, employment, education, and neighborhood characteristics. Individuals with low SES are more likely to have chronic health issues, die prematurely, and have overall poor health. Low income status is highly correlated to a lower than average life expectancy. Lack of gainful employment is linked to several barriers to care, such as lack of health insurance, inability to pay for health care services, and inability to pay for transportation to receive services. Higher education is associated with improved health outcomes and social development at individual and community levels. The health benefits of higher education typically include better access to resources, safer and more stable housing, and better engagement with providers. Factors associated with low education impact an individual's ability to navigate the healthcare system, disparities in personal health behaviors, and exposure to chronic stress. It is important to note that, while education affects health, poor health status may also be a barrier to education. Table 9, to the upper right, includes a number of data points comparing Franklin County to the state overall.

Additionally, in Franklin County:

- The estimated high school graduation rate was higher than the state overall in 2017 (89.5% vs. 86.9%).
- The percent of the population over 25 with an associates' degree or higher was lower than the state overall (35.4% vs. 37.3%) in 2017.

Table 9: Socioeconomic Status

	FRANKLIN/MAINE
Median household income	$43,007 / $50,826
Unemployment rate	4.3% / 3.8%
Individuals living in poverty	14.1% / 13.5%
Children living in poverty	16.2% / 17.2%
65+ living alone	– / 45.3%

SPECIAL POPULATIONS

Through community engagement activities, several populations in Franklin County were identified as being particularly vulnerable or at-risk for poor health or health inequities.

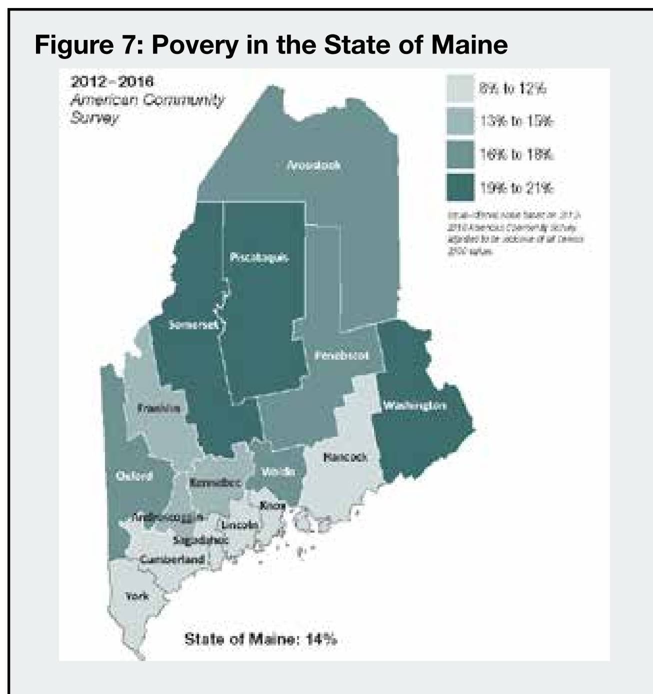
Youth/Adolescents

Young people were identified as a priority population in community forums and other engagement activities. Specific issues of concern were youth mental health issues (in particular depression, suicidality, and the impact of ACEs; substance use (specifically vaping/ Juuling and the impact of parents with substance use issues); lack of education around nutrition and physical activity; and the impacts of poverty (specifically food insecurity and access to care).

Rural/Low-Income

Approximately 83% of the population in Franklin County lives in a rural area, compared to 61% of the state overall. Many of those who participated in community forums and other community engagement events mentioned the difficult aspects of rural living, especially for those that are low-income. Nationally, an ever-evolving economic structure has placed extra strain on individuals and families living in large rural areas with low population density; some of the most well-known causes and conditions of hardship include a lack of and outsourcing of jobs, limited long-term employment opportunities, barriers to accessing health care services, and the need for a personal vehicle. Generational poverty—when a family has lived in poverty for at least two generations—differs from situational poverty in that it typically includes the constant presence of hopelessness. This lack of hope and near-constant state of perpetual crisis creates a cycle of poverty that persists from one generation to the next.

Figure 7: Povery in the State of Maine



In addition to the data collected and analyzed for the County Health Profiles, the Maine CDC created Health Equity Data Summaries (available at www.mainechna.org) which provides selected data analyzed by sex, race, Hispanic ethnicity, sexual orientation, educational, and income. These data are at the state level, as much of the county level data would be suppressed due to small numbers and privacy concerns, and the previous analyses have shown that health disparities found at the state level are generally similar in individual counties.

KEY INDICATORS

The Key Indicators provide an overview of the health of each county. They are a broad sampling of health topics, including health behaviors, outcomes, living conditions, and health care quality and access. See the Franklin County Health Profile for a full set of data. The table uses symbols to show whether there are important changes in each indicator over time and to show if local data is notably better or worse than the state or the nation. See the box below for a key to the symbols:

CHANGE shows **statistically significant changes** in the indicator over time, based on 95% confidence interval (see description above).

- ★ means the health issue or problem is **getting better** over time.
- ! means the health issue or problem is **getting worse** over time.
- ○ means the change was not statistically significant.
- N/A means there is not enough data to make a comparison.

BENCHMARK compares Franklin County data to state and national data, based on 95% confidence interval (see description above).

- ★ means Franklin County is doing **significantly better** than the state or national average.
- ! means Franklin County is doing **significantly worse** than the state or national average.
- ○ means there is no statistically significant difference between the data points.
- N/A means there is not enough data to make a comparison.

ADDITIONAL SYMBOLS

- * means results may be statistically unreliable due to small numbers, use caution when interpreting.
- — means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

	FRANKLIN COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH BEHAVIORS							
Past-30-day alcohol use (high school students)	2011 **31.2%**	2017 **26.4%**	○	2017 **22.5%**	○	–	N/A
Past-30-day alcohol use (middle school students)	–	2017 **8.8%**	N/A	2017 **3.7%**	○	–	N/A
Past-30-day cigarette smoking (high school students)	2011 **12.1%**	2017 **13.1%**	○	2017 **8.8%**	!	–	N/A
Past-30-day cigarette smoking (middle school students)	–	2017 **3.5%**	N/A	2017 **1.9%**	○	–	N/A
Past-30-day marijuana use (high school students)	2011 **20.8%**	2017 **22.5%**	○	2017 **19.3%**	!	–	N/A
Past-30-day marijuana use (middle school students)	–	2017 **7.7%**	N/A	2017 **3.6%**	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **5.0%**	2017 **6.0%**	○	2017 **5.9%**	○	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	–	2017 **1.6%**	N/A	2017 **1.5%**	○	–	N/A
Chronic heavy drinking (adults)	2011-2013 **7.2%**	2014-2016 **8.6%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Current (every day or some days) smoking (adults)	2011-2012 **23.0%**	2016 **18.4%**	○	2016 **19.8%**	○	2016 **17.0%**	N/A
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **29.0%**	2016 **25.0%**	○	2016 **20.6%**	○	2016 **23.2%**	N/A
HEALTH CARE ACCESS AND QUALITY							
Ratio of population to primary care physicians per 100,000 population	–	2017 **47.6**	N/A	2017 **67.3**	N/A	2016 **145.3**	N/A
Ratio of population to psychiatrists per 100,000 population	–	2017 **3.3**	N/A	2017 **8.4**	N/A	–	N/A
Ratio of population to practicing dentists per 100,000 population	–	2017 **14.3**	N/A	2017 **32.1**	N/A	2017 **61.0**	N/A
Uninsured	2009-2011 **11.2%**	2012-2016 **10.9%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	–	2016 **90.8**	N/A	2016 **74.6**	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **81.3%**	2017 **86.1%**	N/A	2017 **73.7%**	N/A	–	N/A
HEALTH OUTCOMES							
Rate of years of potential life lost per 100,000 population	2010-2012 **6,660.9**	2014-2016 **6,341.6**	○	2014-2016 **6,529.2**	○	2014-2016 **6,658.0**	N/A
14 or more days lost due to poor physical health	2011-2013 **24.3%**	2014-2016 **27.6%**	○	2014-2016 **19.6%**	!	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **19.1%**	2014-2016 **27.4%**	○	2014-2016 **16.7%**	!	2016 **11.2%**	N/A
Infant deaths per 1,000 live births	2007-2011 **7.1***	2012-2016 **5.5***	N/A	2012-2016 **6.5**	N/A	2012-2016 **5.9**	N/A
Obesity (high school students)	2011 **10.3%**	2017 **17.7%**	!	2017 **15.0%**	○	–	N/A

	FRANKLIN COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH OUTCOMES							
Obesity (middle school students)	2015 **20.9%**	2017 **21.5%**	○	2017 **15.3%**	○	–	N/A
Obesity (adults)	2011 **35.4%**	2016 **32.0%**	○	2016 **29.9%**	○	2016 **29.9%**	N/A
Diabetes	2011-2013 **9.1%**	2014-2016 **9.9%**	○	2014-2016 **10.0%**	○	2016 **10.5%**	○
Chronic obstructive pulmonary disease (COPD)	2011-2013 **8.9%**	2014-2016 **10.3%**	○	2014-2016 **7.8%**	○	2016 **6.3%**	!
Cardiovascular disease deaths per 100,000 population	2007-2011 **227.2**	2012-2016 **218.8**	○	2012-2016 **195.8**	!	2016 **218.2**	○
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **389.0**	2012-2014 **356.9**	★	2012-2014 **340.9**	!	–	N/A
Overdose deaths per 100,000 population	2007-2011 **11.0**	2012-2016 **8.8**	○	2012-2016 **18.1**	★	2016 **19.8**	★
Suicide deaths per 100,000 population	2007-2011 **14.2**	2012-2016 **13.8**	○	2012-2016 **15.9**	○	2016 **13.5**	○
All cancer deaths per 100,000 population	2007-2011 **190.9**	2012-2016 **164.0**	○	2012-2016 **173.8**	○	2011-2015 **163.5**	○
Lyme disease new cases per 100,000 population	2008-2012 **18.2**	2013-2017 **71.0**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **194.0**	2013-2017 **246.1**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Cognitive decline	2012 **12.7*%**	2016 **14.0*%**	○	2016 **10.3%**	○	2016 **10.6%**	○
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	–	–	N/A	2012-2016 **17.8%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$40,502**	2012-2016 **$43,007**	N/A	2012-2016 **$50,826**	N/A	$2,016.00 **$57,617**	N/A
Estimated high school student graduation rate							
Food insecurity	2012-2013 **16.2%**	2014-2015 **14.7%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A

Leading Causes of Death

The following chart compares the leading causes of death for the state of Maine and Franklin County.

RANK	STATE OF MAINE	FRANKLIN COUNTY
1	Cancer	Heart disease
2	Heart disease	Cancer
3	Chronic lower respiratory diseases	Chronic lower respiratory diseases
4	Unintentional injuries	Unintentional injuries
5	Stroke	Stroke

APPENDIX A: REFERENCES

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APPENDIX B: HISTORY AND GOVERNANCE

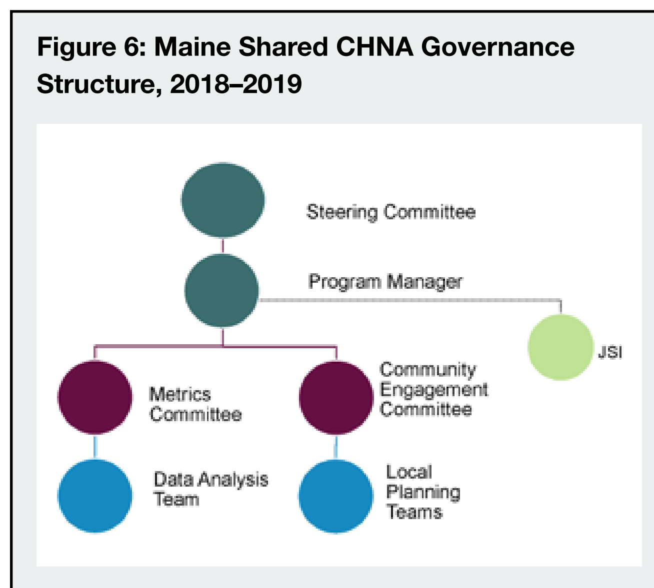
Maine is one of the few states in the nation that conducts a shared public-private statewide community health needs assessment—the Maine Shared CHNA—which was born out of a unique public-private partnership. The partnership began as the OneMaine Health Collaborative in 2007, involving Northern Light Health (formerly Eastern Maine Healthcare Systems), MaineGeneral Health, and MaineHealth. After conversations with the Statewide Coordinating Council for Public Health, the Maine Center for Disease Control and Prevention, an office of the Department of Health and Human Services joined in 2012. In 2013, Central Maine Healthcare (CMHC) joined the group and in 2014, leadership from the signatory partners signed a formal Memorandum of Understanding outlining mutual goals and expectations. A charter was drafted by all five partners to guide a statewide assessment process.

The Maine Shared CHNA is intended to coordinate state and county needs assessments to meet the needs of hospitals, to support state and local public health accreditation efforts, and to provide valuable population health assessment data for a wide variety of organizations across Maine. Our vision is to turn data into action so that Maine will become the healthiest state in the nation.

The Metrics Committee drafted the list of data indicators, and the Community Engagement Committee drafted a method to ensure a robust community engagement process—both of which were approved by the Steering Committee. Each committee was led by the Program Manager, who was the primary point of contact for all entities and partners and was responsible for drafting and implementing the work plans which drove this process. A more detailed outline of these efforts follows. For more information about the committee structure and our partners, please visit the, "About Us" page on our website www.mainechna.org.

The Metrics Committee is charged with updating the common set of health indicators; developing the preliminary data analysis plan; reviewing indicators on emerging health issues; making recommendations for annual data-related activities; and estimating projected costs associated with these recommendations. Members of the Metrics Committee to create processes and deliverables for the Steering Committee to review and approve. Members of the Metrics Committee include representatives of the Steering Committee, public health system partners, Federally Qualified Health Centers, academia, non-profits, and others with experience in epidemiology.

Figure 6: Maine Shared CHNA Governance Structure, 2018–2019



The Community Engagement Committee is charged with making recommendations for approval by the Steering Committee outlining a consistent and robust community engagement process. This process should outline methods of disseminating shared CHNA state and county-level results; identifying priorities among significant health issues; and identifying local, regional, or statewide assets and resources that may potentially address the significant health needs identified. Members of the Community Engagement Committee share their expertisecreate processes and deliverables for the Steering Committee to review and approve. Members of the Community Engagement committee include representatives of the Steering Committee, public health system partners, Federally Qualified Health Centers, academia, and Maine non-profits such as United Ways, Community Action Programs, and others with an interest in broad community representation and input.

APPENDIX C: METHODOLOGY

Per the Maine Shared CHNA charter, the effort was conducted by the Steering Committee, Metrics Committee, and Community Engagement Committee. The Community Engagement Committee was led by the program manager who was the point of contact for all entities and partners and was responsible for meeting planning and facilitation. These committees worked in partnership with the Maine CDC and the contracted vendor, JSI. Maine CDC and its epidemiology contractor, University of Southern Maine, provided a significant amount of data analyses, technical support, and website development. JSI was contracted to support forum facilitation, a subset of data analysis, profile development, and report writing.

The Maine Shared CHNA process was rolled out in three stages:

Data Analysis

- **County Health Profiles** were released in September 2018. Two hundred indicators were selected to describe health outcomes, health behaviors, healthcare access and quality, and the social, community, and physical environments that affect health and wellness. See Franklin County Health Profile at www.mainchna.org.
- **District Health Profiles** were released in November 2018.
- **City Health Profiles** for Lewiston/Auburn, Bangor, and Portland were released in January 2019.

Outreach and Engagement

- **Community outreach** was conducted between September 2018 and January 2019. Community forums with residents and service providers were held in all 16 counties. All forms of engagement included forums and key informant interviews. Some local planning teams also conducted additional targeted outreach, focus groups, and surveys. The purpose of this outreach was to gather feedback on data and to identify health priorities, community assets, and gaps in resources to be used in health improvement planning.

Final Reports

- **Final CHNA reports** for the state, each county, and districts were released in April 2019. These reports included information from the health data profiles, summaries of qualitative information gathered from engagement activities, and a presentation of community health priorities.

DATA ANALYSIS

The Metrics committee identified the approximately 200 health indicators from over 30 sources to be used for the Maine Shared CHNA. The initial list was based on the indicators from the 2016 effort. This list was first scored against the following set of criteria:

- Was it already analyzed for a MeCDC program?
- Is the data from this indicator collected within the last few years?
- Does it “round out” the description of population health?
- Does it address one or more social determinants of health?
- Describe an emerging health issue?
- Does it measure something “actionable” or “impactful”?
- Does the indicator measure an issue that is known to have high health and social costs?

Further refinement included ensuring a mix of Outcomes, Behaviors, Healthcare Access and Quality, as well as Social, Community, and Physical Environment Measures. The final list was then arranged under the current 24 health topics as outlined in the Data Health Profiles.

The Metrics Committee, led by Maine CDC staff, then drafted a data analysis plan that included which indicator was to be analyzed by which demographic characteristics (i.e. gender, race/ethnicity, sexual orientation, income, educational attainment, and insurance status), and geographic stratification (state, public health district, county, and city). This analysis plan was then approved by the Steering Committee.

The **Data Analysis Workgroup** used the set of indicators and the data analysis plan, as laid out by the Metrics Committee, and collected and analyzed the data. Members of the Data Analysis Workgroup shared their years of epidemiological and data analysis experience and knowledge of best practices to inform all aspects of the final health profiles at the county, public health district, city, and state level. This included not only the data analysis but recommendations on best practices for data presentation and visualization.

The Data Analysis Workgroup met weekly from March through August 2018 to discuss and coordinate an approach for analysis and data sharing between the University of Southern Maine (USM), Maine CDC, and John Snow, Inc. (JSI). The group developed rules regarding time frame (e.g., comparisons across time were to be of periods of equal duration; the most recent data used was from 2010 to present), handling complexity (e.g., how to combine years of data when an indicator's data definition changed over time, such as ICD9/ICD10 coding or BRFSS question changes), benchmarking, map and graph formats, and iconography to be used in profile tables. Some of the methodologies are documented in the Data Definitions section of each health profile. More is provided in the "2018 Maine Shared CHNA Data Analysis Technical Definitions" posted on the Maine Shared CHNA website.

OUTREACH AND ENGAGEMENT

Community outreach and engagement for the Maine Shared CHNA included coordination at both the statewide, public health district, and county level. The statewide Community Engagement Committee met monthly from March 2018 through January 2019 to review and provide input on every aspect of engagement process.

In addition to the state-level Community Engagement Committee, a **Local Community Engagement Planning Committee** in each of Maine's 16 counties planned and implemented the logistics of community forums and events within each district. These committees were comprised of hospitals, public health district liaisons, and a variety of additional partners.

Data Health Profiles include:

- 1 State Health Profile
- 16 County Health Profiles
- 5 Public Health District Profiles (One for each of the geographically-based multi-county district. A Tribal District Profile as not possible at this time.)
- 3 City Health Profiles (Bangor, Lewiston/Auburn, and Portland)
- 6 Health Equity Data Sheets, one for each of the following demographic characteristics:
  - Sex
  - Race
  - Hispanic ethnicity
  - Sexual orientation
  - Educational attainment
  - Insurance status

These reports, along with an interactive data form, can be found under the Health Profiles tab at

The 2018 Community Engagement Toolkit was designed to assist the Local Community Engagement Planning Committees in this effort.

Forums and Health Priorities

Criteria for visualizing data included areas identified as a health priority in the last CHNA, significant changes in the data over time, or where a county's data was notably better or worse than the state or the nation. Forum agenda items included remarks from health leaders; a review of previous health improvement efforts; a review of county-level data, discussion, and prioritization in small groups; and an overall forum-wide voting process. The Community Engagement and Steering Committees created and approved a rubric to guide the selection criteria for the subset of data to be presented in each forum's PowerPoint presentations.

Small groups had 35-45 minutes to discuss the data in the presentation and the full county profile, and to share their own experiences in order to identify their top county health priorities. Table facilitators guided these discussions using key questions and worksheets

for reporting purposes. Health priorities identified during these small groups were collated and presented to the larger plenary session, where each attendee voted for their top four priorities. Votes were tallied and a hierarchy emerged.

The summary votes for each forum were used to develop the county level priorities. If multiple forums were held in a county, the forum results for forums held with the general community were included in the total votes for the county. In cases where a forum was held with a specific population, for example, LGBTQ youth or older adults, then the results of their voting and discussion were included in the section describing the needs of that particular population. To arrive at the top countywide community health issues, votes from the broad community forums were combined for each of the priority areas to identify priority areas which fell within 70% of the combined voting total.

The community forum participants also shared knowledge on gaps and assets available in their communities to address each of the top four priorities identified. The information gathered in this report is a start for further asset and gap mapping for each priority selected by the county.

Franklin County Forums

Four community engagement activities were held in Franklin County.

Table 10: Community engagement activites in Franklin County, 2018

TYPE OF ENGAGEMENT	LOCATION & DATE	FACILITATOR	ATTENDEES
Greater Franklin County Health Survey	09/06/2018-09/22/2018	Healthy Community Coalition of Franklin County	317
Community Forum	Farmington 10/25/2018	Local Facilitators	41
Focus Group with Franklin Resource Collaborative	11/14/2018	Healthy Community Coalition of Franklin County	14
Physician Survey	12/03/2018-12/14/2018	Healthy Community Coalition of Franklin County	15

COMMUNITY ENGAGEMENT

Persons representing broad interests of the community who were consulted during the engagement process:

- CC Realty Management
- Community Member
- Franklin County Health Evergreen Behavioral Health
- Franklin County Health Network Pediatrics
- Healthy Community Coalition of Greater Franklin County
- Maine CDC Western District Liaison
- Maine Health Access Foundation
- MaineHealth
- Morning Sentinel
- RSU 9
- RSU 9 student
- Rural Community Action Ministry
- Safe Voices
- St. Rose/St. Joseph's Church
- Tri-County Mental Health Services
- University of Maine Farmington Student
- Western Maine Behavioral Health
- Western Public Health District
- Wilson Stream Family Practice

Key informant interviews

The Steering Committee identified ten categories of medically underserved and vulerable populations to ensure their input was heard and captured. A list of 80 potential interview subjects was created with statewide input. Selected key informants either had lived experience in or worked for an organization that focused on providing services or advocacy for the identified population. No Tribal representatives were able to be interviewed. In the future, we hope to include this important group in the CHNA process. The populations identified included:

- Veterans
- Tribal communities
- Adults ages 65 and older who are isolated or have multiple chronic conditions
- Non-English speakers, undocumented individuals, immigrants, and refugees
- Deaf individuals and those with other physical disabilities
- Adolescents/youth
- LGBTQ
- People with mental health conditions and developmental disabilities
- Rural individuals
- Individuals in substance use disorder recovery/substance use disorder prevention and treatment professionals

The following is a list of organizations who participated in Key Informant Interviews conducted both by JSI and local planning committee members:

- Alpha One
- Androscoggin Home Healthcare + Hospice
- Bingham Foundation
- Cary Medical Center
- Catholic Charities of Maine
- Community Concepts
- Community Caring Collaborative
- Edmund Ervin Pediatric Center, MaineGeneral Health
- EqualityMaine
- Family Medicine Institute
- Frannie Peabody Center
- Greater Portland Council of Governments
- Healthy Acadia
- Healthy Androscoggin
- Healthy Communities of the Capitol Area
- Kennebec Valley Council of Governments
- Long Creek Youth Development Center
- Maine Access Immigrant Network
- Maine Alliance for Addiction and Recovery
- Maine Alliance to Prevent Substance Abuse
- Maine Chapter Multiple Sclerosis Society
- Maine Council on Aging
- Maine Migrant Health
- Maine Seacoast Mission
- Millinocket Chamber of Commerce
- National Alliance on Mental Illness
- Nautilus Public Health
- Northern Light Maine Coast Hospital
- Office of Aging and Disability Services
- Penquis Community Action Agency
- Portland Public Health
- Seniors Plus
- Sunrise Opportunities
- Tri-County Mental Health Services
- United Ambulance Service
- Veterans Administration Maine Healthcare System
- York County Community Action Corporation

The key informant interview guide was developed with input from the Community Engagement and Steering Committee members and consisted of the following five questions.

- We are interested in learning more about the priority health needs for this population (reference population(s) of expertise of interviewee). How would you characterize the health needs for this population? How are they different than for the general population?
- From where you sit and the work you do, what do you feel are the most important health needs to address? Why?
- What do you see as the major resource gaps with respect to health and wellness for this population?
- Are you currently working on anything that contributes to community health and wellness for this population? Are there any areas of health you would like to work on in partnership with others?
- Are there any particular assets or resources to address the needs of this population that can be leveraged?

Thirty-one interviews were conducted by JSI and 11 by members of Local Community Engagement Planning Committees. Information gathered from the key informant interviews is included in discussions where applicable in the county level report within each of the county priorities. For example, when discussing substance use, a discussion of the needs of vulnerable populations within this priority was also included. The state level report provides a summary of key findings from these interviews for each of the ten vulnerable populations.

Data collection

All outcomes from these efforts were collected via the Community Outreach Reporting Tool or the Key Informant Reporting tool. Both of these collection tools were online surveys within Survey Monkey. Other data collection tools included Table Facilitators notes, forum registrations, and sign-ins.

Final Reports

Integrated analysis of all quantitative and qualitative activities and findings was conducted between December 2018 and January 2019. These were used to develop a full description of the risk factors underlying the health priorities for each county.

For more information, contact: **info@mainechna.org**