Aroostook County

Maine Shared Community Health Needs Assessment Report

2025

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Introduction

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

The mission of the Maine Shared CHNA is to:

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

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

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

Aroostook County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Transportation (ME)	Illicit Drug Use	Mental Health (ME)
Housing (ME)	Nutrition (ME)	Cardiovascular Disease
Provider Availability (ME)	Cancer Prevention	Obesity & Weight Status

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

Poverty | Substance Use | Adverse Childhood Experiences | Chronic Conditions

Next Steps

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

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

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

Report Outline

This report is broken into three sections.

1. Data on Aroostook 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 Aroostook 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

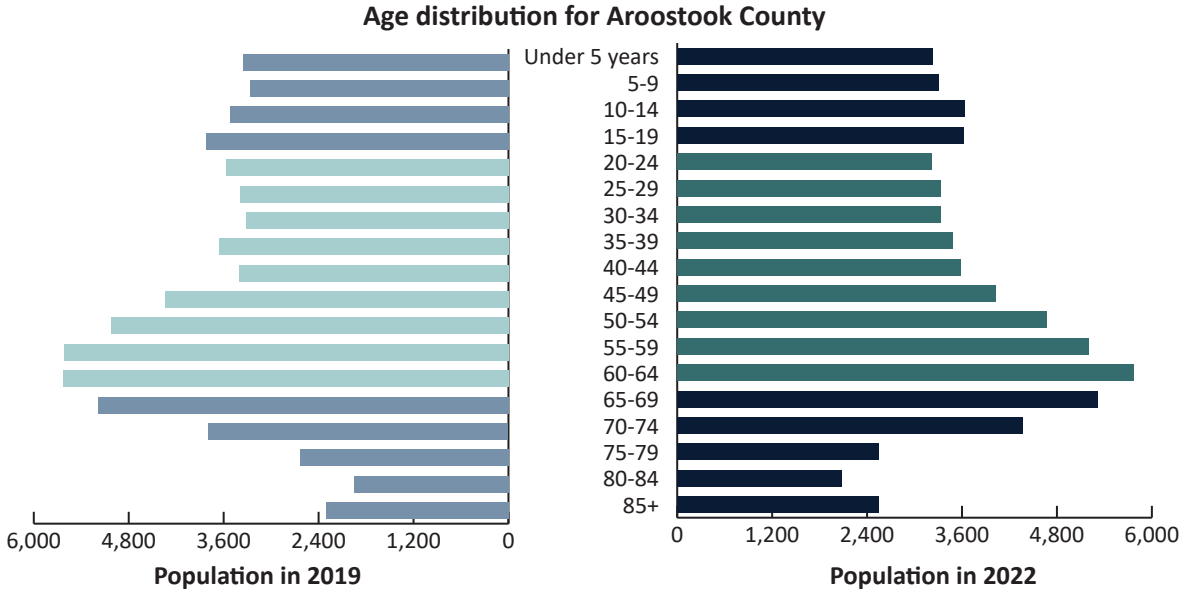
The following tables and chart show information about the population of Aroostook County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Aroostook County Population	State of Maine Population
67,237	**1,366,949**

	Aroostook	Maine
Median household income	**$50,843**	**$68,251**
Unemployment rate	**3.8%**	**3.1%**
Individuals living in poverty	**14.9%**	**10.9%**
Children living in poverty	**18.3%**	**13.4%**
65+ living alone	**32.7%**	**29.5%**

	Aroostook County	
	Percent	Number
American Indian/Alaskan Native	**1.6%**	**1,072**
Asian	**0.4%**	**271**
Black/African American	**0.8%**	**510**
Native Hawaiian or other Pacific Islander	**0.0%**	**30**
Some other race	**0.4%**	**247**
Two or more races	**3.0%**	**2,049**
White	**93.8%**	**63,058**
Hispanic	**1.5%**	**991**
Non-Hispanic	**98.5%**	**66,246**

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 Aroostook County.

Cause of Death	Maine	Aroostook County
Heart disease	**27.2%**	**30.2%**
Cancer	**25.9%**	**23.6%**
Accidents	**10.5%**	**9.5%**
Chronic lower respiratory disease	**6.8%**	**8.7%**
COVID 19	**6.0%**	**5.9%**
Cerebrovascular disease	**4.8%**	**5.3%**
Diabetes	**4.6%**	**3.8%**
Chronic liver disease and cirrhosis	**2.3%**	**2.8%**
Influenza & pneumonia	**2.1%**	**2.7%**
Alzheimer's disease	**4.1%**	**2.3%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**2.2%**
Suicide	**2.0%**	**1.7%**
Parkinson's disease	**1.7%**	**1.4%**

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.

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

Health and Well-Being Priorities

Section Overview

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

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

Socioeconomic Empowerment

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

Populations and Communities

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

Community Resources

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

Crosscutting Priorities

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

Aroostook County Strengths

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

- Locally owned businesses;
- Safe opportunities to be active outside;
- Schools and education for all ages;
- Banks and financial institutions; and
- Safe neighborhoods.

People living in Aroostook County have a positive outlook on their health and well-being – 59% of survey respondents believe their community is healthy or very healthy; 67% rate their own physical health as good or excellent; and 69% 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 Aroostook 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.

Aroostook County Community Conditions		
Transportation	Housing	Provider Availability

Transportation

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

Assessment Findings

In the Aroostook County focus group, "transportation" was identified as a top theme. In the Maine Shared CHNA survey, "lack of transportation" was listed as the fifth of five social concerns negatively impacting the community. In Aroostook County, 8.6% of households do not have a vehicle (2018-2022), significantly higher than Maine (6.9%). In the Maine Shared CHNA survey, 63.6% of survey respondents said transportation negatively impacts them, a loved one, and/or their community. More specifically, a majority of survey respondents said:

- "availability of public transportation" (83.2%),
- "access to transportation" (81.2%), and
- "availability of transportation that meets a variety of specific needs" (77.4%) negatively impacts their community.

Participants in the Aroostook County stakeholder forum echoed many of the sentiments from the survey, discussing the general lack of transportation options. Three-quarters (78.4%) of people in Aroostook County commute alone by car, truck, or van. Forum participants cited Houlton's lack of cab services as an example of the lack of transportation and noted when cab services do exist, they are often associated with high costs. Modivcare is an option for people with MaineCare; however, forum participants believe people are not aware of it, may not qualify for it, or see the advance scheduling requirement as a barrier. The Aroostook Regional Transportation System (ARTS) is another option, but forum participants note barriers to accessibility and bus driver workforce shortages.

Forum participants discussed that in some areas of Aroostook County senior housing is not located near services, putting stress on the transportation system because of the increase in trips needed. This is also the case for many low-income families, who are then beholden to the transportation schedule, which may not align with their needs. Those at the forum note that there is a lack of coordination among programs and services and the transportation system, most notably with food insecurity programs.

Aroostook County is rural by nature and 20.4% of people in Aroostook County have a commute of greater than 30 minutes alone (2018-2022), which data shows is significantly better than Maine (33.9%). Forum participants would like to see investments in roads in Aroostook County and education for seniors that could help them better access and navigate the transportation system.

Populations and Communities Impacted by Transportation

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

Community Resources to Address Transportation

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

- Aroostook Area Agency on Aging
- Aroostook Regional Transportation System
- Bridge to Hope gas cards
- Caribou Area Ride Service
- LogistiCare
- Maine Mobile Health Service
- Modivcare
- Pink Aroostook gas cards

Crosscutting Priorities

Housing

Housing

Housing was the second rated priority for the community conditions category for Aroostook County. For the purposes of the prioritization process, housing includes such topics as: housing availability and affordability, costs associated with home ownership or renting, and costs of utilities.

Assessment Findings

In the Aroostook County focus group, “affordable housing” was identified as a top theme. One focus group participant said:

“Wages have not kept up. You need 30% of your paycheck in order to get housing.”

In Aroostook County, 10.1% of households spend more than 50% of their income toward housing (2018-2022), significantly better than the U.S. (14.1%). Aroostook County stakeholder forum participants echoed the theme of affordable housing, discussing the high cost of rent, electricity, heating fuel, and other utilities, especially for those on fixed incomes, but even those with sustainable incomes are struggling with costs. In general, many people in Aroostook County, struggle to meet basic needs. Median gross rent has increased in Aroostook County from $574 (2015-2019) to $681 (2018-2022), a significant increase; however, rent is significantly lower than Maine ($1,009) and the U.S. ($1,268).

In the Maine Shared CHNA survey, 63.2% of respondents said housing needs negatively impact them, a loved one and/or their community. When asked about specific housing needs, respondents highlighted several areas, specifically housing costs and costs of utilities, echoing those in the stakeholder forum. Additional housing needs are shown in Table 1: Housing Needs.

The "availability of affordable, quality homes/rentals" was cited by 82.2% of respondents as impacting their community. Stakeholder forum participants also discussed the lack of housing inventory, specifically availability of "starter" homes, with forum participants highlighting an estimated 500 housing units needed in Presque Isle to meet overall demand and achieve workforce goals. In Aroostook County 76.1% of housing is occupied (2018-2022) and 2.1% housing units are vacant and for rent or sale (2022). For the housing that does exist, forum participants note it is not in good shape, and it is difficult to get home repairs done. Approximately 65% of housing in Aroostook County was built before 1979 and only 3.5% of houses have been built since 2010.

Forum participants suggested some areas for improvement including consideration of zoning changes to allow for accessory dwelling units or tiny houses.

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	37.9%	44.0%	79.9%	1.1%	5.2%	0.3%
Availability of affordable, quality homes/rentals	25.6%	38.2%	82.2%	1.4%	5.5%	1.1%
Availability of affordable, quality housing for older adults or those with special needs	14.1%	30.7%	77.0%	1.7%	10.3%	1.4%
Issues associated with home ownership or renting	33.6%	35.3%	74.1%	1.7%	10.3%	2.6%
Health risks in homes (indoor air, tobacco smoke residue, pests, lead, mold)	19.8%	26.1%	64.4%	3.4%	20.4%	3.2%
Homelessness or availability of shelter beds	4.9%	12.9%	74.1%	2.6%	15.2%	4.9%
Cost of utilities	58.0%	53.4%	78.2%	0.9%	3.7%	0.6%
Costs associated with weatherization	35.9%	38.2%	71.8%	2.6%	8.6%	3.2%

Socioeconomic Empowerment

When asked about the top five steps that are "very necessary" for helping someone move from poverty to a place of stability, "affordable and safe housing" was listed as 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: older adults, adults, young adults, people with substance use disorder, and unhoused/housing insecure.dults, LGBTQ+, single-parent households, veterans, adults, children, youth, and teens.

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:

- Aroostook County Action Program
- Aroostook Partnerships
- Civic groups
- Efficiency Maine
- Faith-based organizations
- Homeless Services of Aroostook
- Hospitals
- Housing authorities
- Local media
- Local recreation centers
- Mental health providers and programs
- Norman L. Fournier Place
- Primary care providers
- Public housing
- Section 8 Housing
- Transportation services
- Universities

Provider Availability

Provider availability was the third rated priority for the community conditions category for Aroostook 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 in the Aroostook County focus group noted “provider shortages” as a top theme. Focus group participants said:

“Providers are not really seeking new patients.”

“There aren’t enough providers, especially mental health and substance use treatment. Houlton may be a steppingstone in their career, and we appreciate having them, but….”

“Specialists – if you want to see one quickly, you have to go as far as Bangor.”

Aroostook County stakeholder forum participants echoed the lack of providers in general and particularly mental health providers, dentists, and specialists, noting a particular lack for mastectomy aftercare and diabetes care. In Aroostook County there are 1,778 people for every primary care provider; 32,627 people for every psychiatrist; and 4,150 people for every dentist (2024). In Aroostook County 60.4% of adults visited the dentist in the past year (2020).

While telehealth is an option it was noted some mental telehealth services do not take insurance and not everyone has access to the internet. In Aroostook County, 77.4% of

households have a broadband subscription (2018-2022), significantly better than 2015-2019 (69.2%), but significantly worse than Maine (87.3%) and the U.S. (88.3%).

When asked if they or a loved one could not or chose not to get health care in the past year, 46.3% of survey respondents said yes due to "long wait times to see a provider" and "did not feel comfortable with available providers." When asked the same question about mental health services, 39.3% of survey respondents said yes, citing barriers as "long wait times to see a provider" and "did not feel comfortable with available providers." Quantitative data shows in Aroostook County, 87.8% of adults have a usual primary care provider (2019-2021) and 82.3% have been to a primary care provider in the past year (2019-2021), a significant increase from 2015-2017 (74.1%). With regard to insurance, forum participants noted Humana Medicare is no longer accepted at Northern Light Health. Forum participants would like to see efforts by the hospitals to recruit more providers and host mobile or pop-up clinics.

Socioeconomic Empowerment

In the Maine Shared CHNA survey, respondents said "affordable and available health care" is the fifth of five steps that is "very necessary" to move someone from poverty to a place of stability.

Populations and Communities Impacted by Provider Availability

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

Community Resources to Address Provider Availability

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

- Aging-Friendly Communities
- AMHC
- Aroostook Area Agency on Aging Memory Clinic
- Aroostook County Action Program's mobile unit
- Cary/Pines Medical Center
- Fish River Rural Health
- Katahdin Valley Health Center
- Library telemedicine programs, specifically Cary Library Telehealth
- Local health care providers
- Maine Mobile Health Service
- Northern Light Health
- Northern Lighthouse
- Northern Maine Medical Center

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 Aroostook 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.

Aroostook County Protective & Risk Factors		
Illicit Drug Use	Nutrition	Cancer Prevention

Illicit Drug Use

Illicit drug use was the top-rated priority for the protective and risk factors category for Aroostook County.

Assessment Findings

Respondents to the Maine Shared CHNA survey in Aroostook County said, "substance use," which includes illicit drug use, was the top social concern negatively impacting their community and 73.1% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about more specific substance use, 76.7% said "opioid misuse" impacted their community and 22.5% said it impacted a loved one, while 79.4% of respondents said "other illicit drug use" impacted their community and 25.9% said it impacted a loved one. In Aroostook County,

- There was a significant increase in drug-induced deaths per 100,000 people from 2015-2019 (19.6 per 100,000) to 2018-2022 (44.7 per 100,000),
- There were 56 overdose deaths for every 100,000 people (2023).
- 4% of high school students had ever used illicit drugs (2024).
- 1.4% of adults had misused prescription drugs in the past 30 days (2011-2021).
- 3% of high school and 4.2% of middle school students reported prescription drug misuse in the past 30 days (2019).

Participants in the Aroostook County stakeholder forum discussed the spectrum of addressing substance use, citing a lack of prevention programming for substance use at one end and a lack of education about Naloxone on the other. Forum participants note people with high adverse childhood experience scores may be susceptible to illicit drug use and many myths exist about the populations who use substances, inhibiting the ability to adequately address use.

Socioeconomic Empowerment

When asked what steps are "very necessary" to help move people out of poverty to a place of stability, "reduction in substance use" was listed as the fourth step out of five by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Illicit Drug Use

In a pre-forum survey and at the forum, forum registrants were asked to identify populations impacted by their identified priorities. For illicit drug use, respondents cited: older adults, youth, adults, young adults, people with substance use disorder, people with mental health disorders, and teens.

Community Resources to Address Illicit Drug Use

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

- AMHC
- Aroostook County Action Program prevention programs
- Comprehensive treatment centers
- Health care providers
- Law enforcement
- Public schools
- Recovery coaches
- Recovery communities
- SaVida

Crosscutting Priorities

Mental Health

Nutrition

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

Assessment Findings

Three quarters (76.6%) of Maine Shared CHNA survey respondents said "economic needs" negatively impact them, a loved one, and/or their community. Of those respondents, 74.2%, 39.2%, and 39.5% said "access to affordable, quality foods" negatively impacts their community, a loved one, and themselves, respectively. Access to food was also discussed at the Aroostook County stakeholder forum, with participants citing the existence of food deserts and a lack of quality foods, coupled with economic factors. In 2022, 16.2% of adults and 23.5% of youth were food insecure.

Forum participants also discussed barriers that come with food preparation, including not having the skills or knowledge to prepare or preserve food nor having the right equipment for meal preparation. In Aroostook County,

- 40.3% of adults consumed less than one serving of fruits per day (2021).
- 11.9% of adults consumed less than one serving of vegetables per day (2021), significantly better than the U.S. (20.4%).
- 12.9% of high school and 19.1% of middle school students consume five or more servings of fruit and vegetables per day (2019).
- 25.4% of high school and 22% of middle school students consume more than one soda/sports drink per day (2019).

Populations and Communities Impacted by Nutrition

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

Community Resources to Address Nutrition

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

- Adopt a Block programs
- Aroostook Area Agency on Aging, specifically congregate dining and delivered meals
- Community Cupboards
- Community gardens
- Cooperative Extension
- Ending Hunger in Maine by 2030 Task Force
- Faith-based organizations
- Farm Share and Sun Bucks
- Fish River Food Shelf
- Healthy Eating, Active Living
- Lactation counselors
- Libraries
- Local farmers
- Municipalities
- Registered dieticians
- Schools and school nutrition programs
- Soup kitchens and food pantries
- Supplemental Nutrition Assistance Program
- The Purple Ladle
- Women, Infants and Children Program

Cancer Prevention

Cancer prevention was the third rated priority for the protective and risk factors category for Aroostook County. For the purposes of the prioritization process cancer prevention includes topics such as cancer screenings and sunscreen use.

Assessment Findings

In the Aroostook County focus group, "provider shortages" and "timely and affordable care" were top themes. One focus group participant said:

"Providers are not really seeking newer patients."

"Specialists – if you want to see one quickly, you have to go as far as Bangor."

Aroostook County stakeholder forum participants discussed the impact socioeconomic factors can have on access to screenings and the ability to get them. Three quarters (76.8%) of survey respondents said, "chronic health conditions," of which cancer is one, negatively impact them, a loved one, and/or their community. Of those, approximately half of survey respondents said "cancer" negatively impacts their community (46.1%) and a loved one (45.9%). Regarding cancer screenings quantitative data shows in Aroostook County:

- 86.4% of people are up to date with breast cancer screenings (2018 & 2020).
- 85.7% of people are up to date with cervical cancer screenings (2018 & 2020).
- 72.4% of people are up to date with colorectal cancer screening (2020), significantly worse than Maine (81.2%).
- 17.5% of those eligible are up to date with lung cancer screenings (2018-2021).

Forum participants noted several risk factors attributable to cancer in their community. These include exposure to chemical use in agriculture and high radon levels. In Aroostook County, 24.8% of households had tested for radon (2016-2019 & 2021). Forum participants also discussed substance use, specifically high smoking rates and excessive alcohol use as cancer risk factors. In 2021, 22.2% of adults in Aroostook County reported current cigarette smoking,

significantly worse than Maine (15.6%) and the U.S. (14.4%). During the time period 2019-2021, 5.1% of adults in Aroostook County report heavy chronic drinking and 10.4% report binge drinking.

Socioeconomic Empowerment

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

Populations and Communities Impacted by Cancer Prevention

In a pre-forum survey and at the forum, forum registrants were asked to identify populations impacted by their identified priorities. For cancer prevention, respondents cited: youth, young adults, men, adults, older adults, women, people with low-income, and veterans.

Community Resources to Address Cancer Prevention

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

- AR Gould health education programs
- Aroostook County Action Program
- Bridge to Hope Cancer Awareness Walk
- Cary Cancer Center
- Fish River Rural Health Breast Cancer Support Group
- Health care providers
- Maine Breast and Cervical Health Program
- Oral health care providers
- Pink Aroostook Breast Cancer Awareness
- Power of Prevention
- Radon prevention

Crosscutting Priorities

Provider Availability

Health Conditions & Outcomes

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

Aroostook County Health Conditions & Outcomes		
Mental Health	Cardiovascular Disease	Obesity & Weight Status

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Aroostook County. For the purposes of the prioritization mental health includes topics such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, and post-partum depression.

Assessment Findings

In the Aroostook County focus group, one participant said:

"There aren't enough providers, especially mental health and substance use treatment. Houlton may be a steppingstone in their career, and we appreciate having them, but…."

Participants in the Aroostook County stakeholder forum noted hospitals are currently serving as "stop-gaps" for mental health care. There are 32,627 people in Aroostook County for every psychiatrist (2024) and 19% of adults are currently receiving outpatient mental health treatment (2019-2021).

Another focus group participant said:

"Loneliness – being connected through electronics is better than nothing, but it doesn't replace playing pickleball with friends or playing cribbage."

Stakeholder forum participants also discussed topics related to loneliness as factors contributing to mental health. Topics included, isolation, a lack of belonging and sense of alienation, and people who don't have community or family support. In Aroostook County, 32.7% of people 65 and older live alone (2018-2022). Forum participants discussed the lack of resources in general, and specifically with regard to parenting. Stakeholder forum participants also noted the impact of substance use on mental health and those with mental health disorders.

In the Maine Shared CHNA survey, "mental health issues" was the second of the top five social concerns negatively impacting the community and 73.6% of respondents said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about specific mental health needs, "anxiety or panic disorder," "depression," and "general stress of day-to-day life" negatively impact respondents, their loved ones, and their communities. These specifics and other mental health needs are in Table 2: Mental Health Needs.

In Aroostook County,

- 9.6% of adults have current symptoms of depression (2019-2021).
- 20.7% of adults report having had depression in their lifetime (2019-2021).
- 25.1% of adults have ever had anxiety (2019-2021).
- 29.9% of high school and 21.1% of middle school students reported being sad/hopeless for two weeks in a row (2019).
- 15.6% of high school and 18.3% of middle school students had seriously considered suicide (2019).

In the Maine Shared CHNA survey 68.8% of respondents rate their own mental health as "good or excellent" and 39.3% of survey respondents say they or a loved one could not or chose not to get mental health care in the past year. The reasons for forgoing care include: "long wait times to see a provider," "did not feel comfortable with available providers," and "did not feel comfortable seeking help." The notion of not feeling comfortable seeking help was also discussed in the lens of stigma at the stakeholder forum.

Table 2: 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	52.7%	60.4%	48.6%	3.1%	5.6%	2.3%
Depression	44.5%	56.3%	57.3%	2.3%	5.6%	2.8%
Bipolar disorder	8.2%	32.7%	44.0%	6.9%	19.7%	12.0%
Trauma or post-traumatic stress disorder (PTSD)	32.7%	41.7%	47.1%	4.6%	12.8%	6.4%
General stress of day-to-day life	61.1%	54.0%	55.2%	2.6%	7.2%	3.1%
Social isolation or loneliness	26.9%	39.4%	57.8%	3.1%	8.7%	6.6%
Stigma associated with seeking care for mental health or substance use disorders	15.1%	32.5%	55.0%	7.7%	15.1%	9.2%
Suicidal thoughts and/or behaviors	10.2%	29.7%	53.5%	7.7%	17.9%	10.0%
Youth mental health	17.4%	34.0%	56.8%	5.1%	12.3%	8.4%

Populations and Communities Impacted by Mental Health

In a pre-forum survey and at the forum, forum registrants were asked to identify populations impacted by their identified priorities. For mental health, respondents cited: older adults, caregivers, teens, adults, young adults, and youth.

Community Resources to Address Mental Heath

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

- Acadia
- AMHC, specifically crisis services
- Faith-based organizations
- Healthcare professionals
- Medication Assisted Treatment and Medications for Opioid Use Disorder
- Wellness Mobile Foundation

Crosscutting Priorities

Provider Availability **Illicit Drug Use**

Cardiovascular Disease

Cardiovascular disease was the second rated priority for the health conditions and outcomes category for Aroostook County. For the purposes of the prioritization process cardiovascular disease includes topics such as high blood pressure, high cholesterol, heart attack, and stroke.

Assessment Findings

In the Aroostook County focus group, "provider shortages" and "timely and affordable care" were top themes. One participant said:

> **"Providers are not really seeking newer patients."**

Participants in the stakeholder forum also discussed the struggle with the geographic location of Aroostook County, with people needing to drive long distances or fly to access care.

In the survey, 76.8% of survey respondents said, "chronic health conditions," which includes cardiovascular disease, negatively impacts them, a loved one, and/or their community. Of those,

- 42% said "heart disease or heart attack" negatively impacts a loved one.
- "High cholesterol" negatively impacts respondents' community (29.5%), loved ones (47.3%), and themselves (28.5%).
- "High blood pressure" negatively impacts respondents' community (34.1%), loved ones (54.3%), and themselves (36%).

Several cardiovascular disease indicators demonstrate worse outcomes for Aroostook County compared to Maine; however, there have been significant improvements within the county on heart failure hospitalizations and heart attack hospitalizations. These indicators are detailed in Table 3: Cardiovascular Disease.

Stakeholder forum participants discussed risk factors for cardiovascular disease such as tobacco use and smoking, substance use, diet, and a lack of physical activity, which may be impeded by weather conditions that limit opportunities to be outside. As it relates to these root causes,

- 22.2% of adults reported current cigarette smoking, significantly worse than Maine (15.6%) and the U.S. (14.4%, 2021).
- 38.2% of adults reported a sedentary lifestyle, significantly worse than Maine (26.5%) and the U.S. (23.7%, 2021).
- 52.1% of adults met physical activity recommendations, significantly worse than Maine (2017 & 2019, 46.9%).

Table 3: Cardiovascular Disease	Aroostook County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cardiovascular Disease							
Cardiovascular disease deaths per 100,000 population	2015-2019 **200.7**	2018-2022 **220.1**	○	2018-2022 **200.4**	!	2021 **231.8**	N/A
Coronary heart disease deaths per 100,000 population	2015-2019 **87.8**	2018-2022 **z94.9**	○	2018-2022 **82.0**	!	2021 **92.8**	N/A
Heart attack deaths per 100,000 population	2015-2019 **31.3**	2018-2022 **31.6**	○	2018-2022 **24.6**	!	2021 **26.8**	N/A
Stroke deaths per 100,000 population	2015-2019 **33.3**	2018-2022 **37.1**	○	2022 **29.4**	N/A	2021 **41.1**	N/A
High blood pressure hospitalizations per 10,000 population	2016-2018 **14.5**	2019-2021 **18.6**	○	2019-2021 **19.4**	○	—	N/A
Heart failure hospitalizations per 10,000 population	2016-2018 **13.5**	2019-2021 **7.0**	★	2019-2021 **4.5**	!	—	N/A
Heart attack hospitalizations per 10,000 population	2016-2018 **32.3**	2019-2021 **27.8**	★	2019-2021 **18.9**	!	—	N/A
Stroke hospitalizations per 10,000 population	2016-2018 **23.6**	2019-2021 **22.6**	○	2019-2021 **19.2**	!	—	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 Cardiovascular Disease

In a pre-forum survey and at the forum, forum registrants were asked to identify populations impacted by their identified priorities. For cardiovascular disease, respondents cited: young adults, adults, older adults, people with low-income, people living in rural areas, and unhoused/housing insecure.

Community Resources to Address Cardiovascular Disease

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 cardiovascular disease, respondents identified:

- Area Agencies on Aging
- Clinics
- Faith-based organizations
- Food programs
- Health care screenings
- Healthcare professionals
- Healthy You Program
- Hospitals
- Incentives from insurance companies for annual screenings
- Local media
- Lunch and Learns
- Maine Anti-Tobacco Program
- Recreational programs

Crosscutting Priorities

Provider Availability

Illicit Drug Use

Obesity & Weight Status

Nutrition

Obesity and Weight Status

Obesity and weight status was the third rated priority for the health conditions and outcomes category for Aroostook County.

Assessment Findings

In the Maine Shared CHNA survey, 76.8% of survey respondents said, "chronic health conditions," which includes obesity, negatively impacts them, a loved one, and/or their community. Of those, "overweight/obesity" negatively impacts respondents' community (51.2%), loved ones (45.7%), and themselves (41.1%). In 2021, 41.4% of adults in Aroostook County were obese, which is significantly worse than Maine (31.9%) and the U.S. (33.9%). In 2019, 20.5% of high school and 18% of middle school students were obese.

Stakeholder forum participants discussed access to food as a contributing factor to obesity and weight status, specifically food deserts and a lack of nutritious foods. There is also a lack of transportation to access food. In 2022, 16.2% of adults and 23.5% of youth were food insecure. In Aroostook County,

- 40.3% of adults consumed less than one serving of fruits per day (2021).
- 11.9% of adults consumed less than one serving of vegetables per day (2021), significantly better than the U.S. (20.4%).
- 12.9% of high school and 19.1% of middle school students consume five or more servings of fruit and vegetables per day (2019).
- 25.4% of high school and 22% of middle school students consume more than one soda/sports drink per day (2019).

Forum participants noted people may not know how, nor have the time to cook and prepare food. Forum participants feel there is a lack of connectedness between community organizations, which leaves people not knowing where to go for assistance or what services are available in their communities.

Populations and Communities Impacted by Obesity and Weight Status

In a pre-forum survey and at the forum, forum registrants were asked to identify populations impacted by their identified priorities. For obesity and weight status, respondents cited: older adults, children, adults, youth, teens, young adults, and children.

Community Resources to Address Obesity and Weight Status

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

- 100 Miles in 100 Days
- Aroostook Area Agency on Aging, specifically Meals on Wheels
- Aroostook County Action Program, specifically healthy eating, active living resources
- Breaking Gound Program
- Commodity food boxes
- Community Cupboards
- Faith-based organizations
- Farm Share
- Farmers' markets vouchers
- Food banks
- Gyms
- Healthcare professionals
- Home economics programs
- Local recreation centers
- Mediterranean diet program
- Purple Ladle Program
- SAD 1 Adult Education classes
- Supplemental Nutrition Assistance Program
- University of Maine Presque Isle
- Women, Infants and Children Program

Crosscutting Priorities

Transportation **Cardiovascular Disease** **Nutrition**

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;"
- 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

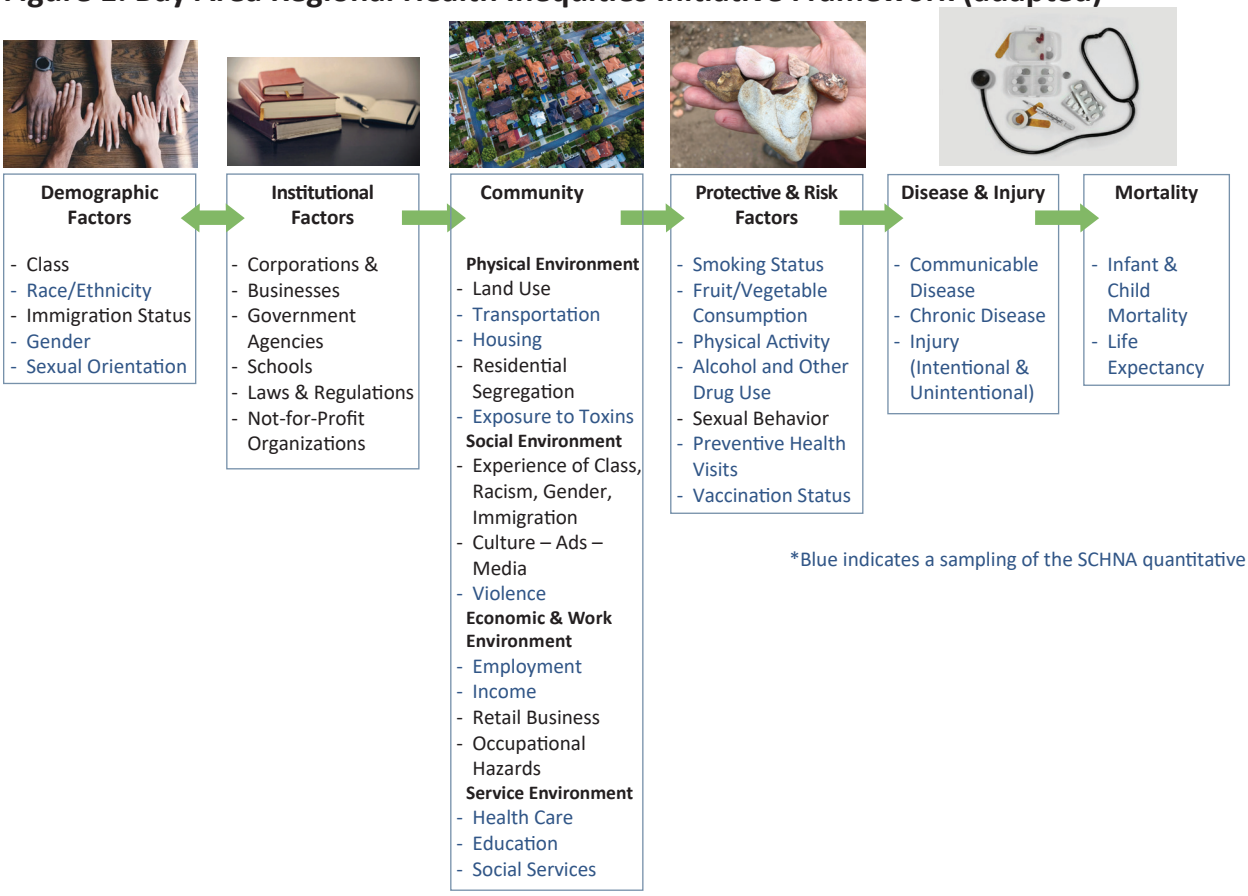
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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[ix] (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.[x] 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 Aroostook County on October 8, 2024, with 31 attendees. People from the following organizations participated in the forum process:

- Aroostook County Action Program
- Aroostook Mental Health Center
- Aroostook Agency on Aging/Aroostook Community Health Improvement Partnership (A-CHIP)
- Cary Medical Center
- Fish River Rural Health
- Houlton Regional Hospital
- Maine Center for Disease Control and Prevention
- Maine Mobile Health Program
- Northern Light AR Gould Hospital
- Office of Senator King
- St. Apollonia Dental Clinic
- The Center for the Advancement of Rural Living
- United Way of Aroostook
- Wabanaki Public Health and Wellness

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
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	13	81.3%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	11	68.8%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	9	56.3%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	9	56.3%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	8	50.0%
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)	8	50.0%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	6	37.5%
Isolation	2	12.5%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	2	12.5%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	12.5%
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.)	2	12.5%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	1	6.3%
Climate Impacts (such as extreme weather events)	1	6.3%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	1	6.3%
Technology (such as access to high-speed internet and phone services)	1	6.3%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	1	6.3%
Systemic Discrimination	1	6.3%
Protective and Risk Factors	**# Votes**	**% of Participants**
Illicit Drug Use	9	56.3%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	7	43.8%
Cancer Prevention (such as cancer screenings, sunscreen use)	7	43.8%

Protective and Risk Factors	# Votes	% of Participants
Alcohol Use (including binge drinking)	7	43.8%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	6	37.5%
Youth Mattering (such as positive role models, community connections, etc.)	5	31.3%
Cannabis Use	5	31.3%
Vaping Use (including tobacco and cannabis)	5	31.3%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	4	25.0%
Adverse Childhood Experiences	4	25.0%
Preventive Oral Health Care	3	18.8%
Immunizations & Vaccinations	3	18.8%
Adult Screening & Preventive Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	3	18.8%
Prescription Drug Misuse	3	18.8%
Injury Prevention (such as fall prevention, always wear a seat belt)	2	12.5%
Foster Care	2	12.5%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	2	12.5%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	1	6.3%
Safe Drinking Water	1	6.3%

Health Conditions and Outcomes	# Votes	% of Participants
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	13	81.3%
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	13	81.3%
Cancer	11	68.8%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	8	50.0%
Diabetes	7	43.8%
Obesity/Weight Status	7	43.8%
Cognitive Decline, Alzheimer's disease and other dementias	6	37.5%
Multiple Chronic Conditions	3	18.8%
Intentional Injury & Death (self-injury)	2	12.5%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	2	12.5%
Non-Infectious Respiratory Disease (such as asthma, COPD)	2	12.5%
Dental Disease	2	12.5%
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)	2	12.5%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	1	6.3%
Arthritis	1	6.3%

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

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

Community Conditions	# Votes	% of Participants
Transportation (such as access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	16	66.7%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	15	62.5%
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)	15	62.5%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	14	58.3%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	12	50.0%

Protective and Risk Factors	# Votes	% of Participants
Illicit Drug Use	14	58.3%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	13	54.2%
Cancer Prevention	12	50.0%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	11	45.8%
Better collaboration between partners	9	37.5%
Community education around risk factors	7	29.2%
Maternal & child health outcomes	4	16.7%
Alcohol Use	2	8.3%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	22	91.7%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	16	66.7%
Obesity/Weight Status	12	50.0%
Cancer	11	45.8%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	11	45.8%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	2	6.3%

Appendix 3: Community Action Agency Profile

About Aroostook County Action Program

The Aroostook County Action Program (ACAP) is a 501(c)(3) nonprofit organization established in 1972. For more than 50 years, ACAP has been a vital resource for individuals and families in Aroostook County. As one of Maine's 10 Community Action Agencies, ACAP is part of a national network of over 1,000 organizations dedicated to supporting local communities. Through partnerships with state, national, and regional organizations, ACAP plays an essential role in helping individuals and families in Aroostook County achieve greater economic and social mobility.

ACAP's mission is: "To lead or collaborate in providing services that support, empower, and improve lives."

Services Offered by ACAP

ACAP provides over 40 programs and services throughout Aroostook County and into parts of Washington County. Our entire team is committed to connecting individuals and families with all of the programs and services they need to reach their goals.

For over 50 years, Aroostook County Action Program (ACAP) has been a key resource for individuals and families in Aroostook County. A nonprofit organization, ACAP is one of 10 Community Action Agencies in Maine and part of a network of over 1,000 across the nation. Together, with our state and national partners, and many local and regional collaborators, ACAP holds a vital role in helping individuals and families in Aroostook County achieve economic and social mobility.

Childcare & Early Childhood Education Services

Preschool Children:

- Childcare for infants to age six
- Childcare for school age children to age 12 (Caribou Community School)
- Coaching and navigation
- Developmental services for children with disabilities
- Head Start and Early Head Start Program for families with expectant mothers, infants and toddlers through age three. Preschool age 3 to 5 years in center based or through public Pre-K partnerships.

Energy & Housing Services:

Education and Training:

- Energy audits

- Home heating assistance including Home Energy Assistance Program (HEAP) and emergency heating assistance
- Overdue electric bills (Arrears Management Program- AMP)

Housing:

- Energy conservation coaching program
- Eviction prevention
- Homebuyer education
- Homelessness and housing insecurity
- Housing for chronically homeless individuals (income based)
- Rent Smart education course

Safe and Warm Homes:

- Heating system cleaning and repair
- Heating system replacement, including heat pumps
- Home repairs and weatherization
- Lead paint inspections and abatement resources
- Oil tank replacement
- Safety aids for individuals with mobility challenges

Employment & Training Services:

Displaced and Laid-off Workers:

- Career counseling
- Job search
- Skills assessment
- Training and certification programs

Education and Training:

- Childcare
- Clothing
- Tools and equipment
- Transportation

Youth and Adults:

- College prep and transition
- High school completion
- Job search
- Occupational training (e.g., CNA and CDL certifications)
- Paid on-the-job training and work experience

Health, Wellness & Nutrition Services

Health Insurance:

- Health Insurance Marketplace navigation, including eligibility determination, option comparison and application/enrollment

Healthy Eating and Physical Activity:

- Programs and resources to reduce negative health effects of obesity

Nutrition and Food:

- Breastfeeding support and counseling (including supplies and electric pump loaner program)

- Community cupboards for food distribution
- Financial support for healthy foods and infant formula
- Infant and toddler health screenings and referrals
- Nutrition education, including nutrition support for childcare providers
- Prenatal vitamins for women of childbearing age
- WIC Farmers Market (seasonal)
- WIC nutrition program for families with young children

Oral Health:

- Dental sealants for elementary school students
- Education and prevention
- Preventative dental cleanings and related services (in participating schools)

Tobacco Prevention:

- Education on nicotine forms and harm reduction
- Policy development for public-facing entities
- Resources and supports for quitting nicotine addiction

Youth Education and Support (ages 10-24):

- Engagement programs for youth empowerment
- Financial literacy
- Personal responsibility
- Pregnancy prevention
- Social-emotional learning

Substance Misuse Prevention:

- Programs to reduce alcohol, marijuana and drug use
- Resources and programs on addiction and harm reduction

Managing Money Services

Financial Stability:

- Free tax return preparation
- Health Insurance Marketplace navigation including: eligibility determination, option comparison and application/enrollment
- Homebuyer education course
- Household and personal budgeting classes
- Matched savings account toward:
  - Training and higher education
  - Starting a small business
  - Home purchase or repairs
  - Vehicle purchase or repair
  - Emergency savings
- Paying for education and training

Household Expenses:

- Child care subsidy program
- Diaper program
- Financial support for healthy foods and infant formula
- Heat Pump Installation Program
- Home heating (HEAP – Home Energy Assistance Program)

- Home weatherization program
- Overdue electric bills and heating costs
- WIC nutrition program for families with young children

Strengthening Families Services

Helping Families with their Overall Economic and Social Wellbeing:

- Child care and preschool services (Head Start, Early Head Start and developmental services for children with special needs)
- Child care for school age children to age 12 (Caribou Community School)
- Coaching and navigation
- Diaper program
- Financial literacy coaching
- School supplies at start of school year
- WIC nutrition program for families with young children

Youth Services

Health and Wellbeing:

- Engagement programs for youth empowerment
- Guidance and counseling
- Personal responsibility
- Physical activity and nutrition
- Pregnancy prevention
- Restorative practices
- Substance use prevention
- Tobacco prevention

Workforce and Financial Supports:

- Childcare assistance
- College prep and transition
- Entrepreneurial skills training
- Financial education
- High school completion
- Job search
- Matching with local mentors
- Occupational training (e.g., CNA and CDL certifications)
- Paid on-the-job training and work experience
- Transportation, clothing, tools and equipment, childcare
- Tutoring

The Hope & Prosperity Resource Center is a warm and safe place where individuals and families can access a variety of services tailored to their needs. All these services are available in one convenient location, making it easier for you to get the support you need.

The ACAP mobile service unit is a retrofitted RV designed to bring ACAP's services to more remote areas of Aroostook County. This mobile unit ensures that individuals and families in hard-to-reach locations can access the support and resources they need.

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

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

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

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

ix BARHII: FRAMEWORK — BARHII - Bay Area Regional Health Inequities Initiative

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