Lincoln 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 Lincoln 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

Lincoln County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Housing (ME)	Substance Use (ME)	Mental Health (ME)
Poverty (ME)	Nutrition (ME)	Substance Use Related Injury & Death
Transportation (ME)	Adverse Childhood Experiences (ME)	Obesity & Weight Status
	Preventive Oral Care	

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

Provider Availability 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 Lincoln 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 Lincoln 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

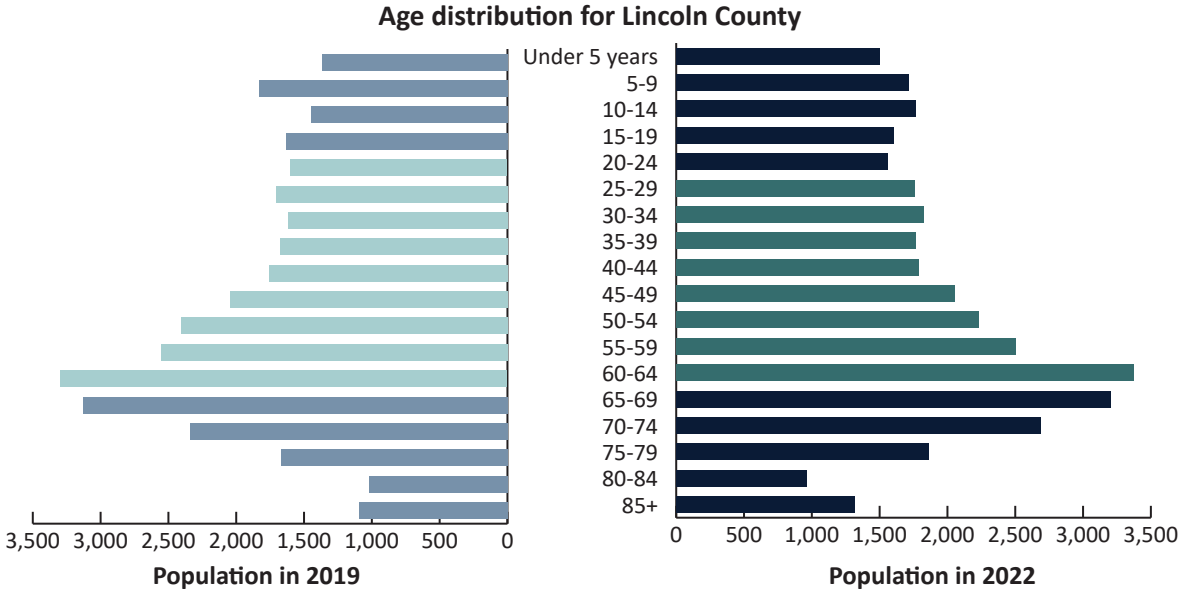
The following tables and chart show information about the population of Lincoln County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Lincoln County Population	State of Maine Population
35,466	**1,366,949**

	Lincoln	Maine
Median household income	**$69,638**	**$68,251**
Unemployment rate	**2.7%**	**3.1%**
Individuals living in poverty	**9.1%**	**10.9%**
Children living in poverty	**14.8%**	**13.4%**
65+ living alone	**28.4%**	**29.5%**

	Lincoln County	
	Percent	Number
American Indian/Alaskan Native	**0.5%**	**163**
Asian	**0.9%**	**306**
Black/African American	**0.5%**	**168**
Native Hawaiian or other Pacific Islander	**0.0%**	**0**
Some other race	**0.3%**	**108**
Two or more races	**3.8%**	**1,352**
White	**94.1%**	**33,369**
Hispanic	**1.6%**	**577**
Non-Hispanic	**98.4%**	**34,889**

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 Lincoln County.

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

Health Equity

Definitions

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

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

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

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

Health Equity and Community Engagement

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

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

Community Engagement Findings

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

Socioeconomic Empowerment

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

Lincoln County	Maine
1)Affordable & quality childcare	1) Jobs that pay enough to support a living wage
2) Affordable & available health care	2) Affordable and safe housing
3) Affordable and safe housing	3) Mental health care and treatment
4) Jobs that pay enough to support a living wage	4) Affordable & available health care
5) Quality educational opportunities (college, trade, or technical school)	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 Lincoln 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.

Lincoln County Strengths

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

- Safe neighborhoods;
- Locally owned businesses;
- Low crime;
- A healthy environment; and
- Safe opportunities to be active outside.

People living in Lincoln County have a positive outlook on their health and well-being – 82% of survey respondents believe their community is healthy or very healthy; 82% rate their own physical health as good or excellent and 81% 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 Lincoln 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.

Lincoln County Community Conditions		
Housing	Poverty	Transportation

Housing

Housing was the top priority for the community conditions category for Lincoln 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 Lincoln County focus group "safe and affordable housing" was a top theme. One participant said:

"Our property manager is very dedicated, but he has 150 apartments – he does the best he can do."

In the Maine Shared CHNA survey, respondents said "housing insecurity" was the third of five top social concerns negatively impacting their community and 66.6% said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs three-quarters or more of respondents said the following impact their community:

- "Availability of affordable, quality homes/rentals" (87.3%).
- "Issues associated with home ownership or renting" (83.6%).
- "Availability of affordable, quality housing for older adults or those with specific needs" (80%).
- "Housing costs" (78.2%).
- "Cost of utilities" (74.5%).

In Lincoln County 9.5% of households spend more than 50% of their income toward housing, significantly better than the U.S. (14.1%, 2018-2022). The median gross rent, based on the most recent data (2018-2022) is $930, significantly higher than 2015-2019 ($819), but significantly lower than Maine ($1,009) and the U.S. ($1,268).

Participants at the Lincoln County stakeholder forum discussed factors impacting housing, with many references to the housing landscape. These include increasing interest rates, decreased variation in housing types, high housing valuation, and outside corporations buying property. Participants noted increases in tourism and short-term rentals, seasonal housing, housing migration, and remote work as impacting housing availability. There is a general lack of availability and a decrease in housing development, which may be due to the "not in my backyard" sentiment, construction costs, lack of builders, zoning limits and housing density, and a lack of land. As of 2022, 1.2% of housing units were vacant and for rent or sale and 66.9% of housing was occupied (2018-2022).

Additional root causes were related to financial concerns, such as fewer landlords accepting vouchers, earning disparities leading to an inability to afford a home, high rental costs, and the cost of utilities. It was also noted Lincoln County does not have a homeless shelter. In 2023, 53 children were experiencing homelessness and 3.1% of high school students were housing insecure.

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 safe housing" was rated number three by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Housing

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

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:

- Boothbay VETS
- Community Housing Improvement Project
- Community Housing of Maine
- Council of Governments
- Department of Economic Community Development
- Developers Collaborative, LLC
- Ecumenical Homelessness Prevention Council
- Genesis Fund
- Habitat for Humanity
- Homeworthy
- Housing Authority
- Knox County Homeless Coalition
- MaineHousing
- Midcoast Humane Society
- Midcoast Maine Community Action
- New Hope Transitional Housing
- Stepping Stones
- Tedford Housing
- United Way, specifically emergency funds and Keep Me Warm funds
- Vet tiny homes

Poverty

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

Assessment Findings

In Lincoln County,

- 9.1% of individuals live in poverty (2018-2022), significantly better than 2015-2019 (12.3%), Maine (10.9%), and the U.S. (12.5%).
- 5.7% of families live below the federal poverty level, significantly better than the U.S. (8.8%, 2018-2022).
- 14.8% of children live in poverty (2018-2022).
- 30.9% of households lived above the federal poverty level, but below the Asset Limited, Income Constrained, Employed (ALICE) threshold for financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy.
- 14% of people were asset poor, meaning they had insufficient net worth to live without income at or above the poverty level for three months, significantly better than Maine (18%) and the U.S. (19%).

In the Lincoln County focus group, one participant said:

"We're on social security; we have to tighten our belts. We have car payments. We don't go out much."

In the Maine Shared CHNA survey, 63% of survey respondents said "economic needs" negatively impacted them, a loved one, and/or their community. When asked about specific economic needs, "availability of quality, affordable childcare" (82.1%) and "access to affordable, quality foods" (76.8%) rose to the top as negative impacts on respondents' communities. In 2022, 11.8% of adults and 18.8% of youth were food insecure. In the Maine Shared CHNA survey, "child care" was the fifth of five social concerns negatively impacting respondents' community. In 2023, 46.1% of children were served in publicly funded state and local preschools and as of 2024, there were 24 child care centers.

In the Lincoln County stakeholder forum, participants discussed the high costs associated with living such as education, medical care, and insurance. They noted that incomes often don't match expenses, and a perception people use credit cards to cover gaps. The median household income in Lincoln County is $69,638 (2018-2022), significantly better than 2015-2019 ($57,720), but significantly worse than the U.S. ($75,149). Participants believe there is a

lack of funding for social programs such as the Women, Infants and Children (WIC) program and Supplemental Nutrition Assistance Program (SNAP). A lack of transportation was also cited as a contributing factor to poverty.

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty and to a place of stability "affordable and quality childcare" was number one, "jobs that pay enough to support a living wage" was rated number four, and "quality educational opportunities" was rated number five by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Poverty

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

Community Resources to Address Poverty

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

- Alfond Fund
- Boothbay Region Resource Council
- Boothbay Vets Housing Program
- Community Housing Improvement Project
- Earn While You Learn
- Faith-based organizations
- Food pantries
- General Assistance
- Habitat for Humanity
- Maine Community College System
- Midcoast Maine Community Action
- Temporary Assistance for Needy Families program
- Town navigators

Crosscutting Priorities

Transportation

Transportation

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

Assessment Findings

"Reliable transportation" was a top theme in the Lincoln County focus group. In the Maine Shared CHNA survey, 62.6% of respondents said "transportation needs" negatively impact them, a loved one, and/or their community. When asked about specific transportation needs, respondents said the following impact their community:

- "Availability of transportation that meets a variety of specific needs" (81.5%).
- "Availability of public transportation" (77.8%).
- "Access to transportation" (75.9%).

Lincoln County stakeholder forum participants echoed the survey respondents, citing a lack of transportation and transportation infrastructure, as well as costs associated with vehicle ownership. Quantitative data shows that in Lincoln County 5.4% of households do not have a vehicle, significantly better than the U.S. (8.3%, 2018-2022) and 36.9% of people have a commute greater than 30 minutes driving alone.

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: rural communities, older adults, young adults, adults, teens, and the disability community.

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:

- Concord Coach
- FISH (Friends in Service Helping)
- Food pantry home delivery
- Lincoln County Regional Planning
- Meals on Wheels
- Midcoast Connector Non-Emergency Transportation
- Midcoast Council of Governments
- Midcoast Public Transportation
- Northern New England Passenger Rail Authority expansion of the Downeaster
- Schools
- Taxis

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 Lincoln 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.

Lincoln County Protective & Risk Factors			
Nutrition	Substance Use	Adverse Childhood Experiences	Preventive Oral Care

Nutrition

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

Assessment Findings

In the Maine Shared CHNA survey, of the 63% of respondents who said "economic needs" impacted them, a loved one, and/or their community, 76.8% said "access to affordable, quality foods" negatively impacts their community, 25% said it negatively impacts a loved one and 17.9% said it negatively impacts them. In Lincoln County,

- 11.8% of adults and 18.8% of youth were food insecure (2022).
- 27.8% of adults consumed less than one serving of fruit per day and 7.7% consumed less than one serving of vegetables per day, both significantly better than Maine (35% and 13.1%) and the U.S. (39.7% and 20.4%, 2021).
- 16.3% of high school and 20% of middle school students consumed at least five servings of fruit and vegetables per day (2023).
- 22.7% of high school and 25.2% of middle school students consumed one or more soda/sports drinks per day (2023).

Lincoln County stakeholder forum participants discussed the impact of community conditions such as poverty and education on nutrition, specifically not knowing what resources are available. They also cited a lack of healthy, convenient food options. Mental health, specifically day-to-day stress, was also mentioned at the forum as related to nutrition. Of the 67.5% of survey respondents who said "mental health needs" negatively impacts them, a loved one, and/or their community, "general stress of day-to-day life" impacts them (50.9%), a loved one (43.9%), and their community (54.4%).

Populations and Communities Impacted by Nutrition

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

Community Resources to Address Nutrition

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

- Backpack programs
- Ecumenical Homelessness Prevention Council
- Farmers' markets
- Food banks, pantries, and help yourself shelves
- Food Security Council in Wiscasset
- Good Shepherd Food Bank
- Head Start
- Healthy Lincoln County
- Kieve Wavus
- Libraries
- Lincoln County Food Initiative
- MaineHealth Medical Groups, Lincoln Hospital Emergency Food Bags and Help Yourself Shelves
- Meals on Wheels
- Schools
- Twin Villages Food Bank Farm
- Veggies to Table
- YMCA

Crosscutting Priorities

Poverty **Mental Health**

Substance Use

Substance use was the second rated priority for the protective and risk factors category for Lincoln County. Participants at the Lincoln County stakeholder forum agreed to combine individual substances into one overarching category of substance use. Substance use includes but is not limited to substances such as: alcohol, cannabis, illicit drugs, and tobacco.

Assessment Findings

In the Maine Shared CHNA survey, "substance use" was the second of five social concerns negatively impacting the community and 56.6% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substance use, a majority of respondents said substances impact their community, including:

- Alcohol use or binge drinking (68.6%),
- tobacco use (68.6%),
- vaping (66.7%),
- other illicit drug use (64.7%),
- adult cannabis use (62.7%),
- opioid misuse (60.8%), and
- youth substance use (54.9%).

Table 1: Substance Use Indicators contains several substance use indicators for Lincoln County related to those highlighted in the Maine Shared CHNA survey.

Table 1: Substance Use Indicators	Lincoln County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Substance Use							
Chronic heavy drinking (adults)	2015-2017 **10.2%**	2019-2021 **8.4%**	○	2019-2021 **8.4%**	○	2021 **6.3%**	N/A
Past-30-day alcohol use (high school students)	2019 **25.8%**	2023 **19.1%**	○	2023 **20.5%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2019 **2.9%**	2023 **4.3%**	○	2023 **4.8%**	○	—	N/A
Binge drinking (adults)	2015-2017 **16.5%**	2019-2021 **14.7%**	○	2019-2021 **15.5%**	○	2021 **15.4%**	N/A
Binge drinking (high school students)	2019 **9.4%**	2023 **7.4%**	○	2023 **9.6%**	!	—	N/A
Binge drinking (middle school students)	2019 **~**	2023 **1.6%**	N/A	2023 **1.8%**	!	—	N/A
Past-30-day marijuana use (adults)	2015-2017 **16.3%**	2019-2021 **22.5%**	○	2019-2021 **21.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2019 **24.9%**	2023 **17.7%**	N/A	2023 **18.7%**	N/A	—	N/A
Past-30-day marijuana use (middle school students)	2019 **3.9%**	2023 **5.4%**	○	2023 **5.0%**	!	—	N/A
Past-30-day misuse of prescription drugs (adults)	2011-2021 **0.8%**	—	N/A	2011-2021 **0.9%**	N/A	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2019 **5.7%**	2023 **6.3%**	○	2023 **5.2%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2019 **2.6%**	2023 **2.3%**	○	2023 **4.9%**	★	—	N/A
Lifetime illicit drug use (high school students)	—	2023 **3.7%**	N/A	2023 **3.6%**	○	—	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.

Stakeholders at the Lincoln County stakeholder forum discussed the impact of healthcare and insurance on substance use, including lack of providers, difficult insurance processes, inadequate insurance, and insurance tied to employment. When insurance is tied to employment, forum participants note this is akin to employment enabling healthcare access. In 2024, there were 40,952 people for every psychiatrist in Lincoln County, 470 people for every mental health provider, and 1,370 people for every primary care provider. In Lincoln County, 8.9% of people are uninsured (2018-2022), significantly worse than Maine (7.1%) and 25.9% of adults are enrolled in MaineCare (2020).

Economic factors contributing to substance use were discussed at the forum including poverty and income disparities, specifically due to the lack of large industry employers. Mental health,

day-to-day stress, stigma, and shame were also discussed as root causes of substance use. Of the 67.5% of Maine Shared CHNA survey respondents who said “mental health needs” negatively impacts them, a loved one, and/or their community, “general stress of day-to-day life” impacts them (50.9%), a loved one (43.9%), and their community (54.4%).

Community conditions such as education, transportation, media and policy influences were identified as contributing factors to substance use, along with cultural norms and generational factors.

Populations and Communities Impacted by Substance Use

Substance use was a priority added during the forum, so not addressed in the pre-forum survey; however, alcohol use was. For alcohol use, respondents cited: adults, young adults, teens, older adults, and people with substance use disorder.

Community Resources to Address Substance Use

In the pre-forum survey, respondents identified assets and resources for alcohol use; those are noted with an asterisk and may apply to other substances. Participants at the forum were asked to identify assets and resources related to their priorities. For substance use, respondents identified:

- 211
- 12 Step Meetings*
- Alcoholics Anonymous*
- Central Lincoln County and Boothbay Region YMCA
- Churches acting as hosts for Alcoholics Anonymous
- Community Resource Center
- Employee Assistance Program
- Health insurances
- Healthy Kids
- Healthy Lincoln County
- Law enforcement
- Lincoln County Community Recovery Center*
- Lincoln County Dispatch and Emergency Management
- Lincoln Hospital Primary Care*
- Maine Center for Disease Control and Prevention
- Maine Prevention Network
- MaineHealth Lincoln Hospital Community Health
- Mid Coast Hospital Addiction Resource Center*
- My Life My Quit
- Naloxone distribution
- OPTIONS
- QuitLink
- School Based Health Centers
- Schools
- Two Bridges Jail

Crosscutting Priorities

Poverty **Transportation** **Mental Health**

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the third rated priority for the protective and risk factors category for Lincoln County. ACEs are potentially traumatic events that occur in childhood, such as experiencing abuse or neglect; witnessing violence; or the death of a family member by suicide and aspects of a child’s environment, such as substance use, mental health problems, and instability in the home due to parental separation or an incarcerated family member.

Assessment Findings

In the Maine Shared CHNA survey, three of the five top social concerns that negatively impact the Lincoln County community could be associated with ACEs – mental health issues, substance use, and housing insecurity. Of the 67.5% of respondents who said "mental health needs" negatively impact them, a loved one, and/or their community, 50.9% and 22.8% said "youth mental health" negatively impacts their community and a loved one, respectively. In Lincoln County,

- 30.3% of high school students had at least four of nine adverse childhood experiences (2023).
- 37.8% of high school and 38.2% of middle school students were sad/hopeless for two weeks in a row, with the percentage of middle school students significantly worse than Maine (32.7%, 2023).
- 20.5% of high school and 26.3% of middle school students seriously considered suicide, with the percentage of high school students significantly worse than Maine (17.8%, 2023).
- For every 1,000 children there were 4.5 in foster care (2024).

Lincoln County stakeholder forum participants also discussed the impacts of mental health on ACEs, specifically day to day stress, stigma, shame, and generational factors. They discussed community conditions such as poverty and education, along with a lack of providers. In 2024 in Lincoln County there were 40,952 people for every psychiatrist and 470 people for every mental health provider.

Populations and Communities Impacted by Adverse Childhood Experiences

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

Community Resources to Address Adverse Childhood Experiences

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

- Chewonki
- Coordinated Entry
- Healthy Families
- Healthy Kids
- Hearty Roots
- Home Counselors, Inc
- Home to Home
- Homeless Hub
- Lincoln Hospital
- Maine Resilience Building Network
- Maine Trans Net
- MaineHealth Lincoln Hospital Community Health
- Midcoast Community Collaborative
- NAMI Maine
- New Hope
- OUT Maine
- Resource Families
- Restorative justice programs
- Schools, specifically counselors and social workers and extracurricular activities
- Sexual Assault Response Services of Southern Maine

Crosscutting Priorities

Poverty **Mental Health**

Preventive Oral Care

During the Lincoln County stakeholder forum, several participants lobbied in favor of including preventive oral care as a fourth priority under the protective and risk factors category and came to consensus to include it. However, participants in the community engagement efforts did not discuss preventive oral care, nor did participants at the Lincoln County stakeholder forum. This is a priority that warrants further discussion by partners to determine ways to address it.

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 Lincoln 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.

Lincoln County Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Obesity & Weight Status**

Mental Health

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

Assessment Findings

In the Maine Shared CHNA survey, "mental health issues" was the number one social concern negatively impacting the community and 67.5% 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," was experienced by survey respondents' loved ones (54.4%) and themselves (42.1%).
- "Depression" was experienced by respondents' community (52.6%) and their loved ones (52.6%).
- "General stress of day-to-day life" was experienced by respondents' community (54.4%), their loved ones (43.9%), and themselves (50.9%).

Data shows in Lincoln County 9.2% of adults have current symptoms of depression, 21.4% have had depression in their lifetime, and 18.9% have had anxiety in their lifetime (2019-2021).

In the Lincoln County stakeholder forum, participants discussed the root causes and contributing factors to mental health. Forum participants noted the various manifestations of stress, including occupational stress, economic stress, and stress endured by minority populations. Insurance access and cost and access to and cost of care were also discussed at the forum. In Lincoln County, 8.9% adults are uninsured, significantly worse than Maine (7.1%, 2018-2022). Cost barriers to health care were experienced by 6.9% of adults, significantly better than Maine (9.7%, 2019-2021).

In the Maine Shared CHNA survey, 80.8% of respondents rated their own mental health as "good or excellent" and 42.3% of respondents said they or a loved one could not or chose not to get mental health care in the past year. Respondents cited barriers such as "long wait times to see a provider," "did not feel comfortable with available providers," and "no evening or weekend hours to receive care." In 2024 there were 40,952 people for every psychiatrist and 470 people for every mental health provider in Lincoln County. During the period 2019-2021,16.8% of adults were receiving outpatient mental health treatment (2019-2021).

Additionally, forum participants discussed the lack of connection and mattering, trauma, isolation, and the impacts of social media as contributing factors to mental health. Forum participants would like to see more activities in the community, specifically for seniors, free access to community centers, and safe gathering spaces for youth. They would also like to see more pediatric mental health care. Forum participants discussed the assets in the community including access to the food system, summer camps and recreation opportunities, more frequently held community events, robust community groups, community-oriented businesses and employer support, and social connectedness.

Populations and Communities Impacted by Mental Health

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

Community Resources to Address Mental Heath

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

- Hearty Roots
- Libraries
- MaineHealth Behavioral Health
- MaineHealth Lincoln Hospital Community Health
- Preschool Pediatric Symptom Checklist Screening
- School Based Health Centers
- Schools
- YMCAs

Crosscutting Priorities

Poverty **Adverse Childhood Experiences**

Substance Use Related Injury & Death

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

Assessment Findings

In the Maine Shared CHNA survey, "substance use" was the second of five social concerns negatively impacting the community and 56.6% said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substance use, a majority of respondents said substances impact their community, including:

- alcohol use or binge drinking (68.6%),
- other illicit drug use (64.7%), and
- opioid misuse (60.8%).

In Lincoln County,

- There were 20 overdose deaths per 100,000 people (2023).
- There were 42.3 drug-induced deaths per 100,000 people (2018-2022).
- There were 16.5 alcohol-induced deaths per 100,000 people (2018-2022).
- 8.4% of adults engage in chronic heavy drinking (2019-2021).
- 14.7% of adults engage in binge drinking (2019-2021).

At the Lincoln County stakeholder forum participants discussed mental health as a theme that impacts substance use related injury and death, specifically trauma, adverse childhood experiences, isolation, stress, specifically occupation related, and a lack of connection through gathering spaces and social groups. Other contributing factors include generational and family dynamics. Respondents would like to see an increase in the use of restorative justice programs and harm reduction programs.

Populations and Communities Impacted by Substance Use Related Injury and Death

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

Community Resources to Address Substance Use Related Injury and Death

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

- Healthy Lincoln County
- Lincoln County Recovery Community Center
- MaineHealth Medical Group, Lincoln Hospital
- Medication Assisted Treatment

Crosscutting Priorities

Adverse Childhood Experiences **Mental Health**

Obesity and Weight Status

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

Assessment Findings

In the Maine Shared CHNA survey, 75.6% of respondents said, "chronic health conditions," of which obesity and weight status is one, negatively impacted them, a loved one, and/or their community. Of those respondents, 46.8% said overweight/obesity negatively impacted their community, a loved one (43.5%), or themselves (30.6%). In 2021, 25.5% of adults in Lincoln County were obese, significantly better than Maine (31.9%) and the U.S. (33.9%). In 2023, 20.6% of high school and 17.1% of middle school students were obese.

Participants at the Lincoln County stakeholder forum discussed community conditions that may contribute to obesity and weight status such as: poverty, geography and transportation, community infrastructure, economics and inflation, the built environment, specifically a lack of outdoor opportunities accessible to all ages and abilities, and land use policies. Of the 62.5% survey respondents who said "environmental needs" negatively impact them, a loved one, and/or their community, "access to parks and green spaces for recreation" negatively impact respondents (24.1%) and their community (53.7%). Of the 55% of survey respondents who said "public safety needs" negatively impact them, a loved one, and/or their community, "pedestrian or bicycle safety" negatively impacts them (20.8%) and their community (60.4%).

Food and nutrition were also discussed as contributing factors. These include poor nutrition and policies that may promote the purchase of processed food, access to healthy, local, affordable food, cooking skills, time constraints for cooking, and a lack of equipment and space for cooking. In Lincoln County,

- 11.8% of adults and 18.8% of youth were food insecure (2022).
- 27.8% of adults consumed less than one serving of fruit per day and 7.7% consumed less than one serving of vegetables per day, both significantly better than Maine (35% and 13.1%) and the U.S. (39.7% and 20.4%, 2021).
- 16.3% of high school and 20% of middle school students consumed at least five servings of fruit and vegetables per day (2023).
- 22.7% of high school and 25.2% of middle school students consumed one or more soda/sports drinks per day (2023).

A lack of physical activity was discussed at the forum, including increased device and social media use, which may detract from activity and promote unhealthy norms. In Lincoln County,

- 24.9% of adults had a sedentary lifestyle (2021).
- 55.5% of adults met physical activity recommendations (2017 & 2019).
- 48.9% of high school and 55.2% of middle school students met physical activity recommendations (2023), both significantly better than 2019 (22.9% and 24.7%) and middle school percentages significantly better than Maine (50.2%, 2023).

Participants believe stress, cultural norms, stigma, and shame may also all contribute to obesity and weight status.

Populations and Communities Impacted by Obesity and Weight Status

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For obesity and weight status, respondents cited: youth, Asset Limited, Income Constrained, Employed (ALICE) families, older adults, teens, young adults, adults, and older adults.

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:

- Central Lincoln County and Boothbay Region YMCAs
- Diabetes prevention programs
- Farms
- Food pantries
- Grow to Give
- Health curriculums
- Healthy Lincoln County
- Hearty Roots
- Local fitness centers
- Local land trusts
- School Meals for All
- Schools
- Supplemental Nutrition Assistance Program
- Teens to Trails
- Women, Infants and Children Program

Crosscutting Priorities

Transportation **Poverty** **Nutrition**

Adverse Childhood Experiences **Mental Health**

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;"[viii]
- 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)

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

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

Community

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

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

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

Service Environment
- Health Care
- Education
- Social Services

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

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

Mortality
- Infant & Child Mortality
- Life Expectancy

*Blue indicates a sampling of the SCHNA quantitative

Stakeholder Forums

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

One in-person stakeholder forum was held in Lincoln County on November 18, 2024, with 28 attendees. People from the following organizations participated in the forum process:

- Boothbay Region Elementary School
- Central Lincoln County YMCA
- Common Space
- Healthy Kids
- Hearty Roots
- Kieve Wavus Education
- LincolnHealth
- Maine CDC Midcoast District Public Health
- Maine Center for Disease Control and Prevention
- Maine Legislature
- MaineHealth
- MaineHealth- LincolnHealth
- MCD Global Health
- Midcoast Maine Community Action
- New Hope Midcoast
- Regional School Unit 40
- Town of Damariscotta
- Town of Newcastle
- United Way of Mid Coast Maine
- Wiscasset Middle High School

Reporting

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

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

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

Appendix 2: Other Identified Health and Well-Being Topics

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

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

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	13	86.7%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	8	53.3%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	8	53.3%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	7	46.7%
Wage Gaps and Income Disparities	6	40.0%
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)	6	40.0%
Education (such as pre-K through post-secondary and technical/trade opportunities)	4	26.7%
Climate Impacts (such as extreme weather events)	3	20.0%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	3	20.0%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	3	20.0%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	2	13.3%
Isolation	2	13.3%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	2	13.3%
Stigma Around Accessing/Accepting Help, Services, or Treatment	2	13.3%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	1	6.7%
Employment Opportunities	1	6.7%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	1	6.7%
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.)	1	6.7%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	20	62.5%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	10	66.7%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	9	60.0%
Adverse Childhood Experiences	8	53.3%
Alcohol Use (including binge drinking)	7	46.7%
Preventive Oral Health Care	5	33.3%
Youth Mattering (such as positive role models, community connections, etc.)	5	33.3%
Illicit Drug Use	5	33.3%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	4	26.7%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	3	20.0%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	3	20.0%
Cannabis Use	3	20.0%
Prescription Drug Misuse	3	20.0%
Cancer Prevention (such as cancer screenings, sunscreen use)	2	13.3%
Access to Child and Family Home Visiting	2	13.3%
Vaping Use (including tobacco and cannabis)	2	13.3%
Injury Prevention (such as fall prevention, always wear a seat belt)	1	6.7%
Immunizations & Vaccinations	1	6.7%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	14	93.3%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	9	60.0%
Cancer	8	53.3%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	8	53.3%
Obesity/Weight Status	8	53.3%
Diabetes	6	40.0%
Intentional Injury & Death (self-injury)	5	33.3%
Cognitive Decline, Alzheimer's disease and other dementias	3	20.0%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	3	20.0%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	2	13.3%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	2	13.3%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	1	6.7%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	1	6.7%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	1	6.7%
Dental Disease	1	6.7%
Multiple Chronic Conditions	1	6.7%

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

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

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	27	96.4%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	17	60.7%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	16	57.1%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	14	50.0%
Wage Gaps and Income Disparities	8	28.6%

Protective and Risk Factors	# Votes	% of Participants
Substance use	19	67.9%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	18	64.3%
Adverse Childhood Experiences	17	60.7%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	14	50.0%
Preventive Oral Health Care	7	25.0%
Alcohol Use (including binge drinking)	5	17.9%
Access to firearms	2	7.1%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	26	92.9%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	21	75.0%
Obesity/Weight Status	10	35.7%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	8	28.6%
Cancer	6	21.4%
Intentional injury	6	21.4%
Unintentional injury	5	17.9%

Appendix 3: Community Action Agency Profile

MIDCOAST MAINE
Community Action
Building better lives for stronger communities

About Midcoast Maine Community Action

Midcoast Maine Community Action (MMCA) empowers people to build better lives for stronger communities. The agency connects the community with resources that promote health and quality of life, education and economic independence. MMCA supports regional activities which encourage economic sustainability and social equity within the Midcoast area.

Services Offered by MMCA

- Assistance with Utility disconnects
- Assistance with heating if tank is under ¼ of a tank and a maximum of 100 Gallons per year
- Health Insurance Marketplace Navigation
- Family Development Account Programs (FDA)
- Women, Infant, and Children Program (WIC)
- Child Abuse and Neglect Prevention Program (Families CAN!)
- Head start and Early Head Start
- Family Development Case Management
- Home Energy Assistance Program (HEAP)
- Judith Williams Scholarship Program
- Diaper Distribution Program
- Whole Families Coaching

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Endnotes

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

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

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

viii 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

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