Sagadahoc 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 Sagadahoc 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

Sagadahoc County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Housing (ME)	Adverse Childhood Experiences (ME)	Mental Health (ME)
Provider Availability (ME)	Youth Mattering	Substance Use Related Injury & Death
Child Care	Cannabis Use	Obesity & Weight Status

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

Transportation

Poverty

Chronic Conditions

Substance Use

Nutrition

Next Steps

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

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

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

Report Outline

This report is broken into three sections.

1. Data on Sagadahoc 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 Sagadahoc 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

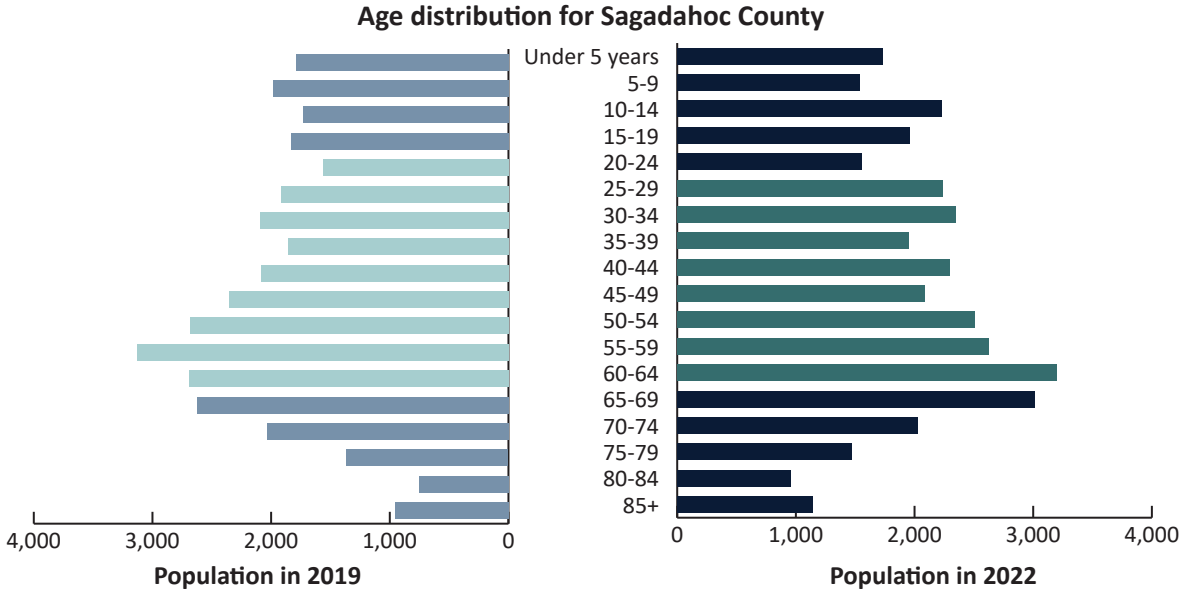
The following tables and chart show information about the population of Sagadahoc County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Sagadahoc County Population	State of Maine Population
36,868	**1,366,949**

	Sagadahoc	Maine
Median household income	**$77,591**	**$68,251**
Unemployment rate	**2.2%**	**3.1%**
Individuals living in poverty	**10.9%**	**10.9%**
Children living in poverty	**11.9%**	**13.4%**
65+ living alone	**24.1%**	**29.5%**

	Sagadahoc County	
	Percent	Number
American Indian/Alaskan Native	**0.3%**	**103**
Asian	**0.7%**	**242**
Black/African American	**0.6%**	**212**
Native Hawaiian or other Pacific Islander	**0.0%**	**0**
Some other race	**0.6%**	**205**
Two or more races	**3.3%**	**1,228**
White	**94.6%**	**34,878**
Hispanic	**2.0%**	**729**
Non-Hispanic	**98.0%**	**36,139**

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 Sagadahoc County.

Cause of Death	Maine	Sagadahoc County
Cancer	**25.9%**	**29.5%**
Heart disease	**27.2%**	**25.4%**
Chronic lower respiratory disease	**6.8%**	**9.1%**
Cerebrovascular disease	**4.8%**	**6.3%**
Alzheimer's disease	**4.1%**	**5.3%**
Diabetes	**4.6%**	**4.4%**
COVID 19	**6.0%**	**4.4%**
Accidents	**10.5%**	**4.1%**
Parkinson's disease	**1.7%**	**3.1%**
Influenza & pneumonia	**2.1%**	**2.5%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**2.5%**
Chronic liver disease and cirrhosis	**2.3%**	**2.5%**
Suicide	**2.0%**	**0.9%**

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.

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

Sagadahoc County Strengths

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

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

People living in Sagadahoc County have a positive outlook on their health and well-being – 76.7% of survey respondents believe their community is healthy or very healthy; 69.8% rate their own physical health as good or excellent and 67.4% 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 Sagadahoc 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.

Sagadahoc County Community Conditions		
Housing	Provider Availability	Child Care

Housing

Housing was the top priority for the community conditions category for Sagadahoc 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 Maine Shared CHNA survey, survey respondents listed "housing insecurity" as the third of five top social concerns negatively impacting their community and 69.7% said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, the following negatively impact respondents' communities:

- "Availability of affordable, quality homes/rentals" (85.7%)
- "Availability of affordable, quality housing for older adults or those with special needs" (71.4%)
- "Issues associated with home ownership or renting" (77.1%).
- "Homelessness and/or availability of shelter beds" (85.7%).
- "Costs of utilities" (74.3%).

In Sagadahoc County data shows,

- 11.6% 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 is $991 (2018-2022), significantly better than the U.S. ($1,268).
- 1.6% of housing units were vacant and for sale or rent (2022).
- 84.5% of housing is occupied (2018-2022).
- 63 children were experiencing homelessness (2023).
- 2.4% of high school students were housing insecure (2023).

Sagadahoc County stakeholder forum participants also discussed the lack of housing availability, attributing it to several factors such as a "not in my backyard" attitude, especially as it relates to services and shelter for the unhoused population; the use of housing for short term rentals; and barriers to building due to land use and zoning regulations. Forum participants also discussed the cost of housing and how housing vouchers may be helpful but come with challenges such as the potential for stigma associated with their use, a lack of landlords who accept them, and unresponsive to changes in cost of living because of voucher funding mechanisms.

Socioeconomic Empowerment

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

Populations and Communities Impacted by Housing

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For housing, respondents cited: older adults, people living in rural areas, people with disabilities, unhoused/housing insecure, New Mainers/immigrants, formerly incarcerated, empty nesters, people with young children, young adults, youth aging out of foster care, people with poor credit, 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:

- Bath Housing Authority
- Bowdoin College homeownership loan forgiveness
- Brunswick Topsham Housing Authority
- General Assistance
- Harpswell Supports Aging at Home
- Immigrant Resource Center of Maine
- Maine Department of Education McKinney Vento
- MaineHousing, specifically Eviction Prevention Programming
- Midcoast Youth Center's Transitional Living
- Municipal Housing Committees
- Nesterly
- Rapid rehousing programs for youth
- Southern Midcoast Housing Collaborative
- Tedford Housing
- The Gathering Place
- Veterans Affairs vouchers

Provider Availability

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

Assessment Findings

In the Maine Shared CHNA survey, 41.9% of respondents said they or a loved one could not or chose not to get health care services in the past year citing "long wait times to see a provider"

as the number one reason. A similar percentage (46.5%) had not received mental health care for the same reason. In Sagadahoc County,

- There were 1,802 people for every physician and 430 people for every mental health provider (2024).
- 90% of adults have a usual primary care provider (2019-2021).
- 77.8% had been to a primary care provider in the past year (2019-2021).
- 20.5% percent of adults were receiving outpatient mental health treatment (2019-2021).

Participants at the Sagadahoc County stakeholder forum discussed root causes and contributing factors to provider availability, many related to the types of providers available, the health system infrastructure, and insurance challenges. Participants noted specific types of providers are lacking, specifically those who work with youth using substances, those who work with older and aging adults, and providers trained in cultural competency. Forum participants believe providers are not compensated appropriately and are not moving to the area to practice upon completion of their degree and training programs. Regarding insurance, participants see the for-profit health insurance industry as problematic and noted providers are not accepting insurance or changes in insurance coverage that prohibit care. In 2020, 21.5% of adults in Sagadahoc County were enrolled in MaineCare and 35.3% of those 0 to 19 were enrolled in MaineCare. In Sagadahoc County 6.4% of people have experienced cost barriers to health care (2019-2021).

Socioeconomic Empowerment

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

Populations and Communities Impacted by Provider Availability

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For provider availability, respondents cited: older adults, New Mainers/immigrants, people who use substances, people with a mental health disorder, youth, adults, children, and teens.

Community Resources to Address Provider Availability

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

- Bath Recovery Center
- Emergency Medical Services
- Federally Qualified Health Centers
- Groups Recover Together
- Jessie Albert Dental Clinic
- MaineCare, specifically the coverage of care management
- MaineHealth Behavioral Health
- MaineHealth Mid Coast Hospital
- Martin's Point
- Medical Debt Forgiveness Programs
- NAMI Maine
- Oasis Free Clinics
- OPTIONS
- Pathways
- Pharmacies
- School-based health centers in RSU 1 and SAD 75
- University of Maine Augusta Dental School
- University of New England Dental Care
- Women, Infants and Children Program

Child Care

Child care was the third priority for the community conditions category for Sagadahoc County. For the purposes of the prioritization process, child care includes such topics as access to child care, quality of child care, and affordability of child care.

Assessment Findings

In the Maine Shared CHNA survey, respondents said "child care" was the fifth of five top social concerns negatively impacting their community. Of the 74.4% of survey respondents who cited "economic needs" as negatively impacting them, a loved one, and/or their community, 78.9%, 21.1%, and 15.8% said "availability of quality, affordable child care" negatively impacted their community, a loved one, and them, respectively. In 2023, 38.1% of children in Sagadahoc County were served in publicly funded state and local preschools and in 2024, there were 18 child care centers.

Sagadahoc County stakeholder forum participants discussed the affordability of child care, noting there are few programs to help people pay for child care and MaineCare often has an eligibility cliff. Available assets in the community include child care vouchers, the child tax credit, and after-care programs. In Sagadahoc County 15% of infants, toddlers, and preschool age children are eligible for Head Start (2017-2021).

Forum participants discussed how it can be expensive to run a child care facility because of regulations, staffing, and wages. In Maine, the average Head Start teachers hourly wage is $17.91 and the average wage for a Head Start teacher's assistant is $13.14 (2021-2022). Currently, stipends for child care workers are an available asset. Participants would like to see heavily subsidized or universal child care, more third spaces for child care, and child care that is developmentally appropriate.

Populations and Communities Impacted by Child Care

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 child care, respondents cited: policymakers, children, youth, teens, employers, grandparents, New Mainers/immigrants, adults, and young adults.

Community Resources to Address Child Care

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 child care, respondents identified:

- Bath Area YMCA
- BIW child care center
- Bowdoin College
- Employer funded day care programs
- Family Focus
- Head Start
- Merrymeeting Adult Education
- Public pre-K
- Vocational education program

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 Sagadahoc 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.

Sagadahoc County Protective & Risk Factors		
Adverse Childhood Experiences	Youth Mattering	Cannabis Use

Adverse Childhood Experiences

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

Assessment Findings

In the Maine Shared CHNA survey, three of the five top social concerns that negatively impact the community could be associated with ACEs – mental health issues, housing insecurity, and substance use. Three-quarters of survey respondents said, "economic needs," a potential root cause of ACEs, impacts them, a loved one, and/or their community. Of the 69.7% of Maine Shared CHNA survey respondents who said "mental health needs" negatively impact them, a loved one, and/or their community, half (55.6%) said youth mental health negatively impacts their community and one-quarter said it impacts a loved one.

In Sagadahoc County,

- 30.5% of high school students in Sagadahoc County had at least four of nine adverse childhood experiences (2023).
- 40.5% of high school students reported feeling sad/hopeless for two weeks or more in the past year, significantly worse than Maine (35%, 2023).
- 35% of middle school students reported feeling sad/hopeless for two weeks in a row (2023).

- 22.8% of high school students seriously considered suicide in the past year, significantly worse than Maine (17.8%, 2023).
- 24.2% of middle school students have seriously considered suicide at least once in their lifetime (2023).

Participants at the Sagadahoc County stakeholder forum discussed root causes and contributing factors for adverse childhood experiences. Several community conditions and systemic factors were noted including poverty, systemic racism, and system failures, such as those within the Maine Department of Health and Human Services. Participants noted the impact of substance use, substance use disorders, and untreated mental health issues on ACEs. They also discussed a lack of social supports and unmet educational needs.

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, as were those at the forum. For ACEs, respondents cited: adults, young adults, children, older adults, and teens.

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:

- 211 Maine
- Bath Area and Brunswick Landing YMCA
- Big Brothers Big Sisters
- Brunswick Welcome Center
- Domestic and sexual violence organizations
- Head Start
- Help Me Grow
- Immigrant Resource Center of Maine
- Libraries
- Maine Children's Alliance
- MaineHealth Mid Coast Hospital
- Medical providers
- Mid Coast Hunger Prevention
- Midcoast Maine Community Action, specifically Families CAN!
- Out of school providers
- Recreational departments
- Schools, specifically school social workers
- Sweetser
- Tedford Housing
- Teen & Youth centers
- United Way of Midcoast Maine

Crosscutting Priorities

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

Youth Mattering

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

Assessment Findings

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

In the Maine Shared CHNA survey,

- Of the 69.7% of respondents who said "mental health needs" negatively impact them, a loved one, and/or their community, half (55.6%) said "youth mental health" negatively impacts their community and 25% said it impacts a loved one. In 2023, 30.5% of high school students in Sagadahoc County had at least four of nine adverse childhood experiences.
- Of the 69.7% of respondents who said "substance use" negatively impacts them, a loved one, and/or their community, 73.5% said "youth substance use" negatively impacts their community.
- Of the 55.8% of respondents who said "public safety needs" negatively impacts them a loved one, and/or their community,
  - 66.7% said "violence between people,"
  - 70% said "racism," and
  - 70% "said "discrimination based on race, ethnicity, gender, LGBTQIA2S+, age, ability, etc." negatively impacts their community.
  - Quantitative data shows in Sagadahoc County, bullying on school property significantly lessened from 2019 (29.3%) to 2023 (21.5%) for high school students. In 2023, 48.1% of middle school students were bullied on school property and 22.3% of high school and 35.6% of middle school students experienced electronic bullying.

At the Sagadahoc County stakeholder forum, participants discussed a lack of community knowledge about the importance of helping youth feel like they matter. Forum participants believe there is a lack of role models, a lack of feeling welcomed and community connections, with the lack of connections more prevalent in rural areas and for those lacking access to transportation to activities. Forum participants discussed the impact of systemic racism on mattering and the lack of funding for programming. Participants would like to see more support in the school community and post-graduation, along with employment navigators.

Populations and Communities Impacted by Youth Mattering

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For youth mattering, respondents cited: youth, young adults, children, teens, and New Mainers/ immigrants.

Community Resources to Address Youth Mattering

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

- Bath Area and Brunswick Landing YMCA
- Big Brothers, Big Sisters
- Brunswick Area Teen Center
- Community Health Improvement Fund (Mid Coast Hospital)
- Downtown associations
- Emergency Medical Services
- Faith-based organizations
- Free community college and technical schools
- Maine Youth Resiliency Teen Center
- Mid Coast Hospital Community Health
- Midcoast Youth Center
- Restorative Justice Projects
- Schools
- School Resource Officers
- Scouting organizations
- Sources of Strength (suicide prevention school-based program)
- Teens to Trails
- Winter Kids
- YMCAs

Crosscutting Priorities

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

Cannabis Use

Cannabis use was the third priority for the protective and risk factors category for Sagadahoc County.

Assessment Findings

"Substance use," which includes cannabis use, was listed as the fourth of five top social concerns negatively impacting the community by Maine Shared CHNA survey respondents and 69.7% said substance use negatively impacts them, a loved one, and/or their community. When asked about specific substances, 70.6%, 26.5%, and 8.8% said "adult cannabis use" negatively impacts their community, a loved one, and them respectively.

In Sagadahoc County, 20.7% of adults in Sagadahoc County (2017-2021), 18.3% of high school students (2023), and 6.7% of middle school students engaged in past 30-day marijuana use.

Sagadahoc County stakeholder forum participants discussed the current climate surrounding cannabis use, including increasing access through legalization, regulations, and community norms. Forum participants would like to see more regulation and testing requirements for cannabis. They believe community norms are perpetuated by modeled behavior and peer pressure and that there is a lack of prevention education.

Populations and Communities Impacted by Cannabis Use

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 cannabis use, respondents cited: children, youth, young adults, adults, older adults, and teens.

Community Resources to Address Cannabis Use

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

- Bath Recovery
- Coaches
- Harm reduction efforts
- Law Enforcement Against Drugs & Violence (prevention program)
- MaineHealth Behavioral Health, substance use disorder care
- MaineHealth Mid Coast Hospital Community Health
- Restorative policies and practices
- Safe storage efforts
- Schools, specifically counselors and social workers
- Southern Midcoast Communities for Prevention Coalition
- Town municipal governments

Crosscutting Priorities

Substance Use Related Injury & Death

Health Conditions & Outcomes

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

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

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Sagadahoc 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

"Mental health issues" were listed as the top social concern negatively impacting the community by Maine Shared CHNA survey respondents and 69.7% said "mental health needs" negatively impact them, a loved one, and/or their community. When asked about specific

mental health needs, while no one topic was dominant, impacts were felt among respondents, their loved ones, and their community, specifically regarding "anxiety or panic disorder" and "general stress of day-to-day life." These details and other topics are in Table 1: Mental Health Needs. In Sagadahoc County, 8.4% of adults have current symptoms of depression, 23.8% have had depression in their lifetime, and 23.3% have had anxiety in their lifetime.

Sagadahoc County stakeholder forum participants discussed a wide range of contributing factors for mental health, citing more proximal factors of trauma and adverse childhood experiences and distill factors of social unrest, climate change and the environment, and culture. Forum participants noted several community conditions impacting mental health including housing, transportation, and access to nutritious food.

In the Maine Shared CHNA survey 67.4% of respondents rate their own mental health as "good or excellent" and 46.5% of respondents said they or a loved one could not or chose not to get mental health services in the past year. The reasons why include: "long wait times to see a provider," "hard to get time off from work," and "did not feel comfortable seeking help." In 2024, there were 430 people for every mental health provider in Sagadahoc County. Forum participants also discussed stigma associated with seeking mental health care.

Table 3: Mental Health, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder	44.4%	58.3%	36.1%	2.8%	2.8%	5.6%
Depression	33.3%	58.3%	47.2%	0.0%	2.8%	0.0%
Bipolar disorder	5.6%	22.2%	30.6%	8.3%	25.0%	16.7%
Trauma or post-traumatic stress disorder (PTSD)	19.4%	38.9%	36.1%	11.1%	11.1%	5.6%
General stress of day-to-day life	52.8%	50.0%	58.3%	2.8%	0.0%	5.6%
Social isolation or loneliness	16.7%	36.1%	55.6%	5.6%	8.3%	11.1%
Stigma associated with seeking care for mental health or substance use disorders	11.1%	30.6%	69.4%	5.6%	2.8%	8.3%
Suicidal thoughts and/or behaviors	11.1%	25.0%	52.8%	2.8%	22.2%	13.9%
Youth mental health	5.6%	25.0%	55.6%	8.3%	11.1%	11.1%

Socioeconomic Empowerment

When asked to rate the top five "very necessary" steps to move people out of poverty and to a place of stability, "mental health care and treatment" was listed as number four by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Mental Health

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

Community Resources to Address Mental Heath

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

- Health care providers
- MaineHealth Behavioral Health, including substance use disorder treatment
- MaineHealth Center for Trauma and Resiliency
- MaineHealth Mid Coast Hospital
- MaineHealth Mid Coast Hospital Community Health
- Mental Health Awareness Trainings
- Mid Coast Hospital and Lincoln Hospital Community Health Improvement Fund
- NAMI Maine
- School based health centers
- Schools, specifically teachers and counselors
- Sweetser
- Yoga studios

Crosscutting Priorities

Adverse Childhood Experiences | **Housing** | **Provider Availability** | **Youth Mattering**

Substance Use Related Injury & Death

Substance use related injury and death was the second priority for the health conditions and outcomes category for Sagadahoc 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

"Substance use" was listed as the fourth of five top social concerns negatively impacting the community by Maine Shared CHNA survey respondents and 69.7% said substance use negatively impacts them, a loved one, and/or their community. When asked about specific substances,

- 70.6% and 32.4% said "alcohol misuse or binge drinking" negatively impacts their community and a loved one, respectively.
- 70.6% said "opioid misuse" negatively impacts their community.
- 64.7% said "other illicit drug use" negatively impacts their community.

In Sagadahoc County there were 11 overdose deaths for every 100,000 people in 2023 and 24 drug-induced deaths for every 100,000 people, significantly better than Maine (55.6 per 100,000, 2018-2022).

At the Sagadahoc County stakeholder forum participants noted stigma associated with substance use disorder, but also the glamorization of the use of substances, especially alcohol, the ease of access to substances, and wide acceptance of use. There were 15.5 alcohol-induced deaths for every 100,000 people (2018-2022) in Sagadahoc County. During the period 2019-2021, 8.5% of adults engaged in chronic heavy drinking and 12.8% engaged in binge drinking.

Participants believe messaging, misinformation, and social media are all contributing factors to substance use. Trauma was also discussed as a root cause of substance use related injury and death.

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: adults, older adults, children, youth, and teens.

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:

- Addiction Resource Center
- Bath Recovery Center
- Midcoast Youth Center
- OPTIONS
- Sweetser

Crosscutting Priorities

Adverse Childhood Experiences **Cannabis Use** **Mental Health**

Obesity and Weight Status

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

Assessment Findings

In the Maine Shared CHNA survey, 76.7% said "chronic health conditions," of which obesity is one, negatively impacts them, a loved one, and/or their community. When asked specifically about overweight and obesity, 57.1% said it impacts their community, 34.3% said a loved one, and 37.1% said it impacts them. In 2021, 26.3% of adults in Sagadahoc County were obese, significantly better than the U.S. (33.9%). In 2023, 16.5% of high school and 17.1% of middle school students were obese.

At the Sagadahoc County stakeholder forum, participants discussed the interplay of nutrition and active living as contributing factors to obesity and weight status. They discussed the prevalence of food deserts and a lack of healthy foods. In Sagadahoc County data shows,

- 32.4% of adults consumed less than one serving of fruit per day, significantly better than the U.S. (39.7%, 2021).
- 10.8% of adults consumed less than one serving of vegetables per day, significantly better than the U.S. (20.4%, 2021).
- 14.9% of high school students consume five or more servings of fruits and vegetables per day (2023).
- 20.1% of middle school students consume five or more servings of fruits and vegetables per day (2023).

Forum participants believe there is a sedentary culture in the community, which is impacted by devices and technology, a lack of public parks, bad weather, and the cost of activities. Of the 67.4% of Maine Shared CHNA survey respondents that said "environmental needs" negatively

impact them, a loved one, and/or their community, 42.4% said “access to parks and green spaces for recreation” negatively impacts their community and of the 55.8% who said “public safety needs” negatively impacts them, a loved one, and/or their community, 76.7% said “pedestrian or bicycle safety” negatively impacts their community.

In Sagadahoc County data shows,

- 23.9% of adults reported a sedentary lifestyle (2021).
- 48.6% of adults said they met physical activity recommendations (2017 & 2019).
- 48.6% of high school and 50.7% of middle school students met physical activity recommendations, both significantly better than 2019 (23.1% and 25.6%).
- 25.2% of high school students reported fewer than two hours of screen time, significantly better than Maine (22.9%, 2023).
- 29.3% of middle school students reported fewer than two hours of screen time (2023).

Participants did note several assets in the community including longer mealtimes and the use of local produce at area schools. 211 Maine was cited as an asset, but participants noted it isn’t always up to date with current resources.

Populations and Communities Impacted by Obesity and Weight Status

Participants at the Sagadahoc County stakeholder forum added obesity and weight status as a priority at the forum, so it was not included in the pre-forum survey and populations were not discussed at the forum.

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:

- Access Health and Get Active Southern Maine Midcoast Coalitions
- Bath Area and Brunswick Landing YMCA
- Bicycle Coalition of Maine
- Bike and Pedestrian Committees and advocacy groups
- Land trusts
- Maine Department of Education
- MaineHealth Mid Coast Hospital: Center for Health & Wellness, Lifestyle Medicine and Community Health Department
- Midcoast Community Action Program
- Mid Coast Hunger Prevention Program and Bath Food Pantry
- Parks and Recreation Programs
- School Meals for All
- SNAP-Ed
- Supplemental Nutrition Assistance Program
- Temporary Assistance for Needy Families
- Women, Infants and Children Program

Appendices

Appendix 1: Methodology

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

Data Commitments

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

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

Quantitative Data

Data Criteria

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

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

Additionally, the Metrics Committee, Maine CDC, and Crescendo Consulting Group (the 2024 Maine Shared CHNA vendor) reviewed the data to check for changes in data sources and definitions, potential new sources of data, and any discrepancies or errors in the data.

Data Profiles & Interpretation

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

Data Limitations, Gaps, & Considerations

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

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

state-level data and aggregation of multiple years of data for more reliable estimates with less suppression. This implies an assumption that disparities found at the state level have similar patterns for smaller geographical areas, which does not account for the unique characteristics of populations throughout the state.

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

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

Data Changes

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

Data Discrepancies

COVID's Impact

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

Health Equity Profiles

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

Qualitative Data

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

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

Considerations for Identifying Populations to Engage With

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

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

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

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

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

Considerations for the Use of Other Assessments

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

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

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

Focus Groups

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

- Statewide Focus Group Participants: 31 (total)

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

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

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

Key Informant Interviews

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

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

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

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

Statewide Community Survey

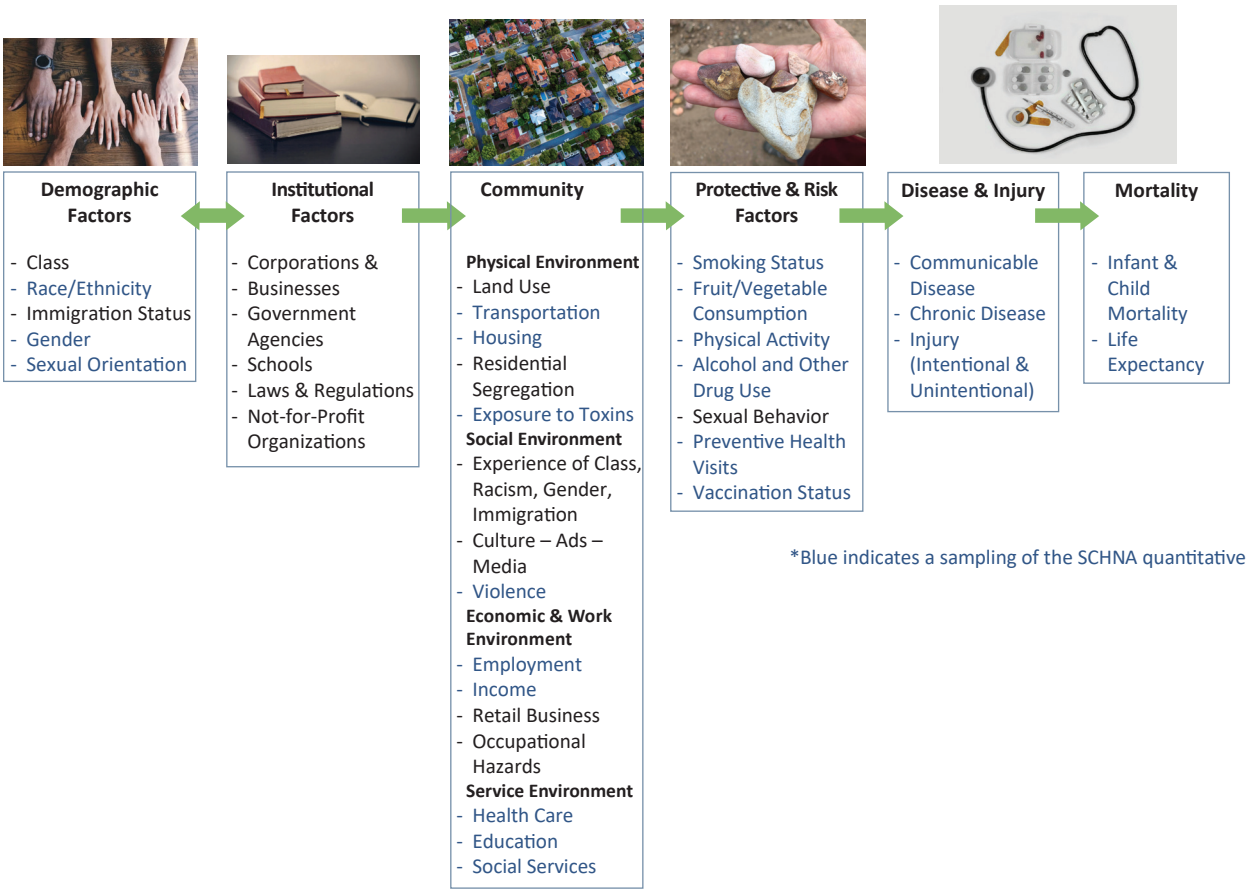
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group,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

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

Bay Area Regional Health Inequities Initiative (BARHII) Framework

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

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



Stakeholder Forums

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

One in-person stakeholder forum was held in Sagadahoc County on November 1, 2024, with 39 attendees. People from the following organizations participated in the forum process:

- Bath Police Department
- Bowdoin College
- Brunswick School Department
- City of Bath
- Cutler - Opioid Settlement
- Maine CDC Midcoast District Public Health
- Maine Center for Disease Control & Prevention
- MaineHealth
- MaineHealth Mid Coast Hospital
- MaineHealth Mid Coast Hospital - Community Health
- Mid Coast Hunger Prevention Program
- Midcoast Maine Community Action
- Midcoast Public Health Council
- Midcoast Youth Center
- People Plus
- Sagadahoc County Emergency Management Agency
- Sagadahoc County Sheriff's Office
- Sexual Assault Support Services of Midcoast Maine (SASSMM)
- Stellar Pediatrics
- Wellness Mobile Foundation
- United Way of Mid Coast Maine

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.aine.

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)	15	88.2%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	10	58.8%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	9	52.9%
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.)	9	52.9%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	8	47.1%
Climate Impacts (such as extreme weather events)	7	41.2%
Bullying	5	29.4%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	4	23.5%
Isolation	3	17.7%
Crime (such as rape/non-consensual sex, intimate partner violence, nonfatal child maltreatment, violent crime rate, etc.)	3	17.7%
Wage Gaps and Income Disparities	3	17.7%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	3	17.7%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	1	5.9%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	5.9%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	1	5.9%
Systemic Discrimination	1	5.9%
Stigma Around Accessing/Accepting Help, Services, or Treatment	1	5.9%
Provider Consistency (such as low turnover rates and ability to develop a long-term provider/ patient relationship)	1	5.9%
Protective and Risk Factors	**# Votes**	**% of Participants**
Adverse Childhood Experiences	9	52.9%

Protective and Risk Factors	# Votes	% of Participants
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	7	41.2%
Cannabis Use	7	41.2%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	6	35.3%
Youth Mattering (such as positive role models, community connections, etc.)	6	35.3%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	5	29.4%
Preventive Oral Health Care	5	29.4%
Vaping Use (including tobacco and cannabis)	5	29.4%
Prescription Drug Misuse	5	29.4%
Immunizations & Vaccinations	4	23.5%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	4	23.5%
Alcohol Use (including binge drinking)	4	23.5%
Injury Prevention (such as fall prevention, always wear a seat belt)	3	17.7%
Illicit Drug Use	3	17.7%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	2	11.8%
Indoor Air Quality	2	11.8%
Foster Care	1	5.9%
Access to Child and Family Home Visiting	1	5.9%
Safe Drinking Water	1	5.9%
Other (please specify): Domestic violence	1	5.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	14	82.4%
Intentional Injury & Death (self-injury)	8	47.1%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	8	47.1%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	7	41.2%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	6	35.3%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	6	35.3%
Obesity/Weight Status	5	29.4%
Cancer	4	23.5%
Non-Infectious Respiratory Disease (such as asthma, COPD)	4	23.5%
Cognitive Decline, Alzheimer's disease and other dementias	4	23.5%
Multiple Chronic Conditions	4	23.5%
Diabetes	3	17.7%
Dental Disease	3	17.7%
Arthritis	2	11.8%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	1	5.9%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	1	5.9%

Health Conditions and Outcomes	# Votes	% of Participants
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	1	5.9%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	1	5.9%

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)	33	94.3%
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)	22	62.9%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	13	37.1%
Cost of living	13	37.1%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	10	28.6%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	10	28.6%
Elder isolation	4	11.4%

Protective and Risk Factors	# Votes	% of Participants
Adverse Childhood Experiences	31	88.6%
Youth Mattering (such as positive role models, community connections, etc.)	25	71.4%
Cannabis Use	22	62.9%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	16	45.7%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	11	31.4%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	35	100.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	28	80.0%
Obesity	11	31.4%
Intentional Injury & Death (self-injury)	9	25.7%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	8	22.9%
Cardiovascular Disease	8	22.9%
Dementia	4	11.4%

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

Acknowledgements

Funding for the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is provided by the partnering healthcare systems and the Maine Community Action Partnership with support from the Maine Center for Disease Control and Prevention (Maine CDC). The Maine Shared CHNA is also supported in part by the U.S. Centers for Disease Control and Prevention (U.S. CDC) of the U.S. Department of Health and Human Services (U.S. DHHS) as part of the Preventive Health and Health Services Block Grant (awards NB01TO000018 & NB01PW000031). The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, the U.S. CDC/DHHS, or the U.S. Government.

We are grateful for the time, expertise, and commitment of numerous community partners and stakeholder groups, including: the Metrics Committee, the Community Engagement Committee, Local Planning Teams, and several Ad-Hoc Committees. Crescendo Consulting Group provided quantitative and qualitative expertise, design and production support, and analysis.

We are grateful to our community partners and stakeholders who took the time to help advertise and recruit for our focus groups, both at the state and county level, and for our statewide community survey. Our utmost thanks also goes to all of the individuals who took part in our key informant interviews. Each of you enabled us to learn more about populations, communities and sectors in Maine. Without all of these efforts we would not have been able to conduct the community engagement aspect of our assessment. A special thank you also goes to the Catherine Cutler Institute at the University of Southern Maine and Maine DHHS' Office of Aging and Disability Services and John Snow, Inc. and Disability Rights Maine for use of their assessments and ability to include their findings in ours.

Significant quantitative data analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. Crescendo Consulting Group provided quantitative and qualitative expertise, design and production support, and analysis. A special thank you to the Children's Oral Health Network for its data contribution, the Maine Integrated Youth Health Survey for use of its LGBTQ+ Student Health fact sheet, and for volunteers from the Aroostook County Action Agency, Central Maine Healthcare, Northern Light Health, MaineHealth and the Roux Institute's Data Analytics for Social Good student group, who helped with our data quality control and assurance process.

Endnotes

i Health Equity in Healthy People 2030 - Healthy People 2030 | odphp.health.gov

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.

iii Health Equity in Healthy People 2030 - Healthy People 2030 | odphp.health.gov

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

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

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

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

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

ix 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

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

xi 3 key upstream factors that drive health inequities | American Medical Association

www.mainechna.org