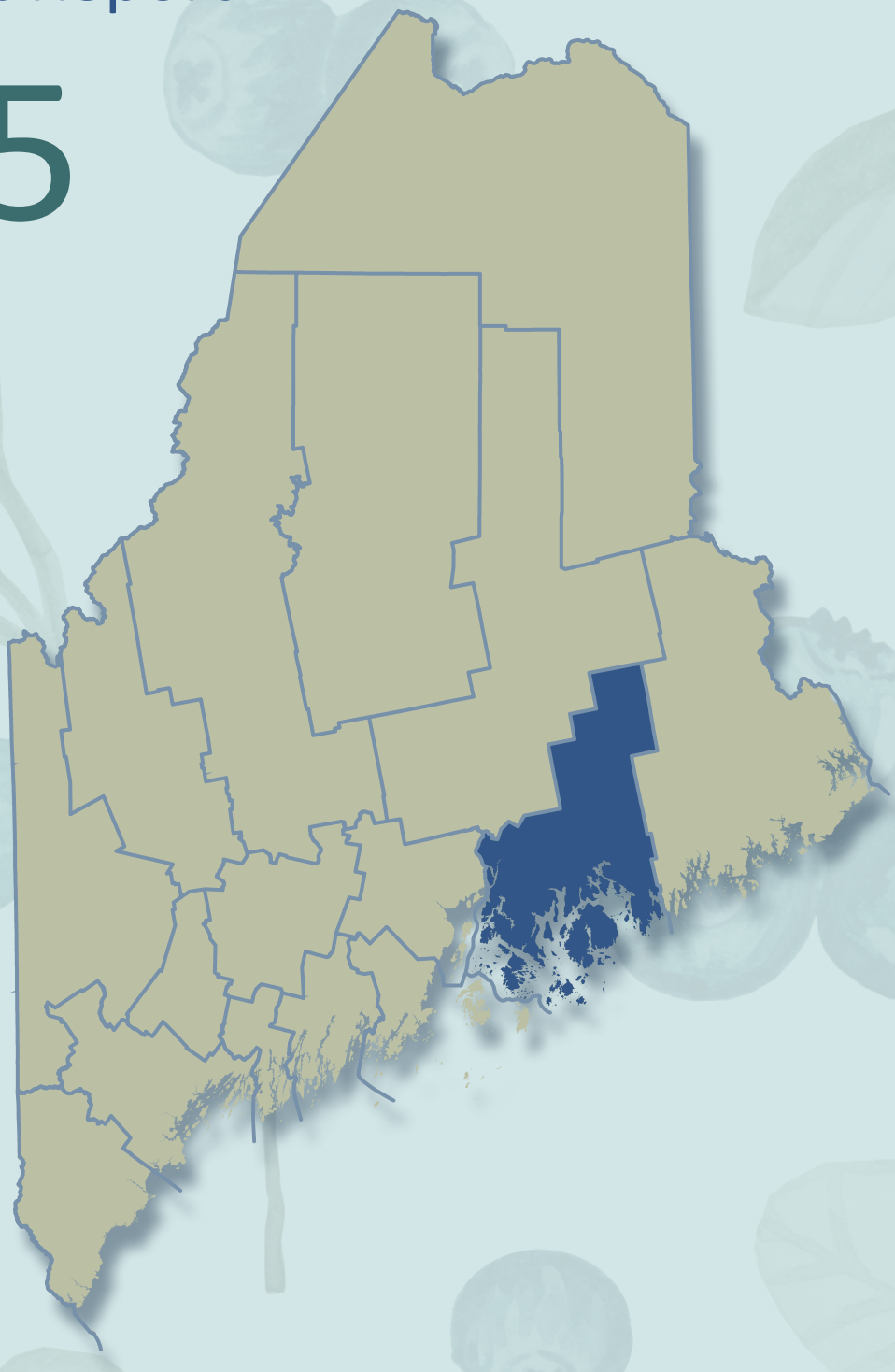
Hancock County

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 Hancock 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

Hancock County Health and Well-Being Priorities

The following table includes the top health and well-being priorities identified by Hancock 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
Aging-Related Services	Substance Use (ME)	Mental Health (ME)
Housing (ME)	Adverse Childhood Experiences (ME)	Access to Long-Term Care
Provider Availability (ME)	Nutrition (ME)	Cardiovascular Disease

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

Transportation Poverty 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 Hancock 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 Hancock 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

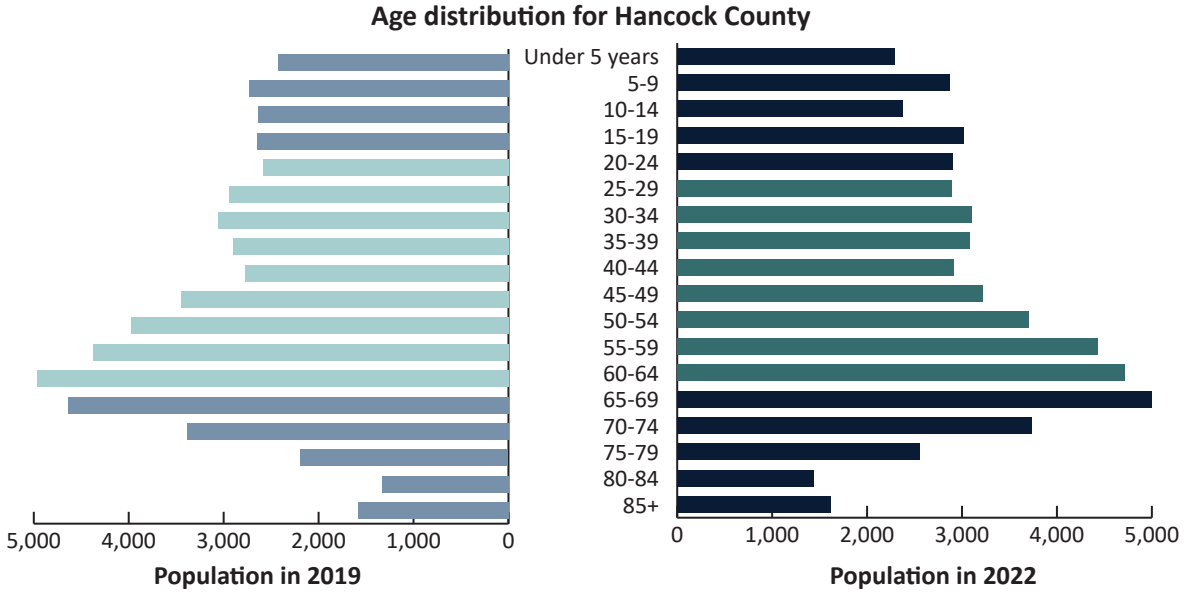
The following tables and chart show information about the population of Hancock County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Hancock County Population	State of Maine Population
55,851	**1,366,949**

	Hancock	Maine
Median household income	**$64,149**	**$68,251**
Unemployment rate	**3.1%**	**3.1%**
Individuals living in poverty	**10.9%**	**10.9%**
Children living in poverty	**13.1%**	**13.4%**
65+ living alone	**30.2%**	**29.5%**

	Hancock County	
	Percent	Number
American Indian/Alaskan Native	**0.4%**	**251**
Asian	**0.9%**	**475**
Black/African American	**0.8%**	**446**
Native Hawaiian or other Pacific Islander	**0.0%**	**0**
Some other race	**0.6%**	**329**
Two or more races	**2.6%**	**1,427**
White	**94.8%**	**52,923**
Hispanic	**1.7%**	**931**
Non-Hispanic	**98.3%**	**54,920**

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 Hancock County.

Cause of Death	Maine	Hancock County
Heart disease	**27.2%**	**29.2%**
Cancer	**25.9%**	**26.3%**
Accidents	**10.5%**	**9.9%**
COVID 19	**6.0%**	**7.3%**
Chronic lower respiratory disease	**6.8%**	**6.3%**
Cerebrovascular disease	**4.8%**	**4.8%**
Diabetes	**4.6%**	**3.9%**
Influenza & pneumonia	**2.1%**	**3.4%**
Nephritis, nephrotic syndrome & nephrosis	**1.8%**	**2.4%**
Parkinson's disease	**1.7%**	**2.0%**
Suicide	**2.0%**	**1.7%**
Chronic liver disease and cirrhosis	**2.3%**	**1.5%**
Alzheimer's disease	**4.1%**	**1.3%**

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.

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

Hancock County Strengths

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

- Safe opportunities to be active outside;
- Low crime;
- Safe neighborhoods;
- Locally owned businesses; and
- Strong sense of community.

People living in Hancock County have a positive outlook on their health and well-being – 67% of survey respondents believe their community is healthy or very healthy; 76.8% rate their own physical health as good or excellent and 78.7% 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 Hancock 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.

Hancock County Community Conditions		
Aging-Related Services	Housing	Provider Availability

Aging-Related Services

Aging Related Services was the top-rated priority for the community conditions category for Hancock County. For the purposes of the prioritization process, aging related services include such topics as long-term care, assisted living access, and in-home care support services.

Assessment Findings

In the Hancock County focus group, "older adult care" was a top theme. One participant noted challenges with finding appropriate levels of care for older adults saying:

"Adult day programs are getting [people] with nursing home levels of care."

Access was a theme that emerged in the Hancock County stakeholder forum, specifically a lack of community-based healthcare and nursing homes and a lack of assistance navigating services that are available. Stakeholder forum participants also discussed a lack of insurance and for those who have it, a potential lack of understanding their benefits. This may specifically impact older adults' ability to access aging related services. In Hancock County, 10.2% of adults are uninsured (2018-2022). As people migrate out of Hancock County, older adults may be left without family supports. In Hancock County, 30.2% (2018-2022) of people aged 65 and older live alone and 5.3% (2017, 2019, & 2021) of adults provide regular care or assistance to a friend or family member who has a health problem or disability for at least 20 hours per week.

Impacting both care availability and resource navigation is a workforce shortage identified by forum participants, potentially attributable to a lack of workforce housing. In the Hancock County focus group, one participant said:

"Housing – there is a lack of providers due to this…"

In the Maine Shared CHNA survey, respondents living in Hancock County listed "aging health concerns" as the fourth of five social concerns impacting their community. Of respondents who noted housing was a concern for them, a loved one, and/or their community (67.4%), 76.6% said the "availability of affordable, quality housing for older adults or those with special needs" impacts their community and of those who said transportation impacts someone in their lives (62.3%), 75.1% said "availability of transportation that meets a variety of special needs," which includes older adults, impacts their community.

Populations and Communities Impacted by Aging-Related Services

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For aging related services, respondents cited: older adults living alone, adults, people living in rural areas, caregivers, people with a mental or behavioral health disorder, businesses, the public and private sectors, and volunteers.

Community Resources to Address Aging-Related Services

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

- Adult Protective Services
- Age-friendly communities
- Community Health & Counseling Services
- Maine Department of Health and Human Services Office of Aging and Disability Services
- Downeast Community Partners
- Eastern Area Agency on Aging, specifically Caregiver Respite Care and caregiver support groups
- Federally Qualified Health Centers
- Friends in Action
- Friendship Cottage
- Home supports
- Hospice volunteers
- Island Connections
- Mount Desert Nursing Association
- Municipalities
- Non-profits
- Northern Light Home Health
- YMCA

Crosscutting Priorities

Housing **Provider Availability** **Access to Long Term Care**

Housing

Housing was the second rated priority for the community conditions category for Hancock 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 Hancock County focus group, "affordable housing" was a top theme and in the Hancock County stakeholder forum the theme of housing availability and access emerged. One focus group participant said:

"My family is 'over-housed.' We have five people living in two bedrooms. When I have to pay electricity without the assistance from [local assistance program], it would be impossible."

In Hancock County, 11.2% (2018-2022) of households spend more than 50% of their income toward housing. The median gross rent is $949 per month (2018-2022), significantly worse than 2015-2019 ($818), but significantly better than Maine ($1,009) and the U.S. ($1,268).

In the Maine Shared CHNA survey, respondents living in Hancock County listed "housing insecurity" as the third of five social concerns negatively impacting their community and 67.4% of survey respondents said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, "availability of affordable, quality homes/rentals" impacted respondents' communities (83.5%), loved ones (37.8%) and themselves (23.4%) and "costs of utilities" impacted respondents' communities (73.4%), loved ones (43.1%), and themselves (50.5%). In Hancock County, 61.2% of housing is occupied (2018-2022) and 1.7% of housing units are vacant and for rent or sale (2022).

Stakeholder forum participants identified the age of the current housing stock and factors impacting the construction of new homes, such as regulations associated with building, attitudes of "not in my backyard" and the costs of construction. Just under half (44%) of homes in Hancock County were built from 1980 to 2009 and only 6.8% have been built since 2010. Forum participants would like to see more legislative action to encourage and protect affordable housing projects.

Stakeholder forum participants also discussed the possibility of outside influences on housing availability in Hancock County, specifically the use of housing for short term rentals, and the increase in remote work, enabling people to live further from their place of employment. Forum participants also noted that a lack of housing is felt by people experiencing domestic violence who may be unable to find safe and secure housing.

Socioeconomic Empowerment

When asked about the top five steps that are "very necessary" for helping someone move from poverty to a place of stability, "affordable and safe housing" was listed as number two by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Housing

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For housing, respondents cited: unhoused/housing insecure, workforce, older adults, adults, young adults, and people living in rural areas.

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:

- Affordable housing organizations
- Community Health and Counseling Services
- Downeast Community Partners
- Government programs
- Hancock County Technical Center
- Homeless shelters
- Large employers providing housing, such as The Jackson Laboratory
- Maine Continuum of Care
- Maine State Housing, specifically the first-time homebuyer program
- Mount Desert Island-Ellsworth Housing Authority
- Municipal government
- Next Step Domestic Violence Project
- Private developers
- Seasonal worker housing
- USDA Rural Housing

Provider Availability

Provider availability was the third rated priority for the community conditions category for Hancock 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 Hancock County focus group, top themes included "mental health services," "specialty care access," and "substance use services, including recovery." Focus group participants said:

"When I call [my provider], you can't get a person [on the phone]."

"Doctors are apparently not interested in rural settings."

Data shows for every 1,001 people in Hancock County there is one primary care physician (2024) and 86.3% of adults have a usual primary care provider (2019-2021). In Hancock County 77.2% of adults have been to a primary care provider in the past year (2019-2021), significantly better than 2015-2017 (70.3%).

The lack of primary care and specialty care services was also discussed in the Hancock County stakeholder forum, attributing it to workforce challenges. These challenges are seen in staffing burnout, which may be due to an older patient population with more complex conditions, compensation and licensing challenges, and a lack of training programs and sustainable career pathways. Forum participants also noted there is a lack of housing for providers who may want to move to the area to work.

Forum participants discussed the use of telehealth, which may benefit some, but be challenging for others who lack Internet access or have technology challenges. In Hancock County, quantitative data shows 87.4% of households have a broadband subscription, significantly better than 2015-2019 (82.2%) and 92.1% have a computer (2018-2022), with computer rates significantly worse than the U.S. (2018-2022).

Participants at the stakeholder forum also discussed issues of access, that while not a cause of provider availability, impact a person's ability to obtain care. These include a lack of child care and transportation to enable people to get to a medical appointment. There are 31 child care centers in Hancock County (2024) and 5.6% of households do not have a vehicle (2018-2022). They also include a lack of insurance and access to out of network options. In Hancock County 10.2% of adults are uninsured (2017-2021), significantly worse than Maine (7.1%) and the U.S. (8.7%).

Populations and Communities Impacted by Provider Availability

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

- Adult Education
- AMHC
- Beth C. Wright Cancer Resource Center
- Bucksport Regional Health Center
- Community Health and Counseling Services
- Community-based health centers
- Downeast Community Partners
- Free clinics
- Friends in Action
- Hancock County Technical Center
- Island Housing Transportation
- Job shadowing
- Maine Seacoast Mission
- Mount Desert Island Hospital Primary Care Clinics
- Northern Light Health Primary Care Clinics
- Private providers
- Rural clinical rotation placements
- School-based health centers
- Telehealth hospital specialists
- Youth pathways programming

Crosscutting Priorities

Aging-Related Services **Housing** **Substance Use**

Mental Health **Access to Long-Term Care**

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 Hancock 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.

Hancock County Protective & Risk Factors		
Substance Use	Adverse Childhood Experiences	Nutrition

Substance Use

Substance use was the top-rated priority for the protective and risk factors category for Hancock County. Participants at the Hancock County 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 Hancock County focus group, a top theme was "substance use services, including recovery." Stakeholder forum participants cited a lack of residential recovery and treatment services, mental health providers, and screenings and interventions. In 2024 there were 220 people for every mental health provider in Hancock County.

"Substance use disorders have seemed to have increased."

"A lot of drug issues may have to do with hard working jobs like lobstermen or seasonal work. "

The sentiment of substance use tied to the industry in which one works was echoed in the stakeholder forum, with participants discussing the impact of industries reliant on physical labor and jobs that lack benefits.

A focus group participant said:

"My son, after work at a restaurant job, would go to Denny's with his coworkers. It closed during the pandemic. Some have turned to drugs with nowhere to hang out beside bars."

The perception that a lack of activities may be leading people to use substances was shared by stakeholder forum participants, who discussed a lack of community activities and a generational and community culture of substance use. Stakeholder forum participants believe the legalization of cannabis has resulted in increased use.

In the Maine Shared CHNA survey, "substance use" was listed as the first of five social concerns negatively impacting the community and 60.4% of respondents said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substance use, respondents noted several impact their community including:

- "alcohol misuse or binge drinking" (77.1%),
- "other illicit drug use" (72%),
- "tobacco use" (70.9%), and
- "youth substance use" (67.4%).

Other substances impact survey respondents' loved ones including:

- "alcohol misuse or binge drinking" (28.6%),
- "tobacco use" (25.7%), and
- "adult cannabis use" (23.4%).

Table 1: Substance Use Indicators contains quantitative data for substance use in Hancock County. Mental health's impact on specific populations was discussed at the Hancock County stakeholder forum and how these groups may be at risk to use substances. These include people who are impacted by adverse childhood experiences, those experiencing feelings of despair, people who are isolated, people experiencing domestic violence, and people who may be stigmatized due to seeking treatment.

Table 1: Substance Use Indicators	Hancock County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Substance Use							
Chronic heavy drinking (adults)	2015-2017 **10.2%**	2019-2021 **9.3%**	○	2019-2021 **8.4%**	○	2021 **6.3%**	N/A
Past-30-day alcohol use (high school students)	2019 **26.0%**	2023 **~**	N/A	2023 **20.5%**	N/A	—	N/A
Past-30-day alcohol use (middle school students)	2019 **4.1%**	2023 **~**	N/A	2023 **4.8%**	N/A	—	N/A
Binge drinking (adults)	2015-2017 **17.5%**	2019-2021 **13.4%**	○	2019-2021 **15.5%**	○	2021 **15.4%**	N/A
Binge drinking (high school students)	2019 **8.8%**	2023 **~**	N/A	2023 **9.6%**	N/A	—	N/A
Binge drinking (middle school students)	2019 **0.6%**	2023 **~**	N/A	2023 **1.8%**	N/A	—	N/A
Past-30-day marijuana use (adults)	2015-2017 **17.8%**	2019-2021 **25.1%**	○	2019-2021 **21.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2019 **21.5%**	2023 **~**	N/A	2023 **18.7%**	N/A	—	N/A
Past-30-day marijuana use (middle school students)	2019 **2.4%**	2023 **~**	N/A	2023 **5.0%**	N/A	—	N/A

Table 1: Substance Use Indicators	Hancock County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Past-30-day misuse of prescription drugs (adults)	2011-2021 **0.5%**	—	N/A	2011-2021 **0.9%**	N/A	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2019 **6.1%**	2023 **~**	N/A	2023 **5.2%**	N/A	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2019 **2.5%**	2023 **~**	N/A	2023 **4.9%**	N/A	—	N/A
Lifetime illicit drug use (high school students)	—	2023 **2.5%**	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.

Populations and Communities Impacted by Substance Use

Forum participants discussed the impact of substance use on all populations. While substance use is an additional priority, not originally selected in the pre-forum prioritization process, pre-forum survey respondents did identify populations related to alcohol use. These include adults, older adults, teens, young adults, and youth.

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 also be applicable to other substances. Participants at the forum were asked to identify assets and resources related to their identified priorities. For substance use, respondents identified:

- Alcoholics Anonymous*
- AMHC*
- Bucksport Regional Health Center
- Downeast Treatment Center
- Downeast Treatment Network
- Groups Recover Together
- Harm reduction
- Healthy Acadia's Inspire Center
- Medication Assisted Treatment programs
- Mount Desert Island Hospital*
- Narcotics Anonymous
- Northern Light Health*
- Recovery coaching
- Schools, specifically the use of restorative practices

Crosscutting Priorities

Provider Availability **Adverse Childhood Experiences** **Mental Health**

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) was the second rated priority for the protective and risk factors category for Hancock 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 Hancock County community could be associated with ACEs – substance use, mental health issues, and housing insecurity. Just under 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 64.6% of Maine Shared CHNA respondents who said "mental health needs" negatively impact them, a loved one, and/or their community, half (54.7%) said youth mental health negatively impacts their community and 26.8% said it impacts a loved one. In Hancock County 31.7% of high school and 23% of middle school students report being sad or hopeless for two weeks in a row and 17.1% of high school and 18.6% of middle school students report seriously considering suicide (2019).

In the Hancock County focus group, participants noted "activities for youth" as a top theme and participants at the Hancock County stakeholder forum discussed an overall lack of protective factors for youth. Stakeholder forum participants discussed the impact of generational cycles of trauma as a contributing factor to adverse childhood experiences. Forum participants also noted the impact of unaddressed mental health issues and substance use, as well as, domestic violence, sexual abuse, and bullying on ACEs.

Populations and Communities Impacted by Adverse Childhood Experiences

Adverse childhood experiences was a priority added at the forum, so registrants did not list populations during the pre-forum survey process. At the forum, respondents cited: children, asylum seekers, and refugees.

Community Resources to Address Adverse Childhood Experiences

Participants at the forum were asked to identify assets and resources related to their identified priorities. For ACEs, respondents identified:

- AMHC
- Child Development Services
- Community case managers
- Community mental health providers
- Daycare
- Department of Health and Human Services Child Protective Services
- Head Start and Early Head Start
- Hospitals and emergency departments
- Law enforcement
- Maine Families and Home Visiting
- Next Step Domestic Violence Project
- Primary care providers
- Schools

Crosscutting Priorities

Housing | Substance Use | Mental Health

Nutrition

Nutrition was the third rated priority for the protective and risk factors category for Hancock 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, respondents living in Hancock County noted obesity as the fifth of five top social concerns negatively impacting their community. In 2021, 27.2% of adults in Hancock County were obese and as of 2019, 15.2% of high school students and 20% of middle school students were obese.

Of the Maine Shared CHNA survey respondents who noted economic needs (70.7%) negatively impact them, a loved one, and/or their community, 67.3% said "access to affordable, quality foods" impacts their community, 23% said it impacts a loved one, and 28.1% said it impacts them. Participants at the Hancock County stakeholder forum also discussed food access, including an overall lack of access to healthy food and a lack of access to safe, potable water. They noted there are food deserts in Hancock County and a lack of transportation to access food.

When food is available, forum participants believe people may be impeded by their ability to prepare nutritious meals, given a lack of knowledge and understanding of food's nutritional content, which may be impacted by marketing of less nutritious foods, as well as, having the time, equipment, and physical ability to prepare food.

In Hancock County,

- 35.9% of adults consumed less than one serving of fruit per day (2021).
- 12.9% of adults consumed less than one serving of vegetables per day (2021), significantly better than Maine (20.4%).
- 17.1% of high school students and 15.8% of middle school students report five or more servings of fruits and vegetables per day (2019).
- 17.5% of high school students and 17.4% of middle school students report one or more soda/sports drinks per day (2019).
- 12.7% of adults and 18.7% of youth were food insecure (2022).

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, as were those at the forum. For nutrition, respondents cited: children, older adults, people with low-income, youth, and people living in rural areas.

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
- Cancer patient food boxes
- Faith-based organizations
- Farmers' Markets
- Food pantries and meal sites
- Free produce pop-ups
- General Assistance
- Good Shepherd Food Bank
- Hannaford
- Head Start and Adult Day Care educational programs
- Healthy Acadia Gleaning
- Healthy Peninsula's Magic Food Bus
- Hospitals and healthcare systems
- Mount Desert Island Hospital
- Northern Light Health
- School nutrition programs
- Senior food boxes
- SNAP-Ed
- Supplemental Nutrition Assistance Program
- University of Maine Cooperative Extension
- Women, Infants and Children Program

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 Hancock 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.

Hancock County Health Conditions & Outcomes		
Mental Health	**Access to Long-Term Care**	**Cardiovascular Disease**

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for Hancock 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 Hancock County focus group, "mental health services" was noted as a top theme. Participants in the Hancock County stakeholder forum noted there is a stigma related to mental health, and it can be difficult to identify mental health conditions. Additionally, the cost of mental health services, especially for those with low income can be a challenge to obtaining

services. In Hancock County, 10.2% of adults are uninsured (2018-2022), significantly worse than Maine (7.1%) and the U.S. (8.7%) and 9.7% report cost barriers to health care (2019-2021). In the Maine Shared CHNA survey, 38.2% of respondents said in the past year they could not or chose not to receive mental health care, with top barriers including "long wait times to see a provider," "did not feel comfortable with available providers," and "had health insurance, could not afford care." Hancock County has one psychiatrist for every 7,911 people and one mental health provider for every 220 people (2024) and 20.7% of adults were receiving outpatient mental health services (2019-2021).

Respondents to the Maine Shared CHNA survey listed "mental health issues" as the second of five social concerns negatively impacting their community and 64.6% said mental health needs negatively impact them, a loved one, and/or their community. When asked about specific mental health needs, "general stress of day-to-day life," "depression," and "anxiety or panic disorder" impact respondents' community, loved ones, and themselves. This is detailed in Table 2: Mental Health Needs, along with other specific mental health needs.

In Hancock County from 2019-2021, 10.4% of adults reported current depression symptoms and 23.9% report experiencing depression in their lifetime. Just under one quarter (22.4%, 2019-2021) of adults report experiencing anxiety in their lifetime, significantly worse than 2015-2017 (16.2%).

Stakeholder forum participants noted the impact of stress and isolation on mental health. They discussed trauma, such as family violence and adverse childhood experiences as root causes to mental health disorders, as well as the use of substances. Other contributing factors noted by stakeholder forum participants include the impact of social media and technology.

In Hancock County, 78.7% of Maine Shared CHNA survey respondents rate their own mental health as "good or excellent."

Table 2: Mental Health, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder	38.9%	50.5%	46.3%	1.1%	10.5%	1.6%
Depression	38.9%	52.6%	52.1%	3.2%	7.4%	2.1%
Bipolar disorder	2.6%	20.5%	41.1%	6.3%	27.4%	9.5%
Trauma or post-traumatic stress disorder (PTSD)	26.8%	29.5%	46.3%	4.7%	17.9%	7.4%
General stress of day-to-day life	53.2%	51.1%	54.7%	3.7%	6.8%	1.1%
Social isolation or loneliness	18.9%	34.2%	56.8%	3.7%	9.5%	5.8%
Stigma associated with seeking care for mental health or substance use disorders	15.8%	26.3%	51.6%	6.8%	21.1%	5.8%
Suicidal thoughts and/or behaviors	12.1%	23.2%	45.3%	6.3%	26.3%	5.8%
Youth mental health	10.5%	26.8%	54.7%	4.2%	17.9%	8.4%

Socioeconomic Empowerment

When asked to rate the top five steps that are "very necessary" for moving people from a place of poverty to stability, "mental health care and treatment" was rated fifth 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: teens, young adults, adults, older adults, and youth.

Community Resources to Address Mental Heath

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

- 211
- 988 (National Suicide Hotline)
- AMHC
- Community Health and Counseling Services
- Counselors
- Federally Qualified Health Centers
- FindHelp.Org
- Health providers
- Healthy Acadia
- Healthy Peninsula
- Hospitals
- Mount Desert Island Hospital
- Municipalities
- Next Step Domestic Violence Project
- Non-profits
- Northern Light Health
- Private sector and employers
- Public health organizations
- Schools
- Shelters
- YMCA

Crosscutting Priorities

Provider Availability **Substance Use** **Adverse Childhood Experiences**

Access to Long Term Care

Access to long term care was the second rated priority for the health conditions and outcomes category for Hancock County. Participants at the Hancock County forum agreed to add access to long term care as a priority. While not a health condition or outcome, it does play a role in the health conditions and outcomes of people in Hancock County.

Assessment Findings

In the Hancock County focus group, "older adult care" was a top theme. One participant noted challenges with finding appropriate levels of care for older adults and said:

"Adult day programs are getting [people] with nursing home levels of care "

In the Maine Shared CHNA survey, respondents living in Hancock County listed "aging health concerns" as the fourth of five social concerns impacting their community. In Hancock County,

9.1% of adults 45 and older have experienced cognitive decline (2018 & 2020). Of those who are 65 and older, 30.2% live alone (2018-2022). In the Maine Shared CHNA survey, of respondents who noted housing was a concern for them, a loved one, and/or their community (67.4%), 76.6% said the "availability of affordable, quality housing for older adults or those with special needs" impacts their community. Of survey respondents who said transportation was a concern for them, a loved one, and/or their community (62.3%), 75.1% said "availability of transportation that meets a variety of specific needs," which includes older adults and physical or cognitive needs, impacts their community.

Participants at the Hancock County stakeholder forum identified several workforce related causes to accessing

Populations and Communities Impacted by Access to Long Term Care

Access to long term care was a priority added at the forum, so registrants did not list populations during the pre-forum survey process. At the forum, respondents cited: people with disabilities, older adults, and caregivers.

Community Resources to Address Access to Long Term Care

Participants at the forum were asked to identify assets and resources related to their identified priorities. For access to long term care, respondents identified:

- At-home care
- Downeast Community Partners
- Eastern Area Agency on Aging
- Friendship Cottage
- Hancock County Hospice Volunteers
- Healthy Peninsula and Healthy Island Project's Bridging Neighbors Program
- Home health care
- Life-alert systems
- Mount Desert Nursing Association
- Non-profits
- Private sectors
- Robert and Mary's Adult Day Program
- Strauss Center Adult Day Program

Crosscutting Priorities

Aging-Related Services **Housing**

Cardiovascular Disease

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

Assessment Findings

In the Maine Shared CHNA survey, 71.5% of respondents said, "chronic health conditions," which includes cardiovascular disease, negatively impacts them, a loved one, and/or their community. When asked about specific chronic health conditions,

- 40.4% and 30.5% of survey respondents said heart disease or heart attack impacts their community or a loved one.

- 36.9%, 31.5% and 28.1% of survey respondents said high cholesterol impacts their community, a loved one, or them.
- 37.4%, 36.9%, and 31% of survey respondents said high blood pressure or hypertension impacts their community, a loved one, or them.
- Overweight/obesity had the most impact across survey respondent groups with 48.8% saying it impacts their community, 39.9% a loved one, and 40.4% themselves.

In Hancock County,

- There were 30.8 heart attack deaths for every 100,000 people (2018-2022), significantly worse than Maine (24.6 per 100,000).
- There were 186 cardiovascular disease deaths for every 100,000 people (2018-2022).
- 34.2% of adults have high blood pressure (2021).
- 37.9% have high cholesterol (2017 & 2019).

At the Hancock County stakeholder forum, participants discussed a variety of factors contributing to cardiovascular disease, with several related to healthy eating and active living – food scarcity, lack of nutrition education, cost of quality food, sedentary lifestyles, and obesity. The increase in screen time and social media were specifically noted as impacting sedentary lifestyles. In Hancock County 22.8% of adults report a sedentary lifestyle (2021) and 56.1% met physical activity recommendations (2017 & 2019). In 2019, 21.1% of high school and 26.4% of middle school students met physical activity recommendations.

Forum participants discussed chronic stress and anxiety, having multiple chronic conditions, and oral health as impacts on cardiovascular disease. Related to these, in Hancock County, 6.2% of adults have three or more chronic conditions (2019-2021) and 67.3% of adults have been to the dentist in the past year (2020).

On a systemic level, participants noted the cost of healthcare and lack of preventive care. In Hancock County 10.2% of adults are uninsured (2018-2022), significantly worse than Maine (7.1%) and the U.S. (8.7%) and 9.7% report cost barriers to health care (2019-2021).

Populations and Communities Impacted by Cardiovascular Disease

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For cardiovascular disease, respondents cited: older adults, people with low income, people with substance use disorder, people with mental health disorders, people experiencing domestic violence, adults, and people living in rural areas.

Community Resources to Address Cardiovascular Disease

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

- Beth C. Wright Cancer Resource Center
- Downeast Public Health Council
- Farmers' markets
- Federally Qualified Health Centers
- Food pantries
- Health centers
- Healthcare providers
- Healthy Acadia
- Hospitals
- Maine Center for Disease Control and Prevention
- Mount Desert Island Hospital
- Non-profits
- Northern Light Health
- Public health
- Schools
- US Center for Disease Control and Prevention
- Women, Infants and Children Program
- YMCA/YWCA

Crosscutting Priorities

Provider Availability **Nutrition** **Mental Health** **Access to Long Term Care**

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

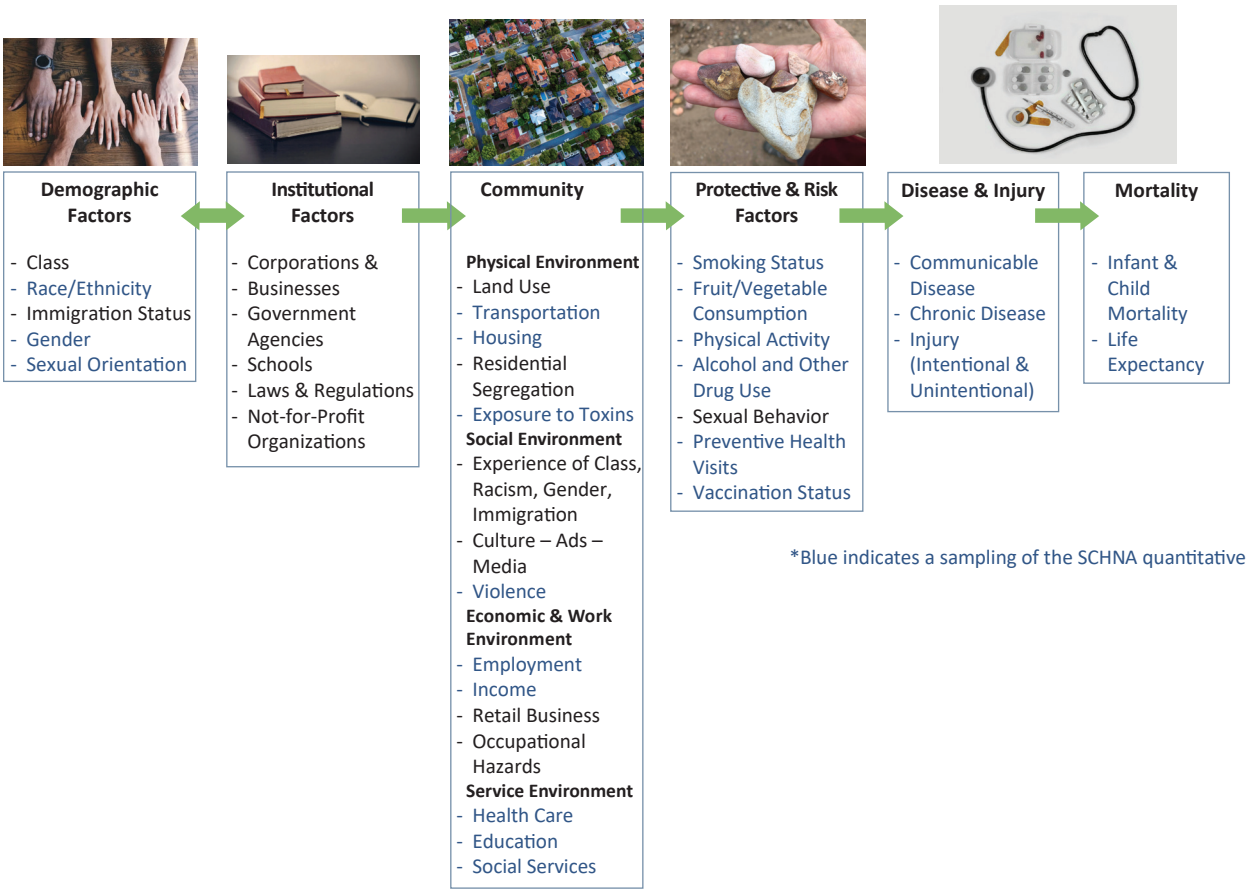
The Maine Shared CHNA also conducted a statewide, community survey on health and well-being. The survey was developed in collaboration by a small working group comprised of members of the Community Engagement and Metrics Committees, the Maine Shared CHNA Program Manager, and Crescendo Consulting Group, 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 Hancock County on September 24, 2024, with 35 attendees. People from the following organizations participated in the forum process:

- Age-Friendly Sullivan
- Beth C. Wright Cancer Resource Center
- Bucksport Regional Health Center
- Caring Hands of Maine
- Community Health and Counseling Services/Hub 8
- Department of Health and Human Services Office of Behavioral Health Children's Behavioral Health Services
- Downeast Community Partners
- Eagles' Nest Clubhouse
- Eastern Area Agency on Aging
- Emmaus Homeless Shelter
- Hancock County Emergency Management Agency
- Healthy Acadia
- Healthy Peninsula
- HOME INC Emmaus Homeless Shelter
- Maine Center for Disease Control and Prevention
- Mount Desert Island Hospital
- Next Step Domestic Violence Project
- Northern Light Blue Hill Hospital
- Northern Light Maine Coast Hospital

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)	16	94.1%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	16	94.1%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	8	47.1%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	7	41.2%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	6	35.3%
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.)	6	35.3%
Isolation	4	23.5%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	3	17.7%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	3	17.7%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	2	11.8%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	2	11.8%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	2	11.8%
Wage Gaps and Income Disparities	2	11.8%
Technology (such as access to high-speed internet and phone services)	1	5.9%
Education (such as pre-K through post-secondary and technical/trade opportunities)	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%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	1	5.9%
Ambulatory Care Sensitive Conditions	1	5.9%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	9	52.9%
Alcohol Use (including binge drinking)	9	52.9%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	8	47.1%
Preventive Oral Health Care	7	41.2%
Cancer Prevention (such as cancer screenings, sunscreen use)	6	35.3%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	6	35.3%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	6	35.3%
Adverse Childhood Experiences	6	35.3%
Illicit Drug Use	6	35.3%
Youth Mattering (such as positive role models, community connections, etc.)	5	29.4%
Immunizations & Vaccinations	3	17.7%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	3	17.7%
Safe Drinking Water	3	17.7%
Foster Care	2	11.8%
Cannabis Use	2	11.8%
Other (please specify): Lack of support services; Mental health and well-being	2	11.8%
Access to Child and Family Home Visiting	1	5.9%
Indoor Air Quality	1	5.9%
Foster Care	1	3.1%
Indoor Air Quality	1	3.1%

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%
Cancer	13	76.5%
Obesity/Weight Status	10	58.8%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	9	52.9%
Diabetes	7	41.2%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	7	41.2%
Cognitive Decline, Alzheimer's disease and other dementias	5	29.4%
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	17.7%
Multiple Chronic Conditions	3	17.7%
Intentional Injury & Death (self-injury)	2	11.8%
Dental Disease	2	11.8%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	1	5.9%
Non-Infectious Respiratory Disease (such as asthma, COPD)	1	5.9%
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%
Other (please specify): All disease and ailments, mental, physical, and holistic	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
Aging Related Services (such as long-term care, assisted living access, and in-home care support services)	20	69.0%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	17	58.6%
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)	14	48.3%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	13	44.8%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	12	41.4%
Lack of mental health support services	12	41.4%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	10.5%	4

Protective and Risk Factors	# Votes	% of Participants
Substance use	18	62.1%
Adverse Childhood Experiences	16	55.2%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	13	44.8%
Adult services	11	37.9%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	8	27.6%
Preventative Oral Health Care	8	27.6%
Alcohol Use (including binge drinking) (52.9%)	7	24.1%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	5	17.2%
Water quality	3	10.3%
Vaping Use (including tobacco and cannabis)	8	25.0%
Preventive Oral Health Care	7	21.9%
Cannabis Use	7	21.9%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	22	75.9%
Access to long-term care	14	48.3%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	12	41.4%
Cancer	10	34.5%
Aging in place services	9	31.0%
Home-based care especially for those lacking transportation	8	27.6%
Obesity/Weight Status	6	20.7%
Labor & delivery - rural OB	6	20.7%

Health Conditions and Outcomes	# Votes	% of Participants
Climate impact	2	6.9%
Diabetes	1	3.5%

Appendix 3: Community Action Agency Profile

About Downeast Community Partners

Downeast Community Partners (DCP) was formed in 2017 with the merging of two of the most venerable organizations in the region, Child and Family Opportunities and the Washington Hancock Community Agency. With a mission to improve the quality of life and reduce the impact of poverty in Downeast communities, DCP is committed to creating and delivering services and programs that treat community members with dignity and compassion and offer them the possibility of achieving their goals and dreams.

Our Mission: Downeast Community Partners' mission is to improve the quality of life and reduce the impact of poverty in Downeast communities.
Our Vision: Downeast Community Partners is a catalyst for improving life in Downeast Maine.
Our Values: Dignity. Compassion. Possibility.

Services Offered by Downeast Community Partners

Children's Education

- Early Care and education programs such as Head Start, Early Head Start, and Family Futures Downeast help provide childcare, meals, education, and more to children and families in Hancock and Washington County.

Elder Services

- Our day program, called Friendship Cottage, provides a place for elders to spend time during the day and where they can still feel integrated into our community. At Home provides support for seniors wanting to maintain independent living in their current home by installing safety railings, delivering meals and medications, and more.

Energy and Housing Services

- We have multiple programs that help people pay for heating services during the winter, as well as provide home repairs and weatherization services.

Transportation

- Transportation assistance is offered for doctors' appointments, grocery shopping, and more. Downeast Community Partners has a fleet of vans and cars dedicated to transporting people in our community to and from vital destinations.

Supportive Services

- We also have programs that are based more on coaching and providing knowledge to people or families in need. Our Whole Family Coaching program aims to help families succeed and reach their goals. We also have nursing services as well as maternal and child health services. We also provide pantry food boxes to people and families in need.

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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.

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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.

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

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

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

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

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