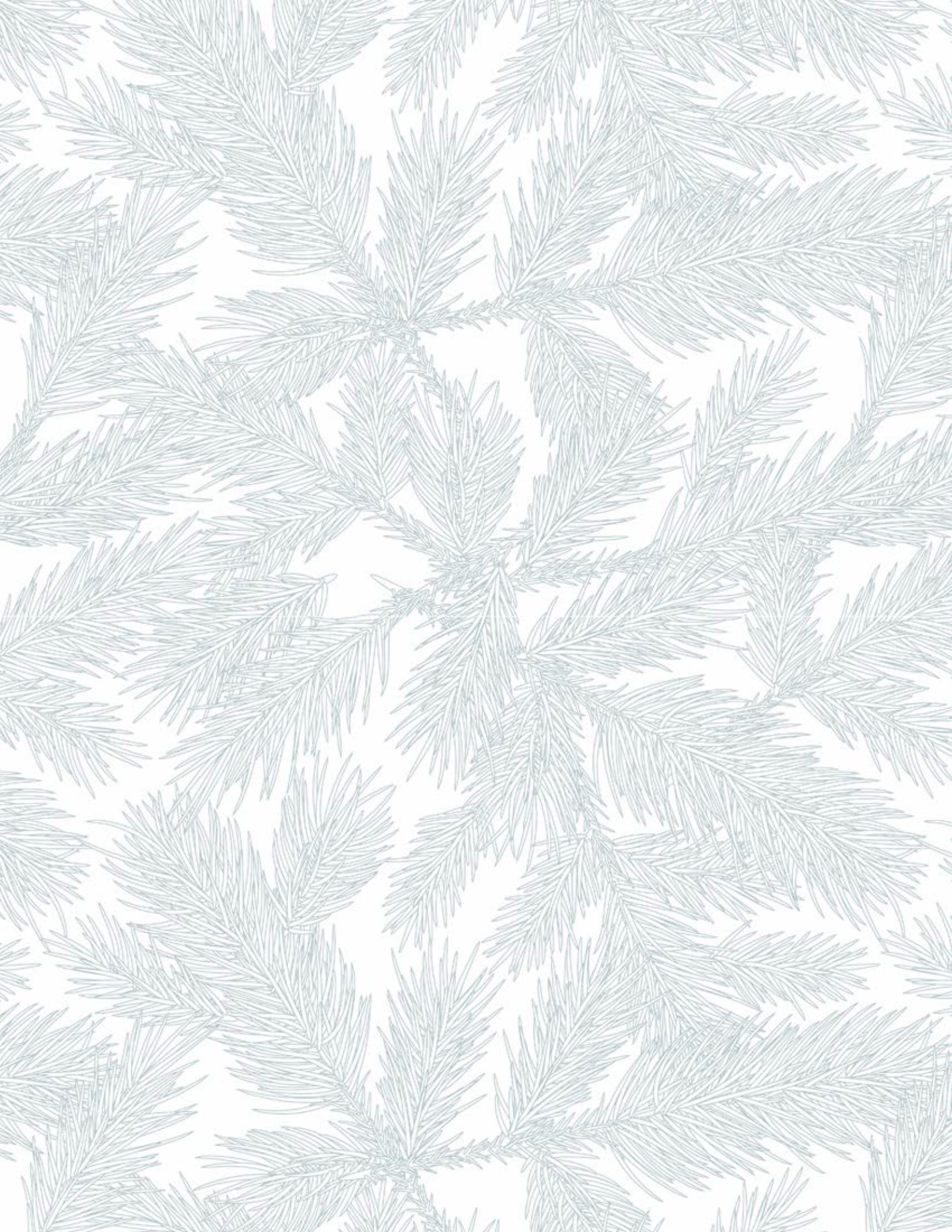
2019 Maine Shared
Community Health Needs Assessment

Somerset County

Northern Light Health℠



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Key companion documents available at www.mainechna.org:

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

EXECUTIVE SUMMARY

PURPOSE

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

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

DEMOGRAPHICS

Somerset County is one of two counties that make up the Central Public Health District. The population of Somerset County is 51,363 and 19.0% of the population is 65 years of age or older. The population is predominantly white (96.8%), 1.0% are Hispanic, and 1.8% are two or more races. The median household income is $40,484, approximately $10,000 less than the state average. Educational attainment measures for high school graduation (86.4%) and associates' degree or higher (27.0%) are lower than the state average.

TOP HEALTH PRIORITIES

The forum held in Somerset County identified a list of health issues in that community through a voting methodology. See Appendix C for a description of how priorities were chosen.

Table 1: Somerset County Health Priorities

PRIORITY AREA	% OF VOTES
Mental Health*	20%
Older Adult Health/Healthy Aging*	16%
Substance Use*	16%
Social Determinants of Health*	12%

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

NEXT STEPS

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

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

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

ACKNOWLEDGEMENTS

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

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

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

HEALTH PRIORITIES

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

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

Table 2: Somerset County Forum Voting Results

PRIORITY AREA	% OF VOTES
Mental Health*	**20%**
Older Adult Health/ Healthy Aging*	**16%**
Substance Use*	**16%**
Social Determinants of Health*	**12%**
Food Insecurity	11%
Youth/Adverse Childhood Experiences (to be discussed as part of Social Determinants of Health)	9%
Access to Care*	6%
Physical Activity, Nutrition, and Weight	5%
Chronic Disease	5%

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

MENTAL HEALTH

Mental health affects all segments of the population, regardless of age, socioeconomic status, race/ethnicity, or gender. Poor mental health contributes to a number of issues that affect both individuals and communities. Mental health disorders, when left unmanaged, may affect an individual's ability to form and maintain relationships with others, cope with challenges, and lead a healthy and productive life. Individuals with serious mental illness (e.g., major depression or schizophrenia) are at a higher risk of developing other medical conditions, including cardiovascular disease, diabetes, stroke, and Alzheimer's disease. While the reason for this link is unclear, research suggests that those with mental illness may experience more barriers to medical care and prevention strategies, and may find it harder to care for themselves.[1]

More than 25% of adults with a mental health disorder also have a substance use disorder; this comorbidity occurs more among adults with depression, anxiety disorders, schizophrenia, and personality disorders. While mental health conditions may lead to drug or alcohol use, the reverse can also be true—the misuse of certain substances may cause individuals to experience symptoms of a mental health disorder.[2]

QUALITATIVE EVIDENCE

Participants discussed how isolation and mental health conditions are a burden to other parts of the community such as schools and employers. Within health care access, mental health was a service with the largest gap. While many said there was a need for behavioral health services in general, they identified inpatient services and pediatric services as specific gaps in the spectrum of care.

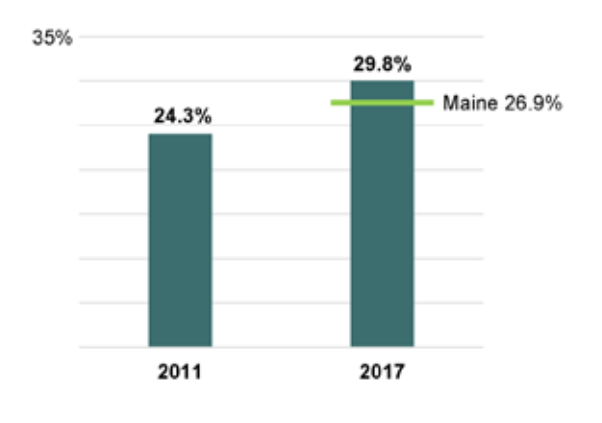
Although mental health issues affect all individuals, community forum participants identified youth, post-partum women, and individuals with a substance use disorder, as populations that were at risk for poor mental health, or as segments who had unique mental health needs. At risk youth include those whose parents have a substance use disorder. There was discussion of the need to focus on the impact of adverse childhood experiences (ACEs), and how community services build resilience and mental wellness for those most at risk. For youth, many participants discussed the need for increased education on risk factors and coping skills, provider training, and child psychiatrists. In addition, social factors that contribute to an increase in the rates of youth who report being sad and hopelessness within the past 30 days need to be addressed. Stigma, or the disapproval or discrimination against a person based on a particular circumstance (e.g., mental health condition) was identified by several participants as a major barrier to care. Stigma prevents individuals from receiving the help they need, as individuals with a mental health issue may not seek care for fear that they will be shamed or discriminated against. Community members called for more education around mental health issues, for both providers and residents, to reduce the burden of stigma.

QUANTITATIVE EVIDENCE

In Somerset County:

- The percentage of high school students who reported that they had been sad/hopeless for more than two weeks in a row increased significantly between 2011 and 2017, from 24.3% to 29.8%. This was significantly higher than the state overall (26.9%).

Figure 1: Sad/Hopeless For 2+ Weeks In A Row (High School)



- The percentage of high school students who reported having seriously considered suicide increased between 2011 and 2017, from 14.2% to 17.0%.

See Key Indicators on page 16 as well as companion Health Profiles on our website **www.mainechna.org**. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

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

Table 3: Assets and Gaps/Needs (Mental Health)

ASSETS	GAPS/NEEDS
• Kennebec Behavioral Health • Northern Light Acadia Hospital – Bangor • Assistance Plus • Screening at Physician office for caregivers • 211 Maine • Somerset Public Health • Kennebec Valley Community Action Program	• Child Psychiatry • Address mental health bias • Not enough providers • Stigma • No reimbursement • Lack of beds • Community understanding of mental health • Transportation • Recreational trails/green space • First responders

OLDER ADULT HEALTH/HEALTHY AGING

The World Health Organization's definition of active aging and support services are those that "optimize opportunities for health, participation and security in order to enhance quality of life as people age." Maine's older population is growing in all parts of the state, and it remains the oldest state in the nation as defined by median population—44.3 years of age in 2017 compared to the national median age of 37.8. Gains in longevity create an opportunity for active lives well after age 65. Along with the increase in an older population is a concurrent increase in strengthening the infrastructure of health services for this group, as well as addressing wellness.

QUALITATIVE EVIDENCE

Community forum participants discussed the need for a continuum of services for people as they age, including coordination of health and support services and palliative care. Community forum participants and key informants identified a need for education and services to address depression and isolation amongst older adults. Older adults experience loneliness for many reasons; it may come as a result of living alone, limited connections with family, friends, or communities, and can make living independently a challenge. Socialization was discussed as an important protective factor to cognitive decline. Limited access to transportation was identified as a key barrier to accessing health care for older adults, but also access to other needed goods and services that are important for those living with chronic disease and the general adult population (e.g., groceries, prescriptions, physical activity). The rising cost of healthcare and prescriptions was a key theme in discussions around older adults.

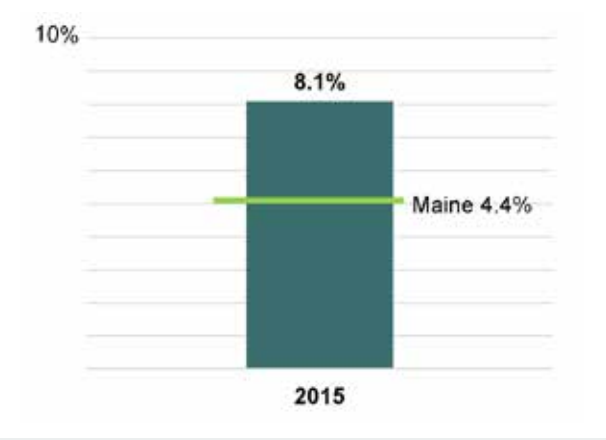
The need for affordable and safe housing was another critical issue. Many older adults want to "age in place," staying in their own home or their own community. However, for some older residents, this is difficult or impossible, for financial, medical, or safety reasons. The need for heating fuel assistance was specifically identified as a need in the forum. Additionally, with aging in place as a preferred lifestyle, concerns around isolation become more significant. Caregiving to support aging adults was highlighted as a major need in Somerset County, and that there are significant supports needed for the caregivers. Older adult falls were highlighted as an area where more prevention efforts could reduce injury.

QUANTITATIVE EVIDENCE

In Somerset County:

- The percent of the population age 65 and older living alone was higher than the state overall (46.7% vs. 45.3%) in 2012-2016.
- The percentage of adults with arthritis increased between 2011–2013 and 2014–2016, from 30.8% to 36.2%.
- The fall-related injury (unintentional) emergency department rate per 10,000 was significantly higher than the state overall (448.8 vs. 340.9) in 2012–2014.
- The traumatic brain injury emergency department rate per 10,000 increased significantly between 2009-2011 and 2012-2014, from 107.7 to 124.4. The rate was significantly higher than the state overall (85.1).

Figure 2: Adults Who Reported Caregiving of 20 Hours or More A Week



- The percent of adults who reported caregiving of 20 hours or more a week was 8.1% in 2015, almost twice that of the state average of 4.4%.

See Key Indicators on page 16 as well as companion Health Profiles on our website **www.mainechna.org**. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS OLDER ADULT HEALTH/ HEALTHY AGING

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

Table 4: Assets and Gaps/Needs (Older Adult Health/Healthy Aging)

ASSETS	GAPS/NEEDS
• Area Agency on Aging • 211 Maine • Spectrum Generations • Care managers • Primary care support • YMCA • American Association of Retired Persons (AARP) • Local resources for older adults	• Transportation in rural areas • Safety concerns related to aging adults • Support for community volunteers • Healthcare worker shortage • Not enough geriatricians • Follow up support • Health literacy • Home adaption • Polypharmacy • Housing/home maintenance • Structural support for caregivers • Primary care support

SUBSTANCE USE

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 8% of adults in the United States have had a substance use disorder in the past year.[3] Tobacco, alcohol, marijuana, and nonmedical use of prescription pain relievers (e.g., OxyContin, Vicodin) are the leading substance use health issues for adults.[4] Tobacco, alcohol, and marijuana are the most common substances misused by adolescents, followed by amphetamines (e.g., Adderall) and non-medical use of prescription pain relievers.[5] Those with substance use disorders often face a number of barriers that limit access to and hinder engagement in care. One study estimates that more than 50% of individuals with mental health and substance use issues are not engaged in needed services.[6] Barriers to care include a lack of education, awareness, and understanding around the signs, symptoms, risk factors, and consequences associated with substance use, social stigma, and workforce shortages. Many forum participants and key informant interviewees statewide identified gaps in access to substance use treatment and recovery services. Finally, those who are uninsured or underinsured are more likely to face barriers to care, and historically, coverage for substance use services has been less comprehensive than for physical health services. Even for those who are eligible for free or discounted services, or for those with commercial insurance, substance use treatment is complicated by the cost of co-pays, transportation, and medications. Many substance use treatment providers to not accept any insurance, including commercial insurance, and require payment out-of-pocket.

QUALITATIVE EVIDENCE

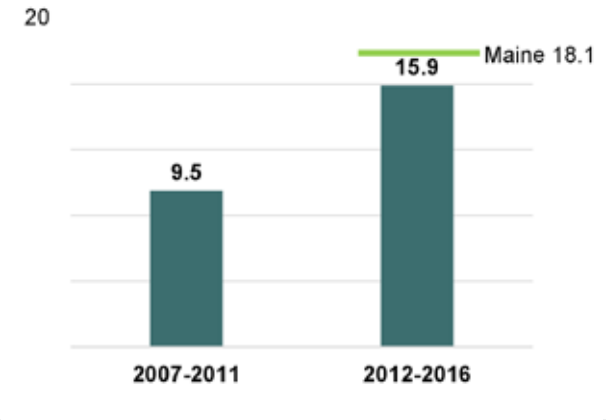
Opioid use disorder was the leading substance use issue discussed in the community forum. Participants discussed the need for more comprehensive, accessible, and affordable services to help those in need. The need for intensive outpatient services, faith-based programs, short and long term inpatient services, and harm reduction (e.g., needle exchange) services were identified as gaps in the spectrum of care. Particular concerns were raised for youth living with adults with untreated substance use disorder and ensuring timely and effective treatment of parents.

Statewide, key informants identified a number of challenges faced by those who are struggling with substance use disorder. Those challenges include understanding how to access healthcare, find a usual source of primary and dental care, and how to access treatment that can address co-occuring mental health and substance use. Informants also identified needs specific to youth, including information on where and how to access treatment and improved access to confidential services. Another key theme was the need to provide better access to many of the resources that make up the social determinants of health: affordable, safe, and supportive housing; transportation; and nutritious foods.

Tobacco, alcohol, and marijuana were also identified as issues of concern. Tobacco and alcohol use are known risk factors for a number of chronic and complex conditions, including cancer, respiratory diseases, cardiovascular diseases, and liver disease. Tobacco and alcohol are also contributing factors to mental health conditions, obesity, and cognitive decline. The rise in use of tobacco through vaping, especially among youth, was identified as a risk for increased tobacco use. Some participants identified marijuana use as an emerging issue—there is a lack of clarity on health effects, recreational vs. medicinal use, and the short-term and long-term impacts on both individuals and communities.

QUANTITATIVE EVIDENCE

Figure 3: Overdose Deaths per 100,000 Population



In Somerset County:

- Past-30-day cigarette smoking among high school students significantly decreased between 2011 and 2017, from 17.1% to 9.8%. The percentage was higher than the state overall (8.8%).
- Environmental tobacco smoke exposure among middle school students was significantly higher than the state overall (33.9% vs. 22.8%) in 2017.
- Overdose deaths per 100,000 population increased between 2007-2011 and 2012-2016, from 9.5 to 15.9.

See Key Indicators on page 16 as well as companion Health Profiles on our website www.mainechna.org. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE USE

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

Table 5: Assets and Gaps/Needs (Substance Use)

ASSETS	GAPS/NEEDS
• Primary care provider efforts for substance use disorder prevention • Kennebec Behavioral Health • MaineGeneral Behavioral Health/Addiction Medicine • First Responders • Behavioral health agents • Access to Narcan	• Stigma reduction • Opiate bias trainings • Education on marijuana • More trained workers • Money • More training for law enforcement • Recovery programs and treatment funding • Every primary care provider providing opiate and behavioral health treatment • More creativity in prevention efforts • More access to measures to treat addiction

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people live, work, learn, and play that affect their health; factors include socioeconomic status (e.g., education, income, poverty), housing, transportation, social norms and attitudes (e.g., racism and discrimination), crime and violence, literacy, and availability of resources (e.g., food, health care). These conditions influence an individuals' health and define quality of life for many segments of the population, but specifically those that are most vulnerable. According to the Kaiser Family Foundation, social factors like education, racism, and poverty accounted for over a third of total deaths in the United States.[7] The community also discussed the impact of Adverse Childhood Experiences (ACEs) on youth health, and the need to focus on mental health to support at risk youth.

QUALITATIVE EVIDENCE

A dominant theme from key informant interviews and the community forum was the tremendous impact that the underlying social determinants, particularly housing, and transportation, have on residents in Somerset County. Access to affordable and reliable forms of transportation was problematic. Lack of access to the use of a personal vehicle may be due to any number of factors including affording the vehicle itself, or the insurance, repairs, or even perhaps a license suspension or revocation. This is can be especially challenging in areas without reliable public transportation, like in rural Maine. This results in difficulty accessing health services, employment, and basic necessities (e.g., food, clothing, medication). This issue is further complicated for older adults with mobility impairments and individuals with disabilities who require specialized forms of transportation or extra assistance.

Food insecurity was identified as a significant concern, especially for youth and low-income families, and older adults. Discussion centered on the need to consider policy solutions to address food insecurity in addition to the existing resources of Supplemental Nutrition Assistance Program (SNAP), food kitchens, and meals on wheels. SNAP benefits were identified as an asset; however, families' ability to access stores and markets can be challenged by lack of access to transportation.

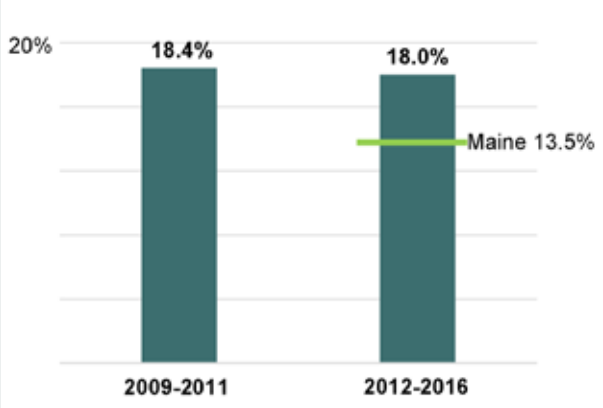
Food insecurity refers to a lack of resources to access enough nutritional food for a household. Food insecurity has both direct and indirect impacts on health for people of all ages, but is especially detrimental to children.[8] Chronic diseases and health conditions associated with food insecurity include asthma, low birthweight, diabetes, mental health issues, hypertension, and obesity.[9] In Somerset County, 16.2% of households lack enough food to maintain healthy, active lifestyles for all household members (vs. 15.1% for the state overall).

QUANTITATIVE EVIDENCE

In Somerset County:

- The percentage of individuals living in poverty was higher than the state overall (18.0% vs. 13.5%) in 2012–2016.
- The percentage of children living in poverty was higher than the state overall (26.2% vs. 17.2%) in 2012–2016.
- The percentage of high school students who reported at least 3 adverse childhood experiences was higher than the state overall (25.6% vs. 23.4%) in 2017.

Figure 4: Individuals Living in Poverty



- The percentage of households that lack enough food to maintain healthy, active lifestyles for all household members was higher than the state overall (16.2% vs. 15.1%) in 2014-2015.

See Key Indicators on page 16 as well as companion Health Profiles on our website **www.mainechna.org**. Those documents also include information on data sources and definitions.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

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

Table 6: Assets and Gaps/Needs (Social Determinants of Health)

ASSETS	GAPS/NEEDS
• 211 Maine • Kennebec Valley Community Action • YMCA • Local food pantries • United Way food drives • Boys and Girls Club of Somerset County • Soup kitchens • Community gardens • Child and Adult Care food program • United Way of Mid-Maine food project • Meals on Wheels • Food bags at primary care practices • Supplemental Nutrition Assistance Program • School programs	• School Staff Training • Nutrition Education • Gap in child protective services/Department of Health and Human Services workers • Lack of understanding • Gap in transportation to resources • Need jobs with livable wages • Parent education in schools • Resource gap • Stigma surrounding being able to afford food • Gap in food access • Books

COMMUNITY CHARACTERISTICS

AGE DISTRIBUTION

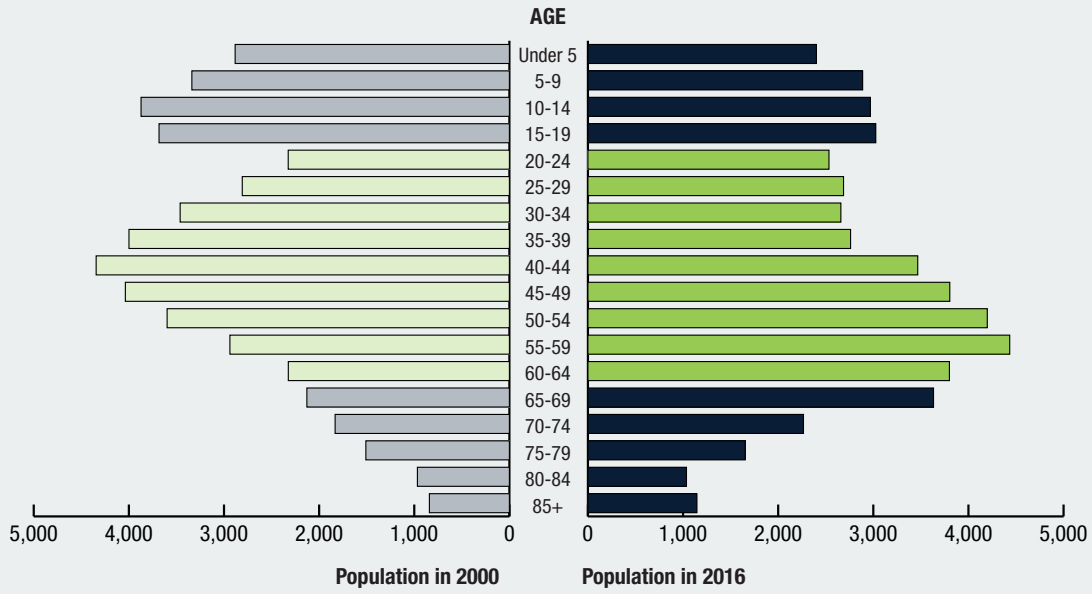
Age is a fundamental factor to consider when assessing individual and community health status; older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.[10] With an aging population comes increased pressure on the healthcare system and shortages in the healthcare workforce, especially geriatricians, nurses, social workers, and direct care workers like home health aides and certified nursing assistants, to meet the needs of older adults.[11]

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

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

- In Somerset County, 19.0% of the population is 65 years of age or older.

Figure 5: Age Histogram of Somerset County



RACE/ETHNICITY

An extensive body of research illustrates the health disparities that exist for racial/ethnic minorities, non-English speakers, and foreign-born populations. According to the U.S. Centers for Disease Control and Prevention (CDC), non-Hispanic Blacks have higher rates of premature death, infant mortality and preventable hospitalization than non-Hispanic Whites.[12] Individuals with limited English proficiency (LEP), defined as the ability to read, speak, write or understand English "less than very well," have lower levels of medical comprehension. This leads to higher rates of medical issues and complications, such as adverse reactions to medication.[13,14] Cultural differences such as, but not limited to, the expectations of who is involved in medical decisions can also impact access to health care and to health information. These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.

In Somerset County:

- The population is predominantly White (96.8%), 1.8% were two or more races, and 1.0% were Hispanic.

Table 7: Race/Ethnicity in Somerset County 2012-2016

	PERCENT/NUMBER
American Indian/Alaskan Native	0.4% / 215
Asian	0.3% / 161
Black/African American	0.5% / 274
Hispanic	1.0% / 507
Some other race	0.0% / 23
Two or more races	1.8% / 921
White	96.8% / 49,743

SOCIOECONOMIC STATUS

Socioeconomic status (SES) is measured by such things as income, poverty, employment, education, and neighborhood characteristics. Individuals with low SES are more likely to have chronic health issues, die prematurely, and have overall poor health. Low-income status is highly correlated to a lower than average life expectancy.[15] Lack of gainful employment is linked to several barriers to care, such as lack of health insurance, inability to pay for health care services, and the inability to pay for transportation to receive services. Higher education is associated with improved health outcomes and social development at individual and community levels.[16] The health benefits of higher education typically include better access to resources, safer and more stable housing, and better engagement with providers. Factors associated with low education impact an individual's ability to navigate the healthcare system, disparities in personal health behaviors, and exposure to chronic stress. It is important to note that, while education affects health, poor health status may also be a barrier to education. Table 8 includes a number of data points comparing Somerset County to the state overall.

Additionally, in Somerset County:

- The estimated high school graduation rate was similar to the state overall in 2017 (86.4% vs. 86.9%).
- The percent of the population over 25 with an associate's degree or higher was lower than the state overall in 2011-2016 (27.0% vs. 37.3%).

Table 8: Socioeconomic Status

	SOMERSET/MAINE
Median household income	$40,484 / $50,826
Unemployment rate	5.7% / 3.8%
Individuals living in poverty	18.0% / 13.5%
Children living in poverty	26.2% / 17.2%
65+ living alone	46.7% / 45.3%

SPECIAL POPULATIONS

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

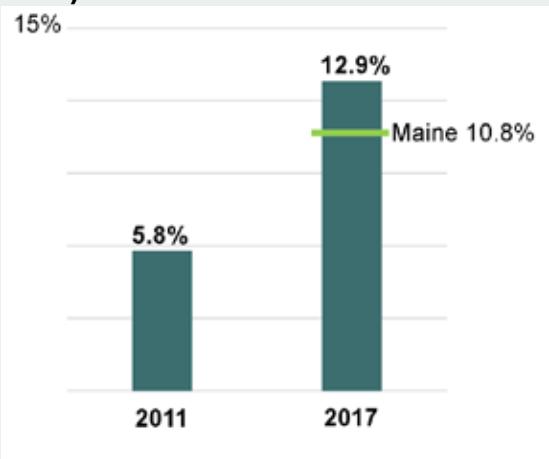
Older Adults

Maine is the oldest state in the nation by median age. Older adults are more likely to develop chronic illnesses and related disabilities, such as heart disease, hypertension, diabetes, depression, anxiety, Alzheimer's disease, Parkinson's disease, and dementia. Older adults with multiple chronic conditions are at a higher risk for losing the ability to live independently at home. Community forum participants cited barriers to access to care for older adults, including lack of transportation, inability to pay for needed healthcare services/high cost of medications, and depression/isolation as problems in their community. To support long-term aging in place, the community discussed the need for additional supports and a stronger continuum of services for aging adults that included older adult health/social service planning, supports for safe living at home, and palliative care.

Youth

Youth were identified as a priority population in the Somerset County Community Forum. Specific issues of concern were youth mental health issues (specifically depression and stress), access to oral health care, substance use (specifically opioids, marijuana, and tobacco), and need for more prevention activities to support education and promotion around nutrition and physical activity. Related to both physical activity and mental health, community members discussed the need to address screen time. The number of youth that self identify as Gay, Lesbian, or Bisexual (GLB) increased between 2011 and 2017. LGBTQ youth face higher rates of depression, obesity, and have other health risks. One key informant who works with youth identified a need for them to be able to access low-cost and anonymous health services, specifically reproductive and substance use services, without parent permission.

Figure 6: Gay, Lesbian, and Bisexual (High School)



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

KEY INDICATORS

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

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

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

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

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

ADDITIONAL SYMBOLS

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

	SOMERSET COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
SOCIAL, COMMUNITY & PHYSICAL ENVIRONMENT							
Children living in poverty	2007-2011 **25.0%**	2012-2016 **26.2%**	N/A	2012-2016 **17.2%**	N/A	2016 **21.1%**	N/A
Median household income	2007-2011 **$37,875**	2012-2016 **$40,484**	N/A	2012-2016 **$50,826**	N/A	2016 **$57,617**	N/A
Estimated high school student graduation rate	2014 **83.9%**	2017 **86.4%**	N/A	2017 **86.9%**	N/A	–	N/A
Food insecurity	2012-2013 **16.8%**	2014-2015 **16.2%**	N/A	2014-2015 **15.1%**	N/A	2015 **13.4%**	N/A
HEALTH OUTCOMES							
14 or more days lost due to poor physical health	2011-2013 **24.3%**	2014-2016 **19.0%**	○	2014-2016 **19.6%**	○	2016 **11.4%**	N/A
14 or more days lost due to poor mental health	2011-2013 **21.9%**	2014-2016 **20.6%**	○	2014-2016 **16.7%**	○	2016 **11.2%**	N/A
Years of potential life lost per 100,000 population	2010-2012 **7,283.6**	2014-2016 **7,889.5**	○	2014-2016 **6,529.2**	!	2014-2016 **6,658.0**	N/A
All cancer deaths per 100,000 population	2007-2011 **208.0**	2012-2016 **192.7**	○	2012-2016 **173.8**	!	2011-2015 **163.5**	!
Cardiovascular disease deaths per 100,000 population	2007-2011 **237.8**	2012-2016 **256.7**	○	2012-2016 **195.8**	!	2016 **218.2**	!
Diabetes	2011-2013 **11.8%**	2014-2016 **11.7%**	○	2014-2016 **10.0%**	○	2016 **10.5%**	○
Chronic obstructive pulmonary disease (COPD)	2011-2013 **9.0%**	2014-2016 **12.4%**	○	2014-2016 **7.8%**	!	2016 **6.3%**	!
Obesity (adults)	2011 **32.6%**	2016 **36.5%**	○	2016 **29.9%**	○	2016 **29.6%**	!
Obesity (high school students)	2011 **13.4%**	2017 **18.0%**	○	2017 **15.0%**	○	–	N/A
Obesity (middle school students)	2015 **17.2%**	2017 **22.7%**	○	2017 **15.3%**	!	–	N/A
Infant deaths per 1,000 live births	2007-2011 **9.3**	2012-2016 **7.7***	○	2012-2016 **6.5**	○	2012-2016 **5.9**	○
Cognitive decline	2012 **17.1%**	2016 **10.8%**	○	2016 **10.3%**	○	2016 **10.6%**	○
Lyme disease new cases per 100,000 population	2008-2012 **11.1**	2013-2017 **68.5**	N/A	2013-2017 **96.5**	N/A	2016 **11.3**	N/A
Chlamydia new cases per 100,000 population	2008-2012 **193.8**	2013-2017 **291.2**	N/A	2013-2017 **293.4**	N/A	2016 **494.7**	N/A
Fall-related injury (unintentional) emergency department rate per 10,000 population	2009-2011 **452.3**	2012-2014 **448.8**	○	2012-2014 **340.9**	!	–	N/A
Suicide deaths per 100,000 population	2007-2011 **14.3**	2012-2016 **18.2**	○	2012-2016 **15.9**	○	2016 **13.5**	○
Overdose deaths per 100,000 population	2007-2011 **9.5**	2012-2016 **15.9**	○	2012-2016 **18.1**	○	2016 **19.8**	○

	SOMERSET COUNTY DATA			BENCHMARKS			
KEY INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/–**	**U.S.**	**+/–**
HEALTH CARE ACCESS AND QUALITY							
Uninsured	2009-2011 **12.0%**	2012-2016 **11.3%**	N/A	2012-2016 **9.5%**	N/A	2016 **8.6%**	N/A
Ratio of primary care physicians to 100,000 population	–	2017 **41.9**	N/A	2017 **67.3**	N/A	–	N/A
Ratio of psychiatrists to 100,000 population	–	2017 **1.9**	N/A	2017 **8.4**	N/A	–	N/A
Ratio of practicing dentists to 100,000 population	–	2017 **10.0**	N/A	2017 **32.1**	N/A	–	N/A
Ambulatory care-sensitive condition hospitalizations per 10,000 population	–	2016 **97.8**	N/A	2016 **74.6**	N/A	–	N/A
Two-year-olds up-to-date with recommended immunizations	2014 **76.5%**	2017 **73.9%**	N/A	2017 **73.7%**	N/A	–	N/A
HEALTH BEHAVIORS							
Sedentary lifestyle – no leisure-time physical activity in past month (adults)	2011 **31.2%**	2016 **23.0%**	○	2016 **20.6%**	○	2016 **23.2%**	N/A
Chronic heavy drinking (adults)	2011-2013 **5.5%**	2014-2016 **6.2%**	○	2014-2016 **7.6%**	○	2016 **5.9%**	N/A
Past-30-day alcohol use (high school students)	2011 **29.4%**	2017 **19.6%**	★	2017 **22.5%**	○	–	N/A
Past-30-day alcohol use (middle school students)	2011 **8.3%**	2017 **4.3%**	○	2017 **3.7%**	○	–	N/A
Past-30-day marijuana use (high school students)	2011 **22.4%**	2017 **19.2%**	○	2017 **19.3%**	○	–	N/A
Past-30-day marijuana use (middle school students)	2011 **6.3%**	2017 **5.3%**	○	2017 **3.6%**	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2011 **7.4%**	2017 **4.4%**	★	2017 **5.9%**	★	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	2011 **2.3%**	2017 **2.5%**	○	2017 **1.5%**	○	–	N/A
Current (every day or some days) smoking (adults)	2011-2012 **26.5%**	2016 **24.1%**	○	2016 **19.8%**	○	2016 **17.0%**	N/A
Past-30-day cigarette smoking (high school students)	2011 **17.1%**	2017 **9.8%**	★	2017 **8.8%**	○	–	N/A
Past-30-day cigarette smoking (middle school students)	2011 **5.8%**	2017 **2.3%**	★	2017 **1.9%**	○	–	N/A

Leading Causes of Death

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

RANK	STATE OF MAINE	SOMERSET COUNTY
1	Cancer	Heart disease
2	Heart disease	Cancer
3	Chronic lower respiratory diseases	Chronic lower respiratory diseases
4	Unintentional injuries	Stroke (tie for 4)
5	Stroke	Unintentional injuries (tie for 4)

APPENDIX A: REFERENCES

1 National Institute of Mental Health. (n.d.).Chronic illness & mental health. Retrieved from https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/index.shtml

2 National Institute of Mental Health. (2017). Mental health and substance use disorders. Retrieved from https://www.mentalhealth.gov/what-to-look-for/mental-health-substance-use-disorders

3 Substance Abuse and Mental Health Services Administration. (2016). Mental health and substance use disorders. Retrieved from https://www.samhsa.gov/disorders.

4 Lipari, R.N. & Van Horn, S.L. (2017). Trends in substance use disorders among adults aged 18 or older. Retrieved from https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

5 National Institute on Drug Abuse. (2014). Principles of adolescent substance use disorder treatment: A research based guide. What drugs are most frequently used by adolescents? Retrieved from https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/frequently-asked-questions/what-drugs-are-most-frequently-used-by-adolescents

6 Mental Health America. (2017). Access to care. Retrieved from http:// www. mentalhealthamerica.net/issues/mental-health-america-access-care-data

7 Bernazzani, S. (2016). The importance of considering the social determinants of health. Retrieved from https://www.ajmc.com/contributor/sophia-bernazzani/2016/05/the-importance-of-considering-the-social-determinants-of-health

8 Food Research and Action Center. (2017). Hunger and health: The impact of poverty, food insecurity, and poor nutrition on health and well-being. Retrieved from http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf

9 Food Research and Action Center, Hunger and Health

10 Lyons, L. (2013, March 11). Age, religiosity, and rural America. Retrieved from http://www.gallup.com/poll/7960/age-religiosity-rural-america.aspx

11 Rowe, J.W. et al. (2016, September 19). Preparing for better health and health care for an aging population: A vital direction for health and health care. Retrieved from https://nam.edu/wp-content/uploads/2016/09/Preparing-for-Better-Health-and-Health-Care-for-an-Aging-Population.pdf

12 Centers for Disease Control and Prevention. (2015, September 10). CDC Health Disparities and Inequalities Report (CHDIR). Retrieved from https://www.cdc.gov/minorityhealth/chdireport.html, September 10, 2015

13 Wilson, E., Chen, A.H., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. Journal of General Internal Medicine, 20(9), 800-806.

14 Coren, J.S., Filipetto, F.A., & Weiss, L.B. (2009). Eliminating barriers for patients with limited English proficiency. Journal of the American Osteopathic Association, 109(12), 634-640.

15 Chetty, R., Stepner, M., Abraham, S. et al. (2016). The association between income and life expectancy in the United States, 2001-2014. Journal of the American Medical Association, 315(16), 1750-1766.

16 Zimmerman, B., Woolf, S.H., & Haley, A. (2015). Population health: Behavioral and social science insights – Understanding the relationship between education and health. Retrieved from https://www.ahrq.gov/professionals/education/curriculum-tools/ population-health/zimmerman.html, September 2015

APPENDIX B: HISTORY AND GOVERNANCE

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

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

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

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

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

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

APPENDIX C: METHODOLOGY

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

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

Data Analysis

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

Outreach and Engagement

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

Final Reports

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

DATA ANALYSIS

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

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

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

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

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

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

OUTREACH AND ENGAGEMENT

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

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

Data Health Profiles include:

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

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

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

Forums and Health Priorities

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

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

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

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

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

Somerset County Forums

One community engagement activity was held in Somerset County.

Table 9: Community engagement activites in Somerset County, 2018

TYPE OF ENGAGEMENT	LOCATION & DATE	FACILITATOR	ATTENDEES
Community Forum	Skowhegan 10/17/2018	JSI	54

COMMUNITY ENGAGEMENT

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

- All Saints Church
- Central Public Health District
- Community member
- HealthReach Community Health Centers
- Healthy SV
- Kennebec Valley Community Action Program Child and Family Services
- Local First Group, LLC
- Main Street Skowhegan
- Maine CDC
- Maine Federation of Farmers' Markets
- MaineGeneral Health
- MaineGeneral Medical Center
- MSAD #53
- Maine State Legislature, District 107
- New Balance
- Northern Light Health
- Northern Light Health Acadia Hospital
- Northern Light Sebasticook Valley Hospital
- Outdoor Sport institute
- Redington-Fairview General Hospital
- RSU 54/MSAD 54
- Sebasticook Valley Hospital
- Skowhegan Area Chamber
- Somerset Public Health
- Spectrum Generations
- State of Maine, Maine CDC, Office of Rural Health and Primary Care
- United Way of Mid-Maine
- Walgreens
- Worksite Wellness Consultant

Key informant interviews

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

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

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

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

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

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

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

Data collection

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

FINAL REPORTS

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

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