Community Engagement Profile:

Executive Summary: Maine Overview

2024

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Introduction

The Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is a collaborative partnership between Central Maine Healthcare, Northern Light Health, MaineGeneral Health, MaineHealth, the Maine Center for Disease Control and Prevention, and the Maine Community Action Partnership. 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. This is the sixth collaborative Maine Shared CHNA.

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.

Community Engagement

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. Drawing on narrative and lived experience we are better positioned to identify the root causes of health and well-being behaviors and outcomes and not just what those behaviors and outcomes are. 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's community engagement included: focus groups, key informant interviews, and a statewide community survey.

The Maine Shared CHNA recognizes the need to work 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.

This document contains a summary of key themes from the key informant interviews, statewide focus groups, and the statewide community survey. In addition, this document discusses the findings from the 2024-2028 Statewide Needs Assessment conducted by the Catherine Cutler Institute, University of Southern Maine on behalf of the Maine State Plan on Aging, Office of Aging and Disability Services (OADS) and the 2023 Health Care Access Survey conducted by John Snow, Inc. on behalf of Disability Rights Maine (DRM).

The Maine Shared CHNA's community engagement process and data commitments are outlined in the Appendix. The community engagement overviews, as well as additional information and data, can be found online at the Maine Shared CHNA's website – www.mainechna.org.

Focus Groups and Key Informant Interviews

Focus Group Participants: 31

Key Informant Interview Participants: 26

Community Strengths and Needs

Throughout focus groups and interviews with community members and stakeholders across the state, many individuals discussed themes that spanned across identities. These discussions focused on both the strengths and the needs of all people living in Maine.

Strengths

Participants discussed strengths as they applied to community members across the state rather than specific populations. These statewide strengths included:

- **Strong sense of community**
- **Increased use of telehealth and telehealth accommodations**
- **Creative public health initiatives**

"We all work together. If I couldn't mow my lawn, my neighbor would do it for me - probably wouldn't even have to ask […] we all help each other out and that's just how it is."

- *Maine Shared CHNA focus group participant*

Needs

Across focus groups and interviews, participants discussed the needs of the community as a whole as well as needs specific to their unique population. The needs that were common across the state included:

- **Housing and housing support**
- **Transportation**
- **Healthcare access**
- **Social needs**
- **Health equity efforts**

"[…] the system has inequities and none of the people chose to be in the situations they're in. Collectively, we first need education to understand these challenges, [and understand the] impact of a lifetime of disparities. We need to get people out of individual mindset. […] We need to look at the system to fix these things and then focus on individuals."

- *Maine Shared CHNA focus group participant*

Comparison of Identified Needs with Other Assessments

Groups within the state of Maine have conducted multiple assessments on statewide needs for certain populations including an assessment of the needs of aging adults needs by the Office of Aging and Disability Services (OADS) [1] and an assessment of health access by Disability Rights Maine (DRM).[2] These reports offer a comprehensive overview of the needs and priorities of their specified populations. These primary needs and priorities identified by these two reports overlapped significantly with the needs identified in this report as indicated in the following table.

	Housing	Transportation	Food and Nutrition Access	Healthcare Access	Social Needs	Health Equity
Maine Statewide Community Health Needs Assessment **(Maine SCHNA)**	☑	☑		☑	☑	☑
Maine State Plan on Aging Needs Area Agency Assessment **(OADS)**	☑	☑	☑	☑	☑	☑
Equitable Access to HealthCare for Mainers with Disabilities Report **(DRM)**	☑	☑		☑		☑

Needs By Population

Focus groups were held with populations that are systemically disadvantaged to understand the needs of their communities. These focus groups included **multigenerational Black/African American, veterans, LGBTQ+, women, youth,** and **young adults.** Although the **migrant population** was unable to provide feedback in a focus group setting, many stakeholders and community members shared their experience regarding the needs of this population. Key stakeholders that work closely with the focus group populations were also interviewed to have a holistic understanding of the needs and concerns of these unique communities. Prevalent needs that were discussed can be found in the figure below. **Stigma, healthcare access,** and **community resources** were the most frequently discussed across all groups, however each population often had its specific concerns within these areas.

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[1] Maine Department of Health and Human Services. (2024). *Statewide Plan of Action final report*. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/SPOA-Final-Report-2024.pdf

[2] Disability Rights Maine. (2023). *Equitable access to health care for Mainers with disabilities*. https://drme.org/assets/brochures/DRM-Equitable-Access-to-Health-Care-for-Mainers-with-Disabilities-Final.pdf

Maine Shared CHNA Prevalent Needs by Population Matrix

Population	Prevalent Needs		
Multigenerational Black/African American	STIGMA Systemic racism Lack of representation	HEALTHCARE ACCESS Inequitable quality of care Cultural competence	
Veteran	STIGMA Internalized	HEALTHCARE ACCESS Mental & behavioral care	COMMUNITY RESOURCES Housing
LGBTQ+	STIGMA Societal	HEALTHCARE ACCESS Insurance coverage	
Women	HEALTHCARE ACCESS	COMMUNITY RESOURCES Childcare	
Youth	HEALTHCARE ACCESS Oral health Substance use	PUBLIC SAFETY Pedestrian and biker safety	
Young Adult	HEALTHCARE ACCESS Oral health Mental health	COMMUNITY RESOURCES Childcare Housing	
Migrant Immigrant, refugee, asylee, seasonal worker	HEALTHCARE ACCESS Language barriers	STIGMA Internalized Xenophobia	EMPLOYMENT

Multigenerational Black/African American

Number of Focus Group Participants: 12

Top Themes

- Stigma, including systemic racism and lack of representation
- Healthcare Access, including equity and cultural competence

The following section includes select quotes from focus group participants and interviewees:

Systemic racism

“It's easy to see homogeneous [white] Maine if you don't know any better. There's a wide range of health needs in the community due to diversity, and we need to work harder to reach the most vulnerable because they're spread out.”

“The acknowledgement that there is an issue has been good. The challenge has been that the level of investment in community pales in comparison to long historical underinvestment in these communities, especially for the multigenerational Black community.”

“Until we get to a place where our [morbidity and mortality] numbers are going down and our health is going up, there’s a reason why we don’t seek a counselor or get help for substance abuse, it’s because of systemic racism in our healthcare system.”

“There’s so much research on the wage gap, especially with Black women which comes with the ability to buy healthy food, take time off work, choose where you live. And folks who are underemployed don’t have the ability to move up the ladder.”

Lack of Representation

“Our biggest need is to be represented and prioritized in process and policies related to [social drivers of health].”

“I would make sure that state health policy and procedures were revamped so that they were built with the most marginalized and vulnerable in mind and that programs and initiatives were designed to address that population first and foremost and that funding would reflect those priorities.”

“If the state continues to push down how race and ethnicity is considered in mechanisms, strategies, and programs, then you get to a point where its meaningless.”

Equity

“We had a white doula because I knew stepping into the room diminished our outcomes. I’ve come to terms with the fact that me being in a room diminishes the outcomes of my partner and my soon to be child.”

“There is a mistrust in the Black community with the healthcare system due to prior injustices…”

Cultural Competence

[It is important that medical providers,] “have cultural fluency and medical knowledge to understand how black women's bodies and health issues are different than white

"When I go to a dermatologist, I'm looking for help to save things that matter to me. Hair is a thing for us - it's been vilified, laws about what we can do with our hair. I'm looking for help to save aspects of my identify that are important to me […] Those things are mitigated if you're viewed as a whole person."

"The long game is to reduce unnecessary barriers that prevent more people of color from going into these professions in the first instance. When you are in the process of being trained, having cultural competency be prioritized and included from day one is really important. If issues of race and ethnicity are included in training and education from day one, it gives multiple opportunities for individuals to be sensitive to issue and aware of how it may manifest in different areas of practice."

"I would procure a greater number of healthcare providers of all backgrounds fitting the populations of the communities they're in."

Veterans

Number of Focus Group Participants: 7

Top Themes

- Internalized Stigma
- Healthcare Access
- Mental and behavioral health
- Housing

The following section includes select quotes from focus group participants and interviewees:

Internalized Stigma

"A lot of veterans won't ask for help. Think they can do it themselves."

"People feel 'I don't want to take a resource from other people to use for myself.'"

"I used to think this way. Recently, I was shown the more people that apply for benefits, the more that is available for everyone."

"That was my attitude for many years, 'I can take care of myself. The VA is for someone who can't afford it.' Once I had access to the care, that's what made it easier for me. I earned it."

Healthcare Access

"At Togus it is easy. For others, it is not so easy. Especially for the older people who can't drive." Another shared, "My dad is disabled vet. He's able to use telehealth for his appointments, otherwise he has to go down to Augusta, Bangor, Caribou. Some people can't travel all over to get the care they need."

"There are some support systems, but they're in the city or the big veterans' home is in Augusta, which is a good hundred miles away and is only good if you can get in."

"Too many veterans don't reach out to get help, so lack of awareness of available support. Even if they do reach out, there are too few practitioners."

Mental and Behavioral Health

[Needs within the veteran population are,] “different than issues affecting the civilian community who haven't been asked to do the unthinkable.”

“Vets are more likely to open up to other vets rather than civilian therapists […] this is a barrier for people to get care…mental health providers who are vets, or understand vets” would be beneficial.

“If you need extensive [substance use disorder] services you need to go out of state.”

Housing

“I was homeless on and off three years. A worker for Togus picked me up at the shelter and offered to bring me here. Most of us pay 30% of our income and that includes everything. We need more stuff like this.”

“I would only leave for two reasons: to go to a nursing home or to die. I could not afford somewhere else.”

LGBTQ+

Number of Focus Group Participants: 5

Top Themes

- Societal Stigma
- Insurance Coverage

The following section includes select quotes from focus group participants and interviewees:

Societal Stigma

“Knowledge of LGBT identities and issues is something that should be standard in medicine.”

“People don't understand non-binary or what it means even about sexual health or sexual violence.”

“The healthcare system is not adequate or trauma-informed through race, class, cultural-socioeconomic lens especially for severely radicalized and violent incidents.”

“People shouldn't call services and be told they're too traumatized for services which leaves them to dysfunctional coping strategies.”

“They're talking about mental health issues but not addressing roots of violence, so leaving nonviolent people with mental health needs at risk.”

Insurance Coverage

“This is literally a life and death matter – we need to figure out how to get people healthcare.”

Women

Number of Focus Group Participants: 1

Top Themes

- Healthcare Access
- Childcare

The following section includes select quotes from focus group participants and interviewees:

Healthcare Access

"I was seeing a provider last month, she wasn't working or listening to me […] so I was transferred to new provider, and I'd have to wait five months to see a new OB-GYN. But I was dealing with women's health issues at the time and needed to see someone and it took me six phone calls before someone got me in to see an interim doctor."

"Some services have been closed. Some practices aren't willing to see patients who won't be there throughout their pregnancy […] never mind if providers understand the language and culture."

Childcare

"Childcare is really expensive. My sister stopped working for two years because it was cheaper for her to stop working than for her to use daycare."

"There are some nice and affordable options, but long wait lists, like two years. A lot of people choose to stay home or use relatives to watch kids; Childcare is very much needed."

"Childcare is hard to find. Language plays a big piece for kids who don't speak or understand English. Hard to even be placed on a wait list - they won't get a translator."

"[We need] treatment supports for moms. If you need to be separated from their child, they would not get the treatment, especially for parents who have substance abuse issues for treatment programs. Hard to go to treatment if you don't have childcare."

Youth

Number of Focus Group Participants: 3

Top Themes

- Oral Care
- Substance Use
- Pedestrian and Bike Safety

The following section includes select quotes from focus group participants and interviewees:

Oral Care

“Dental disease is the #1 most common preventable disease in kids. Starting early preventive care is key. Access to preventive oral care for all members of the family, because bacteria are transmitted among family members.”

“Dentists don't get enough peds training. We need more hygienists to do cleanings for prevention. Even if there were enough, providers aren't accessible. We should integrate into primary care more; some primary care providers are doing dental screenings.”

“[We need an] army of hygienists out in communities: public health hygienists to work in territories, with at least one covering each county or region. They could train primary care providers and others on dental care.”

Substance Use

“A lot of young people are getting crushed by drugs, and many young people don't have alternatives to substance abuse, no other passion in life or something they've been really good at, or it's been overshadowed by substance abuse. Once addiction sets in, you're not open to other opportunities. What works? Prevention.”

“Vaping is a serious health issue for kids that are still developing, and their brains are still developing.”

“Smoking in general, weed, that was something I used to use and in the moment it was good and then when I was done I was not feeling the best and this impacts people’s mental health.”

“Youth treatment for substance abuse is lacking. There is a screening and intervention program in school-based health centers called SBIRT, but when youth screen for severe substance abuse issues they have to wait at least 6 months to receive treatment. Intermediate programs for some support but it's really a waiting game – there are not enough beds for kids that need help. It feels hopeless to parents because there's nowhere to go.”

“If a young person is already in a space where they need treatment, a peer may be beneficial. People in recovery don't generally go into schools because it can be more harmful than helpful. But in other cases, it may help and the state is starting to put more money into peer support.”

Pedestrian and Bike Safety

“People that are stopping to let people go on crosswalks. This is a big thing where I live, cars just don't stop.”

“Watching out for people. There are lot of bikers and you are supposed to go around them and people just drive right next to them.”

Young Adults

Number of Focus Group Participants: 3

Top Themes

- Oral Health
- Mental Health
- Childcare
- Housing

The following section includes select quotes from focus group participants and interviewees:

Oral Health

“We don’t have a lot of dental care places that you can get into as a new patient. When we moved here I had a pediatric dentist but I don’t qualify for that anymore and I can’t get into one.”

Mental Health

“I feel like growing up in the school systems, you’re told you can get help with mental health but they don’t say where.”

“I feel like people also don’t know what are ‘mental health problems’ they should be aware of. Like they might be experiencing something and not even know it’s something they need help from.”

“I feel like we can empathize with somebody but we can’t help them. We can say ‘you should go there to get help’ instead of coaching them through that. We’re missing the middle step to talk to them and get them comfortable to go get help.”

Childcare

“Everybody’s looking for a daycare. We might have two or three good ones that people say. But I feel like I hear people always say they need a daycare – like a business and not someone’s house.”

Housing

“Housing is hard for someone my age. You can’t afford a house when you’re in college. I think the prices are always on the up and up since COVID and we can’t really bring it back down.”

“[We need to] look at housing as infrastructure to increase the supply to catch up with the need. 83,000 homes are needed in Maine and we will need decades to catch up. Federal government needs to fund it as part of healthcare costs.”

Migrant Populations (Immigrants, Refugees, Asylees, and Seasonal Workers)

While one specific focus group was not conducted with members of the migrant, minority, or immigrant communities, these populations were thoughtfully discussed throughout stakeholder interviews and during the focus groups.

Top Themes

- Healthcare Access, including language barriers
- Stigma, including internalized stigma and xenophobia
- Employment and Financial Barriers

The following section includes select quotes from focus group participants and interviewees:

Language Barriers

"Discharge papers are in English, and that's hard for people whose first language isn't English."

"Navigating different health plans under MaineCare or otherwise, especially for people whose first language isn't English. Hospitals use an iPad and can chose any language, and someone comes on the screen, but it's still an obstacle for providers – it takes up time, they can see fewer patients, it's costly."

"Even with people translating, it's a big rush and it's hard to pick apart translation - things are lost in the process. Maine Med has language line and in-person interpreters, the person on the phone is really quick and sometimes they give misinformation. Some in-person interpreters who know people going into appointments. Patients are worried about confidentiality, so there's a huge trust issue going into the doctor."

Internalized Stigma

"Childhood trauma, generational trauma, depressive disorder, anxiety, PTSD and a few others tend to be most common, but it's hard to talk with them about it due to stigma. We need to talk about symptoms rather than diagnosis."

"There is stigma of asking for help. Chinese students are going through real mental challenges due to healthcare and housing, but feel like they can't go to counseling because 'we don't do that,' and they don't know where to go. There's a culture of 'we're going to just take it, it will be fine.' Cultural background is also due to war and trauma. Asking for help is weak."

Xenophobia

"Hate crimes and bias, which tie into mental health. We need to educate people on where to go for help."

"Many Asians have been admitting to alcoholism since the pandemic to cope because the community was under such a scope during the pandemic."

Employment and Financial Barriers

“Some farm workers may make a lot of money in a short period of time, but annually is not a lot. They can't include dependents who live outside the area even though they financially support them […] some people don't get paystubs or get paid in different ways.”

“Access to food and basic items, people don't know how cold it is and all they have are sandals. Where do people get cold weather clothes? Migrants use last paycheck to get to the right place.”

“There is an influx of asylum seekers from Angola and Congo, and they don't have the same status as refugees and can't get the resources because they're waiting for asylum hearing and have no status.”

Older Adults

The following section includes select quotes and excerpts from the Maine State Plan on Aging Needs Assessment related to the top themes in the Maine Shared CHNA:

Healthcare Access

"She's still got a lot of years left, and she should feel that providers care about her and her medical needs.”

“[…] My [primary care provider] is 45 minutes away, as is my ophthalmologist. Luckily a fairly good retinologist is the same distance, but my specialists are all in Boston, five hours away.”

Oral and Auditory Health

“Dental and hearing aid assistance. Too expensive to even consider seeking help to resolve. Eating problems due to missing and rotten teeth. Need dentures but cannot afford.”

Pedestrian and Bike Safety

“1. Fewer physical barriers and greater safety for walking in downtown and neighborhoods. 2. A bike friendly sharing service (e bikes, tricycles and tandems)

Housing

Aging individuals had similar concerns regarding the affordability of quality housing that is appropriate for their needs, including one-story housing and shared housing to foster socialization among this demographic. Respondents shared concerns that they would not be able to afford housing taxes after retirement and concerns about the cost of assisted living facilities as well.

Disability Community

The following section includes select quotes and excerpts from the Disability Rights Maine Assessment related to the top themes in the Maine Shared CHNA:

Lack of Representation

While Black community members called for more representation in policies and initiatives, the DRM report called for more representation in data collection for individuals with disabilities. This report shared that the lack of data inhibits the state from monitoring equity and healthcare access within this population.

Stigma

"I've faced such chronic shame that if I go to a medical professional and feel like they are shaming me in any way, I will not return. As a trans person, I have to find care that is trauma-informed and competent."

Health Insurance Coverage

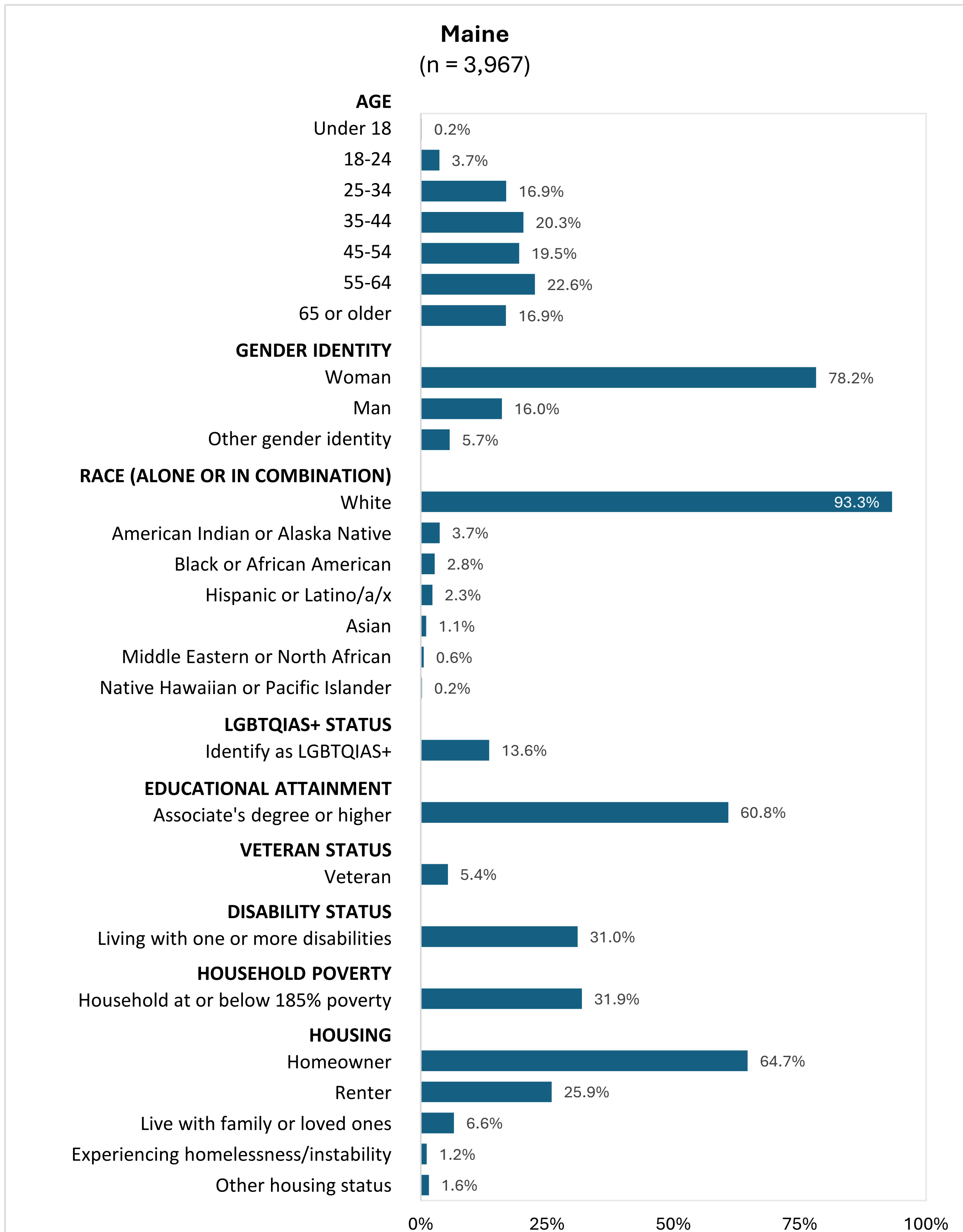
People in Maine with disabilities also reported health insurance coverage as a barrier to healthcare, specifically due to fewer and lower employment opportunities available for this population. Additionally, when individuals do have healthcare access, it still may not cover necessary services needed for care related to specific disabilities.

Mental Health

"Children with mental health conditions and their families are a neglected, underfunded and underserved component of health care. […] The wait time to see a psychiatrist, therapist, HCT (Homecare team) and OT is totally unacceptable and dangerous."

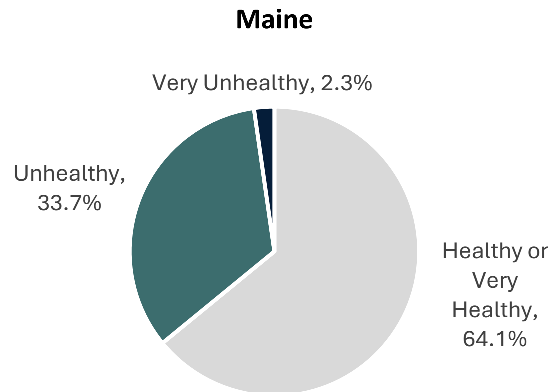
Community Survey

Respondent Demographics



Community Health Status

Overall health and well-being of the community where you live



Top 5 strengths of the community

Maine Shared CHNA Statewide Community Survey Responses
1) Safe opportunities to be active outside
2) Locally owned businesses
3) Safe neighborhoods
4) Schools & education for all ages
5) Low crime

Top 5 social concerns that negatively impact your community

Maine Shared CHNA Statewide Community Survey Responses
1) Mental health issues (anxiety, depression, suicide, etc.)
2) Substance use (alcohol, cannabis, prescription drugs, illicit drugs, etc.)
3) Low incomes and poverty
4) Housing insecurity
5) Obesity

Community Health Needs

Please indicate if _______ negatively impacts you, a loved one, and/or the community where you live.

Percentage of respondents who answered 'Impacts me, a loved one, and/or my community'

Maine Shared CHNA Statewide Community Survey Responses	
Economic needs	76.1%
Chronic health conditions (cancer, high blood pressure, heart disease, high cholesterol, etc.)	75.7%
Mental health needs	73.6%
Substance use	68.5%
Housing needs	68.5%
Transportation needs	60.9%
Environmental needs	58.4%
Public safety needs	53.7%

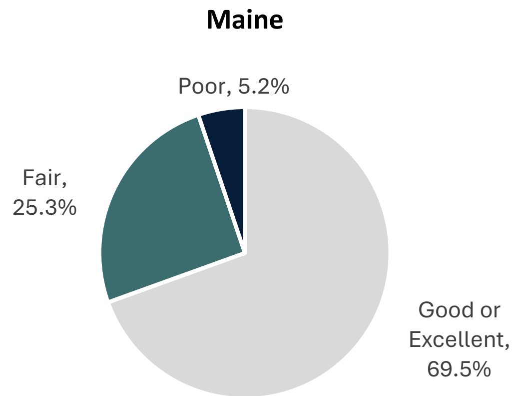
Socioeconomic Empowerment

Top 5 items rated by respondents as 'very necessary' steps to help move people out of poverty and to a place of housing stability & financial stability.

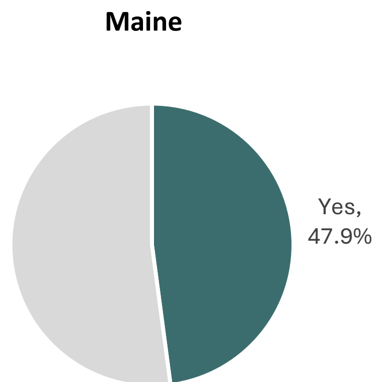
Maine Shared CHNA Statewide Community Survey Responses
1) Jobs that pay enough to support a living wage
2) Affordable and safe housing
3) Mental health care and treatment
4) Affordable & available health care
5) Affordable & quality childcare

Physical Health Status

How would you rate your own physical health?



Within the past year (365 days), have there been 1 or more times when you or a loved one needed health care services but could not or chose not to get it?

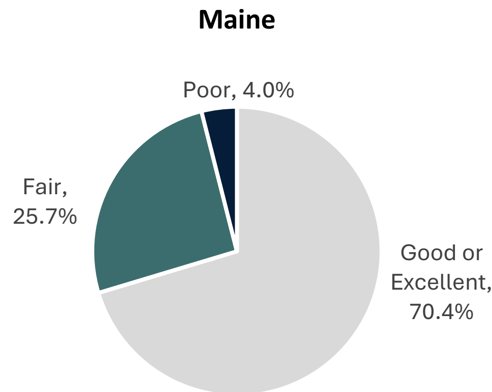


If yes, what stopped you from getting care when you needed it? (Select all that apply)

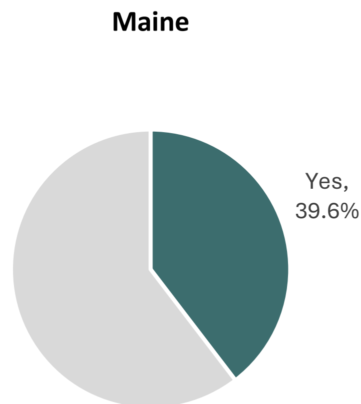
Maine Shared CHNA Statewide Community Survey Responses
1) Long wait times to see a provider
2) Had health insurance, could not afford care
3) No evenings or weekend hours to get care

Mental Health Status

How would you rate your own mental health?



Within the past year (365 days), have there been 1 or more times when you or a loved one needed mental health care services but could not or chose not to get it?



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Acknowledgements

Funding for the Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is provided by the partnering healthcare systems and the Maine Community Action Partnership with support from the Maine CDC. The Maine Shared CHNA is also supported in part by the U.S. Centers for Disease Control and Prevention (U.S. CDC) of the U.S. Department of Health and Human Services (U.S. DHHS) as part of the Preventive Health and Health Services Block Grant (award 1 NB01TO000018). The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by the U.S. CDC/DHHS, or the U.S. Government.

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

We are grateful to our community partners and stakeholders who took the time to help advertise and recruit for our focus groups, both at the state and county level, and for our statewide community survey. Our utmost thanks also goes to all of the individuals who took part in our key informant interviews. Each of you enabled us to learn more about populations, communities and sectors in Maine. Without all of these efforts we would not have been able to conduct this 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.

Appendix

Community Engagement Process

Considerations for Identifying Populations to Engage With:

The Maine Shared CHNA is charged with taking 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 identify and lived experiences or their "intersectionality." It should be noted the voices we hear in focus groups and interviews are not meant to be representative of their entire identified population or community.

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. 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;
- 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.

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.

Populations and Sectors Identified for Engagement

Focus Groups

Using the former criteria listed above, the Maine Shared CHNA ultimately identified the following populations for community engagement through focus groups:

- Multigenerational black/African American
- Veterans
- LGBTQ+
- Women
- Youth
- Young Adults

As part of the Community Services Block Grant reporting, the Community Action Programs are also 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.

While we held focus groups with these specific populations and communities, we attempted to recognize participants' intersectionality by asking them to voluntarily share any other identities they may have. In addition to the abovementioned populations, 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.

Key Informant Interviews

The Maine Shared CHNA identified additional populations and sectors to engage through key informant interviews. The populations and sectors were based on: those who did not lend themselves as easily to a focus group; provided a systems and/or programmatic perspective; and/or represent a sector specific topic.

The populations and sectors the Maine Shared CHNA conducted interviews with were:

- Unhoused/Homeless
- Migrant/Agricultural Workers
- Disability Community

- Incarcerated/Formerly Incarcerated
- Child Welfare
- Emergency Management
- Environment/Climate
- Substance Use (including prevention, treatment and recovery)
- Transportation
- Food Security
- Older Adults
- Mental/Behavioral Health
- Oral Health
- Immigrants
- Veterans

Other Assessments Used

The Maine Shared CHNA identified two other assessments to use as part of our assessment using the criteria outlined above. 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.

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 open to anyone living in Maine. 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.

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 include a commitment to:

- Correctly assign the systemic factors that compound and contribute to health behaviors and health outcomes rather than social or demographic categories. 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.
- Report results in an actionable form to improve the lives of those represented in the data.
- Acknowledge missing data and data biases and limitations.
- Identify and address important issues for which we lack data.
- Empower professionals and community members to use data to improve their work and their communities.
- Share data with communities affected by challenges to share analysis, reporting and ownership of findings.