COMMUNITY READINESS ASSESSMENT

SOMERSET AND KENNEBEC COUNTIES COMMUNITY PARTNERSHIP

COMMUNITY READINESS ASSESSMENT

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EXECUTIVE SUMMARY

Healthy Living for ME® (HL4ME®), a Community Care Hub (CCH), organizes and supports a network of Maine community-based organizations (CBO) to address health-related social needs (HRSNs). HL4ME's CCH mission is to coordinate and align community resources to improve the health and wellness of the people of Maine. Its vision is to provide Maine residents with the skills and resources to exercise control of their health and build healthier lives.

In early March 2023, the Maine State Department of Health and Human Services (DHHS) awarded HL4ME $400,000 under Award Number CDM-23-1560, Rural Community Health Improvement Partnership (R-CHIP) Phase 1 Demonstration Project. That award has three deliverables:

1. Create a community partnership between healthcare, community-based organizations (CBOs) and the Maine Center for Disease Control and Prevention Public Health Central District.
2. Perform a Community Readiness Assessment (CRA) for the geographic or community named in the proposal and provide answers to the following:
    a. A description of existing community-level or regional collaboration(s) pertaining to HRSNs, including gaps and opportunities for strengthening the Community Partnership;
    b. A description of current health care, public health, and social service funding and service delivery arrangements, identifying barriers to addressing HRSNs and opportunities for improvement;
    c. An assessment of the adequacy and appropriateness of the current system of care for identifying and addressing HRSNs in the community, identifying gaps, barriers, and opportunities for improvement;
    d. A description and assessment of HRSN screening systems, cross system communications and information sharing concerning HRSNs, and opportunities for improvement; and
    e. A description and assessment of existing workforce capacity and needs for addressing HRSNs.
3. Use the CRA as a planning guide to research governance models, service delivery methods, needed partnerships, isolate needed system reforms for CBO and healthcare integration, and show the necessary funding needed in a future and presently unfunded Phase 2 implementation project.

By the end of March 2023, HL4ME convened the Somerset and Kennebec Counties Community Partnership (SKCCP) with the goal of improving community health and resilience for people with HRSNs in Somerset and Kennebec Counties. Over the course of the first half of the Phase 1 Project SKCCP found the systemic barriers that are adversely affecting community access to and service delivery from healthcare and social services in these two counties. That resulted in this Community Readiness Assessment or CRA you are reading today.

The second half of the Phase 1 project will be to develop a thoughtful and communicative Phase 2 Implementation Plan (Plan) to remove these identified barriers through improved collaboration, coordination and integration between healthcare and community-based organizations. This Plan will use the framework of the CRA to highlight the needs of our community, creating a new system design that addresses HRSNs with a person-centered/whole-person approach. It is our goal that our Plan will tackle such issues as the creation of a culture of collaboration and coordination; joint governance; the infrastructure needed for long-term success; fiscal and operational sustainability; data collection, security and transfer; service delivery integration, and most importantly, continuous community voice and perspective for all planned initiatives.

To this end, the SKCCP has already organized itself into three (3) distinct but intertwined workgroups:

1. **Collaborative Workgroup**
2. **Community Voice Workgroup**
3. **Infrastructure/Sustainability Workgroup**

During the Plan development process, SKCCP will decide the implementation schedule and cadence that will maximize community impact and the project's return on investment. However, it is important to remember that funding for Phase 2 Implementation is not a guarantee. Figuring out the Plan's associated costs and prospective funding sources will be an important part of the Plan's development.

Our Plan should be ready for publication and feedback by the end of 2024. Thank you.

PURPOSE

The R-CHIP Demonstration Project's purpose is to identify and address HRSNs in a rural community, by building a community partnership, developing an effective governance structure among health care, social service, and other CBOs, and identifying financing and payment models to incentivize and sustain systems of care that promote equity and address systemic HRSNs.

Maine itself is a uniquely diverse state with different geographies and communities. As a rural state, Maine faces considerable challenges regarding its population health. Through R-CHIP, SKCCP aims to proactively address HRSNs and improve the overall health outcomes of all residents in Somerset and Kennebec Counties.

PARTNERSHIP

The principle R-CHIP Demonstration Project deliverable was to formalize and build a community partnership; this deliverable was quickly achieved with the formation of the SKCCP. The SKCCP is a multi-sector partnership, made up of 13 CBOs, 2 health systems, 1 healthcare advocacy entity, and the Maine Center for Disease Control and Prevention Public Health Central District. To date, SKCCP has developed its shared Purpose, Mission, Vision, and Objective, along with its governance structure, meeting cadence, and workgroups.

Purpose: Partnering to build effective systems that create healthier communities

Mission: Create a framework for radical multi-sector communication and action that optimizes well-being of all who live in Somerset and Kennebec Counties

Vision: The SKCCP framework will create health equity for residents of Somerset and Kennebec Counties through coordinated services, improved access to services, increased capacity, and collaboration

Objective: Improve community health and resilience for people with HRSNs in Somerset and Kennebec Counties by identifying and removing barriers to access through communication and creating connections with community-based resources and support organizations

Additionally, each SKCCP member supplied a comprehensive brief of their organization's capacity and social responsibility; these briefs were subsequently merged into a partnership community asset map (see page 30).

"Achieving systems of care to address HRSNs in the health care system is still very much a work in progress. With limited evidence regarding the effectiveness of different strategies, policymakers, health care and social service providers, payers, philanthropy, and communities are experimenting and testing different approaches."

(Andrew Coburn & Deborah Deatrick – Maine Rural Health Action Network)

HL4ME, www.healthylivingforme.org.
Maine's CCH organizes and supports a network of community-based organizations, integrating them with healthcare and providing services to address HRSNs. It centralizes administrative functions and operational infrastructure including, but not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.

Spectrum Generations (SG), www.spectrumgenerations.org.
An Area Agency on Aging (serving Somerset and Kennebec Counties) and a provider of numerous Home and Community-Based Services programs.

MaineGeneral Medical Center (MG), www.mainegeneral.org.
A regional health system covering Somerset and Kennebec Counties.

HealthReach Community Health Centers (HealthReach), www.healthreach.org.
Federal Qualified Health Center with practices throughout Somerset and Kennebec Counties.

Kennebec Behavioral Health (KBH), www.kbhmaine.org.
A comprehensive community mental health provider serving Somerset and Kennebec Counties.

Kennebec Valley Community Action Program (KVCAP), www.kvcap.org.
A robust community action program, with specific expertise in children and families, housing, and transportation and the elimination of poverty in Somerset and Kennebec Counties.

Capital Area New Mainers Project (CANMP), www.newmainersproject.org.
A cross-cultural organization that welcomes immigrants and works to build a thriving, integrated community in central Maine.

United Way of Kennebec Valley (UWKV), www.uwkv.org.
United Way partners with 49 partner programs in Kennebec County that share their view that the way to improve lives is by mobilizing the caring power of Kennebec County communities.

Healthy Communities of the Capital Area (HCCA), www.hccame.org.
Partners with local people who work to improve the health and quality of life in Kennebec County. HCCA is a non-profit organization working on local, public health district, and state-level goals to improve public health. Their work includes a focus on the complexities of minority stress, a unique set of experiences related to LGBTQ+ identity, which is chronic, and can have adverse impact on a person's health.

Mid-Maine Homeless Shelter & Services (MMHSS), www.shelterme.org.
Specializing in homeless services, housing, financial stability, education, family & children, transportation, safety planning, social, employment, legal, mental health, domestic violence support, and substance abuse.

Somerset Public Health (SPH), www.somersetpublichealth.org.
A Somerset County non-profit changing the culture of health in all parts of the communities we serve through training, technical assistance, and education.

Hallowell Pride Alliance (HPA), www.facebook.com/hallowellpridealliance.
A non-incorporated, grassroots alliance that celebrates Hallowell and its LGBTQ+ community by offering education, outreach, advocacy, and celebration in and around Hallowell.

SKILLS, Inc., www.skillsinc.net.
Supports adults with Intellectual and Developmental Disabilities and Autism with residential and community-based programs in Somerset and Kennebec counties.

Family Violence Project (FVP), www.familyviolenceproject.org.
A private non-profit organization whose mission is to end domestic abuse in Somerset and Kennebec counties.

Maine Primary Care Association (MPCA), www.mepca.org.
A membership organization that represents the collective voices of Maine's 20 Community Health Centers, which provide high quality, primary and preventive medical, behavioral health, and dental services for 1 in 6 Mainers. Since its founding in 1981, MPCA has provided technical assistance and training, housed relevant programs and services, and advocated on behalf of Maine's healthcare safety net and the hundreds of thousands of patients it serves each year.

The Maine Center for Disease Control and Prevention Public Health Central District (District 5 Somerset and Kennebec Counties), www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district5/index.shtml.
The mission of Maine's Center for Disease Control and Prevention agency is to provide leadership, expertise, information and tools to assure conditions in which all Maine people can be healthy.

Technical Assistance Hub

MCD Global Health was awarded a contract by Maine DHHS to serve as R-CHIP's Technical Assistance Hub. MCD served as subject matter experts to assist in the completion of SKCCP's CRA. The technical assistance provided allowed for an outside party perspective in the information gathering and analytical process to confirm the partnership's work and eliminate any potential bias as it relates to coding, data analysis, and reporting.

Methods

SKCCP's robust Community Readiness Assessment (CRA) employed a mixed methods approach. Dedoose, a data analysis web application tool designed for mixed methods research, was used to capture both qualitative and quantitative research data for analysis. By utilizing Dedoose capabilities, HL4ME was able to organize documents and data from a wide variety of formats including the lived experiences of community members and provider interviews, detailed surveys to non-SKCCP members/organizations servicing Somerset and Kennebec Counties, and pertinent data and information from existing near-recent reports.

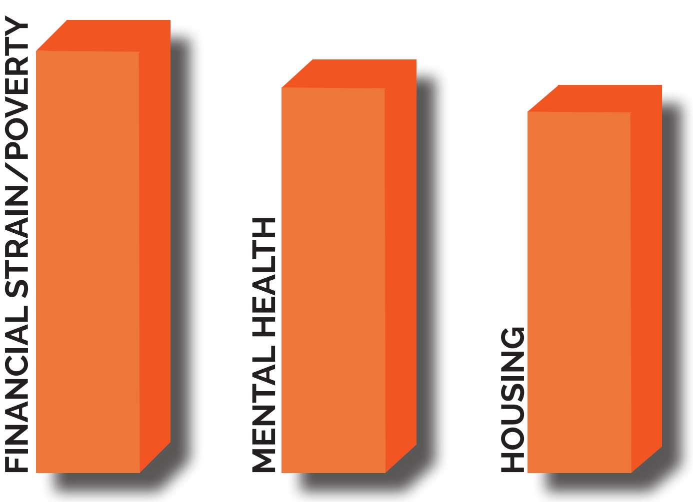
Key findings

SKCCP's compiled data and shared resources allows SKCCP to focus its efforts on what systemic changes will positively impact health outcomes for Somerset and Kennebec Counties residents.

CRA results show the underlying barriers include but not limited to:

- **the siloed-nature of healthcare and CBO service delivery systems that are currently in place;**
- **the relational divide, or lack of integration, between healthcare and the community-based sectors; and**
- **the difficulties people experience in navigating and understanding service delivery offerings.**

Regardless of an individuals' HRSNs these three barriers were consistently present.



Additionally, throughout SKCCP's community readiness work, several HRSNs were identified and assessed as adversely impacting people's lives when accessing and utilizing healthcare and community-based services in the two counties. Through the Dedoose analytical process, three HRSNs stood out as being most prevalent and effecting individuals more than any other.

These HRSNs are:

1. **Financial Strain/Poverty**
2. **Housing**
3. **Mental Health**

It is also quite common for HRSNs to co-occur with each other; for example, transportation co-occurs with all three of the top HRSNs.

SKCCP determined that the top three HRSNs would be the focus of our CRA, with the CRA outlining a series of recommendations and conclusions that provide a framework for SKCCP's work for the remainder of the project period.

INTRODUCTION: THE NEED

WHEN IT COMES TO HEALTHCARE, THE HIGHEST UNDERSERVED POPULATIONS IN MAINE ARE THOSE LIVING IN REMOTE AND RURAL AREAS. Somerset and Kennebec Counties are both classified as exclusively rural by the federal government.

Historically, rural healthcare has struggled to extend its focus beyond clinical providers. Medical providers and staff are typically overwhelmed in managing the clinical aspect of the physical and mental health of complex (multiple chronic conditions and high utilization) patients. Unfortunately, they must often treat non-clinical services, such as the patient's health related social needs (HRSNs) as secondary or tertiary priorities.

When a patient is encouraged to utilize a Community-Based Organization (CBO) service to address their HRSN, many Somerset and Kennebec residents do not know where to turn for screening, information, and referral services by CBOs. The majority of these community services are only open Monday–Friday from 8 a.m.–5 p.m. Additionally, healthcare systems do not always know to which community organizations to refer patients for the various much-needed benefits and resources. Additionally, CBOs often lack organizational capacity and financial resources to meet the compliance and infrastructure required by healthcare organizations to compliantly coordinate patient care.

Fortunately, federal policy and regulations are now driving the healthcare industry to address the HRSN of clinical patients and subscribers to health plans (commonly known as insurance companies). As social needs are accepted as a key component of integrated, whole person care, we are on the precipice to improve health outcomes, reduce healthcare costs, and improve health equity. Prudent healthcare enterprises are embracing this transformation, restructuring their business models and care models, and realigning their organizations toward this new strategic vision. Somerset and Kennebec Counties are fortunate that two of SKCCP's healthcare partners, MaineGeneral Health and HealthReach FQHC, and the convening 13 CBO partners, and 1 healthcare advocacy entity, are welcoming this emerging and promising vision for rural healthcare. It is this vision that is motivating the SKCCP in performing this critical work.

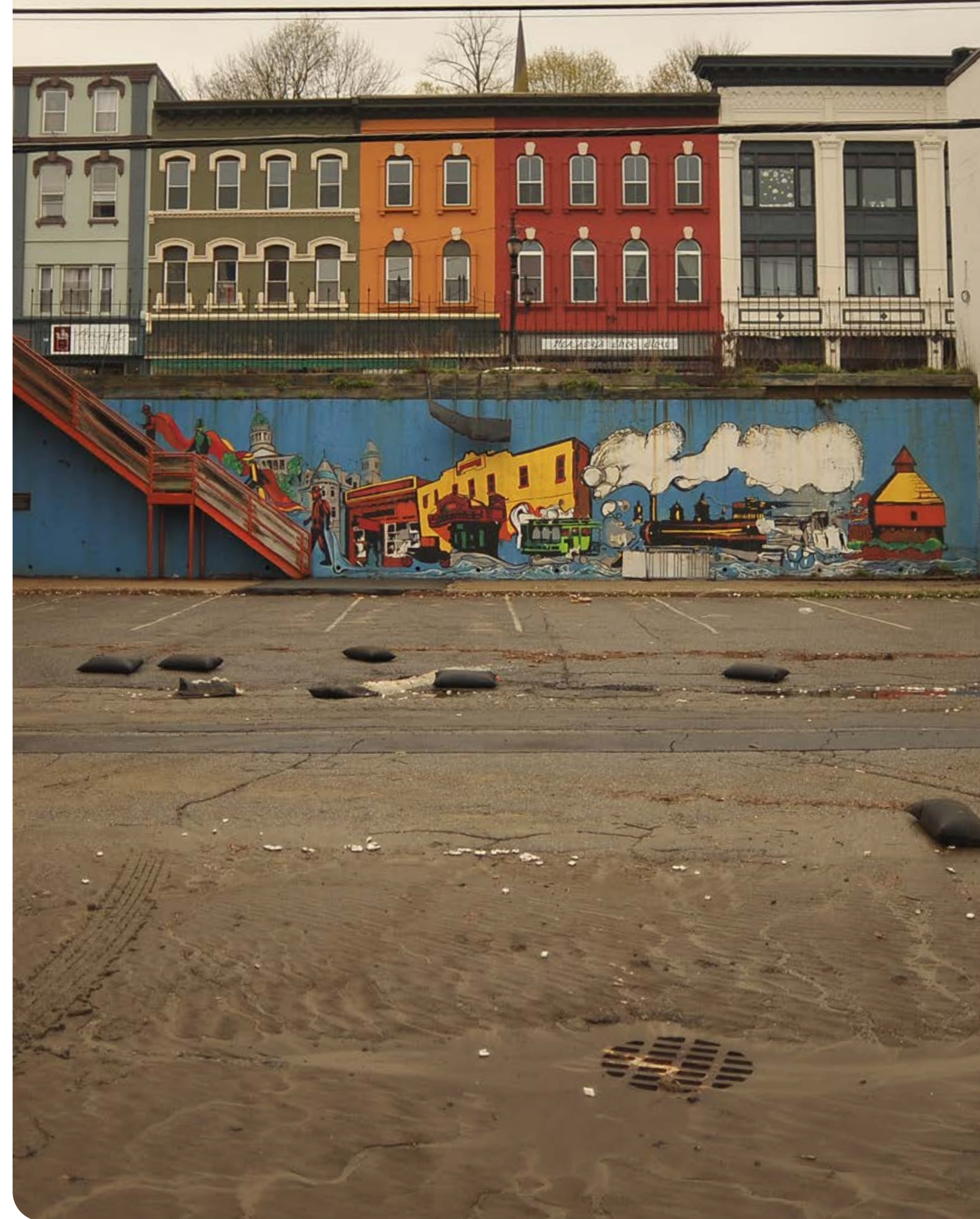
Every person in Somerset and Kennebec Counties should have the opportunity to attain their full health potential, regardless of their socially determined circumstance. This is the very definition of health equity!

What is Health Related Social Needs (HRSNs)?

The term "Health-Related Social Needs" is sometimes used interchangeably with Social Determinants of Health (SDOH), but an important distinction can be made. *(Health-Related Social Needs vs The Social Determinants of Health, Oregon Health Authority - www.oregon.gov/oha)*

HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more. SDOH, on the other hand, refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more. In a way, disparities in HRSN are best understood as a result of the SDOH. Addressing the conditions in which people live and their underlying factors is often out of scope for traditional healthcare entities. However, healthcare has identified the need to take steps to address the resulting health-related social needs through understanding which ones their unique patients face, referring them to local community services, partnering with community-based organizations, or producing other creative interventions.

This CRA is a critical first step in addressing the adverse impact HRSNs/SDOHs have on health outcomes in Somerset and Kennebec Counties.



THE COMMUNITY READINESS ASSESSMENT (CRA) REPORT

SKCCP, with consultation from MCD, chose a mixed method approach in developing this CRA. The information gathered and entered into Dedoose enabled the SKCCP to combine state and county level data, community member's and provider's lived experience, a variety of community insights reports such as UWKV's Impact32, issued community surveys, and SKCCP partner information to assess and recommend priority HRSNs of Somerset and Kennebec Counties.

CRA Mixed Methodology

HOW WAS DEDOOSE USED?

Leveraging Dedoose enabled SKCCP to better understand trends and themes that occur related to HRSNs in Somerset and Kennebec Counties. In Dedoose, HL4ME coded keywords of documents to understand the impact of how often they occurred throughout and across any source material (i.e., reports, documents, video, etc.). HL4ME's document coding and analysis allowed SKCCP to better understand the co-occurrence of HRSN themes such as how Financial Strain/Poverty were related to Housing. Through this method, HL4ME was able to learn how and what HRSNs occurred in Somerset and Kennebec Counties, what HRSN themes occurred most frequently and how co-occurring HRSN themes were related. This resulted in SKCCP determining, with a high degree of confidence, what the community's priority needs are in Somerset and Kennebec Counties.

EXAMPLES OF SOURCE MATERIAL INCLUDED:

- Documents: community health profiles, impact reports, reviewed articles, and others.
- Reports and Data: Maine Shared Community Health Needs Assessment (MSCHNA), Census, Maine.gov and others.
- Surveys: HL4ME disseminated a series of surveys to community entities (i.e., associations, municipalities, school systems, CBOs, Emergency Medical Services, etc.) that are not directly involved in SKCCP. SKCCP recognized that additional feedback was valuable around how they address HRSNs and what they perceive as community needs and priorities. Surveyed responses/ feedback are in our CRA where applicable. For a full breakdown of survey responses, see Appendix page 36.

Lived Experience

WHY ARE COMMUNITY LIVED EXPERIENCES IMPORTANT IN SKCCP'S COMMUNITY READINESS ASSESSMENT?

Lived experience matters for numerous reasons, not least of which is that only someone who has been through an experience knows its nuances and complexities. That is why it was important for SKCCP to ensure there were diverse voices of people, who have been through different rural healthcare experiences. SKCCP did not feel it had the subject matter expertise to correctly gather lived experience from the Somerset and Kennebec communities. SKCCP subcontracted this work to LIFT Healthcare (LIFT) *(www.lifthealthcare.com)*.

Why did we choose LIFT?

LIFT

LIFT is a healthcare insight, design, marketing, and patient education agency teeming with patient empathy and creative capabilities. LIFT brings lived experience to life through the lens of human-centered design. LIFT is founded on the belief that human realities are the driving force in better healthcare experiences and healthier outcomes — and set its foundation on ethnography and design thinking as the driving principles of how we engage. LIFT leverages qualitative research methods which foster a deep dive into patient, community, clinician, and related stakeholder realities — facilitating a better understanding of the complexity, breadth, and range of lived experience. With this human-centered approach, LIFT has served hospitals and health systems, advocacy organizations, research groups and organizations and the life sciences field.

LIFT used a qualitative research methodology to capture insights into the lived experience of individuals within Kennebec and Somerset Counties experiencing HRSNs, such as food and housing instabilities, lack of transportation, etc. and the five dimensions of emotional truth (needs, motivations, fears, hopes, and beliefs) that contribute to healthcare access, health competency and literacy levels, and ultimately both short- and long-term health outcomes.

INCORPORATED INTO THE CRA

1. Maine, Kennebec County, and Somerset County Reports
   a. Somerset County Shared Community Health Needs Assessment (CHNA), 2022
   b. Kennebec County Shared CHNA, 2022
   c. United Way of Kennebec Valley Impact2032, 2021
   d. MeCAP Statewide Community Needs Assessment, 2021
   e. Disability Rights Maine (DRM) Equitable Access to Health Care for Maine, 2023
   f. Central Public Health District Oral Health Profile, 2023
   g. KidsCount Databook Interactive, 2023
   h. LIFT's Insights and Recommendations Report (LIFT R-CHIP Report), 2023
2. Online Data Sources
   a. United for ALICE (Asset Limited, Income Constrained, Employed)
   b. Maine Health Profile
   c. Maine Census Data
   d. Maine.gov Data Bases
   e. Somerset and Kennebec County Health Profiles
3. Community/Municipal Surveys
   a. 20 Responses
4. Non-SKCCP Organization Surveys
   a. 19 Responses
5. Emergency Medical Services (EMS) Surveys
   a. 1 Response

SKCCPs lived experience results consistently showed the underlying barriers include but are not limited to:

- **The siloed-nature of healthcare and CBO service delivery systems that are currently in place;**
- **The relational divide or lack of integration between healthcare and the community based sectors; and**
- **The difficulties people experience in navigating and understanding service delivery offerings.**

Regardless of an individuals' HRSNs these three barriers were always present.

Additionally, LIFT saw three initial opportunities for intervention that they identified through the data collection and analysis of the lived experience 1:1 community and provider interviews and surveys. These are:

1. **Community Provider Check-In Meetings;**
2. **The further research and development of the Community Care Hub concept; and**
3. **A Bi-Annual Community Solutions Workshop that is open to community residents of Somerset and Kennebec Counties.**

See Appendix page 38 for the full version of LIFT's Insights and Recommendations Report (LIFT R-CHIP Report) prepared for this CRA.

From our work with LIFT, the voice of Somerset and Kennebec Counties' residents became a major component of the CRA.

POPULATION BREAKDOWN

	MAINE	KENNEBEC COUNTY	SOMERSET COUNTY
TOTAL POPULATION	1,385,340	125,540	51,098
Total # of Households	571,064	52,752	21,596

Maine Census Data 2022

American Indian/ Alaskan Native	9,419	661	244
Asian	15,323	1,108	194
Black/ African American	21,983	1,039	313
Native Hawaiian or Pacific Islander	277	85	Not Available
Hispanic	23,068	1,900	554
Some other race	5,442	224	60
Two or more races	28,536	2,106	950
White	1,263,287	116,530	48,759
	Maine Health Profile 2021	*Kennebec County Health Profile 2021*	*Somerset County Health Profile 2021*

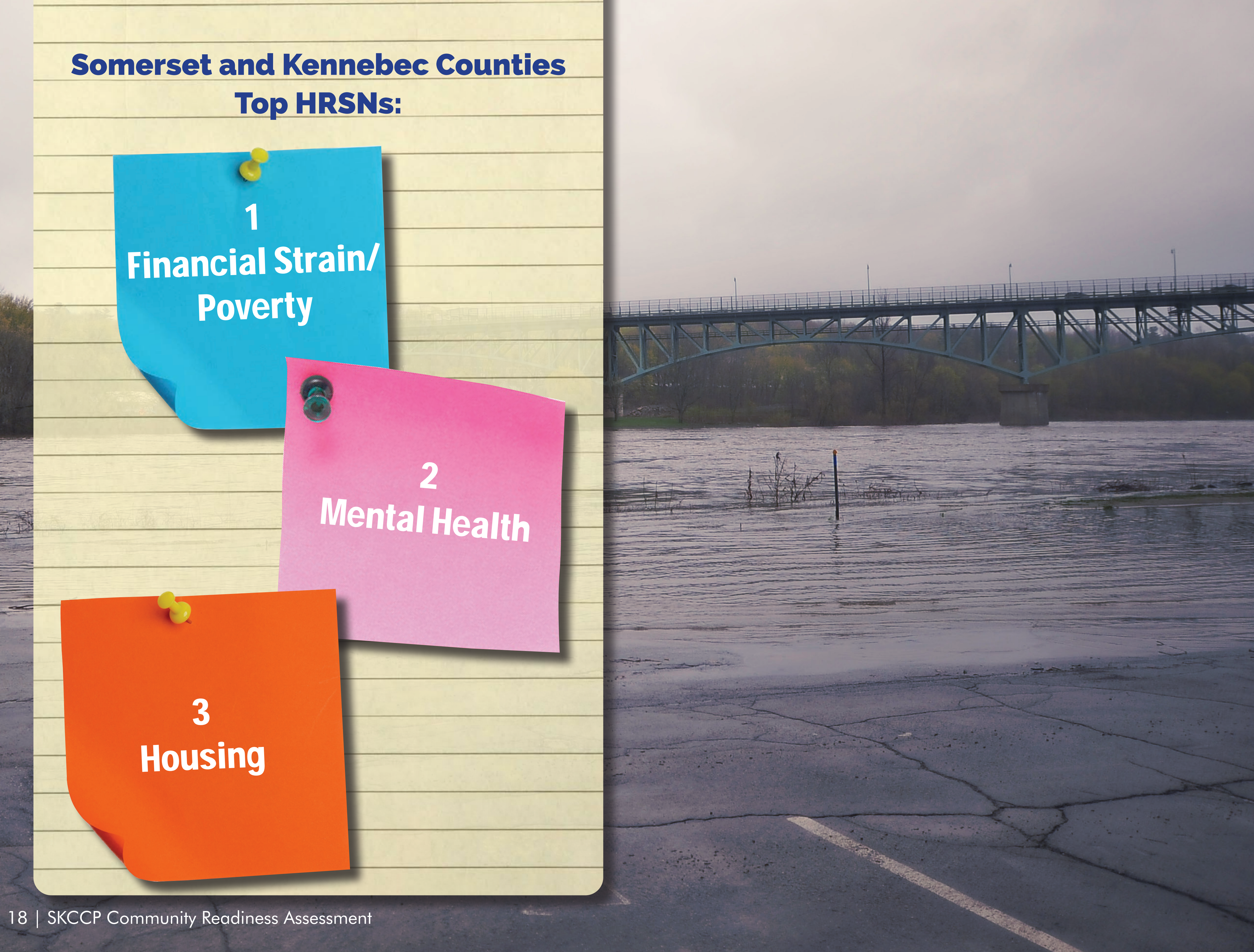
Population by Age (2021)	MAINE	KENNEBEC COUNTY	SOMERSET COUNTY
0-4	62,120	5,929	2,353
5-9	67,423	6,460	2,816
10-14	73,282	7,048	2,593
15-19	78,961	7,620	2,746
20-24	78,772	7,148	2,384
25-34	166,576	14,268	5,480
35-44	164,831	14,416	5,661
45-54	170,509	16,295	7,233
55-59	103,217	10,285	4,017
60-64	109,127	9,254	4,344
65-74	182,606	14,895	6,668
75-84	86,002	6,956	3,147
85+	33,812	2,719	982
Median Age:	45	44	47

Maine Census Data 2021 Population

A description and assessment of community health needs and priorities

Demographics are a key element to understanding our communities and their unique health and social needs; furthermore, an understanding and consideration of population breakdown is critical to addressing HRSNs.

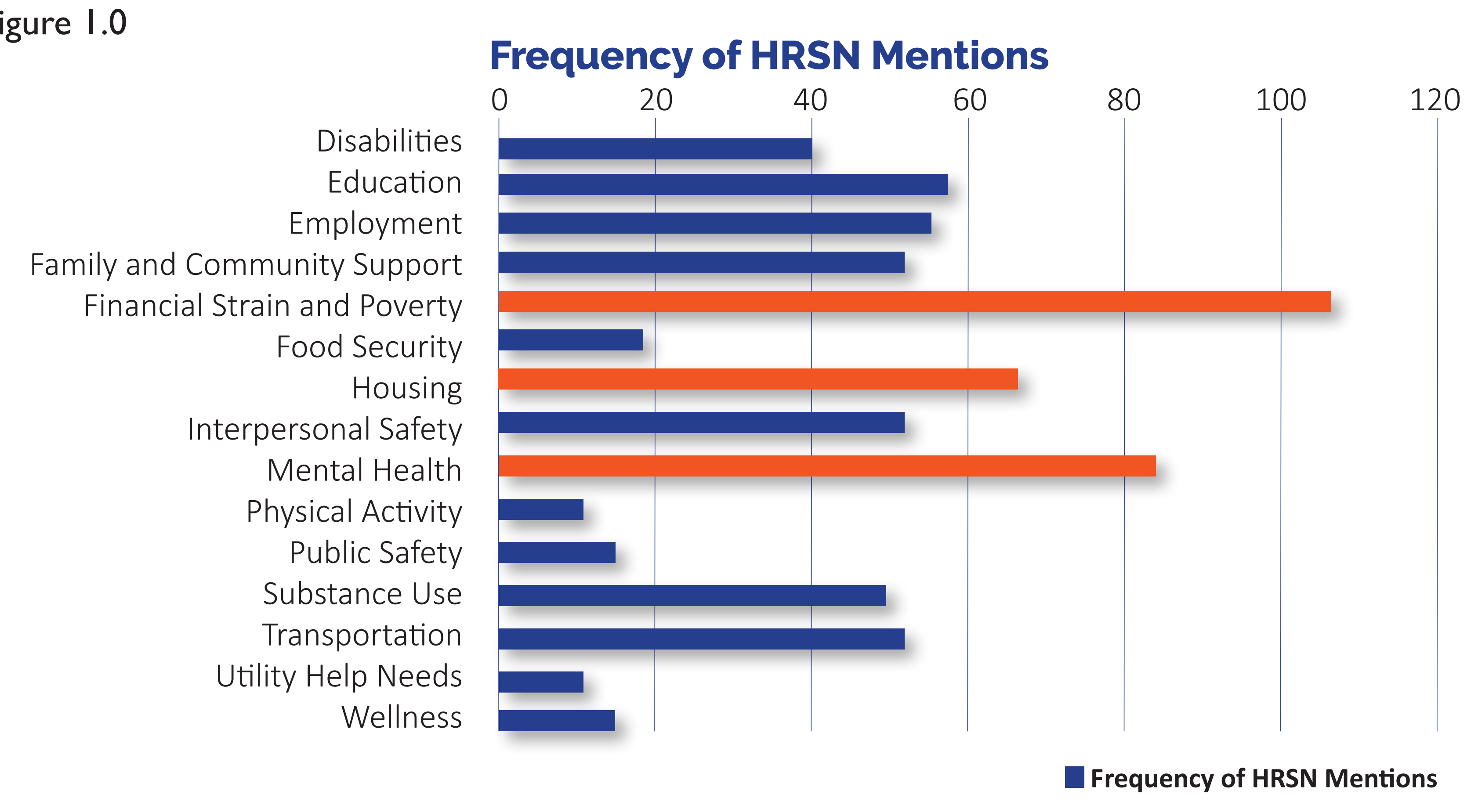
Maine residents, specifically Somerset and Kennebec Counties' community members, reside in rural areas in combination with race, disability status, socioeconomic status, language ability (defined as including speaking, understanding, reading and writing), age, and other factors which have intricate implications on their health and well-being. Maine faces unique needs when it comes to its population.


Somerset and Kennebec Counties
Top HRSNs:
1
Financial Strain/
Poverty
2
Mental Health
3
Housing

Analyzing and Identifying the Top Three Health Related Social Needs (HRSNs)

After entering and coding the aforementioned documents, reports, community surveys, lived experience and community provider insight interviews into Dedoose, all HRSNs were assessed and analyzed (see Figure 1.0) to the frequency of how often each HRSN was identified as having impact in the community. It was categorized that the frequency to which each was mentioned across these sources varied with certain HRSNs occurring more frequently than others. With an emphasis on the overlap of all HRSNs, the SKCCP chose to focus this CRA on the most prevalent – top three – in Somerset and Kennebec Counties.

Figure 1.0



FINANCIAL STRAIN/POVERTY (x104)

	MAINE	KENNEBEC COUNTY	SOMERSET COUNTY	SOURCE
Median Household Income	$57,918	$55,365	$44, 256	Central District PH Profile 2022 Maine.gov
Median Household Income for Individuals with a Disability	$22,938			
Population in Poverty	11.8%	12.8%	20.4%	Central District PH Profile 2022 Maine.gov
Individuals with a Disability	27%	Not Available	Not Available	
Population in Poverty (children)	38.2%	36.6%	64.0%	Central District PH Profile 2022
ALICE (Asset Limited, Income Constrained, Employed)	29%	30.0%	31.0%	United for ALICE 2021
Unemployment Rates (Oct 2023)	2.6%	2.5%	3.5%	Maine.gov
Individuals with a disability (Sept 2023)	3.9%	Not Available	Not Available	
High School Graduation Rate	87.4%	86.9%	80.1%	Central District PH Profile 2022
Food Insecurity	12.4%	12.9%	17.0%	Central District PH Profile 2022
Among youth	18.1%	18.9%	26.5%	
Cost Barriers to Health Care	10.6%	11.0%	8.0%	Central District PH Profile 2022
Access to broadband	88.6%	99.1%	58.6%	Central District PH Profile 2022
Income >$75K	95%			
Income <$20K	60%			

"A recent Augusta Housing Authority report found that 3,000 households in the City of Augusta alone struggled to pay for housing in 2019." -Impact2032 (p48)

"Lack of access to affordable childcare, reliable transportation, or living in rural communities with few high-paying jobs are all factors that make it difficult to maintain full-time employment." -MeCAP (p34)

"Community members face barriers such as geographic isolation and proximity to health and social services, financial challenges, lack of transportation, health incompetency and poor health literacy, etc. all of which make it more difficult to access the care and support they need."
-LIFT R-CHIP Report (p9)

"Approximately one in four individuals who have less than a high school diploma in Maine lives below the Federal Poverty Level (FPL) compared to only 4.1 percent of individuals who have earned a bachelor's degree or higher."
-MeCAP (p72)

"Low-income households are also disproportionately affected by internet access due to high costs and few providers." -MeCAP (p95)

FINANCIAL STRAIN/POVERTY **THEMES**

HRSNs that overlap with Financial Strain/ Poverty (frequency of mentions):

1. Housing (x31)
2. Employment (x26)
3. Food Security (x11)
4. Education (x10)
5. Transportation (x10)

BARRIERS mentioned with Financial Strain/ Poverty (frequency of mentions):

1. Affordability (x35)
2. Availability (x13)
3. Pay/Cost of living (x13)
4. Childcare (x7)
5. Transportation (x6)

FINANCIAL STRAIN/POVERTY
DEMOGRAPHICS

Age-Range (frequency of mentions)

1. **Early Childhood (x20)**
2. **Childhood (x20)**
3. **Older Adults & Seniors (x9)**
4. **Young Adults (x4)**
5. **Mid-Adults (x1)**

THE IMPACT

Far too many households in Somerset and Kennebec Counties struggle to afford basic life essentials such as housing, childcare, food, and transportation. Poverty hinders adequate access to health care and resources. People with limited finances may have more difficulty obtaining health insurance or paying for expensive procedures and medications. In low-income areas, methods of transportation may be unreliable and impede a patient's ability to attend medical appointments. Neighborhood factors, such as limited access to healthy foods and higher instances of violence, can affect health by influencing health behaviors and stress. Poverty affects health by limiting access to proper nutrition and healthy foods, shelter, safe neighborhoods, clean air and water, utilities, and other elements that define an individual's standard of living. Financial strain and poverty can also limit access to opportunities such as education and employment that further contribute to income inequality and continues the cycle effect. Unmet social needs, environmental factors, and barriers to accessing healthcare contribute to worse health outcomes for people with lower incomes.

The National Health Council, Lillian Witting, "Limited Access: Poverty and Barriers to Accessible Health Care." 1/20/2023

"Elementary school kids already have complex and significant trauma in their family systems, and the kids carry this weight in addition to other issues like food insecurity, poverty."
-MeCAP (p21)

"With everything that has happened over the last few years, inflation and people losing their jobs and all sorts of stuff, like just having basic needs met have been difficult for a lot of families. And food is one of the main ones. -Woman, 26, Kennebec County"
-LIFT R-CHIP Report (p41)

Affected populations: Top 3 (frequency of mentions)

1. **Parents/Caregivers (x10)**
   "While all members of the community that we spoke to are typically limited in some way based on various qualifying factors (income level, resident status, employment, etc.), caregivers find themselves balancing the needs of their family while also having to navigate an oversaturated system with limited resources and time—limiting them from adequately providing the care and assistance they want/need to."
   -LIFT R-CHIP (p8)

2. **People with disabilities (x7)**
   "People with disabilities are nearly three times more likely to live in poverty than people without disabilities. A contributing factor to this is the intersection between employment and health insurance. With lower employment, fewer people with disabilities can access employer-sponsored health plans."-DRM (p25)

3. **BIPOC (x7)**
   "Black or African Americans noted poverty, unemployment, and food insecurity issues."-Somerset County MSCHNA (p10)

MENTAL HEALTH (x83)

	MAINE	KENNEBEC COUNTY	SOMERSET COUNTY	SOURCE
Ratio of Mental Health Providers	900:1	200:1	570:1	County Health Rankings & Roadmaps, 2018
Mental health emergency dept. rate per 10,000 population	181.5	224.6	183.5	Central District PH Profile 2022
Overdose emergency service responses per 10,000 population	76.7	90.2	77.8	Central District PH Profile 2022
Depression (lifetime)	23.0%	23.2%	21.4%	Central District PH Profile 2022
Frequent mental health distress	12.7%	16.0%	17.0%	MeCAP Statewide Report 2021
Chronic disease in co-occurrence with depression	30.8%	29.6%	28.8%	Central District PH Profile 2022
Receiving outpatient mental health treatment	18.0%	18.8%	16.2%	Central District PH Profile 2022
Seriously considered suicide				Central District PH Profile 2022
Middle School	16.4%	15.7%	18.3%	
High School	19.8%	20.3%	19.8%	
LGBTQ Students	38%			MYHIS 2021
Sad/hopeless for two weeks in a row				
Middle School	24.8%	25.8%	23.2%	Central District PH Profile 2022
High School	16.4%	20.3%	19.8%	
LGBTQ Students	62%			MYHIS 2021
Intentional Self-Injury				
Middle School	18.9%	18.6%	19.4%	Central District PH Profile 2022
High School	18.7%	17.9%	19.4%	
LGBTQ Students	50.0%			MYHIS 2021

"Kennebec County is among the top 10% of U.S. counties in terms of mental health care providers per population, but more should be done to improve awareness, reduce stigma, and link people with appropriate treatment."
-Impact2032 (p44)

"More than 200 Maine youth visit emergency rooms each month with suicidal ideation or having made a suicide attempt."
-Kids Count (p18)

"Many participants spoke of substance use and mental health issues together. There was a consensus that the area needs more affordable, accessible, effective services. Eliminating social stigma associated with mental health and substance use treatments was suggested by several members." -Impact2032 (p34)

"Many parents who have children using behavioral health services in the community report having to travel far distances and make it through extremely long waitlists before they can get in for an appointment.

Losing money while utilizing behavioral health services seems to be a very common experience for most parents—especially those who have more than one child utilizing these services. This financial strain can be due to a variety of reasons, but the most common being: having to take time off work, gas used to travel to and from the appointment(s), paying for specialists, increased copays, dedicated extracurricular activities, and more.

Additionally, many individuals appear to be conflating mental and behavioral needs with substance abuse disorders, particularly when considering adults experiencing either of the HRSNs."
-LIFT R-CHIP Report (p41)

MENTAL HEALTH **THEMES**

HRSNs that overlap with Mental Health (frequency of mentions):

1. Interpersonal Safety (x15)
2. Substance Use (x13)
3. Housing (x6)
4. Financial Strain/Poverty (x4)
5. Transportation (x4)

BARRIERS mentioned with Mental Health (frequency of mentions)

1. Availability (x22)
2. Lack of provider (x17)
3. Stigma (x11)
4. Transportation (x6)
5. Waitlists (x5)

DEMOGRAPHICS

Age-Range (frequency of mentions)

1. Childhood (x31)
2. Early childhood (x13)
3. Young adult (x4)
4. Mid-adult (x4)
5. Older adult/Senior (x3)

Affected populations: Top 3 (frequency of mentions)

1. **LGBTQ (x7)**

   "Community members facing systemic disadvantages, (including the formerly homeless or homeless, low-income adults, and the LGBTQ+ community) mentioned a lack of treatment and recovery resources in the state. They noted a lack of harm-reduction programming, a need for supportive living environments, and skill-building programs for independent living." -Somerset County MSCHNA (p14)

   "For many younger LGBTQ+ people quarantining with family or having to move back home when colleges or jobs shut down was not just isolating, in some cases it was dangerous." -MeCAP (p30)

2. **People with disabilities (x2)**

   "Individuals with disabilities have a higher prevalence of chronic and secondary health conditions, higher rates of mental health conditions or labels, lower rates of engagement in preventive care, and experience more frequent barriers when accessing health care services."-DRM (p14)

3. **BIPOC (x2)**

   "Painful loneliness which can create mental health challenges/lack of community even though Black population is increasing in Maine. A real threat is isolation – it just happens in Maine – particularly in winter and more so with COVID."-MeCAP (p31)

"Youth with two or more ACEs, youth in rural areas, and youth who identify as LGBTQ+ especially need access to appropriate mental health supports." -KidsCount2023 (p2)

MENTAL HEALTH
THE IMPACT

In May of 2022, a White House brief reported that a significant share of those with serious mental illness with perceived unmet needs reported not receiving care in the past year due to reasons related to costs: 46 percent reported that they could not afford the cost of treatment, and 19 percent reported that their health insurance did not pay enough for mental health services. 29 percent reported that they did not know where to go for services, suggesting issues related to access. *

The rural nature of Somerset and Kennebec Counties exacerbates the challenges of mental health treatment. Persons with mental health challenges and co-related HRSNs can experience significant impacts when trying to access healthcare. Those experiencing mental health challenges face barriers such as social isolation, communication and interactions with others; educational attainment, employment rates, and lower salary implications if employed, leading to increased poverty rates. Increase mental health issues leads to co-occurring disorders such as substance use disorder.

This significant connection was cited in Maine Community Action Partnership (MeCAP) Statewide Community Needs Assessment, 2021 where it was stated *"Mental health and substance use are definitely tied together. Many of our families are impacted by substance use. It has a ripple effect in our classrooms - some kids are born with substances onboard and/or being cared by a single parent or grandparent because a parent became incarcerated or died. (Kennebec & Somerset Counties)" MeCAP (p21).*

* *"Reducing the Economic Burden of Unmet Mental Health Needs." www.whitehouse.gov; 5/31/2022*

HOUSING (x67)

	MAINE	KENNEBEC COUNTY	SOMERSET COUNTY	SOURCE
Households that spend more than 50% of income towards housing	12.0%	11.2%	13.3%	Central District PH Profile 2022
Housing cost burdened (households spending more than 30% of their income on rent, mortgage, housing needs)	29.7%	27.5%	29.7%	MeCAP Statewide Report 2021
People living in rural areas	66.2%	100%	100%	Central District PH Profile 2022
Commute of greater than 30 minutes driving alone	32.9%	31.5%	35.9%	Central District PH Profile 2022
No vehicle for household	2.1%	2.1%	1.8%	Central District PH Profile 2022
Housing insecure (high school students)	3.3%	3.3%	3.6%	Central District PH Profile 2022

MAINE POINT IN TIME (PIT) COUNT – JANUARY 24, 2023
MAINE POINT IN TIME (PIT) COUNT TOTAL: 4,258

GENDER	
Male	2,077
Female	1,129
Gender non-conforming	13
Transgender	38
RACE	
Multiple Races	145
Native Hawaiian/Other Pacific	5
American Indian/Alaska Native	34
Asian	17
Black/African American	2,013
White	2,044

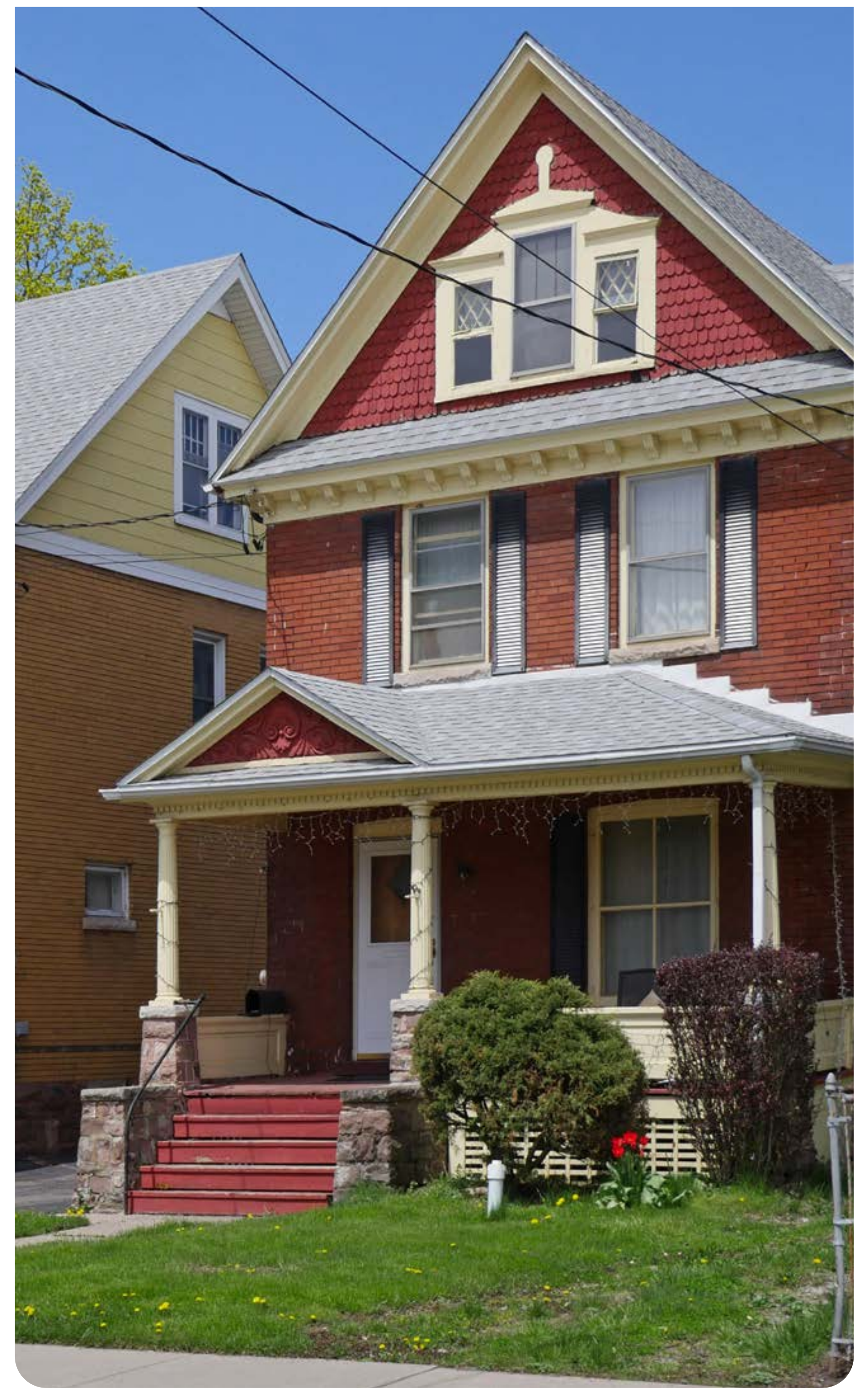
SUBPOPULATIONS	
Under the age of 18	1,236
Unaccompanied Youth	169
18-24	145
Under 18	24
Adult survivors of domestic violence	245
Adults with substance use disorder	299
Adults with a serious mental illness	674
Veterans	123

Source: Maine State Housing Authority

"Maine is experiencing sharp rises in rental costs along with an inadequate housing stock, making it increasingly difficult for families to and affordable rental housing. Maine needs 22,500 more units of afford-able housing to meet demand for low-income renters." -KidsCount (p35)

"Maine public school data from the 2018-2019 school year shows that an estimated 2,552 public school students experienced homelessness or housing instability over the course of the school year." MeCAP (p97)

"Many participants that are currently reliant on subsidized housing or their community shelter reported issues with pest control, crime, and defective (or limited) utilities, making them hesitant to make use of that resource. Additionally, individuals experiencing this HRSN were much more likely to report issues with unempathetic staff, feeling a lack of empowerment due to a lack of available housing, and generally feelings 'stuck' as they try to manage this very important need." -LIFT Report (p39)



HOUSING **THEMES**

HRSNs that overlap with Housing (frequency of mentions)

1. Financial Strain/ Poverty (x31)
2. Employment (x15)
3. Education (x8)
4. Transportation (x8)
5. Substance Use (x7)

BARRIERS mentioned with Housing (frequency of mentions)

1. Affordability (x18)
2. Availability (x9)
3. Unhoused (x7)
4. Stigma (x6)
5. Transportation (x4)

AGE-RANGES (frequency of mentions)

1. Childhood (x5)
2. Early Childhood (x5)
3. Older adults/ Seniors (x5)
4. Young Adults (x3)
5. Mid-Adults (x1)

"The linkage between MH / SUD and employment and housing challenges highlights the need for concurrent expansion according to interviewees." -MeCAP (p20)

"Many individuals with substance abuse that we spoke with indicated that it was a secondary concern to other needs that they perceived as more important, such as housing, food, etc. The individuals that we spoke with who were in recovery shared that they discovered the resources that were available to them through word-of-mouth and the support of friends or other individuals who had similar experiences." -LIFT Report (p39)"

Affected populations: Top 3 (frequency of mentions)

1. **Veterans (x3)**
   "Because of my veteran status I was able to go from a five year housing waiting list to a two month waiting list. I finally received a house which I can't move into yet because the state hasn't completed their inspection on the new building. Once they do, hopefully I can move into there permanently. —Man, 60, Somerset County"
   -LIFT R-CHIP Lived Experience Report (p39)

2. **People with Disabilities (x3)**
   "Maine's seniors are the age group most likely to live with at least one disability. Seniors may need additional services or accommodations made to their housing to make it more accessible for them to continue to safely live at home."-MeCAP (p113)

3. **BIPOC (x2)**
   "Survey respondents were more likely to be non-white as compared to Maine's population, which is 93% white. The 2023 PIT was comprised of 50% females (vs. 42% in 2022) and 52% racial minorities (vs. 40% in 2022) with Black or African American making up 47% of the PIT."
   -2023 Point in Time Count (p2)

HOUSING
THE IMPACT

Housing quality can directly impact a person's health. Housing quality typically refers to the physical condition as well as the quality of the social and physical environment of the home's location. Factors that can determine quality of housing include air quality, home safety, space per individual, and the presence of possible irritants, such as mold, asbestos, and lead. Experts associate poor quality housing with many negative health outcomes, including chronic disease, injuries, and poor mental health.

Typically, people from low income households are more likely to live in poorer quality housing, which can negatively impact their health. For instance, if a person lives in an overcrowded place, they may be at an increased risk of poorer mental health, food insecurity, and infectious diseases. In addition, some people may not have the means to improve the safety and quality of certain systems and appliances. Consequently, they may not be able to adequately heat their home, which may lead to higher blood pressure levels and result in a heart attack. Moreover, homes of people from lower income households may be more susceptible to various types of damage that can affect health if not repaired. For example, water leaks may lead to mold growth, which can cause damage to respiratory health.

Lack of housing or poor quality housing, and its direct relationship to financial strain/poverty, is a concern in rural Somerset and Kennebec Counties. Without secured and conistent housing, residents cannot address other HRSNs. Housing issues can affect other HRSNs (poverty, mental health, employment, transportation, substance use, personal safety, etc.) which increases the barriers of accessing the healthcare resources one needs.

Medical News Today, Louise Morales-Brown, "How can housing influence health?." May 13, 2021

CRA LIMITATIONS

Data Table

Each row of data is not meant to be cross compared due to the information being pulled from diverse sources. Instead, it shows related data that is available regarding the HRSN.

Additionally, data on the unhoused population is historically lacking nationally and in Maine specifically. It was important to capture what information was available, but this data does not show the true depth of the lack of affordable, safe, and available housing in Somerset and Kennebec Counties.

Another specific limitation for information regarding individuals living with Intellectual and/or Developmental Disabilities (I/DD), is that the employment information is traditionally skewed because if/when they are not employed, the numbers do not accurately reflect the employment status of people with I/DD.

Themes

Other HRSN and barrier themes in the report are revealed alongside the top three HRSN – Financial Strain/Poverty, Mental Health, and Housing. It does not necessarily mean that this is definite in terms of rated needs, however, in the reviewed materials these are the themes that are co-linked with each other and were more frequently mentioned in the documents reviewed.

Demographics

For an age group related to a specific HRSN, such as Financial Strain/Poverty, the age group is specifically stated with a number. Age-related information gathered was too broad around the population age related to HRSNs to be co-linked with a specific age group. The ones with a specific age group are the ones that are presented in the literature used for the report. However, there are still limitations to their validity due to the above statement. The same explanation holds for populations. In order to be related, a population needs to be specifically mentioned in the report or document; if reports are too broad the co-link cannot be tagged.

A description of existing community-level or regional collaboration(s) pertaining to HRSNs, including gaps and opportunities for strengthening the Community Partnership.

The SKCCP created a Community Asset Map (See Figure 2.0). This map specifically identifies within the partnership which organizations address specific HRSNs. The diversity of the partnership's capability and capacity to provide services in the community are identified as a strength and will be leveraged during Phase 2 planning where gaps and opportunities to further strengthen the partnership will be sought.

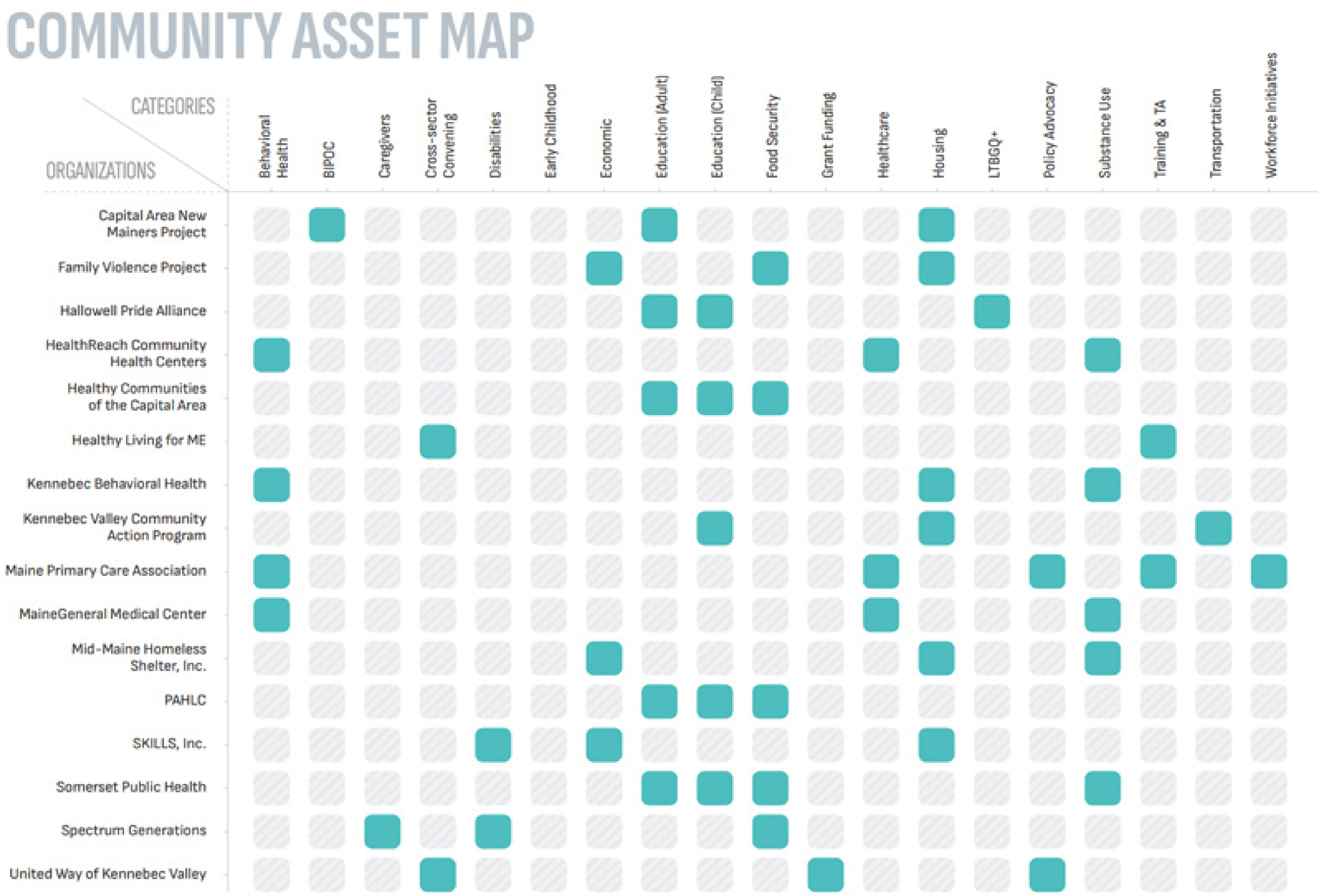


Figure 2.0

Additionally, SKCCP also wanted to survey other community entities not directly engaged with SKCCP. This was conducted to best understand how these entities contribute to addressing HRSNs and identify the challenges these entities face when attempting to address HRSNs in an isolated manner. This feedback will be considered during Phase 2 planning as SKCCP seeks to strengthen these community assets with potential strategies and investment (see Figure 3.0).

MUNICIPALITIES

Current Community-level / Regional Collaborations

- Sharing names and locations of resources
- Funding of community resources through town budgeting process
- Staff cross-training on community resources in area

Challenges to Collaborations / What can strengthen them?

- Lack of available funding in town budgets
- Lack of staff capacity
- Lack of awareness regarding opportunities for collaboration and coordination with other municipalities
- Limited information technology (IT) infrastructure

Ideas were not identified for ways to strengthen collaboration.

COMMUNITY-BASED ORGANIZATIONS (CBOs)

Current Community-level / Regional Collaborations

- Sharing information/data via resource directories
- Willingness (not capacity) to coordinate service deliveries to complex community members
- Letters of support for CBOs applying for grants
- Occasional cross-training of staffs

Challenges to Collaborations / What can strengthen them?

- Lack of staff capacity
  - -Seek specific funding for CBO/healthcare collaboration and coordination
- Lack of awareness regarding opportunities for collaboration
  - -Dedicated meeting(s) to discuss upcoming grant opportunities
  - -Joint grant applications
  - -Development of an information/data sharing capability
  - -Look for overlaps and redundancies in service delivery

EMERGENCY MEDICAL SERVICES (EMS)

Current Community-level / Regional Collaborations

- Partnership with Behavioral Health

Challenges to Collaborations / What can strengthen them?

- EMS too associated with healthcare
  - -Identify where EMS can be used for CBO service delivery
- Limited time; always responding to emergencies

Figure 3.0

A description of current health care, public health, and social service funding and service delivery arrangements, identifying barriers to addressing HRSNs and opportunities for improvement.

Within the partnership there are a variety of service delivery types, funding sources, barriers, and opportunities leveraged by the organizations of SKCCP. While each organization is unique, they face the same challenges to address HRSNs in the communities they serve. As part of Phase 2 planning, the SKCCP sees an opportunity for using this variety of funding and service delivery arrangements to maximize specific competencies, address service delivery gaps, remove redundancies, and build a collaborative and sustainable funding stream that supports rural healthcare and CBO integration for the long-term.

Below is a breakdown of SKCCP's current delivery, funding, barriers, and opportunities. See Appendix page 37 for the full breakdown of each SKCCP organization.

Service Delivery Types:

- Not-for-profit
- Health systems
- Non-incorporated

Funding Sources:

- Federal
- State
- Program revenue
- In-kind support
- Philanthropic grants
- Payments and fees
- Private donations
- Insurance reimbursement
- Section funding
- Annual funding
- Contracts
- Endowments

Barriers to Addressing HRSNs:

- Transportation
- Internet/phone access
- Housing
- Client aid
- Legal support
- Under-reporting
- Funding
- Recruitment
- Staff capacity
- Lack of closed loop referral
- Limited resources
- Data integration/sharing
- Increased demand for services
- Severity of co-occurring disorders
- Cost of living
- Disconnected/siloed systems

Opportunities for Improvement:

- Service expansion
- Strengthened partnerships
- Collaborations with other organizations
- Screening tools
- Staff
- Partner support/buy-in
- Funding
- Virtual platforms/offerings

An assessment of the adequacy and appropriateness of the current system of care for identifying and addressing HRSNs in the community, identifying gaps, barriers, and opportunities for improvement.

In addition to assessing SKCCP organizations' systems of care, SKCCP sent out surveys to additional community entities to see if there were any gaps, barriers, and opportunities for improvement in their identified systems of care. As shown in Figure 4.0, surveys determined that there is no established consistent system of care to identify and address HRSNs. If an entity had a system of care established, it was unique to them and has no cross over to other entities or sectors other than itself. This is a critical area for improvement and will be part of the SKCCP's Phase 2 plan.

MUNICIPALITIES

Current screening system(s)/assessment

- Customized/organization created
- Other

Barriers/challenges to identify/address HRSNs

- Lack of resources
- Inadequate training
- Absence of established pathway
- Perceived time to investigate

Opportunities to improve addressing HRSNs

- Improved communication to the community
- Collaborations with other organizations
- Funding
- Filling staff vacancies

COMMUNITY ORGANIZATIONS

Current screening system(s)/assessment

- Customized/organization created
- Other

Barriers/challenges to identify/address HRSNs

- Lack of resources
- Perceived time to investigate
- Absence of established pathway

Opportunities to improve addressing HRSNs

- Funding
- Collaborations with other organizations
- Filling staff vacancies

EMERGENCY MEDICAL SERVICES (EMS)

Current Screening System

- No current screening system in place

Barriers/challenges to identify/address HRSNs

- Lack of providers
- Lack of funding

Opportunities to improve addressing HRSNs

- Funding for more positions

Figure 4.0

A description and assessment of HRSN screening systems, cross system communications and information sharing concerning HRSNs.

Not all the SKCCP organizations offer direct service and therefore do not have any applicable assessment set in place. Furthermore, a few service delivery partners do not currently utilize a screening assessment. SKCCP organizations who screen for HRSNs utilize screening systems that are all unique to their organization and there is no cross-system communication or data-sharing.

Effective systems can streamline referrals and improve coordination of care in addition to providing systematic reporting and analysis of HRSNs in the community. The SKCCP sees a potential opportunity to develop a cross system HRSN assessment screening tool that can be easily utilized and shared between healthcare and CBOs and will make it a planning priority for Phase 2.

Below is the list of screening systems used by SKCCP. See Appendix page 42 for the full breakdown of each SKCCP organizations' screening system/tool.

Screening Systems/Tools:

- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
- Customized tool
- Electronic medical record
- Comprehensive assessment
- Coordinated entry
- Built for Zero
- Patient screening questions
- In-person interviews

A description and assessment of existing workforce capacity and needs for addressing HRSNs.

SKCCP organizations collectively voiced that workforce availability and capacity is a grave issue in Somerset and Kennebec Counties.

All partners provide community members a service(s) in several ways, whether it be referrals, direct service or both. Capacity and organization type and funding vary across the partnership. An organization may have one employee, while others have 300+. Others utilize volunteers and unpaid staff to drive the work of their respective organization. Figures 5.0 and 6.0 provide a snapshot of identified local workforce concerns.

The shortage and reduced capacity of our rural healthcare and CBO workforce is not unique to Somerset and Kennebec Counties; it is a fundamental problem facing the state and the nation. While SKCCP will not be able to address the macro issues affecting workforce shortfalls, it will seek to identify more micro solutions during Phase 2 planning.

Related Themes for Workforce
(frequency of mentions)

- **Need for more training – (x41)**
- **Low workforce capacity – (x27)**
- **Pay/cost of living – (x23)**
- **Workforce shortage – (x23)**
- **Lack of funding – (x14)**
- **Burnout – (x14)**

Figure 5.0

Having an Adequate Workforce Capacity for Addressing HRSNs

Municipalities (20 respondents)

- Yes: 6
- No: 9
- No Response: 5

Community organizations (19 respondents)

- Yes: 3
- No: 7
- Other: 7

EMS (1 respondent)

- No: 1

Figure 6.0

NEXT STEPS

Key Opportunities and Phase 2 Planning

This Community Readiness Assessment (CRA) serves as a catalyst for SKCCP's future work and will be utilized as a critical reference for the next step of the R-CHIP Phase 1 project. The next step is to develop a thoughtful and communicative Phase 2 Implementation Plan (Plan) to remove the barriers that were identified by the CRA through improved collaboration, coordination and integration between healthcare and community-based organizations.

The CRA highlights the needs of the community. It also shows the readiness of SKCCP to address HRSNs and do the necessary work to improve service delivery for better health outcomes in this rural part of Maine.

While the compiled data, information and findings of Somerset and Kennebec Counties does not come as a surprise to SKCCP, it confirms the need for implementing a cross-sector system integration Plan to help better connect resources for community residents of Somerset and Kennebec Counties, and in turn, improve both their access to healthcare and community resources that result in more positive engagement experiences, improved community health outcomes and an enriched quality of life.

LIFT saw three initial opportunities for intervention that they identified through the data collection and analysis of the lived experience 1:1 community and provider interviews and surveys. These are:

1. Community Provider Check-In Meetings;
2. The further research and development of the Community Care Hub concept; and
3. A Bi-Annual Community Solutions Workshop that is open to community residents of Somerset and Kennebec Counties.

In general, the larger opportunity, when we narrow our focus to the relationships between CBOs, healthcare and their respective consumers/patients, is to create opportunities for collaboration within the larger landscape of the community. As we consider what those opportunities for collaboration look like and how they might come to fruition, it is important to plan for the tactful actions we will take to make those opportunities possible.

For Phase 2 planning purposes, rather than address one or two specific HRSNs, SKCCP has chosen to focus on improving cross-sector (healthcare and CBOs) collaboration, coordination and integration, with an emphasis on infrastructure development and sustainability. The resulting expectation by the SKCCP is that most if not all HRSNs will be impacted toward the positive. Additionally, for the Phase 2 planning process and beyond, community voice and perspective will remain front and center in SKCCP's decision-making process.

During Phase 2 planning, SKCCP will use the framework of the CRA to highlight the needs of our community, creating a system design that addresses HRSNs with a person-centered/whole-person approach. It is our goal that our Plan will tackle such issues as the creation of a culture of collaboration and coordination; joint governance; the infrastructure needed for long-term success; fiscal and operational sustainability; data collection, security and transfer; service delivery integration, and most importantly, continuous community voice and perspective for all planned initiatives.

SKCCP's initial work on Phase 2 planning will utilize 3 workgroups described as follows:

1. **COLLABORATIVE WORKGROUP**
   - Research and evaluate effective collaborative governance models;
   - Maintain SKCCP's SharePoint for collaboration and coordination;
   - Sustain SKCCP organizations' directory and be ready to onboard new SKCCP members;
   - Utilize SKCCP's rules of collaboration and coordination for grant writing support; and
   - The development of Community Provider Check-in Meetings.

2. **COMMUNITY VOICE WORKGROUP**
   - Become further trained, by LIFT, in engagement methods and data collection of capturing and incorporating community voice;
   - Maintain SKCCP's framework for continuous community voice and perspective for all initiatives (planning and implementation);
   - Maintain SKCCP's process for ensuring the community participates in its decision-making process; and
   - The development of Bi-Annual Community Solutions Workshop that is open to community residents.

3. **INFRASTRUCTURE/SUSTAINABILITY WORKGROUP**
   - Maintain and continue to develop SKCCP's shared lexicon;
   - Develop SKCCP's data sharing Memorandum of Understanding;
   - Research health system workflow for points of integration with CBOs;
   - Create shared domains and pathways of improved wellbeing that facilitate cross-sector integration for individuals needing social and health care services simultaneously;
   - Research and evaluate effective infrastructure models and Social Health Access Referral Platforms (SHARP) for service and data integration; and
   - Investigate the Community Care Hub model and determine whether it can help eliminate identified barriers:
     - the siloed-nature of healthcare and CBO service delivery systems;
     - the relational divide, or lack of integration, between healthcare and the community-based sectors; and
     - the difficulties people experience in navigating, understanding and qualifying for community service delivery offerings.
   - Identify the necessary funding required in a future and presently unfunded Phase 2 implementation project.

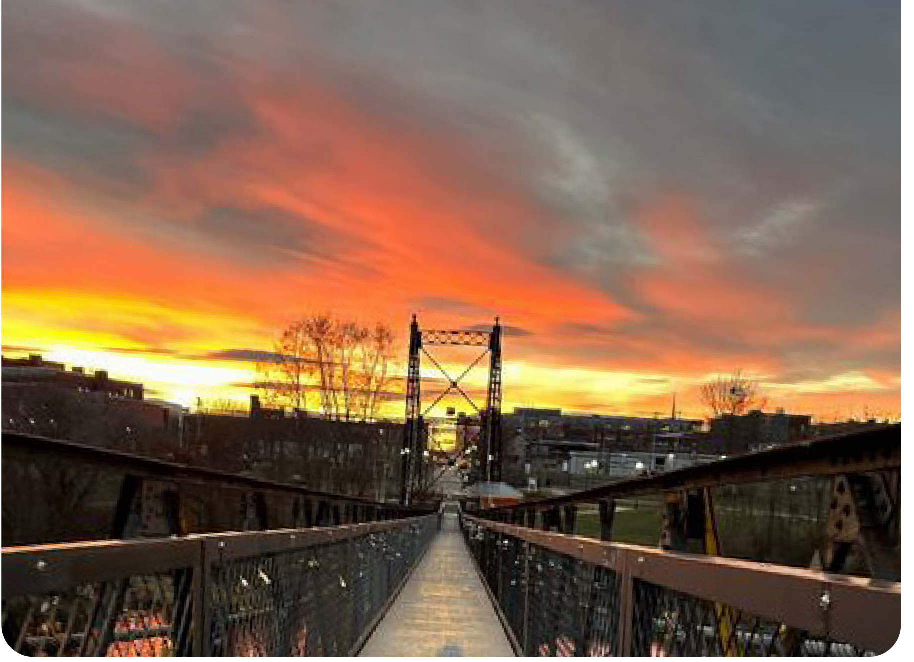
CONCLUSION

During the Plan development process, SKCCP will decide the implementation schedule and cadence that will maximize community impact and the project's return on investment. As the Plan emerges, the SKCCP will utilize the most prevalent HRSNs, financial strain/poverty, housing, and mental health to evaluate potential governance models, service delivery methods, needed partnerships, and needed system reforms for CBO and healthcare integration.

It is important to remember that funding for Phase 2 Implementation is not a guarantee, and figuring out the Plan's associated costs and prospective funding sources will be an important part of the Plan's development.

Knowing that rural healthcare is failing for all involved, we, the Somerset and Kennebec Counties Community Partnership, are excited for this this opportunity to make positive changes and committed to see it through toward continues improvement. Thank you.

SKCCP CRA APPENDIX



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ATTACHMENT A: REPORTS INCLUDED IN THE CRA

- Maine, Kennebec County, and Somerset County Reports
    1. Somerset County Shared Community Health Needs Assessment (CHNA), 2022
    2. Kennebec County Shared CHNA, 2022
    3. United Way of Kennebec Valley Impact2032, 2021
    4. MeCAP Statewide Community Needs Assessment, 2021
    5. Disability Rights Maine (DRM) Equitable Access to Health Care for Maine, 2023
    6. Central Public Health District Oral Health Profile, 2023
    7. Kids Count Databook Interactive, 2023

- R-CHIP LIFT Insights and Recommendations Report- See page 39

ATTACHMENT B: SURVEY RESPONDENTS

Community/Municipal

1. Town of Fairfield
2. Highland Plantation
3. Town of Mount Vernon
4. Town of Sidney
5. Town of Clinton
6. City of Gardiner
7. Town of Pittston
8. Town of Smithfield
9. Town of Oakland
10. Town of Chelsea
11. Town of Readfield
12. Town of Monmouth
13. Town of Moscow
14. Town of Cambridge
15. Town of Fayette
16. Town of China
17. Hartland town office
18. Town of Cornville

Organizations

1. Maine CDC Public Health Nursing
2. Center for Youth Policy & Law
3. Kennebec Behavioral Health
4. Faith Food Pantry
5. Family Violence Project
6. Southern Kennebec Child Development Corp
7. Rural Community Action Ministry
8. Alfond Youth & Community Center
9. Literacy Volunteers of Kennebec (LVK)
10. MSAD 11/RSU 11
11. Maine Children's Home
12. Sexual Assault Crisis & Support Center
13. State YMCA of Maine
14. Kennebec Valley Community Action Program
15. MaineTransNet
16. Augusta Food Bank
17. Crisis and Counseling Centers
18. Catholic Charities
19. Maine Boots2Roots

Emergency Medical Services

1. Kennebec County Emergency Management

Prepared for the Rural Community Health Initiative Project (R-CHIP)
SERVING KENNEBEC & SOMERSET COUNTIES
INSIGHTS AND RECOMMENDATIONS
AROUND COMMUNITY NEEDS, MOTIVATIONS, BELIEFS, AND BARRIERS TO HEALTH
LIFT

MEET YOUR DATA

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STUDY OVERVIEW

THE OPPORTUNITY:

Understanding the lived experiences of individuals experiencing Health-Related Social Needs (HRSNs) and their viewpoints of the support systems in place for the communities of Kennebec and Somerset counties allows the various community provider stakeholders currently involved in the Rural Community Health Initiative Project (R-CHIP) to better understand how individuals make decisions about and advocate for their physical and social health, as well as how the various stakeholders of the Somerset and Kennebec Counties Community Partnership (SKCCP) can intersect with and improve those service experiences.

Empirical insights uncovered through ethnographic research interviews with community members and providers can deliver a deeper and more nuanced understanding of community outreach, support, and funding opportunities that may exist. These insights can also be leveraged to improve positioning as trusted community resources and help frame more inclusive and accessible offerings by community health and social service providers.

PROJECT GOALS:

1. To capture insights into the existing health-related social needs of patients living within Kennebec and Somerset Counties.

2. To better understand the types of barriers that exist in terms of receiving community and social health services as citizens in the community.

3. To reveal insights that support efforts to address the existing gaps and barriers in community health, as well as gauge what specific resources, campaigns, services, etc. could potentially fill those gaps.

4. To better understand the economic, social, and physical barriers that impact community health, in order to efficiently improve access to care and other services for individuals that are limited by various health-related social barriers, and formulate stronger, more efficient ways for the providers of those individuals to improve both short- and long-term community outcomes.

This project was supported by the Maine State Department of Health and Human Services (DHHS) under Award Number CDM-23-1560, Rural Community Health Improvement Partnership (R-CHIP) Demonstration Project.

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PROJECT METHOD:

LIFT Healthcare employed a **qualitative research approach** by holding 1:1, in-depth qualitative interviews to collect data from community members in both Somerset and Kennebec counties that fit the categories of the targeted Health-Related Social Needs (HRSNs) we aimed to better understand.

These qualitative interviews were approximately 90 minutes in length and conducted via ZOOM video conference as well as via phone. Interviews were facilitated by a LIFT Healthcare ethnographer.

+ Total Consumer Interview N's = 23
+ Total Provider Interview N's = 7
+ **Total Interview N's = 30**

Interview participants consisted of residents from both Kennebec and Somerset counties that had experience with one or more HRSNs *(see list below)*, either personally, as a caregiver, or professionally. The data from individuals whose experience has been solely professional was analyzed and reported separately from the data of individuals who have personal experience with one of the targeted HRSNs.

+ IDD Community, Mental & Behavioral Health
+ Queer Community
+ Chronically Ill & Physically Disabled
+ Survivors of Domestic Violence, Sexual Assault & Trafficking
+ Food Insecure
+ Single Parents
+ Housing Insecure
+ Veterans
+ New Mainers/Immigrants
+ Substance Use Disorder Patients

NOTE:

The targeted Health-Related Social Needs (HRSNs) were identified by the Somerset and Kennebec Counties Community Partnership (SKCCP) stakeholder group through the distribution of a group survey in which community providers suggested and voted on the HRSNs and other factors that are experienced by the individuals that they serve.

Some participants also reported experiences with other social needs such as transportation barriers, utility shut-off, declining physical health, absence of familial support, poor interpersonal safety, etc. While we did not outline these in the list of HRSNs above, we did account for questioning as appropriate in the 1:1 interviews and have included insights regarding these needs in this report.

EXECUTIVE SUMMARY

MEET THE PARTICIPANTS:

Generally, the people that we spoke with in Kennebec and Somerset counties viewed themselves and their neighbors as resilient and determined, and shared stories of their efforts to improve their own quality of life. LIFT ethnographers spoke with these individuals in 1:1 interviews held via Zoom or over the telephone, and conversation explored the lived experiences that these individuals had related to Health Related Social Needs (HRSNs) and their utilization of community services or resources. While we spoke to people experiencing different HRSNs, utilizing different community resources or services, and of different ages and demographics, there were some commonalities expressed by many participants that shed light onto the potential role of community health, resources, or services (phrases that are used interchangeably by participants and throughout this report).

For many participants, 'community health' as it currently exists is a system that, while providing needed services, falls short when compared to what it could be. Participants expressed idealized versions of community health that revolved around a true sense of 'community' in which individuals feel empowered by and connected to the individuals and organizations that serve them. This idealized prospect of community health reflects the need expressed by participants for a sense of partnership and equality between community health organizations and the individuals that are served. For many participants, this sense of equality and partnership lies within a need for empathic, engaged providers (of community health services, not just healthcare providers). Many participants discussed the importance and value of these individual providers and expressed that they understand that these providers are often overburdened, both emotionally and physically, in their roles, but also shared a desire or need for more empathy and less judgement (either from personal experience or on behalf of others).

The people that we spoke with are very aware of many barriers that they themselves face in their goal to engage with community services and/or improve their quality of life and also spoke to common barriers faced by others. Many people discussed how services could be improved to better address not only their own needs, but the needs of others. Most participants expressed concern or worry for others that they perceived to be 'worse off' than themselves.

These individuals, who desire better for themselves and, importantly, for their neighbors, are representative of a community ripe for empathic, engaged services centered on and supported by both the individual providers and receivers of those services.

KEY INSIGHTS AT A GLANCE:

Success is Not Linear

Through our qualitative analysis, we sought to understand how successful interaction with community services may be indicated in different ways. In doing so, we uncovered Five Key Indicators of Success that can help us to understand not only the factors that impact an individual's ability to obtain what they need from currently established community resources, but to also uncover how we may be able to identify opportunities to improve success among the community.

These Five Indicators of Success are identified as:

1. **Utilization** [how often an individual may use community services]
2. **Orientation** [how an individual feels about community services]
3. **Knowledge Level** [how aware an individual is about services available, and how to properly use them]
4. **Access** [an individual's proximity and attainability to community services]
5. **Self-Perceived Level of Need** [an individual's discernment of how much (or little) exposure they need to community services]

Note: It is important to keep in mind that the tools and insights presented throughout this report were gathered and defined knowing that they would have to be applicable to more than one type of stakeholder and community service provider. Regardless of the area of expertise a community stakeholder may have, or the way their organization aids the residents in their area, these insights can be applied to multiple areas and the tools provided can be utilized by many different types of stakeholders.

Identifying Bespoke Opportunities for Improvement

How we identify opportunities to better assist those in the community depends on a variety of factors—the most important being how we can best meet them where they are. Providing additional services to reach more people in need may be a shared goal amongst most community organizations, but without considering how, where, and to whom those services need to be provided we cannot efficiently improve outcomes.

Opportunities for intervention, whether that be focusing on improvement of current services, expanding to include additional types of services, etc., need to be bespoke and appropriate to the person or family they are meant to serve. As we consider what types of opportunities for improvement exist for individuals served, we must first understand: who and where they are, what they may need now and going forward by way of support, and what they currently have access to in terms of resources.

Understanding Access vs Utilization

Another vital piece of insight comes with discerning the key differences (and similarities) between two important pieces of the process—access versus utilization among the community.

There are obvious differences in the definitions of both terms—access referring to one's ability to reach services and utilization referring to one's ability to properly consume those resources over time. Aside from the obvious differences between defining both terms, it is also important to understand the roles they both play in terms of process as we consider

where additional support and improvement need to go. For example, residents living in extremely rural areas of Somerset county may have challenges with both accessing and utilizing support services that are easily available and attainable to other people that may reside in Kennebec county; therefore, the solutions we tailor to those individuals should look different.

Addressing Health-Related Social Needs

In designing the Lived Experience portion of the project through qualitative research, we sought to determine the specific social needs we wanted to address through 1:1 interviews and analysis. We determined these priority health-related social needs by distributing a short survey to the stakeholders on SKCCP in which stakeholders could "vote" towards the HRSNs they were most interested in investigating further in the community. From there, we set out to build an interview guide that accounted for inclusive, diverse questioning and answers, where we were able to tailor the conversation for each individual present. This allowed us to maintain a semi-structured interview, while still taking into consideration that each person's story, experiences, and responses would be different.

As we consider approaches to address current and future health-related social needs in the community, maintaining that semi-structured, flexible mindset could help community providers take a more individual approach to care and support. In doing so, community providers are able to reach more people and serve them in the ways that best fit their lifestyle and needs, while considering any barriers that may exist as well.

DRAWING CONNECTIONS

Community members that are utilizing community health and social services are looking for more.

Individuals and their families want and expect more from the various organizations that serve their community: more empathic concern, more knowledge, more time, and more effort overall. These community members and their caregivers feel they are unique individuals with needs that require a tailored, bespoke approach to treatment and outreach to address these various needs.

Comprehensive, empathic, and personalized routes to intervention will not only elevate the experience but will also build trust in the minds of community members. Individuals are seeking help from organizations who are anticipating their needs and will be their community advocate, especially during difficult challenges.

Caregivers are lacking the emotional and physical support they need to meet the needs of patients.

Caregivers are doing the best they can with the resources, time, and strength they currently have in order to meet the needs of their families. Unfortunately, many caregivers are unable to cover all aspects of care and encouragement without losing something in the process, whether this be emotional support, time, money, patience, etc.

While all members of the community that we spoke to are typically limited in some way based on various qualifying factors (income level, resident status, employment, etc.), caregivers find themselves balancing the needs of their family while also having to navigate an oversaturated system with limited resources and time—limiting them from adequately providing the care and assistance they want/need to.

Caregivers and families are expected to know how to provide daily care and assistance, be an advocate and emotional support provider, know how to understand and navigate policy, and coordinate care and assistance going forward as the landscape continues to change—all without the consistent knowledge and aid to do so.

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Community members are facing a multitude of barriers when it comes to accessing the community services available and understanding how to utilize them properly.

While many individuals can understand the overall benefits of social and health services in the community, many find themselves having trouble accessing those services and understanding how to best utilize them for their advantage. Many times, this is translated as community members assuming that "others need it more," or that they just don't qualify to participate in the services available to them. For many community members and their families/caregivers, access and understanding can be significant challenges.

Community members face barriers such as geographic isolation and proximity to health and social services, financial challenges, lack of transportation, health incompetency and poor health literacy, etc. all of which make it more difficult to access the care and support they need.

Individuals in the community want to be successful but often feel ignored or overlooked by the systems put in place that provide aid.

Generally speaking, the communities and people in Kennebec and Somerset counties are incredibly adaptable and resilient. They are very stoic, and when needed, sometimes quite resourceful when it comes to meeting their needs. We heard from participants that existing barriers to community services, while they can be discouraging, won't necessarily stop them from "doing what they have to" to survive.

Some community members have had negative experiences with community service organizations in the past, which makes them hesitant to seek out help in the future. Others that have had decent experiences believe that community providers are limited by unreasonable time constraints, heavy workloads, and waitlists, all of which make it difficult for them to effectively communicate with and assist the community members they serve.

MAPS & VISUAL TOOLS

LANGUAGE MAP

Pragmatic language analysis permits the creation of language maps, sometimes called concept maps, about people's belief systems. By utilizing this methodology, we can better illustrate how and why individuals and their families choose and pursue community health and social services in the ways they do, and even what they avoid, throughout their consumer journey. This insight gives us a better view into how consumers progress along this pathway and how their levels of competency and engagement can impact their perception of their needs and experiences, as well as the more specific behaviors they display.

UNDERSTANDING THE LANGUAGE MAP VISUAL

Throughout the language map, readers can note that there are two primary varying behaviors thatin this context, affect consumers' levels of engagement in community services:

+ Seeking behaviors [represented in the green gradient] which refer to what consumers are actively gravitating towards.
+ Avoidant behaviors [represented in the red gradient] which refer to the things that consumers are steering clear of.

Readers will also see that we've created a yellow gradient in the middle section, which refers to more neutral key moments and statements shared by participants.

Aside from identifying the behaviors themselves, we have also grouped these key moments and quotes into three main categories where general themes have emerged. These themes are typically referred to as a linguistic key:

AWARENESS / ACCESS / IMPACT

The following figure shows a neurolinguistic (language) map, which attempts to decipher the consumer mindset when discussing the experiences and processes they experience in their journey.

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LANGUAGE MAP

COMMUNITY INTERACTION

SEEKING BEHAVIOR

AWARENESS

"I would've loved to have an updated catalog of resources sent to me. I don't know if that's available, but it should be. Maybe it gets updated each year, or even quarterly. Something that can say 'if you need help with xyz, call this number or go to this office.'"

"It (resources) has to be easy to find and navigate, and available in many different ways for many different people."

"We need to do a better job of providing education on not only where to go for help but how to get there, how the process works. People need the full picture."

"I love events where you can go to and get information and see what stuff is about. Like a community day would be great. You could get food, walk around, learn about stuff..."

"I think if the people who were creating these rules and laws truly knew what it was like to navigate this system alone we wouldn't be here."

"I have a friend who prefers digital and another one that would rather someone talk on the phone with them, I guess it just depends on the person."

ACCESS

"I wish there were more culturally inclusive things available to the community...not having to travel to a specialty grocery store to have your favorite cultural foods as an immigrant is bigger than people realize."

"There's classes that are available and they focus on general like health, which is cool. You can take cooking, yoga, and other stuff."

"Most case managers are wonderful...even with limited resources they are just doing the best they can for the people they work with."

"It's not the system that's changing. It's the people around us that are leaning on each other and advocating for themselves rather than waiting on doctors to advocate for us."

"I've done stuff in person and on like ZOOM, both are fine. At the time COVID was still an issue and I just took what I could get."

"There's a waitlist for everything these days, it seems like."

IMPACT

"I think most of us just want to feel heard and seen in the system we've been told we can depend on."

"I want to see people who look like me, who understand diversity and can relate to me on that level or just understand what I go through as a single mom."

"Just something that brings people together as a community, I think we lost that with COVID."

"Empathy is huge—if the approach doesn't consider humanity and empathy it's pointless. You won't get anywhere."

"There needs to be a bigger effort to change things on a policy level. There's so much red tape to get my kids the help they need, there's not enough of anything."

"I've had to get crafty with how I do things from time to time, to make things work."

AWARENESS

"My turning point was when I was hospitalized for postpartum depression. I had no idea what to expect as an inpatient, but it wasn't that."

"I'm sure there's so much out there that I don't know about...but that might tell you something about their outreach efforts."

"Things can get confusing and intimidating. One bad experience deters people from getting help again. So the people that need stuff the most don't even know about what else is out there."

"Most people understand their families and themselves enough to know what they need. It's simple things... affording groceries and child care, not having to sacrifice work because if you're not working, you're at risk."

"The people that need this information aren't that open to it so it's a vicious cycle of trying to open them up to stuff they don't seem to care about."

"I can't depend on normal child care, I work nights. From what I know night shift day care doesn't exist...I mean, it's 'day' care for a reason, right?"

ACCESS

"There's a lack of support for everyone everywhere."

"I think we have to go about it differently...if you want those that need them to utilize services then you can't pose it as assistance. It has to make them feel in control again. Especially the older folks that are really proud."

"Why would I want to see that doctor I waited forever to get in to see when they're dismissive? They don't listen. Maybe they don't have enough time, I don't know."

"I think people find themselves in a box sometimes, do this or that. Make a decision and move on."

"If you ask anyone if they feel safe being at the shelter they would say absolutely not. There's so many limitations too–what you can and cannot do. People already feel down and like they don't have control."

"I don't think there's anyone who hasn't had to jump through hoops...to get a diagnosis...get approval and then hope that (their) school is supportive to their needs. It's stressful, it takes a toll."

IMPACT

"Everyone is different with different needs. I think services should reflect that."

"It's not about numbers, it's about people. Human beings. I think (the government) forgets about that."

"I said enough with the pill pushing...I got off of everything over time. It was the best thing I could've done for myself."

"The system hasn't worked for a while, and I think there's agreement on both sides (physician and patient)."

"It's a cycle. No one has enough of anything—people, time, money...the list goes on."

"Individuals in that (IDD) community are at risk for being taken advantage of. Not everyone has the support from family members. I can't imagine my son being in that position....having no one."

RADAR MAP

INTRODUCTION:

The radar map is a visual representation of how different types of personas interact with the various health-related and social services they use (and don't use) within their community. This is broken down in depth in five specific categories that represent "Indicators of Success":

+ Utilization [how often individuals use these services]
+ Orientation [how individuals feel about these services]
+ Knowledge [how aware individuals are about the services & how to use them]
+ Access [proximity and attainability to services]
+ Perceived Level of Need [an individual's discernment of how much/little exposure to services they require]

We categorize the various Indicators of Success by percentage. But what exactly do these percentages mean?

PERCENTAGE BREAKDOWN:

Please see the numerical breakdown of the radar map categories for context:

60% & up = High

Utilization: High percentages represent individuals that are typically using at least two social and/or health-related services on a weekly basis throughout the year—most "high" individuals have been consumers of these services for a significant amount of time.

Orientation: High percentages represent individuals that have a positive outlook and familiarization towards the various social and/or health-related services currently available in their community.

Knowledge: High percentages in this category represent individuals that have a thorough understanding of the existing options available in terms of health-related or social services in their community.

Access: High percentages in the access category refer to the higher level of proximity that individuals have to various social and health-related services in their community. Typically, individuals residing in more rural areas are lower on this scale, whereas those residing in areas closer to a city are higher.

Perceived Level of Need: High percentages of perceived level of need refer to individuals that view themselves having a demand for a hands-on user experience when it comes to using various social or health-related services in their community. These individuals typically do not have the tools or the knowledge to self-diagnose and address their needs alone.

RADAR MAP

COMMUNITY INTERACTION

40–59% = Moderate

Utilization: Moderate percentages represent individuals that are typically using at least one social and/or health-related service, sometimes on a weekly or bi-weekly basis—most "moderate" individuals are new consumers or have consumers for a year or less.

Orientation: Moderate orientation levels among individuals indicate that they have an average outlook on the various social and health-related services available in their community—it's not inherently good, nor is it bad, but rather somewhere in the middle.

Knowledge: Moderate knowledge levels among individuals indicate that they have an average level of awareness around the social and health-related services available to them (or others) in their community, as well as an average understanding of what exactly those services do.

Access: Moderate percentages in the access category refer to the average level of proximity that individuals have to various social and health-related services in their community. This is often affected by where they reside, work, and go to school.

Perceived Level of Need: Individuals with a moderate perceived level of need, typically do not demand a very hands-on user experience, but might need some coaching on how to properly use or access the services available to them in their community. These individuals may have some tools or knowledge on how to self-diagnose, but cannot address their needs entirely alone.

0–39% = Low

Utilization: Low percentages represent individuals that are typically not using any social or health-related services—or have never used them. Most "low utilizers" are potential consumers or were consumers in the past and may have struggled to utilize them long term.

Orientation: Lower orientation levels among individuals indicate that they have a more negative outlook on the various social and health-related services available in their community—this can be affected by word of mouth, or personal past experiences with a particular service.

Knowledge: Low percentages in this category represent individuals that have a vague understanding of the existing options available in terms of health-related or social services in their community. This can be affected by the individual's location, or what the outreach methods are of the organization(s) in question.

Access: Low percentages in the access category refer to a low level of proximity that individuals have to the various social and health-related services in their community. Typically, individuals residing in more rural areas, as well as those who are unhoused fall lower in this category.

Perceived Level of Need: Individuals with a low perceived level of need, typically do not believe they need services at all. These individuals typically believe they have most, if not all, of the tools and knowledge necessary to self-diagnose and treat existing needs.

The following image represents a few different variations in which a radar map can take form, based on specific demographic and personal characteristics. Each persona has their own defined radar map version (to be seen on pages 19–27). These individual radar maps include a more in depth breakdown of how we can better understand, categorize, and address the needs of different types of individuals. For now, let's take a look at the overlaid image to see how different versions appear when compared closely.

RADAR MAP

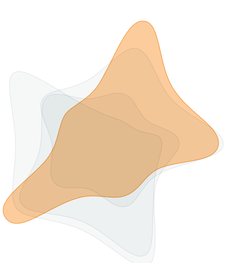
COMMUNITY INTERACTION

KNOWLEDGE
ORIENTATION
ACCESS
UTILIZATION
CARE NEEDED
0%
50%
100%

PERSONA 1 (NOELLE)

High Knowledge, Utilization, and Access

Low Care Needed and Orientation

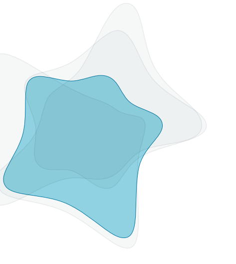


PERSONA 2 (MARTIN)

High Utilization, and Care Needed

Moderate Orientation and Access

Low Knowledge

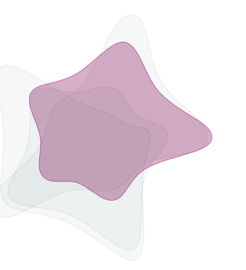


PERSONA 3 (JESSE)

High Knowledge and Access

Moderate Orientation

Low Utilization and Care Needed

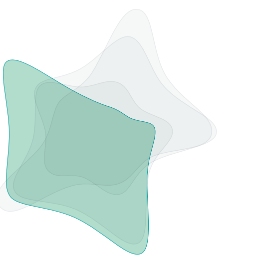


PERSONA 4 (WALTER)

High Utilization, Care Needed, and Orientation

Moderate Access

Low Knowledge



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PERSONA PROFILES

A persona is a semi-fictionalized representation of a type of person or a group of people with significant similarities. These personas and the corresponding maps of their behaviors and viewpoints do not depict “real” people, but rather a synthesis of the key attributes and experiences of the individual community members we surveyed in this research. Personas are helpful tools that can be used in “pull-through” efforts in future marketing, community outreach, and even in problem-solving efforts.

We categorized these persona profiles by analyzing their individual consumer radar maps—which were created by noting patterns of behavior, emulating certain viewpoints, etc.

Each persona profile has an assigned name; radar map percentage breakdown; identified opportunities for intervention; a demographic breakdown that includes their age, pronouns, county of residence, and relevant socioeconomic factors. We’ve also provided a “back story” narrative that provides deeper insight into who they are and what they need.

For more information on how to read the individual radar maps, visit page 16.

PERSONA 1

COHORT: YOUNG ADULT

NOELLE, 27 (SHE/HER)

KENNEBEC COUNTY

Number of people in household: 4

HRSN's/Socioeconomic factors: *Physically disabled, domestic violence survivor, in recovery from substance use disorder, unemployed, MaineCare recipient, struggles with mental health, non-high school graduate, lack of reliable transportation, low health literacy, in need of safe and affordable child care options*

Noelle is a 27-year old single mother, a Somerset County resident, and has been in recovery from substance use disorder for the last few years. She lives quaintly in a mobile home in Windsor, Kennebec county and lacks transportation completely, so she relies on services such as KVCAP and rideshare when possible.

Part of the ongoing process of her recovery is working on regaining full custody of her three young children, going back to school to get her GED, as well as working on her physical health so she may be able to start working. Her hope is to eventually get a college degree and work as a counselor with other patients that are facing similar hardships—like substance use disorder, domestic violence, depression, etc.

Aside from Noelle's daily battle with the social systems in her community to keep her family together, she also struggles with being physically disabled as a result of a traumatic childhood injury, as well as complications from years of consistent substance use. In order to maintain her disability status, she is unable to work even a part-time job to make extra money for herself, and instead puts her efforts into volunteering with women and children.

When asked about her experiences with utilizing the various health and social services in her area, she feels that since she entered her journey in recovery that help is "scarce," and that she is left to "navigate" these various solutions "completely alone." These feelings are what is driving her to continue her volunteer work in the community—so that she can be a "helping hand" to those who are doing their best to navigate a complicated and unsupportive system.

60%+ = High
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40%—59% = Moderate
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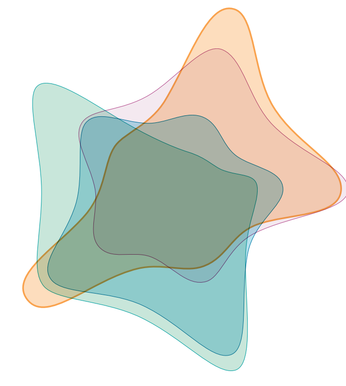


NOELLE

KNOWLEDGE

ORIENTATION

ACCESS

UTILIZATION

CARE NEEDED

RADAR MAP BREAKDOWN

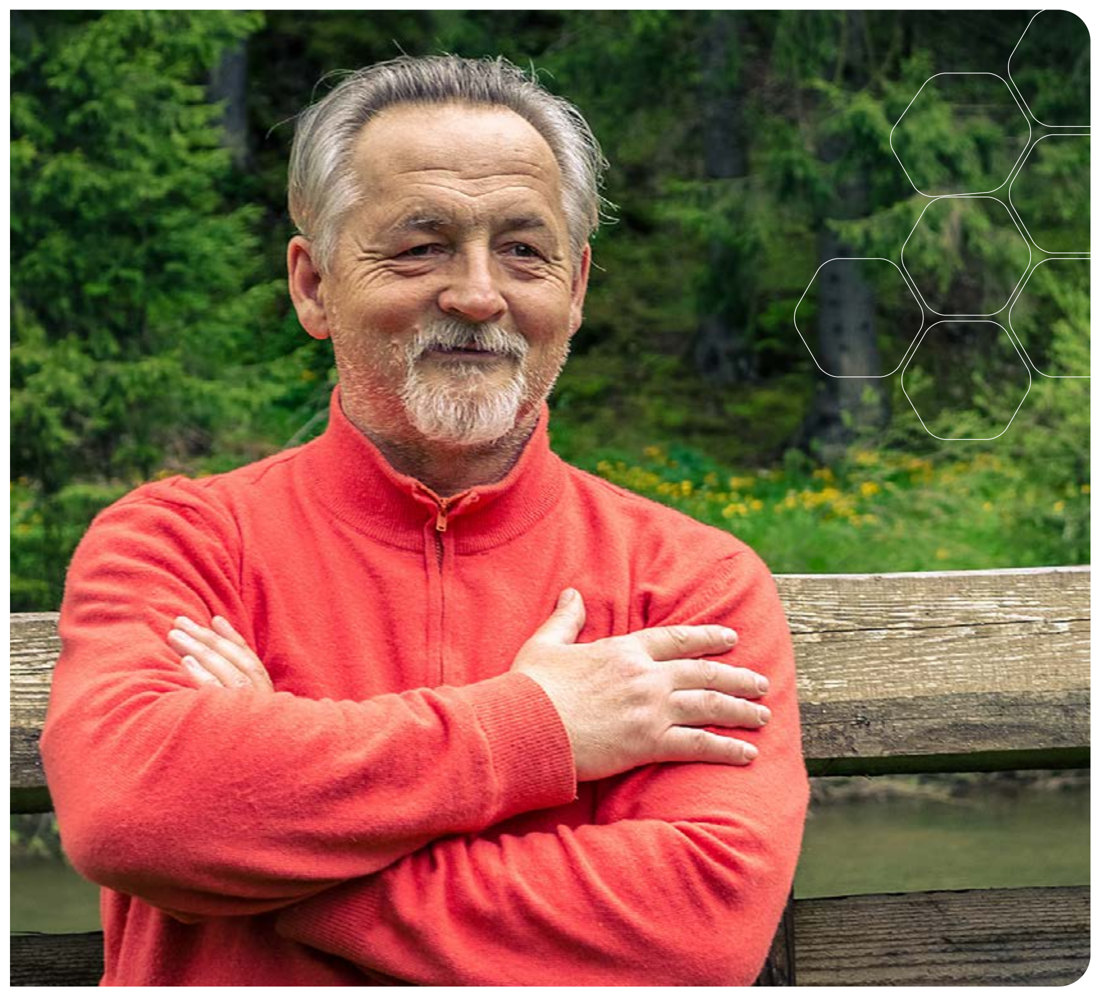
+ Utilization: *96% [High utilizer]*
+ Orientation: *39% [Moderate orientation]*
+ Knowledge Base: *98% [High knowledge base]*
+ Access: *85% [High access]*
+ (Self) Perceived level of care needed: *42% [Moderate self-perceived level of need]*

OPPORTUNITIES FOR INTERVENTION:

+ Provide a more hands-on experience that guides Noelle through the legal custody process.
+ Reiterate what her options are in the community for affordable child care and walk her through the sign up process.
+ Provide expanded options for transportation so she can go back to work and pick up her children from school.

PERSONA 2

COHORT: OLDER ADULT



MARTIN, 60 (HE/HIM)

SOMERSET COUNTY

Number of people in household: 1 (himself)

HRSN's/Socioeconomic factors: *Veteran, unhoused, physically disabled, unemployed, MaineCare recipient, struggles with mental health, lack of reliable transportation, resides in a rural community*

Martin is a 60-year old unhoused veteran and resident of Somerset county that finds himself struggling nearly every day to get through his day-to-day routine, and get in touch with the various services he needs. He was born and raised in Maine and left the state briefly to serve his country nearly four decades ago. After returning to his home state, he pursued a career as a flight attendant and served in that industry until a brutal car accident left him permanently disabled.

Martin lost his long term partner in 2020 due to complications from COVID-19. After struggling to make ends meet, he had to surrender their home to the state and since then has been unhoused. While he does have a community case manager that he is fond of and works well with, he is unable to utilize his local homeless shelter because they will not accept him with a dog—whom he refuses to leave behind.

Because of his various limitations, he has been able to seek temporary housing with his nephew, who allowed him to use his camper, and "tries his best to be as supportive as possible while still caring for his own young family." According to Martin, the last winter he spent in the camper was "brutal," and many nights he had no choice but to layer "six or eight blankets, while wearing a winter coat, pants, gloves, and a hat," to bed to battle the harsh cold.

This year, however, Martin was informed that it will no longer be possible to live in his camper, according to a new town policy. Since then, he has been working hands-on with his case manager to get into permanent, affordable housing. He has been moved up on the waitlist due to his veteran status and has about two months left of his six month waiting period—which is reportedly a "big change from the two year wait others have."

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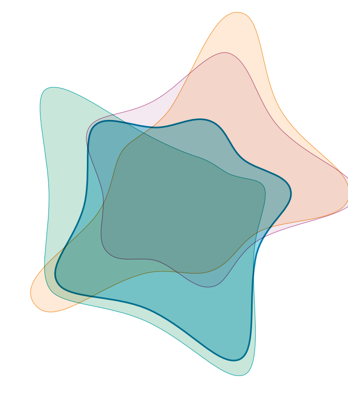

MARTIN

KNOWLEDGE

ORIENTATION

0%

50%

100%

ACCESS

UTILIZATION

CARE NEEDED

RADAR MAP BREAKDOWN

+ Utilization: *80% [High utilizer]*
+ Orientation: *58% [Moderate orientation]*
+ Knowledge Base: *40% [Low knowledge base]*
+ Access: *55% [Moderate access]*
+ (Self) Perceived level of care needed: *90% [High self-perceived level of need]*

OPPORTUNITIES FOR INTERVENTION:

+ Set up a strong, direct line of contact for veterans seeking community health and social services to case managers that only serve veterans and their immediate family members.
+ Provide temporary housing (outside of shelters) specifically for the unhoused veteran community while they wait for permanent housing.
+ Create a local list of affordable food options that are accessible to those of all needs: digitally available on several community websites, printed flyers posted around town, and sent through the mail.

PERSONA 3

COHORT: MID-AGED ADULT

JESSE, 39 (THEY/THEM)

KENNEBEC COUNTY

Number of people in household: 2

HRSN's/Socioeconomic factors: *Queer, struggles with chronic illness, heavily reliant on mental services, seeking rehabilitation services for physical ailments*

Jesse is a non-binary resident of Kennebec county and has been living with their long term partner for several years. Jesse is heavily reliant on consistent care from their primary care provider, as well as several specialty care providers including, but not limited to: hematology, rheumatology, psychiatry, etc. Jessie finds themself taking an upwards of "30 meds a day," to manage their chronic pain but remains in "high spirits" and tries to focus on being a "cheerleader" for their inner circle of friends and family.

In learning to live with several chronic conditions, Jesse has become quite involved with their local community and focuses their efforts on outreach, fundraising and event planning on a variety of different organizations, but focuses primarily on assisting the community's queer youth population. When asked about what inspired their outreach work, Jesse reflected back on a time where their chronic conditions were just beginning to appear, and they were struggling to cope with their new reality: "When I first got sick years back, I ended up having to move back in with parents because I was drowning in medical debt and bills...I couldn't work, couldn't prepare meals to feed myself properly, and it took a toll on me. Going back to live with them and depend on them to help me with the (social and political) differences we had, was extremely difficult."

Jesse's goal going forward is to continue to take their experiences with chronic health management in stride as they continue their outreach work within the community and push for safe spaces and reliable resources for all that may need them. Their goal is to help reconstruct the way others perceive and seek help from the various social and health-related organizations that serve the community: "How do we help reframe people's thinking about needing help...that it's not a weakness...but rather that needing help is calling on your community at large. That is strength."

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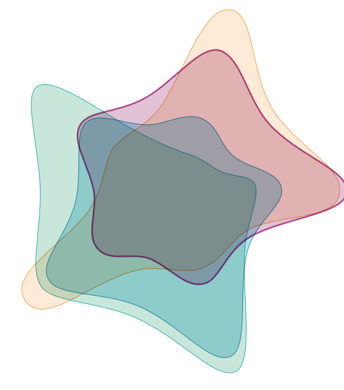

JESSE

KNOWLEDGE

ORIENTATION

ACCESS

UTILIZATION

CARE NEEDED

RADAR MAP BREAKDOWN

+ Utilization: *50% [Low utilizer]*
+ Orientation: *60% [Moderate orientation]*
+ Knowledge Base: *96% [High knowledge base]*
+ Access: *89% [High access]*
+ (Self) Perceived level of care needed: *58% [Low self-perceived level of need]*

OPPORTUNITIES FOR INTERVENTION:

+ Reinforce the notion that seeking community help for ailments and hardships is not a sign of weakness, but rather a sign of hope and strength.
+ Create a "community resource board" of resources for chronically ill individuals part of the queer community.
+ Work to address the mental load of managing a chronic illness (especially in the beginning right after diagnosis) by providing expanded community support.

PERSONA 4

COHORT: MID-AGED ADULT

WALTER, 50 (HE/HIM)

SOMERSET COUNTY

Number of people in household: 2

HRSN's/Socioeconomic factors: *Intellectually & physically disabled, chronically ill, relies on his caregiver/guardian full-time, lacks consistent transportation and is unable to drive himself, has a negative past experience with guardianship with a family member, suffers from depression and anxiety.*

Walter is a 50-year old man living in Somerset county with his sister, who is also his legal guardian, and has been local to Maine for the last several years. He is originally from Boston, and moved to Maine a few years back to live with his older sister. He had to leave Boston after he was neglected by his brother, and was found wandering the streets in his neighborhood after being stranded for several days. When he was found, his other siblings realized their brother had lied about having guardianship over Walter.

At the time, Walter was making money each month between his part time job and his disability checks, which were being intercepted by his brother. Walter's family caught up to what was happening when their brother was unable to procure Walter's guardianship papers. Because his brother also failed to report that Walter was working, Walter ended up having to pay money back to social security over the last 20 years, and just paid back his last portion this past year. With that being said, he hasn't let his past experiences negatively affect the way he trusts and loves those around him, and has found tremendous support from his counselors, case managers, and family: "My counselor really helped me, I felt a lot better...not anxious and I got my depression under control. I am really close with my sister and I know she will always be there for me."

Walter also depends on various community and state-funded programs and services such as: KVCAP, QMB, his local food pantry, and previously utilized Assistant Plus and also had a PCA (personal care assistant). He works closely with his local food pantry as a volunteer unloading produce and shipments which makes him "feel good," and like he is "helping people that need it," just like he himself has depended on the help of others.

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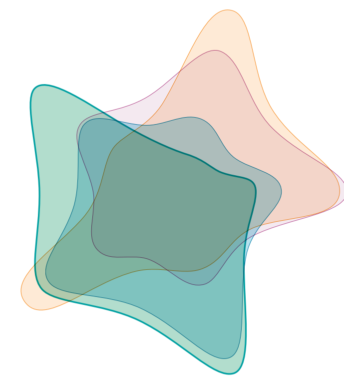


WALTER

KNOWLEDGE

ORIENTATION

ACCESS

UTILIZATION

CARE NEEDED

0%

50%

100%

RADAR MAP BREAKDOWN

+ Utilization: 85% *[High utilizer]*
+ Orientation: *90% [High orientation]*
+ Knowledge Base: *20% [Low knowledge base]*
+ Access: *42% [Moderate access]*
+ (Self) Perceived level of care needed: *98% [High self-perceived level of need]*

OPPORTUNITIES FOR INTERVENTION:

+ Work closely with families and guardians of individuals with disabilities to encourage regular check-ins so they may avoid situations of neglect and better support those individuals.
+ Increase and concentrate outreach efforts to connect individuals and families to programs that assist the IDD community–focusing specifically on counseling, occupational training, overall health and wellness, etc.
+ Work to de-stigmatize perceptions around the IDD community and combat existing prejudices that exist heavily outside of healthcare settings—school, work, social settings, etc.

JOURNEY
MAP

WHY MAP A CONSUMER'S JOURNEY?

Journey maps serve industry professionals and decision makers by providing a clear visual to build understanding and ensure that real consumer challenges are being recognized and addressed along their journey.

Quite simply, mapping helps us identify, visualize, and make sense of consumer experiences over a specified period of time. Mapping also helps us identify and isolate behaviors of interest which can be targeted for change, or prominent pain points which can be earmarked as opportunities to intervene with additional resources, guidance, or support.

The following Journey Map contains four different journeys that follow different personas [young adult, middle aged adults, and older adult]. The map aims to provide meaningful context around a consumer's decision to adopt healthcare and social services during their larger journey.

The core elements of this Journey Map are:

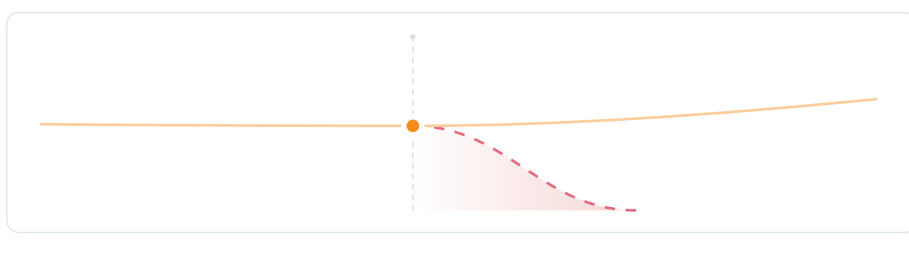
+ **Phases:** What are the overarching phases of a consumer's journey to adopt a service or type of assistance into their lives? Where does it typically begin and end?
+ **Actions:** What is happening within a particular phase? Who are they interacting with?
+ **Emotions:** What are the dominant emotions experienced within a particular phase? How might those emotions fluctuate within a journey (or even within a single phase) in response to what is happening?
+ **Pain Points:** What are the common challenges associated with what is happening? What are the common limitations and dependencies experienced by stakeholders, and are these challenges self-inflicted or externally driven?
+ **Core Needs:** What do stakeholders want, or deem necessary, in order to properly navigate activities and challenges confronted in each phase of the journey more easily? These "core needs" can be practical, physical, or emotional in nature.
+ **Opportunities:** What are the potential opportunities for intervention/ improvement during each phase? How can strategists and decision makers improve the consumer's experience? What are the proposed solutions or considerations?

Aside from the core elements of the Journey Map listed above, we've also included specific moments in each consumer's journey that indicate where there is a "Fall Off Point."

A "Fall Off Point" is a moment in an individual consumer's journey where there is a strong possibility that they might fall off their intended pathway.

There can be more than one Fall Off Point throughout an individual's journey, although they may present differently as time goes on depending on other determining factors—such as emotional toll, finances, physical barriers, etc. Consumers that experience these fall off moments might inevitably delay progress in their journey to pursue assistance, knowledge, services, etc. and even find themselves needing to start over. These Fall Off Points can be anything—but many times consist of: unexpected losses, traumatic events, a new physical diagnosis, or logistical barriers.

Fall Off Point Identifier:



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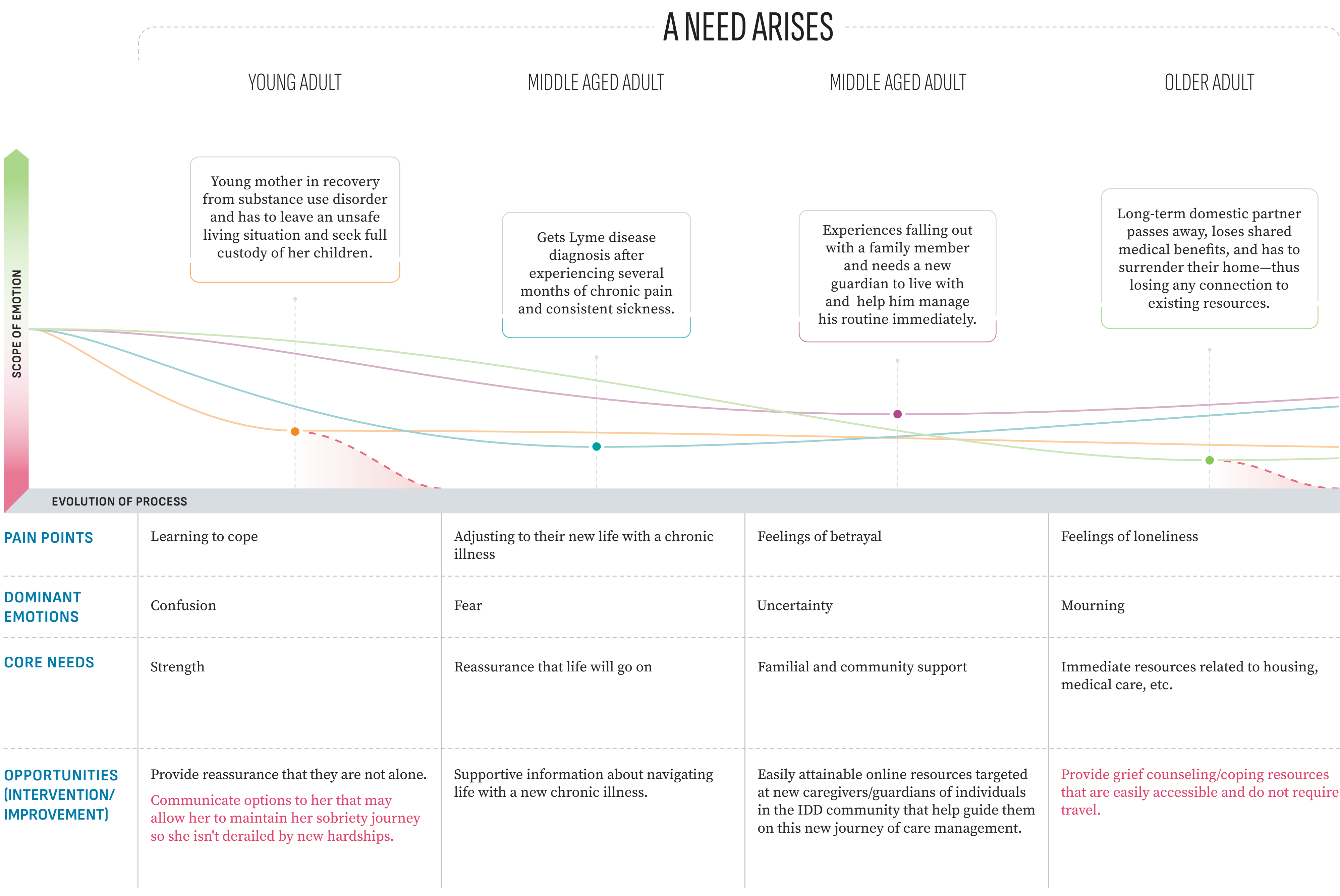
JOURNEY MAP

COMMUNITY ENGAGEMENT



	YOUNG ADULT	MIDDLE AGED ADULT	MIDDLE AGED ADULT	OLDER ADULT
PAIN POINTS	Learning to cope	Adjusting to their new life with a chronic illness	Feelings of betrayal	Feelings of loneliness
DOMINANT EMOTIONS	Confusion	Fear	Uncertainty	Mourning
CORE NEEDS	Strength	Reassurance that life will go on	Familial and community support	Immediate resources related to housing, medical care, etc.
OPPORTUNITIES (INTERVENTION/ IMPROVEMENT)	Provide reassurance that they are not alone. Communicate options to her that may allow her to maintain her sobriety journey so she isn't derailed by new hardships.	Supportive information about navigating life with a new chronic illness.	Easily attainable online resources targeted at new caregivers/guardians of individuals in the IDD community that help guide them on this new journey of care management.	Provide grief counseling/coping resources that are easily accessible and do not require travel.

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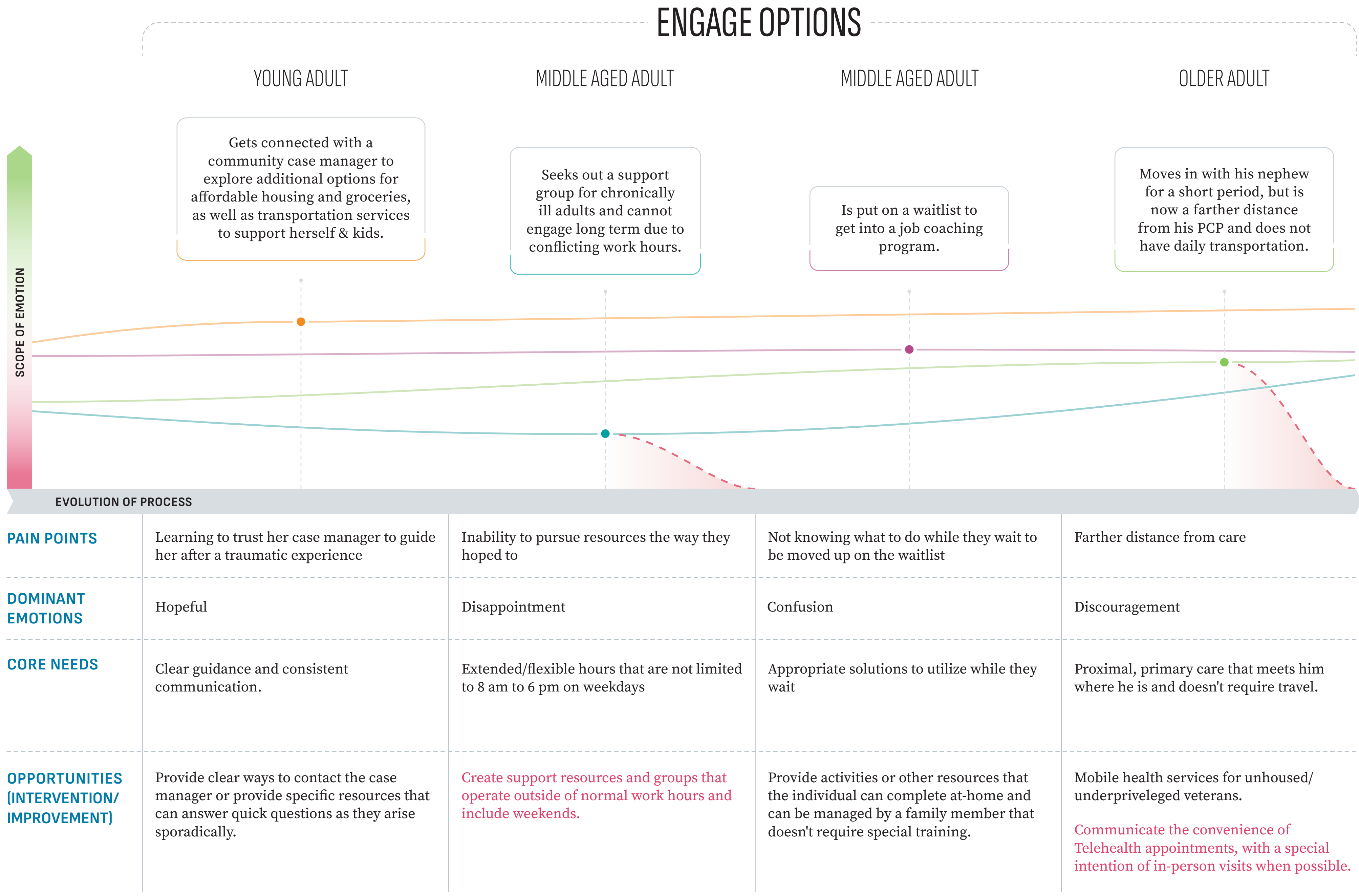
IDENTIFY OPTIONS

	YOUNG ADULT	MIDDLE AGED ADULT	MIDDLE AGED ADULT	OLDER ADULT
	Finds information for a local DV organization in her county that provides legal assistance, but doesn't have a car to get to appointments.	Reluctantly moves back home to central Maine and in with their parents, begins to research free legal help to file for disability and support groups for adults with chronic illnesses and disabilities.	Gets in touch with a local case manager after moving to Maine, and adjusts to life utilizing the resources that are currently available.	Becomes homeless, but maintains contact with VA and his current case manager to look for housing options.
EVOLUTION OF PROCESS				
PAIN POINTS	Navigating unfamiliar territory	Misunderstandings around how various processes work	Navigating a new relationship with a case manager and adjusting to a new life	Lacks consistent housing
DOMINANT EMOTIONS	Overwhelmed	Overwhelmed	Hopeful	Wary
CORE NEEDS	Connection to the specific programs she needs	Tactical support	In depth introductions, clear path of communication	Reassurance that the case manager is his advocate.
OPPORTUNITIES (INTERVENTION/ IMPROVEMENT)	Outline available programs & necessary contact information. Provide options for discreet and safe transportation, as well as remote appointments for DV survivors and their family for legal appointments and court dates.	Clearly outline and define the programs that are available & necessary contact information needed to engage. Increase outreach for existing legal aide services available to the community; focus on emotional support resources.	Solidify new relationship with individual and their family by providing consistent communication and reassurance.	Providing consistent updates around what housing options are/are not available to him about once a month.

SCOPE OF EMOTION

JOURNEY MAP

COMMUNITY ENGAGEMENT



	Young Adult	Middle Aged Adult	Middle Aged Adult	Older Adult
PAIN POINTS	Learning to trust her case manager to guide her after a traumatic experience	Inability to pursue resources the way they hoped to	Not knowing what to do while they wait to be moved up on the waitlist	Farther distance from care
DOMINANT EMOTIONS	Hopeful	Disappointment	Confusion	Discouragement
CORE NEEDS	Clear guidance and consistent communication.	Extended/flexible hours that are not limited to 8 am to 6 pm on weekdays	Appropriate solutions to utilize while they wait	Proximal, primary care that meets him where he is and doesn't require travel.
OPPORTUNITIES (INTERVENTION/ IMPROVEMENT)	Provide clear ways to contact the case manager or provide specific resources that can answer quick questions as they arise sporadically.	Create support resources and groups that operate outside of normal work hours and include weekends.	Provide activities or other resources that the individual can complete at-home and can be managed by a family member that doesn't require special training.	Mobile health services for unhoused/ underpriveleged veterans. Communicate the convenience of Telehealth appointments, with a special intention of in-person visits when possible.

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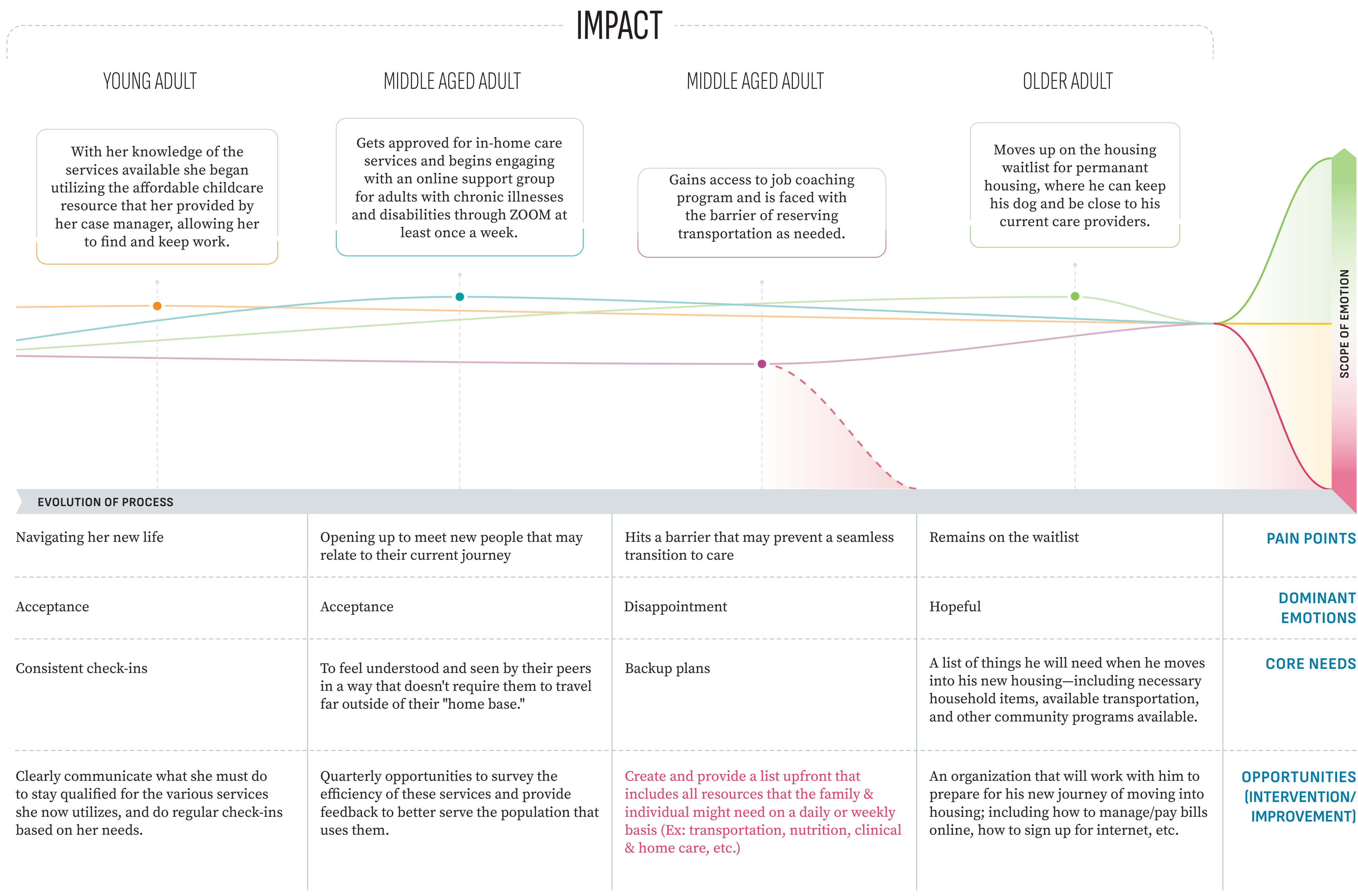

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KEY THEMES

Thematic analysis of the qualitative interviews with participants revealed key themes related to their experiences with community resources, including healthcare, as well as their beliefs and perceptions of and their hopes for community resources. We've explored these key themes in the following pages, including the barriers and facilitators of engagement with community resources, HRSN-specific insights that were learned during 1:1 interviews, and the most prevalent aspects of ideated or idealized community health and resources from the perspective of the consumers of those resources.

GENERAL BARRIERS AND FACILITATORS

Participants reported multiple barriers and facilitators to not only accessing community resources, but also utilizing those resources, including healthcare. Within this report, access is understood as the proximity and attainability of community resources and services. While access is, of course, necessary for the utilization of services and resources, and there is some overlap in the barriers and facilitators of both access and utilization, many individuals reported a disconnect between access and utilization that can heavily impact the level of success when engaging with a community resource.

	ACCESS		UTILIZATION	
	FACILITATORS	**BARRIERS**	**FACILITATORS**	**BARRIERS**
LOGISTICAL	Community Resource Transportation Providers (When Meeting Expectations) Transportation Vouchers	Lack of Transportation Regional, or Rural, Difficulties Underserved Demographics Services Available Only During Traditional Working Hours	Support Staff Competent in Multiple Resource Options or Types Engaging Service/Resource Users to Provide Input	Ongoing or Newly Developed Access Barriers 'Unrealistic' Systems That Aren't Set Up for the Communities Served Significant Red Tape or Complicated Requirements
INTERNAL	Word of Mouth Desire to Improve Quality of Life	Perceived Level of Need (Personal, or Required) Perception that Benefiting from Community Resources Makes One 'Weak'	'Community'-Based Resources Empathic and Culturally Competent Staff	Feelings of Limitation or Restriction A Lack of Empathy Overburdened Support Staff

Read on to further explore the facilitators and barriers of successful engagement with community resources, including healthcare.

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FACILITATORS OF ACCESS

LOGISTICAL

As you review the logistical facilitators to access below, you will see that participants shared experiences with programs or services designed to address common barriers to access. However, many participants reported issues or struggles that they experienced with these programs—concerns that are important to keep in mind when considering these facilitators to access.

Community Resource Transportation Providers (When Meeting Expectations): Several participants shared that there are transportation providers that support the needs of individuals who struggle to access services due to a lack of transportation, whether that be due to financial means or capabilities. ***These providers can act as a major facilitator of access, but only when they meet expectations***, such as arriving on schedule. Unfortunately, many 1:1 interview participant shared that these transportation providers are often late, resulting in missed appointments and frustration on the part of the individual.

*"We have [a transportation provider] and they are a real sh*t show. When they show up, they're constantly running late."* —Woman, 58, Kennebec County

Transportation Vouchers: Some respondents reported participation in a transportation voucher program that allowed them to utilize cab services to attend doctor's visits or view potential housing options. Unfortunately, individuals who reported this information also shared how occasionally the vouchers can cause additional issues with drivers who aren't interested in providing transportation for individuals unable to pay cash or who are leaving or returning to a homeless shelter.

INTERNAL

While the impact of logistical factors is clear, participants reported multiple internal, or attitudinal, factors that inform an individual's ability or willingness to engage with a community resource. These internal experiences, while often informed by logistical facilitators, are representative of desires, hopes, fears, etc., that were shared in 1:1 interviews.

Trust in Word of Mouth: Many individuals that we spoke with discussed the importance of their own community in identifying resources for themselves. We heard this across multiple HRSNs, including individuals struggling with addiction, caregivers of special needs children, and individuals who are homeless or have unstable housing, as well as individuals from multiple age groups. Oftentimes, the 'community' that informs this knowledge is made up of individuals who have experienced or are currently experiencing similar needs or struggles.

The role of word of mouth in facilitating engagement with community or healthcare resources is not uncommon. Word of mouth encourages a flow of information between known or trusted individuals, and ***we heard from participants that learning of resources via word of mouth builds trust in the resource*** and, when the knowledge comes from an individual who has experienced similar struggles, provides confidence in one's own ability to both access and successfully utilize the resource.

Desire to Improve Quality of Life: This is two-fold—individuals are motivated to take necessary steps to engage with community resources by their own desire or need to improve their quality of life *and* individuals are more likely to engage with resources that have demonstrated success in fulfilling their role or purpose. Individuals that we spoke with generally reported a willingness or desire to 'do the work' to improve their quality of life. Many also shared that they believe this to be true of others as well.

"People want to be happy and healthy. They really do. They want to be successful." —Non-binary individual, Age 32, Kennebec County

BARRIERS TO ACCESS

LOGISTICAL

The logistical barriers below are significant and, according to the individuals who participated in 1:1 interviews, widespread. Individuals report experiencing more than one of the barriers listed below, and these barriers often compound on one another, causing additional difficulties when attempting to access community resources.

Lack of Transportation: Unsurprisingly, many individuals reported a lack of transportation as a major barrier to receiving healthcare or accessing community resources that would otherwise be available to them. This barrier is well-known throughout the community. Nearly every individual that participated in 1:1 interviews noted that transportation is a problem, regardless of whether or not they themselves were impacted or experiencing that problem.

Regional, or Rural, Difficulties: Many participants report a lack of resource availability in more rural areas. Particularly when combined with transportation difficulties, this barrier can cause significant access issues for individuals who reside in more rural areas and don't have access to private transportation. Even amongst individuals with private transportation, the distance of travel required to access resources can cause a barrier given the time required and associate travel costs.

"You know, they feel inferior because they're not being included. And that's a lot of the problem up here. It's like, you know, all these programs that they create here in the state of Maine are all wonderful if you live in the Portland area. Right. They don't expand those programs out to other regions of the state. They keep them right in Lewiston, Bangor, Augusta, and the coast. And if you don't live in that region, you go without." —Man, Age 60, Somerset County

Underserved Demographics: There is a perception that there are underserved demographics of individuals—particularly older adults—who are unable to access community resources that support their unique needs. In particular, participants (both older adults speaking from their own experience and other individuals speaking of their perceptions) discussed a great need for social interaction and connection amongst older adults, as well as healthcare for aging individuals. There is a perception that both of these needs are not address by currently available community resources.

Services Available Only During Traditional Working Hours: Unsurprisingly, many individuals reported being unable to access community resources, including healthcare (particularly specialized healthcare that is unavailable in urgent clinics), that aren't available outside of normal business hours. Accessing these resources can result in income loss, needing to acquire childcare, or difficulty for individuals relying upon shared transportation.

INTERNAL

The internal barriers that were reported by participants center largely around their perceptions related to their own level of need, as well as general perceptions of the type of individual that benefits from community resources.

Perceived Level of Need (Either Personal, or Required): Many participants spoke to their own perceived level of need—some indicated that they felt like their level of need wasn't significant, others shared that they felt that their level of need was significant and that they were highly reliant upon community resources. Each of these perceptions can impact an individual's willingness or ability to access community resources. Those who viewed their own level of need as low were less likely to engage in community resources, indicating that they thought that services were designed for individuals with a much higher level of need. This perception was particularly prevalent amongst older adults.

Perception that Benefiting from Community Resources Makes One 'Weak': Similarly, many individuals indicated that being reliant upon community resources makes one 'weak' or that it is something to be avoided at all costs. This perception can cause embarrassment or hesitation to engage in community resources.

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FACILITATORS OF UTILIZATION

LOGISTICAL

When considering logistical facilitators of utilization, it's important to consider the types of interactions or engagement that benefit the individuals utilizing community resources and encourages ongoing interaction. Unsurprisingly, many of the facilitators (and barriers) of utilization are similar to the facilitators and barriers to access, as those experiences can arise at any time.

Support Staff Competent in Multiple Resource Options or Types: Some individuals that we spoke with in 1:1 interviews shared that support staff (in many situations, case workers) who were knowledgeable about multiple resource types were very helpful in making use of available services. These individuals were known to help manage the red tape and/or difficulties that can be caused by using multiple resources, particularly government-provided resources that are known to have very complex rules or requirements.

Engaging Service/Resource Users to Provide Input: Some 1:1 interview participants discussed being asked by community resource providers to share input or participate on boards that allowed users of community resources to have an input on expectations, rules, etc. This type of engagement supported the self-determination of the individuals we spoke with and gave them the opportunity to feel as though they were a part of the team providing resources, as well as receiving the resources themselves.

INTERNAL

The internal facilitators of utilization revolve heavily around feelings of being heard, understood, and respected. The desire for these experiences was heard from nearly all participants that we spoke with in 1:1 interviews and ought to be considered in the design, staffing, and ongoing development of any community resource or service.

'Community'-Based Resources: Many individuals shared that the value of community resources and services is the existence of 'community' within those resources. Many people that we spoke with reported that engaging with others who would benefit or are benefiting from community resources allows them to feel connected and understood. Some participants of 1:1 interviews also discussed the value of community resource staff who engage with users of community resources not only from a service-provider perspective, but also in a friendly, easy, and connected way. This type of community-based interaction with providers allowed the participant's that we spoke to feel more engaged, less judged, and more connected.

"For me, using community resources... you'll probably find somebody that has already experienced your story and has survived it. That's what I get out of community resources." —Woman, Age 41, Kennebec County

Empathic and Culturally Competent Staff: Similarly, 1:1 interview participants reported that, when available, working with staff who were kind, supportive, non-judgmental, and aware of the many barriers that exist when engaging with community resources results in a feeling of trust, being heard, understood, and respected, and made participants feel more confident in their ability to improve their own quality of life. As you will see when reviewing the barriers to utilization, however, not all participants have had this experience, and many spoke of experiences that were the opposite of this positive engagement with community resource staff or volunteers.

BARRIERS TO UTILIZATION

Below you'll find an overview of key barriers to the utilization of resources or services that were reported by the participants we spoke with. While it is understood that access is required for utilization, ongoing participation in services and resources can often present different difficulties experienced by the individuals that we spoke with.

LOGISTICAL

The logistical barriers shared below were expressed by participants in 1:1 interviews and revolved heavily around the complications of engaging in resources on a regular basis versus one-time or short-term engagement.

Ongoing or Newly Developed Access Barrers: It is important to note that many barriers to utilization, particularly logistical barriers, are the same as barriers to access—for logistical barriers to access may arise at any point for many individuals and further hinder utilization of community resources. These include, but are not limited to transportation, under-served locations, or hours of access.

Significant Red Tape or Complicated Requirements: The amount of 'red tape' required to make use of many community resources was a significant barrier discussed by many 1:1 interview participants. They shared that, particularly when engaging with multiple services or resources, the heavy lift necessary to fulfill requirements can cause significant burnout or struggles to continue engaging.

'Unrealistic' Systems: Many individuals spoke to the barriers listed above in the context of unrealistic systemic issues that affect individuals across age groups and HRSNs. There was a general consensus amongst individuals—even those who have a positive orientation towards the resources they have engaged with—that the overarching system and available resources are generally not set up with a realistic understanding of the individuals that they serve.

"Because I think that, like we're thinking about community health from the wrong perspective, we're thinking about it as like who is doing the treating, but we need to be thinking about it like who is being treated? Set it up for them and not the other way around. And I don't think that is happening." —Non-Binary Individual, Age 32, Kennebec County

INTERNAL

Feelings of Restriction or Limitation: Many participants report experiences that they feel disrupt their own capacity for self-determination, which negatively impact their ***orientation towards services*** and resources and, over time, have a detrimental effect on an individual's ***mental health*** and sense of hope, capability, success, etc., occasionally resulting in individuals neglecting to utilize available resources or seeking out alternatives.

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This barrier appears to be most prevalent in situations in which perceived need is great and significant utilization is required over time—for example, amongst individuals with unstable housing, both when making use of available temporary shelter resources and longer-term resources like housing vouchers. Individuals who have or are currently utilizing temporary shelter resources report feeling limited by what they consider to be unreasonable rules that remove their ability to make decisions about their own daily lives, such as required 'bedtimes', shelter lock-out periods, and limited safe storage options.

Unfortunately, many individuals with unstable housing also report struggles to make use of housing vouchers due to a limited housing market. Individuals who experience significant delays or disruptions that limit their ability to make use of housing vouchers report feelings of hopelessness or "being stuck" within a system that is not set up for their success.

"With the housing thing, it seems like there are so many buildings that are like abandoned and locked that I'm just… I don't know. I feel like it shouldn't be so hard to find housing. I wish that more communities have the idea of like Habitat for Humanity where you, like, build your own house. Because I would do that, if I had the skills." —Woman, Age 33, Kennebec County

A Lack of Empathy: We spoke with a significant number of 1:1 interview participants who shared negative experiences with community support resource/service staff that resulted in feelings of judgement, shame, or a lack of confidence in their own abilities to improve their quality of life.

Overburdened Support Staff: Many individuals who reported negative experiences with community resource staff discussed perceptions that the reason for a lack of empathy is largely because staff are overburdened. Generally, 1:1 interview participants indicated that they believed that the work done by support staff is taxing, particularly mentally and emotionally. Most viewed support staff as good people who wanted to help people, but who were ultimately limited by too much red tape, not enough support staff, and generally being overworked or overburdened, resulting in burnout and less-than-ideal interactions with the people they serve.

HRSNS AND RELATED THEMES

HOUSING INSECURE / UNHOUSED

Many participants that are currently reliant on subsidized housing or their community shelter reported issues with pest control, crime, and defective (or limited) utilities, making them hesitant to make use of that resource. Additionally, individuals experiencing this HRSN were much more likely to report issues with unempathetic staff, feeling a lack of empowerment due to a lack of available housing, and generally feelings 'stuck' as they try to manage this very important need.

"So, I don't really do too much, just really kind of head diving in to trying to find some housing so that's really my full time… at the moment. I know when that comes, it'll be more looking for the next goal as far as employment." —Woman, Age 30, Kennebec County

VETERANS

Veterans experiencing housing and food insecurity, substance use disorder complications, etc., generally report similar experiences to other individuals experiencing those HRSNs. However, veterans also report improved access to housing through their veteran status.

"Because of my veteran status I was able to go from a five year housing waiting list to a two month waiting list. I finally received a house which I can't move into yet because the state hasn't completed their inspection on the new building. Once they do, hopefully I can move into there permanently." —Man, 60, Somerset County

SUBSTANCE USE DISORDER

Many individuals with substance use disorder that we spoke with indicated that it was a secondary concern to other needs that they perceived as more important, such as housing, food, etc. The individuals that we spoke with who were in recovery shared that they discovered the resources that were available to them through word-of-mouth and the support of friends or other individuals who had similar experiences.

"I was lucky in like, a lot of, friends and family had already experienced being in a methadone clinic, and that kind of got me to go into it. Because they [the methadone clinic] don't really promote themselves or what they do for people. So, I just heard about it." —Woman, 41, Kennebec County

NEW MAINERS / MIGRANTS

The New Mainers that participated in 1:1 interviews generally reported a lack of diversity and cultural understanding amongst community resources, including healthcare. While these individuals indicted that they experience many of the same barriers experienced by individuals with other HRSNs, they also shared that they also experienced a lack of cultural connection, understanding, or respect, and also felt limited in terms of healthy eating due to a lack of diverse food options.

"It's probably social aspect because like, depending on your ethnic and cultural background. I mean… I feel comfortable and like I relate mostly to similar people who have a similar background. But like in rural communities, which are mostly white, you don't get that much diversity and chances to connect with different people." —Woman, 26, Kennebec County

DOMESTIC VIOLENCE AND SEXUAL ASSAULT SURVIVORS

A large majority of participants living with (at least one) chronic disease, also report experience with trauma (including, but not limited to: emotional, physical, sexual, etc.).

Individuals who had experienced domestic violence and sexual assault generally reported feeling unsupported and entangled in a complex emotional and legal web, with little support from resources or friends and family.

"So, I didn't have a lot of support. The family supported me as far as finding the services, making sure they had what they wanted, but there was no supporting with the guardianship thing for my family."—Woman, 48, Kennebec County

CHRONICALLY ILL/DISABLED

Seniors and older participants experiencing chronic illness or disability report lacking social interaction outside of their day-to-day caregiver(s) across the board. This occurs for a few different reasons: older adults feel like there is not enough places for them to go to gain that social interaction (such as community centers, clubs, etc.), and/or there is no way for them to get outside of their living quarters so that they might have that social desired interaction (Example: lack of consistent transportation, chronic illness/ disability, etc.).

"And there are older adults that are part of our aging population… that are socially isolated. Most of them are completely homebound and no one would ever know. Because when we go through our daily lives, we just we don't realize it." —Woman, 56, Kennebec County

IDD COMMUNITY

Members of the IDD community (caregivers in particular) report a relatively strong understanding of the resources that are available to them, as well as a strong community that provides word-of-mouth recommendations and knowledge sharing.

Caregivers, however, also report being burnt out, frustrated, spread too thin, and lack the emotional and tactful support from existing community organizations to help them manage day-to-day tasks for themselves and the individuals they are caring for.

Generally, struggles largely exist around the wait times for support, the requirement of a diagnosis for some services, and the need for early intervention, which can be difficult to achieve as a parent or caregiver with no experience in this area.

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"We in Maine rely a lot on, especially in the special needs parent community, word of mouth and recommendations. Unfortunately, a lot of the ones who have a lot of [good] recommendations aren't taking patients or their MaineCare panel is full." —Women, Age 30, Kennebec County

FOOD INSECURE

Nearly every participant acknowledged and expressed concern regarding food insecurity in their community. While not everyone was currently fully reliant on resources like their local food pantry or SNAP—each participant had experienced some type of food-related issue in their lives—whether that be food availability, anxiety around the cost of food, or lack of inclusive dietary options available at a low cost.

"With everything that has happened over the last few years, inflation and people losing their jobs and all sorts of stuff, like just having basic needs met have been difficult for a lot of families. And food is one of the main ones." —Woman, 26, Kennebec County

SINGLE PARENTS

Single parents expressed needing help with gaining access to services and solutions that will allow them to ***save time*** without sacrificing their child's safety (or their own). This was particularly prevalent in single mothers that were struggling to find consistent childcare—and even more prevalent for single mothers that work full time.

"They can't find staff to necessarily give all these kids a space. They have a big space that they could serve a ton more kids in. However, they can't staff enough to bring these kids on. So, they still have this waiting list because they're kind of limited." —Woman, 36, Kennebec County

QUEER COMMUNITY

Members of the queer youth community residing in rural areas do not feel **safe**, understood, and supported by their peers or community institutions.

"'You're a tomboy. You're not actually a boy. There's no such thing as non-binary.' All those arguments are around the community. I mean, we've had trans people in the community before who put like pride flags up in their windows and stuff. And I noticed that either the pride flags quickly were put away or those people would move out very soon." —Non-binary Individual, 17, Kennebec County

MENTAL AND BEHAVIORAL HEALTH

Many parents who have children using behavioral health services in the community report having to travel far distances and make it through extremely long waitlists before they can get in for an appointment.

Losing money while utilizing behavioral health services seems to be a very common experience for most parents—especially those who have more than one child utilizing these services. This financial strain can be due to a variety of reasons, but the most common being: having to take time off work, gas used to travel to and from the appointment(s), paying for specialists, increased copays, dedicated extracurricular activities, and more.

Additionally, many individuals appear to be conflating mental and behavioral needs with substance use disorders, particularly when considering adults experiencing either of the HRSNs.

"I didn't realize I had perceptions of people with substance use disorders, people that had mental health disorders. But going through that experience, I didn't realize that I had been pretty jaded and snobby about some of my views. And it [recovery] was just, it was very humbling." —Woman, Age 42, Kennebec County

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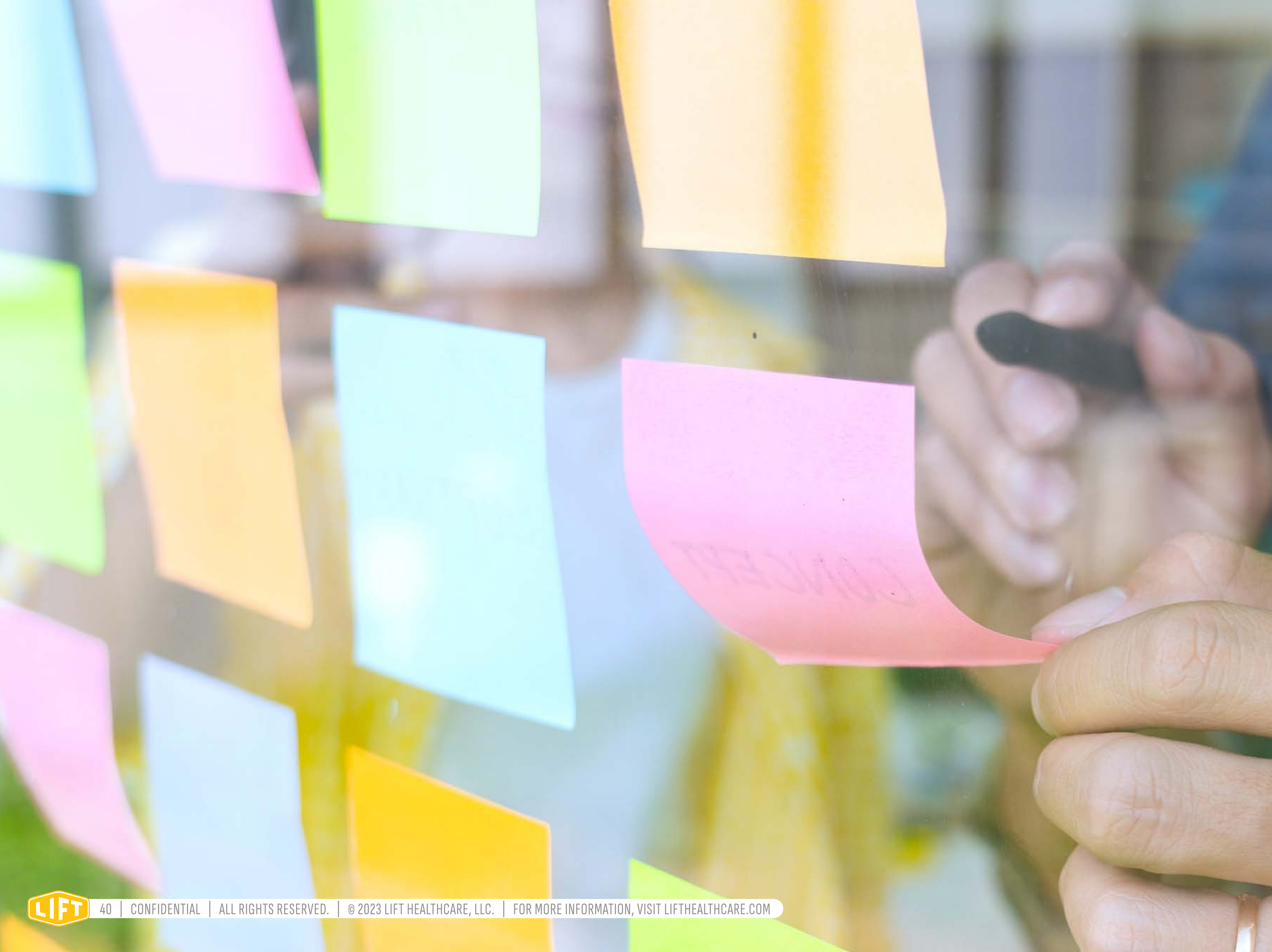

STRATEGIC RECOMMENDATIONS

In general, what do organizations need to be considering to become more useful, accessible, and effective in serving the individuals within their community? The answer is: a broader focus on community and redefining how we think about and approach the process of serving. This can be made possible by focusing on the Five Key Indicators of Success (Utilization, Orientation, Knowledge, Access, and Self-Perceived Level of Need).

It is important to note, that while some of these include more specific examples specific to a particular HRSN, they can be considered generalizable based on what was learned in 1:1 interviews.

INDICATORS OF SUCCESS:

+ **Utilization** [how often individuals use these services]
+ **Orientation** [how individuals feel about these services]
+ **Knowledge** [how aware individuals are about the services & how to use them]
+ **Access** [proximity and attainability to services]
+ **Self-Perceived Level of Need** [an individual's discernment of how much/little exposure to services they require.]

RECOMMENDATIONS:

Understanding how individuals view the severity of their needs can give us an idea of how we can best serve them in a way that is functional and efficient for them and meets them where they are. Self-perceived levels of need among consumers may also give us ideas on how to best transition individuals into the various services when they are "new users."

+ Older adults/seniors often feel that the services available to their age group are for people who are "worse off" than them. There is an opportunity to reframe the wide assumption that those organizations only serve a select group of people in dire need, and instead encourage the view that community organizations are there to provide tailored assistance to whomever may need it.
+ Individuals with life-long chronic illnesses, as well as those that have consistently struggled with meeting their needs (food, shelter, medical care, etc.) may become "desensitized" and accept their situation as normal, preventing them from seeking out help because "it's always been that way."
  + "Check-ins with the Community" that go out as surveys through text and email.

+ Single parents that are used to "doing it all" often neglect to seek out (or are just unaware of) the resources that may provide help. Providing and marketing support services to parents that work outside of the normal 9-5 hours is imperative in reaching everyone.
  + Nighttime childcare incentive to assist parents that are essential workers.
+ Individuals that are struggling with, or recovering from situations like substance use disorder or trauma, may neglect or be unable to balance their mental health care and instead focus directly on physical health in recovery/rehabilitation.
  + Communicate the importance of "overall" wellness and recovery by teaching the "6 Dimensions of Wellness:" Physical, Emotional, Social, Occupational, Spiritual, and Intellectual.
+ Create resources for community members that can act as a "checklist" for individuals that may not be able to discern problems/ailments that are non-severe vs. those that are acute.
  + Visual diagrams, tables, etc. that can point out life-threatening ailments/problems and where the community can go to get immediate care.

How the community has oriented itself to existing services can help us understand not only what their individual experiences have been like as consumers, but also that of their caregivers, family, and friends. Recommendations through word of mouth are a powerful tool and a heavily used tactic among the community and can greatly affect the way individuals choose to (or choose not to) utilize the resources available to them.

+ Put the "Community" back in "Community Resources": Respondents are looking for empathetic and engaged communities of support.
+ Address the community's need for not only competent support, but empathic support.
+ Address community provider burnout.
  + Case managers, community health workers, home health workers, etc. are overworked and find themselves lacking proper time and resources to serve everyone adequately.
  + There may be individuals who are empathetic and competent, but they are burdened by and limited by a broken system and being overworked/underpaid.
+ Reinforcing the idea that utilizing services does not make you "weak" or a "leech," but that leaning on your community is instead a sign of strength and courage.
+ Focusing on positive testimonials from both consumers and providers that will not only help improve morale for those coordinating health and social services but reinforce the positive effect that these services have on the individuals and families in the community.

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KNOWLEDGE

The level of awareness among the community about the various services that provide assistance can tell us more about the efficacy of current marketing and outreach efforts that have been used to connect the community to these resources. Understanding where the community's knowledge level is stronger and weaker, can show us the areas that may require more concentrated outreach efforts.

- Multiple respondents specifically referenced a need for a specific place in which support services or case worker-style individuals could provide one-on-one guidance related to available resources.
- Bringing information to the community by meeting them where they are (digital, printed materials sent by mail, community events, community postings in public buildings and community facing organizations–shelters, informative "teaching" sessions on how to access and properly use existing resources.)
- Creating a navigation system for community members to help them understand the roles of the organizations serving the community, and how they can efficiently use these services as well.
  - Ex: "If you need _____, call or go online to: ________, they can answer questions such as: ____________."
- Providing a community resource "guide" for families with children in the IDD community that can indicate what types of avenues they can pursue for short and long term care and answer the questions that may come up along the way.
  - Ex: "How to apply for MaineCare, and what it does/does not cover." "What you need to know about utilizing speech therapy services in-school and privately."
- Bringing knowledge about career paths and nonprofit volunteer opportunities to students so they may gain access to those resources if/when they need them.
  - Community Fair Day at public schools that is inclusive to all grades.

ACCESS

The conversation on how to improve access to community resources is ongoing and feels as if it is never perfect. While not every system put in place can be tailored to every single individual, there are opportunities that will bring the community together and in doing so, create a more efficient and accessible experience for everyone involved.

- A heavier focus on mobile services, especially in rural areas—bringing access to where people are each day (school, work, church, extracurriculars, etc.)
  - "Servicing Our Community Near and Far"
- Creating a "portal" to bridge the gap between community providers, case managers, and consumers to avoid unnecessary wait times and to help ease pressure on community providers.
  - "My Community Portal"
- Encourage communities and neighborhoods to participate in a garden/food share program that is sustainable year round, while also making some items (when possible) available in the local food pantries and community cupboards.
  - "Grow it and Can it" Community Program

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- Lean into the communities of parents with high/special needs family members that are heavily dependent on health and social services and create a larger shared space of information.
  - A community-based app for families that may benefit from: rideshare to appointments and group activities, “how-to” guidance for IEPs and referrals, information on inclusive and handicap-accessible extracurricular activities, etc.
- Provide the necessary coverage for community health workers to be able to travel with individuals to necessary appointments.
  - While community health workers are prohibited from transporting patients/community members to and from appointments themselves, there could be an opportunity to open up public transportation or rideshare resources so they may travel together as needed.

Significant barriers around utilization exist for individuals in general, but we see this especially in those that are wanting to make use of and improve on their own skills and their overall situation.

The following suggestions provide high-level tactical ideas on how we may address these barriers.

- Recognize and support individuals’ need for self-determination, particularly in housing situations and employment training.
  - Provide day programs that focus on “job prep” training that teach the skills needed to apply for and maintain jobs in the current market.
- Champion empathic procedures to uplift individuals utilizing community resources for the first time.
- Simplify the process for “first timers” and relate to them as another member of the community as we help them jump through the hoops that exist on a structural and policy level.
  - Making “How-to” guides focusing on navigation available, as well as “Need to Know” informational guides that users can refer to when needed. This could also help decrease communication barriers between case managers and their clients.
- Understanding that the day to day needs of the community may not fall in the hours where “most” need them. Community members need communication and information to be available outside of normal working hours.
  - 24 hour “help hotline” that can help answer specific questions about application and approval processes, where to find immediate help or shelter, etc. This may not take form to be available 24/7 but can be test driven as a strategy twice a month to measure rate of utilization.
- Focus on immediate, low barrier access so individuals (and their families) are not limited by discriminatory practices.

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Prepared for the Rural Community Health Initiative Project (R-CHIP)

COMMUNITY PROVIDER INSIGHTS

MEET YOUR DATA

EXECUTIVE SUMMARY

NAVIGATING THIS REPORT

In this condensed report, the focus is on understanding the barriers, beliefs, routines, and feedback of community service providers in Kennebec and Somerset counties—including those that serve individuals in both the healthcare and social services areas—as well as their perceptions of the experiences of those who make use of the services they provide. As we elaborate on findings in this report, we seek to expand our understanding of the experiences of community members, as well as the key themes of barriers and facilitators that providers experience when they work with the individuals and families in the community.

In terms of visual maps and tools, we have also included a community provider journey map that explores the phases of provider-consumer interactions and the various factors that may affect this relationship over time (communication barriers, transportation, etc.). We also outlined a more condensed persona profile that aims to humanize the community provider perspective by giving them a face, name, and story. This persona profile aims to provide guidance to community service organizations as they consider the best ways to connect and communicate with their community and manage professional relationships with other neighboring community organizations.

Throughout the report, readers will also note important key moments and quotes pulled directly from 1:1 interviews held with community providers. These quotes will offer insight into the verbiage and emotions shared by those working closest with the people in the community.

AN OVERVIEW OF PROVIDER PERSPECTIVE

Generally, those we spoke to in the community service provider space reported frustrations and concerns with the systems that support healthcare and social services, as a whole (these include, but are not limited to government funding, public policy, etc.). While these frustrations were shared widely throughout the various provider participants we spoke with, they also acknowledged that many of these shared frustrations (around funding, "red-tape," barriers in the referral and diagnosis processes, etc.) seemed "out of their control" and were the product of an overworked, "burnt out" (state and national) structure.

As community providers acknowledged and elaborated on these barriers, frustrations, and concerns, they also revealed their shared drive to make these existing systems more efficient, more influential, and easier to navigate for the families and individuals who rely on them. Through exploring these facilitators to provide services and care, however, community providers as a whole shared their hopefulness for improvement in day-to-day processes, and for stronger inter-organizational relationships with their colleagues and communities. Many of these solutions and ideas are further noted in the visual maps and tools sections in the report.

STUDY METHOD

OVERVIEW

- Qualitative (1:1) Interviews about 90 minutes long.
- Total Provider Interviews = 7
- Total Interview N's (including consumers) = 30

GOALS

To capture insights into the day-to-day routines and perspectives of community providers in Kennebec and Somerset counties.

To better understand the types of barriers that exist for community providers in terms of delivering social and health-related services to individuals and families.

To reveal insights that support efforts to address existing gaps and barriers in community health, as well as gauge what specific resources and services could potentially fill those gaps.

To better understand how community providers manage their inter-organizational relationships with each other and delegate the needs of the community accordingly.

PARTICIPANT BREAKDOWN

Interview participants consisted of community service providers serving (and residing in) both Kennebec and Somerset counties.

The community providers we interviewed focus on serving populations experiencing a variety of health-related social needs (HRSNs) including, but not limited to:

- IDD Community, Mental & Behavioral Health
- Queer Community
- Chronically Ill & Physically Disabled
- Survivors of Domestic Violence, Sexual Assault & Trafficking
- Food Insecure
- Single Parents
- Housing Insecure
- Veterans
- New Mainers/Migrants
- Individuals with Substance Use Disorder

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KEY THEMES

BARRIERS

The inability to transport patients/community members to appointments as a Community Health Worker (CHW).

"That's a big limit to what we can do—I wish I could take patients (to their appointments) myself, but unfortunately we just can't, and I do understand because we aren't licensed to transport and it is a huge liability. I've had many people miss appointments because their family members can't take them at the last minute. I hate to see them cancel or have to miss important appointments, it feels unfair."

Lack of funds and overall support for community organizations (which includes a lack of staff) leading to services getting cut—leaving community members in need.

"In a perfect world we would have enough funds spread adequately among the community. Everyone is just doing the best they can with the resources, funding, time, [etc.] that they have. That's all we can do right now."

Community providers unfamiliar with how to manage/treat consumers with intellectual disabilities in a way that prioritizes empathy and deeper understanding.

"I definitely think it's an educational issue early in MD's careers and the (general) population to be familiar with them (IDD patients). To better understand what people are saying and what they're not saying."

Managing patients/community members that feel "unsafe" and "judged" in various community environments and trying to encourage them to pursue services.

"One of the patients I work closely with in community health is a member of the queer youth community and she has really struggled to feel heard and understood, not only by her doctors but by those at home and in her inner circle as well. The toll that takes on someone's mental health is huge, and many times, they don't want to engage with their health after that…it's exhausting and debilitating to have to constantly advocate and fight for yourself."

High demand services with high throughput, with no ability to limit/cap scheduling—causing oversaturation.

"The biggest issue is, we have high demand from everyone—not just those that are high risk, and we have a large throughput. I can't necessarily control my schedule or cap the number of patients I take so it gets overwhelming and can feel like an overburdened system. I think that's largely due to the lack of other available providers in the field."

Lack of physicians in the area (specifically ones in pediatric psych and behavioral health).

Note: This community provider is speaking to the barriers faced with the lack of physicians in the area, contributing to overburdened systems. In this quote, she is speaking to a recent experience at a conference where she discussed the important role that housing for residents/student physicians play in where they end up practicing long-term. Hospitals and teaching programs that can offer affordable and accessible housing options typically see a higher yield of physicians practicing in local programs.

"I was at a conference last week talking and meeting with a whole bunch of other people and they were saying, 'That's the big thing.' That's what makes certain sites more popular, versus less popular…is if they (hospitals) provide housing (to students and residents)."

Long wait times and prolonged referral processes to connect consumers to the services they need—especially health-related services.

"Yeah, so it starts with a referral. They fill out a form that has basic demographic information and then information about their child's diagnosis. If they don't have a diagnosis yet, there's a step before where they'll need to have an evaluation, which is sort of a clog in the system. Right now, it's very hard to get evaluations for children. So if they have that, then there'll be a referral and then they're placed on our waitlist and depending on staffing and availability in our various programs."

FACILITATORS

Helping community members to feel safe utilizing the services available for them; thus allowing community providers to be able to engage them.

Note: This community provider is referring to feedback received from members of the community not feeling entirely safe or comfortable utilizing various resources (such as outdoor spaces) even while having easy access to them. These concerns expressed branched from social and safety concerns due to past traumas, to even more specific preferences related to preferred types of interactions.

"We have so much at our disposal, so much to offer in terms of natural beauty and outdoor activities to keep our community healthy, but not everyone feels comfortable using everything. Not everyone likes indoor, group exercise classes. Not everyone feels well represented in those community groups."

Adequate staffing levels for community provider organizations.

"I think our [organization] does our best and I'm really proud of that...I will say, there are a number of schools who don't have anyone in my position at all. It's not necessarily shocking, given everything [going on]. But I can't help but wonder, who is helping these kids then? Who is working with them on getting through the necessary issues, problems, etc.?"

Mental/emotional support for community providers that are consumer-facing with high risk families and children.

"It's hard not to hold on, and take work home with you. I think anyone can struggle with that to some degree. For me, I work so closely with young children and their families...I will say, our team does a great job of encouraging us to talk about stuff, and get counseling and help when needed to stay healthy."

Weekly/biweekly "check-ins" with consumer-facing community provider teams to manage satisfaction levels and provide solutions to existing (or budding) problems and questions.

Disclaimer: These check-ins are part of routine exercised by community providers, however these happen rather sporadically and are not crossing between all community resource organizations.

"There's power in numbers, regardless of who or where you are."

Making accessible, continued education training programs available to various community providers for consumers with special needs.

Disclaimer: This "training" is a development that is currently in progress among a few specific community organizations, but has not yet developed into widespread practice among clinicians and MDs throughout the area.

"I think the biggest factor would be if the health care systems had better training or a [deeper] understanding of how to filter out what health concerns may be present [in a special needs patient] based on the behaviors that they're seeing, rather than the very superficial behavior diagnosis that person has."

Widely available, well-trained community liaisons that communicate between families (consumers) and the organizations (providers) to properly manage expectations and provide necessary knowledge to those who need it.

"My position is dedicated to listening to those families [in need], and I think what came out of it is that we realized as a community that parent-family-teacher engagement is so critical. Those relationships are largely affected by the school reaching out their hand first and saying, 'We're here to help...we are in this together.'"

Understanding that even community providers are consumers in some way, and utilizing an approach to service that considers the viewpoint and needs of the individual in the community in a way that meets them where they are.

"Community health is not just physical health, but rather overall wellness and having access to the things that make you feel well, overall. It's about access–to services, knowledge, technology, etc. Anything that people need in order to live their lives well. It's about more than surviving, it's [about] understanding and planning for what a community needs before they are in need, and making sure that it's available right off the bat if/when they might [need it]."

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PERSONA

STACEY, 33 (SHE/HER)

KENNEBEC COUNTY

Position/Title: Community Resource Coordinator / Case Worker

Stacey was born and raised in Androscoggin County, and after graduating from University of Maine with degrees in psychology and social work, pursued a career in social and health services supporting individuals and families in Kennebec and Somerset counties.

For the last four years, she has been serving as a licensed social worker (LSW) and community case worker, working mostly with survivors of domestic abuse, underserved and special needs children, as well as those experiencing housing and food insecurity.

When discussing her day-to-day routine, Stacey describes it as “multifaceted.” She splits her time between delivering knowledge and connecting services to the individuals she serves, and being a supportive hand to her professional peers in other community organizations. While this unique balance of relationships allows her to hold a deep knowledge of the various services and information available to the community, it also requires her to wear many different hats, leaving her feeling “stretched thin.”

When asked about the current barriers she experiences or concerns she may have about her ability to manage day-to-day, she describes it being an experience had by most community providers. According to Stacey’s experiences, many community providers feel unable to meet everyone’s needs and expectations:

“I think we are all just doing our best to help the people we can help, while still trying to remember that there’s only so much we can do, at the end of the day. I don’t really think it’s anyone’s fault (that we can’t meet everyone’s needs), but at the same time, there are so many families and kids out there in the community that shouldn’t have to jump through these hoops, or go without just because they don’t meet every piece of criteria required…as the middle person in all this…I feel frustrated. I can’t say the system is messed up, I just have to make the most out of what I can do. They’re frustrated. I get it, I’m frustrated too…I think we all are, as a community.”

COMMUNITY ASSET MAP

A community asset map is typically defined as a visual aid where a geographic community's assets are identified, defined and grouped into relevant categories to better understand their role as a service and/or knowledge provider in a particular area or (several areas).

Utilizing community asset mapping can be a tool in understanding not only the individually defined role of a particular community organization, but also in understanding how organizations can better support each other based on expertise, self-perceived need among residents in the area, all whilst uncovering existing barriers in the community. In short, asset mapping in this regard is about involving the larger community in identifying where opportunities for improvement exist, and how to work together more effectively.

In this project, it was important that we represented the various roles that the stakeholder organizations play and how those roles align with the health-related social needs among the community. The categories we utilized are defined as:

+ BEHAVIORAL HEALTH
+ BIPOC
+ CAREGIVERS
+ CROSS-SECTOR CONVENING
+ DISABILITIES
+ EARLY CHILDHOOD
+ ECONOMIC
+ EDUCATION (ADULT)
+ EDUCATION (CHILD)
+ FOOD SECURITY
+ GRANT FUNDING
+ HEALTHCARE
+ HOUSING
+ LGBTQ+
+ POLICY ADVOCACY
+ SUBSTANCE USE
+ TRAINING & TA
+ TRANSPORTATION
+ WORKFORCE INITIATIVES

HOW TO READ THE COMMUNITY ASSET MAP

In order to best understand how the Community Asset Map works and to best utilize it as a tool, we suggest that readers start by first reviewing the stakeholder organizations listed on the left-hand side of the map. Moving horizontally across the page, the reader can see the types of assistance services these stakeholder organizations provide to the community by noting where there is color shading. For example, Capital Area New Mainers Project provides services that fall under the categories of Housing, Adult Education, and BIPOC, which are shaded as appropriate.

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MAPS & VISUAL TOOLS

COMMUNITY ASSET MAP

ORGANIZATIONS / CATEGORIES	Behavioral Health	BIPOC	Caregivers	Cross-sector Convening	Disabilities	Early Childhood	Economic	Education (Adult)	Education (Child)	Food Security	Grant Funding	Healthcare	Housing	LTBGQ+	Policy Advocacy	Substance Use	Training & TA	Transportation	Workforce Initiatives
Capital Area New Mainers Project		●						●					●						
Family Violence Project							●			●			●						
Hallowell Pride Alliance								●	●					●					
HealthReach Community Health Centers	●											●				●			
Healthy Communities of the Capital Area								●	●	●									
Healthy Living for ME				●													●		
Kennebec Behavioral Health	●												●			●			
Kennebec Valley Community Action Program									●				●					●	
Maine Primary Care Association	●											●			●		●		●
MaineGeneral Medical Center	●											●				●			
Mid-Maine Homeless Shelter, Inc.							●						●			●			
PAHLC								●	●	●									
SKILLS, Inc.					●		●						●						
Somerset Public Health								●	●	●						●			
Spectrum Generations			●		●					●									
United Way of Kennebec Valley				●							●				●				

JOURNEY MAP

This visual map represents the individual journey of a direct care worker as they move through the multiple phases involved in delivering care services to individuals (or families) in the community. Outlined below, readers can identify the individual events involved in these phases, as well as the dominant emotions that accompany them–both from the perspective of the care worker and the consumer(s) they serve. Readers can also identify the various pain points that may arise on behalf of the direct care worker as they work to address problems, identify consumer goals, and work closely with other community provider organizations.

IDENTIFY COMMUNITY NEED(S)

A community member at a local shelter is in need of career planning support and doesn't know where to start.

The community member discovers that pursuing employment will disqualify them from receiving disability, which they currently rely on.

GET CONNECTED

Set up a meeting with the community member in question and identify their goals for employment.

Discuss any and all relevant professional/personal background information that might affect the employment application/decision process.

PLAN & PROBLEM SOLVE

Connect the community member with a local employment/skills-based organization that can work with them to identify appropriate jobs that align with their skill set and logistical capabilities.

Follow up with the community member to ensure they were able to meet with the organization's coordinator, and discuss next steps and any additional needs going forward (transportation to/from work, housing, etc.)

EVOLUTION OF PROCESS	Identify Community Need(s)	Get Connected	Plan & Problem Solve
DOMINANT EMOTIONS (PROVIDER)	Observant, Analytical, Understanding	Tactful, Inquisitive, Involved	Rational, Communicative, Detail-Oriented
DOMINANT EMOTIONS (CONSUMER)	Discouraged, Scared, Uncertain	Hopeful, Nervous, Cautiously Optimistic	Motivated, Purposeful, Confident
PROVIDER PAIN POINTS	Attempting to understand the scope of consumer need without having the full picture.	Learning how to best communicate and work with a community member with specialized needs for the first time; while gathering all relevant information as quickly and efficiently as possible.	Tackling the identified problems and addressing goals head on, in a way that meets the consumer where they are without pushing them too far out of their comfort zone.

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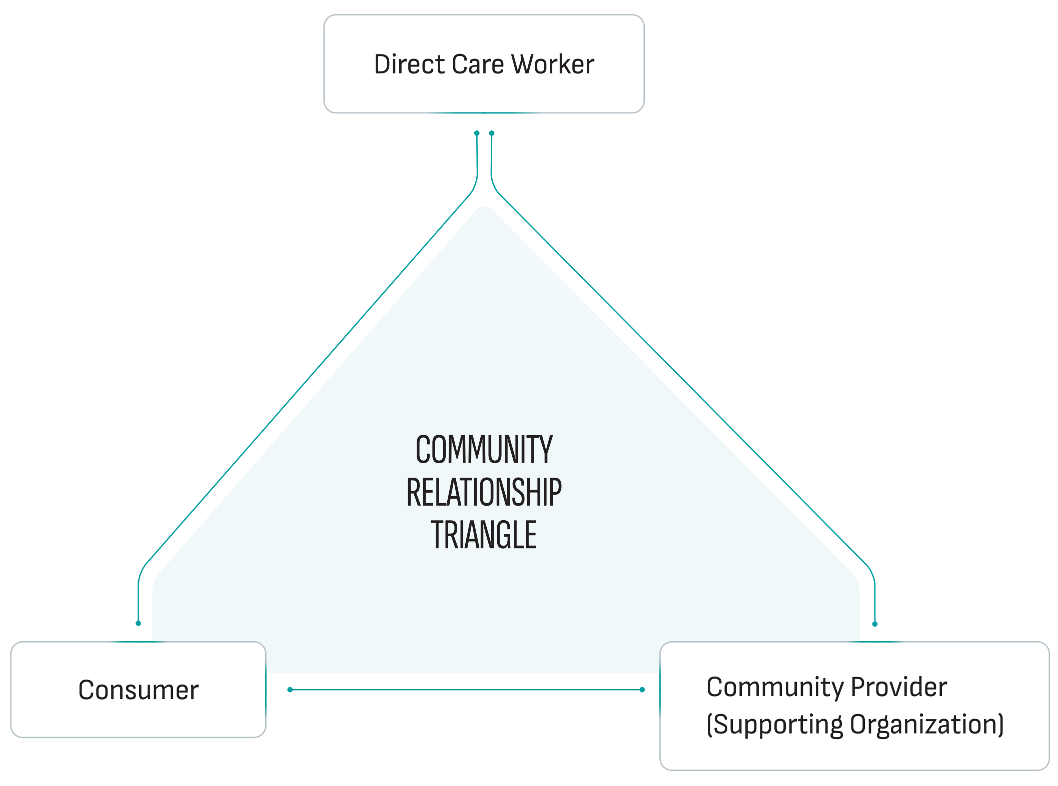
ONGOING EVALUATION OF PROGRESS

Begin the "hand off" process between the consumer and supporting community provider–focusing on how the relationship will be managed going forward and confirming preferred methods of communication.

Assess the plan for achieving goals as a community care team, and plan "accountability check-ins" between the community provider team and the consumer seeking services.

EVOLUTION OF PROCESS

Determined, Focused, Positive	DOMINANT EMOTIONS (PROVIDER)
Relieved, Supported, At Ease	DOMINANT EMOTIONS (CONSUMER)
Keeping up with the consumer throughout life's future and unexpected challenges while being an involved team member with other direct care workers working with the consumer to address additional needs.	PROVIDER PAIN POINTS



This "Community Relationship Triangle" is a tool used to broadly visualize the consumer-care worker relationship and how it is interconnected with other supporting community provider organizations. This tool allows us to understand how consumers in the community that are seeking services are interconnected to the providers of those services. In this visual, the reader will notice three points: the direct care worker, the consumer, and the community provider (supporting organization). As time goes on, points may be added to this relationship as needs evolve and as the landscape of what is offered by way of social and health-related services changes in the community.

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KEY OPPORTUNITIES

In general, the larger opportunity, when we narrow our focus to the relationships between provider and consumers, is to build opportunities for collaboration within the larger landscape of the community. As we consider what those opportunities for collaboration look like and how they might come to fruition, it is important to plan for the tactful actions we would take to make those opportunities possible.

There are three main opportunities for intervention that we have identified through 1:1 community provider interviews: Community Provider Check-In Meetings, the Community Care Hub, and the Bi-Annual Community Solutions Workshop.

The intention of including an opportunity like a **Community Provider Check-In Meeting** is to provide a designated time for community providers to work together on shared cases to discuss progress and ways to problem solve and address current barriers, as well as stay organized and in touch with the other organizations supporting the individual/family being served. These "check-ins" are designed specifically for any community provider that is interacting directly with the individual/family–for example: case managers, legal aid workers, advocates, community health workers, etc.

The **Community Care Hub** was designed to support everyone in the community—including both community consumers and providers—by allowing access to knowledge and relevant information on assistance services available, as well as providing a solution that keeps them up-to-date with the details of their open case(s). The Hub, however, looks different depending on an individual's role. For consumers, this may look like having access to a community-wide events calendar, a portal for appointment reminders with case workers, and being able to check on the status of pending applications. For community providers, the Hub may serve more of a tactful purpose in managing several cases and staying up to date on progress made in those cases so they may be better equipped to work with that individual or family.

The **Community Workshop** is just that—a hands-on, interactive day for community providers to come together and problem solve, brainstorm solutions, share success stories, etc. The idea of the workshop is to create a "round table" type setting, where a diverse group of community providers from all areas of expertise, can spend time getting to know each other and their individual roles better. The end goal is to not only create a more equipped team of community providers, but to also understand the ways that they might work better, together.

In this section, we have included a more in depth breakdown of what these opportunities might look like when/if they come to fruition.

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COMMUNITY PROVIDER CHECK-IN MEETINGS

The purpose of these Community Provider Check-in Meetings are to provide industry professionals with the opportunity to stay connected as they move through the process of addressing both individual and familial cases. Community providers that are working with consumers that have needs for specific services—especially those that are working to address several needs—would have the opportunity to come together and discuss progress, barriers, and concerns about their shared cases. These check-in meetings very well may look different for every group or community provider, and may take place in-person or through a video conference like ZOOM.

These meetings can consist of two individuals—one individual case manager and one service-based coordinator from a local community organization (Ex: SKILLS, Inc. Mid-Maine Homeless Shelter, etc.). Meetings may also include more than two individual providers if the consumer's case being discussed requires assistance across multiple needs. For example, a case manager and service-based coordinator working in housing might meet together along with a community health worker to discuss the consumer's progress in seeking affordable housing, as well as the current state of their health. While all individuals involved have different roles in addressing the various needs of the consumer, the check-in meetings may provide opportunities to work together to not only evaluate the individual's progress, but to also address any existing barriers or concerns that prevent them from fulfilling the consumer's needs and overall goals.

In order to best visualize how a Community Provider Check-In Meeting might go, we have included a "mock" agenda here.

Community Provider Check-In Meeting [#1]: January 8, 2024 @ 10:00 AM EST

Community Case #: 5678 [Dalton, Theresa] DOB: 02/05/1989

Attendance (4 out of 4 present)

+ Stacey [Case Manager]
+ Cheryl [Community Health Worker–Maine General]
+ William [Referral Coordinator–Kennebec Behavioral Health]
+ Bonnie [Director of Family Services–Family Violence Project]

Housekeeping & Important Reminders

Offices closed 01/15/2024 for MLK Day

Progress Updates

Stacey

+ Application for Theresa's housing voucher is still pending (application was submitted 01/03/2024).

William

+ Upcoming appointment with Kennebec Behavioral Health to discuss services for Adult Rehabilitation. Cheryl will be accompanying her to the appointment, transportation will be provided by Theresa's mother.

Cheryl

+ Follow up dentist & primary care appointments were scheduled last week for mid-February. Dentist appointment will be to discuss ongoing tooth pain due to cavities; primary care appointment is scheduled with her new PCP (Dr. Ford, MD) at Elmwood Primary Care in Waterville.
+ Discussions with Theresa around diet are ongoing, we hope to make more progress in this area after tooth pain is resolved after her appointment next month.
+ We have also begun discussing options for light exercise when she is feeling up to it—she has expressed her discomfort with "group" exercise settings. Our focus will remain on clinical care and diet until she feels more comfortable.

Bonnie

+ Request for legal services has been fulfilled—Theresa was referred over to Pine Tree Legal Assistance last week to discuss the custody process.
+ Theresa has requested more information on domestic abuse survivor support groups as well as CDVIP; we spoke yesterday about the support groups offered within FVP and how she may want to be involved. She made it clear she would like the option to do in-person as well as online support, if possible. She also requested that we connect her with a past CDVIP participant so that she may better understand what is involved from a "user" point of view.
+ We will regroup later this week after she is able to consider the information provided and so we may address any outstanding questions that may have come up.

Looking Ahead

+ Next CP check-in meeting: Monday, March 4, 2023 @ 10:00 AM EST
+ Theresa will need help renewing her MaineCare plan. The deadline for renewal is the last week of March.
+ Theresa also has an upcoming court date for seeking partial custody of her 3 children: February 2, 2024 at 9:00 AM; she will be accompanied by her mother.

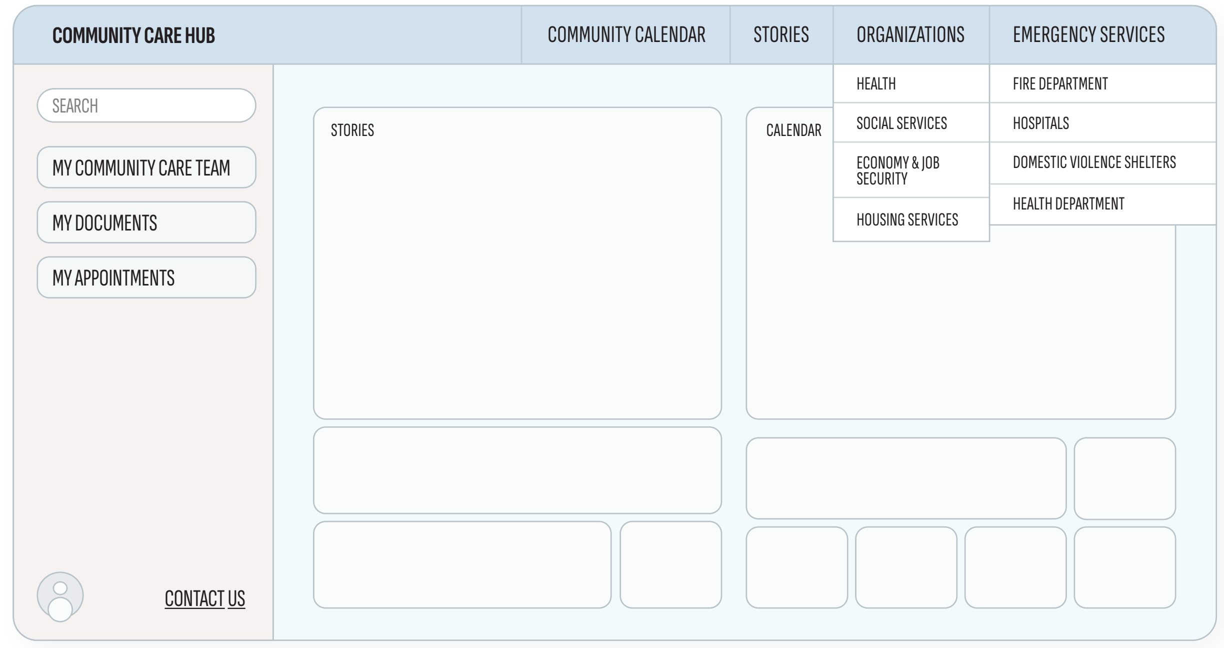
COMMUNITY CARE HUB

"A Community Care Hub is a community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs." (Partnership to Align Social Care, 2) The intention is to create a one-stop for both providers and consumers when it comes to utilizing and delivering services in the community, as well as seeking out general knowledge on existing resources. The Hub would focus on providing an easier means of communication between direct care workers, case managers, etc. and consumers, as well as a more seamless communication and planning process between multiple providers working on a shared case (or multiple shared cases).

Aside from the Hub being a communication platform, it was important that it also provide other avenues that are vital to the success in providing those services, such as:

+ The ability to view, complete, and organize necessary documents.
+ Give consumers and providers the opportunity to check the status of various applications that may be outstanding—such as for housing vouchers, legal services, healthcare referrals, etc.
+ Provide appointment reminders
+ Provide a simple route to seeking general knowledge about existing community resources and upcoming events (job fairs, cultural days, hospitals & free clinics, etc.).

Since the platform is two-fold, and caters to both sides of the aisle (those providing community-based services and those utilizing those services), the Hub would consist of two different portals:



PROVIDER PORTAL

COMMUNITY CARE HUB
COMMUNITY CALENDAR
STORIES
ORGANIZATION DIRECTORY
EMERGENCY SERVICES DIRECORY
HEALTH
SOCIAL SERVICES
ECONOMY & JOB SECURITY
HOUSING SERVICES
FIRE DEPARTMENT
HOSPITALS
DOMESTIC VIOLENCE SHELTERS
HEALTH DEPARTMENT
SEARCH
MY APPOINTMENTS
CALENDAR
PENDING DOCUMENTS
ADD NEW CASE
STORIES
TECH SUPPORT

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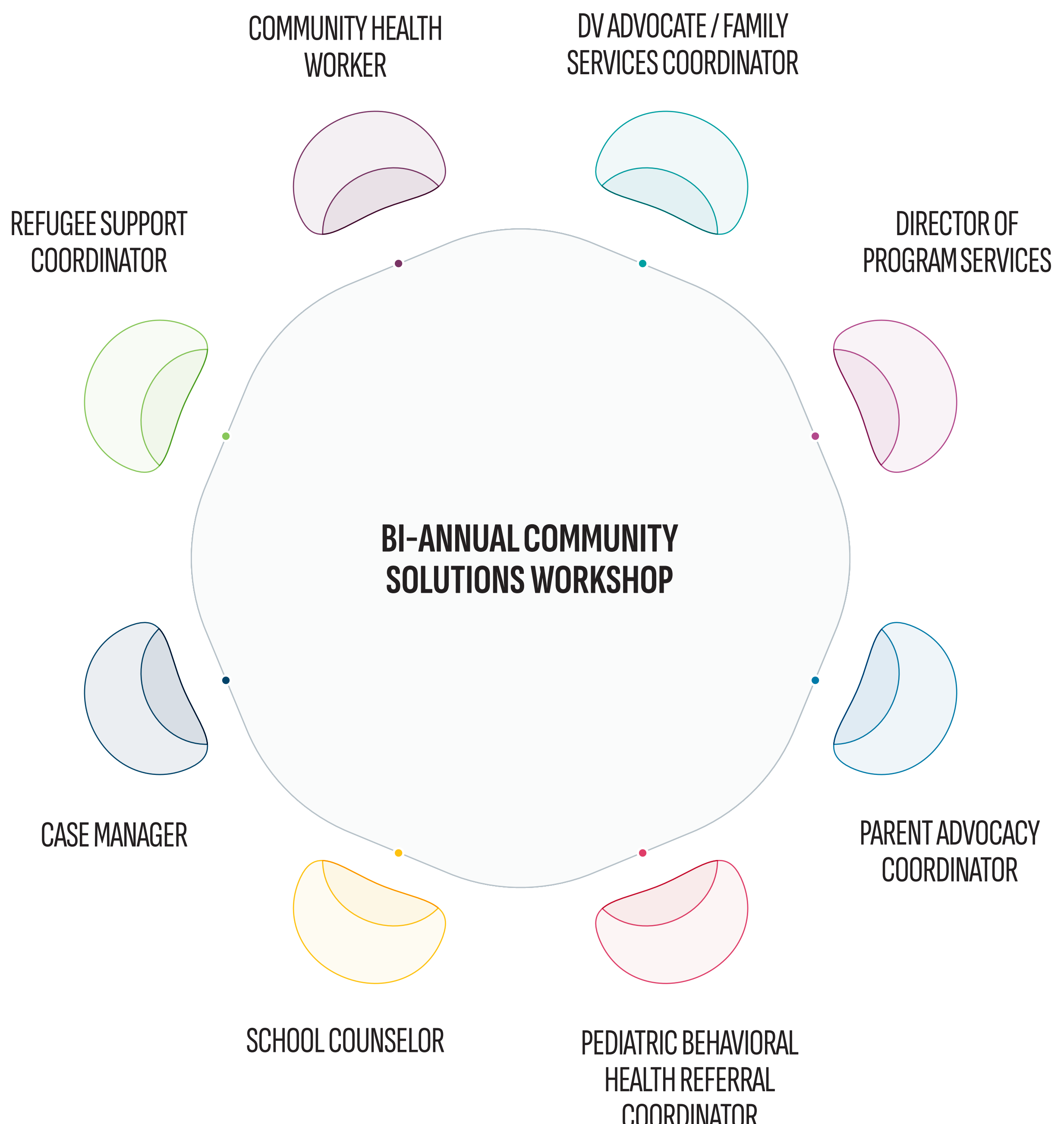
BI-ANNUAL COMMUNITY SOLUTIONS WORKSHOP

This bi-annual, solutions-based community workshop is catered to consumer-facing provider organizations, as well as case managers working closely with individuals and families in Kennebec and Somerset Counties.

The workshop aims to create a productive, safe space for community providers to come together and have deep discussions on community issues, address barriers to care, share success stories, discuss upcoming policy changes and new legislation that may affect the landscape of community services, and brainstorm ways to work more effectively.

Ideally, the workshop would be held in-person (with options to join remotely) and would be roughly half a day to allow providers to move through discussions, exercises, and problem-solving tactics at an easy pace. As we consider how to organize the groups within this workshop, it is important that each table at the workshop can provide a diverse point of view by having providers from different service sectors (health, social, economic, and housing), especially focusing on mid-level providers that are largely community facing (such as: service coordinators, health workers, advocates, etc.) To provide additional context, we have provided a mock up of a workshop "round table."



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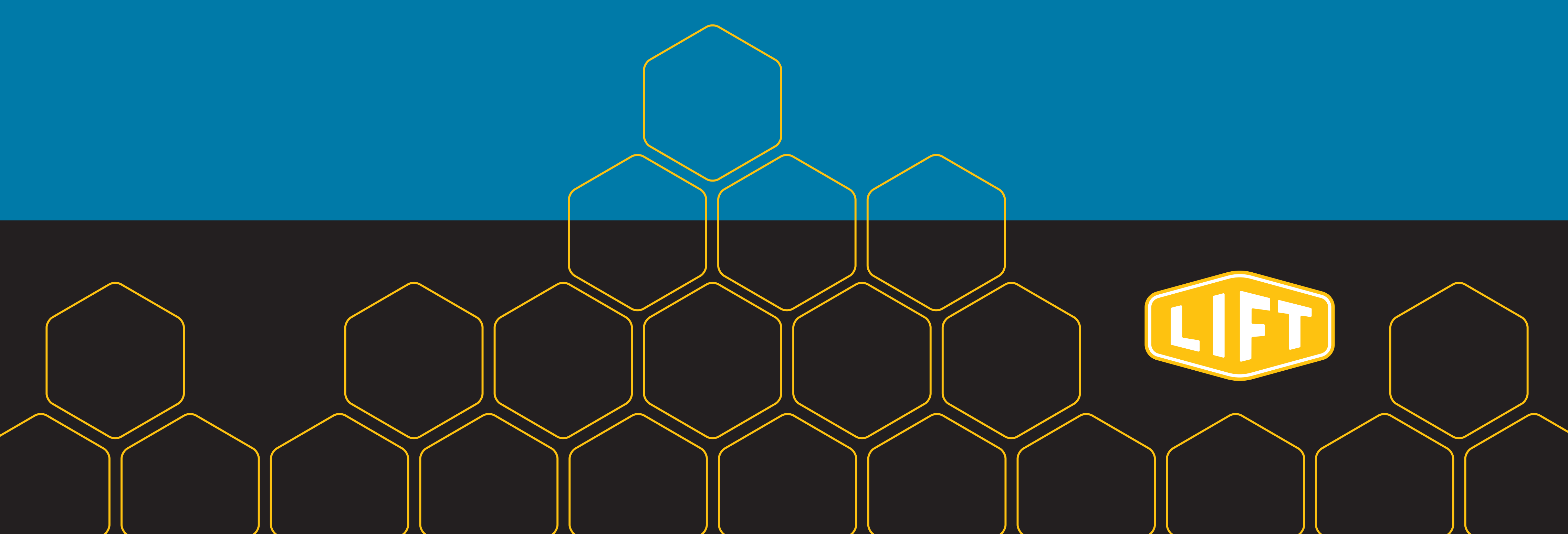

ATTACHMENT C: FULL BREAKDOWN:

A description of current health care, public health, and social service funding and service delivery arrangements, identifying barriers to addressing HRSNs and opportunities for improvement:

SKCCP Organization	Service delivery type	Funding	Opportunities	Barriers
Capital Area New Mainers Project (CANMP)	Not-for-profit organization	Public & private	None reported	None reported
Family Violence Project (FVP)	501(c)(3) not-for-profit organization	Federal/ state/ private grants, Program revenue, in-kind support, UW, PPP Funds, & Misc.	•Transportation •Internet •Housing •Client aid •Phone service •Legal support •Under-reported	•Funding •Recruitment •Staff capacity
Healthy Communities of the Capital Area (HCCA)	501(c)(3) not-for-profit organization	State, federal, & philanthropic grants	Federal/ state/ private grants, Program revenue, in-kind support, UW, PPP Funds, & Misc.	•Transportation •Internet •Housing •Client aid •Phone service •Legal support •Under-reported
HealthReach	Health system	Insurance payments & patient fees, Section 330 funding, 340b pharmacy program revenue, other grants, & private donation	•Dedicated staff •Collaborations with other organizations •Screening tools	•Workforce shortage •Lack of local resources •Lack of close loop referral

ATTACHMENT C: FULL BREAKDOWN CONTINUED

SKCCP Organization	Service delivery type	Funding	Opportunities	Barriers
Healthy Living for Maine (HL4ME)	•Health Promotion & Disease Prevention •Social Care Coordination	Contracts with Insurers, federal/ state/ foundation/ other grants, ACL grant(s), & Other Partnerships	•ACL/ CMS/ Other Federal partners support the CCH model	•Social Health Access Referral Platform (SHARP) software •New concept/model •Information Security & Compliance of partner CBOs
Hallowell Pride Alliance (HPA)	Non-incorporated organization	Annual funding & donations	•Funding •Organization to partner with for support of services	•Increased demand and need for services
Kennebec Behavioral Health (KBH)	Not-for-profit organization	Medicaid/ MaineCare, Commercial insurance, Medicare, & State/ federal grants	•Certified community behavioral health clinic •Partnerships & collaboration •Increased focus on peer support •Recovery coaching services	•Increased demand for services •Increase behavioral health acuity •Severity and co-occurring disorders •Increasing aging population with co-occurring physical and mental health needs •Workforce challenges •Capacity issues •Lack of transportation
Kennebec Valley Community Action Program (KVCAP)	501(c)(3) not-for-profit organization	Grants, MaineCare, Maine Children's Trust/Maine Families, Maine DoE, Maine DHHS, Maine Housing, NeighborWorks, Partnerships with Public Schools (RSU #19, 49, 54, 74 and Waterville), Penquis CAP, Private/ Philanthropic grants, & UWKV	•Enhanced transportation	•Enhanced transportation •Recruitment & retention •Changes in the workforce / workplace culture •Rise in inflation •Flat funding for many programs •Staying competitive with compensation •Increasing Mental Health needs of clients, staff, & the community •Stigma of poverty

ATTACHMENT C: FULL BREAKDOWN CONTINUED

SKCCP Organization	Service delivery type	Funding	Opportunities	Barriers
Maine General Health (MGH)	Health System	Medicare, private/ commercial insurance, MaineCare, & other	•Virtual health platform in place •Remote patient monitoring in place •Assisting patients with technology	•Effort not supported by economic model (reimbursement) •Care model primarily based on treating illness •Data on HRSNs collected in clinical sites only •Data system does not currently allow for export/report of HRSNs
Mid-Maine Homeless Shelter	Not-for-profit organization	ESHAP, MaineCare, grants, contracts, & other	None reported	•Rental vacancy
Maine Primary Care Association (MPCA)	Not-for-profit organization	Federal Government, HRSA, CDC, Maine WIN, & Public/ private grants	•CHCs are integrated into underserved rural communities	•Inadequate resources/ waitlists •Lack of system level coordination •Antiquated systemic approaches •PHE pressures •Workforce challenges •Payment misalignment Political will
Peter Alfond Prevention and Healthy Living Center (PAPHLC)	Not-for-profit health system	2 Peter Alfond Foundation endowments & grant funding	•Systems Theory Change (For PHL programs/ experiences, CHW program) •Overall systems change •More efficient use of resources when kept to smaller geographic area •Better understanding in communities served	•Need more community health workers

ATTACHMENT C: FULL BREAKDOWN CONTINUED

SKCCP Organization	Service delivery type	Funding	Opportunities	Barriers
SKILLS, Inc.	501(c)(3) not-for-profit organization	Section wavers, room and board, private pay, & contracts	•Technology and health monitoring •Telehealth Monitoring devices •Station MD Pilot •Better communication on "normal" behaviors versus health exacerbated behaviors •A potential untapped workforce (entry-level employees) •Societal value and community integration •SIS (Supports Intensity Scale)	•Healthcare doesn't value the provider knowledge of the person being supported •Generalizations vs. significant differences in ability & requirements for access •Housing affordability & availability •Non-medical transportation •Decentralization of services •System not built to support highest level of needs •Staff shortage and wage compression
Somerset Pubic Health (SPH)	Part of Reddington-Fairview Hospital	Federal and state grants	None reported	•Do not have a universal client "intake" process to assess gaps/ barriers to HRSNs
Spectrum Generations (SG)	501(c)(3) not-for-profit organization	Title III Older Americans Act, Alzheimer's Respite Program, Respite for ME Program, USDA, Animeals, Community Center Activities, hybrid funding, State and federal contract awards, Fee-for-service, & Donations	•Data security •Closed loop Social Health Access Referral Platform (SHARP)	•Workforce shortages •Lack of volunteers •Economic impacts •Ability to address the needs of New Mainers •Funding •Increasing consumer/ patient complexity •Data shortage •Lack of closed loop referral system
United Way of Kennebec Valley (UWKV)	501(c)(3) not-for-profit organization	Workplace, Corporate gifts, Residential, Board designated rollover, UWKV events, Investment account, & 365 Small business circle	•Individuals and providers working together to prioritize needs •Connected systems using shared language and platforms •Increased efficiency and effectiveness for better outcomes	•Increasing costs (forced to make difficult decisions i.e., food versus prescriptions, electricity versus gas for car, etc.) •Disconnected/siloed systems (difficulty navigating, hoops to jump through, no shared language, need to repeat the same story multiple times, etc.) •Staff shortages and turnover (waitlists, stories lost, etc.) •Barriers with funding (service eligibility requirements, etc.) •Lack of available resources (housing, transportation, etc.)

ATTACHMENT D: FULL BREAKDOWN:
A description and assessment of HRSN screening systems, cross system communications and information sharing concerning HRSNs:

Capital Area New Mainers Project	N/A
Family Violence Project	N/A
Healthy Communities of the Capital Area	N/A
HealthReach	PRAPARE tool to gather SDOH data: Protocol for Responding to & Assessing Patients' Assets, Risks, and Experiences (PRAPARE) (designed to equip healthcare and their community partners to better understand and act on individuals' social drivers of health [SDOH], Evidence-based, designed through stakeholder engagement, paired with an Implementation and Action Toolkit, standardized across ICD-10)
Healthy Living for ME	Customized PRAPARE and CMS tool, HRAs/contract
Hallowell Pride Alliance	N/A
Kennebec Behavioral Health	DHHS Licenses: Mental health, Substance Use Disorder, Assisted Housing for Residential Care Facilities, Accreditation: Commission on Accreditation of Rehabilitation Services – CARF (Seventh Re-Accreditation, Represents an alternative to Joint Commission) / Clubhouse International (All 4 KBH Clubhouses are Accredited), KBH completes a comprehensive bio-psychosocial assessment for every new client entering services. This includes a thorough assessment of health-related social needs. This bio-psychosocial assessment then determines services and informs treatment planning. Many of these needs get identified and addressed through care coordination and case management services. The bio-psychosocial assessment is also updated annually, and treatment/service plans are updated at a minimum every 90 days.
Kennebec Valley Community Action Program	N/A
MaineGeneral Medical Center	Done in clinical settings (primary care mostly) and recorded in electronic medical record.
Mid-Maine Homeless Shelter & Services	Built for Zero, Coordinated entry
Maine Primary Care Association	Not applicable (no direct services provided)
Peter Alfond Prevention & Healthy Living Center	Patient screening questions about social factors like housing and food access – use data to inform care and provide referrals
SKILLS, Inc.	No HRSN specific screening; Person-Centered Plan and SIP (Service Implementation plan) provides goal, services, and strategies to meet.
Somerset Public Health	Surveillance (MIYHS, BRFSS, County health rankings), Patient/client data (RFGH, Partner client data), In-person qualitative (Interviews, focus groups, anecdotal)
Spectrum Generations	For Older Americans Act programs: jointly developed with state and other AAA's. For HL4ME social care coordination assessment used are requested by the payor; however, most assessments tend to derive from the evidence-based Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool.
United Way of Kennebec Valley	Not applicable (no direct services provided)

ATTACHMENT E: FULL BREAKDOWN:

A description and assessment of existing workforce capacity and needs for addressing HRSNs:

Capital Area New Mainers Project	Family Mentor Teams, coordinating with resettlement agencies to find housing, working with partner programs to provide clothing, furniture, and other essentials
Family Violence Project	32 employees, 14 board members, 102 volunteers, 3 offices, 2 emergency shelters, 2 supportive housing buildings. Responsive services: 24/7 hotline / Emergency sheltering / Housing navigation / Supportive housing / Individual safety plants / Substance-use wrap-around services / Court advocacy / Child protective services liaison, Preventative services: Youth-based education / Community-based education / Certified domestic violence intervention program (ChangeWork)
Healthy Communities of the Capital Area	11 Staff members Tobacco Prevention: Maine Prevention Network (primarily state funds) / Maine Cancer Foundation. Substance Use Prevention: Maine Prevention Network (state and federal funds) / State Opioid Response (SOR) , Substance Abuse Prevention and Treatment Block Grant (SABG) / Substance Abuse Prevention and Treatment Block Grant- American Rescue Plan Act , Strategic Prevention Framework- Partnerships for Success (PFS) / Prevention and Treatment Fund / Drug-Free Communities (DFC). Health Equity/Special Projects: United Way of Kennebec Valley. Healthy Eating/Active Living: Maine Prevention Network (state funds) / Maine SNAP-Ed / Community Health Options. Food Systems (fiscal & staffing home to ME Farm & Sea to School Network and ME Farm to Institution): Elmina B. Sewall Foundation / Henry P. Kendall Foundation / USDA / ME Department of Agriculture / Shelburne Farms / VT FEED / FRSAN (Farm & Ranch Stress Assistance Network) / Full Plates Full Potential / Onion Foundation / TSNE Missionworks
HealthReach	Primary Care Services, Behavioral Health Services-Counseling and Psychiatric Medication Management, Substance Use Disorder Services, Outpatient Podiatry services, Dental Services at 2 sites: Bingham and Strong
Healthy Living for ME	Social Care Coordination: Complex care coordination, Health risk and social needs assessment, Short-term care coordination after a health incident and discharge, Complex care management addressing high Emergency Room (ER) utilization and at-risk clients with no supports; extension of Federally Qualified Health Center, Medical Nutrition Therapy (MNT). Caregiving: Building Better Caregivers, Savvy Caregiver. Program Trainings for Partners' Staff/Volunteers, Tablet Loaning Program, Diabetes Management and Prevention Programs (National Diabetes Prevention programs, Living Well with Diabetes, Better Health Now with Diabetes), Chronic Disease and Pain Management programs (Living Well for Better Health, Better Health Now, Living Well with Chronic Pain, Better Health Now with Pain, Living Well with HIV), Falls Prevention programs (Tai Chi for Health & Balance Part I and Part II, A Matter of Balance, Bingocize, EnhanceFitness), Self-Advocacy Program – Intellectual and/or Developmental Disability Support, HealthMatters
Hallowell Pride Alliance	15 Board Members, 8 Committees: Public policy, education and outreach, volunteer, membership, and more

Kennebec Behavioral Health	BHH & CASE MANAGEMENT (Whole person-based support and case management services for adults and youth.), CHILD & FAMILY (In-home and school-based services for children and families in need of behavioral support and treatment.), CLINIC-BASED (Counseling, outpatient and medication management services for youth and adults at a clinic site.), CLUBHOUSES (Vocational rehabilitation, training, and temporary employment for adults with a mental illness.), COMMUNITY REHABILITATION (Community-based services and supports for adults and families living with severe and persistent mental illness.), DEVELOPMENTAL SERVICES CASE MANAGEMENT (Services for adults who are eligible for case management based on an ID diagnosis.), HOMELESS OUTREACH (Support services for youth and adults experiencing homelessness and mental health concerns.), HOUSING & RENTAL SERVICES (Residential, PNMI and independent housing services for adults living with a mental illness. – LAA for Kennebec and Somerset Counties), OPIOID HEALTH HOME (Care coordination and high-level integrated Medication-Assisted Treatment (MAT) for active opioid use disorder.), RECOVERY COACHING (Free personal guide and mentor service that promotes recovery by removing barriers and obstacles.), REPRESENTATIVE PAYEE SERVICES (Rep. payee services for adults who require financial management and support to meet daily needs.), SUBSTANCE USE & PREVENTION (Prevention and treatment services for substance use disorders in youth, adults and families.), Local (Town Offices, MidMaine Homeless Shelter, Local Food Banks, Local Behavioral Health Providers, Primary Care/FQHCs, Law Enforcement, Crisis Services, City of Augusta), Regional (Somerset County Public Health, Maine General Hospital, Redington Fairview, Sebasticook Valley Hospital, Somerset County Jail, KVCAPP, NAMI, Maine Community Military Network, United Way, District Public Health Coordinating Council, Family Violence Project, Health Communities of the Capital Area), Statewide (DHHS Office of Behavioral Health, DHHS Office of Child and Family Services, DHHS Office of Aging and Disability, DHHS Office of MaineCare, Maine Prisoner Re-entry Network), National (SAMHSA, National Council for Mental Wellbeing)
Kennebec Valley Community Action Program	340 employees
Maine General Health	Care managers (RNs, LCSWs) [primary care], Mental health nurse practitioners [primary care], Care navigators [cancer], Financial navigators, HELP (Hospital Elder Life Program, for dementia), Geriatric medicine [long term care], Connecting to primary care for discharge patients without PCP, Substance use: Harm reduction/ Addiction medicine practice/ MaineMOM pilot (mothers with substance use)/ Substance use screening [primary care], SDoH: Screening (captured in EMR) [primary care]/ Emergency food bags distributed at time of screening / Resources directors and connectors distributed at time of screening /Transportation vouchers available
Mid-Maine Homeless Shelter & Services	Coordinate entry: Resource centers and access points (access, problem solving, prioritize after)
Maine Primary Care Association	Community-based health care providers offering services for a patient regardless of insurance status/ability to pay
Peter Alfond Prevention and Healthy Living Center	Social workers, community health workers, and/or community-based organizations providing direct support/assistance to meet patient social needs
SKILLS, Inc.	100 full time employees, 20 per diem employees, 18 locations (9 group homes, 4 PNMIs, 3 community support locations, 2 admin offices); 30 FT DSP openings on average
Somerset Public Health	Trauma informed staff: Behavioral health, Social work, Education, Arts, Health, Dietetics, Local government
Spectrum Generations	100 employees, 200-250 per-diem employees, 360 volunteers, FY22, Nutrition (313,577 home-delivered meals (Meals on Wheels – MOW) served, An average of 1,206 persons served 5 days per week, 26,231 social dining meals served, An average of 108 persons are served every weekday, 26,000 units of nutrition education, 7,854 boxes of USDA food shares (30lbs)), Aging and Disability Resource Center (8,966 calls for information and assistance, 2,631 individuals reached through case management activities, 2,487 unduplicated rides were given for transportation, 36,144 people reached through public education/outreach efforts, 288 caregivers received support), Community Case Management (An average of 299 clients with intellectual and/or developmental disabilities served each month), Bridges Home Services (An average of 175 homebound clients provided personal service support each month, 106 clients served in our Adult Day and Community Supports each month)
United Way of Kennebec Valley	Additional staff support – UWKV specific, Individual & partner collaboration, Connected systems, Shared language, Shared platforms, Funding that supports HRSN(s), available resources

GLOSSARY

TERM/DEFINITION

Term	Definition
Access to broadband	Percentage of residents with access to broadband internet.
Adverse Childhood Experiences (ACEs)	Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example: experiencing violence, abuse, or neglect. witnessing violence in the home or community.
Centers for Disease Control and Prevention (CDC)	Is the national public health agency of the United States. It is a United States federal agency under the Department of Health and Human Services and is headquartered in Atlanta, Georgia. The Maine Center for Disease Control and Prevention, headquartered in Augusta, Maine is the public health entity for Maine. CDC's main goal is the protection of public health and safety through the control and prevention of disease, injury, and disability.
Centers for Medicare and Medicaid Services (CMS)	Is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Children living in poverty	Percentage of children, ages 0-17 years, who live in households where the total income of the householder's family is below the established federal poverty level.
Chronic disease among persons with depression	The percentage of adults who have reported current symptoms of depression and have three or more chronic conditions. Chronic conditions include skin cancer, other types of cancer, cardiovascular disease [such as stroke], coronary heart disease [such as heart attack], arthritis, COPD and asthma, obesity, and chronic kidney disease.
Community Care Hub (CCH)	A community-centered entity that organizes and supports a network of community-based organizations (CBOs) providing services to address health-related social needs. A CCH centralizes administrative functions and operational infrastructure, including but not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.
Community Health Worker (CHW)	A member of a community who is chosen by community members or organizations to provide basic health and medical care within their community, and is capable of providing preventive, promotional and rehabilitation care to that community. Other terms for this type of health care provider include lay health worker, village health worker, community health aide, community health promoter, and health advisor.
Community-based organizations (CBOs)	Refers to an organization aimed at making desired improvements to a community's social health, well-being, and overall functioning. Community organization occurs in geographically, psychosocially, culturally, spiritually, and digitally bounded communities.
Currently receiving outpatient mental health treatment (adults)	Percentage of adults who are currently taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.

Depression, lifetime	Percentage of adults who have ever been told by a healthcare provider that they have a depressive disorder.
Federally Qualified Health Center (FQHC)	Is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status. Thus, they are a critical component of the health care safety net. FQHCs are called Community/Migrant Health Centers (C/MHC), Community Health Centers (CHC), and 330 Funded Clinics. FQHCs are automatically designated as health professional shortage facilities.
Health Related Social Needs (HRSNs)	Are an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).
High school student graduation	Percentage of high school students who graduate with a regular diploma four years after starting ninth grade. Graduation rates are determined for students in all public schools and in all private schools that have 60% or more publicly funded students.
Housing insecure (high school students)	The percentage of high school students who report they usually do not sleep in their parent's or guardian's home. Data collected in odd numbered years.
Individuals living in poverty	Percentage of individuals who live in households where the total income of the householder's family is below the established federal poverty level.
Intentional self-injury (middle & high school students)	Percentage of students who have ever done something to purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose. Data collected in odd numbered years.
Maine Department of Health and Human Services (DHHS)	Is a cabinet-level executive branch department of Maine's state government created to protect the health of the Maine people and provide essential human services.
Median Household Income	Dollar amount that divides all households in the specified geographic area into two equal groups: half of the households having more income and the other half having less income.
Mental health emergency department per 10,000 population condition	Rate per 10,000 people of emergency department discharges with a principal diagnosis of a mental health condition
Overdose emergency medical service from responses per 10,000 population	Rate per 10,000 population of overdose emergency medical service responses, including the overdose of drugs, medications, alcohol, and inhalants.
People living in rural areas	Percentage of residents in the specified geographic area who live in rural areas, as defined by the New England Rural Health Roundtable.
Person-Centered Counseling/Planning (PCC/P)	Allows individuals to be engaged in the decision-making process about their options, preferences, values and financial resources

Persons with a disability Percentage of residents who report having any one of the six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, independent living difficulty.

Population Percentage of the total Maine population who reside in the specified geographic area (e.g. Maine or a Maine County) or belong to a specific population group.

Sad/hopeless for two weeks in a row (middle & high school students) The percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row during the past 12 months that they stopped doing some usual activities. Data collected in odd numbered years.

Seriously considered suicide (middle & high school students) Percentage of students who seriously considered attempting suicide during the past 12 months. Data collected in odd numbered years.

Social Determinants of Health (SDOHs) Refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more.

Social Health Access Referral Platform (SHARP) Are technology solutions that manage data and referrals between social services and healthcare. Health care entities and CBOs use SHARPs to connect patients for services that address social determinants of health through closed-loop referrals to community-based organizations (CBOs) that provide these services.

Unemployment Percentage of non-institutionalized civilians in the labor force who were not employed. Reported monthly and rates are averaged for the full year.