Cumberland County

Maine Shared Community Health Needs Assessment Report

2025

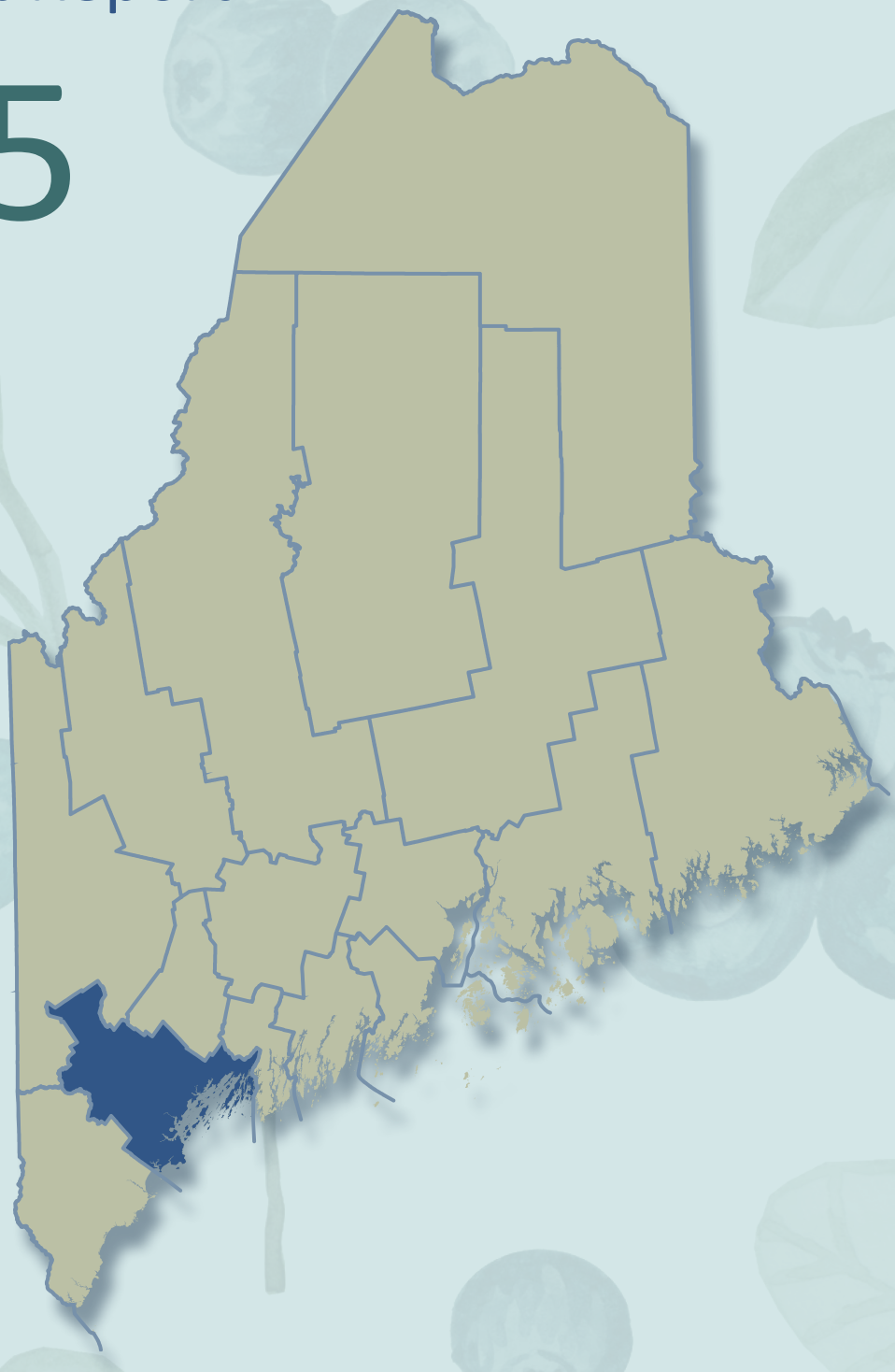


Table of Contents

Introduction

The Maine Shared Community Health Needs Assessment (Maine Shared CHNA) is a collaborative partnership between Central Maine Healthcare (CMHC), Northern Light Health (NLH), MaineGeneral Health (MGH), MaineHealth (MH), the Maine Center for Disease Control and Prevention (Maine CDC), and the Maine Community Action Partnership (MeCAP). By engaging and learning from people and communities and through data analysis, the partnership aims to improve the health and well-being of all people living in Maine.

The mission of the Maine Shared CHNA is to:

- Create shared CHNA reports,
- Engage and activate communities, and
- Support data-driven improvements in health and well-being for all people living in Maine.

This is the fifth collaborative Maine Shared CHNA and the fourth conducted on a triennial basis. The Maine Shared CHNA began with the One Maine Collaborative, a partnership between MaineGeneral Health, MaineHealth, and Northern Light Health, which published its first community health assessment in 2010. Community Action Agencies (CAAs) have a long history of community needs assessments (CNA), most recently as a collective system conducting a statewide assessment in Maine. The Maine Community Action Partnership, which represents the CAAs in Maine, and the Maine Shared CHNA partners most recently joined together in recognition that the partners' missions cut across the multitude of factors that influence a person's health and well-being and the overlap in service areas, patient populations, and services and programs. Additionally, common elements run through each partner's federal and accreditation reporting requirements leading to efficiencies and effectiveness in conducting a health and well-being assessment.

This assessment cycle, the Maine Shared CHNA has continued its collection and analysis of data covering community conditions and social drivers of health, protective and risk factors, and health conditions and outcomes at the urban, county, state, and national level. This cycle saw expanded efforts to engage communities across Maine, conducting statewide focus groups with specific populations, county level focus groups, key informant interviews, and a statewide community survey. Both the quantitative and qualitative data were used to inform a health and well-being prioritization process held with stakeholders at 17 forums, one in each county and two in Cumberland County. The resulting priorities for Cumberland County are outlined in the following report, along with a summary of related and contributing data, community engagement findings, and forum discussions. A more detailed explanation of the Maine Shared CHNA methodology can be found in Appendix 1.

Executive Summary

Cumberland County Health and Well-Being Priorities

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

Community Conditions	Protective & Risk Factors	Health Conditions & Outcomes
Lakes Region		
Transportation (ME)	Community Mattering	Mental Health (ME)
Poverty (ME)	Adverse Childhood Experiences (ME)	Substance Use Related Injury & Death
Housing (ME)	Substance Use (ME)	Cardiovascular Disease
Greater Portland Region		
Housing (ME)	Adverse Childhood Experiences (ME)	Mental Health (ME)
Poverty (ME)	Nutrition (ME)	Substance Use Related Injury & Death
Transportation (ME)	Illicit Drug Use	Cardiovascular Disease

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

Lakes Region: Nutrition, Provider Availability, Chronic Conditions

Greater Portland Region: Substance Use, Provider Availability, Chronic Conditions

Next Steps

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

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

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

Report Outline

This report is broken into three sections.

1. Data on Cumberland County's select demographics, including socioeconomic indicators, race and ethnicity, age, and leading cause of death are presented to give a broad view of the make-up of people living in Cumberland County and to provide context for which health and well-being conditions and outcomes may or may not prevail.
2. A section is devoted to discussing health equity and related terms and the Maine Shared CHNA's approach to community engagement.
3. The remainder of the report provides an in-depth discussion of each of the health and well-being priorities, grouped by the categories of community conditions, protective and risk factors, and health conditions and outcomes. Each discussion includes findings from the county focus group representing people with low-income, county specific results from the statewide community survey, summary discussions from the county stakeholder forum, and county specific quantitative data from the County Health Profile, as relevant and applicable.

Additional reports highlighting the results of the health and well-being assessment, including data profiles and community engagement overviews, as well as reports for each county and the state, are available online at www.mainechna.org.

Select Data

Demographics

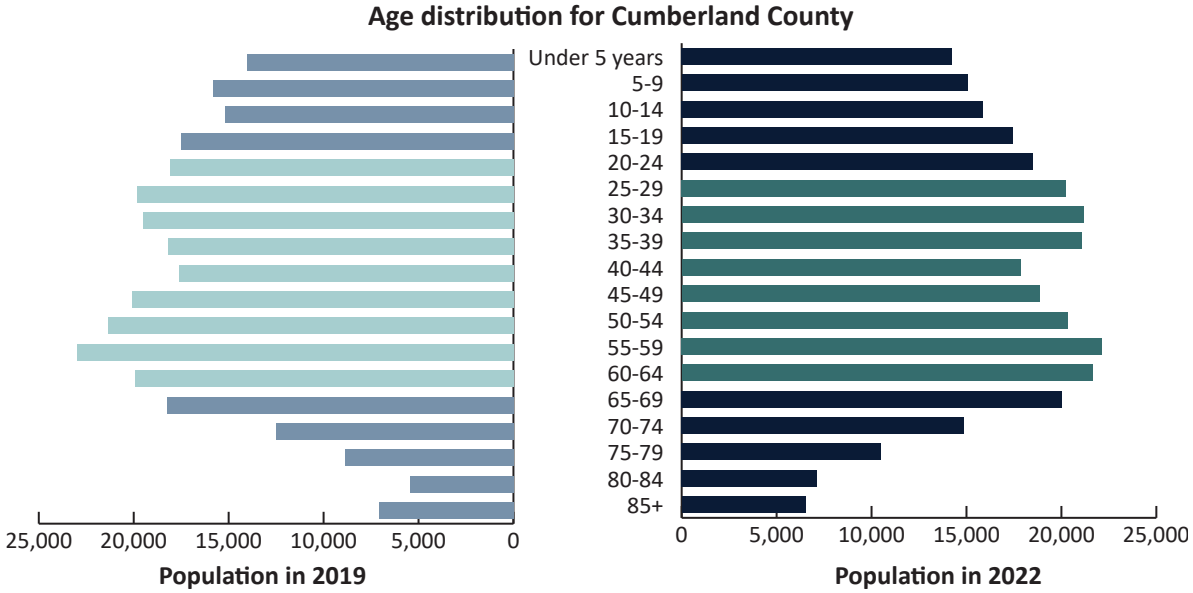
The following tables and chart show information about the population of Cumberland County. The differences in age and poverty are important to note as they may affect a wide range of health and well-being outcomes.

Cumberland County Population	State of Maine Population
303,357	**1,366,949**

	Cumberland	Maine
Median household income	**$87,710**	**$68,251**
Unemployment rate	**2.3%**	**3.1%**
Individuals living in poverty	**7.2%**	**10.9%**
Children living in poverty	**6.9%**	**13.4%**
65+ living alone	**29.7%**	**29.5%**

	Cumberland County	
	Percent	Number
American Indian/Alaskan Native	**0.2%**	**524**
Asian	**2.2%**	**6,576**
Black/African American	**3.2%**	**9,630**
Native Hawaiian or other Pacific Islander	**0.0%**	**98**
Some other race	**0.7%**	**2,187**
Two or more races	**4.7%**	**14,405**
White	**89.0%**	**269,937**
Hispanic	**2.3%**	**6,895**
Non-Hispanic	**97.7%**	**296,462**

The chart below shows the shift in the age of the population between 2015-2019 and 2018-2022. As Maine's population grows older, there may be impacts on health care costs, caregivers, and workforce capacity, while on the other end, increases in children may cause impacts on child care availability and educational institutions.



Leading Causes of Death

When reviewing the top health and well-being priorities it is important to consider how they may fit into the leading causes of death for the county and Maine. In some instances, they may overlap, in others they may contribute to or cause a leading cause of death, and in others they may be distantly related. The priorities identified demonstrate the continuum of health and well-being and the impact of other factors, such as social, institutional, and community conditions, and protective and risk factors on health and well-being outcomes.

Leading Causes of Death, 2022

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

Cause of Death	Maine	Cumberland County
Cancer	**25.9%**	**28.2%**
Heart disease	**27.2%**	**26.3%**
Accidents	**10.5%**	**11.3%**
Chronic lower respiratory disease	**6.8%**	**5.6%**
COVID 19	**4.1%**	**5.1%**
Cerebrovascular disease	**6.0%**	**4.8%**
Diabetes	**4.8%**	**4.7%**
Alzheimer's disease	**4.6%**	**4.6%**
Chronic liver disease and cirrhosis	**1.7%**	**2.0%**
Influenza & pneumonia	**2.3%**	**2.0%**
Suicide	**2.1%**	**1.9%**
Nephritis, nephrotic syndrome & nephrosis	**2.0%**	**1.9%**
Parkinson's Disease	**1.8%**	**1.7%**

Health Equity

Definitions

Healthy People 2030 defines **health equity** as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[i] In order to achieve health equity, actions must be taken to improve access to conditions that influence health and well-being, specifically for those who lack access or have worse health. This in turn should impact everyone's outcomes positively. "Equity" means focusing on those who have been excluded or marginalized.[ii]

Healthy People 2030 defines a **health disparity** as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systemically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristic historically linked to discrimination or exclusion."[iii] Disparities in health and well-being are how progress is measured toward health equity and are the preventable differences in health and well-being.[iv]

Social drivers of health (SDOH) are conditions in the environments where people are born, live, work, play, worship, and age – the community-level factors – that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social drivers of health are sometimes used interchangeably with social determinants of health; however, "determinants" can be interpreted to suggest nothing can be done; that our health and well-being is determined. Whereas "drivers" reframes the conversation with a focus on health and demonstrate changes can be made to improve health and well-being outcomes.[v]

Health-related social needs (HRSNs) is another term often used. These are the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They refer to individual-level factors, such as financial instability, lack of access to healthy food, lack of access to housing, and lack of access to health care and social services, that put people at risk for worse health and well-being outcomes and increased health care use.[vi]

Health Equity and Community Engagement

The Maine Shared CHNA takes a broad approach to assessing health and well-being throughout the state. While we attempted to reach many populations in our assessment process who have disparate health and well-being experiences and outcomes, some choices about which groups to include were necessary. We ultimately engaged directly with LGBTQ+ people, multigenerational black/African Americans, people with low-income, veterans, women, young adults, and youth through focus groups and several other populations and sectors through interviews. Additionally, we heard from a diverse audience through a statewide survey.

It should be noted the voices we heard in focus groups and interviews are not meant to be representative of their entire identified population or community. We recognize that for many people, their lives and their health is affected by multiple aspects of their identity and lived experiences or their "intersectionality." We attempted to recognize participants' intersectionality by asking them to voluntarily share any other identities they may have. The totality of focus group participants also identify as: a Tribal member, older adults, non-English speaker, immigrant, asylee, migrant, Latino/Latine/Latinx, residents of rural, urban, and suburban areas, people with substance use disorder, people with mental health disorder, members of the disability community, people who are deaf or hard of hearing, people who are incarcerated or formerly incarcerated, people who are unhoused or experiencing homelessness, and caregivers.

Community Engagement Findings

The Maine Shared CHNA recognizes the findings of our assessment do not encompass all populations and communities in Maine, nor the diverse experiences of those within the populations and communities we have engaged with. Maine is a diverse state with approximately 51,696 people who identify as American Indian/Alaskan Native (6,722), Asian (15,071), Black/African American (21,775), or some other race (8,128). An additional 53,704 people identify as two or more races. The Maine Shared CHNA will continue to develop meaningful and transparent relationships with these populations and others, in an effort to continuously improve our assessment process and ultimately drive improvement in health and well-being outcomes. Additional information on the qualitative data process can be found in Appendix 1: Methodology and the complete community engagement findings can be found at www.mainechna.org.

Socioeconomic Empowerment

The Maine Shared CHNA recognizes the impact poverty and low incomes have on health and well-being. Community Action Agencies are funded through the Community Services Block Grant to administer support services that alleviate the causes and conditions of poverty in under resourced communities[vii] and identify those causes and conditions through the community needs assessment process. In an effort to reach this aim, the Maine Shared CHNA survey asked respondents to rate the top five items that are "very necessary" steps to help move people out of poverty and to a place of housing stability and financial stability. The table below represents the ratings for the county and Maine and when applicable, are referenced in each priority discussion.

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

Health and Well-Being Priorities

Section Overview

The following section contains the top health and well-being priorities for each category – community conditions, protective and risk factors, and health conditions and outcomes. The categories are derived from the Bay Area Regional Health Inequities Initiative (BARHII) framework. More information on the framework is in Appendix 1: Methodology.

Each priority contains a discussion of the related quantitative and qualitative data and stakeholder forum takeaways. Within each priority the following sections are also included, as applicable:

Socioeconomic Empowerment

- This provides the step or steps rated by Maine Shared CHNA survey respondents that help move a person from poverty to stability that relate to the priority. The complete list of the top five rated steps is outlined in the health equity section of this report.

Populations and Communities

- This includes populations and communities impacted by the priority as identified in a pre-forum survey and at the forum.

Community Resources

- This includes a list of assets and resources to address the priority as identified in a pre-forum survey and at the forum.

Crosscutting Priorities

- This section includes a list of the other health and well-being priorities for Cumberland County that are related or connected to the priority of discussion. Readers are encouraged to reference these to gain more insight into the interconnectivity of the priorities and overall health and well-being.

Cumberland County Strengths

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

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

People living in Cumberland County have a positive outlook on their health and well-being – 82.1% of survey respondents believe their community is healthy or very healthy; 82.7% rate their own physical health as good or excellent and 78% say their mental health is good or excellent.

Lakes Region

Community Conditions

Community conditions include the physical environment (environmental exposures, housing, transportation, etc.), economic and work environment (employment, income, etc.), social environment (discrimination, crime, community safety, etc.), and service environment (health care and social service access, education, etc.). Social drivers of health (SDOH), which are the policies, systems, structures, life experiences, and social supports that influence a person's health, most often fit into the context of community conditions. The following section outlines the top community conditions priorities for the Lakes Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Lakes Region Community Conditions		
Transportation	Poverty	Housing

Transportation

Transportation was the top priority for the community conditions category for the Lakes Region. For the purposes of the prioritization process, transportation includes such topics as: access to transportation, availability of transportation, and transportation that meets a variety of specific needs.

Assessment Findings

In the Lakes Region focus group "reliable transportation" was a top theme. One focus group participant said:

> **"We don't have a bus system or taxis. It would be a six mile walk or more to get to the food pantry and then another six miles uphill to get home."**

Related to reliable transportation, Lakes Region stakeholder forum participants discussed the impact transportation, or lack thereof, has on the ability to find jobs, especially those that pay well. In Oxford County, 43.4% of people have a commute of greater than 30 minutes driving alone, significantly worse than Maine (33.9%) and the U.S. (36.5%, 2018-2022). In addition, for those who take public transportation, the Lakes Region Explorer only has four round trips per day and while it stops at the centrally located Bridgton Community Center, it may be difficult for more rural residents to access. In Oxford County, 0.1% of people use public transportation to commute to work (2018-2022).

In the Maine Shared CHNA survey, 57.6% of respondents in Cumberland County said transportation needs negatively impacted them, a loved one, and/or their community. When

asked about specific transportation needs, roughly three-quarters of survey respondents said the following impacts their community:

- "access to transportation" (79.9%);
- "availability of transportation that meets a variety of specific needs" (79.9%);
- "availability of transportation" (77.6%); or
- "costs associated with owning and maintaining a vehicle" (72.1%).

Data shows that in Cumberland County, 7% of households do not have a vehicle, significantly better than the U.S. (8.3%, 2018-2022)

Forum participants discussed the role local government can play in many of the priorities, with the need for collaboration among community development planners, town managers, and city planners regarding transportation. In addition, forum participants noted there needs to be more public participation in local government meetings.
lists the types of transportation people 16 and older use in Kennebec County to get to work.

Populations and Communities Impacted by Transportation

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For transportation, respondents cited: teens, people living in rural areas, people with low-income, older adults, and young adults.

Community Resources to Address Transportation

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

- Bridgton Community Center
- Home Health's payment of employee bus passes
- Moving Maine Network
- Public transportation

Poverty

Poverty was the second rated priority for the community conditions category for the Lakes Region. For the purposes of the prioritization process, poverty includes topics such as: individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, and Asset Limited, Income Constrained, Employed (ALICE) thresholds.

Assessment Findings

In Cumberland County,

- 12.4% of individuals live in poverty (2018-2022).
- 6.8% of families live below the federal poverty level, significantly better than the U.S. (8.8%, 2018-2022).
- 17% of children live in poverty (2018-2022).
- 28.8% of families lived above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold of financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy.
- 20% of people were asset poor, meaning they have insufficient net worth to live without income at or above the federal poverty level for three months (2021).

In Oxford County,

- 14% of individuals live in poverty (2018-2022), significantly worse than Maine (10.9%) and the U.S. (12.5%).
- 4.9% of families live below the federal poverty level (2018-2022), significantly better than 2015-2019 (6.6%), Maine (6.4%), and the U.S. (8.8%).
- 21.2% of children live in poverty, significantly worse than Maine (13.4%, 2018-2022).
- 37% of households live above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold for financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy.
- 15% of people were asset poor (2021), meaning they have insufficient net worth to live without income at or above the federal poverty line for three months.

In the Lakes Region focus group participants discussed several topics related to poverty, saying:

"[Services for older adults] If you're on MaineCare or on a fixed income, that's not going to be available unless you have a good chunk of change to be able to pay for it."

"How does a single mom of three sustain a household of four? She has a $1,600 budget but that doesn't cover everything you need: housing, food, car, child care, and more."

"Sometimes there's not enough incentive to go back to work, with inflation."

In the Maine Shared CHNA survey, respondents listed "low incomes and poverty" as the fifth of five top social concerns negatively impacting their community. Forum participants also discussed the connection of income and poverty, noting seasonality's impact on jobs and the economy, which in turn have an impact on other priorities. Quantitative data shows,

- The median household income in Cumberland County is $87,710 (2018-2022), significantly better than 2015-2019 ($73,072) and significantly better than Maine ($68,251) and the U.S. ($75,149).
- Whereas, in Oxford County, the median household income is $54,780 (2018-2022), significantly better than 2015-2019 ($49,204), but significantly worse than Maine ($68,251) and the U.S. ($75,149).
- As of 2023, 2.3% of people in Cumberland County were unemployed and in Oxford County, 3.1% of people were.

Three-quarters of Maine Shared survey respondents (77.7%) said "economic needs" negatively impacted them, a loved one, and/or their community. When asked about specific economic needs, 77.9% said "availability of quality, affordable childcare," 74.9% said "access to affordable, quality foods," and 66.7% said "availability of jobs and employment opportunities" impacted their community. Related to these needs in Cumberland County:

- 26.6% of children were served in publicly funded state and local preschools (2023) and there were 197 child care centers as of 2024.
- 10.6% of adults and 13.9% of youth were food insecure (2022).

The “ability to contribute to savings, retirement” impacted people across the board, with 53% reporting it impacts them, 46.7% a loved one, and 67.5% their community.

Forum participants see an increase in broadband access as something that would benefit the working population. In Oxford County, 82.8% of households have a broadband subscription, significantly worse than Maine (87.3%) and the U.S. (88.3%, 2018-2022).

Socioeconomic Empowerment

When asked to rate the top five items that would move someone out of poverty and to a place of stability, “jobs that pay enough to support a living wage” was ranked second and “affordable and quality child care” was ranked fifth by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Poverty

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

Community Resources to Address Poverty

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

- Community Action Agencies
- Community based organizations

Housing

In the Lakes Region focus group “affordable and reliable housing” was a top theme. In Cumberland County, 12% of households spend more than 50% of their income toward housing, significantly better than the U.S. (14.1%, 2018-2022). The median gross rent in Cumberland County is $1,389 (2018-2022), significantly worse than 2015-2019 ($1,131), Maine ($1,009), and the U.S. ($1,268). In Cumberland County, 85.5% of housing is occupied (2018-2022) and 1.5% of housing units are vacant and for sale or rent (2022).

Participants at the Lakes Region stakeholder forum noted housing has become an increasing strain with people shifting to remote work, which may enable people to live in the area and further from their place of employment and for those with higher incomes to move to the region, driving up home prices. Seasonality also impacts housing, with a participant noting almost half of the housing in Bridgton is seasonal. The affordability of housing and the increase in short-term rentals, which detracts from long-term housing, are concerns in the Lakes Region area.

Respondents to the Maine Shared CHNA survey listed “housing insecurity” as the third of the top five social concerns negatively impacting their community and 75.7% of respondents said “housing needs” negatively impact them, a loved one, and/or their community. When asked about specific housing needs, three-quarters of those respondents said the following impact their community:

- “availability of affordable, quality homes/rentals” (84.8%),
- “availability of affordable, quality housing for older adults or those with special needs” (81.9%),
- “housing costs” (81.1%),
- “issues associated with home ownership or renting (79.9%),
- “homelessness or availability of shelter beds (79.9%),
- “costs of utilities” (76.5%), and
- “costs associated with weatherization” (72.2%).

In 2023 in Cumberland County, 999 children were experiencing homelessness and 2.9% of high school students were housing insecure.

Forum participants discussed the role local government can play in many of the priorities, with the need for a housing expert, community development planners, more town managers, and city planners, which could potentially impact housing. In addition, participants noted there needs to be more public participation in local government meetings.

Socioeconomic Empowerment

When asked to rate the top five items that would move someone out of poverty and to a place of stability, “affordable and safe housing” was ranked number one by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Housing

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. For housing, respondents cited: older adults, young adults, adults, New Mainers/immigrants, and refugees/asylees.

Community Resources to Address Housing

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

- Avesta Housing
- Community Block Grant
- Community Housing of Maine
- Quality Housing Coalition

Protective & Risk Factors

Protective and risk factors are aspects of a person or environment that make it less likely (protective) or more likely (risk) that someone will achieve a desired outcome or experience a given problem. The more protective factors a person experiences, the more likely they are to have positive health and well-being outcomes, whereas the more risk factors, the greater the likelihood of experiencing negative health and well-being outcomes. Protective and risk factors can occur at both the individual and the environmental level, often overlapping with topics that fall within community conditions. The following section outlines the top protective and risk factor priorities for the Lakes Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Lakes Region Protective & Risk Factors		
Community Mattering	**Adverse Childhood Experiences**	**Substance Use**

Community Mattering

Community mattering was the top priority for the protective and risk factors category for the Lakes Region. Participants at the Lakes Region forum agreed to change this priority from youth mattering to community mattering to be more inclusive of all ages. Community mattering includes topics such as positive role models and community connections.

Assessment Findings

A top theme in the Lakes Region focus group was “community cohesion.” The general sense of Lakes Region stakeholder forum participants is that mattering impacts more than youth, including older adults, and should be expanded to “community” as part of the prioritization process.

In the Maine Shared CHNA survey respondents reported four of their top five community strengths relate to community mattering: “safe neighborhoods,” “locally owned businesses,” “schools and education for all ages,” and “low crime.”

In the Maine Shared CHNA survey 77.4% of respondents said “mental health” impacts them, a loved one, and/or their community and of those, 63.3% said “social isolation or loneliness” impacts their community. In Cumberland County, 78% of Maine Shared CHNA survey respondents rate their own mental health as “good or excellent.”

Forum participants describe loneliness among the elderly community as an epidemic and see potential opportunity for programming that connects youth with the older adult population. Forum participants believe transportation has an impact on isolation, independence, and connection among the younger and older populations. In Cumberland County, 29.7% of adults 65 and older live alone and in Oxford County, 26.5% of adults 65 and older live alone (2018-2022).

Of the 53.4% of Maine Shared CHNA survey respondents who said public safety impacts them, a loved one, and/or their community, specific topics impacting their community include: violence between people (84.4%), racism (77.3%), and discrimination based on race, ethnicity, gender, LGBTQIA2S+, age, ability, etc. (72.9%). Forum participants also said systemic racism, bullying, poverty, adverse childhood experiences, and social safety nets impact community mattering.

In Cumberland County,

- 20% of high school and 42.2% of middle school students had experienced bullying on school property, with middle school percentages significantly better than Maine (48.6%, 2023).
- 18.8% of high school and 30.3% of middle school students had experienced electronic bullying, with middle school percentages significantly better than Maine (35.1%, 2023).

In Oxford County,

- 23.6% of high school and 55.7% of middle school students had experienced bullying on school property, with middle school percentages significantly worse than 2019 (48.2%) and Maine (48.6%, 2023).
- 19.2% of high school and 42.1% of middle school students had experienced electronic bullying, with middle school percentages significantly worse than Maine (35.1%, 2023).

Forum participants would like to see more community spaces and transportation options, especially those that are universally accessible; businesses involved in community give back programs and businesses that connect with year-round residents; social safety nets and senior assistance programs; school representation in community affairs; more diversity, equity and inclusion efforts throughout the region; and the use of plain language and American Sign Language interpreters.

Populations and Communities Impacted by Community Mattering

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For community mattering, respondents cited: youth, older adults, veterans, people with disabilities, unhoused/homeless, kinship guardians, LGBTQ+, youth, teens, young adults, children, and people living in rural areas.

Community Resources to Address Community Mattering

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

- Bridgton Community Center
- Bridgton Recreation Department
- Cumberland County Public Health Department
- Hospitals
- Immigrant and multicultural youth serving organizations
- Lakes Region Recovery Center
- Libraries, specifically Bridgton Public Library
- Magic Lantern 4H Program
- NFI North – Bridge Crossing
- OUT Maine
- Pine Tree Society
- Play Warriors
- Schools
- The Fuller Center
- The Opportunity Alliance
- Youth serving organizations

Crosscutting Priorities

Transportation **Poverty**

Adverse Childhood Experiences

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

Assessment Findings

In 2023 in Cumberland County, 21.5% of high school students reported at least four of nine adverse childhood experiences, while in Oxford County 29.8% of high school students reported ACEs.

In the Lakes Region focus group one participant said:

"…we have kids that have approved IEPs [Individualized Education Plans] and are approved for services, but there are no providers. They've been approved for years and there's no one to give them services."

As of 2024, in Cumberland County there were 120 people for every mental health provider and 3,505 people for every psychiatrist. In the Maine Shared CHNA survey, four of the top five social concerns identified that negatively impact the community could be associated with ACEs – mental health issues, substance use, housing insecurity, and low incomes and poverty. Three-quarters of survey respondents said economic needs (77.7%), mental health needs (77.4%), and housing needs (75.7%), potential root causes of ACEs, impact them, a loved one, and/or their community.

Of those who identified mental health needs, 62.7% said “youth mental health” impacts their community. In 2023 in Cumberland County, 32.7% of high school students and 28.8% of middle school students were sad/hopeless for two weeks in a row, with middle school percentages significantly worse than 2019 (22.2%) and 16.8% of high school and 19.6% of middle school students had seriously considered suicide.

Lakes Region stakeholder forum participants also cited poverty, a lack of social safety nets, isolation, and systemic racism as potential causes of ACEs. Forum participants would like to see more community spaces and transportation options, especially those that are universally accessible; businesses involved in community give back programs and businesses that connect with year-round residents; social safety nets and senior assistance programs; school representation in community affairs; more diversity, equity and inclusion efforts throughout the region; and the use of plain language and American Sign Language interpreters.

Populations and Communities Impacted by Adverse Childhood Experiences

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For ACEs, respondents cited: children, youth, teens, young adults, LGBTQIA2S+, minorities, youth with disabilities, unhoused/homeless, victims of trauma-inducing events, older adults, people with disabilities, kinship guardians.

Community Resources to Address Adverse Childhood Experiences

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

- Bridgton Recreation Department
- Cumberland County Public Health Department
- Hospitals
- Libraries
- Loon Echo Land Trust
- OUT Maine
- Schools
- The Opportunity Alliance

Crosscutting Priorities

Transportation **Poverty** **Housing** **Community Mattering**

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

Substance Use

Substance use was the third rated priority for the protective and risk factors category for the Lakes Region. Participants at the Lakes Region forum agreed to combine individual substances into one overarching category of substance use. Substance use includes but is not limited to substances such as: alcohol, cannabis, illicit drugs, and tobacco.

Assessment Findings

In the Maine Shared CHNA survey “substance use” was the second of the top five social

concerns negatively impacting the community and 68.9% of respondents said “substance use” negatively impacts them, a loved one, and/or their community. When asked about more specific substance use, approximately three-quarters cited multiple substances impacted their community including:

- opioid misuse (77.2%),
- other illicit drug use (76.3%),
- tobacco use (75.1%),
- alcohol misuse or binge drinking (74.6%),
- vaping (74%), and
- youth substance use (71.3%).

Lakes Region forum participants specifically discussed substance use prevention, early initiation of use, and youth use in general. Table 1 includes indicators on youth substance use in Cumberland County. Forum participants did note there seem to be efforts in substance use prevention and more infrastructure for prevention programming at the local and state levels. Participants identified poverty and a lack of social safety nets, systemic racism, and isolation as potential root causes and contributing factors to substance use.

Table 1: Youth Substance Use Indicators

	Cumberland County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Substance Use							
Past-30-day alcohol use (high school students)	2019 **24.1%**	2023 **22.5%**	○	2023 **20.5%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2019 **3.4%**	2023 **4.1%**	○	2023 **4.8%**	○	—	N/A
Binge drinking (high school students)	2019 **8.8%**	2023 **11.3%**	○	2023 **9.6%**	○	—	N/A
Binge drinking (middle school students)	2019 **1.2%**	2023 **1.4%**	○	2023 **1.8%**	○	—	N/A
Past-30-day marijuana use (high school students)	2019 **23.9%**	2023 **19.1%**	N/A	2023 **18.7%**	N/A	—	N/A
Past-30-day marijuana use (middle school students)	2019 **2.9%**	2023 **2.9%**	○	2023 **5.0%**	★	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2019 **5.4%**	2023 **5.5%**	○	2023 **5.2%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	20198 **2.7%**	2023 **4.8%**	○	2023 **4.9%**	○	—	N/A
Lifetime illicit drug use (high school students)	—	2023 **3.9%**	N/A	2023 **3.6%**	○	—	N/A

The County Health Profile contains more information on data interpretation and additional indicators.

★ means the health issue or problem is getting statistically significantly better over time.

! means the health issue or problem is getting statistically significantly worse over time.

○ means the change was not statistically significant.

N/A means there is not enough data to make a comparison.

— means data is unavailable.

Forum participants would like to see more community spaces and transportation options, especially those that are universally accessible; businesses involved in community give back programs and businesses that connect with year-round residents; social safety nets; school representation in community affairs; more diversity, equity and inclusion efforts throughout the region; and the use of plain language and American Sign Language interpreters. Additionally, they would like school board of education to address substance use prevention through policies, such as restorative justice.

Populations and Communities Impacted by Substance Use

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For substance use, respondents cited: youth, LGBTQIAS2+, minorities, people with disabilities, unhoused/homeless, veterans, and isolated populations.

Community Resources to Address Substance Use

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

- Cumberland County Public Health Department
- In-school programs
- Libraries
- Maine Prevention Network of Maine CDC
- Schools
- The Opportunity Alliance
- Youth Mattering

Crosscutting Priorities

Transportation **Poverty** **Community Mattering**

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

Health Conditions & Outcomes

Health conditions and outcomes are the state of a person's health and well-being either as a current disease state, one that has been experienced, or the category of injury and death. These are at the downstream of the Bay Area Regional Health Inequities Initiative (BARHII) continuum (Appendix 1) and those that we ultimately hope to reduce and/or prevent through earlier changes in policies and systems, programs, and interventions at the upper stream levels. The following section outlines the top health conditions and outcomes priorities for the Lakes Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Lakes Region Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Cardiovascular Disease**

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for the Lakes Region. For the purposes of the prioritization process, mental health includes topics such as: depression, anxiety, sad/hopeless, suicide, depression during pregnancy, and post-partum depression.

Assessment Findings

In the Maine Shared CHNA survey, respondents in Cumberland County ranked "mental health issues" as the top concern negatively impacting their community and 77.4% said "mental health needs" negatively impact them, a loved one, and/or their community. About half of those people said "anxiety or panic disorder" impacted them (49.6%), a loved one (56.6%), or and/or their community (52.5%). "General stress in day-to-day life also impacted respondents, with 64.3% saying it impacts them, 61.7% a loved one, and 61.4% their community. The impact of other specific mental health needs are outlined in Table 2: Mental Health Needs. In Cumberland County, 8.6% of adults report current symptoms of depression, 22.3% report depression in their lifetime, and 22.5% of adults report anxiety in their lifetime (2019-2021).

In the Maine Shared CHNA survey, 78% of respondents say their own mental health is "good or excellent" and approximately 40% say they or a loved one either could not or chose not to get mental health care in the past year. The reasons for forgoing care include: "long wait times to see a provider," "had health insurance, could not afford care," and "not sure where to go for help." In 2024, there were 120 people for every mental health provider and 3,505 people for every psychiatrist in Cumberland County. During the period 2019-2021, 8.7% of people in Cumberland County reported cost barriers to health care.

Participants at the Lakes Region forum would like to see more done to address mental health. This includes more specific resources to assist various populations, such as: perinatal mental health resources, trauma-specific therapists, school-based mental health services, and senior mental health and more funding dedicated to mental health prevention. They would also like to see more mental health training and resources, telehealth, safe spaces, and increased use of recreation and trail systems.

Table 2: Mental Health, 2024

	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder	49.6%	56.6%	52.5%	1.9%	5.6%	1.9%
Depression	36.5%	56.0%	58.4%	2.4%	3.8%	1.6%
Bipolar disorder	3.8%	20.1%	38.3%	8.0%	28.2%	11.8%
Trauma or post-traumatic stress disorder (PTSD)	20.9%	30.6%	54.2%	6.2%	12.9%	6.7%
General stress of day-to-day life	64.3%	61.7%	61.4%	2.9%	5.1%	1.9%
Social isolation or loneliness	17.7%	31.9%	63.3%	4.6%	7.8%	6.2%
Stigma associated with seeking care for mental health or substance use disorders	12.6%	29.0%	65.4%	7.8%	8.8%	8.6%
Suicidal thoughts and/or behaviors	6.7%	24.4%	58.4%	8.6%	13.7%	8.8%
Youth mental health	10.7%	29.2%	62.7%	3.5%	9.1%	8.3%

Socioeconomic Empowerment

"Mental health care and treatment" were ranked third out of five for steps that are "very necessary" to help move people out of poverty and to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Mental Health

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For mental health, respondents cited: adults, older adults, children, youth, teens, LGBTQIA+, minorities, people with disabilities, veterans, unhoused/homeless, people with ACEs, youth, people who are isolated, and people with mental health conditions.

Community Resources to Address Mental Heath

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

- Bridgton Hospital
- Lakes Region Recovery Center

Crosscutting Priorities

Poverty **Community Mattering** **Adverse Childhood Experiences**

Substance Use Related Injury & Death

Substance use related injury and death was the second rated priority for the health conditions and outcomes category for the Lakes Region. For the purposes of the prioritization process, substance use related injury and death includes topics such as: drug affected infant reports, overdose, and opiate poisoning.

Assessment Findings

One participant in the Lakes Region focus group said:

"We have a recovery center; we have AA meetings. But if you don't have a license, you can't get the help you need. The only full-time house out here is for women, there isn't one for men. We need to have a local facility that is 24/7 to receive support and stay at. A recovery house."

Similar sentiments were shared by participants at the Lakes Region stakeholder forum. There was an overall theme of more centralization and connection for people to access substance use resources and expansion of existing programs that have been successful. For example, there is a community center and recreation department, but participants would like to see a central hub for all ages. Forum participants would like to see more programming and services such as: harm reduction and low barrier day treatment; transportation for people in Medication Assisted Treatment (MAT) programs; availability of counselors; and crisis support teams.

In the Maine Shared CHNA survey, Cumberland County respondents listed "substance use" as the second of five concerns negatively impacting their community and 68.9% said it negatively impacts them, a loved one, and/or their community. Three-quarters of respondents said, "opioid misuse" (77.2%), "other illicit drug use" (76.3%), "alcohol misuse or binge drinking" (74.6%), negatively impacts their community. In Cumberland County,

- There were 45 overdose deaths per 100,000 people (2023).
- There were 32.1 drug-induced deaths per 100,000 people, significantly better than Maine (55.6 per 100,000, 2018-2022).
- There were 14.7 alcohol-induced deaths per 100,000 people.
- 9.3% of adults report chronic heavy drinking (2019-2021).
- 18.9% of adults report binge drinking, significantly worse than Maine (15.5%, 2019-2021).

Populations and Communities Impacted by Substance Use Related Injury and Death

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For substance use related injury and death, respondents cited: those experiencing social isolation, older adults, people with mental health conditions, LGBTQIA+, minorities, people with disabilities, veterans, unhoused/homeless, people with ACEs, young adults, adults, teens, and people with substance use disorder.

Community Resources to Address Substance Use Related Injury and Death

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

- In-school programs
- Lakes Region Recovery Center
- Maine Prevention Network of Maine CDC
- Narcan distribution sites
- Opioid response
- OPTIONS
- Sober living homes
- Syringe exchange programs
- Youth Mattering projects

Crosscutting Priorities

Transportation **Illicit Drug Use**

Cardiovascular Disease

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

Assessment Findings

In the Maine Shared CHNA survey, 71% of respondents said, “chronic health conditions,” which includes cardiovascular disease, impacts them, a loved one, and/or their community. Of those respondents,

- 35.3% said heart disease or heart attack impacts a loved one and 40.9% said it impacts their community.
- 45% said high cholesterol impacts a loved one.
- 54.6% said high blood pressure or hypertension impacts a loved one.

In Cumberland County, quantitative data shows people are doing significantly better than Maine on a number of cardiovascular disease indicators, with the exception of high blood pressure hospitalizations, which have gotten significantly worse from 2016-2018 (12.1 per 10,000) to 2019-2021 (16 per 10,000). These are detailed in Table 3: Cardiovascular Disease Indicators.

Table 3: Cardiovascular Disease	Cumberland County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cardiovascular Disease							
Cardiovascular disease deaths per 100,000 population	2015-2019 **169.2**	2018-2022 **171.4**	○	2018-2022 **200.4**	★	2021 **231.8**	N/A
Coronary heart disease deaths per 100,000 population	2015-2019 **60.5**	2018-2022 **61.1**	○	2018-2022 **82.0**	○	2021 **92.8**	N/A
Heart attack deaths per 100,000 population	2015-2019 **19.0**	2018-2022 **15.6**	○	2018-2022 **24.6**	★	2021 **26.8**	N/A
Stroke deaths per 100,000 population	2015-2019 **30.4**	2018-2022 **27.4**	○	2022 **29.4**	N/A	2021 **41.1**	N/A
High blood pressure hospitalizations per 10,000 population	2016-2018 **12.1**	2019-2021 **16.0**	!	2019-2021 **19.4**	★	—	N/A
Heart failure hospitalizations per 10,000 population	2016-2018 **9.2**	2019-2021 **5.1**	★	2019-2021 **4.5**	○	—	N/A
Heart attack hospitalizations per 10,000 population	2016-2018 **14.8**	2019-2021 **11.6**	★	2019-2021 **18.9**	★	—	N/A
Stroke hospitalizations per 10,000 population	2016-2018 **19.2**	2019-2021 **17.1**	★	2019-2021 **19.2**	★	—	N/A
High blood pressure	2015 & 2017 **31.4%**	2017 & 2019 **32.7%**	○	2017 & 2019 **35.5%**	○	2021 **32.4%**	N/A
High cholesterol	2015 & 2017 **36.7%**	2017 & 2019 **33.6%**	○	2017 & 2019 **36.2%**	○	2019 **33.1%**	N/A
Cholesterol checked in past five years	2015 & 2017 **84.9%**	2017 & 2019 **89.6%**	★	2017 & 2019 **87.2%**	○	2019 **86.6%**	N/A

The County Health Profile contains more information on data interpretation and additional indicators.

★ means the health issue or problem is getting statistically significantly better over time.

! means the health issue or problem is getting statistically significantly worse over time.

○ means the change was not statistically significant.

N/A means there is not enough data to make a comparison.

— means data is unavailable.

Populations and Communities Impacted by Cardiovascular Disease

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were participants at the forum. For cardiovascular disease, respondents cited: unhoused/housing insecure, women, minorities, people with disabilities, older adults, adults, people with low-income, people living in rural areas, and multigenerational Black/African Americans.

Community Resources to Address Cardiovascular Disease

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. No assets or resources were listed for cardiovascular disease.

Greater Portland Region

Community Conditions

Community conditions include the physical environment (environmental exposures, housing, transportation, etc.), economic and work environment (employment, income, etc.), social environment (discrimination, crime, community safety, etc.), and service environment (health care and social service access, education, etc.). Social drivers of health (SDOH), which are the policies, systems, structures, life experiences, and social supports that influence a person's health, most often fit into the context of community conditions. The following section outlines the top community conditions priorities for the Greater Portland Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities..

Greater Portland Region Community Conditions		
Housing	Poverty	Transportation

Housing

Housing was the top-rated priority for the community conditions category for the Greater Portland Region. For the purposes of the prioritization process, housing includes topics such as: housing availability and affordability, costs associated with home ownership or renting and costs of utilities.

Assessment Findings

"Affordable housing" was a top theme among participants of the Greater Portland Region focus group. One participant said:

> **"Housing! There are so many families living in hotels or even campgrounds because housing just isn't available."**

In Cumberland County,

- 12% of households spend more than 50% of their income toward housing (2018-2022), significantly better than the U.S. (14.1%).
- The median gross rent is $1,389 (2018-2022), significantly worse than 2015-2019 ($1,131), Maine ($1,009), and the U.S. ($1,268).
- 85.5% of housing is occupied (2018-2022).
- 1.5% of housing units are vacant and for sale or rent (2022).

Greater Portland stakeholder forum participants noted factors related to the ability to afford housing including, wealth disparities, income gaps, and inflation. They identified factors related to housing availability such as the lack of supply, aging housing stock, municipal ordinances,

density issues, and high construction costs. Over half (56.8%) of housing in Cumberland County was built before 1979 and 8.2% of housing was built in 2010 or later (2018-2022).
Respondents to the Maine Shared CHNA survey listed "housing insecurity" as the third of five concerns negatively impacting their community and 75.7% of respondents said "housing needs" negatively impact them, a loved one, and/or their community. When asked about specific housing needs, three-quarters of those respondents said the following impact their community:

- "availability of affordable, quality homes/rentals" (84.8%),
- "availability of affordable, quality housing for older adults or those with special needs" (81.9%),
- "housing costs," (81.1%),
- "issues associated with home ownership or renting" (79.9%),
- "homelessness or availability of shelter beds" (79.9%),
- "costs of utilities" (76.5%), and
- "costs associated with weatherization" (72.2%).

For those who are unhoused, stakeholder forum participants said there is a lack of safe and supportive housing and shelter options. In 2023, 999 children were experiencing homelessness and 2.9% of high school students were housing insecure in Cumberland County.

Stakeholder forum participants also discussed systemic issues that have resulted in present day housing inequities such as racism and redlining, perceived and realized attitudes such as the "not in my backyard" mentality, and a preference for single-family homes.

Forum participants noted collaborative efforts to address housing are occurring between transportation and healthcare; public and private partnerships; and using other community health needs assessments to help inform the work. While collaboration is happening, participants noted there continues to be siloed work and funding stipulations which prohibit how collaborative an organization is able to be.

Socioeconomic Empowerment

When asked to rate the top five items that would move someone out of poverty and to a place of stability, "affordable and safe housing" was ranked number one by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Housing

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

Community Resources to Address Housing

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

- Avesta
- Community Action Agencies
- Community based organizations
- Community Housing of Maine
- Efficiency Maine
- Equality Community Center
- Faith-based organizations
- First-time homebuyer programs
- General Assistance
- Hope Aces
- Low Income Housing Tax Credit Program
- Maine Access Immigrant Network
- Maine Equal Justice
- MaineHousing
- Patient assistance line to provide support for venues for low-income housing
- Pine Tree Legal
- Portland Housing Authority
- Portland Public Housing
- Prevention and Diversion/Homeless Outreach Engagement Program
- Prosperity Maine
- Quality Housing Coalition
- Resettlement Program
- Section 8 Housing
- Shelters

Crosscutting Priorities

Poverty

Poverty

Poverty was the second rated priority for the community conditions category for the Greater Portland Region. For the purposes of the prioritization process, poverty includes topics such as: individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, and ALICE (Asset Limited, Income Constrained, Employed) thresholds.

Assessment Findings

In Cumberland County,

- 7.2% of individuals live in poverty (2018-2022), significantly better than 2015-2019 (9%), Maine (10.9%), and the U.S. (12.5%).
- 3.2% of families live below the federal poverty level (2018-2022), significantly better than 2015-2019 (5%), Maine (6.4%), and the U.S. (8.8%).
- 6.9% of children live in poverty (2018-2022), significantly better than 2015-2019 (9.8%), Maine (13.4%), and the U.S. (16.7%).
- 29.2% of households live above the federal poverty level but below the Asset Limited, Income Constrained, Employed (ALICE) threshold for financial survival (2022). The ALICE Household Survival Budget is the bare minimum cost of household basics necessary to live and work in the current economy.
- 16% of people are asset poor (2021), meaning they have insufficient net worth to live without income at or above the federal poverty line for three months.

Participants in the Greater Portland Region focus group highlighted several topics relevant to poverty, although it wasn't a top theme in and of itself, such as "affordable care" and "affordable housing." One participant noted:

"SNAP [Supplemental Nutrition Assistance Program] benefits can be important. However, many families do not financially qualify for them are still in need of that support."

In the Maine Shared CHNA survey, respondents listed "low incomes and poverty" as the fifth of five top concerns negatively impacting their community and 77.7% said "economic needs" negatively impacted them, a loved one, and/or their community. When asked about specific economic needs, respondents said the following impact their community:

- "availability of quality, affordable childcare" (77.9%),
- "access to affordable, quality foods" (74.9%), and
- "availability of jobs and employment opportunities" (66.7%).

Related to the needs highlighted in the survey, in Cumberland County:

- In 2023, 26.6% of children were served in publicly funded state and local preschools and there were 197 child care centers as of 2024.
- In 2022, 10.6% of adults and 13.9% of youth were food insecure.
- The median household income is $87,710 based on the most recent data (2018-2022), significantly better than 2015-2019 ($73,072) and significantly better than Maine ($68,251) and the U.S. ($75,149).
- As of 2023, 2.3% of people were unemployed.

The "ability to contribute to savings, retirement" impacted people across the board, with 53% reporting it impacts them, 46.7% a loved one, and 67.5% their community. Greater Portland stakeholder forum participants discussed similar economic needs, citing a lack of jobs, specifically for those with degrees and barriers to transferring foreign academic credentials, wealth inequities, and lack of generational wealth. Other causes related to poverty discussed at the forum include the cost of housing, benefit cliffs, and the impact of student loans.

Socioeconomic Empowerment

When asked to rate the top five items that would move someone out of poverty and to a place of stability, "jobs that pay enough to support a living wage" was ranked second and "affordable and quality child care" was ranked fifth by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Poverty

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For poverty, respondents cited: single parents, grandparents, undocumented people, people without work permits, migrants, minors raising children, unhoused teens, LGBTQ+ youth and older adults, racial and ethnic minority groups, adults, older adults, children, youth, and teens.

Community Resources to Address Poverty

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

- Avesta
- Career Centers
- Community Action Agencies
- Fedcap
- FindHelp
- Gateway Community Services
- In Her Presence
- MaineCare
- MaineHealth's Access to Care
- McKinney-Vento
- Portland Adult Education
- Prosperity Maine
- Public Housing Authority
- School Meals for All
- Schools
- Supplemental Nutrition Assistance Program
- United Way, specifically United for ALICE (Asset Limited, Income Constrained, Employed)

Crosscutting Priorities

Housing

Transportation

Transportation was the third rated priority for the community conditions category for the Greater Portland Region. For the purposes of the prioritization process, transportation includes topics such as: access to transportation, availability of transportation, and transportation that meets a variety of needs.

Assessment Findings

In the Maine Shared CHNA survey, 57.6% of respondents in Cumberland County said transportation needs negatively impacted them, a loved one, and/or community member. Of those respondents roughly three-quarters said:

- "access to transportation" (79.9%),
- "availability of transportation that meets a variety of specific needs" (79.9%),
- "availability of transportation" (77.6%), or
- "costs associated with owning and maintaining a vehicle" (72.1%) impacted their community.

In Cumberland County, 7% of households do not have a vehicle, significantly better than the U.S. (8.3%, 2018-2022) and 31.6% of people have a commute of greater than 30 minutes alone, significantly better than the U.S. (36.8%, 2018-2022).

Populations and Communities Impacted by Transportation

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

Community Resources to Address Transportation

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

- Age Friendly Communities
- Greater Portland bus system, including discounted bus tickets
- Greater Portland Council of Government
- ITN International
- Modivcare
- Moving Maine Network
- Regional transportation planning
- Taxi options
- Uber
- Volunteer driver programs

Protective & Risk Factors

Protective and risk factors are aspects of a person or environment that make it less likely (protective) or more likely (risk) that someone will achieve a desired outcome or experience a given problem. The more protective factors a person experiences, the more likely they are to have positive health and well-being outcomes, whereas the more risk factors, the greater the likelihood of experiencing negative health and well-being outcomes. Protective and risk factors can occur at both the individual and the environmental level, often overlapping with topics that fall within community conditions. The following section outlines the top protective and risk factor priorities for the Greater Portland Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Greater Portland Protective & Risk Factors		
Adverse Childhood Experiences	**Nutrition**	**Illicit Drug Use**

Adverse Childhood Experiences

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

Assessment Findings

In 2023, 21.5% of high school students in Cumberland County reported at least four of nine adverse childhood experiences, significantly better than Maine (26.7%). In the Maine Shared CHNA survey, four of the top five social concerns identified that negatively impact the community could be associated with ACEs – mental health issues, substance use, housing insecurity, and low incomes and poverty.

Three-quarters of Maine Shared CHNA survey respondents said economic needs (77.7%), mental health needs (77.4%), and housing needs (75.7%), potential root causes of ACEs, impact them, a loved one, and/or their community. Of those who identified mental health needs, 62.7% said "youth mental health" impacts their community. In 2023, 32.7% of high school students and 28.8% of middle school students were sad/hopeless for two weeks in a row, with middle school percentages significantly worse than 2019 (22.2%). In 2023,16.8% of high school and 19.6% of middle school students had seriously considered suicide.

At the Greater Portland Region stakeholder forum, participants discussed several topics that relate to those cited by survey respondents. These included topics such as: trauma and a lack of mental health services and therapy and access issues specifically associated with language and culture. Forum participants discussed people not having insurance or insurance that doesn't cover some services and the benefits cliff. In Cumberland County 5% of people are uninsured (2018-2022), significantly better than Maine (7.1%) and the U.S. (8.7%). As of 2020, 20.9% of adults were enrolled in MaineCare and 31.5% of youth, ages zero to nineteen, were.

Systemic issues were also discussed at the forum such as discrimination and including people who might otherwise be left out of processes but not enabling them to have leadership opportunities. While there are several contributing factors for health and well-being outcomes of people with ACEs, assets exist such as churches, resilience programs, and the MaineHealth Community Health and Resilience team.

Populations and Communities Impacted by Adverse Childhood Experiences

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities. Because ACEs were added as a priority at the forum, there were no responses. However, those who participated at the forum cited: new parents, caregivers, foster care parents, grandparents, people with mental health conditions, people in the criminal justice system, unhoused/housing insecure, unemployed people, people involved with the Child Protective Services system, people who are undocumented, LGBTQ youth, women, New Mainers/immigrants, people who have experienced trauma, people in poverty, people experiencing racism, and marginalized communities.

Community Resources to Address Adverse Childhood Experiences

Participants in the pre-forum survey were also asked to identify assets and resources related to their identified priorities. Again, because ACEs were added as a priority at the forum, none were listed; however, participants at the forum cited:

- Faith-based organizations
- MaineHealth Community Health and Resilience team
- Resilience Programs

Nutrition

Nutrition was the second rated priority for the protective and risk factors category for the Greater Portland Region. For the purposes of the prioritization process, nutrition includes topics such as fruit and vegetable consumption and soda/sports drink consumption.

Assessment Findings

At the Greater Portland Region focus group, one participant said:

> **"SNAP [Supplemental Nutrition Assistance Program] benefits can be important. However, many families do not financially qualify for them are still in need of that support."**

When asked about specific economic issues that impact them, a loved one, and/or community member, of the 77.7% respondents, 74.9% said "access to affordable, quality foods" impact their community, 24.9% a loved one, and 27.3% themselves. Greater Portland stakeholder forum participants also noted the ability to afford food discussing the inadequacy of incomes and the benefits cliff. In Cumberland County,

- 10.6% of adults and 13.9% of youth were food insecure (2022).
- 31.7% of adults report less than one serving of fruit per day, significantly better than the U.S. (39.7%, 2021).
- 12.2% of adults report less than one serving of vegetables per day, significantly better than the U.S. (20.4%, 2021).
- 17% of high school and 24.2% of middle school students report five or more servings of fruits and vegetables per day, both significantly better than Maine (14.2% and 18.9%, 2023).
- 21.9% of high school and 18.8% of middle school students report one or more soda/sports drinks per day, both significantly worse than 2019 (15.9% and 12.1%), but significantly better than Maine (25.3% and 23.3%, 2023).

Forum participants also discussed food availability, noting the existence of food deserts and the impacts of weather events, which may lead to prolonged power outages and food spoilage, as well as food insecurity in general. Forum participants discussed the lack of cultural foods and nutritional materials in plain language and American Sign Language.

Populations and Communities Impacted by Nutrition

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For nutrition, respondents cited: pregnant people, Asset Limited, Income Constrained, Employed (ALICE) people, those with religious or dietary needs, people with a disability, people with medical needs, unemployed people, older adults, those who are undocumented, those whose first language isn't English, adults, children, youth, and teens.

Community Resources to Address Nutrition

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

- Bright Bodies
- Common Space
- Diabetes Prevention Programs
- Food pantries, specifically those offered by MaineHealth
- Hannaford
- Let's Go 5210
- Maine Prevention Network, specifically school district wellness policies, nutritional training, and technical assistance for school nutrition programs
- Maine.edu, specifically the resources for those who are deaf or hard of hearing
- Mid Coast Hospital Community Education
- SNAP-Ed
- Supplemental Nutrition Assistance Program
- Wayside Food Services
- Women, Infants and Children Program

Crosscutting Priorities

Poverty

Illicit Drug Use

Illicit drug use was the third rated priority for the protective and risk factors category for the Greater Portland Region.

Assessment Findings

In the Maine Shared CHNA survey "substance use" was the second of the top five social concerns negatively impacting the community and 68.9% of respondents said "substance use" negatively impacts them, a loved one, and/or their community. When asked about specific substance use, 77.2% cited "opioid misuse" and 76.3% cited "other illicit drug use" impacted their communities. In Cumberland County,

- There were 45 overdose deaths per 100,000 people (2023).
- There were 32.1 drug-induced deaths per 100,000 people, significantly better than Maine (55.6 per 100,000, 2018-2022).
- 5.5% of high school and 4.8% of middle school students misused prescription drugs in the past 30 days (2023).
- 3.9% of high school students report lifetime illicit drug use (2024).

Forum participants at the Greater Portland Region stakeholder forum noted several gaps in resources that may serve as contributing factors to illicit drug use. These include a general lack of opportunity for treatment and specifically with regard to a lack of clinics, recovery resources, assessment and support, and a lack of insurance coverage. Data shows in Cumberland County, 5% of people are uninsured (2018-2022), significantly better than Maine (7.1%) and the U.S. (8.7%). There was also discussion about the need for free transportation to services and a lack of coordination and community partners.

Populations and Communities Impacted by Illicit Drug Use

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For illicit drug use respondents cited: people in recovery, people with mental health disorders, unhoused/ housing insecure, formerly incarcerated, unemployed people, caregivers, people involved with Child Protective Services, people who are undocumented, people whose first language isn't English, LGBTQ youth, women, adults, older adults, children, youth, and teens.

Community Resources to Address Illicit Drug Use

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

- Church of Safe Injection
- Common Space
- Comprehensive Addiction Medicine
- Detox beds
- Emergency departments
- Health care providers
- Maine Access Points
- Syringe Exchange Programs (SSPs)
- Peer Programs
- Preble Street
- SAMHSA's Sequential Intercept Model (SIM)
- Social service agencies
- Wayside Food Services

Crosscutting Priorities

Poverty **Transportation** **Substance Use Related Injury & Death**

Health Conditions & Outcomes

Health conditions and outcomes are the state of a person's health and well-being either as a current disease state, one that has been experienced, or the category of injury and death. These are at the downstream of the Bay Area Regional Health Inequities Initiative (BARHII) continuum (Appendix 1) and those that we ultimately hope to reduce and/or prevent through earlier changes in policies and systems, programs, and interventions at the upper stream levels. The following section outlines the top health conditions and outcomes priorities for Greater Portland Region of Cumberland County, findings from the assessment process, steps necessary to move from poverty to stability, populations and communities impacted by the priority, assets and resources related to the priority, and crosscutting priorities.

Greater Portland Health Conditions & Outcomes		
Mental Health	**Substance Use Related Injury & Death**	**Cardiovascular Disease**

Mental Health

Mental health was the top-rated priority for the health conditions and outcomes category for the Greater Portland Region. For the purposes of the prioritization process, mental health includes topics such as: depression, anxiety, sad/hopeless, suicide, depression during pregnancy, and post-partum depression.

Assessment Findings

In the Maine Shared CHNA survey, respondents in Cumberland County ranked "mental health issues" as the top concern negatively impacting their community and 77.4% said mental health needs negatively impact them, a loved one, and/or their community. About half of those respondents said "anxiety or panic disorder" impacted them (49.6%), a loved one (56.6%), and/or their community (52.5%). "General stress in day-to-day life" also impacted respondents – 64.3% saying it impacts them, 61.7% a loved one, and 61.4% their community. The impact of other specific mental health needs are outlined in Table 4: Mental Health Needs. In Cumberland County 8.6% of adults report current symptoms of depression (2019-2021), 22.3% report depression in their lifetime (2019-2021), and 22.5% of adults report anxiety in their lifetime.

Greater Portland stakeholder forum participants discussed root causes related to those addressed in the survey including isolation, loneliness, and a sense of belonging. Forum participants discussed the impacts of social determinants of health on mental health, specifically low incomes and income inequality. They also noted the existence of systemic and institutional racism on mental health. A related theme included cultural and linguistic care, which forum participants felt is lacking in general and specifically training for providers to provide appropriate care to LGBTQ+ people and for those who have different backgrounds. In general, there is a lack of a diverse workforce and providers. In 2024, there were 3,505 people for every psychiatrist in Cumberland County and 120 people for every mental health provider.

In the Maine Shared CHNA survey 78% of respondents say their own mental health is "good or excellent" and approximately 40% say they or a loved one either could not or chose not to get mental health care in the past year. The reasons cited include: "long wait times to see a provider," "had health insurance, could not afford care," and "not sure where to go for help." Forum participants discussed barriers to screening and referrals to treatment for post-partum depression due to programmatic and insurance barriers; there are gaps in where screening happens, and treatment providers are limited due to many providers not taking MaineCare and/or commercial insurance. As of 2023, 21.6% of people of all ages and 35.7% of those aged 0 to 19 were enrolled in MaineCare. Forum participants would like to see more dedicated federal funding for mental health.

Table 4: Mental Health, 2024	Impacts me	Impacts a loved one	Impacts my community	Doesn't have an impact	I don't know	Not applicable
Anxiety or panic disorder	49.6%	56.6%	52.5%	1.9%	5.6%	1.9%
Depression	36.5%	56.0%	58.4%	2.4%	3.8%	1.6%
Bipolar disorder	3.8%	20.1%	38.3%	8.0%	28.2%	11.8%
Trauma or post-traumatic stress disorder (PTSD)	20.9%	30.6%	54.2%	6.2%	12.9%	6.7%
General stress of day-to-day life	64.3%	61.7%	61.4%	2.9%	5.1%	1.9%
Social isolation or loneliness	17.7%	31.9%	63.3%	4.6%	7.8%	6.2%
Stigma associated with seeking care for mental health or substance use disorders	12.6%	29.0%	65.4%	7.8%	8.8%	8.6%
Suicidal thoughts and/or behaviors	6.7%	24.4%	58.4%	8.6%	13.7%	8.8%
Youth mental health	10.7%	29.2%	62.7%	3.5%	9.1%	8.3%

Socioeconomic Empowerment

"Mental health care and treatment" was ranked third out of five for steps that are "very necessary" to help move people out of poverty and to a place of stability by Maine Shared CHNA survey respondents.

Populations and Communities Impacted by Mental Health

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For mental health, respondents cited: older adults, specifically those using substances, unhoused/housing insecure, LGBTQ+, racial and ethnic minorities, New Mainers/immigrants, youth, caregivers, people with disabilities, pregnant people, those without insurance and underinsured, incarcerated and formerly incarcerated, the deaf and hard of hearing community, adults, children, youth, and teens.

Community Resources to Address Mental Heath

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

- 211
- 998
- Behavioral health programming
- Catholic Charities
- Community organizations
- Faith-based organizations
- Hospitals
- MaineHealth Behavioral Health
- MaineMOM
- Medication management
- Mid Coast Hospital
- NAMI Maine
- Peer support
- Primary care
- Public libraries
- Southern Maine Agency on Aging
- Sweetser

Crosscutting Priorities

Poverty **Adverse Childhood Experiences**

Substance Use Related Injury & Death

Substance use related injury and death was the second rated priority for the health conditions and outcomes category for the Greater Portland Region. For the purposes of the prioritization process, substance use related injury and death includes topics such as: drug affected infant reports, overdose, and opiate poisoning.

Assessment Findings

In the Maine Shared CHNA survey, Cumberland County respondents listed "substance use" as the second of five concerns negatively impacting their community and 68.9% said it negatively impacts them, a loved one, and/or their community. Three-quarters of respondents said, "alcohol misuse or binge drinking" (74.6%), "opioid misuse" (77.2%), and "other illicit drug use" (76.3%) negatively impacts their community. In Cumberland County,

- There were 45 overdose deaths per 100,000 people (2023).
- There were 32.1 drug-induced deaths per 100,000 people, significantly better than Maine (55.6 per 100,000, 2018-2022).
- There were 14.7 alcohol-induced deaths per 100,000 people (2018-2022).
- 9.3% of adults report chronic heavy drinking (2019-2021).
- 18.9% of adults report binge drinking, significantly worse than Maine (15.5%, 2019-2021).

Greater Portland stakeholder forum participants discussed isolation, loneliness, and a sense of belonging as potentially impacting substance use. Forum participants discussed the connection of social determinants of health on substance use, specifically low incomes and income inequality. They also noted the existence of systemic and institutional racism on substance use. A related theme included cultural and linguistic care, which forum participants felt is lacking in general and specifically training for providers to provide appropriate care to LGBTQ+ people and for those who have different backgrounds. Forum participants discussed how substance use disorder may be viewed differently by various cultures and religions and can impact how people get care. In general, there is a lack of a diverse workforce and providers.

Forum participants highlighted a lack of youth substance use disorder programming. They also discussed the challenge of getting case management or peer support services for those with substance use disorder, because of the need for a primary behavioral health diagnosis for insurance to cover case management – stand-alone case management and stand-alone peer services are often not accessible in substance use disorder treatment due to insurance barriers.

Populations and Communities Impacted by Substance Use Related Injury and Death

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For substance use related injury and death, respondents cited: older adults, specifically those using substances, unhoused/housing insecure, LGBTQ+ people, racial and ethnic minorities, New Mainers/immigrants, youth, caregivers, people with disabilities, pregnant people, those without insurance and underinsured, incarcerated and formerly incarcerated, the deaf and hard of hearing community, adults, children, youth, and teens.

Community Resources to Address Substance Use Related Injury and Death

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

- Behavioral health programs
- Day One
- Faith-based organizations
- Healthcare providers
- MaineMOM
- MaineHealth Behavioral Health Comprehensive Addiction Psychiatry Services (CAPS)
- MaineHealth Comprehensive Addiction Medicine – Portland
- MaineHealth and Preble Street Learning Collaborative, specifically Project CONNECT
- Medication Assisted Treatment
- Narcan
- Peer support services
- Project Lifeline
- Public libraries
- Social service agencies
- Transportation grants for people attending substance use treatment
- Virtual behavioral health

Crosscutting Priorities

Poverty **Adverse Childhood Experiences** **Illicit Drug Use** **Mental Health**

Cardiovascular Disease

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

Assessment Findings

In the Maine Shared CHNA survey, 71% of respondents said, “chronic health conditions,” which includes cardiovascular disease, impacts them, a loved one, and/or their community. Of those respondents,

- 35.3% said heart disease or heart attack impacts a loved one and 40.9% said it impacts their community.
- 45% said high cholesterol impacts a loved one.
- 54.6% said high blood pressure or hypertension impacts a loved one.

In Cumberland County, quantitative data shows people are doing significantly better than Maine on a number of cardiovascular disease indicators, with the exception of high blood pressure hospitalizations, which have gotten significantly worse from 2016-2018 (12.1 per 10,000) to 2019-2021 (16 per 10,000). These are detailed in Table 3: Cardiovascular Disease Indicators.

Table 3: Cardiovascular Disease	Cumberland County			Benchmarks			
Indicator	**Point 1**	**Point 2**	**Change**	**Maine**	**+/-**	**U.S.**	**+/-**
Cardiovascular Disease							
Cardiovascular disease deaths per 100,000 population	2015-2019 **169.2**	2018-2022 **171.4**	○	2018-2022 **200.4**	★	2021 **231.8**	N/A
Coronary heart disease deaths per 100,000 population	2015-2019 **60.5**	2018-2022 **61.1**	○	2018-2022 **82.0**	○	2021 **92.8**	N/A
Heart attack deaths per 100,000 population	2015-2019 **19.0**	2018-2022 **15.6**	○	2018-2022 **24.6**	★	2021 **26.8**	N/A
Stroke deaths per 100,000 population	2015-2019 **30.4**	2018-2022 **27.4**	○	2022 **29.4**	N/A	2021 **41.1**	N/A
High blood pressure hospitalizations per 10,000 population	2016-2018 **12.1**	2019-2021 **16.0**	!	2019-2021 **19.4**	★	—	N/A
Heart failure hospitalizations per 10,000 population	2016-2018 **9.2**	2019-2021 **5.1**	★	2019-2021 **4.5**	○	—	N/A
Heart attack hospitalizations per 10,000 population	2016-2018 **14.8**	2019-2021 **11.6**	★	2019-2021 **18.9**	★	—	N/A
Stroke hospitalizations per 10,000 population	2016-2018 **19.2**	2019-2021 **17.1**	★	2019-2021 **19.2**	★	—	N/A
High blood pressure	2015 & 2017 **31.4%**	2017 & 2019 **32.7%**	○	2017 & 2019 **35.5%**	○	2021 **32.4%**	N/A
High cholesterol	2015 & 2017 **36.7%**	2017 & 2019 **33.6%**	○	2017 & 2019 **36.2%**	○	2019 **33.1%**	N/A
Cholesterol checked in past five years	2015 & 2017 **84.9%**	2017 & 2019 **89.6%**	★	2017 & 2019 **87.2%**	○	2019 **86.6%**	N/A

The County Health Profile contains more information on data interpretation and additional indicators.

★ means the health issue or problem is getting statistically significantly better over time.

! means the health issue or problem is getting statistically significantly worse over time.

○ means the change was not statistically significant.

N/A means there is not enough data to make a comparison.

— means data is unavailable.

Greater Portland stakeholder forum participants discussed root causes of cardiovascular disease including isolation, loneliness, and a sense of belonging. Forum participants discussed the impacts of social determinants of health on cardiovascular disease, specifically low incomes and income inequality. Overall participants note there are insufficient services to prevent and treat cardiovascular disease. Forum participants discussed the lack of cultural and linguistic care, specifically training for providers to provide appropriate care to LGBTQ+ people and for those who have different backgrounds. In general, there is a lack of a diverse workforce and providers.

Populations and Communities Impacted by Cardiovascular Disease

In a pre-forum survey to identify initial priority topics, forum registrants were asked to identify populations impacted by their identified priorities, as were those at the forum. For cardiovascular disease, respondents cited: unhoused/housing insecure, LGBTQ+ people, racial and ethnic minorities, New Mainers/immigrants, youth, caregivers, people with disabilities, those without insurance and underinsured, incarcerated and formerly incarcerated, the deaf and hard of hearing community, adults, older adults, refugees/asylees, multigenerational Black/African Americans.

Community Resources to Address Cardiovascular Disease

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

- Access to outdoor spaces for exercise
- Bright Bodies
- Faith-based organizations
- Hospitals
- Lifestyle programming
- Maine QuitLink
- Pharmacies
- Primary care providers
- Public libraries
- Southern Maine Agency on Aging
- Supplemental Nutrition Assistance Program
- Women, Infants and Children Program

Crosscutting Priorities

Poverty

Appendices

Appendix 1: Methodology

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

Data Commitments

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

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

Quantitative Data

Data Criteria

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

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

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

Data Profiles & Interpretation

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

Data Limitations, Gaps, & Considerations

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

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

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

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

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

Data Changes

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

Data Discrepancies

COVID's Impact

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

Health Equity Profiles

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

Qualitative Data

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

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

Considerations for Identifying Populations to Engage With

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

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

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

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

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

Considerations for the Use of Other Assessments

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

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

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

Focus Groups

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

- Statewide Focus Group Participants: 31 (total)

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

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

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

Key Informant Interviews

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

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

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

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

Statewide Community Survey

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

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

Bay Area Regional Health Inequities Initiative (BARHII) Framework

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

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

Demographic Factors
- Class
- Race/Ethnicity
- Immigration Status
- Gender
- Sexual Orientation

Institutional Factors
- Corporations & Businesses
- Government Agencies
- Schools
- Laws & Regulations
- Not-for-Profit Organizations

Community

Physical Environment
- Land Use
- Transportation
- Housing
- Residential Segregation
- Exposure to Toxins

Social Environment
- Experience of Class, Racism, Gender, Immigration
- Culture – Ads – Media
- Violence

Economic & Work Environment
- Employment
- Income
- Retail Business
- Occupational Hazards

Service Environment
- Health Care
- Education
- Social Services

Protective & Risk Factors
- Smoking Status
- Fruit/Vegetable Consumption
- Physical Activity
- Alcohol and Other Drug Use
- Sexual Behavior
- Preventive Health Visits
- Vaccination Status

Disease & Injury
- Communicable Disease
- Chronic Disease
- Injury (Intentional & Unintentional)

Mortality
- Infant & Child Mortality
- Life Expectancy

*Blue indicates a sampling of the SCHNA quantitative

Stakeholder Forums

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

Two in-person stakeholder forums were held in Cumberland County. One in the Lakes Region on October 1, 2024, with 23 attendees and one in the Greater Portland Region on October 22, 2024, with 35 attendees.

People from the following organizations participated in the Lakes Region forum process:

- Bridgton
- Bridgton Community Center
- Bridgton Public Library
- Central Maine Healthcare
- Central Maine Healthcare/Rumford Hospital/ Bridgton Hospital
- Cumberland County Public Health Department
- Disability Rights Maine
- Healthy Androscoggin/Central Maine Healthcare
- Loon Echo Land Trust
- The Opportunity Alliance
- Through These Doors
- Town of Bridgton
- Town of Bridgton Recreation Department
- U.S. Representative Chellie Pingree (ME-01)
- United Way of Southern Maine

People from the following organizations participated in the Greater Portland forum process:

- City of Portland
- City of Portland Public Health
- Consumers for Affordable Health Care
- Cumberland County Public Health Department
- Disability Rights Maine
- Equality Community Center
- Greater Portland Health
- Maine Access Immigrant Network
- Maine Center for Disease Control and Prevention
- Maine House of Representatives
- MaineHealth
- MaineHealth Behavioral Health
- MaineHealth Community Health Improvement
- MaineHealth Medical Group - Population Health Management Department
- Maine Medical Center – Preventive Medicine
- Northern Light Mercy Hospital
- PHA
- The Opportunity Alliance
- Through These Doors
- United Way of Southern Maine

Reporting

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

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

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

Appendix 2: Other Identified Health and Well-Being Topics

Lakes Region Other Identified Health & Well-Being Topics

Prior to the stakeholder forums, registrants were asked to take part in a review of quantitative and qualitative data, in the form of data health profiles and community engagement overviews. Based on their interpretation of this information and their own knowledge, expertise, and experience, registrants were asked to vote on their top five health and well-being priorities in each of the following categories: community conditions, protective and risk factors, and health conditions and outcomes. This priority identification was the first step in the overall Maine Shared CHNA health and well-being prioritization process. The complete results are depicted in the table below.

Table 1: Complete Results of the First Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	13	68.4%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	12	63.2%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	10	52.6%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	10	52.6%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	7	36.8%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	5	26.3%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	5	26.3%
Climate Impacts (such as extreme weather events)	4	21.1%
Systemic Discrimination	4	21.1%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	4	21.1%
Isolation	3	15.8%
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	3	15.8%
Education (such as pre-K through post-secondary and technical/trade opportunities)	3	15.8%
Technology (such as access to high-speed internet and phone services)	2	10.5%
Wage Gaps and Income Disparities	2	10.5%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	1	5.3%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	5.3%
Employment Opportunities	1	5.3%
Stigma Around Accessing/Accepting Help, Services, or Treatment	1	5.3%
Competency of Providers to Serve Patients with Diverse Needs (such as cultural, linguistic, abilities, etc.)	1	5.3%

Community Conditions	# Votes	% of Participants
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	1	5.3%
Other (please specify): Guaranteed income	1	5.3%

Protective and Risk Factors	# Votes	% of Participants
Youth Mattering (such as positive role models, community connections, etc.)	10	52.6%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	9	47.4%
Preventive Oral Health Care	9	47.4%
Adverse Childhood Experiences	9	47.4%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	8	42.1%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	7	36.8%
Alcohol Use (including binge drinking)	6	31.6%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	5	26.3%
Illicit Drug Use	5	26.3%
Vaping Use (including tobacco and cannabis)	4	21.1%
Safe Drinking Water	4	21.1%
Other (please specify): Lack of financial resources to move beyond poverty; Economic security, housing security; Community belonging and mattering for ALL populations – not just youth	3	15.8%
Cancer Prevention (such as cancer screenings, sunscreen use)	2	10.5%
Foster Care	2	10.5%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	2	10.5%
Injury Prevention (such as fall prevention, always wear a seat belt)	1	5.3%
Immunizations & Vaccinations	1	5.3%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	1	5.3%
Cannabis Use	1	5.3%
Prescription Drug Misuse	1	5.3%
Indoor Air Quality	1	5.3%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	16	84.2%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	11	57.9%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	11	57.9%
Cancer	9	47.4%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	5	26.3%
Obesity/Weight Status	5	26.3%
Intentional Injury & Death (self-injury)	4	21.1%
Cognitive Decline, Alzheimer's disease and other dementias	4	21.1%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	4	21.1%

Health Conditions and Outcomes	# Votes	% of Participants
Diabetes	3	15.8%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	3	15.8%
Dental Disease	3	15.8%
Multiple Chronic Conditions	3	15.8%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	2	10.5%
Non-Infectious Respiratory Disease (such as asthma, COPD)	2	10.5%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	1	5.3%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	1	5.3%

After a presentation of key quantitative and qualitative findings and breakout discussions, participants were asked to take part in a second round of voting to narrow the health and well-being priorities for their county to the top three in each category of community conditions, protective & risk factors, and health conditions & outcomes. The complete results are depicted in the table below.

Table 2: Complete Results of the Second Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Transportation (such as access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	18	85.7%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	18	85.7%
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	17	81.0%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	7	33.3%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	3	14.3%
Protective and Risk Factors	**# Votes**	**% of Participants**
Everyone Mattering (such as positive role models, community connections, isolation etc.)	16	76.2%
Adverse Childhood Experiences	15	71.4%
Substance use	14	66.7%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	7	33.3%
Preventive Oral Health Care	6	28.6%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	5	23.8%
Health Conditions and Outcomes	**# Votes**	**% of Participants**
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	21	100.0%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	19	90.5%

Health Conditions and Outcomes	# Votes	% of Participants
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	15	71.4%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	6	28.6%

Greater Portland Other Identified Health & Well-Being Topics

Prior to the stakeholder forums, registrants were asked to take part in a review of quantitative and qualitative data, in the form of data health profiles and community engagement overviews. Based on their interpretation of this information and their own knowledge, expertise, and experience, registrants were asked to vote on their top five health and well-being priorities in each of the following categories: community conditions, protective and risk factors, and health conditions and outcomes. This priority identification was the first step in the overall Maine Shared CHNA health and well-being prioritization process. The complete results are depicted in the table below.

Table 3: Complete Results of the First Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	23	95.8%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	11	45.8%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	10	41.7%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	9	37.5%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	8	33.3%
Food (such as access to food, quality of food, food costs, culturally competent food options, etc.)	8	33.3%
Childcare (such as access to childcare, quality of childcare, affordability of childcare, etc.)	7	29.2%
Wage Gaps and Income Disparities	6	25.0%
Climate Impacts (such as extreme weather events)	5	20.8%
Aging Related Services (such as long term care, assisted living access, and in-home care support services)	5	20.8%
Systemic Discrimination	4	16.7%
Built Environment (such as crosswalks, sidewalks, universal access, bike lanes, access to parks and green spaces etc.)	3	12.5%
Technology (such as access to high-speed internet and phone services)	3	12.5%
Isolation	3	12.5%
Environmental Exposures (such as tobacco smoke, arsenic, PFAS, lead and radon exposure)	2	8.3%
Employment Opportunities	2	8.3%
Insurance Status (such as MaineCare enrollment, children with dental insurance, cost barriers to health care)	2	8.3%
Other (please specify): Time and support for providers to care for patients with complex needs (as opposed to competency); Healthcare affordability	2	8.3%

Community Conditions	# Votes	% of Participants
Opportunities for Community Involvement (such as activities for seniors and youth, volunteer opportunities, etc.)	1	4.2%
Community Safety (such as vandalism, neighborhood watch programs, well-lit areas, etc.)	1	4.2%
Bullying	1	4.2%
Stigma Around Accessing/Accepting Help, Services, or Treatment	1	4.2%

Protective and Risk Factors	# Votes	% of Participants
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	14	58.3%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	12	50.0%
Illicit Drug Use	10	41.7%
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	9	37.5%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	9	37.5%
Adverse Childhood Experiences	9	37.5%
Alcohol Use (including binge drinking)	9	37.5%
Immunizations & Vaccinations	8	33.3%
Vaping Use (including tobacco and cannabis)	7	29.2%
Injury Prevention (such as fall prevention, always wear a seat belt)	4	16.7%
Youth Mattering (such as positive role models, community connections, etc.)	4	16.7%
Preventive Oral Health Care	3	12.5%
Cancer Prevention (such as cancer screenings, sunscreen use)	3	12.5%
Birth control use (including general use rates, knowledge of options, access, affordability, etc.)	3	12.5%
Cannabis Use	3	12.5%
Prescription Drug Misuse	3	12.5%
Tobacco Use (including e-cigarettes and MaineQuit Link users)	2	8.3%
Other (please specify): All early substance use and youth access to tiered behavioral health resources; Access to affordable housing and social services	2	8.3%
Foster Care	1	4.2%
Access to Child and Family Home Visiting	1	4.2%
Indoor Air Quality	1	4.2%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	20	83.3%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	17	70.8%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	13	54.2%
Obesity/Weight Status	10	41.7%
Cancer	8	33.3%
Diabetes	8	33.3%
Special Health Care Needs (those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by people generally)	7	29.2%
Intentional Injury & Death (self-injury)	5	20.8%

Health Conditions and Outcomes	# Votes	% of Participants
Multiple Chronic Conditions	5	20.8%
Cognitive Decline, Alzheimer's disease and other dementias	4	16.7%
Unintentional Injury & Death (such as fall-related, traumatic brain injury, car accidents, firearms, work-related)	3	12.5%
Pregnancy and Birth Outcomes (such as c-sections, low birth weight, pre-term births, teen pregnancy, infant mortality)	3	12.5%
Infectious Respiratory Disease (such as pertussis, tuberculosis, pneumonia, COVID)	3	12.5%
Non-Infectious Respiratory Disease (such as asthma, COPD)	3	12.5%
Infectious Disease (such as hepatitis C Lyme Disease vector-borne infectious diseases, etc.)	3	12.5%
Sexually Transmitted Infections (such as hepatitis A and B, Chlamydia, Gonorrhea, HIV, Syphilis)	2	8.3%
Dental Disease	2	8.3%
Arthritis	1	4.2%
Other (please specify): Drug poisoning deaths	1	4.2%

After a presentation of key quantitative and qualitative findings and breakout discussions, participants were asked to take part in a second round of voting to narrow the health and well-being priorities for their county to the top three in each category of community conditions, protective & risk factors, and health conditions & outcomes. The complete results are depicted in the table below.

Table 4: Complete Results of the Second Round of Health and Well-Being Prioritization

Community Conditions	# Votes	% of Participants
Housing (such as housing availability and affordability, costs associated with home ownership or renting, costs of utilities)	23	69.7%
Poverty (such as individuals and children living in poverty, unemployment, asset poverty, Head Start eligibility, ALICE thresholds)	18	54.6%
Transportation (such access to transportation, availability of public transportation, transportation that meets a variety of specific needs)	14	42.4%
Timeliness of Healthcare and Social Services (such as wait times for an appointment, inability to easily access providers to ask questions, inability to get care when you need it, etc.)	11	33.3%
Systemic Oppression	10	30.3%
Built environment - availability of schools, grocery stores	9	27.3%
Provider Availability (such as availability of primary care physicians, dentists, psychiatrists, and mental health providers, access to mental health treatment, access to drug and alcohol treatment, caregiving, and prenatal care)	8	24.2%
Nutrition and food security	7	21.2%
Domestic Violence	1	3.0%

Protective and Risk Factors	# Votes	% of Participants
ACEs	23	69.7%
Nutrition (such as fruit and vegetable consumption, soda/sports drink consumption)	19	57.6%
Illicit Drug Use	17	51.5%
Adult Screening & Preventative Visits (such as annual well visits, cholesterol checked, A1c checked, eye exams)	16	48.5%

Protective and Risk Factors	# Votes	% of Participants
Physical Activity (such as met aerobic guidelines, screen time, sedentary lifestyle)	12	36.4%
Child/Youth Screening & Preventative Visits (such as annual well visits, developmental screening, child preventative visits)	12	36.4%

Health Conditions and Outcomes	# Votes	% of Participants
Mental Health (such as depression, anxiety, sad/hopeless, suicide, depression during pregnancy, post-partum depression)	27	81.8%
Substance Use Related Injury & Death (such as drug affected infant reports, overdose, opiate poisoning)	23	69.7%
Social Determinants of Health*	22	66.7%
Cardiovascular Disease (such as high blood pressure, high cholesterol, heart attack, stroke)	10	30.3%
Oral Health	8	24.2%
Obesity/Weight Status	4	12.1%
Cancer	3	9.1%
Domestic Violence	3	9.1%

*Social Determinants of Health was voted as a top priority, but the forum participants came to consensus that it was a better fit for the Community Conditions category and a crosscutting theme throughout prioritization categories.

Appendix 3: Community Action Agency Profile

About The Opportunity Alliance

The Opportunity Alliance (TOA) is a dynamic, results-focused Community Action Agency providing dozens of integrated community-based and clinical programs serving more than 24,000 people annually throughout Maine. With 60 years of experience, TOA draws from a comprehensive set of programs that address issues such as mental health, substance use, homelessness, lack of basic needs, and access to community support. Through an array of services, TOA provides opportunities for individuals to stabilize fragile situations and then works with them to achieve self-sufficiency. TOA is client-focused and has extensive experience working with diverse client populations. TOA programming includes four key sectors of service:

- Community Well-Being
- Poverty and Economic Mobility
- Childcare and Early Childhood Education/Head Start
- Behavioral Health and Wellness

TOA works in partnership with organizations and community members to identify and address barriers for individuals and families to thrive and create a strong community fabric. As an integral part of this work, TOA is committed to helping individuals and their families advocate for the resources and support they need to achieve positive outcomes. At its foundation, TOA has three organizations with a long history of serving communities throughout Maine: Ingraham, Peoples Regional Opportunity Program (PROP), and Youth Alternatives. The three organizations merged in 2011 to form The Opportunity Alliance.

TOA tackles some of our community's most pressing problems: poverty, homelessness, mental illness, substance use, and domestic violence. Amongst the most challenging health problems facing our community is the rampant misuse of opioids, which has reached epidemic levels. Many of the individuals we serve have serious mental illnesses that are often complicated by chronic health conditions and substance use disorders.

We work diligently to keep families intact, housed in stable homes, and integrated into a neighborhood community where all members can thrive and pursue their aspirations. We believe that the pathway to healthier individuals and families is created through an integrated continuum of formal and informal supports that address the fundamental factors that place communities at risk, such as poverty, homelessness, mental illness, high rates of substance use, trafficking, and child neglect and abuse. That's why, as much as possible, we work with residents to identify and address barriers to community success. We place a particularly high

value on services that empower families and individuals to connect with natural supports and local resources. To that end, we have developed working partnerships with a broad range of individuals, organizations, and community institutions, including schools, faith communities, law enforcement, businesses, social services agencies, and other non-profits.

TOA is the primary crisis services provider for Cumberland County, with three distinct crisis services offering someone to call, someone to respond, and somewhere to go according to the Ideal Crisis System Model. We operate the Maine Crisis Line (MCL), the State's crisis response call center. Trained crisis call specialists provide free and confidential support via call, text, or chat 24/7 for individuals or families experiencing a behavioral health crisis or having thoughts of suicide and/or self-harm. MCL is also the call center answering the State's 988 Suicide and Crisis Lifeline calls, texts, and chats. Our Mobile Crisis team responds to individuals in crisis in the community with trained crisis intervention specialists and has an 8-bed adult crisis residential facility in the Greater Portland area.

We provide mental health services through TOA's residential mental health treatment facilities as well as case management programs for children, youth, and adults. The 2-1-1 information line provides 24/7 statewide support via text and calls from those seeking critical resources in their communities. We are a co-occurring competent agency offering programs for individuals attempting to recover from substance use and mental health co-occurring disorders, and we are a leader in peer-to-peer and parent-to-parent partnering supports and services. We also collaborate closely with Maine's Department of Health and Human Services (DHHS), the Department of Corrections (DOC), community organizations, and cities and towns throughout the state.

TOA is a clinically effective organization, and we make a difference in the lives of tens of thousands of individuals each year addressing the root causes of poverty, working with people to overcome mental illness, and strengthening families and communities. TOA is committed to being a data-informed and data-driven organization that takes a multi-factored approach with roots in the Results-Based Accountability framework. First, each program contract is reviewed for expected service deliverables and associated performance measurement reporting. Then, staff seek to answer the central question, "Is anyone better off?" as program performance measures are considered from the perspective of impacts on desired client and community outcomes. Finally, TOA seeks guidance from external stakeholders to understand the current service landscape and align with existing service initiatives, evaluation efforts, and sector best practices.

TOA embraces SAMHSA's trauma-informed principles as a framework to inform interventions with clients and interactions with each other. Trauma-informed care also emphasizes physical, psychological, and emotional safety for both clients and providers and helps survivors rebuild a sense of control and empowerment. An Implementation team comprised of direct care and clinical staff assists programs with a deeper understanding of how to apply the principles in practice and translate a trauma-informed approach into skills that lead to better outcomes for those we serve.

TOA programs are accredited by the Council on Accreditation (COA), Inform USA (formerly AIRS), and by the American Association of Suicidology. TOA has recently been re-accredited by the COA through a process involving a detailed review and analysis of our organization's administration, management, and service delivery functions against international standards of best practice. The standards driving accreditation ensure that services are well-coordinated, culturally competent, evidence-based, outcomes-oriented, and provided by a skilled and supported workforce. Additionally, TOA holds both Mental Health Agency and Substance Abuse Agency licenses from DHHS, which are now organized under the combined Behavioral Health Organization's adopted rule.

Services Offered by TOA (Updated Nov 24)

Community Well Being: Programs and services working with youth, families, neighbors, and partner organizations to build strong networks and healthier communities.

- Lakes Region Collective Action Network (LRCAN) – Lakes Region – Cumberland County
- 211
- Maine Youth Action Network (MYAN)
- Community Builder in South Portland

Poverty and Economic Mobility: Programs and services designed to increase income and basic needs by ensuring access to food, safe and stable shelter, utilities, and volunteer opportunities.

- Cumberland County Homeless Prevention Program (CCHP)
- Energy Crisis Intervention Program (ECIP)
- Foster Grandparent Program
- Home Energy Assistance Program (HEAP)
- Senior Companion Program
- Wrap Funds

Childcare & Early Childhood Education: Programs and services working in partnership with families and the community to ensure children are ready for school.

- TANF Whole Family - TogetherWeWork
- Early Childhood Education – (Head Start/Early Head Start)
- Parent Education
- Maine Families
- First4Me
- Project WIN
- Community School Development Project
- McAuley House
- The Maine Diaper Project
- Women, Infants, Children Program (WIC)

Behavioral Health & Wellness: Community and residential mental health services for children and adults.

Community Services:

- Behavioral Health Home (BHH)
- Broadway Crossings Adult Crisis Stabilization Unit
- Children's Behavioral Health Home (CBHH)
- The Women's Project
- Mobile Crisis Response Services
- High-Fidelity Wraparound
- Homeless Youth Services (HYS)
- The Maine Crisis Line
- PATH Program

Residential Services:

- Gordon Green
- Helen Winslow Ray House
- Morrison Place
- Ocean Street
- The Bridge

Acknowledgements

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

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

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

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

Endnotes

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

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

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

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

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

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

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

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

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

x Heller, J.C., Givens, M.L., Johnson, S.P. and Kindig, D.A. (2024), Keeping It Political and Powerful: Defining the Structural Determinants of Health. Milbank Quarterly., 102: 351-366. https://doi.org/10.1111/1468-0009.12695

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

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

www.mainechna.org