Community Health Improvement Plan

Cumberland County, Maine
2022–2025

PublicHealth
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Cumberland County, Maine

FOREWORD

Liz Blackwell-Moore, Cumberland County Public Health Director

For the past two decades, the local public health infrastructure in Cumberland County has been through many changes. Maine CDC, the City of Portland Public Health Division, The Opportunity Alliance, the Cumberland District Public Health Council and various local community coalitions have been a part of local public health efforts over many years. How entities are funded, the geography they cover, and the public health issues they address has been in flux as state and federal leadership has changed. In 2021, based on years of community discussions around a strong desire for regional public health programming and thorough budget planning to ensure long-term stability, Jim Gailey, the Cumberland County Manager, created the Public Health Director position to build out a County Public Health Department.

As I started this new position in October of 2021, it was clear to me there are many successful public health efforts already underway throughout the county. The county does not just need "more public health." The fundamental goal of the new Public Health Department is to address persistent or remaining gaps in public health, to create stronger partnerships and collaborations, and to build capacity within the county to address the needs of people and communities who have the greatest barriers to health and well-being. While Cumberland County on the whole has some of the lowest rates of disease and highest rates of health, these overall rates obscure the health inequities that continue to exist. According to the World Health Organization, "Health inequities are differences in health status or the distribution of health resources between different population groups, arising from the social condition in which people are born, grow, live, work, and age." In Cumberland County, people who identify as LGBTQ+, Black, Indigenous, people of color (BIPOC), people who are low-income, have a disability, and/or live in a rural area have more barriers to health than the average person and therefore have higher rates of disease and early death.

This County Health Improvement Plan is just the County Public Health Department's initial response to improving health inequities. The plan outlines some foundational equity goals (Goal 1) that will guide my work to build out the Department. This includes using an equity lens on all public health problems and ensuring the use of culturally relevant approaches to addressing them (Strategy 1a). Using an equity lens means finding and using disaggregated data to inform the work (Strategy 1b) ensuring culturally relevant approaches means spending more time engaging and supporting cross-sector partnerships with communities that have the most barriers to health (Strategy 1d and 1e), and carefully considering how public health policies and practices will impact those communities.

The plan is also a call for Public Health in Cumberland County to shift more of our focus upstream. While many people still lack consistent access to quality healthcare and have unmet behavioral and oral health needs, health inequities stem from societal and institutional inequities that impact the community conditions in which people live, learn, work, and play. Implementing strategies to reduce racism and discrimination (Goal 5) and focusing on issues related to transportation (Goal 4), housing (Goal 6), food security (Goal 7), and environmental justice (Goal 8), will fundamentally improve the community conditions in which people live, reduce barriers to health, and give all people the opportunity to live a healthy life. Our efforts to address healthcare access (Goals 2 & 3) will only be more effective when they are combined with efforts to improve the community conditions in which people live.

While this is a 4-year County Health Improvement Plan, we view this as a living document that will expand and grow over the next 4 years as we cultivate collaborations and build a stronger public health infrastructure. I am thrilled to have the opportunity to help guide its implementation and to strengthen and grow partnerships in service to its goals.

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ACKNOWLEDGMENTS

Over 250 people from a broad range of community and professional perspectives participated in key informant interviews and focus groups to help inform the County Health Improvement Plan (CHIP). People from all over the county offered their time, expertise, and experiences to help create a plan that is guided by communities' needs and strengths. We are so grateful to all who participated.

We give special thanks to the Advisory Committee for putting in several hours each month to help guide the CHIP process. Your expertise and connections within the community were invaluable to the creation of this plan. Your continued efforts and collaboration will be vital to the implementation of this CHIP and ultimately, to the impact that we have on the health of our communities.

Becca Boulos, Maine Public Health Association

Bridget O'Connor, The Opportunity Alliance

Emily Rines, United Way of Southern Maine

Jana Richards, The Opportunity Alliance

Kristine Jenkins, Maine CDC

Malory Shaughnessy, Alliance for Addiction and Mental Health Services, Maine

Nèlida Berke, City of Portland

Sarah McLaughlin, University of Southern Maine

Tina Harnett Pettingill, City of Portland

We would like to acknowledge some specific limitations of this CHIP. The period of time in which most of the community engagement was conducted coincided with a nationwide worker shortage and a large influx of people seeking asylum to Greater Portland. Many people and organizations that work with and for immigrants, refugees, and people seeking asylum were unable to participate in the CHIP discussions because they were attending to the humanitarian crisis. We relied on previous community health needs assessments completed by people who identify as immigrants as well as interviews with a few key community leaders to identify the needs and possible strategies. We acknowledge there is more community engagement that needs to be done and that goals and strategies related to the health of immigrants, refugees, and people seeking asylum will need to unfold as we continue to engage in meaningful ways with those communities and the organizations that work with them over the next several years.

Maine Cumberland County

ZOE MILLER STRATEGIES
PLANNING & ENGAGEMENT

This project was supported, in whole or in part, by federal award number 21.027 awarded to Cumberland County by the U.S. Department of the Treasury.

The plan document was written by Liz Blackwell-Moore, MPH, Director, Cumberland County Public Health Department and Zoe Miller, MPH, Principal, Zoe Miller Strategies.

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EXECUTIVE SUMMARY

This Community Health Improvement Plan (CHIP) presents a shared four-year vision for improving the health of people and communities in Cumberland County and reducing health inequities. Good health and well-being require much more than medical care and healthy choices. Our lives are shaped by the conditions in which we are born, grow, live, work, play and age—along with the distribution of power and the systems that determine our opportunities. The plan used a health equity lens and an intensely collaborative process to result in prioritizing strategies that address the social, structural, and political determinants of health and well-being.

Vision

We envision a Cumberland County where communities are thriving; residents, organizations, and local governments connect and invest in collaborative actions; and every person has an equitable opportunity to live a healthy life.

Goals

1. To create a countywide Community Health Improvement Plan that acts as a guiding document for public health organizations in Cumberland County over the next 4–5 years.

2. To identify the foundational public health programs and capabilities that belong within the Cumberland County Public Health Department.

Implementation

This plan provides a shared vision for catalyzing action on health equity in Cumberland County. Cumberland County will continue to work collaboratively with public health stakeholders to carry this vision forward through convening a CHIP Implementation Collaborative and developing an implementation plan with indicators to track progress on the goals and strategies.

Priority Issues & Strategies

Priority Area 1: Advancing Health Equity

Goal 1: Expand Use of Cross-Cutting Equity Approaches

Priority Area 2: Ensuring Healthy Minds & Bodies

Goal 2: Advance Behavioral Health

Goal 3: Support Access to Oral Health Care

Priority Area 3: Building Healthy Communities

Goal 4: Improve Transportation Access

Goal 5: Address Racism & Discrimination

Goal 6: Improve Housing Safety and Security

Goal 7: Expand Food Security

Goal 8: Advance Environmental Justice

PLANNING PROCESS

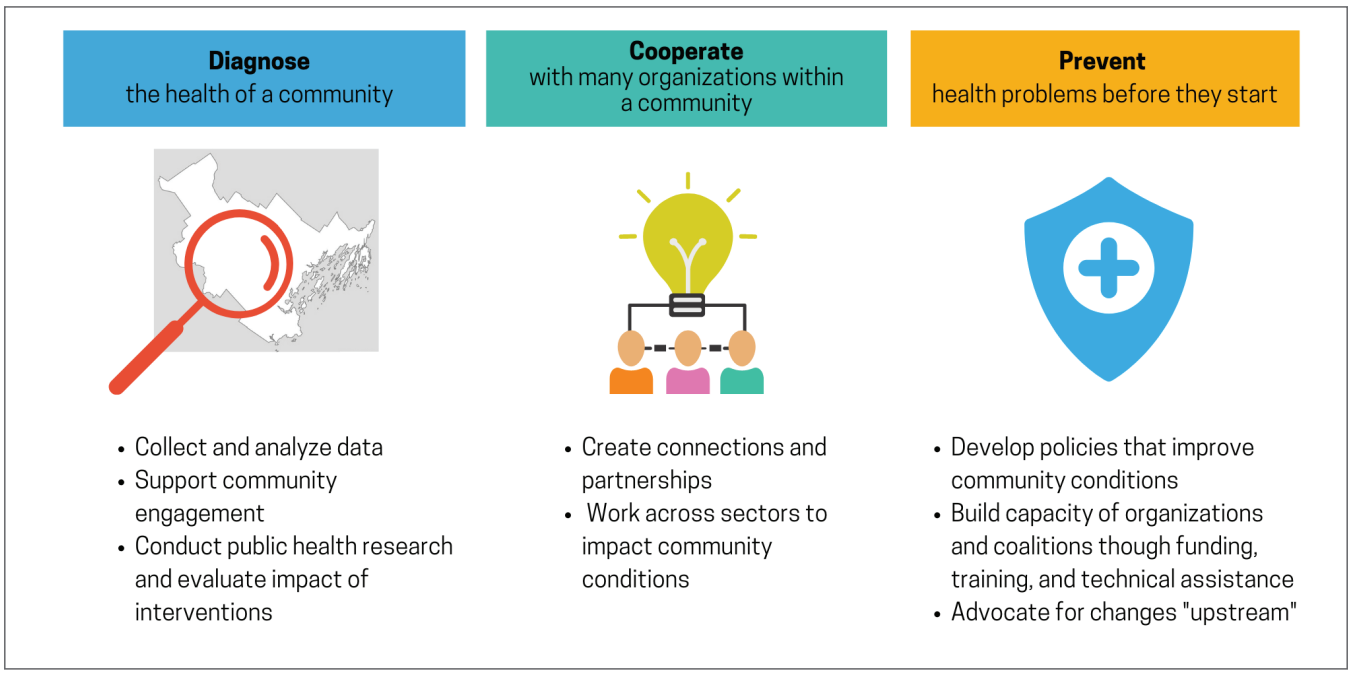
Introduction

Cumberland County, Maine is the most populous and racially and ethnically diverse county in the state. With roughly 305,000 residents, Cumberland County is home to 20 percent of the state's population. Greater Portland has many urban and suburban communities and is home to over 25,000 immigrants from countries around the world. Many towns in the western part of the county meet the USDA rural development classification of "rural." While the overall rate of poverty in Cumberland County is 8%, well below the state average of 11%, there are towns in Cumberland County with poverty rates as high as 16%. Though Cumberland County overall has relatively low levels of disease and a high life expectancy, there are great health inequities; with many groups, communities, and neighborhoods experiencing high rates of disease and early death.

What is the Role of Public Health?

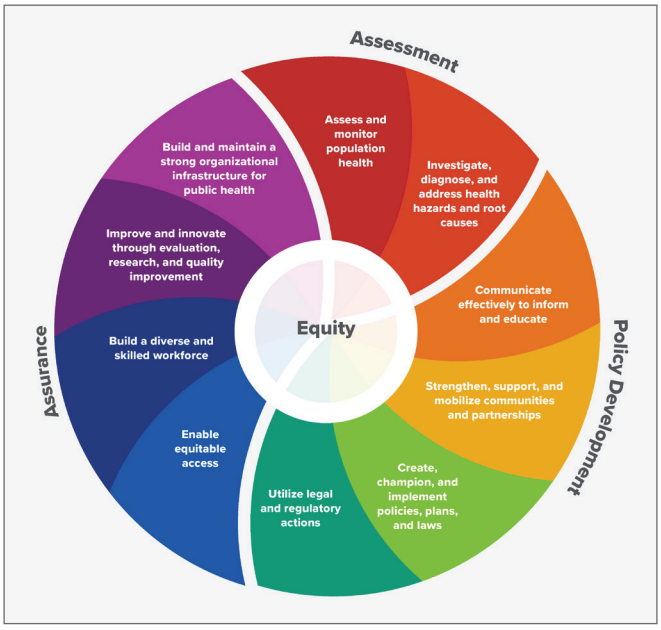
The health of each person is influenced by their individual genetics, but it is also influenced by decisions they make and the family and community conditions in which they live. Public health experts listen to and engage the community, collect and analyze data, and look for patterns in what is affecting the health of individuals and the whole community. They use science to diagnose problems and bring together everyone who can stop health threats before they start or reduce the harm once they have taken hold. Thus, public health is distinct from health care.

FIGURE 1 The Role of Public Health



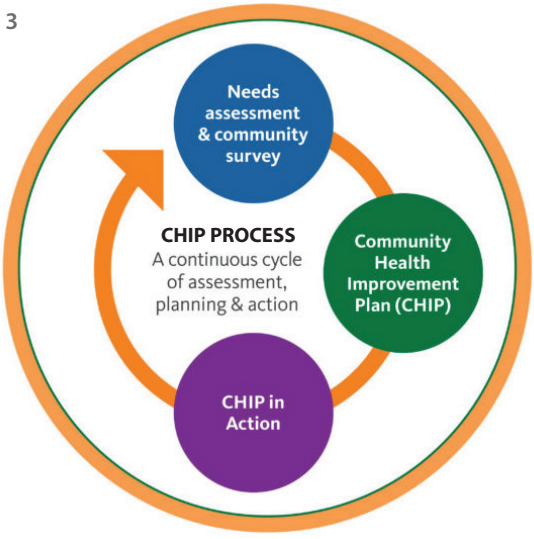
Despite being rich with mainstream health care service providers and programs addressing specific health problems, Cumberland County has a limited public health infrastructure to address inequities in a systematic way. To support a more comprehensive public health infrastructure, Cumberland County Government recently created a Public Health Department and hired its first director, tasked with creating and managing a public health department and developing a 4–5-year work plan.

FIGURE 2 The Ten Essential Services of Public Health



Public Health National Center for Innovations, 2020

FIGURE 3



What is a Community Health Improvement Plan?

The fundamental purpose of public health is defined by three core functions: assessment, policy development, and assurance. A Community Health Improvement Plan (CHIP) is a vehicle for combining these functions into an action plan. A CHIP is typically part of an ongoing community health improvement process that looks at the bigger picture of how the efforts of many public health organizations and initiatives contribute to community health improvement and deliver on the ten essential services of public health (see Figure 2). A CHIP ideally includes robust community engagement, collaborative leadership, and uses community health data to identify priority issues and determine the strategies and policies for implementation. There are numerous models and frameworks for conducting a CHIP. Most share the continuous cycle of assessment, planning, and action (see Figure 3). Ultimately, a CHIP serves as a catalyst for action, providing a working document that enables the community to direct capacity and resources in the most impactful way.

Goals

This County Health Improvement Plan (CHIP) presents a shared four-year vision for improving the health of people and communities in Cumberland County and reducing health inequities. Made possible through the investment of American Rescue Plan Act Funds, the CHIP is also focused on addressing the negative health impacts of the COVID-19 pandemic. The pandemic has exacerbated the existing health inequities for the County's historically underserved people, families, and communities. With leadership and convening from the Cumberland County Government's new Public Health Director, the planning process set out to accomplish two goals.

1. To create a countywide Community Health Improvement Plan that acts as a guiding document for public health organizations in Cumberland County over the next 4-5 years.

2. To identify the foundational public health programs and capabilities that belong within the Cumberland County Public Health Department.

Project Team

To ensure adequate capacity and technical support for the planning process, Cumberland County hired a consultant team through a competitive procurement process. The selected team, Zoe Miller Strategies includes Principal Zoe Miller, MPH and associate Rick Harbison, AICP. Zoe provided data analysis, community engagement, research, and writing of the plan, while Rick provided data visualization and graphic design. Together with Liz Blackwell-Moore, and MPH intern Sarah McLaughlin, they composed the Project Team.

Advisory Committee

To ensure the CHIP aligns with community needs and opportunities, Cumberland County partnered with groups, organizations, and individuals from across the county. In late 2021, the Cumberland County Public Health Department Director formed an Advisory Committee composed of public health professionals to steer the process. The Committee met monthly throughout the process to fulfill the following roles and responsibilities:

Health Improvement Planning in Cumberland County

Every three years, a Cumberland County Community Health Needs Assessment (CHNA) is completed by the Maine CDC in partnership with local hospitals as part of the Maine Shared CHNA. In 2017, the Cumberland District Public Health Council completed a two-year district health improvement plan to address a few of the key priorities identified in the 2016 CHNA. Since that time there have been various assessments conducted in the County, including the 2021 Cumberland County Health Profile, 2018 Minority Health Assessment, and The Health of Portland Report. While there are various assessments and available data, the County does not currently have a countywide health improvement plan to support more coordinated and connected public health efforts and to address widening health inequities.

- Create a vision and parameters for the CHIP.
- Identify the priority health concerns and goals to be addressed in the CHIP.
- Create criteria for choosing strategies.
- Identify organizations, community groups, and people with lived experience for engagement on possible strategies.
- Provide guidance on ways of engaging the different groups and ensuring a healing-centered approach to engagement.
- Review and provide feedback on drafts of the CHIP.

Advisory Committee members and their organizational affiliations are listed below.

Becca Boulos, MPH, PhD
Executive Director, Maine Public Health Association

Bridget O'Connor, MPP, PS-C
Public Health Manager, The Opportunity Alliance

Emily Rines, MPH
Director of Health, United Way of Southern Maine

Jana Richards, MSW
Healthy Lakes Program Manager, The Opportunity Alliance

Kristine Jenkins, MA
Cumberland District Liaison, Maine CDC

Malory Shaughnessy, MPPM
Executive Director, Alliance for Addiction and Mental Health Services, Maine

Nèlida Berke, MPH
Minority Health Program Coordinator, City of Portland

Sarah McLaughlin, MPH candidate
University of Southern Maine

Tina Harnett Pettingill, MPH
Public Health Director/ Deputy Director of HHS, City of Portland

Vision

The CHIP Advisory Committee worked together to draft a vision for the plan that articulates the focus on systems level solutions and the lens of health equity shaping the plan. The resulting vision was adopted by consensus.

We envision a Cumberland County where communities are thriving; residents, organizations, and local governments connect and invest in collaborative actions; and every person has an equitable opportunity to live a healthy life.

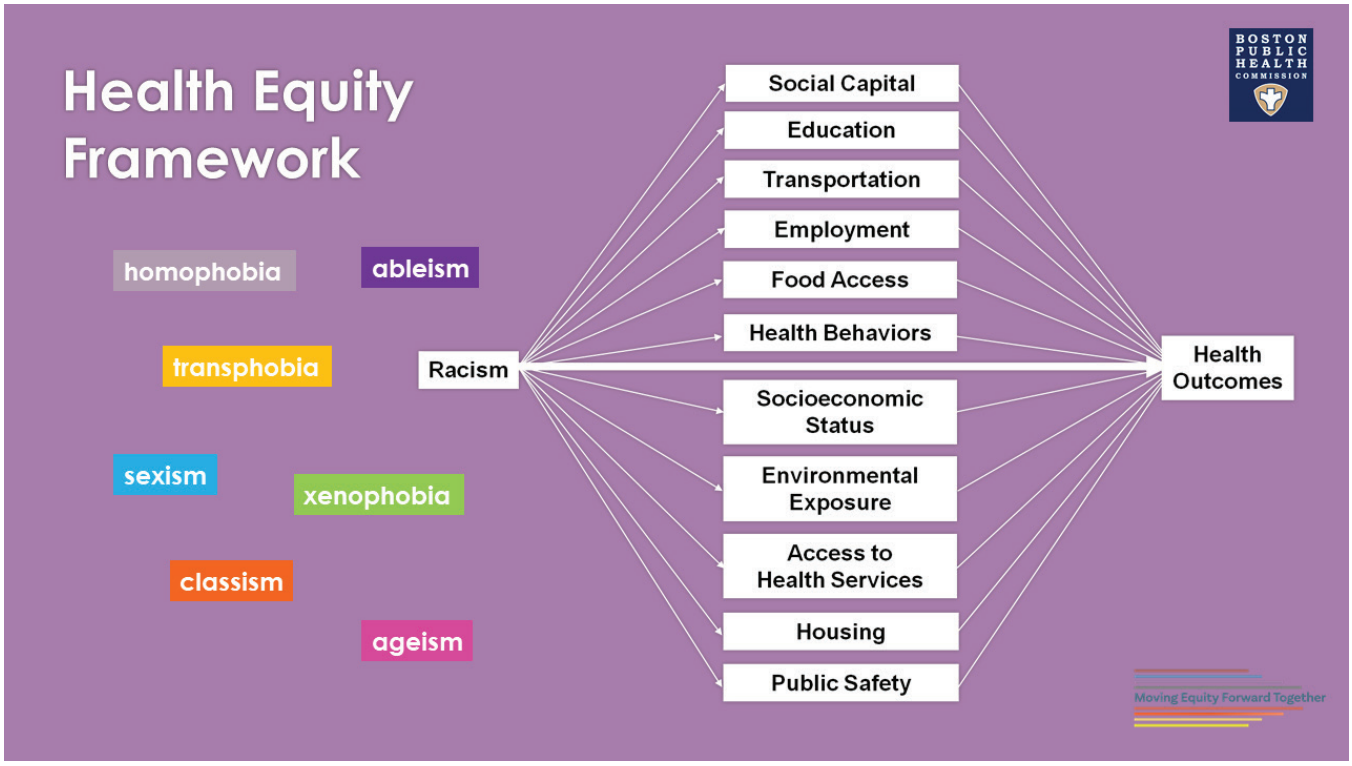
FRAMEWORKS THAT GUIDED THE PROCESS

Cumberland County relied on several established and emerging public health frameworks to guide its approach to developing the CHIP.

A Health Equity Lens

Good health and well-being require much more than medical care and healthy choices. Our lives are shaped by the conditions in which we are born, grow, live, work, play and age—along with the distribution of power and the systems that determine our opportunities. Using a health equity lens means intentionally looking for ways to address the social, structural, and political determinants of health and well-being. It means paying attention to the impact of discrimination, stereotyping, and prejudice based on sex, gender, age, race, ethnicity, low economic status, or disability. Discriminatory practices are often embedded in institutional and systems processes, leading to some groups being under-represented in decision-making at all levels or underserved. Using a health equity lens also means considering the potential positive and negative impacts of policy and programs on under-represented and/or underserved groups and getting input from the population of focus.

FIGURE 4

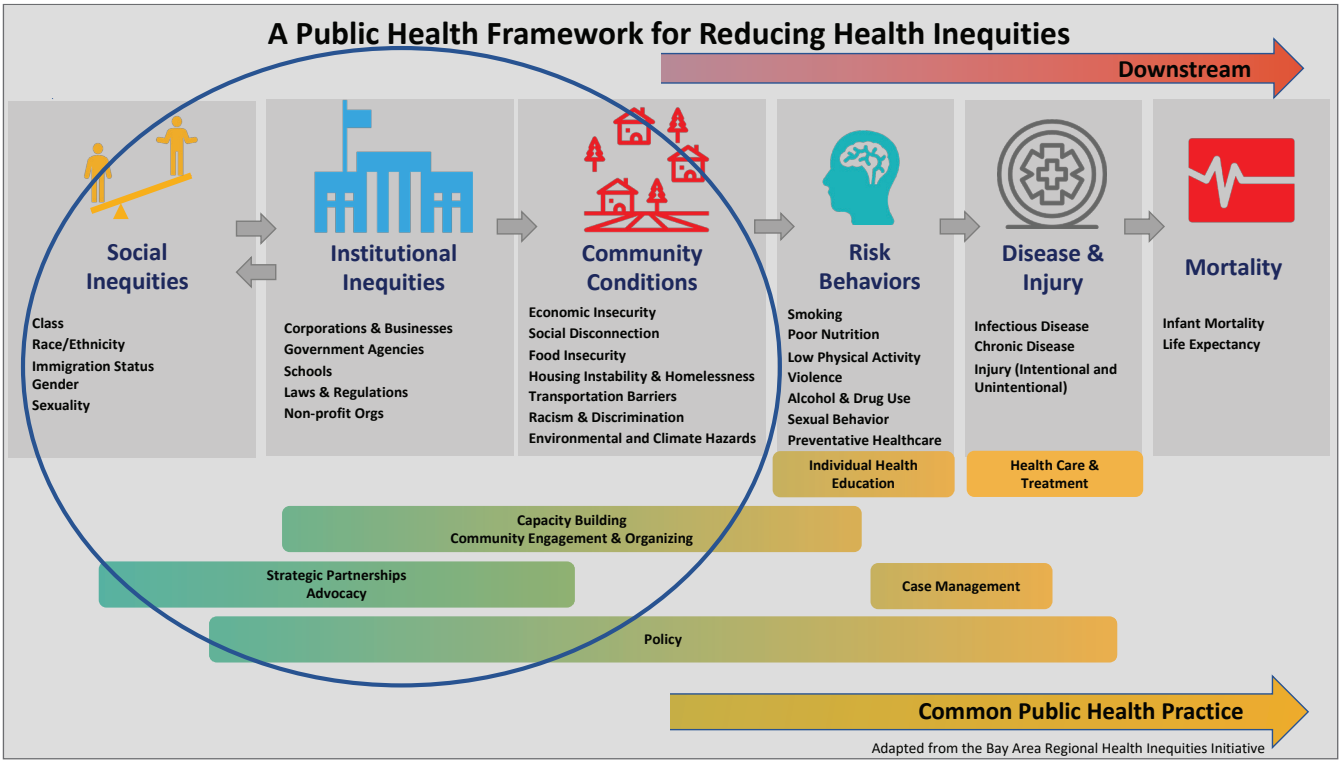


A Public Health Framework for Reducing Health Inequities

Inspired by the work of California's Bay Area Regional Health Inequities Initiative (BARHII), the Cumberland County Project Team developed an adapted conceptual framework. This framework (Figure 5) illustrates the connection between social inequalities and health and focuses attention on measures which have not characteristically been within the scope of a public health department's data analysis. This framework focuses its efforts upstream, specifically in the areas within the circle on the diagram. The CHIP Advisory Committee adopted the framework for use in communication and decision-making.

> Using a health equity lens means intentionally looking for ways to address the social, structural, and political determinants of health and well-being.

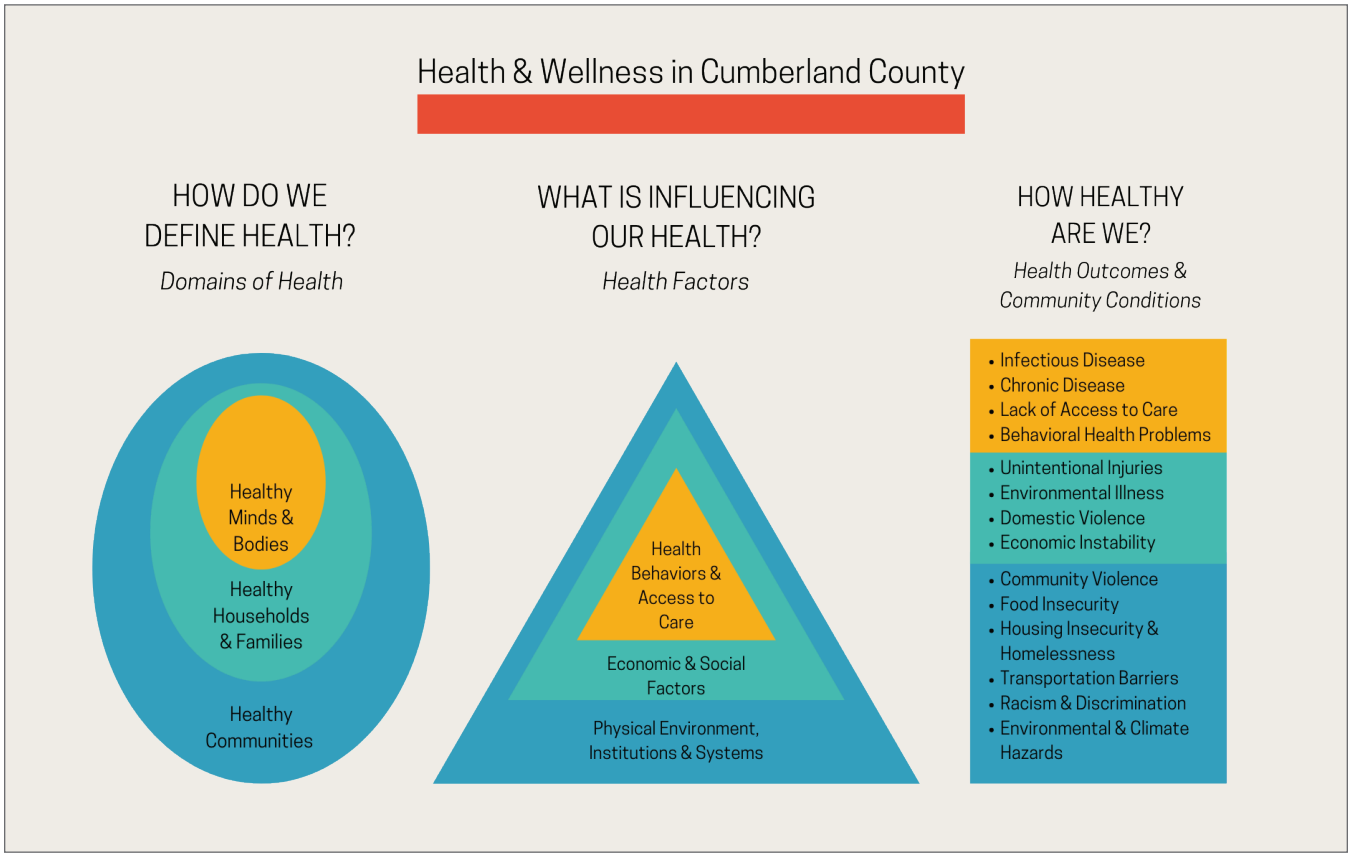
FIGURE 5



Cumberland County CHIP Framework

Early in the process, the Cumberland County Project Team worked with the Advisory Committee to develop a structure for conceptualizing health and wellness in Cumberland County. Inspired by the approach the City of Portland used for their CHIP, the Cumberland County CHIP framework (see Figure 6) focuses on three interrelated domains of health and wellness. These are shown on the far left in the ovals. The ovals are nested within one another to communicate how the domains are interconnected. For each domain, the team outlined factors that are "influencing our health" (shown in the middle in nested triangles). Finally, the framework includes specific health problems and community conditions (shown on the right in rectangles) which are used to measure "how healthy we are." This framework was used to organize data being analyzed for health outcomes and community conditions. Later, it was used to frame conversations with the many stakeholders engaged through interviews and group sessions.

FIGURE 6 The Cumberland County CHIP Framework



Data Collection and Analysis

Once the Advisory Committee agreed on the health problems and community conditions to be explored, the project team began collecting and analyzing data on county-level magnitude and severity, along with disproportionate negative impacts. For most of the problems, county-level data was available, and, in some cases, municipality-level data was also available. Indicators for disproportionate impact were more challenging to find, especially for adults. This is due in part to small sample sizes, which make disaggregation by race, ethnicity, and other demographic factors impossible. This is also because many sources do not collect information about race/ethnicity, gender, sexuality, disability, education, or income. State-level disaggregated data was frequently used as a proxy.

When possible, disaggregated data collected by individual organizations at the county or town level was used. The Maine CDC's Integrated Youth Health Survey, which includes extensive demographic questions, was a helpful source for identifying health disparities. Other sources consulted included the Behavioral Risk Factor Surveillance System, the American Community Survey, and the Maine Health Data Organization All Claims Database. The Maine CDC's Community Health needs Assessment Data Portal was used extensively as a "one-stop shop" for a range of data sources. Once collected, data was organized into the technical document showing overall magnitude in Cumberland County and groups that experience health inequities. Figure 7 shows many of the indicators for which data was reviewed.

FIGURE 7 Problems and Community Conditions for Data Collection

Healthy Minds & Bodies

Infectious Disease	Chronic Disease	Lack of Access to Care	Behavioral Health Problems
STIs HIV & Hep C TB COVID	Diabetes Heart Disease Cancer	Lack of access to Primary Care Lack of Oral Health Care Lack of Prenatal Care Lack of Access to Behavioral healthcare	Substance Use Disorder Mental Health Problems

Healthy Households & Families

Unintentional Injuries	Household Toxics	Domestic and Sexual Violence	Economic Instability
Falls Motor Vehicle Deaths Poisonings	Lead Radon Pests Mold	Intimate Partner Violence Sexual Violence	Poverty Unemployment Educational Attainment Livable Wage Jobs Childcare

Healthy Communities

Social Disconnection	Food Insecurity	Housing Insecurity & Homelessness	Transportation Barriers	Racism & Discrimination	Environmental & Climate Hazards
Social Isolation Adverse Childhood Experiences (ACEs) Lack of Safe & Inclusive Public Spaces	Hunger Access to Healthy Foods Access to locally grown foods	Cost Burdened Households Homelessness	Car Access Transit Access Bike/Ped Injuries & Deaths Walkability	Bullying Hate Crimes Lending Discrimination Disproportionate Arrest/Incarceration Stigma of SUD and MH	Air, Water & Soil Pollution Tick-born Illnesses Flooding PFAS Chemical Exposure Extreme Weather Days

Community Engagement

The engagement process for this CHIP was designed to collect a broad range of perspectives about health and health inequities in Cumberland County. The process also served as an opportunity to build awareness of the new County Public Health Department. A health equity lens informed both the questions that were asked, and the people who were engaged. Through individual and group conversations, community members shared information about current efforts to address health problems, gaps in efforts, and needed strategies to address those gaps. The process was especially focused on engaging organizations and individuals working with populations with the most barriers to health and who experience health inequities, including immigrants and refugees, people who are Black, Indigenous or people of color (BIPOC), LGBTQ+ people, older adults, people with substance use disorder and mental health problems, people with disabilities, and others. More than 250 individuals provided their input and feedback. A list of the individuals, groups, and organizations engaged is included on the next page. It's important to acknowledge that because of the CHIP timeline and the intensive work many organizations and community members were putting into supporting people seeking asylum arriving in Greater Portland, we were unable to hold a focus group specifically focused on the health of immigrants, refugees, and people seeking asylum. There were several key-informant interviews and previous surveys related to the topic which informed many aspects of the CHIP, but we also included a priority strategy 1e. "Foster cross-sector partnerships and collaboration to reduce barriers and improve health among people who are immigrants, refugees and/or seeking asylum" to acknowledge the need for public health entities to invest more time and capacity to fostering those relationships and ensuring immigrant and refugee stakeholders continue to inform the strategies.

Key Informant Interviews

The Public Health Director conducted interviews with 40+ community stakeholders from a broad range of sectors and perspectives. Each interviewee was asked to recommend other stakeholders to be engaged, including coalitions or organizations who should be included in a focus group. Questions explored during these conversations included the following:

- What health issues or community conditions that impact health are you most concerned about for the group of people you or your organization work with and for?
- What data do you wish you had?
- How are the health problems being addressed now? (Interventions and actors)
- Is there a duplication of efforts or lack of coordination? How well do you believe the current interventions are working?
- What do you think is missing in terms of interventions and why do you think they are not happening?

The engagement process for this CHIP was designed to collect a broad range of perspectives about health and health inequities in Cumberland County.

Interview participants included:

Alex Hughes	City of Portland
Anna Bullett	The Opportunity Alliance
Anne-Marie Brown	United Way of Southern Maine
Becca Matusovich	Children's Oral Health Network of Maine
Ben Strick	Spurwink
Bethany Campbell	United Way of Southern Maine
Bridget Rauscher	City of Portland
Cullen Ryan	Community Housing of Maine
Damon Yakovleff	Cumberland County Soil and Water Conservation District
Deqa Dhalac	Gateway Community Services, Mayor of South Portland
Emily Rines	United Way of Greater Portland
Erica King	Catherine Cutler Institute
Faye Luppi	Cumberland County Government
Gia Drew	Equality Maine
Heather Biggar	Through These Doors
Jana Richards	The Opportunity Alliance
Jen Annis	Through These Doors
Jen Daigle	Greater Portland Health
Jess Maurer	Maine Council on Aging
Jim Hanna	Cumberland County Food Security Council
Julie Rosenbach	City of South Portland
Katlyn Blackstone	Southern Maine Agency on Aging
Kristin Styles	Cumberland County
Louise Marsden	The Opportunity Alliance
Milena Germon	Maine Immigrant Access Network
Matthew Jarrell	United Way of Southern Maine
Mufalo Chitam	Maine Immigrant Rights Coalition
Nelida Burke	City of Portland
Patrick MacRoy	Defend our Health
Pedro Vasquez	Chair of the Human Rights Commission in South Portland
Quinn Gormley	MaineTransNet
Regina Phillips	Cross Cultural Community Services
Roberto Rodriguez	Cultivating Community; City Councilor in Portland
Sanaa Abduljabbar	Maine Immigrant Access Network
Sarah Lewis	Maine Immigrant Access Network
Sarah Mills-Knapp	Greater Portland Council of Governments
Sergio Cahueque	Defend our Health
Terry Swain	Alpha One
Tom Doherty	Milestone Recovery

Focus Groups

The Project Team conducted 14 interactive focus group sessions that engaged 170+ stakeholders. Many of these were held during a standing meeting time of an existing coalition, initiative, or organization. A handful of the sessions were scheduled specifically for the CHIP to convene stakeholders around a topic that does not have a standing coalition. Each session focused on the health problem or problems of concern to that group. In some cases, it was one topic only (i.e., food security) while for others the discussion covered several health problems. Each session featured a discussion of barriers, missing efforts, and the desired role of public health. Sessions held include:

- Cumberland County Coalition for Substance Use Prevention
- Cumberland County Food Security Council
- Cumberland County Substance Use Disorder Prevention Providers Group
- Cumberland County Violence Intervention Partnership
- Cumberland County Homelessness Hub Advisory Group
- Lake Region Collective Action Network
- Opportunity Alliance's Family Services Division staff
- Oral Health Equity Coalition
- Partners for Thriving Youth Advisory Group
- School Superintendents
- Stakeholders working on LGBTQ+ health
- Town/City Managers—two sessions by region
- Transportation & Community Network

Strategy Identification

Community input played a prominent role in strategy selection. Using an equity lens in strategy selection meant placing the priority on responding to local needs and culturally responsive approaches. Stakeholder responses to these three key prompts were especially influential and helpful in identifying the initial list of strategies:

- Level of coordination
- Barriers in the way of current efforts
- Interventions that are missing and needed

Once the initial list of strategies was created, the project team consulted public health literature to identify available evidence to support the effectiveness of each intervention. Available evidence became one of several factors used for prioritization as we sought to intentionally balance community wisdom with institutional knowledge. The project team summarized the findings for each proposed strategy. They are included in the technical document in Appendix A.

Prioritization

The prioritization process was multi-stepped and aimed to be inclusive, participatory, and data driven. Prioritizing questions were developed by the project team and refined by the Advisory Committee (see Figure 9). These questions shaped the data analysis and community engagement. The information gathered using these questions was summarized and utilized by the Advisory Committee in each phase of prioritization. A summary of each phase is provided here.

FIGURE 8 Prioritizing Questions

- What is the magnitude and/or the severity of the problem?
- What communities have disproportionate negative impacts?

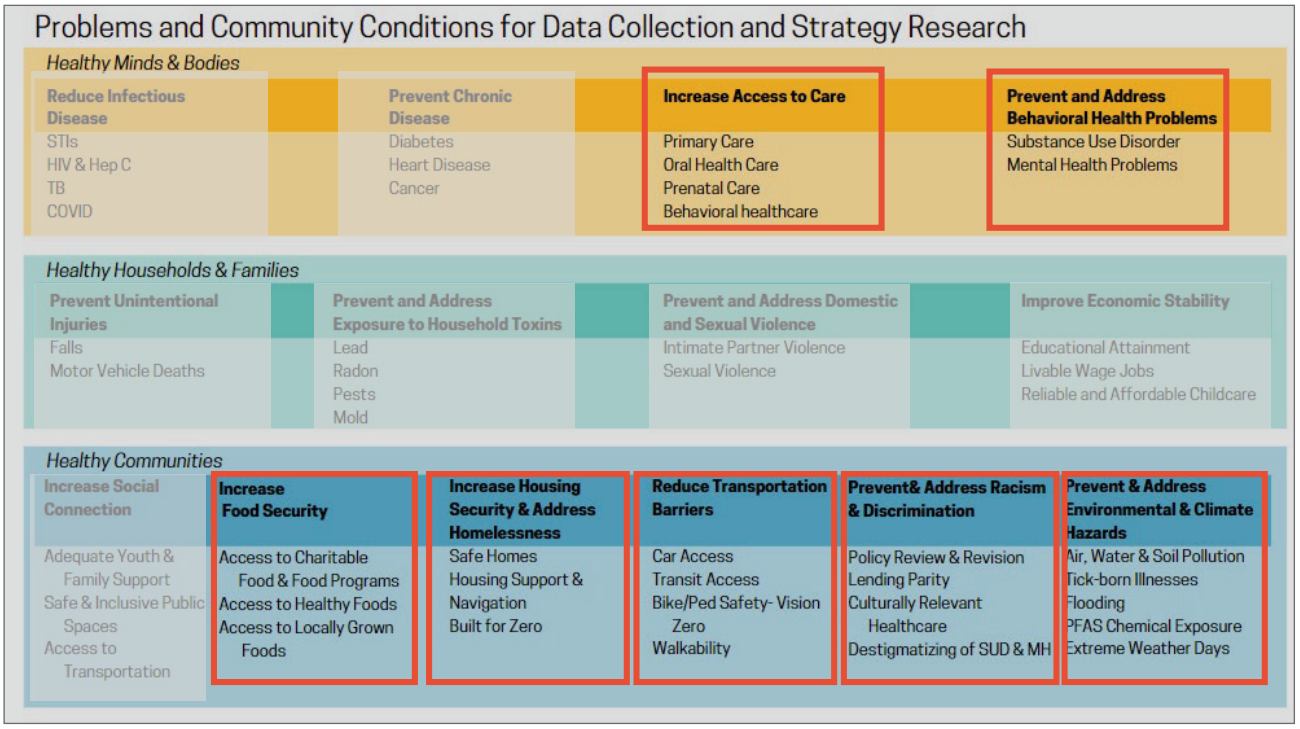
- How is this problem being addressed now? (Interventions and actors)
- What is the evidence (including culturally relevant practices) that interventions can change the problem?
- Are there opportunities to intervene at the prevention level?
- What is the community capacity to act?
- What is the community willingness to act?
- Which sector is best suited to address this problem?
- What is the availability of resources to address the problem?
- Is this is root cause of other problems?
- What are the challenges or barriers to addressing the problem?

- How important is this problem to your community?
- What strategies to address the problem best fit the culture of your community?
- Does addressing the problem align with an organization or community's current priorities?
- What is the community's ability to contribute finances and resources to address the problem?
- Who is best capable and has the capacity to implement the strategies?

Phase 1—Narrowing the Scope:
The first phase of prioritization involved narrowing the number of topics using findings from the data analysis and key informant interviews. Equipped with data on health inequities and information about barriers and missing interventions, the Advisory Committee decided to remove four health problems from further consideration. See faded sections in Figure 9. The rationale is that infectious disease and chronic disease are downstream indicators that can be used to measure impact for structural approaches, such as Goal 5: Address Racism and Discrimination. Likewise, unintentional injuries can be an indicator of success for improving safe and accessible transportation and preventing and addressing household toxins can be a strategy for increasing housing stability. The Advisory Committee removed Economic Stability since there are other organizations already leading efforts and there were challenges assessing a clear leadership role for public health at this moment. Increase Social Connection was removed because there is limited data yet many of the strategies fall under behavioral health.

Phase 2—Ranking Issues and Strategies:
The second phase of prioritization focused on ranking the issues and strategies in order. The ranking used a scoring rubric containing six prompts based on the prioritizing questions. Each strategy was assessed for a score of up to 100 points. In addition to the Advisory Committee, scorers included Courtney Kennedy of Good Shepherd Food Bank—representing the Cumberland District Public Health Coordinating Council—and Melinda Thomas, a Community Health Worker with the New England Arab American Organization, representing the Lakes Region area of the County. After all strategies received an initial ranking, the group met to discuss. As a result of the meeting, a few strategies were added to address gaps or reworded to provide better clarity. The Priority Issues and Strategies that follow reflect the outcome of this collaborative process.

FIGURE 9



PRIORITY ISSUES & STRATEGIES

Priority Area 1: Advancing Health Equity

Goal 1: Expand Use of Cross-Cutting Equity Approaches

Problem Statement

Improving health equity requires multisector and multifaceted approaches with a focus on policy and systems that center lived experience. Discrimination, racism, fear of institutions, lack of transportation, and language barriers inhibit access to care and basic needs for rural people with low-incomes, people who identify as LGBTQ+, people who are immigrants, refugees, or seeking asylum and people who are Black, Indigenous, or people of color (BIPOC). Too often, the communities most affected by health inequities are not appropriately included in the decisions about how public health entities will respond to these health inequities. Likewise, timely data that tracks differences by key demographics such as age, race, ethnicity, and LGBTQ+ status is needed to help practitioners better understand how new and ongoing policies and programs affect historically underrepresented groups of people.

People who identify as BIPOC, LGBTQ+ and/or have low socioeconomic status have the largest barriers to accessing consistent and regular healthcare.

BIPOC and LGBTQ+ students are **10–15%** less likely than average to have seen a dentist in the past year.[1]

13% of Cumberland County residents needed to travel 30 miles or more to be seen by a primary care provider.[3]

42% of trans and gender diverse Mainers reported feeling they needed to "teach a primary care provider about trans people" to receive care.[2]

[1] Maine Integrated Youth Health Survey, 2019
[2] Maine TransNet survey, 2021
[3] Cumberland County Maine Shared Health Needs Assessment, 2022

Priority Strategies

- **1a** Ensure the use of an equity lens and culturally relevant approaches across priority interventions.
- **1b** Build capacity within the County to collect and analyze data, and communicate findings, especially disaggregated data.
- **1c** Support service provider organizations in improving language access supports.
- **1d** Foster cross-sector partnerships and collaboration to reduce barriers and improve health among people who identify as LGBTQ+.
- **1e** Expand and build the capacity of cross-sector partnerships and collaborations to reduce barriers and improve health among people who are immigrants, refugees, and/or seeking asylum.
- **1f** Increase the availability of Community Health Workers (CHWs)—especially in rural areas.

Public Health can play a key role in reducing health inequities by collecting and sharing disaggregated data and convening or participating in cross-sector collaborations focused on specific populations with the highest barriers to health.

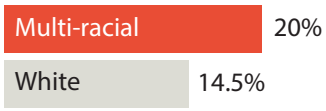
Goal 2: Advance Behavioral Health

Problem Statement

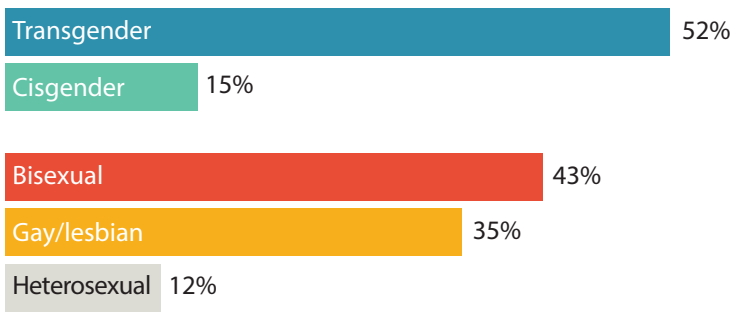
Substance use disorders and mental health problems continue to be a top health issue of concern in Cumberland County. Overdoses continue to occur at alarmingly high rates and lack of coordination is hampering efforts that are needed to respond to and prevent them. Schools and law enforcement agencies are increasingly the front line for prevention and early intervention around mental health and substance misuse, but a lack of consistent community support and internal capacity means efforts are limited. Parents and schools often lack the capacity and support to help young people who are struggling with behavioral health concerns.

People who identify as LGBTQ+ face high levels of social stigma, discrimination, violence, and harassment. Black, Indigenous, and people of color are more likely than white people to experience discrimination, live in poverty, and be housing insecure. These experiences put people who are LGBTQ+ and BIPOC at greater risk for mental health problems and substance use disorders.

Cumberland County high schoolers who seriously considered suicide:[4]



Maine high schoolers who seriously considered suicide:[4]



115 people died of overdoses in Cumberland County in 2021.[5]

[4] Maine Integrated Youth Health Survey, 2019
[5] Maine Attorney General's Office, 2022

Priority Strategies

2a Support efforts to embed Coordinated Behavioral Health Liaisons and Youth Liaisons into law enforcement agencies.

2b Convene a coordinated countywide overdose/harm reduction response.

2c Support comprehensive school-based interventions including Behavioral Health Coordinators at the school district or county level, support for Gay-Straight-Trans Alliances and Black Student Unions, restorative policies and practices, stronger connections between schools and municipalities on their joint approaches to address behavioral health problems.

Schools and law enforcement agencies are ideal settings for embedded clinicians that can fill gaps in needed services and link people to outside care. Across the board, more detox, substance use treatment and prevention, and mental health services are needed —especially options that are culturally and linguistically relevant for young people, LGBTQ+ people, and people who are immigrants.

Additional Strategies

2d Encourage the development of more culturally relevant detox and treatment (focused on LGBTQ+, BIPOC, and survivors of domestic and sexual violence).

2e Support expanded access to behavioral health support by survivors of domestic and sexual violence.

2f Support behavioral health organizations to build a culture of staff wellness to prevent secondary trauma. (CE-CERT)

Goal 3: Support Access to Oral Health Care

Problem Statement

National data shows that access to good oral health is connected to a person's income, race, and ethnicity, thus creating inequities. The prevalence of treated and untreated tooth decay among children of color is considerably higher and their access to preventive care tends to be lower than white children. In Maine, children with dental insurance through MaineCare have limited provider options. Thus, children with MaineCare are less likely to receive preventative care. There are also high rates of children with no dental insurance coverage, many of whom are likely to go without preventative dental care.

Dental disease is the most widespread, chronic, infectious disease in children. Nationally, barriers to dental care for families with low incomes and/or those who identify as BIPOC have been well documented.

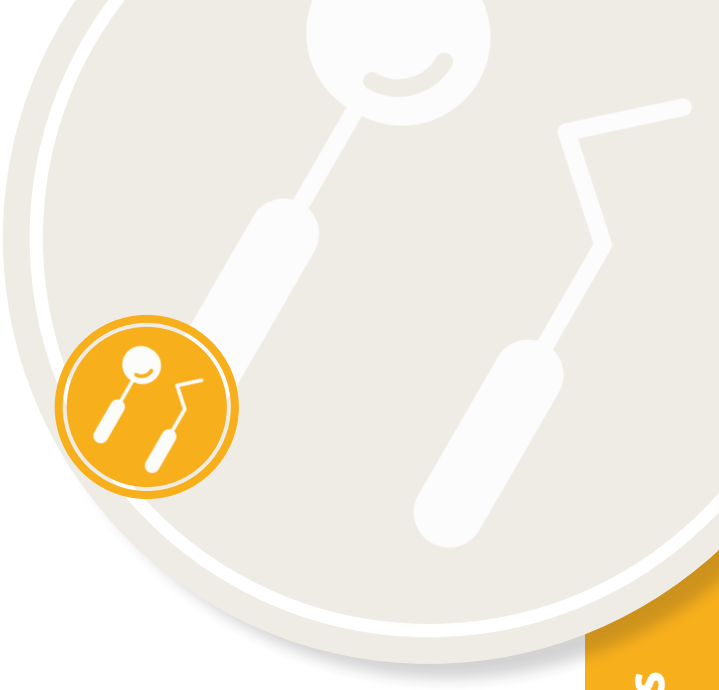
22,000 children in Cumberland County have no dental insurance coverage (out of 56,000 children 1–18).[6]

LGBTQ+ and BIPOC students in Maine were **10–15%** less likely than average to have seen a dentist in the past year.[7]

Cumberland County children who had at least one preventive dental claim in 2020:[6]

Received preventive care:

[6] Maine Health Data Organization, All Payer Claims Database, 2020
[7] Maine Integrated Youth Health Survey, 2019



Priority Strategies

- **3a** Provide an infrastructure for building out a more robust delivery system for children's preventive oral healthcare in preschools and schools.
- **3b** Support efforts to improve culturally responsive oral healthcare for children and adults.
- **3c** Increase the number of Community Health Workers able to support oral healthcare.

Capacity for coordination across Cumberland County's oral healthcare delivery system is the key ingredient to addressing the health inequities in access to care. Likewise, addressing barriers to care experienced by people with low incomes, people who identify as BIPOC, and LGBTQ+ people requires a commitment to culturally responsive care.

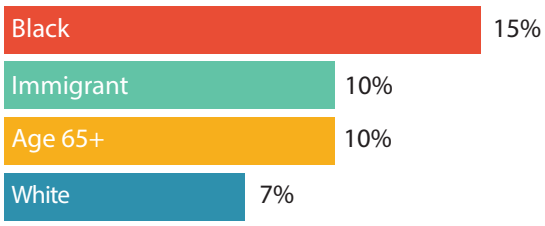
Goal 4: Improve Transportation Access

Problem Statement

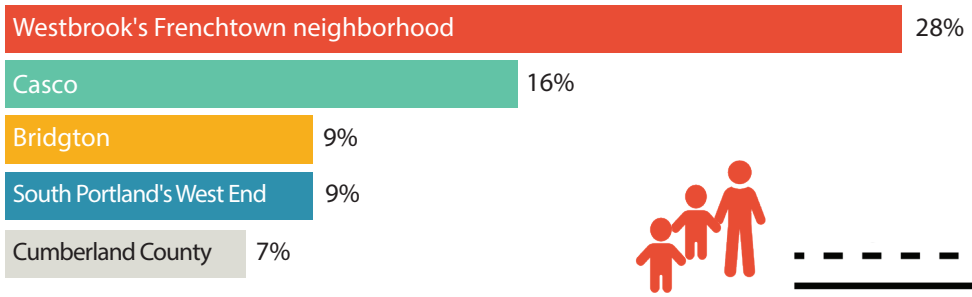
Transportation is key to accessing such opportunities as employment, education, and health care. But not everyone in Cumberland County has equal access to high-quality, reliable, and safe transportation. In Cumberland County, transportation to healthcare was named as a big challenge for many people who live in rural areas, are low-income and/or immigrants. Lack of transportation was named as a barrier to employment for people with disabilities, for youth to access out-of-school-time opportunities, and for people experiencing homelessness in getting to food stores and looking for housing.

Households without vehicle access are more likely to include people of color, immigrants, and older adults as the data on this page illustrates. In some rural parts of the state, the percentages are as high as 18%.[8] Vehicle cost is a major factor with the average car ownership cost estimated at $10,728 a year, or $894 a month.[9]

Maine households with no vehicle access: [10]



Cumberland County households with no vehicle access: [10]



[8] National Equity Atlas
[9] AAA
[10] U.S. Census

Priority Strategies

- **4a** Establish financing mechanism to fund fare-free transit for low-income communities.
- **4b** Build capacity of Mobility Management initiatives to improve transportation access.

With leadership from the Greater Portland Council of Governments, the Maine Council on Aging, and the Moving Maine Network, these strategies are being pursued in Cumberland County. The CHIP Advisory Committee will look for ways to leverage public health support for these efforts.

Additional Strategies

- **4c** Support the adoption of Complete Streets policies countywide.
- **4d** Elevate the public health voice in educating decision-makers about the health, equity, and economic benefits of bike and pedestrian friendly communities.
- **4e** Adopt Vision Zero programs at county and municipal level.
- **4f** Support the development of community volunteer driver programs.
- **4g** Increase bicycle and pedestrian funding for the region.

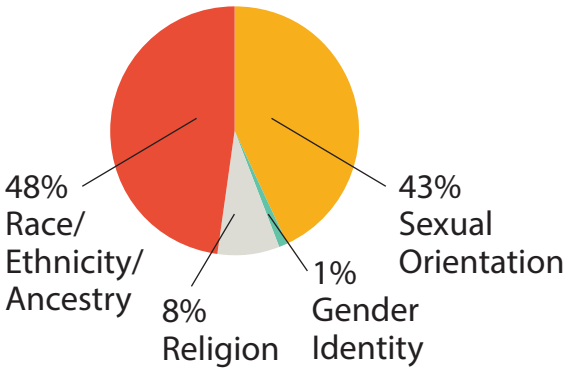
Goal 5: Address Racism & Discrimination

Problem Statement

A growing body of research shows that centuries of racism has had a profound and negative impact on communities of color. The impact is pervasive and has created inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions are key drivers of health inequities within communities of color. Similar health inequities are experienced by LGBTQ+ people, immigrants and refugees, and Indigenous communities.

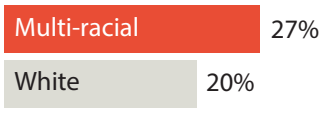
The impact of racism and discrimination on health outcomes is well documented. As a result of structural barriers and trauma, BIPOC and LGBTQ+ people experience higher rates of poor health and disease.[11]

84 hate crimes were reported in Maine in 2020.[12] They were categorized by "bias motivation" as follows:

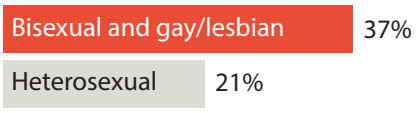


Black people made up **3%** of Maine's population yet **11%** of people arrested in Maine in 2020.[13]

Cumberland County high schoolers who were bullied at school:[14]



Maine high schoolers who were bullied at school:[14]



[11] U.S. CDC
[12] U.S. Department of Justice
[13] Maine Department of Public Safety
[14] Maine Integrated Youth Health Survey, 2019

Priority Strategies

5a Build capacity for maintaining and expanding Gay-Straight-Trans Alliances (GSTA) and Black Student Unions in middle and high schools.

5b Offer participatory grantmaking/funding opportunities for BIPOC communities.

5c Develop cross-sector collaborations and build capacity of municipalities and organizations to address systemic racism.

The CHIP Advisory Committee recognizes that there is significant work for public health entities to do in meaningfully engaging people impacted by racism and discrimination in decision-making about interventions. The strategies here—and under Goal 1—reflect an effort to start where there is momentum and continue building capacity.

Priority Area 3: Building Healthy Communities

Goal 6: Improve Housing Safety and Security

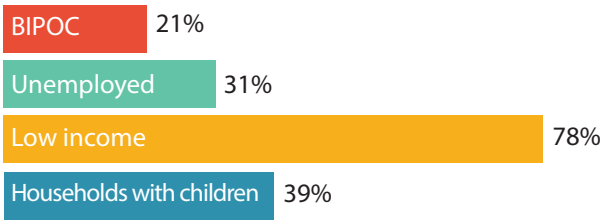
Problem Statement

Even before the housing affordability crisis in Cumberland County began to make news headlines, low-income renters and homeowners, especially in rural parts of the county, were facing challenges. Eviction moratoriums triggered by the COVID pandemic rescued many from eviction but with their expiration, eviction rates are increasing. Low-income renters and rural homeowners are more likely to experience health challenges related to household toxins including mold, lead, and contaminated well water. Yet financial support for mitigation is very limited and renters need support for approaching landlords about toxins without fear of losing their housing.

Housing insecurity and homelessness are at an all-time crisis level in Cumberland County. Demand for housing has surged as buyers move into the area from other states and an unprecedented number of asylum seekers continue to arrive from Central African countries.

One in 10 Mainers were behind on their rent as of August 2022.[15]

They were:

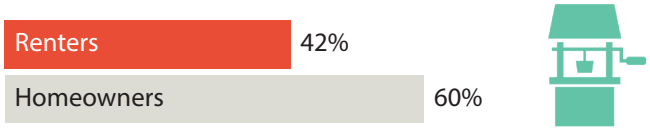


46% of Maine renters spend more than 30% on housing.

55% of BIPOC women renters spend more than 30% on housing.[16]

One in three Cumberland County homes get water from a well.[17]

Cumberland County wells tested for arsenic:[18]



[15] Rent Debt Dashboard—uses U.S. Census Pulse Survey
[16] U.S. Census, 2019
[17] Behavioral Risk Factor Surveillance System, 2015–17. Obtained from Maine tracking Network Environmental Public Health Data portal.
[18] State of Maine Health and Environmental Testing Laboratory.

Priority Strategies

- **6a** Advocate for increasing availability of vouchers and aligning General Assistance payments with market housing rates.
- **6b** Build capacity of "housing diversion" programs (eviction prevention), especially in rural areas of the county.
- **6c** Build capacity for testing and remediation of housing related toxins, especially within rental housing (soil, wells, lead, mold).

Additional Strategies

- **6d** Expand housing navigation and supportive housing programs.
- **6e** Provide education for decision-makers on best practices approaches to addressing the problem.
- **6f** Expand support for renters to work with landlords on addressing household toxins.
- **6g** Expand programs to support low-income households to empty and/or replace septic tanks/leach fields.

Though Cumberland County has a robust network of stakeholders working to address housing insecurity and homelessness, more efforts are needed to keep people from losing their housing because of eviction or unsafe conditions.

Priority Area 3: Building Healthy Communities

Goal 7: Expand Food Security

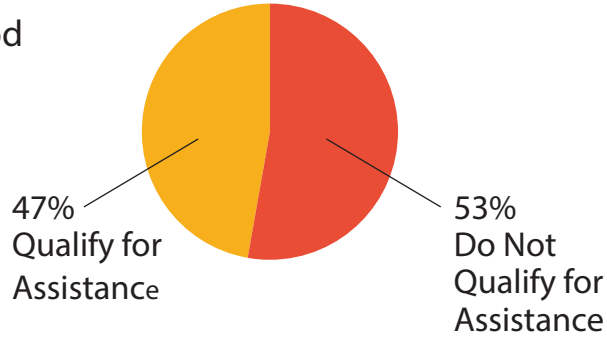
Problem Statement

While the problem of food insecurity in Cumberland County is being addressed by many organizations and community initiatives, stakeholders agree that there continue to be gaps. A significant number of people who qualify for federal benefits are not accessing them. Within the charitable food system—including school-based pantries—more local and culturally important foods are needed. In the bigger picture, a deeper understanding food insecurity and solutions is needed among elected and appointed officials, especially at the municipal level.

Households receiving supplementary food benefits in Southern Maine are more likely to include people over 60 or children under 18, a person who is disabled, and/or people who identify as BIPOC.[19]

One in ten Cumberland County adults and one in six children are food insecure.[20]

Cumberland County adults who are food insecure:



[19] USDA Food and Nutrition Service SNAP household profile Maine Congressional District 1
[20] Feeding America Map the Meal Gap

Priority Strategies

7a Advocate for expanded access to Electronic Benefits Transfer (EBT)-based programs—including SNAP (Supplemental Nutrition Assistance Program) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—through improved program convenience, benefit flexibilities, and coordination to ensure eligible people are enrolled.

7b Increase culturally important foods in charitable food distribution and in school nutrition programs.

7c Increase opportunities and support for food and agricultural education in schools.

7d Create messaging that helps the public and leaders understand food insecurity as a PH problem not an individual problem.

7e Support efforts to improve local food procurement in school nutrition programs.

To ensure that all eligible people can access available benefits, more support is needed to help people navigate complicated eligibility guidelines and interpreting the rules of what can be purchased. The CHIP Advisory Committee will look for ways to partner with and leverage the existing work of the Cumberland County Food Security Council to advance many of these strategies.

Additional Strategies

7f Build capacity of local food production, especially infrastructure for local food processing.

Goal 8: Advance Environmental Justice

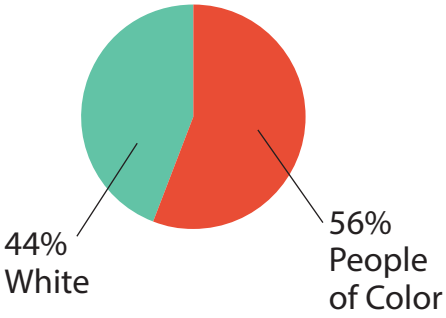
Problem Statement

While efforts to respond and adapt to climate change have been ramping up in Cumberland County, there remains gaps in meaningfully engaging "frontline communities"—those most vulnerable to climate change impacts—in looking at solutions and climate policies critically and asking questions about benefits and burdens. Likewise, the region lacks capacity for collaboration between grassroots environmental justice groups and the government entities making policy decisions.

Race and socioeconomic status are the most significant predictors of whether a person in the U.S. lives near contaminated air, water and soil.

As Cumberland County responds and adapts to climate change, engaging and listening to "frontline communities"—those most vulnerable to climate change impacts—will be deeply important. This requires building capacity for bridging between the government sector and individuals and grassroots groups. It also means considering the root causes of inequity and acknowledging racism and socioeconomic status as key factors influencing climate vulnerability and exposure to hazardous air, water, and soil.

People living near toxic waste sites in the U.S.:[21]



People with low incomes and people of color are **2–5 times** more likely to be exposed to endocrine-disrupting chemicals—which are linked to diabetes and other health conditions.[22]

Priority Strategies

8a Foster cross-sector collaboration and build capacity for assessing and increasing environmental justice initiatives.

[21] U.S. Environmental Protection Agency
[22] American Diabetes Association

IMPLEMENTATION AND NEXT STEPS

This plan provides a shared vision for catalyzing action on health equity in Cumberland County. Cumberland County will continue to work collaboratively with public health stakeholders to carry this vision forward.

Implement Collaboratively

Cumberland County will convene a CHIP Implementation Collaborative with membership from the sectors and organizations that are key to advancing the goals.

Measure Progress

Cumberland County will work with partners to develop an implementation plan with indicators to track progress on the goals and strategies. A public-facing dashboard will be developed to allow for a shared understanding of the progress being made.

Build Capacity

The Cumberland County Public Health Department will use this plan to inform its continued development. The strategies outlined under Goal 1: Expand Use of Cross-Cutting Equity Approaches are foundational to the Department—and to building health equity across the county. Available resources and emerging opportunities will determine the extent to which goals can be met. Cumberland County will seek to act as a catalyst and conduit for leveraging additional resources that can be directed to the most appropriate and culturally relevant entities to do the work.

Appendix A:
Assessment & Possible Strategies, Partners, Funding

Maine Cumberland County

ZOE MILLER STRATEGIES
PLANNING & ENGAGEMENT

CONTENTS

ADVANCING HEALTH EQUITY

GOAL 1: EXPAND USE OF CROSS-CUTTING EQUITY APPROACHES

LACK OF ACCESS TO PRIMARY CARE – DATA		
Overall Magnitude in Cumberland County		
Uninsured 5.8% (2015-2019)*	Adults who had a regular physical in the past year 73% (2015-2017)**	Adults with any mental illness who DID NOT receive treatment in the last year*** 40.4%
Groups that have disproportionate negative outcomes		
Group	Uninsured*	Physical in the past year**
State	*8%*	*71.3%*
Male	9%	66.3%
American Indian/Alaskan Native	17.7%	
More than one race	11.6%	
Black/African American	11.7%	
Income: less than $25k	11.2%	
Income: $25-50k	11.3%	
Income: $50-75k	9.5%	
Education: Less than HS	13.7%	
Education: HS Diploma	11.6%	

- Men are more likely to be uninsured and less likely to have had a physical.
- People of color, people with lower incomes, and those with less education are more likely to be uninsured.
- People who identify as American Indian/Alaskan Native two times as likely to be uninsured compared to the state average.
- There is a lack of local data on access to health care for people who are trans and gender diverse but nationally, a third of trans people who saw a healthcare provider had negative experiences related to being trans and 23% did not see a doctor when they needed to because of fear of being mistreated. (US Trans Survey, 2015)
- In a 2021 MaineTransNet survey of 151 people who identify as trans and gender diverse in Cumberland County 68% saw a primary care provider in the past year (including tele-health visits). 42% said that had to teach a primary care provider about trans people to receive care.

Percentages shown in the chart are confirmed to be statistically significant differences.

Source	Limitations
*American Community Survey. **Behavioral Risk Factor Surveillance System. ***National Survey on Drug Use and Health. All obtained from Maine Interactive Health Data Portal.	Disaggregated data not available at county level. Demographics do not include LGBTQ+ status.

LACK OF ACCESS TO PRIMARY CARE – CURRENT EFFORTS AND PERCEIVED GAPS

How is this problem being addressed now and what is the geography of current efforts?

Trans Health: Much of the work regarding Gender Affirming healthcare is happening in Greater Portland. Current efforts to improve access to care for people who are transgender and gender diverse include:

- Gender affirming project at Greater Portland Health (GPH)
- Gender Clinic at Maine Medical Center (MMC)
- Provider education through Maine Trans Net offers provider education
- MaineHealth is undertaking DEI work and better data collection.

Immigrant Health: There is no single point of coordination for immigrant health but many people working on improving access and culturally relevant care:

- GPH, MaineHealth, and Mercy provide primary and specialty care (no maternal health at GPH).
- Portland Public Health (PPH) has maternal health nurses working with immigrants.
- Catholic Charities of Maine does some level of health screening and support for refugees and some other immigrants.
- Various Immigrant led organizations have CHWs supporting immigrants to get access to care.

Rural Health: The Opportunity Alliance (TOA) convenes stakeholders focused on behavioral health in Bridgton area and employs a Community Health Worker (CHW).

Coordination currently happening (low, medium, high)

- LGBTQ+: Low. Some level of coordination on trans health care at the state level around cancer. Stakeholders agree that more coordination and connection between organizations and with public health is needed.
- Immigrant: Medium
- Rural: Medium

What barriers are in the way of current efforts:

Trans Health:

- Only a small number of primary care providers will care for trans patients. Most want to refer a specialized provider. Too few mental health providers trained in culturally relevant care for LGBTQ+ people.
- Limited capacity and staffing of LGBTQ+ organizations to write grants, provide trainings, etc.

Immigrant Health:

- Between responding to COVID and its economic impacts and the large volume of asylum-seekers being supported, immigrant-led organizations have little capacity for long range planning.

Rural Health: Lack of mobile and/or local outreach by countywide agencies.

Interventions that are missing and needed:

- More education of healthcare providers on culturally relevant care is needed. Discrimination is frequently reported related to Emergency and Crisis care.
- Transportation to healthcare is still a big challenge for many people who are low-income and/or immigrants.
- Addressing high deductibles for people who are low-income, people who need SUD treatment, and people who are undocumented.
- More CHWs to support people to get the healthcare they need are needed in rural areas and for underserved communities.

Is this a root cause of another problem? Is it the result of other root causes?

Lack of access to healthcare is both.

Engagement still needed:	Groups and individuals engaged:
Group conversation to reach consensus on strategies for immigrant health	– Group conversation on LGBTQ+ health with Gia Drew, Equality Maine; Quinn Gormley, MaineTransNet; and Jen Daigle, GPH – Nelida Berke, City of Portland Minority Health Program – Dani Egeberg, Maine Cancer Foundation – Regina Phillips, Cross Cultural Community Services (CCCS) – Sarah Lewis, Sanaa Abduljabbar, Malena Germon, Maine Access Immigrant Network (MAIN) – Melinda Thomas, New England Arab American Organization (NEAAO) and TOA Jana Richards, TOA

CROSS-CUTTING APPROACHES - CURRENT EFFORTS AND PERCEIVED GAPS
Key Findings
– Inadequate language access services is a major concern across health topics. – Lack of local presence of public health programs in rural communities is leading to a transportation burden and lower access. – Mistrust and fear of institutions is inhibiting access to care and basic needs for rural folks with low-incomes, LGBTQ+ people, and people from racial and ethnic minority communities.
Coordination currently happening (low, medium, high)
– Low
Interventions that are missing and needed:
– Build capacity within CBOs to expand culturally relevant activities within a bunch of topics – Improve language access across all public health topics – Move toward co-creation of programs and activities – Funds to support strategic planning for community-based organizations. (Could be modeled off of Health Equity Capacity RFP from state) – More CHWs in rural areas

EXPAND USE OF CROSS-CUTTING EQUITY APPROACHES – POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	**Evidence for Strategies**	**Possible Partners**	**Possible Funding**	**Proposed Geography**
Foster cross sector partnerships and collaboration to reduce barriers and improve health among people who identify as LGBTQ+.	Numerous studies have found that those who access gender-affirming medical care during adolescence had lower odds of suicidality and other adverse mental health outcomes when compared with those who are unable to access such care. However, medical intervention alone is not sufficient in addressing mental health disparities for trans and gender diverse youth. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789433	Equality Maine; MaineTransNet; greater Portland Health	Maine CDC Office of Population Health Equity	Countywide
Expand and build the capacity of cross sector partnerships and collaboration to reduce barriers and improve health among people who are immigrants, refugees and/or seeking asylum.	NA	Pious Ali, Cross Cultural Community Services, Maine Access Immigrant Network	Maine CDC Office of Population Health Equity, Robert Wood Johnson Foundation	Countywide
Increase the availability of CHWs – especially in rural areas	CHWs are effective liaisons between healthcare providers and community members, especially in rural communities. They have historically helped address healthcare gaps and improved health outcomes for underserved populations. One study shows that many transgender patients avoid seeking medical care due to fear of discrimination. Finding a provider who is knowledgeable, gender-affirming, and covered by insurance is often a difficult and stressful experience. CHWs, or health navigators, can provide beneficial psychosocial support, help these patients navigate the healthcare system, and connect them with known reliable providers. A study completed in 2019 reported that both healthcare providers and community members alike support the usage of CHWs to help improve the relationship between the transgender community and health systems to improve gender-affirming care in rural areas. – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8366980/ (trans health specific) – https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf (CHWs in rural areas) https://www.mdpi.com/1660-4601/18/23/12700/htm	NEAAO, TOA, Tri-County Mental Health Services, Maine Primary Care Association, Southern Maine Agency on Aging	HRSA, Maine CDC CHW projects	Sebago Lakes Region, Gorham, Gray-New Gloucester, and other areas as appropriate

Ensure the use of an equity lens and culturally relevant approaches across priority interventions.	NA			Countywide
Build capacity within the County to collect and analyze data, and communicate findings, especially disaggregated data.	NA	City of Portland, Maine CDC	Maine CDC Office of Population Health Equity	Countywide
Support service provider organizations in improving language access supports.	NA	Maine Immigrant Rights' Coalition	Maine CDC Office of Population Health Equity	Countywide

ENSURING HEALTHY MINDS & BODIES

GOAL 2: ADVANCE BEHAVIORAL HEALTH

BEHAVIORAL HEALTH – SUBSTANCE MISUSE AND USE DISORDERS - DATA			
Overall Magnitude in Cumberland County			
ADULTS	Chronic heavy drinking 9.9% (2015-2017)*	Current smoking – every day or some days 11.4% (2015-2017)*	
YOUTH	Used alcohol in the past 30 days 24.1% (2019)**	Used marijuana in the past 30 days 23.9% (2019)**	Used e-cigarettes in the past 30 days 29.2% (2019)**
YOUTH & YOUNG ADULTS	Disconnected Youth 6.6% (2015-2019)***		
ALL AGES	Overdose deaths per 100,000 population 32.5 (115 total – 2019)****		

Groups that have disproportionate negative outcomes		
Group	Adults current smoking (2015-17)	High schoolers who used alcohol (past 30 days - 2019)
State	17.3%	22.9%
Hispanic	-	28.5%
American-Indian/AN	38.7%	44%
More than one race	30%	-
Native Hawaiian/Pacific Islander	-	44.8%
Black/AA	-	-
Bisexual	33.5%	27%
Gay/Lesbian	-	-
Sexuality – not sure	-	-
Trans (yes)	Not available	-
Trans (not sure)	Not available	-
MaineCare	37.5%	Not available
Uninsured	38.7%	Not available
Education: Less than HS	35.2%	Not applicable
Education: HS diploma	24.8%	Not applicable

- LGBTQ+ youth and adults in Maine experience more violence, more family and social disconnection, and more housing and job insecurity than cisgendered hetero peers. They also have much higher rates of substance misuse.
- Maine high schoolers who identify as American-Indian/Alaskan Native or Native Hawaiian/Pacific Islander were twice as likely to have tried alcohol as the average.
- Cumberland County had about 2,200 "Disconnected Young People" ages 16-24 before the pandemic. They are not connected to education or employment. *Percentages shown here are confirmed to be statistically significant differences.*

Source

*Behavioral Risk Factor Surveillance System. **Maine Integrated Youth Health Survey. *** Measure of America https://www.measureofamerica.org/DYinteractive/#County . ****Maine Office of Chief Medical Officer

Limitations

Disaggregated data for adults not available at county level.

BEHAVIORAL HEALTH – SUBSTANCE MISUSE AND USE DISORDER - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
Prevention -SUPS at City of Portland, Casco Bay CAN, TOA -DFC in SoPo, Westbrook, and Windham/Raymond -Partners for Thriving Youth at TOA Harm Reduction City of Portland and Amistad Syringe Service Programs	Enforcement -SUD and BH Liaisons in many Police Departments -Some Departments use OD Map -Re-entry supports at Cumberland County Jail through COSSAP/Building Bridges grants Treatment -Growing number of Tx options for people, mostly in Greater Portland area. Recovery -Robust Portland Recovery Community Center and peer supports at Amistad -Certified recovery housing growing with more MAT
Coordination currently happening (low, medium, high)	
– Cumberland County Coalition on Substance Use Prevention (CCCSUP) – Prevention organizations meet bimonthly. – Lack of coordination outside of Portland on the overdose & harm reduction side. There is coordination in Portland but not really outside of that. – No regular meetings for Behavioral Health Liaisons to help coordinate responses.	
Interventions that are missing and needed:	
– More detox and treatment – especially that is culturally responsive to various groups of people. – Need more BIPOC individuals at all tables – Lack of capacity at schools to deal with behavioral health in general.	– Limited capacity of LGBTQ+ organizations tasked with supporting LGBTQ+ young people. – Over use of punishment to address behavior issues in schools. – Not all Police Departments using OD Map or using it regularly. – Young people who have been incarcerated need more housing support, workforce development.
Is this a root cause of another problem? Is it the result of other root causes?	
It is a result of other root causes (like social disconnection, racism/discrimination, economic stability, etc) but is also a root cause of housing stability, economic stability, and exacerbates domestic and sexual violence.	

Engagement still needed:	Groups and individuals engaged:	
Behavioral Health Liaisons	-County Prevention Group (8 people) -Bridget Rauscher, City of Portland -Jana Richards, TOA -Erica King, Cutler Institute -Faye Luppi, VIP at County	-Oliver Bradeen, Milestone -PTY Advisory Committee -Superintendents -CCCSUP group (32 people from prevention through recovery organizations)

BEHAVIORAL HEALTH – MENTAL HEALTH PROBLEMS - DATA			
Overall Magnitude in Cumberland County			
ADULTS	Current depression symptoms 8.5% (2015-2017)**		
YOUTH	HS students who felt sad or hopeless for last two weeks 30% (2019)***	HS and MS students who seriously considered suicide 18.4% (2019)***	Suicide deaths per 100,000 population 12.5 (2015-2019)*

Groups that have disproportionate negative outcomes		
Group	HS students who felt sad or hopeless for last 2 weeks (2019)	Adults with current depression (2015-17)
State	32.1%	9.6%
Female	38.4%	-
Hispanic	39.5%	16%
American-Indian/AN	39.7%	21.6%
More than one race	42%	21.7%
Black/AA	-	-
Bisexual	66.6%	22.3%
Gay/Lesbian	57.6%	13.9%
Sexuality – not sure	41.8%	Not available
Trans (yes)	71.7%	Not available
Trans (not sure)	64.6%	Not available

- LGBTQ+ youth and adults in Maine experience more violence, more family and social disconnection, and more housing and job insecurity than cisgendered hetero peers. They also have much higher rates of mental health problems and suicide attempts and deaths.
- Female-identifying high schoolers are more likely to report being depressed.
- Rates of depression among adults and high students who identify as Hispanic, multiracial, and American-Indian/Alaskan Native are 8-10% higher than the average. For adults, this is double.

Percentages shown in the chart are confirmed to be statistically significant differences.

Source
* Maine CDC Vital Records. **BRFSS. ***MIYHS
Limitations
Disaggregated data for adults not available at county level.

BEHAVIORAL HEALTH – MENTAL HEALTH PROBLEMS - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
Prevention – Partners for Thriving Youth Program at The Opportunity Alliance (TOA) partnering with schools on youth mental health. – Mental Health First Aid training offered in schools for youth and in community for adults (culturally relevant version for youth). – Black Student Unions and more affinity support/empowerment groups happening in many schools. Harm Reduction and Peer Support – Mobile crisis services and suicide- specific services for young people at TOA – Living Room at Spurwink – - Amistad daytime drop in	Enforcement Substance Use Disorder and Behavioral Health SUD and BH Liaisons in many Police Departments Treatment – School Based Health Centers in Portland, Westbrook, and South Portland offering mental health services to young people in school. – Many non-profits providing treatment. Spurwink, Gateway, and Greater Portland Health (GPH) offering specifically culturally relevant MH services to immigrants. GPH working on becoming center of excellence for LGBTQ+ health Recovery – Amistad and Spurwink are training and hiring people with lived experience with mental illness as peer support workers.
Coordination currently happening (low, medium, high)	
– Medium	
Interventions that are missing and needed:	
– Too few youth providers meaning long waitlists, and time waiting in ER for inpatient and outpatient beds. – No support system for Gay Straight Trans Alliances (GSTA) in schools since GLSEN went under. – More Social Emotional Learning work needed at the high school level and more restorative and clinical responses to behavior issues that are sometimes caused by mental health issues. – Better pay is needed for the workforce – MaineCare reimbursements remain too low for organizations to keep or expand services. – Need more culturally relevant services for young people and adults who are immigrants.	
Is this a root cause of another problem? Is it the result of other root causes?	
It is a result of other root causes (like social disconnection, racism/discrimination, economic stability, etc) but is also a root cause of things like housing instability, economic instability and social disconnection.	
Groups and individuals engaged:	
– Gia Drew, Equality Maine – Ben Strick, Spurwink – Brian Townshend, Amistad – Sanaa Abduljabbar, MAIN	– Inza Outarra, Catholic Charities – Elizabeth Jackson, GPH – Malory Shaughnessy, Alliance – Partners for Thriving Youth Advisory Committee (8 people) – 14 Superintendents

ADVANCE BEHAVIORAL HEALTH - POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	Evidence for Strategies	Possible Partners	Possible Funding	Proposed Geography
Support efforts to embed Coordinated Behavioral Health Liaisons and Youth Liaisons embedded in law enforcement agencies.	A study by Stanford University evaluating a "community response" approach to mental health and substance abuse crises shows a significant decrease in police-reported criminal offenses with the use of this model. – https://www.science.org/doi/10.1126/sciadv.abm2106	TOA, Police, Spurwink, Preble St, Muskie	Partnerships for Thriving Youth (PTY), ARPA, SAMHSA, DOJ	Countywide
Convene a coordinated countywide overdose/harm reduction response.	For overdose/harm-reduction strategies to be productive, coordinated, active participation of community partners is necessary. An article by The Pennsylvania Opioid Overdose Reduction Technical Assistance Center (TAC) describes the importance of community stakeholders (particularly public health & public safety officials) building partnerships and working together openly to address the issues at hand. Upon collecting and assessing needed data, coalitions can effectively work together to build strategic evidence-based plans to reduce harm. – https://tupjournals.temple.edu/index.php/commonwealth/article/view/192 (TAC article) – https://academic.oup.com/painmedicine/article/12/suppl_2/S77/1918825?login=true (project lazarus referenced in TAC) article) – https://journals.sagepub.com/doi/full/10.1177/00333549211012407 (data to inform community response) This case study shows how an integrated response program would work. https://www.nsc.org/getmedia/acda2bfa-69ad-4ff4-bacf-13334c7e0bc5/cak-madison-dane-case-study.pdf		NACCHO, Maine CDC, ARPA, SAMHSA	Countywide
Support comprehensive school-based interventions including Behavioral Health Coordinators at the school district or county level, support for Gay-Straight-Trans Alliances and Black Student Unions, restorative policies and practices, stronger connections between schools and municipalities on their joint approaches to address behavioral health problems.	Studies show that established GSTAs are associated with decreased odds of discrimination and/or bullying based on sexual orientation. Supporting these programs has the potential to impact school climate and reduce discrimination, creating a stronger feeling of safety for students in schools, and may also help reduce risk of suicidal behavior. – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193472/pdf/nihms804490.pdf – http://healthcareguild.com/presentations_files/Goodenow%20-%20School%20Support%20Groups%20and%20Safety%20for%20Sexual%20Minorities.pdf – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4716826/ –		PTY, Maine CDC, SAMHSA, Thrive 2027	Countywide

	Research shows that restorative practices are effective and lead to a reduction in disciplinary inequities (ie. suspension for African American or economically disadvantaged students), improved relationships between teachers and students, and overall improved student behavior. – https://dm0gz550769cd.cloudfront.net/shape/5d/5d-75418901f4ed14b77d94193032dc8e.pdf – https://srm.policyresearchinc.org/img/resources/Restorative_Practices_Brief-461672.pdf			
Encourage the development of more culturally relevant detox and treatment (focused on LGBTQ+, people of color, and survivors of domestic and sexual violence).	Research and literature reviews display that culturally competent addiction treatment programs experience more engagement from participants in therapeutic activities, improved relationships with therapists, and higher retention rates of patients. These improved factors all lead to improved treatment outcomes. – https://ses.library.usyd.edu.au/bitstream/handle/2123/22022/Gainsbury%20Cultural%20competence%20in%20the%20treatment%20of%20addictions%202016.pdf;jsessionid=687AE1F6E8F-6C87DF0D5F2D8C6352767?sequence=1 Culturally relevant and responsive care allows patients to acknowledge the impact of culture, acculturation, and discrimination on physical and mental health. SAMHSA resource on the importance of culturally competent treatment and care and recommendations on how to achieve it: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf	Maine Association of Recovery Residences	NACCHO, Maine CDC, ARPA, SAMHSA	County-wide
Support expanded access to behavioral health support by survivors of domestic and sexual violence.			Office of Violence Against Women, SAMHSA, Maine Office of Behavioral Health	County-wide
Support behavioral health organizations to build a culture of staff wellness to prevent secondary trauma. (CECERT)	The National Center on Domestic Violence, Trauma & Mental Health's 2016 report "Promising Practices and Model Programs: Trauma-Informed Approaches to Working with Survivors of Domestic and Sexual Violence and Other Trauma" outlines ample evidence for using trauma-informed practices. This includes centering the perspectives of trauma survivors, creating a service environment that is responsive to the effects of trauma, and a commitment to staff well-being. http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2016/01/NCDVTMH_PromisingPracticesReport_2015.pdf		Maine OBH, SAMHSA	

ENSURING HEALTHY MINDS & BODIES

GOAL 3: SUPPORT ACCESS TO ORAL HEALTH CARE

LACK OF ORAL HEALTH CARE – DATA		
Overall Magnitude in Cumberland County		
Insured children with at least one preventative dental visit in past year 67.6% (2019)*		Children covered by dental insurance 56% (2019)*
Groups that have disproportionate negative outcomes		
Group	Insured children with at least one preventative visit	High School students who saw a dentist in the past 12 months (2019)**
State	*62.6%*	*83.4%*
MaineCare insurance	57%	NA
0-2 year olds	43.1%	NA
19-20 year olds	46.7	NA
Hispanic	NA	74%
American Indian or AN	NA	69.7%
Black/African-American	NA	66.1%
Asian	NA	74.2%
Bisexual	NA	77.1
Sexuality - not sure	NA	75.7%
Trans (yes)	NA	70.8%
Trans (not sure)	NA	68.3%
– Of children who had at least one preventative dental claim in 2020, 40% had MaineCare and 60% had commercial insurance – About 22,000 children in Cumberland County have no dental insurance coverage (out of 56,000 children 1-18) – Among Maine high schoolers, LGBTQ+ and students of color were 10-15% less likely than average to have seen a dentist in the past year. *Percentages shown above are confirmed to be statistically significant differences.*		
Source		
*Maine Health Data Organization, All Payer Claims Database. **Maine Integrated Youth Health Survey.		
Limitations		
*No disaggregated data at the county level. Demographics include only age and MaineCare vs. private insurance.		

LACK OF ORAL HEALTH CARE - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
– MaineCare covers youth oral health, and the recent expansion means adults with MaineCare will have dental benefits. – Several stakeholders are delivering school-based oral health services: Mainely Teeth mobile unit, GPH, and UNE Dental Clinics – From the First Tooth (a program of MaineHealth) educates parents and providers on best practices in oral health	
Coordination currently happening (low, medium, high)	
– Cross Cultural Community Services is convening stakeholders around the needs of immigrants and people of color. – Children's Oral Health Network of Maine (COHNM) is providing some convening.	
What barriers are in the way of current efforts:	
– No infrastructure for ensuring accountability in the implementation of preventative oral health at schools – Lack of support for families that need higher levels of care	– Very few dentists accept MaineCare. – Lack of cultural competence among many dental providers for working with low-income people and immigrants. – Inadequate language access services.
Interventions that are missing and needed:	
– Culturally relevant dental care for youth and adults who are low-income and/or immigrants – Dental care for people who are incarcerated, in foster care, experiencing homelessness – Language access services – Virtual Dental Home model: youth are seen at mobile, FQHC, or school clinic for regular appt and then to dentist when needed.	
Is this a root cause of another problem? Is it the result of other root causes?	
Yes. This is a root cause of chronic diseases as well as economic stability and behavioral health.	
Engagement still needed:	Groups and individuals engaged:
	-Becca Matusovich, COHNM -Regina Phillips, CCCS -Cumberland County Oral health group: Amber Lombardi at Mainely Teeth, Kathy Martin at GPH, Melissa Watson at Community dental, Albert Abena at UNE, Louise Marsden at TOA, Nicole Breton and Katelyn Christiansen at Maine CDC, Beth Pearce at Primary Care Association, Kalie Hess at COHN

SUPPORT ACCESS TO ORAL HEALTH CARE - POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	**Evidence for Strategies**	**Possible Partners**	**Possible Funding**	**Proposed Geography**
Provide an infrastructure for building out a more robust delivery system for children's preventative oral healthcare in preschools and schools	Maine-based Children's Oral Health Network (COHN)prioritizes access to school-based oral healthcare as one of their top strategies. The Community Preventive Services Task Force (CPSTF) recommends school-based programs to deliver dental sealants and prevent dental caries (tooth decay) among children. https://www.thecommunityguide.org/sites/default/files/assets/OnePager-Oral-Health-School-Sealants.pdf	**COHN,** Mainely Teeth, Greater Portland Health, Community Dental, UNE	**Maine CDC Office of Population Health Equity** *(OPHE)*, **ARPA**	**Countywide**
Support efforts to improve culturally responsive oral healthcare for children and adults	Studies have shown that culturally appropriate oral hygiene education is effective in improving knowledge and attitudes surrounding oral hygiene have led to behavior modifications. Modifying education interventions so that they are culturally appropriate increases the likelihood of participants modifying their behavior. CHWs are in a unique position to deliver culturally appropriate oral health workshops to community members. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6621922/	**COHN,** Mainely Teeth, Greater Portland Health, Community Dental, UNE	**Maine CDC** *OPHE*	**Countywide with emphasis on rural areas and immigrant communities**
Increase the number of CHWs able to support oral healthcare	The use of CHWs to improve community access to oral health education and care has been seen in many states across the U.S. and has been very effective. Community health workers are trusted members of the community and are able to more readily meet people where they're at (schools, community centers, etc). CHWs are particularly effective in targeting at-risk populations. – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7968011/ – https://www.ruralhealthinfo.org/project-examples/815 https://www.nashp.org/wp-content/uploads/2022/06/MN-Fact-Sheet-V2.pdf	**COHN,** Mainely Teeth, Greater Portland Health, Community Dental, UNE	**Maine CDC** *OPHE*	**Countywide with emphasis on rural areas and immigrant communities**

GOAL 4: IMPROVE TRANSPORTATION ACCESS

<table>
<tr><th colspan="2">TRANSPORTATION – BIKE/PED INFRASTRUCTURE & SAFETY - DATA</th></tr>
<tr><td colspan="2">Overall Magnitude in Cumberland County</td></tr>
<tr><td>Crashes involving pedestrians*

All: 81 (2021)

Deaths: 2 (2021)</td><td>Crashes involving bicyclists*

All: 62 (2021)

Deaths: 1 (2021)</td></tr>
<tr><td colspan="2">Groups that have disproportionate negative outcomes</td></tr>
<tr><td colspan="2">– Older adults and people walking in low-income neighborhoods were struck and killed at much higher rates than other populations in 2020, as with past years. People of color, particularly Native and Black Americans, are more likely to die while walking than any other race or ethnic group. (2022 Dangerous by Design report from Smart Growth America).

– National data shows a disproportionate impact of crashes on traditionally underserved populations. Studies have concluded that neighborhoods with low socioeconomic status or a higher proportion of residents of color have less supportive environmental conditions for walking and other forms of active transportation, which may contribute to lower rates of physical activity and higher rates of poor health outcomes such as obesity, diabetes, and cardiovascular disease. From U.S.DOT's 2020 "Toward a Shared Understanding of Pedestrian Safety.</td></tr>
<tr><td colspan="2">Source</td></tr>
<tr><td colspan="2">*Maine Department of Transportation https://mdotapps.maine.gov/MaineCrashPublic/PublicQueryStats</td></tr>
<tr><td colspan="2">Limitations</td></tr>
<tr><td colspan="2">*No demographic data beyond gender and age</td></tr>
</table>

TRANSPORTATION – BIKE/PED INFRASTRUCTURE & SAFETY - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
Policy and Advocacy – The Moving Maine Network is developing a policy initiative and coordinating a Learning Community across the state that supports regional efforts. – Build Maine and GrowSmart Maine are leading policy actions for 2023 that including enhanced funding for bike/ped/transit and advancing implementation of Complete Streets – Bicycle Coalition of Maine (BCM) does advocacy, education, and technical assistance to increase bike/ped friendly infrastructure and to encourage motorists to slow down. BCM has a program called Community Spokes that trains and connects local advocates. – The Greater Portland Council of Governments (GPCOG) is working on a regional Vision Zero program and a regional Complete Streets Policy for the federally designated PACTS region(Portland Area Comprehensive Transportation System). – Community Transportation Leaders Program at GPCOG - individuals with lived experience – are advocating for changes. – Many communities have Complete Streets policies and/or Bike/Ped committees (Portland, South Portland, Yarmouth, Westbrook and ??)	
Coordination currently happening (low, medium, high)	
– Bicycle Coalition of Maine plays a coordination role for advocacy through its Advocacy Coordinator and Community Spokes program. – GPCOG convenes the Transportation & Community Network – which meets bimonthly for information sharing and networking. – The Moving Maine Network coordinates a Learning Community across the state. – BuildMaine and GrowSmart Maine are convening stakeholders to work on policy actions for 2023.	
What barriers are in the way of current efforts:	
– Political will around the equity, economic, and health value of walkable/bikeable communities – No implementation mechanism for ADA	
Interventions that are missing and needed:	
– Comprehensive approach like Vision Zero to slow vehicles and reduce bike/ped crashes – Health and equity in all transportation decisions/policy – Mechanism to get compliance with Complete Streets policies – More greenways and shared use paths	
Is this a root cause of another problem? Is it the result of other root causes?	
Engagement still needed:	Groups and individuals engaged:
– Portland Trails	– Moving Maine, – Bicycle Coalition of Maine – GPCOG

TRANSPORTATION – ACCESS & AFFORDABILITY - DATA	
Overall Magnitude in Cumberland County	
Households with No Vehicle 6.8% (2015-2019)*	Average cost of vehicle ownership $10,728 per year (2022)**
Groups that have disproportionate negative outcomes	
Group	Households with no vehicle access
State	*7%*
Black/African-American	15%
American Indian/Alaskan Native	13%
Other Race	13%
Immigrant	10%
Town of Bridgton	8.5%
Town of Casco	16%
– In Cumberland County, 7% of households have no vehicle. Some rural towns have even higher percentages, including Bridgton at 8.5% and Casco at 16%. – In Maine, 10% of 65+ households and 15% of Black/African American households, are without a vehicle. – Disability Rights Maine reports that transportation is the biggest barriers for getting to work among their constituents.	
Source	
*American Community Survey. American Community Survey. Obtained from the National Equity Index and US Census website. **AAA	
Limitations	

TRANSPORTATION – ACCESS & AFFORDABILITY - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
Education/Access: – Mobility for All Program at GPCOG has programs to help people know and access options (Bus Ambassadors, Travel Helpers. Southern Maine Mobility Guide. – City of Portland and Cumberland County working with bus agencies to develop a free/reduced fare program for low income people across bus agencies Policy: – Community Transportation Leaders Program at GPCOG - individuals with lived experience who advocate for changes. – The Moving Maine Network is developing a policy initiative at the statewide level and supporting regional efforts - includes a focus on access and affordability.	
Coordination currently happening (low, medium, high)	
– GPCOG convenes the Transportation & Community Network in Cumberland and York Counties. – The Moving Maine Network is developing a policy initiative at the statewide level and convenes a statewide Mobility Learning Community.	
What barriers are in the way of current efforts:	
– Lack of coordination between transportation providers and stakeholders. – Lack of capacity to support work on solutions.	
Interventions that are missing and needed:	
– Free/reduced fare program for low-income people that is easy to access and across agencies – Language access for scheduling rides through Modivcare and local paratransit (RTP) – Additional volunteer driver programs in rural communities – Improvements to paratransit services – Increased investment in bike/ped safety infrastructure	
Is this a root cause of another problem? Is it the result of other root causes?	
Caused by low wages and high cost of living, lack of public transportation investment	
Engagement still needed:	Groups and individuals engaged:
	– Kat Violette, GPCOG – Cumberland County transportation stakeholders convened in Fall 2021 – Transportation & Community Network (11 people) – Town Managers

IMPROVE TRANSPORTATION ACCESS - **POSSIBLE STRATEGIES, PARTNERS & FUNDING**				
Proposed Strategies	Evidence for Strategies	Possible Partners	Possible Funding	Proposed Geography
Adopt Vision Zero programs at county and municipal level	A study from Edmonton, Alberta, Canada, found that speeds on residential streets decreased significantly when limits were lowered and supported with enforcement or other measures (Islam et al., 2013). A study by the Insurance Institute for Highway Safety (IIHS)concluded that lowering the speed limit by 5 mph can improve safety for motorists, pedestrians, and bicyclists alike by reducing speeding.	GPCOG and PACTS, Community Transportation Leaders, Moving Maine, Bicycle Coalition of Maine, Portland Trails, local bike/ped groups	US DOT Safe Streets and Roads grant program (GPCOG is applying)	County-wide
Advance adoption and implementation of Complete Streets policies at the county and municipal level.	The Community Preventive Services Task Force (CPSTF) recommends built environment approaches combining transportation system intervention with land us and environmental design. Increasing walking and biking safety, convenience, and feasibility would not only lead to a decrease in injury or deaths but would also give many people more mobility options and a sense of independence. Studies also show that increased access to walking and biking also provides easy access to exercise opportunities and encourages individuals to be more physically active. Built environments that are more conducive to walking and biking as a reliable method of transportation are linked to better population-health. https://www.thecommunityguide.org/findings/physical-activity-built-environment-approaches	GPCOG and PACTS, Community Transportation Leaders, Moving Maine, Bicycle Coalition of Maine, Portland Trails, local bike/ped groups	US DOT Safe Streets and Roads grant program (GPCOG is applying)	County-wide
Increase bicycle and pedestrian funding for the region	This report provides a comprehensive evaluation of the impact of investments in improving cycling and walking conditions, and also reviews the type of costs and/or savings associated with this improved infrastructure. Research has shown that people want to walk and bike as a main method to travel, but experience infrastructure obstacles and are unable to do so. Expanding access to active transport has financial benefits for community members, reduces roadway maintenance costs, improves social equity, promotes physical activity, and can help reduce traffic congestion. https://www.vtpi.org/nmt-tdm.pdf	Moving Maine, Bicycle Coalition of Maine, Build Maine, GrowSmart Maine	Governor's Office of Policy and Innovation Resilience Grants	County-wide
Elevate the public health voice in educating decision-makers about the health, equity, and economic benefits of bike and ped friendly communities.			Voices for Health Kids	County-wide

Establish financing mechanism to fund fare-free transit for low-income communities.	Across interventions for food security, housing stability, and access to care, access to public transportation appears as a needed strategy. Numerous models exist for financing free and low-cost transit through various funding mechanisms. A 2021 study titled "Comparison of Reduced-Fare Programs for Low-Income Transit Riders" outlines lessons learned and policy options https://journals.sagepub.com/doi/full/10.1177/03611981211017900			In areas with transit
Support the development of community volunteer driver programs.	A study by the Transportation Research Board indicates that volunteer driver programs can be an effective means to accommodate the unmet mobility needs of older adults and other "transportation-disadvantaged" people in rural communities where transit, paratransit and taxi services are limited or cost prohibitive. There is considerable potential for these programs to be implemented or expanded on a coordinated basis to provide low-cost and accessible transportation in underserved or unserved rural communities.			County-wide with an emphasis on locations with high needs and lacking programs
Build capacity of Mobility Management initiatives to improve transportation access	Programs are being used around the US and supported by the Federal Transit Administration and the federal interagency Coordinating Council on Access and Mobility as a key strategy for addressing transportation needs of vulnerable communities. https://nationalcenterformobilitymanagement.org/measuring-the-value-of-mobility-management/		Federal Transit Administration Innovative Coordinated Access and Mobility Grants (RFP to be released in Fall 2022)	County-wide

GOAL 5: ADDRESS RACISM & DISCRIMINATION

RACISM & DISCRIMINATION - DATA

Overall Magnitude in Cumberland County

HS students bullied on school property in past 12 months*

20.2% (2019)

Groups that have disproportionate negative outcomes

Group	Statewide HS students bullied on school property in the past 12 months (2019)	Cumberland County HS students bullied on school property in the past 12 months (2019)
State	23.3%	NA
Female	27.1%	-
14 or younger	-	25.3%
Grade 9	27.6%	24.5%
Hispanic	28.6%	-
American-Indian/AN	32.5%	35%
More than one race	29.4%	26.6%
Native Hawaiian/PI	39.1%	36%
Black/AA	-	-
Bisexual	36.5%	Not available
Gay/Lesbian	37.2%	Not available
Sexuality – not sure	-	Not available
Trans (yes)	44.4%	Not available
Trans (not sure)	42.4%	Not available

- Not a lot of data at the County level
- In Cumberland County, 35% of American Indian/Alaskan Native, 36% Native Hawaiian/Pacific Islanders, and 26.6% multi-racial high schoolers statewide were bullied on school property compared to 20% of Cumberland County high schoolers overall.
- Statewide, 36.5% of bisexual and 37% gay/lesbian high schoolers were bullied on school property compared to 23% of high schoolers overall.
- In 2020, 84 hate crimes were reported statewide (up from 19 in 2019 and 20 in 2018). 48% were motivated by race and 43% were motivated by sexual orientation. **
- Also in 2020, 11% of people arrested in Maine were black compared to 3.2% of population.***

Percentages shown in the chart are confirmed to be statistically significant differences.

Source

*MIYHS, **U.S. Department of Justice, ***Maine Department of Public Safety

Limitations

Little county-level disaggregated data for adults available.

RACISM & DISCRIMINATION - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
– Racial Equity Steering committees within City of Portland and City of South Portland. – Organizations and businesses doing racial equity trainings, practice and policy reviews, and working to hire a more diverse workforce. – Gay Straight Trans Alliances in many high schools and some middle schools	
Coordination currently happening (low, medium, high)	
– Low	
What barriers are in the way of current efforts?	
– Lack of regional capacity-building support for racial equity efforts within municipalities	
Interventions that are missing and needed:	
– Support for GSTAs – More collaboratives to support municipalities in their efforts to address systemic racism. – Participatory Grantmaking opportunities for people who identify as BIPOC	
Is this a root cause of another problem? Is it the result of other root causes?	
Both	
Engagement still needed:	Groups and individuals engaged:
– Portland racial equity committee members	– Pedro Vasquez, South Portland Human Rights Commission – Roberto Rodriguez, Portland City Council – Regina Phillips, Cross Cultural Community Services – Deqa Dulac, South Portland Mayor, Gateway Community Services – Gia Drew, Equality Maine – Quinn Gormley, Maine Trans Net

ADDRESS RACISM & DISCRIMINATION - POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	Evidence for Strategies	Possible Partners	Possible Funding	Proposed Geography
Build capacity for maintaining and expanding Gay Straight Trans Alliances (GSTA) and Black Student Unions in middle and high schools.	Studies show that established GSTAs are associated with decreased odds of discrimination based on sexual orientation. Supporting these programs has the potential to impact school climate and reduce discrimination and may also help reduce risk of suicidal behavior. – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193472/pdf/nihms804490.pdf – http://healthcareguild.com/presentations_files/Goodenow%20-%20School%20Support%20Groups%20and%20Safety%20for%20Sexual%20Minorities.pdf – https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4716826/	MaineTransNet, OutRight		Countywide
Develop cross sector collaborations and build capacity of municipalities and organizations to address systemic racism.	The Government Alliance on Race & Equity has developed a strategic approach to institutional change that uses data and partnerships to build racial equity. The approach is showing promising results in cities and regions across the U.S. – https://livingcities.org/wp-content/uploads/2021/02/Racial-Equity-Here-Learning-Report_-Lessons-from-5-Cities-Operationalizing-Racial-Equity.pdf – https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf	City of Portland, City of South Portland Human Rights Commission		Countywide
Advocate and provide support for participatory grantmaking/funding opportunities for people and communities who identify as BIPOC.	Participatory grantmaking allows for more informed, equitable, and impactful decision-making to be made in marginalized communities. – https://learningforfunders.candid.org/wp-content/uploads/sites/2/2018/12/DecidingTogether_Final_20181002.pdf			Countywide

BUILDING HEALTHY COMMUNITIES

GOAL 6: IMPROVE HOUSING SAFETY AND SECURITY

HOUSING – **SAFE AND HEALTHY HOUSING** – DATA		
Overall Magnitude in Cumberland County		
Wells tested that exceed state guideline for arsenic of 10 ug/L 17.5% (1999-2013)*	Asthma Emergency department visits per 10,000 15.1 (2020)**	Estimated Number of Children with a Blood Lead ≥5 ug/dL 273 (2015-2019)***
Groups that have disproportionate negative outcomes		
Municipality	Wells tested with arsenic exceeding 10 ug/L*:	Children with elevated blood lead level ≥5
Gorham	50.5%	
Scarborough	35.8%	
Standish	27.2%	
Gray	25.5%	
Windham	20.2%	
Portland	11.7%	134
Westbrook	Insufficient data	41
South Portland	Insufficient data	22
Bridgton	1.7%	14
– Low-income renters and rural homeowners are more likely to experience health challenges related to household toxins. – In Cumberland County, over a third of homes get water from a well (33.5%)**** – Among Cumberland County renters who rely on a well, only 42.2% reported they had their well water tested for arsenic, compared to 60.2% of homeowners.**** – Five Cumberland County towns have arsenic exceeding 10 ug/L in over 20% of wells tested. *Percentages shown in the chart are confirmed to be statistically significant differences.*		
Source		
*State of Maine Health and Environmental Testing Laboratory. **Maine Health Data Organization. ***Maine CDC Childhood Lead Poisoning Prevention Unit. Obtained from Maine tracking Network Environmental Public Health Data portal. ****2017 BRFSS data		
Limitations		
Insufficient demographic data on who is most impacted by household toxins.		

HOUSING – **SAFE & HEALTHY HOUSING** - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
<u>Policy</u> – Defend our Health works on policy to protect people from household toxins. <u>Prevention</u> – Cumberland County Soil and Water Conservation District (CCSWCD) supports families to get soil tested for lead. – City of Portland provides education on lead in homes in Portland, Westbrook and financial assistance for lead abatement to homeowners and landlords within Portland. – Defend our Health has a community outreach staff person working with immigrants on education and support regarding household toxins. They also have a well water testing program to support low-income people with testing.	
Coordination currently available (low, medium, high)	
– Low	
Interventions that are missing and needed:	
– More resources for lead testing in soil – More support for renters to talk with and get landlords to fix household toxins – More financial support for landlords to remedy household toxins	
Is this a root cause of another problem? Is it the result of other root causes?	
Engagement still needed:	Groups and individuals engaged:
Pine Tree Legal	-Kirsten Faucher, City of Portland -Sergio Cahueque, Defend out Health -Damon Yakovleff, CC Soil and Water District -12 Town Managers

HOUSING – HOMELESSNESS & HOUSING INSECURITY - DATA		
Overall Magnitude in Cumberland County		
Households spending more than 30% on housing: 28.85% (2015-2019)*	Evictions filed annually 932 (FFY2015-19 average - FFY20 was 587 - reduction related to COVID moratorium)**	HS students experiencing housing instability 2.8% (2019)***
Groups that have disproportionate negative outcomes		
Group	Statewide HS students experiencing housing instability	Cumberland County HS students experiencing housing instability
State	*3.3%*	NA
18 and older	6.3%	6.2%
Grade 12	4.7%	
Hispanic	10.7%	8.6%
American-Indian/AN	8.6%	14.3%
Asian	9.7%	7.7%
More than one race	5.1%	
Native Hawaiian/PI	31.6%	29.2%
Black/AA	9.1%	7.5%
Bisexual	5.2%	Not available
Gay/Lesbian	8.4%	Not available
Sexuality – not sure	10.1%	Not available
Trans (yes)	17.1%	Not available
Trans (not sure)	17.4%	Not available
Trans (did not understand question)	17.2%	Not available

- In Maine, 55% of women of color renters in Maine spend more than 30% on housing (2019). Overall, 46% of Maine renters spend more than 30% on housing. (State-level data by race, gender available on the National Equity Atlas)
- As of May 2022, 10% of Mainers were behind on their rent. 12% of those behind on their rent are People of Color; 39% are unemployed; 84% are low income; 33% are households with children. (Rent Debt Dashboard – uses U.S. Census Pulse Survey).
- Among Maine high school students, youth of color and LGBTQ+ youth experience housing instability at far higher rates. Trans youth were seven times more likely than average to experience housing instability.

Percentages shown here are confirmed to be statistically significant differences.

Source
* ACS housing unaffordability index. **MaineHousing 2021 Evictions in Maine report. ***MIYHS.
Limitations
Insufficient demographic data on evictions. No disaggregated data at county level.

HOUSING – HOMELESSNESS & HOUSING INSECURITY - CURRENT EFFORTS AND PERCEIVED GAPS		
How is this problem being addressed now and what is the geography of current efforts?		
Intervention – Many organizations are working to support people experiencing homelessness through case management and navigation, with a majority of services based in Portland. – New Homelessness Hub led by United Way is using Built for Zero approach in Cumberland County. Policy – Several assessments are happening or recently completed: HUD city/county housing barriers study is happening, a county-wide (?) housing needs assessment was completed in the spring, South Portland completed a study in late 2021. Housing Development – Cumberland County and the City of Portland have formed a HOME Consortium to receive an annual allocation of $2 million HOME Investment Partnership funds through HUD for the creation of affordable housing development throughout the county.		
Coordination currently happening (low, medium, high)		
– Coordination exists in pockets and by population. – Comprehensive Homelessness HUB coordinated by United Way just starting, with a focus on improving coordination of services for people experiencing homelessness.	– Maine Immigrant Rights Coalition (MIRC) coordinates many of the efforts to support recently arrived people seeking asylum. – Individual and neighboring municipalities convening groups to coordinate assistance for people experiencing homelessness.	
Interventions that are missing and needed:		
– Housing navigation, especially for people new to the country. – Triage case management and day space for people experiencing long term homelessness. – Transportation for people experiencing homelessness. – Targeted housing vouchers for young people coming out of incarceration – More rental options (supported, independent, etc) beyond inpatient treatment. – Expand Housing First options – Build more housing – Education for decision-makers on upstream/regional approaches	– Expand on peer support for rapid rehousing – Housing supports and funding that are not tied to mental health diagnosis/svs – Training for social services staffers on housing/homelessness resources so intervention and support is available in more places (i.e., at syringe services) – More coordination across sectors – especially related to hospital and jail discharges, and with/between recovery residences – Flexible financial assistance for rent and other needs – Connect renters and landlords to lead-safe mitigation, well-water/arsenic mitigation programs managed by CAP agencies (to prevent homelessness)	
Is this a root cause of another problem? Is it the result of other root causes?		
Caused by low wages and high cost of living. Exacerbated by barriers to development.		
Engagement still needed:	Groups and individuals engaged:	
– Pine Tree Legal	– Group meeting on homelessness with TOA, Amistad, Preble st,, MIRC, CoP, MANA, Spurwink, QHC, GPH, Gateway, Milestone – Mufalo Chitam, MIRC – Erica King, Cutler Institute – Anne-Marie Brown, United Way	– Victoria Morales, Quality Housing Coalition (QHC) – Belinda Ray, GPCOG – Matthew Jarrell, United Way – 12 Town Managers – Cumberland County Homelessness Hub Advisory Committee (11people)

HOUSING – SAFE AND HEALTHY HOUSING - HOMELESSNESS AND HOUSING INSECURITY - POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	Evidence for Strategies	Possible Partners	Possible Funding	Proposed Geography
Build capacity for testing and remediation of housing-related toxins, especially within rental housing (soil, wells, lead, mold)	An assessment by the Pew Trusts and Robert Wood Johnson Foundation recommends that states and localities should prevent displacement of tenants in homes with lead hazards by freezing any eviction proceeding initiated without just cause and within six months of a finding of a high blood lead level or lead hazard in the home and should prohibit landlords from re-renting units that poisoned a child or where lead has been found until hazards are addressed. https://www.pewtrusts.org/-/media/assets/2017/08/hip_childhood_lead_poisoning_report.pdf	Defend Our Health, Cumberland County Soil and Water Conservation District		Countywide – focus on rural and areas with high poverty
Expand support for renters to work with landlords on addressing household toxins		Defend Our Health, Cumberland County Soil and Water Conservation District		Countywide – focus on rural and areas with high poverty
Expand programs to support low-income households to empty and/or replace septic tanks/ leach fields		Municipalities, Department of Environmental Protection		Countywide – focus on rural and areas with high poverty
Build capacity of "housing diversion" programs (eviction prevention), especially in rural areas of the county.	Collaborative housing diversion programs that offer financial assistance, financial counseling, and access to legal services result in less judgements for evictions and more settlements, an increase in eviction expungements, and stronger relationships between program providers, the courts, and landlords. – https://rhls.org/wp-content/uploads/Achieving-Housing-Stability-with-Eviction-Diversion-Programs-during-COVID-and-Beyond.pdf – https://www.urban.org/sites/default/files/publication/104148/eviction-prevention-and-diversion-programs-early-lessons-from-the-pandemic.pdf	United Way Homelessness Hub		Countywide – focus on rural and areas with high poverty
Expand housing navigation and supportive housing programs	The Community Preventive Services Task Force (CPSTF) recommends permanent supportive housing with Housing First Programs to support people who are experiencing homelessness and have a disabling condition.	QHC, MIRC		Countywide

Increase availability of vouchers and aligning General Assistance payments with market housing rates	The Community Preventive Services Task Force (CPSTF) recommends tenant-based housing voucher programs to advance health equity.	QHC, MIRC		Countywide
Provide education for decision-makers on best practices approaches to addressing the problem	The Frameworks Institute has developed evidence-based strategies for framing the issue of homelessness and leading productive public conversations about inclusive housing policy and community development. – https://www.frameworksinstitute.org/publication/finding-a-better-frame-how-to-create-more-effective-messages-on-homelessness-in-the-united-kingdom/ – https://www.frameworksinstitute.org/publication/piecing-it-together-a-communications-playbook-for-affordable-housing-advocates/	United Way, QHC, MIRC		Countywide

BUILDING HEALTHY COMMUNITIES

GOAL 7: EXPAND FOOD SECURITY

FOOD SECURITY – DATA			
Overall Magnitude in Cumberland County			
Food Insecure Adults 10.1% (29,660 individuals – 2019)*	Food Insecure Children 13.6% (7,500 individuals - 2019)*	Food Insecure Adults that DO NOT Qualify for Assistance 53% (2019)*	SNAP Participation 25,540 individuals (March 2022)

Groups that have disproportionate negative outcomes		
Characteristic	Households Receiving SNAP	Households *not* Receiving SNAP
With one or more people 60 and up	49%	44.1%
With child(ren) under 18	33.2%	23.5%
With disabled individuals	59%	22.1%
Below poverty level	41.8%	6.5%
Black/African-American	3.2%	0.8%
Asian	2.2%	1.0%
Other Race	1.2%	0.2%
Hispanic	3.1%	1.3%

- Compared to households not receiving SNAP, households receiving SNAP in Southern Maine are more likely to include:***
    - People over 60 or children under 18
    - A person who is disabled
    - And/or people who identify as BIPOC
- National data indicates that households with children headed by a single woman and women or men living alone are more likely to be food insecure.

Percentages shown in the chart are confirmed to be statistically significant differences.

Source

*Feeding America Map the Meal Gap

**Maine DHHS Data and Reports

***SNAP household profile Congressional District 1 from USDA Food and Nutrition Service

Limitations

Disaggregated data not available for the county.

FOOD SECURITY - CURRENT EFFORTS AND PERCEIVED GAPS		
How is this problem being addressed now and what is the geography of current efforts?		
Local Food Access: -Increasing local food production to close the hunger gap (CCFSC) -Food Fuels Learning in Portland Public Schools (CCFSC) -Community and School Gardens -Cultivating Community Farmer training program Policy – Ending Hunger in Maine by 2030	Community food programs – Pantries in most schools – Locker Project – Preble Street – Food hub and soup kitchens – More culturally important foods in charitable meals (Wayside, Presente Maine, In Her Presence, Angolan Community meal program at hotels) – Maine Medical Center is opening a pantry for patients – SMAAA supports food delivery and congregate meal programs	
Coordination currently happening (low, medium, high)		
– Cumberland County Food Security Council convenes monthly coordination meetings – Maine's Roadmap to End Hunger by 2030		
What barriers are in the way of current efforts:		
– Inadequate language access – Racism – Lack of accurate and disaggregated data		
Interventions that are missing and needed:		
– Expand Food Fuels Learning model to more school districts. – Expand local and culturally important foods in school pantries and charitable food system. – Expand municipal support on food security and local food systems. – Communication infrastructure to promote and expand what's working. – Infrastructure investments for local food processing and food businesses.	– Funding pools for experimental projects – Public perception that food insecurity is an individual problem and lack of understanding why people experience food insecurity	
Is this a root cause of another problem? Is it the result of other root causes?		
Caused by low wages and high cost of living. Exacerbated by barriers to eligibility for food assistance through the Supplemental Nutritional Assistance Program and restrictions on cash assistance for families experiencing poverty.		
Engagement still needed:	Groups and individuals engaged:	
Presente Maine	– Jim Hanna, CC Food Security Council – Anna Bullett, WIC – Alexis Guy, Snap Ed	– Cumberland County Food Security Council Meeting (27 people) – Katlyn Blackstone and Dan Knox, SMAA

EXPAND FOOD SECURITY - **POSSIBLE STRATEGIES, PARTNERS & FUNDING**				
Proposed Strategies	Evidence for Strategies	Possible Partners	Possible Funding	Proposed Geography
Support efforts to improve local food procurement in school nutrition programs.	A 2020 report by Feeding America reviewed current evidence on proven, promising, and emerging interventions for improving food security – as well as those not yet evaluated but seen as likely to be effective. The Food Fuels Learning approach combines many of the most effective interventions into one comprehensive strategy. https://www.feedingamerica.org/sites/default/files/2020-12/Food%20Security%20Evidence%20Review%20August%202020.pdf	Cumberland County Food Security Council, Town Managers		Countywide – focus on school districts with high poverty
Increase opportunities and support for healthy food and agricultural education in schools.		Cumberland County Food Security Council, Town Managers		Countywide – focus on school districts with high poverty
Increase culturally important foods into charitable food distribution and in school nutrition programs.		Cumberland County Food Security Council, Town Managers		Countywide – focus on school districts with high poverty
Build capacity of local food production, especially infrastructure for local food processing.	Many communities are using this strategy but there isn't much literature on its effectiveness for improving food security. Examples from New England: – Johns Hopkins Center for a Livable Future https://clf.jhsph.edu/ – Frontiers https://www.frontiersin.org/journals/sustainable-food-systems	Cumberland County Food Security Council, Town Managers		Countywide
Create messaging that helps the public and leaders understand that food insecurity as a PH problem not an individual problem.	The Frameworks Institute has developed evidence-based strategies for reframing hunger to change how Americans think about the issue of hunger. By helping people see hunger as widespread and not a personal failing, we can build support for nutritional assistance programs and elevate understanding of the food system we need. https://www.frameworksinstitute.org/publication/reframing-hunger-in-america/ https://www.feedingamerica.org/sites/default/files/2020-12/Food%20Security%20Evidence%20Review%20August%202020.pdf	Cumberland County Food Security Council, Town Managers		Countywide

Advocate for improved program convenience and benefit flexibilities for participants of Electronic Benefits Transfer (EBT)-based programs (e.g., Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) to increase participation in these vital programs and allow the programs to better promote food and nutrition security				Countywide

BUILDING HEALTHY COMMUNITIES

GOAL 8: ADVANCE ENVIRONMENTAL JUSTICE

<table>
<tr><th colspan="3">ENVIRONMENTAL & CLIMATE HAZARDS - DATA</th></tr>
<tr><td colspan="3">Overall Magnitude in Cumberland County</td></tr>
<tr><td colspan="2">Heat illness hospitalizations per 100,000

11.2 (2019)*</td><td>Lyme disease cases per 100,000 population

30.3(2019)**</td></tr>
<tr><td colspan="3">Groups that have disproportionate negative outcomes</td></tr>
<tr><td>Group</td><td>Heat illness hospitalizations</td><td>Lyme disease cases</td></tr>
<tr><td>State</td><td>17.1</td><td>83.8</td></tr>
<tr><td>15-34-year-olds</td><td>25.1</td><td></td></tr>
<tr><td>5-14-year-olds</td><td>-</td><td>105.6 (no conf intervals)</td></tr>
<tr><td>65+</td><td>-</td><td>126.9 (no conf intervals)</td></tr>
<tr><td colspan="3">– Growing research shows that extreme heat and other hazardous weather events disproportionately affect low-income people and people of color (Kaiser Family Foundation). Nationally, between 2004 to 2018, American Indian and Alaska Native people had the highest rates of heat-related death, followed by Black people. ***
– Maine data shows 15–34-year-olds have higher than average rates of heat illness hospitalizations. No other demographics are available.
– National data indicates racial disparities in testing and diagnosing Lyme Disease.***
– Maine data shows higher rates of Lyme Disease among older adults (65+) and children and young teens (5-14-year-olds).
Rates shown in the chart are confirmed to be statistically significant differences.</td></tr>
<tr><td colspan="3">Source</td></tr>
<tr><td colspan="3">*Maine Health Data Organization. Obtained from the Maine Tracking Network portal. ** Maine CDC's Infectious Disease Program. ***U.S. CDC.</td></tr>
<tr><td colspan="3">Limitations</td></tr>
<tr><td colspan="3">County data disaggregated by gender only. No disaggregated data with race, ethnicity, income, education, or LGBTQ+ status.</td></tr>
</table>

ENVIRONMENTAL & CLIMATE HAZARDS - CURRENT EFFORTS AND PERCEIVED GAPS	
How is this problem being addressed now and what is the geography of current efforts?	
– City of Portland and South Portland have a climate action plan and are actively working on it. – Maine CDC worked with Cumberland County Emergency Management Association to develop an extreme weather plan. – Local Health Officers support towns to educate the public on ticks, Brown Tail Moth and other environmental hazards.	
Coordination currently happening (low, medium, high)	
– GPCOG is coordinating climate resilience efforts with five communities and seeking funding to support an additional five beginning in Fall 2022. State of Maine is making municipal and regional grants through its Community Resilience Partnership program.	
What barriers are in the way of current efforts?	
– Lack of regional coordination around environmental justice.	
Interventions that are missing and needed:	
– Capacity for assessing and increasing environmental justice initiatives.	
Is this a root cause of another problem? Is it the result of other root causes?	
National studies indicate that drought conditions result in higher probabilities of elevated arsenic levels in domestic wells. More study is needed.	
Engagement still needed:	Groups and individuals engaged:
– South Portland air quality group – Casco Bay Estuary Partnerships	– Julie Rosenbach, City of South Portland – Kristine Jenkins, Maine CDC – Sarah Mills-Knapp, GPCOG – Town Managers

ENVIRONMENTAL & CLIMATE HAZARDS - POSSIBLE STRATEGIES, PARTNERS & FUNDING				
Proposed Strategies	**Evidence for Strategies**	**Possible Partners**	**Possible Funding**	**Proposed Geography**
Foster cross sector collaboration and build capacity for assessing and increasing environmental justice initiatives.		**Maine Environmental Education Association, Just Maine for Just Us, Maine Youth Action**	**Governor's Office of Policy and Innovation Resilience Grants**	**Countywide**

Climate and Health https://www.cdc.gov/climateandhealth/site_resources.htm

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