2022 Maine Shared
Community Health Needs Assessment

Cumberland County

Northern Light Health[SM]

COVID-19 AND OUR HEALTH

While our quantitative data pre-dates the COVID-19 pandemic, the 2021 community health needs assessment outreach took place during the pandemic, and participants noted its impacts in deep and meaningful ways. It was impossible not to recognize the pandemic's impacts on healthcare, health outcomes, behavioral health, and social support systems, especially for those who experience systemic disadvantages.

Challenges in accessing care have impacted chronic disease management and caused delays in non-emergency procedures. Rates of those seeking medical care for even acute health events such as heart attack, stroke, and uncontrolled high blood sugar were low during the early phase of the pandemic due to COVID-19 concerns. This occurred even while the use of telemedicine increased (Kendzerska, et al., 2021). Later in the pandemic, health care usage data from July 2020 through July 2021 show that increases in ICU bed occupancy were followed weeks later by a higher number of deaths not caused by COVID than typically seen before the pandemic. ICU bed occupancy had exceeded 75% of capacity nationwide for at least 12 weeks as of October 25, 2021 (French G., et al., 2021).

Previous disasters have shown that the secondary impacts on population health are long-lasting. For instance, 10 years after Hurricane Katrina, Tulane University Health Sciences Center saw a significant increase in heart disease and related risk factors such as increases in A1C levels, blood pressure, and LDL cholesterol (Fonseca, et al., 2009). The after-effects of disasters such as the Iraqi occupation in Kuwait in 1990, the London bombings in 2005, and the tidal waves and the nuclear meltdown in Fukushima, Japan in 2011 have revealed the need for immediate as well as long-term mental health care (McFarlane & Williams, 2012).

Emerging concerns on the lasting impacts of this pandemic also include the long-term effects of COVID infection as our newest chronic disease. A recent systematic review estimates that more than half of COVID-19 survivors worldwide continue to have COVID-related health problems six months after recovery from acute COVID-19 infection (Groff, et al., 2021). New evidence shows increases in adult diagnoses of diabetes, the risk for diabetes among children, and worsening diabetes among those who already had diabetes after COVID-19 infection (Barrett, et al, 2022).

There are some concerns that the pandemic has had negative impacts on health behaviors. However, the evidence is not yet clear. In Maine, newly available 2020 Maine Behavioral Risk Factors Surveillance System (BRFSS) data on a few key measures give us an early snapshot of the health of Maine adults in the first year of the pandemic. These data do not show any evidence of adverse impacts on trends in smoking, alcohol use, overweight, obesity, or physical activity. Self-reported alcohol use, binge drinking, and current smoking in 2020 were at the lowest levels since 2011 (Maine CDC, unpublished analysis). Drug overdose deaths increased by 33% in 2020 and by another estimated 23% in 2021 according to preliminary findings (Maine Attorney General's Office); it is not clear whether this is a continuation of previous trends, other factors, or due to the pandemic.

The pandemic is affecting different segments of the population more than others. The August 2021/COVID Resilience Survey showed that younger people, people of color, and those with lower incomes all had elevated stress (American Psychological Association). In Maine, Black or African Americans experience a disproportionate share of the COVID-19 burden as they are only 1.4% of Maine's total population yet, as of January 19, 2022, makeup 3.1% of cases and hospitalizations (Maine DHHS).

Thus, the findings in the 2022 Maine Shared CHNA Reports which show the most often identified priorities such as mental health, substance and alcohol use, access to care, and social determinants of health take on new meaning and an increased sense of urgency.

References:

American Psychological Association (2021). Stress in America™ 2021: Stress and Decision-Making During the Pandemic. Last accessed 4/5/2022: https://www.apa.org/news/press/releases/stress/2021/october-decision-making

Barrett CE, Koyama AK, Alvarez P, et al. (2022). Risk for Newly Diagnosed Diabetes >30 Days After SARS-CoV-2 Infection Among Persons Aged <18 Years — United States, March 1, 2020–June 28, 2021. *Morbidity and Mortal Weekly Report*. January 14, 2022;*71*(2); 59–65. DOI: http://dx.doi.org/10.15585/mmwr.mm7102e2

French G, Hulse M, Nguyen D, et al. (2021). Impact of Hospital Strain on Excess Deaths During the COVID-19 Pandemic — United States, July 2020–July 2021. *Morbidity and Mortal Weekly Report*. November 19, 2021;70(46);1613–1616. DOI: http://dx.doi.org/10.15585/mmwr.mm7046a5

Fonseca, V. A., Smith, H., Kuhadiya, N., et al. (2009). Impact of a Natural Disaster on Diabetes, *American Diabetes Association Diabetes Care.* September, 2009. 32(9); 1632-1638, DOI: 10.2337/dc09-0670. Last accessed 4/5/2022: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2732170/

Groff, D., Sun, A., Ssentongo, A. E., et al. (2021). Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection: A Systematic Review. *JAMA network open*, 4(10), e2128568. https://doi.org/10.1001/jamanetworkopen.2021.28568

Kendzerska, T., Zhu, D. T., Gershon, A. S., et al. (2021). The Effects of the Health System Response to the COVID-19 Pandemic on Chronic Disease Management: A Narrative Review. *Risk management and healthcare policy*. Volume 2021:14, 575–584. https://doi.org/10.2147/RMHP.S293471

Maine Attorney General's Office, Overdose Data. Last accessed 4/5/2022: https://www.maine.gov/ag/news/article.shtml?id=5041404

Maine Department of Health and Human Services, (Maine DHHS) COVID-19 Dashboard, last accessed 1/20/2022: https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus/data.shtml

McFarlane, A.C., Williams., R. (2012). Mental Health Services Required after Disasters, *Depression Research and Treatment.* Volume 2012, Article ID 970194, DOI: 10.1155/2012/970194 10.1155/2012/970194. Last accessed 4/5/2022: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3395273/pdf/DRT2012-970194.pdf

TABLE OF CONTENTS

Introduction....1
Executive Summary. 2
Health Priorities 2
Mental Health....4
Social Determinants of Health 7
Access to Care 11
Substance and Alcohol Use....15
Other Identified Needs 19
Appendix: Methodology....20
Acknowledgments 24

INTRODUCTION

The **Maine Shared Community Health Needs Assessment (Maine Shared CHNA)** is a collaboration between Central Maine Healthcare (CMHC), Maine Center for Disease Control and Prevention (Maine CDC), MaineGeneral Health (MGH), MaineHealth (MH), and Northern Light Health (NLH). The vision of the Maine Shared CHNA is to turn health data into action so that Maine will become the healthiest state in the U.S.

The mission of the Maine Shared CHNA is to:

- Create Shared CHNA Reports,
- Engage and activate communities, and
- Support data-driven health improvements for Maine people.

This is the fourth Maine Shared CHNA and the third conducted on a triennial basis. The Collaboration began with the One Maine initiative published in 2010. The project was renamed to the Shared Health Needs Assessment and Planning Process in 2015 which informed the 2016 final reports, and renamed to the Maine Shared CHNA in 2018, which informed the 2019 final reports. The 2021 community engagement cycle has informed the 2022 final reports.

New this cycle is an expanded effort to reach those who may experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted in this effort. One effort included nine community sponsored events hosted by organizations representing the following communities: Black or African Americans; people who are deaf or hard of hearing; people with a mental health diagnosis; people with a disability; people who define themselves or identify as lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ+); people with low income; older adults; people who are homeless or formerly homeless; and youth. In addition to these events, 1,000 oral surveys were conducted in collaboration with eight ethnic-based community organizations' community health workers to better reach Maine's immigrant population. A complete description of how these efforts were deployed, as well as a listing of those who provided input, is provided in the Methodology section on page 20.

All of the County, District, and State reports and additional information and data can be found on our web page: www.mainechna.org.

EXECUTIVE SUMMARY

LEADING CAUSES OF DEATH

One way to view the top health priorities is to consider their contributions to Maine's morbidity, mortality, and overall quality of life issues. It is important to note Maine's leading causes of death to put the community-identified health priorities into perspective. This includes underlying causes of death such as tobacco use, substance and alcohol use, and obesity.

Table 1. Leading Causes of Death

RANK	MAINE	CUMBERLAND COUNTY
1	Cancer	Cancer
2	Heart Disease	Heart Disease
3	Unintentional Injury	Unintentional Injury
4	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
5	Stroke	Alzheimer's Disease

TOP HEALTH PRIORITIES

The participants at the Cumberland County forum have identified the following health priorities.

Table 2. Top Health Priorities for Cumberland County

PRIORITIES	% OF VOTES
Mental Health	51%
Social Determinants of Health	42%
Access to Care	41%
Substance & Alcohol Use	34%

Statewide, participants identified similar top four priorities in the 2021 engagement process as was in 2018.

Table 3. Top Health Priorities for County/State

PRIORITIES	2018		2021	
Mental Health	✓	●	✓	●
Social Determinants of Health	✓	●	✓	●
Access to Care	✓	●	✓	●
Substance & Alcohol Use	✓	●	✓	●
Older Adult Health	✓	●		
Physical Activity, Nutrition, and Weight		●		

✓ County Priority ● State Priority

Common themes identified by participants in 2021 include an emerging mental health crisis; challenges in access to healthcare, issues related to poverty, transportation, substance and alcohol use, in both the rural and urban portions of the county.

The following pages describe each of these priorities in more detail including the **major health concerns** identified by participants in the community engagement process. There is a description of community-identified resources available to address those concerns as well as any related gaps or needs. Where available, there is also information for certain groups that are at higher risk due to systemic disadvantages. Finally, following the sections that discuss each of the health priorities is a listing of other health issues that were raised by community members but were not identified as priorities.

DEMOGRAPHICS

Cumberland has the largest population in the state. The coastal communities have higher incomes, educational attainment, and lower rates of those living in poverty compared to the western half. It has a younger population than the state overall.

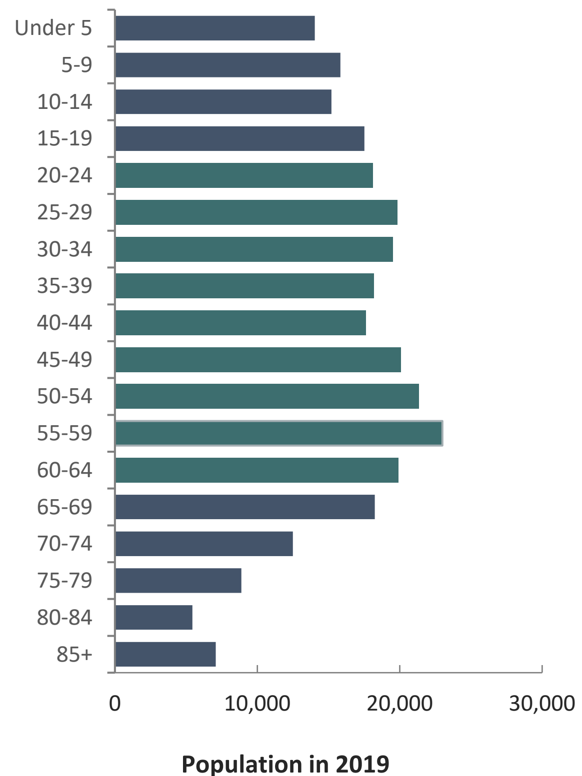
Table 4. Selected Demographics

	COUNTY	MAINE
Population numbers	286,246	1.34M
Median household income	$73,072	$58,918
Unemployment rate	5.3%	5.4%
Individuals living in poverty	9.0%	11.8%
Children living in poverty	9.2%	13.8%

Table 4. Selected Demographics (continued)	COUNTY	MAINE
65+ living alone	29.8%	29.0%
Associate's degree or higher (age 25+)	56.3%	41.9%
Gay, lesbian, and bisexual (adults)	4.4%	3.5%
Persons with a disability	11.4%	16.0%
Veterans	7.2%	9.6%

Table 5. Race/Ethnicity in Cumberland County	PERCENT	NUMBER
American Indian/Alaskan Native	0.2%	587
Asian	2.2%	6,350
Black/African American	3.0	8,863
Native Hawaiian or other Pacific Islander	-	-
White	91.7%	268,151
Some other race	0.4%	1,091
Two or more races	2.5%	7,240
Hispanic	2.1%	6,061
Non-Hispanic	97.9%	280,185

Figure 1. Age distribution for Cumberland County



HEALTH EQUITY

There is significant agreement between the priorities chosen during county forums and those identified through community-sponsored events and oral surveys. The underlying root causes for those who may experience systemic disadvantages differ depending on local resources and unique characteristics and cultural norms for each sub-population. These differences are best identified through further collaboration at the community level.

For a detailed look at what each community identified as priority health topics, as well as any gaps or barriers and resources or assets, please see the State Report, found on the Maine Shared CHNA website, www.mainechna.org.

For a quantitative look at how these differences affect health outcomes, see the Health Equity Data Sheets, also found on the Maine Shared CHNA website, www.mainechna.org.

NEXT STEPS

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

- For hospitals, create an informed implementation strategy designed to address the identified needs.
- For District Coordinating Councils, create District Health Improvement Plans.
- For the Maine CDC, create an informed State Health Improvement Plan.

This report will also be used by policymakers, non-profits, businesses, academics, and countless community partners to support strategic planning, coalition building, and grant writing. Taken together, these steps can lead to Maine becoming the healthiest state in the nation.

PRIORITY: MENTAL HEALTH

KEY TAKEAWAYS FOR CUMBERLAND COUNTY

Mental health was the top priority identified in Cumberland County. It was also identified as a top health concern in all other counties and among underserved communities in the state. Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.[1]

Participants in an event hosted for those with a mental health diagnosis noted extremely long waitlists for services, highlighting a need for more high-quality mental health services. Participants also suggested the need for more case management, supportive, and wrap-around services, as those with a mental health diagnosis required varied and nuanced care and treatment.

"There are significant concerns about how things will look post-COVID. Concerns about trauma."

Availability of mental health providers in Cumberland County was the most frequently mentioned indicator related to mental health. While Cumberland County has more mental health providers per person than other parts of Maine, forum participants expressed concerns about other issues related to access to care. There are long waitlists to access care, as well as **cost barriers** and insurance-related issues that prevent individuals from receiving needed mental health care.

"The state has made it quite complicated to provide services"

Mental health issues among youth were concerning to those in the community, the second most frequently mentioned health issue. In 2019, 18.4% of middle school students seriously considered suicide, a significant increase from 14.0% in 2017. Also in 2019, 22.2% of middle school students reported feeling sad or hopeless for two or more weeks in a row. The rate of high school students who reported suicidal ideation was 14.9% in 2019. That same year, 30.0% reported feeling sad and hopeless, up from 25.3% in 2017.

There were concerns about the impact of the COVID-19 pandemic on youth, including potential increases in adverse childhood experiences (ACEs) resulting from the pandemic which forced homeschooling in potentially unsafe situations while decreasing access to school-based supports.

Mental health emergency department usage was the third most frequently identified health indicator related to mental health. The discharge rate for those with a mental health diagnosis from the emergency department from 2016-2018 was 160.7 per 10,000. This rate is significantly lower than the state overall (181.5).

Adults receiving outpatient mental health care was the fourth most frequently mentioned health indicator. In 2015-2017, 18.6% of Cumberland County adults received outpatient mental health care. This rate is similar to the state (18.0%).

Community resources mentioned by participants to address mental health issues include Maine Behavioral Healthcare Peer Support Program, The Opportunity Alliance, recovery coaches, Massachusetts General Hospital Center for Telehealth psychiatry care, and Tri-County Mental Health Services.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[1] Centers for Disease Control and Prevention. Available from: https://www.cdc.gov/mentalhealth/index.htm

MAJOR HEALTH CONCERNS FOR CUMBERLAND COUNTY

	CUMBERLAND COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
MENTAL HEALTH							
Mental health emergency department rate per 10,000 population	—	2016-2018 **160.7**	N/A	2016-2018 **181.5**	★	—	N/A
Depression, current symptoms (adults)	2012-2014 **8.0%**	2015-2017 **8.5%**	○	2015-2017 **9.5%**	○	—	N/A
Depression, lifetime	2012-2014 **22.6%**	2015-2017 **23.0%**	○	2015-2017 **23.7%**	○	2017 **19.1%**	N/A
Anxiety, lifetime	2012-2014 **19.5%**	2015-2017 **22.1%**	○	2015-2017 **21.4%**	○	—	N/A
Sad/hopeless for two weeks in a row (high school students)	2017 **25.3%**	2019 **30.0%**	○	2019 **32.1%**	○	—	N/A
Sad/hopeless for two weeks in a row (middle school students)	2017 **18.8%**	2019 **22.2%**	○	2019 **24.8%**	○	—	N/A
Seriously considered suicide (high school students)	2017 **13.4%**	2019 **14.9%**	○	2019 **16.4%**	○	—	N/A
Seriously considered suicide (middle school students)	2017 **14.0%**	2019 **18.4%**	!	2019 **19.8%**	○	—	N/A
Chronic disease among persons with depression	—	2011-2017 **20.9%**	N/A	2011-2017 **30.8%**	★	—	N/A
Ratio of population to psychiatrists	—	2019 **5,419.0**	N/A	2019 **12,985.0**	N/A	—	N/A
Currently receiving outpatient mental health treatment (adults)	2012-2014 **17.6%**	2015-2017 **18.6%**	N/A	2015-2017 **18.0%**	N/A	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS MENTAL HEALTH

Community members identified multiple available treatment options and the presence of youth mental health resources as assets available for the Cumberland County community. The community also identified barriers to care, including an insufficient number of inpatient psychiatric beds, a need for culturally competent care, additional funding for youth mental health services, a lack of focus on prevention, and the potentially serious consequences of untreated mental health issues as ongoing challenges Cumberland County will need to overcome.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 6. Gaps/Needs and Available Resources (Mental Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration Work to integrate mental health and primary care (2) Public health organizing bodies in Cumberland County are active (2) **Treatment** Maine Behavioral Health Peer Support Program (6) Sweetser available at Bridgton Hospital 5 days per week Recovery coaches (3) Telehealth (e.g., Massachusetts General Hospital Center for TeleHealth provides telepsychiatry) (3) Tri-County Mental Health Services (2) Crooked River Counseling - Bridgton (2) Strong inpatient network and partnerships (2) Strong research institute to pilot novel treatments **Awareness/stigma** The knowledge that there are resource gaps (3) Increased attention/focus on mental health because of COVID Public and legislative support and momentum around mental health **ACEs/trauma** Knowledge/awareness of the effects of adverse childhood experiences (ACEs) **Other Services** The Opportunity Alliance	**Barriers to Treatment** No inpatient or outpatient beds Need more emergency acute care for mental health emergencies (6) Long wait times (5) Cost of care (3) Stigma Lack of transportation (2) Impacts of COVID Lack of transitional housing (2) Lack of preventive care (2) **Providers** Lack of providers (18) Lack of providers taking MaineCare (3) No training programs (2) Licensing/regulatory requirements make it hard to provide services **Culturally Competent Care** Culturally responsive care (9) Lack of specialized/culturally appropriate care (2) **Youth Mental Health** Lack of funding for youth programs Youth prevention/harm reduction **Funding** Services provided by unstable funding (2) Gaps in treatment for Assertive Community Treatment (ACT) services Limited funding to support caregivers **ACEs/Trauma** Misunderstanding about the role of trauma in mental health

PRIORITY: SOCIAL DETERMINANTS OF HEALTH

KEY TAKEAWAYS FOR CUMBERLAND COUNTY

Social determinants of health were selected as a top priority in Cumberland County. It was also identified as one of the top health concerns in 14 other counties in the state and among underserved community groups. Social determinants of health are the conditions in which people live, learn, work, play, worship, and age. Domains include education, economic stability, health care access and quality, the environment, and social connectedness. Examples include access to healthy food, housing, water, air, and relationships.[2] Differences in social determinants can create disparities that impact vulnerable populations and rural areas in Cumberland County.

Poverty was the most frequently mentioned health indicator related to social determinants of health in Cumberland County. According to recent estimates, 9.0% of individuals and 9.2% of children in Cumberland County live in poverty. While this is significantly lower than the state overall for both individuals (11.8%) and children (13.8%), this still equates to 25,762 of individuals in Cumberland County living in poverty. Forum participants noted the county has many available resources but there is a lack of knowledge about how to access them.

"The county is resource-rich, but there is difficulty in connecting people to resources.

Housing Insecure youth was the second most frequently mentioned health indicator. In 2019, 2.8% high school students report they usually do not sleep in their parents or guardian's homes. Recent data shows 12.8% of residents spent more than **half their income on housing**. The **cost of housing** was the third most mentioned health indicator.

Adverse childhood experiences (ACEs) are a list of potentially traumatic events that occur during childhood and increase the likelihood of negative health and behavioral outcomes later in life. In 2019, 17.6% of high school students in Cumberland County reported having experienced four or more ACEs. This was the fourth most frequently mentioned health indicator.

"So much relates to the trauma of poverty-lack of education, lack of food, lack of housing. Without a good set of baseline assets, it's difficult to navigate."

Rurality is the fifth most frequently identified social determinant of health indicator. In 2019, 33.3% of Cumberland County residents lived in a rural area. Forum members expressed concerns about access to care due to rurality.

Community members facing systemic disadvantages can be especially impacted by social determinants of health. Individuals with disabilities mentioned how they are impacted by a lack of transportation and face issues of discrimination. Minority groups also noted poverty, unemployment, and food insecurity issues. Older adults mentioned living on limited incomes and the need to rely on the support of others to address transportation needs and food insecurity.

Community resources mentioned by participants include Catholic Charities, The Opportunity Alliance, Maine Rural Health Research Center, and Maine Access Immigrant Network.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[2] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Available from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

MAJOR HEALTH CONCERNS FOR CUMBERLAND COUNTY

	CUMBERLAND COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SOCIAL DETERMINANTS OF HEALTH							
Individuals living in poverty	2009-2011 **10.7%**	2015-2019 **9.0%**	★	2015-2019 **11.8%**	★	2019 **12.3%**	N/A
Children living in poverty	2018 **8.0%**	2019 **9.2%**	○	2019 **13.8%**	★	2019 **16.8%**	★
Children eligible for free or reduced lunch	2020 **31.8%**	2021 **26.3%**	N/A	2021 **38.2%**	N/A	2017 **15.6%**	N/A
Median household income	2007-2011 **$57,267**	2015-2019 **$73,072**	★	2015-2019 **$57,918**	★	2019 **$65,712**	N/A
Unemployment	2018 **2.7%**	2020 **5.3%**	N/A	2020 **5.4%**	N/A	2020 **8.1%**	N/A
High school student graduation	2019 **88.2%**	2020 **87.9%**	N/A	2020 **87.4%**	N/A	2019 **87.1%**	N/A
People living in rural areas	—	2019 **33.3%**	N/A	2019 **66.2%**	N/A	—	N/A
Access to broadband	2015 **99.2%**	2017 **99.4%**	N/A	2017 **88.6%**	N/A	2017 **90.4%**	N/A
No vehicle for the household	2007-2011 **2.5%**	2015-2019 **2.4%**	○	2015-2019 **2.1%**	○	2019 **4.3%**	N/A
Persons 65 years and older living alone	2011-2015 **30.9%**	2015-2019 **29.8%**	N/A	2015-2019 **29.0%**	N/A	2019 **26.6%**	N/A
Households that spend more than 50% of income toward housing	—	2015-2019 **12.8%**	N/A	2015-2019 **12.0%**	○	—	N/A
Housing insecure (high school students)	2017 **2.7%**	2019 **2.8%**	○	2019 **3.3%**	○	—	N/A
Adverse childhood experiences (high school students)	—	2019 **17.6%**	N/A	2019 **21.3%**	★	—	N/A
Associate's degree or higher among those age 25 and older	2007-2011 **48.8%**	2015-2019 **56.3%**	N/A	2015-2019 **41.9%**	N/A	2019 **41.7%**	N/A
Commute of greater than 30 minutes driving alone	—	2015-2019 **31.4%**	N/A	2015-2019 **32.9%**	N/A	2019 **37.9%**	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Cumberland County community members point to several resources available that improve social determinants of health. These include many resources available to assist residents with accessing healthy foods, community cohesion, health screenings, and new revenue streams becoming available. However, community members also identified several challenges related to social determinants of health, including high levels of poverty, lack of resources for housing and transportation, high levels of food insecurity, isolation, and a lack of culturally responsive translation services.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 7. Gaps/Needs and Available Resources (Social Determinants of Health)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Organizing bodies in Cumberland County (2) Provider resource networks A wide array of social service agencies Health systems dedicated to population health improvement Bridgton Community Center Lakes Region Collective Action Network Maine Rural Health Research Center Public libraries Catholic Charities of Maine Local interest in Two Generational approaches The Opportunity Alliance Maine Access Immigrant Network **Food** Food banks (2) School meal programs Supplemental Nutrition Assistance Program (SNAP) benefit increase **Housing** Expansion of supportive housing (2) **Screening** New screening tools in electronic health record (3) **Funding** Availability of resources in various areas which aren't known to the public (e.g., Katie Beckett program) American Rescue Act Funds	**Poverty** Poverty (4) Lack of economic development **Community connections** Impacts of COVID Need more community engagement Helplessness to change/intervene Internet connectivity/broadband (5) Need to adopt 'Health in All Policies approach **Linkages to Services** Need wraparound safety net services (2) Lack of knowledge of existing resources Linkages to resources/services Links to services after screening **Education** Job training (2) Education missing as a priority Lack of funding for employment specialist/vocational training **Food** Food insecurity (7) **Housing** Housing issues (21) - affordability, safety, evictions, racist/predatory practices Criminalization of homelessness **Transportation** Lack of transportation resources (5) **Equity** Culturally responsive translation services (2)

Table 7. Gaps/Needs and Available Resources (Social Determinants of Health, Continued)

AVAILABLE RESOURCES	GAPS/NEEDS
	Health care access Cost of care Lack of insurance coverage Training for how to screen (3) **Resources/Funding** Lack of funding (3) Services provided by unstable funding (2) Lack of knowledge of available resources The disconnect between resources (2) **Other Issues** Adverse Childhood Experiences (ACEs) Criminalization of substance use disorder Nutrition, obesity (2)

PRIORITY: ACCESS TO CARE

KEY TAKEAWAYS FOR CUMBERLAND COUNTY

Access to care was identified as the third top priority in Cumberland County. It was also identified as a top health concern in all other counties in the state and among underserved community groups. Access to care means having the timely use of health services to achieve the best possible health outcomes It consists of four main components: availability of insurance coverage, availability of services, timeliness of access, and the health care workforce.[3]

Cost barriers to care were the most frequently identified health indicator related to access to care. In 2015-2017, 9.1% of adults reported there was a time during the last 12 months when they needed to see a doctor but could not because of the cost. This is similar to Maine overall (10.6%).

A lack of health insurance was the second most frequently mentioned health indicator by community members. From 2015-2019, 5.8% of Cumberland County residents were **uninsured.** This is significantly lower than the state uninsured rate of 7.9% over that same period.

"It's hard to recruit people here as lack of affordable housing is a major barrier."

Availability of primary care providers in Cumberland County was the third most frequently mentioned as a barrier to access to care. Recent data shows that 73.0% of Cumberland County residents **saw a primary care provider in the past year**. This means 27% of those in Cumberland County were at risk for not receiving routine preventative care.

In 2019, 12.8% of Cumberland County residents needed to **travel 30 miles or more to be seen by a primary care provider**. It was also identified as a common gap/need in Cumberland County with 19% of Lakes Region and 11% of Greater Portland participants mentioning this as a concern. In 2017, 99.4% of residents had **access to broadband** providing opportunities in telehealth and access to global economies.

"Barriers that overlap with social determinants of health- transportation, cost barriers, education, cultural competency, and language barriers."

Disparate communities experience barriers related to access differently. Black or African American community members expressed concerns about representation and culturally competent care, as well as issues with health literacy. Similarly, individuals with disabilities noted a lack of provider training in providing culturally competent care and communication. Additionally, the LGBTQ+ community identified a need for primary care, behavioral health, and other providers who offer affirming care for the LGBTQ+ population. For those who live in a rural setting, having to travel great distances to care poses unique challenges.

Despite the challenges that Cumberland County faces with access to care, community forum participants noted area resources such as Community Health Workers, access to telehealth, Maine Youth Access Network, Northern Light Home Care and Hospice, University of New England's Oral Health Program, and Greater Portland Health.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[3] Chartbook on Access to Health Care, Agency for Healthcare Research and Quality. Available from: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html

MAJOR HEALTH CONCERNS FOR CUMBERLAND COUNTY

	CUMBERLAND COUNTY			BENCHMARKS			
INDICATOR	POINT 1	POINT 2	CHANGE	MAINE	+/-	U.S.	+/-
ACCESS							
Uninsured	2009-2011 9.1%	2015-2019 5.8%	★	2015-2019 7.9%	★	2019 9.2%	N/A
MaineCare enrollment (all ages)	2019 17.5%	2020 20.9%	N/A	2020 29.1%	N/A	2020 24.1%	N/A
MaineCare enrollment (ages 0-19)	2019 27.7%	2020 31.5%	N/A	2020 43.8%	N/A	—	N/A
Ratio of population to primary care physicians	—	2019 1,018.0	N/A	2019 1,332.0	N/A	—	N/A
Usual primary care provider (adults)	2012-2014 89.6%	2015-2017 89.5%	○	2015-2017 87.9%	○	2017 76.8%	N/A
Primary care visit to any primary care provider in the past year	2012-2014 72.5%	2015-2017 73.0%	○	2015-2017 72.0%	○	2017 70.4%	N/A
Cost barriers to health care	2011-2013 9.5%	2015-2017 9.1%	○	2015-2017 10.6%	○	2016 12.0%	N/A
Primary care visits that were more than 30 miles from the patient's home	—	2019 12.8%	N/A	2019 20.0%	N/A	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS ACCESS TO CARE

Available resources in Cumberland County to address issues related to access include cohesion of the community, the presence of community organizations that increase access to care, emerging technologies, alternatives to in-office care, health care education, and a development plan for the health care workforce. Community members were also able to identify potential barriers to care. These included limited numbers of healthcare providers, a lack of services for new Mainers, the need for transportation resources in the rural areas of the county, and a lack of affordable housing.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 8. Gaps/Needs and Available Resources (Access to Care)

AVAILABLE RESOURCES	GAPS/NEEDS
Community Cohesion Public schools Municipal departments Public safety Public libraries Provider resource networks Public health organizing bodies in Cumberland County are active (2) **Community Organizations & Programs** Federally Qualified Health Centers (6) Northern Light Home Care and Hospice (2) Hospitals (2) Public health nurses (2) University of New England Oral Health (2) Primary care organizations Primary care provider and retail care options Charity care at hospitals Maine Access Immigrant Network (2) Maine Youth Action Network **Technology** Telemedicine (8) **Access with alternatives** Community health workers (CHWs) (5) Independent dental hygienists (2) Mainely Teeth Response to COVID Greater Portland Health is working to become a Center of Excellence for LGBTQ care **Education** Health ed in schools	**Culturally Competent Care** Services for New Mainers Need to center inclusion/diversity Services for Trans population Food offered in hospitals not culturally competent (2) Lack of language access Impacts of COVID **Barriers to Access** Lack of home care (2) Cost of care (14) Distance Long wait times (10) Access to broadband (3) Insurance issues (9) **Providers/workforce** Lack of competitive salaries for certain disciplines (2) Nursing shortage (5) Lack of providers/workforce shortages (10) Not enough Primary Care Providers Training for allied health professions (4) **Alternative Care/Missing Services** Lack of home care (2) Need funding for community paramedicine Lack of patient-centered medical homes Emergency acute care (2) Lack of dental services Services for the homeless population Alternate ways to move for people w/ chronic disease Misuse/overuse of Emergency Department (3) **Education** Health education in school

Table 8. Gaps/Needs and Available Resources (Access to Care, Continued)

AVAILABLE RESOURCES	GAPS/NEEDS
	Housing Not enough affordable housing for staff/providers (4) Insufficient shelter/housing options (2) **Transportation** Transportation (11)

PRIORITY: SUBSTANCE & ALCOHOL USE

KEY TAKEAWAYS FOR CUMBERLAND COUNTY

Substance and alcohol use was selected as a top priority in Cumberland County. It was also identified as one of the top health concerns in all other counties in the state and among underserved community groups. Recurring use of alcohol and/or drugs can have significant negative impacts, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance and alcohol use has also been linked to co-occurring mental health issues such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), among others.[4]

Overdose deaths were identified by 39% of forum participants as a concern. In 2020, the rate of overdose deaths per 100,000 population in Cumberland County was 32.5, a decrease from 33.9 in 2019. The rate in Maine overall was 37.3 in 2020, higher, but not to a significant degree.

Drug-induced deaths increased significantly from 12.3 per 100,000 in 2007-2011 to 27.3 in 2015-2019. These deaths are attributed to chronic use of prescription drugs.

"For those with substance use disorder, it's not easy to find help. It feels like there's no access and there's no one to call."

Community forum participants expressed concerns about multiple drug and alcohol use health indicators, including, **chronic heavy drinking, alcohol-induced deaths**, **and alcohol-impaired driving deaths.** The rate of alcohol-induced deaths in Cumberland County was 11.4 per 100,000 residents between 2015 and 2019. This is significantly higher than 6.9 in 2007-2011.

Hospital utilization was the third most frequently mentioned health indicator for substance and alcohol use. Between 2019 and 2020, overdose emergency medical service responses per 10,000 residents decreased significantly from 90.6 to 81.2. This remains higher than the 2020 state rate (76.7).

The **misuse of prescription drugs** was mentioned by 19% of forum participants. In 2019, 2.7% of middle school students reported having misused prescription drugs, a significant increase from 1.4% in 2017.

"At a needle exchange event recently and it feels like you're just constantly pulling people out of the river and with no chance to even look up and see who's tossing them in in the first place."

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

A common barrier mentioned by participants was a lack of substance and alcohol use treatment providers and programs, including those that offer Medication-Assisted Treatment (MAT). Resources mentioned include Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) Initiative, recovery community centers particularly Lakes Region Recovery Center, McAuley House, and needle exchanges.

For more information about how those who may experience systemic disadvantages are impacted by this priority health topic area, please see the State CHNA Report.

[4] Mental Health and Substance Use Disorders. Substance Abuse and Mental Health Services Administration (SAMHSA). Available from: https://www.samhsa.gov/find-help/disorders

MAJOR HEALTH CONCERNS FOR CUMBERLAND COUNTY

	CUMBERLAND COUNTY			BENCHMARKS			
INDICATOR	**POINT 1**	**POINT 2**	**CHANGE**	**MAINE**	**+/-**	**U.S.**	**+/-**
SUBSTANCE USE							
Overdose deaths per 100,000 population	2019 **33.9**	2020 **32.5**	○	2020 **37.3**	○	2019 **21.5**	N/A
Drug-induced deaths per 100,000 population	2007-2011 **12.3**	2015-2019 **27.3**	!	2015-2019 **29.5**	○	2019 **22.8**	N/A
Alcohol-induced deaths per 100,000 population	2007-2011 **6.9**	2015-2019 **11.4**	!	2015-2019 **11.6**	○	2019 **10.4**	N/A
Alcohol-impaired driving deaths per 100,000 population	2018 **1.4**	2019 **1.7**	N/A	2019 **3.8**	N/A	2019 **3.1**	N/A
Drug-affected infant reports per 1,000 births	2017 **41.7**	2018-2019 **29.4**	★	2018-2019 **73.7**	★	—	N/A
Chronic heavy drinking (adults)	2012-2014 **7.9%**	2015-2017 **9.9%**	○	2015-2017 **8.5%**	○	2017 **6.2%**	N/A
Binge drinking (adults)	2012-2014 **19.8%**	2015-2017 **19.7%**	○	2015-2017 **17.9%**	○	2017 **17.4%**	N/A
Past-30-day marijuana use (adults)	2013-2016 **11.1%**	2017 **17.0%**	!	2017 **16.3%**	○	—	N/A
Past-30-day misuse of prescription drugs (adult)	—	2013-2017 **1.4%***	○	2013-2017 **1.0%**	○	—	N/A
Past-30-day alcohol use (high school students)	2017 **24.1%**	2019 **24.1%**	○	2019 **22.9%**	○	—	N/A
Past-30-day alcohol use (middle school students)	2017 **3.1%**	2019 **3.4%**	○	2019 **4.0%**	○	—	N/A
Binge drinking (high school students)	2017 **8.9%**	2019 **8.8%**	○	2019 **8.2%**	○	—	N/A
Binge drinking (middle school students)	2017 **0.9%**	2019 **1.2%**	○	2019 **1.3%**	○	—	N/A
Past-30-day marijuana use (high school students)	2017 **19.4%**	2019 **23.9%**	!	2019 **22.1%**	○	—	N/A
Past-30-day marijuana use (middle school students)	2017 **2.7%**	2019 **2.9%**	○	2019 **4.1%**	★	—	N/A
Past-30-day misuse of prescription drugs (high school students)	2017 **6.1%**	2019 **5.4%**	○	2019 **5.0%**	○	—	N/A
Past-30-day misuse of prescription drugs (middle school students)	2017 **1.4%**	2019 **2.7%**	!	2019 **3.0%**	○	—	N/A
Narcotic doses dispensed per capita by retail pharmacies	2019 **9.0**	2020 **8.7**	N/A	2020 **12.1**	N/A	—	N/A
Overdose emergency medical service responses per 10,000 population	2019 **90.6**	2020 **81.2**	★	2020 **76.7**	○	—	N/A
Opiate poisoning emergency department rate per 10,000 population	—	2016-2018 **11.1**	N/A	2016-2018 **9.9**	!	—	N/A
Opiate poisoning hospitalizations per 10,000 population	—	2016-2018 **1.3**	N/A	2016-2018 **1.4**	○	—	N/A

CHANGE columns shows statistically significant changes in the indicator over time.	
★	means the health issue or problem is getting better over time.
!	means the health issue or problem is getting worse over time.
○	means the change was not statistically significant.
N/A	means there is not enough data to make a comparison.
BENCHMARK columns compare the county data to the state and national data.	
★	means the county is doing significantly better than the state or national average.
!	means the county is doing significantly worse than the state or national average.
○	means there is no statistically significant difference between the data points.
N/A	means there is not enough data to make a comparison.
ADDITIONAL SYMBOLS	
*	means results may be statistically unreliable due to small numbers, use caution when interpreting.
—	means data is unavailable because of lack of data or suppressed data due to a small number of respondents.

COMMUNITY RESOURCES TO ADDRESS SUBSTANCE & ALCOHOL USE

Community members in Cumberland County identified peer recovery and treatment resources available as potential strengths to address substance and alcohol use in their county, along with harm reduction strategies and funding sources. Additionally, barriers to substance and alcohol use issues were identified by community members, including a lack of available treatment programs, a need for additional recovery coaches, widely available addictive substances, and a lack of coordination among providers.

The following information was gathered from participants during a group activity, where participants were asked to share their knowledge of the gaps and needs or resources and assets in their communities about the identified health priorities. The numbers in parentheses indicate the number of times community members mentioned or concurred with what was listed.

Table 9. Gaps/Needs and Available Resources (Substance & Alcohol Use)

AVAILABLE RESOURCES	GAPS/NEEDS
Collaboration	**Collaboration**
Organizing bodies in Cumberland County (2)	Need better coordination (4)
Governor's Task Force	**Prevention**
	No funding for prevention
Prevention	**Stigma**
Prevention programs	Stigma
	Treatment
Recovery	Increased severity/complexity of overdose
Recovery Community Centers (2)	Not tracking relapse
Expansion of McAuley house (3)	Lack of providers (3)
Lake Region Recovery Center (10)	Lack of detox programs (3)
	Lack of residential treatment (2)
Treatment	Case management not provided by state
Increased access to Medication-Assisted Treatment (2)	**Harm Reduction**
COVID-related waivers for providers (telehealth, MAT)	Lack of understanding of harm reduction
Strong research institute to pilot novel treatments	Needle exchange is 1 for 1
	Recovery
Harm Reduction	Need more recovery homes
Harm reduction programs	**Youth**
Availability of Naloxone	Youth access to e-cigarettes (3)
Overdose Prevention Through Intensive Outreach	Youth access to substances (3)
Naloxone and Safety (OPTIONS) initiative	Need for earlier intervention (2)
Needle exchange	Teen alcohol use
	Missing early detection in schools
Law Enforcement	**Workforce**
Law enforcement/community awareness	Workforce issues (2)
	Misunderstanding the role of trauma
Organizations	Cohesion among providers
Organizations run by Black, Indigenous, and people of color (BIPOC)/new Mainers	Funding/Resources
	Impacts of COVID
The Opportunity Alliance	Services provided by unstable funding (2)
	Cost of care
Funding	**Specific Substances**
Federal/state funding	The rise in vaping (2)
Funding available	Hard drug use (heroin)
Specific Substances	Changing norms around marijuana
Improved focus on stimulant use disorders	

OTHER IDENTIFIED NEEDS

The following is a list of all health priorities identified in the Cumberland County forum. Each participant was allowed to vote for up to 4 priorities from a list of twenty-four priorities. The first column is the name of the priority, the second column is the total number of votes that priority received, and the final column is the percentage of participants who voted for that priority.

Table 10. All Priority Health Topic Areas for Cumberland County

PRIORITIES	# OF VOTES	% OF PARTICIPANTS
Mental Health	49	51%
Social Determinants of Health	41	42%
Access to Care	40	41%
Substance and Alcohol Use	33	34%
Older Adult Health	19	20%
Physical Activity, Nutrition, and Weight	10	10%
Health Care Quality	7	7%
Infectious Disease	7	7%
Unintentional Injury	6	6%
Oral Health	5	5%
Intentional Injury	4	4%
Immunization	4	4%
Pregnancy and Birth Outcomes	4	4%
Cardiovascular Disease	3	3%
Other	3	3%
Environmental Health	3	3%
Tobacco	2	2%
Diabetes	2	2%
Children with Special Needs	2	2%

APPENDIX: METHODOLOGY

The Maine Shared CHNA is a public-private collaboration governed by a Steering Committee, which is made up of representatives of each member organization (CMHC, MGH, MH, NLH, and Maine CDC). The Steering Committee sets fiscal and operational goals that are then implemented by the Maine Shared CHNA Program Manager. Input is provided by key stakeholder groups including the Metrics Committee and the Health Equity/Community Engagement Committee.

The **Metrics Committee** is charged with creating and reviewing a common set of population/community health indicators and measures every three years. Before the 2018-2019 Maine Shared CHNA, the Metrics Committee conducted an extensive review of the data using the following criteria as a guide: 1.] describes an emerging health issue; 2.] describes one or more social determinants of health; 3.] measures an actionable issue; 4.] the issue is known to have high health and social costs; 5.] rounds out our description of population health; 6.] aligns with national health assessments (e.g..: County Health Rankings, American Health Rankings, Healthy People); 7.] data is less than 2 years old; 8.] data was included in the previous data set, or 9.] the Maine CDC analyzes the indicator in a current program. This review process was carried into the 2021-2022 Maine Shared CHNA, where the Metrics Committee also reviewed the previous data set to check for changes in data sources, potential new sources of data to round out certain topics, and to deepen Social Determinants of Health data which many of our partners have included in their work.

The **Health Equity/Community Engagement Committee** is charged with updating outreach methodology to ensure a collection of broad, diverse, and representative qualitative data from groups that are more likely to experience health disparities. To ensure these methods reflect the needs and cultural expectations this committee included representatives from a variety of Maine's ethnic-based and community-based organizations, along with representatives from public health and healthcare, and a variety of additional partners.

The 2021-2022 Maine Shared CHNA process involved three phases.

Data Analysis

The first phase of the project involved the analysis of more than 220 health indicators for the state, counties, public health districts, selected cities, and by specific demographics when available.

Data analysis was conducted by the Maine CDC and its epidemiology contractor, the University of Southern Maine with additional support from the contracted vendor, Market Decisions Research.

Community Outreach and Engagement

Community outreach and engagement for the Maine Shared CHNA included the following efforts:

- 17 County Forums (Maine)
- 9 Community Sponsored Events
- 1,000 Oral Surveys

County Forums were held in each of Maine's 16 counties, with one county, Cumberland, hosting one event in western Cumberland and one in eastern Cumberland in recognition of the differences between Greater Portland (Maine's most densely populated area) and the Lakes Region, (a more rural area). Local planning teams led by local healthcare and public health district liaisons organized and promoted these events. Participants were shown a PowerPoint presentation with relevant county data and were led through guided discussions to identify indicators of concern. Participants then voted to identify their top four health priorities. They were then asked to share their knowledge on gaps and assets available in their communities to address each of the top priorities identified.

New this cycle was an expanded effort to reach those who experience systemic disadvantages and therefore experience a greater rate of health disparities. Two types of outreach were piloted. One effort included nine community-sponsored events. The hosts were chosen for their statewide reach.

The communities included:

- Black or African American
- Homeless or formerly homeless
- LGBTQ+ community
- Older adults
- People who are deaf or hard of hearing
- People who live with a disability
- People with low income
- People with a mental health diagnosis
- Youth

These events followed the same methodology as county forums with hosts providing input on the data presentation and leading the effort to recruit participants

Oral surveys were conducted in collaboration with 10 ethnic-based community organizations' (ECBO's) community health workers to better reach Maine's immigrant population. There were 1,000 surveys were conducted in either English (32%), Somali, (24%), Arabic (23%), French (8%), Spanish (5%), Lingala (3%), and other languages including Swahili, Maay Maay, Portuguese, Oromo, Eretria, Kirundi, and Amara. When asked for their countries of origin, respondents most commonly cited the United States (212), Iraq (205), Somalia (157), The Democratic Republic of Congo (81), Djibouti (70), Kenya (30), and Mexico (29).

Other countries of origin mentioned included Rwanda, Ethiopia, Angola, Syria, Guatemala, South Africa, Palestine, Puerto Rico, Morocco, Afghanistan, El Salvador, Nigeria, Canada, Burundi, Eritrea, France, Honduras, Uganda, Jamaica, Mali, Gabon, Sudan, Nicaragua, Peru, and Brazil

The survey was an adaptation of the City of Portland's Minority Health Program Survey conducted in 2009, 2011, 2014, and 2018. In 2021, a small group of stakeholders convened to adapt this survey to meet the needs of the Maine Shared CHNA. This group included those who deployed the survey as well as other interested parties.

Groups that piloted these new outreach methods were offered stipends for their time.

Due to concerns related to COVID-19, community engagements efforts were conducted virtually except the event for the deaf or hard of hearing, which was held in a gymnasium at the Governor Baxter School for the Deaf on Mackworth Island. Oral surveys were conducted telephonically or by following current U.S. CDC COVID-19 protocols.

Community engagement was supported by John Snow, Inc. (JSI), who also conducted the initial qualitative analysis. All support materials including Data Profiles and PowerPoints were produced by Market Decisions Research.

Reporting

Initial analysis for each event and the oral surveys were reviewed by local hosts for accuracy and to ensure the information the community may find sensitive was flagged. Final CHNA reports for the state, each county, and districts were developed in the spring of 2022. Final Reports were written and produced by Market Decisions Research.

In addition to Urban, County, and Health District reports, the County, District, and State level data are also available on an Interactive Data Portal. The data in the portal is arranged by health topic and provides demographic comparisons, trends over time, definitions, and information on the data sources. Visit www.mainechna.org and click on **Interactive Data** in the menu to the left. The Maine Shared CHNA website is hosted by the Maine DHHS. (www.mainechna.org).

There were two virtual community forums held in Cumberland County, one in the Greater Portland area on October 5, 2021, with 68 attendees; and one in the Lakes Region on October 26, 2021, with 33 attendees. Persons from the following organizations representing broad interests of the community were consulted during the engagement process:

Bridgton Hospital
Central Maine Healthcare
City of Portland
City of Portland - Public Health Division
Hospital Community Representative
Cumberland County Government
Cumberland Public Health District
From the First Tooth
Gateway Community Services
Good Shepherd Food Bank
Greater Portland Health
Healthcare Coalition of Maine
Healthy Androscoggin
Lake Region Community Health Committee
Macdonald Motors
Maine Access Immigrant Network
Maine Access Points
Maine Behavioral Healthcare
Maine Medical Center
Maine Medical Center Research Institute
Maine Medical Partners
Maine Medical Partners Pediatrics
MaineHealth
Northern Light Beacon Health
Northern Light Health
Northern Light Home Care & Hospice
Northern Light Mercy Hospital
Northern New England Poison Center
Planned Parenthood of Northern New England
Portland Public Schools
Protech Solutions / Good Grid
Rural Health &Primary Care Program; Department of Health and Human Services
Spring Harbor Hospital
The Opportunity Alliance
The Opportunity Alliance WIC
The Opportunity Alliance; Lake Region Community Health Committee
Through These Doors
Town of Raymond
United Way of Southern Maine

For a complete listing of organizations consulted for each of the 10 health equity outreach efforts, please see the Acknowledgements, page 24. The State Report, found on the Maine Shared CHNA website, www.mainechna.org, provides a full description of findings by each community-sponsored event.

ACKNOWLEDGMENTS

Funding for the Maine Shared CHNA is provided by the partnering healthcare systems with generous support from the Maine CDC and countless community partners and stakeholder groups. Additional funding was provided by the Maine Health Access Foundation and the Maine CDC to conduct additional outreach to engage those whose voices would not otherwise be distinctly heard. The Maine Shared CHNA is also supported in part by the U.S. Centers for Disease Control and Prevention (U.S. CDC) of the U.S. Department of Health and Human Services (U.S. DHHS) as part of the Preventive Health and Health Services Block Grant (awards NB01OT009343-01 & NB01OT009413-01). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by the U.S. CDC/HHS, or the U.S. Government.

The infrastructure for community-led efforts is gaining strength. We are grateful to those who put their trust in the Maine Shared Community Health Needs Assessment process. Together, the MSCHNA and each of our community hosts have strived to ensure their voices are reflected herein.

Oral Survey Sponsors	Community Event Sponsors
Capital Area New Mainers Project	Consumer Council System of Maine
City of Portland's Minority Health Program	Disability Rights Maine
Gateway Community Services	Green A.M.E. Zion Church
Maine Access Immigrant Network	Health Equity Alliance
Maine Community Integration	Maine Continuum of Care
Maine Department of Health and Human Services*	Maine Council on Aging
Maine Immigrant and Refugee Services	Maine Primary Care Association
Mano en Mano	Maine Youth Action Network
New England Arab American Organization	
New Mainers Public Health Initiative	

*Includes the Manager of Diversity, Equity, and Inclusion and the Maine CDC.

Months of planning were conducted by stakeholder groups including the Metrics Committee, Data Analysis Team, Community Engagement Committee, Health Equity Committee, and Local Planning teams. For a complete listing please visit the Maine Shared CHNA website About Us page. Significant analysis was conducted by epidemiologists at the Maine CDC and the University of Southern Maine's Muskie School of Public Service. Market Decisions Research provided quantitative and qualitative analysis and design and production support. John Snow, Inc. (JSI) provided methodology, community engagement, and qualitative analysis expertise and support. The oral survey was adapted from the City of Portland's Minority Health Program's survey. Special thanks to the Partnership for Children's Oral Health for their data contribution.