



Health & Human Services and Public Safety Committee

**Tuesday, January 14, 2020, 5:30 PM
Room 209, City Hall**

Councilor Belinda Ray, District 1, Chair
Councilor Tae Chong, District 3
Councilor Pious Ali, At-Large

1. Announcements
2. Review and Approval of Minutes from November 12, 2019
 - a. November 12, 2019 Draft Meeting Minutes.
3. Public Health Director Search Update
4. Health of Portland Report
 - a. Staff Overview
5. HHS & PS 2020 Work Plan Discussion
 - a. Potential Topics/Issues for the 2020 Work Plan
6. Next Meeting: February 11, 2019

NOTE: Since there are no action items on the agenda, there will be no opportunity for public comment at this meeting. Please feel free to send comments to members of the committee on any issue at any time via email. Councilors email addresses are available on the city website: www.portlandmaine.gov

The meeting can be watched online via livestream: www.portlandmaine.gov/livestream

Keep up to date with the new shelter design and planning process at the City's website

www.portlandmaine.gov/shelterplanning



Health & Human Services and Public Safety Committee Minutes

Tuesday, November 12, 2019, 5:30pm, Room 209, City Hall

Committee Attendance:

Belinda Ray, Chair (District 1), Brian Batson (District 3), Pious Ali (At-Large)

Councilors in Attendance:

Kimberly Cook (District 5)

City Staff:

City Manager, Jon Jennings; Kristen Dow, Director of Health and Human Services; Aaron Geyer, Director of Social Services; Sara Fleurant, Director of Oxford Street Shelter; Jennifer Thompson, Associate Corporation Counsel; Adam Harr, Executive Assistant

Meeting called to order at 5:36 PM.

AGENDA ITEM 1 – Announcements

- Chair Ray received an email asking about the requirements for the site planning for the new Homeless Services Center. She created a document showing the timeline; creating the site plan is the next step and site plan review after that. The email referred to requirements outlined in the updated shelter ordinance as well as design and conditional use standards. These include the proposed use not having a greater impact than the uses in the zone; Chair ray listed some uses in the document shared.

AGENDA ITEM 2 – Approval of Minutes

- Councilor Batson moved to approve the minutes, Councilor Ali seconded and the minutes were approved unanimously.

AGENDA ITEM 3 – Shelter Policy

Committee Questions and Discussion

- At the October 29th meeting, Chair Ray read the proposed resolution into the record.
- The Committee had not gained consensus on a cap leaving the following options on the table:
 - The committee could not recommend a cap.
 - Set a cap.
 - Forward a blank cap to be worked out at the Council.
- Chair Ray proposed language for three option:

- a. Set a cap of 200 beds at the new HSC, and develop a policy for how staff will respond to clients who present when the cap has been met.
 - b. Ensure the new facility is built with ample capacity to handle our current average annual nightly census for the previous 12 months. As of 9/30/19, the average nightly census for the previous 12 months is 210.
 - c. Do not set a cap on the number of beds at the new facility at this time. Instead, ensure the new facility is built with ample capacity to handle our current average annual nightly census for the previous 12 months. As of 9/30/19, the average nightly census for the previous 12 months is 210. Ensure the facility is built
- Councilor Ali said his overflow question is unanswered; what would happen when someone presents when the shelter is at capacity.
 - He described a personal story of some time ago when someone without resources who mistakenly flew to Portland and was assisted with a hotel room.
 - How would the new shelter handle this situation?
 - Kristen said that the City would reach out to partners and does not see a situation where someone would be turned away.
 - City staff are heading to Pine Street Inn on Friday to learn about their intake and diversion process.
- How are people assisted under GA?
 - Jen said that many of these questions are situation-specific.
 - This person would go through the usual diversion of the shelter and when screened for GA eligibility, she suspects that that person would not be eligible as they do not intend to make Portland their permanent home.
- Councilor Ali described a youth shelter where when someone younger presents when at capacity, the oldest guest would need to find an alternative. How would the HSC handle a similar situation?
 - Sara explained that situations like this occur often when youths at the teen center who are near the upper age limit or are nearing the residency threshold are referred to Oxford Street.
 - Whether there is a cap or there is not a cap, staff will continue to explore the options available to someone.
 - There will be a capacity in one form or the other; the current 154 bed capacity is set by the fire department.
- Is there an orientation for people staying the shelter?
 - There are daily orientations at OSS.
 - One is for housing and area resources
 - One is for expectations at the shelter including being a good neighbor.
- Chair Ray proposed substituting the bed count chart for more complete numbers.
 - Councilor Batson seconded and Councilor Ali agreed.
- Metro Regional Coalition amended their language to change burden to responsibility to care for the homeless population.
 - The committee agreed.
- Councilor Batson does not have questions and is leaning to B. He wants to set a number that provides adequate space for the people we currently serve. He does not feel strongly on setting the cap as much as the space is adequate.
- Councilor Ali is still unclear on policy for need over capacity

- The resolution affirms space for occasional overflow.
 - There will be a capacity, effective due to fire safety code or prescribed.
 - Staff will not turn people away; they will work diligently and the next day will find an alternative place for that person.
 - Find alternatives when at capacity in a more immediate way.
- The plan is to have overflow capacity on site, either a flex space of bunked beds, even mats on the floor in an office.
 - This answered Councilor Ali's question.
- Councilor Cook asked where in Bangor's City Code does it cap their shelter's capacity at 60?
 - There is a cap on the non-profit shelter of 60 beds based on what was shared at a previous meeting.
 - Bangor's General Assistance ordinance limits the shelter to individuals who are GA eligible.
 - When Hope House sought to expand their transitional housing program, the Bangor City Council reduced the emergency shelter's bed count.
 - This is likely in a land use agreement due to the land being owned by the City of Bangor.
 - Bangor limits shelter to GA eligibility.
 - Of the attached ordinances for review, Jen did not see another ordinance with GA eligibility requirements.
 - Individuals and families housed in city-run shelter must qualify for general assistance.
 - Most ordinances are consistent.
 - Most municipalities have screen GA eligibility at town halls.
- Councilor Ali asked about employed people who leave early or late due to employment.
 - This is an operational question that would be addressed by the shuttle and operational decisions made when further on in the process.
- Is there a problem with having a date in the resolution?
 - Jen said it can be specific in the ways you would like it to be?
- Chair Ray is leaning to option B.
 - It sends a message to other communities about our capacity to assist and that others must work to assist members of their community.
 - She is hopeful for the downward trend but is cautious about the hazard of building too small as it is hard to scale up; she wants to be sure we can serve our current need.
- Councilor Ali asked if it possible to strike out number 9 and make it a continuation of B, but thinks it is ok the way it is.
- Councilor Ali had been leaning towards leaving it blank until he heard the explanation of staff operational decisions and the plan for on-site overflow.
 - Councilor Ali will support B to bring this forward in discussion at the full Council.
 - He thinks 9 may be more likely to remain attached to B
 - Chair Ray thinks on its own makes its longevity more likely.
- The committee agreed to adopt 8.B

- Ensure the new facility is built with ample capacity to handle our current average annual nightly census for the previous 12 months. As of 9/30/19, the average nightly census for the previous 12 months is 210.
- [If no cap set in #8, consider adding the following language or something similar here]: Over time, as the average nightly census regularly and on a year-round basis comes in below 200, consider establishing an appropriate cap on city services at the facility, with sufficient advanced notice to other communities and the State government regarding when said cap will go into effect.
 - Should a future cap be considered?
 - Councilor Batson asked if City staff foresee any hypothetical situations at the State or Federal level that would see a cap needing to be revisited?
 - If services or vouchers were reduced.
 - If there were major changes to General Assistance.
- Councilor Ali asked about overflow: if there is a difference between occasional or as needed?
 - Occasional infers it is not meant to be regular.
 - From the client perspective if occasional or as needed means a person may not present.
 - It does not influence operations; overflow would be opened when needed.
 - The committee agreed to change occasional to as needed.
- Is 10's on an annual basis clear?
 - Staff: Yes.
 - Chair Ray noted if we are going way above 200 in the Winter, it would be good to have an adequate cap.
- Councilor Cook appreciates the work the committee has done. She was not aware that the committee was working towards a resolution.:
 - She asked the language to be considered:
 - Add the residency demographic of who is served over the past three years in the 'whereas' section.
 - Clarity on the services offered at the shelter being for shelter clients other than the health clinic and community policing.
 - This is an oversight and was in a previous draft.
 - Add as a number 13.
- 13
 - Develop clear guidelines that services are for people staying in shelter.
 - Some city services are grant funded and considerations to who those funded services are intended for are encompassed by this constriction.
 - For confidentiality reasons, limiting services to people in shelter will protect privacy.
 - Community partners shared the sentiment of this recommendation.
 - It will not be like Preble Street's community meal program, there will be meals for shelter guests; the Homeless Services Center meals is not meant to supplant community meals for others.
 - Separate entrance Services
 - The Greater Portland Health will serve the public and shelter guests.
 - Community policing would be open to the community.

- All services provided at or by the shelter are only for shelter guests only except for the health clinic and Community Policing.
 - At: return to the council.
 - By: leaves space for expansion without being limited to the two defined exceptions.
 - Services are required to be offered on-site at the shelter and can include:
 - Housing Assistance
 - Case management
 - Life skills training
 - Counseling
 - Employment
 - Educational Services
 - Whereas added above regional responsibility:
 - Page 2 of the resolution adding a saying they Intakes from the past three years are individuals stating they are from Portland, X% from Other Maine Towns, X% from out of state and country.
 - Whereas over the past two years, the Oxford Street Shelter as served X%
- Councilor Ali asked if the required services listed are offered at OSS?
 - Many are offered but we don't have the on-site space for some services and currently work creatively to find space to offer them.
 - Commute partner services offered to guests on site at the shelter are limited to those staying at the shelter as a satellite serving the shelter guests (the service providers can serve anyone they choose at their sites.)
 - Staff seeking partners and offering space would be providing services.
- Chair Ray is comfortable with 'at' the shelter as the clinic and community policing would be separate from the shelter.
- Councilor Ali asked about someone wanting to shower who is not staying in the shelter.
 - They would need to do an intake at the shelter in order to use the shower.
 - It is a safety issue.
 - Kristen likened it to what was offered at the Expo this past summer: meals, healthcare and other services were offered on site to those sleeping at the Expo.
- Councilor Ali asked about a hypothetical about someone camping near the shelter who has done an intake?
 - That would be an operational decision.
 - Currently, day services are only offered to people staying in shelter.
 - Meals would be a new service but otherwise the HSC is similar to current shelter operations.
 - Someone coming for services only would be held to different standards as they would not have signed a resident contract with behavioral standards.
 - Jen offered to think about what the objective of the committee is: The Council would like to limit the services offered at the shelter be for shelter guests and that guidance be used by staff in their operational decisions.
 - The guidance is clearly stated but these specific questions may not be able to be answered.
- Councilor Ali will need clarification for his conscience in order to vote.
 - Will need this understanding in order to vote affirmatively at the full Council.

- Councilor Batson is understanding there is a question on when is a person a resident of the shelter and when are they no longer eligible for on-site services?
 - We are an emergency shelter and no one is ever considered a resident of the shelter as the goal is exit homelessness quickly.
 - Someone entering shelter for the first time during the day who would do an intake that night can stay in the space as they work on resources that day. The next day the guest/client can freely access resources.
 - Councilor Batson wanted to highlight these are judgement calls.
 - The dedicated staff of the shelter will work with each person's unique situation and try and find a solution for that individual.
 - Councilor Batson wants it to be safe and fair for those in the shelter.
 - If someone stays at the shelter and does an intake, they have access to services for 90 days.
- Councilor Cook asked about people saying sporadically can access services for 90 days?
 - Current operations look at names staying the past seven days.
 - This is a practice not a policy.
 - It may be helpful to describe current practice make a written reference such as an employee manual.
 - Jen is looking at the City Council and the Staff as her client and is mindful of the charter and the clear distinctions between the purview of staff and the City Manager or the City Council
 - Policy for the City Council side is ordinance
 - Policy on the staff side are operational decisions on the ground.
 - We are in a unique space in the state and country being a municipality operating two low barrier shelters.
- Councilor Cook commented intake policy is not memorialized in the resolution. She prefers an intake be done at a general assistance office and that a city shelter would fulfill our General Assistance obligation to provide emergency shelter.
 - The Shelter is how we would serve our general assistance emergency shelter obligation.
 - Chair Ray clarified if we are a community that has a full shelter and someone eligible for emergency shelter under general assistance
- Councilor Cook commented on number 9 "Ensure the new facility has adequate capacity to handle occasional overflow onsite."
 - We are providing guidance on not offering overflow at another location.
 - We are guiding staff to build a shelter that is significantly larger than the current shelter.
- Councilor Cook asked how we would prioritize; those from Portland would be insured a space at the shelter.
 - A residency requirement or prioritization would not be legal.
 - Chair Ray had been interested in such a prioritization but there would be no legal way to this because inter and intra state travel is cannot be restricted.
- Any legal questions at Monday's Council meeting will be able to trigger an executive session.
 - Councilor Cook would prefer a memo on prioritization and who must be served by the emergency shelter.

- Intake: if it were added, Chair Ray prefers add the national best practice on site that we do. We perform intake on-site without requiring people to queue up outside. She is not interested in doing intake off-site with hours that close in the afternoon.
 - Councilor Batson does not see a need to put it in.
 - Chair Ray asked if we should add it to clarify to other Councilors who know we have researched it?
 - Councilor Batson is cautious about being too narrow, possibly precluding adding intake off site.
 - Jen's concern is that we are complying with GA statute which requires we have enough flexibility to make operate within the time limit applications must completed.
 - Councilor Cook asked about the best practices and doing intakes until 2:00 AM:
 - Best practice is to do when people present: 6:00 to 2:00 is based on when people present and that applications done earlier often lead to people mitigating their situation before going into shelter that night supplanting staff time one paperwork that is not used.
 - The diversion program is being researched now to do as soon as possible.
- Chair Ray asked about Councilor Cook's concern that overflow would only be on-site.
 - There will be space at the new facility that the current facility does not have.
 - Such as a day room that can become a dormitory at night and then go back to its regular ruse during the day.
 - The previous and current system necessitates navigating around the town in the street or a separate day shelter.
 - Providing overflow on-site will create stability and prevent crowds in the area protect the privacy of shelter guests.
 - The committee agreed to keep the current language.
- Councilor Cook asked staff to assess the 200 number on what 210 plus adequate overflow looks like for Monday's Council meeting.
 - # beds
 - # Overflow beds: mats or beds.
 - Amount of space
 - Math can be done with the fire department.
 - Does the 20,000 square foot with 200 beds and overflow space draft model fit with this?
- Amendments:
 - 13 services provided
 - Develop clear guidelines establishing that services provided at the shelter, including meals, are only for shelter guests who have completed or are completing the intake process.
 - At or by?
 - Councilor Batson likes the specificity of by the shelter to exclude GPH but include community partners brought into the shelter in partnership.

- Develop clear guidelines establishing that services provided by the shelter, including meals, are only for shelter guests who have completed or are completing the intake process.
- o Whereas added above regional responsibility:
 - Page 2 of the resolution adding a saying the intakes from the past three years are individuals stating they are X% from Portland, X% from other Maine Towns, X% from out of state and country.
- o 8: amendment B.
- o 9: change occasional to as needed.
- Councilor Batson moved to recommend the resolution to the full council, Councilor Ali seconded and the motion passed unanimously

AGENDA ITEM 4 – Next Meeting

- Monday November 18, 2019 City Council Meeting.
 - o Executive session language for the Council Meeting.
 - o Councilor Cook suggested a Council workshop with consultant.
 - Chair Ray prefers that be done after the resolution passes.
- Noted: the next HHS&PS meeting is with the Economic Development Committee to discuss marijuana business licensing on November 26, 2019.

The meeting adjourned at approximately 7:36 PM.

Health of Portland



2019 - 2020



HHS + PS Committee

January 14, 2020

AGENDA



Welcome to the HOP

A brief introduction to the report.



How did we get here?

A look into the process of creating the HOP.



Data Overview

A review of some statistics that already have us talking.



Where are we going?

Insight into what's next for the HOP and the Public Health Department.

Welcome to the HOP

What is it?



What purpose does it serve?



Contents + Layout



Health of Portland Report



Public Health

Prevent. Promote. Protect.

Portland Public Health Division

City of Portland, Health and Human Services Department

2019 - 2020



Research & Evaluation Program, Public Health Division
Health and Human Services Department, City of Portland

Phone: 207-874-8633
www.portlandmaine.gov

What is it?



- Portland-specific health needs assessment
- Primary and secondary data sources
- Qualitative data and storytelling
- A benchmark to allow for trending and surveillance

What purpose does it serve?



- To provide descriptive information about the health status and factors influencing the health of Portland residents
- To create opportunity to improve health outcomes for all Portland residents
- To be available and accessible to all who wish to utilize it - it's the community's data

Contents



- Introduction + Acknowledgements
- 16 Chapters
 - Demography
 - Social Determinants of Health
 - Community Assets
 - Access to Care
 - Maternal & Child Health
 - Chronic Disease
 - Cancer
 - Infectious Disease
 - Environmental Health
 - Injury & Exposure to Violence
 - Mental Health
 - Substance Use
 - Death & Dying
- Appendix - Indicators + Sources

Layout



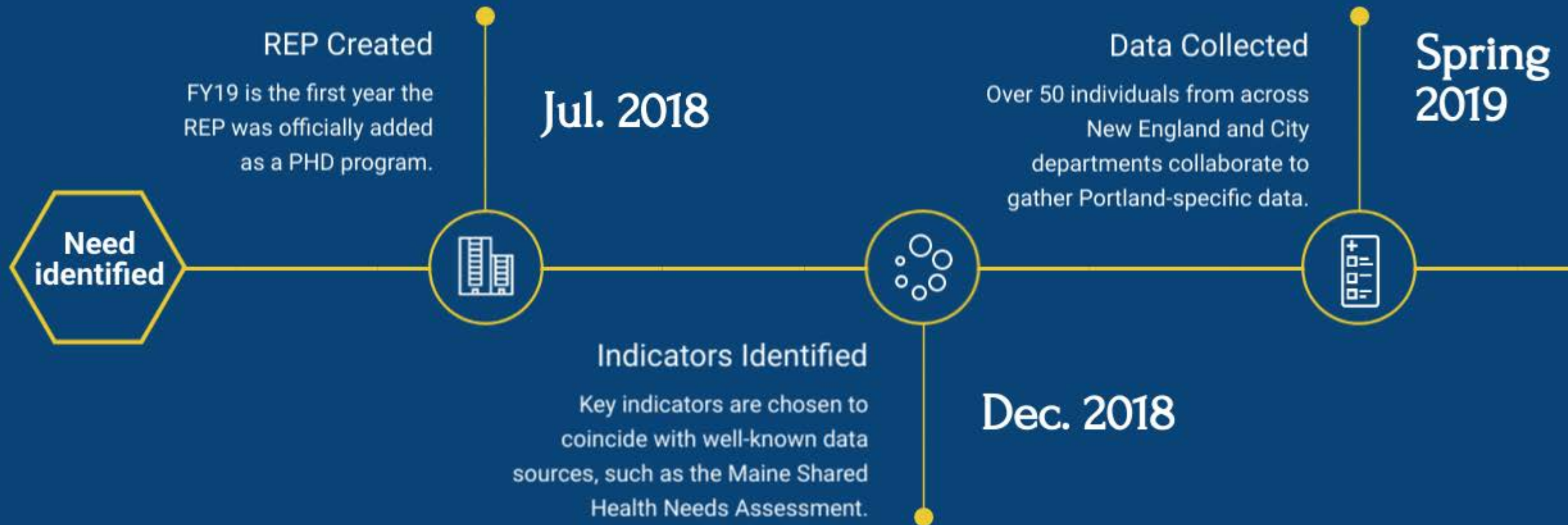
- Each chapter is 2 pages long, with the exception of substance use
- For each chapter - one page provides quantitative data and the other provides narrative and highlights different PHD programs



HOW DID WE GET HERE?



How Did We Get Here?



How Did We Get Here?





Data Overview

SOCIAL DETERMINANTS OF HEALTH

EDUCATION

JOBS

HOUSING

INCOME

ACCESS

POVERTY

POVERTY

Poverty

26%

of children live in households where the total household income is below the federal poverty level

17%

of adults live on income that is below the federal poverty level

Food Insecurity

47%



of Portlanders live more than a 1/2 mile from the nearest grocery store

ACCESS

15%

of Portland's population sometimes or always speak a language other than English at home

SWAHILI KHMER FRENCH
BOSNIAN SERBIAN CHINESE SOMALI
RUSSIAN JAPANESE HINDI ARABIC
PORTUGUESE ACHOLI VIETNAMESE
LINGALA CROATIAN KINYARWANDA

COMMUNITY ASSETS

LIVE

WORK

PLAY

61

Portland's walkability score is 61/100, compared to an average of 43/100 across the United States' 500 largest cities.

87%

Portland residents live within a half mile walk to a local park 87%



Portland residents have more park access compared to an average park access of 61% across the United States' 500 largest cities.

ACCESS TO CARE & HEALTH EQUITY

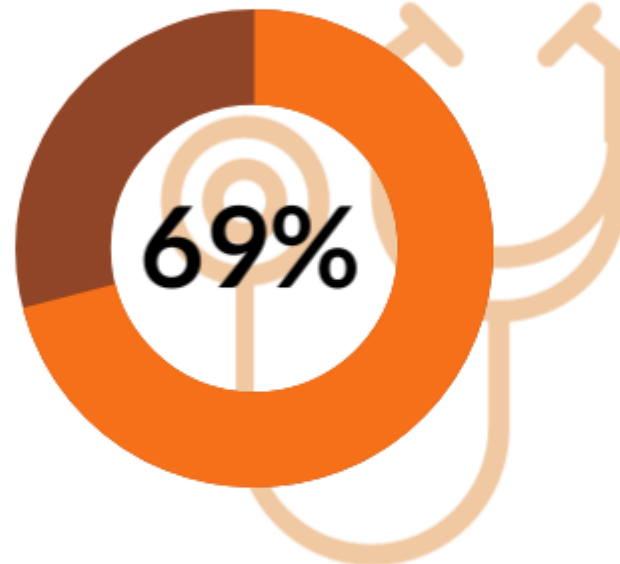
AVAILABILITY

BARRIERS

ELDER HEALTH

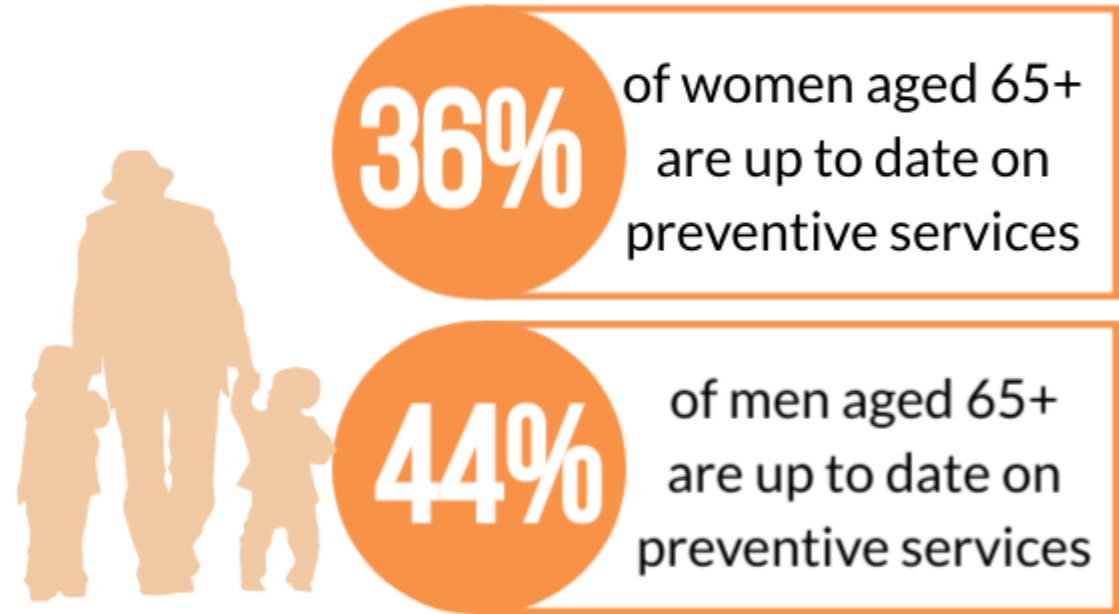
PREVENTIVE CARE

PREVENTIVE SERVICES



of adults receive routine wellness check ups

ELDER HEALTH



MATERNAL & CHILD HEALTH

PREGNANCY

BIRTHS

BREASTFEEDING

CHILD WELLNESS

PREGNANCY WELLNESS

88%

births for which
prenatal care began
in the 1st trimester

3%

new mothers smoke
cigarettes during
3rd trimester

36

drug-affected infant
reports per 1000
births

BREASTFEEDING

97%

babies are ever
fed breast milk

CHRONIC DISEASE

NUTRITION

PHYSICAL ACTIVITY

HEALTHY WEIGHT

TOBACCO

TOBACCO

17%

of Portland adults are current smokers

8%

of high school students used tobacco in the last 30 days

29%

of high school students used E-Cigarettes in the last 30 days**

**Data for Cumberland County. Portland not available.

INFECTIOUS DISEASE

CHLAMYDIA

GONORRHEA

SYPHILIS

HEPATITIS C

IMMUNIZATIONS

CHLAMYDIA

492

NEWLY DIAGNOSED CASES

of chlamydia per 100,000 people

GONORRHEA

146

NEWLY DIAGNOSED CASES

of gonorrhea per 100,000 people

SYPHILIS

29

NEWLY DIAGNOSED CASES

of infectious syphilis per 100,000 people

HEPATITIS C

339

NEWLY DIAGNOSED CASES

of chronic hepatitis C per 100,000 people

Chlamydia, gonorrhea and syphilis rates are 2018. Hepatitis C is 2017.

ENVIRONMENTAL HEALTH

LEAD



53%

of housing units
were built pre-
1950s

500-Cities average

5.5

9

Portland has a higher Lead Exposure Risk Index score of **9/10**, compared to an average of 5.5 across the United States' 500 largest cities.

LEAD

POLLUTION

ASTHMA

TICKS

RADON

LEAD

ONLY 27%

of children 0-3
years received a
blood lead test



149

Children with
lead poisoning



INJURY & EXPOSURE TO VIOLENCE

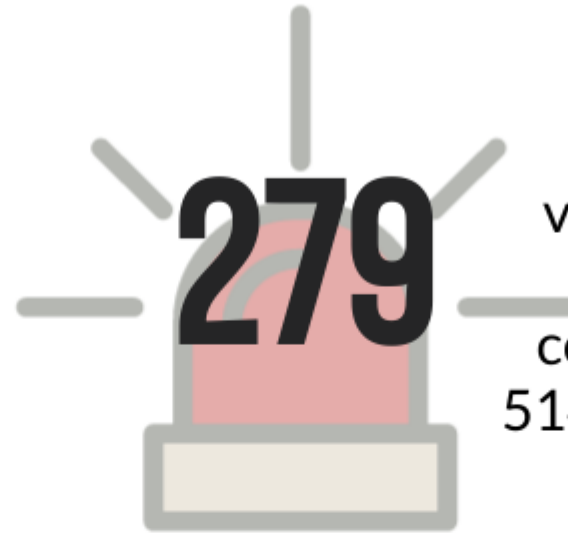
FIREARMS

CRIME

FALLS

MOTOR VEHICLE

POISON



violent crime offenses per
100,000 population,
compared to an average of
514 across the United States'
500 largest cities



409

fall-related emergency
department visits per
10,000 people



24

fall-related deaths
per 100,000 people

MENTAL HEALTH

DEPRESSION

SUICIDE

ACCESS

UTILIZATION

POLICE CALLS FOR SERVICE

5509

behavioral health-
related Calls for Service
to Portland Police Dept.

UTILIZATION

297

mental health emergency
department visits per
10,000 people

SUICIDE

14%

of high school students
seriously consider suicide

21%

of middle school students
seriously consider suicide

13

completed suicides per
100,000 people

SUBSTANCE USE

INJURY & DEATH

22

substance-use
hospitalizations per
10,000 people

17

alcohol-induced
deaths per 100,000
people

34

total opioid-related
deaths

44

total overdose-
related deaths



37%

middle school students
think alcohol is easy to get

58%

high school students think
alcohol is easy to get



ALCOHOL

MARIJUANA

OPIOID

INJURY

DEATH

DEATH & DYING

PREMATURE
DEATH

LIFE EXPECTANCY

END OF LIFE

MORTALITY

DEMENTIA

ALL-CAUSE MORTALITY

CANCER



deaths due to cancer
per 100,000 people

HEART DISEASE



deaths due to heart
disease/heart failure
per 100,000 people

INJURY



deaths due to
injury per
100,000 people

CHRONIC LOWER
RESPIRATORY
DISEASE



deaths due to
chronic lower
respiratory disease
per 100,000 people

STROKE



deaths due to
stroke per
100,000 people



WHERE ARE WE GOING?

NEXT STEPS



Dissemination of HOP

- Translation of Materials
- Community Engagement
- Partner Organization Engagement



Community Health Improvement Plan

- Community forums
- Program planning



System Integration

- SMART City
- Transparent reporting



Policy-making

- Systemically addressing health



Resource and Asset Mapping

- Streamline
- Identify assets



Research and Evaluation Program



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THANK YOU

Health of Portland Report



Public Health
Prevent. Promote. Protect.

Portland Public Health Division
City of Portland, Health and Human Services Department

2019 - 2020



Research & Evaluation Program, Public Health Division
Health and Human Services Department, City of Portland

Phone: 207-874-8633
www.portlandmaine.gov

A Letter from the Director of Public Health

October 28, 2019

Welcome to the Health of Portland Report

On behalf of the City of Portland, Health and Human Services Department, Public Health Division, I am pleased to share our first Health of Portland Report with you. This health report provides a broad overview of the overall health and well-being of our unique city. Here we cover a variety of health variables that directly affect the health of Portlanders. These data points help us understand where our strong health outcomes are and where we have room for improvement. I hope this report serves as a baseline and provides a foundation of current and local data for further discussions and coordinated planning to better the health of our city as a whole.

Here at Portland Public Health, our mission and vision statements speak to our purpose.

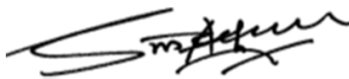
Mission: The mission of Portland Public Health is to improve the health of individuals, families, and the community through disease prevention, health promotion, and protection from environmental threats.

Vision: Portland will be the “go to” public policy thought-leader in creating communities in which the public can enjoy health & well-being; a clean environment; protection from public health threats; and having access to quality health care.

We will continue to provide qualitative and quantitative data for Portland residents, organizational partners, and community stakeholders. Special thanks to Hayley Prevatt for putting this report together - great job!

I encourage readers of this report to reach out to our Portland Public Health's Research and Evaluation Program with feedback and let us know how you're using this report to support you in your work. Thank you!

Yours in good health,



Kolawole Bankole, MD, MS, MBA
Portland Public Health Director / Administrator
City of Portland Local Health Officer
www.portlandmaine.gov/PublicHealth



Acknowledgements

The creation of the Health of Portland Report was a labor of love that would not have been possible without the support and guidance of numerous colleagues from different organizations across the state. We relied heavily on the individuals below to guide the report's content, analyze data, write narratives, and think critically about Portland's health. It is with most humble thanks that we acknowledge those who gave their valuable time and effort - this report would not be what it is without your help. Thank you!

Maine Department of Health and Human Services

Bobbie J. Johnson
Mandy Milligan
Andrew Oliver

University of Southern Maine

Jamar Croom
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Reid Plimpton
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Kim Haggan
Choanna LeClair
Sheila Nelson

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Tim Cowan
Kathleen Fairfield
Joanna Morrissey
Kim Murray
Kerri Barton

Alzheimer's Association, Maine Chapter

Peter Baker

Maine Hospice Council

Kandycy Powell
Kathryn Randall

Portland ConnectEd

Katie Soucy

Portland Housing Authority

Trevor Nugent

University of New England

Toho Soma

A special thank you to City of Portland staff who spent time writing narratives and poring over the data. This report would be stark in comparison without your thoughtful prose, inquisitive questioning and dedication to the health and well-being of Portlanders and beyond.

City of Portland

Kolawole Bankole	Christina DeMatteo	Amanda Hutchins	Shawn Peterson
Nelida Berke	Janet Dosseva	Brendan Johnson	Bridget Rauscher
Isabella Borerro	Lizzy Garnatz	Mary Anne MacDormand	Hawa Shir
Zoe Brokos	Lena Geraghty	Troy Moon	Larisa Stout
Kelly Crotty	Karlene Hafemann	Kirsten Goodrich	Nancy Valenti

We would also like to thank the Boston Public Health Commission's Research and Evaluation Office for their guidance in the initial stages of this report. Additionally, thank you to Corey Templeton for the beautiful photographs seen throughout the report.

Last, but certainly not least, thank you to the residents of Portland for sharing your stories with us and for making Portland such a wonderful place to live, work and play. Thank you, all!



Hayley M. Prevatt, MPH

Research and Evaluation Program Coordinator

<https://www.portlandmaine.gov/2365/Research-and-Evaluation-Program>

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How it All Fits

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Executive Summary

Through our combined efforts, The Health of Portland Report will result in a number of health and system improvements for Portland residents including, but not limited to, the following outcomes illuminated from the qualitative and quantitative data in the report:

Areas where Portland is performing poorly compared to Cumberland County and/or Maine:

Indicator	Portland	Cumberland Co.	Maine	Source
Asthma-related emergency department visits per 10,000 people	2010-2014 85	2010-2014 34	2010-2014 39.7	Maine Environmental Public Health Tracking Program
Children living in poverty	2012-2016 25.60%	2012-2016 13.30%	2012-2016 17.20%	Maine Shared CHNA, Portland Profile
Fall-related emergency department visits per 10,000 people	2012-2014 408.6	2012-2014 272.1	2012-2014 340.9	Maine Shared CHNA, Portland Profile
Mental health emergency department visits per 10,000 people	2012-2014 297.3	2012-2014 164	2012-2014 167.6	Maine Shared CHNA, Portland Profile
Met physical activity recommendations of 60 minutes per day, high school	2019 17.10%	2019 20.00%	2019 20.90%	Maine Shared CHNA, Portland Profile
Overall death rate per 100,000 people	2012-2016 756.3	2012-2016 683.6	2012-2016 753.1	Maine Shared Community Health Needs Assessment (CHNA), Portland Profile
Newly diagnosed cases of infectious syphilis per 100,000 people	2017 26.9	2017 9.9	2017 6.2	Maine Infectious Disease Surveillance System
Overdose-related deaths per 100,000 people	2018 66.2	2018 29.97	2018 26.45	Expanded Maine Drug Death Report, 2018
Percentage of women, aged 50 - 74, who have had a mammogram within the past two years	2016 73.40%	2014 & 2016 84.60%	2016 80.20%	Portland and Maine: 500 Cities Cumberland County: Maine Shared CHNA, Cumberland County Profile
Poisoning deaths per 100,000 people	2018 37.1	2012-2016 18.4	2012-2016 17.6	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile
Substance-use hospitalizations per 10,000 people	2016 21.5	2016 11.8	2016 18.1	Maine Shared CHNA, Portland Profile
Years of potential life lost before age 75 per 100,000 people	2014-2016 7600	2014-2016 5354.3	2014-2016 6529.2	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile

Areas where Portland is performing well compared to Cumberland County and/or Maine:

Indicator	Portland	Cumberland Co.	Maine	Source
Firearm Deaths per 100,000 people	2018 4.4	2012-2016 5.8	2012-2016 9.5	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile
Incidence of lyme disease per 100,000 people	2018 45.3	2018 97.8	2018 105.1	Maine Environmental Public Health Tracking Program
Obesity, high school students	2019 10.60%	2019 10.80%	2019 15%	Maine Shared CHNA, Portland Profile
Percentage of babies who are ever breast fed	2018 97.46%	2016 81.90%	2016 82%	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile
Percentage of high school age students who used alcohol in the last 30 days	2019 20.80%	2019 24.10%	2019 22.90%	Maine Integrated Youth Health Survey
Percentage of high school age students who used tobacco in the last 30 days	2019 7.80%	2019 9.30%	2019 10.60%	Maine Integrated Youth Health Survey
Percentage of new mothers who smoked cigarettes during 3rd trimester	2018 3.10%	2016 7.00%	2016 14.50%	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile
Percentage of residents with park access	2017 86.90%	2015 28%	2015 17%	Portland: CityHealthDashboard.com Cumberland County and Maine: National Environmental Public Health Tracking Network
Rate of death due to heart disease per 100,000 people	2012-2016 133.7	2012-2016 164.3	2012-2016 195.8	Maine CDC Data Research and Vital Statistics
Violent crime offenses per 100,000 people	2017 279.1	2014-2016 394.4	2014-2016 366.7	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile

It is the hope of Portland Public Health that the data compiled in this report will allow subsequent initiatives and programmatic interventions to be tailored to the needs of Portlanders. This report serves as a compass for Portland Public Health and we plan to use it as a guide for our community health improvement plan, system integration, policy and decision-making, and resource and asset mapping. To read more about our plan, head to the *Next Steps* chapter, beginning on page 30.



= Portland is performing worse than comparison indicator



= Portland is performing better than comparison indicator



= Unable to confidently compare due to differences in source year

DEMOGRAPHY | PORTLAND

POPULATION

AGE

RACE

POPULATION

66,417

PORTLANDERS

3.3%



Portland has grown by 3.3% since 2000.



3,053
veterans



9%
of Portland's population is disabled



median age is

36

years old



98 males per 100 females*

*Biological sex data are collected from the US Census Bureau, which does not account for gender identity. We recognize that this is not inclusive of the Portland community and are looking for other avenues for more diverse data reporting.

AGE

The AGE COMPOSITION of the Portland population is:



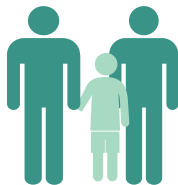
5%

Ages 0-4



11%

Ages 5-17



45%

Ages 18-44



25%

Ages 45-64

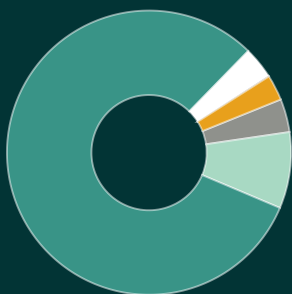


14%

Ages 65+

RACE

Portland's Race & Ethnicity



- Asian, non-Hispanic 3.8
- Black, non-Hispanic 8.7
- White, non-Hispanic 81.1
- Hispanic, any race 3.6
- American Indian or Alaska Native 0.1
- Two or more races, any ethnicity 2.9

13% of Portland's residents are foreign born



Portland has a racial/ethnic diversity score of 45.2/100, compared to an average of 64.1 across the United States' 500 largest cities.

Demography Discussion

Population: Portland is the largest city in Maine and serves an immediate geographic area of approximately 250,000 residents. The City continues to grow in size, so perhaps it's not surprising then that Portland has become the hub for many health and social services that may not be offered in other parts of the state.



Sexual Orientation: Although it is hard to obtain exact figures on the lesbian, gay, bisexual, transgender, questioning (LGBTQ) population in Portland, particularly among youth, Portland has a reputation for being a welcoming city for all forms of diversity including sexual orientation. In 1992, Portland became the first city in Maine to pass legislation protecting its residents from discrimination due to sexual orientation. Since that time several Maine communities and the state of Maine have voted to protect Mainers from discrimination based on sexual orientation.

Biological Sex: Biological sex data are collected from the US Census Bureau. However, this figure does not account for gender identity, making it difficult to ascertain exact figures on gender identity in Portland.



Age: "Americans are living longer than ever. The increase in the number of older adults in the United States stems from the large number of children born between 1946 and 1964 - commonly known as the Baby Boomers. One in three Americans is currently aged 50 or older and by 2030, one out of every five people will be 65 years old or older. Portland has seen its share of this increase with a larger elderly population calling Portland "home". As a result of these changing demographics, our nation is grappling with many age-related issues and causing many to look for ways to support this population in their own homes and communities." - Portland, Maine Age-Friendly Community Work Plan, January 2017.

Race and Ethnicity: In a state where only about 5% of the total population is non-white, Portland is home to a very diverse population of ethnic minorities, both immigrants and refugees, from more than 50 different countries. 13% of Portland's residents are foreign born and more than 60 different languages are spoken in homes across the city.



The Importance of Understanding Our Community

The data included in this Demography chapter serve as the foundation for the Health of Portland Report. In order to fully understand what is happening in Portland, we need to understand who calls Portland "home". The next chapters delve deeper into the health outcomes of Portlanders and also take into account the multiple factors that determine our health.

We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health, but health starts in our homes, schools, workplaces, neighborhoods, and communities. Our health is determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. All of these factors combined are called the Social Determinants of Health (SDOH) and these conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be (HealthyPeople 2020).

SOCIAL DETERMINANTS OF HEALTH

PORTLAND

EDUCATION JOBS HOUSING
INCOME ACCESS POVERTY

EDUCATION

53%

of 3rd graders scored "proficient" or above in reading



ABSENT

16%

of students missed 15 or more school days in a school year



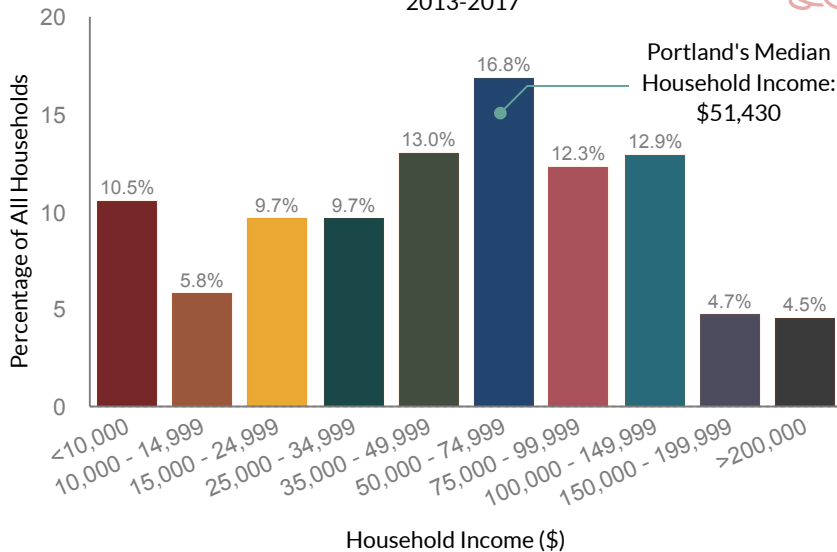
87%

of students graduate high school within 4 years of entering 9th grade

INCOME

Portland Income Distribution

2013-2017



POVERTY

Poverty

26%

of children live in households where the total household income is below the federal poverty level

17%

of adults live on income that is below the federal poverty level

Food Insecurity

47%



of Portlanders live more than a 1/2 mile from the nearest grocery store

HOUSING & HOMELESSNESS

median home value

= \$261,100

40%

of households spend 30% or more of their income on housing costs

The Portland Family Shelter provided

51,788

bed nights for 183 families (644 individuals)

UNEMPLOYMENT



2.6%



Unemployment rate in Portland

ACCESS

15%

of Portland's population sometimes or always speak a language other than English at home

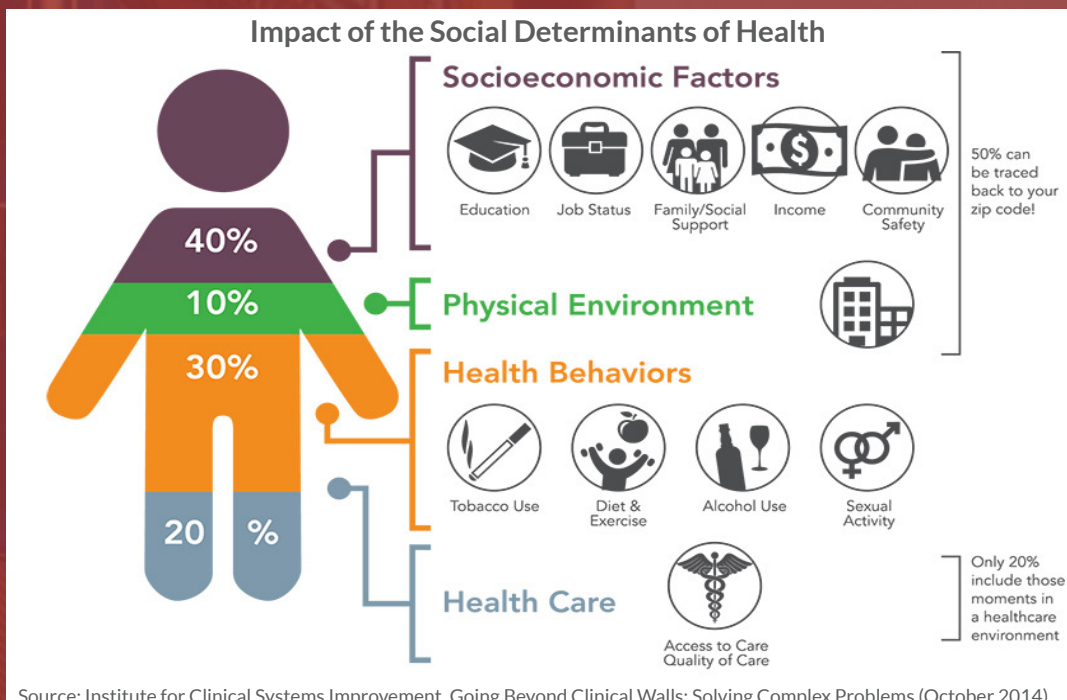
SWAHILI KHMER FRENCH
BOSNIAN ARABIAN CHINESE SOMALI
RUSSIAN VIETNAMESE
PORTUGUESE HINDI
LINGALA CROATIAN KINYARWANDA

Public Health 3.0

Public health is what we do together as a society to ensure the conditions in which everyone can be healthy. As seen in the image below, most factors that impact our health occur in our homes and neighborhoods and do not involve clinical care. Understanding the relationship between how population groups experience their surroundings and the impact they have on health is fundamental to addressing social determinants of health.

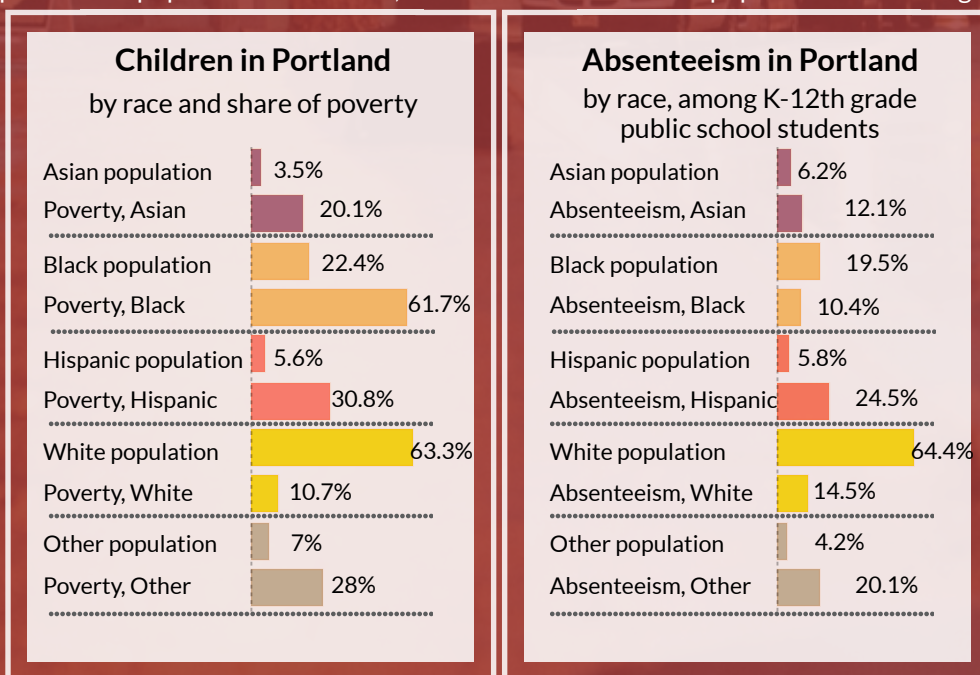
To meet these new challenges head on, local public health has been reinventing itself in partnership with others in their communities, and is transforming into a new model of public health we call Public Health 3.0 (PH3.0). Under this new model, public health agencies are adding special attention to the social determinants of health in order to achieve health equity for all (HealthyPeople.Gov). It is the mission of Portland Public Health to be on the forefront of leading Portland and other Maine communities into this new era of public health

through collaboration and cross-sector partnerships, collective strategizing and implementation of upstream initiatives and the curation and utilization of reliable and actionable data.



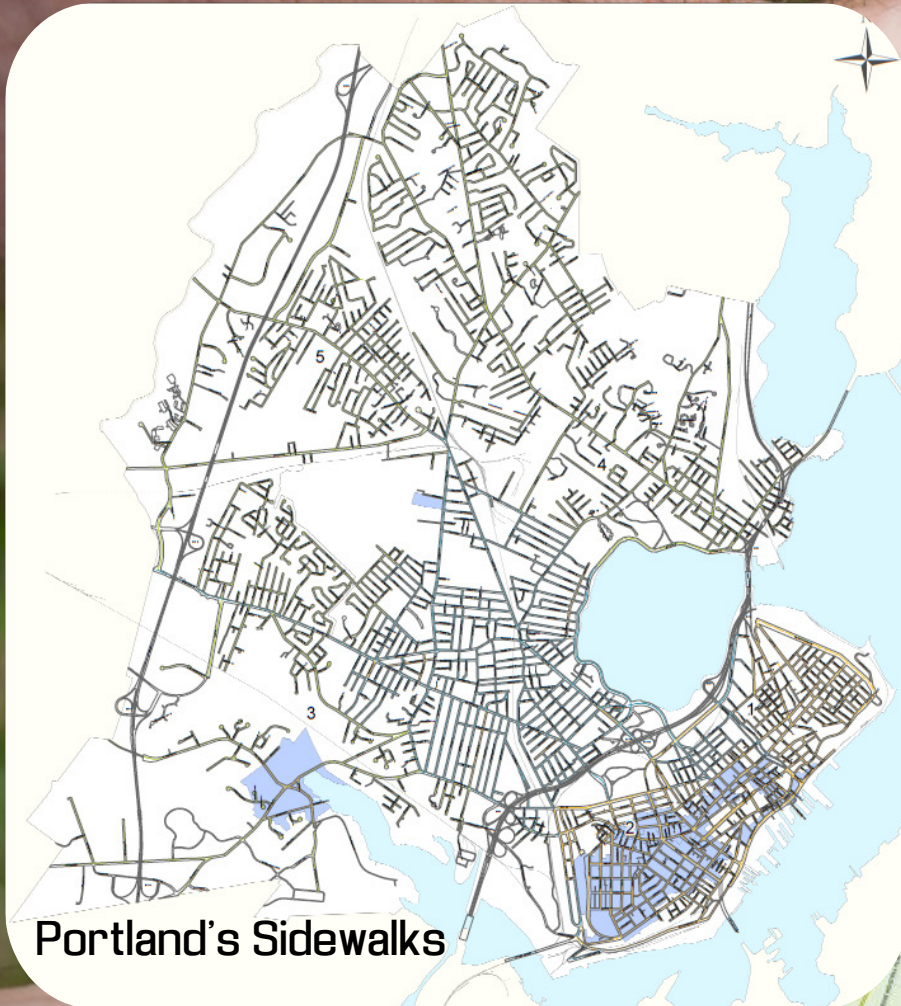
Social Determinants of Health (SDOH) Data

Data that leverages social determinants of health (SDOH) paint a more comprehensive picture of health beyond clinical indicators. The data below are examples that illustrate how different populations carry the burden of SDOH and utilizing this type of data is important in understanding population health. Looking at the poverty indicator below, we see that children of minority races carry a higher burden of poverty. We know that there is an established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death (HealthyPeople.Gov). We also know that children living in poverty typically are absent more at school (U.S. Department of Education, *Chronic Absenteeism in the Nation's Schools*) and this is reflected in the data below as we see higher rates of absenteeism in Portland's more impoverished populations. However, absenteeism in the black population seems to go against this trend and they are experiencing lower rates of absenteeism. This could be because of different protective factors held within the black community. Protective factors, such as community engagement, stable housing and strong social supports are positive influences that help people achieve success in the face of adversity. More research is needed to pinpoint exactly what protective factors are at play for black children in Portland. Additionally, Portland Public Health is committed to continuing our long-standing partnership with Portland Public Schools and other organizations to help build the resiliency of minority and ethnic children to increase school attendance.



COMMUNITY ASSETS: PORTLAND

LIVE WORK PLAY LAND

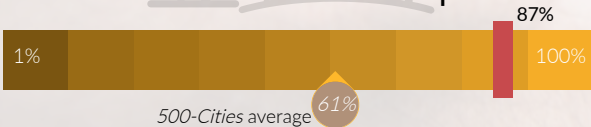


61

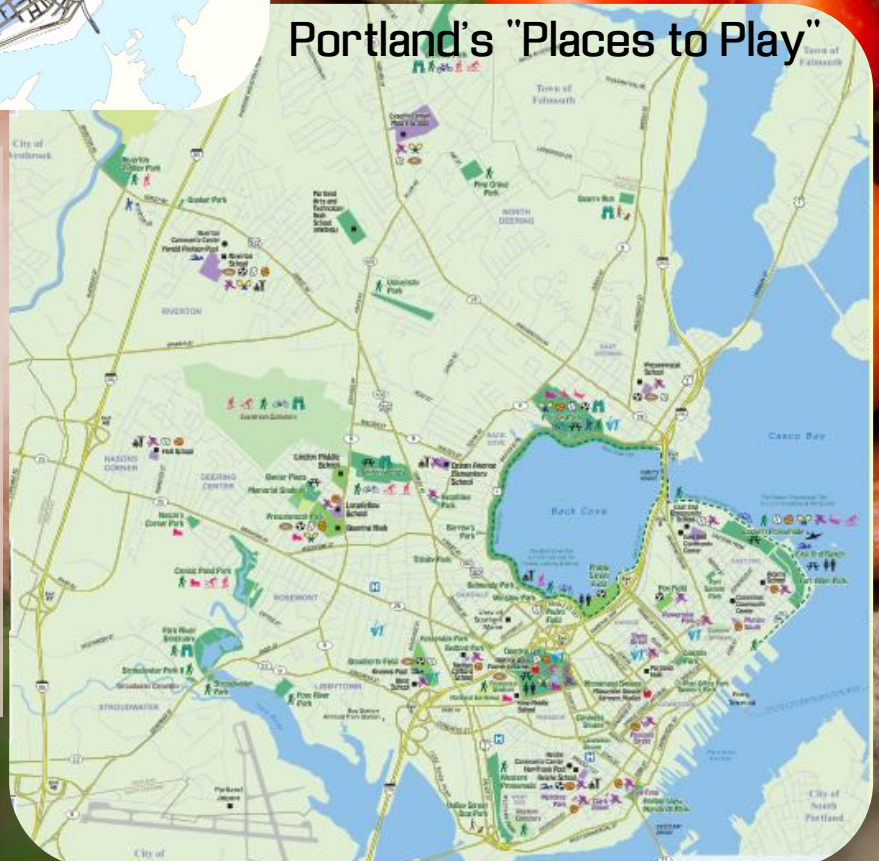
Portland's walkability score is 61/100, compared to an average of 43/100 across the United States' 500 largest cities.

87%

Portland residents live within a half mile walk to a local park



Portland residents have more park access compared to an average park access of 61% across the United States' 500 largest cities.



TO CHECK OUT MORE MAPS, VISIT
<https://portlandme.maps.arcgis.com>

Where We Live Matters for Our Health

You may have heard the saying, “your zip code matters more than your genetic code.” While genetic code and health behaviors are vitally important to your overall health, an ever-growing volume of evidence shows that one’s health is also influenced by a variety of physical and social environmental elements. In short, the neighborhoods we live in shape our behavior and influence our health. Let’s look at exercising, for example. An individual’s ability to exercise can be constrained by the physical environment of living in a neighborhood that lacks safe areas for exercise and sidewalks. If there is not a safe place to go for a walk, an individual might not be interested in doing so. Additionally, health can be shaped by the social environments of neighborhoods and the characteristics of the social relationships among the residents. A neighborhood that shares a degree of mutual trust and connectedness among neighbors may be more likely to work together to promote cleaner and safer spaces or discourage crime.

Individuals and populations are able to achieve better health when they have access to a variety of important health supports, or health assets. People who have access to strong community assets are better able to practice healthy living and obtain the services necessary to lead a healthy life. On the flip side of this, people with asset deficits are at a higher risk for adverse health outcomes. Examples of community assets include:



It is important to consider community assets and their accessibility to all. At the City of Portland, we have identified several community assets and mapped them such as sidewalks and walking trails, playgrounds and greenspaces, and municipal services. We are interested in furthering the identification and **mapping of community assets** in and around Portland in order to analyze and address the health challenges affecting Portlanders.

ACCESS TO CARE & HEALTH EQUITY | PORTLAND

AVAILABILITY

600:1

ratio of population to
one primary care
provider*

1040:1

ratio of population to
one dentist*

150:1

ratio of population to
one mental health
provider*

*Ratio for Cumberland County. Portland not available.

BARRIERS

1 IN 10

Portlanders **do not** have health insurance

15%

do not have a specific source of ongoing care**

12%

have difficulty accessing healthcare due to cost**

7%

live in a limited English speaking household

**Data for Portland-South Portland MMSA. Portland not available.

ELDER HEALTH

36%

of women aged 65+ are up to date on preventive services

44%

of men aged 65+ are up to date on preventive services

PREVENTIVE SERVICES

69%

of adults receive routine wellness check ups

66%

of adults receive regular dental care

PORTLAND COMMUNITY FREE CLINIC

909 clinical encounters WITH **347** total patients

52% new patients

48% returning patients

CARE PROVIDED BY

104
volunteers

1906
volunteer hours

A Day in the Life of a CHOW

Working as a Community Health Outreach Worker (CHOW) with Portland Public Health's Minority Health Program is exciting as every day brings new opportunities and challenges to work through with clients. The goal of this type of community health work is to help patients become self-sufficient enough to be able to manage their affairs on their own and navigate complicated systems without support. If I am doing my job correctly, clients gain the skills they need to be successful after we are done working together.

Some clients I work with I see once or twice in order to help connect them with the proper services and they move along. Others are more complicated in nature and require months of work and support. Home visits are the backbone of the work I do as they provide a safe and comfortable atmosphere to get to know the patient and build trust. Ultimately, this makes my job easier as it also gives me access to pieces of information about their life and situation that cannot be seen in a doctor's office. We strive to connect with patients almost immediately after they've accessed the emergency department so we can be as responsive as possible to their immediate needs. Community health work is extremely rewarding and the impact that you can have on your community is immediate and long lasting. Giving your clients the gift of self-sufficiency not only impacts their health but gives them tools to use in other areas of their lives.

• *Brendan Johnson - CHOW*



2018 Minority Health Assessment Report

<https://www.portlandmaine.gov/DocumentCenter/View/23309/2018-Minority-Health-Assesment-Report>

Mobile Medical Outreach

The Mobile Medical Outreach Project, which began in May 2017 during the height of Maine's opioid epidemic, allows experienced paramedics to provide low-barrier, on-site medical care to individuals experiencing homelessness. Since its inception, a team of six paramedics have provided medical care over 600 times to individuals receiving services at the Oxford Street Shelter (OSS). In 2019, the Project is on track to provide services over 400 times. As a result of this multi-departmental collaboration between Social Services, Public Health, and the Fire Department, emergency calls for service to OSS have decreased. In April 2019, the project expanded to include services for clients of the Needle Exchange Program, located at 103 India Street. On a weekly basis, a paramedic is available at the India Street Public Health Center to assess injection-site wounds or abscesses, provide wound care kits, and make other referrals and recommendations as needed. The Mobile Medical Outreach Project is funded by the Community Development Block Grant (CDBG), Maine Substance Abuse and Mental Health Services (SAMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

• *Bridget Rauscher - Program Manager*

Portland Community Free Clinic

The Portland Community Free Clinic (PCFC), located at 103 India Street, opened its doors in October 1993 and has been providing high-quality healthcare to uninsured residents of Cumberland and York counties for over 25 years. The Clinic provides no-cost, comprehensive primary health care to adults who are:



Care at the PCFC is provided by volunteer physicians, nurse practitioners, and nurses. Volunteers include primary care, internal medicine, and specialty services. The Clinic works with a network of providers in the community to obtain no-cost or low cost services for patients that require care beyond the scope of Clinic services. All on-site services at the PCFC are provided at no charge. The PCFC is financially supported in part by the Friends of the Portland Community Free Clinic, a 501(c)3 non-profit organization with a mission to raise funds so that the PCFC can continue its important work. Every \$1 donated to the PCFC translates into \$13.50 worth of services and care for patients.

• *PCFCME.com*



MATERNAL & CHILD HEALTH

PREGNANCY WELLNESS BIRTH BREASTFEEDING CHILD WELLNESS

PORTLAND

PREGNANCY WELLNESS

88%

births for which prenatal care began in the 1st trimester

3%

new mothers smoke cigarettes during 3rd trimester



36

drug-affected infant reports per 1000 births

BREASTFEEDING

97%

babies are ever fed breast milk

BIRTH RATES



44 BIRTHS

per 1000 women, aged 15 - 50



8 BIRTHS

per 1000 women, aged 15-19



7%

babies born with a low birth weight (2,500 grams)



8%

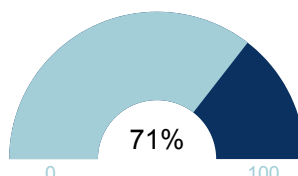
babies born before their due date

C-SECTIONS

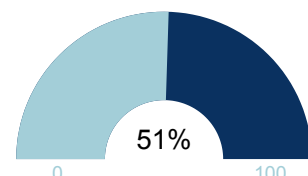
37%

c-sections among low-risk births

CHILD WELLNESS



2 year olds up to date with recommended immunizations*



13-18 year olds up to date with recommended immunizations*

Maternal-Child Health (MCH) Program

The City of Portland's Maternal-Child Health Program (MCH) aims to help mothers have a healthy pregnancy, teach parents about growth and development and give infants and children a healthy start at life. MCH employs Maternal-Child Health nurses who visit prenatal women, post-partum women, newborns and children under age 5 in their homes. They offer the following services: health checks for pregnant and postpartum mothers; prenatal education; growth and developmental assessment for children 0-5; newborn care, education, and weight checks; lactation counseling and breastfeeding support; lead education and screening; and referrals to health & community services. Interpreters are provided for non-English speakers.

To support parent-child engagement, MCH nurses host a weekly children's playgroup where the nurses can check in with both mom and child. Additionally, the MCH nurses visit the Portland Family Shelter two times a week to connect new families to prenatal and primary care.

The MCH nurses also provide vital in-home lead education on all of their home visits. They assist families with obtaining free dust wipe kits, and make referrals to the City of Portland's Healthy Homes Program as needed. The State's Childhood Lead Poisoning Program refers lead poisoned children to Portland's MCH nurses to provide targeted lead education home visits and MCH nurses conduct capillary lead screenings for children at Head Start Centers throughout Cumberland County.

These services provided by MCH are free and open to residents of the City of Portland and are supported by a Title V Federal Block Grant, Housing and Urban Development grant money, and city funding.

- Larisa Stout, RN-BSN, MS - Maternal-Child Health Nurse
- Mary Anne MacDormand, RN-BSN - Maternal-Child Health Nurse



MCH BY THE NUMBERS 2018

523

clients referred
to MCH

408

clients served
by MCH

892

home visits
provided to clients

68

children screened
for lead

1,314

playgroup attendees

174

people living in
the Family Shelter
referred to a
Medical Home

8

women living in
the Family Shelter
referred to the OB
Clinic

MCH Spotlight

On a routine home visit from the City of Portland's Maternal-Child Health Nurses, Kate*, a Portland resident and first-time mom, was experiencing concerning symptoms from high blood pressure. High blood pressure during pregnancy impacts not only the mother's health, but can also endanger the health of the unborn child. Recently, Kate's car had stopped working and she was unable to afford other means of transportation, leaving her to walk over four miles to and from work each evening. Learning this, the Maternal-Child Health Nurses worked with Kate and local organizations to secure free, reliable transportation while Kate saved enough money to fix her car. The nurses also made sure Kate had a scheduled appointment with her doctor to check in on her blood pressure. Eventually, both mom and baby had a safe delivery and are doing well.

*This story is a generic example of the services provided by the Maternal-Child Health Nurses to clients of the program.

CHRONIC DISEASE | PORTLAND

NUTRITION PHYSICAL ACTIVITY HEALTHY WEIGHT COPD
ALCOHOL DIABETES HEART DISEASE TOBACCO

NUTRITION, PHYSICAL ACTIVITY & HEALTHY WEIGHT

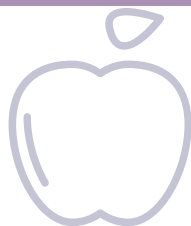
Adult

28% eat less than one serving of fruit per day*

12% eat less than one serving of vegetables per day*

1 IN 4

adults are obese



High School

38% eat less than one serving of fruit per day

54% eat less than one serving of vegetables per day

1 IN 10

youth are obese

18% report no leisure-time physical activity



17% meet physical activity recommendations of 60 minutes per day

*Data for Portland-South Portland MMSA. Portland not available.

HEART DISEASE

28%

adults diagnosed with high blood pressure

16

heart attack hospitalizations per 10,000 people**

16

heart failure hospitalizations per 10,000 people**

19

stroke hospitalizations per 10,000 people**

83

coronary heart disease deaths per 100,000 people

CHRONIC OBSTRUCTIVE PULMONARY DISEASE



12

COPD hospitalizations per 10,000 people

42

COPD deaths per 100,000 people



TOBACCO

17%

of Portland adults are current smokers

8%

of high school students used tobacco in the last 30 days

29%

of high school students used E-Cigarettes in the last 30 days**

DIABETES

8%

have diagnosed diabetes

diabetes hospitalizations per 10,000

13

18

diabetes deaths per 100,000

Obesity Prevention Program

In an effort to create healthier environments for children and families and combat the obesity epidemic, the Obesity Prevention Program uses a multi-setting approach to reach children and their families where they live, learn, work, and play. The Program utilizes evidenced-based initiatives and policy recommendations that address healthy eating and active living throughout Cumberland County. The Obesity Prevention Program focuses on:

Food Security



Nutrition Education



Policy



Systems & Environment



The Obesity Prevention Program relies on grant funds and is comprised of three major funding sources. The program receives grant funds from the Fund for a Healthy Maine via the Let's Go! Program, UNE SNAP-Ed, and The United Way of Greater Portland. This braided funding model allows the Obesity Prevention Program to function as a team and a true collaborative effort. Each stream comes with prescribed programming, goals, and objectives. Staff strategically work together to refer partners to specific programs within Obesity Prevention to assure all of their healthy eating and active living needs are met leading to greater impact in the communities we serve.

Obesity Prevention Program
reached nearly

11,000

children and adults across
Cumberland County in 2018.

• Amanda Hutchins, MS - Program Coordinator

Tobacco Prevention Program

The Tobacco Prevention Program is a grant-funded program that serves the community in reducing the harmful effects of tobacco use, including exposure to second hand and third hand smoke. The Tobacco Prevention Program is implemented by MaineHealth Center for Tobacco Independence in collaboration with fourteen Maine community-based sub-recipients, the City of Portland being one recipient. The Tobacco Prevention Services Grant is funded by the Maine Center for Disease Control and Prevention (Maine CDC). The City of Portland's Tobacco Prevention Program covers a variety of establishments, with whom the District Tobacco Prevention Partners (DTPPs), collaborate with to establish or update tobacco policies in hopes to meet model policy. The DTPPs work with school districts, youth serving entities, municipalities, housing units, colleges, career and trade schools, behavioral health agencies, hospitals, and lodging establishments within Cumberland County.

Tobacco Prevention
Program supported
the passing of

24

tobacco-related
policies from Oct.
2018 - May 2019

In addition to policy work, the Tobacco Prevention Program also provides education and resources to animal welfare agencies and provides non-clinical, technical assistance to local social service agencies by training and educating staff about the Maine Tobacco Helpline. The Tobacco Prevention Program offers various presentations for youth and adults in regards to tobacco use. In 2019, the most requested presentations were about vaping and the health implications of vaping. DTPPs work alongside youth through the Sidekicks Program where participants are encouraged to have conversations about tobacco use using motivational interviewing techniques.

• Hawa Shir, Community Health Promotion Specialist

CANCER

BLADDER FEMALE BREAST CERVICAL SKIN LUNG
COLORECTAL PROSTATE TOBACCO-RELATED

PORTLAND

ALL CANCER

462 NEW CASES

of cancer (any type)
per 100,000 people

166 DEATHS

due to cancer (any type)
per 100,000 people

TOBACCO-RELATED

136 NEW CASES

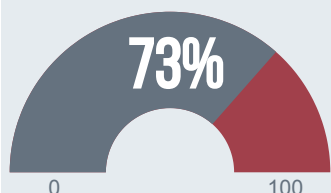
of tobacco-related cancers*
per 100,000 people

*Tobacco-related cancers exclude lung and bronchus cancers and are defined as cancers of the oral cavity and pharynx, esophagus, stomach, colon and rectum, liver, pancreas, larynx, cervix uteri, urinary bladder, kidney and renal pelvis, and acute myeloid leukemia.

FEMALE BREAST

121 NEW CASES

of female breast
cancer per 100,000
women



women aged 50 -
74 who have had a
mammogram within
the past two years

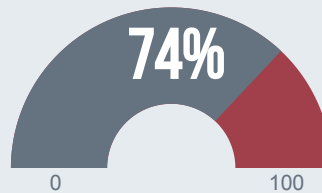
19 DEATHS

per 100,000 women
due to breast cancer

COLORECTAL

38 NEW CASES

of colorectal cancer
per 100,000 people



adults aged 50-75
who have received a
colorectal cancer
screening

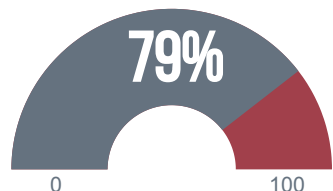
14 DEATHS

per 100,000 people due
to colorectal cancer

CERVICAL

<10 NEW CASES

of cervical cancer per
100,000 women



women aged 21-65
have had a pap test in
the past three years

LUNG

68 NEW CASES

of lung cancer per
100,000 people

50 DEATHS

per 100,000 people
due to lung cancer

PROSTATE

95 NEW CASES

of prostate
cancer per
100,000 men

BLADDER

26 NEW CASES

of bladder
cancer per
100,000 people

MELANOMA

23 NEW CASES

of melanoma
(skin) cancer per
100,000 people

Colorectal Cancer Screening in Underserved Populations

Colorectal cancer (CRC) is the third leading cause of cancer-related death in Maine, but it is preventable. While CRC occurs across all races and income levels, ethnic minorities and people with low socioeconomic status are screened at lower rates, leading to a higher mortality risk. However, patient navigation has been proven to increase CRC screening rates among underserved populations and a unique partnership set out to do just that.

In 2017, Portland Public Health's Minority Health Program was awarded a two-year grant of \$100,000 from the Maine Cancer Foundation to focus on increasing CRC screening rates and improve the colorectal health for vulnerable populations in Greater Portland. The initiative relies on collaboration between Maine Medical Partners - Portland Family Medicine and the City of Portland's Community Health Outreach Workers (CHOWs) to help patients overcome barriers to screening, such as language and cultural barriers, low health literacy, complicated scheduling processes and stigma to name a few.



Check out the CRC Project on WMTW.

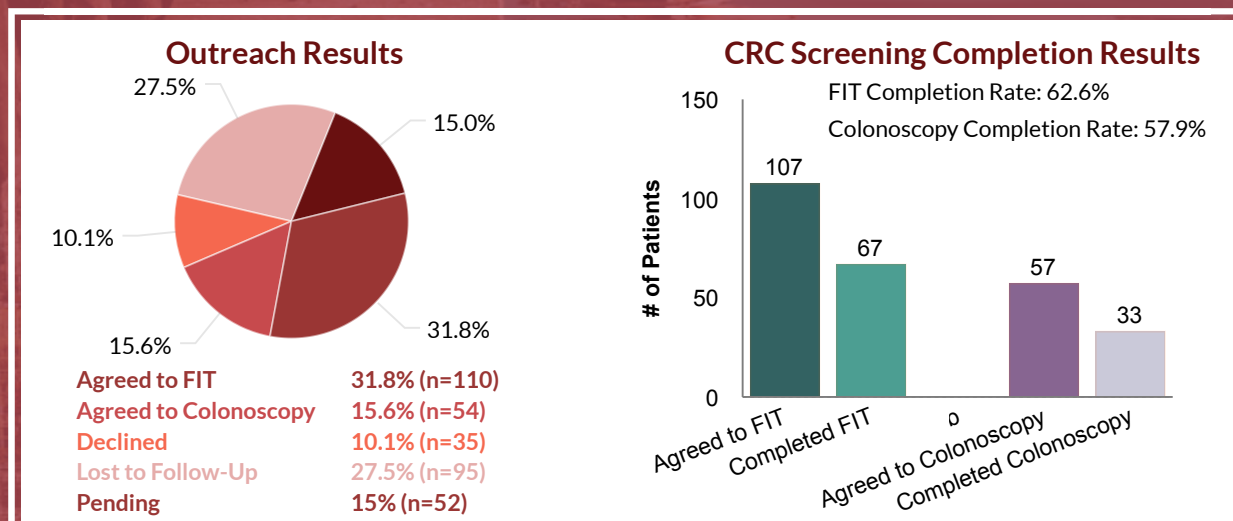
<https://www.wmtw.com/article/health-care-workers-connect-mainers-with-life-changing-services/19505385>

To be tested, patients must meet the following criteria:

- Be between 50 to 75 years old
- Due for CRC screening
- Utilize Medicaid or are uninsured
- Speak one of the following languages: Arabic, English, French, Kinyarwanda, Russian, Somali, Spanish or Vietnamese

8 CHOWs were trained in CRC screening outreach and were assigned to their own ethnic communities. From there, CHOWs made multiple attempts to contact patients via telephone and mail, offering a fecal immunochemical test (FIT) or colonoscopy. CHOWs then provided education, access to transportation, reminders and health insurance applications to patients who expressed interest in screening. Below are the outreach and screening results as of 5/1/2019.

• *Nelida Berke, MPH - Program Coordinator*



INFECTIOUS DISEASE | PORTLAND

CHLAMYDIA GONORRHEA
HEPATITIS C

SYPHILIS
IMMUNIZATIONS

CHLAMYDIA

2018

492

NEWLY DIAGNOSED CASES

of chlamydia per 100,000 people

GONORRHEA

2018

146

NEWLY DIAGNOSED CASES

of gonorrhea per 100,000 people

SYPHILIS

2018

29

NEWLY DIAGNOSED CASES

of infectious syphilis per 100,000 people

HEPATITIS C

2017

339

NEWLY DIAGNOSED CASES

of chronic hepatitis C per 100,000 people

IMMUNIZATIONS

2%

kindergarteners have
immunization
exemptions for
philosophical reasons

two-year-olds in
Cumberland County
who are up to date with
recommended
immunizations*

71%

47%

adults in Cumberland
County received
influenza vaccination in
the past year*

Maine children received
influenza vaccination in
the past year**

62%

*Data for Cumberland County. Portland not available.

**Data for State of Maine. Portland and Cumberland County not available.

Sexually Transmitted Diseases Clinic

India Street Public Health Center has offered low-barrier health care services for over 20 years. Each program at India Street addresses the unique needs of the community through education, outreach and clinical services. The STD Clinic is the only publicly funded clinic in Maine specializing in sexually transmitted diseases, disease surveillance, HIV prevention and the diagnosis and treatment of STDs.

Staff conduct in-service and community trainings on STDs and overdose response and awareness. The York Hospital system, Martins Point, and other primary care practices have received in-service training on STD rates, testing, and treatment, pre-exposure prophylaxis (PrEP), and sexual history intakes. In addition, staff regularly offer outreach testing at Cumberland County Jail, Crossroads and Milestone. Other off-hours testing takes place at local bars and around community events, such as PRIDE.

In October 2017 the STD Clinic started prescribing Truvada as PrEP for the prevention of HIV; PrEP is over 90% effective at preventing HIV infection. More than 100 patients have accessed PrEP at India Street since the program's inception. For many, this includes access to patient financial support programs that can eliminate any out of pocket costs for the medication.

The STD Clinic is also a learning hub for medical residents from Maine Medical Center. Residents receive a tour of the Needle Exchange, observe a sexual history intake, and get hands-on experience with patients, including administering treatment. Residents receive additional training they may not get otherwise in a setting that tackles highly stigmatized conversations. Through this partnership, more providers who offer primary care are equipped to address local health issues including the increase in STDs.

- Christina DeMatteo, DO, MPH - Medical Director
- Isabella Borrero, M.Sc - Laboratory Director
- Zoe Brokos - Program Coordinator

- Shawn K. Peterson, MPH - Community Health Promotion Specialist
- Lizzy Garnatz, LCSW - Community Health Promotion Specialist
- Kimberly Meehan-Brown - Disease Intervention Specialist

STD CLINIC BY THE NUMBERS

JULY 2017 - JUNE 2018

CLINICAL CARE



705

clients served by
STD Clinic

Oral test: 216
Blood draw: 810

1,026

HIV tests
administered

Rapid test: 86
Blood draw: 119

205

Hepatitis C tests
administered

Males: 556
Females: 149

Positive Tests:
10

Detections:
52



OUTREACH

Oxford Street Shelter
Jewel Box Blackstones
Leavitt's Mill Health Clinic
Unitarian Universalist
Church Saco
Space Gallery

7

Outreach Testing
Events

ENVIRONMENTAL HEALTH

LEAD POLLUTION ASTHMA
TICKBORNE DISEASES RADON

PORTLAND

LEAD



53%

of housing units
were built pre-1950s

500-Cities average

5.5

9

Portland has a higher Lead Exposure Risk Index score of **9/10**, compared to an average of 5.5 across the United States' 500 largest cities.

ONLY 27%

of children 0-3 years
received a blood lead test



149

Children with
lead poisoning

AIR POLLUTION

Portland has a better annual average concentration of fine particulate matter (PM2.5) at **7.8**, compared to an average of 9.2 across the United States' 500 largest cities.

WATER



Portland's tap water
meets or exceeds all
quality standards.



ASTHMA

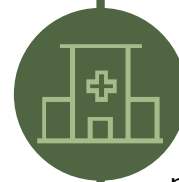
11% Asthma prevalence
among adults, aged 18+

10% Asthma prevalence among
children, aged 0-17*



85

Asthma-related
emergency
department visits
per 10,000 people



6

Asthma-related
hospitalizations
per 10,000 people

TICKBORNE DISEASES



45

new cases of Lyme Disease
per 100,000 people

RADON

Portland is located in an
EPA-designated

ZONE 1

Counties designated as a Zone 1
have the highest potential for radon.

HEAT-RELATED ILLNESS

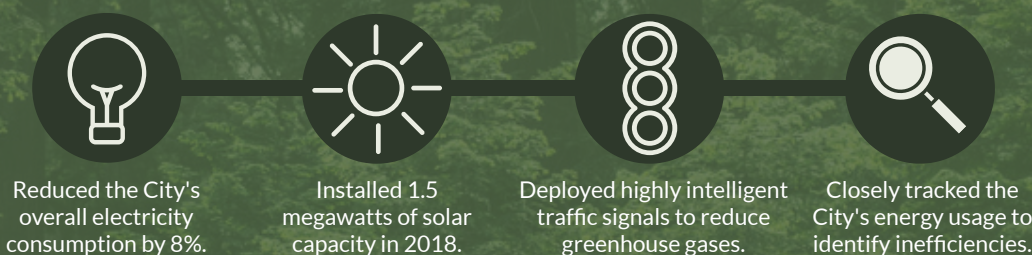
10

heat-related illness emergency
department visits per 100,000
people*



Portland's Focus on Climate Change

Climate change has been in the headlines recently as communities around the world feel its effects. Portland is not immune. Casco Bay has risen over 8 inches during the past hundred years and the pace is quickening. Information from the Bayside Adapts study completed in 2017 says we should anticipate between 2 feet and 3.5 feet of sea level rise in Portland by 2050. Research shows that we should expect more coastal flooding, more intense and frequent storms, and more extremely hot days in the coming years. This is happening because we continue to burn large amounts of fossil fuels that emit carbon dioxide and other greenhouse gases (GHG) into the atmosphere. Moving to clean energy sources quickly will mitigate the worst impacts of climate change. To do its part, the City of Portland has committed to reducing community-wide GHG emissions 80% by 2050 and to use 100% clean energy for municipal operations by 2040. Here are some of the important steps the City has already taken to work toward these goals:



Last, but certainly not least, Portland and South Portland have partnered to develop a climate action and adaptation plan, One Climate Future, that will identify specific strategies needed to reach the climate action goals. The planning process will include a comprehensive Greenhouse Gas inventory, a climate vulnerability assessment, and extensive community outreach. One Climate Future wants to incorporate feedback from as many community voices as possible and will be holding focus group sessions as well as utilizing surveys.



One Climate Future
<https://oneclimatefuture.org/index.php>

• *Troy Moon, Sustainability Coordinator*

Lead Poisoning Prevention

The City of Portland has received funding from the Maine CDC to conduct prevention and education work in the high risk areas of Portland and Westbrook since 2011. A large part of the work involves building local capacity through convening community stakeholders. These meetings provide critical information and resources to community organizations on efforts in Portland and Westbrook to reduce childhood lead poisoning and allows community members to share how this issue is impacting the families they work with. Currently, the group consists of almost 50 members from over 20 organizations. Recent guest speakers included the Federal Environmental Protection Agency and the Maine Affordable Housing Coalition.

It's easy for lead dust to get into a child's mouth.



Have your kids been tested for lead poisoning?
Ask their doctor. Protect your family.

maine.gov/healthyhomes



• *Karlene Hafemann, LCSW - Community Health Promotion Specialist*

INJURY & EXPOSURE TO VIOLENCE

FIREARMS CRIME FALLS
MOTOR VEHICLE POISON

PORTLAND

EXPOSURE TO VIOLENCE

Property crime

DECREASED

1.83% from 2016 to 2017



279

violent crime offenses per 100,000 population, compared to an average of 514 across the United States' 500 largest cities



Violent crime

INCREASED

8.6% from 2016 to 2017

INTENTIONAL INJURY

4

firearm deaths per 100,000 people

13

suicides per 100,000 people

12%

of Cumberland County women have been the victim of rape/non-consensual sex*

UNINTENTIONAL INJURY

37

poisoning deaths per 100,000 people

16

motor vehicle traffic crash deaths per 100,000 people

74

traumatic brain injury emergency department visits per 10,000 people in Cumberland County*

409

fall-related emergency department visits per 10,000 people

24

fall-related deaths per 100,000 people

Community Policing - A Portland Asset

Portland Community Policing is made up of approximately 13 police officers and six civilian coordinators. The coordinators are spread throughout different neighborhoods on the peninsula and each have their own section of Deering. Community Policing Centers are in the following neighborhoods:

West End



East Bayside



Midtown



Munjoy Hill



Parkside



Portland Housing
Authority



While the positions are the same, our roles in the community look different depending on the neighborhoods we serve. In Midtown, my office is located on Portland Street and much of my daily interactions are with people experiencing homelessness as well as those struggling with mental health and substance use disorder. As one can imagine, the main struggle for folks in this population stems from access to healthcare and consistency of that care. Unfortunately, we tend to see a revolving door of people who need a higher level of care but are unable to meet the requirements of the system.

Community policing works closely with the Behavioral Health Unit at the Police Department to facilitate conversations and find creative ways to bring services to some of the most vulnerable individuals. We also regularly connect with the social service providers in the area to keep an open dialogue about what we are seeing.

One of our roles as community coordinators is to review calls for service in our respective areas. Officers may respond to a call at a home and notice that the individual is having a hard time or living in poor conditions. We are able to follow up with these people and connect them to services that they often have never heard of. Partnering with officers allows us to witness the needs of our neighborhood first hand. We refer to a variety of services such as, in-home healthcare, Adult and Child Protective Services, rides to appointments, substance use detox and treatment options, and case management.

With the national opiate crisis and the subsequent increase in use of other substances, the Midtown office is seeing so many individuals struggle to meet even their most basic needs, but we're here to help.

• Kelly Crotty - Midtown Community Policing Coordinator



<https://www.portlandmaine.gov/203/Community-Policing>

MENTAL HEALTH | PORTLAND

DEPRESSION SUICIDE ACCESS UTILIZATION

DEPRESSION

Approximately



Cumberland County adults have been diagnosed with depression in their lifetime*

13%

of Portland adults report frequent mental distress

Approximately



high school students report feeling sad or hopeless for 2 weeks in a row

UTILIZATION

297

mental health emergency department visits per 10,000 people

ACCESS

150:1

ratio of population to one mental health provider*

POLICE CALLS FOR SERVICE

5509

behavioral health-related Calls for Service to Portland Police Dept.

SUICIDE

14%

of high school students seriously consider suicide

21%

of middle school students seriously consider suicide

13

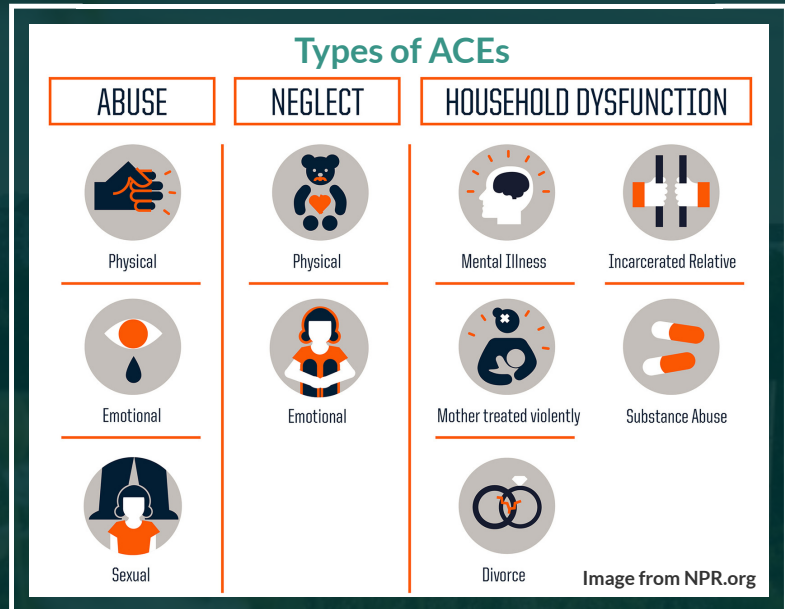
completed suicides per 100,000 people

Portland Addresses Youth Mental Health

From 2011 to 2018, Portland Public Health and Maine Behavioral Healthcare co-convened Portland Defending Childhood, a unique collaboration among numerous local organizations to address youth mental health.

Portland Defending Childhood was one of eight sites in the country that worked to both prevent children's exposure to violence and reduce negative effects of violence. We offered information, support and evidence-based treatment. Portland Defending Childhood implemented and supported a broad range of prevention programs and activities throughout Portland.

PDC provided ongoing training and technical assistance to city-based nurse home visitors so that families and children were screened for exposure to violence and referred to supportive community resources, and worked closely with the Portland Public Schools and local early education classrooms to provide evidence-based violence prevention curricula for students and to support teachers in content delivery.



PDC increased awareness of children's exposure to violence to pediatric staff at MMC and implemented screening and assessment of violence exposure. Over the past few years, Maine Behavioral Healthcare has worked in partnership with MaineHealth, Maine Medical Center, and Maine Medical Partners to examine the impact, improve support, and provide intervention to children and families experiencing trauma and Adverse Childhood Experiences (ACEs). Co-led by the MBH Clinical Innovation Department, this program includes an interdisciplinary team of leaders and content experts focused on leading the MaineHealth system in the development of best practice models for education, prevention, screening and treatment of ACEs. To learn more about this work, please visit the MaineHealth ACEs webpage.

To learn more about Portland Defending Childhood, contact:

Rebecca Hoffmann Frances

Director of Clinical Innovation

Email: rhfrances@MaineBehavioralHealthcare.org

Phone: 207-661-6506



<https://mainehealth.org/maine-behavioral-healthcare/services/counseling-therapy-services-adult-child/trauma/portland-defending-childhood>

SUBSTANCE USE | PORTLAND

PART 1

ALCOHOL MARIJUANA
OPIOID INJURY DEATH

ALCOHOL



1 IN 5

adults binge drink



1 IN 5

high school students
used alcohol in the last
30 days



37%

middle school students
think alcohol is easy to get

58%

high school students think
alcohol is easy to get



MARIJUANA

26%

marijuana use among high
school students

EMERGENCY SERVICES

75

overdose emergency
medical service responses
per 10,000 people

1063

drug-related Calls for
Service to Portland
Police Dept.

2575

alcohol-related Calls
for Service to Portland
Police Dept.

INJURY & DEATH

22

substance-use
hospitalizations per
10,000 people

17

alcohol-induced
deaths per 100,000
people

34

total opioid-related
deaths

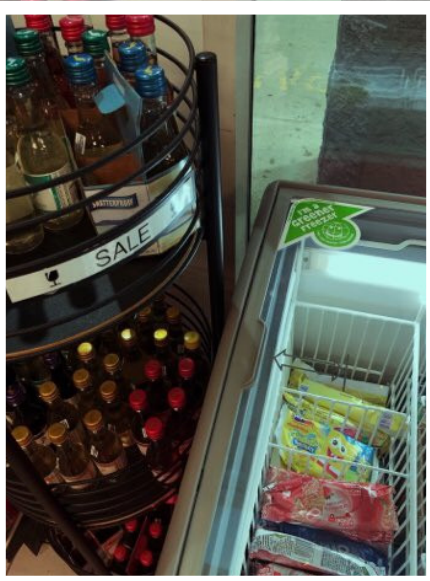
44

total overdose-
related deaths

Substance Use Prevention Program

The City of Portland's Substance Use Prevention (SUP) Program utilizes evidence-based practices to delay the onset of substance use and encourage healthy behaviors and safe use. Primary prevention among youth is the key focus, but efforts extend to parents, educators, and community partners as well. The SUP Program is made possible by grant funding from Maine Prevention Services to address alcohol, marijuana, and prescription drug use and misuse among populations aged 12 and older within the Portland community. Staff enjoy incorporating creative approaches to prevention and one way of doing so is with a prevention-centered project called Photovoice.

Spongebob Ice Cream



"Small bottles of alcohol on-sale are right next to ice cream that is intended to be sold to young children. This makes it extremely accessible and appeals to underage people since the bottles are small and cheap."

Friendship



"Friendship represents the interpersonal level of the Socio-Ecological Model. My friends are a protective factor since we do fun things together and have fun without getting in trouble with drugs and alcohol."

Shiny, Sparkling, Beautiful & Within Reach



"This photo is a risk factor that can be found in almost all households. It shows how substance usage can start in your home and be a part of your family's past."

This project was implemented with a group of Portland High School students during a weekly study hall over the course of eight weeks. The project incorporated public health concepts, specifically the Socio-Ecological Model that considers the connection between individual knowledge, interpersonal networks, organizations and social institutions, community relationships, and public policy in impacting an individual's risk for substance use. Students captured photos on their own time and were encouraged to be creative, but to use the Socio-Ecological model as a guide in looking at the risks and protective factors in their own lives. The students were very thoughtful with their photography and chose their favorite photos to be displayed during an art exhibit held at City Hall. The SUP program is pursuing other creative approaches to prevention and plans on utilizing Photovoice with other groups in the future.

- Janet Dosseva, MPH - Community Health Promotion Specialist

SUBSTANCE USE | PORTLAND

PART 2 NEEDLE EXCHANGE NALOXONE DISTRIBUTION

NEEDLE EXCHANGE PROGRAM

229

new enrollees of the
Needle Exchange
Program in 2018



3,316

total enrollees of the
Needle Exchange
Program in 2018

204,259

syringes collected and
disposed of



199,439

syringes distributed

4,189

Housing
referrals

700

Case
Management
referrals

2,564

STD Clinic
referrals

2,103

HIV Testing
referrals

1,081

Substance Use
Treatment
referrals

3,889

Primary Care
referrals

115

Anti-Trafficking
Coalition
referrals

200

Family Planning
Organizations
referrals

15,835

referrals made, as necessary

365

Hepatitis
Testing
referrals

629

Other referrals

NALOXONE DISTRIBUTION PROGRAM

715

clients enrolled in the
naloxone distribution
program

1,314

doses of naloxone
dispensed as refills

1,871

doses of naloxone dispensed
to new registrants

190

overdoses reversed,
as reported by clients

100+

"Overdose Recognition, Response and Naloxone"
Trainings provided by Needle Exchange Program Staff

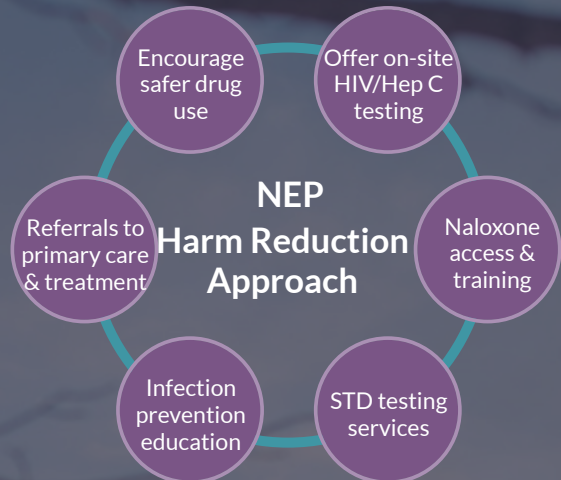
Portland Needle Exchange Program

The Portland Needle Exchange Program (NEP) was the first needle exchange program offered in the state of Maine and with over 200,000 needles exchanged and 3,316 individuals enrolled, it is also the state's largest. The NEP is rooted in harm reduction philosophy, as demonstrated by the services they provide:

At the NEP, clients receive education on risk reduction, overdose prevention education, naloxone, case management services, testing for HIV, Hepatitis C and STDs, as well as referrals to drug treatment programs upon request. In addition to providing services at the India Street Public Health Center, volunteer outreach teams provide needle exchange services on the corner of Elm and Oxford Streets four days a week.

The NEP has also distributed naloxone since 2015 and offers "Overdose Recognition and Response" trainings, free of charge, to anyone enrolled in the program who would like to gain the skills to recognize and respond to

opioid overdose. This training is also available to community partners and organizations throughout York and Cumberland County. The NEP prides itself on their efforts to "meet clients where they're at" and their welcoming and non-judgmental environment.



Jenny's Journey

Jenny* signed up in the Portland Needle Exchange Program after learning about it at a community event downtown. It took her a few visits to open up, but once she felt confident that the staff were non-judgmental and truly concerned about her health and well-being, she started to talk about her substance use disorder, her childhood trauma, and losing custody of her children due to domestic violence in her home. Each time Jenny came in, she felt a little more comfortable. One day she asked for an HIV and Hepatitis C test. She and her partner had been sharing injection equipment and she was worried. Her test did come back positive for Hepatitis C, so the next few visits were spent discussing health insurance, resources and linking her to primary and specialty care at the hospital. She knew she was at risk due to her drug use and risky behavior, but testing positive for Hepatitis C really stunned Jenny. From this, she felt compelled to teach others by using her experience as an example.

She started talking to peers and loved ones about the Portland Needle Exchange Program and she brought several people in for testing and supplies. She talked about overdose prevention and showed people how to use naloxone. One day, Jenny came in asking for treatment for her substance use. She had never been to a rehabilitation center and she was scared. Staff at the Portland Needle Exchange Program were able to find her a scholarship bed since she was uninsured.

It was three years before staff saw Jenny again. She had treated her Hepatitis C, was on medication assisted treatment, living in a recovery residence and was working on getting back full custody of her children. She felt that her experience at the NEP helped her feel safe enough to talk openly about her substance use and helped her get connected to the services in the community she needed.

• Zoe Brokos, Program Coordinator



Needle Exchange Program

103 India St.
Portland, ME

207.756.8024

*Due to the nature of the NEP's work, all client information is anonymous. This story is a generic example of the referral process typically utilized in the NEP.

DEATH & DYING

PREMATURE DEATH

LIFE EXPECTANCY

END OF LIFE

LEADING CAUSES OF MORTALITY

DEMENTIA

PORTLAND

MORTALITY

7600

years of potential life
lost before age 75 (per
100,000 population)

Life Expectancy*



women
82.3
years old*

men
78.1
years old*



OVERALL DEATH RATE

756

deaths from any cause
per 100,000 people

ALL-CAUSE MORTALITY

CANCER

167

deaths due to cancer
per 100,000 people

HEART DISEASE

133

deaths due to heart
disease/heart failure
per 100,000 people

INJURY

59

deaths due to
injury per 100,000
people

CHRONIC LOWER RESPIRATORY DISEASE

46

deaths due to chronic
lower respiratory
disease per 100,000
people

STROKE

32

deaths due to
stroke per
100,000 people

HOSPICE

HOSPICE UTILIZATION, 2017

57%

of total Medicare Deaths were
Medicare Hospice Deaths*



DEMENTIA

21

deaths due to Alzheimer's
per 100,000 people



601
DEATHS

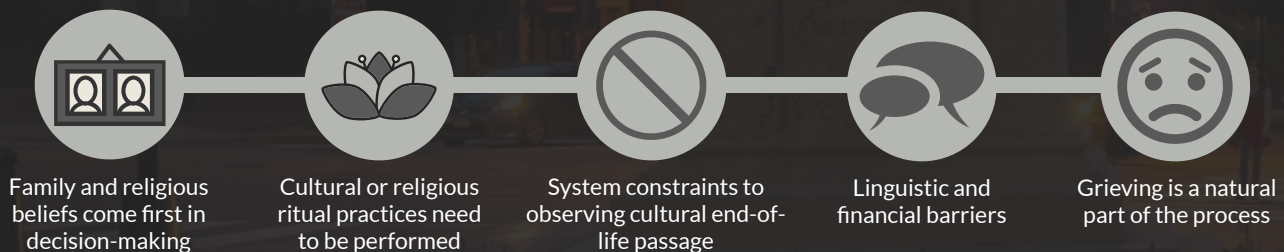
statewide due to
Alzheimer's Disease

End-of-Life Needs: Through Cultural Eyes

As Portland continues to grow, it is imperative that our health system grows with it and responds to the needs of community members. The city's diversity has grown in so many different ways, but none more exponentially than racial and ethnic diversity. With this ever-growing population, Portland Public Health recognizes the impact of race, culture, language, gender and class on seeking care.

One particularly difficult aspect of healthcare for minority groups is end-of-life care. Often times, there are structural and cultural barriers to accessing services for minority groups. Accessing the health care system can be hard due to structural barriers such as lack of health insurance, high out of pocket expenses and lack of transportation. Additionally, the system can be hard to access due to cultural barriers like interaction styles and expectations, integration of traditional health care practices and linguistic barriers. The Minority Health Program set out to explore community perceptions, barriers and possible solutions to end-of-life issues as well as provide education to service providers on cultural matters related to end-of-life care.

In a series of six focus groups with six different minority communities (Latino, Somali, Sudanese, Russian, Serbian and French), Minority Health Program staff worked to understand barriers and identify common themes. Several common themes were identified:



Several recommendations were also made:



In recognition that cultural competency is a journey, not a destination, the staff of Portland Public Health work to incorporate culturally and linguistically appropriate services across the division.

Next Steps

It is the hope of Portland Public Health that the data compiled in this report will allow subsequent initiatives and programmatic interventions to be tailored to the needs of Portlanders. This report serves as a compass for Portland Public Health and we plan to use it as a guide for our community health improvement plan, system integration, policy and decision-making, and resource and asset mapping.

Community Health Improvement Plan (CHIP)

In order to properly plan for and address local health concerns, Portland Public Health will utilize community and stakeholder engagement strategies to first understand what those concerns are. To do so, we plan on hosting focus groups and community forums to encourage the Portland public to share their opinions and perceptions. We will also strengthen our commitment to cultural competency and inclusion of individuals with diverse backgrounds in response to Portland's ever-growing diversity. Together, the data and feedback will provide the foundation for an updated Community Health Improvement Plan for Portland.



System Integration

Because the Health of Portland report pulls data from several sources, Portland Public Health will work with state and local entities to create and provide a database for the public to utilize. This work will be done in collaboration with the City of Portland's Innovation Working Group that is looking to streamline data and implement modern systems to increase efficiency city-wide. We will also be using the data to strengthen reporting requirements in accordance with the Public Health Accreditation Board (PHAB).



Policy-making

Portland Public Health will explore avenues within the City and beyond to address health concerns at a policy level in hopes of addressing health systemically and improving compliance with national, evidence-based strategies.



Resource and Asset Mapping

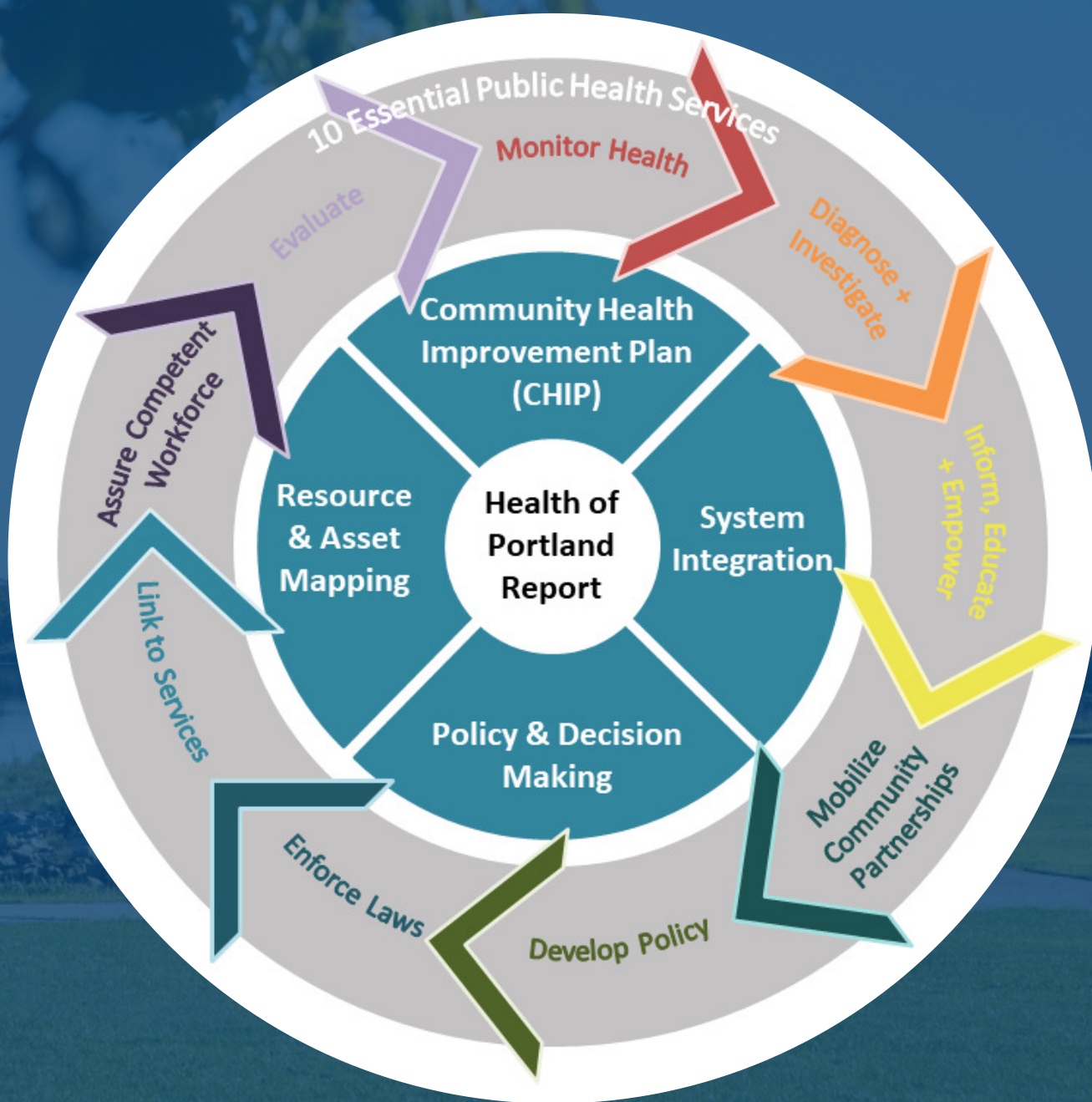
Portland Public Health will continue collaborating with organizations across the City and the state to identify and utilize resources that could be harnessed in addressing under-performing health areas. This will involve significant collective effort from divisions across the City, Portland residents and local organizations. Additionally, we hope this report will support Portland Public Health in streamlining programs and funding resources to address identified needs and areas of concern.



How it all fits

As a nationally accredited health department, Portland Public Health utilizes the 10 Essential Public Health Services as a framework to guide our public health initiatives. These essential services, developed by The Core Public Health Functions Steering Committee, serve as a foundation for any public health activity and provide structure and measurement to assess our performance. It is vital that all our current and future efforts are guided by evidence-based practice and are evaluated consistently to address the growing needs of the public.

Below, you will see that we have aligned Portland Public Health's next steps with the 10 Essential Public Health Services in recognition of the framework and the union of our work with national best practices. It is our intention that the Health of Portland Report sits at the center of our work and guides our next steps in alignment with the essential services and ultimately, supports our mission of improving the health of individuals, families, and the community through disease prevention, health promotion, and protection from environmental threats





Appendix A - Indicators and Sources					
Demography					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Population estimate	2018 66417	2018 293557	2018 1338404	US Census Bureau Quick Facts	All persons who are "usually resident" in a specified geographic area.
Veterans	2018 3053	2018 18469	2018 110362	US Census Bureau Quick Facts	Veterans are men and women who have served, but are not currently serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard.
Disabled population	2018 9.10%	2018 7.80%	2018 11.80%	US Census Bureau Quick Facts	In an attempt to capture a variety of characteristics that encompass the definition of disability, the ACS identifies serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation.
Median age	2018 36	2018 41.6	2018 44	US Census Bureau Quick Facts	The age that divides a population into two numerically equal groups - that is, half the people are younger than this age and half are older.
Male population	2018 49.60%	2018 48.50%	2018 49%	US Census Bureau Quick Facts	Sex is based on the biological attributes of men and women (chromosomes, anatomy, and hormones).
Female population	2018 50.40%	2018 51.50%	2018 51%	US Census Bureau Quick Facts	
Persons under 5 years old	2018 5.30%	2018 4.90%	2018 4.80%	US Census Bureau Quick Facts	Age estimates of the population are produced for the United States, states, and counties. Because age is a critical element in determining federal funding, it is imperative to have high quality age data.
Persons under 18 years old	2018 16.50%	2018 18.70%	2018 18.70%	US Census Bureau Quick Facts	
Persons 65 years and over	2018 13.70%	2018 18.40%	2018 20.60%	US Census Bureau Quick Facts	
Asian, non-Hispanic	2018 3.80%	2018 2.30%	2018 1.20%	US Census Bureau Quick Facts	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black, non-Hispanic	2018 8.70%	2018 3.10%	2018 1.60%	US Census Bureau Quick Facts	A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black or African American," or report entries such as African American, Kenyan, Nigerian, or Haitian.
White, non-Hispanic	2018 81.10%	2018 90.40%	2018 93.10%	US Census Bureau Quick Facts	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
Hispanic, any race	2018 3.60%	2018 2.10%	2018 1.70%	US Census Bureau Quick Facts	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
American Indian and Alaska Native alone	2018 0.10%	2018 0.40%	2018 0.70%	US Census Bureau Quick Facts	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
Two or more races	2018 2.90%	2018 2.00%	2018 1.80%	US Census Bureau Quick Facts	People may choose to provide two or more races either by checking two or more race response check boxes, by providing multiple responses, or by some combination of check boxes and other responses.
Foreign born persons	2018 13.40%	2018 6.20%	2018 3.60%	US Census Bureau Quick Facts	The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national at birth. This includes respondents who indicated they were a U.S. citizen by naturalization or not a U.S. citizen.
Racial/Ethnic Diversity Score	2017 45.2/100	NA	NA	CityHealthDashboard.com	Distribution of the population by race/ethnic group within a city or census tract (index).

Social Determinants of Health					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Reading proficiency	2017 53%	NA	NA	CityHealthDashboard.com	Percentage of 3rd Graders who scored, "proficient" or above in reading.
Absenteeism	2017-2018 16%	NA	2017-2018 16.46%	Maine Department of Education	Percentage of students who missed 15 or more school days in a year.
4-Year Graduation Rate	2017-2018 87%	2017-2018 87.70%	2017-2018 86.74%	Maine Department of Education	Percentage of students who graduate with a regular diploma four years after starting ninth grade.
Median household income	2013-2017 \$51,430	2013-2017 \$65,702	2013-2017 \$53,024	US Census Bureau Quick Facts	Dollar amount that divides all households into two equal groups: half of the households having more income and the other half having less income.
Total household income less than \$10,000	2013-2017 10.50%	2013-2017 5.80%	2013-2017 6.40%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$10,000 - \$14,999	2013-2017 5.80%	2013-2017 4.40%	2013-2017 5.70%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$15,000 - \$24,999	2013-2017 9.70%	2013-2017 7.90%	2013-2017 10.80%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$25,000 - \$34,999	2013-2017 9.70%	2013-2017 8.20%	2013-2017 10.60%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$35,000 - \$49,999	2013-2017 13.00%	2013-2017 11.90%	2013-2017 13.80%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$50,000 - \$74,999	2013-2017 16.80%	2013-2017 17.70%	2013-2017 19.20%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$75,000 - \$99,999	2013-2017 12.30%	2013-2017 13.80%	2013-2017 12.90%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$100,000 - \$149,999	2013-2017 12.90%	2013-2017 16.80%	2013-2017 12.80%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$150,000 - \$199,999	2013-2017 4.70%	2013-2017 6.60%	2013-2017 4.10%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Total household income \$200,000 or more	2013-2017 4.50%	2013-2017 6.80%	2013-2017 3.70%	American Community Survey 5-Year Estimates	This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.
Children living in poverty	2012-2016 25.60%	2012-2016 13.30%	2012-2016 17.20%	Maine Shared Community Health Needs Assessment (CHNA), Portland Profile	Percentage of children, ages 0-17 years, who live in households where the total income of the householder's family is below the established federal poverty level.
Adults living in poverty	2013-2017 17.10%	2013-2017 10.15%	2013-2017 11.97%	American Community Survey 5-Year Estimates	Percentage of adults, ages 18 years and older, whose income in the past 12 months is below the established federal poverty level.
Food insecurity	2015 47.30%	NA	NA	CityHealthDashboard.com	Population living more than 1/2 mile from the nearest supermarket, supercenter or large grocery store.

Social Determinants of Health					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Median home value	2013-2017 \$261,100	2013-2017 \$259,400	2013-2017 \$179,900	US Census Bureau Quick Facts	Value is a tabulation of ACS respondents' estimate of how much their property (house and lot) would sell for if it were for sale.
Excessive housing costs	2017 39.60%	NA	NA	CityHealthDashboard.com	Households where greater than or equal to 30% of household income is spent on housing costs.
Portland Family Shelter Bed nights provided Number of families	2018 51,788 183	NA	NA	City of Portland, Family Shelter	--
Unemployment	2018 2.60%	2018 2.70%	2018 3.40%	Maine Department of Labor, Center for Workforce Research and Information	Percentage of non-institutionalized civilians in the labor force who were not employed.
Language other than English spoken at home	2013-2017 15.10%	2013-2017 7.50%	2013-2017 6.20%	US Census Bureau Quick Facts	Percent of persons age 5 years+ who speak a Language other than English at home.

Community Assets					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Walkability	2018 61.3	NA	NA	CityHealthDashboard.com	This metric includes the density of intersections and residences, as well as the accessibility on foot of amenities such as grocery stores, parks, and restaurants in a neighborhood.
Percentage of residents with park access	2017 86.90%	2015 28%	2015 17%	Portland: CityHealthDashboard. com Cumberland County and Maine: National Environmental Public Health Tracking Network	This metric includes those who live within a 10 minute walk (or half mile) of green space.

Access to Care					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Ratio of population to one primary care provider	NA	2016 600:1	2016 890:1	CountyHealthRankings.Org	The ratio represents the number of individuals served by one physician in a county, if the population was equally distributed across physicians.
Ratio of population to one dentist	NA	2017 1040:1	2017 1590:1	CountyHealthRankings.Org	The ratio represents the population served by one dentist if the entire population of a county was distributed equally across all practicing dentists.
Ratio of population to one mental health provider	NA	2018 150:1	2018 220:1	CountyHealthRankings.Org	The ratio represents the number of individuals served by one mental health provider in a county, if the population were equally distributed across providers.
Uninsured population	2012-2016 10%	2012-2016 7.50%	2012-2016 9.50%	Maine Shared CHNA, Portland Profile	Percentage of people who do not currently have any form of health insurance (either privately, through their employer or through the government).
Source of on-going care	2017 *14.8%	NA	2017 15.20%	Selected Metropolitan/ Micropolitan Area Risk Trends of Behavioral Risk Factor Surveillance System (SMART BRFSS)	Percentage of adults who have an on-going source of care, age-adjusted. *Portland-South Portland MMSA.
Access to care barriers - cost	2017 *12%	NA	2017 13.30%	Selected Metropolitan/ Micropolitan Area Risk Trends of Behavioral Risk Factor Surveillance System (SMART BRFSS)	Percentage of adults who could not see a doctor in the last 12 months because of cost, age-adjusted. *Portland-South Portland MMSA.
Language spoken at home/ linguistically isolated population	2017 7.20%	2017 2.70%	2017 1.60%	US Census Bureau Quick Facts	Percentage of households where no members, 14 years and older, speak English well.
Women, aged 65+, up to date on preventive services	2016 36.30%	NA	2016 35.30%	500 Cities	Percentage of women aged >=65 years who are up to date on a core set of clinical preventive services (flu shot past year, pneumococcal shot ever, colorectal cancer screening, mammogram past 2 years), age-adjusted.
Men, aged 65+, up to date on preventive services	2016 43.70%	NA	2016 42.20%	500 Cities	Percentage of men aged >=65 years who are up to date on a core set of clinical preventive services (flu shot past year, pneumococcal shot ever, colorectal cancer screening), age-adjusted.
Routine wellness check-ups, adults	2016 70.30%	NA	2016 69.40%	500 Cities	Percentage of adults aged >=18 years who have visited a doctor for routine checkup within the past year, age-adjusted.
Routine dental check-ups, adults	2016 66.60%	NA	2016 62.60%	500 Cities	Percentage of adults aged >=18 years who have visited a dentist or dental clinic, age-adjusted.
Portland Community Free Clinic	2017-2018				
Crude number of clinical encounters	909				
Crude number of patients seen	347				
Crude number of returning patients	165	NA	NA	Portland Community Free Clinic	--
Crude number of new patients	182				
Crude number of volunteers	104				
Crude number of volunteer hours	1906				

Maternal and Child Health					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Percentage of births for which prenatal care began in the 1st trimester	2014-2016 88.10%	NA	NA	CityHealthDashboard.com	Percentage of births for which prenatal care began in the first trimester of pregnancy.
Percentage of births for which the mother received more than 80% of expected prenatal visits	NA	2016 80.60%	2016 80.60%	Maine Shared CHNA, Cumberland County Profile	Percentage of new mothers who had more than 80% of the expected prenatal visits.
Percentage of new mothers who smoked cigarettes during 3rd trimester	2018 3.10%	2016 7.00%	2016 14.50%	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Percentage of new mothers who smoked cigarettes during the last three months of pregnancy.
Drug-affected infant reports, per 1000 births	2017 35.7	2017 41.7	2017 77.9	Portland: Maine Office of Child and Family Services Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 1,000 births of infants for which a healthcare provider reported that there was reasonable cause to suspect the baby may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure or has a fetal alcohol spectrum disorder.
Percentage of babies who are ever breast fed	2018 97.46%	2016 81.90%	2016 82%	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Percentage of babies who were ever fed breast milk.
Rate of births to women, aged 15 - 50, per 1,000 women	2017 44	2017 40	2017 49	American Community Survey 5-Year Estimates	Number of women, 15 - 50 years old, who gave birth in the past 12 months, per 1,000 women aged 15 - 50 years old.
Rate of births to women, aged 15-19, per 1000 women	2014-2016 8	2016 7.4	2016 14.5	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 1,000 women, ages 15-19 years, who gave birth.
Percentage of pre-term live births	2012-2016 8%	2012-2016 7.80%	2012-2016 8.20%	Maine Shared CHNA, Portland Profile	Percentage of babies born before 37 weeks of gestation.
Percentage of babies born with low birth weight	2012-2016 6.90%	2012-2016 6.80%	2012-2016 7.10%	Maine Shared CHNA, Portland Profile	Percentage of babies born with a weight less than 2,500 grams.
Percentage of low-risk births for which a cesarean section was completed.	2018 37.09%	2014-2016 22.80%	2014-2016 22.40%	Portland: Maine CDC Data Research and Vital Statistics Maine Shared CHNA, Cumberland County Profile	Percentage of low-risk births for which a cesarean section was completed.
Percentage of 2 year olds who are up to date with recommended immunizations	NA	2017 71.30%	2017 73.70%	Maine Shared CHNA, Cumberland County Profile	Percentage of children, ages 24-35 months, who are up-to-date with all recommended immunizations, assessed on December 31 of each year.
Percentage of 13 to 18 year olds who are up to date on recommended immunizations	NA	2017 51.30%	2017 53.70%	Maine Shared CHNA, Cumberland County Profile	Percentage of children, ages 13-18 years, who are up-to-date with all recommended immunizations, assessed on December 31 of each year.

Chronic Disease					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Percentage of adults who eat less than one serving of fruit per day	2017 28.20%	2015 31.90%	2017 31.80%	Portland and Maine: Selected Metropolitan/ Micropolitan Area Risk Trends of Behavioral Risk Factor Surveillance System (SMART BRFS) Cumberland County: Maine Shared CHNA, Cumberland County	Percentage of adults aged >=18 years old who consumed fruit less than one time per day, age-adjusted. *Portland-South Portland MMSA.
Percentage of adults who eat less than one serving vegetables per day	2017 12.10%	2015 14.80%	2017 13.00%	Portland and Maine: Selected Metropolitan/ Micropolitan Area Risk Trends of Behavioral Risk Factor Surveillance System (SMART BRFS) Cumberland County: Maine Shared CHNA, Cumberland County	Percentage of adults aged >=18 years old who consumed vegetables less than one time per day, age-adjusted. *Portland-South Portland MMSA.
Obesity, adults	2016 26.30%	2016 27%	2016 29.90%	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	This metric includes adults, aged 18 or older, who report having a body mass index (BMI) of 30 or higher.
No leisure-time physical activity, adults	2016 17.90%	2015 15%	2016 19.30%	Portland and Maine: 500 Cities Cumberland County: CountyHealthRankings.org	Percentage of adults >=18, who report no leisure-time physical activity.
Fruit consumption, high school students who eat less than one serving per day	2019 37.50%	2019 34.20%	2019 39%	Maine Integrated Youth Health Survey	Percentage of high school students who consumed fruit less than one time per day.
Vegetable consumption, high school students who eat less than one serving per day	2019 54.20%	2019 49.70%	2019 55.40%	Maine Integrated Youth Health Survey	Percentage of high school students who consumed vegetables less than one time per day.
Obesity, high school students	2019 10.60%	2019 10.80%	2019 15%	Maine Integrated Youth Health Survey	Percentage of high school students who were obese (i.e., at or above the 95th percentile for body mass index, by age and sex).
Met physical activity recommendations of 60 minutes per day, high school	2019 17.10%	2019 20.00%	2019 20.90%	Maine Integrated Youth Health Survey	Percentage of high school students who were physically active for a total of at least 60 minutes per day on seven of the past seven days.
Percentage of population diagnosed with high blood pressure	2016 28.40%	NA	2016 28.60%	500 Cities	Percentage of adults aged >=18 years with high blood pressure.
Rate of heart attack hospitalizations per 10,000 people	NA	2016 16	2016 23.4	Maine Shared CHNA, Cumberland County Profile	Rate per 10,000 people of hospitalizations with a principal diagnosis of a heart attack.
Rate of heart failure hospitalizations per 10,000 people	NA	2016 16	2016 19.8	Maine Shared CHNA, Cumberland County Profile	Rate per 10,000 people of hospitalizations with a principal diagnosis of heart failure.
Rate of stroke hospitalizations per 10,000 people	NA	2016 18.6	2016 21.4	Maine Shared CHNA, Cumberland County Profile	Rate per 10,000 people of hospitalizations with a principal diagnosis of stroke.
Rate of coronary heart disease deaths per 100,000 people	2018 83	2012-2016 61.6	2012-2016 84.1	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of deaths with coronary heart disease as an underlying cause of death.
Chronic obstructive pulmonary disease (COPD) hospitalizations per 10,000 people	2016 12.4	2016 9.5	2016 16.5	Maine Shared CHNA, Portland Profile	Rate per 10,000 people of hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD).
Chronic obstructive pulmonary disease (COPD) deaths per 100,000	2018 41.5	NA	NA	Maine CDC Data, Research, and Vital Statistics	Rate per 100,000 people of deaths due to chronic obstructive pulmonary disease (COPD).

Chronic Disease					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Percentage of Portland adults who are current smokers	2016 16.50%	2016 13.90%	2016 19.80%	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Percentage of adults who have smoked at least 100 cigarettes in their lifetime and currently smoke.
Percentage of high school students who used tobacco in the last 30 days	2019 7.80%	2019 9.30%	2019 10.60%	Maine Integrated Youth Health Survey	Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, dip, or dissolvable tobacco products on one or more of the past 30 days.
Percentage of high school age students who used E-cigarettes in the last 30 days	NA	2019 29.20%	2019 28.70%	Maine Integrated Youth Health Survey	Percentage of high school students who used an electronic vapor product at least one day in the last 30 days.
Percentage of Portland adults who have diagnosed diabetes	2016 8.30%	NA	2016 8.30%	500 Cities	Percentage of adults, aged 18 or older, who report having been told they have diabetes.
Rate of diabetes hospitalizations per 10,000 people	2016 13.3	2016 9	2016 11.9	Maine Shared CHNA, Portland Profile	Rate per 10,000 people of hospitalizations with a principal diagnosis of diabetes.
Rate of diabetes deaths (underlying cause) per 100,000 people	2012-2016 18.3	2012-2016 15.7	2012-2016 22	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths with diabetes as an underlying cause of death.

Cancer					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
All cancer new cases per 100,000 people	2012-2014 461.5	2012-2014 459.3	2012-2014 473.7	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of new cases of any type of cancer.
All cancer deaths per 100,000 people	2012-2016 166	2012-2016 161.5	2012-2016 173.8	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths from any type of cancer.
New cases of tobacco-related cancer per 100,000 people	2010-2014 135.8	2012-2014 132.6	2012-2014 134.1	Maine CDC Cancer Registry	Rate per 100,000 people of new cases of tobacco-related cancers (excluding lung and bronchus defined as cancers of the oral cavity and pharynx, esophagus, stomach, colon and rectum, liver, pancreas, larynx, cervix uteri, urinary bladder, kidney and renal pelvis, and acute myeloid leukemia).
New cases of female breast cancer per 100,000 women	2010-2014 120.5	2012-2014 128.7	2012-2014 125	Portland: Maine CDC Cancer Registry Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 females of new cases of breast cancer.
Rate of female breast cancer deaths per 100,000 women	2014-2016 19.4	2012-2014 18.7	2012-2014 18.4	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 females of deaths from breast cancer.
Percentage of women, aged 50 - 74, who have had a mammogram within the past two years	2016 73.40%	2014 & 2016 84.60%	2016 80.20%	Portland and Maine: 500 Cities Cumberland County: Maine Shared CHNA, Cumberland County Profile	Percentage of women, aged 50 - 74, who have had a mammogram within the past two years.
New cases of colorectal cancer per 100,000 people	2010-2014 37.6	2012-2014 34.9	2012-2014 37.4	Portland: Maine CDC Cancer Registry Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 people of new cases of colon or rectum cancers.
Rate of colorectal cancer deaths per 100,000 people	2014-2016 13.6	2012-2016 11.8	2012-2016 13.1	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths from colorectal cancer.
Percentage of adults, aged 50-75, who have received a colorectal cancer screening	2016 73.50%	2014 & 2016 78.90%	2016 73.30%	Portland and Maine: 500 Cities Cumberland County: Maine Shared CHNA, Cumberland County Profile	Percentage of adults, aged 50-75, who have received a colorectal cancer screening.
New cases of cervical cancer per 100,000 women	2010-2014 <10	NA	NA	Maine CDC Cancer Registry	Rate per 100,000 females of new cases of cervical cancer.
Percentage of women, aged 21-65, who have had a pap test in the past three years	2016 78.50%	2014 & 2016 83.90%	2016 83.90%	Portland and Maine: 500 Cities Cumberland County: Maine Shared CHNA, Cumberland County Profile	Percentage of women, aged 21-65, who have had a pap test in the past three years.
New cases of lung cancer per 100,000 people	2010-2014 68.4	2010-2014 65.9	2010-2014 73.3	Maine CDC Cancer Registry	Rate per 100,000 people of new cases of lung cancer.
Rate of lung cancer deaths per 100,000 people	2018 50.4	2012-2016 44.4	2012-2016 50.5	Portland: Maine CDC Cancer Registry Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths from lung cancer.
New cases of prostate cancer per 100,000 men	2010-2014 94.6	2012-2014 86.7	2012-2014 87.1	Portland: Maine CDC Cancer Registry Cumberland County and Maine: Maine Shared CHNA, Portland Profile	Rate per 100,000 males of new cases of prostate cancer.

Cancer					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
New cases of bladder cancer per 100,000 people	2010-2014	2012-2014	2012-2014	Portland: Maine CDC Cancer Registry	Rate per 100,000 people of new cases of bladder cancer.
	25.7	26.1	27.1	Cumberland County and Maine: Maine Shared CHNA, Portland Profile	
New cases of melanoma cancer per 100,000 people	2010-2014	2012-2014	2012-2014	Portland: Maine CDC Cancer Registry	Rate per 100,000 people of new cases of melanoma of the skin.
	23.2	31.1	24.5	Cumberland County and Maine: Maine Shared CHNA, Portland Profile	

Infectious Disease						
Indicator	Portland	Cumberland Co.	Maine	Source	Definition	
Newly diagnosed cases of chlamydia per 100,000 people	2017 544.2	2017 405.5	2017 340.9	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of chlamydia.	
Newly diagnosed cases of chlamydia per 100,000 people	2018 492.3	NA	NA	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of chlamydia.	
Newly diagnosed cases of gonorrhea per 100,000 people	2017 131.6	2017 61.5	2017 43.2	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of gonorrhea.	
Newly diagnosed cases of gonorrhea per 100,000 people	2018 146.1	NA	NA	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of gonorrhea.	
Newly diagnosed cases of infectious syphilis per 100,000 people	2017 26.9	2017 9.9	2017 6.2	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of syphilis.	
Newly diagnosed cases of infectious syphilis per 100,000 people	2018 28.6	NA	NA	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of syphilis.	
Newly diagnosed cases of hepatitis C per 100,000 people	2017 338.7	2017 193.5	2017 140.4	Maine Infectious Disease Surveillance System	Rate per 100,000 people of newly diagnosed cases of chronic hepatitis C.	
Immunization exemptions among kindergarteners for philosophical reasons	2017-2018 1.60%	2018-2018 4.20%	2017-2018 4.60%	Maine Shared CHNA, Portland Profile	Percentage of kindergarteners who were exempted from school immunization requirements due to philosophical reasons.	
Two-year-olds up to date with recommended immunizations, Cumberland County	NA	2017 71.30%	2017 73.70%	Maine Shared CHNA, Cumberland County Profile	Percentage of children, ages 24-35 months, who are up-to-date with all recommended immunizations, assessed on December 31 of each year.	
Influenza vaccination in the past year, adults, Cumberland County	NA	2014-2016 46.80%	2014-2016 42.30%	Maine Shared CHNA, Cumberland County Profile	Percentage of adults who had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in their nose during the past 12 months.	
Maine children received influenza vaccination in the past year	NA	NA	2016-2017 59%	Maine Shared CHNA, Cumberland County Profile	Percentage of children, ages 6 months to 17 years, who received an immunization for influenza during the school year.	

Environmental Health					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Housing units built pre-1950s	2013-2017 53%	2013-2017 29.50%	2013-2017 28.30%	Maine Environmental Public Health Tracking Program	Percentage of occupied housing units built before 1950.
Children, 0-3 years, who received a blood lead test	2013-2017 26.50%	2013-2017 19.54%	2013-2017 28.81%	Maine Environmental Public Health Tracking Program	Percentage of children screened for blood lead.
Children with lead poisoning	2013-2017 149	2013-2017 304	2013-2017 1783	Maine Environmental Public Health Tracking Program	Percentage of children with a blood lead level at or above 5 micrograms per deciliter (ug/dL), among those screened. The estimated number of children with a blood lead level ≥ 5 ug/dL is the number with confirmed tests plus 38% of the children with unconfirmed 5-<10 ug/dL tests.
Air pollution - PM2.5 Concentration, annual average	2015 7.8	2014 8	2014 7.4	Portland: CityHealthDashboard.com Cumberland County and Maine: National Environmental Public Health Tracking Network	Average daily concentration of fine particulate matter (PM2.5) per cubic meter (average).
Public water supply	2018 Exceeds standard	NA	NA	Portland Water District, 2018 Annual Water Quality Report	--
Asthma prevalence, adult	2016 11%	NA	2016 12.70%	500 Cities	Current asthma prevalence among adults aged ≥ 18 years, age-adjusted.
Asthma prevalence, youth	NA	2014-2016 10.20%	2014-2016 9.00%	Maine Shared CHNA, Cumberland County Profile	Percentage of children, ages 0-17 years, whose parents have been told by a healthcare provider that they had asthma and that they still have asthma.
Asthma-related emergency department visits per 10,000 people	2010-2014 85	2010-2014 34	2010-2014 39.7	Maine Environmental Public Health Tracking Program	Rate of asthma emergency department visits per 10,000 population. Only emergency department visits with a primary diagnosis of asthma are included.
Asthma-related hospitalizations per 10,000 people	2010-2014 6.3	2016 2.4	2016 3.2	Maine Environmental Public Health Tracking Program	Rate of asthma hospitalizations per 10,000 population. Only hospitalizations with a primary diagnosis of asthma are included.
Incidence of lyme disease per 100,000 people	2018 45.3	2018 97.8	2018 105.1	Maine Environmental Public Health Tracking Program	Incidence rate (per 100,000 population) of confirmed and probable cases of Lyme disease in the population.
EPA-Designated Zone, Radon potential	2019 Zone 1	2019 Zone 1	2019 Zones 1 + 2	Environmental Protection Agency	Zone 1: Counties with predicted average indoor radon screening levels greater than 4 pCi/L. Zone 2: Counties with predicted average indoor radon screening levels from 2 to 4 pCi/L.
Heat-related illness emergency department visits, per 100,000 people	NA	2017 10.3	2017 15	Maine Environmental Public Health Tracking Program	Rate of heat illness emergency department (ED) visits.

Injury and Exposure to Violence					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Property crime decrease	2016 1.83%	NA	NA	Portland Police Department, 2017 Annual Report	Property crimes are comprised of Arson, Burglary, Larceny-Theft, and Motor Vehicle thefts.
Violent crime increase	2016 8.60%	NA	NA	Portland Police Department, 2017 Annual Report	Violent crimes are comprised of Murder, Robbery, Forcible Rape, and Aggravated Assault.
Violent crime offenses per 100,000 people	2017 279.1	2014-2016 394.4	2014-2016 366.7	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of violent crime offenses (murder, aggravated assault, robbery, forcible rape).
Firearm deaths per 100,000 people	2018 4.4	2012-2016 5.8	2012-2016 9.5	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of deaths due to firearms, all intents.
Suicides per 100,000 people	2012-2016 13.1	2012-2016 12.6	2012-2016 15.9	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths due to suicide.
Rape/non-consensual sex (among females, lifetime)	NA	2012, 2014, 2016 11.50%	2012, 2014, 2016 14.50%	Maine Shared CHNA, Cumberland County Profile	Percentage of females who have ever had sex with someone after they said or showed that they didn't want them to or without their consent.
Poisoning deaths per 100,000 people	2018 37.1	2012-2016 18.4	2012-2016 17.6	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of deaths due to poisonings of unintentional and undetermined intent.
Motor vehicle traffic crash deaths per 100,000	2018 16.3	2012-2016 5.9	2012-2016 10.8	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of deaths due to unintentional motor vehicle crashes.
Traumatic brain injury emergency department visits per 10,000	NA	2012-2014 74	2012-2014 85.1	Maine Shared CHNA, Cumberland County Profile	Rate per 10,000 people of emergency department discharges with a diagnoses of traumatic brain injury.
Fall-related emergency department visits per 10,000 people	2012-2014 408.6	2012-2014 272.1	2012-2014 340.9	Maine Shared CHNA, Portland Profile	Rate per 10,000 people of emergency department discharges with a diagnoses of a fall-related injury.
Fall-related deaths per 100,000 people	2018 23.7	2012-2016 10.2	2012-2016 9.6	Portland: Maine CDC Data Research and Vital Statistics Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of deaths due to unintentional falls.

Mental Health					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Adult depression, lifetime	NA	2014-2016 22.30%	2014-2016 22.80%	Maine Shared CHNA, Cumberland County Profile	Percentage of adults who have ever been told by a healthcare provider that they have a depressive disorder.
Frequent mental distress, adults	2016 12.70%	2016 11.00%	2016 14.00%	Portland and Maine: 500 Cities Cumberland County: CountyHealthRankings.org	Mental health not good for ≥14 days during the past 30 days among adults aged ≥18 years (%), age-adjusted.
High school students who report feeling sad or hopeless for 2 weeks in a row	2019 32.10%	2019 30.00%	2019 32.10%	Portland: Maine Integrated Youth Health Survey	Percentage of high school students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.
Mental health emergency department visits per 10,000 people	2012-2014 297.3	2012-2014 164	2012-2014 167.6	Maine Shared CHNA, Portland Profile	Rate per 10,000 people of emergency department discharges with a principal diagnosis of mental health condition.
Ratio of population to one mental health provider	NA	2018 150:1	2018 220:1	CountyHealthRankings.Org	The number of individuals served by one mental health provider in a county, if the population were equally distributed across providers.
Police calls for Service - behavioral health	2018 5509	NA	NA	Portland Police Department	Calls to Portland Police Department that are behavioral health-related (suicide attempts, suicide threats, behavioral health).
Percentage of high school students who have seriously considered suicide	2019 13.80%	2019 14.90%	2019 16.40%	Portland: Maine Integrated Youth Health Survey	Percentage of high school students who seriously considered attempting suicide during the past 12 months.
Percentage of middle school students who have seriously considered suicide	2019 20.60%	2019 18.40%	2019 19.80%	Portland: Maine Integrated Youth Health Survey	Percentage of seventh- and eighth-grade students who seriously considered attempting suicide during the past 12 months.
Rate of completed suicides per 100,000 people	2012-2016 13.1	2012-2016 12.6	2012-2016 15.9	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths due to suicide.

Substance Use, Part One					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Percentage of adults who binge drink	2016	2016	2016	Portland and Maine: 500 Cities	Percentage of women, aged 18 or older, who report consuming more than four alcoholic drinks on one occasion or men, aged 18 or older, who report consuming over five alcoholic drinks on one occasion.
	18.90%	19.10%	21.60%	Cumberland County: CountyHealthRankings.org	Excessive Drinking measures the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days.
Percentage of high school students who use alcohol	2019 20.80%	2019 24.10%	2019 22.90%	Maine Integrated Youth Health Survey	Percentage of high school students who had at least one drink of alcohol on at least one day in the past 30 days.
Percentage of middle school students who think alcohol is easy to get	2019 36.90%	2019 39.40%	2019 35.60%	Maine Integrated Youth Health Survey	Percentage of middle school students who answered "Sort of easy" or "Very easy" when asked, "If you wanted to get some alcohol, how easy would it be for you to get some?"
Percentage of high school students who think alcohol is easy to get	2019 57.50%	2019 63.40%	2019 60.5%	Maine Integrated Youth Health Survey	Percentage of high school students who answered "Sort of easy" or "Very easy" when asked, "If you wanted to get some alcohol, how easy would it be for you to get some?"
Percentage of high school students who use marijuana	2019 26.40%	2019 23.90%	2019 22.00%	Maine Integrated Youth Health Survey	Percentage of high school students who used marijuana at least one time in the last 30 days.
Overdose emergency medical service responses per 10,000 people	2018 75	2018 43.7	2018 51	Maine Emergency Medical Services	Rate per 10,000 population of overdose emergency medical service responses, including overdoses from drugs/medication, alcohol, and inhalants.
Drug-related calls for service	2016 1063	NA	NA	Portland Police Department, 2017 Annual Report	Calls to Portland Police Department that are drug-related (drug overdose, drug possession, drug sale/manufacture).
Alcohol-related calls for service	2016 2575	NA	NA	Portland Police Department, 2017 Annual Report	Calls to Portland Police Department that are alcohol-related (drinking in public, intoxicated person, incapacitated person).
Substance-use hospitalizations per 10,000 people	2016 21.5	2016 11.8	2016 18.1	Maine Shared CHNA, Portland Profile	Rate per 10,000 population of hospitalizations with a principal diagnosis of substance-use.
Alcohol-induced deaths per 100,000 people	2012-2016 16.7	2012-2016 8.6	2012-2016 9.7	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths for which alcohol is the underlying cause, including those attributable to acute alcohol poisoning and those from medical conditions resulting from chronic alcohol use.
Opioid-related deaths per 100,000 people	2018 51.19	2018 23.85	2018 21.14	Expanded Maine Drug Death Report, 2018	Rate per 100,000 people of deaths for which opioid-use is the underlying cause.
Opioid-related deaths, crude number	2018 34	2018 70	2018 283	Expanded Maine Drug Death Report, 2018	Crude number of deaths for which opioid-use is the underlying cause.
Overdose-related deaths per 100,000 people	2018 66.2	2018 29.97	2018 26.45	Expanded Maine Drug Death Report, 2018	Rate per 100,000 people of deaths due to a drug overdose.
Overdose-related deaths, crude number	2018 44	2018 88	2018 354	Expanded Maine Drug Death Report, 2018	Crude number of deaths due to a drug overdose.

Substance Use, Part Two				
Indicator	Portland	Cumberland Co.	Maine	Source
2018				
Number of new enrollees of the Needle Exchange Program	229	NA	NA	Annual Hypodermic Apparatus Exchange Report, 11/1/2017 - 10/31/2018
Total number of enrollees of the Needle Exchange Program	3316			Annual Hypodermic Apparatus Exchange Report, 11/1/2017 - 10/31/2018
Number of syringes collected and disposed of	204259			Annual Hypodermic Apparatus Exchange Report, 11/1/2017 - 10/31/2018
Number of syringes distributed	199439			Annual Hypodermic Apparatus Exchange Report, 11/1/2017 - 10/31/2018
Number of referrals made	15835			Annual Hypodermic Apparatus Exchange Report, 11/1/2017 - 10/31/2018
Number of clients enrolled in the naloxone distribution program	715	NA	NA	Portland Needle Exchange Program, Naloxone Distribution Report 2018
Number of doses of naloxone dispensed as refills	1314			Portland Needle Exchange Program, Naloxone Distribution Report 2018
Number of doses of naloxone dispensed to new registrants	1871			Portland Needle Exchange Program, Naloxone Distribution Report 2018
Number of overdoses reversed, as reported by clients	190			Portland Needle Exchange Program, Naloxone Distribution Report 2018
Number of "Overdose Recognition, Response and Naloxone" Trainings provided by Needle Exchange Program Staff	100+			Portland Needle Exchange Program, Naloxone Distribution Report 2018

Death and Dying					
Indicator	Portland	Cumberland Co.	Maine	Source	Definition
Life Expectancy		2012	2012		
Life Expectancy, Women	NA	82.3	81.5	Maine Shared CHNA, County Summary 2015	Life expectancy at birth.
Life Expectancy, Men		78.1	76.7		
Years of potential life lost before age 75 per 100,000 people	2014-2016 7600	2014-2016 5354.3	2014-2016 6529.2	Portland: CityHealthDashboard.com Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	Rate per 100,000 people of the total number of years lost before the age of 75.
Overall death rate per 100,000 people	2012-2016 756.3	2012-2016 683.6	2012-2016 753.1	Maine Shared CHNA, Portland Profile	Rate per 100,000 people of deaths from any cause.
All-cause mortality	2012-2016 Cancer Heart disease Unintentional injury Chronic lower respiratory disease Stroke	2012-2016 Cancer Heart disease Unintentional injury Alzheimer's disease Chronic lower respiratory disease	2012-2016 Cancer Heart disease Chronic lower respiratory disease Unintentional injury Stroke	Portland: Maine Shared CHNA, Portland Profile Cumberland County and Maine: Maine Shared CHNA, Cumberland County Profile	List of top 5 causes of mortality, per 100,000 people.
Rate of deaths due to cancer per 100,000 people	2012-2016 167.1	2012-2016 161.5	2012-2016 173.8	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths from any type of cancer.
Rate of deaths due to heart disease per 100,000 people	2012-2016 133.7	2012-2016 164.3	2012-2016 195.8	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths with cardiovascular disease as an underlying cause of death.
Rate of deaths due to unintentional injury per 100,000 people	2012-2016 59.2	2012-2016 59.3	2012-2016 67.9	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths due to injuries.
Rate of deaths due to chronic lower respiratory disease per 100,000 people	2012-2016 45.5	2012-2016 39.9	2012-2016 48.1	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths due to chronic lower respiratory disease.
Rate of deaths due to cerebrovascular disease (stroke) per 100,000 people	2012-2016 32	2012-2016 30.6	2012-2016 33.4	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths with stroke as an underlying cause of death.
Hospice utilization	NA	2017 57.40%	2017 50.30%	Maine State Hospice Report, 2017	Percentage of total Medicare deaths that occurred as Medicare hospice deaths.
Rate of deaths due to Alzheimer's per 100,000 people	2012-2016 21.1	NA	NA	Maine CDC Data Research and Vital Statistics	Rate per 100,000 people of deaths with Alzheimer's as an underlying cause of death.
Total number of deaths due to Alzheimer's, statewide	NA	NA	2017 601	Alzheimer's Association, Maine Alzheimer's Statistics	Crude number of deaths with Alzheimer's as an underlying cause of death.

Health & Human Services and Public Safety Committee

Councilor Belinda Ray, District 1, Chair

Councilor Tae Chong, District 3

Councilor Pious Ali, At-Large

Potential Topics/Issues for the 2020 Workplan

*Items 1-4 (**in bold**) are currently in process at the committee.*

*Items 5-6 (**in red**) were previously identified as priorities by the 2018 committee but have not yet been fully addressed.*

*Items 7-9 (**in green**) are under consideration by staff. They will likely need to go through the committee process, unless the committee or the council declines to take them up.*

1. **The city's new Homeless Services Center (replacement for the OSS) – Planning, Design, Construction**
2. **Marijuana Regulations – Working through this in tandem with the Economic Development Committee**
3. **Opioid Misuse: Follow up to GPCOG MRC workshop (January 30th) – next steps for the city to take to address opioid misuse and other addiction/substance use disorder issues**
4. **Sprinklers in ADUs – this is a part of the Chapter 10 changes that went through committee in 2019. At November 2019 Council meeting we opted to send this portion of the ordinance back to the committee for further review in accordance with a staff/council request**
5. **Small shelter zoning (in limbo after the Planning Board declined to act on it without licensing regulations determined prior to PB Review in 2017)**
6. **Sober/Recovery Housing: Regulation or Accreditation Process (2017)**
7. **Lodging House Regulations: Review in joint meeting with Housing Committee**
8. **Vaping Regulations – CDC is enacting a flavor ban, but there may still be reason for follow up at City level, particularly with regard to menthol e-cigarettes**
9. **Noise Ordinance – Amendment requested regarding fee for sound mitigation plan review**
10. Facial Recognition Technology – appears likely to land here in the latter half of the year, pending a Council workshop on June 15th

11. Homelessness – apart from shelter plans, other ways to address homelessness and its underlying causes (homelessness identified as a Council priority in 2016 and 2020)
12. 100-foot requirement for issuing entertainment licenses: Discuss measuring technique and evaluate if 100 feet is the appropriate distance (came up during noise ordinance discussions)
13. Creating 8-80 Cities, walkable communities, etc. (Expanding public transit identified as a Council priority in 2020; having walkable communities, easily accessible for all is an important piece in expanding access to public transit and specifically addresses the Public Health components of transit)
14. Rock Row concert noise issues, the City's letter to Waterstone, Waterstone's response, current status of concerts/sound regulation in Westbrook
15. Retail Fur Ban in stores within the City (suggested by constituents in late 2018)
16. Regulations for Backyard Fire Pits (suggested by multiple constituents over the years)
17. Wellness check program for seniors / emergency management plan for assisting vulnerable community members, such as the elderly, during power outages/extreme weather events (suggested by a constituent at a District meeting)

Items on which the committee may seek updates:

- Portland Opportunity Crew: # served, efficacy of program, potential for expansion
- Long Term Stayers Initiative
- India Street Public Health Updates: # served by various programs, ongoing initiatives and projects
- Barron Center: census, programming, etc.