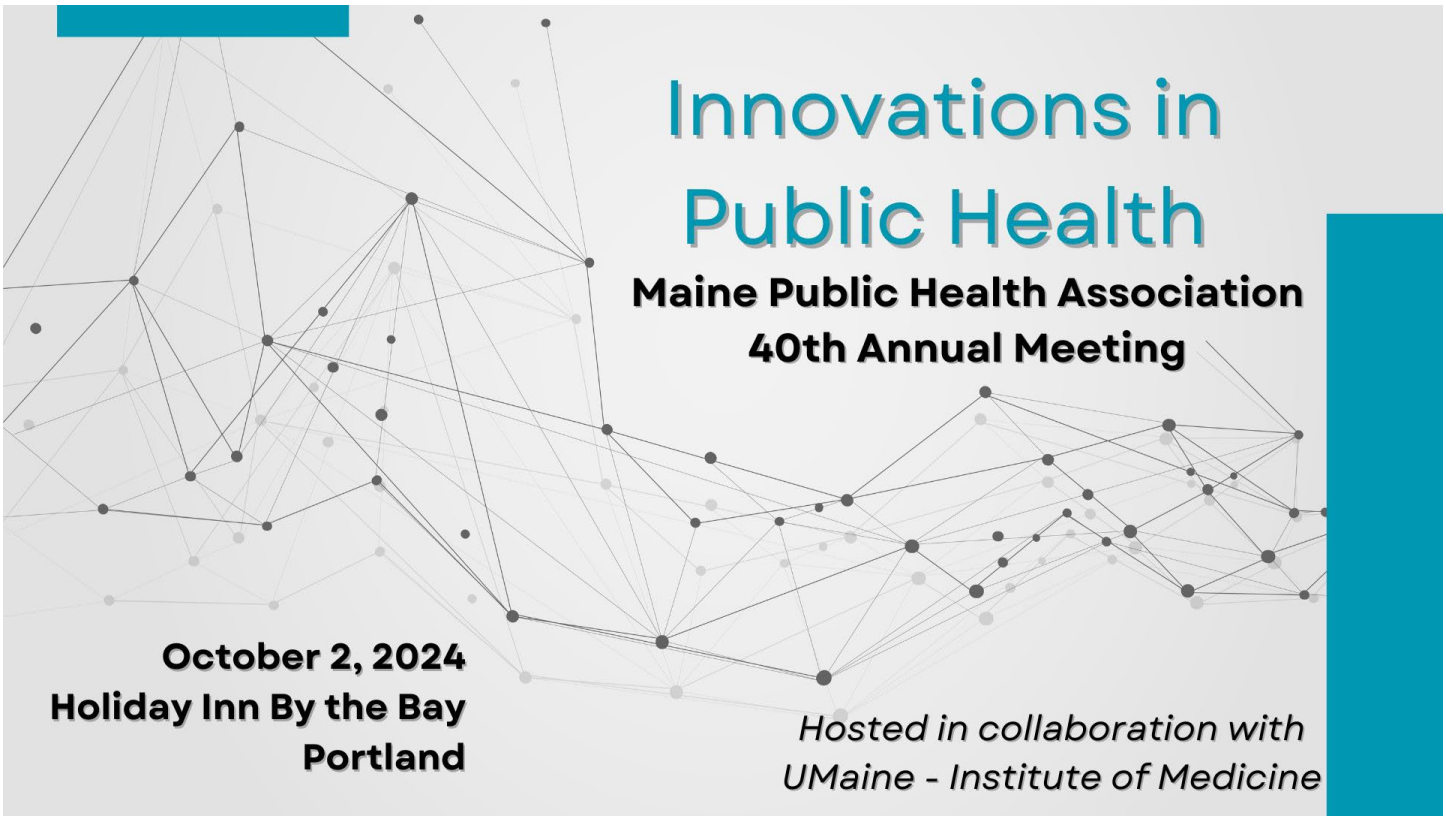
Innovations in Public Health
Maine Public Health Association
40th Annual Meeting
October 2, 2024
Holiday Inn By the Bay
Portland
Hosted in collaboration with
UMaine - Institute of Medicine

Thank You to Our Conference Sponsors!

Silver Sponsors

MaineHealth

NEW ENGLAND PUBLIC HEALTH TRAINING CENTER

Puritan®
Quality since 1919

Bronze Sponsors

MCF Maine Cancer Foundation

mti Maine Technology Institute

Friend Sponsors

MARKET DECISIONS RESEARCH

1865 THE UNIVERSITY OF MAINE
Institute of Medicine
Advancing Health and Wellbeing

Public Health Partners
Strategic Solutions for Public Health Problems

Keynote Speaker Sponsor

Northern Light Health℠

Coffee Breaks Sponsor

RESURGAM
THE RESURGAM GROUP

Breastfeeding Room Sponsors

WinterKids
WINTERKIDS.ORG

Ronald McDonald House Charities® Maine
Keeping families close™

Please Visit Our Conference Exhibitors!

AdCare Educational Institute of Maine
American Lung Association
AstraZeneca
Bangor Public Health and Community Services
BeSMART for Kids
Boston University School of Public Health
City of Portland, Health and Human Services Department, Portland Public Health Division
Community Health Options
Consumers for Affordable Health Care
CSL Seqirus
GSK Vaccines
Harvard School of Public Health
Hospice of Southern Maine
Maine Cancer Foundation
Maine CDC Breast and Cervical Health Program
Maine CDC Lead Poisoning Prevention Program
Maine Chapter, American Academy of Pediatrics
Maine Community Health Worker Initiative
Maine Conservation Voters
MaineGeneral Health
MaineHealth
Maine Initiatives
Maine Primary Care Association
Maine State Breastfeeding Coalition
Maine Technology Institute
MCD Global Health
New England Public Health Training Center
Partnerships for Health
Patagonia Health
Pfizer
Pharming
Project REACH: Research Evidence-to-Action for Community Health
Puritan Medical Products
ReVision Energy
Safe Communities Coalition
Sanofi
The Ridge
University of New England Graduate Programs in Public Health
University of Southern Maine
Western Maine Community Action
** Italics indicate a Sustaining or Alliance organizational member*

MPHA
Maine Public Health Association

Innovations in Public Health

Wednesday October 2, 2024 • Holiday Inn By the Bay
2024 Maine Public Health Association Conference Agenda

7:30am-8:15am	**Registration, Breakfast, Networking & Exhibits (Foyer & Casco Bay Exhibit Hall)**
8:15am-8:30am	**Welcoming Song (Vermont/New Hampshire)** Brett Lewey, Citizen of Passamaquoddy Nation
8:30am-8:55am	**Welcome and Announcements (Vermont/New Hampshire)** Rebecca Boulos, MPH, PhD, Jay Knowlton, MPH & Leo Waterston, MA (Maine Public Health Association)
8:55am-10:00am	**Keynote Presentation: Walking Together, Learning Together: How Collaboration Across Sectors Can Drive Public Health Innovation (Vermont/New Hampshire)** Mehul Dalal, MD, MSc, MHS (Connecticut Department of Social Services & Yale University School of Medicine)
10:00am-10:15am	**Break**
10:15am-11:15am	**Plenary Panel: Innovative Strategies to Foster Community and Mental Well-being (Vermont/New Hampshire)** Moderator: Allegra Hirsh-Wright, MSW (MaineHealth Center for Trauma, Resilience, and Innovation) Panelists: Christopher O'Connor (Equality Community Center), Justin Bondesen (NorthStar, Bryant Pond 4-H Center), Matt Brown (Living Room Crisis Center & Co-Founder of Hope Squad), Sarah Lewis (Maine Access Immigrant Network)
11:20am-12:20pm	**Poster Session (Foyer) & Coffee Break/Exhibits (Casco Bay Exhibit Hall)**
12:30pm-1:30pm	**Lunch (Casco Bay Exhibit Hall)**
1:45pm-2:45pm	**Breakout Session #1**
3:05pm-4:05pm	**Breakout Session #2**
4:15pm-4:30pm	**Closing Remarks, Raffle Winners (Vermont/New Hampshire)**
4:30pm	**Adjourn**

Lactation Room: Board Room (2nd Floor)

Presentation Formats

- In rooms with one presentation, the talk will last 50 minutes, with 10 minutes for questions.
- In rooms with two presentations, each talk will last 25 minutes, with 10 minutes for questions for both presenters.

*Denotes presenter/s

Keynote Presentation 9:00am-10:00am

Vermont/New Hampshire

Walking Together, Learning Together: How Collaboration Across Sectors Can Drive Public Health Innovation
Mehul Dalal, MD, MSc, MHS (Connecticut Department of Social Services & Yale University School of Medicine)

Drawing on his experiences working with the healthcare, public safety, and social services sectors, Dr. Dalal will discuss his observations on key lessons that can support learning and innovation in everyday public health.

Learning Objectives

1. Cite 3 examples of public health collaboration across sectors.
2. Discuss how such collaborations led to practical innovations.

Plenary Presentation 10:15am-11:15am

Vermont/New Hampshire

Innovative Strategies to Foster Community Health and Wellbeing
Moderator: Allegra Hirsh-Wright, MSW (MaineHealth Center for Trauma, Resilience, and Innovation)
Panelists: Christopher O'Connor (Equality Community Center), Justin Bondesen (NorthStar, Bryant Pond 4-H Center), Matt Brown (Living Room Crisis Center & Co-Founder of Hope Squad) & Sarah Lewis (Maine Access Immigrant Network)

Learning Objectives

1. Describe the importance of community support in overall health and wellbeing.
2. Identify four unique ways fostering community health promotes overall mental and physical health in Maine.

Poster Session: 11:20am-12:20pm

Location: Foyer

Disparities in Stage at Diagnosis for Breast, Lung and Bronchus, Colorectal and Prostate Cancers in Maine, 2017-2021 – *Kathleen Fairfield, MD, MPH, DrPH (MaineHealth)

Rollout of a Mobile Culinary Medicine Application Across a Rural Health System – *Lauren Ciszak, MD (MaineHealth)

Secondhand and Thirdhand Smoke and Pets – *Vicky Wiegman, MEd, CAS, Tobacco Treatment Specialist - Certified, PS-C (Healthy Androscoggin)

It's Worth the Try: An Innovative Tobacco Quit Support Curriculum for LGBTQ+ Youth – *Adlin Deering (Healthy Communities of the Capital Area) & *April Hughes, MPH, PS-C (Healthy Communities of the Capital Area)

Appointment-Powered Progress in Maine: Enhancing Maine QuitLink Connections with Personalized Scheduling – *Amy Giles, BA, NCNTT (MaineHealth) & *Shannon O'Brien, BA (MaineHealth)

Culinary Medicine for Chronic Disease Management – *Arabella Solari (MaineHealth) & *Katherine Sharp, MD, MPH (MaineHealth)

Evaluating Engagement and Collaboration Among Hospitals in the Maine Rural Maternal & Obstetrics Management Strategies (RMOMS) Network – *Molly Voit (MaineHealth)

Community Mattering StoryWalk: The Importance of Youth Mattering – *Sarah Young (Healthy Communities of the Capital Area) &*April Hughes, MPH PS-C (Healthy Communities of the Capital Area)

The Impact of Harm Reduction Education on Clinician Knowledge, Attitude, and Stigma of People Who Use Drugs – *Allison Walker-Elders, MPH, OMS-II (MaineHealth Institute for Research) & *Kinna Thakarar, DO, MPH (MaineHealth Institute for Research)

From Data to Doorsteps: Designing a Targeted Outreach Campaign with the Maine Tracking Network – *Val Johnstone, MPH (City of Portland Public Health) & Chloe Dietrich (City of Portland Public Health)

Unlocking Health: A Roadmap for Connecting the Uninsured to Vital Resources – *Kim Beaudoin (MaineHealth) & *Kathy Pipkin (MaineHealth)

Medically Tailored Meals for Patients with Heart Disease in Rural Maine: Lessons Learned and Next Steps – *Emily Follo, MD, MPH (MaineHealth)

Evaluating the Extent Access to Prescribed Medications Impacts Healthcare Utilization and Health Outcomes – *Carol Zechman, MSW, LCSW (MaineHealth), Karen Deschaies (MaineHealth) & *Tim Cowan, MSPH (MaineHealth)

The Relationship Between Food Insecurity and Substance Use Disorder in Maine – *Lauren Ciszak, MD (MaineHealth)

The Psychosocial Effects of Rurality on Patients with Type II Diabetes – *Charlotte Collins, BS (MaineHealth Institute for Research) & Liz Scharnetzki, PhD (MaineHealth Institute for Research)

Assessing the Effectiveness of Boot Camp Translation for Lung Cancer Screening Awareness: A Process Evaluation – *Olivia Weeks (MaineHealth Institute for Research) & Liz Scharnetzki, PhD (MaineHealth Institute for Research)

Responding to Public Health Requests for More Training in Maternal Mental Health: A Collaboration between the RMOMS Network, Public Health Nursing, and Maine Families Home Visitors – *Katherine Crothers, MPH, BSN, RN (MaineHealth Center for Health Improvement) & *Celia Demos, BSN, RN, CLC (Maine CDC)

Socioeconomic and Location-Based Risk Factors Associated with Financial Sacrifices Among Cancer Patients – Lina Gomez, BS candidate (Universidad de los Andes) & *Jessica DiBiase, MPH (MaineHealth Institute for Research)

A Preliminary Investigation into the Assessment, Prevalence, Pattern, and Predictors of Psychosocial Distress in Gynecological Cancer Patients treated at MaineHealth – Ethan Furr (MaineHealth Institute for Research), *Liz Scharnetzki, PhD (MaineHealth Institute for Research) & Kevin Stein, PhD, FAPOS (MaineHealth Institute for Research)

Distribution of Harm Reduction Access in Rural Maine Areas (DHARMA): Drug Checking Activities for Identifying Substances in Community Drug Supply – *Francesca Piccolo, MS, MPH (MaineHealth Institute for Research) & Chasity Tuell (DHARMA)

Helping People Overcome Barriers to Seeking Community Resources: The Patient Assistance Line Approach – *Ryan Bouchard, MEd (MaineHealth)

Implementing and Evaluating Electronic Consultations – *Brianna Holston, BSPH (University of Southern Maine) & Andrew Solomon, MPH (MCD Global Health)

Data Visualization Strategies to Provide Interactive, Accessible, and Equitable Maternal and Child Health Surveillance Data to Partners – *Andrea Lenartz, MPH (University of Southern Maine) & Fleur Hopper, MPH, MSW (University of Southern Maine)

Assessing Nonfatal Intentional Self-Harm Emergency Department and Inpatient Events and Intervention Opportunities Using Maine All Payer Claims Data – *Kimberley Fox, MPA (University of Southern Maine) & *Bridget Noe, MS (University of Southern Maine)

Assessing Dental Home Utilization Among Maine Children: Dental Insurance Does Not Guarantee Access to Care – *Kimberley Fox, MPA (University of Southern Maine) &*Apsara Kumarage (University of Southern Maine)

Linking Vital Records to Reportable Disease Data to Improve Surveillance of Syphilis Infection During Pregnancy in Maine – *Lexi Wilhelmsen, MPH (CSTE/Maine CDC)

Drive Time Changes to Birthing Hospitals from 2014 to 2022 in Maine – *Lexi Wilhelmsen, MPH (CSTE/Maine CDC)

Using Evaluation to Empower Community Health Work – *Rachel Gallo, MPH (University of Southern Maine) & Hayley Prevatt, MPH (City of Portland Public Health Division)

**The 3i HoME Model: A Paradigm Shift -- Independent Housing Options for Maine People with Disabilities and Complex Needs – ***Paul Linet, JD (3iHoME)

Breakout Session #1 1:45pm-2:45pm

Foyer
Posters available for viewing

Massachusetts Room
Shining a Light on Prevention, Harm Reduction, Treatment and Recovery in Lincoln County
*Larissa Rhea, MPH (Healthy Lincoln County) & *William Matteson, PPS (Healthy Lincoln County)

In late 2022, Healthy Lincoln County (HLC) was posed with an idea, how can Lincoln County better connect those who work with, live with, and are affected by Substance Use Disorder (SUD)? The larger community of area experts had such a great network to lean on, but how could Lincoln County better uplift community members that had been touched by substance use? How could very real stories within our community shine light onto the important work happening in prevention, harm reduction, treatment, and recovery?

From this idea, the innovative project “716 Candles” was born. 716 Candles signify lives lost to opioid overdose in 2022. Rather than taking one day in August (International Overdose Awareness Day) to acknowledge the somber truth of how substance use impacts Maine and the Lincoln County community, the HLC team and partners tasked itself with hosting five different community opportunities across the county, each intentionally different than the rest, to commemorate the multi-faceted topic of substance use. Our community taskforce identified five main towns to host projects: each varied in content; strengthened by ideas from community members; and incorporating access to local resources, integration with the arts, and a commemorative candle lighting service.

As a direct result of this project, a series of photographs continues to live within the community, highlighting stories of loss, recovery and hope. 716 Candles laid the foundation for the Lincoln County community to better

access local services, provided space for grieving families to heal, informed community members about the local impact of SUD, and shone a light for those affected by substance use for years to come.

Learning Objectives

1. Discuss the integration of prevention partnerships in harm reduction, treatment and recovery services to move the needle in discrimination against those who use substances and seek help.
2. Demonstrate need for new approaches to honest conversations in rural communities on the importance of remembrance and acknowledgement of those lost to Substance Use Disorder.
3. Explain coordinated multi-sector approach as a strategy to successfully engage community leaders in collaborative goals related to substance use.

Empowering Recovery through Community Partnerships and Best Practice Patient Centered Care

*Tina Pettingill, MPH (Groups Recover Together), *Melissa Caminiti, RN, MPH (Groups Recover Together) & *Melissa Dunham, LCSW, CCS (Groups Recover Together)

Groups Recover Together is a national provider of rapid access opioid use disorder (OUD) treatment. Our telemedicine-enabled, hybrid care model ensures that no matter where someone lives, they are able to access high-quality addiction treatment, social and health care services, and a holistic support system for a thriving recovery. Our treatment model is built around three pillars: evidence-based medicine, community powered recovery and whole person care. Through this model that exists within a public health framework, we have been able to far exceed national OUD treatment benchmarks and standards.

In this session, we will explore national treatment benchmarks for OUD such as retention, remission and all-cause mortality rates, delving into the origins of these benchmarks, who captures this data and the lack of opportunity and transparency that exists for sharing data for the greater good. Presenting Group's state and national data, we will facilitate dialogue about whether innovation in treatment models, enhancements in telehealth and evolution of harm reduction practices indicate if we can or should push for tougher national industry standards.

Recent research indicates that approximately 22% of individuals with OUD receive evidence-based treatment with life-saving medications. We believe a key program strength is helping to close the OUD treatment gap in our communities by partnering with local organizations who serve higher-needs populations and welcoming individuals who are new to treatment through our low barrier access to care. Community partnerships make it easier for people who otherwise have limited options to get rapid access to high-quality OUD care. They also reduce staff workload for partner organizations involved in finding care for the communities they serve. We will discuss some of our innovative partnerships with public health departments, jails, prisons and homeless shelters and how these partnerships have bridged the treatment divide.

Learning Objectives

1. Describe national benchmarks for Opioid Use Disorder treatment outcomes and how these data are captured and shared.
2. Describe the complexities and successes of ensuring rapid access treatment opportunities are available for some of our most vulnerable populations and why community partnerships are essential to patient-centered care.
3. Describe the existing gap between people who need treatment and seek it.

New Hampshire Room

How to Swim Upstream: Leveraging Existing Resources to Screen for HRSNs and Address SDOH

*Eisha Khan, ALM (MaineHealth), *Naomi Schucker, MPH (MaineHealth) & Dora Ann Mills, MD, MPH, FAAP (MaineHealth)

This presentation delves into the nexus between healthcare and public health. Embracing a holistic approach that encompasses both healthcare and public health, the MaineHealth Center for Health Improvement utilizes a community-centered approach to screen patients for health-related social needs (HRSNs) while addressing broader social drivers of health (SDOH) through targeted community engagement and closely working with community-based organizations. This transformative strategy relies on private-public partnerships to effectively deliver essential community health services. Utilizing a hub-and-spoke model, collaboration is streamlined across community hospitals and community-based organizations, integrating diverse expertise. Our approach is rooted in community-based care, which addresses social drivers of health at multiple levels, and incorporates evidence-based practices such as community health worker interventions, care coordination and lifestyle and self-management programs to foster lasting health improvement and health equity. With strategic resource alignment and a population focus, the MaineHealth Model (MHM) aims to screen 100% of appropriate patients system-wide for health-related social needs by FY2027. Our goal is to foster trusting partnerships to improve and promote the overall health, environmental and economic well-being of the communities we are privileged to serve. In FY2024, through provider education and community trust-building efforts, MHM has achieved over 70% screening completion rate in the inpatient setting within the first 6 months of implementation. This session will explore how MaineHealth's interprofessional collaboration, data sharing and community engagement can aid in addressing Social Driver of Health and advancing health equity.

Learning Objectives

1. Identify strategies for a two-pronged approach: 1) Strategies to implement screening and interventions to address individuals' unmet Health-related Social Needs (HRSN). 2) Strategies to address the underlying social drivers of health through targeted community engagement and policy initiatives.
2. Demonstrate how to leverage private-public partnerships to share data and build collaboration via trusting relationships.
3. Examine how to leverage data through the integration of data collection and community input to help bridge the gap between clinical practices and community health needs.

Vermont Room

Panel Presentation: Serving our Communities "Boots On the Ground!"

*Jennifer Edwards (City of Auburn), *Catherine Ryder, LCPC, NCC, MS (Spurwink Services), *Detective Joe Philippon (Lewiston Police Department) & *Chief Robert Chase (City of Auburn Fire Department)

We have long known that to truly address the health needs of those who remain unhoused, untreated, unseen, and unheard, we must don our cultural humility and move onto the streets to find them. This panel presentation will provide an overview of a five-year program that has been “boots on the ground” in our Maine communities. It will highlight the formal collaboration between behavioral health, law enforcement, fire and rescue as they seek to serve those who often face early death. A program that seeks to move them forward to hope and recovery while also providing needed support to professional responders.

The population focus is those at risk of overdose, repeat overdose, arrest, and incarceration as well as other harms from living unhoused and exposed. Our goal is to meet people in need where they are as there is much greater potential to bring hope and recovery. Our programs offer anti-crime strategies that address individuals in a compassionate humane manner. The service provides on-scene crisis de-escalation and mental health

resources; connects individuals with evidence-based ongoing treatment options to achieve recovery and improve quality of life; provides officers and EMS with resources to address crisis calls related to substance use and mental health; and builds an infrastructure focused on recovery, treatment engagement, and reduction in criminal system involvement.

This panel will include representation from Spurwink Services, City of Lewiston and City of Auburn as they describe the genesis of the programs, the collaboration that was the recipe for their successful implementation, and the strategies that are addressing the needs of those most at risk for early death, victimization, or incarceration.

Learning Objectives

1. Describe how "boots on the ground" programming saves lives.
2. Design a cross-organizational collaboration with focus on outreach to those most at risk of death or other harms in our communities.
3. Identify key strategies for harm reduction and crisis de-escalation on the streets.

Connecticut Room

Nourishing Communities at the Farmers' Market

*Jimmy DeBiasi (Maine Federation of Farmers' Markets)

Learn how the Maine Federation of Farmers' Markets (MFFM) continues to evolve and adapt to support the farmers' market community and increase fresh healthy food access for all. This presentation will share a few stories of innovation.

First, we'll explore how MFFM's services innovated to the unique needs of volunteer-run farmers' markets so that they can accept SNAP/EBT and offer Maine Harvest Bucks, the nutrition incentive bonus bucks program offered at 45 farmers' markets across Maine. The systems-building work MFFM is engaging in has reduced burdens on farmers, boosted efficient processes, and allowed for markets to expand new programs - like Kids POP Club and Senior Farmshare – with relative ease.

Our second innovation is a new program. With Bumper Crop, MFFM launched a workplace wellness program that connects people & their workplaces to local farmers' markets. Simply put, employees receive gift certificates from their employers that can be redeemed at over 50 markets across the state. In 2024, over $300,000 of these gift certificates are in circulation. Come learn about the evolution of Bumper Crop and how it is meeting workplace wellness goals while supporting local agriculture and communities.

Learning Objectives

1. Identify the unique barriers of Maine's farmers' markets in hosting public health programs and how MFFM's services help address these barriers.
2. Examine the Bumper Crop program and its potential impact in boosting public health goals as a workplace wellness program.

Responding to Local Healthy Food Access Needs: MaineHealth's Hospital-Based Food Pantries

*Rachel Freedman (MaineHealth) & *Gina McKenney, MPH (MaineHealth)

This presentation will highlight key successes, challenges, and learnings from MaineHealth's implementation of three hospital-based food pantries. Utilizing Community Health Needs Assessment findings and building on

efforts to screen all primary care and inpatient patients for food insecurity, MaineHealth opened three hospital-based food pantries at MaineHealth Franklin Hospital, MaineHealth Stephens Hospital and MaineHealth Maine Medical Center Portland. These pantries offer culturally important, healthy foods in a client-centered, trauma-informed environment that aims to ensure a welcoming, dignified, stigma-free experience. Hospital-based food pantries stand apart from community-based food pantries given their focus on distributing healthy foods, particularly fresh produce, and providing wrap-around services for patrons affected by social drivers of health.

Our presentation will describe outcomes and unique innovations from all three locations (including data demonstrating that, based on the amount of food shared, the Portland-based pantry has become the 10th largest pantry in the state, of Good Shepherd Food Bank's 660 pantry affiliates).

We will focus on replicable interventions, such as: addressing social isolation by offering weekly walking groups and free coffee socials to pantry patrons as they do at the Stephens' pantry; and/or staffing the Franklin food pantry with Health Educators and SNAP Ed Coordinators who offer healthy recipes, tips and tricks for shopping on a budget, and who can enroll eligible patients in a chronic disease self-management program that builds cooking skills, chronic disease knowledge, stress management techniques and more. And, at the Portland food pantry, where 85% of patrons are new community members best served in French, Portuguese or Spanish, the pantry employs multilingual Cultural Brokers and Interpreters. The MaineHealth Access to Care team is also on-site to support SNAP and WIC applications, and connections to other social drivers of health resources.

Learning Objectives

1. Describe two innovative strategies employed by MaineHealth's hospital-based food pantries to engage patrons.
2. Explain how MaineHealth's hospital-based food pantries are addressing more than just food insecurity as a social driver of health.

Rhode Island Room

South Portland Youth Transportation Leaders: How Public Health Can Support Youth-Led Advocacy

*Angela Giordano, MPH, PPS (Cumberland County Public Health), *Alexis Guy, MPH, RD (Cumberland County Public Health), Lee Anne Dodge, MS, PS-C (SoPo Unite), *Teta Keza (youth team member), *Divina Gomes (youth team member) & *Madolyn Roy (youth team member)

Mobility for youth and families is a systems challenge that crosscuts the prevention goals of the Healthy Eating Active Living and Substance Use Prevention (SUP) teams at Cumberland County Public Health Department (CCPHD). A network of youth out-of-school time program providers in South Portland was established in 2022, facilitated by CCPHD's SUP Team Lead. They highlighted transportation as a barrier to equitable access to their programs, limiting youth opportunity to community spaces that support physical health, social connectedness, and mental well-being. Across the variety of assets that exist in the city, such as the bike-pedestrian committee, local bus service, and trail networks, there are no mechanisms to include youth voices in local transportation-related decision-making. In collaboration with SoPo Unite, the city's Drug-Free Communities Coalition, we recruited a team of 8 youth leaders from South Portland High School. They designed an engagement process to understand needs and elevate solutions to improve transportation systems for youth. The youth team collected 100+ survey responses and held discussions with students in South Portland. They drew themes from the data and developed recommendations to share at a community meeting they hosted for local decision makers. Seventeen (17) representatives attended, including those from city council, the city's executive office, relevant boards and committees, and community-based organizations. Youth leaders were offered a variety of next steps to move this advocacy forward, such as presenting to the State Climate Council

and regional Transit Task Force, leading bus education for peers, and supporting the development of a youth-focused activity map. This session will highlight key conditions that enabled this youth-led advocacy project, barriers experienced, and outline the participatory research process. The session will feature youth from the leadership team to reflect on their experience. An update on the projects that resulted from the community meeting will also be shared.

Learning Objectives

1. Describe a process for including youth in local-level decision-making processes.
2. Identify and articulate key conditions that facilitated the success of this youth-led community change initiative.

Oxford Room

A Public Health Response to Anti-Abortion Centers

*Cait Vaughan (Grandmothers for Reproductive Rights (GRR!)) & *Elayne Richard (Grandmothers for Reproductive Rights (GRR!))

Anti-abortion centers (AACs), often called crisis pregnancy centers, are organizations that exist to prevent pregnant people from accessing abortions. They do so by spreading disinformation about sexual and reproductive healthcare, vilifying people who have and perform abortions, and deploying emotional manipulation, fake science and religious doctrine. AACs promote abortion stigma and shame while targeting vulnerable pregnant people, especially teens, communities of color and newly arrived immigrants, low-income Mainers, and those lacking insurance. Prior to the 2022 Supreme Court decision in Dobbs v. JWHO, AACs outnumbered legitimate abortion clinics 3:1, and that ratio is only worsening. There are twelve such centers currently operating in Maine, from York to Aroostook County. Collectively, they jeopardize the health of Maine communities, warranting a public health response. Despite the prevalence of AACs and their spurious claims about common sexual and reproductive health (SRH) services, there is a lack of ongoing public initiatives to address the potential public health crises they engender. Grandmothers for Reproductive Rights (GRR!) works through intentional partnership to fill gaps in public health education and awareness efforts via our Reproductive Options Exist (ROE) Campaign. Our talk will focus on the public health threats posed by AACs and highlight a replicable example of a collaborative public health initiative to mitigate harm, increase health system literacy, and direct targeted populations to trusted community-based sexual and reproductive healthcare providers. One model was piloted in collaboration with GRR!, Planned Parenthood of Northern New England, and the city of Portland's Public Health Department; this effort included the creation of a web-based resource with legally vetted language that warns about the harms of CPCs while directing visitors to legitimate SRH providers, a social media campaign, and palm cards for distribution to local organizations led by and focused on young people, immigrants, and low-income women. Additionally, GRR! has launched a newer initiative to collaborate with school nurses statewide for professional development trainings and the creation of educational resources specific to secondary school students.

Citation: Montoya MN, Judge-Golden C & Swartz JJ. 2022. The problems with Crisis Pregnancy Centers: Reviewing the literature and identifying new directions for future research. *Int J Womens Health*, 14:757–763.

Learning Objectives

1. Describe the barriers to comprehensive sexual and reproductive health services presented by AACs and be able to identify ones in operation in Maine.
2. Understand the possibilities of collaborative and innovative education efforts in improving access to SRH services and public health among Mainers who can become pregnant.
3. Identify potential collaborators for a public health collaboration in their local areas.

One Size Does Not Fit All: Cancer Screenings and the LGBTQIA+ Community Experience

*Michelle Munsey, MA (Partnerships For Health) & *Michelle Mitchell, MSocSc (Partnerships For Health)

Individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other (LGBTQIA+) can face unique barriers to being screened for cancer. Literature suggests that this is, in part, because they may face provider discrimination, gender dysphoria, and lack of information about cancer risks and screening guidelines. In Maine, the extent of these barriers is unknown. This information is needed to ensure public health projects are effective in addressing disparities and reducing the cancer burden for all Maine communities. In 2023, a formative, mixed-methods evaluation was undertaken to increase understanding of both the clinical providers' and community members' knowledge, attitudes, and practices around cancer screenings. The clinical survey was based on a national survey of oncologists at the National Cancer Institute. The community survey included similar concepts and questions to enable comparisons between providers and LGBTQIA+ community members. Using a series of traditional and non-traditional data collection techniques, 35 clinical and 206 community surveys were analyzed. Qualitative and quantitative analysis included between- and within-group comparisons. Preliminary results suggest differences in cancer screening knowledge, attitudes, and experiences among LGBTQIA+ community members based on their gender identity and sexual orientation. Results also reflect community and clinical perspectives on LGBTQIA+ barriers to cancer screenings, as well as recommended solutions.

Learning Objectives

1. Describe traditional and non-traditional data collection methods for reaching clinical providers and community members.
2. Describe various clinical and community perspectives around cancer screenings for members of Maine's LGBTQIA+ community.
3. Gain insight into recommendations to reduce barriers and increase cancer screenings for members of the LGBTQIA+ community in Maine.

Somerset Room

Identification of Gaps in Care for Patients with Chronic Pain through the Establishment of a State-wide Pain Registry in Maine - Pain Registry for ME

*Ling Cao, MD, PhD, MPH (University of New England), *Penhleakhena Ou, OMS-II (University of New England), Elizabeth N. Bean (University of New England) & Wendy Y. Craig, PhD (MaineHealth)

Chronic pain is a serious public health problem in Maine. We initiated a pain registry for the adult population across Maine to characterize the population with persistent or recurrent pain, with a special focus on the relationships between social determinants of health (SDOH) and chronic pain suffering and management, therefore, to identify targeted public health interventions to improve pain care in Maine. The registry uses the REDCap data collection platform to administer an anonymous survey, which included questions regarding pain characteristics, pain management, and demographic and SDOH factors. The survey was distributed through both hard- and e-Copies of a flyer. The initial descriptive analysis of the first 109 respondents showed that compared to Maine's census data, the current participant pool is over-represented in biological females, individuals 65 and older, and minority racial/ethnic groups, but under-represented in veterans. The majority of participants had suffered from pain for more than a year and described their pain as moderate to severe. Low back was the most reported pain location, trauma/injury was the most perceived cause, and physical therapy was the most used treatment. Fatigue, sleep disturbance, and reduced ability to participate in social roles and activities were major co-morbidities. High cost in pain treatment was the top challenge to pain care but provider-related challenges were also frequently reported. Higher SDOH risk was significantly associated with

worse pain-related outcomes. Being younger and having lower education degrees were associated with increased anxiety and depression and reduced cognitive function. Within the current participant pool, biological sex, veteran status and race did not significantly affect any pain outcomes. In summary, additional recruitment efforts to reach all socioeconomic groups are warranted and further data analysis could inform research in pain and pain treatment as well as public health strategies for pain prevention in Maine.

Funding: The Northern New England Clinical & Translation Research Network (NNE-CTR) pilot program.

Learning Objectives

1. Explain why chronic pain is a public health problem in Maine.
2. Describe the experience of Mainers who live with chronic pain.
3. Identify SDOH factors that may affect Mainers' pain experience.

Healthy Together: Revolutionizing Chronic Disease Management with Shared Medical Appointments

*Brenna Nelson, RD, LD, CLC (MaineGeneral Medical Center), *Julie Kaupin, CHES, RTY (MaineGeneral Medical Center), Anne Conners, MA, MPH (MaineGeneral Medical Center) & Alyssa Finn, MD (MaineGeneral Medical Center)

Many Americans suffer from multiple chronic conditions yet engaging them in self-management has proved challenging to medical and public health practitioners alike. MaineGeneral Medical Center (MGMC) has developed an innovative, integrative group medical visit model, shared medical appointments (SMAs), that take place in an accessible, low-barrier environment whether that be a brick-and-mortar Teaching Kitchen or through a Mobile Kitchen set up in a primary care practice. Following a proactive outreach process, patients learn from medical staff (a physician, physician's assistant or nurse practitioner) as well as a Community Registered Dietitian and/or a Culinary Health Educator about hands on-techniques to cook healthy food at home as well as guidance on new recipes and recipe modification. Adopting changes in cooking and eating have demonstrated improved clinical outcomes such as weight loss, improved blood sugar control, lowered LDL, and decrease in A1c, along with many other benefits. Participants also learn about mindfulness and physical activity in a community-building approach to improving their health outcomes. By offering sessions over time (4-6 weeks), participants also receive social support from one another, which results in longer-term behavior change. The SMA model also offers medical staff a satisfying way to interact with patients and reduce burnout. Staff from the Peter Alfond Prevention and Healthy Living Center at the MGMC have developed a curriculum to guide the intervention with learning objectives, recipes, and key activities for SMA participants. Guidance is provided around reimbursement for SMAs as well as patient recruitment and retention.

Learning Objectives

1. Name 3 reasons group visits are valuable to the health system.
2. Identify two ways to engage patients in nutrition education and lifestyle modification.
3. Identify strategies for patient engagement and recruitment for shared medical appointments.

York Room

Relationship Between Childhood Trauma, Adverse Childhood Experiences, and Self-Management of Type 1 and Type 2 Diabetes

*Deserie O'Toole, PhD

In 2022, the cost of diabetes in the U.S. exceeded $400 billion, and each year, individuals pay thousands of dollars to manage their disease, even with insurance. Given these expenditures, efforts to understand

predictors of better self-management are needed. Contemporary trauma theory suggests that early childhood trauma increases the risk of negative health-related consequences in adulthood. The purpose of this quantitative, nonexperimental study was to examine whether diabetes type (Type 1 and Type 2), childhood trauma, and adverse childhood experiences predict diabetes self-management (glucose management, dietary control, physical activity, health care use, total self-management). Data were collected from patients diagnosed with Type 1 and Type 2 diabetes (N=233), recruited from an anonymous online survey done through Survey Monkey. Respondents completed three assessments: Childhood Trauma Questionnaire, Adverse Childhood Experience Questionnaire and the Diabetes Self-Management Questionnaire. Standard multiple regression analyses showed that (a) higher levels of physical neglect and emotional abuse predicted poorer overall self-management, (b) higher levels of physical neglect predicted poorer glucose management, (c) diabetes type predicted health care use with Type 2 diabetics using healthcare more frequently than Type 1, (d) higher levels of physical neglect predicted lower levels of healthcare use, and (e) higher levels of emotional abuse predicted lower levels of physical activity. These results may be used for positive social change by informing health care providers about factors that impact diabetes self-management and underscore the need for a trauma-informed approach to patient care. Health care practitioners and organizations may use the results to design educational programs or counseling interventions with diabetes patients to improve diabetes self-management behavior.

Learning Objectives:

1. Describe the tenets of Contemporary Trauma Theory.
2. Explain why childhood trauma increases the risk of poorer diabetes self-management.
3. Explain healthcare utilization and cost associated with diabetes diagnosis.

Planting New Seeds: How Help Me Grow Maine Supports Children and Their Families Using Data to Advocate for Innovative Solutions

*Kelly Finck Waters, MPH, MSEd (University of Southern Maine), *Melinda Corey, MEd (State of Maine Office of Child and Family Services) Katherine Russum, LSW (State of Maine Office of Child and Family Services), Jessica Wood, LSW (State of Maine Office of Child and Family Services) & Fleur Hopper, MPH, MSW (University of Southern Maine)

The Department of Health and Human Services' Office of Child and Family Services launched Help Me Grow Maine in November 2022. The Help Me Grow (HMG) model serves as a conduit for cross-system collaboration to promote early childhood well-being, strengthen resilience in families, and promote equity and protective factors. In Maine, this free service aims to help families of children from birth to eight, as well as pregnant caregivers, navigate the systems and resources they may need to access to support their child's development and other family needs. Throughout the State of Maine, there is an existing grid of resources that works to keep children healthy and helps them develop to their full potential. HMG Maine's central access point provides families a pathway for linkage to information, resources, and connections to the existing services. Other key components of HMG Maine include conducting outreach, collaborating with health providers, and collecting and analyzing data. In its first 18 months of operation, HMG Maine tracked several key indicators to better understand the characteristics and needs of the families it serves. Nearly 50% of families served who have children less than one year old report needing help accessing basic needs like diapers and car seats. Approximately 1 in 4 families served by HMG speak a language other than English at home. Of the calls to HMG Maine about behavioral/mental health concerns, over 40% of families report experiencing waitlists for related services. To address these needs, HMG Maine is pairing developmental screening events with the distribution of basic needs, implementing communication tools to connect with caregivers in their home language, and successfully advocated for a remote caregiver training pilot program for families experiencing waitlists for behavioral health services.

Learning Objectives

1. Describe the Help Me Grow model of developmental screening and referral and linkage to community resources.
2. Explain how Help Me Grow is using its data to determine priorities and advocate with partners.

Cumberland Room

Public Health's Vital Role in Creating a Culture of Healthy Aging in Maine Communities

*Valerie Jackson (Maine Council on Aging) & *Renee Page, MPH, CLC, PS-C (Healthy Communities of the Capital Area)

In Maine, people over age 65 outnumber people under age 18, and there is growing awareness that older people are an increasingly important part of Maine's future. This creates an imperative to ensure older people remain healthy, connected, and engaged in all aspects of life – employment, community, and quality appropriate care when needed. Unfortunately, ageism creates a formidable barrier to seeing older people as a part of Maine's future and as such, we don't invest and prioritize healthy aging in later life the way we do in younger life. Remarkably, the same things older people need are often the same things younger people need – flexible employment, connection to community, a sense of belonging and mattering, supports and care appropriate for their age, etc. The work, then, is to overcome ageism, chart a pathway to good health in later life, and begin to systematically improve the significant deficiencies in care and support for older people we've allowed to grow unimpeded. This session introduces the Maine Council on Aging's groundbreaking "Reducing Ageism Barriers to Healthcare" project, funded by the Maine Health Access Foundation, and highlights how combining age-positive practices with proven public health strategies can help prevent chronic diseases and promote healthy aging. Attendees will learn how to see, name, and disrupt ageism and learn creative approaches to identifying and addressing gaps in preventive care, meeting older adults' unique needs, and fostering inclusive environments for engaged, healthy, and supportive aging. Presenters will share actionable strategies, best practices, and real-world case studies demonstrating age-positive healthcare initiatives' transformative impact. Join us to explore cutting-edge solutions to one of our most pressing demographic challenges. Learn how healthcare professionals, policymakers, and community leaders can champion age-positive change, ensuring a brighter, healthier future for all of us that live, work and age together in our great state of Maine.

Learning Objectives

1. Describe the impacts of ageism on healthcare.
2. Describe how to see, name and disrupt ageism.
3. Describe age-positive, public health community-based prevention activities and engagement strategies.

Kennebec Room

Project Lifeline: Community Collaboration Reconnecting Perinatal People to Care

*Alane O'Connor, DNP (MaineHealth/MaineMOM) & *Brandon Farley (Portland Fire Department)

Substance use related deaths, including drug overdoses, account for a substantial proportion of pregnancy-associated mortality in the US. Among pregnant and postpartum women, drug overdose mortality increased approximately 81% from 2017 to 2020. Substance use disorder (SUD) is associated with a variety of medical complications that can lead to early delivery, stillbirth and extended hospitalizations. Maine has one of the highest rates of substance exposed pregnancies in the US and, in response, Maine DHHS developed the MaineMOM model which provides integrated SUD treatment and perinatal care. Maine Medical Center (MMC) has the largest MaineMOM program and serves high-risk patients including those who are

unsheltered/unhoused and have complex mental health and polysubstance use disorders. Using MaineMOM funding, Project Lifeline was launched in late 2023. This partnership is between MMC MaineMOM and Portland Fire's mobile medical outreach (MMO) team where paramedics provide medical outreach to MaineMOM patients in shelters and on the street. An addiction medicine specialist joins the team several times per month. Evidence suggests that community paramedicine programs are effective in improving health outcomes, reducing the use of emergency services and lowering health care costs. Project Lifeline provides expanded access to care, breaks down barriers and builds trust with vulnerable/marginalized individuals, and delivers wrap-around, patient-centered care "where they are" It also provides enhanced SUD and obstetrical education to paramedics and other emergency medical professionals. Project Lifeline is evidence-based and modeled after Project Swaddle, a community paramedicine program that serves perinatal patients in Indiana. In the past year, we have engaged unsheltered/unhoused pregnant women in perinatal and SUD treatment services as well as re-enroll postpartum MaineMOM patients who had been lost to follow up. We would like to share our learnings and experiences from this pilot, with others interested in paramedicine collaborations around the State and region.

Learning Objectives

1. Describe an innovative strategy for conducting mobile medical outreach to high-risk populations.
2. Describe strategies to reduce barriers to care and build trust with vulnerable populations.
3. Reflect on opportunities to replicate this model in other parts of the state.

Lincoln Room

Turning an Unequitable System on its Head: Using a Networked Approach to Build an Oral Health System that Works for All

*Kalie Hess, MPH (Children's Oral Health Network) & *Becca Matusovich, MPPM (Children's Oral Health Network)

Oral health is something many people who have always been connected to a dental home take for granted. Dental disease is the most common chronic disease of childhood; however, only 1/3 of kids in Maine who have dental insurance are getting at least one exam and one cleaning per year, and adults with MaineCare face even more challenges. There is no capacity in the system to serve more people; in fact, our dental system was never actually designed to meet everyone's needs, prioritizing instead people with privilege. The Children's Oral Health Network is using a networked approach to work on shared priorities with partners statewide to design a new system, flipping the current oral health system on its head and building foundational principles of equity into the design of a new system that can better serve everyone and meet people where they are with the right care, at the right place, at the right time. The Network is using current science, systems-change frameworks, and engagement of local partners to design solutions to bring innovative and evidence-based oral health services right into communities instead of requiring every person in Maine to play musical chairs for the few slots in dental offices using the traditional model of care delivery. Over the past seven years, this approach has resulted in significant advancements in our shared understanding of what is needed to ensure all children grow up free from preventable dental disease, grown impressive partnerships, spurred alignment of services across provider organizations, resulted in policy gains, and has begun to change mental models around what it means to get quality oral health care. This model for addressing wicked public health problems delivers results, and can be applied to other systemic challenges.

Learning Objectives

1. Demonstrate a basic understanding of the types of work needed to create lasting systems changes to improve a pervasive public health problem.

2. Differentiate between the traditional dental delivery model and a community-engaged care delivery system and its potential to revolutionize quality oral health care access in Maine.
3. Describe the advancements in oral health care that allow for more high-quality and appropriate care to be delivered in community settings by a wider array of professionals.

Breakout Session #2: 3:05pm-4:05pm

Massachusetts Room

Bringing Food Home in Lincoln County

*Larissa Rhea, MPH (Healthy Lincoln County)

Healthy Lincoln County (HLC) has long supported food security initiatives in Lincoln County. HLC serves the Lincoln County community by providing Supplemental Nutrition Assistance Program (SNAP) Education services, serves as the county-wide sponsor for the Summer Food Service Program "Summer Meals", as well as housing the Lincoln County Gleaners. Most recently, HLC was awarded two USDA programmatic grants to address access to supplemental services such as SNAP, as well as identifying ways in which gleaned produce and produce education can be made more widely available to youth in the area. Rather than silo this incredibly important work, HLC opted to pilot combining each of these services through use of the beloved Summer Meals van, Lulu the Lunch Wagon. In 2023 HLC introduced weekly gleaned produce for Lulu to deliver along her mobile route during the summer months. Each week the van was outfitted with programmatic services that neighboring organizations could offer to families and a large tote of locally procured veggies, harvested by the Lincoln County Gleaners. Families responded to the pilot incredibly well, distributing about 500 pounds of vegetables in just two months. Due to HLC's funding through the USDA, Lulu's adventures will further expand in 2024. HLC's mobile unit will formalize share tables at each stop along the summer route, host HLC's SNAP Educator to lead taste tests with procured produce and offer information on farms within the county that accept SNAP benefits and/ or offer Maine Harvest Bucks and Farm Fresh Rewards. Streamlining food security initiatives already housed at HLC only strengthens each program by working with families regularly to ensure that they know not only how to access their available benefits, but to also gain a familiar face within the community who is willing to help get them to the right resources at the right time.

Learning Objectives

1. Discuss the importance of integration with food security initiatives as a way to engage families with available services.
2. Explain coordinated approach to address the need of food security services within Lincoln County.
3. Demonstrate need for innovative strategies aimed to meet families where they are at with food security programming and services in an effort to reduce stigma.

Leveraging Farm-to-Institution as Public Health Strategy

*Alida Farrell, MS (Healthy Communities of the Capital Area)

Farm-to-institution initiatives in Maine enhance public health by connecting food-serving institutions like schools, hospitals, and correctional and long-term care facilities with Maine's vibrant local food scene. Sourcing fresh, local products promotes healthier diets among vulnerable populations including children, patients, incarcerated individuals, and older adults, while also supporting local producers and bolstering Maine's agricultural economy. This approach fosters a sustainable and resilient local food system and ensures nutritious, high-quality food reaches those who need it most, contributing to overall community wellness. Maine Farm & Sea to Institution (MEFTI) at Healthy Communities of the Capital Area seeks to build a healthy, sustainable regional food system by leveraging the power of institutional food procurement. One initiative is

the Maine Farm & Sea to School Institute, a yearlong program that empowers school communities to increase healthy food access, create a culture of equity and wellness, and strengthen their local food systems. The Institute promotes local food procurement and supports education about the benefits of fresh, nutritious foods, cultivating lifelong habits of healthy eating and appreciation of Maine's agricultural and sea-based bounty. Through workshops, networking opportunities, and resource sharing, the institute fosters a robust connection between Maine's educational institutions and its vibrant agricultural community. The Maine Marinara Collaborative, another MEFTI project, aims to make fresh, local ingredients readily available in institutional settings, fostering healthier dietary options for diverse populations. By collaborating with farmers, processors, distributors, and institutional buyers, the collaborative sources local ingredients, processing them into a sauce for distribution to institutional kitchens across Maine. MEFTI navigates Maine's public health challenges with collaborative innovation and sustainable food systems leadership, demonstrating how farm-to-institution strategies can catalyze healthier communities through partnerships and grassroots advocacy. MEFTI offers five distinct workgroups that promote farm-to-institution initiatives through a range of approaches, from policy advocacy to technical support, providing numerous opportunities for engagement.

Learning Objectives

1. Evaluate the effectiveness of farm-to-institution strategies in Maine in improving dietary habits and health outcomes among vulnerable populations, such as children, patients, incarcerated individuals, and older adults, based on quantitative data and case studies.
2. Identify barriers and challenges faced by institutions and local producers in adopting farm-to-institution practices in Maine and propose evidence-based strategies to overcome these challenges, leveraging insights from MEFTI's workgroups.

New Hampshire Room

Improving Family-Provider Communication and Understanding About Developmental Screenings

*Sarah Lewis, MBA (Maine Access Immigrant Network), *Simane Ibrahim (Maine Access Immigrant Network), Cristina Nzumba (Maine Access Immigrant Network), Emilie Swenson (Data Innovation Project), Angela Mowatt (MaineHealth) & Christine Stam (MaineHealth)

Since 2019, MaineHealth, Maine Access Immigrant Network (MAIN), and the Data Innovation Project have been working together to better understand and improve the developmental screening experiences of immigrant, refugee, and asylum-seeking families and their young children. Our goals are that all children (and their caregivers) experience culturally appropriate and relevant developmental screenings; parents (caregivers) are more aware of the meaning and purpose of these screenings; and that staff and medical providers increase understanding of caregiver and parent experience of screenings. Through a process funded by the Maine Health Access Foundation that has involved parent, Community Health Worker, and provider feedback, the team has designed and implemented a pilot to serve these goals in Portland. Community Health Workers (CHWs) from MAIN connect with families before and after their baby's 9-month well child visit to share more about their upcoming developmental screening and visit and follow up to learn more about their experience. As parents have shared, these calls have supported their understanding of what a screening is and feel better prepared for their visit. Additionally, because the developmental screening has been translated and the CHW is able to communicate with the parent in their preferred language, parents experience greater ease in communication and comfort in the experience. The CHW is able to directly communicate relevant information to the parent in a more time efficient manner. This presentation will then explore ideas for continued improvement for well child visits and communication with caregivers and parents. As Maine's population becomes increasingly diverse, this approach provides new insight on how to improve health messaging and communication cross-culturally in primary care and community health settings.

Learning Objectives

1. Identify benefits of organizational partnerships and peer-to-peer communication to promote positive messaging around vaccinations.
2. Describe what can help caregivers to feel more prepared for their child's well child visit.
3. Reflect on their understanding and experiences of early childhood development and consider how this information may inform their work.

Vermont Room

Community Health Worker Panel: Innovative Strategies to Enhance Public Health and Reduce Disparities

Moderator: Benjamin Hummel, BA (Maine CDC, MCD Global Health)
Panelists: Karen Garland-Kidder, RN (MaineHealth), Alison Prior, Michelle Mitchell, MSocSc (Partnerships For Health) & Caitlyn Allen, MS (Partnerships For Health)

As a bridge between healthcare institutions and communities, Community Health Workers (CHWs) are a crucial part of the public health workforce. This panel presentation will use examples of CHW programs in Maine to highlight the vital role they plan in addressing social drivers of health and increasing trust and access to culturally competent services. They will discuss the impact of CHW's contributions to the healthcare system across diverse organizational contexts and share perspectives on the future of CHWs in Maine.

Learning Objectives

1. Understand the importance of CHW's role to address community health needs and enhance the public health field.
2. Describe the effectiveness of CHW-led interventions in promoting health equity and reducing healthcare disparities within underserved communities.
3. Compare and contrast CHW integration strategies across different organizational contexts and identify best practices.

Connecticut Room

The Power of Care: A Joint Campaign to Promote Voluntary Vaccinations in Long-Term Care

*Angela Cole Westhoff, MA (Maine Health Care Association), Brenda Gallant, RN (Maine Long Term Care Ombudsman Program) & Maureen Carland, RN-BSN, LNHA (Maine Health Care Association)

Join us for an informative conference session as we delve into our successful partnership with the state's long-term care ombudsman in a joint venture that has reshaped immunization efforts. The "Portraits of Power: Immunization Campaign," initiated in the fall of 2021, has been pivotal in enhancing vaccination rates among direct care staff in long-term care facilities in Maine. The primary objective of this campaign has been to elevate vaccination rates by focusing on education and outreach targeted at direct care staff. We will share our strategies for effectively communicating the numerous benefits of vaccination against communicable diseases, including the flu and COVID-19. Additionally, we will discuss how we've worked to normalize COVID-19 vaccination as a standard practice, championing the slogan, "If not for you, for them." Building upon this success, we have expanded our efforts, creating "The Power of Care" program. This program is specifically designed to enhance voluntary immunization rates for influenza and COVID-19 among residents, their families, and the dedicated staff who care for them within long-term care facilities. Through "The Power of Care," we are fostering unity between caregivers, residents, and their family members, recognizing the profound influence they have on vaccination decisions. Join us to learn about the strategies, tools, and collaborative approaches that have made "The Power of Care" a transformative force in promoting immunization in long-

term care settings. Together, we can ensure the safety and well-being of our community by staying up to date with voluntary immunizations.

Learning Objectives

1. Describe how to employ social media and marketing techniques to improve vaccination rates of older adults and long-term care employees.
2. Identify key barriers and strategies to overcome to address vaccine hesitancy among long-term care residents, their family members, and caregivers.

A Population Modeling Approach to Characterizing the Health of Older Citizens of Maine

*Kevin Konty, PhD (Apriqot), Xinyan Liu (Apriqot) & Nicole Hewes (Apriqot)

In Maine, generating accurate community-level health estimates poses significant challenges. We present further developments of a population modeling approach to producing such estimates that was first presented at the 2023 MPHA meeting. Our methodology synthesizes diverse data sources “including health surveys, censuses, administrative records, disease registries, vital statistics, and electronic medical records” to construct detailed demographic models. These models provide both a framework for estimating health outcomes and behaviors using unit-level small area estimates as well as highly detailed denominators. The system facilitates the production of health estimates for regions of any shape while incorporating uncertainty and safeguarding against disclosure risks. We present findings from collaborative efforts to characterize the health of older citizens of Maine, with a focus on Alzheimer’s Disease and Related Dementias (ADRD). Surveillance of ADRD is the focus of the CDC’s BOLD Programs across New England states. Our approach provides three benefits to public health officials in Maine. First, detailed population models provide a mechanism to extend methods currently used to produce ADRD estimates at state and county levels to finer geographic scales. Second, our method provides a framework for producing community-level estimates of dementia-related outcomes and behaviors, including social determinants of health and chronic conditions. Such estimates could enrich understanding of the health of older Maine citizens. Third, the population model provides denominators for constructing observed rates when using data from registries or claims databases, allowing for disaggregated estimates of population rates and proportions. Our modeling framework demonstrates its utility to inform public health efforts in Maine and New England. It provides a novel mechanism to coherently bring together information from multiple data sources to address a variety of needs across multiple stakeholders. The resulting estimates aid the strategic allocation of resources and enhance the capacity for effective public health intervention and monitoring at increasingly granular levels.

Learning Objectives

1. Describe how a cutting-edge population modeling technique can combine demographic, health, and geographic data to produce community-level estimates for health outcomes and behaviors.
2. Explore an application of the estimation methods to the surveillance and detection of Alzheimer's Disease and related dementias in Maine.
3. Explore and discuss additional use cases for this novel modeling framework.

Rhode Island Room

MaineHealth: Innovative Fall Prevention Initiatives for Older Adults

*Jessica J. Bolduc, DrOT, MSOTR/L, FAOTA (MaineHealth), *Tamara H. Herrick, PhD (MaineHealth), Kirsten Dorsey, OTR/L (MaineHealth) & *Maureen Higgins, MSW (MaineHealth)

Falls are a significant concern for adults over age 65. One in four older adults has a fall resulting in ~14 million falls and ~39,000 fall related deaths nationally (78 per 100,000) (CDC MMRW, 2023). Maine, in 2020, recorded over 80,000 falls and in 2021 there were 325 deaths (or 128 per 100,000) (CDC Data Surveillance, 2024; CDC Falls Data Research, 2024). The U.S. healthcare system spends over $50 Billion yearly on older adult fall related care and in 2022 Maine had a total medical cost of $14.5 million (CDC Cost of Falls, 2024; WISQARS Cost Of Injury (cdc.gov)). Maine is ranked as one of the highest with older adult falls and fall related deaths (CDC MMRW, 2023). Recognizing the severity of this issue, MaineHealth has implemented innovative strategies and technologies to prevent falls and improve care. MaineHealth's multifaceted approach to fall prevention encompasses education, technology, and community engagement. These initiatives address diverse factors contributing to falls and provide care team members and patients with tools and resources within the clinical and community space. Integrating the Age-Friendly 4M approach with the CDC's STEADI initiative, MaineHealth is improving fall prevention screening, embedding fall risk assessment, and highlighting evidence-based interventions within the EMR. Secondary benefits anticipated include increased patient and care team engagement to reduce falls, fall risk, and healthcare costs. A newly developed internal virtual A Matter of Balance: Managing Concerns about Falls (MOB) program helps increase access to an evidence-based program. MaineHealth fosters a strong sense of community for older adults through its programs and collaboration with community partners and is working with all our local health systems to help increase in-person offerings of MOB. MaineHealth is uniquely positioned to address fall prevention through a public health lens, ensuring that the older adult community emerges as the healthiest in America.

Learning Objectives

1. Recognize the innovative integration of the Age-Friendly 4M approach and the CDC's STEADI initiative to enhance the quality of fall prevention screening and interventions for the older adult.
2. Identify the enhanced access to evidence-based programs for fall prevention within MaineHealth and in collaboration with local communities.

Oxford Room

Bridging the Gap: Partnering with a Cultural Broker to Successfully Reach BIPOC Communities in Maine

*Patrick Madden (Market Decisions Research) & *Deqa Dhalac, MSW, MDP (Cross Cultural Community Services)

Public health research is often focused on obtaining information and data from traditionally underrepresented populations in which traditional recruitment methods are not always adequate. In 2023, the Maine Center for Disease Control and Prevention (CDC) and Market Decisions Research (MDR) collaborated on a perinatal needs assessment to help address some of these gaps in data and information within the state. A focus of the project was obtaining key input from Black, Indigenous, and People of Color (BIPOC) regarding their experience with perinatal care across Maine. The traditional recruitment methods deployed by MDR such as address-based mailings, telephone calls, and online/social media recruitment were not appropriate to recruit BIPOC mothers in Maine who often spoke a language other than English. After failed attempts at engaging with this community, we partnered with a cultural broker, Cross Cultural Community Services (CCCS) to recruit and co-moderate focus groups. Our BIPOC perinatal discussions included 55 participants across four focus groups and nine in-depth interviews. During our work on this project, we identified some crucial steps to effectively

involve a cultural broker in community research and evaluation. These steps include early engagement, autonomy over recruiting, input on data collection tools and collection, and sharing results. Partnering with CCCS was essential in engaging BIPOC mothers in this project and allowing the unique experiences of this population to be collected and shared with the Maine CDC.

Learning Objectives

1. Explain why BIPOC communities are often underrepresented in public health data.
2. Identify the gaps in perinatal data that exist within the state, particularly among BIPOC communities.
3. Describe the steps to successfully work with a cultural broker to engage BIPOC communities in Maine.

Improving Health Outcomes with Just in Time Case Management

*Caroline Lindemann (MaineHealth)

Access to Care's New Mainer Initiative (NMI), beginning in the Outpatient Clinics at Maine Medical Center, is a Just-in-Time case management program. The program began because providers within the clinics saw significant increases in the complexity of needs, especially Social Drivers of Health (SDOH), facing their newest patients. Maine has seen five years of increases in newly arrived immigrants, in 2022 this number has ballooned to more than 6,000 people, over 8% of the population of Portland. This number is 6% greater than the rate of NYC and 2% greater than that of Boston. The NMI case management program is tailored to provide immediate support and connect individuals within the immigrant community to essential services and community-based organizations addressing these needs without requiring formal onboarding processes typical of case management models.

Key components of the program:

1. Response: Meeting with patients during their medical appointments lowers barriers and ensures they receive support quickly.
2. Assessment and Referral: Case managers assess SDOH needs, such as transportation, healthcare access, employment, housing, and legal services. Consumers are referred to appropriate community-based organizations after providing culturally sensitive and trauma informed explanations of the support.
3. Adaptability: Honoring the diverse backgrounds and situations of immigrants, the program maintains flexibility to address shifting needs.
4. Support: Social and Cultural education, monitoring of progress and follow-up ensure clients are making connections and achieving their goals.

This approach addresses immediate needs and empowers clients by fostering resilience and self-sufficiency with complex systems. Leveraging community resources and support networks, the program enhances the overall well-being and integration of immigrants into the local community. Since beginning in October 2022, the program has connected 1,500 people with SDOH support, coordinated over 900 rides for medical appointments, and has expanded from supporting 1 clinic to 3 with more being added.

Learning Objectives

1. Demonstrate ways in which case management can be quicker and more responsive to the individual needs of consumers, removing barriers and streamlining access to SDOH supports.
2. Discuss the potential of expansion across demographics, systems, and organizations.
3. Identify patient stories of success with accessing medical and social supports, assisting them in building safe and healthy lives.

Somerset Room

Visualizing Food Insecurity in Maine

*Kendall Penndorf, MPH (Good Shepherd Food Bank) & *Jada Wensman, MS (Good Shepherd Food Bank)

Good Shepherd Food Bank's bold vision is that by 2030, everyone in Maine will have reliable access to the food they need to live a full and healthy life. Recent estimates from Feeding America's Map the Meal Gap study paint a startling picture of hunger in Maine, showing that 1 in 7 Mainers, including 1 in 5 children, are food insecure. This data, while a valuable tool, is already two years outdated by the time it reaches the food bank, policymakers, and advocates and lacks information on the impacts of hunger minority communities in our state. To supplement national datasets, the Food Bank began enrolling partner food pantries in a new data collection software, Service Insights on MealConnect (SIMC) in 2023. A product of Feeding America, a nationwide network of food banks, food pantries and local meal programs, SIMC collects demographic information, SNAP program enrollment, and visit frequency data on households that access the charitable food network. SIMC's powerful integrated data visualization dashboard allows pantries to access real-time data about the communities they serve. This has proven to significantly impact programmatic decision-making at the pantry level and cumulatively. This dataset will provide the most extensive contemporary view of hunger and its impact on the state. Since 2023, nearly 15,000 unique households have logged 81,000 pantry visits at 30 pantries across the state. Data from SIMC will provide the Food Bank, partners, and public health advocates with a timely understanding of trends in food insecurity and emergency food system use. This presentation will introduce Service Insights on MealConnect to Maine's public health community and discuss the food bank's plans to expand its reach in the coming years. It will also examine what the data tells us so far across the state and regionally and discuss opportunities for future collaborations.

Learning Objectives

1. Describe the importance of timely data collection and reporting in food insecurity research.
2. Analyze high-level pantry data.
3. Describe next steps for collaboration.

Innovative Nutrition Care Solutions for High-Risk Pregnancies

*Emily Sylvester, MS, RD, LDN, IBCLC (Mother of Fact (NurtureTalk, Inc.))

Background: Minority populations with low incomes, low health literacy, and obesity face increased rates of gestational diabetes mellitus (GDM), leading to elevated risks of adverse maternal outcomes. GDM, affecting 10% to 20% of US pregnancies, surged by 13% in 2021, disproportionately impacting lower-income groups. Individualized medical nutrition therapy (MNT) effectively reduces GDM risk, yet pregnant individuals on Medicaid encounter challenges in timely Registered Dietitian (RDN) referrals, particularly in maternal care deserts.

Project Description: Mother of Fact is the first on-demand nutrition care ecosystem for at-risk moms and babies from pregnancy through the first year. Our HIPAA-secure mobile platform offers clinical support via SMS, RDN telehealth consultations, and nutrition monitoring. Funded by MaineHealth RMOMS, we partnered with Northern Light Health Eastern Maine Medical Center to provide on-demand nutrition support for at-risk pregnancies.

Public Health Implications: Providing timely, accessible, and culturally competent nutrition care to vulnerable populations can reduce GDM incidence and related complications, improving health equity and access for underserved communities. However, more innovation is needed to establish sustainable methods.

Results: From January 1st, 2024, to June 21st, 2024:
- 132 patient referrals, with 42% active on the app.
- 30% of patients on government assistance; 17% were Black, African American, Native American Indian, or mixed race.
- Average time from referral to booking an initial session was 1.4 days, with 10.75 days to the first session.
- Top referral reasons: obesity, advanced maternal age, family history of diabetes.
- 122 nutrition telehealth sessions completed, 1,818 chat messages shared.
- Estimated reimbursement opportunity for the hospital system exceeded $10,000.
- Patient activity: 1,148 goals completed, 450 journal entries.

Conclusions: This program shows promise in addressing nutrition care gaps for at-risk pregnant individuals. Platform engagement rates and patient activity highlight its potential to improve maternal and child health outcomes, advancing health equity and access.

Learning Objectives

1. Identify and explain at least three ways in which low income, low health literacy, and obesity contribute to higher rates of GDM among minority populations, with a focus on the rural Maine ecosystem.
2. Identify three strengths and three weaknesses in the impact analysis of a digital health program for high-risk pregnancies in Maine.
3. Develop and propose at least two new public health strategies or interventions inspired by enhancing access to nutrition care for underserved communities.

York Room

De-Cloaking the Disability Experience: Building Data and Health Equity for Mainers with Disabilities

*Michelle Fong, MPH (University of Maine) & *Jennifer Battis, MRes (Disability Rights Maine)

Disability status is not yet a standard demographic question, resulting in a lack of adequate data and the underrepresentation of people with disabilities in state public health statistics. This creates a knowledge gap for policymakers regarding the lived experience of this population and prevents monitoring of policy and program effects on them. Ensuring that disability status is collected and reported as a demographic characteristic across Maine's public health system is crucial in defining the tools and supports necessary to reduce disparities in healthcare access and outcomes. During the COVID-19 pandemic, the lack of disability data led to wide variations in states' early vaccine prioritization of people with disabilities. Maine's COVID-19 response was based on disaggregated data using commonly collected demographic characteristics. However, there was no way to identify the experience of people with disabilities because Maine's COVID-19 data could not be sorted by disability status. Because of this, Maine missed an opportunity to characterize healthcare access and outcomes for the many Mainers with disabilities, especially important for those who lived in congregate settings or received home and community-based personal care services, increasing their likelihood of acquiring COVID-19 and their inability to obtain the services they need. This presentation will share a landscape scan intended to define Maine's public health data sources and identify and address barriers to operationalizing data practices for Mainers with disabilities that are equitable with Maine's other minority populations. Moreover, it will educate public health workers in Maine about the need to collect and report disability data and the impacts of not doing so. The landscape scan includes a review of relevant literature, a summary of statewide interviews with key stakeholders and public health data gatekeepers, a network map of Maine's public health data organizations, and opportunities to advance data equity practices.

Learning Objectives

1. Describe current research, legislation, and best practices around disability data equity.
2. Describe the impacts of including disability as a demographic characteristic (and not).
3. Describe the current network of state and local agencies, organizations, and people working towards implementing disability data equity practices in Maine.

Leveraging Technology and Language Justice to Bridge Health Disparities Among Immigrants and New Mainers

*Nooralain Almasoodi (New Mainers Public Health Initiative), Hibo Omer, MPH (New Mainers Public Health Initiative) & Selam Runyon-Baruch (New Mainers Public Health Initiative)

In the rapidly evolving landscape of public health, innovative approaches are essential to address health disparities and ensure equitable access to vital health information. This presentation highlights a pioneering initiative that leverages technology and social media to deliver preventative health education to immigrants and new Mainers, while also benefiting the broader community. Our program creates monthly educational videos focusing on building healthier habits, understanding the importance of vaccinations, self-care, regular health check-ins, and engaging in healthy activities. To ensure language justice and inclusivity, we translate these videos into Somali, Arabic, French, Portuguese, Lingala, and English, thus overcoming language barriers and making critical health information accessible to diverse populations. Utilizing platforms such as Instagram, YouTube, Facebook, WhatsApp, and newsletters, we effectively disseminate our content, ensuring it reaches the community's phone screens. This method not only addresses the information gap but also provides essential resources to individuals who may lack healthcare coverage or literacy skills, allowing them to listen and watch videos to stay informed. Our innovative approach has received positive feedback from community partners and organizations, who also utilize our videos to support their constituencies. Collaborations with subject matter experts further enhance the value and credibility of our content. This presentation will delve into our strategies for operationalizing public health programming through technology, the impact of our multilingual outreach, and the role of community feedback in refining our efforts. By sharing our experiences and insights, we aim to inspire other public health practitioners to adopt similar innovative strategies to improve health equity and outcomes.

Learning Objectives

1. Analyze the effectiveness of utilizing social media platforms for disseminating preventive health information to diverse communities.
2. Evaluate the impact of social media outreach on health awareness and engagement among immigrant and new Mainer populations.
3. Identify strategies for incorporating language justice into public health education to improve accessibility and inclusivity.
4. List and describe at least three methods for translating and adapting health education materials to cater to multilingual audiences effectively.

Cumberland Room

Rural Health Innovation through the Somerset and Kennebec Counties Community Partnership

*Maija Dyke, R-CHIP (Healthy Living for ME) & *Julia Rand, MPH (Healthy Living for ME)

Background: In March 2023, Healthy Living for ME® (HL4ME®), Maine's Community Care Hub (CCH), was awarded one of three Rural Community Health Improvement Partnership (R-CHIP) Demonstration Project awards from the Maine Department of Health and Human Services. Tasked with building a multi-sector community partnership to identify and address health-related social needs (HRSNs), HL4ME® convened the

Somerset and Kennebec Counties Community Partnership (SKCCP) within the same month. SKCCP currently consists of 12 community-based organizations, three health systems, one healthcare advocacy organization, and the Maine CDC. Its mission is to create a framework for radical multi-sector communication and action that optimizes the well-being of all who live in Somerset and Kennebec Counties. Results: As the executive sponsor and convener of SKCCP, HL4ME® has implemented and adapted numerous teachable strategies that have sustained partner engagement and collaboration over the last 15 months, including but not limited to trust-building retreats; development and utilization of a secure SharePoint site; recurring monthly meetings; and consistent, transparent communication methods. These strategies helped to lay the foundation for SKCCP's work of conducting a community readiness assessment, identifying top HRSNs, and the decision to focus on addressing not a single need but rather redesigning the system of how individuals are connected with services. Community and other stakeholder engagement is central to this process and SKCCP has developed additional practices and frameworks to support this engagement, which can be applied by other projects and initiatives. Conclusion: With representation from public health, healthcare, housing, economic development, violence prevention, and more, as well as significant variance in partner capacity and resources, SKCCP provides a unique example of productive cross-sector relationships and integration of community voice in pursuit of a common goal - cornerstones of effective, innovative solutions to complex public health challenges.

Learning Objectives

1. Describe lessons learned and best practices related to convening and effectively engaging multi-organization/cross-sector partnerships with a focus on building and maintaining trust across all partners.
2. Apply unique frameworks to effectively engage community members and stakeholders in the processes of identifying barriers to services and implementation of community-driven solutions.

Building Climate Resiliency: Empowering Community Health Workers Through Education

*Leslie Lorentzen, MPHc (Maine Primary Care Association)

This presentation discusses Leslie Lorentzen's MPHA Qualidigm Fellowship in Healthcare Quality and her capstone project for her Master of Public Health degree, titled "Healthcare in a Changing Climate: Strategies for Well-being in Maine Communities." In partnership with the Maine Public Health Association, the Maine Primary Care Association, and support through collaboration with other community organizations, this project aimed to understand and address the impacts of environmental health and climate change on human well-being, emphasizing equitable solutions in the healthcare sector.

Throughout the project, various topics were explored, including understanding the impact of extreme weather and climate variations on health, vector-borne disease prevention and management, respiratory health education, mental health support in the face of climate change, addressing disparities in climate health impacts, community engagement and education, and disaster preparedness and response. These topics were integrated into the project's goals and activities, which included establishing climate change programming at the Maine Primary Care Association and providing climate change awareness training for Community Health Workers (CHWs) and community support roles in Maine. The presentation will outline the project's goals and activities and share the results of an assessment that shaped the development of the training series and resource guide aimed at addressing identified gaps and needs.

Learning Objectives

1. Identify strategies for educating Community Health Workers on climate resiliency and explain how these strategies can be applied in their communities.
2. Summarize the key findings from the project and recommend best practices for future climate resiliency education programs for CHWs.

Kennebec Room

A Comprehensive Approach in Rural Maine to Address the Opioid Epidemic

*Katherine Whitney, MPH (MaineHealth) & *Ashley McCarthy (Maine Health)

Over the past seven years, Franklin County, Maine, has evolved from having minimal services and programs to address the opioid epidemic to developing a comprehensive network of support and initiatives. Central to this transformation has been Healthy Community Coalition's (HCC) efforts in building community trust and acting as a community convener to enhance capacity through diversified partnerships. Through evaluation and community assessment, HCC effectively gauged community readiness and tailored the strategies accordingly. HCC's efforts have focused on educating the public in a non-judgmental manner and meeting individuals where they are. This has led to increased access to substance use disorder (SUD) treatment, a reduction in community stigma related to harm reduction, and the expansion of harm reduction services. Key initiatives include establishing a syringe service program (SSP), launching a harm reduction mobile health unit (MHU), creating a recovery center, and implementing innovative community initiatives. A cornerstone of HCC's success is the establishment and sustainability of an active multi-stakeholder consortium that meets monthly. This consortium has been vital in increasing partnerships and fostering a collaborative community environment. HCC's accomplishments stem from thorough planning, such as building community readiness and engaging those most likely to be resistant, including medical providers, law enforcement, first responders, and individuals with lived experiences. HCC's comprehensive approach has led to significant progress in addressing the opioid crisis, demonstrating the power of community-driven solutions. As an organization, we aim to share our experiences and insights to guide and inspire similar efforts in other rural communities.

Learning Objectives

1. Identify 3-5 key community partners essential for a successful comprehensive approach to implementing harm reduction programs.
2. Discuss the impact of key harm reduction initiatives in a rural community.
3. Describe the strategies used in a rural community to build community trust and foster diversified partnerships.

Lincoln Room

Addressing Chronic Disease and Social Drivers of Health through an Intensive Health Behavior and Lifestyle Intervention in Rural Maine

*LeeAnna Lavoie, MPH (MaineHealth) & *Sabrina Keene (MaineHealth)

The MaineHealth Franklin Hospital's Food is Medicine (FIM) program is a unique community-based intervention for improving health through skill building and social connectedness. With pilot funding from Hannaford Supermarkets' Eat Well, Be Well program, it pairs hospital-based healthy food pantry access with evidence-based lifestyle interventions to improve food security, social connectedness, and health outcomes. This year-long program brings together existing services that address food insecurity and chronic disease to promote healthy living and provide more comprehensive care for patients. Currently being piloted in Franklin County, patients ages 18+ are eligible for the program if they 1) have limited access to healthy food and 2) have documented metabolic disease. Program participants receive healthy food and corresponding recipes for 10 meals each week for up to four household members, while also attending two evidence-based programs: chronic disease self-management (Living Well with Chronic Disease) and healthy cooking on a budget (Cooking Matters). In addition, the program focuses on building peer support and offers other educational topics to

address social drivers of health (SDOH). FIM Franklin receives program evaluation services from the Center for Interdisciplinary Population & Health Research, a center within the MaineHealth Institute for Research. Areas of evaluation include participants' clinical outcomes, experience, and factors affecting healthy well-being, examination of feasibility, cost, replicability, effectiveness, and engagement. The evaluation will inform future iterations and adaptations of this program. This type of community-based programming may be an effective way for local health systems to provide lifestyle interventions and/or address social drivers of health. Dedicating resources to evaluating these programs is impactful and can inform other, locally tailored efforts as they are planned and implemented.

Learning Objectives

1. Identify 2 outcomes to measure when evaluating a Food is Medicine intervention.
2. Describe strategies to incorporate community and clinical integration to support community-based interventions in a healthcare setting.
3. Describe 2 components that lead to success when implementing a Food as Medicine intervention in rural communities.