

2017 MPHA ANNUAL CONFERENCE

BREAKOUT SESSION DETAILS

BREAKOUT SESSION 1 (9:35am - 10:35am)

Hannaford Hall

Rural Health Issues & Community Responses

Presentation 1:

Diagnosis: Poverty

Presentation 2:

Transportation Issues and Solutions for Maine Cancer Patients

Room 109

Health Equity & Chronic Disease

Presentation 1:

Female Genital Mutilation/Cutting Knowledge and Attitudes in Maine: Results from statewide survey

Presentation 2:

The Health Needs of Recent Arrival Immigrants

Room 110

Cultural Competency

Presentation 1:

Increasing Health Equity through Enhanced Access to Unaffordable Medicines

Presentation 2:

Creating Cultural and Linguistically Appropriate Services in Local Health Care Settings

Room 213

Maine Health Challenges

Presentation 1:

Smoking, Lung Cancer, and the Health Care System: Views from rural Mainers at risk

Presentation 2:

Smoking and Disparate Populations: Problems and solutions

Room 214

Panel Discussion

Partnering to Address Hunger in Rural Maine: Connecting patients and families with healthy food

BREAKOUT SESSION 2 (10:40am - 11:40am)

Hannaford Hall

Rural Health Issues & Community Responses

Presentation 1:

Community Efforts to Address Depression in a Rural Community in Maine

Presentation 2:

Mental Health Crisis Intervention and Collaborations between Police Officers and Behavioral Health Professionals to Improve Outcomes

Room 109

Data & Health Equity

Presentation 1:

Using Data to Promote Health Equity

Presentation 2:

All Data Sources are Not Created Equal: Measuring and analyzing race and ethnicity data from five data sources in Maine

Room 110

Short Orals (Clinical Focus)

1. Integrated Substance Use Prevention and Care: When SBIRT meets IPE
2. Improving Patient Activation through Evidence Based Self-Management Programs
3. Creation of Colonoscopy Instructions in Pictogram Format for Individuals of Lower Health Literacy
4. Improving Cost of Care Discussions in the Clinical Setting using Publicly Reported Cost Information
5. Centralized Hub: Linking patients to community evidence-based programs to ensure access for all

Room 213

Health Systems Addressing Health Equity

Presentation 1:

Recovering People, Recovering Communities

Presentation 2:

Interdisciplinary Team Develops Chronic Pain Education Programming for Patients and Families in Central Maine

Room 214

Workshop

Implicit Bias Workshop

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BREAKOUT SESSION DETAILS

BREAKOUT SESSION 3 (1:10pm - 2:10pm)

Hannaford Hall

Rural Health Issues & Community Responses

Presentation 1:

Midcoast Community Alliance: Addressing mental health using a public health model

Presentation 2:

Hospital to Home: Improving patient transitions through a multidisciplinary approach

Room 109

Environmental Health Equity

Presentation 1:

The Clean Air Act as a Tool Against Environmental Health Threats

Presentation 2:

Death by Degrees: The health crisis of climate change in Maine

Room 110

Short Orals (Rural Focus)

1. Realizing RALA Potential: How a statewide Rural Active Living Assessment (RALA) will be used to impact Maine's health
2. One of UNE's Efforts to Increase the Number of Rural Health Providers
3. Isolation, Alzheimer's Disease, and Dementia in Maine: A look at new public health data, challenges, and solutions
4. Rural Health Disparities in Maine
5. Patient Preferences for Physical Activity Support

Room 213

Short Orals (Community Focus)

1. Unsealed Fate: The unintended consequences of inadequate safeguarding of juvenile records in Maine
2. Relationships Between Lung Cancer Mortality and Smoking, Education and Poverty in Maine
3. Clinical Community Linkages as a Population Health Strategy
4. Addressing the Age and Diversity Gaps in the US SUD Prevention Workforce
5. Tobacco-Free Old Port Fest: A data-driven and collaborative approach

Room 214

Walk Audit

Walk audit with keynote speaker Mark Fenton. Meet in room 214.

A walk audit is a facilitated group walk of an area to observe both challenges to and opportunities for healthy eating and physical activity. This session will demonstrate how walk audits can serve to inspire community leaders and stakeholders, educate participants on healthy design principles and best practices, and provide practical planning for specific interventions, policy, and environmental improvements. **Wear your walking shoes**, as we'll be walking as well as talking about how to lead such a walk.

BREAKOUT SESSION 4 (2:15pm - 3:15pm)

Hannaford Hall

Rural Health Issues & Community Responses

Presentation 1:

A County-Wide Model for Health Improvement from the Oxford County Wellness Collaborative

Presentation 2:

Leveraging Social Determinants of Health Data to Improve Population Health Outcomes

Room 109

Maine Health Challenges

Presentation 1:

Lead Poisoning is Preventable: Maine's data-driven primary prevention strategy

Presentation 2:

Addressing the Arsenic Crisis in Maine: The rural/urban divide

Room 110

Short Orals (F&N Focus)

1. Evaluating Strategies for Improving the Food Security Network in Rural Maine
2. Food Sovereignty Policy: Increasing access or an outbreak waiting to happen?
3. Nutrition Incentives in Maine: Health in public spaces
4. Assessing the Extent of Digital Food and Beverage Marketing to Students in Middle Schools: A national sample

Room 213

Health Systems Addressing Health Equity

Presentation 1:

Health on the Move: Promoting health equity

Presentation 2:

Access to Care: Bridging the gap for Portland's most vulnerable citizens

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ABSTRACTS

Presentation Title: Diagnosis: Poverty

Lead Presenter: Andrea Richards, BS, CHES

Second Presenter: Tracy Harty, BSN

Third Presenter:

Organization: Healthy Community Coalition of Greater Franklin County

Abstract:

Economic stability and opportunity have a significant impact on the health of individuals as well as the community. During the most recent Community Health Needs Assessment for Franklin County, stakeholders prioritized poverty as one the top 5 factors having the most influence on health. In Franklin County about 15% of the population is living in poverty which is about 20% of children who live in poverty. Healthy Community Coalition of Greater Franklin County Maine, with support from the Maine Health Access Foundation has implemented a project addressing poverty as a health issue. The goal of project H.O.P.E. (Health Opportunities through Poverty Elimination) is to create social and physical environment change in the community, reducing the shame and stigmas of poverty, and to increase the health and well-being of all of members.

The Healthy Community Coalition partnered with Donna Beegle and adopted her Opportunity Community Model™. The model focuses on creating relationships, making connections to resources and building on the strengths of the community members in need, Neighbors. Neighbors have been identified through the schools and other social service agencies that the neighbors seek resources from. Neighbors are then connected with a Navigator. Navigators are community members who want to help others and are willing to donate 8-12 hours of time to working with a Neighbor for a year.

A recent kicked off with Donna Beegle brought the community together creating awareness and capacity for this work. An initial group of Neighbors and Navigators have been connected and resources have been utilized through this collaboration. Information on meetings, resources needed, health screenings and more will be collected and shared with key stakeholders.

This MPHA oral presentation session will offer a panel discussion regarding the planning and implementation of project H.O.P.E. and lessons learned and early success will be shared.

Learning Objectives:

1. To discuss poverty's implications on health of individuals and communities.
2. To describe how Project H.O.P.E. will connect people through building of relationships and connections made to the community.

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ABSTRACTS

Presentation Title: Transportation Issues and Solutions for Maine Cancer Patients

Lead Presenter: Patrick Madden, MBA

Second Presenter: Aysha Sheikh, RN, MPH

Third Presenter: John Charles, MS

Organization: Market Decisions Research

Abstract:

Access to transportation is critical for cancer patients. Studies have demonstrated that lack of transportation and greater travel distances significantly reduce the likelihood that cancer patients receive first-line treatment and influence the types of treatment patients receive. Transportation barriers disproportionately affect Maine cancer patients because many live in rural areas without access to cancer care providers.

With the goal of supporting access to cancer care, Maine Cancer Foundation and Market Decisions Research conducted a comprehensive transportation needs assessment, analyzing where cancer patients in Maine travel to receive care, transportation barriers, and the availability of cancer care providers by geography.

We combined data from multiple sources, including 2015 Maine hospital encounter data, cancer incidence rates, licensed provider lists and a survey of transportation providers to assess cancer care transportation needs by geography, demographics and type of treatment received. Key findings include:

- A lack of access to cancer care providers and greater need for transportation services in Northern and Downeast Maine
- Three Maine counties have no onsite oncology providers and nine no radiation treatment providers
- Cancer patients living in the most rural areas of the state travel nearly 60 miles per trip to receive treatment
- Lower socioeconomic status is associated with elevated cancer incidence rates and greater transportation barriers
- Transportation barriers vary greatly from county to county
- Three-quarters of transportation providers rely on volunteer drivers and half do not have adequate funding to meet demand

Because transportation barriers vary statewide, solutions to transportation needs must be unique to regions and specific communities. Our assessment shows that community organizations are a vital piece of Maine's transportation network and will be a key player in reducing transportation barriers. In addition to increased transportation funding, solutions may also include policy change, telemedicine, lodging resources, and the implementation of community-based driver networks.

Learning Objectives:

1. Identify regions of the state and demographic groups with the largest cancer care transportation needs.
2. Understand the availability of transportation resources by geography and barriers to access.
3. Assess potential solutions to help address transportation barriers and reduce transportation inequalities in Maine.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Female Genital Mutilation/Cutting (FGM/C) Knowledge and Attitudes in Maine: Results from a statewide survey

Lead Presenter: Michelle Mitchell, MSocSC

Second Presenter: Michelle Munsey, MA

Third Presenter:

Organization: Partnerships For Health

Abstract:

The arrival of refugees and immigrants into the demographically homogenous state of Maine exposes a healthcare system that is unprepared to provide culturally sensitive care to women and girls who have experienced Female Genital Mutilation/Cutting (FGM/C). This cultural disconnect often prevents these New Mainers from receiving adequate, equitable health care. In 2016, the Maine Access Immigrant Network received federal funding to implement the Honor our Bodies, Educate our Community, Respect our Heritage (HER) Initiative aimed at reducing the risk of FGM/C and decreasing gaps in clinical services for women who have experienced FGM/C.

In Spring 2017, PFH surveyed clinical providers and New Mainers about their perceptions of FGM/C. Over 70 clinicians from 14 counties and 400 community members from 19 countries completed surveys.

Most (85%) clinical providers understood the importance of discussing FGM/C with their patients and acknowledged that these conversations can be challenging. There was an overall knowledge gap, particularly about FGM/C prevalence, treatment and reporting. Nearly 40% of providers did not receive any FGM/C-related education as part of their medical training. For example, at least one-third were unsure if FGM/C affects the number of births a woman can have and if it increases the risk of sexually transmitted diseases. Almost all (98%) providers wanted to learn more about FGM/C.

The majority (82%) of community members did not support the practice of FGM/C and 65% viewed FGM/C as a type of violence against women. The community members reported less of a knowledge gap, particularly around the law and medical consequences. However, many respondents were not able to separate myths from facts.

The paper will highlight other initiative findings, including differences among provider specialties and gender in the community. These findings will be used to initiate conversations and encourage appropriate, culturally sensitive care for women who have experienced FGM/C.

Learning Objectives:

1. Identify cultural and clinical myths, fallacies, and facts about FGM/C.
2. Discuss clinical and community views on FGM/C.
3. Demonstrate an understanding of facilitating culturally appropriate conversations surrounding FGM/C within the immigrant and clinical settings.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: The Health Needs of Recent Arrival Immigrants

Lead Presenter: Heather Shattuck-Heidorn, Ph.D.

Second Presenter: Tarlan Ahmadov, MA

Third Presenter:

Organization: Catholic Charities

Abstract:

Over the last 35 years nearly 10,000 primary refugees have settled in Maine, along with some 20,000 other international migrants who came as secondary migrants or asylum seekers. These populations are some of the most vulnerable in Maine, and as resettlement expands out of the larger cities such as Lewiston and Portland, it is important that providers and community health workers understand 1) how differences in immigrant status relate to differences in health histories, and 2) the health needs of these populations, currently available resources, and identified gaps.

Maine's foreign-born immigrant population has general health needs that will be familiar to practitioners and community health workers, such as dental care, diet concerns, chronic disease, or asthma, as well as health needs that are specific to geographic and social history. Many immigrants come from areas of the world with endemic diseases that are relatively rare in the United States, such as helminthes or tuberculosis. Trauma is also common among refugee populations, including trauma related to torture. In this presentation, we consider common needs and differences among the immigrant communities in Maine, including distinguishing between asylum seekers, refugees, and secondary migrants. Using retrospective data from the domestic medical screenings delivered to refugees, we identify the top five most common refugee health needs, and speak to current resources available to meet those needs, as well as areas where we could focus more efforts.

Learning Objectives:

1. Participants will be able to explain the differences in immigrant status groups (asylum seekers, refugees, immigrants) and how this relates to health.
2. Participants will be able to better identify health needs and resources for addressing those needs in Maine's immigrant population, and where gaps exist.

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ABSTRACTS

Presentation Title: Increasing Health Equity through Enhanced Access to Unaffordable Medicines

Lead Presenter: Martha Morrison, M.S.

Second Presenter:

Third Presenter:

Organization: MedHelp Maine

Abstract:

Health equity cannot be attained while Mainers of limited means do not have the same access to needed medicines as those who are well-insured or who can afford increasingly costly prescription drugs. The inability of financially needy patients to obtain their medications leads these individuals to have more preventable ER visits and hospitalizations, a decreased quality of life, and even a greater likelihood of premature death.

Prescription drugs increasingly manage chronic disease and prevent loss of life. And yet, despite Medicare drug plans and enrollment in marketplace insurance, national surveys show that 40% of patients either do not fill their prescriptions at all or cut pills or skip doses to lessen their drug expenses. Indeed, access to affordable medicines is identified as a Healthy People 2020 priority, one that addresses the social determinant of health of limited financial resources.

There are many public benefit, retail discount, co-pay foundation, and brand name and generic drug manufacturer programs that offer free or low-cost medicines. However, because navigating their widely differing and frequently changing eligibility and application requirements is so burdensome and time-consuming, few medical practices can help all qualified patients.

Many Maine hospitals have therefore created centralized prescription assistance programs to manage the medication access process on behalf of all area prescribers and these clinicians' patients. More efficient and cost-effective than the work of individual practices, these programs now obtain many millions of dollars' worth of free or low-cost meds for thousands of needy patients of hundreds of Maine doctors each year.

This breakout session will describe how these hospital resources are enhancing public health by increasing access by Maine's neediest residents to those prescription drugs needed for successful disease management.

Learning Objectives:

1. List three situations in which Mainers may find their prescription drugs to be unaffordable.
2. Cite one benefit each to clinicians, patients, and hospitals of enhanced medication access.
3. Explain how centralized hospital-based prescription assistance programs are helping Maine prescribers obtain unaffordable medicines for their patients.

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ABSTRACTS

Presentation Title: Creating Cultural and Linguistically Appropriate Services in Local Health Care Settings

Lead Presenter: Patricia H. Hart, MS, CPH

Second Presenter: Holly Lasagna, MLS

Third Presenter: Lindsay Gannon, MPA

Organization: Market Decisions Research

Abstract:

Maine is one of the oldest and whitest states (95% Caucasian), with little experience in providing culturally appropriate services to newcomers. In the past 15 years the population of African immigrants in Lewiston/Auburn has reached 11%. This is a significant issue for health care institutions that are unprepared to provide appropriate services to a growing portion of the community. Issues such as language, religion, gender roles, and race are not well understood by providers and oftentimes ignored. Yet, provider reports of patient miscommunication, lack of follow-through or missing appointments are commonplace. To fill this need, Healthy Androscoggin, a local community health organization, secured a Racial and Ethnic Approaches to Community Health (REACH) grant from the US CDC to help local health-related agencies improve their cultural and linguistic competency. The local REACH project worked with providers using a structured process to assess their agency's cultural competency against national Cultural and Linguistic Appropriate Service (CLAS) standards. The results informed a plan for improvements and included training and technical assistance. The goal of the project is to help the agencies increase cultural and linguistic competency ultimately benefiting the whole community. This session will share the project outcomes including the improvements made by each agency, client satisfaction, the standards-based replicable process, and the suite of training and technical assistance provided.

Learning Objectives:

1. Understand a standards based process for assessing an organization's cultural competency.
2. Discuss implementing strategies for measurable improvement.

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ABSTRACTS

Presentation Title: Smoking, Lung Cancer, and the Health Care System: Views from rural Mainers at risk

Lead Presenter: Jean A. Talbot, PhD, MPH

Second Presenter: Martha Elbaum-Williamson, MPA

Third Presenter: Erika Ziller, PhD

Organization: University of Southern Maine

Abstract:

Background: Lung cancer is a major public health concern in Maine. Compared to other states, Maine ranks in the top ten for lung cancer incidence and in the top twenty for lung cancer deaths (US Cancer Statistics Working Group, 2017). Within Maine, residents of low-income, rural areas such as Oxford, Somerset, and Washington Counties are disproportionately affected. These three counties have lung cancer mortality rates above the state average, and Washington County has the highest rate of all Maine counties (countyhealthrankings.org) One fifth to one quarter of adults in these counties are smokers (countyhealthrankings.org), a fact that likely contributes to their high rates of lung cancer morbidity and mortality.

Purpose: Research suggests that rural residents face unique structural (Bennett et al., 2008) and cultural (Hartley, 2004) obstacles to participation in lung cancer prevention, screening, and treatment. However, little is known about how these barriers operate in specific Maine contexts, or how best to engage the state's vulnerable, rural populations in the promotion of respiratory health. The Maine Lung Health Study, a project of the Maine Lung Cancer Coalition, was designed to address these questions.

Participants: Fifty residents of Oxford, Somerset, and Washington counties who were aged 40 or older and who were former or current smokers.

Methods: Two focus groups were conducted in each of the three target counties. Qualitative analyses of focus group transcripts traced themes within and across groups.

Findings: Analyses will provide insights into participants' views on the following themes:

- Factors affecting engagement/disengagement in relationships with health care providers
- Barriers/facilitators to addressing smoking in the context of patient-provider relationships
- Factors influencing smoking and cessation
- Personal risk for lung cancer: how to appraise it and whether it can be changed

Learning Objectives:

1. Identify at least two factors that could affect rural Mainers' levels of engagement in relationships with health care providers.
2. Gain insights into rural Mainers' perceptions about their own smoking and personal risk for lung cancer.
3. Discuss how findings may be used to inform the practice of health care providers engaged in lung cancer prevention, screening, and treatment.

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ABSTRACTS

Presentation Title: Smoking and Disparate Populations: Problems and solutions

Lead Presenter: Edward J. Perka, Jr., CASAC, TTS

Second Presenter:

Third Presenter:

Organization: MaineHealth

Abstract:

Since the mid 1960's, the rate of smoking in the United States has dropped dramatically, saving millions of lives and leading to significant reductions in tobacco-related morbidity and mortality. Not all groups, however, have benefitted from this trend. Hidden among the decline is the reality that smoking rates remain high among the poor and the less educated, among certain racial and ethnic groups, and the LGBTQ community. In addition, smoking rates are very high among individuals with mental health and substance use disorders.

This workshop will examine these disparities with respect to the burden of tobacco-related disease and will explore some of the social and environmental factors that contribute to the on-going issue using a bio-psycho-social framework. In addition, we will discuss the perceived and real barriers to quitting smoking for these populations, and the relationship between tobacco and other substances of abuse.

Finally, the evidence base for effective tobacco use disorder treatment will be presented, and will include specific strategies and approaches that have been shown to be effective across a broad range of population groups. The discussion will also include a review of effective approaches to engaging an individual in a discussion about tobacco use as well as practical counseling (e.g. problem-solving skills, stress reduction, and coping with high-risk situations) and relapse prevention strategies.

Learning Objectives:

1. Participants will be able to explain that smoking rates remain high among the poor and the less educated, among certain racial and ethnic groups, and the LGBTQ community.
2. Participants will be able to describe the social and environmental factors that contribute to higher smoking rates in disparate populations.
3. Participants will be able to name effective approaches to delivering tobacco use disorder treatment.

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ABSTRACTS

Presentation Title: Partnering to Address Hunger in Rural Maine: Connecting patients and families with healthy food

Lead Presenter: Jessica Shaffer, MS

Second Presenter:

Third Presenter:

Organization: Eastern Maine Healthcare Systems (EMHS)

Abstract:

Maine has the third highest rate of food insecurity in the northeast and ranks the ninth highest in the country for “very low” food security. Nearly 16% of households in Maine are food insecure, and rates of food insecurity in northern Maine are disproportionately higher than in other areas of the state. The Northern Maine Rural Collaborative (NMRC), a prevention network convened by Eastern Maine Healthcare Systems (EMHS) and funded by a CDC Partnerships to Improve Community Health (PICH) grant, has worked since 2014 with communities and partners in seven rural Maine counties to improve access to healthy foods, especially among vulnerable, rural Mainers. Through collaboration with community health coalitions, medical providers, and food security organizations, the NMRC has worked to implement a hunger screening process to identify patients and caregivers who are food insecure and to connect these individuals with reliable sources of healthy food.

This presentation will describe a scaled intervention approach to engaging clinical and community partners to address a significant barrier to good health. Panelists representing clinical and community perspectives will share unique approaches used to better connect food insecure patients with local food resources.

We will highlight specific strategies for implementing a screening and referral process, implementation challenges unique to rural communities, lessons learned, and opportunities for replication.

Learning Objectives:

1. Participants will gain information about the burden of food insecurity in Maine and will learn about the impact of NMRC efforts to identify those at risk in seven northern counties.
2. Participants will learn about NMRC efforts to implement a validated screening tool to identify food insecure individuals and specific strategies for adapting this approach for a variety of clinical settings.
3. Participants will learn about NMRC efforts to develop community referral pathways and create relationships between clinical and community partners to improve food security for rural Maine people.

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ABSTRACTS

Presentation Title: Community Efforts to Address Depression in a Rural Community in Maine

Lead Presenter: Mahvish Junaidi MD, MPH

Second Presenter: David Ettinger MD

Third Presenter: Titilola Balogun MBBS, MPH, DrPH

Organization: University of New England

Abstract:

Introduction:

The prevalence of depression is higher in Maine than it is in the United States. In rural areas, availability, accessibility, and acceptance of mental health services along with the lack of community awareness complicate the delivery of mental health services.

Objectives:

This study determined the prevalence of depression as seen at a critical access hospital in a rural community in Maine, and identified opportunities for collaboration between providers of primary care, mental health services, and integral input from stakeholders in the community.

Methods:

A cross sectional study determined the prevalence of depression among patients 18 and older seen in the ER of a critical care facility between January and March 2017 using the PHQ-9 depression screening tool.

Results:

Of 350 participants, 13% screened positive for depression (18% of women and 7% of men). Meetings with primary care providers and providers of mental health services revealed that despite a high prevalence of mental illness in the community, only patients who present to their PCPs with symptoms are screened for mental illness. In addition, there is a lack of coordination of care and exchange of information between the providers and behavioral health counselors.

To optimize effective and efficient care, the team will meet regularly to coordinate activities and provide improved services given limited resources. Efforts are now in place to improve the integration process. Outpatient facilities now plan to offer screening to all patients regardless of the presence of symptoms of mental illness. State grants and local donations will be actively sought to support education and projects necessary for screening and managing mental illness.

Conclusion: Depression is treatable, therefore improved community awareness and better coordination between health care providers will lead to overall improved health of rural communities.

Learning Objectives:

1. Compare the prevalence of depression in a rural town in Maine to the State average.
2. Identify the role of healthcare providers and hospital administrators to combat depression in an underserved area.
3. Identify the role of behavioral counselors, community leaders and community activists to combat depression in an underserved area.

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ABSTRACTS

Presentation Title: Mental Health Crisis Intervention and Collaborations between Police Officers and Behavioral Health Professionals to Improve Outcomes.
Lead Presenter: Stephanie LeBlanc, LCSW, CCS
Second Presenter: Brendan Schauffler
Third Presenter:
Organization: Oxford County Mental Health Services

Abstract:

The Oxford County Wellness Collaborative (OCWC), a network comprised of 300+ individual and organization partners, strives to engage all community members in working together to transform personal, environmental, and economic health across the county by building strong relationships among people and organizations. OCWC works to foster positive health outcomes by providing opportunities for citizens to build social capital, and by supporting a collective framework approach to health production. OCWC is organized into five workgroups, including a Behavioral Health group focused on mental health and substance use. Members of this workgroup saw a need for law enforcement officers to be better trained to address mental health crisis situations in the county. Escalation of crisis situations is often more costly and more dangerous to both officers and the individuals involved (Compton, 2014). Led by Oxford County Mental Health Services, the workgroup launched a successful effort to seek grant funding to allow police officers to be sent to a 40-hour Crisis Intervention Team (CIT) training. Working with the Maine chapter of the National Alliance on Mental Illness, the workgroup organized two CIT trainings, allowing 20 officers, representing every department in the county, to attend. Since then, there have been multiple observed cases of police officers and mental health services co-responding to crisis situations, and improved communication and collaboration between police departments and mental health services. This presentation will go over how collaboration between police departments and mental health services can increase safety for officers and those involved in mental health crises.

Learning Objectives:

1. Describe the importance of crisis intervention training for police officers addressing mental health crises.
2. Assess the potential benefits and challenges of a partnership between police officers and county mental health services.

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ABSTRACTS

Presentation Title: Using Data to Promote Health Equity

Lead Presenter: Caitlin Pizzonia, MPH

Second Presenter:

Third Presenter:

Organization: University of Southern Maine

Abstract:

Valid and informative data are needed to understand the scope of health inequities and the factors contributing to health disparities. It is also critical to monitor inequities to ensure progress towards comprehensiveness, long-term reductions in disparities. The University of Southern Maine, in collaboration with the Maine CDC, used data, literature and stakeholder interviews to summarize:

- How available public health data systems can promote a health equity perspective;
- How data can be used to highlight the relationship between health and social determinants of health;
- What we currently know about populations with health disparities in Maine.

Findings from the research resulted in a report, "Using Data to Promote Health Equity." (http://www.maine.gov/dhhs/mecdc/documents/Health-Equity-Report_Final_3.20.17.pdf) This presentation will summarize the framework and findings of this report. This includes results of analyses of the quality of health disparities in key public health surveillance systems; available indicators to measure social determinants of health; and gaps in data on key populations in Maine. Recommendations from the report will be discussed, along with progress that has been made in improving data to promote health equity in Maine. Findings from a recent report on social determinants of health in Maine will also be reviewed.

Learning Objectives:

- 1.Explain how Maine created a public health surveillance framework to address health equity, including social determinants of health and health disparities.
- 2.Understand challenges with availability, collection, and analysis of data on populations with health disparities in Maine.
- 3.Describe where to find data on social determinants of health and social determinants of health published by the Maine CDC and other community organizations.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: All Data Sources Are Not Created Equal: Measuring and analyzing race and ethnicity data from five data sources in Maine
Lead Presenter: Alison Green-Parsons, BA
Second Presenter: Caitlin Pizzonia, MPH
Third Presenter:
Organization: University of Southern Maine

Abstract:

Nationally, many health conditions unequally impact racial and ethnic minorities. Accurate and quality data are needed to detect differences in disease rates. The purpose of these analyses was to examine the quality of race and ethnicity variables in administrative data sources, including completeness and accuracy. Race and ethnicity fields in Maine's death certificate, birth certificate, inpatient hospital discharge data, outpatient emergency department data, as well as Maine's Behavioral Risk Factor Surveillance System (BRFSS) and Maine Integrated Youth Health survey were analyzed. Assessing data completeness involved evaluating the percent of missing data in the race and ethnicity fields each year. Accuracy was determined by comparing the distribution of race categories in the dataset to the census distributions. Changes in race field coding over time and inconsistencies in race reporting were found in some datasets. Certain populations such as tribal members, refugees, and migrants were difficult to identify in these sources due to collection definitions or methods. Though survey data may collect race and ethnicity information accurately, surveys may lack cultural competence in asking respondents about health behaviors or conditions. Results suggest that race and ethnicity data are relatively complete and generally reflect the distributions of these groups in the population. However, there are limitations to using administrative data to study health disparities by race and ethnicity. These sources continue to be monitored for race and ethnicity data quality and additional analyses are planned to continue to improve the quality of public health surveillance data.

Learning Objectives:

1. Describe and compare how race and ethnicity fields are defined in five data sources: hospitalization, births, mortality, BRFSS, and MIYHS.
2. Explain benefits and challenges of providing accurate data analyses on racial and ethnic minorities using public health surveillance data.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Integrated Substance Use Prevention and Care: When SBIRT meets IPE

Lead Presenter: Clay Graybeal, Ph.D., M.S.W.

Second Presenter: Bethany Fortier, M.P.H.

Third Presenter: Brianna Nalley, M.P.H.

Organization: University of New England

Abstract:

The University of New England Interprofessional Education Collaborative has more than fifteen years of experience in developing and implementing interprofessional education and training involving more than a dozen health professions. Most recently this has included a SAMHSA funded grant to provide students from eight health professions with training in Screening, Brief Intervention, and Referral for Treatment (SBIRT) in the classroom, simulation and clinical education. The ultimate goal is for graduates to become SBIRT leaders as they move into the field.

Beyond the basic training in the components of SBIRT, there are three foci to this program: basic skills in motivational interviewing, interprofessional education (learning with, from, and about each other), and leadership development. This formulation is grounded in our perception that substance use should be addressed regardless of when and where an individual first makes contact with health care providers. In other words, any entry point can and should lead towards education and intervention as appropriate.

This workshop will provide an overview of the program, followed by brief Q & A to help participants consider ways to incorporate core elements of SBIRT into their own IPE setting.

Learning Objectives:

1. Participants will be able to explain how and why SBIRT works in an interprofessional context.
2. Participants will be able to identify ways that SBIRT could be integrated into their own clinical or educational setting.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Improving Patient Activation through Evidence Based Self-Management Programs

Lead Presenter: Kristin Overton, MBA

Second Presenter: Doug Wilson, MS/MIS

Third Presenter:

Organization: Spectrum Generations

Abstract:

As Maine's population continues to age, and fall related injuries and chronic diseases become more of a challenge for our population and health systems, innovative work is underway to address these challenges at the community level. In 2016, the Administration for Community Living granted a total of over \$1M to Southern Maine Agency on Aging and Spectrum Generations to address Falls Prevention and Chronic Disease Self-Management. These collaborating agencies are building a network across the state to increase the availability of evidence-based self-management programs, as well as building partnerships with healthcare providers to promote referral to workshops that can augment clinical care and engage participants more actively in their own health management. Learn more about the programs, including: A Matter of Balance, Tai Chi for Arthritis, and the Chronic Disease Self-Management Education suite, as well as the benefit these programs bring to participants and the healthcare community. Finally, learn how to access or refer to a workshop.

Learning Objectives:

1. Describe current grant efforts related to evidence based programs in Maine.
2. Discuss the role of evidence-based programs in patient activation and self-management.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Creation of Colonoscopy Instructions in Pictogram Format for Individuals of Lower Health Literacy

Lead Presenter: Karen Palin, PhD. Lecturer in Biology

Second Presenter: Akira Townes, BA

Third Presenter:

Organization: Bates College

Abstract:

Individuals of lower health literacy and limited English proficiency, particularly immigrants, refugees, and the elderly, are at increased risk for failure of colonoscopy bowel preparation, resulting in the need to reschedule the procedure, with increased inconvenience and cost for all. To improve patient understanding and increase compliance with colonoscopy preparation instructions, we created a two-sided handout comprised primarily of pictograms, with dietary instructions on one side and medication instructions on the other. We began with currently available patient colonoscopy preparation instructions in both text and illustrated text formats. We removed the illustrations from the text and invited members of two convenience samples, one a group of college students with little knowledge of colonoscopy procedures and the other a group of adult English language learners, to interpret the dietary and medication instructions conveyed by each illustration. After we disclosed the intended instructions for each illustration, we asked each group for their suggestions to make the dietary and medication instructions clearer and more culturally appropriate. This input was used to construct our current handout with pictograms we drew or images we accessed through public domain on the internet. Two community health workers and a graphics designer with cross cultural experience worked with us to insure clarity and appropriate messaging; a nurse educator vetted the dietary and medication information for accuracy. In addition, we have formatted the instructions into bookmarks by day of colonoscopy preparation for patient home use. The handout and bookmarks are available for patient education, particularly for those with lower health literacy and limited English language proficiency. We are soliciting feedback on the use of these materials.

Learning Objectives:

1. Describe methods for creation of a visual, culturally appropriate handout and solicitation of input from a population of lower health literacy.
2. Design visual teaching tool that provides instructions for colonoscopy preparation for use with patients with limited English proficiency.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Improving Cost of Care Discussions in the Clinical Setting Using Publicly Reported Cost Information

Lead Presenter: Kimberley Fox, MPA

Second Presenter: Karynlee Harrington, Executive Director Maine Health Data Organization

Third Presenter:

Organization: Muskie School of Public Service, University of Southern Maine

Abstract:

As consumers face higher out-of-pocket health care expenses and increased cost-sharing, understanding and discussing the costs of diagnostic and treatment options is important to both patients and providers because it ultimately can affect patients' decisions about whether, when and where to get recommended care. The State of Maine has made a commitment to helping consumers understand health care costs through its state price transparency website, CompareMaine. Developed by the Maine Health Data Organization (MHDO) and given an A grade by Consumer Reports for its easy-to-use cost and quality information, CompareMaine shows average costs for selected medical procedures across facilities in Maine using data from Maine's All Payer Claims Database. In 2016, the Muskie School of Public Service in partnership with Maine Quality Counts (QC) and MHDO received a grant from the Robert Wood Johnson Foundation to study how patients and healthcare providers can improve discussions about cost of different treatment options using CompareMaine and other publicly-available cost information. As part of this initiative, 6 Maine primary care practices are working with QC to test new tools and strategies for integrating cost-of-care conversations into the practice workflow using a team-based approach to help patients better understand health care costs and the cost/value equation, initially focusing on the diagnosis and treatment of low-back pain. The project builds off the American Board of Internal Medicine Foundation's "Choosing Wisely®" initiative, developing cost-of-care tools and training practice teams to talk with patients about their financial health using empathic communication and discussing the relative value of treatment options. This presentation describes the CompareMaine website and presents preliminary study results from the RWJF Cost-of-Care pilot describing how practices are integrating cost-of-care discussions into the clinical workflow and how these discussions of relative value of treatment options and price variation affect patients' treatment decisions and choice of provider.

Learning Objectives:

1. At the end of this session, participants will be able to describe how Maine practices are integrating cost-of-care conversations into clinical discussions with patients and the impact these conversations are having on provider and patients' experience and treatment choices.
2. At the end of this session, participants will have a basic understanding of what cost and quality information is available on CompareMaine to help inform cost of care conversations and patient treatment choices and how to use the website for personal or professional use.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Centralized Hub: Linking patients to community evidence-based programs to ensure access for all

Lead Presenter: Vicki Foster

Second Presenter: Alicia Rice

Third Presenter:

Organization: MaineGeneral Medical Center

Abstract:

The chronic disease burden is increasing as Maine's population ages. In the Central Public Health District, nearly 70% of the population is overweight or obese, 10% have diabetes and 25% are sedentary. Individual organizations alone cannot combat the chronic disease epidemic. MaineGeneral Medical Center developed a centralized hub system within the Prevention and Healthy Living department. The "hub" is staffed by health educators. Patients are linked to health care, dental services, evidenced-based programs, community resources and other basic needs programs, such as housing, transportation, etc. The Hub is a telephone service center where patients and community members can call to be linked with needed programs and services. A critical component in strengthening and supporting the clinical-community linkage is the use of the electronic medical record (EMR) by providers to refer their patients to health education programs and community resources. A population health approach is also used to support primary care practices by identifying and addressing the needs of patients for disease self-management, connecting patients within various health systems and community resources, and monitoring the engagement and completion of evidence-based programs. This project brought together clinical, public health, and community partners to expand population health efforts outside the walls of each organization to better serve our communities.

Learning Objectives:

1. Describe the hub model and how it can help impact health outcomes.
2. Describe the strategies implemented to develop the hub model.
3. Describe how key partnerships support the hub model.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Recovering People, Recovering Communities

Lead Presenter: Jesse Harvey, CIPSS

Second Presenter:

Third Presenter:

Organization: Peer Support Coordinator, Greater Portland Health

Abstract:

The presentation will explore lived experience with active substance use and recovery as it relates to the current best practice research. Strength and community based solutions to substance use disorders (SUD, DSM-V) increase help seeking behaviors, reengage individual and collective resiliency, promote hope and perseverance, cultivate personal confidence and empower recovery allies. We will identify and define implicit bias, review SAMHSA's definition of recovery, assess SUD within the DSM-V (2013), and explore the historical, acute and sustained role language plays within stigma, discrimination and recovery engagement.

Learning Objectives:

1. Will discuss how participants can contribute to more recovery-friendly systems of care and more recovery-ready communities.
2. Will demonstrate how certain language can stigmatize the person and will identify and discuss alternatives
3. Participants will be able to design and implement in their specialty area(s) the components needed for recovery oriented systems of care (ROSCs) that are in line with modern and evidence-based best practices.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Interdisciplinary Team Develops Chronic Pain Education Programming for Patients and Families in Central Maine

Lead Presenter: Malindi Thompson, MPH

Second Presenter: Wendy Jorgensen, PA, MHP

Third Presenter: Lidwina Groen, DO

Organization: MaineGeneral Medical Center

Abstract:

The state of Maine has responded to the opioid crisis by enacting stricter prescribing laws, which greatly impacts patients with chronic pain. One major aspect of the new opioid prescribing law is that providers are required in 2017 to compassionately reduce, or “taper”, opioid prescriptions for patients with high daily dosages, and keep other patients’ dosages at a minimum. Many providers and patients do not know where to turn for alternative and non-pharmaceutical ways to manage chronic pain and ensure highest quality of life. Additionally, a short office visit is often not enough time to educate the patient about their options and cover self-care techniques that can improve functionality and wellbeing.

In 2016, MaineGeneral’s Prevention and Healthy Living (PHL) department organized an interdisciplinary team of psychologists, physiatrists, physical and occupational therapists, primary care providers and health educators to begin working to improve supportive services for patients with chronic pain. The team developed an education program to increase the understanding of chronic pain and treatment options available. Topics include: chronic versus acute pain, self-care techniques, treatment options (medication, cognitive or other therapies, and includes complementary approaches such as acupuncture), and other PHL classes (cooking, physical movement and healthy mind-body connections).

A population health approach involving primary care teams and electronic health data was part of the implementation plan, identifying the chronic pain population (based on high daily doses of opioid medications) who may benefit, giving providers the option to refer to the program in the electronic medical record.

This presentation describes the process that PHL used to launch a new chronic pain education program, and lessons learned from working with primary care practices to engage patients as well as the community.

Learning Objectives:

1. List key partners to be involved in developing a new chronic pain education program.
2. Describe opportunities for further development or growth of chronic pain programming in the healthcare setting.
3. Describe lessons learned from implementing a new chronic pain education program, and important considerations when launching.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Implicit Bias: An unconscious barrier to health equity

Lead Presenter: Kathryn L. Vezina, RN, MSN, JD, CPHQ

Second Presenter:

Third Presenter:

Organization: Hanley Center for Health Leadership

Abstract:

"Implicit Bias" is a term that describes the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Implicit bias is activated quickly and unknowingly by situational cues (eg, a person's skin color or accent or other characteristics), silently exerting its influence on perception, memory, and behavior. Implicit biases can influence health and healthcare at the individual and systemic level in multiple ways. Verbal and nonverbal communication between providers and patients is affected. Patients feel a lack of respect or caring when providers have no conscious awareness that they may be fostering that perception. Decision making by individual healthcare providers, health system administrators, and public policy makers is also influenced by implicit bias. A healthcare professional's implicit bias can influence treatment recommendations when a patient is seen as likely to be less cooperative with treatment. Policy makers may see some populations as less worthy because of unconscious bias. Those unconscious reactions contribute to less effective patient-provider relationship with both patient and provider feeling less satisfied with a therapeutic interchange and often not knowing why. They also contribute to individual and systemic health inequities, those avoidable differences in health status or outcomes related to membership in a disadvantaged population.

A fundamental component of any successful drive to promote health equity is a heightened awareness of the existence and reduction of implicit bias. The Daniel Hanley Center for Health Leadership has developed a Train-the-Trainer Implicit Bias Curriculum designed to raise awareness about implicit bias and to share evidence informed strategies to mitigate bias and its negative effects. This breakout session will share selected resources from this curriculum and engage participants in an interactive exercise and an active discussion about implicit bias and strategies to address it.

Learning Objectives:

1. Describe the impact of Implicit Bias on healthcare interactions and health outcomes.
2. Identify a specific action step that the participant will take to address personal and/or systemic bias and health inequities.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Midcoast Community Alliance: Addressing mental health using a public health model

Lead Presenter: Melissa Fochesato, PS-C

Second Presenter: Jamie Dorr

Third Presenter:

Organization: Mid Coast Hospital

Abstract:

In July 2016, five local organizations came together to address the high rates of depression, anxiety, suicide, and more found within our community. By the fall, the Midcoast Community Alliance had grown to include nearly 50 people from 25 different organizations all working together to reduce mental health stigma, to encourage help seeking and, ultimately, to be a suicide-free community.

Coalition members reviewed local data and experiences of youth, schools, affected others and created a mission, vision and goals. The coalition is focusing on increasing the number of youth who feel valued in their community, decreasing the higher than state average number of high school youth who have considered suicide, and increasing awareness of support. Mid Coast Hospital supports the community mental health promotion efforts through a SAMHSA Now is the Time Project Aware grant to offer free Mental Health First Aid trainings and mental health awareness.

Midcoast Community Alliance co-founder and coordinator, Jamie Dorr and Mid Coast Hospital Community Health Promotion Director, and MCA member, Melissa Fochesato will share successes, barriers, and future plans of the coalition.

Learning Objectives:

1. Discuss public health strategies communities can implement to prevent youth suicide.
2. Describe community sectors key to a successful community mental health coalition
3. Identify 1 potential funding source for mental health first aid and promotion.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Hospital to Home: Improving patient transitions through a multidisciplinary approach

Lead Presenter: Kayla Blais, MPH

Second Presenter: Bonnie Carleton, BS CHES

Third Presenter:

Organization: MaineHealth

Abstract:

Background: The transition from hospital to home is one of the most potentially problematic aspects of medical care in the U.S. High readmission rates are linked to lack of education, misunderstanding of diagnosis and/or medication use, and noncompliance. Maine Medical Center's (MMC) Family Medicine practice assessed how patient education, shared decision making and health care provider resources can be combined to lower readmission rates. This led to the creation of the Hospital to Home program (H2H), which utilizes local level system change to impact patient outcomes post-discharge. H2H promotes health equity for all of our patients. Health educators provide tools and clarification to an underserved community to improve patient understanding of health management and increase self-efficacy.

Method: Two MMC Family Medicine practices use a multidisciplinary approach called the Hospital to Home program (H2H). H2H incorporates a team approach to better address the needs of patients who have been recently discharged from the hospital. The following providers are part of the H2H team: health educator, attending physician, pharmacist, social worker, registered nurse, medical office assistant, medical students/resident, care manager and translator. Patients have the opportunity to meet individually with each member of the care team during their visit. The health educators address several topics, including: goal-setting, advance care planning, information about health condition(s) and health education resources available.

Results: The outcome for the initial 6-month pilot was a reduction in readmission rates from 14.2% to 12.6%. H2H demonstrates that patient education and communication between systems are key to reduction of 30 day readmissions.

Conclusion: H2H strives to empower patients and their families to manage their health conditions and avoid readmission to the hospital. Using a multi-disciplinary approach, we're able to better meet individual healthcare needs. H2H has proven to be effective for decreasing hospital readmissions by improving patient-centered care.

Learning Objectives:

1. Describe how a multidisciplinary approach can promote health equity.
2. Name at least 2 health education components that can increase patient self-efficacy.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: The Clean Air Act as a Tool Against Environmental Health Threats

Lead Presenter: Lance Boucher

Second Presenter:

Third Presenter:

Organization: American Lung Association

Abstract:

This session will focus on how the Federal Clean Air Act has been designed and used as a tool for health equity in environmental health threats. It is well known that minority and impoverished communities, rural and urban, experience more exposure to air pollution. These exposures may be the result of where power plants, incinerators or large industrial facilities like paper mills are located. They may also arise from the siting of highways, railways and other sources of toxic emissions.

In this session we will review the provisions of the Clean Air Act that can and have been used by communities to push back against efforts to site or expand significant sources of air pollution. Some of these will be success stories and others will not. We will discuss strategies that can be used in Maine to address projects that will increase toxic emissions with a focus on unique situations in our state such as biomass energy production.

Finally we will discuss the threats to the Clean Air Act under the current administration, what is being done to push back and how attendees can get involved.

Learning Objectives:

1. Understand how the Clean Air Act can be used to respond to environmental health threats Identify local threats and opportunities to address air pollution using the Clean Air Act.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Death by Degrees: The health crisis of climate change in Maine

Lead Presenter: Janis Petzel, MD, DFAPA

Second Presenter:

Third Presenter:

Organization: Physicians for Social Responsibility Maine Chapter

Abstract:

Since PSR Maine first published the Death by Degrees (DbD) report over 17 years ago, climate change has taken hold of our state's fragile ecosystem. Sea levels have risen on our coast on average by a little over half an inch in just over a decade and about 7.5" since 1912. Temperatures are also on the rise. Maine's three climate divisions are warmer now than 30 years ago.

Maine has some of the highest rates of asthma in the country. The Maine CDC data shows that 11.7% of Maine adults currently have asthma compared to 8.9% nationally. The rate of asthma in Maine children is 9.1% similar to the 8.1% nationally. It is one of the leading reasons kids miss school.

Lyme disease is also on the rise following tick population growth in both number and distribution through Maine. In 2001, there were 108 cases of probable Lyme in Maine. Cases rise almost every year and in 2016, they reached 1488. (<http://bit.ly/MaineLymeGrowth>).

Respiratory problems and Lyme disease are the most notable effects of climate change on the health of all Mainers, but climate related illness and injury will likely disproportionately affect the health of the populations most at risk like children, elderly frail, those who are already ill, and low-income populations.

The best way to thwart these threats is to prevent them through climate mitigation, adaptation, public policy, and education.

The DbD presentation serves to educate medical and healthcare professionals, policy makers, and climate and health advocates about the health effects of climate change in Maine. The presentation and the 2015 report of the same name highlights some of the major health implications as a result of increased rainfall and temperatures and sea level rise.

Learning Objectives:

1. Identify the major connections between the influence of climate change and the resulting health consequences of vulnerable Maine populations
2. Understand public policy initiatives and options that can help to mitigate carbon pollution through energy efficiency and alternative and renewable energies.
3. Feel empowered to take action on and advocate for public policy changes and reform that would mitigate climate change or facilitate adaptation to protect human health.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Realizing RALA Potential: How a statewide Rural Active Living Assessment (RALA) will be used to impact Maine's health

Lead Presenter: Amanda Jordan, MSUS - MCC Environmental Steward

Second Presenter: Dawn Littlefield-Gordon, Healthy Weight Coordinator

Third Presenter: Doug Beck, Outdoor Recreation Supervisor

Organization: Medical Care Development, Inc.

Abstract:

Background: In 2009-2010, the Maine Center for Disease Control contracted with individual public health coalitions for Rural Active Living Assessments (RALA) to be performed in every municipality. This was done in order to determine the existence and adequacy of outdoor recreation facilities and programming (or lack thereof) throughout the state. Because rural communities often face higher levels of health inequity in terms of accessibility to public or private amenities for recreation and/or funding for these amenities, the information obtained by the RALAs can be instrumental in determining areas for improvement and future planning consideration for municipal, county, state and tribal agencies.

Statewide Impact: This data is currently being cleaned and verified. It will be used to inform the next iteration of the State Comprehensive Outdoor Recreation Plan (SCORP) set to launch in 2019.

The Maine State Comprehensive Outdoor Recreation Plan (SCORP) is used to qualify Maine to receive Federal Land and Water Conservation Funds and satisfies state legislative requirements that help guide the state's Bureau of Parks & Lands decision making. The SCORP identifies the demand for and supply of outdoor recreation areas and facilities based on available information, and discusses outdoor recreation issues of statewide importance based on public input.

Municipal Impact: The RALA data will be included in the data sets provided by the Municipal Planning Assistance Program to communities creating or updating their comprehensive plans, thereby assisting planning committees in addressing the adequacy of recreation facilities and programming in their comprehensive plans. Local jurisdictions can harvest this data to inform their needs assessment of places for physical activity, especially when the data is used in relation to local demographics in the context of proximity to potential user groups.

Learning Objectives:

1. Demonstrate how RALA data can be used to identify areas for improvement and future planning considerations at the municipal, county, state and tribal agencies levels relating to outdoor recreation facilities and programming.
2. Explain the SCORP and the important role RALA data plays in informing the next iteration of the plan.
3. Discuss how RALA data can be harvested by the Municipal Planning Assistance Program to help communities as they begin updating their own comprehensive plans in relation to the overall SCORP.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: One of UNE's Efforts to Increase the Number of Rural Health Providers

Lead Presenter: Janet Dosseva, MPH

Second Presenter: Ian Imbert, MPH

Third Presenter:

Organization: University of New England

Abstract:

The University of New England (UNE) is a leader in providing health profession education in Maine. Maine is the most rural state in the United States and is home to a significant aging population per the 2010 US Census. To address the unique healthcare needs associated with these findings, UNE faculty in the Center for Excellence in Health Innovation (CEHI) developed the Rural Health Immersion (RHI) in 2016. The program was piloted in Spring of 2016 in Aroostook County, Maine's northernmost county. The RHI was created to expand clinical learning opportunities in rural communities and to increase student interest in rural health. Students of various health professions participate in an interprofessional setting and are exposed to rural health, public health, and cultural issues that these communities face. Student and faculty feedback was evaluated and incorporated into implementing additional rural healthcare immersions. Two more immersions were launched, in March 2017 in Western Maine and in May 2017 in Mid Coast Maine. Students from UNE's College of Osteopathic Medicine, College of Pharmacy, College of Dental Medicine, and Nursing program have participated in the RHI program. 43 students have participated in total between the three RHIs, and a pre/post survey shows that perception of rural health and future interests in practicing in rural settings have improved. These immersions were supported in part by the Maine Area Health Education Center (AHEC), the Josiah Macy Jr. Foundation, the UNE Center for Excellence in Health Innovation, as well as specific colleges within UNE. UNE's Center for Excellence in Health Innovation plans on not only continuing to offer these RHI experiences, but also to create new immersive programs to address health disparities, raise awareness, and provide innovative interprofessional clinical education opportunities to additional graduate health professions students.

Learning Objectives:

1. Assess the strengths and challenges of a rural community and the role of health care and public health.
2. Describe the benefits and strategies for team-based care in a rural community.
3. List skills and competencies required for working in rural health.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Isolation, Alzheimer's Disease, and Dementia in Maine: A Look at new public health data, challenges, and solutions

Lead Presenter: Adam Lacher

Second Presenter:

Third Presenter:

Organization: Alzheimer's Association, Maine Chapter

Abstract:

Living alone has a health detriment comparable to smoking 15 cigarettes a day and is associated with higher incidences of Alzheimer's disease and other forms of dementia. Here in the United States 1/3 of those aged 45 and over who report worsening memory problems live alone. A June 2017 Alzheimer's Association survey found 2 out of 3 Alzheimer's and dementia family caregivers felt isolated or alone in their situation, and more than 4 in 5 caregivers would have liked more support with caregiving. Data from the 2015 Behavioral Risk Factor Surveillance System for Dementia Caregiving in Maine found 1/3 of Alzheimer's and dementia family caregivers have provided unpaid care at home for more than 5 years. This is a significant increase from the 1/5 who were doing so in 2009. A May 2017 report from the Centers for Disease Control found deaths of Alzheimer's at home (vs. nursing homes and long-term care facilities) increased during the 1999-2014 time period, from 14 percent to 25 percent. This presentation will explore various local and federal efforts currently in place to address this pressing public health issue. Participants will be introduced to the local Social Engagement Programs, the Prevention and Public Health Funds, the Alzheimer's Disease Initiative, the Alzheimer's Disease Supportive Service Program, the Healthy Brain Initiative, the State Plan for Alzheimer's Disease and Related Forms of Dementias in Maine, new encouraging risk reduction research on developing Alzheimer's and other forms of dementia, as well as new research from Tufts Medical Center demonstrating the benefits of early diagnosis and care planning.

Learning Objectives:

1. Identify at least one way to improve the quality of life for those who live alone with Alzheimer's disease or other form of dementia
2. Identify at least one way to support family caregivers of those with Alzheimer's disease or other form of dementia.
3. Identify at least one way to reduce the risk of developing Alzheimer's disease or related form of dementia.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Rural Health Disparities in Maine

Lead Presenter: Dora Anne Mills, MD, MPH, FAAP

Second Presenter:

Third Presenter:

Organization: University of New England

Abstract:

Several recent analyses have highlighted the increasing health disparities seen in rural America. With Maine being one of the most rural states in the nation (61% of Mainers living in rural areas, compared with about 20% nationally), it is especially important that rural disparities are addressed in Maine. This presentation will review some recent national analyses that include Maine data, note some of the challenges in measuring rural disparities, and engage with the audience to develop some overarching strategies to address rural disparities in Maine.

Learning Objectives:

1. Identify at least three areas of health disparities faced by those living in rural Maine and that are backed by credible data sources.
2. Describe challenges in measuring rural health disparities.
3. Discuss strategies and challenges to addressing rural health disparities in Maine.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: What People Want: Patient preferences of primary care support to increase physical activity in a rural\New England free health clinic population
Lead Presenter: Patricia Thompson Leavitt, DNP, FNP
Second Presenter:
Third Presenter:
Organization: University of Southern Maine

Abstract:

Introduction:

Nationwide, adults engage in less than recommended levels of physical activity despite known benefits. Little research has been done to determine the factors that encourage adults to pursue and maintain a physically active lifestyle. This study expands current knowledge about the preferences of disadvantaged rural dwelling adults regarding primary care support for increasing patient exercise levels.

Methods:

A low literacy postal survey was developed, combining validated survey instruments (RAPA™ and Exercise Readiness Scale), a previously reported survey that explored patient preferences for physical activity support (Daley, et al., 2011), and de novo questions. Survey questions required forced-choice responses with no open comment fields. The purposive survey sample included adult patients who had a wellness exam within the 24 months prior to the survey mailing (N = 206).

Results:

Fifty seven surveys (28%) were returned. The respondent mean age was 53 years; 70% were females; 90% were white/non-Hispanic. Most (63%) were overweight or obese. Most respondents (58%) reported physical activity levels below recommended national standards. Thirteen percent of respondents were in either pre contemplation or contemplation stages of readiness to exercise; 44% were in the preparation or action stage; and 32% percent of respondents were in the maintenance stage.

Learning Objectives:

1. Describe the methods used in this study to elicit patient preferences about support for exercise efforts.
2. Discuss the key findings of the survey research and its application to public health planning activities.
3. Formulate potential research activities to assess the exercise support preferences of target populations.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Unsealed Fate: The unintended consequences of inadequate safeguarding of juvenile records in Maine

Lead Presenter: Susy Hawes, BA

Second Presenter: Jill Ward, JD

Third Presenter: George Shaler, MPH

Organization: University of Southern Maine

Abstract:

Introduction: This research explores the extent to which limited safeguarding of juvenile records stemming from involvement in the juvenile justice system puts individuals in Maine at risk of facing collateral consequences.

Methodology: Researchers from the University of Southern Maine, in collaboration with the University of Maine School of Law, employed a mixed-methods approach including statute research, practice and policy review and qualitative data collection. Focus groups, interviews and surveys with more than 200 people throughout Maine provided insights into the juvenile justice system, what is commonly understood about the handling of records related to system involvement, and the impact of such records.

Findings: Results reveal persistent misunderstanding, confusion and inconsistencies surrounding the policies, practices and laws that govern safeguarding and sealing juvenile records. The myth that records are automatically sealed at age 18 makes it less likely that individuals will seek to have their records sealed and increases the likelihood they will face collateral consequences that impact social, economic, and environmental determinants on health. Individuals with juvenile records report experiencing marginalization and stigmatization and face significant barriers in application processes, securing employment, enrolling in the military and to a lesser extent, accessing housing, education and financial supports.

Recommendations: Suggestions that were most consistently cited throughout the research include increasing stakeholder training and education, revising or developing and formalizing system and personnel guidance, making changes in law and administrative practice, raising public awareness, and ensuring youth and families access to information.

Learning Objectives:

1. Discuss potential collateral consequences of having a juvenile record in Maine.
2. Identify possible opportunities for reform based on the research that would improve how juvenile records are safeguarded in Maine.
3. Explain whether or not juvenile records in Maine are automatically sealed at age 18.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Relationships Between Lung Cancer Mortality and Smoking, Education and Poverty in Maine

Lead Presenter: Lee Lucas, RN, MS, PhD

Second Presenter: Leo Waterston, MA

Third Presenter: Kathleen Fairfield, MD, MPH, DrPH

Organization: Maine Medical Center

Abstract:

Background: Maine Lung Cancer Coalition (MLCC) is a statewide effort to improve prevention, screening and access to treatment for lung cancer.

While MLCC has a statewide reach, it has a particular focus on addressing the needs and barriers of rural, low-income people who are not well connected to the healthcare system. We have conducted preliminary analyses to describe regional differences in lung cancer mortality and the relationship between lung cancer mortality and social determinants to inform local outreach for prevention and screening.

Methods: We conducted a population-based cross-sectional analysis of: 1) lung cancer deaths in Maine from 2010-2014, ascertained by the state death registry; 2) smoking prevalence 3) education and (4) income, all ascertained by the Behavioral Risk Factor Surveillance System (BRFSS). Analyses examined small-area geographic variation in and association between all of these factors at the Hospital Service Area (HSA) Level, focusing on identifying predictors of lung cancer mortality.

Results: Among 784,873 adults aged 35+ in Maine HSAs, 4635 died of lung cancer between 2010-2014. Lung cancer mortality rates (age and sex adjusted) varied markedly by HSA, ranging from 61.3 to 165.7 deaths per 100,000 person-years. There were marked differences across the 32 Maine HSAs in rates of smoking (range 12.4% to 28.6%), low education (4.7%-17.0%) and poverty (4.4% to 21.1%). We observed strong correlations between regional prevalence of smoking, poverty, low education, and lung cancer mortality.

Conclusions: There is substantial small-area geographic variation in lung cancer mortality, smoking, and sociodemographic characteristics, which are all strongly correlated with one other. Efforts to improve prevention and screening for lung cancer should include targeting high risk areas with innovative engagement strategies that address social determinants of health. Future analyses will include tumor registry data to ascertain differences in incidence and stage at diagnosis by hospital service area.

Learning Objectives:

1. Understand regional variation in lung cancer mortality and risk factors across Maine.
2. Describe the relationship between lung cancer mortality and social determinants.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Clinical Community Linkages as a Population Health Strategy

Lead Presenter: LeeAnna Lavoie, CHES

Second Presenter: Brie Karstens

Third Presenter:

Organization: MaineGeneral Medical Center

Abstract:

Health care, public health and community based organizations are working together to improve the health of populations in the Central Public Health District. MaineGeneral, HealthReach Community Health Centers, Redington Fariview General Hospital and privately owned primary care practices have formed a partnership to improve linkages from the clinic to community located evidence based programs (EBP) to improve health. The US CDC defines clinical-community linkages (CCL) as "connections between clinical and community sectors to improve population health." Clinical-community linkages should: ensure patients with or at risk for chronic disease have access to community resources and support to prevent, delay, or manage these conditions; integrate interventions such as clinical referral, community delivery, and third-party payment to ensure effective programming; and increase the likelihood that people with or at risk for chronic disease will follow providers' orders to take charge of their health (Lane & Jayapaul-Philip, 2014).

This partnership was initiated with funds from CDC's, Partnerships to Improve Community Health (PICH) program. CCL requires implementation of system changes in primary care so population of patients are screened for disease risk and referred to EBP. Valuable population health data on disease risk informs the community partners re programs needed to support health in the community. Through this grant, we've implemented system changes to standardize screening and referral to community EBPs and built a network of EBPs at the YMCAs, Spectrum Generations, housing projects, churches, town offices, senior living centers, primary care practices, etc.

In order to reach the most vulnerable populations, staff identified 18 census track areas where there were high levels of poverty and low education attainment. This information informed us where to deliver EBP to reach this population. Over the past 3 years we've expanded community partnerships and delivery sites from 24 to 52 and enrolled hundreds of patients in EBPs.

Learning Objectives:

1. Understand the concept of clinical community linkage.
2. Learn 2-3 systems change processes to standardize screening and referring to evidence based programs.
3. Understand key strategies to building capacity as the referral demands increase.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Addressing the Age and Diversity Gaps in the US SUD Prevention Workforce

Lead Presenter: Scott M. Gagnon, MPP, PS-C

Second Presenter:

Third Presenter:

Organization: AdCare Educational Institute of Maine, Inc.

Abstract:

SAMHSA's Center for Substance Abuse Prevention National Advisory Council (CSAP NAC) has been engaged in a year and a half project focused on the nation's substance use disorder (SUD) prevention workforce. The project entailed gathering quantitative data as well as conducting key informant interviews to provide a window on the state of the SUD prevention workforce and where it needs to go from here. The ultimate goal was to analyze the data and information gathered and formulate recommendations to SAMHSA on how it could develop initiatives and objectives to advance the SUD prevention workforce. Data gathered included demographic data from the International Certification & Reciprocity Consortium (IC & RC) which provides the national certification for prevention professionals. This data demonstrates that, like other fields within behavioral health, the prevention workforce is an aging workforce. Additionally, analysis shows that there are huge demographic gaps within the national credentialed prevention workforce, notably in the areas of gender and ethnicity/race. These gaps have significant implications for the work of prevention especially within the context of providing prevention programming that is culturally competent. This presentation will provide an overview of the data gathered by the CSAP NAC, a discussion of the implications of the data, and the recommendations made to SAMHSA to advance a diverse and sufficiently skilled prevention workforce.

Learning Objectives:

1. Describe the demographics of the nation's SUD prevention workforce.
2. Describe the implications of demographic gaps in the prevention workforce.
3. Describe CSAP NACs recommendations to SAMSHA to address SUD prevention workforce demographic gaps.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Tobacco-Free Old Port Fest: A data-driven and collaborative approach

Lead Presenter: Anne Lang, MPH

Second Presenter: Amy Geren, MS

Third Presenter:

Organization: City of Portland

Abstract:

Tobacco use is the most preventable cause of disease, death, and disability in both Maine and the United States. Additionally, secondhand smoke exposure has been causally linked to cancer, respiratory and cardiovascular diseases in adults, and adverse effects on infant and child health, such as respiratory and ear infections. While the percentage of Maine adults who smoke cigarettes has declined significantly over time, about one-fifth of Mainer and 17.0 percent of Cumberland County adults still smoke. Youth secondhand smoke exposure in Cumberland County is significantly lower than the state average, however, it is still high at 30.6%.

A 2016 year-end program evaluation of Portland Downtown's International Downtown Association award winning Police Cadet Program found that smoking violations were consistently the highest ordinance violation throughout the season. Consequently, Portland Downtown (PD) reached out to the City of Portland's Tobacco Prevention Program (TPP) manager for assistance affecting change. At the TPP's suggestion, PD added another level of data collection to the cadets' reporting, including knowledge of the ordinance and awareness of no smoking signage in areas where smoking is prohibited, and instructed the cadets to offer Maine Tobacco Helpline information to offenders receptive to cessation materials. PD's relationship with the TPP resulted in a partnership initiative to pilot a smoke- and tobacco-free Old Port Festival (OPF). Observations and enforcement at the OPF indicated the effort was impactful: the few violators complied when reminded, event organizers received words of praise and appreciation for the initiative, and frequent downtown visitors commented on air quality in the festival zone.

This presentation will introduce learners to creative data collection techniques that support public health demand for smoke- and tobacco-free initiatives, and simple implementation strategies to make large events smoke- and tobacco-free, including educating the community and event partners on the initiative.

Learning Objectives:

1. Assess perceptions and violations regarding public smoking and cigarette litter.
2. Implement simple strategies to make a big event smoke- and tobacco-free.
3. Educate community and partners on smoke- and tobacco-free initiatives.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: A County-Wide Model for Health Improvement from the Oxford County Wellness Collaborative

Lead Presenter: Jim Douglas, M.Ed.

Second Presenter: Brendan Schauffler

Third Presenter:

Organization: Oxford County Wellness Collaborative

Abstract:

The Oxford County Wellness Collaborative (OCWC), a network comprised of 300+ individual and organization partners including local healthcare and Maine-based philanthropies, strives to engage all community members in working together to transform personal, environmental, and economic health across the county by building strong relationships among people and organizations. OCWC works to foster positive health outcomes by providing opportunities for citizens to build social capital, and by supporting a collective framework approach to health production. The Collaborative priorities are based on innovative county-wide community engagement work, which culminated in a large group gathering centered on root cause analysis of health challenges. This process identified isolation/disconnection/not feeling valued as the most common concern in regards to poor health and wellness. Subsequently, a series of Community Health Needs Assessment forums identified obesity and substance use disorders as the specific health issues most needing attention. Five workgroups address OCWC's initiatives: Community Safety, Healthy Eating, Active Living, Community Engagement, and Behavioral Health. Successful activities of the five workgroups include Crisis Intervention Team training for law enforcement, film showings to foster conversations about childhood trauma and resilience, regional conferences on active living, and Restorative Community Dialog trainings. Surveys support the positive influence that OCWC membership has had on personal health behaviors, perceptions of others, and commitment to supporting action to build a healthier county. Results from the Wilder Collaborative Factors Inventory point to the idea that OCWC is a healthy, valuable network for driving change. This presentation will highlight a unique collective framework partnership of community, healthcare, and philanthropy, focused on place-based health and wellness.

Learning Objectives:

1. Explain how social isolation and feelings of disconnectedness can contribute to obesity and substance use disorder.
2. Describe essential components of a collective framework approach to socio-behavioral change and health outcomes.
3. Lessons learned in community engagement.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Leveraging Social Determinants of Health Data to Improve Population Health Outcomes

Lead Presenter: Kalie Hess, MPH

Second Presenter: Ashley Mills, MHA

Third Presenter:

Organization: Maine Primary Care Association

Abstract:

The Federally Qualified Health Center (FQHC) model of care recognizes that in order to achieve progress on health outcomes both health care and social services must be provided. Patients with significant challenges related to their social determinants of health (SDH) are less likely to have positive health outcomes. As such, FQHCs across the state have been involved in projects working with a range of community partners to best serve patients with these needs. Despite progress on this front, there remain challenges in the primary care setting with regards to collecting SDH data, acting on patient needs, and representing data in a standardized way.

The Maine Primary Care Association (MPCA), in partnership with the FQHCs, has begun an initiative to build on current progress to address these challenges. All FQHCs have agreed to begin collecting standardized data on food, housing, and transportation needs because we know many FQHC patients struggle with these needs. To support this work, MPCA will provide technology, work flow, and community referral support as well as data aggregation and analysis to link SDH data with health outcomes at the local level. By supporting health centers to collect this data and create referral and follow-up networks, FQHCs can leverage partnerships and drive alignment with other community based organizations to truly meet the basic needs of Maine's most vulnerable citizens.

This presentation highlights Maine FQHC successes and challenges with collecting and acting on SDH data, as well as the challenges with representing this data in a standardized way; how the MPCA plans to advance this initiative through technology support, work flow support, and data collection; and how this project has the potential to create opportunities for policy change and advocacy in Maine. Finally, we will elicit knowledge sharing approaches for improvement and partnerships in the project.

Learning Objectives:

1. Demonstrate challenges primary care settings have in collecting social determinants of health data and addressing identified needs.
2. Discuss the successes, solutions, and opportunities for improvement with regards to collecting social determinants of health data and addressing identified needs.
3. Identify opportunities for alignment of effort between community partners and for advocacy purposes using this data.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Lead Poisoning is Preventable: Maine's data-driven primary prevention strategy

Lead Presenter: Karyn Butts, MPH

Second Presenter:

Third Presenter:

Organization: Maine CDC

Abstract:

While lead poisoning is one of the greatest environmental health threats for children in Maine, it is preventable. In 2005, the Maine Legislature established the Lead Poisoning Prevention Fund (LPPF) in order to accelerate progress toward the elimination of childhood lead poisoning. Maine CDC is the steward of this dedicated source of revenue that comes from a fee of \$0.25 assessed on every gallon of paint sold in the state. In this session we will review the town-level spatial analyses of lead poisoning surveillance, poverty and housing data that are driving how Maine uses the resources of the LPPF to target community-based primary prevention activities in areas at high risk for childhood lead poisoning. Data gathered from case management activities, including findings that majority of children identified with lead poisoning live in housing built before 1950, are enrolled in MaineCare, and/or live in rental housing are also used to target prevention activities and messages. We will also describe the community-based efforts that have been ongoing in Maine's high-risk areas since 2009 and discuss how lead poisoning rates have decreased in all high-risk areas since. Comparing data from 2011-2015 to a baseline period of 2003-2007 shows declines in the percentages of children with lead poisoning in all high-risk areas, ranging from a decrease of 70% in Bangor to 37% in Lewiston/Auburn. Efforts to prevent lead poisoning in subpopulations such as immigrants, refugees and asylum seekers amidst complications such as lead exposures that occurred prior to entering the US will also be discussed. We will finish the session with a discussion of how we plan to continue this success story and the future of lead poisoning prevention efforts in Maine.

Learning Objectives:

1. Explain the way Maine targets lead poisoning primary prevention resources.
2. Describe changes in lead poisoning rates in areas at high risk for childhood lead poisoning.
3. Identify challenges to preventing childhood lead poisoning among immigrant, refugee and asylum seekers.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Addressing the Arsenic Crisis in Maine: The rural/urban divide

Lead Presenter: Emily Postman

Second Presenter:

Third Presenter:

Organization: Environmental Health Strategy Center

Abstract:

A growing body of evidence traces elevated rates cancers to arsenic exposure in drinking water. A 2016 study at the National Institutes of Health cited a statistically significant correlation between higher rates of bladder cancer in Northern New England and elevated levels of arsenic the water in those regions, including Maine.

While those who live in urban and suburban areas can expect water that comes out of the tap to meet specific science-based safety thresholds set forth by the EPA, those standards only apply to municipal water supplies -- leaving rural communities, which rely primarily on well water, completely unprotected. Over half of the population in Maine relies on well water, and 1 in 8 of those wells are contaminated with arsenic levels which exceed the EPA's safety threshold, sometimes by more than thirty fold.

To help address this problem, a team of public health organizations, local businesses, and directly-affected individuals successfully passed LD 454 into law this past summer, a major milestone for this issue in Maine. This legislation will increase outreach and educations efforts, and help provide funds for free test kits for low-income Mainers. However, more work is needed to address the disparate impacts of arsenic in Maine. Looking forward, Maine must continue to prioritize education, invest funding for testing and treatment for lower-income families, and institute protections for tenants to ensure our rural communities are protected.

During this session, we'll describe the process and coalition that resulted in the passage of LD 454, and discuss the remaining challenges that need to be overcome. We will present opportunities for health care providers and public health advocates to eliminate the urban and rural disparities in drinking water safety and the health impacts they cause.

Learning Objectives:

1. Describe the arsenic crisis and how it is affecting rural.
2. Maine Identify strategies to help address the arsenic crisis.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Evaluating Strategies for Improving the Food Security Network in Rural Maine

Lead Presenter: Jennifer Pratt, AA

Second Presenter: Anush Hansen, MS, MA

Third Presenter: Brenda Joly, PhD

Organization: University of Southern Maine

Abstract:

Maine has the highest rate of food insecurity in the northeast, and ranks the ninth highest in the country for “very low” food security. About one in four children in Maine are food insecure and approximately fourteen percent (14%) of seniors are food insecure. The Northern Maine Rural Collaborative (NMRC), based at Eastern Maine Healthcare Systems (EMHS) and funded by a CDC Partnerships to Improve Community Health (PICH) grant, has worked since 2014 with communities and partners in seven rural Maine counties to improve food security and access to healthy foods, especially among vulnerable, rural Mainers. By collaborating with community health coalitions, the Good Shepherd Food Bank, and area food pantries, the NMRC has worked to improve food pantry capacity, nutrition policies, gleaning efforts, communication, and resource sharing, to enhance the food security network and increase access to healthy foods in northern Maine.

This presentation will describe the University of Southern Maine’s evaluation of NMRC activities with local food pantries, and the use of a statewide Food Pantry Director Survey to inform and measure the strategies used by NMRC partners to improve the food security network in northern Maine. We will highlight specific NMRC food security strategies, evaluation methods, baseline and follow-up survey findings, lessons learned, and opportunities for replication in other rural areas.

Learning Objectives:

1. Participants will learn about community based approaches for increasing food pantry capacity and policies related to procuring, storing, and distributing healthy foods to residents in need.
2. Participants will learn about evaluation methods for measuring the NMRC, and the impact of NMRC efforts to help enhance the capacity of area food pantries, and the food security network in the seven northern counties of Maine.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Food Sovereignty Policy: Increasing access or an outbreak waiting to happen?

Lead Presenter: Jennifer Gunderman, MPH

Second Presenter:

Third Presenter:

Organization: University of New England

Abstract:

According to the Maine Shared Community Health Assessment (2015), almost 1 in 5 adults in Maine have one or less serving of vegetables a day. This health measure indicates a significant public health issue. Key factors contributing to poor diet is lack of access to healthy foods. Lack of access can be due to challenges with transportation, personal economic instability, food deserts, food retailers who do not participate in assistance programs, and easy access to fast food retailers.

While many Mainers face obstacles to accessing health foods, the state is experiencing a growth in farms/food producers, farmers' markets, and programs aimed at decreasing obstacles to access. There is wonderful opportunity for farmers to be financially successful and for people to have increased access to healthy foods. This has set the stage for food sovereignty policy.

Food sovereignty policies allow farmers/local producers to sell their food without adhering to state food licensure laws. By law, certain foods must be processed under strict policy that include inspections of facilities and testing of products. Farmers and food producers have reported increase burden and costs. For example, laws require meats to be processed at USDA certified locations. These locations are limited in Maine and result in higher costs for farmers. To overcome these obstacles, communities are passing food sovereignty laws.

While food sovereignty policy has been crafted with an aim to support its community, it also increases the risk of foodborne outbreak. Food licensure and inspection laws were created to protect consumers from disease and injury. A compromise to these laws can lead to outbreaks resulting in significant illness, long term injury, and death.

Public health has a role in balancing the two priorities- increasing access to health foods and protecting the community from disease.

Learning Objectives:

- 1. Describe purpose, key components, and status of food sovereignty policy in Maine.
2. List the impacts of food sovereignty policy on public health.
3. Explain how public health practice can address the issues of access to health foods and food safety.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Nutrition Incentives in Maine: Health In Public Spaces

Lead Presenter: Shannon Grimes

Second Presenter: Sherie Blumenthal

Third Presenter: Jimmy DeBiasi

Organization: Maine Farmland Trust; Maine Local Foods Access Network

Abstract:

Nutrition incentive programs like Maine Harvest Bucks make the healthy choice an easier choice for low-income Mainers by providing bonus local fruits and vegetables to customers who shop, typically using SNAP/EBT, at participating venues. Now with more than 75 participating sites including farmers markets, CSAs, food hubs, a mobile market, food co-ops and other small stores offering nutrition incentive programs across the state, locally-grown fruits and vegetables are becoming more accessible to all.

The benefits are many: Increased access to healthy foods for those in need; an expanded consumer base for local farmers; and stronger community connections between growers and eaters. Nutrition incentives make it easier for low-income Mainers to choose the healthy option and purchase more fruits and vegetables for their families. Our data indicate that SNAP shoppers want to eat healthy (and support their local farmers) and will make the choice when they have the financial means to do so. In 2016 alone, our programs provided over \$130,000 worth of local fruits and vegetables to households using SNAP/EBT benefits (food stamps) and the impact continues to grow.

In 2016, nutrition incentive programs reached more than 3,000 SNAP households in Maine and there is much more work to be done. Partnering with the health community is a priority for the Maine Local Foods Access Network, a group of organizations that have been collaborating to support the implementation of nutrition incentive programs in Maine since 2011. With so many more Mainers who could benefit from a healthier diet but who may struggle to access or afford fruits and vegetables, nutrition incentives are a proven tool to put produce within reach. And spreading the word about nutrition incentive programs can provide an opening to discuss diet and health in public spaces.

Learning Objectives:

1. Learn the impact nutrition incentive programming has had in Maine so far.
2. Discuss other barriers to low-income access to healthy, local food Identify how to help expand the reach of nutrition incentive programming.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Assessing the Extent of Digital Food and Beverage Marketing to Students in Middle Schools: A national sample

Lead Presenter: Michele Polacsek, PhD MHS

Second Presenter:

Third Presenter:

Organization: University of New England

Abstract:

Background:

Food advertising affects children's food choices, food purchase requests, diets, and health. The food industry spent nearly 2 billion dollars on youth-directed food marketing in 2012 – 90% of which was for unhealthy foods high in sugar, fat and sodium. Schools are important targets for marketing because advertising at school is especially powerful. Children and parents trust what happens at school. Additionally, adolescent youths are exceptionally vulnerable to marketing due to age-related developmental and social insecurities. School-based marketing conflicts with the purpose and values of education and reinforces marketing outside of school, which threatens health, self esteem, body image, learning processes and personal development. Digital marketing (DM) is relatively low cost, but powerful. It is often disguised as entertainment (e.g. advergames) and is highly engaging and interactive. Children's digital use tends to be unsupervised and they often determine for themselves how much and how long they are exposed to marketing.

Aims:

Aim 1: Pretest, pilot, and prepare to field a school-based DM survey developed under previous funding. Aim 2: Assess DM environments (policies, practices, administrators' attitudes) using the new survey tool in a national sample of middle schools comparing census regions, urban and rural, as well as minority and majority population school districts. Aim 2a: Pilot the student response section of the DM tool to explore use of school and personal digital devices, students' use of social media during the school day, and perceptions about DM at school among 100 middle school students in one Maine school district. Aim 3: Based on survey findings, develop recommendations for further assessment, policy, and practical approaches to limit DM to students.

Results:

Study findings as well as draft policy recommendations will be presented. Data analysis is beginning June 2017

Learning Objectives:

1. Name threats posed by DM.
2. Describe middle student exposure to DM, nationally.
3. Outline key policies and procedures that can be used by schools and school districts to minimize unwanted DM.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Health on the Move: Promoting health equity

Lead Presenter: Kolawole A. Bankole, MD, MS, MBA

Second Presenter: Caity Hager

Third Presenter:

Organization: City of Portland

Abstract:

Health on the Move (HOTM) is a collaborative mobile health access project that brings health resources into community settings to break down barriers that limit access to preventive health services and screenings for vulnerable populations.

The primary goal of HOTM is to reduce health disparities by bringing health resources to the communities where the target population lives. HOTM events are planned by a team including District Coordinating Council members, local organizations that know and serve the target population, and members of the community. The Cumberland District Public Health Council collaboratively led eight HOTM events that reached nearly 500 community members and provided services such as flu immunizations, blood pressure screenings, vision screening with access to eyeglasses, dental screenings, chronic disease prevention information, and linked those in need to a primary care provider and health insurance resources. At each community event, data was collected on the number of community members accessing preventive health services at the events as well as information about the planning team and process leading up to the events. At many of the events, participant feedback surveys collecting demographic information and information regarding individual's access to preventive health care were collected. Following an initial series of pilot HOTM events, a HOTM toolkit was created to share best-practices and provide a tested format for planning, executing, and evaluating a successful community event.

The HOTM program enhanced community partnerships, increased access to preventive services for vulnerable populations, and produced replicable model that can be used in other communities to help reduce health disparities.

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Learning Objectives:

1. Participants will learn about a model to increase access to screenings, preventive services, primary care providers, and health promotion resources.
2. Participants will learn how to create success events to reach vulnerable populations with limited resources, time, and funding.
3. Participants will learn how to enhance emergency preparedness capacity and the public health system's ability to reach underserved communities quickly when needed.

2017 MPHA ANNUAL CONFERENCE

ABSTRACTS

Presentation Title: Access to Care: Bridging the gap for Portland's most vulnerable citizens

Lead Presenter: Bridget Rauscher PS-P

Second Presenter: Matthew Sholl, MD

Third Presenter:

Organization: City of Portland Public Health Division

Abstract:

Through a collaboration between Portland's Public Health Division, the Portland Fire Department, the Oxford Street Shelter and Milestone Foundation, the Mobile Medical Outreach, Resources and Education (MMORE) Project was created as a pilot in response to the need for increased access to substance use prevention services and quality medical care for Portland's homeless citizens, who are disproportionately impacted by health disparities. Based on the model of community paramedicine, MMORE providers are intentionally placed in areas of Portland where individuals cannot or do not access preventative medical care.

Throughout the thirteen month project period (5/1/17-6/30/18), specially trained paramedics are placed with Milestone Foundation's Homeless Outreach and Mobile Engagement (HOME) Team as well as at the Oxford Street Shelter. The paramedics are available to assess and respond to medical concerns and provide community resources and referrals in response to their needs, under medical direction.

In the project's first eight weeks, paramedics made contact with 51 unique individuals. Of these 51 individuals, 46 reported a history of substance use and 42 reported not being connected to primary care. Each individual received a primary care referral to either Greater Portland Health or the Maine Medical Center/Preble Street Learning Collaborative. These referral sources were chosen in part, due to proximity, but additionally because each program relies on outreach case managers to assist with ensuring follow up for the individual.

While the project is still in its infancy, we anticipate a reduction in inpatient hospital visits for those who actively engage in primary care. We will also be tracking health disparities related to substance use and the trend toward housing stability for these individuals. We intend to gather primary care follow up and housing data on a quarterly basis, as well as estimated cost savings for the provision of preventative care for specific cases.

Learning Objectives:

1. Demonstrate correlation between chronic homelessness and access to primary care.
2. Discuss high rates of substance use among chronically homeless individuals in Portland. Evaluate cost savings of community-based paramedic pilot project.