Shining Light on Inequities in Pediatric Care

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Steve DiGiovanni, MD – MaineHealth
Chris McLaughlin, MSW, LCSW – Inspired Consulting Group

March 28, 2026

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Overarching Learning Objectives

- Identify key health disparities affecting pediatric populations and describe how structural and systemic inequities influence access to care, quality of services, and health outcomes for children and adolescents.
- Apply concepts related to health equity to clinical practice by analyzing pediatric case examples that highlight disparities in assessment, treatment planning, family engagement, and care coordination.

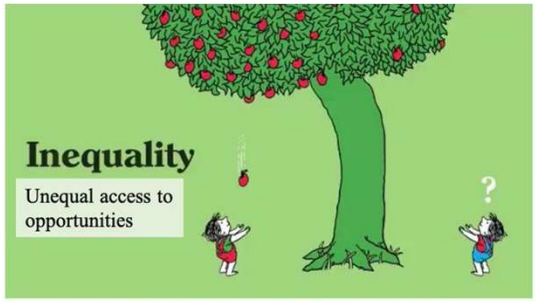
2

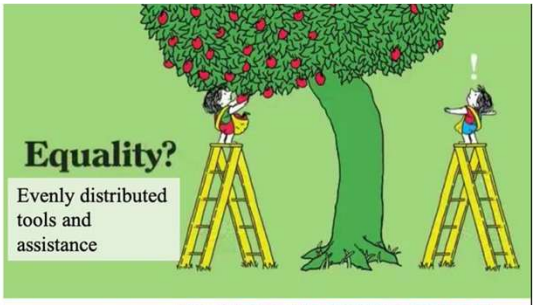
Shared Purpose

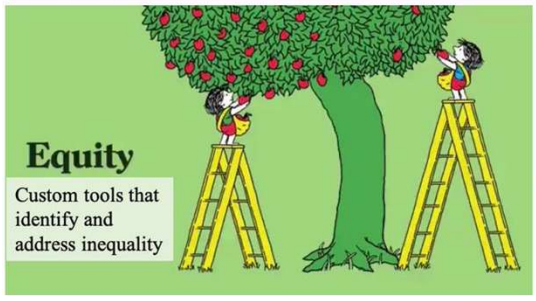
Prevention Protection Possibility

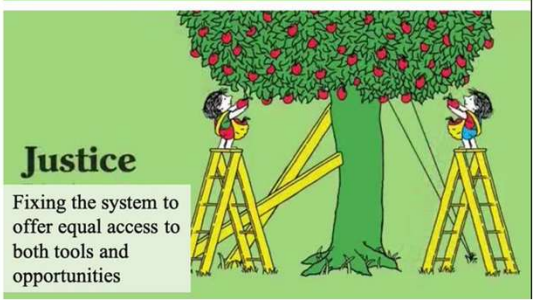
3

The Principle of Health Equity









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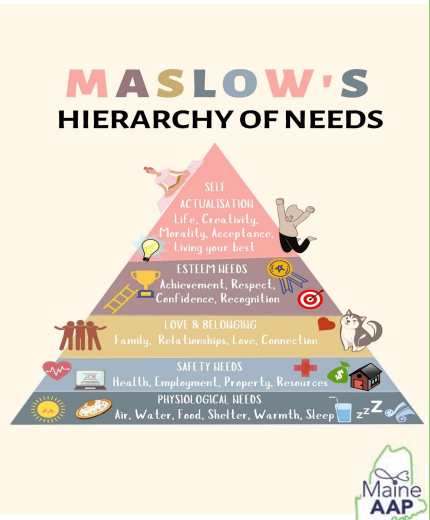
Social Determinants of Health (SDOH)

1. Native Americans and Alaska Natives have an infant mortality rate that is 60% higher than the rate for their white counterparts.
2. Socioeconomic status is related to such outcomes as healthcare consistency, involvement with the Child Protective System, and rates of childhood obesity.
3. Residents of neighborhoods with fewer fresh produce sources ("food deserts") are at higher risk of obesity and diabetes.



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Differences That Matter

When we're talking health inequities, we're talking about differences that really matter!

These differences are:

1) Systemic
2) Avoidable
3) Shaped by systems, not individual choices and actions

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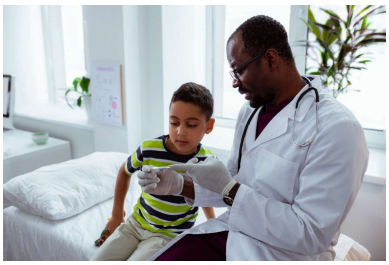
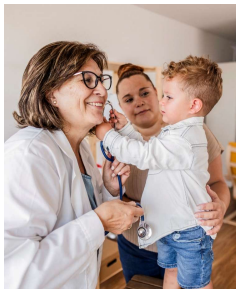
Where Inequities Show Up in Clinical Care

Access

Communication



Trust



Outcomes

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Today's Lens

- Adolescent and vaping
- Lead exposure
- Immigration enforcement and trauma

GOAL: Strengthening Equity in Practice

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Case #1 – Adolescent Vaping

Annie Coates, MD, FAAP, FCCP, ATSF

Associate Professor of Pediatrics

Pediatric Pulmonary Medicine

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Objectives

1) Identify systemic symptoms associated with vaping.
2) Identify social determinants of health which contribute to vaping use in youth.
3) Identify different advocacy strategies to prevent and reduce vaping use in youth.

No disclosures

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Scope of the Problem

How We Got Here

2010s
E-cigarette use, commonly known as vaping, gained widespread popularity among youth.

2011-2018
E-cigarette use rose dramatically, from just 220,000 high school students in 2011 to over 3 million by 2018.

2016
The Surgeon General's report on E-cigarettes.

2018
The 20th U.S. Surgeon General to declare youth vaping an epidemic.

2019
Vaping usage among high school students was nearly 1 in 3.

2024
More than 1.6 million U.S. youth reported currently vaping.

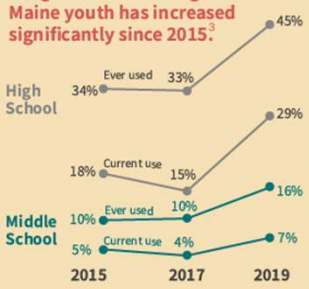
E-cigarette use by Maine youth:

1 in 2 (45%) high school students &

1 in 6 (16%) middle school students

have ever used e-cigarettes.

E-cigarette use among Maine youth has increased significantly since 2015.[3]



Ever used = Ever used an e-cigarette
Current use = Past 30-day use of an e-cigarette

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Case #1: MJ

- 17-year-old female is admitted to the BBCH PICU secondary to status asthmaticus
- Asthma diagnosed at age five
- Previously managed with daily inhaler until loss of insurance coverage over a year ago
- Worsening asthma symptoms over the past week
- Significant shortness of breath and difficulty breathing, with episodes of feeling unable to catch her breath
- Increased use of albuterol inhaler, two to three puffs per episode, sometimes with a spacer
- Asthma symptoms limit physical activities
- Nocturnal coughing most nights even prior to this presentation; endorse restless sleep
- Longest period without albuterol in the past several months is two to three days
- Endorse jitteriness independent of Albuterol use
- Endorse vaping and marijuana dab use with friends. "Likes the flavors"
- Endorse depression

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Clinical Symptoms

What Are The Symptoms Of Vaping Use (And/Or Nicotine Withdrawal) in JM?

- Cough
- Asthma Exacerbations
- Feeling irritable, jumpy, restless
- Feeling sad
- Difficulty sleeping
- Having a hard time concentrating
- Hypertension
- Abdominal pain
- Craving nicotine

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Back to the Case: JM

- Lives in a hotel with her parents who smoke tobacco cigarettes and marijuana
- Her friends vape and use marijuana dabs and supply her with them
- Exposed to animal dander
- "Home schooled" since 8th grade. "Difficult to focus"
- No medical insurance for at least 1 year
- Last saw her pediatrician "years ago"
- No interval vaccines

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Health Equity Lens: JM's Risk Factors

- Social acceptance and use within peer and family circles.
- Low perceived risk of flavored products.
- Use of other drugs (cannabis).
- Smoking prevalence is strongly inversely related to socioeconomic status (SES), with higher rates of smoking, lower quit rates, and higher tobacco-related mortality concentrated among individuals with lower income, education, and occupational status.
- Vaping prevalence shows a complex relationship with SES. In the U.S., some studies indicate higher adolescent vaping rates in wealthier households, while others find higher rates in low-SES, high-stress environments.
- Marketing Exposure: Adolescents from lower-SES backgrounds may have higher exposure to pro-vaping ads in their communities.
- Social Stressors: Marginalized groups, including low-SES, sexual minorities, face higher stress, leading to higher rates of risky health behaviors like vaping.
- Product Costs: While some higher-SES individuals may afford more expensive, specialized devices, the rise of affordable, disposable vapes has increased access across all income levels, with higher uptake in lower-SES groups.

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What Can You Do?

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Policy in Action

Maine to see new taxes and minimum wage increase in 2026

Taxes on streaming services, cannabis, and tobacco go into effect in the new year.

Bangor schools receiving piece of national e-cigarette settlement over 'youth vaping epidemic'

by Kathleen O'Brien
March 22, 2023

A school principal in rural Maine sounds the alarm on the youth vaping epidemic

BDN by Opinion Contributor
April 27, 2021

Portland Press Herald

Effort to ban flavored tobacco products in Maine builds momentum

Joe Lawlor, Portland Press Herald, Maine
Fri, March 17, 2023 at 11:59 PM EDT

Add Yahoo on Google · 8

Hallowell becomes 7th Maine community to ban flavored tobacco sales

About 10,000 postcards coming to Maine State House Tuesday to endorse efforts by Flavors Hook Kids Maine

By Marleigha Clipston
Published: Feb. 12, 2024 at 8:57 PM EST

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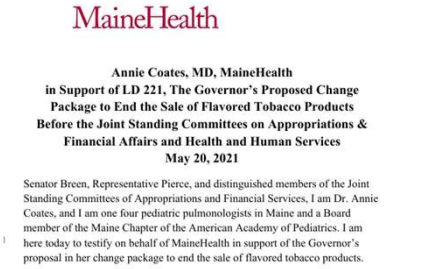
What Can You Do?

- Set An Example: Walk the Walk!
- Screen and Educate in clinical interactions
- Encourage open, nonjudgemental dialogues with parent/guardians
- Write an Op Ed!
- Testify: In person or writing
- Report Retailers Selling E-Cigarettes to Minors to the FDA
- Educate Yourself



MaineHealth

Annie Coates, MD, MaineHealth
in Support of LD 221, The Governor's Proposed Change Package to End the Sale of Flavored Tobacco Products Before the Joint Standing Committees on Appropriations & Financial Affairs and Health and Human Services
May 20, 2021

Senator Breen, Representative Pierce, and distinguished members of the Joint Standing Committees of Appropriations and Financial Services, I am Dr. Annie Coates, and I am one four pediatric pulmonologists in Maine and a Board member of the Maine Chapter of the American Academy of Pediatrics. I am here today to testify on behalf of MaineHealth in support of the Governor's proposal in her change package to end the sale of flavored tobacco products.

Letter to the editor: Flavored tobacco can fuel lifelong addiction

Posted November 12, 2022

1 min read | Font size + | Gift Article | Print | Share

I am a pediatric pulmonologist and board member of the Maine Chapter, American Academy of Pediatrics. I work with the MAAP to educate patients and families on the significant dangers of tobacco products. Despite the FDA's ban on flavored cigarettes in 2009, over a

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Submit an op-ed

Op-ed submissions may be emailed to: opinion@mefia.org. Please include your name, address and phone number. Full information and guidelines here.

SPECIAL ARTICLES | OCTOBER 10 2025

E-Cigarettes and the Nicotine Epidemic: Statement From the International Pediatric Association

Monika Arora, PhD; Muralidhar M. Kulkarni, MD; Shishirendu Ghosal, MPH; Aishwarya Sathyan, MPH; Mansi Gupta, MOT; Simran Verma, MPH; Mychelle Farmer, MD; Adamos Hadjipanayis, PhD; Jonathan D. Klein, MD, MPH; Jonathan Winickoff, PhD; Naveen Thacker, MD; Stanton A. Glantz, PhD

Address correspondence to: Monika Arora, PhD, HRIDAY, Second floor, N-25, Green Park Extension, New Delhi 110016, India. monika@hriday-shan.org

Pediatrics (2025) 156 (5): e2025072337.
https://doi.org/10.1542/peds.2025-072337 **Article history**

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Success Story

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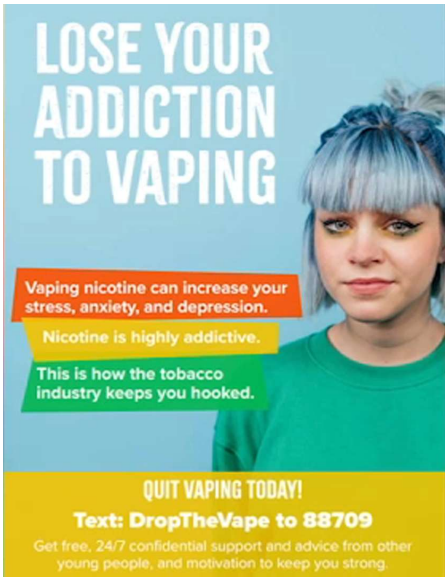
Thank You



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References

- 2019MIYHSVapingInfographic (1).pdf
- A systematic review on risk factors and reasons for e-cigarette use in adolescents
- The adverse effects of vaping in young people - ScienceDirect
- E-Cigarettes and the Nicotine Epidemic: Statement From the International Pediatric Association | Pediatrics | American Academy of Pediatrics
- Vaping Risks for Young People: Lungs, Heart, Brain, and Parenting Guidance | ColumbiaDoctors

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Case #2 – Childhood Lead Poisoning

Meredith Jackson, MD, FAAP

Newborn and Pediatric Hospitalist Medicine

Assistant Professor of Pediatrics, Tufts School of Medicine

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Objectives

1) Review lead screening recommendations
2) Identify social determinants of health which contribute to childhood lead poisoning
3) Discuss what happens *after* a case of childhood lead poisoning is identified

No disclosures

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Childhood Lead Screening

- There is **NO SAFE LEVEL** of lead
- Current national CDC reference level is 3.5 micrograms/dL of blood in children
- Screen all children at 1 and 2 year well child appointments with capillary or venous blood lead level
  - –Since June 2019
  - –If level > 3.5, confirm with venous ASAP (required in Maine since 10/1/2022)
- AAP RECOMMENDATION: Screen all children at every WCC through age 6mo – 6y with risk assessment questionnaire

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Lead Poisoning Risk Factors

- Spending a significant amount of time in a building built before 1960 (such as a home or daycare) especially if there is peeling paint or recent renovations
- Insured through MaineCare
- Recent immigrant, adoptee or refugee
- Behavioral – children with pica or developmental delays

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Maine CDC Lead Poisoning

Confirmation Schedule

CAPILLARY BLOOD LEAD LEVEL	CONFIRM WITH VENOUS TEST WITHIN
3.5 - <10 ug/dL	As soon as possible, but no later than 3 months
10 - <20 ug/dL	As soon as possible, but no later than 1 month
20 - <45 ug/dL	As soon as possible, but no later than 2 weeks
45+	Immediately, but no later than 48 hours

Venous Blood Lead Test Follow-up Schedule

BLOOD LEAD LEVEL	FOLLOW-UP VENOUS TEST SCHEDULE	RECOMMENDED ACTIONS BASED ON CONFIRMED VENOUS BLL
3.5 - <10 ug/dL	Within 3 months*	• Complete risk assessment questionnaire to identify potential sources of exposure • Educate on key messages • Inform patient that Maine CDC will be reaching out
10 - <20 ug/dL	Within 2 months*	• Items above plus: • Ensure child does not have iron deficiency • Check child's development to ensure appropriate milestones are being met
20 - <45 ug/dL	Within 1 month*	• Items above plus: • Consider performing abdominal x-ray to check for lead-based paint chips and other radiopaque foreign bodies
45+ ug/dL Urgent Action Needed	Immediately (place order as STAT)	• Items above plus: • Perform complete history and physical exam including detailed neurological exam • Urgent consult with Northern New England Poison Center: 1-800-222-1222

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Prevention of Childhood Lead Toxicity

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Pediatrics. 2016;138(1). doi:10.1542/peds.2016-1493

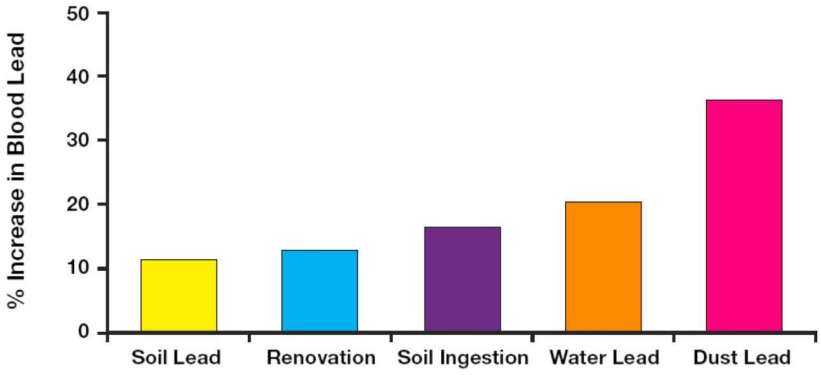

Figure Legend:

Contribution of lead exposure to children's blood lead concentrations. Adapted from Lanphear et al[31] and Spanier et al.[45]

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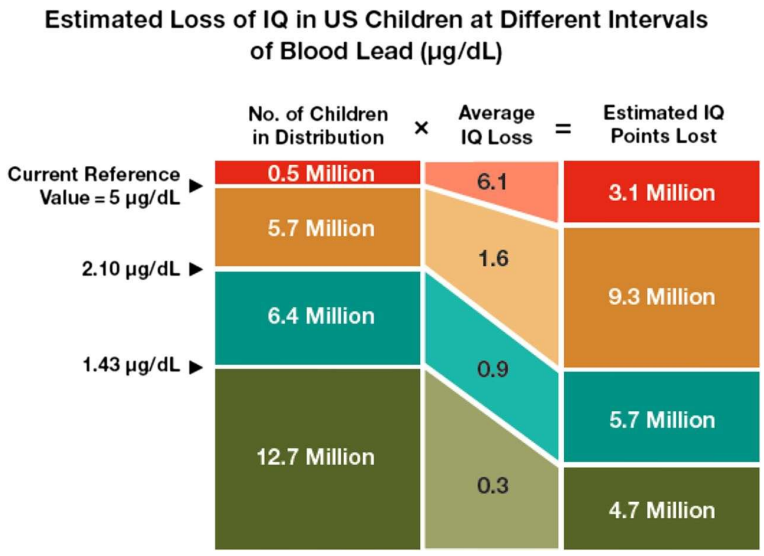
Prevention of Childhood Lead



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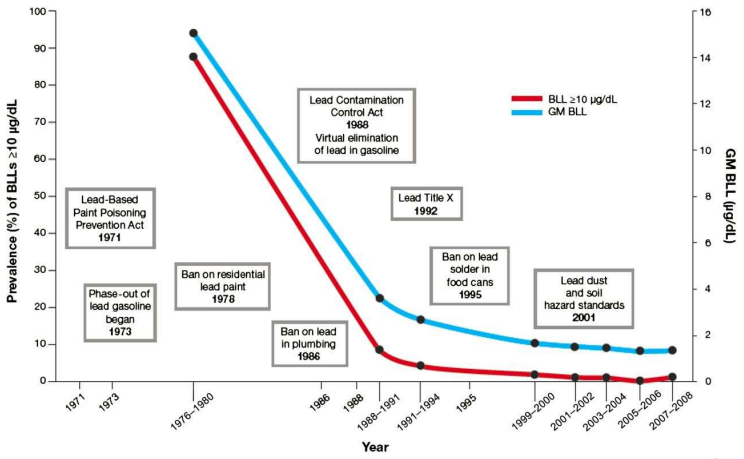
Where is the Exposure Coming From?

- Homes and buildings
- Hobby materials
- Home remedies
- Workplaces
- Food bowls painted with lead glazes
- Toys, jewelry, furniture
- Water that has been in contact with lead pipes, lead solder, or older plumbing fixtures



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Case #2 – EK

- 12 month well child check – routine capillary lead test = 26
- Venous lead confirmation – 47 (returned > 1 week later)
- Repeat level ~1 week later – 44.8
- Repeat one day later – 50

Risk Factors:

- MaineCare
- Lives in apartment complex built prior to 1950
- Lower SES status
- Parents are refugees/immigrants

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Treatment Guidelines

CHILDHOOD LEAD POISONING TREATMENT GUIDELINES
GUIDELINE #2: INPATIENT CHELATION WITH CHEMET (SUCCIMER, DMSA)

CRITERIA FOR TREATMENT:

This protocol is appropriate for children with confirmed venous blood lead levels (VPb) 45-69 ug/dL if the following conditions are met:

1) The patient is asymptomatic. If the patient has signs of acute encephalopathy treatment guideline #4 is recommended. A careful history should be taken for possible signs or symptoms of acute toxicity. Symptoms of lead poisoning include the following:
   - GI: Anorexia, constipation, abdominal pain, vomiting
   - CNS: Irritability (may be subtle), lethargy, change in sleep or behavior patterns, headache, decreased play, ataxia, decreased coordination, vomiting
   - Severe involvement: Seizures, coma, hypertension, papilledema, cranial nerve paralysis
2) Absence of a history of allergy to Chemet
3) Absence of pre-existing renal or hepatic disease
4) No treatment with other chelating agents within the past 2 weeks. It is best to wait 2-4 weeks between consecutive courses of Chemet.
5) An absolute neutrophil count ≥ 1200 prior to the initiation of treatment
6) Arrangements for the completion of Chemet chelation therapy as an outpatient should be explored prior to initiation of inpatient treatment. (See Guideline #1)
7) Phone inpatient lab and pharmacy to assure adequate access to lab testing requirements and medications.

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PRIOR TO TREATMENT:

1) A careful history and physical exam should be conducted to verify that the patient is asymptomatic.

2) Exposure history, including occupational history of parents, should be obtained and documented.

3) Obtain BP. Confirm height and weight (for dosing).

4) Laboratory: The following baseline laboratory data should be obtained:

   - Repeat VPb – (Venous Lead) from State of Maine: 0.5 ml in royal blue top – order STAT
   - ZPP – (Zinc Protoporphyrin): 0.2 ml in lavender micro
   - CMP: 0.6 ml in mint green micro
   - CBC with differential (calculate ANC): 0.5 ml in lavender micro
   - Urinalysis (for protein)
   - Iron studies – Iron, Ferritin, TIBC: 3 ml in gold

5) Radiologic Evaluation:
   Obtain an abdominal x-ray on any child with newly diagnosed lead poisoning or any child with known lead poisoning with an increase in lead level not consistent with a post-chelation rebound. X-ray evidence of lead in the gastrointestinal tract, particularly in the stomach and small intestine, indicates the need for gut decontamination. Lead has no appreciable absorption in the colon or rectum.

6) All families should be referred for a social work assessment (for housing assistance)

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Maine CDC's Public Health Response

For Confirmed Venous Blood Lead Levels ≥3.5 µg/dL

Maine CDC Childhood Lead Poisoning Prevention Unit Response for Children (Ages 0 - <72 months) With Venous Lead Levels	3.5 - <5	5 - <10	10 - <45	≥45
Offer free home lead dust test and if dust levels are high, provide environmental investigation and case management services described below	X			
Conduct environmental investigation of the child's home to identify and remove lead hazards		X	X	X
Provide case management services to: discuss outcomes of investigation, prevent further exposure, and monitor blood lead level		X	X	X
Offer home visit from a public health nurse		As Needed	X	X
CDS referral (lead poisoning is a qualifying diagnosis for CDS)		X	X	X
Coordinate with providers and Northern New England Poison Center on urgent evaluation for chelation therapy and investigation of the child's home environment for lead hazards				X

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Health Equity/SDOH

Children who live in older, poorly maintained housing or older housing that undergoes renovation are at high risk for lead exposure.

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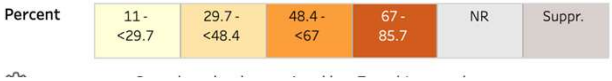
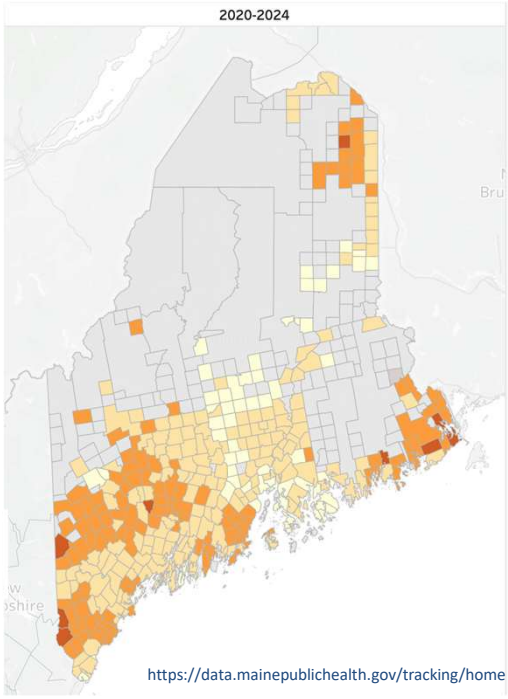
Percent of Children Age < 3 with a Blood Lead Test (2020 – 2024)





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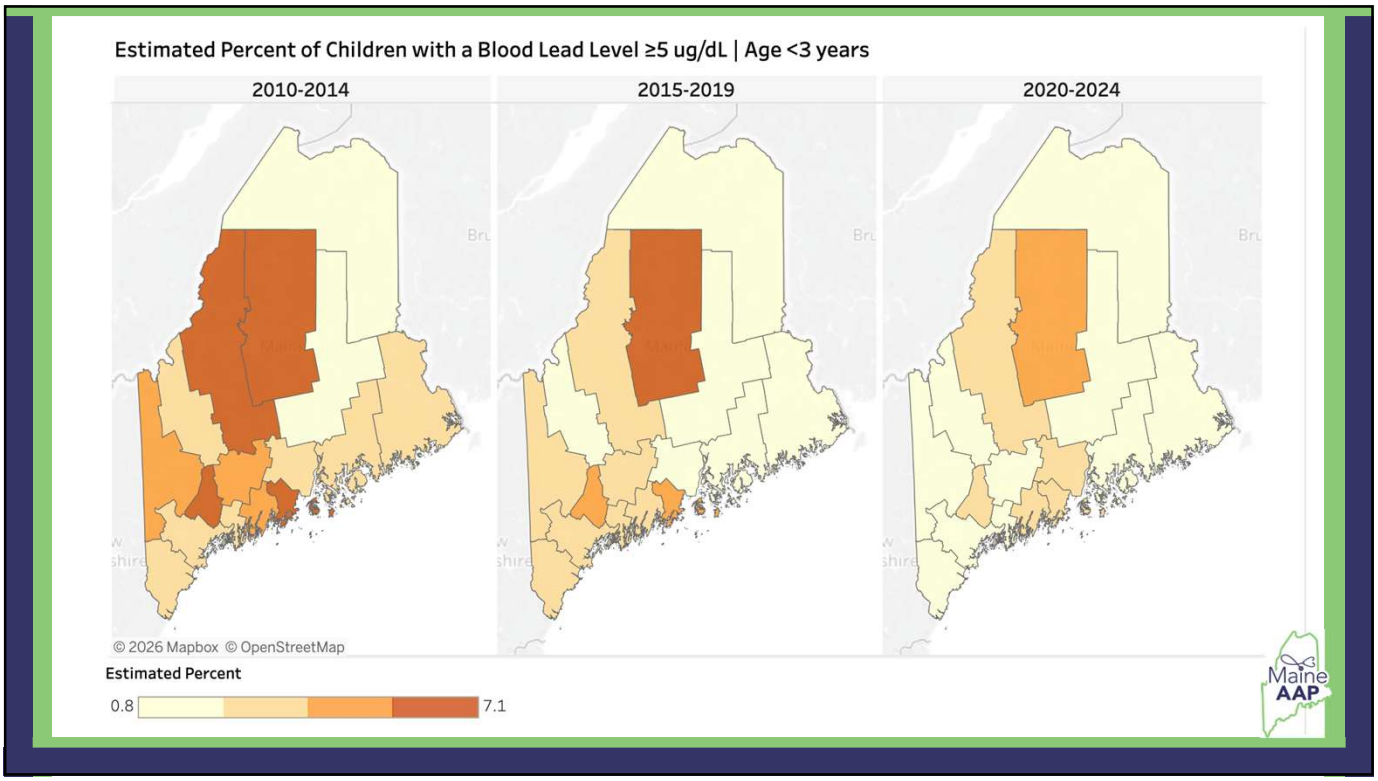
Estimated Percent of Children with a Blood Lead Level ≥5 ug/dL | Age <3 years
2010-2014
2015-2019
2020-2024
© 2026 Mapbox © OpenStreetMap
Estimated Percent
0.8
7.1
Maine AAP

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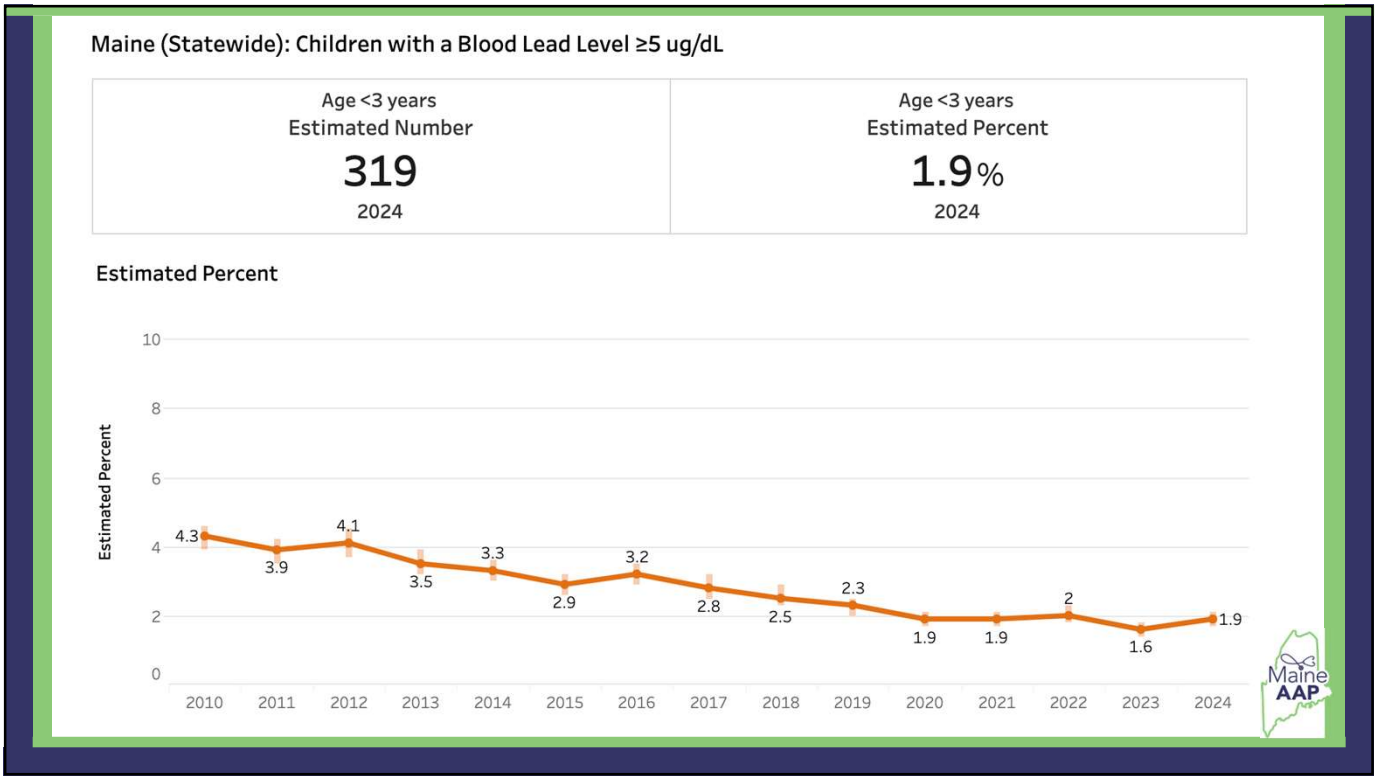
Maine (Statewide): Children with a Blood Lead Level ≥5 ug/dL
Age <3 years
Estimated Number
319
2024
Age <3 years
Estimated Percent
1.9%
2024
Estimated Percent
Estimated Percent
10
8
6
4
2
0
4.3
3.9
4.1
3.5
3.3
2.9
3.2
2.8
2.5
2.3
1.9
1.9
2
1.6
1.9
2010
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2024
Maine AAP

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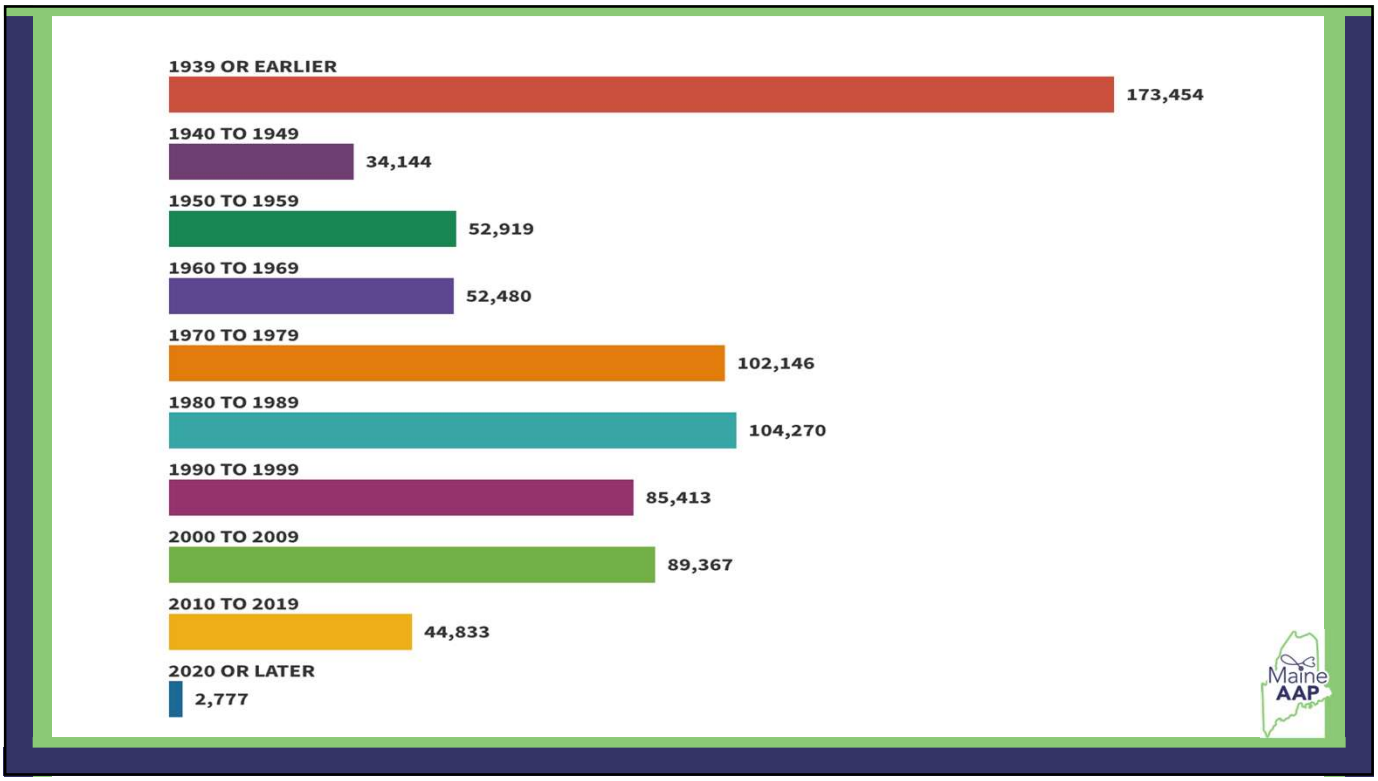
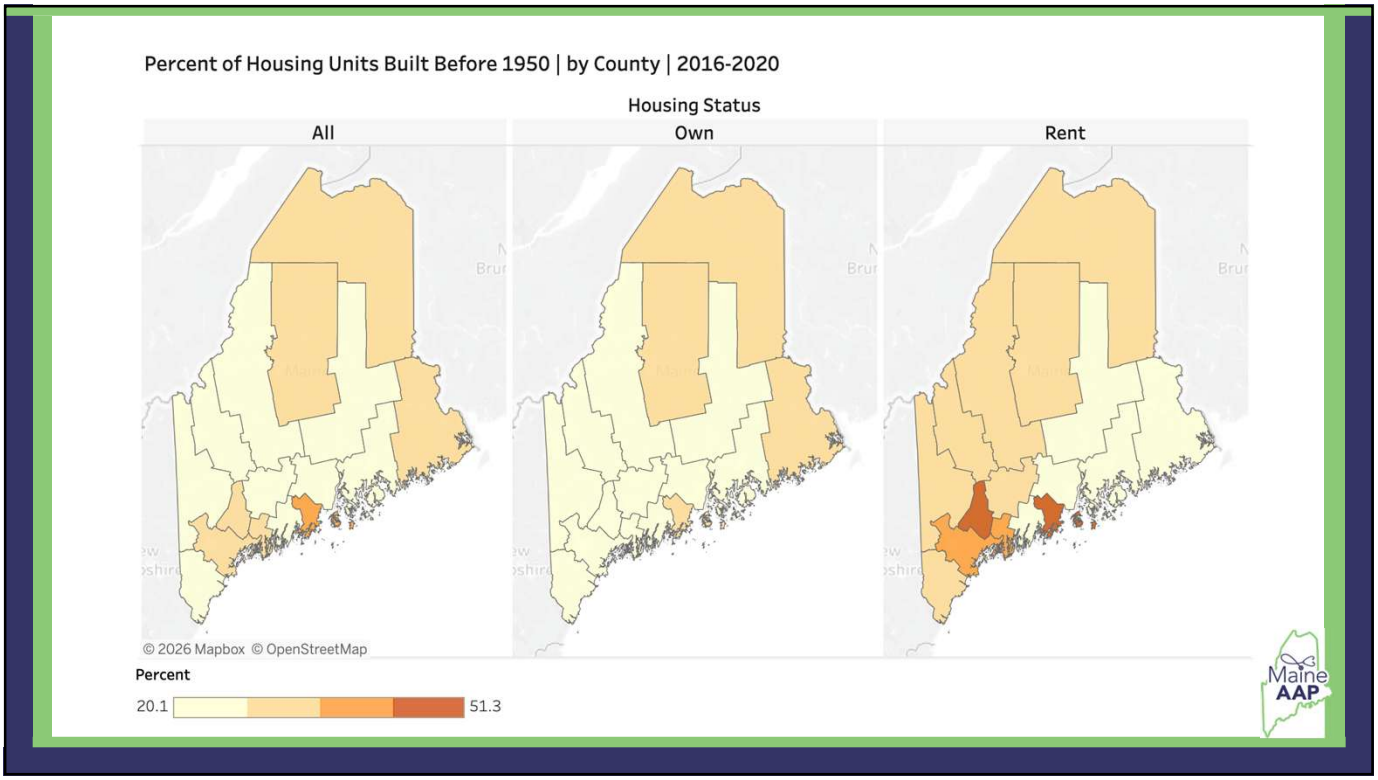
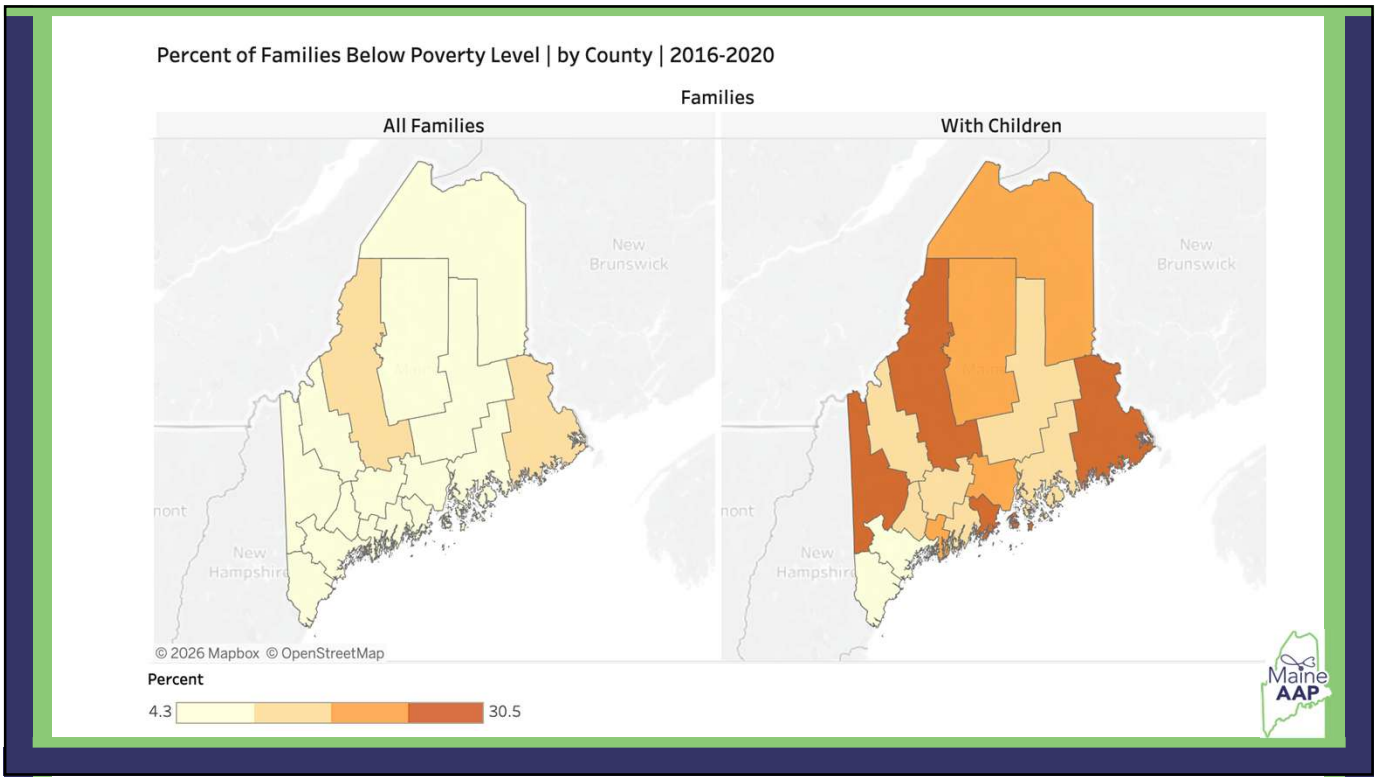

1939 OR EARLIER
173,454
1940 TO 1949
34,144
1950 TO 1959
52,919
1960 TO 1969
52,480
1970 TO 1979
102,146
1980 TO 1989
104,270
1990 TO 1999
85,413
2000 TO 2009
89,367
2010 TO 2019
44,833
2020 OR LATER
2,777

39


Percent of Housing Units Built Before 1950 | by County | 2016-2020
Housing Status
All
Own
Rent
© 2026 Mapbox © OpenStreetMap
Percent
20.1
51.3

40


Percent of Families Below Poverty Level | by County | 2016-2020
Families
All Families
With Children
New Brunswick
New Hampshire
© 2026 Mapbox © OpenStreetMap
Percent
4.3
30.5
Maine AAP

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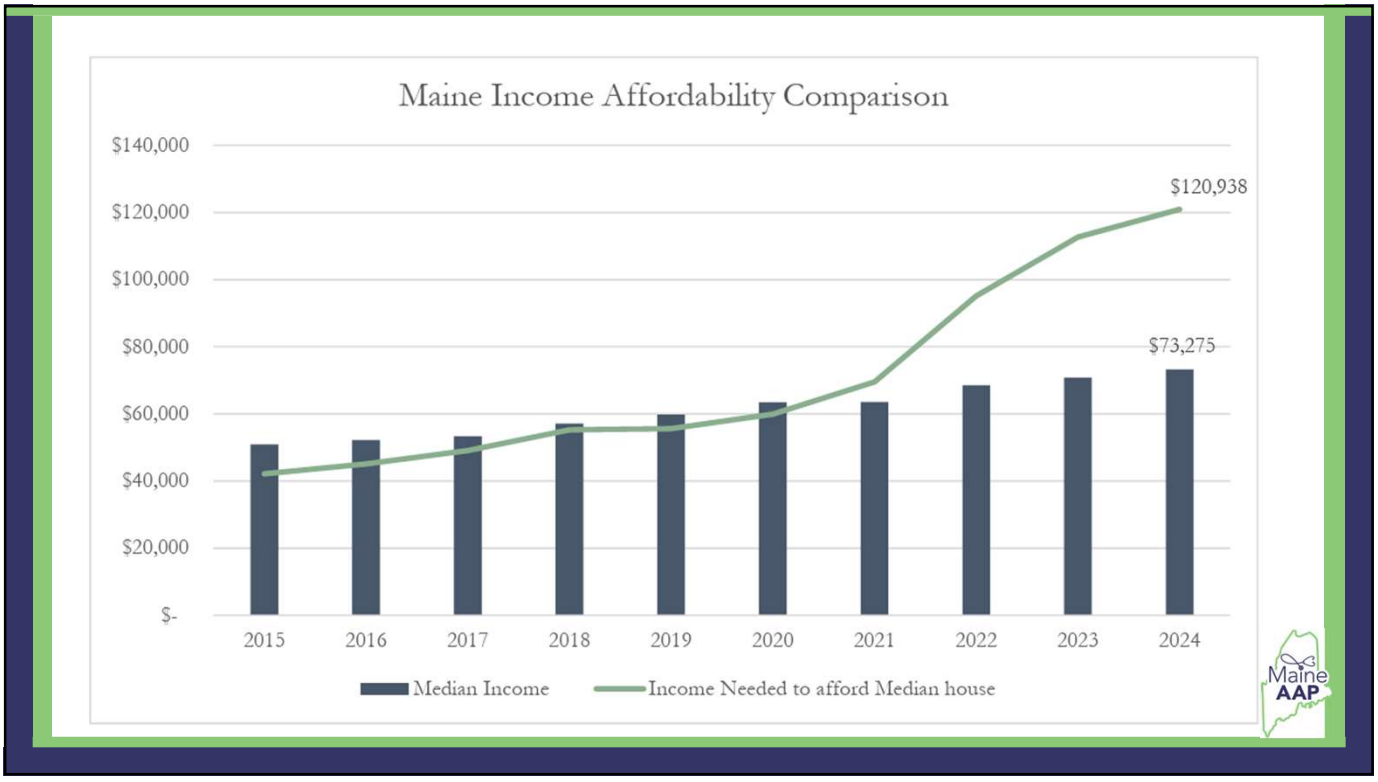
Maine Income Affordability Comparison
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$-
$120,938
$73,275
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
Median Income
Income Needed to afford Median house
Maine AAP

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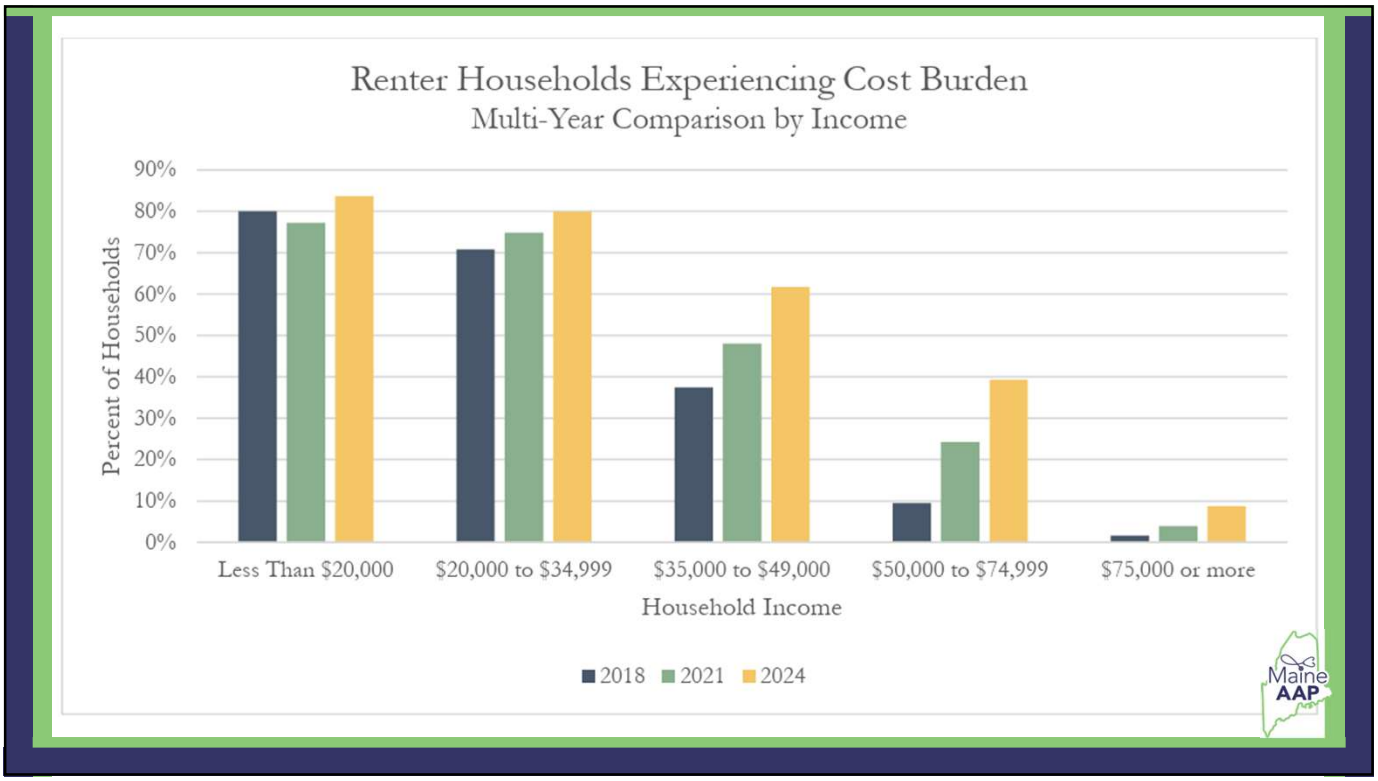

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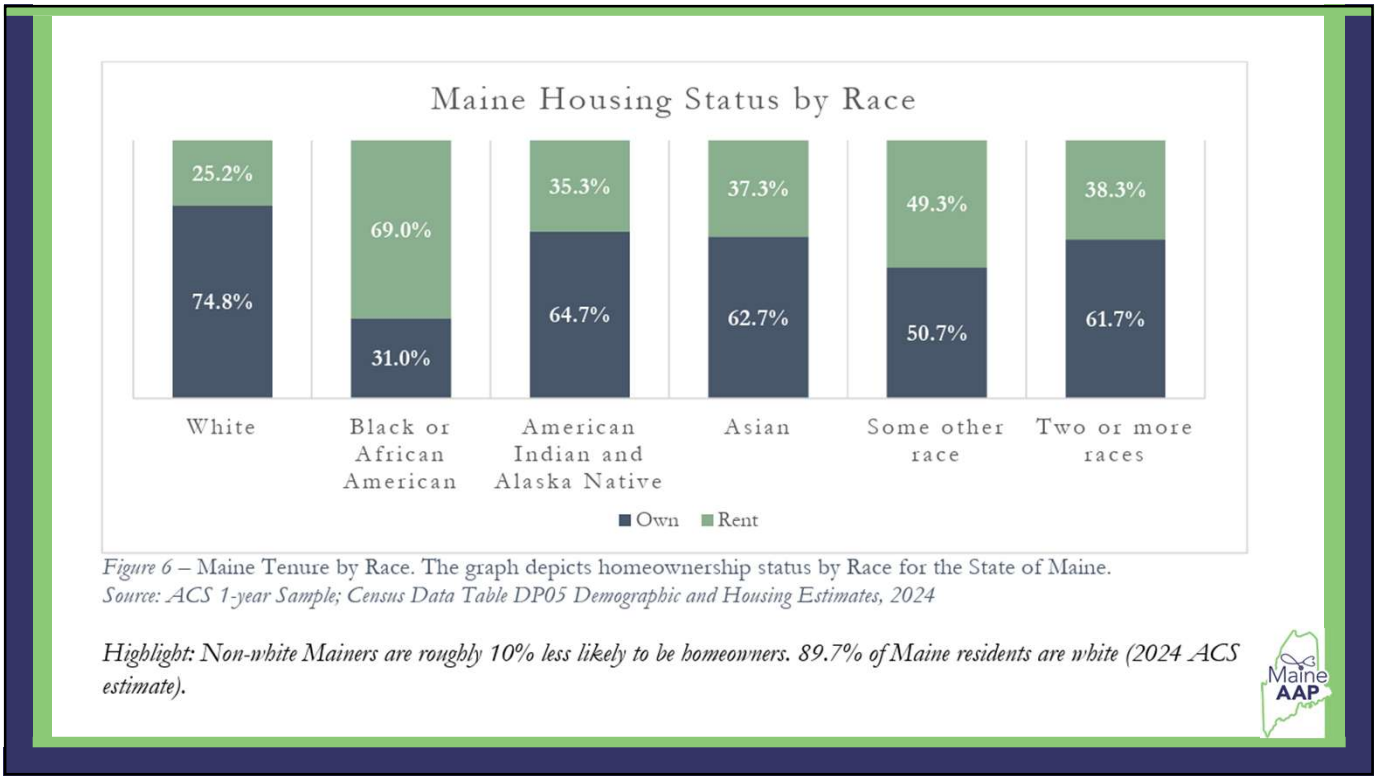

Figure 6 – Maine Tenure by Race. The graph depicts homeownership status by Race for the State of Maine.
Source: ACS 1-year Sample; Census Data Table DP05 Demographic and Housing Estimates, 2024

Highlight: Non-white Mainers are roughly 10% less likely to be homeowners. 89.7% of Maine residents are white (2024 ACS estimate).

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Housing in Maine

- Not only is it old….
- There's not much of it
- It's expensive

In Maine, the number of people in shelters, unsheltered, or in transitional housing remained close to 2,300 in 2025 – comparable to pre-pandemic averages.

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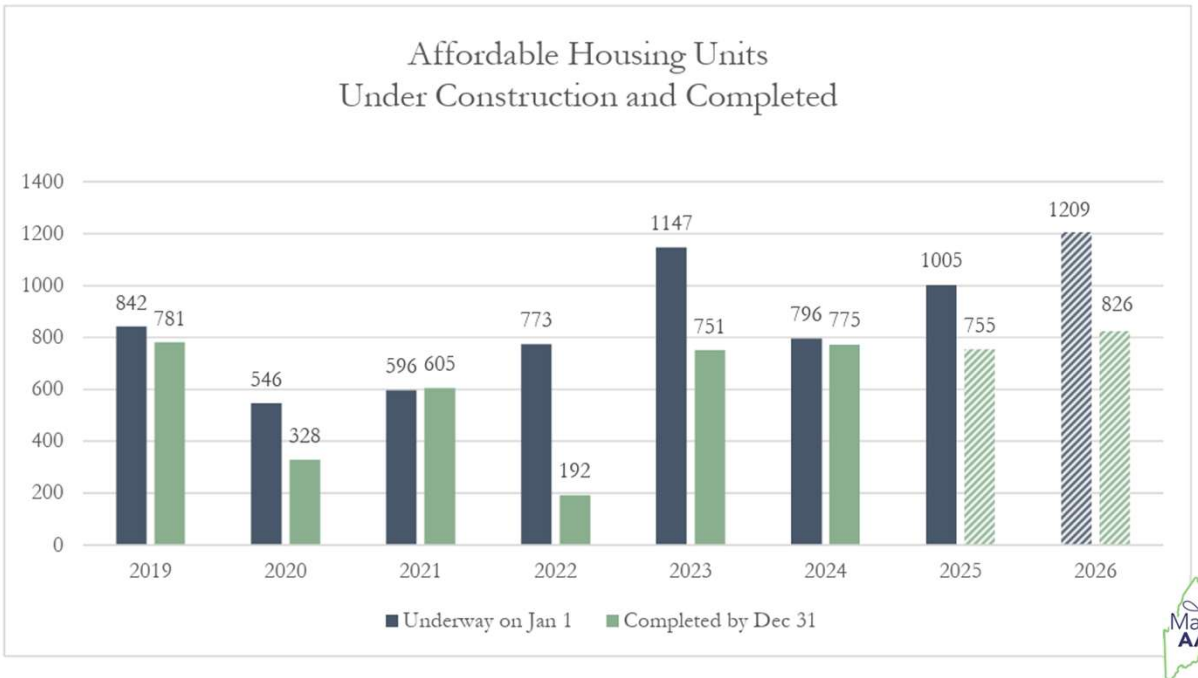

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Abatement ≠ Lead Free

- Best: entirely replace
- 2nd best: "sand to bare" to get rid of all lead paint (safely) and then paint over with non-leaded paint
- Last: paint over hazard(s)

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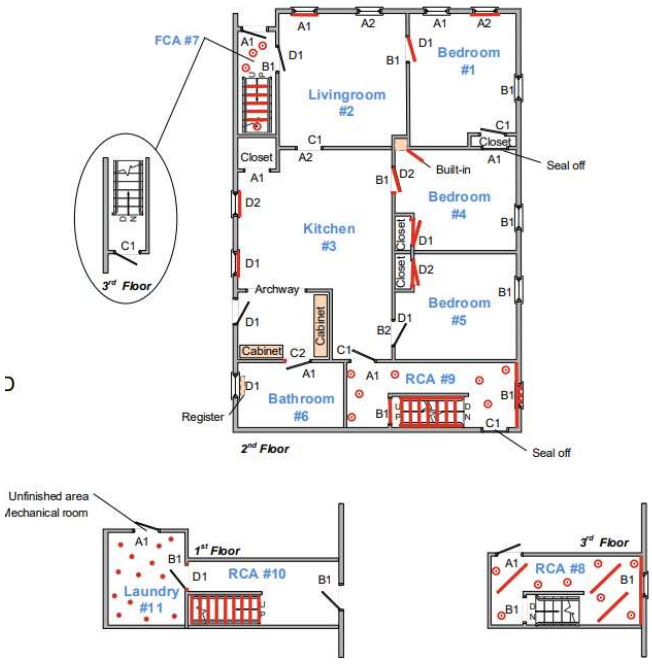

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Bite marks (bottom of windowsill)

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Treatment

TREATMENT:

1) If there is x-ray evidence of lead in the gastrointestinal tract, GI decontamination should be carried out. Polyethylene glycol solution (GoLytely) can be used for lead densities in the stomach and/or small intestine. Lead has no appreciable absorption in the colon or rectum. The dose of GoLytely is 20-40 ml/kg/hr up to a maximum of 1000 ml per hour via nasogastric tube for a minimum of 4 hours and/or until the patient has a bowel movement.

2) Begin Chemet at 10 mg/kg (rounded to the nearest 100 mg) PO TID (see dosing schedule below) for 5 days, then BID for 14 days (as an outpatient). The drug comes in 100 mg capsules that may be opened and sprinkled on food or in beverages; ice cream works well.

DOSING (TID x 5 days; then, BID x 14 days)

LBS	KG	DOSE (MG)	NUMBER OF CAPSULES/DOSE
18-35	8-15	100	1
36-55	16-23	200	2
56-75	24-34	300	3
76-100	35-44	400	4
≥ 100	≥ 45	500	5

3) Iron should not be administered simultaneously with Chemet. If indicated for iron deficiency anemia, it may be given 2-3 hours after the dose.

4) Observe for any side effects of treatment as listed above. If fever or signs of infection are noted, check CBC with differential; consider withholding treatment for ANC < 1200.

TREATMENT, Continued:

5) On DAYS 6 and 20 of therapy, the following labs should be repeated.

- VPb, from State of Maine: 0.5 ml in royal blue top – order STAT
- ZPP: 0.2 ml in lavender micro
- CMP: 0.6 ml in mint green micro
- CBC with differential: 0.5 ml in lavender micro. *Calculate ANC and consider withholding treatment for ANC <1200.*
- Urinalysis (for protein)

CRITERIA FOR DISCHARGE:

1) The child must be discharged to a lead safe environment. The lead status of the home will be determined for Maine patients by the Maine Childhood Lead Poisoning Prevention Program (MCLPPP), (207) 287-4311, or for New Hampshire patients by the Health Homes and Lead Poisoning Prevention Program (HHLPPP), (603) 271-4507 and (800) 897-5323.

2) The parent or caregiver must be able to comply with the treatment protocol.

3) The parent or caregiver must be able to attend follow-up appointments and laboratory testing.

FOLLOW-UP:

1) The first follow-up visit should be one week after chelation has been completed, and, then, again at two weeks after chelation has been completed. Follow-up should continue at monthly intervals until the VPb is < 15 ug/dL, then, every two to three months.

2) The following labs should be obtained at each follow-up visit

- VPb, State of Maine: 0.5 ml in royal blue top
- ZPP: 0.2 ml in lavender micro

Rechelation is indicated if at any time after 2 weeks, the VPb is > 45 ug/dL, or > 40 ug/dL in the face of a large lead burden (elevated ZPP). Many children will require more than one round of chelation therapy.

3) Continue monitoring until VPb is < 15 ug/dL on two occasions, three months apart

4) All children with significant lead exposure, and, especially, those who have undergone chelation, require a neurodevelopmental assessment. This should be obtained within 2 months of completion of the initial course of chelation, and, then, yearly until the age of 6.

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Key Takeaways

- The key to stopping lead poisoning is PREVENTION
- Risk factors for lead poisoning are intertwined with social determinants of health
- Screen with blood testing for all children at 12- and 24-month WCC
- Screen with risk questionnaire 6 mo – 6 years
- Resources and data available – Maine CDC, HealthyChildren.org, AAP and more

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Thank You

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Case #3 – Trauma-Informed Approaches in the Time of Immigration Enforcement

Stephen DiGiovanni, MD

Medical Director, Internal Medicine – Pediatrics Portland, Maine

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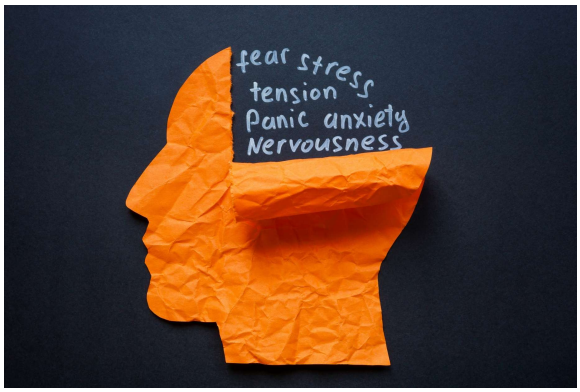
Objectives

1) Review the triple trauma framework and the impact of immigration enforcement on families living in Maine
2) Using a case examples, analyze real-world barriers to care while recognizing both risk and protective factors that shape immigrant family functioning and health outcomes



No disclosures

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Displaced Persons: Triple Trauma Paradigm*

Pre-Flight	Flight	Post-Flight
War	Fear	Language/cultural barriers
Violence and Torture	Lack of access	Financial instability
Arrests	Hiding	Housing instability
Fear, threats	Risks	Immigration stressors
Lack of access	Lack of basic needs	Change in roles
Secrecy	Unknowns	Family tension
Disrupted daily life	Violence	Differing acculturation
Separation and death	Leaving others behind	Discrimination
Loss	Loss	Loss
More	More	More

*Center for Victims of Torture

Immigration enforcement through the lens of the triple-trauma paradigm

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Risk Factors

A variety of risk factors place immigrant children at risk for emotion, behavioral or relational problems

- High intelligence and education level does not protect children from post-traumatic disorders.
- Disrupted family composition by death or other loss increases risk as do single parent families and parental mental illness.
- Persistent poverty, particularly associated with housing and food insecurity, are significant cumulative risk factors.
- Either overt, implicit or perceived prejudice are all associated with increased risk of individual symptoms of stress.

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Protective Factors (Resiliency)

Protective Factors for Immigrant Children

- As with all children, family functioning mediates the effects of poverty on emotional and behavioral health.
- Being part of an engaging community of fellow immigrants from the same country of origin on arrival also leads to better mental health outcomes.
- Perceived acceptance in receiving communities, safety in schools and strong neighborhood connections are protective.
- Blended Biculturalism (and bilingualism) appears to be the most adaptive response retaining important elements for the culture of origin but adopting many values from the new culture.

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Trauma Informed Care

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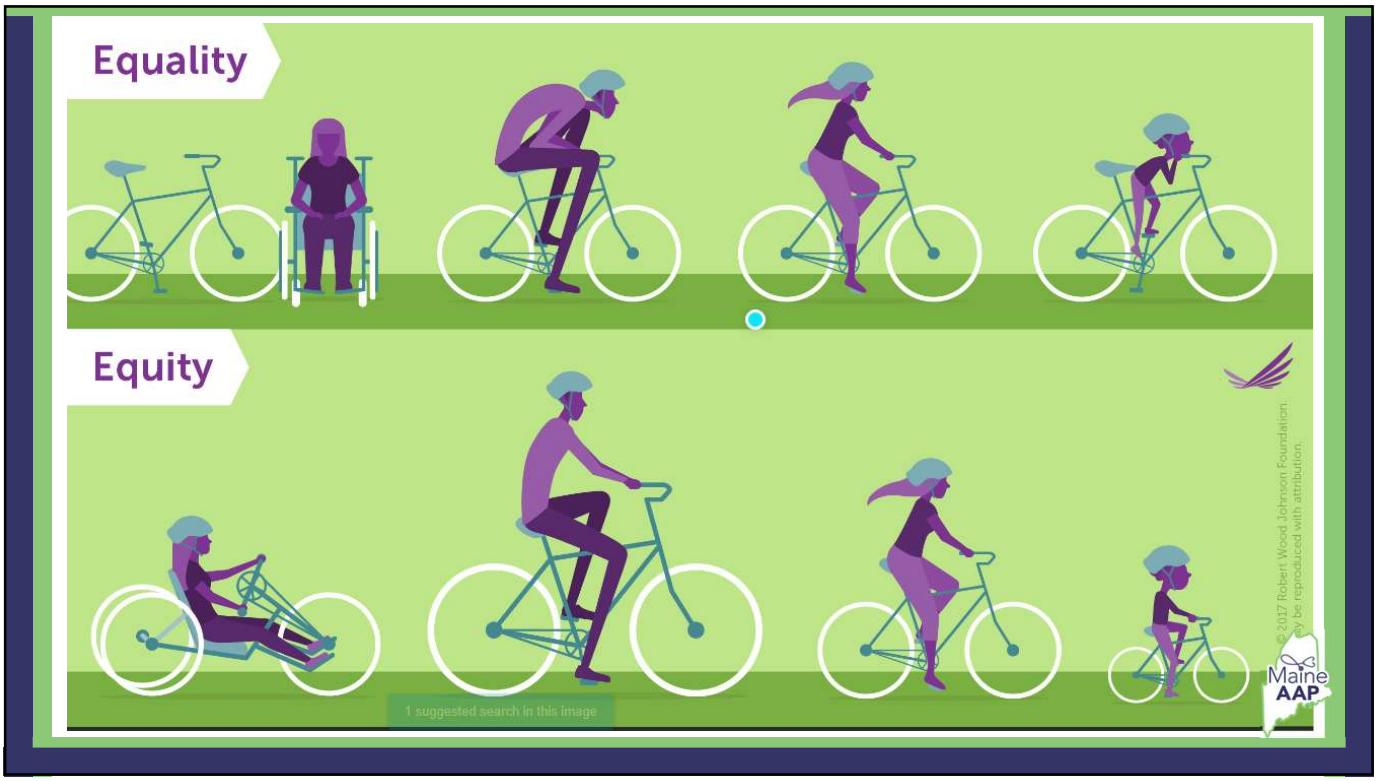

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MMC Clinics: Support Over 3 Weeks

27 home healthcare visits

- Collaboration with Community Paramedicine
- Combined with SDOH deliveries

BUILD TRUST EVERYDAY

Averaged 20-40 SDOH Deliveries a week

- Food Formula Diapers supported 865 individuals
  - 378 adults
  - 487 children
- Donations from multiple food pantries
- Fundraising
- Diaper and Food purchases through supply chain
- Diaper purchases and donations from Maine Needs
- Many Volunteers!!!!!! Came from the clinics, residency program, and other sites

Maine AAP

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The Power of Registries

- Children under age 2 with food insecurity in the past year
- Active outreach initiated focusing on the youngest children
- Outreach to 135 families
- Approx 90% that were contacted needed assistance

Kristin- 1/30 delivery, needs food,diapers,formula,kleenex
Needs delivery - Des spoke w/ mom
Needs Delivery - Deb spoke with family - Diapers, wipes, food 1/30/26
Kristin -1/30 delivery of diapers, wipes, and milk
Kristin- VM not set up-unable to contact- ATC tel enc shows resources given on 1/27
Kristin- unable to contact - no answer and VM full
Linda-1/30.Needs Food,diapers,Formula.
Kristin - Delivery for Friday anytime(food diapers,wipes & SIM Blue Volunteer interpreter to call on 2/4
Allie - **delivered 1/27**
ATC & Allie - **Celeste**
Kristin- Delivery 1/30
Kristin - VM box not set up 1/29
Sanford address
Kristin - 1/30 delivery
Kristin - Pt has transfered to Biddeford Peds
Allie - **Wayside program delivering food**
All set - Dpyle
Needs Delivery 1/30/26 - Family of 5 Mom +4 kids, Diapers, Wipes, Food, Formula & Infant tylenol Dpyle
Linda-1/30.Needs Food,diapers,wipes.High need
No answer DPyle
1/30/26 needs delivery family of 7, food, diapers and wipes - High need, out of formula for 4 days
Linda-2/2-Diapers,Wipes
Armando-2/3 PC unreachable, only whatsapp maybe acceptable
Yes Dpyle - Diapers, Food, Wipes & Milk - 8 members of family Needs Vit D & Vaseline for skin
Deb Yes - diapers, food, Wipes, formula - requests home visit for f/u ER
Allie & OB - **Alicia delivered 1/27**
Allie - messaged 1/30 - awaiting response. **Delivering 1/30**
Alicia- **delivered 1/23 & 1/28 (comm volunteer)**
Linda-2/2-Food,Diapers,Wipes
Deb Needs formula & diapers - Only wants to do home visit for 2/11 WCC, sending to SD

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Partnership with Community Paramedicine

What is Community Paramedicine

- Utilizes EMS providers for preventive and public health-focused care
- Delivers care directly in the community and home
- Designed to reduce access barriers (distance, transportation, availability)
- Built on trust and shared lived experience

Why it works!

- EMS providers are embedded and trusted community members
- Familiar with local culture, geography, and resources
- Similar to Community Health Worker model
- Enhanced by advanced medical training

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Challenges & Interventions

Challenges Identified

- Medication access and comprehension
- Polypharmacy and dosing confusion
- Transportation and pharmacy barriers
- Fear or persecution-arrest

Community Paramedicine Simple Intervention

- Extended time with patients
- Medication education ("why, how, when")
- Organization strategies
- Facilitation of home delivery or access - medication, medical supplies, food, SDOH needs
- Close collaboration with medical teams
- Close collaboration with SDOH Community Partners

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Home Visiting – Best Practices

Safety & Infection Control

- Thoughtful equipment placement
- Hand hygiene before and after care
- Environmental awareness
- Equipment disinfection
- Team-based visits possible

Patient-Centered Communication

- Cultural humility and trust-building
- Trauma-informed care
- Plain language communication
- Translation Services
- Teach-back and chunking
- Address emotional and social needs
- Focus on "what matters most"

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Patient Story #1

- Lingala speaking family
- 2 children: 10 months and 3 years
- **Family disruption as father taken into detention by ICE**

Home visit:

- Mom with significant despair/sadness and scared to leave the home
- Older sibling with probable Autism, parents declined further evaluation at most recent visit. No current resources or schooling
- At home visit provided multiple bags of food, diapers, formula, Vaseline.
- Confirmed growth, development, safe sleep and smoke detectors
- Provided lead paint prevention – peeling paint in hallway
- Older sibling set-up with 3 yo WCV in March

Access to Care contacted family the following week

- Direct contact to Project Home Maine: assistance provided
- Connected to Wayside Home Food Delivery
- Education on MotiveCare transportation provided

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Patient Story #2

6-month-old, 25-week GA preemie

- Retinopathy of Prematurity Stage 3
- Hx IVH grade 2
- Congenital Hypothyroidism
- Constipation

- Born at MMC: NICU admission for prematurity
- Transferred to Mass General for treatment of ROP.
  - Discharged with 1-month follow-up
- Established with MMC Pedi Clinic one week after discharge
  - Loss to follow-up with Mass Eye and Ear
  - Clinic Admin team, Early Childhood Support Specialist (ECSS) and PCP worked together to re-establish patient with Mass Eye & Ear, obtain MaineCare PA and transportation.
  - Mass Eye&Ear appointment in January -surgery in 2 weeks
- ICE enforcement began: unable to attend Eye surgery
  - Clinic provided telemedicine 6 mo WCV
  - ECSS re-connected with Mass Eye and Ear- appointment late February
  - Re-scheduled for 6-month immunizations late February
  - Retinopathy treatment completed in Boston March

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Patient Story #3

- **Newborn,** Mom, Dad, and 2-year-old at home
- One small room in a shared apartment
- High fear – all doors guarded, windows blocked
- Need for diapers, formula, and food

- Initial Home visit – supported normal weight gain, exam, breast feeding and pumping support, safe sleep education.
  - Next day metabolic screen positive for sickle cell disease
  - F/U call provided – diagnosis reviewed
- Home visit to deliver PCN, discuss diagnosis, review safety issues provided.
  - Parents requesting repeat blood test prior to starting PCN
- Second Home visit to provide ongoing support and answer questions
  - Parents requesting repeat blood test prior to starting PCN
- In person visit scheduled for 1 mo WCV and repeat state metabolic screening

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Take Home Messages

Meeting Basic SDOC Needs is Essential to Health

Response to Immigration enforcement:

- Build Trust Everyday
- Trauma Informed Lens
- SDOH needs
- Medical home visits
- Team-work
- Registries

- Deep appreciation from the patients and parents
- Requires a high level of coordination from team members
- Pre-visit preparation is essential
- Set which patients to focus on for home medical visits
  - Newborns
  - CMC (Children with Medical Complexity)
  - Acute evaluation where telehealth not adequate
- Safety evaluation on-site is so much better than in the office ☺
- Community Paramedicine is amazing
- Mom and baby assessed together ☺

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Thank You

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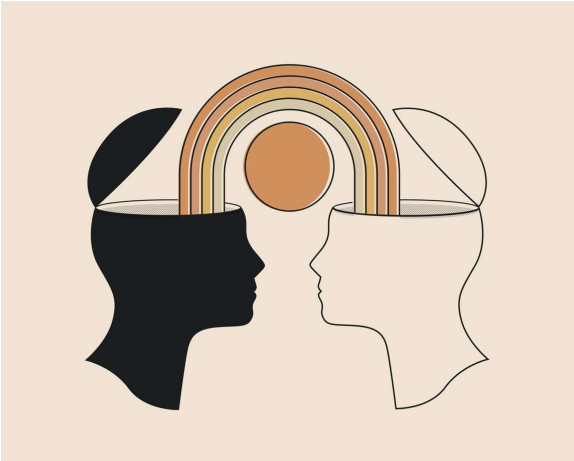
What We've Seen Today

Different cases.

Shared patterns…

1) Risk is not evenly distributed
2) Access is not equally available
3) Trust is not automatic



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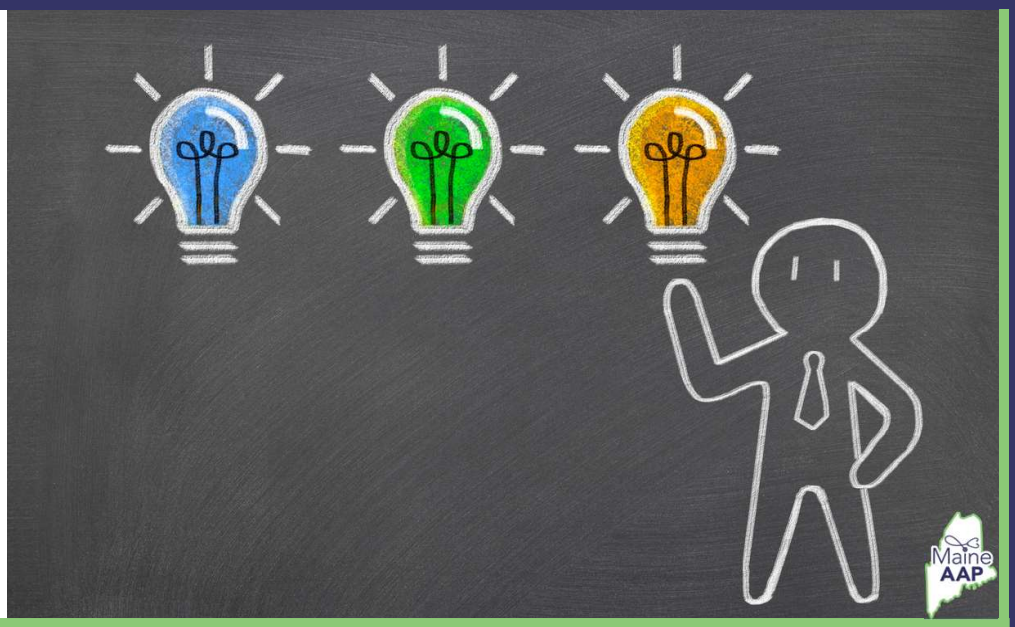
3 Takeaways

Curiosity

Expand

Influence



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Q&A and Audience Reflections

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The Role of Pediatric Providers

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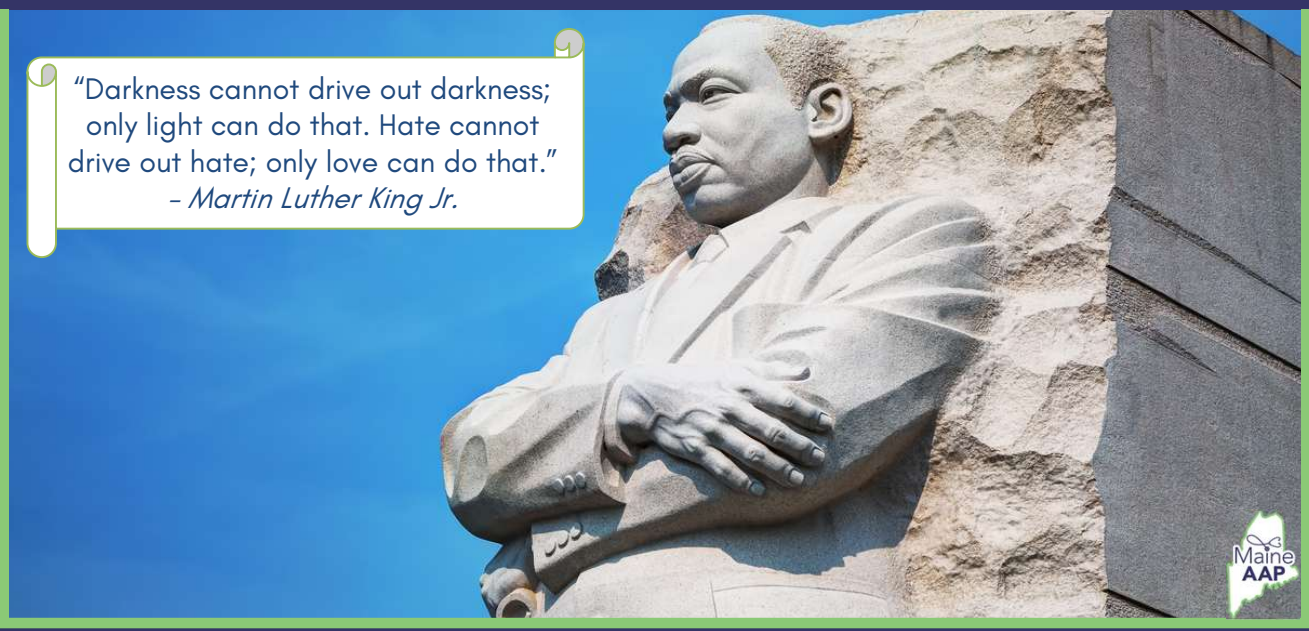
Thank You!



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