Maternal and Child Health Services Title V Block Grant

State Narrative for Maine

Application for 2011 Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All appropriate Assurances, Non-construction Programs, and Certifications regarding debarment and suspension, drug free work place requirements, lobbying, program fraud civil remedies act, and environmental tobacco smoke are on file in the Maine Center for Disease Control and Prevention's, Division of Family Health and will be made available for review. Requests can be made through email to: Katie.N.Woodbury@maine.gov or by telephone at 207-287-9917.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

MCH programs elicit ongoing public input and consumer representation on committees and in activities. The Children with Special Health Needs (CSHN) and Youth Suicide Prevention Programs have successfully engaged youth in planning and advisory capacities resulting in youth oriented materials and activities specific to their needs. The CSHN Program actively involves parents on the advisory committee. Parents and consumers are recognized as critical components of successful programs and their input has been assured through their integration into routine program functions. Families of CSHN and youth are invited to review and comment on the application. Members of the CSHN family and youth advisory councils are also invited to review and comment on the application.

The annual MCHBG planning and reporting processes, as well as, the annual application were discussed with the Joint Advisory Committee (Genetics and CSHN Programs), Newborn Hearing Advisory, School Health Advisory Committee, local WIC directors, medical providers, advocates and annual program and stakeholder meetings with requests made for public input. Consumer, provider, and family input is solicited at every opportunity at public forums such as committee and grantee meetings, conferences, and liaison groups. No public comments were received. During FY10 the Division of Family Health (DFH) widely distributed emails to specific listservs sharing the Title V agency link and asking for input on the comprehensive strengths and needs assessment (CSNA) priority setting process.

A link to TVIS and the MCH Block Grant was added to the DFH home page so visitors to the site can view the application http://www.maine.gov/dhhs/bohdcfh/FamilyHealth/family.html . For those who visit the DFH website they can access the block grant which contains the Title V Director and CSHN Directors contact information.

The DFH will seek to collaborate with the Maine CDC's new Office of Local Public Health (OLPH) to identify ways to link to and engage local and district level stakeholder input related to maternal

and child health. The DFH leadership had discussions with the OLPH leadership on how to include local public health districts in its 5-year CSNA. These discussions led to the OLPH supporting our CSNA by inviting the DFH to include key MCH leaders in local Public Health Service Assessment meetings in each of the 8 Public Health District's across the state. These meetings were held to conduct assessments to determine existing resource and service assets in relation to the 10 Essential Public Health Services, as well as, public health needs and gaps in each district.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Maine's 5 Year CSNA was guided by a quantitative and qualitative analyses. For example, quantitative data (e.g. hospital discharge, YRBS, PRAMS) showed that mental health disorders and violence are important issues affecting the MCH population in Maine. Qualitative data from focus groups also identified mental health and the lack of available services, as well as domestic violence as key needs. As such, we have 4 priorities; child and adolescent mental health, women's mental health, violence against women and childhood exposure to violence.
Many of the same concerns are present in both sets of priority needs, but the ways in which the priorities are grouped have changed, indicating a deliberate attempt to be more specific with each priority; a change from 2005 as MCH programs and stakeholders perceived the 2005 priorities to be too broad. There is some overlap between the 2005 and 2010 priorities. The priority needs selected for the 2010 CSNA and those from the 2005 CSNA are outlined below.

Improve Birth Outcomes was replaced with the more specific priorities of family planning and adolescent sexual activity, as well as violence against women, obesity and overweight are all aspects of this broader priority

Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries: The new priorities of intentional self-harm and suicide, violence against women, unintentional injury and childhood exposure to violence are all aspects of this priority

Improve the respiratory health of the MCH population was ranked 16th on the list and replaced by the more specific priorities in other areas

Increase the proportion of the MCH population who are at a healthy weight and physically active was replaced with the new priority of obesity and overweight among children and adults

Improve the mental health system of services and supports for the MCH population was replaced but reflected in two new priorities: Child and adolescent mental health and women's mental health

Foster conditions to improve oral health services and supports for the MCH population was ranked 11th and replaced by the more specific priorities in other areas

Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based system of care that enables the whole CSHN population to achieve optimal health. This priority did not rank high in the final list, but autism spectrum disorder was selected as the specific CSHN priority. In addition CYSHN will be incorporated into most of the new priorities, specifically: intentional self-harm and suicide, violence against women, family planning, obesity and overweight among children and adults, child and adolescent mental health, women's mental health, unintentional injury, adolescent sexual activity and childhood exposure to violence

Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population. Since this issue was difficult to define and thus hard to implement, it did not rise as a top priority in 2010. During problem mapping, we anticipate that this may be a strategy proposed for a number of the new priorities

Improve cultural and linguistic competence within the system of services for the MCH population:

A similar priority of addressing diversity did not rank high enough for specific inclusion, but it is an underlying value of the MCH program in Maine to address such issues within all of our work. For each priority selected, disparities and culturally competent approaches will be part of the problem analysis

Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs was replaced and reflected in some priorities specific to this population (adolescent sexual activity and children and adolescent mental health) as well as a part of other priorities that are not specific to the population, including intentional self-harm and suicide, family planning, violence against women, obesity and overweight among children and adults, unintentional injury, and childhood exposure to violence

The methodology for determining the 2010 priority needs built upon the experience of the 2005 CSNA. In 2005 we set out to ensure all voices were heard and from this process we gained a wealth of information not only from those working with the MCH population but from the consumers seeking services. To compliment the quantitative data, 17 focus groups were held to hear what participants perceived to be the strengths and needs of women, children, adolescents, and families. In addition issue experts from across the broad range of MCH, families and public health professionals, internal and external to Maine CDC and DHHS, were invited to respond to web-based surveys to provide input on narrowing the list of priorities. Fact sheets were developed for the top 30 priorities and reviewed and finalized by an expert for the specific issue. In 2005, the DFH did not solicit this broad input and as such we did not feel that all voices were represented in the priority setting process and that perhaps we were making decisions without having access to a comprehensive set of data.

While we have made many positive strides during the past five years, we continue to be challenged in our work by ongoing state and federal budget reductions. Therefore, the more specific priorities we developed for 2010 will allow us to more closely align our funding with priorities.

The Maine Title V, Five Year CSNA is the first step in a cycle for continuous improvement of MCH health. Beginning in late summer 2010 a strategy mapping process will be initiated to create a road map to address and track the 10 priorities so that we can be better informed on our progress toward improving the overall health of our MCH population. The many partnerships we have fostered over the years will be critical to the MCH Title V Program and our work during the next five years.

III. State Overview

A. Overview

Maine is the northernmost and largest state in New England and the easternmost state in the United States. Maine's population is growing at a slower rate than most of the U.S., but aging at a faster rate. The majority of residents reside in rural towns and small cities. The demographic and geographic factors that contribute to Maine's uniqueness among the New England states are the very same factors that create complex challenges for Maine's Title V agency as we strive to improve the health outcomes of the maternal and child health (MCH) population.

Note: All references noted throughout this section are documented in the Comprehensive Strengths and Needs Assessment.

There are 1.32 million people residing in the state of Maine.1 Between 2000 and 2008 Maine's overall population increased 3.3% compared to 8.0% in the U.S. Most of Maine's population growth was due to migration from other states (61.9%) and natural causes (excess births over deaths; 28.6%). However, 11.4% of the growth was due to international migration, which has resulted in increased racial and ethnic diversity within the state. In contrast, 63.5% of the U.S. population change in this period was due to net natural increases.2

Although 80% of American residents reside in metropolitan areas, the majority of Maine's population resides in rural towns and small cities. Statewide, 59.8% of the population lives in rural areas, as compared with 21.0% of the US population.8 More than one third (36.3%) of Maine's population lives in the two southernmost counties (Cumberland and York).7 However, these counties account for only 6% of the state's land area.7 In five Maine counties, 90% or more of the population lives in rural areas; 2 of these counties are 100% rural. 9

Maine has three major cities: Portland (pop. 62,561), Lewiston (pop. 35,131) and Bangor (pop. 31, 756).10 Collectively, only 10% of Maine's population resides in these three cities and each city experienced a population decline between 1990 and 2008 (2.8%, 11.6%, and 8.2% decreases respectively). 11 Augusta is the state capital of Maine and has a population of 18,282; Augusta's population has declined by 14% over the past two decades. 11-12

The average population density of Maine is 42.7 people per square mile, compared to 86.0 people per square mile in the United States. However, the population density of Maine varies dramatically across the state, from 330.4 people per square mile in Cumberland County, where Maine's largest city (Portland) is located, to 4.3 people per square mile in Piscataquis County.7

The median age of Maine's population is 41.1 years and is the highest in the country.3 Nationally, the median age is 36.4 years.3 The U.S. Census Bureau projects that by 2020, 19.1% of Maine's population will be under 18 years and there will be more people age 65 years and older than children under age 18.4 Between 2005 and 2020, Maine's population of 65 year old and older residents will increase by 52.7%, while the population under the age of 18 will decrease by 4.8%. Based on census projections, Maine's median age will be 46.9 years in 2020, compared to 39.0 years nationally.4

Maine's MCH populations (i.e., children, including those with special health needs and women of reproductive age) represent a significant proportion of the population. In 2008, children under 18 years of age plus women ages 18-44, represented 37.9% of Maine's population of 1.32 million.1 Children under 18 years of age comprised 20.8% of the state's population. (Nationally, children under age 18 composed 24.3% of the population.)1 Across the state's 16 counties the proportion of children ranged from 18.9% to 22.6%.5

The median age of women in Maine is 42.2 years.3 In 2008, women aged 15-44 years comprised 19% of Maine's population, similar to the proportion nationally (20.4%).1 Across the state, the

proportion of women of reproductive age within each county ranged from 16.8% to 21.5%.5

Prevalence estimates of current disability or special health needs among Maine children range from 10% to 20%, depending on the definition used. According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS?CSHCN), there were nearly 49,000 CSHCN in Maine, representing 17.7% of children under age 18.6

Demographics
Family

According to estimates from the 2005-2007 American Community Surveys (ACS), the average household size in Maine was 2.4 people and the average family size was 2.8.3 Less than one-third (30.4%) of households in Maine included one or more children under age 18 - slightly fewer than in the U.S. (34.6%).3 Of the households with a child under age 18, 23.3% were female-headed households; 10.8% were male-headed households. Of the households with a child under age 18 nationally, 25.1% were female-headed and 8.4% were male-headed.3 Of Maine women aged 15 years and over, 51% were currently married, 13.4% were divorced, 1.4% were separated, 10.4% were widowed, and 23.7% were never married.3

Racial and Ethnic Diversity

According to 2008 Census estimates, Maine's population is 96.4% white (95.3% of Maine's population described themselves as white alone, non-Hispanic), 0.6% American Indian or Alaska Native, 1.0% black or African-American, 0.9% Asian, and 1.5% two or more races. The Hispanic population is about 1.3%.13 Of Maine's children under age 18, 91.0% are non-Hispanic white and 1.8% are Hispanic.13

Although Maine's population is predominantly white, the state is gradually becoming more racially diverse. The proportion of the population that is white decreased from 98.4% on the 1990 census to 96.9% on the 2000 census,14 to 96.4% according to the most recent census estimates.13 Similarly, the proportion of Maine students in public and approved private schools who are white decreased from 97.5% in the 1993-1994 school year to 94.6% in the 2006-2007 academic year. During that school year, 2.3% of students were Black or African American; 1.4% were Asian/Pacific Islander; 0.7% were American Indian; and 1.0% were Hispanic.15

Based on 2005-2007 data from the ACS, nearly 22,000 Mainers identify as American Indian alone or in combination with one or more other races.3 There are five federally recognized Indian tribes in Maine today: Aroostook Band of Micmacs, Houlton Band of Maliseet Indians, Passamaquoddy Tribe of Indian Township, Passamaquoddy Tribe at Pleasant Point, and Penobscot Indian Nation. 16 The majority of Maine's native American population resides in or near the five small, rural communities of Indian Island (Penobscot Nation), Pleasant Point (Passamaquoddy tribe), Indian Township (Passamaquoddy tribe), Houlton (Houlton Band of Maliseet) and Presque Isle (Aroostook Band of Micmac).17

A total of 3,369 Passamaquoddy tribal members are listed on the tribal census rolls with 1,364 on the Indian Township census and 2,005 listed on Pleasant Point census.18 The Aroostook Band of Micmacs is estimated at 1,000 members.19 The Houlton Band of Maliseet Indians is comprised of approximately 800 members.20 The Penobscot Nation population is estimated at 2,365 members.21

In 2005-2007, 3.2% of Maine residents were foreign-born; the proportion within Maine's counties ranged from 1.2% to 5.2%.3 Approximately 30% of Maine's foreign born population was born in North America, 10.3% in Latin America, 27.5% in Europe, 21.3% in Asia, and 10.0% in Africa. Among Maine's foreign born, 77.4% entered the U.S. before 2000. Slightly more than half of Maine's foreign born population are naturalized U.S. citizens (51.1%). Across Maine, 7.6% of the population aged 5 and older spoke a language other than English at home; approximately 1.9%

spoke English less than "very well." 3

Emerging populations in Maine include people of Somali, Sudanese, and Iraqi ancestry arriving in Maine as primary refugees or secondary migrants. Refugees are individuals granted refugee status overseas by the U.S. Department of Homeland Security and are brought to the U.S. for resettlement by the U.S. Department of State and are assisted with resettlement in U.S. communities through the Office of Refugee Resettlement and voluntary agencies.22 In FY 08, sixty refugee arrivals were initially resettled in Maine (31 originating from Somalia, 19 from Sudan, and 3 from Iraq). 23 In FY07, there were 118 primary refugees who were resettled in Maine, 142 in FY06, and 151 in FY05. 23 "Secondary Migration" is a legal term which refers specifically to refugees who are placed for resettlement initially in one location in the United States, and who decide to relocate to another part of the United States. Although immigration data does not track secondary migration, it is the largest force affecting immigration into Maine. It has been estimated that far more foreign-born arrive in Maine every year through secondary migration than are placed here through federal refugee resettlement placements.16 For example, beginning around 2001, the number of people with Somali ancestry living in Maine began to steadily increase, both as primary and secondary immigrants, primarily resettling in Lewiston and Portland. The City of Portland's Refugee Service Program estimates that approximately 80% of Maine's immigrant population is due to secondary migration. 16 According to a March 2009 news article, 111 Iraqis have relocated to Maine from other states, and an additional 200 to 300 families are expected to arrive. 24

Educational Attainment

In 2005-2007, 88.8% of Maine residents ages 25 and over were high school graduates compared to 84.9% nationally.3 The county-specific proportion of residents ages 25 and over who graduated high school ranges from 87.9% to 92.3%.3 Although a slightly higher percentage of Maine residents over age 25 years have completed high school compared to the U.S., a slightly lower percent have a higher education degree. About one-quarter of Maine residents over age 25 have a bachelor's degree, and less than one in 10 (8.9%) completed an advanced degree. 3 Among Maine women, 93.2% of those aged 25-34 years and 93.7% of Maine women aged 35-44 years were high school graduates according to data from 2000, the most recent year available; both proportions were higher than that found among women of these age groups in the United States (85.9% and 86.6%, respectively).25

Socioeconomic Indicators
Income and Poverty

The Maine Department of Labor's Center for Workforce Research and Information estimated a "livable wage" of what Maine families need to earn to make ends meet, taking into account actual living expenses, including housing, health care, child care, transportation, and taxes.26 They estimated that the annual income required for a 2-parent (2-earner) 2-child Maine family to meet a basic needs budget was $54,384.26 The county-specific livable wage for this family type ranged from $47,746 (Aroostook County) to $58,515 (Cumberland County). Among 1-parent Maine families with 1 child in pre-school and 1 in public school, the annual income required was $41,615, with county-specific estimates ranging from $28,504 (Aroostook County) to $45,844 (Cumberland County).26 The livable wage is considerably higher than both the federal poverty level and the income of a minimum wage earner. Maine's $7.50 per hour minimum wage is 25 cents higher than the federal standard. 27, 28 In Maine, a full time year-round minimum wage worker will earn $300 per week, or $15,600 per year. The national poverty level for a family unit consisting of two people is $14,570 per year.29 The federal poverty level (FPL) for a family of four in 2009 was $22,050 and for a family of three was $18,310.29 As such, while significant portions of the MCH population are under the FPL, even higher proportions live in families that do not earn livable wages.

Based on ACS data, the median household income in Maine between 2005-2007 was nearly $5,000 less than in the U.S. overall ($45,211 vs. $50,007).3 Although states in the Northeast tend to have median incomes above the U.S. median, Maine's falls below the U.S. median. There is considerable variation in income across Maine counties. The median household income ranged from $33,171 in Washington County to $53,768 in Cumberland County.3

According to the 2007 ACS, 16.4% of the Maine's population had incomes below 125% of the poverty threshold based on household size; 4.5% had incomes below 50% of the poverty threshold; 7.5% had incomes between 50% and 100% of the threshold; and 4.4% were between 100% to 125% of the threshold. Poverty is inversely related to educational attainment; among females over age 25, 28.8% of those with less than a high school diploma were below the FPL, compared to 14.3% of high school graduates, 10.5% of those with some college, and 4.8% of those with a bachelor's degree or higher.3

Across Maine, 12.8% of residents and 16.3% of children under 18 years lived below the FPL between 2005 and 2007.3 The county-specific proportions of children under age 18 below the FPL ranged from 11.2% in Hancock County to 28.0% in Washington County. Among female-headed households with children under 18 years of age, 38.9% lived in poverty (U.S.= 36.9%).3 Approximately one in five (20.4%) families with children under age 5 were living below poverty and more than half (59.4%) of female-headed households with children under 5 lived in poverty between 2005-2007; this is slightly higher than similar households in the U.S.(45.5%).3

Labor Force and Employment

Maine's civilian labor force was estimated at 705,000 at the end of 2008.30 The proportion of adults aged 16 to 64 years old in the labor force ranges from 70.1% in Aroostook County to 80.5% in Cumberland County. The proportion of children with all parents in the labor force is 62.9%, and ranges from 50.9% in Sagadahoc County to 71.0% in Somerset County.3 Among women ages 16 to 64 years, 71% are in the civilian labor force. Median earnings for females in 2005-2007 were 67% of male earnings ($23,344 vs. $34,392).3

Maine, like the rest of the country has experienced a downturn in the economy. As of February 2010, there were an estimated 58,600 unemployed Mainers or 8.3% of the workforce.31 In comparison, in 2001, 3.1% were unemployed. According to the Maine DOL, since January 2008 Maine has lost 32,000 jobs (nonfarm payroll). Job losses have resulted in longer periods of unemployment, and the average duration for collecting unemployment compensation has risen from 14.0 to 17.4 weeks.32 Unemployment figures do not reflect the number of underemployed and those who have become discouraged and stopped looking for work. Based on US Census data, Maine has a larger proportion of its jobs in education, health care, and retail trade sectors than in the US overall, while a smaller proportion of its jobs are in manufacturing, wholesale trade, and administrative services sectors.3

Income Assistance

Between 2005 and 2007, approximately 23.3% of children under the age of 18 were living in households that in the previous 12 months had received Supplemental Security Income, cash public assistance income, or Supplemental Nutrition Assistance Program (SNAP).3 This proportion varied by family type. Among children living in married couple family households, 13.6% had household income from one or more of these sources; among children living in households with a female householder (no husband present) 48.3% had received assistance, and among children living in households with a male householder (no wife present), 34.9% had received assistance from one or more of these sources.3

SNAP assistance is one of the most wide-spread low-income benefit programs in Maine. According to recent data, approximately 16% of Maine's overall population was receiving food stamps. Preliminary data suggest that monthly food stamp participation increased by 18%

between June 2008 and June 2009.33 The monthly benefit per person averages $94.52 in Maine.

According to the Margaret Chase Smith Policy Center at the University of Maine, increases in food stamp use in earlier years (2001-2006) were explained more by changes in the administration of the program, such as increased outreach efforts rather than by increases in the level of need. However, the current increase in food stamp program participation is likely closely related to increased levels of need related to the economic downturn.34

Housing

According to 2005-2007 ACS data, 78.5% of Maine's housing units are occupied.3 Among Maine's 542,424 occupied housing units, 72.9% are owner-occupied and 27.1% are rented.3 The median gross monthly rent is $650. One-third of renter-occupied units consume 35% or more of the household incomes of renters. Approximately two-thirds of Maine's owner-occupied housing units have mortgages; 15.8% of owner-occupied housing units with mortgages have housing costs which consume 35% or more of the household incomes of owners.3

Among the Maine's occupied housing units, 6.3% have no vehicles available, 32.6% have one vehicle, and 61.1% have 2 or more vehicles available.3 Four percent of occupied housing units have no telephone service available. Nearly 70% (68.5%) of Maine's occupied housing units are detached single-unit structures, and 9.3% are mobile homes. Nearly 3 of 10 housing units (29.1%) were built before 1940.3

Finding affordable housing is a challenge for many Maine residents. According to a 2009 Maine State Housing Authority (MSHA) Report on housing costs in Maine, the median price of homes increased 69% between 2000 and 2007 but dropped 17.6% between 2007 and 2009. Maine's median income increased only 20% during the period 2000-2007 and increased only slightly (4.4%) between 2007-2009.35 The most affordable communities are in the more rural parts of the state (Aroostook, Piscataquis, and Somerset) with the least affordable in the southern and coastal areas.35 Similarly, rents increased almost twice as fast as income, leaving Aroostook county as the only affordable place to live.36

Homelessness

Homeless children are by most accounts among the fastest growing segments of the homeless population. Compared to their peers, homeless children are more likely to have health problems, developmental delays, learning disabilities, emotional difficulties, and mental disorders.

Homelessness has increased significantly in Maine in recent years. A Point in Time Survey conducted by the MSHA on January 27, 2010 revealed 885 people, including 177 children, were homeless. Factors most frequently cited as reasons for homelessness included: severe and persistent mental illness (43%), chronic disability (37%), and chronic substance abuse (26%). In a January 2009 MSHA report on rural homelessness, providers noted anecdotally seeing an increase in teen parents and young families between the ages of about 16-24 who lack skills needed to live independently thus increasing the burden on shelters. 114

In 2007, over 7,000 people stayed in Maine's emergency shelters, including domestic violence shelters.37 Of the 7,083 people who used emergency shelters, 15% used domestic violence shelters, and of the remaining: 47% were adult individuals, 22% were people in families (one or more adults with at least one child under age 18) and 16% were unaccompanied youth (persons age 23 or younger). Maine's emergency shelters and programs served a total of 513 families in 2007 which included 1,543 people of whom 867 were children under age 18. The most common reason for homelessness given by families in shelters was eviction; three in four families staying in shelters were led by a female head of household.37

Throughout 2007, Maine's emergency shelters and programs served 1,048 unaccompanied

youth; 59% male and 41% female. Approximately 30% of unaccompanied youth were age 17 or under, while 37% were age 18 to 20 and 33% age 21 to 23. The most common reasons for homelessness given by unaccompanied youth in shelters were health or safety, substance abuse, lack of employment, housing affordability, and family conflict. Males reported substance abuse as a primary contributor at over twice the rate as females, while females reported family conflict as a primary contributor at a 50% higher rate than males.37

Current Political Climate

During the past eight years under the democratic administration of John Elias Baldacci there has been strong support for issues of concern for the MCH population. In addition, the Democratic Party has retained leadership of the Maine House and Senate. Maine's congressional delegation is divided among the Republican and Democratic Parties. Olympia Snowe (R) and Susan Collins (R) represent Maine in the Senate and Chellie Pingree (D) and Michael Michaud (D) in the House. An election is scheduled in November to elect a new Governor and as such, with any change in administration there is an opportunity to remind the incoming administration of the need to support MCH related issues.

In 2004 Governor Baldacci merged the Departments of Human Services and Behavioral and Developmental Services to become the Department of Health and Human Services and the new DHHS was mandated to improve services, increase efficiencies, and improve relations with community organizations. The improvement in services, efficiencies, and relations apply to all segments of DHHS from direct and purchased service sections to finance and operations sections. (See Organizational Structure Section III C) Brenda Harvey is the Commissioner of DHHS.

Impact of Welfare Reform on Women and Children

The advent of Title XXI, SCHIP in 1997 prompted changes in insurance coverage in Maine. Maine responded by renaming our Medicaid program to MaineCare, and creating Medicaid-like Child Health Insurance Program. This state operated insurance program for children, which includes EPSDT, was for ages birth through 18 years in families 200% of the FPL. There is some cost-sharing for the MaineCare Program. Through the MaineCare Member Services Program (EPSDT), within the DFH, serves approximately 130,000 children ages 0--20 are served. Expansion of Medicaid and MaineCare not withstanding, there are still serious concerns about the changing composition of our uninsured populations. In addition to the traditional numbers of uninsured working poor, there is a growing number of middle-income earners who cannot afford the escalating cost of premium co-pays required for dependent coverage.

Maine, like so many other states, continues to experience a decrease in state revenues resulting in a state budget shortfall. The most recent cuts have directly impacted service areas, particularly those purchased through the State Medicaid Agency. While enrollment and eligibility for MaineCare services have not been reduced, some services have been limited along with reductions in provider fees. State and federal budget cuts have resulted in changes to MaineCare services that include reductions in children mental health services, foster care, occupational and physical therapy and rule changes that will restrict targeted case management services. Primary Care Case Management eligibility will be expanded to include members with SSI income who are not eligible for Medicare, and participating physicians must oversee and manage care plans for patients with chronic conditions. The 2010-2011 biennial budget requires many budget reduction initiatives within MaineCare. We anticipate the MCH population will be impacted by the reductions.

Statewide Health Care Delivery System (County and Local Health Departments)

Maine's rural nature and town meeting format of local government essentially preclude any significant County government structure or influence. The two largest cities (Portland and Bangor)

maintain local health departments (LHD) however there are no other health departments in Maine. Most public health functions are concentrated at the state level with minimal staffing and funding. The absence of LHDs and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. These challenges require the Maine CDC to provide some direct services in order to ensure statewide public health services access for our most vulnerable populations. The State's capacity to perform many categorical public health functions is extended through contracts with private health agencies; i.e. home health agencies; hospitals; rural health centers; and private physicians. Access is augmented by a developing telemedicine system statewide both in the areas of physical and mental health services. Hospitals and health centers particularly in the northern portion of the state are beginning to connect with specialists and tertiary care centers for consultation. Sunbeam Island Health Services (SIHS), a program of the Maine Sea Coast Mission offers health promotion and screening clinics via telemedicine to several of Maine's more remote islands. The Telemedicine program operates from the Sea Coast Mission ferry and is seen as an essential program to sustainable life on the isolated islands off the coast. Services vary from follow-up checks between prenatal visits to public health education. SIHS worked with the Ellsworth WIC office to become a WIC site and provides WIC services to Island women and infants.

Through Public Health Emergency Preparedness (PHEP) efforts the Maine CDC and its' public health partners continue to focus on strengthening public health functions at the local level. Establishment of regional epidemiology teams occurred through the state's PHEP activities, with the state divided into six regions that align with the Emergency Medical Services regions. Renewed discussions around Maine's public health infrastructure began during FY06 when legislation was passed (L.D. 1614) to establish a system of Comprehensive Community Health Coalitions (CCHC). From this legislation a Public Health Workgroup (PHWG) was formed to design and make a recommendation on the framework for Maine's public health system. By January 1, 2007 the PHWG submitted to the Legislature its report on required core competencies, functions and performance standards for CCHCs and the resource inventory and integration of funding sources. The report included identification of administrative units and regions for the purposes of administration, funding and the effective and efficient delivery of public health services. Maine CDC Director, Dr. Dora Mills, was a member of the workgroup. The new agreed upon structure is described in Section IV A.

The Governor's Office of Health Policy and Finance led the development of Dirigo Health legislation passed at the end of the first session of the 121st Legislature. A major component of the legislation was the creation of a Health Insurance Program that included health promotion, disease management, quality initiatives and health coverage through private insurance carriers that individuals, self-employed, and small businesses could buy into. Harvard pilgrim provides the health benefit package for Dirigo Health. Enrollment in the Dirigo Health Insurance Plan started January 1, 2005. Funding of the program continues to be controversial. A very contentious issue during 2006 was a Savings Offset Payment (SOP), a fee assessed on private insurers to support the program, determined by the savings resulting from Dirigo reforms in the state's health care system. Effective July 1, 2007 enrollment was temporarily suspended for individuals and September 1, 2007 for small businesses and self employed to allow the Dirigo Health Program to look for ways to cut costs after the legislature did not approve the Governor's request for additional funds to expand enrollments. Exceptions were made for babies born to women who were already covered by Dirigo and new employees of small businesses with Dirigo contracts. L.D. 1005 was passed on June 8, 2009 repealing the SOP and establishing a health access surcharge of 2.14% on all paid claims. As of September 2007, when new enrollment was suspended, 15,123 members were enrolled in Dirigo Choice; 28% were sole proprietors, 25% small groups, and 47% were individuals. No decision has been made on when enrollment will be reopened for those currently on waiting lists.

In May 2006 Governor Baldacci created a Blue Ribbon Commission to make recommendations for long-term funding and cost containment so that Dirigo Health could increase the affordability, accessibility, and quality of healthcare for Maine people. The report was issued in December

2006 and recommended funding the program from the State General Fund that could include taxes on specific behaviors and products that have a negative influence on health, for example tobacco products, snack tax, and a tax on bottled soft drinks to name a few. Regarding the cost containment, the Commission recommended a group be formed to carry out an independent review of the cost drivers in healthcare that effect both providers and payers. The Advisory Council on Health Systems Development released its report in April 2009. The report concluded that high health care costs resulted from health care variation in inpatient and outpatient use of care, high outpatient hospital services, and high emergency department use. The full report that includes strategies to control cost growth can be found at: http://www.maine.gov/tools/whatsnew/attach.php?id=70889&an=1.

In April 2008 the 2008-2009 State Health Plan was released. The Maine CDC has been assigned responsibility for many of the activities that will focus on reducing Maine's healthcare costs driven primarily by utilization and inefficiency. Details of the plan can be found at: http://www.maine.gov/governor/baldacci/cabinet/health_policy.html

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center (MMC) in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (30 are birth hospitals with obstetrical services); 15 critical access hospitals; 20 Federally Qualified Health Centers (FQHC) which includes 1 FQHC Look-a-like (Community Clinical Services in Lewiston) and 50 community health centers; 5 Indian Health Service funded health centers (3 on Reservations, 1 in Presque Isle, 1 in Houlton); and one osteopathic medical school. In 2009 MMC began an affiliation with Tufts University School of Medicine in Boston (allopathic medical school). 20 of 36 seats are reserved for Maine students. Three schools (University of Southern Maine, University of Maine at Orono and Husson College in Bangor) offer Nurse Practitioner Programs. The University of New England offers a Physician Assistant program. The University of New England is planning to open a new dental school.

Prenatal Care

Efforts to improve maternal and infant status in Maine are complicated by our geography and population distribution. Multiple services are available locally prior to the occurrence of a normal pregnancy and continue through the postpartum period for women and through the first year for infants. However, our high-risk services are located in our three largest cities: Portland, Bangor, and Lewiston. Level III facilities are located in Portland and Bangor. A Level II facility is located in Lewiston. Women without insurance or documentation can access service through a free-care pool of providers and monies. The CSHN Program, through its Genetics Unit, manages a grant with Maine Medical Center for the provision of perinatal outreach, which includes education of providers and consumers regarding issues pertinent to pregnancy outcomes.

Maine women receive routine clinical checks and pre-natal education. The PTM is aggressively addressing smoking cessation among pregnant women. More than three of four new Maine mothers reported that during a prenatal health care visit, their health care provider discussed how smoking during pregnancy could affect their baby. Among women who smoked in the three months before they were pregnant and had received prenatal care, 72.8% received at least some form of prenatal counseling on smoking cessation, according to 2004 -- 2007 data from PRAMS. In 2004-2007 PRAMS, 65.1% of Maine new mothers reported they had any alcohol in the three months before becoming pregnant; 9% reported alcohol use in the last three months of pregnancy. Currently the Caring Community Collaborative in Washington County and the Portland Women's Task Force in Cumberland County focus on perinatal addiction. The Perinatal Nurse Manager maintains contact and provides consultation to both groups.

High-Risk Care

The geographic distribution of Level III facilities increases the challenge of improving the proportion of VLBW infants in Level III hospitals. To date, the only two counties in Maine that have achieved the Healthy People 2010 goal for VLBW infants born in Level III facilities are the counties that contain Maine's two Level III facilities (Penobscot and Cumberland). Mothers in Knox and Androscoggin counties have been significantly less likely than Maine mothers overall to deliver their VLBW infants in a Level III facility.40 A small portion of the states MCH funds support the 24-hour statewide availability of perinatology and neonatology consults for providers. Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and equipped neonatal transport team utilizing both air and ground transport. With the departure of its neonatologist, the Level II nursery in Lewiston limits its scope to pregnant women and neonates beyond 32 weeks gestation.

Pediatric Services

Pediatric services are provided by pediatric and family practice physicians as well as pediatric and family nurse practitioners and physician assistants. There are 1,007 actively licensed Certified Nurse Practitioners in Maine but the Board of Nursing is unable to report on practice location. We estimate that 95.1% of our children (0-18 years old) now have insurance. Because of this, we phased out the PHN Well Child Clinics and are encouraging the connection of children to a pediatric medical home. Title V funds focus on specialty or wrap-around services (e.g. pre-delivery genetic testing and post-delivery genetic counseling, or the services of a pediatric specialist (e.g. pediatric endocrinologist). A recent challenge to health care services for all populations insured through MaineCare has been reimbursement for services provided. The OMS (Medicaid) transitioned to a Claims Management System (MECMS) in January 2005. MECMS was HIPAA compliant requiring more detailed billing information, however ongoing challenges with MECMS resulted in the decision to outsource to a fiscal agent, UNISYS via contract. Implementation of Maine's Integrated Health Management System is expected to take place in August 2010.

CSHCN Services

In an effort to address issues faced by children and youth with special health needs and their families, the CSHN is moving to a public health system of care. Utilizing State Implementation Grant for Integrated Community Services funds the CSHN Program has enhanced community development and systems integration by partnering with Maine Family Voices and the Maine Chapter of AAP to expand access to medical homes across the state. The Hood Center for Children and Families Initiative, Partners in Chronic Care was used to introduce and expand comprehensive care coordination services including transition to adulthood. The CSHN Program is focusing efforts on strengthening core program functions by establishing regional Youth Advisory Committees and Family Advisory Committees. A major programmatic change during FY08 was the implementation of a move from being a purchaser of medical services, serving a limited number of children and youth with special health care needs, to a program that assures a community-based system of care exists for all children and youth with special health care needs. The direct services team developed a ranking system (described in PM # 4) for use as a guide in making decisions around service provision during the transition period from direct to population-based and infrastructure services.

Financial constraints during FY06 resulted in the CSHN Program taking measures to reduce overall caseload. The CSHN Program no longer readily accepts those children served by MaineCare unless a particular service such as metabolic foods is not covered. The CSHN Program further reduced its number by requiring parents to submit an IRS 1040 form that more accurately describes a family's income. Previously the program accepted self-declaration of income. This initiative further reduced the total number of children who receive direct service coordination. Currently the CSHN Program is serving 230 infants, youth and children with primary

conditions of cleft lip and/or palate, inborn errors of metabolism and those children grandfathered in due to family financial need. The Department of Education (DOE), Division of Special Services reports that 30,751 (3-20) were served by special education. The DOE continues to experience a reduction in the overall number of students served by special education and reports school enrollment across Maine is declining. The DOE houses Child Development Services (Maine's Part C Program) and reported a total of 999 children ages 0 -- 2 were served.

Maine statute established the Birth Defects Program (BDP) in 1999. Legislation authorized the BDP to require reporting from Title 22, Hospitals and Title 32, Licensed Professionals; assure access to medical records, and allow contact with families to offer information and referral services. Mandatory reporting began in May 2003.

The BDP believes that the foundation for improving public health activities is the capacity of the system to identify problems through surveillance, tracking and follow-up services. Through a cooperative agreement with the University of Maine, College of Education and Human Development, ChildLINK, an electronic data tracking system, was developed. ChildLINK, was started with a goal of enhancing the screening, diagnostic assessment, and service delivery for children identified through the Newborn Hearing Program. ChildLINK rapidly expanded to include birth defects, newborn bloodspot, and cleft lip and/or palate.

During 2004-2007 there were 418 birth defects diagnosed in 292 babies. The most common birth defects were heart defects, orofacial defects, and neural tube defects.

Maine's Access to Dental Care

In 2009, 38 of Maine's 46 Dental Care Analysis Areas (DCAA) were designated as Dental Health Professional Shortage Areas. Several of these areas, e.g., Portland, Lewiston, and parts of York County, no longer meet requirements for federal designation; however, for many MaineCare members and low-income persons in those areas, access to dental care remains difficult.

The number of dentists in Maine is a challenge to access to care. Based on data collected by the Maine ORDRVS in 2008, which counts the number of providers in active practice, there were 608 licensed active dentists practicing in Maine resulting in a statewide ratio of 1 dentist for every 2,493 residents. (Source: ODRVS, Maine Cooperative Health Manpower Resource Inventory) Maine's dental workforce is not distributed evenly across the state; the range was from 1,633 people per active dentist in Cumberland County to 4,671 people per active dentist in Somerset County. Nearly one-third of all Maine dentists practice in Cumberland County, although this county is home to 21% of Maine's population. The Kaiser Family Foundation reports that 16.9% of Maine's population is underserved and living in a Dental Health Professional Shortage area compared to 10.4% nationally. (Source: Kaiser Family Foundation, statehealthfacts.org)

According to the 2008 survey, most active Maine dentists are currently accepting new patients (87%), while only 136 dentists (26%) indicated they are accepting new MaineCare patients. Fewer than half (47%) of active dentists in 2008 reported that they treated MaineCare patients; this has decreased since 2002 when 57% of active dentists reported that they treated Medicaid patients. Among the providers who accepted MaineCare, 58% reported limiting the proportion of these patients in their practice. In the past decade, MaineCare dental reimbursement decreased significantly relative to the costs of providing care, in spite of several targeted increases. This and difficulties with the state's payment system during the past few years have had an impact on the extent of dentist participation in MaineCare. Anecdotally, people across the state report waiting longer than they would like to for routine appointments or to find a dentist taking new patients. The reasons for this are complex, related to factors such as the distribution of the dental workforce and the aging of the dentist workforce as a group. For the population as a whole, however, combining data from three surveys using data from 2003, 2007 and 2008, we can estimate that roughly 27% of Mainers had not seen a dental care professional in the past 12 months; but this is regardless of age or insurance status.

Efforts to improve access to dental services in Maine have continued. The OHP continued to support the statewide Maine Dental Access Coalition, which functions as network and broad-based stakeholder group for oral health. The Dental Services Development and Subsidy Program (DSDSP), authorized by the Legislature in 2001 to fund a capacity-building competitive grants program and a subsidy program for community-based dental clinics, continues to have strong support. In FY10, eleven agencies providing services at 18 sites (consolidated to 16 later in the year) participated in the Subsidy Program. Capacity-building grants were continued through June 30, 2008. In May 2009 a decision was made to direct all available funds to the Dental Subsidy Program. Since the state had no capacity to continue supporting new initiatives, we decided these funds would be better spent helping to sustain existing infrastructure rather to expand it. In Maine's planning document for the decade, Healthy Maine 2010, a developmental objective was set to "Increase the geographic areas in Maine that have comprehensive oral health initiatives that include such components such as school-linked oral health programs, community water fluoridation, and nonprofit dental centers." It is worth noting that now, in 2010, the number of those non-profit dental centers increased from the 13 identified 10 years ago to 23, assisted not only by state funding but also private foundation support and expanded funding from HRSA's Bureau of Primary Health Care.

The OHP, with support from a State Oral Health Collaborative Systems Grant from MCHB, published a state oral health improvement plan in 2007. With the continuing support from the US CDC's Division of Oral Health in its State-based Oral Disease Prevention Program, the plan will be updated and refined starting in the fall of 2010, with a projected publication date in 2012. The Plan, and other required activities, particularly around policy development and policy action planning, along with supporting water fluoridation and school-based dental sealant programs, will certainly address expanding access to dental services in Maine.

Behavioral Health Services

The merger of Maine's Departments of Behavioral and Developmental Services and Human Services in July 2004, created a new DHHS and opened a myriad of possibilities for the Maine Title V and Office of Child and Family Services to unite in leadership to strengthen the systems and policies to support healthy emotional and cognitive development for all children and families. Early childhood intervention and home visiting services are shared between the Offices, with Public Health Nursing, Parent's are Teachers Too, and Alternative Response Programs aligning to offer a range of home visiting services. Programs are being integrated with other services provided to those populations for a more effective and efficient delivery of care. New opportunities that have already emerged include:

1. The strong emphasis in the Humane Systems for Early Childhood Grant on social and emotional health. The Children's Growth Council (formerly the Task Force on Early Childhood) has an action team that specifically addresses how the state early childhood plan will recommend action steps to humanize and de-stigmatize our approach as a state to this issue.
2. Collaboration between Children's Behavioral Health Services (CBHS) and Title V on systems issues such as transition from youth to adulthood of people with special health needs and vulnerable groups such as high-risk youth who have disconnected from services as they transition from the pediatric to the adult system of care and services. In addition CBHS brought Title V into the planning for implementation of Project LAUNCH through the Washington County Community Caring Collaborative.
3. Continued involvement of Title V leadership in a SAMHSA grant to strengthen state and local mental health systems as they relate to emergency preparedness.
4. Continued involvement of Title V leadership with efforts to strengthen systems of care for children affected by trauma.
5. A project, led by the Maine AAP and the Maine CDC, to raise awareness and change the role of physicians in schools so that they become engaged as leaders in collaboration to address school health issues that relate to social and emotional development.

6. Integration of members of the MIPP into the OCFS, Child Death and Serious Injury Review Panel to bring a stronger public health approach to the panel.
7. Inclusion of the Maine CDC, MCH Medical Director on the MaineCare drug utilization review panel. This has lead to the inclusion of the Medical Director on the antipsychotic workgroup and collaboration in developing guidelines for safely prescribing and tracking outcomes for these potent and potentially toxic medications.

The purpose of public health, as defined by the Institute of Medicine, is to foster conditions that will enable the whole population to achieve optimal health. We continue to sharpen and increase our focus on issues involving the medical and behavioral health care systems.

Despite a significant growth in the number of licensed clinicians and psychiatrists in Maine, the need continues to outstrip demand. Primary care physicians have been identified by their patients as the preferred source for behavioral health services, yet these providers often have limited training and expertise in diagnosis and management of complex behavioral health problems. Also, the primary care providers struggle with referring patients to a complex fragmented and confusing behavioral health system with a history of less than optimal communication and collaboration. In recent years, CBHS embarked on a search to explore new and innovative means of addressing the challenges. The Maine Title V Program has been a partner in this search with child and adult behavioral health since 2003.

A promising model that we want to put into practice in Maine is an integrated system of primary care and behavioral health through the Patient Centered Medical Home Improvement Project. While still relatively new, this system has been successfully implemented in other states. Although its details vary according to the unique needs and strengths of communities, the model views the primary care physician as the primary source of behavioral health care and focuses on developing a link between the child's medical home and the behavioral health care system.

CBHS took steps to further address this issue through action led by the Medical Director for Behavioral Health, Dr. Elsie Freeman, who expanded the reach of this effort to include services for people of all ages; and started work with MaineCare to alter its rules to facilitate integration. At this time, there are about 25 sites around the state that are using a variety of approaches to integration, and a number are studying outcomes. Also, the Department, including Title V, continues to strongly support integration and, in particular, Ed Wagner's Care Model out of Washington State. The Humane Early Childhood Systems Plan, released by the Children's Cabinet in March 2006, strongly emphasizes the need for strengthened integration of behavioral health and socio-emotional development into an early childhood system that provides essential resources, shares common standards for quality, and respects the diversity of Maine's children and families. CBHS, in partnership with Title V and many other agencies, is implementing its Trauma-Informed System of Care Grant. The emphasis of this grant on family and youth involvement, interagency collaboration, and cultural and linguistic competence mirrors the philosophy for humane systems change in Maine Title V. A uniquely strong partnership between the Trauma-Informed System of Care Grant (Project THRIVE) and Title V has emerged.

The MCH Medical Director's leadership has helped to identify and recruit a group of Maine pediatric practices for testing the models; made sure that the efforts of the State Early Childhood Comprehensive Systems Grant are connected with those of the project; and advocated strongly for family and community involvement in all phases of the project.

B. Agency Capacity

Our many partnerships and collaborations expand our capacity to ensure good penetration of services in all but the most northern area of our state and a few other remote pockets where we continue to be challenged by difficult access to care. The goal of both the DFH and the Division of Chronic Disease (DCD) is to collaboratively promote health and prevent disease, injury and

disability through a variety of cross programmatic public health interventions ranging from primary prevention through broad-based community health promotion initiatives, early detection, health systems interventions, delivery of health services and the promotion of healthy public policies. The vision is "that individuals, families and communities in Maine will achieve and sustain optimal health and quality of life" through:

1. Building systems and community capacities
2. Initiating and advocating for public health policy
3. Developing and delivering programs and services
4. Collaborating with others
5. Providing leadership

We are part of an ongoing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. We use the five-year planning process as an opportunity to reassess our overall direction. Because we must continue to be the "safety net," and provide direct services for some of our most vulnerable residents, changes in program focus and activities must be done with great care and forethought. This is a multi-year process, requiring transitioning of resource allocations from traditional to current and emerging priorities. Continued collaboration with stakeholders and representative advisory groups is critical.

Strong relationships with organizations, in particular the University of Southern Maine (USM), Muskie School; University of Maine at Orono; Medical Care Development; and the Maine Center for Public Health are critical to our programs success. These organizations not only provide manpower but also make available critical expertise on issues important to Mainers. The Muskie School, specifically the Cutler Institute, Population Health and Health Policy, have also provided guidance and education regarding strategic planning and coalition building, skills essential to a healthy Title V program.

Beginning in 2000 the DFH has focused increased financial and human resources to develop a strong MCH Epidemiology Team (Epi Team). The MCH Epi Team has had 3 FTE epidemiologists since 2008; one doctoral-level epidemiologist, Dr. Erika Lichter and 2 MPH epidemiologists, Cindy Mervis and Denise Yob. Combined with the DCD funded epidemiologists there are a total of 6 epidemiologists. During FY11, three additional staff positions will be added to the MCH and chronic disease Epi Team. The MCH Epi Team is financed through SSDI State MCHBG match funds and several federal categorical grants.

During the past ten years, the DFH has significantly expanded its capacity specific to epidemiology. An area for growth is evaluation. Staff within the DFH has the capacity to conduct simple process evaluation. We contract with evaluators from the University of Maine, Maine Center for Public Health, and consulting firms such as Hornby Zeller Associates for more complex evaluation plans and specific time limited projects. A DFH priority is to develop capacity within the Title V programs related to evaluation, which will strengthen Title V resources available to the emerging public health districts.

Title V funded programs serving pregnant women, mothers, infants and children are detailed on the attached Table 1.

An attachment is included in this section.

C. Organizational Structure

The State Title V Agency in Maine is within the Department of Health and Human Services (DHHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the DHHS's Maine Center for Disease Control and Prevention (Maine CDC). Programs, that focus primarily on the Maternal and child health (MCH) population are found in both the Division of Family Health (DFH) and the Division of Chronic Disease (DCD). The day-to-day management

of the MCH Block Grant is carried out in the DFH, with Valerie Ricker designated as the manager with ultimate responsibility for administration of the MCH Block Grant.

Brenda Harvey, Commissioner of Maine's DHHS, reports directly to Governor John E. Baldacci. Dora Anne Mills, M.D., M.P.H. serves as Director of the Maine CDC and is the State Health Officer. Valerie Ricker, M.S.N., M.S. is Director of the Maine CDC, DFH which houses primarily direct service programs. Ms. Ricker reports to the Deputy Director of the Maine CDC, Christine Zukus-Lessard. Debra Wigand, MEd, CHES is the Director of the Maine CDC, DCD which houses population-based prevention and health promotion services. Stephen Meister, M.D., MHSA, is the MCH Medical Director. We have 3 MCH epidemiologists, Erika Lichter, ScD., Cindy Mervis, MPH and Denise Yob, MPH. The DFH continues to support a women's health coordinator position in an effort to focus attention on women's health in a more comprehensive manner.

A recent partner, Maine's tobacco prevention program, known as the Partnership for a Tobacco-Free Maine (PTM), supports various MCH efforts through the Fund for a Healthy Maine (FHM). This fund was established in 1999 by the Legislature to receive and disburse tobacco settlement payments. Annually the largest proportion of FHM funds are directed toward tobacco prevention efforts. PTM routinely collaborates with the Teen and Young Adult Health, Women, Infant and Children, and Home Visiting Programs on tobacco-related issues. Other MCH related areas receiving FHM funds include providing support for childcare subsidies, school-based health centers, and family planning. PTM is located in the Maine CDC, DCC.

On September 17, 2005 phase 2 of the DHHS reorganization became law. Contained in the law were several components which impacted the Title V Program. First was a change in name of the Bureau of Health to the Maine CDC. Second was the movement of the Early Childhood Initiative (ECI) and the Home Visitation Program (HV) to a new Early Childhood Division within the Office of Child and Family Services (OCFS), the state child welfare agency. The change in physical location, as well as, reporting configuration became effective January 2008. The ECI coordinator continues to meet regularly with the Title V Director and the MCH Medical Director on the ECI and home visiting activities.

In May 2005 the Maine CDC started a strategic planning process based upon knowledge gained through The Strategy-Focused Organization by Robert S. Kaplan and David P. Norton. The strategic planning process resulted in relocation of several programs within the Maine CDC. The Maine Injury Prevention and Control and Teen and Young Adult Health Programs are now located within the DFH.

A hiring freeze continues to delay filling federally funded positions, although to date Maine CDC has been successful in its requests for exemptions to the freeze for key positions. Maine's remote location and salaries that are non-competitive with neighboring state's urban areas continue to pose recruiting challenges for the Department. Ongoing shortfalls in the state budget pose difficulty in hiring into state funded positions. Starting in March 2009 however, other on-going vacancies prevented programs from carrying out all planned activities for the current fiscal year.

The MCH leadership has clinical training and expertise. They maintain membership with their respective professional organizations i.e. Maine Nurse Practitioner Association, Maine Chapter of American Academy of Pediatrics, and North East Rural Pediatric Association ensuring an ongoing relationship with primary care providers. Several MCH personnel are also involved in statewide and national initiatives that involve primary care.

In 2007 Dr. Dora Anne Mills, Maine CDC Director approved the reorganization of the DFH. The reorganization groups the DFH programs into four sections; children with special health needs, public health nursing, women infants and children, and population health and prevention with the leader of each section reporting to the DFH Director.

Organizational charts indicating positions and/or programs supported with Title V funds are attached.

An attachment is included in this section.

D. Other MCH Capacity

The majority of the MCH Title V program staff are centrally located in Augusta, our State Capital. Staff classifications include: clerical support, health planners, planning and research assistants, health educators, program managers, accountants, and MCH medical director and administrative senior managers. Title V also funds 6 positions outside the Divisions of Family Health and Chronic Disease: 1 person in the Office of Data, Research and Vital Statistics; 2 in the Health and Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); 1 in the Office of Minority Health, Project LAUNCH; and 2 in the Department of Education (work with schools to develop and utilize comprehensive health education curricula). All of these positions contribute to the achievement of MCH priorities. Parents of children with special health needs form the leadership and body of the Family Advisory Council (FAC). Youth with special health needs are the body of the Youth Advisory Council (YAC) with staffing provided by the youth coordinator. The recent opportunity to add a 5th delegate to Maine's AMCHP members initiated conversations to identify the most appropriate person to represent Maine families. A young adult with special health needs and a parent of a child with special health needs were hired through the State Implementation Grant. Each of these positions is a liaison to the larger FAC and YAC. The parent conducts follow-up for the Newborn Hearing Screening Program for infants identified with a refer at hospital discharge and is the AMCHP delegate. The young adult coordinates youth-focused activities and reviews materials, from a youth perspective, for both the State Implementation Grant and the Healthy Ready To Work National Center.

The Office of Data, Research and Vital Statistics (ODRVS) provide data for this grant application and meet with the Epi Team and Division of Family Health (DFH) managers for specific data needs. Our increased epidemiology capacity is leading to increased cross-divisional work between the DFH and ODRVS on MCH priorities. The Department of Education (DOE) works closely with the Manager of the Coordinated School Health Program, to develop and use comprehensive health education curricula that include sexual health. We believe that by facilitating the development of individuals who understand their bodies and take ownership of their health care we have lowered our teen pregnancy rates, increased abstinence and decreased the incidence of sexually transmitted diseases. Through SSDI and other categorical funds we have increased our epidemiology capacity. Our epidemiologists have worked closely with the DOE and other public health partners to develop a survey with multiple health indicators that will help us monitor Maine's children's health status and develop a long-term surveillance system within the Maine CDC. The Maine Integrated Youth Health Survey (IYHS) was designed to consolidate the number of surveys that schools were asked to participate in and optimize school acceptance of these surveys. The first IYHS was administered in 2009 and data became available in Spring 2010.

During the early 1990's support for many state funded positions was assumed by the MCHBG. A state budget deficit resulted in positions being cut if other funding sources could not be identified. Converting PHN, Teen and Young Adult Health, Maine Injury Prevention, CSHN and Oral Health positions to federal funds facilitated maintenance of staff providing services to the Title V population. In FY02, staff salaries exceeded available federal funds. A short-term alleviation included salary savings through vacancies and medical leave, freezing vacant lines and extensive reductions in purchased supplies and materials. A medium-term remediation involved generation of revenue to support positions to be accomplished through fee-for-service and targeted case management. Once again in March 2010 salaries exceeded revenue resulting in lines being frozen. Currently there are 7 vacancies within the programs serving the MCH population. The vacancies are within the Children with Special Health Needs, Public Health Nursing, Population Health and Prevention and Teen and Young Adult Health Programs. Recruitment is ongoing for

all vacant positions. Filling clinical positions such as PHN are particularly difficult due to low salary differences between state government and the private sector.

Title V partially supports 54 Public Health Nurses (4 supervisors and 50 field nurses) who are based statewide in 13 regional satellite offices. These nurses provide direct services via home visits, school health, immunizations, well child and specialty clinics, and participate in our program planning/evaluation. The Title V Program also has an agreement with the University of Southern Maine's Muskie School of Public Service for assistance with facilitation, training, and performance measurement, and quality improvement activities.

Senior level management include: Valerie J. Ricker, Director of the Division of Family Health, which has administrative responsibility for Title V. Ms. Ricker has 30 years of experience in MCH, 14 years with the Maine CDC as Title V Director. She has a BSN and MSN in Nursing and MS in MCH, focusing on Public Health. Dr. Stephen Meister, MCH Medical Director, is a graduate of Tufts University School of Medicine. He served his internship and residency at The Children's Hospital of New York at Columbia Presbyterian Medical Center. He later was awarded a Masters in Health Services Administration from The George Washington University School of Medicine and Health Sciences. During his active duty in the US Navy, Dr. Meister served as Division Head of the Pediatric Acute Care Clinic at the Naval Medical Center in San Diego. In 2003 and again in 2007, Dr. Meister received recognition by the American Academy of Pediatrics with a Special Achievement Award for his work with the Pediatric Rapid Evaluation Program, a program developed to evaluate the medical and mental health needs of children entering foster care in Maine. Dr. Meister has been in practice as a general pediatrician for 23 years. He is the author of presentations on the assessment of stress/trauma in children and the medical needs of foster children. Toni Wall is the Director of the CSHN Program and has been in this position for 11 years. She has 23 years experience working in Maine CDC Programs. Her past experience has prepared her to influence and manage the program. Toni holds a Masters in Public Administration with a concentration in Health Care Administration. Jan Morrissette has been the Director of Public Health Nursing for 5 years. She has been with PHN for 25 years starting as a field nurse. She holds BSN and MSN degrees and is a Robert Wood Johnson Executive Nurse Fellow. Lisa B. Hodgkins received her B.A in Psychology and M.Ed in Counseling from the University of Maine at Orono. She has worked in both the private and public sectors and has spent twenty years of her career in state government, most recently as the Director of the Women, Infants and Children's Nutrition Program. Her years in the private non-profit sector were in the areas of children's behavioral health and school based health care. Nancy Birkhimer is the Section Leader for Population Health and Prevention within the DFH at the Maine CDC. This section includes the Maine Injury Prevention Program, Women's Health, Teen and Young Adult Health, the Safe Families Partnership, and the state's MCH Epidemiology Unit. Previously, Ms. Birkhimer served as the Director of the Teen and Young Adult Health Program and the State Adolescent Health Coordinator for ten years. Ms Birkhimer has a Masters of Public Health in Epidemiology and International Health from Boston University.

Dr. Erika Lichter, the MCH Epidemiology Team leader, has a ScD in Public Health with a major in MCH and minors in Biostatistics and Epidemiology from the Harvard School of Public Health and a master's degree in Developmental Psychology from the University of Arizona. Cindy Mervis, MPH brings 13 years of experience as an Epidemiologist, many of which were with the federal CDC. Approximately 50% of her time is focused on MCH related projects. Denise Yob, MPH brings experience with needs assessments within a statewide network of community-based family support centers and Early Head Start sites. She also assisted in analysis for the National Evaluation of Fetal and Infant Mortality Review Programs. Her focus is on MCH activities.

Biographical sketches are on file in the Maine CDCs Division of Family Health and will be made available for review on request.

E. State Agency Coordination

The Maine CDC/Division of Family Health has several methods for establishing working relationships/collaboration with other entities. (Table 2 attached) We make a concerted effort to establish personal contact with others we believe to be representatives of key stakeholders in issues that involve shared populations. Others approach us when they determine that we are stakeholders in their initiatives. Finally, we convene planning groups and ask for consensus on group membership and involvement. Maine Title V has been responsible for:

- Creating a Children's Growth Council of varied state, community, and family representatives

- Developing comprehensive grant proposals for early childhood systems, women's health, integrated services for CSHN, and implementation grant for traumatic brain injury

- Sharing resources and ideas for survey development

- Providing leadership in the development of an integrated youth health survey to reduce the number of survey requests made to schools

- Connecting the Department of Labor with Child Care Resource Development Centers to meet MCH population needs for child care when seeking training or employment

- Leading ad hoc groups to study and report on the prevention of prematurity and, on early childhood as an economic development issue

- Engaging, with the MCH Medical Director's involvement, the Maine Chapter of AAP participation in a family centered survey dealing with child care in the workplace

- Promoting interagency training, including cultural and linguistic competence, oral health, and assets

- Supporting the Maine Chapter of AAP in developing a website for their organization

- Coordinating a group of state and non-governmental partners to take a public health approach to domestic violence and sexual assault through the Maine Safe Families Partnership

- Implementing a Maternal and Infant Mortality Review Panel

The Maine CDC Division of Family Health (DFH) continues to develop a relationship with Maine's primary care organization "Maine Primary Care Association" (MPCA). This organization has many competing priorities; the patient population served by community and rural health centers covers the lifespan, thus MPCA involvement in MCH issues is limited. Over the last three years MPCA led a campaign to increase funding for childhood immunizations allowing Maine to return to being a universal vaccine state. In addition MPCA has partnered with the DFH in developing learning collaboratives related to women's mental and behavioral health (depression and substance abuse).

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

The Maine MCH Program strives to put into practice systems to improve the health and safety of the MCH population. The following examples show how the Health Systems Capacity Indicators will help us to become clearer on how to connect data to action.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.0	23.5	18.9	22.1	22.1
Numerator	149	165	134	158	
Denominator	67660	70245	70744	71459	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 hospitalization data are not yet available. 2008 data were used as an estimate.

Notes - 2008
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Numerator = hospitalizations of children <5 years of age for which the principal diagnosis was asthma

2008 population estimate from the US Census as of July 1, 2008 was used as denominator.

Notes - 2007
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Numerator = hospitalizations of children <5 years of age for which the principal diagnosis was asthma

2007 population estimate from the US Census was used as denominator

Narrative:
The data for this indicator are derived from Maine's Inpatient Hospital Discharge Database and population estimates from the US Bureau of the Census. Based on the most recent data available, the rate of hospitalization for children under age 5 was 22.1 per 10,000 in 2008. This rate is slightly higher than the 2007 rate, but since 2004, the rate of asthma hospitalizations among this population has remained relatively stable.

In FY09 the MAP conducted a school health survey to gain a better understanding of asthma in schools. All schools were contacted and the survey was administered with the individual who handled student asthma--related issues; in most cases this was the school nurse. 566 responses were received from 631 schools. Preliminary results indicated that 9% of students were diagnosed with asthma; with the highest rate in the northernmost area of the state (12%); over 1/3 of the children with asthma have persistent asthma and need daily medication, and 37.5% of students with asthma had asthma plans on file with the school. High school (HS) students were slightly more likely to have an asthma diagnosis (9.8%) than elementary school (ES) students (8.6%), but less likely to be on daily medication. HS students with asthma were significantly less likely to have an asthma plan (29.9%) than ES (41.9%). The final report is anticipated by late

summer.

New data on childhood asthma were also collected as part of the Maine IYHS, a school-based survey of children in grades 5-12 and parents of kindergarten and 3rd graders administered in Spring 2009. Among middle schools students, 22.8% reported that they had ever been told they had asthma. Of these students, 47% still have asthma. Similarly, 26.8% of HS students reported that they have ever been diagnosed with asthma and 45% of these students still have asthma. Of students in 5th and 6th grade, 17% had been diagnosed with asthma and 15% of parents of kindergarteners and 3rd graders reported that their child had been diagnosed with asthma.

Through federal CDC funds, the MAP has been working to improve asthma management among children with the goal of reducing hospitalizations; efforts include working with physicians in schools to increase the number of children with asthma management plans, providing community grants to increase asthma management education, providing peak flow meters to children, and training school nurses on asthma management plans. Other strategies include enhancing Maine's asthma surveillance system, and building and evaluating partnerships.

In the state asthma plan children are identified as a population that is disparately affected by asthma and there are several objectives related to improving asthma management among children. The MAP developed a pre-school brochure, intended for parents of young children, to inform them about asthma management. MAP hopes to pilot the brochure at a Head Start site with plans to disseminate to all Head Start agencies and day care centers in the state.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	86.1	89.9	88.6	89.4	87.0
Numerator	6335	6494	6711	6685	6722
Denominator	7354	7221	7574	7477	7723
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2009 indicator is for Federal Fiscal Year 2009 (10/1/08-9/30/09).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the infant had a claim.

Notes - 2008
The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2008 indicator is for Federal Fiscal Year 2008 (10/1/07-9/30/08).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the infant had a claim.

Notes - 2007
The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2007 indicator is for Federal Fiscal Year 2007 (10/1/06-9/30/07).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the infant had a claim.

There have been several changes in MaineCare staff calculating this measure over the years; we are uncertain as to whether consistent criteria were used across the years.

It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
Data for this indicator are provided by Maine's OMS. In FY09, 87.0% of MaineCare enrollees under 1 year of age received at least 1 initial periodic screen. However, due to claims bundling by Rural Health Centers, FQHCs, and ambulatory hospital based clinics, this estimate may not be accurate because there is no way to tell if a service received at one of these settings is a periodic screening for infants. All we can do is count whether or not the infant had a claim. This number is comparable to FY06-FY08 data.

Overall management of the EPSDT Program resides within the OMS. In 2007, the informing and referral assistance component was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the DFH, home of Maine's Title V agency and is currently managed by the CSHN Program. Movement of this component into the CSHN Program provides the opportunity to influence infant access to periodic screening as well as the content of information provided to MaineCare subscribers.

In Fall 2008, EPSDT convened a work group of stakeholders to discuss improving Maine's program. The CSHN Director and MCH Epidemiologist are part of this group. The federal CMS requires that States report EPSDT participation rates every year. We are expected to have at least an 80% participation rate but this past year Maine was at 59% participation. One of the goals of this group is to develop strategies to help MaineCare to attain the 80% benchmark participation for Maine children and youth.

The EPSDT workgroup is also trying to improve data collection on physician practice during

EPSDT visits. Currently physicians who see MaineCare patients for a well-child visit are required to fill out a Bright Futures form that include information on health history, screenings, and guidance. Starting in March 2008 all of these forms were entered into a database. Previously only forms that required follow-up by PHNs were entered. Entry of all forms into the system will provide the Title V program with a better picture of physician practice around screening and guidance.

As part of Maine's SSDI application, Maine's Title V agency has started formalizing a partnership with the OMS. Through this partnership, which will lead to the use of linked MaineCare and birth certificate data, Title V will work towards increasing the number of infants who receive early screening and address the measurement of this indicator.

In Spring 2010, Maine, in collaboration with Vermont was awarded 1 of 10 grants from the U.S. DHHS to improve the quality of health care delivered to children, with a focus on children enrolled in Medicaid and SCHIP. Maine and Vermont will share $11.3 million in funding from the CMS over 5 years. With this grant, MaineCare, the Maine CDC and the Office of Vermont Health Access will work with their state universities to develop and test several initiatives to determine whether or not they are effective in improving children's health.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	75.0	87.9	82.6	77.3	73.2
Numerator	27	29	19	17	30
Denominator	36	33	23	22	41
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2009 indicator come from the Office of MaineCare Services and is for federal fiscal year 2009 (10/1/08-9/30/09).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

Notes - 2008

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2008 indicator is for federal fiscal year 2008 (10/1/07-9/30/08).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

Notes - 2007
The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2007 indicator is for federal fiscal year 2007 (10/1/06-9/30/07).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

It is difficult to interpret any differences between the 2006 indicator and indicators for prior years due to a change in MaineCare staff calculating this measure; we are uncertain as to whether consistent criteria were used across the years. There was a large percentage increase in the 2006 indicator, but this estimate is unlikely to be stable due to the small numbers. It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
Data for this indicator are provided by Maine's OMS. In FY09, 73.2% of MaineCare enrollees under 1 year of age received at least one initial periodic screen (30 out of 41 enrollees). The small number of infants enrolled in SCHIP may cause this estimate to vary substantially over time.

Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP Program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, FQHCs,

and ambulatory hospital based clinics are permitted to bundle their MaineCare claims. With claims bundling, the MaineCare agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. As a result, this indicator may be underreported.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population. Maine's State System Development Initiative will also help monitor infant receipt of periodic screens by allowing Maine's Title V agency to access linked birth certificate and Medicaid data.

Maine's new Child Health Insurance Program Reauthorization Act (CHIPRA) grant should help improve the quality of care received by children enrolled in SCHIP, including receipt of early and periodic screens (see HSCI #2 for more information on this initiative).

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.5	87.1	86.5	84.7	84.8
Numerator	12316	12297	12163	11506	11399
Denominator	14072	14121	14068	13582	13435
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data from this measure are from Maine's 2009 electronic birth certificate database from Maine's Office of Data, Research and Vital Statistics.

Notes - 2008
Data from this measure are from Maine's 2008 electronic birth certificate database from Maine's Office of Data, Research and Vital Statistics.

Notes - 2007
Data from this measure are from Maine's electronic birth certificate database from Maine's Office of Data, Research and Vital Statistics.

Birth certificate data on this measure are similar to 2007 PRAMS data. According to PRAMS, 84.8% of women reported greater than or equal to 80% prenatal care on the Kotelchuck Index.

Narrative:
Data on prenatal care are derived from birth certificates provided by Maine's ODRVS. In Maine, 84.8% of women with a live birth in 2009 received at least adequate pre-natal care (defined as

80% on the Kotelchuck Index). Since 2003, Maine's estimate on this indicator has remained fairly stable with adequate prenatal care estimates ranging from 83.8%-87.5%.

Maine's Title V Program is working on improving the adequacy of prenatal care in the State through ongoing monitoring efforts. Maine has had the PRAMS in place since its inception. These data provide valuable information on women's pre and post pregnancy behaviors. Maine also examines and publishes data on pre-natal care and birth outcomes using birth certificate data. Through an SSDI grant, Title V will begin working with MaineCare to link birth certificate and MaineCare data to examine birth outcomes in relation to pre-natal care. By examining these data and disseminating the results, we hope to increase the % of women in Maine receiving adequate prenatal care. Title V also works very closely with WIC to encourage women enrolled in WIC to obtain prenatal care.

Efforts to improve prenatal care include 1) Maine's HV Program, which now has a contracting performance measure related to the % of prenatal enrollments into the HV program; 2) The Perinatal Substance Abuse Collaborative Project, a vibrant multi-disciplinary group that addresses systems issues such as ensuring a non-punitive approach to the new neonatal drug exposure reporting law and establishing standards for breastfeeding among women taking methadone; 3) The Early Childhood Plan has several recommendations related to prenatal care, and 4) Maine's MIMR Panel.

Maine received a SAMHSA grant to address unmet child health needs between the ages of prenatal to 8 years of age in Washington County. This Project LAUNCH demonstration is working with pregnant women who are at risk for a preterm birth and/or a prolonged hospitalization due to neonatal abstinence syndrome. One initiative is a pre-delivery visit by the mother, her support person and one of her service providers to the EMMC NICU. This visit prepares the mother for the potential needs of her baby in the postpartum period as well as familiarizes her with EMMC staff, starts hospital discharge planning including follow up visits.

In Fall 2007, district-level health profiles were released.
http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm
These profiles included data on the % of women receiving prenatal care in the 1st trimester by district and showed statewide racial and ethnic disparities in accessing early prenatal care. By raising awareness of key MCH-related health issues in individual districts across the state, such as adequate prenatal care, Maine's Title V Program hopes to work more closely with communities to improve this indicator. Tables with district-level public health data can be found at.
http://www.maine.gov/dhhs/boh/health_indicator_comparison.htm

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.6	94.0	94.2	92.9	92.9
Numerator	113657	124443	125159	124443	127412
Denominator	139367	132322	132805	134015	137128
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Data are from the Office of MaineCare Services, Maine Department of Health and Human Services.

2009 indicator is for Federal Fiscal Year 2009 (10/1/08-9/30/09). Indicator is for 1-21 year olds.

Notes - 2008
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Data are from the Office of MaineCare Services, Maine Department of Health and Human Services.

2008 indicator is for Federal Fiscal Year 2008 (10/1/07-9/30/08). Indicator is for 1-21 year olds.

Notes - 2007
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2007 indicator is for Federal Fiscal Year 2007 (10/1/06-9/30/07). Indicator is for 1-21 year olds.

In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
According to Maine's Medicaid office located within the OMS, 92.9% of MaineCare eligible children received a service paid for by the MaineCare Program in FY08. This is approximately the same percent as was reported for FY06-FY08. Between 2001-2006, the percent of MaineCare eligible children who have received a service from MaineCare steadily increased indicating that more children who are eligible for services from MaineCare were receiving them, but has leveled off in recent years.

As mentioned under HSCI # 02, in November 2007, the informing and referral support component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the DFH, home of Maine's Title V agency. This component of the EPSDT Program is currently managed by Maine's CSHN Program. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population.

Maine's OMS has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT services. This group was convened in September 2008 and continues to meet on a regular basis. One of the goals of this group is to develop strategies to help MaineCare in attaining the 80% benchmark participation for Maine children and youth as required by federal CMS.

The CHIPRA grant received by Maine and Vermont in 2010 is designed to increase the quality of care among children enrolled in MaineCare. This project should help increase use of medical

services among Maine children enrolled in Medicaid (see HSCI #2 for a full description).

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	40.1	43.0	44.6	48.1	49.6
Numerator	7825	8582	11786	12799	13520
Denominator	19534	19972	26421	26610	27253
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Data are from the Office of MaineCare Services, Maine Department of Health and Human Services.

2009 indicator is for federal fiscal year 2009 (10/1/08-9/30/09).

Notes - 2008
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

2008 indicator is for federal fiscal year 2008 (10/1/07-9/30/08).

Notes - 2007
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

2007 indicator is for federal fiscal year 2007 (10/1/06-9/30/07).

It is important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
The OMS reported that 49.6% of EPSDT eligible children aged 6-9 received any dental services within FY09. The %t has increased over time since 2006. It is difficult to interpret any differences between the 2006 indicator and indicators for prior years due to a change in MaineCare staff

calculating this measure; we are uncertain as to whether consistent criteria were used across the years.

The Maine OHP continued to fund and coordinate the school-based/school-linked SOHP. For the 2007-08 school year, there were 79 grants to schools, school districts and several community agencies throughout the state, providing oral health education and dental screening in 242 participating elementary schools. Children in many schools participate in a weekly fluoride mouthrinse program, and in about half of all participating schools, 2nd graders may receive dental sealants at school. School eligibility for the SOHP is determined by a formula that includes the proportion of students eligible for the Free and Reduced Lunch Program and MaineCare as well as the proportions of the community receiving fluoridated public water and whose family income is at the FPL. In this way, the SOHP is directed toward those communities and schools where children are more likely to have problems with accessing dental services, since socio-economic status is directly related to the ability to obtain dental care. Local SOHP directors work to assure that children who may be eligible for MaineCare do enroll; they also often work within their communities to find dental care for children who do not have a regular source for care.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance components of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population regarding EPSDT eligible infants and dental services.

Maine's OMS has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT services. This group was convened in September 2008 and continues to meet on a regular basis. A representative from Maine's OHP is a member of this group.

The CHIPRA grant received by Maine and Vermont in 2010 is designed to increase the quality of care among children enrolled in MaineCare. This project should help increase use of dental services among Maine children enrolled in Medicaid (see HSCI #2 for a full description).

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.3	0.4	0.3	0.2	0.2
Numerator	9	12	9	5	5
Denominator	2821	2938	3096	3080	3228
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The numerator is from Maine's CSHN program. The denominator comes from the federal Social Security Administration: http://www.ssa.gov/policy/docs/statcomps/ssi_sc/#state

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program stopped serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare.

Notes - 2008
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program stopped serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare.

Notes - 2007
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program is no longer serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare.

Narrative:
The CSHN Program currently serves 235 children through the medical services program. This program pays for specialty medical care that includes in/out patient care, medications, durable medical equipment, specialists, and other medical services that are deemed medically necessary. Based on data from Maine's CSHN Program, less than 1% of SSI beneficiaries under age 16 receive services from Maine's CSHN program. This is due to the CSHN Program no longer serving (as of July 1, 2005) those clients who receive all of their services through MaineCare. Since the SSI population automatically receives MaineCare this population has been reduced. As of December 2009 the Social Security Administration reported that 3,228 children under the age of 16 were receiving SSI. During FY09 the Maine CSHN Program served 5 of these children.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	other	7.1	5.5	6.3

Notes - 2011

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2009.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2009.

Non-Medicaid: Calculated by subtracting the Medicaid number of low birthweight babies from the All number of low birthweight babies and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

Maine's Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. Another potential data source for this indicator is the 2008 PRAMS survey, which found that 7.1% of MaineCare births were low birthweight, compared with 4.7% of non-MaineCare births and 5.9% of all births statewide.

Narrative:
Maine has put a great deal of energy into expanding eligibility for MaineCare and simplifying the enrollment process. MaineCare incorporates the Child Health Insurance Program (CHIP). It covers pregnant women and children birth through 18 up to 200% of the federal poverty level.

It is important to note that the data presented for the non-MaineCare population include those who are uninsured, as well as those who have private insurance. The percent of low birth weight babies among MaineCare enrolled infants is higher than those not enrolled in MaineCare. In addition, those insured through MaineCare are less likely to start prenatal care in the 1st trimester and have adequate prenatal care, as defined by the Kotelchuck Index. The 2009 data suggest that infant mortality rates are better among those receiving MaineCare compared to non-MaineCare. However, obtaining an accurate count of deaths among those enrolled in MaineCare has been challenging. MaineCare's data analyst currently conducts a manual search in the Medicaid data for infants who died using a list provided by the Maine Vital Records Office. We are working on formalizing a request for a linked infant birth/death file that we can link with MaineCare data to allow for better identification of infant deaths among those enrolled in MaineCare.

Collaborations with MaineCare on understanding the differences within HSCI #5 have allowed us to understand the complexity of MaineCare -- how, for example, the MaineCare population includes a heterogeneous mix of recipients who qualify through multiple categories; and how the way that MaineCare defines eligibility (one month versus 11 month enrollment in a given year) significantly affects the indicators. At the same time, by working together, MaineCare has learned from Title V that MaineCare enrollment itself does not translate into full access to a Medical Home for a recipient. Through Maine's SSDI grant, we plan on increasing collaborations between Title V and MaineCare to better understand these differences and work towards improving this indicator.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State					

Infant deaths per 1,000 live births	2008	other	1.8	9.4	5.6

Notes - 2011
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2009. MaineCare manually matched the names on a list of infant deaths (provided by the Office of Data, Research and Vital Statistics at the Maine CDC) against the MaineCare database. Due to the manual match technique used, it is likely that some deaths were missed. The low number of infant deaths in the state each year also makes this comparison difficult to interpret.

Non-Medicaid: Calculated by subtracting the Medicaid number of infant deaths from the All number of infant deaths and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2008. Mortality data are not yet available for 2009.

Narrative:
An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other	84.8	92.7	88.6

Notes - 2011
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2009.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2009.

Non-Medicaid: Calculated by subtracting the Medicaid number of infants born to pregnant women receiving prenatal care starting in the first trimester from the All number of infants born to pregnant women receiving prenatal care beginning in the first trimester and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. Another potential data source for this indicator is the 2008 PRAMS survey, which found that 84.6% of women enrolled in MaineCare received prenatal

care during the first trimester, compared with 96.9% of women who were not enrolled in MaineCare and 90.2% of women statewide.

Narrative:
An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other	81.2	88.5	84.8

Notes - 2011
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2009. The statistic is calculated including all births. It is not restricted to only women age 15-44.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2009. Data are restricted to only those age 15-44.

Non-Medicaid: Calculated by subtracting the Medicaid number of pregnant women with adequate prenatal care from the "All" number of pregnant women with adequate prenatal care and dividing that by the number of total women giving birth minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year) and slightly different denominators (women giving birth vs. live births; age differences), this figure is a rough estimate, rather than an actual value.

Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. As such, we also present the following values from the 2008 PRAMS survey:
"Medicaid" population: 83.9%
"Non-Medicaid" population: 88.4%
"All" population: 86.0%

(Note: For the PRAMS analysis, a woman was considered to be in the "Medicaid" population if she reported that she was enrolled in Medicaid/MaineCare just before pregnancy or that Medicaid/MaineCare was one of the payers for her prenatal care or delivery.)

Narrative:
An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
In Maine, SCHIP is combined with MaineCare. Together, these programs cover infants, children and pregnant women up to 200% of the federal poverty level. Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. In 1999, MaineCare blended SCHIP with Title XIX.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 150 150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	 200

Narrative:
An overall discussion of HSCI 06 can be found under HSCI 06A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Pregnant Women	2008	200

Narrative:
An overall discussion of HSCI 06 can be found under HSCI 06A.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Maine has a SSDI in place to help increase the capacity of the Maine Title V Program to have access to policy and program relevant information and data. Maine's SSDI grant has helped to increase the epidemiology capacity of the Title V Program to allow us to support the Title V Program and analyze data for the MCH Block Grant. A doctorate-level MCH epidemiologist was hired in 2005 and three masters' prepared epidemiologists are currently involved with MCH programs. The SSDI initiative also helped Maine's Title V Program complete the CSNA for the 2005 Block Grant. In December 2006, Maine's Title V received continued SSDI funding. Through this grant, the Title V Program is working on increasing its data capacity by: (1) linking WIC and birth certificate data and MaineCare and birth certificate data, (2) enhancing the birth defects surveillance system, (3) developing a database for a new MIMR Panel, and (4) supporting the

development and sustainability of school health surveys. In addition, used the funds to conduct a CSNA to inform the 2010 MCH Block Grant.

In addition, funding from the SSDI has allowed us to explore our existing data sources to inform program policies and activities. For example, we have conducted in-depth analyses of Maine's linked birth-infant death database to examine in more detail the demographic and systems-level characteristics associated with infant mortality in the state. These analyses will inform the work of Maine's new MIMR Panel. In addition, we have built a relationship with the OMS to access MaineCare data for key MCH indicators. We are also working with the University of Maine to enhance the usability of Maine's ChildLink system, which includes infant birth and death data, newborn hearing, newborn screening, and birth defects. This past year, we also started examining linked data systems in other states to build Maine's data linkage capacity.

In 2009, Maine administered the Maine IYHS. This ambitious survey includes questions from the Youth Risk Behavior Survey, Maine's Youth Drug and Alcohol Use Survey, as well as other questions added by programs within the Maine CDC, including many MCH-related programs. High school, middle school, and elementary school versions were created and distributed. Many of the questions on these surveys will inform MCH programs. Data on many items will be available at the local level, which will help community-based MCH efforts. The survey is coordinated by the director of the Maine CDC's Teen and Young Adult Health Program and SSDI funding will be used to ensure data quality and for analysis. The survey has achieved over a 60% response rate. The data became available in Spring 2010.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Maine Integrated Youth Health Survey	3	Yes

Notes - 2011

Narrative:
Maine has several data systems in place that allow us to monitor tobacco use among youth in grades 9-12. Between 1995-2007, Maine administered the Youth Risk Behavior Survey (YRBS) to middle school and high school students biennially. The YRBS is a statewide representative sample of youth and includes several questions on tobacco use in the past month and during the lifetime. Starting in 2002, in alternate years, all high schools and middle schools in Maine were invited to participate in the Maine Youth Drug and Alcohol Use Survey (MYDAUS)/Youth Tobacco Survey (YTS). This survey included detailed questions about substance use, including tobacco, within the past month and during the lifetime. Data for both the YRBS and MYDAUS/YTS are available online. Schools that participated in the MYDAUS/YTS are able to access school-level data online as well.

In Spring 2009, Maine administered the Maine IYHS. This survey includes question from the YRBS, MYDAUS, as well as other questions, including many on tobacco use. High school, middle school, and elementary school versions were created and distributed. The high school survey includes several questions on tobacco use within the past 30 days, including the use of cigarettes, cigars, and chewing tobacco. The survey achieved over a 60% response rate and the data became available in Spring 2010.

Maine has seen dramatic drops in adolescent tobacco use in recent years, showing a 60% decrease over 8 years. These drops can be attributed to a comprehensive approach that includes: (1) Maine adequately funding tobacco control and prevention, one of only six states to meet the CDC's minimum funding recommendations, (2) restricting youth access to tobacco products, through enforcement of laws and tobacco-free schools policies, (3) smoke-free environments, including restaurants and bars, and (4) high tobacco taxes.

An in-depth analysis of 2001-2007 YRBS tobacco questions was recently conducted for Maine's Tobacco Program. Results revealed that smoking has declined in high and low risk youth, but there has been a greater relative decline in the lower risk population. These results provide evidence for a concentration of smoking in high risk youth and encourage collaborative strategies between programs within the health department to reduce smoking as well as other high risk behaviors (e.g., suicide ideation, risky sexual behavior). These analyses have been incorporated into a paper that was submitted for publication.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Maine is unique for a number of reasons. Geographically, Maine's land area is the size of the other 5 New England states combined, is divided into 16 counties, has 3 large cities, Portland, Lewiston-Auburn and Bangor and has a population of 1.32 million people, more than 1/3 of whom live in the 2 southern most counties of the state. (See Section III A for more detail.) The state has a long history of local civic engagement with an independent, can-do spirit that fosters cooperation regardless of political beliefs. Towns continue to be the core of Maine's governmental structure in which roughly 344 of the 432 towns and cities maintain the direct democracy, town meeting format of government. County government, on the other hand, is weak.

Maine's state bureaucracy remained relatively small and underdeveloped until the 1970's and 1980's, when many federal responsibilities were transferred to the states, including Title V. In a widely published 1983 report to the National Governors' Association (America's Children: Powerless and in Need of Friends), Maine's DHHS provided a compelling argument for why the unmet needs of our nation's children require governmental and societal support. Maine's public health system, including MCH, was built upon this structure. Most public health functions are concentrated at the state level. While the 2 largest cities (Portland and Bangor) have local public health departments, the state does not have any county health departments. The Maine CDC's PHNs, public health educators, health engineers, district and tribal liaisons, and restaurant inspectors provide the local Maine CDC public health presence. The State's capacity to perform many categorical public health functions is extended through contracts with private health care providers and community-based organizations.

Maine's Robert Wood Johnson Turning Point Grant resulted in a recommendation for a regional public health infrastructure (RPHI). Many of the Turning Point recommendations were addressed in the Governor's Dirigo Health Plan legislation in 2003. The Governor's Office of Health, Policy, and Finance lead the discussion regarding RPHI. The Public Health Workgroup (PHWG) was convened in 2005 and charged with outlining a regional structure. Maine's State Health Plan (SHP) for 2006-2007 included objectives to build a statewide public health infrastructure (PHI) for the purposes of improving efficient and effective public health capacity and the delivery of the 10 essential public health services and 3 core functions of public health statewide. The emerging infrastructure includes a statewide network of Comprehensive Community Health Coalitions; an enhanced Local Health Officer system; 8 districts, each with a District Coordinating Council for Public Health (DCC); Maine CDC Public Health Units located in DHHS regional offices; existing Tribal and Municipal Health Departments, and Maine CDC and Office of Substance Abuse in the DHHS. The emerging public health system will coordinate with and build upon the strengths of existing infrastructure that includes health care and education systems, family planning and MCH systems, other non-profit organizations, emergency management, and other regional and local government entities. The 8 districts are based on county lines and are as follows: Aroostook; Cumberland; Penquis; Downeast; Midcoast; Central Maine; Western Maine; and York. The districts were chosen based on population, geographical spread, county borders and hospital service areas and are the same configuration as those used by the district court system and tourism bureau. The Maine DHHS recently adopted the same district boundaries and is implementing them within the child welfare and mental health sections within DHHS. Public Health Units of the Maine CDC will eventually be aligned to serve these districts. Each district is convening a DCC as a collaborative interface between local and state public health entities. The DCC's will help assure coordinated, effective and efficient public health delivery in each district. They are also responsible for developing district public health improvement plans (DPHIP) and their planning will contribute to the SHP as well as local health planning efforts. The PHWG completed its planning work and submitted a final report "Current Plans and Recommendations for a Statewide Public Health Infrastructure to be Developed Within Existing Resources Over the Next Five Years". (http://www.maine.gov/dhhs/boh/phwg/index.htm#report)

A statewide Coordinating Council (SCC) was formed and will build upon the work of the PHWG to implement a statewide PHI that assures a more coordinated system for delivery of public health services. A search was conducted and the Director of the Office of Local Public Health (OLPH) and the 8 District Public Health Liaison (DPHL) positions were filled. OLPH activities to date include: setting up the OLPH, hiring DPHLs developing a Local Health Officer Training, forming DCC's in all districts, conducting Local Public Health System Assessments in all 8 districts, and providing assistance to the HMPs around the Mobilizing for Action Through Planning and Partnerships (MAPP) assessments. The MAPP assessments will be completed in 2011 and included in DPHIPs, currently in development. Maine's PHI was codified in statute in 2009.

Looking at the conceptual framework for the services of the Title V MCHBG, Maine's resources have fallen more heavily within the Direct Services (DS) area resulting from the state's limited local resources. Over the past 14 years, under the direction of Valerie Ricker, the Title V Program has shifted its priorities from primarily funding direct MCH services to also supporting efforts and projects that promote the development of family-centered MCH systems of services and care. The emphasis has shifted from relying on the MCHBG for DS provision to using it as an innovative planning and system building tool in promoting better health and developmental outcomes. Thus, we have adjusted the balance of human and financial resources so that they are more in alignment with Title V's role in strengthening public health capacity and infrastructure at the local and regional level. The beauty of Title V is that it gives states the flexibility to adjust their role and function to that of placing a greater focus on core public health functions and quality assurance in relation to DSs provided at the local and regional level. Maine's Title V activities, by level of the pyramid for the MCH population, are summarized in the attached Table 3.

An attachment is included in this section.

B. State Priorities

In late 2008, the priority setting process began with Maine's DFH senior leadership team and program staff designing an objective and deliberate process for the selection of the 2010 priorities. The overall goal was to compile a set of priorities, based on strengths, needs and assets to assist in guiding the DFH's work over the next five years. To ensure widespread investment in the chosen priorities, there was significant staff and stakeholder involvement in the selection of priorities. Consensus about the proposed process was reached in March 2009 among DFH program managers and stakeholders.

The process for selection of the priorities for 2010 changed considerably from 2005. One criterion in 2005 was a desire to be inclusive in the priorities selected, and to capture a wide array of needs within the priorities. By contrast, in 2010, there was consensus among MCH programs and stakeholders that the 2005 priorities were too broad and thus a deliberate attempt was made to be specific with each priority. The priorities selected for the next five years were developed based upon an in-depth analysis of the health of the MCH population through quantitative and qualitative data. While the priorities are listed as 1-10, this does not mean that number 1 has a higher rating than 10.

The 10 priorities selected in 2010 and rationales are as follows:

1. Suicide and Self-inflicted Injury: Reduce suicide and self-inflicted injury in the maternal and child population in Maine.

Suicide is the second leading cause of death among youth and the 4th leading cause of death among women age 15-44 years in Maine. Each year, approximately 1 in 10 adolescents consider taking their own lives. The impact of suicide is devastating to survivors including family, friends, schools and entire communities. Risks for suicide include poor mental health, substance abuse, and trauma.

Progress on this priority will be measured using NPM #16 and SPM #1 (new in 2011).

Other related measures include: SPM #2, SPM #6, SPM #7

2. Violence Against Women: Reduce the prevalence of domestic violence and sexual assault and associated health disparities.

Every year over 7,000 Maine women are physically or sexually assaulted by an intimate partner. In 2008, approximately 48% of homicides in Maine were related to domestic conflicts. In the same year 373 rapes were reported to law enforcement, a 19% increase from 2004. Violence against women is linked to poor physical and mental health outcomes for women and children, such as depression, suicide, sexually transmitted infections, unwanted pregnancies, traumatic brain injury, and chronic pain. A public health approach to the problem is essential to preventing violence before it occurs and reducing its harmful effects.

Progress on this priority will be measured using SPM # 2 (New in 2011)

Other related measures include: SPM#1, SPM #4, SPM #6, SPM #7

3. Obesity and Overweight: Reduce the prevalence of overweight and obesity among children and adults in Maine.

In Maine, like the rest of the nation, obesity and its associated health consequences are increasing exponentially. Data from 2009 show the problem is pervasive from youth to adulthood. Almost 2 out of 3 Maine adults (64%) are considered either overweight (38%) or obese (26%). The percent of obese adults in Maine has increased 87% since 1995 when 14.1% of Maine adults were obese. In 2009, according to the Maine Integrated Youth Health Survey, about 1 in 4 Maine high school and middle schools students (26.4%, 26.2% respectively), 30.5% of 5th and 6th graders, and 33% of kindergarten and third graders were overweight or obese. Obesity is a risk factor for chronic conditions, such as heart disease, diabetes, cancer, and arthritis, and is associated with premature death. Obesity is the number-two killer, after tobacco, in total number of deaths due to preventable causes. Encouraging state-wide efforts that help people achieve recommended levels of physical activity and proper nutrition is critical to improving the long-term health of Maine's MCH population.

Progress on this priority will be measured using: NPM #14 and SPM #3 (new in 2011); additional data will be available from Maine's CHIPRA grant

4. Family Planning: Improve reproductive health outcomes for Maine women.

By improving women's reproductive health, we can improve women's health and infant birth outcomes. This priority encompasses unintended pregnancy, access to contraception, pre-conception care, as well as birth outcomes. Public health actions can greatly impact women's reproductive health. Education regarding contraception and available and affordable methods of birth control are crucial in reducing the number of unintended pregnancies. Increased awareness of preconception health and family planning may improve the chance of having a healthy baby.

Progress on this priority will be measured using: NPM #08, #15, # 18, HSCI # 04, HSI #01A, #01B, #02A #02B #05A, #05B, SPM #4 (continued from 2005)

Other related measures include: SPM #2, SPM #6

5. Child and Adolescent Mental Health: Improve behavioral/mental health and trauma status of infants, children and adolescents by offering responsive support, services and educational information.

Historically, the role of trauma was underestimated within the youth population. SAMHSA recently

reported that 39% of children have experienced trauma. Research informs us that exposure to trauma even in utero can have profound and lasting implications on children's mental health and well-being. Early responsive intervention is essential and serves as a primary prevention tool for mental health/behavioral and addiction issues. Developing early intervention services and trauma responsive services and supports is the foundation for changing current rates of mental health and behavioral problems in our 18 and under population.

Progress on this priority will be measured using: NPM#16

Other related measures include: SPM#2, SPM #7

A new state performance measure on child and adolescent mental health will be developed in the coming year after we identify the areas of children's mental health where Maine's Title V agency will focus its efforts.

6. Autism: Ensure early identification and a comprehensive and coordinated family-centered system of care for children with autism spectrum disorder.

Maine will ensure that all children with ASD/DD are identified as soon as possible in order for the child and family to receive the full benefit of early intervention services and supports. Public and private entities will work together with families to ensure intervention services and supports will be effective, accessible, coordinated, comprehensive, of high quality and delivered in a culturally competent manner. All services and supports for children with ASD/DD will be incorporated into a comprehensive family-centered system of care, with continuous quality improvement.

Progress on this priority will be measured using: NPM#2, #3, #5

A new state performance measure on child and adolescent mental health will be developed in the coming year after we identify the areas of children's mental health where Maine's Title V agency will focus its efforts.

7. Unintentional Injury: Reduce the incidence of unintentional injuries to Maine's MCH population.

In Maine, during 2002-2006, unintentional injuries were the leading cause of death among 1-44 year old residents. Unintentional motor vehicle traffic crashes were the leading cause of injury deaths for children and youth ages 1-24 and unintentional poisoning was the second leading cause of death among those age 15-24 years. Injuries are a preventable public health problem and reducing injuries and the resulting disabilities and deaths are among the objectives of Healthy Maine 2010 and Healthy People 2010. A solid injury prevention infrastructure in the state health agency is essential to reducing the burden of injury.

Progress on this priority will be measured using: NPM #10, HSI #03A, #03B, #03C, #04A, #04B, and #04C, SPM #5 (new in 2011)

8. Adolescent Sexuality: Improve adolescent sexual health.

Adolescent sexual activity, including vaginal, anal, and oral intercourse, carries the risk of unintended pregnancy and STD transmission. In 2007, 45% of Maine high school students reported ever having had sexual intercourse, 5% before age 13. Additionally, 41% of teens did not use a condom during their last sexual intercourse and 20% were under the influence of drugs or alcohol before their last sexual intercourse. In Maine teen pregnancy rates declined by 41% from 1991-2006 compared to a 32% decline nationally. However, similar to the U.S., Maine has seen its teen birth rate increase in recent years.
Continued initiatives by state sponsored agencies are necessary to reduce pregnancy rates and the incidence of STDs among teens and young adults in order to ensure the best future for all

Maine youths.

Progress on this priority will be measured using: NPM # 08, HSI #05A

9. Women's Mental Health: Improve women's mental health and access to mental health treatment for women suffering from a mental health condition, including postpartum depression.

More than 1 in 4 women in Maine have ever been diagnosed with depression or have current symptoms of depression. Women are more likely than men to have higher rates of disorders such as major depression, anxiety, posttraumatic stress disorder, and eating disorders. Risks for mental illness can be biological, social and neurological. Women are vulnerable to depression around the time of pregnancy and during the postpartum period. In addition, trauma-related experiences during childhood and adulthood can increase risk for mental illness. There is evidence based on the Adverse Childhood Experience study that early trauma can have life-long effects on physical and mental health. Recent studies suggest that counseling that integrates trauma, mental health, and substance abuse disorders is associated with improved outcomes. However, a challenge for many who are suffering with a mental health disorder in Maine is finding and accessing treatment.

Progress on this priority will be measured using: SPM # 6 (New in 2011)

Other related measures include: SPM#1, SPM #2, SPM #4

10. Childhood Exposure to Violence: Reduce children's exposure to violence at home, in school and the community.

Violence experienced during childhood is a major, worldwide public health problem. Children can be exposed to a wide range of traumatic events including injury to self, witnessing serious injury or the death of others, or experiencing the imminent threat of injury or death to self or others. Traumatic events may elicit overwhelming feelings of terror and helplessness. They may be acute, occurring at a particular place and time like a physical assault or disaster or terror event; or they may be events that occur repeatedly over an extended period of time. A history of exposure to violence or experiencing trauma can have a significant negative effect on a child's behavior, development and can make it more likely that an individual will engage in tobacco use and or substance abuse, criminal activity, teen pregnancy and self-injurious behavior including suicidality.

Progress on this priority will be measured using: SPM # 7 (New in 2011), SPM #2,

Related measures include: SPM #1, SPM #4 SPM #6

The Maine Title V Program has selected 7 performance measures related to the above priorities; they are;

1. The rate of suicide deaths (per 100,000) among those age 20-44 years.

This measure was chosen because the MIPP is expanding its efforts to address suicide and self-inflicted injury across the lifespan. The number of suicides among males and females in this age group is among the highest of any age group in Maine. When an adult dies by suicide, it can have serious consequences for the families and children who are survivors. Data from this measure are from death certificates maintained by the Maine ODRVS within the Maine CDC.

2. The percent of adult women reporting sexual assault or intimate partner violence within the previous 12 months.

By reducing the occurrence of domestic violence and sexual assault, we can reduce the

consequences. Data from this measure come from the Maine BRFSS System. Maine's Title V program is committed to maintaining questions on the BRFSS to track this outcome over time.

3. Percent of students in grades 5-12 who are overweight or obese.

Children who are overweight or obese are at increased risk of becoming overweight adults and developing chronic conditions, such as Type II diabetes, at a young age. Establishing healthy lifestyle habits among children decreases this risk. Data for this measure are from the Maine Integrated Youth Health Survey (MIYHS).

4. The rate of unintended births among women less than 24 years of age.

Unintended births in Maine among young women have steadily increased over time. Unintended pregnancy can be a consequence of preconception factors such as access to contraception, substance use, and intimate partner violence. The consequences of unintended pregnancy include inadequate prenatal care, poor birth outcomes, postpartum depression, and child maltreatment. This SPM was included as part of the 2005 CSNA and we have chosen to maintain it for this priority. The data are from Maine's Pregnancy Risk Assessment Monitoring System.

5. The hospitalization rate (per 10,000) of unintentional poisonings among children and youth aged 0-24 years.

The MIPP, through its CDC Injury Core Capacity grant, has two priorities related to unintentional injury that apply to the MCH population: (1) motor vehicle crashes, and (2) unintentional poisoning. There is a national performance measure and several health status indicators related to motor vehicle crashes and unintentional injury mortality and hospitalization. Unintentional poisoning has been increasing in the state and MIPP has been working with the Northern New England Poison Control Center and the Maine Office of Substance Abuse to examine and address the problem. Data for this measure come from the Maine Hospital Discharge Dataset, which is produced on an annual basis by the Maine Health Data Organization.

6. The percent of women with depressive symptoms receiving medication or treatment for a mental health or emotional condition by a doctor or other healthcare provider.

The determinants of mental illness can be biological, social, and neurological. They can include experiences with violence as an adult or child, stressful life events, and lack of social support. It is critical that health care providers screen for signs of mental distress and help patients receive needed treatment. Research suggests that primary care providers can play a critical role in detecting and treating depressive symptoms. This measure will help us assess whether women who are struggling with depression are receiving care. Data are from the Maine BRFSS.

7. The rate of substantiated cases of child abuse and neglect assessed by Maine's Office of Child and Family Services.

Although childhood exposure to violence can occur outside of the home in schools and communities, we have selected to measure childhood exposure to violence in the home. Childhood maltreatment has been linked to poor health outcomes throughout the lifespan including mental illness, chronic disease, substance use, and disability or death. The data for this measure are collected by Maine's Office of Child and Family Services. By reducing children's exposure to violence, we will decrease the number of cases assessed by the state for maltreatment.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	26	24	18	32	20
Denominator	26	24	18	32	20
Data Source				Maine Newborn Screening Program	Maine Newborn Screening Progran
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Starting July 1, 2008, Maine started screening for cystic fibrosis. In 2009, 13,285 infants were screened and 9 were confirmed through sweat tests to have the condition. All are currently receiving treatment.

Notes - 2008
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Starting July 1, 2008, Maine started screening for cystic fibrosis. Since the implementation of this screening test 6,906 infants have been screened and 8 were confirmed through sweat tests to have the condition. All are currently receiving treatment.

Notes - 2007
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

The Joint Advisory Committee (JAC) for Newborn Screening (NBS) and Children with Special Health Needs (CSHN) recommended in FY06 that the 19 optional screening disorders become

part of the mandatory panel. Effective, January 2006, the panel included 28 disorders. During FY07 the JAC undertook a planning process for including cystic fibrosis screening for all newborns. The JAC recommended that it be added in July 2008. The Genetics Program coordinator worked with all stakeholders and interested parties to ensure systems were in place to ensure infants were receiving 100% follow-up in a timely manner.

a. Last Year's Accomplishments

Maine participates with the New England Newborn Bloodspot Screening Program (NBSP) in a regional effort to assure babies receive timely, accurate, high quality screening and receive timely follow-up. Program staff report abnormal screens to the primary care physician (PCP) including recommendations for evaluation and follow-up and make referrals to appropriate specialty providers. All abnormal results are reported out within 24 hours of receipt based on the urgency of the results. A phone call is made to the PCP with a follow-up result letter outlining the phone discussion. If there is a high likelihood of the child having the disorder, NBS staff make a follow-up call to the provider the following day to confirm they were able to reach the family to check on the baby's condition. NBS staff monitor for repeat specimens and communicate with specialty clinics to assure children enter into care and receive appropriate treatment. 95% of results are reported out the day results are received. The remaining 5% are not urgent, or either we are not able to reach the provider, or we need to ensure a staff person is available after the phone call to answer questions. Our contract with the New England NBSP Laboratory includes program coverage on days when NBS staff are not available to ensure no delays in reporting abnormal results.

The data for this measure come from Maine's NBSP. In 2009, one hundred percent of newborns that screened positive for one of the conditions monitored by Maine's NBSP panel had timely follow-up to definitive diagnosis and clinical management. Maine has maintained this high standard since at least 2002 and preliminary data from 2010 indicate that we continue to provide timely follow-up to all positive screens.

Maine consistently screens over 99% of infants born in the state. During CY 09 Maine screened 13,285 of the 13,353 births that occurred in the state (99.5% of newborns screened). Of these, 20 were identified with disorders, including 9 newborns confirmed to have cystic fibrosis which was added to the screening panel July 1, 2008. Those infants not screened either died in the first few days of life or parents refused screening. All affected infants received appropriate consultation and treatment within 48 hours of confirmation. Maine's success can be attributed to our ability to link metabolic screening data with birth certificate data. Maine has also developed a close working relationship with our two specialty centers thus ensuring timely follow-up for infants.

Maine has two major medical centers that have Genetic Programs and Cystic Fibrosis (CF) Clinics. The Maine NBSP benefits from consultation with these specialists and with pediatric endocrinologists and hematologists. Maine now screens for 32 disorders.

During FY09 the NBSP conducted periodic evaluations of the CF screening protocols. The review showed that provider offices varied in their response to our recommendations for follow-up. Most (90%) did follow; the remaining 10% either did not schedule sweat tests through genetics allowing for genetic counseling to occur at the sweat test site or choose to inform families over the phone or call them in urgently to discuss the screening results. Fact sheets were updated to clarify recommendations and the script used to report results has been adapted to stress the importance of following our recommendations.

The NBSP completed a review of several areas of Quality Assurance and Quality Improvement (QA/QI) including the usefulness of our result report letters to providers. Several result letters and fact sheets were revised to provide accurate and up to date information and guidance to the PCP for evaluation and follow-up of abnormal screening results.

Financial responsibility and contract management with the regional laboratory was transferred to

the CSHN Program in July 2008. Previously these responsibilities resided with the State Health and Environmental Testing Laboratory. This transition has enabled the program to more closely monitor revenues and expenditures and oversee contract activities.

The Joint Advisory Committee continues to be more family centered in its structure through parent participation on the committee. Parent members represent families with children who have PKU, Congenital Hypothyroidism, Fatty Acid Disorder and CF. The Committee is co-chaired by a health care provider and a parent member. The co-chairs assist in directing committee projects and preside over committee meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Explore new approaches to providing screening education including developing a newsletter to be distributed to health care providers electronically and made available on the website.				X
2. Evaluate effectiveness and efficiency of CF screening system.				X
3. Facilitate access to comprehensive genetic services statewide.				X
4. Evaluate screening recommendations for NICU infants.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Preliminary data from CY09 indicate that Maine continues to screen nearly all babies. During CY 2009, there were 13,285 out of 13,353 newborns receiving a bloodspot screening test. Of these, 20 were confirmed to have a disorder and received treatment in a timely manner. During 2009, there were 9 newborns found to have cystic fibrosis.

The NBSP is now fully staffed with the arrival of Nurse Education Coordinator, Liz Plummer in November 2009. Her background in health education and nursing blends well with the programs future goals of improving communication with health care providers and providing information about newborn screening for families.

There has been a great deal of press recently around retention and use of residual blood spots. The NBSP will work with the Advisory Committee to review current practice of storing residual bloodspots indefinitely and for what purposes, and seek recommendations. Staff have been responding to inquiries about Maine's policy on this issue and has accommodated the requests of families to have the leftover specimens returned to them.

The NBSP has been formalizing policies and procedures related to all aspects of the program and meeting monthly with MCH leadership in preparation for Maine CDC voluntary accreditation.

c. Plan for the Coming Year

Maine has continued to set an objective of 100% for this measure and we will continue to communicate with PCPs and Specialists to maintain our current follow-up rate.

The NBSP will continue to collaborate with statewide CF Centers and examine the effectiveness of CF screening and the system of diagnosis and services; including CF screening education efforts; and refine fact sheets and education materials.

The NBSP will continue to monitor national and regional policy discussions, and review and revise policies on retention and use of leftover bloodspots.

The National Secretary Advisory Committee on Heritable Disorders in Children has made a recommendation for all states to add severe combined immunodeficiency (SCID) to the screening panels. SCID is a new screening method that is being piloted at the New England Regional NBSP and in Wisconsin. There is an opportunity for Maine to begin testing. NBSP staff will explore the potential of applying for these funds and discuss with its Advisory Committee whether or not to move forward.

Efforts will continue to enhance and more fully integrate newborn screening data into ChildLINK, an electronic data tracking system that currently houses newborn hearing and birth defects data and information on births and deaths of children, to allow for more accurate documentation of screening refusals. This will also assist in long-term follow-up of children. Once the baby is identified and confirmed it will be added to ChildLINK for tracking and follow-up.

Refine protocols related to neonatal intensive care unit (NICU) babies. The National Clinical Laboratory Standards Institute has published guidelines for screening infants in NICU. The NBSP will review these guidelines and the protocol used by the New England NBSP, consult with the two major medical centers and the Joint Advisory Committee, to determine if Maine will change its screening recommendations for NICU infants.

The NBSP is resuming hospital site visits and will continue in FY11. The program will partner with perinatal nurse managers on QA/QI for NBS to obtain input on the most effective methods for delivering education and newborn screening information.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**13353**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	13285	99.5	32	1	1	100.0
Congenital Hypothyroidism (Classical)	13285	99.5	147	6	6	100.0
Galactosemia	13285	99.5	9	0	0	

(Classical)						
Sickle Cell Disease	13285	99.5	0	0	0	
Biotinidase Deficiency	13285	99.5	7	1	1	100.0
Cystic Fibrosis	13285	99.5	56	9	9	100.0
Homocystinuria	13285	99.5	50	0	0	
Maple Syrup Urine Disease	13285	99.5	36	0	0	
Expanded Metabolics	13285	99.5	53	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	13285	99.5	57	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	13285	99.5	1	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62.8	62.8	65	60.7	60.7
Annual Indicator	62.8	62.8	60.7	60.7	60.7
Numerator					
Denominator					
Data Source				NSCSHCN 2005/2006	NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.7	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objective for 2010 is based in part on a "report card" administered by the Maine Children with Special Health Needs Program to

about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objectives for 2009 are based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objectives for 2007 and beyond were changed based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

a. Last Year's Accomplishments
Maine's Children with Special Health Needs (CSHN) Program values the input it receives from the families it serves and works diligently to ensure families are involved in decisions regarding their child's health and services received from health care providers and the CSHN Program.

Data from the most recent National Survey of Children with Special Health Care Needs (NS-CSHCN) indicate that over 60% of Maine families partner in decision making and are satisfied with the services they receive. There was not a significant change in this measure between the 2001 and 2005/2006 Surveys and Maine is comparable to the national average on this indicator. Maine ranks 14th overall in the United States on this indicator.

A major programmatic change in FY08 was a transition from direct to population-based and infrastructure services. The Maine CSHN Program met with Utah and Colorado CSHN Programs to learn about their experience in transitioning from direct to infrastructure services. Anna Cyr, a family consultant, was included in the discussions to ensure the family perspective was represented. In re-organizing, Maine adopted a similar model to the other states.

As part of our re-organization, CSHN staff developed mission, vision, and values statements to serve as a program guide. This proved to be a challenge for staff as they moved from the more traditional direct service program, where eligibility was narrowly defined by certain conditions, to a broader public health focus that included the entire population of children and youth with special health care needs (CYSHCN).

The CSHN Program had hoped to work with an evaluator to follow up with parents to learn how they were coping with the change. The follow-up did not occur but anecdotally we heard that of the 1,000 children moved off the program, less than 1% expressed concern about having to manage costs on their own. Of those, we reviewed all cases and have retained some on the program. To assist staff in making determinations around retaining families, the direct services staff developed a ranking system from one to three. A rank of 1 -- children may be on medications with an annual visit to a specialist and have health insurance therefore cost to the family is minimal. Those children were removed from the program as they came up for re-enrollment. A rank of 2 -- children may have multiple medications and multiple physician visits and may or may not have health insurance. The program scheduled phone calls with families prior to removing from the program. A rank of 3 -- children are highly involved, parents may or may not have health insurance, and their ability to pay co-payments and deductibles presents a financial burden making it very difficult for the program to drop families.

Overall families expressed appreciation for the program support provided in the past and were supportive of the change. Staff continue to assist families in coordinating needed resources.

Families were actively involved in all aspects of the CSHN Program. Families are members of all CSHN sponsored advisory councils:
1. Joint Advisory Council for Newborn Screening and CSHN (JAC) -- Family members co-chair the council.
2. Acquired Brain Injury Advisory Council (ABIAC) -- Family members and individuals participated on many sub-committees and continued to make recommendations to the BI Program within the Office of Adults with Physical and Cognitive Disability.
3. The Family Advisory Council (FAC) - The FAC meets quarterly to discuss and make recommendations on improving services for CSHN in Maine to the CSHN program.
4. Youth Advisory Council -- Meets quarterly to discuss issues affecting youth with special health care needs, particularly in the area of transition.
5. Newborn Hearing Advisory Committee -- Families co-chaired and actively participated in providing insight and guidance in policy development.

The CSHN Program worked with Dr. Richard Aronson to develop diversity training for the Youth Advisory Council. The training was designed to enhance cultural and linguistic competence as a component of leadership development for youth with special health needs. It was a three part series with two objectives: 1) enable youth to strengthen their capacity to understand and respect themselves and each other, honoring their diversity and, at the same time, discovering and acting upon their shared humanity; and 2) begin to understand the definition and essential elements of cultural and linguistic competence.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to recognize families as partners through the Family Advisory Council Joint Advisory Council, Acquired Brain Injury Advisory Council and Newborn Hearing Screening Council.		X	X	X
2. Continue to have parents complete Form 13 and expand to family members on other councils.		X	X	X
3. Continue to contract with a family and youth consultant as appropriate.		X	X	X
4. Continue active family participation on all MCH boards and councils.		X	X	X
5. Engage youth and families in the regions to participate in the MCH priority mapping.		X	X	X

6. Work with the Office of Public Health Emergency Preparedness to identify the CSHN Program role in emergency preparedness for families with children with disabilities.				X
7. Make recommendation to Office of Local Public Health District Liaison to invite a CSHN representative to sit on the District Coordinating Council.				X
8. Update CSHN rules to be in alignment with the transition to population-based and infrastructure based program focus.				X
9.				
10.				

b. Current Activities
Although there was no change in this measure over the past four years, data from Maine's parent report card for 2006 suggest that families would like to play a more active role in policy making.

The program is developing a brochure describing its re-structure to care-coordination and what that means for families. It is being reviewed by the Maine Parent Federation (MPF) and Families First to ensure it is family friendly. We anticipate being able to market to families and physicians by Summer 2010.

A fulltime Family Consultant, Anna Cyr, was hired in July 2009. Her responsibilities include; organizing quarterly Family Advisory Committee meetings, working with the Family to Family (F2F) health regions through the MPF, attending Medicaid Advisory Committee meetings, and representing both Family Voices and CSHN on a variety of State committees.

Using Utah's model of community mapping process, Anna and Toni are working with the F2F Health Coordinator at a northern Maine hospital to begin a process of mapping existing resources available to CYSHCN and their families and gaps in services.

Anna and Mallory Cyr, the Youth Coordinator, participated in the MCHBG Comprehensive Strengths and Needs Assessment by coordinating focus groups with CSHN youth and parents and participated in the priority setting process.

The CSHN Program added a section to its website to assist families with CSHN in planning for emergencies. Information can be found at:www.maine.gov/dhhs/boh/cshn/erprep/index.html

c. Plan for the Coming Year
Maine's objective for this measure in future years is 65.0%. We believe this is an obtainable objective given our efforts in this area, our shift towards infrastructure building, and the use of the regional report card grades allows us to actively involve families and youth at various levels. Given that we plan to engage the regions with the results we anticipate that families and youth will work with the F2F Health Information Center partners to create systems that ensure children, youth and family needs are met.

During FY11 the CSHN Program will focus on fully developing and providing leadership training for the 6 regional FACs and Youth Advisory Councils. Our family consultant, Anna Cyr, will conduct the trainings.

We will work with the new public health districts and F2F regions to ensure people with special health needs have a voice at the local level. Through improved communication with the Healthy Maine Partnerships and Comprehensive Community Health Coalitions we hope to create awareness of children with special health needs.

The JAC, Newborn Hearing Screening Council, ABIAC and FAC will continue to provide advice

and recommendations to the CSHN Program and the Office on Brain Injury on policy and development.

Develop an overarching CSHN logo that represents the newly re-organized CSHN Program.

As a new AMCHP family leader mentor, Anna will mentor a new family leader. This opportunity will enhance her work with the Maine Family Advisory Council.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	65	51.7	51.7
Annual Indicator	60	60	51.7	51.7	51.7
Numerator					
Denominator					
Data Source				NSCSHCN 2005/2006	NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51.7	55	55	55	55

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern

revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

a. Last Year's Accomplishments

Data from the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) for Maine indicate that about half of parents (51.7%) with a CSHN received coordinated, ongoing, comprehensive care within a medical home. Due to changes in the 2005-06 NS-CSHCN, we cannot compare the results from the 2005-2006 Survey with the 2001 NS-CSHCN. Maine's percentage on this indicator is higher than the national average of 47.1% and Maine ranks 13th overall in the U.S. on this measure.

The Hood Center at Dartmouth University was awarded a HRSA grant to "Improve Access to Care for Children and Youth with Epilepsy". The project is using a learning collaborative structure to increase the effectiveness and quality of care received in a medical home in four key practices in New Hampshire and Maine with diffusion to other providers through education and community outreach. The Maine CSHN Project worked with Kennebec Pediatrics and Southern Maine Neurology to improve care coordination between the primary care pediatric practice and specialists working with families to de-stigmatize epilepsy for youth and families. Families were involved in the selection of the action plan and medication list for epilepsy and commented on what parents may need once they left the primary care practice office.

During FY09 the National Initiative for Children's Healthcare Quality Learning Collaborative on Epilepsy focused on enhancing the capacity of primary care providers and pediatric neurologists to co-manage the care of children and youth with seizure disorders. This was accomplished by creating a more effective system of co-management of seizures between pediatricians and pediatric neurologists through increasing awareness and understanding of a child's seizure disorder and the related challenges faced by those with epilepsy. Kennebec Pediatrics in Augusta partnered with Southern Maine Neurology in Portland, to work effectively with approximately 20 children and youth with epilepsy. Both practices developed epilepsy care plans and medication cards for youth to carry in the event they have a seizure. Husson Pediatrics in Bangor partnered with Neurology Associates of Eastern Maine to work effectively with approximately 25 children and youth with seizure disorder.

In November 2007 the MaineCare Member Services Early Periodic Screening Diagnosis and Treatment (EPSDT) was moved from the Infectious Disease Division's Immunization Program to the Division of Family Health (DFH). MaineCare Member Services is responsible for assuring that MaineCare members under the age of 21 who receive full MaineCare (Medicaid) benefits are informed of and receive the services and assistance available to them under the MaineCare Program. As a result of MaineCare Member Services relationship with Title V, the Title V program now plays a more active role in ensuring that children receive ongoing, coordinated access to medical care. The CSHN Program and MaineCare Member Services are in the process of instituting a health care coordination component that provides resource information to family community-based services. Encounters will be tracked through ChildLINK, the CSHN Program database.

L.D. 625, "Resolve, To Ensure all Children Covered by MaineCare Receive EPSDT", directed the Maine DHHS to form a Workgroup to evaluate its EPSDT system and make recommendations to the HHS Committee by January 15, 2010. The CSHN Program was on the workgroup and assisted in preparation of the report to the legislature. Recommendations included; increase immunization rates; increase participation rates (from 59% to 85%); increase screening for lead; and increase screening for developmental delays and autism. No action was taken by the HHS Committee however prior to passage of LD 625 an existing EPSDT workgroup was comprised primarily of State programs; the CSHN and EPSDT Programs have expanded the Workgroup to

include external stakeholders. (A list of workgroup members is attached)

CSHN is also represented on the EPSDT Advisory Committee and provided recommendations to MaineCare on revisions to client lead poisoning brochures, incorporating oral health information in client mailings, reviewed client health information to ensure it was family centered, and worked with MaineCare to review child health services periodicity.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue collaboration and partnership with the Maine Chapter of the AAP.			X	X
2. Participate at the Maine Chapter of AAP Annual Meeting.				X
3. Work with Patient Centered Medical Home Pediatric sites to ensure comprehensive, coordinated and family-centered values exist for all children including CSHN.				X
4. Work actively on the CHIPRA project and in developing the Pediatric Quality Council.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Included in the State Health Plan is a recommendation to enhance development of integrated care models by designing and implementing a Patient Centered Medical Home (PCMH) pilot. The AAP describes the Medical Home (MH) as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. A MH works with providers and the family to ensure the care delivered is child centered.

The collaborative worked with private payers and MaineCare to develop an alternative payment model that recognizes the infrastructure and system investments needed to deliver primary care in accordance with the PCMH model and rewards practices for demonstrating high quality and efficient care. The pilot will be evaluated using a comprehensive approach that includes nationally recognized measures of quality, efficiency, and patient-centered measures of care that reflect the six aims of quality identified by the Institute of Medicine (i.e. safe, effective, timely, efficient, equitable, and patient-centered). The ultimate goal of this effort is to sustain and revitalize primary care to both improve health outcomes for all Maine people and reduce overall healthcare costs. 26 practices (4 of which are pediatric) were chosen; selection criteria included a high level of MaineCare recipients, geographic distribution, adoption of an electronic health record and a demonstrated commitment to providing coordinated care services.

c. Plan for the Coming Year

Maine is working to ensure that all children have a medical home and we hope to see improvement in this measure in the coming years. Our overall goal is to have at least 55% of parents reporting that their child is receiving care through a medical home by the release of data from the next NS-CSHCN, which we anticipate will occur in approximately 2 years.

The DFH partnered with MaineCare and the Office of Child and Family Services (OCFS) and our counterparts in Vermont to apply for a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Grant. We were awarded $11.3 million to implement 26 Medicaid child specific quality measures. The 4 pediatric PCMH pilot sites will act as the first practices to implement the quality measures. The program will also include development of a statewide Pediatric Quality Council (PQC) to foster implementation of screening tools and quality improvement projects in practices caring for children throughout the state. The PQC is being developed with the support and guidance from the Maine Chapters of the AAP and Family Practice. The Council membership will include representatives from pediatrics, family practice, Nurse Practitioners and Physician Assistants as well as parents and other providers.

The MCH Medical Director is the Chair of the PQC and will work closely with the professional organizations and the Director and manager of the CHIPRA project. Sustainable accomplishments expected from this project include implementation of child specific quality measures to improve delivery of scheduled preventive services and better identification of children and families at risk. Linkages between state and private sector information systems to improve access to and coordination of care, decreasing redundant and unnecessary services and improving timeliness of care, and improved measurement of quality indicators to better track outcomes of care delivered.

As a part of these efforts, we will work with EPSDT/MaineCare to determine scope of services provided and identify ways that the CSHN Program can enhance care coordination.

The CSHN Program will develop a brochure for families on the purpose and function of the Medical Home along with a description of what to expect from a Partners in Care Coordination. The brochure will be disseminated with other informational materials by EPSDT to families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67.3	67.3	70	70	70
Annual Indicator	67.3	67.3	70	70	70
Numerator					
Denominator					
Data Source				NSCSHCN 2005/2006	NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	75	75	75	75

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we are cautious about anticipating improvements in this measure over the next several years. However, given new health care reform initiatives, we have set our objectives to reflect improvement in this measure.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we don't anticipate improvements in this measure over the next several years. We hope to maintain the current level.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we don't anticipate improvements in this measure over the next several years. We hope to maintain the current level.

a. Last Year's Accomplishments
According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 70% of families with CSHN in Maine reported that they had adequate private and/or public insurance to pay for services they needed. This is slightly (although not statistically significantly) higher than the 2001 Survey (67.3%). In both survey years, Maine's rate was significantly higher than the national average. In 2005-2006, Maine ranked 2nd overall in the U.S. on this measure; 97% of Maine CSHN had some form of health insurance at the time of the 2005/06 Survey. Half (51%) of CSHN had private health insurance coverage only, 33% had public insurance only, and 13% had a combination of public and private insurance.

In an effort to remain within budget, in July 2005, the CSHN Program ceased enrolling children receiving MaineCare into the medical services payment component of the CSHN Program, with the exception of those with inborn errors of metabolism and cleft lip and/or palate. Beginning July 2006 families were required to submit their most recent IRS 1040 as verification of income, further reducing the number of children eligible for CSHN Program services; in the past the program accepted self-declaration. These two steps reduced overall direct care numbers by 50%. During CY09 direct services were provided to 125 infants, children and youth; 18 were less than one year old. The Program's major expenses continue to be (50%) medications and medical supplies.

During FY09 the Program continued to administer the Southern Maine Cleft Lip and Palate Clinic and supported the Northern Maine clinic at Eastern Maine Medical Center. The CSHN Program discontinued funding for the 4 Developmental Evaluation Clinics across the state due to budget reductions. This resulted in the closure of 1 hospital-based clinic in Northern Maine and 1 agency-based clinic in Central Maine. The two remaining hospital-based clinics continue to struggle financially due to small reimbursement rates from both MaineCare and private insurance.

In FY08 the CSHN Program moved from providing direct services to population-based and infrastructure services. To assist staff in making determinations around service provision during

the transition period, the direct services staff developed a ranking system from one to three. A rank of 1; children may be on medications with an annual visit to a specialist and have health insurance therefore cost to the family is minimal. Those children were removed from the program as they came up for re-enrollment. A rank of 2; children may have multiple medications and multiple physician visits and may or may not have health insurance. The program scheduled phone calls with families prior to removing from the program. A rank of 3; children are highly involved, parents may or may not have health insurance, and their ability to pay co-payments and deductibles presents a financial burden making it very difficult for the program to drop families. The 125 children served fall into this category. CSHN staff worked with those families moved off the program to ensure they had insurance and assisted if there were issues with providers around covered services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to build on the existing relationship with the Office of MaineCare Services.		X	X	X
2. Monitor changes in benefit plans both public and private.		X	X	
3. Work with the National Catalyst Center to improve health care insurance and financing for children and youth with special health needs.		X		X
4. Fully develop the Partner's in Care Coordination to assist families in navigating and locating available resources.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On January 1, 2010 the Maine WIC Program and MaineCare (Medicaid) adopted a 2001 federal regulation identifying MaineCare as the primary payer of special/prescription formulas for individuals participating in both programs. WIC participants that are also MaineCare members now receive their special/prescription formulas through their MaineCare insurance. The CSHN Program is working with MaineCare to identify a payment mechanism for those CSHN (10) receiving special medical foods who are covered by MaineCare. Currently the CSHN Program covers the cost (up to $3000/year) of special medical foods for those clients.

L.D. 1198, "An Act to Reform Insurance Coverage to Include Diagnosis for Autism Spectrum Disorders (ASD)" was passed on April 12, 2010. This bill requires group health policies to provide coverage for diagnosis and treatment of ASD for children 5 years and under; the original bill was requesting for persons 21 years and under. It is estimated, using claims data from FY09, that there are currently 681 MaineCare members (0-5 years old) with ASD.

c. Plan for the Coming Year

Maine's objective for this measure for the next four years is 70%. In other words, we do not anticipate improvement on this measure in the next few years. Given the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we will be successful if we maintain our current level. We will monitor changes in benefit plans both public and private for any potential impact on CSHN.

We will continue to monitor activities related to insurance changes at the federal level and how those changes may impact services of both MaineCare and other insurances, provide input as appropriate on MaineCare service changes, and work with MaineCare to discuss services and assist families as needed.

As we move from providing direct services we will assist families in navigating through barriers to enrollment and re-enrollment in MaineCare and link to necessary resources. We will work with families on seeking alternative methods for payment of services such as physical and occupational therapy, and review potential funding gaps in services for those families most in need by developing criteria for qualification to receive funds.

Provide assistance to MaineCare on determining payment mechanisms for the 10 CSHN children requiring special medical foods.

The CSHN Program will make available, on its website, data on children with special healthcare needs to include but not limited to SLAITS, National Survey of Children with Special Health Care Needs, Newborn Hearing Bloodspot Screening, and Birth Defects statistics; providing our stakeholders with information on the CSHN population.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.3	77.3	79	87.9	87.9
Annual Indicator	77.3	77.3	87.6	87.6	87.6
Numerator					
Denominator					
Data Source				NSCSHCN 2005/2006	NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87.9	90	90	90	90

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

Due to changes in this indicator between the two CSHCN surveys, we have changed our objective to 90%.

a. Last Year's Accomplishments

Approximately 88% of families with a CSHN in Maine report that community-based service systems are organized so they can use them easily according to the 2005-2006 NS-CSHCN. Due to changes in the wording and placement of the questions between the 2001 and 2005-2006 NS-CSHCN, we cannot make any statements about changes with this measure. Maine's performance on this measure is slightly lower, but comparable to the national average of 89.1%. Maine ranks within the bottom third of states on this measure.

The CSHN Program, Direct Services Team developed an action plan to transition from direct services to a community-based system of services. Discussions centered on the impact of this change for both staff and families. Prior to this change there were about 500 children participating in the medical services payment aspect of the program. As discussed under PM # 4 we are using a ranking system to move families off the program, while at the same time expand our role to support families of CSHN by locating other state systems, community-based systems and other agencies to assist with payment of such items as durable medical equipment. The program is expanding its role in linking families with, rather than providing payment for, medical services. The new program called Partners in Care Coordination assists families, healthcare providers, and communities improve the health, development, and well-being of Maine's children with special health care needs.

The program has successfully transitioned all but 125 children off; those remaining are at a Level 3 ranking. The only children for whom the program provides financial services are those with cleft lip and palate, and inborn errors of metabolism.

The CSHN Program continued to partner with Maine Parent Federation/Family Voices Regional Family-to-Family (F2F) Health Information Centers. CSHN staff held four statewide meetings with Family Voices and the 6 Regional F2F Health Information Coordinators. The first meeting provided information on the CSHN Program; subsequent meetings were to provide input, through a focus group, on the 5-year comprehensive strengths and needs assessment; review legislation that could potentially have an impact on CSHN; and complete the annual MCHBG Form 13. Anna Cyr, the Family Consultant, organized and facilitated the meetings.

The Service Tapestry database (a user-friendly, searchable database of resources for youth, family members, educators and service providers to locate supports and services within their area) consisting of information and resources for children ages birth - 25 years is operational and can be found at: http://www.servicesforme.org/. This website was created using funding from the State Implementation Grant for CYSHCN and currently resides on the Maine Support Network's server. Plans are under way to move the information to the Maine CDC, CSHN website/server.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate activities among MCHB funded initiatives.				X
2. Support 29th Annual Special Family Weekend.				X
3. Support the 6 regional Family to Family Health Information Coordinators.				X
4. Update the CSHN website to include sections for families, providers and other resources.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Partners in Care Coordination (PCC) program provides health, community and referral information to families of children and youth with special health needs. As the CSHN Program transitions from direct service to infrastructure based services this program will ensure that families continue to access needed services.

Through the PCC, the CSHN Program is expanding the number of children with special health needs served. The focus of this program is on the total CSHN population not condition specific children. The CSHN Program and the Family Consultant are developing a brochure outlining the services offered by PCC. During its development family input was solicited to ensure it was family centered. A copy of the brochure is included in the Appendix.

CSHN staff engaged MaineCare Member Services (EPSDT) to review and revise materials sent to families and to include important information such as; lead in homes, periodicity, oral health, and immunization. CSHN is also working very closely with families to assist them in keeping appointments and when an appointment is missed following up to determine the cause.

c. Plan for the Coming Year

Currently, Maine families with CSHN report that 87.9% of community services are organized and easy for them to use. Our objectives for this measure anticipate an increase over time reaching 90% by 2011 when the next survey results are available.

Maine has an emerging public health infrastructure comprised of eight Public Health Districts. The new infrastructure has the potential of enhancing the existing six Regional F2F Health Information Centers in several areas: 1) strengthen efforts to enhance the delivery of the 10 essential public health services specific to CSHN families; 2) develop local and regional health improvement plans; and 3) assure accountability for use of state resources. The CSHN Program will work to have F2F coordinators establish a relationship with the new Public Health District Liaisons to share resources on community-based resources for CSHN families.

As funding permits, we will continue to fund both the Youth and Family Consultant positions to optimize the delivery of services in the six F2F Health Information Centers in Maine. This will be accomplished by building the infrastructure to support six regional family and youth advisory councils through enhanced leadership development.

Conduct community service system mapping process in Aroostook county to identify unmet CSHN needs.

The Family Consultant will begin developing a Family Advisory Council section for the CSHN Program website.

Solicit input, through the Family Advisory and Youth Advisory Councils on the CSHN website. They will engage families and youth to review the overall organization of the website for ease of use by those accessing information.

Servicesforme, developed under the HRSA Integrated Services Initiative, allowed the CSHN program to move the Service Tapestry from the University of Maine to a temporary site at the Maine Support Network. The program anticipates being able to transition to the state website once protocols to accommodate searchable websites are developed.

Implement the PCC model across the state and work with evaluation contractor to develop an evaluation plan for follow-up with families to assess whether or not the information provided was helpful and if they were able to obtain the services they needed.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14.9	14.9	16	49	49
Annual Indicator	14.9	14.9	49	49	49
Numerator					
Denominator					
Data Source				NSCSHCN 2005/2006	NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	49	51	51	51	51

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

a. Last Year's Accomplishments
Maine is at the forefront of helping youth with special health needs transition to adulthood. About half (49%) of Maine families with a CSHN age 12-17 report their children have received services to make this transition according to data from the 2005-2006 NS-CSHCN. Due to substantial changes to the set of questions that constitute this measure, we cannot compare the 2001 and 2005-2006 NS-CSHCN results. However, Maine's percentage on this measure exceeds the national average of 41.2% and Maine ranks 9th in the U.S. on this measure.

Through the Integrated Services Grant the Youth Coordinator, Mallory Cyr, worked with youth and youth groups together on various issues impacting young adults with disabilities. She initiated and moderates a facebook page titled "Maine YAC" for youth to share and discuss issues related to school, work or living at home. Through the Healthy and Ready to Work (HRTW) and Integration Grants we collaborated with families and youth to address youth leadership and build a strong interagency partnership with the Department of Education (DOE) to address issues of higher education and employment. The Maine Support Network contracts with the DOE to provide workshops to school departments and has added a session on transition to address HRTW.

While the CSHN Program is not a partner with, it does support the efforts of Project THRIVE. The Maine Parent Federation and the statewide Maine chapter of Family Voices are working with the Maine DHHS Division of Children's Behavioral Health, Tri-County Mental Health Services and the Substance Abuse and Mental Health Services Administration on this initiative. THRIVE principles include building a seamless system of care for children and their families; a new method of working as a community to offer services that are family driven, youth guided, and culturally and linguistically competent, while creating systems and services that are trauma informed.

The youth coordinator developed a web-based self-determination program for young adults to acquire skills to self-advocate in various settings such as; employment, health care, and navigating a college campus. The current economy has posed a challenge in working with youth. Many of those involved with the program have graduated from high school but haven't continued on to college or been able to secure employment thus it has been difficult to motivate them to engage in project activities.

The CSHN Program worked with the youth coordinator to administer a youth self-assessment to determine where youth felt they were in their growth as a leader. Results revealed that many youth wanted additional mentoring on communication to better prepare to self-advocate; wished to be more familiar with services as they age out of children's programs and into adult services; to be involved at the forefront when policies are developed that will effect them; and finally, they believe that increased knowledge will allow them to more actively participate in state policy decisions regarding CYSHN. Utilizing assessment results the CSHN Program will discuss supports required to facilitate growth in the areas identified and design a leadership training based on a national model of what youth feel they need to become leaders in Maine.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain partnership with young adults (THRIVE) who are either homeless or have other cognitive issues.		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In collaboration with the Maine Support Network and the CSHN Youth Consultant, the CSHN Program has established a statewide Youth Advisory Council (YAC) with representation in four of the eight Public Health Districts. The youth coordinator established a facebook page as a mechanism to convene the YAC's rather than the traditional face-to-face quarterly or semi-annual meeting format. This format is a widely used communication tool by youth and we feel they may be more willing to discuss youth issues via this medium rather than in person.

c. Plan for the Coming Year

Due to substantial changes to this measure between the 2001 and 2005-2006 Surveys, we have changed our objective on this measure to 51%.

The CSHN Program will review MaineCare member materials and offer suggestions on transition, to include with the MaineCare letter sent to children prior to their 18th birthday, informing them of coverage termination.

Continue to identify and invite youth to participate on a regional or statewide YAC.

Conduct needs assessments in particular regions of the state for youth with special health needs to monitor progress. For example, the youth coordinator may periodically pose a question on facebook to assess the degree to which youth utilize this communication medium.

Review and revise the Youth Advisory Council section of the CSHN website.

As funding permits, continue to fund the Youth Coordinator position to optimize the delivery of services to CYSHN by supporting the youth advisory councils through enhanced leadership

development. Youth leadership development will be based on the National Consortium on Leadership and Disability for Youth and Family Leadership on trainings developed by the University of Vermont and the Parent Advocacy Coalition for Educational Rights (PACER) Center. The mission of the PACER Center is to "expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents". Continued work in this area will allow us to assess services and be responsive to anticipated needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	82.5	84	85	80
Annual Indicator	83.3	79.8	77.6	76.2	76.2
Numerator					
Denominator					
Data Source				National Immunization Survey 2008	National Immunization Survey 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	78	79	80	81

Notes - 2009
Data are from the 2008 National Immunization Survey. 2009 survey data are not yet available; 2008 data are used as an estimate.

Notes - 2008
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 2008 is based on the National Immunization Survey 4:3:1:3:3 series.

Notes - 2007
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 2007 is based on the National Immunization Survey 4:3:1:3:3 series.

a. Last Year's Accomplishments

Maine's childhood immunization data are obtained from the National Immunization Survey (NIS), a continuing nationwide sample survey conducted among families with children 19-35 months of age and their healthcare providers.

According to NIS data, Maine's immunization rates among 19-35 month olds, based on the 4:3:1:3:3 series, have not changed significantly over time. However, Maine's 2008 immunization rate was the lowest it has been in recent years. In 2008, 76.2% of children received the full 4:3:1:3:3 schedule. Only 17 states in the U.S. had lower 2008 immunization rates. Ten years ago in 1997, Maine's 4:3:1:3:3 immunization rate of 78.4% was the second highest in the country. Therefore although Maine's immunization rates have not declined significantly over time, other states have been able to improve their rates. Maine's Immunization Program (MIP) hypothesizes that this may be due to several factors. Between 1999 and 2003 a significant portion of program resources were shifted to develop the ImmPact Immunization Registry with less available for provider education. In addition, the MIP centralized its staff from contracts at the county level to staff centrally located in the capitol (Augusta). This resulted in some communities without readily available educational resources. Federal funding decreases resulted in the state's inability to match the Advisory Committee on Immunization Practices (ACIP) recommendations for Maine to be a universal vaccine state. This resulted in a decision to be a Vaccine For Children only state covering uninsured, underinsured, Medicaid, and American Indian children. In addition confusion around thimerosal in vaccines along with a tendency for some parents to delay the schedule of vaccines for their children out of concern for receiving so many together resulted in some children not being vaccinated and others not fully vaccinated according to ACIP periodicity.

Although MIP is not able to determine the number of physicians reporting to ImmPact, over 500 practices report. Of those practices, approximately 300 are pediatric, 100 are family practices and 100 are long term care facilities.

MIP partnered with the Department of Education school nurses to provide immunization resources. School nurses are encouraged to include immunization when they talk about physical health by asking children to ask their parents if they and their siblings received a vaccination.

95.7% of enrolled children in home visiting (HV) during FY09 were up to date on immunizations; the refusal rate is 1%, under immunized is 1%, and the remaining 2% consists of those taking action to catch up on vaccinations, the vaccine was not available, or those whose doctor left and the new doctor is not yet in place (rural area). The under immunized represents that group of parents selecting which vaccines they want their children to have; varicella is the most common vaccine parents choose to opt out of having their child receive. Overall 2,543 children were served by HV. Immunization is embedded in the curriculum of HVs and is a performance measure for the contracted community agencies. As they become aware of barriers families encounter (i.e. transportation) and assist with working through them, the HVs record the data and share it with the MIP.

Maine's HV partnered with MIP to develop core messages for public service announcements, an informational activity in an effort to raise immunization rates. Materials were included in the home visiting "Welcome Baby Bags" that promoted immunization. Home visitors talk with parents about their specific concerns and risks and encourage them to talk with their doctor about immunization.

Maine's tribal immunization rates are significantly higher than the state rates, primarily because the tribes invest a great deal of effort in ensuring children are immunized. 3out of the 5 Maine tribal health centers report to the ImmPact system.

Since Well Child Clinics were discontinued, and the HV Program was started, Public Health Nursing (PHN) contact with families is less. PHN sees only those with an identified health need and generally for a short period of time. For those seen, immunization history is part of intake and evidence-based information is given following the Bright Futures Standards.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and guidance regarding best practice and quality assurance/improvement.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The most recent data for this measure suggest that about 76.2% of children age 19-35 months in Maine received the full 4:3:1:3:3 immunization schedule in 2008. This is not as high as the state would like it to be and Maine's Immunization Program has been working to improve this rate.

In an effort to reduce barriers for providers, the MIP is promoting data exchange between the electronic medical record and the ImmPact system. By eliminating double entry more providers may be willing to report.

In addition to MIP, other programs in the state are working to increase children's immunization rate. The MIP is working with HV to access their data to provide the program with more in-depth information on vaccines and the barriers faced by families trying to get their children immunized.

On April 2, 2010 the Governor signed L.D. 1408, "An Act to Establish the Universal Childhood Immunization Program". This bill creates a system of universal vaccination in which all children, regardless of health insurance coverage, have access to the vaccinations they need. The bill establishes the Maine Vaccine Board that will make decisions on which vaccines to provide and the MIP will purchase and distribute the vaccines to providers.

The MIP is partnering with Maine Medical Center to provide education to pregnant women before their child is born to prepare them for receiving vaccines. The child also receives its first vaccine before leaving the hospital.

c. Plan for the Coming Year

Maine's Title V program will continue to work with the MIP to learn about barriers to childhood immunization through the ImmPact2 system and through our HV Program. We will also investigate whether other data sources, such as MaineCare offer additional data that would be helpful in identifying geographic or demographic groups that could be the focus of intervention efforts.

While Public Health Nursing (PHN) collects immunization data it is contained in a medical record protected by HIPAA. PHN anticipates adding a SQL server that will allow the program to run public health data reports thus they can begin generating reports on immunization rates of children served. Community Health Nursing (CHN) will assess the feasibility of making changes to their database to collect immunization data on the children served.

PHN and CHN work with families referred to the program for an identified health need. Referrals are for a limited time, often within one to two months, which is prior to the first immunizations. While under their care, PHN/CHN check on the immunization status of those served, provide families with schedules and provide immunization education during visits. At the point of discharge PHN/CHN continue to refer those families still requiring support to HV thus ensuring additional follow up to obtain, in a timely manner, all appropriate immunizations for their children.

MIP will continue to work with the Early Childhood Director, Early Childhood Comprehensive Systems Initiative, and HV Program to identify ways to link their respective databases and share data in an effort to provide a more complete picture of immunization of Maine residents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.3	10.4	9.6	9	10
Annual Indicator	10.7	9.9	9.4	10.3	9.8
Numerator	292	271	251	268	246
Denominator	27257	27291	26825	26003	25037
Data Source				Birth certificates, Maine Vital Statistics Office	Birth certificates, Maine Vital Statistics Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.7	9.6	9.5	9.4	9.3

Notes - 2009
2009 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. 2009 population estimates are from the US Bureau of the Census as of July 1, 2009.

Notes - 2008
2008 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. 2008 population estimates are from the US Bureau of the Census as of July 1, 2008.

Notes - 2007
2007 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. 2007 population estimate from US Census Bureau as of July 1, 2007.

a. Last Year's Accomplishments

Maine's adolescent pregnancy rate had been declining since 1998 and has consistently been lower than the U.S. rate. In recent years, we have seen the rate of decline diminish and more variation in the rates over time. Maine's 2008 rate of births among 15-17 year olds was 10.3 per 1,000 compared to 21.7 per 1,000 in the United States. This is higher than the 2007 rate of 9.4 per 1,000, but the difference is not statistically significant. Maine's 2007 teen birth rate was the lowest the state had seen in the past 17 years. Preliminary data for 2009 suggest that the rate will not continue to rise (2009=9.8 per 1,000). Maine met its Healthy Maine 2010 objective on this indicator of 13.6 per 1000 females.

Data from the 2009 Maine Integrated Youth Health Survey reveal that 46.5% of high school students in Maine have ever had sexual intercourse; Among 16-17 year olds, 52.7% have had sex; Of high school students age 15 years or younger, 31.0% report having had sex. The percent of high school students reporting ever having sex has not changed substantially over the past few years (42.4% in 2007), but the % who report using a condom at last intercourse has increased since 1995 from 46.9% to 60.5% in 2009 and oral contraceptive use remains relatively high at 34.2%, revealing the importance of family planning to lowering Maine's teen birth rates.

Maine is committed to keeping our teen birth rate low through its work with Family Planning (FP) clinics, ongoing data monitoring, and with educational programming. A significant change for FP during FY09 was a shift from providing outreach and family life education services to providing only clinical services. The Teen and Young Adult Health Program (TYAHP) has been encouraging FP to look at these services to determine the effectiveness of their work in this area on reducing unintended pregnancy.

FP clinics served 29,471 (95% of its goal) clients including 9,349 teens in FY09. Although the overall number of clients served is virtually unchanged from FY08, the number of teens increased by 15.43%. Clinics reported economic factors prevented a decrease in services as clients reported loss of a job and/or insurance for seeking FP services and contraceptive supplies. During FY08, the cost of the oral contraceptive, Ortho increased significantly in price due to a change in federal rules. MaineCare began covering Implanon, a 3-year implantable contraceptive in FY09, however FP centers have not yet been able to bill for the device as they do not have a CPT code. (they currently use a local Z-code system) MaineCare is moving to a new billing system that is anticipated to be on line in late FY10. FP will then to able to bill for Implanon using the CPT code system.

Full reproductive health services are offered at 8 school-based health centers.

Maine's FP Association continues to work with some of Maine's racial and ethnic minorities. Through Somali Peer Educators they provided information on healthy sexuality and related issues. FP has seen the positive impact of its work over the past year. Somali women know how to access birth control with more using it, and also understand the importance of regular check-ups.

The Annual Comprehensive Sexuality Education Conference was held April 14, 2009. The conference is intended for school administrators and health educators to increase school leadership support for comprehensive family life education, as well as to increase and update participant knowledge and skills in sexuality education.147 participated in the conference. This is a continuation of a collaborative effort between TYAHP, Family Planning Association, Department of Education (DOE), University of Maine at Farmington, New Beginnings of Lewiston and the Maine HIV/STD Program.

RESOLVE Chapter 99, LD 1105 was passed and signed by the Governor on June 8, 2009. This resolve requires the DOE to review its policies and rules regarding faculty training and student education on dating violence prevention for students in grades 7 to 12, and policies of the various school administrative units, and to report on the findings of its review to the Joint Standing Committee on Education and Cultural Affairs by March 1, 2010. Kelly Jackson, a federal CDC

public health prevention specialist assigned to the Maine CDC to coordinate a Safe Families Project worked with the DOE on the report. While MCHB does not fund the Action Learning Lab that led to Safe Families, they did support it.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Clinical Services.	X			X
2. Community-based pregnancy prevention using evidence-based programs.		X	X	X
3. Comprehensive Family Life Education consultation.			X	X
4. SBHC base funding, technical assistance and standards implementation.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DOE facilitated a professional development for the Maine Coalition Against Sexual Assault to assist sexual assault educators statewide in effective strategies to work with schools, classroom teachers, and in the development of effective presentations/activities/lessons in alignment with the Maine Learning Results for health education.

Douglas Kirby Ph.D., nationally known for his work in the field of adolescent sexuality, particularly for his reviews of the research on school and community programs to reduce adolescent sexual risk-taking behaviors was the keynote speaker at the Annual Comprehensive Sexuality Education Conference held in April, 2010.

Several changes in the TYAHP during FY10 significantly impacted the program. The Program Manager position was vacated in May 2009. A re-organization within the program shifted family planning to the Women's Health Initiative, and staff re-deployment to assist with H1N1 activities hampered the programs ability to carry out planned activities.

Data analysis of the first Integrated Youth Health Survey administered in 2009 is underway. Survey changes based upon stakeholder feedback are being made and the survey will be administered again in FY11.

c. Plan for the Coming Year

The Family Planning Association of Maine, pending no funding cuts, will implement the new evidenced-based programming for teen pregnancy prevention.

FP is also facing some MaineCare funding cuts that will significantly impact their overall budget. If the cuts are implemented FP may have to close clinics and significantly reduce hours in others. Such a move will create access concerns, particularly for teens if they have to travel long distances to obtain confidential services.

Family Planning Association will work with districts around the state that identify adolescent pregnancy as a priority as they go through the Mobilizing for Action Through Planning and

Partnerships process.

The Maine DOE will promote Key Concepts, a document that links key concepts in family life education, sexual assault prevention, and alcohol and other drug use prevention to the health education standards and performance indicators outlined in the 2007 Maine Learning Results, to health educators, school health coordinators and other school personnel which support pregnancy prevention, disease prevention, and healthy sexuality.

Despite the recent increase in the teen birth rate in Maine in 2008, 2009 data suggest that we will not continue to see a rise on this measure. We project that Maine will continue to show progress. Our objectives for the next five years reflect a return to our previous low of 9.4 per 1,000 from 2007 and surpassing this rate. Although our objective is consistent with trends over the years prior to 2008, recent national trends and proposed budget cuts to services such as family planning may make achieving this objective challenging.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56.6	58	60	60	60
Annual Indicator	56.6	56.6	56.6	56.6	58.9
Numerator	636	636	636	636	208
Denominator	1123	1123	1123	1123	353
Data Source				Maine Child Health Survey	Maine Integrated Youth Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59	60	60	61	61

Notes - 2009
Data for this measure come from the oral health screenings conducted as part of the 2009 Maine Integrated Youth Health Survey (MIYHS)--kindergarten/third grade version. The response rate of the k/3 MIYHS was 31%, so the data were not weighted. This may limit the generalizability of the data to the entire population of third graders in the state.

Parent report of dental sealants was also collected as part of the k/3 MIYHS--73% of parents who were surveyed reported that their third grade ever had sealants.

Notes - 2008
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2008 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 third graders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The Maine Child Health Survey, which will include an oral health assessment of 3rd graders was administered in 2009. We anticipate having updated data for the 2010 MCHBG.

Notes - 2007
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2007 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 third graders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The Maine Child Health Survey, which will include an oral health assessment of 3rd graders, is due to be administered in 2009. We anticipate having updated data for the 2010 MCHBG.

a. Last Year's Accomplishments
Maine is using data from the 2009 kindergarten/3rd grade Maine Integrated Youth Health Survey (IYHS) to report this measure. The data are not weighted due to a low response rate to the survey (31%) and may not be generalizable to 3rd graders in the state. Of the children screened, 58.9% were found to have received a sealant on at least one permanent molar tooth, a finding consistent with our previous survey in 2004. For third graders, this was consistent regardless of race or ethnicity. Medicaid data from FFY 2009 reveal that about 48.1% of EPSDT eligible children in Maine between the ages of 6 and 9 received dental services within that year.

Within funding limits, the Oral Health Program (OHP) maintains the dental sealant component of its School Oral Health Program (SOHP) that also supports classroom-based education and fluoride mouthrinse programs. In the 2008-09 school year, 20 programs provided sealants in 75 schools; 755 2nd-graders received 2253 sealants (average of 3 sealants each). An additional 213 3rd-graders also received 240 sealants. We were not able to bill MaineCare for sealants in FY09 to gain additional revenue to the OHP to support school-based sealant programs, but we encouraged larger school-linked sealant programs to bill for these services to supplement our funding. See Current Activities for more information on the SOHP.

The OHP competed for a 5-year State-Based Oral Disease Prevention Program grant from the US CDC (started 7/31/08). The required activities of this cooperative agreement support refinement of the OHP's school-based programs, particularly our dental sealant component. This grant intends to strengthen state oral health program infrastructure and capacity; it includes activities to develop an oral health surveillance plan and report, an oral health policy plan, support water fluoridation activities, encourage program collaboration, an oral health coalition, other partnerships, and has a robust evaluation component.

The OHP Director continued involvement with the implementation of the Maine IYHS, and the OHP's health educator, a dental hygienist, participated in training school nurses to conduct screenings and provided the screenings when school nurses could not.

The OHP continued to implement its grant from MCHB under the Targeted Oral Health Service

Systems program [the "Kids Oral Health Partnership (KOHP) (www.kohp.org)]. It will increase the number of young children who receive oral health assessments and preventive dental visits and are identified as having a dental home. During FY09 the KOHP implemented outreach and training activities toward this goal and developed relationships with local agencies (e.g., Head Start) and provided training and assistance to child care and medical care providers.

The OHP's public health educator (PHE) focused on coordination of the SOHP and the dental sealant component, and continued to update our educational resources and website. Related to activities of our CDC grant, she planned to coordinate a training session on implementing school-based sealant programs during the first half of the 2009-10 school year for school nurses, health coordinators and hygienists, but this was delayed due to pending changes in the SOHP and also because of the focus on H1N1 during the fall of 2009.

Supported by a workforce development grant from HRSA's Bureau of Health Professions, the OHP coordinated a 2-day conference for medical and dental professionals in early May 2009, "Synergies in Comprehensive Patient Care," with a strong focus on issues significant to the MCH population.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain the number of schools with sealant programs.	X		X	
2. Implement database or other tool for sealant program data collection and school oral health program.		X		X
3. Determine efficacy of resuming billing as MaineCare provider for sealants and or seek other supplementary funding.				X
4. Collaborate on continuing refinement and implementation of the Maine Integrated Youth Health Survey (includes an oral health component).			X	
5. Coordinate implementation of components of State Oral Health Improvement Plan, and initiate process of updating the Plan.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHP coordinates the school-based SOHP as noted above. School eligibility is determined by a formula including the proportion of students eligible for free and reduced lunch and for MaineCare and the proportions of the community receiving fluoridated public water and whose family incomes are at the federal poverty level. The SOHP is thus directed toward schools where children are more likely to have problems accessing dental services, since socio-economic status is directly related to the ability to obtain dental care.

The OHP continues to support the KOHP and implement the activities of the State Based Oral Disease Prevention grant, both described above.

In the biennial budget for FY10 and 11, state funding supporting the SOHP was reduced by $250,000; we were directed to use another funding source that is intended for other oral health programs. For FY11, more state dollars will be removed, to be replaced with funds meant to support school entrance oral health screenings. Eligibility and performance standards for the

coming school year were reviewed; the fluoride mouthrinse component has been reduced. It is unclear how the SOHP will be sustained without significant restructuring after FY11. With increasing demands from the programs that must be funded from reduced resources, we are concerned that a proven prevention program must compete with one that subsidizes restorative care for uninsured adults.

c. Plan for the Coming Year

The objectives for this measure increase every two years reflecting the biennial availability of the Maine IYHS data.

The OHP's PHE will continue to focus on coordination of the SOHP and the dental sealant component as noted above. Related to activities of our CDC grant, she plans to coordinate a training session on implementing school-based sealant programs during the first half of the 2010-11 school year for school nurses, health coordinators and hygienists. In addition, she is also implementing a software tool that will allow better data collection and facilitate a cost-benefit analysis of our school-based sealant program. She will also continue to update our educational resources and website.

A proposed school entrance oral health screening program, first funded during the 2006 legislative session, was not implemented as planned due to staff constraints and some limitations imposed by the enabling statute. Additional legislative action in 2009 directs DHHS, through the OHP, in collaboration with the Department of Education, to implement up to three pilot programs and report back in February 2011. Because this did not happen in the 2009-10 school year, largely due to the impact of H1N1, we will be attempting to implement this program to some degree in the coming year. However, as noted above, funding for the screening program has been diverted to support the SOHP. We will be challenged to find ways to do both.

Related to the CDC cooperative agreement, OHP staff will continue to implement required activities. Our State Oral Health Improvement Plan, published in November 2007, is due to be updated and revised, and we will start that process during FY11, engaging a broad range of stakeholders. We will also work with USM epidemiologists to implement our oral health surveillance plan, following up on the burden of oral disease report (surveillance report) due to be published before the end of September 2010. The KOHP Project, having moved into its implementation phase, will focus more on sustainability planning, and is working with Head Start's Oral Health Initiative (a partnership with the American Academy of Pediatric Dentistry to promote all children having dental homes).

Through a combination of resources, the OHP will support the Maine Dental Access Coalition, a broad-based stakeholder group. A number of activities of the CDC cooperative agreement also involve the Dental Access Coalition; these activities include promoting collaborations that can support school-based oral health education and sealant programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.2	3	3	3.2	3.1
Annual Indicator	3.3	3.6	3.2	2.6	2.6

Numerator	38	40	36	29	
Denominator	1149644	1126308	1126269	1118193	
Data Source				Death certificates, Maine Vital Statistics Office	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.5	2.4	2.3	2.2	2.1

Notes - 2009
2009 death certification data are not yet available; 2008 data were used as an estimate.

The 2008 indicator is the 5-year average for 2003-2007. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819.

Notes - 2008
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Data are from the Maine Office of Data, Research and Vital Statistics.
The 2008 indicator is the 5-year average for 2004-2008. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819. Using the HP definition, the rates for the past 3 five year periods are as follows:

2002-2006: 34/1126308=3.0 per 100,000
2003-2007: 33/1126269=2.9 per 100,000
2004-2008: 31/1118193=2.8 per 100,000

Maine is below the Healthy People 2010 goal of 9.2 per 100,000.

Notes - 2007
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Data are from the Maine Office of Data, Research and Vital Statistics.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819. Using the HP definition, the rates for the past 2 five year periods are as follows:

2002-2006: 34/1126308=3.0 per 100,000
2003-2007: 34/1126269=3.0 per 100,000

Maine is below the Healthy People 2010 goal of 9.2 per 100,000.

a. Last Year's Accomplishments
Motor vehicle crashes are the leading cause of death among children age 1-14 years in Maine. Maine's 5-year average rate of motor vehicle deaths among children age 14 and younger for 2004-2008 was 2.6 per 100,000 children. This is the lowest 5-year average rate Maine has experienced dating back to 1992-1996. Maine's rate has generally been lower than the U.S. rate over time but this difference is not statistically significant. According to Maine's Integrated Youth Health Survey (IYHS), the % of middle school students who never or rarely use a seat belt declined recently. Based on 2009 IYHS data 8.6% of middle school students reported never or rarely wearing a seatbelt when riding in a car. This is a significant decline from 10 years ago when more than 1 in 4 middle school students (26.5%) reported never or rarely wearing a seatbelt. However, only 59.2% of middle school students reported that they always wear a seatbelt. Data from Maine's Pregnancy Risk Assessment Monitoring System reveal that almost all new mothers (>99%) report that their infants always ride in an infant car seat.

Data on Maine's motor vehicle death and injury rates led the Maine Injury Prevention Program (MIPP) to identify motor vehicle traffic crashes as a priority in their program plan.

There are 36 Child Safety Seat Program sites across the state. The program provided 2,035 car seats to families that met WIC income guidelines during FY09. As of January 2009, the Bureau of Highway Safety (BHS) assumed the statewide responsibility of ordering and distributing child passenger safety seats to all Child Passenger Safety (CPS) sites and fitting stations. This change has impacted the ready availability of data regarding seat distribution previously maintained by the MIPP. While we receive a total number of seats distributed we are not able to obtain a breakdown by age group. We are looking into the possibility of obtaining this information from volunteer sites in the future.

As of October 2009, the CPS Coordinator focus is child passenger safety as it relates to motor vehicles. The CPS Coordinator serves in a supportive role rather than lead on providing training and awareness related to transporting pre-school age children and children with special needs on school vehicles.

Maine's Home Visiting Program conducts safety assessments every 6 months and provides information to families related to car safety. Families are encouraged to have their car seats checked by a certified car seat installer. The assessment covers four areas: children are never left alone in the car; a child safety seat is placed in the back seat facing in the appropriate direction for age and weight; a child safety seat is used on every ride; and caregivers buckle up on every ride.

Over 13,000 pieces of injury prevention materials related to traffic safety were distributed to organizations throughout the state. Some materials are being made available via the website and more material requests are being sent via email.

A CPS survey designed to measure knowledge retention and skills of CPS technicians was administered in April 2009. The results indicated that technicians maintained a high level of knowledge across time in all areas except for special needs children and federal laws. Assisting special needs children with car seats is generally performed at hospitals and not by local

technicians. The technicians had high scores on the Maine law which is more specific and applicable to their work. Findings will be used to enhance delivery of CPS training and devise ways to better support technicians after certification. The Children's Safety Network, MIPP's partner in this project is interested in learning more about Maine's work to potentially highlight in future nationwide correspondence as Maine is perhaps the only state to undertake this level of child passenger safety evaluation.

CPS survey findings were presented at a child passenger safety symposium held in June 2009. A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was also conducted. Results of the SWOT analysis will be used to identify strategies and initial steps to create and/or enhance CPS partnerships in Maine and support the work of the CPS Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide child safety and booster seats to children birth to 8 years old.		X	X	X
2. Present to groups and organizations on the importance of child passenger safety.		X		X
3. Provide support and education to fitting stations.				X
4. Collect data on correct installation of seats at check-up events.				X
5. Assist in the planning and implementation of a tri-state transportation safety conference – Maine / NH / VT.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Traffic Safety Education position was vacated in July 2009. A statewide recruitment process commenced and the position was filled in December 2009. As part of the grant renewal process the position title was changed to Child Passenger Safety Coordinator.

During FY10 the MIPP completed a systems analysis of how the program administers its data collection instruments. Based on the results the program is re-evaluating its data collection system. MIPP is working with the BHS to establish one instrument to be used at all sites in the state.

The Department of Education (DOE) held its 25th annual Maine Schoolsite Health Promotion Conference in June 2010. Motor vehicle safety topics were included.

The DOE distributes injury prevention materials to health education teachers and wellness team leaders.

c. Plan for the Coming Year

The objectives for this measure anticipate continued improvement in this measure over time.

During FY11 MIPP will:

- Establish a statewide CPS Advisory Committee to provide support and guidance to the child

passenger safety program through a combination of hands on assistance or by sharing knowledge that can help shape program goals.

· Manage statewide Child Passenger Safety program resources.

· Develop, assist, and support a cadre of trained, certified technicians to maintain their child passenger safety skills and knowledge.

· Increase public awareness of Child Passenger Safety program resources in Maine by providing resources and support to CPS professionals in Maine enabling them to sustain their volunteer child passenger safety work.

· Increase public access, especially for income eligible and diverse populations, to resources that show how to safely and correctly secure their children in child restraint systems by providing outreach to health and child care providers on how to access program resources.

· Assist in raising awareness of the availability of seats to families in need including those with special needs.

· Continue to work with the media and legislators to educate the public on child passenger safety issues.

· Provide annual child passenger safety training to Child Passenger Safety Seat Program staff at various locations around the state via telecommunication technology.

· Continue to provide educational materials and resources on child passenger safety to professionals, advocates and the general public.

· Maintain a current list of locations of car seat check locations and car seat distribution sites on MIPP website, on 2-1-1, and on the BHS website.

· Continue work on program website for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to other Maine and national injury prevention resources.

· Coordinate activities with Safe Kids Maine in promoting child passenger safety.

· Convene site managers once yearly to celebrate their accomplishments and provide program and car seat updates.

· Continue to participate on Maine Transportation Safety Coalition and other CPS related committees and councils.

· Attend Lifesavers Conference and other CPS applicable training opportunities.

· Update CPS website housed on MIPP site

· Assist in the planning and implementation of a statewide injury prevention conference which will include a CPS track.

· Survey instruments will be reviewed and updated. A survey of technicians is planned for the spring of 2011.

DOE will continue to participate in programming with the MIPP and Coordinated School Health Program. Partnerships will be expanded with the Department of Transportation Safe Routes to Schools Program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		38	41	47	44
Annual Indicator	36.9	40.6	46.1	43.3	45.7
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	47	48	49	50

Notes - 2009
Data for the 2009 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2009 indicator represents the percent of children in Maine, born in 2006, who were breastfed for 6 months. Data from the 2007 and 2008 surveys were combined to obtain this estimate. Data for this indicator will not be final until the 2009 survey results are available.

Notes - 2008
Data for the 2008 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2008 indicator represents the percent of children in Maine, born in 2005, who were breastfed for 6 months. Data from the 2006, 2007 and 2008 surveys were combined to obtain this estimate.

Notes - 2007
Data for the 2007 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2007 indicator represents the percent of children in Maine, born in 2004, who were breastfed for 6 months. Data from the 2005, 2006 and 2007 surveys were combined to obtain this estimate.

Our objectives were changed to be aligned with the new reporting methodology.

a. Last Year's Accomplishments
There are four surveillance systems that include Maine breastfeeding data; the national CDC Pediatric Nutrition Surveillance System is the data source specific to the WIC population. The other data sources include the CDC Pregnancy Risk Assessment and Monitoring System (PRAMS), the Maine Newborn Breastfeeding Surveillance System (breastfeeding rates at hospital discharge), and the National Immunization Survey (NIS). Maine has chosen to use the NIS because it is the only data source that is generalizable to all women in Maine and includes women who are at least 6 months postpartum.

The NIS now presents breastfeeding information according to the child's year of birth, rather than the year the respondent was interviewed. Due to NIS changes to data presentation, the most recent data available for this measure are based on children born in 2006. According to these data, 45.7% of children born in Maine in 2006 were breastfed for at least 6 months and 18.1% were exclusively breastfed for 6 months. These percentages are higher than the national average, but not statistically higher. Maine ranks 22nd in the U.S. on this measure. According to NIS, 75% of children born in 2006 were ever breastfed. Maine 2007 PRAMS data indicate that 78.2% of Maine mothers initiated breastfeeding and 57.5% were still breastfeeding when they

completed the survey, which is usually when their infants are about 3 months old.

Programs in Maine focused on improving breastfeeding rates among new mothers are WIC, Home Visiting (HV), and Public Health Nursing (PHN).

The WIC Nutrition Program conducted trainings on new food benefits with all local agency staff. The new food benefits promote establishing adequate breast milk supply by limiting supplemental formula to a maximum of one can of powered formula in the 1st month. New educational materials were developed to help local agency staff in their work with new mothers, reassuring them in their ability to produce sufficient milk for their babies. As an additional incentive, mothers choosing to exclusively breastfeed receive more food for themselves throughout the first year of their baby's life. Their infants also receive a larger amount of jarred fruits and vegetables than the non breastfed infant, as well as infant meats between 6 and 12 months of age.

There are 4 breastfeeding peer counselors in 2 local WIC agencies. Peer counselors are mothers who have previously breastfed, are enthusiastic about breastfeeding and are trained to offer encouragement, information and support to mothers enrolled in WIC. Studies completed in various parts of the country have shown the Breastfeeding Peer Counselor Program to be effective in increasing both breastfeeding initiation and duration for WIC participants.

HV actively encourages new mothers to breastfeed and links mothers to resources such as hospital breastfeeding classes and lactation consultants. Through WIC, the HV has increased the number of lactation counselors embedded in HV programs. In FY09 the % of HV families that were breastfeeding at 6 months was 39.7%. Overall the exclusively breastfeeding at 6 months rate was at 19.6% and of the any breastfed, 30.2% were still breastfeeding at 1 year old. During this time period the family is seen minimally once a month but some may be seen weekly. At every visit there is a check in to see if the mother is breastfeeding exclusively. Prenatal enrollment is slightly lower than postnatal. Those enrolled prenatally are frequently those primary care physicians have concerns about; i.e. food insecurity, very young.

Due to both the geography of the state and limited PHN staff, the Women and Children's Preventive Health Services Program funds 3 Community Health Nursing (CHN) contracts to provide home health nursing services to mothers and children in portions of central and southern Maine. During FY09 CHN provided 10,754 visits to 4,173 clients. Of the 10,754 visits, 1,058 were at risk parenting visits, 5,806 children visits, 30 children with special needs visits, 3,554 postpartum visits, and 306 prenatal visits.

During FY09 PHN provided 16,681 home visits to individual clients. Of these visits 4,965 were children, 2,914 parenting, 2,622 postpartum, 462 prenatal, and 72 lead, for a total of 11,035 related to MCH.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate data sources and improve the accuracy of WIC breastfeeding data.				X
2. Offer training opportunities for WIC counselors, public health nurses, and home visiting on the development of counseling and clinical skills to support optimal breastfeeding practices.				X
3. Enhance the WIC breastfeeding peer counselor program.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
WIC is collaborating with the Maine Department of Labor (DOL) to create a document that explains L.D. 373 "An Act to Facilitate Lactation at the Workplace by New Mothers" which requires an employer to provide both an appropriate space and the time for mothers to pump their breast milk. This information will be sent to businesses around the state by the DOL and by WIC counselors and hospital lactation consultants to breastfeeding women returning to work. The desired outcome is to help women to continue to breastfeed for a longer period of time.

WIC is collaborating with MaineCare to improve outreach to households with pregnant women or children under the age of five to effectively reach those families with information regarding WIC services and locations.

Other breastfeeding promotional efforts include tote bags with a message "Breast milk the Original Fast Food" and bumper stickers "Affordable Health Care Begins With Breastfeeding".

11 local WIC agency staff members plan to complete the Certified Lactation Counselor (CLC) training in FY10. With the addition of these 11 there will be approximately 60 local WIC agency staff trained as CLCs and 4 trained as International Board Certified Lactation Consultants. HV has 11 Certified Lactation Counselors across the state; most have been certified for a number of years, two were certified two years ago, and two were certified in April 2010.

c. Plan for the Coming Year
Based on the most recent estimate available, we have adjusted our objectives and hope to increase our breastfeeding at 6-month rates by at least 1% each year.

The WIC Program will focus on attaining two goals: 1) Maine WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC participants. The breastfeeding indicators that reflect these goals are: 1) increase the number of WIC mothers who are breastfeeding their babies at six months, and 2) provide pregnant and/or breastfeeding women access to a qualified lactation counselor.

Expansion of the Breastfeeding Peer Counselor Program to a total of four local agencies (previously 2 agencies) will assist the WIC Program to address the goal of increasing the number of WIC mothers who are breastfeeding their babies at six months. Other breastfeeding educational opportunities will be provided, including a CLC training and a three day Breastfeeding Peer Counselor training. The program will continue to collaborate with the local WIC agencies and the Maine State Breastfeeding Coalition to enhance breastfeeding promotion and support strategies.

If the outreach through MaineCare is successful WIC will continue to send informational letters to WIC eligible parents on a regular basis.

The WIC Program will continue to promote the food benefit changes with health care providers and hospital nursing staff.

The HV Program will continue efforts to increase prenatal enrollment and work with WIC to help reinforce messages on breastfeeding.

HV will develop a web-based training that includes a breastfeeding 101 module, as part of its core training, so all staff receive the same consistent information. One in person training will be offered and video-taped. The video will be archived for access by others such as WIC and PHN, as a resource.

PHN is working on improving their data system to track improvements in client outcomes, such as breastfeeding initiation and duration.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	96.5	96.8	97
Annual Indicator	91.7	95.1	97.1	96.1	96.1
Numerator	12827	13318	13560	12974	
Denominator	13988	14009	13969	13500	
Data Source				Maine Newborn Hearing Program	Maine Newborn Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97.1	97.4	97.6	97.8	98

Notes - 2009
2009 data are not yet available. 2008 data are used as an estimate.

The 2008 data are from the Maine Newborn Hearing Program as of December 21, 2009.

The denominator is the number of occurrent births in Maine in 2008.

Notes - 2008
Source: Maine Newborn Hearing Program Data as of December 21, 2009.

MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. The 2005-2008 estimates include all hospitals.

In 2005, babies who had a hearing screen record but both ear results were 'N/A' were counted as having been screened. For 2006-2008 data, we did not count those as screens to reflect more accurate reporting.

The denominator is the number of occurrent births in Maine in 2008.

Notes - 2007
MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. The 2005, 2006, and 2007 estimates include all hospitals.

In 2005, babies who had a hearing screen record but both ear results were 'N/A' were counted as having been screened. For 2006 and 2007 data, we did not count those as screens to reflect more accurate reporting.

For 2003 and prior years, this indicator reflected the percentage of newborns who had *access* to a hearing screen before hospital discharge. Beginning in 2004, the indicator reflects the percentage of newborns that were actually screened.

a. Last Year's Accomplishments
The Maine Newborn Hearing Program (MNHP) was established in 1999. Since January 2003, every birthing facility has been required to report to the MNHP the number of babies born in the facility, the number of newborns who received a hearing screen, the result of the hearing screen and the number of newborns whose parents declined hearing screening.

An electronic data tracking system, ChildLINK, links newborn hearing screening data with the electronic birth certificate, enabling the MNHP to verify that every baby born in Maine has a newborn hearing screen and to track follow-up services regarding audiological evaluations and referrals to and participation in early intervention services. Birthing facilities and audiologists have the capability of submitting screening and diagnostic data via this web-based system.

There are currently 30 birthing facilities in Maine and all receive site visits, regular communication with the MNHP and technical assistance as appropriate. CY09 financial constraints resulted in 1 hospital ceasing to offer maternity services. In CY08, 27 of the 33 birthing facilities in Maine had a greater than 98% screening rate with 6 facilities obtaining 100%. Only 3 facilities had a less than 95% rate. The remaining 3 facilities had rates between 95% and 98%. It is unlikely that all the birthing facilities will reach the 100% screening rate because the rate is based on the number of live births at each facility and does not take into account parent refusal or death of a baby shortly after birth.

Data submitted to ChildLINK during CY08 indicated 13,500 births occurred in Maine with 13,178 (98%) being screened for hearing loss. Of these, 12,973 (98.4%) were screened by 1 month of age. Of the 13,178 screened, 199 (1.5%) did not pass the screening. Of the 322 babies not screened, 58 expired prior to having the hearing screen, 26 were not screened due to parent refusal and 238 were unknown. To date, we have received 137 (69%) reports on those referred to an audiologist. Of the 137 reports, 18 were identified with hearing loss. We received reports on 9 who passed or missed their newborn hearing screen and were identified with hearing loss. Of the 18 babies who referred on their hearing screen and were identified with hearing loss, we received reports that 4 children have Individual Family Service Plans with Child Development Services, our Part C provider in Maine.

LD 2295 was implemented on January 1, 2009. This law requires that when a newborn receives a newborn hearing screening result of 'refer', the facility that performed the screening schedule the newborn for a follow-up appointment with an audiologist and report the information to both the baby's PCP and the MNHP.

In CY08, ninety-three (42.9%) of the children who did not pass the newborn hearing test had "unknown" results or were lost to follow-up. The number of children lost to follow-up is

decreasing. In CY06, 62% were lost to follow-up, in CY07 that number decreased to 47% and CY08 results showed that 31% were lost to follow-up. We anticipate this decline to continue with the implementation of LD 2295 and our continued efforts in working with screening facilities, families and health care providers to further improve babies receiving timely follow-up care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor compliance of hospitals and audiologists reporting via the electronic reporting system.				X
2. Create a hearing screening training module for birthing facilities.				X
3. Provide tracking of newborns who do not pass the hospital screen.		X		
4. Educate providers about the mandated requirement of providing results of audiological evaluations to the Newborn Hearing Program.				X
5. Collaborate with CDS, Part C agency to facilitate referrals into early intervention.		X		
6. Continue to facilitate the Newborn Hearing Program Advisory Board.				X
7. Evaluate comprehensive screening and service system.				X
8. Create an educational brochure on hearing screening to be provided to prenatal classes as well as health care providers who offer obstetric services.				X
9. Work with Maine nurse midwives to improve access to newborn hearing screening for those children born at home.				X
10.				

b. Current Activities

MNHP applied for and was awarded additional grant funds from the Health Resources Services Administration MCHB in CY09. These funds are for three years (2009-2012) and require specific additional work to be done to reduce loss to follow-up documentation.

MNHP objectives include ensuring that NICU infants receive a hearing screen as soon as medically appropriate, that any known risk factors for late onset, progressive, or acquired hearing loss are indicated on the hearing screen record, that the child's primary care provider is identified and provided to MNHP, that the PCP and the child's family are aware of the importance of ongoing audiological exams when indicated and that the results of any diagnostic audiological exams are reported to MNHP. Using the National Initiative for Children's Healthcare Quality (NICHQ) Model for Improvement (improving children's health by improving the systems that deliver healthcare through adopting best practices and ensuring high quality care), MNHP is working with Eastern Maine Medical Center (EMMC) to focus on newborns admitted to the EMMC NICU, either from within EMMC or from secondary/tertiary facilities. The Team consists of the CSHN Director, MNHP Coordinator, a parent consultant, a nurse educator, nurse managers, two neonatologists and an audiologist from EMMC's NICU.

c. Plan for the Coming Year

Data for CY08 indicates that Maine is maintaining its level of newborn hearing screening while increasing its rate for follow-up testing, evaluation, diagnosis and enrollment in appropriate early intervention services.

During FY11, MNHP plans to continue to implement and monitor quality assurance and quality improvement plans in the management of a statewide universal newborn hearing system, improve audiology reporting and access to early intervention services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	7.5	8	5.6
Annual Indicator	6	7	5.6	5.5	5.5
Numerator					
Denominator					
Data Source				Current Population Survey 2006-2007	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.4	5.3	5.2	5.1	5

Notes - 2009
2009 data for this indicator are not yet available. The 2008 indicator is used as a proxy.

The 2008 indicator reflects analysis of the state data from the pooled 2007 and 2008 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Notes - 2008
The 2008 indicator reflects analysis of the state data from the pooled 2007 and 2008 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Notes - 2007
The 2007 indicator reflects analysis of the state data from the pooled 2006 and 2007 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Our objectives reflect anticipated future trends. Insurance rates have been increasing with the result that families are being asked to assume larger co-pays and deductibles. Anecdotal information suggests families are beginning to drop their insurance coverage as a result of higher out of pocket expenses. We anticipate these external forces will create the likelihood of increased uninsured rates in future years.

We have seen declines in uninsured children in recent years. Our objectives in the future are influenced by persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform, Dirigo Health Plan.

a. Last Year's Accomplishments

Since 1996 there has been a considerable decrease in the % of Maine children without health insurance. According to 2007-2008 Current Population Survey estimates, 5.5% of children under age 18 in Maine were without any health insurance. About 34% were covered by MaineCare and 58% were covered by private health insurance. The US child uninsured rate was 10.3% in 2008. Maine has the 6th lowest uninsured rates in the U.S. and the 11th highest Medicaid insured child population. By ensuring access to school-based health centers, home visiting, and public health nursing, Maine's Title V program is working to decrease or maintain the percent of children without health insurance in the State.

School-based health centers (SBHCs) provide a safety net for children who might not otherwise seek needed health care services. While not every community has created the necessary partnership between health care providers and schools, there continue to be 27 schools with SBHCs in the state. The Teen and Young Adult Health (TYAH) Program provided base funding for 19 SBHCs. 7,821 students were enrolled in these 19 funded SBHC's in Maine during FY09. There were 14,742 encounters, 28% of all visits were for mental health services and 31% of the primary diagnoses at medical visits were for preventive care services. About 52% of users were screened for major adolescent risk behaviors; including tobacco use, physical inactivity, poor nutrition, sexual activity, substance abuse, depression and behaviors connected to unintentional injury. Changing adolescent health behaviors can be challenging but data from the SBHCs shows that when unhealthy behaviors were identified, intervention was possible and change did occur. For example, of the 208 identified as tobacco users, 93 received treatment that resulted in 27 reducing or quitting tobacco use, and of the 378 identified with poor nutrition, 319 received an intervention with 27 showing improvement.

91% of SBHC enrollees had an identified primary care provider, 94% of those enrolled in SBHC's had insurance (public or private), 50% with MaineCare, while 3% had no insurance. SHBC staff assisted those children with no insurance in getting connected with insurance providers. Data on SBHC services continued to improve in quality and detail through the assistance of an in-state helpdesk, and contracted data analysis services.

The Maine Association of Health Plans and SBHC Reimbursement Study is completed. The study purpose was to look at the costs and benefits of providing reimbursement to SBHC's without a prior primary care provider referral or approval. Unfortunately, due to staffing shortages the final report has not been completed.

99.7% of children enrolled in the Home Visiting Program in FY09 had access to a primary care provider and 97.8% had health insurance, 65.1% through MaineCare (this percent varies by area of the state). Key to this high rate of insured children is the referral for eligibility determination made during the initial family engagement. The remaining 2.2% of uninsured children represent those in the process of applying for MaineCare, those who are in the period of time before private insurance becomes valid, those whose children may be in state custody, or those whose circumstances are complex because of job loss and subsequent loss of insurance. Home visitors assist families in completing MaineCare forms, and locating transportation to get to their first appointments.

During FY09, of the 4,173 clients served by Community Health Nursing (CHN), 41.07% were insured through MaineCare, 46.49% had private insurance, and 0.58% had no insurance. The focus of CHN is to ensure clients obtain access to a primary care provider to obtain the required health care. They do monitor whether or not the client has insurance and provide clients with information on how to obtain insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SBHC providing assessment of insurance status, education and assistance in enrollment.		X		
2. Monitor changes in insurance coverage.				X
3. Monitor for changes in MaineCare services and work with the Office of MaineCare Services to facilitate MaineCare reimbursement for adolescent health services.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Base-funding from state MCH matching funds and the Fund for a Healthy Maine (Master Tobacco Settlement funds) for 19 SBHCs continues to assist in maintaining access to services as the SBHCs and sponsoring agencies face more stringent budgets. On average, this funding provides 34% of the average SBHC budget. A small portion of the MCHBG allows these sites to provide services to uninsured and underinsured students without impacting the ability to bill MaineCare and other insurers, which are projected to provide 14% and 6% of SBHC revenues respectively.

As SBHC's transition to electronic medical records (EMR) new data collection formats are causing increased challenges to collecting outcome data. Our first experiences with this demonstrate that it is possible, but requires careful quality checks. The database software (Clinical Fusion) used by Maine's SBHCs that do not have an EMR was developed years ago in Colorado and has not had any significant upgrades for a number of years with none anticipated in the future. The TYAHP is working with its evaluators to identify more modern data collection software that is cost effective.

The TYAHP continues to advocate with Kid's Count to provide adolescent specific data on uninsured rates. Past national data suggests that adolescents have higher rates of un-insurance. While the majority of students that use the SBHCs are insured we do not have data on the 45% of students in those schools that have not enrolled in the SBHC.

c. Plan for the Coming Year

The TYAHP will fund 19 SBHC grants in FY11, continue the evaluation contract to support better data collection, seek opportunities to improve services and sustainability of SBHCs, including promoting preventive health, addressing behavioral health issues, and expanding partnerships.

Home visiting programs not only document the insurance status of enrolled children but also track reasons why children are not insured. In some instances parents choose not to enroll in public health insurance when they initially begin to participate in the Home Visiting Program. Because home visitors are trained to engage families in the steps to promote child health and well being, each family's barriers are addressed individually, and home visitors may assist families in the application process.

Given the ongoing state budget deficits Maine is unable to increase the percentage of insured

children using state funds. However with the passage of the Patient Protection and Accountability Care Act (PPACA), Maine is preparing to respond to all PPACA provisions that would increase the percentage of children with health insurance. The percentage increase of those insured through MaineCare will be limited as the income eligibility level is at 200% of the federal poverty level.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	31	30	36
Annual Indicator	33.6	33.1	38.0	37.9	30.9
Numerator	3461		4685	5016	5845
Denominator	10298		12337	13239	18911
Data Source				Maine WIC Program	Maine WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30	29	28	27	26

Notes - 2009
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2012. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2008
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2010. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2007
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2010. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

a. Last Year's Accomplishments
Maine uses data collected by the local WIC agencies to determine the percent of children > 2 years enrolled in the WIC Program at or above the 85th percentile for weight. Based on this data, 18% of children between the ages of 2-5 who were enrolled in WIC in 2009 were overweight (BMI between 85%-95%) and 12.8% were obese (BMI >95%). Overall, 30.9% had a BMI over the 85th

percentile for their age.

In FFY04, the Maine WIC Nutrition Program implemented nutrition education procedures that presented a change in philosophy from nutrient and diet focused education to helping parents recognize the importance of a healthy parent child feeding relationship. Maine WIC staff foster healthy behaviors and family meals.

During FY08, the Maine WIC Nutrition Program implemented Value Enhanced Nutrition Assessment (VENA). VENA was developed jointly by the Food and Nutrition Service and the National WIC Association to improve nutrition services in the WIC Program. Standards were developed for the enrollment process to ensure a thorough assessment for each individual participant. Information gleaned is used to determine WIC eligibility as well as individualized nutrition education, referrals, and tailor food benefits. During FY08 basic VENA skill training was provided in several competency areas including: rapport building, critical thinking, cultural competency, stages of behavior change, positive health outcomes, and emotion-based counseling. VENA was fully implemented during FY09. The training created awareness with staff on the need to prioritize and individualize discussions with participants. The State Agency encourages Local Agency staff to share stories that exemplify successes they have had using VENA principles, or reflect a situation that could have been handled differently if VENA principles had been used.

During FY09, the State WIC agency conducted new food benefits trainings for all local agency staff as well as authorized vendors. The new WIC food benefits, developed by United States Department of Agriculture, Food and Nutrition Service in response to recommendations from the Institute of Medicine, include several changes that may directly impact the rising rate of childhood overweight and obesity:

1. Milk: Reduced fat, lowfat or skim only for all children 24-60 months.
2. Cheese: Maximum one pound per month unless otherwise prescribed by a health care provider.
3. Fruits and vegetables: Monthly $6.00 cash value voucher which may be used to purchase fresh, frozen or canned fruits and vegetables.
4. Juice: Reduction in total amount issued each month.
5. Whole grains: Variety of whole grain items (whole wheat bread, brown rice, oatmeal, whole grain tortillas) which may be purchased each month.
6. Breastfeeding support: Reduction in the amount of formula allowed for partially breastfed infants to encourage more of the baby's nutrition to be supplied by mother's milk.
7. Infant foods: Exclusively breastfed infants receive more infant foods (fruits, vegetables, meats) than partially breastfed or non-breastfed infants.

Research indicates the longer infants are breastfed the lower the probability of being overweight. The Maine WIC Nutrition Program continued to provide breastfeeding education to all pregnant women and encouragement and support to breastfeeding women and their families.

The Maine WIC program collaborated with the Maine Physical Activity, Nutrition and Healthy Weight Program (PAN-HW) on ways to incorporate healthy eating messaging in local WIC agency offices. Offices were repainted and colorful posters and pictures promoting nutrition and physical activity messages were provided to several WIC permanent sites. The goal was to impact client awareness and knowledge of healthy lifestyles.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate on-going VENA training provided to local agency				X

staff.				
2. Evaluate WIC agency contract indicators to achieve the WIC Goals.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Maine WIC Nutrition Program continues to work with local agencies on the VENA initiative. A VENA training for all new staff members hired in the past 2 years will be held in August 2010. The State WIC Agency has also been conducting a special project grant funded by the Food and Nutrition Service, Revitalizing Nutrition Education through VENA: Skill Building for Cultural and Linguistic Competence. This project will test an approach and model for continuous skill building in cultural and linguistic competence to improve staff and organizational performance in providing WIC services. Results for this three year grant will be reported in 2012.

New food benefits trainings began June 2009 for all WIC agencies and vendors and were completed by September 2009. The changes were implemented October 1, 2009. Trainings have been well received by local WIC agency and vendor staff members. The local agencies are conducting participant surveys to obtain feedback on how the food changes have been accepted. Results will be reported in FY11.

Five local WIC agencies received funds to pilot a program through the Maine Nutrition Network (MNN) called "Veggies For Me". With guidance from MNN project managers, WIC local agency staff members hold monthly food demonstrations on the preparation of different vegetables, with a goal of reaching a minimum of 50 people per month.

c. Plan for the Coming Year
The WIC Program will focus on attaining two goals: 1) Maine WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC participants. The nutrition education indicators outlined in the WIC agency contracts that reflect these goals are: 1) increase the number of WIC participants who are at a healthy weight and 2) ensure that all WIC staff reinforce VENA methods in participant nutrition assessments.

The Maine WIC Nutrition Program will focus on reducing the number of WIC children who are overweight. The Program will collaborate with Local WIC Agencies, as well as, other partners to enhance strategies that will help to reduce the rate of overweight children in Maine.

The State WIC Agency will continue to monitor food benefit changes to determine their impact. Redemption of the monthly cash value vouchers will be assessed, with participant and vendor feedback used to focus activities for improving use of this benefit.

A session at the Maine WIC Annual conference in October 2010 will be devoted to a discussion of childhood overweight and obesity, and successful strategies counseling staff members may use as they work with WIC parents.

Development of a Maine State Breastfeeding Coalition website that includes breastfeeding

resources for WIC participants is also planned. Inclusion of a section where breastfeeding women can post a question anonymously will be considered.

The State WIC Program website will be redesigned, with pages devoted to healthy feeding relationships and helpful links for additional breastfeeding information.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		19	17	16.5	19
Annual Indicator	20	17.5	19.9	19.4	19.4
Numerator					
Denominator					
Data Source				Maine PRAMS	Maine PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18	17	16	15	14

Notes - 2009
Data for this measure are from the Pregnancy Risk Assessment Monitoring System (PRAMS). 2009 PRAMS data are not yet available. Therefore, 2008 data are used as an estimate.

Notes - 2008
Data for this measure are from the 2008 Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2007
The data source for this measure is the 2007 Pregnancy Risk Assessment Monitoring System.

PRAMS data are weighted. Therefore the numerator and denominator for this measure are not presented.

a. Last Year's Accomplishments
The 2009 Maine Pregnancy Risk Assessment Monitoring System (PRAMS) indicated that 19.4% of pregnant women smoked during the last three months of pregnancy. There is no change from 2007 or 2008. Despite no significant changes in the %, the Partnership For A Tobacco-Free Maine (PTM) remains committed to reducing the percentage of pregnant women who smoke.

During FY09 PTM collaborated with the Maine WIC Program, the Perinatal Outreach Nurse Educator, American Heart Association, the Women and Heart Health Committee, and the Maine Safe Families project which addresses domestic violence and sexual assault. PTM also participated on the Maine Women's Health Campaign, a collaborative that addresses women's issues. The collaborations allow PTM to have discussions about tobacco with those who work

with populations disproportionately affected by tobacco use.

In the Fall of 2008 PTM began a collaborative with the New England Rural Health Roundtable (NERHRT) to address the issue of smoking during pregnancy in rural areas. The NERHRT invited CC Gaffney, an expert in smoking cessation for pregnant and parenting smokers, to partner with the group. To gain a better understanding of the smoking behaviors of rural pregnant women a series of telephonic focus groups were conducted in the spring of 2009. Twenty one pregnant women from 5 New England states were recruited to participate in the focus groups. Results indicated that stress, anxiety, isolation, frequent moves, few friends to lend support and a co-morbidity (mental health issues) were contributing factors for not wanting to quit smoking during pregnancy. They also expressed not having provider support for smoking cessation treatment.

In the Spring of 2009 PTM conducted 3 focus groups with 18 -- 24 year old pregnant women who smoke. Key observations included mixed messages where the women were aware of health concerns to their babies but not themselves. They do not think of the long term consequences and smoke due to daily stress, financial and relationship concerns and for relaxation. Feedback indicated that direct messages are needed for this population. A focus group held with fathers who smoke indicated they too do not think about the future. Stress keeps them smoking; they don't support their partner in quitting, and become irritated and upset by anti-tobacco messaging. They related that they would not call the Maine Tobacco HelpLine (MTHL) because they did not want anyone telling them what to do. Focus group results confirmed that this is a challenging population to reach and a better approach may be to partner with providers in developing materials for their use in motivating pregnant women to quit.

The MTHL continued to offer quitting materials and coaching sessions to pregnant women who smoke. The number of callers to the HelpLine was tracked through a series of 3 questions. 56 callers to the HelpLine during FY09 were currently pregnant, 55 were planning a pregnancy within 6 months, and 16 were currently breastfeeding for a total of 127; unchanged from FY08, (60, 45 and 22 respectively).

A presentation titled; The Confident Conversations About Tobacco, used to train WIC staff on how to offer brief tobacco interventions with clients was revised for use with social service providers (Domestic Violence shelters, Homeless shelters, YMCA/YWCA, Head Starts and Day Care Centers). District Tobacco Coordinators were trained and will train social service providers.

The PTM website was redesigned and launched in August 2008 (www.tobaccofreemaine.org). A section for women and pregnant women was added. To aid in broader dissemination of materials a new on-line ordering system was added to the PTM website.

The Tobacco Treatment initiative began a Face to Face Tobacco Treatment Center in Portland, to offer patients with chronic diseases, co-morbidities, and behavioral health conditions a more intense intervention to quit tobacco. Pregnant women are welcomed but to date, none have visited the center.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Redesign and promote Program and materials based on NERHRT results and PTM strategic plan.		X		
2. Provide Basic Skills Trainings for healthcare, social service, and other providers.				X
3. Promote the Maine Tobacco HelpLine through print and other media.		X	X	X
4. Collaborate with the MCH Program and MaineCare services to		X	X	

increase coverage for tobacco cessation treatment for pregnant women referrals.				
5. Promote programs and messages at the local level through HMP's and District Tobacco Coordinators.		X	X	
6. Collaborate and expand partnerships with other MCDC programs (WIC, Women's Health Initiative) and Office of Substance Abuse to address quitting with their clients.		X		X
7. Increase capacity of local organizations and grantees to address priority populations, using results from the PTM 5 year strategic plan.				X
8. Evaluate programs and track prevalence rates.				X
9. Provide proactive counseling to all pregnant women through the Maine Tobacco HelpLine and face to face coaching.			X	
10.				

b. Current Activities
A brochure, "What women need to know about tobacco" was developed to help women understand that tobacco use is different and more difficult to quit when compared to men. 7,762 brochures were requested, from June 30, 2009-April 20, 2010.

Beginning September 1, 2009 any person violating the law; "An Act To Protect Children in Vehicles from Secondhand Smoke" will be charged a fine of $50.00, unless the law enforcement officer gives a written warning. The law prohibits smoking in a vehicle when a person who has not attained 16 years is present.

District Tobacco Coordinators continue promoting "Confident Conversations About Tobacco" with social service providers.

PTM and the Center for Tobacco Independence (CTI) presented at the Perinatal Nurse Managers of Maine meeting in December 2009 (20 attendees) to equip them with tools to help pregnant women and new mothers quit smoking. Participants volunteered to critique PTM/CTI materials being developed for healthcare providers. Participants requested a specific training to address pregnant women who smoke.

c. Plan for the Coming Year
The PTM will use focus group results to develop materials for healthcare providers to assist pregnant women to quit smoking. Second and third hand smoke, and addressing partners and families who smoke, will be included. PTM, CTI and a media contractor are developing materials for use by providers to encourage pregnant women to quit. Materials will be distributed to health care providers during CTI's clinical outreach trainings.

PTM will continue as a member of the Maine Women's Health Campaign, Women Heart Health Group, Maine Safe Families Partnership and work with the new Maine CDC Women's Health Coordinator.

New objectives and strategies are planned for inclusion in a Healthy Maine Partnership (HMP) Request for Proposals requiring local coalitions to address the issue of smoking during pregnancy.

The District Tobacco Coordinators will continue to offer trainings for social service providers on the "Confident Conversations about Tobacco" quitting tool.

At the Fall 2010 Maine Association of Women's Health, Obstetric, and Neonatal Nurses meeting our Tobacco Treatment contractor, CTI, will offer a training for nurses on tobacco interventions for

use in helping pregnant women who smoke to quit.

PTM will collaborate with the Office of Substance Abuse on developing materials on the harmful effects of tobacco and alcohol on the health of the fetus.

PTM will conduct an in-depth analysis of smoking during pregnancy using PRAMS survey data.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	9.9	9.2	8.3	9
Annual Indicator	9.3	8.4	10.0	9.9	9.9
Numerator	43	39	46	45	
Denominator	463598	463424	460684	454793	
Data Source				Death certificates, Maine Vital Statistics Office	Death certificates, Maine Vital Statistics Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.8	9.7	9.6	9.5	9.4

Notes - 2009
2009 mortality data are not yet available. The 2008 indicator is used as an estimate.

The 2008 indicator is the 5-year average for 2004-2008. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics

Notes - 2008
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The 2008 indicator is the 5-year average for 2004-2008. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics

Notes - 2007
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics.

a. Last Year's Accomplishments
Maine's youth suicide rate has fluctuated over the past several years. The 5-year rate for 2004-2008 was 9.9 per 100,000, similar to the 2003-2007 rate of 10.0 per 100,000. There were 7 suicides among youth age 15-19 in Maine in 2008. Analyses of Maine's hospitalization and outpatient emergency department visits demonstrate an increase in self-inflicted injuries between 2000 and 2008. In addition, adolescent self-reported ideation and attempts were higher in 2009 compared to 2007 based on the 2009 Maine Integrated Youth Health Survey (IYHS). We are closely watching these trends to see whether they continue.

The Maine Youth Suicide Prevention Program (MYSPP) applied for a National Violent Death Reporting System Grant. Although we were not funded the state recognizes this as a priority and the MYSPP will direct some resources to gather and analyze data to increase our understanding of suicides occurring in Maine.

MYSPP received a federal grant, Caring About Lives in Maine (CAL ME), to implement and evaluate best-practice suicide prevention programs in 11 high schools and their related communities. A major focus of the grant was developing relationships between schools and community mental health providers.

268 individuals attended the annual Beyond the Basics conference. Speakers included Dr. Alec Miller and Dr. Michael Hollander. Topics included; dialectical behavior therapy (therapy to decrease self-harm) with suicidal adolescents, self injury, and cyber bullying. The number of social workers attending increased from 21 in 2008 to 77. A total of 71 training programs were offered to 2,021 participants during FY09.

The Lifeline Student Lessons were updated and significantly improved. MYSPP also updated videos and resource materials and added a closed captioned component to make resources more accessible to the deaf community. The MYSPP formed a partnership with Hazelden Publishing, a national disseminator of health education, to offer the Lifelines Program nation-wide. MYSPP also applied to list the lifeline student lessons in the National Registry of Evidence Based Programs and Practices (NREPP) for Suicide Prevention. Maine was notified in December of 2009 that it was accepted.

The Department of Education's (DOE) annual Comprehensive School Health Education Spring Workshop was held in May 2009. 134 elementary and middle school teachers, high school health education teachers, administrators and school health coordinators attended. Injury prevention round table sessions included healthy relationships, cyber bullying, substance abuse, and a keynote presentation on health education and prevention.

In June 2009, DOE held its' annual Maine Schoolsite Health Promotion Conference. 209 attendees from 30 school systems participated. Sessions offered specific to injury included: substance abuse prevention and cyber bullying prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate statewide access to crisis assistance and suicide prevention resources through promotion of statewide hotline and website.			X	
2. Provide suicide prevention training and education programs statewide.		X		X
3. Provide suicide prevention and intervention guidance and technical assistance to school and community personnel.			X	X
4. Evaluate effectiveness of selected program components.				X
5. Conduct surveillance of, analyze, interpret and disseminate reports on self-inflicted injuries and suicide among youth.				X
6. Support implementation of CAL ME Project.				X
7. Support implementation of plan goals, objectives, and activities as resources permit.				X
8. Maintain and form new partnerships to effectively integrate youth suicide prevention activities in related programs and services.				X
9. Work collaboratively to improve the quality and timeliness of self-injury data.				X
10.				

b. Current Activities

Maine was one of two states selected by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to present on its evaluation model for suicide prevention. MYSPP will meet with evaluation teams from across the country to discuss Maine's model.

DOE included a section specific to injury and violence prevention and mental health in its Linking Key Concepts to the Maine Health Education Standards document; a document that links key education and prevention concepts to the health education standards and performance indicators outlined in the Maine Learning Results.

Transition lessons were developed and piloted at two high schools. The lessons focused on transitions students face when leaving high school. MYSPP and DOE collaborated to develop the lessons.

MYSPP embarked on a strategic planning process to update its state plan to 2015 and restructured its Advisory Council to enhance stakeholder input to the program.

c. Plan for the Coming Year

Our performance objectives for the coming years reflect the challenges of reducing the youth suicide rate and of monitoring trends given small numbers. We hope that the 2007 and 2008 youth suicide rates will not be reflective of an overall change in the trend and that suicide mortality and self-injury hospitalizations decrease in the coming years. However, the limited reach of the program to Maine schools and communities, plus state cuts to mental health services, may impact Maine's ability to change our rates.

We will continue to provide gatekeeper training sessions, training of trainers, awareness education, Lifelines and Transitions Lessons Teacher Training, an annual suicide prevention week event, an annual suicide prevention conference, and begin development of middle school lessons. We developed and are providing a new clinician assessment training series.

We will continue to promote the 24-hour crisis hotline, the program website, and in all education and training sessions; explore ways to better use technology in an effort to reach our audience, monitor trends in suicide and self inflicted injuries among the Maine population, and distribute updated fact sheets and resource materials in a variety of formats.

We will complete our 2015 strategic plan and widely distribute newly revised information booklets.

We will continue to implement the CAL ME youth suicide prevention project and associated evaluation activities and produce reports describing progress achieved.

MYSPP will explore the feasibility of providing training on suicide prevention for clergy in working with Gay, Lesbian, Bisexual and Transgendered and other high risk youth.

DOE will expand professional development opportunities in health education for elementary teachers and target training for middle and high school health educators to be determined by School Health Profiles data and the Maine Integrated Youth Health Survey results.

DOE and MYSPP will continue to work together to train teachers on Lifelines Student Lessons and to pilot Transition Student Lessons in high schools.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	81	81.5	82.2	82.3
Annual Indicator	80.5	81.1	82.1	81.8	83.5
Numerator	659	672	690	667	662
Denominator	819	829	840	815	793
Data Source				Birth certificates, Maine Vital Records Office	Birth certificates, Maine Vital Records Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	85	86	87	88

Notes - 2009
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2009 indicator is the 5-year average for 2005-2009. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

Notes - 2008
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2008 indicator is the 5-year average for 2004-2008. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

Notes - 2007
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

a. Last Year's Accomplishments
In 2009, 88.3% of Maine's very low birth weight (VLBW) infants were born at specialized facilities, the highest rate of the past 20 years.

Maine has 2 Level III nurseries; Eastern Maine Medical Center in Bangor and Maine Medical Center (MMC) in Portland, and 1 Level II nursery, Central Maine Medical Center in Lewiston. Given the geography of the state and the population distribution it is not reasonable to expect all VLBW infants will be delivered at Level III hospitals. The neonatal transport system and statewide perinatal education and consultation remain important and active factors in obtaining better outcomes for pre-term infants born in Maine.

In-depth analyses were conducting on this performance measure in Spring 2009. Results indicate that in Maine, the geographic distribution of Level III facilities increases the challenge of improving the proportion of VLBW infants born in Level III hospitals. To date, the only 2 counties in Maine that have achieved the HP2010 goal for VLBW infants born in Level III facilities are the counties that contain Maine's 2 Level III facilities (Penobscot and Cumberland). Mothers in Knox and Androscoggin Counties have been significantly less likely than Maine mothers overall to deliver their VLBW infants in a Level III facility.

In FY08, L.D. 2253, An Act to Provide Access to Certain Medications to Certified Midwives was passed. This bill allowed midwives access to and the right to administer certain medications during a homebirth. The responsibility for monitoring use was assigned to the Maine CDC, DFH. Rules were developed by the Department of Professional and Financial Regulation and became effective February 2009. Reporting began in late FY09.

The DFH continues to collaborate with the Perinatal Outreach Education and Consultation Program (POEC) at MMC. The POEC provides education and consultation and assumes a leadership role in a variety of public health activities, including the establishment of the MIMR process. The POEC contributed to the quality of perinatal care in Maine by providing 58 formal education programs reaching 1,296 health care professionals during FY09. In addition, 6 transport conferences were provided for 93 attendees. Perinatal outreach team members provided 14 lectures on Perinatal Addiction and Neonatal Narcotic Abstinence. Other lectures included Neonatal Resuscitation, Late Preterm Birth: Perinatal and Neonatal Concerns, using the Edinburgh Postpartum Depression Tool, and 15 interdisciplinary lectures on Shaken Baby Prevention in Maine. The Period of Purple Crying was also offered in response to reports from providers indicating an increase in the number of Shaken Baby Syndrome cases.

The POEC Program provides consultation regarding perinatal issues and is available to guide evaluation and resuscitation or can provide a transport team to be present at birth occurring at a local hospital to stabilize the baby for transport. The CSHN/Genetics Program assisted the POEC Program, through grant funds, to purchase a SimNewB, an electronic training tool for resuscitation and stabilization of neonates. The simulator has helped hospitals evaluate their skills in a more concrete manner. The POEC Nurse Educator, a neonatologist and a respiratory therapist conducted the trainings.

The Child Death and Serious Injury Review Panel (CDSIR) was asked by the Maine DHHS to consider the safety of home birth care in Maine. The request was based on anecdotal reports concerning serious adverse events necessitating transfer of mother and child from home to hospital either during or immediately after birth. The panel's charge was to identify areas in the system of care that could be changed to improve outcomes and prevent or minimize risk of harm to infants and mothers in the state. The panel determined that specific areas in home birth need to be addressed including: a consistent definition of level of risk with only low risk birth or pregnancy related procedures delivered in the home setting; a protocol for safe and efficient transfer of cases from one provider to another be developed; documentation standards developed and followed by all providers; agreement arranged with the emergency transport system should rescue services be needed; improvement in the understanding and value of screening for and early identification of newborn disorders; and informed consent be codified so families understand the risks, benefits and possible events that may occur during pregnancy and delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide education to perinatal care providers regarding high risk care and monitor trends in service delivery.				X
2. Assure statewide access to perinatal and neonatal transport systems.	X	X		
3. Partner in the Prematurity Prevention Campaign led by the March of Dimes.			X	X
4. Monitor health and safety of home births.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In February 2010, one of the MIMR panel members, a physician at Maine Medical Center, reviewed the records of infants born under 33 weeks gestation admitted to Maine Medical Center NICU during fiscal year 2009 (10/08-9/09) who were born at a referral hospital (n=13). After reviewing these cases, he concluded that there was no evidence for inappropriate decisions regarding location of delivery.

L.D. 2253, "An Act to Provide access to Certain Medications to Certified Midwives" was passed in FY08. The DFH role is to monitor the use and complications related to the use of these medications. Sample reporting forms were developed and distributed to midwives and the DFH has started receiving reports on the use of certain medications and any adverse reactions. The midwives are also required to report annually on the purchase, destruction, medication use and

any adverse effects to the Board of Pharmacy.

L.D. 1599, "An Act Regarding the MIMR Panel", was enacted March 2010. This bill repealed the sunset clause to allow the panel to continue to work indefinitely. It also added the authority to review stillbirths beyond 28 weeks of gestation. With passage of this bill we anticipate a significant increase in the number of cases to review.
Every birthing hospital in the state has been trained to provide the Period of Purple Crying (POPC) program to all new parents. POPC is an educational and evidenced-based program for parents aimed at reducing incidents of abusive head trauma.

c. Plan for the Coming Year
Collaborations will continue with the Maine Medical Center POEC Program. Issues of concern to healthcare providers are often presented to the POEC nurse educator for consultation and assistance with evaluation, education and improvement to achieve best practice standards. Transport Conferences reviewing clinical cases and other educational programs will be promoted in areas that have not requested such programs in the past, building new relationships and connections.

Maine's Office of MaineCare Services has contracted with Schaller Anderson Medical Administrators Inc. to help reduce costs. Schaller Anderson has a high risk pregnancy program to identify targeted care management intervention to women insured by MaineCare at high risk of developing complications during pregnancy. They have a goal of getting newly pregnant women into prenatal care as soon as possible and intervene to promote healthy birth outcomes. They provide educational materials to both high and low risk pregnant women each trimester. In the coming year, we will try to learn more about this program and examine the materials they distribute to determine whether they are teaching women about the signs of early labor. They also have a case management database that tracks members' perinatal information. Some of the measurements in this system include the VLBW rate in their population, NICU admission rate, and timeliness of prenatal care.

Future epidemiologic analyses will include an examination of trends of infant mortality and associated risk factors. We will also examine trends in home births and their outcomes in the state.

Continue to review cases of infant deaths through the MIMR panel. The Coordinator will consider adding new members to the Panel to assure all stakeholder groups are represented.

Continue to consult with MCH Medical Director on perinatal issues.

Based on the trend of the past ten years, we hope to make incremental improvements in this measure over the next five years. We anticipate that these changes will be possible through the work of the MIMR panel and ongoing epidemiologic analyses of this issue. In addition, the new regional public health infrastructure will allow us to focus our efforts to specific parts of the state where this is an issue.

Explore possible Public Health Prevention Specialist assignment to work with MIMR and other stakeholders to perform activities related to this objective.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	89	90	90	90	90
Annual Indicator	87.8	87.4	87.1	86.8	88.6
Numerator	12392	12370	12295	11814	11652
Denominator	14111	14152	14110	13606	13148
Data Source				Birth certificates, Maine Vital Records Office	Birth certificates, Maine Vital Records Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2009.

Notes - 2008
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2008.

Notes - 2007
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics

a. Last Year's Accomplishments
Between 1998 and 2008, there has not been a statistically significant change in the percent of women receiving prenatal care beginning in the first trimester. Each year about 88% of women in Maine receive prenatal care in the first trimester. In 2006, the most recent year with comparable US data, Maine ranked second in the U.S. in the percent of women receiving prenatal care in the first trimester (among those using the unrevised birth certificate). However, if we examine early prenatal care by race, among Non-Hispanic Whites, Maine ranked 19th out of the 32 states using the unrevised birth certificate and Maine had the fifth lowest rate of early prenatal care among Blacks. Efforts to increase early receipt of prenatal care are based in Maine's Home Visiting Program (HV), Public Health Nursing Program (PHN), and WIC Nutrition Program.

The Maine HV Program is available universally to any teen parent and first time family throughout the state. An effort is made to enroll women before they give birth to help assure proper prenatal care and healthy pregnancies. During FY09 fourteen agencies in all 16 counties provided 20,368 home visits to 2,646 families. 35.3% were enrolled in the home visiting program prenatally. Parents reported that their participation resulted in positive changes in many areas: home safety and child nutrition (98%), car safety (95%), breastfeeding (87%) and exposure to second hand smoke (89%). In FY09, using the Kotelchuck Index to measure adequacy of prenatal care, 94% of participants with babies born during that year attained adequate care. Of the 1,069 new mothers enrolled in the HV Program, 81 enrolled during their first trimester.

Maine's HV Program focused on using data to inform quality improvement during the reporting period. The HV Program provided technical assistance to sites on ways to enroll families earlier. Unfortunately, with the end of the ability to receive Medicaid reimbursement for home visiting services pending much of the year, staff vacancies were not filled and capacity to serve was reduced. This resulted in wait lists at many of the sites. Although prenatal referrals increased, prenatal enrollment did not due to the wait list situation.

For FY09, it became a contractual expectation that the HV contracted sites increase their prenatal enrollment to 50%. This has resulted in increased efforts to engage prenatal clients.

Standards of Practice for home visiting programs were further refined to provide more detailed guidance to programs. Topics included skills training, supervision, caseload, and collaboration. The Standards were added as a contractual performance expectation for the 14 agencies providing services. A copy of the standards is included in the Appendix.

It is a challenge for public health nursing (PHN) to see individuals prenatally. A relatively small proportion of PHN visits (2.0% of all visits for PHN and 2.5% for CHN) are for prenatal care as an identified health need is required for referral. PHN outreach consisted of providing hospitals with information of services provided and location of district offices. The primary referral source for home visiting is hospitals through childbirth classes and this is usually in the last trimester. OBGYN's generally only refer if the mother is considered at risk. There has been no significant increase in prenatal referrals.

In early FY09 the state's MaineCare Program contracted with a Medical Administrator (MA) to provide case management to pregnant MaineCare members identified to be at high risk in an effort to improve health outcomes. The case manager works with enrollees to ensure they make regular visits with their provider and receive early referral to high risk providers in an effort to prevent NICU days. The PHN Program contacted the MA to offer assistance in conducting long-term assessments but few referrals have been made to date.

The WIC Nutrition Program is collaborating with the PHN staff and other partners to enhance provision of services to pregnant women in their first trimester. WIC enrollments increased during FY09, due in part to the economy. When a client is enrolled in WIC and is pregnant they are asked if they are receiving prenatal care and the enrollment health history has an option for a pregnant woman to check at the first visit if they are receiving HV services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the Home Visiting Programs with reciprocal referral, PHN/CHN identifying health needs, Maine Home Visiting Program identifying non-medical family support and parent education services.	X			X
2. Provide technical assistance to providers of parent education and support services related to implementation and maintenance of parent education and support services.				X
3. Enhance collaboration with the local WIC agencies, PHN and other partners to enhance access to services for pregnant women.		X		X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Data from 2009 births in Maine reveal that 89% of new mothers received prenatal care in the 1st trimester. This is slightly higher than the 2006-2008 rates of 87%.

HV programs are collectively developing outreach strategies to engage Family Planning and health care clinics for earlier prenatal referrals. The curriculum used for prenatal enrollments, which requires a specific skill set for engaging parents before the child is born, has been reviewed and updated and became part of the core knowledge expectations of home visiting professional development.

The HV Program's ability to track first trimester enrollees will improve with the utilization, during FY10, of a new web-based database. In this fiscal year, we anticipate being able to determine which sites are receiving the earliest referrals and from which sources.

c. Plan for the Coming Year
Maine's objective for this measure is that the percent of women receiving prenatal care in the first trimester reach 90%. This is the same as the HP2010 goal and the Healthy Maine 2010 for this objective.

The WIC Program will continue to focus on outreach efforts to increase the number of WIC women enrolled in the first trimester of pregnancy. In FY09 one of the indicators for the local WIC agencies was to increase the number of WIC women enrolled in the first trimester of pregnancy. The Program will continue to collaborate with the local WIC agencies, PHN and other partners to enhance access to services for pregnant women.

Work with MaineCare to determine if the WIC Program could distribute, through EPSDT, an informational letter about the importance of obtaining pre-natal care in the first trimester of pregnancy and to inform pregnant women of the availability of WIC benefits in their first trimester.

The HV and WIC Programs will work together to explore ways to market services and create referral strategies that result in earlier referrals to each other's programs.

WIC will also work with the Perinatal Nurse Managers to increase outreach.

D. State Performance Measures

State Performance Measure 1: *The percentage of births in women less than 24 years of age that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	58	46	45	44	43
Annual Indicator	54.1	59.2	56.8	54.5	54.5
Numerator					
Denominator					

Data Source				Maine PRAMS	Maine PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42	41	40	39	

Notes - 2009
2009 PRAMS data are not yet available; 2008 were used as an estimate.

Notes - 2008
The data source for this measure is the Maine 2008 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

Notes - 2007
The data source for this measure is the 2007 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

a. Last Year's Accomplishments
According to the most recent data from Maine's Pregnancy Risk Assessment Monitoring System (PRAMS), over half (54.5%) of births to Maine women less than 24 years of age in 2008 were unintended. The 2008 data on unintended births among women age less than 24 years mark the first time this measure has decline in recent years. The percent of unintended births among this population has been increasing over time since 2004, but remains lower than it was earlier this decade; between 2000-2002, the average percent of unintended births was 61.7%.

Analyses of unintended pregnancies using data from the 2004-2007 PRAMS survey were conducted to gain more insight into the correlates of the problem in the state. These analyses revealed that unintended pregnancy was associated with low educational status, low income, and Medicaid enrollment prior to pregnancy. In addition, women in Maine who had unintended births were less likely than other women to receive prenatal care in the first trimester (79% vs. 90%) and were less likely to receive at least adequate prenatal care as measured by the Kotelchuck Index (84% vs. 90%). Women who had an unintended birth were more likely to smoke during the last 3 months of their pregnancy (27% vs. 13%) and were 2 times more likely than other women to report experiencing three or more stressful life events prior to the birth of their child (48% vs. 23%). Women who reported an unintended birth were also more likely than other women to report experiencing domestic violence from a current or ex-partner during the 12 months prior to their pregnancy (6.8% vs. 2.6%) and to report abuse during their pregnancy (3.6% vs. 1.2%). Women who had an unintended birth were also more likely to report a diagnosis of depression after the birth of their child compared to women whose child was intended (19% vs. 11%). Results of these analyses are part of Maine's 2010 Comprehensive Strengths and Needs Assessment.

The Teen and Young Adult Health (TYAH) Director sits on the, Shared Youth Vision Council, convened by the Children's Cabinet. The Council coordinates efforts around transition for disconnected youth. Their focus is on social service support systems rather than on the more traditional economic and education systems.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family Planning Clinical Services.	X			
2. Community-based pregnancy prevention using evidence-		X	X	X

based programs.				
3. Continue to monitor via PRAMS.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Despite the lack of new resources, reductions in existing resources and continued success of current strategies, the TYAH Program continues to examine our strategies and compare them to the growing research base on effective practices. Because of the greater consequences for younger pregnant and parenting teens, and the importance of early knowledge and skill development that carries into young adulthood, the majority of unintended pregnancy prevention resources continue to focus on school-aged youth. However, without eliminating this focus, we are increasing outreach and clinical efforts to reach young adults, as well as working with young adults in minority communities.

c. Plan for the Coming Year
The basic infrastructure of the TYAH program will remain in place, however funding reductions and increased health care costs preclude any increases in services and will continue to challenge our ability to maintain current levels of services. This measure will continue to be one of Maine's State Performance Measures over the next five years. We anticipate a decline in this measure over time. However, we acknowledge that proposed budget cuts to family planning services may challenge our ability to make significant progress on this measure.

State Performance Measure 2: *The percentage of 0-11 month old children enrolled in WIC who were ever breastfed.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		55	56	57	58
Annual Indicator	58.2	55.9	63.2	61.5	63.3
Numerator			5028	4611	4373
Denominator			7960	7503	6913
Data Source				Maine WIC Program	Maine WIC Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59	60	61	61	

Notes - 2009
Data are from the Maine WIC program and represent children enrolled in WIC who were born between 1/1/09-12/31/09 who were breastfed for at least 1 week.

Notes - 2008
Data are from the Maine WIC program and represent children enrolled in WIC who were born between 1/1/08-12/31/08 who were breastfed for at least 1 week.

Notes - 2007
Data are from the Maine WIC program and represent children born between 1/1/07-12/31/07 who were breastfed for at least one week..

a. Last Year's Accomplishments
The Maine WIC Nutrition Program has two performance based contracting goals for the local grantee agencies. One goal is to increase the percentage of infants born to WIC mothers who were, at one time, exclusively breastfed based on the number of exclusively breastfed infants born to WIC mothers in the previous year. Unfortunately, the WIC Program experienced problems with the accuracy of the breastfeeding goal data as a result of changes to the data software during CY08. The WIC program is unable to provide recent breastfeeding data at this time. A project to implement a new data system within the next two years is in progress.

The WIC Program, adapted materials from Texas, to create a document titled "The Hospital Experience" for new families. The document includes such topics as how to be prepared for a hospital stay, how to make a birthing plan, and how to begin breastfeeding.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work toward the development of an efficient data system for collection of WIC breastfeeding data.				X
2. Provide technical assistance to local WIC agencies to increase breastfeeding rates and duration.				X
3. Continue to provide training opportunities for WIC counselors on the development of counseling and clinical skills to support optimal breastfeeding practices.				X
4. Evaluate VENA training provided to local agency WIC staff.				X
5. Implement and evaluate indicators to achieve the WIC Goals.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to the most recent data available from the Maine WIC Nutrition Program, in CY2009 63.3% of WIC infants were ever breastfed. The WIC database is currently in the process of revision and we hope that with these revisions, the breastfeeding data from WIC participants will become more reliable and we will have more information on breastfeeding duration among WIC participants.

The Maine State Breastfeeding Coalition, Maine Lactation Consultant Association and the WIC Program collaborated on the annual breastfeeding education conference for health care professionals. The title of the May 2010 conference was "Breastfeeding Through Life Challenges". 75% of local agency staff attended. The conference provided an opportunity for local WIC agency staff to learn current evidence based breastfeeding practices that can be applied when counseling participants.

The WIC Program continues to use loaner electric breast pumps in 5 local agencies. Recently, ten electric breast pumps were purchased to assist with the limited supply of electric breast pumps in the Kennebec County area. Local agency staff are able to loan these pumps to WIC participants when needed. Feedback from participants who have used this pump has been

positive; they have found it to be both easy to use and effective.

c. Plan for the Coming Year
Work with home visitors to improve breastfeeding rates.

Continue to provide technical assistance to local WIC grantee agencies in meeting the WIC breastfeeding performance goal.

Work with Early Head Start home visitors to increase their ability to support breastfeeding.

State Performance Measure 3: *The motor vehicle death rate per 100,000 among children 15 to 21 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	28	26	25	24	23
Annual Indicator	27.1	27.6	26.1	26.4	26.4
Numerator	174	178	166	166	
Denominator	641315	644640	636635	629495	
Data Source				Death certificates, Maine Vital Statistics Office	Death certificates, Maine Vital Statistics Office
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22	21	20	20	

Notes - 2009
2009 mortality data are not yet available; 2004-2008 data were used as an estimate.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rate for 15-21 years olds is:

=2004-2008: 178/629495=28.3

Notes - 2008
The motor vehicle death rate per 100,000 among children 15 to 21 years of age. The number of motor vehicle deaths is a 5 year average of 2004-2008.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rate for 15-21 years olds is:

2004-2008: 178/629495=28.3

Notes - 2007
The motor vehicle death rate per 100,000 among children 15 to 21 years of age. The number of motor vehicle deaths is a 5 year average of 2003-2007.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rate for 15-21 years olds is:

2003-2007: 1623626635=25.6

a. Last Year's Accomplishments
Maine's 5-year average motor vehicle death rate among youth 15-21 years in 2004-2008 was 26.4 per 100,000. This is very similar to Maine's 2003-2007 rate of 26.1 per 100,000 and translates into about 33 deaths per year. In Maine, due to the small population size, we present 5-year averages for many rates to help stabilize estimates over time. The rate of death among 20-21 year olds is generally slightly higher than 15-19 year olds, but there is not a significant difference between the two age groups. Based on this data, motor vehicle crash deaths and injuries are a priority area in the Maine Injury Prevention Program (MIPP) plan.

The Department of Education, Health Education and Health Promotion Program promoted, through exhibits, driving safety and seat belt safety at their June 2009 Annual Schoolsite Health Promotion Conference. 209 attended from 30 school systems. They also promoted bicycle and walking safety and encouraged participants to incorporate these concepts in the school health education curriculum.

On September 13, 2009, An Act to Establish a Distracted Driver law went into effect. It is now a traffic violation to fail to maintain control of a motor vehicle if the person either commits a traffic violation, or is involved in a reportable accident, while distracted at the time of the violation/accident. The violator can be cited for both this offense and any other traffic violation committed while distracted (e.g., if a violator speeds while distracted, the violator can get both a speeding ticket and a ticket for failure to maintain control).

In January 2009, MIPP staff joined the Trauma Advisory Committee (TAC), a group consisting of trauma surgeons, emergency room physicians and other health care providers. The TAC, as part of the Emergency Medical Services (EMS) system, is responsible for preventing injuries and, when not able, mitigating the impact of those injuries on patients and family. The TACs primary focus is on secondary prevention but is interested in keeping abreast of opportunities to partner in primary prevention activities.

The MIPP joined the newly formed Teen Driver Safety Committee hosted by the Bureau of Highway Safety (BHS). The committee, comprised of representatives from Maine Department of Transport, American Automobile Association, Office of Substance Abuse, Maine State Police, Maine Driver Education Association, and the Bureau of Motor Vehicles, is identifying its goals and objectives for the coming year. This work will be incorporated into the BHS Plan.

In June 2009, the MIPP hosted a teen driver symposium to identify strategies to 1) Increase the understanding of the burden of motor vehicle injury among Maine teen drivers, 2) Increase the knowledge of strategies that work to reduce motor vehicle injury among teen drivers, 3) Show an "evaluated for effectiveness" teen driver program, 4) Identify initial steps to develop and/or enhance teen driver collaborations in Maine, and 5) Identify strategies and initial steps to implement an effective teen driver intervention program in Maine.

New outreach partnerships included participation, and presentation at the Eastern Maine Medical Center's newly formed Injury Prevention Committee. Led by the Center's Trauma Coordinator,

this group is comprised of area hospital staff working to identify injury prevention opportunities before, during, and after a hospital visit or stay.

MIPP provided data and resources to Maine Medical Center staff convened to address teen drivers in two of Maine's largest high schools.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop resource materials on young driver safety.		X		X
2. Plan and conduct statewide injury prevention conference.				X
3. Assist in the planning and implementation of a tri-state transportation safety conference – Maine / NH / VT.				X
4. Distribute the Injury and Violence Prevention Mapping Report.				X
5. Distribute the Injury and Violence Prevention Toolkit Report.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As a result of recommendations made at the 2008 teen driver symposium, MIPP contracted to have a statewide survey of all injury and violence prevention activities, initiatives and/or programs, and a state and national search on all available evidence based and or promising practices injury and violence prevention programs. This work will culminate with two reports which will be distributed to MIPP partners and stakeholders and posted on the MIPP website. Motor vehicles were included as a topic.

MIPP staff participated in a study involving 60 films shown during 2003-2007. The top 25 domestic box office grosses with a G or PG rating for each year as reported by Variety were reviewed for injury prevention practices i.e. safety belt use, pedestrian safety, and firearm safety. The results were published in the American Academy of Pediatrics.

MIPP developed a public health burden of injury reports for each of the Office of Local Public Health districts for use in decision-making around injury in their specific district.

MIPP provided resources, data, and technical assistance to Jay Middle School students and their Lego League work on the issue of teens and distracted driving. The students subsequently took first place in the statewide competition and recognized the MIPP for its strong support. The team competed nationally in April 2010.

c. Plan for the Coming Year

Given MIPP activities related to teen driving and recent legislative initiatives, we anticipate that Maine's teen motor vehicle death rate will decrease over the next few years.

Federal funds distributed through the Preventive Health and Health Services Block Grant now focus on newly established goals including adding two vehicle related objectives: increasing availability of child passenger safety seats and reducing motor vehicle deaths. This will allow the MIPP to further its efforts around child passenger safety.

During FY11 MIPP will:

1. Provide training and information to advocates on safe driving and the importance of buckling up.
2. Update the MIPP web site to disseminate prevention resources, contacts, data, training opportunities, and links to other Maine and national injury prevention resources.
3. Collaborate and coordinate with the Maine Transportation Safety Coalition and other committees, and state agencies to protect Maine's young drivers.
4. Upon request disseminate current data through MIPP fact sheets.
5. Identify community partners with whom to conduct a teen driver safety intervention to be evaluated.
6. Develop and distribute an RFP for the DHHS public health districts to conduct injury prevention activities which may include motor vehicle issues.
7. Participate on the BHS plan development team.
8. Continue to participate on appropriate motor vehicle related committees.
9. Begin planning a statewide injury prevention conference which will include motor vehicle issues as a track.

DOE will hold its annual Comprehensive School Health Education workshop in 2011 for health education and classroom teachers. A round table and/or exhibit addressing motor vehicle safety education is planned.

State Performance Measure 4: *The percentage of high school students (grades 9-12) who are overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10.5	10.5	12.8	10
Annual Indicator	10.9	10.9	12.8	12.8	12.5
Numerator					
Denominator					
Data Source				Maine YRBS	Maine YRBS/MIYHS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	9.5	9.5	9	

Notes - 2009
Data are from the 2009 YRBS module of Maine's Integrated Youth Health Survey. This measure reflects the percent of children at or above the 95th percentile for BMI. The measure was developed prior to the recommendation that the terms "overweight" and "at-risk for overweight" be changed to "obese" and "overweight" for children. The data are weighted, therefore a numerator and denominator are not entered for this indicator

Notes - 2008
Data are from the 2007 YRBS and represent the percent of children at or above the 95th percentile for BMI. This measure was developed prior to the recommendation that the terms "overweight" and "at-risk for overweight" be changed to "obese" and "overweight" for children. The data are weighted, therefore a numerator and denominator are not entered for this indicator

In 2009, Maine administered the Maine Integrated Youth Health Survey. Data from this survey will be available in summer 2009 and will inform this measure in future years.

Notes - 2007
Data are from the 2007 YRBS and represent the percent of children at or above the 95th percentile for BMI. This measure was developed prior to the recommendation that the terms "overweight" and "at-risk for overweight" be changed to "obese" and "overweight" for children. The data are weighted, therefore a numerator and denominator are not entered for this indicator

a. Last Year's Accomplishments
This measure was developed prior to the recommendation that the terms "at-risk for overweight" and "overweight" be changed to "overweight" and "obese." Therefore, this measure tracks the % of obese high school students in Maine using YRBS data. In 2009, Maine administered the IYHS, a comprehensive survey of the health of students in kindergarten, 3rd grade and 5th-12th grade. The high school version of the survey had 4 modules. One of these modules served as Maine's YRBS. The data from this module are used for this measure because the overall Maine IYHS used a different weighting methodology and it is not recommended that the Maine IYHS be used when examining trends over time until further analyses are conducted.

Maine's 2009 data reveal that the %t of overweight and obese high school and middle school students did not changed significantly between 2001-2009. The most recent YRBS data from 2009 indicate that 15.1% of high school students are overweight (85th-95th percentile of BMI) and 12.5% are obese (>95th percentile). Therefore, more than 1 in 4 adolescents are above a healthy weight. Maine's % of obese youth in 2009 is not statistically different than the 2009 U.S. %, and there is no difference between the U.S. and Maine in the % of youth who are overweight. The HP2010 goal for adolescents age 12-19 is 11%.

SBHCs address nutrition and physical inactivity. The centers are asked to do a health risk assessment of any student enrolled in and who visits the center for a service. Based on the assessment results individual plans are developed with students who want them and may include referrals to in or out of school fitness programs/activities. The SBHC's are asked to follow up to determine if there is a behavior change. 516 students were identified as being physically inactive during FY09 and of those approximately 189 (37%) received counseling and guidance on developing a plan to be more physically active. 16% of those who received an intervention showed improvement. During the same period 88 students were identified as having poor nutrition. 39 received an intervention and of those, 8 showed improvement.

On June 16, 2009 Governor Baldacci signed into law L.D. 319, "An Act to Track the Prevalence of Childhood Obesity in Maine". This bill will create protocols for school nurses to follow in the collection of BMI data from children. A report will go to the Maine DHHS, Maine CDC and the Maine DOE. Since 2001, school nurses have collected data on grades K, 1,3,5,7, and sometimes 9th grades following the screening pattern for vision and hearing.

L.D. 1140 "Resolve, Directing the DOE and the Department of Agriculture, Food and Rural Resources to Convene a Work Group to Strengthen Farm-To-School Efforts in the State" was passed in June 2009. The Workgroup was directed to study farm-to-school initiatives and programs in the State and develop recommendations for strengthening these efforts. A major component of this effort will be working with school food service programs to determine how to incorporate the farm to school effort into their programs which are federally regulated.
In early 2009 a pilot program, Guiding Stars (GS), between a major grocery chain (Hannaford) and a southern Maine high school to rate prepared meals, snacks, salad bar and grab-and-go items according to their nutritional value was started. This science-based program was the first of its kind when implemented in select grocery stores in 2006 in response to consumer demand for a simple, easy-to-understand tool for making good nutritional choices as they shop. The rating system credits all edible foods based on the presence of vitamins, minerals, dietary fiber and whole grains, and debits for the presence of trans fat, saturated fats, cholesterol, added sugars and added sodium. Food items are awarded zero, 1, 2 or 3 stars -- one star means good nutritional value; two stars, better nutritional value; and three stars, best nutritional value. The

program gives students more information to easily identify the foods with the greatest nutritional value and make healthy food choices. Another benefit is the consistency of seeing GS both in school and the grocery store. Students and their families can talk about nutritious food choices based on information that is accurate and easy to use and understand. No evaluation was undertaken in this school however anecdotally we have heard that students, food service staff, and other school staff like and use the program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with partners to achieve the Healthy People 2010 nutrition/physical activity and fitness objectives.			X	X
2. Enhance Maine's nutrition and physical activity surveillance infrastructure.				X
3. Continue monitoring trends in overweight through the Maine Integrated Youth Health Survey.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Coordinated School Health Program (CSHP), in line with its new federal CDC workplan, provided mini grants to add new sites under the coordinated school health model. CSHP focused on low performing schools and those most likely to have higher obesity rates and high risk behaviors. 7 priority schools were awarded $5,000 grants to assess current health efforts in their schools, plan new priorities, and focus policy and environmental change to improve student health. All priority schools were required to select an evidence-based intervention to increase physical activity among students.

DOE continues to develop the High School Wellness Portfolio project with health and physical education teachers, and school health coordinators. The group is tasked with developing wellness portfolios for students to achieve health education and physical education standards as part of high school graduation requirements. All high school students are required to have health education and physical education course work. When students are not enrolled in a health or physical education class they have to establish a personal fitness and personal health goal for the year that they must work on throughout the year.

GS was implemented in another high school and is being evaluated there. Baseline data collection included capturing what students chose for breakfast and lunch on a particular day. Post-implementation data will include what students chose as well as a survey on attitudes towards GS.

c. Plan for the Coming Year

Although the rates of obesity and overweight in Maine have not increased significantly over the past few years, the high rates point to a need to address the issue before the health consequences of excess weight cause lasting problems.

The Physical Activity and Nutrition Program will collaborate with the DOE to consider further modifications of food guidelines for school lunch programs.

SBHC's will continue to work with enrolled students to develop physical activity and nutrition plans.

DOE will promote its Key Concepts curriculum development tool to health educators, school health coordinators and other school personnel which support nutrition education, eating disorder prevention, and physical activity. DOE will also continue to facilitate the development process for the High School Wellness Portfolio.

State Performance Measure 5: *The percentage of high school students (grades 9-12) who feel like they matter to people in their community.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		57	60	57.3	63
Annual Indicator	57	57	57.3	57.3	50.2
Numerator					
Denominator					
Data Source				Maine YRBS	Maine YRBS/MIYHS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	63	65	65	66	

Notes - 2009
The 2009 data are from the YRBS module of the Maine Integrated Youth Health Survey (MIYHS). The methdology of the MIYHS is slightly different than the MIYHS and the sample size is larger, which may account for the change in this measure.

Notes - 2008
The data used for this measure come from the 2007 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator.

In Spring 2009, Maine administered the Maine Integrated Youth Health Survey. Data from this survey will be available in summer 2009 and will inform this measure in future years.

Notes - 2007
The data used for this measure come from the 2007 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator

a. Last Year's Accomplishments
This measure was selected based on our desire to look at adolescent strengths and not just deficits. It is based on positive youth development theories regarding the relationship between increased youth assets and decreased risk behavior. Vermont has monitored 5 assets of youth strength for several years and using this indicator moved us toward a shared regional measure. The question was first asked in Maine in the 2005 Youth Risk Behavior Survey (YRBS). In 2005, 57% of adolescents reported that they felt like they mattered to people in their community. In 2007, the % was similar (57.3%). This measure and other asset-based measures for youth were included in the Maine IYHS. This survey combines Maine's YRBS, Youth Drug and Alcohol Use Survey, and Youth Tobacco Survey. Maine's IYHS was administered in February 2009; 80% of

middle and high schools participated. This survey provides information on this measure as well as other asset-based measures of health. The other asset based measures include: having support from teachers, talking with parents about school, spending time in clubs or other organizations outside of school, and involvement in community service. One advantage of the IYHS over the YRBS is that data on these questions are available at the public health district, county and school level; therefore, schools and communities directly receive data on how they are working to increase adolescent assets.

Results from the 2009 IYHS indicate that 50.2% of high school students agree or strongly agree that they matter to people in their community. This % is slightly lower than the values on this measure in previous years. This could be due to slightly different methodologies used for the YRBS and the IYHS. Males were more likely to report they matter to people in their community compared to females (52.8% vs. 47.4%). There were no differences by age, grade, or race/ethnicity on this measure.

Active youth involvement in public health efforts recognizes the value of youth. In addition to informing state programs about youth concerns directly, this demonstrates our commitment to youth inclusion to our community partners.

The 25th annual Peer Leadership Conference titled, The Change in ME Starts with YOUth, was held in fall 2008 with 318 youth and adults in attendance. Workshops featured leadership and teen health topics such as: youth activism and policy change, youth and adult partnerships, group development, anti-tobacco, physical activity and nutrition, facilitation skills, diversity awareness, substance abuse, youth suicide prevention, dating violence, and bullying prevention. 6,605 individual resources were distributed at the conference. As a result of the conference, all 6 youth planning team members reported significant increases in their skills and experience related to their ability to partner effectively with adults, to plan and carry out a project, to be a productive team member, to set goals and meet deadlines, to understand other's perspectives, to lead and take charge when necessary, public speaking skills, communication skills, decision making skills, anticipating and addressing challenges, being a role model and self confidence.

The 5th annual Stop, Quit, Resist Youth Tobacco Summit brought together 172 youth and adults for skill building, networking and information sharing around anti-tobacco advocacy. 4 youth from across the state were involved in planning and implementing all aspects of the summit. Workshops focused on increasing the skills and knowledge of participants related to leadership, advocacy and anti-tobacco topics. 58% of workshop presenters were youth. All groups attending were trained on and created action plans on how to create change in their community. For the first time, groups presented their action plans to panelists of youth and adult community leaders, getting input and resource suggestions to improve their plans.

Youth Advocacy Program (YAP) groups worked on policy and environmental changes in their communities to reduce access to tobacco and second-hand smoke, increase physical activity and improve nutrition. The Maine Youth Action Network (MYAN) worked with YAPs to create action plans and better integrate with the core activities of the Healthy Maine Partnerships (HMP). MaineCDC staff worked with MYAN to develop a resource guide and provide guidance on expectations for HMPs regarding youth involvement and ensure youth involvement was included in HMP data collection.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Youth involvement and leadership technical support, training, and networking.				X
2. Coordination and collaboration in youth-related initiatives.				X

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MYAN continues to re-evaluate and refine its work processes and outcomes to determine how to best utilize youth talents and skills to benefit both youth and MYAN. They are engaging more college interns and is hopeful this strategy will increase youth participation.

MYAN increased its training offerings, adding new topics of advocacy and youth on boards and councils to its menu. Trainings are being held around the state on these topics as well as youth/adult partnership and youth involvement.

MYAN launched a new on-line community offering visibility and greater connection opportunities for youth, adults and organizations across the state. MYAN also launched a face book page and quickly had many fans, offering another way for youth and adults to connect to the statewide network and each other.

DOE participated in the revision and expansion of a Youth Activity Resource Guide specific to coordinated school health. The guide is developed and distributed by MYAN to YAP coordinators around the state.

Through focus groups arranged by School Health Coordinators (SHC) in the northern and southern part of the state, youth input was solicited for the comprehensive strengths and needs assessment. The SHCs invited youth to talk about the most important health and safety needs of teens, activities they participated in to be safe and healthy, barriers to accessing needed services, and what they felt to be the top priority for teens in Maine. Parent and youth consent was required to participate.

c. Plan for the Coming Year
Data on this indicator will continue to be collected as part of Maine's IYHS.

The joint annual peer leadership conference/youth anti-tobacco summit, youth-adult partnership training, technical assistance, and networking will all continue as part of the new contract requirements.

Continue to coordinate with the Communities for Children and Youth Initiative, and the HIV Prevention Education Program at the Maine Department of Education for further training and shared understanding of positive youth development as time allows.

State Performance Measure 6: *The percentage of elementary schools that have developed and implemented a comprehensive approach to the prevention of bullying in collaboration with the Maine Injury Prevention Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009

Performance Data					
Annual Performance Objective		8	9	10	11
Annual Indicator	7.2	7.2	5.3	5.3	5.3
Numerator	40	40	29	29	29
Denominator	559	556	545	545	545
Data Source				Maine Injury Prevention Program/DOE	Maine Injury Prevention Program/DOE
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	12	12	12	

Notes - 2009
Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2007-2008 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The number of schools that received a comprehesive bullying prevention program was incorrectly reported in prior years. To date, the Maine Injury Prevention Program has worked with 29 schools to implement a comprehensive bullying prevention program. New training institutes have trained additional school personnel to implement the program, but MIPP has no way of following up with the personnel to determine if the program has been implemented.

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

Notes - 2008
Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2007-2008 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The number of schools that received a comprehesive bullying prevention program was incorrectly reported in prior years. To date, the Maine Injury Prevention Program has worked with 29 schools to implement a comprehensive bullying prevention program. New training institutes have trained additional school personnel to implement the program, but MIPP has no way of following up with the personnel to determine if the program has been implemented.

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

Notes - 2007

Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2006-2007 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The number of schools that received a comprehesive bullying prevention program was incorrectly reported in prior years. To date, the Maine Injury Prevention Program has worked with 29 schools to implement a comprehensive bullying prevention program. New training institutes have trained additional school personnel to implement the program, but MIPP has no way of following up with the personnel to determine if the program has been implemented.

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

a. Last Year's Accomplishments
The model for implementing bullying prevention training in Maine changed over the course of the 2005-2010 MCH Block Grant period. As a result, we do not have data for this measure for the current year and we do not plan to continue this measure in the next 5-year MCH Block Grant cycle.

All Maine schools are required to have a Code of Conduct policy and bullying prevention is included in this policy. Over the past two years the MIPP has changed its focus from bullying prevention to establishing a school climate based on restorative practices. During FY09 student and staff surveys were developed to gather baseline data on school climate issues from schools that partner with MIPP to integrate restorative practices. Approximately 1,000 fifth, sixth, and seventh graders participated in the online survey.

The Peace and Reconciliation Studies (PRS) Program at the University of Maine and the Maine Law and Civics Education (MLCE) at the University of Southern Maine partnered with the Restorative Justice Project of the Midcoast in the "Restorative School Practices Collaborative of Maine". The collaborative focused on supporting Maine schools in reducing youth violence, peer aggression and misbehavior, and in strengthening protective factors for students, through implementation of restorative practices and discipline, school climate change and conflict resolution education.

The collaborative worked intensively with two middle schools to integrate restorative practices and discipline in a whole-school approach. The integration included developing evaluation tools, collecting data, meeting with school administrators, establishing and meeting with leadership teams, providing staff training and development, and providing ongoing technical assistance in all phases of school-level implementation. These schools have a total of approximately 80 staff members and 800 students in grades 6-8.

A statewide, comprehensive, three-day summer institute in restorative school practices was held for educators. Thirty-seven Maine educators attended. Over the three days, participants learned about, observed and practiced: the restorative approach philosophy, community circles, restorative discipline, accountability, restorative dialogue, the connection between restorative practices and bullying prevention, problem-solving circles, resolution (detention) circles, and restorative conferences.

Connections were made to introduce the restorative approach with 16 additional Maine schools or districts in this period.

As a statewide resource for Maine educators, technical assistance, consultation, website access and information, a listserv, and library materials in restorative school practices, conflict management, peer mediation, school climate, bullying prevention, diversity, character and peace education, and related fields were provided.

Two, Changing Ways Newsletters were produced and mailed to a statewide audience including all K-12 guidance counselors, principals, superintendents and approximately 1500 other educators. The newsletter serves as the only Maine resource focused on increasing awareness, understanding, support and engagement with restorative school practices, including restorative discipline, conflict management education, and efforts to create safe, fair and responsive school environments.

Dr. Jose Salgado was the keynote speaker at the Department of Education's (DOE) annual Wellness Conference. He spoke about his experience of taking a very difficult inner school and turning it into an exemplary one by addressing school climate that included bullying. The title of his presentation was; "Reshaping the Culture in Schools Through Comprehensive Wellness Programs".

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training, TA, assessment tools & procedures to Maine schools in restorative school practices to prevent youth violence & suicide by reducing risk factors & enhancing protective factors for students by creating safe, fair & responsive schools.		X		X
2. Conduct educational forums around the state to provide educators with opportunities to learn about the restorative approach, gain skills in restorative practices, gather resources, and network with other educators.		X		X
3. Increase statewide awareness, understanding, support & engagement with restorative school practices, including restorative discipline, conflict management education, & efforts to create safe, fair and responsive school environments.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MLCE closed its doors on December 31, 2009 and a new partner, Safe Schools for All, joined the collaborative with the PRS Program at the University of Maine and the Restorative Justice Project of the Midcoast in the "Restorative School Practices Collaborative of Maine". The collaborative supports Maine schools in reducing youth violence, peer aggression and misbehavior, and in strengthening protective factors for students, through implementing restorative practices and discipline, school climate change and conflict resolution education. The focus and efforts of the collaborative evolve around four key areas:

· Increasing communication, respect and trust between adults and students in schools;
· Promoting school climate and cultures that support inclusivity, tolerance, and nonviolent means to resolve conflicts;
· Enhancing student connectedness with adults and schools;

· Implementing new discipline policies and strategies that keep children connected to adults and schools, and that help children learn important lessons in personal behavior, accountability, empathy, and healthy relationships.

New partnerships were started with five additional schools to integrate restorative practices in a school-wide approach. These schools have a total of 180 staff members and 1400 students.

The Coordinated School Health Program conducted a training on addressing bullying for school bus drivers in August 2009.

c. Plan for the Coming Year

Although the MIPP anticipates that the number of elementary schools that have a comprehensive bullying prevention program will increase, we are unable to track this measure in a definitive manner. However, given the importance of this issue, additional data sources to program evaluation are being explored that contain information on bullying experiences that could be used to track this issue in future years. These sources include the MCHS and the Maine IYHS, both of which will be administered to students biennially through the schools. A collaboration with the DOE will be sought to establish a system to monitor the number of schools with bullying policies. However, this state performance measure will not be continued into the next MCH Block Grant cycle.

If funding and priorities allow, during FY11, the PRS will:

Continue to serve as the statewide resource for Maine schools seeking assistance in reducing youth violence, peer aggression and misbehavior, and in strengthening protective factors for students, through the implementation of restorative practices and discipline, school climate change and conflict resolution education.

Continue to work intensively with the six schools we began partnerships with in either 2009 or 2010 to integrate restorative practices and discipline in a whole-school approach, including gathering essential data to determine the effectiveness of these efforts.

Continue making connections with and identifying up to four new schools or districts that would like to implement the restorative approach in a comprehensive, whole-school model.

Continue to meet with administrative teams and/or introduce the restorative approach and restorative discipline for all schools that seek this information.

Conduct two statewide, introductory workshops on restorative school practices in Fall 2010, to be held tentatively in Bangor and Lewiston.

Offer a Spring 2011 follow-up workshop on restorative school practices for educators who will have attended previous trainings, to increase the network of Maine educators using restorative practices, strengthen their efforts and assist them with concerns and problems.

Conduct a statewide, comprehensive, three-day summer institute in restorative school practices for educators in Augusta at the end of June 2011. The purpose of this institute is to engage participants in learning about, observing and practicing: the restorative approach philosophy, Community Circles, restorative discipline, accountability, restorative dialogue, the connection between restorative practices and bullying prevention, problem-solving circles, resolution (detention) circles, and restorative conferences.

As a statewide resource for Maine educators, continue to provide technical assistance, consultation, website access and information, a listserv, and library materials in restorative school

practices, conflict management, peer mediation, school climate, bullying prevention, diversity, character and peace education, and related fields.

State Performance Measure 7: *The rate per 1000 of emergency department visits for asthma among women ages 15-44.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		9.5	9.3	9.1	9.8
Annual Indicator	11.6	11.4	10.2	10.6	10.6
Numerator	3055	2960	2579	2649	
Denominator	263510	259544	254024	249738	
Data Source				Maine Outpatient Hospital Discharge Database	Maine Outpatient Hospital Discharge
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.7	9.6	9.5	9.4	

Notes - 2009
2009 outpatient hospital discharge data are not yet available; 2008 data were used as an estimate.

Notes - 2008
Data from the 2008 Maine Outpatient Hospital Discharge Database. Asthma cases selecetd based on ICD-9 code 493 as the principal diagnosis.

Notes - 2007
Data from the 2007 Maine Outpatient Hospital Discharge Database. Asthma cases selecetd based on ICD-9 code 493 as the principal diagnosis.

a. Last Year's Accomplishments
Maine uses data from its statewide hospital discharge database for this measure. The most recent data available are from 2008. Emergency department visits for asthma among both men and women have not changed significantly over time in the state, but women consistently have higher rates than men. In 2008, the emergency department rate of asthma among women age 15-44 years was 10.6 per 1,000 compared to 6.6 per 1,000 men. Among females, the highest rates of emergency department visits are among those ages 15-44 compared to those under age 15, females 45-64 years, and females over age 65. Among males, the highest rates of emergency department visits for asthma are among boys, ages 0-14 years (14.0 per 1,000).

An asthma surveillance document The Burden of Asthma in Maine: 2008 was published in FY08 (http://www.maine.gov/dhhs/bohdcfh/mat). These data reveal that the prevalence of asthma is higher among women and so is hospitalization and emergency department use. It remains unclear whether this gender disparity is due to women's inclination to seek healthcare more often than men, physician inclination to label women's symptoms as asthma, or a physiologic difference between women and men that cause more women to have asthma and to have difficulty managing their asthma. The literature in this area is also not clear in this regard.

While the primary population focus of the Maine Asthma Program (MAP) is school age children the program does attempt, where possible through its work, to incorporate activities to address this measure. In FY08 the MAP held a Phoenix event that brought together a number of partners to talk about ways to work together. The event ended with a re-energized group committed to addressing asthma in the state.

During FY09 the MAP began a re-building process that led to a more actively engaged Maine Asthma Council. Three workgroups were formed; Homes, Workplaces and Schools. The Homes Workgroup developed a "Beat Asthma Triggers on Your Own Home Turf" (copy included in Appendix) brochure that includes a quiz to enable parents to identify and improve their home environment by eliminating or reducing asthma triggers. The brochure was disseminated to housing authorities, and through public health nursing and home visitors as well as at health fairs around the state.

In partnership with the American Lung Association of Maine the MAP developed a data sheet, "Asthma, It can Take Your Breath Away", to distribute to business and community leaders to create awareness about asthma. A copy is included in the Appendix. Several Informational cards were also developed for parents, athletes and coaches outlining things to be aware of for those with asthma who want to participate in sports. An informational card "Healthy Mama" was also developed for pregnant women with asthma. All informational cards can be found on the MAP website at: http://www.maine.gov/dhhs/bohdcfh/mat/index.html under the Asthma Information tab.

The MAP continued its partnership with the Office of MaineCare Services (state Medicaid Program), to disseminate a brochure for pregnant women; "Asthma and Pregnancy" (Copy included in Appendix). Any woman calling by phone to sign up for MaineCare is asked 3 questions: Are you pregnant? Do you smoke? and, Do you have asthma? If they are pregnant and have asthma the brochure is included in a package of materials that is mailed to the enrollee.

The MAP also worked with the WIC program to distribute Asthma and Pregnancy brochures through the local WIC offices. Brochures were also sent to Head Start Programs and each of the federally qualified health centers (FQHC).

The MAP submitted a successful competitive application to the federal CDC allowing it continue efforts to address asthma in the state over the next three years.

Maine schools that receive state tobacco funding are required to train staff on the signs and symptoms of asthma. The MAP worked with schools to develop a talking points guide for school nurses "Asthma at School" (Copy included in Appendix) to assist them in training school staff. Many staff and faculty that participate in the training are women between the ages of 25 and 44.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with Healthy Maine Partnerships, to promote health and prevention of disease at the community level.			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The Workplace Workgroup is working with the Bureau of Labor Standards to develop materials to create awareness about the most common triggers in the workplace and determine appropriate ways to educate employers on how to address the triggers to avoid lost days from work. The initial focus is on those employers with the highest number of triggers in the workplace.

The MAP worked with NAACP to translate the asthma and pregnancy brochure into Spanish (Copy included in Appendix)

c. Plan for the Coming Year
During FY11 the MAP will collaborate with partners to carry out the following activities;

1. Disseminate educational materials to MaineCare enrollees who report pregnancy and a history of asthma, also distribute through local WIC offices, FQHC's and Head Start Programs. Materials will reflect the new National Asthma Education and Prevention Program (NAEPP) guidelines pertaining to asthma and pregnancy (the guidelines can be found at: http://www.nhlbi.nih.gov/guidelines/asthma/)
2. Disseminate to MaineCare providers and FQHCs to post in their exam rooms a copy of "Asthma Stepwise Approach" (Copy included in Appendix), developed by Colorado. This 2 page document summarizes the new asthma guidelines and is designed as a quick reference to assist clinicians in the management of asthma. The MAP will also disseminate a guide for controller and quick relief medications developed by its MaineHealth partner. A copy is included in the Appendix.
3. Work with Public Health Nursing, Children with Special Health Needs, Teen and Young Adult Health, WIC, and the Office of Minority Health to promote, inform and educate about asthma.
4. Work with the Homes Workgroup to develop trainings on the asthma triggers to look for in homes. The audience for the trainings will be home visitors, code enforcement officers, weatherization technicians, and landlords.
5. Work with the Schools Workgroup to develop an Asthma Schools Tool Box. The Tool Box will include sections for school staff, school nurses, parents, and community, and will include sample policies.
6. Disseminate newly revised school asthma action plan to school nurses, school based health centers and school health coordinators across the state.

State Performance Measure 8: *The percent of licensed child care centers serving children age birth to five who have on-site health consultation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10	11	12	12
Annual Indicator					
Numerator					
Denominator	720	720	720	720	720
Data Source					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	12	12	12	

Notes - 2009
The 2009 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6. We were not able to develop a data system to track this measure over time. The measure will not be continued.

Notes - 2008
This is a developmental measure. The 2008 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

Notes - 2007
This is a developmental measure. The 2007 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

a. Last Year's Accomplishments
There have not been any new developments in the state's efforts to develop a data system to track this performance measure accurately therefore we will not continue this measure beyond 2010. Maine Childcare Facilities Licensing Rules for facilities licensed for 13 or more children require: The facility must have a written agreement with a physician, a nurse practitioner, physician's assistant, or nurse with a pediatric or child care experience to serve as a health consultant and the facility must have a written plan approved by the health consultant. This is enforced when Maine child care licensing staff complete their licensing reviews. In addition to having a written agreement and approved health plan, programs must provide evidence that their staff have been trained on the health plan. Child care programs contact their health consultant to clarify specific issues and answer questions. The data available from Licensing is neither electronic nor updated with any regularity and any efforts to track child care health consultation must remain in limbo until a new Quality Rating System has been fully implemented.

All Maine Head Starts are licensed child care programs and all have health care consultants on staff. There are 86 Head Start Centers statewide.

The enhancement of a child care health-consulting infrastructure is a primary goal in the Early Childhood Comprehensive System State Plan. The Department of Health and Human Services Early Childhood Division (ECD) helped create an infant-toddler child care professional credential that integrates social and emotional health. The ECD and the Children's Behavioral Health Division developed and fund a system of behavioral health consultants which also sets a foundation for comprehensive health systems in child care settings. Behavioral health consultant visits are tracked and outcomes measured. A training program for behavioral health consultants working in a childcare setting was developed and 24 consultants have been trained. Unfortunately the system is not self-sustaining and faces termination.

Quality for ME, a voluntary four-step quality rating system designed to increase awareness of the basic standards of early care and education, to recognize and support providers who are providing care above and beyond those standards was implemented statewide in March 2008. The standards can be found at: http://maine.gov/dhhs/ocfs/ec/occhs/qualityforme.htm. All centers that receive subsidies are required to be in the quality rating system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Commence discussions across Maine DHHS offices to ensure coordination with the public health districts and to obtain funding support for the child health objectives of the child care health consultant network.				X

2. Develop, plan, and implement CCHC trainings for designated health care providers throughout Maine. Implementation will commence with a pilot training that will be evaluated and revised prior to training expansion across the state.				X
3. 3. The Health Consultant will coordinate with credentialing organizations to secure continuing education contact hours for the health consultant training.		X		X
4. Maine Roads to Quality, in coordination with the Health Consultant, will develop and maintain a health consultant registry.				X
5. CCHC will collaborate with the Center for Community Inclusion and Disability Studies (CCIDS) to plan shared portions of HC training related to collaborative consultation as well as those that focus on caring for young children with special needs.				X
6. In unison with stakeholders from Child Care Licensing, Head Start, CCIDS, and the Resource Development Centers, the Health Consultant will identify and develop templates for health-related policies and procedures.				X
7.				
8.				
9.				
10.				

b. Current Activities
According to National Association for the Education of Young Children (NAEYC) emerging criteria, accredited child care centers should have a visit from a childcare health consultant twice per year. There are now 79 NAEYC accredited childcare centers in Maine.

A Health Consultant was hired in February, 2010 with Child Care Development Funds. The Health Consultant attended the National Training Institute in May 2010; the training period extends through August 2010. Trainings for Maine health care consultants will occur in FY11. The consultant began participating in Healthy Child Care New England (HCCNE) activities in February 2010, including regular conference calls and the initial training of the HCCNE web portal. Collaboration within this group will contribute to the coordination of Maine's health care consultant trainings and network development.

The Health Consultant is in the process of engaging the Child Care licensing office to determine the health training needs of both providers and licensing staff.

A major factor in having on-site health consultants is funding. While centers recognize the importance of having an on-site health care consultant, the current economic climate challenges center budgets. Funding is not available from the state to pay for childcare health consultant services and payment for services would be borne by parents who are already burdened by high childcare costs. Without payment health professionals lack the incentive to provide on-site consultation.

c. Plan for the Coming Year
Child care health consultants (CCHC) play a critical role in promoting healthy and safe child care environments and supporting education for children, their families, and childcare providers. This support specifically includes children with special health needs. CCHCs also improve access to preventive health services such as medical and dental homes, early intervention and family support.

It is a challenge to encourage consultants who must either be a physician, nurse practitioner, physician assistant, or nurse with pediatric or childcare experience to attend training even when CEUs are awarded.

Maine will continue to implement its longstanding goal to improve child care center access to health consultation however, we are not confident that the data to track our progress will be available in the next 12 months. In the meantime, the Health Consultant will review, adapt, and implement medication administration training, and coordinate child care training and support systems to assure adherence with recommended practices. Note: the American Academy of Pediatrics has recently released a medication administration training that will serve as the foundation for this activity.

The Health Consultant will explore use of an intern or VISTA volunteer to review licensing data to develop a database of current CCHCs in Maine.

E. Health Status Indicators

Introduction

The Health Status Indicators (HSI) provide key information on several risk factors that are among the leading causes of morbidity and mortality in Maine. The data from these indicators have been used in public documents, state health plans, and direct efforts of public health programs in the state.

The Health Status Indicators reported in the Title V Block Grant inform many of Maine's priorities, including: (1) improving birth outcomes; (2) improving the safety of the MCH population; (3) improving mental health systems; (4) fostering conditions to enable the CSHN program to move to a community-based system of care; (5) improving cultural and linguistic competence; and (6) integrating services for adolescents. By continuing to track the HSIs through the Title V Block Grant, we will be able to evaluate whether we are making progress in these priority areas.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.8	6.8	6.3	6.7	6.3
Numerator	963	966	892	909	832
Denominator	14111	14152	14110	13606	13149
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data source: Maine Office of Data, Research and Vital Statisitics, 2009

Denominator includes all 2009 resident births.

Notes - 2008

Data source: Maine Office of Data, Research and Vital Statisitics, 2008

Denominator includes all 2008 resident births.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Narrative:
Low birth weight is one of the leading causes of infant mortality in the state. Maine's rates of low birth weight and very low birth weight have not changed substantially in the past 4-5 years and Maine has one of the lowest low birth weight rates in the U.S. However, we rely heavily on these indicators as measures of the quality and capacity of our health systems for pregnant women and children and these measures continue to be monitored on an ongoing basis. In 2009, 6.3% of infants were born weighing less than 2,500 grams. Data on this indicator were used to help pass legislation to initiate a Maternal and Infant Mortality Review Panel (MIMR) in the state. This panel is reviewing cases of infant deaths in order to examine how system change can improve care, reduce the incidence of low birth weight and premature babies, and decrease infant mortality and morbidity. A Perinatal Periods of Risk (PPOR) analysis was conducted and presented to the MIMR panel. Results from this analysis were consistent with PPOR analyses conducted by other states and demonstrated highest risk for infant mortality among VLBW infants.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.4	5.2	4.9	5.2	4.7
Numerator	743	717	671	685	598
Denominator	13647	13703	13627	13185	12716
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: Maine Office of Data, Research and Vital Statistics

Denominator includes all 2009 singleton births to Maine residents.

Notes - 2008
Data source: Maine Office of Data, Research and Vital Statistics

Denominator includes all 2008 singleton births to Maine residents.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statistics

Denominator includes all singleton births to Maine residents.

Narrative:
There were 13,149 births and 12,716 singleton births to Maine residents in 2008. Of singleton births, 4.7% were low birth weight compared to 6.3% of all births. (See HSI #01A for more information on activities aimed at reducing low birth weight in Maine.)

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.3	1.2	1.2	1.0	1.0
Numerator	182	176	173	134	128
Denominator	14111	14152	14102	13606	13149
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: Maine Office of Data, Research and Vital Statisitics, 2009

Denominator includes all 2009 resident births.

Notes - 2008
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all 2008 resident births.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Narrative:
In 2009, there were 128 babies in Maine that were born weighing less than 1,500 grams - 1.0%. Maine's very low birth weight (VLBW) rate has been between 1.0% and 1.3% over the past 5 years. During FY09, an analysis of where VLBW babies were born (e.g., high risk facilities vs. other) was conducted. Results from these analyses indicate that the transfer rate of VLBW infants varies by geographic location. However, as part of Maine's MIMR Panel, a physician at Maine Medical Center reviewed all cases of premature infants who were treated at the NICU at Maine Medical Center, but not transferred there before the birth of the child. Results of this analysis reveal that protocols for care were appropriate for all cases. Current transfer protocols designed to produce the best outcomes for these infants are effective.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.0	0.9	0.9	0.8	0.8
Numerator	131	124	124	100	99
Denominator	13647	13703	13630	13185	12716
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data Source: Birth certificate database, Maine Office of Data, Research, and Vital Statistics

Denominator includes all 2009 Maine resident births.

Notes - 2008
Data Source: Birth certificate database, Maine Office of Data, Research, and Vital Statistics

Denominator includes all 2008 Maine resident births.

Notes - 2007
Data Source: Birth certificate database, Maine Office of Data, Research, and Vital Statistics

Narrative:
Of the 12,716 singleton infants in the state, 100 or (0.8%) were born weighing less than 1,500 grams. (See HSI #02A for more information.)

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.7	7.0	7.2	6.7	6.7
Numerator	77	79	81	75	
Denominator	1149644	1126308	1126269	1118193	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 mortality data are not yet available. 2004-2008 data are used as an estimate.

Notes - 2008
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

A 5-year average is reported. The 2008 indicator is for 2004-2008.

Data are from Maine's Office of Data, Research and Vital Statistics.

Notes - 2007
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger. (Injuries).

A 5-year average is reported. The 2007 indicator is for 2003-2007.

Data are from Maine's Office of Data, Research and Vital Statistics.

Narrative:
Due to small numbers, 5-year average rates are reported for this indicator. Between 2004-2008, there were 75 unintentional injury mortality deaths among children aged 14 years and younger in Maine, a rate of 6.7 per 100,000. The majority of these deaths were due to motor vehicle crashes (see HSI #3B, #3C for more information). The Maine Injury Prevention Program (MIPP) is working to reduce deaths due to unintentional injury through efforts to reduce motor vehicle crashes, unintentional firearm deaths, drowning, fires, and unintentional poisonings.

HSI data on unintentional injury in Maine were used to secure funding from the Centers for Disease Control and Prevention to improve Maine's injury surveillance capacity. These data have also helped to increase collaborative efforts between MIPP and Maine's Bureau of Highway Safety, maintain funding for a car seat safety program, and successfully tighten restrictions on teen drivers' licenses. Unintentional injury data have also been incorporated into Healthy Maine 2010, a public document that outlines the health objectives for Maine residents.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.3	3.6	3.2	2.6	2.6
Numerator	38	40	36	29	
Denominator	1149644	1126308	1126269	1118193	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 mortality data are not yet available. The 2004-2008 rate is used as an estimate.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2008
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Child Motor Vehical Crash Mortality is calculated as a five year average. Thus, the indicator reported for 2008 of 2.6 represents a five year average for 2004-2008.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2007
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. (Injuries)

Child Motor Vehical Crash Mortality is calculated as a five year average. Thus, the indicator reported for 2007 of 3.4 represents a five year average for 2003-2007.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Narrative:
Rates of unintentional injury and motor vehicle crash deaths among youth have not changed significantly in recent years in Maine. Between 2004-2008, there were 29 deaths due to motor vehicle crash injuries to children age 0-14, a rate of 2.6 per 100,000. Unintentional injuries, specifically motor vehicle crashes, are the leading causes of death among Maine youth. Therefore, based on this data, the MIPP has identified motor vehicle crashes as a priority in their program plan and is expanding their efforts to address the issue. One of these efforts is working with Maine's Office of Substance Abuse to obtain toxicology screens on all motor vehicle related deaths in the state. With this information the program will be able to better understand the role of substance use in child and adolescent motor vehicle deaths. In addition, the MIPP is now coordinating Maine's CODES (Crash Outcome Data Evaluation System) Project. The CODES Project links hospitalization and death certificate data with police crash data to examine health outcomes related to motor vehicle crashes. The linkage will be conducted during FY11.

A new child passenger safety coordinator was hired in December 2009. The position had been vacant since July 2009.

In June 2009, Maine's Distracted Driver law (Senate Bill 15: "Failure to Maintain Control of a Motor Vehicle") was passed. If a driver is engaging in an activity that impairs his/her ability to operate the vehicle, the driver is failing to maintain control of the vehicle and is committing a traffic violation.

The Bureau of Highway Safety, University of Southern Maine, and the Children's Safety Network, and MIPP developed and distributed Maine's first web based Child Passenger Safety survey. The purpose was to gather baseline data on knowledge and retention, level of participation among Maine's 192 CPS Technicians statewide. The preliminary findings were presented at the CPS Symposium in June 2009.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	27.0	28.5	26.7	26.5	26.5
Numerator	236	247	230	226	
Denominator	872800	868006	862750	851676	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 mortality data are not yet available. Data from 2004-2008 are used as an estimate.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2008
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
A 5-year average rate is presented for years 2004-2008.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2007
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
A 5-year average rate is presented for years 2003-2007.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Narrative:
Motor vehicle crashes are the leading cause of death among youth in Maine age 15-24. Between 2004-2008, 226 adolescents died as the result of a motor vehicle crash, a rate of 26.5 per 10,000. In an effort to address adolescent motor vehicle deaths, the MIPP in June 2009 held a symposium on Teen Drivers, which included epidemiologic mortality, hospitalization and crash data. The goals of the symposium were to teach stakeholders more about the issue, learn about ongoing efforts in the state to improve safety among teen drivers, and identify possible interventions (See HSI #3B for more information)

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	180.8	180.0	194.9	142.2	142.2
Numerator	400	405	437	315	
Denominator	221233	225055	224216	221511	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 hospitalization data are not yet available. 2008 data were used as an estimate.

Numerator = # of hospitalizations in 2008 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator= 2008 US Census estimate as of July 1, 2008

Notes - 2008
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2008 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset, 2008

Denominator= 2008 US Census estimate as of July 1, 2008

Notes - 2007
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired."

Denominator= 2007 US Census estimate as of July 1, 2007

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2008, 315 children between the ages of 0-14 years were hospitalized for a non-fatal injury. This is a rate of 142.2 per 100,000. (See HSI #3A and #3B for activities related to reducing unintentional injuries in the state.)

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	15.4	15.1	16.5	11.7	11.7
Numerator	34	34	37	26	
Denominator	221233	225055	224216	221511	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 hospitalization data are not yet available. 2008 data were used as an estimate.

Numerator = # of hospitalizations in 2008 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2008

Notes - 2008
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2008 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2008

Notes - 2007
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2007

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2008, 26 children between the ages of 0-14 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code. This is a rate of 11.7 per 100,000. (See HSI #3B for activities related to this indicator.)

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	139.6	135.7	119.9	110.2	110.2
Numerator	254	233	201	183	
Denominator	182012	171682	167673	166038	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 hospitalization data are not yet available. 2008 data are used as an estimate.

Numerator = # of 2008 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2008.

Notes - 2008
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Injuries)

Numerator = # of 2008 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2008.

Notes - 2007
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Injuries)

Numerator = # of 2007 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired." Source: Maine Hospital Discharge Dataset

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2007.

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2008, 183 adolescents and young adults between the ages of 15-24 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code. This is a rate of 110.2 per 100,000. (See HSI #3C for activities related to this indicator.)

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.6	15.1	15.3	14.8	13.6
Numerator	619	664	667	633	582
Denominator	45573	43949	43500	42743	42947
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data are from the Maine HIV/STD program.

The denominator for the 2009 estimate is based on the 2009 US Census estimate as of July 1, 2009.

Notes - 2008
Data are from the Maine HIV/STD program.

The denominator for the 2008 estimate is based on the 2008 US Census estimate as of July 1, 2008.

Notes - 2007
Data are from the Maine HIV/STD program.

The denominator for the 2007 estimate is based on the 2007 US Census estimate as of July 1, 2007.

Narrative:
Overall, the number of chlamydia cases reported in 2009 represented a slight decline in annual chlamydia counts. This was the only annual decline noted among cases reported in Maine since 2001. Maine's chlamydia rates among women had been increasing over time, but 2009 represented the first decrease in the rates in several years. Rates of chlamydia declined slightly in 2008 and again in 2009 among girls age 15-19 to 13.6 per 1,000. Rates also decreased slightly among women age 20-44 in 2009 to 5.5 per 1,000. Maine's STD Program is doing targeted testing with females ages 15-24 through their Infertility Prevention Project (IPP) and aims to increase re-screening of those who test positive. To address the increasing rates, the Maine STD Program is also providing treatment at the IPP sites. In addition, the program is following up testing with adequate treatment verification, case follow up for prioritized disease that includes notification of disease, and partner notification, testing and treatment. Prevention messaging and education are also provided at partner sites. Maine's HIV/STD program is continuing to conduct targeted testing and treatment and raising awareness of the importance of testing.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.6	4.6	5.4	5.7	5.5
Numerator	996	991	1131	1175	1107
Denominator	217937	215595	210524	206995	202878
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are from the Maine HIV/STD program.

The denominator is based on the 2009 US Census population estimate for women 20-44 as of July 1, 2009.

Notes - 2008
Data are from the Maine HIV/STD program.

The denominator is based on the 2008 US Census population estimate for women 20-44 as of July 1, 2008.

Notes - 2007
Data are from the Maine HIV/STD program.

The denominator is based on the 2007 US Census population estimate for women 20-44 as of July 1, 2007.

Narrative:
See HSI #5A for more information on this indicator.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	13739	12794	241	121	182	7	394	0
Children 1 through 4	57023	52001	1672	563	881	37	1869	0
Children 5 through 9	72180	66206	2122	624	1148	36	2044	0
Children 10 through 14	76490	71572	1660	563	1033	34	1628	0
Children 15 through 19	88481	83666	1616	684	1015	38	1462	0
Children 20 through 24	81616	77377	1450	724	956	30	1079	0
Children 0 through 24	389529	363616	8761	3279	5215	182	8476	0

Notes - 2011

Narrative:
The HSI demographic data allow Maine's Title V agency to gauge the scope of the population they are charged with serving. Maine's population is becoming more diverse and the HSIs allow Title V to track the changing demographics of the population in order to adapt our programs for a broad audience and remain aware of the need for cultural and linguistic competence in our efforts. Data for these indicators are from many programs from around the state and gathering the data has helped to build collaborations across programs.

Based on US Census estimates for Maine as of July 1, 2009, 96.1% of Maine's population is white, 1.2% are Black/African American, 0.6% are American Indian, 1.0% are Asian, 0.04% are Native Hawaiian or other Pacific Islander, 1.1% are two or more races; and 1.4% are Hispanic. However, over time Maine's population has become more diverse, and we can see this especially

among youth age 0-24 years. Among those age 0-24, Whites comprise 93.4% of the population compared to 97.3% of the population in Maine over age 24; 2.3% of Maine's 0-24 year olds are Black/African American compared to 0.7% of those over age 24; 2.2% of Maine's 0-24 year old population are more than one race compared to 0.6% of the population over age 24. These differences are even higher among the youngest children in the state. Among children age 1-4 years, 2.9% are Black and 3.3% are more than one race. A similar pattern is seen for ethnicity, as Maine's Hispanic population continues to increase. Overall, 1.4% of Maine's population is Hispanic. However, among 1-4 year old, 2.2% are Hispanic. We expect to see Maine's population continue to diversify in the coming years and many programs within the Maine CDC including the Children with Special Health Needs Program, Injury Prevention Program, Oral Health Program, and WIC program are working to improve culturally competent practices and to engage diverse communities in prevention and intervention efforts.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	13438	301	0
Children 1 through 4	55387	1636	0
Children 5 through 9	70096	2084	0
Children 10 through 14	74811	1679	0
Children 15 through 19	86800	1681	0
Children 20 through 24	80052	1564	0
Children 0 through 24	380584	8945	0

Notes - 2011

Narrative:
An overall discussion of HSI 06 can be found under HSI 06A.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	8	8	0	0	0	0	0	0
Women 15 through 17	246	238	2	1	3	0	2	0
Women 18 through 19	782	746	15	12	4	0	5	0
Women 20 through 34	10304	9700	282	92	153	13	49	15
Women 35 or older	1808	1674	76	5	41	3	5	4
Women of all	13148	12366	375	110	201	16	61	19

ages								

Notes - 2011

Narrative:
Among all racial/ethnic groups, the majority of births are among those age 20-34 years. However, data on births to adolescents reveal large disparities within the state. Based on data from 2009, the pregnancy rate for Whites between the ages of 15-19 was 24.2 per 1,000 live births. Among Black/African Americans, the rate was 22.9 per 1,000 live births and the rate for American Indians was 37.2 per 1,000 live births. The adolescent pregnancy rate among Hispanics is 15.0 per 1,000 compared to 16.4 per 1,000 among non-Hispanics. In partnership with the Maine Family Planning Association, we also mapped all adolescent pregnancies in the state by town in an effort to identify gaps in services.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	7	1	0
Women 15 through 17	240	6	0
Women 18 through 19	766	14	2
Women 20 through 34	10167	130	7
Women 35 or older	1768	38	2
Women of all ages	12948	189	11

Notes - 2011

Narrative:
See HSI #07A for information.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	76	66	3	2	0	0	0	5
Children 1 through 4	17	16	1	0	0	0	0	0
Children 5 through 9	11	10	0	0	0	0	0	1
Children 10 through 14	7	6	0	0	0	0	0	1
Children 15	47	47	0	0	0	0	0	0

through 19								
Children 20 through 24	61	59	0	0	0	0	0	2
Children 0 through 24	219	204	4	2	0	0	0	9

Notes - 2011

Narrative:
Due to the very small numbers of deaths among youth, it is difficult to draw any conclusions based on these data. In 2008, preliminary data suggest that there were 219 deaths among children and youth age 0-24 years. Ninety-three percent of these deaths (n=204) were among Whites and 1.8% (n=4) were among Black/African American youth. There were no deaths among the Asian population, Native Hawaiian/Other Pacific Islanders, and those of more than one race. There were 2 reported deaths among American Indian youth and 9 deaths among those with unknown race. The Maine Office of Minority Health is working to improve collection of race and ethnicity data on Maine's death certificate. Maine is moving towards an electronic death certificate system and adopting the new standard US death certificate. Maine's MIMR Panel and Maine's Child Death and Serious Injury Review Panel will continue to review infant and child deaths in the state in an effort to identify systems-level causes and possible solutions to reduce the probability of child death moving forward.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	70	0	6
Children 1 through 4	15	0	2
Children 5 through 9	10	0	1
Children 10 through 14	7	0	0
Children 15 through 19	42	0	5
Children 20 through 24	56	0	5
Children 0 through 24	200	0	19

Notes - 2011

Narrative:
See HSI #08A for information.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native**	**Asian**	**Native Hawaiian or Other**	**More than one**	**Other and Unknown**	**Specific Reporting Year**

				Alaskan		Pacific Islander	race reported		
All children 0 through 19	307913	286239	7311	2555	4259	152	7397	0	2009
Percent in household headed by single parent	32.4	31.7	0.0	47.8	0.0	0.0	33.3	65.1	2008
Percent in TANF (Grant) families	11.3	8.5	42.0	12.0	10.0	21.7	12.9	0.0	2009
Number enrolled in Medicaid	131205	107695	5392	1952	1314	169	0	14683	2009
Number enrolled in SCHIP	26877	22682	535	311	259	29	0	3061	2009
Number living in foster home care	1715	1436	43	25	5	1	117	88	2009
Number enrolled in food stamp program	104044	77311	4530	1369	772	90	2381	17591	2009
Number enrolled in WIC	23252	19892	1471	186	264	10	1429	0	2009
Rate (per 100,000) of juvenile crime arrests	2551.1	2523.7	5233.1	1258.2	903.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.1	4.1	4.8	6.0	2.7	0.0	0.0	0.0	2008

Notes - 2011
Data are from the US Census estimates as of July 1, 2009.

Based on estimates from the 2006-2008 American Community Survey.
For several race categories, data were not available because of the small number of sample cases.

Data source: DHHS Office of Integrated Access and Support

Data from the Office of MaineCare Services from FFY 2009.

Data are from the Office of MaineCare Services for FFY2009.

Data from the Maine DDHS Office of Integrated Access and Support.

Data are from the Maine WIC program.

Data are from the Maine Office of Public Safety from 2008 and represent arrests of juveniles age 17 years and younger. Race data are only reported on Whites, Blacks, Asian/Pacific Islanders, and Native Americans.

Data are from the Maine Department of Education and represent drop-outs during the 2008-2009 academic year. Data are collected on Whites, Black/African Americans, Native Americans and Asian/Pacific Islander. We cannot separate Pacific Islanders from other Asians and there are no data on those of more than 1 race.

Data provided by the Maine Office of Child and Family Services. The data are a point in time estimate of the number of children in care or custody of DDHS on 5/4/2010.

Narrative:
Efforts to obtain data for the HSI forms have increased collaboration across state agencies. This increased contact is leading to improvements in Title V's surveillance capacity. For example, through contact with the Office of MaineCare Services, Maine's Title V has built the foundation for increased access to Medicaid data to link with birth certificate data. Maine's WIC program is also working closely with Title V to link birth certificates to WIC enrollment data. Further, increased involvement with the Governor's Children's Cabinet has led to significant progress in Title V's partnership with KidsCount, MaineMarks, and other data sources outside of public health.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	300532	7381	0	2009
Percent in household headed by single parent	31.7	0.0	78.3	2008
Percent in TANF (Grant) families	9.9	9.4	0.0	2009
Number enrolled in Medicaid	0	281	131205	2009
Number enrolled in SCHIP	0	60	26877	2009
Number living in foster home care	1480	87	148	2009
Number enrolled in food stamp program	90053	1583	12408	2009
Number enrolled in WIC	22273	979	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	6.1	0.0	2008

Notes - 2011
Data are from the US Census estimates as of July 1, 2009.

Data are from the 2006-2008 American Community Survey. Data by ethnicity were not available because the number of sample cases was too small.

Data from the DHHS Office of Integrated Access and Support.

Data are from the Office of MaineCare Services. Data on ethnicity are not collected separately by race data by MaineCare.

Data are from the Office of MaineCare Services. Data on ethnicity are not collected separately by race data by MaineCare.

Data are from the Maine DHHS Office of Integrated Access and Support.

Data are from the Maine WIC Program.

Data are from the Maine Office of Public Safety from 2008 and represent arrests of juveniles age 17 years and younger. Data are hispanic ethnicity are not reported.

Data are from the Maine Department of Education and represent drop-outs during the 2008-2009 academic year. Ethnicity data are collected separately from race data by the Department of Education.

Data provided by the Maine Office of Child and Family Services. The data are a point in time estimate of the number of children in care or custody of DDHS on 5/4/2010.

Narrative:
See HSI 09A for information.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	124089
Living in urban areas	123781
Living in rural areas	179821
Living in frontier areas	4311
Total - all children 0 through 19	307913

Notes - 2011
Estimated by applying the percent of Maine's population living in metropolitan areas on the 2000 Census (40.3%) to population estimates as of July 1, 2009.

Estimated by applying the percent of Maine's population living in urban areas on the 2000 Census (40.2%) to population estimates as of July 1, 2000.

Estimated by applying the percent of Maine's population living in rural areas on the 2000 Census (58.3%) to population estimates as of July 1, 2009.

Estimated by applying the percent of Maine's population living in frontier areas on the 2000 Census (1.4%) to population estimates as of July 1, 2009.

Narrative:
In the United States overall, about 21% of the population lives in a rural area. In Maine, 60% of the population lives in a rural area. This presents challenges for accessing health care and providing services. Maine's diverse geography and large size also makes it challenging to understand the needs of Maine residents throughout the state. However, Maine has recently developed a local public health infrastructure through the creation of eight public health districts. By working with the districts, which have an organizational structure that is community-driven, Maine's Title V program is gaining a better understanding of the unique needs and strengths of the different geographies around the state.

In Fall 2007, health profiles with data for each of the districts were released to allow each district to identify areas where they may want to focus prevention and intervention efforts. District health tables were released in 2008 and updated in 2009. Several of the HSI, including low birth weight, motor vehicle death rate, chlamydia rates, and population demographics by race, were included in these profiles. Several of the indicators were also included in a table as part of Maine's State Health Plan. During 2009, each of Maine's public health districts conducted local capacity assessments to gauge how well they are able to meet the needs of their population. Results will be available in 2010.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1316524.0
Percent Below: 50% of poverty	4.0
100% of poverty	12.0
200% of poverty	29.9

Notes - 2011
Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Narrative:
According to the 2008 Current Population Survey, Maine's poverty rate of 12.0% ranks 20th in the United States and is the highest in New England. Maine's childhood poverty rate of 16% is the 23rd highest in the U.S. and the highest in New England; 1 in 5 (20%) children under the age of 6 in Maine are living in poverty. With the current economic climate in the state, we don't expect improvement in the state's poverty levels.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	309101.0
Percent Below: 50% of poverty	6.3
100% of poverty	17.1
200% of poverty	35.9

Notes - 2011
Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Based on the 2009 Current Population Survey, Annual Social and Economic Supplement.

Narrative:
See HSI #11 for information.

F. Other Program Activities

Maine Safe Families Partnership

The Maine Safe Families Partnership (MSFP) has coordinated various initiatives that combine the work of public health, health, and domestic and sexual violence statewide. One of the initial awareness sessions was with the Maine CDC in 2007. Members of the original leadership team set out to promote and inform Maine CDC staff and leadership about the relationship between public health and domestic violence (DV) and sexual assault (SA) through meetings with senior leaders and a staff informational session.

In November 2007, the partnership held a training for home visitors, WIC staff, Federally Qualified Health Center (FQHC) staff, HIV/STD clinic staff, and family planning staff to build awareness of DV and SA prevention in the public health and health sector; provide education on local resources; and clarify legal mandates and reporting requirements for domestic and sexual violence. The training also addressed screening for DV, SA, and intimate partner violence (IPV) in rural, community and public health settings and provided tools to participants to help them communicate more effectively with clients. It encompassed cultural and linguistic competency training to address perinatal health disparities related to DV, SA and IPV among rural, minority and underserved populations. The training reached more than 140 health and DV and SA leaders statewide.

In the spring of 2009, MSFP held 4 regional trainings for public health and hospital-based nurses. The trainings focused on DV and included more than 60 nurses. In the spring of 2010 MSFP convened a meeting for nurses on sexual assault/abuse. The meeting was organized through a collaborative effort using the expertise and resources of the Maine Coalition to End Domestic Violence, The Coalition Against Sexual Assault, the Maine CDC's Maternal and Child Health Epidemiologist, the Sexual Assault Forensic Examiners Director, and the Public Health Nursing Program staff. The full day training took place in four locations (Augusta, Portland, Presque Isle, and Hampden) in order to reach all of the regions of Maine. All public health nurses were trained and the sessions also included hospital based nurses. A total of 113 nurses statewide attended one of the four training sessions.

Most recently, the partnership has received two funding awards to assist Maine with continuing to raise awareness in preventing DV, SA and dating violence within various communities in Maine. These awards include:

Prevention of Violence Against Women and Girls

The Office on Women's Health (OWH) is providing the MSFP funding for events or activities intended to prevent, raise awareness of, or respond to the epidemic of violence against women and girls in the United States. MSFP's project proposal addresses providing early intervention and prevention training to school nurses on dating violence; planning to develop a training on culturally and linguistically competent approaches to DV, SA, and IPV with minority and underserved populations in Maine; process/resource planning for strategic planning; and support

for WIC during their annual conference.

Family Violence Prevention Fund -- Project Connect

The Family Violence Prevention Fund (FVPF) and OWH are partnering with statewide teams to develop policy and public heath responses to domestic and sexual violence in women's health programs. Per grant requirements the projects had to focus on two of the following four program areas: Reproductive and Sexual Health, Home Visitation, Adolescent Health, and other MCH/perinatal programs. Maine's Project Connect will continue the work of the MSFP by building collaborations and expanding initiatives with the Family Planning Association (FPA) of Maine and the Maine Coordinated School Health Program (CSHP). Both of these efforts involve educating health care providers on DV, SA and dating violence, and training them to respond appropriately. We will also work with our partners to ensure that the evidence-based practices that are implemented are culturally competent.

The support of the partners makes it possible for us to compete for funding opportunities, improve our capacity to provide support and information to programs and organizations working in this area, and further reduce the impact of DV and SA statewide.

The Maine Youth Integrated Youth Health Survey

In 2009, the Maine Department of Education, the Maine Office of Substance Abuse, and the Maine CDC implemented the Maine Integrated Youth Health Survey (IYHS), with the intent of repeating the survey every two years. The IYHS is designed to:

- Ensure the State's ability to provide federal and State level data while still providing localized reports to schools and counties to assist in efforts to reduce health risks and improve health protective factors and youth assets;
- Ensure voluntary and anonymous participation for students and parents;
- Reduce the burden to schools and students from over-surveying by State agencies, including providing for fewer surveys sponsored by State agencies and for shorter survey instruments.

The survey was fielded in February, 2009 in most schools, in April in a few schools and two additional high schools administered it in May.
The survey instruments consisted of:

- Four versions for the high school: from 99-108 questions -- 58 core questions asked of all students, 201 questions overall. One version satisfies US CDC's requirements for the Youth Risk Behavioral Survey (YRBS).
- Four versions for the middle school (7th-8th grades): each 80 questions -- 54 core questions asked of all students, 160 questions overall. One version satisfies US CDC's requirements for the YRBS.
- One 5th/6th grade version (50 questions)
- One kindergarten/3rd grade parent survey (51 questions)
- K, 3rd, and 5th grade also had direct measure of heights, weights, and oral health.

Overall Response Rates were:

- HS: 60% - 69%
- MS: 63% -70%
- 5th/6th grade: 76%
- K/3rd grade parent survey: 32% (after two mailings and follow-up phone calls.)

Question revisions are underway and will be finalized in August 2010 for the 2011 survey. The 5th grade oral health screening will not be repeated in 2011. Numerous reports and analyses are in development. A searchable website can be found at:
http://www.maine.gov/maineyouthhealthsurvey.org

G. Technical Assistance

Please refer to Form #15. We will request technical assistance from the Maternal and Child Health Bureau and other appropriate entities such as other State Public Health Agencies, Academic Institutions with expertise in public health and public administration, non-profit organizations with MCH/CSHN expertise, and other federal partners such as the Centers for Disease Control and Prevention for the following:

1. Technical assistance for cultural and linguistic competence within Title V programs.
2. Technical assistance with survey analysis.
3. Technical assistance on injury prevention toolkits.
4. Technical assistance from an experienced Women's Health Coordinator to mentor our Women's Health Coordinator.

The request for technical assistance (#1) was selected for continued progress in the development of culturally and linguistically competent systems of care for the MCH population in Maine. Such progress is an essential component for creating and sustaining humane policies and services. This is particularly important as the population in Maine becomes more racially and ethnically diverse, and as we become increasingly aware of the impact of class and geography on health disparities. Specifically, Maine is asking for assistance in identifying tools to assist our many partners in their endeavors to be culturally and linguistically competent for all persons living in Maine.

The request for technical assistance (#2) for survey sample analyses was selected because the Maine Title V program uses several surveys to address the needs of the MCH population including PRAMS, the Integrated Youth Health Survey, the Behavioral Risk Factor Surveillance System and the Maine Child Health Survey. Survey data require analytic techniques that are not familiar to all staff and there have been changes to statistical software, specifically Statistical Analysis Software (SAS), to conduct these analyses. The Maine CDC, MCH epidemiologists and program staff could benefit from a training on survey analysis that would include topics such as: combining years of weighted data, using SAS to analyze survey data, and conducting regional analyses of stratified data. We have identified an expert in survey sampling analysis, Donna Brogan, who provides trainings in these topics. Assistance in the area can be accomplished by procuring/arranging a training session in Maine.

The request for technical assistance (#3) on Injury Prevention toolkits was selected as a result of a change in the strategic direction of the Maine Injury Prevention Program (MIPP). The MIPP previously conducted direct outreach and education and recently has shifted its focus to one of being "the link to data, training and resources." As such, having toolkits comprised of key injury prevention topics will be an important resource that will assist community groups in conducting outreach and education. However, because this is a new direction, MIPP would like further technical assistance to ensure the resources created are aligned with best practices in the field. The MIPP will approach AMCHP and the Children's Safety Network to determine whether they can provide the needed technical assistance. The MIPP welcomes suggestions of other resources for this type of technical assistance.

The request for reverse technical assistance (#4) for women's health was selected due to having a new women's health coordinator in a position that has been vacant for approximately a year. The previous coordinator had several grant related projects that have now ended, and with new staff, women's health is in a position to re-energize the work in this area. While there have been some training opportunities at various conferences, we have not identified a national conference that can provide our new Coordinator with a broad orientation to public health efforts in women's health. The opportunity to observe an effective State Women's Health Program and be mentored by an experienced women's health coordinator will assist Maine in developing an effective program while at the same time meet the professional development needs of our staff. The Title V Director will inquire on the availability of the Women's Health Coordinator in Wisconsin, Millie

Jones, for this type of technical assistance. The Title V Director will also contact the Women's Health Director at AMCHP for suggestions on Women's Health Coordinators in other states.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	3507118	3507118	3507117		3507118	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	10431736	15687237	9594118		9740069	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	13938854	19194355	13101235		13247187	
8. Other Federal Funds *(Line10, Form 2)*	21414040	25211753	25961274		25211753	
9. Total *(Line11, Form 2)*	35352894	44406108	39062509		38458940	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	603471	809850	591110		557389	
b. Infants < 1 year old	3640810	5232211	3537184		3601134	
c. Children 1 to 22 years old	4359284	6188074	4003223		4259021	
d. Children with	2554797	3005601	2308029		2068642	

Special Healthcare Needs						
e. Others	2548451	3673369	2419547		2528242	
f. Administration	232041	285250	242142		232759	
g. SUBTOTAL	13938854	19194355	13101235		13247187	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	1122354		1341396		933017	
b. SSDI	100000		61030		60097	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	18154743		22344668		22344668	
h. AIDS	0		0		0	
i. CDC	722028		274257		275185	
j. Education	0		0		0	
k. Other						
FAMILY PLANNING	0		420322		110274	
HGWY	0		138200		72512	
SAMHSA	524304		1381401		1416000	
HIGHWAY	209802		0		0	
SS FAMILY PLANNING	580809		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	8598951	10395800	7334758		7174772	
II. Enabling Services	909408	1356765	813713		936386	
III. Population-Based Services	1407204	2587196	1556380		1785580	
IV. Infrastructure Building Services	3023291	4854594	3396384		3350449	
V. Federal-State Title V Block Grant Partnership Total	13938854	19194355	13101235		13247187	

A. Expenditures

For a summary of any variances please refer to Section VB - Budget.

B. Budget

The Division of Family Health expended $19,194,355 for maternal and child health services in FY09; including $15,687,237 of state funds and $3,507,118 of Title V funds. Expenditures by populations served include 59% ($11,240,285) expended on primary care and preventive services for children; 16% ($3,005,601) expended for children with special health needs; 4%

($809,850) expended for pregnant women; 19% ($3,673,369) for others; and just under 2% ($285,250) for administration. The "other" category is comprised primarily of women of reproductive age who are not pregnant or recently postpartum. In FY 09 there was a slight decrease in expenditures in most population groups with a more significant decrease in CSHN and administration and a slight increase in "others". The decrease in CSHN expenditures is due to the Program's shifting away from a primary focus upon direct services to a community-based system of services.

Delineating expenditures by levels of the MCH Core Services Pyramid, 54% ($10,395,800) was expended on direct services; 7% ($1,356,765) on enabling services; 14% ($2,587,196) on population based services; and 25% ($4,854,594) was expended on infrastructure building services. The decrease in direct and infrastructure service level expenditures supported an increase in expenditures for population-based and enabling services. Overall expenditures in FY09 were $5,255,501 more than budgeted. This is a result of some state funds being carried over from FY 08; however the majority comes from the expenditures within the state home visiting program. While the home visiting program funds were removed from the Division of Family Health's budget when the program moved to the Office of Child and Family Services, organizationally the expenses are still being reported as part of the Maine CDC budget. We will work on correcting this by the next annual report.

In FY11 the Division proposes to spend $3,507,118 of Title V funds, with no carry forward from FY10. Of the Title V funds, 63% ($2,209,954) is allocated to primary care and preventive services for children; 30% ($1,064,406) to children with special health needs; and 7% ($232,758) is available for administrative expenses. Considering the total federal and state budgets, the Division proposes the following expenditures, categorized by level of the MCH Core Services pyramid: 54% ($7,174,772) will be allocated for direct services; 7% ($936,386) for enabling services; 14% ($1,785,580) for population based services; and 25% ($3,350,449) for infrastructure building services.

The FY11 budget is $145,951 more than FY10 because of increases in the costs related to family planning services and newborn bloodspot screening. Included in the annual MCHBG budget is approximately $70,000 to cover expenses related to out of state travel to attend regional or national meetings that are important in advancing the health of Maine's MCH population. These funds will be used by staff in the programs working with the MCH population on the priorities outlined in the comprehensive strengths and needs assessment.

Regional and national meetings staff will attend during FY11 include: MCHB Partnership, Association of Maternal Child Health Programs, American Public Health Association, National Association of School Based Health Centers, National Network of State Adolescent Health Coordinators, Association of State and Territorial Dental Directors Partners, Federal CDC Division of Oral Health State Dental Directors' Workshop, Society for Adolescent Medicine, Association of State and Territorial Directors of Nursing, New England Regional Genetics Group, National Eating Disorders, National Newborn Screening and Genetic Testing Symposium, National Women's Health Coordinators, State and Territorial Injury Program Directors Association, American Cleft Palate Association, National Birth Defects Programs, National Perinatal Association, Newborn Bloodspot Screening, North American Brain Injury Society, American Evaluation Association, Region I MCH and CSHN Directors, North East Regional Public Health Leadership Institute, on-site Public Health Prevention Specialist interviews at Federal CDC, Women's Health Summit, March of Dimes Annual Meeting on Quality Improvement to Prevent Prematurity, Annual New England Birth Defects Consortium, Children's Health Care of Atlanta, Cleft Lip and Palate Symposium, National Improvement Partnership Network, Child Health Insurance Program Reauthorization Act meetings, Association of State and Territorial Health Officials Accreditation, Boston University School of Public Health MCH Advisory Board, New England Health Resources and Services Administration Continuing Education Collaborative, CDC Core Injury Surveillance, Safe States, Substance Abuse and Mental Health Services Administration National Highway Traffic Safety Administration Crash Outcomes Data Evaluation

System Grantee, National Violent Death Reporting System, Region I Women's Health Workgroup as well as the Society of State Directors of Health, Physical Education, and Recreation and the American Alliance for Health, Physical Education, Recreation and Dance, and Regional and National meetings related to accreditation preparation. Maine will send the Title V Director, CSHN Director, and MCH Medical Director to the AMCHP and MCHB Partnership meetings.

Conferences include: MCH Epidemiology, American Association of Suicidology, MCH Leadership Institute, Leadership Enhancement in Adolescent Health, Life Savers, Moving Kids Safely, Region 1 Minority Health, Public Health Nursing Informatics, and conferences or meetings that are needed as a part of the orientation of new staff and for staff development. In addition Nancy Birkhimer will attend 2 to 3 meetings to share Maine's innovative and collaborative approach to student health survey data collection, the Maine Integrated Youth Health Survey. The federal CDC assigned Public Health Prevention Specialist will attend two multi-day national conferences relevant to the assignee's scope of work with Maine CDC.

In an effort to better connect the state and federal funds budgeted for maternal child health with the outcomes desired for Maine's MCH population, the Division of Family Health embarked on a process to integrate a quasi zero based budgeting (ZBB) model into our business processes. It is a quasi ZBB as our budgets are predetermined by the Legislature; however we apply the ZBB principles to make data driven budget decisions. The process started with Public Health Nursing as a pilot in FY 2007 and since then has spread to the other programs within the Division of Family Health. While this is a work in progress, this process has resulted in each program developing a decision matrix that is used for efficient and effective budget decisions. The individual program matrices document the functions and activities of a program that is mapped to the resources allocated such as personnel, non-personnel expenses, total expenses and is sorted by the funding sources. This is helping programs to articulate their core business model and priorities and then link their resources to the functions that will achieve those priorities. It is a tool that allows the decision maker to work towards the allocation of resources to the highest use that meets the needs of the MCH population in a cost effective manner. It also allows the decision maker to think about emerging issues and how to modify the program budget. The aggregate Division ZBB is attached.

In moving forward with the integration of ZBB into Title V business practice the program and division ZBB matrices will be expanded to include looking at resource allocation by the 10 essential public health services. Then they will develop input-output models and create outcomes and performance measures which will lead to ongoing analyses related to the return on investment (ROI) in order to make data driven decisions not only on budget expenditures but also upon strategies to achieve improved health outcomes for Maine's MCH population.

An attachment is included in this section.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.