



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Maine**

**Application for 2009  
Annual Report for 2007**



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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**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **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: Mary.Colson@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; expires May 31, 2009.

### **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 committee are 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. The DFH will, during FY09, widely distribute emails to specific listservs sharing the Title V agency link and ask for comments on the MCHBG application. No public comments were received.

A link to TVIS and the MCH Block Grant was added to the Division of Family Health (DFH) home page so visitors to the site can view the application. A statement was added asking for comments along with an email address to submit comments on the FY09 application.

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 has discussed with the OLPH leadership how to include local public health districts in the upcoming 5-year comprehensive strengths and needs

assessment. Discussions are ongoing.

## II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

We were guided in the selection of the priority needs by the quantitative and qualitative analyses we completed. Quantitative data showed that mental disorders are an important issue affecting the MCH population in Maine. Qualitative data from the dialogue groups also identified mental health and the lack of available services, as well as family stress as key needs. As such, one of our new priority areas is to improve the mental health system of services and supports for the MCH population.

We developed our 10 priorities based on the data results, presented the priorities to Title V Program Managers, a wide array of stakeholders, and the public at large for their review and response, including all of the participants in the dialogues. From the responses, we finalized the priority list.

The priorities are broad in nature. This was intentional in that all people who work with and care about the MCH population have a stake in working together in a synergistic way on achieving these priorities. Furthermore, the wording of the priorities, expressed in terms such as improve, increase, and foster conditions, reflect our commitment to viewing MCH issues within a positive context and our vision for this document as a strengths and needs assessment.

The 2000-2005 priorities focused more on how we would achieve our work. The 2005-2010 priorities identify specific areas requiring health status improvement, but at the same time are broad enough to ensure inclusion of the whole MCH population in focused activities and in all aspects of a priority. We felt that too much specificity would jeopardize the obvious importance of many issues not making the list, and give the false impression that we favor addressing only certain segments and age groups of the MCH population. Our priorities, not expressed in rank order, are the following:

1. Improve birth outcomes
2. Improve the safety of the MCH population including the reduction of intentional and unintentional injuries
3. Improve the respiratory health of the MCH population
4. Increase the proportion of the MCH population who are at a healthy weight and physically active
5. Improve the mental health system of services and supports for the MCH population
6. Foster conditions to improve oral health services and supports for the MCH population
7. 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
8. Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population
9. Improve cultural and linguistic competence within the system of services for the MCH population
10. Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs

The 2004-05 MCH Dialogues confirmed what we had hypothesized going into the Assessment: That we have made great strides in partnership building and collaboration during the past 5 years. We continue to develop new partnerships including: collaborating with Physicians for

Social Responsibility and Maine Primary Care Association on a project to train health care providers on screening for domestic violence. Both organizations are actively involved in projects of the Safe Families Partnership, Maine Coalition to End Domestic Violence, Maine Coalition Against Sexual Assault and the Violence Intervention Project of Cumberland County; we are working with faculty and researchers at the University of Maine on domestic violence and rurality; Office of Minority Health is assisting with engaging members from minority communities such as the Maine Labor Council for Latin American Advancement; statewide Boys to Men Initiative is also actively engaged. ***//2009/ During FY08 the Divisions of Family Health and Chronic Disease collaborated with public health program (PH) evaluation faculty and staff from the University of Southern Maine and Maine Center for Public Health to design and implement a standardized PH evaluation framework. Through this framework the Divisions can realize efficiencies in funding the evaluation function for PH programs and progress to measuring longer-term program impacts and health outcomes. The Division of Family Health (DFH) is working with the new Office of Local Public Health to coordinate our 5-year CSNA with the PH district needs assessment. DFH is also working with the Office of Child and Family Services, Children's Behavioral Health and the Community Caring Collaborative of Washington County to create a seamless system of care that is individually designed for each child and family through a wraparound process under the umbrella of PH. //2009//***

Internal to the MCH Title V Program is our much-strengthened epi capacity through the addition of several new staff. We are now able to assign a liaison to each program within MCH permitting the Epi's to develop expertise about a program and its relevant data resources. This enhanced Epi capacity will have a positive long-term impact on our ability to collect, track, analyze, and apply accurate data to program planning and design. ***//2009/ We are also working with students and interns. We hosted a MCHB graduate intern during summer 2007 and a Colby College senior worked with the MCH Epi Team during January 2008 compiling MCH Block Grant data to be included in a Maine MCH Databook. The MCH Epi's also played a key role in the development of District Health Profiles which contain several MCH-related measures. The profiles were released to PH stakeholders around the state in Fall 2007. //2009//***

In 2006 the DFH embarked on a strategic redirection process, looking in depth at how the available MCH human and financial resources are aligned with achieving the 10 MCH priorities developed in 2005. This process was completed in FY08.

***//2009/ The new DFH structure consists of 5 sections; Community Collaboration, Integrated Systems, Operational Support, Public Health Nursing, and Special Needs (See Section III C Organizational Structure Division of Family Health organizational chart). The team leaders of these units comprise a senior management team which work with the Division Director in planning for programs within the division to ensure systems of care and service are in place to address needs of the MCH population. The special needs section, which brings together CSHN, Genetics, Newborn Screening and EPSDT, is involved in a strategic planning process that is expected to be completed by Fall 2008. //2009//***

### **III. State Overview**

#### **A. Overview**

##### Geography

The demographic and geographic factors that account for Maine's uniqueness among the New England states are the very same factors that create complex challenges for the Maine Center for Disease Control and Prevention (Maine CDC) and Division of Family Health as they strive to improve health outcomes for the state's 1.3 million residents.

The other 5 New England states can fit into the 35,385 square miles occupied by the state of Maine. The population is distributed unevenly across the state; a third (35.8%) of Mainers live in the 2 southernmost counties (Cumberland and York), which together account for only 7% of the square miles in the state. Statewide we average only 41.3 people per square mile, as compared to 79.6 people per square mile in the United States as a whole. The population density varies dramatically across the state, from 317.9 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. Statewide, 59.8% of the population lives in rural areas, as compared with 21.0% of the US population overall. In 5 Maine counties, 90% or more of the population lives in rural areas; 2 of these counties are 100% rural. Maine's large geographic area and widely dispersed population create challenges for accessing health care.

MCH populations (i.e., children, including those with special health needs and women of reproductive age) represent a significant proportion of Maine's population. In 2002, children under 18 years made up 21.4% of the state's 1.3 million people, with a range from 19.7% to 22.9% across the state's 16 counties (Comprehensive Strengths and Needs Assessment - CSNA) Children represented a smaller proportion of the population in Maine than they did in the United States as a whole, where 25.7% of the population was under 18 years of age. (CSNA)

In 2000, 32.4% of Maine households included 1 or more children under 18 years, as compared with 36.0% of US households. The range across Maine counties was 30.1% to 35.3%. (CSNA) 6.2% of Maine households consisted of a female householder with her own children under 18 years of age and no husband present; the range across counties was 5.0% to 7.5%. (CSNA) The comparable figure for the United States was 7.2%. (CSNA)

Grandparents are the primary caregivers for a small proportion of children in Maine. The 2000 Census found that 1.7% of Maine adults aged 30 and over lived with grandchildren under 18 years of age. Similarly, 1.7% of Maine households included grandparents living with grandchildren. More than a third (38.9%) of the grandparents who lived with grandchildren were grandparent caregivers, defined as having primary responsibility for coresident grandchildren younger than 18. A third (28.1%) of grandparent caregivers were aged 60 and over. In half of the cases of grandparent caregivers, the child's parents were not in the household. One third (34.5%) of grandparent caregivers had been responsible for their grandchildren for 5 or more years. (CSNA)

The 2001 National Children with Special Health Needs Survey found that 15.5% of Maine children aged birth to 17 years had special health care needs, (CSNA) defined broadly as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (CSNA) The corresponding proportion for the United States was 12.8%, which is significantly lower than that found in Maine. (CSNA) The proportion of children with special health needs in Maine increased with age, from 8.8% of 0-5 year olds to 16.2% of 6-11 year olds to 20.1% of 12-17 year olds. The US percentages for these age groups were 7.8%, 14.6%, and 15.8%, respectively. 23.5% of Maine households had 1 or more children under 18 years of age who had special health care needs, as compared with 20.0% of households in the

## U.S. (CSNA)

Women of childbearing age, defined as 15-44 years, represented 21.0% of the Maine population in 2002, which was similar to the US figure of 21.7%. The range across Maine counties was 18.4% to 22.4%. (CSNA)

Children under 18 years plus women of childbearing age together represented 40.5% of the Maine population in 2002, with a county range of 36.0% to 42.0%. (CSNA)

Maine has 16 counties of significantly varying sizes and population densities. Health care providers and infrastructure are distributed in direct relationship to population density. The largest, and one of the most sparsely populated counties, is Aroostook to the extreme north with 6,829 square miles, a population of 73,122 and only 73 primary care providers (physicians stating primary care as first specialty). These providers must serve a large, remote geographic area with essentially no major thoroughfares, limited resources, minimal support services, and hospitals designated as critical access only. In contrast, Cumberland County, one of the smaller and more densely populated counties to the south, has 1,217 square miles, a population of 269,083, three hundred eighty-seven primary care providers (physicians stating primary care as first specialty) and an extensive network of surface streets and roads.

Maine has three major cities: Portland population 64,249 (+1.8 % from 1990-2000); Bangor population 31,473 (-9.0%); and Lewiston population 35,690 (-10.3%). However, collectively the three largest cities account for only 10% of the state's residents. While 80% of American residents reside in metropolitan areas, the majority of Maine's residents continue to reside in rural towns and small cities that comprise the core of Maine's governmental structure.

## Demographics

The 2000 Census provided a snapshot of the racial and cultural diversity of Maine's population. (Note: Census data are for the entire state population, not just the MCH population.) In 2000, Maine was 96.9% white, with little variation across counties. Statewide, 0.7% of Mainers were Asian, 0.6% were American Indian or Alaska Native, 0.5% were black or African-American, 1.0% were two or more races and 0.2% described themselves as being some other race. Less than 1% of the entire population was Hispanic; 1.2% of children under age 18 were Hispanic. A much larger proportion of the entire population is French-American; on the 2003 Behavior Risk Factor Surveillance System (BRFSS) survey, 19% of Maine adults ages 18 and over reported that they were French-American or Franco-American.

While Maine's population is predominantly white, the state is very 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. 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 95.8% in the 2002-2003 school year.

In the 2002-2003 school year, 77 languages other than English were spoken by school children in Maine. The nine most common languages spoken by Maine's Limited English Proficient (LEP) students in 2002 were French (spoken by 16.8% of LEP students), Spanish (12.9%), Passamaquoddy (10.7%), Somali (9.2%), Khmer (8.9%), Vietnamese (4.5%), Cantonese (4.0%), Russian (3.7%), American Sign Language (3.4%), and Serbo-Croatian (2.8%). (Note: The National Clearinghouse for English Language Acquisition & Language Instruction Educational Programs' Web site glossary states that LEP refers to students who have insufficient English to succeed in English-only classrooms.)

LEP students make up a small, but growing, proportion of Maine's school children. During the 2003-2004 school year, 1.6% of Maine students were LEP. This represented a 68.6% growth in LEP enrollment since the 1993-1994 school year; during this same time period, the total school

enrollment in the state decreased by 10.9%.

Culturally and linguistically diverse (CLD) is another term used to describe diversity. The National Clearinghouse for English Language Acquisition and Language Instruction Educational Programs' Web site glossary states that the phrase refers to individuals from homes and communities where English is not the primary language of communication, although the individual may be bilingual or a monolingual English speaker. While statewide statistics are not available, in October 2003, 25.4% of Portland's public school students were CLD; the school-specific proportions ranged from 0.0% to 62.3%.

Statewide in 2000, 0.5% of Maine children 5-17 years old lived in linguistically isolated households, defined as households in which all members aged 14 years and older speak a non-English language and also speak English less than very well. The highest concentration (6.7%) of children in linguistically isolated households was found in the Madawaska primary care service area in Aroostook County.

Beginning around 2001, the number of people with Somali ancestry living in Maine began to steadily increase. People from Somalia who were assigned to Maine through the Refugee Resettlement Program found the size and safety of the communities in Maine and the values of Maine communities were compatible with the values of the communities they left behind in Somalia. Word spread through the network of Somali people in other parts of the United States resulting in an in-migration of people of Somali ancestry from other parts of the United States. Since 2001 approximately 3,000 Somalis have moved into Lewiston representing about 8% of the small city's population (2006 US Census estimate of 35,734). The same period saw over 1,600 Somalis moving to Portland. Initially Maine's largest cities of Portland and Lewiston were not prepared to provide services of the magnitude needed by refugee secondary migrants, Maine's newest residents. The initial year or so had some rough waters; however as the numbers of residents grew the capacity to provide more culturally appropriate services has grown and improved services continue to attract new arrivals at a rate of approximately 30 each month; most are settling in Lewiston.

The availability of interpreter and translation services has increased since 2000, with the greatest growth in capacity in Portland and Lewiston, two of our largest cities. Public Health Nursing (PHN), a Title V program, uses a combination of individual translators and a language phone line. RISinterpret, a program of Catholic Charities Maine Refugee and Immigrant Services, has an ongoing contract with PHN to provide translation services. The other Title V programs rely primarily upon language phone line translators.

#### Current Socioeconomic Indicators

At the time of the 2000 Census, 79.2% of Maine women ages 22-44 were in the labor force; 3.9% of these women were unemployed. The corresponding figures for the United States were 73.4% and 5.4%. The proportion of women ages 22-44 who were in the labor force ranged from 72.7% to 81.9% across Maine counties. The county-specific proportion of women in the labor force who were unemployed ranged from 2.8% to 7.8%. (CSNA) The average unemployment rate for Mainers (male and female combined) in 2003 was 5.1%. ***//2009/ Maine, like the rest of the country is experiencing a downturn in the economy. A large portion of Maine's economy is service related and as money tightens people tend to stop using services they feel can be delayed indefinitely, and reduced services result in higher unemployment. With economic activity slowing, the Maine Department of Labor reported a preliminary seasonally adjusted May rate of 5.4% up from 4.7% for May 2007. We anticipate the rate to increase in the coming months as high gas prices are expected to impact the state's tourist industry. Job gains were recorded in the areas of health care, professional and business services and leisure and hospitality services. Job losses continue to be in manufacturing, construction and financial services. //2009//***

Maine women ages 18-64 with disabilities are less likely to be employed than are women in the same age range who do not have disabilities. The 2000 Census found that 44.6% of women with a sensory disability, 30.7% of women with physical disabilities, 28.4% of women with mental disabilities, 18.4% of women with self-care disabilities, 31.7% of women with go-outside-home disabilities, and 56.7% of women with employment disabilities were employed. The employment rates for Maine women ages 18-64 without each of these disabilities ranged from 72.3% to 75.2%. (CSNA) Maine has not yet met the Healthy People 2010 goal to eliminate disparities in employment rates between working-age people with and without disabilities.104 (CSNA)

Statewide in 1999, 16.2% of children under 5 years were below the federal poverty level, as were 12.9% of children 5-17, and 10.0% of individuals ages 18-64. (CSNA) The comparable percentages in 1989 were 15.7%, 13.1%, and 8.9%, respectively. (CSNA) ***//2009/ A 2008 Maine Development Foundation report showed an increase in the poverty rate of Maine children 0-5 years from 13.9% in 2000 to 23.6% in 2006. The national rate was 19.3% and 20.7% respectively. //2009//***

Looking at families in 1999, 16.0% of families with related children under 5 years of age were below the poverty level in Maine; the comparable figure for families with children under 18 years was 11.9%. A third (36.4%) of families with a female householder, no husband present, and related children under age 18 were below the poverty level; that figure rises to half (54.7%) of such families with children under age 5. (CSNA)

There is considerable variation in poverty and income measures across Maine counties. For example, the county-specific proportions of children under age 5 who are below the federal poverty level range from 10.5% to 25.2%.

The Maine Center for Economic Policy has calculated estimates of what Maine families need to earn to make ends meet in today's marketplace. This livable wage is based on a basic needs budget that takes into account actual living expenses, including housing, health care, child care, transportation, and taxes. The livable wage is considerably higher than both the federal poverty level and the income of a minimum wage earner. The federal poverty level for a family of four in 2002 was \$18,100. The annual income required for a 2-parent (2-earner) 2-child Maine family to meet a basic needs budget, in contrast, was \$44,964, or 248% of the federal poverty level. The county-specific livable wage for this type of family was \$41,207 to \$50,111, or 228% to 277% of the federal poverty level. (CSNA) As such, while significant portions of the MCH population are under the federal poverty level; even higher proportions are in families that do not earn livable wages. On March 31, 2006 Governor Baldacci signed into law L.D 1854, An Act to Expand the Alternative Aid Program. This bill increased the availability of alternative aid assistance in connection with the Temporary Assistance for Needy Families Program from a one time opportunity to once per calendar year in order to assist families who seek short-term assistance to obtain or retain employment or housing. The income eligibility limit for this program was increased to 133% of the poverty level. Another bill that directed the Department of Health and Human Services to annually report to the joint standing committee of the Legislature (Health and Human Services) having jurisdiction over health care matters on the Department's efforts toward meeting a goal of ensuring that at least 70% of eligible children had access to child care subsidies was voted out unanimous ought not to pass. ***//2009/ The WIC Program has seen a significant increase in the number of participants. Monthly enrollment has increased by almost 1,000. In addition there has been a sharp increase in the cost of WIC packages. //2009//***

The Maine Development Foundation reported in 2004 that for the past 8 years only about 66% of jobs in Maine had paid a livable wage. (CSNA) In an effort to help the many Maine residents who struggle with one or more jobs to make ends meet, on April 13, 2006 Governor Baldacci signed into law L.D. 235 An Act to Increase the Minimum Wage. This bill increased the minimum wage from \$6.50 to \$6.75 October 1, 2006 and to \$7.00 per hour effective October 1, 2007. While this rate is higher than the federal minimum it continues to lag behind other New England states

(Vermont \$7.25, Rhode Island \$7.10 and Connecticut \$7.40). ***/2009/ LD 1697 signed by Governor Baldacci on April 17, 2008 will increase Maine's minimum wage to \$7.25 October 1, 2008 and \$7.50 starting October 1, 2009. //2009//***

Homelessness has increased significantly in Maine in recent years. It is estimated that in 2002 about 1,200 people were homeless in the state on any given night; 400-500 of these individuals were children. Over the course of a year, nearly 10,000 people spend time in homeless shelters; about 12% of these individuals meet the federal definition of chronic or long-term homelessness. In March 2002, people who were chronically homeless used as much as 70% of shelter resources in the state. Maine State Housing Authority (MSHA) data for July 2002 showed that 36% of people seeking shelter were female and 28% were under 18 years of age. Over half of shelter guests had substance abuse issues, but only 16% were currently receiving substance abuse services. A third (33%) of homeless individuals had serious mental illnesses; 40% had dual substance abuse and mental illness diagnoses. (CSNA)

***/2009/ A Point in Time Survey conducted by the MSHA on January 30, 2007 revealed 829 people, including 176 children were homeless. Of the people identified as homeless, 516 agreed to complete the survey. 454 respondents were adults (18 years or older) and 46 were youth (under 18 years old). Of those for which gender data was collected, 37% were female, with the number of females peaking between the ages of 20 and 29. Fourteen percent of Maine's homeless population reported being homeless for more than one year with half of these homeless for more than 2 years. In contrast, 64% reported being homeless for 6 months or less. Four counties, Cumberland (31%), Androscoggin (14%), Kennebec (9%), and Penobscot (22%) accounted for 76% of Maine's homeless population. These same counties account for nearly 49% of the total population.***

***Factors most frequently cited as reasons for homelessness included inability to find work or pay rent, mental health issues, alcohol or drug abuse, and lack or loss of transportation. Domestic violence was reported as a contributing factor by 9% of respondents. Mental health conditions, especially depression, topped the list of conditions reported with 49% of respondents reporting depression, 40% reported anxiety and 14% reported other mental health issues. About 49% reported receiving any mental health services. //2009//***

In 2002, housing resources for homeless people in Maine included 699 shelter beds for individuals, 356 shelter beds for families, 781 transitional housing units for individuals, 415 transitional housing units for families, 820 permanent supportive housing units for individuals, and 124 permanent supportive housing units for families. There are, however, gaps in program capacity. Shelters are sometimes completely filled and available beds are not always located within a reasonable distance of where homeless individuals are. As of 2002, 861 additional transitional housing units for individuals were needed, as were 994 transitional housing units for families, 621 permanent supportive housing units for individuals, and 640 permanent supportive housing units for families. (CSNA)

***/2009/ Affordable housing continues to create challenges for many Maine residents. According to MSHA 13 of 16 Maine counties were considered to have affordable housing in 2000. Cumberland, Lincoln and Knox counties, all in southern Maine, were not considered affordable. By 2006, only 2 Maine counties were considered to have affordable housing; Aroostook and Somerset, both in the northern part of the state. In addition, a slowing economy, high heat and gas costs and rising food prices are major issues facing Maine's most vulnerable. //2009//***

#### Health Disparities

The majority of states have traditionally reported health disparities as health status differences between Blacks (African Americans) and Whites (Caucasians). In Maine our statistics don't show

this ethnic disparity, probably because there is statistical insensitivity to the small numbers of Black residents in Maine. Maine's disparities are correlated with differences in education, income and low population densities of our rural areas. As part of Healthy Maine 2010 the Maine CDC looked at seven factors that may lead to health disparities in Maine: 1) race and ethnic background 2) sexual orientation (gay, lesbian, bisexual, transgender) 3) socioeconomic status (low income/less education) 4) disability 5) geography (urban versus rural) 6) gender and 7) age. The Maine CDC, in conjunction with the University of Southern Maine, Muskie School worked together to define the collection and reporting of data by race and ethnicity in response to federal OMB-15. The result of this work was to include the following racial categories on various Maine CDC forms: White, Black/African-American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and Other. Ethnic categories include Hispanic and given the state's large Franco-American population the workgroup recommended that the Maine CDC pilot Franco-American as an ethnicity option on forms and surveys. Pilots were conducted through the Maine Child Health fifth grade survey and the BRFSS. Analysis of the BRFSS pilot was conducted to determine potential relationships and correlations with health outcomes. Analysis revealed modest differences that seemed to be accounted for by differences in socioeconomic status and were most often not statistically significant.

### Current Political Climate

During the 1995 to 2002 administration of Governor Angus King there was significant support for issues of concern for the MCH population. Activities including the formation of the Children's Cabinet, support for SCHIP, and dedication of State awarded tobacco settlement funds to public health illustrate this commitment. As with any change in administration there was concern there would be a loss of support for MCH related issues. Fortunately this did not occur.

John Elias Baldacci, the first Democratic Governor in 16 years, was elected Governor in November 2002 and is . was re-elected in November 2006. The Democratic Party also won leadership of the Maine House and Senate. In the 2004 elections, the Democratic Party retained leadership of the Maine House and Senate. Maine's congressional delegation remains divided among the Republican and Democratic Parties. Olympia Snowe (R) and Susan Collins (R) represent Maine in the Senate and Thomas Allen (D) and Michael Michaud (D) in the House.

In 2002, during the gubernatorial election, now Governor John E. Baldacci promised to merge the Departments of Human Services and Behavioral and Developmental Services and to significantly change the structure and culture. Effective July 1, 2004 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. During FY05, the Department focused on determining the new organizational structure that would best achieve the statutory mandates listed above. The Legislature approved the plan submitted by Commissioner Nicholas. (See Organizational Structure Section III C) John R. Nicholas was confirmed Commissioner of DHHS in April 2004. Commissioner Nicholas retired in January 2006. Brenda Harvey, the acting commissioner of the former Department of Behavioral and Developmental Services was appointed acting commissioner of the DHHS. In April 2006, Governor Baldacci nominated Ms. Harvey to be the permanent head of the DHHS. She was confirmed on April 27, 2006.

Maine continues to be challenged economically particularly with our Native American population, some of Maine's poorest residents. Several referendum efforts put before the residents of Maine for improving the economic status of the Penobscot and Passamaquoddy tribes were defeated. Since November 2003 little progress has been made on potential economic sources of independence. In March of 2005 hope of a liquefied natural gas terminal on tribal land was lost when the local community voted against the terminal. LD 1911, worth a total of \$1 million a year for two years, before the Legislature's Appropriations Committee would provide Maine Indian tribes with crucial seed money to bid on federal contracts and develop niche businesses that would expand economic opportunity across the state. These funds were to assist the tribes with

feasibility studies, implementation of economic projects, matching funds and economic development planning activities. Some business ideas included precision machining, wind-power generation, and highway construction. The Houlton Band of Maliseet Indians announced in early 2006 their intent to build a bio-diesel processing plant on tribal land in southern Aroostook County. A feasibility study was completed but financing has not been secured. The Penobscot Nation opened a distribution center on Indian Island for mail-order prescription drugs (maintenance drugs for chronic conditions such as diabetes, high blood pressure and high cholesterol) in late 2005. The mail-order prescription drug distribution center closed in early 2007 as a result of lower than anticipated sales. The tribes continue to seek business opportunities that will improve their economic status.

#### 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 expanding Medicaid and creating CubCare, a Medicaid-like Child Health Insurance Program (CHIP). This state operated insurance program for children, which includes EPSDT, was for ages birth through 18 years in families between 133% and 185% of the federal poverty level. In October 1999 the eligibility level was increased to 200% FPL. There is some cost-sharing for the CubCare Program. Outreach activities resulted in an increase in Medicaid enrollment to a current maximum of approximately 162,000. There are 27.5% (82,415) children ages 0-17 participating in Medicaid. Expansion of Medicaid and CubCare notwithstanding, 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. During the first session of the 120th Legislature, the name of the public insurance programs (i.e. Medicaid, CubCare, etc.) was changed to MaineCare. The name change went into effect in 2002.

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. ***//2009/ 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. //2009//***

#### Statewide Health Care Delivery System (County & 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 maintain local health departments, 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 local health departments and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. All 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. *//2007/* 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. Recently SIHS worked with the Ellsworth WIC office to become a WIC site and now provides WIC services to Island women and infants. SIHS also met with and had a Case Manager, Occupational, and Speech Therapist from the Child Development Center in Ellsworth make a trip to one of the Islands to do pre-school screenings. The Program also arranges with providers around the state to deliver educational sessions via videoconference. Recent sessions included topics on domestic violence and Lyme disease. //2007//

Through Public Health Emergency Preparedness (PHEP) efforts and activities related to the Maine Turning Points Project, the Maine CDC and its' public health partners continue to focus on strengthening public health functions at the local level. Legislation to develop regional public health areas was withdrawn pending an assessment of its' fit with the Governor's proposed health plan. Establishment of regional epidemiology teams occurred through the state's PHEP activities, with the state divided into six (6) regions that align with the Emergency Medical Services regions. /2007/ Renewed discussions around Maine's public health infrastructure began during the past year 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 is to report to the Legislature on any action that it has taken with regard to core competencies, functions and performance standards for CCHCs and the resource inventory and integration of funding sources. The report must also include 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, is a member of the workgroup. //2007// **/2009/ The new agreed upon structure is described in Section IV A. //2009//**

The Governor's Office of Health Policy and Finance lead 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. Anthem Blue Cross and Blue Shield won the award to provide the health benefit package for Dirigo Health. Enrollment in the Dirigo Health Insurance Plan started January 1, 2005. **/2009/ Effective January 1, 2008 Harvard Pilgrim took over coverage for DirigoChoice subscribers. //2009//** As of June 1, 2005 enrollment in Dirigo, including dependents was 7,311. Of those 2,925 were small business employees, 2,525 self-employed individuals, and 1,861 individuals who were unemployed or did not receive coverage through their employer. The Dirigo Health Agency reported 10,111 members enrolled as of May 31, 2006 an increase of 2,800 since June 30, 2005. More than 47% or 1,322 enrolled during January 2006. The higher January numbers were attributed to renewals or new plans that typically take place during January of each year. In addition Dirigo placed a cap on individual enrollment for the period June through December 2005 resulting in a flurry of activity when enrollment re-opened. Funding of the program continues to be controversial. A very contentious issue during 2006 was a Savings Offset Payment, 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. The state's Superintendent of Insurance determined the savings to be \$43.7 million, a figure insurers felt was far less; no resolution was reached. 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 and on proposed changes in the program. Exceptions will be made for babies born to women who are already covered by Dirigo and new employees of small businesses with Dirigo contracts. **/2009/ As of August 2007 Dirigo Choice was covering about 15,113 individuals (49%) and employees of small businesses (23%); the remaining 28% are sole proprietors.**

***LD 2247 "An Act to Continue Maine's Leadership in Covering The Uninsured was signed by the Governor on April 16, 2008. In part this bill repealed the savings offset payment and replaced it with a health access surcharge on paid claims, broadened beer and wine taxes and imposed wholesale taxes on soda and syrup to fund the program providing for greater access to the uninsured. //2009//***

In March 2006 Governor Baldacci proposed moving the Dirigo health plan out of Anthem Blue Cross/Blue Shield, the private insurer who had provided coverage during the prior year. He wanted Dirigo's Board to self-insure by creating a non-profit entity to run the insurance program. The Governor felt that self-insuring would eliminate the profit incentive allowing for the savings to pay for more coverage for Maine's uninsured. 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. ***//2009/ 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: [www.maine.gov/governor/baldacci/cabinet/health\\_policy.html](http://www.maine.gov/governor/baldacci/cabinet/health_policy.html). //2009//***

#### 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 (33 are birth hospitals with obstetrical services); 12 critical access hospitals; 17 Federally Qualified Health Centers (FQHC); 1 FQHC Look-a-like (St. Mary's 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. ***//2009/ In 2009 MMC will begin an affiliation with Tufts University School of Medicine in Boston (allopathic medical school). 20 of 36 seats will be reserved for Maine students. Three schools (University of Southern Maine, University of Maine at Orono and Husson College) offer Nurse Practitioner Programs. //2009//***

#### 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 Genetics Program 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. Historically a greater proportion of Maine women (between 86 and 89%) receive prenatal care during the 1st trimester. Maine women receive routine clinical checks and pre-natal education. The Partnership for A Tobacco-free Maine is aggressively addressing smoking cessation among pregnant women and the 2000 PRAMS has added a smoking question to begin capturing data on this issue. There has been a decrease in the number of women who report drinking alcohol during pregnancy. In 1990 11% reported consuming alcohol while pregnant and in 2002, 5% reported drinking alcohol during the last 3 months of pregnancy. (PRAMS). We are hoping this is a reflection of increased education and awareness among patients, providers and staff who interface with pregnant women and new

mothers. ***//2009/ A Perinatal Substance Abuse Workgroup was formed in October, 2003 by the MCH Medical Director to address the growing issue and number of babies exposed to prescribed narcotics and illicit drugs while in utero. Several educational conferences have been held for nurses, physicians, social workers and recovery treatment providers. Since his departure in January of 2008, Kelly Bowden, coordinator of the Perinatal Outreach Grant, is leading the group. A Future Search Conference is planned for winter 2009 on the topic of perinatal addiction. //2009//***

#### High-Risk Care

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. The Level II nursery in Lewiston has notified area hospitals that, with the departure of one of their neonatologists, it can no longer care for infants at less than 32 weeks gestation. Eastern Maine Medical Center, Level III Nursery in Bangor is gradually recovering from staffing changes through recruitment of nurses and neonatal Nurse Practitioners. An experienced neonatologist joined the staff in 2005. The Central Maine Medical Center in Lewiston continues to limit its scope to pregnant women and neonates beyond 32 weeks gestation.

#### Birth Defects

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. Rules for the BDP were promulgated in April 2003 and mandatory reporting began in May 2003. Through a collaborative partnership with the University of Maine's Center for Community Inclusion and Disabilities Studies the database system, ChildLINK, was developed to link public health data systems such as birth certificates, infant deaths, newborn hearing screening, newborn bloodspot screening and birth defects.

Abstraction of medical records for the BDP started in August 2003. Use of the ChildLink database and tracking system began implementation in March 2004 with the first hospital, Eastern Maine Medical Center in Bangor, beginning to report hearing screening results directly into the online database system. The MBDP reports on the birth prevalence of 17 major birth defects. These birth defects fall into four major categories; central nervous system, chromosomal, musculoskeletal, and cardiac. During CY05 there were 47 confirmed cases and 6 for CY06. The coordinator is in the process of confirming the remaining 200 cases. ***//2009/ During FY07 the MBDP analyzed data from May 1, 2003 - December 31, 2006. Of the 52,210 births 197 infants had a confirmed birth defect. With Maine's relatively low birth rate (approximately 14,000 per year) it may take several years of data gathering to determine the occurrence rates of selected birth defects. The MBDP will use the data to provide information to the public and health care professionals about factors that may reduce or increase a woman's chance of having a baby born with a birth defect. The MBDP is planning to expand the list of reportable birth defects to include upper and lower limb deformities and hypospadias //2009//***

#### 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 963 Certified Nurse Practitioners in Maine but the Board of Nursing is unable to report on practice location. We estimate that 94% of our children 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 Office of MaineCare Services (Medicaid) transitioned to a Client Management Information System beginning in January 2005. The new system is HIPAA compliant and requires more detailed billing information than with the prior system. This resulted in the rejection of numerous claims from service providers. The problems are gradually being resolved though many service providers/agencies remain in a precarious financial situation until all issues are resolved. ***/2009/ Ongoing challenges with the system resulted in the decision to outsource to a fiscal agent, UNISYS, via contract. Transition planning is underway with projected implementation in July 2010. //2009//***

#### CSHCN Services

***/2009/ 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 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 513 infants, youth and children with primary conditions of cleft lip and/or palate (46%) and diabetes (20%). The Department of Education (DOE), Division of Special Services reports that 38,314 students (3-21) 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 996 children ages 0 - 2 were served. //2009//***

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 6 regional Youth Advisory Councils and Family Advisory Councils. These 12 advisory councils submit an annual report card on the extent to which the six outcomes are being achieved.

#### Maine's Access to Dental Care

In 2005, thirty-nine of Maine's 46 Dental Care Analysis Areas were designated as Dental Health Professional Shortage Areas (30 as population designations, including 2 Indian reservations, 9 as service area designations) along with the two state-administered mental health facilities in Augusta and Bangor. Two areas, Portland and Lewiston, may lose those designations with changes in area income characteristics and are proposed for withdrawal. Figures from the 2006 Maine Cooperative Health Workforce Resource Inventory indicate that the resident to dentist ratios in 11 of the 16 counties remain substandard to the state ratio of 1 dentist to 1700 residents. Fewer than half of Maine's practicing dentists treat MaineCare patients and relatively few will accept new MaineCare patients. Many dental practices in Maine continue at or close to capacity and many individuals, regardless of insurance or financial status, report difficulty in finding a dentist who is accepting new patients. In certain areas timely access to services continues to be of great concern. 24 private non-profit dental clinics in Maine (of which 11 are federally qualified health centers), 3 state operated clinics that serve behavioral health clients, and 3 Indian Health Services dental clinics; there are also a number of preventive dental services programs and 3

programs that rely on volunteer dentists and referral networks.

Efforts to improve access to dental services in Maine have continued. The Oral Health Program (OHP) continued its support of the statewide Maine Dental Access Coalition, which functions as network and constituency 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. 13 agencies, providing services at 17 sites, participated in the Subsidy Program in FY05. Through the late 2003 round of DSDSP competitive grants, 10 agencies received funding; 8 grants were made for development and expansion and 2 for case management and community education. These grants included three budget periods, one through June 30, 2004 and the others for the succeeding state fiscal years, terminating on June 30, 2006. ***//2009/ These grants were continued through June 30, 2008. A planned RFP has been delayed pending decisions about funding allocations and consistency with other funding programs relative to Maine's new public health districts. The OHP, with support from a State Oral Health Collaborative Systems Grant from MCHB, published a state oral health improvement plan in 2007. Stakeholder groups will be brought together to focus on developing action steps and accountabilities for the Plan strategies.***

***On September 14, 2007, Governor Baldacci signed an Executive Order establishing the Task Force on Expanding Access to Oral Health Care for Maine People. The Task Force is charged to develop recommendations for "short and long term solutions to expand access to high quality oral health care programs for all Maine residents," particularly children, the elderly, the underinsured and the uninsured, and to identify existing barriers to access and provide oral health care for Maine residents. The Task Force includes a representative from DHHS Office of MaineCare Services and staffing assistance is being provided by the OHP. The Task Force has been directed to (1) review relevant data and information on the status of oral health in Maine, as well as national studies on access to oral health care; (2) define a multi-year systems development approach to improving oral healthcare infrastructure, access to dental services and oral health status in Maine; and (3) consult with public and private individuals and organizations that provide medical and oral health care currently for the purpose of building upon existing relationships and partnerships.***

***The University of New England, a private institution with a unique emphasis on osteopathic medicine and health care workforce development, has embarked on a planning process to determine the feasibility of a dental school for Maine and Northern New England. UNE's Board made a preliminary endorsement of the College of Dental Medicine on May 9, 2008. Work will continue over the summer preparing for internal approval and final Board approval in October 2008, with a goal of starting classes in fall 2010.***

***The University College of Bangor (UCB), a campus administered by the University of Maine Augusta, sponsors the only accredited program for certified dental assistants in Maine. In the fall of 2008, UCB will launch its new Dental Assisting at a Distance program. The goal is to increase the pool of people who would be eligible to enroll in Expanded Function Dental Assistant (EFDA) training programs. EFDAs are seen as contributing to the productivity of dental practices and thereby to increasing access to services. //2009//***

#### Mental Health Services

Traditionally the Office of System Integration had leadership responsibility for mental health in the state. The creation of the new DHHS in July 2004 opened up a myriad of possibilities for the Title V and Mental Health Agencies to unite in leadership to strengthen the systems and policies to support healthy emotional and cognitive development for all children and families. Mental health services (including substance abuse services) are divided into two populations, adult and children. These are being integrated with other services provided to those populations for a more

effective and efficient delivery of services. 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 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 fallen through the cracks.
3. Continued efforts, particularly through a Healthy Tomorrows Grant for a Behavioral and Developmental Clinic in York County and a Maine Health Access Foundation Grant to Kennebec Valley Mental Health, to integrate mental health into primary health care systems for the MCH population. *//2009/ In April 2008, after negotiations between Southern Maine Medical Center and the Maine DHHS Commissioner Brenda Harvey, Dr. Donald Burgess succeeded in getting his pediatric office practice certified as a mental health provider; a first in the state. Dr. Burgess, the President of the Maine AAP Chapter, has been a champion in efforts to integrate mental health services into primary health care for children and youth. //2009//*
4. Continued involvement of Title V leadership in a SAMHSA grant to strengthen state and local mental health systems as they relate to emergency preparedness.
5. Continued involvement of Title V leadership with efforts to strengthen systems of care for children affected by trauma. Such involvement included participation in a statewide conference in May 2005 on the relationship between adverse childhood experiences (ACE) and adult morbidity and mortality.
6. A new 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.

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. At the center of public health is the human mind and spirit. The Maine Title V Program views the mental and spiritual health of children and families within the context of our five global priority areas as outlined in Section IV B of this application. We continue to sharpen and increase our focus on issues involving the mental health and primary 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 are left picking up the slack, and they have to deal with a complex 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 mental health since 2003.

A promising model that we want to put into practice in Maine is an integrated system of primary care and mental health. 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 mental health care and focuses on developing a link between the child's medical home and their mental care system.

In 2001, at a meeting of the Public Health Committee of the Maine Medical Association, facilitated by Maine CDC Director Dr. Dora Mills, physicians identified mental health services as a pressing public health concern. In 2002, CBHS joined with the Maine Center for Public Health (MCPH) to continue this dialogue. In 2003, the MCPH, with strong support and involvement by the MCH Medical Director, received a planning grant from the Maine Health Access Foundation. The intent of the grant, conducted in partnership with CBHS, Maine Medicaid, and the Maine CDC, was to develop evidence-based integrated practice models that would be tested in a subsequent two-year applied research project. We hope that testing the models at a small number of sites will

lead us to understand what works and what doesn't. The model can serve as a strategy for the state as a whole.

The planning grant ended in 2004. The Maine Health Access Foundation did not express interest in a follow-up system of care grant so the grant expired. CBHS took steps to further address this issue through action led by a newly hired Medical Director for Mental Health, 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 mental 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 newly funded 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. /2008/ A uniquely strong partnership between the Trauma-Informed System of Care Grant (Project THRIVE) and Title V has emerged. Since Title V, Project THRIVE, and the CBHSs of DHHS share a strong commitment to Future Search Principles (getting the whole system in the room, explore the whole context before acting on parts of it, focusing on common ground, and sharing management and responsibility), this new partnership is a natural fit. The MCH Medical Director's leadership on cultural and linguistic competence parallels and complements the work of Project THRIVE. At the September 2006 Future Search Conference, "Coming Together to Create Family Centered Practice: A Future Search for Child and Family Systems in Maine", the Executive Director and Youth Coordinator at THRIVE played an instrumental role in assuring that youth involvement and cultural competence were two key common ground items that everyone agreed to. The Early Childhood Coordinator and the MCH Medical Director helped plan and facilitate this conference, and the ECC Coordinator has led the follow-up efforts which involve THRIVE. Further, both THRIVE and CBHS took part in the remarkable Maine AAP Open Forum on Adverse Child Experience Study and Resiliency held in November 2006. //2008//

The MCH Medical Director's leadership has helped to identify and recruit a group of Maine pediatric practices that are ripe for testing the models; made sure that the efforts of the State Early Childhood Comprehensive Systems Grant are connected with those of the project; advocated strongly for family and community involvement in all phases of the project; and joined in a panel on public policy at a statewide conference on mental health and primary health care in June 2004.

/2008/ Efforts are underway through Title V and Maine AAP, in consultation with ACE researcher Vincent Felitti, and resiliency researcher Emmy Werner to develop a clinical practice tool that will enable primary care health providers to screen for traumatic experiences and protective factors. The long-term goal is to create a system that will foster the conditions needed to minimize and ultimately prevent adverse child experiences. //2008//

## **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 Division of Family Health and the Division of Chronic Disease 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

Maine Department of Health and Human Services, Division of Chronic Disease and Family Health (1997) and Family Health (1999), Vision Statement.

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 Muskie School of the University of Southern Maine; 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 Institute for Public Sector Innovation representations, have also provided guidance and education regarding strategic planning and coalition building, skills essential to a healthy Title V program.

For several years the Division of Family Health has worked to increase our MCH epidemiology capacity. The State Systems Development Initiative (SSDI) grant was restructured during fiscal year 2000 to provide partial support for the salary of a Masters prepared Epidemiologist specific to MCH. The SSDI funds were pooled with funds from the Childhood Lead Poisoning Prevention and Asthma Programs to hire a full-time Masters prepared Epidemiologist (Kathy Decker, MPH), who began in December 2000. During the summer of 2000, the Title V Director worked with Dr. Sonnenfeld, Chronic Disease Epidemiologist, in developing an application for a grant from the Council of State and Territorial Epidemiologists (CSTE) to support the hiring of a PhD prepared Epidemiologist for MCH. The application was approved and in the spring of 2002 Dr. David Ehrenkrantz, PhD in Public Health Administration, was hired as the MCH Epidemiologist. Dr. Ehrenkrantz resigned the position in April of 2004. In July 2004 a second Masters prepared epidemiologist was hired (Cindy Mervis, MPH), bringing the Epi Team to a total of 3 staff. A year long search resulted in the hire of Dr. Erika Lichter as the new PhD prepared MCH Epidemiologist, bringing the Epi Team to a total of 4 Epidemiologists as of June 2005. Also in 2004, the Title V Program was successful in obtaining an MCH Epidemiology Fellow, Meredith Anderson, MPH, for a two-year fellowship through the CDC and CSTE. In 2006 the Chronic Disease Division successfully obtained a Chronic Disease Epidemiology Fellow, Shannon DeVader for a 2-year fellowship through the CDC and CSTE. While her primary focus is chronic disease, she expressed an interest in MCH projects. In May 2007 Kathy Decker resigned her position. A process is underway to fill the position. **//2009/ Anthony Yartel, MPH was hired in November 2007, and Denise Yob, MPH came on board in May 2008 bringing the Epi Team to a total of 5 Epidemiologists. //2009//**

In the spring of 2005 the Childhood Lead Poisoning Prevention Program (CLPPP) organizationally moved from the Division of Family Health to the Environmental Health Unit (EHU). The EHU monitors and provides technical assistance in the area of adult lead poisoning. It was determined synergies would be gained by connecting CLPPP with EHU. The CLPPP Director attends the monthly Title V Program Manager meetings and meets quarterly with the MCH Medical Director and the Title V Director. To date this relationship has proven effective in

maintaining collaboration and coordination of the CLPPP with the Title V Program. /2008/ Over time it has been difficult to maintain a close connection with the CLPPP. As the Family Health Division completes its' organizational restructure and evaluates how business is achieved we will look at ways to better integrate. //2008// **/2009/ The leadership of the CLPPP was recently promoted to a local public health district liaison position resulting in a search for a new program director. In addition, the MCH Medical Director left his position resulting in no DFH representation on the CLPPP Advisory Committee. The Title V Director will work with the interim CLPPP Director to identify a new DFH representative for the CLPPP Advisory Committee. Recruitment for a new MCH Medical Director will begin in early FY09. //2009//** 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 the Maine Department of Health and Human Services (DHHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with DHHS's Center for Disease Control and Prevention (MCDC).

Programs, which focus primarily on the 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 Division of Family Health, with Valerie Ricker designated as the manager with ultimate responsibility for administration of the MCH Block Grant. /2007/ 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 MaineCDC Division of Chronic Disease. //2007// The Childhood Lead Poisoning Prevention Program (CLPPP) organizationally relocated to the Environmental Health Unit (EHU). Over the years the CLPPP and EHU had increasing programmatic interests which led to a greater understanding of the synergies that could be achieved with augmented day to day integration of the programs. The CLPP Program Manager will continue to participate in the monthly MCH Program Manager meetings and will meet, at least quarterly, with the Title V Director and the MCH Medical Director.

/2007/ September 17, 2005 phase 2 of the DHHS reorganization became law. Contained in the law are several components which impact the Title V Program. First is a change in name of the Bureau of Health to the Maine Center for Disease Control and Prevention (MaineCDC). Second is 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 is occurring gradually. The transfer is expected to be complete by June 2007. /2008/ Organizationally the ECI and HV moved to OCFS along with primary supervision of the ECI coordinator. The ECI coordinator physically remains within the MCDC until such time as OCFS identifies space to house the position. //2008// **/2009/ The ECI coordinator is now physically housed in the OCFS effective January 2008. She continues to meet with the Title V Director on the ECI and home visiting activities. //2009//**

In May 2005 the MaineCDC started a 5-month 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 MaineCDC. The Maine Injury Prevention and Teen and Young Adult Health Programs are now located within

the Family Health Division. The Chronic Disease Division experienced a change in leadership in December 2005. Ron Bansmer, MBA, formerly the WIC Director, was promoted to the Chronic Disease Director. //2007// /2008/ The Chronic Disease Director, Ron Bansmer, vacated the position in September 2006. A new director will begin in July 2007. //2008// **/2009/ Rebecca Matusovich, MPPM, formerly the Prevention Team Manager in the Office of Substance Abuse within the Maine DHHS was hired in July 2007. //2009//** John R. Nicholas, Commissioner of Maine's DHHS, reports directly to Governor John E. Baldacci. Commissioner Nicholas retired in January 14, 2006. Brenda Harvey was confirmed as the new Commissioner on April 27, 2006. Dora Anne Mills, M.D., M.P.H. serves as Director of the MaineCDC and is the State Health Officer. Commissioner Harvey reports directly to Governor Baldacci. She is responsible for implementing the merger of the Departments of Human Services and Behavioral and Developmental Services into the new Department of Health and Human Services. **/2009/ As part of an effort to streamline service delivery and seek administrative savings Commissioner Harvey submitted to the Governor a proposed consolidation within DHHS to reduce the number of offices from ten to six. The legislature approved the legislation. The MaineCDC will become part of HealthCare Management and Quality and Dr. Mills will report to Geoffrey Greene, Deputy Commissioner of HealthCare Management and Quality. //2009//** Ms. Ricker reports to Dr. Mills. Valerie Ricker, M.S.N., M.S. is Director of the MaineCDC Division of Family Health which houses primarily direct service programs. Rebecca Matusovich, MPPM is the Director of the MaineCDC Division of Chronic Disease which houses population-based prevention and health promotion services. Richard Aronson, M.D., MPH, is the MCH Medical Director **/2009/ Dr. Aronson resigned his position in January 2008. //2009//** We have 2 MCH epidemiologists, Kathy Decker, MPH and Erika Lichter, PhD. **/2009/ Kathy Decker took over duties in another MaineCDC Division and her MCH duties were partially assumed by Cindy Mervis, MPH. //2009//** The Division of Family Health continues to support a women's health coordinator position in an effort to focus attention on women's health in a more comprehensive manner. **/2009/ The women's health coordinator vacated in March 2008. A search to fill the position is underway. //2009//**

/2008/ A hiring freeze continues, although to date MCDC 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 positions. //2008// **/2009/ The freeze has delayed filling federally funded positions. //2009//**

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.

/2008/ In April 2007 Dora Anne Mills, MaineCDC Director approved the reorganization of the Family Health Division (FHD). The reorganization groups the FHD programs into 4 sections; special needs, public health nursing, community collaboration, and integrated systems development with the leader of each section reporting to the FHD director. Within the next year a fifth section will be developed which will focus on operational support in the areas of finance, contract management, and grant application development. //2008// **/2009/ The Integrated Systems Development section leader position vacated in March 2008 to fill a District Public Health Liaison position in the states newly emerging public health infrastructure. A process is underway to fill the position. //2009//**

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 5 positions outside the Divisions of Family Health and Chronic Disease: 1 person in the Office of Data, Research & Vital Statistics; 2 in the Health and Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); and 2 in the Department of Education (work with schools to develop and utilize comprehensive health education curriculums). 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 Young Educators and Advocators of Maine (YEA ME) Advisory with staffing provided by the CSHN Director. No staff has been hired because they are parents of CSHN although several staff members do have children with special health needs. /2008/ 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. //2008// ***/2009/ A young adult with special health needs and a parent of a child with special health needs have been hired through the State Implementation Grant. Each of these positions is a liaison to the larger FAC and YEA ME. The parent conducts follow-up for the Newborn Hearing Screening Program for infants identified with a refer at hospital discharge. 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. //2009//***

The Office of Data, Research and Vital Statistics (ODRVS) provide data for this grant application, attend the MCHBG review session, and meet with the Epi Team and DFH managers for specific data needs. Our increased epidemiology capacity is leading to increased cross-divisional work between Maine CDC and ODRVS on MCH priorities. Health & Environmental Testing Laboratory staff meets regularly with the Lead Poisoning Prevention program staff and also the STD/HIV (Sexually Transmitted Disease/HIV) staff. The Department of Education (DOE) works closely with the Manager of the Coordinated School Health Program, to develop and use comprehensive health education curriculums that include sexual health. We believe that by facilitating the development of citizens 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, CSTE 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. /2006/ The survey called, the Maine Child Health Survey (MCHS), has been administered by the Asthma Prevention and Control Program since its inception in 2002. During FY06 a plan will be developed to transition the MCHS to a more appropriate and permanent home. //2006// /2007/ Transition planning is ongoing. The planning team agreed the MCHS would be located within ODRVS. Transition planning includes identifying the human resource to provide leadership. //2007// /2008/ Changes in Asthma and Division of Chronic Disease leadership as well as the temporary reassignment of the Title V Director prevented further movement on the MCHS in 2007. Transition planning will be a high priority in FY08. //2008// ***/2009/ The planning group determined that the MCHS would become part of Maine's Integrated Youth Health Survey. The goal of this effort is to consolidate the number of schools that are asked to participate in state student health surveys and optimize school acceptance of these surveys. An RFP is currently in development that includes administration of the MCHS. Funds to conduct the survey should be awarded in Fall 2008 with an anticipated survey administration date of Spring 2009. //2009//***

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, TYAH, 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. Long-term remediation involves generation of revenue to support positions to be accomplished through fee-for-service and targeted case management. Currently there are 4 vacancies within the programs serving the MCH population. The vacancies are within the Children with Special Health Needs, Public Health Nursing Programs, and the Women's Health Initiative. 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.

In addition, Title V partially supports 52 Public Health Nurses (4 supervisors and 48 field nurses) who are based statewide in 14 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 25 years of experience in MCH, 9 years with the MaineCDC as Title V Director. She has a BSN and MSN in Nursing and MS in MCH, focusing on Public Health. Dr. Richard Aronson, MCH Medical Director, has 27 years of experience in State and Maternal Child Health Programs. Dr. Aronson is a trained Developmental Pediatrician. His previous positions were with Wisconsin and Vermont State Health Agencies. He assumed the MCH Medical Director position in August 2002. **//2009/ Dr. Aronson resigned his position in January 2008. A search is underway to fill the position. //2009//** Toni Wall is the Director of the CSHN Program and has been in this position for 5 years. She has 16 years experience working in MaineCDC Programs prior to CSHN. 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. Kathy Decker has a Masters in Public Health with a concentration in Epidemiology. She brings 5 years experience of working in State and Local Programs. Kathy has been working with the Maine CDC since December 2000. **//2006/** Dr. Erika Lichter joined the MCH Epidemiology Team in early June 2005. Dr. Lichter has an ScD in Public Health with a major in MCH and minors in Biostatistics and Epidemiology. Prior to coming to the the MaineCDC, Dr. Lichter taught at the Harvard University School of Public Health. Biographical Sketches are on file in the MaineCDC's Division of Family Health and will be made available for review on request. **//2006// //2007/** Cindy Mervis, MPH joined the Epi Team in July 2004. Ms. Mervis 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. **//2007// //2008/** Kathy Decker resigned her position in May 2007. A search is underway to fill the vacancy. **//2008// //2009/ Anthony Yartel, MPH joined the Epi Team in November 2007. Mr. Yartel was formerly with the Maine CDC Infectious Disease Division working on statewide surveillance of food-borne and vector-borne infectious diseases. His efforts will be focused on chronic disease. Denise Yob, MPH came on board in May, 2008. Ms. Yob 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 will be on MCH activities. //2009//**

## **E. State Agency Coordination**

The Maine CDC/DFH 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. The work of the Task Force on Early Childhood through the Humane Systems grant is exponentially creating ripples of communication among state agencies, community partners, and families. Maine Title V has been responsible for:

- Creating a Task Force on Early Childhood of 120 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
- 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 Dr. Aronson'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
- Providing facilitation and staffing to the Interdepartmental Women's Health Committee

The Maine CDC, Division of Family Health (DFH) continues to develop a relationship with Maine's primary care organization "Maine Primary Care Association". This organization has many competing priorities, and the former executive director did not identify MCH as a major area of focus. Their new director has experience working closely with MCH and we are anticipating an enhanced relationship with the association. The new Director, Kevin Lewis, formerly worked in Wisconsin as the Legislative Liaison for the Department of Health and Family Services. The current MCH Medical Director for Maine, who held a similar position in Wisconsin, worked closely with Mr. Lewis on a number of MCH related issues, including legislation for the Birth Defects Program. Dr. Aronson reconnected with Mr. Lewis in Maine, and they have already discussed collaboration on issues involving domestic violence, Native American health, and the fostering of primary care systems rooted in the principles of family-centered care, resiliency, and cultural and linguistic competence.

/2005/ The Women's Health Coordinator represents the DFH on the Maine Primary Care Association's Violence Against Women Governmental Affairs Planning Grant Committee. The DFH, in partnership with the Maine Primary Care Association and the Department of Behavioral and Developmental Services, submitted an application to the Maternal Child Health Bureau on a women's health grant in April 2004. The MCHB funding focused on three areas of women's health: development of comprehensive systems of services, obesity, and mental health. The DFH application focused upon the mental health area and was titled Women's Behavioral Health Systems Building: Innovative Ideas for Local and State Collaboration. Review of grants is scheduled for late June. If successful in our application this funding will assist us in continuing a focus on women's health and create new partnerships for the Division and Bureau. //2005// /2008/ Maine was successful in its' application. Activities of the grant were included in the 2006-2007 State Health Plan. The grant ends August 31, 2007. //2008//

***An attachment is included in this section.***

## **F. Health Systems Capacity Indicators**

### **Introduction**

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	36.1	22.9	22.0	23.5	
Numerator	243	155	149	165	
Denominator	67374	67628	67660	70245	
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	

**Notes - 2007**

2007 hospitalization data are not yet available.

**Notes - 2006**

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

2006 population estimate from the US Census was used as denominator

**Notes - 2005**

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

2005 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 Maine's Office of Data, Research and Vital Statistics. Based on the most recent data available, the rate of hospitalization for children under age 5 was 23.5 per 10,000 in 2006. This rate is slightly higher than the 2005 rate, but since 2004, the rate of asthma hospitalizations among this population has remained relatively stable.

Through funding from the Centers for Disease Control and Prevention, the Maine Asthma Program (MAP) has been working to improve asthma management among children with the goal of reducing hospitalizations. These 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 and providing peak flow meters to children, and training school nurses on asthma management plans. MAP received a CDC grant to continue to develop strategies to improve asthma management in the State. These strategies include enhancing Maine's asthma surveillance system, and building and evaluating partnerships. However, the MAP was without a full-time program manager for most of the past year. This has slowed down progress on implementing the strategies outlined in the grant. In addition, Maine's MCH Medical Director left his position in early 2008. He was a key link between Maine's Title V program and the MAP. Maine's MCH Epidemiologist continues to be involved in some of the data-related activities concerning asthma and in some of the evaluation efforts of the MAP. A full-time program manager was hired in late 2007, Ruth Lawson-Stopps. Ms. Lawson-Stopps has been

meeting with stakeholders across the state to develop partnerships and is currently working on revising Maine's State Asthma Plan.

MAP is also now part of the Healthy Maine Partnership Initiative. This initiative provides funding to communities to address health issues that are important in their community and in the state. By funding local community-based coalitions, we anticipate increased efforts across the state to improve childhood asthma management. Maine also is in the process of building local public health infrastructure to improve the health of the population. Regional public health districts will have Maine CDC staff to coordinate and build community partnerships. It is anticipated that increased local public health infrastructure will lead to improvements in many health outcomes across the state, including asthma.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	92.9	86.8	86.1	89.9	88.6
Numerator	11730	6034	6335	6494	6711
Denominator	12632	6952	7354	7221	7574
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 - 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.

**Notes - 2006**

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

2006 indicator is for Federal Fiscal Year 2006 (10/1/05-9/30/06).

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. The large increase in the numerator in 2000 reflects a greater understanding by Medicaid of what the data means. Specifically, starting in 2000, Medicaid pulled any claim whatsoever, while prior to 2000, it pulled claims by a combination of category of service and procedure codes. The HEDIS methodology of using 11 months of continuous eligibility is not used. The denominator is based on children determined to be Medicaid eligible on a month to month basis. If a child is eligible for any one month, he or she is counted for inclusion. The denominator increased in 2001 primarily due to increased enrollment for the Healthy Maine Prescriptions Rx Program. The Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

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.

#### **Notes - 2005**

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

2005 indicator is for Federal Fiscal Year 2005 (10/1/04-9/30/05).

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. The large increase in the numerator in 2000 reflects a greater understanding by Medicaid of what the data means. Specifically, starting in 2000, Medicaid pulled any claim whatsoever, while prior to 2000, it pulled claims by a combination of category of service and procedure codes. The HEDIS methodology of using 11 months of continuous eligibility is not used. The denominator is based on children determined to be Medicaid eligible on a month to month basis. If a child is eligible for any one month, he or she is counted for inclusion. The denominator increased in 2001 primarily due to increased enrollment for the Healthy Maine Prescriptions Rx Program. The Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

It is difficult to interpret any differences between the 2004 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.

**Narrative:**

Data for this indicator are provided by Maine's Office of MaineCare Services (OMS). In FY07, 89% of MaineCare (Medicaid) enrollees under 1 year of age received at least one initial periodic screen. However, due to claims bundling by Rural Health Centers, Federally Qualified Health Centers, 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 data.

In November 2007, the administration of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency. The EPSDT Program is currently managed by Maine's Children with Special Health Needs Program. With increased oversight of this program, Maine's Title V agency will be better able to ensure infant access to periodic screens.

In addition, as part of Maine's State Systems Development Initiative 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.

Finally, the Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	62.3	72.0	75.0	87.9	82.6
Numerator	71	18	27	29	19
Denominator	114	25	36	33	23
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 - 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.

**Notes - 2006**

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 2006 indicator is for federal fiscal year 2006 (10/1/05-9/30/06).

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 maymake 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.

**Notes - 2005**

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 2005 indicator is for federal fiscal year 2005 (10/1/04-9/30/05).

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 2004 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.

**Narrative:**

Data for this indicator are provided by Maine's Office of MaineCare Services. In FY06, the data indicate that 82.6% of MaineCare enrollees under 1 year of age received at least one initial periodic screen. This represents a decrease between FY06 and FY07. However, 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, Federally Qualified Health Centers, 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. We believe this results in under reporting for this indicator.

As mentioned above, in November 2007, the administration 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. With increased oversight of this program, Maine's Title V agency will be better able to ensure infant access to periodic screens. 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. Finally, the Dirigo Health Plan will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	86.1	86.9	87.5	87.1	86.5
Numerator	11899	12074	12316	12297	12163
Denominator	13821	13899	14072	14121	14068
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 - 2007**

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

**Notes - 2006**

The data source for this measure comes from Maine's electronic birth certificate database.

Data from Maine's 2006 PRAMS survey reveal a very similar value; 87.5% of women surveyed had adequate prenatal care.

**Notes - 2005**

Numbers updated in FY08 application.

**Narrative:**

Data on prenatal care are derived from birth certificates provided by Maine's Office of Data, Research and Vital Statistics. In Maine, 86.5% of women with a live birth in 2007 received at least adequate pre-natal care (as defined as 80% on the Kotelchuck Index). Since 2003, Maine's estimate on this indicator has remained fairly stable with at least 86% of women between the ages of 15-44 receiving adequate prenatal care.

Maine's Title V is working on improving the adequacy of prenatal care in the State through ongoing monitoring efforts. Maine has had the Pregnancy Risk Assessment Monitoring System in place since its inception. These data provide valuable information on women's pre and post pregnancy behaviors. In addition, Maine's Title V Program examines and publishes data on pre-natal care and birth outcomes using birth certificate data. Through Maine's 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 statewide and to local communities, we hope to increase the percent of women in Maine receiving adequate prenatal care. Title V also works very closely with WIC, which is part of the Family Health Division of Maine CDC, where Title V resides, to encourage women enrolled in WIC to obtain prenatal care.

Efforts to improve prenatal care include 1) Maine's Home Visitation Program, as several of the local programs include pregnant women; 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) A New England Region I conference at Boston University School of Public Health on October 7, 2007 on taking a life course approach to Maternal and Child Health; 4) The Humane Systems for Maine Early Childhood Plan, which has several recommendations related to prenatal care, and 6) The start of the Maternal and Infant Mortality and Resiliency Review (MIMRR) Panel, funded by the Maine March of Dimes with a unique focus on incorporating resiliency into the reviews.

As part of the development of Maine's local public health infrastructure, communities will be conducting health assessments to examine the health of their population. Many MCH indicators, such as pre-natal care, will be included in these assessments. These assessments will help guide community efforts, and could help prompt more local level initiatives designed to improve the adequacy of prenatal care in the state. In Fall 2007, district-level health profiles were released to provide regional-level data to Maine's new public health infrastructure.

([http://www.maine.gov/dhhs/boh/maine\\_dhhs\\_district\\_health\\_profiles.htm](http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm))

These profiles included data on the percent of women receiving prenatal care in the 1st trimester by district and showed statewide racial and ethnic disparities in accessing early prenatal care.

These profiles have been widely distributed across the state and a summary table of the data reflected in the profiles is due to be updated and re-released in Fall 2008. 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.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	78.4	81.3	81.6	94.0	94.2
Numerator	118870	111523	113657	124443	125159
Denominator	151651	137134	139367	132322	132805
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 - 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.

**Notes - 2006**

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

2006 indicator is for Federal Fiscal Year 2006 (10/1/05-9/30/06). 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.

**Notes - 2005**

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

2005 indicator is for Federal Fiscal Year 2005 (10/1/04-9/30/05). Indicator is for 1-21 year olds.

**Narrative:**

According to Maine's Medicaid office located within the Office of MaineCare Services, 94% of MaineCare eligible children received a service paid for by the MaineCare Program in FY07. This is the same percent as was reported for FY06. Since 2001, the percent of MaineCare eligible children who have received a service from MaineCare has steadily increased indicating that more children who are eligible for services from MaineCare are receiving them.

As mentioned previously, in November 2007, the administration of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency. The EPSDT program is currently managed by Maine's Children with Special Health Needs Program. With increased oversight of this program, we anticipate that Maine's Title V agency will have better information on services received by Medicaid eligible children.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	35.5	45.4	40.1	43.0	44.6
Numerator	11330	11333	7825	8582	11786
Denominator	31954	24939	19534	19972	26421
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 - 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.

**Notes - 2006**

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

2006 indicator is for federal fiscal year 2006 (10/1/05-9/30/06).

Maine care staff calculating this variable have changed several times 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.

#### **Notes - 2005**

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

2005 indicator is for federal fiscal year 2005 (10/1/04-9/30/05).

It is difficult to interpret any differences between the 2004 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.

#### **Narrative:**

The Office of MaineCare Services reported that 44.6% of EPSDT eligible children aged 6-19 received any dental services within FY07. This is similar to the 43% reported for FY06. 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 Oral Health Program (OHP) funds and coordinates the school-based/school-linked School Oral Health Program (SOHP) via approximately 74 grants to schools, school districts and several community agencies throughout the state, providing oral health education and dental screening in 240 participating elementary schools. Children in many schools participate in a weekly fluoride mouthrinse program, and in about half of all participating schools, second 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 for MaineCare as well as the proportions of the community receiving fluoridated public water and whose family income is at the federal poverty level. 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, the majority of whom are school nurses, 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 that care.

The OHP also coordinates a funding program, using state tobacco dollars, which supports development and expansion efforts by community agencies to increase capacity for oral health services. Staff participate on MaineCare's Dental Advisory Committee reviewing proposed policy and administrative changes that may increase access to dental services for children. In addition, the OHP is a partner with a private non-profit organization in Maine's Watch Your Mouth campaign, of which the primary objectives are to educate the public about the connections between oral health and overall health and between oral disease and diminished school performance and to advocate for wider access to preventive services, such as dental sealants and fluoride, and regular dental exams for all children.

As mentioned above, in November 2007, the administration 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. With increased oversight of this program, Maine's Title V agency will be better able to ensure EPSDT eligible infants are receiving dental services.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	9.1	1.1	0.3	0.4	0.3
Numerator	247	30	9	12	9
Denominator	2713	2776	2821	2938	3096
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 - 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.

**Notes - 2006**

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.

**Notes - 2005**

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:**

CSHN Program currently serves 513 infants, children and adolescents ages 0 -- 21. Based on data from Maine's Children with Special Health Needs Program, 1% of SSI beneficiaries under age 16 received 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 2007 the Social Security Administration reported that 3,096 children under the age of 16 were receiving SSI. During FY07 the Maine CSHN Program served 5 children. The reduction in the number of children served is a result of the CSHN Program moving from direct service to a focus on building infrastructure and capacity to serve a larger number of children with special health needs. This fundamental change will allow the program to serve a greater number of children receiving SSI by assisting the medical home to first identify those children on SSI and assure their needs are being met through care coordination activities.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	other	7.3	5.3	6.3

**Notes - 2009**

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2007.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2007.

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 2006 PRAMS survey, which found that 7.3% of MaineCare births were low birthweight, compared with 4.8% of non-MaineCare births and 6.0% of all births statewide.

**Narrative:**

Maine has put a great deal of energy into expanding eligibility for MaineCare and simplifying the enrollment process. MaineCare now 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 appear less likely to start prenatal care in the 1st

trimester and have adequate prenatal care, as defined by the Kotelchuck Index. The 2006 and 2007 data suggest that infant mortality rates are better among those receiving MaineCare compared to non-MaineCare. However, the numbers are much different from prior years. It is unclear whether this is a significant change in the infant mortality rates of MaineCare clients, or whether changes in staff calculating the measure or changes in the MaineCare data system contributed to the difference over time. We are working with the MaineCare analysts to determine how we can better identify infant deaths in the Medicaid Data System. In addition, we are in the process of conducting in-depth analyses of infant mortality in the state, which we hope will help shed light on this issue.

Although lower-income populations typically do not fare as well, Maine's Title V agency is engaged in several efforts such as Home Visitation, WIC, and Public Health Nursing to help reduce the magnitude of the income disparity for maternal and infant health.

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	2.8	10.3	6.3

**Notes - 2009**

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2007. 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 possible 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: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2006. Mortality data are not yet available for 2007.

All: 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.

**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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	83.9	91	87.2

**Notes - 2009**

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2007.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2007.

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 2006 PRAMS survey, which found that 90.1% of women enrolled in MaineCare received prenatal care during the first trimester, compared with 95.9% of women who were not enrolled in MaineCare and 93.2% 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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to	2007	other	76.7	97.7	86.5

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]					
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**Notes - 2009**

Data sources:

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2007. 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 2007. 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 All 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 2005 PRAMS survey:

"Medicaid" population: 82.2%

"Non-Medicaid" population: 92.2%

"All" population: 87.5%

(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)*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2006	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2006	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*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to )	2006	150 150
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 5) (Age range to ) (Age range to )	2006	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*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2006	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2006	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.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid	3	No

Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> 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 - 2009**

**Narrative:**

Maine has a State Systems Development Initiative 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 two masters' prepared epidemiologists are currently involved with MCH programs. The SSDI initiative also helped Maine's Title V Program complete the Comprehensive Strengths and Needs Assessment 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 Maternal and Infant Mortality and Resiliency Review Panel, and (4) supporting the development and sustainability of school health surveys. In addition, we again plan to use the funds to conduct a comprehensive strengths and needs assessment to inform the 2010 MCH Block Grant. Planning for this effort is already underway.

In addition, funding from the State Systems Development Initiative has allowed us to explore our existing data sources to inform program policies and activities. For example, analyses were conducted using Maine's Youth Risk Behavior Survey to examine in-depth the risk factors for suicide attempts and ideation among Maine youth. Results indicated that multiple victimization experiences are strongly associated with youth suicide ideation. As a result, we are expanding our measurement of victimization experiences in Maine's new Integrated Youth Health Survey, which will be administered in 2009. The results have also been disseminated to several groups within Maine and at the National Maternal and Child Health Epidemiology Conference to increase awareness of this risk factor. We have also started conducting 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 Maternal and Infant Mortality and Resiliency Review Panel.

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

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes
Maine Youth Tobacco Survey/Maine Youth Drug and Alcohol Use Survey	3	Yes

**Notes - 2009**

**Narrative:**

Maine has several data systems in place that allow us to monitor tobacco use among youth in grades 9-12. Maine administers 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. In alternate years, all high schools and middle schools in Maine are invited to participate in the Maine Youth Drug and Alcohol Use Survey (MYDAUS)/ Youth Tobacco Survey (YTS). This survey includes 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.

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.

It has become increasingly challenging getting school participation in health surveys, given classroom time constraints and pressure and restrictions in the No Child Left Behind legislation with which schools must comply. An interagency group has been working to develop one survey that will alleviate the burden on schools and also increase the availability of local data, with an intended result that we will continue to get enough school participation to have data that is representative of the state's students. The Teen and Young Adult Health Program within the Title V Agency is co-leading this process with the Maine Department of Education. The final development and implementation of the integrated survey will be supported in the current State Systems Development Initiative.

## **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. It is divided into 16 counties and has 3 large cities, Portland, Lewiston-Auburn and Bangor. Maine has a population of 1.3 million people (2007 estimate), 2/3 of whom live in the southern third of the state. (See Section III A for more detail.) The state has a long history of local civic engagement. It has 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 400 of the 450 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 Department of Health and Human Services 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 two largest cities (Portland and Bangor) have local public health departments, the state does not have any county health departments. The Maine CDC's Public Health Nurses, public health educators, health engineers, and restaurant inspectors provide the local 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. /2006/ In the past six years several proposals have been made to address the lack of a more locally based public health presence. Maine received a Robert Wood Johnson, Turning Points Grant, which provided a vehicle for convening the public health related community to design plans for a Regional Public Health System in Maine. Legislation for such a structure was submitted in the 1st year of the 121st Legislative Session. At the same time the Governor's Office put forth legislation for the Dirigo Health Plan which addressed many of the issues in the Turning Points legislation. It was agreed to hold the Turning Points legislation until the Dirigo Health Plan was implemented and its implementation could be evaluated. The Governor's Office of Health, Policy, and Finance is leading the discussion regarding Regional Public Health Infrastructure. The Public Health Workgroup (PHWG) was convened in 2005 and charged with outlining a regional structure.

/2008/ Maine's State Health Plan for 2006-2007 included objectives to build a statewide public health infrastructure 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; eight districts, each with a District Coordinating Council (DCC) and 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 maternal child health systems, other non-profit organizations, emergency management, and other regional and local government entities. The eight 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. The eight public health districts 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 will be expected to convene DCCs 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 will also be responsible for developing district health improvement plans and their planning will contribute to the State Health Plan as well as local health planning efforts. //2008// /2009/ **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 replace and build upon the work of the PHWG to implement a statewide public health infrastructure 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 3 of the 8 District Public Health Liaison positions were filled (York, Western Maine and Midcoast). All central level OLPH staff will organize services in the remaining districts until the liaison positions can be filled. OLPH activities to date include: setting up the OLPH, hiring 2 additional District Public Health Liaisons by summer 2008, developing a Local Health Officer Training, forming DCC's in all districts, and providing assistance to the Healthy Maine Partnerships around the Mobilizing for Action Through Planning and Partnerships (MAPP) assessment process. //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 area resulting from the state's local limited resources. However, over the past nine 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 MCH Block Grant for direct service provision to using it as an innovative planning and system building tool and to implement a view of child and family health within an interlinked ecological context. The interlinked ecological context refers to the role of environments at the family, neighborhood, community, state, and societal levels 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 direct services 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.

***An attachment is included in this section.***

## **B. State Priorities**

The Maine MCH Title V Program uses the 1988 Institute of Medicine definition of public health as the process of assuring the conditions in which people can be healthy. The Maine Title V Program is rooted in the vision that families and communities, and our state as a whole thrive when children of all ages enjoy optimal health; feel physically and emotionally safe; are treated with dignity and respect; enter adulthood equipped with intense curiosity about the world, a deep desire to learn, a resilient spirit, and a healthy balance of cognitive and emotional skills; and have a sense of purpose, hope, and power about their lives, so that they can become compassionate and productive individuals.

The priorities selected for the next five years were developed based upon the 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. From the Title V Program perspective, they are all of equal value. The priorities are very broad in nature. This was intentional in that all people who work with and care about the MCH population have a stake in working together in a synergistic way on achieving these priorities. Also, while the MCH Block Grant is the fuel that drives our leadership, the MCH Title V Program is much more than the Block Grant itself. In addition, we decided to word the priorities in positive phrases such as improve,

increase, and foster conditions to reflect our commitment to measuring strengths as well as needs.

Although the priorities are broad, they are more specific than the priorities selected in 2000. The 2000-2005 priorities were more focused upon how we would achieve our work and a couple of specific health priorities. The 2005-2010 priorities identify specific areas of health, but at the same time are broad enough to ensure inclusion of the whole MCH population in focused activities and in all aspects of a priority. We felt that too much specificity would jeopardize the obvious importance of many issues not making the list, and give the false impression that we favor addressing only certain segments and age groups of the MCH population.

The 10 priorities and rationales are as follows:

1. Improve Birth Outcomes

While Maine does better on many birth outcomes than does the nation as a whole, the state has not yet met many birth-related Healthy People 2010 and Healthy Maine 2010 objectives, and the proportion of premature births has increased significantly during the past decade. We view the following objectives as examples of what we intend to address for achieving this priority: reductions of prematurity, low birth weight, and perinatal morbidity and mortality, including perinatal substance abuse; reductions in teen pregnancy; and increases in social support for pregnant women and early prenatal enrollment for WIC and home visiting.

2. Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries

Unintentional injuries are the leading cause of death for 1-19 year olds and the second leading cause of death for women ages 20-44 in Maine. Unintentional injuries also are one of the most common principal diagnoses of hospitalizations among these groups. Suicide is the second-leading cause of death among 15-24 year olds and the fourth leading cause of death among women ages 20-44 in the state. The definition of safety encompasses physical, psychological, and emotional safety and includes a public health approach to the prevention of violence. Injuries range from those sustained in automobile crashes or falling off the equipment at the playground to those intentionally inflicted by another or by oneself. The ability of our families and children to feel safe at all times is paramount and this can only be accomplished through a variety of mechanisms to include a wide variety of violence prevention, including domestic, physical, sexual, child abuse and neglect, bullying, suicide and poisoning prevention initiatives.

3. Improve the respiratory health of the MCH population

Almost 1 in 11 kindergartners in Maine have asthma, as do nearly 1 in 8 women ages 18 and older. Only 37% of kindergartners with asthma have a written management plan. Asthma also is one of the most common principal diagnoses in hospitalizations of 1-9 year olds in the state. Smoking, and second-hand smoke affect the respiratory health of a large proportion of the MCH population in Maine. Research has shown that children are able to learn and adults are more productive if living and working in healthy environments. We feel this can only occur if we support efforts that include the reduction of environmental [indoor and outdoor] hazards, such as first and second hand smoke, mold, and smog; and the reduction of the incidence and burden of asthma.

4. Increase the proportion of the MCH population who are at a healthy weight and physically active

Large segments of the MCH population in Maine are overweight or at risk for overweight. The problem begins in early childhood (where 16% of 2-4 year olds enrolled in WIC are overweight and another 17% are at-risk-for-overweight) and continues through adulthood (where nearly half of women aged 18 and older are at risk for health problems related to being overweight). In

addition, significant proportions of the Maine MCH populations are not physically active. For all our children, including CSHN and people with disabilities, to thrive and be healthy and happy they need to engage in physical activity and have access to information on nutrition as well as nutritious food. This is an area that a wide range of partners in public health can contribute to both individually and collectively.

5. Improve the mental health system of services and supports for the MCH population

Mental disorders affect a large proportion of the MCH population in Maine. For example, these disorders are one of the most common principal diagnoses for hospitalizations among Maine children ages 5-19 and Maine women 20-44 years old. One study estimated that 1 in 6 rural Maine children has a behavioral health problem. One in four high school students reported feeling so sad or hopeless for 2 or more weeks in a row that they stopped doing some usual activities. More than half of all new mothers in the state reported at least some degree of postpartum depression. Mental health and the lack of available services, as well as family stress, were identified as key needs by dialogue group participants. When we use the word mental health, we are including all aspects of social, emotional, and behavioral health as important components of the mental health system. It is time to formalize the reality that mental health is integral to MCH. Research indicates that a large percentage of children with the most significant behavioral and emotional symptoms never receive any services at all. A lack of licensed clinicians and psychiatrists results in primary care physicians having to provide services. Through enhanced partnerships with our colleagues in mental health at the state and local level, and through such initiatives as the Behavioral Women's Health Grant, Early Childhood Comprehensive Systems Grant, and the Harvard Prevention Resource Center we will aim to integrate mental health into primary health for the MCH population.

6. Foster conditions to improve oral health services and supports for the MCH population

Our state's large geography coupled with a shortage of dentists has resulted in large numbers of the MCH population lacking adequate dental care. Dialogue group participants identified the lack of dental care resulting primarily from a demand that exceeds the number of providers as a key issue in the state. Poor oral health can and does impact the overall health of individuals. We will work to support efforts that enable increased access for our children and families to integrate oral health into primary health care and schools for the MCH population.

7. 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

CSHN must have the opportunity to achieve their optimal potential in all areas of health and development. We can be much more successful in this effort through systemic change that uses a public health approach to serving this population. Our challenge is to transform our CSHN Program so that it aims to put into practice systems of care that support family-centered and culturally and linguistically competent service in all communities for all children with special health needs.

8. Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population

We know that the quality of life for families improves when obstacles to needed services and resources are removed. Our care coordination approach, as currently incorporated into the medical home model for children with special health needs, is an example of what we should make available to the whole MCH population. A Health Home includes but goes beyond the Medical Home. It is rooted in our vision of health and includes the physical, mental, emotional, and spiritual realms of the person and family. It represents a standard that we will aim to make available for all children in our state.

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

It is essential that we honor and respect the culture and language of all children, families, and communities in Maine; and that we incorporate cultural and linguistic competence into every aspect of MCH in Maine. Such an approach is necessary in aiming to move toward the Healthy People 2010 objective of 100% access to health care and zero disparities in health status for all citizens. It depends on the capacity of all of our health and human systems, including education, childcare and mental health, to deliver culturally and linguistically competent care and services. Dialogue group participants felt that Maine is not yet doing a very good job of supporting issues of diversity and culture and that this is an important issue to address. We will begin this process by first conducting an assessment of cultural and linguistic competence within the Title V Agency and MCH supported agencies, and identify goals and actions for improvement. We will use these self-assessments to work with our partners on areas of improvement.

10. Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs

To foster life-long healthy habits and health, youth need services, supports and opportunities. Health care services, including oral and mental health care, must be provided where young people are and be sensitive to the unique concerns and barriers that they face. Supportive environments and adult allies can help them develop competencies and connections that help prevent unhealthy risk behaviors and promote overall health. Actively partnering with youth in meaningful ways fosters conditions for successful endeavors and continued participation.

The Maine Title V Program has selected 7 performance measures related to the above priorities. We anticipate over the next two to three years we will develop one to three additional measures related to the 10 priorities. Areas under consideration for developing future state performance measures include: tobacco use in pregnancy, mental health, cultural and linguistic competence, early childhood, child abuse, and something state specific related to asthma. /2007/ Child care health consultants play a critical role in promoting healthy and safe child care environments and supporting education for children, their families, and child care providers. This support specifically includes children with special health needs. Child care consultants also improve access to preventive health services such as medical and dental homes, early intervention and family support. During the past year Maine along with 5 other Region 1 states worked collaboratively to create a developmental state performance measure beginning in FY07 to increase the number of licensed child care providers that receive annual visits from a child care health consultant. The new measure is; "The percent of licensed child care centers serving children age birth to five who have on-site health consultation". This measure is consistent with recommendations from the AAP, APHA, and MCHB/HRSA. //2007// The performance measures selected for Maine are:

1. The percentage of births in women less than 24 years of age that are unintended.
2. The percentage of 0-11 month old children enrolled in WIC who were ever breastfed.
3. The motor vehicle death rate per 100,000 among children 15 to 21 years of age.
4. The percentage of high school students (grades 9-12) who are overweight.
5. The percentage of high school students (grades 9-12) who feel like they matter to people in their community.
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.
7. The rate per 1,000 of emergency department visits for asthma among women ages 15-44.

/2007/

8. The percent of licensed child care centers serving children age birth to five who have on-site

health consultation. //2007//

### 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	98	98	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	23	21	26	24	18
Denominator	23	21	26	24	18
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

#### 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.

#### Notes - 2006

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)

Indicators prior to 2002 are not accurate for this measure due to a misunderstanding concerning how it should be calculated. The 2002 and 2003 indicators were updated in September 2005 to meet the definitions provided in the block grant guidance.

As of July 2001, Maine screens for 9 mandatory conditions (including hemoglobinopathies) and has an optional panel of 19 metabolic disorders.

#### Notes - 2005

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)

Indicators prior to 2002 are not accurate for this measure due to a misunderstanding concerning how it should be calculated. The 2002 and 2003 indicators were updated in September 2005 to meet the definitions provided in the block grant guidance.

As of July 2001, Maine screens for 9 mandatory conditions (including hemoglobinopathies) and has an optional panel of 19 metabolic disorders.

The 2005 indicator was updated for the FY08 application.

#### **a. Last Year's Accomplishments**

The data for this measure come from Maine's Newborn Screening Program (NBSP). In 2006, 100% of newborns that screened positive for one of the conditions monitored by Maine's NBSP had timely follow-up to definitive diagnosis and clinical management. Maine has maintained this high standard since at least 2002 and preliminary data from 2007 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 CY06, Maine screened 13,923 of the 14,009 births that occurred in the state (99.4% of newborns screened). Of these, 24 were identified with disorders. All affected infants were receiving appropriate consultation and treatment within 48 hours of confirmation.

In July 2001, Maine began offering an optional expanded panel of screening for 19 tests for newborns. The expanded screening program has been very successful with over 99.9% of babies receiving additional testing. Maine's success can be attributed to our ability to link metabolic screening data with birth certificate data. In addition Maine has developed a close working relationship with our 2 specialty centers thus ensuring timely follow-up for infants. The Joint Advisory Committee (JAC) for Newborn Screening 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.

The JAC continues to be more family centered in its structure through parent participation on the committee. Additional parent members were added and now represent families with children who have PKU, Congenital Hypothyroidism, Fatty Acid Disorder and Cystic Fibrosis. The Committee is co-chaired by a health care provider and a parent member. The co-chairs assist in drafting agendas and directing Committee projects.

The NBS coordinator position has been vacant since late 2005. Several factors contributed to the extended vacancy including; a state hiring freeze, time constraints required to obtain necessary approvals for a more appropriate classification, and insufficient funding. Recruitment for the position will begin upon approval of the reclassification and budgetary resources. The Genetics Program coordinator assumed many responsibilities of the NBSP. The secretary position vacated in June 2007 further challenged the programs ability to meet its commitment to high quality follow-up. Communication with health care providers and hospitals continues to be a priority focus.

The NBS Program brochure was revised to meet the needs of expectant and new parents. Input from providers, parents and the advisory committee members was considered. The brochure

provides an introduction to newborn screening and the importance of follow-up. Several models were considered, including one developed by HRSA. The New England Regional Genetics Collaborative subcommittee on education developed a regional brochure that was adapted for Maine. The brochure has been translated into 15 languages and is available on the New England Regional Genetics Collaborative website. Healthcare providers and birthing hospitals were notified of the link so they could access the translated version. Translation was funded through the New England Genetics Collaborative and multiple copies will be disseminated to each state to share with birthing hospitals. A newborn screening parent education packet under development will include a copy of the brochure.

A division-wide reorganization presented the opportunity to enhance collaborations and restructure programs using a functional approach. The Genetics and CSHN Programs combined leadership, assessed capacity and explored new approaches to early identification and services for CSHN. This new structure facilitated data sharing, quality assurance and comprehensive planning efforts.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Cystic Fibrosis screening as part of newborn screening panel.			X	
2. Develop program resources.				X
3. Develop and distribute quarterly newsletter on Genetics and Newborn Screening.			X	
4. Evaluate effectiveness of the screening system.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Implementation of Cystic Fibrosis (CF) screening is planned for July 2008. A CF Workgroup was established that includes professional staff from both CF Clinics, Directors of each CF accredited sweat labs, geneticists, neonatologists, a practicing pediatrician, a parent and NBS Program staff. The workgroup enhanced the service system to facilitate early identification, diagnosis and services for infants with CF. Materials were developed for primary care providers to assist in referring infants with a positive CF screen for further evaluation and treatment. Grand Rounds presentations will be held in several birthing hospitals statewide as well as education with perinatal nurses. Teleconferencing will increase the numbers of providers who can participate. Additionally materials will be mailed to all perinatal care providers and others who educate families about screening activities.

The JAC also recommended that Maine align the screening panel with that recommended by the American College of Medical Geneticists, including all core conditions detected by bloodspot screening. In addition to screening for CF, 3 other conditions will be added to the conditions screened for in Maine; Carnitine Uptake Deficiency, Trifunctional Protein Deficiency and Multiple Carboxylase Deficiency. We do not anticipate these additions will affect our 100% follow-up rate as we have a strong collaborative relationship with specialty providers.

**c. Plan for the Coming Year**

Maine has continued to set an objective of 100% for this measure and we do not foresee any problems maintaining our current follow-up rate.

The CSHN/Genetics Program will continue to collaborate with statewide CF Centers to implement newborn screening for CF and examine the effectiveness of screening and the system of diagnosis and services.

Establish further quality improvement measures by reviewing timeliness of repeats for NICU babies. This will be monitored by reviewing the time between a request for a repeat and the final resolution of an out of range result, and will also review the impact of inter and intra-hospital transfers and discharges on obtaining required screens.

We will explore approaches to long-term follow-up and outcome assessment as part of a comprehensive newborn screening system. Discussions will include the JAC, parents and other partners, including the New England Regional Genetics Collaborative. Data collection will begin in FY09.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	62.8	62.8	62.8	62.8	65
Annual Indicator	62.8	62.8	62.8	62.8	60.7
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60.7	60.7	60.7	65	65

**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.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 62.8 % is the value for Maine from the the first National CSHCN Survey carried out in 2001. It is comparable to the national indicator of 57.5%. An objective of 65% is projected for 2007 when data become available from the second administration of the survey. The objectives for 2007 and beyond were changed this year 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.

The indicators for 1998 to 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. The method for determining the score changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator of 62.8 % is the value for Maine from the the first National CSHCN Survey carried out in 2001. It is comparable to the national indicator of 57.5%. An objective of 75% is projected for 2007 when data become available from the second administration of the survey.

The indicators for 1998 to 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. The method for determining the score changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

#### **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.

As part of our State Implementation Grant for Integrated Community Based Services for Children and Youth with Special Health Needs, the CSHN Program used "Report Cards" (copy included in Appendix) to assess family satisfaction with the 6 performance measures. More than 200 report cards (return rate of 42%) were completed representing every county and Family-to-Family Health Information Region of the state. The regions are: Region 1 - Cumberland, York, Androscoggin and Oxford; Region 2 - Waldo, Knox, Lincoln, Sagadahoc and Brunswick area; Region 3 - Kennebec, Somerset, Franklin and Piscataquis; Region 4 - Northern Penobscot, Northern Washington and Southern Aroostook; Region 5 - Washington, Hancock, and Bangor area; and Region 6 - Central and Northern Aroostook County.

Report cards submitted by families for this measure indicated that 56% of respondents felt they partnered in decision-making and were satisfied with the services they received. Responses

ranged from a low of 49% in Region 3 to a high of 63% in Region 2.

Families were actively involved in all aspects of the CSHN/Genetics Program. Families are members of all CSHN/Genetics sponsored advisory councils:

1. Joint Advisory Council for Newborn Screening and CSHN (JAC) -- Family members co-chaired the council and played an active role in the determination of adding cystic fibrosis to the screening panel.
2. Acquired Brain Injury Advisory Council (ABIAC) -- An individual with TBI presided as co-chair. Family members and individuals participated on many sub-committees and continued to make recommendations to the Brain Injury Program within the Office of Adults with Physical and Cognitive Disability. Two public hearings were held in October and November 2007 to obtain public input on unmet needs.
3. The Family Advisory Council and Youth Advisory Council to the CSHN were combined and met bi-monthly. They collaborated on developing a new youth and family report card. This proved to be a positive effort as the ideas and values of parents and youth were aligned as youth perceived parents ready to listen.
4. Newborn Hearing Advisory Committee -- Families co-chaired and actively participated in providing insight and guidance in policy development.

As diversity continues to increase in Maine it is important that the CSHN Program understand, develop and deliver services that are meaningful, accessible, and culturally appropriate to our changing consumer base. The CSHN Program worked with the National Center on Cultural Competence to conduct a needs assessment on cultural and linguistic competence. Through this process we focused first on our program to determine if CSHN Program and staff could communicate effectively, and convey information in a manner that is easily understood by diverse audiences including individuals with disabilities. For the CSHN Program to respond effectively to the health literacy needs of the population we serve we determined that policies, structures, practices, and procedures must be in place to support this capacity, a process that began in FY07. The CSHN Program also engaged Family to Family regional coordinators in cultural competency training at monthly meetings in an effort to report progress back to the regions. The CSHN Program continues to engage staff on a monthly basis to discuss 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 contracts with families/parent consultants as appropriate.		X	X	X
4. Continue active family participation on all MCH boards and councils.		X	X	X
5. Engage families in cultural competency training through regional FACs.		X	X	X
6. Engage youth and families in the regions to respond to the analysis of the regional report cards.		X	X	X
7.				
8.				
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. CSHN/Genetics Program actively involves families and youth in policy development that has an impact on them. For example, a program decision to discontinue paying for all medical services and change to a wrap around system was shared with and well received by the FAC. General consensus was the program should only be paying for those not able to. The FAC expressed they are looking forward to designing a program using a community based services model that provides for all Maine CSHN.

Through Maine's New Freedom Initiative the CSHN Program is using regional report cards to determine specific community-level needs for children with special health needs and their families. Maine recognized that families and youth face diverse challenges depending on where they live in the state. To assess regional needs the CSHN Program reformatted the Measuring and Monitoring (M&M) tool developed by the Early Intervention Research Institute at Utah State University. Report cards are completed by youth and family members throughout the state to assess the status of services and supports. Maine's Family-to-Family Health Information Centers and Maine Parent Federation partnered in this effort and will play an integral role as the Program reports findings back to the regions.

## **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 Family-to-Family Health Information Center partners to create systems that ensure children, youth and family needs are met.

During FY09 the CSHN/Genetics Program will focus on developing the 6 regional Family Advisory Councils (FAC) and Youth Advisory Councils (YAC). The CSHN Program will work with the Maine Parent Federation to conduct additional analysis of report card results. Findings will be used to develop training programs and workshops specific to the needs in each region.

We will work with the new public health districts and Family-to-Family 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 6 Regional Family-to-Family Health Information Centers and Resource Coordinators will participate in monthly cultural competency awareness trainings under the guidance of Dr. Richard Aronson. The CSHN Program will contract with Dr. Aronson using State Implementation Grant funds. This will be a continuation of the May 30, 2007 cultural competency training by the National Center for Cultural Competence. The CSHN Program, Maine Injury Prevention Program and WIC sponsored the event.

The JAC, Newborn Hearing Screening Council, ABIAC and FAC will continue to provide advice and recommendations to the CSHN/Genetics Program and the Office on Brain Injury on policy and development.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	60	60	60	60	65
Annual Indicator	60	60	60	60	51.7
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	51.7	51.7	51.7	55	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%.

### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2005 indicator of 60% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 52.6 %. An objective of 65% is projected for 2007 when data from the next administration of the survey become available. The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special 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.

The percentages for 1998 to 2001 refer to the original NPM # 3. For 1998 the numerator and denominator were based on estimates from the 1992 National Health Information Survey (NHIS), adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence rate based on the work of Paul Newacheck.

### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator of 60% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 52.6 %. An objective of 72% is projected for 2007 when data from the next administration of the survey become available.

The percentages for 1998 to 2001 refer to the original NPM # 3. For 1998 the numerator and denominator were based on estimates from the 1992 National Health Information Survey (NHIS),

adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence rate based on the work of Paul Newacheck.

#### **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.

As part of our State Implementation Grant for Integrated Community Based Services for Children and Youth with Special Health Needs, the CSHN Program used "Report Cards" (copy included in Appendix) to assess family satisfaction with the 6 performance measures. More than 200 report cards (return rate of 42%) were completed representing every county and Family-to-Family Health Information Region of the state. (See PM # 2 for list of regions)

Report cards submitted for this measure indicated that 59% of respondents felt they received coordinated, ongoing, comprehensive care within a medical home. Responses ranged from a low of 48% in Region 3 to a high of 67% in Regions 2 and 4. A Family-to-Family Health Information Center representative from each region sits on the Medical Home Advisory Committee to ensure information provided to families is more region-based.

The terms Partners in Chronic Care, Medical Home, and Advanced Medical Home are used throughout this measure; following is a definition of each.

Partners in Chronic Care (PCC) is a Medical Home Initiative for providing quality care coordination for children with complex chronic conditions in the primary care office. It provides a mechanism for a family, pediatrician, practice care coordinator, PCC coordinator and others identified by the family to solve a range of issues faced by children with complex medical issues. Medical Home is a coordinated and respectful health care partnership between a child, his or her parents, and the child's primary care doctor. Advanced Medical Home is a patient-centered care model based on the principles of the chronic care model (an adult care model commonly used with patients who have chronic diseases such as diabetes).

The CSHN Program continued to partner with the Hood Center at Dartmouth University to promote the PCC Model of Care Coordination. PCC promotes collaboration between key providers that include primary care, school, insurers, family, specialty care, and the broader community-based resource providers. The CSHN Program identified four pediatric practices; Kennebec Pediatric, Bridgton Pediatrics, Husson Pediatrics and Noble Pediatrics and completed team meetings for 20 children. The PCC model was generalized to become the usual standard of care throughout the practices. A home assessment was initiated in an effort to assess family and child needs. The home assessment discussed past medical history, medical status, adaptive equipment needs, educational needs, environmental access, cultural considerations, psychosocial demographics and the families identified needs/concerns/priorities. The Hood Center at Dartmouth College has demonstrated that care coordination reduces costs. Use of the PCC model in New Hampshire decreased ED usage resulting in approximately \$900,000 savings over 3 years. Maine is currently unable to obtain utilization data but is working with the Office of MaineCare Services to determine a mechanism to access. The CSHN Program is initiating systems development by moving away from direct care and placing an increased focus on population-based and infrastructure as a whole.

A 2006 merger of the CSHN and Genetics Programs created a working organizational chart. One component of the merger was movement of the EPSDT informing and reporting from the Infectious Disease Division's Immunization Program to the Family Health Division. The reporting component will be completed in FY08.

The Maine Chapter of AAP dedicated its Spring 2007 Conference entirely to children with special health needs. CSHN/Genetics Program staff assisted in the planning of the conference "Special Kids, Special Needs". CSHN held a workshop on Transition and the PCC model of Care Coordination. Both were well received by the 20 practices in attendance and all expressed an interest in learning more about the PCC.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the Medical Home Learning Collaborative.	X	X	X	X
2. Continue collaboration and partnership with the Maine Chapter of AAP.			X	X
3. Participate at the Maine Chapter of AAP Annual Meeting.				X
4. Participate in the Partners in Chronic Care Model.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

A report based on data from the NS-CSHCN for Maine was completed in Spring 2008. Results of this report revealed there was wide variation in this measure based on the classification of a child's special health need. For example, the % of CSHN who had a medical home was significantly higher for CSHN whose conditions were managed by prescription medications only (61.3%) than children whose conditions resulted in functional limitations (39.0%). Overall, parents of Maine CSHN reported positive experiences with their health care providers, though again there were some differences by type of special health need. Results of this report will be compared to the "report card" surveys given to parents of CSHN in Maine by Maine's CSHN Program to examine the comparability of results to help drive future efforts.

The Hood Center at Dartmouth Medical College was awarded a HRSA grant to "Improve Access to Care for Children and Youth with Epilepsy". The project will use 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 is currently working with Kennebec Pediatrics and Southern Maine Neurology to improve care coordination between the practice and specialists working with families to de-stigmatize epilepsy for youth and families.

**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. Due to changes in wording of this indicator between the 2001 and the 2005 National Survey's for CSHCN we have changed our objective for this measure to make it more realistic. We recognize there is a disparity between those children managed by prescription medications only and functional limitations, 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 four years.

As mentioned under accomplishments, Maine is engaged in a pilot project in collaboration with the Hood Center at Dartmouth University with four Pediatric practices in Maine. The Hood Center is in the process of evaluating the affect of this pilot on emergency department visits and hospitalizations for CSHN. We are considering expanding the evaluation to examine in a qualitative manner how the program is working for the providers involved in the project in order to determine how the project could be successfully expanded to other practices.

One of the major strategies recommended in the biennium State Health Plan released in April 2008 to enhance the development of integrated care models is to design and implement a Patient Centered Medical Home pilot. The CSHN Program will support the work of the Task Force.

Other activities include:

Follow-up with those practices that expressed an interest in the PCC model presentations at the Spring 2007 Maine AAP Conference to determine how the program can assist.

Continue to revise and update web site to include information on program activities.  
<http://www.maine.gov/dhhs/boh/cshn/>

Continue to collaborate and enhance our relationship with the Maine Chapter of AAP through increased awareness of medical home and partners in chronic care.

Expand the Partners in Chronic Care Model to three additional pediatric practices including transition to adult providers.

Continue discussions with Lisa Letourneau, DO Clinical Director of Integration For Maine Quality Counts, on integrating a pediatric track in the Advanced Medical Home Learning Collaborative.

Work with EPSDT to determine scope of services provided and how the CSHN Program can enhance care coordination by providing additional resources or brokering connections with Family-to-Family Health Information Centers.

Initiate conversations with liaisons for the newly formed public health districts to provide information on the medical home. Information would consist of a definition of a medical home and what it would mean if the term were used in communities.

Develop a collaborative relationship with the Office of MaineCare Services, Care Coordination Contractor to work on their care coordination model to provide support and share resources.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	67.3	67.3	67.3	67.3	70
Annual Indicator	67.3	67.3	67.3	67.3	70
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	70	70	70	70	70

**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.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 67.3% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 59.6 %.

An objective of 70% is projected for 2007 when data from the next administration of the survey become available. The objectives for 2007 and beyond were changed this year 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 - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator of 67.3% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 59.6 %.

**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. Thirty-Three percent had public insurance only and 13% had a combination of public and private insurance.

As part of our State Implementation Grant for Integrated Community Based Services for Children and Youth with Special Health Needs, the CSHN Program used "Report Cards" (copy included in Appendix) to assess family satisfaction with the 6 performance measures. More than 200 report cards (return rate of 42%) were completed representing every county and Family-to-Family Health Information Region of the state. (See PM # 2 for list of regions)

Report cards submitted for this measure indicated that only 51% of respondents felt they had adequate insurance to pay for the services they needed. Responses ranged from a low of 43% in Region 3 to a high of 60% in Region 2. Responses clearly indicated much work is needed in this

area. Further analysis of report card results is needed to help us gain a better understanding of the types of services not being fully covered.

In an effort to remain within budget, in July 2005 the CSHN/Genetics 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 CY07 direct services were provided to 513 infants, children and youth; 29 were less than one year old. The Program's major expenses (62%) were medications and medical supplies.

The Program continued to administer the Southern Maine Cleft Lip and Palate Clinic and 4 Developmental Evaluations Clinics (DEC). The statewide DEC's saw approximately 509 children during FY07.

L.D. 841 "An Act to Extend Health Insurance Coverage for Dependent Children up to age 25 Years of Age" was passed and signed by the Governor in May 2007. This legislation provided an added benefit for children with special health needs; previously they lost coverage at age 18.

**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	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.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In a report compiled in Spring 2008 using data from NS-CSHCN for Maine, we found that more families with CSHN were insured through public insurance in 2005-2006 compared to 2001. Given the current economic climate and proposed budget cuts to MaineCare in the state, we are unsure if this could affect the health insurance status of CSHN in Maine. Also, new MaineCare policies that now require documentation of citizenship and identity are causing many families in Maine to not re-enroll in MaineCare. Costs associated with obtaining birth certificate copies, particularly if from another state, if families have misplaced or lost them is a deterrent. Outreach efforts are currently underway to locate these families and encourage them to re-enroll.

The CSHN Program continues to remain abreast of MaineCare service changes in an effort to determine what, if any, impact they will have on children with special health needs and to intervene when potentially unintended consequences occur. For example, MaineCare no longer pays for over-the-counter medications. The CSHN Director recently intervened when a child was in need of a life saving prescription medication that was considered to be over-the-counter by

MaineCare.

**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.

The CSHN program will continue to collaborate with the Office of MaineCare Services to support care coordination and integration of services at the community level; continue to enroll children in the Partners in Chronic Care model of care coordination; and disseminate the updated insurance primer.

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.

Work with families to determine barriers to re-enrollment in MaineCare and link to necessary resources.

The CSHN Program will develop, for stakeholders, a plan for sharing data on CSHN to be made available via its website.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	77.3	77.3	77.3	77.3	79
Annual Indicator	77.3	77.3	77.3	77.3	87.6
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	87.9	87.9	87.9	90	90

**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%.

#### **Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 77.3% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the 74.3 % for the nation as a whole. An objective of 79% is projected for 2007 when the data from the next administration of SLAITS will be available.

The objectives for 2007 and beyond were changed this year 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.

This was a new measure in 2002; no data are available prior to 2002

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator of 77.3% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the 74.3 % for the nation as a whole. An objective of 85% is projected for 2007 when the data from the next administration of SLAITS will be available. This was a new measure in 2002; no data are available prior to 2002.

#### **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.

As part of our State Implementation Grant for Integrated Community Based Services for Children and Youth with Special Health Needs, the CSHN Program used "Report Cards" (copy included in Appendix) to assess family satisfaction with the 6 performance measures. More than 200 report cards (return rate of 42%) were completed representing every county and Family-to-Family Health Information Region of the state. (See PM # 2 for list of regions)

Report cards submitted for this measure indicated that 48% of respondents felt community-based service systems were organized so they could use them easily. Responses ranged from a low of 40% in Region 1 to a high of 58% in Region 4. We believe the report card provides a more accurate picture of family concerns in the six Family to Family Regions based on responses to the following questions: 1) Children and/or youth have a written service plan that coordinates all providers and services; 2) The lead coordinator for the plan of care is clearly communicated to the family; 3) Families are able to access comprehensive services for their children and family; and 4) Specialty care is available within a reasonable distance. Families continued to be dismayed by the "systems" that appear to be fractured and non-communicative with each other. Families continued to consider themselves as the primary case manager responsible for locating services for their child.

To address these issues the CSHN/Genetics Program continued to partner with Maine Parent Federation/Family Voices Regional Family-to-Family (F2F) Health Information Centers. CSHN/Genetics staff held several meetings with the 6 Regional F2F Health Information Coordinators to coordinate and support regional Family Advisory Council efforts. The regional coordinators are responsible for educating, informing and serving as advocates to families in need.

The F2F coordinators met with Newborn Hearing Program staff and local Early Child and Family Service (ECFS) coordinators through the Baxter School for the Deaf. The focus of ECFS is on Newborn Hearing and identifying hearing resources for families in the community where F2F, through the Maine Parent Federation, have expertise on advocating for school issues and other resource needs. The collaboration between these groups has worked very well as they compliment each other's strengths in advocating for families who have children with hearing loss.

The CSHN/Genetics Program supported the Maine Brain Injury Association Annual Conference. The 18th Annual 2-day Conference, "Evolving Concepts in Brain Injury: Integrating Individuals and Families with Clinical and Community Resources, was held in April 2007. Approximately 150 people that included health care providers, allied health professionals, individuals with TBI, family members, and state and private agencies attended the conference.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update CSHN/Genetics website as required ( <a href="http://www.maine.gov/dhhs/boh/cshn/home.html">www.maine.gov/dhhs/boh/cshn/home.html</a> ).		X	X	X
2. Coordinate activities among MCHB funded initiatives.				X
3. Sponsor 18th Annual Brain Injury Association Meeting.				X
4. Support 27th Annual Special Family Weekend.				X
5. Support the 4 regional FAC Coordinators.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In a report completed in Spring 2008, we examined how this measure varied by type of special health need. Parents of CSHN with functional limitations were significantly less likely to report that services were organized in ways they could easily use them. While 96% of parents with CSHN managed by prescription medications reported ease in using community-based services, only 73% of parents with CSHN whose condition results in functional limitations reported ease in using community based services. This is important information for Maine's CSHN Program, which primarily works with children with functional limitations.

Maine has an emerging public health infrastructure comprised of 8 regional public health districts. The new infrastructure has the potential of enhancing the existing 6 Regional F2F Health Information Centers in several areas: 1) strengthen efforts to enhance the delivery of the 10 essential public health services; 2) develop local and regional health improvement plans; and 3) assure accountability for use of state resources.

In July 2007 the CSHN Program hired, through contract, a parent of a child with hearing loss for the Newborn Hearing Screening Program. Her primary responsibility is to address follow up on infant referrals to determine if they had an audiologic test or if an audiologic test is scheduled.

She also provides resources and support for infants identified with a "refer" at hospital discharge.

**c. Plan for the Coming Year**

Maine's objective for this measure changed from 79% to 90% due to changes in the survey measurement of this indicator. Our goal is to reach 90% in four years, when the next survey results are available.

During FY09 we plan to:

Based on Report Card results the CSHN program will hold regional focus groups to gain a better understanding of existing services in the regions and what additional services and resources families need.

The CSHN Program will form six Regional Family and Youth Advisory Councils to be located in the six F2F Health Information Regions. Representatives from each council will form a larger statewide Family and Youth Council. The regional councils will be responsible for assessing community needs via Report Cards reporting back to the region and with assistance from the CSHN Program enhance and improve systems currently in place. Discussions will be initiated with the Office of Local Public Health to involve the eight public health districts.

Continue to explore options to move 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) in-house and add additional information and resources for children ages birth - 25 years. <http://www.servicesforme.org/>

Continue to enhance coordination among Maine's MCHB funded grants to optimize funds and resources.

Establish a relationship with new District Public Health Liaisons to share resources on community-based resources for CSHN families.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	14.9	14.9	14.9	14.9	16
Annual Indicator	14.9	14.9	14.9	14.9	49
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	49	49	49	51	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%.

#### **Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The indicator of 14.9% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the national indicator of 5.8%. Maine is the only state in the county with sufficient sample size to reliably report on this measure.

An objective of 16% is projected for 2007 when the survey data from the next administration of SLAITS is available. The objectives for 2007 and beyond were changed this year 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.

This was a new measure in 2002; no data are available before 2002.

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The indicator of 14.9% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the national indicator of 5.8%. Maine is the only state in the county with sufficient sample size to reliably report on this measure.

An objective of 20% is projected for 2007 when the survey data from the next administration of SLAITS is available. This was a new measure in 2002; no data are available before 2002.

#### **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.

As part of our State Implementation Grant for Integrated Community Based Services for Children and Youth with Special Health Needs, the CSHN Program used "Report Cards" (copy included in Appendix) to assess family satisfaction with the 6 performance measures. More than 200 report cards (return rate of 42%) were completed representing every county and Family-to-Family Health Information Region of the state. (See PM # 2 for list of regions)

Report cards submitted for this measure indicated that 40% of respondents felt their children

received the necessary services to transition to all aspects of adult health care, work and independence. Responses ranged from a low of 35% in Region 2 to a high of 43% in Region 1.

Through the Integrated Services Grant the Youth Coordinator worked with youth and youth groups to bring them together on various issues impacting young adults with disabilities. She initiated a chat room for youth to share and discuss common issues; directed five regional youth advisory coordinators; worked with youth to complete the youth version of the report card; and will translate the results into regional presentations on issues facing youth.

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 added a session on transition to address Healthy and Ready to Work (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 is 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. It is a new way 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 CSHN Program partnered with the Maine Chapter of AAP to address issues of transition from pediatric to adult health care providers. For over 9 years the Maine CSHN Program demonstrated its commitment to enhancing and promoting the successful transition of youth to adulthood as the recipient of MCHB/HRTW needs assessment, Phase I and Phase II HRTW Projects. These projects provided Maine with extensive knowledge on incorporating youth and families in policy activities and Maine is recognized as a leader in transition change activities. In 2002 Maine was the first state to have a Youth Advisory Council (YAC) to its' CSHN Program. These efforts were rewarded when Maine was awarded the MCHB Healthy and Ready to Work National Center Grant in FY07.

In collaboration with the Maine Support Network the CSHN Program held a gathering for 6 youth at the Samoset in Rockland in February 2007 to set the stage for establishing 4 regional YACs. Three are current members of the YEA ME (Maine's Youth Advisory Council to the CSHN/Genetics Program) and 3 are new to the concept of youth participating in leadership and policy development.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gather, through report crds, regional youth issues and use results to design educational opportunities to enhance knowledge on transition.		X		X
2. Maintain partnership with young adults (THRIVE) who are either homeless or have other cognitive issues.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				
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**b. Current Activities**

As mentioned under FPMs 4 and 5, a report using the NS-CSHCN data for Maine was completed in Spring 2008. Similar to other measures, the report revealed that transition discussions were more likely to occur with children managed by prescription medications only compared to children with functional limitations.

The HRTW youth coordinator is reviewing youth materials for the National Center to ensure they are youth appropriate and contain language used by today's youth. She presented on transitioning to adult health, from her perspective, at the National Initiative for Children's Healthcare Quality conference in March 2008.

The youth coordinator is developing a web-based self-determination program for young adults to learn how to self-advocate in various settings such as; employment, health care, and navigating a college campus.

YACs meet bi-monthly with Family-to-Family (F2F) Advisory Regional Coordinators and family members not associated with the F2F regions to discuss incentives for increasing the number of youth Report Cards completed. The results will be used as an additional data source for CSHN.

**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%. Although Maine is doing much work to improve CSHN transition to adulthood, funding cuts, especially those to Maine's Office of Adults with Cognitive and Physical Disabilities, may make transitioning a challenge for many CSHN youth.

In collaboration with the Maine Support Network we plan to establish at least four YACs in the regions; work with Maine Chapter of AAP and Dr. Lisa Letourneau to establish a medical home track for pediatricians to ensure transition from pediatric to adult health care and what that means; continue to work with practices involved with Partners in Chronic Care model of care coordination to integrate transition into the practice; and through YACs convene regional stakeholder groups to develop educational workshop suggestions based upon analysis of youth Report Cards.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	78	72	80	82.5	84
Annual Indicator	78.6	82.1	83.3	79.8	79.8
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	85	86	87	88	89

**Notes - 2007**

2007 data are not yet available; 2006 data are used as an estimate.

**Notes - 2006**

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 2006 is based on the National Immunization Survey 4:3:1:3:3 series. (Note: The 2002 and 2003 indicators were corrected for the FY06 block grant application; the values reported in prior applications were incorrect.)

**Notes - 2005**

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 1998-2005 is based on the National Immunization Survey 4:3:1:3:3 series. (Note: The 2002 and 2003 indicators were corrected for the FY06 block grant application; the values reported in prior applications were incorrect.)

**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. Between 2002 and 2006, the rates have fluctuated between a low of 78.6% in 2003 and a high of 83.3% in 2005. In 2006, 79.8% of children received the full 4:3:1:3:3 schedule. Maine's immunization rate is the 34th highest in the U.S. 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. The Maine Immunization Program (MIP) hypothesizes that this may be due to several factors. Between 1999 and 2003 a significant portion of program resources were focused on developing the ImmPact Immunization Registry with less available for provider education. In addition, the MIP centralized its staff from contracts on the county level to staff centrally located in the capitol (Augusta). This resulted in some communities without readily available educational resources. The MIP also experienced decreased staffing levels through resignations and delays in filling health educator, data registry manager and vaccine coordinator vacancies due to a state hiring freeze.

To gain a better understanding of the immunization decline the MIP partnered with the USM Muskie School in the fall of 2006 to develop and implement a survey with Maine parents of preschool children to identify both barriers to and incentives for getting children immunized. Of the 8,526 randomly selected mothers of children born in Maine between 2002 and 2006, 31.1% responded. The survey revealed that on average those whose children were not all immunized had more children under age 5 in their households and reported a higher level of completed education. While those reporting that not all children were immunized or all their children were immunized agreed with statements about the health protection of childhood immunization, the value of physicians' recommendations about vaccination, and the risk of childhood diseases,

levels of agreement were lower among those whose children were not immunized. The most often cited reasons for not immunizing pre-school children were the number of shots administered at one time and concerns about autism. Survey results will be used to help identify public health practices that are most likely to result in children who have age-appropriate immunizations and to inform ongoing program planning priorities.

ImmPact2 was launched in FY07 with the provider recall/reminder functionality allowing each provider or practice to review the immunization status of a selected population, identify children needing additional immunizations, and print recall cards or letters to the family. Of the nearly 500 provider practices in Maine, 200 participate in the ImmPact system. However, there is no manager for this system, therefore it is currently being underutilized.

While overall immunization rates are down, 95% of enrolled children in home visiting during FY07 were up to date on immunizations compared with 85% of children in Maine and 83% of children nationally on the 4:3:1 immunization schedule based on data from the 2006 NIS. Immunization is embedded in the curriculum of home visitors and continues to be a performance measure for the contracted community agencies. As they become aware of the barriers families encounter (i.e. transportation) and assist with working through them, the home visitors record this data and share it with the MIP.

Public Health Nursing, under an agreement with the MIP, continued to audit assigned medical care practices in Maine to assess the 2-year old immunization rates and to assess and offer education related to the storage of vaccines supplied by the MIP. Eleven PHNs interacted with 55 medical practices during CY07. Full CASA audits were performed at 32 practices and an additional 23 practices received a Co-CASA assessment and education related to the handling of vaccines. The numbers are down from CY06 as a result of medical practices utilizing the ImmPact immunization information system.

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

The most recent data for this measure suggest that about 79.8% of children age 19-35 months in Maine received the full 4:3:1:3:3 immunization schedule in 2006. 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 addition to MIP, other programs in the state are working to increase children's immunization rate. Maine's Home Visiting Program (HVP) found that 95% of children enrolled are up to date on their vaccines. The MIP is working with the HVP 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.

Through the Early Childhood Director, Early Childhood Comprehensive Systems Initiative (ECSI), the HVP is working with the MIP to begin engaging childcare providers as an audience to support immunization. In addition, families who are enrolled in home visiting have significantly higher rates of being age appropriately immunized. The very close relationship that families have with home visiting provides a unique opportunity to refer to health professionals or provide support around the need to immunize children.

**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 HVP. 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.

The MIP and ECSI will explore ways to support the fieldwork of Child Care Health Consultants within the newly designed public health districts (discussed in Section IV A) as another trusted consistent connection to families to improve immunization rates.

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.

In partnership with the MIP and other appropriate entities, findings from the USM Muskie School report will be used to begin addressing barriers to and incentives for immunizations.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	12.8	12.6	12.3	10.4	9.6
Annual Indicator	12.4	10.5	10.7	9.9	9.4
Numerator	339	284	292	271	251
Denominator	27319	27155	27257	27291	26825
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

	2008	2009	2010	2011	2012
Annual Performance Objective	9	8.7	8.4	8.1	7.8

**Notes - 2007**

2007 birth rate per 1,000 female population 15-17 is provisional and subject to revision. 2007 population estimate from US census as of July 1, 2007 for females age 15-17.

**Notes - 2006**

2006 birth rate per 1,000 female population 15-17 is provisional and subject to revision. 2006 population estimate from US census as of July 1, 2006 for females age 15-17.

**Notes - 2005**

2005 birth rate per 1,000 female population 15-17 is provisional and subject to revision.

**a. Last Year's Accomplishments**

Maine's adolescent pregnancy rate has been declining since 1998 and has consistently been lower than the U.S. rate. Based on data from 2006, Maine's rate of teen births was 9.9 per 1,000 females ages 15-17 compared to 22.0 per 1,000 in the United States. Maine's teen birth rate declined in 2006, even as the U.S. rate increased for the first time since 1991. For teen pregnancies in this age group, Maine met its 2010 goal in 2006 of 13.6 per 1000 females. Maine is committed to keeping our teen birth rate low through its work with Family Planning clinics, ongoing data monitoring, and with educational programming.

Family Planning clinics served 31,051 clients including 8,921 teens in FY07 a decrease of 2.89% from FY06. According to Maine census data, the decrease is associated with a decline in the teen population in Maine and according to Youth Risk Behavior Survey (YRBS) data, teen delays in sexual activity. In addition, family planning clinics have been essentially flat funded while costs have been increasing. During FY07, the oral contraceptive, Ortho increased significantly in price causing a formulary adjustment. Fortunately NuvaRing was included in the 340B Program at a price that allowed programs to include it in their formulary. In addition MaineCare began allowing it on their preferred drug list beginning January 2007. Services continue to be offered at 6 school-based health centers (SBHC). Evaluation efforts in FY07 focused on continued use of contraceptives in returning clients, and STD/HIV counseling and follow-up. Chart reviews showed an overall return rate for all clients of 57% and of the total number who returned for an annual exam a year following their last one, 95% were continuing with contraception. With respect to STD and HIV counseling following a positive STD, chart reviews revealed that 100% of records indicated that clients had been contacted, treated and provided information about the prevention of STDs. 33% of all clients diagnosed returned for re-screening after four months. Efforts continue to improve the % of clients re-screened after a positive test to reach the projected 60%. Quality assurance of clinical services continued through the use of satisfaction surveys and chart reviews. Client surveys continued to show high levels of client satisfaction.

In fall 2006, Maine's Teen and Young Adult Health Program (TYAHP) published "The 2006 Maine Report on Teen and Young Adult Sexual Health." This report provided demographic, trend and risk factor data on youth sexual health in the state. Results of this report have been used to highlight racial and ethnic disparities in adolescent births in the state and have helped guide the selection of questions for Maine's new Integrated Youth Survey, to be implemented in 2009. This survey will expand on the information collected on adolescent sexual health through the YRBS and will provide local level data to Maine schools and communities to help guide prevention and intervention efforts.

In FY07 Family Life Education Consultants provided curriculum consultation, teacher training, and technical support to 34 priority schools and consulted with an additional 77 schools, serving a total of 854 educators. Activities included increased parent programs, with 31 programs serving 578 participants.

During FY07 Family Planning collaborated on a project with the United Somali Women of Maine (USWM) to train Peer Educators as family planning specialists in an effort to provide reproductive health information to the Somali population in a culturally appropriate manner. The goal of the project is to expand access to reproductive health information, counseling and services to Somali families in the Lewiston/Auburn area where approximately 3,000 Somalis reside. The USWM conducted 5 focus groups reaching 42 Somali women. Reproductive health issues emerged as an interest and concern among focus group members.

The Annual Comprehensive Sexuality Conference titled "Sexually Healthy: The Way Maine Should Be" was held April 5, 2007. 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. 155 participated in the conference. This is a continuation of a collaborative effort between TYAHP, Family Planning Association, the DOE, and the Maine HIV/STD Program.

**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 and family planning outreach.		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**

2007 Maine YRBS data reveal the % of teens who have had sexual intercourse has not changed substantially over the past few years (45.4% in 2007), but the % who report using a condom at last intercourse has increased since 1995 from 46.9% to 58.9% in 2007 revealing the importance of family planning to lowering Maine's teen birth rates.

Of concern is a \$190 million State supplemental budget deficit. A significant reduction in family planning services funding was proposed and although the cuts were not adopted by the Legislature some may still occur in 2010. Such cuts threaten the most marginal family planning clinics in the most rural areas and closures could result in increases in pregnancy rates that have been on the decline in recent years.

During fall 2007 Maine's SBHCs came under pressure when a City of Portland middle school committee voted to allow the City's Public Health Division to provide prescription birth control to middle school students enrolled in the SBHC making it the first middle school in Maine to make prescription birth control available to 6, 7 and 8 grade girls. Despite much adverse media attention the school committee resisted pressure to reverse their decision or to set limits on providing prescription birth control to children younger than 15. As part of the policy change the SBHC revised its parent information and enrollment form and asked parents to re-submit forms mid-year. Most enrolled students were re-enrolled and the new policy was implemented.

**c. Plan for the Coming Year**

In 2009, Maine is planning on administering an Integrated Youth Health Survey. Through this effort, all school-based surveys will be combined and any school will be eligible to participate. Questions on adolescent sexual health and behaviors will be included in the survey and data on some of these questions will be available at the local level. This will allow Maine's TYAHP to better focus its intervention efforts at the community level.

The Family Planning Association of Maine will continue to develop partnerships with racial and ethnic minority populations to address disparities. A planning process to ensure the most effective, science-based strategies are being applied to Maine will continue, with a focus on family life education and community-based pregnancy prevention strategies. A re-examination of intermediate outcome measures will be part of this process. Service numbers are likely to decrease if proposed budget cuts are approved.

We project that Maine will continue to show progress on this measure. Our objective is to reach a low of 8.4 per 1,000 in 2011. Although our objective is consistent with trends over the past 5-10 years, 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	55	34	56.6	58	60
Annual Indicator	22.7	56.6	56.6	56.6	56.6
Numerator	1405	636	636	636	636
Denominator	6194	1123	1123	1123	1123
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	60	60	60	60

**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.

The 2003 indicator reflects the percentage of Medicaid-eligible children ages 8 to 9 years who

had at least one sealant placed on a permanent tooth. The data do not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

**Notes - 2006**

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

The 2006 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 thirdgraders 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 2001-2003 indicators reflect the percentage of Medicaid-eligible children ages 8 to 9 years who had at least one sealant placed on a permanent tooth. The data do not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

Prior to 2001, the indicators for this objective came from the 1999 Smile Survey.

It is unknown at this time when the Maine Child Health Survey will be conducted again.

**Notes - 2005**

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

The 2005 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 thirdgraders 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 2001-2003 indicators reflect the percentage of Medicaid-eligible children ages 8 to 9 years who had at least one sealant placed on a permanent tooth. The data does not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

Prior to 2001, the indicators for this objective came from the 1999 Smile Survey.

The Maine Child Health Survey of kindergartners and third graders will be conducted again in 2006-2007.

**a. Last Year's Accomplishments**

Maine is using data from the 2003-2004 Kindergarten/3rd grade Maine Child Health Survey (MCHS) to report on this measure. These data are not weighted due to a low response rate to the survey (18%) and may not be generalizable to 3rd graders in the state. The MCHS survey will be administered again in 2009. It has been problematic for Maine's Oral Health Program (OHP) and Title V agency to accurately track this measure. We have been looking for additional data to provide insight into children's oral health in the state and whether children are receiving adequate preventive services. Based on data from the 2003 National Survey of Children's Health, 80% of Maine parents with children between the ages of 1-17 years reported that the condition of their children's teeth was excellent or very good. Among children in the age group that includes 3rd graders (6-11 year olds), only 13.1% reported not seeing a dentist for routine preventive care during the past year. Dental insurance appears to be a problem for children in this age group with 22% not having dental insurance coverage; similar to national data. Although the NCHS provides useful information on children's oral health the survey is only conducted every four years. Medicaid data from FFY 2006 reveal that about 43% of EPSDT eligible children in Maine between the ages of 6 and 9 received dental services within that year. We plan to continue to work with MaineCare to try to get accurate sealant data for children enrolled in MaineCare.

The OHP continues to maintain the dental sealant component of its School Oral Health Program (SOHP) that supports classroom-based education and fluoride mouthrinse programs. The sealant component began in 1998 with 22 schools providing sealants for 403 second-grade students. In the 2006-07 school year, 22 programs provided sealants in 125 schools; 1274 second graders received 4032 sealants (an average of 3.16 sealants each) and the retention rate was 94%, based on screenings of 1175 third graders.

Funding constraints due to internal budget allocations to the OHP in FY07 resulted in terminating grants using the MCHBG state match for support to 3 agencies providing clinical dental services to at-risk children. They maintain services but do not provide data to the OHP. These funds were partially redirected to the SOHP, after a reduction in the OHP's internal allocation from the state general fund, previously used to fully fund the SOHP. For SFY07 a one-time grant was made to the City of Bangor to help pilot a preventive oral health program with the WIC program in Penobscot and Piscataquis Counties. The City determined the program to be congruent with its goals and has maintained it; a new foundation began providing support in July 2007 as part of its efforts to promote early intervention and dental disease prevention. After a reduction in the internal allocation to the OHP from the Preventive Health and Health Services Block Grant (PHHSBG), the rest of these MCH funds were used to provide partial support of programs coordinated by community agencies in 2 large rural counties (Aroostook and Washington).

During this reporting year, the OHP continued to experience vacancies in two positions. One position (funded by Title V) was changed from a Public Health Educator II to a Planning and Research Associate and filled in November 2006. This position assists with contract and data management, resulting in better, more timely reporting of our school-based programs. Efforts to hire a qualified dental hygienist continued to be unsuccessful. Requirements for the position were reviewed during summer 2007; a decision was made to drop the requirement for hygienist licensure and recruitment was re-opened at the end of 2007, resulting in a new hire in March 2008. Because of a reduction in the allocation to the OHP from the PHHSBG, this position is funded at half-time.

The State Oral Health Improvement Plan was published in FY07. The Advisory Committee chose to refer ongoing monitoring of its implementation to the existing Maine Dental Access Coalition, a broad-based stakeholder group. Many of the Plan's strategies are intended to enhance state infrastructure and broad-based initiatives that would support increasing the proportion of Maine third-graders who receive sealants.

[[http://mainegov-images.informe.org/dhhs/boh/files/odh/MEOralHealth\\_Plan07.pdf](http://mainegov-images.informe.org/dhhs/boh/files/odh/MEOralHealth_Plan07.pdf)]

**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. Re-evaluate plan and implement database for sealant program data collection and school oral health program.		X		X
3. Continue as MaineCare provider for sealants.				X
4. Collaborate on integration of the Maine Child Health Survey with other school-linked health surveys, including an oral health component.			X	
5. Coordinate implementation of components of State Oral Health Improvement Plan.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

A workgroup was formed in 2007 to examine how to improve the MCHS and its response rate. It was determined that the MCHS will become part of Maine's Integrated Youth Health Survey. An RFP, in development, includes administration of the MCHS with an oral health assessment as part of the proposal. Funds to conduct the survey should be awarded in Fall 2008 with an anticipated survey administration in Spring 2009. We anticipate that the new integrated survey will help Maine's OHP obtain accurate, generalizable data for this measure

The OHP successfully applied for a new 4-year grant from MCHB under the Targeted Oral Health Service Systems Program. Funding began in September 2007. Activities will implement our curriculum, "Maine Smiles Matter-An Early Childhood Caries Prevention and Intervention Program for Non-Dental Providers" and work to increase collaborative networks in Maine to promote an effective medical-dental interface. Our intent is to increase the number of young children who receive oral health assessments and preventive dental visits and are identified as having a dental home. Expected outcomes are that (1) more children will receive earlier preventive care; (2) their parents/caregivers will have better access to appropriate education; and (3) dental and non-dental health providers will better coordinate their interactions so that children are referred appropriately.

**c. Plan for the Coming Year**

We have not changed Maine's objective for this measure and plan to keep it at 60% until we receive representative data on sealants from the Maine Integrated Youth Health Survey in 2009. However, we are continuing to investigate alternative sources for data on this measure. We are planning to meet with Maine's Medicaid agency to determine whether we can access MaineCare data on sealants in the Medicaid population and we are working with Maine's Home Visiting Program and Public Health Nursing Program to explore the data they collect on children's preventive oral health services.

The OHP will continue to encourage inclusion of sealant components in the SOHP within the constraints of available funding. We resumed billing in 2007 as a MaineCare provider to bring additional revenue to the OHP to support school-based sealant programs and will encourage larger school-linked sealant programs to bill for these services to supplement funding.

The health educator/hygienist will focus on coordination of the SOHP and the dental sealant component and updating the OHP's educational resources, particularly those that can assist

schools, other organizations and individuals in oral health promotion and dental disease prevention activities. There are tentative plans for her to coordinate a training session during the first half of the 2008-09 school year for school nurses, health educators and hygienists about the SOHP with particular attention to the sealant component.

Our plan had been to start a new five-year grant cycle for the SOHP with new contracts in SFY09. In light of available resources and changes in the Maine CDC's approach to grant-making, as well as an expected reorganization of school districts in SFY09, we are extending current contracts for one year. We plan to re-evaluate the components of the program and the basis for eligibility in consultation with appropriate staff including the School Nurse Consultant in the Department of Education (DOE) and the Maine CDC's Coordinated School Health Program.

The OHP continues to support the Maine Dental Access Coalition, a broad-based stakeholder group. The Coalition has responsibility for overall monitoring of the implementation of the State Oral Health Improvement Plan. Many of the Plan's strategies are intended to enhance state infrastructure and broad-based initiatives that would support increasing the proportion of Maine third-graders who receive sealants.

During the 2006 legislative session, a proposal to include mandated oral health screenings in school entrance health screenings was heard by the Education Committee and funded at \$25,000 annually. DHHS and the DOE convened a task force to develop definitions and explore models for school entrance oral health screenings, with a referral component as directed by the Legislature. The OHP manager co-convened this group with DOE staff. Our expectations are that the screening project program can be implemented by the end of calendar 2008.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	3.5	3.5	3.2	3	3
Annual Indicator	3.4	3.8	3.3	3.5	3.5
Numerator	41	45	38	39	
Denominator	1195448	1174980	1149644	1126308	
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	3.2	3.1	3	2.9	2.8

**Notes - 2007**

2007 mortality data are not yet available. 2006 data are used as an estimate.

**Notes - 2006**

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

The 2006 indicator is the 5-year average for 2002-2006. 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. The last 5 years of MV crashes among 0-14 year olds using this definition is:

1998-2002:  $31/1235796 = 2.6$  per 100,000  
1999-2003:  $34/1194879 = 2.8$  per 100,000  
2000-2004:  $36/1174411 = 3.1$  per 100,000  
2001-2005:  $32/1149644 = 2.8$  per 100,000  
2002-2006:  $33/1126308 = 2.9$  per 100,000

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

#### **Notes - 2005**

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

The 2005 indicator is the 5-year average for 2001-2005. 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. The last 5 years of MV crashes among 0-14 year olds using this definition is:

1998-2002:  $31/1235796 = 2.6$  per 100,000  
1999-2003:  $34/1194879 = 2.8$  per 100,000  
2000-2004:  $36/1174411 = 3.1$  per 100,000  
2001-2002:  $32/1149644 = 2.8$  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 2002-2006 was 3.5 per 100,000 children. 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 Youth Risk Behavior Survey (YRBS) the % of middle school students who never or rarely use a seat belt has declined recently. Based on 2007 YRBS data 9.8% 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. Data from Maine's PRAMS 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 to identify motor vehicle traffic crashes as a priority in their program plan.

The number of Child Safety Seat Program (CSSP) sites continues to fluctuate due to changes or loss in staff at sites, new sites, or site closures (33 active sites). The program provided 2,271 car seats during FY07. Infant/toddler seats (birth-40 pounds) represented 53%, combination seats (2-4 age group) 22%, high back boosters (4-8 year olds) 19%, and 6% were high weight and special need seats. Special need seats include seats for children too small or too large for standard seats, harness systems for children with behavioral issues, and specially constructed

seats for children with health related issues. Although we lost one site in the Portland area, a second site was able to continue with a high volume of seat distribution. This site is one of three located in urban areas working with minority populations and provided the highest number of seats to families. They provided training and seats to 654 families from October 1, 2006 through September 30, 2007 representing approximately 28% of all seats provided during the period.

The Traffic Safety Educator (TSE) collaborated with the Maine Department of Education (DOE) and the Maine Association for Pupil Transportation (MAPT) in 2007 to further develop and offer an awareness course related to transporting pre-school age children and children with special needs on school vehicles. The course was provided to 40 school Department Transportation Directors at the MAPT conference in July 2006.

During FY07, National Highway Safety Administration CPS technician classes were held in Old Town in May and in Vassalboro at the Maine Criminal Justice Academy in June. A total of 25 new CPS technicians received training; almost half of which were law enforcement officers.

More than 36,541 (including the Buckle Me Up Moose Stickers and Help ME Bike Safely bike helmet stickers) pieces of injury prevention promotional materials related to traffic safety were distributed to organizations throughout the state

The program continues to provide technical assistance to members of the public who request information on car seats.

**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. Evaluate CPS Technician training.				X
4. Provide support and education to fitting stations.				X
5. Collect data on misuse and number of seat checks.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Recent efforts on this measure have included a focus on examining safety restraint use in motor vehicles. Analyses of Maine's Fatal Accident Reporting System (FARS) were conducted in Spring 2008. Results revealed that between 2002-2006, twenty-seven of the 39 MV-related deaths among children 0-14 years were captured in the FARS data system. Of these, 19 (70.4%) were using some type of passenger restraint system, 6 (22.2%) were not using any restraint and 2 (7.4%) had unknown restraint use. All but one of the 14 (0-7 year olds) who were in cars, SUVs, minivans, or vans (excluding pickups) were seated in a back seat.

In 2007 the Muskie School at the University of Southern Maine conducted 2 studies of safety restraint use in Maine; 1 of these studies on children found that 90% of children under age 12 in the state were using some sort of safety restraint device.

<http://muskie.usm.maine.edu/Publications/ChildSafetyRestraintUseMaine2007.pdf>

We are working with the Children's Safety Network to begin evaluation of our CPS Technician Training. The evaluation is being conducted to; 1) investigate high rates of CPS technicians not re-certifying after 2 years and, 2) to ensure parents are receiving the best education on transporting their children safely.

We continue to market the program through 2-1-1, a community helpline for families to locate services.

**c. Plan for the Coming Year**

We anticipate continued improvement in this measure and we have slightly adjusted our objectives based on the results of the most recent data. Maine's Office of Substance Abuse is planning on providing funding to Maine's Office of the Medical Examiner to conduct toxicology screens of drivers of motor vehicles. We plan to examine the information gathered by the Medical Examiner's office to examine the role of substance use in the motor vehicle deaths of young children and youth.

MIPP will continue the following activities during FY09:

1. Provide child safety seats and technical assistance to safety seat programs statewide. Provide seats to families in need including those with special needs.
2. Continue to work with the media and legislators to educate the public on child passenger safety issues.
3. Provide annual child passenger safety training to Child Passenger Safety Seat Program staff at various locations around the state via telecommunication technology.
4. Provide at least one daylong Child Passenger Safety (CPS) Technician update class for certified CPS Technicians.
5. Provide child passenger safety technician training based on the National Highway Traffic Safety Administration, child passenger safety standardized curriculum.
6. Continue to provide educational materials and resources on child passenger safety to professionals, advocates and the general public.
7. Maintain a current list of locations of car seat check locations and car seat distribution sites on our website, on 2-1-1, and on the Bureau of Highway Safety website.
8. 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.
9. Continue to educate school transportation personnel on the intricacies of transporting pre-school aged and special needs children on school buses.
10. Collaborate and coordinate activities with Safe Kids Maine in promoting child passenger safety.
11. Convene site managers once yearly to celebrate their accomplishments and provide program and car seat updates.

**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	2003	2004	2005	2006	2007
Annual Performance Objective				38	41
Annual Indicator			36.9	40.6	46.6
Numerator					
Denominator					

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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	47	48	49	50	51

**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 and 2006 surveys were combined to obtain this estimate.

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

**Notes - 2006**

Percent of mothers who breastfed their infants at 6 months of age.

Data from the 2005 National Immunization Survey; 2006 data are not available.

**Notes - 2005**

Percent of mothers who breastfed their infants at 6 months of age.

Data from the 2004 National Immunization Survey; 2005 data are not available.

Data from 2004 PedNSS indicate that 23.8% of WIC mothers breastfeed their infants at 6 months.

**a. Last Year's Accomplishments**

There are four surveillance systems that include Maine breastfeeding data; the CDC Pediatric Nutrition Surveillance System (PedNSS) 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 National Immunization Survey 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 year of the child's birth, rather than the year that the respondent was interviewed. Due to changes to the presentation of data from the NIS, the most recent data available for this measure are based on children born in 2004; 46.6% of children born in 2004 were breastfed to at least 6 months; 15.9% were exclusively breastfed for 6 months. This percentage is not statistically higher than the national average, but Maine has the 14th highest breastfeeding rate at 6 months in the United States and the 7th highest exclusive breastfeeding at 6 months rate. According to NIS data from 2000-2004, Maine's breastfeeding rate has fluctuated over time, but in 2003 and 2004, more women reported ever breastfeeding and breastfeeding for at least 6 months, compared to previous years. Maine PRAMS data do not reveal a discernable trend in breastfeeding initiation between 2000 and 2005. Maine 2005 PRAMS data indicate that 78.6% of Maine mothers initiated breastfeeding and 58% were still breastfeeding when they completed the survey, which is usually when their infants are about 3 months old. Data on WIC participants from PedNSS indicate that breastfeeding rates

among women enrolled in WIC increased gradually over time between 2002-2005, but show a slight decline in 2006. In CY06, about 56% of women enrolled in WIC ever breastfed their infants. Breastfeeding rates at 6 months postpartum among WIC women have not changed over time. 23.4% of WIC enrolled women breastfed their infants until 6 months in CY06. (Table 1 attached)

The programs in Maine focused on improving breastfeeding rates among new mothers are WIC, Maine's Home Visiting Program, and Public Health Nursing (PHN).

Two local WIC agencies received USDA funding to implement breastfeeding peer counseling programs in FY05; these programs continued in FY07. There are currently 4 breastfeeding peer counselors in these two agencies. Peer counselors are mothers who have successfully breastfed their infants; and are trained to offer encouragement, information and support to mothers enrolled in the WIC program.

During FY07, a student intern evaluated WIC's Breastfeeding Peer Counselor Program. The agencies that implemented the Breastfeeding Peer Counselor Program reported more women exclusively breastfeeding, breastfeeding for at least six months and initiating breastfeeding after the start of the program compared to before the program start date. The Maine WIC Breastfeeding Peer Counselor Program has demonstrated positive outcomes for breastfeeding mothers.

The Home Visiting Program actively encourages new mothers to breastfeed and links mothers to resources such as hospital breastfeeding classes and lactation consultants. In FY07 the % of home visiting families that were breastfeeding at 6 months was 36%.

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 FY07 CHN provided 10,560 visits to 4,221 clients. Of the 10,560 visits, 1,005 were at risk parenting visits, 5,582 children visits, 152 children with special needs visits, 3,556 postpartum visits, 259 prenatal visits and 6 childhood death visits.

During FY07 PHN provided 19,750 visits to individual clients. Of these visits 5,430 were children, 2,830 parenting, 2,924 postpartum, 398 prenatal for a total of 11,582 individual visits.

***An attachment is included in this section.***

**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 and public health nurses on the development of counseling and clinical skills to support optimal breastfeeding practices.				X
3. Enhance the WIC breastfeeding peer counselor programs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The WIC Nutrition Program has 3 major initiatives that will impact the provision of services. The Program: 1) issued a RFP to select a Local Agency for each district of the Maine DHHS for FFY09; 2) implemented Value Enhanced Nutrition Assessment (VENA), initiated by the Food and Nutrition Service of USDA to provide guidance and structure to the WIC nutrition assessment process, and 3) is applying for a WIC Special Projects Grant to deliver VENA through improved cultural and linguistic competence of WIC staff. These initiatives will provide infrastructure for enhancing the focus of WIC's breastfeeding activities.

In FY08 five local WIC agency staff members plan to complete Certified Lactation Counselor (CLC) training. With these 5 staff there will be approximately 32 local WIC agency staff trained as CLCs and 4 trained as International Board Certified Lactation Consultants. The WIC breastfeeding peer counselor programs will continue; one of the breastfeeding peer counseling sites will expand its program.

**c. Plan for the Coming Year**

Due to changes in the way the NIS calculates this measure, we have adjusted our objectives and hope to increase our breastfeeding at 6 month rates by at least 1% each year through 2011. 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 outlined in the RFP 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.

The WIC Program will focus on increasing the number of WIC mothers who are breastfeeding their babies at six months, and on providing pregnant and/or breastfeeding women access to a qualified lactation counselor. The Program will continue to collaborate with the local WIC agencies, the Maine State Breastfeeding Coalition and the Maine Physical Activity, Nutrition and Healthy Weight Program to enhance breastfeeding promotion and support strategies.

The WIC Program will maintain the two local agency breastfeeding peer counselor programs with one of the agencies expanding the program to include another clinic. The WIC Program will continue to provide technical assistance to the local agency breastfeeding coordinators and ensure that data is collected according to standard procedures and methods.

Public Health Nursing 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	95	75	90	91	96.5
Annual Indicator	98.4	88.9	91.7	95.0	95.3
Numerator	12883	12208	12827	13307	13317
Denominator	13097	13733	13988	14009	13969
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	96.8	97	97.2	97.4	97.6

**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.

**Notes - 2006**

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 and 2006 estimates includes 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 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.

**Notes - 2005**

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 estimate includes 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 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**

Since 2004 when data were collected on the number of children screened and not just the number of children that had access to newborn screening, Maine's screening rate increased from 88.9% to 96.6 % in 2006; 95% of infants were screened within the 1st month of life. It is important to note that Maine's data for this measure does not reflect only infants that were screened before hospital discharge. It includes infants who were ever screened as reported by hospitals. In Form

11, we report the % screened by 1 month of age as a proxy for those screened at hospital discharge. Maine's newborn screening rates in 2005 and 2006 were comparable to U.S. rates published by the National Center for Hearing Assessment and Management.

Through a cooperative agreement with the University of Maine at Orono the Genetics Program developed an electronic tracking system called ChildLINK. The system links newborn hearing screening data with the electronic birth certificate, enabling the Maine Newborn Hearing Program (MNHP) to verify that every baby born in Maine has a newborn hearing screen and to track follow up services. Birthing hospitals and audiologists have the capability of submitting screening and diagnostic data via this secure web-based system. ChildLINK allows the integration of information necessary for tracking individual children through hearing screening, identification and intervention. By 2003 all Maine birthing facilities (32 hospitals and 1 free-standing birthing clinic) had established newborn screening programs. During CY06 18 birthing facilities had a greater than 98% screening rate with 5 of these facilities obtaining a 100% rate. Only 2 facilities had less than a 95% screening rate. The remaining 13 facilities had screening rates between 95% and 98%. It is unlikely that all 33 birthing facilities will reach 100% as the rate is based on the number of live births at each facility and does not take into account parent refusal or other instances where a baby dies shortly after birth. During 2007 all 33 birthing facilities received a site visit with an in-service and technical assistance as appropriate.

Successful enrollment of all birth hospitals into the electronic reporting system enables accurate and timely information needed to successfully track all infants for confirmation of hearing screening and results of hearing screening. Data system enhancements and quality improvement activities provided for more accurate screening information for infants born in CY06. For CY06, 13,539 infants received hearing screens of the 14,009 Maine births (96.7%). Of the 13,539 screened, 330 (2.4%) were referred for audiological evaluations. The program received 113 or 34.2% reports on those referred. 93 or 82% of the 113 for whom the program received audiological evaluations were seen by 3 months of age. Of the 113 reports received, 14 were identified with hearing loss.

Maine audiologists play an important role in diagnostic evaluations for infants who screen positive for hearing loss. The challenge to the MNHP was a lack of results being reported back to the program. As a result the program worked with the Maine Academy of Audiologists and MNHP Advisory Board to submit legislation (LD 1142) requiring that all hospitals licensed in the State and other providers of services that have established hearing screening or diagnostic procedures for newborns, infants, and children up to 3 years of age report to the department all data on hearing screening, evaluation, and diagnosis of newborns, infants and children up to age 3 years of age. The bill was signed by the Governor on June 6, 2007.

LD 1239 "Resolve, To Establish a Working Group to Study the Effectiveness and Timeliness of Early Identification and Intervention for Children with Hearing Loss in Maine" was introduced and signed into law by Governor Baldacci, became effective June 27, 2007.

To address awareness about the benefits of newborn hearing screening and early identification the MNHP held a symposium on September 7-8, 2006. This symposium brought together Maine's Early Intervention specialists from Part C, Child Development Services and Maine's Center on Education for Deaf and Hard of Hearing, Early Childhood and Family Services (ECFS) to develop and promote a best practice model for early intervention of infants with hearing loss. At the end of the first quarter of CY07, the ECFS Program was providing early intervention services for 48 children birth to 3 years of age.

**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. Provide tracking of newborns who do not pass the hospital screen.		X		
3. Educate providers about the mandated requirement of providing results of audiologic evaluations to the Newborn Hearing Program.				X
4. Collaborate with CDS, Part C agency to facilitate referrals into early intervention.		X		
5. Establish a Models for Improvement Team.				X
6. Facilitate the Newborn Hearing Program Advisory Board.				X
7. Evaluate comprehensive screening and service system.				X
8.				
9.				
10.				

**b. Current Activities**

Although newborn hearing screening is not mandatory in Maine, approximately 97% of infants are screened indicating that parents and health care providers are aware of the importance of the issue and Maine's Newborn Hearing Program is effectively ensuring that newborns have access to hearing tests.

Recent analyses of newborn hearing screening have focused on documentation of infants that did not pass the initial screening and quality improvement efforts are being made to increase documentation and follow-up of newborns that did not pass the screen.

LD 1142, An Act to Enhance the Maine Newborn Hearing Program mandates reporting of audiological evaluations and diagnosis of infants went into effect in September 2007. Consistent reporting of audiological evaluation results are needed on all infants referred from hospital newborn hearing screening for appropriate and timely follow-up.

During FY08 the Working Group established by LD 1239 will examine issues of access to timely and accurate diagnosis of hearing loss by age 3 months and review the process by which families are informed of their options for communication and finding providers in the State.

We are working on developing a MOA between the Maine DHHS and the Department of Education to facilitate referrals of children birth to 8 years old into early intervention services through Child Development Services. Through this agreement, we will explore access to case specific early intervention and outcome data.

**c. Plan for the Coming Year**

Preliminary data for 2007 indicate that Maine is maintaining its level of newborn hearing screening; about 97% of infants born in 2007 were screened for hearing. We hope to see an increase in this rate in the years approaching 2010. In addition to our current efforts, we have planned an in-depth statistical analyses of the infants who are not screened for hearing in the state, using data from MNHP, which is linked to our birth and infant death certificate, Newborn Screening and Birth Defects data through Maine's ChildLink data system. Using this data system we will be looking at factors that may explain why some children are not screened, such as premature birth, location of birth (e.g., home birth or birthing center), or infant death. These analyses will provide us with a better estimate of our hearing screening rate and provide us with in-depth information to help focus our efforts towards improving the screening rates.

During FY09 the MNHP plans to use the "Model for Improvement" model that identifies 4 key

elements of successful process of improvement. MNHP formed a model for improvement team at the 2008 Early Hearing Detection and Intervention Conference in New Orleans. At the conference we identified 5 system levels where improvements to the system could be implemented resulting in a reduction in the loss to follow-up. Those 5 levels include birthing centers, primary care providers, families, audiologists, and Part C early intervention. MNHP will continue to ensure that all babies are screened; collect individual data on screening results through ChildLINK, provide families with information about newborn hearing screening prior to screening and written documentation of the results of the screening; provide information in a culturally sensitive manner in the preferred language of the parent; provide information necessary for primary care providers to provide care and, ensure that birth facilities make audiological diagnostic appointments prior to discharge for families whose newborn fails a hearing screening.

The MNHP will 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	10	10	10	10	7.5
Annual Indicator	7	6	6	7	
Numerator					
Denominator					
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	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	8	8.5	9	9.5	10

**Notes - 2007**

2007 data for this indicator are not yet available.

The 2006 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.

Our objective of 10% by 2012 is influenced by persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform, Dirigo Health Plan.

**Notes - 2006**

Percent of children without health insurance.

Our objective of 9.5% by 2011 is influenced by persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform, Dirigo Health.

Not enough time has passed to see the longterm impact of increasing cost of living (heating oil, gas, rent, and food) expenses. In addition, we do not know at this time what the impact of the Dirigo health changes will be. During the most recent legislative session, funding was not approved to expand enrollment. As a result, as of July 1, 2007, enrollment of individuals in Maine's Dirigo health program was temporarily suspended; as of Sept 1, 2007, enrollment will be suspended for small businesses and self-employed as the program looks for ways to cut costs. Furthermore, the Deficit Reduction Act opened the door for states to take the opportunity to make changes in medicaid packages. Maine has not made any changes as yet to MaineCare and we do not know what the impact will be if this occurs.

We will continue to work with the Governor's Office on Health Policy and Finance to monitor over time to determine the anticipated direction of this trend.

#### **Notes - 2005**

Percent of children without health insurance.

The 2005 indicator reflects analysis of 2003-2004 state data from the pooled 2005 and 2006 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 objective of 10 % by 2009 is influenced by persisting economic uncertainty mixed with anticipated benefits from Maine's new health care reform, Dirigo Health Plan.

The indicator of 10% reflects 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.

#### **a. Last Year's Accomplishments**

Since 1996 there has been a considerable decrease in the % of Maine children without health insurance. According to the 2006 Current Population Survey, 6.4% of children under age 18 in Maine are currently without any health insurance. About 29% were covered by MaineCare and 69% were covered by private health insurance. The US child uninsured rate was 11.7% in 2006. Maine has one of the lowest uninsured rates in the U.S. 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

8,169 students were enrolled in school-based health centers (SBHCs) in Maine in FY07. There were 16,299 encounters, 27% of all visits were for mental health services, 22% of the primary diagnoses at medical visits were for preventive services, and approximately 55% of the users had a preventive care visit. About 40% of users were screened for major adolescent risk behaviors including tobacco use, physical inactivity, poor nutrition, sexual activity, substance abuse, depression and suicide and behaviors connected to unintentional injury.

84% of SBHC enrollees had an identified primary care provider, while 5% 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 Assembly of School Based Health Care (MeASBHC), through a Kellogg Foundation

Grant, continued to increase SBHC sustainability through community involvement and mobilization, including youth involvement and clinical improvement initiatives. The TYAH Program is an active partner in this public private partnership and provided base funding for 20 SBHCs.

Nearly all children enrolled in the Home Visiting Program in 2007 had access to a primary care provider (99.6%) and 97% had health insurance, more than half through MaineCare. Key to this high rate of insured children is the eligibility determination made during the initial family engagement. The remaining 3% 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.

During FY07, of the 4221 clients served by Community Health Nursing, 40.16 % were insured by MaineCare, 44.49 % had private insurance, and 1.16 % had no 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 Maternal and Child Health matching funds and the Fund for a Healthy Maine (Master Tobacco Settlement funds) for 20 SBHCs continues to assist in maintaining access to services as the SBHCs and sponsoring agencies face more stringent budgets. The legislature increased funding for SBHCs slightly; on average, this funding provides 27% 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 12% and 2% of SBHC revenues respectively.

**c. Plan for the Coming Year**

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.

The TYAHP will continue to fund 20 SBHC grants in FY09, 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.

Despite these efforts, in Maine, this is the only measure for which we foresee worsening conditions over time. Due to persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform plan (Dirigo) and cuts to MaineCare (Medicaid) and SCHIP, we unfortunately do not anticipate any improvements in Maine's child health insurance rate in the near future.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				32	31
Annual Indicator			33.6	33.1	
Numerator			3461		
Denominator			10298		
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	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	30	29	28	28	27

**Notes - 2007**

2007 data are not yet available.

**Notes - 2006**

Data are CY2006 PedNSS.

**Notes - 2005**

This is a new measure. 2005 data are not yet available. TVIS requires that an estimate be entered for 2005; we used 2004 data from PedNSS as the 2005 estimate.

**a. Last Year's Accomplishments**

Maine uses national Center for Disease Control and Prevention (CDC) Pediatric Nutrition Surveillance System (PedNSS) data to determine prevalence of children > 2 years enrolled in the WIC Program at or above the 85th percentile for weight. The PedNSS data shows that Maine rates of children enrolled in WIC at or above the 85th percentile for weight have remained consistently high for the past five years. (Table 1 attached) The Healthy People 2010 goals are to reduce to 10% and 5%, respectively, the proportion of youth who are at risk for overweight or overweight.

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 continued to foster an emphasis on healthy behaviors and family meals. In FY07, USDA implemented the WIC Risk Revision; this revision includes emphasis on thorough assessment, including qualitative assessment of feeding behaviors for all participants.

Another major initiative that the Maine WIC Nutrition Program initiated during 2007 was the

implementation of Value Enhanced Nutrition Assessment (VENA) for all Local and State Agency WIC Staff. VENA was developed jointly by the Food and Nutrition Service and the National WIC Association to improve nutrition services in the WIC Program by establishing standards for the assessment process used to determine WIC eligibility and to individualize nutrition education, referrals, and food package tailoring. An overview of VENA with an emphasis on rapport building and health outcomes was provided at the annual WIC conference held for all State and Local Agency staff.

**An attachment is included in this section.**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publicize Maine Pediatric Nutrition Surveillance data on the Maine CDC website.		X		X
2. Submit the Special Project Grant to USDA for consideration of application in FY09.				X
3. Implement and evaluate VENA training provided to local agency staff.				X
4. Implement and evaluate RFP indicators to achieve the WIC goals.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Maine WIC Nutrition Program has 3 major initiatives that will impact the provision of WIC services. The Program: 1) issued a Request for Proposal to select a Local Agency for each Maine DHHS district for FFY09; 2) implemented VENA, initiated by the Food and Nutrition Service of USDA to provide guidance and structure to the WIC nutrition assessment process, and 3) is applying for a WIC Special Projects Grant to deliver VENA through improved cultural and linguistic competence of WIC staff. These initiatives will provide some infrastructure for enhancing the focus of WIC's counseling and education activities.

The guiding principle for VENA is to strengthen and realign the primary purpose of WIC nutrition assessment to personalizing nutrition services in order to maximize the impact WIC nutrition services have for participating families. During FY08 basic skill training will be provided in several competency areas including: rapport building, critical thinking, cultural competency, stages of behavior change, health-outcome assessment, emotion-based counseling, nutrition knowledge, and breastfeeding.

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

**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 RFP 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 participate in VENA training and apply training to participant nutrition assessments.

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

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				19	17
Annual Indicator			20	17.5	17.1
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	16.5	15	14.5	14	13.5

**Notes - 2007**

The data source for this measure is the Pregnancy Risk Assessment Monitoring System. Data for 2007 are unavailable. Therefore, 2006 data are used as an estimate for 2007.

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

**Notes - 2006**

The data source for this measure is the Pregnancy Risk Assessment Monitoring System. Data for 2006 are unavailable. Therefore, 2005 data are used as an estimate for 2006.

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

**Notes - 2005**

The data source for this measure is the Pregnancy Risk Assessment Monitoring System. Data for 2005 are unavailable. Therefore, 2004 are used as an estimate for 2005.

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

**a. Last Year's Accomplishments**

Data from Maine's Pregnancy Risk Assessment Monitoring System (PRAMS) reveal that the smoking rate among pregnant women in the state has fluctuated over time, but has not changed

significantly. It reached a high of 20% in 2004 and data from 2005 and 2006 suggest that it may be declining, but this decrease is not statistically significant. 17.5% of pregnant women reported smoking during the last three months of pregnancy in 2005 and in 2006, 17.1% reported smoking. According to MCHB's Title V Information System, Maine had the 11th highest rate of smoking during pregnancy out of the states that reported data for this measure in 2006.

During FY07 a significant amount of the Partnership for Tobacco-Free Maine (PTM) staff time was spent working on structural changes. A new RFP released in September was the first to braid local grant funds across DHHS programs with the intent of being more effective and efficient. A key component of the RFP was a requirement for District Tobacco Coordinators to ensure tobacco is addressed at the local level.

PTM presented to 20 childcare providers in February 2007; topics addressed included secondhand smoke (SHS), adverse effects of smoking and SHS on the health of pregnant moms, new moms, children, and family members, not smoking in homes and cars, residue SHS, Maine Laws, and getting family members to quit. The ABC's of second hand smoke: Training module for Child Care Providers was provided to attendees. A DVD titled "Stop Smoking Now" was shown to attendees.

PTM attended numerous events to educate providers who serve women and provide materials and resources for women on the importance of quitting. PTM attended the Women, Infant and Children (WIC) annual meeting (October 2006) and held discussions about tobacco with WIC staff. PTM attended the 5th Annual Perinatal Nursing Conference, and the Association of Women's Health, Obstetric and Neonatal Nurses annual meeting. PTM also participated in two March of Dimes events: Prematurity Campaign Summit "Preconception Health Care and Disparities in Birth Outcomes and the March of Dimes Prematurity Awareness Day "Premie 1372 Project".

PTM awarded 12 Healthy Maine Partnership (HMPs) local grantees a nine-month mini-grant to address a population with high smoking prevalence rates. Two grantees chose pregnant women specifically addressing quitting and relapse. Healthy Portland partnered with the Family Birthing Center at Maine Medical Center in Portland to address tobacco and offer brief interventions to new moms on quitting. All staff were trained to deliver brief interventions and develop a process to help pregnant women and family members to quit including materials and the Maine Tobacco HelpLine. Follow-up phone calls after leaving the hospital is now standard protocol and are deemed helpful to women when relapse is most likely to occur. Attempts to call women 6 months after completion of the grant were unsuccessful due to small numbers. The second grantee located in rural Maine chose to collaborate with a local Hospital and its' affiliates to refer women to PTM programs; Every Mothers' Wish (EMW), Maine Tobacco HelpLine, and local cessation programs developed for pregnant moms. Health care providers and staff were trained to offer brief interventions and track progress at each office visit. This rural area presented many challenges; staff turnover, initial difficulty with the hospital's buy-in and small numbers of pregnant women in the area. However after 9 months the hospital was on board and assisted with writing a grant to continue the work. The grant was not awarded but the relationship continues. Two additional grants addressed tobacco use among low-income young families at WIC, HeadStart, and Family Planning agencies in two very rural counties in Maine. The low SES population is reached through these providers, including pregnant and new moms.

The Maine Tobacco HelpLine offers quitting materials and coaching to pregnant women. The number of pregnant callers who smoke is tracked through a series of 3 questions. Seventy-Seven callers to the HelpLine during FY07 were currently pregnant, 62 were planning a pregnancy within 6 months, and 20 were currently breastfeeding. These numbers were significantly lower than FY06. (172, 172 and 52 respectively) possibly due to the EMW being updated and not available during this time.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Redesign and promote the Every Mother's Wish Program to providers.		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. Promote programs and messages at the local level through Healthy Maine Partnerships.		X	X	
5. Collaborate and expand partnerships with other MaineCDC programs (WIC, Women's Health Initiative) and Office of Substance Abuse to address quitting with their clients.		X		X
6. Collaborate with the Office of MaineCare Services to reduce the morbidity, mortality and healthcare costs associated with tobacco use.				X
7. Evaluate programs and track prevalence rates.				X
8. Provide proactive counseling to all pregnant women through the Maine Tobacco HelpLine and face to face coaching.			X	
9.				
10.				

**b. Current Activities**

PTM presented at five regional WIC trainings in Spring 2008 to train staff on referring pregnant and new moms to the Maine Tobacco HelpLine and local cessation services. WIC staff were introduced to District Tobacco Coordinators within their region and encouraged to use them as a resource.

Epidemiologic analyses of 2005 Maine PRAMS data have been conducted and revealed that the highest rates of smoking are among young women (<24 years old) and those with a high school or less than a high school education. Low-income women, including those enrolled in MaineCare and WIC, report higher rates of smoking during pregnancy compared to higher income women. In 2006, 1 in 3 (31.1%) pregnant women enrolled in Maine's MaineCare program smoked during pregnancy. During 2007, in-depth analyses comparing Medicaid enrolled new mothers and non-Medicaid enrolled mothers were conducted to examine patterns in smoking and the cessation methods offered to each group. Results revealed that Medicaid enrolled mothers were more likely to have smoked prior to pregnancy, during pregnancy and were more likely to resume or continue smoking after pregnancy. There were few statistically significant differences in the types of cessation methods offered to Medicaid enrollees compared to non-Medicaid enrollees. These analyses have been helpful to the PTM Program in their examination of whether cessation methods are being advocated for all populations.

**c. Plan for the Coming Year**

We have set the objective for this measure to decline approximately 1.5% each year over the next 5 years. We believe this is attainable due to several factors including Maine's new public health infrastructure that encourages tobacco cessation efforts at the community level and increased collaboration between Maine's PTM and Title V program. Maine's PTM program in collaboration with Maine's Title V program is planning to conduct more in-depth analyses of smoking behaviors among pregnant women using PRAMS data. We also plan to examine other data sources such as WIC and Maine's Home Visiting database for smoking information that can be used by the program to improve their cessation efforts with pregnant women and women's

reproductive age.

PTM recognizes the barriers and challenges for pregnant women to quit smoking. The Healthy Maine 2010 goal is to reduce smoking rates to 5 %. To achieve this goal PTM will redesign the EMW Program based on focus group feedback and Strategic Planning Workgroup input. PTM is considering piloting the revised EMW in twenty OBGYN offices to evaluate its impact. PTM will use WIC trainings as a basis for reaching other agencies (i.e. TANF, Home Visitors, Head Start), and provide fax referrals to the Maine Tobacco HelpLine. A provider brochure will be developed and will include resources and materials along with a users guide. Emphasis will be on the Maine Tobacco HelpLine and local cessation resources.

Resolve 34 "Regarding Tobacco Cessation and Treatment" directed the Maine Department of Health and Human Services, PTM Program and the Office of MaineCare Services to undertake a study of best practice treatment and clinical practice guidelines for tobacco cessation treatment and report back to the Joint Standing Committee on Health and Human Services by January 15, 2008. Low SES pregnant women who smoke were identified to conduct a pilot that will include intensive face to face counseling during FY09.

Regional clinical outreach specialists will promote the Public Health Service Guidelines to Treating Tobacco Use and Dependence (revised 2008) to provider offices with an emphasis on pregnant women.

Conduct a training session on smoking during pregnancy for PHN at their annual fall staff development day.

The PTM website is currently being updated to be more informative. A section for women and pregnant women will be included.

Work with Maine CDC liaison and new District Tobacco Coordinators to ensure tobacco is a focus and that all HMPs are addressing tobacco at the local level

Work with the Home Visiting Program to determine a mechanism for enrolling women prenatally in home visiting.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	11	11	10	9.9	9.2
Annual Indicator	10.1	11.3	9.3	8.4	8.4
Numerator	46	52	43	39	
Denominator	457310	459295	463598	463415	
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

	2008	2009	2010	2011	2012
Annual Performance Objective	8.3	8.2	8.1	8	7.9

**Notes - 2007**

2007 mortality data are not yet available; 2006 data were used as an estimate.

**Notes - 2006**

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

The 2006 indicator is the 5-year average for 2002-2006. 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

**Notes - 2005**

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

The 2005 indicator is the 5-year average for 2001-2005. 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

**a. Last Year's Accomplishments**

Maine's suicide rate has fluctuated over the past several years. However, based on the most recent data available on suicide deaths among youth in the state, the 2002-2006 suicide rate among 15-19 year olds declined compared to the prior 5-year period. In 2002-2006, our suicide rate among 15-19 year olds was 8.4 per 100,000. This rate is lower than our 2006 objective of 9.3 per 100,000. Hospitalization rates for self-injury among 15-19 years also declined in 2005 and 2006 suggesting that our work is making a difference. Based on the data that reveal that suicide is the 2nd leading cause of death among youth age 15-19, the Maine Injury Prevention Program has identified suicide as one of 4 priority areas in their program plan.

The Maine Youth Suicide Prevention Program (MYSPP) launched two new web sites at a Blaine House tea on September 13, 2006. One site specifically for youth was designed with significant input from youth. Once launched it was evaluated by 175 youth and additional revisions made. The site can be accessed at: [www.mainesuicideprevention.org/youth](http://www.mainesuicideprevention.org/youth). A major feature of the web site for adults at [www.mainesuicideprevention.org](http://www.mainesuicideprevention.org) was a "Contact Us" option that generates an average of 2 requests per week for additional information.

The program participated in the Campaign for Mental Health Recovery sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Alliance on Mental Illness focused on 18-25 year olds. A plan was developed that involved dividing the state by media markets and identifying a local champion in each one. Over 4500 brochures, "What A Difference a Friend Makes" were distributed to colleges and other agencies in Maine.

The 3rd annual Beyond the Basics of Suicide Prevention conference was held in Portland in April 2007. The list of presenters included Dr. Barent Walsh (treating self-injury), Dr. Shawn Shea (eliciting suicidal ideation), and Bev Cobain (working with survivors).

The MYSSP Training and Education Project Director co-presented a workshop at the American Association of Suicidology annual conference in New Orleans in April 2007 on criteria for selecting suicide prevention videos. Fact sheets were developed for specific audiences including the elderly, college, American Indian and clergy.

In collaboration with the Department of Education's (DOE) Health Education and Coordinated School Health Program the annual Comprehensive School Health Education Spring Workshop was held in May 2007. 130 elementary and middle school teachers, high school health education

teachers, administrators and school health coordinators attended. Injury prevention sessions included eating disorders, understanding the choking game, what's happening in the drug scene and inhalant abuse.

In June 2007, DOE held its' Annual Schoolsite Health Promotion Conference. 44 school systems participated for a total of 320 attendees. Sessions offered specific to injury included: adults addressing youth and teen depression; youth suicide prevention in Maine schools; and gentle and effective ways for dealing with at risk and difficult children. Teams draft their Wellness plans at the conference, bring them back to their larger school team to finalize and implement during the year. The final plan is submitted to DOE by September 30th of each year. Fall and winter meetings are held to follow-up on progress and offer technical assistance.

Mailings were sent to all school principals and all Maine colleges to generate interest in available training programs and to acquaint them with resources available through the program. Extensive training was conducted to support the SAMHSA grant received in 2005. A total of 1,894 people (both SAMHSA and non-grant participants) were trained during FY07. They included:

1. 297 attended an annual Beyond the Basics of Suicide Prevention conference
2. 26 regional, invitational, and school-based Gatekeeper Training programs reached 578 individuals
3. 30 youth attended a workshop at the Maine Youth Action Network conference
4. 767 people attended 29 statewide Suicide Awareness Programs
5. 86 people attended 6 Training of Trainers programs to prepare individuals to present awareness programs
6. 3 School Protocol Development workshops were attended by 31 school administrators and their designees
7. 32 school personnel attended Lifelines Teacher Training programs, and
8. 73 people attended a session to learn about the significant findings from the CDC grant project

**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 information through promotion of statewide hotline.			X	
2. Provide suicide prevention training and education programs statewide.		X		X
3. Provide guidance and technical assistance to school and community personnel for suicide prevention and intervention.			X	X
4. Evaluate effectiveness of selected MYSPP 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 SAMHSA funded Intervention Project.				X
7. Support implementation of MYSPP 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**

Although 2007 death certificate data are not yet available on suicide, hospitalization data suggest that suicide attempts in Maine are declining. A similar pattern is seen in Maine's 2005 and 2007 Youth Risk Behavior Survey data, which also show a decline in suicide ideation and attempts, especially among adolescent girls. As we expand the Lifelines Program to additional schools through SAMHSA funding, we hope to continue to see declines in our suicide rates, self-injury hospitalization rates, and adolescent self-reports of suicidal ideation and attempts.

Maine was one of 5 national demonstration sites for a Coping and Support Training, a model program shown to reduce suicidality in high-risk youth. A staff member participated in a webcast in collaboration with the Campaign for Mental Health Recovery focused on reducing stigma associated with seeking help for mental illness.

MYSPP recognized 10 years of progress at a Blaine House Tea on September 12th an event that garnered significant media coverage.

Collaboration opportunities with the Veterans Administration, AFSP Maine, Maine colleges, and the New England Institute of Addiction Studies are being explored.

### **c. Plan for the Coming Year**

Our performance objectives for the coming year and beyond reflect the challenges of reducing the youth suicide rate. We hope to continue to see a modest decline in the suicide rate and self-injury hospitalizations over time and anticipate a continued downward trend in reported suicidal behaviors among middle and high school students. Our 2007 objective is to reduce Maine's suicide rate to 9.2 per 100,000. However state cuts to services, especially mental health services, may impact Maine's ability to change our rates.

Our plan includes continuing to provide gatekeeper training sessions, training of trainers (preparation to conduct suicide prevention awareness education), Lifelines teacher training, training for youth partners, and an annual advanced suicide prevention conference. We also plan to explore development of a booster session for high school seniors on transition, depression, and suicide; and to continue to provide technical assistance to communities and schools as resources permit.

In addition, we will continue to promote the 24-hour crisis hotline to callers statewide through distribution of materials, the program website, and in all education and training sessions. We will complete the current SAMHSA funded youth suicide prevention project and associated evaluation reports describing progress achieved. We anticipate potential additional SAMHSA funding to support reaching more Maine schools and communities to implement and evaluate best-practice suicide prevention programs. Finally, we will monitor trends in suicide and self inflicted injuries among the Maine population and widely distribute updated fact sheets and resource materials in a variety of formats including the MYSPP web site.

The DOE will explore including a section specific to injury prevention in its Key Concepts Document, a document that links key concepts in nutrition education, tobacco use prevention, alcohol and other drug use prevention to the health education standards and performance indicators outlined in Maine's Learning Results.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	80	80.5	81	81	81.5
Annual Indicator	80.7	80.8	80.5	81.1	82.1
Numerator	638	636	659	672	690
Denominator	791	787	819	829	840
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82.2	82.3	82.4	82.5	82.6

**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.

**Notes - 2006**

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2006 indicator is the 5-year average for 2002-2006. 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.

**Notes - 2005**

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2005 indicator is the 5-year average for 2001-2005. 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**

The percent of Maine's very low birth weight (VLBW) infants born at high risk facilities has not changed significantly over the past nine years; about 80% of infants who should be delivered at high risk facilities are delivered there. Over this same time period, we have also not seen a significant increase in the percentage of very low birth weight babies born in the state. This suggests that although 4 out of 5 infants are being delivered at appropriate facilities, increased efforts are needed to increase this rate to ensure healthy outcomes for VLBW infants.

Maine has 2 Level III nurseries; Eastern Maine Medical Center in Bangor and Maine Medical Center 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 remains an important and active factor in obtaining better outcomes for pre-term infants born in Maine.

The Division of Family Health continues to collaborate with the Perinatal Outreach Education and Consultation Program (POEC) at Maine Medical Center (MMC). The POEC provides education and consultation and assumes a leadership role in a variety of public health activities, including the establishment of the Maternal and Infant Mortality Review process. The POEC contributed to

the quality of perinatal care in Maine by providing 61 formal education programs reaching 786 health care professionals during FY07. In addition, 7 transport conferences were held with 124 professionals attending. Transport conferences provided an opportunity for education and consultation during the review of specific facility-selected cases. Overall, program attendees continued to be primarily registered nurses (60.0%), although many physicians (20.0%), and others (21%) participated in the educational programs, including advanced practice nurses and home birth midwives. Highlights included topics such as perinatal substance abuse, domestic violence and prematurity. The POEC continued to provide basic and advanced skills in assessment, management and resuscitation for high risk pregnancies.

Maine Medical Center hosted the 5th Annual Perinatal Conference titled, "The Realities of Addiction". Approximately 200 participated, supporting continued interest in understanding perinatal substance abuse.

In CY05 Title V submitted a successful proposal to the Maine March of Dimes for a grant for a Maternal and Infant Mortality Review Initiative (MIMR). The overall goal of the initiative is to strengthen community and state resources and a wide array of systems and policies for women, infants, and families. MIMR is modeled after the National FIMR Program to learn how to prevent maternal, fetal, and infant deaths by considering the broad environmental, social, and economic context in which those deaths occur. During FY07 Administrative rules for MIMR were drafted.

A full Review Panel was convened July 18, 2007. An update of available data was discussed and a review of an infant death was completed using a "mock" case as an introduction to the Panel process. Feedback was obtained on the process for use in developing Panel protocols.

**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.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MIMR rules drafted in FY07 went to public comment and were adopted in February 2008. Panel protocols, including confidentiality, case review, and maternal and family interview guidelines are being drafted. Consultation with other state-based MIMR and FIMR programs resulted in refinement of procedures and protocols for Maine. The protocols were reviewed by key stakeholders and finalized in June 2008.

Analyses on infant mortality in Maine and the primary risk factors of infant death, low birth weight and prematurity are currently being conducted. These analyses are part of Maine's MIMR Panel, which was recently legislated in the state. These analyses will help us to identify characteristics associated with very low birth weight infants not delivered at high risk facilities. Geographic

variations and health systems factors will be considered in these analyses. We hope the results will be used by the MIMR panel in their reviews and recommendations for systems-level changes to improve birth outcomes.

Title V leadership partnered with the March of Dimes to plan the October 2007 Prematurity Summit. Over 150 perinatal nurses, nurse midwives, physicians and substance abuse counselors attended the conference. The Prenaturity Summit featured Milton Kotelchuck, PhD, MPH, Chairman and Professor, MCH, Boston University, School of Public Health. His presentation addressed "Women's Health and Preconception Care between Pregnancies: The Development of Inter-natal Care Programs".

**c. Plan for the Coming Year**

The Maternal Infant Mortality Review panel will be convened to complete an orientation including a maternal review in July of 2008. Evaluation of the process will assist with finalizing the protocols for future reviews of actual cases. The process for case selection will be established and implemented with Review Panel meetings scheduled at least quarterly.

Collaborations will continue with the Maine Medical Center Perinatal Outreach Education and Consultation 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.

Partner with March of Dimes to plan 2009 Prematurity Summit.

Initiate the process to invite families to participate in the review process and/or interview for the MIMR.

Provide bereavement training to Panel members and other interested parties in an effort to ensure that all components of the program, in particular, case reviews and family interviews demonstrate sensitivity to and understanding of the grieving process.

Based on the trend of the past nine years, which has shown little change, 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.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	88	89	89	90	90
Annual Indicator	87.2	88.1	87.8	87.4	87.2
Numerator	12070	12276	12392	12370	12295
Denominator	13846	13929	14111	14152	14102
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90	90	90	90	90

**Notes - 2007**

Data source: Maine Office of Data, Research and Vital Statistics

**Notes - 2006**

Data source: Maine Office of Data, Research and Vital Statistics

**a. Last Year's Accomplishments**

Between 1998 and 2006, 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 received prenatal care in the first trimester. In 2004, the most recent year with comparable US data, Maine ranked fourth in the U.S. in the percent of women receiving prenatal care in the first trimester (among those using the unrevised birth certificate). 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 have given birth to help assure proper prenatal care. During FY07 fifteen agencies in 16 counties provided 20,484 home visits to families, a 10% increase in home visiting services from FY06. More than 5,609 families were served in FY07, almost half with home visits. 30% were enrolled in the home visiting program prenatally. Parents receiving a greater frequency of visits per month (3-4 visits) were more likely to report an improvement in parenting ability than those receiving fewer visits.

During FY07 the evaluation focus of Maine's HV Program shifted to using data to inform quality improvement. The HV Program evaluator conducted site visits with program managers of the 15 individual programs that comprise the program. The purpose of the visits was to solicit information on unique efforts or practices each program is engaging in and the successes or challenges they had with those efforts. The report was intended as a reference guide for program managers. For example one success story shared in the report was from a program that determined their breast feeding rates were down so redesigned the program to increase rates. The state program administrator uses monthly program manager meetings to share the knowledge gained from this report and from peers.

Standards of Practice for home visiting programs were developed during FY07 utilizing program manager input. Topics included skills training, supervision, caseload, and collaboration. The standards were added as a contractual performance expectation for the 15 agencies providing services beginning July 2007. A copy of the standards will be made available via the web in early FY09 with the redesign of the home visiting website.

It is a challenge for both home visiting and public health nursing to see individuals prenatally. A relatively small proportion of PHN visits 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.

The WIC Nutrition Program is collaborating with the PHN staff and other partners to enhance the

provision of services to pregnant women in their first trimester.

**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, Healthy Families 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 2007 births in Maine reveal that 87% of new mothers received prenatal care in the 1st trimester. This is the same rate as 2006. Several programs within Maine's DHHS are attempting to increase the number of women they serve prenatally and encouraging them to seek early prenatal care. According to data from Maine's HV Program about 36% (976 children out of 2,713 enrolled) of children enrolled in 2007 were seen during the prenatal period. It is a priority for the HV Program to increase the number of children enrolled early. In FY07, 88% of women enrolled in Maine's HV Program reported adequate prenatal care, which is comparable to the Maine rate of 87%. WIC is also using outreach to increase the number of women who enroll in the program during the prenatal period.

State budget challenges are forcing programs to look more closely at creative funding structures. The HV Program is using data collected from contracted agencies to create a funding formula as a basis for distributing funds. It will be based on first time births, weighted very heavily on past performance of how well an agency has been able to enroll individuals prenatally, get to first time births, how long individuals remained with the agency and if they received a minimum of at least two visits. The programs priority will be looking at the number of prenatal to 6 months after birth enrollments.

**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. In order to help us reach this goal, we plan to undertake an in-depth analyses of prenatal care among Maine women using birth certificate and PRAMS data to understand the characteristics and geographical location of women who do not receive prenatal care in the first trimester to better understand this group and help guide activities in this area.

This data will help inform outreach efforts for the HV programs that collectively are developing

strategies to engage Family Planning and health care clinics for earlier prenatal referrals. In addition, the curriculum used for prenatal enrollments, which requires a specific skill set for engaging parents before the child is born, is being reviewed and updated and will become part of the core knowledge expectations of home visiting professional development.

The WIC Program will 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 is 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.

## 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	58%	57%	58	46	45
Annual Indicator	50.7	46.9	54.1	59.2	59.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	44	43	42	41	40

#### Notes - 2007

2007 PRAMS data are not yet available; 2006 data were used as an estimate.

#### Notes - 2006

The data source for this measure is the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

Please note that the estimate for 2003 was changed from 59.2 to 50.7 when it was discovered that previous data had been provided for women less than 25 years of age instead of 24 years of age. The 2003 and 2004 data reflect unintended pregnancies among those under age 24. We could not change the values prior to 2003.

#### Notes - 2005

The data source for this measure is the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

Please note that the estimate for 2003 was changed from 59.2 to 50.7 when it was discovered that previous data had been provided for women less than 25 years of age instead of 24 years of age. The 2003 and 2004 data reflect unintended pregnancies among those under age 24. We could not change the values prior to 2003.

#### a. Last Year's Accomplishments

According to the most recent data from Maine's Pregnancy Risk Assessment Monitoring System (PRAMS), over half (59.2%) of births to women less than 24 years of age in Maine are

unintended. This rate has been increasing since it hit a low of 46.9% in 2004. Unintended pregnancy in Maine is most common among young women, women with less than a high school education, and low-income women. It is especially difficult to attempt to reduce unintended pregnancies among women age 20-24 who are no longer in school; over half of these pregnancies are unintended.

In December 2006, our Maternal and Child Health Epidemiologist presented analyses at the 2006 Maternal and Child Health Epidemiology conference that showed associations between unintended pregnancy and recent intimate partner violence, a lack of informal social support, and postpartum depression. There have been recent efforts in the state to address violence against women through Maine's Safe Families Partnership Initiative (See Other Program Activities) and a legislative effort to monitor depression and postpartum depression among women and new mothers. These initiatives may help to reduce unintended births in the state.

**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 and family planning outreach		X	X	X
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 Teen and Young Adult Health 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**

Maine's objectives for this measure through 2011 anticipate a decline in this measure over time. We hope that the recent trend we have seen in the percent of unintended pregnancies in this age group will change direction. However, we acknowledge that proposed budget cuts to family planning services may challenge our ability to change the direction of this measure.

The basic infrastructure of the 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.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				55	56
Annual Indicator		53.8	58.2	55.9	55.9
Numerator		5813			
Denominator		10804			
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	57	58	59	60	61

**Notes - 2007**

2007 PedNSS data are not yet available; 2006 data were used as an estimate.

**Notes - 2006**

Data are from 2006 PedNSS.

**Notes - 2005**

Data are from 2005 PedNSS.

**a. Last Year's Accomplishments**

The Maine WIC Nutrition Program had 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 CY07. Consequently, the program has not used the breastfeeding goal data because it is unreliable.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
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 and opportunities for WIC counselors on the development of counseling and clinical skills to support optimal breastfeeding practices.				X
4. Implement and evaluate VENA training provided to local agency WIC staff.				X
5. Implement and evaluate RFP indicators to achieve the WIC goals.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The breastfeeding data that is specific to the Maine WIC Nutrition Program shows that only 56% of WIC infants were ever breastfed and 23% were breastfed at six months. The National Immunization Survey data shows that exclusive breastfeeding rates of 42% at 3 months were achieved but only 16% were exclusively breastfed at 6 months.

The Maine State Breastfeeding Coalition, Maine Lactation Consultant Association and WIC Program collaborated on the annual breastfeeding education conference for health care professionals. The title of the May conference was "Breastfeeding 2008-Identifying Pieces of the Puzzle". The conference provided an opportunity for local WIC agency staff to learn current evidence based breastfeeding practices that can be applied when counseling participants.

**c. Plan for the Coming Year**

Continue, through the Maine Family Network, to support breastfeeding and lactation.

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.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	27	26	28	26	25
Annual Indicator	28.7	26.6	27.1	27.1	27.1
Numerator	178	168	174	175	
Denominator	620921	630463	641315	644640	
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	24	23	22	21	20

**Notes - 2007**

2007 mortality data are not yet available.

**Notes - 2006**

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 2002-2006.

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 rates for 15-21 years olds are:

- 1998-2002: 187/610243 = 30.6
- 1999-2003: 174/619849= 28.1
- 2000-2004: 164/630463= 26.0
- 2001-2005: 169/641315 = 26.4
- 2002-2006: 168/644640=26.1

**Notes - 2005**

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 2001-2005.

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 rates for 15-21 years olds are:

- 1998-2002: 187/610243 = 30.6
- 1999-2003: 174/619849= 28.1
- 2000-2004: 164/630463= 26.0
- 2001-2005: 169/641315 = 26.4

**a. Last Year's Accomplishments**

Maine's 5-year average motor vehicle death rate among youth 15-21 years in 2002-2006 was 27.1 per 100,000. This is the same as Maine's 2001-2005 rate. This translates into about 35 deaths per year and is a similar rate to the 2001-2005 U.S. rate. In Maine, due to the small population size, we tend to present 5-year averages for many rates to help stabilize estimates over time. However if we examine single year deaths rates, we see that in 2003, Maine's single year motor vehicle death rate for youth age 15-21 was the lowest it had been in 15 years at 19.3 per 100,000. Since then it has climbed and in 2006, it reached a rate of 32.6 per 100,000, the highest it has been since 2001. 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.

In order to try to decrease the motor vehicle death rate in the state, the MIPP actively participated to seek passage of a mandatory seat belt law (L.D. 24) by providing data, and testimony. The bill allows a police officer to detain and cite a vehicle operator or passenger 18 years of age or older solely for failing to wear a seat belt. The law went into effect September of 2007.

L.D. 161, "An Act to Prohibit the Use of Cellular Telephones by Minors While Driving" was passed and signed by the Governor on June 11, 2007 and went into effect in September 2007. This bill prohibits a person who has not attained the age of 18 years from using a cellular telephone while operating a motor vehicle. The bill makes the offense a traffic infraction.

The MIPP provided technical assistance to the Maine Transportation Safety Coalition and other state and public agencies to develop instruments to evaluate Maine's "Get Out Alive" Challenge for young drivers. The program provides classroom education, an interactive website, a teen newsletter and culminates in a driving challenge for teens and their parents.

The Department of Education, Health Education and Health Promotion Program promoted, through exhibits, driving safety and seat belt safety at their Annual Schoolsite Health Promotion Conference in June 2007. They also promoted bicycle and walking safety and encouraged participants to incorporate in the school health education curriculum.

**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. Work with the Bureau of Highway Safety on a CPS Observational Study.				X
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MIPP is working to complete its Strategic Plan 2007-2010 Revision. The four injury priorities are unintentional poisoning, suicide, falls among older adults and motor vehicle crashes across the lifespan.

The MIPP continues to work under a CDC Integrated Core Injury Prevention Grant to build capacity for evaluation and data collection for injury prevention to provide technical assistance to community interventions involving younger and older drivers. Members of the motor vehicle workgroup continue to brainstorm potential interventions with a focus on teen driving issues.

Although 2007 data on motor vehicle deaths are not yet available, 2007 Youth Risk Behavior Survey (YRBS) reveal that about 77% of high school students in Maine always or most of the time wear a seat belt when driving in a car with another person. About 1 in 5 (21.8%) reported driving in a car with someone who had been drinking in the past month and 8.8% reporting drinking and driving in the past month. These data suggest that there is still work to be done to decrease some of the major causes of motor vehicle death among youth.

**c. Plan for the Coming Year**

Given recent legislative initiatives, we anticipate that Maine's motor vehicle death rate will decrease over the next few years. Maine's Office of Substance Abuse is planning on providing funding to Maine's Office of the Medical Examiner to conduct toxicology screens of drivers of motor vehicles. We plan to examine the information gathered by the Medical Examiner's office to examine the role of substance use in the motor vehicle deaths of youth. Maine's Injury Prevention Program is also exploring the possibility of evaluating Maine's "Get out Alive" Program, a program designed to provide education and awareness to teen drivers and their parents.

During FY09, MIPP staff will continue to:

1. Provide training and information to advocates on safe driving and the importance of buckling up.
2. Maintain 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. Disseminate current data through MIPP fact sheets upon request.
5. Conduct a MIPP sponsored teen driving symposium as part of the CDC Integrated Core Injury Prevention grant.
6. Identify community partners with whom to conduct a teen driver safety intervention to be evaluated.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				10.5	10.5
Annual Indicator	12.8	12.8	10.9	10.9	12.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.8	10	10	9.5	9.5

**Notes - 2007**

Data are from the 2007 YRBS. The data are weighted, therefore a numerator and denominator are not entered for this indicator

**Notes - 2006**

Data from YRBS are weighted therefore a numerator and denominator are not entered for this indicator.

The indicator for 2006 is the same as 2005 because the YRBS is administered every other year. The next survey will be administered in 2007 and data should be available in 2008.

**Notes - 2005**

Data from YRBS are weighted therefore a numerator and denominator are not entered for this indicator

**a. Last Year's Accomplishments**

Maine uses data from its Youth Risk Behavior Survey (YRBS) to track this measure. These data reveal that the percent of overweight and obese high school and middle school students in Maine has not changed significantly between 2001 and 2007. The most recent YRBS data from 2007 indicate that 13.1% of high school students are overweight (85th-95th percentile of BMI) and 12.8% are obese (>95th percentile). Therefore, more than 1 in 4 Maine adolescents are above a healthy weight. Maine's 2001-2005 rates are comparable to those of the United States. The Healthy People 2010 goal for adolescents age 12-19 is 11%.

In January of 2007, the Physical Activity and Nutrition Program (PANP) assumed the role of Maine CDC liaison to the Maine Nutrition Network (MNN). The MNN is a collaboration between Maine CDC and the USM Muskie School funded by the USDA Food Stamp Program. Nutrition education and physical activity initiatives are developed to reach participants in or those eligible for the Food Stamp Program. These activities are designed and implemented through collaborative partnerships with various community agencies, organizations and individuals. PANP partnered with the MNN to develop messages, education and media materials for a Healthy Weight Awareness Campaign, a social marketing campaign designed to provide Maine food stamp recipients with information on healthy lifestyle behaviors. During FY07 the campaign worked on an environmental change project with 6 local DHHS offices (3 intervention, 3 control) where the office spaces in the intervention sites were transformed with paint, banners with nutrition and physical activity (PA) messages, and photo images of families engaging in healthy eating and PA which is generally described as emotional messaging. Evaluation of the campaign to date has shown that DHHS staff react very positively to the environmental changes. Evaluation of client reaction is ongoing. In other locations where emotional messaging has been used with a similar audience, the messages proved effective in encouraging positive behavior change.

The Physicians in Schools Initiative is a private/public partnership that began in 2004 to promote cooperation between physicians and schools to improve student health and academic success through a coordinated approach to school health. An early focus of this group was around asthma management of school students but in FY07 the focus shifted to obesity and the schools role in

addressing the problem. The PANP manager assumed a co-lead responsibility in working with this group of physician organizations, Maine DHHS, the Department of Education (DOE), American Academy of Pediatrics, Maine Chapter, and the Maine Academy of Family Physicians.

In May 2007, Public Law 184, Chapter 156 was signed into law. The bill prohibits brand-specific food or beverage advertising on school grounds, except for water and product packaging, and prohibits the use of tobacco on school grounds by members of the public.

The "Let's Go! Takes 5-2-1-0 to School Initiative" a component of the private sector Let's Go! Campaign was made available to 12 southern Maine communities during FY07. The primary goal of the initiative is to increase PA and healthy eating amongst children and youth up to age 18. The initiative addresses policies, environments, and practices that influence the following health behaviors in the school setting; eating 5 fruits and vegetables per day, limiting screen time to 2 hours per day, engaging in 1 hour of physical activity per day, and increasing water consumption as well as low fat milk while limiting sugar sweetened beverages.

Through the Healthy Maine Partnership (HMP) Initiative 28 local partnerships are funded to implement comprehensive community-level interventions that promote and support a healthier lifestyle. The PANP provided technical assistance and guidance to the HMPs and School Health Coordinators to bring about policy and environmental change within schools and communities. For example, all Maine schools participating in the National school lunch program passed wellness policies that were implemented during the 2006-07 school year.

The DOE Health Education Consultant worked with health education teachers, physical education teachers, elementary classroom teachers, curriculum coordinators, school health coordinators, and school nurses to ensure PA and physical education and nutrition were incorporated in the health education curriculum across all grade levels.

**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 via the YRBS.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

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.

In June 2007 LD 1442 "Resolve, To Increase Physical Education for Elementary School Students" passed, stating that a PE4ME Planning and Oversight Committee (POC) would develop recommendations for increasing physical education (PE) in grades K-8. In September 2007 the PE4ME POC convened to determine how to provide quality PE to all Maine students in grades K-8. The PANP served on behalf of the DHHS Commissioner as one of the co-conveners

of the group, with the Governor's Council on Physical Activity and the DOE. On December 31, 2007 the Team presented recommendations to the Legislature that called for schools to provide 30 minutes of physical activity every day, 150 minutes of PE per week and funding that would include financing the cost of expanding PE, obesity control and prevention, and increased school health coordinators. The financing would be drawn from an obesity and chronic disease fund generated from surcharges on obesity related consumer expenditures such as junk food and soda. The program content and student assessment would comply with nationally established standards. While the focus of this effort and LD 1442 is not high school students, the hope is that behaviors developed at a younger age will continue into the high school years.

**c. Plan for the Coming Year**

Maine hopes to see gradual declines in the rate of adolescent obesity over the next five years, although we acknowledge that it is challenging to see changes in this outcome on a short-term basis even if our efforts are making a difference. Maine's PANP is committed to improving its' capacity for surveillance of childhood and adolescent obesity in the state. We are working with school nurses to develop protocols for measuring student height and weight and reporting this data to the state. Several objectives of the state's HMPs are related to improving nutrition and healthy weight management and could help reduce adolescent overweight and obesity. These include: increasing the number of public places with designated areas for breastfeeding, increasing the number of childcare centers with policies and programs to improve nutrition education, and providing nutrition education to families through schools. HMPs will work with local communities to achieve these objectives and their activities and data will be collected through a centralized database. Maine's Title V program will continue to collaborate with Maine's PANP to monitor the success of these initiatives across the state.

During FY09 the DOE Health Education staff will convene a working group made up of health education and physical education teachers to create a syllabus of their course work that assures teachers are covering all the Maine Learning Results Health Education and Physical Education Standards. The syllabus will be submitted to a review process and must pass the review for students to meet high school diploma requirements. Another component will be a wellness portfolio at the high school level for students to achieve health education and physical education standards as part of high school graduation requirements. All high school students will be required to have health education and physical education course work. When students are not enrolled in a health education or physical education class they will have to establish a personal fitness and personal health goal for the year that they must work on throughout the year.

The PANP will collaborate with the DOE to consider further modifications of food guidelines for school lunch programs.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				57	60
Annual Indicator			57	57	57.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>

Annual Performance Objective	57.3	63	63	65	65
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**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

**Notes - 2006**

The data used for this measure come from the 2005 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator.

The 2006 percentage is the same as 2005 because the YRBS is administered every other year. The next survey will be administered in 2007 and data should be available in 2008.

**Notes - 2005**

The data used for this measure come from the 2005 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 strengths and not just deficits. It is based in the Search Institute's knowledge 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 YRBS. In 2005, 57% of adolescents reported that they felt like they mattered to people in their community. In 2007, the percentage remained virtually the same at 57.3%. Boys were slightly more likely than girls to positively respond to this question (60.4% vs. 54.4%). There were no differences by age or grade level 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. In FY07, the Maine Youth Action Network (MYAN) continued to provide training and networking support to youth leadership programs throughout the state.

In an effort to make resources more readily available, youth created a Youth Leadership page on the MYAN website, enhanced the website's Youth and Adult Partnership resource section including creating new printable resources on the topic, and MYAN youth staff and other youth in the network contributed articles and ideas to all nine editions of the e-newsletter "News to Use" (883 recipients).

The 23rd annual Peer Leadership Conference was held on November 30th and December 1st, 2006. Over 560 youth and adults were in attendance. The conference theme was "Light a Candle for Me" because youth from around the state believed they had the power to inspire and light the way for Maine's many communities. Workshops featured a range of leadership and teen health topics such as: youth activism and policy change, youth and adult partnerships, bullying prevention, diversity awareness, youth suicide prevention and dating violence. 101 youth presenters co-facilitated workshops. 4,264 individual resources were distributed at the conference. As a result of the conference, 100% of the youth planning team said they felt more prepared to partner effectively to create positive change, 100% said they gained knowledge skills and connections to help them create positive change, and 100% felt their input was heard and respected.

The third annual Stop, Quit, Resist Youth Tobacco Summit brought together youth and adults for skill building, networking and information sharing around anti-tobacco advocacy. 175 attended including 116 youth and 57 adults. 7 youth from across the state were involved in planning and implementing all aspects of the summit. 105 Youth Advocacy Project (YAP) members were in attendance. 99% of youth and 95% of adult attendees reported that as a result of their

participation in the Summit, they felt more prepared to create positive change within their school and/or community.

YAP members worked with the Evaluation Subcommittee on creating and piloting a process measure tool to help all YAPs qualitatively evaluate their projects in a consistent manner. They also supported the review and collection of YAP Coordinator input on the Partnership for a Tobacco-Free Maine logic model and started connecting with the Physical Activity and Nutrition Program on its' logic model. This process was intended to assist YAP coordinators in identifying activities, strategies, outputs and outcomes that the Healthy Maine Partnerships look for in their work with youth.

A group of 12 youth worked to create a successful and interactive training to educate health care and other professionals working with GLBTQ on issues of cultural competency and how to create safe spaces for this population.

MYAN also worked with the Maine Youth Suicide Prevention Program to create a bookmark that was distributed to high school libraries across the state. Through her involvement with the network, one youth was able to start a suicide prevention program in her school.

**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 is expanding its training offerings with new youth/adult partnership regional trainings. The one-day sessions that include both youth and adults, trainers and participants provide skills on how to work together so that community health initiatives can positively involve youth in healthy changes in schools and communities.

A RFP is being developed for administration of Maine's Integrated Youth Health Survey. This survey is slated for Spring 2009 and will provide information on this measure as well as other asset-based measures of health.

A state team is participating in the "Spotlight in Positive Youth Development", an Initiative funded through the US CDC, and facilitated by the Cooperative Extension 4-H Program at the University of Arizona. This year long project involves training teams of four adults and two youth followed by monthly web casts and further trainings in the state for communities interested in promoting youth adult partnerships.

The Strategies for Healthy Youth Work Group is going through additional transformation. Its advisory purpose for the Office of Substance Abuse will continue through a separate advisory board dedicated to this purpose. The continuation of joint planning and capacity building related

to prevention, health promotion and youth development continues in part through the Healthy Maine Partnerships Initiative, but further collaboration is still in the planning stages.

**c. Plan for the Coming Year**

For 2011, Maine's Annual Performance Objective for this measure is 65%. This may be ambitious given the lack of change in this measure between 2005 and 2007, but the integrated survey will provide local level data on this measure. This will allow specific schools and communities to examine the data from their students and work at the local level to improve adolescents' relationships with their communities.

Data on this indicator will continue to be collected as part of Maine's 2009 Integrated Youth Health Survey.

In FY08, the MYAN contract was extended one additional year to provide some stability to this source of technical assistance during a period when significant community funding is being re-competed and while local and regional public health infrastructure is being developed. The funding went out to bid according to State purchasing requirements. This process will be completed in the summer of 2008 with a new contract in place for the new State fiscal year.

The annual fall conference, the youth anti-tobacco summit, youth-adult partnership training, technical assistance, and networking will all continue as part of the new contract requirements.

The State's participation in the Spotlight in Positive Youth Development will continue, bringing together our Communities for Children and Youth Initiative, the HIV Prevention Education Program at the Maine Department of Education, and the Teen and Young Adult Health Program for further training and shared understanding of positive youth development.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				8	9
Annual Indicator	4.7	6.3	7.2	7.2	5.3
Numerator	27	34	40	40	29
Denominator	579	539	559	556	545
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	10	11	12	12	12

**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 comprehensive 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 - 2006**

Data Sources:

Numerator: Maine Injury Prevention Program

Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2005-2006 (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 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 - 2005**

Data Sources:

Numerator: Maine Injury Prevention Program

Denominator: Maine Department of Education, 2004-2005

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.

#### **a. Last Year's Accomplishments**

The data reported for this measure are based on implementing the Maine Bullying Prevention Education Program (BPEP), coordinated by Maine Law and Civics Education (MLCE) at the University of Southern Maine (USM) through a Cooperative Agreement with the Maine Injury Prevention Program (MIPP).

29 schools in Maine have implemented bullying prevention programs through the MIPP. The 2008 project evaluation report shows statistically significant ( $p < .01$ ) decreases in certain bullying behaviors among elementary students (grades 3-5): the percent of elementary students who reported experiencing teasing, being called hurtful names, being threatened, or being hit, kicked or pushed frequently (everyday or 1-2 times a week) decreased by 16-25%; the percent of elementary students who reported frequently witnessing bullying behavior such as teasing, being called hurtful names, being left out of things on purpose, threatening, or hitting, kicking or pushing decreased by 14-26%; the percent of elementary students who reported they frequently bully others by name-calling, teasing, saying mean things, or hitting, kicking or pushing decreased by 25-45%; and the largest decreases were seen in teasing and name-calling.

During FY07 the BPEP continued in a middle school and a K-12 island school with a combined total of 680 students and 87 staff participating in the program. A shift from providing direct training and technical assistance to schools to one of training the trainers in school districts who in turn train their staff and implement the program in school districts led to a significant decrease in the numbers of student and staff participants. The middle school students were re-surveyed in April 2007. There was little difference at the end of the year between pre-program and post-program responses regarding the frequency and type of bullying. This may be due to the heightened awareness of bullying among the students.

MLCE conducted a weeklong Bullying Prevention Training Institute for 25 educators from Maine School Districts in March 2007. Participants received the Bully-Free-ME Coordinating Committee Manual, which was updated for the Institute.

As a result of this training of trainers program, at least six additional schools have conducted student surveys and initiated implementation activities for a comprehensive bullying prevention program. At least four additional schools are in the beginning stages of administering student surveys and planning staff training in bullying prevention.

Since the Maine Injury Prevention Program has changed its strategies relating to training of schools to adopt comprehensive bullying prevention programs, it is now challenging to track the number of elementary schools that have this type of program in place.

As part of its annual Comprehensive School Health Education Spring Conference, the Department of Education included a session on cyber bullying. It was well received by those in attendance.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct a bullying prevention training institute for school coordinators.				X
2. Provide guidance and technical assistance to school coordinators implementing comprehensive school-based bullying prevention programs.				X
3. Develop and disseminate accessible bullying prevention surveys and reporting tools to facilitate evaluation of the impact of the programs.				X
4. Provide training, technical assistance, and guidance to schools in restorative practices to reduce risk factors and enhance protective factors for at-risk students.				X
5. Develop and disseminate accessible surveys and reporting tools to facilitate evaluation of the impact of restorative practices in the schools.				X
6. Conduct a restorative practices institute for Maine school administrators and educators.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Activities are moving from working with individual schools to providing training, technical assistance and ongoing support to school coordinators to enable them to lead program implementation and train others within their school systems. A second bullying prevention training institute was held for 18 school coordinators in April 2008. The Bully-Free-ME Coordinator Manual is being revised and significantly expanded to include information on cyber bullying, relational aggression, and new resources. To enable local schools to evaluate the effectiveness of their bullying prevention programs and corresponding school policies and procedures, the student bullying survey and a staff survey are being developed in an online format accessible to schools.

MLCE, in collaboration with the Peace Studies Program at University of Maine, presented a 2 1/2-day conference "Transforming Discipline: Building Community through Restorative Practices" in November 2007 for 66 participants from Maine and New England. An electronic network has been established for schools interested in restorative practices implementation. One school district was selected for technical assistance and training in implementing a cohesive, whole school restorative framework that supports development of a healthy school climate. To date the school has utilized a community resolution conference with an at-risk male student to develop an accountability plan and increased school support to help him remain on track.

### **c. Plan for the Coming Year**

Although 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. After discussions with the MIPP program and Maine's Title V Director, we anticipate that this measure will not be one of the state's performance measures after this year. However, given the importance of this issue, additional data sources are being explored that contain information on bullying experiences that could be used to change the measure for future years. These sources include the Maine Child Health Survey and the Maine Integrated Youth Health Survey, both of which will be administered to students biennially through the schools.

Research suggests that suicide and interpersonal violence, such as bullying and harassment, share a number of important risk and protective factors (Lubell and Vetter, 2006). Children who are bullied are 5 times more likely to be depressed; bullied boys are 4 times more likely to be suicidal; bullied girls are 8 times more likely to be suicidal (Hawker and Boulton, 2000). Both bullies and victims express more suicidal tendencies than their non-involved peers (Roland, 2000). Suicide and violence prevention approaches which are integrated and directed at reducing risk factors and enhancing protective factors common to both have the promise to be most effective (Lubell and Vetter, 2006).

In order to adopt such an integrated approach, our plan is to broaden our activities beyond suicide prevention and bullying prevention to include enhancing such protective factors as connectedness, problem solving, and bonding to school through Restorative Practices. Such practices include using circles in the classroom for connection and problem solving, and more formal conferencing circles for restorative discipline and accountability. The broader approach holds promise for reducing school risk factors and increasing school and individual protective factors involved in both suicide and violence prevention.

MCLE will continue the training of trainer institutes for bullying prevention, as this approach is the most cost-effective means of spreading bullying prevention implementation strategies throughout Maine elementary schools. MCLE will establish an e-network to provide ongoing advice and resources.

MCLE with its partners plans to implement restorative practices in up to 4 K-12 schools. Implementation will include developing evaluation tools, meeting with school administrators, establishing school leadership committees, providing staff training and development, and providing technical assistance in all phases of school-level implementation. At least some of these schools will have bullying prevention strategies already in place. MCLE will establish an e-network and hold a 1-day fall conference for sharing resources and assisting with implementation issues. MCLE will coordinate an extensive summer institute on restorative practices in June 2009.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				9.5	9.3
Annual Indicator		9.9	11.6		
Numerator		2648	3055		
Denominator		266261	263510		
Is the Data Provisional or Final?					
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	9.1	8.9	8.7	8.5	8.3

**Notes - 2007**

2007 emergency department data are not yet available.

**Notes - 2006**

2006 Emergency Department data are not yet available.

**Notes - 2005**

Data are based on Maine's 2005 emergency department dataset.

Population estimate based on US Census estimates for Maine as of July 1, 2005.

**a. Last Year's Accomplishments**

Maine uses data from its statewide hospital discharge database for this measure. The most recent data available are from 2005. 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 2005, women's rate per 1,000 of emergency department visits for asthma was 11.6 per 1,000 compared to 6.1 per 1,000 men.

The Maine Asthma Program (MAP) lacked consistent leadership for most of the reporting period. The Program Manager position vacated in August 2006 and remained vacant until February 2007 when it was filled temporarily. The current Program Manager was hired in November 2007. As a result of the vacancy no activities were undertaken to address this measure.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Work with Healthy Maine Partnerships to promote health and prevention of disease at the community level.			X	X
2. Support the Maine Health AH! Program pictogram asthma management book designed for adults of all ages and from all language backgrounds who are not literate in their language.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

An asthma surveillance document and chartbook were produced in 2007. They are currently undergoing in-house review and are expected to be published on the MAP website by late spring.

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, doctors being more likely to label women's symptoms as asthma or whether there is 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.

In November 2007 the Program Manager (PM) position was filled and the new manager is determining opportunities available to address the needs of women between the ages of 15-44 who are diagnosed with asthma. The PM is devoting time to re-establishing relationships with: MaineCare; MaineHealth who developed the Ah! Asthma program and a pictorial guide and education tool for low literate and non English speaking mothers; Healthy Maine Partnerships, there are 28 contract organizations that are part of the state public health infrastructure offering public health resources at the local level; and the American Lung Association of Maine offering regular training of asthma educators at their Asthma Institute. All are partnering with the MAP to identify activities to address this measure.

### **c. Plan for the Coming Year**

Maine's Asthma Program, in collaboration with Maine's Title V Agency, plans to investigate the effects of women's asthma on childhood birth outcomes in more detail in the coming years. We will determine whether asthma information is collected on birth certificates or in PRAMS. In addition, we will investigate whether MaineCare data would be useful for examining asthma among women of reproductive age and studying the birth outcomes of asthmatic pregnant women.

In addition, during FY09 the MAP will collaborate with partners to carry out the following activities;

1. Develop educational materials to be distributed to MaineCare enrollees who report pregnancy and a history of asthma. Materials will reflect the new NAEPP guidelines pertaining to asthma and pregnancy (the guidelines can be found at: <http://www.nhlbi.nih.gov/guidelines/asthma/>)
2. Include educational materials in mailings to all primary care providers who work with the MaineCare population. Materials will reflect the new NAEPP guidelines pertaining to asthma and pregnancy.
3. Participate on Self Care Management Team to assist Healthy Maine Partnerships to work with community members who have asthma by encouraging use of the Self Care Model.
4. Participate on Worksite Team to assist HMPs develop healthy workplace programs within their communities. Focus will be on care and treatment of people in the workforce with asthma.
5. Update the MAP website to offer information to women of reproductive age.
6. Develop a flyer on NHLBI guidelines that addresses staying on controller medications during pregnancy and disseminate to Public Health Nurses to hand out when doing prenatal visits and for WIC agencies to display in waiting rooms.
7. Explore the possibility of providing quick fact sheets on asthma management and control for all hospital emergency departments (ED) to give to people when they leave the ED.
8. 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.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				10	11
Annual Indicator					
Numerator					
Denominator			720	720	720
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12	13	14	15	16

**Notes - 2007**

This is a developmental measure. The 2006 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

**Notes - 2006**

This is a developmental measure. The 2006 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

**Notes - 2005**

This is a developmental measure. The 2005 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6. Starting in 2007, pilot data should be available to populate this measure.

**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. All child care centers in Maine are required to have a child care health consultant on record, but we are unable to track whether a visit from the consultant has occurred.

The enhancement of a child care health-consulting infrastructure is a primary goal in the Early Childhood Comprehensive System (ECCS) State Plan. With the impetus from Maine's Strengthening Families Initiative, we also created an infant-toddler child care professional educational track that integrates social and emotional health with overall health by including behavioral health consultants as part of the consultant infrastructure, which also sets a foundation for comprehensive health systems in childcare settings.

All licensed center-based facilities that serve children under age 6 are required to have a visit from a health care consultant. Staffing constraints have challenged Maine's ability to track the 778 centers. A major factor in the number of consultants is funding. While centers recognize the importance of having health care consultants the current economic climate has delayed the process. Funding is not available from the state to pay for child care health consultant services and payment for services would be borne by parents who are already burdened by high child care costs. Without payment, health professionals lack incentive to become a consultant.

A planned pilot project sponsored by the Maine Division of Early Childhood in Maine's Midcoast Region in 2007 did not take place. The project was to facilitate contact between child care centers and health consultants and develop a database to track health consultant visits.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Commence discussions across Maine DHHS offices to ensure coordination with the public health districts that are forming and to obtain funding support for the child health objectives of the				X

child care health consultant network.				
2.				
3.				
4.				
5.				
6.				
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 child care health consultant twice per year. As of Winter 2008, there were 68 NAEYC accredited child care centers in Maine, but only 12 have been accredited through the new system.

A Governor's Economic Summit held in October 2007 generated a great deal of momentum on early childhood care. Business leaders provided much input on the impact to their business with lost workdays when their employee's children are sick. Four issue briefs were developed on: Economics of Healthy Families, Economics of Healthy Children, Economics of a Healthy Early Care and Education System, and Use of Data to Look at Early Childhood as a System. As a result of the summit the Governor tasked the Department of Economic and Community Development and the Early Childhood Initiative (ECCS) to convene a Business Roundtable on Early Childhood Investment (May 2008). The Roundtable's task is to generate a business plan with an employer perspective for the existing ECCS plan, "Invest Early in Maine".

Quality for ME, a voluntary 4 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>

**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 child care 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.

We will continue to track this outcome using NAEYC accreditations in the state, but it remains unclear whether this measure will have an adequate tracking system.

**E. Health Status Indicators**

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. For example, low birth weight is one of the leading causes of infant mortality in the state. The data on this indicator were used to help pass legislation to initiate a Maternal and Infant Mortality and Resiliency Review Panel in the state. This panel will examine all 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. ***/2009/ To inform this panel and other perinatal health efforts in the state, we are currently in the process of conducting in-depth infant mortality analyses, including a Perinatal Periods of Risk (PPOR) assessment. 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 birthweight 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. //2009//***

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 Maine's Injury Prevention Program 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. ***/2009/ Although the rates of unintentional injury and motor vehicle crash deaths among youth have not changed significantly in recent years in Maine, we recognize that unintentional injuries, specifically motor vehicle crashes are the leading cause of death of among Maine youth. Therefore, based on this data, the Maine Injury Prevention Program has identified motor vehicle crashes as a priority in their program plan and is expanding their efforts to the address the issue. One of these efforts is working with Maine's Office of Substance Abuse (OSA) 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 adolescent motor vehicle deaths. //2009//***

***/2009/ Maine's chlamydia rate among women age 15-19 and 20-44 has increased over the past 5 years. This is a nationwide trend, but the reason for the increase is not clear. It may be due in part to increased testing efforts. Maine's STD program is doing targeted testing with females ages 15-24 through their Infertility Prevention Project (IPP), and aims to increase rescreening of those who test positive. To address the increasing rates, the Maine STD program is conducting targeted testing and 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. //2009//***

The health status indicator 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 health status indicators 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. ***/2009/ Maine is also in the process of developing a local public health infrastructure through the creation of eight public health districts. 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. Several of the Health Status Indicators, 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. //2009//***

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.

Maine developed new priorities for the 2005 Title V Block Grant and over the past year, the Title V program has been working to incorporate these priorities into program planning and surveillance efforts. 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 Health Status Indicators through the Title V Block Grant, we will be able to evaluate whether we are making progress in these priority areas.

## **F. Other Program Activities**

### **Traumatic Brain Injury**

The Maine Health Access Foundation through the Dartmouth-Hitchcock Foundation at Dartmouth Medical School in New Hampshire working in collaboration with the Maine Department of Health and Human Services, Brain Injury Program funded a Maine National Guard TBI Project. The two major project goals are: (1) Teach physicians and other health care providers on the use of state-of-the-art technology to accurately diagnose TBI and to provide a coordination consultation for Dr. Mark Lovell and his team through the University of Pittsburgh Medical Center, the leader in concussive sports injury assessment and intervention. ImPACTTM, a Windows-based computer program that can be administered by non-clinical personnel with minimal training is used to screen for TBI. ImPACTTM is a validated instrument widely used among professional sports teams to manage sports-related concussions. Beginning in January 2008, all Maine National Guard troops deployed were scheduled to receive pre-deployment and upon return post-deployment ImPACTTM testing; (2) Develop a system of integrated care to meet the needs of returning soldiers through collaborative partnerships between the Maine VA center and community-based providers. A team-based approach to coordinating care that has proven success in increasing health outcomes while lowering overall health care costs is used. The Partners in Chronic Care model of care coordination has proven to be a successful model of care coordination that teaches new collaborative skills with a resulting 57% decrease in health care costs while increasing health outcomes and patient satisfaction with care.

This model will allow the VA health system and community providers to leverage the maximum benefit of a system with limited capacity. The numbers of returning soldiers with head trauma is a developing health crisis and this project provides an opportunity to proactively plan to meet the needs of this population through all avenues of care. Recognition by the VA, Maine National Guard and community providers to collaborate is outstanding and application of a proven model making use of sports concussion technology as a tool of assessment and identification is an important contribution to the health and functional outcomes of Maine veterans and their families.

### **Abusive Head Trauma Group**

In fall 2007 the MCH Medical Director was contacted by several providers from Maine Medical (MMC) and Eastern Maine Medical Centers (EMMC) with concerns at seeing a number of perceived cases of head trauma. The Medical Director convened a group to discuss the issues. The Family Health Division Director assumed the leadership role in early 2008 when the Medical Director position vacated. Five conference calls were held resulting in enough energy generated to bring interested stakeholders (Maine Children's Trust, MMC and EMMC neonatologists, perinatal outreach coordinator, Children's Behavioral Health Services, Early Childhood, Child Welfare, Maine Children's Alliance, Maine CDC Epidemiologists, Maine Injury Prevention Program, CSHN Director, Division of Family Health Director, Maine Academy of Pediatrics,

several practicing pediatricians, and Director of Don't Shake Jake Initiative) together for a facilitated session on June 11, 2008 to develop an action plan for abusive head trauma. The Office of Child and Family Services and Maine CDC co-facilitated the session.

#### Maine Touchpoints

In July 2007 the Maine Touch Points home visiting training team consisting of 1 fulltime coordinator and 2 program managers developed an intensive 3 day training with technical assistance from Brazleton Touch Points in Boston. Seven trainings were held across the state. Trainings are followed up with mentoring, supplemented with mentoring reflective practice supervision at program manager meetings to reinforce the model of helping to maintain fidelity and creating sustainability. The goal of touch points is for parents to feel confident about their role as parents, are able to with flexibility adapt and address and anticipate developmental milestones and what that means to their household and to their children.

#### Safe Families Project

In Fall 2006 Maine was 1 of 4 states selected to participate in an Action Learning Lab sponsored through the Association of Maternal and Child Health Programs (AMCHP) and the Family Violence Prevention Fund (FVPPF) to reduce perinatal disparities due to intimate partner violence and sexual assault. As part of this initiative, a group of partners from within and outside of state government came together to develop strategies to address this issue. This group, the Safe Families Partnership (SFP) held a statewide stakeholder meeting in May 2007 to engage partners in developing an action plan. In November 2007 a training on screening for intimate partner violence and sexual assault was held for public health staff, many of whom are part of the Division of Family Health at the Maine CDC, home of Maine's Title V Program, including those in WIC, Public Health Nursing, Family Planning, Home Visiting, and HIV/STD prevention. Over 100 people participated in the training. We are currently in the process of evaluating the training to determine whether it increased screening in many of the public health programs in attendance. In addition, SFP has enhanced the state's capacity to address this issue through increased access to data by including questions on Maine's BRFSS and a surveillance plan has been developed. Although the formal partnership with AMCHP and FVPPF has ended, there is a commitment from all partners involved to continue the initiative.

#### Eating Disorders Learning Collaborative

The Teen and Young Adult Health Program Manager oversees a foundation grant and serves on the Advisory Committee for the Eating Disorders Learning Collaborative. The collaborative provides training and ongoing performance improvement and support related to best practices for treating eating disorders. The teams provide services to children, teens, and young adults with eating disorders. An initial training was held in October 2007 for 12 treatment teams and follow-up activities have included one web-cast and team meetings. This network of care providers is expected to result in earlier and more effective treatment. A second training for new teams with an opportunity for existing teams to attend one day is planned for fall 2008. Plans are underway to bring trainers in the Maudsley Treatment Method, one of a number of evidence-based treatment methods, to Maine in early fall 2008.

#### Other Activities

The Division of Family Health (DFH) has initiated conversations with the new Office of Local Public Health regarding the extent to which we can link our upcoming five year comprehensive strengths and needs assessment with the work the eight districts are doing using the national

Mobilizing for Action Through Planning and Partnerships Assessment. Discussions will continue during the summer to determine if they have the ability to collect data on the MCH population that will inform our assessment and conversely if we are collecting data that will benefit their process. By doing so we hope to build a stronger relationship at the district and community level through this collaborative effort while at the same time create greater efficiencies within the Maine CDC by integrating efforts.

The DFH is continuing to build capacity at both the program and division level. To maximize resources and the usefulness of program evaluation, the Divisions of Family Health and Chronic Disease are collaborating with public health (PH) program evaluation faculty and staff from USM and the Maine Center for Public Health to design and implement a standardized PH evaluation framework. Through a standardized evaluation framework, the Divisions can realize efficiencies in funding the evaluation function for PH programs and progress to measuring longer-term program impacts and health outcomes.

## **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 on implementing strengths based assessment.
2. Technical assistance for cultural and linguistic competence within Title V programs.
3. Technical assistance on sampling methodology.
4. Technical assistance with survey analysis.
5. Technical assistance on determining a more accurate estimate of primary sources of coverage for the number of individuals served under Title V.

The above requests for technical assistance are in order of priority. Technical assistance #1 was selected in preparation for the 2010 CSNA. During the development of the 2005 CSNA, understanding of the general concept of strengths based assessment was developed; however many questions remained regarding how does one really conduct an assessment of strengths. The literature has grown in the area of assessing individual strengths, but it was very difficult to locate literature and guidance regarding assessment of the strength of systems. From an epidemiologic perspective questions remain on how to integrate data from multiple sources; how to choose a model; how to put the concept of a strengths based assessment into practice/action. Maine specifically is asking for assistance in defining measures of system strength and the preparation of a plan for system assessment. Technical assistance in this area will assist the state of Maine in conducting the 2010 Comprehensive Strengths and Needs Assessment and integrating this information into our programs. Based on responses to the Region I workshop on including strengths in the 2005 Comprehensive Needs Assessment, it appears that interest in this topic is shared widely among Title V programs in the US. Our New England Region I State Title V Programs have taken this on as a regional priority.

The request for technical assistance #2 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 #3 was selected because the Department of Education, the Maine CDC and the Office of Substance Abuse Services are working together to create a coordinated approach for the design and administration of its 3 youth surveys (YRBS, YTS, MYDAUS). A single survey is not feasible because of the large number of questions required for inclusion. A module based approach was envisioned but does not meet program needs and community desire for more local-level data. We seek assistance with the sampling component of the survey, since only a non-traditional approach is likely to succeed.

The request for technical assistance (#4) 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 Youth Risk Behavior 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 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.

We would also like to request technical assistance (#5) on determining a more accurate estimate of primary sources of coverage for the number of individuals served under Title V (Form 7). Historically, Maine has relied on the Office of MaineCare Services (OMS) for these numbers but since the inception of HIPAA the OMS has not been able to provide this information. We are seeking assistance from the Maternal and Child Health Bureau to identify other states we could work with who have developed a formula to calculate the estimated percentages of individuals served that Maine could replicate.

## **V. Budget Narrative**

### **A. Expenditures**

For a summary of any variances please refer to Section VB - Budget.

### **B. Budget**

The Division of Family Health expended \$18,058,479 for maternal and child health services in FY07; including \$14,982,998, of state funds and \$3,075,481 of Title V funds. Expenditures by populations served include 58% (\$10,404,690) expended on primary care and preventive services for children; 19% (\$3,322,696) expended for children with special health needs; 4% (\$784,857) expended for pregnant women, 18% (\$3,314,442) for others; and 1% (\$231,794) for administration. The decrease in expenditures for primary care and preventive services for children, children with special health needs, and others categories supported a slight increase in the pregnant women category. The other category is comprised primarily of women of reproductive age who are not pregnant or recently postpartum.

Delineating expenditures by levels of the MCH Core Services Pyramid, 61% (\$11,140,369) was expended on direct services; 7% (\$1,178,183) was expended on enabling services; 10% (\$1,823,103) was expended on population based services; and 22% (\$3,916,824) was expended on infrastructure building services. The slight decrease in population based and infrastructure level expenditures supported a slight increase in expenditures for direct and enabling services. Overall expenditures in FY07 appear to be approximately \$847,000 more than budgeted. This is the result of expanding the mandated conditions screened for in the newborn bloodspot screen which required education of health care providers and families. In addition there were unplanned expenditures related to starting the Maternal Infant Mortality Review Panel (MIMR) and a report on adolescent pregnancy.

In FY09 the Division proposes to spend \$3,507,118 of Title V funds, with no carry forward from FY08. Of the Title V funds, 61% (\$2,159,232) is allocated to primary care and preventive services for children; 32% (\$1,115,845) is allocated to children with special health needs; and 6.2% (\$293,546) 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: 62% (\$8,598,951) will be allocated for direct services; 6% (\$909,408) for enabling services; 10% (\$1,407,204) for population based services; and 22% (\$3,023,291) for infrastructure building services.

The FY09 budget is \$4,406,008 less than FY08 due to the relocation of the Home Visiting Program to the Office of Child and Family Services, Division of Early Childhood. The FY09 budget passed by the Legislature and signed by the Governor includes a reduction of \$350,000 in State MCH funds. Included in the annual MCHBG budget is approximately \$40,000 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 FY09 include: MCHB Partnership, Association of Maternal Child Health Programs (AMCHP), American Public Health Association (APHA), National Association of School Based Health Centers, National Network of State Adolescent Health Coordinators (NASBHAC), Association of State and Territorial Dental Directors (ASTDD), Society for Adolescent Medicine (SAM), Association of State and Territorial Directors of Nursing (ASTDN), New England Regional Genetics Group (NERGG), National Eating Disorders, National Newborn Screening and Genetic Testing Symposium, National Women's Health Coordinators (NWHC), State and Territorial Injury Program Directors Association (STIPDA), American Cleft Palate Association (ACPA), National

Birth Defects Programs (NBDP), National Perinatal Association (NPA), Newborn Bloodspot Screening Program, North American Brain Injury Society (NABI), American Evaluation Association (AEA), Region I MCH and CSHN Directors Regional meetings, North East Regional Public Health Leadership Institute (NEPHLI), Women's Health Summit, as well as, Region I Women's Health Workgroup quarterly meetings. Conferences include: MCH Epidemiology, American Association of Suicidology (ASA), MCH Leadership Institute, Leadership Enhancement in Adolescent Health (LEAH), 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.

## **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.

## **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.