

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **ME**

APPLICATION YEAR: **2005**

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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.

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 Bureau of Health'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; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

MCH programs elicit ongoing public input and consumer representation on committees and in activities. The 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.

/2005/ The annual MCHBG planning and reporting processes, as well as, the upcoming FY05 application have been discussed with the Joint Advisory Committee (Genetics and CSHN Programs), Newborn Hearing Advisory, and Childhood Lead Poisoning Prevention Advisory Committees, with requests made for public input.

Planning for the 5-year comprehensive strengths and needs assessment began in the fall 2003 and is ongoing. Consumer, provider, and family input has been solicited at every opportunity at public forums such as committee and grantee meetings, conferences, and liaison groups. //2005//

Annually a notice is placed in local newspapers (Copy attached) indicating that the block grant application is being prepared and will be made available, upon request, to review and provide comment. /2004/ Two requests were made for copies of the grant application with no subsequent comment.//2004// ***/2005/ No requests were made for copies and no comments were received on the grant application. //2005//***

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

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 Bureau of Health's Division of Community Health and Division of Family Health as they strive to improve health outcomes for the state's 1.2 million residents.

All other five New England states can fit into the ~31,000 square miles occupied by the state of Maine. This large land mass and low population accounts for Maine ranking 38th nationally in population density. We average only ~40 people per square mile, as compared to Massachusetts with a population density of ~777 people per square mile. Maine's average population figure is deceptive because the majority of our citizens live in the southern third of the state and along the coast.

Preliminary data from the 2000 census reveals our population essentially held steady at 1.2 million over the past ten years, but continued to shift southwest as the southern coastal counties grew and the northern counties lost population. /2003/ Data from the 2000 census shows our population remained stable at 1,274,923. If we consider those citizens included in the MCH population, 22.3% of our total population is women ages 15-44 and 26.3% are children ages 0-19 years of age. Overall Females accounted for 51.3% and males 48.7% of the total population. Children 0-4 years declined from 85,722 in 1990 to 70,726 in 2000 (-17.49%). Children 5-9 years declined from 88,506 in 1990 to 83,022 in 2000 (-6.20%), however, children 10-14 years increased from 84,579 in 1990 to 92,252 in 2000 (+9.07%) and teenagers 15-19 years increased from 87,927 in 1990 to 89,485 (+1.77%). Other significant changes included a -19.04% decline in young adults aged 20-24 years and a -23.30% decline in young adults aged 25-34 years. There was a +54.38% increase in adults aged 45-54 years of age, and + 13.4% increase in citizens 65 years and older who constitute 14.4% of our citizens. Our citizens aged 85+ years, who constitute 1.8% of our population, also showed a +27.93% change from 1990 to 2000.

Maine has sixteen 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 6,672 square miles, a population of 73,938 (-15% since 1990) and only 41 primary care providers (i.e. pediatricians, general practitioners and family practitioners). 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 835 square miles, a population of 265,612 (+ 9.2% since 1990), 200 providers (pediatricians, general practitioners and family practitioners), and an extensive network of surface streets and roads. /2003/ Throughout Maine there are ten counties containing towns (69 towns total) that qualify as "frontier" areas or inhabited by 0-6 individuals per square mile. Six of these counties are classified as "very rural". Piscataquis County is classified as frontier in total, making it the only frontier county east of the Mississippi.

Maine has three major cities: Portland population 64,000 (-0.2% since 1990); Bangor population 31,000 (-5.1%); and Lewiston population 35,000 (-10.2%). However, Scarborough, the 10th largest city in Maine which is on the coast just south of Portland, gained 4,452 residents for a change of +35.6%. Collectively the three largest cities account for only 10% of the state's residents. While 80% of American citizens reside in metropolitan areas, the majority of Maine's citizens continue to reside in rural towns and small cities that comprise the core of Maine's governmental structure. Almost 500 of these municipalities maintain the town meeting format of direct democracy.

Demographics

Racially Maine is predominantly white (97%), with small minority populations including four tribes of Native Americans (0.6%); African Americans (0.5%); Asians (0.7%), two or more races 1.0% and Other 0.2%. Ethnically Maine is 99.3% non-Hispanic and 0.7% Hispanic. In CY00 we welcomed

approximately 247 refugees from their country of first asylum (Catholic Charities and Jewish Community Alliance). In addition, a new phenomena for Maine is the arrival of "secondary migrant refugees" who move here from their initially assigned state, sometimes within hours of reaching this country. Actual counts are difficult to obtain, however, Catholic Charities estimates ~ 385 of these individuals moved to Maine last year. Once these individuals move from their initial state they lose all automatic enrollment in social services such as Medicaid, TANF, job placement, case management, etc. This presents a challenge to the Bureau of Health (especially our Public Health Nurses) as we strive to identify these individuals and develop strategies to ensure they access needed services. Most secondary migrants were originally from Somalia, the Sudan and Russia. Our refugees settle primarily in the southern portion of the state (Portland, Lewiston, Biddeford, and Sanford) where there are greater social service resources and employment opportunities. All of these ethnically diverse citizens represent approximately 3% of the state's total population. /2003/ Although the 2000 census data indicates no change in the racial composition of Maine's citizens, there has been considerable recent resettlement activity within the refugee and immigrant populations. Catholic Charities (the contract agency for refugee resettlement services) estimates approximately 200-250 individuals were resettled in Maine as their primary settlement site. However, Catholic Charities also notes that within the last 18 months Maine has become an increasingly popular destination for persons who entered our country as refugees, but who are dissatisfied with the living conditions in their primary settlement site. They estimate an additional 3,500 individuals have moved to Maine as secondary migrant refugees since February 2001. The original country of origin for the majority of these refugees is Somalia. All five tribes of Somalia are represented in Maine. Each tribe uses an oral communication, but none of the dialects are standard between tribes. This further complicates communication with the new population. Additional countries represented include the Sudan, Congo and Iraq. The traditional draws of affordable housing, transportation and employment were best in the Portland area until a few years ago. Maine State Housing Authority now estimates the 2001 occupancy rate in Portland to be about 97%, and the median home costs \$146,950. The Portland area's unemployment rate for April 2002 was 2.6% and in April 2001 it was 2.0%. Within the past 3-4 years an effort has been made to settle refugees in less crowded and more inexpensive areas. Even so, about 2,500 of these refugees moved to the Portland area. The other 1,000 moved to the Lewiston-Auburn area where their compatriots had been settled. While housing may be more affordable in the Lewiston Auburn area,(in 2001 the median home cost \$83,250), the unemployment rate was 4.1% in April 2002 and 4.0% in April 2001. There is concern among the Lewiston-Auburn citizens that an influx of refugees/immigrants will exacerbate the area's unemployment problem and overwhelm available social services. (See Supporting Document Page # 17) Civic and community leaders in Lewiston-Auburn are working with state agencies and members of the refugee/immigrant communities to address emerging issues. Venues to address concerns have been town meetings and focused educational/training sessions with social service providers. Elders from the Somali community residing in the Lewiston-Auburn area have been communicating with Somali elders in other areas of the United States to encourage a slow down in secondary migration to Maine because of strained social services and decreased housing and job availability. Exact numbers are impossible to know, but Catholic Charities believes members of non-refugee ethnic minority groups with limited English speaking skills are also moving to Maine in search of a better life.

/2004/ New residents to Maine continue to be concentrated in the southern part of the state. Increasing housing costs create challenges in safe and affordable housing for longtime and newly arriving residents with limited income. According to the Maine State Housing Authority, the median cost of a home in Portland in 2002 was \$163,000.00, a 10.9% increase over the previous year while in Lewiston there was an increase of over 20% in the median home cost from 2001. ***/2005/ The expanding real estate market continues to burden the state social service system. Median home prices continue to rise (16.5% in the Portland area and 14% increase in Lewiston from 2002) further impacting the availability of affordable housing. This raises concern of the potential for an increase in homelessness for our most vulnerable populations as housing costs rise and unemployment increases, particularly in the manufacturing sector (discussed under Current Socioeconomic Indicators below). //2005//***

The cities of Lewiston-Auburn and Portland continue to direct human and financial resources to developing improved systems of services for new residents with limited English proficiency. In the fall of 2002 the Department of Human Services formed a New Residents Committee, (NRC) to seek

federal and private funds to assist these efforts, as well as, to develop resources to aid other communities in their response to new residents with limited income and/or English proficiency. Members of the NRC include state agencies; Department of Human Services, Department of Education and Department of Labor; municipal government; and local services providers; Catholic Charities and Community Assistance Program (CAP) agencies. //2004//

/2005/ The work of the NRC as outlined in statute that created the committee was completed in the fall of 2003. Many members of the NRC have continued to meet to summarize the ongoing needs of new residents. Recommendations are being finalized for presentation to the Governor's Task Force on Refugee and Immigrant Policy. //2005//

Current Socioeconomic Indicators

Maine's three largest sources of private sector revenue are the lumber industry, fishing industry and tourism. Underemployment is a chronic problem due to the seasonal nature of our economy. Approximately 2% of workers are employed in farming and Maine's Bureau of Labor reports for 2000 that Maine's non-farming workforce was distributed as follows: 14.1% employed in manufacturing; 20.4% in retail; 4.5% in wholesale trade; 30.2% in services (health, business, education, etc.); 5.3% in finance/insurance/real estate; 16.5% in public administration; 4.9% in construction; 4.0% in transportation and utilities.

Over the past decade Maine has continued the trend of losing manufacturing jobs with workers transitioning into service sector positions. Since women tend to be employed in the service sector more often than men, the net result is that women's annual average unemployment rate in Maine is 3.8% compared to 4.4% for men. In 1999 there were 309,000 women employed in Maine; 225,000 working full-time and 84,000 working part-time. (Maine Bureau of Labor 1999). Although more women may be employed, the median weekly earnings for women in Maine working full-time is \$455.00. For men it is \$545.00. Therefore Maine's women are earning only 83.3% of men's wages. One third of our women live at less than 200% of the poverty level. One in four Maine children live in poverty. /2004/ Maine's unemployment rate continues to rise with an increase of 1% over April 2002. The Department of Labor Statistics reported in April 2003 a rate of 5.3% (not seasonally adjusted) for the state. This is not surprising given the number of large manufacturing businesses that have either discontinued operations or implemented downsizing resulting in a significant number of layoffs. //2004//

/2005/ As discussed under FPM # 13 Maine's economy continues to be challenged as the state's manufacturing base declines. The not seasonally adjusted unemployment rate for April was 4.8 %, down a half percent from 2003. Job gains were recorded in health care and social assistance, construction, retail trade and food services. Losses, according to the Maine Department of Labor, were registered primarily in manufacturing, with the largest declines in textiles, paper, wood products, and computers and electronic products. Unemployment rates (not seasonally adjusted) for Maine counties ranged from 2.6 % in Cumberland County to 10.1 % in Washington County (large manufacturing base). //2005//

Maine's rate of poverty ranks 20th among the 50 states. However, this ranking is deceptive because the U.S. Bureau of Labor's most recent wage statistics (1999) show that in terms of annual wages Maine ranks 39th in the U.S. and last in New England. Maine's average wage (\$26,888) would have to increase 39% to equal the New England average wage (\$35,962). These factors keep many Maine residents, our "working poor", on the brink of poverty even though the state's actual poverty rate remains close to the national average. /2005/ ***According to a 2003 report prepared by the Margaret Chase Smith Center for Public Policy at the University of Maine, 45 % of below poverty households are living alone, while 22 percent are headed by single women with children. A 2000 Census report showed that 46.8% of Cumberland County and 44.4% of York County households with incomes less than \$35,000 were paying more than 35% of monthly income for housing. //2005//*** Twice a year, the Maine State Housing Authority (MSHA) conducts detailed surveys of clients using the 42 homeless shelters that receive funding from MSHA. In March 2000 there was an unduplicated count of 2,288 clients using shelter beds (an increase of 177 clients

from March 1999). 34% were women (+2% from 1999) and 22.3% (-2.8%) were children under 18 years of age. There were 145 families with children headed by a single female 18 years or older who sought shelter accommodations in March 2000. We are hoping to obtain trend data so we can analyze the significance of these statistics. ***//2005/ Maine State Housing Authority survey results for March 2003 show an unduplicated count of 2,320 clients using shelter beds, a decrease of 46 from the same period in 2002. Of those, 32.7 % were women, and 20.6 % were children under the age of 18. There were 177 families headed by a single female (age range not available as MSHA no longer collects this data). //2005//***

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 citizens in Maine. Maine's disparities are correlated with differences in education, income and low population densities of our rural areas. /2003/ As part of Healthy Maine 2010 the Bureau of Health (BOH) is looking 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. BOH has established a workgroup with the University of Southern Maine (USM) to explore the standardization of Maine definitions and categories of race and ethnicity. Currently race is based on OMB-15 and for ethnicity we plan to expand beyond Hispanic to include our Franco-American citizens. This will help us track and monitor our data more effectively.

Our initial analysis of the Maine Medical Assessment Foundation data report does show an increased risk of lead poisoning among Medicaid recipients similar to national findings. However, lead poisoning in Maine is not necessarily related to a lower socio-economic status. We have found that upper and middle-class families who are renovating older homes also risk exposing their children to lead poisoning.

In his 1999 paper "The Health Status of Maine's Native American Population" Paul Kuehnert, MSN Director of the Bureau of Health's Division of Disease Control, identified several areas of concern for this minority population. Specifically, they were noted to have lower per capita income, higher unemployment rates and lower high school completion rates as compared to Maine as a whole. In addition, their population was found to be younger and experienced an increased birth rate. Additional findings are a lower crude mortality yet significantly shorter life expectancy. No clear explanation for this discrepancy was identified. Native Americans were found to have experienced a decrease in mortality related to cardiovascular disease yet an increase in cancer mortality, especially related to lung cancer. This may be a result of tobacco use. Perhaps because cigarettes are less expensive on federally regulated land, the statewide decreased smoking rate associated with Maine's increased cigarette excise tax will not be experienced on tribal lands. It is important for MCH to recognize and respond to specific needs within this Native American population even though they have their own system of five Indian Health Service (IHS) centers and IHS support. Efforts are underway to increase collaboration with IHS in order to better serve all MCH population. In the fall of 2000 meetings were held with 2 of the tribe to discuss possible areas for partnering.

/2004/ The Bureau of Health continues its' relationship building with the Native American tribes in Maine. While initial activities were specific to categorical areas, the Bureau seeks opportunities to expand in a coordinated manner. Maine's response to Public Health Emergency Preparedness includes the development of Regional Epidemiologic teams. One Epidemiologist, an Advanced Practice Registered Nurse (APRN), works specifically as a liaison between the Bureau of Health and the Maine Tribes. //2004//

Current Political Climate

In 1996 Maine's Bureau of Health (BOH) was restructured in response to a mandate from the legislature to reduce the number of divisions within all State Bureaus. Significant administrative and

leadership changes accompanied this reorganization. In 2000 the departure of Randy Schwartz, Director of the Division of Community & Family Health, resulted in another reorganization. The large DCFH was reconfigured into two smaller divisions: Division of Family Health (DFH) and Division of Community Health (DCH). This was not accompanied by major changes in leadership.

During this same time period, national trends regarding the role of state public health organizations have continued to shift toward a strong emphasis on states assuming responsibility for the core public health functions of assessment, assurance, and policy development. States such as Maine, without sufficient infrastructure to delegate direct services, find themselves assuming the dual role of carrying out core public health functions and providing direct services.

We believe MCH can be a leader in facilitating a comprehensive, seamless system of care with state-wide coordination of services and funding streams. Through Integrated Case Management and other initiatives we must identify and tap funding sources and grants. MCH must also continually evaluate our existing programs for quality and effectiveness. Persistent and emerging health issues affecting women and children will require new approaches and modifications to existing programs. /2003/ The BOH/DFH continues to facilitate development of community-based direct service delivery systems. As the Healthy Families, Parents as Teachers, and Parents Are Teachers Too programs become established, we are striving to integrate these programs into a non-duplicative system. We have begun to identify the strengths of each particular program and options to use them to their best advantage. We are working with USM to identify and establish performance measures for each program and also "core" measures that can be used to evaluate outcomes across all three programs. The Adolescent Parenting and Pregnancy Projects Program and the CHSHN Program also continue to work closely with community members and parents.

In 2002 a new governor will be elected as Governor King will be completing his two term limit tenure. During his administration Governor King has been supportive of 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. It is crucial that with the change in administration we assess and educate the new officials regarding Maine's MCH population and issues.

/2004/ John Elias Baldacci was elected Governor in November 2002 and is the first Democratic Governor in 16 years. The Democratic Party also won 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.

Three of Governor Baldacci's leading campaign issues were to address the declining economy and the growing budget deficit; rising health care costs and access to health care; and merging the Departments of Human Services (DHS) and Behavioral and Developmental Services (BDS). The administration has been efficient in addressing the first two issues with Part I budget passed in late March 2003 and Part II budget passed in April 2003. The health plan package was presented to the Legislature May 5, 2003 with a request to pass prior to the end of the current session in June 2003. Focus on the merger of DHS and BDS is proposed to commence in summer 2003. On May 13, 2003, Governor Baldacci announced his appointment of a 12 member Advisory Council to develop a plan for the merger of the two departments. Membership is comprised of leaders in the business community, 4 state legislators, the Acting Commissioners of the Department of Human Services, Behavioral and Developmental Services, Department of Administrative and Financial Services, and the Attorney General (Ex Officio). Valerie Landry, former Commissioner of the Department of Labor chairs the Advisory Council. While the members do not have a background in public health, many public health professionals have informal linkages with Advisory members. The Advisory Council is charged with developing a report/plan to be presented to the Legislature in January 2004. The Advisory Council will meet monthly and subcommittees will meet more regularly to address specific components. //2004//

//2005/ The Governor's Merger Council for the unification of the Departments of Human Services and Behavioral and Developmental Services (state health and human services agency and state mental health agency) met monthly from May 2003 through January 2004. Their recommendations for the merger were released through a public report in January 2004. The report provided the framework for the Governor's legislation merging the two departments. It was passed, with some modifications, in late April 2004 and was signed by the Governor in early May 2004. (A copy of the final legislation is included in the Appendix).

In April 2004 the Senate confirmed the appointment of John R. Nicholas as Commissioner of the Department of Human Services. With the merger, he will become the Commissioner of the Department of Health and Human Services. As of this report, the specifics of the merger have not been released.

Maine continues to be challenged economically but nowhere is it more ubiquitous than with our Native American population, some of Maine's poorest residents. The Penobscot and Passamaquoddy tribes had hope for improving their economic status in a referendum put before the citizens of the state in November 2003 that would allow the construction of a casino in the states southern most county. If approved, a casino was projected to bring thousands of jobs to the state as well as an estimated \$50 million annually to the tribes. More importantly, the tribes hoped it would bring self-reliance. The tribes also had plans to market, through the casino, Indian Guide services for fishing expeditions on the Penobscot River since the removal of 2 dams on the river would attract sport fishermen.

Their vision was shattered when the referendum was soundly defeated. The tribes perceived this to be a vote against them by not allowing self-reliance and sovereignty. Voters did approve another gambling initiative that did not include the tribes, the development of racinos that would allow slot machines at horse racing tracks.

The primary issues associated with a casino were: the language of the law specifically could not be unilaterally amended by the legislature for 20 years, therefore if it wasn't working the legislatures hands were tied and the social costs to the state could, potentially, be far greater than what the state would gain. Despite the outcome state officials have made efforts to maintain communication with the tribes and have been discussing other potential initiatives that would allow the tribes to become more independent.

Areas of discussion included:

- Wind Turbine Farms on tribal land that would expand the state's renewable energy while at the same time generate income for the tribes***
- Use of a tribal warehouse as a prescription drug distribution center for the state's senior citizens***
- The tribes could use their minority status to help secure federal defense contracts***
- The state could study the possibility of allowing tax revenues from tribal owned businesses to benefit the tribes through a tax compact***
- An initiative, the Pine Tree Zone, would attract business and industry to low income, high unemployment and high out-migration through tax incentives. The tribal lands are included in these zones***

While no decisions have been made talks continue on potential economic sources. A recent development could, potentially, create approximately 900 short-term and 60 long-term positions with an estimated \$4 to \$6 million in annual revenue for the Passamaquoddy tribe in Eastern Maine. An Oklahoma liquefied natural gas company is seeking to locate a gas terminal on tribal land. Negotiations are currently underway and the tribes are optimistic that an agreement can be reached. //2005//

Impact of Welfare Reform on Women and Children

The advent of Title XXI, SCHIP in 1997 instigated changes in insurance coverage in Maine. Maine

responded by expanding Medicaid and by creating CubCare, a Medicaid-like Child Health Insurance Program (CHIP). This state operated insurance program for children, which includes EPSDT, is for ages birth through 18 years in families between 150% 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 have 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. In 1999 PrimeCare, the State sponsored and sole managed care plan for Medicaid recipients, began expanding beyond the original three pilot counties. The current unduplicated count shows 55,000 insured through Medicaid are enrolled with a Primary Care Provider (PCP) via PrimeCare. By 2001 the Bureau of Medical Services plans for all residents in all counties insured through Medicaid to be enrolled in PrimeCare. /2003/ 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.

There has been minimal managed care penetration within our state. The three HMO's that do exist are primarily in the southern region near Portland. Difficulty establishing networks of providers and services is probably a significant factor in limiting HMO market penetration. The Maine Bureau of Insurance reported in March 2000 that all but one of Maine's HMO's were operating at a loss. Most recently the Bureau of Medical Services has enrolled all Medicaid recipients in their managed care program and have renamed it "MaineCare". ***/2005/ Maine, like so many other states in FY04, continues to experience a decrease in state revenues resulting in a state budget shortfall. Over the prior two legislative sessions state agencies made significant cuts in their budgets, doing all that was possible to spare cuts to direct service areas. 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. //2005//***

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 three 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. In response to secondary migration of immigrants leading to problems of access there is an effort to increase collaboration between the 3 city health departments in order to coordinate services. All these challenges require the Bureau of Health 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. Hospitals, particularly in the northern portion of the state have acquired this technology and are beginning to connect with specialists and tertiary care centers for consultation.

/2004/ Through Public Health Emergency Preparedness (PHEP) efforts and activities related to the Maine Turning Points Project, the Bureau of Health 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 (EMS) regions.//2004//

/2005/ The Governor's Office of Health Policy and Finance (GOHPF) is leading the development

of Dirigo Health, legislation passed at the end of the first session of the 121st Legislature. (Final legislation is included in the Appendix) A major component of the legislation is the creation of a Health Insurance Program that includes health promotion, disease management, quality initiatives and health coverage through private insurance carriers that individuals, self-employed, and small businesses can buy into. Eligibility for enrollment will expand over five years with the projection that all Mainers will have access to health insurance by 2009. Other key components include costs and quality. Dirigo Health will work with hospitals, doctors, patients, businesses and insurance companies in an effort to control rising health care costs to ensure that all Maine people have the health care they need at an affordable cost.

The Bureau of Health is involved in the Maine Quality Forum (MQF) represented by Bureau Director, Dr. Dora Anne Mills, and has a significant responsibility in the review of and recommendations regarding Certificate of Need (CON) requests. In addition the MQF will collect and disseminate research, and promote evidence based medicine and best practices.

The GOHPF released a request for proposals from the private insurance market regarding the health insurance benefit package in early May 2004. Proposals were due by mid June 2004. Initial steps are currently underway to implement the health plan so it can be fully operational by fall of 2004 with the first enrollment scheduled in late summer 2004. //2005//

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (33 are birth hospitals with obstetrical services); 23 federally funded 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. There are no allopathic medical schools in Maine.

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 Women and Children's Preventive Health Services 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. /2003/ (CY2000) Nationally 83.2% of women received pre-natal care. In Maine 88.1% received prenatal care. Besides routine clinical checks, Maine women receive additional pre-natal education. The Partnership for 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 1999 there were 6%. (PRAMS data.) New mothers enrolled in WIC showed a decline in drinking alcohol from 7% in 1990 to 2% in 1999. 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.

High-Risk Care

A small portion of this grant funds 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. /2003/ In CY2000 84.9% of VLBW infants were delivered at Level III facilities. This is unchanged from CY1999.

/2005/ The Level III nursery in Bangor recently had a significant reduction in the number of neonatal nurse practitioners working in their Neonatal Intensive Care Unit (NICU). Their perinatologist has also been called to active duty. The hospital is taking steps to rebuild its capacity. However, in the meantime providers will rely more heavily upon the resources of the Level III nursery in Portland. 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. //2005//

Birth Defects

The Maine Genetics Program established a CDC Cooperative Agreement to develop and implement a state-based birth defects surveillance program. Year 2 will encompass 2/00-1/01. /2003/ The program was successful in their competitive application for continued funding. The new funding cycle begins March 01, 2002. The Program is in the implementation stage and has not yet established a data base. Numbers for birth defects are derived from birth and death certificates. We plan for the Genetics Program to have an official surveillance program in place by January 2003 which will use provider generated data. In 2001 the percent of newborns screened for PKU, hypothyroidism, galactosemia and hemoglobinopathies was 99.8%. The percent of newborns screened for hearing before discharge has risen from 39.5% in 2000 to 79.6% in 2001 due to an increased number of hospitals acquiring the screening equipment.

/2004/ Rules for the Birth Defects Program (BDP) were promulgated in early 2003 and became effective May 1, 2003. In collaboration with the University of Maine, Orono a database and tracking system, ChildLink, was developed that can be used by both the BDP and the Newborn Hearing Program (NHP). //2004//

/2005/ Abstraction of medical records for the BDP is underway. Use of the ChildLink database and tracking system is prepared for full implementation upon approval of the contract between the Department of Human Services and the University of Maine. //2005//

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 631 Nurse Practitioners licensed in Maine but the Board of Nursing is unable to report on practice location. /2003/ We estimate that 94% of our children now have insurance. Because of this, we are phasing out the PHN Well Child Clinics. 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).

/2005/ Implementation of prior authorization for pediatric medications paid for by MaineCare began in late 2003. Initial implementation of prior authorization was burdensome to pediatric providers. The Division of Family Health acted as liaison between providers and MaineCare to articulate the issues and develop resolutions that were amenable to all parties. //2005//

CSHCN Services

During FY00 the CSHCN Program served 1,736 children through a variety of specialty clinics and those accessing the Program for third party payment of specialty services and care coordination. As reported in the 2000 Maine Kids Count Data Book there were 297,266 children between the ages of 0 - 17. Using an 18% prevalence rate as noted by Newacheck, P. W., et al Pediatrics 1998 "An Epidemiologic Profile of Children with Special Health Care Needs" there are an estimated 53,508 children with special health needs in Maine. The Department of Education, Division of Special Services reported that 34,306 children were served by special educational services and an additional 842 children 0 - 2 were served by Child Development Services (Part C).

*//2004/ In FY02 1936 children were served by the CSHN Program. The 2000 U S Census reported 301,238 children between the ages of 0 - 17 residing in Maine. Of those, the SLAITS data estimated 46,807 were identified with a special health need. The Department of Education, Division of Special Services, reported that 37,139 children ages 3 -- 21 were served by special education services and an additional 1,078 ages 0 - 2 were served by Child Development Services, (Part C). //2004//
//2005/ In FY03 2,087 infants, children, and youth were served by the CSHN Program. The Department of Education, Division of Special Services, reported for school year ending June 2003 that 37,784 children ages 5 - 21 were served by special education services; an additional 1,078 children ages 0-2 years (Part C), and 4,482 children ages 3-5 years (Part B) were served by Child Development Services, a total of 45,431 infants, children and youth. //2005//*

Maine's Access to Dental Care

//2004/ Thirty-nine of Maine's 46 Dental Care Analysis Areas are now designated as Dental Health Professional Shortage Areas (30 are population designations and 9 are service area designations), along with the mental health facilities in Augusta and Bangor. Current figures indicate that the resident to dentist ratios in 11 of the 16 counties were worse than the state's average. Not only do fewer than half of Maine's practicing dentists treat MaineCare patients but also, relatively few will take new Medicaid patients (estimates vary from less than 20 to almost 40 in any given month). It is also important to note that many dental practices in Maine are apparently at or close to capacity, and many individuals, regardless of their insurance or financial status, report difficulty in finding a dentist who is taking new patients.//2004//

//2005/ As previously noted, thirty-nine of Maine's 46 Dental Care Analysis Areas are designated as Dental Health Professional Shortage Areas (30 are population designations, including two Indian reservations, 9 are service area designations) along with the two state-administered mental health facilities in Augusta and Bangor. Although newer figures are not available, all indications are that the resident to dentist ratios in 11 of the 16 counties remain substandard to the state average. As noted, fewer than half of Maine's practicing dentists treat MaineCare patients but also, relatively few will accept new Medicaid patients (estimates vary from less than 20 to almost 40 in any given month). It is also worth noting that many dental practices in Maine are apparently at or close to capacity, and many individuals, regardless of their insurance or financial status, report difficulty in finding a dentist who is accepting new patients. In certain areas of the state, timely access to services continues to be of great concern.

Efforts to improve access to dental services in Maine have continued through various channels. The OHP has continued its support of the statewide Maine Dental Access Coalition, which continues to function as network and constituency for oral health. The Dental Services Development and Subsidy Program, 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 legislatively. During the period covered by this report, there were 18 grants to 16 agencies for a variety of capacity-building initiatives, and 11 agencies participated in the subsidy program. The Request for Proposals for the next round of competitive grants in the Dental Services Development Program was released later than expected, in August of 2003. Awards were made to 10 agencies, eight grants for development and expansion and two for case management and community education. The grants will include three budget periods, one through June 30, 2004 and the others for the succeeding state fiscal years, terminating on June 30, 2006. Several of the previous awardees competed successfully for the new awards. //2005//

Mental Health Services

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is responsible for addressing the mental health needs of Maine's citizens. They have seven regional centers. This department also provides Medicaid behavioral care services. There is an increasing issue of lack of access to mental health services. /2003/ In the first session of the 120th Legislature, the Department of Mental Health, Mental Retardation and Substance Abuse Services was renamed the Department of Behavioral and Developmental Services (BDS). The name was shortened in an attempt to simplify it and yet continue to represent the full range of services provided by the Department. The Substance Abuse program remains within BDS.

/2005/ 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. During the past year, we have sharpened and increased our focus on issues involving the mental health and primary health care systems.

Recent Maine-based epidemiological research shows a significant increase in the rate of mental health disorders among children. These findings are consistent with national trends, which suggest that 14 to 20 percent of all children have one or more mental health disorders in the moderate to severe range and that the overall incidence is increasing. A large number of these children are neither identified nor treated. One national study estimates that pediatricians do not identify 80% of children with diagnosable behavioral and emotional problems, and that even fewer receive mental health services. Research in Maine indicates that a large percentage of children with the most significant behavioral and emotional symptoms never receive any services at all. Isolation and cultural attitudes complicate the use of mental health services in Maine, as they do in other rural states.

This lack of identification and treatment has major implications for Maine children and, indeed, for the state's social fabric. Untreated mental health problems often lead to high rates of medical services and place children at increased risk for chronic psychosocial illnesses. Early intervention, particularly in young children, can significantly reduce problems before they become more difficult and costly to treat.

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, the Department of Behavioral and Developmental Services (BDS) has embarked on a search to explore new and innovative means of addressing the challenges. During the past two years, the Maine Title V Program has joined with BDS in this search.

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 Bureau of Health Director Dr. Dora Mills, physicians identified mental health services as a pressing public health concern. In 2002, BDS joined with the Maine Center for Public Health to continue this dialogue. In 2003, the Center, 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 BDS, Maine Medicaid, and the Bureau of Health, is to develop evidence-based integrated practice models that will 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 could then serve as a strategy for the state as a whole.

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; joined in a panel on public policy at a statewide conference on mental health and primary health care in June 2004; and included the project in grant proposals dealing with child abuse and home visitation that Maine Title V submitted to the CDC in February 2004. //2005//

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 Community Health 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 (including mental health)
- 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 Human Services, Division of Community and Family Health (1997) and Family Health (1999), Vision Statement.

The attached Table 1 describes the Title V Funded Programs for Pregnant Women, Mothers and Infants in Maine.

We are part of a growing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. We used 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 citizens, 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 will be critical.

Strong relationships with organizations, in particular the Muskie School of the University of Southern Maine (USM); University of Maine at Orono; and Medical Care Development; 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 first step was redirecting part of our SSDI grant to hire a master's prepared MCH epidemiologist. More recently we hired a doctoral prepared MCH epidemiologist with a grant from the Council of State and Territorial Epidemiologists (CSTE). Both epidemiologists are on the faculty at USM and are excited about applied epidemiology in a state health agency. The newly hired MCH Medical Director has a strong background in public health work at the state level, including close work with MCH related epidemiology. This position will provide oversight and leadership for the coordination of MCH surveillance within the Bureau of Health.

//2005/ The doctoral prepared MCH Epidemiologist resigned his position effective May 1, 2004. Recruitment is underway to fill the vacancy. The Division of Community Health has hired a masters-prepared Epidemiologist who will begin in late June 2004. //2005//

C. ORGANIZATIONAL STRUCTURE

The State Title V Agency in Maine is the Maine Department of Human Services (DHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with DHS's Bureau of Health (BOH). Until September 2000 the MCH Block Grant was managed in the BOH's Division of Community and Family Health (DCFH). The September departure of the DCFH Division Director, Randy Schwartz, resulted in a reorganization of this very large division into two smaller divisions, Division of Family Health (DFH) and Division of Community Health (DCH). While DCFH has been organizationally divided into two separate entities to improve efficiencies, both Divisions and the Bureau remain committed to integrated, cross Divisional, cross program activities. The transition has gone smoothly with strong leadership from Valerie Ricker and Barbara Leonard division directors for Division of Family Health and Division of Community Health respectively. In addition their joint presence and participation in Bureau of Health administration has helped to insure that issues critical to Maine's MCH population are addressed.

Responsibility for Title V in Maine is within the Department of Human Services (DHS). Programs within DHS which focus primarily on the MCH population are found in both DFH and DCH. It should be noted however that only three programs working with the Family Health population reside in the Division of Community Health. 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. ***//2005/ The childhood Lead Poisoning Prevention Program (CLPPP) organizationally relocated to the Environmental Health Unit (EHU). The CLPP and adult lead programs are in the process of merging. 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. //2005//***

Kevin Concannon, Commissioner of Maine's Department of Human Services, reports directly to Governor Angus S. King, Jr. Dora Anne Mills, M.D., M.P.H. serves as Director of the Bureau of Health (BOH). *//2003/*Dr. Mills is on maternity leave which began in late March 2002 and extends through August 2002. Dr. Lori Graham, M.D., MPH is the Acting Director of BOH during Dr. Mill's leave. Both Commissioner Concannon and Dr. Mills have indicated an interest in working with the new administration. It is unknown if they will continue in their current capacity once the new Governor assumes office. The Division Director positions, and those reporting to them, are not appointed and are expected to remain unchanged. *//2004/* Commissioner Kevin Concannon resigned his position effective February 14, 2003. Deputy Commissioner Peter Walsh was named Acting Commissioner for the Department of Human Services. Appointment of a permanent Commissioner is improbable prior to the merger of the Departments of Human Services and Behavioral and Developmental Services. Dr. Dora Anne Mills continues to serve as Director of the Bureau of Health. *//2004// //2005/ John R.*

Nicholas was confirmed as the Commissioner of the Department of Human Services in April 2004. Commissioner Nicholas reports directly to Governor Baldacci. He 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. He is in the process of appointing Deputy Commissioners and some new Bureau Directors. Dr. Dora Anne Mills continues as the Director of the Bureau of Health and the State Health Officer. //2005//

Valerie Ricker, M.S.N., M.S. is Director of the BOH's Division of Family Health which houses primarily direct service programs. Barbara Leonard, M.P.H. is the Director of the BOH's Division of Community Health that houses population-based prevention and health promotion services. Fredericka Wolman, MD, MPH is the MCH Medical Director. /2003/ In October 2001 Dr. Wolman resigned from the Bureau of Health, leaving the MCH Medical Director position temporarily vacant. Richard Aronson, M.D., MPH will join us in late August as our new MCH Medical Director. We have hired a Master's prepared MCH epidemiologist, Kathy Tippy, MPH. She joined us in December 2000. We continue to recruit for a PhD MCH epidemiologist. /2003/ Through a grant with the Council of State and Territorial Epidemiologists (CSTE) we have been successful in hiring a doctoral prepared MCH Epidemiologist. David Ehrenkrantz, Dr. P. H. joined us in May 2002. **/2005/ Dr. David Ehrenkrantz resigned his position effective May 1, 2004. The Division of Family Health is actively recruiting for a new doctoral prepared MCH Epidemiologist. //2005//** The Division of Family Health was successful in its application for an Integrated Comprehensive Women's Health grant from the Maternal Child Health Bureau. Starting in July 2002, Sharon Leahy-Lind, M.S. will assume the new Women's Health Coordinator position which will administer this initiative. **/2005/ On March 8, 2004 Sheryl Peavey, BA assumed the new Early Childhood Coordinator position which will administer the Early Childhood Comprehensive Systems Initiative funded by the MCHB. //2005//** Maine's remote location and salaries that are non-competitive with neighboring state's urban areas continue to pose recruiting challenges for the Department. Our recently identified \$90 million shortfall has precipitated a new freeze on all state employee hiring except for federally funded positions. Since most of our positions are federally funded, we hope to fill vacancies as they occur. /2004/ Notwithstanding available Federal funds, the hiring freeze remains in place. //2004// **/2005/ Minimal success has been achieved in hiring into vacant federal lines. Positions funded through the state general fund continue to be subject to the hiring freeze. //2005//**

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.

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

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 Community Health: one person in the Office of Data, Research & Vital Statistics; 2 in the Health & 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. /2003/ We also include parents of children with special health care needs on the CSHN Parent Advisory Board. No staff has been hired because they are parents of CSHCN although several staff members do have children with special health care needs.

/2004/ The CSHCN Program contracts with a member of their Family Advisory Committee who is a

Registered Nurse to provide oversight on the Medical Home Advisory Committee (MHAC). The MHAC is planning a conference on medical home in October 2003. The CSHN Program also contracts with a parent consultant to provide peer support to parents/families receiving services through the Southern Maine Metabolism Clinic. //2004//

The Office of Data, Research & Vital Statistics (ODRVS) provide data for this grant application, attend the MCHBG review session, and meet periodically with DFH managers for program specific data needs. Our increased epidemiology capacity will lead to increased cross-divisional work between BOH and ODRVS on MCH priorities. The Health & Environmental Testing Laboratory Director meets quarterly with Valerie Ricker, Director of DFH, to review shared 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 works closely with the Manager of the Teen Young Adult 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. Both of our new epidemiologists are working 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 BOH. /2004/ 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, 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 13 vacancies within the programs serving the Maternal Child Health population.//2004//

/2005/ Currently there are 8 vacancies within the programs serving the MCH population. Four positions are funded through the MCHBG and 4 through the General Fund. Recruitment is underway to fill 2 MCHBG positions, 1 in the Maine Injury Prevention Program, 1 in Public Health Nursing and 2 General Fund positions in Public Health Nursing (PHN). All PHN positions being filled are for field nurses who provide services to Maine residents and communities. //2005//

In addition, Title V partially supports 56 Public Health Nurses (5 supervisors and 51 field nurses) who are based statewide in 17 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 strategic planning and training.

/2004/ Senior level management include: Valerie J. Ricker, Director of the Division of Family Health, which has administrative responsibility for Title V. Ms. Ricker has 23 years of experience in MCH, 7 years with the Maine Bureau of Health 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 25 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. Toni Wall is the Director of the CSHN Program and has been in this position for 3 years. She has 16 years experience working in Bureau of Health Programs prior to CSHN. Her past experience has prepared her to influence and manage the program. Toni holds a BS and is currently studying for a Masters in Public Administration with a concentration in Health Care Administration. Kathy Tippy 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 Bureau of Health since December 2000. She has also

taken additional coursework in Regression Models Healthcare Sciences, SAS, SUDAN, and Arc View. David Ehrenkrantz, Dr. PH has spent 10 years working in the field with some focus on MCH. He has many years of experience in Community and Social Health. Prior to coming to the Bureau of Health in May 2002, David spent 3 years in another State Health Department. Biographical Sketches are on file in the Bureau of Health's Division of Family Health and will be made available for review. //2004//

//2005/ Ms. Wall completed her graduate studies and received her MPA in May 2004. Dr. Ehrenkrantz resigned his position effective May 1, 2004. The Division of Family Health is actively recruiting to fill the doctoral prepared MCH Epidemiologist position. //2005//

/2003/ Title V now partially supports an additional 2 field nurses for a total of 58 Public Health Nurses (5 supervisors and 53 field nurses). Approximately 50% of PHN positions are funded by MCHBG. Their services have had a positive impact on our prenatal care rates, our number of children immunized, our infant mortality rate and our teen pregnancy rate.

E. STATE AGENCY COORDINATION

/2003/ The BOH/DFH has several methods for establishing working relationships/collaboration with other entities. 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. For example, we have asked our Asthma Advisory Committee to meet and identify other entities with interest in the asthma issues.

//2005/ 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. In the past year, Maine Title V has been responsible for:

- Creating a Task Force on Early Childhood comprised of 120 varied state, community, and family representatives***
- Developing comprehensive grant proposals for early childhood systems, women's health, child abuse and neglect, and a statewide prevention infrastructure***
- 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 //2005//***

See Table 1 Attached for listing of Key Title V Relationships

/2003/ The BOH/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.

/2004/ 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.//2004//

//2005/ The Women's Health Coordinator represents the Division of Family Health on the Maine Primary Care Association's Violence Against Women Governmental Affairs Planning Grant Committee. The Division of Family Health (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//

F. HEALTH SYSTEMS CAPACITY INDICATORS

//2004/ The Maine MCH Program is rooted in the vision that families, communities, and our state as a whole thrive when all children 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 citizens. This vision reflects an underlying belief in the potential for communities as a whole to be healthy and for the core human values of dignity and respect to become the cornerstones for healthy children and families.

We strive in our Title V Program to design and put into practice humane systems that make it easier for Maine to fulfill this vision. Such systems foster the conditions for home and community environments to nurture children unconditionally; for childcare and education to provide safe and stimulating environments; for medical, dental, and mental health homes to be accessible, and to engage with families in a spirit of affirmation and partnership. Developing humane systems to improve the health and safety of the MCH population requires that we carefully identify and measure the outcomes that we want to see in the health status of Maine's children, families, and communities. Measurement requires information that is in thoughtful alignment with the strengths and needs of Maine's MCH population, and that has the potential to spark community and state level action.

How are Maine's children and families doing? Are they better off or worse off than they used to be? Which populations of children and families do well? Why? Which populations are most vulnerable to not doing well? Which populations experience health inequalities and disparities? Why?

We welcome the Health Systems Capacity Indicators because they help us to answer these questions and, in turn, to catalyze the kinds of creative systems and community wide changes that are most likely to improve the health and safety of Maine's children. The Health Systems Capacity Indicators also support Maine's public health plan for 2010 that includes a special supplement entitled HealthyMaine2010: Opportunities for All. This document (available at <http://www.state.me.us/dhs/boh>) identifies populations in Maine that face health inequalities and presents a compelling case for action to reduce these inequalities.

The following examples show how the Health Systems Capacity Indicators will help us to become clearer on how to connect data to action:

Indicator #1 - Asthma Hospitalization Rate in Young Children: Routine analysis of hospital discharge data gives us benchmarks in the determination of asthma morbidity among young children. It also reflects on the quality of and access to health care. The lack of a medical home and inappropriate asthma management are directly related to the increased probability of unnecessary hospitalizations. Asthmatic children unable to gain access to primary care or prescription medications due to uninsured

or underinsured status are also at a greater risk of needing hospitalization. Hospitalization rates may vary according to geographic location and point to a disparity in access to ambulatory primary care between urban and rural communities. Not only are there direct costs associated with unnecessary asthma hospitalizations, but the indirect costs associated with lost parental work days along with the overall decrease in the quality of life are immeasurable. For these reasons, analyzing and reporting hospitalization data are crucial.

Indicator #5 -- Medicaid and Non-Medicaid Comparison. Maine has put a great deal of energy into expanding eligibility for Medicaid and simplifying the enrollment process. Medicaid 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. To what extent does the Medicaid population differ from the non-Medicaid population with respect to low birth weight, infant mortality, and prenatal care? Although lower-income populations typically do not fare as well, we are eagerly interested in knowing if our MCH efforts such as home visitation, WIC, and Public Health Nursing may be reducing the magnitude of the income disparity for maternal and infant health. Indicator #5 opens the door for such probing. It also challenges us to intensify our efforts to strengthen collaboration with the Medicaid Program.

Indeed, the process required for us to report on this indicator heightened our understanding of the complexity of Medicaid -- how, for example, the Medicaid population includes a heterogeneous mix of recipients who qualify through multiple categories; and how the way that Medicaid defines eligibility (one month versus 11 month enrollment in a given year) significantly affects the indicators. At the same time, by working together, Medicaid learns from us that Medicaid enrollment itself does not translate into full access to a Medical Home for a recipient; and that family-centered and culturally competent systems are essential to families feeling honored and respected when they seek preventive care. Also, the Medicaid-MCH dialogue bears fruit as we carefully watch for the impact of the nation's economic downturn and state fiscal crises on the health of the lower income population. To date Maine hasn't made cuts in eligibility levels or significant cuts in services, but we must anticipate potential changes in the future, and plan how to deal with them.

Collaboration is the highest form of working together. It involves not only coordinating and cooperating with each other -- but also sharing resources and capacity. Thus, the Health Systems Capacity Indicators serve the vital function of enriching the collaboration between Medicaid and MCH.

Indicator #9A -- General MCH Data Capacity: As MCH leaders, we can make sound decisions about our policies, strategies, and systems only if useful, clear, accurate, and timely information is available to us and to all of our partners -- including the families and communities that we serve. Maine's vision and passion for creating and sustaining healthy families in healthy communities must be fueled by public health information systems that grow out of culturally competent and family-centered organizations. Such systems are central to how we address Health Systems Capacity Indicator #9A: the ability of states to assure that the Title V Agency has access to policy and program relevant information and data. This directly supports the Infrastructure Building activities of the MCH Pyramid.

No single information source can fuel the complex multifaceted work of maternal and child health. Historically, we have collected information using single-purpose or program-specific databases, some of which were recorded on paper forms or charts; and we have typically not included families in designing, implementing, and evaluating such information. Computerized databases often constitute independent data "silos" from which data exchange is difficult and at times impossible. This significantly impairs the capacity of Title V, families, and communities to plan MCH efforts in thoughtful, inclusive, and visionary ways. We are challenged to make a major shift in the way we approach and use data, so that it is more reliable, family-centered, population and system based, and tailored to addressing health disparities.

The Bureau of Health, which houses the Title V MCH Program and is part of the Department of Human Services, is in the process of developing an Integrated Public Health Information System (IPHIS). This web-based information system will consolidate the roughly 30 databases that reside in the Bureau of Health into a newly created Public Health Data Warehouse. The web-based system will

format the databases so that they meet a core set of privacy and security standards established by the Centers for Disease Control and Prevention. The databases will be able to interact with each other in ways that lend themselves to in-depth analyses, dialogue, and action. The system will be able to link Bureau of Health databases from multiple sources such as Vital Records, WIC, and the Lead Poisoning Prevention Program. The system will be accessible to the Bureau of Health (and other state agencies per data sharing agreements) for public health assessment, program planning, and evaluation. The data repository will also feed information to a public web-based community health information system. This will be an independent and stand-alone system that provides up-to-date real-time comprehensive information on health status, quality of care, and population-based health outcomes. The Integrated Public Health Information System is expected to be fully designed by January 2005 and fully operational by January 2008. As we address Health Systems Capacity Indicator #9A, it is critical that we work closely with the IPHIS staff.

In response to Health Systems Indicator #9A, we plan to link WIC records to other data bases, including infant birth and death certificates and hospital discharge data. This will strengthen our capacity to answer the following questions and take action accordingly: 1) What percentage of babies born to women receiving WIC have low birth weight (less than 2500 grams) and are premature (less than 37 weeks gestation)? How have these percentages changed over time? How do they compare to indicators for the state's population as a whole? If the birth outcomes are significantly better, why? 2) To what extent do infants born to women who enroll in WIC in the first trimester of pregnancy have more adequate prenatal care and better birth outcomes than those born to women who enroll in the third trimester? If so, to what extent? What are the implications of the response to this question on WIC's outreach activities, including its collaboration with other resources such as Public Health Nursing? 3) What is the average newborn hospitalization charge for a baby born to a woman who received WIC during pregnancy? How does this compare to the population of babies born to women who did not receive WIC? 4) To what extent is WIC effective in reducing and preventing obesity?

Another way that we will address Indicator #9A concerns child abuse. In January 2003, the Acting Commissioner of the Department of Human Services (DHS) initiated an effort to unite the wide array of people, organizations, and communities involved in the prevention of child abuse and to highlight its importance as a public health issue. Despite three decades of legislatively mandated child protection services in Maine and across the country, the number of children reported and confirmed as victims of child abuse and neglect remains alarmingly high. In 2000, DHS confirmed a total of 4,279 Maine children as victims of abuse and neglect. In addition, an increasing number of reports received by DHS warranted Child Protective Services. The Acting Commissioner is exerting his leadership position to inspire the citizens of Maine to make child abuse prevention a top priority and to create a culture in our state that raises the societal value of parenting to a much higher level.

A clear role for Title V is to assure that our expertise in developing humane and effective systems is interwoven with accurate information and data analysis. This helps to define the issue and monitor the extent to which changes in systems improve the health and safety of children and families. To better address Health Systems Capacity Indicator #9A, we are challenged to link databases that exist within the Bureau of Health and beyond. For child abuse, this means connecting hospital discharge, birth, and death records; Medical Examiner and police files; and DHS databases. This effort will require the kind of inter-disciplinary collaboration and sensitivity to families and cultures that are at the heart of systems change.

Measuring Maine's progress on the Health Systems Capacity Indicators will grow with our newly established Epidemiology Team (Epi Team). The Epi Team consists of the two MCH epidemiologists, three health promotion and chronic disease prevention epidemiologists, and the epidemiologist for the Behavioral and Risk Factor Surveillance System. Instead of narrowly assigning staff to projects, the Epi Team reviews all project priorities and assigns responsibility to the epidemiologist with the best mix of skills and knowledge related to the project. The MCH Medical Director provides guidance and oversight to the Epi Team. The Epi Team will pay special attention to making sure that families and communities are involved in its efforts from start to finish, including populations that experience health disparities and inequalities.

The Health Systems Capacity Indicators also will help guide us in the 2005 Title V Strengths and Needs Assessment. We intend to involve families and communities in the assessment; move from a needs only assessment to also include strengths; measure systems with respect to their capacity to be family-centered, culturally competent, and focus on resiliency; take indicators previously expressed as morbidity, mortality, and risk and frame them in a positive light as well; incorporate mental and spiritual health and social capital; use non-jargon language that avoids pejorative terms such as "targeted"; measure the extent to which children feel honored and respected; and more humanely report on the variables of age, education, gender, income, race, ethnicity, culture, and geography that may show disparities.

Maine is uniquely poised to address the Health System Capacity Indicators. We have a long history of investing in services and systems for children and families. In 2003, Maine led the nation in health care reform by enacting a plan that aims to assure universal access to health insurance coverage for all citizens by 2008. Our new Governor is in the process of restructuring state government so that it is more integrated in how it supports children and families. As previously mentioned, the Bureau of Health is in the process of developing an integrated public health information system that will eventually support more detailed analysis of MCH related data.

And finally, we must always keep in mind that behind every statistic is a human being -- someone who has personal, professional, and spiritual aspirations just like all of us. Each has friends and family, hobbies, dreams, eccentricities, all the things that make us wonderfully exasperatingly human. And, as Rev. Martin Luther King, Jr., said almost 50 years ago, "Our nettlesome task is to discover how to organize our strength into compelling power". //2004//

/2005/ The Family and Community Health Epidemiology Team continues to grow. With the addition of a fourth epidemiologist in June 2004, the team now consists of Kathy Tippy, Katie Meyer, and Cindy Mervis. Recruitment is currently under way to replace David Ehrenkrantz, who left his position in May 2004.

In preparation for the 2005 Strengths and Needs Assessment, which will establish new state priorities, the Maine Title V Program articulated a unique direction for the assessment. We view the assessment as an ideal opportunity to strengthen our Title V leadership by incorporating three key principles into the methodology for the assessment. These principles are the following:

1. Strengths, not just needs: We believe that our work to improve the health of the state's children and families should be rooted in addressing strengths as well as needs. We understand that children, families, communities, and systems are more likely to change for the better when the context for such actions includes their strengths, assets, and resiliency. Why do some families do better than others in the face of similar circumstances? How can we collect information so that it will enable us to track the answers to this and other such questions? Thus, we shall conduct a Strengths and Needs Assessment and shall seek, from start to finish, to identify and measure positive factors.

2. Quality, not just quantity: We aim to foster conditions that will enable children to thrive in environments that honor and respect them and that affirm their dignity. To achieve this aim, we are challenged to measure the health of the MCH population in ways that illuminate the quality of their lives and of the policies and systems that affect them. The quantitative measures with which we are most familiar and comfortable -- such as infant mortality, low birth weight, and youth suicide rates -- continue to be important. However, our Strengths and Needs Assessment should also focus on qualitative indicators at all levels. The questions that form the foundation for our assessment should stretch and flow well beyond the boundaries of numbers. To what extent are Maine's children "thriving"? To what extent are our MCH services, organizations, and systems culturally and linguistically competent? To what extent are they family-centered?

3. Inclusion of Stakeholders: One reason that Title V is a such a precious resource is that it requires us to not only assure decent services for the whole MCH population but also to establish the foundation needed to sustain such services from one generation to the next. The Strengths and Needs Assessment is a central component of this foundation and its strength rides on our commitment to involve all stakeholders in building it. Thus, family and community involvement from start to finish is central to every last detail. And before we even start to design our assessment, our initial task is to ask again and again: Who should be at the table? Whom have we forgotten? And how do we ensure that everyone feels welcomed and that his or her voice matters in this process?

4. Cultural and Linguistic Competence: Healthy People 2010 has established a Year 2010 public health objective of 100 % access to health care and zero disparities in health status for all citizens. The attainment of such an ambitious and significant public health objective depends on the capacity of all of our health and human systems, including education and childcare and mental health, to deliver culturally and linguistically competent care. The recognition that cultural and linguistic issues affect all aspects of public health practice heighten the importance of striving to incorporate cultural competence into our Maine MCH Strengths and Needs Assessment.

On May 11, 2004, we held a one-day workshop on cultural and linguistic competence for 20 program managers from the Bureau of Health. Two consultants from the National Center for Cultural Competence joined with a panel of Maine family and community representatives to guide the process. The purposes of the May 11 workshop were to start a process that will enable us to incorporate cultural competence into all aspects of the Strengths and Needs Assessment. This will include an organizational self-assessment of cultural competence within the Title V Agency itself; increased awareness of the dynamics inherent when cultures and languages interact; and the design of the assessment methodology so that it will give us information related to culturally competent practices at the community and state level. By infusing cultural competence into the assessment, we will aim to enrich and enhance the recognition throughout Maine that cultural and linguistic competence is a high priority and a foundation for healthy and safe children and families, and the systems and policies to support them. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2004/ 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 1.2 million people, 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 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 three largest cities (Portland, Lewiston, and Bangor) have local public health departments, the state does not have any county health departments. The Bureau of Health'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.

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 seven 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. 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.//2004//

/2005/ With the advent of the State Early Childhood Comprehensive Systems grant (SECCS) award and the impending merger of the departments of Human Services and Behavioral and Developmental Services, Maine has begun a thoughtful process to build more humane and family-centered systems within both state government and local communities. The Task Force on Early Childhood, a function of the Children's Cabinet, refined its mission and objectives with broad stakeholder input and expanded its membership to truly represent a partnership with the common voices from among state agencies, community organizations, and Maine families. The Task Force members are analyzing current infrastructure and expenditures, reviewing the literature and research related to child and family outcomes, and will provide data-driven, sound recommendations to enhance and improve the supports for Maine's MCH population. These recommendations will influence policy and business protocol, effectively linking state intent with local service delivery. The timing of the department merger is providential; Maine's executive and legislative branches seek meaningful guidance to develop a unified department granting families "no wrong door" to access state services.

The decision to bring the two departments under one roof has also expanded the thinking about the connections and relationships among parent education, child care, mental health, substance abuse, and child abuse and prevention efforts. It is complemented with a statewide prevention plan, the result of state and community interagency collaboration, which blends the goals of child abuse and neglect councils, substance abuse and domestic violence prevention and intervention, mental health services and a host of health related concerns. The prevention plan relies heavily on existing MCH programs, including home visitation and public health nursing, to implement its objectives. //2005//

B. STATE PRIORITIES

/2004/ In reviewing Maine's performance measures, some may perceive that we place a relatively greater focus on youth. Maine has made a conscious decision to continue on this track. We feel that our focus on youth can provide them, at a critical stage of development, with a stronger foundation for their physiologic, behavioral, and spiritual health that they will carry with them into adulthood. We believe that this focus is a significant contributing factor to the State's positive outcomes and ranking with respect to many of the national performance and outcome measures. In addition, the Title V philosophy of promoting family-centered systems permeates all aspects of our program. By supporting families and involving parents and adult care providers in the design of services, we are able to have a positive impact on their physiologic, behavioral, and spiritual health as well as that of their children. What may appear as a focus on the child is, in fact, rooted in Maine's strong commitment to promote healthy parenting and create a culture that honors parenthood as the most important of all "occupations". //2004//

The Division of Family Health and the Division of Community Health have made a long-term commitment to improving the health outcomes of Maine's citizens. During FY00 the MCH program developed a strategic plan with the vision of a Maine where all individuals, families, and communities enjoy optimal health and quality of life. Attention to five priority areas for focusing our human and financial resources is critical to achieving this vision. These areas are:

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

The above are global organizational priorities that strive to strengthen our infrastructure and will be integrated throughout our MCH programs. As a result of our strategic planning and needs assessment activities, the following five focused and more readily measured priorities have also been identified. These reflect our efforts to move toward less categorical and more core public health functions. They are as follows:

- 6) Establish a broad based Maternal and Child Health Program Advisory Committee
- 7) Improve nutrition and physical activity for the MCH population
- 8) Enhance adolescent health initiatives and programs
- 9) Integrate MCH activities with tobacco cessation and prevention activities.
- 10) Coordinate across Programs and Divisions on common issues

/2004/ Progress has been made in all areas with the exception of establishing the Maternal Child Health Program Advisory Committee. Evidence of progress on the nine (9) priority areas is documented throughout the annual report and plan. Establishment of the Maternal Child Health Advisory Committee is critical as we face challenging financial times and adjust services to children

and families through the merger of the Departments of Human Services and Behavioral and Developmental Services. The new MCH Medical Director brings with him a successful experience in developing and sustaining a diverse, cohesive, and engaged state MCH Advisory Committee. He will be a knowledgeable resource in planning and implementing an advisory committee for Maine's Title V Program. //2004//

//2005/ Planning for a Maine MCH Advisory Committee started in the fall of 2003. Title V leadership worked with MCH related program managers to develop drafts of the mission, role, responsibilities, and structure of the Advisory Committee. The purpose of the Advisory Committee will be to advise the Bureau of Health on how best to strengthen the capacity of the Maine MCH Title V Program to carry out its mission, which is to assure optimal health and safety for all children and families in the state; by creating humane systems and policies that promote a family-centered philosophy, state and community wide leadership, and cultural and linguistic competence; and by creating communities where citizens are responsible, productive, and compassionate.

The structure of the MCH Advisory Committee will allow for co-chairs, one of whom will be a family representative; the use of non-jargon, non-bureaucratic, and non-military language; and a membership of about 25 people, one-third of whom will be state agencies outside of the Bureau of Health, one-third providers, and one-third family and youth representatives. The committee will have its initial meeting in the fall of 2004 and will have four regular meetings per year. The initial focus of the Advisory Committee will be on the five-year Title V strengths and needs assessment as described above. //2005//

//2004/ The following is a list of Maine's State Performance Measures and our rationale for selecting them.

The percent of unintended births in women less than 24 years of age. (SPM#2)

Children and families have better health outcomes when they are adequately able to take care of themselves. In addition, women giving birth during adulthood are more likely to be successful in their parenting. The assurance that pregnancies occur when families are prepared and desirous of children is a priority for Maine's Title V Program. Intended pregnancies are strongly correlated with improved birth outcomes. This correlation likely results from healthy behavioral changes related to substance use, including tobacco, and nutrition.

Percent of Women enrolled in WIC that are breastfeeding their infants at six months of age. (SPM #3)

Research consistently demonstrates better health status of both mother and infant when the infant is breastfed for at least six months. Breastfed infants have as much as 60% fewer acute care visits to the physician in the first year of life due to improved immunity and nutritional status. In addition, the maternal-infant bonding that occurs through breastfeeding promotes maternal self-confidence and may reduce the incidence of child abuse. The State Title V Program is interested in initiating and increasing breastfeeding among all women giving birth in the state. This supports the Healthy People 2010 goal of 50% of infants being breastfed until 6 months of age. At this time, Maine does not have a system to collect breastfeeding data on the whole population. However, the WIC population is one tangible and consistent source of available data. Title V hopes to one day be able to collect this data on all women who give birth in the state.

The percentage of adolescents who have received routine dental care in the last year. (SPM # 4)

Good oral health is necessary to enable people to live healthy and productive lives. We identified this measure as critical to bringing attention to the oral health of the MCH population in Maine, and to the importance of adolescents receiving routine dental care. Preventive oral health care through a Dental Home is essential in order to prevent or alleviate pain or infection, and to contribute to better overall health. Children and youth in pain from preventable tooth decay often lose time from school and when

in school are unable to concentrate, affecting their ability to learn. Children and youth are an excellent population for preventive strategies since they can reduce long-term negative outcomes. In addition, an increasing body of evidence suggests that maternal oral health status has a significant impact on pregnancy and birth outcomes. Adolescents receiving routine preventive oral health care will presumably receive this information and apply it when preparing for parenthood.

The motor vehicle death rate per 100,000 among children 15 to 21 years of age. (SPM # 5)

The national performance measure for motor vehicle death rate looks at children 1-14 years old. Motor vehicle related injuries in Maine are the leading cause of death for the age 15 to 21 population. The rural nature of the state is conducive to having a greater number of young drivers on the road and increasing the risk for serious injury and death. This measure enables us to look at methods to better prepare our young drivers and identify areas where focused alternatives would have the greatest impact.

The Percent of children with special health needs receiving services from the State Title V CSHN Program (SPM # 6)

When Maine was initially developing its measures, we selected this one to draw attention to children with special health needs. Looking at the number of children the program serves, we continually asked ourselves how effectively we were in reaching all children with special health needs in the state. We could report serving a specified number of children, but we wanted to know what proportion of children with special health needs in Maine we were serving. Therefore, we had to identify the total number of children and as well as the number we were serving. Although quantifying the total number of children with special health needs is a challenge, this performance measure has catalyzed the program to look at how we can have a broader impact and change our view of the program from one of direct service to one of infrastructure building. With that said, we have decided to discontinue this measure and evolve to a state measure that looks more at the quality of care to the CSHN population. Starting in FY04, we will begin reporting on a new measure.

Timely Provision of Genetics Services to women receiving services provided by Title V (SPM # 7)

When originally developed, we chose this measure to focus on pregnant women and to determine the quality of genetic services and system capacity for this population. At the time, we hypothesized a significant delay from the time a pregnant woman received a referral for genetic services until the time she actually received the service. This delay had the potential to have an impact on the family's decision to make choices about pregnancy. In monitoring this measure for several years, we identified that the system and capacity to respond to genetic disorders is effective and strong. We concluded that this measure had served its purpose. . We are now prepared to discontinue it and add a new measure that deals with the quality of genetic services. Starting in FY04 we will be adding and reporting on a new measure # 12.

The percent of overweight adolescents in Maine. (SPM # 8)

We identified the nutritional and physical activity status of Maine youth as important in influencing not only their self-esteem and mental health but also their health status as adults with respect to developing chronic disease. Because more than a third of high school students were not participating in vigorous activity on a regular basis, we selected this population for the measure. The YRBS represented the best current data regarding overweight and youth in the state. Monitoring the status of youth provides opportunities to intervene before behaviors become established. This measure has become even more important in light of the nation's current obesity and overweight epidemic.

The Percent of Overweight Children (SPM # 9)

Maine is currently monitoring overweight in adolescents and understanding that behavior can be

modified through early intervention. The Asthma Prevention and Control Program developed a Child Health Survey for kindergarten and 5th grade children. One component of this survey is a height and weight measurement of the children surveyed. This survey will provide a consistent source of measure and allow for early intervention. This measure fits well with the Healthy Weight Awareness Campaign that Maine has developed to focus on the importance of changing behaviors related to soda consumption, television/computer time, physical activity, and portion sizes to reduce the risk for overweight among youth. This rate will allow for measurement in attaining the Healthy People 2010 Objective of reducing the proportion of children and adolescents who are overweight.

To reduce physical fighting among adolescents in Maine. (SPM # 10)

We selected this measure to address our commitment to preventing youth violence in Maine. Since most children spend a large percentage of their time in schools, prevention work in the school setting is especially important. Behavior and response patterns to conflict, developed during the adolescent years, often play out in adulthood. Early intervention can prevent less violent behavior in later years.

To decrease the percentage of Maine children ages 5-12 with a need for obvious dental care (SPM # 11)

Early intervention in the dental disease process is essential in order to prevent or alleviate pain or infection, and contribute to better overall health. This measure provides an opportunity through the Maine Child Health Survey of Kindergarten children to intervene at a younger age. The Child Health Survey along with the Smile Survey allows for a consistent population-based data source. Since children at kindergarten age are just beginning to lose their primary teeth, this measure will assist in identifying problems prior to development of their permanent teeth and, with appropriate interventions, will prevent premature loss of teeth later in life.

To increase Primary Care Providers knowledge of the impact of genetics on the health of their population (SPM # 12)

While the timeliness of pregnant women receiving genetic services is a measure that has consistently been met in the past few years, we believe that genetics continues to require attention as a state measure. Parent members of the Joint Advisory Committee of Newborn Screening and Children with Special Health Needs Programs identified a concern in relation to primary care provider's (PCP) awareness of the impact of genetics on the health of their patients. Increasing the awareness and knowledge of PCP's can increase appropriate referrals to genetic centers and improve the PCP's ability to act as a medical home for the child and family with a genetic disorder. Initial focus of activities for this measure will be with PCP's for individuals identified with inborn errors of metabolism. Through this measure, we can address parental concerns as well as focus on systems capacity and the ability to manage these newly developing metabolic disorders.

To increase the percentage of children with special health care needs less than 18 years of age receiving care coordination (SPM # 13)

Discussions with the Division of Quality Improvement in the Bureau of Medical Services raised awareness of the difference in how Medicaid's definition of care coordination for children with special needs differs from that of our CSHN Program. This measure will give us the information needed to determine if health and cost outcomes for children who receive care coordination through MaineCare's Primary Case Management Program differ from those who receive care coordination from the CSHN Program. Care coordination through the CSHN Program is more comprehensive. We believe that this information would be a good starting point for looking at the quality of our services and the impact of care coordination. We will begin reporting on this measure in FY04. //2004//

The ten, State MCH priorities as previously listed are purposely developed based on a broad frame to accommodate activities that will have a long-term impact on the national and state performance

measures. There is a common thread among our priorities around systems development and/or infrastructure building which is the focus of Title V.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Maine consistently screens over 99% of infants born in the state. During CY02, Maine screened 13,356 of the 13,370 births that occurred in the state during the year. This represents 99.9 % of newborns screened. Protocols were completed and adopted for Newborn Screening and Children With Special Health Needs to assure timely access to treatment and services. Several states have requested copies of these protocols for use as models in assuring timely follow-up for newborn screening.

In July 2001, Maine began offering an expanded panel of screening for 19 tests to newborns. 99.8% of Maine infants that received the mandatory screens were also screened during CY02 for the expanded panel of disorders. During CY02, 18 infants were identified with disorders through newborn bloodspot screening. The increase from CY01 is not statistically significant as more tests were being performed as of July 2001. The disorders included Partial Biotinidase Deficiency, PKU, Congenital Hypothyroidism, Galactosemia Duarte Variant, MCAD, HMG, MCC, and VLCAD. Three infants were identified with more rare disorders through the optional expanded screen. All infants, except two, did not have a family history of disorders and would not have been identified early without newborn screening. All affected infants were receiving appropriate consultation and treatment within 48 hours of confirmation.

b. Current Activities

In FY03 the Newborn Screening Program Advisory Committee added more family members and took steps toward being more family centered in its structure. A parent co-chairs the committee. The committee, now known as the Joint Advisory Committee (JAC), advises both the Newborn Screening and Children with Special Health Needs Programs for the identification and management of children with conditions discovered through newborn blood spot screening.

A survey was administered in the spring of 2003 to evaluate the effectiveness of parental education related to newborn bloodspot screening. When the Advisory Committee recommended Optional Expanded Screening, the intent was that all mothers would receive a booklet describing the screening program and a discussion would occur with a health care provider to determine if the optional expanded screening was accepted or declined. Mothers, over the age of 18, who gave birth to a live infant during February 2003, received the survey. A total of 815 surveys were distributed with 209 responses, a 26% response rate. Respondents reported limited knowledge of newborn screening.

- 16.8% had never heard of newborn bloodspot screening.
- 38% were unsure if their baby had been screened for the mandated disorders
- 72.9% were unsure if their babies had received the optional screening.
- Less than half the mothers remembered receiving a brochure.

Survey results were shared with the JAC and will be distributed to Perinatal Nurse Managers. A recommendation was made by JAC for the program to consider further educational efforts, in varied formats, at all levels. Staffing shortages delayed progress in this area during the reporting period. The program is currently at full staff allowing work to begin.

A technical review team from the National Newborn Screening and Genetics Resource Center visited Maine in April 2004. All aspects of the Program were reviewed and recommendations are pending.

c. Plan for the Coming Year

A plan is in place to evaluate the effectiveness of parental education relating to the Newborn Screening Program. Evaluation of the effectiveness of the Newborn Screening Program, including the optional expanded panel, will continue in FY05. The Program will continue to gather data from screening records on the optional expanded screening program, i.e., acceptance rate, false positive rates and prospective outcomes of infants identified. Resource materials related to all disorders included in the Maine Newborn Screening Program are being completed and distributed for use by staff, medical home and other professionals, clinics and parents. A program manual will be finalized and distributed to Obstetric and Pediatric health care providers and birthing hospitals. The manual will consist of information on the Newborn Screening Program, the conditions included in the screening panels, program and provider responsibilities, as well as, a list of resources.

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)

a. Last Year's Accomplishments

Family and youth participation is a core value of the Maine Children with Special Health Needs (CSHN) Program. The CSHN Family Advisory Council (FAC) was active in planning and presenting the 4th annual parent conference October 3, 2003, "Traveling the Journey with Others", attended by 80 families. Keynote speaker, Deborah Kline, presented "Life with an Exceptional Child".

In keeping with our commitment, youth and families played a central role in planning and participated in all phases of the "Stepping Stones Medical Home Conference". Linda Pulsifer, Co-chair of the FAC, was instrumental in the design and outcome of the conference.

The CSHN Program again supported the 20th annual Special Family Weekend held in Castine on May 30, 31, and June 1, 2003. This 3-day event provides a respite opportunity for families to spend time away from home at a coastal retreat. The CSHN Program provided mileage reimbursement to those families not having the financial capacity to attend. Approximately 100 families attended the weekend festivities that provided childcare, information on the CSHN Program, sibling issues, family relationships and YOUTHSPEAK.

During FY03 the Maine Parent Federation (MPF) in collaboration with the CSHN Program established seven regional health information centers in Maine providing resources, information and support to families. The CSHN Program provided stipends and mileage reimbursement to 40 families who attended the Parent Training. Those trained mentor parents of children newly diagnosed with a similar disability. The mentors provide support and assist in the identification of resources available in Maine.

Linda Pulsifer, FAC Co-Chair, and Elijah Steward, a member of the YEA ME Youth Advisory, reviewed the MCH Block grant application and attended the review in Boston in August 2003.

The CSHN Program applied for and was awarded a HRSA Traumatic Brain Injury Planning Grant. This grant will address the following 4 components: 1) establish an advisory board; 2)

conduct a statewide needs assessment; 3) designate a lead state agency; and, 4) develop a statewide action plan. In keeping with the impetus of this performance measure the program established a diverse advisory council comprised of individuals with TBI, families, public and private agencies and other interested parties.

b. Current Activities

In FY03 the Family Advisory Council completed Form 14 giving the program an overall rating of 13 points. This rating is reflective of the continued need for more family involvement, an area of future focus of the program.

The Maine Works for Youth Project (MWFY) is currently surveying the 300 families who received the Care Notebook described in FPM # 3 in 2003. Results of the survey will be used to make adaptations to the current draft prior to dissemination. The Care Notebook will be disseminated widely to all families currently enrolled in the CSHN Program, Early Intervention (Part C) sites, Primary Care offices, and other interested parties. The Care Notebook will also be available on the MWFY website.

During March 2004 the CSHN Program distributed a Family Satisfaction Survey to 150 families currently enrolled in the Program. The Family Survey was adapted from the American Academy of Pediatrics Medical Home Assessment Questionnaire, Family Version. Preliminary analysis indicates that families are least satisfied with the knowledge of their primary care practices regarding community-based resources. Final analysis and report is anticipated by September 2004.

The CSHN Program, in collaboration with the Brain Injury Association of Maine (BIA), received a HRSA, Traumatic Brain Injury planning grant in April 2003. This two-year planning grant provided an opportunity for Maine to develop extensive partnerships with both private and public agencies through the Acquired Brain Injury Council (ABI). The ABI Council is well represented by individuals with TBI, family members, advocacy groups, rehabilitation agencies and state agencies such as; education, elder and adult services and labor. The BIA of Maine was contracted to conduct a three-pronged needs assessment. During November and December 2003, the BIA conducted 12 focus groups with individuals and youth with TBI and their families. The results are currently being compiled and a summary will be available in the summer of 2004. In addition, individual interviews took place during the spring of 2004 with legislators, providers and individuals with TBI and their families to corroborate and/or strengthen the focus group data. A written survey will be distributed within the next several months to providers, individuals with TBI and their families, legislators and others currently serving individuals with TBI, to assess the needs and resources at the community level. Use of these inquiry methods will provide the CSHN Program and the ABI Council a more accurate picture of the current resources available in Maine.

c. Plan for the Coming Year

During FY05 the Family Advisory Council (FAC) will re-evaluate its structure and function with respect to its mission and bylaws. Recently, members of the FAC and CSHN Program staff reviewed member's priorities and agreed that the FAC, as an advisory council to the CSHN Program, is committed to assisting children, youth and families with special health needs. FY05 strategies include training in the areas of advocacy, mental health and legislation. In addition the FAC will collaborate with the Young Educators and Advocators of Maine (YEA ME) to discuss similar interests. The intended outcome is to build a stronger link between the CSHN Program, FAC, YEA ME and others. The FAC has expressed a desire for regular updates on the CSHN, as well as, other MCH family programs.

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)*

a. Last Year's Accomplishments

2,087 children were served through outside clinical services and the CSHN Program in FY03. The attached Table illustrates totals by type of service. The data indicates that the Developmental Evaluation Clinics have seen a steady increase in the number of children evaluated for a developmental disability. The increase, we feel, results from individual clinic efforts to advertise their services to a broader audience as well as the clinics ability to provide a wide range of assessments appropriate to the referring agency's request.

The Children with Special Health Needs Program, the Center for Community Inclusion, the Maine Chapter of American Academy of Pediatrics (AAP), and Family Voices convened the Maine Medical Home Advisory Committee in February 2003 to plan the statewide medical home conference. The conference took place October 2003, and was titled "Stepping Stones: Enhancing Quality Care for CSHN, A Workshop on the Medical Homes". We were fortunate to have Dr. Monique Fountain, Director of the Medical Home Initiative, from MCHB attend the conference and deliver the keynote address. 60 individuals that included families, youth, health care professionals, state personnel and others interested in the medical home concept attended the conference.

In an effort to adhere to our strong commitment, youth and families played a central role in planning and participating in all phases of the conference. One component of the Stepping Stones conference was the allocation of time for participants to engage in action planning and strategies. Many strategies were generated, however, the following resonated throughout all topic areas; establish mentoring programs, enhance the capacity of the Maine Chapter of AAP to communicate with it's members, actively involve families and youth in the process, and expand access to community resources. Information gathered during the action planning session was used to frame the planning for the Medical Home Application Maine was preparing to submit to MCHB in January 2004. We were notified in late December that funds would not be available in this priority area. Despite the lack of funding we have continued to work with the Maine Chapter of AAP, and look forward to assisting them in a statewide needs assessment related to the status of medical home components of care, as well as, support them in their effort to disseminate best practice materials and resources. These strategies are now the basis for our Champions in Progress proposal through the Early Intervention Research Institute at Utah State University. Youth leaders from the Young Educators and Advocators of Maine presented, What We want Health Providers to Know, to the Maine School Nurses Association in October 2003 and students in a University of Maine Social Work class in April 2003.

b. Current Activities

The CSHN Family Survey was distributed to 150 families currently enrolled in the Children with Special Health Needs Program. The rate of return for the mailed survey was 60 percent. The survey adapted from the AAP Medical Home Questionnaire, Family Version is designed to elicit a family's perception of the quality of care received in the following seven core areas; accessible, family-centered, comprehensive, coordinated, continuous, compassionate, and culturally competent. Analysis is currently underway. The Bureau of Medical Services, MaineCare (Maine's Medicaid Program) conducted Coordination of Care for Children with Special Health Care Needs telephone survey during May and June of 2003. Telephone interviews were completed with 1,251 parents or guardians receiving MaineCare benefits through Title V, Katie Beckett, Foster Care, Adoption Services or SSI. Results of this survey will be reported in FY04.

c. Plan for the Coming Year

Strategies gathered during the action planning session of the Stepping Stones conference held in October 2003 will guide planning for FY05.

The CSHN Program was a successful recipient of a Champions of Progress grant that will commence in July 2004. With these funds we propose to; A) formalize the Medical Home Advisory Committee to the Bureau of Health, Children with Special Health Needs Program, B) conduct a comprehensive strengths and needs assessment of primary care practices, C) enhance communication between The Maine Chapter of AAP members; and D) prepare recommendations for the implementation of medical homes that is responsive to the needs and strengths of Maine health care providers, children with special health care needs and their families.

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

a. Last Year's Accomplishments

CSHN Program Care Coordinators served 1017 children with special health care needs as of September 2003. 833 children (82%) had a source of insurance for primary and/or specialty medical care, 184 (18%) were provided coverage for specialty services through the CSHN Program. The attached Table summarizes the sources of insurance.

To address the complex issue of adequate insurance coverage the Hood Center for Families and Children in New Hampshire, utilizing funds from MCHB, collaborated with the Children with Special Health Needs Program and the Center for Community Inclusion to implement the "Partners in Chronic Care (PCC) Model: Partnership for Enhanced Managed Care in Maine". This is an innovative model of collaborative, family-centered, integrated, cost efficient care in which families partner with a care coordinator in the primary care setting to define and guide the complex services necessary for their child's optimal care. Maine Works For Youth (MWFY) and CSHN staff organized a meeting with state Medical Directors from the Bureau of Medical Services MaineCare (Medicaid), Department of Behavioral and Developmental Services, Family Voices and the Division of Family Health. The meeting was convened for the purpose of introducing the Partners in Chronic Care model to the various players in Maine. The Maine Chapter of AAP was unable to attend but has been kept informed of all activities and will play an integral role in recommending five to six practices to pilot the PCC concept in Maine.

b. Current Activities

The health insurance curriculum was widely disseminated to school nurses, health coordinators, and superintendents in all Maine middle and high schools. A survey for educators was included in a mailing to school nurses, health coordinators, and superintendents in all Maine middle and high schools. Survey results are pending and will be reported in FY05.

As discussed elsewhere, the majority of activities surrounding this performance measure have centered on establishing pilot sites for the Partners in Chronic Care Model in Maine. We continue to collaborate with the Bureau of Insurance in responding to the needs of CSHN families. In an effort to continually update data files regarding private insurance changes, the CSHN Program routinely works with the Bureau of Medical Services, Third Party Liability Unit.

c. Plan for the Coming Year

Representatives from the Bureau of Medical Services, Title V leadership, Department of Behavioral and Developmental Services, Children's Services, Dr. Ardis Olsen and Elizabeth Pearson from the Hood Center met in July 2003 to discuss the Partners in Chronic Care project and the Hood Center's objective to pilot the project in 5-6 primary care practices in southern Maine. Initially, the proposal to identify those MaineCare (Medicaid) children with special health needs in the primary care setting and coordinate with the practice to reduce overall expenditures was met with encouragement. However, little movement has been made to develop a partnership between the CSHN Program and the Bureau of Medical Services. Significant changes related to the adoption of a new client management system at the Bureau of Medical Services may have temporarily impeded solidifying this partnership. The Partners in Chronic Care Project is scheduled to begin in the summer of 2004 and we anticipate a strengthening of the collaborative relationship as it evolves.

During FY05 the Maine Chapter of AAP will inform its members of the Partners in Chronic Care model to solicit interest from practices in becoming pilot sites. This activity will commence during the summer of 2004. The CSHN and Maine Works for Youth staff have also made contact with Anthem Blue Cross and Blue Shield to discuss their Pediatric Care Program. Anthem's Pediatric Care Program is free to members and works in partnership with families to address the medical and non-medical needs of children with special health needs.

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)

a. Last Year's Accomplishments

The Maine Parent Federation, in collaboration with the CSHN Program, has established seven regional family health information centers. As previously discussed, the CSHN program provides reimbursement for mileage and a stipend to families who attend the parent training. This training is designed to assist parents in becoming familiar with advocating, communication skills, community and state level resources, and being a supportive parent. As of this report, 40 parents have been trained across the state.

Brian Harnish, a Young Educators and Advocators of Maine (YEA ME) member and Project Coordinator for the Maine Works Project, has completed the CSHN website. It is currently being reviewed in preparation for installation in late summer or early fall of 2004.

Over the past year we have worked with Eastern Maine Medical Center (EMMC) to assume responsibility for the Cleft Palate Clinic. The process commenced in early fall 2003 and proceeded more slowly than anticipated. It has taken six months to build EMMCs capacity to become self-sufficient at processing invitations, summarizing clinic information and identifying those children and families who need to return to the clinic for continuation of prescribed treatment plans. With management of the clinics transferred to EMMC the role of the CSHN Program will be one of assuring the effectiveness of the clinic through assessing the accessibility, quality and standards of care that each child and family receive. This will be accomplished by using the American Cleft Palate Craniofacial Association's "Parameters of Evaluation and Treatment of Patients with Cleft Lip/Palate or Other Craniofacial Anomalies."

b. Current Activities

The Maine Parent Federation and the CSHN Program, through Project REACH, continue to support the regional information centers, by providing training to parents. Parents receive information on state and local systems of care, communication and advocacy skills, and community resources. The goal of Project REACH is to establish family-directed community-

based health care information centers across Maine. A state-wide advisory committee and regional advisory committee has been established to advise and support parent to parent activities in Maine.

c. Plan for the Coming Year

The CSHN Program will begin moving toward outsourcing the two remaining clinics, Southern Maine Metabolism Clinic and Southern Maine Cleft Clinic currently being administered from central office.

CSHN will begin discussions with the Maine Parent Federation and others on the sustainability of the Regional Family Health Information Centers across the state.

The CSHN Program, through a Champions of Progress Grant, will continue to collaborate with the Maine Chapter of the American Academy of Pediatrics to design and develop a website for use by local primary care physicians, establish a working medical home advisory committee, and survey primary care practices in Maine regarding knowledge of the medical home concept. As discussed under FPM # 2, families have commented on the lack of knowledge of community-based resources by their primary care practices. A survey of the primary care practices is relevant to either support or add a new dimension to address this need.

During FY05 CSHN will collaborate with the Environmental Public Health Tracking Program to develop a surveillance system using the current Developmental Evaluation Clinic Model. Phase I will involve physician and staff interviews to determine current data, method of collection, and data use. Phase II will involve defining common measures, indicators and data collection protocols.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

The CSHN Program, in collaboration with the Center for Community Inclusion (CCI) and the Young Educators and Advocators of Maine (YEA ME) has become a national leader in addressing youth in transition. According to SLAITS Maine holds the distinction of being the only state in the nation able to report on this indicator.

During FY03 YEA ME met 6 times, developed by-laws that firmly establish YEA ME as an advisor to the CSHN Program, and elected, from among its membership, Brian Harnish as co-chair. Members also elected Toni Wall as the adult co-chair of the group. Youth also played a central role in planning and took part in all phases of the "Stepping Stones Medical Home Conference". Elijah Steward reviewed the annual MCH Block Grant Application and attended the review in Boston, in August of 2003.

YEA ME members continue to present YOUTHSPEAK to various groups across Maine including health care providers, parents, teachers, and peers. The Maine Works for Youth Project (MWFY) released the Second Edition of YOUTHSPEAK 2003 which includes the new presentation "What We Want our Peers to Know". MWFY continues to maintain the on-line Service Tapestry providing links to private and public agencies that can assist youth and families during the transition process. <http://www:ume.maine.edu/cci/servicetapestry/index.html>

The YEA ME have also presented at national meetings. Zach Pulsifer presented at the CSHN Leadership Institute in Baltimore June 2003; Mallory and Ann Cyr at the KenCrest "Children

Who Are Medically Fragile or Technology Dependent Conference: Building Relationships and Respecting Diversity" March 2003; Jesse Bell, Marie Noyes, Brian Harnish, and Laura Son at TASH Boston December 2002. Three of our YEA ME members have continued on to college but remain active in their role as advisors. They also work to engage others in their commitment to involve youth in creating a community that is responsive to their needs.

The MWFY Project collaborated with the two federally funded benefits counseling programs at Alpha One and Maine Medical Center. These programs provide necessary information regarding SSI or SSDI benefits to individuals with disabilities allowing them to continue work and maintain access to health insurance.

b. Current Activities

In an effort to capture true youth participation in the CSHN Program we redesigned MCHB Form 13, Family Participation in the CSHN Program, to address youth participation. The CSHN Program asked the YEA ME members to complete the form "Six Characteristics of Documenting Youth Participation in the CSHN Program". The program received a 12 with high marks on youth involvement, however, still needs to work toward ensuring a broad population of youth with special health needs.

During the spring 2004, YEA ME members attended the Special Family Weekend in Castine to encourage the involvement of youth from our most rural counties in Maine. Brian Harnish, a YEA ME member and Special Projects Coordinator for MWFY, has completed web sites for both the CSHN Program and YEA ME. The YEA ME website is currently available through the Maine Works website at: www.ume.maine.edu/cci/service/maineworks. We are currently in the process of reviewing the proposed CSHN website before activation. The YEA ME continues to provide general oversight to the MWFY project and plays a prominent role in developing materials that are youth friendly. YEA ME members continue to deliver YOUTHSPEAK presentations in Maine and nationally.

The database and case management system that will allow CSHN Care Coordinators to appropriately plan for and assist families and youth in all aspects of transition from birth to graduation from the program is nearing completion (anticipated for late fall 2004). As previously stated, this will allow the CSHN Program to meet the needs of youth in transition and their families.

c. Plan for the Coming Year

Youth involvement in all aspects of the CSHN and MCH Programs will continue with Elijah Steward, a YEA ME member, reviewing the current MCHB Grant.

As we begin implementing the Partners in Chronic Care with the Hood Center at Dartmouth Medical School in New Hampshire, youth will play an active role on the Medical Home Advisory Committee. Youth will continue to participate in all project activities, review materials for distribution to youth, families and health care professionals, and present YOUTHSPEAK. CSHN continues to serve on a number of committees and initiatives that address transition requirements of youth with special health care needs and disabilities in our state. CSHN encourages active participation of youth and families on many of these committees.

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.

a. Last Year's Accomplishments

Maine's childhood immunization data is 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.

In 2002 Maine achieved 72.8% for the 4:3:1:3:3 immunization series. This continues a trend of gradual decreases since 1998. No one issue appears responsible for the decreased level of immunizations rather a series of issues appear to be present. A difference in reporting requirements between NIS/CDC and CASA is one issue that emerges. Maine's CASA data shows a substantially higher rate of immunization than that of NIS. Other apparent contributing factors include: focus on the development of the Impact Immunization Registry (1999-2003) and less focus on provider education; centralization of the immunization staff to state staff rather than the previous contracts for county level staff (the transition left some communities without local contracts); Maine uses a 3-dose HIB series and NIS may be using the 4-dose series as the base for their survey; and lastly, there was a loss of staff responsible for provider education during FY04 resulting in minimal provider education sessions conducted.

The Maine Immunization Program (MIP) anticipates all provider education staff vacancies will be filled by September 2004. The Immunization Program contracts with PHN to conduct the CASA surveys and to provide education to providers during the feedback section of the review. The MIP also contracts with PHN to conduct needed follow-ups related to EPSDT services.

b. Current Activities

Public Health Nursing continues to conduct the immunization survey (WINCASA and VFC surveys) for the Bureau of Health, Division of Disease Control's Immunization Program. PHN anticipates completing 170 surveys. The survey provides an opportunity to educate providers of current best practices, as well as, focus attention on methods to strengthen quality improvement practices.

c. Plan for the Coming Year

Public Health Nursing will continue to conduct the CASA survey in FY05.

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

a. Last Year's Accomplishments

Community outreach education through the Family Planning Association of Maine continued in 2003 with increased focus on building relationships with other community organizations and business. The program worked with 215 community organizations, 201 businesses, and 26 community coalitions, reaching over 7,866 adults and 9,299 teens. An evaluation completed in this year showed that youth appreciated opportunities to ask questions in comfortable and safe learning environments and their knowledge increased. Community organization staff felt that the program was meeting a critical need for their clients and outreach education strengthened the capacity of the community organizations to serve their clients. 29 family planning clinics served 31,452 clients including 10,195 teens. Evaluation efforts in FY03 showed a high degree of continued use of contraceptives in returning clients and a lower than desired use of condoms.

In FY03 Family Life Education Consultants provided consultation for 80 non-priority schools and 1,094 educators. 755 other adults and 7,064 children and teens were also served. 40 priority schools received in-depth technical assistance. A new evaluation system was instituted in FY03 year and demonstrates that the priority schools moved forward in the curriculum

adoption process an average of 6 steps in a 15-step process developed by Maine's Department of Education. This process moves school districts from forming an inclusive committee, through research, resource gathering, curriculum development to teacher training, implementation and assessment.

The Maine Youth Action Network (MYAN), a program of the People's Regional Opportunity Program and the University of Southern Maine, Muskie School of Public Service continues to grow. In FY03 a new contract between the Partnership for a Tobacco-free Maine, Maine Cardiovascular Health Program, Maine Youth Suicide Prevention Program and Teen and Young Adult Health Program leveraged funding to increase resources contributed to this project. The additional funding has increased youth participation in the project through staff positions and youth facilitators. Technical assistance is provided to Youth Advocacy Groups of the Healthy Maine Partnerships, as well as traditional peer leader groups the network has included. Other youth leadership groups have been invited to participate in Network activities and both the Youth Leadership Action Team, a group of youth in care, and the CSHN youth council, Young Educators and Advocators of Maine, has presented and participated in MYAN events. 15 regional meetings were held where youth and advisors gained new knowledge and skills and participated in action planning for their local programs. The annual conference had 441 youth and advisors participating in a broad array of learning opportunities, including 66 adult and 67 youth from peer programs presenting.

b. Current Activities

The contract with the Family Planning Association of Maine continues. Goals for the grant are being refined to meet upcoming changes in Title X requirements, as well as to streamline reporting for grantees having multiple grants with the Bureau of Health for women's health services. This process also includes the Maine Breast and Cervical Health Program and the HIV/STD Program. The program also continued to evaluate efforts in increasing the use of condoms (a Healthy Maine 2010 objective) and continuing contraceptive use among existing clients.

In FY03, consultation and technical assistance based on the teen pregnancy rates and readiness of the school to address Family Life Education as part of a comprehensive school health education curriculum continued to 40 priority schools, and progress in curriculum development and implementation was tracked. 20 SBHCs are currently supported through Bureau of Health funds. A planning grant was awarded to one SBHC in 2003 to work with the community on exploring expansion of services.

FY02 was a planning year for other pregnancy prevention projects. According to the 2001 YRBS 24.6% of Maine's High School sexually active students used alcohol and drugs prior to last intercourse. The established connection between alcohol use and sexual activity led to discussions with Maine's Office of Substance Abuse, a relationship that is continuing while we search for funding for a joint project. An RFP was issued and an award made to develop a new media campaign directed at parents of adolescents, and encouraging conversations about sexuality and abstinence. Funding is available through Section 510 Abstinence Education funds. Budget constraints prevented other primary prevention activities. An interdepartmental workgroup is exploring funding opportunities to address multiple adolescent health risk behaviors.

The Maine Youth Action Network offered a fall conference in 2003, and regional meetings were expanded to five regions in the state, reducing travel time for youth groups. Continuing feedback from the programs involved in the network is used to refine services offered by the Maine Youth Action Network staff. In addition to topical training on various issues, training on youth-adult partnerships and on advocacy has been offered. Three statewide projects to include youth in planning and policy change have been initiated; including the issues of

tobacco, suicide prevention and bullying.

c. Plan for the Coming Year

The Bureau of Health continues to maintain the programs described under current activities. Due to budget restraints, many service numbers are not anticipated to increase, and may decrease slightly in some areas.

The Bureau of Health will continue to support 20 SBHCs in the form of grants and technical support.

In FY05, The TYAH Program will work closely with its contractor, Ethos Marketing, to develop and launch the new Abstinence Education media campaign that will focus on parental communication with adolescents.

The Family Life Education Consultants are using a newly piloted evaluation rubric to document the progress schools are making in curricula development. This rubric is based on the 15-step process that the Department of Education has developed for the development, implementation and assessment of Comprehensive School Health Education. Support to the current 32 identified priority schools will continue in FY05. This continuation and the specific activities undertaken with each school will be determined by the evaluation rubric now in use.

The Maine Youth Action Network, developed by the People's Regional Opportunity Program, will continue to offer training and technical assistance to youth leadership programs throughout the state. A November 2004 conference is being planned, as well as, 2 regional trainings in eight regions of the state. A website, biannual newsletter, and monthly email to participating programs will be used to disseminate information, gather input, and involve youth in program planning. Youth continue to be involved in statewide projects focused on tobacco use prevention, youth suicide prevention and bullying prevention.

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

a. Last Year's Accomplishments

Since the 1999 Smile Survey was conducted, the OHP continued to support and expand the voluntary dental sealant component of its School Oral Health Program which supports school-based classroom education and fluoride mouthrinse programs. For the school year ending June 2003, there were sealant components at 109 individual schools, providing 3,936 sealants to 1,221 children (an average of 3.2 sealants per child). Again, the retention rate was close to 91 %.

The attached table illustrates the overall impact the sealant component has had in providing sealants to children in need who otherwise would not have access to this preventive oral health service. Data may differ slightly from previous reports due to consolidation of reports and finalization of program data.

In August 2002, the CDC awarded a one-year cost extension to the Oral Health Program's grant, Oral Disease Prevention in School-Aged Children Using School-based or School-linked Oral Health Programs. Funding continued to support the activities of the Maine School Oral Health Initiative (MSOHI), a cooperative effort of the Maine Department of Education and the Oral Health Program, activities meant to facilitate Maine's ability to strengthen, improve and evaluate school oral health programs, better integrate them into comprehensive school health education programming and improve access to oral health education, promotion and treatment

services for at-risk school-aged children. This supplementary funding supported further analysis and implementation of the findings of the School Oral Health Program evaluation conducted during the 2001-2002 academic year. As a result of the evaluation, revised SOHP Eligibility Guidelines were developed and incorporated into the application process for schools for the 5-year grant cycle beginning July 1, 2003. In addition, under the extension, an area of focus was developing a sustainability plan by establishing guidelines and procedures needed to identify alternative billing procedures for reimbursement of preventive dental services provided through the School Oral Health Program.

Grants, using the state match to the MCHB Grant, continue to be made to three community agencies that provide clinical dental services to at-risk children for purposes of general support. Data indicate that a minimum of 1,689 children received sealants through these clinics, although the specific number of third graders among that total is not available. This general support assisted those clinics in providing roughly 19,500 dental visits to approximately 14,600 individuals, the great majority of whom were under age 21, during the reporting year.

b. Current Activities

As an integral part of the Maine Child Health Survey, the 2004 Smile Survey is underway; planning to coordinate with the Maine Asthma Prevention and Control Program was initiated in June 2003.

c. Plan for the Coming Year

The School Oral Health Program will continue to include sealant components in participating schools. There are 119 schools with sealant components in the 2003-2004 school year. The OHP will continue to encourage inclusion of sealant components in the school-based program, and the number of schools is expected to continue to grow pending the availability of funding.

Our experience as a MaineCare provider will be monitored.

The surveillance plan for the Oral Health Program has been developed and identifies various objectives, populations, data sources, data collection timeframes and other parameters; program efforts include strategies to capture the data as outlined in the document, "Oral Health Surveillance" (Copy included in Appendix). An application for three years of funding will be submitted to Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) State Oral Health Collaborative Systems Grant Program and will describe the development of a state Oral Health Advisory Committee, including developing a state oral health plan for Maine, and the implementation and evaluation of the oral health data and surveillance system, the continued inclusion of an oral health component in the Maine Bureau of Health's Child Health Survey, and the role of a broad-based stakeholder group, based on the existing Maine Dental Access Coalition. All of these activities will support both increasing the proportion of Maine third-graders who have received sealants, and our ability to track the data and evaluate the program.

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

a. Last Year's Accomplishments

The Child Safety Seat Loan Program sites remained at 41 throughout the reporting period. With enactment of the new Booster Seat Law, (requiring children between the ages of 4 and 8 and under 80 pounds to be secured in a federally approved child restraint system and children under the age of 12 and under 100 pounds must ride in the back seat of a vehicle), in January

2003 the program saw an increase in the demand for seats. Through a grant from the Bureau of Highway Safety the amount of money available for the purchase of child safety seats increased from \$20,000/year to \$163,000. The program distributed 1,631 infant/toddler seats, 1,590 high back booster seats and 703 no back booster/convertible seats. In addition, the program provided a total of 289 special need seats.

The traffic Safety Educator position filled in January 2002 vacated in October 2002 resulting in some program plans for child passenger safety during the reporting period not being accomplished. The position remained vacant for the remainder of the reporting period due to state budget challenges. The delay in hiring for this position created a staffing shortage that resulted in cancellation of the annual Child Safety Seat Site Manager Workshops.

Despite challenges brought about by the vacancy, MIPP contracted with Medical Care Development to provide two National Highway Traffic Safety Administration (NHTSA) 4-day Child Passenger Safety Technician courses, one in Brunswick September, 2002 the other in Bangor April, 2003. Thirty-four new technicians were trained. The program also offered 2 one-day refresher courses for technicians requiring re-certification. Seventy-two technicians participated in the training.

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

b. Current Activities

More than 36,000 pieces of injury prevention promotional materials related to traffic safety were distributed to organizations throughout the state. With the passage of Maine's Booster Seat Law and with the assistance of WIC and the Bureau of Highway Safety, over 115,000 Law Cards were mailed to school children statewide, in Grades K-6, advising of the new law that went into effect January 1, 2003. Funding for the mailing was made available through a grant from State Farm Insurance Company. Wide distribution of the law cards resulted in increased requests for program promotional materials. In addition, the program provided 434 master copies of printed information. Master copies are provided in lieu of sending large quantities of printed materials. The recipient is able to copy the master as needed. This results in a significant undercounting of the numbers being distributed.

In collaboration with State Farm Insurance, the Bureau of Highway Safety and the Women Infant and Children (WIC) Program over 415,000 law cards were printed for distribution to schools in Maine advising of the new child safety seat law (described elsewhere in this report) that became effective January 1, 2003.

The Traffic Safety Educator vacancy prevented many activities from being carried out during FY03. The position was filled in November 2003.

c. Plan for the Coming Year

MIPP will continue the following activities during FY05.

1. Provide child safety seats and technical assistance to 41 safety seat programs statewide. Provide at least 1500 infant/toddler seats, 2,000 booster seats and 350 special needs seats.
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 at least 41 loan program staff in at various locations around the state.
4. Provide at least one daylong Child Passenger Safety (CPS) Technician re-certification class for certified CPS Technicians.
5. Provide training and technical assistance to Bucklebear Project sites on child passenger

safety issues.

6. Provide child passenger safety technician training based on the National Highway Traffic Safety Administration, child passenger safety standardized curriculum.
7. Continue to provide educational materials and resources on child passenger safety to professionals, advocates and the general public.
8. Continue to promote the Injury Prevention Program's new website and the access to various injury prevention links.
9. Maintain a list of Child Passenger Safety Technicians available to assist parents and caregivers on the proper use of child restraint systems in communities throughout Maine.
10. MIPP will continue to collaborate and coordinate activities with the Maine Transportation Safety Coalition (MTSC) in promoting child passenger, bicycle, and pedestrian safety issues.
11. The program will develop and maintain a Web site for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to other Maine and national injury prevention resources.
12. MIPP will continue to collaborate and coordinate on occupant protection safety issues with the Maine Transportation Safety Coalition as well as other committees, and state agencies involved in protecting the safety of Maine's young drivers.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Our most accurate data source for breastfeeding rates at hospital discharge continues to come from the newborn screening filter paper forms. Information collected at the time of newborn screening, near or at the time of hospital discharge during CY 2003 show the following data on method of feeding. Of the 13,356 infants who received a newborn screen, 8,072 were exclusively breastfed (60.4%), 4,722 were formula fed (35.3%). Only two infants were reported to receive both breast milk and formula and 3.4% of infants had no feeding method documented.

Review of the revised newborn screening filter paper forms during 2003 regarding feeding methods reveals clearer information with respect to indicating 'breast milk' or 'formula' feeding.

b. Current Activities

The WIC, Public and Community Health Nursing Programs continue to increase and strengthen the resources available to support new mothers in breastfeeding their babies. Public Health Nursing (PHN) staff in Kennebec and Somerset County attend WIC infant feeding class when available. In addition, WIC discusses breastfeeding at each prenatal visit. PHN works with standardized nursing interventions addressing breastfeeding in prenatal and postpartum client individualized plan of care. The interventions include health teaching, guidance and counseling, surveillance and case management. PHN breastfeeding resource nurses are active in their local breastfeeding coalitions, involved in community fairs, are a resource for reference materials on breastfeeding, collaborate with WIC on developing a brochure, and provide breastfeeding education at local Baby Basic Classes.

c. Plan for the Coming Year

The Genetics Program will continue to promote complete and accurate information on the filter paper forms.

The WIC Program will continue sponsoring opportunities to increase the number of Certified Lactation Counselors. The WIC, Public and Community Health Nursing Programs will continue

to provide education and support specific to breastfeeding for prenatal and postpartum women and their families.

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

a. Last Year's Accomplishments

Interest among birth hospitals and providers in providing newborn hearing screening prior to discharge is increasing. During CY02, Twenty-eight of the 32 birth hospitals were providing hearing screening services. 97.5% of newborns had access to hearing screening prior to discharge from the hospital.

Rules requiring hospitals to report the number of newborns screened and the status of the screen were promulgated and became effective January 1 2004. In the future, Maine will be able to report on actual newborns screened. Materials have been developed and distributed for parents and professionals, including information on follow-up when the screening results are 'refer' pattern, and a flip chart of resources for parents when a diagnosis of hearing loss is confirmed.

b. Current Activities

By June 2003, 100% of hospitals had newborn hearing screening equipment and were screening infants. Audiologists consult with birth hospitals regarding screening results and quality assurance issues.

Currently, birth hospitals do not receive outcome information for infants that did not pass the initial screening. As hospitals and providers begin reporting screening results to the program, and the database is fully implemented, screening and follow-up data will be integrated and outcomes can be measured.

The Newborn Hearing Advisory Board, established through statute, provides oversight and advice to the program. Membership composition includes representation from parents, advocates, deaf and impaired hearing individuals, health care providers and educators, hospitals, public health policy makers and insurers. The membership assures input from all stakeholders. The Board assists in the development of program guidelines, rules, educational materials, resources and referral system. Two members of the Newborn Hearing Advisory Board attended the National Early Hearing Detection & Intervention (EHDI) meeting in Washington, DC in February 2004.

c. Plan for the Coming Year

During FY05 the Newborn Hearing Advisory Board will develop a Parent Information Notebook for families of a child identified with a hearing loss. This concept is modeled after the CSHN Care Notebook and PKU Resource Notebook and provides a more comprehensive overview of information for families than a brochure. As program implementation continues, confirmation of hearing loss and enrollment into early intervention programs will be critical to the success of the program. At present, audiologists appear supportive and agreeable to voluntary reporting. The Board will consider supplementary legislation, if required, to mandate audiology reporting on results of confirmatory testing of infants.

ChildLink, a database tracking system created by the University of Maine, links data from each of the Genetic Program initiatives (Newborn Screening, Newborn Hearing Screening and Birth

Defects Surveillance), as well as, with Vital Records information to assist with tracking and evaluation. The ChildLINK database system will provide the platform for our data management, tracking and evaluation. ChildLINK will be initiated throughout the state in FY05. Implementation is complete in the two largest hospitals, Maine Medical Center and Eastern Maine Medical Center. Other birthing hospitals will be added in a progressive manner.

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

a. Last Year's Accomplishments

In FY03, over 8000 students received services at SBHCs in Maine. Our database revealed that 1800 of these students were uninsured. The centers provided MaineCare enrollment information to these students. In addition, over 2700 preventive care visit occurred in FY03.

The final evaluation of Well Child Clinics completed in the summer of 2002 concluded through their findings to discontinue the Well Child Clinics. The remaining well child clinics held during FY03 were funded by the MCH Program. Of the 22 clinics held, 142 clients were served. Funding of these clinics will not continue in FY04.

b. Current Activities

Linkages with medical homes and insurance continued in SBHCs in FY03. In 2001, a collaborative project with the major health plans in Maine was initiated to measure cost-effectiveness of private insurers covering SBHC services. As part of the insurance pilot project, protocols were developed to strengthen the relationships between primary care providers and SBHCs. In FY03 fifteen SBHCs, participating in the pilot project, were credentialed by the major private insurers and contracts were developed. One insurer began reimbursement ahead of schedule in January of 2004. Funding from the Maine Healthcare Access Foundation is supporting the evaluation of this project for the first two years. In FY03, an RFP for additional SBHC grants was issued, and five additional centers were funded, including two new SBHCs. The Bureau of Health is also actively working with the Bureau of Medical Services to improve the reimbursement processes for MaineCare, and exploring sustainability factors in SBHCs to better inform our policies.

Maine continues to be economically impacted, particularly in the manufacturing sector, with the announced closure in late 2003 of two shoe company's located in the central and southern part of the state and early 2004 of 2 paper manufactures in Brewer and Lincoln. These closures represented the loss of 1270 jobs creating an additional burden on state revenue and further challenging the ability of families to maintain insurance coverage. The mills were purchased in late May, however, only the Lincoln plant will be reopened. Early estimates indicate approximately 360 employees will be back to work when the mill is fully operational in late July or August 2004. The Brewer mill will not be reopened.

On May 5, 2003, the Governor announced a 15- point plan, Dirigo Health, to increase access to health care. The plan included establishment of comprehensive, affordable health coverage offered through private insurers to part and full-time employees who work in small businesses and are self-employed as well as to individuals without health insurance. Parents with income up to 200% of the Federal Poverty Level (FPL) and childless adults with income up to 125% FPL would receive MaineCare benefits. Employees not eligible for MaineCare could purchase insurance on a sliding scale based on ability to pay if their income is below 300% FPL. In addition, employees in self-insured businesses would be eligible to have a portion of their premium subsidized. The uninsured with incomes over 300% of poverty could purchase their coverage at cost. Funding sources include employer, employee, state and federal, which would be pooled to lower health care costs. Maine's new health-care program scheduled to start in

September 2004 is designed to fill the gap in coverage for an estimated 160,000 uninsured Mainers. Approximately 30,000 will be covered at the plans inception with the balance to be phased in over the next 5 years.

c. Plan for the Coming Year

The Bureau of Health, through a small contract and the provision of technical assistance, will continue to work with SBHCs, the Maine Children's Alliance, and private insurers to support the Insurance Pilot Study for school-based health centers. The Bureau of Health is an active partner in a Kellogg Foundation proposal to increase SBHC sustainability through community involvement and mobilization. Base-funding for 20 SBHCs is helping to maintain access to services as the SBHCs and sponsoring agencies face more stringent budgets.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

During 2003 Public Health Nursing (PHN) increased collaboration with the EPSDT Program by assisting children needing services following a well childcare visit to a primary care provider. PHN worked cooperatively with the Maine Immunization Program and the Bureau of Medical Services to provide interventions to parents and guardians of children receiving MaineCare benefits. These children were identified as needing additional services or family support in the areas of assistance with referrals for specialty medical care, screenings, developmental services, mental health services, parenting issues, lead screening follow-up, and transportation. During interactions with families public health nurses frequently addressed many other health issues not previously identified. Parents, guardians, and the public health nurses involved in this project reported a greater ability to schedule appointments for children to receive the necessary follow-up care. PHN completed 5,582 EPSDT follow-ups in CY2003 accounting for 2,680 hours of nursing staff time.

b. Current Activities

In an effort to increase the number of children with insurance coverage, Maine's SCHIP goals are:

1. Collaborate with the Covering Kids and Families Outreach Campaign to provide technical training to staff of community agencies and health care providers, improve quality of technical training provided to staff of community-based agencies, and increase MaineCare participation.
2. Improve relevant, desired drug outcomes for designated medical conditions as measured by the percentage of patients on designated drugs, rate of ED/hospital visits, LOS, readmission rates for patients with designated diagnoses.
3. Increase involvement of members and providers in Health Promotion as measured by the number of providers attending technical training provided by Covering Kids and Families Campaign, EPSDT mailings, and follow-up to all members and quarterly educational newsletters to members and Primary Provider Profile to providers.
4. Provide Quality Care to Members as measured by the increase in member satisfaction and reduction in rate of potentially avoidable hospitalizations.

c. Plan for the Coming Year

Use of the home visiting database, created for the evaluation of the Healthy Families, Parents as Teachers, Parents as Teachers Too, Adolescent Pregnancy and Parenting Programs,

started in the first quarter of FY04. Data analysis will be completed and available early fall 2004.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Maine continues to have a lower percentage of VLBW babies than the nation as a whole.

b. Current Activities

A recent reduction in neonatal Nurse Practitioners coupled with the call to active duty of the Perinatologist has created a void at the Level III nursery in Bangor. The Portland Level III nursery is assisting in support while the Bangor hospital takes steps to rebuild capacity. In addition, the Lewiston hospital has notified area hospitals that, with the departure of a neonatologist, it can no longer care for infants at less than 32 weeks gestation.

During the past 3 years the Title V Program has focused on building its capacity in relation to MCH Epidemiology. The development of our Epidemiology team enables Title V to obtain a greater understanding of the factors contributing to achievement or lack of achievement related to national and state performance measures. Areas worthy of further analysis include anecdotal reports of increased maternal drug use, a gradual diversification of Maine's racial and ethnic population through migration and resettlement of refugee populations, and the impact of assisted reproductive technology.

The Title V Program has been unable to conduct an in-depth analysis of factors contributing to VLBW due to the planned departure of the Ph.D. Maternal Child Health Epidemiologist.

c. Plan for the Coming Year

Recent reports from substance abuse and perinatal centers suggest that an increasing number of pregnant women in Maine are using opiates and other illegal drugs. Also, an ongoing concern about maternal alcohol consumption persists. These reports challenge the public health, health care, substance abuse, mental health, educational, public safety, and other systems to come together in a systems-oriented way to analyze this problem in depth and to discuss collaborative strategies to address it, using a family-centered and culturally competent approach that views this as a major public health issue.

With this in mind, the Maine MCH Program, in partnership with the Office of Substance Abuse at Behavioral and Developmental Services (BDS) and the Perinatal Nurse Manager at Maine Medical Center, formed a diverse work group to address these issues. The group initially met in October 2003, and then met again in April 2004. Health and substance abuse providers from several agencies were present, and we also were fortunate to have representation from families affected by this issue. All shared their concern and unique experience and wisdom regarding the issue of substance abuse during pregnancy. To better determine the magnitude and extent of the problem, we explored potential sources of data including information from hospital discharge data.

To guide our work in perinatal substance abuse, we agreed on the following principles: 1) A wide array of people and organizations in Maine should become informed of the problems of alcohol and other drug use by pregnant women and assume responsibility for addressing it. 2) A healing, non-punitive services and systems approach should engage women and their families in a way that is most likely to keep them involved in prevention and treatment. 3) Pregnant women who use alcohol, opiates, and other drugs should be identified as early as

possible, preferably before they become pregnant. 4) Services and systems should meet the unique needs and strengths of women, be culturally competent, look at the whole family context, and reduce stigma associated with seeking treatment. 5) The outcomes of our work should be carefully measured.

The Perinatal Outreach staff serve on various statewide committees and workgroups related to reducing morbidity and mortality. During FY05 Staff will remain active on the March of Dimes Prematurity Campaign, Program Services Committee and the Folic Acid Council. Staff will also work with the Bureau of Health and Office of Substance Abuse co-sponsored Workgroup addressing perinatal substance abuse and neonatal drug withdrawal. Educational programs will continue to be offered statewide and will include prevention of prematurity, resuscitation, stabilization and management of premature or sick infants. Many programs are skills based, teaching or reviewing essential skills needed to promote safe and high quality maternity and newborn care.

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

a. Last Year's Accomplishments

Suicide continues to be the second leading cause of death for Maine youth aged 15-19 years old. The 5-year moving average for the period 1998-2002 was 10.4/100,000. The national rate for the year 2001 was 7.9/100,000. 5 of 10 youth suicides during this period were completed with a firearm and 4 of 10 by hanging representing a shift in method away from firearms. There were 888 hospitalizations between 00-02 for self-injurious behavior of 10-24 year olds in Maine, a 12% increase from 98-00. Of all self-injury hospitalizations, youth ages 15-19 were most likely to be hospitalized with a greater incidence of females than males. 10-24 year old females were twice as likely as males to be reported in calls to the Northern New England Poison Center for self-injury with the number of female self-poisonings increasing by 19.8 % in the period 2000-2002.

The majority of the 1,500 MYSPP School Guidelines for Suicide Prevention, Intervention and Postvention were disseminated to Maine school personnel. 1,770 were downloaded from the MYSPP website in 2003. Copies were also distributed through suicide prevention awareness and gatekeeper sessions for use as a model in policy and procedure development. Participants included school personnel, community-based educators, child-care providers and community agency leaders.

The MYSPP produced video, "A Life Saved", detailing the successful intervention led by three eighth grade boys following their participation in the Lifelines class was debuted at the programs annual suicide prevention event in May 2003. Use of the video was incorporated within the Lifelines student curriculum and during suicide prevention awareness sessions. An out-of-state video production company, impressed by the video, exchanged copies of their youth suicide prevention video for copies of "A Life Saved". Both videos are being distributed to training participants in the Lifelines curriculum.

School/Community Based Youth Suicide Prevention Intervention was a major program focus during FY03. 12 Maine High Schools were selected to carry out the comprehensive youth suicide prevention program. All project schools worked on establishing their school protocols for addressing suicide prevention, intervention, and postvention issues and developed agreements with local mental health crisis service providers. All High Schools organized a Gatekeeper Training session for local school and community leaders for late summer and early fall 2003. 69 gatekeepers were trained in one of six Training of Trainers sessions to deliver suicide prevention awareness education programs. They, in turn, presented awareness

education sessions to all staff in project schools.

The Lifelines student curriculum was significantly revised to increase connections to the Maine Learning Results. Three groups of youth-produced warning sign cards and role-plays were developed to clarify curriculum components and enhance teaching of the curriculum with fidelity.

b. Current Activities

Resource materials distributed during FY03 included 7,000 printed information booklets, 800 program brochures, 65 copies of the video "A Life Saved", over 100 copies of the video "Kids and Guns: Making the Right Choice", numerous teen produced posters, book covers, Teen Yellow Pages, and several copies of the MYSPP Plan. A one-page fact sheet "Removing Access to Lethal Means" was revised and is being distributed to law enforcement upon request and at presentations and health and safety activities.

Over 1,000 individuals participated in the one and two-hour youth suicide prevention awareness education sessions in CY03. A total of 4,754 individuals participated in awareness education since the program's inception in 1998. These trainings have resulted in a much greater awareness of suicide in schools, the medical community, and childcare agencies statewide. In addition, suicide prevention information is being requested via the website and through the MIP Program.

Six of 12 project schools attended the June 2003 Reconnecting Youth Training Institute. A second session was planned for November 2003 for five additional schools. The program teaches at-risk students skills to build resiliency with respect to risk factors and to moderate the early signs of substance abuse.

Funding from the Centers for Disease Control allowed MIPP to work with an Epidemiologist to analyze data and improve ongoing monitoring of suicidal behavior among Maine youth. The Epidemiologist is working with the MIPP Health Planner analyzing hospital discharge data. They are also working with the EMS database to improve program capacity to follow incidence of suicide attempts over time. Since there are far more attempts than deaths this information will be very useful in planning future suicide prevention activities.

c. Plan for the Coming Year

Implementation of the comprehensive youth suicide prevention program in 12 schools began in earnest in spring 2003. The program is funded through the CDC School/Community Based Youth Suicide Prevention Intervention Grant.

Continue to provide 1-2 hour Suicide Prevention Awareness Education Sessions to schools, agencies and community members statewide.

Continue to provide twenty 1-day Gatekeeper Training Sessions to schools and communities statewide.

Continue to provide printed and electronic informational materials statewide on request.

Continue to promote the 24-hour crisis hotline to callers statewide through distribution of materials, the program website and all education and training sessions.

Continue to provide suicide prevention training to crisis clinicians statewide.

Continue to provide Reconnecting Youth Training Sessions and technical assistance to high

school instructors who enroll in this training institute.

Continue to monitor suicide and self inflicted injuries among Maine youth statewide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

The Perinatal Outreach Program provided education and consultation to providers statewide. Capacity to provide education increased significantly during FY03 with the addition of a second nurse educator. 125 programs were presented and reached 1,144 health care professionals. Attendees were predominantly Registered Nurses, although many advanced practice nurses, nurse practitioners, physicians assistants, nurse midwives and home birth midwives as well as physicians also benefited from these educational offerings. The topics of greatest interest related to reducing infant mortality and morbidity and reducing neonatal/childhood illness.

The Maine Birth Defects Program (BDP) implemented reporting of selected birth defects in May 2003. The BDP worked closely with the CSHN Program to assure access to services. All infants with conditions served by CSHN were referred and enrolled.

b. Current Activities

Required reporting to the Birth Defects Program (BDP) began in May 2003. Provider groups have been reporting and abstraction and review of medical records is getting underway. Input from physicians and specialists will be used to plan future expansion of conditions of interest or concern to be included in the reporting requirements and other program improvements. 100 cases of birth defects have been reported from birth hospitals, neonatal intensive care units, through medical record ICD-9 listings and CSHN referrals. These include 4 infants with more than one reportable birth defect. Although no detailed analysis has been conducted, a few types of birth defects appear to have occurred more frequently during the first 13 months of reporting. These include gastroschisis, omphalocele, and cleft lip and palate.

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. Recent staffing changes at the Level II nursery in Lewiston has resulted in Central Maine Medical Center no longer being able to care for infants at less than 32 weeks gestation. This change will mean an additional impact on the Level III nursery in Portland. In addition, the Level III nursery in Bangor serving the state's northern population has been significantly impacted with the loss of several neonatal Nurse Practitioners, as well as, their perinatologist who has been called to active duty.

c. Plan for the Coming Year

Efforts are underway to put into practice a review process that covers maternal, infant, and child deaths. In April 2004, the MCH Medical Director, in partnership with the Injury Prevention Program, submitted a grant proposal to the CDC that will expand and enhance child death review in Maine. In June 2004, we (Title V) submitted to the Maine Chapter of the March of Dimes a Letter of Intent for a one-year grant to start up a state maternal, fetal, and infant mortality program.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care*

beginning in the first trimester.

a. Last Year's Accomplishments

During 2002 the Public Health Nursing (PHN) program implemented the Carefacts System, a clinical documentation and information management system. All staff were oriented and tested competent with use of the system by January 2003. All PHN field staff document services into this system.

15,415 home visits were provided by PHN to individual clients during CY03. Home visits by case type are illustrated in the attached table and chart. 62% of PHN service time in CY03 was to the MCH population. Increased proficiency by staff on the use of the Carefacts System enabled PHN's to increase home visits by 2811 over the prior year.

During SFY03 the contracts for Community Health Nursing services were opened to competitive bid. Services included CHN services to women, infants, and children with identified health needs and CSHN. The program is intended to positively impact infant mortality, the incidence of LBW and the health status of children by providing home-based nursing services to attend to pre and postnatal needs of women and to assure a seamless system of quality preventive care for these children. During FY03 WCPHS contracted with 3 community health nursing agencies to provide services in portions of central and southern Maine. No services were purchased in northern Maine due to declining population and needs. During FY03 Community health agencies made 1018 prenatal visits to 229 women, 3677 postpartum/parenting visits to 1276 mothers, 7566 visits to 2645 infants and children, 726 visits to 111 CSHN, and 51 visits to children for lead poisoning.

A standard language for nursing practice is required to meet the needs of the profession, the clients, and nursing, to describe and evaluate its impact on patient outcomes, and to generate reliable, useful and valid data. PHN has adopted the research based Omaha Classification System (OCS) consisting of nursing diagnosis/client problems, interventions and client outcomes to document its client care in Carefacts

Use of OCS facilitates tracking client trends and progress, billing, reporting to external accreditors, management decision-making, assessing staffing and scheduling needs, and fosters the inclusion of nursing information into national data sets. Our electronic documentation is able to produce data that describes client outcomes. Their knowledge, behavior and status are measured upon admission and discharge. Three nursing diagnoses tracked were Income, Ante/Postpartum and Growth and Development.

Preliminary results demonstrate, nursing interventions by staff appear to be producing positive outcomes for clients.

In CY02, the Adolescent Pregnancy and Parenting Projects (APP) served 644 parenting teens and young adult parents who had given birth as teens. These numbers have decreased over the last several years, due in part to a declining teen birth rate. 78% of pregnant teens served by the APP projects in CY2002 received pre-natal care in their first trimester.

b. Current Activities

In FY03 nearly 3000 families were strengthened through home visiting services provided by the Healthy Families Program grantees. Of these families, 35% enrolled in the prenatal period; 93% of two year olds enrolled in the program were up to date on immunizations compared with 83% of children in Maine and 79% of children nationally; and 97% of enrolled children were connected with a primary care provider and regularly utilized well child care. Approximately 25% of enrolled caregivers reported smoking. Of those families provided with information on the effects of tobacco, 43% found the information provided by the program helpful and that it

had changed their behavior. Of the families responding to the survey about the home visiting services provided by grantees, 82% reported that their parenting ability had experienced moderate to great improvement as a result of their participation in their local program, 89% reported a moderate to great improvement in their understanding of child development.

During the initial assessment of each client by public health nursing, an assets checklist is completed to establish a baseline and to assist the Public Health Nurse in development of an individualized plan of care for the client. The attached chart depicts client perception of their assets when admitted to PHN services.

Conclusions:

- 27% do not have child care
- 24% are unaware of their immunization status
- 18% do not use dental care
- 13% do not know how to access services

These data will be used to assist PHN in identifying client problems and formulating interventions.

Through the competitive bid process, contracting for home visitation services was reduced from 16 to 14 agencies with the continuation of services in the same quantity and geographic distribution as that prior to the new process.

The TYAH program continues to collaborate with WIC to refer prenatal women to Public Health Nursing within the first or second visit. Public Health Nursing continues follow-up through birth and the postnatal period.

c. Plan for the Coming Year

The Public Health and Community Health Nurses will continue to conduct home visits for pregnant women, mothers and children to support a healthy pregnancy and/or support their transition to parenting.

Contracts for the provision of home visitation services will be awarded late FY04 and early FY05 according to the State's competitive bid process.

The Healthy Families Program will continue to provide technical assistance and support to agencies implementing these programs.

Public Health Nursing will continue to monitor documentation and analysis of data using CareFacts using the data to inform practice and priorities.

Continue working with evaluation of the home visitation program, Healthy Families, by conducting a thorough analysis of FY04 data and implementing appropriate standards of data documentation in an effort to assure accurate, clean data.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Evaluate effectiveness of the screening system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop program resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop a plan for education of providers and the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue work with CSHN re: transition of clients between programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Finalize and disseminate program manual to health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Continue to recognize families as partners through the Family Advisory Council	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to have parents complete the Family Participation in CSHCN Programs forms to determine true parent participation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Enhance activities of FAC by exploring and integrating activities with other existing family groups similar to those involved with the planning of the Special Family Weekend	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue contracts with parent consultants as appropriate	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Active participation on Lead Advisory Board, Newborn Hearing Advisory Board, JAC of the Newborn Screening and CSHN Program, Early Childhood Comprehensive Systems Grant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Involve the Family Advisory Council in the development of the Champions for Progress Grant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Established a Medical Home Advisory Committee	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partnership with the Maine Chapter of AAP	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop a mechanism with conference participants for mentoring individuals/practices in adopting the Medical Home Framework within their clinical practice(s)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Participate in Hood Center for Children and Families at Dartmouth, NH MCHB Health Insurance and Financing Initiative	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to enhance relationship between the Bureau of Medical Services and CSHN Program on aspects of care coordination of children with special health needs through the Partners in Chronic Care Initiative	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to assist eligible families to enroll in MaineCare	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Establish partnership with the Maine Chapter of AAP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Formalize the relationship with the Hood Center for Children and Families at Dartmouth Medical School	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Activate CSHN website during FY05	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to update YEA ME website linked to the Healthy and Ready to Work website at the Center for Community Inclusion (www.ume.maine.edu/cci/service/maineworks)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with Genetics Program on SPM #12 to increase pediatric care				

providers knowledge & comfort/skill in caring for children with metabolic disorders by assisting with the development of materials and/or site visits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Family to Family Information Initiative with MPF to develop sustainability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue transitioning specialty clinics to community-based agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Begin discussions with Title V Leadership and others on the proposed shift of CSHN Program from a direct services entity with a focus on a small population of children to one that focuses on the broader population of CSHN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Youth will continue to be prominent players on the YEA ME Youth Advisory Council	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Elect a co-chair from among the membership	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Youth will continue to present at State and National Conferences on youth partnering and policy making decisions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. YEA ME member to continue review of MCH Block Grant and participate in review with federal partners	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Continue to conduct CASA Survey for the Immunization Program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to provide education and guidance regarding best practice and quality assurance/improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Family planning clinical services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Community-based pregnancy prevention and family planning outreach	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Comprehensive family life education consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Abstinence Only media campaign	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. SBHC base funding, technical assistance and standards implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Youth involvement and leadership technical support, training, and networking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Maintain and increase the number of schools with sealant programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Evaluate plan and continue implementation of database for sealant program data collection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue as MaineCare provider for sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analyze and report on 2004 Smile Survey data and plan for sustainability of statewide Smile Survey as component of Maine Child Health Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Provide child safety and booster seats to children birth to 8 years old	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide training for Child Passenger Safety Technicians	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to present to groups and organizations on the importance of child passenger safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to monitor impact of Booster Seat Law	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Evaluate data source and improve accuracy of reporting of feeding method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue increasing capacity for support of breastfeeding through Breastfeeding Counselors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue specified education to prenatal and postnatal service providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue work with Loving Support Campaign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Initiate reporting requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide tracking of newborns who do not pass the hospital screen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Evaluate screening system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to facilitate Newborn Hearing Program Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. SBHC providing assessment of insurance status, education and assistance in enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide assessment of insurance status, education & assistance in enrollment for APP, HF, PAT, PATT, PHN, CHN, WIC, and CSHN Programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Monitor changes in insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Monitor for changes in MaineCare services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. SBHC insurance pilot study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Public Health Nursing to continue to work closely with MIP to ensure EPSDT population receive care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Monitor implementation of the two core performance measures in relation to this section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. HF, PAT, PATT, CHN, APP and PHN staff maintain knowledge regarding EPSDT and MaineCare services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. HF, PAT, PATT, CHN, PHN, and APP educate and assist clients in applying for and utilizing MaineCare insurance benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live				

births.				
1. Provision of education and technical assistance to health care providers through Perinatal Outreach	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. In depth Epidemiological analysis of factors contributing to VLBW (Will begin when doctoral prepared Epidemiologist position is filled)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Partner in the Prematurity Prevention Campaign led by the March of Dimes	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Provide statewide access to crisis assistance and suicide prevention information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide training and education programs statewide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide guidance and technical assistance to school and community personnel for suicide prevention and intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Evaluate effectiveness of MIPP training and education programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct surveillance of, analyze, and disseminate youth self-inflicted injuries and suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement CDC funded Intervention Project	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Continue to provide education to perinatal care providers regarding high risk care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to assure statewide access to perinatal and neonatal transport systems	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue abstraction and review of medical records for Birth Defects Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Solidify processes for consistently abstracting data on birth defects				

reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partner in the Prematurity Prevention Campaign led by the March of Dimes	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Adolescent Pregnancy and Parenting Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Incorporation of teen parents as a priority population in the Home Visitation Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue collaboration with the Healthy Families Programs with reciprocal referral, PHN/CHN identifying health needs, Healthy Families identifying non-nursing supportive services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide technical assistance to providers of parent education and support services related to implementation and maintenance of parent education and support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *To decrease the percentage of Maine Children ages 5-12 with a need for obvious dental care (SPM # 11) New FY04*

a. Last Year's Accomplishments

The Oral Health Program, on behalf of the Maine Dental Access Coalition, received a \$50,000.00 grant award from the Maine Health Access Foundation (MeHAF) in its first round of funding in July 2002. The grant is intended to support the development and implementation of a comprehensive statewide Early Childhood Caries Prevention and Intervention Program. Additional support for the project comes from a small supplemental grant from the MCHB in the Health Resources and Services Administration, and in-kind contributions from the Oral Health Program and various collaborating organizations. Efforts over the next year and a half resulted in the production of a CD-based curriculum for non-dental health providers. The curriculum will be piloted with the Train-The-Trainer Sessions in cooperation with the Pediatric Residency Program at Maine Medical Center in the fall of 2004, with broader implementation expected thereafter, in collaboration with the Maine Chapter of the American Academy of Pediatrics.

b. Current Activities

The OHP secured funding through a one year Maternal Child Health Block Grant, State Oral Health Collaborative Systems Grant Program, for the 2004 Smile Survey and in collaboration with the Maine Asthma Prevention and Control Program implemented the survey beginning in late spring of 2004.

As planned, OHP expanded database capacity, within the program and for grantee agencies and schools, to include more schools providing sealant data electronically.

c. Plan for the Coming Year

The Smile Survey data, collected during the 2003-2004 school year, will be analyzed and be a major component of the Oral Health module of Maine's 2005 strengths and needs assessment. In collaboration with the Maine Asthma Prevention and Control Program and other partners, plans for securing funding for the Maine Child Health Survey (MCHS) and its various components will be pursued. If successful with a pending application for MCHB funding, the OHP will partially support the MCHS in 2006. With further refinement and implementation of the OHP's plan for data and surveillance, and expansion of the database used to track sealant program data, the OHP expects to enhance tracking of SPM #11. To date, there is insufficient data available to analyze the Medicaid claims data in a meaningful way.

As stated in FPM #9 Plan an application for three years of funding will be submitted to HRSA/MCHB, State Oral Health Collaborative Systems grant program, and will describe the development of a state oral health advisory committee, including developing a state oral health plan for Maine, and the implementation and evaluation of the oral health data and surveillance system, the continued inclusion of an oral health component in the Maine Bureau of Health's Child Health Survey, and the role of a broad-based stakeholder group, based on the existing Maine Dental Access Coalition. All of these activities will support both decreasing the proportion of children ages 5-12 with an obvious need for dental care, and our ability to track relevant data and evaluate relevant program components.

State Performance Measure 2: *The % of unintended births in women less than 24 years of age*

a. Last Year's Accomplishments

In an effort to reduce duplication, activities related to this performance measurement have been discussed under FPM # 8.

Twenty-nine family planning clinics across the state served 31,452 clients, including 10,195 teens.

b. Current Activities

The TYAHP facilitates a listserv for girls health issues and programs and provides technical assistance in this area. The listserv supports a comprehensive approach to promoting girls healthy development, including sexuality issues. Resources available to address unintended pregnancy are shared on the listserv.

c. Plan for the Coming Year

During FY05 the TYAH Program plans to maintain the number of clients served at 32,900. Funding reductions and increased health care costs preclude any increase in services and will

create a challenge for maintaining current levels of services.

In an effort to further promote the importance of collaboration, the TYAH staff will continue to serve on the following committees: the Maine Health Education Coalition, the Kids Count Committee, the Suicide Prevention Steering Committee, the School Health Advisory Council, the Planning and Policy Team for the Campaign for a Healthy Maine, the Bureau's Evaluation Workgroup, the Physical Activity and Nutrition Workgroup, as well as, two committees of the Office of Substance Abuse One ME Special Incentive Grant, the Preventive Women's Health Workgroup, the Women's Health Service Task Force and a State Youth Survey Committee.

The TYAH Program will continue to collaborate with the Maine Women's Health Campaign on girl's health issues and activities, including facilitating the creation of a listserv.

State Performance Measure 3: *Percent of women enrolled in WIC that are breastfeeding their infants at six months of age.*

a. Last Year's Accomplishments

In preparation for the production of a poster promoting breastfeeding and working, the WIC Program contracted with a photographer to photograph women who worked and breastfed their babies. Of the 16 women, one worked in manufacturing, one in a coffee shop (Dunkin Donut) and the other in a restaurant (Friendly's).

Loving Support ads were run on 2 radio stations for 6 weeks and 1 television station for 4 weeks. An ad, adapted from the Loving Support poster, is running from October 2003 through October 2004 in movie theaters in the southern, coastal, west central and east central regions of the state.

Training was held in July 2003 in the 3-step Counseling Method and Making it Work: Supporting Employed Mothers with Breastfeeding for WIC, PHN and Healthy Families home visitors. A training was also held for staff at 2 Head Start centers and 1 child care center to certify the centers as breastfeeding friendly.

The WIC Program also presented on breastfeeding at the Child Care Annual Conference held on February 21, 003 at the Augusta Civic Center.

In June 2003, three WIC and 1 Public Health Nurse completed the Certified Lactation Counseling (CLC) training. WIC encourages staff who have completed the CLC training to undertake steps to become Board Certified Lactation Consultants.

b. Current Activities

Consistent with the goals and objectives of the Food and Nutrition Services Strategic Plan, one of the performance measures is to increase the rate of breastfeeding among WIC participants. Baseline data is being collected and will be reported in FY04.

In collaboration with the Maine State Library the WIC Program distributed, to all Maine public libraries, children's books depicting breastfeeding either as part of a background or as a major component of the book. The Maine State Library produced activity sheets for the books to encourage use of the books in reading circles. The WIC Program also distributed, as a reference, copies of Tom Hale's "Medications and Mothers Milk" to pharmacies in Kennebec and Somerset County. Pharmacies appreciated receiving the books and many reported they were not aware of the book as a resource for breastfeeding women and safety of medications for their infants. During FY05 the WIC Program will be following up with pharmacists to

determine the degree of dissemination.

The WIC Program sponsored Dr. Jack Newman, Director, Breastfeeding Clinic, Hospital for Sick Children, Toronto to present "Medications and Mothers Milk" at grand rounds for Maine Medical Center, an evening reception with a discussion on Hypoglycemia and Jaundice and a 1-day conference; "Supporting, Promoting and Maintaining Breastfeeding, A Day with Dr. Jack Newman" on May 20-21, 2004. Topics included: Colic and the Breastfed Baby; Weight Gain, Poor Weight Gain, Why Babies Don't Gain; Breastfeeding the at Risk Baby with special concentration on the 35-38 week baby and the role of the Healthcare Professional in supporting, promoting and maintaining breastfeeding.

"Breastfeed: Give the Gift of a Lifetime" a book that promotes breastfeeding is being distributed to hospitals, physicians and WIC offices for use in waiting rooms. In addition, the WIC Program, in collaboration with the Oral Health Program, distributed copies to dental offices. Copies were also disseminated to businesses such as accountants, law firms, chiropractors and beauty salons to place in their waiting rooms.

c. Plan for the Coming Year

Continue to work collaboratively with WIC Program to encourage client acceptance of PHN home visitation services.

Continue training of Child Care Centers on supporting breastfeeding mothers. To support breastfeeding friendly environments, childcare centers provide space for mothers to breastfeed their babies, have no images of baby bottles, have plans to train new staff on supporting breastfeeding mothers, and have policies consistent with supporting breastfeeding babies.

Develop poster from photos, of working mother's breastfeeding, taken in FY03 with the phrase "What do all these mothers have in common? They all worked and breastfed their babies and so can you".

Send approximately 10 people to the September 2004 Certified Lactation Consultant training.

Include breastfeeding topic at WIC annual conference in October 2004.

Technical assistance will include sharing with local agencies, activities from other local agencies as well as from states that have improved breastfeeding rates and duration.

State Performance Measure 4: *The percentage of adolescents who have received routine dental care in the last year*

a. Last Year's Accomplishments

Continued support of community agencies and community health centers providing preventive and restorative oral health services, through the Dental Services Development and Subsidy Programs funded by the Fund for a Healthy Maine, Maine's tobacco settlement, has helped to sustain Maine's limited oral health infrastructure.

The OHP staff hygienist, Kristine Perkins, continued to participate on a broad based committee working on a Soda/Snack Vending Machine Policy Initiative for Maine. Among the products of this group's work was a packet for schools interested in instituting policies for vending options limited to healthy food and drink choices. She also presented at the Maine Association for Health, Physical Education, Recreation and Dance statewide conference in November 2002

speaking on first aid for dental emergencies, providing background information on oral-facial injuries among school-aged children during recreation and sports activities, as well as, on safety and the use of mouth guards.

Inclusion of a YRBS question on the frequency of receiving dental care was retained. At this time, this is the only source for statewide data related to the adolescent population.

Consultation and technical assistance was provided as requested, usually for educators, health and social services providers, related to the oral health needs of this population group.

b. Current Activities

Kris Perkins, staff hygienist, participated on the YRBS Planning Team. The OHP continued support of capacity-building for oral health in community programs.

c. Plan for the Coming Year

Kris Perkins will continue to participate on the YRBS Planning Team. OHP will continue its support of capacity-building for oral health in community programs, and continue a dialogue just beginning with other interested parties about oral health and School-Based Health Centers.

State Performance Measure 5: *The motor vehicle death rate per 100,000 among children 15 to 21 years of age*

a. Last Year's Accomplishments

The MIPP Comprehensive Health Planner was appointed to the Data Committee of the Maine Transportation Safety Committee in FY03. The Committee's charge was to compile a Data Notebook outlining sources of transportation related data within the state of Maine. A section of the notebook is dedicated to teen driver issues. The book will be released during FY05 and disseminated to traffic safety advocates, legislators and other public officials interested in transportation safety in Maine.

b. Current Activities

No activities were undertaken during FY03 as the position remained vacant.

c. Plan for the Coming Year

During FY05, MIPP staff will continue to:

1. Provide training and information to advocates on safe driving and the importance of buckling up
2. Provide technical assistance to legislators, organizations, and other professional advocates on a standard safety belt law for all ages in Maine
3. Continue to promote the Injury Prevention Program's new website and the access to various injury prevention links
4. Continue to collaborate and coordinate activities with the Maine Transportation Safety Coalition (MTSC) in promoting child passenger, bicycle, and pedestrian safety issues, including the Safe Communities concept.
5. MIPP in collaboration with the MTSC will continue to identify and recognize local efforts through the Community Transportation Safety Award.
6. The program will develop and maintain a Web site for dissemination of prevention

information that includes prevention resource contacts, data, training opportunities, and links to other Maine and national injury prevention resources.

7. MIPP will continue to collaborate and coordinate on occupant protection safety issues with the Maine Transportation Safety Coalition as well as other committees, and state agencies involved in protecting the safety of Maine's young drivers.

8. Data provided through all MIPP Fact Sheets will be kept current and distributed upon request.

9. Provide two 4-day child passenger safety technician and one 2-day special needs car seat safety courses.

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

11. Continue designation as Maine NHTSA coordinator for child passenger safety and maintain child passenger safety technician list for state.

State Performance Measure 6: To increase Primary Care Providers knowledge of the impact of genetics on the health of their population (SPM # 12 New - will start reporting in FY05)

a. Last Year's Accomplishments

This measure has been discontinued

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 7: Timely provision of genetics services to women receiving services provided by Title V

a. Last Year's Accomplishments

During FY03 689 individuals and their families benefited from comprehensive genetic services at grantee agencies. These included in-patient referrals, high-risk clinic collaborations, specialty clinic consultations, telemedicine and traditional genetic clinic services.

During FY03, 60 presentations were given by Maine genetics providers on various topics. Educational programs reached 1,998 professionals, students and members of the public.

Reporting of selected birth defects began May 1, 2003. All birth hospitals identified two contacts to work closely with the MBDP, one within the nursery and one from medical records. Records are being abstracted to collect clinical data on each case. The Nurse Coordinator works closely with CSHN staff to ensure referrals are made.

b. Current Activities

The Genetics Program Advisory Committee comprised of genetics professionals, consumers, nurses, BOH staff (including the MCH Medical Director), and the CSHN Program Manager continued to consult with the Program regarding provision of comprehensive genetic services in Maine.

The FY05 distribution of grant funds for genetic services will be determined through a Request for Proposal (RFP) process. A request for proposals was released in May 2004. These grants will help support provision of comprehensive genetic services, including risk assessment, clinical and laboratory diagnosis, genetic counseling, case management and treatment for individuals and families with genetic conditions, and education of providers and the public. A previous RFP in 2003 did not result in grant awards.

c. Plan for the Coming Year

The Genetics Program is consulting with the Joint Advisory Committee in development of a survey tool to assess health care providers' knowledge and awareness of the impact of genetics on the health of their population.

The competitive process to award grant funds to support genetic services will increase access to state supported genetic services, outreach and education, and quality of services. As a result of this RFP process, up to \$400,000 in state funds will be awarded to one or more qualified genetic centers. We anticipate the RFP process to be completed and grants in place for September 1, 2004. Current grant agreements were extended to ensure availability during this planning period.

State Performance Measure 8: *The percent of overweight adolescents*

a. Last Year's Accomplishments

Maine data shows a high rate of overweight among its youth. In 2003, 13% of high and middle school students were considered overweight and 15% of high and 18% of middle school were considered at-risk for overweight. In 2002, 16% of WIC participants 2-5 years old were overweight, and 17% were at-risk for overweight compared to 14% and 17% in 2001. The Maine Child Health Survey conducted in 2002 documented 15% of kindergarteners overweight and 21% at-risk for overweight.

To address Maine's overweight problem the BOH submitted an application to the CDC and was awarded \$450,000 per year for 5 years beginning July 1, 2003 to help build capacity for obesity prevention. Year 1 objectives include establishing a coordinated state infrastructure for obesity prevention and control; completing the State Nutrition and Physical Activity Plan; establishing surveillance system components for nutrition, physical activity, and obesity; and planning and initiating the implementation of a soda/snack vending pilot intervention.

Collaboration continued with the Maine Center for Public Health and Harvard Prevention Research Center to evaluate the feasibility of implementing nutrition and physical activity surveillance. Recommendations included possible determinants, measurement criteria, and data collection strategies for pregnancy and early childhood, youth, adults and the environment.

Several components of the Healthy Weight Awareness Campaign were introduced during FY 03. Each phase was designed to present a simple aspect of improving nutrition and increasing physical activity. Components of the Campaign included limiting soda consumption, reducing television and screen time, and incorporating physical activity into simple tasks around the home. A combination of television, newspaper, and radio messages was used, along with posters and a direct mail information packet. Outcomes demonstrated included total awareness of the advertising message about soda consumption by young people (both aided and unaided) summed to 68% of all parents surveyed; 66% of parents had seen the advertising message about the time young people spend watching television; and the walking/trails campaign generated over 30,000 hits to the website that was promoted in the

media campaign during the first two weeks.

Maine Nutrition Network projects focused on children and adolescents during FY03 included training for elementary and middle school teachers as well as food service staff; nutrition education to preschool children, teen parents and families in Waldo county; funds for teaching, demonstration supplies and educational nutrition field trips for elementary age children; nutrition and food preparation lessons to children participating in the National Youth Sports Program; and technical assistance and access to books with food and nutrition themes to town librarians from low-income areas.

b. Current Activities

The MCH Nutrition Program is collaborating with the newly established PAN Program to build Maine's infrastructure to address obesity prevention. The MCH Nutrition Program participates on the PAN Coordinating Council. The purpose of the PAN Coordinating Council is to communicate, coordinate, integrate, and leverage resources to promote optimal standards and practices in and across programs with physical activity and nutrition components. The MCH Nutrition program is also partnering with the PAN Program to plan and implement the completion of Maine's Physical Activity and Nutrition Plan; establish surveillance system components for nutrition, physical activity, and obesity; and plan and initiate the implementation of an a la carte and vending policy in public schools and the impact on health indicators in school-aged children. The a la carte and vending intervention will coincide with a proposed rule change initiated by the Maine Department of Education to remove foods of minimal nutritional value from school vending machines effective September 2004.

The MCH Nutrition Program is collaborating with the Maine Nutrition Network and other colleagues on the development of an action packet with guidelines for implementing policies that support healthy options in vending machines. Other program activities include collaboration on the submission of an application for a Team Nutrition Training Grant, and development of messages for the Healthy Weight Awareness Campaign regarding indoor walking, portion size, and television off and out of the bedroom.

The Bureau of Health released a report on the extent of overweight among Maine youth utilizing the data from the Maine Child Health Survey of 2002 and the Youth Risk Behavior Survey of 2003. This information will help support the need for programs and policies to improve nutrition and physical activity in schools and communities throughout the state.

c. Plan for the Coming Year

The MCH Nutrition Program will maintain its collaboration with the Physical Activity and Nutrition (PAN) Program in building Maine's infrastructure to prevent obesity and other chronic diseases. Initiatives for the PAN Program in FY05 will include development of state and local infrastructure for nutrition and physical activity; completion of a school intervention to improve food options for a la carte and vending machines; and coordination of activities to achieve the strategies from the State's PAN Plan.

The MCH Nutrition Program will continue its partnership with the Maine Nutrition Network to plan and implement the projects of Maine's Food Stamp Nutrition Education Plan funded by the U.S. Department of Agriculture. Collaboration will also proceed with the Maine Nutrition Network and Maine Cardiovascular Health Program on the implementation and ongoing development of the Healthy Weight Awareness Social Marketing Campaign. During FY05, the campaign will focus on lifestyle behaviors related to increasing physical activity and healthy eating messages including promotion of fruits and vegetables.

The MCH Nutrition Program will collaborate with other colleagues to enhance current

guidelines for measuring students and recommended procedures for follow-up and referral. Maine's School Health Manual provides school nurses with guidance on measurement, and includes a sample referral letter to parents when potential problems arise. However, it appears that a more sensitive process is required. Some schools, which conducted weight screenings in the past year, created parental concern about discrimination.

State Performance Measure 9: *The percent of children who are overweight (New FY04)*

a. Last Year's Accomplishments

This measure will be reported on in FY05

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 10: *To reduce physical fighting among adolescents in Maine (New FY04)*

a. Last Year's Accomplishments

During FY03 Youth were involved in selecting, and identified, bullying and teasing as an underlying issue affecting teens across the state. The Maine Youth Action Network (MYAN) through a contract with the Bureau of Health led this effort.

The MIPP obtained a copy of the MCHB "Stop Bullying Now" campaign video launched on April 19, 2004 to be used during FY04 with adult and youth audiences to advance the state's bullying prevention activities. Stop Bullying Now resource materials are being included in MIPP publications to parents, school personnel and community agencies. In spring 2003, eight bullying prevention project schools re-administered the student bullying survey. Key findings included a 13% decrease in the percentage of students reporting they were teased in a mean way and a 17% decrease in those reporting being hit, kicked, or pushed. Students reporting they had witnessed others being teased decreased by 15%, while those witnessing others being called hurtful names, hit, kicked or pushed at least once a month decreased by 13%. The most significant decreases were seen in student reporting of witnessing bullying at least once a month on the bus (25% decrease) and/or at the bus stop (45% decrease). The percentage of students who indicated the situation got better after they told someone increased from 48% at the beginning of the program to 58% at the end (CY2001-2003).

Maine Law and Civics Education and Peace Studies Institute at the University of Maine completed the peer mediation evaluation pilot project in January 2003. A set of surveys for school conflict climate, peer mediator attitudes and skills, as well as a satisfaction survey for completed mediations were developed and reproduced on easy to use scan forms and will be made available, at cost, to schools with peer mediation programs. Schools purchasing and administering surveys for their program evaluation will receive a school report that includes a summary of results. This meets the Injury Prevention Program goal of providing a user-friendly, sustainable method of evaluating peer mediation programs in Maine schools.

The Peace Studies Program and staff at a northern Maine juvenile detention facility collaborated in exploring and integrating conflict management education into the curriculum and daily lives of youth age 12-18. 19 school and 3 correctional staff participated in an initial

training conducted by Peace Studies. Peace Studies staff worked with students and facility staff weekly from January through May 2003 to encourage integration of Conflict Management Education (CME) for youth, presenting CME and life skills to facility students, assisting students in integrating CME in their subjects and offering mediation to youth. Facility staff reported to Peace Studies staff that the CME was valuable for youth in creating awareness around behavior management.

b. Current Activities

30 youth received training and facilitated groups of conference participants in bullying prevention discussions at the November 2003 conference. The Maine Youth Action Project continues to work with Bureau of Health staff to identify gaps in bullying prevention and roles for youth in state-level planning around bullying issues. The MCHB Bullying Campaign kickoff video was obtained for use in FY05 with adult and youth audiences to advance the state's bullying prevention activities.

MLCE and Peace Studies continued coordination of the Peer Mediation Association of Maine, a network of student mediators and school staff coordinators. MLCE conducted 2 regional conferences at the University of Southern Maine, in Fall 2002 and Spring 2003. Students participated in conference planning and facilitated workshops. Professional mediators participated by coaching students in mock mediations. A total of 152 student mediators and adult coordinators participated. Both conferences were highly rated by participants in the areas of improving skills and helping to sustain programs. Peace Studies also conducted two regional conferences at the University of Maine. 56 K-8 peer mediators and their coordinators from 5 schools attended the Fall 2002 training. Both students and coordinators rated the trainings highly as necessary and essential for providing the foundation for further development of their programs throughout the year. Students planned the spring conference for high school peer mediators. 28 high school students and two coordinators attended. High school and college students as well as community members were engaged in a daylong process of defining and creating a peaceful non-violent school. Students and coordinators shared that learning had occurred and were able to apply this learning by planning specific steps they would take in their schools for managing conflicts and fostering an environment of respect and non-violence.

The University of Maine student organization is focusing its efforts on promoting a climate that reduces campus conflict through presentations to classes, student groups, and administrators. A pilot project established in one dormitory provides regular and anonymous presence for students to obtain advice and learn new skills for managing their personal conflicts. The Peace Studies Program continues to offer training for university students and community educators through courses in conflict management and mediation. Three introductory courses were offered during the reporting period (July 2002, January and April 2003) with 40 students participating.

In 2002-03 MLCE presented bullying prevention information to 100 parents in 3 schools and at student assemblies in 2 schools, reaching 625 elementary school students.

MLCE also completed a Bullying Prevention Coordinator Manual and a set of training materials for the program (copy included in Appendix).

c. Plan for the Coming Year

Provide conflict management, peer mediation and bullying prevention training programs and implementation consultation to schools statewide

Conduct the annual Mock Trial Competition for high school students

Conduct a Northern and Southern Maine Peer Mediation Association of Maine Conference for students and staff from high schools statewide

Purchase resource books, curricula and videos for loan to trainers and schools statewide

Produce and disseminate, Changing Ways, newsletter for school staff

The Maine Youth Action network will facilitate youth involvement in an interagency state-level group. A proposal to connect bullying with other risk behaviors and with youth asset building will be submitted to the National Institutes of Health. The input of youth will guide the direction of the grant proposal, as well as assist state-level staff in better understanding the perceptions of youth on this issue.

MLCE evaluator will finalize a report addressing the findings from the student bullying survey in the context of the larger body of bullying prevention research.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) To decrease the percentage of Maine Children ages 5-12 with a need for obvious dental care (SPM # 11) New FY04				
1. Conduct 2004 Maine State Smile Survey, analyze data and utilize in needs assessment process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue support for community-based capacity building to result in increased infrastructure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop a method to look at Medicaid claims data along with school and sealant data to adequately and realistically assess this measure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The % of unintended births in women less than 24 years of age				
1. Family Planning Clinical Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Community-based pregnancy prevention and family planning outreach	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to monitor via PRAMS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of women enrolled in WIC that are breastfeeding their infants at six months of age.				
1. Monitor implementation of WIC performance measure specific to BF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide technical assistance to local WIC agencies to increase breastfeeding rates and duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue implementation of Loving Support Campaign	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue developing Certified Lactation Counselors within WIC, PHN, and CHN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percentage of adolescents who have received routine dental care in the last year				
1. Support for community-based capacity building resulted in increased infrastructure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue with YRBS and middle school dental care question	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

5) The motor vehicle death rate per 100,000 among children 15 to 21 years of age				
1. Develop resource materials on young driver safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with MCH Epidemiologist to better understand factors contributing to Maine's apparent higher child (1-14 year old) motor vehicle death rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with MCH Epidemiologist to conduct more detailed analysis of 15-21 year old motor vehicle death rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor impact of booster seat legislation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) To increase Primary Care Providers knowledge of the impact of genetics on the health of their population (SPM # 12 New - will start reporting in FY05)				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Timely provision of genetics services to women receiving services provided by Title V				
1. Complete competitive bidding process to distribute funds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop plan for education of Primary Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate knowledge and awareness of PCPs through surveys of Providers and families, and focus groups with families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percent of overweight adolescents				
1. Collaborate with partners to achieve the Healthy People 2010 nutrition, physical activity, and fitness objectives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Enhance Maine's nutrition and physical activity surveillance infrastructure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Improve the nutritional and physical activity status of Maine's MCH population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue monitoring via YRBS Survey and the Maine Child Health Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) The percent of children who are overweight (New FY04)				
1. Collaborate with partners to achieve the Healthy People 2010 nutrition, physical activity, and fitness objectives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Enhance Maine's nutrition and physical activity surveillance infrastructure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Improve the nutritional and physical activity status of Maine's MCH population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor Child Health Survey results	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) To reduce physical fighting among adolescents in Maine (New FY04)				

1. Provide resource lending libraries for Youth Violence Prevention Programs and curricula	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide training and technical assistance to elementary, middle and high school staff and students in conflict management, peer mediation, and bullying prevention programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate the impact of the conflict management training program on participating schools, staff members and students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Compile and disseminate data on youth violence statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Facilitate collaboration among key stakeholders and coordinate activities to prevent youth violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide the annual Mock Trial Competition for high schools	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sponsor the statewide PMAM for student mediators	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sponsor CMUM Peer Mediation Program for University of Maine students	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Dr. Aronson, MCH Medical Director, convened a planning meeting on June 11, 2003, to develop methods for incorporating Shaken Baby Syndrome into the public health context for child abuse and neglect prevention.

Inspired by the shared information and effective awareness and prevention models, Dr. Aronson organized a partnership of state agencies, private institutions, local evaluators experienced in child welfare, and child abuse and neglect councils. The partnership cultivated a project proposal to the Centers for Disease Control and Prevention, Safe Start Maine, which intends to develop evidence-based recommendations to reduce the incidence of serious physical abuse in the birth to three population. With its rigorous research, design, intervention, and evaluation components, Safe Start Maine strengthens BOH leadership in violence prevention throughout the state.

Complementing the collaborative work of Safe Start Maine to further highlight the need for an integrated and comprehensive public health approach to child abuse and neglect, the Bureau of Health continued to strengthen its primary and secondary child abuse and neglect prevention strategies through the following activities:

- Active leadership on the Children's Cabinet Task Force on Early Childhood, particularly through the Early Childhood Comprehensive Systems grant (Humane Systems for Early Childhood), to develop policies for parent education to prevent the risk of child abuse and neglect.
- Leadership in convening a Department of Human Services (DHS) conference for 100 people in Augusta on July 30, 2003, "Stop Child Abuse". The Portland Press Herald headlined the conference as: "Agencies confer on curbing child abuse. Advocates say Mainers need to view child abuse as a public health threat."
- Leadership in organizing and following up on a telephone consultation in September, 2003 with staff (Corinne Graffunder, John Lutzker, Rebecca Leeb) from the Division of Violence Prevention at the CDC. This conversation, which involved Maine DHS staff from Child Protection, Children's Cabinet, Injury Prevention, and Title V, focused on ways that Maine could enhance its state health agency capacity to address child abuse through a linked data collection and tracking system. The consultation resulted in two CDC grant proposals submitted in December 2003: Safe Start Maine and The Maine Project: Linking Home Visitor Training and Family Outcomes.
- Participation in press conferences about child abuse and neglect, including Fight Crime! Invest in Kids and the Child Abuse and Neglect Prevention month.

- Media campaign development, in partnership with the Maine Children's Trust, Child Abuse and Neglect Councils, and Parent Education and support providers to provide consistent messaging about the recognition of parenting challenges and offer alternative approaches and supports to prevent abuse.
- Researching and developing a systematic approach to home visitor training through the Maine Project, another CDC grant, that Title V submitted this year. The project proposes to evaluate the best practices in applied behavioral and attitudinal skills of home visitors and incorporate them in a statewide curriculum designed to reduce child abuse and neglect.

While no less significant, tertiary child abuse prevention work through the Task Force on Early Childhood includes:

- Focusing on community intervention programs for families involved with child welfare, which are in the first stages of developing a system based on teamwork with a focus on family support in the context of the community.
- Assistance with funding pursuits for family services for children of drug-addicted or AIDS/HIV positive parents.

In April 2004, the Bureau of Health applied to the CDC for funding the Maine Violent Death Reporting System Cooperative Agreement. This proposal, with Dr. Aronson and Cheryl DiCara (Injury Prevention Program Manager) as principal investigators, includes a significant expansion and enhancement of the Child Death and Serious Injury Review Panel (CDSIRP). All cases reviewed by the panel to date have in common the suspicion of child abuse or neglect as a cause of death or a significant causal factor. The selection of cases is not systematic and the collection of data is not standardized. Between 1998 and 2003, the panel reviewed 29 child deaths for an average of roughly five per year. The panel focuses primarily on increasing the responsiveness of the child protection system and to promote the education of both professionals and the public. It serves as a citizen review panel for the DHS as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247. State statute gives the panel the authority to gain access to all relevant records, including the power to subpoena for their release. The panel bases its deliberations on in-depth retrospective reviews of all records and by oral presentations by providers involved in the case.

In preparing the CDC Cooperative Agreement proposal, Dr. Aronson and Ms. DiCara engaged in a rich dialogue with the Child Death Panel in early April 2004. Panel members enthusiastically agreed to expand the review process to include all cases of violent child death (birth to 18) and to make it part of the Maine Violent Death Reporting System (ME-VDRS). This CDC Cooperative Agreement will allow for the Child Death Review Panel's reviews and reports to become much more systematic and uniform, substantially enriching the potential for policy and system change. As a result, we will gain valuable new information about child deaths from suicides, homicides, and firearms not related to child abuse. This information will be of vital importance in the design and implementation of best practices to prevent such deaths. The Cooperative Agreement will also enable the MIPP to integrate, for the first time, the information gained from child death review into a linked injury data reporting and tracking system. This reporting system will give us a baseline of how we're doing, enable us to set meaningful objectives, and provide us with a rich framework for measuring our progress.

In addition, plans are underway to start up maternal mortality review through a partnership with the Maine Chapter of the American College of Obstetrics and Gynecology and fetal and infant mortality review with the Maine March of Dimes, Maine Medical Center's Perinatal Center, and other organizations.

F. 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, and other federal partners such as the Centers for Disease Control and Prevention for the following:

1. Reverse technical assistance with a state CSHN program that has or is well underway in making the transition from direct services to population based and infrastructure level services.
2. Technical assistance in planning for and conducting a CAST-5 assessment of the Maine CSHN Program.
3. Technical assistance around adolescent health in the areas of building program capacity, integration of categorical risk behavior strategies, and development of a state strategic plan for adolescent health.
4. Technical assistance from the National Center for Cultural Competence in furthering development of linguistic and cultural competence among Maine's Title V programs, and
5. Assistance with financial analysis of MCH resources and development of a plan for appropriate reallocation.

The above requests for technical assistance are in order of priority. Technical assistance #1 was selected because the CSHN program has historically focused upon the provision of direct health services. The program needs to adjust the balance of human and financial resources to provide greater emphasis on population based and infrastructure building services such as quality assurance related to direct services provided at the local and regional level. Several states have started or completed the transition and could provide valuable technical assistance as Maine prepares to make adjustments in the balance of its human and financial CSHN resources.

The request for technical assistance #2 was selected because the CSHN program is preparing to adjust the balance of human and financial resources and needs to set a strategic plan for making those adjustments. Prior to setting the plan it is critical to assess current strengths and weaknesses in relation to CSHN and the 10 essential MCH services. It would be useful to have a neutral facilitator as well as someone with knowledge of CAST-5.

The request for technical assistance #3 was selected because our Teen and Young Adult Health program needs to work with additional government and non-governmental entities to integrate strategies addressing categorical risk behaviors. It also needs to work with these other entities to establish a strategic plan for adolescent health in Maine.

The request for technical assistance #4 was selected in order to continue progressing in the development of culturally and linguistically competent Title V programs in Maine. This is particularly important as the population in Maine becomes more racially, ethnically, and economically diverse.

The request for technical assistance #5 was selected because both the federal and state funds available to Maine Title V are fully utilized with no capacity to respond to emerging issues. Reallocation of funds need to be made in a thoughtful manner that avoid negative impacts upon Maine's many positive outcomes such as low adolescent birth rate, low infant mortality rate, high immunization rate, and high newborn screening rate. No progress was made in this area and remains a priority in FY05 as Maine completes the 5-year strengths and needs assessment and plans priorities for the next 5 years.

Maine is working with the other 5 Region I states to identify methods for measuring strengths. During FY04 Maine Title V staff consulted with Pat Seppanen, Search Institute, and Suzanne Bronheim and Suganya Sockalingham, National Center for Cultural Competence. As Maine continues to prepare the 5-year comprehensive strengths and needs assessment attention to these areas will continue through FY05.

V. BUDGET NARRATIVE

A. EXPENDITURES

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

B. BUDGET

Justification:

The Division of Family Health expended \$17,106,451 for maternal and child health services in FY03; including \$11,722,744 of state funds and \$3,056,255 of Title V funds. Expenditures by populations served include 61% (\$8,993,037) expended on primary care and preventive services for children; 19% (\$2,833,360) expended for children with special health care needs; and 12% (\$1,824,589) expended for pregnant women. Delineating expenditures by the levels of the MCH Core Services Pyramid, 58% (\$8,602,132) was expended on direct services; 8% (\$1,142,162) was expended on enabling services; 12% (\$1,759,266) was expended on population based services; and 22% (\$3,275,439) was expended on infrastructure building services. The slight decrease in enabling and population based service expenditures supported a 2% increase in expenditures for infrastructure services. In FY05 the Division proposes to spend \$3,557,242 of Title V funds, with no carry forward from FY04. Of the Title V funds, 63.01% (\$2,241,559) is allocated to primary care and preventive services for children; 30.7% (\$1,092,049) is allocated to children with special health care needs; and 6.29% (\$223,634) 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: 68% (\$9,021,019) will be allocated for direct services; 8% (\$1,059,795) for enabling services; 9% (\$1,165,388) for population based services; and 15% (2,040,966) for infrastructure building services.

In FY05 budgeted expenditures are on par with the FY04 budget. This appears to reflect a stabilization in funding despite the continued challenges of balancing budget deficits. Reductions appear level with those of FY04. FY04 and FY05 reductions are reflected in a 4% reduction in funds for purchased services, others are reflected in reduced positions and yet others are in administrative and material expenses.

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.