APPENDIX E

Department of Health and Human Services programs funded by Fund for a Healthy Maine funds, November 17, 2011

Fund for a Healthy Maine Fact Sheet

Office: Child and Family Services **Date:** 11-17-11

Program Title: Maine Families Home Visiting

Account: 014-095306, FHM-Home Visitation

I. Program Description:

1) Overview of the program:

Home Visiting was formally established in state statute (Title 22, §262) as an effective primary prevention public health strategy to meet the goals of the Department by improving the health and well-being of Maine's young children and their families through a connected network of home visiting providers.

In accordance with the federal definition of home visiting as outlined in the Social Security Act, Title V, Section 511(b)(U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent, short-term or supplemental home visiting), and is offered on a voluntary basis to mothers, fathers, families, pregnant women, infants, and children.

Maine Families Home Visiting delivers cost-effective focused services to a vulnerable population at the most critical time of children's physical and emotional development.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

The Maine Families Home Visiting Program serves vulnerable families of infants and toddlers. Typically, over 2500 families receive home visits each year. The families who received home visits were largely young (46% under age 23 at their child's birth), single or partnering (60%) and more likely to be facing economic challenges (over 1/3 of the families had incomes under $10,000 for the year). The program is making special efforts to reach the highest risk babies such as those that are drug affected or exposed to family violence.

3) What is purchased with these funds:

Maine Families Home Visiting is an evidence-based program providing focused services in response to an individualized needs assessment and is offered in families' homes. Well-trained professionals work in partnership with parents to insure safe home environments, promote healthy growth and development for babies and young children, and provide key connections to state and local services as needs are identified.

Expectant parents receive support to have a healthy pregnancy and access prenatal care. Parents of newborns are supported in their adjustment to parenthood and information is provided related to critical areas such as prevention of shaken baby syndrome, SIDS, suffocation and unintended injuries. Beyond the newborn period, ongoing educational and support services are provided to the most vulnerable families at a level reflecting the families' needs.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):**
Contracted home visiting program sites are located in various health, educational and community agency settings and are available in every county in Maine. Sites work closely with other community service providers to collaborate and avoid duplication of services.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:**

- State funded community- based home visiting was piloted originally in 1994 and expanded across the state in 2000 with the availability of funding from the Tobacco Settlement Funds.
- 2007, Title 22, §262: Home visiting
- 2011, Ch. 77, LD 1504, *Resolve, to Ensure a Strong Start for Maine's Infants and Toddlers by Extending the Reach of High Quality Home Visitation*
- Social Security Act, Title V, Section 511 (42 U.S.C. §701) as amended by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

III. **Financial Information:**

1) **4 Years of Spending and SFY12 & 13 Budget:**

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 2,653,383	$ 2,653,383
General Fund or Other Special Revenue					$ 2,000,000	$ 2,000,000
Federal Funds					$ 4,000,000	$ 5,200,000
Total	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 8,653,383	$ 9,853,383

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:**
Fund for a Healthy Maine (FHM) funding represents 30.7% and 26.9% of the total funding for the Home Visitation program for FY 2012 and FY 2013 respectively.

IV. **Program Eligibility Criteria:**
Families may take part in the program beginning in pregnancy and may receive visits until their child turns three years of age. Beyond the prenatal/newborn period, eligibility for ongoing services is determined by an individualized needs assessment and is prioritized and focused on the most vulnerable families such as adolescents and those experiencing substance abuse, domestic violence, mental health issues, developmental/ health concerns or family stress.

V. **Are the Fund for a Healthy Maine funds used to meet MOE Requirements?** ☒ **Yes** ☐ **No**

If yes, please explain:

The Affordable Care Act – Maternal, Infant and Early Childhood Home Visiting Program grants (formula based grants and competitive expansion grant) were awarded to "effectively implement home visiting models (or a single home visiting model) in the state's at-risk community(ies) to promote improvements in the benchmark and participant outcome areas as specified in the legislation." States must use the federal funds to supplement, not supplant, funds from other sources for these early childhood home visiting services.

VI. **Goals & Outcomes of the program:**

1) **Please describe the goals of the program:**
   - Healthy and strong parent-child attachment.
   - Family health, emotional and physical well-being.
   - Reduced incidence of child abuse and neglect.
   - Positive and creative learning environment for the child.
   - Family self-sufficiency.
   - Positive and effective parenting.
   - Parental competencies and self-confidence.
   - Community linkages/reduced family isolation.
   - Educational success.

2) **Please describe how the outcomes are measured:**

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering several domains of health and well-being. The state home visiting plan submitted in June 2011 included detailed descriptions of how each benchmark is measured. One example is included below:

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Indicator	Percentage of pregnant women enrolled in the program using tobacco at intake who have ceased tobacco use by 3 months post enrollment
Indicator Type	Outcome Measure
Measurable Objective *Operational definition of improvement*	Increase or maintain the percentage of enrolled pregnant women using tobacco who cease tobacco use within three months post-enrollment from year 1 baseline to the 3-year benchmark reporting period.
Measurement Tool	Behavioral Health Risk Screening Tool for Pregnant Women and Women of Childbearing Age (BHRST)
Validity of proposed measurement tool	The Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Health (VDH) and the Home Visiting Consortium developed the *Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age* based on the Integrated Screening Tool developed by the Institute for Health and Recovery (IHR). (IHR's tool may be located online at www.mhqp.org/guidelines/perinatalPDF/IHRIntegratedScreeningTool.pdf. Virginia follows Bright Futures Guidelines (www.brightfutures.org/mentalhealth) as a framework for prevention and use of standardized screening tools. This tool incorporates the 4P's Plus, EPDS-3 and a Domestic Violence screening question. The 4P's Plus tool reliably and effectively screens pregnant women screened for substance abuse, including those women typically missed by other perinatal screening methods. The overall reliability for the 5-item measure was 0.62. Seventy-four (32.5%) of the women had a positive screen. Sensitivity and specificity was very good at 87% and 76% respectively. Positive predictive validity was low (36%) but negative predictive validity was high (97%). According to the author, "In an evaluation of clinical experience with the 4P's Plus, effective identification of pregnant women at highest risk for substance use can be accomplished within the context of routine prenatal care." (Chasnoff, et al., 2005)

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Population to be assessed	Caregiver (pregnant women)
Sampling Plan, if applicable	N/A All families included
Special Considerations	None
Data Collection Plan (Including schedule/how often)	All pregnant caregivers will be screened for alcohol, tobacco, and drug use using the BHRST. Baseline data results of the screen will be entered into the database, ongoing parent report on current use of tobacco will be collected at each visit and change will be captured in the online database.
Data Analysis Plan *(include plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed)*	Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: • Enrollment from the start of the project period • Families identified as pregnant at enrollment • Tobacco use as noted from enrollment data • Tobacco use at date 3 months from enrollment The calculation will be determined by dividing the total number of pregnant women who cease tobacco use within three months post-enrollment by the number of women enrolled prenatally who are using tobacco (at any intensity) at enrollment.

3) **Please describe the measurable outcomes of the program:**

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering the following domains: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Social Security Act, Title V, Section 511 (d) (1) (42 U.S.C. §701).

Highlights of the recent outcome data for Maine Families Home Visiting:

HEALTH AND DEVELOPMENT OUTCOMES (FY11)

- 99.8% of children have a primary care provider and 97.3% have health insurance.
- 93% are up to date with their well-child check-ups and their immunizations (20% higher than the Maine immunization rate).
- All age-eligible children are screened regularly for possible developmental delays (with parent permission). Seven percent of children on average are identified with possible delays and provided supports to help address those delays early before more costly remediation is needed in school.
- Of children exposed to second hand smoke, 39% are no longer exposed and 29% have reduced exposure, reducing their risk of developing respiratory and other related health issues.
- 94% of expectant mothers received adequate prenatal care (Maine rate 85%) resulting in fewer premature and low birth weight babies and saving significant related health care costs.

SAFETY OUTCOMES (FY10)

- 1% of children in the program were victims of substantiated abuse or neglect. (Maine rate 2.4%)
- Home Safety Assessment improved across all measures, with the largest impacts in fire prevention (23%), outdoor safety (38%) and car safety (27%).

PARENTS' REPORT OF POSITIVE CHANGE AS A RESULT OF PARTICIPATION:

- Child Development 99%
- Home Safety 98%
- Child Nutrition 98%
- Child Discipline 98%
- Car Seat Safety 96%
- Breastfeeding 91%
- Second-hand Smoke 92%

Fund for a Healthy Maine Fact Sheet

Office: MaineCare Services **Date:** 11/17/11

Program Title: Drugs for the Elderly

Account: 014-10A-Z01501

I. Program Description:

1) Overview of the program:
22 §254-D. ELDERLY LOW-COST DRUG PROGRAM was first adopted in 2005. Policy 10-144 Chapter 10 Section 2. DEL is funded by all state dollars and rebates from drug manufacturers. Part D became effective in 2006 and changed the program.

DEL provides prescriptions and nonprescription drugs, medication and medical supplies to disadvantaged, elderly and disabled individuals. The program is limited to drugs where the manufacturer has a DEL rebate agreement in place.

The program covers individuals who are disabled between the ages of 19-61. The members who are not yet eligible for Medicare (they must be disabled for 24 months) receive assistance with prescription medications, the State will pay 80% less $2 the member pays the rest. Members over 62 receive the same benefit until they receive Medicare.

The DEL program has a wrap benefit that assist members who have other insurance. This benefit follows the formulary of the plan or Medicare. The wrap will cover:

- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductable*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

*Part D plans are contracted by the state. The pharmacy unit will go through the RFP process and select qualified benchmark plans. We do an intelligent assignment where we look at a members drug profile and assign to a plan that best fits their needs. The average cost is $31 PMPM.

*Excluded drugs are drugs that do not have to be covered by the plan according to CMS, for example – benzodiazepine drugs are not required to be covered by a part D plan so this class of drug is considered excluded. The ACA has changed this so now there are no excluded drugs.

In 2006 when Part D started, DEL members were enrolled into Part D insurance

plans. Before part D the DEL wrap cost was nearly $13mil. This included all the items mentioned above. Part D premiums were roughly $6mil.

In April of 2007 the Department expanded the Medicare Savings program, this moved most DEL members to MSP. As an MSP member, individuals received additional benefits such as having the PART B premium paid, assistance with coinsurance and deductable, smaller copay's, no longer have a donut hole.

WRAP cost today are approximately $3.3mil and the part D premiums are roughly $500k annually.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

DEL Population per fiscal year

	2008	2009	2010	2011
DEL COMBO (DRUGS FOR THE ELDERLY COMBINATION)	5037	3796	3645	4022
DEL COMBO / QI, AGED	1553	2135	2847	2999
DEL ONLY (DRUGS FOR THE ELDERLY ONLY)			1	
DEL COMBO / QI, DISABLED / QI, BLIND	436	614	781	858
DEL COMBO / QMB - AGED	16795	18297	21114	21714
DEL COMBO / QMB - DISABLED / QMB - BLIND	5234	6444	7641	8537
DEL COMBO / SLMB - AGED	3726	4243	5217	5586
DEL COMBO / SLMB DISABLED / SLMB BLIND	1022	1215	1491	1664
DEL COMBO / SSI AND-OR STATE SUPPLEMENT (NO MEDICAID)	2			
	33805	36744	42737	45380

3) What is purchased with these funds:
The Wrap program:
- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductable*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

4) What is the service delivery (i.e. state personnel, contracted services, etc):
- Part D plans are contracted so that the Department can pay the members premium.
- Legal Services for the Elderly are contracted to provide appeal services for the population
- Goold Health Services is contracted to enroll members into Part D plans as well as participate in the billing process. DEL claims are transmitted through the MEPOPS program, TROOP is calculated, costs are avoided as with any other third party plan.
- Part B Premiums
- This account funds legislative membership in the National Legislative Association on Prescription Drug Prices (NLARx). Membership runs from July 1 through June 30. Executive Director of NLARx is Sharon Treat.

5) Department Program Staff:
Number of employees: _____ Cost of employees: $ _____

- Limited period positions ended in June 2011, no other personnel are paid from this budget.

II. Relevant Legislative History:

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund 014-Z01501	12,069,185	11,488,182	12,839,107	12,352,334	11,934,230	11,934,230
General Fund or Other Special Revenue 010-020201 014-020201 010-092701 014-092701	2,788,244 534,559 18,000 209,310	3,982,679 677,555 18,000 257,193	1,176,556 0 151,979 4,843	6,530,197 0 48,275 118	4,462,786 0 0 135,736	4,462,786 0 0 135,736
Federal Funds						
Total	15,619,298	16,423,609	14,172,485	18,930,924	16,532,752	16,532,752

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:

Part B premiums: 73.67%
$13,129,639
64.85% 014-18F-092101 - Tobacco Settlement
35.15% 014-18F-092102 - Slots (Racino)

All Other DEL: 26.33%
FHM - $4,691,958

IV. Program Eligibility Criteria:

Members with disability who are not eligible for Medicaid, QI, QMB and SLMB members receive the WRAP benefit.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☐ No
If yes, please explain:

Note: I would say yes to this because we can't roll back the MSP this is a violation of the MOE. We can eliminate the DEL only portion of the program.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:
Provide assistance to the Elderly and Disabled to receive drugs.

2) Please describe how the outcomes are measured:

Note: we have never measured the program

3) Please describe the measurable outcomes of the program:

Fund for a Healthy Maine Fact Sheet

Office: Office of Substance Abuse **Date:** 11-17-11

Program Title: FHM - Substance Abuse

Account: 01414G094801

I. Program Description:

1) Overview of the program: The Maine Office of Substance Abuse is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, treatment, and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

The Prevention, Intervention, and Treatment Services all receive funds from the Fund for a Healthy Maine.

Prevention Services are evidence based curriculum driven services that are provided to youth in school and community settings though 9 prevention contracts. On average the FHM funds 30% of the total amount of these contracts.

Data collection and performance monitoring of Prevention contracts is provided through the KIT Solutions contract who provide OSA Web-based Monitoring and Reporting System. FHM fund 16.5% of the KIT Solutions contact. This also provides prevention data required by OSAs SAMHSA Substance Abuse Prevention and Treatment Block Grant.

OSA contracts with the Maine Association of Substance Abuse Programs to fund Maine's Higher Education Alcohol Prevention Partnership (HEAPP). HEAPP is a prevention initiative collaboratively developed between the Maine Office of Substance Abuse and many of Maine's colleges and universities which aims to reduce college students' high-risk alcohol use and its impact upon individuals, campuses, and communities statewide. Forty percent (40%) of the budget is funded by the Fund for Healthy Maine which is supported with tobacco settlement dollars. Approximately 50% of HEAPP's operating budget supports mini-grants to colleges/universities for the implementation of evidence-based substance abuse prevention, early intervention, and enforcement strategies.

Intervention services provided with partial funding of is the Prescription Monitoring Program contract with PMP Web Portal Company Health Information Design at approximately 39% of this contact. Treatment Services provided primarily during SFY 12 for the provision of Substance Abuse Residential Treatment statewide.

Treatment services that are provided through 9 contracts funded in part with FHM include primarily Substance Abuse Residential Services, but may also include Outpatient, and Intensive Outpatient Services. The percent of FHM funds in these ranges from

2) Who is served with these funds (i.e. # of people, # of programs, etc):

Prevention Programs: 1925 participants in 18 recurring evidence based curriculum prevention programs provided by 13 Prevention Provider Agencies. These same agencies

with this funding provided outreach to 4296 people through single events, meetings, media campaigns, etc. and disseminated 1430 prevention materials.

HEAPP works to bring about long-term, systemic change in how high-risk drinking and other substance abuse issues among Maine college/university students are addressed at both the state and local level. All the Strategies and activities of the statewide initiative aim to engage all colleges and universities in Maine that are interested in addressing underage and/or high-risk student drinking so that the non-campus specific environmental factors and capacity for evidence-based prevention may be improved.

Intervention Program: The Prescription Monitoring Program is to assist all Mainers; however access is limited and falls under the PMP rules. Pharmacists, prescribers and their medical assistants can access the system for information regarding their own patients, and prescribers can download a list of all prescriptions attributed to them. Medical Assistants Licensing boards may use the information for investigations they are conducting. Law enforcement officials can access the data only through the Attorney General's Office by grand jury subpoena for a case they are currently investigating. MaineCare's Program Integrity Unit has access for fraud investigations. The Office of the Chief Medical Examiner is allowed access for cause of death determination in their investigations. Individuals may come to Augusta to receive information about themselves up request.

Treatment Programs: Individuals who have a substance abuse or dependence diagnosis or those individuals who are affected by another's use (affected other). These funds during SFY 12 were primarily used for the provision of Substance Abuse Residential Treatment Services. In 2011, 538 clients received treatment services in part with this funding combined with other funds through the continuum of services.

3) What is purchased with these funds:

Prevention: Evidence based curriculum driven services to youth in school and community settings. These are programs that are aimed at youth 12 – 18 that are at risk of substance abuse. KIT Solutions performance based monitoring system for Block Grant reporting and OSA contract monitor and reporting. HEAPP: Maine University and College campuses self-selecting to implement the local component of the HEAPP program receive mini-grants to develop/enhance campus-community coalitions to assess and plan evidence based substance use prevention efforts.

Intervention: Funds part of the PMP contract with Health Information Designs the developer of the electronic prescription monitoring system that Maine uses.

Treatment Services: Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted Community Providers statewide.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History: Allocations of the Fund for Healthy Maine for Substance abuse prevention and treatment are stated in Maine Statute Title 22 §1511. Fund for a Healthy Maine established, 6. Health purposes. Allocations are limited to the following health-related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [1999, c. 401, Pt. V, §1 (NEW).]
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [1999, c. 401, Pt. V, §1 (NEW).]
C. Child care for children up to 15 years of age, including after-school care; [1999, c. 401, Pt. V, §1 (NEW).]
D. Health care for children and adults, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
F. Dental and oral health care to low-income persons who lack adequate dental coverage; [1999, c. 401, Pt. V, §1 (NEW).]
G. Substance abuse prevention and treatment; and [1999, c. 401, Pt. V, §1 (NEW).]
H. Comprehensive school health and nutrition programs, including school-based health centers. [2007, c. 539, Pt. IIII, §3 (AMD).]

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	**SFY09 Actual**	**SFY10 Actual**	**SFY11 Actual**	**SFY12 Budget**	**SFY13 Budget**
FHM Fund	$6,374,744	$6,349,924	$6,351,468	$4,919,385	$3,286,345 **($2,028,679 – 094801;** $1,257,666 – 094802)	TBD
General Fund or Other Special Revenue	$11,445,840 $697,455	$10,933,307 $744,874	$11,493,871 $643,297	$11,678,870 $667,782	$14,966,404	TBD
Federal Funds **SAPT -BG**	$5,428, 433 + $6,820,035	$5,942,379 + $6,512,077	$6,060,038 + $5,300,042	$1,412,778 + $6,415,223	$7,117,834 + $7,306383	TBD
Total	$30,766,507	$30,482,561	$29,904,455	$25,094,038	$32,647,255	TBD

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program for 2012: For 094801 = 6.21%; For 094802 = 3.85% Combined = 10.06%

IV. Program Eligibility Criteria:

Prevention Services: Provided by Substance Abuse Prevention Providers that are awarded through an RFP process. The programs that are funded are evidence based. Providers through the RFP process need to state the need for the program and the populations that they will be serving based on the identified need. Some services may be prevention support services as the

KIT Prevention system are needed for data collection for Block Grant requirements, but also help in monitoring and reporting the work being provided.

Intervention Services: The Prescription Monitoring program contract with Health Information Design was awarded through an RFP process and use of the PMP Electronic system is limited to prescribers and dispensers that are registered through the PMP.

Treatment Services: Individuals must be diagnosed with a substance abuse or dependence disorder or be an individual affected by another's use of substances.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? X Yes ☐ No
If yes, please explain:

These funds are part of state funds that are used in the Maintenance of Effort Requirement for the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that Maine's receives annual. This funding helps to ensure that Maine receives its maximum amount of SAPT BG allotment available for Substance Abuse Prevention and Treatment programs.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

Prevention: To prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.

Intervention: The primary goals of the Prescription Monitoring Program are to reduce the quantity of controlled substances obtained by fraud from doctors and pharmacies and reduce the adverse effects of controlled substance abuse. A secondary goal of the program is to assist investigators for the Maine Boards of Pharmacy and Licensure in Medicine, and other health care licensing boards, in the identification of prescription drug diverters.

Treatment: Works with the statewide provider network to assure access to a full continuum of quality treatment services and provides technical assistance to providers around program development, implementation, and best practices in alcohol and drug treatment programs.

2) Please describe how the outcomes are measured:

Prevention: Prevention services are tracked in the Web-based KIT Prevention System and the outcomes that are developed are specific to each Contracted Provider and the evidence-based program that they are implementing and the outcomes that the program is designed to address. Quarterly narrative and fiscal reports are used to monitor progress on deliverables and outcomes.

Intervention: Through the HID contract the outcomes are met through the deliverables of HID. Here are some of the outcomes and deliverables of an extensive list: Collection of Schedule II, III, and IV drug data from dispensers; Creating editing processes for the importing of the pharmacy data to aid in the cleaning of the data to ensure it is as accurate

and complete as possible; development of a secure database to manage the data collected from the pharmacies; loading of the pharmacy data into the database must take place at least once a week; programming, development, and mailing of at least three sets of notification reports that will show unacceptable thresholds of prescription use on a variety of levels.

Treatment: A combination of compliance and outcome measures via the treatment data system database. In addition, OSA staff (assigned responsibility for contract oversight, management, and technical assistance) conduct site visits, work with the Division of Licensing and Regulatory Services and the Office of Maine Care services to ensure quality programming is occurring.

3). Please describe the measurable outcomes of the program:

Prevention: The outcomes are based on addressing risk and protective factors that and in turn changes in attitudes, behaviors, and prevalence rates of use of substances. The outcomes are measured through program level surveys, local level surveys, or surveillance surveys depending on the reach and impact of the program and availability of data. An example of a long term outcome is: By the end of the academic year, 75% of SIRP participants will report a decrease in their frequency and/or quantity of their use of alcohol, tobacco, and other drugs. This will be measured by the pre-survey and the 90-day survey.

Intervention: The PMP has the following board outcomes that the HID contract assists in meeting: Accurate background information on a new patient can be obtained. Current patients can be monitored. Threshold reports provide warnings on patients who may be misusing or diverting prescription drugs and can assist prescribers in coordination of care. Reports are automatically sent to prescribers when threshold numbers of prescribers and pharmacies have been reached or exceeded by a patient during a given quarter. Contract specific outcomes and deliverables are monitored by the PMP Coordinator to ensure that deliverables are being met by HID.

Treatment: (Collect data that is ultimately reflected in the National Outcome Measures and per SAPTBG Statutory requirements regardless of payer source)

Outpatient

- Time from first call to first face to face: 5 days
  Time to first treatment appointment: 14 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Intensive Outpatient

- Time from first call to first face to face: 4 days
- Time to first treatment appointment: 7 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Tracking measures:

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem

- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment

Referral to Mental Health Services

Substance Abuse Residential Programming:

There are varying levels of residential care (LOC) based on medical necessity. There are also population specific measures. The most common indicators are below with minimum standards set for each based on LOC and population

PERFORMANCE INDICATORS

Abstinence/drug free 30 days prior to discharge
Reduction of use of primary substance abuse problem
Employability
Participation in self-help during treatment
Referral in the Continuum of Care
Completed Treatment

TRACKING ONLY

Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement
Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine program effectiveness, as this may be requested by OSA.

Fund for a Healthy Maine Fact Sheet

Office: Office of Substance Abuse **Date:** 11-17-11

Program Title: FHM - OSA Medicaid Match

Account: 01414G094802

I. Program Description:

1) Overview of the program: The FHM- OSA Medicaid Match is a portion of the budget that OSA has obligated under the Office of Maine Care Services for the provision of the continuum of substance abuse services statewide. These services include Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management.

2) Who is served with these funds (i.e. # of people, # of programs, etc): The number represented here is the number of people served through Medicaid Funding (combined General Fund and FHM. We cannot delineate which individuals were served by just one funding source or another). In SFY 11 individuals served in the treatment continuum were 6,923. Please note that this was collected via Treatment Data System (TDS) database. The accuracy is contingent upon providers putting in the required data.

3) What is purchased with these funds: Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management.

4) What is the service delivery (i.e. state personnel, contracted services, etc): As with Maine Care State Plan Services, it is community based "any willing provider", who is licensed and qualified to provide the service. As of 11/15/11 there were 50 known agencies able to bill Maine Care. There are no direct service state personnel.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History: Allocations of the Fund for Healthy Maine for Substance abuse prevention and treatment are stated in Maine Statute Title 22 §1511. Fund for a Healthy Maine established, 6. Health purposes. Allocations are limited to the following health-related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [1999, c. 401, Pt. V, §1 (NEW).]
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [1999, c. 401, Pt. V, §1 (NEW).]
C. Child care for children up to 15 years of age, including after-school care; [1999, c. 401, Pt. V, §1 (NEW).]
D. Health care for children and adults, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
F. Dental and oral health care to low-income persons who lack adequate dental coverage; [1999, c. 401, Pt. V, §1 (NEW).]
G. Substance abuse prevention and treatment; and [1999, c. 401, Pt. V, §1 (NEW).]

H. Comprehensive school health and nutrition programs, including school-based health centers. [2007, c. 539, Pt. IIII, §3 (AMD).]

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund	$6,374,744	$6,349,924	$6,351,468	$4,919,385	$3,286,345 ($2,028,679 – 094801; **$1,257,666 – 094802**)	TBD
General Fund or Other Special Revenue	$11,445,840 $697,455	$10,933,307 $744,874	$11,493,871 $643,297	$11,678,870 $667,782	$14,966,404	TBD
Federal Funds **SAPT -BG**	$5,428, 433 + $6,820,035	$5,942,379 + $6,512,077	$6,060,038 + $5,300,042	$1,412,778 + $6,415,223	$7,117,834 + $7,306383	TBD
Total	$30,766,507	$30,482,561	$29,904,455	$25,094,038	$32,647,255	TBD

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program for 2012: For 094801 = 6.21%; For 094802 = 3.85% Combined = 10.06%

IV. Program Eligibility Criteria: Individuals must be diagnosed with a substance abuse or dependence disorder or be an individual affected by another's use of substances.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: These funds are part of state funds that are used in the Maintenance of Effort Requirement for the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that Maine's receives annual. This funding helps to ensure that Maine receives its maximum amount of SAPT BG allotment available for Substance Abuse Prevention and Treatment programs.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

Treatment: Works with the statewide provider network to assure access to a full continuum of quality treatment services and provides technical assistance to providers around program development, implementation, and best practices in alcohol and drug treatment programs.

2) Please describe how the outcomes are measured: A combination of compliance and outcome measures via the treatment data system database. In addition, OSA staff (assigned responsibility for contract oversight, management, and technical assistance) conduct site visits, work with the Division of Licensing and Regulatory Services and the Office of Maine Care services to ensure quality programming is occurring.

3) Please describe the measurable outcomes of the program: (Collect data that is ultimately reflected in the National Outcome Measures and per SAPTBG Statutory requirements regardless of payer source)

Outpatient

- Time from first call to first face to face: 5 days
  Time to first treatment appointment: 14 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Intensive Outpatient

- Time from first call to first face to face: 4 days
- Time to first treatment appointment: 7 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Tracking measures:

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
  Referral to Mental Health Services

Substance Abuse Residential Programming:

There are varying levels of residential care (LOC) based on medical necessity. There are also population specific measures. The most common indicators are below with minimum standards set for each based on LOC and population

<u>INDICATOR</u>
Abstinence/drug free 30 days prior to discharge
Reduction of use of primary substance abuse problem
Employability
Participation in self-help during treatment
Referral in the Continuum of Care
Completed Treatment

<u>TRACKING ONLY</u>

Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement

Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine program effectiveness, as this may be requested by OSA.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** 11/17/11

Program Title: FHM - Oral Health

Account: 01410A095301

I. Program Description:

1) Overview of the program:
   a. Dental Services Subsidy Program ($350,000): subsidizes dental care provided at nonprofit clinics to low income patients who have no insurance.
   b. School Oral Health Program ($250,000): provides funds to schools based on community risk guidelines for classroom education, fluoride mouthrinse, and dental sealant application.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
   a. In SFY 12, 6 contracted organizations provided dental services at 12 sites. In FY 10, 13 organizations participated, with over 33,700 dental services provided at 18 locations to an estimated 18,407 individuals. In FY 11, at 19 locations, they provided just under 37,000 dental services to 19,259 people.
   b. In SFY 11 (the 2010-11 school year), 77 school districts funded to reach 23,248 children in grades K-4 participating in over 230 schools; of these children 75% participated in the mouthrinse program. In SFY 10, there were 30,514 children in grades K-6 participating in over 230 schools; of these children, 74% participated in the mouthrinse program. In all years, about half of participating schools are funded to offer dental sealants to second graders; over the past several years, the average number of children served has been about 1000 with each child receiving an average of 3.3 sealants.

3) What is purchased with these funds:
   a. Dental Services Subsidy Program: provides a subsidy or offset to eligible community organizations providing care to eligible individuals (who have no insurance for dental care and are low-income (below 200% of the Federal Poverty Level).
   b. School Oral Health Program: provides funds to schools and school districts based on community risk guidelines to assist them to implement classroom-based oral health education programming in grades K-6, a weekly fluoride mouthrinse program in grades K-4 (cut back from K-6), and a dental sealant program for second-graders. Washington and Aroostook counties have been a priority for funding.

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted (state personnel oversee contracts.)
   a. Dental Services Subsidy Program: contractors provide detailed invoices that document care provided to eligible individuals and are paid accordingly within the limits of funds allocated to this program.
   b. School Oral Health Program: schools and community agencies are contracted to provide program components.

5) Department Program Staff:
   Number of employees: none Cost of employees: $ N/A

II. Relevant Legislative History:
   a. Dental Services Subsidy Program: was established by legislation in 1999/2000 (22 MRSA § 2127) and rules (10-144, ch 295) with initial funding in 2001. $350,000 annually is the present funding amount; no other sources of funds pay for this service.

b. School Oral Health Program: funding first authorized by the Dental Education Act in 1975.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget (reflects all funds used by OHP):

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	1,043,143	991,953	927,453	925,047	600,000	600,000
General Fund or Other Special Revenue	358,608	365,622	396,905	92,000	94,980	94,980
Federal Funds	515,761	884,574	994,189	1,274,141	753,630	473,630
Total	1,917,512	2,242,189	2,318,547	2,291,188	1, 448,610	1,168,610

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 41.4% in current year (FY 12). All sources remaining equal, this will be 51% in SFY13.

IV. Program Eligibility Criteria:

a. Dental Services Subsidy Program: Community-based dental clinics are eligible to participate, within the limits of existing funds. They may choose not to; they must be able to meet program reporting requirements, see MaineCare eligible patients, and offer dental services on a sliding fee scale. Patients for whom a subsidy is claimed must have no insurance for dental care and be low-income (below 200% of the Federal Poverty Level).

b. School Oral Health Program: eligibility is determined at the school or community level. School eligibility is determined based on the proportion of students eligible for the Free & Reduced Lunch Program and the extent of fluoridated public water as primary factors; it is thus directed to schools where children are more likely to have problems getting dental care, since socio-economic status is directly related to the ability to obtain that care. Grants are made according to a per capita funding formula, within the limits of funding.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes X No
If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

a. Dental Services Subsidy Program: to offset the costs of providing essential dental care to low-income uninsured individuals (mostly adults) receiving care at community-based dental clinics. The legislative intent for this program was to facilitate access to dental care for such individuals by helping to keep sliding fee scales affordable.

b. School Oral Health Program: to provide oral health education and primary dental disease prevention services in elementary schools assessed to represent children at highest risks of having untreated dental disease and less ability to access the dental care system.

2) Please describe how the outcomes are measured:

a. Dental Services Subsidy Program: contractors report the numbers of individuals seen, the numbers of patient visits and the numbers of services provided.
b. School Oral Health Program: the Maine Integrated Youth Health Survey includes dental screenings and by a random sample includes some participating schools; schools provide screening data to the Oral Health Program along with data describing participation in the fluoride mouthrinse and dental sealant components of the school-based programs.

3) Please describe the measurable outcomes of the program:
   a. Dental Services Subsidy Program: contractors document the numbers of patients seen whose care is facilitated by this funding.
   b. School Oral Health Program:
      1) The Maine Integrated Youth Health Survey indicated the following:
      - In 2009, 18.2% of kindergarten students and 29.5% of 3rd graders had tooth decay, compared to 31.4% of grade K and 44.7% of the 3rd graders in 1999.
      - The proportion of Maine 3rd grade students with dental sealants has increased from 47% in 1999 to 61% in 2009.
      2) Reports from participating schools have documented improvements in the oral health of children in their communities.

4) Total funds for Oral Health:

FHM: funds major portions of the program carried out by staff and contracts.

- School Oral Health Program ($250,000): provides funds to schools based on community risk guidelines for classroom education, fluoride mouthrinse, and dental sealant application
- Dental Services Subsidy Program ($350,000): subsidizes dental care provided at nonprofit clinics to low income patients who have no insurance
- Donated Dental Services ($38,463): funds a contract to support a program that connects patients to dental offices that donate their services free for disabled or elderly with no other means

State General Fund:

- Supports program administration ($21,684) including rent, etc. for 2 FTEs.
- Match for Maternal Child Health Block Grant: $48,296 supports program administration and some of the School Oral Health Program component.

State Special Revenue - $25,000 (ME School Oral Health Fund) – supports screening and coordination component in several School Oral Health Program contracts.

Federal Funds:

- Federal CDC - $374,354 for the project year July 31, 2011- July 30, 2012. No match required. Supports 2.0 FTE and associated costs, to administer the program and 0.5 FTE in Drinking Water Program to work on quality assurance in water fluoridation. This grant also pays for epidemiology services, program evaluation assistance, and program coordination.
- Federal HRSA, MCH Block Grant - $99.276 supports 1.84 FTE (Division's FHM pays for .16 FTE)
- Federal HRSA, Bureau of Health Professions: $280,000 in SFY12 (grant ends 8/31/12) support dental workforce development initiatives: dental education loan repayment and dental equipment revolving loan programs at FAME.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control **Date:** 11/17/2011

Program Title: Tobacco Prevention, Control & Treatment

Account: 01410A095302

I. Program Description:

1) Overview of the program:

The program was established in statute in 1997 to prevent youth from ever using tobacco and assist youth and adults who currently smoke and use other tobacco products to discontinue use as well as to protect people from secondhand exposure. The purpose is to eliminate the health and economic burden of tobacco use using a mix of educational, clinical, regulatory, and social strategies.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

All of Maine's citizens are affected by program initiatives. This is a comprehensive program that educates and motivates youth and adults not to smoke using a full range of media, as well as educating citizens on dangers of secondhand smoke.

- Provides tobacco cessation counseling and medication for those who use tobacco.
- Provides cessation training to multiple classes of providers, offering academic detailing and continuing education credits.
- Assists retailers to support access to tobacco laws affecting youth.
- Increases awareness of dangers of secondhand smoke, supports policies to create smoke free areas and support for compliance with smoke free laws.

3. What is purchased with these funds: **See answer for Q4**

4. What is the service delivery (i.e. state personnel, contracted services, etc):

Most of program services are contracted:

a. Public Education, Communication, and Media: $1,800,000

These funds support multiple educational interventions using a wide variety of media:

- Research-driven and tested messages to counter Tobacco Industry advertising
- Educational and motivational materials for distribution to schools, healthcare providers, and members of the public
- Materials that assist population groups who are disproportionately affected by tobacco use
- Messages and materials to raise awareness about the availability and effectiveness of the tobacco treatment and the Maine Tobacco HelpLine
- Youth-directed counter-marketing messages to prevent beginning to use tobacco
- Materials and training to support local community and school efforts

b. Tobacco Treatment and Medications $2,600,000

The Maine Tobacco HelpLine provides outreach and support for those who want to quit tobacco use. Trained counselors work with callers by phone. The contract also provides training for healthcare providers and tobacco treatment specialists on how to assist those who want to quit. Medications are provided to eligible participants who do not have insurance coverage –nearly doubles quit rate to use medications.

c. Evaluation – $500,000

Contractors monitor program activities, assess efforts and provide performance data to make programs and initiatives more effective. The program helps support two major

surveys (contracted) used by state, community and private organizations to monitor and evaluate health-related programs.

d. Enforcement and Compliance $150,000

Enforces workplace, public place and tobacco retail laws. Supports training for retailers and their personnel to better meet compliance..

5. Department Program Staff:

Number of employees: 7 staff Cost of employees: $580,050 for SFY2012

2 Partnership For A Tobacco-Free Maine – public health educators

3 Physical Activity, Nutrition, Healthy Weight Program, program manager and 2 health planners

1 Cardiovascular Health Program – public health educator

1 Division of Population Health – office manager

II. Relevant Legislative History: Tobacco Prevention and Control Program was established in statute by Title 22, Subtitle 2, Part 1, Chapter 102 (PL 1997, c. 560, PT, D, Section 2) 272. Laws related to public place and workplace smoking and smoke exposure and in Title 22 for DHHS to enforce.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund						
Personal Services	262,951	262,459	443,322	538,391	580,050	599,379
All Other	5,992,203	6,466,853	6,569,657	4,412,244	5,822,030	5,822,114
Total	6,255,154	6,729,312	7,012,979	4,950,635	6,402,080	6,421,493

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 85%. Federal CDC provides 15% of funding annually. This grant requires a 1-4 match. One-time awards under ARRA and ACA provided extra funds, mainly for the Helpline.

IV. Program Eligibility Criteria:

The state's HelpLine/Quitline is available to any Maine resident who wishes to use its services. People who are ready to quit within 30 days are eligible for the multi-call program. Multi-call program participants who are over 18 years old can receive up to three months of Nicotine Replacement Therapy (NRT) at no cost provided they pass a medical screen and do not have insurance that covers NRT

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes x No

If yes, please explain:

IV. Goals & Outcomes of the program:

1. Please describe the goals of the program:
   a. Prevent initiation among young and young adults
   b. Promote quitting among adults and youth

c. Eliminate exposure to secondhand smoke
d. Identify and eliminate tobacco related disparities among population groups

2. Please describe how the outcomes are measured:
Long-term outcomes are measured by indicators tracked by the state adult and youth surveys, which the program contributes funds to support.

3. Please describe the measurable outcomes of the program:

Outcomes: Data points tracked over time –top level, other data is tracked.
Youth smoking High School 18% in 2009, YRBSS; high of 39% in 1997
Smoked a Cigarette before age 13 (HS) 12% 2009, YRBSS; high of 30% in 1997

Adult smoking 18% in 2010, BRFSS; high of 25% in 1995
Young adult (age 18-24) Smoking 23% in 2010, BRFSS; high of 35% in 1996

Other relevant data:
Former smokers in population – 30% in 2010, BRFSS
Attempted to quit in past 12 months among smokers:
Adults – 59% 2010, BRFSS
High School youth – 44% 2010,BRFSS

Rules for no smoking in home (adults age 18+) – 83% in 2010
Hours exposed to any smoke at work in a week (adults age 18+) – 18 hours average exposed in 2010, BRFSS
Seen people smoking on school grounds (adults age 18+) – 14% saw smoking in 2010, BRFSS

MaineCare population smoking rate (adults age 18+) – 42% 2009, BRFSS
Maine tribes smoking rate 44% (average 2005,2006 BRFSS)

Women Smoking (adults age 18) rate 17% 2010, BRFSS
Pregnant Women who smoke (adults age 18) 21 %, 2009, PRAMS
MaineCare Pregnant women who smoke(adults age 18) 36% 2009, PRAMS

Smoking rates by Education:
Less than High School – 35% 2010, BRFSS
High School (HS) or GED – 26% 2010, BRFSS
Some post HS – 20% 2010, BRFSS
College Grad – 7% 2010, BRFSS

4. Total Funds for Tobacco Program:

FHM funds major portions of the tobacco prevention and control program that are carried out by staff and through contracts. Initiatives include youth prevention, tobacco cessation and treatment, and preventing exposure to secondhand smoke (which includes enforcement of state laws related to workplace, public place and retail sales laws).

Staff – FHM covers 2 FTE tobacco prevention and control program Health Educator positions who implement evidence-based interventions to decrease tobacco use initiation, increase cessation, and protect people from second hand smoke.

PTM does not receive any General Funds; the only state funds received are FHM.

Federal Funds:

- Federal CDC grant - about $979,248 annually. Requires a 1-4 match; the grant pays for 6 program staff and 2.15 Division cross program positions.
- Federal CDC ARRA grant - $548,000 one-time funds; 2 year period ending February 2012; enhanced Helpline outreach.
- Federal CDC ARRA grant - $49,753 one-time funds; ending February 2012.
- Federal CDC ACA grant - $53,098 one-time funds; 2 year period ending September 2012 to learn more about MaineCare member motivation to quit smoking.
- Federal FDA grant - $701,299 annually (Oct. 1-Sept. 30) to support FDA tobacco retail regulations in the state. No state related work can be done under this money from FDA.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control and Prevention **Date:** November 17, 2011

Program Title: Community/School Grants & State-wide Coordination

Account: 01410A095307

There are several content areas covered in this allocation. Each content area is broken out into a letter. For instance, a in each section refers to Division of Local Public Health, b refers to Healthy Maine Partnerships, etc.

I. Program Description:

1) Overview of the program:
   a) Positions for Division of Local Public Health to support Maine's Public Health Districts and associated seat costs
   b) Healthy Maine Partnerships, 26 local Comprehensive Community Health Coalitions that focus on tobacco, obesity, and chronic disease
   c) Tribal Public Health District (District Liaisons and Healthy Maine Partnership)
   d) School Based Health Centers
      The Department has funded SBHCs since 1987. SBHCs educate youth about: healthy/unhealthy behaviors and how that will affect their future health; appropriate use of the health care system (i.e. not using the ER for non emergency care, etc.); preventive care such as routine exams, immunizations and anticipatory guidance; and they provide screening, including a health risk assessment, and early intervention for adolescents for both physical and behavioral health issues.
   e) Prevention initiative to address obesity in youth
2) Who is served with these funds (i.e. # of people, # of programs, etc):
   a) Entire population of Maine
   b) Entire population of Maine
   c) All Tribal members of Maine's Tribal nations
   d) Eight organizations are funded and operate 16 SBHCs across Maine. Annually, approximately 7,000 students (3/4 high school and ¼ middle school/junior high) are enrolled in school-based health centers.
   e) Entire population of Maine
3) What is purchased with these funds:
   a) Approx .3 FTE of salaries for 5 District Liaisons and 1 Office Director in the Office of Local Public Health (2.34 FTE)
   b) (26) HMPs across Maine work to assist local communities, schools, organizations and businesses in changing policies and creating community environments that support healthy behaviors and healthy lifestyles
   c) (2) Tribal Liaisons and (1) Tribal HMP Director
   d) School-based, physical and mental health services and program evaluation and quality improvement service
   e) Education and training for obesity prevention and control in children

4) What is the service delivery (i.e. state personnel, contracted services, etc):
   a) State personnel for Division of Local Public Health
   b) Contracted services for 26 Healthy Maine Partnerships
   c) Contracted personnel for 1 Tribal District
   d) Contracted services in 16 School Based Health Centers
   e) Contracted services for one Prevention Research Center, located at the University of New England, Center for Community and Public Health

5) Department Program Staff:
Number of employees: 2.34 FTE Cost of employees: $ 315,000

II. Relevant Legislative History:
Maine State Law: Title 22; § 411 – 412 defines and establishes multiple public health structures to enhance the delivery of public health services across Maine. Included in in the statute are the State Coordinating Council, District Coordinating Councils, Tribal District, the Healthy Maine Partnerships, and District Public Health Units. This applies to sections a), b), and c). No legislation applies to sections d), and e).

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$9,345,000	$9,182,000	$8,489,745	$7,876,458	$7,777,979	$7,788,922
General Fund or Other Special Revenue	a) 0 d) 223,915	a) 233,863 d) 223,915	a) 379,923 d) 219,945	a) 368,056 d) 232,013	a) 442,153 d) 232,013	a) 442,153 d) 223,013
Federal Funds	a) 0 b) USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .156 b) USDA - $.3 CDC Asthma $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .248 b)USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c)CDC CVH - $.05 d) 0 e) 0 f) 0	a) .296 b) USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .330 b) USDA - $.3 CDC Asthma - $.016 OSA BG - $.08 c) CDC CVH - $.05 d) 0 e) 0	a) .300 b) USDA - $.3 Asthma - $16,00 OSA BG - $.08 c) CDC CVH – $.05 d) 0 e) 0
Total						

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:
a) 29%
b) 88%
c) 86%
d) 66%
e) 100%

IV. Program Eligibility Criteria:
a) Positions for Division of Local Public Health - None
b) Healthy Maine Partnerships - Must be a designated Healthy Maine Partnership to receive these grant funds; awarded through a competitive process that identifies necessary characteristics to receive funding.

c) Tribal Public Health District – Tribal member
d) School Based Health Centers - High school or middle school/junior high students whose parents enrolled them in the SBHC
e) Initiatives to address obesity - NA

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☒ No

If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:
   a) Oversee and Coordinate the local Public Health infrastructure
   b) 1. Ensure that Maine has the lowest smoking rates in the nation;
      2. Prevent the development and progression of obesity, substance abuse, and chronic disease related to or affected by tobacco use;
      3. Optimize the capacity of Maine's cities, towns and schools to provide health promotion, prevention, health education and self-management of health;
      4. Develop and strengthen local capacity to deliver essential public health services across the state of Maine.
   c) Provide and coordinate public health services to Maine's Tribal members
   d) The overarching goal is to improve access to healthcare for adolescents, a population that historically does not receive preventive health care through the traditional health care system. This provides a health safety net. Identify tools and practices that are effective in addressing the fight against obesity
   e) The goal is to increase physical activity, improve nutrition and reduce overweight and obesity in Maine. The contractor provides evidence-based strategies, training and technical assistance, and evaluation support to the Healthy Maine Partnerships as well as to other communities, partners and organizations.

2) Please describe how the outcomes are measured:
   a) Quarterly reports on work plan deliverables are received and reviewed by staff; site visits are held annually.
   b) Quarterly reports on work plan deliverables are received and reviewed by staff; site visits are held annually.
   c) Quarterly reports on work plan deliverables are received and reviewed by staff; attendance at tribal meetings.
   d) SBHCs provide us with data twice a year, which is compiled, analyzed and monitored for the results. Baselines are established at the start of the competitively bid contract and we look for continuous improvement in subsequent years
   e) Quarterly reports on workplan deliverables are received and reviewed by staff; staff also participate in quarterly meetings

3) Please describe the measurable outcomes of the program:
   a. Completion of local Public Health Improvement Plans and District Public Health Improvement Plans in each Public Health District
   b. Highlights of a recent evaluation report of the 26 Healthy Maine Partnerships include:
      - Worked with 884 employers to promote the services offered through the Maine Tobacco HelpLine.
      - Collaborated with 84 hospitals, primary care offices & organizations to establish links with health care providers that connect patients to needed community resources for better management of their chronic diseases.
      - Provided resources and assistance to 148 community organizations to help increase opportunities for family-based physical activity.

- Developed policies/procedures that added an average of 20 minutes per day of physical activity for all students in the school.

c. Improved ability to serve Maine's tribes with community-based prevention activities.
d. Outcomes include (1) increasing the health knowledge, positive attitudes and skills for adolescents, (2) decrease risky health behaviors, including smoking, and risky sexual behavior, (3) increase healthy habits, including appropriate use of health care, good nutrition, physical activity, use of seat belt and helmets, and (4) help-seeking for behavioral health issues, particularly depression and suicidal ideation.
e. Highlights of recent accomplishments include:
    i. Completed case studies of schools in Maine that are exceptional in providing students with opportunities to by physically active throughout the school day.
    ii. Completed an evaluation report on the final year of the Maine Youth Overweight Collaborative involving more than 20 physician practices statewide on strategies to prevent and treat overweight and obese youth.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control and Prevention **Date:** November 17, 2011

Program Title: Public Health Infrastructure

Account: 01410A095308

I. Program Description:

1) Overview of the program: This program is part of the Healthy Maine Partnerships initiative and works to develop and strengthen local capacity to deliver key essential public health services across the state of Maine. In addition to this work, the account has been used in the past to fund (1) position dedicated to staffing the Maine Children's Cabinet.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
The entire population of Maine is reached through each of the public health districts.

3) What is purchased with these funds:
Local HMP coalition participation and contribution to the local public health infrastructure including the development of local and District Public Health Improvement Plans

4) What is the service delivery (i.e. state personnel, contracted services, etc):
Contracted services

5) Department Program Staff:
Number of employees: (1) FY 2010 and 2011 only
Cost of employees: Vacant position; no cost at this time

II. Relevant Legislative History: Maine State Law: Title 22; § 411 – 412 defined and establishes multiple public health structures to enhance the delivery of public health services across Maine. Included in in the statute are the State Coordinating Council, District Coordinating Councils, a Tribal District, the Healthy Maine Partnerships, and District public health units.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$1,267,008	$1,462,393	$1,365,572	$1,420,437	$1,366,802	$1,369,315
General Fund or Other Special Revenue						
Federal Funds						
Total	$1,267,008	$1,462,393	$1,365,572	$1,420,437	$1,366,802	$1,369,315

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 90%

IV. Program Eligibility Criteria: Must be a designated Healthy Maine Partnership to receive these grant funds; disbursed through an RFP process.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☒ No

If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program: Develop and strengthen local capacity to deliver essential public health services across the state of Maine.

2) Please describe how the outcomes are measured: Evaluation and monitoring through quarterly reports

3) Please describe the measurable outcomes of the program: Development of 26 Local Public Health Improvement Plans. Development of 8 District Public Health Improvement Plans

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** November 17, 2011

Program Title: Family Planning

Account: 01410A095601

I. Program Description:

1) Overview of the program: The FHM funds supplement the clinical family planning services that are purchased through Maine CDC and OCFS blended funding. The supplemental work that FHM supports focuses upon adolescent pregnancy prevention by providing training and professional development opportunities to teachers, school nurses, guidance counselors, school health coordinators and community-based organizations regarding puberty, adolescent development, and the delivery of age appropriate health and sexuality education to Maine youth. To supplement clinical services, teen pregnancy/STI prevention activities are targeted toward high teen pregnancy rate areas of the State that have hard-to-reach and vulnerable populations. Training on how to engage their communities in addressing the multiple factors that can play a role in teen pregnancy and sexually transmitted infections (STIs) is provided along with how to identify and implement evidence-based programs that have been proven effective. Print and web-based materials are made available to family and community members.

2) Who is served with these funds (i.e. # of people, # of programs, etc): Last year 8 schools/community-based organizations (CBOs) were served, reaching over 500 youth. 144 school and CBO staff participated in training and professional development opportunities. This does not include youth and staff served with federal PREP funding. Over 800 FACTS (Families And Children Talking About Sexuality) magazines were distributed to parents

3) What is purchased with these funds: What is the service delivery (i.e. state personnel, contracted services, etc): contracted services.

4) Department Program Staff: 0
Number of employees: _____ Cost of employees: $ _____

Relevant Legislative History: **(See funding table below) In FY09, the allocation for family planning within the Social Services Block Grant was reduced by $415,000. In response, the legislature approved a one-time increase within family planning's Fund for a Healthy Maine appropriation. In the FY10-11 biennium, the State Social Services line received a one-time increase of $300,000 per year, intended to offset the end of that one-time FHM increase. That increase does not affect the baseline funding and will not be carried into the FY 12-13 biennium.*

The State Purchased Social Services account also received a decrease in FY 08 due to a 4th quarter curtailment and a $90,000 one-time reduction in the FY10 Curtailment Order.

II. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	468,942	884,240*	448,183	425,061	401,430	401,430
General Fund:**						
SPSS	205,055	273,406	573,406	505,155	281,599	281,599
MCHBG match	285,843	285,843	306,843	329,965	306,843	306,843
Community FP	225,322	225,322	225,322	225,322	225,322	225,322
Federal Funds: ***						
SSBG	525,552	110,274	110,274	110,274	410,274	410,274
PREP					241,317	241,317
Total	1,710,714	1,779,085	1,664,028	1,595,777	1,866,785	1,866,785

* See above "legislative history"

** SPSS - State Purchased Social Services
MCHBG - Maternal and Child Health Block Grant
Community Family Planning

*** SSBG - Social Services Block Grant
PREP – Personal Responsibility Education Program

Note: SPSS and SSBG funds are administered by the Office of Child and Family Services, Maine DHHS, and blended with Maine CDC funding

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: average of 22% to 26%

III. Program Eligibility Criteria: Schools and CBOs statewide are eligible to participate. Parent information is available to anyone that requests it.

IV. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes **X** No
If yes, please explain:

V. Goals & Outcomes of the program:

1) Please describe the goals of the program: Increase knowledge, skills and attitudes around teen pregnancy and STI/HIV prevention. Increase understanding of evidence-based programs and how to select them based on community needs and how to implement them with fidelity. Support parents by enhancing their knowledge of sexual development and encouraging communication with their children around their health issues and healthy relationships. Provide on-line information for professionals, parents, adults and teenagers.

2) Please describe how the outcomes are measured: Baselines were established at the start of the contract period and we review reports to establish whether or not goals have been met. Pre and post surveys assess changes in knowledge, attitudes, skills and/or intended behaviors. Attendance at educational offerings. Tracking of materials distributed. Web hits and feedback received. A Grants Management Team meets regularly to monitor and evaluate efficiency and effectiveness of programs through reports, site visits and analysis of data.

3) Please describe the measurable outcomes of the program: Outcomes include 1) increasing the number of schools and CBOs selecting and implementing evidence-based approaches to preventing teen pregnancies and STIs, 2) increasing the knowledge, skills and comfort level of teachers and youth serving CBO staff in delivering comprehensive health and sexuality education to Maine youth, and 3) improving the knowledge, skills and attitudes of Maine parents, family members and community members around the issues of sexuality and reproductive health.

   For activities under this funding three objectives have been established and eleven activities will be implemented to meet those objectives. Reports will be reviewed twice yearly for compliance with contract commitments.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** 11/17/11

Program Title: FHM – Donated Dental

Account: 01410A095801

I. Program Description:

1) Overview of the program:
These dollars fund a contract with Dental Lifeline Network (National Foundation of Dentistry for the Handicapped) to administer a donated services program for those who are disabled or elderly and have no other means of paying for dental care.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
The DDS program coordinates care for elderly, disabled, and certain other medically needy/compromised individuals who have no insurance to cover dental care and meet the program's financial criteria. In SFY11, 102 patients were treated; of the 154 volunteer dentists enrolled in the program, 90 were involved with completed cases. There were 44 volunteer dental labs enrolled in the program (labs provide prosthetics such as dentures) and 24 of them were involved with completed cases. These numbers are typical of recent years as the DDS program has become more established.

3) What is purchased with these funds: The contract is used to support a part-time coordinator who matches clients with volunteer dental providers who donate their services and coordinates their care; it also helps offset some operational expenses. In SFY 11, the value of care to patients treated was $281,714 and the value of donated lab services was $22,857. The ratio of donated treatment per dollar of operating costs in SFY 11 was $7.11. Since its inception in 1999, the DDS Program has provided care to 873 patients with the total value of care to patients treated estimated to be $2.07 million.

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted

5) Department Program Staff:
Number of employees: none Cost of employees: $ N/A

II. Relevant Legislative History: Legislation was first submitted in 1999 to support a Donated Dental Services Program in Maine, in collaboration with the ME Dental Association (which solicits dentists to volunteer) and the National Foundation of Dentistry for the Handicapped. The initial contract may have been supported with a State General Fund allocation and was changed to the FHM (by legislative direction) when those funds became available. It was, and has remained, a separate budget item from other oral health allocations.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$42,562	$42,562	$40,654	$36,823	$36,463	$36,463
General Fund or Other Special Revenue	0	0	0	0	0	0
Federal Funds	0	0	0	0	0	0
Total	$42,562	$42,562	$40,654	$36,243	$36,463	$36,463

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 100%

IV. Program Eligibility Criteria: This program is open to disabled, aged, or medically at-risk individuals who have no insurance to cover needed dental care and have no other means.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes X No
If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program: Each year, the DDS program sets goals for the numbers of people to be seen and for whom treatment will be completed, as well as for the dollar value of contributed lab services. The DDS program is not a source of ongoing care; it provides a resolution for a defined problem and can only be utilized once by an individual.

2) Please describe how the outcomes are measured: The contractor provides quarterly reports that itemize patients according to the numbers of active cases, referrals, and patients treated; the numbers of applicants and pending applications; the numbers of volunteer dentists and dental labs and the numbers involved with completed cases; the value of care to patients treated; the average value of treatment per case; the value of paid and donated lab services; operating costs; and the ratio of donated treatment per dollar of operating costs.

3) Please describe the measurable outcomes of the program: See #2 immediately above. These figures are provided quarterly and annually and can be aggregated over the life of this program in Maine.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC Date: 11/17/11

Program Title: Maine Immunization Program

Account: 014-10A-Z04801

I. Program Description:

1) Overview of the program:
Several hundred people die every year in Maine from vaccine-preventable influenza and bacterial pneumonia. Influenza vaccine can prevent 60% of hospitalizations and 80% of deaths from influenza-related complications among the elderly. 23% of Mainers 65 and older in 2007 have not had a flu shot, and this is greatly improved from 36% in 1995. 29% of Mainers 65 and older in 2007 have not had a pneumonia shot, and this is greatly improved from the 65% in 1995.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
This funding for influenza and pneumococcal vaccines has supported purchasing these vaccines for employees and patients in long-term care facilities, patients served by health centers, Bangor and Portland public health clinics, hospitals, and uninsured individuals in private practices.

3) What is purchased with these funds:
About 90,000 doses of vaccines distributed to providers in multiple settings, including FQHCs & RHCs, Hospitals, Long-term care facilities, City/local public clinics, Adult and pediatric medical practices.

4) What is the service delivery (i.e. state personnel, contracted services, etc):
No personnel or contracted services are purchased with these funds.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History:
No legislative history directly relevant to the FHM funding or influenza vaccine.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	1,035,301	1,090,710	1,085,499	1,078,884	1,078,884	1,078,884
General Fund or Other Special	342,562	1,018,791	739,765	0	$7,000,000	12,000,000

Revenue						
Federal Funds	2,955,488	3,382,414	3,033,557	2,914,480	2,914,480	4,171,376
Total	4,333,351	5,494,915	4,858,821	3,993,364	10,993,364	17,250,260

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:
The Fund for a Healthy Maine makes up less than 10% of total funding to the Maine Immunization Program for combined vaccine purchase and operations (personnel, contractual and IT costs). However, the vast majority of funding to the program is directed specifically to pediatric vaccine, and no other funds specifically provide for the purchase of influenza and pneumococcal vaccines for adults. A single dose of influenza vaccine costs about $10, but when provided to a vulnerable person or in a susceptible setting, can prevent an institutional outbreak of influenza or prevent complications leading to hospitalization and possibly death. By comparison, the cost of a treatment course of oseltamivir (Tamiflu) costs over five times that amount, which does not include the cost of medical treatments or hospitalizations.

IV. Program Eligibility Criteria:
Vaccine purchased with FHM funds is made available to:

- Employees of schools that provide onsite vaccine clinics on school days
- Pregnant women and their partners (through health care providers who routinely care for pregnant women)
- Nursing home employees and residents
- Any Underinsured or Uninsured adult in any setting (if the patient's insurance does not cover vaccines or if the patient does not have insurance)
- All individuals served by Tribal health centers and Municipal Health Departments

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☐X No
If yes, please explain:

VI. Goals & Outcomes of the program:
1) Please describe the goals of the program:
The Maine Immunization Program strives to ensure full protection of all Maine children and adults from vaccine-preventable disease. Through cooperative partnerships with public and private health practitioners and community members, the MIP provides vaccine, comprehensive education and technical assistance, vaccine-preventable disease tracking and outbreak control, accessible population-based management tools, and compassionate support services that link individuals into comprehensive health care systems.

The goal of the Fund for a Healthy Maine immunization funds is to reduce the impact of respiratory infectons on the health of Maine people. We do this by providing access to influenza and pneumococcal vaccine to individuals or group settings where it can

provide the greatest benefit.

2) Please describe how the outcomes are measured:
The most appropriate measure of program effectiveness is state specific estimates of immunization rates. Immunization rates are estimated annually through public health surveys conducted across the United States.

3) Please describe the measurable outcomes of the program:
The number of people over age 65 who have not had a flu or pneumococcal vaccine in Maine has improved considerably since 1995.

	1995	2007	2009	2010
>65 w/o flu	36%	23%	27%	28%
>65 w/o pneumo	65%	29%	29%	28%

Fund for a Healthy Maine Fact Sheet

Office: Office of Child & Family Services **Date:** 11/17/11

Program Title: Head Start

Account: 014-095901; FHM- Head Start

I. **Program Description:** Eligible Maine children receive high quality, comprehensive early care and education services that foster children's growth and development by supporting and nurturing their social, emotional, cognitive and physical development. The primary mission has been to prepare children for success in school and local programs have worked hard to meet the rigorous standards in serving children and families.

1) **Overview of the program:** Provide a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education. Significant emphasis is placed on the involvement of families, as the program engages parents in their children's learning and helps make progress toward their own educational, literacy and employment goals. Eleven Head Start grantees in Maine are funded primarily through the federal Office of Head Start. Three additional Head Start programs are funded by the Tribal Office of Head Start and are managed by the Passamaquoddy, Micmac and Maliseet tribes within their communities. Head Start provides early care and education, as well as health, nutrition, mental health, social and family support to low income families.

2) **Who is served with these funds (i.e. # of people, # of programs, etc):** Head Start and Early Head Start Programs begin serving children 6 weeks up to 5 years of age/ school age unless the approved federal grant provides otherwise. 65% of the families must have income at or below the federal poverty level. The State of Maine contracted with 11 Head Start Programs and served 4,638 children & 76 pregnant women for a total of 4,714 according to the 2010-2011 Program Information Report (PIR).

3) **What is purchased with these funds:** Head Start Programs are Evidence-Based programs that utilize Federal Performance Standards that measure Goals, Objectives and Outcomes. Head Start funds assist with providing a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):** Contracted Head Start Program sites are located in educational and community agency settings and services are available in every Maine County. Head Start Programs work closely with DHHS, DOE, Resource Development Centers and other community providers to ensure that needs are being met with minimal duplication of services.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:** State General Funds were first implemented in 1983 as part of a broad education reform effort, which included pre-k (4year olds only) in the Essential Programs and Services formula for school funding. The Legislature specifically designated funds for Head Start comprehensive services to expand those services where current federal Head Start programming existed and must be directed to Head Start grantees in the State of Maine. The

services supported by these funds must align with Federal Head Start Performance Standards. These Head Start funds must be awarded to the agencies competitively selected and awarded the Federal Head Start Program by the Administration for Children and Families, U.S. Department of Health and Human Services. An agreement supporting a single Head Start program for the State of Maine was signed by the Maine DHHS and the US DHHS on 5/10/2000. This agreement states that Maine has the authority to allocate State funds to existing Federal grantees only. On December 12,2007 President Bush signed Public Law 110-134 "Improving Head Start for School Readiness Act of 2007" reauthorizing the Head Start Program. This law contained significant revisions to the previous Head Start Act and authorizes Head Start through September 30, 2012.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 1,520,939	$ 1,575,264	$ 1,507,256	$ 1,440,941	$ 1,354,580	$ 1,354,580
General Fund or Other Special Revenue	$ 2,390,129	$ 2,443,514	$ 2,441,940	$ 2,354,169	$ 2,448,875	$ 2,448,875
Federal Funds	$ 65,831	$ 42,724	$ 119,261	$ 38,300	$ 109,152	$ 109,152
Total	$ 3,976,899	$ 4,061,502	$ 4,068,457	$ 3,833,410	$ 3,912,607	$ 3,912,607

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:** Fund for a Healthy Maine allocations make up 34.6% of the overall funding for the FY2012 and FY 2013 Head Start Program allocations.

IV. **Program Eligibility Criteria:** Under the current contract structure; children 6 weeks to compulsory school age are eligible for services under this agreement unless the approved federal grant provides otherwise. 65% of families must have income at or below the federal poverty level.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: Block Grant Requirement is to spend no less than 70% of Mandatory and Matching grant on child care services.

VI. Goals & Outcomes of the program:

- **Please describe the goals of the program:** Provide Maine families with high quality, comprehensive services that foster each child's growth by supporting and nurturing the child's social, educational, emotional, cognitive and physical development.

- **Please describe how the outcomes are measured:** Head Start Programs outcomes are measured by the Federal Head Start Performance Standards. The current Performance Standards require that each program, at least once a year, conduct a self-assessment to examine how the program is meeting its own goals and objectives and its success in implementing the Program Performance Standards and other federal regulations. The process must involve program parents, staff and the community, and self-assessment results are intended to influence future program planning and continuous program improvement.

- **Please describe the measurable outcomes of the program:** As a recipient of Federal Head Start funds, Maine is required to demonstrate progress on the 24 Federal Performance Measures. The five overall objectives reflect Head Start's philosophy and successful track record of promoting school readiness through a comprehensive, integrated set of strategies and services.

- **Objective 1-** Enhance children's healthy growth and development

- **Objective 2-** Strengthen families as the primary nurturers of their children

- **Objective 3-** Provide children with educational, health, and nutritional services

- **Objective 4-** Link children and families to needed community services

- **Objective 5-** Ensure well-managed programs that involve parents in decision-making

Fund for a Healthy Maine Fact Sheet

Office: Office of Child & Family Services **Date:** 11/17/11

Program Title: Child Care

Account: 014-096101; FHM- Purchased Social Services

I. **Program Description:** **Child Care Subsidy Program (CCSP)** Provide assistance to Maine Families who Gross income does not exceed 85% of State Median Income (SMI) level; and the Child's Parents are employed and /or attending Job Training or Educational Program. The parent fee or Co-pay cannot exceed 10% of the families' gross income.
12-15 year old Afterschool Program- Improve and/or enhance educational, social, cultural, emotional, and physical development through developmentally appropriate activities.

1) **Overview of the program:** **CCSP-** The purpose of the Maine Child Care Subsidy Program is to increase the availability, affordability, and quality of Child Care Services. In order to maximize parental choice for purchasing child care, Maine provides financial support for eligible low-income families and other designated client groups through the use of vouchers.
12-15 yr. old Afterschool Program- Provide Maine youth with a safe, healthy, quality environment that will enhance their social, cultural, emotional and physical development.

2) **Who is served with these funds (i.e. # of people, # of programs, etc):** **CCSP-** Provides direct service to eligible Maine families. Redetermination of benefits occurs every 6 months. The Fund for a Healthy Maine will assist/ support up to 925 children.
12-15 Afterschool Program- 18 agencies receive a total of $677,368 which helps assist/ support over 2,200 youth in the State of Maine.

3) **What is purchased with these funds:** **CCSP –** High quality child care from a Licensed Child Care Provider.
12-15 year old Afterschool Program- Quality Afterschool Programming that is geared toward providing a safe environment that will enhance their social, cultural, emotional and physical development.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):** **CCSP-** Provide direct service to eligible families through contracts, subsidy and or awards.
12-15 year old Afterschool Program is a contracted service; with sites located in educational and community agency settings and services are available in every Maine County. The 12-15 Afterschool Programs works closely with DHHS and Maine Afterschool Network to ensure that quality Afterschool Programming occurs as well as to stay abreast of current best practices & Anti-delinquency efforts.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:** Maine Revised Statute Title 22, Chapter 1052-A: Child Care Services 22 Title 22, §3731-3740

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$4,203,946	$4,489,375	$3,780,006	$4,015,056	$3,942,236	$3,942,236
General Fund or Other Special Revenue	$1,259,364	$1,270,583	$1,277,425	$1,249,639	$1,300,000	$1,300,000
Federal Funds	$20,526,757	$14,290,765	$13,850,859	$16,808,882	$17,159,186	$16,159,186
Total	$25,990,067	$20,050,723	$18,908,290	$22,073,577	$22,401,422	$21,966,501

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:** Fund for a Healthy Maine allocation makes up 17.6% for FY12 and 17.9% for FY13 overall funding.

IV. **Program Eligibility Criteria:** **CCSP** – Maine Families whose gross income does not exceed the 85% State Median Income (SMI); and the Child's Parents are employed and /or attending Job Training or Educational Program. All families must meet Financial and Program Eligibility Requirements.
12-15 year old Afterschool Program- Participant must be between the ages of 12-16 (less than 16) and/ or 16-19 but less than 19 who are physically and/or mentally incapable of self-care.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: Block Grant Requirement is to spend no less than 70% of Mandatory and Matching grant on child care services. If we do not make MOE this would impact services to 1740 children.

VI. **Goals & Outcomes of the program:**

- **Please describe the goals of the program:** **CCSP:** Increase the availability, affordability, and quality of Child Care Services.
  12-15 year old Afterschool Program – Provide Maine youth with a safe, healthy, quality environment that will enhance their educational, social, cultural, emotional and physical development.
- **Please describe how the outcomes are measured:** **CCSP:** In order to maximize parental choice for purchasing child care, Maine provides a system of financial support for eligible low income families and other designated client groups through the use of vouchers.
  12-15 year old Afterschool Program- Performance outcomes are measured by having Performance based contracts. Contracts are monitored by Program Staff which include

but are not limited to Agency Monitoring Meetings, Site Visits, Fiscal Reports, Quarterly Reports, Attendance Counts, Participant/Parent Surveys, and Narratives.

- **Please describe the measurable outcomes of the program: CCSP:** As a recipient of Child Care Development Funds, Maine is required to conduct ongoing comprehensive audits and site visits to ensure that CCDF funds are being administered according to Federal Guidelines. (Time of initial application to subsidy granted, financial and program requirements are reviewed as well as Improper Authorization Payments (IAP) are reviewed ongoing/Federal audit every 3 years for CCDF funds.

12-15 year old Afterschool Program:

- **Objective 1**- Developing emotionally supportive relationships with adults and other youth;
- **Objective 2-** Developing skills and interest;
- **Objective 3-** Improve academic achievement
- **Objective 4-** Strengthening physical ability
- **Objective 5-** Community Service- increase tolerance for diversity, self-knowledge, increase leadership skills and increase feeling of being connected to community.

APPENDIX F

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention recommended funding levels for state tobacco prevention programs

FY2011 Rankings of Funding for State Tobacco Prevention Programs

State	FY2011 Current Annual Funding ($millions)	CDC Annual Recommendation (millions)	FY2011 Percent of CDC's Recommendation	Current Rank
Alaska*	$9.8	$10.7	92.0%	1
North Dakota*	$8.2	$9.3	88.1%	2
Hawaii	$9.3	$15.2	61.1%	3
Montana	$8.4	$13.9	60.4%	4
Wyoming	$5.4	$9.0	60.0%	5
Delaware	$8.3	$13.9	59.5%	6
Maine	$9.9	$18.5	53.5%	7
Oklahoma	$21.7	$45.0	48.2%	8
Vermont	$4.5	$10.4	43.4%	9
Minnesota	$19.6	$58.4	33.6%	10
Arkansas	$11.8	$36.4	32.4%	11
South Dakota	$3.5	$11.3	31.0%	12
Utah	$7.1	$23.6	30.2%	13
New Mexico	$7.0	$23.4	29.8%	14
Florida	$61.6	$210.9	29.2%	15
Arizona	$19.8	$68.1	29.1%	16
Mississippi	$9.9	$39.2	25.3%	17
New York	$58.4	$254.3	23.0%	18
West Virginia	$5.7	$27.8	20.4%	19
Iowa	$7.3	$36.7	20.0%	20
Washington	$13.4	$67.3	19.8%	21
North Carolina	$18.3	$106.8	17.1%	22
California	$75.0	$441.9	17.0%	23
Louisiana	$9.0	$53.5	16.9%	24
Oregon	$7.1	$43.0	16.6%	25
Nebraska	$2.9	$21.5	13.3%	26
Colorado	$7.0	$54.4	12.9%	27
Indiana	$9.2	$78.8	11.7%	28

State	FY2011 Current Annual Funding ($millions)	CDC Annual Recommendation (millions)	FY2011 Percent of CDC's Recommendation	Current Rank
Wisconsin	$6.9	$64.3	10.7%	29
Pennsylvania	$14.7	$155.5	9.5%	30
Virginia	$9.4	$103.2	9.1%	31
Idaho	$1.5	$16.9	8.9%	32
South Carolina	$5.0	$62.2	8.0%	33
Maryland	$4.3	$63.3	6.9%	34
Illinois	$9.5	$157.0	6.1%	35
District of Columbia	$569,000	$10.5	5.4%	36
Massachusetts	$4.5	$90.0	5.0%	37
Rhode Island	$735,095	$15.2	4.8%	38
Kentucky	$2.6	$57.2	4.5%	39
Texas	$11.4	$266.3	4.3%	40
Kansas	$1.0	$32.1	3.1%	41
Michigan	$2.6	$121.2	2.1%	42
Georgia	$2.0	$116.5	1.8%	43
Alabama	$860,000	$56.7	1.5%	44
Connecticut	$400,000	$43.9	0.9%	45
New Jersey	$600,000	$119.8	0.5%	46
Tennessee	$222,268	$71.7	0.3%	47
Missouri	$60,000	$73.2	0.1%	48
Nevada	$0	$32.5	0.0%	51
New Hampshire	$0	$19.2	0.0%	51
Ohio	$0	$145.0	0.0%	51

* Alaska and North Dakota currently fund tobacco prevention programs at the CDC-recommended levels if both state and federal funding is counted.

Appendix A

History of Spending for State Tobacco Prevention Programs FY2006 - FY2011

	FY2011		FY2010		FY2009		FY2008		FY2007		FY2006	
	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.
States Total	**$517.9**	**14.0%**	**$569.3**	**15.4%**	**$670.9**	**18.1%**	**$717.2**	**44.8%**	**$597.5**	**37.2%**	**$551.0**	**34.4%**
Alabama	$0.9	1.5%	$0.8	1.3%	$1.2	2.1%	$0.8	2.9%	$0.7	2.6%	$0.3	1.2%
Alaska	$9.8	92.0%	$9.2	86.0%	$8.2	76.6%	$7.5	92.5%	$6.2	76.6%	$5.7	70.5%
Arizona	$19.8	29.1%	$22.1	32.5%	$21.0	30.8%	$23.5	84.6%	$25.5	91.8%	$23.1	83.1%
Arkansas	$11.8	32.4%	$18.7	51.4%	$16.0	44.0%	$15.6	87.1%	$15.1	84.3%	$17.5	97.7%
California	$75.0	17.0%	$77.1	17.4%	$77.7	17.6%	$77.4	46.9%	$84.0	50.9%	$79.7	48.3%
Colorado	$7.0	12.9%	$11.1	20.4%	$26.4	48.5%	$26.0	105.9%	$25.0	101.8%	$27.0	110.0%
Connecticut	$0.4	0.9%	$6.1	13.9%	$7.4	16.9%	$0.0	0.0%	$2.0	9.4%	$0.0	0.2%
Delaware	$8.3	59.5%	$10.1	72.7%	$10.7	77.0%	$10.7	123.8%	$10.3	119.4%	$9.2	106.6%
DC	$0.6	5.4%	$0.9	8.1%	$3.6	34.3%	$3.6	48.1%	$0.5	6.7%	$0.0	0.0%
Florida	$61.6	29.2%	$65.8	31.2%	$59.5	28.2%	$58.0	74.0%	$5.6	7.1%	$1.0	1.3%
Georgia	$2.0	1.8%	$2.1	1.8%	$2.3	2.0%	$2.2	5.3%	$2.3	5.4%	$3.1	7.3%
Hawaii	$9.3	61.1%	$7.9	52.0%	$10.5	69.1%	$10.4	96.3%	$9.1	84.0%	$5.8	53.8%
Idaho	$1.5	8.9%	$1.2	7.1%	$1.7	10.1%	$1.4	12.6%	$0.9	8.2%	$0.5	4.9%
Illinois	$9.5	6.1%	$8.5	5.4%	$8.5	5.4%	$8.5	13.1%	$8.5	13.1%	$11.0	16.9%
Indiana	$9.2	11.7%	$10.8	13.7%	$15.1	19.2%	$16.2	46.6%	$10.9	31.3%	$10.8	31.1%
Iowa	$7.3	20.0%	$10.1	27.5%	$10.4	28.3%	$12.3	63.5%	$6.5	33.6%	$5.6	28.9%
Kansas	$1.0	3.1%	$1.0	3.1%	$1.0	3.1%	$1.4	7.8%	$1.0	5.5%	$1.0	5.5%
Kentucky	$2.6	4.5%	$2.8	4.9%	$2.8	4.9%	$2.4	9.4%	$2.2	8.8%	$2.7	10.8%
Louisiana	$9.0	16.9%	$7.8	14.6%	$7.6	14.2%	$7.7	28.3%	$8.0	29.5%	$8.0	29.5%
Maine	$9.9	53.5%	$10.8	58.4%	$10.9	58.9%	$16.9	151.2%	$14.7	131.3%	$14.2	126.9%
Maryland	$4.3	6.9%	$5.5	8.7%	$19.6	31.0%	$18.4	60.7%	$18.7	61.7%	$9.2	30.4%
Massachusetts	$4.5	5.0%	$4.5	5.0%	$12.2	13.6%	$12.8	36.2%	$8.3	23.4%	$4.3	12.1%
Michigan	$2.6	2.1%	$2.6	2.1%	$3.7	3.1%	$3.6	6.6%	$0.0	0.0%	$0.0	0.0%
Minnesota	$19.6	33.6%	$20.3	34.8%	$20.5	35.1%	$22.1	77.2%	$21.7	75.8%	$22.1	77.2%
Mississippi	$9.9	25.3%	$10.6	27.0%	$10.3	26.3%	$8.0	42.6%	$0.0	0.0%	$20.0	106.4%
Missouri	$0.1	0.1%	$1.2	1.6%	$1.7	2.3%	$0.2	0.6%	$0.0	0.0%	$0.0	0.0%

	FY2011		FY2010		FY2009		FY2008		FY2007		FY2006	
	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.
Montana	$8.4	60.4%	$8.4	60.4%	$8.5	61.2%	$8.5	90.6%	$6.9	73.7%	$6.8	72.6%
Nebraska	$2.9	13.3%	$3.0	14.0%	$3.0	14.0%	$2.5	18.8%	$3.0	22.5%	$3.0	22.5%
Nevada	$0.0	0.0%	$2.9	8.9%	$3.4	10.5%	$2.0	14.8%	$3.8	28.2%	$4.2	31.2%
New Hampshire	$0.0	0.0%	$0.0	0.0%	$0.2	1.0%	$1.3	12.3%	$0.0	0.0%	$0.0	0.0%
New Jersey	$0.6	0.5%	$7.6	6.3%	$9.1	7.6%	$11.0	24.4%	$11.0	24.4%	$11.5	25.5%
New Mexico	$7.0	29.8%	$9.5	40.6%	$9.6	41.0%	$9.6	70.1%	$7.7	56.2%	$6.0	43.8%
New York	$58.4	23.0%	$55.2	21.7%	$80.4	31.6%	$85.5	89.2%	$85.5	89.2%	$43.4	45.3%
North Carolina	$18.3	17.1%	$18.3	17.1%	$17.1	16.0%	$17.1	40.2%	$17.1	40.2%	$15.0	35.2%
North Dakota	$8.2	88.1%	$8.2	88.2%	$3.1	33.3%	$3.1	38.4%	$3.1	38.0%	$3.1	38.0%
Ohio	$0.0	0.0%	$6.0	4.1%	$6.0	4.1%	$44.7	72.4%	$45.0	72.9%	$47.2	76.4%
Oklahoma	$21.7	48.2%	$19.8	44.0%	$18.0	40.0%	$14.2	65.1%	$10.0	45.8%	$8.9	40.8%
Oregon	$7.1	16.6%	$6.6	15.3%	$8.2	19.1%	$8.2	38.8%	$3.5	16.3%	$3.5	16.3%
Pennsylvania	$14.7	9.5%	$17.7	11.4%	$32.1	20.6%	$31.7	48.3%	$30.3	46.2%	$32.9	50.2%
Rhode Island	$0.7	4.8%	$0.7	4.6%	$0.9	6.1%	$0.9	9.5%	$1.0	9.6%	$2.1	21.2%
South Carolina	$5.0	8.0%	$2.0	3.2%	$0.0	0.0%	$2.0	8.4%	$2.0	8.4%	$0.0	0.0%
South Dakota	$3.5	31.0%	$5.0	44.2%	$5.0	44.2%	$5.0	57.5%	$0.7	8.1%	$0.7	8.1%
Tennessee	$0.2	0.3%	$0.2	0.3%	$5.0	7.0%	$10.0	31.0%	$0.0	0.0%	$0.0	0.0%
Texas	$11.4	4.3%	$11.4	4.3%	$11.8	4.4%	$11.8	11.4%	$5.2	5.0%	$7.0	6.8%
Utah	$7.1	30.2%	$7.1	30.1%	$7.2	30.5%	$7.3	47.7%	$7.2	47.3%	$7.2	47.3%
Vermont	$4.5	43.4%	$4.8	46.2%	$5.2	50.0%	$5.2	66.0%	$5.1	64.5%	$4.9	61.9%
Virginia	$9.4	9.1%	$12.3	11.9%	$12.7	12.3%	$14.5	37.3%	$13.5	34.7%	$12.8	32.9%
Washington	$13.4	19.8%	$15.8	23.5%	$27.2	40.4%	$27.1	81.1%	$27.1	81.3%	$27.2	81.6%
West Virginia	$5.7	20.4%	$5.7	20.5%	$5.7	20.5%	$5.7	40.0%	$5.4	38.1%	$5.9	41.7%
Wisconsin	$6.9	10.7%	$6.9	10.7%	$15.3	23.8%	$15.0	48.1%	$10.0	32.1%	$10.0	32.1%
Wyoming	$5.4	60.0%	$4.8	53.3%	$6.0	66.7%	$5.9	80.1%	$5.9	79.9%	$5.9	79.9%
Total	**$517.9**	**14.0%**	**$569.3**	**15.4%**	**$670.9**	**18.1%**	**$717.2**	**44.8%**	**$597.5**	**37.2%**	**$551.0**	**34.4%**

* In 2007, the CDC updated its recommendation for the amount each state should spend on tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the updated recommendations are higher than previous ones. Starting in FY2009, this report assessed the states based on these new recommendations.

CDC Best Practices for Comprehensive Tobacco Control Programs Oct 2007

Appendix B Funding Recommendation Formulations

In *Best Practices for Comprehensive Tobacco Control Programs—August 1999*, funding formulas were provided for the nine specific elements of a comprehensive program. These formulas were based on evidence from scientific literature and the experience of large-scale and sustained efforts of state programs in California and Massachusetts.[1]

In December 2006, technical consultation was sought from a panel of experts regarding the best available evidence to determine updated cost parameters and metrics for major components of a comprehensive tobacco control program. The panel reviewed data relevant to potential changes in the 1999 funding recommendations, including state experience and findings on program effectiveness that have emerged since the release of *Best Practices—1999*. The panel generally agreed that the published funding formulas remained sound but that technical updates were necessary.[2] A listing of participants in the expert panel is provided in Appendix A.

Funding recommendations in this publication are based on the funding formulas presented in 1999, with adjustments to specific variables to account for changes in the total population (2006), population of persons aged 18 years and older (2006), public (2006) and private (2003) school enrollment, and smoking prevalence (2006), as well as an increase to keep pace with the national cost of living (June 2007).[3-7]

The original basis for budget recommendations is as follows:[1]

- Community Programs: $850,000-$1,200,000 (statewide training and infrastructure) + $0.70-$2.00 per capita
- Tobacco-Related Disease Programs: Average of $2.8 million - $4.1 million per year
- School Programs: $500,000-$750,000 (statewide training and infrastructure) + $4-$6 per student (K-12)
- Enforcement: $150,000-$300,000 estimated range for youth access and smoke-free air enforcement + $0.43-$0.80 per capita
- Statewide Programs: $0.40-$1.00 per capita
- Counter-Marketing: $1.00-$3.00 per capita
- Cessation
  - Minimum: $1 per adult (screening) + $2 per smoker (brief counseling)
  - Maximum: $1 per adult (screening) + $2 per smoker (brief counseling) + $13.75 per smoker (50% of quitline cost for 10% of smokers) + $27.50 per smoker for NRT (assumes approximately 25% of smokers treated are covered by state-financed programs)
- Surveillance and Evaluation: 10% of program total
- Administration and Management: 5% of program total

As with the funding guidance first published in 1999, recommended annual costs can vary within the lower and upper estimates provided for each state. Therefore, to better assist states, specific guidance is now provided regarding each state's recommended level of investment within its range. These recommended levels of annual investment factor in state-specific variables, such as the overall population; smoking prevalence; the proportion of the population uninsured or receiving publicly financed insurance or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for quitline services; and the cost and complexity of conducting mass media campaigns to reach targeted audiences, such as youth, racial/ethnic minorities, or people of low socioeconomic status.[3,6,8-14]

Per capita formula adjustments for 2007 include:

- Community Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Tobacco-Related Disease Programs: Total budget numbers were adjusted for inflation and distributed to each state on a per capita basis.
- School Programs: Budget numbers were adjusted for inflation and applied to state school enrollment.
- Enforcement: Budget numbers were adjusted for inflation.
- Statewide Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Counter-Marketing: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account relative media costs and the complexity of the media market.
- Cessation:
  - Health care systems (screening and brief counseling) budget numbers were adjusted for inflation.
  - Quitline support: (number of callers enrolled in quitline) x (per person cost for counseling) + (per person cost for NRT). Formula assumes 6% of adult smokers in the state receive treatment each year.
- Surveillance and Evaluation: 10% of program total.
- Administration and Management: 5% of program total.

Appendix B Funding Recommendation Formulations

Multiplying state per capita funding recommendations by state population will provide the total funding recommendations presented in the total funding summary table and the state-specific pages. Because total funding recommendations are rounded to the nearest hundred thousand, the reverse calculation might produce slightly different per capita estimates. The recommended levels of investment (per capita and total) are presented in 2007 dollars using 2006 population rates. These should be updated annually according to the U.S. Department of Labor Consumer Price Index and U.S. Census Bureau.[3,7]

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APPENDIX G

Memorandum from Senator Roger Katz to Members of the Commission to Study Allocations of the Fund for a Healthy Maine, November 28, 2011

125th Legislature
Senate of Maine
Senate District 24

Senator Roger J. Katz
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Home (207) 622-9921

TO: Members of the Commission to Study Allocations of the Fund for a Healthy Maine

FR: Senator Roger Katz

RE: Commission Meeting Tuesday, November 29, 2011

DT: November 28, 2011

Dear Colleagues:

I am really sorry that I am unable to attend Tuesday's Commission meeting, but I have a trial in Penobscot County that I could not change.

As we went through our meetings and reviewed the large amount of materials available to us, I was struck by several things:

- The Commission Members with whom I serve are a diverse and talented group of people who bring a wide range of expertise to the discussion;
- A full exploration of the issues before us would take several more meetings; but
- We must do the best we can with our mandate and the short period of time we have been given.

I wanted to take one more opportunity to summarize my personal thoughts on what we ought to do. From my perspective, we are in a unique position to re-deploy our limited Fund for Healthy Maine dollars in order to maximize their impact. To me, the key principle is "prevention". But what should we be trying to prevent? My own thought is that we should focus like a laser on the major drivers of our ever-increasing health care costs: tobacco use and obesity. As we have learned, these largely-preventable conditions contribute as much as 30%-40% to our burgeoning MaineCare expenses. With about $50

million of tobacco settlement money available to us each year, I think we should direct these funds to those two goals.

I must tell you I come to the discussion from the perspective of someone who serves on the Appropriations Committee. I sit there in our budget discussions constantly having to vote "no" to public investments which I know would move our state ahead. More money for higher education. More money for teacher development. More research and development funding to improve our economy. The list goes on. But the sad reality is that our skyrocketing public healthcare costs are slowly but inexorably sucking all the oxygen out of the room in terms of the ability to fund them. It is from that perspective that I come to my conclusions.

Accordingly, I would personally ask with respect to every program we are asked to fund through FHM:

A. How does it directly impact on tobacco use in the State of Maine; and

B. How does it directly impact on the prevalence of obesity within our population?

If a program cannot answer at least one of these questions in a direct and quantifiable way, I respectfully suggest it should not continue as part of the Fund for Healthy Maine allocation process. There may be several programs we now fund which are of significant benefit to critical populations within our state. If so, and if they do not meet the above criteria, they should compete for dollars with other programs through the General Fund budget process. I would be the first to advocate for several of them based upon their own unquestioned merit. However, for at least this Commission member, the Fund for Healthy Maine should concentrate on programs which have the best chance of reducing our healthcare costs in the most dramatic of ways.

I thank you in advance for considering my thoughts and again express my apologies for my absence.

Best regards,

Roger J. Katz
State Senator, District 24
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RJK/cam

APPENDIX H

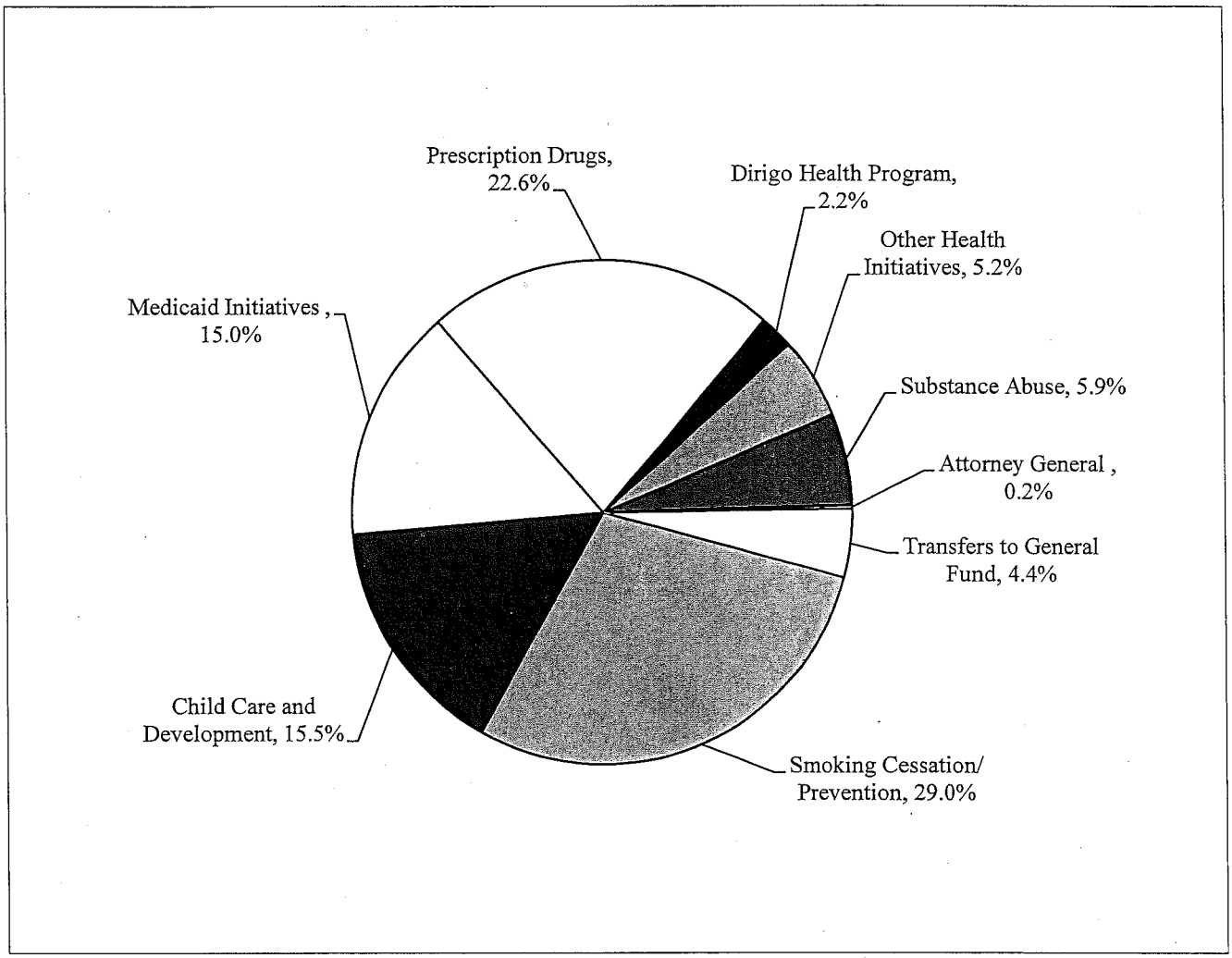
Office of Fiscal and Program Review pie chart of Fund for a Healthy Maine program spending

Updated 11/28/2011

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses *

2012-2013 Biennium



	2011-12	2012-13	Biennium
Smoking Cessation/ Prevention	$15,258,943	$15,289,299	$30,548,242
Child Care and Development	$8,163,919	$8,163,919	$16,327,838
Medicaid Initiatives	$7,876,677	$7,906,432	$15,783,109
Prescription Drugs	$11,934,230	$11,934,230	$23,868,460
Dirigo Health Program	$1,161,647	$1,161,647	$2,323,294
Other Health Initiatives	$2,742,788	$2,745,301	$5,488,089
Substance Abuse	$3,105,972	$3,105,972	$6,211,944
Attorney General	$111,840	$119,687	$231,527
Transfers to General Fund	$1,375,000	$3,240,000	$4,615,000
Totals	$51,731,016	$53,666,487	$105,397,503

** Reflects Budgeted Allocations and Uses through the 125th Legislature, 1st Regular Session*

Prepared by the Office of Fiscal and Program Review

Updated 11/28/2011

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses Detail*

2012-2013 Biennium

	2011-12	2012-13	Biennium
Smoking Cessation/ Prevention	**$15,258,943**	**$15,289,299**	**$30,548,242**
0953-02 FHM - BoH Tobacco Prevention and Control	*$6,402,080*	*$6,421,493*	*$12,823,573*
0953-07 FHM - BoH Community/School Grants	*$7,777,979*	*$7,788,922*	*$15,566,901*
Z015 FHM - Immunization	*$1,078,884*	*$1,078,884*	*$2,157,768*
Child Care and Development	**$8,163,919**	**$8,163,919**	**$16,327,838**
Z068 FHM - School Breakfast Program	*$213,720*	*$213,720*	*$427,440*
0953-06 FHM - BoH Home Visits	*$2,653,383*	*$2,653,383*	*$5,306,766*
0959 FHM - Head Start	*$1,354,580*	*$1,354,580*	*$2,709,160*
0961 FHM - Purchased Social Services	*$3,942,236*	*$3,942,236*	*$7,884,472*
Medicaid Initiatives	**$7,876,677**	**$7,906,432**	**$15,783,109**
0960 FHM - Medical Care	*$7,876,677*	*$7,906,432*	*$15,783,109*
Prescription Drugs	**$11,934,230**	**$11,934,230**	**$23,868,460**
Z015 FHM - Drugs for the Elderly & Disabled	*$11,934,230*	*$11,934,230*	*$23,868,460*
Dirigo Health Program	**$1,161,647**	**$1,161,647**	**$2,323,294**
Z070 FHM - Dirigo Health	*$1,161,647*	*$1,161,647*	*$2,323,294*
Other Health Initiatives	**$2,742,788**	**$2,745,301**	**$5,488,089**
0953-01 - BoH Oral Health Program	*$600,000*	*$600,000*	*$1,200,000*
0953-08 - BoH Public Health Infrastructure	*$1,366,802*	*$1,369,315*	*$2,736,117*
0956 FHM - Family Planning	*$401,430*	*$401,430*	*$802,860*
0958 FHM - Donated Dental	*$36,463*	*$36,463*	*$72,926*
0950 FHM - Health Education Centers	*$100,353*	*$100,353*	*$200,706*
0951 FHM - Dental Education	*$237,740*	*$237,740*	*$475,480*
Substance Abuse	**$3,105,972**	**$3,105,972**	**$6,211,944**
0948-01 FHM - Substance Abuse	*$1,848,306*	*$1,848,306*	*$3,696,612*
0948-02 FHM - Substance Abuse	*$1,257,666*	*$1,257,666*	*$2,515,332*
Attorney General	**$111,840**	**$119,687**	**$231,527**
0947 FHM - Attorney General	*$111,840*	*$119,687*	*$231,527*
Transfers to General Fund	**$1,375,000**	**$3,240,000**	**$4,615,000**
Totals	**$51,731,016**	**$53,666,487**	**$105,397,503**

** Reflects Budgeted Allocations and Uses through the 125th Legislature, 1st Regular Session*

Prepared by the Office of Fiscal and Program Review