Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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January 16, 2020

Senator Geoff Gratwick, Chair
Representative Patricia Hymanson, Chair
Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, Maine 04333-0100

Dear Senator Gratwick, Representative Hymanson and Members of the Joint Standing Committee on Health and Human Services:

Enclosed please find the report pursuant to Resolves 2019, Chapter 66: Resolve, To Improve Access to Early and Periodic Screening, Diagnostic, and Treatment Services for Children from Birth to 8 Years of Age.

It should be noted that the Legislature did not provide any resources to the Department for the convening of stakeholders, research, and report production for this Resolve.

Sincerely,

Jeanne M. Lambrew, Ph.D.
Commissioner

JML/klv

Enclosure

Report: Resolve, To Improve Access to Early and Periodic Screening, Diagnostic, and Treatment Services for Children

January 2020

Required by:
Resolves 2019, Ch. 66 (LD 1635)

Maine Department of Health and Human Services

GENERAL OVERVIEW

The Department of Health and Human Services (DHHS) and the Department of Education (DOE) strongly value investment in early childhood programs. One of the main goals of the Children's Cabinet is to ensure that "all Maine children are prepared to succeed in kindergarten." As James Heckman, PhD, a Noble Prize Winner in Economics writes, "The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families. Starting at age three or four is too little too late, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness. The best investment is in quality early childhood development from birth to five for disadvantaged children and their families."[1]
This report is in response to RESOLVE Chapter 66, L.D. 1635, 129th Maine State Legislature, Resolve, To Improve Access to Early and Periodic Screening, Diagnostic and Treatment Services for Children from Birth to 8 Years of Age. This report provides information on the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit and programs providing early intervention and developmental screening services in the Maine Department of Health and Human Services (DHHS), including work done under the Office of MaineCare Services (OMS), at the Maine CDC under the Maternal Child Block Grant, Public Health Nursing (PHN), Maine Families Home Visiting, and Women and Infants Program (WIC), and the Office of Child and Family Services (OCFS). The report also includes information on Child Find under the Department of Education and the early intervention system, including Child Development Services (CDS), Early Head Start, and Head Start.

It is also noted that L.D. 1635 was signed into law at the time when several other needs assessments and evaluations of the Early Intervention System were taking place in Maine. Over the last year, the Children's Behavioral Health System Report by the Public Consulting Group was completed in 2018,[2] and the Office of Child and Family Services identified priority areas for short and long-term implementation in 2019. In the Spring of 2019, the Governor reestablished the Children's Cabinet in Maine which includes a staff working group that is developing strategies to ensure that "all Maine children enter kindergarten prepared to succeed." L.D. 1715 was also passed which is, "An Act to Reorganize the Provision of Services for Children with Disabilities from Birth to 5 Years of Age" that has an independent review of the state's early education services, birth to five years. Part One of the evaluation is a review of previous studies and analysis of national models that is targeted to be completed in the Spring of 2020. Part Two of the study is an implementation plan based on the work in part one. In addition, the Department of Education received the Preschool Development Planning Grant in 2019 that included a needs assessment that was completed in December 2019 and a strategic plan that will be completed by the Spring 2020. The PDG's State of Maine Needs Assessment: Vulnerable Children Birth to Age 5 and Their Families was done in conjunction with RMC Research. There was a strong

[1] Heckman J. Invest in Early Childhood Development: Reduce Deficits, Strengthen the Economy https://heckmanequation.org/resource/invest-in-early-childhood-development-reduce-deficits-strengthen-the-economy/. Published December 7, 2012. Accessed December 5, 2019.
[2] Maine DHHS. Children's Behavioral Health Services Assessment Final Report. https://www.maine.gov/dhhs/ocfs/cbhs/documents/ME-OCFS-CBHS-Assessment-Final-Report.pdf. Published December 15, 2018. Accessed December 18, 2019.

focus in PDG report on the early childcare and education system in Maine. The Maine CDC is also working on a Maternal Child Block Grant Needs Assessment that occurs every five years and is anticipated to be complete in the Summer of 2020. Further, DHHS is receiving technical assistance on its EPSDT benefit from Manatt Consulting and the Center for the Study of Social Policy as part of the Pediatrics Supporting Parents Medicaid-CHIP State Implementation Workgroup with seven states.[3] It is anticipated that several of the aforementioned external evaluations and technical assistance will also provide information on Maine's early intervention systems.

As part of L.D. 1635, the stakeholder group named was the Developmental Systems Integration (DSI) Steering group. It met in August, September, October, and November 2019. A list of attendees is noted in the **Appendix A**. This group was able to provide historical context for state programs that provide EPSDT and Child Find Services and background on eligibility requirements for services for the 1635 report.[4] A cross department group from DHHS and DOE met monthly from September to December. This report was completed by DHHS and DOE staff and provides program overviews, available data, and recommendations on improving access to EPSDT. We note that these recommendations do not represent the position or proposals of DHHS (or DOE); they reflect the recommendations of the work groups assembled under L.D. 1635.

[3] Manatt Health. Executive Summary: Keeping Medicaid's Promise: Strengthening Access to Services for Children with Special Healthcare Needs. https://www.manatt.com/Manatt/media/Documents/FINAL-Keeping-Medicaid%e2%80%99s-Promise-Executive-Summary-09-30-19.pdf. Published October 2019. Accessed December 5, 2019. Manatt Health. Issue Brief: Keeping Medicaid's Promise: Strengthening Access to Services for Children with Special Healthcare Needs. https://www.manatt.com/Manatt/media/Documents/FINAL-Keeping-Medicaid_s-Promise-Issue-Brief-10-01-19.pdf. Published October 2019. Accessed December 5, 2019.

[4] Some historical background on EPSDT and Child Find is available in this report. Additional information can be obtained from members of the Developmental Systems Integration Steering Group and Sue Mackey Andrews.

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OVERVIEW OF EPSDT

EPSDT, or Early and Periodic Screening, Diagnosis, and Treatment services, is Medicaid's benefit for low-income infants, children and adolescents under 21 required under Section 1905(r) of the Social Security Act.[5] State EPSDT requirements under Medicaid include:

- Inform all Medicaid-eligible children under age 21 and their families about EPSDT on a timely basis (i.e., within 60 days of enrollment for children and immediately following birth for newborn infants).
- Use effective methods of communication and clear, non-technical language in informing families with a recommended combination of face-to-face, oral, and written information.
- Inform Medicaid-eligible pregnant women about EPSDT, as well as adoptive and foster care parents of eligible children.
- Offer and provide, if requested and necessary, assistance with transportation to medical care. Specify in the state Medicaid plan the state's responsibility for transportation assistance and describe the methods to be used.
- Offer and provide, if requested and necessary, assistance with scheduling appointments for EPSDT visits and services.

In addition, Title V agencies, both the HRSA's Maternal and Child Health Bureau (MCHB) and state MCH programs receive block grant funding, play an important role in helping Medicaid agencies fulfill these EPSDT requirements. By promoting and helping to implement EPSDT, Title V agencies help Medicaid agencies better fulfill their responsibilities, particularly to provide effective outreach, information, and assistance to families.

Under federal law, all children enrolled in Medicaid receive the EPSDT benefit. In Maine, EPSDT supports health assessments for children using the periodicity schedule recommended by the American Academy of Pediatrics through the Bright Futures Guidelines.[6] EPSDT services for individuals consist of: a comprehensive health and development history, including physical and mental assessments; physical examination; immunizations; laboratory tests, including blood lead levels; and health education. Other services include: vision services, that at a minimum, include diagnosis and treatment of defects in vision, including eyeglasses; dental services, that at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health; and hearing services, that at a minimum include diagnosis and treatment of hearing defects, including hearing aids, must also be provided.

EPSDT services also encompass other health care, diagnostic services, treatment, and other measures that are coverable under Medicaid and are medically necessary. Federal law requires

[5] CMS. EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. Published 2014. Accessed December 2019.
[6] American Academy of Pediatrics. Bright Futures Guidelines and Pocket Guide. https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx. Accessed December 2019.

that Medicaid cover a medically necessary treatment recommended through an EPSDT evaluation so long as the service is coverable by Medicaid regardless of the service being explicitly outlined in the state's Medicaid State Plan. Pursuant to MaineCare Benefits Manual (MBM) Section 94.05-2, treatment services are described as: services covered under the EPSDT Program consisting of all medically necessary services listed in §1905(a) of the *Social Security Act* (42 U.S.C. §1396(a) and (r)) that are needed to correct or ameliorate defects and physical or mental conditions detected through the EPSDT screening process.[7] Maine's EPSDT benefit allows coverage of a medically necessary service for children under age 21 meeting the criteria described above that are not otherwise covered under Maine's State Plan; because they are not of a type described in any other regulation, the frequency exceeds that covered by regulation, or the duration exceeds that covered by regulation.[8] Treatment services must be scientifically valid, not considered experimental, and medically necessary. Prior authorization is necessary for treatment services and EPSDT allows for consideration of the relative cost effectiveness of alternatives as part of the prior authorization process by Maine's Department of Health and Human Services.

Most EPSDT services are covered under preventive services by MaineCare. For example, EPSDT services for hearing, vision, and oral health assessments are paid under standardized procedure codes. Maine requires a modifier, "EP" on claims for EPSDT services not otherwise covered via State Plan as described above. The "EP" modifier is rarely used except for Durable Medical Equipment (DME) and transportation. In 2018, the EPSDT modifier was only used for 120 claims for 93 patients with the majority of claims for durable medical equipment (91/120 claims) and transportation (19/120).

Table 1: Maine Care member claims for EPSDT services for members 8 & under for SFY 2017 and 2018, Data Source: MIHMS DSS (Run Date Oct 10, 2019)

		SFY 2017		SFY 2018	
Procedure Code	**Procedure**	**Patients**	**Claims**	**Patients**	**Claims**
92551	SCREENING TEST PURE TONE AIR ONLY	916	996	953	1,049
92552	PURE TONE AUDIOMETRY AIR ONLY	804	1,012	626	772
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	102	105	70	80
99174	INSTRUMENT BASED OCULAR SCR BI W/RMT ANAL & RPT	1,035	1,279	948	1,473
99177	INSTRUMENT BASED OCULAR SCR BI W/ONSITE ANALYSIS	210	472	365	877
D0145	Oral eval for pt <3 yrs. & counsel w caregiver	5,056	8,568	4,861	8,095
D1206	Topical application of fluoride varnish	24,054	38,647	23,857	39,717

[7] Gurny P, Hirsch M, Gondek K. Chapter 11: Description of Medicaid-Covered Services. Health Care Financing Review. 1992 Supplement. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191224dl.pdf. Accessed December 2019.

[8] OMS. MaineCare Benefits Manual. http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s094.docx. Accessed December 2019.

MaineCare's EPSDT policy initially went into effect April 2004 and had one revision in May 2010 to update language and terminology to current practice. MaineCare, as the state's administrator of the EPSDT benefit previously had a coordinator charged with overseeing Maine's EPSDT program and the position was eliminated in 2016.

MaineCare historically aided in the assessment, referral, and linkage to necessary treatment services through its Targeted Case Management (TCM) program.[9] Prior to 2009, TCM had a target group dedicated to infants and children who were diagnosed or at risk of a delay in physical, cognitive, communication, adaptive, or behavior and emotional development. This target group, anecdotally described by constituents, was critical for providing access to developmental screening, referral and linkage to medically necessary services, and family support in securing resources to aid in supporting their child's condition. Due to anticipated state budget shortfalls in 2009, this target group, among others, was cut to realize savings and aid in balancing the state budget. As part of this budget cut, the zero to five age group was added to the other children's target groups (mental health, developmental disabilities, and chronic medical conditions) to retain coverage of children in this age range. Similar services for this age group are also supported through the MaineCare Primary Care Case Management (PCCM) program. PCCM providers are required through policy and enrollment to offer EPSDT services when serving children under age 21. Despite coverage options, feedback from constituents has been that knowledge and expertise of the early childhood age group was lost when the TCM target group was removed.

Additionally, prior to 2011, MaineCare had a section of policy devoted to developmental therapies, covered through what was Section 27 of the MaineCare Benefits Manual (MBM). Section 27 covered assessment and developmental screening for children birth to five, IFSP development, developmental therapies, and social work services in school or the child's natural environment. This program operated from 1992 through 2011, when the policy was repealed. Leading up to the repeal were several major audits of providers which identified a number of areas of inappropriate billing, fraud, waste, and abuse.

Examples of audit findings included, but were not limited to, billing while children were asleep, billing for recreational activities, billing for educationally based goals, billing for services not identified in the treatment plan, billing when the facility was closed or children absent, no documentation of any service provided, and for billing parents for daycare services for the same period that was billed to MaineCare. Due to the extreme financial impact of these findings and that similar services could be delivered through other sections of policy, the state made the decision to repeal Section 27 in March 2010.

The two services described above, TCM and developmental therapies, are directly related to the assessment and screening, referral, and treatment of young children that L.D. 1635 intends to reach. While children may receive similar services through multiple sections of policy currently, namely TCM, PCCM, OT, PT, Speech, Behavioral Health Services, and Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional

[9] OMS. MaineCare Benefits Manual. [4] http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s013.docx. Accessed December 2019.

Limitations, the result of terminating these services has exacerbated the perception of a fragmented system, which is partly validated by historically low screening rates in Maine.

OVERVIEW OF CHILD FIND

In Maine, the responsibility of Child Find is clearly defined in the Maine Unified Special Education Regulations (MUSER) IV.1-2 (2017).[10] Under the Individuals with Disabilities Act (IDEA), states must, at public expense, conduct Child Find activities. These activities include identifying, locating, and evaluating children, birth to age 20, who need special education and related services and determining their eligibility to receive those services. Maine Revised Statute 20-A M.S.R § 4701-B also requires school administrative units to screen students in kindergarten through second grade who have difficulty in the following areas: phonological and phonemic awareness, sound-symbol recognition, alphabetic knowledge, decoding skills, rapid naming skills, and encoding skills.

Child Find, Birth Through 2

For infants and toddlers, birth through age 2, Child Find is the responsibility of Child Development Services' (CDS) Part C program. CDS distributes annual Child Find notices and conducts ongoing outreach to potential referral sources. Eligibility of infants and toddlers who are referred to CDS is determined by the presence of a significant developmental delay as identified by a comprehensive developmental evaluation, a diagnosed condition with a high probability of resulting in a developmental delay, or through the use of Informed Clinical Opinion.

As of November 2019, the identification rate for Maine infants (under age 1) was 0.065%, an increase of 0.004% over FFY17. For infants and toddlers (birth through age 2), the identification rate is 2.88%, an increase of 0.49% over FFY17. It is noted that there is a margin of error in looking at the identification rates. In Maine, children younger than kindergarten (age 5), with the exception of those attending public 4-year-old programs, are not enrolled in public school. As a result, the identification rates indicated above are based on live birth data resulting in an unknown margin of error.

Challenges impacting CDS' Part C Child Find effort include Maine's highly dispersed population, the prevalence of infants and toddlers in family childcare, and a lack of a comprehensive, cross-departmental system coordinating the statewide administration of developmental screenings by appropriate agencies and entities, effectively ensuring that infants and toddlers are referred to CDS when the screening results indicate the need to do so. An additional barrier is the lack of funding to support a robust and proactive CDS Part C Child Find effort, which would include community screenings in settings such as childcare, medical practices, shelters, library story times, and community events.

[10] Maine Department of Education. Maine Unified Special Education Regulation Birth to Age Twenty. https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/State%20Regulation%20Chapter%20101MUSER.pdf. Published August 25, 2019. Accessed December 2019.

Child Find for Children Ages 3-20:

School Administrative Units (SAU) are required by state rules and federal law to ensure that all children between the ages of 3 and 20 who need special education and related services are identified, located, and evaluated at public expense. For the subgroup of children age 3 to under kindergarten-age 5, Child Find is the responsibility of CDS' Part B §619 program. Final identification of children with disabilities and programming for such children occurs only after an appropriate evaluation and a determination by the Individual Educational Program team. This requirement includes children who are homeless, wards of the state or state agency clients, children attending private schools, children receiving home instruction, highly mobile children, children with 10 full days of unexcused absence or 7 consecutive days of unexcused absences, and children who are incarcerated.

Challenges for SAUs include difficulty locating children who are not enrolled in school, evaluating children who are frequently absent from school, and completing evaluations of highly mobile children. Specific to the age 3 to kindergarten-age 5 population, barriers to Child Find include limited public 4-year old programs and children in family childcare.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM OVERVIEW

The Maine Department of Health and Human Services (DHHS) oversees several programs that provide developmental screening and early intervention services, including work done under the Office of MaineCare Services, the Maternal and Child Block Grant at the Maine CDC, Public Health Nursing (PHN), Maine Families Home Visiting, and the Women and Infants Program (WIC).

In 2010, Maine (MaineCare) and Vermont were recipients of a Federal Child Health Insurance Program Reauthorization Grant (CHIPRA) grant to provide quality improvement support to improve children's health which was called the "Improving Health Outcomes for Children" (IHOC) program.[11] As part of the Federal CHIPRA program, 24 core child health measures were originally proposed that included developmental screening. The CHIPRA measure for developmental screening looks at the rate of developmental screening for children by ages 1, 2, and 3 using a standardized tool. MaineCare worked closely with the Muskie School at the University of Southern Maine (USM) on operationalizing the CHIPRA child health measures.[12] As part of the work, MaineCare also opened several billing codes for preventive services for children.[13] Currently, the state has a mandate to file a CMS 416 report on child health measures annually, but can select which measures to include. **(Appendix B)** Beginning in 2024, federal

[11] Smith. L. MaineCare Summary of Child Core Measure Set, 2012-2016. https://www.maine.gov/dhhs/oms/pdfs_doc/children_IHOC/CY12-CY16-Core-Measures-Summary-FINAL.pdf. Published October 2018. Accessed December 2019.
[12] OMS. Improving Outcomes for Children (IHOC). https://www.maine.gov/dhhs/oms/provider/ihoc.shtml. Accessed December 2019.
[13]OMS. Pediatric Preventive Health Screenings. https://www.maine.gov/dhhs/oms/pdfs_doc/children_IHOC/Pediatric%20Preventive%20Health%20Screenings%20revised%20Feb%202018.pdf. Published 2018. Accessed December 2019.

law will mandate that states will be required to report all of the measures in the core set, which is widely expected to continue to include one or more developmental screening metrics.

From 2011-2015, MaineCare worked closely with Maine Quality Counts (QC/now Qualidigm) and its partners to implement the First STEPS Learning Collaborative (Strengthening Together Early Preventive Services), a four-year project focused on improving rates of childhood immunizations, developmental screening, autism screening, lead screening, and interventions on healthy weight and oral health. The project worked initially with 24 primary care practices across Maine. By 2016, over 100 practices were trained on best practices around screening and the use of screening tools as part of the Developmental Systems Integration Project, Patient Centered Medical Home (PCMH) pilot, and the State Model Innovation Grant (SIM) initiative. It is estimated that this work impacted the health status of more than 20,000 children between the ages of 0-5 years and 84,000 children between the ages of 0-21 years. In addition, as part of the IHOC work, a periodicity schedule was developed based on the AAP Bright Futures Schedule which was last updated in 2016.[14] Notably, after the Federal CHIPRA funding was completed, the state issued an RFP to continue the work on measures and adolescent health. This contract was awarded to the Muskie School at USM but was cancelled prior to the start by the previous administration. The Muskie School continues to do reporting on the CMS Child Health Core Set through a cooperative agreement with OMS.

DEVELOPMENTAL SYSTEMS INTEGRATION PROJECT (OMS AND CDC)

In 2012, MaineCare and the IHOC project worked with QC on improving developmental screening rates as part of the First STEPS work. This work built upon previous work by the Maine Children's Growth Council and the Maine Developmental Disability Council (MDDC). The Maine Children's Growth Council published several reports on the importance of early intervention and screening between 2011 and 2018.[15] The MDDC had a HRSA grant to work on building system of care for autism. MDDC did grand rounds for medical providers and worked with five pediatric practices on autism screening. In 2012, the IHOC project expanded this training to work with additional practices across Maine on developmental screening. Subsequently, in 2013, the Developmental System Integration Project (DSI) was launched to bring together partners across early childhood sectors to focus on systems integration to increase developmental screening rates for children ages 0-3 and help them access early invention services sooner. This was initially funded by the Maine CDC through the Preventive Services Block Grant and then the Maternal Child Block Grant. Partners include Early Head Start, Head Start, Child Development Services, Public Health Nursing, MaineCare, Medical Practices, Behavioral Health providers, the Maine Children's Alliance, Maine Families Home Visiting, the Department of Education, Maine Developmental Disabilities Council, Autism Society of Maine and the Maine Parent Federation. The DSI Steering Committee has worked toward the goals of increasing screening rates; reducing duplicate screening; ensuring that children who require further evaluation and services receive appropriate and timely follow-up care; and completing the communication loop to make sure that screening and evaluation results are communicated

[14] OMS. Periodicity Schedule for Primary Care .http://mainequalitycounts.org/wp-content/uploads/2018/01/First-STEPS-Periodicity-Schedule-for-Primary-Care.pdf. Published 2018. Accessed December 2019.
[15] Maine Children's Growth Council. Maine Children's Growth Council Reports. http://mainecgc.org/news/resources/. Accessed December 2019.

back to both child healthcare providers and referring organizations that work with children and their families.

In 2013, the DSI Steering Committee conducted a survey to better understand where and how Maine children ages 0-3 were receiving developmental screening, and how screening results were communicated to families, clinicians, and others. The survey was completed by 325 stakeholders statewide who work with children ages 0-3, including physicians and other medical providers, Maine Families Home Visitors, early childhood educators, early intervention providers (e.g. Child Development Services), Early Head Start/Head Start programs, and public/community health providers. Over half of respondents (52.2%) were physicians.

Based on the survey findings, six recommendations were made to improve developmental screenings:

1. Build awareness of the importance of developmental screening in children ages 0-3 with families and professionals working with young children and their families.

2. Create a coordinated system of referring children that includes training and technical assistance to all those giving and receiving referrals.

3. Design a standard 0-3 screening process that includes standardized developmental screening tools and can be used across all early childhood settings. This was later defined by the DSI Steering group as the ASQ and PEDS for developmental screening and the MCHAT-R for autism screening. The Survey of Well Being of Young Children (SWYC) was subsequently added in 2017 to the list of screening tools.

4. Improve communication and develop methods to share information that honors the family's privacy, yet at the same time connects them to timely, appropriate resources.

5. Connect developmental screening results and referrals to electronic records to help improve communication, tracking, and data collection

6. Carefully look at developmental services across the continuum of surveillance, screening and formal evaluation.

In the first year of DSI, a communication tool was developed so that common language would be used across the medical, educational, and social service agencies to define developmental screening, surveillance, assessment and evaluation. **(Appendix C)** Work was initiated to improve the referral and care coordination process. A common referral form was developed but was not formally adopted due to legal and program requirements of the community partners and DHHS. **(Appendix D)** In 2018-19, four care coordination on-line modules were also developed to provide education and a common foundation across sectors in order to make training more robust.[16] Additionally, work was done around cultural competency and working with families

[16] Qualidigm/Maine Quality Counts Learning Lab. Care Coordination Modules. https://qclearninglab.org/course/approaches-to-care-coordination-in-maine-focused-on-families-caregivers-and-children-0-through-8/. Accessed December 2019.

with English as a second language to provide information on developmental milestones and screening. An environmental scan was done of other states working on cultural competency and screening as well as a review of standardized tools.[17] Outreach was done to cultural brokers in Portland and Lewiston around developmental screening and young families.

As part of DSI, quality improvement projects were piloted in four Maine communities working across early childhood sectors with primary care practices to improve developmental screening and close the loop on referrals to early intervention services.[18] Mapping was done in each community around referrals. An example of the work done in Cumberland County is in **Appendix E.**

With the DSI work, there has been an increase in the rate of developmental screening for children from 2011 MaineCare baseline data for children ages 1, 2, and 3 from 1-3% to over 27-33% in FY2016, surpassing the initial target of a 3% increase each year.

Table 2: Developmental Screening Rates Based on MaineCare Claims Data

Age	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
Age 1	1.7%	3.3%	12.50%	18.5%	23.79%	24.61% (+23)	28.01% (+26.31)	31.71% (+30)
Age 2	2.5%	5.8%	17.11%	25.6%	28.38%	30.11% (+27.6)	33.69% (+31.19)	37.19% (+34.69)
Age 3	1.1%	1.6%	11.93%	19.0%	20.79%	21.39% (+20.3)	27.32% (+26.22)	32.24% (+31.14)

MaineCare has also tracked developmental Screening data by county and has noted an improvement in screenings where significant quality improvement work has been done, including Cumberland County, which is highlighted in green.

Table 3: Developmental Screening Rates by County

	2016					
	Age 1		Age 2		Age 3	
	#Mbrs	#Clms	#Mbrs	#Clms	#Mbrs	#Clms
Androscoggin	425	644	490	975	470	702
Aroostook	101	101	101	108	103	154
Cumberland	65	74	150	174	92	104
Franklin	30	33	89	90	78	80
Hancock	44	45	54	68	33	33

[17]Maine Quality Counts. Environmental Scan: Multi-Cultural Messaging & Materials on Developmental Screening. http://mainequalitycounts.org/wp-content/uploads/2018/05/4.-2017-Developmental-Screening-Cultural-Materials-Package.pdf. Published 2017. Accessed December 2019.
[18]Maine Quality Counts. Developmental Screening Community Initiative –Cumberland County. http://mainequalitycounts.org/wp-content/uploads/2018/01/DSCI-Cumberland-County-2017.pdf. Published 2017. Accessed December 2019.

Kennebec	356	464	335	494	244	323
Knox	114	114	110	123	37	39
Lincoln	10	10	23	23	14	14
Oxford	2	2	38	38	24	24
Penobscot	266	364	160	243	77	103
Piscataquis	4	4	6	7	3	3
Sagadahoc	1	1	1	2	0	0
Somerset	0	0	0	0	0	0
Unknown or Other	7	7	8	9	6	6
Waldo	0	0	1	1	0	0
Washington	0	0	4	4	1	1
York	217	218	176	182	145	148
	1,642	2,081	1,746	2,541	1,327	1,734

** The Unknown or other category refers to out of state providers or providers for which county-level information is unavailable.

	2017					
	Age 1		**Age 2**		**Age 3**	
	#Mbrs	**#Clms**	**#Mbrs**	**#Clms**	**#Mbrs**	**#Clms**
Androscoggin	370	465	424	646	395	537
Aroostook	144	144	114	122	100	142
Cumberland	139	149	107	128	121	126
Franklin	55	67	94	98	96	107
Hancock	37	41	38	51	23	23
Kennebec	356	361	369	440	244	252
Knox	81	81	93	108	50	58
Lincoln	7	7	10	11	6	6
Oxford	1	1	26	26	28	29
Penobscot	258	334	264	332	206	236
Piscataquis	17	17	8	8	6	6
Sagadahoc	3	3	3	4	1	1
Somerset	0	0	0	0	0	0
Unknown or Other	10	10	14	16	4	4
Waldo	0	0	2	2	0	0
Washington	1	1	70	71	19	19
York	237	240	201	205	171	176
	1,716	1,921	1,837	2,268	1,470	1,722

** The Unknown or other category refers to out of state providers or providers for which county-level information is unavailable.

	2018					
	Age 1		Age 2		Age 3	
	#Mbrs	#Clms	#Mbrs	#Clms	#Mbrs	#Clms
Androscoggin	401	519	389	493	394	447
Aroostook	137	138	172	184	121	158
Cumberland	184	197	303	335	202	216
Franklin	59	60	99	102	89	113
Hancock	56	57	44	67	25	25
Kennebec	374	388	327	343	279	284
Knox	93	93	54	57	52	55
Lincoln	0	0	3	3	2	3
Oxford	2	2	4	4	17	18
Penobscot	265	388	279	401	208	234
Piscataquis	11	11	13	13	7	7
Sagadahoc	7	10	5	8	1	1
Somerset	2	2	4	4	8	9
Unknown or Other	11	11	13	17	15	22
Waldo	0	0	0	0	0	0
Washington	1	1	62	65	68	69
York	150	151	208	219	193	201
	1,753	2,028	1,979	2,315	1,681	1,862

* The Unknown or other category refers to out of state providers or providers for which county-level information is unavailable

BACKGROUND ON HELP ME GROW

In addition, in 2015 as part of the DSI work, it was recognized that to move the work forward and improve coordination across the programs, there needed significant system changes around how early intervention services were coordinated in the state. As part of the DSI work, the Help ME Grow Model out of Connecticut was investigated. Help Me Grow is a system model that utilizes and builds on existing resources to develop and enhance a comprehensive approach to early childhood system-building in any given community.[19] Help Me Grow exists in 28 states and has four components:

1. Centralized telephone access point for connection of children and their families to services and care coordination
2. Community and family outreach to promote the use of HMG and to provide networking opportunities among families and service providers (daycare providers, community providers)
3. Child health provider (medical providers) outreach to support early detection and early intervention
4. Data collection and analysis to understand all aspects of the HMG system, including the identification of gaps and barriers (HMG has been collecting evaluation data across states)

[19]Help Me Grow National Center. The HMG System Model. https://helpmegrownational.org/hmg-system-model/

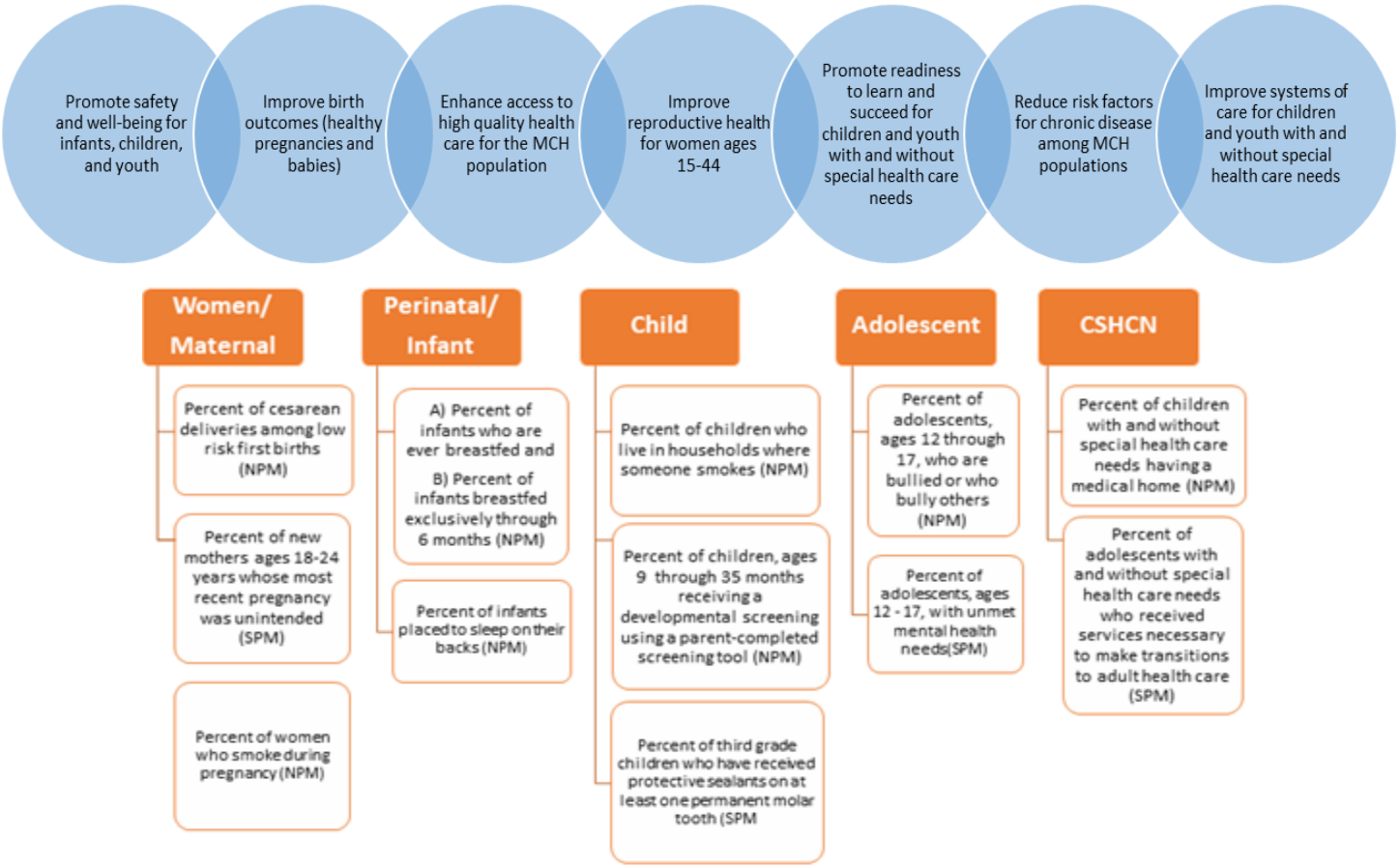
Successful implementation of the Help Me Grow model requires communities to identify existing resources, think creatively about how to make the most of existing opportunities, and build a coalition to work collaboratively toward a shared agenda. In 2015, Maine had a site visit by the Connecticut HMG team. There was also as a 12-month planning process around potential HMG Implementation. In 2016, a report was produced around how HMG could be implemented in Maine with appropriate staffing and funding. Due to leadership changes at the state level and the need to identify a sustainable funding mechanism, HMG has been in holding pattern. In 2016, Maine Quality Counts joined as a member to be able access HMG materials, participate in the annual meeting, learn from other states, and continue planning for an annual fee ($3500) as part of the DSI work. If Maine was to move towards implementation, additional support could be obtained from the HMG National Office and other states, including Vermont, who have implemented the program in the last 10 years.

MAINE CDC: MATERNAL AND CHILD HEALTH PROGRAM

The Maternal and Child Health (MCH) Program is part of the Maine CDC. The MCH Program administers several programs that are involved in preventive services and services for women and children, including the Children with Special Health Needs (CSHN) Program, Newborn Hearing Screening, Newborn Bloodspot Screening, Birth Defects Program, Cleft Lip and Palate Program, care coordination, Maine Families Home Visiting, family planning services and parent navigation for CSHN. The Program receives the Federal Title V Maternal and Child Health Block Grant ($3.3 million) and the Home Visiting grant from HRSA as well as various other federal grants.

More specifically, Maine's Title V Maternal and Child Health (MCH) Block Grant Program, in partnership with the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), is responsible for addressing the health needs within Maine for the target population of mothers, infants and their children, which includes children with special health care needs and their families. The grant promotes the development and coordination of systems of care for the MCH population, which are family-centered, community-based and culturally appropriate. As part of the MCH Block Grant, the Maine CDC works and reports on measures for development screening and medical homes. The current five-year priorities follow:

Figure 1: Maine Maternal Child Health Title V Priorities, July 2018



***(NPM) National Performance Measures, selected from a list provided by HRSA. (SPM) State Performance Measures, reflect state priorities.**

Under the MCH Block Grant there are two specific goals that relate to early invention services. The first is the increase the percent of children, ages 9-35 months, receiving a developmental screening using a parent-completed screening tool. The second is to increase the percent of children with and without special health care needs, age 0 through 17, who have a medical home. A note that the Federal CMS CHIPRA measure on developmental screening is slightly different than the MCH Block Grant developmental screening measure.

Table 4: Developmental Screening: Data source: Nation Survey of Children's Health

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.			
Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	2017	2018
Annual Objective			32.5
Annual Indicator		31.6	35.7
Numerator		8,946	10,678
Denominator		28,318	29,884
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	36.8	37.9	39.0	40.2	41.4	42.6

Table 5: MCH Medical Home Metric

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home – Children with Special Health Care Needs			
Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) CSHCN			
	2016	2017	2018
Annual Objective			42.6
Annual Indicator		42.2	47.8
Numerator		24,729	27,913
Denominator		58,672	58,422
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	49.2	50.7	52.2	53.8	55.4	57.1

MAINE CDC: CHILDREN WITH SPECIAL HEALTH NEEDS CARE COORDINATOR

Under the MCH Block grant, there is a Children with Special Health Needs Care Coordinator that is at the Maine CDC that can help families navigate through complex medical systems and guide families and organizations to resources that best fit the needs of their child. Care coordination is a unique resource that is available at no-cost for Maine families, health care providers, and communities. The goal of the care coordinator is to help families get the services they need for optimal health, development and well-being of children with special health needs. The Care Coordinator can help families with navigating health care systems; insurance appeals; application processes; referrals; finding resources; connecting to support from other parents of children with similar healthcare needs; and advocacy.

MAINE CDC: PUBLIC HEALTH NURSING

Public Health Nursing (PHN) is another program located within the CDC that has done some developmental screening over the years. PHN is a voluntary program offered to pregnant women, postpartum women, parents or primary caregivers of children and the pediatric population. In August of 2019, PHN expanded eligibility to offer nursing visits to all pregnant women and children up to age one regardless of insurance type. The goal of the program is to strengthen the equality of access to local public health services for Maine citizens. These services include; breastfeeding education, infant and pediatric growth and development, and postpartum assessments. The Maine CDC Public Health Nurses are registered professional nurses, working to improve and protect the health and quality of life for all Maine citizens. The Public Health Nursing program accomplishes this through providing the three core functions of public health; assessment, assurance and policy development, and the 10 Essential Public Health Services. The funding for the Public Health Nursing Program (PHN) comes from two sources: funds from the Maternal and Child Health Block Grant, and state general funds. If the program was fully staffed it would receive up to $1.9 million from MCH Block grant funding and $500,000 funding from the Maintenance of Effort ("MOE") associated with the MCH Block Grant. The MOE provision requires federal grant recipients "to maintain non-federal funding for activities described in their application at a level which is not less than expenditures for such activities during the fiscal year prior to receiving the grant or cooperative agreement." PHN also receives $4.2 million from General Funds.

In the past, PHN did developmental screening of children that were in the appropriate age groups. PHN currently has work to do in this area. Recent new hires and change in leadership have impacted the performance of developmental screening within the program. PHN is in the process of training staff how to administer the ASQ screening tool. Additionally, work needs to be done to clarify that these tools are to be used for developmental screening and not child assessment. PHN is also working collaboratively with Maine Families to assure that they are not duplicating efforts when both organizations are providing services to these families. In terms of data collection, PHN uses CareFacts as an electronic medical record and can accurately pull data back to 2017.

Table 6: Number of Public Health Staff, children served, screened, and referred in CY2017 and CY2018

	CY2017	CY2018	Total
Total # staff providing services (Direct service only, not supervisors)	29	29	58
Total # children served (0-8 yrs.)	822	840	1,662
***Total # children who received developmental screening (0-8 years) (due to the limitations of the data, unclear what specific screening tool was used)**	278	415	2,373
Race of children served by Public Health Nursing			
American Indian/Alaskan Native	5	27	32
Asian	1	1	2
African American	23	11	34
Native Hawaiian/Pacific Islander	2	1	3
White	237	22	259
More than One Race	17	17	34
Hispanic	2	5	7
Unknown	535	545	1,080
Socio economic breakdown of children served by Public Health Nursing:			
***<51% of Federal Poverty Guidelines**	34%	24%	37%

Table 7: PHN: Number of children referred and result by county

	2018	2017
County	**# referred**	**# referred**
Androscoggin	9	13
Aroostook	39	41
Cumberland	3	4
Franklin	6	3
Hancock	15	17
Kennebec	47	35
Knox	13	8
Lincoln	7	4
Oxford	12	14
Penobscot	50	38
Piscataquis	9	6
Sagadahoc	8	2
Somerset	25	25
Waldo	11	13
Washington	19	21
York	0	1
Total	273	245

Public Health Nursing's capacity to serve children will vary between districts across the state. District 1 and 2; York and Cumberland County have the best staffing ratio currently. District 1 and 2 currently are supervised by one PHN supervisor and are staffed with 4 PHN II and 2 PHN

I. District 7 has a limited capacity because of current staffing ratios this could potentially impact the Capacity to serve children in this district. The remaining Districts have an average of 4 RNs that have one supervisor/consultant per district, which is sufficient staffing ratios to assist with serving children 0-8.

MAINE CDC: WOMEN, INFANTS & CHILDREN PROGRAM (WIC)

The Women, Infants & Children recently started doing developmental surveillance using materials from the CDC's Learn the Signs Act Early Program. The (WIC) Nutritional Services is a voluntary program that provides low-cost healthy foods, nutritional education, breastfeeding promotion, and support and referrals to other services to women, infants and children who are at nutrition risk. The program is designed to allow women to enroll during pregnancy and for children to remain enrolled up to the age of five. WIC serves children 0-5 currently. WIC serves women who are pregnant (in any trimester), who are breastfeeding, or who had a baby in the last six months. WIC serves infants and children up to the age of five living in Maine regardless of immigration status, including adopted and foster children. WIC is almost entirely federally funded, $23 million, except for a small amount of state dollars for the Farmers' Market Nutrition Program, $10,000. WIC is working to increase participation in the program. Currently, WIC is moving to an EBT card in 2020 to improve shopper experiences. Beginning in 2019, all children seen at WIC are provided with materials on developmental surveillance appropriate for their age. WIC documents any developmental concerns found and provides them to the parent to give to a medical provider for further review. WIC uses the SPIRIT System as the MIS and data is available back to 2012.

Table 8: WIC Number of Staff, Children Served, Children offered Developmental Surveillance, 2012-December 31, 2018

	2012*	2013	2014	2015	2016	2017	2018
Total # staff providing services	121	140	135	129	123	136	137
Total # children served (0-8 yrs.)	22,970	27,986	26,495	25,229	24,123	22,725	21,767
Total # children who received developmental screening (0-8 years)	Not tracked until 2019						
Total # of children referred to CDS and %		27	76	84	117	112	196
Race of children served							
White	19,368	23,471	22,104	20,986	19,945	18,531	17,635
Black	1,523	1,988	1,979	1,990	2,046	2,245	2,321
Asian	229	302	296	284	282	252	240
Native American	194	226	203	201	191	147	143
Pacific Islander	7	17	21	21	27	30	25
More than One Race	1,640	1,937	1,844	1,696	1,591	1,469	1,359
Undeclared**	9	271	45	72	41	51	44

Socio economic breakdown of children served							
SNAP	2,072	1,762	956	672	465	299	220
TANF	510	632	509	391	293	233	194
ME	19,729	23,859	23,076	22,280	21,564	20,501	19,420
Other	217	183	69	25	12	4	0

*****Partial year

** Undeclared means that the participant chose not to disclose their race

MAINE PARENT FEDERATION (MPF)

Maine Parent Federation's (MPF) Family Support Navigator (FNS) program is a peer to peer program which provides one to one assistance to families of children with special healthcare needs. The program is staffed by four full-time equivalent positions who coordinate FSN trainings, connections to families, and feedback. FSNs are parents of children with special healthcare needs, professionals working with families who have children with special healthcare needs or a relative to a child with special healthcare needs. Before FSNs can work with families they must attend a two-day training. Once training is complete, FSNs are matched to families who have needs within a FSN's geographic region, as well as lived experience. FSNs can assist families navigating all systems of care including, but not limited to; MaineCare, including Katie Beckett, state waivers such as 28, 21, & 29, Case Management, Social Security, Special Education, including Early Intervention services, Transition to Adulthood, Assessments and Screenings and Guardianship, including Supported Decision Making. The FSN program is funded by a state contract through the Maine CDC and the Maternal and Child Health Block Grant. MPF is additionally connected to three federal grants to ensure services continue if needs exceed the means. MPF participates on the Developmental Systems Integration (DSI) to represent parents' voices. Often, however, when families contact MPF they have already gone through the screening process and as a result have been referred to MPF for assistance navigating systems of care.

MPF collects data through an intake process using the filemaker system. MPF respects the rights of families to reveal what they are comfortable with, and thus MPF does not push to collect financial conditions or ethnic backgrounds. Some of this information can be derived from meeting with the family and those data are then recorded in the database. MPF will record applicable data, noting most of the families served have already been referred to and received screenings and because of those screenings have been connected to MPF. If there is no information within the graph below then it does not pertain to MPF programming. MPF works with families and not directly with children, therefore entered numbers refer to families of children within the desired classification. MPF does not perform any screenings of children but may refer a family to do their own parental referral to Child Development Services (CDS).

Table 9: MPF Data: Number of Staff, Children Served, Children Screened calendar year data from 2010-December 31, 2018

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total # staff providing services							4 FTE 25 avg. FSNs	4 FTE 20 avg. FSNs	4 FTE 25 avg. FSNs
Total # children served (0-8 yrs.)	143	315	52	56	83	107	108	119	140
Race of children served									
White	32%	35%	31%	13.5%	22%	37%	37%	39%	39%
Black	0.4%	1.5%	0.19%		0.32%	0.28%	1.8%	0.11%	0.69%
Tribal	0.3%	0.44%		0.22%	0.11%	0.24%	0.4%	0.41%	0.83%
Asian	0.01%	0.41%	0.06%		0.48%	0.43%	0.4%	0.18%	0.1%
Unavailable	38%	0.47%	53%	77%	66%	60%	54%	50%	52%
Declined	0.4%	0.2%	0.3%	0.23%	0.21%	0.14%	0.46%	0.46%	0.49%
Socio economic breakdown of children served									
Income Eligible	36%	0.39%							

MAINE FAMILIES HOME VISITING (MFHV)

Maine Families Home Visiting is a voluntary program available for pregnant women, expectant couples, and parents or primary caregivers of children from birth to age three. Highly trained family visitors work with families to ensure safe home environments, promote healthy growth and development for babies and toddlers, and connect families to needed community services. Family visitors use a non-judgmental and compassionate approach that empowers parents with skills, tools, and confidence to nurture the healthy growth of their baby. This program is offered in every county of the state through a well-established and rigorously accountable system of performance-based contracts with local agencies, which are affiliates of the international Parents as Teachers (PAT) evidence-based model. Maine Families is funded through a mix of federal and state dollars: Maternal, Infant, and Early Childhood Home Visiting grant: $5,419,712; Temporary Assistance for Needy Families: $1,878,225; and state General Fund: $2,000,000.

Family Visitors provides ongoing and child development monitoring and surveillance to track progress toward developmental milestones and assist in early detection of possible developmental delays, behavioral concerns, and health issues through standardized screenings with parent permission. Regular developmental screenings are conducted using the Ages and Stages Questionnaires-Third Edition (ASQ-3) and the Ages and Stages Questionnaires: Social-Emotional 2 (ASQ-SE 2). The initial developmental screening (comprised of both the ASQ-3 and the ASQ-SE 2) must be completed within 90 days from enrollment (postpartum enrollments) or 90 days from birth (prenatal enrollments). The ASQ-3 is done at minimum at 2, 4, 9, 12, 18, 24, 30 and 36 months. of age. The ASQ-SE2 occurs as part of the initial screening and is completed at least annually thereafter.

Copies of the ASQ-3 and ASQ-SE 2 results are provided directly to the Primary Care Provider (PCP) with the family's written permission and must be made available to families who may wish to share the form with their children's medical or child care providers. If a possible delay is noted in any areas on the ASQ-3 or ASQ-SE 2, parents are informed of options, such as referral to their PCP, Child Development Services, or appropriate clinicians, as well as provided with developmental promotion ideas and activities that may be done in the home to address the concern.

Child health screening is completed by the time the child turns 7 months if enrolled before four months of age, or within 90 days of enrollment for those enrolled after 4 months of age. Screenings are completed annually thereafter during each reporting year (July through June). A complete health screening includes a review of health status, safety, vision and hearing elements.

Maine Families staff document all activities in ERIN, the Maine Families' Family record system which has been in use since October 1, 2016. Maine Families staff capture all screening data in the family record system, ERIN within two days of each home visit. Supervisors conduct record reviews at least quarterly to ensure the accuracy of the data entered and discuss individual family needs on an ongoing basis with staff through reflective supervision. In addition, state-level administrative staff conduct annual record reviews to verify data quality and completeness and discuss any concerns identified in site reviews. Data on the results of referrals is based on client self-report, unless consent has been given for the family visitor to contact CDS or another provider directly. For this reason, not all referral information may be complete, particularly when families end services shortly after a referral is made.

Table 10: Number of Maine Families staff, children served, screened, and referred in CY2017 and CY2018

If a child was served in both calendar years, the child is counted once in each year. The total column includes an unduplicated count of each data point over the two years.

	CY2017	CY2018	Total
Total # staff providing services (Direct service only, not supervisors)	98	95	
Total # children served (0-8 yrs.)	2,075	2,119	3,108
Total # children who received developmental screening (0-8 years) (ASQ-3)	1,510	1,699	2,373
Total # of children referred to CDS	113	133	228
Race of children served by Maine Families			
American Indian/Alaskan Native	32	27	42
Asian	15	17	25
African American	97	127	168
Native Hawaiian/Pacific Islander	4	4	7
White	1,713	1,768	2,557
More than One Race	173	165	258
Unknown	41	11	51

Socio economic breakdown of children served by Maine Families: Household Income in Relation to Federal Poverty Guidelines			
<51% of Federal Poverty Guidelines	38%	35%	37%
51%-100%	19%	18%	19%
101%-133%	12%	12%	11%
134%-200%	12%	13%	13%
201-300%	11%	12%	11%
>300%	7%	8%	8%
Unknown	<1%	1%	1%
Average age of child when they enter program	3 weeks	3 weeks	3 weeks

Table 11: MFHV Number and percent of children receiving at least one developmental screening (ASQ-3) by age and county

If a child was screened more than once during the fiscal year, the child is counted once in each age category based on their age at the time of each screening (i.e., if screened at two and four months the child is counted once under <12 months. If screened at 9 and 12 months in the fiscal year the child is counted (once in each category).). Total children screened column shows the unduplicated count of children screened in each county during the fiscal year.

SFY 2018					
County (of residence)	**<12 mths**	**12-23 mths**	**24-35 mths**	**36 mth+**	**Total children screened**
Androscoggin	80	29	18	6	109
Aroostook	86	40	24	2	122
Cumberland	125	54	21	10	167
Franklin	72	51	36	8	120
Hancock	56	21	28	4	89
Kennebec	94	39	26	1	128
Knox	31	20	17	5	60
Lincoln	28	7	6	2	36
Oxford	46	22	14	3	71
Penobscot	118	61	37	7	179
Piscataquis	12	3	4	3	19
Sagadahoc	25	7	4	0	30
Somerset	44	23	15	2	65
Waldo	29	18	12	1	47
Washington	90	64	33	8	147
York	135	51	27	4	180
Total children screened	**1,071**	**510**	**322**	**66**	**1,569**

SFY 2019					
County (of residence)	**<12 mths**	**12-23 mths**	**24-35 mths**	**36 mth+**	**Total children screened**
Androscoggin	102	41	21	3	136
Aroostook	81	50	18	3	118
Cumberland	162	66	35	8	229
Franklin	65	51	38	14	118
Hancock	73	31	19	8	140
Kennebec	105	56	32	7	154
Knox	41	23	9	3	60
Lincoln	29	10	4	1	36
Oxford	61	16	8	4	80
Penobscot	123	58	44	13	186
Piscataquis	17	5	3	2	22
Sagadahoc	33	11	3	0	38
Somerset	44	14	9	0	62
Waldo	31	16	14	5	50
Washington	80	58	43	9	141
York	152	78	32	12	214
Total children screened	**1,199**	**584**	**332**	**92**	**1,748**

Table 12: MFHV Number and percent of children receiving at least vision/hearing/oral/safety screening by age and county, 2018

If a child was screened more than once during the fiscal year, the child is counted once in each age category based on their age at the time of each screening (i.e., if screened at two and four months the child is counted once under <12 months. If screened at 9 and 12 months in the fiscal year the child is counted (once in each category). Total children screened column shows the unduplicated count of children screened in each county during the fiscal year.

SFY 2018					
	<12 mths	**12-23 mths**	**24-35 mths**	**36 mth+**	**Total children screened**
Androscoggin	44	19	13	1	**75**
Aroostook	60	20	15	0	**95**
Cumberland	77	35	18	0	**127**
Franklin	38	33	19	0	**89**
Hancock	32	16	23	0	**69**
Kennebec	63	24	19	0	**105**
Knox	27	15	9	0	**50**
Lincoln	19	5	4	0	**27**
Oxford	28	17	12	1	**56**
Penobscot	66	34	20	0	**121**
Piscataquis	5	3	1	0	**12**

Sagadahoc	17	2	5	0	**24**
Somerset	23	15	5	0	**43**
Waldo	16	16	10	0	**42**
Washington	54	42	15	0	**110**
York	80	29	19	0	**126**
Total children screened	**651**	**328**	**208**	**2**	**1,173**

Table 13: MFHV Number and percent of children receiving at least vision/hearing/oral/safety screening by age and county, 2019

SFY 2019					
	<12 mths	**12-23 mths**	**24-35 mths**	**36 mth+**	**Total children screened**
Androscoggin	58	28	13	0	**97**
Aroostook	56	34	16	0	**102**
Cumberland	78	44	23	0	**146**
Franklin	43	33	28	0	**99**
Hancock	39	18	14	1	**72**
Kennebec	61	34	27	0	**121**
Knox	27	15	9	0	**51**
Lincoln	19	9	0	2	**29**
Oxford	31	11	9	0	**50**
Penobscot	77	36	28	0	**137**
Piscataquis	9	3	2	0	**14**
Sagadahoc	20	8	2	1	**30**
Somerset	27	10	10	0	**47**
Waldo	17	10	9	0	**35**
Washington	42	34	31	0	**104**
York	95	47	24	3	**167**
Total children screened	**700**	**372**	**247**	**7**	**1,304**

Table 14: MFHV Number of children referred and result by county, 2018

If a child was referred more than once, the child is counted once in the # referred. If a child is referred more than once and the referrals had different results, they are counted once for each result type.

SFY 2018						
			Result of referral			
County	**# screened (ASQ-3)**	**# referred**	**# received**	**# did not receive**	**# not eligible**	**# declined referral**
Androscoggin	109	6	1	2	0	3
Aroostook	122	11	3	1	0	7
Cumberland	167	15	3	1	4	7
Franklin	120	7	1	0	1	5

Hancock	89	7	5	0	2	0
Kennebec	128	11	3	1	0	7
Knox	60	6	5	2	0	0
Lincoln	36	3	1	2	0	0
Oxford	71	8	2	1	1	4
Penobscot	179	12	3	3	4	3
Piscataquis	19	1	1	0	0	0
Sagadahoc	30	2	0	0	2	0
Somerset	65	5	2	0	0	3
Waldo	47	7	3	2	0	4
Washington	147	8	3	0	4	1
York	180	24	12	2	4	10
Total	**1,569**	**133**	**48**	**17**	**21**	**54**

Table 15: MFHV Number of children referred and result by county, 2019

SFY 2019						
County	**# screened (ASQ-3)**	**# referred**	**# received**	**# did not receive**	**# not eligible**	**# declined referral**
Androscoggin	136	8	6	2	0	2
Aroostook	118	8	3	2	1	2
Cumberland	229	16	4	5	4	3
Franklin	118	7	4	2	0	5
Hancock	140	7	2	5	0	0
Kennebec	154	14	4	8	1	3
Knox	60	6	3	1	0	1
Lincoln	36	1	0	0	1	0
Oxford	80	3	1	0	1	1
Penobscot	186	10	7	2	1	2
Piscataquis	22	1	1	0	0	0
Sagadahoc	38	1	1	0	0	0
Somerset	62	5	4	0	0	1
Waldo	50	4	3	2	0	0
Washington	141	13	3	2	1	7
York	214	23	13	4	6	4
Total	**1,748**	**127**	**59**	**35**	**16**	**31**

Maine Families' current capacity is to serve 1,174 families at any point in time (approximately 15 families per visitor). Families can range in size and staff conduct developmental screening and surveillance with any children in the home under age three. On average about 2,100 children are served over the course of a year.

OFFICE OF CHILD AND FAMILY SERVICES (OCFS)

Since 2003, the Child Abuse Prevention and Treatment Act (CAPTA) requires states that receive CAPTA funds to develop provisions and procedures for the referral of a child under the age of three who is involved in a substantiated case of abuse or neglect to Early Intervention Services funded under Part C of IDEA. In Maine, OCFS receives those funds and is responsible for adhering to the CAPTA requirements. OCFS has a policy, developed in 2004, that outlines the policy and procedure for referrals to CDS. In 2015, OCFS worked with CDS to explore the procedures and decided to automate the referrals required under CAPTA. Rather than requiring each Child Welfare caseworker to fax or email the referral to CDS, OCFS centralized the process which is now completed by the Information Services data team. This has ensured that all required referrals are being delivered to CDS in a streamlined and consistent way taking the administrative burden off from caseworkers.

In 2019, OCFS and CDS reconvened to assess the effectiveness of the new process. Based on the data below there are additional process improvement strategies needed including the communication with families by child welfare about the benefits of CDS.

Since the change in process, while the total number of referrals is at an all-time high of 100% sent and received, the rate of parent engagement in CDS services following a referral from child welfare is suffering. CAPTA referrals are CDS' second largest referral source following physicians. CDS has found that the engagement rate of families when referred by physicians is more than twice that of referral by CAPTA referrals.

OCFS CHILD DEVELOPMENT SERVICE REFERRAL CANDIDATES

The following chart shows children under the age of 3 that were involved in an assessment that resulted in a finding. Data is displayed by calendar year and the county of residence for the family at the time of the intake report.

Between 2008 and 2018, OCFS had an average of 1222 children annually under age 3 that were candidates for a CDS referral.

Table 16: OCFS Referrals to CDS

COUNTY OF RESIDENCE	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Androscoggin	163	172	150	167	161	152	121	120	124	124	109
Aroostook	68	96	62	46	77	94	68	51	65	56	61
Cumberland	239	163	163	161	146	177	182	136	136	123	95
Franklin	41	32	34	34	32	26	23	26	17	12	15
Hancock	63	55	32	44	56	56	66	52	43	45	51
Kennebec	91	100	96	106	135	131	134	130	196	150	159
Knox	40	27	23	22	42	34	31	29	36	29	27
Lincoln	20	16	6	6	25	20	8	26	27	37	23

Oxford	52	71	73	54	52	49	57	38	40	40	29
Penobscot	190	208	165	166	193	174	172	161	166	149	193
Piscataquis	21	17	23	12	9	10	24	14	13	13	13
Sagadahoc	20	15	18	11	14	23	17	13	27	15	11
Somerset	92	91	79	73	83	98	94	97	94	76	73
Waldo	45	20	28	30	60	45	39	38	44	20	22
Washington	41	35	28	30	36	44	31	27	38	31	34
York	162	188	176	151	192	228	172	194	161	161	233
Total	**1348**	**1306**	**1156**	**1113**	**1313**	**1361**	**1239**	**1152**	**1227**	**1081**	**1148**

Table 17: Child Development Service Referral Candidates Resulting From Drug Affected Baby/Substance Exposed Newborn Report

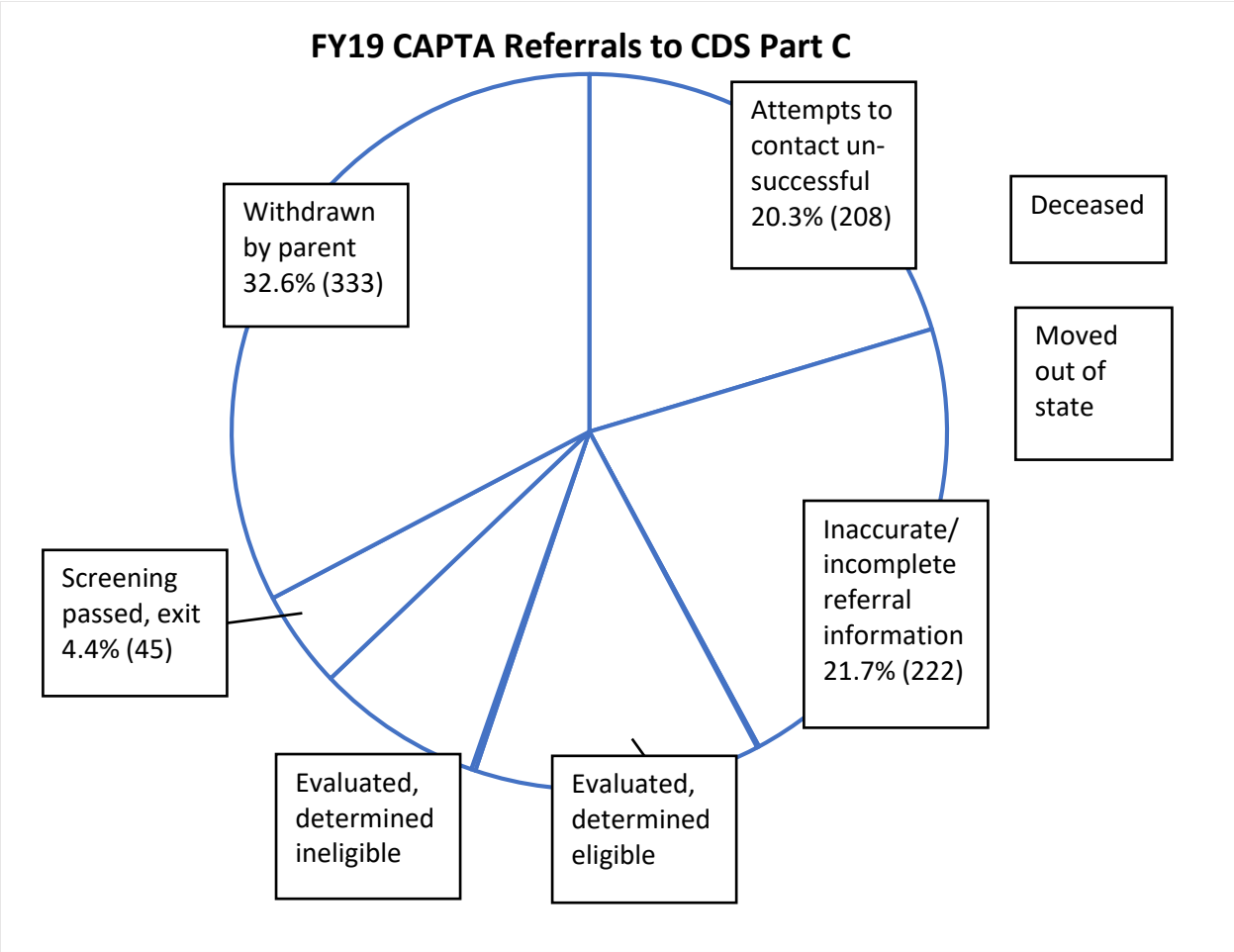
This chart shows the percentage of children under the age of 3 that were involved in an assessment that resulted in a finding where the assessment originated from a report of a drug affected baby/substance exposed newborn of all the candidates for a CDS referral. Data is displayed by calendar year and the county of residence for the family at the time of the intake report.

COUNTY OF RESIDENCE	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Androscoggin	4%	9%	10%	12%	12%	13%	13%	8%	14%	8%	14%
Aroostook	1%	6%	0%	2%	9%	4%	9%	0%	6%	9%	13%
Cumberland	2%	7%	6%	11%	9%	14%	14%	18%	10%	17%	20%
Franklin	0%	0%	3%	3%	9%	8%	0%	15%	6%	8%	7%
Hancock	5%	4%	9%	2%	11%	9%	17%	12%	21%	9%	6%
Kennebec	5%	5%	6%	8%	5%	6%	10%	9%	13%	6%	11%
Knox	5%	0%	9%	9%	24%	18%	3%	14%	6%	10%	15%
Lincoln	5%	0%	0%	17%	12%	10%	13%	8%	15%	5%	9%
Oxford	8%	4%	5%	6%	2%	4%	2%	3%	8%	15%	17%
Penobscot	6%	9%	12%	7%	12%	17%	23%	16%	20%	19%	10%
Piscataquis	0%	12%	13%	0%	11%	30%	25%	50%	38%	0%	0%
Sagadahoc	0%	0%	6%	0%	7%	9%	6%	23%	19%	0%	18%
Somerset	7%	7%	13%	12%	18%	17%	16%	15%	7%	16%	11%
Waldo	11%	5%	7%	7%	10%	11%	0%	3%	14%	10%	9%
Washington	0%	20%	7%	7%	3%	11%	10%	4%	11%	32%	9%
York	3%	1%	4%	5%	6%	7%	6%	14%	13%	8%	8%
Total	4%	6%	7%	8%	10%	11%	12%	12%	13%	12%	11%

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states have provisions and procedures for the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services funded by Part C of the Individual with Disabilities Act (IDEA). In Maine, OCFS is responsible for referring these children to CDS' Part C program. Once referred, CDS' Part C program attempts to contact and engage the family/caregiver and to determine the child's eligibility for Part C services. In FY19, per CAPTA requirements, OCFS referred 1022 infants and toddlers to CDS' Part C program. The chart below reflects the outcome of CDS' Part C programs attempts to contact and engage

the families/caregivers of those children. CDS has found that the engagement rate of families when referred by physicians is more than twice that of referral by CAPTA referrals.

Figure 2: CAPTA Referrals to CDS Part C



DHHS/DEPARTMENT OF EDUCATION

HEAD START PROGRAMS

Head Start was first launched in 1965 to provide comprehensive health, nutrition, and education services to children in poverty. The Head Start model, developed over the decades, has been built on evidence-based practices and is constantly adapting - using the best available science and teaching techniques to meet the needs of local communities. Head Start takes a comprehensive approach to meeting the needs of young children. There are four major components to Head Start:

- Early Education: Providing a variety of learning experiences to help children grow intellectually, socially, and emotionally.

- Health/Nutrition: Providing health services such as immunizations, dental, medical, mental health, nutritional services, and early identification of health problems.

- Parent & Community Engagement: Engaging parents/families in the planning and implementation of activities. Parents serve on policy councils and committees that make administrative decisions; participate in classes and workshops on child development; and volunteer in the program.

- Social Services: Provide outreach to families to determine what services they need.

Current funding is provided to 17 partners and 13 grantees in Maine at approximately $40.2 million for FY 2019. Federal Funding goes directly to Head Start. State funds are administered by OCFS to Head Start through contracts with the Head Start grantees. The federal grant funds for the State Head Start Collaboration Director position are managed out of DOE. It is a federal requirement that Head Start Grantee's collect the following information for all newly enrolled children: 30 Days – Immunization Records; 45 Days – Health and Developmental screenings (vision, hearing, developmental); 90 Days – Well Child Exams, Dental Exams. Each grantee collects this information if previously completed or support the family to obtain these services within the program or through a community partner. Each grantee has documented screening procedures in place to assure screenings are completed and results are reviewed with parents/guardians. All Maine Head Start Grantee's are required by the Federal Head Start office to complete an annual Program Information Report (PIR) at the end of each program year. Reports can be pulled for the last 10 years by different levels; national, state, grantee, and program. All Maine Head Start Grantee's have been using the platform "ChildPlus" as their data base, since the end of 2016 and can pull program level data as needed. In early 2018, all Head Start grantees reviewed the Program Information Report questions to assure alignment across the state. Each program agreed to answer each question using data to accurately provide the Federal Head Start Office with consistent information among programs. Prior to this, some programs interpretation of the questions was unclear.

Table 18: Head Start: Number of Staff, Children Served, Children Screened (calendar year data from Jan 1,2010-December 31, 2018)

STATE LEVEL DATA	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Total # staff providing services (includes all staff)	1,274	1,309	1,197	1,123	1,063	1,144	1,318	1,379	1,524
Cumulative Total # children served (0-5 yrs)	4,638	4,698	4,697	4,322	3,844	4,075	4,044	3,972	3,851
Total # newly enrolled children who received dev. screening (0-8 years)	3,923	3,489	2,580	2,545	2,374	2,578	2,356	2,094	2,058
Total # of newly enrolled children referred to CDS and %	350/47.11% (3-5yrs) 47/53.41% (0-3yrs)	416/51.42% (3-5yrs) 58/53.70% (0-3yrs)	369/47.49% (3-5yrs) 63/53.85% (0-3yrs)	352/49.79% (3-5yrs) 51/43.97% (0-3yrs)	321/50.47% (3-5yrs) 45/44.12% (0-3yrs)	327/49.32% (3-5yrs) 65/48.51% (0-3yrs)	251/38.32% (3-5yrs) 54/37.76% (0-3yrs)	250/47.26% (3-5yrs) 63/42.28% (0-3yrs)	218/41.13% (3-5yrs) 53/38.97% (0-3yrs)

Head Start's capacity to serve children is based on the Grantee's total number of federal funded slots within their catchment area. Each grantee is awarded a certain number of slots within multiple age groups and categories. For example, one program may be funded to serve 250 preschool aged children and 150 infants and toddlers. Within the 250 preschool slots, 75 might be for an extended day Head Start within a public-school system, and the other 175 might be full/day full/year services with wrap around childcare. Within the 150 infant and toddler slots, they might have 50 who are receiving Early Head Start Home Visiting services and the other 100 who are full/day full/year services with wrap around childcare. Typically, grantees are not able to serve more children than their funded slots, because of the cost of care. These costs include staffing wages and benefits, facilities, etc. Grantee's highly depend on their partnership with community providers to meet the needs of children and families and meeting federal requirements.

Funding for Head Start has fluctuated. In 2012, a budget cut was made as part of many social service cuts in that year's supplemental budget; $2M was cut from state General Funds support for Head Start, reducing it to $444,000 a year starting in FY 13. Since then, Head Start has received General Funds support up to $1.2M a year, leaving an $800,000 gap per year. This gap in Head Start funding has continually been a challenge for programs across the state. Head Start grantees have strategically reorganized and re-evaluated their programming in order to serve as many children as possible with the funding they have.

DEPARTMENT OF EDUCATION

CHILD DEVELOPMENT SERVICES

Child Development Services (CDS), a quasi-state agency under the supervision of the Maine Department of Education (DOE). It is the lead state agency for the administration of IDEA Part C and Part B§619 programs (birth through 2 and 3 to kindergarten-age 5, respectively). The two programs, as identified in state and federal regulations are distinctly different from one another and from special education services for 5 to 20 year-old students. Services provided in the Part C program address family-identified concerns and priorities reflected in the Individual Family Service Plan (IFSP) and are provided in the child's natural environment. Services provided in the Part B§619 program address educational needs as identified in the Individualized Education Plan (IEP) are provided in the Least Restrictive Environment (typically a general or special education preschool program).

CDS changed its eligibility for services in 2003 upon instructions from the administration to implement the federal minimum standard of services as set forth in the IDEA, resulting in substantial changes to eligibility for both 0-2 and 3-5. Maine is one of 16 states that currently used Category C eligibility criteria. The definitions for eligibility are below:

- Category A: At Risk, Any Delay, Atypical Development, one standard deviation in one domain, 20% delay in two or more domains, 22% in two or more domains, 25% delay in one or more domains. (16 states)

- Category B: 25% in two or more domains, 30% delay in one or more domains, 1.3 standard deviations in two domains, 1.5 standard deviations in any domain, 33% delay in one domain. (19 states)

- Category C: 33% delay in two or more domains, 40% delay in one domain, 50% delay in one domain, 1.5 standard deviations in 2 or more domains, 1.75 standard deviations in one domain, 2 standard deviations in one domain, 2 standard deviations in two or more domains. (16 states)

Due to the variations in eligibility across the states, point in time national 0-3 enrollment ranged from a low of 0.82% (AR) to a high of 9.54% (MA) in 2017.

Additional historical changes have impacted how CDS is structured. In 2006, An Act to Improve Special Education provided for the centralization of fiscal, audit, data and human resources of the CDS System, and established the CDS Central Office continuing as the State Intermediate Educational Unit (SIEU). Further, in 2010, as a cost savings effort, CDS sites were consolidated from the existing 16 regional sites to 9 regional sites with 7 satellite offices. In 2012, OPEGA published their evaluation of the CDS system pursuant to Legislative interest in reviewing this program stemming from recurring supplemental budget requests and private provider complaints:

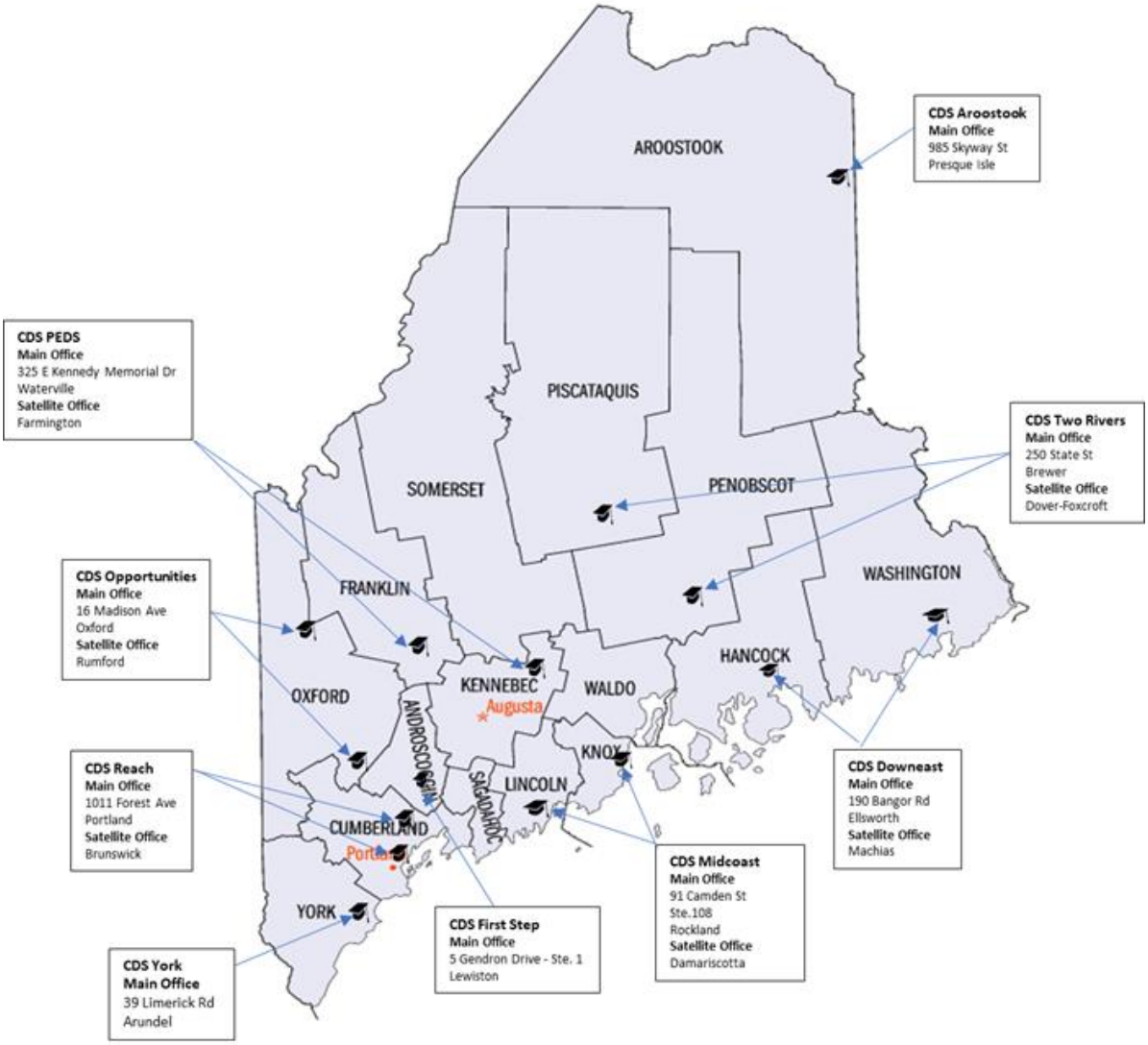
> *Recent legislator interest in a review of the CDS program stemmed primarily from recurring supplemental budget requests for the program over the past several years. Changes made to the CDS System in 2006 were projected to result in several million dollars of General Fund savings and appropriations were reduced accordingly. In fact, however, program costs did not go down. Even with multiple supplemental budget appropriations over the five years, annual revenues have consistently been insufficient to cover actual expenses. As a result, the CDS program was carrying forward a deficit of over $3 million by the end of fiscal year 2011. CDS's independent financial auditor noted this and, in November 2011, the Governor approved a Financial Order shifting $3.6 million in General Purpose Aid to the CDS program to cover the deficit.*[20(p.2)]

In 2012, as Part OO of the Supplemental Budget bill passed in the spring of 2012 eliminated the regional boards and gave responsibility for oversight of the operations of the regional sites to the CDS Director who is the Director of Early Childhood Special Education.

Currently, CDS operates nine regional sites across Maine, Figure 6, with a central state office which is housed at MDOE in Augusta. At the regional site level, service coordination and case management are provided by CDS staff, while direct services are provided by both CDS-employed and contracted providers (both sole proprietors and programs), agencies, and School Administrative Units. Staff at the state office are responsible for general oversight of regional sites, including budget development and monitoring, human resources, accounts payable and billable, centralized contracting, quality assurance, and the collection, analysis, and federal reporting of site- and state-level data.

[20] https://www.maine.gov/legis/opega/reports/Final%20CDS%20Report%207-17-12.pdf. Accessed December 2019.

Figure 3: Map of CDS Offices



For Fiscal Year 2020, CDS has an operating budget of $43,790,922. CDS' operating budget for Fiscal Year 2019 was $37,499,983. State appropriations accounts for approximately 83% of that budget, federal grants for approximately 12.3%, third party revenue (MaineCare and private insurance) for approximately 1.2%. Currently, the percentage of CDS' Part C program costs funded by Medicaid is significantly less than the national average of 29%.[21] Achieving the 29% average would result in an additional $2,561,000 to Maine's Part C program. Currently, CDS is unable to identify the total amount of MaineCare reimbursement that contracted providers receive for services provided to children referred by CDS. CDS is currently working with MaineCare to identify more ways that they can support Part C services.

[21] Interview with Roy Fowler- estimate from The IDEA Infant and Toddler Coordinators Association, which is the national professional organization for State Part C Coordinators. December 2019.

CDS' Part C program typically does not conduct development screenings, with the exception of those infants and toddlers for whom the content of the referral does not clearly indicate the need for a comprehensive developmental evaluation or which does not indicate an established condition under which an infant or toddler would be considered to be eligible for Part C services.

Instead, CDS' relies on referral sources to complete developmental screenings to determine if a referral is appropriate and asks that a copy of those screenings accompany the referral to the Part C program. Ideally, if the necessary resources were available, CDS' Part C program would conduct a robust and proactive Child Find effort by conducting developmental screenings in community settings such as childcares, library story times, play groups, etc.

When it has available resources, CDS' B§619 program supports SAUs in their screening of children in the spring prior to kindergarten entry. In recent years, CDS' B§619 program's ability to support SAUs in these screenings has been significantly impacted by staff shortages and the resultant caseloads of remaining staff.

On July 1, 2016, CDS implemented Child Information Network Connection (CINC) which is a web-based data system that includes child-, site-, and state-level data. CINC allows access to data through reports embedded in the data system and through ad hoc queries. Prior to the implementation of CINC, CDS utilized a relatively antiquated Access data system (Case-e) which has since been sunset. Currently, accessing the data contained in Case-e is not possible.

Prior to the implementation of CINC, the amount of data collected and available for analysis was limited. In addition to the challenge in accessing the data contained in the past data system, the accuracy of that data may be questionable due to flaws inherent in that system and to the shift in the definition of specific data components, timeline, time frame, and point-in-time which specific data components reflect. The data reported below, prior to Calendar Year 2017 and Fiscal Year 2017, was gathered from the annual CDS Legislative Reports

Figure 4: 0-3 Child Count, Point in Time

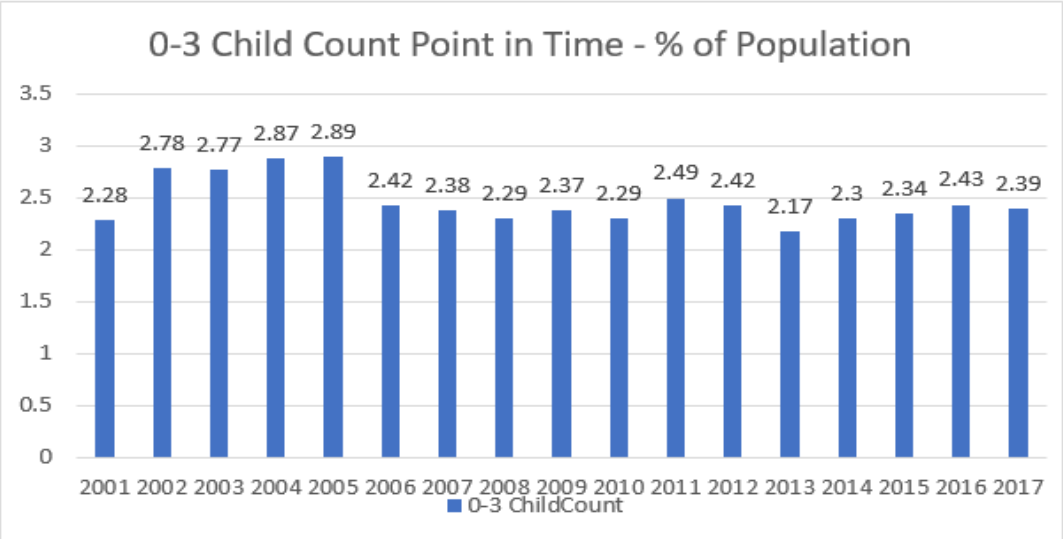


Table 19: CDS Data:
Number of Staff, Children Served, Children Screened calendar year data from Jan 1, 2010-December 31, 2018

	2013	2014	2015
Total # staff providing services	359	359 293.5 FTEs	387 321.5 FTEs
Total # children served (0-8 yrs)	Part C: 833 Part B§ 619: 3,665*	Part C: 889 Part B§619: 3,184*	Part C: 908 Part B§619: 3,405*
Total # children who received developmental screening (0-8 8years)	Part C: 650 Part B: 1680	Part C: 678 Part B: 1768	Part C: 748 Part B: 1765
Total # of children referred to CDS and %	Part C: 3,194 referred; 38.5% eligible Part B§619: 4,395 referred; 30.5% eligible	Part C: 3,086 referred; 40.5% eligible Part B§619: 4,748 referred; 30.5% eligible	Part C: 3,353 referred; 37.6% eligible Part B§619: 5093 referred; 24.39% eligible
Racial breakdown	Part C: American Indian or Alaska Native: 5 Asian: 16 Black or African American: 35 Hispanic/Latino: 12 Native Hawaiian or Other Pacific Islander: 2 Two or more races: 12 White: 751 Total: 833	Part C: American Indian or Alaska Native: 15 Asian: 21 Black or African American: 44 Hispanic/Latino: 11 Native Hawaiian or Other Pacific Islander: 3 Two or more races: 21 White: 774 Total: 889	Part C: American Indian or Alaska Native: 16 Asian: 18 Black or African American: 61 Hispanic/Latino: 41 Native Hawaiian or Other Pacific Islander: 3 Two or more races: 71 White: 698 Total: 908

	Part B: American Indian or Alaska Native: 57 Asian: 38 Black or African American: 153 Hispanic/Latino: 35 Native Hawaiian or Other Pacific Islander: 14 Two or more races: 101 White: 3267 Total: 3665	Part B: American Indian or Alaska Native: 56 Asian: 48 Black or African American: 161 Hispanic/Latino: 81 Native Hawaiian or Other Pacific Islander: 14 Two or more races: 121 White: 2703 Total: 3184	Part B: American Indian or Alaska Native: 16 Asian: 52 Black or African American: 186 Hispanic/Latino: 71 Native Hawaiian or Other Pacific Islander: 3 Two or more races: 115 White: 2962 Total: 3405
Socio economic breakdown	Data not available	Data not available	Data not available
Average age of child at referral	Part C: 1.55 Part B§619: 3.62	Part C: 1.67 Part B§619: 3.66	Part C: 1.68 Part B§619: 3.60

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<tr><th></th><th>2016</th><th>2017</th><th>2018</th></tr>
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336 FTEs</td><td>366
311 FTEs</td><td>360
298 FTEs</td></tr>
<tr><td>Total # children served (0-8 yrs.)</td><td>Part C:
935
Part B§619:
3,215**</td><td>Part C: 2,280
Part B§619:
5,058</td><td>Part C: 2,309
Part B§619: 6063</td></tr>
<tr><td>Total # children who received developmental screening (0-8 8years)</td><td>Part C:
759
Part B§619: 1770**</td><td>Part C:
880
Part B§619:
1817</td><td>Part C:
864
Part B§619:
1337</td></tr>
<tr><td>Total # of children referred to CDS and %</td><td>Part C:
3,763 referred;
28.9% eligible
Part B§619:
5072 referred;
19.2% eligible**</td><td>Part C:
2,656 referred;
38.5% eligible
Part B§619:
4846 referred;
39.6% eligible</td><td>Part C:
2,910 referred;
67.7% eligible
Part B§619:
4663 referred;
42.2% eligible</td></tr>
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<tr><td>American Indian or Alaska Native</td><td>9</td></tr>
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<tr><td>Black or African American</td><td>95</td></tr>
<tr><td>Hispanic/Latino</td><td>27</td></tr>
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<tr><td>Hispanic/Latino</td><td>44</td></tr>
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<tr><td>Asian</td><td>37</td></tr>
<tr><td>Black or African American</td><td>100</td></tr>
<tr><td>Hispanic/Latino</td><td>52</td></tr>
<tr><td>Native Hawaiian or Other Pacific Islander</td><td>2</td></tr>
<tr><td>Two or more races</td><td>110</td></tr>
<tr><td>White</td><td>1993</td></tr>
<tr><td>Total</td><td>2309</td></tr>
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	Part B: American Indian or Alaska Native: 36 Asian: 40 Black or African American: 120 Hispanic/Latino: 41 Native Hawaiian or Other Pacific Islander: 4 Two or more races: 88 White: 2886 Total: 3215	Part B: American Indian or Alaska Native: 58 Asian: 64 Black or African American: 208 Hispanic/Latino: 63 Native Hawaiian or Other Pacific Islander: 7 Two or more races: 147 White: 4511 Total: 5058	Part B: American Indian or Alaska Native: 73 Asian: 74 Black or African American: 244 Hispanic/Latino: 87 Native Hawaiian or Other Pacific Islander: 20 Two or more races: 198 White: 5367 Total: 6063
Average age of child at referral	Part C: 1.67 Part B: 3.76	Part C: 1.72 Part B: 3.85	Part C: 1.74 Part B: 3.88

*Single-Day Child Count (October 1st)

**New Database System 7/1/2016 to 12/31/2016

Table 20: Data on disposition of referrals to Child Find/CDS by county, state FY 018, FY 2019

County	Part B FY 2018					
	# of children screened	Referred for Eligibility Determination	# of children determined eligible	Services not provided in a timely manner	Declined services	Unable to contact
Androscoggin	109	341	194	13	18	21
Aroostook	150	479	75	7	31	15
Cumberland	95	928	507	82	28	35
Franklin	15	69	36	2	12	8
Hancock	60	189	58	40	15	18
Kennebec	36	335	201	8	31	46
Knox	34	104	63	3	14	10
Lincoln	3	110	40	13	15	25
Oxford	95	142	68	19	17	34
Penobscot	512	796	194	4	75	81
Piscataquis	47	73	16	0	5	15
Sagadahoc	2	108	54	6	13	22
Somerset	27	121	59	0	17	15
Waldo	42	86	53	14	15	23
Washington	99	202	62	15	18	32
York	501	788	284	75	75	86

County	Part B FY 2019					
	Screened	Referred	# of children determined eligible	Services not provided in a timely manner	Declined services	Unable to Contact
Androscoggin	86	427	200	28	25	42
Aroostook	161	431	79	8	33	56
Cumberland	34	970	510	135	52	64
Franklin	10	73	33	3	11	13
Hancock	10	209	70	40	22	25
Kennebec	13	372	191	39	49	57
Knox	12	106	57	6	13	15
Lincoln	16	103	73	3	18	35
Oxford	86	196	98	5	22	25
Penobscot	142	500	189	74	47	59
Piscataquis	12	35	16	5	8	5
Sagadahoc	22	102	53	6	24	35
Somerset	17	112	50	5	26	32
Waldo	21	129	51	19	18	31
Washington	57	201	51	16	27	41
York	418	883	333	29	63	87

County	Part C FY 2018					
	Screened	Referred	Children determined eligible	Services not provided in a timely manner	Declined services	Unable to contact
Androscoggin	91	326	120	8	33	31
Aroostook	79	152	57	5	23	24
Cumberland	189	624	234	34	75	76
Franklin	17	54	21	0	5	8
Hancock	37	123	36	1	15	20
Kennebec	75	291	92	8	33	39
Knox	21	63	34	1	10	9
Lincoln	31	60	33	1	5	8
Oxford	18	89	37	2	7	11
Penobscot	67	233	64	7	33	42
Piscataquis	12	26	8	0	5	3
Sagadahoc	39	70	34	3	3	4
Somerset	31	97	32	3	12	18
Waldo	29	48	23	0	5	8
Washington	19	80	26	0	10	6
York	83	461	222	32	65	77

County	Part C FY 2019					
	Screened	Referred	Children determined eligible	Services not provided in a timely manner	Declined services	Unable to Contact
Androscoggin	83	357	127	14	50	59
Aroostook	88	221	60	8	23	41
Cumberland	208	625	280	35	58	75
Franklin	28	68	18	2	8	10
Hancock	43	119	32	2	17	33
Kennebec	101	289	109	9	48	65
Knox	26	104	45	0	13	11
Lincoln	12	68	30	2	11	14
Oxford	24	143	35	4	23	44
Penobscot	67	305	72	7	66	83
Piscataquis	12	43	11	0	8	7
Sagadahoc	39	54	26	1	5	7
Somerset	31	104	23	3	15	32
Waldo	29	66	30	2	13	20
Washington	19	69	22	1	10	13
York	83	338	243	28	57	83

Table 21: At exit from Part C, children are either determined not eligible, eligible, or eligibility not determined.

	FY 18	FY 19
Number of children exiting C, not eligible for Part B§619 / eligibility not determined	219	242
Number of children exiting C, eligible for Part B§619:	397	424
Number of children exiting Part B§619 into school-age special education	1458	1515

In addition to CDS at DOE, The Office of Special Services provides support and oversight of SAUs' special education programs, disbursement and reporting of IDEA funds. Funding is from IDEA grant funds and state allocation. The office doesn't conduct developmental screenings, but screenings are conducted by SAUs for incoming kindergarten students. Student data comes from the DOE data warehouse. The earliest year available is 2015. Data is not available on the number of staff or about screenings conducted within SAUs. Data is available on the number of children served by age 6, 7, and 8 from 2015-2018.

Table 22: Number of Children Serviced by DOE by the Office of Special Services, Ages 6, 7, and 8 years

	2015	2016	2017	2018
Total # children served (0-8 yrs.)* *by age of child*	6- 1857 7- 2030 8- 2293	6-1944 7-2137 8-2266	6- 1969 7- 2202 8- 2450	6- 2119 7- 2232 8- 2421

CDS CURRENT CAPACITY TO SERVE CHILDREN 0-5

In the Part C program, shortages of providers and the resultant delay in the provision of services are somewhat isolated and incidental. This is primarily a result of the model in which services are provided – a primary provider/coaching model – in which services by 'professionals' are provided at minimal frequency and intensity and which focus on increasing parent/caregiver-capacity to implement intervention strategies throughout daily routines and activities. Typically, when a delay in service provision is experienced, that delay can be measured in days rather than weeks or months. The exception to the Part C program's ability to provide timely services is in the provision of Early Start Denver Model (ESDM), an intervention for young children with autism spectrum disorder which requires highly specialized training on the part of the provider. At times, the delay in providing ESDM services can be as long as two months. It is anticipated that as CDS' outreach efforts increase, it's capacity to provide Part C services to all identified infants, toddlers and their families may be further compromised.

Due to the increasingly significant needs of children and the frequency and intensity of services and compounded by the shortage of qualified personnel, Part B§619 programs at regional CDS sites have reach a 'tipping point' – typically mid- to late-winter - at which the demand for services exceeds the system's capacity to provide those services in a timely manner. Children identified post-'tipping point' often, by necessity, wait until summer to receive some, or all, of the services identified on their IEP. Because of this, a significant number of children, ages 3 to school-age 5, do not receive the comprehensive services, determined by the IEP Team, in a timely manner. In the past several years, CDS has experienced perennial, incremental shifts of this 'tipping point' to earlier in the year.

Systemwide, CDS experiences significant shortages of personnel, particularly in its Part B§619 program. In addition, programs in which to place children 3 to school-age 5 are also limited. Currently, the most pressing need is for speech-language pathologists, although the availability of physical therapists, occupational therapists, special education teachers and consultants, and pediatric psychologists are also limited in their availability. The shortage of qualified personnel and programs exists statewide.

For FY20, CDS requested and received a significant increase in funding in the state biennial budget. In addition to addressing substandard compensation and benefits for employees and the anticipated increase in reimbursement for contracted services, the requested increase ($8.2 million for FY20 and FY21 each) included funding for positions which CDS had identified as necessary to meet the needs of children and families in a timely manner. Although the increased funding allowed the creation of additional 21 new positions, many of those positions and those included in the previous fiscal year's budget that have been vacated by previous employees, remain vacant. As of November 2019, CDS has 48 full-time equivalent (FTE) vacant positions statewide. Below are the details on the position types and their assignment to CDS' Part C or Part B§619 programs. The information is provided as FTE at both the state and CDS Regional Site level.

Table 23: Vacant Part B§619 Positions Included in the CDS FY20 Budget:

	Ed Tech III	**Teacher of Students with Disabilities**	**SLP***	**SLPA**	**OT***	**PT***	**Case Manager**	**Program Manager**	**Ed Consultant**
CDS Aroostook	1		.5			.5			
CDS Downeast	1		1			.5			
CDS First Step	2					.5	1		
CDS Midcoast			1			.5			
CDS Opportunities		1	1		1	.5			
CDS PEDS	.75		1				1	1	
CDS REACH	1		1				3	1	
CDS Two Rivers	3		1			.5	1		
CDS York	1		1						
State	9.75	1	7.5		1	3	6	2	

Table 24: Vacant Part C Positions Included in the CDS FY20 Budget:

	Ed Tech III	Teacher of Students with Disabilities	SLP*	SLPA	OT*	PT*	Case Manager	Program Manager	Ed Consultant
CDS Aroostook		.33	.5			.5			
CDS Downeast		.33				.5			
CDS First Step	.5	.5	1			.5			
CDS Midcoast		1.5				.5			
CDS Opportunities		.5	1			.5			
CDS PEDS		.5							
CDS REACH	1	1	1			1			
CDS Two Rivers		.33				.5			
CDS York	1	1	1						
State	2.5	6	4.5	0		4	0	0	0

In addition to those approved in the FY20 budget, CDS has submitted a supplemental budget request for FY21 to create an additional 26.25 FTE new positions. This supplemental budget request was made once CDS developed a clear understanding of the impact that the new FY20 positions on its ability to meet the needs of all children in a timely manner. The anticipated cost of these new positions is $780,000. Below are the proposed positions and the CDS regional site to which they will be assigned.

Table 25: Proposed Part B§619 Positions to be Requested in the Supplemental Budget:

	Ed Tech III	Teacher of Students with Disabilities	SLP*	SLPA	OT*	PT*	Case Manager	Program Manager	Ed Consultant
CDS Aroostook						.5			
CDS Downeast			1		1	.5	1		
CDS First Step									
CDS Midcoast	3.75				1				
CDS Opportunities	4.5		.5	2		.5			
CDS PEDS						.5			
CDS REACH									1
CDS Two Rivers									
CDS York		1					1		
State	7.25	1	1.5	2	2	2	2	0	1

Table 26: Proposed Part C positions to be Requested in the Supplemental Budget:

	Ed Tech III	Teacher of Students with Disabilities	SLP*	SLPA	OT*	PT*	Case Manager	Program Manager	Ed Consultant
CDS Aroostook	1								
CDS Downeast									
CDS First Step					1				
CDS Midcoast									
CDS Opportunities									
CDS PEDS									
CDS REACH						.5			
CDS Two Rivers	1				1				
CDS York		1							
State	2	1	0	0	2	.5	0	0	0

*These new and proposed positions partially reflect CDS' intent reduce its reliance on contracted providers for these services given the significant savings that will be realized.

DOE: PRESCHOOL DEVELOPMENT GRANT (PDG)

Maine was awarded the $1 million, 1-year Preschool Development Grant (PDG), B-5 in January 2019. This was an opportunity for Maine to learn more about the Birth to 5-year-old mixed delivery system, including early care and education and services supporting our youngest children and their families, with a strong emphasis on vulnerable children and their families. The two main objectives of this grant were to conduct a statewide needs assessment and develop a strategic plan. For the first half of the year, the needs assessment involved collecting data and reports and conducting focus groups, interviews, work groups and surveys of stakeholders. The last stakeholder group was completed at the end of September and the final needs assessment report was submitted to U.S. D.H.H.S. in December 2019. Work on the strategic plan is currently underway and is expected to be completed in early 2020.

During the needs-assessment process, many lessons were learned, and several high priority needs became evident. Stakeholders indicated a strong need to reach all families early on and to connect them with services if warranted. There were concerns that there are families not connected to any services and who, therefore, have limited opportunities for early health and developmental screenings. Families expressed the desire for a resource to be able to ask for information when seeking child care, developmental and other services, and help with navigating systems. Parents of children with special needs further expressed the need for a single access system to make connecting with multiple services easier, and a need to strengthen screening processes. This should include increased training for providers and coordination between services offering screenings. These are a few of the items that will be explored while finalizing the strategic plan.

Another strong focus in the PDG needs assessment was the need to expand the capacity of Maine's higher education institutions to meet the state's need of qualified personnel to work in early childhood education and early intervention services. Given the multiyear timeline for qualified personnel to graduate from Maine's higher education institutions, outreach to soon-to-be graduates of colleges and universities in other states and incentives for relocation to Maine is necessary to meet the state's immediate needs. During the PDG Needs Assessment conversations, much was learned about the work at the multiple Higher Education Institutions (HEI) and work happening around Early Childhood Education programming. There are a variety of choices for students, innovated work at each institute and partnerships happening between the different schools. Questions also came up about what the different programs required for admission, what classes were offered and what opportunities were available for students. To better understand options that students have available for studying Early Childhood Education, the PDG Director and the Higher Education Committee are working together to do an inventory of Maine's Early Childhood Education programs. The HEIs are interested in understanding other programs and the State will have a better understanding of the education pathways for students and barriers for attaining early childhood degrees.

In November 2019, the state applied to the PDG, B-5 renewal grant which will give the state the opportunity to implement the strategic plan and improve the B-5 mixed delivery system. Unfortunately, Maine did not receive this highly competitive grant that would have provided $10 million a year for three years.

DOE: FIRST 10 INITIATIVE

First 10 Schools and Communities (F10SC) bring together elementary schools and the early childhood mixed-delivery system to improve the quality of education and care for young children and their families. To ensure all children learn and thrive, F10SC perform 4 key roles—promoting professional collaboration to improve teaching and learning; coordinating comprehensive services for children and families across the birth to age 10-year span; fostering culturally responsive partnerships with families; and engaging in strategic leadership and ongoing assessment to determine quality and effectiveness of programming. Central to the tenants of F10SC is the integration of a variety of available student supports to achieve stronger outcomes for children, which can include connecting families to timely developmental screenings. Research has demonstrated that these models can lead to improved attendance, effort, and engagement; higher academic achievement; reduced high school dropout rates; and better social and emotional outcomes.[22]

Essential to the success of F10SC are First 10 coordinators who are typically responsible for facilitating the collaboration of schools, families, and community partners in support of

[22] Walsh, M. Practice Brief: What is a School Coordinator. Center for Optimized Student Support at Boston College's Lynch School of Education and Human Development. https://www.bc.edu/content/dam/bc1/schools/lsoe/sites/coss/pdfs/What%20is%20a%20School%20Coordinator.pdf Published 2019.

children/students.[23] Research has identified that the role of First 10 Coordinators can have positive impacts on children's academic, social-emotional, and health related development. First 10 Coordinators engage with community families to build relationships by linking children and families with comprehensive support services, providing opportunities for them to develop positive relationships with the local school system, supporting transitions into the school, and ensuring the coordinated systems of support remain in place as children move through the early elementary grades.

In the fall of 2018, a cross-agency team made up of specialists from Maine DOE and Maine DHHS formed to study the research associated with F10SC. During this same span of time, 13 PreK Expansion Grant sites developed Birth-Grade 3 (B3) plans, a variation of the First 10 Community model. While these plans are just now beginning to be implemented, the state level cross-agency team sees great promise for their impact but recognizes that a key component missing from their design is an onsite coordinator.

To expand and enhance F10SC models in Maine, Maine DOE would like to develop a F10SC pilot in 7-12 schools across Maine. The pilot will provide sub-grants to elementary schools with public pre-k programs to develop F10SC implementation plans. Funded F10SC must hire First 10 Coordinators. Funding to establish the pilot, including consultative support, is estimated to be $900,000 a year. Funding for this pilot was proposed in Maine's PDG Renewal application but Maine did not receive this funding.

DOE: EARLY CHILDHOOD INTEGRATED DATA SYSTEM (ECIDS)

As part of the initial Preschool Development Grant (PDG) activities, efforts have been made to position Maine to construct an Early Childhood Integrated Data System (ECIDS.) After a thorough investigation, a decision has been made to embed the ECIDS in MDOE's Statewide Longitudinal Data System (SLDS) which will be undergoing significant upgrading over the next several years. A portion of the initial PDG-5 funding has supported planning an ECIDS that will feed data into MDOE's data warehouse and Common Education Data Standards (CEDS) data structure. When fully built, this system will provide access to data important for studying the availability and quality of services as well as program evaluation and system improvements.

Initially, the ECIDS will rely on data linking processes that currently exist but will shift to a bi-directional data exchange. For instance, the MDOE and MDHHS currently have established a link between Maine's Automated Child Welfare Information System (MACWIS) and the MDOE's Student Information System (Synergy) and Operational Data Store (NEO). This weekly data linkage moves foster care and socio-economic status data for Maine students receiving public services. When MDHHS upgrades MACWIS to a Comprehensive Child Welfare Information System (CCWIS), a bi-directional data exchange will be implemented and will improve frequency, quality and volume of data.

[23] Walsh, M. Practice brief. What is a School Coordinator. Center for Optimized Student Support at Boston College's Lynch School of Education and Human Development. https://www.bc.edu/content/dam/bc1/schools/lsoe/sites/coss/pdfs/What%20is%20a%20School%20Coordinator.pdf. Published 2019. Accessed December 2019.

As enhancement to MDOE's SLDS occurs, cross-agency data linkages will be built to include child care, home visiting, Head Start and Early Head Start, MaineCare, TANF, SNAP, health related data systems within the Center for Disease Control, and MDOL. IDEA Part B, Section 619 and IDEA Part C programs are part of the MDOE and the data system for those programs will become part of the SLDS system. State pre-K and public primary education through grade 3 are already within the MDOE data system. The estimated annual cost of the data system is $355,000 and DOE is currently applying for grant funding.

DOE: WORK WITH MEDICAID-ELIGIBLE STUDENTS IN SCHOOLS

In October of 2019, select staff from Department of Education, Child Development Services, Office of Child and Family Services, Office of MaineCare Services, and the Attorney General's Office attended the 2019 National Alliance for Medicaid in Education Conference which was held in Albuquerque, NM. Some challenges for school districts in billing MaineCare for school-based services were identified. The group has recommended that departments issue guidance going forward on joint letterhead, to reiterate the collaboration that has been happening between departments. The other major recommendation from the group was that a position needs to be in place at DOE to oversee MaineCare related issues. It is critical that MaineCare's current State Medicaid Educational Liaison remain at MaineCare to provide oversight on the Medicaid side at the same time. An additional position at DOE would provide greater oversight for school districts and other school personnel with barriers relating to the provision of MaineCare services. The team also examined the additional training and support schools will need as MaineCare proposes a new section of policy tailored for school-based service providers. DOE and OMS are currently determining the most effective way (and associated costs) to provide SAUs the supports necessary to significantly increase their accessing of MaineCare funds.

OVERALL BARRIERS IDENTIFIED

There were several challenges identified to screening and accessing early intervention services by the stakeholder group as well as organizations offering screening. These included the need to work with families and community partners to better explain the benefits of early screening, the necessary steps of the referral process to CDS, and what CDS services are available. Some providers noted that increased training and guidance is needed on how to provide socio-culturally and linguistically-responsive and trauma informed screenings for families with no or limited English proficiency. In addition, some providers shared that caregivers declined screening due to fear, denial, and stigma. Another barrier for families was the lack of single access point for services in state and having to complete multiple, duplicate intake forms, including for CDS, PHN, Home Visiting, and WIC. Families also noted the lack of transportation to/from services and the difficulty of managing multiple appointments for children with special health care needs.

Another set of challenges were related to providers. Some stakeholders noted low participation rates from providers and that some primary care providers prefer a "watch and wait" approach rather than referral. In addition, some providers referred to medical providers instead of CDS/Part C. Providers also noted challenges getting information from CDS regarding referred

families and ensuring that they were connected to CDS. There were also issues with not enough trained professionals to conduct screenings and the need to retrain staff due to turnover. It was also noted that there was a lack of centralized training of developmental screening across state offices and medical providers. Additionally, community agencies and entities who were well-positioned to offer developmental screenings were not doing screening or are not sharing results with medical providers or CDS.

Available data on developmental screenings was an additional challenge. Current state-level data does not reflect screening from private insurance, HS, EHS, MFHV, PHN and other groups doing screening since they are not billing MaineCare. Also, some providers, like Federally Qualified Health Centers (FQHC), do not bill for developmental screenings due to bundled billing and lack of payment incentive to use the billing code. As noted in the program overviews, many data collection systems have changed at the state level over the last 3-5 years, limiting the ability to track trends and gather data across departments.

Eligibility has also been identified as a barrier. Due to the strict eligibility requirements to receive CDS services, some children determined to be ineligible for Part C or Part B§619 may subsequently be determined eligible in kindergarten or later. Currently, infants and toddlers with mild-to-moderate developmental delays or risk factors are not eligible for Part C services under the program's current eligibility criteria. For Part B§619 services, per IDEA, eligibility requires the presence of a disability and that, as a result of that disability, a child needs special education services to make progress in school.

There were also challenges highlighted due to the workforce and available services. There was a general concern that if screening is done, there may not be services available for children because of waitlists and time to get services in place, lack of providers in rural communities, and the shortage of qualified personnel to offer CDS services which often results in increased workload of existing CDS staff.

Finally, funding and reimbursement continued to be identified as challenges around screening. The reimbursement rates for providers to do developmental screening and preventive services under MaineCare are low. Several states and private insurers pay at higher rates for the screenings. There was also an up-front cost to providers using standardized developmental screening to buy toolkits. In addition, CDS noted that they have limited funding to do screening because of minimal MaineCare funding of Part C services and the inability to bill MaineCare for screenings conducted by CDS' Part C and Part B§619 programs. Further, changing state priorities and insufficient funding to implement a "whole system" approach to early intervention services has led to a system that is challenging for families and providers to navigate.

CONCLUSION AND RECOMMENDATIONS

There has been a lot of work in the past ten years in Maine to increase developmental screening rates and early preventive services in Maine, but much work remains to ensure that all children in the state are receiving developmental screening and early intervention services, if needed, in a

timely fashion. The system is often fragmented for families and the EPSDT benefit and Child Find system should be improved.

As noted in the beginning of this report, there are several different evaluations, needs assessments, and taskforces that are occurring in 2019-2020 that are looking at different aspects of the prenatal to eight system in the state, including the PDG Needs Assessment and Strategic Plan, Maternal Child Health Needs Assessment, CBHS final report, and the evaluation of the CDS system. There are no easy solutions for improving this complex system, but several recommendations are outlined below that may be part of the solution. All of these recommendations will need a substantial investment of state leadership, funding, and resources in order to build a comprehensive early childhood system in the state. Short, medium, and long-term recommendations are detailed based on resources required, what can be accomplished within DHHS and DOE, and what requires legislative support and funding. We note that these ideas, especially those requiring funding, do not represent the position or proposals of DHHS (or DOE); they reflect the recommendations of the work groups assembled under L.D. 1635.

SHORT TERM

1. **Identify an organizing entity at the State level to coordinate and align Child Find, EPSDT, developmental screening, and early intervention services.**

   Since 2013, this role was done by the Developmental Systems Integration Steering Committee but funded ended in December 2019. Over the last year, the PDG Oversight Committee also served as an organizing entity but funding for PDG will end in the spring of 2020. Over the last six months, the Children's Cabinet and Children's Cabinet staff meeting has assumed some of this organizing role. DHHS, DOE, and the Children's Cabinet will identify the appropriate structure moving forward to build a strong system from prenatal to age 8 to coordinate and align Child Find, EPSDT, developmental screening, and early intervention services. The entity needs to work towards a more seamless transition between DHHS and DOE programs for families that is based on a family/human centered design and is focused on connected, integrated services. Nationally, *Zero to 3* has identified three priorities to support early childhood: good health, strong families, and positive learning experiences.[24] Several states have built a core system for prenatal to age 8 that starts with services based on Help ME Grow, early childhood educators, PHN, and Home Visiting. The organizing entity should have a horizontal platform that brings together the many vertical programs offering services to young children that encourages collaboration and coordination. In addition, a comprehensive MOU between DHHS and DOE (including CDS) around early intervention services would improve oversight over system improvements. It will also be important to get input on early intervention systems from families and external stakeholders and decide whether this work will be under the Children's Cabinet Early Childhood Advisory Group or a separate group.

[24] Zero to Three. Zero to Three Home Page. https://www.zerotothree.org/. Accessed December 2019.

2. **Ensure that EPSDT is firmly grounded in DHHS Child Health Priorities.**

   DHHS established a Child Health Leadership Group in October 2019 to provide leadership on children's health across DHHS and the State. The group is establishing strategic priorities for the next year that are aligned with the two Children's Cabinet Priorities: All Maine children enter kindergarten prepared to succeed and all youth enter adulthood healthy and connected to the workforce and/or pursuing their education. DHHS is working towards five main priorities for children: 1) Establishing a Perinatal System of Care; 2) Ensuring Access to High Quality Preventive Services; 3) Building a Strong Behavioral Health System That Supports The Social Emotional Health Of Children And Families; 4) Ensuring that substance use screening, treatment and support for recovery is available for families, including mothers, infants and children; and 5) Ensuring that adolescents receive appropriate preventive and behavioral health services and have access to community-based services so they can stay in their community with natural supports. EPSDT services are an important component of the DHHS priority areas and will be a focus over the next year. DHHS is currently receiving technical assistance on the EPSDT benefit from Manatt Consulting and the Center for the Study of Social Policy as part of the Pediatrics Supporting Parents Medicaid-CHIP State Implementation Workgroup with seven states that will inform future policy work.

   DHHS will also work to align activities to support EPSDT and Child Find. DHHS will build stronger connections between OMS and the CDC so that the Maternal and Child Health goals are coordinated with EPSDT and Child Find programs. There is a Title V requirement to coordinate with Medicaid and Title V MCH to ensure services are accessed. In addition, DHHS and DOE will work to strengthen the relationship between CDS and OCFS to ensure that referrals for infants and toddlers, identified under CAPTA, contain complete and accurate information and that parents/caregivers are aware that a referral to the CDS Part C program has been made and for what purposes. OCFS will also work to ensure that EPSDT and Child Find Goals are aligned as they work to build a Quality Child Care plan. OCFS will also review the Children's Behavioral Health Individual Planning Fund to see if any changes are needed to support EPSDT.[25]

3. **Review roles, responsibilities, and positions within the Office of MaineCare Services to ensure direct oversight of the administration of the State's EPSDT and Child Health Insurance Program (CHIP).** DHHS supports the creation of an EPSDT coordinator position as part of L.D. 1399.

MEDIUM TERM

4. **Establish a Statewide Longitudinal Data System (SLDS) in Maine that ensures cross-agency data linkages are created across early childhood programs and track completion of preventive screenings and outcomes data.** DOE is seeking funding for this work. DHHS supports DOE efforts on SLDS.

[25] State of Maine Office of Child and Family Services. Children's Behavioral Health Services. https://www.maine.gov/dhhs/ocfs/cbhs/programs.shtml. Accessed December 2019.

5. **Develop a Communication Strategy for EPSDT and Child Find.**

DHHS and DOE will consider how to rebrand EPSDT and Child Find programs to make them more family-friendly. MaineCare is currently looking at ways to improve communication with newly enrolled MaineCare members who join the Primary Care Case Management (PCCM) program to encourage establishing relationships with primary care providers and empower them to utilize preventative services. This effort will include implementing new approaches on how OMS contacts members and the information provided. OMS could also relook at annual eligibility notices that MaineCare provides to members and determine if these notices could include preventive services and planning for transitions like work happening in Kentucky.[26] DHHS should develop updated information for medical providers on EPSDT and Child Find and its annual provider notification around EPSDT and Preventive Services billing codes.[27] DHHS and DOE can consider combining efforts and funding of DOE and DHHS to do an awareness campaign for EPSDT and Child Find. DOE could consider 'rebranding' CDS' Part C and Part B§619 programs separately to clarify that they are two distinctly different services to two distinctly different populations. The continuation of "CDS" as an umbrella term fails to provide this necessary delineation and may perpetuate prejudices based on past experiences or information which may not be currently accurate. DOE could also look at other options for partnering with organizations to conduct outreach on Child Find. Some states contract with Family Voices partner to do outreach on Child Find. Funding in Medicaid or CHIP may be available to support an improved communication strategy for EPSDT and Child Find.

LONG TERM

6. **Consider avenues to ensure no wrong door for families to access services and establish a centralized entity around developmental screening and care coordination for early intervention services.**

Maine should consider establishment of the Help Me Grow system which would involve identifying a sustainable funding source ($500,000-700,000 per year) to build a strong centralized access point for families to be able to receive information on developmental promotion, screening, and services. HMG would be part of a robust, proactive, and comprehensive statewide Child Find system for children birth to kindergarten-age 5 to increase Maine's rate of developmental screenings, to ensure appropriate and effective referrals to CDS, and to collect and analyze screening, referral, and engagement data. This information would inform the work in Maine as well as nationally as HMG has been collecting evaluation data across states. As part of the HMG work, technology could be used based on work happening in other states to increase the number of developmental screenings and improve care coordination with a database that connects screening and referral information. HMG could also work to connect different agencies being funded to do care

[26] Commonwealth of Kentucky. Pediatric to Adult Transition Resources. https://chfs.ky.gov/agencies/ccshcn/Pages/transitionresources.aspx. Accessed December 2019.
[27] OMS. Pediatric Preventive Health Screenings. https://www.maine.gov/dhhs/oms/pdfs_doc/children_IHOC/Pediatric%20Preventive%20Health%20Screenings%20revised%20Feb%202018.pdf. Published 2018. Accessed December 2019.

coordination for families including specialized family navigators, the Children with Special Health Needs Care Coordinator, Cradle ME Referral system, DOE First 10 Coordinators, WIC, OMS and OCFS staff who work directly with families to ensure a more integrated experience for families. Another idea is to secure funding for CDS to support 7 full-time equivalent positions (projected cost of $475,000) to establish regional outreach teams to conduct developmental screenings at medical practices, child cares, play groups, library story times, etc. As noted earlier in the report, significant planning has already been done in the state to support HMG implementation over the last five years. Funding for HMG was proposed in Maine's PDG Renewal application that was not awarded.

7. **Review MaineCare policies to support and expand EPSDT.**

   The Department will balance Legislative recommendations based on L.D. 1635 with the Department's priority of improving children's health to determine which areas to address first. As part of this work, OMS will review the Primary Care Case Management Program and identify ways that it can support improvement in Children's Health and EPSDT benefits including improving capacity of care coordination. In addition, OMS will work with DOE to review the role of school-based services as an additional access point for early childhood services, look at how to provide more reimbursement for medical services provided to Medicaid-eligible students in schools, and see how MaineCare can further support early intervention services offered by CDS. An assessment of EPSDT rates will be part of a comprehensive rate system evaluation.

8. **Consider using school requirements to increase Preventive Health Screening Rates.**

   The state could consider requirements for standard dental and physical exams for entry into Pre-Kindergarten and Kindergarten, and periodically done throughout K-12 that includes hearing, vision, lead, asthma, immunizations, oral health, and behavioral health. Currently 22 States require physical exams for PreK/K/School entry and 14 States require dental screening in schools. [28] A state requirement for screening could increase family awareness of EPSDT requirements and connect families with medical providers to do screening for early intervention services.

9. **Explore the feasibility of expanding the eligibility criteria for Part C services through CDS.**

   Currently, Maine is one of 16 states that utilize significantly restrictive eligibility requirements for these services. An expansion of eligibility criteria would allow an increased number of children and families to qualify for early intervention services; however, it would require increased funding and additional qualified personnel. A change in Maine's Part C eligibility criteria, and the viability thereof, would need to be addressed through the legislative process. Additionally, DOE could also create a more formal system for children who do not qualify for EI services through CDS and reevaluation process. Finally, CDS

[28] Gracy D, Fabian A, Basch CH, et al. Missed opportunities: Do states require screening of children for health conditions that interfere with learning?. *PLoS One*. 2018;13(1):e0190254. Published 2018 Jan 17. doi:10.1371/journal.pone.0190254.

could ensure that the families of children determined to be ineligible for CDS services are aware of and are connected to EPSDT services. A determination of ineligibility for CDS services does not necessarily indicate the absence of a developmental delay or disability – only that the significance of that delay or disability does not meet the threshold for eligibility. Many children could benefit from EPSDT services despite CDS' determination of ineligibility for Part C and Part B§619 services.

10. **Increase opportunities to expand the capacity of the early childhood education and early intervention workforce.**

    In the long run, supporting the early childhood infrastructure in Maine involves expanding the workforce and developing partnerships with Maine's higher education institutions to meet the state's need of qualified personnel; increasing collaboration with SAUs to increase the statewide capacity for the timely provision of necessary services; and providing competitive compensation for staff for recruitment and retainment.

Appendix A: List of people who attended at least one of three DSI Stakeholder Meetings for LD 1635:

Crystal Arbour	Child Health Services Program Manager	Maine DHHS - OCFS
Amy Belisle	Chief Child Health Officer	Maine DHHS - Commissioner's Office
Karen Bergeron	Preschool Development Grant Director	Maine DOE
Janine Bonk	Office Manager	Qualidigm
Nikki Busmanis	211 Maine Program Manager	United Way of Mid-Maine
Kayla Cole	Consulting Services Manager	Qualidigm
Trista Collins	State Medicaid Educational Liaison	Maine DHHS - MaineCare
Nancy Cronin	Executive Director	Maine Developmental Disabilities Council
Nena Cunningham	Head Start Collaboration Director	Maine DOE
Cathy Dionne	Executive Director	Autism Society of Maine
Nicole Evans	Director of Financial Stability	United Way of Greater Portland
Susan Fairchild	Parent Information Specialist	Maine Parent Federation
Roy Fowler	CDS State Director & State Part C Coordinator	Maine DOE - Child Development Services
Rita Furlow	Senior Policy Analyst	Maine Children's Alliance
Cassandra Grantham	Director of Child Health Programs	MaineHealth
Maryann Harakall	Maternal and Child Health Director	Maine DHHS - Maine CDC
Shawn Kalback	Psychologist	Edmund Ervin Pediatric Center
Sue Mackey-Andrews	DSI Consultant	Maine Highlands Investment Partnership
Holly Richards	Newborn Screening and Follow-Up Program Manager for Children with Special Health Needs	Maine DHHS - Maine CDC
Jackie Tiner	Project Assistant	Qualidigm
Kini Ana Tinkham	Executive Director	Maine Resilience Building Network
Carrie Woodcock	Executive Director	Maine Parent Federation
Elissa Wynne Emily Poland	Associate Director State School Nurse Consultant	Maine DHHS – OCFS Maine DOE

List of DHHS/DOE Contributors

DHHS:

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Ann Belanger

Karen Bergeron

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Nena Cunningham

Roy Fowler

Leanne Larsen

Nicole Madore

Kris Michaud

Emily Poland

Appendix B: CMS 416 Data for FY 2018, Up to Age 9

State Code ME	Fiscal Year 2018	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9
1a. Total individuals eligible for EPSDT	CN:	124,294	5,972	12,527	18,464	24,999
	MN:	58	2	0	9	10
	Total:	124,352	5,974	12,527	18,473	25,009
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	CN:	119,398	4,889	12,141	17,907	24,228
	MN:	50	2	0	8	9
	Total:	119,448	4,891	12,141	17,915	24,237
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	10,858	1	862	1,972	2,598
	MN:	8	0	0	1	1
	Total:	10,866	1	862	1,973	2,599
2a. State Periodicity Schedule			7	4	4	4
2b. Number of Years in Age Group			**1**	**2**	**3**	**4**
2c. Annualized State Periodicity Schedule			7.00	2.00	1.33	1.00
3a. Total Months of Eligibility	CN:	1,270,954	35,589	128,952	191,922	263,358
	MN:	98	4	0	13	26
	Total:	1,271,052	35,593	128,952	191,935	263,384
	CN:	0.89	0.61	0.89	0.89	0.91

3b. Average Period of Eligibility	MN:	0.16	0.17	0.00	0.14	0.24
	Total:	0.89	0.61	0.89	0.89	0.91
4. Expected Number of Screenings per Eligible	CN:		4.27	1.78	1.18	0.91
	MN:		1.19	0.00	0.19	0.24
	Total:		4.27	1.78	1.18	0.91
5. Expected Number of Screenings	CN:	143,828	20,876	21,611	21,130	22,047
	MN:	11	2	0	2	2
	Total:	143,839	20,878	21,611	21,132	22,049
6. Total Screens Received	CN:	128,563	25,848	34,237	16,058	17,147
	MN:	2	0	0	0	2
	Total:	128,565	25,848	34,237	16,058	17,149
7. SCREENING RATIO	CN:	0.89	1.00	1.00	0.76	0.78
	MN:	0.18	0.00	0.00	0.00	1.00
	Total:	0.89	1.00	1.00	0.76	0.78
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	112,611	4,889	12,141	17,907	22,047
	MN:	11	2	0	2	2
	Total:	112,622	4,891	12,141	17,909	22,049
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	62,427	4,635	10,071	10,686	12,289
	MN:	2	0	0	0	2
	Total:	62,429	4,635	10,071	10,686	12,291
10. PARTICIPANT RATIO	CN:	0.55	0.95	0.83	0.60	0.56
	MN:	0.18	0.00	0.00	0.00	1.00
	Total:	0.55	0.95	0.83	0.60	0.56
11. Total Eligibles Referred for	CN:	11,919	4,156	1,637	1,845	2,323
	MN:	0	0	0	0	0

Corrective Treatment	Total:	11,919	4,156	1,637	1,845	2,323
12a. Total Eligibles Receiving Any Dental Services	CN:	45,130	146	2,203	7,119	12,050
	MN:	1	0	0	1	0
	Total:	45,131	146	2,203	7,120	12,050
12b. Total Eligibles Receiving Preventive Dental Services	CN:	40,115	38	1,980	6,703	11,175
	MN:	1	0	0	1	0
	Total:	40,116	38	1,980	6,704	11,175
12c. Total Eligibles Receiving Dental Treatment Services	CN:	18,648	96	232	2,113	5,070
	MN:	1	0	0	1	0
	Total:	18,649	96	232	2,114	5,070
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	0				0
	MN:	0				0
	Total:	0				0
12e. Total Eligibles Receiving Dental Diagnostic Services	CN:	36,617	108	1,720	5,912	9,487
	MN:	1	0	0	1	0
	Total:	36,618	108	1,720	5,913	9,487
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	34,161	391	5,020	5,579	7,041
	MN:	1	0	0	0	0
	Total:	34,162	391	5,020	5,579	7,041
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	CN:	67,819	521	6,251	10,577	16,121
	MN:	2	0	0	1	0
	Total:	67,821	521	6,251	10,578	16,121

13. Total Eligibles enrolled in Managed Care	CN:	103,092	4,335	11,271	15,986	21,030
	MN:	4	0	0	0	0
	Total:	103,096	4,335	11,271	15,986	21,030
14a. Total Number of Screening Blood Lead Tests	CN:	4,643	28	3,308	1,132	118
	MN:	0	0	0	0	
	Total:	4,468	28	3,308	1,132	
14b. Methodology used for calculating the Total Number of Screening Blood Lead Tests		CPT Code 83655 within certain diagnoses codes (Method I)	**Enter X For Method I** X	HEDIS (Method II)	**Enter X For Method II**	Combination Methodology (Method III)

Appendix C: Terminology

REVISED: 5/2/2016-DSI: SAIEL Steering Committee

Maine's Early Childhood Birth to Three Developmental Screening, Identification and Assessment Terminology Chart

	DEVELOPMENTAL SURVEILLANCE	DEVELOPMENTAL SCREENING	DEVELOPMENTAL EVALUATION (Diagnostic)	DEVELOPMENTAL ASSESSMENT (Ongoing)
Purpose	Determining strengths and identifying children who may be at risk for developmental delays in one or more domain* through a gathering of history, observation, parental concerns, and documentation of changes over time	Administration of brief, standardized tool aiding the identification of children at-risk of a developmental disorder in one or more domain*	Identifies/diagnoses the existence of a delay or disability, identifies the child's strengths and needs in one or more area of development* and determines the scope, intensity and duration of a therapeutic service(s) should a delay be identified	Collects, synthesizes, and interprets information about children from several forms of evidence of the child's learning, growth, and development on an ongoing basis over a period of time. The assessment process identifies a child's unique strengths and needs in developmental domains* and the child's unique approach to learning and development. Methods can be both formal and informal, including standardized testing, observations, and parent input.
Instrumentation	Routinely performed on a periodic basis utilizing observation, parent input, and documentation of changes over time (e.g., AAP Bright Futures)	Conducted on a periodicity schedule using a standardized tool. (e.g., General Developmental Screening: *ASQ-3, PEDS, SWYC;* Autism Screening: *MCHAT-R)*	Conducted on an inter-periodic basis utilizing a standardized or norm-referenced instrument (e.g., BDIST, CDI, HELP, PPVT-IV, GFTA-2, ASQ-SE)	An ongoing process that is conducted initially and periodically to determine a baseline of skills and as an ongoing process to measure child growth and development (e.g., Teaching Strategies GOLD, AEPS, High Scope COR)
Administrator	Conducted by medical practices during well-child visits, Public /Community Health Nursing, Maine Families, Early Head Start and early childhood teachers with informed, active parental input and participation	Performed/facilitated by medical practices, CDS/Part C, Public/Community Health Nursing, Maine Families, Early Head Start and early childhood teachers with informed, active parental input and participation	Performed by CDS/Part C, pediatric developmental specialists, child psychologists, SLP, OT, PT and social workers with informed, active parental input and participation	Performed by CDS/Part C, Early Head Start, medical sub-specialists, SLP, OT, PT, social workers with informed, active parental input and participation. Contributes to individualized curriculum planning and parental support services. If eligible for CDS, information is used to develop the individualized Family Services Plan that defines and guides early intervention services across the developmental domains*
Periodicity	Ideally conducted for all children 0-3 in multiple settings in partnership with parents and caregivers on an inter-periodic basis according to the AAP Periodicity schedule minimally	Conducted for all children 0-3 minimally according to the AAP Periodicity Schedule or on an inter-periodic basis when concerns are expressed by a parent/caregiver or by surveillance. For EHS-complete within 45 days of enrollment	Conducted for children 0-3 who have been referred as a result of screening and/or parental or medical practice concerns. For CDS/Part C, must be completed within 45 calendar days of referral	Conducted in early childhood education settings including Early Head Start as part of curriculum and individualized planning as well as for children who may have been identified as having developmental concerns and are eligible for CDS. Frequency varies by program and purpose
Frequency	Newborn, 3-5 days, 1, 2, 4, 6, 12, 15 and 24 months, 3 years	_____ months	Initially and at least every 3 years or more frequently as determined by clinical judgment	Initial and ongoing

*Domains: cognitive, communication, adaptive, social-emotional, physical

Appendix D: Consent Form

Universal Consent for Referral and Release of Information Form
Prenatal and Children Through Age Five

Section 1: Referral

REFERRAL TO: (Check ONE)

- ☐ Early Head Start (Prenatal to 3)
- ☐ CDS - Part C/Early Intervention (0-3)
- ☐ CDS – 3-5 Part B/Special Education
- ☐ Head Start (3-5)
- ☐ Other:
- ☐ Maine Families (Prenatal to 3)
- ☐ Public Health Nursing (All ages)
- ☐ Medicaid
- ☐ Behavioral Health
- ☐ Developmental Pediatrician

Section 2: Who is Making this Referral	
Referral Source	Name: _____ Agency/Program: _____ Street Address: _____ Town: _____ ME Zip Code: _____ Phone: _____ Office FAX: _____ E-Mail: _____ Preferred Communication: ☐ Phone ☐ Email ☐ Other:
Section 3: Who is Being Referred? (Complete as applicable)	
	Child ☐ Expectant Family
Infant/Child Information	Name: _____ Child's DOB: /_____/_____ Child's Gender: ☐ Male ☐ Female Parent(s)/Guardian(s): _____ Street Address: _____ Town: _____ ME Zip Code: _____ Phone: E-mail: _____ Primary Language Spoken in the Home: _____
Expectant Family	Name: _____ Date: _____ DOB: _____/ /_____ Anticipated Due Date: _____ Street Address: _____ Town: _____ ME Zip Code: _____ Phone: E-mail: Primary Language Spoken in the Home:
Section 4: Reason for Referral	
Reason for Referral (Check all that apply)	Early care/education Parent support services Child Care Health Concern Concerning Screen: _ASQ-3 _ASQ-SE____PEDS____MCHAT Developmental Concern, Delay or Disability (check each of the domains where concerned) __Hearing/Vision _Communication_____Physical/Gross Motor _Social-Emotional __Problem-Solving/Cognition _Fine Motor/Adaptive Skills ____Further Evaluation Assist Child Development Services in determining eligibility **Inform the child's health care provider about developmental services and progress** Assist in the development of the Individualized Family Service Plan/Education Plan Other: _____
Section 5: Specific Information that Can Be Shared Between Parties (Check each one desired)	
Information to be Released/ Obtained (Check all that apply)	**Outcome/Disposition of Referral (eligible/ineligible/declined/can't locate)** Initial and ongoing Developmental/Autism screening results Sensory Screening/Evaluation (vision and hearing screening/evaluation) Program Eligibility Determination documentation and results (if applicable) Program Enrollment confirmation On-going developmental assessment results Individualized Family Services Plan (IFSP)/Individualized Education Program (IEP) Direct Service Progress Notes Well Child Care documentation Other: _____

Child's Name:	Date of Birth:
Section 6: Conditions for Referral and Release to Share Information	
Consent to Refer/Share Information	I acknowledge that I have read and understand the following. • Any services that I receive will not be affected by my willingness or my refusal to sign this form. • A photocopy or fax of this consent to share and release information, which has not been altered, will be treated in the same way as the original consent form. • This authorization form or a copy of it will be included with my original records. • I have the right to change my mind and withdraw this authorization for referral at any time. I am aware that, if I do revoke my authorization, this will not affect any information which has already been released in accordance with this authorization. • I understand that any information disclosing alcohol or substance abuse treatment without my specific authorization will not be shared (Federal Regulation (42 CFR Part 2)). • This consent is valid for one year unless I change my mind and retract this consent in writing before this release expires. If I do change my mind, it does not apply to any actions that have already happened. • I have the right to inspect and/or receive a copy the information to be released. A copy fee may be charged as permitted by law. • I will always be informed of program and services changes before they happen. Signing this release doesn't affect any future health, medical, early intervention or other early childhood/ education/ developmental service. • I have received a copy of this referral and release form for my own records.
E-Mail Consent	I understand that the parties to this Consent to Share and Release Information may not be able to send my information securely through email. I understand that email and the internet have risks that cannot be controlled and that the information potentially could be read by a third party. I accept those risks and still request that my information be sent by email. Initials _____
Section 7: Parent/Guardian Consent for Referral and Release of Information	
Signature of Consent for Referral and to Share and Release Information	**I have been provided a copy of my rights and responsibilities with respect to making this consent for referral and information sharing.** **The consent to share and release information takes effect the day I sign it and will expire in one year from the date signed, unless otherwise indicated.** **I have checked the specific actions and/or documents in Section 5 of this form which I agree may be shared between the person/agency who is making this referral and the person/agency who is receiving it.** **The authorization for consent takes effect the day I sign it and will expire one year from the date signed, unless otherwise noted here:** **I, _____ (self/parent/guardian name) _, give my permission for** **(referring person/organization)** **to share or obtain information specified on this form regarding me/us and/or my child,** **_____** **(self/child's name)** **with _____ (receiving person/organization) _.** **Signature: _____ (self/Parent/Guardian)** **Signature: _____ (self/Parent/Guardian)** **Date: _____**

Appendix E: Community Referral Tools

July 9th, 2018

Early Childhood Community Referral Tools

Developmental Screening Community Initiative (DSCI), Cumberland County

The Developmental Screening Community Initiative (DSCI) in Cumberland County is a community-based initiative to improve developmental screening efforts and related referral systems for young children (up to 5 years of age), with specific focus on children ages birth to three. Through this initiative, medical practices and community partners collaborate to streamline information sharing, referrals, and service communication to ensure that children are screened in all developmental domains at critical ages and that they are successfully connected to appropriate developmental supports and services in Cumberland County.

With facilitation from Maine Quality Counts, DSCI created *Early Childhood Community Referral Tools* aimed at supporting medical homes in successfully connecting families to key early childhood community programs that support families across a spectrum of developmental promotion, prevention, and intervention needs.

The *Early Childhood Community Referral Tools* provide medical homes with the decision-making support and referral information needed to develop effective workflows for connecting families from medical practices to pivotal community resources supporting children birth-5yrs. The community resources listed span behavioral health, early education, developmental evaluation and interventions, in-home parenting support, in-home nursing services, and peer-led parent support services. The specific programs and agencies named are participants in the DSCI collaborative in Cumberland County.

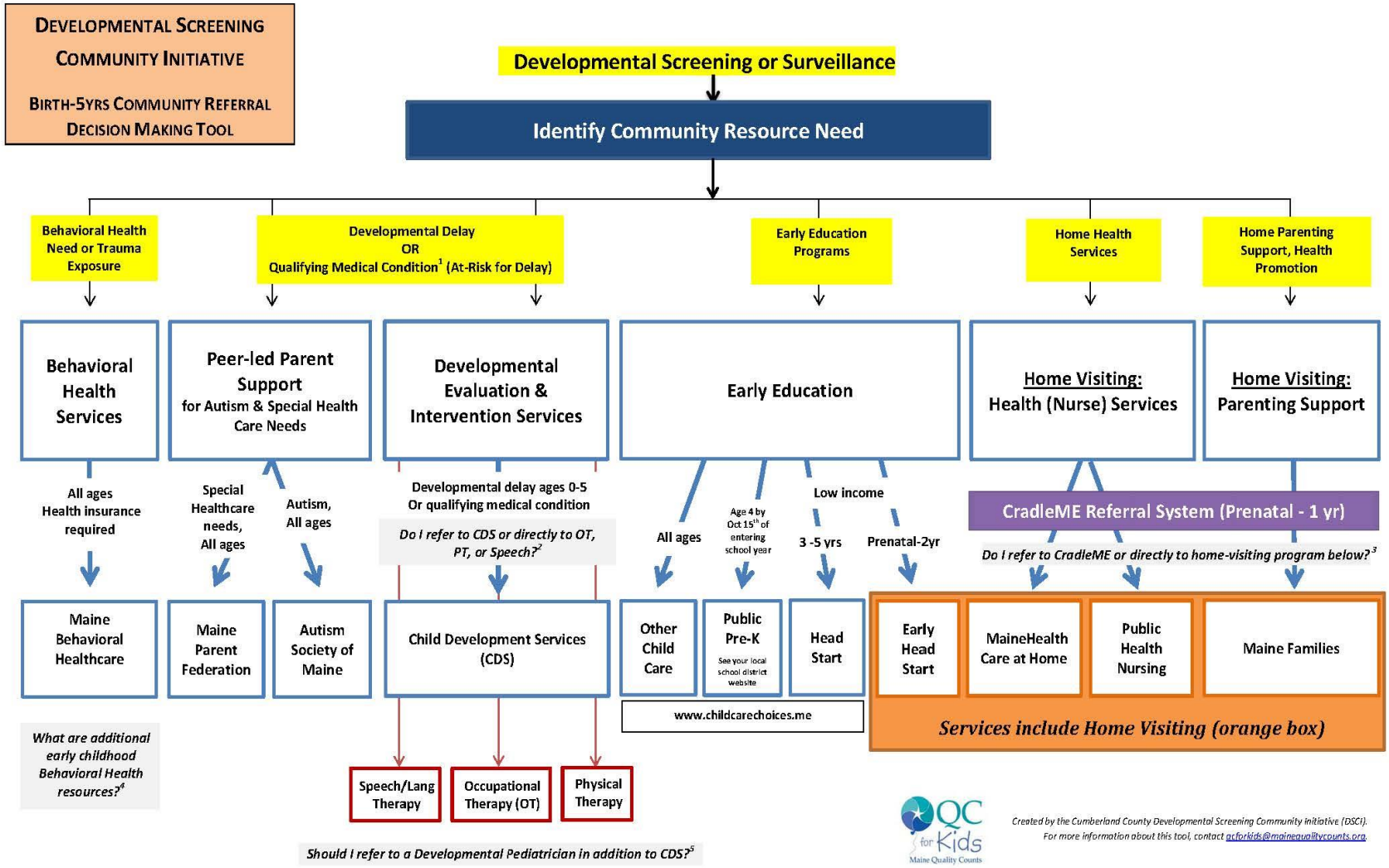
These *Early Childhood Community Referral Tools* support a medical home team in identifying 1) Where to refer families of young children for developmental supports, 2) How to introduce an identified community program to a family, and 3) How to successfully refer a family to an identified community program. As these tools can both guide individual patient referrals as well as broader referral system improvement, they are designed to be shared across medical home teams, including medical providers, medical assistants, nurses, community health workers, integrated behavioral health providers, referral specialists, and practice managers. These tools are a response to medical providers' frequently asked question-- "where should I refer patients when there's a concern on a developmental screen?". On a broader level, these tools are designed to strengthen communication between medical homes and early childhood community programs so that families experience a more coordinated early childhood system of care in Cumberland County.

While we recognize programs and referral information changes over time, these tools are starting point to support medical homes in responding to the developmental and family support needs of children birth-5 yrs.

For questions or feedback on these tools, please contact Maine Quality Counts for Kids: QCforkids@mainequalitycounts.org.

We would like to extend a sincere thank you to all of the Developmental Screening Community Initiative (DSCI) participants who contributed to these tools:

- Catherine Morrill Day Nursery
- Child Developmental Services (CDS)
- Heads Start/Early Head Start, Opportunity Alliance
- Maine Behavioral Healthcare
- Maine Families, Opportunity Alliance
- Maine Medical Partners
- Maine Medical Center
- Maine Quality Counts
- MaineHealth
- MaineHealth Care at Home
- Martin's Point Health Care
- Greater Portland Health
- Mercy Dr. Harry E. Davis Pediatric Center
- Maine Parent Federation
- Autism Society of Maine
- Northeast Hearing and Speech
- City of Portland, Maternal & Child Health
- Starting Strong
- United Way of Greater Portland


DEVELOPMENTAL SCREENING COMMUNITY INITIATIVE
BIRTH-5YRS COMMUNITY REFERRAL DECISION MAKING TOOL
Developmental Screening or Surveillance
Identify Community Resource Need
Behavioral Health Need or Trauma Exposure
Developmental Delay OR Qualifying Medical Condition[1] (At-Risk for Delay)
Early Education Programs
Home Health Services
Home Parenting Support, Health Promotion
Behavioral Health Services
Peer-led Parent Support for Autism & Special Health Care Needs
Developmental Evaluation & Intervention Services
Early Education
Home Visiting: Health (Nurse) Services
Home Visiting: Parenting Support
All ages Health insurance required
Special Healthcare needs, All ages
Autism, All ages
Developmental delay ages 0-5 Or qualifying medical condition
Do I refer to CDS or directly to OT, PT, or Speech?[2]
All ages
Age 4 by Oct 15th of entering school year
3 -5 yrs
Low income
Prenatal-2yr
CradleME Referral System (Prenatal - 1 yr)
Do I refer to CradleME or directly to home-visiting program below?[3]
Maine Behavioral Healthcare
Maine Parent Federation
Autism Society of Maine
Child Development Services (CDS)
Other Child Care
Public Pre-K
See your local school district website
Head Start
Early Head Start
MaineHealth Care at Home
Public Health Nursing
Maine Families
www.childcarechoices.me
Services include Home Visiting (orange box)
What are additional early childhood Behavioral Health resources?[4]
Speech/Lang Therapy
Occupational Therapy (OT)
Physical Therapy
Should I refer to a Developmental Pediatrician in addition to CDS?[5]
QC for Kids
Maine Quality Counts
Created by the Cumberland County Developmental Screening Community Initiative (DSCI).
For more information about this tool, contact qcforkids@mainequalitycounts.org.

EARLY CHILDHOOD COMMUNITY REFERRALS: BIRTH-5 YRS

Community Program Introductions

PROGRAM	INTRODUCTION
Maine Behavioral Healthcare Services	Maine Behavioral Healthcare offers a variety of behavioral healthcare services to our communities. For young children, this includes counseling, community based care and treatment, case management, hospital treatment services, and psychiatry. They also have specific programs that specialize in serving children with neuro developmental disorders, and children who have experienced stress and adversity.
Maine Parent Federation	Maine Parent Federation (MPF) provides information, referral, one on one telephone and peer support, and training to parents of children with disabilities or special health care needs and the professionals who work with these families. Services are offered at no cost to parents, and are available throughout the state.
Autism Society of Maine	The Autism Society of Maine supports individuals with autism spectrum disorder and their families. Their mission is to promote lifelong access and opportunity for all individuals with ASD to become participating members of their communities. They provide education, advocacy, public awareness. They have autism information specialists who help families navigate various systems in Maine. They work one-on-one with families to provide training and workshops.
Child Development Services (CDS)	Child Development Services offers confidential, free developmental screenings and evaluations for any child birth to 5-years old. CDS serves young children and families of Maine through a network of regional sites. They help in understanding developmental delays and disabilities and provide supports and services to children and families.
Northeast Hearing and Speech	NE Hearing & Speech provides speech and language therapy and audiology (hearing) services to people of all ages. They can help support your child's communication through hearing and speech services.
Early Head Start & Head Start	Head Start programs prepare young children to succeed in school and in life beyond school. These programs offer services to children and families around early learning, health, and family well-being while engaging parents as partners every step of the way. Programs are free for low income families.
Other Child Care	The Childcare choices website provides a database of childcare options in Maine. It's a resource to help you pick the right childcare for your child. www.childcarechoices.me/
Public School Pre-K Programs	Free preschool education programs for children turning 4 yrs old by October of the entering school year. Classes use nationally validated curricula and follow the Maine State Early Childhood Learning Guidelines. Programs also include developmental screening, assessment and referral services, and coordination and transition with school personnel for Individual Education Plans, as needed. More detailed information is available on your school departments' website.
CradleME *(State Service that triages referrals to MaineHealth Care at Home, Public Health Nursing, & Maine Families)*	CradleME is a free program for all families in Maine who are expecting or have just had a baby. Signing the CradleME referral form helps connect you with a phone call from a family visitor, a nurse, or both depending on your needs. If you sign up to receive a call from CradleME today, the family visitor and/or nurse who calls you will tell you about the services that they can offer and answer any questions or concerns that you may have.
MaineHealth Care at Home	At the request of your medical provider, a specially trained registered nurse will come to your home to provide health services, education, and resources specific to your questions and your child's healthcare needs. They work with you to keep your child healthy and safe. They also offer ideas on activities to nurture your child's physical and emotional development. These services may be covered by a grant program called Cradle ME funded by the state of Maine, or by your insurance." (Ex; lactation, weight check, nursing care for special healthcare need, lead testing)
Public Health Nursing	A nurse will visit your home to provide you and your child with health services, education, and resources specific to your questions and your child's healthcare needs. They work with you to keep your child healthy and safe. They also offer ideas on activities to nurture your child's physical and emotional development. (Ex; lactation, weight check, nursing care for special healthcare need, lead testing)
Maine Families	Maine Families partners caring and professional Family Visitors with parents and parents-to-be. During regularly scheduled visits, they provide information and resources that can support the physical and emotional well-being of your baby and entire family. They also provide a safe space to talk about the joys and challenges of having a new baby (ex: feeding, sleep, safety, development, discipline, etc.)

EARLY CHILDHOOD COMMUNITY REFERRALS: BIRTH-5 YRS

How to Refer to Community Programs
Cumberland County

	BEHAVIORAL HEALTH SERVICES	DEVELOPMENTAL EVALUATION & INTERVENTION SERVICES		EARLY EDUCATION
Program	**Maine Behavioral HealthCare**	**Child Development Services (CDS)**	**Northeast Hearing and Speech**	**Early Head Start & Head Start**
Eligibility	**Age**: all ages **Health Insurance:** Must have health insurance (MaineCare accepted). Limited grant funding.	**Age**: Birth-5 yrs old **Health Insurance:** not needed Suspected developmental delay, autism OR Qualifying Medical Condition that increases risk of delay (See Attached List for medical conditions)	**Age**: all ages **Health Insurance:** Must have health insurance (MaineCare accepted)	**Age:** Birth-5 yrs **Health Insurance:** not needed **Eligibility:** low income **Prioritization:** psychosocial risk factors: Ex: homelessness, caregiver depression, family substance use
Services	Full spectrum of behavioral healthcare services to as part of the MaineHealth System. Includes counseling, community based care and treatment, case management, hospital treatment services, and psychiatry. Also offers programs that specialize in serving children with neuro developmental disorders, and children who have experienced stress and adversity.	Developmental and educational services for children with developmental delays or qualifying medical conditions. Includes developmental evaluations, individualized service plans, targeted developmental interventions, parent coaching, and transition to special education.	NE Hearing & Speech provides speech and language therapy and audiology (hearing) services to people of all ages. Mission is to help people communicate. Services include: Speech Language Therapy & Evaluations, Audiological Evaluations, Hearing Aids, Follow up for newborns who do not pass hearing screens upon birth.	Early childhood education program whose prime goal is to prepare children and their families for Kindergarten. Services span health, nutrition, social, and educational services. Center-based and home-based components.
How to Refer	1) Call General Intake at 844-292-0111 **OR** fax referral form to (207) 661-6370 (attached) 2) Fax a ROI to (207) 661-6370. *For **Trauma**-related referral questions: Call Dory Hacker / (207) 661-6513	**State-wide System** 1) Complete CDS Referral form online http://www.maine.gov/doe/cds/families/referrals/child-find.shtml **OR** Fax Paper Referral Form (attached) to (207) 624-6661 2) Fax signed CDS ROI (CDS ROI specifically) with referral to (207) 624-6661 (online below or see attached paper) www.maine.gov/doe/cds/families/referrals/documents/AuthorizationToRequestShareInformationAndRecords_12-19-2016.pdf	1) Fax medical referral to (207) 874-1068 2) Fax signed ROI with referral to (207) 874-1068	**For Opportunity Alliance Head Start Programs** 1) Call (207) 553-5811 (Opportunity Alliance). Identify yourself as referring source. **OR** Complete application online https://www.opportunityalliance.org/programs/early-childhood-education/ **OR** paper fax Application Form to 207-874-1155 (attached). 2) Fax signed ROI with referral to 207-874-1155(Opportunity Alliance) to enable feedback communication with referring provider **To locate other regional Head Start/Early Head Start Providers:** http://maine.gov/dhhs/ocfs/ec/occhs/headstart.htm

Program	Maine Behavioral HealthCare	Child Development Services (CDS)	Northeast Hearing and Speech	Early Head Start & Head Start
Referral Tips	- Call Dory Hacker if unsure if the referrals is appropriate for trauma services or if facing barriers introducing family to services - Insurance required, but organization makes every attempt not to turn families away; call. Call to discuss specific case.	- Send CDS-specific ROI with every referral - Ensure referral sent to **state** CDS office; state office will then send to correct county-based office	- Insurance information is needed **at the time of referral** (including newborn). - Make sure the Service requested is clear—audio evaluation, speech evaluation, or both? - Don't refer for "speech therapy" before child has a "speech-language evaluation (SLE)". NE Hearing Speech can do those SLE evaluations.	- Refer families as EARLY as possible - Identify urgent referrals by calling.
Info for Families	Rack Cards https://mainehealth.org/maine-behavioral-healthcare/services	CDS Early Intervention Brochures Rack Cards	Website: http://www.nehearingandspeech.org	Flyers Website: https://eclkc.ohs.acf.hhs.gov
Expectation for Family Contact	Families receive call within 48 hrs from Intake Department.	Family will receive phone call within 3 business days; if no response, they send a letter in mail to the family. If ROI sent with referral, CDS will contact referring provider if family unable to be reached.	Families receive a call to schedule and paperwork is sent with appointment date/time. - Audiological Services and Speech Language Evaluations are available within a few weeks/months. - Speech Therapy may have longer waitlists.	Family will receive call within 3 business days; will leave message if able. Will send letter to family.
Contact Information	**For Trauma Specific Services:** Dory Hacker, LCSW Phone: (207) 661-6502 dhacker@mainebehavioralhealthcare.org **General Intake**: 1-844-292-0111	**CDS REACH** (Cumberland County only) 1011 Forest Avenue, Portland, ME 04103 Phone: (207) 781-8881 Fax: (207) 781-8855 Cheryl Hillicoss / Program Manager, Part C (Birth to 3 yr) Cheryl.Hillicoss@maine.gov Julie Kirby / Program Manager, Part B (3-5 yrs) Julie.Kirby@maine.gov For Other Regional Offices: https://www.maine.gov/doe/cds/sitelocations.html	75 West Commercial Street, Portland, ME 04101 Phone: (207) 874-1065 Laurie Mack, Executive Director lmack@nehearingandspeech.org	50 Lydia Lane, South Portland, Maine 04106 Phone: (207) 553-5821 Jean Cousins, Program Director jean.cousins@opportunityalliance.org **To locate other regional Head Start/Early Head Start Providers:** http://maine.gov/dhhs/ocfs/ec/occhs/headstart.htm

Refer to CradleME: State Central Referral System for Home Visiting Services Below

CradleME is a free program for all families in Maine who are expecting or have just had a baby. Signing the CradleME form helps connect families with a phone call from a family visitor, a nurse, or both depending on needs. Once you refer to CradleME, a family will receive a call from a state nurse or home visitor who will describe services. Through CradleME, families are connected to Public Health Nursing, MaineHealth Care at Home, or Maine Families; or a combination of services based on reason for referral. The option to refer directly to each program below still exists as well.

	HOME VISITING: HEALTH (NURSE) SERVICES		HOME VISITING: PARENTING SUPPORT
Program	**Public Health Nursing, City of Portland**	**MaineHealth Care at Home**	**Maine Families**
Eligibility	**Age:** Prenatal- 5 yrs old **Health Insurance:** not needed **Demographic:** Reside in City of Portland	**Age:** Prenatal- 5 yrs old **Health Insurance:** not needed	**Age:** Referral accepted for prenatal until child turns 3 months old (or 6 months old for a parents < 21 yrs old). Once enrolled, program may provide services through 3 yrs old. **Health Insurance:** not needed **Prioritization:** psychosocial risk factors
Services	In-home nursing assessments of prenatal, post- partum women and children under age 5. **Service Examples:** Weight checks, blood pressure checks, developmental screenings, safe sleep education, breastfeeding/feeding and parental support; home lead testing.	In-home nursing assessments of prenatal, post-partum women, and children. **Service Examples:** Weight checks, blood pressure checks, developmental screenings, safe sleep education, breastfeeding/feeding and parental support; home lead testing	Home- and community-based visits to families who are expecting or have a new baby. **Services Topics:** healthy pregnancy, infant care, child development, parenting strategies, safety, feeding, sleep, discipline, local resources, more.
How to Refer	**Referring Through CradleME for Pregnant Women & Infants Ages Birth-1Yr** (http://cradleme.org/) 1) Fax form: http://cradleme.org/CradleME_Referral_form.pdf (or see attached copy) to (207) 287-4577 **OR** Call 888-644-1130 to refer **Parent signature required on CradleME form* 2) Fax a signed ROI to (207) 287-4577 with referral		
	OR Direct Referral: Call City of Portland Public Health Nursing (207) 874-8475	**OR Direct Referral :** Call Central Referral Line 1-866-255-8744 or Greg Burns (207) 775-5515	**OR Direct Referral** **For Cumberland County (Opportunity Alliance)** 1) Call (207) 553-5801 **OR** 2) Fax Referral form to (207) 842-6886 http://www.mainefamilieswc.org/wp-content/uploads/2013/06/MF-Referral-Form-2014-pdf1.pdf 3) Consider faxing ROI to assist in additional communication with Maine Families **For Other Counties**, see website for regional provider: http://www.mainefamilies.org/

Program	Public Health Nursing, City of Portland	MaineHealth Care at Home	Maine Families
Referral Tips	- If referring via CradleME, indicate clearly if clinical nurse is needed. - Provide detailed explanation of nursing need of referral. - Call direct program contact for more urgent referrals.	- If referring via CradleME, indicate clearly if clinical nurse is needed. - Provide detailed explanation of nursing need of referral. - Call direct program contact for more urgent referrals.	- Refer as EARLY as possible (<3 mos age, or <6 mos if parent <21 yrs) - Identify referrals with more urgent need
Info for Families	CradleME Brochure https://www.portlandmaine.gov/387/Maternal-Child-Health	CradleME Brochure https://mainehealth.org/services/home-health-care/parent-child-home-health	CradleME Brochure Rack Cards, Flyers http://www.mainefamilies.org/
Expectation for Family Contact	**Via CradleME**: Within 3-5 days **Direct Referral:** The day after discharge from a hospital or within 24- 48 hours during a week day.	**Via CradleME**: Within 3-5 days **Direct Referral**: The day after discharge from a hospital or within 24- 48 hours during a week day.	Family receives call within 3 business days If no response, family will receiving mailing and follow up with texts or another call for 1-2 months
Contact Information	**Maternal and Child Health** **City of Portland** Mary Anne MacDormand, RN Email: mmacdormand@portlandmaine.gov Phone: (207) 874-8475	**MaineHealth Care at Home** Greg Burns, RN Email: gburns@homehealth.org Phone: (207) 775-5515	**Maine Families Cumberland County** **The Opportunity Alliance** Liana Popkin, Program Director Email: liana.popkin@opportunityalliance.org (207) 553-5801 Fax: (207) 842-6886 Area: Cumberland County / See website for other counties http://www.mainefamilies.org/

PEER LED PARENT SUPPORT for Autism & Special HealthCare Needs		
Program	**Autism Society of Maine**	**Maine Parent Federation**
Eligibility	**Age**: birth to adults (0 to 100) **Health Insurance:** not needed	**Age**: Birth-26 (but will provide in kind assistance to those older than 26) **Health Insurance:** not needed
Services	Information and referral agency. The Autism Society of Maine provides education and resources to support the valued lives of individuals on the autism spectrum and their families. ASM is a statewide agency. Services offered: Autism Information Specialist (AIS) who work one on one with parents or individuals with ASD to provide support, attend IEP or PCP, help to navigate services offered through the state both DHHS and DOE, free lending library, 2 free summer camps, family retreat weekend, provide presentation on variety of topics, First Responder and Law Enforcement program, track legislative issues and provide alerts, provide a state wide calendar of events, adult social group and teen social group, parent to parent referral list, send out packets for autism awareness month and throughout the year.	Maine Parent Federation (MPF) is a private non-profit grant funded organization providing information, referral, resources, one on one telephone support, peer to peer support, and training to parents of children with disabilities or special health care needs and the professionals who work with these families. Services are offered at no cost to parents and are available statewide. All of the services are free for families and a family does not have to qualify for MaineCare, Katie Beckett, or have any insurance to receive our assistance. All a family needs to have is a suspicion of a diagnosis of a disability or special healthcare need for their child and Maine Parent Federation will assist them in navigating any and all systems of care. We meet families where they are at and take them as far as they are willing to go.
How to Refer	1) Call 1-800-273-5200 or 207-377-9603 or Fax 207-377-9434, **OR** 2) Email any staff member: Tara Perry tara@asmonline.org, Tena Hinds tena@asmonline.org, Susan Vincent susan@asmonline.org, Cathy Dionne asm@asmonline.org, **OR** 3) Walk-in to office: 72B Main Street, Winthrop, ME	1) Family calls (800) 870-7746 / (207) 588-1933 or email parentconnect@mpf.org, **OR** 2) Provider completes Family Support Navigator Release Form with the family, (http://mpf.org/documents/Family_FSN_match_app.pdf) and faxes, mails or emails it to our office. (Requires Caregiver Signature)
Referral Tips	For general calls any staff can answer questions. For library information call or email Tara. For the AIS program call or email Tena . For website or event calendar call or email Susan. For adult services call or email Cathy. For children services call or email Tena or Tara.	Warm hand offs do work the best for connecting with families. If it is at all possible to make the initial phone call with the family that would ensure they are able to connect with our office and services. However, if warm handoff not possible, filling out the Release form (above) and sending it to our offices allows us to initiate contact which sometimes is easier for families and ensures connection to the services.
Info for Families	Offer 8 different brochures: Autism Information Brochure, Autism Spectrum Disorder, Children's brochure, ASM two sided card, ASM program brochure, First Responder and Law Enforcement, Summer camp, and Family Retreat Weekend. Quarterly newsletter online.	Family Navigator Cards Maine Parent Federation Brochure http://mpf.org/resources.html
Expectation for Family Contact	If requesting material families receive within 3 days and requesting AIS will receive a call within 3 days.	Expect contact within 24 business hours of parent call or within 24 business hrs of receiving the release to contact.
Contact Information	Cathy Dionne, Executive Director Email – asm@asmonline.org 1-800-273-5200 www.asmonline.org 72B Main Street, Winthrop, ME 04364	Carrie Woodcock, Executive Director Email – cwoodcock@mpf.org Office – (207) 588-1933 Cell – (207) 229-2006 Fax – (207) 588-1938 484 Maine Avenue, Farmingdale, ME 04344

QC for Kids
Maine Quality Counts

Created by the Cumberland County Developmental Screening Community Initiative (DSCI).
For more information about this tool, contact qcforkids@mainequalitycounts.org.

EARLY CHILDHOOD COMMUNITY REFERRALS: BIRTH-5 YRS

Referral Diagram FAQs

DIAGRAM FOOTNOTES	
1	**What is a Qualifying Medical Condition for Referral to Child Development Services (CDS)?** Child Development Services has a list of Qualifying Medical Conditions; these conditions make a child eligible for CDS services regardless of developmental screening or evaluation. See attached list. Referrals for children with these conditions should be sent as early as possible to CDS (ex: from newborn nursery).
2	**Should I Refer to CDS or Directly to Occupational Therapy (OT), Physical Therapy (PT) or Speech Services?** For children with suspected developmental delay, most referrals should go to CDS first. CDS will then do a screening or evaluation to identify developmental needs in multiple domains and identify subsequent service plans to address these needs. However, you may choose to refer directly to Occupational Therapy, Physical Therapy, and Speech/Hearing Services. Review the considerations below. Of note, CDS referrals do NOT require health insurance. However, direct referrals to OT, PT, or Speech/Hearing services do generally require health insurance or freecare. **Consider Direct Referral to Occupational Therapy (OT) or Physical Therapy (PT) if:** - Child has Isolated delay in motor development AND child has health insurance - Child has identified medical need for which OT/PT/Speech are an indicated services; these services may precede a referral to CDS **Consider Direct Referral to Speech/Hearing Services (Ex: NE Hearing & Speech) or Pediatric ENT Specialist (audiology) if:** - Newborn failed hearing screen at birth or passed with risk factors - Need for audiological evaluation in setting of medical condition or developmental delay ***Health insurance needed for NE Hearing & Speech if direct referral (MaineCare accepted)** ***Health insurance or FreeCare needed for Maine Medical Partner ENT or Mercy ENT (MaineCare accepted)**
3	**Should I Refer to Cradle ME or Directly to Maine Families and Home-Visiting Nursing Programs?** CradleME is a free program for all families in Maine who are expecting or have just had a baby **(Prenatal- Age 1yr)**. CradleME is a central referral system through which families can receive a family visitor, a nurse, or both depending on the identified needs. Referring through CradleME for **pregnant women & children ages Birth-1yr** is recommended to optimize resources across public health nursing, MaineHealth Care at Home, and Maine Families. However, if you have an urgent need for a home visiting nurse (ex: breastfeeding concerns), you may still call MaineHealth Care at Home or Public Health Nursing to ensure immediate response.

4	**What are additional Early Childhood Behavioral Health community resources?** The diagram is NOT a comprehensive representation of behavioral health services that serve young children. In addition to Maine Behavioral Healthcare, there are additional community agencies that support the social and emotional wellbeing of young children. Also there are integrated behavioral health clinicians in many medical homes. Other community behavioral health resources include: The Opportunity Alliance https://www.opportunityalliance.org/ Spurwink https://spurwink.org Sweetser https://www.sweetser.org/ You may call **2-1-1** for help identifying a behavioral health resource in any county in Maine.
5	**Should I refer to a Developmental Pediatrician in addition to CDS?** Consider the MaineHealth Referral Guidelines below. "Referral guidelines are meant to help providers decide if a specialty referral is needed. They are not intended to be comprehensive management algorithms." **Developmental Delay** https://mainehealth.org/-/media/mainehealth/pdfs/pediatric-guidelines-and-protocols/dbp-developmental-delay.pdf?la=en **Concern for Autism** https://mainehealth.org/-/media/mainehealth/pdfs/pediatric-guidelines-and-protocols/dbp-austim.pdf?la=en

OTHER FREQUENTLY ASKED QUESTIONS

Which of the Programs in the Diagram Provide Case Management Services?

All programs listed provide some amount of care coordination and resource connection for families. The model and intensity of coordination services varies throughout. Some programs have dedicated case managers, while others have service providers performing a dual role that includes case management. If a family needs intensive case management services to facilitate connection to multiple early childhood resources, consider a separate referral for independent case management.

*For immigrant and refugee families, consider linkage to the **Maine Access Immigrant Network (MAIN)** –an organization that can support families to connect with healthcare and social services in Portland.
http://main1.org/about-us/

Which Community Programs in the Diagram Require Health Insurance?

Northeast Hearing & Speech and Maine Behavioral Healthcare are the only specific programs listed that require health insurance. Both accept MaineCare.