



Maine Head Start Directors Association

Doug Orville, Chair

Child & Family Opportunities, PO Box 648, Ellsworth, ME 04605

Phone (207) 667-2995

October 13, 2015

Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333-0100

RE: Study of the Allocations of the Fund for a Healthy Maine

Dear Sen. Brakey, Rep. Gattine and Members of the Committee:

I serve as the Chair of the Maine Head Start Directors Association, which brings together the Executive Directors of Maine's 11 Head Start programs. Together, we provide Head Start services to over 3,000 Maine children and their families. I want to inform you about the important services we provide for Maine children and families and the ways in which the Fund for a Healthy Maine supports those services.

Assistance for Vulnerable Children and Families

Maine Head Start providers serve the most severely at risk children aged birth to 5 years old in Maine, starting with Early Head Start, which targets pregnant women and children from birth to 3 years old and then Head Start, assisting children ages 3-5. All children from families with incomes at or below the federal poverty level (\$24,250 for a family of four in 2015) are eligible for Head Start. Of those children, Head Start selects the most vulnerable and at risk. Head Start provides comprehensive early care and education, as well as a variety of assistance to these children and their families. These include health, nutrition, vision, hearing and mental health services for children, as well as home visits, family literacy and vocational support for families.

The Effectiveness of Head Start

There is overwhelming evidence of the effectiveness of Head Start. The research in this area reaches the following conclusions:

1. Head Start increases educational achievement
2. Head Start has a significant positive impact on child and family health
3. Head Start assists parents in going to work or school
4. Head Start graduates are less likely to turn to crime
5. Head Start is a sound investment, with a return on investment of \$7 to \$9 for each dollar invested.

These benefits are well-documented in available research. Attached is my March 16, 2015 letter to this Committee which specifically addresses research on the impact of Head Start. The Maine Head Start 2014 Annual Report, also attached, provides additional detail on Head Start and relevant research.

Law enforcement officials are on record supporting head start and quality child care as a means to reduce crime. Maine Sheriffs, Police Chiefs and prosecutors have been vocal supporters of early care and education before this Committee. Fight Crime: Invest in Kids Maine makes this case eloquently in their report *I'm the Guy You Pay Later* (<http://fightcrime.s3.amazonaws.com/wp-content/uploads/ME-Im-the-Guy-Report.pdf>).

The research also demonstrates that Head Start and other quality child care programs have a positive impact on our economy. Quality Head Start and child care improve the performance of young children, which will produce a higher quality work force in the future. As well, they allow Head Start parents to work or improve their education, thus improving Maine's work force right now. This position is held by a wide variety of Maine people, including business leaders (See the Maine Development Foundation and Maine Chamber of Commerce report *Making Maine Work: Investment in Young Children = Real Economic Development* - <http://www.mdf.org/publications.php>).

The Demand for Head Start

The demand for Head Start far outstrips our resources. We are able to serve less than half of the 3-5 year olds who are eligible. According to the 2014 Maine Head Start Annual Report, “only 28% of income eligible children were served in a Head Start program due to funding availability. This means that 72% of the children who were income eligible did not have the opportunity to benefit from this comprehensive early learning program.” Maine's Head Start providers currently have 1,000 families on waiting lists.

Our providers are committed to serving as many children as possible. However, cuts to our programs in recent years have forced us to close classrooms and reduce the number of students served.

Funding for Head Start and Child Care

Head Start is a federally funded program. Maine's providers receive \$32 million each year and must raise a 20% local match. Because that funding is nowhere near sufficient to serve all eligible children and because of the importance of early care and education to child development, Maine has provided state support for Head Start programs since the 1980s. Maine is one of 19 states that provide support for Head Start.

Families with children in Head Start facilities also receive assistance through the state's child care voucher program. Vouchers are funded through the federal Child Care Development Fund (CCDF), a

block grant program that requires state match. Vouchers allow Head Start children to receive full day, full year services and also provide access to the regular child care classrooms provided by Head Start agencies and hundreds of other providers statewide.

In this year's budget, Head Start received an additional \$575,000 per year in one-time support through the Fund for a Healthy Maine (FHM) for state fiscal years 2016 and 2017. In addition to allowing us to serve additional children, this increase can be used by the Department to draw down available federal Child Care Development Funds. While this added funding will greatly help our efforts, state support is still considerably below where we were a few years ago. In FY 12, state support for Head Start was \$2.44 million from the General Fund and \$1.35 million from FHM, equaling \$3.79 million total. Below is a summary of state support for Head Start for last year and each year of the current biennium:

<u>Head Start Funding</u>	<u>FY 15</u>	<u>FY 16</u>	<u>FY 17</u>
Fund for a Healthy Maine	\$1,350,000	\$1,350,000	\$1,350,000
Fund for a Healthy Maine One-Time		\$575,000	\$575,000
General Fund – base allocation	\$440,000	\$1,190,000	\$1,190,000
General Fund – supplemental	\$750,000		
TOTAL STATE SUPPORT	\$2,540,000	\$3,115,000	\$3,115,000

From the chart above, you can see that, while funding in this fiscal year and next has markedly improved over FY 15, it's still \$675,000 less than where the program once was.

In FY 15, Head Start agencies served 137 children with state funds. Maine DHHS required that all children be placed in classroom based Early Head Start services. Early Head Start serves children aged 0-3 and is the most expensive form of Head Start. DHHS has recently changed the policy and is allowing each Head Start agency to determine the best use of state funds.

Currently, Head Start agencies are serving 160 children with available state funding, with the majority of those children still in classroom based Early Head Start. Their current state contracts do not include the supplemental \$575,000 in one-time FHM resources. It appears the Department drew up contracts based on the initial budget proposal (\$2.54 million) and have yet to add the new funding.

Support from the Fund for a Healthy Maine is integral to Head Start. It has provided constant assistance to low-income families and their children since the creation of the Fund. It allows us to serve many more eligible children and families. Many agencies also use these funds as local match for their federal funds.

We appreciate the continued support from FHM and look forward to discussing it with the Committee.

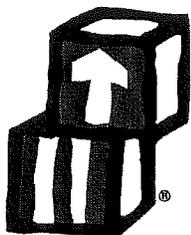
Sincerely,

A handwritten signature in cursive script, appearing to read "Doug Orville".

Doug Orville

Attachments

March 16, 2015 Letter from Doug Orville, MHSDA to the AFA and HHS Committees
2014 Maine Head Start Annual Report



Maine Head Start Directors Association

Douglas D. Orville, Chair
Child & Family Opportunities, PO Box 648, Ellsworth, ME 04605
Phone (207) 667-2995 x230

March 16, 2015

Appropriations and Financial Affairs Committee
Health and Human Services Committee
100 Statehouse Station
Augusta, ME 04333

Dear Committee Members:

During the March 6th public hearing on children's services in the budget, Head Start providers were asked several questions by Committee members. This letter will attempt to respond to those questions.

Unmet Need and Waiting Lists

Doug Orville noted that less than 30% of eligible children are currently receiving Head Start. He was asked for more specific data. This is provided in the 2014 Head Start Report prepared by the Head Start Collaboration Office. Copies were attached to Mr. Orville's March 6 testimony and can be viewed online.¹

The Report indicates that 4,394 children were served by Early Head Start and Head Start in 2013 representing 28% of the eligible children. 11,299 eligible children did not receive Head Start services due to a lack of capacity.

Another measure of unmet need are the waiting lists maintained by the 11 non-tribal Head Start providers in Maine. Together we have 1,000 children on our waiting lists.

Research on Head Start Benefits

In her testimony, Heidi LeBlanc of Penquis noted the many positive outcomes of Head Start documented in research. Head Start has been shown to increase graduation rates, increase home ownership and wages, improve *family* health and reduced incarceration rates, among other things. There is a great deal of research on Head Start and other comprehensive early

¹ https://ccids.umaine.edu/files/2015/01/mhssco_2014_annual_report_final-012615.pdf

care and education programs. Attached is a summary of the research with citations to the underlying research prepared by the National Head Start Association (NHSA).

I want to highlight the health effects of Head Start. In my testimony, I noted our emphasis on immunization. Research shows that participation in Head Start improves health outcomes for children *and* their families. Head Start children have lower mortality rates, are more likely to receive dental care, and problem behavior is less frequent and less severe. Head Start parents have "greater quality of life satisfaction; increased confidence in coping skills; and decreased feelings of anxiety, depression, and sickness."

Additional research on the benefits of Head Start is cited on page 16 of the Head Start Report.

Trostel Study

A Maine focused economic analysis of the best research on early care and education was prepared by Philip Trostel of the University of Maine.² That report, Path to a Better Future: The Fiscal Payoff of Investment in Early Childhood in Maine, assesses the economic impact of a comprehensive early childhood system (like Head Start) in Maine. Trostel determines the economic benefits of the program will include:

1. Lower special education costs
2. Lower juvenile and adult corrections costs
3. Savings from lower rates of grade retention
4. Reduced public assistance during the children's lifetime (Medicaid, state SSI, and other assistance)
5. Increased tax revenues due to greater educational attainment and higher lifetime earnings for participants

Trostel concluded that "the total lifetime fiscal benefit of participating in the high-quality early care and education system is about \$125,400 per individual, which is 4.8 times greater than the initial fiscal cost."

Some national studies have found returns of 7:1 (see NHSA research summary).

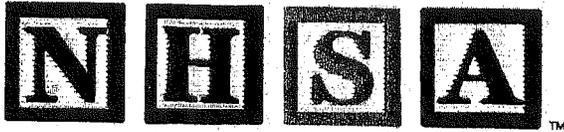
Thank you for your interest in Head Start. I will be present at the HHS Committee work session on March 17th to answer any questions.

Sincerely,



Douglas D. Orville

² Summary - <http://mainecgc.org/docs/Summary%20Path%20to%20a%20Better%20Future.pdf>
Full report - http://melig.org/pdfs/Path_to_a_Better_Future_Full_Report.pdf



NATIONAL HEAD START ASSOCIATION

Benefits of Head Start and Early Head Start Programs

The federal government's historical commitment to sponsor and encourage research and evaluations in the HS and EHS programs has generated a large corpus of research on HS and EHS. This research reveals that HS and EHS programs provide educational, economic, health, and law enforcement benefits.

Educational Benefits

Substantial research finds that HS and EHS programs provide educational benefits. HS graduates, by the spring of their kindergarten year, were essentially at national norms in early reading and early writing and were close to meeting national norms in early math and vocabulary knowledge.¹ By the spring of their kindergarten year, HS graduates' reading assessment scores reached national norms, and their general knowledge assessment scores were close to national norms.² Reliable studies have found that HS children experience increased achievement test scores and that HS children experience favorable long-term effects on grade repetition, high school graduation rates, and special education.³ Regarding special education, data analysis of a recent Montgomery County Public Schools evaluation found that a MCPS child receiving full-day Head Start services requires 62 percent fewer special education services. This saves taxpayers \$10,100 annually for every child in special education.⁴

Likewise, findings from the EHS Impact Study show that EHS children on average had a higher cognitive development score than their control group.⁵ EHS children at age 3 had larger vocabularies than the control group children had. EHS children demonstrated a higher level of social-emotional development than their control group.⁶

Economic Benefits

Research demonstrates how HS is a wise investment that hedge fund managers and Wall Street bankers would envy. Multiple studies have found that for every \$1 invested in Head Start, Head Start pays a Return On Investment (ROI) ranging from \$7 to \$9.¹⁵ Moreover, an econometric study found that Head Start had significant favorable impacts on the long-term outcomes of adults 19 years or older who attended Head Start. These outcomes consisted of an index of six young adult outcomes: high school graduation, college attendance, idleness, crime, teen parenthood, and health status. This study found that Head Start provides 80 percent of the benefits of small model early childhood programs at 60 percent of the cost.¹⁶ In other words, Head Start is operated more efficiently than these model early childhood programs. Head Start parents receiving health literacy decreased annual Medicaid costs by \$232 per family.¹⁷

Health Benefits

Studies demonstrate that HS and EHS improve the health of the children and families they serve. Head Start reduces by as much as 50 percent the mortality rates for 5- to 9-year-old children and making them equivalent to the rates for comparable children who were not enrolled in Head Start. In fact, Head Start reduced the rates to the national average of mortality rates for all 5- to 9-year-old children.⁷ Economists have calculated that a Head Start child is up to 25 percent less likely to smoke as an adult.⁸ HS provides health and dental services to children and families who might otherwise not have them.⁹ Parents who participate in HS are found to have greater quality of life satisfaction; increased confidence in coping skills; and decreased feelings of anxiety, depression, and sickness.¹⁰ Research suggests that HS reduces childhood obesity.¹¹ The HS Impact Study demonstrated that a much higher proportion of HS children received dental care than those children who did not receive HS services.¹² HS children are at least eight percentage points more likely to have had their immunizations than those children who did not attend preschool.¹³ Similarly, EHS children had a higher immunization rate than children in a control group.¹⁴

Law Enforcement Benefits

Along with improving the health of its children and families, HS benefits its children and society-at-large by reducing crime and its costs to crime victims.¹⁸ States can save the \$29,000 per year for each prisoner that they incarcerate because Head Start children are 12 percent less likely to have been charged with a crime.¹⁹

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The National Head Start Association, an independent membership organization, advocates on behalf of the entire Head Start community and provides training and resources to Head Start programs nationwide.

¹ Zill, N. and Sorongon, A. (2004). *Children's Cognitive Gains during Head Start and Kindergarten*. Presentation at the National Head Start Research Conference, Washington, DC. June 28-30, 2004.

² Ibid.

³ Barnett, W. (2002, September 13). The Battle Over Head Start: What the Research Shows. Presentation at a Science and Public Policy Briefing Sponsored by the Federation of Behavioral, Psychological, and Cognitive Sciences; Garces, E., Thomas, D. and Currie, J.. (2002, September). Longer-Term Effects of Head Start. *American Economic Review*, 92(4): 999-1012. Ludwig, J. and Miller, D. (2007). Does Head Start improve children's life chances? Evidence from a regression discontinuity design. *The Quarterly Journal of Economics*, 122 (1): 159-208.

⁴ NHTSA Public Policy and Research Department analysis of data from a Montgomery County Public Schools evaluation. See Zhao, H. & Modarresi, S. (2010, April). *Evaluating lasting effects of full-day prekindergarten program on school readiness, academic performance, and special education services*. Office of Shared Accountability, Montgomery County Public Schools.

⁵ U.S. Department of Health and Human Services. (2002, June). Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start, Executive Summary, 3.

⁶ _____. (2002). Research Practice, Talking Points: Overall Findings Presentation "Long Version." Early Head Start Research and Evaluation Project. Slide 12.

⁷ Ludwig, J. and Miller, D. (2007). Does Head Start improve children's life chances? Evidence from a regression discontinuity design. *The Quarterly Journal of Economics*, 122 (1): 159-208.

⁸ Anderson, K.H., Foster, J.E., & Frisvold, D.E. (2009). Investing in health: The long-term impact of Head Start on smoking. *Economic Inquiry*, 48 (3), 587-602.

⁹ Hale, B., Seitz, V., and Zigler, E. (1990). Health Services and Head Start: A Forgotten Formula. *Journal of Applied Developmental Psychology*, 11, 447-458.

¹⁰ Parker, F., Piotrkowski, C., and Peay, L. (1987). Head Start as a Social Support for Mothers: The Psychological Benefits of Involvement. *American Journal of Orthopsychiatry*, 57(2): 220-233.

¹¹ Frisvold, D. (2007, January). *Head Start Participation and Childhood Obesity*. Paper presented at the Allied Social Science Association Meetings, Chicago, IL.

¹² U.S. Department of Health and Human Services. (2005, June). Executive Summary, Head Start Impact Study First Year Findings, xv.

¹³ Currie, J. and Thomas, D. (1995, June). Does Head Start Make a Difference?. *The American Economic Review*, 85(3): 341-364.

¹⁴ U.S. Department of Health and Human Services. (2002). Research Practice, Talking Points: Overall Findings Presentation "Long Version." Early Head Start Research and Evaluation Project. Slide 11.

¹⁵ Ludwig, J. and Phillips, D. (2007). The benefits and costs of Head Start. *Social Policy Report*, 21 (3: 4); Meier, J. (2003, June 20). Interim Report. Kindergarten Readiness Study: Head Start Success. Preschool Service Department, San Bernardino County, California; Deming, D. (2009, July). Early childhood intervention and life-cycle skill development: Evidence from Head Start. *American Economic Journal: Applied Economics*, 1 (3): 111-134.

¹⁶ Deming, D. (2009, July). Early Childhood Intervention and Life-Cycle Skill Development: Evidence from Head Start. *American Economic Journal: Applied Economics*, 1 (3): 111-134.

¹⁷ Herman, A. (2005, Fall). Making a difference in Head Start families' health care. *Dialog Briefs*, 9(1): 4. Available at http://www.nhsa.org/research/dialog_briefs.

¹⁸ Fight Crime: Invest In Kids. (2004). Quality Pre-Kindergarten: Key to Crime Prevention and School Success. Available at <http://www.fightcrime.org/> on July 23, 2004, 1.

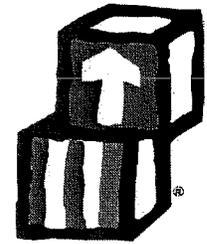
¹⁹ Reuters. (2009, March). *Cost of locking up Americans too high: Pew study*; Garces, E., Thomas, D. and Currie, J. (2002, September). Longer-term effects of Head Start. *American Economic Review*, 92 (4): 999-1012.



Maine Head Start



**2014
Annual Report**



Dear Maine Community,

The Maine Head Start Directors' Association (MHSDA) and the Maine Head Start State Collaboration Office (MHSSCO) are pleased to share our 2014 Annual Report on Head Start and Early Head Start in Maine communities.

For 50 years, Head Start has provided services to support the healthy development of Maine's most vulnerable children and their families. The model, developed in 1965 to provide preschool children with a "head start," is synonymous with a focus on school readiness. Informed by the known effects of poverty on child well-being, the initial comprehensive services program design provides services that support early education as well as health, nutrition, mental health, and social and family support services. With the emergence of research on the importance of learning and development in the early years and the increased numbers of children and families living in poverty, Head Start is even more relevant today.

In Maine, there are eleven Head Start grantees that operate 24 programs. The federal government provides 80% of the annual cost to operate Head Start programs with the remaining 20% coming from matching contributions. The State of Maine provides a small amount of funding allowing programs to serve additional children and families. The information presented in this report illustrates the unique features of the Head Start program, as well as how our efforts are aligned, connected, and support the broad goal of increased investment in high quality early childhood education in Maine.

As an early childhood partner concerned with the healthy growth and development of Maine's citizens, Head Start continues to make vital contributions to the early care and education system in Maine. As Maine continues to build a comprehensive early childhood system, Head Start has a critical role to play. Collaboration among early care and education programs is necessary to achieve greater access to high quality programs. There is no single agency that can meet all of the diverse needs affecting low-income families. Head Start has a long and successful history in Maine of demonstrating effective outcomes for participating children and families. It is our hope that the 2014 Maine Head Start Annual Report will contribute to the work in Maine by providing this information to our citizens and decision makers.

Sincerely,

Douglas D. Orville

Douglas D. Orville
Chair, Maine Head Start Directors' Association
Executive Director, Child and Family Opportunities, Inc.

Linda Labas, M.Ed., Director
Maine Head Start State Collaboration Office

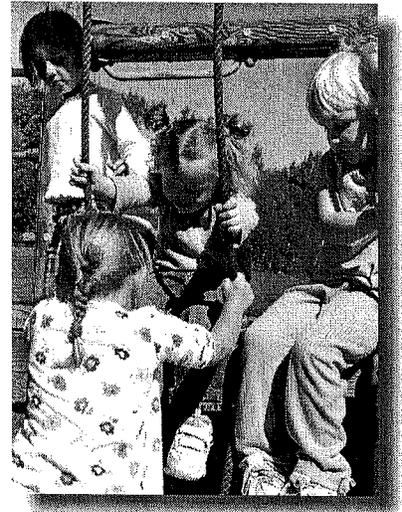
Introduction

The goal of Head Start is to improve outcomes for young children (ages 6 weeks to 5 years) from low-income families by promoting school readiness through a continuum of comprehensive services (early childhood education, health, nutrition, and social services) that support children's development and family functioning. The term "Head Start" refers to the Head Start program as a whole which serves pregnant women, infants, toddlers, preschool-aged children, and their families in various service options (home visiting, center-based, and family child care).

This annual report presents aggregate data from the 11 non-tribal Head Start grantees in Maine for the 2012-2013 program year. All of the data related to services, staff, children, and families cited in this report are obtained from the Office of Head Start 2012-2013 Program Information Report (PIR)¹ unless otherwise indicated. This data clearly demonstrates Head Start's positive impact on Maine's children, families, communities, and economy.

Head Start is a well-established, research-based, and innovative program. As an active partner in the early childhood service delivery system, Head Start is dedicated to the healthy growth and development of the youngest and most vulnerable members of our communities. It is grounded in a two generation approach that is necessary to improve the lives of young children and their families.

The Maine Head Start State Directors Association provides leadership in educating, advocating, and promoting the quality and quantity of early childhood education and supports to families. The Maine Head Start State Collaboration Office facilitates coordination and collaboration between Head Start and local and state agencies designed to benefit low-income children and families. For an in-depth description of Maine Head Start and the Maine Head Start State Collaboration Office, please visit <http://umaine.edu/ccids-mhssco/>.



My oldest, that is now 6 and in the first grade, started out in Head Start. He's the best reader in his class and needs extra work sent home to give him the challenge they can't give him in class with the other kids. The head start he received is still continuing to pay off. - Alyssa

¹ The Head Start PIR data reports are available upon request. Contact information found at <http://eclkc.ohs.acf.hhs.gov/hslc/data/pir>

Head Start Matters

Head Start Fast Facts

What is Head Start?

Head Start is a federally funded, community-based program that promotes the school readiness of preschool children from low-income families by enhancing their cognitive, social, and emotional development.

Head Start's comprehensive services design is unique. Enrolled children and families participate in a wide array of services and supports, including education, health, mental health, nutrition, and social services.

Head Start preschool services may be center-based, home-based or a combination, and operate as a half-day or full-day.



Both Head Start and Early Head Start services are provided in a variety of ways depending on the needs of the local community. Through the years, both programs have included community partnerships with local family child care homes, center-based child care programs, and/or local public school Pre-Kindergarten programs.

According to the Maine Department of Education, there are currently 210 Public Pre-K programs. Head Start is a collaborative partner with 74 of these programs (or 35% of the Public Pre-K programs in Maine).

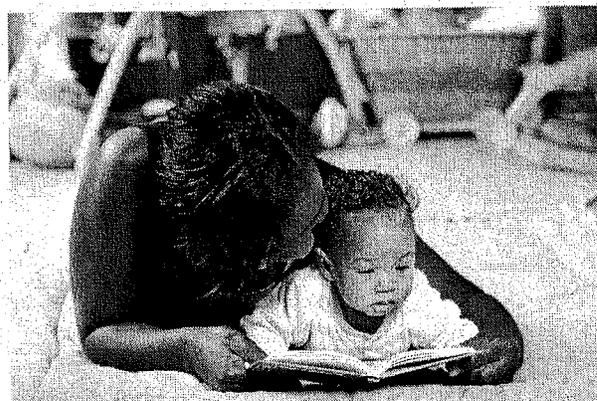
Head Start was the first early intervention program providing services to those with established risks including families living in poverty, experiencing homelessness, and children in the child welfare system.

(Brekken and Corso, 2009)

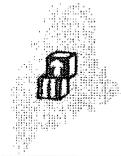
What is Early Head Start?

Early Head Start operates year round and incorporates all of the Head Start program content areas into a comprehensive program for younger children, ages 6 weeks to 3 years. Early Head Start supports an integrated continuum of care for children and families in centers, home-based settings, and in combination program options based on the needs of the local community.

For pregnant women enrolled in Early Head Start, home visits are conducted to ensure that expectant mothers have access to comprehensive prenatal and postpartum care. Children and families who receive home-based services meet twice monthly with other enrolled families for a group learning experience facilitated by Early Head Start staff.



A Snapshot of Head Start in Maine for the 2012-2013 Program Year



Demographics

Maine has 11 non-tribal Head Start grantee organizations and 24 programs.

4,394 pregnant women, infants, toddlers, and preschoolers served in Maine's Head Start programs
Head Start (3,207) Early Head Start (1,115) Pregnant Women (72)



Families Served

- 4,027 families served by Head Start.
- 3,777 families received at least one of the available family services.
- 747 families received mental health services.
- 433 families experienced homelessness.



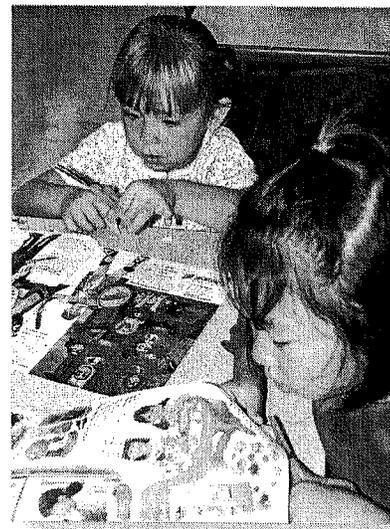
Children's Health

- 97% of children had access to health insurance at the end of enrollment year.
- 98% of enrolled children had a medical home.
- 89% of enrolled children were current on all immunizations.
- 67% of enrolled children's daily nutritional needs were supplied by Head Start.
- 14% of enrolled children received mental health consultation services in Head Start.



Economic Impact

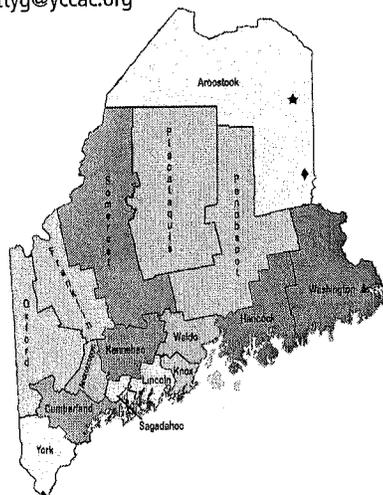
- 1,185 Maine citizens are employed by Head Start.
- 73% of Head Start preschool teachers have a baccalaureate or advanced degree.
- 64% of Head Start parents are employed.
- 16% of Head Start parents are in school/training.



Source: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, Early Childhood & Knowledge Center. (2014). *2012-2013 Program Information Report (PIR)*. [Data file]. Retrieved from <http://eclkc.ohs.acf.hhs.gov/hslc/data/pir>

Maine Head Start Grantees

- Androscoggin Head Start & Child Care
County served: Androscoggin
Coburn School
269 Bates Street, Lewiston, ME 04240
(207) 795-4040 ext. 316
Betsy Norcross Plourde, Director
bplourde@androkids.com
- Aroostook County Action Program
County served: Aroostook
P.O. Box 1116, 771 Main Street
Presque Isle, ME 04769
(207) 768-3045 ext. 670
Sue Powers, Director
spowers@acapme.org
- Child & Family Opportunities, Inc. (CFO)
Counties served: Hancock and Washington
P.O. Box 648, Ellsworth, ME 04605
(207) 667-2995 ext. 230 or 1-800-834-4378
Doug Orville, Director
DougO@childandfamilyopp.org
- Community Concepts, Inc.
Counties served: Oxford and Franklin
17 Market Square, South Paris, ME 04281
(207) 739-6516
Heath Ouellette, Director
Houellette@Community-Concepts.org
- Kennebec Valley Community Action Program (KVCAP)
Counties served: North Kennebec and Somerset
97 Water Street, Waterville, ME 04901
(207) 859-1618
Kathy Colfer, Child & Family Services Director
kathyc@kvcap.org
- Midcoast Maine Community Action
Counties served: Sagadahoc, Lincoln, and
Greater Brunswick
34 Wing Farm Parkway, Bath, ME 04530
(207) 442-7963 ext. 214 or 1-800-221-2221
Sue Kingsland, Director
sue.kingsland@mmcacorp.org
- The Opportunity Alliance
County served: Cumberland
510 Cumberland Avenue, Portland, ME 04101
(207) 553-5823
Louise Marsden, VP, Family and EC Education
louise.marsden@opportunityalliance.org
- Penquis Community Action Program
Counties served: Penobscot, Piscataquis, and Knox
P.O. Box 1162, Bangor, ME 04402-1162
(207) 973-3500
Heidi LeBlanc, Director
hleblanc@penquis.org
- Southern Kennebec Child Development Corporation
County served: Southern Kennebec
337 Maine Avenue, Farmingdale, ME 04344
(207) 582-3110, ext. 12
Michele Pino, Director
michelep@skcdc.org
- Waldo County Community Action Partners
County served: Waldo
P.O. Box 130, Belfast, ME 04915
(207) 338-6806, ext. 204
Kim Cummings, Director
kcummings@waldocap.org
- York County Community Action Corporation
County served: York
P.O. Box 1964, Biddeford, ME 04005
(207) 710-2404
Betty Graffam, Director, Children's Services
bettyg@yccac.org



Tribal Head Start

- ★ Little Feathers Head Start Aroostook Band of Micmacs
Area served: Houlton and Presque Isle
13 Northern Road, Presque Isle, ME 04769
(207) 768-3217
Tammy Deveau, Director
tdeveau@micmac-nsn.gov
- ◆ Maliseet Head Start
Area served: Houlton
1 Maliseet Drive, Houlton, Maine 04730
(207) 521-2410
Tracie Botting, Director
tbotting@maliseets.com
- ▲ Passamaquoddy Head Start
Area served: Perry
P.O. Box 344, Perry, ME 04667
(207) 853-4388 & (207) 454-2128
Betty Lewey, Director
passamaquoddyheadstart@roadrunner.com

Maine was one of the first states to have a Head Start program.

(Maine Head Start Association)

Head Start Matters

Enrollment in Maine

2013 Federal Poverty Level

Head Start enrollment is prioritized for families living in poverty. Programs use the 2013 Federal Poverty Guidelines. Up to 10% of the children enrolled may be from families that exceed the low-income guidelines. For the purpose of eligibility, a child from a family that is homeless, receiving public assistance, or a child in foster care, is eligible even if the family income exceeds the income guidelines (U.S. DHHS, ACF, Head Start, ECKC, Head Start Performance, 2008).

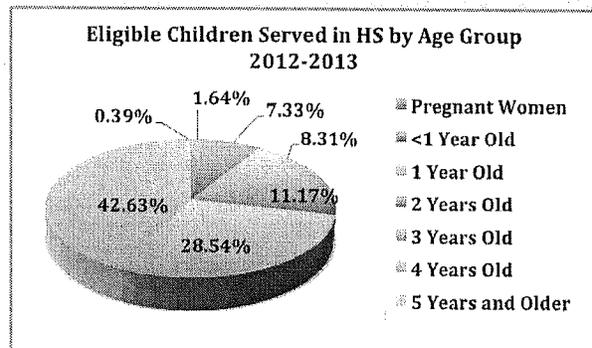
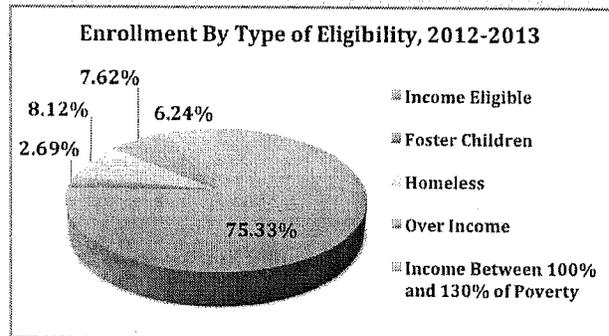
2013 Federal Poverty Guidelines

Family Size	Annual Income
1	\$11,490
2	\$15,510
3	\$19,530
4	\$23,550
5	\$27,570
6	\$31,590
7	\$35,610
8	\$39,630

Add \$4,020 for each additional family member above 8

Source: U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from <http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines>

In 2012, only 28% of the income eligible children in Maine were served in a Head Start program due to funding availability. This means that 72% of the children who were income eligible did not have the opportunity to benefit from this comprehensive early learning program (Maine Children's Alliance, Health, 2013).



Head Start Matters for Maine Children

Effective programs are based on child development research. Providing supportive relationships and safe environments can improve outcomes for all children and ensure that they have a solid foundation for a productive future.

(Center on the Developing Child, *InBrief: Early*, 2014)

What does the research say?

The foundations for school readiness are set in the early years and prepare children for life.

School readiness focuses on all aspects of healthy development, including physical, cognitive, social, and emotional development. Higher quality preschool programs have greater impacts on children's development and are more likely to create gains that are sustained after the child leaves preschool.

Recent evidence suggests that high quality preschool positively contributes to the language, literacy, and mathematics skills growth of both low- and middle-income children, but has the greatest impact on children living in or near poverty (Yoskikawa, et al., 2013).

Research consistently affirms that children in classrooms with higher CLASS (Classroom Assessment Scoring System) scores demonstrate more positive social and early academic development (U.S. DHHS, ACF, Understanding, 2012).

When I started in our Head Start agency, the agency was shifting to a new curriculum in all Head Start classrooms. Now that we're in year two of curriculum implementation, we're starting to look at aggregate CLASS data and children's learning gains—and it's so exciting! We're definitely seeing gains in both areas.

- Cristina, Maine Head Start Grantee Operations Director

How does Head Start measure up?

While Head Start always strives for excellence, the Head Start Act explicitly states that all programs implement scientifically valid curricula. This ensures that children's learning experiences are of the highest quality and are age and developmentally appropriate.

"The Head Start Approach to School Readiness" means that children are ready for school, families are ready to support their children's learning, and schools are ready for children.

Head Start views school readiness as children possessing the skills, knowledge, and attitudes necessary for success in school and for later learning and life (U.S. DHHS, ACF, Head Start Approach, 2014).

The Head Start Act (2007) requires periodic monitoring of all Head Start classrooms using a "valid and reliable research-based observational instrument." The instrument used is the Classroom Assessment Scoring System (CLASS).

What is the picture in Maine?

Head Start performance standards helped to inform the development of Quality for ME, Maine's Child Care Quality Rating Improvement System. All Head Start grantees participate in Quality for ME.

Maine Head Start programs are above the New England regional average in Classroom Assessment Scoring System (CLASS) instructional support scores.

All Maine grantees measure child achievement based on developmental measures that reflect developmentally appropriate school readiness. Child school readiness improvement is measured at the beginning, middle, and end of the year.

To learn more about Maine grantee program demographics and monitoring reports including CLASS reviews, visit <https://edkc.ohs.acf.hhs.gov/hslc/data/psr>

Head Start Matters for the Health of Maine Children

Physical and emotional health are necessary for children to fully participate in learning. Being healthy is critical to school readiness.

(U.S. DHHS, ACF, ECKC, *Healthy Children*, 2012)

What does the research say?

High quality early care and education programs that buffer young children from excessive stress could promote health and prevent disease, not just prepare the children to succeed in school (Center on the Developing Child, Foundations, 2014).

Healthy children need the following:

- Health Insurance
- Medical Home (continuous accessible physical and mental health care)
- Dental Home (continuous accessible dental care)
- Developmental Screening
- Healthy Parents
- Healthy Food

Nutrition

When children live in families facing food insecurity and hunger, their brain architecture is affected, causing harm to their physical, mental, social, and emotional health throughout their lives.

(Maine Children's Alliance, Social, 2013)

Head Start provides children with up to two-thirds of their daily nutritional needs.

Many children living in poverty are facing malnourishment, hunger, or can be overweight or obese.

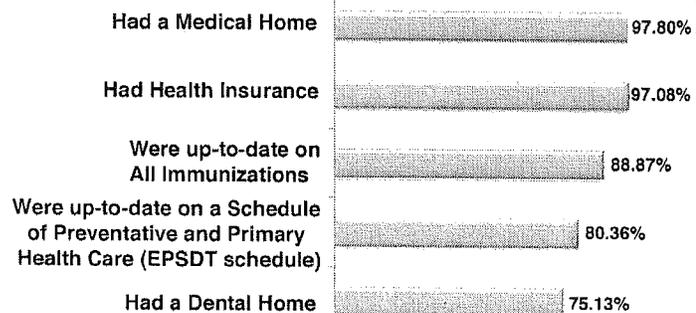
Head Start offers nutritious, ethnically diverse, and child-friendly food through a state-of-the-art food service program. All Head Start grantees participate in the U.S. Department of Agriculture's Child and Adult Care Food Program.

How does Head Start measure up?

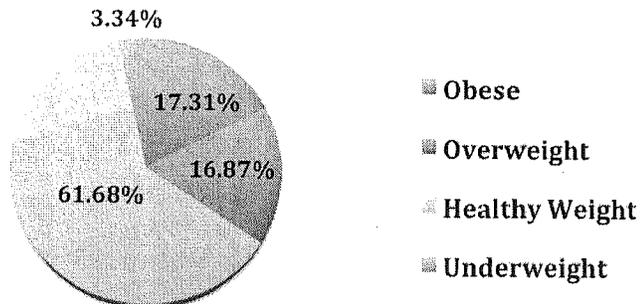
Head Start focuses on wellness for all enrolled children. By following a schedule of visits with primary health care providers with a focus on prevention, problems are quickly identified and addressed.

At enrollment, 2,044 Maine children were up-to-date on their primary and preventative health care (Early Periodic Screening, Detection, and Treatment – EPSDT schedule). By the end of the year, that number jumped to 3,473, which represents a 70% increase in children up-to-date according to the EPSDT schedule.

At the End of the Enrollment Year 2012-2013



Body Mass Index at Enrollment 2012-2013



Head Start Matters for the Mental Health of Maine Children

Early childhood mental health is synonymous with general health and well-being. It impacts children's learning and school readiness.

(U.S. DHHS, 2009 Head Start Bulletin, *Mental Health*)

Mental Health

What does the research say?

Evidence suggests that children's mental health and specifically, emotional adjustment, plays an important part in predicting their likelihood of school success. Programs that focus on social skills have been shown to have improved outcomes related to drop-out rates, attendance, repeating a grade, and special education referrals. They also have improved grades, test scores, and reading, math, and writing skills.

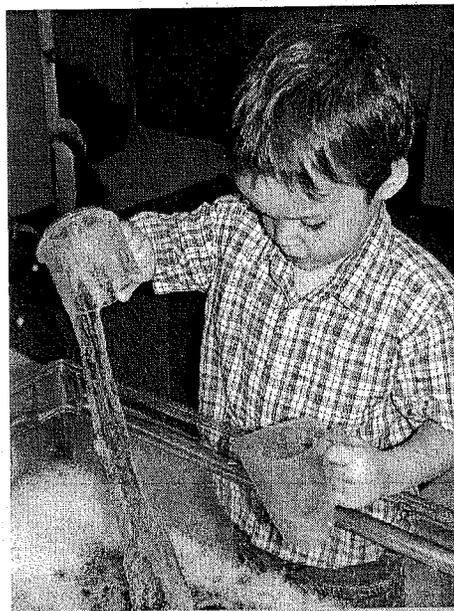


Mental health includes a broad spectrum of services to children and families including promotion, prevention, early identification, and treatment. Head Start staff also benefit from mental health resources that provide education and promote wellness (Zins, et al., 2004).

How does Head Start measure up?

Head Start focuses on children's social and emotional development and supports their behavioral and mental health care needs.

Head Start and Early Head Start programs partner with local professionals and other programs to ensure that children, families, and staff have access to prevention and intervention services. Programs are required to provide on-site mental health consultation. Head Start's commitment to social-emotional wellness includes the long-standing practice of not suspending or expelling any child.



What is the picture in Maine?

595 children received staff consultations for mental health services; of those, **28%** received **3** or more consultations.

241 parents received consultations about their children's mental health; of those, **35%** received **3** or more consultations.

90% of the children referred for mental health services outside of Head Start received services.

Head Start Matters for Maine Children with Disabilities

Head Start's comprehensive child development model often provides the first opportunity to identify a disability or health condition affecting a young child's development.

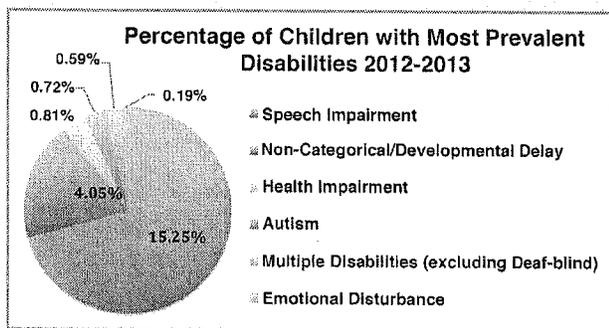
(U.S. DHHS, ACF, *Advisory Committee*, 2012)

Children with Special Needs and Disabilities

What does the research say?

Head Start has created the infrastructure, training resources, coordination, and partnerships to make inclusion not only possible, but also successful (Brekken & Corso, 2009).

Access to early learning environments, participation in the regular education curriculum and activities, and supports to children, families, and professionals are all necessary to ensure that the needs and priorities of infants and young children with disabilities and their families are met in inclusive settings (Cate, et al., 2010).



How does Head Start measure up?

Head Start is the largest provider of inclusive services for young children with disabilities in the United States (University of Washington, Head Start Center, n.d.)

Head Start programs are required to make at least 10% of funded slots available for children with disabilities (University of Washington, Head Start Center, n.d.).

Head Start programs must develop a disabilities service plan providing strategies for meeting the special needs of children with disabilities and their parents.

The Head Start Performance Standards and other regulations assure that children with disabilities and their families are included in the range of comprehensive services and program options available to all families.

What is the picture in Maine?

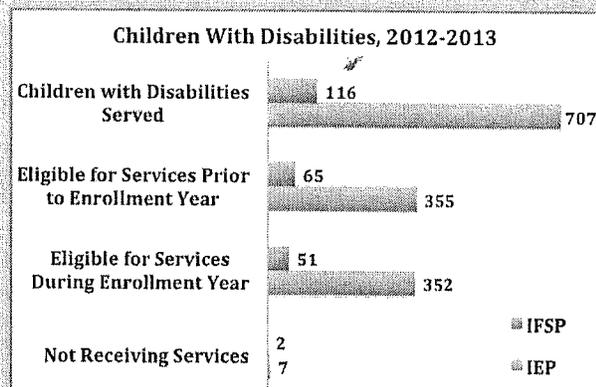
823 children with disabilities attended Head Start programs.

707 children ages 3-5 had an Individual Education Plan (IEP).

116 children ages birth-3 had an Individual Family Service Plan (IFSP).

All Head Start grantees in Maine are approved programs for special education services through the Maine Department of Education, Child Development Services (CDS).

Maine Head Start grantees work in partnership with local school districts to coordinate transition services.



Head Start Matters for Maine Families

Recognizing the inseparable importance of providing services that are informed by family and community needs and by authentically including and engaging families, Head Start is based on a two-generational model addressing life-long learning and economic advancement for both children as well as families.

(Annie E. Casey Foundation, 2014)

What does the research say?

The family is the primary force in preparing children for school and life, and children benefit when all of the adults who care for them work together (Bronfenbrenner, 2005).

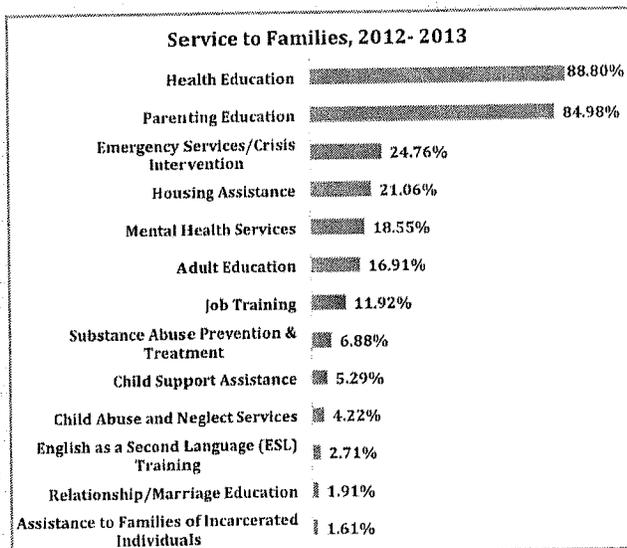
How does Head Start measure up?

Head Start recognizes that parents are the primary educators of their children. The comprehensive services approach extends to and includes building relationships with families. These relationships help to support family well-being, strong parent-child relationships, and ongoing learning and development of parents and children.

Head Start authentically engages families in activities that support their own development, including the following;

- Volunteering in the classroom;
- Participating in educational opportunities;
- Participating in work initiatives, health and wellness services;
- Joining program governance structures such as policy councils, giving them an opportunity to contribute to and exert a degree of local ownership and investment in their community program.

Head Start staff must offer parents an opportunity to develop individualized family partnership agreements. These agreements are developed by parents with the support of Head Start staff and are designed to provide support to families in direct response to their interests, goals, strengths, and needs.



What is the picture in Maine?

5,894 people provided volunteer services during the 2012-2013 enrollment year, including **3,599** parents. (Parent volunteers accounted for **61%** of all volunteers.)

3,422 families participated in Head Start parenting education programs.

Head Start has seen an increase in the numbers of children and families experiencing homelessness. Family support services include supporting families to find stable housing.

Of the **443** homeless families with **504** children served during the 2012-2013 enrollment year, **191** or **4.7%**, successfully acquired housing.

Research shows that one of the best investments we can make in a child's life is high quality early education.

(President Barak Obama, 2014)

Head Start Matters for Maine's Economy

What does the research say?

Every dollar invested in quality early childhood education for disadvantaged children delivers economic gains of 7%-10% per year through increased school achievement, healthy behavior, and adult productivity. Quality early childhood education is a cost-efficient strategy for reducing deficits and promoting growth (First Five Years Fund, 2014).

Young children who receive the supports and developmental experiences they need are more likely to succeed in grades K-12, graduate on time, attend college, become employed, earn higher wages, and avoid criminal justice system involvement—all consequences that have major cost implications for governments and taxpayers (Trostel, 2013).

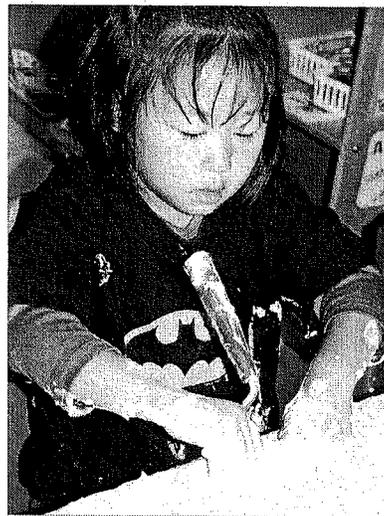
In 2012, the early childhood education workforce was comprised of about one million center-based teachers and caregivers directly responsible for children age birth through 5 years, not yet in kindergarten; and another one million paid home-based teachers and caregivers serving the same age group (U.S. DHHS, ACF, National Survey, 2013).



How does Head Start measure up?

Head Start is a program that supports families' efforts to attain economic security by offering parenting and financial planning programs, referrals to community and state resources, job skills, educational opportunities, and health care.

Nationally, Head Start is a significant employer: in 2013, Head Start programs employed and contracted with 250,000 staff. Parents of current or former Head Start children made up 23% of Head Start staff.



Head Start supports parents who work which positively impacts the economy. When parents have access to reliable, quality early care and education, they are less stressed or distracted and more productive in their jobs. They can financially care for their own families and contribute to federal, state, and local taxes.

What is the picture in Maine?

Maine Federal Head Start funding in 2012-2013 was **\$29,881,312** (U.S. DHHS, ACF, Head Start, 2013).

Maine State Head Start funding for 2012-2013 was **\$1,803,455**.

Head Start Matters for the Education of Maine Children

Head Start has made deliberate and successful efforts to improve teacher qualifications, but improvements in wages have not kept pace.

(Whitebook, Phillips and Howes, 2014)

What does the research say?

Outcomes in early childhood classrooms are more positive when teachers have higher levels of educational attainment and in particular, a bachelor's degree (Kelly & Camilli, 2007).

While a recognized measure of quality in early childhood education is the educational attainment of teachers, the wages of teachers depend more on where they work and the ages of the children they teach than on the qualifications (Whitebook, et al., 2014).

How does Head Start measure up?

The Head Start Act specifies that 50% of center-based preschool teachers nationwide should have a baccalaureate degree in early childhood education by 2013.

Nationally, 66% of all Head Start center-based preschool teachers had a baccalaureate or advanced degree in early childhood education (ECE), or in a related field with experience.

What is the picture in Maine?

Head Start programs throughout Maine employed **1,123** individuals and contracted with an additional **62** staff. Current or former Head Start parents accounted for **296** of these Head Start employees. In Maine, **73%** of the Head Start teaching staff had a baccalaureate degree in the 2012-2013 program year.

Maine Head Start Teacher Qualifications FY 2012-2013

226 Preschool Teachers

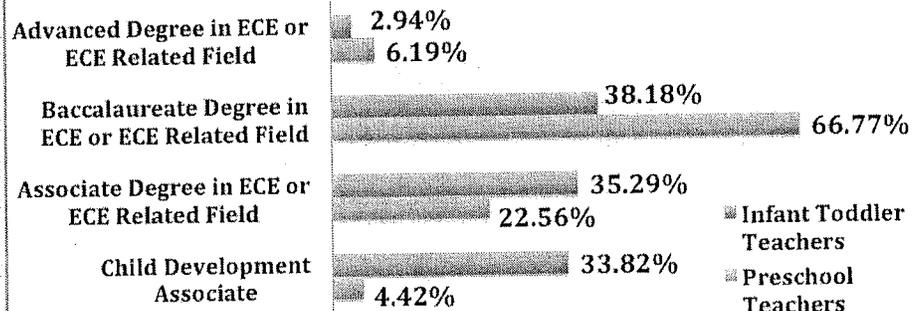
- 14 advanced degrees in ECE/related field (6.19%)
- 151 bachelor's degrees in ECE/related field (66.77%)
- 51 associate degrees in ECE/related field (22.56%)
- 10 Child Development Associate (4.42%)

68 Infant Toddler Teachers

- 2 advanced degrees in ECE/related field (2.94%)
- 28 bachelor's degrees in ECE/related field (38.18%)
- 24 associate degrees in ECE/related field (35.29%)
- 23 Child Development Associate (33.82%)



Staff Education, 2012 -2013



Early childhood education is an efficient and effective investment for economic and workforce development. The earlier the investment, the greater the return on investment.

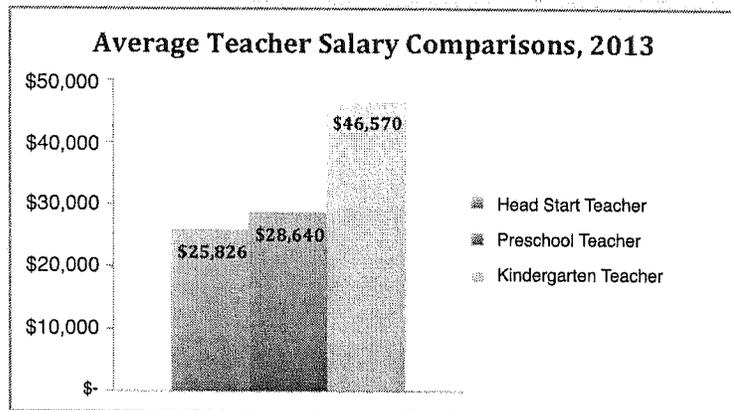
(Heckman, 2012)

Head Start Matters for the Education of Maine Children (cont.)

A comparison between the U. S. Dept. of Labor Bureau of Labor Statistics 2013 Annual Mean Wages for Maine Preschool Teachers (occupation code 25-2011) and Kindergarten Teachers (occupation code 25-2012) with 2012-2013 salary data from the U.S. Department of Health and Human Services, Office of Head Start, reveals that Maine Head Start teachers earn considerably less (\$25,826) than other early education teachers in the state (\$28,640 - \$46,570).

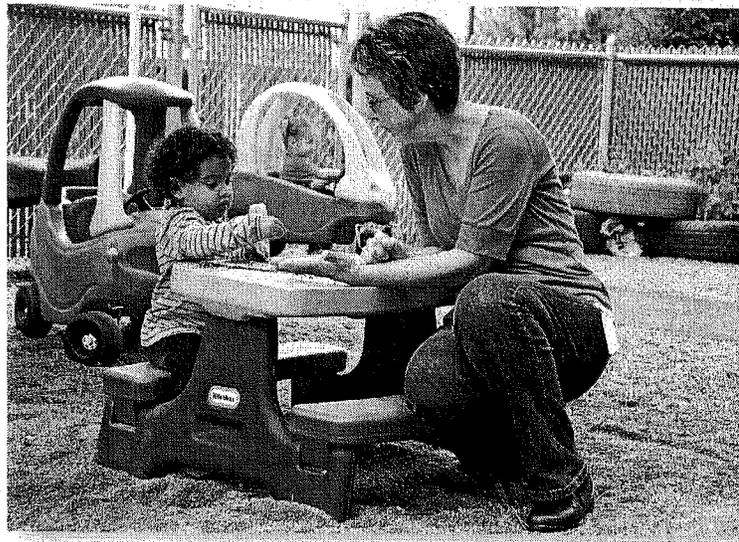
This income inequality for Head Start teachers prevails regardless of educational attainment and higher mandated standards for evidence-based practices and program outcome measures.

For many Head Start educators, these earnings are barely enough to keep them out of poverty. Without parity in compensation, Head Start will continue to have difficulty attracting and retaining high quality teachers for the youngest and most vulnerable members of our communities (Whitebook, et al., 2014).



Maine Early Education Teacher Annual Mean Wages (2012-2013)

Head Start Teacher	\$25,826 (OHS, 2012-2013 PIR)
Preschool Teacher*	\$28,640 (Maine DOL, 2013)
Kindergarten Teacher	\$46,570 (Maine DOL, 2013)



*Preschool Teacher – instructs preschool-age children in activities designed to promote social, physical, and intellectual growth needed for primary school in preschool, day care center, or other child development facility. United States Dept. of Labor, Bureau of Labors Statistics Standard Occupational Classification <http://www.bls.gov/soc/2010/soc252011.htm>

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2014 Maine Head Start Annual Report

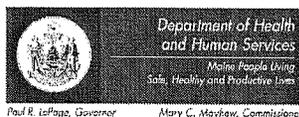
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MAINE AFFORDABLE HOUSING COALITION

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Androscoquin Bank
Anew Development LLC, Portland
ArcheType Architects, Portland
Associated General Contractors of Maine
Auburn Housing Authority
Augusta Housing Authority
Avesta Housing, Portland
Bangor Area Homeless Shelter
Bangor Housing
Bangor Savings Bank
Bank of America
Bath Housing
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Becker Structural Engineers, Portland
Benchmark Construction, Westbrook
Berrisford Star, Portland
Biddeford Savings Bank
Boston Capital
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Genesis Fund, Damariscotta
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Homeless Voices for Justice, Portland
Housing Foundation, Orono
Housing Initiatives of New England, Portland
Housing Partnership, Portsmouth, NH
Hunt Capital Partners, Boston, MA
Island Institute, Rockland
Isleboro Affordable Property
John Antoni, Consultant, Portland
Kennebec Savings Bank
Kennebec Valley Community Action, Waterville
KeyBank
MacDonald Associates, Bath
Maine Community Action Association
Maine Department of Health & Human Services
Maine Real Estate Managers Association
Maine Workforce Housing LLC, Portland
Mama en Mama, Millisbridge
Murray Plumb & Murray, Portland
Neighborhood Housing League, Lewiston
Nickerson & O'Day, Inc., Bangor
North Haven Sustainable Housing
Northern ME Housing Investment Fund, Portland
Norway Savings Bank
Old Town Housing Authority
Opportunity Alliance, South Portland
Otis Anwell CPAs, South Portland
PBT Architects, Portland
Peaks Island Home Start
Penquits, Bangor
People's United Bank
Planning Decisions, Hallowell
Portland Builders
Portland Housing Authority
Preble Street, Portland
Richard Curtis & Associates, Portland
Roy & Associates CPAs, Bangor
Rural LISC, Portland
Ryan Senatore Architecture, Portland
Sea Coast Management Company, Topsham
Shalom House, Portland
Smoke-Free Housing Coalition of Maine
South Portland Housing Authority
Sparhawk Group, Yarmouth
Strategic Energy Group, Portland
Sunrise Opportunities, Machias
TD Bank
Trefford Housing, Brunswick
The Caleb Foundation, Swamscott, MA
The Park Danforth, Portland
Thornton Tomasetti, Portland
Total Construction Management, Winterport
TPO Construction Co., Sanford
United Way of Greater Portland
Veterans Inc., Worcester, MA
Volunteers of America of Northern NE
Wahk Engineering Associates, Portland
Westbrook Housing Authority
Western ME Community Action, E. Wilton
Wishamper Companies, Portland
Wright-Ryan Construction, Portland
Year-Round Housing Corp., Long Island
York County Community Action, Sanford
York County Shelter Programs, Alfred
York Housing Authority
Zachau Construction, Freeport

October 13, 2015

Senate Chair Eric Brakey
House Chair Drew Gattine
Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333-0100

Re: The Fund for a Healthy Maine and Lead Poisoning

Dear HHS Committee Members,

I am the Director of the Maine Affordable Housing Coalition (MAHC), a diverse coalition of more than 120 private and public sector organizations committed to ensuring that all Mainers are adequately and affordably housed.

During the most recent legislative session, we worked with Senator Amy Volk on LD 1115 regarding lead poisoning of children. The lead issue is relevant to your review of the Fund for a Healthy Maine (FHM) because LD 1115 was rolled into this year's budget and funded with one-time resources from the Fund.

LD 1115 sought to lower the blood lead level (BLL) required to trigger action by the Maine CDC. This is necessary because there is no safe level of lead exposure. Exposure has been shown to cause learning disabilities, lower intelligence, language or speech delays, behavior problems, and hearing damage. CDC actions include a lead inspection of the residence of a child found to have elevated BLL. If the inspection confirms the presence of lead in an apartment, the landlord is required to abate the lead.

This Committee reported LD 1115 out Ought to Pass as Amended by a 10-3 vote. The amendment allowed the CDC to pursue civil action against landlords who fail to comply with an abatement order. Under prior law, such action could only be pursued as a criminal matter. Implementation of LD 1115 requires additional staff at the CDC to manage cases of lead poisoning and funding for additional lead inspections, which are carried out by a third party contractor. As a result, the bill had a fiscal note.

LD 1115 was included in the biennial budget (2015 Public Law 267) as Part LLLL. The necessary funding was added to the appropriation section of the budget (language attached). The Appropriations Committee utilized a portion of one-time FHM revenues for this purpose. As you can see from the language, the budget makes clear these are one-time allocations to address lead poisoning.

The Centers for Disease Control is currently in the processing of implementing the budget language. Three things need to be done. The new staff needs to be approved by the Administration and then the positions must be advertised and staff hired. Rulemaking needs to be completed to formally change the effective blood lead level in Maine. Finally, DHHS needs to issue an RFP for the lead inspection work. Once in place, these changes will respond to the lead poisoning of many Maine children, preventing or mitigating the damage caused by lead exposure.

We appreciate this Committee's support of this effort.

Sincerely,

A handwritten signature in cursive script that reads "Greg Payne".

Greg Payne
Director

Attachment (1)

PART KKKK

Sec. KKKK-1. 36 MRSA §1760, sub-§9-H is enacted to read:

9-H. Fuel used in certain agricultural production. Ninety-five percent of the sale price of all fuel purchased for use at a greenhouse facility occupying at least 1,000,000 square feet of indoor space operated by an agricultural employer that employs at least 100 employees and is engaged in the year-round commercial production of fruits or vegetables.

This subsection is repealed December 31, 2019.

Sec. KKKK-2. Effective date. This Part takes effect January 1, 2016.

PART LLLL

Sec. LLLL-1. 22 MRSA §1315, sub-§5-C, as amended by PL 1995, c. 453, §5, is further amended to read:

5-C. Lead poisoning. "Lead poisoning" means a confirmed elevated level of blood lead that is injurious, as defined in rules adopted by the department using ~~intervention~~ reference levels no higher than ~~those set~~ the 97.5th percentile of blood lead levels in children established by a national health and nutrition examination survey adopted by the federal Department of Health and Human Services, Centers for Disease Control and Prevention.

Sec. LLLL-2. 22 MRSA §1325, as amended by PL 1999, c. 276, §17, is further amended to read:

§1325. Violation

In addition to any other penalty imposed under this chapter, any person who violates any section of this chapter may be punished for each violation by a fine of not more than \$500 or by imprisonment for not more than 6 months, or by both. A person who violates any section of this chapter or rules adopted pursuant to this chapter commits a Class E crime. In addition, other than for a violation covered under section 1316-A, the department may, in accordance with Title 5, chapter 375, subchapter 4, impose an administrative penalty not to exceed \$500 for a violation of this chapter or rules adopted pursuant to this chapter. Each day a violation continues constitutes a separate offense. Violations existing within individual dwelling units are considered separate violations. An action commenced by the department to enforce any administrative penalty imposed under this section may be brought in the name of the State in the Superior Court in the county where the violation occurred or in Kennebec County and must be prosecuted by the Attorney General. The court shall award to the State all costs in bringing the enforcement action as well as reasonable interest on penalties not paid. This section does not limit the authority of the Department of Environmental Protection to seek penalties for violations under the authority of Title 38, section 349. All penalties and awards collected under this section must be deposited in the Lead Poisoning Prevention Fund established under section 1322-E.

Sec. LLLL-3. 22 MRSA §1326, as amended by PL 2005, c. 530, §5, is further amended to read:

§1326. Injunction requiring removal

If the lead-based substance remains an environmental lead hazard at the expiration of 30 days or at the expiration of an extension given by the commissioner pursuant to section 1321, that is a violation of this chapter and the State, in addition to any other remedies it has, may seek a mandatory injunction ordering the environmental lead hazard removed by a suitable 3rd party at the expense of the owner of the dwelling, premises, residential child-occupied facility, child care facility, premises of the family child care provider or nursery school.

PART MMMM

Sec. MMMM-1. Transfer; Fund for a Healthy Maine; Maine State Housing Authority, Other Special Revenue Funds. Notwithstanding any other provision of law to the contrary, the State Controller shall transfer \$200,000 from the Fund for a Healthy Maine to the Maine Home Repair Program, Other Special Revenue Funds account within the Maine State Housing Authority no later than October 1, 2015. The authority shall use the funds to provide loans and grants to low-income homeowners for repairs to remediate arsenic in drinking water.

PART NNNN

Sec. NNNN-1. 38 MRSA §341-G, sub-§1, as amended by PL 1991, c. 817, §8, is further amended to read:

1. Transfer funds. The amount transferred from each fund must be proportional to that fund's contribution to the total special revenues received by the department under chapter 2, subchapter 2; sections 551, 569-A and 569-B; ~~and~~ chapter 13, subchapter 4, and section 1364. Any funds received by the board from the General Fund must be credited towards the amount owed by the Maine Environmental Protection Fund, chapter 2, subchapter 2.

PART OOOO

Sec. OOOO-1. 5 MRSA §13090-K, sub-§2, as amended by PL 2013, c. 368, Pt. M, §1, is further amended to read:

2. Source of fund. Beginning July 1, 2003 and every July 1st thereafter, the State Controller shall transfer to the Tourism Marketing Promotion Fund an amount, as certified by the State Tax Assessor, that is equivalent to 5% of the 7% tax imposed on tangible personal property and taxable services pursuant to Title 36, section 1811, for the first 6 months of the prior fiscal year after the reduction for the transfer to the Local Government Fund as described by Title 30-A, section 5681, subsection 5, except that, from October 1, 2013 to ~~June 30~~ December 31, 2015, the amount is equivalent to 5% of the 8% tax imposed on tangible personal property and taxable services pursuant to Title 36, section 1811 and beginning July 1, 2016 the amount is equivalent to 5% of the 8% tax

Initiative: Deallocates funding from the Maine Center for Disease Control and Prevention program, Immunization account.

FUND FOR A HEALTHY MAINE	2015-16	2016-17
All Other	(\$1,078,884)	(\$1,078,884)
FUND FOR A HEALTHY MAINE TOTAL	<u>(\$1,078,884)</u>	<u>(\$1,078,884)</u>

Maine Center for Disease Control and Prevention 0143

Initiative: Provides one-time funding for contracted lead inspections.

FUND FOR A HEALTHY MAINE	2015-16	2016-17
All Other	\$694,126	\$636,386
FUND FOR A HEALTHY MAINE TOTAL	<u>\$694,126</u>	<u>\$636,386</u>

Maine Center for Disease Control and Prevention 0143

Initiative: Provides funding to hire 8 limited-period Environmental Specialist III positions through June 10, 2017 to review inspections, issue orders to abate hazards, track to make sure abatements occur and work with families on interim controls to reduce hazards until the abatement is complete.

FUND FOR A HEALTHY MAINE	2015-16	2016-17
Personal Services	\$447,780	\$612,686
All Other	\$37,669	\$50,226
FUND FOR A HEALTHY MAINE TOTAL	<u>\$485,449</u>	<u>\$662,912</u>

MAINE CENTER FOR DISEASE CONTROL AND PREVENTION 0143

PROGRAM SUMMARY

GENERAL FUND	2015-16	2016-17
POSITIONS - LEGISLATIVE COUNT	67,000	67,000
Personal Services	\$5,419,571	\$5,538,988
All Other	\$3,464,015	\$3,461,199
GENERAL FUND TOTAL	<u>\$8,883,586</u>	<u>\$9,000,187</u>

MYAN and Maine Youth are Sparking Positive Changes!

*"No matter what age you are,
you can make a difference."*

~MYAN youth participant



Maine youth Hattie Simon, Old Orchard Beach

Maine Youth Action Network

MYAN

a program of the
Opportunity
Alliance

The Maine Youth Action Network (MYAN) **contributes to creating healthier and more productive communities in Maine** by ensuring youth are aware of, informed about and taking action on critical issues such as tobacco.

Youth are **creating lasting community changes** and **shifting social norms** about tobacco by:

- * Creating tobacco-free recreation areas
- * Improving tobacco-free school policies
- * Reducing tobacco marketing targeted to kids in local stores
- * Increasing tobacco awareness in their peers

These efforts are proven to reduce initiation and use of tobacco among youth and adults.

"Efforts to minimize tobacco use are much more effective when young people are involved."

Centers for Disease Control and Prevention.
Best Practices User Guide

92% of adult smokers had their first cigarette before the age of 19.

So if we want to lower health care costs and increase productivity for Maine businesses, we need to reduce Maine's youth smoking rate.

MYAN supports youth engagement in tobacco and substance abuse prevention, health promotion, and positive community change across the state of Maine. Learn more at www.myan.org.

MYAN is funded by the Fund for a Healthy Maine.

FUND FOR A
HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

MYAN empowers and prepares youth to:

- Be proactive, involved leaders in their schools and communities
 - Youth engaged in their schools and communities are more likely to stay in school, make healthy choices, graduate and to go on to be productive, engaged citizens in their communities as adults.
 - Increased leadership skills will help young people grow up to be the productive problem solvers, key assets Maine businesses want for a strong work force.
 - Youth with leadership skills and experience with the government process can help make a difference now and in the future, both locally and at the state level.
- Create lasting policy and environmental changes which make Maine citizens healthier by changing social norms.
 - Youth engagement in efforts to prevent obesity, substance abuse and tobacco use will reduce future chronic health conditions and their associated costs.
*For every \$1 spent on preventing disease and promoting good health, \$7.50 is saved in health care costs within 5 years.**
 - Healthier citizens create a healthier workforce and a healthier economy, leading to increased productivity and reduced health care costs, which help Maine be supportive to business.

MYAN empowers and prepares adults to:

- Establish youth-adult partnerships which positively impact youth and communities
 - Adults value the diversity of youth perspective and gain insight into community issues by listening to youth.
 - Adults build their skills and competence for empowering youth to create and carry out sustainable positive community change.



*Trust for America's Health (2009), www.healthyaamericans.org/reports/prevention08/Prevention08.pdf.

Youth Engagement: *Making the Case*

Youth enhance state and local tobacco control efforts by challenging conventional thinking, advocating for policies, and changing the social norms around tobacco use.

Youth play a unique and important policy advocacy role that contributes to an effective, comprehensive tobacco control program. The initiation of and addiction to tobacco often occurs before young people are legally able to buy tobacco products – an age when they are also highly targeted by the tobacco industry. Because they are targets, young people must be engaged in tobacco control efforts. Youth are powerful allies in the fight against pro-tobacco influences, key partners in denormalizing tobacco use, and important levers in determining the future of tobacco control policy.

The Power of Youth

- ▶ **Advocate for policy change**
Young people can be effective at garnering support for policy development and change. Youth capture the attention of political leaders and the media, making them important partners in policy advocacy.³
- ▶ **Project a powerful voice**
Youth have credibility with peers and community members. This allows them to help educate the community to reduce pro-tobacco influences and increase healthier norms and behaviors.
- ▶ **Expose tobacco industry tactics**
Young people can be effective partners in the fight against the tobacco industry by exposing its manipulative tactics and undermining its efforts.
- ▶ **Offer energy and vitality**
Youth bring energy to activities and events. Tobacco control programs should work to channel this energy into action, resulting in increased awareness and policy change.
- ▶ **Reflect genuine concern**
Youth generally volunteer their time to be involved in tobacco control efforts. They do this because of the stake they have in their own future.
- ▶ **Bring diverse representation and provide generational insight**
Youth can provide important insight about their generation. Involving youth in tobacco control efforts ensures the design of effective, population-specific policies.
- ▶ **Invoke creativity and innovation**
Young people naturally challenge the traditional attitudes that may restrict and limit how adults think and act. They add innovation and creativity to any program, making it more attractive to other youth and policy makers. Their novel ideas for policy advocacy strategies help push efforts forward.⁴
- ▶ **Mobilize their peers**
Youth have the ability to mobilize their peers for activities and facilitate access to many arenas. These actions add strength to tobacco control policy efforts while also broadening the type and number of venues involved in message delivery.

Youth Engagement: *How To*

Impact of Youth Actions on Health Outcomes



How Should Programs Engage Youth?

Young people join tobacco control efforts for many of the same reasons adults do. Some young people have an aversion to the smell of cigarette smoke; some have family members who have died from tobacco-related causes; others are themselves victims of diseases caused by secondhand smoke.³² As a result of strong education efforts, many young people have learned about the negative health effects of tobacco and have become advocates for policy change in their communities.

Whatever the reason for their passion for tobacco control, one thing is clear from history: young people

are ready to stand up for their beliefs, rise up against social injustice, and make a difference in peoples' lives. It is important that they are not overlooked as valuable participants in tobacco control and other important public health issues.

.....
"We are cultivating not only youth leadership but also creating a pipeline for the next researchers and organizers who will focus on tobacco prevention and control."

- Reggie Moore,
 Legacy



**Counter-Marketing Media Contractor (Tobacco)
Contact Information:**

Laura Davis, President
(laura@rinckadvertising.com)

Nikki Jarvais, Account Planner
(nikki@rinckadvertising.com)

Background and Overview

Last year, Tobacco Companies spent \$43.5 million¹ in Maine to target our youth and continue to keep Mainer's hooked on their products - that's almost \$33 per person in the State of Maine.² In Maine, we are spending an average of \$0.50³ per person to prevent, educate and reduce tobacco-use.

All counter-marketing campaigns focus on **four strategic goal areas** for the Partnership for a Tobacco-Free Maine

- Prevent Youth and Young Adults from Starting To Use Tobacco (**Prevention**)
- Motivate and Assist Tobacco Users To Quit (**Cessation**)
- Eliminate Involuntary Exposure To Secondhand Smoke (**Involuntary Exposure**)
- Identify and Eliminate Disparities Related to Tobacco Use Among Population Groups (**Disparate Population**)

Results of the Current Efforts

Highlights:

- Close to 14 million digital impressions served, resulting in an average of our message being served to each Mainer 105 times over a 6 month period. (per person = 17 times per month)
- Counter-marketing messaging made up 85% of total visits to theQuitLink.com website site totaling almost 38 thousand site visits during a 6 month time period.
- The engagement average duration is 33 seconds, pages/session 2.45 with a bounce rate of 1.47%.

Why Counter-Marketing Works?

- The CDC's Best Practices for Comprehensive Tobacco Control Programs concluded that public education (counter-marketing) campaigns are an integral part of efforts to both prevent initiation of tobacco use and to encourage tobacco cessation.⁴
- Mass-media counter-marketing health messages reduce tobacco use among young adults by 5% and increase use of cessation resources by 132%.⁵
- The scientific evidence is substantial and clear: public education campaigns reduce the number of youth who start smoking, increase the number of smokers who quit, and make tobacco industry marketing less effective, saving lives and health care dollars.⁶
- Mass media campaigns that provide information about how to get help with quitting can be particularly effective in promoting quit attempts.⁷

¹ http://www.tobaccofreekids.org/facts_issues/toll_us/maine

² <http://quickfacts.census.gov/qfd/states/23000.html>

³ 2015 Partnership for a Tobacco-Free Maine Counter Marketing work plan and budget

⁴ Campaign for Tobacco-Free Kids, Public Education Campaigns Reduce Tobacco Use Fact Sheet

⁵ Guide to Community Preventive Services. Reducing tobacco use and secondhand smoke exposure: mass-reach health communication interventions. www.thecommunityguide.org/tobacco/massreach.html. Last updated: 12/09/2013. Accessed 04/04/2014.

⁶ 2015 Partnership for a Tobacco-Free Maine Counter Marketing work plan and budget

⁷ Ibid.



HelpLine/QuitLink SEM (Search Engine Marketing):

Target Audience:	Maine
Campaign Duration:	6 Months
Impressions:	71,881
Clicks:	2,228
CTR:	3.10% (industry standard is 2.0%)
Engagement on site:	
Avg. Session Duration:	1 minute and 14 seconds
Pages/Session:	3.96 pages
Bounce Rate:	0.18%
Mobile Results:	
Mobile Click-to-Call:	1,464
Calls to the HelpLine:	170 calls
Conversion Rate:	11.61% (industry standard is 4.0%)
Average Call Duration:	8 minutes and 48 seconds

HelpLine Digital:

Target Audience:	Age 18-34; Maine, Age 25-54; Maine, Age 35-65; Maine
Campaign Duration:	3 Months
Impressions:	3,931,080
Clicks:	9,930
CTR:	0.25% (industry standard is 0.05%)
Engagement on site:	
Avg. Session Duration:	16 seconds
Pages/Session:	2.4 pages
Bounce Rate:	2.15%

QuitLink Digital:

Target Audience:	Age 18-34; Maine, Age 25-54; Maine, Age 35-65; Maine
Campaign Duration:	3 Months
Impressions:	3,613,035
Clicks:	3,860
CTR:	0.11% (industry standard is 0.05%)
Engagement on site:	
Avg. Session Duration:	18 seconds
Pages/Session:	2.45 pages
Bounce Rate:	1.03%

QuitLink Paid Facebook:

Target Audience:	Age 18-34; Maine
Campaign Duration:	10 weeks
Impressions:	3,757,648
Clicks:	28,703
CTR:	0.76% (industry standard is 0.43%)
New Page Likes:	2,701
Engagement on site:	
Avg. Session Duration:	44 seconds
Pages/Session:	2.33 pages
Bounce Rate:	0.63%

**HelpLine TV:**

Target Audience: Age 25-54; Maine

Broadcast Campaign Duration: 11 weeks
Portland: 638 spots / 2,629 GRP's
Augusta: 319 spots / 2,416 GRP's
Presque Isle: 220 spots / 2,661 GRP's

Cable Campaign Duration: 10 weeks
Portland: 410 spots
Augusta: 410 spots
Bangor: 410 spots
Brunswick: 410 spots
Lewiston: 410 spots
York: 410 spots
Presque Isle: 410 spots

Secondhand Smoke Radio:

Target Audience: Age 18-65; Maine
Campaign duration: 8 weeks
Portland: 2,432 spots / 2,891 GRP's
Augusta: 1,264 spots / 2,181 GRP's
Bangor: 1,792 spots / 3,133 GRP's
Presque Isle: 1,104 spots / GRP's unavailable for this market

Secondhand Smoke Pre-Roll Video:

Target Audience: Age 18-65; Maine
Campaign duration: 6 weeks
Impressions: 2,484,357
Clicks: 10,880
CTR: 0.96% (industry standard is 0.85%)
Engagement on site:
Avg. Session Duration: 16 seconds
Pages/Session: 2.34 pages
Bounce Rate: 3.38%

MaineCare Postcard Mailing:

Target Audience: 110,000 MaineCare Recipients
Budget: \$69,250.00
Campaign Duration: 1 week
Calls to HelpLine: Evaluation is still being conducted

Definitions According to Google

Impressions: An impression is counted every time your ad is shown on a search result page

Ad Clicks: An ad click is the number of times users have clicked on the ad

CTR (Click Through Rate): Click through rate is used to measure how often people click your ad after it is shown to them. It helps determine the effectiveness of the ad. (Clicks divided by impressions)

Conversion Rate: Connected calls divided by the number of clicks

Bounce Rate: Bounce rate is the percentage of single-page visits to the site or visits in which the person left your site from the entrance page

Digital display and pre-roll video advertising is shown passively to users in order to gain brand awareness.

Industry Standards

- **CTR:** 2.0% (AdWords), 0.05% (Digital Display), 0.43% (Paid Social)
- **Conversion Rate:** 4.0% or higher
- **Pages/ Visit:** 2 pages (AdWords and Digital Display)
- **Average Session Duration:** 1 minute (AdWords)
- **Bounce Rate:** 65.0% or less (AdWords) 85.0% or less (Digital Display and Paid Social)



UNIVERSITY OF NEW ENGLAND

School of Community and Population Health

Maine AHEC Network

Westbrook College of Health Professions

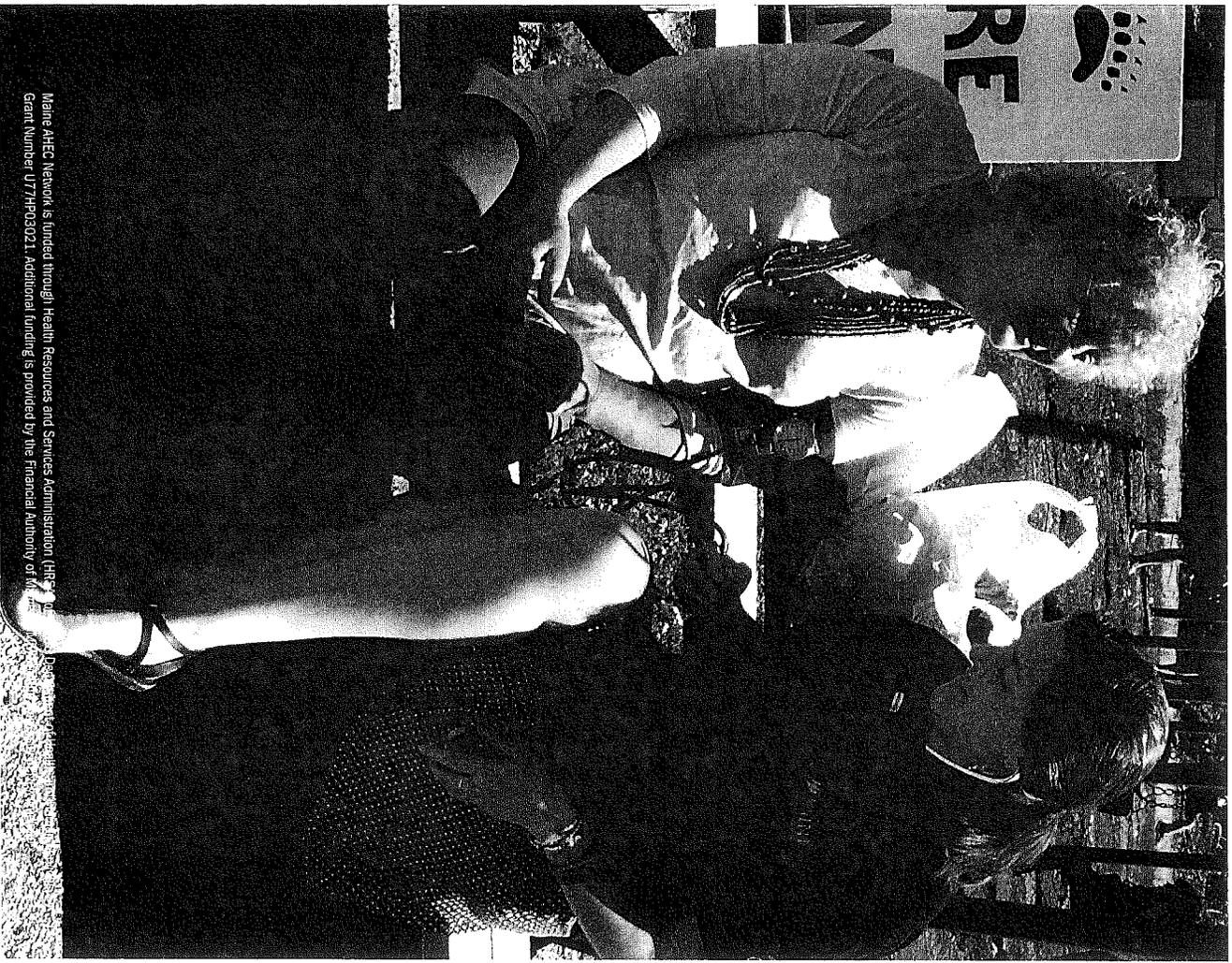
School of Community and Population Health

University of New England

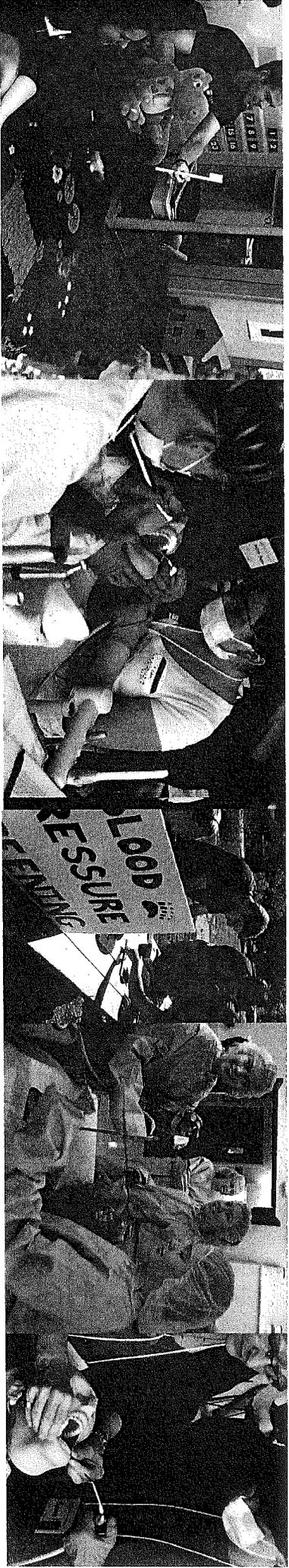
716 Stevens Avenue

Portland, ME 04103-2670

MAINE AHEC NETWORK MAKES A DIFFERENCE



Maine AHEC Network is funded through Health Resources and Services Administration (HRSA) Grant Number U77HP03021. Additional funding is provided by the Financial Authority of Maine.



PRIORITY INITIATIVES 2015-16

PIPELINE

- Collaborate with the Hanley Center for Health Leadership to expand the number of paid internships in health settings for students in rural communities
- Support health professions peer mentoring for University of Maine (UMO) students from rural communities
- Develop new pipeline initiatives (e.g. Dentist4Day)
- Implement pipeline tracking system and collect consistent pipeline competencies data

CLINICAL EDUCATION

- Identify and develop new preceptors from across the state
- Increase collaboration between UNE AHEC and MMC/TJMS Medical School program
- Develop/Implement enhanced community health rotation in Franklin and Washington Counties
- Increase connections to COM students interested in rural health/primary care

CONTINUING EDUCATION

- Participate in National AHEC Organization's HPV education program
- Continue to provide the Veteran's Administration with educational programs and evaluate the effectiveness of those programs

OVERALL

- Finalize data system that will improve accessibility and quality of data
- Develop/enhance partnerships (e.g. Maine Migrant Health, Maine Indian Education, FQHCs)

MAINE AHEC NETWORK, 2015 HIGHLIGHTS

EASTERN MAINE AHEC

In conjunction with UMO, Tufts University School of Medicine (TUSM), and Athenahealth, the Eastern Maine AHEC at Penobscot Community Health Care (PCHC) conducted a successful outreach and student service-learning program in Waldo County called Medical Outreach Maine. Ten UMO undergraduate students pursuing medical, dental, physician assistant and nursing degrees, along with five TUSM Maine Track medical students, spent four days in Waldo County volunteering over 230 contact hours while engaged in a number of community activities including:

- Dental health outreach to 64 pre-school students
- Tick identification and prevention education with 306 elementary school students
- 37 blood pressure screenings and nutritional outreach at the Belfast Farmer's Market

A survey of the UMO and TUSM students following participation in the program shows an increase in the likelihood of participating in a rural rotation while attending professional school, and of considering practice in rural and underserved areas. There was also an increased understanding of the needs of a medically

MAINE AREA HEALTH EDUCATION CENTER (AHEC) NETWORK

The Maine Area Health Education Center (AHEC) Network works to alleviate shortages of health professionals in Maine's rural and underserved areas by actively engaging with academic and community partners to:

- Develop a health career pipeline for Maine youth and mid-career professionals who are most likely to stay in Maine to live and work.
- Provide rural, community-based clinical training experiences for medical and other health professions students.
- Support practicing health professionals with continuing education and distance learning opportunities to train and to retain Maine health professionals within the state of Maine.

HOW TO CONTACT US

1 EASTERN MAINE AHEC

Penobscot Community Health Care
Bangor, Maine
Contact: Sarah Dubey, M.M.E.L., M.Ed., center director
Phone: (207) 992-9200, ext. 1402
Email: sdubey@pochbangor.org

2 WESTERN MAINE AHEC

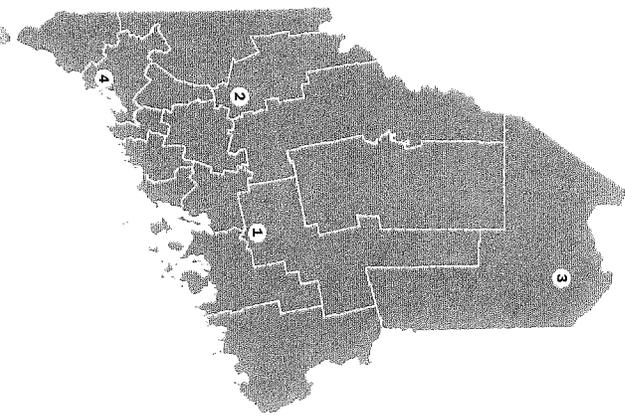
Franklin Memorial Hospital
Farmington, Maine
Contact: Lori Brown, center director
Phone: (207) 779-2381
Email: lfbrown@fahm.org

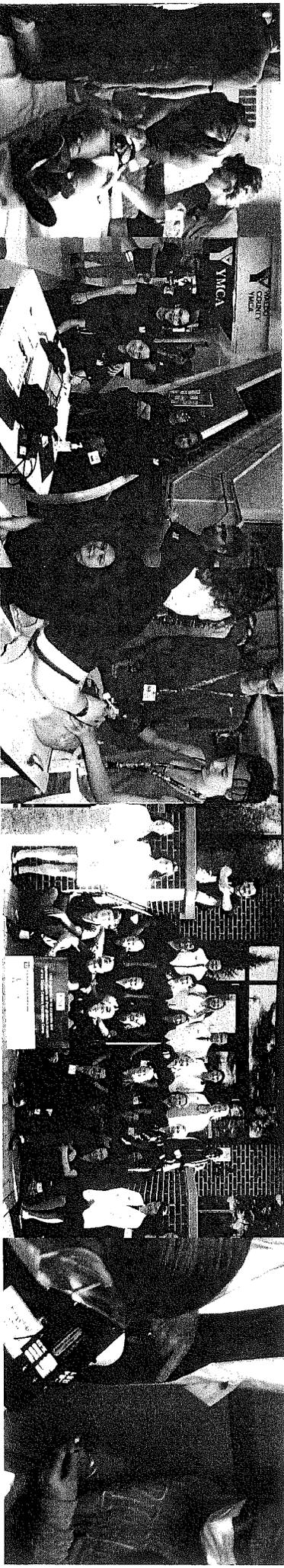
3 NORTHERN MAINE AHEC

Northern Maine Community College
Presque Isle, Maine
Contact: Leah Buck, M.S.B., center director
Phone: (207) 768-2768
Email: lbuck@nmcc.edu

4 AHEC PROGRAM OFFICE

Westbrook College of Health Professions
School of Community and Population Health
University of New England
716 Stevens Avenue
Portland, Maine
Phone: (207) 221-4561





WESTERN MAINE AHEC

Western Maine AHEC hosted its 12th Summer Scrub Club in June 2015 at the Franklin Memorial Hospital in Farmington. The annual Scrub Club is an exploration camp for students entering grades 8-12. It is designed to introduce participants to a wide variety of careers available in health care. The 40 students participating in this year's Scrub Club learned about physical therapy, sports medicine, nursing, dental, pharmacy, radiology, anesthesiology, orthopedics, medical lab science, mental health counseling, maternal child health and emergency medical services. Students participated in unique hands-on activities and demonstrations such as casting, suturing, prostheses, lab analysis and emergency response to a mock accident. Participants also had hands-on experience drilling teeth on a dental simulator. All of the students also earned a certification in American Heart Association Heartsaver CPR.

"The best part about Scrub Club was learning about all of the different jobs and being able to practice using hands-on materials."

— Student at Summer Scrub Club

NORTHERN MAINE AHEC

The Washington County Community College in Calais hosted a group of 12 high school students on March 13, 2015 for Northern Maine AHEC's Doc4Day program. The Doc4Day program encourages high school students from underrepresented minority groups, or educationally and economically disadvantaged backgrounds, to explore careers as physicians. The students attended a presentation about the various pathways to becoming a physician and spoke with medical students and residents from Maine Medical Center – Tufts University School of Medicine (MMC-TUSM) during a round table lunch discussion about their experience pursuing careers in medicine. Additionally, the high school students gained hands-on experience with clinical lab activities, such as practicing suturing skills with the guidance of the MMC-TUSM students and residents, and participating in emergency room patient scenarios.

"This program was phenomenal! Thank you so much for bringing it to Downeast Maine. The students were engaged, asked great questions and I sincerely feel that this program will help us to 'grow' our own medical providers in the rural corner of Maine."

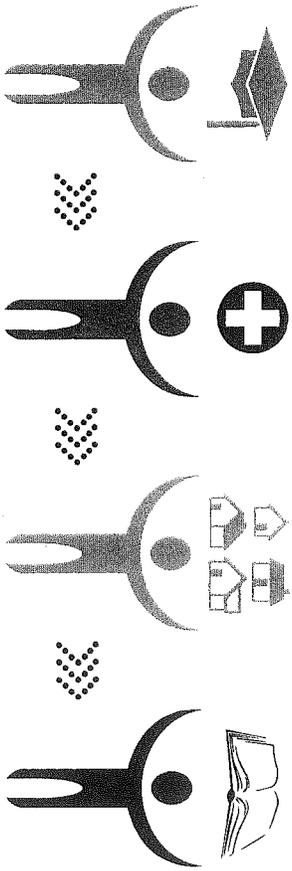
— Guidance Director in Washington County

DENTAL CAREERS EXPLORATION CAMP

The Maine AHEC Network Program Office hosted 20 high school students at the University of New England (UNE) for the 5th annual Dental Careers Exploration Camp during August 2015. Student interest in the dental health field was fostered through participation in a broad range of experiential activities at UNE's Oral Health Center. Activities included learning and practicing suturing techniques, taking dental impressions, performing X-ray imaging and crown-making, and practicing teeth-drilling on dental mannequins. Students also received CPR training and participated in job shadow experiences at area dental offices. Throughout the three-day camp, students had the opportunity to interact with and learn from current students of UNE's Doctor of Dental

Medicine program

A PIPELINE FOR COMMUNITY-BASED HEALTH PROFESSIONS EDUCATION



The Maine AHEC Network continually strives to create opportunities to connect students to careers, professionals to communities, and communities to better health. During this past year the Maine AHEC Network was successful in:

ENGAGING STUDENTS IN HEALTH CAREER EXPLORATION

1816 students were introduced to health career opportunities. Of those students, 125 participated in AHEC health programs of 10+ hours, providing them with health career exposure, professional mentorship and academic enhancement to prepare them for health professions training programs.

INCREASING COMMUNITY-BASED TRAINING

305 health professions students received training at 41 community-based training sites. The majority of those sites were located in underserved areas, including designated Health Professions Shortage Areas. Federally Qualified Health Centers, and Community Health Centers. Nearly 60% of a total of 1298 weeks of clinical training was provided to students training to become physicians (23%), physician assistants (23%), pharmacists (12%) and medical assistants (9%).

FOSTERING PROFESSIONAL DEVELOPMENT

1593 contact hours of health education programs were provided across the state of Maine, with 1902 health professionals receiving training through AHEC continuing education programs. More than half of the continuing education participants were physicians (7%), nurse practitioners (4%), nurses (29%) and first responders (5%).



UNIVERSITY OF
NEW ENGLAND
School of Community and
Population Health



Maine AHEC
Network
Healthcare Workforce
Recruitment and Retention

Maine Area Health Education (AHEC) Network

Presentation to Legislative Committee

October 13, 2015

Karen O'Rourke, MPH

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Director, Maine AHEC Network

University of New England, School of Community and Population Health

AHEC Mission

The Mission of the Maine AHEC Network is to alleviate shortages of health professionals in Maine's rural and underserved communities by engaging academic and community partners to:

- Develop a career pipeline for Maine youth and mid-career professionals
- Provide rural, community based clinical training experiences for medical and other health profession students
- Support practicing health professionals with continuing education and distance learning opportunities for practice improvement and retention

AHEC Structure

Program Office:

University of New England, School of Community and Population Health, oversees the program and has a statewide focus (FY15 approximately 2.75 FTEs)

Eastern Maine AHEC:

Penobscot Community Health Care, covering Penobscot, Piscataquis, Waldo, Somerset, Hancock Counties

Western Maine AHEC:

Franklin Memorial Hospital, covering Franklin, Oxford, Androscoggin, Kennebec, Counties

Northern Maine AHEC:

Northern Maine Community College covering Aroostook and Washington Counties and tribal communities

Funding

AHECs are funded through the US Health Resources and Services Administration (HRSA). We are currently beginning the 4th year of a 5-year cooperative agreement.

AHECs have a required one-to-one match for funding.

FY16 funding:

HRSA \$310,650 (50%)

Match UNE \$204,474 (32%)

Match FAME FHM \$112,376 (18%)

Total FY16: \$627,500

Fund Distribution

Three quarters (3/4) of HRSA funds and about ¾ of FAME funds are allocated to the AHEC Centers for local programs. FHM dollars remaining at UNE are used to support AHEC programs within the University and in the community. FHM dollars are not used for UNE salaries.

Use of Funds/Accountability

HRSA considers the match a required part of the cooperative agreement so matching funds must follow the same rules for allowable expenses as the HRSA funds and the matching funds must be used to meet the HRSA approved workplan for the Maine AHEC Network. We also have an Advisory Committee made up of stakeholders and collaborators including the Director of the Office of Rural Health and Primary Care.

Services Provided (*Varies yearly, but bolded items are those most likely to use FHM dollars*)

Pipeline – Recruiting Maine’s Future Workforce:

- **Intensive multi-day health careers exploration** – 3 programs
- **Doc4ADay** – half day program --Maine Medical Center provides physicians and simulator
- **Job Shadows**
- **Health Fairs/Career Fairs – Including Tribal Career Expo**
- **Mentoring for rural pre-health professions students – UMaine Orono**
- **Development of paid summer internships in rural health care settings for undergraduate students** – collaboration with Hanley Health Leadership
- **Medical Outreach Maine** – Collaboration with UMaine Orono, MMC/Tufts Medical Students and local community schools and organizations

Community Based Placement of Health Professions Students –Experience practice in rural and underserved communities

- Place students in rural and underserved communities as part of their clinical rotations
- Developed Enhanced Community Health Rotation to ensure students from UNE’s College of Osteopathic Medicine have a positive rural health experience
- Work with multiple health professions and multiple universities and colleges
- **Support students to learn about/consider practicing in rural and underserved areas through conferences and speaker support**
- **Provide opportunities for students to practice in an interprofessional environment**

Continuing Education – Retention of the Health Care Workforce

- Collaborate with other continuing education such as Alzheimer’s Disease Conference and the Minority Health Conference
- Ensure community providers have access to continuing education and credential renewal

Costs

- Materials and supplies to put on pipeline programs and continuing education programs
- Stipends/fees for counselors, speakers, interns, instructors
- Travel costs
- Staff time (administrative support)
- Continuing Medical Education Credits



Maine AHEC
Network

Healthcare Workforce
Recruitment and Retention

Selected Outcomes FY 15

Youth Outcomes
*Recruiting Maine's future health
professionals*

Pipeline Programs Outcomes FY15

216 students participated in structured health careers programs (e.g. career camps)

1,569 students participated in unstructured programs (such as health career fairs)

80 students participated in job shadows

Intensive Summer Pipeline Programs

Scrub Club – Western ME AHEC – 4 days

- 40 students attended in June 2015
- 35 students completed Post-only (w/ Retrospective Pre-Post)
- 8th – 12th graders, 86% female

Survivor Aroostook – Northern ME AHEC – 5 days

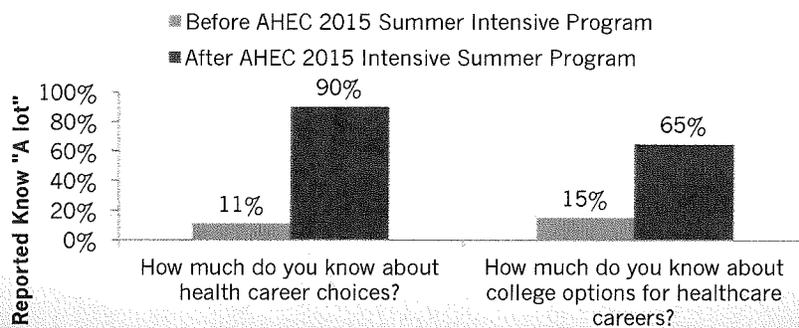
- 42 students attended in June 2015
- 31 linked pre-post
- 9th graders, 90% female

UNE Dental Camp – 3 days

- 19 students attended in August 2015
- 18 linked pre-post
- 9th – 12th graders, 72% female

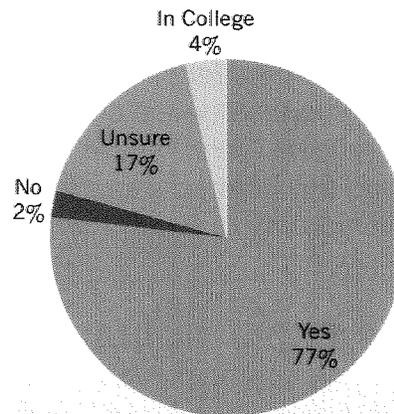
Intensive Summer Health Career Camps in Aroostook, Farmington & Portland

**% of Students Reporting They Know "A Lot"
Before and After AHEC Intensive Summer Program
(N=84)**



Tribal Youth Career Fairs

% of Students Reporting "Plan to attend college"



Health Professions Student Outcomes

Training health professions students for practice in rural and primary care

Reach FY2015

- 306 student clinical placements
- Health Profession Students Include:
 - Medical
 - Dental
 - Nursing
 - Physician Assistant
 - Medical Assistant
 - Pharmacy
 - Nurse Practitioner

AHEC Enhanced Aroostook Community Health Rotation

"The complexity of the medical care made this rotation a wonderful learning experience. Often times the patients required consideration of several medical comorbidities in the decision making and this created a challenging and rewarding learning process."

3rd year UNECOM medical student after participation in Enhanced Aroostook Rotation

AHEC Interprofessional Community Health Rotation @ MaineGeneral

"I think this rotation prepared me to be a better team member in the future."

"It encouraged me to always work with those around me and lean on/reference those who have a strength in something that may not be a strength of mine."

3rd year UNE medical and pharmacy students after participation in IP Rotation at FMI-MG

Health Professional Outcomes

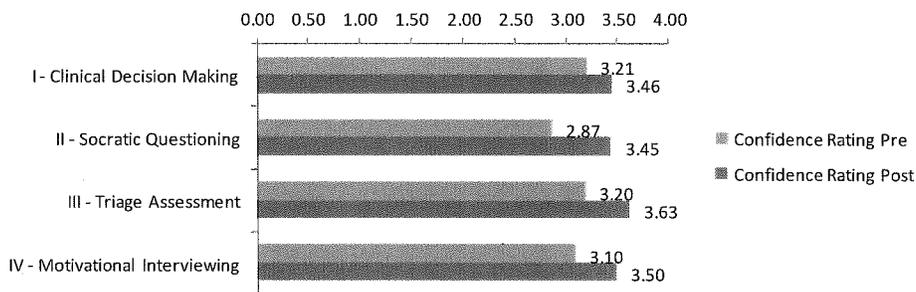
Retaining health professionals In Maine through training

Continuing Education Reach FY15

- 1,733 participants
- Programs topics include:
 - Interprofessional Practice and Education
 - Population Health for Veterans Administration providers
 - Alzheimer's Disease
 - Paramedicine
 - Basic Cardiac Life Support
 - Emergency C-Section Training
 - Patient Safety
 - Opioid Drug Dependency

AHEC Training for Nurses Outpatient Clinics

Figure 1 - Confidence Ratings - Retrospective Pre/Post



At each session, average confidence ratings increased and two-tailed paired t-tests revealed that all of these increases were statistically significant ($p < .05$).

Overall CE Evaluation Reports

- 60% of attendees were participating for certification and/or recertification courses as well as educational requirements;
- 75% reported an increase in knowledge of the subject discussed;
- 70% said that they had improved their skill;
- 75% reported they intended to use at least one practice improvement.

2014-15 School Year Maine SBHC Data Analysis

Presented by:
George Shaler, MPH

What are School-based Health Centers?

- School based health centers (SBHCs) are like a doctor's office in school.
- They provide quality primary and mental health services where kids are - keeping them healthier, in school and ready to learn.
- Currently, the ME CDC provides modest funding to 16 SBHCs.

What do SBHCs provide Maine Youth:

- **Access to Care.** With adolescents receiving less health care than any other age group in the State, SBHCs serve a critical role in providing care to Maine's underserved youth.
- **Value-based Quality Care.** SBHCs not only keep our youth healthier, but also make great financial sense by reducing Medicaid expenditures and inappropriate hospitalizations and emergency room visits.

Maine Centers for Disease Control & Prevention & SBHCs

- Since the 1987 the Maine CDC has provided modest financial support to SBHCs. These resources cover uncompensated care.
- The SBHCs bill for their services.
- SBHCs are held to performance standards established by the ME CDC.
- ME SBHCs engage in ongoing QI.
- The Muskie School evaluates these 16 SBHCs.

ME SBHC Evaluation

This analysis compares activity at Maine School-Based Health Centers (SBHCs) for the 2014-15 school year with data from previous school years.

Objective I – Performance Indicators

1. % of students enrolled in an SBHC with a PCP (2014-15 school year – 79%; 4 year average - 83%)
2. % of enrollees with charts that record a biennial physical (2014-15 school year – 48%; 4 year average - 53%)
3. % of SBHC users with charts that record an annual risk assessment (2014-15 school year – 61%; 4 year average - 60%)

Objective 2 -

Performance Indicators

- Percentage of enrolled tobacco users who receive treatment (2014-15 school year – 46%; 4 year average - 42%)
- Percentage of those identified as physically inactive who receive intervention (2014-15 school year – 79%; 4 year average - 59%)
- Percentage of those identified with poor nutrition who receive intervention (2014-15 school year – 85%; 4 year average - 86%)
- Percentage of those identified as sexually active who receive counseling (2014-15 school year – 64%; 4 year average - 60%)

Objective 2 -

Performance Indicators (cont.)

- Percentage of students w/ asthma, who have a copy of an up-to-date school asthma plan on file at the SBHC (2014-15 school year – 56%; 4 year average - 50%)
- Percentage of those identified as using alcohol who receive intervention by an SBHC provider (2014-15 school year – 44%; 4 year average - 53%)
- Percentage of those identified as using other drugs who receive intervention by an SBHC provider (2014-15 school year – 41%; 4 year average - 56%)
- Percentage of depressed users who are screened for depression using an evidence-based tool (2014-15 school year – 31%; 4 year average - 48%)

Objective 3 -

Performance Indicators

1. % of eligible students enrolled (2014-15 school year – 39%; 4 year average - 43%)
2. Proportion of students enrolled in the SBHC who are seen for at least one visit (2014-15 school year – 54%; 4 year average - 52%)
3. % of students enrolled at SBHCs who have insurance (public or private) – 88%
4. # of encounters –medical (2014-15 school year – 5,021; 4 year average – 5,046) & behavioral health (2014-15 school year – 6,870; 4 year average – 5,463)

Questions?



Youth Online: High School YRBS

Maine 2013 and United States 2013 Results

High School Youth Risk Behavior Survey						
Question	Maine 2013	United States 2013	p-value	Maine 2013 More Likely Than United States 2013	United States 2013 More Likely Than Maine 2013	No Difference
Unintentional Injuries and Violence						
Never or rarely wore a bicycle helmet (among students who had ridden a bicycle during the 12 months before the survey)	63.8 (58.7–68.6) [†]	87.9 (85.0–90.2)	0.00		●	
Never or rarely wore a seat belt (when riding in a car driven by someone else)	7.1 (6.2–8.2)	7.6 (6.4–9.1)	0.55			●
Rode with a driver who had been drinking alcohol (in a car or other vehicle one or more times during the 30 days before the survey)	—	21.9 (20.0–23.9)	~			
Drove when drinking alcohol (one or more times during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	6.6 (5.6–7.8)	10.0 (8.5–11.8)	0.00		●	
Texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	—	41.4 (38.2–44.7)	~			
Carried a weapon (such as, a gun, knife, or club on at least 1 day during the 30 days before the survey)	—	17.9 (16.5–19.4)	~			
Carried a gun (on at least 1 day during the 30 days before the survey)	—	5.5 (4.8–6.3)	~			
Carried a weapon on school property (such as, a gun, knife, or club on at least 1 day during the 30 days before the survey)	7.1 (6.2–8.1)	5.2 (4.4–6.2)	0.00	●		
Were threatened or injured with a weapon on school property (such as, a gun, knife, or club one or more times during the 12 months)	5.3 (4.7–5.9)	6.9 (6.2–7.7)	0.00		●	

before the survey)					
Were in a physical fight (one or more times during the 12 months before the survey)	17.0 (16.2–17.8)	24.7 (23.2–26.2)	0.00		
Were injured in a physical fight (one or more times during the 12 months before the survey; injuries had to be treated by a doctor or nurse)	2.1 (1.8–2.5)	3.1 (2.7–3.5)	0.00		
Were in a physical fight on school property (one or more times during the 12 months before the survey)	5.7 (5.2–6.4)	8.1 (7.5–8.9)	0.00		
Did not go to school because they felt unsafe at school or on their way to or from school (on at least 1 day during the 30 days before the survey)	5.4 (4.8–6.0)	7.1 (6.0–8.3)	0.01		
Were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	20.6 (19.4–21.9)	14.8 (13.7–15.9)	0.00		
Were bullied on school property (during the 12 months before the survey)	24.2 (22.9–25.6)	19.6 (18.6–20.8)	0.00		
Were ever physically forced to have sexual intercourse (when they did not want to)	7.6 (6.9–8.3)	7.3 (6.6–8.1)	0.63		
Experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	9.0 (8.3–9.8)	10.3 (9.2–11.4)	0.06		
Experienced sexual dating violence (one or more times during the 12 months before the survey, including kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	—	10.4 (9.4–11.5)	~		
Felt sad or hopeless	25.1 (24.0–26.2)	29.9 (28.3–31.6)	0.00		

(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)						
Seriously considered attempting suicide (during the 12 months before the survey)	14.3 (13.4–15.3)	17.0 (15.8–18.2)	0.00			
Made a plan about how they would attempt suicide (during the 12 months before the survey)	12.4 (11.7–13.1)	13.6 (12.3–15.0)	0.12			
Attempted suicide (one or more times during the 12 months before the survey)	8.1 (7.3–8.9)	8.0 (7.2–8.9)	0.91			
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	—	2.7 (2.3–3.1)	~			
Tobacco Use						
Ever tried cigarette smoking (even one or two puffs)	32.1 (29.0–35.3)	41.1 (38.4–43.8)	0.00			
Smoked a whole cigarette before age 13 years (for the first time)	6.4 (5.6–7.4)	9.3 (7.8–11.1)	0.00			
Currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	12.8 (11.3–14.5)	15.7 (13.5–18.1)	0.04			
Currently smoked cigarettes frequently (on 20 or more days during the 30 days before the survey)	5.2 (4.4–6.2)	5.6 (4.4–7.1)	0.64			
Smoked more than 10 cigarettes per day (among students who currently smoked cigarettes on the days they smoked during the 30 days before the survey)	12.7 (10.5–15.4)	8.6 (6.6–11.2)	0.01			
Did not try to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	—	52.0 (48.7–55.1)	~			
Smoked cigarettes on school property (on at least 1 day during the 30 days before the survey)	—	3.8 (3.1–4.8)	~			
Usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.6 (5.9–9.7)	18.1 (14.4–22.4)	0.00			

Ever smoked at least one cigarette every day for 30 days	—	8.8 (7.2–10.8)	~		
Smoked cigarettes on all 30 days (during the 30 days before the survey)	4.0 (3.3–4.9)	4.0 (3.0–5.3)	0.98		●
Currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	6.0 (5.2–7.0)	8.8 (7.3–10.6)	0.00		●
Currently used cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	10.6 (9.9–11.4)	12.6 (11.4–13.9)	0.01		●
Currently used tobacco (current cigarette use, current smokeless tobacco use, or current cigar use)	17.3 (15.8–18.9)	22.4 (19.9–25.0)	0.00		●
Alcohol and Other Drug Use					
Ever had at least one drink of alcohol (on at least 1 day during their life)	56.6 (54.5–58.7)	66.2 (63.7–68.5)	0.00		●
Drank alcohol before age 13 years (for the first time other than a few sips)	13.3 (12.1–14.6)	18.6 (17.2–20.0)	0.00		●
Currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	26.6 (24.8–28.5)	34.9 (32.8–37.1)	0.00		●
Usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	40.6 (38.1–43.1)	41.8 (39.4–44.1)	0.48		●
Had five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	14.4 (13.2–15.8)	20.8 (19.1–22.7)	0.00		●
Reported that their largest number of drinks in a row was 10 or more (within a couple of hours during the 30 days before the survey)	—	6.1 (5.2–7.1)	~		
Ever used marijuana (one or more times during their life)	—	40.7 (37.9–43.5)	~		
Tried marijuana before age 13 years (for the first time)	7.1 (6.2–8.1)	8.6 (7.4–10.1)	0.07		●
Currently used marijuana (one or more times during the 30 days before the survey)	21.3 (19.5–23.2)	23.4 (21.3–25.7)	0.14		●
Ever used cocaine (any form of cocaine, such as, powder, crack, or freebase, one or more times during their life)	—	5.5 (4.7–6.6)	~		

Ever used hallucinogenic drugs (such as LSD, acid, PCP, angel dust, mescaline, or mushrooms, one or more times during their life)	—	7.1 (6.0–8.4)	~		
Ever used inhalants (sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high, one or more times during their life)	9.1 (8.3–10.1)	8.9 (7.9–10.1)	0.80		
Ever used ecstasy (also called "MDMA," one or more times during their life)	—	6.6 (5.6–7.7)	~		
Ever used heroin (also called "smack," "junk," or "China white," one or more times during their life)	—	2.2 (1.7–2.8)	~		
Ever used methamphetamines (also called "speed," "crystal," "crank," or "ice," one or more times during their life)	—	3.2 (2.6–4.0)	~		
Ever took steroids without a doctor's prescription (pills or shots, one or more times during their life)	—	3.2 (2.7–3.6)	~		
Ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	12.4 (11.6–13.3)	17.8 (15.9–19.9)	0.00		
Ever injected any illegal drug (used a needle to inject any illegal drug into their body one or more times during their life)	2.4 (2.0–2.8)	1.7 (1.3–2.3)	0.04		
Were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.4 (16.7–20.3)	22.1 (20.2–24.1)	0.01		
Sexual Behaviors					
Ever had sexual intercourse	42.6 (39.7–45.5)	46.8 (43.7–49.8)	0.05		
Had sexual intercourse before age 13 years (for the first time)	3.4 (3.0–3.8)	5.6 (4.9–6.5)	0.00		
Had sexual intercourse with four or more persons (during their life)	10.5 (9.6–11.6)	15.0 (13.6–16.6)	0.00		
Were currently sexually active (sexual intercourse with at least one person during the 3 months before the survey)	31.0 (28.7–33.3)	34.0 (31.6–36.5)	0.07		
Did not use a condom (during last sexual intercourse among students who were currently sexually	42.2 (39.7–44.7)	40.9 (38.1–43.7)	0.47		

active)						
Did not use birth control pills (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	64.3 (61.9–66.6)	81.0 (78.3–83.4)	0.00			
Did not use an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	97.3 (96.2–98.0)	98.4 (97.8–98.9)	0.02			
Did not use a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	93.8 (92.2–95.1)	95.3 (94.2–96.2)	0.09			
Did not use birth control pills; an IUD or implant; or a shot, patch, or birth control ring (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	55.4 (52.4–58.3)	74.7 (71.6–77.6)	0.00			
Did not use both a condom during and birth control pills; an IUD or implant; or a shot, patch, or birth control ring before last sexual intercourse (to prevent STD and pregnancy among students who were currently sexually active)	83.0 (81.6–84.3)	91.2 (89.7–92.5)	0.00			
Did not use any method to prevent pregnancy (during last sexual intercourse among students who were currently sexually active)	9.0 (7.5–10.8)	13.7 (12.2–15.4)	0.00			
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	18.4 (16.4–20.5)	22.4 (20.7–24.3)	0.00			
Were never taught in school about AIDS or HIV infection	13.2 (11.4–15.2)	14.7 (12.6–17.0)	0.30			
Were never tested for HIV (not including tests done when donating blood)	—	87.1 (85.6–88.5)	~			
Dietary Behaviors						
Did not eat fruit or	5.1 (4.4–6.0)	5.0 (4.5–5.7)	0.85			

drink 100% fruit juices (during the 7 days before the survey)						
Did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	—	6.6 (5.9–7.4)	~			
Did not drink milk (during the 7 days before the survey)	15.1 (13.9–16.4)	19.4 (17.9–20.9)	0.00			
Drank a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	—	77.7 (75.6–79.6)	~			
Drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	27.0 (23.8–30.5)	~			
Drank a can, bottle, or glass of soda or pop two or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	19.4 (16.5–22.6)	~			
Drank a can, bottle, or glass of soda or pop three or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	11.2 (9.6–13.1)	~			
Did not eat breakfast (during the 7 days before the survey)	—	13.7 (12.3–15.2)	~			
Did not eat breakfast on all 7 days (during the 7 days before the survey)	—	61.9 (60.3–63.5)	~			
Physical Activity						
Did not participate in at least 60 minutes of physical activity on at least 1 day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	14.0 (13.0–15.0)	15.2 (13.9–16.6)	0.15			
Were not physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	56.9 (54.2–59.6)	52.7 (50.8–54.7)	0.01			
Were not physically active at least 60 minutes per day on all 7 days (doing any kind of physical activity that increased their heart rate	77.7 (76.1–79.2)	72.9 (71.2–74.5)	0.00			

and made them breathe hard some of the time during the 7 days before the survey)						
Did not participate in muscle strengthening activities on 3 or more days (such as push-ups, sit-ups, or weight lifting during the 7 days before the survey)	—	48.3 (46.1–50.5)	~			
Played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	36.8 (35.1–38.6)	41.3 (39.2–43.4)	0.00		●	
Watched television 3 or more hours per day (on an average school day)	23.1 (21.1–25.3)	32.5 (30.4–34.7)	0.00		●	
Did not attend physical education classes on 1 or more days (in an average week when they were in school)	59.8 (56.3–63.2)	52.0 (46.2–57.8)	0.02	●		
Did not attend physical education classes on all 5 days (in an average week when they were in school)	95.5 (93.0–97.2)	70.6 (65.9–74.9)	0.00	●		
Did not play on at least one sports team (run by their school or community groups during the 12 months before the survey)	—	46.0 (43.7–48.4)	~			
Weight Control						
Were obese (\geq 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	11.6 (10.2–13.3)	13.7 (12.6–14.9)	0.03		●	
Were overweight (\geq 85th percentile but $<$ 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	14.2 (13.3–15.0)	16.6 (15.4–17.8)	0.00		●	
Described themselves as slightly or very overweight	—	31.1 (29.8–32.5)	~			
Were not trying to lose weight	—	52.3 (50.5–54.0)	~			
Did not eat for 24 or more hours to lose weight or keep from gaining weight (during the 30 days before the survey)	—	13.0 (12.0–14.1)	~			
Took diet pills, powders, or liquids (without a doctor's advice, to lose weight or to keep from gaining weight during the 30 days before the survey)	—	5.0 (4.3–5.8)	~			

Vomited or took laxatives to lose weight or to keep from gaining weight (during the 30 days before the survey)	—	4.4 (3.9–5.0)	~		
Other Health Topics					
Had ever been told by a doctor or nurse that they had asthma	25.1 (24.0–26.2)	21.0 (20.0–22.0)	0.00		
Sometimes, rarely, or never wore sunscreen (with an SPF of 15 or higher, when they were outside for more than 1 hour on a sunny day)	—	89.9 (88.9–90.9)	~		
Used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	—	12.8 (10.6–15.4)	~		
Did not have 8 or more hours of sleep (on an average school night)	—	68.3 (66.8–69.8)	~		

Footnotes

†	Percentage, confidence interval
'—'	Data not available
~	P-value not available

Application URL: <https://nccd.cdc.gov/youthonline/App/Results.aspx?>

TT=G&OUT=0&SID=HS&QID=QQ&LID=ME&YID=2013&LID2=XX&YID2=2013&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&F
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Youth Online: High School YRBS

Maine 2013 and United States 2013 Results

High School Youth Risk Behavior Survey						
Question	Maine 2013	United States 2013	p-value	Maine 2013 More Likely Than United States 2013	United States 2013 More Likely Than Maine 2013	No Difference
Unintentional Injuries and Violence						
Never or rarely wore a bicycle helmet (among students who had ridden a bicycle during the 12 months before the survey)	63.8 (58.7–68.6) [†]	87.9 (85.0–90.2)	0.00		●	
Never or rarely wore a seat belt (when riding in a car driven by someone else)	7.1 (6.2–8.2)	7.6 (6.4–9.1)	0.55			●
Rode with a driver who had been drinking alcohol (in a car or other vehicle one or more times during the 30 days before the survey)	—	21.9 (20.0–23.9)	~			
Drove when drinking alcohol (one or more times during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	6.6 (5.6–7.8)	10.0 (8.5–11.8)	0.00		●	
Texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	—	41.4 (38.2–44.7)	~			
Carried a weapon (such as, a gun, knife, or club on at least 1 day during the 30 days before the survey)	—	17.9 (16.5–19.4)	~			
Carried a gun (on at least 1 day during the 30 days before the survey)	—	5.5 (4.8–6.3)	~			
Carried a weapon on school property (such as, a gun, knife, or club on at least 1 day during the 30 days before the survey)	7.1 (6.2–8.1)	5.2 (4.4–6.2)	0.00	●		
Were threatened or injured with a weapon on school property (such as, a gun, knife, or club one or more times during the 12 months)	5.3 (4.7–5.9)	6.9 (6.2–7.7)	0.00		●	

before the survey)					
Were in a physical fight (one or more times during the 12 months before the survey)	17.0 (16.2–17.8)	24.7 (23.2–26.2)	0.00		
Were injured in a physical fight (one or more times during the 12 months before the survey; injuries had to be treated by a doctor or nurse)	2.1 (1.8–2.5)	3.1 (2.7–3.5)	0.00		
Were in a physical fight on school property (one or more times during the 12 months before the survey)	5.7 (5.2–6.4)	8.1 (7.5–8.9)	0.00		
Did not go to school because they felt unsafe at school or on their way to or from school (on at least 1 day during the 30 days before the survey)	5.4 (4.8–6.0)	7.1 (6.0–8.3)	0.01		
Were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	20.6 (19.4–21.9)	14.8 (13.7–15.9)	0.00		
Were bullied on school property (during the 12 months before the survey)	24.2 (22.9–25.6)	19.6 (18.6–20.8)	0.00		
Were ever physically forced to have sexual intercourse (when they did not want to)	7.6 (6.9–8.3)	7.3 (6.6–8.1)	0.63		
Experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	9.0 (8.3–9.8)	10.3 (9.2–11.4)	0.06		
Experienced sexual dating violence (one or more times during the 12 months before the survey, including kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	—	10.4 (9.4–11.5)	~		
Felt sad or hopeless	25.1 (24.0–26.2)	29.9 (28.3–31.6)	0.00		

(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)						
Seriously considered attempting suicide (during the 12 months before the survey)	14.3 (13.4–15.3)	17.0 (15.8–18.2)	0.00			
Made a plan about how they would attempt suicide (during the 12 months before the survey)	12.4 (11.7–13.1)	13.6 (12.3–15.0)	0.12			
Attempted suicide (one or more times during the 12 months before the survey)	8.1 (7.3–8.9)	8.0 (7.2–8.9)	0.91			
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	—	2.7 (2.3–3.1)	~			
Tobacco Use						
Ever tried cigarette smoking (even one or two puffs)	32.1 (29.0–35.3)	41.1 (38.4–43.8)	0.00			
Smoked a whole cigarette before age 13 years (for the first time)	6.4 (5.6–7.4)	9.3 (7.8–11.1)	0.00			
Currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	12.8 (11.3–14.5)	15.7 (13.5–18.1)	0.04			
Currently smoked cigarettes frequently (on 20 or more days during the 30 days before the survey)	5.2 (4.4–6.2)	5.6 (4.4–7.1)	0.64			
Smoked more than 10 cigarettes per day (among students who currently smoked cigarettes on the days they smoked during the 30 days before the survey)	12.7 (10.5–15.4)	8.6 (6.6–11.2)	0.01			
Did not try to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	—	52.0 (48.7–55.1)	~			
Smoked cigarettes on school property (on at least 1 day during the 30 days before the survey)	—	3.8 (3.1–4.8)	~			
Usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.6 (5.9–9.7)	18.1 (14.4–22.4)	0.00			

Ever smoked at least one cigarette every day for 30 days	—	8.8 (7.2–10.8)	~		
Smoked cigarettes on all 30 days (during the 30 days before the survey)	4.0 (3.3–4.9)	4.0 (3.0–5.3)	0.98		●
Currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	6.0 (5.2–7.0)	8.8 (7.3–10.6)	0.00		●
Currently used cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	10.6 (9.9–11.4)	12.6 (11.4–13.9)	0.01		●
Currently used tobacco (current cigarette use, current smokeless tobacco use, or current cigar use)	17.3 (15.8–18.9)	22.4 (19.9–25.0)	0.00		●
Alcohol and Other Drug Use					
Ever had at least one drink of alcohol (on at least 1 day during their life)	56.6 (54.5–58.7)	66.2 (63.7–68.5)	0.00		●
Drank alcohol before age 13 years (for the first time other than a few sips)	13.3 (12.1–14.6)	18.6 (17.2–20.0)	0.00		●
Currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	26.6 (24.8–28.5)	34.9 (32.8–37.1)	0.00		●
Usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	40.6 (38.1–43.1)	41.8 (39.4–44.1)	0.48		●
Had five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	14.4 (13.2–15.8)	20.8 (19.1–22.7)	0.00		●
Reported that their largest number of drinks in a row was 10 or more (within a couple of hours during the 30 days before the survey)	—	6.1 (5.2–7.1)	~		
Ever used marijuana (one or more times during their life)	—	40.7 (37.9–43.5)	~		
Tried marijuana before age 13 years (for the first time)	7.1 (6.2–8.1)	8.6 (7.4–10.1)	0.07		●
Currently used marijuana (one or more times during the 30 days before the survey)	21.3 (19.5–23.2)	23.4 (21.3–25.7)	0.14		●
Ever used cocaine (any form of cocaine, such as, powder, crack, or freebase, one or more times during their life)	—	5.5 (4.7–6.6)	~		

Ever used hallucinogenic drugs (such as LSD, acid, PCP, angel dust, mescaline, or mushrooms, one or more times during their life)	—	7.1 (6.0–8.4)	~		
Ever used inhalants (sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high, one or more times during their life)	9.1 (8.3–10.1)	8.9 (7.9–10.1)	0.80		
Ever used ecstasy (also called "MDMA," one or more times during their life)	—	6.6 (5.6–7.7)	~		
Ever used heroin (also called "smack," "junk," or "China white," one or more times during their life)	—	2.2 (1.7–2.8)	~		
Ever used methamphetamines (also called "speed," "crystal," "crank," or "ice," one or more times during their life)	—	3.2 (2.6–4.0)	~		
Ever took steroids without a doctor's prescription (pills or shots, one or more times during their life)	—	3.2 (2.7–3.6)	~		
Ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	12.4 (11.6–13.3)	17.8 (15.9–19.9)	0.00		
Ever injected any illegal drug (used a needle to inject any illegal drug into their body one or more times during their life)	2.4 (2.0–2.8)	1.7 (1.3–2.3)	0.04		
Were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.4 (16.7–20.3)	22.1 (20.2–24.1)	0.01		
Sexual Behaviors					
Ever had sexual intercourse	42.6 (39.7–45.5)	46.8 (43.7–49.8)	0.05		
Had sexual intercourse before age 13 years (for the first time)	3.4 (3.0–3.8)	5.6 (4.9–6.5)	0.00		
Had sexual intercourse with four or more persons (during their life)	10.5 (9.6–11.6)	15.0 (13.6–16.6)	0.00		
Were currently sexually active (sexual intercourse with at least one person during the 3 months before the survey)	31.0 (28.7–33.3)	34.0 (31.6–36.5)	0.07		
Did not use a condom (during last sexual intercourse among students who were currently sexually	42.2 (39.7–44.7)	40.9 (38.1–43.7)	0.47		

active)						
Did not use birth control pills (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	64.3 (61.9–66.6)	81.0 (78.3–83.4)	0.00			
Did not use an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	97.3 (96.2–98.0)	98.4 (97.8–98.9)	0.02			
Did not use a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	93.8 (92.2–95.1)	95.3 (94.2–96.2)	0.09			
Did not use birth control pills; an IUD or implant; or a shot, patch, or birth control ring (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	55.4 (52.4–58.3)	74.7 (71.6–77.6)	0.00			
Did not use both a condom during and birth control pills; an IUD or implant; or a shot, patch, or birth control ring before last sexual intercourse (to prevent STD and pregnancy among students who were currently sexually active)	83.0 (81.6–84.3)	91.2 (89.7–92.5)	0.00			
Did not use any method to prevent pregnancy (during last sexual intercourse among students who were currently sexually active)	9.0 (7.5–10.8)	13.7 (12.2–15.4)	0.00			
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	18.4 (16.4–20.5)	22.4 (20.7–24.3)	0.00			
Were never taught in school about AIDS or HIV infection	13.2 (11.4–15.2)	14.7 (12.6–17.0)	0.30			
Were never tested for HIV (not including tests done when donating blood)	—	87.1 (85.6–88.5)	~			
Dietary Behaviors						
Did not eat fruit or	5.1 (4.4–6.0)	5.0 (4.5–5.7)	0.85			

drink 100% fruit juices (during the 7 days before the survey)						
Did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	—	6.6 (5.9–7.4)	~			
Did not drink milk (during the 7 days before the survey)	15.1 (13.9–16.4)	19.4 (17.9–20.9)	0.00			
Drank a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	—	77.7 (75.6–79.6)	~			
Drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	27.0 (23.8–30.5)	~			
Drank a can, bottle, or glass of soda or pop two or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	19.4 (16.5–22.6)	~			
Drank a can, bottle, or glass of soda or pop three or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	—	11.2 (9.6–13.1)	~			
Did not eat breakfast (during the 7 days before the survey)	—	13.7 (12.3–15.2)	~			
Did not eat breakfast on all 7 days (during the 7 days before the survey)	—	61.9 (60.3–63.5)	~			
Physical Activity						
Did not participate in at least 60 minutes of physical activity on at least 1 day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	14.0 (13.0–15.0)	15.2 (13.9–16.6)	0.15			
Were not physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	56.9 (54.2–59.6)	52.7 (50.8–54.7)	0.01			
Were not physically active at least 60 minutes per day on all 7 days (doing any kind of physical activity that increased their heart rate	77.7 (76.1–79.2)	72.9 (71.2–74.5)	0.00			

and made them breathe hard some of the time during the 7 days before the survey)					
Did not participate in muscle strengthening activities on 3 or more days (such as push-ups, sit-ups, or weight lifting during the 7 days before the survey)	—	48.3 (46.1–50.5)	~		
Played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	36.8 (35.1–38.6)	41.3 (39.2–43.4)	0.00		
Watched television 3 or more hours per day (on an average school day)	23.1 (21.1–25.3)	32.5 (30.4–34.7)	0.00		
Did not attend physical education classes on 1 or more days (in an average week when they were in school)	59.8 (56.3–63.2)	52.0 (46.2–57.8)	0.02		
Did not attend physical education classes on all 5 days (in an average week when they were in school)	95.5 (93.0–97.2)	70.6 (65.9–74.9)	0.00		
Did not play on at least one sports team (run by their school or community groups during the 12 months before the survey)	—	46.0 (43.7–48.4)	~		
Weight Control					
Were obese (\geq 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	11.6 (10.2–13.3)	13.7 (12.6–14.9)	0.03		
Were overweight (\geq 85th percentile but $<$ 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	14.2 (13.3–15.0)	16.6 (15.4–17.8)	0.00		
Described themselves as slightly or very overweight	—	31.1 (29.8–32.5)	~		
Were not trying to lose weight	—	52.3 (50.5–54.0)	~		
Did not eat for 24 or more hours to lose weight or keep from gaining weight (during the 30 days before the survey)	—	13.0 (12.0–14.1)	~		
Took diet pills, powders, or liquids (without a doctor's advice, to lose weight or to keep from gaining weight during the 30 days before the survey)	—	5.0 (4.3–5.8)	~		

Vomited or took laxatives to lose weight or to keep from gaining weight (during the 30 days before the survey)	—	4.4 (3.9–5.0)	~			
Other Health Topics						
Had ever been told by a doctor or nurse that they had asthma	25.1 (24.0–26.2)	21.0 (20.0–22.0)	0.00			
Sometimes, rarely, or never wore sunscreen (with an SPF of 15 or higher, when they were outside for more than 1 hour on a sunny day)	—	89.9 (88.9–90.9)	~			
Used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	—	12.8 (10.6–15.4)	~			
Did not have 8 or more hours of sleep (on an average school night)	—	68.3 (66.8–69.8)	~			

Footnotes

†	Percentage, confidence interval
—	Data not available
~	P-value not available

Application URL: <https://nccd.cdc.gov/youthonline/App/Results.aspx?>

TT=G&OUT=0&SID=HS&QID=QQ&LID=ME&YID=2013&LID2=XX&YID2=2013&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&F
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MIYHS CORE QUESTIONS: 2011 VERSUS 2013 COMPARISON REPORT

SAGADAHOC COUNTY

2013 MIYHS HIGH SCHOOL REPORT

UNDERSTANDING THE DATA

Reporting Thresholds and Student Confidentiality

Core reports have been run on the following levels for individual geographic units receiving weighted data*:

- **Grade 5-6: State, Public Health District (PHD), SAU, and School**
- **Middle School: State, PHD, County, SAU, and School**
- **High School: State, PHD, County, SAU, and School**

** In order for a report to be run on the State, PHD, County, and SAU levels, the geographic unit in question must have at least 2 participating schools and an overall response rate of at least 50% (overall response rate = school response rate within the geographic unit * student response rate for participating schools within the geographic unit). Schools must have at least a 50% student participation rate within the eligible grades of a module to receive a report.*

To protect student confidentiality, responses based on fewer than 6 individuals will not be shown. Also, individual reports have not been generated for schools or school districts yielding fewer than 20 participating students.

How to Read this Report

For the Grade 5-6 core reports, all non-demographic questions included on the 2013 MIYHS survey instrument are presented. For middle school (MS) and high school (HS), only questions that appeared on all four survey modules are included in the core reports. Questions are grouped by topic area.

Please note that the numbers listed to the left of the questions in this report are for formatting purposes only; they do not represent actual question numbers on the survey instruments themselves.

When questions and/or answer options have changed from 2011 to 2013 and there may be a change in the way the results could be interpreted, the word "Modified" is listed after the question. Please go to <https://data.mainepublichealth.gov/mihs/files/methodology/modifiedvar.pdf> for more information on the modified variables.

Each estimate is the weighted percentage of students who answered in the way specified in the question title; for instance, in 2011, 28.0% of Maine's high school students said they had consumed alcohol at least once in the 30 days prior to taking the MIYHS. The percentages are weighted to adjust for non-response and to make the estimates more representative of all Maine students, not just those who took the survey.

Because the weighted percentage is an estimate, there is some error involved. This is reflected in the Confidence Interval, which is bounded by the **Lower Confidence Limit (LCL)** and the **Upper Confidence Limit (UCL)**. Confidence intervals reflect how precise and stable the percentages are for students in the geographic unit in question. In 2011, 28.0% of Maine high school students indicated that they drank alcohol in the past 30 days. There was a LCL of 27.0% and a UCL of 29.1%; this means that there was a 95% chance that between 27.0% and 29.1% of Maine students engaged in this behavior in the past 30 days, and a 5% chance that fewer than 27.0% or more than 29.1% of students engaged in this behavior. In other words, if the survey were conducted 100 times, 95 of those times the percent of students who drank alcohol in the past month would be between 27.0% and 29.1%. Wider confidence intervals reflect more variability in student responses compared to more narrow confidence intervals. The narrower the confidence limits, the more confidence we have in the percentage. In general, the greater the proportions of eligible students taking the survey, the more confidence we have that the percentages reflect the true underlying population of students.

UNDERSTANDING THE DATA

Comparing Data: Is a Difference Statistically Significant?

In the last three columns of the tables in the core report, we present the results of statistical tests designed to determine whether the difference between values is more than would have been expected by chance. Each geographic unit is compared to the state in 2011 and in 2013, and the values for these two survey years are compared within the geographic unit as well. If there is an "H" in a *significance tests* column, the percentage on this indicator is statistically higher than the state average or the previous survey year; if there is an "L", this indicates that the percentage on this indicator is statistically lower than the state average or the previous survey year. If the cell is blank, then the difference is not statistically significant. Another means of assessing statistical significance is to compare confidence intervals. If the confidence interval around one percentage does not overlap with the confidence interval around another percentage, then the estimates are considered significantly different.

Sagadahoc County

Demographics 2013 MIVHS High School Report

Category	2011 County Count	2011 County Percent	2011 Maine County Count	2011 Maine Percent	2013 County Count	2013 County Percent	2013 Maine County Count	2013 Maine Percent
Total	1,324	100.0%	39,301	100.0%	1,287	100.0%	37,328	100.0%
Female	676	51.1%	19,584	49.8%	644	50.0%	18,641	49.9%
Male	628	47.4%	19,069	48.5%	626	48.6%	18,264	48.9%
Missing	20	1.5%	648	1.6%	17	1.3%	423	1.1%
Grade 9	314	23.7%	10,253	26.1%	329	25.6%	10,182	27.3%
Grade 10	319	24.1%	10,117	25.7%	332	25.8%	9,548	25.6%
Grade 11	365	27.6%	9,550	24.3%	311	24.2%	8,912	23.9%
Grade 12	301	22.7%	8,578	21.8%	296	23.0%	8,055	21.6%
Missing	25	1.9%	803	2.0%	19	1.5%	631	1.7%

Demographic counts of students with usable surveys are unweighted
 ^ Data not available for 2011

**Sagadahoc County
Unintentional Injury -- 2013 MYHS High School Report**

				Significance Tests				
Questions	Answers of Interest	County 2013 95% CI*	County 2011 95% CI*	Maine 2013 95% CI*	Maine 2011 95% CI*	A. County 2013 vs. Maine 2013	B. County 2011 vs. Maine 2011	C. County 2013 vs. County 2011
1. How often do you wear a seat belt when riding in a car driven by someone else? (hnl1/hn11)	Percentage of students who answered "Never" or "Rarely"	6.9% (6.1% - 7.6%)	7.1% (6.5% - 7.6%)	7.6% (7.0% - 8.3%)	8.5% (8.0% - 9.0%)		L	
2. How often do you wear a seat belt when driving a car? (hn213)	Among students who drive, the percentage of students who answered "Never" or "Rarely"	6.7% (5.7% - 7.7%)	^	7.1% (6.4% - 7.8%)	^		^	^

* CI = Confidence Interval

A. *H/L*=County 2013 is significantly Higher Lower than Maine 2013

B. *H/L*=County 2011 is significantly Higher Lower than Maine 2011

C. *H/L*=County 2013 is significantly Higher Lower than County 2011

** Because of confidentiality, estimates have been suppressed due to either very small or very large cell sizes.

^ Data not available for 2011

**Sagadahoc County
Violence -- 2013 MTHHS High School Report**

						Significance Tests		
Questions	Answers of Interest	County 2013 95% CI*	County 2011 95% CI*	Maine 2013 95% CI*	Maine 2011 95% CI*	A. County 2013 vs. Maine 2013	B. County 2011 vs. Maine 2011	C. County 2013 vs. County 2011
3. Do you agree or disagree with the following statement? "I feel safe at my school." (hn33/hm33)	Percentage of students who answered "Strongly agree" or "Agree"	83.5% (79.2% - 87.7%)	88.0% (83.0% - 93.1%)	87.8% (86.6% - 88.9%)	88.1% (87.0% - 89.2%)			

* CI = Confidence Interval

A. *H/L*=County 2013 is significantly Higher Lower than Maine 2013

B. *H/L*=County 2011 is significantly Higher Lower than Maine 2011

C. *H/L*=County 2013 is significantly Higher Lower than County 2011.

** Because of confidentiality, estimates have been suppressed due to either very small or very large cell sizes.

^ Data not available for 2011

**Sagadahoc County
Bullying -- 2013 MYHS High School Report**

				Significance Tests					
	Questions	Answers of Interest	County 2013 95% CI*	County 2011 95% CI*	Maine 2013 95% CI*	Maine 2011 95% CI*	A. County 2013 vs. Maine 2013	B. County 2011 vs. Maine 2011	C. County 2013 vs. County 2011
4.	During the past 12 months, have you ever been bullied on school property? (m34/m34)	Percentage of students who answered "Yes"	28.5% (26.1% - 30.8%)	23.8% (22.5% - 25.0%)	25.8% (24.9% - 26.8%)	24.0% (23.0% - 25.0%)			H

* CI = Confidence Interval

A. *H/L*=County 2013 is significantly Higher Lower than Maine 2013

B. *H/L*=County 2011 is significantly Higher Lower than Maine 2011

C. *H/L*=County 2013 is significantly Higher Lower than County 2011

** Because of confidentiality, estimates have been suppressed due to either very small or very large cell sizes.

^ Data not available for 2011

**Sagadahoc County
Suicide & Depression -- 2013 MTHHS High School Report**

Questions	Answers of Interest	Significance Tests						
		County 2013 95% CI*	County 2011 95% CI*	Maine 2013 95% CI*	Maine 2011 95% CI*	A. County 2013 vs. Maine 2013	B. County 2011 vs. Maine 2011	C. County 2013 vs. County 2011
5. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities? (hn42/hn42)	Percentage of students who answered "Yes"	29.6% (28.6% - 30.5%)	26.9% (21.9% - 31.9%)	24.3% (23.4% - 25.2%)	22.7% (21.7% - 23.6%)	H		
6. During the past 12 months, when you felt sad or hopeless, from whom did you get help? (Select only one response.) (hn43/hn43a)	Among students who have ever felt sad or hopeless during the past 12 months, the percentage of students who answered that they got help from an adult	22.5% (21.4% - 23.6%)	22.3% (20.4% - 24.2%)	22.3% (21.4% - 23.1%)	20.2% (19.3% - 21.1%)			
7. During the past 12 months, did you ever seriously consider attempting suicide? (hn44/hn44)	Percentage of students who answered "Yes"	19.7% (18.2% - 21.2%)	14.7% (11.5% - 17.8%)	14.6% (13.9% - 15.3%)	12.7% (12.0% - 13.3%)	H		H

* CI = Confidence Interval

A. *H/L* = County 2013 is significantly Higher Lower than Maine 2013

B. *H/L* = County 2011 is significantly Higher Lower than Maine 2011

C. *H/L* = County 2013 is significantly Higher Lower than County 2011

** Because of confidentiality, estimates have been suppressed due to either very small or very large cell sizes.

^ Data not available for 2011



11 Parkwood Dr
Augusta, ME 04330
MOHC@mcdph.org
www.maineoralhealthcoalition.org

October 13, 2015

Senator Eric Brakey and Representative Drew Gattine
Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333

Senator Brakey, Representative Gattine and Members of the Committee of the Health and Human Services:

My name is Judith Feinstein and I am here today on behalf of the Maine Oral Health Coalition, representing a diverse and statewide group of organizations and individuals who work together as a network to raise awareness and support for oral health through community education and advocacy. Among the Coalition's core beliefs are that oral health care is valued as part of overall health, that all people deserve access to oral health care services, and that community-based dental disease prevention services are an integral part of overall preventive health care. My role with the Coalition is as a volunteer, but in the interests of full disclosure I feel that I should share with you that until this past June, I was the program manager of the Maine CDC's oral health program, and in that role was the agency's program contact for Maine CDC oral health contracts using Fund for a Healthy Maine dollars.

The Maine Oral Health Coalition believes strongly that continued use of the Fund for a Healthy Maine for its intended purposes is imperative, and wants me to share with you what the Fund means for oral health. The Fund provides support to programs that provide access to oral health care services for low income individuals, children and adults, and primarily those without dental insurance or MaineCare. This letter describes how the Fund supports school-based preventive oral health programs in elementary schools, and a subsidy program that helps to offset the costs incurred by several non-profit clinics in providing care to uninsured, lower-income adults.

The Maine CDC Oral Health Program's School Oral Health Program uses \$150,000 from the Fund to support preventive programs in about 180 elementary schools, many in rural areas where children are more likely to encounter challenges in finding regular access to dental care, and in schools and communities that meet criteria for community-level risk factors (primarily the proportion of children eligible for the Free and Reduced Lunch Program and limited access to fluoridated public water supplies). These programs offer classroom or assembly-based education and about half also provide dental sealants and fluoride varnish applications for second-graders. There are about 18-20,000 children in grades K to 4 attending schools hosting state-funded school oral health programs, who receive the benefits of that targeted health education. Schools must participate in the broader School Oral Health Program in order to receive any additional funding for dental sealants, a proven preventive measure. During the 2013 and 2014 school years, an average of 94 schools provided sealants to over 1600 children, who received an average of 3.2 sealants each. Out of pocket costs per child for 3 sealants can be as much as \$120 or more; MaineCare reimburses at the rate of \$16 per sealant. This is evidence-based prevention, providing oral health services that have been proven to keep kids healthy, out of pain and in the classroom. This program saves dollars now and contributes to success in school and work over a lifetime.

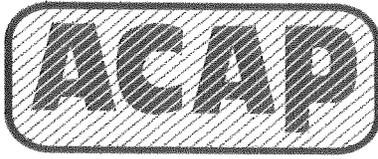
The School Oral Health Program supports these preventive interventions in individual schools, school districts, and through contracts with several community agencies. I have with me letters from two of the funded community agencies, the Aroostook County Action Program and Sunrise Opportunities in Washington County, who were unable to send representatives here to speak to you.

You will see in the letter from Sue Powers, Senior Manager at the Aroostook County Action Program, that with FHM support last year, ACAP's Oral Health Coordination and Outreach program provided dental sealants to 326 children in 26 Aroostook County elementary schools. She also tells you that "In addition to the children who received sealants, ACAP provided education and fluoride varnish to 1128 children in grades Pre-K through 6. ACAP receives \$64,490 from FHM through the Maine CDC Oral Health Program. Because this funding is available to establish a foundational oral health program, ACAP has leveraged additional foundation funds to expand services available in Aroostook."

Teresa Alley, the Oral Health Coordinator at Sunrise Opportunities, writes "During the 2014-2015 school year, Sunrise Opportunities provided preventive oral health services for 998 children who otherwise would not have access to these vital services. In addition, we provided dental sealants to 402 children, saving families estimated out-of-pocket costs of \$7000." Sunrise Opportunities receives \$64,490 from FHM through the Maine CDC; Ms. Alley also notes that "without the framework of our School Oral Health Program, there would be no mechanism for service delivery. Additionally, this core funding has allowed Sunrise Opportunities to leverage an additional \$65,000 annually from private philanthropic foundations for our Oral Health Program."

The Maine Oral Health Coalition also supports use of Fund dollars to support the Maine CDC's Dental Subsidy Program. In SFY 14, \$150,000 supported 5 community organizations in providing over 4,600 dental services to about 2360 patients in 10 locations. The Subsidy Program was implemented to help offset the costs of providing reduced fee services to low income patients at community-based dental clinics. It has been reduced considerably since SFY 11, when 13 agencies with dental clinics in 19 locations participated and provided just under 37,000 dental services to 19,259 people, for a total of \$714,033. We know that oral health status has been shown to have a significant impact on chronic conditions such as diabetes and cardiovascular disease, and poor oral health can have adverse effects on an individual's ability to work productively and safely. Appropriate, timely treatment provides an opportunity to address oral issues before they become emergencies, and the Dental Subsidy Program assists several organizations to make that treatment more accessible.

Thank you for your consideration, and I will be happy to answer any questions you may have.



Aroostook County Action Program

P.O. Box 1116, Presque Isle, Maine 04769-1116 - (207) 764-3721 or 1-800-432-7881
Fax: (207) 768-3022 - www.acap-me.org

October 9, 2015

Senator Eric Brakey and Representative Drew Gattine
Co-chairs, Joint Committee on Health and Human Services
C/O Legislative Information Office
100 State House Station
Augusta, ME 04333

Dear Senator Brakey, Representative Gattine and the joint Committee on Health and Human Services:

The Aroostook County Action Program works to "Make Life Better" for the people of Aroostook County. Resources and services in Aroostook are limited and ACAP is the sole source provider of many services as a result of State and Federal funding. The Fund for a Healthy Maine provides resources that allow ACAP to address Oral Health Coordination and Outreach services throughout The County.

The Oral Health Coordination and Outreach program delivers educational supplies and materials at local health fairs, community gatherings and school departments reaching approximately 12,000 Aroostook citizens each year.

The School Based Sealant Program, designed to seal the teeth of 2nd grade students in an effort to prevent decay in molars, last year provided dental sealants to 326 children in 26 Aroostook County elementary schools. In addition to the children who received sealants, ACAP provided education and fluoride varnish to 1128 children in grades pre-k through 6.

During sealant and fluoride varnish clinics, 288 children were identified as needing restorative dental health care and were referred to a local dentist or dental clinic. ACAP's dental hygienist provides follow-up with parents and dentists on the children needing dental care from a dentist. This follow up, in many cases, makes a difference as to whether or not a child actually makes it to the dentist. Children without proper dental care miss more school, perform at a lower level and have higher rates of absenteeism. Healthy teeth lead to a healthy life and a greater ability to participate in community, school and family.

These services would not be possible without funding from the Fund for a Healthy Maine. ACAP receives \$64,490 from FHM through the Maine CDC Oral Health Program. Because this funding is available to establish a foundational oral health program, ACAP has leveraged additional foundation funds to expand services available in Aroostook. Recently, we received a small grant from American Dental Association to support an oral health training program at a local nursing home reaching elderly dementia patients. Smiles Across America provides funding to expand the fluoride varnish program delivery and education to other populations in Aroostook.

Thank you for your continued support as we take care of the oral health needs of Aroostook County's most vulnerable populations.

Sincerely,

Sue Powers
Senior Manager, ACAP Family Services



Providing Mental Health and Supportive
Living Services for Children and Adults

Central Office

P.O. Box 88
Kay Parker Building
26 Hadley Lake Road
Machias, ME 04654

tel: 207-255-8596
fax: 207-255-6110
deaf or hearing impaired
relay 800-457-1220

E-mail
bus. off: cenoff@sun-rise.tv
exec. dir: tmichaud@sun-rise.tv

October 9, 2015

Senator Eric Brakey and Representative Drew Gattine
Joint Standing Committee on Health and Human Services
C/O Legislative Information Office
100 State House Station
Augusta, ME 04333

Dear Senator Brakey and Representative Gattine and the entire joint standing committee of the Health and Human Services:

Since 1976, Sunrise Opportunities' Oral Health Program has administered school-based oral health promotion and education programming at all Washington County schools and in community settings. This program receives \$46,490 (30% of our annual fiscal budget) each year from the Fund for a Healthy Maine for coordination and outreach of oral health services. Our contract from the Maine Center for Disease Control includes another \$18,000 from another source, which is approximately 13% of our annual fiscal budget, for service delivery and coordination. Together these two contract pieces complement each other well, meaning each of these funding sources do not have the capacity to stand alone. Without the framework of our School Oral Health Program, there would be no mechanism for service delivery. Additionally, this core funding has allowed Sunrise Opportunities to leverage an additional \$65,000 annually from private philanthropic foundations for our Oral Health Program.

During the 2014-2015 school year, Sunrise Opportunities provided preventive oral health services for 998 children who otherwise would not have access to these vital services. In addition, we provided dental sealants to 402 children, saving families estimated out-of-pocket costs of \$7000. We continue to collect data regarding the oral health status of preschool and school aged children. Historically, we observed active decay rates of 35% in Washington County. That was prior to our collaboration with New York University (NYU). In three short years, the decay rates for children in the Machias area have dropped to as low as 16%. Without the support through the Fund for a Healthy Maine, Sunrise Opportunities wouldn't have the ability to sustain the preventive and restorative care children receive during the annual weeklong Dental Outreach Program in Machias. NYU has provided eight of these events that are no cost to families and are attended by thousands of children and adults. Sunrise Opportunities' Oral Health Program provides two preventive aftercare visits between each of the Outreach Program events. Without our efforts, the collaboration with NYU would come to an end, and the majority of these families would go without dental services.

Sincerely,

Teresa Alley, Registered Dental Hygienist
Oral Health Coordinator

Sunrise Opportunities is a private not for profit organization

Patricia A. Kimball, President MASAP
Wellspring, Inc.
98 Cumberland Street, Bangor Maine 04401
941-1612 ext. 202, pkimball@wellspringsoa.org

Good Morning Senator Brakey and Representative Gattine and the Members of the Joint Standing Committee of Health and Human Services. My name is Pat Kimball and I am the Executive Director for Wellspring a substance abuse and mental health treatment center in Bangor and the President of the Maine Association of Substance Abuse Providers (MASAP). I am here today representing MASAP to share information about 8 programs that receive allocations from the Fund for Healthy Maine (FHM).

In our research we found that approximately 1.5 million of FHM allocations are used to support prevention and treatment contracts with agencies that are MASAP members. They are MASAP, Mid Coast Hospital (Addiction Resource Center), Crossroads, Catholic Charities Maine, Day One, Maine General Hospital, Aroostook Mental Health Center and Wellspring. Each of these agencies has a contract with the State of Maine Office of Substance Abuse and Mental Health Services to provide prevention or treatment. These contracts are braided funded which this means that your total contract can come from different funding sources. As an example your total contract dollars could be funds from FHM, Federal Block Grant Dollars and General Funds. After receiving information from SAMHS in regards to our contracts we can share that without the allocation from the FHM the programs served in these contracts would close or be unable to continue.

All of the programs that I will share with you today have performance based contracts with indicators to ensure that the funding is going to a quality programs. These programs follow best practice standards, and are making a difference in the lives of those with a substance use disorder. All of these agencies are mandated to participate in the State of Maine Data Collection system called WITS (formerly the Data Treatment System TDS) and they are monitored regularly by the department including an annual site visit. All of the data for the programs can be accessed through the Office of Substance Abuse and Mental Health Services (SAMHS).

In the area of prevention, MASAP has a braided contract to provide awareness and education programs through the Maine Alliance for Prevention of Substance Abuse (MAPSA). The FHM funds are for the Methamphetamine Watch Program. This program as well as other prevention and recovery work done by MAPSA and Maine Alliance for Addiction Recovery (MAAR) as will no longer be offered because the contract with MASAP was eliminated. This program will no longer be able to continue. There is also another prevention program offered by Mid Coast Hospital (Addiction Resource Center).

In the area of treatment, six of the programs receiving allocations from the FHM are residential programs. All of the programs are licensed by the State of Maine, are co-occurring capable, provide services 7 days per week, -24 hours per day and serve those clients who are in a chronic stage of their disorder. These program include assessments, group and individual counseling, life skills training, vocation programs and developing aftercare plans with clients for support after they complete the program. I am here today to give a short description of these very vital programs who have served the people of Maine for many years. These programs are old established programs but have never stayed stagnant, they have made many changes over time to ensure that our complex clients have evidence based programs that will assist them in a healthy recovery.

Here are the MASAP treatment programs served with Fund for Healthy Maine Allocations:

- Crossroad: The Children and Mothers Program (CAMP) which is the ONLY women and children's program in the state. The treatment center serves pregnant and/or mothers who have children 5 or under and are in need of substance abuse treatment. This program is designed for a length of stay of 60 days and assist women in recovery and parenting skills.
- Catholic Charities: These funds support the St. Francis Recovery Center which is a 45 day program serving men who are in the chronic stages of their substance use disorder. They have a full range of treatment offered and ensure that they have an aftercare plan when completing the program.
- Day One: Has three residential programs for adolescence (both male and female) located in Hollis, Buxton and Hinckley. These programs are the ONLY adolescent residential programs in the state and serve males and females ages 13 to 18. There is a school component integrated into the program to ensure that teens not only work on their recovery but also continue with their education.
- Aroostook Mental Health Center (AMHC): This contract to operate a 28 day co-occurring residential program located in Limestone called The FARM. It is a 12 bed facility that serves both males and females from all over the State of Maine. This program is one of only two 28 programs in the state.
- Maine General: The Maine General Residential Services is a long term residential program that has 8 beds for women and 12 beds for men. This program is a long term residential program and serves those clients who are in a late stage of their substance use disorder. This program is co-occurring capable and assist the clients in moving towards a health recovery.
- Wellspring: Is a residential treatment program (halfway house) located in Bangor that has a 13 bed facility for men and a 15 bed facility for women. Both programs focus on offering programs that serve clients in the chronic stage of their substance use disorder and work closely with the recovery community to start the steps toward recovery.

The majority of the treatment programs I have shared with you today have wait lists to enter their programs. All of these programs work very closely together to ensure that we have the services to assist our clients in entering treatment. Our programs are co-occurring capable and are trauma responsive programs that use evidence based programs to ensure our clients are working towards recovery. Each of these programs welcome the opportunity for you to visit us and see firsthand how well invested the contract dollars are. I am unable today to share exact data because we did not have enough notice of this meeting but the agencies are more than willing to take questions and respond in writing to the committee questions and concerns.

MASAP is also willing to take the time to discuss our concerns over the elimination of the MASAP contract and the loss of our prevention and recovery programs.

Thank you for this opportunity to share with you the amazing work that these programs do for our citizens and families. MASAP looks forward to working with our legislators in moving Maine forward in creating healthy communities. Thank you for your time today.

**Testimony Regarding Allocations From the
Fund for a Healthy Maine
October 13, 2015**

Good morning Senator Brakey, Representative Gattine, and distinguished members of the Health and Human Services Committee.

My name is Lisa Kavanaugh and I am the CEO of Community Dental. We operate dental centers in Rumford, Lewiston, Farmington, Portland, and Biddeford. We are the oral health home for approximately 20,000 children and adults, providing over 48,000 oral health visits each year. Our Mission "improves the lives of children and adults in our communities by providing needed, accessible, comprehensive, quality oral health care."

Approximately 76% of our patient population is living at or below 150% of federal poverty, with almost 50% over the age of twenty-one. We are a key component of the "Health Care Safety Net" for Maine's most vulnerable citizens; including almost 3,000 adults with special needs.

Low income adults are the most challenged population trying to access comprehensive oral health care. Even our deeply discounted fees for care can be unaffordable for many low income individuals. As you know, Mainecare will only reimburse for care to treat "urgent or emergency needs" for its members.

In the past three years, Community Dental has been allocated approximately \$52,000 per year to help "subsidize" the true cost of providing care to patients who meet the income eligibility for our Income Based Sliding Fee Scale. In previous years, our allocation from the Fund for a Healthy Maine varied between \$150,000 to a high of almost \$300,000. The overwhelming number of individuals who qualify for the Sliding Fee Scale are adults who are living at, or below, 150% of the Federal Poverty level.

We believe that no child, adult, or older adult should go without access to comprehensive, high quality oral health care. By offering a Sliding Fee Scale, Community Dental is able to offer "Access" to low-income and uninsured patients who are offered dramatically reduced fees for their oral health care. Fulfilling our mission means providing care for patients who cannot afford our full fees, despite the fact that our full fees are discounted by 20% or more relative to average Maine private practice fees.

The lowest fees we offer are even more affordable; on average, approximately 65% of our already reduced full fees. Funds from the Fund for a Healthy Maine help to sustain this program referred to as "ACCESS." Unfortunately, the ongoing sustainability of this program is continually threatened by inadequate funds to offset the true cost of providing comprehensive care to eligible individuals.

In FY 2015, Community Dental provided a community benefit of approximately **\$570,000** in discounts to patients who were eligible to utilize our income based sliding fee schedule. **The Community Dental full fee value of the oral health care rendered to these individuals was around \$1,600,000. Organization wide, every \$1 spent yielded the equivalent of approximately \$1.50 in oral health care to individuals living at or below 150% of federal poverty.**

Continued funding from the Fund for a Healthy Maine, and a return to previous allocations, is crucial to our ability to provide care at a lower charge for our low-income, uninsured patient population. In FY 2015, "ACCESS" made it possible for 4,176 individuals (more than 10,000 visits with the dentist and/or hygienist) who used the sliding fee scale to receive comprehensive oral healthcare they would not otherwise be able to afford.



Dental Lifeline

Network • *Helping*

Make a Difference

Maine Donated Dental Services (DDS)

P.O. Box 2282
Augusta, ME 04338-2282
Phone 207.620.8276
Fax: 207.626.2946
www.DentalLifeline.org

MAINE DONATED DENTAL SERVICES (DDS) PROGRAM

Annual Report for July 1, 2014 - June 30, 2015

Fourth Quarter Report for April 1, 2015 - June 30, 2015

Performance Snapshot

Patients Treated

Goal  134

Actual  137

0 50 100 150

Donated Treatment

Goal  \$440,000

Actual  \$428,633

\$0 \$200,000 \$400,000 \$600,000

Annual Highlights

- 137 patients accessed \$428,633 worth of care, exceeding the goal for patients served.
- \$8.96 worth of care donated for every \$1 spent supporting services.
- 10 new dentists signed up to volunteer through DDS.

The DDS Program in Action

Thirty-seven-year-old Ms. H. of Woolwich suffers from multiple autoimmune disorders, including rheumatoid arthritis and cellular dysfunction syndrome. In addition, she has severe gastroparesis and vomits many times a day. Her oral health was terrible and was exacerbating her medical problems. Ms. H. was missing fillings and other teeth were broken, decayed and infected, making eating difficult. The stomach acid from her frequent vomiting was eroding the enamel on her teeth, making her susceptible to cavities and infection. She must take multiple immunosuppressant medications due to her autoimmune disorders, and the decay and infection from her mouth could harm her overall health.

Ms. H. desperately needed dental treatment to regain her oral health, but sadly, she couldn't afford it. Though she receives food stamps and a Social Security Disability benefit, she wasn't able to pay her monthly bills. And her Medicaid coverage only paid for emergency dental care, not the comprehensive treatment she needed. It seemed she had no where to turn.

Thankfully, Ms. H.'s primary care doctor referred her to the DDS program. An oral surgeon who accepted her Medicaid coverage extracted a few teeth, and a generous volunteer dentist restored 12 other teeth and donated four crowns and a night guard which his in-house lab fabricated. **Thanks to this kind dentist, Ms. H. received \$7,709 in free care that restored her oral health!** She wrote to express her appreciation for this life-changing gift.

"You saved my smile, one I was very proud of once. I am so happy to have that back. I owe you everything."

Please Note:

You have a special relationship with Dental Lifeline Network! To ensure you receive our occasional email notifications, please click on the link below or type it into your browser to sign up. **Even if you currently receive this report by email**, an additional sign-up is necessary to receive e-Newsletters. It takes less than a minute!

<http://bit.ly/signupDLN>
(case-sensitive)

Helping People With Disabilities in Who We Choose to do the Right Thing

Program History

- Established in 1999 with Maine Dental Association
- 1,161 total patients served
- \$3,493,739 in total care donated by volunteers
- Statewide Volunteer Network: 177 dentists and 20 labs

Accomplishments

The DDS program exists to help individuals with disabilities or who are elderly or medically fragile and cannot afford or otherwise access treatment for severe dental conditions. Maine's DDS program is part of a national network of similar programs in 42 other states. Collectively these programs helped 7,456 individuals access nearly \$24.6 million in services during the fiscal year.

Goal: Help 134 people with disabilities or who are aged or medically fragile receive \$440,000 worth of comprehensive dental care during the fiscal year, including \$40,000 in laboratory fabrications.

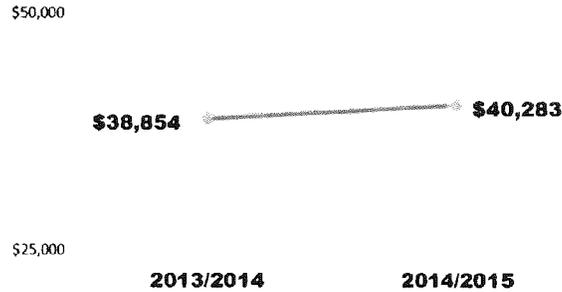
Results: 137 patients received \$428,633 of treatment, including \$40,283 in lab fabrications, exceeding the goal for patients treated and just slightly less than the original estimate for donated treatment. (Nine of these patients received \$17,220 in routine care from volunteer dentists who had donated the patients' initial treatment and wanted to continue donating ongoing, maintenance services.) Each patient treated (with the exception of the nine patients receiving ongoing maintenance services) received an average of \$3,214 worth of dental treatment; comprehensive care that illustrates the generosity of the volunteer dentists and labs.

At the end of the June 30th reporting period, 101 individuals had been referred to volunteer dentists and were receiving care (i.e., active patients). (Some of the patients treated this fiscal year are still undergoing treatment and are included in the 101 active cases.)

As the graphs below indicate, we treated more patients and generated more donated treatment this fiscal year compared to last fiscal year.



Donated Lab Services



Applications

We received 144 applications this fiscal year and at the end of the June 30th reporting period, 157 people were waiting to be referred to a volunteer. The wait list includes people who applied this fiscal year as well as during prior years.

When the waiting list gets too long, the Coordinator spends a significant amount of time processing new applications and responding to people requesting applications; time that instead could be spent referring people to dentists and coordinating services. We continually monitor the waiting list and assess whether and where we can accept applications. Doing so helps the Coordinator process applications more efficiently so she has sufficient time to refer people to the volunteers. Currently, we are unable to accept applications in Franklin, Waldo and York counties.

Volunteers

The volunteers are the backbone of the program, and we are truly grateful to the **177 dentists** and **20 dental laboratories** that participate statewide.

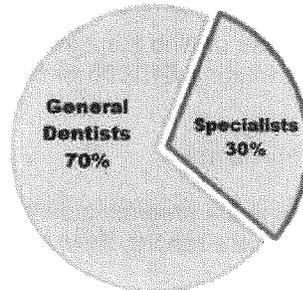
27%
Maine dentists who
volunteer for DDS

12%
National Average

With so many volunteer dentists, one might think that most of the pending applicants could be paired with a volunteer reasonably soon. Unfortunately, that is not the case. Most volunteer dentists treat just one patient per year due to the comprehensive nature of the treatment provided. And, 53 of the volunteers are specialists who may not be called upon every year, leaving 124 general dentists to accept initial referrals.

Complicating the referral process, the geographic distribution of applicants and the pool of available dentists are not always aligned, especially in Maine's rural areas. With 137 patients treated this fiscal year, 101 active cases and 157 individuals on the wait list, more volunteers are needed.

The Chair of the Dental Lifeline Network · Maine Leadership Council delivered presentations at dental society meetings during the year to promote the DDS program and recruit more volunteers. The Maine Board of Dental Examiners now distributes information about the DDS program to dentists when they first become licensed in the state of Maine, and the Maine



Dental Association does the same with new members. During the fiscal year, six volunteers retired and 10 new dentists signed up to volunteer through DDS. We hope to continue recruiting additional volunteers.

Many dental laboratories also volunteer for the Maine DDS program. Along with the 20 labs physically located in Maine, additional out-of-state labs that are part of Dental Lifeline Network's national cadre also volunteer to help. This fiscal year, 16 such labs contributed their services for Maine DDS patients. We truly appreciate the generous efforts of all of our volunteers.

"I am glad this program exists to help people who may not have been helped otherwise. I am glad to be part of it."

- Dr. P. of Windsor, a DDS volunteer since 1999.

Staffing

The Coordinator determines applicant eligibility, links patients with nearby volunteer dentists, monitors patient progress and arranges laboratory services and the help of specialists as necessary. The Coordinator resolves any problems that may interfere with care and ensures all parties have a positive experience.

Ms. Ann Caron manages services part-time from an office in Manchester generously donated by the Maine Dental Association. Last fiscal year, we were able to increase Ms. Caron's hours from 20 hours per week to 24 thanks to funds raised at the Maine Dental Association's "Dancing with the Dentists" fundraiser the year before.

Financial Information

During the fiscal year, volunteers donated \$8.96 in care for every dollar spent supporting contributed services! While the volunteer dentists and many of the dental laboratories donate their services, we must raise funds to support their efforts and pay for the DDS Coordinator, lab reimbursements when we cannot find labs to donate, office supplies and other program expenses.

\$8.96
in care donated for
every \$1 spent

The State Oral Health Program has provided this needed funding that we then leverage into thousands of dollars worth of contributed treatment. Northeast Delta Dental Foundation has provided grants in the past to supplement the state government support for some of the laboratory fabrications when we have needed more lab services than expected.

Future Plans

In the next fiscal year —July 1, 2014 to June 30, 2015— our goal is to help 140 people with disabilities or who are aged or medically fragile receive at least \$443,000 worth of free dental care, including \$43,000 worth of donated laboratory fabrications.

Attachments

Attached is a program summary report as well as a financial report for the fiscal year. Also included are reports showing treatment donated by city and disability.

**Maine Donated Dental Services (DDS) Program
Report of Services**

<u>CATEGORY</u>	<u>1st Qtr. FY15 7/14-9/14</u>	<u>2nd Qtr. FY15 10/14-12/14</u>	<u>3rd Qtr. FY15 1/15-3/15</u>	<u>4th Qtr. FY15 4/15-6/15</u>	<u>FY 2015 Total</u>
<u>PATIENTS</u>					
# of Active Cases	99	106	101	101	101 ¹
# of Referrals	43	49	46	49	167 ²
# Deceased or Otherwise Withdrawn	0	1	1	1	3
# of Patients Treated	39	37	30	51	137 ^{2,3}
<u>APPLICANTS</u>					
# Received	37	24	35	48	144
# Not Eligible	4	9	16	2	31
# of Applications pending (as of 6/30/15)	151	135	135	157	157
<u>VOLUNTEERS</u>					
# of Volunteer Dentists	174	174	176	177	177
# involved with Patients Treated	40	33	31	44	105 ²
# of Volunteer Labs in Maine	22	22	22	20	20
# of Contributing Labs outside of Maine	7	2	5	4	16 ²
# involved with Patients Treated	16	8	9	11	28 ²
<u>FINANCIAL</u>					
Value of Care to Patients Treated	\$98,313	\$120,698	\$69,328	\$140,294	\$428,633 ³
Average Value of Treatment/Case	\$2,522	\$3,288	\$2,311	\$3,118	\$3,214 ⁴
Value of Donated Lab Services ⁵	\$13,808	\$9,674	\$7,641	\$9,160	\$40,283
Value of Paid Lab Services	\$0	\$357	\$1,101	\$79.00	\$1,537
Operating Costs	\$9,538	\$11,878	\$13,136	\$13,264	\$47,816
Ratio: Donated Treatment to Operating Cost	\$10.31	\$10.16	\$5.23	\$10.58	\$8.96

TOTALS SINCE START OF PROJECT (1999)

Total Completed Cases	1,161
Total Value of Completed Treatment	\$3,493,739

1 – Some of the 137 patients treated are still undergoing treatment and are included in the 101 active cases.
2 – Total may be lower than sum of quarterly periods because it reflects an unduplicated count.
3 – Of this amount, 9 patients received \$17,220 in ongoing care from DDS volunteer dentists who provided these patients with initial restorative treatment and have elected to continue providing them with routine and ongoing care.
4 – Does not include treatment for patients receiving ongoing care.
5 – Value also included in Value of Care to Patients Treated.

Treatment by City

7/1/2014 Thru 7/1/2015

For Ann Caron

Printed 7/9/2015

<i>City</i>	<i># of Transactions</i>	<i>Treatment Value</i>
Albion	1	\$3,933.00
Alfred	2	\$7,336.00
Athens	2	\$417.00
Auburn	2	\$5,853.00
Augusta	5	\$8,509.00
Bangor	2	\$1,859.00
Bath	3	\$3,500.00
Belfast	1	\$220.00
Biddeford	3	\$4,800.00
Brewer	1	\$209.00
Bridgton	4	\$22,495.00
Bristol	5	\$6,115.00
Brownfield	1	\$2,930.00
Brunswick	5	\$12,547.00
Bryant Pond	1	\$4,839.50
Burnham	1	\$1,200.00
Calais	1	\$1,650.00
Crawford	1	\$474.00
Damariscotta	2	\$6,667.00
Dover-Foxcroft	1	\$1,640.00
Ellsworth	4	\$9,351.00
Fairfield	3	\$6,105.00
Falmouth	1	\$14,518.00
Farmingdale	1	\$2,908.00
Freeport	1	\$706.00
Gardiner	4	\$8,180.00
Georgetown	2	\$3,275.00
Gorham	1	\$2,610.00
Grand Isle	1	\$7,000.00
Gray	1	\$11,328.00

Treatment by City

7/1/2014 *Thru* 7/1/2015

For Ann Caron

Printed 7/9/2015

<i>City</i>	<i># of Transactions</i>	<i>Treatment Value</i>
Greenbush	1	\$6,279.00
Harrison	1	\$1,150.00
Hebron	1	\$150.00
Hiram	1	\$1,500.00
Hope	1	\$3,449.00
Jackson	2	\$3,839.00
Lee	1	\$3,320.00
Lewiston	5	\$16,307.00
Lisbon Falls	1	\$1,700.00
Litchfield	1	\$2,298.00
Madison	2	\$2,107.79
Millinocket	4	\$8,027.00
Milo	2	\$6,167.00
No. Turner	1	\$178.00
North Berwick	1	\$4,498.00
Norway	2	\$774.00
Oakland	1	\$2,818.00
Old Orchard Beach	1	\$594.92
Patten	1	\$1,240.00
Poland	1	\$3,257.00
Portland	15	\$33,564.00
Presque Isle	2	\$8,779.00
Readfield	2	\$5,100.00
Rockland	5	\$18,039.00
Rockport	1	\$3,100.00
Roque Bluffs	1	\$1,950.00
Sabattus	1	\$2,478.00
Saco	2	\$3,798.00
Sanford	8	\$17,555.00
Sangerville	1	\$495.00

Treatment by City

7/1/2014 Thru 7/1/2015

For Ann Caron

Printed 7/9/2015

<i>City</i>	<i># of Transactions</i>	<i>Treatment Value</i>
So Portland	1	\$75.00
South China	1	\$2,576.00
South Harpswell	1	\$258.00
South Paris	4	\$5,042.00
South Portland	4	\$2,020.00
Springvale	4	\$6,552.00
Standish	3	\$14,475.00
Stockton Springs	1	\$677.00
Stonington	1	\$2,100.00
Topsham	1	\$3,900.00
Waldoboro	1	\$2,006.00
Waterboro	2	\$3,745.00
Waterville	6	\$21,705.61
Westbrook	7	\$17,070.50
Windham	1	\$7,508.00
Winslow	4	\$2,564.00
Winthrop	2	\$964.00
Woolwich	1	\$7,709.25

Summary

Total Patients Treated 137

Total Treatment \$428,633.57

Treatment by Disability 7/1/2014 Thru 7/1/2015

*For Ann Caron
Printed 7/9/2015*

<i>Disability</i>	<i># of Transactions</i>	<i>Treatment Value</i>
Acquired Immune Deficiency	2	\$1,938.00
Blood Disorders	2	\$1,325.00
Brain Damage/Disorders/Disease	6	\$11,298.00
Cancer	16	\$47,063.50
Circulatory Disorders	6	\$15,873.00
Cerebral Palsy	1	\$209.00
Developmental Disorders or Delay	1	\$2,844.00
Diabetes	16	\$34,346.50
Emotionally Disturbed	1	\$1,950.00
Elderly	14	\$45,271.00
Epilepsy or Seizure Disorders	2	\$5,476.00
Hearing Impaired/Deaf	1	\$2,726.00
Heart Disease	15	\$46,464.00
Auto-immune Diseases	5	\$16,628.25
Intestinal Disorders	5	\$14,468.00
Kidney/Renal Diseases	21	\$35,642.00
Liver Diseases	1	\$3,257.00
Mental Retardation	1	\$4,907.00
Muscle Disorders	3	\$8,367.00
Neurological Disorders	7	\$20,295.00
Obesity	1	\$1,150.00
Orthopedic Diseases	29	\$72,561.61
Other Disorders/Disabilities/Diseases	5	\$12,099.79
Respiratory Diseases	8	\$14,226.00
Spinal Cord Injuries	2	\$3,275.00
Serious and Persistent Mental Illness	6	\$4,972.92

Summary

Total Patients Treated 137

Total Treatment \$428,633.57

Page 1 of 1

Dental Lifeline Network
Maine DDS Program
 Budget vs Actual
 For the Twelve Months Ending June 30, 2015

	Actual	Year-to-Date Budget	Variance	Annual Budget
Revenues				
Grants - Government	\$36,483	\$36,483		\$36,483
Grants - Foundations / Assoc	2,413		2,413	
Contributions - Miscellaneous	564		564	
Net Assets - Temporarily Restricted	8,377	11,196	(2,819)	11,196
Sub - Total	47,817	47,659	158	47,659
Donated Treatment Services	388,351	400,000	(11,649)	400,000
Donated Laboratory Services	40,283	40,000	283	40,000
Sub - Total	428,634	440,000	(11,366)	440,000
Total Revenue and Support	476,451	487,659	(11,208)	487,659
Expenses				
Salaries - DDS Coordinators	26,788	24,513	(2,275)	24,513
Payroll Taxes	2,091	2,204	113	2,204
Employee Benefits	2,048	2,872	824	2,872
Auditing	380	300	(80)	300
Insurance - Liability	304	525	221	525
Lab Reimbursements	1,537	2,500	963	2,500
Office - Equipment Purchases	236	200	(36)	200
Office - Supplies	613	850	237	850
Postage	1,110	1,800	690	1,800
Printing & Copying	1,178	1,500	322	1,500
Technical & Administrative	7,351	16,000	8,649	16,000
Telephone	1,610	1,950	340	1,950
Training, Dues & Subscriptions	94	100	6	100
Travel - Staff	2,047	2,000	(47)	2,000
Volunteer Recognition	429	250	(179)	250
Sub - Total	47,816	57,364	9,548	57,364
Donated Treatment Services	388,351	400,000	11,649	400,000
Donated Laboratory Services	40,283	40,000	(283)	40,000
Sub - Total	428,634	440,000	11,366	440,000
Total Expenses	476,450	497,364	20,914	497,364

Dental Lifeline Network
Budget Detail
Maine Donated Dental Services Program

130 Active
6 ongoing
24 hrs/wk

Project Number:	2015 - 2016
1300	Budget

Support and Revenue:

Grants - Government	36,463
Contributions - Miscellaneous	8,847
Sub Total	45,310

Donated Treatment Services	400,000
Donated Laboratory Services	43,000
Sub Total	443,000

Total Support and Revenue **\$ 488,310**

Expenditures:

Salaries	25,006
Payroll Taxes	2,133
Employee Benefits	2,947
Program Support	5,025
Auditing Services	400
Insurance: Liability	425
Lab Reimbursements	1,500
Office: Equipment: Purchases	200
Office: Supplies	850
Postage & Shipping	1,000
Printing & Copying	1,200
Technical & Admin. Support	2,475
Telephone	1,800
Training	100
Travel & Meetings-Staff	
Volunteer Recognition	250
Sub Total	45,310

Donated Treatment Services	400,000
Donated Laboratory Services	43,000
Sub Total	443,000

Total Expenditures **\$ 488,310**

**Fund for Healthy Maine
Donated Dental Services (DDS)
Talking Points**

Hello, my name is Ann Caron. I am the coordinator for the Donated Dental Services (DDS) Program here in Maine.

On behalf of Dental Lifeline Network and the Donated Dental Services (DDS) program, I would like to thank the Maine State Legislature for your continued financial support of our DDS program. I would also like to thank the Maine Dental Association for their incredible support.

1. Year-end numbers. We just handed out the 2014-2015 DLN annual report. As you will see, the DDS program helped 137 people last year receive almost \$429,000 in comprehensive dental treatment that they could not otherwise afford. Patients in our program not only have a financial need, but they are also our most vulnerable neighbors – those living with disabilities or elderly, or medically fragile – meaning that without much-needed dental treatment, they could not be medically cleared for life-saving treatment such as chemotherapy and kidney transplants.

Patients in the DDS program receive extensive treatment; most of the treatment plans take 6-9 months to complete and on average our patients receive \$3,200 in dental care. The care is provided by our network of 177 dentists and 20 labs who volunteer their time and services.

2. Funding/contract. The state government funding contract for 15-16 is \$36,463, Thank you for your continued support! We are again requesting the same amount for the 2016-2017 fiscal year.

The total operating budget for this year is \$45,310, which includes your support and an additional \$8,800 in additional revenues from a dental fundraiser called “Dancing with the Dentists.”

3. How the money is spent. You have a copy of the 2015-16 budget in your handouts. 77% of the funds are used for my salary as the local program coordinator, benefits, training and program support. \$1,500 is allocated for lab reimbursements (when we cannot get these donated),

\$2,500 is for technical and administrative support (payroll, bill paying, etc), and the remaining line items are program-related.

For every dollar received, almost \$9 is generated in donated care.

As the coordinator, it is my job is to make the process easy for volunteer dentists and labs by:

- Screening to determine patients' eligibility, to make sure those most in need are helped.
- Ensure that patients arrive on time for appointments including solving transportation issues.
- Act as the liaison between volunteers and the patients readily available to solve problems, using a customized database system
- Arrange for assistance from specialists and laboratories.

Our volunteer dentists:

- Determine the patient's treatment plans; &
- See patients in their own offices.

Our volunteer labs:

- make corrective dental devices and replacements for natural teeth, such as dentures, partials, etc.
- Can offset direct costs by taking advantage of national material donations from some of the most widely used companies in the industry.

4. **Number served.** From last year to this year, 24 more patients received almost \$53,000 more in donated treatment, and 20 more people applied to the program.

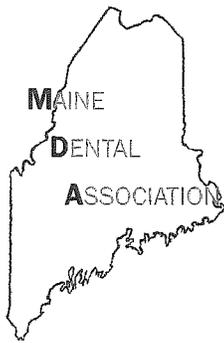
5. **The DDS program transforms the lives of the patients we serve**, like 37-year-old Ms. H. of Woolwich who suffers from multiple autoimmune disorders, including rheumatoid arthritis and cellular dysfunction syndrome. In addition, she has severe gastroparesis and vomits many times a day. Her oral health was terrible and was exacerbating her medical problems. She was missing fillings and other teeth were broken, decayed and infected, making eating difficult. The stomach acid from her frequent vomiting was eroding the enamel on her teeth, making her susceptible to cavities and infection. She must take multiple immunosuppressant medications due to her autoimmune disorders, and the decay and infection from her mouth could harm her overall health.

Ms. H. desperately needed dental treatment to regain her oral health, but sadly, she couldn't afford it. Though she receives food stamps and a Social Security Disability benefit, she wasn't able to pay her monthly bills. And her Medicaid coverage only paid for emergency dental care, not the comprehensive treatment she needed. She had nowhere else to turn.

Thankfully, Ms. H.'s primary care doctor referred her to the DDS program. An oral surgeon who accepted her Medicaid coverage extracted a few teeth, and a generous volunteer dentist restored 12 other teeth and donated four crowns and a night guard which his in-house lab fabricated. **Thanks to this kind dentist, Ms. H. received \$7,709 in free care that restored her oral health!** She wrote to express her appreciation for this life-changing gift, and she said: *"You saved my smile, one I was very proud of once. I am so happy to have that back. I owe you everything."*

to Dental life line and all it may
concern. I want to acknowledge how far
I've come. I feel that there is a program such
as this. I am blessed to qualify, meeting
your criteria, the work you all do is
is wonderful. Recruiting dental profess-
ionals, creating expectations, filtering them,
checking to make the specific goals
if actions are met. Coordinating matches
pressing all this in a timely fashion,
all to help people like me who
otherwise would have no other
resource. I could go on and on
praising the extraordinary work.
This would express all that is
already stated, and known. I
would be most anxious to
dental life in promoting and
advancing in any possible
way that you might find helpful.
Again my gratitude with
a complete and similar
x 1 0 5

Thank you big time!
Sue M



October 8, 2015

Senator Eric Brakey and Representative Drew Gattine
Members of the Joint Standing Committee on Health and Human Services
C/O Legislative Information Office
100 State House Station
Augusta, ME 04333

Re: Fund for a Healthy Maine funding for the School Oral Health Program

Senator Brakey, Representative Gattine and Members of the Joint Standing Committee on Health and Human Services,

The Maine Dental Association supports the use of FHM funding for the Maine CDC's School Oral Health Program and the effort through that program's Dental Sealant Program to bring dental sealants to the children the program serves. We understand that the Sealant Program focuses on second-graders. The schools that receive funding meet community level criteria that assure that children who receive this preventive service at school are those most unlikely to be able to obtain sealants otherwise.

The Fund for a Healthy Maine supports approximately 75 percent of the School Oral Health program, including the Sealant Program. The School Oral Health Program provides education to children – and thus their parents – about fundamental preventive behaviors to help them learn how they can have and maintain good oral health, for example, about daily tooth brushing and the impact of nutrition. The funds go through the offices of school superintendents. They designate a staff person, generally the school nurse, to select a local dental provider to place the sealants.

Sealants are a plastic film painted on the chewing surfaces of the child's molars. The film protects the teeth from decay, and sealants last an average of five to seven years or more.

The Fund for a Healthy Maine funding for the School Oral Health Program is crucial for the work to be done. The Oral Health Program in the Maine CDC tracks the sealant work done and reports the results to the federal Maternal and Child Health Bureau and others.

Sincerely,

Cindy Sullivan
Executive Director, Maine Dental Association

MAINE DENTAL ASSOCIATION

29 Association Drive, PO Box 215, Manchester, Maine 04351

P: 207-622-7900 F: 207-622-6210 Website: www.medental.org



October 5, 2015

Senator Eric Brakey and Representative Drew Gattine
Members of the Joint Standing Committee on Health and Human Services
C/O Legislative Information Office
100 State House Station
Augusta, ME 04333

Re: Dental Lifeline Network

Senator Brakey, Representative Gattine and Members of the Joint Standing Committee on Health and Human Services,

The Maine Dental Association supports the Dental Lifeline Network in its efforts to bring free dental care to many of the elderly and the physically and mentally challenged citizens of Maine. The treatment for many of these patients is required prior to many lifesaving surgeries.

One hundred and seventy seven of our member dentists currently volunteer their services, giving free care to dozens and dozens of needy Mainers each year. The MDA also provides free office space in our building in Manchester for the Dental Life Line coordinator.

The funding for the coordination of these 177 dentists provided by Dental Lifeline is crucial to their work. As the Dental Lifeline Coordinator, Ms. Caron, provides oversight, patient navigation, and dentist coordination, without which some of the patients may not be able to receive needed medical care.

The Dental Lifeline Network tracks all of the work done in Maine, and reports the results to the MDA, the MCDC's Office of Oral Health and the legislature. Attached you will find a copy of last year's annual report.

Sincerely,

Cindy Sullivan

Executive Director, Maine Dental Association

MAINE DENTAL ASSOCIATION

29 Association Drive, PO Box 215, Manchester, Maine 04351

P: 207-622-7900 F: 207-622-6210 Website: www.medental.org