Early Childhood Comprehensive Systems

Asset and Gap Analysis

October 25, 2022

I. Executive Summary

In August 2021, the Maine CDC at the Maine Department of Health and Human Services (DHHS) was awarded a five-year Early Childhood Comprehensive Systems grant from the U.S. Health Resources and Services Administration (HRSA). Maine's Early Childhood Comprehensive Services (ECCS) Health Integration Perinatal-to-Three (P-3) Program will increase statewide access to integrated, effective, culturally appropriate, evidence-based early intervention practices and services during the prenatal to early childhood period.

The first phase of the ECCS Program was to conduct a Systems Asset and Gap Analysis (SAGA) in order to understand the landscape of Maine's early childhood system and existing efforts, address integration of the early childhood system and the health sector and identify gaps in promoting early developmental health and family well-being. The SAGA provides the foundation for the ECCS Strategic Plan – to be completed in early 2023 – and drives a re-assessment of current or future priorities, objectives, and implementation timelines.

The SAGA process was conducted by representatives from the Maine's Children's Cabinet, the Maine DHHS, and Maine Department of Education (DOE). The ECCS Advisory Council – referred to as the Collaborating Partners Advisory Group (CPAG) – provided guidance and input from key perinatal-to-three system stakeholders throughout the SAGA process. In addition to representatives from state-level programs and departments, the CPAG includes parent representatives and representatives from parent-serving organizations as well as health care sector partners.

Based on an audit review of early childhood-related reports and needs assessments, as well as focus groups with parents and family-serving organizations, the ECCS project team identified assets and opportunities in Maine's early childhood system across five goal areas: 1) Infrastructure 2) Advancing a common vision 3) Health system transformation 4) Policy and financing and 5) Equity.

Infrastructure

Leadership: Under the leadership of Governor Janet Mills, Maine's early childhood system has a renewed focus and is a priority for state leadership. Significant investments have been made in leadership capacity over the past three years through the Maine's Children's Cabinet, the Early Intervention Workgroup (EIWG), and the Perinatal System of Care (PSOC) workgroup. Many of the goals and priorities of these state-level initiatives overlap and intersect. **Through the ECCS**

Strategic Plan, Maine will continue to align and integrate programs and services across Maine's early childhood and perinatal system of care in order to develop a comprehensive P-3 system in Maine.

Statewide Data Systems: The need for better early childhood data and improved data systems was identified as a key gap through the SAGA process. Efforts are underway to develop an Early Childhood Integrated Data System (ECIDS) for Maine. An ECIDS will provide state leaders across agencies with information to make informed decisions about programs and policies that promote access, quality, and a strong workforce to support all Maine children ages zero to five. **Key phases of the ECIDS development and implementation process will be reflected in the ECCS Strategic Plan.**

Workforce: Workforce development – specifically challenges to recruiting, hiring, and training a skilled early childhood and perinatal workforce - was a significant theme throughout the SAGA process. Maine has made substantial investments over the past two years to address these challenges including investments in early childhood infrastructure, salary supplements, and training and professional development for early childhood and health sector providers. **The ECCS Strategic Plan will build on these investments in order to recruit, prepare, and retain a strong and diverse P-3 workforce for Maine.**

Advancing a Common Vision

Shared Strategic Plans: Maine has several state-level strategic plans in place which reflect and integrate ECCS priorities and provide an opportunity to improve linkages between Maine's perinatal system (P-1) and early care and intervention services (0-3). The state's ECCS program priorities were developed based on the statewide strategic plans discussed in detail in Section two. of the SAGA. **Maine's ECCS Strategic Plan will build on the goals of these current plans, updating strategies and objectives to reflect findings identified through the SAGA process**.

Advisory Council Structure: The Collaborating Partners Advisory Group (CPAG) was established as a cross-sector advisory council to advance the work of Maine's ECCS program. As noted throughout the SAGA, Maine has numerous initiatives focused on various aspects of the P-3 system. Many of the CPAG members have existing relationships and are supporting aspects of existing P-3 work. The CPAG provides an opportunity to centralize that work, share data and information among the stakeholders, and come to consensus on goals and strategies to address the needs of the P-3 population in Maine. **The CPAG will continue to be engaged in, and contribute to, the development of Maine's ECCS Strategic Plan.**

Strengthening Partnerships: When establishing the CPAG, the ECCS Project Manager conducted a review of key stakeholders in Maine's early childhood system and health sector who are engaged in and/or served by Maine's P-3 system and identified gaps in partner representation.

As a result of this assessment, the CPAG is currently comprised of more representatives from outside of state government than representatives from state agencies, including partners representing children with special health care needs. This assessment is ongoing to continuously identify missing partners and conduct additional outreach and will continue throughout the strategic planning process.

Health System Transformation

Models for Health Integration and Practice Transformation: There are a variety of models of health integration and practice transformation being implemented and piloted in Maine. Initiatives vary in their geographic reach – community-based, county, statewide - and connection to resources. Models highlighted in the SAGA include: the Ages and Stages Questionnaire (ASQ) Online System, coordinating work on substance exposed infants, the Early Childhood Consultation Program, MaineCare reform, and value-based payment initiatives. These models are being developed and implemented by Maine DHHS, the Children's Cabinet, the EIWG, and/or the PSOC Workgroup. **These models are key components of a comprehensive P-3 system for Maine, and strategies to expand and strengthen their reach and impact across the state will be included in the ECCS Strategic Plan.**

Statewide Early Childhood Systems and Health Sector Linkages: Currently, there is no central oversight of the perinatal system (P-1) in Maine and despite overlapping partners with the early intervention system, there is a lack of continuity between the systems. Over the last year, the PSOC Workgroup has brought medical and public health partners together to discuss how to strengthen the system of care and reduce infant mortality rates. Maine was recently awarded multiple maternal health and perinatal grants to begin focusing on this work. Much of the work will be led by Maine's perinatal collaborative (PCQ4ME) with strong collaboration from the Maine CDC. **Maine's ECCS Strategic Plan will build on and strengthen linkages between the state's early childhood system and the health sector, particularly in the areas of perinatal systems of care and early intervention services for children 0-3.**

Coordinated Intake and Referral Systems (CIRS): SAGA parent and family focus groups highlighted parents' struggle to navigate and access early childhood programs and services. Help Me Grow – a national care coordination model – has been identified as a best practice solution and is currently being implemented in Maine. Establishing a "no wrong door" P-3 care coordination model to strengthen and improve linkages across the maternal and early childhood system is one of the key goals of the ECCS program. With a significant investment from the State of Maine, Help Me Grow provides this model**. Maine's ECCS Strategic Plan will include short, intermediate, and long-term strategies related to successful implementation of Help Me Grow.**

Policy and Financing

Policy: Under the leadership of Governor Janet Mills and the Maine's Children's Cabinet, has made significant efforts over the past two years to invest in and change state-level policies to improve, expand, and enhance services for Maine's P-3 population. Many of these policy changes are the direct result of early childhood system strategic planning efforts and reflect recommendations included in the *Children's Cabinet's Plan for Young Children*, the *PDG Strategic Plan*, the Perinatal System of Care Framework, and Maine's ECCS proposal. **Maine's ECCS Strategic Plan will build on these policy changes and include recommendations for additional areas of support.**

Financing: Formal fiscal mapping has not been completed for efforts relevant to ECCS. However, early childhood system leaders at the state level expect project and program managers to conduct long-term sustainability planning for any grant-funded programs. To maximize resources, state-level leaders look for opportunities to braid or blend funding whenever possible. Braided funding – between state and federal dollars as well as across state agencies – has been more successful within early childhood programs. To date, fewer opportunities have been identified in Maine's perinatal of care system. However, as mentioned previously, Maine received multiple grants addressing perinatal systems of care work both at the state level (Maine CDC) and at the organizational level (PQC4ME). **This is an area that could be addressed in the ECCS Strategic Plan.**

Medicaid Partnerships: MaineCare is a partner on this ECCS program and a member of the EIWG which ensures alignment between MaineCare programs and the broader P-3 system. One of the Children's Cabinet's goals is that by 2025, 60% of children on MaineCare will receive developmental screenings by ages 1, 2 and 3. If Maine increased its developmental screening rate to 60%, an additional 4,320 children who receive MaineCare would be screened each year. This would place Maine in the upper quartile of the 26 states who report this measure to CHIP and ensure that more children are ready to learn and thrive. **This goal will be included in the ECCS Strategic Plan.**

Equity

Family Leadership: Parents and family members are a key voice in the leadership of the ECCS. Maine's ECCS program includes a Family Leadership Liaison (FLL) to lead efforts to ensure authentic, diverse, and active engagement of family leaders in Maine's early childhood system. Family leaders from the Maine Parent Federation, Autism Society of Maine, Parent Ambassador Program, Maine Developmental Disabilities Council, the G.E.A.R. Parent Network, Adoptive and Foster Families of Maine, and Starting Strong serve on the CPAG and provide critical input into P-3 programs to improve services for families. The FLL is responsible for developing strategies that ensure continuity of parent involvement, diversity of representation, and authentic participation at multiple levels of leadership throughout the ECCS program. The ECCS program

provides a way to expand leadership opportunities for families to not only provide input and feedback for programs and services, but to more actively participate in the decision-making process. **This is an area for growth and strategies to further enhance family leadership and engagement will be included in the ECCS Strategic Plan.**

State-Community Coordination: State-community coordination typically occurs through programs that are administered by state agencies such as Maine DHHS but implemented through subgrants or contracts at the local or community level. Maine has a relatively small population – 1.3 million people – but a large geographic area – over 35,000 square miles, significantly larger than any of the other five New England states. Implementing state and federal programs in partnership with county and community providers ensures that early childhood initiatives meet the needs of children and families at the local level. Maine's early childhood system leaders continue to find new and creative approaches of working successfully at the community level. **The ECCS Program provides an opportunity to expand these partnerships and where applicable, Maine will include recommendations for strengthening community-level Early Childcare Systems in the ECCS Strategic Plan.**

Equitable Systems: Maine recognizes that work needs to be done to build commitment and capacity in the state's P-3 system to address factors that contribute to the early developmental, family, and maternal health disparities and drive equity progress. The ECCS program provides an opportunity to focus on this work and develop targeted strategies to address health disparities based on geographic region, race, ethnicity, and socioeconomic status. The CPAG brings together stakeholders who are working with underserved P-3 populations and can identify systemic factors that contribute to health disparities and links them to state leaders who can impact policy and practice barriers. The CPAG includes parent and family representatives who are recipients of P-3 services and provide a perspective from lived experience. **Addressing inequities in Maine's P-3 system and improving access to and coordination of P-3 services and programs for underserved populations is priority for Maine's ECCS Strategic Plan.**

I. Introduction

Overview of the needs of the P-3 population in Maine

Approximately million people live in Maine and on average, 12,000 infants are born annually.[1,2] According to US Census population estimates, there are approximately 50,500 children aged 3 years and under in the state.[3] Maine's population is growing at a slower rate than most of the

[1] https://www.census.gov/library/stories/state-by-state/maine-population-change-between-census-decade.html
[2] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics.
[3] US Census, Population Division, Annual Estimates of the Resident Population by Single Year of Age and Sex for Maine: April 1, 2020 to July 1, 2021 (SC-EST2021-SYASEX-23)

U.S.[4] The number of births in Maine has been declining steadily. In 2006, 14,151 babies were born to Maine residents compared to 11,534 in 2020, a 18.5% decrease. [5] While the number of Maine resident births to Maine residents increased by about 4.5% in 2021 (to 12,001) it is unclear whether this trend will continue.[6]

Although Maine's population is predominantly White, it is becoming more racially diverse. The percent of the population that is White alone decreased from 96.7% in the 2010 Census to 90.8% in the 2020 Census.[7] Just under 2% of Maine's population identifies as Black or African American alone, and 1.2% identifies at Asian alone. Close to 5% identifies as more than one race. Approximately 2.5% of Maine residents identify as American Indian alone or in combination with one or more other races.[8] There are four federally recognized Indian tribes in Maine today: the Mi'kmaq, Maliseet, Passamaquoddy, Penobscot nations. These nations are collectively known as the Wabanaki. While American Indian/Alaska Native people live throughout Maine, many Wabanaki people reside on or near tribal lands including those at Indian Island (Penobscot Nation), Sipayik/Pleasant Point (Passamaquoddy tribe), and Motahkokmikuk/Indian Township (Passamaquoddy tribe), as well as in and around the towns of Houlton (Houlton Band of Maliseet) and Presque Isle (Aroostook Band of Micmac Indians).[9]

The diversity of Maine's birthing people has increased over the past 20 years. In 2020, 90.2% of Maine births were to White birthing people; 4.5% were among Black/African American birthing people; 1.7% were to Asian birthing people; 0.7% were to birthing people who identify as American Indian/Alaska Native alone; and 2.2% were to women who identify as more than one race. About 2.2% of births were to birthing people of Hispanic ethnicity. The proportion of Maine resident births to birthing people who identify as Black or African American increased an average of 7.5% per year between 2000 – 2020. [10]

Maine has a growing New Mainer population who may need extra assistance accessing prenatal, postpartum and early childhood, services due unique challenges, including eligibility restrictions related to federal immigration regulations, unfamiliarity with the American health and social service system, and/or language barriers. For the past several decades, an increasing number of individuals and families from East and Central Africa and the Middle East have settled in Maine as primary refugees, secondary migrants, and asylees.[11] In 2020,

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[4] https://www.census.gov/library/stories/state-by-state/maine-population-change-between-census-decade.html
[5] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2006-2020
[6] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2021
[7] US Census Redistricting Data (Public Law 94-171) Summary File. Accessed August 5, 2022: https://www.census.gov/library/stories/state-by-state/maine-population-change-between-census-decade.html
[8] https://www.census.gov/library/stories/state-by-state/maine-population-change-between-census-decade.html
[9] Four Directions Development Corporation. Accessed August 9, 2022: https://fourdirectionsmaine.org/about-four-directions/wabanaki-tribes/
[10] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics
[11] Catholic Charities of Maine Refugee and Immigration Services. Accessed August 5, 2022: https://www.ccmaine.org/refugee-immigration-services/faqs#Fact2

approximately 3.6% of Maine residents were born outside of the US.[12] Between 2000 and 2020, the proportion of Maine resident births that occurred to birthing people born outside of the US nearly doubled. In 2020, 9% of births in Maine were to birthing people who were born outside of the US. In two of Maine's most populous counties, Cumberland and Androscoggin, 17% of births between 2016-2020 were to birthing people born outside of the US.[13]

Most Maine residents reside in rural towns and small cities. The average population density of Maine is 44.2 people per square mile compared to 93.8 people per square mile in the United States.[14] About 62% of births are to birthing people living in a rural area. In four counties (Aroostook, Franklin, Knox, and Washington), 100% of births are to women living in isolated or small rural areas. [15]

About 14% of Maine children live at 100% of the federal poverty level (FPL); 5% live in extreme poverty. Close to two in five (39.7%) African American children and close to one in three (32.8%) Native American children in Maine live in poverty.[16] Almost one-quarter of children (23%) live in households that receive food or cash assistance.[17] About 19% of Maine children are food insecure. In some of Maine's most rural counties, the food insecurity rate among children is about one in four. Maine has the highest child food insecurity rate in New England and the 8th highest in the United States.[18]

Approximately two-thirds of Maine's adult population aged 25 years and older has not obtained a bachelor's degree or equivalent level of education.[19] In 2020, 53.7% of infants born to mothers aged 25 and older did not have a bachelor's degree. Educational attainment among birthing people varies widely by county. In Washington and Somerset Counties, close to three in four birthing people aged 25 and older have not completed college (74.9% and 74%, respectively), while in Cumberland County, only about one-third of birthing people 25 and older have not completed college. [20]

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[12] US Census 2020 American Community Survey 5-year estimates Accessed August 5, 2022: https://data.census.gov/cedsci/profile?g=0400000US23&utm_campaign=20220315mscups1ccstame&utm_medium=email&utm_source=govdelivery

[13] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2016-2020.

[14] U.S. Census, TIGER/Line Shapefiles and Gazetteer Files. Accessed August 5, 2022: https://www.census.gov/quickfacts/ME

[15] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics.

[16] Kids Count Data Center, Anne E. Casey Foundation. Accessed August 5, 2022: https://datacenter.kidscount.org/data/tables/9738-children-in-poverty-by-race-and-ethnicity-5-yr-acs?loc=21&loct=2#detailed/2/any/false/574,1729,37,871,870,573,869/10,172,9,12,1,13,185/19003

[17] Kids Count Data Center, Annie E. Casey Foundation. Accessed August 5, 2022: https://datacenter.kidscount.org/data/tables/8857-children-in-families-that-receive-public-assistance?loc=1&loct=2#detailed/2/21/false/1729,37,871,870,573,869,36,133,35,16/any/17739,17740

[18] Kids Count Data Center, Annie E. Casey Foundation. Accessed August 5, 2022: https://datacenter.kidscount.org/.

[19] US Census, 2020 American Community Survey 5-year estimates. Accessed August 5, 2022: https://data.census.gov/cedsci/profile?g=0400000US23&utm_campaign=20220315mscups1ccstame&utm_medium=email&utm_source=govdelivery

[20] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020.

Maternal health

Several interrelated health challenges are prevalent among Maine residents, including tobacco use, hypertension, and diabetes, are also known risk factors for adverse maternal health and birth outcomes. In 2020, 11.6% of Maine births occurred to a birthing person who smoked cigarettes during pregnancy, compared to 5.5% nationally. [21] There are wide sociodemographic and geographic disparities in smoking during pregnancy in Maine. In 2018-2020, the proportion of birthing people who smoked during pregnancy ranged from 5.2% in Cumberland County to 20% in Piscataquis and Oxford counties.[22] During the same time period, smoking was most prevalent among American Indian/Alaska Native birthing people (27%) and least prevalent among Asian birthing people (1.8%).[23]

Hypertension impacts many Maine women in their primary childbearing years. According to Maine's 2019 Behavior Risk Factor Surveillance System (BRFSS), 11.5% of Maine women aged 25-44 years reported they had ever been told by a healthcare provider that they had hypertension.[24] The rates of both gestational and pre-existing hypertension in among Maine resident births have increased over the past several years. In 2014, 1.5% of births occurred to a Maine birthing person with chronic hypertension, and 4.4% occurred to a birthing person with gestational hypertension. In 2020, 4.8% of resident births were to a birthing person with chronic hypertension, and 9% were to a birthing person with gestational hypertension.[25] Maine's prevalence of hypertensive disorders of pregnancy is higher than that of the US overall. [26]

Severe maternal morbidity (SMM) is a measure of maternal health developed by the US CDC to describe "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health."[27] SMM includes 21 conditions and procedures present at delivery admission or developed during the delivery encounter. In 2016-2020, Maine's SMM rate was 85.4 per 10,000 delivery discharges (54.0 excluding blood transfusions). Maine's SMM rate did not changed substantially between 2016 and 2020. The five most common maternal morbidities in Maine between 2016-2020 were transfusion, acute renal failure, disseminated intravascular coagulation, hysterectomy, and adult respiratory distress

[21] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html on Aug 5, 2022

[22] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics,2019-2020

[23] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics,2018-2020.

[24] Maine Behavior Risk Factor Surveillance System, 2019

[25] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics.

[26] Butwick AJ, Druzin ML, Shaw GM, Guo N. Evaluation of US State–Level Variation in Hypertensive Disorders of Pregnancy. JAMA Netw Open. 2020;3(10):e2018741. doi:10.1001/jamanetworkopen.2020.18741].

[27] US CDC, Severe Maternal Morbidity in the United States. Accessed August 5, 2022: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

syndrome. About 3.6% of 2020 delivery discharges had severe preeclampsia or eclampsia diagnoses.[28]

Preeclampsia is associated with an increased risk of maternal mortality and co-occurring severe maternal morbidities.[29] In 2020, close to 3.6% of Maine resident in-hospital deliveries were to birthing people who received a diagnosis of severe preeclampsia (i.e., chronic hypertension w/ superimposed pre-eclampsia, severe pre-eclampsia, HELLP syndrome, and eclampsia). In 2016-2020, the rate of severe maternal morbidities (excluding transfusion) among Maine resident delivery discharges with a diagnosis of severe preeclampsia was 444.1 per 10,000. Among all Maine resident hospital deliveries in the 2016-2020, the rate was 54.0 per 10,000.[30] Gestational hypertension, chronic hypertension, or eclampsia was present in close to one-third of Maine resident births in which the birthing person was transferred prior to delivery. More than 37% of birthing people admitted to ICU during delivery had gestational hypertension, chronic hypertension, or eclampsia. Over 40% of births to birthing people with gestational or chronic hypertension or eclampsia were delivered via c-section.[31]

Infant health

Between 2016 and 2021, an average of 68 Maine infants under one year old died annually. Maine's infant mortality rate in 2020 was 6.2 deaths per 1,000 live births. Maine death certificate data indicate that the infant mortality rate fell to 5.2 in 2021. In 2020, Maine had the highest infant mortality rate in the New England region.[32] In 2016-2020, infants born to mothers with a high school diploma/GED or less education died at two times the rate of infants born to mothers with at least some college (8.4 deaths per 1,000 births vs 4.2 deaths per 1,000 births, respectively). The mortality rate among infants whose births were covered by Mediciad/MaineCare was 1.5 times higher than those covered by all other payers (7.2 deaths per 1,000 births versus 4.8 deaths per 1,000 births, respectively).[33] Coverage by MaineCare at birth indicates that an infant was born to a birthing person with a lower household income and not an indication of the quality of care provided. The mortality rate among infants born to Maine resident Black/African American birthing people was 7.6 per 1,000 live births (n=21);

[28] Maine Health Data Organization (MHDO), Inpatient Encounters Dataset, 2016-2020

[29] Hitti J, Sienas L, Walker S, Benedetti TJ, Easterling T. Contribution of hypertension to severe maternal morbidity. Am J Obstet Gynecol. 2018;219(4):405.e1-405.e7.

[30] Maine Health Data Organization (MHDO), Inpatient Encounters Dataset, 2020

[31] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2018-2020.

[32] United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current-expanded.html.

[33] Maine linked death and birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2016-2020.

among infants born to American Indian/Alaska Native mothers it was 11 per 1,000 (n=7); and among infants born to white mothers it was 5.7 per 1,000 (n=315). [34]

Prematurity is a leading cause of infant mortality in Maine. Infants born prematurely and/or at a low birthweight are also at increased risk for adverse childhood health outcomes, including developmental delays, mental and behavioral health challenges, vision and hearing impairments, and asthma.[35] In 2021, 8.5% of Maine infants were born preterm.[36] .[37] Maine's prematurity rate is lower than the U.S. rate of 10.1% but has been increasing since 2012. Similarly, the percentage of low birthweight infants born to Maine women has also increased in recent years and is currently about 7.3%.[38] This is lower than the U.S. rate of 8.24%.[39] Maine birthing people insured by MaineCare, Maine's Medicaid program, are more likely to have a low birthweight infant (9.6% vs. 6.2% among those with private insurance).[40] Birthing people who identify as Black or African American are more likely to have a low birthweight infant compared to White birthing people (8.8% vs. 7.2% respectively).[41]

Each year, an average of about 900 infants are reported by a healthcare provider to Maine's Office of Child and Family Services due to substance exposure.[42] While these reports may include exposure to a range of illicit and prescribed substances, including cannabis, prenatal exposure to opioids is more frequent among infants in Maine than elsewhere in the US. In 2019, Maine had the second highest rate of infants born with neonatal abstinence syndrome (NAS) in the United States; Maine's rate was exceeded only by West Virginia.[43] In 2020, 220 Maine resident birth hospitalizations included a diagnosis of NAS, a rate of 20.5 per 1,000 birth hospitalization. The rate of NAS is much higher among birth hospitalizations in which Medicaid/Mainecare was recorded as the primary insurance payer versus those covered by a private insurance payer (45.9 per 1,000 vs. 4.8 per 1,000, respectively).[44]

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[34] Maine linked death and birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2016-2020.

[35] Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. Preterm Birth: Causes, Consequences, and Prevention. Washington (DC): National Academies Press (US); 2007. Accessed August 9, 2022: https://www.ncbi.nlm.nih.gov/books/NBK11356/

[36] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020.

[37] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020.

[38] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020.

[39] US CDC, National Center for Health Statistics, Birthweight and Gestation, Accessed August 9, 2022: https://www.cdc.gov/nchs/fastats/birthweight.htm

[40] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020

[41]Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2018-2020

[42] Kids Count Data Center, Annie E. Casey Foundation. Accessed August 5, 2022: https://datacenter.kidscount.org/data/tables/9828-babies-born-exposed-affected-to-substances#detailed/2/any/false/2048,574,1729,37,871,870,573,869,36,868/any/19127,19128

[43]HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). September 2021. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats; Accessed August 5, 2022

[44] Maine Health Data Organization, Inpatient Encounters Dataset, 2020

Healthcare access

As of August 2022, Maine has 24 birthing hospitals located across the state, most of these are small community hospitals. Maine's two largest hospitals have Level III or higher Neonatal Intensive Care Units (NICUs) with a combined total of 60 level III+ NICU beds.[45] Since 1998, eight hospitals have ceased providing obstetric services, and several hospital mergers have occurred, limiting access to birthing facilities in some of Maine's most rural counties. Annually about 80% of Maine's very low birth weight infant are born in a Level III+ facility. VLBW infants whose mothers live in urban settings are more likely to be born in a Level III+ facility compared to infants whose mothers reside in a rural area.[46]

In 2019, Maine DHHS, with a team from the DHHS Commissioner's Office and the Maine CDC's Office of Rural Health, conducted six Rural Health Listening Sessions in six of Maine's most rural communities, as part of the DHHS Rural Health Transformation Initiative.[47] One of the issues that concerned many rural areas was the number of maternity unit closures at rural hospitals over the last twenty years which has led to families driving longer distances to access maternity care.[48]

Timely and adequate prenatal care plays an important role in identifying maternal health conditions that could contribute to maternal, fetal and infant morbidities and mortality. In 2016-2020, 86.6% of birthing people in Maine received adequate prenatal care. While this is higher than the 2019 national average, rates in Maine vary by race, ethnicity, and maternal place of birth. Birthing people who are White are considerably more likely to receive adequate prenatal care compared to other racial groups in Maine. The greatest disparities are between White women (87.6%) and Native Hawaiian or Other Pacific Islanders (63.6%), Black/African American women (70.0%), women that identify with another race (77.9%) and American Indian/Alaska Native women (79.7%). Women who are of Hispanic/Latinx ethnicity (80.6%) and women born outside of the United States (78.2%) also less likely to receive adequate prenatal care. [49] Based on 2019 Maine data from the Pregnancy Risk Assessment Monitoring System (PRAMS), 91% of Maine women who are White received prenatal care as early as they wanted compared to only 60% of Black/African American women.

Postpartum care also plays a crucial role in insuring birthing parents receive appropriate screening for conditions such as depression and anxiety, as well as on-going care for chronic

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[45] MaineHealth, Accessed August 10, 2022: https://www.mainehealth.org/Services/Prenatal-Care-Childbirth/NICU; Northern Light Health, Accessed August 10, 2022: https://northernlighthealth.org/Services/Pediatric-Care/Neonatal-Intensive-Care-Unit-(NICU)

[46] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics.

[47] Maine Department of Health and Human Services. Listening to Maine's Rural Communities. Accessed August 9, 2020 at https://www.maine.gov/dhhs/documents/RHTT-2019-Listening-Session-Report-021920.pdf

[48] https://www.bostonfed.org/publications/new-england-public-policy-center-regional-briefs/2019/declining-access-to-health-care-in-northern-new-england.aspx. Published April 9, 2019. Accessed March 3, 2020.

[49] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics.

and/or pregnancy associated health conditions. In 2019, 92.7% of new birthing parents in Maine had a postpartum checkup. New birthing parents enrolled in Mainecare were significantly less likely to have received a postpartum checkup (84.3%).[50] Beginning August 1, 2022, birthing parents enrolled in MaineCare will be able to continue receiving care for 12 months postpartum.[51]

About 5% of Maine children 0-5 years of age (approximately 4,000) do not have health insurance; close to 1 in 3 (28.2%) Maine parents report that their child's insurance is inadequate and/or had gaps in coverage in the past year. Children without health insurance and those with inconsistent health insurance are less likely to have had a preventive medical visit in the past year. [52] In Maine, children and pregnant women are eligible for MaineCare if their income is less than or equal to 300% of the Federal Poverty Level (FPL). Maine implemented Medicaid expansion in January 2019. In 2020, 39% of births to Maine residents were paid for by MaineCare. The percentage ranged from 26.2% in Cumberland County to 62.9% in Washington County.[53]

About 91.7% of Maine children saw a health care provider for any medical care in the previous year; 89.1% had at least one preventive medical visit. Parents of close to 4% of children reported that in the past year their child had needed healthcare but not receive it. Of those who did not receive care, 20.8% reported it was because the service was not available in their area and 45% reported it was due to issues related to cost.[54]

Developmental screening and special healthcare needs

Parents of about four in ten Maine 9–35-month-olds (42.3%) report that their child received a parent-completed developmental screening in the past 12 months, which is which is not statistically significantly different from the 36.9% figure seen nationwide. The proportion of Maine children screened increased from 31.6% in 2016 to 42.3% in 2019-2020, though the change was not statistically significant. . [55] Among children with public health insurance, 37.4% received a developmental screening in 2016-2020. The proportion of children screened was slightly higher among those with private health insurance (43.1%), however this difference was not statistically significant. Among those enrolled in MaineCare, the percent of children 0-3 years with a claim for a developmental screening has been steadily increasing. In 2012, about

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[50] Maine Pregnancy Risk Assessment and Monitoring Survey (PRAMS), 2019.

[51] Office of Governor Janet T. Mills (June 16, 2022) "Governor Mills announces extension of MaineCare health coverage for new mothers." Accessed August 9, 2022: https://www.maine.gov/governor/mills/news/governor-mills-announces-extension-mainecare-health-coverage-new-mothers-2022-06-16

[52] NSCH: National Survey of Children's Health (data are from 2019-2020, unless otherwise noted) -- https://www.childhealthdata.org/

[53] Maine birth certificate data, Maine Center for Disease Control and Prevention, Data, Research and Vital Statistics, 2020.

[54] NSCH: National Survey of Children's Health (data are from 2019-2020, unless otherwise noted) -- https://www.childhealthdata.org/

[55] National Survey of Children's Health (data are from 2019-2020, unless otherwise noted) -- https://www.childhealthdata.org/

11% had a claim for a developmental screening compared to 24.6% in 2021.[56] Among those enrolled in Maine Families Home Visiting in FFY21, 83.3% received at least one developmental screening at the appropriate age.[57]

Most Maine children are reported by their parents to be in very good or excellent health (92.1%). This figure is significantly lower among parents of children insured by MaineCare (86%), and of children who have experienced more than two adverse events in childhood (81.4%). About one in four Maine children are reported to have a special health care need (23.6%), significantly more than in the US as a whole (19.4%). The prevalence of special healthcare needs is lower among younger children. Parents of about one in ten Maine children aged 0-5 report their child has a special healthcare need (10.9%), similar to the US as a whole (10.6%). Special healthcare needs are more common among Maine children who have experienced two or more adverse events compared to those who have experience no adverse events (42.1% vs. 14.8%, respectively). Parents of only one in seven children with a special healthcare need report their child receives care from a "well-functioning" system (14.4%). About 5% of Maine children aged 0-5 are currently receiving special services to meet their developmental needs. [58]

Maine's Statewide Early Childhood System and ECCS Goals and Objectives

Led by the Maine Center for Disease Control and Prevention's Maternal and Child Health Program (Maine's Title V agency), Maine's Early Childhood Comprehensive Systems (ECCS) Health Integration Prenatal-to-Three (P-3) program will increase referrals to, and utilization of, P-3 programs and services by making Maine's complex health and early childhood development systems easier for families to more effectively access and navigate.

The ECCS program supports one of the main goals of the Maine Children's Cabinet, to ensure that all Maine children enter Kindergarten prepared to succeed, and outlines strategies that will increase access to affordable early care and education, prevention, and early intervention services for young children and their families. Maine's ECCS program will increase statewide access to integrated, effective, culturally appropriate, evidence-based early intervention practices and services during the prenatal and early childhood period.

Over the last ten years, there have been several initiatives by different organizations and state agencies that promote early developmental health and family well-being for the P-3 system; however, more work needs to be done in Maine to bridge the efforts happening around

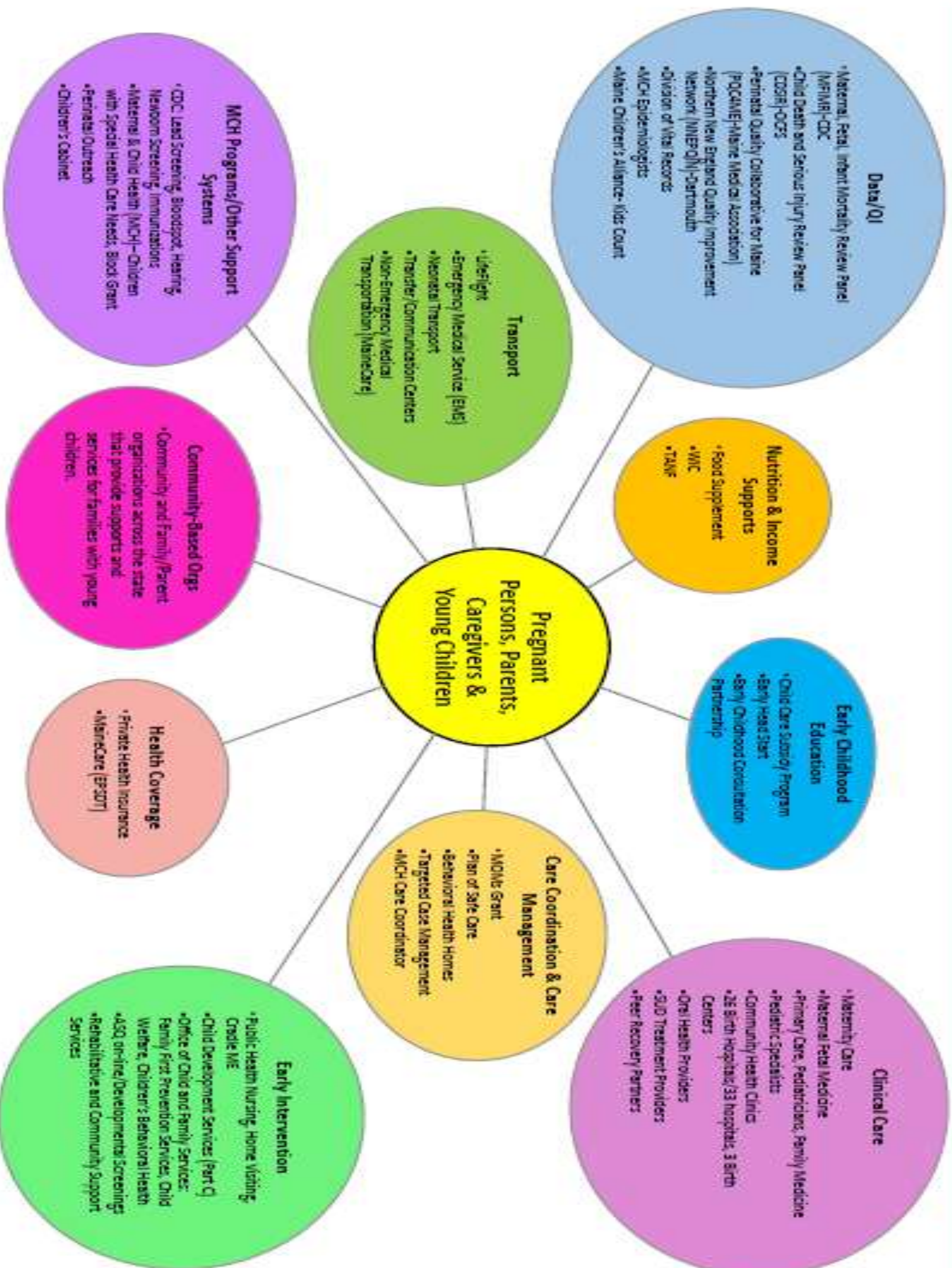
[56] Office of MaineCare Services, Maine Department of Health and Human Services

[57] Electronic Record Information System (ERIN), Maine Families Home Visiting, Maine Center for Disease Control and Prevention.

[58] NSCH: National Survey of Children's Health (data are from 2019-2020, unless otherwise noted) -- https://www.childhealthdata.org/

perinatal systems of care (P-1) and prevention and early intervention services (0-3). Although there are often overlapping stakeholders and service providers between the systems, the work has been siloed as a result of different funding streams for programs, staff capacity and ways that the medical, social service, and public health programs are structured.

Maine's existing P-3 system:



Goals and objectives of Maine's ECCS program:

1. Strengthen the perinatal system of care and integrate programs and services across the maternal and early childhood system.
2. Establish a "no wrong door" P-3 care coordination model for Maine to strengthen and improve linkages across the maternal and early childhood system.
3. Convene state-level education and early childhood leaders and stakeholders to identify resources needed to sustain and advance ECCS priorities and programs.
4. Develop targeted strategies to address health disparities based on geographic region, race, ethnicity, and socioeconomic status.

II. Methods

The System Asset and Gap Analysis (SAGA) process was led by the ECCS Lead (referred to as the Project Manager) in partnership with the Maine Children's Cabinet, the Maine Department of Health and Human Services (DHHS), and the Maine Department of Education (DOE). The ECCS Advisory Council – referred to as the Collaborating Partners Advisory Group (CPAG) – provided guidance and input from key P-3 system stakeholders throughout the SAGA process. In addition to representatives from Maine DHHS programs and departments, the CPAG includes parent representatives and representatives from parent serving organizations as well as health care sector partners.

Although an asset and gap analysis fully inclusive of Maine's ECCS priorities does not currently exist, there are multiple reports produced in the last three years which focus on the state's maternal and child health (MCH) systems that have provided foundation for the ECCS SAGA. The ECCS Project Manager conducted an audit review of these reports and needs assessment and identified existing opportunities and barriers related to the effectiveness and strength of coordination and integration between the early childhood system and the health sector.

Reports include the recent MCH Block Grant Needs Assessment and Five-Year Plan, and the MIECHV Home Visiting Needs Assessment. In 2019, the Maine Department of Education (MDOE) received a Pre-school Development Grant (PDG) that included a needs assessment and a strategic plan that was completed in spring 2020. There was a strong focus in the PDG needs assessment on the early childcare and education system in Maine. In addition, L.D. 1635, *Resolve, To Improve Access to Early and Periodic Screening, Diagnostic and Treatment Services for Children from Birth to 8 Years of Age*, provides information on the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit and programs providing early intervention and developmental screening services in Maine.

DHHS also received technical assistance on its EPSDT benefit from Manatt Consulting and the Center for the Study of Social Policy as part of the Pediatrics Supporting Parents Medicaid-CHIP

State Implementation Workgroup with seven states. There have also been two reports on children's behavioral health, the Children's Behavioral Health System Report by the Public Consulting Group that was completed in 2018, and the OCFS strategic planning document that identified priority areas for short and long-term implementation in 2019.

In 2019, L.D. 1715*, An Act to Reorganize the Provision of Services for Children with Disabilities from Birth to 5 Years of Age,* was also passed and provided an independent review of the state's special education services, birth to five years. In addition, under Maine Quality Counts/ Qualidigm, an Infant Mortality (IM) needs assessment was undertaken in 2019-2020 to study the rise in IM rate in the state between 2013 and 2015. The cause of the higher infant mortality rate was found to be multi-factorial and one result of the project was to create a visual framework of an ideal perinatal system of care.

To identify additional barriers that may not be included or captured by existing statewide needs assessments, the ECCS SAGA process included targeted focus groups with underserved populations and the agencies and organizations working with these populations. Focus groups were conducted with representatives from:

- GEAR Parent Network
- New Mainers (immigrant and refugee families)
- EduCare Central Maine Parent Ambassador Alumni Group
- Adoptive and Foster Families of Maine
- Aroostook County Health Care Providers

Several common themes emerged from these conversations and are reflected throughout the SAGA including:

1. The need for better awareness of and access to perinatal and early childhood services.
2. The need to strengthen family and provider engagement and shared decision making.
3. Care coordination across providers, programs, and services.
4. Helping families navigate the developmental screening and referral process.
5. Workforce challenges (hiring, retention, professional development) that make it difficult for families to access care when and where they need it.
6. Ensuring equitable systems that meet the needs of Maine's vulnerable and underserved populations including children and families living in poverty, families in rural areas, children with special healthcare needs, tribal families, and immigrant and refugee families.
7. The impact of COVID-19. COVID has led to isolation, cancelled, or postponed appointments, staffing challenges, and stress across all systems of care.

These themes, as well as findings from the existing statewide needs assessments, were shared with the CPAG which convenes quarterly to receive progress updates from the ECCS Project

Manager, provides a feedback loop on program activities, identifies additional barriers, and shares best practices. The CPAG identified additional strengths, challenges, opportunities, and threats of Maine's P-3 system. They also reviewed and provided feedback on the findings of the SAGA process.

III. Analysis of Findings

1. Infrastructure Development

a. Capacity of Early Childhood System Leaders

Capacity of Maine's Early Childhood Leadership

Under the leadership of Governor Janet Mills, Maine's Early Childhood System has a renewed focus and is a priority for state leadership with significant investments made in early childhood system leadership capacity at the state level over the past three years through the Maine Children's Cabinet, the Early Intervention Workgroup, and the Perinatal System of Care Workgroup.

Maine Children's Cabinet: The Maine Children's Cabinet is the most visible evidence that early childhood system collaboration and leadership is of central importance at the highest level of state government. In her inaugural address in 2019, Governor Mills announced that she would reinstate the Children's Cabinet after an eight-year hiatus. Through its work, the Children's Cabinet is committed to ensuring that all Maine children enter Kindergarten prepared to succeed. There are three areas of focus for the Children's Cabinet related to young children:

1. Increase access to affordable early care and education and preventive and early intervention services for young children and their families;
2. Raise the quality of Maine's early care and education system and supporting families to access quality programming; and
3. Recruit, prepare, and retain a diverse early childhood workforce.

By statute, Maine's Children's Cabinet members include the Commissioners of the Departments of Health and Human Services, Education, Labor, Public Safety, and Corrections. Currently, Department of Health and Human Services (DHHS) Commissioner Jeanne Lambrew serves as chair of the Children's Cabinet. The Children's Cabinet is coordinated by staff from the Governor's Office of Policy Innovation and the Future (GOPIF) with support from key staff from each participating agency.

The work of the Children's Cabinet has fostered the development and capacity building of early childhood system champions and leaders across state agencies. When developing the goals and strategies for the Children's Cabinet, Commissioners and high-level staff worked to align the

early childhood plan with Maine's PDG Strategic Plan and other plans developed by a variety of staff. This effort has helped to validate and elevate the early childhood programming and policies being implemented by agency staff, supporting these program directors and others to be acknowledged for the key role that they are playing in reaching the goals of the Children's Cabinet and support them to take ownership of this important work as well as make key decisions about how these initiatives will be implemented. The Children's Cabinet provides a framework for early childhood staff to engage Commissioners and provides an opportunity to influence decisions made by those at the top. The greater collaboration between agencies has encouraged directors and managers to take initiative to identify ways that they can work together and strengthen early childhood policy and programming through greater communication and workgroups to implement key early childhood system strategies.

Early Intervention Workgroup: The Children's Cabinet formed a subgroup with state agencies on early preventive and intervention services – the Early Intervention Workgroup (EIWG). The EIWG began meeting in the spring of 2020 and comprises staff from the Maternal and Child Health Division at the Maine CDC, the Office of Child and Family Services, the Early Learning Team at DOE, Child Development Services, Office of MaineCare Services, Office of Family Independence and the DHHS Commissioner's Office.

The EIWG provides an opportunity for staff managing early intervention policies and programs for young children to coordinate and collaborate efforts to better serve families and ensure that young children receive necessary screenings, evaluations, and services to support their healthy development. In 2021, the EIWG identified three initiatives that it will support to meet its goal of integrating and aligning maternal and early childhood programs and services. The team will support efforts to: 1.) implement the ECCS grant, 2.) expand developmental screenings through the implementation of the Ages and Stages Questionnaire (ASQ) online, and 3.) support families to better understand and access existing programs through the implementation of the national Help Me Grow model in Maine.

Perinatal System of Care Workgroup: Led by Maine's Chief Child Health Officer out of the DHHS Commissioner's Office, and comprised of representatives from state agencies, health systems and birth hospitals, Emergency Medical Services for Children (EMS-C), MaineCare, Public Health Nursing, the Perinatal Quality Collaborative for ME (PQC4ME), and the Maine CDC Maternal and Child Health Program, including MCH Epidemiologists, the goal of the Perinatal Systems of Care (PSOC) Workgroup is to develop an overarching, cohesive perinatal system of care in Maine that ensures access, coordination, and quality care across the different systems, including public health, medical care, and social service organizations. The development and testing of a coordinated system has the potential to improve the lives of moms and babies, promote integrated and comprehensive care, and drive down costs for expensive care. Overarching goals for the PSOC work include:

1. Achieve healthy pregnancies and the best possible maternal and birth outcomes in all areas of the state, and across all populations.
    a. Reduce the Infant Mortality Rate to four deaths per 1000 live births over the next five years in Maine.
    b. Reduce Maternal Morbidity and Mortality Rates up to 12 months post-partum.
2. Ensure all mothers and infants receive the right care in the right place at the right time through perinatal regionalization efforts.
    a. Ensure access to perinatal care for all areas of the state, especially rural, so that all women and infants receive timely and high-quality care.
    b. Assure appropriate transport of women and infants.
    c. Measure: % of VLBW babies (<1500g) born at Level 3 or higher hospitals, Goal 90% (Healthy People 2010/2020) (78.8% in 2021)

To support these goals, three subgroups were formed in the fall of 2020 focused on (1) Levels of Care (LOC), (2) referral and transport, and (3) risk assessment tools. To date, Maine's PSOC work has been hospital-based and newborn and maternity provider focused. While not formally connected to the Maine Children's Cabinet, there is overlap in staff who participate on the PSOC Workgroup, the EIWG, and the Children's Cabinet. The PSOC Workgroup identifies and articulates challenges in Maine's MCH system through the perinatal lens and elevates those concerns to the Title V Program and DHHS leadership.

The ECCS program provides an opportunity to bridge together work that is happening on early intervention services for children ages 0-3 and strengthen the PSOC in Maine by better utilizing existing assets, building a more cohesive public-private framework, and using a data driven approach at the state and community level to reduce maternal and infant morbidity and mortality rates as well as ensure that children are getting appropriate health and education screening so that they are ready to succeed in kindergarten.

Diversity, Equity, Inclusion, and Justice in Leadership and Decision-Making at the State Level

In recognition of the need to enhance diversity, equity, inclusion, and justices (DEIJ) at the state level, in 2021 the Maine DHHS published *A Strategic Plan to Advance Diversity, Equity, and Inclusion at the Maine Department of Health and Human Services, 2021-23.* Led by DHHS Commissioner Jeanne Lambrew, the Strategic Plan recognized that while DHHS's 3,000+ workforce mirrors Maine's racial and ethnic demographics, it does not reflect the communities served. Social determinants of health – the conditions in which people are born, grow, age, live, and work – affect health outcomes. All those factors have been shaped by generations of systemic inequity and discrimination, resulting in health disparities for some communities, especially for people that identify as Black, Indigenous, and People of Color, immigrants, refugees and asylum seekers, LGBTQIA+, rural and low income, veterans, and/or persons with

disabilities. The disproportionate impact of these social determinants of health means that some communities are overrepresented in Maine's service population.

Workforce, community engagement, data analysis, and the equitable distribution of State resources are the focus of the DEI Strategic Plan. Over the next three years, DHHS's DEI work will focus on these systemic challenges to advance the department's health equity infrastructure and ensure that DHHS can best partner with health systems and public health leaders statewide to advance health equity. The plan is intended to provide a guide for DEI work at DHHS that is intentionally flexible, understanding that the department will need to continuously engage staff and members of the community in the execution of all strategies. These strategies are discussed in more detail in ***Section 2 – Advancing a Common Vision – Shared Strategic Plans*** and will be reflected in the ECCS Strategic Plan.

Maine DHHS recognizes that to comprehensively address health equity, the staff that develops, designs, and administers services must both reflect a diversity of lived experiences and prioritize professional development that further develops knowledge and skills to provide culturally and linguistically appropriate services. To that end, DHHS leadership has taken several steps such as hiring a Manager of Diversity, Equity and Inclusion (DEI) in December of 2019, creating the Workforce Committee for DEI, and supporting the creation of CORE (Culture of Respect and Empathy). CORE is an introductory training for all staff that introduces concepts necessary for the equitable administration of services and the development of an inclusive culture. The Department has also reestablished the Office of Population Health Equity to guide work at the Maine Center for Disease Control and Prevention (CDC) and further integrate equity into the work of disease surveillance and prevention.

Opportunities for Families to Participate as Leaders

While there are opportunities for families to participate as leaders in Maine's early childhood system, this is an area for growth and a focus of Maine's ECCS program. Representatives from Maine DHHS recognize that they do a good job of getting input from parents about programs and services. For example, in the PDG Needs Assessment, the perspectives of parents were gathered through focus groups, short surveys and interviews geared to particular groups of parents, summaries of existing parent surveys, and targeted interviews with advocates who work with parents of vulnerable children, including children with disabilities, immigrant and refugee populations, and migrants.

Most state-level program advisory groups have at least one parent representative, including the Children's Cabinet Early Childhood Advisory Council. While this is helpful, parents reported in ECCS focus groups that they often feel uncomfortable being the lone parent voice "at the table" and feel that they are being put in a position of speaking for all parents when lived experience

is so varied from family to family. Families also report that they like to get feedback on how their input was used but they feel that does not occur routinely.

To address this concern, the CPAG, which serves as the advisory group to the ECCS program, was deliberately designed to increase parent participation. Of the nearly 40 participants on the CPAG, half are parent representatives or represent parent-serving organizations including the Maine Developmental Disabilities Council, Maine Parent Federation, Autism Society of Maine, Educare Central Maine, Parent Ambassador Program, Maine Children's Alliance, New Mainer's Public Health Initiative, Tribal organizations, G.E.A.R Parent Network, and others. As a result, the CPAG has provided valuable information for the ECCS SAGA and Strategic Plan in areas such as awareness of and access to programs and services, staffing challenges, quality, equity, family engagement, and the impact of COVID-19.

To expand the role of parents beyond that of participant and train parents as leaders, Maine is leveraging the experience of Educare Central Maine's Parent Ambassador Program (PAP). Maine is one of only two states that have established a PAP for parents whose children are participating in Head Start. PAP is year-long leadership program to develop parent leaders who advocate for their children and themselves. The program works to build parents' confidence and involve them in their children's education as well as influence other families by sharing their story. Maine's initial PDG project piloted PAP with three Head-Start grantees and has since expanded to include parents from almost all of Maine's Head Start programs.

In 2022, DHHS contracted with Educare Central Maine to offer PAP trainings to parents outside of Head Start who are engaged in other early childhood system programs – i.e., Child Care, Home Visiting, WIC. Training will include two cohorts of 24 parents each and will occur over a period of ten months with four two-day in-person workshops and monthly phone check-ins. Educare Central Maine will also provide an Intensive Family Engagement training to providers/organizations who want to increase family engagement within their own organization.

The ECCS program provides an opportunity to expand leadership opportunities for families to not only provide input and feedback for programs and services but to more actively participate in the decision-making process and to build out more sustainable infrastructure for parent voices. **This is an area for growth and strategies to further enhance family leadership and engagement will be included in the ECCS Strategic Plan.**

Assessment of ECCS Project Leadership Capacity

The ECCS Project Manager is coordinating the implementation of Maine's ECCS program. The Project Manager works directly with the Maine Children's Cabinet, the ECCS Project Director and the MCH Director. The ECCS Project Manager oversees daily operations associated with the

ECCS grant and serves as a liaison across health and early childhood systems, both public and private, to facilitate improved coordination and delivery of maternal and early childhood services. The Project Manager is housed within the Maine Center for Disease and Prevention's Division of Disease Prevention, Maternal and Child Health Program.

In addition to the ECCS Project Manager, leadership to advance systems innovation and improvement of Maine's maternal and early childhood system of care is provided by the MCH Program Director, MCH Program Manager, Children's Cabinet Coordinator, ECCS Family Leadership Liaison, and DHHS Chief Child Health Officer, in order to strengthen the connection between Maine's perinatal systems of care and the state's early childhood system.

Maine's Title V Program is the ECCS grant recipient and is responsible for the overall management and oversight of the project. The Title V Program is also responsible for making final decisions, in partnership with the Maine's Children's Cabinet, about the work and direction of the ECCS program, including the Early Childhood Strategic Plan and selection of key strategies for advancing Maine's maternal and early childhood systems of care.

b. Existing Structure to Advance Goals

Statewide Data Systems

Integrating data on early childhood is a priority of Maine's Children's Cabinet. The Children's Cabinet is building a data dashboard to track identified performance measures related to the goal that all Maine children enter Kindergarten prepared to succeed. The data dashboard will provide the Children's Cabinet, stakeholders, and the public a more robust picture of childhood data across programs and services for young children.

The need for better data to inform policy was also a central focus of the recommendations of the PDG Strategic Plan in 2020. The PDG grant provided funding for Maine to conduct a pilot study that aimed to integrate data within a specific region to determine an unduplicated count of children participating in early learning programs such as Pre-K, Head Start, Child Development Services, and the Child Care Subsidy program.[59] Funds were also used to perform an inventory of data systems that housed data on young children in Maine. The needs assessment conducted for the PDG grant identified several challenges and needs related to data on young children, which led to renewed recommendations about building an Early Childhood Integrated Data System (ECIDS) for Maine.

In the fall of 2021, the Office of Child and Family Services (OCFS) dedicated federal American Rescue Plan Act (ARPA) funds to hire a full-time coordinator to lead the work of developing an

[59] https://stateofmaine-my.sharepoint.com/personal/katherine_johnston_maine_gov/Documents/Onboarding%20Documents/IMPORTANT/Unduplicated%20child%20count_ReportDeliverable_wDatasharingTemplate.pdf

ECIDS for Maine. The ECIDS coordinator sits within the Governor's Office of Policy Innovation and the Future and works closely with staff in both DHHS and DOE.

In March 2022, Maine launched a readiness assessment process to learn more about the state's data systems related to young children and the level of readiness to integrate across data systems. This process was designed to learn more about the number and type of databases, the extent of current integrations, the roles of the people managing data on young children, the potential benefits from integrating data, and the anticipated challenges.

Over twenty surveys and follow-up interviews were completed with a wide range of individuals working across DHHS, DOE, and contracting organizations. Surveys and interviews will continue while additional databases are identified and as conversations continue with IT and legal staff from across the relevant departments.

The draft *Maine Early Childhood Integrated Data System (ECIDS) Readiness Assessment Report* was completed in September 2022. This readiness report highlights the characteristics and complexity of the early childhood data landscape in Maine. This is the first step in understanding where data on young children live, how data are stored, who works with data, and how an ECIDS could benefit Maine.

The assessment determined that Maine currently has at least 18 formal data systems that collect information on young children.[60] The following databases contain information on children ages 0-5 in Maine. (Note: green indicates DHHS, blue indicates DOE, yellow indicates the database is externally managed.)

Data Systems with Early Childhood Data in Maine

Database Name	Department	Division/Program Name	Category
Automated Client Eligibility System (ACES)	DHHS	Office for Family Independence	Benefit eligibility for SNAP, TANF, and MaineCare
CareFacts	DHHS	CDC – Public Health Nursing	Home Visiting, Cradle ME referrals
Child Information Network Connection (CINC)	DOE	Child Development Services	IDEA Part B and Part C
ChildPlus	Head Start Grantees (11)		Head Start and Early Head Start
Database Application for Vital Events (DAVE)	DHHS	CDC – Division of Research and Vital Statistics	Birth records
ECCP Information System (EIS)	DHHS	Office of Child and Family Services	Early Childhood Consultation Program

[60] *Maine Early Childhood Integrated System (ECIDS) Readiness Assessment Report – Working Paper*, September 2022, Katherine Johnson, Early Childhood Data and Policy Analyst & ECIDS Lead, Governor's Office of Policy Innovation and the Future.

Electronic Record Information Network (ERIN)	DHHS	CDC- Maternal and Child Health contracts with Medical Care Development	Home Visiting
Head Start Enterprise System (HSES)*	DOE	Head Start State Collaboration Office	Head Start and Early Head Start
ImmPact	DHHS	CDC	Immunizations and Lead Screening
Katahdin	DHHS	Office of Child and Family Services	Child Welfare
Maine Automated Child Welfare Information System (MACWIS)	DHHS	Office of Child and Family Services	Child Care Licensing and Subsidy
Maine Integrated Health Management System (MIHMS)	DHHS	Office of MaineCare Services	MaineCare Claims Data
Maine Roads to Quality Professional Registry (MRTQ)	DHHS	Contracted to UMaine	Workforce
NEO (name source unknown)	DOE	Commissioner's Office	Public Pre-K
Quality Rating Improvement System Database (QRIS)	DHHS	Contracted through Maine Roads to Quality at UMaine	Child care quality
Spirit	DHHS	CDC	Women, Infants and Children (WIC)
Statewide Health Information Exchange	External	HealthInfoNet.	Medical data
All Payer Claims Database	External	Maine Health Data Organization	Medical claims

*ChildPlus databases contain detailed, child- and program-level data for Head Start, housed at each grantee. HSES is the aggregate reporting system to the federal government that contains high-level information and can be accessed by state staff.

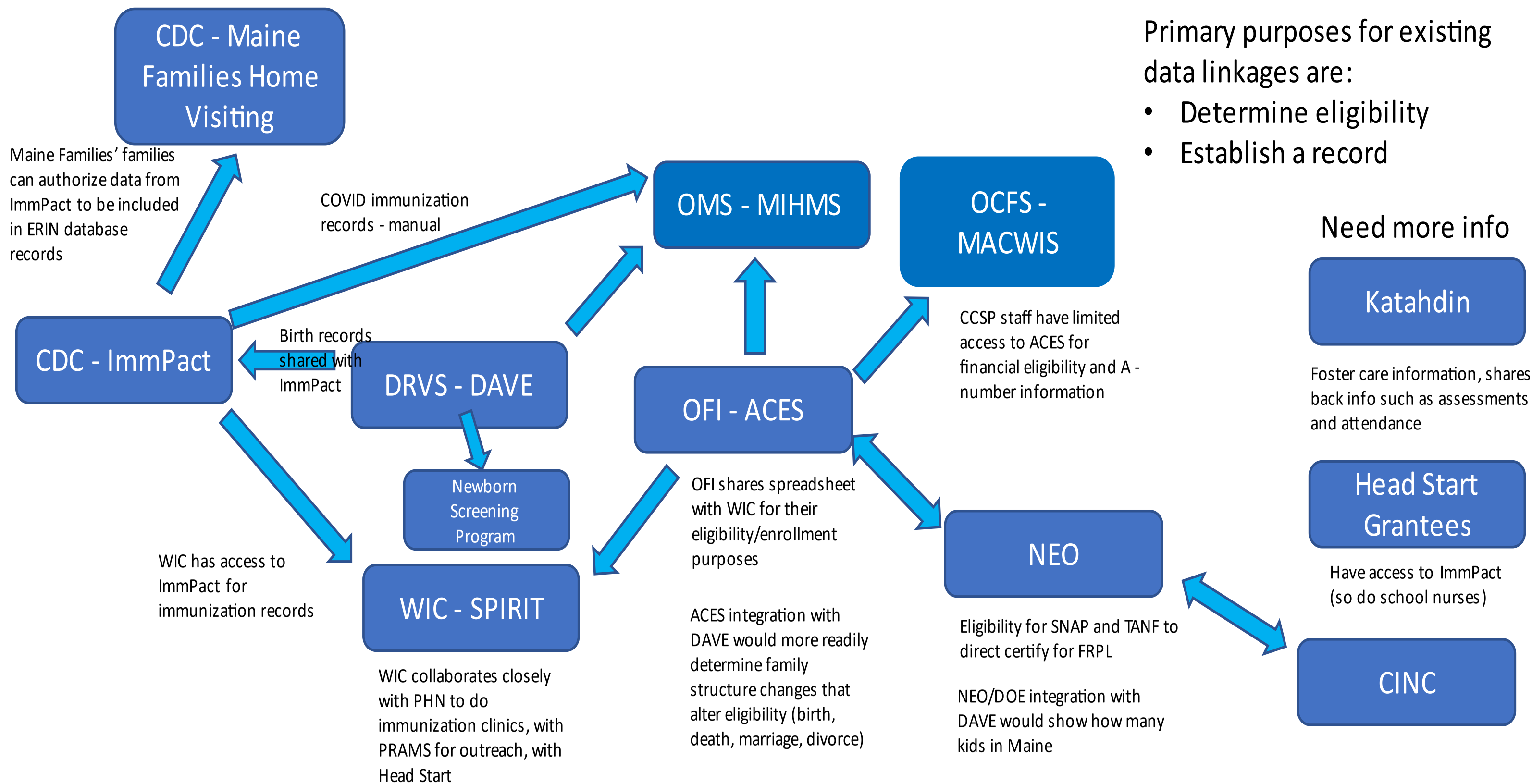
Represented above are two state departments (DHHS and DOE) and numerous divisions and programs within DHHS. Head Start is a unique situation in that the Head Start State Collaboration Office has access to high-level data for federal reporting; however, child-level data are only available in detail through each of the eleven regional Head Start grantees. Several other databases, such as the Maine Roads to Quality Professional Development Network (MRTQ PDN) Professional Registry, are contracted out to vendors from whom the state data teams do not have direct access, but they can request data.

Uses of data, analytic capacity, and database types vary widely across each program. For many, data are primarily used for federal reporting purposes and responding to data requests by internal and external stakeholders (e.g., MACWIS, NEO). A handful of databases are also used for programmatic purposes, such as regular continuous quality improvement initiatives and Federal reports (e.g., CINC, ECCP, ERIN). Others store extensive, dynamic information that gets updated by providers statewide on a live basis (e.g., ImmPact, MIHMS).

There are very few linkages between systems, though some limited data exchanges exist. The following figure is a visual that begins to map some of the linkages between data systems. The arrows below describe that some data sharing is happening across systems, though this is most

often via program managers sharing spreadsheets with each other. In some cases, program managers have logins to other programs' data systems in order to retrieve information to incorporate in their own (e.g., ERIN staff accessing ImmPact with permission). In other cases, there is a formal, automated data sharing process (integration) where data are exchanged through a data bussing system and updated automatically (e.g. MACWIS data with QRIS and MRTQ).

Existing Data Sharing (in progress)



Primary purposes for existing data linkages are:

- Determine eligibility
- Establish a record

Need more info

The most common use of data across all systems was for state and federal reporting purposes, typically on an annual basis. Other uses include data-driven decision making, continuous improvement of programs and services, formal or informal monitoring and evaluation, gain a better understanding of Maine communities, and fulfill data request/requirements. It is important to note that nearly all databases were developed for the purpose of meeting federal reporting requirements, with additional fields added over time.

Building an ECIDS provides state systems with data-driven insights to enhance program quality, inform policy and decision-making, and ultimately improve outcomes for children and families. An ECIDS can help Maine target resources to better serve vulnerable young children and their families by coordinating and aligning services, reducing duplication, and ensuring continuity of services.

The following phases illustrate where the assessment process fits within the overall development of an ECIDS for Maine.

- **Phase I: Assess** - understand current data systems, linkages, where integrated data would be beneficial
- **Phase II: Plan** – gather input on purpose and vision for the system, prioritize policy questions
- **Phase III: Pilot** – pilot data integration projects to inform ECIDS system and function
- **Phase IV: Develop** – build out IT infrastructure, policies, procedures, governance functions; continue to pursue sustainable funding sources
- **Phase V: Implement** – launch an integrated system, beginning with a few databases to answer priority questions. Build out over time.

Development of an ECIDS over the next three years is a priority for Maine's early childhood system and of the Children's Cabinet to ensure that state leaders have the information they need to make strategic investments that produce the best outcomes for Maine's youngest children and their families. These phases will be reflected in the ECCS Strategic Plan. Funding to support the ECIDS is expected to be included in Maine's 2022 PDG B-5 Renewal Grant proposal which is currently under development and will be submitted to U.S. DHHS by November 7, 2022. Maine is also exploring a Master Person Index that could help link Maine's perinatal system with the ECIDS.

Community and State-level Early Childhood System Coordination and Communication Structures

Community and state-level early childhood system coordination and communication tends to occur primarily within individual programs which have state-level oversight with community-level implementation – such as home visiting and Head Start. Systemic coordination and communication structures between state and community-based early childhood system partners have not been formally established.

Improving collaboration, communication, and coordination between and among state and community organizations and partners was a consistent theme in prior P-3 needs assessment and strategic planning discussions. For example, in the PDG needs assessment, conversations about collaboration surfaced the following themes:

- Better **inter-agency communication**, specifically connections among DOE, DHHS, and Department of Labor with a desire for cross-training so that department staff could better understand each other's policies related to vulnerable children and their families
- Strong connections between the **legal system and public health;**
- More deliberate alignment and stronger connections of the early care and education system and **K-12 education**;
- Looping in the **medical community** as a partner with early care and education providers to provide "next steps" information to families with a child who has delays or disabilities;
- **Coordination of information** collected from and provided to family customers—common eligibility requirements, a "one access" or "one stop" approach;
- Reduction of **regulatory burdens** (e.g., background checks) imposed by different agencies on providers by aligning and streamlining requirements;

To address these needs, the *PDG Strategic Plan 2020-2025* includes State and Regional Coordination as one of five goal areas: *Increase and strengthen connections and communication among state agencies and with community partners to expand access to services, create efficiencies, and reduce overlap and redundancies.*

With leadership from the Children's Cabinet, progress has been made towards this goal. For example, Children's Cabinet staff meet regularly to exchange information. The larger cross-agency Early Intervention Workgroup meets monthly to share information across partners and understand referral processes and enrollment in programs. A reference document has been created for staff and providers to understand early childhood programs. Health care providers are included and engaged in the CPAG and will be engaged in Help Me Grow (HMG). HMG staff will conduct outreach to pediatricians and other health care providers to broaden understanding of early intervention programs and referral processes. The Maine Medical Association is supporting the updating and development of materials for ECCS program such as the Care Coordination Module.

Increasing and strengthening connections and communication among state agencies and with community partners will continue to be a key component of building Maine's perinatal-to-three infrastructure.

ECCS Engaged Partners

State-level engagement and governance of Maine's P-3 system is considered a strength of Maine's ECCS program.

Within state-level government, partners engaged in the ECCS program sit within the Governor's Office, DHHS, and DOE. Maine's P-3 system includes programs and initiatives at both DHHS and MDOE.

The Children's Cabinet plays a vital role in convening and facilitating coordination across state agencies on initiatives and policies that improve and promote the healthy development of children and youth in Maine. The Children's Cabinet convenes the Commissioners of the Departments of Health and Human Services, Education, Labor, Public Safety, and Corrections to coordinate and align policies and programs related to children and youth statewide. Staff from each of these agencies sit on workgroups of the Children's Cabinet which meet regularly to share information, coordinate resources, and develop policy solutions to address the needs of families and young children in Maine.

The **Governor's Office of Policy, Innovation, and the Future (GOPIF)** has dedicated resources to lead and support Maine's ECCS program and other early childhood related initiatives. Staffing resources include GOPIF's Senior Policy Analyst and Children's Cabinet Coordinator who also serves on the ECCS Project Team and the GOPIF Early Childhood Data and Policy Analyst who is leading the ECIDS development process.

Maine DHHS includes several offices that focus on maternal and child health and are engaged partners on the ECCS program including the Maine Center for Disease Control (MCDC), Office of Child and Family Services (OCFS), Office of MaineCare Services (Maine's Medicaid program), and the Office of Family Independence (OFI). Representatives from these offices serve on the ECCS CPAG to coordinate partnerships and communications pathways across the various program serve families and children. The CPAG also includes representatives from specific DHHS programs and initiatives that serve families and children including Maine Families Home Visiting, Public Health Nursing, and Help Me Grow. Maine's MCH Program Director and Family Leadership Liaison also serves on the CPAG. Maine's Title V Program, led by the Maine CDC, is the ECCS grant recipient and is responsible for the overall management and oversight of the project.

Staff from the DHHS Commissioner's Office are also actively involved in the ECCS program including the Chief Child Health Officer who is leading efforts to strengthen linkages between Maine's perinatal system of care and the state's early childhood system. Led by the DHHS Commissioner's Office staff, the DHHS Child Health Leadership group was formed and meets monthly to coordinate maternal and early childhood services throughout the Department.

The **MDOE** partners with DHHS on early learning and early intervention programs, including Early Head Start and Head Start, Early Childhood Education, and Child Development Services (CDS). CDS is a quasi-state agency which operates nine regional sites under the supervision of the MDOE. It is the lead state agency for the administration of IDEA Part C (birth through age two) and Part B§619 programs (age 3 to kindergarten-age 5, respectively). A representative of the Part C program serves on the CPAG.

c. Workforce Development

Workforce development – specifically challenges to recruiting, hiring, and training a skilled early childhood workforce - was a significant theme in several of the P-3 system needs assessments and other reports reviewed for this SAGA. Needs identified include:

- There is no centralized source of information about workforce needs, availability, and information about entrants into the profession; however, the pipeline of qualified early childhood educators appears to be slowing. During PDG needs assessment interviews and discussions, representatives from Maine's teacher preparation institutions reported declining interest in early childhood education (ECE) majors.[61]
- Workforce shortages are at the root of many challenges associated with providing high quality early care and education for Maine's vulnerable children and families. Some examples from the PDG needs assessment:
    - Eighty percent of childcare employers reported difficulty hiring staff and 57% reported reducing services because they were not able to fill positions
    - Statewide Head Start programs reported 30% of staff vacancies were still unfilled by the end of the school year; and
    - Child Development Services reported 15% of positions were vacant, resulting in students not receiving services.
    - Shortages are acute in some positions and specialties: mental health providers for the birth to age five population; bilingual staff, early childhood-special needs teachers, and home visitors.
- Maine has a gap in formal licensed childcare for working parents. The number of Maine children under six with all available parents working exceeded the number of licensed childcare slots by 4,920 (9.2%), with a higher gap in Maine's rural areas. The COVID-19 pandemic has exacerbated this problem for families in Maine.
- ECE providers report that they are working with an increasing number of children who have high needs, including multiple adverse childhood experiences (ACES) and delays or disabilities.[62]

[61] *State of Maine Needs Assessment: Vulnerable Children Birth to Age 5 and Their Families.* Prepared by M. Christine Dwyer, PMC Research. October 2019.
[62] Ibid

- The workforce is aging, childcare workers are leaving the field, and the field is not attractive to those seeking new careers.[63]
- Low pay is a primary barrier to recruiting and retaining staff. In 2020, the average hourly wage of a Maine childcare worker was $14.31, one-third less than the state average wage. Many childcare programs are apprehensive to raise fees more because parents already find that paying for childcare is a strain on their budgets.[64]
- There is a lack of local primary care and specialty perinatal providers in rural areas, especially areas that have lost their maternity services.[65]
- Perinatal providers need more training in screening and referrals for services, and on special topics such as trauma-informed care.[66]
- Additional training is needed for primary care and other providers who do not offer perinatal care but who see infants and women of reproductive age.[67]
- Cultural sensitivity and bias training are needed for providers who care for diverse populations. This includes topics related to race/ethnicity, including tribal families, poverty, and rurality.[68]

Efforts in Place to Develop Maine's Early Childhood Workforce

In response to the needs identified above, Maine has made significant investments over the past two years to recruit, prepare, and retain a strong and diverse early childhood workforce. Efforts include:

Child Care Stabilization Grants: The Office of Child and Family Services distributed $22 million in quarterly grants through 2021 and distributed monthly grants to stabilize and support childcare programs facing financial challenges and increased costs as a result of the COVID-19 pandemic. The monthly Child Care Stabilization grants, administered by the OCFS, totaled an additional $73 million investment in the childcare industry and provided monthly grants to over 90% of all licensed childcare programs including a $200 monthly stipend for staff working directly with children. These grants represent significant, historic investments to stabilize and support the childcare industry.

State Funded Child Care Salary Supplements: The Governor included $12 million in state General Funds in her supplemental budget to continue the stipends for early childhood educators working directly with children in licensed childcare programs. State funding for the stipends will start in October 2022. In July 2023, stipends will change from a uniform amount to

[63] Ibid
[64] Ibid
[65] Flaherty, Katherine, ScD, MA (lead author). Qualidigm©. *Understanding and Addressing the Drivers of Infant Mortality in Maine*. January 2020.
[66] Ibid
[67] Ibid
[68] Ibid

a tiered system with increased stipends for educators with greater experience and/or education.

TEACH Program: OCFS allocated $200,000 per year from the Child Care Development Block Grant to fund the TEACH program which provides scholarships to support individuals working in childcare programs to access post-secondary education in early childhood education.

Maine Early Childhood Consultation Partnership (ECCP®): Stakeholders participating in the 2019 PDG Needs Assessment also identified the increased stress of working with children with high needs as a factor in staff retention. In 2021, OCFS continued to implement and expand the Maine Early Childhood Consultation Partnership (ECCP®) program, an infant and early childhood mental health consultation program that addresses the social-emotional needs of children birth to age eight (0-8) by offering support, education, and consultation to the adults who provide education and care for them.

The original legislation provided funding for pilot sites in five counties (Androscoggin, Aroostook, Cumberland, Kennebec, and Penobscot). With additional coronavirus relief funds, OCFS expanded the pilot to eight counties, adding Hancock, Washington, and York, ensuring the program served more childcare programs and children during this challenging time. Eight ECCP® consultants, who work for three behavioral health providers in Maine, are now providing services to licensed childcare centers, licensed family childcare programs, and public pre-K programs in the eight pilot counties. The program will expand to statewide in 2023.

From the start of implementation in early January of 2021 through December 14, 2021, the ECCP® program served 508 children with core classroom services and 32 children with child-specific services. Over 230 childcare provider staff attended trainings in this time period. None of the children who received child-specific services were suspended or expelled from their childcare programs.

Maine Pediatric and Behavioral Health Partnership: Three quarters of patients with mild to moderate behavioral health concerns first present in the primary care setting. One promising strategy to improve access to mental health services for children is to help primary care pediatricians provide more robust mental health care.[69] With funding from HRSA, the Maine CDC established the Maine Pediatric and Behavioral Health Partnership (MPBHP) in partnership with Northern Light Acadia Hospital and MaineHealth, which provide psychiatric consultations and referrals. Since initiating services in March of 2021, 579 primary care providers from 99 practices, half of which are located in rural or underserved areas, have registered with MPBHP. MPBHP has conducted consultations on the care of 406 children, a third of which are for

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[69] Hua, L. L., Alderman, E. M., Chung, R. J., Grubb, L. K., Lee, J., Powers, M. E., ... & Wallace, S. B. (2021). *Collaborative care in the identification and management of psychosis in adolescents and young adults*. Pediatrics, 147(6).

practices serving rural or underserved areas. In addition, MBPHP has provided 227 referrals for mental health treatment resources.

MPBHP also disseminated best practices for children's mental health conditions through 52 monthly web-based training opportunities that come with CEUs, which reached 1,552 providers. MPBHP recently initiated Project ECHO focused on children's mental health. ECHO is a collaborative model of medical education and care management that helps primary care providers provide expert-level care to patients wherever they live. Psychiatrists use video-conferencing technology to train, advise, and support primary care providers.

Next steps include increasing enrollment as well as utilization of the program. Program Coordinators are working through an outreach plan and are trying to re-engage with practices that may have enrolled but have not utilized the program. As initial funding comes to a close this year, Coordinators are also focused on sustainability and opportunities to expand the program statewide and into other areas related to mental health such as adolescents with substance use disorder and maternal mood disorder.

Perinatal System of Care Initiatives: Two goals on the Perinatal System of Care Workgroup relate to workforce development:

1. *Develop perinatal workforce capacity - look at simulation opportunities for delivery rooms, obstetrics emergency training in rural non-birth hospitals for First Responders and Emergency Department staff.*
2. *Provide education around preconception health, chronic disease management during pregnancy, and post-partum health.*

In response to developing the perinatal workforce, DHHS and the Maine CDC Perinatal Nurse Outreach Educator, in partnership with the Maine EMS for Children program, will offer six to eight training opportunities for "Basic Life Support in Obstetrics (BLSO)" in 2022-23 for pre-hospital and emergency department personnel in rural areas. The pilot is being funded by a Maine CDC COVID Disparities grant that has a focus on supporting rural areas. This course, developed by the American Academy of Family Physicians is designed to improve the management of normal deliveries, as well as obstetric emergencies, by standardizing the skills of first responders, emergency department personnel, and maternity care providers. BLSO offers evidence-based, hands-on workshops with mnemonics and case-based discussions that can play an important role in promoting teamwork. Pre-hospital resuscitation, communication in transit, and transition to hospital care can be improved when pre-hospital and hospital providers share a conceptual framework. This course is open to EMS clinicians, RNs, PAs, NPs, MDs, and DOs and there is no cost for attendees. Course fees, text, and certification is included. CEH/CME is being offered for RNs, Advanced Practice Providers, MD/DOs, and EMS clinicians.

To expand education opportunities, the PSOC Workgroup with the Perinatal Quality Collaborative for Maine is currently taking inventory of what education materials are being used in perinatal settings. These include Alliance for Innovation on Maternal Health (AIM) bundle materials, CDC Hear Her Now Materials, Educating Patients on Pre-eclampsia, and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) post-birth materials in a variety of languages.

Maine Roads to Quality Professional Development Network: Continuing education is important for recruiting and retaining entry level staff in the early childhood profession, enabling staff to increase their level of skill, compensation, and job satisfaction. Maine's professional registry system, Maine Roads to Quality Professional Development Network (MRTQ PDN), is a source for professional development opportunities and is designed to help educators track the training they have completed so that continuing education can be recognized and rewarded. MRTQ's Professional Development Network provides onsite support and operates communities of practice for early care and education professionals.
MRTQ PDN has used CRSSA and ARPA funding to strengthen and expanding training opportunities for early childhood providers, educators, and families. CRSSA/ARPA initiatives include:

- *Strengthening Business Practices*: Facilitated training for family childcare and center-based programs. Upon completion of the training, participants receive a laptop and business software. Pilot offering was funded with CRSSA, subsequent offerings funded with ARPA.
- *MRTQ PDN Statewide Apprenticeship Program:* Supports individuals new to the field or those that are early in their career; apprenticeship funded with CRSSA; wage supplements funded by ARPA.
- *On-Demand Parent Engagement Training*: MRTQ PDN will be developing a training on parent engagement; the on-demand format provides practitioners more equitable access to training content; intended as an intro to garner interest in MRTQ PDN's more intensive, facilitated 'Partners in Caring' training; funded with ARPA.
- *Child Care Health Consultant*: Using ARPA funds, MRTQ PDN will hire/contract with a Statewide Child Care Health Consultant; this position will support appropriate and consistent statewide practices through the creation of a statewide network of CCHCs, the provision of resources, informing the development and revision of training, etc.
- *Maine Credential Awards*: Provision of financial awards for Maine practitioner who earn a Maine Credential.
- *Child Care Choices Enhancements*: Enhancements to the Child Care Choices website to improve functionality, ease of use for both providers and families, and collection of data.

- *Designing Early Learning Training*: MRTQ developed and facilitated the initial offering of Designing Early Learning, a facilitated training which covers assessment and curriculum; participants receive funding for the purchase of curriculum or curriculum-related materials upon completion.
- *Maine Early Learning and Development Standards (MELDS) and Infant and Toddler Maine Early Learning and Development Standards (IT MELDS):* Using ARPA funds and in response to demand, MRTQ PDN significantly increased the number of MELDS and IT MELDS offerings for the upcoming academic year.
- *Go NAPSACC*: Using CRRSA and ARPA funds and to support its coordination and implementation, the administration of the Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) initiative was moved to MRTQ PDN.

Efforts to Ensure a Diverse Workforce

While the overall population of Maine is only 5.4% non-White, the population of entering first graders of color is closer to 12% with about one third of those coming from a non-English speaking family.[70] Maine's population has been augmented over the past 40 years with New Mainers--refugees, migrants, and asylees from 30 different countries. Maine has recently been receiving refugees from East Africa and the Middle East-- Somalia, Sudan, Congo, Ethiopia, Burma, Iran and Iraq—adding 150-750 new families annually.[71] The changing demographics have created greater population diversity in Maine's urban areas. The trend means that early childhood and health sector providers need a deeper understanding racial and cultural differences, their own cultural biases and blind spots, and the challenges faced by children and families of color.[72] **Increasing efforts to ensure a diverse workforce that reflects the cultural, linguistic, and lived experience backgrounds of Maine's population is a priority of the ECCS program and an area that will be addressed in detail in the ECCS strategic plan.**

A diverse workforce is a priority for the Maine DHHS, as illustrated by the recently released *Strategic Plan to Advance Diversity, Equity, and Inclusion*. Maine DHHS is committed to hiring a diverse workforce and promoting diversity through talent requirement and pipeline development. The Department is also committed to developing and promoting an inclusive work environment where all employees feel safe and are encouraged to contribute their diverse perspectives.

Other efforts to strengthen Maine's early childhood workforce include:

- MRTQ is working with Early Childhood Education Departments at Maine's Community Colleges and universities to streamline and strengthen articulation agreements with these organizations. MRTQ is coordinating with Eastern Maine Community College and

[70] The Maine Children's Alliance (2019). *Maine Kids Count data book 2019*. Augusta, ME: Author.
[71] Interview with Tarlan Admadov, State Refugee Coordinator for our Office of Maine Refugee Services, 7/2/2019.
[72] Interview with Phillip Berezney Migrant Education Program Director, Mano en Mano, 6/26/2019.

University of Maine at Presque Isle to pilot articulation agreements that will allow students who have completed MRTQ core trainings to count these as core credits towards their degree.

- OCFS will spend the winter and spring of 2023 revamping the salary supplement program for early childhood educators to recognize educators for their education and experience.
- Maine's 2022 PDG B-5 Renewal Grant application will have a strong focus on workforce. For example, partners at DOE and DHHS will look to strengthen career pathways for early childhood educators by expanding early childhood education programming at Maine's Career and Technical Education (CTE) schools to attract young people to enter the field.

2. <u>Advancing a Common Vision</u>

a. Shared Strategic Plans

Maine has several state-level strategic plans in place which reflect and integrate ECCS priorities and provide an opportunity to improve linkages between Maine's perinatal system (P-1) and early care and intervention services (0-3). The state's ECCS program priorities were developed based on the statewide strategic plans discussed below. Maine's ECCS Strategic Plan will build on the goals of these current plans, updating strategies and objectives to reflect findings identified through the SAGA process.

***Children's Cabinet Plan for Young Children*:** The ECCS Strategic Plan will align with state-level early childhood priorities laid out in the *Children's Cabinet Plan for Young Children*. The Plan was developed in the fall of 2019, guided by the findings of the comprehensive needs assessment conducted by the Maine DOE and Maine DHHS as part of the PDG Planning Grant.

The Children's Cabinet is implementing key strategies to promote the healthy development of all young children in Maine and ensure that all children grow up in healthy, safe, and supportive environments. Key areas of focus include 1) increase access to affordable early care and education, preventative and early intervention services for young children and their families 2) raise the quality of our early care and education system and support families to access quality programming 3) recruit, prepare and retain workforce.

Specific strategies currently included in the Children's Cabinet Plan which are directly related to ECCS priorities include:

- Build the infrastructure for an Early Childhood Integrated Data System (ECIDS)
- Support families to navigate Child Find, EPSDT, and CDS to ensure children receive necessary health and intervention services.

- Ensure that substance use screening, treatment, and support for recovery is available for pregnant persons through infancy.
- Ensure no wrong door for families to access services, such as SNAP, MaineCare, and WIC, and establish a centralized entity around developmental screening and care coordination for early intervention services.
- Ensure access to and utilization of high-quality prevention services for young children and their families.

The ECCS Strategic Plan will augment and strengthen the Children's Cabinet Plan by adding a perinatal-to-year 1 focus and strengthen integration with the healthcare system.

Maine Title V Maternal and Child Health Block Grant Needs Assessment and Five-Year State Action Plan: As illustrated below, the ECCS program aligns with and advances several of the priority areas for Maine's MCH populations as identified in the *Maine Title V Maternal and Child Health Block Grant Needs Assessment and Five-Year State Action Plan*.

Maine Maternal and Child Health Priorities 2021-2025

Women	Perinatal	Child	Adolescent	Children with Special Health Needs
Enhance access to high quality physical and mental health care for women	Support healthy pregnancies and healthy babies	Promote children's readiness to learn and succeed	Ensure adolescents' safety and well-being	Improve systems of care for children with special health care needs
Improve care for women's mental health	Reduce infant mortality	Optimize children's physical and oral health	Address adolescent unmet mental health needs	Improve care coordination for children and families with special health care needs
SPM: Percent of women who report that their health care provided asked them about depression in the 12 months prior to pregnancy	NPM 5: Percent of infants placed to sleep on their backs; placed to sleep on a separate approved surface; sleep without soft bedding	NPM 8.1: Percent of children, ages 6-11, who are physically active at least 60 minutes per day; NPM 13.2: Percent of children who had a preventive dental visit	SPM: Percent of high school students who had depressive symptoms in the past year	SPM: Percent of children with special health care needs who receive effective care coordination, among those who need it
Increase women's access to high quality healthcare	Increase breastfeeding initiation and duration	Ensure early detection and intervention for developmental delay	Prevent bullying and its consequences	Support adolescents with CSHN's transition to adult care
NPM 1: Percent of women, ages 18-44, with a preventive medical visit in the past year	NPM 4: (a) Percent of infants who are ever breastfed; (b) Percent of infants breastfed exclusively through 6 months	NPM 6: Percent of children aged 9-35 months who received a developmental screening using a parent-completed screening tool in the past year	NPM 9: Percent of adolescents who are bullied or who bully others	NPM 12: Percent of children without and without a SCN (12-17 yrs) who received services necessary to make transitions to adult health care

NPM: National Performance Measure; SPM: State Performance Measure

In particular, Maine's ECCS program will implement strategies that will support Maine's P-3 system to increase women's access to high quality healthcare, reduce infant mortality, ensure early detection and intervention for developmental delay, and improve care coordination for children and families with special health care needs. The Five-Year State MCH Action Plan includes key strategies, objectives, and outcome measures which will be included in the ECCS Strategic Plan as applicable.

Preschool Development Grant (PDG) Strategic Plan**:** In January 2019, Maine was awarded a $1 million, one-year PDG planning grant. This was an opportunity for Maine to learn more about the birth to 5-year-old mixed delivery system, including early care and education and services supporting Maine's youngest children and their families, with a strong emphasis on vulnerable children and families. The two main objectives were to conduct a statewide needs assessment and develop a strategic plan. The PDG Needs Assessment documented:

- Access challenges experienced by vulnerable families
- Limitations on distribution, capacity, and availability of early care and education services;
- Issues related to the quality of providers;
- Workforce challenges;
- Gaps in serving children with special needs
- Absence of data needed for decision making.

The joint PDG Oversight Committee (members from Maine DHHS and Maine DOE) guided the development of an ambitious strategic plan to address these needs over the next five years. The framework for the strategic plan was derived directly from the concerns and gaps identified in the PDG Needs Assessment. Six work groups, each comprised of agency staff and external members, tackled six major topics derived from the needs assessment priorities. The stakeholders were broadly representative of state agencies, contracted service providers, childcare and preschool directors, child and family advocacy groups, parents, higher education, services for children with special needs, and community organizations.

The PDG Strategic Plan charts a detailed five-year course of action to strengthen Maine's mixed delivery system for early care and education, maximizing the availability of opportunities for vulnerable children and families, while improving quality and taking advantage of coordinated work to reduce inefficiencies. Maine's ECCS program aligns with the goals detailed in the PDG Strategic Plan:

Goal 1 State and Regional Coordination. Increase and strengthen connections and communication among state agencies and with community partners to expand access to services, create efficiencies, and reduce overlap and redundancies.

Goal 2 Workforce Development. Recruit, prepare, and retain a strong and diverse early childhood workforce.

Goal 3 Access to Child Care. Increase availability of affordable childcare and access to family services for vulnerable children.

Goal 4 Quality Improvements. Increase the availability of high-quality early care and education.

Goal 5 Integrated Data Systems. Create an efficient, cross-agency early childhood integrated data system (ECIDS) to inform policy, programming, and evaluation.

The ECCS program will help advance these goals and address many of the needs identified through the PDG needs assessment and strategic planning process.

Understanding and Addressing the Drivers of Infant Mortality in Maine**:** In 2019-20, DHHS focused on strengthening Maine's perinatal system of care with a diverse set of stakeholders. In January 2020, DHHS collaborated with the Maine Quality Counts/Qualidigm to develop an infant mortality (IM) comprehensive assessment that included an extensive review of data with the Maine CDC MCH Epidemiologists and an external consultant who is an expert in MCH and who conducted over 35 key stakeholder interviews in Maine. The goals of this one-year project were to identify the drivers of infant mortality in the state using quantitative and qualitative data and develop recommendations to reduce IM that reflect the populations, cultures, and environments of Maine.

Results from this assessment provide an opportunity to define the components of an ideal perinatal system of care for Maine. Examining the current system, key challenges include fragmentation in the continuum of care, a lack of coordination across components, and barriers to services particularly in rural areas. These findings reveal several opportunities for improvement which include:

- Improved access to primary care for women before and between pregnancies
- More perinatal screenings
- Enhanced mechanisms in place to ensure risk-appropriate care
- Improved access to mental health services
- New models of care for women with substance use disorder
- Strategies to ensure that all families that qualify for programs like Public Health Nursing, Maine Families and WIC enroll in these programs
- New or enhanced strategies to address perinatal labor shortages and access to maternity services in areas where these services have closed such as rural areas
- Increased access to specialists
- Increased provider trainings
- Increased family engagement and education
- Stronger communication and collaboration between primary and specialty care providers who share patients
- Increased number of statewide and regional activities designed to improve the quality of care and outcomes for mothers and infants.

The report also identified a number of assets and strengths to build upon such as: the statewide Perinatal Quality Improvement for Maine (PQC4ME) that includes birth hospitals across the

state; the new Children's Cabinet that brings together all state agencies involved in child-related policy and initiatives; longstanding partnerships between Maine DHHS, Maine CDC and private sector physicians, hospitals and others; and providers of all types across the state who are deeply committed to ensuring that Maine pregnant women, infants and children experience the best possible outcomes.

Recommendations were organized by the strategic areas outlined in the Ideal Comprehensive Perinatal System of Care for Maine framework developed for the report. Strategies include:

1.) Infrastructure to support the strategies and actions for the ideal comprehensive perinatal system of care for Maine
2.) Access to services
3.) Workforce and training
4.) Referrals, coordination and collaboration
5.) Family engagement and education
6.) Policies and programs
7.) Assessment, monitoring and evaluation.

Figure 6. Components of an Ideal Comprehensive Perinatal System of Care in Maine

Goals: *1) Achieve healthy pregnancies & the best possible maternal & birth outcomes in all areas of the state, and across all populations.2) Ensure all mothers and infants receive the right care in the right place at the right time through perinatal regionalization efforts.*

Target populations: *Low-, medium- and high-risk women of reproductive age; prenatal, intrapartum & post-partum women; & infants up to the age of one. Includes vulnerable populations at risk due to clinical, psychological, social, & economic factors.*

Place of birth*: Birth hospitals, birth centers, home.*

Access to Services	Workforce & Training	Referrals, Coordination & Collaboration	Family Engagement & Education	Public Policies & Programs
Local pre- & post-pregnancy well-woman care including: primary care screenings, chronic disease management & reproductive life planning.	**Adequate supply of providers** - OBs, midwives, FMs, PEDs, nurses, SWs & other MH providers.	Maternal & neonatal **referrals & transports mechanisms** in place, as needed, to hospitals **w/higher level of care.**	Referrals & care/services provided involve **shared decision-making between families & providers.**	**Public policies support payment mechanisms** (e.g., MaineCare) to cover **needed perinatal services.**
All recommended screenings completed & addressed including: clinical/genetics & social/behavioral screens (e.g., substance use, mental health, oral health, domestic violence, social determinants of health).	**Availability of medical specialists:** perinatal ultrasound, genetics/ counseling, MFM & neonatology to all areas of the state.	**Mechanisms for referral & F/U** to **community-based services, including Early Intervention,** in place.	Providers who care for perinatal populations provide **families with information and education on priority topics** (e.g., smoking, safe sleep).	**Policies and procedures in place to ensure that eligible perinatal populations participate in public programs/services that promote good birth outcomes** (e.g., Maine Families, PH Nursing, MaineCare, EI, WIC, SNAP, TANF).
Prenatal, intra-partum, post-partum & pediatric care, including all level of risk & trauma-informed care across the different care settings.	**Perinatal providers trained** in all screening & referral activities, and current topics (e.g., trauma-informed care, shared decision-making, telehealth).	**Team-based care; inter-provider communications & collaboration** re: shared patients (w/ patients' consent).	Families across the cultural spectrum are invited to participate in program development and evaluation as **family advisors** in practices.	**Federal, state and other perinatal funding opportunities (e.g., CDC, CMS, HRSA) monitored & pursued** to enhance availability of services.
Mental health (MH) services.	**Interdisciplinary perinatal trainings for SU, MH, DV providers** caring for these populations.	**Statewide & local efforts** established to **collaborate and coordinate perinatal activities** (e.g., QI projects through PQC4ME).		
Substance use (SU) services, including nicotine.	**Training for all providers** caring for diverse families on cultural competency & structural & implicit bias (e.g., race).			
Domestic violence (DV) services.				
Other public and private community-based services such as case management (e.g., PH Nursing, WIC, Maine Families), including services for CYSHCN.				
Telehealth, including care & referrals, as needed.				

Assessment, Monitoring & Evaluation – Includes: 1) **quality assurance processes** to review adverse perinatal outcomes to ID & address causes; 2) **review panels** for maternal, fetal & infant deaths (Maine CDC) & child deaths and serious injury (OCFS), 3) statewide & regional key **perinatal outcome data identified, reported & distributed.**

Maine's perinatal system has several strong assets and is connected through the major health systems and MCH programs, however there is no overarching, cohesive perinatal system of care in Maine. Having a cohesive perinatal system would ensures access, coordination, and quality care across the different systems, including public health, medical care, and social service organizations. The development and testing of a coordinated system have the potential to improve lives of moms and babies, promote integrated and comprehensive care, and drive down costs for expensive care. The Perinatal System of Care Workgroup (PSOC) was formed to lead the state's efforts to develop a comprehensive perinatal system of care for Maine. Current goals of the PSOC workgroup include the following which will be reflected in the ECCS Strategic Plan:

1. Continue to build infrastructure to Strengthen the Perinatal System of Care in Maine
2. Provide hospitals feedback on QI efforts with annual data collected from birth certificates
3. Start implementation of AIM Bundles in Maine as part of ECCS grant
4. Continue to build pathways for maternal transport
5. Gather more information on gaps in the perinatal system around health equity
6. Develop perinatal workforce capacity- look at simulation opportunities for delivery rooms, OB emergency training in rural non-birth hospitals for First Responders, ED staff
7. Provide education around preconception health, chronic disease management during pregnancy, and post-partum health
8. Continue work around improving care for pregnant people with substance use disorders/opioid use disorder and substance exposed infants

Additional details about PSOC Workgroup are provided in ***Section 3. Health Systems Transformation*** below.

b. ***Advisory Council Structure***

ECCS Advisory Council: Maine established a cross-sector advisory council to support the advancement of the ECCS goals. The ECCS Advisory Council – referred to as the Collaborating Partners Advisory Group (CPAG) - is a subcommittee of the EIWG. This structure ensures alignment of the ECCS program with the work of the Children's Cabinet which provides the leadership, financial resources, and policy decisions necessary to build an integrated maternal and early childhood system of care for Maine.

In addition to ECCS staff and representatives from Maine DHHS programs and departments, the CPAG includes parent representatives and representatives from parent serving organizations as well as health care sector partners:

- Maine Parent Federation
- Developmental Disabilities Council
- Autism Society of Maine
- Parent Ambassador Program
- Maine Children's Alliance
- Maine Primary Care Association
- Maine Medical Association/Perinatal Quality Collaborative for Maine
- Midwifery
- Maine Children's Trust
- Early Head Start
- Maine foundations
- Maine Roads to Quality
- Tribal Health Centers
- New Mainer's Public Health Initiative
- Maliseet Tribe
- G.E.A.R Parent Network
- Maine Association of Infant Mental Health
- Adoptive and Foster Families of Maine
- Maine Resilience Network
- Starting Strong
- Mano en Mano

The CPAG engages in and fosters collaboration by providing an opportunity to bring all of the relevant initiatives, providers, and other stakeholders who are addressing the needs of Maine's P-3 population together working towards a common vision. As noted throughout the SAGA, Maine has numerous initiatives focused on various aspects of the P-3 system. Many of the CPAG members have existing relationships and are supporting aspects of existing P-3 work. Several of the programs represented on the CPAG are housed under the MCH umbrella. Those existing relationships will help foster collaboration because these stakeholders know each other and are familiar with each other's work. The CPAG provides an opportunity to centralize that work, share data and information among the stakeholders, and come to consensus on goals and strategies to address the needs of the P-3 population in Maine.

The CPAG membership overlaps with the membership of Children's Cabinet Early Childhood Advisory Council (CCECAC) to ensure coordination between the two advisory groups. The CCECAC serves as the state's federally mandated early childhood advisory council and as an advisory board for the Children's Cabinet on policies and programs related to its goal to ensure that all children enter Kindergarten prepared to succeed. The CCECAC has focused most of its attention and effort on strengthening Maine's early childhood care and education system for children birth through age five. Membership of the CCECAC includes childcare providers, a health care provider, one parent representative, representatives from philanthropy, higher education and the business community and state legislators.

c. Strengthening Partnerships

The ECCS Lead has not conducted a formal network analysis. However, when establishing the CPAG, the ECCS Project Manager conducted a review of key stakeholders in Maine's early childhood system and health sector who are engaged in and/or served by Maine's P-3 system

and identified gaps in ECCS partnerships. As a result of this assessment, the CPAG is currently comprised of more representatives from outside state government than representatives from state agencies. This assessment of partners is ongoing to continuously identify missing partners and conduct additional outreach.

3. Health System Transformation

a. Models for Health Integration and Practice Transformation

There are a variety of models of health integration and practice transformation being implemented and piloted in Maine. Initiatives vary in their geographic reach (community-based, county, statewide) and connection to resources. All of the models highlighted below include a focus on P-3 populations. These models are being developed and implemented by Maine DHHS, the Children's Cabinet, the EIWG, and/or the PSOC Workgroup. As all of these entities are partners in Maine's ECCS program, ensuring connection and consistency with Maine's P-3 goals and priorities.

Models for Health Integration and Practice Transformation

Developmental Systems Integration Project: In 2013, the Developmental System Integration Project (DSI) was launched to bring together partners across early childhood sectors to focus on systems integration to increase developmental screening rates for children ages 0-3 and help them access early invention services sooner. This built on the previous work of the Maine Care CHIPRA grant quality improvement project to improve developmental screening by primary care practices. The goals of DSI were to increase screening rates, reduce duplicate screening, ensure that children who require further evaluation and services receive appropriate and timely follow-up care, and complete the communication loop to make sure that screening and evaluation results are communicated back to both child healthcare providers and referring organizations that work with children and their families. A diverse set of stakeholders participated in the project.

In the first year of DSI, a communication tool was developed so that common language would be used across the medical, educational, and social service agencies to define developmental screening, surveillance, assessment and evaluation. In addition, three care coordination online modules were developed to provide education and a common foundation across sectors to make training more robust.[73] Work was completed around cultural competency and working with families with English as a second language to provide information on developmental

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

milestones and screening. An environmental scan was conducted of other states to identify standardized tools around cultural competency and screening.[74]
As a result of the DSI work, there has been an increase in the rate of developmental screening for children from 1-3% in 2011 (MaineCare baseline data for children ages 1, 2, and 3) to 34-39% in 2020, surpassing the initial target of a 3% increase each year. Despite the success of the DSI work, the funding ended in 2019.

Ages and Stages Questionnaire (ASQ) Online System: Building on the DSI work, Maine DHHS is working with the Children's Cabinet and the EIWG to implement the Ages and Stages Questionnaire Developmental Screening and Social Emotional Screening (ASQ-SE) program, moving from a paper to an online screening program. One reason for the shift to the ASQ online system is that many practices and organizations went to virtual visits with the COVID-19 pandemic. Groups using a paper-based program were having a hard time getting developmental screening done. With the ASQ online, families can fill out the screening on the phone or computer and the provider can review the results. A provider can also do a paper-based form with the family and enter the results online if needed.

ASQ online implementation is being done with a cross-office team at DHHS. The Project Manager developed a project charter and workplan. Materials from other states, including Vermont, Michigan, Kansas, and Utah were also reviewed. The team also had several discussions with the Vermont and Utah teams on implementation. For the ASQ implementation, the structure was identified as having one overarching "Hub" account and five "Enterprise" accounts for different state programs/offices.

A pilot for the ASQ online system started in summer 2022 in order to test the system before rolling it out statewide. Currently, there are six childcare centers, five Public Health Nursing sites, 11 Child Development Services (CDS) sites, one school system for PreK and K, and four Head Starts/Early Head Starts in the pilot. The Help Me Grow ASQ site is also online as the program gets ready to launch this fall. For the pilot, a communication plan was developed and information on the ASQ online was posted on the Help Me Grow website. A provider resource guide was also completed to assist new users of the system. After the pilot is complete, the ASQ online system will expand enrollment to child health care providers, Maine Families Home Visiting, and other interested parties in the fall-winter of 2022.

Coordinating Work on Substance Exposed Infants

Maine's ECCS program aligns with and integrates with work happening in Maine to support pregnant people with substance use disorder (SUD) and substance exposed infants (SEI)

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[74]Maine Quality Counts. Environmental Scan: Multi-Cultural Messaging & Materials on Developmental Screening. http://mainequalitycounts.org/wp-content/uploads/2018/05/4.-2017-Developmental-Screening-Cultural-Materials-Package.pdf. Published 2017. Accessed December 2019.

specifically related to how to improve care coordination for families and caregivers in the P-3 system. The Maine CDC has a Project Manager focused on Infant and Maternal Substance Use Prevention Coordination. OCFS is implementing the Plan of Safe Care (POSC) with birth hospitals and MaineCare has federal funding to support women with Opioid Use Disorder (OUD) called MaineMOM.

Plan of Safe Care: OCFS leads the efforts to implement the POSC to support pregnant people with SUD diagnosis during and after their pregnancy. Maine implemented phase one of PSOC on January 1st. A federally mandated document, the primary goal of a POSC is deliberate attention to ensuring the supported and ongoing safety, well-being and best possible long-term health and developmental outcomes for substance exposed infants, their parents and other caregivers. The POSC is created between a healthcare or social services provider, mother and/or other caregivers, and captures the level of need, referrals and services required to ensure SUD does not impact the family's ability to safely care for their child/ren. The goal of the POSC is to remove barriers to support through conversations rooted in open ended questions, the use of destigmatizing language, and a stance of collaboration. The POSC facilitates meeting the clinical/social needs of the birthing person, their family, the newborn and/or people caring for the infant. At birth, the infant's needs will be integrated into the POSC.

Since January 2021, the goal of OCFS is to create a POSC for every substance exposed infant with a longer-term goal of having universal POSC for every pregnant person in Maine. To date, POSC templates have been created for a variety of providers who work with pregnant person with an SUD diagnosis including case workers, hospital staff, public health nurses, and resource, kinship, foster, and adoptive families. These forms are available at the Maine DHHS website: https://www.maine.gov/dhhs/mecdc/population-health/mch/plan-safe-care.shtml

Maine MOM Grant**:** Maine received $5.3 million in federal funds as one of 10 states selected by the Centers for Medicare and Medicaid Services (CMS) to participate in the Maternal Opioid Misuse (MOM) model, which aims to improve care for pregnant and postpartum people with OUD and their infants by integrating maternal and substance use treatment services. Under the model, Maine is taking steps to create a statewide system of evidence-based and comprehensive care for people with SUD through MaineCare. MaineCare MaineMOM services:

- Offer a team-based approach to care, including a perinatal provider, substance use counselor, patient navigator, nurse care manager, recovery coach, and perinatal provider.
- Provide pregnant and parenting individuals with a treatment plan for counseling, recovery support, and treatment, including medications.
- Provide coordination and a plan for supportive prenatal, delivery, and postpartum care, including family planning.

- Coordinate referrals for other services a person might need during and after pregnancy like health care, housing, or transportation.

Currently Maine has an approved State Plan Amendment from CMS and is working on finalizing the MaineMOM policy. Once finalized, anticipated in early spring 2023, MOM will become a MaineCare service, billable through claims. Currently Maine has key care delivery partners who developed and implemented the model with MaineCare. Once the policy is completed, Maine MOM will be expanded statewide. Currently, MaineMOM has 80 actively enrolled patients, with a three-year total enrollment of 106. The goal is to increase access to high-quality treatment and reduce costs while better coordinating and integrating care.
The Maine MOM Coordinator is currently developing an online training module designed to reduce stigma and bias of words commonly used while caring for pregnant and parent people with substance use disorder that aligns with the Office of MaineCare services Words Matter toolkit.

Early Childhood Consultation Partnership (ECCP®): Detailed in ***Section 1. Infrastructure – Workforce*** above, the Maine Early Childhood Consultation Partnership is an infant and early childhood mental health consultation program that addresses the social-emotional needs of children birth to age eight (0-8) by offering support, education, and consultation to the adults who provide education and care for them. ECCP® provides strategies, support, and training to improve the capacity of early childhood educators as they work with children who have challenging behaviors or social-emotional concerns. ECCP® also incorporates brief consultation to families of children referred for support through the child's early childhood education setting. A statewide cross-agency workgroup which includes staff from OCFS, Child Development Services, Maine Roads to Quality, the Center for Community Inclusion and Disability Studies, DOE and the ECCP model developers meet regularly to support the integration of ECCP® into the continuum of supports for early care and intervention.

Medicaid/CHIP Reform and Value-based Payment Initiatives

Expansion of Health Coverage for Children and Youth: In Spring 2022, Governor Mills' Supplemental Budget for SFY 22 & 23 expanded health coverage for children and youth by:

- Providing funding to expand the Children's Health Insurance Program (Cub Care) to 300% of the federal poverty level to improve health coverage for thousands of Maine children and youth.
- Improving accessibility to the Children's Health Insurance Program by eliminating premiums and waiting periods.
- Providing funding to Maine CDC to expand access to preventive oral health services in Maine schools, including funding for an Oral Health Coordinator position.

Primary Care Plus (PCPlus): On July 1, 2022, MaineCare implemented a new primary care initiative called Primary Care Plus. PCPlus is MaineCare's new value-based approach to support Maine's critical primary care system, improve healthcare quality, and reduce inefficient health care spending. With PCPlus, MaineCare is able to offer primary care practices a single, integrated initiative with greater flexibility and incentives to effectively meet MaineCare members' health care needs. Over 225 primary care practices are participating PCPlus. Participation includes taking accountability for a defined patient population; focusing on coordination and integration of primary and behavioral health care; building bridges to community resources; meeting standards of care for preventive services and screenings; using data to inform patient panel and performance management; and, working collaboratively with families and MaineCare members to improve service delivery. PCPlus will be one of the main ways to connect MaineCare primary care providers to technical assistance, trainings, and other learning opportunities. PCPlus is an example of an Alternative Payment Model (APM) that moves Maine's health care system away from a volume-based (fee-for-service) payment system toward an approach that provides population-based payments tied to cost and quality-related outcomes.

LD 1781, An Act to Align Postpartum MaineCare Coverage with Federal Law: LD 1781 allows the state to extend postpartum coverage for those receiving MaineCare during pregnancy from 60 days to 12 months following the birth of a child. This coverage will remain in place as long as it is allowed by the federal government. Currently this coverage is set to expire on April 1, 2027.

b. Statewide Early Childhood Systems and Health Sector Linkages

Maine's ECCS Program provides an opportunity to build on and strengthen linkages between the state's early childhood system and the health sector. Particularly in the areas of perinatal systems of care and early intervention services for children zero to three. This is done by better utilizing existing assets, building a more cohesive public-private framework, and using a data driven approach at the state and community level to reduce maternal and infant morbidity and mortality rates as well as ensure that children are getting appropriate health and education screening so that they are ready to succeed in kindergarten.

Perinatal System of Care

Currently, there is no central oversight of the perinatal system (P-1) in Maine and despite overlapping partners with the early intervention system, there is a lack of continuity between the systems. Over the two years, Maine DHHS has worked to bring medical and public health partners together to discuss how to strengthen the system of care and reduce infant mortality rates.

Over the last twenty years, quality improvement work on perinatal care has been done by the Maine CDC, hospitals, medical providers, and non-profits. There are several groups and panels that are working to better understand systems' issues related to infant and maternal mortality at the state level. Under the Maine CDC umbrella, the Maternal, Infant, Fetal Mortality Review (MFIMR) Panel was legislatively created in 2005 and meets quarterly. The OCFS oversees the Child Death and Serious Injury Review (CDSIR) Panel which meets monthly and reviews all cases of child deaths in the state where OCFS is involved with the family. The Maine CDC's Perinatal Nurse Outreach Educator provides education and transport conferences to all the birth hospitals with Maternal Fetal Medicine (MFM) physicians and neonatologists. Maine medical center, the only MFM group in the state, has established a strong network of telehealth, virtual, and onsite consultation to the birth hospitals throughout the state. There have also been several obstetric quality improvement projects done in the hospitals, including reducing the number of primary caesarian sections and NICU-based projects with the Vermont Oxford Network.

Perinatal Quality Collaborative for ME (PQC4ME): Between 2013 and 2015, the Maine CDC convened a multi-disciplinary workgroup to focus on high-quality obstetric and newborn care to assure that home birth families are provided full spectrum care in appropriate settings. Building on best practices, the group worked to enhance the choice, access, experience, and safety of pregnant women and newborns. The Continuum of Care Collaborative (CCC) developed a communication tool for the transfer of care that has a potential impact for any transfer of care (home to hospital or community hospital to tertiary care center). In addition, the Maine CDC was part of the National Infant Mortality Collaboration Improvement and Innovation Networks (CoIIN) to reduce infant mortality and led meetings on safe sleep and reducing maternal smoking between 2014 and 2017.

After the CCC and CoIIN were complete, the Perinatal Quality Collaborative for ME (PQC4ME) was developed by several of the CCC leaders and located within Maine Quality Counts in 2018. The PQC4ME developed a state steering committee and encouraged birth hospitals to join the Northern New England Perinatal Quality Improvement Network (NNEPQIN) which is located at Dartmouth. Projects for the PQC4ME include training all the birth hospitals on improving care for substance-exposed infants through the Eat, Sleep, Console project. Concern about the number of unsafe sleep deaths in Maine led DHHS to launch a Safe Sleep Initiative in 2019 that included developing a public education campaign, hosting a website at www.safesleepforME.org, and working with the PQC4ME to ensure that the 26 birth hospitals achieved Bronze Level as part of the Cribs for Kids National Safe Sleep Hospital Certification Program. In addition, the Maine CDC launched a program that allows for hospitals that are safe sleep certified to be reimbursed for sleep kits they distribute. Sleep kits consist of a cribette, sleep sack, and a fitted sheet.

The ECCS program will advance the work of the PQC4ME to improve the state of perinatal health care in Maine. The Maine Medical Association Center for Quality Improvement (MMA-CQI) hosts the PQC4ME. Through the ECCS program, MCH will subcontract with MMA-CQI for the five-year grant period to:

- Assist the state in developing a sustainable perinatal quality improvement program that would support the ECCS system building work and connect health care providers to the MCH Block Grant programs. This will include:
    - Helping to lead quality improvement work developed by The Alliance for Innovation on Maternal Health (AIM) Program
    - Assisting in implementing quality improvement work around Maternal and Neonatal Levels of Care, Risk Assessment, and Maternal Transport
- Update previously developed Care Coordination Modules to ensure that the P-3 system is included and help disseminate work to stakeholders.
- Help design referral pathways between P-3 systems that include health care providers, hospitals, public health, social service agencies, and early intervention services and provide education and training to health care provider to strengthen these systems.

Perinatal Systems of Care Workgroup**:** In 2019, Maine DHHS, with a team from the DHHS Commissioner's Office and the CDC's Office of Rural Health, conducted six Rural Health Listening Sessions.[25] One of the issues that concerned many rural areas was the number of maternity unit closures (seven) at rural hospitals over the last twenty years, which has led to families driving longer distances to access maternity care.[26] As a result of the listening sessions, four priority areas for the Rural Health Transformation initiative were identified: Engaging communities, strengthening statewide infrastructure, supporting regional models for high-needs services, and developing rural care model and payment pilots. One component of the Supporting regional models for high-needs services priority was investigating perinatal regional models of care. At the rural listening sessions, several groups recommended that DHHS look at how Emergency Medical Services (EMS) and the CDC's Office of Rural Health set up the trauma system in Maine as a blueprint for a perinatal system of care.

As part of the work to strengthen the perinatal system of care in Maine, in the spring of 2020, DHHS held two stakeholder meetings to discuss the current perinatal system and issues related to access in rural areas. Representatives included state agencies, health systems, professional associations and foundations. As a result of the stakeholder meetings, a workgroup was established to continue work on strengthening the perinatal system of care. Overarching goals for strengthening the perinatal system of care were outlined:

1. Achieve healthy pregnancies and the best possible maternal & birth outcomes in all areas of the state, and across all populations

    a. Reduce the Infant Mortality Rate to 4 deaths per 1,000 live births over the next five years in Maine
    b. Reduce Maternal Morbidity and Mortality Rates up to 12 months post-partum
2. Ensure all pregnant persons and infants receive the right care in the right place at the right time through perinatal regionalization efforts
    a. Ensure access to perinatal care for all areas of the state, especially rural, so that all pregnant persons and infants receive timely and high-quality care
    b. Assure appropriate transport of pregnant persons and infants
    c. Measure: % of VLBW babies (<1500g) born at Level 3 or higher hospitals, Goal 90% (Healthy People 2010/2020) (Current 83.8% in 2019)

Subgroups were formed around Levels of Care (LOC), referral and transport, and risk assessment tools in the fall of 2020. Pilot initiatives are currently underway in each of these areas:

1. *Levels of Care:* In 2020, Maine DHHS asked all of the hospitals in Maine to complete an assessment from the Federal CDC on maternal and neonatal Levels of Care (LOC) using the LOCATe tool as the state works towards strengthening the perinatal system of care and reducing infant and maternal morbidity and mortality rates. Maternal and neonatal levels of care are ranked across four areas. Maternal levels of care are defined as:
    - *Level 1:* Care of low-to moderate-risk pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal–fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until patient can be transferred to a facility at which specialty maternal care is available.
    - *Level 2:* Level 1 facility plus care of appropriate moderate to high risk antepartum, intrapartum, or postpartum complications.
    - *Level 3:* Level 2 facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions.
    - *Level 4:* Level 3 facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and post-partum care.

    In 2021, DHHS and the MCH Team at the Maine CDC met with each hospital to review their LOCATe tool results and determine the appropriate maternal and newborn LOC. Of Maine's 33 hospitals, nine do not provide birthing services of any kind. Of the remaining 24 Maine hospitals, 16 provide Level 1 care for maternity and neonatal, three provide Level 2 maternity care and level 1 neonatal care, three provide both level 2 maternity and neonatal care, and one hospital provides Level 3 maternity and neonatal care. Only one hospital in Maine, Maine Medical Center located in far southern Maine in Portland, is designated a Level 4 facility.

2. *Referral and Transport and Pre-term Labor Risk Assessment Tool:* The PQC4ME is currently implementing the Risk Assessment and Maternal Transport Pilot Project. The goals of the project are to improve the system of care for pregnant women and their infants in Maine birthing and non-birthing hospitals, and to reduce maternal and infant morbidity and mortality. The objectives of the project are to 1) pilot test and refine a preterm labor algorithm to strengthen risk assessment and 2) pilot test a maternal transport data collection form to identify numbers of women need transport to a facility with a higher level of care and to identify systems issues to address in improving maternal transport. The pilot is funded through a private Maine foundation and the ECCS grant.

   The Pilot Project is currently underway at three Maine hospitals and matched with EMS data from these hospitals through October 2022. Hospital staff will then be interviewed about the usability of the tool, what changes (if any) are needed, and how can the program be expanded to other hospitals around the state. A draft report will be provided to the PSOC Workgroup with discussion of adapting the tools for other health conditions that may require transport to a hospital with a higher level of care.

Early Intervention Services

Early childhood services outside of the health system play a key role in helping families access needed care, provide developmental screening, and/or provide services that promote child development and health. These services include Early Head Start, Maine Families Home Visiting, WIC, Public Health Nursing, Child Development Services (Part C), and the newly funded MaineMOM grant. These programs make every effort to work collaboratively within their community and state infrastructures to provide appropriate services to the target populations. Without exception, each of these programs uses a strengths-based approach to work with their populations. They also recognize the importance of connecting with early intervention and special education systems as natural partners in identifying and addressing concerns for young children. These programs also acknowledge the importance of mental health support and services, particularly in relation to encouraging healthy caregiver and child attachments.

Public Health Nursing (PHN) is a voluntary program offered to pregnant persons, postpartum persons, parents or primary caregivers of children and the pediatric population. The goal of the program is to strengthen the access to local public health services for Maine citizens. These services include: chest feeding education, infant and pediatric growth and development, and postpartum assessments.

Maine Families Home Visiting (MFHV) is a voluntary program available for pregnant people, expectant couples, and parents or primary caregivers of children from birth to age three. Highly trained family visitors work with families to ensure safe home environments, promote healthy growth and development for babies and toddlers, and connect families to needed community

services using the Parents as Teachers (PAT) evidence-based model. Family Visitors provide ongoing and child development monitoring and surveillance to track progress toward developmental milestones and assist in early detection of possible developmental delays, behavioral concerns, and health issues through standardized screenings with parent permission. Regular developmental screenings are conducted using the Ages and Stages Questionnaires-Third Edition (ASQ-3) and the Ages and Stages Questionnaires: Social-Emotional 2 (ASQ-SE 2).

WIC Nutritional Services (WIC) is a voluntary program that provides low-cost healthy foods, nutritional education, breastfeeding promotion, and support and referrals to services to women, infants and children who are at nutrition risk. The program allows people to enroll during pregnancy and for children to remain enrolled up to the age of five. WIC is almost entirely federally funded except for a small amount of state dollars from the Farmers' Market Nutrition Program.

Enrollment in Maine's early intervention programs has been declining over time. This may be due to decreased birth numbers, but data indicates that capacity may exist to enroll a greater percentage of births in these programs. In 2019, about 1,300 children under age 3 were enrolled in Head Start programs in Maine. Between 2010 and 2019, total Head Start enrollment decreased by 15%.[75] Maine's WIC program serves about 18,000 participants in an average month. About 50% of eligible participants are served by Maine's WIC program.[76] Enrollment in Maine's WIC program decreased 16% between FY16 and FY19.[77] MFHV Program serves about 2,000 households each year. In 2018, 8% of all births in Maine were enrolled in MFHV prenatally or postnatally. Between FY16 and FY19, enrollment numbers decreased 12%.[78] Maine's PHN program conducted 3,112 prenatal and postpartum visits during 2019.[79] There is additional work to be done by programs to work with caregivers to convert referrals into enrollment into services. Some of this work will be part of the ECCS grant as part of developing a more coordinated referral system.

2019 Enrollment in Early Childhood Programs			
Head Start (<3)	**MFHV**	**WIC**	**Public Health Nursing**
1,374 children	2,011 households	17,476 participants	3,112 visits

Early childhood programs provide referrals to needed community services to families. Based on data from MFHV, the most frequent referrals provided by home visiting were to smoking

[75] Kids Count Data Center, Annie E. Casey Foundation, https://datacenter.kidscount.org/.
[76] WIC 2017 Eligibility and Coverage Rates, U.S. Department of Agriculture, Food and Nutrition Services. https://www.fns.usda.gov/wic-2017-eligibility-and-coverage-rates
[77] WIC Data Tables. U.S. Department of Agriculture, Food and Nutrition Service. https://www.fns.usda.gov/pd/wic-program
[78] Electronic Record Information System (ERIN), Maine Families Home Visiting, Maine Center for Disease Control and Prevention.
[79] CareFacts, Maine Public Health Nursing Program, Maine Center for Disease Control and Prevention.

cessation programs, WIC, mental health counseling, public health nursing, and heating assistance. The most common services received by home visiting participants were MaineCare, WIC, a visit with a medical provider, receipt of SNAP benefits, mental health counseling, and PHN. Services for basic needs such as SNAP, TANF, housing, and food banks were also commonly accessed by home visiting participants.[80] Maine's MIECHV needs assessment identified barriers to accessing these services such as lack of transportation for non-medical appointments, long waitlists, not enough services/slots for the need, eligibility restrictions, and limited availability of services.

Maine ECCS Program provides an opportunity to increase referrals to and utilization of early intervention services, particularly through the roll out of Maine's new **Help Me Grow** program – detailed below.

c. Coordinated Intake and Referral Systems

CradleME is Maine's primary coordinated intake and referral system for pregnant people and families who have just had a baby. Coordinated by the Maine CDC Public Health Nursing staff, CradleMe services are available statewide and at no cost. CradleME helps connect families with the right home-based or virtual early intervention services. CradleME is a partnership between many programs: Public Health Nursing, Maine Families, WIC, MaineMOM and CDS Early Intervention Program. Pregnant and parenting people can request to have a nurse, family visitor, or program specialist give them a call and learn more about what their services can offer their family. Then, families can choose to set up a time to meet in their home, online virtually, or continue visits via phone.

CradleME's primary focus is prenatal to age one. In the past, CradleME was a referral line – not a program – and primarily referred families to Public Health Nursing and Maine Families Home Visiting. It has expanded to include referrals to MaineMOM, WIC, and CDS. However, parents often need access to additional supports, services for children beyond infancy, and help navigating the early childhood system. Several parents in the SAGA focus groups reported that they had not heard of CradleME or many of the services CradleME refers families to – including Public Health Nursing and home visiting.

Help Me Grow: The 2019 PDG Needs Assessment highlighted parents' struggles to navigate and access early childhood programs and services and identified Help Me Grow (HMG) as a best practice solution. To strengthen Maine's care coordination services, in 2021 the legislature passed and the Governor signed LD 1712 which empowers Maine DHHS to implement HMG, a care coordination model currently used in 28 states that utilizes and builds on existing

[80] Electronic Record Information System (ERIN), Maine Families Home Visiting, Maine Center for Disease Control and Prevention.

resources to develop and enhance a comprehensive approach to early childhood system-building. HMG provides a comprehensive, statewide, coordinated system of early identification, referral, and follow-up for ALL children from prenatal care up to eight years and their families. HMG staff will be trained on care coordination, provide expanded referrals/referrals to early intervention services, conduct developmental screening and provide more robust follow-up than CradleME. Part of the ECCS work is to figure out how these two programs can work together in an efficient manner.

Led by OCFS in partnership with the Children's Cabinet EIWG, implementation of HMG began in the summer of 2022. Once fully implemented, HMG is expected to:

1. Increase the percentage of children screened for developmental, social or emotional issues at all appropriate locations, including, but not limited to, early childhood education facilities, childcare facilities, Head Start facilities, Early Head Start facilities, regional sites of the CDS System, and health care providers to ensure access to early periodic screening, diagnosis and treatment and other related services to promote children's healthy development.
2. Develop a coordinated system of early identification, referral and follow-up services across early childhood education, childcare facilities, home visiting, Head Start, Early Head Start, CDS, health care providers, and family supports;
3. Improve the delivery of services covered by EPSDT required by Medicaid and other related services to promote children's healthy development;
4. Develop a centralized access point for families, caregivers and professionals to obtain information about EPSDT. The centralized access point must be available by telephone, the Internet and other communication platforms;
5. Compile and maintain an electronic directory of resources with respect to service providers and use appropriate methods of communication to assist families and caregivers and connect them with early intervention services, primary care and appropriate EPSDT to children at risk; and,
6. Collect data necessary to align the system with evaluation requirements from the national Help Me Grow Center as well as identify gaps in services by type and region and barriers to obtaining appropriate services.

Establishing a "no wrong door" P-3 care coordination model for Maine to strengthen and improve linkages across the maternal and early childhood system is one of the key goals of Maine's ECCS program. With a significant investment from the State of Maine, Help Me Grow provides this model. Maine ECCS Strategic Plan will include short, intermediate, and long-term strategies related to successful implementation of Help Me Grow.

4. Policy and Financing

a. Policy

Under the leadership of Governor Janet Mills and the Children's Cabinet, Maine has made significant efforts over the past two years to invest in and change state-level policies to improve, expand, and enhance services for Maine's P-3 population. Many of these policy changes are the direct result of early childhood system strategic planning efforts and reflect recommendations included in the *Children's Cabinet's Plan for Young Children*, the *PDG Strategic Plan*, the Perinatal System of Care framework, and Maine's ECCS proposal.

In 2021, Governor Mills signed LD 1712, *An Act to Support Children's Healthy Development and School Success,* which establishes and provides funding for Help Me Grow and the First 4 ME Early Care and Education Program. Help Me Grow, detailed above in Section 3.c., increases access to developmental screenings through the ASQ and treatment services recommended by the American Academy of Pediatrics or its successor organization; and, increases access and referrals to early intervention services for children prenatal up to eight years of age and their families. First 4 ME is a community-based approach to improving access to quality early care and education and is modeled after the successful Early Head Start-Child Care Partnership. First 4 ME will deliver two generation, community driven whole family programing and support services to vulnerable families; provide support to childcare providers to ensure high quality early care and education in center and family childcare settings; and, ensure access to increase social, emotional, physical and education outcomes for children birth to Kindergarten entry.

In Spring 2022, Governor Mills signed a bipartisan supplemental budget and several bills that made the following key investments and policy changes to improve the health and well-being of and opportunities for children, youth and their families:

Initiatives Passed in LD 1995, the Supplemental Budget for SFY 22 & 23

Expansion of health coverage for children and youth:

- Provides funding to expand the Children's Health Insurance Program (Cub Care) to 300% of the federal poverty level to improve health coverage for thousands of Maine children and youth.
- Improves accessibility to the Children's Health Insurance Program by eliminating premiums and waiting periods.

Investments in Child Care Infrastructure:

- Provides $5.2 million in Federal ARPA dollars to increase the Maine Jobs and Recovery Plan initiative to over $15 million support construction and expansion of both family childcare and child care facilities, helping to address geographic gaps and supporting additional sites across Maine.

Investments in Child Welfare:

- Invests over $10 million in child welfare programs and separate funding is provided to strengthen the Office of Maine's Child Welfare Ombudsman:
- $2.8 million ($2.2 million General Fund) investment in staff, including an additional 16 caseworkers and three caseworker supervisors dedicated to night and weekend shifts.
- $3.2 million investment ($2.6 million General Fund) to extend and expand the Homebuilders Program to support families.
- $2 million investment of General Fund dollars to expand family visit coaching from a successful pilot to a statewide program.
- $1 million investment of general fund dollars in the Parents as Teachers Program, allowing it to expand services.
- $822,000 investment to expand access to Kinship Navigators services, to create a Parent Mentor Program, and to create a Child Protective Services' contingency fund.

Initiatives passed through individual bills:

- LD 1747, *An Act to Require Screening for Cytomegalovirus in Certain Newborn Infants*, provides funding to the Maine CDC to establish a cytomegalovirus screening program for newborn infants.
- LD 1781, *An Act to Align Postpartum MaineCare Coverage with Federal Law*, allows the state to extend postpartum coverage for those receiving MaineCare during pregnancy from 60 days to 12 months following the birth of a child. This coverage will remain in place as long as it is allowed by the federal government. Currently this coverage is set to expire on April 1, 2027.
- LD 1537, *An Act to Clarify Health Insurance Coverage for Postpartum Care,* clarifies that private health insurers who provide maternity benefits must include coverage for 12 months of postpartum care that meets the recommendations of the American College of Obstetricians and Gynecologists. This requirement applies to both individual and group contracts issued by insurers and health maintenance in Maine.

These policies are primarily implemented by the Maine DHHS or the Maine DOE who are required to submit annual reports to the Maine Legislature. The Children's Cabinet publishes an annual report that outlines the initiatives for young children and youth that moved forward in the prior year and highlights plans for continued implementation of the Children's Cabinet strategies in the coming year. Details about initiatives supported by the Children's Cabinet and staff from state agencies participating in the Children's Cabinet, including Maine DHHS and Maine DOE, are included in this annual report.

b. Financing

Fiscal Mapping

Formal fiscal mapping has not been completed for efforts relevant to ECCS. However, early childhood system leaders at the state level expect project and program managers to conduct long-term sustainability planning for any grant-funded programs. To maximize resources, state-level leaders look for opportunities to braid or blend funding whenever possible. Braided funding – between state and federal dollars as well as across state agencies – has been more successful within early childhood programs. Examples include:

- ***Head Start***: Maine is one of the first states to supplement federal Head Start dollars with State general fund dollars in order to expand the impact of the program and address the demand for head start programming among low-income families. Maine has eleven Head Start grantees that operate 24 programs, with over 240 classrooms, and three Tribal Head Start grantees that serve three classrooms with a total of 60 children. The federal government provides 80% of the annual cost to operate Head Start programs with the remining 20% coming from matching contributions including State general funds.[81]
- ***Maine Families Home Visiting (MFHV)***: MFHV is Maine's evidence-base home visiting grant funded through HRSA's Maternal, Infant and Early Childhood Home Visiting Grant (MIECHV). Administered by the Maine CDC's MCH program, MFHV leverages State general funds as well as TANF funds to provide home visiting services in all 16 Maine counties.
- ***Early Childhood Consultation Partnership (ECCP®):*** The ECCP® provides an example of a program initially funded with federal dollars which is being sustained and expanded with State dollars. Funding from the federal Child Care and Development Fund supported an initial five site pilot to test the benefit of the ECCP program in Maine. To sustain and expand the program statewide, Governor Mills singed LD 533, *An Act to Expand the Statewide Voluntary Early Childhood Consultation Program* in spring 2022. State general fund dollars will be used to expand the program from 8 to 16 counties in Maine.
- ***Help Me Grow:*** Help Me Grow, Maine's recently funded comprehensive, statewide, care coordinated system for children from prenatal care up to 8 years and their families provides an opportunity for Maine's early childhood system leaders to braid and blend funding across the P-3 system. Administered by the Maine DHHS and incorporating early intervention and referral supports from multiple offices in DHHS as well as Maine DOE, implementing Help Me Grow will help early childhood system leaders understand better what programs are funded and how and where the gaps are in systems, services, and funding.

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[81] *Maine's Head Start and Early Head Start Snapshot Report,* 2021. https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/2021_HS_SnapShot.pdf

- ***Pre-K Partnerships between Schools and Head Start Programs***: Over the last decade, Maine has encouraged schools to partner with local Head Start programs to expand public pre-K programming for 4-year olds. These partnerships look different in each community – some programs are housed within elementary schools with Head Start teachers coming into the school to teach the young children while other programs are housed in Head Start programs with schools providing funding to help pay for staff time and other costs to the program. All of these programs bring together Head Start, state and local funding to provide quality pre-K programming to 4-year olds.

Over the past year, Maine has been awarded $10.6 million to support a number of projects related to addressing risk and health issues related to pregnancy and childbirth, and to improve the State's perinatal system of care:

- $5 million State Maternal Health Innovation grant over five years awarded by HRSA to support the Maine CDC Maternal and Child Health Program in an effort to bring the voices of key stakeholders, including health care providers, community-based organizations, and Maine people together to address risk factors facing birthing people before and during pregnancy and after birth that can cause pregnancy loss and death in pregnant people and infants.
- $1.375 million capacity building grant over five years awarded by the US Centers for Disease Control and Prevention (US CDC) to the Maine Medical Association Center for Quality Improvement at the Maine Medical Association (MMA CQI) in partnership with In Her Presence, the Maine Primary Care Association, and Maine CDC Public Health Nursing. The funding will support the PQC4ME as Maine's center of excellence for perinatal quality improvement initiatives by enhancing its capacity to make measurable improvements in care and health outcomes statewide; expand implementation of the AIM Severe Hypertension in Pregnancy Safety Bundle to all of Maine's birthing hospitals; and advance health equity in the diagnosis and management of hypertension during pregnancy by engaging those experiencing health inequities in evaluating tools and resources used in patient and family education.
- $300,000 over two years from the US CDC ERASE Maternal Mortality (CDC ERASE MM) funding for Maternal Mortality Review Committee Expansion awarded to the MMA CQI to expand Maine's capacity to review maternal deaths as part of the existing Maternal Fetal and Infant Mortality Review Panel (MFIMR) at the Maine CDC.
- $4 million from HRSA over the next four years to MaineHealth to improve access to and continuity of care for pregnant people and new parents in rural Maine with a focus on strengthening the state telehealth infrastructure for rural hospitals who need to access high risk obstetrics consultation through the Rural Maternity and Obstetrics Management Strategies Program (RMOMS). MMA CQI is partnering with MaineHealth

and the RMOMS Network of rural hospitals to improve care during and after pregnancy in rural areas and planning education and training for the management of chronic conditions in pregnancy such as hypertension, obesity, and diabetes.

Alignment with American Rescue Plan Funding

Strengthening Maine's Child Care Subsidy Program: OCFS dedicated federal funding from regular Child Care and Development Block Grant funds, the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act to increase access to affordable childcare by strengthening the Child Care Subsidy Program. These initiatives include:

- **Waiving parent copayments for the Child Care Subsidy Program:** With federal funding, OCFS has waived all copayments for families participating in the Child Care Subsidy Program (CCSP). CCSP helps parents who are working or participating in education or training pay for childcare. Families with incomes up to 85% of the state median income (which is an annual salary of $64,379 for a family of 3) are eligible for assistance from CCSP. Without the co-payment waiver, families are expected to pay up to 10% of their income towards their childcare expenses. The copayment waiver will stay in place for all families until October 1, 2022 and for families with incomes below 60% of the median income until September 30, 2024. In August 2021, OCFS conducted a survey of participating families to measure the impact of the waived copays. Parents reported that the fee waivers not only improved the affordability of childcare but also allowed them to continue to work or go back to work, explore educational opportunities, and achieve better financial security.
- **Providing 35% increase in reimbursement rates for childcare programs participating in CCSP and serving children with special needs.** OCFS is committed to encouraging inclusive policies and practices that support childcare programs to serve children with special needs.
- **Reimbursing based on enrollment instead of attendance.** CCSP typically reimburses childcare programs for the hours that a child attends a program. With a greater need to stabilize the market, offering reimbursement based on enrollment provides childcare programs accepting CCSP greater stability and alleviates strain from the current pandemic. CCSP will reimburse based on enrollment until September 30, 2024.
- **Translating CCSP materials in multiple languages.** OCFS is committed to continually improving access to the CCCSP. In 2021, OCFS used funding from the American Rescue Plan to translate the eligibility guidelines, the parent application, Child Care Subsidy provider Agreements, Child Care Subsidy Program Rules, and Child Care Licensing Rules into multiple languages, including Arabic, Kinyarwanda, Portuguese, Spanish, Swahili, and Lingala. OCFS is currently funding the translation of the Child Care Rules for Providers into multiple languages to support programs operated by New Mainers.

c. Medicaid Partnership

The Office of MaineCare Services, under the Maine DHHS, administers MaineCare. MaineCare provides free or low-cost health insurance, other health benefits, and assistance to kids under age 21 who meet income guidelines or disability criteria. A child under age 19, who is over the income level for MaineCare, may qualify for the Children's Health Insurance Program (CHIP) or Cub Care. If a child under age 19 loses MaineCare coverage because family income goes up, families can buy MaineCare coverage for up to 18 months or until the child turns 19, whichever comes first. MaineCare also oversees the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program which is Medicaid's benefit for low-income infants, children and adolescents under 21.

MaineCare is a partner on this ECCS program and a member of the EIWG which ensures alignment between MaineCare programs and the broader P-3 system. The Maine CDC's Title V program has an MOU with MaineCare that outlines the roles and responsibilities between the two agencies. These include participating in projects that each office does – such as the ECCS program, data sharing, and ensuring Title V is the payor of last resort.

Efforts to Address Inequities

From 2010 to 2016, MaineCare was a recipient of a Federal Child Health Insurance Program Reauthorization Grant (CHIPRA) grant to provide quality improvement support to improve children's health. As part of the CHIPRA grant, MaineCare and its subcontractors led several quality improvement projects with primary care medical practices to improve children's health based on the CHIPRA quality measures. Developmental screening was one of the 24 core child health measures that looked at the rate of developmental screening for children by ages one, two and three using a standardized tool. As a result of this grant, MaineCare continues to track rates of developmental screening and has opened several billing codes for preventative services for children.

In 2018 and 2019, the Maine CDC partnered with MaineCare on the Medicaid Innovation Accelerator Program for the Maternal and Infant Health Initiative. This project has since ended but served as a catalyst to additional projects and provided a mechanism for the Maine CDC and MaineCare to develop strong staff relationships. Additional collaborations include a MaineCare representative is a member of the MCH Domain Lead and Partner Team that meets monthly to coordinate MCH efforts across programs responsible for implementing the MCH Block Grant work plan. In addition, Maine CDC collaborated on the MaineMOM grant proposal submitted by MaineCare. The Maine CDC Title V Director attended planning meetings, connected MaineCare to other partners, provided viewpoints/resources, and drafted narrative sections for inclusion in MaineCare's application.

In 2019, MaineCare hired a new CHIP Outreach Coordinator and an EPSDT Outreach Coordinator to expand its capacity to help families with young children to access needed health care coverage and ensure children on MaineCare access needed health care services. Both of these positions serve on the CPAG.

In 2021, the Maine Legislature passed LD 1781, *An Act to Align Postpartum Maine Coverage with Federal Law*, which allows the state to extend postpartum coverage for those receiving MaineCare during pregnancy from 60 days to 12 months following the birth of a child.

MaineCare provides bundled payments for obstetric services. As long as the patient is eligible for MaineCare for the entire pregnancy, the provider can bill the global code. The global code requires eight or more visits over a period of at least four months in the antepartum period. The provider must bill per service if the patient does not have MaineCare coverage for the whole pregnancy. The provider may also choose to bill per service, even if the patient has MaineCare coverage for the whole pregnancy.

MaineCare also has a limited benefit for Family Planning Services for women at 214% of the FPL. In addition, to improve access to family planning services in the immediate post-partum period, OMS unbundled Long-Acting Reversible Contraceptives (LARC) from the delivery payment bundle in 2017.

One of the Children's Cabinet's goals is that by 2025, 60% of children on MaineCare will receive developmental screenings by ages 1, 2 and 3. If Maine increased its developmental screening rate to 60%, an additional 4,320 children on MaineCare would be screened each year. The goal would be to boost rates from 30% to over 60% in five years, which would place Maine in the upper quartile of the 26 states who are reporting this measure to CHIP and ensure that more Maine children are ready to learn and thrive.

In order to improve developmental and socio-emotional screening, the Office of MaineCare Services in 2021 received a State Plan Amendment to use Health Services Initiative (HSI) funds to purchase and set up the ASQ Online screening system by the summer of 2021. Using the ASQ online will also align with the OCFS Children's Behavioral Health, particularly with the work around L.D. 997 to provide socio-emotional consultation to EC educators. Funding from HSI funds is used for the purchase of the online system, toolkits, and OIT support.

The ECCS Project Manager is working closely with the MaineCare EPSDT and CHIP Coordinators to implement this work across the different departments in order to improve developmental screening and build connections between the systems that would streamline referral pathways and family access, and ensure timely access to early intervention services. Implementing this project will help Maine organizations build relationships needed for a stronger early childhood comprehensive system.

MaineCare Data

MaineCare manages an internal data system. Annually Maine's Title V program requests data on children enrolled in MaineCare by age, sex, race/ethnicity, county, and rurality. MCH also requests and receives data on developmental screenings paid for by MaineCare. Title V also has a linked MaineCare/birth certificate file, which can be used to stratify analyses by enrollment in MaineCare. There is a checkbox on the birth certificate that indicates whether the birth was paid for by Medicaid. Through the linked MaineCare/birth certificate file, Title V can analyze data related to infant health (low birth weight, infant mortality, rate of substance exposure), maternal health (postpartum check-up), and health care access (enrollment in MaineCare). Data can be analyzed based on race, ethnicity, and geographic location. MaineCare data are used to identify underserved populations, target outreach for programs, allocate resources, educate and inform providers, inform public policy, and develop new models of care.

5. Equity

a. Family Leadership

Parents and family members are a key voice in the leadership of the ECCS. Maine's ECCS program includes a Family Leadership Liaison (FLL) to lead the efforts to ensure authentic, diverse, and active engagement of family leaders in Maine's early childhood system. The FLL is working directly with multiple service content leaders with the intentional practice of engaging families to improve services for children and families. To support ongoing leadership for family representatives, the FLL is recruiting families to engage in a variety of stakeholder meetings, including the CPAG, and leadership training initiatives; overseeing the training and support functions related to parent volunteers and representation at meetings and stakeholder groups; and, conducting both formal and informal data gathering of parent perspective to include surveys, focus groups, summary reports and presentations.

Family leaders from the Maine Parent Federation, Autism Society of Maine, Parent Ambassador Program, Maine Developmental Disabilities Council, the G.E.A.R. Parent Network, Adoptive and Foster Families of Maine, and Starting Strong serve on the CPAG and provide critical input into P-3 programs to improve services for families. Funding is provided in the ECCS budget to provide a stipend and travel reimbursement to each family member/parent to participate in the CPAG meetings. The FLL is responsible for developing strategies that ensure continuity of parent involvement, diversity of representation, and authentic participation at multiple levels of leadership throughout the ECCS program.

Formal support and training for family leaders currently occurs through several Maine programs: Children with Special Health Care Needs program, the Maine Parent Federation, and Educare Central Maine's Parent Ambassador Program.

Children with Special Health Care Needs (CSHN) Program: The involvement of families in the care of their CSHN is essential to ensuring consistent and quality care. Ensuring that families are partners in decision-making at all levels including the healthcare team and supporting parent leaders to be actively involved in policy development results in improved outcomes for children and the system of care. Families are contributing members across many of the programs housed in the CSHN Program. There is family representation on the Maine Newborn Hearing Advisory Board, the Birth Defects Advisory Board, and the Joint Advisory Board for Bloodspot Screening. The CSHN Director/Title V Director participates on the Developmental Disabilities Council which includes individuals with developmental disabilities as well as family members. Recognizing that the system is complex, the CSHN Program contracts with the Maine Parent Federation (MPF) to assist families as they navigate the system of services.

Maine Parent Federation: MPF provides information, referral, one-on-one support, and training to parents of children with disabilities/special health care needs and the professionals that work with them. MPF designed the Family Support Navigator Program to connect families to a network of supports, services and information at the local, state, and national level. The navigators assist families with locating medical care and understanding results. MPF served 1,608 families of CSHN and trained 1,821 professionals in 2019.

Parent Ambassador Program (PAP): The PAP is a year-long leadership and advocacy program for parents with children enrolled in Head Start in Maine. The goal is to develop parent leaders and empower parents to advocate for themselves and their children. Each year parents with children enrolled in a Head Start program, including at Educare Central Maine, are selected to become parent ambassadors using a competitive process. Maine's initial PDG project piloted PAP with three Head-Start grantees. The PAP has expanded to include parents from almost all of Maine's Head Start programs.

Educare Central Maine staff have also started a Parent Ambassadors alumni group which consists of parent leaders who have completed PAP and want to remain engaged in advocacy efforts. A member of the PAP alumni group sits on the Children's Cabinet Early Childhood Advisory Council and the Children's Cabinet Coordinator has participated in alumni group meetings to receive feedback from parents on EC policies and programs. With funding from Maine DHHS, Parent Ambassador training is more being offered to parents outside of Head Start who are engaged in other early childhood system programs.

The ECCS program provides an opportunity to expand leadership opportunities for families to not only provide input and feedback for programs and services but to more actively participate

in the decision-making process. **This is an area for growth and strategies to further enhance family leadership and engagement will be included in the ECCS Strategic Plan.**

b. State-Community Coordination

State-community coordination typically occurs through programs that are administered by state agencies such as Maine DHHS but implemented through subgrants or contracts at the local or community level. Maine has a relatively small population – 1.3 million people – but a large geographic area – over 35,000 square miles, significantly larger than any of the other five New England states. Implementing state and federal programs in partnership with county and community providers ensures that early childhood initiatives meet the needs of children and families at the local level. Examples of successful state-community coordination in the early childhood system and health sector include:

- ***Maine Families Home Visiting*** is administered by the Maine CDC MCH program but is delivered statewide through a contract with the Maine Children's Trust who subcontracts with 11 local implementing agencies (LIA). While the program can be molded to the needs of each county, the MFHV Standards of Practice ensure consistency across agencies. MFHV uses a statewide, web-based data system to track the work with families as well as demographic and family information.
- ***Head Start*** is supported by the Head Start State Collaboration Office at Maine DOE. State funds to support Head Start are managed by OCFS. Maine has 11 Head Start grantees that operate 24 Head Start programs throughout Maine. Grantees include Community Action Programs and other nonprofits. Maine DOE also funds three Tribal Head Start programs, ensuring access to early education and support for tribal families.
- ***First 4 ME*** a public-private partnership model for early care and education and workforce development, will be administered by the Maine DHHS. Competitive grants will be awarded to up to five pilot projects around the state submitted by community coalition that include representatives from child care providers, home visiting, mental health, public school, health care sector, and other early childhood system stakeholders. Maine DHHS will prioritize funding to projects that serve communities with high numbers or a high percentage of children who are economically disadvantaged or that effectively involve a wide variety of providers or other entities in the community, including school districts.
- ***Plan of Safe Care*** a federally mandated document, the primary goal of a Plan of Safe Care is deliberate attention to ensuring the supported and ongoing safety, well-being and best possible long-term health and developmental outcomes for substance exposed infants, their parents and other caregivers. POSC is being implemented at the community level through local birthing hospitals.

While these programs provide examples of successful models of state-community coordination, Maine's early childhood system leaders continue to find new and creative approaches of working successfully at the community level. **The ECCS Program provides an opportunity to expand these partnerships and where applicable, Maine will include recommendations for strengthening community-level early childhood system in the ECCS Strategic Plan.**

c. Equitable Systems

Maine recognizes that work needs to be done to build commitment and capacity in the state's P-3 system to address factors that contribute to the early developmental, family, and maternal health disparities and drive equity progress. The ECCS program provides an opportunity to focus on this work and develop targeted strategies to address health disparities based on geographic region, race, ethnicity, and socioeconomic status. The CPAG brings together stakeholders who are working with underserved P-3 populations and can identify systemic factors that contribute to health disparities and links them to state leaders who can impact policy and practice barriers. The CPAG includes parent and family representative who are recipients of P-3 services and provide a perspective from lived experience.

State-level Efforts to Address Equity

The COVID-19 pandemic laid bare the inequities in health care, particularly for racial and ethnic groups in Maine. It also evidenced the need to re-examine DHHS's infrastructure to address those needs. The disparate impacts of the virus upon Maine populations were not, however, caused by the pandemic, and the DHHS acknowledges that to achieve health equity for all Mainers will require a focus on those communities that have traditionally gone underserved.

Office of Population Health Equity: In 2021, DHHS re-established the Office of Population Health Equity (OPHE) within the Maine CDC. The OPHE advances health equity by illuminating and addressing underlying conditions and systems that limit the full potential of all Maine people to lead healthy, safe, and opportunity-rich lives. OPHE collaborates with programs – including P-3 initiative - across the Maine CDC and partners with community leaders to ensure that Maine's public health initiatives are informed by and reflect the needs of the people served with a focus on the promotion and protection of the health of people and the communities where they live, learn, work, and play.

Manager of Diversity, Equity, and Inclusion at DHHS: In 2019, the Manager of Diversity, Equity, and Inclusion was hired to focus on health equity across the department, including issues around children's health. This position is leading the development of innovative and practical solutions to address the economic and social conditions that affect people's health and quality of life. The Manager of DEI is also leading efforts at DHHS to develop a workforce of diverse talent and promote an equitable and inclusive work environment, including the development of

the Department's recently released *Strategic Plan to Advance Diversity, Equity, and Inclusion (DEI) at the Maine Department of Health and Human Services, 2021-2023*.

Strategic Plan to Advance Diversity, Equity, and Inclusion (DEI) at the Maine Department of Health and Human Services, 2021-2023: Discussed previously in this SAGA in ***Section 1. – Infrastructure***, the DEI Strategic Plan focuses on workforce, community engagement, data analysis, and the equitable distribution of State resources. Maine DHHS is committed to developing an infrastructure dedicated to health equity, utilizing data-driven approach to assess health disparities and inequities throughout Departmental programs and policies, and increasing supplier diversity. DHHS also recognizes the need for meaningful stakeholder engagement throughout the work of the Department, including improved language access services.

PQC4ME: Diversity, Equity, Inclusion, and Belonging Framework: In addition to state-level goals to address equity, cross-sector bodies such as the PQC4MEare developing tools to guide their work through in equity lens. In November 2021, PQC4ME established the Diversity, Equity, Inclusion and Belonging (DEIB) Workgroup. In Spring 2022, the Workgroup presented a draft Diversity, Equity, Inclusion and Belonging Framework to the PQC4ME Steering Committee and the PSOC Working Partners Group. The DEIB Framework includes the following mission, vision, and goals:

- *Vision*: PQC4ME works to advance equity, diversity, inclusion and belonging in all efforts to improve perinatal outcomes in Maine, from preconception through pregnancy, birth, postpartum, and first year of life outcomes for infants, parents, and families.
- *Mission*: PQC4ME is committed to promoting healthy births and optimizing perinatal well-being for those who give birth, infants, and families in Maine while proactively addressing social determinants of health. The PQC4ME applies the Quality Improvement process, along with knowledge, attitudes, practices, and policies to reduce the effects of poverty, discrimination, and other factors with an aim to improve health equity in healthcare delivery and outcomes for the people of Maine.
- *Goals:*
    1. Increase diversity in the PQC4ME Steering Committee.
    2. Create and implement a DEIB toolkit for PQC4ME projects with open access for all health care providers and the public.
    3. Raise awareness of qualitative and quantitative data on maternal and infant health in Maine and nationally and historically disadvantaged communities.
    4. Promote racial diversity in Maine's perinatal care workforce.
    5. Support and participate in QI projects involving historically disadvantaged communities in Maine.

6. Continue/expand the DEIB Workgroup to assure goals and activities are met and needed resources are secured.

As Maine works to strengthen the state's perinatal system of care through the ECCS program, these goals will be reflected in the ECCS Strategic Plan.

Underserved Populations

Racially and Ethnically Diverse Populations: While the overall population of Maine is only 5.4% non-White, the population of entering first graders of color is closer to 12% with about one third of those coming from a non-English speaking family.[82] The trend means that schools and other providers in education and service fields need a deeper understanding of dual language learners, racial and cultural differences, their own cultural biases and blind spots, and the challenges faced by children and families of color.[83] For example, stakeholders report both that differences in child rearing philosophies may be leading to referrals for special services that are not appropriate and also that families from certain cultures may be unwilling to seek mental health counseling because expressing needs for support in their countries of origin are stigmatizing.[84]

Cultural, language, and service gaps pose challenges for refugee and immigrant parents of young children in need of care. When families are not comfortable with placing young children in care or do not know how to access care, the consequences hold back the adjustments to a new life for women and children. If women are staying home with children and not able to work or study English, their choices become limited. Children from non-English speaking families who enter Kindergarten without a pre-K experience are disadvantaged compared to their peers.[85]

Children from refugee and immigrant families face some unique challenges in regular childcare settings. Providers lacking cultural competency skills may have difficulty understanding behaviors manifested by children who have experienced traumatic situations or grown up in survival situations. Further, families who themselves may not have had experiences in traditional schools are not able to help their children with issues they face, including behaviors that are perceived as disruptive by providers.[86]

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[82] The Maine Children's Alliance (2019). *Maine Kids Count data book 2019*. Augusta, ME: Author.
[83] Interview with Phillip Berezney Migrant Education Program Director, Mano en Mano, 6/26/2019.
[84] Focus group of Professional Development Network technical assistance providers, Maine Roads to Quality focus group of TA providers, 4/25/2019; Interview with Tarlan Admadov, State Refugee Coordinator for our Office of Maine Refugee Services, 7/2/2019.
[85] Interview with Tarlan Admadov, State Refugee Coordinator for our Office of Maine Refugee Services, 7/2/2019.
[86] Interview with Kris Michaud, State Early Childhood Special Education Technical Advisor, 619 Coordinator, 3/18/2019.

Some New Mainers have shown interest in becoming trained and licensed to provide care within their cultural communities. Barriers include substandard housing conditions that would not meet licensing requirements, landlords who will not allow family childcare, and the lack of sources of start-up funds.[87]

Over the past few years, several reports have examined barriers and challenges in Maine's early childhood system to meeting the needs of diverse populations. **Findings and recommendations from these reports will inform strategies that address and advance equity in Maine's P-3 system to be included in Maine's ECCS Strategic Plan.**

LD 1113: Racial Disparities in Prenatal Access in Maine: In 2021, the Maine Permanent Commission on the Status of Racial, Indigenous, and Tribal Populations (referred to subsequently as "The Commission") was directed to conduct a study on disparities in access to prenatal care in Maine. Specifically, LD 1113 directed the Commission to: 1) Study the extent of disparities in access to prenatal care for the State's racial, indigenous, and tribal populations through data and other information 2) Study the causes of the disparities in access to prenatal care, including through interviews with those women who had no prenatal visit until the last trimester or had no prenatal care at all 3) Recommend solutions to disparities in access to prenatal care in the State. Key finding of this report include:

1. Systemic racism has created an environment in which maternal health outcomes—already among the worst in the world—are significantly worse for communities that are Black, Indigenous, and of color (BIPOC).
2. One factor that helps improve maternal health outcomes for every population is access to uninterrupted, high quality prenatal care.
3. BIPOC communities not only have worse maternal health outcomes in Maine that their White counterparts, they also have reduced access to prenatal care.

Recommendations:

1. Expand community-led data gathering and align with statewide systems
2. Invest in relationship-centered care
3. Address structural inequities
4. Support community-led education
5. Enhance statewide data collection to better serve communities

Early Childhood in Portland: Perspectives on Child Care and Development, September 2020: The purpose of this project was to ascertain a more detailed understanding of parents' views on developmental screenings and family, friend, and neighbor care for young children from immigrant, refugee, and/or asylee communities in Portland, Maine with the intention of informing strategies that could be implemented by local, county, or state leaders to ensure that

[87] Interview with Tarlan Admadov, State Refugee Coordinator for our Office of Maine Refugee Services, 7/2/2019

all children experience culturally appropriate and relevant developmental screenings and have equitable access to high quality early child care in culturally appropriate ways, which puts them on the pathway to kindergarten readiness and third grade reading proficiency.

Child Care: While the majority of participants report they would ideally have the mother or a close relative care for a young child for at least the first year of life, this is often not an option for immigrant, refugee and asylee families. This is particularly true for this target population as they often move to communities alone or without their extended families for support. When considering alternative options for care, the most important qualities include safety, acceptance and appreciation of the family's home culture, engaging and educational activities, and socialization. Encompassing all these is the need for an innate sense of trust between the parent and provider. Parents most often report using in-home or center-based care, splitting care between parents or relying on older siblings to care for younger children. However, with these choices came concerns about the cost of care, hours that do not match work schedules and long wait lists. Additionally, parents reported experiencing racism and unequal treatment, and shared examples and fears of unfounded reports to DHHS when their children are involved in more formal systems of care.

Recommendations:

1. Support families to find safe, quality childcare that meets their needs
2. Provide targeted support to help people open licensed home childcare settings
3. Address the issue of childcare affordability – especially for parents who do not qualify for vouchers
4. Advocate for paid parental leave
5. Support a community builder or cultural navigator role to bridge and build understanding and trust among community members and daycare providers
6. Provide regular training for daycare providers in care settings on cultural humility, inclusion, and bias
7. Build diversity of childcare center staff

Developmental Screening: When parents understood the purpose of developmental screenings and were spoken to with respect, they saw the screening process for young children as an opportunity to learn more about their child's development and get access to additional support, as needed. However, the majority of participants included in this research shared questions, confusion, and concern with developmental screenings and the processes surrounding their use. Many parents did not understand the intention of the tools; they found questions and concepts overwhelming, embarrassing, and caused them to worry about their child's development. Additionally, participants provided multiple examples of ways in which the tools lacked cultural sensitivity or responsiveness, likely resulting in irrelevant or inappropriate results that are not reflective of children's actual development. Data indicate the tools do not

take into account different cultural beliefs around development, which may lead parents to question the results or recommendations of providers.

Recommendations:

1. Increase parent understanding of what developmental screenings are and what to expect in visits with their doctor or other provider who conducts screenings.
2. Promote family involvement in the process
3. Educate parents about their rights
4. Consider the extent to which screenings respect culture and language
5. Ensure positive and respectful communication with families
6. Provide training to medical interpreters about developmental screenings so they care more appropriately address questions and concerns of parents

Maine Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment update (2020): Families served by MFHV are more diverse than Maine's population in general. About 87% of adults enrolled in Maine families are White; 8% are Black/African American; 4% are Hispanic. Among children, 82% of those enrolled are White; 7% are Black/African American; 8% are more than one race; 4% are Hispanic.

The New Mainer population of recent immigrants and refugees to Maine is primarily concentrated in two of Maine's metropolitan areas, Portland and Lewiston/Auburn, which are located in Cumberland and Androscoggin counties respectively. The MFHV programs in these counties have made a concerted effort to engage with this population. In Androscoggin County in 2019, about 20% of families served were Black or African American; in Cumberland County, 40% of families served were Black or African American. In Cumberland and Androscoggin counties, 42% and 18% of enrolled families speak a language other than English as their primary language, respectively.

Agencies working with New Mainers, including asylum seekers, contract for interpreter services. The MFHV program purchased translated developmental screening forms and MFHV has translated other materials, such as participation agreements, releases for referrals, and recruitment materials.

Although some MFHV LIAs are actively engaging with recent immigrants and refugees, MFHV program directors note that many New Mainers may be fearful about the paperwork requirement. Program directors believe some New Mainers are concerned about how the information will be used. Concern was expressed that the Parents as Teachers model is not culturally sensitive enough and does not allow programs to be culturally adaptive and flexible. In addition, MFHV's required staff qualifications and credentials can make it difficult to employ individuals from diverse communities. Many New Mainers do not have a college degree when they arrive in Maine.

Prior to July 2022, Maine did not have any Tribal-specific home visiting programs. Tribal members can be served by any of the existing Maine Families LIAs. The percent of American Indian adults served by MFHV in counties with reservations is about the same or slightly higher than the estimated percentage of American Indians living in Aroostook and Washington Counties, but lower in Penobscot county. Many Mainers who are American Indian also identify as more than one race, which makes it difficult to accurately assess how well they are being reached by MFHV.

To reach tribal populations, one agency has attended health fairs on the reservations and has partnered with other agencies located on the reservation, such as WIC. Agencies in these counties acknowledge they could do more to engage Maine's tribal population in home visiting.

This past summer, Wabanaki Public Health and Wellness received a Tribal Maternal, Infant and Child Home Visiting Program Grant from the U.S. Department of Health and Human Services which will provide home visiting services among tribal families. Wabanaki Public Health and Wellness serves four federally recognized tribes located in five communities: the Houlton Band of Maliseet Indians, the Aroostook Band of Micmacs, the Passamaquoddy Tribe at Indian Township, the Passamaquoddy Tribe at Pleasant Point, and the Penobscot Nation.

Other Underserved Populations

Other underserved populations who experience inequities in Maine's P-3 system include:

Families Living in Rural Areas
Limited transportation options in rural areas affect access to healthcare and early childhood services. In the focus groups conducted as part of this SAGA process, parents, care givers, and providers frequently listed transportation as a significant barrier to accessing services, especially in rural areas. Many families cannot afford to own or maintain a vehicle. One parent noted that she doesn't even have a driver's license because driver's education classes are too expensive.[88] Public transportation is extremely limited outside of Maine's three major metropolitan areas. Parents and providers noted the unreliability of transportation services provided or reimbursed by MaineCare, leading them to opt for more costly alternatives. [89] One ECCS Focus Group participant notes that sometimes families are penalized when their child misses an appointment due to lack of transportation which can result in that child losing their slot for services.[90]

Parents reported that the COVID-19 pandemic actually helped mitigate some transportation challenges because service providers had to get creative around delivering services online and

[88] ECCS-SAGA, G.E.A.R. Parent Network Focus Group, 7/20/22
[89] Focus groups of current Parent Ambassadors and alumni Parent Ambassadors, 3/23/2019 and 3/30/2019.
[90] Ibid

families could conduct appointments such as counseling, medical visits, speech therapy, and occupational therapy from home.[91] However, another parent noted:

> *"I have been thinking about services during Covid time. We had WIC, Penquis CAP, Developmental Peds, Doctor appointments, I think overall there was a lot less interaction, less services available in general. We got what we needed but I pushed. We had several WIC appointments over the phone, which I felt was not entirely helpful. If I were seeking advice or support I don't feel it would have been adequate. While in the office, we often talk about more than would be typical over the phone."*[92]

Access to childcare is also a challenge to families living in rural areas. Families reported having to travel long distances – in the opposite direction from where they work – to find adequate child care.[93]

Lack of mental health services is a challenge throughout Maine but particularly difficult in rural areas. – "*Maine was already overwhelmed by a lack of mental health providers and COVID only made that worse*."[94]

Access to perinatal care can be challenging particularly in rural areas.[95] More specifically:

- The closures of delivery services have occurred primarily in rural areas where populations are already at risk for IM because of other factors. Over the past two decades, Labor and Delivery units closed in seven counties (Androscoggin, Cumberland, Hancock, Lincoln, Penobscot, Washington and York), and nine cities/towns (Blue Hill, Boothbay Harbor, Brunswick, Calais, Lincoln, Millinocket, Sanford, Bridgton and Lewiston).
- For some pregnant people, the closures have limited access to local hospitals for Labor and De- livery, as well as prenatal and post-partum care (OBs, midwives, FM, nurses and social workers).
- Many women also must wait for, or travel long distances to, specialty obstetrical care.
- Local pediatric shortages were also reported for general pediatricians, as well specialists (neonatologists). Currently, the neonatologists are in the two NICU's in Portland and Bangor. To fill the shortages, some of the rural communities use locums, who do not provide continuity of care.
- Shortages in mental health providers with perinatal expertise were reported all over the state.

Individuals with Substance Use Disorder and Substance Exposed Infants

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[91] ECCS-SAGA G.E.A.R. Parent Network Focus Group, 7/20/22
[92] ECCS-SAGA Adoptive and Foster Families of Maine Focus Group, 8/24/22
[93] ECCS-SAGA G.E.A.R Parent Network Focus Group, 7/20/22
[94] ECCS-SAGA Educare Central Maine Parent Ambassador Alumni Focus Group, 7/20/22
[95] Flaherty, Katherine, ScD, MA (lead author). Qualidigm©. *Understanding and Addressing the Drivers of Infant Mortality in Maine*. January 2020.

Each year, an average of about 900 infants are reported by a healthcare provider to OCFS due to substance exposure.[96] Prenatal exposure to opioids is more frequent among infants in Maine than elsewhere in the US and in 2019, Maine had the second highest rate of infants born with neonatal abstinence syndrome (NAS) in the United States.

Parents report challenges navigating the recovery system. One parent who is receiving medication assisted recovery services report that sometimes the dose is too high, and it negatively impacts their ability to parent which can lead to Child Protective Services being called. This does not help the recovery process. Parents feel that there is too much judgment about substance use disorder and not enough support. The additional of more recovery peers would be helpful.[97]

Families who participated in a New Mainer focus group as part of this SAGA process noted that substance use disorder has always been a taboo subject in many immigrant and refugee communities. However, lately parents are asking for help and providers need assistance in how to communicate information about SUD in ways that is culturally sensitive.[98]

Families of Children with Special Healthcare Needs

Parents and advocates for children who are vulnerable because of developmental delays and disabilities express concerns about access to and availability of services. Through Maine's PDG needs assessment process, parents noted that it is difficult to get information about specialized services for their children from CDS, medical providers, and for themselves, e.g., parent support groups. Parents desire more information about guidelines, service entitlements, and how to navigate the CDS system.[99]

Experiences in securing access to formal referrals vary, depending on the provider involved and their skill in navigating CDS channels. For example, Head Start and pre-K family advocates may guide parents though each step of the process while a family referred by a pediatrician may simply give up if they have no support to work through the steps. One member of the medical community also noted that there is no feedback loop to learn if a child who has been referred has been diagnosed so that the referring agent can follow up with the family.

Parents are most upset when it takes a long time for children who have been diagnosed to begin receiving services although they are very aware of and sympathetic with CDS' shortages of qualified staff (especially for speech therapy, occupational therapy, and physical therapy)

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[96] Kids Count Data Center, Annie E. Casey Foundation. Accessed August 5, 2022: https://datacenter.kidscount.org/data/tables/9828-babies-born-exposed-affected-to-substances#detailed/2/any/false/2048,574,1729,37,871,870,573,869,36,868/any/19127,19128

[97] ECCS-SAGA G.E.A.R Parent Network Focus Group 7/20/22

[98] ECCS-SAGA New Mainer Focus Group, 6/17/22

[99] *State of Maine Needs Assessment: Vulnerable Children Birth to Age 5 and Their Families.* Prepared by M. Christine Dwyer, PMC Research. October 2019.

and high caseloads (see more in Chapter V, Workforce Development, and VI, Supporting Children with Special Needs). Some parents believe the delays in providing services have hampered their child's development and readiness for success in Kindergarten.

While they may be concerned about the delays in referral and evaluation, parents do tend to express greater satisfaction once their children are receiving services through CDS providers, including the quality of providers and their empathy and care for children, and ability to explain diagnosis and services. As would be expected, parents advocate for an increased amount of one-to-one services with specialists. The nature of CDS service provision changes at transition points at ages three and five. Parents are aware of gaps in coordination and communication between home-based providers and center-based care at those transition points, and feel they were not prepared for the transition between developmental services and special education.[100]

Over the last couple of years, CDS staff have taken a number of steps to increase referrals and child count. These included:

- Development and implementation of a statewide, annual outreach plan
- Updated and expanded list of established conditions of risk that make children under age 3 automatically eligible for Part C
- Addition of Maine's Early Intervention Program on CradleME request form and the 1st page of Maine's Plan of Safe Care
- Targeted outreach with birthing hospitals and other primary referral sources to increase community awareness about eligibility under established conditions
- Cross-department collaboration between CDS and DHHS programs (e.g., WIC, PHN, Maine Families, CSHN, etc.) to identify and/or improve referral pathways for children with established conditions and/or concerns for development
- Translation of written materials into the top 10 languages of families enrolled in Part C

As a result, between federal fiscal year 2018 and federal fiscal year 2021, the number referrals to CDS for Part C IDEA services increased from 2,847 to 3,551 children. The number of eligible children for Part C IDEA services increased significantly from 1,176 to 1,406 children between FFY 2020 and FFY 2021.

Tribal Communities

Maine DHHS and DOE continue to work to connect with and providing services to Maine's tribal communities in Maine's P-3 system. The ECCS program provides an opportunity to leverage connections made with Maine's Tribal Health Centers during the COVID-19 pandemic. At the

[100] Family Home Child Care Providers survey; Maine Parent Federation survey; Interviews with parents from Maine Parent Federation, June 2019; Focus groups of current Parent Ambassadors and alumni Parent Ambassadors, 3/23/2019 and 3/30/2019; Interviews with PEG school-provider pairs: Heather Manchester and Kimberley Bessette from Oxford Hills on 6/24/2019 and from Lewiston, Monica Miller and Monica Redlevske on 6/26/2019.

beginning of the pandemic, Dr. Nirav Shah, Director of the Maine CDC, convened Tribal leaders and Tribal Health Centers to offer support as their nations navigated this crisis. Those meetings continue on a monthly basis and are led by the Senior Advisor, Delivery System Change at DHHS. They primarily include the Tribal Health Directors, the Public Health non-profit serving the five Tribes, and representatives from offices within DHHS. The process has demonstrated the benefit of regular communication that respects Tribal sovereignty but offers collaboration and support where it is desired.

IV. Appendix

2021 Children's Cabinet Annual Report. Prepared by the Governor's Office of Policy Innovation and the Future. December 2021.
https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/GOPIF_CC_AnnualReport2021.pdf

Children's Cabinet Plan for Young Children.
https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/GOPIF_CC_PlanYoungChildren.pdf

Early Childhood in Portland: Perspectives on Child Care and Development. Prepared for Starting Strong and MaineHealth – Cumberland County Developmental Screening Initiative by the Data Innovation Project and Main Access Immigrant Network. Portland, Maine. September 2020.

LD 1113: Racial Disparities in Prenatal Access in Maine. Report to the Maine Legislature. Submitted by the Permanent Commission on Racial, Indigenous, and Maine Tribal Populations. January 15, 2022.

Maine Community Action Partnership 2021 Statewide Community Needs Assessment. Completed by Crescendo Consulting Group. December 2021.

Maine Early Childhood Integrated System (ECIDS) Readiness Assessment Report – Working Paper. Prepared by Katherine Johnson, Early Childhood Data and Policy Analyst & ECIDS Lead, Governor's Office of Policy Innovation and the Future. September 2022.

Maine's Head Start and Early Head Start Snapshot Report, 2021.
https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/2021_HS_SnapShot.pdf

Maine Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment Update. Prepared by the University of Southern Maine's Muskie School of Public Services for the Maine Center for Disease Control and Prevention's Maternal and Child Health Program. October 2020

Maine Title V Maternal and Child Health Block Grant Needs Assessment and Five-Year State Action Plan. Prepared by Brenda Wolford, Renee Schwalberg, and Rebecca Hofer, Altarum Consulting. 2020.

State of Maine Needs Assessment: Vulnerable Children Birth to Age 5 and Their Families. Prepared by M. Christine Dwyer, PMC Research. October 2019.
https://www.maine.gov/doe/sites/maine.gov.doe/files/2021-03/FINAL%20Needs%20Assessment%201-6-20.pdf

State of Maine Strategic Plan for Meeting the Needs of Vulnerable Children Birth to Age 5 and their Families. 2020-2025 https://www.maine.gov/doe/sites/maine.gov.doe/files/2021-03/Maine%20B-5%20Strategic%20Plan%20Report%2011.2020%20.pdf

Strategic Plan to Advance Diversity, Equity, and Inclusion (DEI) at the Maine Department of Health and Human Services, 2021-2023. Prepared by Jeanne Lambrew, Commissioner, Maine Department of Health and Human Services. September 2021, https://www11.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Strategic%20Plan.pdf

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