Invest Early

A Working Plan for Humane Early Childhood Systems

2006

in Maine

‘People who have quality early care and education have better opportunities for success.’

Governor John Elias Baldacci
1/18/06 State of the State Address

In memory of Dylan Peavey
1997-1999

This project is funded by the U.S. Department of Health and Human Services, Maternal and Child Health Bureau

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A Product of the
Maine Governor's Children's Cabinet
Task Force on Early Childhood
March 2006

Introduction

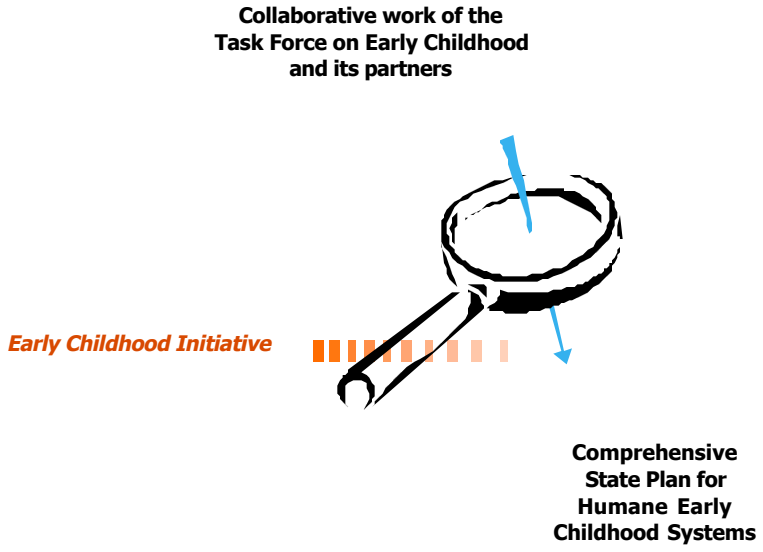
Why should Maine have a plan for humane early childhood systems?

- Research has shown that before age five, children experience an extremely significant period of brain development that has a substantial influence on their social, emotional, physical, and cognitive development.
- Healthy child development can be significantly delayed when young children experience environmental stressors and other negative risk factors that influence the brain.
- Maine has created a new Department of Health and Human Services to better serve the unique and diverse needs and build on the strengths of Maine's children and families.
- Investments prevention and resources for infants, toddlers and preschool children lead to long-term savings.
- Every family needs effective support and encouragement to be active participants in their children's development.
- Strong partnerships among state agencies foster humane, culturally competent, sustainable, and integrated systems.
- High quality, inclusive early care and education improves every child's readiness for school, families' ability to work productively and the state's economic development goals.

- Accessible and integrated preventive and therapeutic physical, dental, oral, and mental health services for all young children support their social, emotional, cognitive and physical development.
- It is the state's leadership responsibility to promote the health of its communities and to help reduce the incidence of child abuse/ neglect and domestic and sexual violence.

The federal Maternal and Child Health Bureau has provided the financial support to promote effective systems change through Maine's *Early Childhood Initiative.* The Initiative has served as the tool to focus years of research, dialogues and advocacy from the Governor's Children's Cabinet's Task Force on Early Childhood and its partners into a thoughtful, focused blueprint for how Maine can demonstrate the esteem in which we hold our children.

You hold in your hands a living document, the *State Plan for Humane Early Childhood Systems for Maine*. The Early Childhood Initiative seeks to integrate state and community activity related to early childhood systems. Composed of stakeholders representing families, providers, and state government, the Task Force on Early Childhood (see Section II) has been the primary agent of change that has propelled the Maine Early Childhood Systems Initiative. This document presents some of the best thinking of scores of experts in Maine, including parents and other family members, neighbors, government agencies, community non-profit organizations, business leaders, economists, and service providers. These dedicated groups have analyzed the current resources, costs, gaps, and strengths of our public health and social service systems.



The Task Force's state plan intends to:

- Unite, simplify, and humanize the systems and policies affecting children and families.
- Transform usage of funding streams so that they serve the largest number of children and their families possible and have a positive impact upon these children and families.

- Develop clear and simple language that will strengthen the communication that is vital to the system changes that we seek.
- Integrate dental, oral, medical, social and emotional health, early care and education, and educational systems at the community and state levels.
- Influence Maine's culture so that our actions reflect a powerful commitment to prevention in the prenatal, infant and early childhood stages of life and to parenting as among the most important of all occupations.
- Build an understanding that such a commitment is an essential component to the social, cultural, and economic development of Maine's future.
- Strengthen quality, inclusive early care and education and children's services so that they optimize children's curiosity and readiness for school, the ability of families to work productively, and the capacity of the state to achieve its economic development goals.

What this document is	What this document is NOT
A guide to facilitate thoughtful change in early childhood systems	The final say about what Maine's early childhood system should do or how it should look
A living document that will change over time as efforts toward change are implemented and evaluated	A cast-iron tome that disallows flexibility, modification, new partnership prospects
A means to introduce basic concepts of human development and how they have influenced the recommendations set forth herein	An abridged version of *From Neurons to Neighborhoods* and other excellent works that have propelled our thinking into action steps
A platform to highlight best and promising practices for human service and social capital improvements	A manifesto on evidence-based programs
A summary of examples of potential and existing collaborations	An exhaustive list of projects in Maine working to improving the lives of our children and families
Years of dialogue, research, evaluation and experience in shaping the face of early childhood systems	A manual for early childhood systems change that supercedes the promising and successful work of other initiatives
A guide for other projects and initiatives to understand the scope of compelling early childhood work in Maine through the Governor's Children's Cabinet Task Force on Early Childhood	

We Can Get There from Here

Our Mission is to create and sustain a unified, statewide early childhood service system that provides essential resources, shares common standards for quality, and respects the diversity and uniqueness of all Maine's children and their families. With this system in place, we envision that families will assume responsibility to nurture, protect, and encourage the cognitive, emotional, ethical and physical development of their children. As well, Maine communities will assume responsibility to strengthen families and foster the healthy development of children.

Maine's socio-political history is characterized by a delicate balance between fierce independence and active grassroots coalitions. Maine has been a national leader in demonstrating its vision of connecting communities to better serve young children. We strive to foster conditions for Maine children and families to achieve optimal health, knowing that health encompasses the social, economic, and environmental contexts that shape their lives. However, substantial numbers of our young children continue to enter their school years lacking physical and emotional health and safety; a sense of their own worth and dignity; a resilient spirit; and the capacity to thrive in their schools, families, and communities. These children need powerful friends. For them, Maine is compelled and inspired to continue its groundbreaking systems work through its Early Childhood Initiative.

In the mid-1990's, child advocates and allies in both Executive and Legislative branches of government rallied to advocate for, and subsequently implement, legislation to support Maine's children and families through Start ME Right (SMR), an early intervention/prevention coalition that includes home visiting, health initiatives and child abuse prevention. The SMR movement demonstrated the capacity and willingness for diverse groups and organizations to stand united for a common cause. A principle tenet of this coalition that led to the success of SMR was its members' simple and quiet resolution that all elements of SMR must be implemented; no one element was more important or entitled to funding than another.

Start ME Right helped inspire the Task Force on Early Childhood to host a statewide forum in 2002. The purpose of this forum was to gauge the need and interest of Maine advocates and organizations to undertake unified and effective action for change. In the months that followed the forum, we developed a guide for the activities and energy of the Task Force using four priority domains from the book, From Neurons to Neighborhoods[1]. Specifically, the four goals were assigned to workgroups whose tasks were to:

- Secure needed resources for young children;
- Strengthen and expand commitments to assist parents of young children;
- Balance cognitive development with the emotional and physical needs of young children; and
- Guarantee effective service systems for young children.

Since then, members of the Task Force constructed a list of issues faced by Maine children and families; documented human and material strengths and assets; and generated priority recommendations for the interagency, intercommunity Early Childhood Initiative (ECI). Critical to this process was the use of the Future Search conference, an intensive, evidence-based methodology to find common ground.[2]

This vital systems change work and its message must address some of the underlying social and cultural norms that influence the ways in we value young children and their families. While we estimate that 85% of Maine's children will have all parents in the workforce by 2010, the infrastructure to support working families with quality early care and education needs considerable improvement. Quality, affordable early care and education is a necessity, but more importantly, the ECI knows its work must convey the message that parenting is among the most important of all occupations. We must translate the research showing that the first three years of life are the most important for healthy child development, and in turn, provide all early care providers, especially parents, with the information and tools to enhance their skills as parents and providers.

The ECI recognizes that the responsibility to improve the experiences and environments of children in the first year of life lies with both government and the people. Where those roles intersect will define the success and sustainability of the early childhood systems change movement. Maine government can provide the policy framework for the system, such as helping prevent adolescent pregnancies, providing new parents with child development information, offering the resources to mitigate the sense of isolation in our largely rural state, and supporting early care and education facilities and its workforce[3]. Public will should also reflect the need for these kinds of policies. It must marry the value Mainers place on individual independence with the value of strong economic growth that begins with investing early in our youngest children.

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[1] Shonkoff, J. P. and Phillips, D.A., Eds. (2000). *From Neurons to Neighborhood: The Science of Early Childhood Development*. Washington, D.C.: National Academy Press, p. 6-7.

[2] For more information about this global approach to systems change, see www.futuresearch.net.

[3] See also: Johnson, K. & Knitzer, J. (2006) Early Childhood Comprehensive Systems that Spend Smarter. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health www.nccp.org.

Where is Here?

Before investing in major systems change, Maine took a deeper look past just the anecdotal data that our systems needed reform. We compared the resources we have throughout our state to the deficits that belied integration. The following summarizes our findings and provides context for the priority recommendations in this plan.

The Governor's Children's Cabinet Task Force on Early Childhood
At the same time that the Task Force membership was analyzing the current resources, costs, gaps, and strengths of our public health and social service systems to develop Maine's State Plan for Humane Early Childhood Systems, the Children's Cabinet set its agenda for the upcoming years. Naturally, early childhood health and development emerged as one of its top priorities.

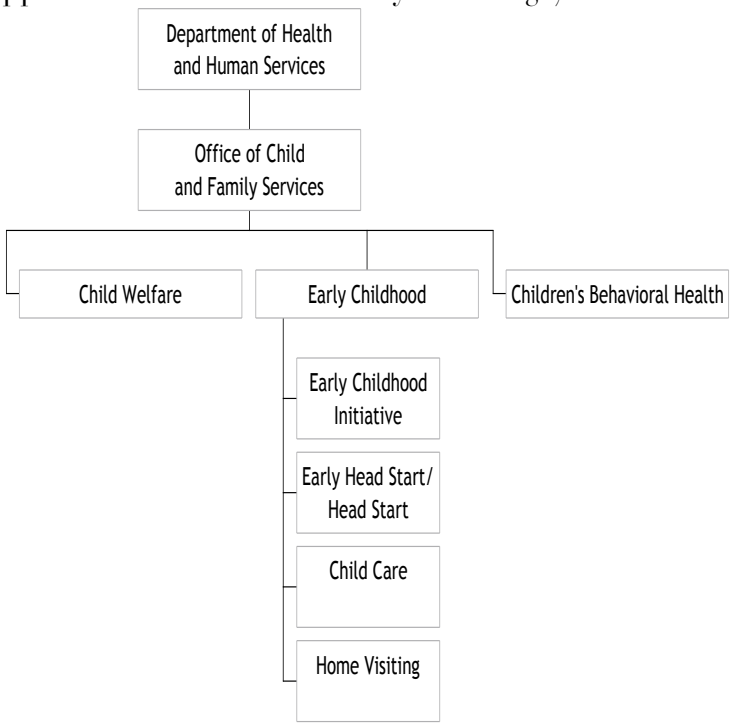
In 2003, the federal Maternal and Child Health Bureau provided the financial support to formally promote effective systems change through Maine's Early Childhood Initiative (ECI). The Initiative has served as the tool to focus years of research, dialogues and advocacy from Governor Baldacci's Children's Cabinet, its Task Force on Early Childhood, and its community partners into a thoughtful, intentional blueprint for how Maine can demonstrate the esteem in which we hold our children.

A New Department of Health and Human Services
The uncertainty and excitement generated by the creation of a new Maine Department of Health and Human Services places the Early Childhood Initiative in an opportune place. Our Health and Human Services Commissioner has proposed an organizational structure that strongly emphasizes integration among formerly separate units or departments to better meet the strengths and needs of children and families.

Children's services are brought together in the Office of Child and Family Services (OCFS), and houses three divisions: Child Welfare, Children's Behavioral Health, and Early Childhood. The Division of Early Childhood, which includes Child Care, Head Start/Early Head Start, Home Visiting, and the Early Childhood Initiative, will

develop and manage early intervention and prevention programs as the OCFS integrates its services in a unified, family-centered, strengths-based practice paradigm.

The integration of Early Childhood, Child Welfare, and Children's Behavioral Health Services will allow a true collaboration at a crucial time in a child's development and better ensure that each child can maximize their natural potential. The role of Child Welfare is to allow this to happen in a safe environment (more than 1/2 of all child abuse happens before children are 5 years of age). Children's Behavioral Health Services, when involved with Early Childhood and Child Welfare will be able to intervene earlier, limiting the potential damage of mental health challenges, and increasing the likelihood of full recovery for the child and family.



Only working together as a team can the three child serving agencies achieve effective, cost efficient, and positive services for Maine's children and families.

The underlying vision for the new department and the core beliefs of the Task Force on Early Childhood are in serendipitous alignment. The Task Force has assembled significant work and energy to support the new Department in its creation, which will help bridge the tension between vision and reality.

Both groups believe that "visions spread because of a reinforcing process of increasing clarity, enthusiasm, communication, and commitment. As people talk, the vision grows clearer. As it gets clearer, enthusiasm for its benefits builds. And soon, the vision starts to spread in a reinforcing spiral of communication and excitement."[4] The willingness of Department leadership to heed and incorporate the Task Force as a natural voice for Maine's children and families is indeed a hallmark of an 'intelligent organization.'[5]

Further strengthening this project, the Governor's office submitted a Resolve requesting legislative approval to authorize the Task Force Steering Committee to serve as a public/private observer of the Department and state early childhood systems. As the vehicle for the Early Childhood Initiative, its goals are as follows:

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[4] Senge, Peter. *The Fifth Discipline*. Doubleday. 1994
[5] Pinchot, Gifford & Elizabeth. *The Intelligent Organization*. Berrett Koehler. 1997

- Provide leadership to integrating service partnerships and communication in support of children in early childhood in order to enhance their ability to enter school healthy and ready to learn.

- Help build an early childhood service system that addresses the critical access to comprehensive pediatric services and medical homes; social-emotional supports for young children; early care and education, parenting education and family support.

The Humane Early Childhood Systems Plan incorporates the existing goals of the Task Force and aligns them with the five mandatory components of the Maternal and Child Health (MCH) funding for the Early Childhood Initiative. These are:

MCH Components	Task Force Goals
Access to Health Care and Medical Homes	Secure needed resources for young children
Mental Health and Social-Emotional Development Programs/Services	Balance cognitive development with the emotional and physical needs of young children
Early Care and Education/Child Care	Guarantee effective service systems for young children
Parent Education Family Supports	Strengthen and expand commitments to assist parents of young children

Using the MCH Components as a guide, here's where Maine was in 2005:

Access to Health Care and Medical Homes
Health care coverage, especially for preventive health services, creates an environment for improved health outcomes[6]. Insurance coverage of well-child care in Maine has improved our rates of immunization and early detection of health problems and developmental delays.

Our data show that Maine children without health insurance are less likely to have a regular health care provider; less likely to have a regular dentist, or to have had a dental visit in the last year; and more likely to be in fair or poor health than low-income, insured children. However, access to health coverage and medical homes in Maine is inconsistent.

Maine does not have enough primary care providers for our children and their families. Fourteen of the state's 16 counties contain at least one town that is a

[6] We would prefer using the word "be-comes" as an alternate to "outcomes" as the word itself evokes a more gradual, thoughtful indicator of change. For Maine families, the use of "outcome" implies the finality of an end point; our vision seeks to acknowledge the phases of personal change along the life cycle and hopes to instill changes that carry through generations of Maine families.

federally designated primary care health professional shortage area; 15 counties contain towns that have federally designated medically underserved areas or populations[7]. We have made some progress: With Title V MCH funding, all birth hospitals in Maine now conduct newborn hearing screening and nearly all Maine newborns are tested for 28 disorders that can cause serious health problems, mental retardation, other disabilities, or even early death.

At times, families of children with special health care needs (CSHN) can have difficulty coordinating their children's health care; a problem seen commonly across the country. Maine, however, is very proud that 93% of its CSHN families have a consistent source of health care and only seven percent (7%) frequently rely on the emergency room for care.

Early oral health intervention also remains elusive for many children. Most of Maine is federally designated as dental health professional shortage areas; there are federally designated dental health professional shortage areas in every county in the state.[8]
Maine has in place several initiatives that are currently addressing some of these health outcomes. The Early Childhood Initiative is coordinating their activities with these initiatives to support and complement the state plan the sum of which moves Maine toward its vision for early childhood. They include:

- Home visiting provides an ongoing connection to community services, particularly assistance with applying for public insurance (MaineCare); participating with Women, Infants and Children (WIC) nutritional services; and obtaining referrals to Child Development Services, Maine's IDEA Part C provider.
- Maine's Governor and Legislature have passed an innovative plan to serve as a safety net of health insurance for many Mainers, Dirigo Choice.
- The Maine Consumers for Affordable Health Care Coalition (www.mainecachc.org) has adopted as its mission to 'advocate the right to health care for every man, woman and child.'
- The Maine Center for Disease Control and Prevention (Maine CDC, formerly the Bureau of Health), with planning funds from the Maine Chapter of the March of Dimes, is developing a Maternal and Infant Mortality and Resiliency Review to better understand where health care gaps could be strengthened and sustained and enhanced to improve obstetrical and infant outcomes.
- The Maine Chapter of the American Academy of Pediatrics has become an active participant in the Task Force on Early Childhood and is exploring ways to maximize time spent with families to better address developmental milestones, oral health and lead poisoning risks.

Mental Health and Social-Emotional Development
The trend of modern medicine and associated health care practice over the past century has progressively contributed to a system that treats mental health and

[7] Maine Title V Block Grant Strengths and Needs Assessment, 2005.
[8] Coulombe M, Office of Rural Health and Primary Care, Maine Bureau of Health, 2005.

physical health as unrelated disorders. The Institute of Medicine notes[9] that communities and the educational and medical systems that work with them to support families must consider the complex and converging influences of genetics, environment and experiences on a child's development. "Circumstances characterized by multiple, interrelated, and cumulative risk factors impose particularly heavy developmental burdens during early childhood[10]."

However, physical and behavioral health systems are not well integrated and lack sufficient qualified mental health providers. Eight of Maine's 16 counties contain towns that are federally designated mental health professional shortage areas[11].

Maine offers training statewide in mental health for primary health care providers, but more is needed for those who work with children in early care and education, child protective services, early intervention, and various other social service and school-based environments. Maine is making some headway with the new reorganization of DHHS and our state plan, and the outlook for positive change is promising.

Maine is a national leader in developing clinical practices for very young children. Maine was the third state to develop a crosswalk facilitating use of and payment for diagnoses defined in the innovative DC:0-3 Diagnostic Classification System developed by Zero to Three specifically for infants and toddlers. Maine has been recognized nationally for this work. The DC:0-3 system emphasizes the centrality of parents in the lives of their children, and focuses treatment efforts on supporting, nurturing and healing this relationship. It reflects our understanding of the complex problems and resiliency of young children and their families and the mental health interventions to serve them. This diagnostic system adds substantially to the Diagnostic and Statistical Manual of Mental Health Disorders IV-Text Revision (American Psychiatric Association diagnostic classifications).

Children's Behavioral Health Services (CBHS) is collaborating with Zero to Three and has supported the development of two Maine DC: 0-3 trainers. It offers monthly clinical supervision via telecommunication and has developed a web-based forum for clinical discussions. DC: 0-3 training for parents and others working with infants and toddlers will be available in mid-2006.

CBHS collaborates with Maine's very active and forward thinking Association for Infant Mental Health, as well as the Children's Committee of the Maine Mental Health Association. With the wisdom of early intervention once again rising to the fore in the face of tight budgets and increasing social service needs, the combined objectives of these groups should garner greater attention and traction in policy and funding development for our youngest children and their families.

Maine is a national leader in integrating physical and mental health treatment services for children and families. Maine has 25 sites throughout the state that are

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[9] Shonkoff, J. P. and Phillips, D.A., Eds. (2000). *From Neurons to Neighborhood: The Science of Early Childhood Development*. Washington, D.C.: National Academy Press.
[10] Ibid, p. 6-7.
[11] Maine Title V Block Grant Strengths and Needs Assessment, 2005.

providing integrated health care delivered by clinicians and physicians. This follows the voice heard from family surveys, with 75% of families expressing a wish to receive mental health services in their primary care medical/mental homes. This move will decrease stigma, increase the follow up on referrals for mental health treatment, shorten mental health treatment, and decrease unnecessary medical visits and medical testing. In addition, many young children and their families participate in infant-toddler groups, infant mental health programs, family therapy, and parent education programs sponsored by CBHS. The Maine Health Access Foundation has made this integration of health care a primary focus of its funding efforts.

Early Care and Education/Child Care

A 2003 report on the early care and education industry in Maine stated that 72% of children ages birth-13 lived in households where all parents were in the labor force. With an increasing number of children now spending a substantial amount of time in early care and education settings, there is a growing recognition of the importance of meeting the needs and strengths of children and families through comprehensive early care and education systems.

Another report estimates that there have been as many as 54,500 Maine children eligible[12] for child care assistance (through vouchers or contracts) who were unable to access a subsidy. Funds are available for only 13,000 children. Many eligible families do not apply, either because they do not know the assistance is available or because the waiting list is inordinately long. In 2002, more than 2,000 children statewide were on voucher waiting lists.[13] Estimating that nearly half of the eligible children would enroll in subsidized care, Maine would need an additional $58.9 million to address the unmet need for early care and education.

Head Start and Early Head Start mitigate this issue of accessibility to a small degree. In 2003-2004, nearly 4,000 children participated in Head Start in Maine. However, trend data indicates that more than twice those numbers of children who were eligible for Head Start in the state were not being served due to insufficient funding.[14]

For children with special learning related needs, being ready to enter and succeed in school partly depends on having had early intervention and ongoing supports in place. Head Start serves children with a broad range of special needs. On average, 25% of children enrolled in Head Start programs have a diagnosed special need. In 2000-2001, 43% of Maine children with special needs had speech or language impairments; 27% had "non-categorical/ developmental delay"; and 20% had other disabilities.[15]

As the number of Maine's eligible children birth through five has increased over the last five years, there was a concurrent increase in the number of children served

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[12] Children whose parents have income below 85% of State Median Income.

[13] Maine Child Care Advisory Council. The State of Child Care in Maine, 2002. Available from: URL: http://www.maine.gov/dhhs/state_of_child_care.pdf.

[14] Maine Child Care Advisory Council. The State of Child Care in Maine, 2002.

[15] Maine Office of Child Care and Head Start. 2002 Maine Head Start Data Report. Available from: URL: http://www.maine.gov/dhhs/maineheadstart2002.pdf.

by the Child Development Services (CDS) system who exited to regular education upon school entry. Moving forward, we seek to understand more clearly the implications of this trend, especially as it relates to the children identified through Head Start and CDS with emotional disorders and the fractured mental health system that must address their needs.

Within the last four years the State has experienced a steady growth in the number of public schools opting to develop public school programs for four-year-old children. Maine's declining enrollment in public schools in recent years has made more elementary school classrooms in many northern and rural areas available to house Pre-K programs[10]. In addition, with the understanding of greater costs to provide services for younger children, the Maine Department of Education Essential Programs and Services funds are being redirected for early childhood programs, thereby compelling financially-strapped districts to implement programs for four-year-olds[11]. We have initiated active community dialogue about the implications on private and non-profit early care and education by expanding public pre-K in Maine. At the core of this debate is the consideration of *working families* in designing a universal pre-K program.

Parenting Education

It is clear that for young children to develop to their fullest potential, parents and caregivers need an understanding of the knowledge and resources that exist to support all aspects of healthy child development. Timely access to such resources and services can have a profound effect on children's ability to learn, their physical and emotional development, and eagerness to explore relationships and their world.

Home visiting is one evidence-based approach to quality parent education and to connection with community supports. Maine's home visitation programs are offered universally to first-time parents prenatally until their children reach age five. Support groups are also effective when offered in conjunction with parent education classes. They provide a continuum of care by offering parents a support system and an opportunity to discuss the application of learned techniques. There are also groups specifically for fathers and parents of children with special needs.

Family Support

Emerging family-centered practice models are being used by agencies that work with families, including families in social, financial, emotional, or physical crisis. These models consider the children's environment and offer approaches that embrace all members of a family even if a single child is the driving factor for accessing assistance.

Unfortunately, most funding streams (including Medicaid) are designed to consider a single client with medically-necessary needs. Historically, most authorizations for treatment or case management services are not rooted in holistic health. They provide no incentive to embrace the family and their needs among such services as behavioral health, Head Start, home visiting, CDS, child welfare, or family independence.

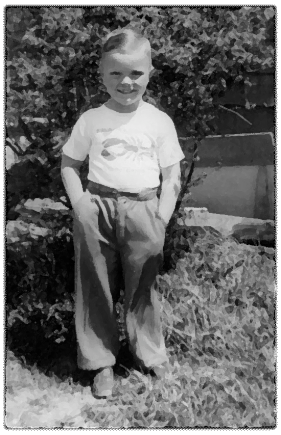
It is apparent that parenting education and family supports are threatened by the general lack of awareness of the return on investing in parenting education and the recruitment and exchange of social capital.[16] However, as the state transitions to a truly integrated system that serves children and families, we can look to community-based resource centers to include the core services: parent education, child development activities, resource and referral, drop-in availability, peer-to-peer supports, and life skills and advocacy. These centers may offer a local structure for integrating new and existing family-centered programs.

Summary of Environmental Scan

The following table highlights some of the critical elements of the state plan and shows the relationship of the plan objectives among the agencies of state government and its partners.

Dept or Office	Health and Human Services						Education	Public Safety	Labor	AG's Office	State Planning Office	External Partners
Select State Plan Element ↓	Office of MaineCare Services	Maine CDC	Child Welfare	Behavioral Health	Early Childhood	OIAS						
Child Abuse/Neglect		√	√	√	√	√		√		√		√
Child Development Services	√	√	√	√	√	√	√					√
Family/Community Resource Centers	√	√	√	√	√	√	√		√		√	√
Home Visiting	√	√	√	√	√	√	√	√	√	√		√
Immunizations	√	√			√		√					√
Prevention • Injury • Lead Poisoning • Fire • Substance Abuse • Domestic Violence	√	√	√		√		√	√		√		√
Insurance	√	√	√	√	√	√	√					√
Investing in Young Children	√	√	√	√	√	√	√	√	√	√	√	√
Maine Family Networks		√		√	√	√	√				√	√
Infant Mental Health	√	√	√	√	√		√	√				√
Oral Health	√	√			√		√					√
Prenatal Care	√	√			√		√					√
Quality Early Care/ Education • Child Care • Head Start • Early Head Start • Univ. Pre-K	√	√	√	√	√	√	√	√	√	√	√	√
Unified OCFS Practice	√	√	√	√	√	√	√		√			√

[16] Lin, Nan. *Social Capital: A theory of social structure and action*. Cambridge University Press 2001.



Where is There?
(aka Objectives/Strategies)

The following pages represent the primary recommendations of the Task Force and provide a functional framework for the state plan. It marks the beginning of the long-awaited and gratifying task of making change happen. The five MCH components mentioned earlier are integrated into each of the Action Team Recommendations. The recommendations are grouped by these levels as strategic themes (family, health, early care and education, community, state), organizing our work with the child always at the center of our plan goals. Each level of the model below represents the points at which the child touches parts of the early childhood system in his or her daily life, beginning with the family.

CHILD	FAMILY	HEALTH	EARLY CARE/ EDUCATION	LOCAL COMMUNITY	STATEWIDE COMMUNITY

Assisting Parents with Home Visiting and Family Networks (**FAMILY**)
The Family theme focuses on the important work of parent education through home visiting. It includes work on an integrated local system adapted to the catchment area of elementary schools, in which networks of all parents self-organize by age cohort of their children (infants, one-year olds, etc.) to provide early connection to their children's medical, educational, and community homes.

Medical Home (**HEALTH**)
"A medical home is where parents and their children know that their "doctor" or "nurse" knows them personally and by name and always respects, cares about and is committed to them, their whole family, and their culture. They know that they will always receive the highest quality of comprehensive primary medical care and humane professional caring regardless of the time of day or day of the year. A hospital emergency room is never a substitute for medical home care. Its use is

limited to true medical emergencies only after a clinician from their medical home recommends such services. If a parent, acting on their own behalf or that of their child, finds that these standards are not met, they can expect that their concerns will be welcomed and that they will be members of a team effort to improve the medical home services provided."

Health care access is at the heart of this ECI component. Work around this theme includes a reform of the healthcare system to make it universally available for the early childhood population. System change will include preventive, developmental and evidence-based alternative services that optimize physical, oral, mental, and social health.

Early Care and Education (**EARLY CARE AND EDUCATION**)
Quality, effective early childhood experiences can serve as a foundation for life long learning. Maine studies on cost and quality indicate caregivers/teachers need support in planning a balance of activities as well as more specialized social-emotional health and literacy training.[17] Another critical element of strategic theme is the regional network of child care health consultants needed to improve general health and safety of licensed and regulated early care and education facilities.

Community Resource Centers (**COMMUNITY**)
Of all the themes, the concept of community-based resource centers has generated some visionary, yet feasible ideas. Maine can capitalize on its rich systems of coalitions that have the capability to initiate early childhood networks to support broader systemic change and validate a broader public health study. For instance, a partner of the Early Childhood Initiative, the State Planning Office, is working to incorporate local early childhood data as a standard element into each municipal planning packet. Use of Maine Roads to Quality Registry mapping will further this ability.[18]

Communities can review this data and implement the promising practices of the Healthy Maine Partnerships and Communities for Children and Youth into their own early childhood networks. For instance, the success of the Totline[19] and use of school readiness indicators for evaluation of the Bucksport Bay Early Childhood Network can support the 2-1-1 phone system we are piloting for statewide coordination. From informal partner conversations to actions requiring only nominal formality, local networks could burgeon in a climate that embraces early childhood as vital to the economic health and development of Maine.

Invest Early in Young Children (**STATE**)
Early Care and Education is not a lucrative business. Early care and education programs for working parents, for instance, do not generate a significant profit margin, as the primary stream of revenue is generated from charging tuition fees to

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[17] Marshall, N.L., Creps, C.L., Burstein, N.R., Squibb, B., Roberts, J., Dennehy, J., Robeson, W.W. & Wang, W. (2004). The Cost and Quality of Family Child Care in Maine. Wellesley Centers for Women, University of Maine at Farmington, and Abt Associates, Inc.
[18] See http://earlychildhood.msstate.edu/atlas/
[19] A local hotline for families with young children supported in part by the ECI and School Readiness project funds.

families. In Maine, early care and education is the fourth largest industry, yet its workforce struggles to earn a livable wage. In turn, accessibility, affordability and quality challenge our working families. The issue is multi-faceted: Quality early care and education worker wages are intimately linked, while school readiness and high literacy rates also have direct connections to quality early care and education programs[20]. This year, the ECI is launching its plan with a high-level meeting of the Task Force, business leaders and legislators that will distribute to Chambers of Commerce a presentation and resource guide and to help assess early care and education as part of the economic infrastructure in their development work.

A Word or Two About Primary Intentions

Primary Intentions are those indicators that let us know we are on track. We easily could have listed the more than 300 ways to measure both our progress (Process Indicators) and the long-term effect of our work on children and families (Outcome Indicators); instead, we chose to keep our resources focused on the work itself, not its measurement. There are only ten each.

Top Ten ECI Process Indicators

1. **Maine Family Networks support the parent/child relationship with their medical and educational homes.**
   - *1.1. Early childhood forums/events sponsored by AAP/Maine Chapter (and others) include both public health and early care and education representation*
2. **Develop measures for social, emotional health/food security**
   - *2.1. Kindergarteners who demonstrate developmentally appropriate skills and behaviors*
   - *2.2. Kindergarten students who can establish and maintain positive relationship with peers and adults*
   - *2.3. Kindergarten students who can function appropriately in group learning activities, participating actively, talking, talking turns, following directions and working cooperatively*
   - 2.4. *Children (age 0-2) with food security (clinical measure malnutrition/not just poverty)*
3. **Improved use of publicly funded resources**
   - *3.1. Children's Section of the State Budget*
4. **Workforce developed and trained to use evidence based practices**
   - 4.1. Catalog/Inventory of Evidence-Based Practices in Training
   - 4.2. All components of the early childhood system demonstrate an understanding of the Early Learning Guidelines and the Infant Toddler Developmental Guidelines
     - *4.2.1. Early Learning Guidelines Training a state employee training option*
     - *4.2.2. Infant Toddler Developmental Guidelines are developed; training developed*
   - 4.3. Improved professional development of early childhood (measured through the numbers on the MRTQ registry)
5. **All families have access to and are referred as appropriate to early care and education support services**
   - *5.1. Completed memoranda of understanding for collaboration (both internal and external to state government). This includes a standardized and simplified referral protocol.*

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[20] RAND Research Brief. (1998). *Early Childhood Interventions: Benefits, Costs, and Savings* (RAND Publication RB-5014).

6. **All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health**
   6.1. Documented policies at each entry point to the early childhood system
   6.2. *Increased/Revitalized use of EPSDT*
7. **Statewide CCHC is established for all centers and PreK**
   7.1. Parents and early care and education providers are partners in child and family health
   7.2. The percentage of licensed early care and education centers serving children age birth to five who have on-site health consultation (including mental health), as defined by the standards in Caring for Our Children (Title V Region 1 Performance Measure)
8. **PreK standards are developed and become the basis for ongoing expansion of Universal PreK**
9. **Public Awareness Campaign outlining the value of investing early in quality of early care and educations services to children and families.**
   9.1. Maine's Early Childhood Initiatives are co-branded
10. **Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan**
   10.1. Each of the process indicators above has a link of accountability to a member of the Task Force on Early Childhood Steering Committee.

Top Ten Outcome Indicators[21]

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age (By 2008, the number of children with blood lead levels ≥ 20 μg/dl will be reduced to 0.)
9. Availability of early care and education programs
10. Rates of child abuse and neglect

Each recommendation includes the primary activities and essential to accomplish the goal and the general timeframe for its completion. These are not necessarily workplans, but can be used as such. The Lead Contacts are those members of the task for who have agreed to initiate those activities and propel us into action.

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[21] These were identified using the rich resources of data assimilation we already have through Maine Kids Count, our School Readiness Indicators, Maine Marks, and the Maternal and Child Health Strength and Needs Assessment.

family

GOAL Maine Family Networks (MFN) will be established by parents of infants and toddlers in every Maine town or city neighborhood

Primary Activities

In distinct geographic regions, identify and propose expansion of naturally existing family networks in elementary school catchment areas.	2005-2006
Maine Family Networks will help parents secure quality, affordable, consistent early care and education programs.	2005-2010
The MFN will support good parenting with the most current child development information derived from the country's leading childhood experts.	2005-2010
Parents will receive "20 Key Messages for Parents of Infants and Toddlers" developed by Maine parents and early childhood professionals with the assistance of Dr. Vincent J. Felitti, a foremost researcher in childhood experiences. Network parents are supported to exchange parenting tips and knowledge, model parenting skills, and share parenting challenges and joys.	2005-2010
MFN will provide links to a variety of support and resources--community health organizations, early care and education providers, schools, government, and human service providers.	2005-2010
Maine Family Networks will support the parent/child relationship with their medical home.	
Maine Family Networks will help parents develop an early relationship with their child's elementary school.	
Home visitors and the community-based, citizen-led Family Resource Coalitions/Centers will provide information about the networks to their clients and constituents and provide backup support and resources to the local networks	2005-2010
Family Resource Coalitions/Centers will help identify public space for parents of infants to gather for play groups and activities	2005-2010

Partners:

Other Parents
Home Visitors
WIC; RDCs
Medical Homes
Libraries
Elementary Schools, esp. Kindergarten Teachers
PTO's
Early care and education Providers
Head Start
Nursery Schools
Public Health Nurses
Healthy Futures Community Nurses
Administrative staff

Lead Contact(s):

Aubrie Entwood
Executive Director
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Primary Intentions

Process Measure(s):

1. Maine Family Networks support the parent/child relationship with their medical and educational homes.
5. All families have access to and are referred as appropriate to early care and education support services
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

family

GOAL

Expand high quality Home Visiting services offering parenting information and support to all communities and all interested families and other primary caregivers

Primary Activities

Facilitate home visiting program integration within new Office of Child and Family Services while maintaining connection to Maternal and Child Health	2005-2006
Develop a plan for by which pregnant women, parents of newborns, and eligible new residents are aware of HOME VISITORS services and a fiscal plan to increase capacity to serve more families	2006
Establish core curriculum aligned with Best Practices document developed by the Home Visiting Coalition and develop in-state training capacity. Develop consistent home visitor professional development standards for Maine.	2006-2007
Coordinate home visitor program with statewide cross-disciplinary training of early care and education professionals regarding balancing social-emotional and cognitive development, literacy, prevention of child abuse, promotion of health practices (see Cross-disciplinary training goal)	2006-2007
Home Visitors collect evaluation data as an integral part of every visit and maintain a data base of the results to share with Invest Early goal workgroup and national agencies	2005-ongoing
Develop Home Visiting Strategic Plan (phase II) to include Quality Assurance/Quality Improvement. Explore use of Touchpoints in concert with the Brazelton Institute	2006
Database of longitudinal data related to a) child outcomes: physical and emotional health, safety and development and b) family outcomes: increased protective factors and stability. Established data for universal home visiting as an evidence based practice	

Partners:

Parents
PHN/CHN
Early Head Start
Physicians
Hospitals
CDS, MOD
Maine CDC
MRTQ
Higher Ed
Schools, Adult Ed
Family Literacy programs
WIC
RDCs
Family Planning programs
Early intervention programs
Businesses
Media
Home Visiting Coalition

Lead Contact(s):

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Primary Indicators

Process Measure(s):

4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

family

GOAL

Home Visiting Programs model and deliver comprehensive, family-centered, collaborative prevention services.

Primary Activities

Home visitors participate in cross-disciplinary training for all providers of child and family services (See Comprehensive CD Training Goal)	2006
Home Visitors provide information about Family Networks, family resource centers, Medical Homes, WIC, CDS, web-based local and regional resource guides, and up-to-date web accessible parent education sites	2006-ongoing
Using Statewide Resource Directory (see Resource Directory Goal), Home Visitors network and coordinate messages establish personal contacts with local Family Networks, Medical Homes, WIC, CDS, and other providers of support and services in their area to ensure a) delivery of consistent messages to parents (e.g., 20 Key Messages) and b) access to services as needed.	2007-ongoing
Home Visitors serve prenatal families	2006-ongoing
Home Visitor policies ensure proactive outreach for consistency between parents and other caregivers (e.g., early care and education, CDS, infant mental health, CPS)	2006-ongoing
Home Visitors serve as the public health conduit for statewide preventive health initiatives and services, including, but not limited to, substance abuse and tobacco use.	2006-ongoing

Partners:

Parents
Public Health/ Community Health Nurses
Early Head Start
Physicians
Hospitals
CDS, MOD
Public Health
Schools, Adult Ed
Family Literacy programs
WIC
RDCs
Family Planning programs
Early intervention programs
Businesses
Media
Home Visiting Coalition
MRTQ
Higher Ed

Lead Contact(s):

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Primary Intentions

Process Measure(s):

3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
10. Rates of child abuse and neglect

GOAL

Health and Safety programs and policies are infused with prevention, early intervention, and chronic care philosophies.

Primary Activities

Convene workgroup to review the policies and practices of all providers of child and family services. (see Unified Practice Goal)	2006
Review the training practices of those working with young children, mapping them to the Strengthening Families framework of the Center for the Study of Social Policy	2006
Provide report of suggested modifications to program policies	2006
Incorporate asset-based language into policy modifications in all new state contracted and state provided direct services	2007
Ensure that all state training for child and family service providers incorporates use of resource directory (see Resource Directory Goal) and referral protocols	2007
Provide performance measures for prevention philosophy compliance	2007
Obtain technical assistance/training from CSSP for the "Protecting Children by Strengthening Families" framework: with funding, seek pilot sites from among child care and Early Head Start/Head Start locations	2007
Revise Medical Homes history intake forms for newborn and annual well child visits to include questions about Adverse Childhood Experiences	2007
Use work of Maine Maternal and Infant Mortality Resiliency Review to improve prenatal care programming and parent education around infant health and safety (e.g., use of car seats, breastfeeding, literacy, "back to sleep", "don't shake Jake", lead poisoning)	2007
Reinvigorate use and consistency of use of EPSDT	2007

Partners:

Parents
Family Resource Coalitions
Home Visitors
WIC; RDCs
Injury Prevention
LEAd Council
Medical Homes
ECE Providers
MRTQ
Head Start/Early Head Start
Public, Private Insurance
Public Health Nurses
Healthy Futures Community Nurses
Communities of faith
HHS, DOE, DPS
Maine Chapter, AAP
March of Dimes
Maine Children's Trust

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Primary Intentions

Process Measure(s):

2. Develop measures for social, emotional health/food security
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

health

GOAL Develop unified, evidence-based practice guidelines based on the shared values and principles upon which all agencies within the OCFS (and partners) conduct their work

Primary Activities

Develop and assign an interdisciplinary work group to identify commonalities and conflicts in beliefs and practice models, as a foundation for developing the practice guidelines based on existing resources.	2006
Revise all administrative systems requirements (policy, regulation, contract requirements, licensing and memoranda of understanding) to reflect the expectations of the practice guidelines.	2007
Align quality assurance for case management, treatment and other supports to monitor implementation and outcomes of services provided to assure fidelity to the unified practice guidelines.	2007
Enable effective and efficient transition among case management, treatment and other support services for which OCFS has direct or oversight responsibility, while eliminating any unnecessary duplication with any one family.	2007
Adopt current healthcare industry practice to ensure the development and management of a sufficient Targeted Case Management workforce with consistent minimum qualifications and core competencies aligned with the practice guidelines.	2007
Clarify eligibility and payments between MaineCare, Part C, IV-E, Title V, EPSDT, etc. when children have multiple eligibility status	
Work to resolve outstanding issues of confidentiality in order to expedite referral and delivery of appropriate services, and ensure that the process of sharing client information guarantees consumer rights to choice and to informed consent	
Coordinate policies to reflect cross-disciplinary understanding of child development, mental health, literacy, etc. (see Infant Mental Health System and Cross-Disciplinary Training Goals)	

Partners:

HHS
Maine Children's Trust
Maine Children's Alliance
Families, Youth
Community providers
Home Visitors
Public Health
ECE providers; RDCs
Primary Care providers
Rural Health Clinics
MaineCare
CPS
Family Independece
LIST NOT COMPLETE

Lead Contact(s):

MACSP
Maine Children's Alliance

Sheryl Peavey
287-3339

Primary Intentions

Process Measure(s):

3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
10. Rates of child abuse and neglect

health

GOAL Develop a coordinated system of infant mental health training/ resources for professionals working with children and families

Primary Activities

Convene a workgroup to itemize existing training resources, common language and disparities related to children's social, emotional and behavioral health	2006
Through process of vetting to various provider stakeholders, confirm common and evidence based training modules for each group. Assure training is consistent, accessible and culturally sensitive	2006
Integrate and formalize ongoing professional and workforce development for Infant Mental Health system	2006-ongoing
Coordinate policies to reflect cross-disciplinary understanding of child development, mental health, literacy, etc. (see Unified Practice and Cross-Disciplinary Training Goals)	2006-2007
Train child welfare workers, court personnel, home visitors, family support team members and others in the principles of early childhood development and their implications in family service systems.	2007
Universal developmental screening that includes social and emotional development will be made available to all young children.	2007
Provision of child care mental health consultant services (see Child Care Health Consultant Goal)	2007-2008
Placement of infant mental health specialists in pediatric offices, rural health clinics	2007-2008
Children who are at-risk will all receive mental health screening	
Family-centered, community based and culturally reinforcing services	
All children 0-3 entering the foster care system receive screening and referrals (as necessary) for family centered mental health services	
All children eligible under IDEA part B (619) and part C, will receive services	
Define, plan, train and implement a truly collaborative and comprehensive Trauma Informed System of Care with the aim to prevent, recognize trauma, intervene early and effectively in the three county (Somerset, Franklin, Androscoggin) area.	2008

Partners:

MPF, Head Start
MADSEC, ACCESS/ELOG
Maine Humanities Council
MeAIMH
CAN Councils
C4CY
ME Principal's Assn
Higher Ed Committee
UMCE
ECE Ed in Vocational Technical
MRTQ, Head Start/Early Head Start, CDS,
Public health nurses
DOE, DHHS, DOL
Home Visitors, RDCs
National Associations, CCI

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Maine Association of Infant Mental Health

Primary Intentions

Process Measure(s):
2. Develop measures for social, emotional health/food security
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
10. Rates of child abuse and neglect

GOAL

All Maine children at risk for lead exposure will receive appropriate and adequate risk assessments, screening tests and follow-up care.

Primary Activities

Develop message for health care providers and parents addressing Lead Poisoning myths, so they understand that lead poisoning is still a problem in Maine; that the risks of lead exposure are not specific to one demographic (or income); that lead screening and its results are helpful to (not harmful) the living environments of young children.	2006
LEAd-ME and partners will identify barriers to screening (with data from such sources as MaineCare, DOE, DEP and local communities) and plan to address those barriers (such as billing). This includes reviewing Maine laws impacting lead-safe housing and identifying gaps in housing laws and policies.	2007
LEAd-ME and Office of MaineCare Services will develop system to identify Medicaid-enrolled children who are not receiving a blood lead screening test.	2007
All providers at child and family system points of entry (including WIC, Head Start, child care, CDS, CBH, CPS, Healthy Families, public Pre-K) will understand how to assess for lead exposure risk in young children and agree to routinely assess and encourage lead screening.	2007-2008
All pediatric health care providers will understand how to assess for lead exposure risk in young children and agree to routinely assess and encourage lead screening.	2007-2008
All child and family system points of entry will serve to routinely screen and refer families for lead exposure.	By 2010
Incorporate blood lead screening information into the state IMMPACT system for immunization registration.	
All child and family system points of entry will serve to routinely screen and refer families for lead exposure.	2007
All lead poisoned children will receive long-term follow up assessments and interventions through the school system and developmental services agencies.	

Partners:

LEAd-ME (Maine Childhood Lead Poisoning Elimination Advisory Council)
Maine CDC
Kids Run Better Unleaded
HeadStart/Early HS
WIC; RDCs
Healthy Families
Maine Chapter, AAP
Maine Public Health Association
DEP
UMCE
CDS, MRTQ
Public health nurses
DOE, DHHS, DOL

Lead Contact(s):

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Primary Indicators

Process Measure(s):

3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age (By 2008, the number of children with blood lead levels ≥ 20 μg/dl will be reduced to 0.)

GOAL Create Child Care Health Consulting infrastructure

Primary Activities

Create and fund State CCHC Coordinator position. This person leads training program within state and as part of regional training collaborative (consider training system to be housed at MRTQ)

Establish state CCHC certification and pay scales

Continue state and regional development of mental health component in child care health consulting (see Infant Mental Health Goal)

Continue family home early care and education networking for training and evaluation related to provider proficiency in Health and Safety standards Ensure that Quality Early Care and Education Standards include Health and Safety (Use Caring for Our Children from NRC)

Propel and implement medication administration guidelines via Maine CDC and child care advisory council as standard in CCHC and early care and education provider training

Connect with SECCS coordinator to pursue options for Family Resource Center (aka HUB in public schools) as viable co-location for local CCHCs (including school nurses and school based health clinic personnel)

Disseminate YIKES (Emergency Preparedness Manual) to early care and education providers, licensing, RDCs, OPHEP, MEMA, MRTQ and work with OPHEP to ensure developmentally appropriate practice in the state public health emergency preparedness plans

Develop template for Early care and education provider health and safety policies and provide updated manual to licensing/providers

Make current regional training flexible and cost effective (e.g., through distance learning) (consider running joint trainings with New Hampshire)

Explore incentives for increasing number of available CCHCs (e.g., loan forgiveness through OPCRH, certification)

Partners:

Health Professionals
OCCHS
Child care licensing
HCC-New England
CCI, DOE/CDS
AAP, ME Chapter
Home Visiting Coalition
CSHCN, BFI, MCA
MEMA, OPHEP
MRTQ and RDCs
State Plan. Office

DECD
AG Office
CAN councils
Parents/Families
Insurers
MaineCare
Dept of Licensing and Professional Regulations
NTI (in NC)
School based health clinics and nurses
UM System

Lead Contact(s):

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Primary Indicators

Process Measure(s):

1. Maine Family Networks support the parent/child relationship with their medical and educational homes.
2. Develop measures for social, emotional health/food security
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
7. Statewide CCHC is established for all centers and PreK
8. PreK standards are developed and become the basis for ongoing expansion of Universal PreK
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

3. Children participating in Maine Care/Percent of insured children
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

early care and education

GOAL All children and families will have access to comprehensive, quality, coordinated and integrated services in all early care and education settings

Primary Activities

Identify and address necessary policy changes to ensure coordination of all early care and education programs with CDS, Children's Behavioral Health, Child Welfare Services, etc. with vigilant consideration of the context of Maine families' economics	2006-2007
Establish benchmarks of qualifications and competency requirements for early care and education practitioners aligned across the system	2007
Establish a system of accountability between DOE and HHS	2007
Continue implementing Early Childhood Learning Guidelines	2006
Complete the development and dissemination of the Infant-Toddler Learning Guidelines	2006-07
Establish standards for schools and communities starting pre-k {LD1513} to include such things as class size and teacher:child ratios	2006
Secure Pre-K Now funding to coordinate regional meetings of stakeholders to strategize community approaches to universal public Pre-K that are mindful of Maine's working families.	2006
Establish a group of representatives from Superintendents, Principals, Early care and education, Head Start, Home visitors, public health, mental health, data & research group in each region to host Regional "Town Meetings" and define Pre-K.	2006-07
Compile report on viable strategies for public Pre-K options in Maine	2007
Identify funding sources [cross reference with Invest Early Action Team and the Funding Collaborative Group] and funding opportunities with existing resources	

Partners:

DOE/CDS; DHHS
Superintendents
Principals
Children's Cabinet
MCA; TFEC; RDCs
Maine CDC
ACCESS; MRTQ
MPF; CCI; C4CY
Chamber of Commerce
Council of Churches
Infant Toddler Initiative
Head Start/Early Head Start
Maine Municipal Associations
ME Econ Dev Corps
Council of Govts
Human Res Assns
ME Women's Lobby
Legislative leadership
IPSI
State government
Pediatricians
LIST NOT COMPLETE

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Primary Intentions

Process Measure(s):

1. Maine Family Networks support the parent/child relationship with their medical and educational homes.
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
7. Statewide CCHC is established for all centers and PreK
8. PreK standards are developed and become the basis for ongoing expansion of Universal PreK
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

4. Percent families who read to their children at least once a day
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

early care and education

GOAL Improve Child Development Services (Part C services under IDEA)

Primary Activities

Nominate committee members as subcommittee of Task Force on Early Childhood to be staffed by the DOE and to be inclusive of family, community and state government representation	2006
Examine the efficacy and compliance of the current early childhood "special education system"	2006
Examine the ability of the current early childhood "special education system" to "strike a reasonable balance between the cognitive development and the emotional and physical needs of young children	2006
Examine national trends/models for governance and service delivery of Part C of IDEA	2006
Consider short and long term costs and benefits of the plan to restructure CDS proposed by Commissioner Gendron in November 2005	2006
Report out to the Task Force on Early Childhood, the Children's Cabinet, and the Health and Human Services and Education/Cultural Affairs legislative committees	Jan. 2007
Submit legislation as deemed appropriate from the findings of the Subcommittee to Study Early Childhood Special Education Services from Birth to Age Eight.	2006-2007

Partners:

DOE/CDS; DHHS
Superintendents
Parents
Principals
Children's Cabinet
MCA; TFEC ; RDCs
Maine CDC
ACCESS; MRTQ
MPF; CCI; C4CY
Chamber of Commerce
Council of Churches
Infant Toddler Initiative
Head Start/Early Head Start
Maine Municipal Associations
ME Econ Dev Corps
Council of Govts
MACSP, Early care and education
Legislative leadership
IPSI
State government
Pediatricians
LIST NOT COMPLETE

Lead Contact(s):

To be determined by Legislative leadership in March 2006 per the amendments of LD 1772, An Act to Improve Early Childhood Special Education

Sheryl Peavey
287-3339

Primary Intentions

Process Measure(s):

3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

early care and education

GOAL Increase salary and benefits to early care and education providers including home visitors commensurate with education and experience to increase stability of care.

Primary Activities

Study and report on disparities among ECE providers (including home visitors and Head Start) and public school ECE providers	2006
Construct cost benefit analysis of necessary funding to improve pay and benefits for qualified, quality and competent providers	2006
Establish competency requirements for early care and education practitioners (See ECE UPK goals)	2006-2007
Develop an outreach campaign regarding low wages versus value of quality and stability of early care and education.	2006-2007
Explore options to consider Dirigo Choice group applicability to ECE networks of providers (including private and non-profit)	2006
Find and develop funding streams that fill the gap between the true cost of quality care and what parents can pay (see Invest Early Goals)	2006 – ongoing
Incorporate these activities into potential Governor Summit on Early Childhood	2006

Partners:

ME Women's Lobby
Maine Center for Economic Policy
Provider associations
Marketing agencies
Employers
Families
DHHS/DOE/DOL
Legislature
Foundations
ECE practitioners
Communities
School systems
MCA, MRTQ, RDCs
Fight Crime: Invest in Kids
LIST NOT COMPLETE

Lead Contact(s):

Sue Reed, Maine Roads to Quality
sreed@usm.maine.edu

ACCESS?

Maine Children's Alliance,
www.mekids.org

Primary Intentions

Process Measure(s):
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
9. Public Awareness Campaign outlining the value of investing early in quality of early care and educations services to children and families.
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):
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6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
9. Availability of early care and education programs
10. Rates of child abuse and neglect

local community

GOAL

Develop public-private partnerships for local child and family services infrastructure via "HUBs" or co-located quality supports

Primary Activities

Recruit key stakeholders to work together on the goal to localize resources for parent education, provider education and supports, health consulting and assurances of a medical home for each child and family.	ongoing
Inventory existing partnerships and available facilities by community.	2006
Examine potential matriculation rates and availability of local school space to co-locate services or access to services in conjunction with other community space as appropriate.	2006
Create a menu of what businesses and communities can do to invest in early childhood initiatives (financial and non-financial). Collaborate with organizers of community and neighborhood events to promote the development of activities for families with young children.	2006
Expand statewide family support infrastructure and develop shared vision for family support services.	2007-2008
Develop family support activities that build on family strengths, use peer-to-peer models, and increase family capacity to self-advocate.	2008
Develop and disseminate a standardized referral protocol that all agencies can use to refer families to appropriate programs and coordinate services.	2008

Partners:

Children's Cabinet
Communities for Children & Youth (C4CY)
Govr's Office for Health Care Policy and Finance
DOE

HHS
United Ways of Maine
RDCs, MRTQ
Head Start/Early Head Start

LIST NOT COMPLETE

Lead Contact(s):

Community Representative?

Aymie Walsh, DOE
Aymie.walsh@maine.gov, 624-6660

FMI: Sheryl Peavey

Primary Intentions

Process Measure(s):
3. Improved use of publicly funded resources
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
7. Statewide CCHC is established for all centers and PreK
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6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
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9. Availability of early care and education programs
10. Rates of child abuse and neglect

local community

GOAL Study and implement Family Resource Center models/coalitions for all Maine communities.

Primary Activities

Recruit key stakeholders to work together on this goal.	ongoing
Work with HUB and FR Coalition workgroup to identify locations in which FRCs would best serve communities. FR Coalitions to include representatives of parents of infants, Communities for Children and Youth Councils or Healthy Start Committees which currently exist in many Maine towns and cities	2005
Study and evaluate existing Family Resource Center models.	2007
Develop a toolkit to assist local communities to develop quality Resource Centers	2007
Disseminate Toolkit to all communities	2008-2010
Provide training and technical assistance to support implementation of plans.	2008-2010
25 Communities will have Community Resource Centers to enhance family capacity to support the growth and development of family members	2008-2010

Partners:

Children's Cabinet
Early Childhood Task Force
Communities for Children & Youth (C4CY)
Family Resource Network
MACAN
Child Abuse and Neglect Councils
RDCs
Home Visiting
Maternal and Child Health
Maine Children's Trust

Lead Contact(s):

Betsy Norcross Plourde
Advocates for Children, MACAN
bplourde@advocatesforchildren.net

Candy Eaton, CAN Councils
Children@downeasthealth.org
667-5304

Primary Intentions

Process Measure(s):
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
9. Public Awareness Campaign outlining the value of investing early in quality of early care and educations services to children and families.
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
5. Families enrolled in TANF
9. Availability of early care and education programs
10. Rates of child abuse and neglect

local community

GOAL Expand the Communities for Children Initiative to include increased community-based projects focusing on young children

Primary Activities

Recruit key stakeholders to work together on this goal.	ongoing
Identify family resource coalitions (in lieu of or in conjunction with Family Resource Centers)	Oct. 2005
Work to provide links to a variety of support and resources--community health organizations, early care and education providers, schools, government, and human service providers.	2006, ongoing
Home visitors and the community-based, citizen-led Family Resource Coalitions will provide information about the networks to their clients and constituents and provide backup support and resources to the local networks.	
Encourage the 72 C4CY partners to be actively engaged in creating a statewide **prevention** system for early childhood.	
Expand C4CY Vista project to include community-based projects focusing on young children.	
Plan for and secure funding to host a statewide prevention conference to include C4CYs, CAN Councils, Home Visiting Coalition, OSA and Healthy Maine Partnerships.	

Partners:

C4CY
CAN Councils
Parents
Home Visitors/Coalition
WIC, RDCs
Medical Homes
Libraries
Elementary Schools, including Kindergarten Teachers, PTO's
Early care and education Providers
Head Start
Nursery Schools
Public Health Nurses
Healthy Futures Community Nurses
Administrative staff
OSA, HMPs

Lead Contact(s):

Susan Savell
Communities for Children and Youth
Susan.savell@maine.gov

Primary Intentions

Process Measure(s):
1. Maine Family Networks support the parent/child relationship with their medical and educational homes.
2. Develop measures for social, emotional health/food security
3. Improved use of publicly funded resources
5. All families have access to and are referred as appropriate to early care and education support services
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):
1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
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8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

statewide community

GOAL Communities include early childhood in municipal planning and towns / cities undertake the cross-disciplinary process of defining shared responsibility.

Primary Activities

Recruit key stakeholders to work together to integrate oral, medical, social and emotional health, child care and educational systems at the community level. Report, recommendations issued to ECTF. Action Team recruited to develop toolkit.	now
Identify and review needs assessments and data sources currently being used by communities to determine community need.	2006
Develop a toolkit to assist local communities and the state with existing early childhood needs assessment process. Toolkit will help to compile early childhood data and identify missing data.	2006
Develop protocol / template for orientation and training materials for members involved in planning and systems development that can be individualized at all levels.	2006
Provide training and technical assistance to support community development of plans based on the needs assessment.	2007
Select 3 communities to pilot the early childhood needs assessment toolkit. Provide support and technical assistance to communities piloting the toolkit. Make revisions to toolkit based on feedback from the communities piloting the toolkit.	2007
Distribute toolkit to communities for widespread use.	
Ensure that every town report includes early childhood information (data, spending) State Planning Office includes early childhood information in all of its municipal reports. This includes *regional* CAN data. (contact local DA offices for county-specific data?)	

Partners:

Maine Children's Cabinet,
Early Childhood Task Force
Towns
Communities
RDCs
Councils of Government

State Planning Office
Healthy Maine Partnerships
Family Resource Coalitions
Family Networks
DOE, HHS
CAP agencies

Lead Contact(s):

Paula Thomson
State Planning Office
Paula.Thompson@maine.gov

Linda Elias, lelias@smaaa.org

Primary Intentions

Process Measure(s):

3. Improved use of publicly funded resources
5. All families have access to and are referred as appropriate to early care and education support services
9. Public Awareness Campaign outlining the value of investing early in quality of early care and educations services to children and families.
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

9. Availability of early care and education programs
10. Rates of child abuse and neglect

statewide community

GOAL Develop and disseminate local and regional resource directories.

Primary Activities

Recruit key stakeholders to work together on this goal.	ongoing
Identify existing directories and referral resources.	2006, ongoing
Create signed Memorandums of Understanding regarding collaboration. Work with DHHS and other relevant departments to ensure that collaboration becomes standard applied policy and that resource directory is used.	2006, ongoing updates
Assess usage, impact of the Bucksport Bay Area Early Childhood Network pilot "Totline", replicate if desired.	2006, ongoing updates
MOU, process for updating early childhood info on 2-1-1 system. Support 2-1-1 system	2007
Develop a Maine State Early Childhood website to link with local & national sites, with protocol for updates	
Market website through local providers. Maintain, update website	2008, ongoing updates

Partners:

Children's Cabinet
Early Childhood Task Force
Communities for Children & Youth (C4CY)
Govr's Office for Health Care Policy and Finance
DOE, DHHS
RDCs

LIST NOT COMPLETE

Lead Contact(s):

Robbie Lipsman
2-1-1 Maine
rlipsman@211maine.org

Rita Fullerton
Resource Development Centers
rita@skcdc.org

Primary Intentions

Process Measure(s):

5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized

statewide community

GOAL Cross-disciplinary training in child social-emotional and cognitive development/literacy among child and family service personnel

Primary Activities

Convene a workgroup to itemize existing training resources, common language and disparities related to children's social, emotional and behavioral health	2006
Through process of vetting to various provider stakeholders, confirm common and evidence based training modules for each group. Assure training is consistent, accessible and culturally sensitive	2006
Integrate and formalize ongoing professional and workforce development within child and family service system	2006-ongoing
Coordinate policies to reflect cross-disciplinary understanding of child development, mental health, literacy, etc. (see Unified Practice and Infant Mental Health System Goals)	2006-2007
Train child welfare workers, court personnel, home visitors, family support team members and other in the principles of early childhood development and their implications in family service systems.	2007
Establish a system of accountability that includes use of statewide resource directory	2007
Further the 0-3 crosswalk training	
Further training in Early Learning Guidelines	
Develop/disseminate use of Infant Toddler Learning Guidelines	

Partners:

MPF, Head Start
MADSEC, ACCESS/ELOG
Maine Humanities Council
MeAIMH
CAN Councils
C4CY
ME Principal's Assn
Higher Ed Committee UMCE
ECE Ed in Vocational Technical HS
CDS, MRTQ,
Public Health Nurses
DOE, DHHS, DOL Home Visitors, RDCs
National Associations, CCI
CSPD?

Lead Contact(s):

Mark Rains, mrains@viennamtn.net
Denise Pendleton
Maine Humanities Council
dpendle@mainehumanities.org

Primary Intentions

Process Measure(s):

2. Develop measures for social, emotional health/food security
3. Improved use of publicly funded resources
4. Workforce developed and trained to use evidence based practices
5. All families have access to and are referred as appropriate to early care and education support services
6. All child and family services points of entry routinely screen for lead, as well as physical, oral and mental health
8. PreK standards are developed and become the basis for ongoing expansion of Universal PreK
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

1. Percent mothers with adequate prenatal care
2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
3. Children participating in Maine Care/Percent of insured children
4. Percent families who read to their children at least once a day
5. Families enrolled in TANF
6. Children receiving nutrition and food support
7. Percent young children age two appropriately immunized
8. Prevalence of blood lead levels > 10 μg/dl in children under 6 years of age
9. Availability of early care and education programs
10. Rates of child abuse and neglect

statewide community

GOAL INVEST EARLY: Coordinated statewide message about the value of investing in our children

Primary Activities

Build Capacity of Quality, Accessible Early Care and Education • Provide incentives for municipal and regional planners to include quality early care and education as part of their critical community infrastructure. (see Planning Goal) • Continue work with DOE to encourage development of HUBs for family and community early care and education programs. (see HUB goal) • Propose a bond package for low-interest loans to develop early care and education facilities and/or improvements to meet community need.	2006
Address the Funding Gaps • Expand Home Visiting to ALL newborns • Provide ALL Children with Quality Early care and education/Early Head Start/Head Start	2006
Increase Early Care and Education Workforce Capacity • Increase funding/eligibility for early care and education financial assistance programs (currently through FAME and University of Maine)Create more accessible ECE degree programs at Maine's colleges and universities; consider loan forgiveness programs • Increase wages/income for 4-year-degreed Early Childhood graduates that work in the field 5 years or more in Maine (including home visiting) • Address insurance barriers for home-based early care and education businesses	2006 ($1.5 million budgeted per Governor's office)
Establish a Public/Private flex fund to build quality, accessible early childhood supports and priorities, particularly in areas with greatest current and projected need	2007
Include early care and education infrastructure in regional redevelopment and military re-use planning beginning with Brunswick Naval Air Station	2007
Implement an Early Care and Education Quality Rating System • Develop a web-based application and review procedure • Offer technical assistance to providers as they work toward a higher level of quality	2006
Develop children's budget section within the state budget report	2007
Adopt a statewide definition of resiliency factors and school readiness for children	2006
Child outcome: Improve educational success (learning begins at birth) and reduce remedial services/expense	
Family Outcome: Quality childcare available and affordable; family supports	
Business Outcome: Reduced absenteeism, improved productivity	
Early care and education Provider: Improved quality and satisfaction of families and staff. Increased professional development and wages	
Educational system: Children entering kindergarten ready to learn and succeed. Improved graduation and advancement to further education.	
Health Care System: Illness prevention/health promotion affecting obesity, smoking, and safety	
Society/Community: fewer dropouts, crime and delinquency (Fight Crime:Invest in Kids).	

Partners:

Maine Women's Lobby
Women to Work, AAFP, AAP, MCA, Business, MCT
Children's Cabinet
ACCESS, MRTQ, RDCs
Fight Crime group
Insurance/MaineCare
Legislators, Parents
MMA, CAN Councils
Providers, DOE, HHS, DPS

Lead Contact(s):

Attorney General, Steven Rowe
Invest Early Workgroup
FMI: Sheryl Peavey
Sheryl.peavey@maine.gov

Primary Intentions

Process Measure(s):

3. Improved use of publicly funded resources
9. Public Awareness Campaign outlining the value of investing early in quality of early care and educations services to children and families.
10. Each recommendation of the State Plan for Humane Early Childhood Systems has a 12 month workplan

Outcome Indicator(s):

2. Number of families enrolled in a home visiting program for three or greater months /# families receiving more than one home visit in the first year
9. Availability of early care and education programs
10. Rates of child abuse and neglect

Governance and Evaluation

The Commissioner of Health and Human Services is implementing an organizational structure for the new department's service delivery that will provide consistent, effective high-quality services based on evidence-based best practices with uniform oversight. The new system will bring increased strength-based collaboration with all programs that are involved with an individual and his family from primary prevention to long-term care. In addition, the new system:

- Supports, strengthens, and integrates primary prevention efforts for all programs;
- Integrates mental health and physical health with social services;
- Recognizes the value and importance of population-based public health efforts in making Maine people healthier and in reducing health-care costs; and
- Eliminates the "silo" approach to services by breaking down barriers to a holistic approach to these services.

During our first year finalizing this plan and moving to implementation, the Early Childhood Initiative sought to:

√	**Goal 1: Provide technical assistance and accountability guidance to DHHS reorganization as it relates to early childhood**
	Objective 1: Actively participate in Children's Service Reform Workgroup
	Objective 2: Develop evaluation plan for measuring accountability and process outcomes
√	**Goal 2: Institutionalize Children's Cabinet Task Force on Early Childhood**
	Objective 1: Provide staff support and coordination of Steering Committee and action teams
	Objective 2: Draft and submit legislation to secure existence in statute
√	**Goal 3: Finalize and submit state Early Childhood plan**

Objective 1: Complete first draft of plan in Fall 2005
Objective 2: Share plan in public forums and modify as necessary
Objective 3: Submit State Plan to federal MCHB by 3/2006 for approval

√ **Goal 4: Galvanize public interest and involvement in Task Force on Early Childhood**
Objective 1: Develop active website for posting of publications, team minutes, state plan and links to partner activities and websites
Objective 2: Continue presentations to new and ongoing partners with updates on Task Force activities and progress
Objective 3: Share challenges and promising practices of efforts in national forums in FY06

√ **Goal 5: Show progress toward sustainable, humane systemic change for Maine's Children and Families**
Objective 1: Work with the Maine Children's Alliance Kids Count to optimally measure and report system change (in conjunction with Maternal and Child Health Block Grant, School Readiness Indicators project, the Children's Cabinet Maine Marks and others)
Objective 2: Incorporate recommendations of Task Force on Early Childhood into Department reorganization and state policies
Objective 3: Support, strengthen and integrate prevention and public health across state agencies.

Most of these goals were already underway or accomplished as we reached the half year mark in March 2006. The Task Force on Early Childhood has been recognized by a legislator as a "pretty good vehicle for getting things done the right way."[22] The Governor's office has submitted a Resolve to recognize the Task Force as a legislatively authorized entity, ensuring that its work in Early Childhood remains an ongoing priority for Maine (see Appendix B for a copy of this document). Our evaluation plan, including the process and outcome indicators, will be a critical report card of our efforts.

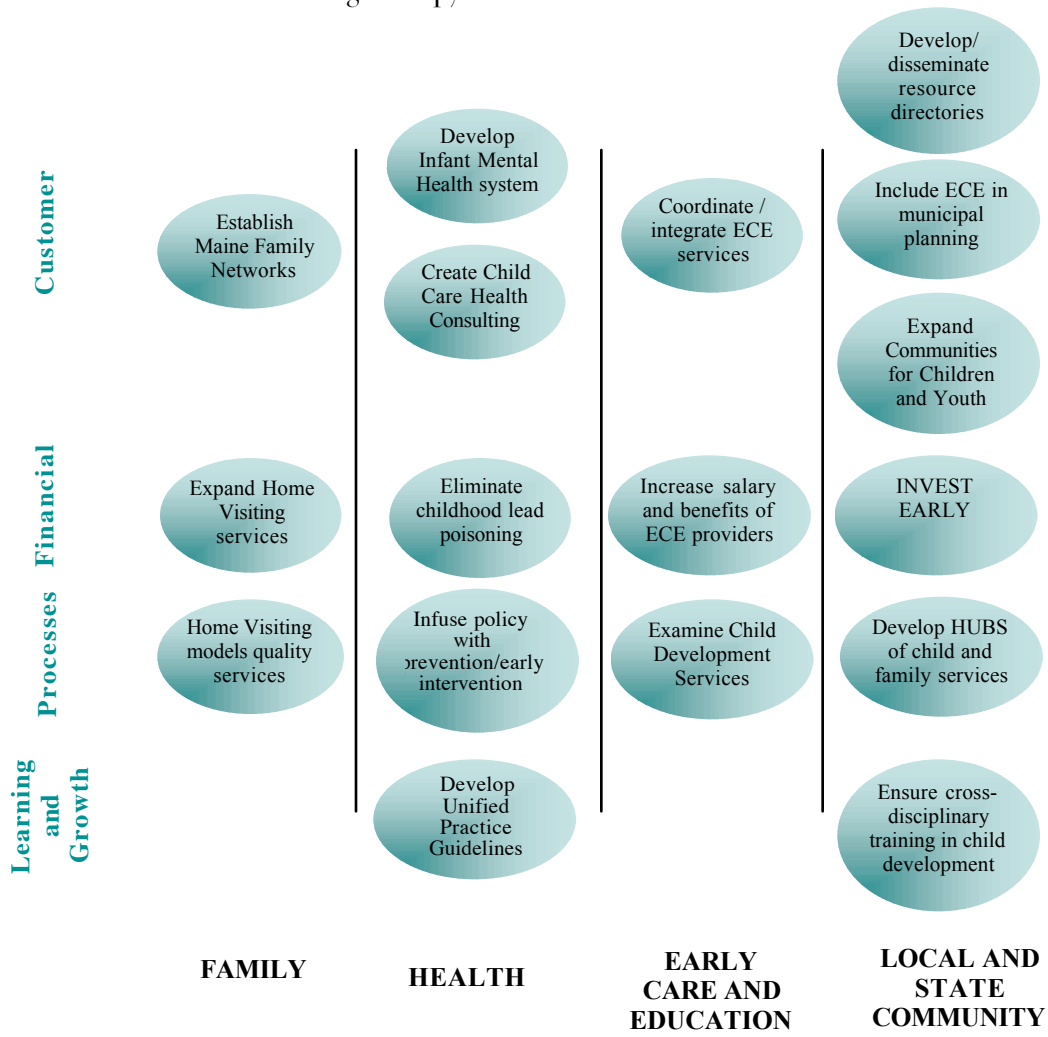
Accountability
The recent strides made regarding the value of the Early Childhood Initiative are encouraging, but require that we share ideas for the proper units of analysis (e.g., individuals, groups, programs), the optimal research design (e.g., how to record baseline data, how to measure progress or change), and the most appropriate data collection methods (e.g., surveys, focus groups, self-assessments) and analysis types.

Our Initiative evaluation draws on indicators and measures already developed by Maine Kids Count, Healthy Maine 2010, the School Readiness Indicators Project, Maine Marks and the Home Visiting Network. At this time, we are exploring ways to improve these measures and their data sources if needed, particularly as we review the quantitative data trends and qualitative focus groups from our Maternal and Child Health Strengths and Needs Assessment.

[22] Comment from a member of the Education and Cultural Affairs Committee of the 122nd Maine Legislature, during a work session on Child Development Services, February 2006.

Core to the success of our self-evaluation will be the degree to which we are able to demonstrate the ten characteristics of **humane** systems, policies, programs and services for the people of Maine. These qualities are in part the product of the work of the Early Childhood Initiative during our initial planning phase.

Linking the outcomes of the current initiatives and work to those of the Early Childhood Initiative is the optimal way to measure Maine's systems change efforts. Evaluating whether our efforts actually generated effects on our intended outcomes requires that we look not only at process objectives, which answer the question: 'Did we do what we said we would do?,' but also that we consider the indicators of our overall ECI objectives. The ECI has adapted the components of a Strategy-Focused Organization[23] to mapping its outcomes to its strategic themes (the figure below illustrates this strategic map).



STRATEGIC THEMES OF A COMPREHENSIVE, HUMANE EARLY CHILDHOOD SYSTEM IN MAINE

[23] Kaplan, Robert S. and Norton, David P. (2001) *The Strategy Focused Organization: How Balanced Scorecard Companies Thrive in the New Business Environment.* Harvard Business School Publishing Corporation.

Our approach considers intermediate outcomes as the application of changes in behavior, knowledge or skills and long-term outcomes as the broader impact or net effect of sustained change in behavior, knowledge or skills[24]. Key questions to be addressed by the outcome evaluation of the ECI include:

- *The extent to which each strategy is accomplishing the goals.* Analysis: Multiple data set analysis prioritizing elements related to the ECI agenda, participants, levels of participation, degrees of understanding, and the potential for systems change.
- *Does the project have a systemic impact on local early childhood care and education systems?* Analysis: Use of outcomes (e.g., changes in local or state policies; opinions of stakeholders and collaborating partners; increase in availability of quality early care and education) as independent variables in explaining the success related to other outcomes, e.g., local vs. statewide early childhood systems change.
- *Is Maine's project sustainable?* Analysis: Review if changes in awareness and attitude support appropriate regulation, accountability, parental and family engagement, planning and governance.

To foster resiliency and healthy early childhood development, we must change our attitudes, beliefs and expectations of each other and society. We must show through system and policy change that we mean it when we say that children are our greatest resource; and that we must enlist their active involvement in order to address the social, economic, and environmental conditions that underlie and perpetuate the health and safety of young children and families. By capitalizing on synchronicity and bringing together people who would not traditionally consider their discrete fields as congruent, our efforts for systems change will generate a truly comprehensive early childhood system in Maine.

We must work together to create caring relationships and positive expectations keys to resiliency and healthy child development within the settings of the medical home, early care and education programs, family support activities, and systems that support them. To foster such resiliency and development, we must change our attitudes, beliefs and expectations of each other and society. We must show through system and policy change that we mean it when we say that children are our greatest resource; and that we must enlist their active involvement in order to address the social, economic, and environmental conditions that underlie and perpetuate the health and safety of young children and families.

When we capitalize on synchronicity and bring together people who would not traditionally consider their discrete fields as congruent, our efforts for systems change will generate a comprehensive early childhood system in Maine.

Next Steps

"As Maine goes, so goes the nation." This timeworn adage, while most often associated with politics in this easternmost state, could apply as equally for the Early Childhood Initiative. The innovative framework of the early childhood stakeholders, the

[24] Backer, T.E; David, S.L.; & Saucy, G. (Eds.) (2000) *The Change Book: A Blueprint for Technology Transfer.* Addiction Technology Transfer Center National Network.

responsiveness to unique demographics in this rural state, the involvement and leadership from the Children's Cabinet, and the creative approaches to ensuring that work gets done have already captured the interest of our leadership. We have identified the resources and needs of our state and have drafted recommendations to achieve change. Our mission embraces a future that not only values the child, but also considers the family, community, and state resources that support each child. With this plan, we have a guide to help dissolve or mitigate obstacles and allow change to occur in a meaningful, sustainable way.

Stay tuned as the Early Childhood Task Force and its partners bring the early childhood agenda to the fore of Maine policy. Look for upcoming Open Forums with the Maine Chapter of the AAP, regional Pre-K meetings, and the Governor's Summit on Early Childhood!

APPENDIX A: Acronym Guide

Acronym	Stands for:
AAP	American Academy of Pediatrics
ACCESS	Alliance for Children's Care, Education and Supporting Services
AG	Maine Attorney General's Office
BFI	Bureau of Family Independence (now called the Office of Integrated Access and Services)
C4CY	Communities for Children and Youth
CAN Council	Child Abuse and Neglect Council
CBHS	Children's Behavioral Health Services
CCHC	Child Care Health Consultant
CCI	Maine Center for Community Inclusion and Disability Studies
CDC	Maine Center for Disease Control and Prevention (formerly Bureau of Health)
CDS	Child Development Services
CPS	Child Protective Services
CSHN	Children with Special Health Needs Program
DECD	Department of Economic and Community Development
DEP	Department of Environmental Protection
DHHS	Maine Department of Health and Human Services
DOC	Maine Department of Corrections
DOE	Maine Department of Education
DPS	Maine Department of Public Safety
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
ECE	Early Care and Education
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HMP	Healthy Maine Partnership
HS/EHS	Head Start/Early Head Start
ICD-9	International Classification of Diseases, Ninth Revision
IDEA	Individuals with Disabilities Education Improvement Act
IPSI	Muskie School of Public Service, Institute for Public Sector Innovation
LEAd ME	Lead Poisoning Elimination Advisory Council of Maine
MACECD	Maine Advisory Council on the Education of Children with Disabilities
MADSEC	Maine Administrators of Services for Children with Disabilities
MCA	Maine Children's Alliance
MCH	Maternal and Child Health
MCT	Maine Children's Trust
MEAEYC	Maine Association for the Education of Young Children
MeAIMH	Maine Association for Infant Mental Health
MEMA	Maine Emergency Management Association
MFN	Maine Family Networks
MOD	March of Dimes
MPF	Maine Parent Federation
MRTQ	Maine Roads to Quality
NAEYC	National Association for the Education of Young Children
OCFS	Office of Child and Family Services
OIAS	Office of Integrated Access and Services
OPHEP	Office of Public Health Emergency Preparedness
OSA	Office of Substance Abuse
PTO	Parent Teacher Organization
RDC	Maine Resource Development Centers
SECCS	State Early Childhood Comprehensive Systems
SMR	Start ME Right
UMCE	University of Maine Cooperative Extension
WIC	Women, Infants, and Children

APPENDIX B

Task Force on Early Childhood *Prenatal through Age Eight*

A Resolve by the Children's Cabinet to Refine the work of the Task Forces on Early Care and Education

Preamble. Whereas, research has shown that the period prenatally through age eight represents an extremely significant period of brain development that has a substantial influence on the social, emotional, physical and cognitive development of all young children; and

Whereas, this development can be significantly delayed when young children experience environmental stressors and other negative risk factors that influence the brain; and

Whereas, investments in infant, toddler and preschool prevention, intervention and support resources leads to higher rates of long-term savings; and

Whereas, every family needs effective support and encouragement to be active participants in their children's development; and

Whereas, strong partnerships among state agencies foster humane, culturally competent, sustainable, and integrated systems; and

Whereas, high quality, inclusive child care improves every child's readiness for school, families' ability to work productively, and the state's economic development goals; and

Whereas, accessible preventative and therapeutic physical, oral and mental health services for all young children support their social, emotional, cognitive and physical development; and

Whereas, it is the state's obligation to promote the health of its communities and to help reduce the incidence of child abuse and neglect and domestic violence; and

Whereas, most recently, the Task Force has been developing a comprehensive state plan for early childhood systems as the "Early Childhood Initiative," to begin implementing in 2006;

Whereas, the Children's Cabinet has a priority of developing a collective will among all stakeholders schools, parents, families, taxpayers, policymakers, business and industry, civic organizations and the general public - to value, commit to, and establish a seamless continuum of early childhood care and education from prenatal through eight years of age;

Be it resolved that with Federal and other resources available,

Sec. 1.Continue the Task Force on Early Childhood:
The Task Force on Early Childhood will advise the various departments in the steps to refine and sustain an early childhood service system. With its state plan as a guide for communities, and new and existing early childhood partnerships Maine will establish policies to assure that all young children in Maine have access to high quality early childhood programs and services which include, but are not limited to, comprehensive pediatric services and medical homes; social-emotional development of young children; quality early care and education, parenting education and family support.

The Task Force will focus on the following partnership priorities determining which of its goals and primary activities will address each priority, study the progress of these efforts, and evaluate their effectiveness:

Partnership Priority 1: Equitable opportunities are provided for access to high quality, inclusive programs and services for all children prenatal through age eight and their families.

Partnership Priority 2: High quality environments are created in order to achieve maximum benefits for all children from prenatal through age eight.

Partnership Priority 3: Community regional partnerships are established to achieve efficient use of resources and optimal outcomes for children, creating "HUBS."

Partnership Priority 4: Community support is strengthened to address and respond to the strengths and needs of young children and their families.

Partnership Priority 5: Efficient and coordinated utilization of early care and education fiscal resources will allow the implementation of quality, non-duplicative services that support the health, development and learning of young children

Sec. 2. Membership:
The Task Force consists of a core Steering Committee and evolving action teams that are content specific to the multiple goals of the state plan. The Steering Committee of the Task Force on Early Childhood shall not be less than 25 persons nor exceed 35 and will consist of members who represent public and private stakeholders in Early Childhood, such as, but not limited to: parents, early care and education providers, state and local government agencies, public schools, media, arts and humanities, child advocates, and health care providers. Members may represent more than one domain of the early childhood system. The Steering Committee of the Task Force will meet no less than four times annually.

Sec. 3. State Plan for Comprehensive Early Childhood Systems:
As a prerequisite for its Federal funding from the Maternal and Child Health Bureau, the Task Force will regularly communicate with the various departments and the public as to the progress of implementation of the State Plan for Comprehensive Early Childhood Systems. The state plan strengthens prior Legislative Resolves and refines more than a decade of work toward the integration of state and community activity related to early childhood systems in Maine. The state plan will include the most effective strategies to accomplish its system change goals, base its activity on sound research and comprehensive planning, and guide its work by intending to:

- Unite, simplify and humanize the systems and policies affecting children and families.
- Transform usage of funding streams so that they are most likely to have a positive impact on the health, education and safety of all children and families.
- Develop clear and simple language that will strengthen the communication that is vital to the system changes that we seek.
- Integrate oral, medical, social and emotional health, child care and educational systems at the community and state levels.
- Influence the culture so that our actions reflect a powerful commitment to prevention in the prenatal, infant and early childhood stages of life.
- Build an understanding that such a commitment is an essential component to the social, cultural, and economic development of Maine's future.
- Strengthen quality, inclusive child care so that it optimizes children's curiosity and readiness for school, the ability of families to work productively, and the capacity of the state to achieve its economic development goals.
- Increase the availability of collaborative community-based prekindergarten.
- Establish expectations for supporting best practices, which encompasses class size and active learning environments through grade three.
- Establish a system for exchanging information with families about the development and learning of young children birth through age eight.

The Task Force will remain committed in its practice to involve families and communities throughout all of its efforts.

Sec. 4. Reporting:
The staff member to the Task Force on Early Childhood Steering Committee shall report regularly to the respective Commissioners who are the lead Commissioners for the Children's Cabinet Early Childhood Priority. The Lead Commissioners will be responsible for taking the recommendations to the Governor's Children's Cabinet, who will facilitate implementation.

Sec. 5.History of the Task Force:
The Task Force on Early Childhood has a history that began in 1993 when the Healthy Start Task Force was authorized to study the potential for creating home visiting programs for parents as a child abuse prevention strategy. This was followed by the Task Force to Study Strategies to Support Parents as Children's First Teachers and the Start Me Right campaign that led to the funding of a universal, statewide system of home visiting for all first time parents and increased resources for child care. With Legislative reauthorization in 2000, the Task Force on Early Care and Education began focusing on development of the home visiting, child care, and parenting education systems in Maine. Most recently, the Task Force has been developing a comprehensive state plan for early childhood systems as the "Early Childhood Initiative" through the financial support of the federal Maternal and Child Health Bureau. For this plan, the Task Force and its five action teams have analyzed the current system structure, costs, and gaps and developed Early Childhood Systems Plan recommendations, preparing for implementation to begin in 2006.

APPENDIX C: Participant List

The following have participated in the Future Search and/or on the Task Force for Early Childhood.

Alan Cobo-Lewis, University of Maine
Alberta Cole
Alex Hildebrand
Amanda Lansdale, Day One
Andrew Jones, Outright
Dr. Andy Cook, Children's Behavioral Health
Angela Palmer, Parent
Ann Conway, Maine Center for Public Health
Anne Graham, Pediatric Nurse Practitioner, Child Care Health Consultant
Anne-Marie Brown, Cumberland County YMCA
Anthony Pileggi, MD, Children with Special Health Care Needs
Aubrie Entwood, Maine Chapter, AAP
Barbara Townley
Bert Meek, Casey Family Services
Betsy Squibb, University of Maine
Betty Abbott
Beverly Baker, Maine Parent Federation
Bill Hager, Child Care Services of York County
Brenda Harvey, Acting Commissioner, DHHS
Brian Dancause, Dept of Economic and Community Development
Burtt Richardson, Pediatrician
Butch Dawbin, Parent
Candee Kaknes, Sagadahoc CAN Council
Candy Eaton, Hancock County Children's Council
Carol Troy, People's Regional Opportunity Program
Carolyn Davis, Catholic Charities
Carolyn Drugge, Child Care and Head Start
Carolyn Roberge
Carrie McFadden, Fetal Alcohol Spectrum Disorder Prevention
Catherine Yomoah Parent
Cathy Wood, Special Children's Friends
Charles Dow, Attorney General's Office
Cheryl Lambert, Resource Development Centers
Chris Lyman, Maine Center for Disease Control and Prevention
Chris Rudd, University of Maine, Machias Child Care
Christina Kennedy
Corenna Howard
Dana Connors, Chamber of Commerce
Dean Crocker, Maine Children's Alliance
Debbie Dunn, Child Development Services
Deborah Schaedler, DHHS Child and Family Services
Debra Crump
Debra Rainey, Center for Community Inclusion and Disability Studies
Denise Pendleton, Maine Humanities Council
Dewey Meteer, CDS, Child Care Advisory Council
Diana Sanderson, Midcoast Mental Health
Diane Brandon, Community Wellness Coalition, Family Resource Center
Diane Lemay Ed.D. UMA-Mental Health & Human Services
Diane Skog, Maine Medical Center
Dick Aronson. MD, Maternal and Child Health
Dick Farnsworth, Woodfords Family Services
Don Burgess, Maine Chapter, AAP
Dona Forke, Bridgton Community Center
Donna Overcash, Former CEO, Quality Care for Children, Child and Family Policy
Dorothy Schwartz, Maine Humanities Council
Doug Patrick, Children's Behavioral Health
Eileen McAvoy, Penquis CAP
Ellen Bridge, Public Health Nursing
Ellen McGuire, Maine Parent Federation
Ellie Goldberg, Maine Children's Alliance
Ernie Reisman, Washington County Parents Are Teachers Too (Home Visiting)
Fatuma Hussein, United Somali Women of Maine
Gail Lombard, Women, Infants and Children (WIC)
Gladys Richardson, Healthy Community Coalition, Maine Family Networks
Glen Davis, MD, Maine General
Jaci Holmes, Department of Education
Jaimie Wood, Youth
Jan Clarkin, Maine Children's Trust
Jan Morrissette, Public Health Nursing
Jane Adams, Waldo Community Action Partners
Jane Brennan, Southern Kennebec Child Development Corporation
Jane Gilbert, Department of Labor
Jane Weil, Maine Association for Infant Mental Health
Janine Blatt, Department of Education
Jeanie Mills, Child and Family Opportunities
Jeanne Ivey, Different Abilities/Maine Parent Federation
Jen Maeverde, Center for Community Inclusion and Disability Studies
Jennifer Capen, Lewiston Career Center
Jessica Bulduc
Joan Churchill, Community Concepts, Inc.
Joanne Thomsen, Family Child Care Provider
Joel Burian, MD, Maine Children's Home
John Nicholas, Former DHHS Commissioner
John Salvato, MD, Maine General
Jonathan Shenkin, Pediatric Dentistry
Judith Smith-Valley, Unitarian Universalist Minister
Judy Feinstein, Maine Oral Health
Judy Reidt Parker, People's Regional Opportunities Program, Head Start
Julia J Bell, Maine Developmental Disabilities Council
Julie O'Brien, Maine State Legislature
Julie Sullivan, City of Portland
Kaileigh Tara, Catholic Charities
Karen Baldacci, First Lady
Karen Cokayne, Downeast Health Services, WIC
Karen Davis, Penobscot Nation
Karen Gallagher, Women, Infants and Children (WIC)
Karen Prescott, Child and Family Opportunities
Karen R. Toothaker , Family Child Care Provider

Karen Thomes, Indian Island Child Care
Karen White, Central Maine Community College, Zero to Three Initiative
Kate Eastman, The Jason Program
Kate Stern, Child Abuse and Neglect Council, Cumberland County
Kathryn Wilcox, Family Studies, High School
Kelly Bowden, Maine Medical Center, Perinatal Outreach
Kerrie Alkurabi, Parent
Kevin Cookson, Health Licensing & Registration
Kolawole Bankole, Minority Health
Lanelle Freeman, Kennebec Valley CAP
Laura Subilia-Bell, The Patient Partner
Lauralee Raymond, Maine Women's Lobby
Lauren Sterling, Children's Cabinet, DOE
Laurie Bertulli, Child Development Services, DOE
Leonardo Leonidas, MD Pediatrics
Linda Butler, Spurwink
Linda Elias, Child Care Connections
Linda Huff, Maine Developmental Disabilities Council
Linda Labas, Center for Community Inclusion and Disability Studies
Linda Lord, Maine State Library
Linda Sisson, Washington County CAP
Linda Stec , Waldo County Preschool Services
Linda Williams, Prevention, Office of Substance Abuse
Lisa Belanger, Public Health Nursing, Home Visiting
Lisa Burgess, Sweetser
Liz Nitzel, Parent
Lori Freid Moses, St. Elizabeth's Child Care
Lu Zeph, Center for Community Inclusion and Disability Studies
Luc Nya, Multicultural Coordinator/DHHS
Lucky Hollander, Legislative Affairs, DHHS
Lynn Faerber
Margaret Craven, Maine State Legislature
Mari Jo Allen, Southern Maine Medical Center
Mark Millar, Casey Family Services
Mark Rains, MEAIMH
MaryAnn Amrich, Children's Lead Poisoning Prevention Program, DHHS
Mary DeRosier, United Way
Mary Duross, Parent
Mary Ellin Logue, University of Maine
Mary Jane Bush, Bucksport Bay Health
Mary Milam, Maine Children's Alliance
Mary Small, Fight Crime: Invest In Kids *Maine*
Matthew Nelson, Aroostook County CAP
Michael Odokara, Youth
Michel Lahti, Muskie School, USM
Nan Simpson, Mid Coast Regional RDC
Nancy DeSisto, DHHS
Pam LaHaye, Univ. of Maine Cooperative Extension, Parents Are Teachers Too
Pam Marshall, Mainely Parents
Pat Day, Maine Birth Defects Program
Patti Wooley , KVCAP
Paula Thomson, State Planning Office
Peter Lindsay, United Way of Midcoast Maine
Peter Taylor, Maine Community Foundation
Priscilla Dreyman, Spiral Arts
Regina Phillips, Maine NAACP
Rhonda Beaudet, RN, Children's Services, Health and Nutrition
Rita Fullerton, Resource Development Centers
Rob Ellis, Mental and Behavioral Health, Child Care
Roberta Lipsman, United Way
Ron Taglienti
Sean Faircloth, Maine State Legislature
Shalom Odokara, Women in Need, Inc.
Sharon Leahy-Lind, Women's Health, DHHS
Sharon Schulberger, Maine Chapter, March of Dimes
Sheila Youmans, Family Focus, Child Care Advisory Council
Sheryl Peavey, Task Force on Early Childhood
Sonja Howard, Maine Roads to Quality
Steve Amato, MD, Physician
Steven Rowe, Attorney General
Sue Burgess, Families and Children Together
Sue Reed, Maine Roads to Quality
Sue Plummer, Governor's Office
Susan Gendron, Commissioner, Department of Education
Susan Savell, Communities for Children and Youth
Suzanne Thivierge, Department of Labor
Takisha Staats, Law Enforcement
Tammy Swasey-Ballow, NAMI
Theresa Gaetjens, Parent, Child with Special Health Care Needs
Toni G. Wall, Director, Children with Special Health Care Needs
Trish Niederowski, WINGS
Trudy Sandock, Parent
Valerie Ricker, Maternal and Child Health, DHHS
Victoria Kuhn, Anthem Blue Cross/Blue Shield
Virginia Jewell, Parent
Wendy Wolf, Maine Health Access Foundation

A Place for NOTES, THOUGHTS, IDEAS

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