A REPORT ON MAINE'S

MATERNAL AND CHILD HEALTH

PROGRAM

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The Health Policy Analysis Project is a cooperative undertaking of the Maine Legislature and the University of Maine's Health Education Resource Center. The purpose of the Project is to provide independent research and analysis services to legislative decision-makers who have responsibility for health care policies and programs

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INTRODUCTION AND OVERVIEW OF THE REPORT

The Legislative Health Policy Analysis Project (HPAP) was assigned the task of studying Maine's Maternal and Child Health Program, specifically those programs funded under Title V of the Social Security Act. While the overall purpose of this assignment was to determine whether the program was being administered rationally and efficiently there were two other purposes in mind. One was to determine whether the program provided medical care access to indigent expecting mothers who previously qualified for AFDC, and thus Medicaid, because of their pregnancy. This group lost this access following the Department of Human Service's decision to drop these clients from enrollment until after the child was born. The other purpose was to generally assess the impact of the program from any data available from the Department.

The following report concentrates almost entirely on the administration of the program and to some extent on program impact. The Congressional mandate and subsequent revisions creating Title V might make it a vehicle for providing medical care to expectant mothers who do not qualify for AFDC and therefore Medicaid prior to giving birth. However, the primary focus MCH Program is not for this purpose. Title V provides maternity services to low income, medically underserved women whether or not the individual has Medicaid or some other type of health care third party payment assistance. This access would be available to these individuals via an MCH funded project of this type within a given locality where a project was operating. Since maternity services funds are available on a limited basis in approximately six counties, the extent of access is limited.

It should be pointed out that the total amount of Title V funds which Maine received are inadequate to provide health services to the total number of low income medically underserved residents in need of maternity and infant health services. Moreover, the Medically Needy Program is probably serving many of these clients on a statewide basis. The dramatic increase in the number of clients in the Medically Needy Program is testimony to this, although the HPAP has no substantive data to prove this. It should also be pointed out that the Director of the Title V effort in Maine was not aware that obtaining these services was a problem for indigent pregnant women. Presently, there is a task force of health planning groups from a coalition of hospitals that is examining the overall picture of pre, peri, and postnatal services in Maine. This task force has only been in operation for a short while and to our knowledge has issued no reports to date.

Due to limitations in the resources available to the HPAP, this report should be received as a preliminary study of Maine's MCH Program. It identifies problem areas within the Program for the Legislature to pursue through its own processes. While we reviewed a substantial amount of information about the program and interviewed by telephone or in-person many individuals involved with the MCH program at the local, state, and federal level, the research for this report was by no means exhaustive. Thus while the HPAP is confident that the contents of the report are accurate additional research would obviously lead to a broader and more detailed analysis of and recommendations about the program.

It became evident while doing research for the report, that the central problems with the MCH program over the past few years have been in its administration. The implementation of the program is largely a state responsibility. Yet the State's administration of this task has lacked coordination, policy direction and leadership. The administration of the

program appears more concerned with cost accountability and cost transferability than service needs, service delivery, and service impact.

This is not to suggest that the program has been ineffective in its effort to provide increased access of both treatment and preventive health services to many individuals who otherwise would not have had access to these services. The range of quality health services provided through the MCH program is extensive. Maternity srrvices, neonatal intensive care services, infant and children services, dental services, genetic counseling services, school health education and patient education services are but some of the projects funded through the MCH Program.

This report does not question the fact that the program has been one avenue, among many, of providing access to health care to people in need and that these services have most likely had a beneficial effect upon the population who have used them. Some of the questions that are raised by this report concern the administration of the program, the viability and openness of the present planning and grant review processes and the lack of evaluation of the activities funded by the program on the population groups within the scope of its projects. What follows is a brief description of the Maternal and Child Health Program in Maine funded through Title V, a critique of its administrative shortcomings and a partial assessment of its impact.

Federal Legislation

The Social Security Act of 1935 contained a section (Title V) which addressed the special need for states to improve health and welfare services for mothers, infants and children. Title V pledged federal support to states in this effort. While this section has frequently been changed to reflect the expansion of national interest in preventive and primary health care for maternal and child health, it remains clearly aimed at those groups who are most in need of health services, particularly the urban and rural poor.

Title V consists of two health delivery service programs. This is reflected in the separate funding formulas described below. On the one hand there is the Maternal and Child Health program. The MCH program is aimed at "reducing infant mortality and otherwise promoting the health of mothers and children," (Sec. 501, SSA) and is concerned primarily with preventive health problems, principally screening and early detection of health problems. However, some medical services are required in the program.

On the other hand, Title V establishes the Crippled Children Service Program (CCS). This program is aimed at "locating, and for medical, surgical, corrective services and other services and care for and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling" (Sec. 501, SSA). CCS, therefore, exists primarily in order to treat health problems which were not prevented. This report is concerned with the MCH program. Aspects of the CCS program are part of this effort only because the CCS and MCH programs are administered by the same division in the Department of Human Services.

State and Federal Funding

For FY 1973 and thereafter for each fiscal year, $350 million has been allotted by Congress to be distributed by the Secretary of HEW for Title V. Ninety percent of the $350 million is allotted to states for both programs: Maternal and Child Health Services and Crippled Children's Services. However, each year the Secretary determines the exact portion of the appropriation to be available for each program. In addition, not less than 6% of the money available from the allotment to Maternal and Child Health Care Services shall be available for voluntary family planning services.

The remaining 10% of the $350 million goes to (1) grants to public and non-profit private institutions of higher learning for training personnal for health care and related services for mothers and children, particularly mentally retarded and handicapped children with special attention to programs training undergraduates, and (2) grants to public and non-profit institutions of higher learning or agencies and organizations engaged in research projects relating to Maternal and Child Health Care and Crippled Children's Services. Special emphasis is accorded to projects studying the need for the feasibility, costs, and effectiveness of comprehensive health care programs in which maximum use is made of health personnel with varying levels of training and in studying training methods for such programs. Grants may also include funds for the training of health personnel for work in such projects.

The actual funding allotments to each state for its Maternal and Child Health Servies are based on two formulas:

(1) Fund A: One-half of the amount determined for maternal and child health services will be awarded to states based on a formula with each state receiving $70,000 plus the percentages of

the remaining money equal to the number of live births in the state compared to the number of live births in the U.S. This allocation has to be matched 50-50 by the state.

(2) Fund B: The remaining one-half is available to states and non-profit institutions of higher learning to carry out the financial needs of the state with regard to the state plan. Money is allocated according to a formula taking into account the number of live births in the state (with rural births given twice the weight of urban births) and the per capita income of the state. These funds are not matched by state funds. However, not more than 25% of Fund B may be allocated for special projects which would contribute to the advancement of maternal and child health.

The funding allotments to states for their Crippled Children's Services are also based on two formulas, which are similar to that for Maternal and Child Health Services.

In the fiscal year 1978, for example, Maine received $1,936,700 in federal funds of which $1,344,200 went for services to maternal and child health services and $592,500 went to crippled children services. The state match to this money was about $1,000,000, of which approximately $600,000 are state funds allocated towards the support of the Public Health Nursing Program of Maine. Additional money also came from local sources and third party payors of project services which qualify.

In order for a state to qualify for the federal funding each state is required to develop a plan stipulating the maternal and child health services and the services for crippled children which it will implement. According to federal regulations this plan must:

(1) Designate the level of state financial participation in the provision of services;

(2) Designate the state health agency responsible for the asministration of the planned program:

(3) Provide for both proper and efficient administration of the personnel involved in the program and for training and use of sub-professional staff as community service aides in the administration of the program;

(4) Designate the state agency responsible for reporting and for compliance to HEW;

(5) Provide for cooperation with groups and organizations (medical, health, welfare, nursing, educational) providing services and with any state agency providing vocational rehabilitation to physically handicapped children;

(6) Provide for payment of reasonable costs of inpatient hospital services;

(7) Provide for early identification and care for child defects and chronic conditions;

(8) Provide for a program of projects which offers reasonable assurance of satisfactorily helping to reduce the incidence of mental retardation and other conditions caused by childbearing and reducing infant and maternal mortality (particularly low income areas);

(9) Provide for a program of projects which promotes the health of children of school and pre-school age (particulary low-income);

(10) Provide for a program of projects for Dental Health of school and pre-school children (particulary low income);

(11) Provide for (a) services for reducing infant mortality and otherwise promoting the health of mothers and children and (b) for services for the locating, for medical, surgical corrective and other services of care and diagnostic hospitalization, and aftercare for children who are crippled or suffering from conditions leading to crippling;

(12) Provide for demonstration services in needy areas (especially child dental care and family planning);

(13) Provide for payment to optometrists for services covered under this act if these services cannot otherwise be obtained in a clinic; and

(14) Provide that (a) the State Health Agency shall be responsible for establishing a plan and for its review by appropriate health personnel for the quality of care and services furnished under the plan; and that (b) the state agency responsible for licensing health institutions will determine whether agencies or institutions (i.e. hospitals) meet the requirements for participation in the planned program.

Prior to submitting the plan to the federal government, Title V regulations also state that the governor should be given reasonable opportunity to comment on it and that upon completion it shall be made available to the public by request.

It is clear from this account of the plan that according to federal law and accompanying regulations, the plan should be the focal point of the program. It is the document which describes the policies, direction, administration and priority areas of the program.

Apart from the plan itself, to qualify for federal funds, the state must implement five specific types of projects. The plan guidelines in the law and the regulations mandate that there shall be a program of projects for:

1. maternal and infant care
2. intensive infant care
3. family planning services
4. health of children and youth
5. dental health for children and youth

For fiscal year '78, the state complied with this latter mandate with five projects, two of which were in Hancock and Washington Counties (1 and 3), two of which were in Kennebec and Somerset Counties (4 and 5), and one of which was located in Cumberland County but serves the whole state (2). Apparently while the guidelines call for a program of projects in each category, HEW allows a state to have only one project to qualify.

State Administration and Operation of the Program

The federal regulations call for the establishment in the state health agency of two organizational units: one to administer the Maternal and Child Health Program and one to administer the Crippled Children's Program. Because Maine is one of the smaller states with regard to population the federal government allows the state to combine the two programs under one bureau.

Functionally the Department of Human Services administers the MCH Program through the Bureau of Public Health through the Director of Specialized Medical Services and the Director of Public Health Nursing. While both have equal formal authority in the Department, the Director of Specialized Services is supposed to have administrative control over the MCH Program. However, the Public Health Nursing Services of the MCH Program are under the direction of its Director, not the Director of the Specialized Medical Services. Thus each director appears to be in charge of their sector of the MCH Program; the Director of Specialized Medical Services is in charge of the grant projects and the Director of Public Health Nursing is in charge of the line services provided by the public health nurses*.

The Maternal and Child Health personnel consists of the Director of Specialized Medical Services, the Assistant Director, a Speech and Hearing Consultant, one social worker, one person who does part-time social work and is part-time administrator of Supplemental Security Income for handicapped children, and seven clerical positions. On the Public Health Nursing side, federal funds also pay for a public health nurse consultant, two supervisors and seven nurses.

Most of the federal money is allocated through grant awards to private sector health care providers to deliver specified health care services. These take the form of projects funded mostly by Title V money but in some cases matched by local sources and third party payors. A brief description of each project funded for FY '78 can be found in the Appendix along with a table showing the

*It should be pointed out that the Director of Public Health Nursing is in charge of monitoring some of the mandated projects.

funding breakdown by county, agency, type of project and the target population and a table showing the amount of funding in each county.

Projects ususlly begin by health care organizations or agencies within the state requesting grants for specific services. The Department does not request proposals for specific program areas. When an organization inquires about the possibility of receiving a grant, the Division of Special Services sends them the specific guidelines which must be met in order to file an application. Once the application for grant funds is received, it is reviewed by a panel consisting of the Deputy Commissioner for Medical Services, the Director of the Bureau of Health, the Director of Public Health Nursing, the Director of MCH, and, depending on the nature of the grant, one or two other health officials.* If they feel there is a need for the program and there is money available it is approved.

Essentially the projects funded through Title V represent a wide array of efforts all aimed at either promoting, maintaining and improving the health of mothers and children or preventing, ameliorating and correcting handicapping conditions of individuals under the age of 21.

In addition to the projects funded through this program through contracts with private agencies, the MCH program also provides nursing services to mothers, infants and children through the Division of Public Health Nursing. This differs from the project approach to delivery services in many ways. One is that providers are public employees at the state or local level. Secondly, unlike some of the projects which are aimed at a specific health problem and may involve medical (diagnostic and treatment) services on either a local or state level, public health nurses perform a variety of maternal and child health services. Most of these, however, are

* However, according to many of the subgrantees of MCH program funds, the Deputy Commissioner for Medical Services appears to have a strong influence the decision on grant funds.

screening services rather than treatment ones.

The exception to this is the Maternal and Child (M & C) Project in Cumberland County and to some extent the M & C Project in York County. These projects actually replace and extend the public health nursing services for these areas. These services are delivered by two separate private, non-profit agencies. This whole effort is somewhat experimental - to test whether a private non-profit agency can deliver these services with more efficiency and economy than a public agency. To date, while the quantity and scope of services have been monitored by the Division of Public Health Nursing, the only evaluation has been in terms of the cost of services not the health status impact of target populations.

Critique of the Program

In many respects, writing a brief and concise description of Maine's Maternal and Child Health Program has not been an easy task. This is primarily due to the lack of specificity in the Federal legislation concerning the program, the wide range of projects funded by the program and the apparent administrative shortfalls in the implementation of the program both at the state and federal level. However, if describing the program is difficult, evaluating it is impossible for the same reasons. What follows is a critique of the MCH program based on the Health Policy Analysis Project's perceptions of the major shortfalls with the program. Following the critique is a description of what the Department of Human Services is presently doing about some of them.

There are two basic shortfalls of the program upon which this critique is based. One is the lack of a clear and comprehensive policy towards the use of MCH funds. This applies both at the state and federal level but, as will be pointed out below, is more serious at the state. The other major shortfall concerns the administration of the program particularly at the state level. In this case, the program's administration appears both uncoordinated and diffused some functions and overly centralized for other functions.

Unlike state law which often tends to be somewhat specific when creating programs, federal law is often more general in delineating the goals and objectives of a program. For social programs in particular, federal agencies are usually charged with specifying the intent of Congress in the implementation process. Title V of the Social Security Act is similar in this respect. The goals of this program as outlined by Congress are fairly broad. For example, the

goals of the Maternal and Child Health Program are "to promote, maintain and improve the health of mothers and children."

The federal policy regarding the intent of the program gets specific in the federal regulations. This is particularly true in regard to the plan and in the five project areas required in order to receive federal funding. While the outline for the plan as delineated by the federal government is somewhat specific, the specifics mostly detail what items the plan must contain and are minimal requirements. The plan is written by the state and allows the state a great deal of discretion in both the contents and the administration of the program. The Regional Office of DHEW is charged with enforcing the regulations of the program. However, the regulations do not appear to tie the hands of the state, as some regulations for federal-state programs do.

Like other programs targeted by federal legislation but implemented by the state, the success of the program is based both on federal-state and state-local cooperative efforts to provide a certain population with essential health services. MCH is clearly not intended to be merely a payor of services like Medicaid and Medicare, not is it supposed to merely provide funds for a wide conglomeration of services at the state or local level like federal revenue sharing. Instead, it is intended as a coordinated and comprehensive attack on what the state sees as the specific health needs of mothers, infants and children. This requires, therefore, a clear policy delineation by the state based on local and statewide need assessments and input. From this would follow the

development of funding priorities based on these needs, the solicitation of proposals for projects, a review process to assess proposals based on content as well as costs, and an evaluation of project-funded activity based on the immediate objectives of this activity and their relationship to the health status of the target populations.

However, there is no real plan in Maine. Rather, the Department has a stack of papers on file which remain in-house. It consists of approximately eleven separate papers containing such things as (1) a copy of each grant submitted during the year and comments on them by the Director of the Program, (2) supporting letters for each grant, (3) year end program reports on the five major programs, (4) descriptions of the regulations and objectives of the program content of the five required projects, and (5) a copy of the state's procedural requirements for obtaining grants.

For many federal or state health care programs, i.e. Medicaid, a plan is not important. For the MCH program, as was pointed out above, the plan should be the focal point of the program. An adequate MCH plan should not merely fulfill the federal requirements for receiving funding, but should go far beyond that. The plan should contain sufficient information delineating the health status and needs of mothers, infants and children of the state by age-group, geographic location and health care access and quality. The targeted needs and type of projects to address them should be prioritized and justified in the plan. The information on needs and priorities should be drawn from reliable data presently available or generated by the Department. The plan should also detail the process by which grant money for projects will be allocated, and the amount of funds available for priority areas of funding.

At best these "documents" according to our conversation with an HEW official, minimally satisfy the federal requirements for receiving Title V funds. As a "plan" it neither informs the public of the basic health needs of mothers, infants and children nor does it guide providers toward priority health needs or inform them what monies will be available to address those areas of need.

However, while federal officials do approve the plan, it is difficult to understand why they do so year in and year out. It is also difficult to understand how it even satisfies their requirements. Their response to this criticism in the preliminary report indicated that they have to take many things into consideration when approving the plan, that there are other variables that are considered in regard to the MCH Program and that the approval process is a complex one.

Furthermore, because there is no plan which describes the maternal and child care needs in the state, which describe funding priorities for the year, and the formula for allocating how funds will be spent in a program area (i.e., the population to staff ratio, the percent allowable for administrative costs), the grant review and awards process is arbitrary.

From discussions with some of the health providers whose agencies are contractors for some of the maternal and child health services it is evident that, due to the lack of information which address these items, the lack of specific cost criteria in the determination of the service costs, and the lack of leadership in the process of granting awards, the grant review and subsequent negotiating process has often been a less than cooperative effort.* The process is often aimed more at cost objectives than health service objectives.

* See Appendix for example

It is true that the federal legislation authorizing the MCH Program and its accompanying regulations give the state a great deal of descretion and flexibility in utilizing the funds for the state's health needs in this area. However, it is difficult to imagine that the intent was to allow the state as much discretion as it has exercised in this case. This is tantamount to revenue sharing at the state level with a minimum of accountability. On the other hand, if the intent was to give the state this much discretion, the Department's failure to coordinate, share information and plan with many of the local agencies which deliver MCH funded services strongly suggests an abuse of that discretion.

A listing of the disease conditions that are amenable to change with limited resources are simply not enough. There should also be information yielding the particularly geographic areas of high-need and the performance standards that it expects to achieve. Instead, the Department has listed the objectives of the MCH Program for a particular year after many of the grants have already been awarded or designated. This is clearly not prioritizing in a rational planning manner.

The MCH Program has lacked cohesive direction which may or may not be rectified by a plan. This is evidenced both by the wide array of projects funded by the Department with MCH monies (see Appendix) and the attitude of the Department towards the five mandated programs within the state MCH Program. The Department apparently views the five mandated projects as a minimal requirement that it must satisfy in order to free up the rest of the MCH money for other uses. Yet there is no clear statement issued by the Department for

an integrated approach to the needs of mothers, infants and children that the MCH money will address over a period of time.

For example, when York County Community Services approached the Department for a Maternal and Infant Care grant, they were told not to bother since no other MIC grants would be funded as the state already has a program going in Ellsworth with Downeast Health Services. The denial was not based on the need in York County, which during the period 1974-77 had a low-weight birth rate average significantly higher than the state rate, but, according to York County Community Health Services, solely on the fact that the state already had its mandated project for MIC.

Those projects not mandated by the law take up more than one-half of the federal funds allocated for Title V projects, yet are subject to less scrutiny, in our view, than the mandated projects. With the exception of the Cumberland and York Counties Maternal and Child Projects, they have fewer reporting requirements and according to the files are monitored less frequently than the mandated projects.

This does not mean that the projects funded are not essential or that they do not address a defined need. It does mean, however, that the MCH Program has funds to disperse, but no clear or coordinated approach in the task of dispersing them. Because needs are not researched, prioritized and published, because the Department does not request proposals based on statewide or localized need assessments, because it is reluctant to fund more than one project in the five mandated program areas, the remainder of the funds are spent by the Department in the way it sees fit. Again, while the

projects that are funded may be needed ones, there is no real way to judge their need on a comparative basis. A provider may go to the Department and attempt to demonstrate a need, but the project may or may not be funded depending upon what appears to be a number of intangible reasons.

The need in this part of the program is not one which has gone unnoticed by state officials, federal officials or by the local agencies who provide MCH services. Nor is it one that the Department is incapable of solving. The next section of this report addresses present activities about this need. For example, the State Health Planning and Development Agency (SHPDA) is providing background papers on Maternal and Child Health in Maine in preparation for the State Health Plan. These documents contain a great deal of information and data which are intended for a real plan for the MCH Program. Furthermore, it is our understanding that the staff of SHPDA has been working with the MCH Program staff to assist them in the development of a plan. If this effort comes to fruition it will go a long way in correcting this shortfall in the program.

However, even with a plan there are other problems with the administration of the program. While an adequate plan may detail how the Department intends to implement with MCH program in any one year, a plan does not guarantee that the program will be administered efficiently and rationally.

The Department's attitude towards ongoing funding of services is contrary to both the intent of Title V and quite possibly the on-going needs of a local area. According to the federal regulations accompanying Title V, if there is an ongoing need in the state or

locale for certain types of maternal and child services, they can and should be funded from these monies. Title V funds are not intended as demonstration project monies in that the project must find other funding sources within a certain time period. Yet the Department's procedural guidelines for grant awards has as a requirement that to be funded "a project must:

(a) Solve the problem it addressed within one year, or

(b) If the project continues beyond one grant year, then it must demonstrate eventual self-sufficiency in funding within a specific period of time, not to exceed three years."

While the guidelines go on to state that in exceptional circumstances a project will be continued beyond three years, the main point is that this identifies the Title V program in Maine as a demonstration grant program rather than a program to fulfill ongoing primary health care needs. It would appear that if there is to be a demonstration, it should be in the way these primary services are met, not in financial self-sufficiency. Preference should not necessarily be given to new programs but to innovative ways of delivering essential health care services to those who cannot get them.

If the present system is unable to provide health services access to significant groups of mothers, infants and children in certain areas of the state, the demonstration criteria should be towards innovative models of service delivery, the diffusion of technology in the practice setting or the establishment of good practice and performance for those groups of individuals who are not getting them.

The Maternal and Child Health Care Program has been in operation for a number of years. However, there has been no substantive evaluation effort made on the impact of the services on the

health status of mothers, infants and children in Maine, nor in the areas where the projects have operated. While the Department has devised outcome objectives for many of the projects it funds and while some data is collected on the five required projects, none of this can be considered an evaluation effort using scientific standards.

The reasons for this are two-fold. On the one hand, the outcome objectives are usually either quantitative (i.e. "increasing the number of clients receiving services" or "reducing the expenditure level of the projects to coincide with the project budget") or they are management oriented (i.e. "to have implemented a problem oriented record system" or "to have provided a teacher's training manual for preparation for patient load"). These types of objectives are not evaluative from a program impact standpoint. For example, increasing the client load of a project says nothing about the quality of services, the need for services or the outcome of the services in terms of reducing a potential health problem.

On the other hand, the data collection effort and the close monitoring of some of the five mandated projects are only one step towards evaluating impact. Even if the project data collected were impact oriented, and much of that collected is not, one would need to analyze it in order to answer any questions concerning program impact. To our knowledge none of the data collected has been analyzed in any scientific way. The only case where some comparable statistics were analyzed was in one county where costs of the previous public health nursing delivery system were compared to the costs of the MCH funded one.

The question is not just one of data collection. Rather, it is also a question of data use. Apart from the data (or lack thereof) collected on specific MCH projects, there is a host of morbidity data collected by various agencies and organizations. For example, data on hospital discharges by place of origin for all age groups for the year 1974 through 1976 exists. While this data is controlled by the hospitals, to our knowledge they have not denied access to it by the Department. Furthermore, with the passage of the Health Cost Information Act of 1978, this data will be controlled by an independent data service and public agencies, including the Department will have more ready access to it. This is an example of data that could be used to demonstrate at least indirectly, the impact of MCH health service projects in a particular area or statewide. Yet, to our knowledge, it is not being utilized.

DEPARTMENTAL ACTIVITY ON THE MCH PROGRAM

While the HPAP has noted some major shortfalls in the MCH program, as mentioned above they are not ones which have gone unnoticed by DHS staff or staff from agencies who provide contract services to the MCH program.* Most of the comments received following the distribution of the Preliminary Report confirmed the analysis of the administrative shortfalls within the program. Some felt

* The Boston Regional HEW Office and the Central Office in Washington is also planning a joint on-site, intensive study of the MCH Program in the late Spring of 1979. According to HEW some of the issues listed in this report, along with many other issues, will be addressed in-depth. This joint federal review will also be accompanied by a list of recommendations. Similar reviews carried out in several other States have proven to be most helpful to both State and HEW personnel to effect the complete implementation of the Title V mandate.

the preliminary report did not go far enough in detailing these shortfalls, others (notably the Department) felt there was a failure to adequately recognize the Department's already existing efforts at attempting to rectify some of the planning and evaluation shortcomings.

The Preliminary Report (p. 19) did note that staff from the State Health Planning and Development Agency (SHPDA) were assisting the Division of Special Services (Maternal and Child Health Program) with both planning and project support. However, it went on to say that it was too early to say how effective that effort would be towards improving the administration and evaluation areas of the program. Further research since the publication of the preliminary report into the efforts of the SHPDA indicate that their work is quite substantial and is already providing part of the MCH program with considerable planning and evaluation support.

This effort has been undertaken on a number of fronts and leads us to believe that the MCH program could benefit from it substantially. For example, an analysis on maternal and child health care in Maine that has been developed by the SHPDA for the State Health Plan give considerable background data and analysis on the scope of health services and health status service indicators in Maine broken down by counties. This will undoubtedly assist the MCH program in the needs assessment areas and can be used to screen some applications for grants.

The SHPDA work on the development of a State Health Plan through its workbooks for Unit Managers and Program Managers provides a practical and uniform approach for public health services planning. The workbooks are designed to assist Program Managers in documenting

health problems or health needs addressed by their program, in assembling comparable data to describe their program's past and current services and accomplishments, and in estimating and forecasting data upon which goals and objectives are based.

This approach, if implemented by Department's top-level administrators could lead to a clearer understanding of resource allocation of MCH program funds, increased support of program and individual project implementation and the generation of evaluative data on the health status of the population of a geographic area that a project is attempting to impact. Since mid-summer the Department has actively engaged in a series of meetings with Downeast Health Services to design and implement a program evaluation system, based on a disease problem oriented approach.

In our view, this is a beginning to the administrative problems that have existed in the MCH program. However, it must be noted that pursuing this approach is not something which can be done without increasing resource support for projects. The generation of data for project evaluation can only be done with training and resources which, to this juncture, have been outside the scope of most project funds. Simply mandating that data be collected for the total population base of the geographic area in which a project is operating will not mean that it will get done. Providing additional support staff either from central office or in the projects to collect if not analyze the data for the population group of a project is more likely to obtain the desired results.

It must be borne in mind that while the implementation of the SHPDA work can assist the MCH program in the planning, allocation and evaluation of resources, it may not effect the decision-making process on grants, or improve communication between the local agencies contracted to provide services unless those who make decisions on grants are willing to utilize this assistance in developing a more coordinated and open approach to the use of MCH funds and thus make awards accordingly.

Therefore, it behooves the Legislature to continue its oversight into the MCH program and other health programs that the state is implementing. Only in this way can there be assurance that this impressive start will continue.

The Impact of the MCH Program

To the non-professional, there may be easy ways to look at the impact of the MCH program. To the professional, however, if the measurement of program impact is desired, there are a number of techniques, but none of them are easily applied. They all require a sophisticated design as well as valid data.

For the non-professional, outcome measures for the state such as maternal mortality rates, infant mortality rates and neonatal mortality rates might indicate MCH program success or failure. However, this may indicate nothing at all about the program or may indicate only that a particular project is useful. For example, in Maine, pregnant women have a low-risk of death related to the pregnancy. Over the last five years (1973-77) there were only three maternal deaths in Maine due to pregnancy.

Neonatal mortality and infant mortality in Maine also enjoy a similar status. Neonatal (age 0-28 days) rates in Maine for 1976 were the lowest in the nation. In 1977, the rate was even lower,

at 6.1 per 1,000 live births, Infant mortality (0-1 year) in Maine was also low. In 1976 the infant mortality rate for Maine was 11.0 per 1,000 live births compared to 12.7 for New England and 15.1 for the U.S.

The incidence of low-birth weight (under 2500 grams) is below the national and New England average. For example, between 1974 and 1976 Maine's rate of low-birth weight was 60.5 low-birth weight per 1,000 live births compared to 63.0 for New England and 62.1 for the United States.

While the Legislature and the people they represent should be heartened by these health statistics and while there are a number of conclusions one could draw from them, one is not that this necessarily indicated the success of any one health program. Only after an empirical and substantive analysis of the program services offered and other services available in a particular geographic area could one conclude that any one program, like MCH, has been responsible for lowered health status indicators. To our knowledge, this has not been done.

This does not mean that the MCH program has not contributed either in small or large part to these low outcome measures of health status. It is simply that this has yet to be determined. Access to health care services is one determination of health status. Change in lifestyle and consumptive habits are equally if not more important. Access to better nutrition through the Food Stamp Program and WIC Program, access to health services through the Medicaid and Medically Needy Programs, and access to better housing through low income housing programs are only a few inputs which must be considered as possible determinants of these lowered outcome measures of health

status. Because there has been no scientific analysis of the effects of any one program on the clients receiving these services, there is no way of knowing if one or a number of them working together have caused these changes.

There is perhaps one exception to this. The Neonatal Intensive Care Center at the Maine Medical Center, which is partially funded by MCH money, appears to have contributed directly towards the lowering of the state's infant and neonatal mortality statistics. As a required MCH activity and as one which services the entire state, the activity of the center alone may be a significant contributor to the lowering some of the statistice cited above.

While not based on any scientific evaluation by the HPAP, the statistics generated from the program indicate this probable impact. In each year since the center started in 1974, there has been a substantial increase in the number of neonates admitted yet at the same time a substantial decrease in the mortality rates of those admitted. For example, in 1974 there were 280 babies admitted of which 17.8% died. In 1974 there were 345 admissions and still only 17.4% died. In 1976 admissions jumped to 360 while only 12% died and in 1977 there were 467 admissions and only 9.2% died.

Moreover, it does not appear that the decline in the mortality rate was a result of an increase of less-sick babies being admitted to the center. This is indicated by the increase in extreme low birth weight babies (under 1500 grams) being admitted each year (with the exception of 1975) yet with an overall annual decrease in the mortality rates of these admissions. For example, 55 extreme low birth weight babies were admitted in 1974. Of this number 25 or 46% died. By 1977, the admission rate of these babies had jumped to 89.

Yet only 17 or 19% deceased. By any standard, it appears that the impact of the Neonatal Intensive Care Center has been impressive.

Using health status indicators that represent the state as a whole, and extrapolating from them the impact of the MCH program is certainly not the way to measure the impact of the program. For reasons cited above this yields only a very general and very indirect representation of program impact with the possible exception of the Neonatal Intensive Care Center Project.

Instead, from an analysis of county health status indicators one could draw some legitimate conclusions about the impact of one or more projects working within a county compared to a county (or counties) which did not have the project. As a technique it can be a reliable yet still indirect way of showing project impact if the data are valid. It is still indirect because one is looking at data taken from a population (or subset thereof) of a whole county only some of whom will have had access to a project's services.

The problem with doing this for the MCH program are many. Of the indicators that are both readily available to the HPAP and can be regarded as legitimate tests of Maternal and Child Program impact with one exception all may substantially fluctuate from year to year due to factors that have nothing to do with the access or lack of access to health services. This is due to the small number of cases in a particular county upon which rates of neonatal mortality, infant mortality and low birth weights are based. Because of this, any fluctuation of only a few cases can throw off the percentages substantially. Thus, one cannot say with any degree of confidence that a change in rates was due to the impact of a particular MCH project or was due to other factors.

In the preliminary report, the HPAP did make an admittedly crude attempt to evaluate the impact of the MCH programs in Hancock and Washington counties, two counties which have had extensive services since 1972*. Three health status measures (neonatal deaths, infant deaths, and low birth weights) and one health service measure (prenatal care) were compared over a multi-year period for Hancock and Washington counties to Franklin, Waldo and Sagadahoc counties. The latter three counties are roughly similar in rural/urban make-up and population yet did not have an MIC or M & C project going during these periods.

Upon calculating the difference from the state rate for these measures (neonatal deaths, infant deaths, low birth weights and prenatal care rate) for each county and graphing that difference, an inspection showed no substantive difference among these indicators between those counties where there were MCH service projects from those that did not have MCH service projects.

In their comments to the Preliminary Report, the Department criticized this work as unreliable. We agree with that assessment. However, they went on to show their own indicator of the impact of the Hancock-Washington County projects. They pointed that between 1963-1966, the infant mortality rate was 30.1, compared to the remainder of the state which was 22.7. Between 1973-1976, however, the rate for Hancock-Washington County was 14.1 which was equal to the rate of the rest of the state. From this they concluded that the project was having a favorable impact.

*The MIC project actually began in 1967, but according to the Director of the MCH program, extensive delivery of services did not begin until 1972.

However, in further analysis by the HPAP, we found that the same thing occurs in both Sagadahoc and Waldo Counties, neither of which had MCH projects. Here the Waldo and Sagadahoc 1963-66 infant death rates were 29.8 and 26.3 respectively. While the 1973-76 rates were 14.8 and 9.7 for each. This shows that their conclusion is not justified by the data they presented. Furthermore, based on our previous discussion, it is questionable whether any of this data is a meaningful indicator of program impact or lack thereof.

Again, this does not mean there has been no impact by the projects operating in Hancock and Washington Counties, only that this data does not show this to be the case. Quite likely the small number of cases which makes our previous comparisons poor indicators also makes these comparisons poor indicators. Finally, even if the data were good indicators, one is compelled to look at other causes in each of the counties, notably the Medicaid Program, the Food Stamp Program or the AFDC program before determining the impact of one program. There is just no way to tell this with this data alone.

Analysis of additional data provided by the State Health Planning and Development Agency lead us to the same conclusions.* Five year averages (1973-1977) for county rates of neonatal mortality, infant mortality and low birth weights were tested for significance with the state average for this period. The findings show that for neonatal mortality the Washington County rate was significantly higher than the state average while the Hancock County rate was not significantly different from the state rate. On the other hand, the Sagadahoc County average was significantly below the state average,

*See Tables I, II, and III following

TABLE I

NEONATAL MORTALITY BY COUNTY

MAINE, 1973-1977

	Total Live Births (1973-1977)	Total Neonatal Deaths (1973-1977)	Average Neonatal Mortality Rate* (1973-1977)	Significantly higher/lower than State Average**
-- Counties with Rates Higher Than State Average --				
Somerset	3,390	41	12.7	yes
Androscoggin	7,009	81	11.6	Yes
Penobscot	9,429	108	11.5	Yes
Knox	2,111	23	10.9	Yes
Washington	2,611	28	10.7	Yes
Waldo	2,066	21	10.2	Yes
Franklin	1,739	17	9.8	No
State	77,370	723	9.3	
-- Counties With Rates Lower Than State Average --				
Aroostook	7,963	73	9.2	No
Kennebec	7,419	68	9.2	No
Hancock	2,542	23	9.0	No
Piscataquis	1,189	10	8.4	Yes
York	8,956	75	8.4	Yes
Cumberland	14,053	113	8.0	Yes
Oxford	3,163	22	7.0	Yes
Lincoln	1,639	9	5.5	Yes
Sagadahoc	3,091	11	5.3	Yes

*Rates expressed per 1,000 live births

Source: Maine Department of Human Services, Division of Research and Vital Records and State Health Planning and Development Agency.

** Based on the rationale and formula described in Vital Statistics of the U.S., 1950, Vol. 1, p. 1-20.

TABLE 2

INFANT MORTALITY BY COUNTY

MAINE, 1973-1977

	Total Live Births (1973-77)	Total Infant Deaths (1973-1977)	Average Infant Mortality Rate* (1973-1977)	Significantly higher/lower ** than State Average
-- Counties With Rates Higher Than State Average --				
Franklin	1,739	30	17.3	Yes
Somerset	3,390	55	16.2	Yes
Knox	2,111	33	15.6	Yes
Androscoggin	7.009	105	14.9	Yes
Washington	2,611	39	14.9	Yes
Piscataquis	1,189	17	14.3	Yes
Penobscot	9,429	133	14.1	Yes
Waldo	2,066	29	14.0	Yes
Kennebec	7,419	99	13.3	No
State	77,370	1,017	13.1	--
-- Counties with Rates Lower Than State Average --				
Aroostook	7,963	99	12.4	Yes
Lincoln	1,639	20	12.2	Yes
York	8,956	108	12.0	Yes
Hancock	2,542	30	11.8	Yes
Cumberland	14,053	165	11.7	Yes
Oxford	3,163	37	11.7	Yes
Sagadahoc	2,091	18	8.6	Yes

*Rates expressed per 1,000 live births

Source: Maine Department of Human Services, Division of Research and Vital Statistics and State Health Planning and Development Agency.

** Based on the rationale and formula described in Vital Statistics of the U.S., 1950, Vol. 1, p. 1-20.

TABLE 3

LOW WEIGHT BIRTH RATES* BY COUNTY

MAINE, 1973-1977

	Total Live Births (1973-1977)	Total Low Weight Births (2,500 gms.) (1973-1977)	Average Low Weight Bith Rate (1973-1977)	Significantly Higher/lower ** than State Average
-- Counties with Rates Higher Than State Average --				
Franklin	1,739	98	68.9	Yes
Androscoggin	7,009	277	68.1	Yes
Somerset	3,390	181	66.4	Yes
York	8,956	456	63.6	Yes
Cumberland	14,053	700	62.8	Yes
Washington	2,611	129	61.1	No
Penobscot	9,429	458	60.9	No
Piscataquis	1,189	56	60.0	No
State	77,370	3,665	59.4	
-- Counties with Rates Lower Than State Average --				
Kennebec	7,419	351	59.1	No
Oxford	3,163	148	58.3	No
Lincoln	1,639	67	50.7	Yes
Aroostook	7,963	318	50.3	Yes
Waldo	2,066	84	50.3	Yes
Hancock	2,542	94	47.7	Yes
Knox	2,111	78	45.6	Yes
Sagadahoc	2,091	70	42.2	Yes

*Rates expressed per 1,000 live births

Source: Maine Department of Human Services, Division of Research and Vital Records and State Health Planning and Development Agency.

** Based on the rationale and formula described in Vital Statistics of the U.S., 1950, Vol 1, p. 1-20.

the Franklin County average was not significant from the state average and the Waldo County rate was significantly higher than the state average.

For infant mortality, Hancock was significantly below the state average while Washington was significantly above it. On the other hand, Sagadahoc was significantly below the state average while Franklin and Waldo were significantly above it.

For low birth weight rate five year averages, the results showed Hancock significantly below the state average and Washington not significant from the state average. Waldo and Sagadahoc, however, were significantly below the state average for this period, while Franklin was significantly above.

Again, from this data we cannot conclude anything significant about the impact of the MCH program in Hancock and Washington Counties. In other words it may have had a significant impact or it may not have had a significant impact. Furthermore, even if one accepts the premise that the data are useful indicators,there is no way that this data demonstrates that the MCH program has had the effect and not the Medicaid, Food Stamp or AFDC programs.

However, the latter analysis on significant differences in these indices from the state average, while not telling one much about impact, do raise questions in regard to project placement. In other words, they suggest guideposts for further health service development. For example it would follow that, other things being equal, those counties which have experienced significantly higher than state average rates in low birth weights ought to receive priority for future maternal and infant care services.

RECOMMENDATIONS ON THE MCH PROGRAM

The following are a list of alternative courses of Legislative action regarding the MCH program. They are suggested as a partial list of oversight activity for the Legislature to insure both that the goals and objectives of the MCH program in Maine are met and that the program is administered fairly, reasonably and effectively.

The suggestions are:

1. Conduct a hearing on the MCH program. The Joint Committee on Health and Institutional Services could conduct at least one hearing on the program. This hearing would consist of a representative selection of MCH agency contractors, particularly those who implement the mandated programs and Federal and State officials involved with administration of the program. The purpose of the hearing should be to discuss the program based on this report, the work of the Department in upgrading planning and evaluation aspects of the program and the Federal plans to evaluate the program.

2. Mandate the completion of an MCH plan for Maine prior to the next fiscal year, In this mandate, specify the general components of the plan to ensure that it is comprehensive and complete.

3. Mandate that the Department revise its regulations to more closely reflect the intended use of MCH funds in the area of demonstration projects, fiscal self-sufficiency, data collection on project clients, and methods of determining unit service or program costs.

4. Mandate an examination of the MCH Program with special emphasis on the organizational relationships between the Division of Special Services, the Division of Public Health Nursing, relevant Community Health Agencies and other State Agencies. This examination should focus on the present fragmentation, line of accountability and lack of coordination in the implementation of the Program with a view towards reorganization.

5. Mandate that a more formal and open process be established for planning, priority setting and awarding grants in the MCH Program.

6. Suggest that the Department utilize its public affairs and communications office to make the public more aware of the efforts, activities and accomplishments of the MCH Program.

APPENDIX

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TABLE IV

MAINE TITLE V GRANTS - FY 1978

Project	Agency	Amount (approximate)	Area Served	Target Population
School Health Education Project	Health Education Resource Center, Farmington	$240,000	Statewide	One School district in each county
Retinitis Pigmentosa	Genetic Counseling Service	45,100	Statewide	Families affected by RP
Neural Tube Defects	Foundation for Blood Research, Scarborough	62,500	Statewide	Families affected by NTD
Children & Youth Project	Downeast Health Services Ellsworth	172,700	Hancock County	Children 1-12
Maternal and Infant Care	Downeast Health Services Ellsworth	269,500	Washington & Hancock Cty.	Women in peri-natal cycle, their infants to age 1.
Poison Control Center	Maine Medical Center Portland	31,000	Statewide	Persons poisoned or at risk of poisoning
Dental Project	Mid-Maine Medical Center Waterville	106,900	Somerset Cty., Northern Kenn. County	Low income children in need of dental care age 0-18
Children's Clinic	Mid-Maine Medical Center Waterville	66,400	Somerset Cty., Northern Kenn. County	Low income children in need of health care age 0-18
Maternal & Child Health Project	Community Health Services Portland	111,650	Rural Cumb. County	Families and children in need of health care

Maternal and Child Health Project	York County Health Services	98,500	York County	Families and children in need of health care
Hemophilia Project	Maine Medical Center Portland	5,000	Statewide	Families with hemophilia who could benefit by coordination of care
School Nursing Support	Four Town Nursing Service Blue Hill	6,000	Communities in central Hancock County	Families and children in need of health care
Handicapped Children's Program	Eastern Maine Medical Center, Bangor	100,000	10 Northern Counties	Children with multiple handicaps
Neonatal Intensive Care Center	Maine Medical Center Portland	41,000	Statewide	Infants in need of intensive medical care
Genetic Service Clinic	Eastern Maine Medical Center, Bangor	54,000	10 Northern Counties	Families in need of genetic counseling
Maine Fetal Risk Project	Maine Medical Association Brunswick	28,000	Statewide	Physicians who deliver babies
Dental Health Education	Multiple School Administrative units	40,000	Statewide	School children in the applicant area

TABLE V

STATE AND COUNTY BREAKDOWN OF TITLE V GRANT

FUNDED PROJECTS FOR FY '78

Statewide	240,000 - 45,100 - 62,500 - 31,000 - 5,000 - 41,000 - 28,000 - 40,000 ---- 492,600
Hancock	172,700 - 135,000 (1) - 6,000 --- 313,700
Washington	134,500 (1) --- 134,500
Somerset	53,500 (2) - 33,200 (3) --- 86,700
Kennebec	53,400 (2) - 33,200 (3) --- 86,600
Rural Cumberland	111,650 --- 111,650
York	98,500 --- 98,500
10 Northern Counties	100,000 - 54,000 --- 154,000

(1) part of a grant that serves both Washington and Hancock counties.

(2) (3) part of a grant that serves both Somerset and Kennebec counties.

TABLE VI

MCH Project Grants Funded to Date for

Fiscal Year 1979*

TITLE OF GRANT	AGENCY	AMOUNT
Mid-Maine Medical Center Prenatal Project	Mid-Maine Medical Center	$ 26,646
Children's Dental Project	Mid-Maine Medical Center	74,509
Rural Dental Care Project	Mid-Maine Medical Center	76,497
Children's Clinic	Mid-Maine Medical Center	162,568
Rural MCH Project	Community Health Services	140,000
AFP Screening Project	Foundation for Blood Research	80,589
Retinitis Pigmentosa	Genetic Counseling Center	61,500
York County MCH Project	York County Health Services	105,000
Clinical Genetic Services	Foundation for Blood Research	18,000
Neonatal Intensive Care Center	Maine Medical Center	62,090.46
Poison Control Center	Maine Medical Center	98,847.55
School Health Education Project	Health Education Resource Center	430,000
Genetic Screening of a Family Planning Population	Genetic Counseling Center	34,671
Cystic Fibrosis Newborn Screening	Eastern Maine Medical Center	7,150
Professional Genetic Education Project	Eastern Maine Medical Center	5,100
High School Genetic Education Project	Foundation for Blood Research	27,960
Comprehensive Genetic Services for Families of the Mentally Retarded	Southern Maine Resource Center	22,800

*Additional grants will be funded in the fiscal year

The Maternal and Child Health Project is administered by Community Health Services in Portland and it serves rural Cumberland County. For FY 1978 it is receiving $111,650.

Some women and children in rural Cumberland County are not receiving health supervision and preventive health services because of barriers of money, apathy, ignorance, and accessibility. This project is intended to reduce the number of persons so effected by providing community nursing services to high risk families and to children via child health conferences, home visits, in school settings, and to mothers for parenting help, and to pregnant women for prenatal and perinatal nursing care.

The target population is low income women and children in rural Cumberland County - 8,000 women and 8,000 children. For FY 1978 it is estimated that 550 women and 2200 children will use this service. Factors placing families at risk are (1) low income, (2) history of poor nutritional intake (overweight, underweight), (3) chronic illness (hypertension, diabetes), (4) little education, (5) drug, alcohol abuse, (6) age, (7) premature or underweight infant, (8) parents who had been abused, (9) physically handicapped or developmentally delayed children, (10) family history of disorders, (11) existence of mental retardation, hyperactivity, learning disability, emotional illness in child or adult member of family, (12) single parent, (13) frequent separation of parents from children, (14) problem pregnancy, (15) many children in family, (16) lack of privacy in living space, (17) poor hygiene, (18) self-imposed isolation of family, (19) poor accessibility to health care, (20) absence of identified family support system.

The MCH Project provides coordinated, integrated, family centered, community health nursing services to families in the growth and development stages of child bearing and child rearing at high risk. These services include child health conferences which seem to have been very successful. These conferences assist parents in identifying certain needs, utilizing health facilities, providing nutritional instruction and helping them to acquire parenting skills. The MCH Project also provides home visits to families at risk requiring specific health improvements such as prenatal and post-partum care. It also provides teenage mothers with family planning information, child rearing techniques and instruction in mothering skills. To cooperating school districts they provide a school health nurse who is available for screening, home visits, consultation and health education.

It is hoped that one of the outcomes of this program will be a decrease in the incidence of child abuse and neglect in this area.

The Children and Youth Project is administered by the Down-east Health Service, Ellsworth. It serves Hancock County and for FY 1978 is receiving $172,700.

Some children in Hancock County may be at risk because they do not receive enough health care, both preventive and corrective, due to barriers of money and know how. It is the purpose of this project to ensure that such care is available. There are 10,000 children in Hancock County. Of these 5,000 meet low income guidelines and about 1,000 participate in the project. These children are referred by any of a number of public and private sources.

Services provided include dental care for children at clinics set up by the project hygenist, height and weight measurements for project children plotted on a growth chart, immunization of children, and regular well-child exams for children up to school age. Special attention is given to children with development problems.

State agencies now perform a number of services which were originally provided by this project, especially to children of school age. The Children and Youth Project has responded by aiming their services more at pre-schoolers. MCH foresees a reduction in the grant for this project in the coming years.

Another Maternal and Child Health Project is administered by York County Health Services in Saco. This program serves families in York County and is receiving $98,500 for FY 1978.

Some women of child bearing and child rearing age in York County do not receive regular health care. Many women at various stages in the maternity cycle need monitoring for early signs of complications.

The target population for this project consists of York County pre-schoolers at risk of receiving inappropriate health care, York County newborns and infants at risk of receiving inappropriate health care, and women at risk of poor outcome of pregnancy. In York County there are approximately 21,380 low income women and children who fall into one of these categories. The expected project population for FY 1978 is women 350 and children 4900.

The MCH project provides: (1) coordinated, appropriate, comprehensive health care for preschoolers at day care centers, (2) home visits to expectant mothers, (3) referral of women of child bearing and child rearing age to appropriate health agencies, (4) coordination of parenting clinics. There is a dental hygienist and nutritionist available at the child clinic centers.

The purpose of this program is to (1) provide adequate pre-natal care and supervision for women of child bearing and rearing age, (2) immunize children adequately, (3) reduce risk of undetected disabilities in children, (4) reduce the incidence of child neglect and abuse, (5) reduce the prevalence of marginal nutritional status in preschoolers and mothers, and (6) reduce chronic illness in children, and (7) provide coping skills for parents.

There is a charge levied for all services performed by the clinic but these services are provided regardless of payment.

The Maternal and Infant Care program is administered by Downeast Health Service in Ellsworth. It serves women in the perinatal cycle in Washington and Hancock counties. For fiscal year 1978, $269,500 was allotted to this program.

There are women and children of low income in Washington and Hancock counties who are at risk of not receiving appropriate health care due to barriers of money, know how, and transportation. This project provides paramedical services and purchases medical and hospital and antepartum care for pregnant women and health care for their infants.

The target group for this year is 600 women and 600 infants of the 1,000 women and 1,000 infants eligible in the population group.

Services provided include routine pernatal and post-natal care for women, information regarding birth control, information regarding WIC services, provision of ingested flouride for children, immunization for children, quarterly check-ups for height and weight and plan of action formulated for all children deviating from normal by more than two standard deviations, neuromotor screening of at-risk babies to identify developmental problems before the age of 12 months and development of groups of teenage pregnant women to whom are provided emotional support, prenatal education, promotion of breast feeding, planning for baby, and nutritional education.

Every effort is made to find third party payors for eligible clients.

The Dental Project at the Mid-Maine Medical Center in Waterville serves children 0-18 years old in Northern Kennebec and Somerset counties. The project has clinics in Waterville serving 1100 children, in Bingham serving 420 children, and in Jackman serving 150 children. Maine has one of the worst rates of dental decay in the nation. The goal of this project is to reduce dental disease and promote dental health through preventive and restorative dental care techniques and educate children who would otherwise not avail themselves of this service. Participants must meet Title XX low income guidelines (parental income less than 195% of poverty level). There are approximately 20,000 children in the service area and approximately 5,000 are school and pre-school children who meet the income guidelines. Of these 1700 participate in the dental project. For FY 1978 the Dental Clinic is receiving $106,900.

The Poison Control Center is administered by the Maine Medical Center in Portland. It serves a statewide area and is funded from year to year. For fiscal year 1978 it is receiving $31,000.

The purpose of the Poison Control Center is to provide immediate help for people who have been poisoned. A staff of trained technicians is available 24 hours a day to answer calls about poisoning and to actually treat poison cases. In fiscal year 1977 there were 4,000 calls for information and 400 victims were treated. There are medical back-up personnel available and linkages have been established with the Regional Boston and national poison control centers.

One of the goals of the Poison Control Center is to find a way to reduce the occasion of poisoning. To this end preventive educational materials are distributed to public and professional services by a staff skilled and equipped to dispense information related to emergency treatment.

There are over 1,000,000 people in Maine. The target population of this program are those people in Maine seeking relief from poisoning - 70% of which are children.

The Children's Clinic is administered by the Mid-Maine Medical Center in Waterville. For FY 1978 the Children's Clinic is receiving $66,400 from MCH.

Due to circumstances of poverty, rurality, limited availability of appropriate manpower, and lack of public awareness, many children in Maine are not receiving adequate health care. The goal of this project is to provide well-child and diagnostic clinics to eligible children 0-18 years of age. Priority is given to those children 0-10 for whom pediatric services have been previously unavailable.

Well-child clinics are operated in Waterville and Oakland approximately 4 times a month. At these clinics medical histories are taken, general physicals given, nutrition counseling, speech and hearing testing, eye and ear exams performed, and lab procedures performed in urinalysis and hematology. EKG's, EEG's and chest X-rays are also performed when indicated. Four times a month there is a diagnostic clinic in Waterville for special diagnostic problems. Physical exams, screening and psychological exams are performed when indicated. Combination of well-child and diagnostic clinics are operated in Bingham monthly and in Jackson quarterly.

The Children's Clinic has linkages with the Children's Dental Project, WIC program, KVRHA, Public Health Nursing, school health nursing, the Kennebec Valley Mental Health Center, and other agencies from whom clients are referred. They also maintain an outreach contract with KVRHA who promotes project services and describes these services to the target population.

The services provided are free to those financially eligible (Title XX guidelines). Other patients are served within the limitations of the staff, and in such cases fees are charged to the patient or other third party. Currently 1,200 children are being served (FY 1978) out of a target population of 8,000 who meet the low income criteria.

The Neural Tube Defects program is administered by the Foundation for Blood Research in Scarborough. Funding for this fiscal year '78 was for $62,500.

The goal of this program is to reduce N.T.D. by 50% in Maine by 1980. There are basically two kinds of Neural Tube Defects, anencephaly, in which the brain or spinal cord fails to develop properly before birth, usually causing fetal death, and spina bifida which causes a number of health problems for the infant and usually means death at an early age.

Neural Tube Defects is a genetic disease. It is estimated that of the 20,000 births in Maine a year, 400 are at high risk of having N.T.D. There are 200 families in Maine identified as at risk families. The NTD project makes these families aware of the risks involved in having a child, makes them aware of their options, shows them means of pursuing options, and gives them access to information regarding etiology, prevalence, and recurrence risks of NTD. They do this through means of pre-natal and post-natal counseling, interviews, and informal discussions with each family.

The target group for this project are the 200 identified families at risk and all women in early pregnancy. Currently, the NTD Project is developing a serum screening program so that women in early pregnancy can be informed if the fetus has NTD so that they will be able to make a decision as to whether they should carry the fetus to term. This program will monitor 50% to 75% of the pregnancies annually.

The Neonatal Intensive Care Unit is administered by the Maine Medical Center in Portland. It serves a statewide area and is receiving $41,000 of FY 78 MCH funds and $57,000 MCH carryover funds from FY '76 and FY '77.

Some newborn infants in Maine (est. 250-350) are either dying or suffering damage which need not occur if the infant can be availed of existing experienced practitioners and sophisticated equipment. This project is intended to ensure that no infant in Maine is deprived of this care.

It is also intended to reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbirth and reducing infant and maternal morbidity and mortality through provision of health care to infants and mothers who are subject to conditions which are hazardous to their health. The NICC provides a broad range of interim medical and surgical services to infants including transportation of endangered infants, follow-up care during the first year of life, and consultive services for mothers. It is also closely coordinated with other Crippled Children's Services, Maternal and Child Health Services, Medicaid, Catastrophic Illness Program, AFDC and other social service agencies.

The Retinitis Pigmentosa Project is a three year project now in its second year. It is administered by the Genetic Counseling Service in Ellsworth and it serves a statewide area. Funding for this project for this year is $45,100.

Retinitis Pigmentosa is a hereditary disease. For those affected the retina slowly degenerates and loses its ability to transmit pictures to the brain. The R.P. Project is a program designed to provide diagnostic services, family studies, and genetic counseling to affected persons, their families and other relatives. It is also designed to study many characteristics of R.P. in Maine.

The services to individuals and families include: (1) collection and analysis of family history, (2) diagnostic consultation if necessary, (3) ERG testing for early identification of persons who will have the disease in the future, (4) genetic counseling for affected persons, (5) identification and genetic counseling of persons known to be carriers or at risk of being carriers of R.P., and (6) identification and genetic counseling of persons in the family free of R.P.

Clients are referred to the R.P. Project by opthamologists, optomotrists, the Division of Medical Eye Care, private physicians, and family contacts through the pedigree process. The goal of the program is to identify most of the people in Maine who are affected by R.P. within a three year period. At that time this program will end and any other people who are found to have R.P. will be sent through the system established by this project with trained personnel reimbursed through other eye programs. The same thing has been done with the Down's Syndrome and Hemophilia projects and it has been found to work well.

The School Health Education Project is a four year program administered by the Health Education Resource Center. It is currently serving one school district in each county, but by the end of the four year period health education should be established in virtually all school districts in the state. For fiscal year 1978 SHEP is receiving $240,000.

The purpose of SHEP is to integrate health education into the cirricula of the schools of Maine. Up to this time health education has been a low priority in the school systems due to a lack of resources, curricular models, local coordinator, initiation, and the uncertainty of state aid appropriations.

The introduction of health education into the cirricula of Maine schools will give these schools a great potential in influencing knowledge and lifestyles in a positive way for a large number of the population over a long period of time. Immediate improvement in child health with respect to obesity, lung disability due to smoking, drug abuse, teenage pregnancy, venereal disease, child abuse, and dental problems is an attainable goal.

In the first year of the project 16 school districts have been funded for purposes of designing and implementing comprehensive K-12 health education curricula in response to local needs. Community, faculty, and students are to be involved in the planning and research of the local curricula projects, and the writing is to be done at the district level.

Each district has selected a health education coordinator to administer the project. Coordinators are selected on criteria established by the individual districts. Their duties include (1) coordinate and supervise the development and implementation of a comprehensive K-12 health education curriculum, (2) develop a process for involvement of the school staff and community, (3) work with the various community-based agencies and resources to insure optimum utilization of their services and expertise, (4) interpret the curriculum to the community and the various publics, (5) provide and coordinate inservice training for the teaching staff, (6) serve as a clearinghouse for health education related materials, and (7) assist with the ongoing evaluation of the curriculum.

It is strongly suggested that the project districts utilize local community resources in health related areas as they develop their curricula, as well as bringing this expertise into the school community.

Next year 48 new school districts will be starting School Health programs through SHEP. It is projected that the cost of starting these programs will be about $500,000 or about twice the present funding level. The response from the 16 school districts currently being served has been very favorable and the Department is committed to increased funding of this project because it is convinced that this is a desirable means of reducing disease through prevention.

Dental Health education is provided in approximately ten school districts throughout the state. The districts are required to match the Maternal and Child Health funds 50-50 for the first year and pay a greater percentage for the next two years. MCH has appropriated approximately $40,000 to the program for fiscal year 1978.

Maine has one of the worst rates of dental decay in the nation. In order to help alleviate this problem, MCH is funding, in cooperation with certain school districts, a program whereby a dental health professional visits classrooms (grades K-6) and gives instruction to children with regard to dental health. This program is designed to strengthen pupil awareness and appreciation of good oral health utilizing standard teaching materials which emphasize plaque control, proper diet, and nutrition and dental safety.

The dental profession also conducts at least two workshops per year for teachers, and is available for consultation regarding dental problems.

A period of dental hygiene is conducted daily by teachers. During this period Sodium Flouride is distributed to pupils (parental permission required), children brush their teeth, and students in grades 4 through 6 floss. There is also a weekly flouride mouth rinse (parental permission required). Materials for these activities are provided through this program.

The School Nursing Support Program is administered by the Four Town Nursing Service in Blue Hill. It serves school districts in central Hancock County and is receiving $6,000 for the school year 1977-78.

Nurses from the Four Town Nursing Service visit schools regularly and provide (1) communicable disease control including T.B. skin tests for all school personnel, surveillance for scabies, lice, empetigo, pinworms, and strep infection, (2) physicial exams to all students, (3) vision screening for all students, (4) hearing screening for all students, (5) developmental tests, (6) follow-up for identified problems, (7) first aid and emergency care, (8) counseling, and (9) review of health records.

This service was previously provided free by the Four Town Nursing Service, but due to rising health costs this can no longer be done. The funding for this program is for only one year so that schools can find funds for these services in their budgets for FY 78-79.

The Genetic Service Clinic is administered by the Eastern Maine Medical Center in Bangor. It is a new comprehensive service serving the ten northernmost counties of Maine. For fiscal year 1978 it is receiving $54,000.

The purpose of the Genetic Service Clinic is to insure that persons living in northern Maine who are affected by genetic diseases have a sufficient understanding of their disease situation to make informed decisions regarding future family planning. Clients are referred to the clinic by physicians, hospitals, clinics, and health agencies. They receive diagnosis, treatment, and counseling. Complete medical histories are obtained, physical exams are performed and pedigrees are obtained for each patient. Upon completion of diagnostic procedures the family is informed of the diagnosis and the probabilities and risks involved in starting or continuing a family. Patient recommendations, management and follow-up procedures are assigned to other professional personnel or agencies as may be required for each case. Linkages have been established with other sub-specialty professionals where services may be needed for special or unusual cases.

Patients pay as they are able according to a sliding scale established by the Eastern Maine Medical Center. Some fees are waived due to extremely low income levels. Grant monies are used as a last resort if no other third party funds are forthcoming. However, no person is denied counseling due to financial need.

The Hemophilia project is administered by the Maine Medical Center in Portland. Funding for this project is for only three months, 7/1/77 to 10/1/77, when federal funds will be available to continue project services. The project received $5,000 for this period.

Most hemophiliacs in Maine were identified by the original hemophilia project which was sponsored by the federal government. The purpose of this project is to reduce to zero the number of hemophiliac families in Maine without knowledge of or access to preventive services of genetic counseling. It is intended to service those families new to Maine and those not served by the original hemophilia project.

The target group for this project is (1) hemophiliac families recently moved to Maine, (2) families with a newly diagnosed hemophilia member, and (3) families being served by the hemophilia treatment center in need of services.

These people are contacted by a social worker who arranges for them to receive genetic counseling and education so that they can make a clear informed choice about reproduction.

The Maine Fetal Risk Project is a three year pilot study administered by the Maine Medical Association in Brunswick. It serves a statewide area and is receiving $28,000 for fiscal year 1978.

Some fetuses suffer preventable damage because signals of danger - either actual or potential- are not appropriately recognized by physicians due to lack of a systematic way of looking at them. It is the purpose of the Maine Fetal Risk project to develop data which would allow physicians to become more aware of conditions leading to a risk of poor outcome of pregnancy. The feeling is that if the danger can be detected the danger can be diminished.

Every delivery physician in the state has been contacted and hopefully at least 100 will participate in the program - at least 50% of these will be from rural areas and at least 33% of the births surveyed will be from rural areas. The basic component of this program is the utilization of a fetal score card which contains information pertaining to the family medical history, mother's health, earlier problem pregnancies, and mother's life style (as it pertains to mother's health). The patient is scored throughout pregnancy and postnatal information on the well-being of the newborn is also supplied. This information is compiled by the Maine Fetal Risk Project and analyzed to determine what conditions during pregnancy lead to risk of a poor outcome.

The end products of this project are: (1) a proven system of identifying high-risk pregnancies installed in the practice of some physicians in Maine, (2) increase in the appropriate utilization of obstetrical consultants and facilities for intermediate and tertiary level neonatal care, and (3) a body of statistical data defining incidence of maternal and fetal and infant morbidity.

This data will allow physicians to make the earliest possible determination of high-risk maternity patients. This data should also allow the Fetal Risk Project to determine by geographic area the incidence of high risk pregnancy, of abortions, both spontaneous and induced, stillbirth, and maternal morbidity as it affects the outcome of pregnancy.

The Handicapped Children's Program is administered by the Eastern Maine Medical Center in Bangor. It serves multiply-handicapped children in the five northernmost counties of Maine. For FY 1978 it is receiving $100,000.

This program serves 200 multiply-handicapped children annually. The major focus of the program is to provide an interdisciplinary outpatient approach to assure the full social, educational and rehabilitative potential of multyply-handicapped children. This is accomplished by providing a comprehensive, interdisciplinary, diagnostic center for handicapped children which provides for the development of individual prescriptive programs of treatment and services based on diagnostic evaluation and follow-up care and treatment in order to coordinate and assure the delivery of appropriate services.

The evaluation components of the program consist of (1) a pedigree evaluation, (2) developmental assessment, (3) psychological exam, (4) educational evaluation, (5) social service evaluation, (6) physical and occupational service evaluation, (7) nutritional assessment, (8) speech and hearing evaluation, (9) psychological consultation, (10) genetic evaluation, (11) medical sub-specialty consultation, and (12) clinical lab studies.

Psychiatric consultation for the behavorial components of handicapping conditions is one of the most important services offered by the program. This counseling is often needed to help both children and parents adjust to and accept handicapping conditions.

The Handicapped Children's Program has developed linkages with the Crippled Children's Program, and the Child Development Center at Orono. They also coordinate these services with other EEMC services, the genetic clinics, the perinatal program and the rural pediatric health services, and aid in the training of students from the University of Maine in child development.

In order to qualify for this program children (0-18) must have at least two handicaps. In the five county area of northern Maine there are approximately 1,000 children who qualify.

There has been a large volume of referrals from other parts of the state indicating a need for this service throughout Maine.

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

DAVID E. SMITH
COMMISSIONER

September 8, 1977

Rec'd Sept. 14, 1977 PCR

Mrs. Doris Reando
York County Health Services, Inc.
103 Main Street
Springvale, Maine 04083

Dear Mrs. Reando:

The purpose of this letter is to notify you of the award of a grant as described below.

Grant number: 11-CH-78
Title of grant: York County Maternal and Child Health Project
Effective date of grant: 1 July 77
Total amount of the grant award: $98,500
Schedule for payment of grant: Quarterly - on receipt of reports.

Conditions of grant:

1. Reports relating to FY 77 grant must be submitted before 1 October 77. Reports not yet received are:

   a. Year end expenditure report
   b. Income report for total grant year
   c. Performance report for quarter 4
   d. Unit costs for quarter 4
   e. Performance report for quarter 4 relating to accomplishment of stated objectives

2. The Child Health Clinic component of your FY 78 budget is to be paid on the basis of monthly billing submitted in accordance with the current clinic agreement. This amount is stated in your budget as $28,800.

3. The budget for the non clinic component of your grant, stated as $105,502, needs to be revised and resubmitted in the amount of $100,000. This latter amount represents the cost of the service if it were being provided by department personnel directly. The basis for the calculation is available to you for examination through Mrs. Zidowecki's office. If the grant continues in future years, this formula method of determining allowed funding will be utilized.

4. Monitoring nursing services are to be provided to all infants in the project area who are discharged from the Neonatal Intensive Care Center at Maine Medical Center. This monitoring is to be provided initially within three months of discharge and at least yearly thereafter for five years, with reports of each visit submitted to the center.

(continued)

5. As with the current year's grant, community nursing services are to be provided as requested by the department without charge for services to persons related to department programs of tuberculosis control, venereal disease control and Crippled Children's Services.

6. The information as required by the department will be completed and submitted by 1 July 78 for all children in your project area registered to enter school in September 78. The specified information is described in the attached form "Preparation for School".

7. Grant payments are conditional upon receipt of required reports, approved by Helen Zidowecki. The required reports and related schedule are:

   a. Expenditure report, by categories, related to approved project budget, are to be submitted quarterly, before 1 November 77, 1 February 78, 1 May 78 and a final year end report by 1 August 78.

   b. A performance report based on stated project objectives, on the same quarterly schedule as above (a).

   c. An income report, displaying all project income, on the same quarterly schedule as above (a).

   The quarterly amount of the grant total of $98,500 is $24,625. Since a payment has already been made to you of $17,500, a balance of $7,125 will be payable now.

8. Arrangements are to be made by you for an audit of project funds for FY 78, to be conducted by a certified public accountant and the report submitted to this office before 1 October 78.

Acceptance by you of the grant funds will be considered as acceptance of the conditions listed above. If the conditions are not satisfied, the department may require return of a portion or all of the grant funds.

Approval of this grant implies approval of the budget as submitted. If it becomes necessary to revise the budget in excess of 10% in any of the stated categories, prior approval must be obtained.

Approval of this grant does not imply continuing support in succeeding years. Subsequent requests will be considered on their own merits.

Helen Zidowecki, Director of Public Health Nursing, has been selected as the department representative with whom you should plan to work in the conduct of this project.

(continued)

We are pleased to award this grant and look forward to working with you on this project.

Sincerely yours,

David E. Smith
Commissioner

DES/ltm
Enc.
cc: Shirley Ouprie

September 19, 1977

Mr. David Smith
Commissioner, Dept. of Human Services
Augusta, Maine 04333

Dear Mr. Smith,

Pursuant to our telephone conversation of 9/14, I am confirming the date of our meeting with you, Mr. Carney, Dr. Dunham and Mrs. Zidowecki, for Thursday, September 29 at 1:30 P.M. in your office. Our Business Manager, Board officers (2) and I will attend.

The Board's concerns are generated from the changes in Grant funding schedules, issued to us this past week, which, added to delayed reimbursements for Clinic services, E.P.S.D.T. and Medicaid, cause extreme financial hardship for our Agency. We are hopeful that our meeting will clarify some of the reasons underlying these problems from your Department's perspective, and that some accommodation or recommendations will evolve to help us with our problems.

I wish to thank you for your open and willing response to the request for this meeting, and look forward to understanding and resolving some of the concerns felt by our Agency.

Sincerely,

Shirley A. Cuprie, R.N.
Executive Director

c.c. W. Carney
M. Dunham
H. Zidowecki
Business Manager
Board officers (2)

SAO:sy

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

DAVID E. SMITH
COMMISSIONER

October 5, 1977

Mrs. Doris Reando
York County Health Services, Inc.
103 Main Street
Springvale, Maine 04083

Dear Mrs. Reando:

This letter is intended to outline the conclusions reached in our meeting of 29 September 77 in relationship to your maternal and child health grant for FY 78.

1. Payment schedule - Payments will be made quarterly according to the following schedule:

   Quarter 1 - payable 1 July 77 - payment has already been received.

   Quarter 2 - payable 1 October 77 - again payment has already been received.

   Quarter 3 - payable 1 January 78, contingent upon receipt of acceptable reports for quarter 1.

   Quarter 4 - payable 1 April 78, contingent upon receipt of acceptable reports for quarter 2.

   The reports required have already been outlined in our letter to you of 8 September 77.

2. Grant amount - the amount of your grant is $98,500 for the home visiting component of your services, plus the amount to be billed for child health conferences in accordance with that separate agreement.

   The total amount of grant has been determined by a formula. This formula in current use is a revision of an earlier one and represents our best efforts to date to determine the department's cost for public health nursing services. As such, it is to be regarded as experimental and may well be subject to revision as we improve our method of cost determination. If it is revised again, we will expect to discuss any changes with you. It must be understood, however, that this or a subsequent formula will form the basis for establishing the amount of funding available from our department to support public health nursing services. Any additional funds will have to be obtained from other sources.

(continued)

All grant conditions not specifically modified by this letter are considered to prevail as outlined in the 8 September 77 letter.

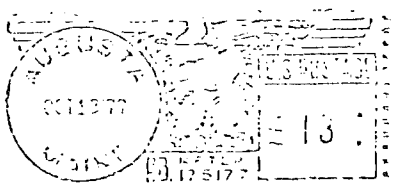
If you have questions, Mrs. Zidowecki will be available to work with you to resolve them.

Sincerely yours,

David E. Smith
Commissioner

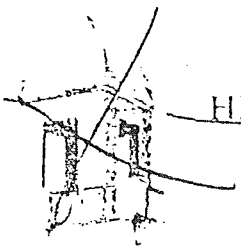
DES/ltm

OF MAINE
F HUMAN SERVICES
UGUSTA, MAINE 04333



Mrs. Doris Reando
York County Health Services, Inc.
103 Main Street
Springvale, Maine 04083

OCT 2 1 1977



HENRIETTA D. GOODALL HOSPITAL, INC.

TWENTY-FIVE JUNE STREET
SANFORD, MAINE 04073
207 / 324-4310

October 19, 1977

Mr. David E. Smith
Commissioner
Department of Human Services
Augusta, Maine 04333

Dear Dave:

We are in receipt of your letter dated October 5, 1977, in reference to the Maternal, Child Health Grant for fiscal year 1978.

There still seems to be some confusion on the agreements reached at our joint meeting of September 29, 1977. I will outline the points of issue and the conclusions reached as we understand them.

1. Payment Schedule

   A. The 1st and 2nd quarter payments are to be made to us by July 1, 1977. We have received these payments.

   B. The 3rd quarter payment to be made by October 1, 1977. Submission of 1st quarter statistical data is to be completed by October 1, 1977.

   C. The 4th quarter payment to be made by January 1, 1978. Submission of 2nd quarter statistical data is to be completed by January 1, 1978.

   D. Third quarter statistical data to be completed and submitted by April 1, 1978.

   E. Fourth quarter statistical data to be completed and submitted by July 1, 1978.

2. We agree with the grant amount of $98,500. However, your letter should have included the following statements:

   A. The school program is to include just the children who attend the clinics.

   B. Paragraph 5 of the letter of September 8, 1977 to be

restated to say, "tuberculosis control, venereal disease control and crippled children services are not to be charged against the grant".

Additionally, we were to receive a copy of the formula used to determine the amount of the grant for this year, and we were to be provided an opportunity to discuss any subsequent changes in this formula.

The last issue is the principle of charging patients on a sliding scale basis for services rendered. We would appreciate a clarification from you on whether we are to attempt to charge patients for services rendered in child health conferences.

In closing, let me thank you for your time and efforts in resolving these issues.

Sincerely,

Joseph Barboza
Treasurer
York County Health Services

JB:jg

cc: S. Ouprie
H. Zidowecki
C. McLaughlin
D. Reando

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

DAVID E. SMITH
COMMISSIONER

NOV 8 19

November 3, 1977

Mr. Joseph Barboza
Treasurer
York County Health Services
303 Main Street
Saco, Maine 04072

Dear Mr. Barboza:

This is in answer to your letter of 19 October 77.

The payment and reporting schedule for your maternal and child health grant is correct as stated in my letter of 5 October. It is our intention to allow one intervening quarter to permit you to prepare statistical reports. Thus, payment for the third quarter, beginning January 1, 1978, will not be made until we have received and approved reports for the first quarter, ending 30 September. This will allow one full intervening quarter to you to prepare the reports. If in fact the reports are available in acceptable form prior to 1 January 78, we will consider payment upon approval.

I am uncertain as to your meaning in your reference to school program being limited to children in clinics. If you are referring to the requirement for reporting information related to school entrants (letter of 8 September 77, paragraph 6), this does in fact apply to the entire group of school entrants, and requires analysis of both the population served by your clinics and the population not so served.

In regard to services being rendered without charge to persons receiving care through the state program of tuberculosis control, venereal disease control and crippled children, our intent is to ensure that these clients will receive public health nursing services from your organization without charge either to the maternal and child health grant, or to the families of clients, or to those specific programs.

Please contact Mrs. Zidowecki directly for information about the formula used to determine the dollar amount of the grant. She is the person most familiar with the details of the formula and she will be available to discuss it fully with you. If the formula presents difficulties you are unable to resolve, please let me know.

It is my understanding that you propose in your grant application to charge fees for child health conferences and thereby generate an estimated $15,000 income. The grant was approved with the expectation that this provision of the program will be implemented.

Sincerely yours,

David E. Smith
Commissioner

DES/ltm
cc: S. Ouprie
C. McLaughlin
D. Reando
H. Zidowecki

July 7, 1978

Ms. Doris C. Reando
York County Health Services, Inc.
103 Main Street
Springvale, Maine 04083

Dear Ms. Reando:

The purpose of this letter is to notify you that a decision has been postponed on your application for a maternal and child health project.

The reason for the postponement is to permit you to modify the application narrative and budget.

1. The scope of this project must be limited to the provision of those services customarily available through the Division of Public Health Nursing. As you are aware, our willingness to fund this project during the past years has been related to our interest in determining whether it is feasible for the department to purchase public health nursing services rather than to provide them directly.

   Thus, we consider the addition of a well woman clinic to be outside the scope of our present intent. Will you, therefore, please delete all budget items related to this project component in the present application.

   If you wish to submit a separate application for such a service, you may do so and we will consider it as a new application. Any such application must, however, be prepared accordingto a format specified by the Department of Human Services. This format is based on a health problems approach. The new format will be available to you on or about 1 October 78.

2. As we outlined to you in our letter of 5 October 77, the dollar amount of the grant for public health nursing services is based on a formula. The maximum amount available to you for FY 79 is $105,000. Please revise your budget so as not to exceed this amount. You may wish to discuss details of the formula application and budget modification with Helen Zidowecki.

When we receive the required change, we will review that material and notify you of our decision on your application.

Sincerely yours,

MCD/ltm
cc: Shirley Oupris
Meradith Hill
Helen Zidowecki

Marguerite C. Dunham, M.D.
Director
Division of Child Health

York County Health Services 308 Main Street, Saco, Maine 04072 Tel. 284-4566

July 13, 1978

Marguerite Dunham, M.D.
Director, Division of Child Health
Department of Human Services
Augusta, Maine 04333

Dear Dr. Dunham,

We are in receipt of your letter of 7 July, 1978, relating to our Maternal and Child Health project proposal, submitted in May, for the project year, 1 July, 1978 to 30 June, 1979. We admit to some confusion regarding the program and regulations under which we apply for MCH funding. Upon our request in March for the regulations governing the MCH programs, we were sent, by Mrs. Zidowecki I believe, a document published by U.S.Dept. HEW, Public Health Service, entitled Maternal and Child Health Services, Programs of Projects Guidelines under Title V, S.S.A. In addition, we have received from your office a document entitled Requirements for Consideration of Proposals for Title V Funds.

In neither publication do we find reference to confining services to those customarily available through the Division of Public Health Nursing. Indeed, if that were the case, services could not change or expand to meet the risk groups' needs, but would have to remain constrained to Public Health Nursing which, as you well know, did not have comprehensive, multi-discipline resources to provide the levels and kinds of service needed. In both of the above-mentioned documents, other services are discussed as needed, i.e., nutritional and psychological counseling specifically mentioned in the program descriptions for Maine, (p 10) and in the Federal guidelines, "Staffing should ----- provide services (medical, dental, nursing, nutrition, social work, psychology etc.)"(p 11). Further, under section F. Eligibility, it reads, "Diagnostic and preventive services are to be available without charge to any woman and/or child living in the project area". We are at a loss in determining how that charge will be carried out in a program called maternal and child health limited to those services customarily provided by public health nurses.

As we again review the issues presented in your letter, we note that you do refer to our application as a "maternal and child health project", and in the subsequent discussion you describe the limits of the project as those services provided by the Division of Public Health Nursing. Does this mean Communicable Disease, Crippled Children and Care of the Sick also, as was previously carried out by the Division Nurses? If so, then are we correct in concluding that this project is not a Title V MCH project, but a contract with the Dept. of Human Services to carry out the services previously provided (in a limited way) by the

Division? Our seeming inability to prepare a proposal that addresses the outlines and guidelines provided for Title V projects and also meet the Department's concept of what services and programs it is funding is due, I believe, to the erroneous perception that it is a MCH project, when it really is not.

It is disheartening, to say the least, to once again hear about a "formula" which we have never seen, even after written memos and notices concerning it. Should we not, in fairness, be able to examine the figures and data being used to arrive at the final amount? We are most anxious to clarify any misconceptions we have concerning our application which was given much research, time, study and preparation to meet each requirement as described in the Title V Guidelines and to provide a comprehensive service to those families with great needs in our area. If other regulations or guidelines should have been addressed, we never were given that indication.

I'm certain that our ultimate goal is the same; how we shall reach that goal, and what resources are to be made available seem to be the blocks. I'd like very much to sit down with you and Helen and Meredith Hill and discuss our concerns together, and plan how we might better meet the MCH needs in York County. I will be calling you, perhaps about the same time as you receive this letter (full of frustration as you can probably guess), and look forward to meeting at your earliest convenience.

Sincerely,

Shirley A. Ouprie

Shirley A. Ouprie, R.N.
Executive Director

SAO:sy

York County Health Services 308 Main Street, Saco, Maine 04072 Tel. 284-4566

July 24, 1978

Mr. Ronald Deprez
c/o Speaker's Office
State Office
Augusta, Maine 04333

Dear Mr. Deprez:

Per your request of July 21 we are enclosing the communications around our MCH project FY 78, and the responses to next year's(or more precisely, this year's) project proposal. Meredith Hill, the MCH Coordinator and I will be meeting on Monday, August 31, with Dr. Dunham. At that time we will present the needs documentation, and request

1.) clarification of the funding program for our project

2.) the "formula" for determining funds to be awarded

3.) categories and regulations for programs.

I hope these copies will answer some of your questions (probably will raise some, too). If we can be of further help, please let me know.

Sincerely,

Shirley A. Ouprie

Shirley A. Ouprie, R.N.
Executive Director

encs.
SAO:sy