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FINAL REPORT OF THE

HEALTHY START TASK FORCE

November, 1994

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EXECUTIVE SUMMARY

INTRODUCTION

Healthy Start Task Force created in 1993.

Resolves 1993, Chapters 25 and 54, created the Healthy Start Task Force to formulate a plan for implementation of a model Healthy Start home visitation program. The 14 members of the Task Force include legislators, state and local agency professionals and public members appointed on the basis of expertise, experience and interest in the prevention of child abuse and neglect or intervention in cases of child abuse and neglect.

PROCEEDINGS

Healthy Start Task Force examined programs that promote healthy families.

The Healthy Start Task Force studied family support programs that promote healthy families. It concentrated on the design and implementation of a community based, home visitation model that is preventative, comprehensive, family-focused and available to all families that want to participate.

Public meetings were held regularly in Augusta, with members of the public and agency professionals invited. In completing the inventory of services the Task Force received assistance in the form of technical work, time and mailing from the staff and students of the School of Nursing at the University of Maine at Orono. The Bureau of Child and Family Services of the Department of Human Services has provided assistance to the Task Force. Through the generosity of the Maine Association of Child Abuse and Neglect Councils the Task Force was able to meet with Barbara Rawn, Executive Director of Virginians for Child Abuse Prevention. The Task Force appreciates this assistance and thanks all who helped in the accomplishment of this report.

The Task Force was directed to consider the recommendations of the Report of the Child Protective Services Oversight Committee to the Department of Human Services dated January, 1993. The Task Force was directed to inventory state and local entities providing Healthy Start-type services. This report and accompanying information and legislation fulfill the duties of the Task Force.

THE HEALTHY START MODEL

Healthy Start model from Hawaii is consistent with the Task Force philosophy and goals.

The Task Force settled on a proven model, the Hawaii Healthy Start Program. The model is consistent with the Task Force philosophy that all families may need help and support at some point and that they can be strengthened through a positive, proactive approach to parenting. The Maine Critical Elements, which build on the model critical elements, will give providers within the Healthy Start system a common understanding, binding them together in their work with families.

RECOMMENDATIONS

Healthy Start pilot projects will work with other providers of services in the community.

The Task Force strongly recommends funding 3 Healthy Start pilot projects. The Task Force recommends consistent program design, comprehensive and uniform training of personnel, and systematic evaluation at all 3 projects. The projects will offer to all new families a core of supportive services which will include information on children's health and developmental needs. The projects will provide more intensive home visitor services to families needing more help. Although the legislation contains full funding for these intensive home visitor services at all 3 pilot projects, pilot projects that collaborate effectively with other agencies that endorse the Maine Critical Elements will realize savings and may not require all of the funding contained in the legislation.

Experience with the 3 pilot projects will show that early intervention produces healthy outcomes for families, produces healthier communities and saves money overall. Successful pilot projects will pave the way for a statewide Healthy Start system with diverse funding sources that uses new and existing community resources.

I. HEALTHY START SERVICES

Healthy Start works for families by working with them.

In the 1990's in most Maine communities mothers deliver babies in hospitals and go home. They rely on families and friends for advice and support. If they need more help, they may not know where to find it. Frequently they face a fragmented system that is difficult to gain access to and that is not user friendly.

A Healthy Start system offers information about support services before and after babies are born. Families are offered home visitors from their communities and information on children's health and developmental needs that matches the ages of their children. Healthy Start service is tailored to the needs and wishes of each family, changing as the times and needs of the family change.

II. MISSION STATEMENT

Healthy Start is a comprehensive, community based, home visitation, family support program.

The mission of the Healthy Start Task Force is to create a plan to implement a community based, home visitation program that is preventative, comprehensive, family-focused and available to all families that want to participate.

The Healthy Start Task Force was charged with the responsibility of developing a Healthy Start home visitation implementation plan for Maine, incorporating the key elements of a model program designed in Hawaii and implemented there and in other states. The Task Force was convened October 7, 1993, and has met formally 23 times since then. The group adopted ground rules, agreed to work by consensus and used a facilitator for a few months to assist the work of the Task Force.

The Task Force reviewed programs in other states, heard presentations from representatives of Maine agencies and identified critical elements of an ideal Healthy Start model. Since submission of an Interim Report in April, 1994, the Task Force met with Dr. Anne Keith, R.N., Ph.D., of the Muskie Institute, regarding evaluation of home visiting systems and Barbara Rawn, Executive Director of Virginians for Child Abuse Prevention, regarding her work with Healthy Start in Virginia. Individual Task Force members also actively participated in the planning and implementation of the Maine Association of Child Abuse and Neglect Councils "Healthy Families Maine Conference" in September, 1994.

Throughout preparation of this Final Report, the Task Force actively solicited input from others in order to establish a broad basis for the findings and recommendations.

The stated philosophies and recommendations incorporate a wide range of written materials reviewed, discussed and accepted through the process of consensus building. They reflect the collective professional and personal judgements of the diverse members of the Task Force. The most essential of these materials include:

- Hawaii's "Proposed Standards for Healthy Start Family Support Programs" as discussed in "Healthy Growth for Hawaii's Healthy Start: Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect."
- Healthy Families America's "Critical Elements for Effective Home Visitor Services."
- Research findings and recommendations in "The Future of Children, Home Visiting," Center for the Future of Children.
- "An Approach to Preventing Child Abuse: The Home Visitor Model" by Anne Cohn Donnelly.

III. THE HEALTHY START MODEL

Healthy Start in Hawaii is a successful home visitation, family support project that serves as a valuable model.

Healthy Start in the State of Hawaii is a community based, home visitor, family support system. It is part of the Maternal and Child Branch of the Department of Health. Hawaii currently administers Healthy Start statewide through contracts. The program is designed to prevent childhood health problems, notably but not exclusively child abuse and neglect. Healthy Start in Hawaii is a vital part of the maternal child health system.

An early identification worker meets with a family at the time of a child's birth in order to assess that family's need for intensive home-based support. A home-based family support worker then works with the family over a 5 year period. Visits begin weekly and progress to bimonthly, monthly and then quarterly. This worker provides emotional support to parents and

models effective skills in coping with everyday problems. The worker teaches parents to develop realistic expectations regarding child development and promotes child development. The worker coordinates with health care providers to assure that the family obtains well child care and assists in direct referral to substance abuse and domestic abuse counseling, literacy training, child care resources, housing, etc. The worker coordinates with child protection services upon detection of imminent danger situations.

After 5 years impressive statistics have begun to come from Hawaii's Healthy Start program. From 1987 to 1991 among 2193 participating high-risk families there were 18 documented cases of child abuse and neglect. This translates into successful outcomes in 99.2% of the families served[1]. Of the 74 families that had prior child protective service involvement, none had subsequent incidences of substantiated child abuse and neglect. Significant improvement occurred among clients in several areas of parent-child interaction and home environment during the project period.[2]

The goal of Healthy Families America is to prevent child abuse and other poor childhood outcomes by laying the foundations for nationwide, voluntary, intensive, home visitor programs based on the experiences of the Healthy Start Program in Hawaii. In 44 states the Healthy Families America initiative has been embraced by public and private agencies interested in creating comprehensive home-based systems for new parents. The Task Force is not labeling its recommendations as an official "Healthy Families Maine" program although the recommendations incorporate many ideas from Healthy Families America.

An effective Maine Healthy Start system will draw upon the best from the Hawaii Healthy Start model and Healthy Families America.

IV. PHILOSOPHY

Healthy Start builds on community support in order to strengthen families.

The Task Force views healthy families as holistic entities, with emotional, social, developmental and physical dimensions. The Task Force believes that all parents may need help and support at some point. It is widely accepted that education in pregnancy, childbirth, child health, child development and family

relations provides families the opportunity to optimize their parent/child relationships. All parents want to be effective and can learn skills specific to the parenting process. The best place for most children to be cared for is within their own families. The integrity of families is strengthened when support is available to the whole family rather than centered solely on its children. Early access to such educational and supportive programs enhances parenting skills, resulting in positive outcomes for families.

The aftereffects of child abuse and neglect include emotional, developmental and physical damage that is both acute and chronic.[3] These effects include the emergence of other social catastrophies, such as domestic violence, teen runaways, prostitution and pregnancy, alcohol and drug abuse, school problems, and juvenile delinquency - all of which hurt the larger community. Prevention of child abuse is possible and systematic identification of family needs is the key to this prevention. Looking at the range of interventions that contribute to the prevention of child abuse and neglect, the United States Advisory Board of the National Center on Child Abuse and Neglect states that "while not a panacea, no other single intervention has the promise that home visitation has." Home visitation is essential to promote healthy families. Regular visitation over a few years is necessary before meaningful change occurs in families. The intensity of service should match the complexity of challenges that the family faces. Home visitation is only one component in a comprehensive service delivery system.

Families and their communities must be committed to Healthy Start services. The community has a responsibility to provide a supportive climate for families, recognizing the cultural, ethnic and economic diversity of families, including non-traditional family configurations and value systems.

The Healthy Start model works because it is part of a larger system of health care services and because it responds by helping families to identify their own needs and the resources available to meet those needs. A Healthy Start system needs a clear philosophy that can be adapted and incorporated into many existing family support services in Maine. Many service entities must cooperate to address the multiple causes of child

abuse and neglect. Agency agreements for 2-way referrals, a team approach and active collaboration between the larger formal agencies and smaller local community services will be required. Appendix G contains a schematic drawing of a Healthy Start system for Maine illustrating this approach.

The Task Force challenges agencies to adopt a Healthy Start philosophy as part of their services to families. The challenge to the state government will be to provide the leadership and incentive to do this.

V. GOALS AND OUTCOMES

Healthy Start promotes a positive approach to parenting.

The Task Force set goals and outcomes for Healthy Start services in Maine. The primary goal is to strengthen families by promoting a positive, proactive approach to parenting. Family support services will help to identify early the physiological and environmental barriers to family health. Early intervention will be less intrusive, less intensive, more economical and will better meet the needs of the family.

The potential outcomes discussed by the Task Force are based on social, developmental, physical and emotional parameters of health for families. Healthy Start outcomes include: improved birth outcomes; optimal child health and development; enhanced parent child interaction; school readiness; increased and appropriate use of community resources; and prevention of child abuse and neglect. Healthy Start families will learn about community resources and be supported in their efforts to use them. Families under stress will get the direct assistance they need to take advantage of existing resources. Well-child visits to primary health care providers will increase and the use of acute care services will decrease. Fewer children will require the intervention of more costly medical and social services. In the short term, referrals to social, developmental and protective services could actually increase, because of the ability to identify earlier the problems and conditions that put children at risk and families in need of assistance. Long term outcomes of Healthy Start will include fewer children abused and neglected and reductions in domestic violence, teen pregnancy, and acute care costs for victims of child abuse and neglect, . See Appendix E for the minimum cost of child maltreatment in Maine.

VI. MAINE CRITICAL ELEMENTS

A Healthy Start system in Maine relies on adoption of the Maine Critical Elements.

The critical elements of this implementation plan represent the blueprint for success for a Healthy Start service system in Maine. All of these critical elements must be adhered to in the development of such a system. Any lure of dilution must be resisted.

The Task Force recommends adoption of a common philosophy to guide a Healthy Start system, based on these Maine Critical Elements.

1. Healthy Start services should be offered on a voluntary basis to all new families in the defined geographic area of the project. For some families, especially those involved with the Bureau of Children & Family Services, there may be some articulated consequences of a family's decision not to participate.

2. First tier supportive Healthy Start services should be universally available to all new parents. They include: (1) community level home-based nursing services to attend to the newborn infant care issues. These are being offered to new families in some areas of the state; (2) periodic outreach that provides child health and development information and encourages families to seek out the help they need. Families that decline intensive home-based services when originally offered may accept at a later time as a result of outreach efforts; (3) use of any other existing family support outreach services in Maine communities, including volunteer outreach.

3. A second tier of more intensive home visitor services should be offered to parents who need them. As families come to need fewer services, the frequency of home visits should diminish. The decision to change a family's level of service from weekly visitation to quarterly visitation eventually should be based on well defined criteria that measure progress in family functioning and other health outcomes, including: frequency of family crisis; quality of parent-child interaction; and the family's ability to use other appropriate community resources.[5]

4. The Hawaii Family Stress Checklist should be used to assist families to identify the intensity of services needed.[6] Screening should identify increased risk for child maltreatment and other poor family health outcomes.

5. Families may begin Healthy Start services prenatally through their childrens' six-month birthdays. Services should continue through age 5.

6. There should be persistent, positive outreach efforts for at least 3 months to encourage families in need of more intensive home visitor services to accept services.[7]

7. Efforts should be family-focused and promote healthy child development. Services should assist the family toward independence.

8. Families should be linked to primary health care providers to assure timely immunizations and well-child care.

9. Healthy Start services should provide comprehensive one-stop shopping for families. Healthy Start projects should work with other community service providers. Depending on the family's need, Healthy Start providers should be able to link families to additional services such as: financial, food and housing assistance; school readiness programs; crisis and counseling services; services available from the Bureau of Child and Family Services; child care; job training programs; family support centers; substance abuse treatment programs; and domestic violence shelters. Healthy Start services should complement any family preservation and support services that are developed from the Omnibus Budget Reconciliation Act of 1993.

10. Healthy Start home visitors should receive ongoing professional supervision to assure service quality. They should have limited caseloads so they have adequate time to spend with each family. [8]

VII. INVENTORY

Healthy Start pilot projects will be built on family support services that already exist in Maine.

With the cooperation of several graduate students from the School of Nursing of the University of Maine in Orono, the Task Force designed and distributed a survey to identify existing Healthy Start-type services. It was sent to nearly 500 human service providers who are currently involved with families with children from prenatal to age 7. 168 surveys, or 37%, were returned. A copy of the survey is attached as Appendix J.

The inventory has proven to be useful and may be expanded upon in the future. As with any survey, it had some limitations: inadvertent duplications, nonresponses and incomplete answers.

The inventory provided valuable information about Healthy Start-type services already existing in Maine. These specified services were: maternal and child health education; prenatal health/support services; postpartal and newborn assessment; parenting counseling, support and education; nutrition education; social service assistance; parent/child interaction activities.

Ninety-two home-based agencies provide Healthy Start type services through social workers, registered nurses, teachers and paraprofessionals. These agencies use a variety of eligibility criteria including: eligibility for Medicaid and AFDC; involvement of the Bureau of Child and Family Services; participation in Headstart; children with established special needs; pregnant and/or parenting teens; residence in a particular town or use of a particular health facility; children aged 0-5; skilled nursing need; removal of a child from home has already occurred or appears imminent; a first child in the home. Very few of these agencies demonstrate the necessary frequency and duration of services required for Healthy Start services by the Maine Critical Elements.

Additionally 76 non-home-based entities provide Healthy Start-type services. The entities include the following: hospitals/health centers/health facilities; parenting classes; child abuse and neglect councils; private social work/mental health clinicians; WIC sites; public and private day cares; community action programs; family planning sites; schools; adult education programs; domestic violence response programs; parent resource centers;

peer support groups; group homes/shelters; Cooperative Extension Service programs. These entities may have the capacity for training or consulting with a Healthy Start system. Administrative departments of state government have this capacity as well. One entity, the University of Southern Maine Child and Family Institute, identified statewide training on some Healthy Start-type issues as its purpose.

Other findings from the inventory include the following: (1) there are home-based and non-home-based entities that are already providing the less intensive supportive services that are first tier Healthy Start services; (2) very few respondents indicated use of a specific needs identification tool; (3) most respondents indicated use of public funding streams, fewer with a public/private mix; (4) the most common collaborators were the Bureau of Child and Family Services, the Bureau of Children with Special Needs, Child Development Services, and community based nurses; (5) there are some community-based centers that provide a wide range of health promotion services, e.g. parenting support groups and classes; and (6) many agencies use paraprofessionals at some level.

Barriers to home-based Healthy Start services at this time include: the amount of available funds in current funding streams; inadequate staff available for the frequency and duration of services required by the Maine Critical Elements; current eligibility criteria that do not include all of the Maine Critical Elements; and divisive issues between area providers instead of cooperation.

Maine hospitals and other health facilities play an important role in the assessment of family needs after the arrival of a newborn. Earlier postpartal discharges have led many hospitals and health facilities to use members of their own nursing staffs or to network closely with community based providers to visit new mothers. Some work with all mothers from that facility. Others work with just families with identified needs. Data from the Bureau of Health show that between 6/92 and 7/93, 9,412 births were tracked at 32 Maine hospitals. Over 4,809 of these births led to referrals to a wide array of community based nurses.

VIII. PROGRAM DEVELOPMENT

Healthy Start services depend on identification of family needs and are tailored to those needs.

The Task Force recognizes the great importance of early, positive public awareness of Healthy Start services. Members of the Task Force were very impressed with Virginia's use of the local public television network to make clear that all parents may at some point need help and that seeking support is a sign of family strength. A strong public education campaign for Healthy Start will contribute significantly to public awareness of the pilot projects, to awareness of community resources and to use of the projects.

A major entry point into a Healthy Start system will be hospitals and other health facilities where children are born. Information about Healthy Start services and referrals should be available from prenatal and social service providers, community nurses, doctor's offices, legal support staff, local child abuse and neglect councils, schools, guidance counselors, family planning clinics, WIC sites, Head Start centers, other child care providers, Child Development Services sites, Cooperative Extension Service offices and community centers. Community centers that provide information, referrals and services are being used at some Healthy Families America sites in the country under collaboration with the National Association of Mothers Centers.[9] Self-referral by families should be part of the Healthy Start system.

Assessment of family needs should be done with pregnant women and new parents to introduce them to the range of services available. Healthy Start home visitors will help families to identify their own needs, using clear goals, specific solutions and measurable outcomes. Families will be directly involved in team building between service providers and themselves. The Healthy Families America Site Summaries suggest starting with a manageable limited project area and using facilities and providers already in place. The 44 Healthy Families America sites across the country use social workers, registered nurses, paraprofessionals and volunteers.

Appendix I presents 2 family scenarios, showing family situation, needs identification, utilization of Healthy Start services and continuing outreach.

IX. TRAINING

Healthy Start training enables staff members to provide services that families need.

A comprehensive and uniform Healthy Start training program should be used to teach the philosophy and practice of Healthy Start. Success requires a firm commitment to coordinate and supervise project staff and to provide integrated training plans using materials available from Healthy Families America and the Hawaii manual. Training should be coordinated with other family intervention training being done in the state and should cover the dynamics of child abuse and neglect, early identification, the Maine Critical Elements, and home visiting.

Pilot projects should join together to train new staff members using trainers who have completed Healthy Families America training.[10] One project or an independent entity should undertake all training.

X. EVALUATION

Healthy Start projects need ongoing evaluation to identify areas for improvement.

The Task Force was most fortunate to meet with Dr. Anne Keith, of the Muskie Institute, who has had experience in the implementation and evaluation of home-based programs. Systematic evaluation based on the Healthy Families America key characteristics should be part of a Healthy Start system. The National Committee to Prevent Child Abuse and Healthy Families America staff are available to provide technical assistance. Hospitals and universities may be able to provide evaluation assistance.[11]

The outcomes being evaluated should primarily measure improved family functioning. Decreased child abuse and neglect and cost savings are secondary outcomes that are a consequence of increased family health. A steady focus on outcomes of healthy family functioning will provide encouraging evaluation results.

Evaluation data should be available to the pilot projects and the community service providers in order to improve the Healthy Start system. One project or an independent entity should provide oversight and evaluation.

XI. PILOT PROJECTS

Healthy Start pilot projects in 3 areas will provide intensive home-based assistance to up to 200 new families per year.

The Task Force recommends 3 pilot projects of 4 years duration to provide intensive home-based assistance to up to 200 new families per year. The projects will show that early intervention works for the families and communities. A long term statewide system could grow from successful pilot projects. Money saved from real collaboration has helped provide for expansion in Virginia at the rate of 2 programs per year.

The Task Force recommends pilot projects that meet these requirements:

1. Contracts with the Department of Human Services should fund the pilot projects .

2. Administrative costs should be limited to no more than 10%. The maximum cost for training should be $10,000 per year per project. One project or an independent entity should provide training. Evaluation costs should be limited to no more than 15%. One project or an independent entity should provide oversight and evaluation.

3. Pilot projects and their communities should demonstrate collaborative efforts and should avoid duplication of services and efforts.

4. Pilot projects should contribute a 25% match of community-based funding by some combination of donations of cash or in-kind space, equipment, staff time, etc.

5. Pilot projects should use the Hawaii Healthy Start manual because it is comprehensive and based on family outcomes. They should incorporate all of the Maine Critical Elements and demonstrate ongoing internal quality assurance.

6. Pilot projects should meet with each other and with the Bureau of Child and Family Services regularly to coordinate efforts, learn from each other, plan for statewide

expansion and coordinate searches for outside funding sources. Pilot projects should report their findings to the Legislature at the end of the 2 year funding cycle. There must be recognition that 2 years is insufficient for conclusive data to be available.

XII. FUNDING

Healthy Start pilot projects will work with existing providers of services for families and will require General Fund support.

The Task Force reviewed the process and status of funding social programs, considered possible funding sources and concluded that the pilot projects need General Fund financing.

Interestingly, Virginia's experience was that initial legislative support actually helped them to attract future private funds. The initial support was viewed by private funders as evidence of the depth of support for Healthy Start and its likelihood of future success and expansion.

The Task Force views all family services funds as resources to provide a range of services to families. There may be Medicaid funds available for case management services for prenatal care and for services to some special needs children. The Children's Trust Fund could be considered as a funding source. Third party payers may begin to fund home visitors to new postpartal mothers as part of the early hospital discharge trend. All of these sources are possible bases on which to build a Healthy Start system.

Implementing a Healthy Start plan in a chosen pilot area may cost less in some areas than in others. Urban areas will likely have more existing home-based and collateral services. The grant process should recognize the characteristics of the particular project proposed and the needs of the families in the region.

Appendix H contains funding information for the pilot projects. Significant savings may be realized if Healthy Start services coordinate with and expand upon services currently provided in the project geographic area. Costs for pilot projects will decrease per family over time as the intensity of services required decreases. The Task Force presents figures for full funding of intensive home visitor services at 3 pilot projects at the following total levels:

Year 1, $ 556,842
Year 2, $ 953,731
Year 3, $1,213,626

XIII. CONSIDERATION OF OVERSIGHT COMMITTEE REPORT

Healthy Start services are consistent with the Child Protective Services Oversight Committee Report.

The Task Force was instructed to consider recommendations contained in the Report of the Child Protective Services Oversight Committee to the Department of Human Services dated January, 1993. The report stated that "the existing Home Health Visitor network provides a well organized base for comprehensive home health visitor services. The current system already includes the inter-organizational relationships and cooperation necessary to effectively deliver a strengthened program." This statement is consistent with the findings of the inventory of Maine services and the foundations upon which this Final Report is built .

The Task Force has complied with the report's recommendations for the following: creating an inventory of existing services; starting the continuum of support for families at the prenatal level in order to promote the identification of high risk families; targeting of intensive focused intervention from pregnancy through a child's fifth birthday; consideration of the potential of supervised paraprofessionals which might allow existing programs to be expanded at lower cost.

XIV. CONCLUSION

Healthy Start pilot projects will provide family support services upon enactment of the accompanying legislation.

The Task Force is pleased to present this final report to the 117th Legislature. Accompanying the report at Appendix M is legislation to establish and fund 3 Healthy Start pilot projects. These projects will provide family support services that will promote healthy families.

FOOTNOTES

1 Hawaii Department of Health, Maternal and Child Health Branch, "Hawaii's Healthy Start's Success Shared at the Ninth International Congress on Child Abuse and Neglect"

2 Hawaii Department of Health, Report to the 16th Legislature of the State of Hawaii on House Bill 139, regarding the Healthy Start Program, page 22 (1992).

3 Children living in homes in which domestic violence occur develop many of the same after effects. "The Impact of Domestic Violence on Children," The American Bar Association, note 13, page 22.

4 See outcome measurement materials, Hawaii Department of Health. Healthy Start Manual, page II-7 (1991).

5 Hawaii Department of Health, Healthy Start Manual, page II-7, July, 1991.

6 Hawaii Department of Health, Healthy Start Manual, Appendix I-6, July, 1991.

7 Hawaii Department of Health, Healthy Start Manual, page 14, July, 1991.

8 Hawaii Department of Health, Healthy Start Manual, page 29, July, 1991.

9 Healthy Mothers, Healthy Babies, "National Achievement Awards Program Information," 1994.

10 Healthy Families America, "Training and Technical Assistance."

11 Some technical assistance in the planning and development of pilot projects is available at no charge. Site visits by Healthy Families America are available for a fee. See Healthy Families America, "Training and Technical Assistance". Information on grant writing forums and countrywide trends in the evolution of Healthy Start type services is available from Healthy Families America through HandsNet communication Healthy Families America, "Communicating About Healthy Families America by Computer Networking".

APPROVED

MAR 18 '94

BY GOVERNOR

CHAPTER

54

RESOLVES

Appendix A

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED AND NINETY-FOUR

H.P. 1298 - L.D. 1753

Resolve, to Extend the Reporting Date of the Healthy Start Task Force Report

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, Resolve 1993, chapter 25, established the Healthy Start Task Force, and directed that appointments be made by July 9, 1993; and

Whereas, appointments to the task force were not completed until September 29, 1993 and the task force was not able to meet until October 8, 1993; and

Whereas, the charge of the task force as presented in Resolve 1993, chapter 25, requires taking inventory of existing services, determining which services need to be developed or expanded and integrating all the existing, new and expanded services into a statewide program that can not be accomplished in a short period of time; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Resolve 1993, c. 25, §1, amended. Resolved: That Resolve 1993, c. 25, §1 is amended to read:

Sec. 1. Task force created and charged. Resolved: That there is created the Healthy Start Task Force, referred to in this resolve as the "task force," which is directed to formulate a plan for implementation of a model Healthy Start home visitation program. The task force shall produce a detailed implementation plan for presentation to the Joint Standing Committee on Human Resources by ~~November 1, 1993~~ December 15, 1994. The task force plan and report must contain findings, recommendations and any necessary implementing legislation; and be it further

; and be it further

Sec. 2. Resolve 1993, c. 25, §9, amended. Resolved: That Resolve 1993, c. 25, §9 is amended to read:

Sec. 9. Interim report; report. Resolved: That the task force shall present an interim report to the Joint Standing Committee on Human Resources no later than April 1, 1994 and submit its report and plan, along with any necessary implementing legislation, to the ~~Second~~ First Regular Session of the ~~116th~~ 117th Legislature no later than ~~November 1, 1993~~ December 15, 1994; and be it further

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

Appendix A

APPROVED
JUN 9 '93
BY GOVERNOR

CHAPTER
25
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-THREE

H.P. 1049 - L.D. 1401

Resolve, to Create the Healthy Start Task Force

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the number of reported child abuse and neglect cases has increased in the State over the past several years, while the capacity of the Department of Human Services to respond to referrals has not increased; and

Whereas, the Healthy Start program has been proven in pilot states to be an effective and cost-effective measure for prevention of child abuse and neglect; and

Whereas, there are a number of programs similar to Healthy Start that have been adopted in other states that are now providing valid data; and

Whereas, there may be federal funding available for prevention programs like Healthy Start in the near future; and

Whereas, it is essential to complete the foundation research and development necessary to quickly bring this effective prevention program into existence in this State, and quickly bring the plan to the Legislature so that an effective program can be implemented at the earliest possible time; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force created and charged. Resolved: That there is created the Healthy Start Task Force, referred to in this resolve as the "task force," which is directed to formulate a plan for implementation of a model Healthy Start home visitation program. The task force shall produce a detailed implementation plan for presentation to the Joint Standing Committee on Human Resources by November 1, 1993. The task force plan and report must contain findings, recommendations and any necessary implementing legislation; and be it further

Sec. 2. Contents of plan and report. Resolved: That the task force shall consider recommendations contained in the report by the Department of Human Services' oversight committee and Healthy Start programs operating in other states and shall identify optimal use of existing state resources in formulating its plan. The task force is directed, as part of its investigation of existing resources, to inventory state and local entities presently providing elements of Healthy Start-type services to families and shall evaluate how these resources could be included in a state Healthy Start implementation plan. The implementation plan must include a budget that identifies the allocation of new funds separately from funds redirected from other state departments or divisions. The plan must include projected long-term cost savings as well as budget projections for 3 years from the date of implementation; and be it further

Sec. 3. Task force membership. Resolved: That the task force consists of 14 members as follows:

1. The Governor or the Governor's designee;

2. The Attorney General or the Attorney General's designee;

3. The Commissioner of Human Services or the commissioner's designee;

4. The Director of the Office of Substance Abuse or the director's designee;

5. One Senator appointed by the President of the Senate;

6. One member of the House of Representatives appointed by the Speaker of the House of Representatives;

7. One public member who was a victim of abuse or neglect as a child, appointed by the Governor;

8. One public member who is a parent who formerly abused or neglected one or more of that member's children and who has

received treatment or advice from an organization that provides child abuse and neglect prevention and intervention services, appointed by the Governor; and

9. Six public members appointed on the basis of expertise, experience and interest in the prevention of child abuse and neglect or expertise and experience in intervention in cases of child abuse and neglect. Of these 6 public members, 2 members must be appointed by the President of the Senate, 2 members must be appointed by the Speaker of the House of Representatives, one member must be appointed by the Senate Chair of the Joint Standing Committee on Human Resources and one member must be appointed by the House Chair of the Joint Standing Committee on Human Resources; and be it further

Sec. 4. Appointment; notification. Resolved: That all appointments to the task force must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once selections have been made; and be it further

Sec. 5. Convening of task force; selection of chair. Resolved: That when appointment of all task force members is complete, the chairs of the Legislative Council shall call the first meeting of the task force no later than 15 days following the completion of appointments. The task force shall select a member as its chair; and be it further

Sec. 6. Assistance. Resolved: That the task force shall request staff assistance from the Legislative Council and the Department of Human Services. The Department of Human Services shall provide office space and administrative support, including technical assistance, to the task force; and be it further

Sec. 7. Compensation. Resolved: That the public members of the task force are entitled to reimbursement for expenses upon application to the Commissioner of Human Services. The Department of Human Services shall absorb the costs associated with the task force within existing resources; and be it further

Sec. 8. Grants. Resolved: That the task force may accept grants and in-kind assistance to assist in funding the work of the task force. Any such assistance accepted must be included in the final report of the task force; and be it further

Sec. 9. Report. Resolved: That the task force shall submit its report, along with any necessary implementing legislation, to the Second Regular Session of the 116th Legislature no later than November 1, 1993; and be it further

Sec. 10. Termination of task force. Resolved: That the task force ends upon the submission of the task force plan and report.

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

APPENDIX B

Healthy Start Task Force
Membership List

Appointed by the Governor:

Rosemary Munoz
Harrison, ME

Buffy Plourde
Lewiston, ME

Meris Bickford
Augusta, ME

Appointed by the President of the Senate:

Senator Mark W. Lawrence
Kittery, ME

Patricia Phillips
Bangor, ME

C. Shawn Yardley
Bangor, ME

Appointed by the Speaker of the House of Representatives:

Representative Mary Cathcart
Orono, ME

Pamela Correll
Bangor, ME

Bonnie Post
Manchester, ME

Appointed by the Chairs, Joint Standing Committee on Human Resources:

Deborah Estelle
Liberty, ME

Lucky Hollander
Portland, ME

Ex Officio:

Diane Towle
Augusta, ME

Phyllis Kamen
Augusta, ME

Deanna Staples
Augusta, ME

APPENDIX C
BIBLIOGRAPHY
Books and Journals:

Breaky, Gail, R.N., M.P.H., and Pratt, Betsy, M.Ed."Healthy Growth for Hawaii's Healthy Start: Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect," Zero to Three, (April 1991).

Gomby, Deanna S., Ph.D., Larson, Carol S., J.D., Lewit, Eugene M., Ph.D. and Behrman, Richard E., M.D., "Home Visiting: Analysis and Recommendations", The Future of Children, Home Visiting, Vol. 3, No. 3., Winter 1993.

Hawaii Department of Health, Report to the 16th Legislature of the State of Hawaii on House Bill 139, regarding the Healthy Start Program, 1992.

Hawaii Department of Health, Healthy Start Manual, July, 1991.

United States General Accounting Office, Child Abuse, Report to the Chairman, Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, United States Senate, August, 1992.

Reports and Typed Materials:

American Bar Association, "The Impact of Domestic Violence on Children," note 13, page 22.

Donnelly, Anne Cohn, D.P.H., "An Approach to Preventing Child Abuse: The Home Visitor Model," Anne Cohn Donnelly, D.P.H.

Hawaii Department of Health, Maternal and Child Health Branch, "Hawaii's Healthy Start's Success Shared at the Ninth International Congress on Child Abuse and Neglect".

Hawaii Family Stress Center and National Center for the Prevention of Child Abuse, "Healthy Start Program, Demonstration Program Description," 1993.

Healthy Families America, "Communicating About Healthy Families America by Computer Networking."

Healthy Families America, "Critical Elements for a Comprehensive Needs Assessment," May, 1993.

Healthy Families America, "Critical Elements for Effective Home Visitor Services," May, 1993.

Healthy Families America, "Key Characteristics for Evaluating Healthy Families America Efforts," May, 1993.

Healthy Families America, "Planning for a Healthy Families America Program."

Healthy Families America, "Site Summaries," March, 1993.

Healthy Families America, "Training and Technical Assistance."

Healthy Families America, "Training Curriculum for Healthy Families Implementation, Basic Orientation Program."

Healthy Mothers, Healthy Babies Coalition, "National Achievement Awards Program Information," 1994.

Laman, Jennifer, "When Health Care is Not Enough: Support Services for Pregnant Women and Infants."

APPENDIX D:
IMPORTANT STATISTICS ON MAINE FAMILIES*

CATEGORY	STATISTIC	SOURCE
ALL BABIES BORN IN 1991	In 1991, there were 16,755 babies born in Maine.	1991 VITAL STATISTICS
FIRST BORN BABIES	In 1991, there were 7,224 babies born who were the first babies for their mothers.	1991 VITAL STATISTICS REPORT
BABIES BORN TO TEENS	In 1991, there were 1803 babies born to teenage mothers (ages 15–19). Of these, 1443 were first babies born to their mothers.	1991 VITAL STATISTICS REPORT
BABIES BORN TO MARRIED TEENS	In 1991, there were 446 babies born to married teenage mothers. Of these, 308 were first babies born to their mothers.	1991 VITAL STATISTICS REPORT
BABIES BORN TO UNMARRIED TEENS	In 1991, there were 1357 babies born to unmarried teenage mothers. Of these, 1135 were first babies born to their mothers.	1991 VITAL STATISTICS REPORT
TEENS WITH AT LEAST ONE PREVIOUS PREGNANCY	In a study between 1988 and 1992, 17% of teenage mothers had had at least one previous birth.	PRAMS 1988–1992**
INFANTS BORN WITH LOW BIRTHWEIGHT (1500–2499 grams) VERY LOW BIRTH WEIGHT (<1499 grams)	1991 762 1991 140 902	Office of Data, Research, Vital Statistics, ME. DHS, 6/93
PRENATAL CARE	In 1991, out of 16,755 births, 2494 received late prenatal care.	Office of Data, Research, Vital Statistics, ME. DHS, 6/93
CHILDREN AND POVERTY	As of 5/94, there were 38,773 children on AFDC.	INCOME MAINTENANCE UNIT–DHS
AVERAGE LENGTH OF TIME FAMILY RECEIVES AFDC	The average length of time a family remains on AFDC in Maine is 42 months.	INCOME MAINTENANCE UNIT–DHS
UNDERIMMUNIZED CHILDREN	29% of children are still underimmunized by age 2.	1994 MAINE IMMUNIZATION REPORT
NUMBER OF CHILDREN AND FETAL ALCOHOL SYNDROME	33 infants per year in Maine are born with fetal alcohol syndrome 660 infants per year in Maine are born with fetal alcohol effects	From "Chemically Dependent Women in Maine", OSA, 1992.
SUBSTANCE ABUSE AND CHILD ABUSE AND NEGLECT	25% of all protective referrals have substance abuse involvement.	From "Chemically Dependent Women in Maine", OSA, 1992.

*Only a partial list of potentially relevant statistics about Maine families

CATEGORY	STATISTIC	SOURCE
DOMESTIC VIOLENCE	67% of mothers participating in the PRAMS study report being physically hurt by a partner or being in a physical fight during the year before their baby was born. Of these mothers: 39% had inadequate prenatal care 11% had been homeless in that year These mothers were twice as likely to describe themselves as not wanting their pregnancy or not knowing how they felt about the pregnancy, as mothers with no violence.	PRAMS 1988–1992**
CHILD ABUSE AND NEGLECT	In 1993, there were 6,379 appropriate referrels for assessment by Child Protective Service of DHS. 2,093 of these referrels were not assigned to a caseworker due to insufficient staff. 4,286 referrals were assigned to staff for assessment. These referrals repre–sented 9,567 children.	1993 Child Protective Services Annual Report on Referrals
	Out of a total 11,439 reported assaults, 4,392 or 38.4% were identified as occuring between household or family members. –Of the 4,392 domestic assaults, 97.5% involved personal weapons (hands, fists, feet) In Maine, a domestic assault occurs every 2 hours, 20 minutes. In 1992, 15 out of 25 homicides were domestic violence related. That is 60% of the total.	"Crime in Maine" 1992, Maine Department of Public Safety

**Prenatal Risk Assessment Monitoring System, Department of Human Services

APPENDIX E: THE MINIMUM COST OF CHILD MALTREATMENT IN MAINE*#

CATEGORY	STATISTIC	SOURCE
COST FOR FOSTER CARE	$36,966,795 is budgeted from state and federal funds for foster care in 1994.** U.S. statistics suggest that 50% of children in foster care are there due to child abuse and neglect.	Office of Fiscal and Program Review – 1994 and Healthy Families America
COST OF CHILD PROTECTIVE SERVICES	$19,784,675 is budgeted from state and federal funds for child protective services in 1994.*	Office of Fiscal and Program Review – 1994
COST FOR MENTAL HEALTH SERVICES FOR CHILDREN	$22,330,323 was spent in 1992 for mental health services for children.	Dept. of Mental Health & Mental Retardation – 1992
COST FOR JUVENILE CORRECTIONAL FACILITIES	$12,598,606 is budgeted from state and federal funds for juvenile correctional services in 1994. U.S. statistics suggest that 68% of youth arrested have a history as child abuse and neglect victims.	Dept. of Corrections 1994 and Healthy Families America.
COST OF TREATMENT TO CHILDREN (age 0–5) COVERED BY MEDICAID FOR WHOM THE PRIMARY DIAGNOSIS WAS CHILD BATTERY OR CHILD MAL-TREATMENT SYNDROME+	During fiscal year 1994, the average outpatient charges were $382.04 per patient. Average inpatient charges were $3,172 per patient.	Maine Medicaid Program, DHS
ESTIMATED LIFETIME COSTS OF TREATING ONE CHILD BORN WITH FETAL ALCOHOL SYNDROME	$500,000	From "Chemically Dependent Women in Maine", OSA, 1992.

This is only a partial accounting of costs of the child maltreatment in Maine. There are many other costs related to child abuse but difficult to quantify and locate in statewide databases. Things like emergency room care, cost of special education services and costs to adjudicate child abuse cases etc. all have a significant impact on state and local budgets.

*The Department of Human Services budgets an additional $4,282,999 for 1994 for administrative services in the child welfare area. Some of this money may be spent for caseworkers and service delivery.

Figures on this chart should not be added together because of the potential of duplications.

+Such diagnoses are considered to be significantly under reported by health providers.

APPENDIX F: THE COSTS OF A COMPREHENSIVE HOME VISITATION PLAN

CATEGORY	STATISTIC	SOURCE
Cost of Healthy Start Program in Hawaii	In 1992, Hawaii projected the following 1994 costs for 2,246 families: a.) $1527/family intervention services b.) $44/family for child development assessment c.) $56/family for data services d.) $704/family for eval/admin/training TOTAL: $2,331/family	1992 Report to the 16th Legislature, Dept. of Health, State of Hawaii
Cost of Implementing Healthy Start Programs in all Maine Communities Using the Hawaiian Model	In 1992, there were 16,003 births in Maine. From this population 2,074 families would utilize tier two family visitor services.* Depending upon the community, the costs could range $2,000 2,500 per family. Thus annual costs could range $4,148,000–$5,185,000.	Healthy Families America projections.
Cost of 3 fully funded Maine Healthy Start Pilot Projects+	Year 1: 3 pilot projects, serving 200 families at a costs of $556,842. Year 2: 3 pilot projects, serving 400 families at a cost of $953,731. Year 3: 3 pilot projects, serving 600 families at a cost of $1,213,626.	Healthy Start Final Report

*See Maine Critical Elements, page 6.
+Includes full funding for tier two family visitor services.

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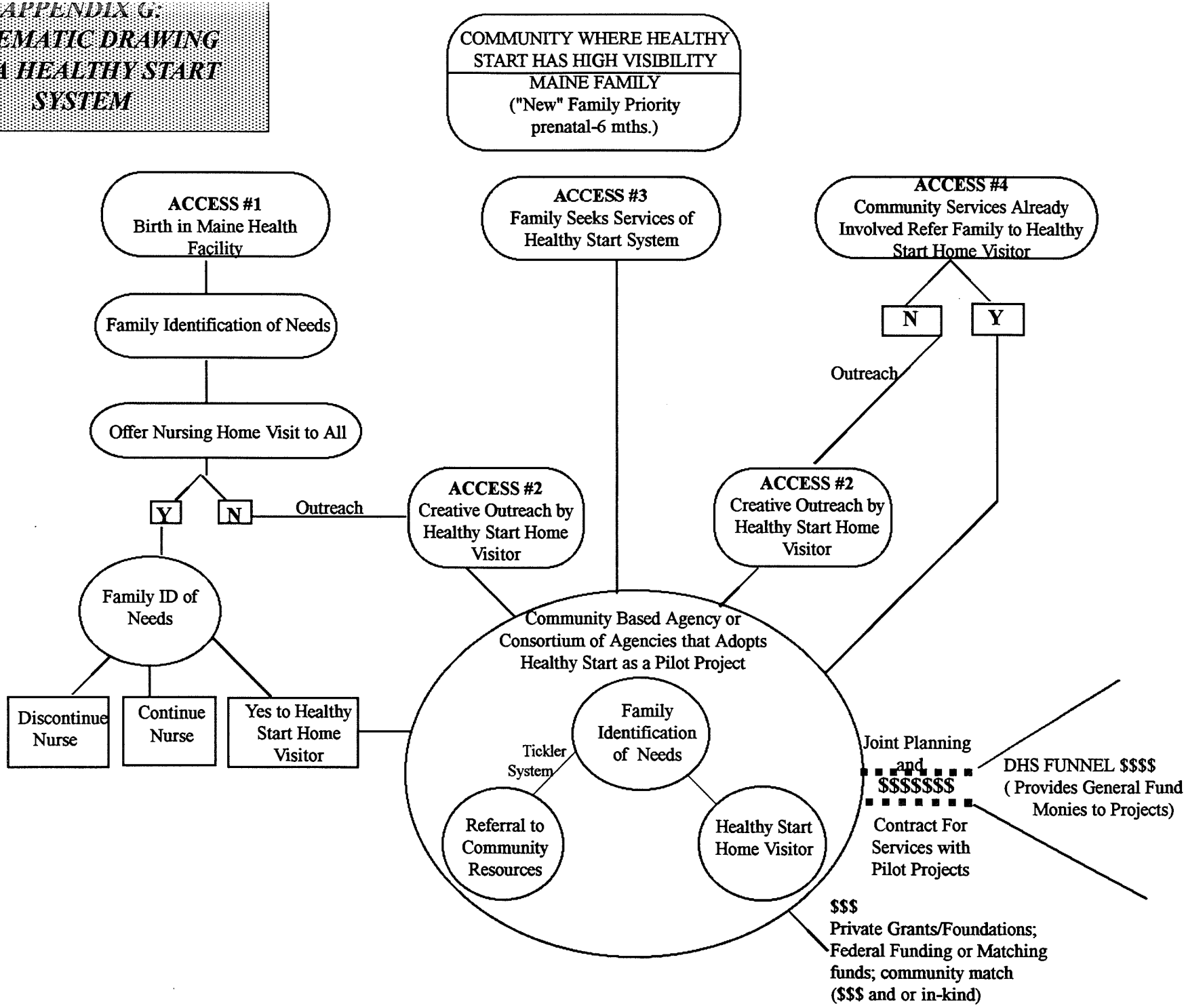
APPENDIX G:
SCHEMATIC DRAWING OF A HEALTHY START SYSTEM



APPENDIX H:
HEALTHY START PILOT PROJECTS
3 YEAR BUDGET PLAN

YEAR 1

PERSONNEL	$ 397,026	Up to 200 families will be provided
OPERATING EXPENSES	$ 78, 493	second tier intensive home–based
EVALUATION	$ 71,327	services.
TRAINING	$ 10,000	Cost per family=$2,784.
TOTAL	**$556,842**	

YEAR 2

PERSONNEL	$754,398	Up to 400 families will be provided
OPERATING EXPENSES	$ 66,242	second tier intensive home–based
EVALUATION	$123,095	services.
TRAINING	$ 10,000	Cost per family=$2,384.
TOTAL	**$953,731**	

YEAR 3

PERSONNEL	$972,477	Up to 600 families will be provided
OPERATING EXPENSES	$ 74,155	second tier intensive home–based
EVALUATION	$156,994	services.
TRAINING	$ 10,000	Cost per family=$2,021.
TOTAL	**$1,213,626**	

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APPENDIX I

HEALTHY START SAMPLE FAMILY SCENARIOS

Family A: First Tier Healthy Start Services

Mother is married and 7 months pregnant with her first pregnancy. She wants to learn all she can about labor and delivery. She has good support from family and friends in the area. Needs assessment is done in the doctor's office, where she learns about Healthy Start. No immediate needs are identified. She visits the project in her area. A Healthy Start worker tells her about home-based services that are available if she needs them in the future. She is referred to services she wants and encouraged to call back if more assistance is needed.

As part of the project outreach work, she is told she will get resource and parenting information in the mail.

After delivery and before discharge, the hospital does a routine assessment of family need. Mother is offered a home visit by the community based nurse and agrees to one, mostly for reassurance. The home visit shows that the family is doing well. No other referrals are made. Mother is encouraged to call Healthy Start for assistance as needed.

Family B: Second Tier Healthy Start Services

Mother is 16, single, and has been living in a homeless shelter after running away from home. The father is not likely to be involved with her after her child is born. Mother plans to stay with a friend, a single mother who is in similar difficult circumstances. Routine assessment of family need is done at the doctor's office when mother comes for her first prenatal visit, at 7 months. She declines repeated offers of referral to early Healthy Start system services. She delivers the baby one month early and it spends time in newborn intensive care. Assessment is done in the hospital and intensive home visiting services are offered. Mother declines. A visit from a community health nurse is offered to monitor the baby's weight and Mother accepts. The nurse visits a few times and determines that frequent ongoing visiting is needed because (1) there is a lack of optimal attachment behavior between mother and child, (2) there is a lack of social support for mother, (3) the roommate is a poor role model for parenting. The nurse encourages her to accept Healthy Start intensive home-based services. Eventually the Healthy Start home visitor sees Mother and baby weekly until there is progress in family functioning, then less frequently as the family progresses, then quarterly visits through age 5. During the time the home visitor works with the family, the home visitor helps mother to understand the needs of the baby, to find an apartment and to return to school. If Mother had declined intensive assistance, the Healthy Start home visitor would have continued outreach efforts for at least 3 months.

APPENDIX J

1994 HEALTHY START TASK FORCE SURVEY

NOTE:

(1) Please let us know if incorrect information has been sent to you (i.e., agency name, address)

(2) Please complete all three pages and return by March 16, 1994 to:

Pam Correll
35 Poplar Street
Bangor, ME 04401

(COMPLETE FOR EACH SERVICE PROGRAM)

Maine Service Programs
serving families with children (prenatal - age 7)

1994 Healthy Start Task Force Survey

Agency Name

Person Completing Form

Program Name

Position of Person Completing Form

Program Telephone #

Program Mailing Address

Date Completed

Counties/Parts of Counties Served by Your Program

Please indicate the following for this program:

Annual number of families served: _____
Annual number of children served: _____
Annual budget: _____
Funding sources: _____

PLEASE COMPLETE ALL 3 PAGES AND RETURN BY MARCH 16, 1994 TO:

Pam Correll
35 Poplar Street
Bangor, ME 04401

(COMPLETE FOR EACH SERVICE PROGRAM)

If your program provides any of the following services, please indicate with a check mark ( ) which of the descriptions at the right apply to the service.

	Home based	Non Home Based	Would like to be home based	Not appro-priate for home based	Family is recipient of service	child is recipient of service	0-2 weeks waiting list for service	2-4 week waiting list for service	> 4 week waiting list for service
1. Maternal/child health education									
2. Prenatal health/ support services									
3. Pregnancy option counseling.									
4. Postpartal/newborn assessment.									
5. Parenting counseling/ support/education.									
6. Therapeutic counseling.									
7. Vocational/school counseling.									
8. Nutrition education.									
9. Child development education.									
10. Social service assistance.									
11. Parent/child interaction activities.									
12. Substance abuse counseling/ education/referral.									
13. HIV education/ referral/counseling									

14. Indicate which three (3) of the services above your program is most involved with:

_____

_____

SEE OVER

(COMPLETE FOR EACH SERVICE PROGRAM)

1. Does this program have any eligibility criteria?
   ___YES ___NO (If YES, please include a copy of the criteria.)

2. Does this program utilize a risk identification tool to determine families' level of need for services?
   ___YES ___NO (If YES, please include a copy.)

3. Can your program provide transportation-to-service assistance if that is needed by a family?
   ___YES ___NO (If YES, do you arrange for transportation or provide it directly?) (circle one)

4. Does the program have a fee for services? ___YES ___NO

   Set fee?
   ___YES ___NO (If YES, please describe.)_____

   Sliding scale?
   ___YES ___NO (If YES, please include.)

5. Please circle the levels of professional staff that are providing direct, home-based services in this program:

How often do direct care program providers have contact with families (on average)? _____

For how many weeks do direct care program providers visit families (on average)? _____

If you would like to provide home based services, what are the barriers to making your services home based?

_____

With what home-based agencies, if any, do you collaborate directly?

_____

_____

What other programs in your community should this survey target?

_____

_____

Appendix K

AGENCIES HOME BASED FOR SERVICES 1,2,4,5,8,10 AND/OR 11

AGENCY/NAME	DAYS OF SERVICE PER MONTH	SERVICE DURATION IN WEEKS	COLLAB-ORATION
ACAP PRESCHOOL SERVICES	4.00	32.00	
AIDS PROJECT	1.00	0.00	
ANDROSCOGGIN HEAD START & CHILDCARE	30.00	32.00	Y
ANDROSCOGGIN HOME HEALTH SERVICE	4.00	3.00	Y
ANDROSCOGGIN HOME HEALTH SERVICES	0.00	0.00	Y
ANDROSCOGGIN HOME HEALTH SERVICES	4.00	0.00	Y
ANDROSCOGGIN HOME HEALTH SERVICES	6.00	12.00	
ANDROSCOGGIN HOME HEALTH SERVICES	4.00	0.00	
ANDROSCOGGIN HOME HEALTH SERVICES	6.00	12.00	
AROOSTOOK CAP	2.00	0.00	Y
AROOSTOOK CAP	0.10	6.00	Y
AROOSTOOK COUNTY ACTION PROGRAM	2.00	24.00	Y
BANGOR PUBLIC HEALTH NURSING	1.00	24.00	
BATH/BRUNSWICK CHILD CARE SERVICES, INC.	4.00	15.00	Y
BCSN	4.00	0.00	Y
BCSN	4.00	52.00	Y
CATHOLIC CHARITIES OF MAINE/HOLY INNOCENTS	3.00	12.00	Y
CDS-SEARCH	0.00	0.00	Y
CHANS	0.00	0.00	Y
CHANS	30.00	2.00	Y
CHANS	2.00	10.00	Y
CITY OF PORTLAND	4.00	6.00	Y
CITY OF PORTLAND, PUBLIC HEALTH DIVISION	2.00	24.00	Y
COMMUNITY CONCEPTS INC.	0.00	0.00	Y
COMMUNITY CONCEPTS, INC.	4.00	9.00	Y
COMMUNITY HEALTH & COUNSELING SERVICE	3.00	0.00	Y
COMMUNITY HEALTH & NURSING SERVICES	0.00	0.00	Y
COMMUNITY HEALTH SERVICES, INC.	6.00	1.33	Y
DAY ONE	4.00	13.00	Y
DEPARTMENT OF HUMAN SERVICES	3.00	26.00	Y
DEPT. OF HUMAN SERVICES	30.00	12.00	Y
DEPT. OF HUMAN SERVICES	1.50	24.00	Y
DEPT. OF HUMAN SERVICES*	1.00	3.00	Y
DHS	2.00	12.00	Y
DHS	10.00	2.50	Y
DHS	3.00	16.00	Y
DIVISION OF PUBLIC HEALTH NURSING	0.00	0.00	F
DIVISION OF PUBLIC HEALTH NURSING	1.00	12.00	Y
DIVISION OF PUBLIC HEALTH NURSING-DHS	0.00	36.00	Y
DOWNEAST HEALTH SERVICES	2.00	24.00	Y
DOWNEAST HEALTH SERVICES, INC.	0.00	0.00	Y
DOWNEAST HEALTH SERVICES, INC.	1.00	12.00	Y
EASTERN MAINE AIDS NETWORK	0.00	0.00	F
EASTERN MAINE MED CENTER*			Y
FAMILIES UNITED OF WASHINGTON COUNTY	3.00	13.00	Y
FISH RIVER RURAL HEALTH SYSTEMS	1.00	18.00	
FOSTER GRANDPARENTS (PROP)	1.00	15.00	Y
FRANKLIN COUNTY CHILDREN'S TASK FORCE	4.00	12.00	Y
FRANKLIN MEMORIAL HOSPITAL, BIRTHING CENTER	0.00	1.00	Y

AGENCIES HOME BASED FOR SERVICES 1,2,4,5,8,10 AND/OR 11

AGENCY/NAME	DAYS OF SERVICE PER MONTH	SERVICE DURATION IN WEEKS	COLLAB-ORATION
GOOD SAMARITAN AGENCY	1.50	2.00	Y
HOME COUNSELORS, INC.	10.00	13.00	F
HOULTON REGIONAL HOSPITAL	0.00	1.00	Y
KEN-A-SET	8.00	52.00	Y
KENNEBEC VALLEY CAP	2.00	32.00	Y
KENNEBEC VALLEY MENTAL HEALTH CENTER	4.00	12.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	1.00	0.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	0.00	0.00	Y
KNO-WALL-LIN HOME HEALTH CARE	0.00	0.00	Y
MID-COAST CHILDREN'S SERVICES, INC.	4.00	0.00	Y
MIDCOAST*	4.00	260.00	Y
MID-COAST HUMAN RESOURCES COUNCIL	0.00	8.50	Y
MIDCOAST MENTAL HEALTH*	2.00	20.00	Y
MOUNT DESERT PUBLIC HEALTH NURSING ASSOC.	0.00	10.00	Y
PENQUIS CAP	2.00	0.00	Y
PENQUIS CAP	8.00	18.00	Y
PENQUIS CAP	1.00	3.00	Y
PENQUIS CAP	0.30	12.00	
PENQUIS CAP	30.00	9.00	Y
PENQUIS COMMUNITY ACTION PROGRAM	2.00	24.00	Y
PINE TREE COUNCIL BOY SCOUTS OF AMERICA	0.00	0.00	F
PLANNED PARENTHOOD*			
REGIONAL MEDICAL CENTER AT LUBEC	0.00	0.00	F
RURAL COMMUNITY ACTION MINISTRY	3.00	24.00	Y
SEBASTICOOK VALLEY HOSPITAL	0.00	0.00	Y
SOUTHERN KENNEBEC CHILD DEVELOPMENT CORP	4.00	8.00	
SWEETSER CHILDREN'S SERVICES	4.00	2.50	Y
UCP	0.00	0.00	Y
UCP	1.00	0.00	
UM COOP. EXTENSION	2.00	52.00	Y
UM COOP. EXTENSION	2.00	52.00	Y
UNIV OF MAINE COOP EXT OF AROOSTOOK CTY	0.00	0.00	
UNIV OF ME COOP EXT/KNOX-LINCOLN	4.00	24.00	Y
UNIV OF ME. COOP EXT CUMB CNTY	2.00	0.00	Y
UNIV. OF MAINE, COOPERATIVE EXTEN.	0.30	0.00	Y
UNIV. OF MAINE, COOP. EX., PATT*	7 TO 1	156.00	Y
VISITING NURSE SERVICE OF SOUTHERN MAINE	6.00	24.00	F
VNA & HOSPICE OF SOUTH PORTLAND	15.00	0.00	Y
WALDO COUNTY COMMITTEE FOR SOCIAL ACTION	1.00	0.00	Y
WALDO COUNTY HOME HEALTH CARE SERVICES	0.00	1.25	Y
WALDO-KNOX AIDS COALITION	4.00	6.00	Y
WESTERN MAINE COMMUNITY ACTION, INC.	4.00	9.00	Y
YORK HOSPITAL	1.00	12.00	Y
YOUTH & FAMILY SERVICES	8.00	3.00	Y
YWCA OF PORTLAND	10.00	0.00	Y
YWCA, LEWISTON-AUBURN	4.00	0.00	Y

* No corresponding data sheet for this agency.

6523LHS-3&4

Appendix L

AGENCIES NOT HOME BASED FOR SERVICES 1,2,4,5,8,10 AND/OR 11

AGENCY/NAME	DAYS OF SERVICE PER MONTH	SERVICE DURATION IN WEEKS	COLLAB-ORATION
ACADIA HOSPITAL	6.00	0.00	Y
ACTION OPPORTUNITIES, INC.	30.00	0.00	Y
ADVOCATES FOR CHILDREN	0.00	0.00	Y
ANDROSCOGGIN HOME HEALTH SERVICES	4.00	0.00	
AROOSTOOK CAN COUNCIL	0.00	0.00	Y
AROOSTOOK CAP	0.00	0.00	Y
AROOSTOOK CAP	2.00	0.00	Y
AROOSTOOK CAP	20.00	1.50	Y
AROOSTOOK CAP	20.00	4.25	Y
BANGOR DEPT. OF HEALTH AND WELFARE	0.00	0.00	Y
BATH-BRUNSWICK CHILD CARE SERVICES	0.00	0.00	F
BBCCS	30.00	0.00	F
CATHOLIC CHARITIES MAINE	30.00	0.00	Y
CATHOLIC CHARITIES OF MAINE	0.00	0.00	F
CATHOLIC CHARITIES, MAINE	1.00	0.00	Y
CENTRAL MAINE MEDICAL CENTER	0.00	0.00	Y
CHILD HEALTH CENTER	30.00	0.00	Y
CHILD HEALTH CENTER	30.00	0.00	Y
CHILD HEALTH CENTER*	VARIES	VARIES	Y
CITY OF PORTLAND, PUBLIC HEALTH DIVISION	2.00	24.00	Y
COASTAL ECONOMIC DEVELOPMENT CORP.	1.00	0.00	
COMMUNITY CONCEPTS INC.	0.00	0.00	Y
COMMUNITY CONCEPTS INC.	0.00	0.00	Y
COMMUNITY CONCEPTS, INC.	4.00	9.00	Y
COMMUNITY CONCEPTS, INC.	4.00	9.00	Y
DHS/FAMILY SERVICES PROGRAMS	0.16	0.00	F
DOWNEAST HEALTH SERVICES, INC.	2.00	0.00	Y
EMMC FAMILY SUPPORT TEAM, P. PHILLIPS	1.00	12.00	Y
FAMILY & CHILDREN TOGETHER	0.00	0.00	F
FISH RIVER RURAL HEALTH SYSTEMS	1.00	18.00	
FREEPORT HEAD START	0.00	0.00	N
HANCOCK COUNTY CHILDREN'S COUNCIL	0.00	0.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	0.00	0.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	0.00	0.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	0.00	0.00	Y
KENNEBEC VALLEY REGIONAL HEALTH AGENCY*	30.00		
LEWISTON HIGH SCHOOL	30.00	0.00	Y
MERCY HOSPITAL RECOVERY CENTER	4.00	0.00	
MID-COAST HUMAN RESOURCE COUNCIL	0.00	0.00	
MSAD 49	0.00	0.00	
NEW HOPE FOR WOMEN	30.00	52.00	Y
NORTHERN CUMBERLAND MEMORIAL HOSPITAL	0.00	0.00	Y
PARENT CHILD DEVELOPMENT PROGRAM, INC.	8.00	0.00	Y
PARENTS ANONYMOUS OF MAINE	0.00	0.00	F
PENOBSCOT BAY MEDICAL CENTER	3.00	52.00	Y
PENOBSCOT NATION HEALTH DEPARTMENT	1.00	4.00	
PENQUIS COMMUNITY ACTION PROGRAM	2.00	24.00	Y
PEOPLE'S REGIONAL OPPORTUNITY PROGRAM	0.50	0.00	Y
PINE TREE STATE 4-H FOUNDATION, UM	0.00	0.00	F

AGENCIES NOT HOME BASED FOR SERVICES 1,2,4,5,8,10 AND/OR 11

AGENCY/NAME	DAYS OF SERVICE PER MONTH	SERVICE DURATION IN WEEKS	COLLAB-ORATION
PORTLAND MINISTRY AT LARGE	30.00	52.00	Y
PORTLAND YMCA	6.00	39.00	Y
PROP	4.00	9.00	Y
PSYCHOLOGICAL SERVICES CENTER	4.00	0.00	
RAPE CRISIS CENTER, INC.	0.00	0.00	F
RAYMOND EXTENDED DAY	0.00	0.00	
REGIONAL MEDICAL CENTER AT LUBEC	0.00	0.00	F
RUMFORD COMMUNITY HOSPITAL	0.50	0.00	Y
SEBASTICOOK VALLEY HOSPITAL	0.00	0.00	Y
SEXUAL ASSAULT CRISIS CENTER	0.00	0.00	F
SOUTHERN KENNEBEC CHILD DEVELOPMENT CORP.	2.00	0.00	Y
SOUTHERN MAINE AREA AGENCY ON AGING	0.00	0.00	
SPURWINK SCHOOL	0.00	0.00	Y
ST. ANDRE'S GROUP HOMES	30.00	52.00	Y
STEPHEN'S MEMORIAL HOSPITAL	0.00	0.00	Y
SUNRISE COUNTY CHILDREN'S TASK FORCE	0.00	0.00	Y
TRI-COUNTY HEALTH SERVICES	8.00	0.00	F
TRI-COUNTY HEALTH SERVICES	0.00	0.00	
UCP	0.00	0.00	Y
UNITED TECH. CENTER, BRENDA HEWES	30.00	52.00	Y
UNIV OF ME COOP EXT/ANDROSCOGGIN SAGADAHOC	0.00	0.00	Y
UNIV OF ME COOP EXT/KNOX LINCOLN	0.00	0.00	Y
USM CHILD & FAMILY INSTITUTE	0.00	0.00	F
WALDO-KNOX AIDS COALITION	1.00	0.00	Y
YORK COUNTY COMMUNITY ACTION CORPORATION	2.00	0.00	Y
YORK HOSPITAL	1.00	12.00	Y
YOUTH ALTERNATIVES OF SOUTHERN MAINE	30.00	0.00	Y
YWCA OF PORTLAND	10.00	0.00	Y
YWCA, LEWISTON-AUBURN	4.00	0.00	Y
	459.16	425.75	

* No corresponding data sheet for this agency.

6523LHS-1&2

APPENDIX M

SECOND REGULAR SESSION

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY FIVE

An Act to Implement the Recommendations of the Healthy Start Task Force.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. The Healthy Start Pilot Project is established in the Department of Human Services to provide in 3 geographically diverse locations a community-based home visitation program that is preventative, comprehensive, family-focused and universally available within the project areas.

The Department of Human Services shall administer a contract program under which 3 pilot projects will be funded. The contracts must require the following elements. All pilot projects must adopt consistent program design, comprehensive and uniform training of personnel and systematic evaluation. They must collaborate with other entities in the community providing services to families in order to expand on existing services.

All pilot programs must use the Hawaii manual and must adopt the following Maine Critical Elements:

1. Healthy Start services must be offered on a voluntary basis to families in the defined geographic areas of the projects.

2. First tier supportive Healthy Start services must be available to all new parents and must include: (1) community level home based nursing services to attend to the newborn infant care issues; (2) outreach that provides periodic child health and

development information and encourages families to seek out help as needed; (3) use of any other existing family support outreach services in Maine communities.

3. Second tier home visitor services must be offered to parents who need them and must continue with frequency that matches the needs of the family.

4. Identification of needs must be done using the Hawaii Family Stress Checklist.

5. Healthy Start projects must accept families prenatally through the children's 6-month birthday. Services must be available through age 5.

6. To encourage acceptance of second tier services where needed, outreach must continue for at least 3 months.

7. Services must be family focused, promote healthy child development and assist the family toward independence.

8. Families must be linked to primary health care providers.

9. Healthy Start projects must work with other community service providers and should complement family preservation and support services that are developed from the Omnibus Budget Reconciliation Act of 1993.

10. Home visitors must receive ongoing professional supervision and have limited caseloads.

All pilot projects must be for 4 years duration, with the first contracts for each program to last 2 years. Administrative costs for each program are limited to 10% of the program cost for general administration. The cost of evaluation is limited to 15% of the program cost. One of the pilot projects or a separate entity must exercise oversight authority over all 3 projects and must evaluate the projects.

All pilot projects must match 25% of the contract amount with community-based funding, which may be a combination of cash and in-kind contributions of space, equipment, supplies, staff time or services.

All pilot projects must meet regularly with the other projects and the Bureau of Children and Family Services to share experiences, coordinate efforts, plan for statewide expansion and coordinate searches for outside funding to supplement any General Fund appropriations for the second 2 years of their duration.

All pilot projects must submit reports on their findings to the Joint Standing Committee on Human Resources and to the Executive Director of the Legislative Council by January 1, 1996.

The following funds are appropriated from the General Fund to carry out the purposes of this Act.

APPROPRIATION

	1995-96	1996-97
DEPARTMENT OF HUMAN SERVICES		
Healthy Start Pilot Project		
All Other	$556,842	$953,731
DEPARTMENT OF HUMAN SERVICES	$556,842	$953,731

STATEMENT OF FACT

This bill implements the recommendations of the Healthy Start Task Force. The bill establishes the Healthy Start Pilot Projects in 3 locations to provide community based, home visitation programs that are preventative, comprehensive, family-focused and universally available within the project areas. The Department of Human Services administers the pilot projects through a contract process. All pilot projects use consistent program design, training and evaluation, the Hawaii Healthy Start manual and the Maine Healthy Start Critical Elements. All pilot projects must collaborate with other entities in the community providing services to families.

The pilot projects are of 4 years duration and are funded for the first 2 years. Administrative costs are limited to 10% and evaluation costs to 15% of the project cost, and training costs to $10,000 per year. All pilot projects must match 25% of the contract amount with community based funding. All pilot projects must meet regularly with the other projects and with the Bureau of Children and Family Services.

Reports to the Joint Standing Committee on Human Resources and the Executive Director of the Legislative Council are due from all pilot projects by January 1, 1996.

There is an appropriation for FY 1995-96 of $556,842 and for FY 1996-97 of $953,731.