State of Maine
124th Legislature
First Regular Session

Report of the LD 1991 Workgroup: Options for Ongoing Funding for the Northern New England Poison Center

To the

Joint Standing Committee on Health and Human Services
Senator Joseph C. Brannigan, D-Cumberland, Chair
Representative Anne C. Perry, D-Calais, Chair

From the

Co-Conveners
Maine Department of Health and Human Services
Northern New England Poison Center

Co-Chairs
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April, 2009

Executive Summary

The Department of Health and Human Services (DHHS) and the Northern New England Poison Center (NNEPC) have completed a report on the activities of a workgroup convened at the direction of the Joint Standing Committee on Health and Human Services to develop options for ongoing funding for the Northern New England Poison Center. DHHS and the NNEPC conducted the workgroup in accordance with Resolve, Chapter 206, 123rd Maine State Legislature. Stakeholders included representatives of MaineHealth, St. Mary's Health System, Eastern Maine Healthcare Systems, the Southern Maine Agency on Aging, and the DHHS Office of Elder Services, as well as representatives of primary care.

The purpose of this report is to summarize workgroup findings on the function of the NNEPC, the range of services it provides to residents of Maine, and the critical piece it plays in the public health infrastructure as well as to provide the Committee with a list of funding options so that the NNEPC can continue to provide its life-and cost-saving services in a sustainable manner.

Summary of Report

Workgroup members found that while the NNEPC provides essential toxicology support to hospitals, health care providers, businesses, and the people of Maine, New Hampshire, and Vermont, the Center is struggling to meet its financial obligations. The Center is funded through a shared agreement among our three states; however, the workgroup concluded that Maine's contribution has not kept pace with its population size or the volume of calls generated and, indeed, is the state whose deficit is highest. New Hampshire pays close to its fair share and Vermont has recently taken steps to fund its proportionate level of contribution. Furthermore, Maine's share of its funding for the NNEPC has declined from a high of $295,000 to a current contribution of $264,392 in state general funds. The Maine CDC also contracts with the NNEPC for additional services related to 3 specific products, Maine Pharmaceutical Cache and Preparedness, After-Hours On-Call Telephone Service, and Emergency Preparedness and Response/Disaster Medicine Medical Expertise. The contract for these specific products totaled $210,704 for the 2008-2009 project period. The ongoing deficit has put the NNEPC in an untenable situation.

While Maine's contribution to the Poison Center has declined over the past six years, the Center's costs have increased in part because the Center is now certified and has been since 2004. Certification requires an increased level of education and certification of staff, computerized databases and toxicosurveillance activities, and supervision by board-certified toxicologists to ensure safe patient care. Federal certification of the NNEPC results in high quality services delivered to residents of Maine and is also important in terms of qualifying for federal funds. Maintaining certification is currently in jeopardy due to insufficient funds for the required staffing pattern and ratios.

At the same time, workgroup members concluded that the NNEPC provides vital services that are a critical part of the public health infrastructure in the state. As a nonprofit, public/private partnership, the NNEPC offers free, confidential services

that are available 24 hours daily, 365 days a year. People who access this service avoid more costly and intensive medical services, such as visits to the emergency department. In fact, a recent study published in a peer-reviewed journal shows that for every dollar spent for poison center services, $36 were saved in unnecessary health care costs.[1] This is a return that few other preventive health services can claim and one that Maine should recognize and support in its ongoing efforts to decrease health care spending and minimize unnecessary use of already overburdened emergency departments.

In addition to its toll-free hotline, the Center provides outreach activities to increase awareness and educate the public on poison prevention. Surveillance activities include real-time data feeds to the national toxicosurveillance database maintained by the American Association of Poison Control Centers. The NNEPC partners with the Maine Center for Disease Control and Prevention (Maine CDC) in its after-hours, on-call system. As a result of this collaborative effort, malicious arsenic, fish-related, mushroom-related and other types of poisonings with public health significance are managed swiftly, protecting more Mainers from poison-related harm. Unintentional child poisonings account for half of Poison Center Calls while substance abuse calls represent a growing trend. As Maine's population ages, the NNEPC is increasing its outreach to adults over the age of 60 who are most frequently involved in unintentional exposures due to medication errors and/or therapeutic errors with cardiac, diabetic, and other potentially dangerous medications. The Center's boarded-and-certified staff provide expert advice to other health care professionals if medication errors occur and are prepared to respond in the event of a bioterrorism attack.

Funding Structure

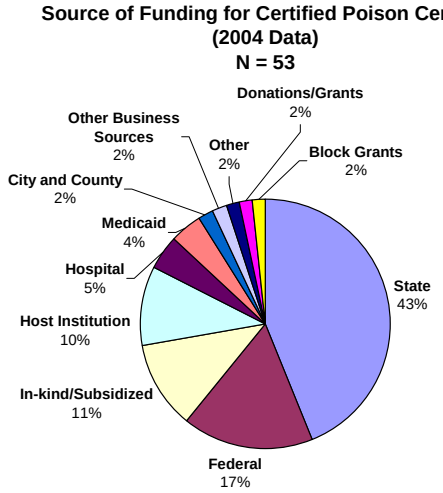
The cost of basic Poison Center services—hotline, outreach and surveillance—is approximately $2 million per year. Of the three states, Maine represents 41 percent of Northern New England's population, which would put the State's fair share based on population at $820,000. New Hampshire represents 40 percent of Northern New England's population and its fair share based on population amounts to $800,000, while Vermont represents 19 percent of the Northern New England's population and its fair share based on population is $380,000. None of the three states currently contribute their fair share, although Vermont has recently taken steps to rectify this. New Hampshire is the closest to meeting its obligation.

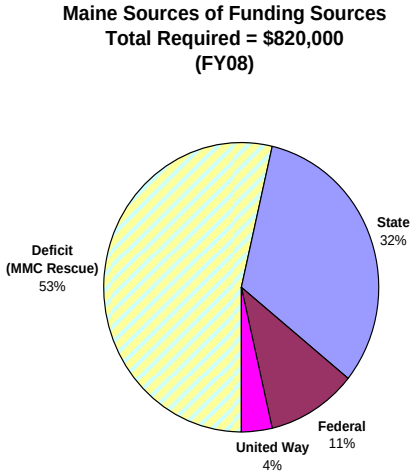
In Fiscal Year 2008, Maine contributed $264,392 in general funds, $87,603 in federal poison center funds, and $28,861 from the United Way, for a total of $380,000. The state's deficit is $439,144. It needs to be noted that the Maine CDC also contracts with the NNEPC for additional services related to 3 specific products which are note included above; Maine Pharmaceutical Cache and Preparedness, After-Hours On-Call Telephone Service, and Emergency Preparedness and Response/Disaster Medicine Medical Expertise. The contract for these specific products totaled $210,704 for the 2008-2009 project period.

New Hampshire pays closest to its fair share with the majority of its contribution coming from bioterrorism funds. New Hampshire contributes $618,390 and its fair share based on population is $800,000, for a deficit of $181,610. It should be noted that New Hampshire receives a significantly higher bioterrorism grant award than Maine due to its geographic proximity to Boston and New York City. In addition its smaller geographic area reduces the cost of delivering emergency preparedness services leaving more financial resources to support New Hampshire's contract with the NNEPC. In FY 08, Vermont also ran a deficit of $218,747. However, during the last legislative session after a dedicated effort to garner legislative support by the Vermont Department of Health, the state decided to increase funding so that it will be able to pay its proportionate share of approximately $400,000. For FY 09, New Hampshire also increased its funding by 4.6 percent—from $563,431 to $589,546.

Other States

- In 2004, of the 53 certified Centers in the country,
  - States paid for anywhere from 51 to 100 percent in nearly 30 of the 53 certified centers;
  - Two received 51-75 percent from Medicaid funds;
  - Two received 26 percent to 50 percent from various block grants;
  - 10 received over a quarter to half of their funding from the federal government.





Overview of Unique Funding Models

Telephone Assessments: At least two large poison centers/systems receive funding through telephone assessments. One is coupled with 911, and is assessed on all landlines and cell phones, but not on Internet service providers. This funding

mechanism increases naturally, covering increased expenses due to salaries and cost-of-living. Another state supports poison center services through a long-distance surcharge on intrastate telephone calls.

Hospital Systems: One center receives funding from all hospitals, which has been mandated through legislation. Another has a voluntary member hospital system and charges all non-member hospitals per consultation with the poison center. This type of charging decreases use of the poison center by some hospitals, which is not in the best interest of patient care. Often those least able to pay are the ones in greatest need of assistance.

Other Options: Options used and under consideration in other states to fund poison centers include: fees on new and renewed drivers' licenses; State Children's Health Insurance Program (SCHIP)—2-1 matching; disproportionate share hospital Medicaid.

Recommendations:

Workgroup members acknowledged the difficult fiscal times facing the Legislature, state agencies, and the people of Maine themselves and deliberated widely in an effort to propose creative solutions to the funding shortfall that would not unduly burden any one entity. The following is a list of possible solutions with the recognition that a longer, perhaps three-year plan should be developed to adequately research all options and propose sustainable solutions. Keys to sustainability are maintaining and enhancing funding source diversity. A workgroup composed of key stakeholders (hospitals, insurers, public safety, etc.) should be charged with more fully researching the possible funding options and developing a long-term plan for sustainability of the NNEPC. For the entire range of options that were considered, please see the workgroup meeting minutes in the Appendix of this report.

Possible funding options

- In collaboration with professional associations in the state and the Maine Department of Professional and Financial Regulation, the workgroup recommended exploring a voluntary check off contribution on licensing applications – that does not impact the established professional license fee – the contribution proceeds would be devoted to NNEPC operations.
- As more than half of the Poison Center hotline calls involve exposure by children, the workgroup recommended exploring whether federal Department of Education block grant funds, such as Title IV-21st Century Schools/Safe and Drug-Free Schools and Communities, could be used to fund Poison Center Services.
- Workgroup members recommended further research on leveraging resources such as whether certain state agency activities would qualify for a federal match.
- In collaboration with DHHS Office of Elder Services, the Governor's Office of Health Policy and Finance, and related advocacy groups, the workgroup members recommended exploring the Drugs for the Elderly program, which is funded by racino proceeds, as a potential source of funding and federal match.

- As one of the most common requests for information from the Poison Center hotline involves substance-abuse related questions, and as the Center frequently provides expert consultation on substance abuse cases, workgroup members recommended exploring whether federal match through the Maine Office of Substance Abuse Services could be accessed and dedicated to the NNEPC's work.
- As law enforcement agencies are interested in data on real-time drug exposures, workgroup members recommended exploring the possibility of whether a proportion of the Department of Public Safety/drug seizure money could be dedicated to NNEPC.
- The workgroup recommended examining grant opportunities offered by the foundations of the major insurance companies operating in the state: Aetna Group, Cigna Health Group, Harvard Community Health Plan Group, and Anthem (Wellpoint Inc., Group).

While funding for the NNEPC has been an ongoing issue, its continued operation and the critical support that it provides for Maine's health care systems is currently in jeopardy – particularly given the impact of the current state and national economies upon hospitals and other health care provider systems in Maine. The workgroup recommends that prompt steps be taken to develop and implement an integrated funding structure for the NNEPC. As the state of Maine focuses upon decreasing the costs of health care, the cost-savings benefits of the NNEPC to the state health care system must not be forgotten or overlooked. The workgroup strongly recommends continued, focused work on developing a sustainable funding structure for Maine's financial contribution toward the operation of the NNEPC.

Recommend next steps include:

- The HHS Committee defines a minimum of three separate workgroups to explore, in detail, a minimum of one funding stream each;
- HHS Committee assigns workgroup members as well as the specific individual funding options that should be studied in detail by July 15, 2009;
- Individual workgroups complete their work by October 31, 2009; and workgroups report back to the HHS Committee with specific recommendations by November 30, 2009.
- The NNEPC be assigned responsibility for convening the workgroups that explore private sector funding
- The Maine CDC be assigned responsibility for convening state agencies for a one time workgroup to look at the feasibility of the workgroup's recommendations related to state agency budgets.

Introduction

Northern New England

The NNEPC is housed at Maine Medical Center (MMC) in Portland, Maine, and MMC makes a significant contribution to its sustainability both in terms of in-kind and financial support. The NNEPC has been in operation since before 1975. By 2004, the states of Maine, New Hampshire, and Vermont had entered into a consortium to provide services to the northern New England region.

The Maine Poison Center moved from the Veteran's Administration Facility in Togus to Maine Medical Center in 1974. At that time, the Center received a few hundred calls each year. This number grew to 26,000 by 2000. Federal legislation in 1999 provided some funding, but also required poison centers to enhance services to meet the national standard of care—national certification-level services. None of the Northern New England States had the combination of education-and certification-level of staff, computerized toxicosurveillance or toxicological supervision necessary to meet these national standards. Additionally, none of the three States could afford to make the changes necessary to meet the standards. As a result, collaboration ensued. Maine moved toward certification, while Vermont and New Hampshire combined with Maine to form one Northern New England Poison Center. A hotline is located at Maine Medical Center in Portland with education satellites in Burlington, Vermont, and Concord, New Hampshire. This model allows high quality of service while achieving well over a million dollars of cost savings. Based on the rural nature of the region, the population size served is optimal and still allows local knowledge to guide care, which in turn benefits patients. The NNEPC achieved national certification in 2004. It is currently at risk of losing this status, and the associated funding, due to lack of sufficient financial support for services in the state of Maine.

Nationally

In 2007, more than 4.2 million calls were captured by the National Poison Data System (NPDS) with 2,482,041 consisting of human exposure calls, 1,602,489 information requests, and 131,744 nonhuman exposure calls. Substances involved most frequently in all human exposures were analgesics (12.5 percent of all exposures). The most common exposures in children less than age 6 were cosmetics/personal care products. Drug identification requests comprised 66.8 percent of all information calls; the NPDS documented 1,597 human fatalities.[2]

Recognition of the many services that poison control centers (PCCs) provide argues for funding and public support. PCCs provide direct patient health care services to the general public and health care professionals and strengthen the services provided by public health entities and health care providers. For every dollar spent on PCCs, another $36 is saved in unnecessary health expenditures. All U.S. PCCs provide 24-hour emergency and information hotline services via the National Poison Center Toll-Free Telephone Hotline; essential follow-up calls regarding the continuing care of poison exposures; education; real-time, nationwide data collection providing epidemiologic surveillance; and access to emergency information as an integral part

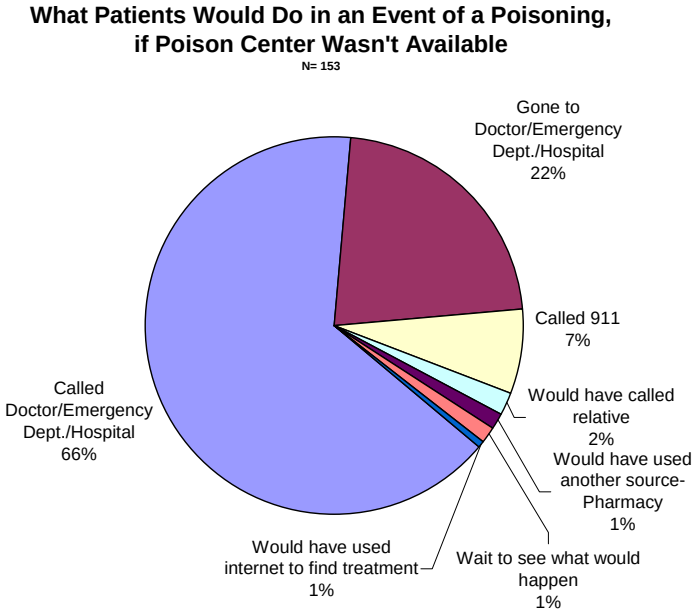
of local, state, and national emergency preparedness and response for natural and man-made disasters.[3]

What would be the result if all Poison Control Centers closed?

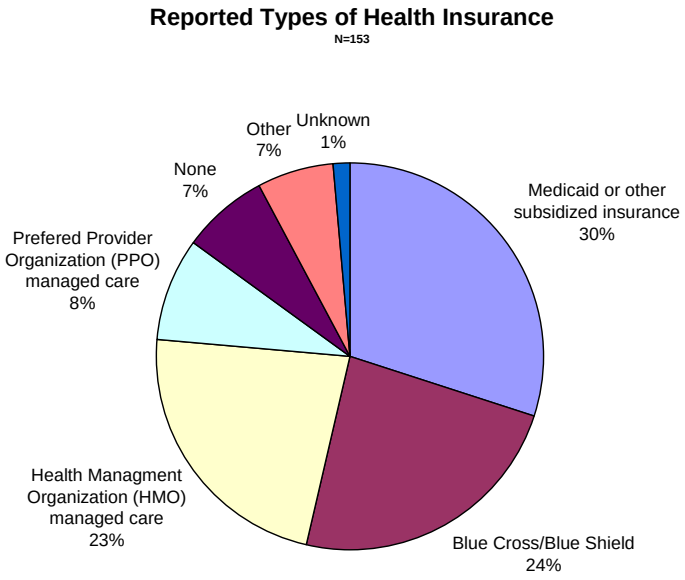
Available data shows that nationwide more than 80 percent of PCC callers are managed by the PCCs without use of hospital services. Most exposures are managed at home, saving unnecessary visits to emergency departments and providing immediate assistance to mitigate adverse outcomes.[4]

In the absence of a PCC to call, many of those individuals with known or suspected toxic exposures currently managed by a PCC would seek significantly more costly and less accessible health care alternatives such as emergency departments, private physician offices, 911/EMS agencies, fire departments, or urgent care centers. Others may not seek help at all, increasing the chances of more serious adverse outcomes.[5] In Maine, the 2007 NNEPC Annual Caller Satisfaction Survey shows that 66 percent of callers would have called doctor/emergency deptartment/hospital if the NNEPC were not available, many of whom would likely be referred for evaluation at a healthcare facility. Twenty-two percent would have gone to the doctor/emergency department or hospital.

The charts below provide additional information on what patients would do if a poison center were not available, as well as insurance source for these patients.



Source: NNEPC Annual Caller Satisfaction Survey



Source: NNEPC Annual Caller Satisfaction Survey

Between July 1, 2007, and June 30, 2008, the NNEPC answered nearly 102,000 calls from Maine, New Hampshire, and Vermont, or approximately 280 calls per day. Region-wide, staff managed 31,623 human exposures and answered 68,608 poison information questions, which represents a 25-percent increase in information calls from the region from 2006-2007.[6]

In Maine, Poison Center staff managed 57,236 Maine calls, 13,104 of which were human exposures. Board-certified, prepared toxicologists provided 495 in-depth consultations and reviewed 47 toxicological cases, which generated 10,244 follow up calls. During the 2007 to 2008 grant year, the NNEPC also answered 42,872 Maine poison information questions through the hotline, which is a 21-percent increase in information calls from Maine during the 2006-2007 grant year.[7]

Most patients involved in Poison Center cases are young children exploring their environment. Nearly half (49 percent) of exposure calls involved children under 6 years of age; 35 percent involved children 2-years-old or younger. However, adults are also poisoned, often by deliberately taking medications to get “high” or in suicide attempts; but also unintentionally through workplace exposure, chemicals in the home, or medications intended to treat medical disorders.[8]

Therapeutic errors occur in all ages, but can have more significant effects in the very young and the very old. Medication interactions are more likely as the number of medications increase, which commonly occurs in older adults. The substances

involved in poisoning vary; however medications are the most common cause of poisoning in all age groups.

Legislative History

In recognition of the life-saving and cost-saving public health benefit of the NNEPC, Senate President Beth Edmonds introduced LD 1991, "*An Act to Ensure Continued Operation of the Poison Hotline*" in December 2007. The Act called for an appropriation of grant funds to the NNEPC to continue operation of the poison hotline in the amount of $170,000 in 2007-2008 and $680,000 in 2008-2009. Due to fiscal constraints faced by the State, the act was amended to a resolve which directed the Maine DHHS to convene a working group to develop options for ongoing funding for the NNEPC. The resolve called for a brief report including options and recommendations for funding to the HHS committee by January 15th, 2009. The HHS Committee may then submit a bill to the First Regular Session of the 124th Legislature in response to the report.

Case Studies

During its sessions, workgroup members compared outcomes that occurred when poison control centers were accessed with those that occurred when services were not accessed. These case studies, while anecdotal, illustrate the importance of the immediate and proper information that the NNEPC can provide.

Bad Outcome (poison center not used): A family living in a rural area was unaware of the existence of a poison center. As a result, they did not quickly flush their daughter's eye after an exposure to a corrosive powder in their home. By the time the child was transported to a health care facility, surgery was required to open the swollen eye in order to flush it. The child lost her eye and damaged the socket behind the eye, making even wearing a glass eye difficult.

Good Outcome (poison center used): A corrosive chemical splashed into the eye of an adult at work. The poison center advised proper flushing from the time of exposure until arrival at the hospital, including during transportation. The emergency department physician called with news that the eye was in excellent condition, and that no significant damage had occurred.

In addition, the NNEPC has provided clinical consultation for the recent carbon monoxide exposure cases in the state. When an ice storm struck the Northeast on December 11, 2008, the Maine CDC needed continual toxicosurveillance information in order to assess the severity and causes of any carbon monoxide exposures. The NNEPC provided multiple reports over the weekend. Causes included generators in basements, garages, or located too close to the house and/or vents or other entry points to the house. Kerosene heaters and outdoor grills used inside were additional sources. Based on this information, outreach was immediately developed in an attempt to prevent further exposures. No deaths occurred in Maine. Additionally, new outreach recommendations and interventions are being prepared for future storms.

In perhaps its most publicized case, the NNEPC provided critical intervention in the arsenic poisoning that occurred in a small rural town in northern Maine. The outbreak was initially thought to be an outbreak of infectious disease or food-borne illness. NNEPC staff and toxicologists consulted with the treating physicians in the rural community regarding patient symptoms and also arranged for laboratory evaluation with the State Health and Environmental Testing Lab. The NNEPC also followed up with patient care to continually monitor and assist in treatment of the patients.

Funding Structure

Despite the uniformity of data collection and the use of a single toll-free number for access, the nation's PCCs are diversely organized and operated entities. Funding struggles are a constant problem for all PCCs.[8] The NNEPC's 2008 Annual Report concludes that "the Center is struggling to provide even the most basic hotline and prevention services. Failure to properly support the Poison Center could result in loss of services, which would lead to further hardship for those who can least afford it and impose an additional burden on an already overwhelmed health care system."[9] Many poison centers have closed over the last 20-25 years, largely due to funding failures. One of the most unstable funding structures during economic downturns is one that includes significant funding from a single host institution.[10]

Recommendations

Workgroup members acknowledged the difficult fiscal times facing the Legislature, state agencies, and the people of Maine themselves and deliberated widely in an effort to propose creative solutions to the funding shortfall that would not unduly burden any one entity. The following is a list of possible solutions with the recognition that a longer, perhaps three-year plan should be developed to adequately research all options and propose sustainable solutions. Keys to sustainability are maintaining and enhancing funding source diversity. A workgroup composed of key stakeholders (hospitals, insurers, public safety, etc.) should be charged with more fully researching the possible funding options and developing a long-term plan for sustainability of the NNEPC. For the entire range of options that were considered, please see the workgroup meeting minutes in the Appendix of this report.

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- The Maine CDC be assigned responsibility for convening state agencies for a one time workgroup to look at the feasibility of the workgroup's recommendations related to state agency budgets.

Resources

NNEPC web site: www.nnepc.org
American Association of Poison Control Centers: http://www.aapcc.org/DNN/
Maine Center for Disease Control: http://www.maine.gov/dhhs/boh/index.shtml

Citations

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[3] Artalejo, L., Crouch, B., Geller, RJ, et. al. The Value of the Poison Control Center. *Report prepared for the Health Resources and Services Administration Poison Control Program*. March 2, 2008.
[4]Ibid.
[5]Ibid.
[6] The Northern New England Poison Center Annual Report for the State of Maine, July 1, 2007 to June 30,2008.
[7] Ibid
[8] Ibid.
[9] Zaloshnja, E., Miller, T. Jones, P. et al. The Potential Impact of Poison Control Centers on Rural Hospitalization Rates for Poisoning. *Pediatrics*. 2006: 118, 5: 2094-2100.
10 Annual Report, July 1-2007 to June 30, 2008.
[10] Litovitz, T., Kearney, T.E., Holm, K., et al. Poison Control Centers: Is There an Antidote for Budget Cuts? *American Journal of Emergency Medicine*. 1994: 12, 5: 585-599.

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APPENDIX

LD 1991 Workgroup

List of Workgroup Members

Co-Chairs

Valerie Ricker, Director, Family Health Division, Maine Center for Disease Control and Prevention, DHHS

Karen Simone, Director, Northern New England Poison Center

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Stephen Meister, M.D.

Tamas Peredy, Medical Director, NNEPC

Anne Perry, Legislator

Becky Smith, Executive Director, Healthy Policy Partners

Ted Trainer, Director, Healthy Aging, Southern Maine Agency on Aging

Maine CDC, Office of Public Health Emergency Preparedness
Northern New England Poison Center
Project and Funding Summary

1. Maine Pharmaceutical Cache and Preparedness
2. After-Hours On-Call Telephone Service
3. Emergency Preparedness and Response / Disaster Medicine Medical Expertise

Maine Pharmaceutical Cache and Preparedness

1. Maine Pharmaceutical Cache and Preparedness

The purpose of the Maine Pharmaceutical Cache is to enable an expedient and life-saving response to unanticipated events affecting the health of Maine citizens. This grant will address the need of all-hazards management by:

- Maintaining the Maine Pharmaceutical Cache;
- Educating health care professionals, including public health partners, about potential public health emergencies, and the medications and supplies available to respond to such emergencies;
- Implementing a system to track the use of antidotes and supplies utilized to respond to a public health emergency;
- Developing a bulk medication repackaging plan for emergency, manual mass distribution of medications and supplies in response to a public health emergency;
- Implementing an antibiotic and antiviral cache plan.
- Continuing to build the collaborative relationships among public health and healthcare partners necessary to enhance response to public health emergencies;
- Testing response capabilities through drills that will assess response.

The State of Maine must prepare for the possibility of a chemical, biological, radiological/nuclear or explosion (CBRNE) incidents. These incidents may involve an act of terrorism; an industrial or highway transportation spill, fume release, fire or explosion; pandemic flu; malicious contamination or tampering; foodborne illness; or other hazard. It is likely that federal support will not be immediately available, and that the State will need a minimum supply of antidotes, medications and supplies with which to treat patients until federal support is available. The Maine Pharmaceutical Cache prepares for the most likely events in a cost-effective manner. CHEMPACK supplemental supplies and instructions enhance the immediate usability of CHEMPACK medications. In addition to building and maintaining antidote caches and supplies, education and drilling will improve readiness, as well as enhance the collaborative relationships that will be the backbone of any successful response to a public health emergency. In addition to supporting the use of antidotes and supplies, The Northern New England Poison Center (NNEPC) maintains a technical system to track antidotes and supplies, and a form a plan to manually distribute large amounts of medications quickly. This tracks antidotes and supplies from their origin to final destination, and enable planning during response to ensure a steady supply of needed medications.

2. After-Hours On-Call Telephone Service

The Maine Center for Disease Control and Prevention (Maine CDC) has the immediate, continuing need to respond, 24 hours a day, seven days a week, to reports of infectious diseases, unsanitary conditions in eating and lodging establishments, environmental toxins, adverse reactions to smallpox vaccine, and other threats to the public's health throughout the state of Maine. Especially critical, is the Maine CDC's need for early detection and response to disease outbreaks and clusters that occur naturally or from acts of bio-terrorism in order to prevent and reduce morbidity and mortality in Maine. The NNEPC is uniquely qualified to assist the ME CDC in addressing the after-hours public health emergency needs of the state of Maine. It is a 24 hour-a-day, 7 day-a-week hotline that provides assessment, triage, and management call services to lay persons and heath care professionals. All calls are documented in a database that allows immediate retrieval of cases based on general and/or specific inquiries. It also provides reports in real time to enhance the Maine CDC after-hours disease surveillance activities. The NNEPC also supports an emergency alphanumeric paging system that contacts large numbers of individuals or specified groups of individuals 24 x 7. This allows rapid activation of and response by the ME CDC's Public Health Incident Command System.

The NNEPC initiated a hotline service for The Maine CDC to allow immediate response 24 hours a day, seven days a week, to reports of threats to the public's health throughout the state of Maine in 2003. Subject matter experts are paged immediately when protocol, provided by the ME CDC dictates. All calls are documented in a database. Daily and monthly reports are made to the ME CDC on non-holiday business days to enhance after-hours disease surveillance. This service continues. Real-time monitoring of poison center data by epidemiologists is now possible due to a new federal Incentive Grant. The Maine CDC (Injury Prevention, Environmental Health, Infectious Disease) and Office of Substance Abuse have access.

3. Emergency Preparedness and Response / Disaster Medicine Medical Expertise

The Maine Center for Disease Control and Prevention, Office of Public Health Emergency Preparedness contracts with the Northern New England Poison Center for specialized emergency preparedness and response medical consultation services provided by the NNEPC Medical Director, Tamas Peredy, MD; providing the following services:

- Liaison: Coordinate and collaborate among public health, healthcare systems and emergency management in order to develop integrated public health emergency response plans among the three disciplines. Provide leadership to the health care systems, public health and emergency communities in the practice of public health emergency preparedness and response; provide expert disaster / emergency medical consultation to the healthcare systems community regarding disaster-

related healthcare medical operations with a focus on Maine CDC / NNEPC projects.

- Leadership: Provide leadership in the deployment and management of medical disaster / emergency resources such as "strike teams, task forces and teams of the Medical Reserve Corps, and the deployment of medical countermeasure such as the OPHEP managed Strategic National Stockpile Project.

- Consultation: Assist in the design of public health preparedness and response strategies including: Preparation of medical disaster / emergency preparedness policy documents for review by Maine CDC senior management; review and provide comments on draft recommendations (usually from federal CDC or ASPR) requiring disaster medical expertise. Develop recommendations and guidelines for Maine CDC, OPHEP regarding healthcare systems preparedness and hospital disaster / emergency operations.

  Time: Anticipated 8 hours per week commitment on average for the duration of the contract including time spent on-site at the Maine CDC / OPHEP Augusta office. Weekly status reports will be provided to the Maine CDC, Director, Division of Public Health Systems.

Summary:
The Northern New England Poison Center and the Maine CDC, OPHEP work collaboratively with hospitals, responders, public health partners and other health care professionals within the State of Maine to enhance preparedness for all hazards with potential to impact the health of Maine citizens. These projects address awareness, education and tracking of antidotes and supplies available in public health emergencies, and health care professional CBRNE agents education. The awareness and education efforts include first responders, public health partners and community health care practitioners. The NNEPC has developed manual bulk medication repackaging planning and procedures, and complete any community-based antibiotic and antiviral stockpiling planning. The Center tests the associated product(s) and plan(s) during each grant period. The Poison Center also provides an after-hours on-call telephone service and disaster / emergency response expertise to ensure Maine health care professionals and citizens have 24-hour access to key Maine CDC and NNEPC personnel after hours in emergencies, enhancing the public health response to all hazards at all times. In addition the NNEPC provides specialized emergency preparedness and response medical consultation services to the Maine CDC, OPHEP.

Funding Summary

Project Period	Funding
2006-2007	$236,993*
2007-2008	$186,496
2008-2009	$210,704

*Funding reflects purchase of medications ($128,757) to update the hospital pharmaceutical cache

Meeting Minutes for
LD 1991 Workgroup Meeting
Wednesday, November 19th, 2008
1-4 p.m.
Maine Department of Health and Human Services Offices
35 Anthony Avenue
Augusta, Maine

Present: Anne Conners, USM/Muskie; Anne Perry, Maine State Legislature, Health and Human Services Committee; Stephen Meister, Physician; Tamas Peredy, NNEPC; Valerie Ricker, Maine CDC; and Karen Simone, NNEPC.

Welcome and Introductions

Valerie Ricker welcomed participants to the meeting; introductions followed.

Background to Workgroup Formation

Ms. Ricker said that for well over a decade, the Northern New England Poison Center (NNEPC) has received funding from the state. The State increased the funding amount to $295,000 annually in 2000 but has decreased gradually as budget reductions have been implemented. Current state funding is $264,392, with $96,387 from the NNEPC specific budget line and $168,005 from the Maternal Child Health Block Grant matching funds.

As Center funding has remained static, call volume has gone up. During the last legislative session, Senator Beth Edmonds sponsored an act to increase NNEPC funding to $680,000 annually. The bill was amended to a resolve directing the Department of Health and Human Services to convene a workgroup to develop options for ongoing funding with representatives of the Center, medical and emergency service providers, and other organizations and interested parties. Ms. Ricker said the bad news is that the budget picture has not improved since the last session.

The NNEPC needs $2 million annually to provide services to the citizens of Maine, New Hampshire, and Vermont. Maine Medical Center, which hosts the NNEPC, contributed $558,293 in FY 08. This is more than double what the hospital agreed to provide, and growing yearly as state funding decreases. Federal poison center funds amounted to $87,603 and United Way funds to $28,861.

Karen Simone said that Maine's fair share based on population is $800,000; New Hampshire is close to that, and Vermont's fair share is $400,000. She noted that if it weren't for Maine Medical Center's support, the Center's operations would be in serious jeopardy. Depending on such a significant portion of funding from one health care facility is an unstable funding model.

Representative Perry said that Maine has a commitment that it's not keeping in terms of its funding obligation to the NNEPC.

Overview of Poison Center

Dr. Simone said that the NNEPC receives 300 calls a day. The most common call concerns children ingesting various substances. Other examples of calls include elderly people with questions about their prescriptions; police who have picked an individual up who has five different medicines on them; mothers who have found something in their kid's backpack; suicide attempts; therapeutic errors, some from health care professionals, some from older people who mistakenly take the wrong medications or take their spouse's medicine by mistake; deliberate misuse; occupational exposure; environmental exposure; terrorism (white powder scares, etc); and neonatal withdrawal.

The specific goal of the NNEPC is to maintain operation of the 24-hour hotline and associated staff and structure. To retain certification, the NNEPC must meet national standard of care levels with a medical director, managing director, 24-by-7 consultation, and clinical staff who are doctors, pharmacists or nurses, who are specially certified.

Other NNEPC functions and responsibilities:

- 24-hour emergency and information hotline services
- 24-7 access to every place in survey area
- Follow up to assess and advise re poisoning cases
- Local and national surveillance
- Epidemiological surveying and reporting to national database
- Public education
- Professional education
- Toxico and public health surveillance
- Patient management guidelines for health care professionals
- Emergency information as part of emergency response at local, state and national levels

Discussion

Stephen Meister said he remembered what it was like to practice medicine before there were regional poison centers and people would show up at the ER or phone the ER. ER doctors would open up a big toxicology book and try to provide care in that manner. This approach resulted in a fair amount of liability for hospitals. Dr. Meister said that the NNEPC is reducing liability for a number of entities. "Look at how many calls you get that relate to business-related toxins. Hospitals or ERs don't get those calls and don't have to accept liability." Dr. Meister suggested that hospitals or their endowments pay a certain fee to offset poison center costs. The value to each could be assessed based on the number of calls received from that region.

Representative Perry said that a number of places that use the Poison Center's services are required, under state law, to be licensed. She asked if there was any reason a portion of licensing couldn't be set aside for the operations of the Poison Center.

In the health care arena, doctors, nurses, physician assistants, EMTs, dentists, all have to be licensed. Dr. Meister said there are approximately 3,500 doctors in the state; probably a total of 10,000 health care professionals in all.

Representative Perry said that professionals may feel much better about their licensing fees if they knew that a piece of that fee would serve what they do from day to day. She suggested gathering the support of professional organizations going forward.

Tamas Peredy said that the NNEPC does not want to jeopardize access to its services by charging a fee and has tried to steer clear of the "nickel for every call you make concept."

Ms. Ricker asked if an assessment should be made on insurers. Representative Perry said that the difficulty in this is that there are so many different types of third party payers; some are licensed within the state; some are national; some are self-insured. Regarding hospitals, Representative Perry said that many rural hospitals are struggling to keep their heads above water and suggested looking at tertiary hospitals. Dr. Meister suggested looking at hospital foundations. In terms of gathering support for the NNEPC, Dr. Meister suggested emphasizing that the center is part of a risk management strategy and also explaining what the consequences would be if the center did not exist. Representative Perry said a good question to ask insurance companies or the Bureau of Insurance would be, "If the poison center did not exist, what might the insurance product look like?"

Participants also discussed checking off a box on an income tax form and or license plates supporting the NNEPC.

Report Outline

Representative Perry said that any presentation has to be informed by the understanding that the state is in tough economic times and that the NNEPC is a vital public health interest. The report should give a sense of what health care would look like without the poison center. She said the state is not paying its fair share of the costs of the center, which is located in Maine and receives its highest number of calls from Maine. The other two states in the compact are close to paying their full share "and we are no where near it." She said if the compact is going to work, Maine has to be in the game or get out of the compact, with the latter option not being a good choice. The report should stress that without the NNEPC there will be greater utilization of the ER and a greater number of bad outcomes. While income in the general fund may be limited, she said that doesn't preclude looking to other sources to fund the center

Dr. Meister suggested including examples of a good and bad outcome from an occupational exposure and a home exposure.

Anne Conners said that a rough report outline would be:

- Executive Summary
- Background and Overview of Issue
- Supporting Research

- Recommendations
- Conclusion
- Appendix: workgroup minutes, participants, reports/studies.

Stakeholder Development

After a discussion, members agreed to invite the following:

- Peter Chalke, CEO, Central Maine Medical Center
- Doug DiVello, VP, Central Maine Medical Center
- Barbara Crowley, MaineGeneral
- Josh Cutler, Maine Quality Forum
- Rene Dumont, St Mary's Health Care
- Anne Head, Commissioner, Professional and Financial Regulation
- Mila Kofman, Superintendent, Bureau of Insurance
- Lisa McPearson, EMMC
- Representative from Maine branch of AARP

Timeframe

Report is due January 15, 2009; however, it must be completed by December 29, 2008 in order to allow time for review process.

Future Meetings

Members decided that one more face-to-face workgroup meeting would be necessary in December and the remainder of work could be conducted via telephone conference calls or electronically.

Stakeholders will be polled regarding the following dates:

- December 10: 8 a.m. to 11 a.m.
- December 16: 1 p.m. to 4 p.m.
- December 17: 1 p.m. to 4 p.m.

Meeting Minutes for
Tuesday, December 16, 2008
1-4 p.m.
Maine Department of Health and Human Services Office
35 Anthony Avenue
Augusta, Maine

Present: Patrick Adams, DHHS/OES; Anne Conners, USM/Muskie; Nancy Dube*, Maine DOE; Katie Fullam Harris, MaineHealth; Rosemary Henry*, St. Mary's Health System; Lisa Harvey McPherson, Eastern Maine Health Care Systems; Don Swartz*, Vermont Department of Health; Anne Perry, Maine Legislature; Valerie Ricker, Maine CDC; Karen Simone, NNEPC; Becky Smith, Healthy Policy Partners; Ted Trainer, Southern Maine Area Agency on Aging. (*Indicates present by phone).

Welcome and Introductions

Co-Chairs Karen Simone and Valerie Ricker welcomed participants to the meeting; introductions followed.

Review of Legislation

Ms. Ricker said that the bill submitted in the last legislative session requested an increase in funding for the NNEPC. While there has been a specific line in the state budget for funding, that funding has been decreased over the last six years through budget shortfalls. Because funding was not available during the last legislative session, the bill was made into a resolve and the Legislature's Health and Human Services Committee asked for the formation of a workgroup that would produce a brief report on funding options. Today's meeting follows one on November 19th with the goal of bringing as many stakeholders as possible to the table to be a part of the discussion and to recommend options.

Minutes

The November 19th minutes were accepted as written.

New Poison Center Cost Savings Article

Dr. Simone distributed a recent article from the *Journal of Medical Toxicology*, which reported that patient home management by a regional Poison Control Center has the potential to save public healthcare dollars by preventing unnecessary utilization of emergency department services. Using conservative assumptions, for every dollar spent by Poison Centers, $36 were saved in unnecessary health care costs.

Review of Poison Center Funding

Ms. Ricker said that it takes approximately $2 million per year to run the Poison Center and that three New England States, New Hampshire, Vermont, and Maine contribute to the costs of the Center's operations. Based on population, the larger states should pay approximately $800,000 yearly and Vermont should pay $400,000. New Hampshire pays close to its share, Vermont has now committed to paying its share and Maine is far below its fair share at $265,000. When looking at population size and the volume of calls that

come in, Maine is the only state that is not paying its share. Maine Medical Center contributes over $500,000 toward the operation of the center and relying on one provider for that amount of funding is not a viable model.

Dr. Don Swartz, Medical Director, Vermont Department of Health: Overview of Funding for the Poison Center

Ms. Ricker introduced Dr. Swartz and thanked him for taking the time to provide his expertise to the group.

Dr. Swartz said that Vermont's solution to funding for the Center was interesting and is a useful case study for the group. The most important resource in the funding process was the Vermont Commissioner of Health, who believed that the services of the Poison Center were a critical part of the public health infrastructure that needed to be preserved. Once that support was in place, the issue then became identifying an appropriate funding mechanism.

Overview of How Vermont Funded the Center in the Past: Funding for the Center was covered by a variety of grants, such as bioterrorism, which became emergency preparedness grants; from the state's academic medical center, Fletcher Allen; and from the Preventative Health and Health Services Block Grant and the Maternal and Child Health Bureau Block Grant (Title V). As emergency preparedness grants became more prescriptive and focused, Vermont became more strapped and began to under pay significantly. Outreach to the Commissioner of the Vermont Department of Health to illustrate the importance of the Poison Center's work was extremely important.

Compelling Public Health Arguments: Having a hotline available to mothers and other emergency personnel in the State was critical and became a major selling point in understanding how the Center worked. Calls would be categorized as Vermont calls and reviewed by Vermont epidemiologists. The Commissioner was impressed by the availability of epi-data that could help in prevention activities as well as by the arsenic story from Northern Maine. Dr. Swartz said that anecdotes can be useful as can a description of the expertise available. Vermont also wanted to address public concerns about asbestos exposure because of the presence of an asbestos mine in the state. The Poison Center prepared the risk communication for the public.

Budget Process in Vermont: In Vermont, the budget is not a line-item process, but a unified budget. The Governor presents a budget and the Legislature examines it, then an Appropriations bill is passed. Funding for the Center was in the Governor's budget and the Appropriation bill. "In our system, once it is in there, it takes an act of will on the part of the Governor or the Legislature to take it out." While this is not a permanent funding mechanism, it is much more stable.

In order to make sure the appropriation survived the review process, the Vermont Department of Health reached out to several other partners regarding the value of the Center's services and activities. For example, Department of Health staff reached out to the state's Medicaid agency and the Agency that directs efforts on behalf of the elderly and the disabled. Both Agencies have an interest in the Center's activities. For the

elderly, medication errors often occur and the Center can advise on the impact and management of the errors. This emphasized "the importance of education and resource management. If those phone calls had resulted in the use of emergency services rather than a phone call, the fiscal implications would have been quite different." The Department of Health also worked with the Department of Public Safety as this agency is very interested in real-time drug identification possibilities and early warning on contamination of Vermont's environment.

Discussion:
Question*: When was work done to integrate funding for the Poison Center?*
Answer: Just this past year. The first appropriation in which it appears is the current fiscal year appropriation.
Question: *As those discussions went on, was your state Legislature grappling with shortfalls*?
Answer: No. This was last year's Legislature. Sure that it would be different this year.
Question*: Can you describe the restrictiveness of emergency preparedness funds?*
Answer: Used to be bioterrorism funds and when the CDC was young, the emphasis was on the states doing what they saw fit. Now the CDC is more prescriptive and much less funding is available for Poison Centers.
Comment: Federal funding around bioterrorism has been cut and has largely impacted rural states like Vermont, Maine, and Wyoming.
Answer: Just the way federal grants are, I think that they should be used for development and relatively short-term activities.
Question*: What other funding opportunities did Vermont consider*?
Answer: Fletcher Allen, our academic medical center, had the Poison Center before the advent of the certified Poison Center process. Fletcher Allen continued its support in the amount of $40,000. The state chose not to go into the community and seek funding, such as from Rotary Clubs.
Question: *Did you look at insurers or users of this service?*
Answer*:* No, because we are putting a lot of pressure on them in other areas of public health. Other states that aren't putting as much pressure on their insurers may find this is a source worth looking at.
Question**:** *How much has the state committed*?
Answer: $300,000 in state money; $40,000 from Fletcher Allen; $60,000 from federal government.
Question: *How does that break down? What did Vermont contribute in the current Fiscal Year?*
Answer: $100,000 from one source; $59,000 from another (the latter was for a specific project and didn't cover hot line services.)
Question: *How do other states provide Poison Center services*?
Answer: It's a mix; for example, Florida has three or four centers.
Question: *In New England*?
Answer*:* Vermont, New Hampshire, and Maine have formed a consortium; Massachusetts and Rhode Island have a partnership; Connecticut has its own Center.

Comment: How centers are divided up depends on population. The easiest population to serve is suburban; the hardest are urban and rural. With three states right now, we're about as big as we could get when considering the rural nature of the population.

Funding Sources Discussion

Katie Fullam Harris asked what the current Poison Center budget is and what is proposed. Karen Simone said it costs approximately $2 million to run the Center. Maine currently contributes $264,000; that figure should be $680,000. Maine Medical Center has been picking up the deficit. Time and effort spent searching for funds to make up the deficits left by Maine's failure to pay for services takes clinical Poison Center staff away from the clinical mission.

Patrick Adams asked if Maine Med was providing in-kind support as well as direct dollars. Dr. Simone said both; that Maine Med pays for some salaries outright; provides space, FICA, fringe, computer, and services of the accounting department as well as critical infrastructure support such as phones and back up (for example in the recent power outage following the ice storm.)

Ms. Fullam Harris asked if the group was considering replacing federal and Maine Medical Center money with funding from the state. Representative Anne Perry said no. Dr. Simone said she feels that having Maine Medical Center pay more than $500,000 yearly creates an unstable funding situation and that a more reasonable figure would be $250,000, including covering occasional deficits. Representative Perry said that the state's deficit is $439,000; Dr. Simone said $820,000, in ball park rounding numbers, is what everyone in Maine would pay together.

Mr. Adams asked how New Hampshire funded its program. Dr. Simone said New Hampshire has some federal money and is taking most of the funding from terrorism money. Lisa Harvey McPherson suggested that the group talk to New Hampshire about its funding mechanisms and suggested that New Hampshire may be a model if it is the only state coming up with its fair share. Dr. Simone said she was not sure it was a good idea to rely on bioterrorism dollars as that money many decrease or go away. Ms. Harvey McPherson asked if the Center uses regional resource funds. "Is there any way to partner these grants to support the Center?" Dr. Simone said she didn't think this source had any money to give away and because the dollars are from bioterrorism, the funding could go away.

Ms. Harvey McPherson asked where Commissioner Brenda Harvey and Director Dora Mills are on this issue. Representative Perry said that both see the importance of the Center, but the issue is the money. Ms. Harvey McPherson asked how the Poison Center fits with the State's public health district effort. Representative Perry and Ms. Ricker said that while it is not considered part of that structure, it is a resource for district public health activities. Ted Trainer said that he sits on the Public Health Councils in both York and Cumberland and thinks that it would be good to increase linkages between the Poison Centers and the public health districts and elder services. Dr. Trainer said that the Center is clearly a resource and that the more information can get out about its services, in terms

of the number of people served per town and county, then networks can emerge. York County, for example, has three hospitals, and the work of the Poison Center isn't well known. While this doesn't help direct funding, it is a long term strategy for sustainability.

The group discussed the role of insurance companies in funding the Center as they benefit from its work. Ms. Harvey McPherson suggested using a voluntary rather than a mandated approach. Several members suggested obtaining funding from the foundations operated by the following insurance companies: Anthem, Aetna, Cigna and Harvard. Another possibility is the Maine Health Access Foundation.

Dr. Simone said that foundation funding is a band aid, not a permanent funding solution, which is the goal of this task force. Due to the continual and worsening funding shortfall, the Poison Center can not afford a grant writer. Therefore, Dr. Simone is the chief "grant writer." As a toxicologist, Dr. Simone said her chief activities should be clinical and that funding activities already consume a disproportionate amount of her time. It is important for any such activities to lead to sufficiently substantial and long-term funding to be worthy of further depleting clinical time, which is necessary for the safety of Poison Center patients. Nancy Duby said that perhaps foundation funding is part of a long-term, three-year strategy.

Representative Perry said that for the State to provide funding, sources need to be found that are not General Fund and noted that it may take some time to pull some of that together. The Center needs a steady source of funding as well as a commitment from the State in one manner or another. The difficulty is identifying a source for the funds given the State's fiscal situation. Ms. Ricker said the group also needs to be cognizant of what State government is asking of the other entities: hospitals/insurers, etc.

Ms. Fullam Harris asked how other states, other than New Hampshire and Vermont, fund their centers. Dr. Simone provided the following breakdown:

- There are 53 Centers:
    - 10 get a quarter or half of their funding from the federal government;
    - Two get 50-75 percent from Medicaid funds;
    - Two get anywhere from 25 percent to 50 percent from various block grants;
    - States pay for anywhere from 50 to 100 percent in nearly 30 of the 53 states.

In New Jersey, a system was developed of charging hospitals, Dr. Simone said; however, forcing such a system on unwilling hospitals can create ill will, which could decrease appropriate use of the Poison Center. She added that some of the older centers have contracts with companies making consumer products, such as S.C. Johnson or Proctor & Gamble. However, these large contracts were largely allocated decades ago. Throughout the country, host institutions, Dr. Simone said, very infrequently pay a significant proportion of the costs of Poison Centers because many Centers that were funded that way in the 1980s and 1990s closed when these institutions fell on difficult financial times.

Ms. Fullam Harris said that she recently had a conversation with the CEO of MaineHealth and he is very committed to supporting the NNEPC. She said that clearly the State's General Fund is not an ongoing dependable source of funding and suggested looking into various federal funding options. For example, in 10 states, 25 to 50 percent of the funding comes from the federal government. Maine's share of federal funds is less. Federal funds typically cover 10 to 15 percent, at most, of necessary Poison Center funding.

Ms. Harvey McPherson asked if Medicaid and Title V are aligned; Ms. Ricker said that they were different funding streams. When other states do tap into Medicaid, how is that done? Ms. Ricker said most likely this process occurred through administrative match, but given the current state of Medicaid, this is probably an unlikely source. For the match to occur, state funds must be available so Maine Medical Center's dollars could not be used to draw down Medicaid.

The group then discussed whether the Maine Office of Substance Abuse, which has an interest in supporting the Center, could draw down federal SAMHSA funds.

Members also considered whether a portion of the funds obtained through the professional licensing process could be allocated for the Poison Center operations. Members decided that this is a political no win as professional organizations generally oppose such efforts and it then also becomes an economic development issue. Members agreed that perhaps the licensing process could be amended so that a voluntary check off could be added so professionals could choose whether a portion of the licensing fee could be allocated to the Poison Center. Members discussed a check off on the tax form; and decided that this mechanism has been oversaturated and doesn't raise much money any more. Same scenario applies to license plates.

Becky Smith said that she represents Friends of The Fund for Healthy Maine, which was founded with tobacco settlement money. The fund has lost 25 percent of its value over the past eight years. One source of funding is a portion of racino funds, which is allocated for the Drugs for the Elderly Program. However, even this fund is looking at $2 million less a year going forward as people aren't gambling. The Fund for Healthy Maine has a $4-$5 million shortfall and is flat funded.

Members also discussed the role hospitals should play in the overall funding picture such as an assessment based on number of admissions. Ms. Harvey McPherson said that the large health systems have to balance the contribution they make to the public benefit. For example, Maine Med is allocating significant dollars to the NNEPC while Eastern Maine Health System makes a significant contribution to underwrite Life Flight in Maine. Meanwhile, most of the small hospitals in the state are at some level of financial crisis; those in the middle are struggling; and the larger hospitals are balancing their public infrastructure responsibilities.

Members discussed whether for each ED visit or hospital admission, a small amount, like 10 or 25 cents, should be charged to third party payers. Ms. Harvey McPherson said that Medicare/Medicaid don't fully pay for the cost of services; therefore a shift occurs to private payers; private payers are saying that they can't afford the shift any longer because the margins are no longer there. Ms. Fullam Harris said that Medicare or Medicaid can't be assessed.

Another funding option discussed was fee-for-service work. Dr. Simone said the Center does some of this already and could go after occupational toxicology; however, it would need staff to provide services and then still have to cover funding for the Poison Center. Also, Dr. Simone said that this type of toxicology work would not be anticipated to provide sufficient funds to underwrite under-funded Poison Center core functions.

Mr. Adams asked how many calls coming in on the hotline can be tied to work-related exposure; Dr. Simone said a small portion of calls fall into this category and that the majority of calls are about childhood exposures, therapeutic errors, suicide, or substance abuse.

Since so many of the calls are related to children, members discussed whether Social Service Developmental Block Grant Funds or Title IV Funds (Educational) could be used. Ms. Harvey McPherson also suggested the Department of Agriculture as a source.

Another strategy would be to have departments and program throughout state agencies contribute smaller dollars, such as $10,000 per program, to the Poison Center operations. However, members agreed that this would need strong executive leadership to execute and would require a long-term approach.

Members discussed whether a voluntary contribution could be asked of towns or municipalities or a fee assessed based on the number of calls; however, members agreed that this would not be a viable strategy given the current economic climate.

Recap of Possible Funding Sources:

- Voluntary Check Off on Licensing Application
- Child Welfare: Social Service Block Grants or Title IVE Funds
- Medicaid Draw Down
- Drugs for the Elderly Program
- Maine Office of Substance Abuse/federal match
- Department of Public Safety /drug seizure money
- Insurance Company Foundations
- Increased use of federal funds (bioterrorism)
- Using Title 5 funds as seed for match

Maine Med's commitment to funding buys the Center a little time; however, a plan needs to be developed going forward.

Report Structure and Deadlines

Representative Perry stressed that given the state's economic crisis and the press of business before the Legislature this session that the report be kept brief with a clear indicator of where legislators can go if they are seeking more information.

Information to include:

- Use by County/town
- Information on other states (structure/funding)
- Research (brief)
- Case study: good outcome/bad outcome
- Prominent acknowledgment of Maine Medical Center's commitment to the work of the Center

Deadline:

Ms. Ricker said that the resolve states that the report is due to the HHS Committee by January 15; however, DHHS needs a two-week window for the review process so the report must be out of the CDC office by January 2nd. A draft of the report will be sent to Workgroup members by December 28th with a response requested by the close of business on December 29th.

Conclusion

Ms. Ricker thanked members for their contribution to the Workgroup and said their expertise was particularly valuable at such a critical time in state government. Further work will be done electronically.