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November 9, 2015

TO: Senator Eric L. Brakey, Senate Chair
Representative Drew Gattine, House Chair
Members, Joint Standing Committee Health and Human Services

FROM: Mary C. Mayhew, Commissioner, DHHS

RE: DHHS Responses to Questions regarding Fund for Healthy Maine Funding requested October 20, 2015

This memo contains DHHS responses to the specific questions posed by the Committee, which have been included here verbatim.

1. A list of all vendors, contractors and subcontractors that receive funding from FHM. The Committee has heard from several organizations with state contracts and scrutinized their activities. In the interests of full information and fairness, the Committee would like to hear from all vendors, contractors and subcontractors with contracts with the Department that include FHM funding

Response: See Attachment A

2. A breakdown of FHM that is spent directly by the Department rather than through contracts (not including the FHM funding that is devoted to MaineCare).

Response: Administrative funding at MECDC using FHM dollars totals 816,262.

3. More detailed information on MaineCare-related FHM funding and how it is used.

Response: FHM – Medical Care Services is transferred directly to Medicaid. It is then used to fund Medicaid reimbursable services that meet the requirements of the FHM statute. FHM medical care services are part of the Medicaid General Fund account, appropriation 0147.

4. Specific expectation by the Department for the use of the \$1 million allocated under Part LLLL of the biennial budget for contracted lead inspection positions for FY 2015-2016. IN the information submitted to the Committee for the last meeting, the Department responded that it was on track to spend all of the FHMN allocated to its programs by the end of FY 2015 – 2016.

Response: Specifically related to Part LLLL, the Department is still in the rulemaking process. This prerequisite to the spending means that the new regulations likely will not be in place in time to use the entire budgeted amount. There is not yet an estimate on how much will be required to complete the fiscal year.

The Department has only concluded one quarter of the fiscal year, but for all other FHM accounts, spending is currently on track.

FHM Vendor List

Tobacco, Prevention, Control and Treatment

AMERICAN LUNG ASSOCIATION
 CD & M COMMUNICATIONS
 CLEARWATER RESEARCH INC
 GOOLD HEALTH SYSTEMS
 Howe, Cahill & Company
 KIT SOLUTIONS LLC
 MAINE BUSINESS SERVICES
 MAINEHEALTH
 PAN ATLANTIC CONSULTANTS INC
 PAN ATLANTIC RESEARCH INC
 RINCK ADVERTISING INC
 THE OPPORTUNITY ALLIANCE
 TRI-STATE STAFFING, INC
 UNIV OF ME SYS
 UNIV OF NEW ENGLAND

Donated Dental Services

NAT'L FOUNDATION OF DENTISTRY FOR THE
 HANDICAPPED

Public Health Infrastructure

AROOSTOOK CTY ACTION PROG INC
 BANGOR CITY OF
 HEALTHY ACADIA
 HOULTON BAND MALISEET INDIANS
 MID COAST HOSPITAL
 PENOBSCOT INDIAN NATION
 PORTLAND CITY OF
 REDINGTON-FAIRVIEW GEN HOSP
 RIVER VALLEY HEALTHY
 UNIV OF NEW ENGLAND

Community / School Grants and State-wide Coordination

Analytic Insight
 AROOSTOOK CTY ACTION PROG INC
 BANGOR CITY OF
 CALAIS CITY OF
 Carole Lynn Martin
 COMMUNITY CLINICAL SERVICES
 DANIEL HANLEY CENTER FOR HEALTH LEADERSHIP
 EASTMAN & GUARE CONSULT
 HEALTHY ACADIA
 HORNBY ZELLER ASSOC INC
 HOULTON BAND MALISEET INDIANS
 LANDRY & ASSOCIATES
 MAINE INFORMATION NETWORK LLC
 MEDICAL CARE DEVELOPMENT
 MID COAST HOSPITAL
 MSAD 60
 MSAD 75
 PENOBSCOT COMMUNITY HEALTH CTR
 PENOBSCOT INDIAN NATION
 PORTLAND CITY OF
 REDINGTON-FAIRVIEW GEN HOSP
 RIVER VALLEY HEALTHY
 RSU #38
 UNIV OF ME SYS
 UNIV OF NEW ENGLAND
 WESTERN MAINE HEALTH CARE CORP

Oral Health

AOS #91
 AOS #92
 AOS #94

AOS 95
 AROOSTOOK CTY ACTION PROG INC
 ATHENS PUBLIC SCHOOLS
 BROOKLIN TOWN OF
 CALAIS CITY OF
 COMMUNITY DENTAL
 DEER ISLE STONINGTON CSD
 HEALTHREACH COMMUNITY HLTH CTR
 KENNEBEC VLY DENTAL COALITION
 KINGMAN ELEMENTARY SCHOOL
 MADAWASKA SCHOOL DEPT
 MSAD #53 / RSU #53
 MSAD 01
 MSAD 15 TREAS OF
 MSAD 17 TREAS OF
 MSAD 20 TREAS OF
 MSAD 24
 MSAD 29
 MSAD 3 TREAS OF
 MSAD 30 TREAS OF
 MSAD 31 TREAS OF
 MSAD 32
 MSAD 33
 MSAD 42
 MSAD 45 TREAS OF
 MSAD 52
 MSAD 54 TREAS OF
 MSAD 59
 MSAD 64
 MSAD 68
 PENOBSCOT COMMUNITY HEALTH CTR
 RIVER VALLEY HEALTHY
 RSU #02
 RSU #10
 RSU #12
 RSU #18
 RSU #20
 RSU #34
 RSU #38
 RSU #58
 RSU 22
 RSU 50
 SEDGWICK TOWN OF
 STEPHANIE J RIZZO
 SUNRISE OPPORTUNITIES
 UCP OF MAINE

Prevention and Support Services

CARY MEDICAL CENTER
 HEALTHY ACADIA
 MAINE ASSOCIATION OF SUBSTANCE ABUSE
 MAYO REGIONAL HOSPITAL
 MID COAST HOSPITAL
 SEBASTICOOK VALLEY HOSPITAL
 THE OPPORTUNITY ALLIANCE

Substance Abuse Prevention

CITY OF BANGOR
 CITY OF LEWISTON
 RESULTS MARKETING & DESIGN LLC
 THE PARTNERSHIP FOR A DRUG-FREE AMERICA
 TOWN OF BRUNSWICK
 TOWN OF CAPE ELIZABETH
 TOWN OF DOVER-FOSCROFT
 TOWN OF MILO

Substance Abuse Prevention

TOWN OF ORONO

TOWN OF RUMFORD

TOWN OF SOUTH BERWICK

TOWN OF YORK

AROOSTOOK MENTAL HEALTH SERVICES

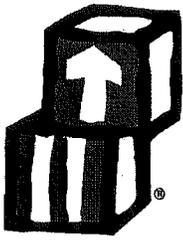
CATHOLIC CHARITIES OF MAINE

CROSSROADS FOR WOMEN

DAY ONE

MAINE GENERAL COMMUNITY CARE WELLSPRING

YORK COUNTY SHELTER PROGRAMS



Maine Head Start Directors Association

Douglas Orville, Chair
Child & Family Opportunities, PO Box 648, Ellsworth, ME 04605
Phone (207) 667-2995

November 9, 2015

Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333

RE: Study of the Allocations of the Fund for a Healthy Maine

Dear Sen. Brakey, Rep. Gattine and Members of the Committee:

I serve as the Chair of the Maine Head Start Directors Association, which brings together the directors of Maine's 11 non-tribal Head Start programs. I'm writing to respond to the questions asked of Rick McCarthy on October 13th, when he appeared before you on behalf of Head Start.

Research on the Effectiveness of Head Start

Senator Brakey asked for some clarity regarding the research on the effectiveness of Head Start. Specifically, he asked about the control groups used in these studies. Is the performance of children in Head Start being compared to children in regular child care or those with no day care? The short answer is that it depends on the research in question. Generally, the control group for these studies includes a mix of children with working parents who require some kind of care during the day and children who stay home. Selecting only children with a parent at home full-time would create other problems because the control would be different from the population receiving quality early education or Head Start services.

Two of the most well known studies are the Perry Preschool Project and the Head Start Impact Study. The Perry Preschool Project was conducted from 1962 to 1967 with evaluations at age 27 and 40. Perry included a control group of children who did not participate in a preschool program. Teachers followed a curriculum focused on active learning with tasks that encouraged decision making and problem solving. The Perry curriculum has been influential in the development of current Head Start curriculums.

The Perry Preschool program has shown significant benefits throughout participants lives compared to the control group. They completed more years of schooling and were significantly (44%) more likely to graduate from high school. They had fewer out of wedlock births and teen pregnancies and were less likely to serve time in jail or be arrested for violent crimes. Economically, they had 42% higher incomes at age 40 and were less likely to receive state assistance.

The ongoing Head Start Impact Study has a control group of children who did not attend Head Start. However, their parents were able to enroll them in other early childhood programs, meaning the control is a mix of children at home (40%) and in child care or other early education programs (60%). The Impact Study showed significant increases in measurements of school readiness for the Head Start children, including measures of vocabulary, spelling, and math skills. Program participants also did better on measures of dental care, health status, behavior, and parent reading to the child.

Additional Information on Head Start Services

Rep. Sanderson requested additional information in three areas. First, she requested a breakdown of where children are being served. Below is a table showing the number of children served with state Head Start funds in each of the state's non-tribal 11 Head Start agencies.

Head Start State Funded Slots

<u>Agency</u>	2015-2016 School Year
Androscoggin	14
ACAP	12
CCI	32
CFO	24
KVCAP	10
Midcoast	12
Penquis	22
SKCDC	8
TOA	9
Waldo	6
York	11
Totals	160

Second, Rep. Sanderson asked for more information on parental involvement in Head Start. The level of involvement varies by parent, as you would expect. As we've discussed, a key strength of Head Start is that we work with parents to engage them in their child's development, to strengthen families and to help connect parents to the larger community. This approach is summarized in the Head Start Parent, Family and Community Framework, which provides a guide for Head Start programs and staff to engage with parents. A detailed summary of the Framework is available online (<http://eclkc.ohs.acf.hhs.gov/hslc/standards/im/2011/pfce-framework.pdf>). Head Start seeks to achieve seven goals in working with families:

1. Improve family well-being
2. Support positive parent-child relationships
3. Families as lifelong educators
4. Families as learners
5. Family engagement in child transitions
6. Family connections to peers and community
7. Families as advocates and leaders

There are a variety of strategies employed to reach these goals. Head Start sits down with parents upon enrollment and does an assessment of the family's situation and encourages the parents to set goals for themselves and their families. We connect them with assistance, such as family literacy programs, health care, child abuse and neglect prevention, substance abuse, domestic violence, or vocational supports. Over 90% of Head Start families receive some kind of support services. A detailed summary of these family supports for Maine are provided in the attached *2015 Head Start PIR Family Information Report*.

Parents are encouraged to be active in their child's education at Head Start and all are involved to some degree. Many provide volunteer hours. Others participate in the Policy Council, which has a formal role in the operation of each Head Start agency. Policy Councils are comprised of Head Start parents and community representatives who meet monthly to review pending issues regarding the Head Start program. The parent Policy Councils have input on major program decisions, including budgeting. The responsibility they exercise in the Council has been the springboard to success for many parents.

Finally, she requested more information on the typical schedule of a student in Early Head Start (age 0-3) and Head Start (4-5). Center based Early Head Start classrooms typically meet for a minimum of 6 hours a day, 5 days a week for the full year. Regular Head Start programs typically last 4 hours a day for 4 days a week during the school year. Programs work with parents to provide coverage for the full working day (10 hours) when that is necessary. I have included as an attachment an excerpt of our *2015-2016 Parent Handbook* that provides additional information regarding a typical day and other information.

Thank you for this opportunity to respond to the questions raised last month

Sincerely,



Douglas D Orville

Attachments

2015 Head Start PIR Family Information Report

Excerpt from Child and Family Opportunities *2015-2016 Parent Handbook*



Office of Head Start - Program Information Report (PIR) Family Information Report - 2015 - State Level

GENERAL INFORMATION

<i>Program Types</i>	<i># Programs</i>
Total	25
Head Start	11
Early Head Start	11
Migrant and Seasonal Head Start	0
Migrant and Seasonal Early Head Start	0
AIAN Head Start	3
AIAN Early Head Start	0

<i>Agency Types</i>	<i># Programs</i>
Community Action Agency (CAA)	17
Government Agency (Non-CAA)	0
Charter School	0
Private/Public For-Profit (e.g., for-profit hospitals)	0
Private/Public Non-Profit (Non-CAA) (e.g., church or non-profit hospital)	5
School System	0
Tribal Government or Consortium (American Indian/Alaska Native)	3

<i>Agency Descriptions</i>	<i># Programs</i>
Delegate agency	0
Grantee that delegates all of its programs; it operates no programs directly and maintains no central office staff	0
Grantee that directly operates program(s) and has no delegates	25
Grantee that directly operates programs and delegates service delivery	0
Grantee that maintains central office staff only and operates no program(s) directly	0

FAMILY AND COMMUNITY PARTNERSHIPS

Number of Families

	# of families at enrollment	Percentage of families
C.35 Total number of families:	3,779	
a. Of these, the number of two-parent families	1,955	51.73%
b. Of these, the number of single-parent families	1,824	48.27%

Employment

	# of families at enrollment	Percentage of families
C.36 Of the number of two-parent families, the number of families in which:		
a. Both parents/guardians are employed	409	20.92%
b. One parent/guardian is employed	904	46.24%
c. Both parents/guardians are not working (i.e. unemployed, retired, or disabled)	642	32.84%
C.37 Of the number of single-parent families, the number of families in which:		
a. The parent/guardian is employed	762	41.78%
b. The parent/guardian is not working (i.e. unemployed, retired, or disabled)	1,062	58.22%
C.38 The number of all families in which at least one parent/guardian is a member of the United States military on active duty	25	0.66%

Federal or Other Assistance

	# of families at enrollment	Percentage of families
C.39 Total number of families receiving any cash benefits or other services under the Federal Temporary Assistance for Needy Families (TANF) Program	946	25.03%
C.40 Total number of families receiving Supplemental Security Income (SSI)	394	10.43%
C.41 Total number of families receiving services under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	2,408	63.72%
C.42 Total number of families receiving services under the Supplemental Nutrition Assistance Program (SNAP), formerly referred to as Food Stamps	2,466	65.26%

Job Training/School

	# of families at enrollment	Percentage of families
C.43 Of the number of two-parent families, the number of families in which:		
a. Both parents/guardians are in job training or school	47	2.4%
b. One parent/guardian is in job training or school	207	10.59%
c. Neither parent/guardian is in job training or school	1,701	87.01%
C.44 Of the number of single-parent families, the number of families in which:		
a. The parent/guardian is in job training or school	251	13.76%
b. The parent/guardian is not in job training or school	1,573	86.24%

Parent/Guardian Education

	# of families at enrollment	Percentage of families
C.45 Of the total number of families, the highest level of education obtained by the child's parent(s) / guardian(s)		
a. An advanced degree or baccalaureate degree	307	8.12%

C.45 Of the total number of families, the highest level of education obtained by the child's parent(s) / guardian(s)	# of families at enrollment	Percentage of families
b. An associate degree, vocational school, or some college	1,239	32.79%
c. A high school graduate or GED	1,682	44.51%
d. Less than high school graduate	519	13.73%

Family Services

C.46 Report the number of families who received the following services since last year's PIR was reported	# of families at enrollment	Percentage of families
a. Emergency/crisis intervention such as meeting immediate needs for food, clothing, or shelter	942	24.93%
b. Housing assistance such as subsidies, utilities, repairs, etc.	710	18.79%
c. Mental health services	805	21.3%
d. English as a Second Language (ESL) training	103	2.73%
e. Adult education such as GED programs and college selection	518	13.71%
f. Job training	425	11.25%
g. Substance abuse prevention	104	2.75%
h. Substance abuse treatment	101	2.67%
i. Child abuse and neglect services	237	6.27%
j. Domestic violence services	118	3.12%
k. Child support assistance	194	5.13%
l. Health education	3,250	86%
m. Assistance to families of incarcerated individuals	98	2.59%
n. Parenting education	3,051	80.74%
o. Relationship/marriage education	39	1.03%
C.47 Of these, the number that received at least one of the services listed above	3,497	92.54%

Father Involvement

	# of programs	
C.48 Program that have organized and regularly scheduled activities designed to involve fathers / father figures	21	
	# of children at end of enrollment	Percentage of children
a. Number of enrolled children whose fathers / father figures participated in these activities	994	24.39%

Homelessness Services

	# of families at enrollment	Percentage of families
C.49 Total number of families experiencing homelessness that were served during the enrollment year	401	10.61%
	# of children at end of enrollment	Percentage of children
C.50 Total number of children experiencing homelessness that were served during the enrollment year	485	11.9%
	# of families at enrollment	Percentage of families
C.51 Total number of families experiencing homelessness that acquired housing during the enrollment year	165	4.37%

Foster Care and Child Welfare

	<i># of children at end of enrollment</i>	<i>Percentage of children</i>
C.52 Total number of enrolled children who were in foster care at any point during the program year	179	4.39%
C.53 Total number of enrolled children who were referred to Head Start/Early Head Start services by a child welfare agency	120	2.94%

Report Filters

Filter Name	Filter Value
Program Year	2015
Program Types	HS, EHS, Migrant HS, Migrant EHS, AIAN HS, AIAN EHS
States	ME

Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook



Our Child Development Philosophy

The fundamental goal of Head Start, Early Head Start and child care is to provide a safe, stimulating and caring environment for all children. The three major components to reach this goal are:

- Health and Nutrition
- Family and Community Services
- Educational Program.

Within our Health and Nutrition component:

- A well-balanced and nutritious breakfast, lunch and snack (in childcare programs) are provided each day at no additional charge. Meal options may vary depending on your child's schedule and program.
- Whole milk is offered to children from 12 months thru 23 months and low-fat or non-fat milk is offered to children ages 2-5 or a substitute nutritionally equivalent to cow's milk. **A written explanation is available to parents upon request.*
- Nourishing, appealing food that meets the needs of children is served family-style in a pleasant atmosphere.
- The staff eat with the children and encourages them to eat well and use acceptable table manners.
- Adults set good examples by trying all foods, engaging in pleasant conversation and having a positive attitude about food and mealtimes.
- The children are introduced to new foods along with the foods they already enjoy; they are encouraged to try new foods, but are never forced to eat.
- All meal components are available to children during meals, and are not withheld or used for punishment or rewards.
- All adults participating in mealtime activities will be expected to follow the same guidelines as children.
- We talk about the basic food groups, vitamins, minerals, and good nutritional habits.
- Infants and young toddlers are fed on demand and infants are held while bottle feeding.
- Our menus are monitored by our Nutrition Manager, a licensed dietician, and posted monthly for parents' information.
- Children wash hands before each meal and brush their teeth after eating; this is one of the many ways children are learning self-help skills.

Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook

Please feel free to share recipes and menu ideas as a way of bringing family culture and traditions into the school.

Because good health and wellness greatly impact your child's learning, development and ability to participate fully in the program, staff work with parents to ensure that basic health screenings are completed for each child enrolled in our programs. These screenings include:

- Physical exams
- Dental exams
- Daily health check
- Hearing and vision screenings
- Height and weight screenings



Each center has a written plan for emergencies, fire drills and evacuations should they become necessary. Centers regularly practice the fire and evacuation drills in accordance with Head Start, State of Maine Child Care Licensing, and CFO standards.

- All current CFO Emergency Procedures are housed in the Emergency Flipbook Publication.
- Flipbooks are located and posted in all classrooms, offices, and relevant agency spaces.
- All programs maintain an Emergency Relocation Shelter Agreement to assure that staff and clients have a safe place to seek shelter in the event of a site evacuation.
- In the event of a site evacuation center staff will contact parents with our location and instructions on how to pick up their children.
- Daily environmental health and safety checks are completed.
- The center should be notified of any changes of address, place of employment, telephone number and emergency contact information. Current information is vital in the event of emergency.



Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook

Our second component is Parent, Family and Community Engagement. Within the Family and Community Services component:

- We realize that the family surrounding the child is his/her major focus and thus it is very important to be aware of what is happening in each child's life.
- Important information is shared between staff and parents daily as they drop their child off in the morning and pick him/her up in the afternoon.
- Parents are asked to share information about their child that might help the teachers anticipate his/her needs while at the center.
- We develop Family Partnership Agreements and continue to work with families throughout the year to meet their goals and aspirations. Again children benefit greatly when family needs and goals are met.
- We have numerous resources in our center, which we hope you will use as you wish.

Our third component is the Educational Program. Using the *HighScope* curriculum, our teachers develop activity plans for individual children and groups of children. Within the Education component:

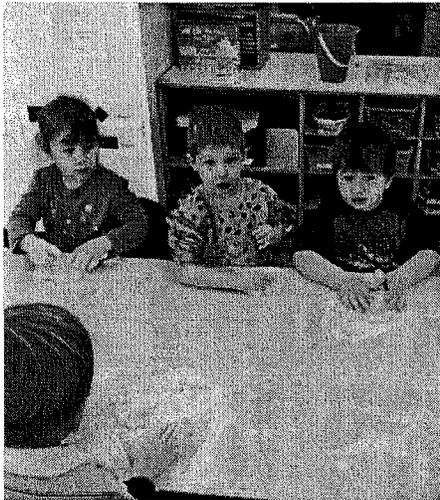
- All children are screened for motor, cognitive, language skills and social emotional development.
- Information gathered through the screenings is used as we plan the program to meet each child's individual needs and strengths.
- Our program focuses on all aspects of the child's development--social, emotional, intellectual, physical.

To support children's overall development we plan the following:

- Our center is set up so children can easily locate any particular area. The activity centers may include: Dramatic Play, Blocks, Sensory Play, Library, Science, Creative Arts, and Outdoor Play.
- The curriculum is based on the individual growth and development of each child. Children learn by doing and through active involvement with their environment and responsive, nurturing adults.
- The entire staff and parents are involved in developing the curriculum, which is posted in the classroom.
- Parents' ideas are welcomed and appreciated. Parents and staff will work together to assess the program, curriculum, and cultural needs of enrolled children and families throughout the year.

Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook



Our curriculum includes the developmental areas of intellectual, emotional, social and physical growth based on Maine Department of Education's Maine Early Learning and Development Standards and the National Head Start Child Development and Early Learning Framework. Our curriculum, materials and activities all support children's intellectual growth and school readiness. The children's interactions with each other and adults, participation in games and conversation throughout the day promote social growth. Children's ability to control their behavior, express their feelings, laugh and play with others are aspects of emotional growth. Physical growth is developed through outside play, block play, games, table top toys, cutting and even eating lunch. During almost any time of our day, one can see goals being reached in all four developmental areas. For children of all ages and developmental stages, we strive to create individualized curriculum that enhances growth and development. **A copy of the written curriculum plan is available to parents upon request.*

Frequently Asked Questions

What will my child need at the center?

- Each child should have a change of clothes which can be left at the center. We play hard and get messy!
- We also want children dressed for the weather; we do go outside on most days so snow gear in the winter is necessary. (Let us know if you need help finding or getting some).
- It is also helpful for children to have shoes to wear inside, along with boots or sneakers (something sturdy) for outside.
- Feel free to label your child's clothing; you can imagine that it can get mixed up.
- All of the children have a cubby to keep their personal belongings in, therefore they do not need to (nor should they) bring a bag or backpack each day. As a safety measure, we

Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook

require that all backpacks are out of children's reach so it is much easier for your child if they do not bring one at all. If you find it necessary to bring a bag on a given day then please speak to the teacher and they will help find a safe place to store it.

- Please do not bring food into the center. Breakfast and lunch (or snack) is provided by us. We eat family style and all children eat the same meal (unless there is a medical reason why they shouldn't). You will be provided with a menu each month; children love to try new foods and along with the actual meal time you will find nutrition activities occurring throughout the month.
- Diapers and wipes are provided to our Early Head Start participants in our Infant and Toddler classrooms. Other program participants who need assistance in acquiring these items should speak with a staff person. It is our wish to accommodate parent's preferences for their children as much as is feasible within the context of our programs. If your child requires special non-medically documented formulas or requirements, you may be required to furnish them.
- To protect children from the sun and biting insects, we provide generic broad-spectrum sunscreen with a minimum SPF 30 and insect repellent containing DEET (American Academy of Pediatrics recommendation). If there is a specific brand of insect repellent or sunscreen you prefer, parents are welcome to provide their own. Any sunscreen or insect repellent supplied by parents, must be in the original container of which it was purchased.
- A rest or nap time is part of our daily schedule in our full day programs. We provide cots or cribs and sheets; pre-school children are welcome to bring a special blanket or pillow from home. Rest time is generally scheduled for after lunch in the preschool classrooms. In our infant and toddler classrooms the children sleep according to their individual schedules. CFO follows safe sleep practices put forth from the American Academy of Pediatrics.

What does a typical day look like?

The staff follows a specific daily schedule which is posted in each room. While flexibility is important with young children, we try to stay within this schedule as much as possible, except for special events, because children gain a sense of security when they know what to expect. A sample full day schedule follows:

- Center Opens
- Open Discovery Time
- Group time, Breakfast
- Discovery Time and Outdoor Play
- Group Time, Lunch
- Rest/Quiet Time
- Wake up and Snack
- Open Discovery Time or Outdoor Play

Child and Family Opportunities, Inc.

Excerpt from 2015-2016 Parent Handbook

How do you discipline the children?

- We believe discipline with love, acceptance, and consistency preserves the child's self-esteem and helps the child gain internal controls.
- The staff uses a positive approach to discipline, telling children what they can do, rather than what they cannot do.
- When correcting the children, we always try to say "chairs are for sitting" instead of "get down" or "no." This allows children to correct their behavior without making them feel negative about themselves for doing something wrong.
- Teachers assist children to learn coping and problem-solving skills so they can learn to be responsible for their own actions. Encouraging role modeling of verbal communications to resolve conflict is a priority of center staff.

The center has a basic set of rules for inside and outside play. Within these, however, we try to be flexible and encourage children to explore their environment, socialize with their friends and develop their own individual interests. If a child's behavior persistently interferes with his/her ability to learn or creates a safety concern to him or herself or others, the parent(s) will be notified and a plan will be formulated. We believe only constructive means of discipline should be used. Corporal punishment, including spanking or shaking, as well as shaming or humiliating, and unusual confinement of a child is prohibited. **Our complete Philosophy on Discipline is available to parents upon request.*



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November 9, 2015

Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333

Dear Senator Brakey, Representative Gattine and distinguished members of the Joint Standing Committee on Health and Human Services,

My name is Lori Moses, and I am here today to speak about child care and the Fund for Healthy Maine. I have worked in the early care and education field in Maine since 1989 in several different capacities. Currently, I am the Executive Director of Catherine Morrill Day Nursery, an accredited child care center in downtown Portland, which is licensed for 85 children and serves children 6 weeks to 5 years. We have prioritized low-income and at-risk children and families since 1919. I believe that I have first-hand knowledge of how the Fund for Healthy Maine has played a critical role in supporting Maine's working parents as well as Maine's early childhood and school-age child care system, and I would like to share my perspective with you today.

The Fund for Healthy Maine has proven to be a critical investment in the health and well-being of Maine children, families and communities. There are so many reasons why investing in the early years is important, backed by neuroscience, early intervention and economics. From my understanding, a significant portion (\$1.9M a year) of Maine's investment in early childhood education (besides public pre-k) rests with the Fund for Healthy Maine to provide the match and maintenance-of-effort dollars that are required to draw down federal Child Care Development Funds. These dollars essentially fund Maine's early care and education and school-age care system, including child care vouchers for non-TANF working families, the licensing of child care homes and facilities, and Maine's early childhood professional development system, Maine Roads to Quality.

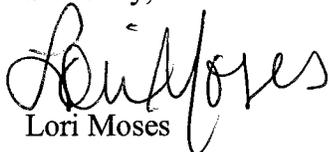
Quality child care enables parents to work or to go school while providing young children with the early childhood education experiences needed for healthy development. There have been numerous studies that show that child care assistance leads to stable employment, which is beneficial for both the parent and the child. The recently released *2015 Education Indicators for Maine* report (<http://www.educatemaine.org/programs/indicators>) emphasized that children who attend quality early learning programs are more likely to achieve in school, and in years to come, be gainfully employed and earn more money. They are less likely to need remediation, to enter the criminal justice system, or to need public assistance. Since Maine is an aging state, we need

every child to reach his or her potential in order for them to graduate and complete secondary education in order to have the requisite skills of the 21st century workforce.

Having worked in Maine's child care field for so long, I have experienced significant changes. Recent years have seen the dissolution of Maine's Child Care Resource Development Centers, family child care networks and Child Care Plus ME, which supported children in child care with developmental and behavioral needs. The reimbursement rates for vouchers have been lowered for quality child care from the 75th percentile of the most recent Market Rate Study to the 50th percentile. At Catherine Morrill, we absorb around \$24,000 in fee reductions a year in order to accept low income families. We are fortunate to receive gap funding from the United Way of Greater Portland, or we would not be able to afford to accept third-party payments. This, in turn, would result in non-private pay families having no access to our program. Additionally, I have never seen families struggle more with the process for determining eligibility for the voucher program, coupled by inaccurate information from the Department, and delays and mistakes in payments. Our state voucher payments are usually 6-8 weeks behind from when the service was provided, periodically forcing us to rely on a line of credit to make payroll or pay our bills. Without the voucher, I have witnessed parents who want desperately to work forced to make other choices, especially when there were wait lists for these vouchers. There's no other way to say it: child care vouchers are essential for low-to-moderate income families to be able to work. And if they can't work, their children and our society will suffer.

Please recognize the importance that the Fund for Healthy Maine has on Maine's economy and on our child care system. Please continue, at a minimum, to maintain the current level of Fund for Healthy Maine support to access Child Care Development Fund dollars.

Sincerely,



Lori Moses

Executive Director

catherinemorrill.director@gmail.com

CHILD CARE AND HEAD START
KEY COMPONENTS OF THE FUND FOR A HEALTHILY MAINE

The Fund for a Healthy Maine has allowed thousands of Maine Children to access quality pre-school, school age, and Head Start programs in virtually every community in Maine. This, in turn, has proven to be an essential investment in the health and well being of children, families and communities. Current science and thought reinforces the benefits of this investment, as noted in the following.

- **"High Quality Early Education and Child Care For children improves their health, and promotes their learning and development."**
American Academy of Pediatrics Study published 2005.

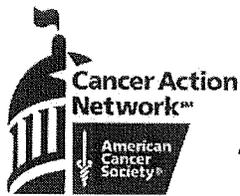
- **"Communities thrive, primarily, when they offer economic and social opportunity to residents, a safe and constructive environment for children and a mix of services, recreation and convenience. More and better quality child care in high quality facilities contribute to those fundamental needs."**
Freddie Mac Foundation/Community Investment Collaborative for Kids Study published 2005.

- **"If we want our children to be smart enough to say no to tobacco, then Legislators need to be smart enough to say yes to making child care and after school programs part of our national strategy for keeping kids healthy and tobacco free."**

Dr. T. Berry Brazelton, Professor Emeritus of Pediatrics at Harvard Medical School

- **"As Law Enforcement Officials, we respectfully ask you to invest in programs like Head Start and other Early Care and Education for Pre-School and After-School Programs for Older Kids."**

A Statement from a National, Bipartisan Non Profit Anti-Crime Organization of over 2,000 Police Chiefs, Sheriffs, Prosecutors and Victims of Violence



To: Members of the Health and Human Services Committee
Fr: Hilary Schneider, Director of Government Relations, American Cancer Society Cancer Action Network; Becky Smith, Director of Government Relations, American Heart Association/American Stroke Association; Lance Boucher, Director of Public Policy, American Lung Association of the Northeast
Date: November 6, 2015
Re: Fund for a Healthy Maine Review re: Maine's public health care and preventive health priorities and goals

As your committee works to identify or review the state's current public health care and preventive health priorities and goals, our organizations would appreciate you taking the following information into consideration.

In 2013, 7,556 Mainers died from cancer, heart disease, lung disease (including COPD and asthma), or stroke.¹ As you can see in the table below, cancer, heart disease, lung disease, and stroke make up four of the top five leading causes of death in Maine.²

Maine Leading Causes of Death, 2013³

Cause of Death	Total Deaths	State Death Rate	State Rank	U.S. Death Rate
Cancer	3,227	175.2	12	163.2
Heart Disease	2,807	152.3	31	169.8
Chronic Respiratory Diseases	902	49.1	16	42.1
Accidents	644	42.6	29	39.4
Stroke	620	33.4	36	36.2
Alzheimer's Disease	401	21.6	29	23.5
Diabetes	373	20.4	28	21.2
Influenza/Pneumonia	258	14	38	15.9
Kidney Disease	252	13.6	25	13.2
Suicide	245	17.4	11	12.6

Note: State death rate is bold where it is higher than the U.S. death rate.

¹ US CDC, Stats of the State of Maine, http://www.cdc.gov/nchs/pressroom/states/ME_2015.pdf, accessed on October 29, 2015.

² The top 5 causes of death of Mainers are cancer, heart disease, chronic lower respiratory diseases (i.e., lung disease), accidents and stroke (listed in order of prevalence).

³ US CDC, Stats of the State of Maine, http://www.cdc.gov/nchs/pressroom/states/ME_2015.pdf, accessed on October 29, 2015.

It is estimated that 8,810 Mainers will be diagnosed with cancer and that 3,300 will die from the disease this year. As of January 1, 2014, the American Cancer Society estimated that there were 79,400 cancer survivors living in Maine. In 2010, 7.5%, or nearly 72,000 of Maine's adults (not living in long term care facilities), reported that their doctor diagnosed them with coronary heart disease. Twenty-nine thousand had a history of stroke.

Much of the suffering and death from all of these diseases could be prevented by more systematic efforts to reduce tobacco use, improve diet and physical activity, reduce obesity, expand the use of established screening tests, and regulate cholesterol and blood pressure. Tobacco use is the leading preventable risk factor for all four of these diseases. The American Cancer Society estimates that in 2015, about 171,000 cancer deaths in the U.S. will be caused by tobacco smoking alone. Tobacco use increases the risk of at least 15 types of cancer, and 30 percent of all cancer deaths, including 80 percent of lung cancer deaths, can be attributed to using tobacco. In addition, Maine's smoking attributable mortality rate is higher than the national average, due in part to Maine's adult smoking rate being higher than the national average.

The World Cancer Research Fund estimates that approximately one-quarter to one-third of the 1.7 million cancer cases expected to occur in the United States in 2015 can be attributed to poor nutrition, physical inactivity, overweight and obesity.

Regular use of established cancer screening tests can prevent cancer through identification and removal or treatment of pre-malignant abnormalities. They can also improve survival and decrease mortality by detecting cancer at an early stage when the disease is more treatable. Also, 1 in 3 adults have high blood pressure. Blood pressure and cholesterol screenings are the first step to reducing the risk of cardiovascular disease and stroke.

It is important to recognize that while there is substantial evidence supporting the types of programs that have proven effective at reducing preventable disease risk factors, there is not one single "silver bullet" solution. Individual health behaviors are influenced and supported by a complex set of factors that not only relate to personal attitudes and beliefs, but also relate to the built environment, culture, race, education, income and many other factors. Social, economic, and legislative factors profoundly influence individual health behaviors. Examples of this include:

- The price and availability of healthy foods and tobacco products
- Incentives and opportunities for regular physical activity in schools and communities
- Content of advertising aimed at children
- Availability of insurance coverage for screening tests and tobacco addiction

Examples of evidence-based programs that decrease preventable risk factors for heart disease, lung disease and cancer include:

- Increases in tobacco excise taxes, restrictions on tobacco use in public places, reducing access barriers to tobacco cessation, and effective media campaigns that counter tobacco industry marketing.
- Establishment of strong nutrition standards for all foods and beverages sold and served in school, increases in the quality and quantity of physical education in K-12 schools, supplemented by additional school-based physical activity, increases in funding for research and interventions focused on improving nutrition, physical activity and reducing obesity, and reducing the marketing of unhealthy foods and beverages, particularly to youth.
- Efforts to improve access to and utilization of recommended screening tests (e.g., mammograms, pap tests, lung and colorectal cancer screening, blood pressure, and cholesterol).
- Effective sun safety community programs in schools and recreation/tourism, which include education about sun safety and providing physical environments (e.g., shaded areas) that support sun safety.
- Well-funded and planned Complete Streets, Safe Routes to School and healthy food financing initiatives.
- Increases in health coverage for all Mainers for prevention and early detection of cancer, heart disease, and lung disease.

Attached is a summary of the U.S. CDC's most-recently updated version of its evidence-based guide for state investment in tobacco control, *Best Practices for Comprehensive Tobacco Control Programs*. Also, attached is a fact sheet from ACS CAN on the link between healthy eating, active living and cancer as well as evidence-based policy strategies related to this topic and one from the American Heart Association with prevention strategies to reduce cardiovascular disease.

We applaud the Health and Human Service Committee's hard work and efforts to tackle the task of reviewing the Fund for a Healthy Maine allocations in light of the state's current public health priorities. However, we caution you from relying on information that is not evidence-based. Each of our organizations holds evidence-based public health at the core of our mission. As such, we believe it is important that you know that our three organizations, as well as the Maine Medical Association, the Maine Osteopathic Organization, and the Maine Public Health Association withdrew support from the State Health Improvement Plan (SHIP) due to actions that were taken during the drafting of this report that resulted in the removal of evidence-based strategies and the addition of strategies that are not evidence-based. While all of our organizations were invited and participated in the development of the plan, we regretfully were compelled to withdraw our support in February 2014 as outlined in the attached communication to Commissioner Mayhew.

Thank you for the opportunity to provide these comments as your Committee undertakes its work. We would be happy to answer any questions you may have about these comments or provide you with additional information.

for Comprehensive Tobacco Control Programs

Defines the specific annual investment needed for state comprehensive tobacco control programs to implement what we know works to improve health.

Core Comprehensive Tobacco Control Program Components:

1. State and Community Interventions
2. Mass-Reach Health Communication Interventions
3. Cessation Interventions
4. Surveillance and Evaluation
5. Infrastructure, Administration, and Management

What is a Comprehensive Tobacco Control Program?

A comprehensive tobacco control program is a statewide, coordinated effort to establish smoke-free policies and social norms, to promote quitting and help tobacco users quit, and to prevent tobacco use initiation. These programs reduce tobacco-related disease, disability, and death.

Goals:

1. Prevent tobacco use initiation among youth and young adults
2. Promote quitting among adults and youth
3. Eliminate exposure to secondhand smoke
4. Identify and eliminate tobacco-related disparities

Comprehensive tobacco control programs work and are a public health "best buy."

- Investments in comprehensive tobacco control programs have high return on investment.
- Sustained funding for these programs improves health and leads to even greater returns on investment.

CDC's Best Practices-2014 Recommended Funding Levels by Program Component

Recommended National Investment	Total	State and Community Interventions	Mass-Reach Health Communication Interventions	Cessation Interventions	Surveillance & Evaluation	Infrastructure, Administration, & Management
Total Level (dollars in millions)	Minimum: \$2,325.3 Recommended: \$3,306.3	Minimum: \$856.7 Recommended: \$1,071.0	Minimum: \$370.1 Recommended: \$532.0	Minimum: \$795.1 Recommended: \$1,271.9	Minimum: \$202.6 Recommended: \$287.7	Minimum: \$100.8 Recommended: \$143.7
Per Person (based on total state population)	Minimum: \$7.41 Recommended: \$10.53	Minimum: \$2.73 Recommended: \$3.41	Minimum: \$1.18 Recommended: \$1.69	Minimum: \$2.53 Recommended: \$4.05	Minimum: \$0.65 Recommended: \$0.92	Minimum: \$0.32 Recommended: \$0.46

FAST FACTS

Tobacco use is the *single most preventable cause of death and disease.*

1 in 4 adults uses tobacco.

There is no risk-free level of secondhand smoke exposure.

Tobacco use costs the United States *\$289-\$332.5 billion in direct health care costs and productivity losses every year.*

Executive Summary

Tobacco use is the single most preventable cause of disease, disability, and death in the United States. Nearly one-half million Americans still die prematurely from tobacco use each year, and more than 16 million Americans suffer from a disease caused by smoking. Despite these risks, approximately 42.1 million U.S. adults currently smoke cigarettes. And the harmful effects of smoking do not end with the smoker. Secondhand smoke exposure causes serious disease

and death, and even brief exposure can be harmful to health. Each year, primarily because of exposure to secondhand smoke, an estimated 7,330 nonsmoking Americans die of lung cancer and more than 33,900 die of heart disease. Coupled with this enormous health toll is the significant economic burden. Economic costs attributable to smoking and exposure to secondhand smoke now approach \$300 billion annually.

Fifty years have passed since the 1964 Surgeon General's report on smoking and health concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." There now is a robust evidence base for effective tobacco control interventions. Yet, despite this progress, the United States is not currently on track to achieve the *Healthy People 2020* objective to reduce cigarette smoking among adults to 12% or less by the year 2020. A 2007 Institute of Medicine (IOM) report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The two-pronged strategy for achieving this goal includes: 1) strengthening and fully implementing currently proven tobacco control measures; and 2) changing the regulatory landscape to permit policy innovations. Foremost among the IOM recommendations is that each state should fund a comprehensive tobacco control program at the level that the Centers for Disease Control and Prevention (CDC) recommends.

Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, as well as tobacco-related diseases and deaths. A comprehensive statewide tobacco control program is a coordinated effort to establish smokefree policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to

protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including: increasing the unit price of tobacco products; implementing comprehensive smokefree laws that prohibit smoking in all indoor areas of worksites, restaurants, and bars, and encouraging smokefree private settings such as multiunit housing; providing insurance coverage of evidence-based tobacco cessation treatments; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multicomponent interventional efforts that integrate the implementation of programmatic and policy initiatives to influence social norms, systems, and networks.

CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014* is an evidence-based guide to help states plan and establish comprehensive tobacco control programs. This edition updates *Best Practices for Comprehensive Tobacco Control Programs—2007*. The 2014 edition describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of state investment to reach these goals and to reduce tobacco use in each state.

These individual components are most effective when they work together to produce the synergistic effects of a comprehensive statewide tobacco control program. On the basis of evidence of effectiveness documented in the scientific literature and the experiences of state and local programs, the most effective population-based approaches have been defined within the following overarching components.

I. State and Community Interventions

State and community interventions include supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. The social norm change model presumes that lasting change occurs through shifts in the social environment—initially or ultimately—at the grassroots level across local communities. State and community interventions unite a range of integrated activities, including local and

statewide policies and programs, as well as initiatives to eliminate tobacco-related disparities.

The most effective state and community interventions are those in which specific strategies for promoting tobacco use cessation, preventing tobacco use initiation, and eliminating exposure to secondhand smoke are combined with mass-reach health communication interventions and other initiatives to mobilize communities and to integrate these strategies into synergistic and multicomponent efforts.

II. Mass-Reach Health Communication Interventions

An effective state-level, mass-reach health communication intervention delivers strategic, culturally appropriate, and high-impact messages through sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program. Typically, effective health communication interventions and countermarketing strategies employ a wide range of paid and earned media, including: television, radio, out-of-home (e.g., billboards, transit), print, and digital advertising at the state and local levels; promotion through public relations/earned media efforts, including press releases/conferences, social media, and local events; health promotion activities, such as working with health care professionals and other

partners, promoting quitlines, and offering free nicotine replacement therapy; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Innovations in health communication interventions include the ability to target and engage specific audiences through multiple communication channels, such as online video, mobile Web, and smartphone and tablet applications (apps). Social media platforms, such as Twitter and Facebook, have facilitated improvements in how messages are developed, fostered, and disseminated in order to better communicate with target audiences and allow for relevant, credible messages to be shared more broadly within the target audiences' social circles.

III. Cessation Interventions

Comprehensive state tobacco control program cessation activities can focus on three broad goals: (1) promoting health systems change; (2) expanding insurance coverage of proven cessation treatments; and (3) supporting state quitline capacity.

Health systems change involves institutionalizing cessation interventions in health care systems and seamlessly integrating these interventions into routine clinical care. These actions increase the likelihood that health care providers will consistently screen patients for tobacco use and intervene with patients who use tobacco, thus increasing cessation. Expanding cessation insurance coverage removes cost and administrative

barriers that prevent smokers from accessing cessation counseling and medications, and increases the number of smokers who use evidence-based cessation treatments and who successfully quit. Expanding cessation insurance coverage also has the potential to reduce tobacco-related population disparities.

Quitlines potentially have broad reach, are effective with and can be tailored to diverse populations, and increase quit rates. Because state quitline services are free, remove time and transportation barriers, and are confidential, they are one of the most accessible cessation resources. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.

IV. Surveillance and Evaluation

Surveillance is the process of continuously monitoring attitudes, behaviors, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability.

Publicly financed programs need to have accountability and demonstrate effectiveness, as well as have access to timely data that can be used for program improvement and decision making.

Therefore, a critical infrastructural component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document key short-term, intermediate, and long-term outcomes within populations. Data from surveillance and evaluation systems can be used to inform program and policy directions, demonstrate program effectiveness, monitor progress on reducing health disparities, ensure accountability to those with fiscal oversight, and engage stakeholders.

V. Infrastructure Administration and Management

A comprehensive tobacco control program requires considerable funding to implement. Therefore, a fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and it enables programs to plan

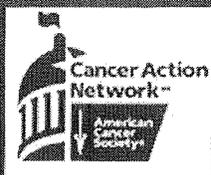
their strategic efforts, provide strong leadership, and foster collaboration among the state and local tobacco control communities.

An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance, and training.

The primary objectives of the recommended statewide comprehensive tobacco control program are to reduce tobacco use and the personal and societal burdens of tobacco-related disease and death. Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. The longer states invest in such programs, the greater and quicker the impact.

Implementing comprehensive tobacco control programs at the levels of investment outlined in this report would have a substantial impact. As a result, millions of fewer people in the United States would smoke and hundreds of thousands of premature tobacco-related deaths would be prevented. Long-term investments would have even greater effects.

We know what works to effectively reduce tobacco use, and if we were to fully invest in and implement these proven strategies, we could significantly reduce the staggering toll that tobacco takes on our families and in our communities. We could accelerate the declines in cardiovascular mortality, reduce chronic obstructive pulmonary disease, and make lung cancer a rare disease. With sustained implementation of state tobacco control programs and policies, the *Healthy People 2020* objective of reducing adult smoking prevalence to 12% or less by 2020 could be attainable.



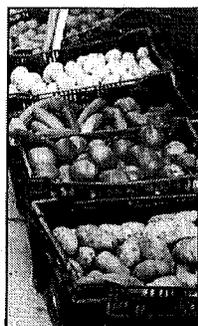
Healthy Eating, Active Living, and Cancer

Making healthy lifestyles a national priority

The Cancer Link

Obesity, physical inactivity, and poor nutrition are major risk factors for cancer, second only to tobacco use. Up to one third of the estimated 589,430 cancer deaths in the US this year can be attributed to poor diet, physical inactivity, and excess weight. Currently, approximately two in three adults and one in three youth are overweight or obese.

Excess weight is associated with increased risk for several common cancers, including colon, esophageal, kidney, pancreatic, endometrial, and postmenopausal breast cancer. The biological link between excess weight and cancer is believed to be related to multiple factors including fat and sugar metabolism, immune function, hormone levels and proteins that affect hormone levels, and other factors related to cell growth. Maintaining a healthy body weight throughout life is key to reducing cancer risk.



Nutrition

Poor nutrition and the consumption of high-calorie foods and beverages are major contributors to excess weight and increase the risk of cancer. The American Cancer Society (ACS) recommends consuming a healthy diet, with an emphasis on plant foods, in order to reduce cancer risk. Recommendations include choosing foods and beverages in amounts that achieve and maintain a healthy weight, limiting consumption of processed and red meats, consuming fruits and vegetables and whole grains instead of refined grain products, and limiting alcohol intake. Recent research has found that non-smoking adults who followed the ACS guidelines for weight control, diet, physical activity, and alcohol lived longer and had a lower risk of dying from cancer and cardiovascular disease.

Physical Activity

Regular physical activity helps maintain a healthy body weight by balancing caloric intake with energy expenditure. Physical activity may also reduce the risk of breast, colon, endometrial, and advanced prostate cancer, independent of body weight. ACS recommends that adults engage in at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity activity each week and that children and adolescents engage in at least 1 hour of moderate- or vigorous-intensity activity each day. Physical activity may also be beneficial after a cancer diagnosis, reducing the risk of recurrence or death and improving quality of life.

Combating the Problem

Despite the evidence linking excess weight, poor nutrition, and physical inactivity to increased cancer risk, the majority of Americans are not meeting recommended nutrition and physical activity targets. Social, economic, environmental, and cultural factors strongly influence individual choices about diet and physical activity. Reversing obesity trends and reducing the associated cancer risk will require a broad range of strategies that include policy and environmental changes that make it easier for individuals to regularly make healthy diet and physical activity choices.

The American Cancer Society Cancer Action Network (ACS CAN) is focused on creating healthy social and physical environments and providing consumers with clear, useful information that support making healthy lifestyle choices.

At the Federal Level

ACS CAN's federal advocacy work is largely focused on protecting and implementing recent improvements in school nutrition and food labeling, increased access to evidence-based obesity screening and weight loss interventions, and funding for evidence-based prevention programs.

Affordable Care Act

The law contains several key prevention and wellness provisions including:

- **Calorie labeling of standard menu items in chain restaurants**, supermarket cafes, convenience stores, and other ready-to-eat food retailers and of items in certain vending machines.
- **Coverage of preventive health services, including obesity screening and counseling and behavioral interventions for weight loss, with no cost sharing** through private insurance plans in the health insurance exchanges and Medicare, and an incentive for states to cover them in Medicaid.
- **The Prevention and Public Health Fund**, providing \$1 billion per year through FY 2017 and increased amounts thereafter for prevention, wellness, and public health activities. A significant portion of this money has been spent on community-based initiatives focused on making community, school, and worksite environments healthier.

ACS CAN strongly supports the full implementation of and opposes efforts to dismantle these key provisions.



Child Nutrition Reauthorization

ACS CAN strongly supported the last bill to reauthorize the federal child nutrition programs, the Healthy, Hunger-Free Kids Act of 2010. This law includes a number of ACS CAN-supported provisions to improve school nutrition and wellness:

- **Updated evidence-based national nutrition standards for school meals**, coupled with increased federal reimbursement;
- **National evidence-based nutrition standards for foods sold in schools during the school day** outside of the school meal programs, including those in vending machines, school stores, and a la carte; and
- **Strengthened local school wellness policies** that require school districts to set goals for food marketing, physical activity, nutrition education and promotion, and foods sold outside of meal programs.

As Congress seeks to reauthorize these programs, ACS CAN will advocate to protect and support continued implementation of the recent improvements in school nutrition and wellness.

At the State & Local Levels

There are also many ways that state and local governments can improve nutrition and increase physical activity through policy change.

- **Quality physical education** for students in grades K-12 provides them with structured physical activity and the information and skills to be physically active for life. Physical education should be required for all students, supplemented with additional school-based physical activity, such as recess, classroom physical activity, intramural sports, and walk-to-school programs, and include knowledge and fitness assessments, to ensure it is having the intended health benefits.
- **Federal school nutrition standards** provide a national baseline, but have some exemptions and will not apply to foods sold in schools after school hours. States and localities should fully implement the federal standards and close loopholes.
- **Food and beverage marketing** influences children's food and beverage beliefs, preferences, and consumption decisions. The marketing to youth of unhealthy foods and beverages should be curtailed, including being prohibited in schools and other youth-focused venues.
- **Funding for research and evidence-based interventions** to improve nutrition, increase activity, and achieve a healthy weight should be increased at all levels of government.

Contributions or gifts to the American Cancer Society Cancer Action Network are not tax deductible.

2015 American Cancer Society Cancer Action Network

FACTS

An Ounce of Prevention... The Value of Prevention for Cardiovascular Disease

OVERVIEW

Cardiovascular disease (CVD) is the leading cause of mortality in the U.S.¹ The factors that increase risk of CVD can begin in childhood¹ and are influenced by unhealthy environments and behaviors and modifiable risk factors such as smoking, obesity, physical inactivity, high blood pressure, elevated blood cholesterol, and type 2 diabetes.^{1,2} Research has shown that preventative measures are cost-effective and have a valuable impact on public health and the productivity of our nation's workforce.³ The ultimate goal of CVD prevention is to increase the number of years that people can enjoy a high quality of life.

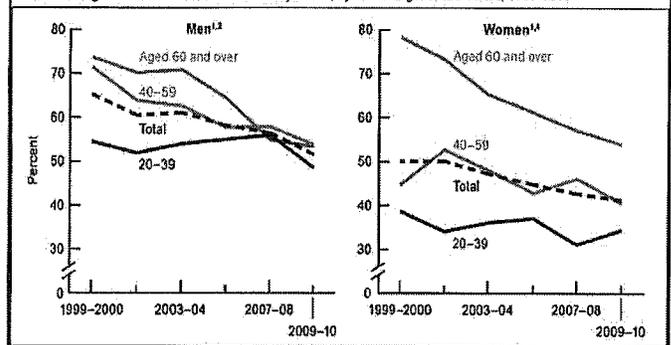
MAKING THE CASE

- Research shows that reducing modifiable risk factors such as hypertension and smoking results in lower incidence of heart attack and stroke.^{1,4}
- Counseling to improve diet or increase physical activity lowers the likelihood of obesity, hypertension, and high cholesterol.^{5,6}
- Comprehensive coverage of tobacco cessation services in the Medicaid program can lead to reduced hospitalizations for heart attacks.⁷ It also leads to \$3.12 in medical savings for each program dollar spent and a \$2.12 return on investment to Medicaid for every dollar spent.^{7,8}
- Approximately 44% of the decline in U.S. age-adjusted CHD death rates from 1980-2000 can be attributed to improvements in risk factors including reductions in total blood cholesterol, systolic blood pressure, smoking prevalence, and physical inactivity.⁹ However, these improvements have been partially offset by increases in body mass index and prevalence of diabetes.⁹
- Estimates of investments in community-based programs to increase physical activity, to improve nutrition, and to prevent smoking and other tobacco use can save \$16 billion on healthcare costs within five years.¹⁰
- Every \$1 spent on workplace wellness, decreases medical costs by about \$3.27 and increases productivity, with absenteeism costs decreasing by about \$2.37.¹¹
- Comprehensive school-based initiatives to promote healthy eating and physical activity can reduce overweight and obesity rates over adolescents' lifespans, decrease medical care costs by \$586 million and have shown a cost effectiveness of about \$900-\$4305 per quality-of-life-year saved.^{12,13,14}

HOW ARE WE DOING?

In 2011-2012, about 92% of adults had at least one of seven risk factors for cardiovascular disease that could be reduced via preventive efforts.¹ Although the prevalence of some risk factors has been decreasing and we are placing a greater emphasis on prevention, we still have a long way to go to reach our goals.¹ In 2013, 43 states had adult obesity rates that equaled or exceeded 25%, with 20 exceeding 30%.¹⁵

Figure 1. Age-adjusted percentage of adults aged 20 and over who have uncontrolled high blood pressure or uncontrolled high LDL cholesterol, or who currently smoke, by sex and age: United States, 1999-2010



SOURCE: Fryer CD, et al. NCHS Data Brief #103: Prevalence of Uncontrolled Risk Factors for Cardiovascular Disease: United States, 1999-2010. August 2012.

- The obesity epidemic is spreading to our children at an alarming rate. 31.8% of children and adolescents ages 2-19 are considered overweight or obese.¹
- The number of obese preschoolers aged 2-5 jumped from 5% to 10% between the late 1970s and 2008.¹⁶ Additionally, research has shown that obese children's arteries resemble those of a middle-aged adult.¹⁷ However, we are making some progress. Recent studies have shown the progression of childhood obesity is slowing in some age groups and in a few major metropolitan areas.¹⁸
- After years of steady progress, declines in the use of tobacco by youth have slowed, however each day more than 3,200 young people under 18 years of age smoke their first cigarette.¹⁹ In 2013, 23.3% of high school students reported current use of at least one tobacco product.²⁰ If the current rate of smoking persists, 5.6 million of today's youth will die prematurely from smoking-related illness. That would represent 1 in every 13 children who are alive today.¹⁹ And children are increasingly using the new smokeless tobacco products entering the market as well as cigars.²¹
- About 1 of 3 U.S. adults (about 80 million people) have high blood pressure.¹ Only 54% of these people have their blood pressure under control.¹

- A sedentary lifestyle contributes to CHD. However, moderate-intensity physical activity, such as brisk walking, is associated with a substantial reduction in chronic disease.^{22,23} It is estimated that for every \$1 invested in walking trails and programs, \$3 could be saved in healthcare costs.^{3,24} Still, 30% of U.S. adults report that they do not engage in any leisure-time aerobic physical activity.¹
- At least 68% of people age 65 or older with type 2 diabetes die from some form of heart disease and 16% die of stroke.¹ Unfortunately, diabetes prevalence increased 90% from 1995-1997 to 2005-2007.²⁵ About 29.2 million have diagnosed or undiagnosed diabetes, and the prevalence of pre-diabetes in the adult population is 35%.^{1,26} Diabetes disproportionately affects African Americans, Mexican Americans, Hispanic/Latino individuals, and other ethnic minorities.¹
- Approximately 27% of U.S. adults have high low-density lipoprotein (LDL), or "bad" cholesterol.¹ Despite cholesterol screening levels reaching as high as 84% in some states, fewer than half of adults with high LDL cholesterol are receiving cholesterol lowering treatment, and only one-in-three with high LDL cholesterol have their condition under control.^{1,27}

THE ASSOCIATION ADVOCATES

In order to achieve its goals of improving the cardiovascular health of the U.S. population by 20% by the year 2020,²⁸ the association advocates for:

- The Prevention and Public Health Fund, maintaining the Fund at funding levels designated through the Affordable Care Act.
- Million Hearts, a national initiative to prevent one million heart attacks and stroke by 2017.
- Comprehensive clean indoor air laws.
- Excise taxes on all tobacco products.
- Funding for comprehensive smoking cessation/prevention programs at all levels and in all coverage plans; for programs that eliminate health disparities; for active transportation such as walking and biking trails, Safe Routes to School, and Complete Streets; coordinated school health programs; and state heart disease and stroke programs.
- Strong implementation of FDA regulation of tobacco.
- Comprehensive health care coverage for preventive services; prevention, diagnosis, and treatment of overweight and obesity;
- Efforts to design workplaces, communities, and schools around active living; integrating physical activity opportunities throughout the day.
- Sports, community recreational opportunities, parks, and green spaces.
- Quality physical education in schools at recommended amounts of activity.
- Accurate measures of obesity and related risk assessments in diverse populations.
- Comprehensive worksite wellness programs.
- Strong local wellness policies in all schools.
- Comprehensive obesity prevention strategies in early childhood and day care programs.
- Access to healthy foods by eliminating food deserts and improving access.

- Updated nutrition standards for all foods sold in school.
- Robust nutrition standards in all government nutrition assistance or feeding programs.
- Strong nutrition and physical activity standards for universal pre-k and child care programs.
- Improved food labeling and menu labeling in restaurants and where foods are sold for immediate consumption.
- The removal of industrial *trans* fats from the food supply and assure the use of healthy replacement oils.
- Less junk food marketing and advertising to children.
- Limiting added sugars and sodium in the food supply.

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² Yang Q, et al. Trends in cardiovascular health metrics and associations with all-cause and CVD mortality among US adults. 2012. *JAMA*. 307:1273-1283.

³ Weintraub, WS, et al. Value of primordial and primary prevention for cardiovascular disease: a policy statement from the American Heart Association. 2011. *Circulation* 124:8: 967-990.

⁴ Spring, B et al. Better Population Health Through Behavior Change in Adults: A Call to Action. 2013. *Circulation* 128:19: 2169-2176.

⁵ Eckel, RH, et al. 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines, 2013. *Journal of the American College of Cardiology*.

⁶ U.S. Preventive Services Task Force. Final Recommendation Statement: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors; Behavioral Counseling. 2014. Available at:

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⁷ Land T, et al. A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease. 2010. *PLoS Med*: 7(12): e1000375.

⁸ Richard P, et al. The return on investment of a Medicaid cessation program in Massachusetts. 2012. *PLoS Med*: 7(1): e29665.

⁹ Ford E, et al. Explaining the decrease in U.S. deaths from coronary heart disease, 1980-2000. 2007. *New Engl J Med*. 356: 2388-2398.

¹⁰ Trust for America's Health. Prevention for a Healthier America: Investments Disease Prevention Yield Significant Savings, Stronger Communities. 2009 Available at: <http://healthiamericans.org/reports/prevention08/Prevention08.pdf>. Accessed on February 17, 2015.

¹¹ Baicker, K., et al. Workplace wellness programs can generate savings. 2010. *Health Affairs*, 29(2). doi: 10.1377/hlthaff.2009.0626

¹² Brown HS et al. The cost-effectiveness of a school-based overweight program. *International Journal of Behavioral Nutrition and Physical Activity*; 4:1: 47.

¹³ Tran BX, et al. Life course impact of school-based promotion of healthy eating and active living to prevent childhood obesity. 2014. *PLoS*; 9(7): e102242.

¹⁴ Wang LY, et al. Long-term health and economic impact of preventing and reducing overweight and obesity in adolescence. 2010. *J Adolesc Health*; 46(5):467-73.

¹⁵ Centers for Disease Control and Prevention. Obesity Prevalence Maps. 2014. Available at: <http://www.cdc.gov/obesity/data/prevalence-maps.html>. Accessed on March 17, 2015.

¹⁶ National Center for Health Statistics. Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008. 2010. Available online at: http://www.cdc.gov/nchs/data/health/obesity_child_07_08/obesity_child_07_08.pdf. Accessed on February 18, 2015.

¹⁷ Le, J, et al. "Vascular age" is advanced in children with atherosclerosis-promoting risk factors. 2010. *Circulation: Cardiovascular Imaging* 3.1: 8-14.

¹⁸ Center for Disease Control and Prevention. Obesity Prevalence Among Low-Income, Preschool-Aged Children—New York City and Los Angeles County, 2003-2011. *MMWR*: 2013; Vol.62, No.2. Available online at: <http://www.cdc.gov/mmwr/pdf/wk/mm6202.pdf>. Accessed on February 18, 2015.

¹⁹ U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. 2014. Available at: http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm. Accessed March 18, 2015.

²⁰ Center for Disease Control and Prevention. Tobacco Use Among Middle and High School Students—United States, 2013. 2014. *Morbidity and Mortality Weekly Report*: 63(45): 1021-1026.

²¹ Centers for Disease Control and Prevention. Tobacco Use Among Middle and High School Students—United States, 2013. 2014. *Morbidity and Mortality Weekly Report*. 63(45):1021-6.

²² Williams PT, et al. Walking versus running for hypertension, cholesterol, and diabetes mellitus risk reduction. 2013. *Arteriosclerosis, thrombosis, and vascular biology*: 33.5: 1085-1091.

²³ American Heart Association. The American Heart Association Physical Activity Recommendations for Adults. 2015. Available at: http://www.heart.org/dlc/groups/heart-public/@wmm/@fd/documents/downloadable/ucm_469557.pdf. Accessed on May 7, 2015.

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Commissioner Mary Mayhew
Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Cc: Dr. Sheila Pinette, Nancy Birkheimer, Debra Wigand

February 24, 2014

Dear Commissioner Mayhew:

After careful review of the final draft of the State Health Improvement Plan (SHIP) that was disseminated to partners on February, 7, 2014, we, collectively, withdraw our support. While it dismays us to do so, each of our organizations holds evidence-based public health at the core of our mission and cannot endorse a plan for the state that does not do the same.

As members of several of the priority workgroups, our organizations volunteered significant time and resources to aid in the development and writing of evidence-based objectives and strategies. As the workgroup charge, contained in materials disseminated for the first tobacco workgroup meeting, stated, "The work group is a selection of subject matter experts for tobacco use reduction in Maine from the public and private sectors, and is expected to lend this expertise for this purpose."

Each workgroup was charged with not only creating these evidence-based objectives and strategies but also with presenting research and evidence that supported each recommendation. It was repeated multiple times that the SHIP is "a plan for the state, not by the state;" this is a document that the MeCDC produces and releases as part of the national accreditation process, it is a non-political plan that various and multiple partners within and outside of the MeCDC will implement. The process of researching, vetting and drafting objectives during workgroups were facilitated and created in that vein. The result was a good plan with reasonable, measurable objectives based in data, research and evidence.

In an email from Nancy Birkheimer dated August 28, 2013, our workgroups were informed that DHHS may not approve the SHIP as written stating that there were "three strategies that we are concerned they [DHHS leadership] may not be comfortable including. We have approval to leave them there for the DHHS leadership to review, but are aware that the sugar-sweetened beverages tax, increases to the tobacco tax and increases to funding for tobacco control may not 'survive' this next step in the approval process. If not, we will let you know." This email also stated that "We are continuing the work on the balance of Maine CDC leading the SHIP process and wanting a state-wide plan that is not only for the agency". This email did not state that other strategies, such as insurance coverage, were concerning.

At that point, our organizations communicated with Maine CDC leadership and the State Coordinating Council (SCC) to let them know that many of our organizations were not comfortable with the removal of these evidence-based strategies and our support would likely be withdrawn if they were removed. Not only does it undermine the facilitated process that people volunteered countless hours to partake in, but it also created a document that was no longer based on evidence-based public health principles but ideology and not science. In addition, removal of evidence-based

strategies put forward through the workgroup process undermined the collaborative stakeholder process in which we were asked to take part. Unfortunately, it was not until an email from Dr. Pinette on February 7, 2014, that the final version was made public. There was no mention of the three strategies that Ms. Birkheimer noted in her email and no one "let us know" the status of survival of those strategies. It was up to us to review the 83 page document and find that this version did in fact remove all three of the aforementioned strategies, as well as several others. It has come to our attention that none of the involved stakeholders (workgroup participants) or SCC members were notified of these changes. This lack of transparency not only de-values the participation of many stakeholders who participated in the creation of this document but also undermines future partnerships where the State is relied upon to finalize documents and plans.

Although there may be others, according to our collective records, the following strategies were deleted or added without consensus or discussion among workgroups/content experts or the SCC. There was also no explanation for the removal of evidence-based strategies and the evidence or subject matter expertise upon which removal was based.

Added: Obesity. 1.5 Strategy: Discourage the consumption of sugar-sweetened beverage by seeking a waiver from the federal government to disallow the use of SNAP benefits for purchase of sugar-sweetened beverages.

Removed: Obesity. 1.3 Strategy: 3. Enact an excise tax on sugar-sweetened beverages. Revenue should be directed to programs that prevent and/or treat obesity and related conditions.

Removed: Tobacco. 1.1. Promote tobacco treatment benefits for MaineCare recipients.

Removed: Tobacco. 1.1. Increase the price of cigarettes by 15% through an increase in tobacco excise taxes and ensure that all tobacco products are taxed at equal levels.

Removed: Tobacco 1.2. Increase access to comprehensive insurance coverage of evidence-based treatment for nicotine dependency.

Removed: Tobacco 1.3. Increase state tobacco funding to 75% of CDC Best Practice State Spending Recommendations.

The measurable objectives that were deleted from the earlier document were evidence-based, CDC-recommended strategies. One example is increasing the price of tobacco. Though this certainly isn't the only example, it is an important one since it is the number one recommended strategy by the CDC and because public health experts know that increasing the price will:

- Reduce the total amount of tobacco consumed
- Reduce the prevalence of tobacco use • Increase the number of tobacco users who quit
- Reduce initiation of tobacco use among young people
- Reduce tobacco-related morbidity and mortality

Another example is promoting tobacco treatment options for Medicaid members. According to CDC Best Practices report, "encouraging and helping tobacco users to quit is the quickest approach to reducing tobacco-related disease, death, and health care costs. The best way to reduce tobacco use is to educate members about their cessation benefits." It is surprising that a strategy that has been proven to increase quitting, reduce costs, and reduce tobacco-related disease in the population most likely to use tobacco would be removed from the plan.

As is the case with all prevention, a comprehensive approach is most effective. Everything can't be solved with an increase in price nor can it be solved when we have a narrow focus such as on smoke-free environments. A State Health

Improvement Plan that aims to make Maine the healthiest state in the nation, needs to be comprehensive, evidenced-based in approach, and take into account our local data, strengths and opportunities.

We would also like to note that there was a recommendation to include a disclaimer that not all organizations, including state government, necessarily agree with every recommendation. It was our hope that the document would stand as written and the disclaimer, if necessary, be included for clarification.

It is with regret that we are now compelled to withdraw our support of the most recent version of SHIP. We request that a prominently placed disclaimer that makes clear that the draft created by workgroups was changed without permission from said workgroups and that, as a result, the following individuals/organizations remove their support for this current plan. We also request to review your final version of SHIP, including the above disclaimer, prior to it being sent to the national accreditation board. If the two above requests are not possible, then we require our names/organizations to be removed from throughout the document. Again, we would like to see and approve the final document before it is sent outside of the state.

Each of our organizations holds evidence-based public health at the core of our mission and cannot endorse a plan that does not do the same. We prefer not to do this as many of us spent significant time and resources in crafting the objectives that were approved and vetted by the committees, but it is critical to us that a public health document that is meant to represent our state as a whole, be reflective of our consensual values and most importantly, is evidence-based.

Sincerely,

American Cancer Society Cancer Action Network

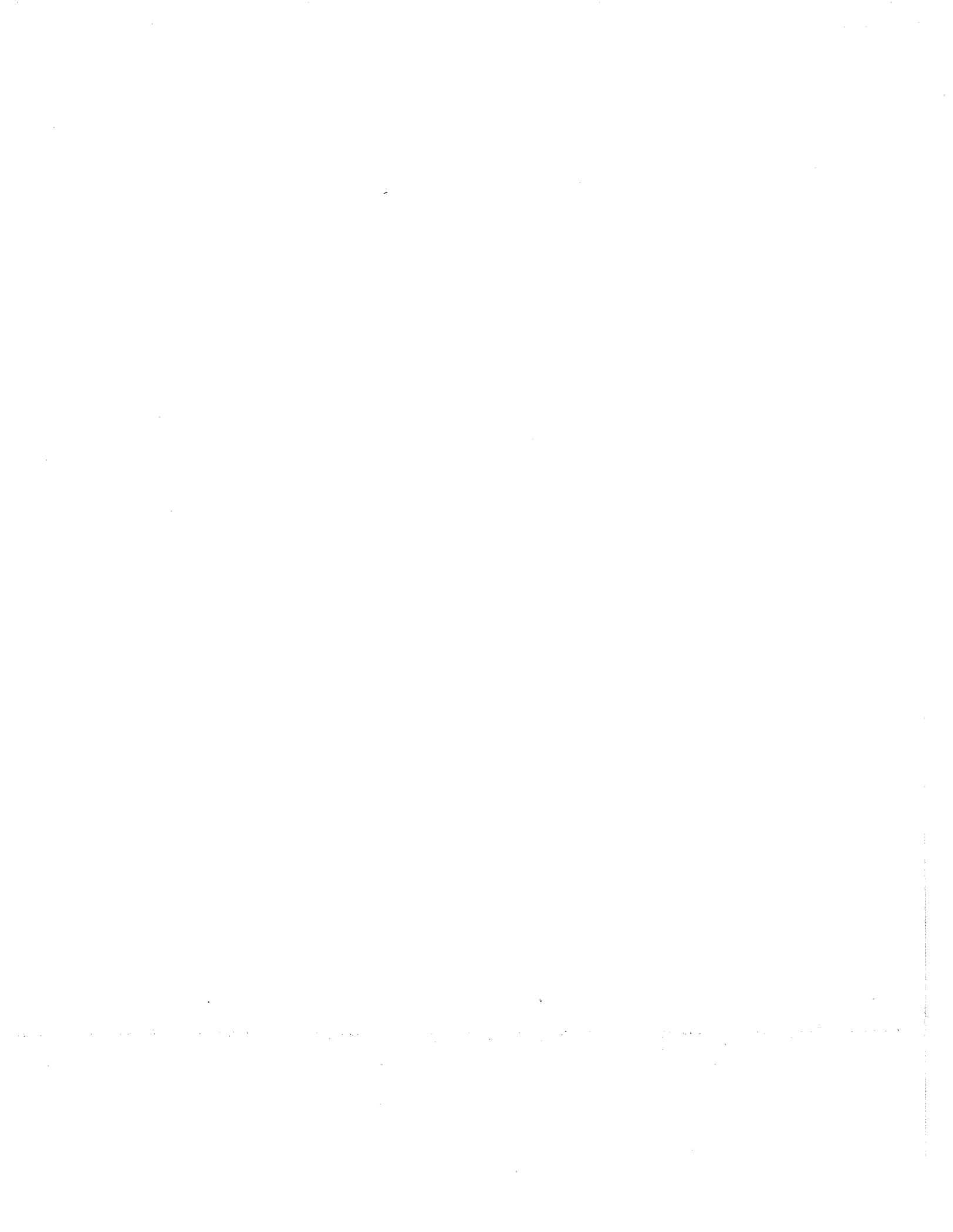
American Heart Association

American Lung Association of the Northeast

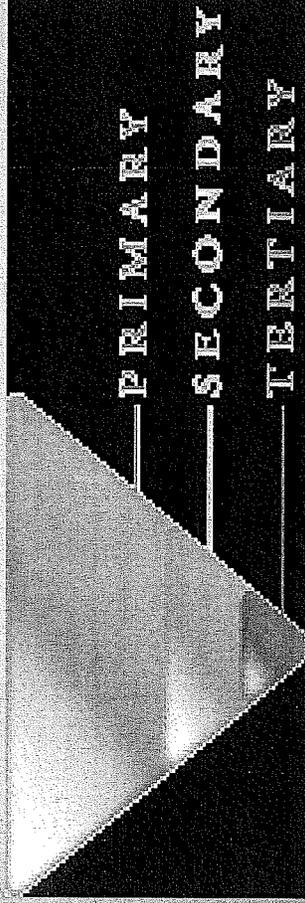
Maine Osteopathic Association

Maine Medical Association

Maine Public Health Association



Substance Abuse Prevention



- Primary prevention – preventing the disease or injury before it occurs.
- Secondary prevention – reducing the impact of a disease or injury that has already occurred.
- Tertiary prevention – soften the impact of an ongoing illness or injury that has lasting effects.

