



## State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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## 1.4 Overview of the State

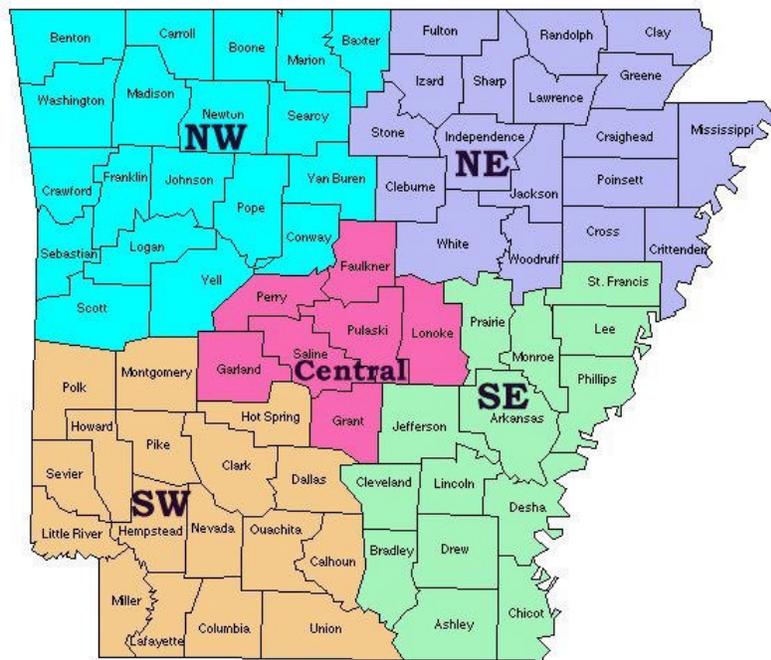


Arkansas' natural scenic beauty, its diverse physical features and unique cultural heritage are all part of the Natural State. Arkansas is the only place on the North American continent where diamonds can be found. The Natural State leads the nation in the production of both rice and poultry. Numerous Fortune 500 companies are headquartered in Arkansas, and it is also home to some of the country's most pristine, unspoiled wilderness areas. Arkansas is consistently ranked among the top states in the country in terms of clean air and has an abundant supply of clean water.

- ◆ Area: 137,742 sq. km (53,182-sq. mi.)
- ◆ Population: 2,551,373
- ◆ Capital: Little Rock 175,800
- ◆ Admission: 1836 as 25th state
- ◆ Median household income: \$27,665 ('98)
- ◆ Percent of population below poverty: 14.8

- ◆ Economy Industry: Services, food processing, paper and allied products, transportation, fabricated metal products, industrial machinery and equipment.
- ◆ Agriculture: Commercial broilers, eggs, turkeys, rice, soybeans, cotton, wheat.

Opportunities to improve the health of Arkansans abound. Almost any health outcome statistic studied reveals that Arkansas could improve relative to other states. There are, however, some areas of health system development that are receiving special attention in this state, which offer special opportunities to improve. Health insurance coverage for children is being addressed through the ARKids First Program, which is leading to a net decrease in the percentage of children without insurance coverage. Primary care physicians serving Medicaid patients are asking that EPSDT children be referred to their offices for screening exams. The state continues to actively pursue programmatic developments in abstinence education, out of wedlock, teen birth prevention, folic acid awareness, injury prevention in children, and smoking cessation. The nurse home-visiting program (Olds Model) has been implemented in all areas planned, and the home-visiting nurses are building their caseloads. A collaborative effort between ADH and UAMS Department of Pediatrics for birth defects surveillance continues to develop as planned. Another collaborative effort between ADH, UAMS, the Area Health Education Centers, and Rural Health and Primary Care programs; The Arkansas Center for Health Improvement is now functioning effectively to improve broad health policy in the state. The Arkansas Center for



**Arkansas Department of Health**  
 Public Health Regions  
 May, 2000

Map 1

Health Improvement (ACHI), with support from the Health Director, the Governor, and many legislators, was able to develop and maintain a coalition of citizens to create and back a health-wide proposal on use of tobacco settlement funds. One part of that plan was a proposal to increase financial eligibility in Medicaid for pregnant women to 200% of poverty. In particular, the Department of Health is moving toward reorganization to create five public health service regions (Map 1) that will be more autonomous and bring decision-making closer to the

community level. Part of this reorganization is the Hometown Health Improvement community based needs assessment process now rolling out across the state. Each of these opportunities will be discussed in other parts of this application.

MCH programs in Arkansas have historically served as gap-fillers of basic preventive health services to women, children and adolescents. In FY 1999 Title V continued as a major service provider for pregnant women (1/4 of the states births). Direct health services to approximately 80,000 children and adolescents are available through the Medicaid managed care Primary Care Physician (PCP) model. Arkansas' version of the child health insurance program (ARKids First) began September 1, 1997 as a Medicaid waiver. Title V has shifted its child health role from direct services to population-based health promotion (injury prevention, infant hearing screening, teenage pregnancy prevention etc.) and assurance (Medicaid Outreach and Education, EPSDT

data analyses, etc.). A service provision role, although reduced, has remained in local health units to respond to the needs of uninsured clients.

The process used to determine the importance, magnitude, value and priority of competing factors related to the health of mothers and children is grounded in two planning processes: The ADH strategic planning effort called ASPIRE (Arkansas Strategic Planning Initiative for Results and Excellence), and this Title V Block Grant application process.

ASPIRE acts as a backdrop to the block grant application process. After conducting internal and external environmental assessments, articulating mission and vision statements, and determining key areas of need and emphasis, ASPIRE developed adaptive strategy statements regarding specific services and activities of the agency. Many relate to MCH services. In most cases these are activities that would have impact only indirectly on the outcome measures addressed in the Title V application. ASPIRE articulated the goals of improving information systems, creating PC-based links between local health units and the central office, and training staff to use and manage that system. ADH has made great progress in achieving these goals. As of June 30<sup>th</sup> 2000 every colleague, field and central office, had an email address. During April, May and June 2000, field staff participated in PC training in basic Windows, email and the Internet. Training was provided to ADH colleagues in communities through Vocational Technical Schools, Adult Education Centers, high schools and community colleges.

The second goal is to create a true system of community-based needs assessment. Programmatic follow-up continues with the spread of Hometown Health Improvement (HHI) sites from one site a year ago to eleven designated sites, plus two joint ventures as of June 30, 2000. Five more HHI sites are earmarked to begin in October 2000. These developments clearly assist the MCH Section in moving toward core public health functions for the use of Title V dollars. In the meantime, the ADH MCH Section is addressing the specific requirements of the Title V Guidance developed to implement the Government Performance and Results Act (GPRA). Goals and objectives were selected because they: 1) addressed the measures required by the Guidance, 2) addressed the larger program developments occurring in the state (increasing children's health insurance, implementing the Medicaid Family Planning Waiver, initiating the Abstinence Education and Unwed Birth Prevention Programs), 3) were measurable and had reliable data sets available to monitor progress, and 4) were compatible with ASPIRE<sup>2</sup>

intentions. The selected goals and objectives complement or carry forward the intentions articulated in the ASPIRE adaptive strategies, where their relationship is evident.

### **1.5 The State Title V Agency**

On February 8, 1999, Dr. Fay W. Boozman, an ophthalmologist, former Arkansas state senator, and republican nominee for U.S. Senator, became the Director of the Arkansas Department of Health.

Dr. Boozman received his medical degree from the University of Arkansas for Medical Sciences, graduating first in his class. He did residencies in both Pediatrics and Ophthalmology. He also completed the School of Aerospace Medicine Primary Care Course at Brooks Air Force Base. Following medical school, Dr. Boozman served as a flight surgeon in the Arkansas Air National Guard and achieved the rank of major. He is currently enrolled in the Masters in Public Health program through Tulane University at the University of Arkansas Medical Sciences Campus.

Dr. Boozman served in the Arkansas Senate for four years. During his tenure, he served on the Senate Revenue and Tax Committee; the City, County and Local Affairs Committee; the Senate Public Health, Welfare and Labor Committee; State Agencies Committee; Children's Welfare Committee; the Advanced Telecommunications Committee and the Joint Budget Committee.

The ADH Leadership Team was formed in September 1999. In addition to Dr. Boozman, the team includes former agency bureau directors and other members of senior staff. The team's mission is to change the agency culture to implement ASPIRE<sup>2</sup> and attain the next level of excellence.

To reenergize ASPIRE, Dr. Boozman and the Leadership Team traveled the state to discuss with ADH colleagues the need for changes in the agency culture and to ask for their input on how to accomplish the changes. Through visits with colleagues throughout the state, in the central office and local health units, he learned that, while many concerns had been addressed as a result of ASPIRE, much remained to be done. Dr. Boozman made presentations to more than 2,550 ADH colleagues stressing that it is unacceptable that Arkansas is the unhealthiest state in the nation. The Leadership Team conducted 206 discussion groups with colleagues to get their feedback in the three areas identified as needing attention: Communication, colleague growth

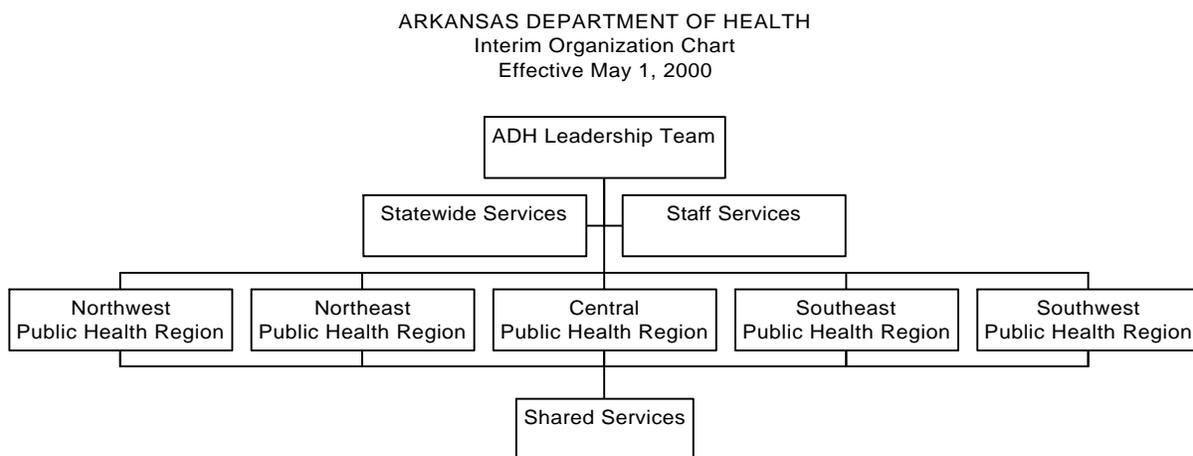
and development, and decision-making. The data from these discussion groups, the results of the organizational excellence survey, and the leadership team's plan to address colleague concerns make up the Arkansas Department of Health's blueprint for excellence called "*Removing Barriers to Excellence*." A copy of the report is available upon request.

### 1.5.1 State Agency Capacity

#### 1.5.1.1 Organizational Structure

The Arkansas Department of Health (ADH) officially began reorganization in April 2000. The new structure is built around information colleagues provided to the leadership team October through December 1999. Changes to the current structure are in response to the barriers to excellence identified during colleague discussion groups last fall. The agency re-organization is expected to facilitate better coordination of direct services, improved methods of data collection and analysis, greater focus on population based initiatives and better communication among ADH colleagues statewide. With an increased focus on customer satisfaction the quality of care and services provided by ADH local Health Units will improve. The new structure establishes a geographic customer focus to replace current program focus. It reduces layers within the organization and establishes team-based management to enable colleagues to make decisions quicker, easier and at the right level. It supports open communication that is direct, two-way and timely. Chart 1 below is the ADH interim organizational chart as of May 1, 2000.

Chart 1



The **ADH Leadership Team** sets the Department’s strategic direction, provides agency-wide oversight and has fiduciary responsibility. **Staff Services** provides staff support to the ADH Leadership Team.

The **Public Health Regions** provide public health services in the geographic region of the state. This unit has broad authority and flexibility for public health activities to meet the needs of customers in the region. **Shared Services** supports the work of the Public Health Regions. This unit also provides services in the region when special expertise is needed or as required by economy of scale.

Chart 2 assigns current work units to the new structure.

Chart 2: Interim Organization Chart  
Assigning Current Units to New Structure  
Effective May 1, 2000



**Statewide Services** supports the work of the ADH Leadership Team by providing a federal interface, grant coordination and state level program coordination. This unit develops programmatic technical expertise through benchmarking, participating in the development of performance measures and promulgating rules and regulations.

Chart 3: Interim Organization Chart  
 Statewide Services  
 Effective May 1, 2000

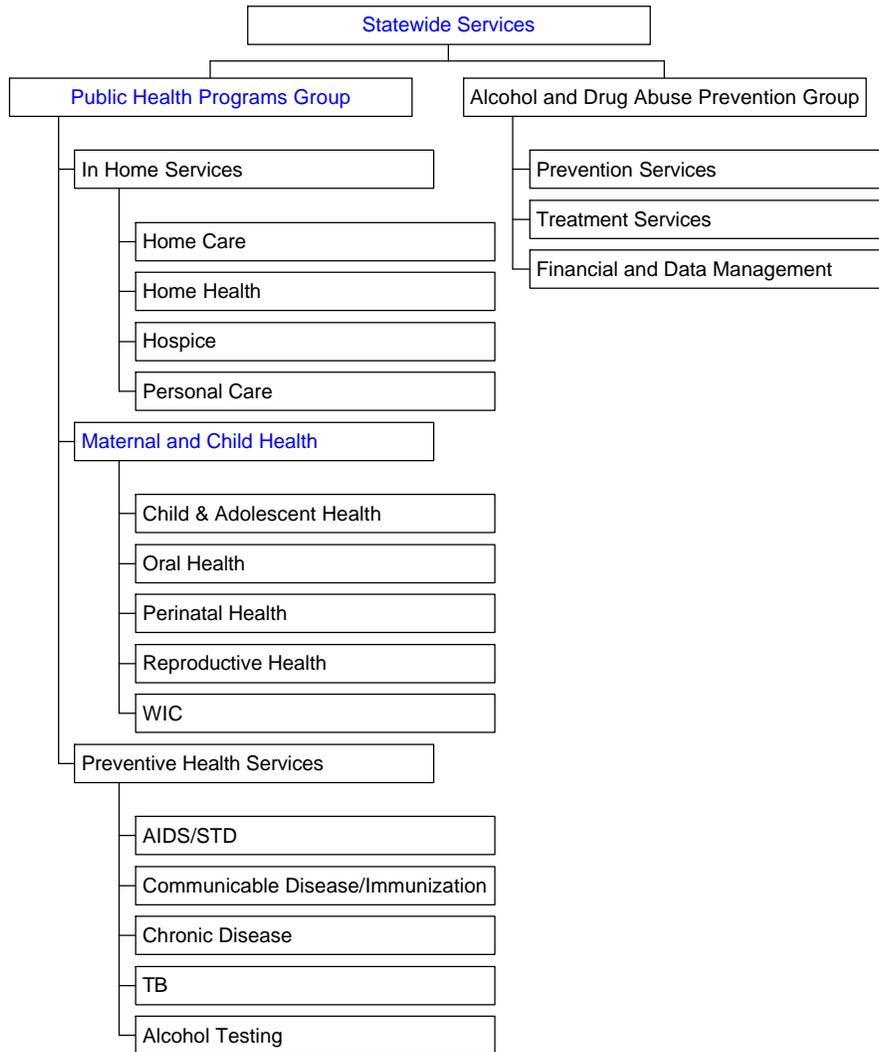
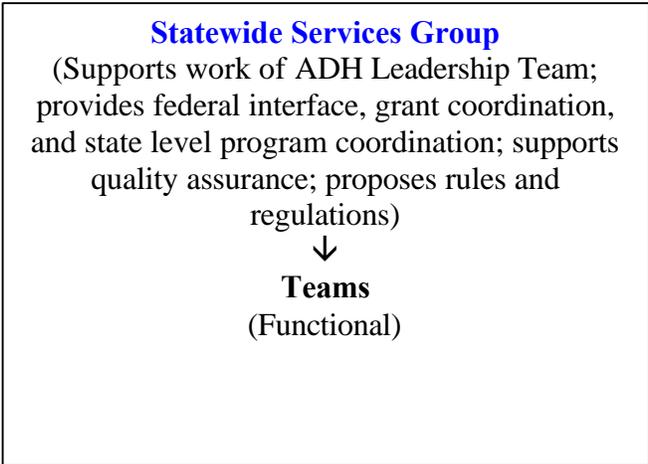
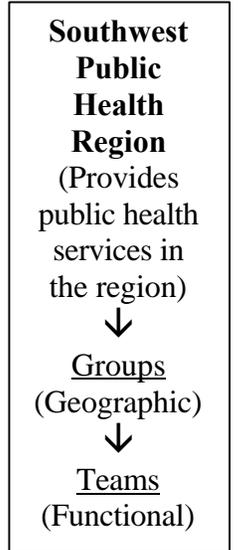
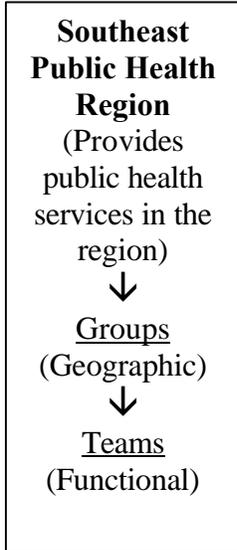
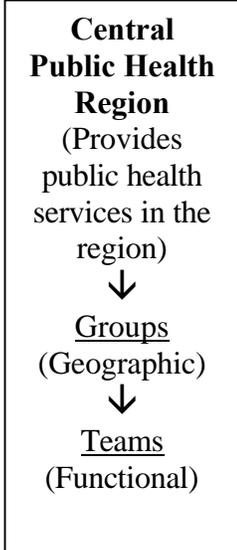
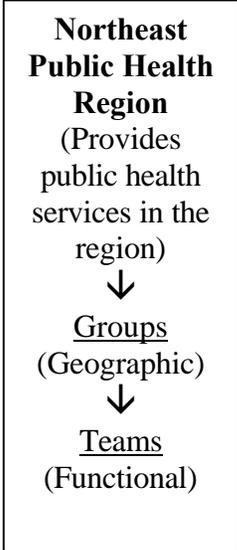
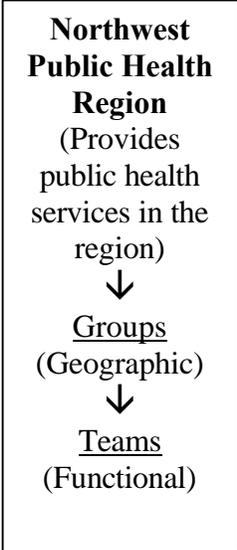


Chart 4 ARKANSAS DEPARTMENT OF HEALTH  
 Future Organization Chart  
 Effective July 1, 2001



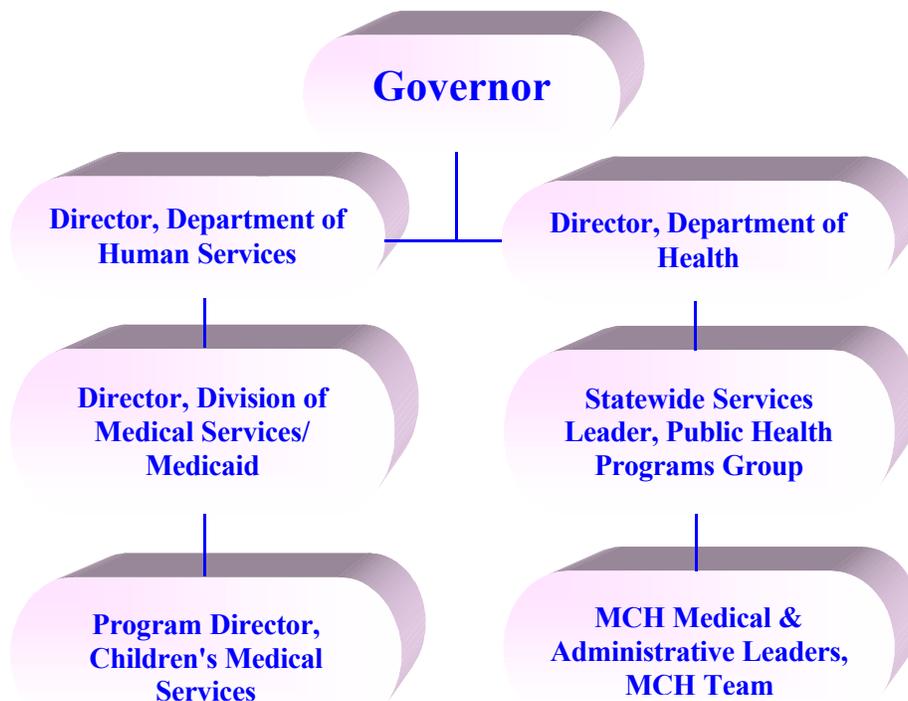
The Division of Medical Services (DMS), Children’s Medical Services, Arkansas Department of Human Services administers the Children with Special Health Care Needs (CSHCN) program. The DMS Director is also the director of the State Medicaid program. Chart 5 shows the relationships of Title V programs in the state.

Act 96 of 1913, A.C.A. 20-7-102 established the Arkansas Board of Health .The State Board of Health oversees the operation of the Arkansas Department of Health. Its members are appointed by the Governor and represent many organizations and professions concerned with public health. The board assures that ADH programs and policies are compatible with developments in other parts of the health care system, whether public, private or nonprofit.

The Governor appoints the Directors of both the Arkansas Department of Health and the Department of Human Services.

Chart 5

**The Relationships of Title V Programs in Arkansas**



A second board, also appointed by the Governor, is more directly focused on maternal and infant health issues. Created in 1988, the Perinatal Advisory Board reviews trends and activities and recommends actions to improve maternal and infant care and health. The board also serves

as the oversight body for the State Infant Mortality Review program. The Board's recommendations, in the form of its annual report, help shape the overall MCH program in Arkansas. The MCH Section provides staff support to the board.

The Childrens Medical Services (CMS) Program operates under authority of Arkansas Statute Annotated 83-109, ACA 20-76-201 (Act of 1939). The Division of Medical Services in the Arkansas Department of Human Services is responsible for the administration of CMS.

### 1.5.1.2 Program Capacity

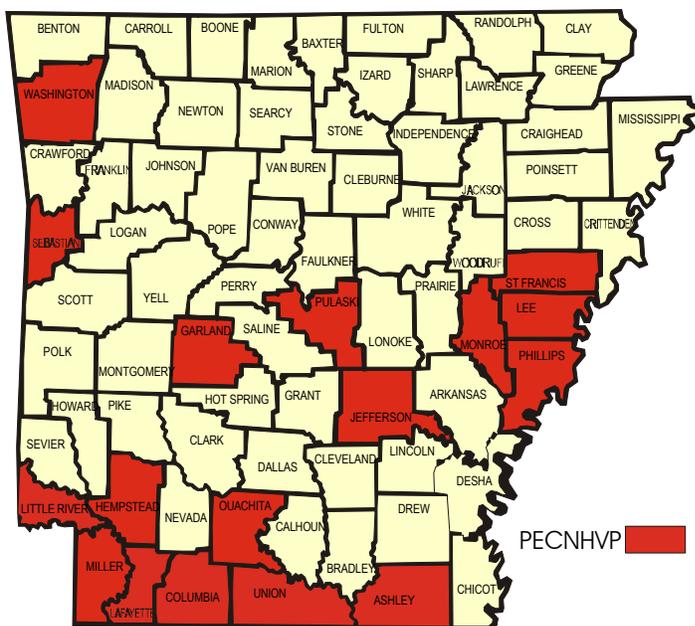
#### 1) Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

◆ The Prenatal & Early Childhood Nurse Home Visiting Program (PECNHV) was established in Arkansas by Legislative Act 1115 of 1999. The program uses the David Olds home visitation model. Registered nurses make home visits to first time pregnant teens between the ages of 15 and 19. Priority status is given to teens with limited resources or support. Participation is voluntary and an agreement of participation is obtained from the pregnant teen. Referrals are accepted from any source including but not limited to teachers, counselors, physicians, Department of Health colleagues, and clients themselves.

The PECNHV curriculum promotes healthy behaviors during pregnancy and provides childcare education, support, and supervision throughout the first two years of the baby's life.

The need for programs like this in Arkansas is obvious. The teen birth rate in Arkansas has been among the highest in the country. In 1998 in Arkansas teenagers ages 15 to 19 had a birth rate of 70.1 births per 1000. In the counties selected for the program, the teen birth rates ranged from a high of 105.6 births per 1000 in St. Francis

### Prenatal & Early Childhood Nurse Home Visiting Program



County to a low of 60.9 per 1000 in Washington County. A total of 6630 babies were born to this age group in 1998.

Areas emphasized in the program include prenatal care and reduction of substance use, healthy sex practices and family planning after delivery, child nutrition, child immunizations, and parenting education. During the first home visit the nurse assesses and evaluates the expectant mother's nutrition and exercise needs. Throughout the pregnancy the nurse monitors the teen's nutrition history and weight gain, offers nutrition education, makes a referral to the WIC program if necessary, offers encouragement and support for breastfeeding, and teaches appropriate baby nutrition.

The potential for adverse effects on the developing baby as result of over the counter, prescription and illicit drug use is discussed with each mother. Substance-use elimination, exposure to unsafe substances such as tobacco, alcohol, and other drugs are topics addressed during the third prenatal visit. Use of condoms during pregnancy to prevent sexually transmitted disease, family planning goals, contraceptive options and responsible sexual behavior for both the mother and her partner are topics covered during subsequent visits.

During later visits these topics are reviewed in context with immunization guidelines and schedules for infants and babies. Parents are encouraged to provide timely, age appropriate immunizations through their local health department or PCP. Immunization levels for infants enrolled in the program are monitored.

Other safety goals of the program include promoting the correct installation and use of child safety seats, and preventing poisonings and other preventable injuries through parenting education. Parenting education begins before delivery and continues until the child is two years old.

Currently sixteen nurse home-visitors and five program specialists are assigned to four home visiting teams, covering 17 counties in Arkansas.

Team 1 - Northwest Public Health Region - Two nurses each for Washington and Sebastian counties.

Team 2 - Central & Southeast Public Health Regions - Two nurses for Pulaski County, one nurse each for Garland and Jefferson counties.

Team 3 - Southeast Public Health Region - One nurse each for Lee, Phillips, St. Francis, and Monroe counties.

Team 4 - Southwest Public Health Region - One nurse each for Miller/Little River; Hempstead/Lafayette; Ouachita/Columbia; and Union/Ashley counties.

Each team will have approximately 100 low-income, first time, pregnant teens, between 15 to 19 years of age. Each nurse will have up to a maximum of 25 clients.

The nursing staff started the first phase of *Olds Method* training in October 1999. The University of Colorado faculty provided the second phase infancy component in Little Rock during May 2000. The final stage of training covering the toddler phase will be provided in early 2001. As of April 1, 2000 there were approximately 120 expectant teen-mothers enrolled in the program.

Data analysis of the home visits is expected to start in mid-year 2000. To ensure that nurse home visitors are equipped with skills specific to maternal and child health populations, the ADH provided them with additional training including the Nursing Child Assessment Training (NCAST) infant feeding scales tool, Partners in Parenting Education (PIPE) and breastfeeding education.

The PECNHV advisory council is composed of ten members, appointed by the Governor, who represent a cross section of professionals, and lay people, as specified in the enabling legislation. To date the Advisory Council has met twice. Additional quarterly meetings are scheduled for July and October 2000. The Advisory Council is interested in actively assisting and guiding the program by forming a legislative subcommittee to promote the program. The Council also wants to develop a financial base to expand service areas statewide.

The ADH Perinatal Health team administers several programs. These include Maternity Services, Lay Midwife Licensure, the Mississippi County Nurse Midwife Program, the Campaign for Healthier Babies, Babies & You and Perinatal Outreach.

◆ Many of perinatal health's resources and efforts support the local health units (LHU) in the provision of direct prenatal care services. The LHU maternity clinics provide prenatal care for 25 to 30% of the approximately 36,865 Arkansas women who deliver annually. LHUs are strengthening alliances with local community physicians and hospitals to coordinate care. More and/or earlier referrals are made from LHU prenatal clinics to local physicians. But this is not possible in all locations, as there remain almost 18 counties (of 75) with no physicians practicing

obstetrics (OB). Several other counties have OB physicians, but they are unable or unwilling to accept additional patients. LHUs remain an important provider of prenatal care statewide.

- ◆ Perinatal Health licenses and subsequently monitors the practices of the 22 licensed lay midwives and 21 licensed lay midwife apprentices in the state. Efforts are underway to revise the *Regulations Governing the Practice of Lay Midwifery in Arkansas*. This remains a legislatively mandated and time intensive program which monitors lay midwife practice for approximately 200 births a year.

- ◆ The Mississippi County Nurse Midwife (CNM) Program provides prenatal care and delivery for approximately 210-230 women a year. This represents roughly 1/4 of all babies born in this county annually. Recruiting and maintaining certified nurse midwives is a challenge. Currently, the program is fully staffed with two CNMs. Long range plans include shifting the overall responsibility for the program to the community.

- ◆ Perinatal Health operates the 1-800 MCH telephone line, 24 hours a day, seven days a week. Callers receive a wide range of resource information concerning specific campaigns and programs within the Department. Routinely, callers receive mail-outs with educational information about MCH services. To facilitate Perinatal Health's ability to provide appropriate referrals, a Resource Directory is updated and maintained that contains more than 1700 entities providing a variety of services.

- ◆ The ConnectCare phone line is operated in conjunction with the MCH Health Line. This line is used in specific Medicaid related campaigns and mail-outs and provides information relevant to Medicaid issues. This includes answering calls and mailing information about the ARKids First Child Health Insurance Program. More than 4200 calls were answered about ARKids First in 1999.

- ◆ Perinatal Health leads the agencies interests in the Campaign for Healthier Babies. The Campaign is in its eighth year of promoting early prenatal care via television ads and incentives (the Happy Birthday Baby Book). Evaluation efforts continue to provide a positive correlation between participation in the Campaign and good birth outcomes. More in-depth evaluation with controls for demographics and risk factors is planned.

- ◆ Perinatal Health works with the Arkansas Chapter of the March of Dimes in promotion and implementation of the worksite prenatal program, *Babies and You*. Currently, 54 companies

around the state provide their employees with information based on the *Babies and You* curriculum, an 11% increase over FY '98. Efforts continue to recruit additional companies.

- ◆ Perinatal Health provides staff support to the Arkansas Perinatal Advisory Board. This Governor-appointed board brings together professionals and consumers with an interest in promoting improvements in perinatal health. A report to the Governor is generated annually. The Board is also active in reviewing and providing input for Epidemiology projects.

- ◆ WIC Breastfeeding Services is part of the MCH team under the Public Health Programs Group that now resides in ADH Statewide Services. Breastfeeding Services (WBS). Central office staff include an Acting Administrator/State Breastfeeding Coordinator, a Nutritionist /Registered Dietitian and an Executive Secretary. The WBS is responsible for the promotion and support of breastfeeding activities statewide, compliance with federal WIC regulations and education of health professionals about lactation. WBS coordinates breastfeeding activities through ten regional Breastfeeding Coordinators, Nutritionists, Home Economists, MCH Nurse Specialists, Peer Counselors, Health Educators, and local field staff. Lactation education is provided through field staff updates, regional workshops, and co-sponsored statewide conferences for health professionals.

- ◆ Nutrition Services works to improve the quality of life by preventing nutrition-related conditions and chronic diseases affecting mothers, infants, children and adolescents. Thirty-two nutritionists (Registered Dietitians/Licensed Dietitians) are funded through WIC. The professional staff provides nutritional counseling for high risk WIC clients and nutrition education for those WIC clients who are at moderate risk. Individualized clinical services are also provided to women in ADH Maternity clinics, teens in clinics co-sponsored by ADH and UAMS, and to people referred by private physicians. Clients include those with gestational diabetes, anemia, failure to thrive, eating disorders, obesity, diabetes mellitus, and other conditions needing medical nutrition therapy. Community level activities include conducting in-services, and speaking at conferences, civic groups, and schools. Nutritionists also provide public health field experience for dietetic interns, post-graduate and under-graduate nutrition students. ADH Nutritionists work within coalitions on projects, such as 5-A-Day, Folic Acid Awareness, and Diabetes Awareness. Staff analyzes and interprets data from the Pediatric Nutrition Surveillance Survey.

The Child and Adolescent Health team leads several programs related to preventive and primary care services for infants. These include the Infant Mortality Review Program, SIDS Information and Counseling Program, the State Genetics Program, Newborn Screening Program and the Infant Hearing Program.

◆ The Infant Mortality Grant began in October 1997. The grant is renewable through October 2000. The goals of the grant are to:

1. Institutionalize the Infant Mortality Review (IMR) process in Arkansas as an integral part of the States core public health function.
2. Identify risk factors and service gaps at the community and state levels that contribute to infant mortality.
3. Integrate the infant mortality review process as a critical component of the MCH Needs Assessment.

◆ The Arkansas Sudden Infant Death Syndrome (SIDS) Information and Counseling Program is a network that provides information and counseling to the bereaved families. Coroners notify the SIDS Program of a possible SIDS death and the ADH contacts the State Medical Examiners office to arrange for an autopsy. ADH and the State Medical Examiners Office share the costs of autopsies. The SIDS Coordinator (40% FTE) in the central office notifies the local health unit of a possible SIDS death and the local public health nurse contacts the family to schedule a home visit to provide bereavement counseling and information on SIDS.

◆ The State Genetics Program is also part of Child and Adolescent Health. The State Genetics coordinator is liaison between the Arkansas Department of Health and other agencies in the state that provide genetic services including, Arkansas Childrens Hospital (ACH) and the University of Arkansas for Medical Sciences (UAMS). The coordinator serves as the chairperson for the Arkansas Genetics Advisory Committee, provides inservice education to hospitals, physician offices and other groups regarding genetic issues and collects and reports statewide statistical data for the Arkansas Newborn Screening Program.

◆ The Newborn Screening Program tests all neonates born in Arkansas for four disorders: phenylketonuria (PKU), congenital hypothyroidism, galactosemia, and hemoglobinopathies. A fee charged for each specimen submitted provides coverage of laboratory and follow-up costs. Medical consultation for the program is provided through Title V funds. In a typical year the program detects two to three cases of PKU, ten cases of congenital hypothyroidism, one case of

classic galactosemia, and 20 to 25 cases of sickle hemoglobinopathies. Health education is available for parents of children identified with sickle cell trait or sickle cell disease.

Act 1113 of 1999 provides families with assistance to purchase certain medically necessary foods and food products for individuals with phenylketonuria. The Act also provides for health insurance plans to assist beyond the amount specified below and for other purposes. Specifically Act 1113 does three things:

1. It allows a tax credit of up to \$2,400 per year per child with phenylketonuria for expenses in purchasing such medically necessary foods and low protein food products started January 1, 1999.
2. It mandates health plans to provide benefits to cover medical foods and low protein food products if prescribed as medically necessary by a physician, and the \$2,400 amount is exceeded, and
3. It provides \$1,000 in allocated funds by the Department of Health toward health care costs when they exceed \$2,400 and the child is uninsured.

◆ The Arkansas Department of Health has been dedicated to the early identification of hearing loss in infants since 1979. The goal is to identify deaf or hard of hearing babies by the age of three months and provide intervention services before they are six months old. The Infant Hearing Program, legislated in 1993, identifies infants at risk for hearing loss. Hospital personnel complete an at-risk questionnaire for each live birth and forward it to ADH. Parents whose infants are found to be at risk are notified and provided with a referral listing for follow-up testing. ADH provides informational materials and referral source listings to all hospitals. The referral listing is updated at least annually. Physicians are notified monthly of at-risk infants under their care who should be tested for hearing loss. All birthing hospitals are completing the at-risk questionnaire. Technical assistance and educational services are also provided to hospital staff, other medical providers and to the public. A benefit of providing technical assistance and educational services to hospital staff is the opportunity to discuss obtaining physiological screening equipment for universal newborn screening. As a result, by the end of CY '99, twenty-four of the 57 birthing facilities had obtained the necessary equipment to conduct physiological newborn screenings in addition to the mandated at-risk questionnaire.

◆ Act 1559 of 1999 established the Universal Newborn/Infant Hearing Screening, Tracking, and Intervention Program and Advisory Board. Under this legislation every birthing hospital

with more than 50 births per year will be required to provide or arrange for a bilateral physiological hearing screening on each birth admission. Medicaid is mandated to reimburse for this service. The advisory board will develop rules and regulations to be promulgated by the Board of Health by July 2000.

## 2) Preventive and Primary Care Services for Children

The ADH Child and Adolescent Health team administers several programs including Blood Lead, EPSDT, SAFEKIDS, Fire Related Burn Prevention (FRBP), Safety Seats, Adolescent Health, and the School Based Health Center Program. Brief descriptions of these programs follow.

- ◆ Screening for elevated blood lead levels in children is conducted in conjunction with EPSDT screening activities. State Medicaid regulations require screening of EPSDT participants at one and two years of age, and at other periodic visits if at-risk criteria are met. Blood specimens are analyzed at the ADH Public Health Laboratories. Children with confirmed (venous) lead levels of 20 ug/dL receive state level case management, medical evaluation and referral as indicated. Those with lead levels in the 10-19 ug/dL range are followed through the local health units, with repeat testing obtained according to written policy.

Environmental inspections of the residences of children with lead levels 20 ug/dL is provided by ADH Environmental Health Protection (DEHP). Recommendations for abatement of lead sources are provided when such hazards are detected. An elevated blood lead level (10 ug/dL) in a child less than 14 years of age is a reportable condition in Arkansas. DEHP enters data from lead reports received from private laboratories and physicians. The Maternal and Child Health Block Grant supports medical consultation for the blood lead-screening program.

- ◆ The Arkansas Department of Health offers EPSDT services to Medicaid recipients less than 21 years of age in local health units. On April 1, 1998, the Department of Human Services (DHS) began requiring a Primary Care Physician (PCP) referral for EPSDT services on any child screened in local health units in 25 of the 75 counties in state. Arkansas' Medicaid program is administered as a gatekeeper managed care system. The goal of the Medicaid program is to enroll all Medicaid recipients and to provide them with their own PCP, thus establishing a comprehensive system of health care and a medical home for each child. DHS determined that 25 counties have enough PCPs to provide sufficient preventive health services to Medicaid

clients. Because of these changes, the Department of Health is less involved in direct delivery of EPSDT services. Staffing in local health units has gradually been reduced in affected counties. These staffing reductions in child health services have affected clinical services for no-source clients. Since the changes in the EPSDT program coincided with increases related to the Family Planning Waiver, pediatric nurse practitioners were cross-trained to provide family planning services.

- ◆ ARKids First children (2 days to 18 years of age) seen in Local Health Units are assessed for periodicity eligibility for a Preventive Health (PH) Screen (like EPSDT). For ARKids First clients who reside in the 25 PCP referral required counties, a referral form is required. ARKids First children (excluding the Preventive Health Screen: Newborn) are eligible for one preventive health screen per State fiscal year.

- ◆ The Arkansas Department of Health and the state as a whole have a number of specific programs designed to prevent injury. However, there has been no central focus to coordinate these efforts. To address these needs, the Arkansas Department of Health, through funding from the Centers for Disease Control and Prevention, has established the “State-Based Core Injury Prevention Program”. The first of five years of funding began in October 1999. The program targets both intentional and unintentional injuries among all age groups and focuses on six goals:

1. Improve coordination and collaboration within the Health Department relative to injury prevention
2. Improve coordination and collaboration among statewide agencies and organizations relative to injury prevention
3. Delineate the magnitude of the state’s injury problem
4. Assess state capacity to prevent injuries
5. Establish a state injury prevention plan
6. And develop support for a statewide injury prevention plan

- ◆ The Office of Childhood Injury Prevention works to prevent unintentional injuries to children ages 14 and under. This office and the Community Outreach Department at Arkansas Children’s Hospital are the leaders of the Arkansas SAFEKIDS Coalition (ASC). The Coalition, formed in 1991, is part of the National SAFEKIDS Campaign the first and only national organization dedicated solely to the prevention of unintentional childhood injury. ASC members represent over 30 community agencies and organizations statewide. Its mission is to reduce the number of

fatal and non-fatal injuries to Arkansas children by creating safer homes and communities through education and intervention.

- ◆ Child and Adolescent Health conducts a low-cost safety seat program available in 80 of the 94 local health units in the state. ADH clients may purchase a new convertible safety seat on an income-based sliding scale. Funding for the program comes from the Preventive Health Block Grant, reimbursements from seat sales and occasionally other sources. Medical consultation for the program is provided through Title V.

- ◆ The Fire Related Burn Prevention Program (FRBP) is in its sixth and final grant year of funding from the Centers for Disease Control and Prevention. A major component of the grant is a research study conducted in Jefferson County. This Study's purpose is to determine the most effective educational strategy to teach proper smoke alarm installation and maintenance.

An important objective of the program is to lower the fire fatality rate in Arkansas. There is a statewide component which provides fire safety education and free smoke alarms for at-risk populations including children age five and younger, seniors (grandparents), ADH In-Home Services recipients, and persons with hearing loss. Its primary methods have consisted of working statewide with local community fire departments and firefighter and fire chiefs' associations, as well as other groups identified within the community. ADH offers technical assistance to coalitions to develop individualized outreach and identification plans, as well as appropriate paperwork completion. The program has been offered to all 75 Arkansas counties with 68 counties electing to participate.

- ◆ The Adolescent Health Program was initiated in 1992 through a five-year MCHIP grant. In FY '98 the state Adolescent Health Coordinator and the School Health Coordinator positions were combined. The new position, Adolescent and School Health Coordinator, is state funded with medical consultation for the programs provided through Title V. The Adolescent and School Health Coordinator provides training and consultation and promotes collaboration among programs that serve youth.

ADH has been involved in the School-Based Health Center program since 1989. Currently, 20 centers located on the school grounds provide services to students and faculty of the host schools. Staffing varies, depending on the population of the student body. A public health nurse, social worker, and clerk staff an average size center. In urban areas, physicians from the community volunteer in the centers on a regular basis. In some rural school districts traditional

school nursing services are provided when the school is unable to recruit nurses. All center staff are Arkansas Department of Health colleagues and function under its policies and procedures. Arkansas law states that all centers are under the control and authority of the local school board and the staff works closely with the school to assure the intent of the legislation is met.

◆ The Violence Prevention Coordinator's primary function is to ensure that middle and high school students across the state receive a structured curriculum on violence prevention. This effort can be achieved by working closely with Hometown Health Improvement and other entities in the perspective communities. In hopes of addressing conflict resolutions among adolescents, the coordinator provides training to colleagues utilizing the Positive Adolescent Choice Training (PACT) curriculum. The PACT approach includes a component of violence-risk education. Many adolescents have misperceptions about violence that cause them to fail to recognize risk and/or provide no motivation for changing behavior, thus making them more vulnerable to violent death or injury. The PACT model recognizes these misperceptions and uses a multi-method intervention that blends interactive education about risk with skills development. It pursues a holistic approach. The training also focuses on models dealing with intentional and unintentional firearm injury.

Other ADH programs providing preventive and primary care services for children:

◆ Unwed birth and teenage pregnancy prevention - The Federal Personal Responsibility Act of 1995 required states to develop plans to reduce both the numbers of unwed births and teenage pregnancies, without an increase in abortions. In response to this state responsibility, three actions were taken by the 1997 Arkansas General Assembly and signed into law by the Governor:

1. HCR 1010 created legislative oversight of activities supported in Act 1159 and Act 1101
2. Act 1159 established the Arkansas Department of Health (ADH) as the coordinating agency for unwed birth and teenage pregnancy prevention
3. Act 1101 appropriated \$1,040,700 for each year of the biennium for this purpose

Funds to support local teen pregnancy prevention coalitions in ten Arkansas counties were awarded during the past year.

◆ The ADH Child and Adolescent Health Team received the Arkansas Healthy Child Care America Grant, a three-year federally funded grant, June 1<sup>st</sup>, 2000. This grant has three

components that focus on improving the health and safety of children in child care: 1) Quality assurance measures aimed at improving the State health and safety standards for children in child care 2) Infrastructure building for establishing a Child Care Health Consultant network in the State; 3) Outreach efforts to increase enrollment of ARKids First and Medicaid eligible children in the child care population.

◆ The Arkansas Departments of Health and Education are in the second, five-year funding cycle of a Coordinated School Health Program (CSHP) grant funded by the Centers for Disease Control & Prevention (CDC). In 1992 Arkansas was one of five states originally chosen by CDC as a national demonstration site for CSHP. The Arkansas demonstration sites are in Paris and Magazine school districts in Logan County and 15 other school districts in the state have implemented components of the program.

CSHPs are designed to enhance the health of students, prevent disease, reduce health related risky behaviors and improve academic performance. The Department of Education is the lead agency on this grant entitled School Health Programs to Prevent Serious Health Problems and Improve Educational Outcomes. The purpose of the initiative is to build an infrastructure that strengthens the capacity of state health and education agencies to plan, implement and evaluate CSHPs. In June 1998 the Departments of Education and Health were awarded a \$5,000 stipend from the Council of Chief State School Officers (CCSSO) and the Association of State and Territorial Health Officials (ASTHO) for ongoing marketing activities to increase public support for coordinated school health programs. CSHP Directors are working to educate and mobilize state and local leaders about the importance of CSHP and to coordinate the marketing campaign.

◆ The ADH Vision and Hearing Screening Program (VHSP) provides training and technical assistance to ensure that quality vision and hearing screenings are conducted in the schools. Following training and certification conducted by the Department, school nurses and speech-language pathologists provide vision and hearing screenings for approximately two hundred and forty thousand (240,000) children annually. Reports of screening results are compiled by staff and shared with each school district superintendent.

Certification by the VHSP is one of the criteria for school nurses providing Medicaid reimbursable, EPSDT hearing and vision screenings. Certification requires completion of the level II training and renewal every three years. A Database listing of certified nurses is maintained and nurses are recertified through examination.

◆ Oral Health - Dr. Lynn D. Mouden joined the Department as the Director of the Office of Oral Health in October 1999. After 16 years in private dental practice in Northwest Missouri, Dr Mouden served eight years as Deputy State Dental Director for the Missouri Department of Health and as an Associate Clinical Professor at the University of Missouri at Kansas School of Dentistry. Dr. Mouden received his DDS degree and a Masters in Public Health from the University of North Carolina.

Dr. Mouden is the founder of the award-winning Prevent Abuse and Neglect through Dental Awareness (PANDA). This successful family violence prevention program has been replicated in five foreign countries and 37 states including Arkansas. Dr. Mouden intends to build upon the dental public health foundation established by previous State Dental Directors. Already he has reinvigorated Arkansas' Community Water Fluoridation Program and revitalized Arkansas' PANDA initiative. Future efforts will build on other successful interventions in dental public health, including oral health education, dental sealant promotion, oral and pharyngeal cancer screening and prevention, tobacco cessation advocacy and promoting the use of mouth guards for sports activities. Specific activities are designed to improve oral health through preventive measures and oral health education and include:

1. Providing information on community water fluoridation for citizens wishing to adjust the fluoride level in their drinking water
2. Providing oral health education for elementary school children and teachers
3. Conducting seminars on oral cancer, infection control, and family violence prevention for dental professionals and community groups and
4. Serving as a point of contact for health care professionals and the lay public on oral health issues through the Arkansas Oral Health Advisory Committee.

### 3) Services for Children with Special Health Care Needs (CSHCN)

Children's Medical Services (CMS) had a total caseload of 25,529 clients as of May 1, 2000, of which 19,851 are active clients. Currently 97.2% of CMS active clients are on Medicaid, up sharply from 93% this time last year (almost 81% of the total CMS caseload are Medicaid clients). The number of active non-Medicaid clients on CMS has dropped from 447 in May 1999 to 259 clients in May 2000, mainly because of the ARKids First program that started in 1997 to

expand Medicaid coverage for uninsured children (with minimal co-pays) up to 200% of the poverty level.

Since December of 1997 much of the CMS effort to serve CSHCN has revolved around a contract with the Medicaid program. The contract has two main objectives:

1. To assure that families with CSHCN receive necessary medical services and are linked with appropriate social, educational and economic services to be able to continue to care for their CSHCN at home.
2. To assure that Federal and State monies allocated to Medicaid and the Title V CSHCN program are utilized for children in a cost-efficient manner.

The services prior authorized by CMS community-based staff for the Medicaid program are targeted case management, durable medical equipment, therapy (OT, PT and ST), private duty nursing, personal care and extension of benefits of medical supplies. CMS community-based teams assure that every CSHCN receives the services they need from specialists as well as primary and preventive care in their “medical homes.” During the past year CMS staff in cooperation with the Department of Education trained Medicaid providers on the prior authorization process at many sites across the State. Also CMS staff worked with specialists (development pediatricians at the University of Arkansas Medical Sciences’ Department of Pediatrics, therapists, psychologists, social workers and parents of CSHCN) to develop standards of care (protocols) to serve as therapy guidelines for specific diagnoses and conditions. The standards of care for therapies were completed last year, and clinical practice guidelines for cerebral palsy, speech language pathology, developmental delay, mental retardation and Down Syndrome have been established. Currently guidelines for autism spectrum disorder are being developed. One of the encouraging results of the 1999 CMS Parent Satisfaction/Needs Assessment Survey was that almost 45% of the survey respondents indicated that the CMS prior approval process had improved their child’s therapy services.

The community-based CMS teams work with private case managers to assure that every CSHCN receives all the care coordination services they need, including school and community services. In addition, the teams work with families in preparing them to be their own case managers. CMS social workers conducted six regional trainings for families in FFY’99. In addition, CMS social workers have done numerous individual family trainings on home visits and at specialty clinics. Resource directories are provided to families.

CMS continues to serve all CSHCN with potential diagnoses by providing diagnostic evaluations if the conditions have not already been diagnosed and provides care coordination and direct pay for medical services to the non-Medicaid population.

In a March 1999 pilot project, CMS expanded dental services for non-Medicaid CSHCN and limited services for clients between 185% and 350% of the poverty level. The pilot project defined dental and oral health needs including orthodontia services to be "special needs." Prior to March 1999 CMS approved orthodontia services only for children with cleft lip and palate or other diagnoses. The pilot project also increased the age limit for non-Medicaid clients from 18 to 21 to correspond with the age limit for Medicaid clients served under EPSDT. However, by September 1999 the expansion was rescinded when demand exceeded the financial capacity of CMS to pay for services. In the fall of 1999, the age limit was returned to 18 and in May 2000 CMS restored the income limit of 250% of poverty for non-Medicaid clients for the program.

In December 1999 CMS concluded the last year of a three-year respite grant under which about 400 CMS clients, both Medicaid and non-Medicaid were served annually. The CMS Parent Advisory Council sponsored a bill in the 1999 legislative session to continue the respite program with a Medicaid waiver. Although the bill did not pass, it did serve as a catalyst to prompt the director of the Medicaid program to authorize the writing of a respite waiver application and to come up with the state general revenue to match the federal Medicaid dollars. Currently the Medicaid director has postponed sending the waiver application to the Health Care Financing Administration due to a budget shortfall in the Medicaid program.

CMS staff continues to attend many medical/habilitation clinics around the State. The Department of Pediatrics at the University of Arkansas for Medical Sciences coordinates the clinics. CMS staff performs clinic checkouts, making sure that families of CSHCN understand the doctors' orders and prescriptions. CMS staff communicates via e-mail with all clinic staff including physicians and, nutritionists.

All children on SSI automatically receive Medicaid in Arkansas. About a third of the CMS Medicaid clients receive SSI. The CMS SSI Coordinator continues to review SSI pending evaluations. She makes referrals as needed to the First Connections (Early Intervention) Program and/or to CMS. Mental Health referrals will be added in the near future.

CMS continues to be a family-centered program as the CMS Parent Advisory Council meets quarterly to provide advice to CMS management staff on policy and procedures. The CMS

Parent Activities Coordinator, who is the parent of a teenager with spina bifida, serves on the CMS Management Team and is in charge of assisting parent support groups in addition to publishing the quarterly CMS Parent Newsletter. He will also head up the CMS transition services effort.

CMS continues to pay for summer medical camps for clients and medical/habilitation clinics for staff. The Department of Pediatrics at the University of Arkansas for Medical Sciences now has the responsibilities of coordinating, transcribing and distributing the dictation from the clinics.

CMS staff help families understand doctor's orders and prescription upon clinic checkout. They interact with the medical professionals in clinics via email.

### **1.5.1.3 Other Capacity**

The number of ADH employees funded by the Maternal and Child Health Block Grant (MCHBG) is not indicative of the number of ADH employees who work on Title V Programs. In FY 1999, approximately 116 personnel, 90 field, were funded by the MCHBG. However, the Title V effort included a total of 207 full time equivalents (FTEs). The ADH, MCH team is part of the Public Health Programs Group. MCH personnel include a Medical Director, Administrative Director, a Chief Nurse Consultant and a Management Project Analyst. Others on the MCH team include colleagues from Child and Adolescent Health, Oral Health, Women's Health, Perinatal Health, Reproductive Health with the Unwed Birth Prevention Project, Abstinence Education and WIC.

Richard Nugent, M.D. has been the Medical Director of the MCH team since 1992. Dr. Nugent is a 1962 graduate of Amherst College, in Massachusetts. He completed his doctor of medicine degree and OB/GYN residency training at the University of Pennsylvania at Philadelphia in 1966. In 1974 he received his Master of Public Health degree from the University of North Carolina at Chapel Hill. He is trained in OBGYN and board certified in General Preventive medicine.

Jean Hagerman became the Administrative Director of the MCH team in March of 1999. She is a 1975 graduate of the University of Arkansas at Little Rock where she also completed a Master of Public Administration degree. She came to the Arkansas Department of Health in 1975 and has 24 years of experience in public health.

Childrens Medical Services (CMS) has a total of 33 community-based teams in 28 cities in Arkansas. Five of the community-based teams are in Pulaski County. As of May 27, 2000, there were 82 community-based staff, 34 central office staff for a total of 115 positions. Eleven parents of CSHCN serve on the staff; seven are nurses, two are secretaries, one is a social worker and one is the Parent Activities Coordinator.

The CMS Management Team is responsible for planning in an advisory capacity and reports to the CMS Program Director. The Team is composed of the Program Director's Administrative Assistant, all three Unit Managers, Community-Based Nursing Supervisors, Clerical Supervisors, the Parent Activities Coordinator, the SSI/TEFRA Coordinator, the Transportation Coordinator, and the Health Information Manager. For evaluation and data analysis purposes, the Information Systems Unit Manager assists the Program Director.

Dr. Gil Buchanan has been the Medical Director of Arkansas Children's Medical Service (Title V, Children with Special Health Care Needs) since 1979. He is a graduate of the University of Arkansas at Fayetteville and the University of Arkansas Medical School. He has been in private practice in Little Rock since 1965. He is board certified in Pediatrics.

Nancy L. Church is the Program Director for Childrens Medical Services. She received her Associate Degree in Nursing in May of 1978 from the University of Arkansas at Little Rock. She also completed four semesters at the Warren A. Candler Hospital, School of Nursing in Savannah, Georgia in 1954-55 while attending Armstrong Junior College. Her work history includes serving as LPN Staff Nurse and Intensive Care Nursery RN at Baptist Medical Center in Little Rock before joining Childrens Medical Services in 1980. She began as a nurse consultant for CMS and was promoted to Nursing Supervisor in 1982. Ms. Church has been the CMS Program Director since 1990.

### **1.5.2 State Agency Coordination**

The Departments of Health, Human Services and Education are three separate state agencies but work closely to meet the needs of the maternal and child health population in Arkansas. Many relevant organizational relationships among and within state agencies also exist at state and local levels:

One of the most significant achievements of the year is the rapid expansion of the department's statewide initiative, Hometown Health Improvement (HHI). What started in

December 1998 with one pilot county (Boone County) has grown into eleven counties designated as HHI, with two additional counties identified as joint ventures and five more counties earmarked to begin their HHI community mobilization by October 1, 2000. The department plans to expand HHI to include 15 to 20 additional counties by the end of the next state fiscal year, June 30, 2001. Viable state and community partnerships, established by Hometown Health Improvement sites to assess, plan, develop, and evaluate local initiatives are paramount to achieving Title V performance goals.

Hometown Health Improvement sites provide organized approaches to identifying and implementing effective community health strategies. This model emphasizes the elimination of duplication of effort. It promotes community based health status assessment and prioritization of health issues and needs. The HHI encourages locally designed strategies to address the Title V national and state negotiated performance measures. It allows communities to create systems that plan for health, promote healthy behaviors and provide services that are appropriate for their needs.

Technical assistance is provided to HHI sites to assist communities in achieving their identified goals. Regional HHI Coordinators are the contacts for general information regarding resources such as model programs and funding sources. Other technical assistance aspects of facilitating HHI's expansion include, data collection/analysis, survey development, focus group research, and media/press contacts, training, prioritizing issues and evaluating results. Technical assistance is also available through the central office staff (Statewide and Shared Services) with expertise in health education and promotion, nursing, social marketing and media, maternal, child and adolescent health, environmental and numerous other areas of public health.

HHI Coordinators utilize presentation packages designed to give communities an overview of HHI. Each package includes general information about coalition development, the assessment process and information about how ADH can assist them. In conjunction with the Arkansas Community Integrated Service System/Community Organization Grant (CISS/COG), a statewide training module was presented in October 1999. It provided participants with information on the criteria for a successful coalition, principal elements that help to sustain a successful coalition, and guidelines on developing community leadership and engaging new community leaders in the process. A second statewide training module designed to expand participant knowledge was presented in conjunction with CISS/COG technical assistance in April 2000. The training was

entitled, “Creating Public/Private Partnerships that Work”. The feedback from participants about the modules was very positive. The presenter plans to return to Arkansas and present these modules at the local level with much broader community involvement.

The agency home page [www.healthyarkansas.com](http://www.healthyarkansas.com) has a section devoted to HHI. This allows individuals to access information about HHI, including the location of current HHI sites and a list of contact people for each site. An internet based resource directory which, will expand as more HHI sites come aboard, contains information on funding sources, model programs, data sources and overall information regarding issues related to minority health, maternal and child health, adolescent health, and elderly issues.

During FFY 99 staff of the State Systems Development Initiative (SSDI) worked to support communities by facilitating the expansion and implementation of HHI models in five public health regions (counties are re-grouped from the 10 former health areas). Currently five HHI Coordinators work with local health unit administrators, local DHS staff, MCH Specialists (field consultants), health educators, nurses, and community leaders to find solutions to locally identified health related problems within the regions. Future plans include placing additional colleagues in the regions as HHI coordinators.

Orientation/training of each new HHI site includes a component on core public health functions. Training sessions provide case studies so participants can apply knowledge learned to activities relevant to core public health functions.

ADH also sponsors the Arkansas Leadership Academy, a joint endeavor with the University of Alabama/Birmingham School of Public Health. The Academy is a six-day training/workshop held over the course of a year. One hundred twenty colleagues have participated in the Academy to date, with 70 slated to attend in FY 2001.

Colleagues are also encouraged to participate in the South Central Public Health Leadership Institute, a multi-state partnership encouraging public health leadership and skills development.

ADH is working with UAMS, health insurers, legislators and others through the Arkansas Center for Health Improvement (ACHI) to enhance public health policy in the state. This group advocates forming a school of public health. Meanwhile, UAMS through an affiliation with Tulane Medical School offers an MPH program requiring part-time attendance of courses in New Orleans. Many ADH colleagues at varying levels, in the field and central office, are enrolled in this program.

Arkansas' State Systems Development Initiative (SSDI) has been working since 1993 to facilitate development of state infrastructure, which in turn supports development of systems of care at the community level. This process strongly correlates with the infrastructure activities of the maternal and child health block grant and combines the efforts of ADH/MCH and DHS/CSHCN. SSDI in Arkansas is working with ADH/MCH and CSHCN to fulfill the requirements of the five-year needs assessment and collect specific data related to the performance measures. The SSDI community needs assessment and technical assistance activities centered on areas such as prioritization of health issues is an integral part of HHI.

Involvement of CSHCN representatives has increased through their participation in the community driven planning process. In the stakeholder identification process at the community level, CSHCN advocates are invited to participate. In Stone County (north central Arkansas), there is a very active community-based health planning committee chaired by a DHS, CMS nurse. A CMS Social Worker is also a member of the committee. This committee has a strong desire to partner with ADH in establishing a foundation for a HHI project in their county. In Scott County (west central Arkansas), a CMS Social Worker is a member of the HHI coalition. In Polk County (west central Arkansas), a CMS Social Worker is a member of the HHI coalition, Healthy Connections, Inc., a 501©3 established in that county. In Baxter County (north central Arkansas), a representative of the Special Services School for Children and Adults is an active participant in that county's coalition.

While these individuals are strong members at the local level, more needs to be done to encourage the support and involvement of advocates for children and adults with special health care needs. Through SSDI, ADH will seek to strengthen the relationship with CMS social workers and nurses at the county level.

In order to achieve local involvement in addressing community health needs, SSDI provided funding for community efforts to improve health status, reduce service gaps and address areas of need identified by the community. This approach provided mini-grants to local coalitions who have shown that local ownership of the planning process enables them to better utilize their resources for service delivery. In 1999, eleven proposals were received and three were funded at levels of \$3,000 to \$5,500. One subgrantee provided funding for printing 170 bound publications of the analysis of the YRBS conducted in Boone County in May 1999. The second provided funding to a rural county coalition that provided Red Cross First Aid and Infant/Child CPR

training and first aid kits to 54 families. It bridges the one-hour gap until a first responder (EMS) can arrive. The third sub-grantee provided funding to create 90 incentive "Bundles of Joy" baskets in support of women receiving first trimester prenatal care.

Communities that partner with HHI develop the capacity to assess the health needs of their communities, enhance their ability to meet those needs and strengthen the essential public health services in their hometowns.

◆ ADH/MCH has cooperative agreements with the state Medicaid program, state Department of Education, University of Arkansas for Medical Sciences, Area Health Education Centers and many community health centers. MCH is represented on boards, which advise Ryan White activities, genetics services, early intervention activities, early childhood education, adolescent mental health services, birth defect prevention and surveillance, perinatal health efforts, and University Affiliated Programs. The MCH program staff meet quarterly with substance abuse and primary care associations to assure coordinated effort.

◆ The Arkansas Department of Human Services and the Arkansas Department of Health implemented a Medicaid Family Planning Waiver Project in 1997. The long-term goal of the project is to reduce the number of unintended pregnancies in Arkansas. The waiver extends Medicaid coverage of family planning services to Arkansas women of childbearing age with a family income at or below 133% of the federal poverty guidelines. It also expands outreach and education to family planning services statewide. The target population is women ages 14 to 44, but all women at risk of unintended pregnancy may apply under the family planning aid category. Each new ADH region is adapting the individualized plans developed by the former areas to:

1. Increase the number of unduplicated women served in public health family planning clinics
2. Increase the percentage of pregnancies that are planned
3. And decrease the number of Medicaid deliveries

The data sources are the ADH Management System, PRAMS and Medicaid paid claims files.

◆ ADH participates, with 19 other states, in the U.S. Public Health Service/MCH Improvement Project Grant awarded to the University of Colorado at Boulder. The goals of the project include diagnosis of hearing loss by the time a baby is four months of age, and initiation of intervention services by six months of age. Components of these efforts are two ADH, Hearing Speech and Vision Services task forces for Assessment, Amplification, and Early Intervention. Task force

members include audiologists, university students in audiology and speech-language pathology and deaf education, the Arkansas Association of Hearing Impaired Children, the Arkansas School for the Deaf Early Intervention Services, Arkansas Children's Hospital, DHS/DDS Part C, and Children's Medical services.

- ◆ County and Regional Interagency Coordination Councils - Children's Medical Services relies on county and regional Interagency Coordination Councils and resource councils to fill gaps in services.

- ◆ Children's Medical Services (CMS) has been working more closely than ever with the State Medicaid Program in its role of issuing prior approvals for specialized services for CSHCN on Medicaid. The CMS Program Director and Community-Based Office Unit Manager participate weekly with Medicaid top management in their staff meeting. CMS staff are involved in assuring that Medicaid eligible CSHCN are age-appropriately immunized and receive EPSDT with the appropriate periodicity schedule. CMS will continue to work with the Early Intervention Program, the Departments of Health and Education, Children & Family Services, Mental Health Services, Rehabilitation Services, Ryan White agencies, the University Affiliated Program, and all other agencies relevant to CSHCN. CMS continues to have a close working relationship with Arkansas Children's Hospital (ACH), the major tertiary care facility in the State for CSHCN.

## **II. REQUIREMENTS FOR THE ANNUAL REPORT**

### **2.1 Annual Expenditures**

*See Forms 3, 4, and 5 in supporting documents.*

Title V partnership expenditures in FFY 1999 totaled \$24,257,888. Contracts for Medicaid quality assurance (outreach and education and CSHCN prior authorization) as well as income from the Family Planning Medicaid Waiver, continues to offset declining reimbursement revenue as a direct service provider.

CSHCN - In the FFY 1999 Title V application, other MCH targeted funding at CMS was estimated to be \$80,000. These were estimated receipts from the transportation program CMS provided for transporting CSHCN for various services. This program was discontinued June 30, 1999 and therefore this projection fell slightly short at \$54,846.

In FFY1998, CMS began assessing Medical Services for children on Medicaid to assure appropriate services are delivered while avoiding over utilization in the Medicaid program

through an agreement with Medicaid. These funds were estimated at \$3,909,352 and are not categorized as program income to Title V. The actual amount of these funds was \$3,109,369 through cost allocation. These funds are considered as income under Other Federal Funds along with the respite grant of \$200,000.

Planned expansion, new positions, and expenditures were curtailed or not initiated early enough to impact expenditures by CMS resulting in a carryover of Title V funds of \$1,373,870 to be expended in FFY 2000.

Expenditures in FFY 1999 did not decline. Total FFY 1999 expenditures were \$9,816,181, which exceeded FFY 1998 total expenditures of \$8,957,707. FFY 1999 carryover will be expended in FFY 2000. CMS budgeted an estimated carryover of \$981,711 for FFY 2000 in the FFY 2001 application.

The state funds expended for CMS totaled \$2,372,859 of which \$176,252 was spent on administrative costs, the remainder is derived from expenditures on direct services for CMS clients, and insurance collections for CMS authorized services. Without insurance collections, CMS would have to pay more out of state funds for direct medical services.

CMS administrative costs for FFY 1999 were 314,340 Title V funds and \$176,252 state general revenue.

The expenditures by types of service are estimated along with the breakdown of administrative costs for each of the four types of services.

## **2.2 Annual Number of Individuals Served**

See Forms 6, 7, 8, and 9 in Section 5.8, *All Other Documents*.

## **2.3 State Summary Profile**

See Form 10 in Section 5.8, *All Other Documents*.

## **2.4 Progress on Annual Performance Measures**

### **Direct Health Care/Enabling:**

#### **1) Preventive and primary care services for pregnant women, mothers and infants**

*State Negotiated Performance Measure: 24*

SP # 24 - The percent of pregnant women counseled for HIV testing. According to PRAMS data for calendar years 1997 and 1998, (reported as weighted frequencies), only 47 percent of new mothers in Arkansas reported that HIV prevention counseling was included in their prenatal care although 71 percent said care givers discussed getting the test and 85 percent were actually

tested. Seventy-one percent of Arkansas mothers received their prenatal care from private physicians and were least likely to be tested. 29% received prenatal care at ADH. Three out of four of those receiving prenatal care at a health department clinic remembered HIV prevention counseling as part of their prenatal education even though 99% of the patients receiving prenatal care at the health department were tested.

Other direct health care/enabling accomplishments for pregnant women, mothers and infants:

- ◆ County health units continued to work closely with local physicians. More local health units (LHU) referred maternity patients to private physicians for maternity care at earlier gestational ages. A few communities made the decision to refer all patients to private doctors and to eliminate the maternity clinic. This had a negative impact on maternity Medicaid revenue, which is used to support maternity services statewide.

- ◆ The work-site prenatal care program, *Babies and You*, continued to be promoted to companies throughout the state. Personal contacts and/or training sessions were provided to more than 135 companies. Fifty-four companies were actively enrolled.

- ◆ As a result of a Rubella outbreak in September of 1999, the perinatal team began evaluating the status of Rubella protection for pregnant women. The Arkansas Department of Health will initiate Rubella screening, counseling and follow-up for all pregnant women during FY 2000.

## 2) Preventive and primary care services for children

*State Negotiated Performance Measure: 22*

SP # 22 - The percentage of children through age 18 and below 200% of poverty enrolled in a child health insurance program. As of June 16, 2000, 53,698 children were enrolled in ARKids First. ARKids First is a Department of Human Services Medicaid waiver program, which offers health insurance to children through age 18 in families with incomes below 200 percent of poverty.

ADH facilitates enrollment of eligible ARKids applicants by providing after-hours coverage of the DHS toll-free help line through the Connect Care and/or MCH Health Line services.

## 3) Services for Children with Special Health Care Needs

*National Core and State Negotiated Measures: 1,2,3 & 25*

Under “Direct Health Care”, CMS has exceeded the annual performance objective for NP #1 and met the APO for NP #2. Under “Enabling Services”, CMS had two performance measures #3 and #26. Due to conceptual and data problems, CMS revised the calculation of the #3 indicator for the second year in a row. In FFY1999 CMS failed to meet the performance objective established for the first year of measurable data, FFY1997, although it did show improvement from the FFY1998 indicator. The main reason for the decreased indicators for FFY1998 and 1999 was the dramatic expansion of the CMS clients on Medicaid, which were added to the CMS database without properly documenting their primary care physicians (which CMS is using as a proxy measure for “medical home”). CMS has become much more careful in its data entry and expects the FFY2000 data regarding PCP’s and medical homes to be much more accurate and complete. On SP #26, CMS changed the denominator to the same figure as the CMS total caseload from Form 7 for FFY1998 in accordance with the regional review recommendation. This resulted in a lower annual performance indicator and CMS lowered the performance objective (since it was based on the ’98 data) accordingly. The indicator for SP #26 was even lower in FY1999 due again to the increase in CMS clients on Medicaid. Many of these clients received specialty services in FFY1998 but ceased receiving them in 1999; yet they were kept on the caseload mainly so that the families could continue to receive the CMS newsletter, participate in support group meetings and receive other information from CMS. This situation is expected to continue in FFY2000.

**Population Based:**

1) Preventive and primary care services for pregnant women, mothers and infants

*National Core and State Negotiated Measures: 4, 9, 10, 19 and 20*

NP # 4- Percent of newborns in the state with at least one screening for PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases). Targets continue to be exceeded with 99-100% of newborns receiving at least one screen during FY99. Staff have dedicated efforts to strengthening the Arkansas Genetic Services Advisory Committee. The goals of the committee include coordinating genetic services to improve care of patients and their families in order to prevent or ameliorate genetic disorders. Members represent the following groups: State Genetics Coordinator, parents/consumers, government officials, service providers, business community, clergy and non-government/public policy individuals. Programmatic

direction is influenced also through staff participation in the Coalition of State Genetics Coordinators that meets in symposium twice annually.

NP # 9 - Percentage of mothers who breastfeed their infants at hospital discharge. Data reported in this application are from the 1996 and 1997 Ross survey. 1998 and 1999 statistics are estimates based on trends observed in breastfeeding rates from PRAMS and applied to 1997 Ross statistics. According to 1998 PRAMS data, 56% of mothers reported initiating breastfeeding.

Although breastfeeding upon hospital discharge is an important indicator, it is also important to consider the duration of breastfeeding as it is directly related to overall infant health. The breastfeeding duration falls short of the intended goals for infant feeding in Arkansas. According to PRAMS data among women who initiate breastfeeding only 53% continued longer than 12 weeks. For successful sustained breastfeeding to occur there must be easily accessible support for mothers. Most difficulties do not occur until after discharge.

NP # 10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge. During FY99, 50% of newborns received a physiologic hearing screening before hospital discharge. The number was slightly higher for CY 99 at 57% of newborns receiving a screening. Since the passage of universal newborn hearing screening (UNHS) legislation (Arkansas Act 1559 of 1999,) many of the state's birthing hospitals have voluntarily initiated UNHS programs in anticipation of promulgation of the rules and regulations.

In accordance with the previous Act 1096 of 1993, 89% of newborns were screened by questionnaire to determine possible high-risk for hearing loss. These "paper" screens were completed by hospital personnel and sent to the ADH. Through the agency's Infant Hearing Program, (IHP) monthly and semiannual reports were generated from the database to monitor IHP activities statewide. A follow-up report was sent to the primary care physician for each infant found to be at risk for hearing loss.

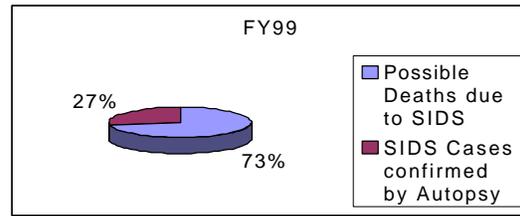
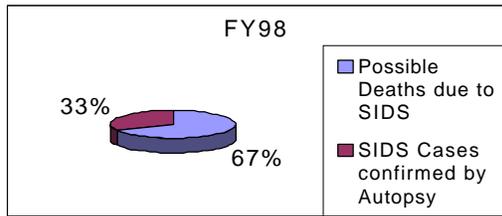
ADH colleagues have continued to provide information, in-services and technical assistance to the public, other professionals, and hospitals concerning UNHS. The ADH provides support for and coordination of the activities of the Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board established in Act 1559.

SP # 19 - The percent of infant deaths reviewed/investigated. The Arkansas Department of Health was awarded the Infant Mortality Review Grant in October 1997. The grant extends to October 2000. The Arkansas Infant Mortality reviews infant deaths, birth to 12 months, statewide. Arkansas has approximately 300 infant deaths each year. The program identifies needs related to potential changes in policies and programs that impact infant mortality.

To date approximately 415 death notices have been sent to the ten IMR Coordinators for investigation and review. A preliminary report was prepared and presented to the Arkansas Perinatal Advisory Committee in November 1999. Subsequently in June 1999, another report was prepared for presentation at the National IMR conference. The latest report identified some needs associated with infant deaths throughout the state:

1. Education related to:
  - b. SIDS, co-sleeping “Back to Sleep” advice
  - c. Signs, Symptoms and management of preterm labor
  - d. Shaken baby syndrome
  - e. Parenting classes
  - f. Abstinence
2. Access to counseling for:
  - a. Smoking cessation
  - b. Genetic health
  - c. Substance abuse
  - d. Physical abuse
  - e. Neural tube defects
3. Access to special perinatal services
  - a. High risk consultation by phone
  - b. Referral to Tertiary care when needed
  - c. Level II Ultrasounds
  - d. Prenatal records incorporated into hospital charts

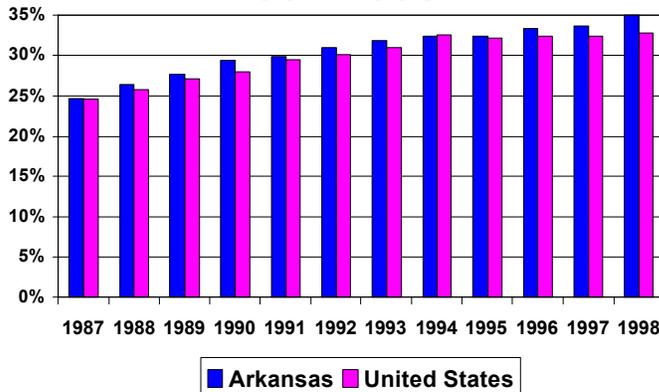
Community Action Teams make recommendations and policy changes as needed to address these issues. Agency colleagues work to improve communication and follow-up with the state's coroners who report suspected cases of Sudden Infant Death Syndrome. In FY98, there were 51



possible deaths due to SIDS reported with 25 of those confirmed by autopsy. In FY99, there were 61 possible deaths due to SIDS reported with 23 of those confirmed by autopsy.

SP # 20 - The percentage of births to unmarried women. In Arkansas live births to unmarried mothers increased 5.4 percent from 12,245 in 1997 to 12,910 in 1998. The increase occurred for both black and white mothers, with 6,710 (23.9) percent) of white live births occurring to unmarried mother and 5,930 (74.4 percent) of black live births occurring to unmarried mothers.

### Percent Unmarried Births Arkansas and United States 1987-1998



The number of live births to adolescent mothers, those under the age of twenty, continued to decrease, from 7,008 in 1997 to 6,831 in 1998. As a proportion of all live births, births to adolescent mothers declined from 19.2 percent in 1997 to 18.5 percent in 1998. This decline in the percentage of adolescent mothers occurred for both blacks and whites (16.3

percent to 16.0 percent for whites and from 30.2 percent to 28.4 percent for blacks).

The State Unwed Birth Reduction Strategy Committee was formed in FY 1997. The mission of the committee is to prevent unmarried teen pregnancy in Arkansas. The program is using a multifaceted approach similar to that of the National Campaign to Prevent Teen Pregnancy. The Reproductive Health team supervises administration of this program.

1997 legislation established the Arkansas Department of Health as the coordinating agency for unwed birth and teenage pregnancy prevention and appropriated \$1,040,700 for each year of

the biennium for this purpose. A multiple component prevention program was implemented and includes:

3. Funding of abstinence only education efforts
4. Appointment and involvement of state level strategy committees
5. Implementation of a Health Care Financing Administration Medicaid waiver which extends coverage for family planning services to 133 percent of poverty
6. Funding to support coalitions in counties with the highest number of unwed births
7. A statewide multimedia campaign
8. Technical assistance to local communities
9. Program evaluation.

In FFY 1999 the 15 Unwed Birth Prevention coalitions became more cohesive and exhibited increased awareness of the negative economic impact teen pregnancy has on communities. Also noteworthy is the increasing number of county unwed teenage pregnancy prevention coalitions that are partnering with local Transitional Employment Assistance (TEA) coalitions to coordinate programs and pool resources improving program effectiveness.

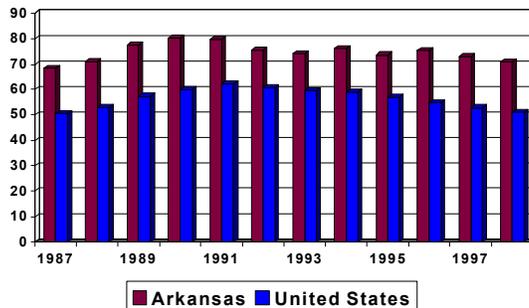
New Futures for Youth, (NFY) the technical assistance and evaluation sub recipient, provided each coalition county-specific data useful in assessing local needs. NFY conducted 17 site visits to monitor progress toward the performance measure during SFY 1999. NFY also provided technical assistance for up to five representatives from each coalition via three conferences. Conference participants shared information about different teen pregnancy prevention curriculum and were exposed to national speakers who presented TPP programs that work.

## 2) Preventive and Primary Care for Children

*National Core and State Negotiated Measures: 5, 6, 7, 8, 21, & 27.*

NP # 5 - Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. Using a data collection system developed by the CDC, the Clinical Assessment Software Application (CASA), the percentage of children less than two years old seen in Arkansas Department of Health (ADH) local health units with completed immunization was 86.8% in CY 1999.

## Teen (15-19) Fertility Rate Arkansas and United States 1987-1998



NP # 6 - The birth rate (per 1,000) for teenagers aged 15 through 17 years.

In 1998 there were 6,680 births to Arkansas women 15 to 19 years of age. There were an estimated 94,528 women of that age living in the state. The Teenage Fertility Rate was 70.7 for Arkansas compared to the national rate of 51.1 in 1998. The

average teenage fertility rate for the period of 1994 through 1998 was 73.7. Teenage fertility rates are highest in eastern Arkansas in the Mississippi Delta region. Phillips County had the highest average fertility rate for women 15-19 years of age at 138.3, while Faulkner County had the lowest at 35.4.

ACT 1159 of 1997 designated the Arkansas Department of Health as the lead agency for unwed birth and teenage pregnancy prevention. ACT 1101 appropriated \$1,040,700 for each year of the biennium for this purpose. Act 1000 of 1999 continues this program. Funds are authorized in the ADH appropriation. Major accomplishments to date include:

- ◆ Appointed a 25 member legislatively strategy committee
- ◆ Hired a program director
- ◆ Set the target or mission of the program
- ◆ Funded of 15 county coalitions
- ◆ Funded technical Assistance/Evaluation provider
- ◆ Sponsored a statewide youth conference held in December 1998
- ◆ Initiated a statewide media campaign in February 1999 (10 TV and 40 radio stations)
- ◆ Sponsored three grantee training sessions

NP # 7 - Percent of third-grade children who have received protective sealants on at least one permanent molar tooth. Sealant utilization and assessment of oral health requires primary data collection or screening of a representative sample of school children. During 1999, the Arkansas

Oral Health Advisory Committee conducted a study to collect data on sealant utilization. This study was expanded for the 2000 survey to include data on decayed, missing and filled primary and permanent teeth; caries rates; and untreated caries along with sealant data.

Elementary schools were randomly selected for the study. Letters of invitation to participate in the study were sent to eighteen school superintendents across Arkansas in November 1999. All eighteen superintendents invited to participate agreed to assist with the survey. Each superintendent notified the Office of Oral Health as to which class in the selected schools would participate.

An information sheet on dental sealants, explaining the survey, was sent to each student's home along with a permission slip for survey participation. Only students whose parents or guardians signed and returned the permission form were screened.

Only licensed dentists are allowed to perform dental examinations in Arkansas. Although the 1999 study used eighteen different volunteer dentists, the 2000 survey was conducted entirely by the Director, Office of Oral Health to maximize comparability of data. The Director traveled across the state during February, March and April, visiting all eighteen schools and examining 299 children.

Each classroom visit included a grade-appropriate educational opportunity on oral health followed by the examinations. Examinations were conducted in the classroom utilizing a portable dental light, and sterile, single-use mirrors and explorers. Each school was asked to provide an adult to enter data as it was collected. Some schools provided adult volunteers while in most schools the teacher did the data entry. The newly created recording form allowed for easy data entry by non-dental personnel.

Following the examinations, each student was provided with a referral form to take home. The form stated that school-based screenings do not take the place of regular dental examinations in a dental office, but are to collect data on a large population. The form allowed the examiner to indicate to the parents that oral health conditions were adequate, conditions existed that needed attention when convenient, or that conditions existed that needed immediate attention. Referrals in the most serious category indicated that the child had apparent pulpal involvement, the child already experienced pain or, in the examiner's clinical judgment, the conditions would soon cause abscess or pain. Referrals in the second or third categories were not made if, in the

examiner's opinion, a carious primary tooth would be exfoliated before more adverse conditions presented.

An estimate of socio-economic level was made using the percentage of children participating or eligible for the free or reduced-cost lunch program. The Arkansas Department of Education provided Free/reduced lunch data for each school.

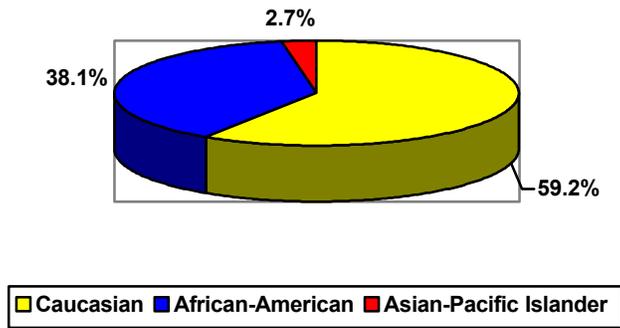
◆ Following completion of data collection, all teachers involved were sent thank you letters with an enclosed survey to measure their satisfaction with the classroom interaction. They were queried about the paperwork involved, the oral health education provided, the disruption of the class schedule and whether they would be willing to participate again in the future. Fifty percent of the teachers returned the follow-up survey. All responses either agreed or strongly agreed with the survey statements:

1. Arrangements before the survey were well handled.
2. The permission letter and information sheet were adequately designed to gain parental support.
3. The paperwork associated with data collection was easily completed.
4. The accompanying education program was of appropriate length.
5. The accompanying education program was presented at an appropriate level for my students.
6. The oral health survey was conducted in a manner to minimize disruption to the class and the day's schedule.
7. I would be willing to participate in the survey again.

**Survey Subjects:**

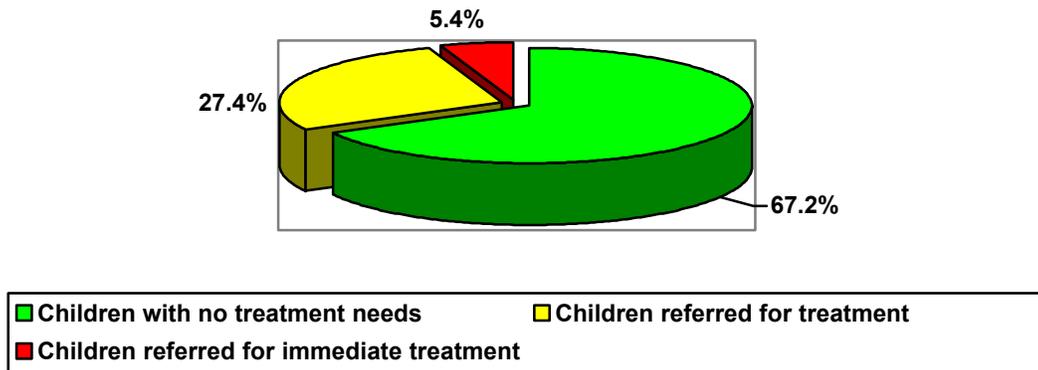
- ◆ A total of 299 children were examined.
- ◆ Of the 229 children participating, 177 were Caucasian (including Hispanics), 114 were African-American, and 8 were of Asian or Pacific Islander heritage.

### Distribution by Ethnic Group



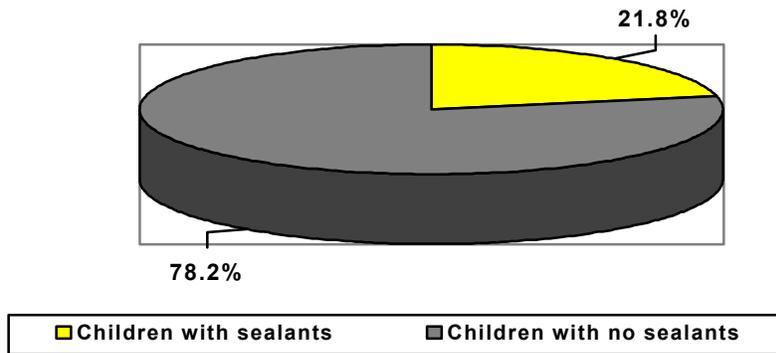
- ◆ An additional 54 children did not participate either because no permission slip was returned or because the parents asked that their child be excluded from the survey.
- ◆ 82 children (27%) were referred for dental care with an additional 16 (5%) referred for immediate attention.

### Children Referred for Dental Care



- ◆ 21.8% of children examined had at least one dental sealant. Individual schools had a sealant rate of from 0.0% to 60.0%.

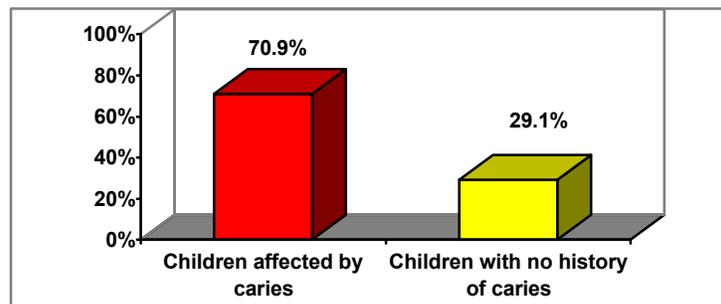
### Children with Sealants on One or More Permanent Molar Teeth



- ◆ The 299 children examined had 893 teeth that had been affected by decay, meaning that the tooth was decayed, had already been filled, or had been lost prematurely due to decay. This resulted in a DMF (decayed, missing or filled) rate of 2.99, meaning that on the average, each third-grade student in the survey has approximately three teeth that are decayed, or have been decayed.
- ◆ Of the children examined, 212 children or 70.9% had teeth affected by caries.

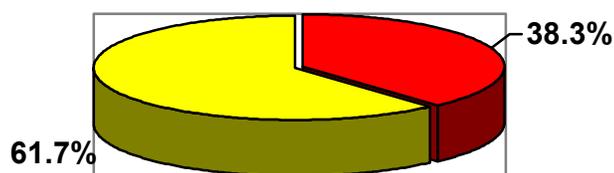
### History of Caries

(Children with one or more teeth decayed, missing due to decay, or filled)



- ◆ Of the children examined, 115 children or 38.3% had untreated dental caries.

### Untreated Decay in Arkansas' Third-Grade Children



■ Children with untreated decay ■ Children with no untreated decay

- ◆ 59% of the children participate or are eligible for the free or reduced cost lunch program in their schools. The rate of eligibility in the individual schools ranged from a low of 8% to a high of 94%.

According to the National Institutes of Health, the placement of sealants is a highly effective means of preventing pit and fissure caries. Sealants are safe and placed easily and painlessly. Sealants are currently underused in both private and public dental care delivery systems. Sealant usage in Arkansas is slightly lower than the national rate (21.8% compared to 23.0% from NHANES III) while the Healthy People 2010 objective 9.9a calls for increasing the proportion of 8-year-old children who have received dental sealants on their first permanent molars to 50%.

The sealant rate did not show significant differences based on ethnic group. The highest sealant rates were seen in schools with the lowest percentage of children on the free and reduced-cost lunch program (60/0%) and in a school located across the street from a hospital-based dental clinic that treats many of the children in the school (62.5%).

The rate of untreated caries was lowest in the school with the highest socio-economic indicator. The overall rate of 38.5% of all third-graders with untreated caries points out that access to quality dental care continues to be a problem for many children. This data shows that Arkansas lags seriously behind the Healthy People 2010 goal of 16% of 6-8 year olds with untreated caries on primary and permanent teeth.

During discussions with the children in the survey, the examiner discovered that many children with mild to severe dental problems either had no regular dentist or had never seen a

dentist. The problem of access to dental care will only increase in the coming years as the number of dentists licensed in Arkansas decreases.

The reasons for the underutilization of sealants are complex, but are affected in great part by the personal preferences of local dentists and their auxiliaries. Intensive efforts should be undertaken to increase sealant use through professional and lay education. Expanding the use of sealants would substantially reduce the occurrence of dental caries in this population.

The 1960's era of "Look mom, no cavities" has not yet arrived in Arkansas. Seven out of ten children are still affected by dental caries. Currently in Arkansas only 58% of the population is served by fluoridated community water systems (cp. Healthy People 2010 Objective of 75%). No statewide fluoride mouth rinse initiative exists. Efforts to expand sealant usage along with other proven preventive measures must be expanded to protect the oral health of our children.

The NP # 8 - Rate of death to children aged 1-14 caused by motor vehicle crashes. The Office of Childhood Injury Prevention provides staff support for the Arkansas SAFEKIDS (ASK) Coalition. ASK is a joint effort between the Arkansas Department of Health and Arkansas Children's Hospital. The coalition includes over 30 organizations that work together to reduce the number of fatal and non-fatal injuries to children. Their efforts focus on creating safer homes and communities through education and intervention. One of the activities ASK is involved in, is educating children and care givers on the importance of using seat belts and child safety seats. ASK, and other health and safety organizations, participate in numerous child safety seat checks across the state. These checks involve examining child safety seats for installation errors, structural damage, and recall issues. In the past year, over 700 seats have been checked in Arkansas, with an improper usage rate of more than 90%. Utilizing federal funds and private donations, several of the check-sites provided new safety seats to families free of charge. The ASK also distributed more than 1000 free bicycle helmets during year to community and school groups, and at health fairs and bicycle rodeos.

To celebrate National SAFE KIDS Week in May, the ASK sponsors an interactive safety event at the Little Rock Zoo every year. In 1999, over 640 children participated in eight different safety stations to win free bicycle helmets and free smoke alarms.

SP # 21 - The percent of Arkansas high school students grades 9 through 12, who have engaged in sexual intercourse. Major accomplishments of the Abstinence Education Program to date include:

- ◆ Monthly meetings of the Governor-appointed Abstinence Education steering committee
- ◆ Sponsored statewide conferences in May 1999
- ◆ Funded 19 abstinence education grantees in January–September 1999
- ◆ Developed an appeals process and written grant review procedure for the abstinence program
- ◆ Initiated a statewide media campaign in February 1999

According to the 1999 Arkansas Youth Risk Behavior Survey, 56% of Arkansas high school students (grades 9-12) reported having had sexual intercourse. Twenty-two percent of all teens reported having sexual intercourse with four or more people in the 1999 survey compared to 25% in 1997.

SP # 27- The percent of overweight among low-income children ages 0 to five years. Arkansas is getting progressively fatter!! For 1999, the state prevalence of overweight children rose to 8.0%, continuing to parallel the upward path of the U.S. rate, which rose to 11%. A breakdown of race/ethnicity overweight data for 1999 shows, for Arkansas, 10.1% of Hispanic children, (same as 1998), 8.5% of African American children (up from 8.3% in 1998) and 7.4% of white children (increase from 7.1% in 1998) are overweight. The data source is the Pediatric Nutrition Surveillance System for 1999. Childhood obesity is a precursor to many of the adult diseases that are the leading causes of death in Arkansas, such as heart disease, cancer and stroke. Effective prevention of adult diseases associated with obesity should start during childhood, because as children age, overweight increases.

A multi-agency, multidisciplinary group will convene July 6, 2000 with the task of developing a document addressing the issues. Task force members represent nutrition, physical education, policy and finance, private and public agencies, professional and voluntary organizations, and experts in city/community planning.

The 1999 Youth Risk Behavior Survey of Arkansas high school students indicates 32.2% perceive themselves to be slightly or very overweight. From self-reported heights and weights, body mass index (BMI) was calculated for each student. Using a BMI of 95th percentile as the cut point indicating obesity, 10.9% of Arkansas youth are obese.

### 3) Services for Children with Special Health Care Needs

The state and National performance measures for Arkansas Childrens Medical Services address direct health care/enabling and infrastructure building services only.

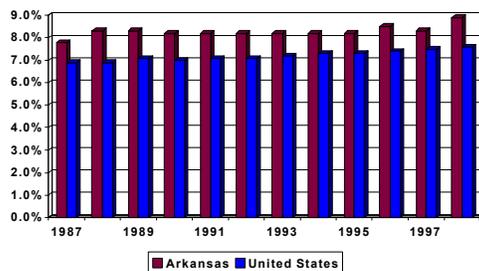
#### **Infrastructure Building:**

##### 1) Preventive and primary care services for pregnant women, mothers and infants

*National Core Measures: 15, 17 & 18.*

NP # 15 - Percent of very low birth weight live births. See NP # 17 below.

**Percent Low Birthweight Births  
Arkansas and United States  
1987-1998**



NP # 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. Thirteen Arkansas hospitals reported having a Neonatal Intensive Care Unit in the 1999 American Hospital Association Survey. Since there is no formal designation of “Level 3” hospitals in Arkansas, the Center for Health Statistics used the list of hospitals reporting a neonatal

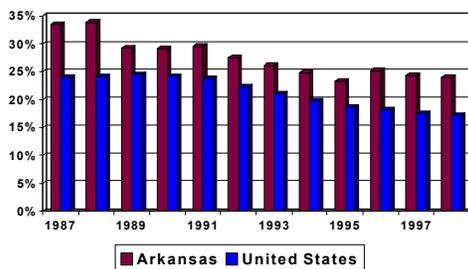
intensive care unit in the 1999 Arkansas Hospital Association annual facility survey. The LSU Medical Center in Shreveport, LA, the Lester E. Cox Medical Center in Springfield, MO and the Regional Medical Center in Memphis, TN also have Neonatal Intensive Care Units (NICUs) and serve many Arkansas residents. The following table contains data on births to Arkansas residents.

## VLBW (less than 1500 grams) births in NICU Hospitals

Table of NICU by Birth Year					
NICU	Birth Year				Total
	1996	1997	1998	1999	
<b>Not in NICU</b>	209 35.01	182 33.96	187 30.56	180 30.00	758
<b>In NICU</b>	388 64.99	354 66.04	425 69.44	420 70.00	1587
<b>Total</b>	597	536	612	600	2345

Frequency  
Col Pct

**Percent No 1<sup>st</sup> Trimester Care  
Arkansas and United States  
1987-1998**



NP # 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. The percentage of Arkansas women receiving no first trimester care in 1998 was 22.1. Jefferson, Ouachita, and Clark counties in Arkansas had the highest average percentages of mothers receiving no first trimester care at 31.0 percent, followed by Phillips, Lee, St. Francis, and Monroe counties at 29.4 percent. The lowest

percentage of women receiving no first trimester care was found in Randolph, Clay, Lawrence, Greene, and Jackson counties at 18.9 percent. In 1998, the average percent receiving no first trimester care ranged from a low of 12.5 percent in Greene County to a high of 41.9 percent in Phillips County. Receipt of prenatal care varies substantially by race. Arkansas' five-year average (1994-1998) for no first trimester care for white mothers was 20.1 percent. The percentage for black mothers was higher at 37.0 percent.

The Perinatal Health team continued efforts to streamline prenatal clinic activities and shift focus to less direct service. Several other policy changes were implemented which were aimed at

reducing staff time while improving quality of care. Two, one-week training sessions are conducted each year for new PHNs providing perinatal care.

The Perinatal Health team continued to provide support for the Campaign for Healthier Babies. The Campaign is a unique coalition of private and public organizations including the ADH, the Department of Human Services, the March of Dimes, UAMS Department of OB/GYN, Arkansas Children's Hospital in partnership with several hospitals throughout the state. During FY 1999, the Campaign was well into its 8th year of media coverage and distribution of the *Happy Birthday Baby Book* (HBBB). The goal of the Campaign is to encourage women to get early prenatal care. The campaign reports that the number of women in the State of Arkansas who respond to the Campaign's call to action has leveled off to approximately 17,800 to 19,700 per year. When compared to over 36,000 births in Arkansas annually, there are approximately 7,000 to 8,000 mothers who do not seek early prenatal care. The Perinatal team is working to reach these mothers with the early prenatal care message through the HBBB. In FFY 1999, a management services firm conducted a research project to understand the rational and emotional motivators for barriers against getting first trimester prenatal care. Their study concluded that women delay seeking prenatal care until they emotionally accept the fact that they are pregnant. Emotional barriers such as loss of self-identity, fear of the unknown, rejection and abandonment, fear of loss of control, and fear of judgment may prolong the acceptance of their condition.

The Perinatal team continued to regulate and monitor the practice of lay midwifery in Arkansas and provide staff support to the Lay Midwife Advisory Board at their annual meetings. In FY 2000, recommendations were made by the Board to revise the existing Regulations Governing the Practice of Lay Midwifery. The Perinatal team is still reviewing the regulations in preparation for possible changes. The North American Registry of Midwives National Certification examination has been implemented as the Arkansas licensing test. This will provide Arkansas midwives with a nationally recognized and validated testing instrument. A database, which includes the births reported by the lay midwives to the department, is used to improve our reporting and monitoring capabilities. Lay midwives are invited to the biannual maternity training course provided for PHNs.

Perinatal Health continued receiving a CDC MCH epidemiology grant. Major ongoing epidemiological projects include:

- ◆ Evaluating (three-years) the Campaign for Healthier Babies
- ◆ Matching the Medicaid Claim files to birth certificate files to enable an evaluation of the births paid by Medicaid
- ◆ Matching the ADH Management Information System to birth certificates to enable an evaluation of patients obtaining prenatal care at ADH.
- ◆ A review of smoking related to woman giving birth.
- ◆ A new publication analyzing perinatal health status indicators such as low birth weight and infant mortality.
- ◆ An in-depth analysis of low birth weight in regard to a significant rise in Arkansas' LBW for 1997.

The 14 member, Governor-appointed, Arkansas Perinatal Advisory Board continued to meet during FY 1999.

## 2) Preventive and primary care services for children

*National Core Measures: 12, 13 & 16.*

NP # 12 - Percent of Children without health insurance. In Arkansas there were approximately 130,000 (14% to 15% of all children) children under 19 years of age, at or below 200% of poverty, without health insurance in 1998. ADH continues to work with DHS through the Connect Care contract to increase enrollment in ARKids First. In addition, local health units continue to encourage enrollment in ARKids First.

NP # 13 - Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. Little data exists in regard to this objective. Population estimates from the Center for Health Statistics project a total of 339,634 children age 0-17 below 200% of poverty. Due to an inability to distinguish duplicate enrollees, the number of children enrolled in Medicaid/ARKids First cannot be determined.

NP # 16 - The rate (per 100,000) of suicide deaths among youths 15-19. The number of teen suicides in CY 1998 was 26 for a rate of 13.4 per 100,000. The Arkansas Department of Health (ADH) participates in the Youth Suicide Prevention Commission directed by the Attorney General's Office. In addition, the ADH has eleven school-based health centers that offer

counseling to students. Masters level social workers provide services to youth in two central Arkansas centers. Several centers in Eastern Arkansas employ Bachelors level social workers that coordinate mental health services. The ADH Adolescent/School Health Coordinator conducted several workshops on Adolescent Depression, and Developmental Assets and Resiliency for school counselors and nurses, state educational cooperative personnel. The coordinator also presented the same topics at the Louisiana Assembly on School Based Health Care.

### 3) Services for Children with Special Health Care Needs

*National Core and State Negotiated Measures: 11, 14, & 25.*

CMS had three infrastructure building performance measures: NP #11, NP #14 and SP #25. Indicators for NP #11 and SP #25 show that the measures were met in 1999 and the measure, for NP #14, was exceeded. Tracking of SP # 25 has been discontinued effective in the 2001 application. A new state performance measure 28 is the percent of 14 to 15 year olds on Children's Medical Services who state that CMS transition services have improved their knowledge and ability to transition into adult life.

#### **2.5 Progress on Outcome Measures**

The Arkansas Infant mortality rate increased from 8.7 deaths per 1,000 live births in 1997 to 9.2 deaths per 1,000 live births in 1998. There were 339 infant deaths in 1998, compared with 316 in 1997. The neonatal mortality rate increased from 5.1 deaths per 1,000 live births in 1997 to 5.7 death per 1,000 live births in 1998. The Postneonatal mortality rate showed a slight decrease, from 3.6 in 1997 to 3.5 in 1998. The Arkansas infant mortality rate remained higher than the national average in 1998 with a rate of 9.2 deaths per 1,000 live births compared to a national rate of 7.2. The Arkansas average was higher than the national average in both neonatal (5.7 versus 4.8) and Postneonatal (3.5 versus 2.4) mortality. Sixty-three percent (214) of the 339 Arkansans who died before their first birthday were less than 28 days old. Congenital Anomalies (birth defects) were the leading cause of infant deaths, claiming 84. Sudden Infant Death Syndrome was the second leading cause of infant deaths, with 37 deaths, followed by "Short Gestation and Unspecified Low Birthweight" with 33 deaths.

The infant mortality rate among blacks increased between 1997 and 1998, from 11.5 deaths per 1,000 live births to 12.8 in 1998. Although there was a decline in fetal, neonatal, and perinatal mortality rates, the increase reflected an increase in Postneonatal mortality, which rose from 3.5 in 1997 to 5.3 in 1998. As with past years, infant mortality rates remained higher for blacks than whites in 1998 at 12.8 versus 7.2 deaths per 1,000 live births. The infant mortality rate among whites increased in 1998, rising from 6.3 to 7.2, due to increases in both neonatal and Postneonatal mortality. The white neonatal mortality rate increased from 4.2 in 1997 to 4.7 in 1998. Similarly, white Postneonatal mortality rose 2.1 in 1997 to 2.6 in 1998.

For FY 98 there were 191 deaths of children 1-14 years of age, the same number as calendar year 1997. The number of Arkansans 1-14 years old (502,347) is estimated from the US Census figures released June 15, 1999 and the July 1, 1998 estimate released on the same date. Using these estimates in Arkansas the child death rate per 100,000 children age 1-14 was 38.0 in FY 98.

Although progress is occurring, IMR targets remain difficult to achieve. Systems changes must continue and be intensified. Through statewide efforts such as the Campaign for Healthier Babies, Arkansas has increased the number of women getting early prenatal care, but low birth weight rates continue to be high, which in turn impacts IMRs. There are many factors contributing to infant mortality and many strategies are needed to successfully impact these indicators. A strictly public health approach will not produce the desired results. Communities, local governments, businesses, and citizens must conduct needs assessments and develop local plans to meet their needs.

### **III. REQUIREMENTS FOR APPLICATION**

#### **3.1 Needs Assessment of the Maternal and Child Health Population**

##### **3.1.1 Needs Assessment Process**

The purpose of the State Systems development Initiative (SSDI) is to assist State Agency MCH and CSHCN programs in the building of State and community infrastructure that results in comprehensive, community-based systems of care for all children and their families. SSDI grant funds for the two-year project period October 1, 1999 to September 30, 2001 are to be used to assist States in the July 2000 five-year needs assessment and ongoing efforts to identify, describe and prioritize Title V MCH program needs.

In the summer of 1999, the Arkansas Department of Health, Section of MCH organized a team to assess the needs of the MCH population. Part of the cycle from data analysis to identifying priority needs includes sharing MCH data with communities through Interim Region Team Leaders (IRLs), Hometown Health Improvement (HHI) coordinators and HHI community coalitions. The MCH Needs Assessment Team conducted meetings with Area Managers, (now region team members) HHI Coordinators and Coalitions to:

1. Provide a brief primer on Title V, its history, purpose and requirements of the block grant.
2. Present Core and Developmental Health Status Indicator (HSI) data.
3. Assist colleagues in prioritizing indicators using a public health framework.
4. Promote data driven interventions/strategies by sharing county specific HSI data with communities.
5. Provide data & technical assistance to seven new Hometown Health Improvement counties.

The Arkansas MCH needs assessment team continues to provide guidance to identify assessment methods and priority needs, establish state performance measures, and collect data. Included on the team are public health and human service colleagues representing:

- |  |   |
|--|---|
| ◆ The State Systems Development Initiative | ◆ WIC   |
| ◆ The MCH Section staff                    | ◆ The Department of Human Services, Childrens Medical Service/CSHCN program |
| ◆ Child and Adolescent Health              | ◆ A parent of a child with special health care needs                        |
| ◆ The Office of Minority Health            | ◆ The Department of Education, Office of Comprehensive School Health        |
| ◆ Perinatal Health                         | ◆ The Arkansas Chapter of the March of Dimes                                |
| ◆ The Office of Primary Care               |   |
| ◆ Reproductive Health                      |   |
| ◆ The Office of Oral Health                |   |
| ◆ The Center for Health Statistics         |   |

The needs assessment process among the Hometown Health Improvement (HHI) sites is on going. HHI is a community driven process. SSDI and MCH must support the decisions made at the local level concerning priorities identified by the HHI coalitions. While SSDI and MCH at the state level recognize the importance of collecting and analyzing data relevant to CSHCN, their families, and over all MCH issues, we must respect the decisions made and the directions charted by the coalitions as they work toward improving the health of their citizens.

Currently three guidebooks in draft form are available to HHI sites. These tools offer communities direction, information and examples to assist them in organizing a local coalition. Guide 1, "Preparing for the Community Process" outlines the very basics of public health at the community level. Guide 2, "Building a Community Health Coalition" outlines stakeholder identification, effective team development, and communication plan guidance and promotion. Guide 3, "Assessing Community Health" defines various types of data and describes how it is collected and analyzed. These guides are available to all ADH colleagues working with HHI and community coalition leaders and representatives. Guide 4 will cover prioritizing issues and Guide 5 will cover the evaluation process. Both will be available in draft form by September 2001.

Other tools available for use in the HHI process are a project time line, a satisfaction survey, a local health planning/education initiatives survey, a local health unit readiness checklist and a local health unit HHI survey.

ADH's Office of Minority Health (OMH), working through HHI coalitions, provides technical assistance to communities to assess their needs. For example, in Sebastian County (northwest Arkansas), a group of minority leaders serving on the local HHI coalition requested needs assessment assistance and the resources available to address them. The Director of OMH contacted the Regional OMH and received funding to provide a one-day training on participatory assessment and planning. Each participant brought at least one other person to the training. Interpreters were on hand to assist with translation needs of the participants. This activity paved the way for translation assistance to the OMH during a recent TB outbreak in that region of the state.

Children's Medical Services (CMS) initiated the required five-year needs assessment in the fall of 1999. The Office of Research and Statistics within the Department of Human Services mailed a five-page survey to more than 20,000 families of children enrolled in CMS statewide. Included with each survey was a return postage paid envelope. All families returning their survey within 30 days participated in a drawing for a cash award. The survey had a response rate of about 20%. To identify priority needs, the CMS management team reviewed the results of six regional focus groups held throughout the State in 1999. The Developmental Disabilities Network sponsored the groups. In addition, members of the CMS Parent Advisory Council submitted comments concerning priority needs of CSHCN.

Systems of care efforts at the community level are supported by the SSDI project. The SSDI project assisted with completion of the data tables and the five-year needs assessment for the 2001 MCH block grant application.

SSDI supported the collection and analysis of relevant data on community identified health problems/indicators by using the Youth Risk Behavior Survey (YRBS). The following counties completed countywide YRBS surveys in their local high schools: Nevada, Montgomery and Pike. Two other counties, located in north central Arkansas, are interested in conducting the PRIDE survey when school reconvenes in the fall.

Boone County, the pilot HHI site, has completed and printed their assessment report. This report includes general demographic data describing Boone County, the results/key findings of the surveys done by each subcommittee and a list of accomplishments. Other HHI sites will publish their assessment/analysis plans as they move through the process.

SSDI works with the ADH/MCH to collect and analysis data from the countywide assessments, PRAMS, and infant death certificates through Title V and the department's Center for Health Statistics.

A UALR graduate student in Health Services Administration worked with the SSDI project coordinator to put together minimum data sets for all counties in Arkansas, documenting trends in areas such as COPD, stroke, heart disease, first trimester prenatal care and others. These data sets are available to the Regional HHI Coordinators to assist them in working with their coalitions in documenting the needs of their communities.

Arkansas is working in several ways to support HRSA's strategic goal to assure 100% access and 0% health disparities for all Americans. HHI works closely with the Office of Primary Care (OPC) in the designation/conversion of rural hospitals into Critical Access Hospitals (CAH). Arkansas currently has seven county hospitals converted to CAH: Izard, Scott, Logan, Franklin, Carroll, Dallas and Yell counties. Three more county hospitals are in the process of converting: Desha, Cross and Lawrence. This collaboration will decrease duplication of effort as we work to improve a community's overall health. The partnership offers opportunities for hospitals to shift their focus from treatment of illnesses to preventive medicine based on the needs of the community.

The Director of the Office of Minority Health (OMH) is the department’s lead person in activities related to Healthy People 2010. The director works within the agency to encourage all programs to use the 2010 goals and objectives in developing their program plans.

The Director of OMH also serves on the eliminating disparities conference planning committee with the HRSA West Central Cluster office in Dallas scheduled for September 6-7, 2000. The conference will encourage the development of a strategic plan for the region with HHS agencies, state partners, and federal grantees.

### 3.1.2 Needs Assessment Content

#### 3.1.2.1 Overview of the Maternal and Child Health Population’s Health Status

In the words of Governor Mike Huckabee, “it’s no secret Arkansas is one of the unhealthiest states in the country. Arkansas is one of 11 states designated by the National Heart, Lung and Blood Institute as part of the Stroke Belt. More than 450,000 citizens lack the basic insurance they need to receive health care.”

Arkansans are sicker and die earlier than most Americans.

According to the 1999 edition of the UnitedHealth Group State Health Ranking, Arkansas ranked 50<sup>th</sup> receiving a lower rating than last year's 48<sup>th</sup> and 1993's ranking of 45<sup>th</sup>. Arkansas has ranked in the bottom six states for the entire decade. High school graduation dropped from 74.9 percent to 69.8 percent of incoming ninth-graders this year and the number of those lacking health insurance increased form 21.7 percent to 24.4 percent

<b>United Health Group's Health Ranking for Arkansas</b>			
	<b>1999</b>	<b>1998</b>	<b>1990</b>
<b>Overall Ranking</b>	50	48	47
<b>Lifestyle</b>			
Prevalence of Smoking	40	38	35
Motor Vehicle Deaths	45	46	47
Violent Crime	29	27	23
Risk for Heart Disease	46	45	19
High School Graduation	28	19	17
<b>Access</b>			
Unemployment	41	34	41
Adequacy of Prenatal Care	46	48	46
Lack of Health Insurance	48	47	45
Support for Public Health Care	41	42	41
<b>Disease</b>			
Heart Disease	34	36	34
Cancer Cases	46	46	43
Infectious Disease	25	30	35
<b>Mortality</b>			
Total Mortality	42	43	35
Infant Mortality	38	43	30
Premature Death	45	46	43

of the population. Since 1990, Arkansas has experienced a slow drop in its healthiness score from 10 percent below to over 20 percent below the national average. Much of the decline is

linked to slower than average improvements in infant mortality, low insurance coverage, increasing crime and increasing risk for heart disease in the population.

Tobacco causes more deaths than any other preventable factor. Arkansas ranked 40<sup>th</sup> in prevalence of smoking in 1999 with more than one in four adults currently smoking. Each hour, an Arkansan under the age of 18 becomes a regular smoker. This year 2,200 Arkansans will be diagnosed with lung cancer and 2,000 will die of lung cancer; almost all of these deaths will be related to smoking cigarettes.

The priority needs section of this application describes in greater detail the specific health status efforts deemed as most critical to MCH populations in Arkansas. Selection of these needs was based upon ADH strategic planning, state and federal legislation, and a shifting focus to core public health initiatives to support local community prioritization and program development.

Section 1.4 describes many challenging public health issues facing Arkansans, all of which affect MCH populations directly or indirectly.

Perinatal Health through a CDC MCH Epidemiology Grant hired staff to work on program evaluation, needs assessment and analysis of common perinatal health indicators. Through the Governors Perinatal Advisory Board, the perinatal team provided the report, *Profiles of Low Birthweight Births* to providers, legislators, and local community leaders. The Perinatal Health team helps analyze the PRAMS data collected by the ADH Center for Health Statistics. Two years of data are completed. Analytic projects are underway investigating smoking during pregnancy, access to prenatal care, and unintended pregnancy as a risk factor for negative health outcomes.

The Arkansas Oral Health Needs Assessment Survey shows that only 21.8% of children surveyed had one or more dental sealants on permanent molars compared to the national Healthy People 2010 goal of 50%. The majority (70.9%) of all children surveyed had been affected by dental disease with an average of almost three decayed teeth per child (DMF = 2.99). Access to dental care is unattainable for many children, evidenced by the high number of children with untreated dental decay (38.3%). Efforts and resources must be targeted to increase the use of dental sealants, increase the percentage of Arkansans that enjoy the benefits of community water fluoridation, and assure that specific preventive and restorative dental services be provided to those children at greatest risk of oral disease.

Children’s Medical Services works with the State Interagency Coordinating Council and the Interagency Council on Self-Sufficiency in an on-going collaborative process of needs assessment and coordinated policy development. This process assures comprehensive, coordinated services for CSHCN and their families. There are collaborative agreements with Early Connections, the Transition Project, Arkansas Children’s Hospital, the Department of Health and several other agencies. Recently an Arkansas Disability Policy Consortium was formed to carry out the above objectives. CMS participates in the consortium with other state agencies and organizations relevant to persons of all ages with disabilities. Collaborative agreements with five nursing schools are renewed annually to provide nursing students with experience working with CSHCN.

No statewide prevalence data are available, nor was this covered on the Children’s Medical Services (CMS) needs assessment survey. However, the following table compares the number of children on Medicaid less than 21 with the CMS population for specific diagnoses.

<b>Chronic Illness/Disability</b>	<b># Of CMS Clients</b>	<b># Of Medicaid Clients</b>
Cerebral Palsy	1238	1874
Asthma	717	10672
Cystic Fibrosis	106	176
Epilepsy	929	1651
HIV/AIDS	6	5
Leukemia	70	135
Sickle Cell Anemia	116	347
Spina Bifida	263	345
<b>Totals</b>	<b>3445</b>	<b>15205</b>

As of May 1, 2000, there were a total of 362,314 Medicaid clients under the age of 21. This figure multiplied by 18% equals an estimated 65,217 CSHCN receiving Medicaid.

### **3.1.2.2. Direct Health Care Services**

### **3.1.2.3. Enabling Services**

As allowed by the guidance direct and enabling care services narratives have been combined. Section 1.4 under common requirements for the application and annual report, section 1.5.1.2. program capacity and section 2.4 of the annual report describes major ADH direct and enabling concerns regarding financial access to care, and cultural acceptability. Shortages of preventive and primary care services are discussed in this section.

Almost 97% of the respondents to the CMS needs assessment/client satisfaction survey indicated that CMS was providing “excellent” or “good” services for the family. More than 76% of the families indicated they were getting “well child checkups” and over 74% indicated they were getting dental checkups. However, of those not getting these checkups, 34% and 68% respectively said they needed them. More than 74% of the respondents said they were getting “sick care” services, but more than 34% of those not getting them said they needed them. About 87% of the respondents said they were getting pharmacy services, but about 35% of those not getting them said they needed them. Almost 98% of the respondents said their children were up-to-date on their shots/immunizations. The chief reason for not being up-to-date was “authorized medical reasons.”

Despite CMS’ extensive coverage of orthodontia during 1999, the percentage of survey respondents reporting that they needed but did not get orthodontia services remained the same at 23% as the last survey in 1997 (when there was very limited coverage of orthodontia and a much lower total caseload). The only other category of specialty services that approached the need of orthodontia was “Assistive Technology”. More than 20% of the respondents not getting assistive technology services said they needed them.

The need for transition services and the need for more and improved care coordination were identified as priorities in the CMS needs assessment. More than 47% of survey respondents indicated that it was important for CMS to help their children transition to adult services, almost 75% said that CMS had not helped them with transition services in the past year. One reason for the 75% negative response might be that only 15% of the survey respondents were for children ages 14 to 18 (who might be viewed as the children most in need of transition services). Concerning care coordination, almost 85% of survey respondents indicated that it was important for CMS to inform them about other services available to their families, but more than 58% said that CMS had not helped them with care coordination during the past year.

Related to the care coordination issue is the fact that more than 19% of the survey respondents indicated that they needed but were not getting parent support group services. Also more than 19% of the respondents indicated that they needed but did not get respite services. The CMS Respite Program had not ended at the time of the survey. The percentage reporting the need for respite care would probably be higher if the survey were conducted today. More than 41% of survey respondents indicated that they needed but were not getting “leisure activities”.

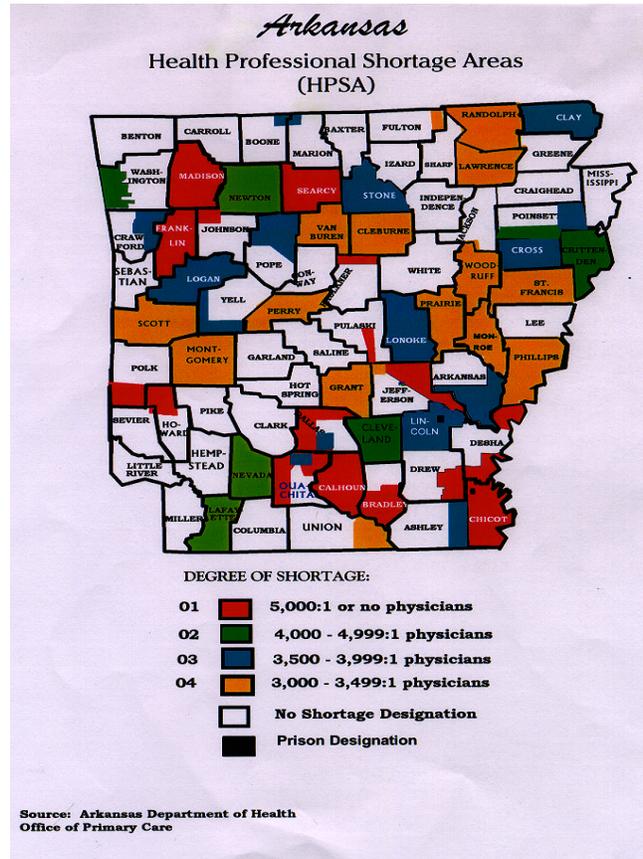
The effects of terminating the CMS transportation program were reported by 19% of the survey respondents who said they needed but did not get transportation to medical services. The importance of transportation in accessing medical services was reflected in the survey results to the question of how long it took to get from home to the primary care physician or the child's specialist. More than 30% of the respondents said it took from 30 minutes to an hour to reach their child's pediatrician (whom the majority identified over family practice and specialists as their child's PCP), and more than five percent said it took from one to two hours. The need for specialists in rural Arkansas was reflected by more than 22% of the survey respondents who indicated it took one to two hours to reach their child's specialists from their homes, and another 22% said it took more than two hours.

More than 78% of survey respondents indicated they were receiving financial assistance but more than 36% of those who said they were not receiving financial assistance said they needed it. Linked to the financial assistance issue, more than 66% of survey respondents stated it was important for CMS to help their family apply for Medicaid, but more than 60% of respondents indicated that CMS had not helped them apply for Medicaid during the past year. However more than 91% of CMS active recipients are already receiving Medicaid. The ARKids First Program which started in 1997 is credited with the drop in the State's percentage of uninsured persons from 24.4% in 1997 to 18.7% in 1999 as reported by the Census Bureau. Currently ARKids First provides Medicaid insurance coverage (with minimal copays) to about 53,698 children.

The Arkansas Medicaid program implemented managed care using a PCP-gatekeeper concept with no capitated rates and it has had little effect on CSHCN. For several years many CSHCN on CMS have been PCP-exempt and have not needed referrals in order to see specialists, who are for the most part already Medicaid providers. However, the PCP-exemption for CMS clients ends July 1, 2000, so it may become a problem in the future. In addition, many Medicaid PCP's have reached the maximum number of children they can serve and it is difficult to enroll with pediatricians in some areas of the State. Availability of care is hampered by a shortage of occupational therapists and private targeted case managers in many rural areas of the State (especially in the Delta region).

Despite market pressure to diminish a direct service role and organizational pressure to transition to Institute of Medicine (IOM) defined core public health, the Title V program continues as a key provider of preventive services for CSHCN.

A total of 59 Health Professional Shortage areas exist in Arkansas: Twenty-seven (27) full counties, twenty-eight (28) service areas, and four population groups. In particular, shortages exist in OB/GYN physicians, Medicaid dental providers, audiologists, certified nurse midwives, and pediatric sub-specialists. Shortages of occupational therapists, private targeted case managers and Medicaid PCPs in rural areas of the state adversely affect access to care among CSHCN.



### 3.1.2.4. Population-Based Services

Section 2.4 of the annual report (population-based services) describes major ADH population based initiatives.

Of the 26% of respondents to the CMS needs assessment survey that indicated their children with special needs were not getting dental checkups, over 68% said that they needed dental checkups. Similarly of the 28% who responded they were not getting dental care services, over 65% said their children needed such services. Some of the comments on the survey indicated that the parents have trouble finding dentists who will accept Medicaid reimbursement rates. Such comments are shared by CMS with Medicaid top management.

The survey indicated fully half of the respondents did not receive information on nutrition, and about one-fifth of that half stated that they needed such information. CMS staff work with the Department of Health staff to help families on CMS receive the nutritional advice they need.

When asked if the CMS Newsletter met their needs, almost 78% of the survey respondents indicated that it did; however, a significant number of respondents said they did not receive the newsletter. Further analysis revealed that the large database of client names and addresses must be updated on a continuous basis. CMS began putting the CMS ID number on mailing labels, so that returned mail is red-flagged for an address update.

### **3.1.2.5. Infrastructure Building Services**

ADH Title V efforts will continue to strengthen core public health roles identified by the Institute of Medicine.

Children's Medical Services (CMS) works with the State Interagency Coordinating Council (ICC) and the Interagency Council on Self Sufficiency (ICSS) to assure comprehensive, coordinated services for CSHCN and their families. CMS interacts with these groups in collaborative processes of needs assessment and coordinated policy development. There are also collaborative agreements with First Connections (Early Intervention), the Transition Project, Arkansas Children's Hospital, the Arkansas Department of Health, the Governor's Partnership and several other agencies. An Arkansas Disability Policy Consortium was formed to carry out the above objectives, and CMS participates in this consortium with other state agencies relevant to persons with disabilities of all ages. Collaborative agreements, which are renewed annually, with five Arkansas schools of nursing provide nursing students experience in community nursing and working with CSHCN.

State support for systems development at the local level is coordinated by the Department of Health's community based initiative, Hometown Health Improvement, of which SSDI is an integral part. Technical assistance at the local level is available through area health coordinators who work with communities to bring together a wide range of people and organizations to identify their health problems and develop and implement strategies that are locally designed and sustained. The concerns of CSHCN are represented in this process.

The CMS Management Team periodically evaluates the program and services it provides and is involved with major planning every time CMS undertakes new policy or program initiatives. The management team, community-based office staff and parents have had several large meetings lasting from one to five days, to develop policy. CMS management and supervisors periodically take on quality assurance audits and monitoring activities. CMS conducts extensive training of new employees, and on-going training of existing employees, providers and families.

CMS has developed many systems of care for families of CSHCN. The CMS computer system developed in conjunction with the University of Arkansas for Medical Sciences provides training and clinical conferences on-line from Arkansas Children’s Hospital. The quarterly CMS newsletter provides up-to-date and relevant information to families of CSHCN.

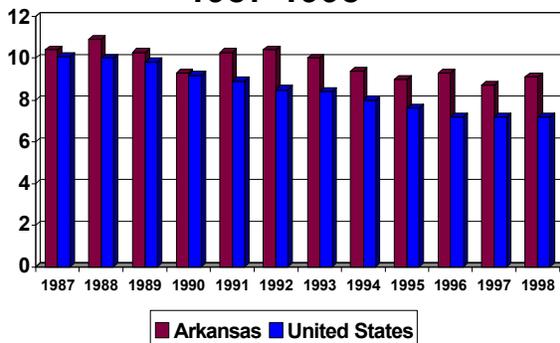
The Arkansas Department of Health Child Health Planning program coordinates the health components of community-based systems including health services for CSHCN. The widespread availability of these health services for CSHCN in communities throughout the state and the existence of a payment mechanism for the services through Medicaid and CMS facilitate this coordination.

The ideal mechanism for coordination and service integration among programs serving CSHCN in Arkansas is the “Together We Can” (TWC) Program. Local teams representing agencies relevant to the needs a particular child work with the family to design a care plan that meets the needs and keeps the family together. The “Together We Can” program available in 22 counties and expands every year. There are also county and regional Interagency Coordinating Councils and monthly and quarterly resource council meetings to help fill the gaps in service. The CMS Program Director is a member of the State Council for “Together We Can” and many CMS nurses and social workers play an active role on county “TWC” teams.

### 3.2. Health Status Indicators

#### 3.2.2. Priority Needs

**Infant Mortality Rates  
Arkansas and United States  
1987-1998**



1. Reduce infant mortality. The infant mortality rate has declined in Arkansas but not as fast as the U.S. rate. In 1998, 36,831 births occurred in Arkansas, and 339 infant deaths. Nationally, the infant mortality rate (IMR) has experienced a long-term decline, dropping from 20.0 in 1979 to 7.2 in 1998. The state infant mortality rate (IMR) for 1998 was 9.2 deaths per 1000 live births. Infant

mortality rates vary tremendously by race. Between 1994 and 1998 the average Arkansas rate was 14.4 for blacks versus 7.7 for whites.

2. Reduce the percentage of births to unmarried women. In 1998 there were 12,910 births to unmarried women out of a total of 36,831 (35.1%). By comparison, the United States percent of births to unmarried women was 32.8. Births to unmarried women were highest in the Delta region of eastern Arkansas. For the 1994-1998 period, births to unmarried women were highest in Phillips County, with an average of 67.8 percent of all live births being born to unmarried women. Grant County, on the other end of the spectrum, averaged only 17.8 percent of live births to unmarried women.

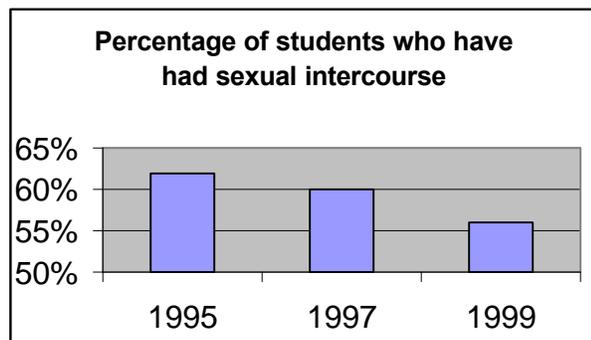
Births to unmarried women differ significantly by race. About 73 percent of black Arkansans giving birth during 1994-1998 were unmarried. The percent was much lower for white Arkansans, at 22.0 percent.

In Arkansas, the long-term trend has been toward an increase in births to unmarried women. In 1983, 21.9 percent of all births in Arkansas were to unmarried women. By 1998, this had increased to 35.1 percent.

3. Increase the number of adolescents postponing sexual intercourse. Based on the 1999 Arkansas Youth Risk Behavior Survey, 56% of Arkansas high school students (grades 9-12) reported that they had sexual intercourse. Twenty-two percent reported having sexual intercourse with four or more people during their life during the 1999 survey in comparison with 25% during 1997.

Major accomplishments of the Abstinence Education Program to date include the following:

- Monthly meetings of the Governor-appointed Abstinence Education steering committee
- Sponsored a statewide conference in May, 1999
- Funded 19 abstinence education grantees in January through September, 1999
- Developed an appeals process and written grant review procedure for the abstinence program
- Initiated a statewide media campaign in February, 1999
- Released an RFP for a statewide program evaluation project.



4. Increase the percentage of children enrolled in a child health insurance program. As of June 16, 2000, 53,698 children ages 0 through 18 were enrolled in the ARKids First Program a 32.4 percent increase from 1999.
5. Increase the percent of pregnant women counseled for HIV testing. HIV/AIDS is declining in males but not in females. From 1990 through 1998, a total of 1,521 HIV (not including AIDS) cases were reported in Arkansas. Twenty-seven (27) babies were born to HIV/AIDS positive women in 1998.
6. Reduce the number of unintentional injuries to children. Motor vehicle crashes are the leading cause of unintentional injury-related death among children ages 14 and younger, accounting for more than 40 percent of all unintentional injury-related deaths. Arkansas' motor vehicle death rate for children ages 1-14 in FY 1998 was 12.4 per 100,000, far above the national average.
7. To improve transition services to youth with disabilities on CMS to help them transition into adulthood.
8. To improve care coordination to families of CSHCN on CMS so that they can better access services available to them.

### **3.3 Annual Budget and Budget Justification**

The FY 2001 Title V appropriation is projected to be \$7,581,008. A total of \$3,261,595 (43%) is budgeted for preventive and primary care for children; \$2,393,118 (31%) for Children with Special Health Care Needs; and \$466,779 (6.2%) for program administration. Each of these budgeted items satisfies federal legislative requirements.

The Title V Block Grant 2001 application for CMS is projected to be \$2,659,020 plus a carryover of \$981,711.36 has been estimated. The state funds to CMS totals \$2,730,867 of which \$197,714 is allocated to administrative costs. The remainder of the required state match is derived from expenditures on direct services at Arkansas Children's Hospital under a contractual

arrangement between CMS and the hospital. Without these insurance collections, CMS would have to pay more out of state funds to the hospital for direct medical services.

CMS is assessing Medical Services for children on Medicaid to assure appropriate services are delivered while avoiding over utilization in the Medicaid program through a contractual agreement with Medicaid. These funds are estimated at \$3,400,000 and will not be categorized as program income to Title V. They will be considered as income under Other Federal Funds along with a respite waiver of \$257,826. The respite waiver and the Medicaid contract funds are federal funds along with state match for those programs.

Administrative costs are budgeted at \$265,902 Title V and \$197,714 state funds.

The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services.

### **3.3.1 Completion of Budget Forms**

See forms 2, 3, 4 and 5 in Section 5.8, *All Other Forms*.

### **3.3.2 Other Requirements**

Arkansas continues to exceed the maintenance of effort from 1989 of \$5,797,136. A total of \$8,668,152 of Title V dollars are budgeted for FY 2001. The unobligated balance to be carried into FY 2001 is \$1,087,144. The state contribution equals \$7,387,079.

Other sources of funds that contribute to the overall Title V expenditures include a contractual arrangement with Jefferson Comprehensive Care Center (a Rural Health Initiative), Washington Regional Hospital, and the Arkansas Department of Human Services. These contracts contribute \$1,109,552 to continuation of Title V related services for women, infants and children.

Program income, which is incorporated into delivery of Title V activities include reimbursement from Medicaid for maternity, EPSDT, hearing speech and vision and family planning services. Fees calculated on a sliding scale and based on federal poverty income guidelines, are collected for nurse midwife, family planning and hearing speech and vision services, and child safety seats. Total income for FY 2001 is expected to \$14,252,150.

Program income is budgeted for the year 2001 to increase by \$3 million over the FY 00 budget. This increase is the result of increased collections from Medicaid for family planning services at ADH, as a direct result of the Family Planning Waiver. The waiver has allowed Medicaid reimbursement for family planning services. These funds are being utilized for

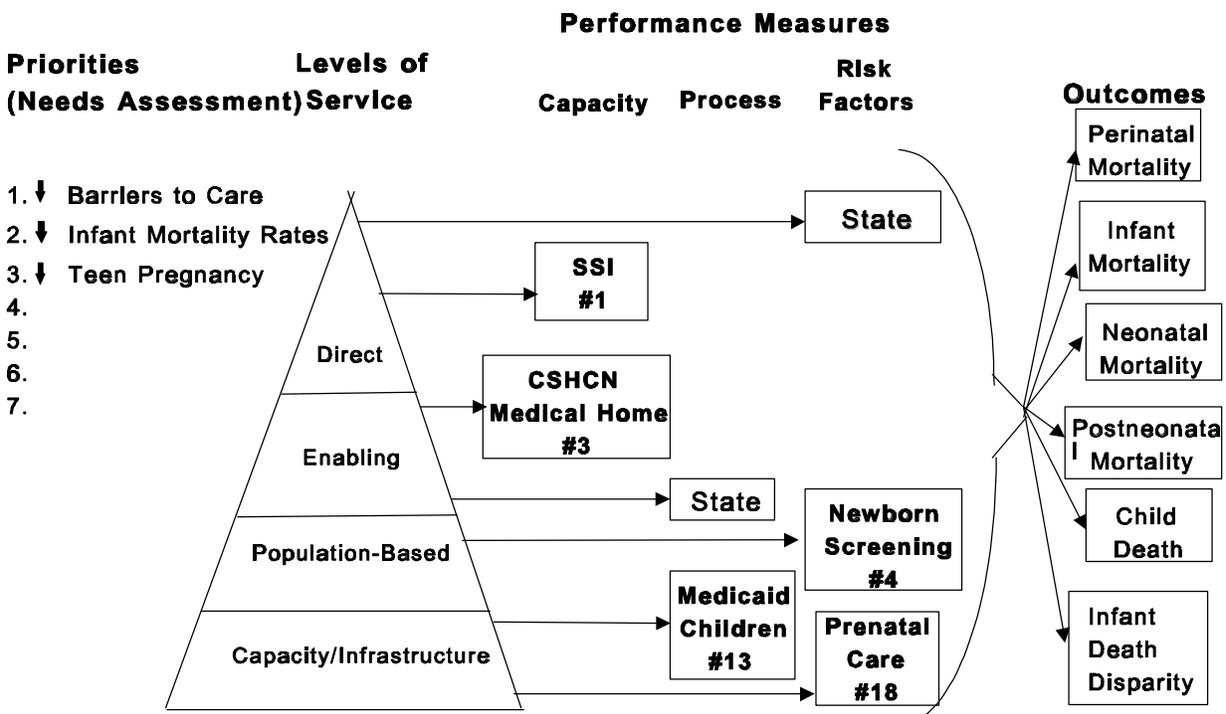
expansion of the family planning services and other MCH related programs, such as a new maternal and infant home-visiting program mentioned in the narrative.

Medicaid revenue is dropping sharply in EPSDT due to Medicaid PCP requirements and to some extent in Maternity due to referral patterns which result in OB patients being included in the delivery physician's caseload at an earlier timeframe. This continues to affect both the expenditures in FY99 and budget for FY 2001.

Federal grants under the control of Title V and supplementing services to women, children, and families include MCHB and CDC funds. Federally funded activities include respite care; prior authorization for special needs children; systems development; abstinence education; health and safety in childcare; MCH epidemiology; injury prevention; and fire burn prevention. Federal funds supporting immunization and WIC are not included in this total because Title V in Arkansas does not manage them.

Figure3

**Title V Block Grant  
Performance Measurement System**



OSCH/MCHB 4/97 \*PERFORMANCE MEASURE NUMBER(Examples Only)

Figure 4  
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers whom breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP#19) The percent of infant deaths reviewed/ investigated.			X			X	
SP#20) The percentage of births to unmarried women.			X				X
SP#21) The percent of Arkansas high school students grades 9 through 12 who have engaged in sexual intercourse.			X				X
SP#22) The percentage of children less than 18 below 200 percent of poverty enrolled in a child health insurance program.		X			X		
SP#23-D (Discontinued) The rate of Deaths to children ages 0-4 related to child safety seats in motor vehicles.			X				X
SP#24) The percent of pregnant women counseled for HIV testing.	X						X
SP#25-D (Discontinued) Conduct at least three workshops for parents of CSHCN and targeted case managers on resources available to access services.				X		X	
SP#26-D (Discontinued) The percent of total CSHCN on the Children's Medical Services program who receive specialty services.		X				X	
SP#27) The percent of overweight among low-income children ages 0 to 5 years.		X					X
SP#28) The percent of 14 to 15 year olds on CMS who state that CMS transition services have helped improve their knowledge and ability to transition into adult life.		X				X	
SP#29) The percent of parents responding to the question on the CMS parent satisfaction survey that CMS Service Coordination teams told them about other services available to them.		X				X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services  
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

### 3.4 Performance Measures

#### 3.4.1 National "Core" Five Year Performance Measures

##### 3.4.1.1 Five Year Performance Targets

#### 3.4.2 State "Negotiated Five Year Performance Measures

##### 3.4.2.1 Development of State Performance Measures

SP #23, the rate of deaths to children ages 0-4 related to child safety seats in motor vehicles has been deleted. Revised national performance measure #08 includes the 0 to 4 populations targeted by the measure. This measure has been stated in previous years as "the rate of deaths to children ages 0-4 related to child safety seats in motor vehicles." While we continue to recognize the significant correlation between child safety seat use and survival, accurate data is not

collected on child safety seat use in fatal motor vehicle crashes. The child safety seat usage rate in Arkansas is 68%, 12 percent below the national rate. In 1999, approximately 500 safety seats were distributed through the ADH Safety Seat Program. Staff worked with the Arkansas SAFE KIDS Coalition, Arkansas Children's Hospital, and the Arkansas Highway and Transportation Department to promote safety seat usage through health fairs, safety seat check stations, and other community events.

The two new negotiated state performance measures for Children's Medical Services are:

1. SP #28 to improve the percent of 14- to 15-year olds on CMS who state that CMS transition services have helped improve their knowledge and ability to transition into adult life. (Process objective – enabling services)
2. SP #29 to improve the percent of parents responding to the question on the CMS parent satisfaction survey that CMS Service Coordination teams told them about other services available to them. (Process objective – enabling services)

#### **3.4.2.2 Discussion of State Performance Measures**

SP#19) The percent of infant deaths reviewed/investigated. This Performance Measure has changed to reflect all infant deaths, not just the postneonatal. The performance objective has changed to about half of infant deaths occurring in the calendar year. Using a sampling method, infant deaths reviewed will represent the racial/ethnic breakdown of that population. Of the 339 infant deaths recorded in 1998 in Arkansas, 211 were neonatal and 128 were postneonatal. Each group is more likely to die as the result of specific causes. The neonate deaths often reflect low birth weight and preterm labor. Postneonatal deaths may often result from SIDS or unintentional injury. Reviewing deaths in both groups will provide Arkansas a greater opportunity to impact all infant deaths.

Monitoring assigned causes of infant deaths helps distinguish diagnostic shifting of the rates from real reductions. Death reviews may shed light on the impact of managed care on changes in the referral patterns of pregnant women in preterm labor. Medical diagnoses may offer the most immediate explanation for the event of death, but may have been preceded and in turn caused by other important factors. For example, congenital anomalies may arise from environmental exposures, and adverse events may raise issues of home safety or maltreatment. Infections may have resulted from inadequate immunization during the first year of life. These are issues, which

warrant a need for infant death reviews. SP #19 corresponds with priority need #1, is an infrastructure building activity and directly affects infant, neonatal, and postneonatal mortality rates and the ratio of black to white IMRs.

SP#20) The percentage of births to unmarried women. The state unwed birth reduction strategy committee was formed in FY 1997. The mission of the 28-member committee is to prevent unmarried teen pregnancy in Arkansas. The program is using a multifaceted approach similar to that of the National Campaign to Prevent Teen Pregnancy. SP # 20 directly corresponds to priority need # 2, is a population based/ risk factor service and affects infant mortality.

SP#21) The percent of Arkansas high school students who have engaged in sexual intercourse. Based on the 1999 Arkansas Youth Risk Behavior Survey, 56% of Arkansas high school students (grades 9-12) reported that they had sexual intercourse. Twenty-two percent reported having sexual intercourse with four or more people during their life during the 1999 survey in comparison with 25% during 1997. SP #21 directly corresponds to priority need # 3, is a population-based/ risk factor service and affects low birth weight and infant mortality.

SP#22) The percentage of children less than 18 below 200 percent of poverty enrolled in a child health insurance program. The definition of the denominator has been changed to reflect the total population of children below 200% of poverty. This amendment provides a more accurate measurement of performance related to ARKids enrollment. SP # 22 directly corresponds to priority need # 4 is an enabling service and affects the child death rate.

SP #24) The percent of pregnant women counseled for HIV testing. According to PRAMS data for calendar years 1997 and 1998, (reported as weighted frequencies), only 47 percent of new mothers in Arkansas reported that HIV prevention counseling was included in their prenatal care although 71 percent said care givers discussed getting the test and 85 percent were actually tested. Seventy-one percent of Arkansas mothers received their prenatal care from private physicians and were least likely to be tested. 29% received prenatal care at ADH. Three out of four of those receiving prenatal care at a health department clinic remembered HIV prevention

counseling as part of their prenatal education even though 99% of the patients receiving prenatal care at the health department were tested.

SP#25-D) **(Discontinued)** Conduct at least three workshops for parents of CSHCN and targeted case managers on resources available to access services.

SP#26-D **(Discontinued)** The percent of total CSHCN on the Children's Medical Services program who receive specialty services.

SP#27) The percent of overweight among low-income children ages 0 to 5 years. Arkansas is getting progressively fatter!! For 1999, the state prevalence rose to 8.0%, continuing to parallel the upward path of the U.S. rate, which rose to 11%. According to the 1999 Pediatric Nutrition Surveillance System, the prevalence of overweight in Arkansas among Hispanic children was 10.1% (same as 1998), African American children 8.5 % (up from 8.3% in 1998) and white children 7.4% (up from 7.1% in 1998). Childhood obesity is a precursor to many of the adult diseases that are the leading causes of death in Arkansas, heart disease, cancer and stroke. Effective prevention of adult diseases associated with obesity should start during childhood, because as children age, overweight increases.

A multi-agency, multidisciplinary group will convene July 6, 2000 with the task of developing a document addressing the issues. Task force members represent nutrition, physical education, policy and finance, private and public agencies, professional and voluntary organizations, and experts in city/community planning.

The 1999 Youth Risk Behavior Survey of Arkansas high school students indicates 32.2% perceive themselves to be slightly or very overweight. From self-reported heights and weights, body mass index (BMI) was calculated for each student. Using a BMI of 95th percentile as the cut point indicating obesity, 10.9% of Arkansas youth are obese. SP #27 is an enabling service and affects the child death rate.

SP#28) To improve transition services to youth with disabilities on CMS to help them transition into adulthood. The CMS Parent Satisfaction/Needs Assessment survey of 1999, reported 47% of CSHCN parents indicated that it was important for CMS to help their children transition to adult services (including adult health care, work and independence), but only 11% indicated that CMS

had actually helped their children do this in the last year. Meeting the priority need of improving transition services for CSHCN on CMS will help achieve one of the 2010 national performance outcomes.

SP#29) To improve care coordination to families of CSHCN on CMS so that they can better access services available to them. On the 1999 CMS Parent Satisfaction survey, 85% of the parents indicated that it was important for CMS Service Coordination teams to inform them about other services available to them, but only 30% indicated that CMS teams had actually done this for them in the last year. By meeting the priority need of improving care coordination services for families of CSHCN on CMS, the national core performance measure of the child death rate (1-14) should be indirectly improved.

### **3.4.2.3 Five Year Performance Targets/Objectives**

### **3.4.2.4 Review of State Performance Measures**

### **3.4.3 Outcome Measures**

## **IV. REQUIREMENTS FOR THE ANNUAL PLAN**

### **4.1 Program Activities Related to Performance Measures**

#### **1) Preventive and Primary Care for Pregnant Women, Mothers and Infants:**

##### **Direct Health Care/ Enabling**

*SP # 22 – The percentage of children less than 18 below 200 percent of poverty enrolled in a child health insurance program.*

*SP # 24 - The percent of pregnant women counseled for HIV testing.*

ADH continues to provide direct prenatal care services in 80% of its LHUs. In many counties these clinics provide services to low income women who would otherwise not be able to access care. ADH will continue to collaborate with local physicians, but will continue in the role of primary care gap-filler. The nursing staff in these clinics will continue to educate patients about eliminating smoking, alcohol and drugs, maintaining appropriate weight and hydration. Staff will continue to advise patients to seek treatment for any infection to decrease risks of having preterm labor a low birthweight baby. Chlamydia testing and subsequent treatment will continue in FY 2001. ADH local health units will continue to counsel women concerning HIV. This includes

services such as nutrition and social work counseling, case management and maternal infant home visiting. These activities also impact National Performance Measures #15 and #18.

*SP #27 The percent of overweight among low-income children ages 0-5 years.*

## **Population Based**

*National Core and State Negotiated Measures: 4, 9, 10, 19 and 20*

NP # 4 - Percent of newborns in the state with at least one screening for PKU, hypothyroidism, galactosemia, hemoglobinopathies. The national objective for this is 95%. Arkansas has consistently exceeded this objective. In FY 1999 99.9% of newborns were screened for these diseases. The program will continue to maintain this level of excellence and plans to implement improvements in laboratory methodology and reporting of results. Key program staff will attend national and regional meetings to stay abreast of emerging technologies and new recommendations for screening for other disorders. ADH will continue to work closely with Arkansas Childrens Hospital (ACH) on this program, specifically for follow-up. ADH will continue to work with the genetics program at ACH to get patients in for treatment. ADH does follow-up and home visits for sickle cell trait disorders and ACH does the outreach on actual sickle cell disease.

NP # 9 - Percentage of mothers whom breastfeed their infants at hospital discharge. WIC Breastfeeding Services (WBS) recognizes that breastfeeding success is dependent on supportive environments both in the hospital and the community. To encourage both kinds of support, WBS will continue to include hospital and community health professionals in all educational offerings. Frequently, this results in collaboration between the public health clinic staff and hospital staff with very positive benefits for the breastfeeding mother. WBS will continue to contribute materials and other types of in-kind support to the Lactation Education program for the Pediatric Residents at UAMS and Arkansas Children's Hospital to ensure that physicians also receive appropriate lactation education. Physician lactation education is a critical factor since most UAMS medical school graduates remain in the state to practice. WBS will continue to assist hospitals in acquiring breastfeeding educational materials, and provide breastfeeding patient education materials to institutions with a high percentage of low-income patients.

NP # 10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge. Act 1559 of 1999 established the Universal Newborn/Infant Hearing Screening, Tracking, and Intervention Program and advisory board. The program ensures early detection of hearing loss for all newborn/infant children in Arkansas. The Arkansas Department of Health will continue its dedication to the early identification of hearing loss in infants. In FY 2001 the Child and Adolescent Health team will continue to identify deaf or hard of hearing babies by the age of four months and facilitate referral to intervention services before they are six months old.

SP # 19 - The percent of infant deaths reviewed/investigated. The Arkansas Infant Mortality Review Project will continue to review about half of all infant deaths, birth to 12 months, statewide according to a sampling scheme. The program will continue to identify needs related to changes in policies and programs that impact infant mortality.

SP # 20 - The percentage of births to unmarried women. The State Unwed Birth Reduction Strategy Committee will continue in FY 2001. Plans include the following activities:

- ◆ Increase enrollment of eligible women in the Family Planning Medicaid Waiver Project
- ◆ Continued funding to support coalitions in 15 counties with the highest number of unwed births
- ◆ Re-institute the statewide multimedia campaign
- ◆ Offer technical assistance to local communities for program evaluation

### **Infrastructure Building**

*National Core Measures: 15, 17 & 18*

NP # 15 - Percent of very low birth weight live births,

NP # 17 - Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates and

NP # 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. ADH will continue to support the Campaign for Healthier Babies, which addresses National performance measures 15, 17, and 18. This coalition-managed campaign will continue to focus heavy media attention on the need for early prenatal care. In FY 2001 it will

continue other activities designed to encourage women to obtain early prenatal care. These include the *Happy Birthday Baby Book*, a coupon book designed to be an incentive for pregnant women, and the *Babies and You* worksite education program.

The MCH Epidemiology Grant awarded from CDC in FY 1997 provided ADH with the ability to conduct more in-depth surveillance and epidemiological studies related to the MCH population. This information has helped the department in this application and for general program planning. A further goal is to develop regular reports focusing on specific aspects of MCH data, and disseminate them to both public and private entities, to provide others with information they need for MCH planning. Several extensive projects are underway which will be circulated in this manner.

The PRAMS grant, awarded to the Center for Health Statistics, also offers Arkansas a great deal of perinatal and MCH related information. It is used extensively in program planning and for dissemination to public and private entities throughout the state.

The Perinatal Advisory Board will continue to be staffed by the ADH Perinatal Health team. This board provides important input with representatives from across the state and is a perinatal health advocate and voice for perinatal issues, activities and information.

## 2) Preventive and Primary Care Services for Children:

### **Direct Health Care/ Enabling**

*State Negotiated Performance Measures: 22 & 27*

SP # 22 - The percentage of children enrolled in a child health insurance program. The ADH Medicaid Outreach and Education (MOE) staff will continue to cover after-hours calls for the Department of Human Services regarding the ARKids First Program. ADH will continue to promote ARKids First and facilitate enrollment at the local level.

SP # 27 - The percent of overweight among low-income children ages 0 to 5 years. In the 1999 Arkansas Legislative Session, the legislature passed SCR 8 directing the Health Department to study the effect of obesity in both adults and children on costly health complications, and to make recommendations for improvement in awareness of the problem of obesity. The recommendations from the MCHB sponsored expert committee on pediatric obesity evaluation and treatment will be incorporated into the state effort.

## **Population Based**

*National Core and State Negotiated Measures: 5, 6, 7, 8, 21 & 23*

NP # 5 - Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The immunization activities described in section 2.4, Progress on Annual Performance Measures will continue in FY 2001.

NP # 6 - The birth rate (per 1,000) for teenagers aged 15 through 17 years. The teen pregnancy prevention and unwed birth prevention activities described in section 2.4, Progress on Performance Measures will continue in FY 2001.

NP # 7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth. The Arkansas Oral Health Advisory Committee will continue to assess oral health needs in the state. The Office of Oral Health (OOH) while undergoing reorganization is working to identify communities in the state with a strong interest in fluoridation. In FY 2001, the OOH will continue to promote oral health education among students, kindergarten through elementary, and promote the appropriate use of dental sealants.

NP # 8 - The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children. The Arkansas SAFE KIDS Coalition will continue to focus on reducing motor vehicle fatalities. The Arkansas Safety Belt Coalition and SAFE KIDS will continue working toward the passage of a primary seat belt law in the next legislative session.

SP # 21 - The percent of Arkansas students grades 9 through 12 who have engaged in sexual intercourse. The Abstinence Education Program is one component of the state's plan to reduce out-of-wedlock pregnancies and reduce the incidence of sexually transmitted diseases. The Governor appointed abstinence steering committee will continue to assist the ADH in facilitating the growth of abstinence education programs in the state. The most significant use of abstinence education funding is for local community group grantees. A Request for Proposal (RFP) for FY2001 was released and applications received are under review currently. The Abstinence

Education Steering Committee has encouraged grantees and applicants to base their plans on the needs determined by their community. Applicants must, demonstrate compliance with the eight tenets included in the federal definition of abstinence education and administrative, programmatic, and fiscal capability.

The Institute for Research and Evaluation was selected to perform an evaluation of Arkansas's abstinence education programs for the period, February 2000 through June 2001. The findings will focus on local program effectiveness and assessment of student's knowledge and behavior regarding sexual health values and practices. This information will be beneficial to the ADH and the steering committee in assessing the relative strengths, potential, and weaknesses of the community programs.

### **Infrastructure Building**

*National Core Measures: 12, 13 & 16*

NP # 12 - Percent of Children without health insurance. The ADH will continue to promote and facilitate enrollment in the ARKids First Program in FY 2001.

NP # 13 - Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. Little data exists in regard to this objective. Population estimates from the Center for Health Statistics project a total of 339,634 children age 0-17 below 200% of poverty. Medicaid indicates that 200,758 children meeting these criteria were enrolled in Medicaid /ARKIDS in 1997-98. However, this number contains duplicate enrollees and does not address children enrolled who do not receive any services.

NP # 16 - The rate (per 100,000) of suicide deaths among youths 15-19. ADH will continue to provide mental health services to students through the School-Based Clinic Program. The agency's Comprehensive School Health Coordinator is co-leader with the Arkansas Department of Education of an interagency Coordinated School Health Action Team that addresses current issues and barriers to promoting school health. Other ADH staff on the action team includes the Adolescent & School Health Coordinator and the Social Work team leader. The DHS Division of Mental Health Services will continue placing mental health workers in public schools.

The *Arkansas Department of Health's Resource Guide for Assisting the Victims of Family Violence* is the product of a multidisciplinary team formed in 1997. The purpose of the guide is to heighten awareness of family violence and provide public health staff with guidelines to aid in assisting clients who disclose family violence. The Social Work team provides family violence prevention training to interested ADH colleagues and communities upon request.

### 3) Preventive and Primary Care Services for Children with Special Health Care Needs:

#### **Direct Health Care/ Enabling**

*National Core and State Negotiated Measures: 1, 2, 3, 28 & 29*

NP # 1 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. Childrens Medical Services has a SSI Coordinator who facilitates SSI services, tracks applications and recipients and trains others to identify children who may be eligible for SSI. All CMS community-based teams refer potentially eligible children and their families for SSI.

NP # 2 - The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. CMS will continue to pay for all specialty and subspecialty services except for home health care for approximately 500 children not on Medicaid.

NP # 3 - The percent of Children with Special Health Care Needs (CSHCN) in the State who have a medical home. CMS community-based nurses and social workers will continue to routinely encourage all children on CMS to have a primary care physician, or medical home. Arkansas Medicaid has the nationally recognized *ConnectCare* program, which is a statewide, multi-strategy campaign to encourage Medicaid clients to obtain a medical home.

SP # 28 - To improve the percent of 14 to 15 year olds on CMS who state that CMS transition services have helped improve their knowledge and ability to transition into adult life (Process objective). To meet the enabling service objective of improving transition services for youth with disabilities, CMS plans to conduct several regional workshops during the next year which will

inform parents about transition services and how to prepare their children to transition into adult health care, work and independence. In addition, CMS will conduct a monthly mail-out of a transition survey and information on transition services to all CMS children turning 14 years. Finally it is hoped that funding will be available during the next year to hold at least one transition weekend for youth with disabilities on CMS where they can learn about various issues related to transition.

SP # 29 - To improve the percent of parents responding to the question on the CMS parent satisfaction survey that CMS Service Coordination teams told them about other services available to them.

Two strategies are planned to meet the enabling service objective of improving care coordination services for families of CHSCN:

1. CMS service coordination teams (including social workers) will be encouraged to make appropriate referrals of families to other needed services.
2. And CMS service coordination teams will talk to families about their needs when conducting home visits.

In addition, the quarterly CMS newsletter will contain information on available services for families of CHSCN.

### **Population Based**

Children's Medical Services has performance measures related to direct health care/enabling and infrastructure building services only.

### **Infrastructure Building**

*National Core and State Negotiated Measures: 11, 13, 14*

NP # 11 - Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care. Based on their needs, CMS applicants are routinely referred to appropriate Medicaid services/ programs such as SSI, Tefra and ARKids First.

NP # 14 - The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. CMS has very strong family participation in program

and policy activities. An active CMS Parent Advisory Council meets quarterly and a full-time Parent Activities Coordinator staff member who is also the parent of a special needs child.

## **4.2 Other Program Activities**

### **Direct Health Care/ Enabling**

#### **1) Preventive and Primary Care for Pregnant Women, Mothers and Infants:**

The Perinatal Health team plans to continue the following programs and activities in FY 2001:

- ◆ Along with perinatal factors, birth defects are among the most common causes of infant death. CDC is funding research centers for surveillance and prevention of birth defects. The Arkansas Center for Birth Defects Research and Prevention was founded two years ago with a grant from CDC and is making excellent contributions to the national research effort. The Center found that between 1992 and 1996, Arkansas's neural tube defect (NTD) rates were among the highest in the nation, and were increasing. This finding motivated the Department of Health to join with the Center, March of Dimes, the Spina Bifida Association, Arkansas Children's Hospital, and others to mount a state public awareness campaign around NTD prevention by dietary fortification and supplementation with folic acid. These groups partnered with news media to develop a television and newspaper effort building on the national campaign. The Department also purchased and is providing free bottles of folic acid tablets to all new family planning patients.
- ◆ Prenatal Case management will continue in FY 2001. Spanish translation will continue to be provided when needed, as will social work, nutrition services, WIC, breastfeeding education and counseling services.
- ◆ Prenatal care clinics in local health units, including basic risk assessment, physical, laboratory screening, general and risk appropriate education.
- ◆ Nurse Midwife services in Mississippi County.
- ◆ Babies and You prenatal education programs in the work sites throughout the state.
- ◆ Maternity Training Program (MTP) which provides basic OB orientation for nurses and Expansion of the MTP outside of ADH to include private provider nursing staff.
- ◆ Lay Midwife licensing and practice monitoring.
- ◆ ConnectCare/ Medicaid Outreach and Education. MOE staff during FY 2000 processed more than 10,443 calls from citizens interested in Medicaid, physicians and hospital emergency rooms.

The ConnectCare Physician Guide was developed and is updated annually to assist Medicaid recipients in their selection of PCPs

- ◆ The 24-hour MCH 1-800 line. Operators will continue to provide telephone coverage for Operation KidCare, Mercury and Fish and a variety of other programs, in addition to the more than 19,000 Campaign for Healthier Babies requests.
- ◆ The Resource Directory, maintained by Perinatal Health, will continue to be updated annually and distributed to local health units and local human service offices statewide to provide accurate referral sources for clients.

## 2) Preventive and Primary Care Services for Children:

- ◆ ADH will continue to provide clinical preventive services to at-risk children and EPSDT screens. ADH pediatricians, contract physicians and pediatric nurse practitioners, staff the clinics. Public health nurses also performed limited numbers of screening physical assessments on non-EPSDT-eligible children.

Additionally, local health units will continue to work with Head Start, HIPPY, and day care centers to provide screens for Medicaid and for non-Medicaid children. The ADH was granted a continuing contract with the DHS Division of Child Care and Early Childhood Education for reimbursement to provide EPSDT-like screens to non-Medicaid children enrolled with the Arkansas better Chance (ABC) program through day care centers and HIPPY programs. In FY 1999, ADH provided 1,041 non-Medicaid screens and 219 immunizations to ABC children. Through April of FY 2000, 705 ABC screens and 188 immunizations were provided. The ADH has received notice that the ABC contract will be continued for FY 2001 in the amount of \$58,700.

- ◆ The ADH Lead Screening program will continue. In FY 1999, 4,352 children were screened through ADH, with 20 confirmed new cases of lead toxicity detected. About half of the confirmed cases had definable lead hazards identified at their residence. State-specific lead screening recommendations based on the latest CDC guidance were disseminated to primary care providers during FY 1999. To address recent reductions in lead screening activity as a result of state Medicaid EPSDT referral requirements, routine lead screening was initiated in WIC clinics in selected Pulaski County health units in FY 1999. WIC clinics in other locales will continue to be studied as potential vehicles for lead screening in coming years.

◆ WIC Breastfeeding Services will continue to work closely with central office and field MCH programs and staff. The purpose of WIC, the Special Supplemental Nutrition Program for Women, Infants and Children, is to improve the health of infants, children and childbearing women by directly supplementing their diets with nutrient-rich foods. The program provides nutrition counseling, education, and referral to other services including Title V services. WIC is available in all 75 counties in Arkansas. Pregnant, breastfeeding and postpartum women, infants and children under age five, are eligible for WIC if they live in Arkansas, are income eligible and have a condition or living situation which places them at nutritional risk. Applicants are considered at nutritional risk if they are homeless and/or have a migrant family member. Applicants receiving TANF/TEA, food stamps or Medicaid (including ARKids First) are income eligible for WIC in Arkansas. WIC is funded through the United States Department of Agriculture, Food and Nutrition Service. No state funds are required to match federal funds. WICs average monthly participation in FFY 1999 was 82,939; including 22,295 pregnant, breastfeeding and postpartum women; 23,045 infants and 37,543 children.

◆ The Social Work team will continue to provide counseling to women who have a high-risk pregnancy in Faulkner, Jefferson, Crittenden, St. Francis and Mississippi counties in the state. Six counseling sessions are Medicaid reimbursable for eligible clients. Social workers make home visits through the Maternal Infant Program in Pulaski, Mississippi and Crittenden counties. Services to families of premature infants are community-based and include home visits in Pulaski and Faulkner counties in central Arkansas. Social workers work among local collaboratives on issues related to prevention of child abuse and domestic violence and provide inservice training to health professionals on topics including grief and parenting.

◆ The Nutrition Services team will continue to work closely with WIC to monitor and reduce the percent of overweight among low-income children ages 0 to 5 years.

### **4.3 Public Input**

A public hearing on the draft FY 2001 Arkansas Title V application was held on June 15, 2000. It was sponsored by the Maternal and Child Health Team and Childrens Medical Services. English and Spanish versions of the public notice appeared in the statewide newspaper for ten days prior to the hearing. Additionally, letters including the notice were sent to agencies and organizations with a known interest in the application. The public notice, and letters stated that

draft copies of the application would be available for review at the Arkansas Department of Health. The proceedings of the public hearing were recorded and transcripts are available for review. All written and verbal comments have been addressed as appropriate. A second public hearing will be held July 27, 2000 after submission of the application.

MCH and CMS following the submission of the application evaluate the methods used for public review. A list has been compiled of those requesting to review the application; their reason for interest in the application; and the method by which they were made aware of the opportunity for review. This information will allow staff to decide the most appropriate means for informing individuals who might be interested in reviewing future applications.

#### **4.4 Technical Assistance**

A center point of agency activity during the next year will be expansion of the Hometown Health Improvement Project. Technical assistance related to evaluating the effectiveness of local coalitions, especially those that are newly formed is requested.

As the Department moves more into core public health functions, more information concerning how other agencies have successfully shifted into this role would be helpful. This is particularly true of the monitoring role. What components are included in monitoring? How was this done without alienating the providers being monitored? Can a direct service role be maintained and monitoring be a responsibility? General information about how this transition has worked in other states would be useful.

### **V. Supporting Documents**

#### **5.1 Glossary**

##### **GLOSSARY**

**Administration of Title V Funds** - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

**Assessment** - (see Needs Assessments)

**Capacity** - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy-making activities. Program capacity results measure the strength of the human and material resources necessary to meet

public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, what does the State need to achieve the results we want?

**Capacity Objectives** - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

**Care Coordination Services for CSHCN** - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

**Carryover** (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

**Case Management Services** - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. [*Title V Sec. 501(b)(4)*]

**Children** -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

**Children With Special Health Care Needs (CSHCN)** - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

## **Children With Special Health Care Needs (CSHCN) - Constructs of a Service System**

### **1. State Program Collaboration with Other State Agencies and Private Organizations**

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

### **2. State Support for Communities**

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

### **3. Coordination of Health Components of Community-Based Systems**

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

### **4. Coordination of Health Services with Other Services at the Community Level**

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

**Classes of Individuals** - Authorized persons to be served with Title V funds. See individual definitions under Pregnant Women, Infants, Children with Special Health Care Needs, Children, and Others.

**Community** - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

**Community-based Care** - Services provided within the context of a defined community.

**Community-based Service System** - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

**Coordination** (see Care Coordination Services)

**Culturally Sensitive** - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

**Culturally Competent** - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

**Deliveries** - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

**Direct Health Services** - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including

immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

**Enabling Services** - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

**Family-centered Care** - A system or philosophy of care that incorporates the family as an integral component of the health care system.

**Federal (Allocation)** (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

**Government Performance and Results Act (GPRA)** - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

**Health Care System** - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

**Infants** - Children under one year of age not included in any other class of individuals.

**Infrastructure Building Services** - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

**Local Funding** (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

**Low Income** - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

**MCH Pyramid of Health Services** - (see [Types of Services])

**Measures** - (see [Performance Measures])

**Needs Assessment** - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

**Objectives** - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also Performance Objectives)

**Other Federal Funds** (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

**Others** (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

**Outcome Objectives** - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

**Outcome Measure** - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, Why does the State do our program?

**Performance Indicator** - The statistical or quantitative value that expresses the result of a performance objective.

**Performance Measure** - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: The rate of women in [State] who receive early prenatal care in 19\_\_\_. This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

**Performance Measurement** - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

**Performance Objectives** - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

**Population Based Services** - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

**Pregnant Woman** - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

**Preventive Services** - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

**Primary Care** - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

**Process** - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?

**Process Objectives** - The objectives for activities and interventions that drive the achievement of higher-level objectives.

**Program Income** (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

**Risk Factor Objectives** - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

**Risk Factors** - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

**State** - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

**State Funds** (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

**Systems Development** - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

**Technical Assistance (TA)** - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

**Title XIX, number of infants entitled to** - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

**Title XIX, number of pregnant women entitled to** - The number of pregnant women who delivered during the reporting period who were eligible for the States Title XIX (MEDICAID) program

**Title V, number of deliveries to pregnant women served under** - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

**Title V, number of infants enrolled under** - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

**Total MCH Funding** - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal

funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

**Types of Services** - The major kinds or levels of health care services covered under Title V activities. See individual definitions under Infrastructure Building, Population Based Services, Enabling Services, and Direct Medical Services.

## 5.2 Assurances and Certifications

### ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects. 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (h) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects. 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176 of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace,
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight  
 Office of Management and Acquisition  
 Department of Health and Human Services  
 Room 517-D  
 200 Independence Avenue, S.W.  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

- 5.3 Other Supporting Documents
- 5.4 Core Health Status Indicator Forms--SD C1.1 – C3.1
- 5.5 Core Health Status Indicator Detail Sheets—SD HSI Detail.1 – .11
- 5.6 Developmental Health Status Indicator Forms—SD D1.1 – 2.8
- 5.7 Developmental Health Status Indicator Detail Sheets—SD DHSI .1 – .17
- 5.8 All Other Forms--
- 5.9 National "Core" Performance Measure Detail Sheets—SD CORE.9 – 18
- 5.10 State "Negotiated" Performance Measure Detail Sheets—SD 16.2 – 16.5
- 5.11 Outcome Measure Detail Sheets—SD CORE.19 - 24