



## 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

### Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 83,557 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's land mass is uninhabited and uninhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain.

Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farm land and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

### Population Information

The 1998 estimated population for Idaho is one million, two hundred twenty-eight thousand, six hundred eighty-four (1,228,684). Idaho ranks 40th in the United States in population. The increase from 1990 to 1998 of 22.0% was the third highest increase in the nation, after Nevada (45.4 %) and Arizona (27.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these

urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties.

**Summary of Population by Region (Health District)**

<b>DISTRICT</b>	<b>POPULATION</b>	<b>PERCENT</b>
District 1	169,405	13.8
District 2	97,286	7.9
District 3	179,853	14.6
District 4	313,979	25.6
District 5	157,257	12.8
District 6	157,150	12.8
District 7	153,754	12.5

**Ethnic Groups**

The estimated racial groups that comprised Idaho’s population in 1998 were: (a) white, 96.9%; (b) black, 0.58%; (c) native American/Eskimo, 1.35%; (d) Asian/Pacific Islander, 1.1%. Hispanics make up 7.2% of the race categories. More than half of Idaho’s Hispanic population resides in two regions (health districts), with 32.2% residing in Health District 3 and 20.7% in Health District 5. The majority of the Native Americans reside on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

Migrant and seasonal farm workers are a significant part of Idaho’s Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho’s Hispanic individuals live in southern Idaho along the agricultural Snake River Plain.

### Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1996-1998) median income in Idaho was \$35,554 compared to \$37,779 for the national average. The number of children living in poverty varies greatly by county from the lowest (6.8%) in Caribou County to highest (34.5%) in Owyhee County. The statewide average is 16.2%.

Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1996-1998), there are approximately 386,000 children under the age of 19 living in Idaho. Of these, approximately 175,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 45,000 of these children come from households that lack health insurance.

### Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96, but leveled out in the 1997-98 school year at 91%. While the U.S. school dropout rate has been declining from 11% in 1985 to 9% in 1995, Idaho's rate is "essentially equivalent" at 10%.

### Health Delivery System in Idaho

As a rural state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance when planning a health care system. Serving distinct populations such as migrant/seasonal farm workers, children

with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

- A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunization, family planning, WIC, STD clinics, and clinics for children with special health problems. (The counties and health districts are shown in **Figure 5**.)
- B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.
- C. In 1999, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,083.
- D. There are 20 Community and Migrant Health Centers in Idaho which served 59,188 patients in 1999. (**Figure 5A**)
- E. As of March 2000, there were 2,226 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 178 physicians providing patient care per 100,000 population. There are 1,013 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 81.

- F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 1999. These clinics provide a wide variety of preventive health services to Native Americans.
- G. Managed care penetration rate for Idaho is 5%.

#### Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1996-1998, there are approximately 386,000 children under the age of 19 living in Idaho. Of these, approximately 175,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 25.7% (45,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who do not have health insurance in 1998. According to Medicaid data, children who did not have health insurance at any point in that year represented 14.7% of the total number of children.

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, while 12.6% of the U.S. population are enrolled in Medicaid. Additionally, the 1998, *Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program*, estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

Many communities in Idaho, especially those in rural and frontier areas, are considered under served. Idaho ranked 50th in the country in 2000 for number of primary care physicians per 100,000 civilian population with 81 primary care physicians per 100,000 population. There are 45 federally-designated primary care shortage areas in Idaho. Access to care in rural areas is especially variable. Providers are usually clustered in small communities but are caring for residents whose homes are

scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel and the deepening fiscal problems of rural health care facilities.

There are 20 community/migrant clinic sites in Idaho. All but one are in southern Idaho. In 1999, they served 59,188 persons. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 27 certified rural health clinics.

#### Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitations on covered conditions in the Children's Special Health Care Program.

Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

#### Current MCH Priorities and Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enable women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for

family planning services, which will reduce unintended pregnancy and improve the well-being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births as mandated. No decision will be made before July 1, 2000, however. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program. We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

Moreover, the Title V agency has been active in the planning and design phases of the Department of Health and Welfare's media campaign to increase awareness of and enrollment in the CHIP Program. cursory review of the monthly enrollment figures for CHIP indicate the campaign has been successful. One outcome of this heightened awareness of CHIP is increased identification of children eligible for Medicaid coverage. Representatives of the Title V agency also played a key role in the development of a "streamlined" version of the Medicaid/CHIP application form which has greatly simplified the enrollment process. Additionally, the SSDI Program in conjunction with the Primary Care Office routinely monitors monthly enrollment figures, including new enrollees and dis-enrollments, to determine enrollment trends.

In November 1998, the **Brighter Futures for Idaho's Kids** project was formally dissolved. The project had been established in November 1997, to address three key children's programs: Early Childhood Development Clearinghouse; Idaho Child Care Program; and Idaho Children's Health Insurance Program. The Early Childhood Development Clearinghouse was a specific directive from former Governor Batt to address the primary need for a single place within state government where parents of young children can access needed information on care, services and development for their children. The Governor directed that the Clearinghouse include information from

the last two decades of research data and findings on a child's brain development and learning in the first three years of life. The Clearinghouse was scheduled to come live in October 1998. It began on schedule.

The focus on the Idaho Child Care Program was threefold: 1) to improve stability of a program that had seen over- and under-spending of budget in its rather brief history; 2) get child care subsidies out to eligible families within the budget limitations; and 3) increase the engagement of the Department with local communities around the broad issue of child care - for all ages, income levels and types of providers, not just those using the subsidy program. The funding of subsidies stabilized and no funds were reverted federally. The Idaho Child Care Program rules were updated and reviewed by the 1999 Legislature. A plan was developed for ongoing quality improvement fund allocation. The Department's Regions across the state are now engaged in several local community coalitions on child care.

The Idaho Children's Health Insurance Program, **CHIP**, was implemented in October 1997, as a Medicaid expansion to take advantage of federal matching funds targeted to getting health insurance available for uninsured children in families with limited incomes. The federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and Legislature. In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Center for Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21

recommendations to the oversight committee in September 1999. The oversight committee has made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts. The importance of outreach was also recognized and has been made a top priority in the regional offices as well as the central office.

As indicated in the FY 2000 block grant, with the dissolution of the **Brighter Futures for Idaho's Kids** task force, MCH participation became a moot point, thus making obsolete the state negotiated performance measure **SP#6**, that had been described in the FY 1999 MCH Block Grant application.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24 month old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with *Scientific Technologies Corporation* to develop a plan for the implementation of the immunization registry. This plan was approved and work has begun to develop a statewide system which will link the existing seven district health department immunization registries. Pilots have begun and are scheduled to be completed by the end of 2000. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

Another recent initiative within the state is an effort to better coordinate health services to clients. It is a plan in development by district health offices and the

department regional offices. The concept is simple, one government agency helps its customers by not only providing a service, but by telling the customer about another program with the agency across the street. It would allow clients who come in for one service at a local health district to have access to another service offered by the Department. This initiative has been tied to the Maternal and Child Health Survey which was part of the five year needs assessment process. The survey, which was distributed statewide, provided public input on health issues and an opportunity to see what the health districts and the Department can do together to impact them. Some key issues identified pointed to the need for CHIP outreach by the districts to get information to families who need and qualify for CHIP. On the other hand, the regional Health and Welfare offices can make a more concerted effort to refer clients to services such as family planning.

Much of the impetus for the above initiatives came from a state philosophy which promotes self-reliance. That message was the essence of welfare and Medicaid reform in Idaho. This reform has resulted in a substantial reduction in welfare rolls with a net impact of increasing available TAFI (Temporary Assistance for Families in Need) funds. The Department of Health and Welfare has opted to use this extra TAFI money to fund a number of key health areas including; adolescent pregnancy prevention, childhood immunizations, and childhood injury prevention.

A re-examination of health priority areas was conducted in May 1999, using a limited needs assessment process. Division of Health and District Health Department representatives reviewed health status data and issues were prioritized based upon criteria identified by the *Family Health Outcomes Project*, University of California, San Francisco including: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amendable to intervention/intervention proven effective by research. This process, re-affirmed Idaho's areas of need and focused MCH activities during FY 2000 to impact these issues which included:

- < Infant mortality and low birth weight
- < Adolescent pregnancy

- < Vaccine preventable diseases
- < Injuries
- < Children with special health care needs program (CSHP) funding
- < Investigation and control of “clusters” of reportable diseases and conditions
- < Early child development information clearinghouse
- < Children’s access to health care coverage

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

### **1.5.1 State Agency Capacity**

#### **1.5.1.1 Organizational Structure**

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Title II, CARE), immunization, WIC, programs for children with special health care needs and most recently the SSDI position and grant. Additional fiscal oversight and program review is provided for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities by the chief of BOCAPS. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, and Bureau of Clinical and Preventive Services are included with this submission (**Figures 6A, 6B, 6C**).

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho code 39-101 to “promote and protect the life, health, mental health, and environment of the people of the state.” The Director is appointed by the Governor, and serves “at will.” He/she serves on the state’s Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and “to advise its directors.” Programmatic goals and objectives are developed to meet the specific

health needs of the residents of Idaho and to achieve the *Healthy People 2000 (HP)* objectives for the nation.

### **Bureau of Clinical and Preventive Services (BOCAPS)**

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

### **Children's Special Health Program**

The Children's Special Health Program (CSHP) is administratively located in the BOCAPS. The CSHP is governed by IDAPA 16. Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." [Online at <http://www2.state.id.us/adm/adminrules/rules/idapa16/0226.pdf> ]

The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

### **Bureau of Laboratories**

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." In 1976, the newborn test battery was expanded to include screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), tyrosinemia, homocystinuria, and biotinidase deficiency, in addition to PKU.

#### **1.5.1.2 Program Capacity**

Statewide service delivery for the state agency is carried out at the district health department level through written contracts between the state and districts at the "program" level. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A

description of the state agency programs and their capacity to provide services for each population group follows.

### ***Pregnant Women, Mothers and Infants***

The **Reproductive Health Program** (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The **WIC Program** provides pregnant and postpartum women and infants with supplemental foods, nutrition counseling and education. The **Immunization Program** purchases and distributes vaccine to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. The program also maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in the development and implementation of a statewide immunization registry called *IRIS*, the Idaho Immunization Reminder Information System. The **Genetics Program**, within the Bureau of Laboratories, provides newborn metabolic screening through a contract with the Oregon Division of Health Regional Laboratory. Additionally, the program contracts with board certified medical geneticists to provide genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided to physicians and other health care professionals involved with all segments of the MCH population.

### ***Children***

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include these several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools,

hospitals and nonprofit organizations in providing preventive health education. The **Oral Health Program** collaborates with state agencies and private entities to assess and promote access to dental care. Funds are contracted to the district health departments to perform surveys of oral health status as well as to conduct the school fluoride mouth rinse and plaque control programs. The **Abstinence Education Block Grant** is administered from this bureau. Presently, the program has contracted with the district health departments to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that addresses adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Governor's Council on Adolescent Pregnancy Prevention which is staffed by the bureau. The **Injury Prevention Program** provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

#### ***Children with Special Health Care Needs***

The **Children's Special Health Program (CSHP)** provides and promotes direct health care services in the form of family centered, community-based, coordinated care for children with special health care needs, including: phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

#### ***All MCH Populations***

The **State Epidemiologist** provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCH EMSC grant. The **STD/AIDS Program** provides HIV

prevention education activities as well as counseling, testing, and epidemiology follow-up. It also distributes HIV/AIDS therapeutic drugs to eligible clients. The **toll-free telephone referral service**, *Idaho CareLine*, as it's called, provides "information and referral" service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. *CareLine* has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is currently under the administration of the Division of Family and Community Services. The Bureau for Vital Records and Health Statistics administers programs that provide for a statewide system of vital records and health statistics. The center employs a **Perinatal Data Analyst** who is currently reviewing a variety of perinatal health status indicators and has conducted a PRATS survey of recently delivered women. Additionally, the Center conducts population based surveys, i.e., the BRFSS. The Office of Rural Health and the Primary Care Cooperative Agreement are focused on improving services in rural areas. The **MCH Systems Development Initiative (SSDI)**, now administered within BOCAPS, is currently reviewing data needs and data sources for several MCH performance measures and health status indicators.

### **1.5.1.3 Other Capacity**

All state level MCH funded personnel (with the exception of the Bureau of Laboratories, Genetics Program personnel) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Vital Statistics and Health Policy are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. The Bureau of Laboratories, Genetics Program, is located on a separate state campus, approximately three miles from the primary office building. Distance does not deter joint collaboration, which occurs via bi-weekly staff meetings, telephone, electronic mail, and FAX communication.

The CSHP program is staffed by a 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist. In addition, services for PKU and high risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.2 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

The Genetics Program is maintained by a 1.0 FTE program coordinator who coordinates genetic clinics to provide counseling, diagnosis and follow-up care to women, infants and children. The Oral Health Program is staffed by a 1.0 FTE program coordinator and a 0.5 FTE secretary.

Systems development activities are now administered through the Bureau of Clinical and Preventive Services. The 1.0 FTE MCH Systems Coordinator (funded through the State Systems Development Initiative), is housed in this bureau. The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 2.0 FTE Public Service Representatives [jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA)] and other Medicaid programs using the service.

The central office MCH program resources total 14 professional management staff. **Figure 6D** provides an organizational view of the individuals and their respective programs, with the exception of Ms. Willis, of the Bureau of Vital Records and Health Statistics, and Ms. Williams of the Idaho CareLine. Future submissions will present the organizational charts inclusive of these individuals. The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

**Roger Perotto, M.S.**, became the **Chief of the Bureau of Clinical and Preventive Services**, in the Division of Health, at the beginning of state FY 1996. He had been the Acting Chief of the Bureau of Maternal and Child Health since January 1995. Concurrent with this appointment, he served as the Chief, Bureau of Communicable Disease Prevention for three years. Prior to that, he served in several capacities within the Bureau of Laboratories, including Manager, Laboratory Improvement Section, and as Acting Chief of the Bureau of Laboratories.

**Susan E. Ault, B.S.N., R.N., A.R.N.P.**, has been the **Family Planning Program Manager** since 1988. This program has been re-named the **Reproductive Health Program**. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

**Christine Hahn, M.D.**, has been the **State Epidemiologist** since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiologic support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

**Leslie Tengelsen, Ph.D., D.V.M.**, has been the **Assistant State Epidemiologist** since 1998. She also provides epidemiologic support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

**Brett Harrell, M.A.**, was appointed **Manager, Children's Special Health Program Coordinator**, in May 1995, after serving as the **Director of Special Projects** since November 1994. Mr. Harrell has considerable experience in administration and management and has directed a regional hospice organization and a statewide diabetes association.

**Judy Peterson, M.S., R.D., L.D.**, provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho WIC Program.

**Christina Giso, M.B.A.**, is Idaho's **MCH State Systems Manager** (formerly designated the **State Systems Development Initiative Coordinator**). Her advanced degree is in health systems administration and her primary focus will be the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

#### Bureau of Health Promotion

**Ginger Franks, Dr.P.H.**, has been the **Injury Prevention Program Manager** since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

**Angela Wickham, M.P.A.**, is the new **Adolescent Pregnancy Prevention**

**Program Manager.** This program, within the Bureau of Health Promotion, develops and implements the MCH funded adolescent pregnancy prevention grant.

**Lisa Penny, B.S., R.D.H.,** has been **Oral Health Program Coordinator** since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

#### Office of Rural Health

**Andrea Fletcher, MPH,** is the **Director of the State Office of Rural Health.** As the Director, she coordinates state programs and responds to grant opportunities to improve health care delivery systems for under-served rural population in the state.

#### Bureau of Laboratories

**Mary Jane Webb, B.S.,** has served as the **Genetics Program Manager** since 1962. Ms. Webb has been instrumental in implementing legislation requirements for the newborn screening program, in organizing contracted services to support the Genetics Program in Idaho, and in establishing support groups for families with genetic disorders. Ms. Webb established and manages the Genetics Laboratory.

#### Bureau of Vital Records and Health Statistics

**Dianna Willis, MA,** has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

#### Division of Family and Community Services

**Pat Williams,** is the **Idaho CareLine** (Early Childhood Information Clearinghouse) **Coordinator,** our toll-free referral service.

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the masters level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Prevention Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

A CSHP advisory group has been developed which contains members of the impacted families as well as providers.

### **1.5.2 State Agency Coordination**

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

#### Other State Agencies

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. This agreement refers to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid

Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

As indicated in the FY 96 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. The Reproductive Health Program is jointly funded by these two federal programs. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient collaboration with the Bureau of Health Promotion with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, and oral health promotion. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated

*CareLine*. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

### Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:

- a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
- b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
- c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
- d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
- e) Healthy Mothers/Healthy Babies Coalition, a statewide association of concerned citizens, health educators, nutritionists, nurses, physicians, and public policy makers who work together to improve the health of mothers and babies.
- f) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
- g) Healthy Child Community, an interdepartmental group interested in promoting the health and well-being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
- h) Boise State University Women's Center Advisory Committee address women's issues including sexual assault prevention.
- i) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.

- j) Immunize By Two Coalition, works to assure 90% of children 0-24 months are immunized as medically recommended.
- k) Idaho Breast and Cervical Cancer Alliance, dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
- l) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
- m) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
- n) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children.
- o) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
- p) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues which affect the state's rural communities.
- q) Idaho Governor's Council on Adolescent Pregnancy Prevention.
- r) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
- s) SANE Solutions Advisory Committee addresses child sexual abuse prevention primarily looking at the offender.

- t) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for child sexual abuse prevention and teens for date and acquaintance rape prevention.
- u) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths.

### Local Health Departments

The seven district health departments, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the district health departments. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

### Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Center for Vital Statistics, has a cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide

immunization status assessments of their clinics as well as identifying barriers to immunization.

### Universities

The department maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho and a survey of medical providers for the Office of Primary Care by Boise State University. Currently, the State Epidemiologist is collaborating with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university is also under contract with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium.

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

### **2.1 Annual Expenditures**

Please refer to forms 3, 4, and 5. See **Figures 2 and 2A**.

#### Budget Narrative

As can be seen on form 5, since FY96, expenditures for direct and enabling services have been reduced, while those for population-based and infrastructure building have increased. Based upon changes in the priority health issues, as well as changes in the availability of some federal/state funds, the program focus shifted and was manifested as follows including: (1) the re-allocation of \$547,000 in MCH funds in FY'97 from the Reproductive Health Program (direct services) to the Immunization, Injury Prevention, Epidemiology, Adolescent Pregnancy Prevention Programs and the Bureau of Vital Statistics (population-based services and infrastructure building); (2) the re-allocation of \$161,000 in MCH funds in FY'98 (available due to the Abstinence

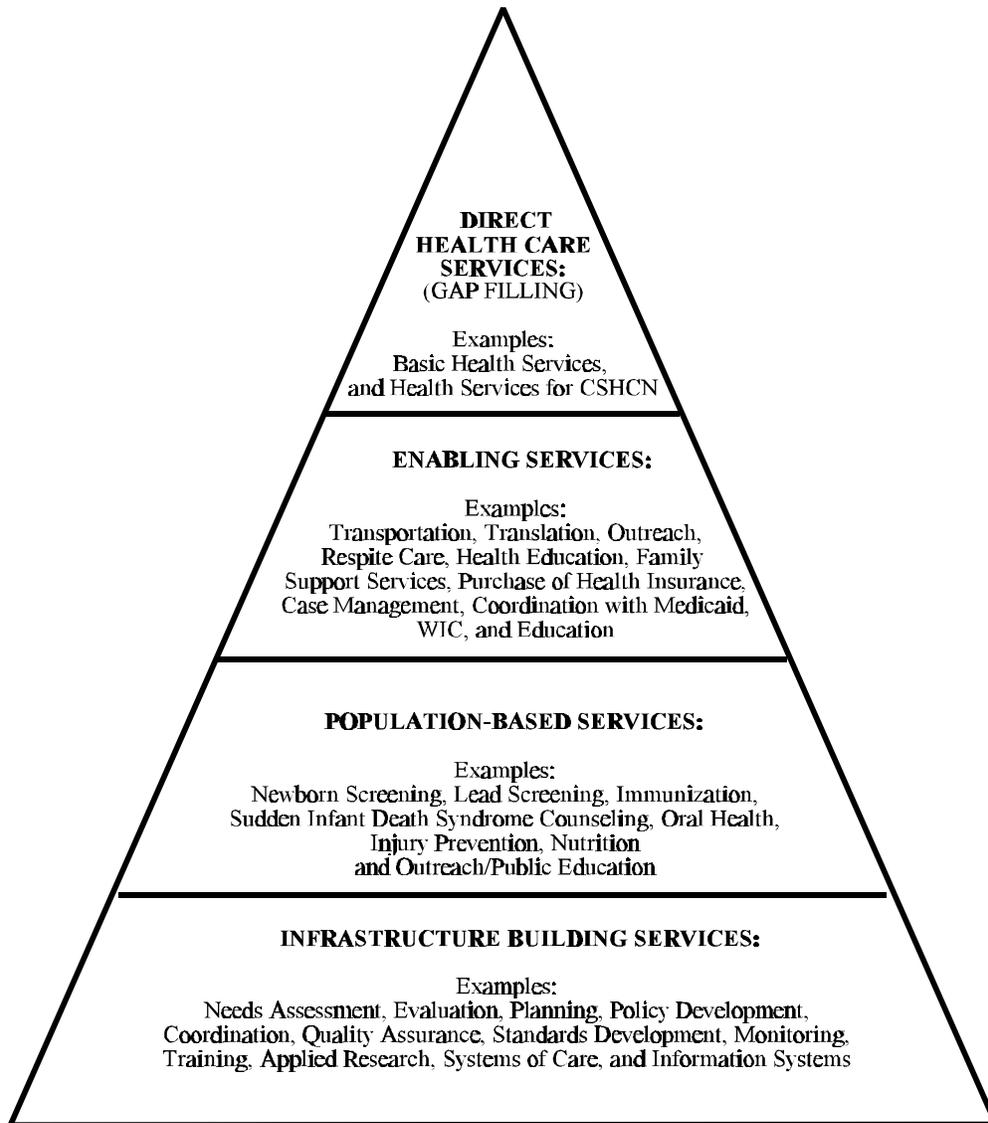
Education Block Grant) to programs involved in population-based services and infrastructure building (Epidemiology, Injury Prevention, and Vital Statistics); and (3) a reduction of State General Funds/local funds for the CSHP Program (direct services).

Also evident from form 5 is the reduction in expenditures for enabling services since FY'96. These reductions are primarily the result of centralizing the "toll-free telephone line" in the Boise office rather than contracting with the district health departments. This approach drastically reduced program costs. Additionally, expenditures were reduced by establishing a cost-sharing process with several other state agencies which use this service.

Although, as seen on form 3, there appears to be no local funding available in FY'2001, this anomaly is the result of combining state and local funds based on our interpretation of the grant guidance instructions. However, the total amount of state general funds expended has indeed been reduced since FY'96 as is reflected on form 3. This has been an administrative decision to shift these funds to other programs outside of Title V based upon Division of Health priorities.

Figure 2

**CORE PUBLIC HEALTH SERVICES  
DELIVERED BY MCH AGENCIES**



## 2.2 Annual Number of Individuals Served

Please refer to forms 6, 7, 8 and 9.

## 2.3 State Summary Profile

Please refer to form 10.

## 2.4 Progress on Annual Performance Measures

Please refer to form 11.

Through the use of Title V, State General Funds and other Federal resources, Idaho is able to report the following accomplishments:

### Direct Medical Care

#### *Pregnant Women, Mothers and Infants*

The **Reproductive Health Program** provided health education, assessment and medical services to 36,676 low income Idahoans in CY 1999. Services are provided through the public health districts and one Planned Parenthood clinic, and clinics are located in 37 of Idaho's 44 counties. Low income, medically under served women are the primary target population and the majority of the client's incomes are less than 100% of the federal poverty level. Medical examinations provided to women include counseling, health education, blood pressure, urinalysis, hematocrit, physical examination, pap smear and STD screens as indicated. The number of women served and the number of women receiving pregnancy tests declined in CY 1999. Two agencies, District VII and Planned Parenthood, have not been able to fill nurse practitioner position and as a result have seen fewer clients. At the Planned Parenthood there has been a 20% reduction in women seen. Data from January through March 2000 however, show a significant increase in clients for the agency.

Approximately 11% of the 19,255 pap smears performed by the program are abnormal. In CY 1999, 2,136 women received counseling, referrals and follow-up of their abnormal pap smears and 174 received colposcopy services on-site. All positive Pap test results require documented follow-up. Chart audits are done at the clinic level. One hundred percent (100%) of the records of women who had any dysplasia identified in a Pap smear, have documentation of follow-up treatment by an appropriate

provider within six weeks of the date the Pap smear result was received.

The **Reproductive Health Program** provided pregnancy testing, risk assessment, and referrals to 10,967 women. Of these women, 3,780 were pregnant and were also screened for substance use or abuse and provided appropriate education, counseling and referral to treatment and care coordination. The number of pregnancy tests performed declined 14%, but the number of unintended pregnancies declined only 10% and as a result, **performance measure SP7** was not met. The Statewide Perinatal Risk Assessment tool was used as a screening device. Because of the increase in violence during pregnancy, screening tools have also been developed for family violence.

The program provide outreach to the Hispanic community, and provided funding for outreach into migrant camps through a contract with the Southwest District Health Department. More than 2,119 clients served speak only Spanish and required interpretation services.

The **Immunization Program** continued to provide free vaccine to district health departments and private providers for the provision of immunization to infants.

### **Children**

A total of 10,358 teens, less than 20 years of age, received physical assessment, education and counseling through the **Reproductive Health Program**. Of those teens, 382 were less than 15 years of age. These are generally high risk youth who receive additional counseling and risk assessment. Because these teens are at increased risk for unintended pregnancy, program records are audited to assure appropriate counseling is provided (**performance measures 6 and SP8**). The rate of births for teenagers ages 15-17 increased slightly from 24.5/1,000 in CY 1998 to 25.1/1,000 in CY 1999. This met the performance objective (**performance measure 6**). The state performance measure (**performance measure SP8**) for percent of positive pregnancy tests in Reproductive Health program participants less than 20 years of age was met. The program reviewed statistics of all active male and female clients ages 13-19, who have had an encounter with a medical provider for the purpose of receiving contraception to assure counseling was provided at each visit and abstinence and

parental involvement counseling were included.

Training on sexual coercion and abuse was provided to District Health Department staff members. Risk assessment and identification of at-risk youth was addressed as well as reporting requirements and community resources and referral networks.

The **Immunization Program** continued to provide free vaccine to district health departments and private providers for the provision of immunization to children.

#### ***Children with Special Health Care Needs***

All children in Idaho who receive SSI are automatically eligible for Medicaid, therefore any rehabilitative services provided to SSI youngsters enrolled in the **Children's Special Health Program (CSHP)** are reimbursed by Medicaid, thus meeting the target for **performance measure 1**. CSHP provided and paid for services in eight of the nine categories listed for **performance measure 2** for 228 patients who had no other payment source. In FY 1999, 63 children were seen in six regional PKU clinics and PKU formula was distributed to an average of 66 individuals in 39 families each month.

During FY 1999, the CSHP Program sponsored 220 speciality clinics in seven regional health departments across the state, staffed by health department staff and some 80 physicians and other providers under contract to the program. Through the year, 1,758 patients generated 2,696 clinic visits in seven major diagnostic areas. Cardiac services remained the most prevalent provided, accounting for 38% of the total; neurological services were second in prevalence with a 15% total, followed by orthopedic with 12%. Cleft lip/palate, craniofacial, cystic fibrosis and rehabilitative services shared the remaining 35% of the total.

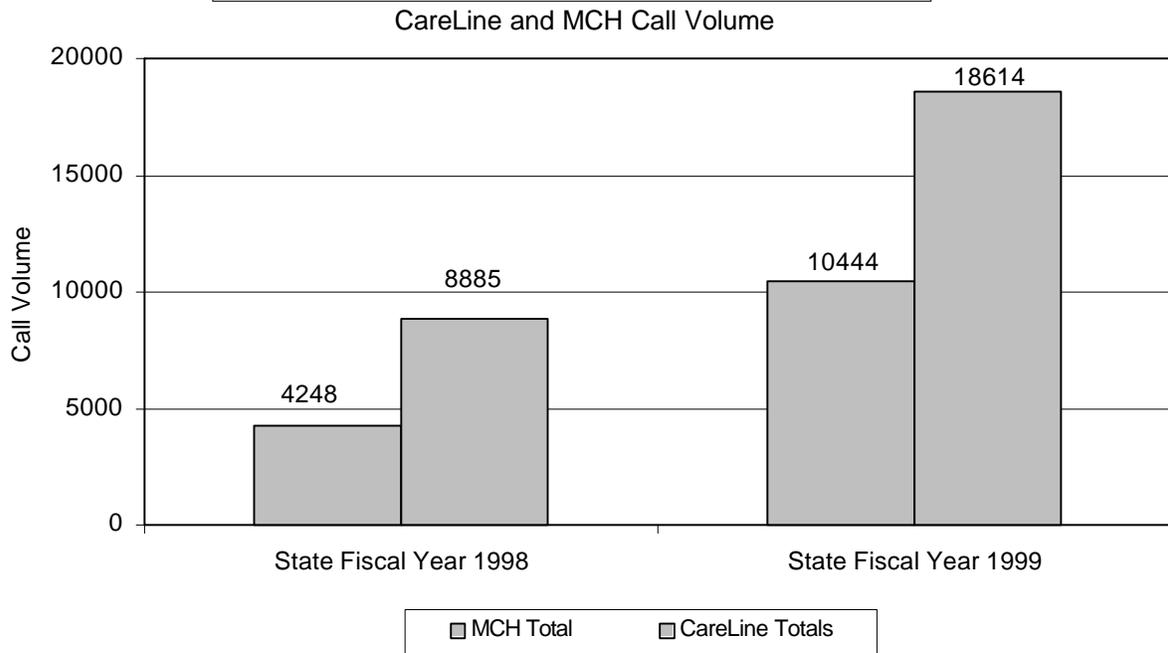
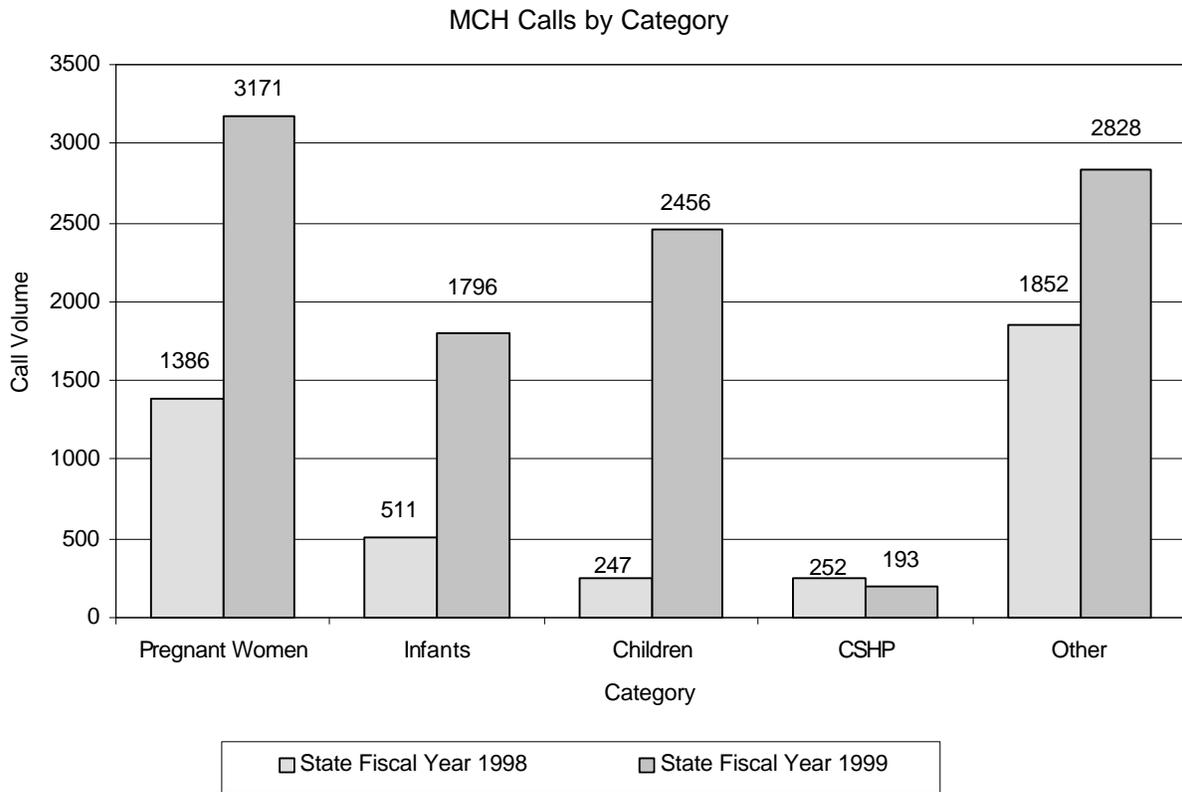
#### Enabling Services

#### ***All MCH Populations***

The **Idaho CareLine**, the toll-free telephone information and referral service for the Idaho MCH population, data summary is reported on Form 9. The Idaho *CareLine* expanded its services in the fall of 1998 to include a statewide clearinghouse for children's services with the immediate focus on early childhood development, child care, and health issues. Two of the four public service representatives staffing the

Idaho CareLine are bilingual, speaking both Spanish and English. Additionally, a contract with AT&T Language Line Services was added, which allowed access in seconds to interpreter services for 140 languages. TDD services are also available for those with hearing disabilities. The database software was upgraded in December 1997 and offers extensive case management options. The database is continually updated by making personal contact, phone or by letter to each service provider. Continued promotion of the toll-free information and referral telephone service to the MCH, Infant Toddler and Medicaid populations (including CHIP referrals ) during the current reporting year, resulted in a phenomenal increase in calls to the Idaho CareLine. An average of 1551 calls per month were received during State Fiscal Year 1999, which represents a continual growth of approximately 110% from FY 1998 to FY 1999. With the overall increase in calls on both health and non-health related children's social and developmental services topics, we far exceeded our target for **performance measure SP3 (Figure 7)**. The following charts graphically represent increases in call volume over the past year. Although CareLine calls increased more than two-fold, MCH-related calls increased by 145%, increasing from 4,248 calls in State Fiscal Year 1998 to 10,444 calls in State Fiscal Year 1999. Likewise, call volume in the majority of the five MCH call categories (pregnant women, infants, children, CSHCN, and other)

also increased. Volume for pregnant women increased by 129%, infants 251%,



children 894%, and other 53%; calls for CSHCN decreased 23%. This is most likely

the result of increased knowledge of the service, the fall 1998 state-wide expansion of the 1-800 line as the information clearinghouse for children's services, and the continued promotion of the service to the MCH populations.

In addition to CareLine services, the Title V agency has been active in the planning and design phases of the Department of Health and Welfare's media campaign to increase awareness of and enrollment in the CHIP Program. cursory review of the monthly enrollment figures for CHIP indicate the campaign has been successful. One outcome of this heightened awareness of CHIP is increased identification of children eligible for Medicaid coverage. Representatives of the Title V agency also played a key role in the development of a "streamlined" version of the Medicaid/CHIP application form which has greatly simplified the enrollment process. Additionally, the SSDI Program in conjunction with the Primary Care Office routinely monitors monthly enrollment figures, including new enrollees and dis-enrollments, to determine enrollment trends.

#### ***Pregnant Women, Mothers and Infants***

The district health departments continued to utilize the Perinatal Substance Abuse Prevention Protocols in **Reproductive Health** clinics. District staff participated with local health and social service providers to reduce substance abuse among all women of child bearing age and improve the system of services for pregnant substance using women.

The program provide outreach to the Hispanic community, and provided funding for outreach into migrant camps through a contract with the Southwest District Health Department. More than 2,119 clients served speak only Spanish and required interpretation services.

Another strategy used by the **Immunization Program** to increase immunization rates in infants, included the collaboration with the WIC program statewide to provide immunization screening and referral services. All WIC clients 0-24 months of age were screened for immunization status and those not up to date were referred to their health care provider (**performance measure 5**). The program also collaborated with one statewide and 12 local coalitions to provide immunization education and outreach

services as well as parent and provider education, and continued a contract to provide for the Baby Track reminder/recall program for parents in 27 birthing centers.

### **Children**

See **Immunization Program** activities above under pregnant women, mothers and infants.

During FY 1999, a variety of health education materials were made available in English and Spanish through the MCH **Oral Health Program** to the district health departments, dental and medical health professionals, educators and the public. State level coordination, consultation and technical assistance were provided to individuals and organizations via the telephone, meetings and printed materials. Outreach efforts included:

- < oral health information placed on the Department's Early Childhood Information Clearinghouse website;
- < dental articles in the Department and professional newsletters;
- < mailing of 1,500 guides for detecting child abuse and neglect to dentists, dental hygienists and dental, dental hygiene and dental assisting students, funded by a grant from the Idaho Dental Hygienists' Association and in collaboration with the *Idaho's Invisible Children* campaign of the Division of Family and Children's Services;
- < presentations to the Idaho State Dental Association and the Idaho Dental Hygienists' Association regarding dental public health program activities;
- < information about the Idaho Child Health Insurance Program (CHIP) sent home with children surveyed through the district dental contracts.

The Oral Health Program continued to promote integration of oral health with other health promotion activities. Coordinated efforts included:

- < ongoing collaboration with the WIC Program to assess BBTD prevalence and risk behaviors, identify and provide teaching materials, and promote client education; during FY 1999, the Texas *Take Time for Teeth* videotape, pamphlets and teaching guides in English and Spanish were duplicated and distributed, impacting approximately 8,300 WIC women and 27,000 infants and children.
- < meetings with State and regional Medicaid, Head Start, public health and

dental society representatives regarding potential collaborations to increase children's access to preventive and restorative dental care, including early childhood caries prevention;

- < participation in the Tobacco Free Idaho Alliance, the Healthy Mothers Healthy Babies of Idaho coalition, and the Coalition for a Healthy Idaho.

Enabling services provided through the MCH Oral Health Program also included contracts for a population-based school fluoride mouth rinse program, quarterly conference calls with the district health departments, and monthly staff meetings with the State MCH Director and other MCH Program Managers. Program support provided to the districts included fluoride mouth rinse supplies, toothbrushes, printed materials, and supplies to conduct oral health surveys and screenings.

Contracts with two dentists, one with a public health background and the other a private practice dentist, provided ongoing consultation to the MCH Oral Health Program, authority to conduct the school fluoride mouth rinse program, a link to the Medicaid Dental Program and liaison to the dental community. Both MCH consultant dentists also serve as dental consultants to the State Medicaid Program.

Training on sexual coercion and abuse was provided to District Health Department staff members through the **Reproductive Health Program**. Risk assessment and identification of at-risk youth was addressed as well as reporting requirements and community resources and referral networks.

#### ***Children with Special Health Care Needs***

The total number of children with special needs in Idaho was unknown in FY 1999, but is estimated at 63,084 using the MCHB definition and prevalence rate of 18%. It is estimated that 81% of that number have a "medical/health home" using the AAP definition (**performance measure 3**). This percentage was established using 1999 BRFSS data. (Previous data listed on Form 11 for the FY 1999 block grant has been revised to reflect this change in the FY 2000 application and in this application).

#### Population-Based Services

#### ***Pregnant Women, Mothers and Infants***

Through **Reproductive Health** contracts with the health districts and Planned

Parenthood of Idaho, more than 50,000 women received public education information on family planning, women's health and risk reduction (**performance measures 6, SP7 and SP8**).

The **Immunization Program** continued to provide free vaccine to district health departments and private providers for the provision of immunizations to children. As reported in last year's grant application, this activity combined with those described in the annual plan, did have a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). However, we were not able to sustain this increase with the rates falling from 79% to 70% for the period January to December 1999 according to the latest National Immunization Program Survey (**performance measure 5**). Also, due to funding shortages in 1999, we were not able to implement the Hepatitis A vaccine program targeting children at kindergarten entry (**performance measure SP10**).

During FY 1999, the **Genetics Program** provided, through contract with the Oregon Division of Health and Regional Laboratory, at least one screening for PKU, hypothyroidism, galactosemia, biotinidase deficiency and maple syrup urine disease to more than 98% of newborns, meeting the target for **performance measure 4**. Although population-based screening for hemoglobinopathies is not conducted, such testing is available by special request.

The 1999 *Idaho Breastfeeding Study* shows that 72.4% of Idaho's infants were exclusively breastfed at or near hospital discharge (**performance measure 9**). This is 3.9% above the performance objective set for FY 1999. A number of activities were undertaken during FY 1999 to increase this percentage including: lactation conferences and speakers in three areas of the State; distribution of breastfeeding educational materials to hospitals, clinics, WIC agencies, and childbirth education programs throughout Idaho. The annual performance indicators have been changed in this FY 2001 block grant to correlate to a change in data methodology which now captures a percent based on records with stated type of feeding. This method differs from prior years where unknowns were included in the denominator. This change was made for year's FY 1996 through FY 1999 and will be used in next year's block grant

application.

The **Child Mortality Review Team** convened its first meeting in December of 1999 and began meeting quarterly throughout the year. Deaths of Idaho resident children under 18 years of age during 1997 were reviewed. The Bureau of Vital Records and Health Statistics identified deaths of these children occurring in Idaho. An abstract of the death certificate was supplied to a smaller screening group which met monthly to preview the abstract and identify potentially preventable deaths. The screening group selected the death for further review when it met one or more of the following criteria:

- death was due to an external cause, or
- death was unexplained, or
- death was due to a cause with modifiable risk factors.

The death was then assessed to identify additional information necessary for a comprehensive review. Additional information was then requested from the appropriate agency. These sources of information included: autopsy reports, coroner reports, law enforcement reports, medical records, EMS records, and child protection records. The team does not have subpoena power and can not always obtain confidential records.

After available records were collected and reviewed, they were presented before the Child Mortality Review Team (CMRT). All 224 deaths in 1997 were reviewed, exceeding **performance measure SP1**. Of these, 138 were considered to warrant further review and were presented to the CMRT. The preventability of the death was stratified by identifying risk factors that might have contributed to the death. The results of these reviews including the risk factors, prevention opportunities, and intervention activities will soon be published as the group's first annual report. A preliminary review of 1999 deaths attributed to SIDS has shown that 94.7% were autopsied, which exceeds the performance objective for **performance measure SP9**.

During FY 1999, Title V agency representatives continued to be active participant in the **Idaho Newborn Hearing Screening Consortium**. This group has focused their efforts on educating birthing hospitals in Idaho about the many benefits of screening newborns for hearing loss. Due to their involvement in this issue, and hospital interest in providing quality care, fourteen hospitals have screening programs in the state. Preliminary 1999 figures indicate that 63.1% of Idaho newborns have received hearing

screening services (**performance measure 10**). Because some hospitals have started their programs during the calendar year 1999, not all newborns at those facilities were screened. For hospitals reporting newborn hearing data, 96.5% of infants eligible for screening services were actually screened. This has been accomplished without a state mandated law. These past efforts have led to better data on newborn hearing. In conjunction with the Idaho Hospital Association's annual meeting, the Consortium brought together hearing screening coordinators from around the state and provided them with educational updates including a session from Karl White, PhD and Director, of the National Center for Hearing Assessment and Management.

### **Children**

The **Immunization Program** continued to provide free vaccines to district health departments and private providers for the provision of immunizations to children. As reported in last year's grant application, this activity combined with those described in the annual plan, did have a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). However, we were not able to sustain this increase with the rates falling from 79% to 70% for the period January to December 1999 according to the latest National Immunization Program Survey (**performance measure 5**). Also, due to funding shortages in 1999, we were not able to implement the Hepatitis A vaccine program targeting children at kindergarten entry (**performance measure SP10**).

The **Injury Prevention Program** contracted with health districts statewide to provide public risk reduction for motor vehicle and bicycle related injuries (**performance measure 8**). Activities included: training of 891 parents, and 35 individuals to teach parents/care givers to correctly install child car safety seats; distribution of 1040 child car safety seats to low income families; conducting 583 child car safety seat checks; providing seat belt education to more than 750 elementary school children; providing bicycle safety education to more than 5000 children; and distributing and fitting bicycle helmets for 4285 children. In addition, the program worked with the Idaho Transportation Department to provide vehicle and bicycle safety promotions statewide. Also working with the Idaho Department of Transportation, the

program provided NHTSA certified technician training to 52 injury prevention specialists statewide, and certified 3 instructors. Further, the Injury Prevention Program worked with the Idaho Transportation Department to provide radio messages (in English and in Spanish) on child passenger safety and bicycle safety to more than 230,000 Idahoans.

An **Adolescent Suicide Prevention Taskforce**, charged with planning prevention efforts at the state level was chaired by the community liaison from Intermountain Hospital. Members represent Health and Welfare, Family and Community Services, drug and alcohol prevention, education, suicide prevention hotlines, and survivors. Intermountain Hospital provides inpatient services to adolescents experiencing drug, alcohol, depression and other problems. State Representative Max Black, a member of the task force, introduced a resolution during the 2000 session of the Idaho legislature, recognizing the destructive effects of suicide and the need to raise awareness on the problem. Although this resolution was adopted, funding to address the problem was not provided. However, despite the lack of specific programmatic activities at the state level, the rate of suicide deaths among youth improved in 1999, exceeding our performance objective (**performance measure 16**).

The MCH **Oral Health Program** contracted with each of the seven district health departments to conduct population-based preventive oral health programs. Through the district contracts, 85,473 persons were served during FY 1999:

- < 36,986 children participated in the school fluoride mouth rinse program. The rinse program targets children in grades 1-6 who are at high risk of developing dental caries and live in fluoride deficient areas.
- < 30,539 persons were reached through statewide school-based preventive dental health education programs for students and teachers. Classroom education reached 29,669 children and in-service training was provided to 870 teachers.
- < 10,569 persons were reached through community-based oral health promotion activities, such as health fairs, parenting classes, and other outreach efforts funded wholly or in part by local and other funding sources.

All contract activities were monitored through quarterly reports submitted by the district health departments and through site visits to each district. Program participation and compliance data were compiled and evaluated quarterly and at the end of the contract year.

See **Epidemiology Program** activities (child mortality review team) above under population-based services.

#### ***Children with Special Health Care Needs***

See **Immunization Program** activities above under Children.

#### Infrastructure-Building Services

#### ***All MCH Populations***

In an effort to decrease the percent of children without health insurance, the Title V agency assisted in planning and design of a media campaign to increase awareness of and enrollment in the CHIP Program. Representatives of the agency also played a key roll in the development of a "streamlined" version of the Medicaid/CHIP application form. This re-design greatly simplified the enrollment process which also impacted the number of children with some kind of health insurance. According to the latest BRFSS survey data, the percent of children without health insurance decreased to 12.4% in 1999, exceeding our performance objective for **performance measure 12**.

The number of potentially Medicaid eligible children who have received a service paid for by the Medicaid program is 76.8% for FY 1999, an increase over FY 1998's rate of 71.7% (**performance measure 13**). [Caution is urged when reviewing data presented on Form 11 for performance measure 13, due to a change in the data source used for measurement. Data for FY 1999 and FY 1998 as presented in this discussion are based upon the same method of measurement]. In previous years Medicaid provided this information by using a report titled the "HCFA-2082". Normally, this report is available each May, this year however, it has been delayed and there is no estimate on availability.

## ***Pregnant Women, Mothers and Infants***

The **Reproductive Health Program** continued meetings with Division of Welfare state and local staff to discuss coordinating efforts to reduce second pregnancies to teens and high risk Temporary Assistance to Families in Idaho (TAFI) recipients (**performance measure 6, SP7 and SP8**). A request for TANF funding to support outreach for low income women was developed but not funded. The request will be resubmitted by July 2000.

The program continues to work with Division of Medicaid staff to develop a 1115 waiver to expand family planning services to Medicaid recipients and all women below 150% of the federal poverty level. A task force has been developed to write the concept paper. The waiver will make the development of culturally appropriate outreach and services to the Hispanic population a priority.

The **Prenatal Care Research Analyst** with the Center for Vital Statistics and Health Policy conducted analysis and provided state, district, and county-level data to the State Systems Initiative Development program, the Rural Health Program and played an integral role in the development and analysis of data for the needs assessment portion of this block grant. Additional services included the development, writing, and publishing of a comprehensive report: *Access to Prenatal Care in Idaho*. The report provides essential data from Idaho's Pregnancy Risk Assessment Tracking System (PRATS) and an analysis of data from Idaho's live birth certificate database. Data provided in the report include onset of prenatal care, adequacy of prenatal care utilization, access to prenatal care resources, and birth outcomes (**performance measures 15, 17 and 18**). (See Notes Section for data change on measure 17).

The **Immunization Program** contracted with Idaho State University to conduct Clinic Assessment Software Analysis (CASA) assessments (AFIX process) of private clinics to identify immunization rates in single clinics and to identify barriers to immunization found in those clinics (**performance measure 5**). The program also collaborated with Medicaid's Healthy Connections (managed care) representatives to perform site visits to Vaccine For Children (VFC) providers throughout the state.

The **Epidemiology Program** contracted with the district health departments to

provide health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigations. Site visits were conducted with each district epidemiology program as part of a quality assurance measure to enhance the statewide epidemiology capacity. The transference of investigations of elevated blood lead levels to the Epidemiology Program during FY 1999, resulted in completion of 100% of these investigations on children with elevated blood lead levels, which exceeded the annual performance objective (**performance measure SP5**).

During FY 1999, the **SSDI Program** primarily focused on the Pregnancy Risk Assessment Tracking System (PRATS) survey. The survey was based on a national mail survey called Pregnancy Risk Assessment Monitoring System (PRAMS) which was developed and promoted by CDC. PRAMS data have been used by various States as a basis for policy decision-making, prioritizing public health programs, and developing budgets and allocating resources. In addition, maternal and child health advocacy groups and health researchers have expressed interest in survey findings.

PRATS was designed to generate Idaho data on preconception, prenatal, and postpartum health status and care. PRATS answers were to supplement the information that is obtained from the birth certificate. Identical questions were asked in the PRATS survey to check for validity with the birth certificates. Preconception and prenatal questions included the intention of the pregnancy, contraceptive behaviors, financial status, domestic violence in the home, maternal stress factors, and onset and utilization of prenatal care. Postnatal questions included questions on labor and delivery, breastfeeding practices, and baby health and medical care status.

Three separate mailings were sent to a sample of women in Idaho who gave birth between September 1998 and March 1999. In addition, if a response was not received after the first mailing, a reminder postcard was sent to the mothers reminding them of the importance of this survey. After the third mailing was sent, if a mother had not mailed a completed survey back, telephone calls were made by a contractor as a final attempt to obtain a response. Overall, 78% of the women who were contacted completed a survey.

Additionally, the SSDI Program Manager assisted the Title V agency in development of the MCH Block Grant, specifically in the five year needs assessment

process and in establishing data linkages with other agencies.

See **Epidemiology Program** activities (child mortality review team) above under population-based services.

### **Children**

With the implementation of the newly developed client application by Medicaid and the roll-out of the CHIP awareness campaign, the percent of CHIP eligible children who were enrolled in the program increased to 42.9%, which exceeds the performance objective for **performance measure SP11**.

The **Immunization Program** contracted with Idaho State University to conduct Clinic Assessment Software Analysis (CASA) assessments (AFIX process) of private clinics to identify immunization rates in single clinics and to identify barriers to immunization found in those clinics (**performance measure 5**).

During FY 1999, the **Adolescent Pregnancy Prevention Program** contracted with the district health departments to conduct abstinence education pregnancy prevention activities. Each district health department employed an adolescent pregnancy prevention coordinator to convene local coalitions (15) that are community based and community driven to provide direction and implementation of abstinence education programs. These 15 coalitions (membership over 300) provided abstinence education activities that addressed positive youth development, mentoring programs and self-esteem workshops. The coalitions brought together parents, educators, clergy, health workers, social workers, business, teens and others to work on community based programs to address teen pregnancy prevention. The target audience is 10 - 14 year olds and their parents/care givers. Some of the activities that the community coalitions conducted include:

- Initiation of the *Peers Encouraging Abstinence Kids (Peak)* Program
- Expanded reach of information on abstinence and healthy living to high-risk youth (alternative high schools, juvenile detention centers, etc.)
- Recruited and retained Vista Volunteers for abstinence education programs
- Maintained and promoted abstinence resource libraries in the community
- Implemented "Baby Think It Over" Programs in Family & Life Sciences class
- Provided trainings on teaching sexuality & abstinence to community educators
- Offered *Can We Talk?* Workshops through school, church, community groups
- Developed youth panels

- Implemented the “Sex Can Wait” curriculum in some schools
- Administered Assets survey
- Worked with Idaho Theater for Youth to provide venues for abstinence education

The coalition collaborated with the Idaho Governor’s Council on Adolescent Pregnancy Prevention in a number of awareness efforts including a statewide radio and television campaign. The rate of births for teenagers aged 15 through 17, is 25.1 per 1000 (**performance measure 6**).

During FY 1999, the **Reproductive Health Program** continued working with Medicaid to develop a 1115(a) waiver to expand Medicaid eligibility to all women up to 150% of the federal poverty level in order to cover more than 80% of the women currently served by the program.

The **Injury Prevention Program** facilitated injury prevention coalitions comprised of partners from law enforcement, education, health care organizations, insurance companies, private industry, and the media. Coalitions were instrumental in planning, implementing and evaluating the injury prevention related activities carried out at the local level (**performance measure 8**).

During FY 1999, the MCH **Oral Health Program** contracted with each of the seven district health departments to conduct oral health surveys as part of the ongoing evaluation of the school fluoride mouth rinse program and to collect sealant prevalence data on a representative sample of third grade students. The oral health surveys were conducted by dental hygienists, who are employed by the districts..

- < 8,763 children participated in school-based dental surveys to collect data on caries experience, treatment needs, sealant prevalence and fluorosis, including 1,184 third grade students.
- < 50.5% of the third grade children surveyed had one or more dental sealants in permanent molar teeth (**performance measure 7**).

Data from the 1997 Idaho State Smile Survey of second and sixth grade students was broken out by demographic indicator to show disparities and reported in the 1998 Idaho KIDS COUNT book, publicized at the KIDS COUNT DAY at the Capitol, and widely distributed to public health and other entities. In other needs assessment

efforts, dental data collected through the 1998 BRFSS state-added questions on dental sealants was analyzed and reported during FY 1999 and the CDC-supported optional dental module was included in the FY 1999 BRFSS.

Other infrastructure-building activities of the MCH Oral Health Program during FY 1999 included efforts to obtain unspent welfare reform money (TANF) and Idaho tobacco settlement dollars to fund a statewide comprehensive preventive dental health program. The funding proposals, developed in collaboration with the District Health Departments and the Coalition for a Healthy Idaho, would have increased local dental public health staffing and funded evidence-based dental public health efforts, such as early childhood caries prevention projects, kindergarten screening, fluoride varnish and sealant projects, and public information media campaigns.

On-going efforts included maintenance of the school database for tracking program eligibility and participation; quarterly monitoring of dental provider participation in the Medicaid Program; updating of the state population profile of water supplies with adequate fluoride levels; and providing information on dental health professional shortage area (HPSA) designation in support of efforts to establish community dental clinics in southeast Idaho. The Oral Health Program Manager continued to serve on the advisory committees for the Terry Reilly Health Services Nampa and Boise dental clinics.

During FY 1999, the Idaho Oral Health Alliance formed in 1998 continued to meet. A priority issue identified during the previous year, i.e., increased Medicaid dental reimbursement, became effective July 1, 1999 as the result of a legislative appropriation. For FY 1999, a priority effort was development of a statewide dental sealant project, modeled after the North Carolina *Seal the State in 1998* Project. The Idaho State Dental Association Board of Trustees adopted the project for National Children's Dental Health Month 2000. Oral Health America committed to provide free sealant material for the project. The purpose of the *Seal Idaho 2000* project is to provide free dental sealants to every second grade child, particularly those who cannot afford regular preventive dental care. The MCH Oral Health Program Manager is Co-Chair of the *Seal Idaho 2000* state planning committee, which includes representatives from the Idaho State Dental Association, the Idaho Dental Hygienists' Association and

Delta Dental Plan of Idaho, Inc. Idaho's Governor and First Lady are Honorary Chairs. The MCH Oral Health Program contracted with the district health departments to facilitate and coordinate local planning for the project.

Finally, the MCH Oral Health Program participated in the ASTDD self assessment program review during FY 1999 and received technical assistance from Dr. Phillip Swango as part of a collaborative agreement between ASTDD and CDC.

See **Epidemiology Program** activities above.

### ***Children with Special Health Care Needs***

In FY 1999, 87% of children enrolled in **CSHP** had a source of insurance to pay for primary and specialty care (**performance measure 11**). A Parental Advisory Committee made up of one family representative from each of Idaho's seven health districts was organized and will meet in person and through telephone conference call throughout FY 2000 (**performance measure 14**).

## **2.5 Progress on Outcome Measures**

Please refer to form 12.

Progress on performance measures (both National and State) is to collectively contribute to positively impacting the National outcome measures. The following discussion on progress on outcome measures is based upon 1999 data, which became available in the fall of 2000. The continuation of current strategies over the next five years is expected to have a favorable result in achieving the goals defined by these outcome measures.

A key indicator of the quality and quantity of perinatal care services is the infant mortality rate (deaths of infants under one year of age) and an even more sensitive indicator is the neonatal mortality rate (deaths of infants within the first 27 days of life). Following 1995's record lows for the number and rate of infant deaths, the number of Idaho resident infant deaths rose almost 25% in 1996 (from 110 in 1995 to 137 in 1996), dropped again in 1997 to 127 deaths, increased to 140 deaths in 1998, and dropped once again in 1999 to 134 deaths. The infant mortality rate (number per 1,000 live births) also increased in 1998, from 6.9 to 7.2, however it decreased to 6.7 in 1999

(**outcome measure 1**). Considering the small size of the data base, some fluctuation from year to year is not unusual.

The Black infant mortality rate increased from 0.0 per 1,000 live births in 1997 to 24.7 per 1,000 live births in 1998(**outcome measure 2**), and further increased in 1999 to 40.0 per 1,000 live births. However, these rates are based upon very small numbers (1997 = 0/65; 1998 = 2/81; 1999 = 3/75) and should be considered over a 3 year period. The three-year rate for 1997 - 1999 was 22.6 deaths per 1,000 live births. Future submissions will include a presentation of Hispanic infant mortality data, along with a brief analysis of trends. A total of 7.4% of the population was of Hispanic origin in 1999, and less than 1% of Idahoans were of Black race. It makes sense to compare the Hispanic mortality rate to the non-Hispanic mortality rate in order to identify disparities in health outcomes in the Hispanic population.

Neonatal and post-neonatal rates also produce yearly changes in Idaho; generally, decreases in one are coupled with increases in the other. The neonatal mortality rate increased from 4.3 in 1997 to 4.6 in 1998, and remained at 4.6 in 1999. The post-neonatal mortality rate remained the same at 2.6 in 1997 and 1998, but dropped to 2.1 in 1999 (**outcome measures 3 and 4**). The perinatal mortality rate (number of deaths of infants within the first six days of life plus number of stillbirths per 1,000 live births) for 1999 decreased to 9.7 from 9.8 in 1998. However 1998's rate represented an increase from 9.4 per 1,000 recorded in 1997 (**outcome measure 5**).

The manner of coding the underlying cause of death changed dramatically in 1999 from using the ninth version of the International Classification of Diseases, ICD-9 codes, (used from 1979 - 1998) to using the tenth version, ICD-10 codes. This change resulted in new titles for causes, the inclusion of terms and titles from one category to another, regroupings of diseases, and modifications in the coding rules. For example, the title for infant deaths due to "congenital anomalies" used with ICD-9 codes changed to "congenital malformations, deformations and chromosomal abnormalities" with ICD-10 codes. Discontinuity between ICD-9 codes and ICD-10 codes is measured using a "comparability ratio". As of October 26, 2000, the National Center for Health Statistics (NCHS) has provided to the State Vital Statistics offices only preliminary comparability

ratios for selected causes of deaths. As of the end of October, NCHS has not provided preliminary ratios for causes of infant deaths. The number of deaths by cause will be provided, however, these data are not comparable to prior years. Infant mortality rates for 1999 will not be shown.

The leading single cause of Idaho infant deaths in 1999 was congenital malformations, deformations and chromosomal abnormalities (32 deaths). Sudden Infant Death Syndrome (SIDS) was the second-leading single cause of infant deaths with 21 deaths. More deaths occurred in the general category, "certain conditions originating in the perinatal period," (62 deaths); this category is sub-grouped to include such conditions as low birth weight (23 deaths) and infections specific to the perinatal period (5 deaths). In 1998, there were 20 SIDS deaths for a rate of 103.4 per 100,000 live births. The 1998 rate was approximately 44% higher than the 1998 U.S. rate of 71.6, but represents a 23% decrease in the 1996 Idaho rate (134.7). Despite recent fluctuations in Idaho, Sudden Infant Death Syndrome is on the decline from levels reported in the 1980s, both nationally and at the state level. **Note: The number of deaths by cause for 1999 are not comparable with prior years because of the transition from ICD-9 codes to ICD-10 codes. Comparability ratios were not available at press time.**

The leading single cause of neonatal mortality was congenital malformations, deformations and chromosomal abnormalities (25 deaths). For infants aged 28 days through 11 months, SIDS was the leading cause at 20 deaths and accounted for 48% of all post-neonatal deaths. Congenital malformations, deformations and chromosomal abnormalities were the second-leading cause of post-neonatal mortality at 7 deaths. **Note: The number of deaths by cause for 1999 are not comparable with prior years because of the transition from ICD-9 codes to ICD-10 codes. Comparability ratios were not available at press time.**

Idaho's child death rate fluctuates from year to year (**outcome measure 6**). The 1997-99 average death rate for children was 32.8 deaths per 100,000 children aged 1-14. This is an increase from the three-year average death rate for children in 1994-1996 (31.8 deaths per 100,000 children aged 1-14), and down from the average rate of

34.7 in 1991-93. Accidents were the primary cause of childhood deaths for children aged 1-14 in 1999, accounting for 52% of Idaho's childhood deaths. While motor vehicle accidents predominate among the unintentional injuries suffered by children, deaths from fires, burns, drowning, and suffocation are particularly common among very young children, aged 1-4.

Idaho's 1999 suicide rate of 13.4 per 100,000 represents a 21% decrease from 1998, when the rate was 17.0 per 100,000. There were 19 deaths in 1998, compared with 15 deaths in 1999 for children aged 15-19. The objective for **performance measure 16** was met for both years. The suicide rate for 1999 is comparable to the suicide rate in 1998. The preliminary comparability ratio from ICD-9 codes to ICD-10 codes for suicide is 1.00.

In May 1997, members of the Department of Health and Welfare began developing a child mortality review team. This working group, consisting of the State Epidemiologist, representatives of the Bureaus of Vital Records and Health Statistics, and Emergency Medical Services, and the Division of Family and Children's Services, developed a protocol to address practical concerns towards forming a working group to look at child deaths. A target population was defined, the focus and purpose of the review process was determined, records needed for review were identified, confidentiality procedures reviewed, protocols established, and the make-up of a long-term team was determined. These recommendations were approved for implementation. Quarterly review of cases began in December of 1998. The efforts of this team are to identify potentially preventable deaths by identifying risk factors, and collect and organize this information into meaningful summaries of causes of child death in Idaho. As a result, specific health promotion interventions and system improvements can be implemented to positively impact the child and infant mortality outcome measures. Title V funds and programs will play an integral part in carrying out these interventions as well as tracking the data. An additional incentive for MCH support in this endeavor, will be more complete investigation of those deaths currently categorized as SIDS deaths. The diagnosis of SIDS is an exclusionary diagnosis that is made after an autopsy, a death scene investigation, and a complete medical history. It is unclear if all deaths currently attributed to SIDS have met this criteria. This review

process should allow us a greater ability to accurately track such deaths.

Efforts to boost Idaho's immunization rates for children through age two, have resulted in an upward trend. As this rate increases, disease morbidity and related child mortality associated with vaccine preventable diseases will decrease. Disease investigation and control activities provided by strengthening disease investigation and control activities provided by strengthening our epidemiology infrastructure will have a similar impact on reducing child morbidity and mortality.

Family planning services provided by the Reproductive Health Program and reduction of teen pregnancies targeted through the abstinence only education grant are expected to impact low birth weight and thereby reduce perinatal, infant, neonatal, and post-neonatal mortality.

### **III. REQUIREMENTS FOR THE APPLICATION [Section 505]**

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

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

To effectively conduct the Five-year Maternal and Child Health Needs Assessment, documentation from the 1995 Assessment was reviewed. Areas of concern as noted in the Block Grant Review conducted in 1995 were noted so that they could be addressed during this needs assessment. The tools used to complete this needs assessment were:

1. A Public Perception Survey
2. Data Collection and Review
3. Prioritization Meetings

The planning for this process began in June of 1999, with a meeting attended by the Division Administrator, Title V MCH Block Grant Director, Bureau Chief for the Center of Vital Statistics and Health Policy, the Health Policy Supervisor, and State Systems Development Initiative Program Manager. This meeting established some basic objectives/strategies for the needs assessment process. First, the Office of Public Participation (OPP) was chosen to facilitate the public participation and the subsequent

planning meetings. OPP is administratively located in the Health and Welfare Director's office (Figure 6A). Second, the needs assessment process would be determined by a committee made up of representatives from each of the seven Health Districts in Idaho. Third, the time line for this process was pre-determined due to the grant requirements. Subsequently the Office of Public Participation was contacted to request their assistance with the project, and to assist with pre-planning activities. Several different methodologies for conducting needs assessments were reviewed including the assessment activities conducted by our neighboring states of Washington and Oregon, and a number of publications on the process including that of the Family Health Outcomes Project of the University of California at San Francisco (*Oliva, Geraldine MD, MPH et. al., "Developing an Effective Planning Process: A Guide for Local MCH Programs", August 1998* and *Peoples-Sheps MD, "Planning and Monitoring Maternal and Child Health Programs" Chapter 15 in Kotch J (ed). Maternal and Child Health: Programs, Problems and Policy in Public Health. Gaithersburg, MD: Aspen Publishers, 1997. pp. 423-460*). The review identified a number of components which are important to maintain the validity of the needs assessment. These components are: data collection/compilation and analysis, community perception assessment, integration of "public comments" with data, collaboration with a larger committee to determine needs, and ongoing monitoring and analysis.

#### Collaboration Process:

The Maternal and Child Health Public Participation Process (MCHPPP) Oversight Committee was formed to include key players around the state in the planning process. Participants included representatives of all 7 district health departments, Divisions of Medicaid, Welfare, Family and Children Services, and Health. It was facilitated by the Department of Health and Welfare's Office of Public Participation. The committee met early in September 1999, to plan for the needs assessment process. Discussion was centered around the three main issues, development of a public survey, data collection and review, and future planning for prioritization meetings. This resulted in the formation of two subcommittees: one to deal with public perception issues, and one to address data needs.

#### Summary of Survey Process

Because past attempts to gain public input via community meetings have had limited success, the Oversight Committee decided to utilize surveys to obtain public perception. The survey subcommittee developed and sent the survey to the Health Districts and Regional Health and Welfare Offices for distribution to the public. Each Office received 500 surveys in English (color-coded to the District/Region) and 50 surveys in Spanish. Extra Spanish surveys were made available upon request. Additionally, IDHW Program Managers were asked to identify names and addresses of individuals they felt should be included as stakeholders. These individuals represented many different organizations and programs. Each was mailed a survey. 8,500 surveys were printed but not all were distributed. 735 surveys were returned. Among the organizations and individuals identified on the returned surveys were:

- |   |                                       |
|---|---------------------------------------|
| District Health Departments             | State Adult/Child Development Centers |
| Private Provider Medical Clinics        | County Government                     |
| State Developmental Disabilities Center | State Family and Community Services   |
| Head Start                              | State Self-Reliance                   |
| State Child Protection                  | Community Health Center               |
| Elementary Schools                      | Housewife                             |
| Immunize by Two Coalition               | Idaho Parents Unlimited, Inc.         |
| Idaho State University                  | Idaho Perinatal Project               |
| ISU Institute of Rural Health Studies   | LDS Church                            |
| League of Women Voters                  | Children Center                       |
| Mayor, City of Preston                  | Mother                                |
| Rape Response & Crime Victim Center     | HIV Planning and Prevention           |
| SAFE KIDS                               | School Districts                      |
| Hospitals                               | State Mental Health                   |
| Teacher                                 | Lactation Consultants                 |
| United Methodist Women                  | State Vocational Rehabilitation       |
| WIC                                     | Youth Services                        |

Maternal and Child Health Survey Process

Survey Development

A subcommittee was formed to develop a survey which would be sent to individuals in the community soliciting input on their perceptions surrounding selected maternal and child health issues. Committee members were:

<u>Member Name</u>	<u>Representing</u>
Roger Perotto	Title V Director

<u>Member Name</u>	<u>Representing</u>
Christina Giso	SSDI Coordinator
Jim Jackson	Office of Public Participation
Norma Sampson	Office of Public Participation
Dianne Waldemarson	Public Health District 2

Development:

Originally, the survey was developed in a manner such that respondents were requested to write down areas of concern. The reasoning behind this was so that results would not equal the current issues being addressed with MCH Block Grant funds. Furthermore, a separate section for each population sub-grouping (pregnant women, infants, children and adolescents, and children with special health care needs) allowed respondents to write in solutions to the problems the writer identified. Upon further review, the survey appeared to be doomed from the start, because it was felt that a limited few would take the time necessary to complete the whole form. The survey was then rewritten and reviewed several times until the final product appeared as follows:

- NOTE: 1. Appearance not true to form.
2. Respondents were asked to rate each issue as high, medium, or low priorities. Circles appeared to the left of the issues under vertical headings of "high", "medium", and "low", that respondents could mark.

[BEGIN SURVEY]

Thanks for helping our mothers and children!

Please help us identify the major health issues affecting mothers and children in your community. Your answers and comments will provide the Idaho Department of Health and Welfare's Division of Health with valuable information for our Maternal and Child Health Needs Assessment.

Rate the following health issues. Tell us if you think they should be a high, medium or low priority in your community. Also, let us know what other health concerns you think women and children are facing in your area.

If you have access to a computer, you can complete this survey on the Idaho Department of Health and Welfare website. Click the Public Participation button at: <http://www2.state.id.us/dhw>.

Pregnant Women: [defined as] A female from the time that she conceives to 60 days after delivery.

<u>Issues</u>	<u>General Comments</u>
Access to Prenatal Care	
Health Insurance	
Alcohol, Tobacco, Drug Use during pregnancy	
Breast-feeding support	
Postpartum Depression	
Domestic Violence	
Other:	

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Infants: [defined as] Children under one year of age.

<u>Issues</u>	<u>General Comments</u>
Newborn Health Screenings	
Immunizations	
Birth Defects	
Sudden Infant Death Syndrome (SIDS)	
Access to Care	
Health Insurance	
Other:	

---

Children: [defined as] Children who are one to nine years of age.

<u>Issues</u>	<u>General Comments</u>
Immunizations	
Oral Health	
Asthma	
Child Abuse	
Health Insurance	
Mental Health	
Other:	

---

Adolescents: [defined as] Children who are 10 to 17 years of age.

Issues  
Alcohol, Drugs, Smoking  
Teenage Pregnancy  
Sexually Transmitted Diseases  
Health Insurance  
Injuries  
Mental Health  
Other:

General Comments

---

Children with Special Health Care Needs: [defined as] Children who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition, and who also require health and related services beyond that required by children generally.

Issues  
Availability of Specialty Care  
Access to Care  
Health Insurance  
Mental Health  
Respite care:  
Other:

General Comments

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Thank you for completing and returning this survey by Jan. 1.

We appreciate your input. Please refold the survey with the prepaid reply address on the outside. Seal with tape, and return before Jan. 1,2000. To receive a survey follow-up and more information about mother's and children's health issues, we'll need a mailing address.

Name \_\_\_\_\_  
Organization \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_

[END OF SURVEY]

The survey was designed to portray public opinions about the same issues, and to get a general feel for issues to be addressed when reviewing existing data. It was not designed to obtain scientific results about public attitude regarding maternal and child issues. Furthermore, it was not designed to be a customer satisfaction survey, therefore does not consider patient wait times or other sentinel measures of customer/consumer/patient satisfaction.

The survey was distributed to the Health Districts and to the Regional Health and Welfare offices. Distribution was left to the judgement of District and Regional

representatives. The surveys were on 8.5 inches by 14 inches colored paper, with a return address (to the Central Offices of Health and Welfare) and other information on the opposite side of the survey. There were 9 separate colors used, one for each Health District and the corresponding Health and Welfare Region, plus a separate color for the Spanish version. Each Health District and Regional office received 500 copies of the survey, plus 50 copies of the Spanish survey with instructions to contact the Bureau of Clinical and Preventive Services for additional copies. Additionally, each office received a display stand to put some surveys in their lobby.

Districts and Regional offices chose different strategies to distribute the surveys. Some chose to display surveys in the lobbies of the District and satellite offices, some chose to distribute the surveys when they participated in meetings with stakeholders, some chose to send surveys to educational institutions, and some mailed the surveys out to their stakeholders. It is estimated that 1,000 surveys (English and Spanish) were not distributed at all, however this is not an accurate count.

Responses were received from all districts, the quantity received was highly dependent upon the method of distribution. In total, over 700 surveys were received, providing input and comments for the needs assessment.

### Results:

One issue to be tackled before conducting surveys in the future is increase development time, and to have the instrument pre-tested to detect problems with design. A problem with this survey that was detected when they were returned to the Department was that many respondents indicated that all areas were (or should be) a high priority. While this may be true, all areas that were listed on the survey are traditionally priority Maternal and Child Health target areas, it did not greatly assist in the prioritization process. This issue could have been identified if time allowed for pre-testing the survey instrument.

The conclusions that can be drawn from the survey are basic, and can be shown in the manner of the following example: in the pregnant women category, the statement can be made that “most respondents felt that access to prenatal care was/should be a high priority area”. [543 respondents marked “high”; 120 respondents marked “medium”; and 27 respondents marked “low”.] Statewide responses are as follows:

Population Group	Interests	High	Medium	Low
Pregnant Women	Access to Prenatal Care	543	120	27
	Health Insurance	525	125	40
	Alcohol, tobacco and drug use during pregnancy	455	150	72
	Breast-feeding support	271	302	111
	Postpartum depression	236	322	126
	Domestic violence	462	157	58
	Other	69	13	3
	Infants	Newborn health screenings	498	145
Immunizations		586	76	24
Birth defects		326	249	98
Sudden Infant Death Syndrome		277	283	111
Access to care		530	124	30
Health insurance		530	119	37
Other		57	5	3
Children		Immunizations	547	118
	Oral health	403	238	46
	Asthma	220	360	97
	Child abuse	524	116	45
	Health insurance	517	133	39
	Mental health	333	265	74
	Other	61	4	2
	Adolescents	Alcohol, drugs and smoking	551	107
Teenage pregnancy		563	103	20
Adolescents	Sexually transmitted diseases	519	133	33

Population Group	Interests	High	Medium	Low
	Health insurance	453	181	51
	Injuries	227	353	94
	Mental health	400	232	53
	Violence	492	162	29
	Other	55	2	1
Children with Special Health Care Needs	Availability of specialty care	484	167	24
	Access to care	512	133	28
	Health insurance	530	105	40
	Mental health	412	209	46
	Respite care	365	238	54
	Other	59	9	3

The predominant response for each area of interest was that it was a high priority. Breast-feeding support, postpartum depression, asthma, and adolescent injuries were all rated as being of medium importance, while sudden infant death syndrome was rated fairly equally as being of high and medium importance.

The second subcommittee formed was the Data Subcommittee. Members of this subcommittee were:

Name	Position/Title	Role
Jan Edmonds	Division Director of Family Health Services, District 3	Member
Carolee Eslinger	Early Childhood Intervention Specialist	Member
Christina Giso	SSDI Program Manager	Co-Chair
Lorraine Hutton	Medical Program Specialist, Division of Medicaid	Member
Maggi Machala	Community Health Director, Health District 5	Member
Roger Perotto	Title V Director	Co-Chair
Patty Rustad	Analyst, Division of Medicaid	Member

Name	Position/Title	Role
Jennifer Smith	Senior Research Analyst, Health District 4	Member
Dianna Willis	Senior Research Analyst, Vital Records and Health Statistics	Member

The Data Subcommittee formed during the original planning meeting was charged with the following tasks:

- Create data categories utilizing the MCH Block Grant Guidelines
- Categorize existing data indicators
- Identify data by health district for consolidation into statewide compilation
- Incorporate public input from surveys
- Identify data gaps by indicator
- Determine need to fill data gaps
- Present recommendations to Oversight Committee

The majority of these tasks were completed satisfactorily, with the exception of the final task of presenting recommendations to the Oversight Committee. This was due to the time constraints of the needs assessment process. The data was compiled and then presented at the two prioritization meetings which were held in February.

Prioritization Process

Two meeting were held for the purpose of prioritizing Idaho’s maternal and child health needs. The Title V agency, BOCAPS, sponsored the meetings. The first meeting, held on February 1, 2000, convened Public Health directors and program managers from across the state. A second meeting, held on February 3, 2000, convened members of the Idaho Department of Health and Welfare Executive Leadership Team. Data were presented on both days about maternal and child health needs and a rational process for prioritizing health problems was conducted. The prioritization process was adapted from the University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, “*Assessment of Health Status Problems*” as incorporated into the San Francisco Family Health Outcomes Project (FHOP) “*Developing and Effective Planning Process: A guide for Local MCH*

*Programs.*” Consultants, trained in the FHOP process, facilitated the prioritization process.

The prioritization process is a rational and inclusive way of organizing the discussion about priorities. It is a method of ensuring that stakeholders have the opportunity to review data on health and health related problems, provide input, hear other’s perspectives and express ideas and opinions and, finally, agree on health priorities. Group decisions are made at several points in the process: the group selects the criteria that will be used to prioritize the health problems or issues; weights the criteria; reviews, amends and adopts the list of health problems; and then using the weighted criteria, individuals rank the health problems. The individual scores for each problem are summed to provide an overall score. These scores are ranked and, based on the numerical ranking, the problems are ranked from highest to lowest priority.

Prior to the prioritization meetings, the Division of Health had conducted a Maternal and Child Health needs assessment survey “Caring for Idaho’s Maternal and Child Health,” reviewed secondary maternal child health data and compiled Maternal and Children’s Health Needs Assessment Fact Sheet Summaries and prepared slide presentations. The data were divided into population-specific categories: pregnant women, mothers and infants; children (including adolescents); and children with special health care needs. When available, Idaho data were compared to United States data, Health People 2010 goals and objectives, and Title V National “core” Performance Measures. Also, when available, Idaho population data were compared for Medicaid and total population and race/ethnic groups and total population. Results of the needs assessment survey were included as a major component of the data descriptions for each health issue.

At each meeting, an overview of the prioritization process was presented; criteria presented, discussed and modified; weighting of criteria discussed and weights assigned; data presented and discussed; and the ranking of health problems was completed.

Data Sources Used:

Center for Vital Statistics and Health Policy: Birth and Death Certificate data, Behavioral Risk Factor Surveillance System Survey (BRFSS) data,

Youth Risk Behavior Survey (YRBS) data, preliminary data from the Pregnancy Risk Assessment Tracking System (PRATS) Survey, and demographic data.

Programmatic Data: WIC, CSHP, Oral Health, Immunizations, Reproductive Health, Epidemiology, STD/AIDS, Rural Health Program, and Primary Care Program.

Other Departmental/Divisional Sources: Department of Transportation, Department of Education, Division of Medicaid, Division of FACS, Division of Welfare.

Other Sources, Non-State: Kids Count (note: Kids Count information primarily based on data from IDHW), Rocky Mountain Poison Center, Ross Mother's Survey on Breastfeeding, Idaho Newborn Hearing Screening Consortium, and the 1999 Health Care State Rankings by Morgan Quitno.

National Data Sources: NIS, NCHS, and other CDC related Web sites, March of Dimes Perinatal Profiles report, and Census Bureau Estimates.

As with the usage of all data, there are certain limitations dependent on the source. Data from vital records are commonly used and the limitations inherent in such data is well known. The two surveys used in the needs assessment have limitations also. First, the Youth Risk Behavior Survey data has not been collected in Idaho since 1995. Furthermore, the 1995 data was not weighted to reflect the statewide population. The second survey, the Pregnancy Risk Assessment Tracking System (PRATS), is based upon the Center's for Disease Control and Prevention national survey, Pregnancy Risk Assessment Monitoring System (PRAMS). This data was received late in November of 1999, and is currently being analyzed by the Center for Vital Statistics. Results used for the Needs Assessment were preliminary, however final results should be available in the Spring of 2000. In 1996, a prior version of PRATS was conducted,

using only telephone interviewing. Questions are not comparable between the two surveys, as the 1999 PRATS is more extensive than the 1996 version.

Programmatic data is limited because it represents only those individuals served, and not the entire population. Arguments can be made at the program level, that the individuals served are those in most need of the services offered and represent an otherwise under-served part of the whole population. Additionally, any self-reported programmatic data is limited by the truthfulness of the client's disclosure. Other departmental/divisional data sources rely on programmatic data and are subject to the same limitations.

#### Data Indicators Used:

To obtain a full picture of the health status of Idaho's Maternal and Child Population, several sources were used to identify appropriate measures to determine health status. The current measures included in the Title V MCH Block Grant (Performance Measures and Outcome Measures) along with the newly designated Health Status Indicators, were selected as appropriate measures for the purposes of data collection. Additionally, Healthy People 2010 Proposed Objectives and measures presented in a Health Systems Research, Inc. report (*Selecting Needs Indicators and Performance Measures for State Title V Programs: A Resource Guide for Idaho Officials*, authored by Dr. Greg Alexander) were examined for inclusion in the process. After discussion with the Data Subcommittee, the indicators were grouped to describe the MCH population subgroups of (a) pregnant women, mothers and infants, (b) children (including adolescents), and (c) children with special health care needs.

The Data Subcommittee reviewed all of the indicators by population grouping and eliminated duplicate and non-relevant indicators. The rest of the indicators were grouped according to topic, ex. breast-feeding, infant mortality, adolescent pregnancy, etc. At this point, data was collected for as many of the indicators as available in order to obtain as complete a picture of the health status of the MCH population as possible.

#### Intervention Evaluation

After an analysis of the data and ranking of health problems was completed, the priority needs which resulted from the process were identified. The Division of Health, in collaboration with the district health departments and the Executive Leadership

Team of Health and Welfare, inventoried existing services which address the priority needs. Since some of the priority needs identified in this current needs assessment process have also been priorities in previous years, some program activities and strategies are currently in place to impact them. These programs were evaluated for adequacy of funding and appropriateness of service. Performance measures were developed for newly identified priority needs based upon the Title V agencies' involvement in program strategy, i.e., outcome objectives for areas with direct activities versus operational objectives for areas with indirect involvement. Resources were allocated to meet the performance measures.

#### Strengths and Weaknesses:

##### Weaknesses:

- Difficulty in categorizing data by population group. Age ranges for data was not always consistent.
- Grouping some issues together (i.e. high-risk teen behavior, abuse (physical), substance abuse across population groups) created some confusion.
- Data limitations (see above)
- Time constraints prohibited a full review of the data with the FHOP representatives prior to the prioritization meetings
- The meeting size on Feb. 1 was too large to effectively facilitate a participatory process designed to gain individual input. A few vocal individuals dominated the meeting.

##### Strengths:

- Involvement of the “public” via the public perception survey.
- Full departmental involvement in the prioritization process and the commitment to work on the health priorities identified.
- Multiple representation from the district health departments and MCH program staff.
- Collaboration with and facilitation by FHOP representatives.

## 3.1.2 Needs Assessment Content

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

#### *Health Status of Maternal and Child Population:*

The priority health needs affecting the maternal and child population are a compilation of the results from the MCH Survey and the prioritization meetings held February 2000. The MCH Survey presents public input to an otherwise departmentalized process.

Priority health needs for infants, children and adolescents may be similar due to data indicators overlapping and applying to the under 19 age group. Efforts were made to separate information by population sub-group to facilitate review of the health issues impacting a particular segment of the population.

#### *Pregnant Women:*

The health needs of pregnant women are: **Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care**. Pre-conceptual planning was also identified as an issue, however, it was at the bottom of the ranking.

Indicators were focused around the following topics: Breast-feeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

#### Breast-feeding:

- Idaho has exceeded the national proportions for breast-feeding at the time of hospital discharge and at six months consistently over the last five years.
- Idaho has also exceeded the Healthy People (proposed 2010) goal of 75% of mothers breast-feeding their infants at hospital discharge over the last five years.
- Idaho is close to meeting the Healthy People (proposed 2010) goal of 50% of mothers breast-feeding their infants at six months.

#### Delivery:

- The percent of live births delivered by Cesarean section in Idaho is lower than the U.S. percentage. Slightly increasing over the past five years.

#### Prenatal Care:

- Five year trend appears to be flat; not getting worse, however, Idaho is not demonstrating improvements.

- Significant gaps in prenatal care exist between all populations in Idaho and the Idaho Medicaid population. Additionally, significant gaps in prenatal care exist across health districts and counties by age, race, ethnicity and source of payment.
- Idaho does not provide direct health services to pregnant women. The Pregnancy Education Evaluation Referral (PEER) program was discontinued in 1995.
- In 1995, Idaho ranked 39th in the nation for percent receiving first trimester prenatal care, according to the March of Dimes “Perinatal Profiles” report.

#### Maternal Mortality:

- Idaho’s maternal mortality rate is higher than the Healthy People (proposed 2010) goal of 3.3 per 100,000 live births.
- Further investigation of this issue is warranted, as the actual numbers over the last 5 years are small. (1994, 1995, 1997 and 1998 – 2 deaths per year; 1996 – 1 death)

#### Tobacco and Alcohol Use:

- Birth certificate data shows that Idaho is much higher than the Healthy People (proposed 2010) goal of a prevalence of no more than 2% for women smoking during pregnancy.
- The Medicaid population, compared to all populations in Idaho, had a higher percentage of women indicating that they smoked during pregnancy as reported on the birth certificate. Native Americans and teen mothers also have a higher prevalence of tobacco use during pregnancy.
- 14.1% of women indicated that they smoked during pregnancy in 1994 versus 13.1% in 1998, as reported on the birth certificate. For the Medicaid population, 24.8% in 1994 indicated they smoked, compared to 27.8% in 1998.
- Alcohol consumption information from the birth certificate has been shown to be unreliable.
- Data from the Pregnancy Risk Assessment Tracking System (PRATS) survey will be available in the near future; note that it is self-reported data.

#### Maternal Morbidity:

- Anemia in low-income pregnant women (generally speaking Supplemental Nutrition Program for Women, Infants and Children (WIC) participants) is lower than the Healthy People (proposed 2010) goal of 23%.
- Maternal morbidity data is limited, can look at data from birth certificate.
- Potential to use data from Medicaid paid claim files.
- Data gap for Idaho.

#### Access to Care/Health Insurance:

- According to estimates from the Behavioral Risk Factor Surveillance System, 84% of Idaho adults had health insurance in 1998.
- The March of Dimes report – “Perinatal Profiles” – indicates that in Idaho 22.9% of women (ages 15-44) did not have health insurance (1996 data), compared to 18% of women in the U.S.
- Eligibility for Medicaid is 133% of the federal poverty level.
- The percent of live births occurring in Idaho using Medicaid for the primary source of payment for delivery dropped from 31.4% in 1996 to 27.4% in 1998.

At the same time, the percent for self-pay increased from 12.6% in 1996 to 14% in 1998.

#### Miscellaneous:

- Approximately 60% of pregnancies seen in Reproductive Health Clinics between 1996 and 1998 were unintended. (1998 – It is estimated that less than 20% of all pregnancies were served in a Reproductive Health clinic in Idaho.)
- The percent of women with a repeat live birth occurring within 18 months of a previous live birth has slightly declined over the past five years.
- The percent of births to not married adult (20+) mothers in Idaho is lower than the U.S. percentage consistently over the past five years, however, the percentages for both Idaho and the U.S. have been increasing over the past five years.

#### Infants:

The health needs of infants are: **Child Abuse, Immunizations, Access to Care and Disparities in Infant Mortality.** Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic, show that Idaho is doing a good job of screening infants.

Indicators were focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity

#### Newborn Screenings:

- 98% of infants are receiving screening tests for PKU, Hypothyroidism, galactosemia, and hemoglobinopathies. Idaho does not screen for sickle cell disease, testing is available upon request. Of the 19,504 infants screened in 1999, 166 tests resulted in “presumptive positive screens”. Of these, a total of 7 cases were positively identified - all were treated or referred for treatment.
- Hearing screening – there is no law in Idaho that requires newborns to be screened for hearing loss.
- 14 of 37 labor and delivery hospitals are currently providing the hearing screening services. Newborn hearing screening in Idaho began in 1997.
- In 1997, assuming that all 14 hospitals were able to provide newborn hearing screening services for the full year to all infants born in their facilities, 14,009 of 17,952 infants, or 78%, would have received screening services. Actual screenings in 1997 – 8,227 or 46% of newborns. Difference is due to program start dates over the past several years.

#### Mortality:

- Idaho’s infant mortality rate is close to the U.S. rate, with both being equal in 1998 (based on preliminary U.S. final rates). In 1998, there were 7.2 infants deaths per 1,000 live births.
- Infant mortality rates are higher for the Medicaid population compared to total Idaho populations. Additionally, while the overall rate for all populations has

- declined, the infant mortality rate for the Medicaid population
- The infant mortality rate due to congenital anomalies in Idaho is higher than the U.S. rate, and has been increasing over the last 5 years. It is also higher than the Healthy People (proposed 2010) goal of 1.2 per 1,000 live births.
- Although the Sudden Infant Death Syndrome mortality rate has been steadily declining over the last five years, Idaho's rate is higher than the U.S. rate and the Healthy People (proposed 2010) goal of 0.3 per 1,000 live births. (The 1998 rate was over three times higher than the Healthy People goal of .3/1,000 live births.)
- In 1995, Idaho ranked 8th in the nation for infant mortality rate, according to the March of Dimes "Perinatal Profiles" report.

#### Birth Weight:

- Idaho has a lower rate of pre-term births than the U.S., however both rates have been increasing over the past five years.
- Idaho has a lower percent of low birth weight live births than the U.S. percentage; both have been increasing slightly over the last five years.
- Multiple births account for approximately 2% of all live births, and the trend for multiple births is not increasing in Idaho, therefore does not adequately explain the increase in low birth weight live births.
- In 1995, Idaho ranked 10th in the nation for low birth weight percent, according to the March of Dimes "Perinatal Profiles" report.

#### Access to Care/Health Insurance:

- The Pregnancy Risk Assessment Tracking System will provide additional data about access and utilization of well-baby care and immunizations.
- 71% of the Medicaid and CHIP 0 – 1 year old population has received an initial or periodic health screen.
- Each of the 7 Health Districts offers a craniofacial clinic during the year where infants with cleft lip or cleft palate can seek treatment. These clinics may occur semi-annually, or quarterly, depending upon the location of the clinic.

#### Morbidity:

- Morbidity data on infants in Idaho is scarce.
- Example – rate of neural tube defects is based upon small numbers and more likely to show wide fluctuations in the rate from year to year. This information is obtained from the birth certificate.
- Medicaid paid claim files could provide a source of information, as well as hospital discharge data.

#### Children:

The health needs of children are: **Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease.**

Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available.

Indicators were focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

#### Immunizations:

- Idaho has made improvements in the percentage of children through age 2 immunized over the past five years, but is below the Healthy People (proposed 2010) goal of 90%.
- In 1998 74.6% of children through age 2 had completed immunizations – this represents a 16.6% increase since 1994.
- Immunization rates for children entering kindergarten are high, mainly due to schools requiring children to be immunized before entry. The goal is to have all children immunized by school entry – in 1998 96% were immunized.
- The rate of children with pertussis is high and has been identified as an area of concern. The Centers for Disease Control and Prevention targeted Idaho as one of four states to participate in a vaccine efficacy study which is currently being conducted.
- The rate for hepatitis A has been approximately 20/100,000 (2 times the national average) and has prompted the CDC to recommend children living in Idaho should receive routine vaccination.

#### Oral Health:

- The proportion of children experiencing tooth decay has been steadily declining since 1984.
- The proportion of children with untreated tooth decay has remained relatively stable based on 1993 and 1997 oral health surveys. According to Kids Count information, “The percentage of Idaho children with untreated tooth decay (26.7%) was lower than the national average of 31%, but above the national objective of no more than 20%” (1997 Kids Count book.)

#### Mortality:

- For children age 14 and under, the death rate due to unintentional injuries has been declining over the past 5 years.
- For children age 15 – 19, the 1998 death rate due to unintentional injuries increased over the 1994 rate.
- The three leading causes of unintentional injury deaths are:
  - Motor vehicle accidents
  - Drownings
  - Accidents caused by firearm missiles
- Youths aged 15 – 19 are at the greatest risk for unintentional injuries.
- The suicide death rate among youths aged 15 – 19 years old has been increasing since 1994, and is higher than the U.S. rate.

#### Access to Care/Health Insurance:

- Information from the March of Dimes “Perinatal Profiles” report indicates that in Idaho, for 1996, 13.2% of children had no insurance, compared to 15% of children in the U.S.
- For children insured by Medicaid, 72.8% of potentially Medicaid eligible children have received a service paid by the Medicaid program in 1998, an increase from 70.4% in 1997.

- In 1997, Idaho had 23 pediatricians per 100,000 population age 17 years and younger. The national rate was 77 pediatricians per 100,000 populations. (Idaho ranked number 50.)

### Morbidity:

- Blood lead levels are negligible for most of Idaho, with the exception of the Bunker Hill Superfund site in Health District 1.
- Medicaid is a potential source of morbidity information using paid claim data.
- Prevalence information regarding specific medical conditions may be available in the future as a national telephone survey will be conducted by the Maternal and Child Health Bureau. See the Children with Special Health Care Needs section.
- Growth retardation among low-income children aged 5 and younger increased from 8.1% in 1994 to 8.8% in 1998.

### Abuse/Injury:

- According to Kids Count Information, “the rate of substantiated abuse or neglect (valid plus indicated cases) per capita child was essentially unchanged from the previous year.
- The 1998 child abuse rate for children under the age of 18 is 7.8 per 1,000 children. 3. A total of 2,742 cases were substantiated.
- Reporting variability between the states makes it difficult to make comparisons between states.
- In 1998, the rate of rapes per 1,000 persons over 12 years of age is .36
- In 1997, 78.6% victims of a forcible sex offence were under age 18 years of age, according to the report “Crime In Idaho”. Most of the rapes were committed by an acquaintance/friend. All victims in 1997 were females.
- The rate of nonfatal injuries due to motor vehicle crashes per 100,000 children under age 19 has declined over the last 5 years.  
The rate for children aged 12 months to 9 years of age has declined by 25.7%  
The rate for children aged 10 to 14 years has declined by 24.1%  
The rate for children aged 15 – 19 years has declined by 28.4%  
Note: Children aged 15 – 19 years old have the highest risk of being injured in a motor vehicle crash.
- The percent of child safety restraint and seat belt use in motor vehicle crashes has steadily increased over the past five years.

### Diet and Exercise:

- In the past several years, it has become apparent that obesity in the nation’s youth is a health concern.
- Idaho does not have any obesity data for children. Some sources for data could be the Youth Risk Behavior Survey.
- Overweight people are at a greater risk for diabetes mellitus, high blood pressure, stroke, coronary heart disease, gallbladder disease, and some types of cancer.

### Health Screenings:

- Hearing and vision screenings are a matter of individual school district policies and vary greatly between localities. There is no central data repository to collect this information.
- Sports physicals are required in every district for every student who participates in competitive sports.
- There are no state laws requiring blood lead screening.

## **Adolescents:**

The health needs of adolescents are: **Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy.**

Indicators were focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence the school dropout rate, and the juvenile arrest rate for violent crimes.

### Teen Pregnancy:

- From 1994 to 1998 the teen pregnancy rate for 15 – 19 years olds declined from 57.2 per 1,000 females to 51.8 per 1,000 females.
- 1998 teen pregnancy outcomes:
  - 13.5% of pregnancies ended in induced abortion
  - 0.4% ended in a stillbirth
  - 86.1% resulted in a live birth
  - 7.4% were low birth weight live births
  - 40.6% of teen mothers received less than adequate prenatal care (APNCU Index)
- The majority of live births in Idaho to teens had Medicaid listed as a method of payment for delivery from 1996 – 1998, as reported on the birth certificate.

### Alcohol, Tobacco and Drug Use:

- Data for this section could be provided by the Youth Risk Behavior Survey, which is not currently being conducted in Idaho.
- Department of Education provided School Incidents Reports which include information for school years '95/'96, '96/'97, '97/'98 and '98/'99.
- The 1998 rate for alcohol incidents per 1,000 children enrolled in school was 2.2. The trend over the past four school years is not consistent.
- The 1998 rate for tobacco incidents per 1,000 children enrolled in school was 7.3. Again, the trend over the past four school years is not consistent.
- The 1998 rate for drug incidents per 1,000 children enrolled in school was 2.7. Again, the trend over the past four school years is not consistent.
- According to the State Tobacco Control 1999 Highlights published by the Centers for Disease Control and Prevention, 24,394 Idaho youth are projected to die prematurely from their smoking.

### Diet and Exercise:

- In the past several years, it has become apparent that obesity in the nation's youth is a health concern.
- Idaho does not have any obesity data for children. Some sources for data could be the Youth Risk Behavior Survey.
- Overweight people are at a greater risk for diabetes mellitus, high blood

pressure, stroke, coronary heart disease, gallbladder disease, and some types of cancer.

#### Health Screenings:

- Hearing and vision screenings are a matter of individual school district policies and vary greatly between localities. There is no central data repository to collect this information.
- Sports physicals are required in every district for every student who participates in competitive sports.
- There are no state laws requiring blood lead screening.

#### Sexual Behavior and Sexually Transmitted Diseases:

- The Youth Risk Behavioral Survey would be a source of data for sexual behavior among adolescents.
- The incidence rate of Sexually Transmitted Diseases (STD) identified in adolescents has increased since 1996.
- The annual number of HIV positive individuals identified aged 15 – 17 has been negligible since 1994.
- In Idaho, the 1998 chlamydia rate increased to 13.0 per 1,000 women aged 15 – 19 years old from the 1997 rate of 10.8. In 1998 there were 842 cases of chlamydia identified in 15 – 19 year old women.

#### Miscellaneous:

- For the 1998/1999 school year the incidents of weapons on school grounds were highest among the 7th and 8th grade population. The incidents then steadily decline in the 9th through 12th grades.
- The school dropout rate declined 16.4% from school year '95/'96 to '97/'98.
- In 1997, the juvenile arrest rate for violent crimes was 2.2 per 1,000 youths, a decline from the 1993 rate of 3.0, according to the 1998 Kids Count report.

#### *Children with Special Health Care Needs:*

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. **Access to Care**, however, is the highest priority need for this population. The other two issues considered are availability of **specialty care and inadequate data**.

Indicators were focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

#### Overview:

The information that exists on Children with Special Health Care Needs

(CSHCN) in Idaho is based on the Children's Special Health Program (CSHP), which serves approximately 2,000 Idaho children. These children often have the most severe medical diagnoses, and fall into the following diagnostic categories:

- Cardiac
- Craniofacial
- Neurologic
- Phenylketonuria (PKU)
- Plastic/Burn
- Cleft Lip/Palate
- Cystic Fibrosis
- Orthopedic

Children with the following conditions are not eligible for state services:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) – CSHP provides for diagnosis of disorder, but not any treatment.
- Blindness or Visual Impairment
- Deaf/Hard of Hearing
- Juvenile Diabetes
- Major Dental

Hospital discharge data would be a source of information about the prevalence and severity of these conditions. Idaho state law does not mandate the collection/submission of hospital discharge data, therefore obtaining morbidity/mortality data from hospitals for any segment of the MCH population is difficult at best.

#### Access to Care:

For the 2,000 (approx.) children CSHP serves, the program covers the following services:

- Medical and surgical subspecialty services
- OT and PT
- Speech, hearing and language services (under the appropriate diagnostic category)
- Respiratory services
- Durable medical equipment and supplies
- Nutrition services
- Care coordination and
- Early intervention services

The program does not pay for home health care.

Idaho CSHCN have access in all 7 Health Districts to specialty clinics. The

clinics are held 2 – 4 times during the year. To approximate the number of CSHCN in the state, an estimate of 18% is applied to the number of children in the state under age 18. (This is based upon research funded by the federal Maternal and Child Health Bureau.) Using said estimates, Idaho would have over 63,000 (approximate 1998 figures) children who would qualify under the federal definition for having a special health need, which is broader than the definition Idaho uses for eligibility in the State program.

Miscellaneous:

The federal bureau of Maternal and Child Health is planning to conduct a special nation-wide telephone survey to determine state specific rates of CSHCN in the next several years. This would assist in the identification of the number of children who have special health needs. The SSDI Program has the goal of conducting a survey in FY 2001 to determine the number of children by health district who have a special health care need. The information generated from the state survey will be compared to the national survey data. This will be possible since the SSDI program has obtained the questions that will be included in the national survey.

The following table is a summary of the needs assessment prioritization meeting, and the survey, results. It includes a column detailing the final set of priorities which were selected by using the three areas of input (survey results, public health results, and Executive Leadership Team results), and combining them based upon weights as assigned during each process.

<b>MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT</b>				
<b>Group:</b>	<b>Survey Results</b>	<b>Public Health (Feb. 1, 2000 meeting) results</b>	<b>Executive Leadership Team (Feb. 3, 2000 meeting) results</b>	<b>Composite across all groups</b>
<b>Women</b>				
	%Access to Prenatal Care %Health Insurance %Domestic Violence %Substance Abuse	%Substance Abuse %Inadequate Prenatal Care %Domestic Violence %Pre-conceptual Planning	%Substance Abuse %Access to Prenatal Care %Health Insurance %Domestic Violence %Pre-conceptual Planning	<b>%Substance Abuse</b> <b>%Domestic Violence</b> <b>%Prenatal Care</b> <b>%Access to Care</b>
<b>Infants</b>				
	%Immunizations %Access to Care / Health Insurance %Newborn Screenings	%Disparities in Infant Mortality %Immunizations	%Access to Health Care %Immunizations %Newborn Screenings %Disparities in Infant Mortality	<b>%Child Abuse</b> <b>%Immunizations</b> <b>%Access to Care</b> <b>%Disparities in Infant Mortality</b>
<b>Children</b>				
	%Immunizations %Child Abuse %Health Insurance	%Unintentional Injury %Child Abuse %Immunizations %Obesity %Dental Disease %Access to Care	%Child Abuse %Access to Care %Immunizations %Dental Disease %Health Insurance %Unintentional Injury %Obesity	<b>%Child Abuse</b> <b>%Immunizations</b> <b>%Access to Care</b> <b>%Unintentional Injury</b> <b>%Dental Disease</b>
<b>Adolescents</b>				
	%Teen Pregnancy %Substance Abuse %STD's %Violence %Health Insurance	%Substance Abuse %Sexual Assault %Teen Pregnancy	%Substance Abuse %STD's %Sexual Assault %Health Insurance %Teen Pregnancy %Violence	<b>%Substance Abuse</b> <b>%Abuse</b> <b>%High Risk Teen Behavior</b> <b>%Access to Care</b> <b>%Teen Pregnancy</b>
<b>Children with Special Health Care Needs</b>				

MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT				
	%Health Insurance %Access to Care %Availability of Specialty Care	%Access to Care %Inadequate Data	%Not Ranked	%Access to Care

**Summary of needs for each segment of MCH Population by service category:**

Based upon these data, the following needs were identified for each segment of the MCH population by service category:

**Direct Health Care Services**

***Pregnant Women, Mothers and Infants***

- < Prenatal care
- < Pre-conceptual planning

***Children***

- < Immunizations
- < Access to care

***Children with Special Health Care Needs***

- < Availability of speciality care

**Enabling Services**

***Pregnant Women, Mothers and Infants***

- < Health education on substance abuse and domestic violence issues
- < SCHIP outreach activities
- < Provision of vaccines

***Children***

- < SCHIP outreach activities
- < Provision of vaccines

***Children with Special Health Care Needs***

- < Access to speciality care

**Population-Based Services**

***Pregnant Women, Mothers and Infants***

- < Immunizations
- < Oral Health
- < Injury Prevention

**Children**

- < Immunizations
- < Oral Health
- < Injury Prevention
- < High Risk Behaviors (markers are STD rates, suicide, violence and teen pregnancy)
- < Substance Abuse

**Children with Special Health Care Needs**

- < Immunizations

**Infrastructure Building Services**

**Pregnant Women, Mothers and Infants**

- < Data

**Children**

- < Data

**Children with Special Health Care Needs**

- < Data
- < Service coordination/case management

The potential for collaboration to address some of these needs exists with several entities, internally and externally. Furthermore, it is beyond the scope, both financially as well as organizationally, for the direct involvement of the Title V agency in attempting to address a number of these issues. For example, the Title V Maternal and Child Health funding has not been used to address issues of substance abuse or physical abuse, however, the Department of Health and Welfare has programs in place to address these problems. It is hoped that the Title V program in Idaho can collaborate with other state Health and Welfare program to impact these issues. Additionally, it is hoped that the identification of such issues will lead to a collaboration between Regional Health and Welfare offices and the District Health Departments. The overriding goal is to identify priority problems and work towards eliminating the problem using effective solutions mutually identified by both entities.

### 3.1.2.2 Direct Health Care Services

### 3.1.2.3 Enabling Services

#### *All MCH Populations*

The most significant barrier that Idaho citizens face in accessing health care is a shortage of both primary care and specialized care providers. Financial, language and cultural, and transportation barriers also exist. Poverty, lack of medical insurance, and reluctance of providers to treat Medicaid clients continue to be the primary financial barriers to care in Idaho. Poverty means an inability to privately pay for services, an associated lack of access to private insurance, and dependence on public sources of medical payment such as Medicaid.

Forty-five service areas are designated as Primary Care Health Professional Shortages (HPSAs) in Idaho. In addition, there are 25 Medically Under-served Areas (MUAs). Maps showing Idaho's medically under-served areas, primary care health professional shortage areas, dental health professional shortage areas, and mental health professional shortage areas are included as **Figures 8A, 8B, 8C, 8D**. Idaho ranks 50th in the nation in terms of primary care providers to population ratio. In 2000, the primary care physician-to-population ratio was 81 physicians per 100,000 population. The "total" physician to patient ratio was 178 physicians providing patient care per 100,000 population.

In a recent manpower survey of 28 of Idaho's counties, only about 14% of the physician manpower in those counties surveyed serve Medicaid patients.

The State Office of Rural Health coordinates state programs and responds to grant opportunities to improve health care delivery systems for under-served rural populations in the state. These offices are located adjacent to the Bureau of Clinical and Preventive Services which allows for a close collaboration between the two agencies and provides frequent updates in health shortages for the Title V agency.

The following narrative presents a summary of State Office of Rural Health and Primary Care recruitment, retention and placement activities.

1. Currently 24 (3 dentists, 13 primary medical, 6 mid-level, 2 mental health professionals) National Health Service Corps (NHSC) Practitioners serve in the state of

Idaho. We continue to rely on their commitment to improving access to care in health professional shortage areas.

2. From 1991 to 1999, the Idaho Health Professional Loan Repayment Program has served as a vehicle to assist Idaho's medically underserved communities in recruiting primary care physicians, nurse practitioners, and physician assistants. The Program was successful in recruiting 32 practitioners to underserved areas, however, a need was further identified to encourage long-term retention.

Idaho continues to experience a statewide mal-distribution of primary care practitioners. From 1994 through 1998, a program deemed **Target-Practice: Rural and Underserved Idaho** demonstrated that a critical component for recruiting and retaining primary care practitioners to Idaho's underserved areas was a strong community infrastructure.

As a result, state legislation was introduced and approved in 2000 to expand the scope of the loan repayment program creating the Rural Health Care Access Program. The program is being developed for the purpose of providing grants to improve access to primary care medical services in areas designated as primary care health professional shortage areas and medically underserved areas. The program is scheduled for implementation July 1, 2001.

Individual grant awards to governmental and not-for-profit entities in health professional shortage areas will be limited to \$35,000 per year for a maximum of three years. There are four categories of grant assistance to include recruitment and retention, telehealth projects, community development projects, and other activities related to improving health care access.

3. A partnership has been renewed between the Mountain States Group (not-for-profit community resource organization) that previously conducted recruitment, retention, and placement assistance to communities, with the State Office of Rural Health, Primary Care Office and nationally the 3Rnet. Activities ceased in this area in October, 1999 due to a loss of funding for the activity. The services were desperately missed in the interim period and the groups involved are committed to improving assistance practices and further partnering with the two Idaho Family Practice Residency Programs to further identify need and develop communities before recruiting

crisis occur.

### ***Pregnant Women, Mothers and Infants***

Because access to health care, especially for the low-income rural population, is limited, the Reproductive Health Program provides an essential adjunct to the public health and preventive care delivery system in Idaho. In addition to pregnancy prevention services, the Reproductive Health Program also provides comprehensive primary reproductive health care and health education services to its clients. The program provided services to 36,676 low income Idahoans in CY 1999. Services are provided through the public health districts and one Planned Parenthood clinic, and clinics are located in 37 of Idaho's 44 counties. Low income, medically under served women are the primary target population and the majority of the client's incomes are less than 100% of the federal poverty level. Limited access to care remains an issue for most low income women in Idaho. Idaho is among the states with the lowest physician to population ratio in the nation. There were 178 physicians per 100,000 people in Idaho in 2000. Medicaid has not expanded coverage. Coverage for pregnancy remains at 133% of the poverty level, while for non-pregnant women, it remains at the AFDC level of 47% of the poverty level. Private insurance coverage is limited for low income women and, therefore, managed care has made few inroads with the MCH populations. Currently, only 5.1% of the Reproductive Health Program participants are covered by Medicaid and only 2.5% have any private insurance coverage.

The state has worked to identify potential sources of funds for local agencies. Unfortunately, the increased cost of contraceptives, including the purchase of Depo Provera, and laboratory services has offset the cost savings. The state continues to work with Medicaid to assure family planning services are properly compensated and included in *Healthy Connections*, the Medicaid managed care package. The major objective of the program since FY 1998, has been to work with Medicaid to develop a 1115(a) waiver. The waiver would expand Medicaid eligibility to all women up to 150% of the federal poverty level and cover more than 80% of the women currently served by the program. A taskforce has been developed to write the concept paper. The waiver

will make the development of culturally appropriate outreach and services to the Hispanic population a priority.

The state has also been working with the Division of Welfare to provide access to contraceptive services to Temporary Assistance to Families in Idaho (TAFI) participants. The Reproductive Health Program continues to meet with the Division of Welfare to discuss coordinating efforts to reduce second pregnancies to teens and high risk TAFI recipients. A request for TANF funding to support outreach for low income women was developed but not funded. The request will be resubmitted July 2000.

The program targets services to populations who may have difficulty accessing care. During CY 1998, the program served 4,901 Hispanic/Latinos. The program provides all educational material in English and Spanish, and strives to have bilingual staff available in all clinic sites. The program provides outreach to the Hispanic community, and provided funding for outreach into migrant camp through a contract with the Southwest District Health Department. More than 2,119 clients served speak only Spanish and required interpretation services.

The Idaho Title V Program does not provide direct health care services to pregnant women. Significant gaps in prenatal care exist between all populations in Idaho and the Idaho Medicaid population. Additionally, significant gaps in prenatal care exist across health districts and counties by age, race, ethnicity and source of payment. From 1989 to 1995, the percent of live births to mothers receiving less than adequate prenatal care was similar for both Idaho and the U.S., fluctuating up and down slightly from year to year. In 1996, Idaho experienced a significant increase in the percent receiving less than adequate prenatal care, from 27.9% in 1995, to 31.8% in 1996. The gap between the U.S. and Idaho is even more pronounced when comparing care by race. In 1998, the U.S. white rate was 7% higher, the U.S. black rate was 7% higher, and the U.S. Hispanic rate was 21% higher than Idaho's corresponding rates. Further, the decline in access to prenatal care is most notable in those without health insurance, Hispanics and those not married. Approximately 16% of the insufficient prenatal care utilization rate in Idaho can be attributed to the high prevalence of at-risk mothers who have no health insurance, low education and/or are Hispanic. Approximately 14% of the insufficient prenatal care utilization rate in Idaho

can be attributed to the high prevalence of unplanned births.

Foreign-born Hispanic women are significantly less likely to utilize Medicaid during pregnancy, compared with both Hispanic women born in the U.S. and non-Hispanic women. The percent of mothers with “unknown” listed for the primary source of payment source of payment for delivery on birth certificates increased since 1995 at a higher rate for foreign-born Hispanic mothers. This is most likely due to changes in Medicaid policy in 1996 with the passage of the Personal Responsibility Act, which limited Medicaid eligibility to U.S. citizens and *qualified* legal non-citizens. Overall in Idaho, there has been a 16.4% decline in Medicaid utilization as the primary source of payment for delivery, from 21.9% in 1995 to 27.5% in 1998. For Hispanics, there has been a 28.2% decline, from 43.2% in 1995 to 31.0% in 1998. For foreign-born Hispanics, the decline has been most pronounced, 50.6% , from 32.2% in 1995 to 15.9% in 1998. Additionally, most foreign-born Hispanic mothers receive their prenatal care visits at hospital clinics rather than at private doctor's offices. The barrier to receiving adequate prenatal care most often identified was money!

#### **Children**

See Immunization Program activities under 3.1.2.4, Population-Based Services.

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. Approximately 45,000 uninsured children live at or below 200% of the federal poverty level. Of that amount approximately 84.2% (37,890) are at or below 150% of the FPL. For the month of December 1999, Title XXI enrollment stands at 4,728 children and Title XIX enrollment for children is 54,318. These figures represent monthly enrollment. Title XXI enrollment for calendar year 1999 was 9,025 unique individuals and Title XIX enrollment was 83,304. Outreach has been made a top priority to increase enrollment in this program. Additionally, a statewide media campaign is planned to increase awareness of the program.

#### **Children with Special Health Care Needs**

Primary barriers to health care access for children with special health care needs continue to be the lack of specialized providers and Idaho's rural nature. Families must travel to an urban area within the state or, in some cases, travel out of

state to access care. CSHP assists such families in overcoming these barriers by providing financial assistance for travel and contracting with physician specialists to travel to local communities to hold clinics.

CSHP nurse coordinators in each of the seven district health departments assume care coordination responsibilities for the variety of services necessary from primary through specialized tertiary levels. This continuum of care includes ongoing communication with physician specialists and therapists contracting with CSHP and a variety of in-state and out-of-state medical centers and rehabilitation facilities. The program has positive working relationships with tertiary centers in both Washington and Utah. Physician specialists from Salt Lake City's Primary Children's Medical Center staff CSHP clinics in eastern Idaho, and their presence enhances communications with and referrals to that institution. Shriner's hospitals in Salt Lake City and Spokane, Washington routinely accept referrals from CSHP and provide lists of patients presently served out of state which are used to identify and close gaps in Idaho's service system.

The CSHP program is currently negotiating with St. Luke's Regional Medical Center of Boise, to provide clinic services in southwestern Idaho, for health districts 3 and 4. In addition to clinical services through pediatric sub-specialties, case management/care coordination and ancillary services of social work, oral health, and nutrition would be provided through St. Luke's Children's Hospital.

#### **3.1.2.4 Population-Based Services**

##### ***Pregnant Women, Mothers and Infants***

Adolescent pregnancy is a statewide problem with serious consequences for the health and well-being of Idaho's teenagers and their children. While the Idaho teen pregnancy rate per 1000 has mirrored the national trend by declining steadily in the 1990s, the health and social consequences of children bearing children are well documented and continues to keep this effort a priority issue in Idaho. Respectively for 10-14 year olds and 15-17 year olds, low birth weight babies occur 16.7% and 10.6% of the time. This is in comparison to the overall 6.3% for the Idaho general population in

1997. One of five children in Idaho under the age of 15 is already sexually active, and another one in five will become so before they graduate from high school (Idaho Youth Risk Behavior Survey, 1995). Each year, almost a thousand adolescent girls in Idaho aged 10-17 will become pregnant. The severe health consequences of teen pregnancy are compounded by the social impacts. Six out of ten teen mothers will not complete high school. Eight out of ten unmarried teen mothers will end up on welfare. The sons of teen mothers have a 13% higher likelihood of going to prison while the daughters are 22% more likely to become teen mothers themselves.

Funded by Child Support Block Grant and state matching dollars, the Governor's Council on Adolescent Pregnancy Prevention was established in 1995. The Council developed and implemented a statewide campaign focused on delaying sexual activity by adolescents and then assessed the impact of the campaign on affecting the behavior and attitudes of Idaho teens. Consistent with a primary prevention strategy, the priority population was 10-14 year old males and females and their adult care givers. In tandem with this statewide effort, educational and enabling strategies were funded by the Abstinence Education Block Grant to sustain the message of abstinence through activities planned and conducted by local communities. Now entering the third fiscal year of this grant, the seven district health departments are contracted to facilitate and coordinate the planning and implementation of activities designed to delay the onset of sexual activity in teens by the fifteen local coalitions that currently operate in Idaho.

### **Children**

Although improving, Idaho's immunization rates for the 19 - 35 month old population continue to be below the HP2000 objective. The latest National Immunization Survey showed Idaho's rates have once again fallen and are currently 73.2% for this population. One cause of this low rate is that many children do not receive the recommended fourth DTaP immunization, which is typically given on a fifth visit to the child's pediatrician. (DTaP is diphtheria, tetanus, and acellular pertussis.) If more kids received this shot, Idaho's immunization rate would be at 90 percent.

The current Governor has made raising Idaho's rates to the 90% level a goal of

his administration and has emphasized its importance by appointing a special position within his office to work on early childhood development and immunization issues.

The Immunization Program's long-standing provision of free vaccine to the seven public health departments as well as to over seven hundred private providers statewide, appears to have had a minimum impact on the improvement of the rates. Therefore, the program continues to implement several strategies intended to do so. The state program has contracted with the district health departments, Idaho State University, and the Idaho Hospital Association, to perform the following endeavors: (1) link the WIC program with immunization through assessment of vaccination status and referral for needed vaccination of children receiving services from the WIC program; (2) implement CDC's AFIX (Assessment, Feedback, Incentive, and eXchange) protocol in the public health and private delivery systems. One major component of this protocol is to conduct CASA assessments (Clinical Assessment Software Applications) of both public and private clinic sites in an attempt to identify barriers to vaccination at each clinic site as well as to establish the actual immunization levels of the clinic's population; and (3) partner with birthing hospitals to increase the number of facilities with an immunization reminder/recall system. The AFIX protocol has also been initiated in contracts with migrant and community health clinics.

Additionally, the program has been a major player in the formation of statewide local coalitions, as well as the Idaho *Immunize by Two Coalition*, which have been active in focusing on parent and provider education on immunization issues. Also, a new record card for parents has been developed and distributed with an evaluation to follow. The state has also begun participating in a collaborative venture with the Hallmark Card Company to send new parents a greeting card and immunization reminder signed by the Governor.

Lastly, the Governor actively supported and signed into law an immunization registry bill. Implementation began in the fall, and the state has contracted with a vendor who is piloting registries at the district health department level for inclusion into a statewide database. The current target is for all district registries to come on line by the end of 2000. In conjunction with these pilots, a general immunization awareness campaign is being undertaken through a media campaign, with a further campaign to

be launched announcing the state registry, the **Idaho Immunization Reminder Information System (IRIS)**.

The Governor officially launched the Idaho Immunization Reminder Information System (IRIS) in Coeur d'Alene. IRIS is voluntary reminder system designed to track immunizations on a statewide basis. The first of the "Hands Across Idaho" IRIS launch events was held at Panhandle District Health in Coeur d'Alene. It was well attended by parents, children, community leaders, legislators, department staff and concerned citizens. Similar events were held at Health District offices in Lewiston, Idaho Falls, Pocatello, Twin Falls and Boise.

Funding for these activities has come from federal immunization grants of the 317 and Vaccine for Children program, as well as State General Funds and the MCH Block grant.

The child death rate reflects the risks to children, including health problems, exposure to hazardous conditions, preventable injuries, and child abuse and neglect. The three year (1994-1996) annualized child death rate in Idaho is 31.8 deaths per 100,000 children aged 1-14, down marginally from 34.7 in 1991-93. Accidents were the primary cause of Idaho's childhood deaths, accounting for 54% in the period 1994 through 1996. Motor vehicle accidents predominate among unintentional injuries suffered by children.

Deaths due to accidents account for the majority of deaths in Idaho among persons aged 1-14. The largest contributor to accidental deaths are motor vehicle fatalities, with Idaho's rate being more than twice the national goal. The second leading cause of death among the population aged 15-24 is suicide. While Idaho's rate of suicide has improved, it still exceeds the national goal for youth aged 15-19.

At the request of the Governor's Children At Risk Taskforce, a Child Mortality Review Team, through Executive Order by the Governor, has been created. The purpose of this group is to review all child deaths to identify potentially preventable deaths among Idaho children, identify the risk factors leading to preventable deaths, and collect and organize this information into meaningful summaries of causes of child death in Idaho. Further, these reviews are used to identify gaps or weaknesses in

preventive services which could prevent child mortality in Idaho. These services include prenatal care, public health education, medical care, access to medical services, pre-hospital care, and child protective services. Identified trends in morbidity and mortality related to injury prevention provide targets for appropriate interventions. Quarterly review of cases began in December of 1998. The team will identify potentially preventable deaths by identifying risk factors, and collect and organize this information into summaries of causes of child death in Idaho. As a result, specific health promotion interventions and system improvements can be implemented to positively impact the child and infant mortality outcome measures. Title V funds and programs will play an integral part in carrying out these interventions as well as tracking the data.

The Injury Prevention Program of the Bureau of Health Promotion collaborates with the Office of Highway Safety of the Idaho Transportation Department to promote a child passenger safety campaign. Statewide motor vehicle safety was promoted by means of media and educational interventions. Child care safety seats were distributed to parents of children less than four years old and weighing less than 40 pounds. In addition, statewide bicycle safety was promoted by means of media and educational interventions. Free to low-cost bicycle helmets were distributed to children. Funding for the Injury Prevention Program is a combination of MCH and Preventive Block Grant dollars.

The Bureau of Family and Children's Services now chairs the Adolescent Suicide Prevention Taskforce, which explores planning prevention efforts at the state level. Taskforce members represent health promotion, drug and alcohol prevention, education, suicide prevention hotlines, and survivors. The program contracts with Boise State University to provide QPR training for teachers, school counselors and principals, addressing suicide risks and referral mechanism for potentially suicidal individuals.

According to Kid Count information, the percentage of Idaho Children with untreated tooth decay (26.7%) was lower than the national average of 31%, but above the national objective of no more than 20%. The Oral Health Program contracts with

the seven district health departments to conduct population-based preventive oral health programs. These include a school fluoride mouth rinse program which targets children in grades 1-6 who are at high risk of developing dental caries and live in fluoride deficient areas. Other programs include school-based preventive dental health education programs and community-based oral health promotion activities such as health fairs and parenting classes. Special one time funding has been used to facilitate and coordinate a statewide dental sealant project.

### **3.1.2.5 Infrastructure Building Services**

As previously indicated, infectious disease outbreaks and reportable conditions play a significant role in the major morbidity for the population of children 1-21 in Idaho. In 1997, 452 cases of pertussis were reported in this population, many reported during an outbreak in northern Idaho. In 1996, Idaho's case rate for *Neisseria meningitidis* was more than twice the national case rate. Thirty-one percent (31%) of Hepatitis A cases occurred in children 1-21. Such large outbreaks require numerous resources to bring appropriate control measures into play, including surveillance, confirmation of diagnosis, follow-up of contacts, follow-up on the initial cases and finally widespread vaccination of susceptible individuals. It is estimated that for each reported case, there are about five contacts that require follow-up. Reportable conditions also require significant follow-up. In 1999, sixty-two percent (62%) of the elevated blood lead levels reported were in children age 1-21, with eighty-one percent of those occurring around the Kellogg Superfund site (**Figure 9**).

The Epidemiology Program is collaborating with Idaho State University, Institute of Rural Health Studies, to conduct a CDC funded study of pertussis vaccine efficacy in children aged six months through four years of age. It will use reported cases from 1998 and 1999 as well as an uninfected cohort as a control.

Epidemiological services are provided through contracts with the district health departments. This approach builds capacity at the local level to respond to infectious disease threats as well as to conduct investigations and surveillance activities on

reportable conditions such as elevated blood lead levels.

CSHP has initiated a change in funding formula for contracting with the district health departments. The program will reimburse health departments for “clinic costs” based upon the Medicaid non-physician hourly rate; “services authorized” based upon a district staff hourly rate; and “service coordination” based upon a district staff hourly rate and the health care and family functioning tier level assessment for each clients family. This approach will save contract funds and will allow CSHP to utilize funds presently committed to health department contracts for clinic services and to provide treatment for those who meet eligibility. CSHP is also collaborating actively with Idaho’s Part C program in new ways, utilizing a jointly developed Individualized Family Service Plan for birth to three year old youngsters served by both programs. A transition project involving Vocational Rehabilitation and Shriner’s hospitals, designed to assist older patients in leaving CSHP for jobs or schools, will be implemented during FY 1999. CSHP has initiated an SSI Interagency Committee with representatives from the State Disabilities Council, Department of Education, Part C program, Welfare/Medicaid, and advocacy organizations, which oversee services to SSI recipients. Additionally, the CSHP Program manager serves on the Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Act (IDEA), Part C.

The CSHP program is currently negotiating with St. Luke’s Regional Medical Center of Boise to provide clinic services in southwestern Idaho for health districts 3 and 4. In addition to clinical services through pediatric subspecialties, case management/care coordination and ancillary services of social work, oral health, and nutrition would be provided through St. Luke’s Children’s Hospital.

As indicated in Section 1.4, approximately 45,000, or 25.7%, of the 175,000 Idaho children living in families with incomes at or below 200% of the federal poverty level do not have health insurance. Children who did not have health insurance at any point in 1998 represented 14.7% of the total number of children regardless of income level. Under the Child Health Insurance Program (CHIP), authorized under Title XXI, Idaho has received an appropriation of \$15.7 million to provide health insurance to

children. Initial implementation has taken the form of a Medicaid eligibility expansion. For the month of December 1999, 4,728 children were enrolled in CHIP. A total of 9,025 children were enrolled during calendar year 1999. Both figures are unduplicated counts of children enrolled, although they represent two different time periods.

A 22-member citizen's taskforce examined the program and recommend a long-term plan for its operation. Two subsequent committees were appointed by the new director of the Department of Health and Welfare to review the initial recommendations. One of the most significant decisions made concerned simplification of the application form, from a 17 page document to a 4 page document. Evaluation of other recommendations is ongoing. Although some of those currently uninsured individuals may be Medicaid eligible, it is estimated that only about 45% of persons eligible for Medicaid in Idaho are actually enrolled in the program. It is, therefore, critical that outreach efforts are undertaken as part of the new program to uncover those eligible kids. Title V programs will provide a format for some of that outreach. In addition, media campaigns are planned as well as outreach through the service coordination efforts described under the current MCH priorities and initiatives section in **1.4**.

Finally, the Idaho State Epidemiologist is a member of the Public Health Committee of the Idaho Medical Association and regularly provides testimony before that group to obtain feedback and recommendations regarding public health issues and policy from the medical community. And while these issues may impact all segments of Idaho's population, MCH concerns play in integral part in those discussions.

According to manpower surveys conducted by the State Office of Rural Health in 28 of Idaho's counties, only about 15% of the dental manpower in those counties surveyed serve Medicaid patients. In an effort to impact this situation, the Idaho Oral Health Alliance, formed in 1998 with the efforts of the Oral Health Program manager, made increased Medicaid dental reimbursement a priority. Through their efforts, an increase was realized as the result of a legislative appropriation. Additionally, the program provides a number of assessment activities including data analysis on dental sealants and updating of the state population profile of water supplies with adequate fluoride levels.

## 3.2 Health Status Indicators

Please refer to forms C1, C2, C3, D1, and D2.

The **Core Health Status Indicators** were used in conjunction with other MCH indicators for the needs assessment data. Data availability was, and will continue to be, variable dependent upon the source. For example, in order for the Idaho Title V program to obtain annual reports from the Division of Medicaid, a minimum cost of \$20,000 would be assigned to programming charges so that a report would automatically be generated at the end of the Medicaid Fiscal Year, which coincides with the MCH Fiscal Year. Additionally, Medicaid data availability during the legislative session depends on the requests for information they receive from the Legislature. Birth and death data for Calendar Year 1999 from Vital Records and Health Statistics was not received until the fall, due to the change from ICD-9 to ICD-10 coding, and that vital records from bordering states was not filed until late this summer.

### Medicaid and CHIP Data:

Form C2 highlights the disparities between the Medicaid and the non-Medicaid populations in Idaho. This information was included, to a degree, in the needs assessment. Further analysis is needed to determine the significance of the differences, however, generally speaking, Medicaid participants have poorer health outcomes when compared to the non-Medicaid populations. Efforts will be made to address the identified health disparities, in pursuit of HRSA's 100% Access - 0% Disparities campaign.

### Data Capacity

#### Annual Data Linkages:

Birth and infant death certificates are housed in the Bureau of Vital Records and Health Statistics. They are linked annually, and the MCH programs have access to data and reports on an as needed basis. The MCH-funded Senior Research Analyst, as well as other analysts in the Bureau, provide data to the MCH programs when requested. Electronic access, by the various MCH programs, to the respective

databases is not currently available.

Areas that have been identified for development in the future are the linking of birth records and WIC eligibility files, and linking of birth records and newborn screening files. This may be easier to accomplish than the linking of the birth records and Medicaid paid claims or eligibility files due to the fact that Medicaid is a separate Division, and the WIC and Newborn Screening programs are located in the Division of Health, as is the Bureau of Vital Records and Health Statistics.

#### Registries and Surveys:

The Idaho legislature does not require the collection of hospital discharge data, therefore, Idaho does not have a hospital discharge database, nor does it have an annual birth defects surveillance system. The political climate in Idaho is such that there is a significant amount of resistance to any type of registry. Hospitals have also expressed significant resistance to the idea of collecting data that could identify them individually, as well as potentially identify individuals. [Idaho's population is small enough in certain geographic areas that would make it easy to identify an individual, even if names and addresses were replaced with unique identifiers.]

There have been efforts, in the past, to develop a birth defects registry, however said efforts have been unsuccessful. No plans exist at this moment to pursue this registry.

The two surveys, one based on the Pregnancy Risk Assessment Monitoring System (PRAMS), the other based on the Youth Risk Behavior Survey (YRBS), both developed by the Centers for Disease Control and Prevention, have been conducted in the past. The Pregnancy Risk Assessment Telephone Survey (PRATS), modeled after CDC's PRAMS, was conducted in 1996 and identified issues by comparing individual survey results to birth certificates. As a result of this, the hospital association took the lead in educating hospitals in Idaho on the proper completion of the fields on the birth certificate. In 1999, a second round of PRATS was conducted; it was renamed the Pregnancy Risk Assessment Tracking Survey and was closely modeled after CDC's PRAMS. Results from the two surveys are not comparable due to significant

differences in the design of the two surveys. This version was completed in the fall of 1999, and a formal report of the results is due out soon. Plans are being made for another survey to be completed in the future, as mentioned earlier in this grant. The Title V agency is providing funding for the Senior Research Analyst to conduct the survey. Funds will cover the costs of contracting with a research firm to conduct the telephone surveys, supplies needed, and the production of a report.

Past plans have been to conduct the PRATS every two years, however, it actually has been conducted every three years. The gap between 1996 and 1999 was due to turnover in the SSDI position. Current plans are to conduct it again in 2001.

The YRBS, on the other hand, was last conducted in 1995, and results were not weighted to be representative of the entire state. YRBS has, in Idaho, been administered through the State Department of Education. It was not conducted between the years of 1996 - 1999 due to political/philosophical differences of the administrator. The current administrator is attempting to revive the survey and enlist the support of school districts across the state. The larger districts are needed to ensure sufficient participation in the survey and to be able to reliably generate statewide estimates.

The **Developmental Health Status Indicators** were also a challenge for some of the same reasons as stated above. Data availability is dependent upon the source. Furthermore, there are some developmental indicators that Idaho will not be able to complete, such as **Indicator 2A** due to the fact that the source for this data is generally hospital discharge databases, which do not exist in Idaho. Data for **Indicator 5B** may be available in the future, and will be included when available. For the most part, data for the demographic indicators **6A, 6B, 7A, 7B, 8A, and 8B** are available from Vital Records. Data for indicator **9A** and **9B** are subject to data collection abilities of other Divisions, such as the Division for Family and Community Services, the Division of Welfare, the Departments of Education, and Law Enforcement, as well as the Division of Medicaid. As previously explained, there are difficulties with obtaining Medicaid data, see the previous discussion under **Core Health Status Indicators**. Another difficulty encountered during the process of compiling the data for these indicators is

that in many instances other Departments and Divisions do not collect data in the manner which MCHB requires it. Also, there have been times that while the data exists in hard copy, there are no electronic records thereby increasing the amount of time spent compiling data to respond to a particular indicator. The Title V Agency will work towards completing these indicators by contacting the respective agencies and identifying resources for this information. Data is available for indicators **10, 11 and 12.**

### **3.2.1 Priority Needs**

As previously described in Section 1.4 and 3.1.1, the priority needs statement developed for the FY 1996 application was reviewed and updated to reflect focus in policy, the evidence gathered through updating our needs assessment data, the direction of programs at the community level and the health status indicators. The **ten** priorities that follow are those directly related to Title V populations. In several instances, programs will address these issues by initiating services and interventions on more than one service level and for more than one segment of the MCH population.

#### **Direct Health Care**

- < To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services and by review of infant mortality records by the Child Mortality Review Team.
- < To reduce the adolescent pregnancy rate through improved access to contraceptive services.

#### **Enabling Services**

- < To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents;
- < To increase access to care - focusing on health insurance - targeting infants and children;

- < To increase prenatal care utilization focusing on population disparities.

### **Population-based**

- < To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age;
- < To reduce morbidity/mortality due to injury;
- < To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STDs;
- < To reduce infant morbidity/mortality by review of child deaths followed by targeted interventions.

### **Infrastructure**

- < To increase capacity for “cluster” investigation/surveillance;
- < To increase data capacity for all MCH populations.

These priority needs are further depicted by MCH population and level of service in matrix form on **Figure 10**. The items listed above represent the top ten needs as identified through the prioritization meetings held in February of 2000. The listing of needs presented at these meetings were representative of the most critical needs of the maternal and child population in Idaho. It should be noted that the list above does not represent all of the needs presented at the prioritization meetings, but do represent the results of the prioritization meetings. None of the four following needs translated into MCH priority needs because they did not score high enough in the ranking process to be included in the “top ten” rankings of needs. Four MCH needs not selected were:

1) oral health for pregnant women, mothers and infants, and children; 2) CHIP outreach activities for pregnant women, mothers and infants, and children; 3) availability of and access to specialty care for CSHCN; and 4) service coordination and case management for CSHCN.



### 3.3 Annual Budget and Budget Justification

#### 3.3.1 Completion of Budget Forms

Please refer to forms 2, 3, 4, and 5.

#### 3.3.2 Other Requirements

##### Maintenance of State Effort

In FFY 1999, the state of Idaho provided state matching funds amounting to \$2,141,219. The FFY2001 MCH Block Grant Application includes \$2,477,384 to ensure a maintenance of state effort.

##### Budget Narrative

**Figure 11** shows a comparison of allocations for FFY97 through the present application proposed for FFY2001. It is broken down by program included in each of the three categories identified in Sec.505(a)(1): (A)preventive and primary care services for pregnant women, mothers, and infants up to age one; (B)preventive and primary care services for children; and (C)services for children with special health care needs. Since some of the program activities cut across several or all of these three categories, budget allocations may be listed in several or all. A composite column is included which provides the totals for each program.

As in FFY 2000, the breastfeeding and newborn hearing screening projects will receive funding through this MCH Block Grant. In addition, last year's projects related to SIDS, the provision of nutrition training for district dietitians dealing with children with special health care needs, and the Child Mortality Review Team will again be funded. An additional \$100,000 has been added to the Oral Health Program budget to provide funding for the Idaho State Smile Survey of 2nd and 6th grade students. Funding for the perinatal analyst position will also be increased by \$47,120 to allow for the Pregnancy Risk Assessment Tracking System (**PRATS**) survey to once again be administered. These increases will be off-set by a reduction in the funding for the CSHP Program, but will still leave that program with more than the 30% grant

requirement. All other program allocations represent essentially a level commitment from last year.

Although not funded by MCH Block Grant funds, the Abstinence Education Program within the Bureau of Health Promotion and the SSDI Program now within the Bureau of Clinical and Preventive Services are both supported by MCH grant funds. In FY2001, the Abstinence Education Program anticipates level funding at \$359,149 and SSDI at \$100,000.

Assuming level funding for the MCH Block grant, the amount of state matching funds projected on Forms 2 and 3 for FFY2001, represent the minimum needed for match requirements against the FFY2000 federal allocation. Actual expenditures will be described in the corresponding annual report. These matching funds are derived from program costs for the district health departments activities, as well as state general funds.

We do not anticipate any unobligated funds from FFY 2000.

### **3.4 Performance Measures**

Please see **Figure 3**.

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

Please see **Figure 4**.



**FIGURE 4**

**PERFORMANCE MEASURES SUMMARY SHEET**

Performance Measure	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 who 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		

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
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

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

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
<b>SP#1)Percent of child deaths reviewed by the Idaho Child Mortality Review Team.</b>			X			X	
SP#2)Percent of children born to a reported Hepatitis B positive mother who are appropriately vaccinated at birth. <b>DISCONTINUED</b>			X				X
<b>SP#3)Use of the Idaho CareLine as a clearinghouse (information/referral) of information for non-health related children’s social and developmental services.</b>		X			X		
SP#4)Reduce the rate of communicable disease acquisition in children during day care outbreaks among children attending day care. <b>DISCONTINUED</b>				X		X	
<b>SP#5)Percent of investigations completed on children with elevated blood lead levels.</b>				X		X	
SP#6)Participation of MCH staff in the state taskforce on child care initiatives and development of on-going performance measure related to child care. <b>DISCONTINUED</b>				X		X	
<b>SP#7)Proportion of all pregnancies seen in Reproductive Health clinics that are unintended.</b>	X						X
<b>SP#8)Percent of positive pregnancy tests in Reproductive Health Program participants of less than 20 years old.</b>	X						X
<b>SP#9)Percent of deaths attributed to SIDS that are autopsied.</b>				X		X	
<b>SP#10)Doses of hepatitis A vaccine administered to children at kindergarten entry.</b>			X				X
<b>SP#11)Percent of CHIP eligible children who are enrolled in the program.</b>				X		X	

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

### 3.4.1.1 Five Year Performance Objectives

Please see form 11.

## 3.4.2 State "Negotiated" Five Year Performance Measures

### 3.4.2.1 Development of State Performance Measures

Please see form 16 and **Figure 4**.

### 3.4.2.2 Discussion of State Performance Measures

**SP#1 - Percent of child deaths reviewed by the Idaho Child Mortality Review Team.** A population-based measure that responds to the state priority need #1 and #4; to reduce the infant morbidity/mortality and child death rate. Trends in morbidity/mortality identified by this process will focus interventions on target populations. This measure also plays a part in priority need #10; to increase data capacity for this population. This performance measure relates to all six national Outcome Measures.

**SP#2 - Percent of children born to a reported Hepatitis B positive mother who are appropriately vaccinated at birth. DISCONTINUED**

**SP#3 - Use of the Idaho CareLine as a clearinghouse (information/referral service) of information for non-health related children's social and developmental services.** An enabling measure that responds to the FY2000 priority need #7; to increase awareness of early childhood development issues, and is related to Outcome Measure #6.

**SP#4 - Reduce the rate of communicable disease acquisition in children during day care outbreaks among children attending day care. DISCONTINUED**

**SP#5 - Percent of investigations completed on children with elevated blood lead**

**levels.** An infrastructure measure that responds to priority need #8; for increased capacity to provide investigation on reported “clusters” of reported disease and is best related to Outcome Measure #6.

*SP#6 - Participation of MCH staff in the state taskforce on child care initiatives and development of on-going performance measure related to child care.* **DISCONTINUED**

**SP#7 - Proportion of all pregnancies seen in Reproductive Health clinics that are unintended.** A direct services measure that responds to the priority need #1 and #9; to reduce infant mortality and low birth weight and increase prenatal care utilization. It is related to all six Outcome Measures.

**SP#8 - Percent of positive pregnancy tests in Reproductive Health Program participants less than 20 years old.** A direct services measure that responds to Priority need #2 and #5; for reduction of the adolescent pregnancy rate. This measure may have impact on all six Outcome Measures.

**SP#9 - Percent of deaths attributed to SIDS that are autopsied.** An infrastructure building measure that responds to priority need #1 by obtaining accurate data on SIDS deaths as a first step in addressing the high rates in Idaho which is a significant cause of infant mortality in the state. It relates to Outcome Measures 1 - 5.

**SP#10 - Doses of hepatitis A vaccine administered to children at kindergarten entry.** A population-based measure that responds to the high rates of hepatitis A in Idaho and conforms to CDC recommendations; related to priority need #3. It is related to Outcome Measure #6.

**SP#11 - Percent of CHIP eligible children who have enrolled in the program.** An infrastructure measure that responds to priority need #7; the need to increase access to health insurance for Idaho’s children. It is related to all six Outcome Measures.

### **3.4.2.3 Five Year Performance Objectives**

Please see form 11.

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

To be performed during block grant review.

### **3.4.3 Outcome Measures**

Please see form 12.

## **IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a) (2) (A)]**

This annual plan flows from the identification of priority needs, the national and state 5-year performance measures and the capacity and resources of this agency. The Division of Health, in conjunction with the Directors of Idaho's seven district health departments, has reviewed health priorities and related MCH funded programs as well as those not funded by MCH, for ongoing need, prevention effectiveness and availability of alternative resources. This will enable the Division to better direct its resources to bolster core public health functions, improve systems development and support community-based prevention initiatives and safety net services. Program activities will be described by level of the pyramid and by segment of the Title V population. Some activities will address multiple service levels of the pyramid and impact more than one segment of the Title V population.

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

#### Direct Medical Care

#### *Pregnant Women, Mothers and Infants*

Although the **Immunization Program** does not contract with the district health departments and private providers for the direct provision of vaccines, it does and will continue to provide vaccines to all public and private providers to reduce barriers to immunization and, thereby, increase the childhood immunization rates (**performance measure 5**). Hepatitis A vaccine will be added to the regimen beginning July 1, 2000.

The **Reproductive Health Program** will continue to contract with the health districts and Planned Parenthood of Idaho to provide family planning services in 37 counties in Idaho. The program will provide comprehensive physical examinations to more than 20,000 women below 100% of the federal poverty level and more than 12,000 pregnancy tests to low income women. The data system will track the number of positive pregnancy tests and whether the pregnancy was intended (**performance measure SP7**). Other demographic and clinic statistics will be collected (age, race, income and payment sources) for new and continuing clients.

During FY 2001, the Reproductive Health Program will continue to provide pregnancy testing, counseling and referrals for prenatal care to more than 4,350 women (**performance measure 18**). The health districts provide Medicaid presumptive eligibility determination to pregnant women and a variety of pregnancy support services.

#### **Children**

The Reproductive Health Program will continue to provide family planning services to more than 11,000 teens less than 20 years of age in FY 2001 (**performance measures 6 and SP8**). Services include comprehensive physical examinations and age appropriate counseling, education and referrals. Parental involvement and abstinence counseling are provided to all teens. Four of the health districts provide special "Teen Clinics" which include a variety of services and access to a social worker and other community health resources.

See **Immunization Program** above.

In an effort to impact the issue of provider supply and participation in Medicaid, the Title V Program will investigate the feasibility of providing regional dental clinics for Medicaid and CHIP children. We will look at contracting with private dentists to staff dental offices in each district health department catchment area (**performance measure 13**).

### *Children with Special Health Care Needs*

The **Children's Special Health Program** (CSHP) will continue to provide resources and support to children who are not covered by other sources of third-party payment. In relation to **performance measure 2**, the program provided and/or paid for eight of the nine services listed in the checklist attachment for approximately 228 young patients in FY 1999. As projected in last year's grant, the number of children without insurance coverage decreased with the continuing implementation of the Children's Health Insurance Program and an increasing number of children eligible for Medicaid. CSHP will continue to work toward increasing the third-party payor reimbursement for clinic services for those children with private insurance (**performance measure 11**). Approximately 17% of youngsters under 16 who are SSI beneficiaries are enrolled in CSHP, and it is anticipated that percentage will remain fairly stable through FY 2001 (**performance measure 1**).

Additionally, CSHP will contract with St. Luke's Regional Medical Center in Boise, to provide clinical services to patients heretofore provided by health district's 3 and 4 in the Treasure Valley area. At this writing, a contract is being developed which will define clinic services, physical facility, sub-specialist and provider access, transportation, staffing and support. Case management/care coordination and ancillary services by social workers, nutritionists and dental hygienists will also be defined.

Finally, the State Systems Development Initiative (SSDI) Program will collaborate with the CSHP program to more accurately assess the number of CSHCN in the state. This will be accomplished by working with the Division of Medicaid to identify sentinel ICD-9/ICD-10 codes for use in generating age-specific reports identifying the number of Children with Special Health Care Needs in Idaho. Also planned, is the development of specific questions for inclusion in the Behavioral Risk Factor Surveillance System (BRFSS) survey to obtain more accurate information about CSHCN in Idaho. Data will be collected during calendar year 2001 and will be available for review mid-2001.

### Enabling Services

***Pregnant Women, Mothers and Infants***

The **Immunization Program** will continue to contract with the district WIC clinics to screen clients for immunization status and refer those not up to date to their health care provider (**performance measure 5**). In addition, the program will contract for coordination of the Immunize by Two Coalition to provide education and outreach services to the parent and providers.

With private providers enrolled in the state vaccine program increasing monthly (over 220% since Idaho became a universal distribution state in 1990), the Immunization Program will continue to supply vaccines at no cost, to district health departments and private providers for the provision of immunizations to infants (**performance measure 5**).

The **Idaho CareLine**, the toll-free information and referral telephone for the Idaho MCH population, expanded its services in the fall of 1998 to include a statewide clearinghouse for children's services with the immediate focus on early childhood development, child care, and health issues (**performance measure SP3**). The Idaho *CareLine* is an important piece of the Early Childhood Information Clearinghouse as a central point of contact for parents, care givers, or professionals to access from the web site to request either printed materials or additional resources or referrals contained in their data base. It is anticipated the role will continue to expand in this area during FY 2000 as the Early Childhood Clearinghouse grows and expands the topics, promotions, and scope of its operations. Due to the ongoing expanding scope of services, additional service needs will be identified and resources developed as appropriate.

The Idaho *CareLine* is now administratively located within the Division of Family and Community Services, within the Idaho Department of Health and Welfare. Strategic planning efforts and goals for the Idaho *CareLine* over the next fiscal year include continued promotion of the services within the Department, development of tools to identify needed service areas, and development of formal staff desk manuals

as well as increase staff development/training to ensure a smooth operation which can efficiently function and maintain a high level of performance in a growing work environment.

The **Title V agency** will work with the Substance Abuse Project of the Bureau of Mental Health and Substance Abuse to provide technical assistance in the form of training on substance abuse issues to district staff involved in Reproductive Health and WIC clinics. Typical topics of training will focus on *gatekeeping* - how to navigate accessing treatment services in the Substance Abuse System; *service options* - what services are available locally and who is providing them; and *addition services* - from a basic substance abuse primer to issues related to specific drugs and how to know who is doing what, by signs and symptoms, that may be observed during a visit to the clinic.

Additionally, the **Title V agency** will work with the Council on Domestic Violence to provide technical assistance in the form of training on domestic violence issues to district staff involved in Reproductive Health and WIC clinics. Under Title X, Reproductive Health clinics have a requirement to screen all minors for coercive relationships and provide counseling and referrals. During some similar training last year, it was noted that there is a lack of medical provider training/screening on violence. And therefore, this population also will be a target for training.

### **Children**

See **Immunization Program** above.

See **Idaho CareLine** above.

See Title V agency above. Additionally, the **Title V agency** will collaborate with the Idaho Children's Trust Fund in the Department of Health and Welfare to implement tobacco settlement funding (the **Idaho Millennium Fund**) for Youth Asset Building. Funding (\$100,000) from the Idaho Millennium Fund was provided by the last session of the Idaho Legislature to provide a Youth-Asset Building Summit and to network Idaho communities. Youth Asset Building is a model of the SEARCH Institute, Minneapolis, MN, which has identified 40 developmental assets that have a strong

influence on young people's lives. These assets help young people to make wise decisions, choose positive paths, and grow up to be more responsible. The Idaho Legislature has chosen to fund a project which embraces this model in an attempt to positively impact high risk teen behavior.

### ***Children with Special Health Care Needs***

Although there is presently no mechanism to determine the total number of special needs children in Idaho, we estimated approximately 99% of those enrolled in **CSHP** during FY 1998 had a medical home. During FY 2001, it is the goal of CSHP to continue to assess the prevalence of children eligible for the program and to raise to 100%, those with a medical home that are enrolled in the program (**performance measure 3**).

The State Systems Development Initiative (SSDI) Program will collaborate with the CSHP program to more accurately assess the number of CSHCN in the state. This will be accomplished by working with the Division of Medicaid to identify sentinel ICD-9/ICD-10 codes for use in generating age-specific reports identifying the number of Children with Special Health Care Needs in Idaho. Also planned, is the development of specific questions for inclusion in the Behavioral Risk Factor Surveillance System (BRFSS) survey to obtain more accurate information about CSHCN in Idaho. Data will be collected during calendar year 2001 and will be available for review mid-2001.

See **Idaho CareLine** above.

### Population-based Services

### ***Pregnant Women, Mothers and Infants***

The Governor's Office established a **Child Mortality Review Team** in FY 1999 via Executive Order (**performance measure SP1**). All child deaths during a given month will continue to be screened by a Child Mortality Screening Group, with selection of cases by this team for more in-depth review. This group will meet regularly to identify deaths which might be preventable, initiate additional data collection for those

cases, and refer them to the Child Mortality Review Team established by the Governor's Office. An annual report on the Review Team's findings will be published as a tool for identification of populations to be targeted and health messages to be promoted.

During FY 2001, the **Genetics Program**, within the Bureau of Laboratories, will continue to contract with the Oregon Division of Public Health Laboratories for newborn metabolic screening (**performance measure 4**). Newborns will be screened for PKU, hypothyroidism, galactosemia, maple syrup urine disease, and biotinidase deficiency and those with a confirmed diagnosis will be referred. While the program does not include nor fund hemoglobinopathy screening in the test battery, it is available on physician request.

During FY 2001, the **Immunization Program** will continue to contract with the district health departments to investigate reported cases of Hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a register, including a tracking and recall system, to assure that the infants complete the Hepatitis B vaccine series.

Additionally, during FY 2001, the Immunization Program will begin a population-based implementation program to increase hepatitis A immunizations by (1) targeting children 2 to 7 years of age to have two doses of hepatitis A vaccine; and (2) providing the vaccine at no cost as part of its general statewide distribution (**performance measure SP10**).

In an effort to impact the national objective of 90% immunization rates for children aged 2 years (**performance measure 5**), the Immunization Program will continue to conduct or contract for activities in four major areas: (1) parent education; (2) provider education; (3) reminder/recall; and (4) review and assessment of WIC clients. Typical activities in each category include:

### **Parent Education**

The Governor's Hallmark Immunization Card Project administered by the Idaho

Center for Vital Statistics and Health Policy assures that each mother of a newborn receives an immunization message within six weeks of delivery. The Immunization Program will collaborate with the Idaho Immunize By Two Coalition to conduct parent education activities such as promotion of special clinics and increased outreach to parents. The program will distribute the official Idaho parent-maintained immunization record card at no cost to providers and parents, and distribute education materials to women participating in the WIC program. It will continue to contract with the district health departments to reduce barriers by extending or changing clinic hours and education efforts. The program will continue contracts with six community/migrant health center agencies to conduct outreach activities (special clinics, increased clinic hours, and prenatal education) to populations at risk for not completing immunizations.

### **Provider Education**

The program will contract with Idaho State University, Institute of Rural Health Studies, to conduct private provider educational sessions and practice-based CASA assessments (AFIX process) to identify provider immunization rates and identify barriers to immunization. The program will hold workshops and support satellite courses on the Epidemiology of Vaccine Preventable Diseases offered by CDC. The program will provide educational information at professional meetings etc., and distribute at no cost, key immunization materials to all providers. The program will collaborate with the *Idaho Immunize by Two Coalition* to develop and distribute provider education materials.

### **Reminder/Recall**

The program will contract to provide oversight and technical assistance to the 23 Baby Track reminder/recall projects presently operating. Providers will be encouraged to implement reminder/recall as part of their overall plan to increase coverage rates.

### **Review and Assessment of WIC Clients**

The program will contract with the health districts to conduct a review and assessment of the immunization history of each child 0-24 months, with those not up-

to-date being referred for follow-up. Each child's immunization history will be reviewed at all certification appointments.

In addition, the Immunization Program will work toward the implementation of Idaho's *Immunization Reminder Information System, IRIS*, by contracting with the district health departments for information system activities as well as provider outreach and education. The registry system is scheduled to be totally operational by January 1, 2001.

The Title V agency will continue to provide financial support to the WIC Program, the primary state program involved in breast-feeding activities, to continue its contract with the Idaho Perinatal Project in a collaborative effort to support the development and implementation of targeted statewide breastfeeding promotion and strategies. These efforts are based on the prioritized recommendations provided by the **Statewide Breastfeeding Promotion Committee**. This committee will continue development of strategies and make recommendations to promote, support, and protect breastfeeding in Idaho and will identify ways breastfeeding can be promoted and supported through existing systems within the Idaho Department of Health and Welfare (**performance measure 9**). If funding permits, attempts will be made to identify needs and provide lactation education and support for hospitals, targeting those hospitals with the lowest breastfeeding rates at hospital discharge.

Beginning in FY 2001, the Title V agency will enter into a memorandum of understanding with the **Idaho Council for the Deaf and Hard of Hearing**, to provide services related to the Idaho Newborn Hearing Consortium. The agency will provide (1) monitoring and data collection; (2) hospital support, recruitment, and community education; (3) training; and (4) consortium support in an effort to increase newborn hearing screening through hospitals and the consortium (**performance measure 10**).

### **Children**

The **Injury Prevention Program** will continue to contract with health districts statewide to provide public risk reduction education for motor vehicle and bicycle

related injuries. The program will train parents and individuals to teach parents/care givers to correctly install child care safety seats. Child car safety seats will be distributed to low income families. It will provide seat belt education to elementary school children and distribute and fit bicycle helmets for children (**performance measure 8**). It will continue to work with the Idaho Transportation Department and the Idaho State EMS to provide NHTSA certified technician training to injury prevention specialists and EMS providers statewide. It will also perform poison prevention activities with pharmacies and the Bureau of EMS.

During FY 2001, the **Adolescent Pregnancy Prevention Program** of the Bureau of Health Promotion plan will again reflect the use of local coalitions to reinforce the abstinence messages that the IGCAPP campaign. As the program enters its fourth year of maturation, the emphasis will accordingly shift the focus of activities from awareness-raising to impact on knowledge and behaviors. Boise State University is again contracted to assist with evaluation and planning of these educational interventions (**performance measure 6**) .

See **Immunization Program** above.

See **Epidemiology Program**, Child Mortality Review Team, above.

***Children with Special Health Care Needs***

See **Immunization Program** above.

Infrastructure Building Services

***All MCH Populations***

The **Title V agency** will continue to work with Medicaid on outreach activities related to the implementation of the Children's Health Insurance Program. It will collaborate with the district health departments and the regional offices of Health and Welfare in the coordination of health services between the two groups (**performance measures 12 and SP11**).

### *Pregnant Women, Mothers and Infants*

During FY 2001, the **Epidemiology Program** will continue to chair the monthly Child Mortality Screening Group as well as participate in the quarterly statewide Child Mortality Review Team (CMRT)(**performance measure SP1**). In an effort to obtain more accurate data regarding statewide SIDS deaths, the Epidemiology Program will advocate within the CMRT for the encouragement of the use of MCH funds for conducting autopsies on all deaths attributed to SIDS in the state (**performance measure SP9**). Although these funds were used sparingly in FY 2000, the team will again be advocating for their use by all county coroner's offices. The program will continue to collect elevated blood lead level reports as part of its surveillance activities. Efforts will be made to ensure investigation of such elevated results on children (**performance measure SP5**).

Additionally, the Epidemiology Program will be working with the Idaho Emergency Medical Services Bureau on its EMSC Partnership Grant. The program will provide a review of available data on pediatric patients treated in the EMS system, examine and evaluate the effect of EMS care and intervention on pediatric patient outcomes and identify EMS service delivery gaps. The scope of work includes identification of the limitations of such data and assistance in the preparation of a report on the epidemiological profile of pediatric patients in the emergency medical care system.

The **Reproductive Health Program** will continue efforts to expand Medicaid eligibility for family planning services. The program will work with Medicaid to develop a 1115 waiver to expand eligibility for all woman up to 150% of the federal poverty level.

### *Children*

The **Injury Prevention Program** will plan, monitor, and evaluate motor vehicle occupant protection and bicycle safety prevention programs. The Bureau of Family and Children's Services will now assume suicide prevention activities. It will maintain

membership in the Idaho Adolescent Suicide Prevention Taskforce along with representatives of the Department of Education, mental health services, and suicide survivors. (**performance measure 15**).

During FY 2001, the **Oral Health Program** will continue to support and direct efforts of the Idaho Oral Health Alliance (IOHA), established during FY 1998 to increase access to preventive and restorative care.

The MCH dental sealant performance measure will be evaluated annually through data collection on a representative sample of third grade students (**performance measure 7**). The third grade surveys will be conducted by the district health departments under a contractual agreement with the State. The Oral Health Program will provide state level coordination, consultation and technical assistance for the third grade sealant survey and will analyze and report the survey results. Additionally, the Idaho State Smile Survey, will be conducted during FY 2001 on a representative sample of second and sixth grade students, and will further validate the results of the third grade surveys. This survey will provide data on sealant prevalence as well as on carries, untreated tooth decay, need for preventive care and need for restorative care.

The **Adolescent Pregnancy Prevention Program** of the Bureau of Health Promotion will continue to support community-based adolescent pregnancy prevention coalitions by contracting with district health departments (**performance measure 6**).

Additionally, the **Reproductive Health Program** will continue to work with Medicaid to develop a 1115(a) waiver to expand Medicaid eligibility to all women up to 150% of the federal poverty level and thereby cover more than 80% of the women currently served by the program (**performance measure 13**).

See **Epidemiology Program** above.

#### ***Children with Special Health Care Needs***

Approximately 87% of the patients in **CSHP** had a source of insurance for primary and speciality care in FY 1999 (**performance measure 11**). It is anticipated that

negotiations with Medicaid and continued implementation of the Children's Health Insurance Program will increase that percentage in FY 2000. The CSHP program will continue to work toward meeting the majority of characteristics defined for family participation (**performance measure 14**) in FY 2001. The Parental Advisory Committee, made up of one family representative from each of Idaho's seven health districts will meet in person and through telephone conference calls throughout FY 2001.

## **4.2 Other Program Activities**

### Direct Care Services

#### *All MCH Populations*

The **Genetics Program**, Bureau of Laboratories, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management. Additionally, nutrition counseling will be provided through contracts with the district health departments for children in all MCH populations and specializing in children with special health care needs.

#### *Children with Special Health Care Needs*

The **CSHP Program** will provide regional PKU clinics in Idaho Falls, Boise, and Spokane, Washington in FY 2001. Patient blood values will be submitted monthly and monitored for acceptability.

### Enabling Services

#### *All MCH Populations*

The **Idaho CareLine** is a toll-free telephone information and referral service whose mission is to assist the people of Idaho in accessing health related services in

their own geographical area. The toll-free number, 1-800-926-9588, is supported by MCH, the Bureau of Developmental Disabilities - Infant Toddler Program, and the Divisions of Medicaid, Family and Children's Services, and Welfare. This number allows the population supported by these programs, specifically women, children and adolescents, public access to the provider database.

The base of operations is at a centralized location in the administrative offices of the Department of Health and Welfare in the state capitol, Boise, Idaho. Calls are answered by three customer service representatives who utilize a computerized database to access referral information as needed by the caller. Numerous categories of agencies are listed in the database including providers of prenatal care, family planning, general child health, early child development, child care, health insurance, nutrition, dental health and health care for children with special needs. Also listed are providers of intervention services, evaluation, family support and respite care for children with developmental disabilities. The customer service representative provides information over the telephone, and then transfers the caller to the appropriate program for printed material or directly to the appropriate service provider.

One of the customer service representatives staffing the Idaho *CareLine* is bilingual, speaking both Spanish and English. Additionally, through a contract with AT&T Language Line Services, interpreter services for 140 languages can be accessed within seconds.

The hours the telephones are answered by live operators are from 7:30 a.m. until 6:00 p. m. Mountain Standard Time, Monday through Friday. The toll-free lines are answered by voice Messaging during the times not regularly staffed. Messages left on the Idaho *CareLine's* voice mailbox are returned immediately each morning. TDD services are also available for those with hearing disabilities and each customer service representative is trained in their use.

The database software, IRis, is specifically developed for information and referral purposes. The database is keyword driven making the database quickly accessible to

the operator. The database was upgraded in December 1997 and offers extensive case management options. The upgraded software allows for very intensive and specific information to be listed on each provider resource. The printing of paper directories for use by specific programs was also made available through the extended programming capabilities of the software upgrade. The database will continually be updated by making personal contact by phone or letter to each service provider. Research for new service providers is ongoing.

The Idaho *CareLine* is used by numerous programs to promote one general number for easy access to information about their specific program. The Immunization, WIC, Medicaid, CHIP, Infant Toddler, Oral Health, Breast and Cervical Cancer, adoption, foster care recruitment, and Child Injury Prevention programs are a few of those that have promoted use of the Idaho *CareLine* to their specific populations. Such promotion has resulted in increased useage. Calls received by the information and referral telephone line totaled 222 during October 1996, increased to 601 for September 1997, and now averaged over 1550 per month for FY 1999.

In the fall of 1998, the Idaho *CareLine* expanded its telephone service to include a statewide clearinghouse on children's services with the focus on early childhood development and health (**performance measure SP3**).

#### Population-Based Services

##### **Children**

During FY 2001, the Idaho Division of Health will contract with the Montana Department of Health and Human Services in the **Bunker Hill Medical Monitoring Service**. Montana has agreed to initiate a pilot program to provide medical monitoring services to current residents of Montana who used to work at the Bunker Hill smelter or who lived in the Silver Valley of Idaho between 1973-1981 and meet certain eligibility criteria. Residents of the Silver Valley will continue to receive lead health education and intervention information and blood lead screening through the Panhandle District Health Department and the Idaho Division of Health, Bureau of Environment Health and

## Safety (Figures 12 and 13).

As indicated in last year's application, the **Idaho Lead Awareness Project (ILAP)** was not funded into a fifth year due to lack of future funding for states that do not have legislation in compliance with the federal EPA lead abatement rules and regulations. Although the project has ended, answering public calls, making referrals, and maintaining the Blood Lead Registry will continue as a public health service to Idahoans and as indicated under *Infrastructure*, page 91, the Epidemiology program will continue investigations (**performance measure SP5**).

The **Oral Health Program** will contract with the district health departments during FY 2001 to conduct school-based fluoride mouth rinse programs for elementary-age children in fluoride deficient areas who are at high risk of developing dental caries. It will also work with various individuals, groups, organizations and agencies to promote oral health as an integral component of comprehensive health programs.

### Infrastructure Building Services

#### ***Pregnant Women, Mothers and Infants***

The **Perinatal Research Analyst** will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP). Projects will include the continuation of PRATS (Pregnancy Risk Assessment Tracking System), a survey of new mothers modeled after CDC's PRAMS survey. Additional projects will include, extensive analysis of access to prenatal care resources using Geographic Information System (GIS) technology, and analysis of the impact of prenatal care utilization on birth outcomes using the Kessner Index, R-GINDEX, and the APNCU (**performance measures 16, 17 and 18**). The data that is obtained will be used to coordinate local level interventions for areas identified with poor outcomes.

#### ***Children with Special Health Care Needs***

The **CSHP Program** will provide regional training opportunities for local dietitians in FY 2001. Additionally, all programs will provide training to district coordinators and

other contractors through annual meetings with state program staff.

### **All MCH Populations**

Goals for the **SSDI Program** during FY2001 are to: (1) work in conjunction with the CSHP Program to more accurately assess the number of CSHCN in the state, the number of CSHCN in the state who have a “medical/health home” (**performance measure 3**) and other issues identified through collaboration with the CSHP manager; (2) work in conjunction with the Idaho Newborn Hearing Screening Consortium to increase the reporting of newborns in the state who have been screened for hearing impairment before discharge (**performance measure 10**); and (3) coordinate with the Title V agency to continue the technical advisory group established for the MCH needs assessment to review and identify data sources for problematic MCH performance and outcome measures and health status indicators.

### **4.3 Public Input [Section 505 (a)(5)(F)]**

The FY2001 MCH Block Grant Application was available July 3, 2000 through July 7, 2000 for public review and comment throughout the state. This effort was coordinated by the Division of Management Services, Department of Health and Welfare. Copies of the block grant application were sent to three regional offices and a legal notice was placed in the respective news services. A legal notice informing the public of the opportunity and methods for comment was placed in the major newspaper for each area for three days prior to the start of the public viewing process. This year, the MCH Block Grant was sent to Region 4 (Boise), Region 6 (Pocatello), and Region 1 (Coeur d’Alene) for viewing. The grant application was available at the regional office for a one week period. Additional copies of the grant were available upon request. Copies were also provided to the Physical Health Directors from each district health department for comments. Comments from the district health departments were incorporated into the final document.

Due to the lack of attendance at past public hearings, public input was solicited in the above described manner rather than holding public hearings.

#### **4.4 Technical Assistance [Section 509 (a)(4)]**

Please see Form 15.

The Oral Health Program has requested TA on early childhood dental caries prevention. The suggested provider is Dr. Pete Domoto of the University of Washington.

### **SUPPORTING DOCUMENTS**

#### **5.1 Glossary**

##### **GLOSSARY**

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

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% of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

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 Children With Special Health Care Needs (CSHCN, see definition below) - 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 years 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 a chronic physical, developmental, behavioral, or emotional condition 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 (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death. Direct Health Care 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 of with Medicaid, WIC and educations. 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.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

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.

Jurisdictions - As used in the Maternal and Child Health block grant program: 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 Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

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 to 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, HIV/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.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

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. (See also, Jurisdictions)

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 State's 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 postpartum 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”.

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

## 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; © 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; (l) 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. 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;

(c) 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;
- (c) 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**

Figure 2A

Distribution of Program Activities

By Levels of Service and MCH Population Groups

Level of Service	Pregnant Women, Mothers, and Infants	Children 1-22	CSHCN	All MCH Populations
<b>Direct Health Care</b>	Genetics counseling; Family Planning clinics; Immunization clinics	Genetics counseling; Family Planning clinics; Immunization clinics	Genetics counseling; Immunization clinics; CSHP clinics	<b>Nutrition;</b> Genetics; counseling; Immunization clinics
<b>Enabling Services</b>	CareLine; Vaccine	CareLine; Vaccine	CareLine; CSHP; Vaccine	CareLine; Vaccine; Translation; Health education
<b>Population Based</b>	Metabolic screening; Immunization	Oral Health survey; Tobacco prevention; Adolescent pregnancy prevention; Immunization	CSHP; Nutrition; Immunization	Injury prevention; Immunization
<b>Infrastructure Building</b>	Perinatal analysis; Disease investigation/ surveillance; Child Mortality Review Committee; SIDS surveillance	Perinatal analysis; Disease investigation/ surveillance; Child Mortality Review Committee	Disease investigation/ surveillance; Child Mortality Review Committee	Planning and policy development; Training; Disease investigation/ surveillance; BRFS; Genetics education for Drs.

**Figure 10**

**Identified Needs in Idaho's MCH Population**

	<b>Direct Health Care</b>	<b>Enabling Services</b>	<b>Population Based</b>	<b>Infrastructure Building</b>
<b>Pregnant Women, Mothers, and Infants</b>	Improved access to contraceptive services	Increased health education on substance and physical abuse; Increased prenatal care utilization	Increased immunization rates	Increased "cluster" investigations/surveillance; Increased data capacity
<b>Children 1-22</b>	Improved access to contraceptive services	Increased health education on substance and physical abuse; Increased access to care	Increased immunization rates; Reduced injury morbidity/mortality; Reduced suicide mortality; Improved access to abstinence messages	Increased "cluster" investigations/surveillance; Increased data capacity
<b>CSHCN</b>	Continued access to clinics for children with special health care needs	Increased # of Medicaid eligibles; Increased access to care	Increased immunization rates	Increased "cluster" investigations/surveillance; Increased data capacity

**Figure 11**  
**Phase00.new**

	FFY 1997	FFY 1998	FFY 1999	FFY 2000	FFY 2001	Receipts	Program	
	Allocation	Allocation	Allocation	Allocation	Projection	Allocation	Total 2001	
<b>Maternal &amp; Infant Services</b>								
MCH Management 03-800	\$20,158	\$21,868	\$22,530	\$23,562	\$24,390		\$73,170	MCH Management
Breastfeeding			\$10,000	\$15,000	\$15,000		\$15,000	Breastfeeding Project
Hearing Projects			\$10,000	\$10,000	\$10,000		\$10,000	Hearing Project
SIDS				\$16,000	\$16,000		\$16,000	SIDS
State Epi 03-830	\$83,431	\$90,431	\$100,150	\$98,160	\$102,399		\$307,197	State Epi
Genetics 03-840	\$12,000	\$12,000	\$12,000	\$12,000	\$12,000		\$12,000	Genetics
CareLine 06-275-350	\$86,000	\$86,000	\$61,000	\$20,000	\$16,000		\$48,000	CareLine
Immunization 03-420	\$76,885	\$76,885	\$76,885	\$76,885	\$76,885		153,770	Immunization
Perinatal Assessment 06-165-650	\$42,448	\$69,822	\$53,880	\$53,880	\$101,000		\$101,000	Perinatal Assessment
Reproductive Health 03-860	\$454,162	\$226,837	\$224,051	\$224,051	\$224,051		\$738,548	Reproductive Health
SSDI/Needs Assessment	\$21,000	\$0	\$0	\$5,000	\$0		\$0	SSDI/Needs Assessment
	<b>\$796,084</b>	<b>\$583,843</b>	<b>\$570,496</b>	<b>\$554,538</b>	<b>\$597,725</b>			
<b>Children &amp; Adolescents</b>								
MCH Management 03-800	\$20,158	\$21,868	\$22,530	\$23,562	\$24,390			
State Epi 03-830	\$83,431	\$90,431	\$100,150	\$98,160	\$102,399			
Oral Health 05-150	\$337,084	\$237,000	\$252,000	\$252,000	\$352,000		\$352,000	Oral Health
Reproductive Health 03-860	\$302,774	\$529,285	\$514,497	\$514,497	\$514,497			
Immunization 03-420	\$76,885	\$76,885	\$76,885	\$76,885	\$76,885			
Adolescent Health 05-550-100	\$180,572	\$0	\$0	\$0	\$0		\$0	Adolescent Health
Injury Prevention 05-400-100	\$87,000	\$197,000	\$17,000	\$10,000	\$10,000		\$10,000	Injury Prevention
SSDI/Needs Assessment	\$21,000	\$0	\$0	\$5,000	\$0			
CareLine 06-275-350				\$20,000	\$16,000			
	<b>\$1,108,904</b>	<b>\$1,152,469</b>	<b>\$983,062</b>	<b>\$1,000,104</b>	<b>\$1,096,171</b>			
<b>Children's Special Health</b>								
MCH Management 03-800	\$20,158	\$21,868	\$22,531	\$23,562	\$24,390			
State Epi 03-830	\$83,431	\$90,431	\$100,150	\$98,160	\$102,399			
CSHP Oral 03-815	\$0	\$0	\$0	\$0	\$0			
CSHP Nutrition 03-815	\$0	\$0	\$0	\$6,000	\$6,000		\$6,000	CSHP Nutrition
CSHP 03-815	\$981,068	\$1,158,350	\$1,381,265	\$1,326,937	\$1,191,616	\$160,000	\$1,351,616	CSHP
SSDI/Needs Assessment	\$21,000	\$0	\$0	\$5,000	\$0			
CareLine 06-275-350				\$20,000	\$16,000			
	<b>\$1,105,657</b>	<b>\$1,270,649</b>	<b>\$1,503,946</b>	<b>\$1,479,659</b>	<b>\$1,340,405</b>			
<b>Indirect</b>	<b>\$245,000</b>	<b>\$245,000</b>	<b>\$245,000</b>	<b>\$268,877</b>	<b>\$268,877</b>		\$268,877	Indirect
<b>TOTAL</b>	<b>\$3,255,645</b>	<b>\$3,251,961</b>	<b>\$3,302,504</b>	<b>\$3,303,178</b>	<b>\$3,303,178</b>	\$160,000	\$3,463,178	<b>TOTAL</b>

## 5.4 Core Health Status Indicator Forms

## 5.5 Core Health Status Indicator Detail Sheets

## 5.6 Developmental Health Status Indicator Forms

## **5.7 Developmental Health Status Indicator Detail Sheets**

## 5.8 All Other Forms

## **5.9 National “Core” Performance Measure Detail Sheets**

## 5.10 State "Negotiated" Performance Measure Detail Sheets

## 5.11 Outcome Measure Detail Sheets