

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: CO

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Colorado first placed its Maternal and Child Health Block Grant, the application for FY 2000, online for review and public input in 1999. Since that time, all narratives have been placed online. Users find on-line access to the grant very convenient, and comments throughout the year are solicited through a return email function on the website.

A draft version of the FY 2005 grant application was placed on the state health department's website this year on May 27, 2004. Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 15, 2004 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application Title V Application/Annual Report for FY 2005 will be available on the department website. Visitors to the website will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available.

A link to a map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

/2001/ /2002/

(Throughout the grant, this heading indicates text that was written in the spring of 2000 for the FY 2001 application submitted July 15, 2000. The text was then revised in the spring of 2001 for the FY 2002 application submitted on July 15, 2001)

Colorado is the seventh largest state in the continental United States and covers 103,600 square miles. Large mountains divide the state into eastern and western halves and serve as the origin of five major U.S. rivers. The western part of Colorado, a vast area known as the Western Slope, is mountainous, with 54 peaks rising over 14,000 feet above sea level. The eastern part is covered by flat plains that support farming and grazing. In the middle of the state, spread north and south along the eastern edge of the Rocky Mountains, is an increasingly populated zone known as the Front Range, which contains most of the state's residents, much of the state's recent population growth, and most of the state's economic activity. In the southern third of the state, by contrast, lies an area with a small population, an elevated poverty rate, and a lower level of economic activity.

The mountains, while very beautiful and the major reason for Colorado's strong tourist industry, present a massive physical barrier to the provision of health care across the state. The rural vastness of much of the state is confirmed by 23 of Colorado's 63 counties qualifying as "frontier counties," containing fewer than 6 persons per square mile. Nonetheless, the population of Colorado was counted in the 2000 Census at 4,301,261, an increase of over one million people since the 1990 Census, when 3,294,394 were enumerated, and the number of frontier counties declined by seven from the 30 counted in 1990. The growth in the past decade, the growth in virtually every county, and the growth particularly since 1995, has been rapid and unprecedented in its size. Growth has occurred to such an extent that the Census Bureau found Colorado's 31 percent increase in population over the decade to be the third highest rate among all the states. Population growth has been particularly strong in the Front Range area, with Douglas County south of Denver showing the highest rate of growth of any county in the U.S., essentially tripling in size between 1990 and 2000, growing from 60,391 to 175,766.

The number of births in the state increased from 53,491 in 1990 to over 65,000 in 2000. The strong Colorado economy, with its exceptionally tight labor force, has encouraged migration to the state to fill jobs in the construction, service, and high technology industries, and in metropolitan and resort areas. The migration of young Hispanic workers and their families has been especially noticeable. In 1990, 9,131 births were to Hispanics; in 2000 the number had nearly doubled to 17,817. Migration of these workers is evident especially in many of the western counties of the state, which have experienced a large influx of population. Many small counties have experienced growth that has also severely strained housing availability.

The increase in the Hispanic population statewide between 1990 and 2000 amounted to 311,299, rising from 424,302 at the beginning of the decade (13 percent of the total population) to 735,601 (17 percent of the total) at the end. While much of the growth is made up of U.S. citizens and immigrants who are in the U.S. legally, some substantial but unknown amount of growth consists of undocumented workers and their families who are not legal residents. All children born in the United States are U.S. citizens and eligible for a variety of government programs, regardless of the status of their parents, but the parents themselves, if they are undocumented, are not eligible for government-funded health care benefits other than emergency Medicaid.

In 2000, the state's unemployment rate reached a record annual low of 2.7 percent, below the 2.9 level found in 1999, and the lowest ever in a series that dates back twenty-three years. The improvements in the state's economy have been accompanied by decreases in poverty statewide. The U.S. Census Bureau estimated an overall poverty level of 10.2 percent in 1997 (the most recent year available), compared to 11.7 percent found in 1990. Declines have also occurred in the poverty level found among children. According to the 1990 Census, 15.3 percent of children under 18 were

below 100 percent of the federal poverty line; the most recent estimate for all children is 14.6 percent (1997). This level implies that there are 161,000 children living below the poverty line in Colorado, as well as at least 100,000 women of childbearing age who also fall in this category.

While Colorado has a strong state economy, there are disparities in the health status of different populations. These are easily noted when making racial/ethnic comparisons of different indicators of access to care, such as first trimester prenatal care, or unintended pregnancy. The racial/ethnic groupings are closely tied to socioeconomic status, which is not well captured from vital statistics data. There are also disparities in different geographic areas of the state, some related to the poverty of the populations (e.g. in the south) and some related to the long distances to metropolitan areas with appropriate services (e.g. in the northwest). A discussion of disparities is included in the Year 2000 Needs Assessment.

/2003/

(Throughout the grant, this heading indicates text that was written in the spring of 2002 for the FY 2003 application submitted on July 15, 2002)

Colorado's population growth is projected to reach 4,487,727 in 2002, nearly 200,000 higher than the 2000 Census. However, with a strong downturn in the local economy in the last year the pace of population growth may have slowed. It is not known if the changes in the economy have prompted people to leave the state, or if newcomers continue to arrive. The number of births in 2001 reached 67,006, an increase of 2.4 percent over the previous year, but well below increases in the previous two years of 4 and 5 percent annually.

The unemployment rate in 2001 was 3.7 percent, compared to 2.7 percent the previous year. In March of 2002, the rate was 5.8 percent, a great deal higher than in 2001, but still a drop from the January 2002 high of 6.0. Problems in the high technology and communications sectors of the economy have contributed to the overall level of unemployment.

During periods of economic downturn, disparities in access to health care and in health outcomes become more pronounced according to race and ethnicity. The lack of access to prenatal care for women who are undocumented workers is clearly an issue that needs to be addressed immediately for Colorado to be able to improve the health outcomes of its youngest residents who are themselves citizens.

/2004/

(Throughout the grant, this heading indicates text that was written in the spring of 2003 for the FY 2004 application submitted on July 15, 2003)

The population for Colorado in 2003 is now estimated to be 4,550,000, continuing to increase from 2002 but at a far slower rate than in the decade of the 1990s.* Short-term economic forecasts show net migration to have been 21,000 in 2002 and 25,000 in 2003. These numbers are significantly lower than the 43,000 and 29,000 forecast previously, and show the impact of increased unemployment in 2002. The unemployment rate in 2002 reached a total annual average of 5.7 percent, up two full percentage points from the annual average in 2001. In April 2003, the rate rose to 6.0 percent, suggesting further change in the unemployment picture.

A preliminary estimate of 2002 births in Colorado is 68,234, up 1.8 percent from the 2001 total of 67,006 births. The 2001 data reveal that now nearly one in every six births is to a woman who was born in Mexico or Central or South America; the total number of births for this group is 10,564. These births present an increasing challenge to the health care system because many of the women lack health insurance and/or access to the health care system. Although the children born here are U.S. citizens, access to care and coverage for them are also extremely problematic.

As a result of the recent economic downturn, state budget problems resulted in changes to many programs. In the spring of 2003, an enrollment cap of 53,000 was placed by the legislature on the

Child Health Plan Plus, Colorado's insurance plan for low-income children who do not qualify for Medicaid. As of the end of March 2003, the number of children enrolled was 48,679, and the cap is anticipated to be met by November 2003. The imposition of the cap means that a number of children will remain uninsured who would have otherwise qualified for the program.

In addition, a program begun in the fall of 2002 that allowed pregnant women of any age who qualified under the income guidelines for the Child Health Plan Plus to be enrolled in the program for prenatal care, was halted on May 5, 2003 by the state legislature. An anticipated 3,000 women would have been served annually by the program. Due to the state budget situation, funding for this program is no longer available, although women enrolled by May 5 will receive coverage throughout their pregnancies.

The state of Colorado's health care system in 2003 also is impacted by the federally-funded community health center system. While Colorado has many clinics across the state, there are not enough to serve the current demand, and waiting lists for services are long. Furthermore, in some areas there are no community health centers and few private providers that are available and willing to accept Medicaid and Child Health Plan Plus patients. One of these counties is El Paso County, where Colorado Springs is located. This county contains the most children out of all 64** counties in the state--147,000 under age 18--one out of every eight children in the state.

In 2003 the community health center system did add four new delivery sites as a result of the President's Initiative to expand capacity at community health centers. In addition, community health centers expanded their capacity to meet the mental health and oral health needs of their patients. Nonetheless, CHCs, like other safety-net providers, are experiencing greatly increased demand due to the increased number of uninsured in the state, at the same time as state and local resources are diminished.

Colorado is one of only a few states that limits its Medicaid and Child Health Plan Plus benefits to the federal minimum requirements. The state's limit on Medicaid is at 133 percent of the federal poverty line, and the limit for the Child Health Plan Plus is at 185 percent. In addition, few services are available for immigrants in general, although prenatal care is provided on a limited basis by some counties and community health centers.

* A Census Bureau study reported in the spring of 2003 that Colorado's 2000 Census was the most accurate count of any state. Population estimates for years since 2000 use that year's count as a starting point.

** Broomfield County was created in November 2001, changing the number of counties from 63 to 64. It is located in the metropolitan Denver area and consists of parts of Adams, Boulder, Jefferson, and Weld counties.

/2005/

(Throughout the grant, this heading indicates text that was written in the spring of 2004 for the FY 2005 application submitted on July 15, 2004)

Colorado's population in 2004 is now estimated to be 4,626,200, 76,000 more than the 2003 population, but only a 1.7 percent increase from the previous year. An estimated 36,300 people (net change) arrived in Colorado in the past year, while there were 69,138 births and 29,410 deaths. The unemployment rate shows a change from the 5.7 percent annual average in 2002 to 6.0 for 2003. The Colorado unemployment rate and the U.S. rate for 2003 were the same.

Births in Colorado rose only 1.0 percent from 2002 to 2003, one of the smallest increases in many years. Nonetheless, the number of births to women who themselves were born in Mexico or Central or South America reached 11,478, up 8.7 percent from 10,564 in 2002. These women and their infants continue to present an enormous challenge to the health care system. Births to all foreign-born women totaled 16,020 in 2002, in fact, and insurance coverage for the 4,542

mothers from other countries is not assured either.

The state's budget problems continued. During the 2004 legislative session a number of attempts to balance the budget were proposed. Tobacco securitization was seen as a way to infuse \$900 million into the state budget, but legislation to make this happen did not pass. A constitutional amendment limiting state revenues may create budget challenges in the future. However, legislation using Tobacco Settlement funds to balance the budget passed at the end of the session.

The enrollment caps in the Child Health Plan Plus program and for prenatal care remained in place for most of the year, but were lifted on July 1, 2004. This change will be a very positive development that should improve access for some Colorado residents.

The judicial decision regarding the elimination of Medicaid eligibility when optional for legal immigrants, as required by 2003 Colorado legislation, was issued in the spring of 2004. The ruling allows the state to go forward with removing certain immigrants, including 905 children currently eligible, from Medicaid. However, the Centers for Medicare and Medicaid has clarified to the state that such children must be made eligible for the Child Health Plan Plus program. Legislation was proposed and enacted in the 2004 session that would require the state to assure that immigrant children are put on the Child Health Plan Plus program when they lose their Medicaid coverage.

The Department of Health Care Policy and Financing is also considering applying for a waiver in 2005 under the Health Insurance Flexibility and Accountability (HIFA) Initiative of 2001. The waiver would allow the state to combine Medicaid and Child Health Plan Plus benefits for children and youth in one program. The intent is to remove barriers to participation through a more streamlined system.

The effort to secure a Family Planning Medicaid waiver that would allow provision of contraception to low-income women and men up to 150 percent of poverty was first prepared by the state health department and the Colorado Department of Health Care Policy and Financing, and was submitted to the Centers for Medicaid and Medicare in 2000. Four years have passed as questions and responses have been exchanged, and as the requirements of the application have been modified by CMS. In the spring of 2004 the Colorado Department of Health Care Policy and Financing considered withdrawing the application, but no final decision has yet been made.

For the first time, a national random sample survey, conducted between 2000 and 2002, provides Colorado-specific estimates of the number of children with special health care needs in the state. A total of 11.7 percent of all children fall in this category, meaning that 169,000 children have health care needs above and beyond those of other children. This survey provides a great deal of new information that informs the work of the state's Health Care Program for Children with Special Needs. //2005//

State Health Department and Title V Priorities

/2001/ /2002/ /2003/

In 1998, the Title V program of the Colorado Department of Public Health and Environment determined ten priority areas for its maternal and child health efforts; in 2000 the list was changed slightly in response to the five-year MCH Needs Assessment completed that year. These areas have great impact on the health of women and children in the state. If addressed appropriately, the health of women and children will be improved; if ignored, their health will be compromised. It is the task of the state agency to highlight these areas, provide information, data, and interpretation of the issues, suggest systemic ways to address the issues, and ensure implementation of logical means for

improvement.

The Colorado Department of Public Health and Environment's strategic plan, "Challenges and Opportunities for a New Century," was published in September 1999 and focuses on a number of areas related to the health of women and children. Prevention is considered to be a critical investment area, particularly in the area of lifestyle behaviors, including tobacco use among teens. Immunizations for children are considered a key investment, as well as unintentional and intentional injury reduction, especially suicide prevention among adolescents. Addressing disparities in health status among groups most at risk is also considered important. The reduction of infant mortality among black infants relative to white is singled out as another critical marker. Also, education of state residents is considered an important strategy to improving health among Coloradans.

The ten priority areas for maternal and child health are consistent with the department's strategic plan. They are listed below, and it is clear that virtually all fall under the heading of prevention.

Prevention

- Reducing teen pregnancy and unintended pregnancy in women of all ages,
- Reducing child and adolescent morbidity and increasing health and safety in child care settings,
- Reducing overweight among children and adolescents,
- Reducing unintentional and intentional injury,
- Increasing access to health care (including behavioral health care),
- Improving state and local infrastructure by increasing capacity to analyze data, carry out evaluations, develop quality standards, etc.
- Reducing substance abuse (tobacco, alcohol, illicit drugs),
- Improving oral health and access to oral health care.

Immunizations

- Improving immunization rates for all children.

Infant Mortality

- Improving perinatal outcomes.

Title V resources are directed toward these ten priority areas. Access to care issues are addressed by the Prevention Services Division, and Colorado's child health insurance program, Child Health Plan Plus (also known as CHP+), is a relatively new source of insurance for many low-income children.

/2004/

Colorado's Medicaid program, one of the "leanest" in the country, was cut for legal immigrants. While many of the participants that were affected were elderly, some pregnant women and children were affected. Legal challenges to the cuts are ongoing and unresolved. The impact of the cuts, however, would be a clear reduction in access to health care for this underserved group.

Cuts for programs run by the state health department include the following: a cut of \$455,741 in immunization funds, \$1,162,461 in Children with Special Health Care Needs funds, and \$2,961,339 in Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funds.

Colorado's STEPP program (State Tobacco Education and Prevention Program), dependent on tobacco settlement funds, was cut by about 75 percent. Plans for FY 2004 had been made before the cuts for \$15 million in funding. At the end of the legislative session, only \$3.6 million remained. This program focuses on tobacco cessation and the prevention of tobacco initiation, and affect the health of the one in three adolescents, one in five Colorado adults, and one in ten pregnant women who smoke. The reduction in funds severely curtails the work of these programs, especially in the area of prevention, and especially at the local level.

The Tony Grampas Youth Services Program (TGYS), a youth crime prevention program, was

removed from the state budget in January 2003, a change amounting to \$9.3 million over two years. This move greatly reduced the state's prevention work for youth. At the state health department, one-third of the TGYS staff of the Division of Prevention and Intervention Services for Children and Youth had to be reassigned or were laid off; and local youth now are less likely to receive a range of prevention and intervention services. In addition, coordination across agencies, with projects like common grant applications, common reporting forms, common evaluation expectations, joint site visits, and technical assistance are now essentially in abeyance.

Cuts in Child Health Plan Plus affecting pregnant women and the number of children covered have resulted in a reduction in the capacity of the state to assure access to health care for women and children. Furthermore, an increasing number of undocumented women and children, primarily from Mexico, continue to lack access to care.

The impact of these cuts on Colorado's progress toward meeting the national and state performance measure targets in FY 2003 and FY 2004 remains unknown at this time. Progress in FY 2002 was limited, with 15 out of 24 measures with specified targets not being met. Progress in FY 2003 is not expected to be better and may be worse, especially in the areas of immunization, child maltreatment, teen violence, child health insurance, and women's access to prenatal care.

While the changes since last year's grant submission are overwhelmingly disheartening, several bright spots emerged in 2003. The state health department, in conjunction with the state department of education, received a substantial federal grant to improve health through a focus in schools on nutrition, physical activity, tobacco, and abstinence-based HIV/AIDS prevention. In addition, federal monies to develop a plan for a comprehensive early childhood system in Colorado that includes access to health care, mental health, early care and education, parent education, and family support services, were also received. Finally, the state health department Health Statistics section, in cooperation with the MCH program and other health-related programs outside the state health department, made plans to begin a Child Health Survey in January 2004. This population-based survey will allow assessment of the health of Colorado children age 1-14, an age group for which there is currently little data.

/2005/

Immunization continues to be a high priority area for the state. Data released in August 2003 showed that Colorado had the lowest immunization rate for 19 to 35 month old children of all the states, a level of 64.3 percent. Funding for Colorado's immunization program will be increased by \$500,000 beginning July 1, 2004.

Infant mortality is also a high priority area for the department. An in-depth analysis was undertaken in the fall of 2004 and a detailed report is now available. This can be found at www.cdphe.state.co.us/ps/mch/Infantmortality/Mortalityreport.pdf, and is also attached to this section. The report concludes that current efforts to reduce infant mortality must be doubled in order to attain the Healthy People 2010 goal by the end of the decade.

Another high priority area for the state health department is the epidemic of overweight in the population. During the past year the Colorado Physical Activity and Nutrition Program, COPAN, has begun to develop a wide-ranging plan to improve the health of Coloradans by increasing physical activity as well as improving nutrition.

Improving oral health is yet another high priority area, but implementing evidence-based preventive oral health strategies continues to be problematic. Due to several communities discontinuing community water fluoridation (Kremmling, Pueblo West, and Telluride) and an increased population in areas currently not fluoridating, the percentage of Coloradans on public water systems served by optimal levels of fluoride has dropped to 74.6 percent, below the Healthy People 2010 objective of 75 percent, which Colorado originally met in the late 1980's. This is not a situation unique to Colorado. The Oral Health Program continues to place

major emphasis on assuring that communities have correct information about the value of fluoridation.

Access to health care is also a priority area for the department. Colorado was selected to participate in the national Medical Home Learning Collaborative in 2004, where medical practices received direct, practical training on how to set up a medical home for children with special health care needs. The training for the participating private pediatric practices was very successful.

Little progress has been made in meeting the national and state performance measures for a variety of health outcomes and risks in the past year. Among 22 objectives that could be measured (out of 28 total), targets set for FY 2003 were met for five. //2005//

B. AGENCY CAPACITY

The MCH Section works with other state health department divisions and programs to promote and protect the health of all mothers and children, including children with special health care needs (CSHCN). The State Overview, Section III A, described the characteristics of Colorado's population and laid out some of the challenges currently facing the state. This section provides information on the state health department's capacity to carry out its mission.

The following section describes the state's program for children with special health care needs, grouped under four headings. These headings were formerly the four "constructs" that were required in the previous MCH Block Grant application format. We provide an abbreviated account of what was written previously for FY 2001, 2002, and 2003. FY 2004 is shown next, followed by FY 2005 in the italicized sections. The fiscal years refer to federal fiscal years ending in September of the year shown.

State Program Collaboration with Other State Agencies and Private Organizations for Children with Special Health Care Needs

/2001/ /2002/ /2003/

Colorado has many strong interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services. One strong interagency group continues to be the Colorado Interagency Coordinating Council for Part C, made up of representatives from the Colorado Departments of Education, Human Services, Health Care Policy and Financing, Public Health and Environment, and the Insurance Commission. This interagency group is assisting with the integration of the early childhood system with Title V CSHCN public health services and supports.

In November 2002, the Health Care Program for Children with Special Needs (HCP) engaged in the Measuring and Monitoring Systems of Care for Children with Special Health Care Needs (M&M) project aimed at identifying data sources and professionals across agencies.

The Colorado Medical Home Initiative has introduced us to new partners who will work with HCP to implement strategies to increase the number of medical homes for CSHCN. The Medical Home Advisory consists of a broad array of professional and advocacy organizations as well as primary and specialty health care practitioners.

/2004/

In 2004, our Medical Home Initiative will complete the second half of the Medical Home Learning Collaborative project. We will continue to foster relationships with the Medical Home Advisory Board

members and will initiate marketing strategies to inform families and partner agencies of our new statewide role in building medical homes for all CSHCN in Colorado. We are working closely with Medicaid's Quality Assurance and EPSDT Outreach programs. This collaborative relationship is reflected in our FY 2003-2004 Memorandum of Understanding.

/2005/

In 2005, HCP will investigate collaborative relationships with the M&M data group and the Child, Adolescent School Health Section to address the Early and Continuous Screening Outcome Measure and the Adequate Insurance Measure. We will develop new plans for the Medical Home Initiative and implement new funding resources for Traumatic Brain Injury care coordination and care coordination for families who have babies in the Neonatal Intensive Care Units across the state. //2005//

State Support for Communities for Children with Special Health Care Needs

/2001/ /2002/ /2003/

The Health Care Program for Children with Special Needs (HCP) places strong emphasis on supporting community systems building through local contracts and state consultation. We continue to focus on the implementation of multi-disciplinary teams to provide technical assistance, training, and consultation statewide.

The implementation of the IRIS (Integrated Registration and Information System) data system provides an example of support to communities. Local users now have access to information about the clients they serve and the ability to run community-level reports.

In FY 2002, there was an increase in consultation to local health departments in national and state data usage with an emphasis on data-driven MCH community planning.

/2004/

Elimination of paid medical services on June 30, 2003, has changed the HCP program focus. This change was due to HIPAA requirements for medical transactions and the long-term difficulties in maintaining such services. The program now can fulfill the direction of the MCH pyramid and core public health functions.

/2005/

In 2005 there will be increased emphasis on supporting the small county nursing agencies. In 2004 they received their first Health Care Program for Children with Special Needs (HCP) contracts as a result of discontinuing direct services. They will also participate in the Traumatic Brain Injury care coordination project. //2005//

Coordination with Health Components of Community-Based Systems for Children with Special Health Care Needs

/2001/ /2002/ /2003/

Public health nurses, with the support of their multi-disciplinary teams at the regional level, work to assure that there is coordination at the local level among the services needed by families and children.

HCP specialty outreach clinics are also instrumental in coordinating health services in rural areas. HCP pays for pediatric specialty providers to attend clinics where those providers are not available.

Local public health nurses coordinate the clinics and assure followup services.

Many communities have local Newborn Hearing Screening and Intervention Consortiums or Task Forces. There are also local Neonatal Intensive Care Unit (NICU) Consortiums in many communities. These groups consist of Part C coordinators, Child Find staff, home health agency representatives, and community centered board case managers who work to coordinate efforts while providing developmentally supportive care to babies.

HCP continues to support a community resource nursing consultant at the Children's Hospital. Responsibilities of this part-time position include assuring that families receive assistance in finding meals and lodging while their children are hospitalized in Denver, and assisting families in registering with HCP, Medicaid, Child Health Plan Plus and SSI.

HCP was very involved in the statewide planning for traumatic brain injury in 2001-2003. This allowed important connections with the Brian Injury Association of Colorado and the Department of Human Services. Recent legislation was passed to create a Traumatic Brain Injury (TBI) Trust Fund. The HCP director was appointed by the governor to the Advisory Board for the TBI Trust Fund.

/2004/

HCP will increase consultation to primary care settings and to other agency coordination services in each community in 2004. HCP provides medical and technical information that many of the coordination services (Developmental Disabilities, Part C, EPSDT) do not provide.

/2005/

In 2005, HCP will increase involvement with the Part C NICU Liaison project to assure that the medical needs of these babies are met. Part C is considering providing funding to HCP for these additional care coordination services. July 1, 2004 was the implementation date for the Interagency Agreement with the Department of Human Services to provide care coordination services to children with traumatic brain injury using new TBI Trust Fund dollars. //2005//

Coordination of Health Services with Other Services at the Community Level for Children with Special Health Care Needs

/2001/ /2002/ /2003/

Local HCP public health staff work especially closely with Part C coordinators to assure that early intervention services are coordinated. Most HCP local staff is also involved in other interagency work such as serving on child protection teams and working with school districts to support parents in special education staffings and developing Individual Education Plans or Individual Family Service Plans.

As of FY 2002, there were 16 Parent Advocates in the 14 local HCP regional offices. Through collaborative efforts with our new Family Voices chapter in Colorado, these parents will also be recipients of Family Voices information, training, legislative updates, and will act as a network for both Title V and Family Voices.

In FY 2003, due to budget reductions, HCP discontinued specialty medical services for children age 0-3. This decision was made in conjunction with Part C and the Colorado early childhood system agencies. The transition was managed well and HCP is now seen as a necessary technical resource, especially for nutrition services in communities.

/2004/

In addition to increased consultation with local agencies and PCPs, HCP will try to access private

resources systematically. Reductions in public funds have required more attention to seeking private funds.

/2005/

In 2005, the HCP parent consultants, in collaboration with Family Voices Colorado, will continue to organize parent groups, faith-based organizations and businesses in local communities to meet health resource needs of families. All HCP offices will provide follow-up on newborns who have missed a hearing screen or need a diagnostic test, functioning as lead offices of the Birth Defects Notification program. //2005//

State Statutes Relevant to Title V Programs

/2001/ /2002/ /2003/

Colorado does not have a statute related specifically to maternal and child health. Under the Colorado Revised Statutes (CRS)1973, however, it is stated that regional health departments "shall include to the greatest extent possible, but not be limited to: (a) Personal health services, including: Communicable disease control; . . . maternal and child health services...." The state health department has always carried out its MCH activities under Titles 25 and 31, the general statutory authority for the department's operation. In 1983, authority to operate a program for children with special health care needs was granted under Title 25 as well.

Colorado also has specific statutes regarding newborn screening. The Newborn Screening and Genetic Counseling and Education Act was added to Title 25 in 1981. This act established the department's obligation to administer programs for newborn screening, and specifically mandated testing for phenylketonuria, hypothyroidism, abnormal hemoglobins, galactosemia, homocystinuria, and maple syrup urine disease. Testing for cystic fibrosis was added in 1987, and biotinidase deficiency was added in 1988. The legislation was then revised to allow the State Board of Health to update the list of mandated tests without further legislation.

In 1997, legislation was passed concerning newborn hearing screening at Colorado hospitals. In 2001, legislation was passed concerning an immunization registry for the state.

The 2002 legislature expanded coverage for pregnant women through Child Health Plan Plus up to 185 percent of poverty. The legislature also passed a measure to create an Office of Homeless Youth placed in the Division of Prevention and Intervention Services for Children and Youth. Finally, the legislature passed a child booster seat law effective in 2003.

/2004/

The 2003 legislature placed a cap on enrollment in Child Health Plan Plus for the total number of children that could be served, and removed pregnant women over the age of 18 from the Plan. In addition, new legislation required WIC staff to report child abuse and neglect, and mandated secure and verifiable identification for its participants.

/2005/

The enrollment caps for the Child Health Plan Plus program for children and pregnant women were removed on July 1, 2004.

The MCH Title V program is administered by the Office of Maternal and Child Health in the Division of Prevention and Intervention Services for Children and Youth. The legislature officially changed the name of the division to the Prevention Services Division during the 2004 session.

The right of a woman to breastfeed in public was approved in April 2004, as the legislature recognized the short- and long-term health benefits of breastfeeding for the infant, and sought to remove societal boundaries to its practice.

Legislation increasing the age for driver license permits was passed in May 2004, strengthening the existing Graduated Drivers Licensing law. In addition, a learner's permit will last for one year instead of six months.

In July, 2002, legislation had been passed to create a Colorado Traumatic Brain Injury Trust Fund and a TBI Board within the Department of Human Services. In July 2004, an Interagency Agreement between the state health department and the Colorado Department of Human Services was implemented to provide Trust Fund dollars for Title V care coordination services for children with special health care needs. //2005//

State Title V Capacity to Provide a Variety of Services

A description of the state's Title V capacity to provide a variety of services is provided below under the following four headings: 1) Preventive and Primary Care Services for Pregnant Women, Mothers and Infants; 2) Preventive and Primary Care Services for Children; 3) Services for Children with Special Health Care Needs, and 4) Culturally competent care that is appropriate to the state's MCH population.

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

Women's Health Services

/2001/ /2002/ /2003/

Women's Health Services provides a small amount of funding for direct prenatal care and population-based enhanced services to women through organized health departments, community health centers, and local nursing services in those communities where uninsured women would otherwise not be served. Direct care is in the form of clinical prenatal care, and enhanced services include preventive services such as smoking cessation and nutritional counseling provided through the Medicaid-funded Prenatal Plus Program.

/2004/

We are still providing direct prenatal care services for about 500 clients per year. Case management, nutrition and psychosocial counseling are being provided to Medicaid-eligible pregnant women through the Prenatal Plus program.

/2005/

During FY 2004 care was provided to 500 clients. However, beginning in FY 2005, care will be reduced to half that number, and we anticipate reducing the number further to no patients in FY 2006. This is due to a decrease in the total amount of MCH block grant funds, and a shift away from direct care, toward population-based, infrastructure-building, and enabling types of services. //2005//

Newborn Screening Program and Newborn Hearing Screening Program

/2001/ /2002/ /2003/

The Newborn Screening Program provides screening at birth and again at 8 to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. More than 1,000 presumptive positive screens are followed annually to make sure that affected infants are diagnosed

and receive timely referral and treatment. Similarly, the Newborn Hearing Screening Program tests the hearing of infants at birth and identifies and refers about 120 deaf and hearing-impaired infants each year. The Early Hearing Detection and Intervention Program (EHDI) received funding beginning in October 2000, and this five-year grant enables a cross-program integration of data (see Section III C for more information). A pilot vision screening program was also started in FY 2002. Vision screening equipment and screening programs are located in six sites across the state.

/2004/

In 2004, the vision screening program will develop a data collection system that will be integrated into the EHDI system. A pilot project grant has been submitted to enhance followup to vision screening in a small rural community. HCP will also hire part-time vision consultants to join our 14 regional multi-disciplinary teams across Colorado.

/2005/

No changes. //2005//

/2004/

Nurse Home Visitor/Nurse Family Partnership Program

The Nurse Home Visitor/Nurse Family Partnership Program, funded through the tobacco settlement, provides intensive nurse home visitation to first-time, low-income mothers during the prenatal period to the child's second birthday.

/2005/

See Section IV D, State Performance Measure 3, for more information on the Nurse Home Visitor/Nurse Family Partnership Program. //2005//

The Family Healthline

The Family Healthline is a statewide information and referral service in the MCH Section. Healthline resource specialists assist women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists speak fluent Spanish and English. Special arrangements are made for assisting the hearing impaired and speakers of other languages. (See Section IV E. for further information.)

/2005/

See Section IV E for more information. //2005//

Population-Based Education Programs

Folic Acid

/2001/ /2002/ /2003/

Although the effectiveness of folic acid in reducing the risk of neural tube defects (NTDs) has been known for a number of years, there is an urgent need to make more women aware of this information and to convince them to act on it. The state health department began to focus on NTD prevention in a collaborative way in 1998 with the formation of the Folic Acid Task Force. The focus of the group has been to design and implement programs that will increase folic acid consumption among women of

childbearing age in Colorado. A campaign directed at lower-income Hispanic women and their health care providers was started, and the Colorado Responds to Children with Special Needs program funded folic acid questions in the state's Behavioral Risk Factor Surveillance Survey.

/2004/

Task Force representatives sponsored an exhibit at the September 2002 Colorado Public Health Association conference. Activities in 2002 also included radio spots, theater slides, and newspaper ads targeted at an Hispanic audience.

/2005/

The Folic Acid Task Force put together a mailing packet of brochures from the March of Dimes and the Spina Bifida Association about folic acid which was sent to 110 local health clinics in March 2004. In addition, a banner listing foods high in folic acid, benefits of folic acid, and appropriate dosages, was created for display at health conferences. A focus on the Hispanic population using radio, TV, and health fairs continues. Finally, interviews with women who have had a neural tube defect-affected pregnancy or child continue to be conducted to ascertain their access to support organizations and information about appropriate folic acid dosages for future pregnancies. //2005//

Inadequate Weight Gain Campaign

/2004/

An in-depth report on low birth weight in 2000 led to the beginning of a statewide campaign to promote adequate weight gain during pregnancy for the one in four women who gain less than the recommended amount. A marketing company was selected, and promotion of adequate weight gain will be a priority in the upcoming fiscal year. See www.cdphe.state.co.us/ps/mch/mchadmin/tippingthescales.pdf for the initial report.

/2005/

An update on this campaign is contained in the narrative for State Performance Measure 13 on inadequate weight gain, which is in Section IV D. //2005//

2. Preventive and Primary Care Services for Children

Child, Adolescent and School Health/Prevention Partnerships for Children and Youth

/2001/ /2002/ /2003/

The Child, Adolescent and School Health Unit, which joined Prevention Partnerships for Children and Youth (PPCY), is dedicated to protecting and promoting the health and well-being of all Colorado children and adolescents. Programs that address important issues include Child Health; Health and Safety in Child Care; EPSDT; the Asthma Program, Covering Kids (to encourage outreach and enrollment in Medicaid and Child Health Plan Plus); Adolescent Health, including Abstinence Education and Developmental Assets; School Nursing; and School-Based Health Centers.

Relatively new programs to the section include the Family Healthline, Healthy Child Care Colorado, the Nurse Home Visitor/Nurse-Family Partnership Program, the Colorado Children's Trust Fund, and the Family Resource Centers. Healthy Child Care Colorado is a Community Integrated Service System (CISS) initiative that recognizes the need to integrate health and safety prevention and promotion activities and social services within the child care setting to assure high quality care and healthier children through consultation, training, and education of staff. The Colorado Children's Trust Fund focuses on child abuse prevention, and the Family Resource Center Program is a partnership

with the Family Resource Center Association to strengthen and fund family resource centers around the state.

/2004/

Beginning in January 2003, the state health department is receiving two years of Healthy Child Care America transition funding through MCHB. From the inception of Healthy Child Care Colorado, the Colorado Office of Resource and Referral Agencies (CORRA) has been an integral partner in its planning and implementation. In the current cycle of funding (2003 to 2005), the state health department has contracted with CORRA to continue implementation of Healthy Child Care Colorado activities, as well as to explore opportunities for future program sustainability. The CISS grant has ended.

/2005/

Early in FY 2004, following the merging of the Prevention and Intervention Services for Children and Youth Division with the Health Promotion and Disease Prevention Division, the Prevention Partnerships for Children and Youth Section decided to return to their original name of the Child, Adolescent and School Health Section. With the receipt of two new grants, a CDC Coordinated School Health grant that goes to the state education department (which subcontracts with the state health department) and the Early Childhood Comprehensive Systems grant, MCH resources were freed to create a more focused approach to addressing child and adolescent health needs. //2005//

Children's Health Insurance Plan

/2001/ /2002/ /2003/

Colorado legislated its Children's Basic Health Plan in 1997. Enrollment grew slowly at first, with 11,840 children enrolled by January 1999, when Colorado received a \$1 million, three-year grant, Covering Kids Colorado, from the Robert Wood Johnson Foundation. The grant was used to simplify the enrollment processes for both Child Health Plan Plus and Medicaid, to enhance and develop innovative outreach and marketing strategies, and to promote interagency collaboration to support the enrollment of children into health insurance plans.

In 2002, the effort was reorganized into a three-agency collaborative including the Colorado Children's Campaign, Associated Catholic Charities, and the Colorado Community Health Network. An intensive effort at the county level was productive in increasing enrollment, and by the end of FY 2002, a total of 43,634 children were enrolled.

/2004/

The state fiscal problems resulted in a cap on enrollment in Child Health Plan Plus, effective November 2003, and a suspension of prenatal care coverage for FY 2004.

/2005/

Enrollment in Child Health Plan Plus was frozen at 54,000 children in November, 2003. In addition, the enrollment of pregnant women, begun in the fall of 2002, was halted in May 2003, and only a small number of women were covered. The 2004 Legislature approved reopening enrollment for both children and pregnant women beginning July 1, 2004. //2005//

Suicide Prevention

/2001/ /2002/ /2003/

The Office of Suicide Prevention was created by the state legislature in 2000, and the office began coordinating a statewide suicide prevention strategy with the Suicide Prevention Coalition of Colorado and many other agencies, communities, mental health professionals, and suicide survivors. In October 2000, the Office received a \$378,000 two-year federal grant to fund work in the area of teen suicide prevention. The Office has been focused on building local capacity to be more effective in suicide prevention for all ages.

/2004/

The Office of Suicide Prevention retained most of its state monies in the spring of 2003, despite state budget problems.

/2005/

An update on suicide prevention is contained in the narrative for National Performance Measure 16 in Section IV C. //2005//

Oral Health Program

/2001/ /2002/ /2003/

The Oral Health Program works to improve the oral health status of Colorado residents by reducing dental diseases through preventive measures and by reducing barriers to accessing oral health care. This is done primarily through preventive health measures like water fluoridation, elementary school fluoride mouth rinses, dental sealants with the "Chopper Topper" program, and oral health education measures. The Program also interacts with WIC, Women's Health, Chronic Disease, and Injury Prevention Programs to bring an oral health perspective to the health education efforts of the program. In FY 2003, the Oral Health Program expanded with the addition of a part-time epidemiologist and a full-time dental hygienist. This staff will develop a state oral health surveillance system and will promote integration of oral health into general health within programs at the state health department.

/2004/

An overview of oral health in Colorado was produced early in 2003. Oral Health: a Portal to General Health, covers just four pages, but contains a wealth of data and information about oral health in the state. Over 10,000 copies are being widely disseminated across Colorado.

/2005/

The Oral Health Program received a one-year grant in FY 2004 from the Maternal and Child Health Bureau to support state program infrastructure and to identify opportunities for system collaborations. The program is currently screening a convenience sample of Head Start and Migrant Head Start children to obtain baseline data for this population, and is participating in the new Colorado Coordinated School Health project and the Early Childhood Comprehensive Systems grant. The program is also expanding capacity by working with the Women's Health Section to develop oral health information packets for prenatal providers. Finally, the program is putting finishing touches on the Oral Health Burden document, which quantifies all the oral health data the program has in the oral health surveillance system, and takes it one step further by adding an economic burden chapter. The document was slated to be printed in July 2004. //2005//

3. Services for Children with Special Health Care Needs

a. To Provide Rehabilitation Services for Blind and Disabled Individuals Under the age of 16 Receiving Benefits under Title XVI (SSI)

/2001/ /2002/ /2003/

In Colorado, all SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. EPSDT outreach workers at the local level make telephone calls to all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. When families have more complex medical or psychosocial needs, the HCP staff in the local health department become involved.

/2004/ See Section III.F, Health Systems Capacity Indicator #08, for more information.

/2005/

See Section III.F, Health Systems Capacity Indicator #08, for more information. //2005//

b. To Provide and Promote Family-centered, Community-based, Coordinated Care including Care Coordination

/2002/ /2002/ /2003/

The capacity of the state to provide and promote coordinated care was a national performance measure prior to FY 2003. Public health staff in local health departments and county nursing services provided nutrition and care coordination services. The seven other standard services were paid through fee-for-service contracts with individual providers and health care facilities. HCP state consultants provided the needed quality assurance and local staff provided the care coordination services that are particularly necessary for these benefits. The demand for care coordination services and specialty clinics in rural areas has increased in recent years. Staff is working with managed care, Part C and developmental disability organizations to coordinate efforts, to decrease financial barriers and to better meet the needs of families.

With the implementation of Child Health Plan Plus as a program separate from Medicaid, local public health agencies have put more effort into coordinating care for children with special needs. Local public health staff help families complete applications for CHP+ benefits, choose HMOs and specialty providers, understand their benefits, and work with primary care providers to assure a medical home.

/2004/ The Health Care Program also continued to administer orthodontia and hearing aid services to Medicaid eligible children and provided care coordination services to these families until the end of state FY 2003 (June 30, 2003). At that time responsibility was transferred to the Colorado Department of Health Care Policy and Financing.

/2005/

In 2005, because of the end of medical benefits in the program, HCP will develop plans for a public education campaign to assure all families of children with special health care needs in Colorado know about the services that are available to them. This campaign will also inform providers and partner agencies. //2005//

4. Culturally competent care that is appropriate to the State's MCH population

/2004/

The MCH program continues to promote the development of policies and practices to support culturally competent services. The Family Healthline provides a vital means of informing families who are primarily Spanish-speaking about services and resources.

During the past year, the Women's Health Program convened a workgroup on Latina Teen Fertility that developed a report describing this group's very high rates of teen birth. In addition, the Newborn Hearing Screening Program is exploring the impact of Hispanic ethnicity on hearing screening rates and followup.

The Prevention Services Division has been actively participating in a workgroup convened by the department's Turning Point Initiative which is addressing health disparities among minority populations. This workgroup is focusing on assessing and improving the capacity of the department to serve Colorado residents who have limited English proficiency. A survey tool to assess capacity to assure effective communication for services delivered at the state level or through contracts at the local level has been developed and tested. The results of the capacity assessment survey will be used to shape policy recommendations to be implemented in 2004.

/2005/

The Turning Point Limited English Proficiency workgroup, a Turning Point Initiative committee, completed its assessment of the capacity to communicate effectively with non-English proficient individuals. Recommendations for improvement for programs that provide services either directly or through contracts were developed. The procedure for quality translations of written materials, developed for MCH programs several years ago, and the practices of the WIC program for assuring good communication, have been incorporated as models for replication.

The Newborn Hearing Screening Program is making a targeted effort to reach Latino families, who appear to be at increased risk of not receiving hearing screening and of not having appropriate followup when the first screen is failed.

Building on the work of last year's Latina Teen Fertility workgroup, a series of focus groups were conducted between March and July 2004 to collect stakeholder input on the issue of high Latina teen fertility. A report will be completed in August 2004. The project is focused on attitudes about births among U.S.-born Latina teens, since they contribute 4 out of every 5 Latina teen births in the state.

In an exciting new move, the state health department is transitioning the Turning Point Initiative into an Office of Health Disparities which will open in the fall of 2004. A series of community meetings were held in the spring of 2004 to gather input into the structure and work of the Office. In addition to the Office of Health Disparities, a Citizen's Commission on Minority Health will coordinate the department's efforts in working with underserved communities. //2005//

C. ORGANIZATIONAL STRUCTURE

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Douglas Benevento, the Executive Director, reports to Governor Owens. The department consists of ten divisions, and the Prevention Services Division is responsible for administering the MCH Block Grant. Both the state MCH and Children with Special Health Care Needs programs are within the division. Organization charts are on file with the MCH program at 4300 S. Cherry Creek Drive, Denver. An organization chart for the department is posted at <http://10.1.0.61/ic/orgchart.pdf>. A chart for the division is attached to this section.

/2001/ /2002/

Legislation approved in May 2000 sought to improve the health and well-being of Colorado's children by coordinating programs at the state level. The state health department was chosen as the lead agency, and a new Division of Prevention and Intervention Services for Children and Youth was created (also referred to as the Prevention Services Division). Programs in the former Family and Community Health Services Division were combined with a number of prevention programs formerly in the Departments of Local Affairs, Higher Education, and Human Services.

The most significant result of the realignment was that the Women's Health Program, the Oral Health Program, and the Rural and Primary Health Care Program were moved out of the division and into the Health Promotion and Disease Prevention Division, and the Immunization Program was moved into the new division.

A new MCH Section was then created, responsible for administering Title V funds; supervising the Child, Adolescent and School Health Unit, the Health Care Program for Children with Special Needs, the Immunization Program, and the Medical Consultation Unit (the Genetics Program, Newborn Screening Followup, and the Asthma Surveillance program). In addition, the MCH section was responsible for coordinating with other MCH-related programs in other divisions.

Two additional programs in the Prevention Services Division operate with funds largely from outside Title V. The Child and Adult Care Food Program and the WIC Program have long been associated with MCH.

New programs to the department and the division included the Tony Grampsas Youth Services Program (TGYS), a state-funded program to reduce crime and violence; Safe and Drug-Free Schools and Communities; the Build A Generation Program (BAG), funding community organizations to maximize existing resources for youth in order to reduce crime; the Family Resource Centers, serving as a point of entry for providing community-based services; the Colorado Children's Trust Fund, providing funds to communities to reduce the incidence of abuse and neglect; and the new Nurse Home Visitor/Nurse-Family Partnership Program.

/2003/

In November 2001, the organizational structure of the Prevention Services Division was revised again. Many of the programs in the Child, Adolescent, and School Health Unit joined with the Prevention Partnerships Section, forming the Prevention Partnerships for Children and Youth Section (PPCY). The Office of Homeless Youth, created by the legislature in July 2002, was also added.

/2004/

During FY 2003, the TGYS and BAG Programs were eliminated. Because of the state's budget problems, \$8 million of TGYS funding was cut in May 2002. The rest of the TGYS funds (\$1.2 million for youth mentoring) was cut in January 2003 and 22 local youth programs in 35 counties ended. The Build A Generation program, totaling over \$600,000, was also cut. The Colorado Children's Trust Fund was tapped for other uses. These budget decisions altered the work of the division and greatly diminished our ability to take the lead in coordinating services for children across state agencies.

In April 2003, the Prevention Services Division and the Health Promotion and Disease Prevention Divisions were merged under the direction of the Health Promotion and Disease Prevention Division director, Jillian Jacobellis, Ph.D. The enlarged division included Oral, Primary, and Rural Health Care, the Women's Health Section, Chronic Disease, the Colorado Cancer Central Registry, Injury Epidemiology, Injury Prevention, the State Tobacco Education and Prevention Partnership, and the Office of Suicide Prevention. Combining the two divisions brought all health department health promotion, disease prevention, and intervention programs together into one unit.

The advantage of working together in one division is viewed as very positive, and the moves of Oral, Primary and Rural Health Care and the Women's Health Sections are simply reversals of moves that

occurred in the year 2000. However, the Immunization Program, though still physically located in the Prevention Services Division, was organizationally moved to another division, making easy collaboration more difficult.

/2005/

For the first time in a number of years, the division experienced no major organizational upheavals. However, several significant changes were nonetheless made. The Office of Homeless Youth was transferred to the Department of Human Services in April 2004 to allow closer coordination of existing DHS programs. The name of the Division was changed in statute from the "Division of Prevention and Intervention Services for Children and Youth" to the "Prevention Services Division." The Family Healthline was moved to the Oral, Rural and Primary Health Section. And funding for the TGYS Program was partially restored, with \$3.4 million budgeted for state fiscal year 2005. (See State Performance Measure 1 in Section IV D for more information.)

The combining of the two divisions into the Prevention Services Division in 2003 has had a very positive impact. Our work in MCH has benefitted from combined division work groups in data analysis, access to care, physical activity and nutrition, and injury prevention. In addition, the appointment of Joan Eden, the state MCH Director, to be the Division Deputy Director, has elevated the status of MCH issues. //2005//

Other programs funded under the total Federal-State Block Grant Partnership are described below.

State Systems Development Initiative (SSDI)

/2001/ /2002/ /2003/

SSDI works to build capacity to access and use data in MCH planning. MCH county data sets first provided in FY 2000 were updated annually and distributed to local public health agencies. SSDI is now focusing on linking Medicaid files and newborn hearing screening and newborn metabolic screening files with birth records.

/2004/

A fourth set of MCH county data was released in January 2003. A great deal of developmental work went into linking Medicaid eligibility files with birth records, but the lack of data on HMO-covered Medicaid births is limiting the usefulness of the result. Moreover, HIPAA regulations have brought linking work to a halt while the Colorado Department of Health Care Policy and Financing and the state health department write a data-sharing agreement.

/2005/

A fifth set of MCH county data was released in February 2004 and can be accessed on the department's website. Trend analyses and a table of each county's rates for the MCH Performance and Outcome Measures, relative to the state's rates and the HP2010 objectives, were also provided to local health departments. The data sharing agreement with the Department of Health Care Policy and Financing that was completed in 2003 resulted in very limited access to Medicaid data. SSDI resources continue to contribute to the linkage of birth certificate and newborn screening data sets in the development of the centralized database for the Early Hearing Detection and Intervention (EHDI) project. //2005//

Abstinence Education

/2001/ /2002/ /2003/

The Colorado Abstinence Education Program, founded in 1997, is implemented through collaboration between the Governor's Office and the state health department. The Program's goal is to reduce out-of-wedlock births and sexually transmitted diseases in teens and to encourage sexual abstinence until marriage by supporting abstinence-only education programs for school-age children in grades 5 through 12. The Program also seeks to increase awareness and acceptance of abstinence by involving parents and the community.

/2004/

The Colorado Abstinence Education Program has continued to run "It's Okay to Say 'No Way'." This campaign reached more than 300,000 Colorado youth and 1.5 million adults ages 25-54 with the message that abstinence is the healthiest choice for avoiding teen pregnancy and sexually transmitted diseases. In early 2003 the program released an Abstinence Educator Training and Community Mobilization request for proposals and awarded 14 grants to assist local programs. //2004//

/2005/

At the end of 2004, the program awarded eight grants to local programs for implementation of community-based abstinence education programs. The program also released a request for proposals to identify an agency to expand and implement the current social marketing campaign.

In June 2004, the Abstinence Education Program director began to report to the Director of External Affairs at the state health department. The program is no longer part of the Child, Adolescent and School Health Section. //2005//

Asthma Program

/2001/ /2002/ /2003/

Colorado is one of 22 states funded for an asthma program by CDC. The Asthma Program seeks to reduce asthma prevalence, morbidity, and mortality and is responsible for a statewide surveillance data system.

/2004/

The Asthma Program continues to expand collaboration with Colorado organizations and individuals. The expansion focused recently on the African-American community because of increased morbidity and mortality in this population.

Through a grant from EPA, the program expanded an ambient air environmental project to look at similar issues in the Arkansas River Valley communities in southeastern Colorado. This project seeks to further refine the connection between measurable changes in outdoor air and the impact on asthmatics in rural settings. This year the program will produce a state asthma plan and a state asthma surveillance report.

/2005/

The Asthma Program completed the first phase of developing a series of brochures for the African American community. The program helped the Colorado Asthma Coalition complete the Colorado Asthma Plan, and the Colorado Asthma Surveillance report has been completed (see attachment to Section III F).

The program applied for the next phase of funding from CDC. The enhanced planning grant monies will be used to expand surveillance in Colorado and to perform a limited number of

targeted interventions. The program is also participating significantly in the STEPS to a HealthierUS grant, a new initiative directed toward the reduction of preventable diseases. //2005//

Early Hearing Detection and Intervention (EHDI)

/2001/ /2002/ /2003/

A five-year CDC grant was received in October 2000. The "Early Hearing Detection Intervention System and Newborn Screening Data Integration Program" (EHDI) grant integrates a variety of databases, beginning with existing universal newborn metabolic screening and newborn hearing screening data. Later it will include the Birth Defects Monitoring Program, an immunization registry, and asthma surveillance data.

/2004/

Clinical databases have been created for Sickle Cell Disease, the Inherited Metabolic Diseases, and infant hearing loss. Work has begun on the central processing database and its linkage to the recently created databases and the Integrated Registration and Information System (IRIS). By the end of FY 2004 we expect to have fully tested the system.

/2005/

The fourth year of the grant is being used to fully implement the CHIRP/NEST (Clinical Health Information Record of Patients/ Newborn Evaluation Screening and Tracking) applications. The use of CHIRP is being promoted in other areas, i.e., traumatic brain injury and autism. //2005//

Developmental and Evaluation (D&E) Program

/2001/ /2002/ /2003/

HCP's Developmental and Evaluation Clinic Program, also called the Diagnostic Evaluation Clinics, provides access to comprehensive, multidisciplinary, developmental evaluation services for children who have or are suspected of having a developmental delay or disability. This program provides the needed medical diagnosis for many children who do not have access to a developmental pediatrician. The program is community-based and coordinated with Child Find and other local specialty providers.

/2004/

In 2004, D&E will provide more consultation and training to primary care physicians so that it is a part of the child's medical home. The role of Child Find and the schools will also be studied and possibly redefined. //2004//

/2005/

The D&E Program continues to provide consultation and training to primary care physicians. The program is working to strengthen its collaborative efforts with Part C and Child Find at the state and local levels in order to prevent duplication and maximize resources. In addition, the roles of telemedicine and parent advocates continue to be emphasized. //2005//

D. OTHER MCH CAPACITY

/2001/ /2002/ /2003/

Title V funds and matching state funds pay for 49 FTE almost exclusively housed at the Colorado Department of Public Health and Environment in Denver. In 2003, the MCH Section added the Family Healthline and the Nurse Home Visitor/Nurse Family Partnership Program, as well as the Immunization Program. The CASH unit was combined with the Prevention Partnerships for Children and Youth section.

/2004/

There are 47.6 FTE currently working in the Division on maternal and child health programs.

/2005/

There are 47.7 FTE currently working in the Division on maternal and child health programs. //2005//

Maternal and Child Health Section Staff

/2001/ /2002/ /2003/

With the creation of the Division of Prevention and Intervention Services for Children and Youth, the MCH Section within the division was assigned responsibility for administering the MCH Block Grant. Previously this function had been part of the duties of the director of the Family and Community Health Services Division.

The new Director of the Division of Prevention and Intervention Services for Children and Youth is Mary Davis, M.P.H., Ph.D., who began in April 2001. Reporting to Dr. Davis is the new MCH Director, Joan Eden, M.S., R.D. Joan has a master's degree in public health and nutrition and has worked at the state public health department for over 20 years in the prenatal, child health, migrant health, children with special health care needs, and WIC programs.

Other staff working within maternal and child health are highly qualified: virtually all program directors possess master's degrees in public health, public administration, finance, or nursing. The staff consists of public health nurses, a physician, a demographer, information systems coordinators, nutritionists, social workers, a physical therapist, an audiologist, a speech pathologist, health educators, dental hygienists, systems staff and clerical support.

Dr. Bill Letson, pediatrician, pursued a fellowship during FY 2001 in MCH epidemiology in Oregon. Rebecca Jordan, formerly with the STD/HIV Prevention Section, became the new program manager for the Immunization Section in February 2001.

/2004/

In April 2003, the Division of Prevention and Intervention Services for Children and Youth was combined with the Health Promotion and Disease Prevention Division, headed by Jillian Jacobellis, Ph.D. Mary Davis will continue to work on interagency prevention issues and implementation of the many requirements in House Bill 00-1342, which created the Prevention and Intervention Services for Children and Youth Division.

/2005/

Joan Eden is now the Deputy Director for the Prevention Services Division, and heads the Office of Maternal and Child Health, formerly the Maternal and Child Health Section. //2005//

Prevention Partnerships for Children and Youth Staff (Child, Adolescent and School Health)

/2001/ /2002/

The Child, Adolescent and School Health Unit is directed by Barbara Ritchen, who has a B.S. in Nursing and a Master's degree in Health Education. The Unit staff of eighteen includes a wealth of expertise and experience, including four master's prepared nurses and two social workers.

Bruce Guernsey, MSW, serves as the Director of the Adolescent and School Health Program. Bruce is a nationally recognized leader in school-based health care. The Adolescent and School Health Program also shares a state school nurse consultant, Judy Harrigan, with the Department of Education. The Adolescent and School Health Program includes the Abstinence Education Program, directed by Carla Beeson, who is hired by the Office of the Governor, and the Asthma Program, directed by Arthur McFarlane.

Rachel Hutson, RN, CPNP, was hired in February 2001 as the new nursing consultant for both the Child Health Program and the Nurse Home Visitor/Nurse Family Partnership Program. Jane Cotler, RN, is a child health nursing consultant and director of the Healthy Child Care Colorado Initiative. Scott Bates, MSW, is the program coordinator for the Colorado Children's Trust Fund and the Family Resource Center programs.

/2003/

Barbara Ritchen took on the leadership of the new Prevention Partnerships for Children and Youth Section when the Child, Adolescent and School Health Unit was combined with the Prevention Partnerships Section. Nigel Gregory was hired in February 2002 as the program manager for Build A Generation. Esperanza Zachman is the program manager of the Tony Grampsas Youth Services Program.

/2004/

Mr. Gregory moved to the State Tobacco Education and Prevention Partnership program when the Build A Generation program lost its funding in FY 2003. Esperanza Zachman now heads the Office of Homeless Youth, created in 2002, after the loss of funding for the Tony Grampsas Youth Services Program. The fiscal officer for the MCH Program is Sally Merrow, who replaced Bob Davis who retired in April 2003. Rachel Hutson became the Director of Child Health, and is working full-time with this program. Jane Cotler, Child Health Nursing Consultant, retired in January 2003. Joan Eden is now the Interim Prevention Services Division Deputy Director. She continues her role as MCH Section Director.

/2005/

The Prevention Partnerships for Children and Youth Section returned to its original name of the Child, Adolescent and School Health Section. In December 2003 a new child health nurse consultant, Cathy White, was hired to focus on the health and well-being of school-aged children. In January 2004, Jason Vahling, MSPH, was hired as the new Director of the Adolescent Health Program. These two new staff, along with Rachel Hutson and Barbara Ritchen, now comprise a new MCH Child and Adolescent Health team.

The Asthma Program was moved to the Chronic Disease Section in the summer of 2003. //2005//

Health Care Program for Children with Special Needs Staff

/2001/ /2002/

The state staff of the Health Care Program for Children with Special Needs (HCP) is provided overall

direction and program coordination by Kathy Watters, M.A. All of the consultation staff, which includes nurses, audiologists, a speech pathologist, a nutritionist and a physical therapist, are licensed or certified in their disciplines and most have master's degrees.

Three new staff members joined HCP. Kelly Stainback-Tracy, MPH, was hired in September 2000 to fill a half-time position created within HCP to assist in building data capacity. Another new staff member is Jean Snoddy, Family Consultant for HCP. Jean is a registered nurse and a parent of two children with special needs. Jean's position was subsequently increased from half-time to full-time to better accommodate the workload of this position. Linda Fudge, Au.D., replaced Vickie Thomson as the EHDI grant.

HCP continues to fund a position at The Children's Hospital to coordinate the inpatient and outpatient services provided through the hospital with those needed and provided in the community. Libby Speers, R.N., provides a valuable link for public health nurses across the state to the hospital.

/2003/

A full-time position was created for a developmental pediatrician. Jim Ledbetter, M.D., was hired to build relationships with primary care physicians in Colorado through the Colorado Medical Home Initiative, and to consult with a variety of other MCH and CDPHE programs and grant projects. Lynn Bindel became Consultation Team Manager. Judy Grange, R.N., was hired to fill Lynn Bindel's position, and her job includes HCP Clinic program management, consulting with the local HCP nurse coordinators, and coordinating with other MCH and state health department programs.

/2004/

Kelly Stainback-Tracy left the program in early 2003 and Jean Snoddy, parent consultant, left to pursue her Master's degree. Budget reductions plus the transfer of Medicaid services and 1.5 FTE to the Department of Health Care Policy and Financing, along with a retirement, reduced the HCP FTE by 4.5.

/2005/

A number of changes took place this past year. In August 2003, Karen Fehringer was hired as the occupational therapist/physical therapist. In October 2003, Eileen Forlenza was hired as the new full-time parent coordinator. She is concentrating on community development by seeking funding and program support from businesses and faith-based organizations. In November 2003, Steve Holloway was hired as the state genetics coordinator. He is connecting all the resources for genetics services in Colorado. The program then added a statistical analyst/epidemiologist, KaraAnn Donovan, MSPH, in December 2003. She is focusing on SLAITS data and local data from the 14 regional offices. Paula Hudson, Ph.D., the Developmental and Evaluation Clinic coordinator and half-time speech pathologist, retired in the spring of 2004, and Anne Marie Baraga, MSW, replaced her in March 2004. As well as fulfilling the responsibilities of the D&E coordinator, Anne Marie is filling the half-time social worker position. She is connecting the Health Care Program for Children with Special Needs with all the mental health grants in the state. We will need to replace the half-time speech pathologist position and will look for a person with expertise in traumatic brain injury. //2005//

The staff listed in the following paragraphs are not formally under the supervision of the MCH Section, but their work is critical to the MCH mission. The MCH Section works closely with each of the staff shown.

Nutrition Services

/2001/ /2002/ /2003/

Kathy Brunner, the Director of the Child and Adult Food Care Program, retired in 2000. Patricia Daniluk, RD, MS, replaced her as Director, and Bruce Rengers, Ph.D., RD, took Patricia's position as Chief Nutritionist for Nutrition Services. Bruce has a particular interest in nutrition and obesity, one of the MCH Program's new priorities, and is assisting with the Division's plans for preventing pediatric obesity.

/2004/

Bruce Rengers left the program in August 2002. Nutrition Services hired a dietitian for WIC, Lori Holladay, whose specialty area is pediatric obesity. Lori heads up a special task force that includes representation from MCH to work on statewide efforts to address early childhood obesity.

/2005/

Tracy Miller, R.D., was hired by the Child and Adult Care Food Program as a nutrition consultant. She is working with Lori Holladay to co-chair the Early Childhood Task Force for the Colorado Physical Activity and Nutrition grant to address early childhood obesity. //2005//

E. STATE AGENCY COORDINATION

Colorado has a long history of interagency coordination and collaboration. An Interagency Prevention Council was established under Governor Romer over ten years ago. Then with the passage of HB00-1342, creating the Division of Prevention and Intervention Services for Children and Youth in 2000, the coordination was mandated through statute. MCH staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees, and cooperative agreements.

Relationships Among the State Human Services Agencies

Colorado Department of Education

MCH staff have worked closely with Colorado Department of Education staff for years in supporting the coordinated school health model, the jointly funded state school nurse consultant position, and school-based health centers. MCH staff have been part of the Department of Education's school health education advisory committee since its inception, and partners in co-funding state conferences, adolescent health training, the Youth Risk Behavior Survey, and the Adolescent Health in Colorado report. The state health department's Advisory Council on Adolescent Health includes representatives from the Department of Education, the Alcohol and Drug Abuse Division and the Independent Living Program within the Department of Human Services. The Youth Partnership for Health, 25 youth recruited from all areas of Colorado, advises both the state health department and the Department of Human Services on policies and programs that affect adolescents.

Colorado Coordinated School Health Program

In March 2003 Colorado was one of five new states to be awarded a five-year Centers for Disease Control grant to build state education and state health agency capacity to implement and coordinate school health programs. The expected outcome of the grant is to help schools reduce important health risks among school youth. These risks include tobacco use, eating patterns, obesity, HIV, STDs and teen pregnancy. An Interagency Plan will be developed that addresses the risks and provides strategies to reduce them.

Colorado Department of Health Care Policy and Financing

MCH staff also work with the Colorado Department of Health Care Policy and Financing staff on a year-round basis. Issues involving EPSDT, lead poisoning, family planning, immunizations, birth defects, Prenatal Plus, and oral health are discussed in ongoing efforts to improve the health of

children and women whose health care is paid for by Medicaid.

Colorado Department of Human Services (DHS)

The state health department also works closely with the Colorado Department of Human Services, in particular with the Division of Developmental Disabilities. The Prevention Services Division ensures that there is an ongoing interface in the provision of services for the many children served by HCP who are also eligible for services through the Colorado DHS. Programs provided by DHS/DDS that work with HCP include Early Intervention Services for child development for infants and toddlers birth to age three; Family Support Services Program for families who maintain a family member with developmental disabilities in the family home (all ages); Children's Extensive Support Waiver (a model 200 waiver) for children birth to 18 who are considered to be the most at risk for out-of-home placement due to the severity of their needs; and the Children's Medical Waiver (a model 200 waiver) for children age birth to 18 with developmental disabilities to access Medicaid state plan benefits who would otherwise be ineligible due to parental income.

In addition, the state health department works closely with the Alcohol and Drug Abuse Division to plan coordinated workforce development and joint training and technical assistance.

Other Departments

The state health department has also been a leader in a collaborative effort to review all child deaths in the state. Multi-disciplinary teams from many departments and agencies work together to determine the underlying causes of children's deaths and to promote preventive programs that may help reduce premature death. The agencies involved include the Colorado Division of Criminal Justice, the Colorado Departments of Human Services and Education, the Division of Youth Corrections, the Kempe National Center, the Colorado SIDS Program, local city and county police departments and coroner's offices, local district attorney's offices, the Denver Child Advocacy Center, the Health Statistics and Vital Records Section at the state health department, and The Children's Hospital. Separate reviews of maternal mortality also take place.

Relationship of State and Local Public Health Agencies

The MCH program works through the Office of Local Liaison, located within the state health department, to address MCH issues in the 39 counties with local nursing agencies. The MCH program works directly with the 15 organized health departments that serve the 25 largest counties in the state. A total of \$4.2 million in MCH funds is given to local health agencies to assess the MCH population needs in their communities and to address priorities.

Aurora Healthy Start Initiative

MCH staff have been involved on a local level with the Aurora Healthy Start Initiative, a response to exceptionally high infant mortality in two zip codes located along East Colfax Avenue in Aurora, Colorado, on the eastern edge of Denver. This effort was funded by an MCHB Healthy Start Initiative grant that was awarded in 1998 and again in 2001 and is guided by a consortium made up of local community members and health and community service providers. The MCH program assists with demographic information and health risk information for the two zip code area, and shares materials and resources from Title V agency programs.

Relationship with FQHCs and Primary Care

The Colorado Community Health Network, CCHN, is the state Primary Care Association representing 15 community, migrant, school-based, public housing, and homeless centers operating 108 health care delivery sites. Colorado's community health centers provide over 1.5 million visits to over 372,000 low-income patients each year. Community health centers are the medical home for an estimated 28 percent of Colorado's low-income, uninsured population, 34 percent of Child Health Plan

Plus enrollees, and 28 percent of Medicaid enrollees.

Colorado's Primary Care Office, the Oral, Rural and Primary Care Program, works jointly with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing, recruitment and retention of health professionals, policy development, and assisting communities with applying for health professional shortage area (HPSA) and medically underserved (MUA) designations. The agencies work to support areas that lack sufficient primary care capacity to meet the needs of their residents.

State Tobacco Education and Prevention Partnership (STEPP)

In May 2000, the state legislature allocated approximately 15 percent of the Master Settlement Agreement monies for tobacco education, prevention and cessation. During state FY 2002 \$11.5 million was dedicated to a grant program to fund comprehensive tobacco control strategies statewide. With the merging of the Prevention Services Division and the Health Promotion and Disease Prevention Division, where STEPP was located, in the spring of 2003, opportunities to work even more closely have emerged. Decreasing youth tobacco initiation, promoting quitting of tobacco among youth and adults, and reducing exposure to environmental tobacco smoke are among the goals of the program that MCH incorporates into its population-based efforts.

State fiscal problems in FY 2003 and FY 2004 resulted in tobacco monies being cut back. Dollars available in FY 2003 were reduced from \$15 million to \$7.5 million, and then again reduced to \$3.6 million for FY 2004. The MCH program will continue to work with STEPP. The FY 2005 legislative appropriations will be \$4.3 million, resulting in near-level funding to our grantees.

Colorado Perinatal Care Council

The MCH program also works closely with the Colorado Perinatal Care Council, a statewide organization of perinatal care providers established by the governor in 1976. The state health department provides space and support for the Council, which is co-located with the MCH program at the department. The Council is a volunteer, non-profit, advisory group whose members include obstetricians, pediatricians, perinatologists, social workers, neonatologists, and nurse practitioners. Its major focus is the coordination and improvement of perinatal care services in Colorado.

Relationship with Tertiary Care Facilities

We also have a good working relationship with Denver Health, the largest community health system in the country. Denver Health includes community health centers, school-based health centers, Denver Hospital, and the public health department for the city and county of Denver.

The MCH program works closely with The Children's Hospital, the state's largest and only hospital specifically for children. The HCP Program funds a position at the hospital to coordinate the inpatient and outpatient services provided through the hospital with those services needed and provided in the community.

Available Technical Resources

MCH staff have a good working relationship with the Department of Preventive Medicine at the University of Colorado Health Sciences Center (UCHSC). During FY 2003 university staff performed an analysis of costs for low birth weight infants in the Medicaid population and wrote a report showing substantial savings for the state's Prenatal Plus Program that provides enhanced services for pregnant women.

The state health department also works closely with JFK Partners, a program between the Departments of Pediatrics and Psychiatry, also at the UCHSC, that focuses on children with developmental disabilities and special health care needs. JFK is the LEND (Leadership Enhancement

in Neurological Disabilities) grantee.

Professional education programs for public health workers are available from the Colorado Regional Institute for Health and Environmental Leadership at the University of Denver. The Institute's Advanced Leadership Training Program is one of several programs available.

Colorado continues to actively participate with Title V directors and staff from other western states in planning initiatives for the on-going development of the Rocky Mountain Public Health Education Consortium, funded through an MCHB grant. We also promote participation of Colorado state and local MCH public health practitioners in the Summer Institute in Maternal and Child Health in Salt Lake City as well as the MCH Certificate program and distance learning courses.

Other technical resources are available from the UCHSC School of Nursing and the Center for Human Investment Policy at the University of Denver. These include providing technical assistance on conducting community needs assessments and regular updates on the impact of proposed new federal and state legislation and on current research and evaluation in the field of maternal and child health.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs, a number of which are highlighted below. Because of space limitations, this list is incomplete.

Covering Kids and Families (formerly Covering Kids)

The MCH program has a working relationship as well with Colorado Covering Kids and Families (CKF), a project aimed at improving and protecting public health insurance programs. CKF has a membership of over 200 community-based organizations, agencies, and individuals, and works through outreach efforts to ensure that all eligible children and adults are enrolled in public health insurance programs.

Healthy Child Care Colorado

During FY 2000 through FY 2002, Healthy Child Care Colorado was a Community Integrated Service System (CISS) initiative located in the Division of Prevention and Intervention Services for Children and Youth. The goals of Healthy Child Care Colorado are to provide safe and healthy child care environments, to increase accessibility to immunizations, and to provide access to quality health, dental and developmental screenings and followup. The initiative is a valuable educational resource to center and family child care providers throughout the state.

Beginning in January 2003, the state health department began to receive two years of Healthy Child Care America transition funding through the MCH Bureau. From the inception of Healthy Child Care Colorado, the Colorado Office of Resource and Referral Agencies has been an integral partner in its planning and implementation. In this current cycle of funding (January 2003 to January 2005), the state health department has contracted with the Colorado Office of Resource and Referral Agencies to continue implementation of Healthy Child Care Colorado activities, as well as to explore opportunities for future program sustainability.

School-Based Health Centers/Colorado Association for School-Based Health Care (CASHBC)

The role of the state health department has been to convene, facilitate, and to provide technical assistance to schools and provider agencies that develop and support school-based health centers. The Colorado School-Based Health Center Initiative is located within the Prevention Services Division. A state interagency workgroup provides policy direction and funding advice for the Initiative for policies supporting integration of resources and services for vulnerable student populations at the local level. Members include the Colorado Departments of Education and Health Care Policy and

Financing, the UCHSC School of Nursing, the Center for Human Investment Policy at the University of Denver, the Colorado Foundation for Children and Families, the Colorado Department of Human Services, and the Colorado Association for School-Based Health Care.

Colorado Oral Health Coalition

Oral Health Awareness Colorado! (OHAC!) is the official name of the statewide oral health coalition. The coalition, which has been meeting for over a year, has two primary goals: to launch a media campaign ("Be a Smart Mouth") and to develop a state oral health plan. The coalition has a new website, www.beasmartmouth.com, containing information about upcoming events and tips about oral health.

Title V Program Coordination with Other Specific Programs

1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

The case management and outreach portions of the Colorado EPSDT program were under the administration of the state health department for over 20 years. However, as of July 2003, the state health department ceased administration of the program. In order to reduce duplication in administrative services, the state legislature decided cost savings could be realized if the Medicaid agency contracted directly with local health agencies.

This administrative change did not change the work that goes on in local health agencies. They continue their outreach and case management services, but are funded directly by Medicaid. In almost every county health agency, the EPSDT coordinators work with other public health service programs such as WIC, prenatal and child health programs and immunization services and the HCP program.

At the state level, MCH staff continues to work with EPSDT, and MCH staff members sit on the EPSDT State Advisory Board. There is much activity currently in defining the relationship of the two agencies regarding data and information-sharing based on new HIPAA requirements. The Health Care Program for Children with Special Needs is very involved with EPSDT as both programs provide case management or care coordination services for children with special needs, and both programs are working on Medical Home issues.

2. Other Federal Grant Programs

WIC

At the state level the WIC Program resides in the same division as the Office of Maternal and Child Health. Joint efforts for improving certain MCH performance measures have been in place for years. Current efforts are focused on increasing immunization and breastfeeding rates and decreasing childhood overweight. WIC and MCH funds go to all of the local health agencies and are used to support coordinated programs for the MCH population.

Early Childhood Comprehensive Systems

Federal funding for July 2003 through June 2005 was obtained for planning for a comprehensive early childhood system in Colorado that includes access to health care/medical home, mental health, early care and education, parent education, and family support services. We are working on creating a systems-building infrastructure, completing a strategic planning process, and finalizing a strategic plan that has a broad base of stakeholder support.

Family Planning

The Women's Health Section at the state health department is the grantee for the Title X family planning program. This section also administers the prenatal component of the MCH Block Grant. As a result of the co-location of these programs, the MCH Block grant and Title X family planning activities are well-integrated. Activities to address unintended pregnancy and teen fertility have been targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around family planning and unintended pregnancy prevention.

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.

The majority of local MCH contractors also serve as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program authorized under Colorado's Medicaid state plan allows Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identify women and infants who are eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), deem them presumptively eligible for Medicaid if the income requirements are met, and refer them to community resources for direct care, case management, etc. Eligibility determinations are also made for Child Health Plan Plus in many of these same sites. Some changes in presumptive eligibility requirements are anticipated during FY 2005 with the advent of the Colorado Benefits Management System (CBMS), the state's automated, rules-based eligibility determination system.

Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs

Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. EPSDT outreach workers at the local level make calls to families of children receiving SSI to assess whether service and support needs are being met. When family needs are complex and the EPSDT outreach worker feels that care coordination by an HCP staff member would be appropriate, a referral is made.

Developmental Disabilities (DHS/DDS)

See the discussion at the beginning of this section under the heading "Colorado Department of Human Services."

Vocational Rehabilitation

Relationships with Vocational Rehabilitation in the Department of Human Services need to be cultivated to focus on the 2010 objective to assure youth with special health care needs are able to transition smoothly to adult services. We also are beginning to discuss this objective with the Department of Education/Special Education section. Both agencies are actively involved with us in the Brain Injury Steering Committee and a task force on Assistive Technology.

HCP is managing a pilot project to transition youth with neurology needs who have been attending the HCP outreach clinics in Weld County to a local adult neurologist. This project is going well; evaluation data will be reported and should facilitate more local projects of a similar nature.

Family Leadership and Support

HCP has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Currently Family Voices is involved in the HCP

Medical Home Learning Collaborative and collaborates with the state parent position and our local parent consultants. HCP will continue to help Family Voice shape its identity and role in the state. Most recently Family Voices has made a positive impact on budget reductions by lobbying at the state capitol to make specific changes that will save money but not harm services to children.

A number of examples of state agency coordination have been provided in this section, but this list does not contain every cooperative effort. Other examples are provided in the text in other sections, particularly the performance measures sections (IV C and IV D).

F. HEALTH SYSTEMS CAPACITY INDICATORS

A number of formerly "core health status" indicators are now reported as health systems capacity indicators. A description of each is provided below.

#01 Health Systems Capacity Indicator

The rate of children hospitalized for asthma (10,000 children less than 5 years old)

/2001/ /2002/

Data are provided for FY 1996 through FY 2000. The rate of asthma hospitalizations is variable, ranging between 51.3 hospitalizations per 10,000 children for a low to 61.1 for a high. The rate for FY 2000 is 56.6 hospitalizations for every 10,000 children age 0 through 4, essentially the same level as in FY 1996.

/2003/

Data are provided for FY 2001 (calendar 2000). The rate is 51.3 hospitalizations for every 10,000 children age 0 through 4, essentially the same level as in FY 1998.

/2004/

Data are provided for FY 2002 (calendar 2001). The rate is 56.8, the same level as in FY 1996 and FY 2000, and within the range established between FY 1995 and FY 1998. This indicator shows no clear trend.

/2005/

Data are provided for FY 2003 (calendar 2002). The rate is 60.8, the highest level in five years, and the second highest level in the nine years of data available. The state's Asthma Program is described in Section III C.

An asthma surveillance report was written this past year, and is provided in the attachment to this section. //2005//

#02 Health Systems Capacity Indicator

The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen

/2001/ /2002/

The level for Colorado Medicaid enrollees was 68.8 percent in FY 1995, and increased to 81 percent in FY 1996 and FY 1997. In FY 1998 it was 79.8 percent; in FY 1999 it rose to 89.4 percent. Since FY 1995, this indicator has jumped by twenty percentage points. Final data for FY 2000 are not yet available from the Health Care Financing Administration due to computer problems. The figures

shown in the table are estimates: the FY 2000 denominator determined as of the date of submission of this application is thought to be an undercount, since the number is lower than in FY 1999. The numerator is estimated, using the FY 1999 percentage.

/2003/

No further update is available.

/2004/

Data now available for FY 2000 show 100.0 percent of enrollees received at least one initial periodic screen. Data for FY 2001 show 97.5 percent receiving an initial screen. These proportions suggest that virtually all eligible infants under age 1 are receiving a screening. No data for FY 2002 were available at the time of grant submission.

/2005/

Data are now available for both FY 2002 and FY 2003. A total of 27,375 Medicaid enrollees received 29,682 periodic screens in FY 2002. It appears that 100 percent of all Medicaid enrollees received an initial screening. Software constraints do not permit entering a numerator larger than a denominator, so the numerator shown in Form 17 is 27,375.

FY 2003 data show a total of 28,854 eligible children receiving 25,516 initial screens (88.4 percent). //2005//

#03 Health Systems Capacity Indicator

The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year who received at least one periodic screen

/2001/ /2002/

The Child Health Plan Plus is not able to provide this information due to limitations in linking datasets between enrollment data and claims data.

/2003/

The Child Health Plan Plus program reports for FY 2001 that 73.9 percent of all children whose age was less than one year and who were enrolled in the program for at least six months received at least one periodic screen. However, the reported figures are for children who were enrolled in the Child Health Plan Plus "network." Many children are enrolled in the network very briefly (less than a month) while the administrative work is done to get them into an HMO. Once they become enrolled in an HMO, no data are available on visits. The figure of 73.9 percent is based on 165 children who remained in the network, which serves children in rural areas. Data for this variable are not available on the majority of CHP+ clients who belong to HMOs, which are located mostly in urban areas.

/2004/

No update is available. A request to the Child Health Plan Plus Program for this information could not be filled because of budget cutbacks in staffing for data tracking and analysis.

/2005/

No update is available. //2005//

#04 Health Status Indicator

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

/2001/ /2002/

Data are available for calendar 1995 through calendar 1999. The decline in the past two years is consistent with the decline in first trimester prenatal care described in the Needs Assessment section update on first trimester care.

/2003/

Data are available for calendar 2000, when the percent fell slightly to 68.4. The decline in the past three years is consistent with the decline in first trimester prenatal care experienced in Colorado since 1997.

/2004/

Data for calendar 2001 show the percentage at 66.4, two points below the rate in 2000.

/2005/

Data for calendar 2002 show the percentage at 66.3, just below the rate the previous year. This is the fifth year in a row that the index has declined, showing fewer women receiving an adequate amount of prenatal care than each of the years before. In fact, the 2002 rate, with just two out of every three pregnant women receiving an adequate amount of care, is the lowest proportion seen in the last twelve years. An analysis of Colorado's ranking (available from the MCH Bureau's website) shows just five other states with proportions this low in recent years. //2005//

#05 Health Systems Capacity Indicator

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

/2001/ /2002/

In 1999 Medicaid births had an 8.9 percent low birth weight rate, while non-Medicaid births had a 7.0 percent low birth weight rate (according to PRAMS data). The PRAMS total for both types of coverage was 7.6 percent; this is lower than the vital statistics birth certificate rate of 8.4 percent.

Infant death rates are not available for Medicaid/non-Medicaid populations. Colorado does not collect Medicaid information on the birth or death certificate, although linking should start to occur between Medicaid files and birth certificate files in 2002. The overall infant death rate is 6.7 per 1,000, according to linked birth and death certificate data for all infants.

The percent of pregnant women entering care in the first trimester is calculated at 69.4 percent for Medicaid births, using PRAMS data. The percent for non-Medicaid births is 88.6, a rate that is significantly higher. Vital statistics data show an overall rate of 81.7 percent, but PRAMS data for the entire group is slightly higher at 82.9 percent.

The percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80 percent [Kotelchuck Index]) among Medicaid births was estimated to be 59.8 percent according to PRAMS data and 75.1 among non-Medicaid births. The Medicaid rate is significantly lower than the non-Medicaid rate. The rate for all births using PRAMS data was 70.8 percent, while the rate using vital statistics data was 68.7 percent, slightly lower.

/2003/

Data are provided for calendar 2000. According to PRAMS, the Medicaid low birth weight dropped from the 8.9 percent shown in 1999 to 8.2 in 2000, although the change was not statistically significant. The non-Medicaid low birth weight rate was 7.2 percent in 2000, compared to 7.0 the year before. Again, infant death rates are not available for Medicaid/non-Medicaid populations. The percent of pregnant women entering care in the first trimester fell to 65.0 percent in 2000 for the Medicaid population and to 84.9 percent for the non-Medicaid population, from higher levels shown above for 1999. These changes were not statistically significant, but are in line with vital statistics data showing a drop overall as well between the two years. The percent of pregnant women with adequate prenatal care according to the Kotelchuck Index is essentially unchanged in 2000, according to PRAMS data.

/2004/

PRAMS data have been delayed in processing at the Centers for Disease Control, and no update is available since the 2000 data were processed. In addition, infant death rates by Medicaid/non-Medicaid are not available. Although birth and infant death certificates are linked, no information is available on Medicaid coverage of the birth.

/2005/

PRAMS data for 2002 are shown, since birth certificate data are not available for Medicaid patients. The rates for low birth weight for Medicaid patients (9.3 percent) are higher than for non-Medicaid patients (7.9 percent). Similarly, first trimester prenatal care rates for Medicaid patients are at 63.4 percent vs. 86.5 percent for non-Medicaid patients. The Kotelchuck Index corroborates the low proportions, with 56.4 percent of Medicaid patients receiving adequate prenatal care, compared to 71.0 percent of non-Medicaid patients. //2005//

#06 Health Systems Capacity Indicator

The percent of poverty level for eligibility in the State's Medicaid and CHIP programs for infants (0 to 1), children, and pregnant women

/2001/ /2002/

The percent of poverty level for eligibility in Colorado's Medicaid plan is 133 percent for pregnant women and for infants and children less than or equal to 5. The rate drops to 100 percent for children 6 to 17. Medicaid eligibility for children age 17 and 18 is at AFDC levels. An assets test is required for all children age 1 or older seeking Medicaid, but not for pregnant women or infants. The state Child Health Plan Plus percent of poverty level is 185 percent. No assets tests apply.

/2003/

No changes.

/2004/

Pregnant women up to 185 percent of poverty began to be served by the CHIP program in the fall of 2002. This expansion of the poverty level was intended to cover an additional 3,000 pregnant women annually. However, because of state budget constraints, the Child Health Plan Plus enrollment was capped for state FY 2004 at 53,000 (expected to be reached in November 2003). The new program for pregnant women was suspended in April 2003.

/2005/

Enrollment in the Child Health Plan Plus program was frozen in November 2003 at 53,000. An

estimated 1,000 children would have qualified for the program each month if enrollment had remained open. Enrollment for pregnant women was also frozen, and no women were accepted. Enrollments were reopened on July 1, 2004 with the beginning of the state's new 2005 fiscal year. //2005//

#07 Health Systems Capacity Indicator

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year

/2001/ /2002/

Data are available only for FY 1999 from HCFA Form 416. Out of 33,633 children eligible for EPSDT services ages 6 through 9, almost half (44.7 percent) received a dental service. Data for FY 2000 and FY 2001 are not available.

/2003/

More recent data for FY 2000 or FY 2001 are not available from the Colorado Department of Health Care Policy and Financing for this measure.

/2004/

Data now available for FY 2001 show that 39.8 percent of EPSDT-eligible children in this age group received Medicaid dental services. This compares to 33.3 percent in FY 2000. While there was a large drop between FY 1999 and FY 2000 (from 44.7 percent to 33.3 percent), the percentage increased in FY 2001, making up about half the difference. These changes reflect a significant effort on the part of Medicaid and the Oral Health Program with help from the NGA Oral Health Policy Academy to market the changes that Medicaid has made to secure new providers at the Rocky Mountain Dental Convention.

/2005/

Data are now available for FY 2002 (43.6 percent) and FY 2003 (50.2 percent). These recent increases indicate a substantial improvement from the FY 2000 level (33.3 percent). From one in three children on Medicaid receiving dental services to one in two children receiving dental services is a real change, and the new level surpasses any previous historical levels. We now have 25 dentists and hygienists participating in the Dental Loan Repayment Program where over 6,200 Medicaid-eligible children have been served, and hygienists have been able to bill Medicaid directly since 2002. In addition, \$2 million in dental safety net clinic expansion funds were distributed in 2003. Finally, there has been an increase of 100 dental Medicaid providers between FY 2002 and FY 2003. These changes have contributed impressively to the numbers of children served. //2005//

#08 Health Systems Capacity Indicator

/2004/

The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program

Data for FY 2002 show that 16.5 percent of all children on SSI (974 out of 5,920) received rehabilitative services from the state Children with Special Health Care Needs Program. This was formerly a performance measure with a goal of 16.0 percent for FY 2002. The goal was met.

In Colorado, all SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. EPSDT outreach workers at the local level make calls to all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In most cases, Medicaid is covering all of the medical needs. When families have more complex medical or psychosocial needs, the HCP staff in the local health department become involved. These families are enrolled for "Care Coordination Only," and are assisted in defining their needs and in developing plans to meet them.

Because most of the contact with families on SSI is for care coordination and not medical or typically rehabilitative needs, Colorado includes care coordination services in its definition of "rehabilitative services."

/2005/

Data for FY 2003 show that 14.0 percent of all children on SSI (802 out of 5,727) received rehabilitative services from the state Children with Special Health Care Needs Program. Since July 1, 2003 these services are no longer covered by the Program. //2005//

#09(A) Health Systems Capacity Indicator

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data

/2004/

Information about the ability of the state to assure access to data is available in Form 19. The MCH program has ready access to birth and infant death certificate data and PRAMS data. The program has the ability to obtain data from the birth defects surveillance system. However, there is no linkage between birth records and WIC eligibility files, nor does the program have access to hospital discharge data. Linkage between birth records and Medicaid claims data was under development, but the Colorado Department of Health Care Policy and Financing has been implementing new HIPAA regulations, and further development has been suspended. Linkage between birth records and newborn screening files, including hearing screening, is under development, since both programs are located at the state health department.

As of June 2003, Colorado added PRAMS data to its queryable website, at <http://www.cdphe.state.co.us/cohid/>. The user can choose a topic and select years, counties, and demographic characteristics of the mothers and obtain reports immediately.

/2005/

There continues to be no linkage between birth records and WIC, nor between birth records and Medicaid records. The MCH Program has access to the hospital discharge data through the state health department's Health Statistics Section. However, access is not timely due to limited staff resources available.

A new birth certificate is planned for January 2006, and the addition of information about Medicaid status of the birth is under consideration. Such an addition would greatly enhance our ability to ascertain the health status of birth outcomes for the Medicaid population. //2005//

#09(B) Health Systems Capacity Indicator

The percent of adolescents in grades 9 through 12 who reported using tobacco products in the past month

/2004/

The Colorado Youth Risk Behavior Survey provides data on this measure every other year. The year 1995 was the last year with a large enough sample size for valid statewide estimates. The year 2001 survey fell just short of being large enough. The next survey will take place in the fall of 2003.

The state health department also coordinates the Youth Tobacco Survey, which was carried out in 2000 and 2002. Access to the database is assured.

In addition, the department has access to the Youth Tobacco Attitudes and Behavior Survey which was carried out in 2001 and is expected to be repeated in 2005.

/2005/

No data are available at this time on tobacco use from the Youth Tobacco Survey carried out in the fall of 2003. Data and analysis are expected early in calendar 2005. //2005//

#09 (C) Health Systems Capacity Indicator

The ability of States to determine the percent of children who are obese or overweight

/2004/

The Colorado Youth Risk Behavior Survey provides data on this measure, but the 2001 survey was not large enough for valid statewide estimates of this age group.

The state WIC program also participates in the Pediatric Nutrition Surveillance System (PedNSS) and data on obesity among children under the age of 5 are available.

/2005/

The Colorado Youth Risk Behavior Survey provides data on this measure, but the 2003 survey, carried out in the fall of 2003, is not expected to yield weighted data. The new Child Health Survey, begun in January 2004, attempts to measure overweight. Data from the new survey will be available in the spring of 2005. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

B. STATE PRIORITIES

The attached chart to this section titled, "Top Ten Priorities for Colorado, National Performance Measures, and State Performance Measures for the MCH Block Grant Application for FY 05," delineates the relationship between the priority areas, the national performance measures, and the state performance measures. Performance measures may be shown for more than one priority, since many address several priorities. For example, the national priority for first trimester prenatal care addresses the state priority of improving perinatal outcomes, the state priority of reducing child morbidity, and the state priority of increasing access to health care. In some instances, there are no national performance measures to address a state priority, so that a state performance measure was created.

After the year 2000 Needs Assessment was completed, the Advisory Council on Health Programs for Women and Children reviewed the results in the fall of 2000, and reconsidered the ten priority areas that had been chosen in 1997. The original list of priorities is shown here:

- Reduce teen pregnancy and unintended pregnancy in women of all ages
- Improve perinatal outcomes
- Reduce child and adolescent morbidity
- Increase health and safety in child care settings
- Improve efforts to reduce unintentional and intentional injury, addressing motor vehicle crashes, suicide, child abuse, and other violence
- Improve immunization rates for all children
- Increase access to health care (including behavioral health care)
- Improve state and local infrastructure by increasing capacity to analyze data, carry out evaluations, develop quality standards, and assure availability of services to all women and children, including children with special health care needs
- Reduce substance abuse (alcohol, tobacco, and drugs)
- Improve oral health and access to oral health care.

Using the conclusions of the Needs Assessment, the Advisory Council recommended that priority areas 3 and 4 be combined, and that a new priority around the issue of obesity be added. The new priority list, in use since FY 02, is shown below.

1. Reduce teen pregnancy and unintended pregnancy in women of all ages
2. Improve perinatal outcomes
3. Reduce child and adolescent morbidity and increase health and safety in child care settings
4. Reduce overweight among children and adolescents, addressing physical activity and nutritional habits
5. Improve efforts to reduce unintentional and intentional injury, addressing motor vehicle crashes, suicide, child abuse, and other violence
6. Improve immunization rates for all children
7. Increase access to health care (including behavioral health care)
8. Improve state and local infrastructure by increasing capacity to analyze data, carry out evaluations, develop quality standards, and assure availability of services to all women and children, including children with special health care needs
9. Reduce substance abuse (alcohol, tobacco, and drugs)
10. Improve oral health and access to oral health care.

With the addition of a new priority area, changes were also made in the state performance measures. Beginning in FY 2002, three new measures were added: inadequate weight gain in pregnancy, relating to number 2 above; injury hospitalization, relating to number 3 above; and child obesity, relating to number 4 above. The chart in the attachment shows the relationships between the priority areas and the national and state performance measures.

Over the past several years in Colorado, there has been a tremendous focus on improving services for children and families during the early years of life, with a number of entities working at both state and local levels. On July 1, 2003, the state health department received a three-year Early Childhood Comprehensive Systems grant that is contributing greatly to this effort and to addressing the priorities shown above. While Colorado has demonstrated strong leadership and many impressive accomplishments in the early childhood field, there is still much to be done to create and support a truly integrated early childhood system. Colorado has countless projects, initiatives, commissions, committees and task forces in the five areas that are defined by the Maternal and Child Health Bureau as critical early childhood system components. The challenge for Colorado is to create a system that allows these efforts to work synergistically rather than in isolation to one another. The Early Childhood Comprehensive Systems grant provides an important opportunity for Colorado to build on existing initiatives and strengthen cross-agency planning and collaboration in the development of a more cohesive and integrated early childhood system.

The goal of the grant is to develop a plan for a comprehensive early childhood system in Colorado that includes the following five components: access to health care/medical home, mental health, early care and education, parent education, and family support services. Objectives to achieve this goal include creating a systems-building infrastructure, completing a strategic planning process, and finalizing a strategic plan that has a broad base of stakeholder support. Collaboration with partner agencies and programs will occur through the Early Childhood State Systems Team. This team includes, but is not limited to, representatives from the Colorado Department of Human Services, Colorado Department of Education, Educare Colorado, Region VIII Administration for Children and Families, Colorado Office of Resource and Referral Agencies, Center for Human Investment Policy, Colorado Children's Campaign, and the Colorado Department of Public Health and Environment.

The Early Childhood Comprehensive Systems grant specifically addresses several of the state priorities previously listed:

- * To reduce child and adolescent morbidity and increase health and safety in child care settings (number 3)
- * To increase access to health care, including behavioral health care (number 7).
- * To assure availability of services to all women and children (number 8).

The following sections describe Colorado's progress on each of the national performance measures and each of the state performance measures.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

The target for FY 2003 for percent of newborns screened was 98.0 percent. The actual proportion screened in that period was 97.5 percent (66,834/68,537), a slight improvement over the 97.4 percent achieved the previous year, but technically short of the target. The figure is based on an estimate by the newborn screening laboratory, which does not yet have the ability

to match the newborn screens with birth certificates in a timely fashion and therefore cannot give exact figures.

The count of births that received a first screening has always been a good but not perfect estimate, because it is not possible to perfectly distinguish late first screens from true second screens (because of name changes for infants in the first few weeks of life), and the inability to link birth certificate information with the newborn screening information in a timely way. The electronically integrated Newborn Evaluation Screening and Tracking (NEST) system, funded by the EHDI (Early Hearing Detection and Intervention) grant and currently being developed, will allow matching of newborn screening data with the electronic birth certificate data, allowing for improved precision in determining the number of Colorado live-born infants who have received at least one newborn screen. This same matching process should allow determination of what proportion of first screen infants receive a second screen as well. Work on the system continued throughout the fiscal 2003 year.

b. Current Activities

The target for FY 2004 continues to be 98.0 percent. We anticipate being able to measure the proportion of newborns screened using the NEST system by the fall of 2004.

The effort to advance newborn screening by tandem mass spectrometry has also moved forward in that the number of children screened by the voluntary program at the University of Colorado Health Sciences Center has increased from several hundred to approximately 2,600 (about 3.7 percent of the birth cohort) between FY 2003 and FY 2004. We are still missing a major hospital system deciding to offer the screening universally, and we still lack major commitment by state government to raise newborn screening fees sufficiently to support addition of universal tandem mass spectrographic screening.

The Newborn Screening Newsletter released in the spring of 2004 is attached to this section. It describes a great number of activities concerning newborn screening in the state.

c. Plan for the Coming Year

The target for FY 2005 will remain at 98.0 percent. With the electronically integrated NEST system development expected during FY 2004, we estimate that we will be able to analyze first and second screens accurately for calendar 2004 and therefore provide a more accurate count for this performance measure for FY 2005. With the additional information this system will provide, we will be able to set appropriate targets for future fiscal years.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

a. Last Year's Accomplishments

Data available from the first State and Local Area Integrated Telephone Survey (SLAITS) to assess this question shows a rate for Colorado of 57.4 percent. This figure was based on surveys conducted in 2000-2002 and constitutes a baseline percentage for comparison in future years.

While a target of 55.0 percent for FY 2003 is shown in Form 11, no SLAITS data are

specifically available for FY 2003, and we do not know if the target was met.

The state Health Care Program for Children with Special Needs believes that affected families will be able to partner in decision making and receive coordinated care if they are able to access care through a medical home. During FY 2003 the state Family Voices co-director was hired to coordinate the family component of the Medical Home Learning Collaborative, which had been started to introduce providers and families with children with special health care needs to the concept of medical home. A full-time parent consultant was also hired in November 2003 to serve as the liaison between parents with special needs children in the community and the state program's 14 regional family coordinators.

During FY 2003 the state program continued designing an annual report, called the HCP End-of-the-Year Report and MCH Plan (HERMAN). This document allows the state program to acquire information from all regional offices about progress toward meeting program contract goals, national performance measures, and infrastructure. Data was collected in 2003 and will begin to be analyzed in the summer of 2004. This effort will be carried out annually, and an annual report will be produced each year, providing a review of outcomes and marking the progress of the program.

b. Current Activities

A target of 55.0 percent was set for FY 2004, as well as for future years for this performance measure. Since the national SLAITS survey will not be repeated until 2005 we do not expect to have new data from the 2005-2007 survey until 2008.

Information from the regional offices in Colorado was collected during FY 2004 through the HERMAN annual report document (see Last Year's Accomplishments), which will be available for analysis during the summer and fall of 2004. The rest of the information will be available for analysis in the early part of 2005. This information will allow the state program to assess progress on how easily families can partner in decision-making, and on their satisfaction with the services they receive.

A public education outreach campaign for the Health Care Program for Children with Special Needs has been planned for late in 2004 to market the program's new goals and priorities to Colorado families with children with special health care needs. Since the discontinuation of paid services in July of 2003, families and other agencies often do not know how the state program can assist children with special health care needs. A strong campaign to help Colorado families identify and utilize the program will be used to continue to reach the families who have been involved with the program and to identify and serve new ones. This campaign will also help identify barriers to access which can then be addressed in planning and infrastructure-building.

c. Plan for the Coming Year

The target for FY 2005 is 55.0 percent.

During fiscal year 2005 the National Center for Health Statistics will begin to collect data regarding Children with Special Health Care Needs through its national telephone survey (SLAITS) that is carried out in every state. These data will be available for analysis in 2008.

The state program will continue to acquire information from all the regional offices regarding their progress towards their goals and our national performance measures through the annual report (HERMAN) document. Data collected in 2004 will be available for analysis in 2005.

The public education campaign, which will have been started at the end of 2004, will continue through 2005. Information provided by the campaign will be incorporated into state program

infrastructure building in order to strengthen partnering in decision-making and satisfaction.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

Data available from the first State and Local Area Integrated Telephone Survey to include this question show a rate for Colorado of 51.6 percent. This figure was based on surveys conducted in 2000-2002 and constitutes a baseline percentage for comparison in future years.

While a target of 50.0 percent for FY 2003 is shown in Form 11, no data are specifically available for that year, and we do not know if the target was met.

During the past fiscal year, Colorado continued to participate in the national Medical Home Learning Collaborative. Infrastructure building around the concept of a medical home was a priority for the state program last year and will continue to be a priority in the future. The Health Care Program for Children with Special Needs also participated in the Measuring and Monitoring Community-Based Systems of Care technical assistance project, which helped the state program collect medical home data across agencies.

During FY 2003 the state program continued designing an annual report, called the HCP End-of-the-Year Report and MCH Plan (HERMAN). This document allows the state program to acquire information from all regional offices in the state about progress toward meeting program contract goals, national performance measures, and infrastructure. Data was collected in 2003 and began to be analyzed in the summer of 2004. This effort will be carried out annually, and an annual report will be produced each year allowing the review of outcomes and marking the progress of the program.

b. Current Activities

The goal for FY 2004 was set at 50 percent of all families of children with special health care needs to receive coordinated, ongoing comprehensive care within a medical home. Since SLAITS data will not be available again until after the 2005-2007 survey is completed, we will not be able to measure the impact of what we have accomplished during this particular fiscal year.

Despite Colorado's stagnant economy, budget reductions in the Medicaid Program, and limitations put on the Child Health Plan Plus program during this fiscal year, we worked through the Medical Home Learning Collaborative with the local chapter of the American Academy of Pediatrics to increase reimbursement for primary care providers. Such increases are integral to building medical homes. In addition, the Health Care Program for Children with Special Needs purchased access to the Peregrine database, which contains information regarding providers and the type of insurance they accept in their practice. Provider information will be utilized along with other data to help to plan and to build medical home infrastructure and participation. The Medical Home Learning Collaborative continued to meet throughout the year with other agencies in the state to address the issues of medical home in Colorado.

The Measuring and Monitoring Community-Based Systems of Care group remains committed to acquiring information from sources around the state to measure outcomes for children with special health care needs; specifically medical home. This group meets quarterly to address data collection, collaboration and dissemination throughout the state. As medical home data become available they will be utilized to measure progress toward the goal of all families with

children with special health care needs having medical homes.

The state health department began collecting data on child health with the new Colorado Child Health Survey in January 2004. These data include information on medical home, and will be available for analysis in the spring of 2005.

Information from the regional offices in Colorado, available through the annual HERMAN document (see National Performance Measure 2, Last Year's Accomplishments), were quantified and entered into a database during the fiscal year. Part of these data became available for analysis during the summer of 2004.

c. Plan for the Coming Year

The target for FY 2005 is 50.0 percent.

During fiscal year 2005 the National Center for Health Statistics will start collecting data for the Children with Special Health Care Needs Survey through their telephone survey (SLAITS). These data will be available for analysis in 2008.

The Colorado Child Health Survey data collected in 2004 will become available for analysis in the spring of 2005. We should be able to measure our progress toward meeting National Performance Measure 3 with these data.

The Health Care Program for Children with Special Needs will continue to acquire information from all the regional offices regarding their progress toward national performance measures through the HERMAN document. These data will be available for analysis in the fall of 2005. These data will also provide HCP with some information regarding local medical home infrastructure barriers and resources.

The Peregrine database will be analyzed again during FY 2005 to provide information on providers statewide and which type of insurance they accept. This analysis will identify gaps in primary care and rural areas of need.

The Medical Home Learning Collaborative will continue to meet during 2005 and the state program will continue efforts to build infrastructure to increase the number of families with children with special health care needs that have medical homes.

A public education campaign is planned for late in 2004 to market the services of the Health Care Program for Children with Special Needs to families in Colorado. Since the discontinuation of paid services in July of 2003, some families do not know if HCP is still available to assist them with their children with special health care needs. A strong campaign to help Colorado families identify and utilize the program will be used to continue to reach families that have been involved with the program and to identify and serve new ones. This campaign will also help identify barriers to access to care and can be incorporated into infrastructure building. This work will assist us in meeting National Performance Measure 3, and in building medical homes for all children with special health care needs in Colorado.

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments

Data available from the first State and Local Area Integrated Telephone Survey (SLAITS) to include this question show a rate for Colorado of 58.2 percent. This figure was based on surveys conducted in 2000-2002 and constitutes a baseline percentage for comparison in future years.

While a target of 55.0 percent for FY 2003 is shown in Form 11, no data are specifically available for that year, and we do not know if the target was met.

A HRSA-sponsored household survey in 2001, the Colorado Health Survey, provided some information regarding insurance coverage for persons of all ages with disabilities. It was reported that a greater proportion of the uninsured have a disability compared to those who are insured. Additionally, the survey results revealed that over half of the uninsured in Colorado are Hispanic.

The annual HERMAN document (see National Performance Measure 2, Last Year's Accomplishments) provides the state program with information regarding regional progress towards contract measures, infrastructure building activities and performance measures. Information collected in FY 2003 became ready for analysis in the summer of 2004.

JFK Partners, Colorado's University Affiliated Program, reported that their data show that public and private insurance is not being fully utilized for children from birth to three years. Instead, some of the covered benefits are being provided through state Early Intervention dollars.

b. Current Activities

A target of 55.0 percent of special needs children having adequate insurance was set for FY 2004.

SLAITS data for 2000-2002, newly available in January 2004, revealed that fully 95.7 percent of children with special health care needs have some type of insurance. However, this insurance may not be adequate for the care the children need. In addition, the proportion of families with insurance in 2004 may well be lower than the proportion found in the SLAITS survey, when the state's economy was stronger.

Given the budget crisis in Colorado, a decrease in Medicaid benefits and a cap on CHP+ enrollment, the Health Care Program for Children with Special Needs believes these numbers are not representative of the current insurance levels in Colorado. The next SLAITS survey is starting in 2005 and data will be available for analysis in 2007-2008.

The Colorado Child Health Survey, which began collecting data in January 2004, will provide information regarding insurance coverage for all children in Colorado. Since the SLAITS survey will not be conducted again until 2005, this state survey is expected to yield data to answer questions about insurance on an annual basis. The data should also give us an estimate of the number children with special health care needs in the state and whether they have insurance coverage. Data will be available for analysis in the spring of 2005.

The annual HERMAN document (see National Performance Measure 2, Last Year's Accomplishments) will provide information regarding insurance for children with special needs families who participate in the Health Care Program for Children with Special Needs. While our regional offices will not be able to estimate the number of families who do not have insurance if they do not access the program, this document will nonetheless help us estimate the proportion of children with special health care families who have insurance and the type of insurance they utilize. Data pertaining to 2003 will be analyzed during FY 2004 and compared to the SLAITS data collected between 2000 and 2002.

c. Plan for the Coming Year

The target for FY 2005 is that 55.0 percent of all special needs children will have adequate insurance. The annual state Child Health Survey should be able to provide data to measure progress on this national performance measure in the spring of 2005. Data from SLAITS will begin to be collected in calendar 2005.

The annual HERMAN document (see National Performance Measure 2, Last Year's Accomplishments) will provide insurance information from all the regional offices in Colorado. These data will be limited to those families with children with special health care needs who access care coordination through the state program. Data pertaining to 2004 will be analyzed in 2005 and compared to 2003 data from the previous year. We will be able to ascertain progress or lack of progress from this information regarding children in our program.

The Measuring and Monitoring Community-Based Systems of Care group will continue to work with Part C, Medicaid and other stakeholders to utilize all possible data to get the best insurance profile for families with special health care needs in Colorado. The group plans to address anticipated gaps in insurance.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

SLAITS data for 2000-2002 showed that 77.4 percent of families with children with special health care needs in Colorado reported well-organized community based systems of services that they could access easily. This data is considered a baseline figure. No more recent data are available.

Through the Measuring & Monitoring group and the Medical Home Learning Collaborative, the Health Care Program for Children with Special Needs identified important representatives from other agencies who can help provide data on children with special health care needs in Colorado. The Part C Memorandum of Understanding committee and the Medical Home Advisory Group were important vehicles for identifying systems issues at the state and local levels. Knowledge from these groups allowed the state program to build community resource networks and relationships to increase the ease of use of such systems by families.

The annual HERMAN document (see National Performance Measure 2, Last Year's Accomplishments) provides information regarding community-based services through the regional offices. Resources available in the area, relationships, and proposed programs to increase the number of resources available for families of children with special health care needs are delineated. These data are being analyzed in 2004 and will give us a much better look at Colorado's infrastructure than the general SLAITS data that is available.

b. Current Activities

The target for FY 2004 was set at 75.0 percent. SLAITS data will not be available to measure this performance measure until 2008. The Colorado Child Health Survey data, although available annually beginning in the spring of 2005, does not contain information on this question. Information from the annual HERMAN document regarding community based services for the year 2003 will be analyzed starting in 2004, however, and should provide some

information on progress on this measure.

The Health Care Program for Children with Special Needs began working with the Traumatic Brain Injury endowment in 2004, and it plans to offer care coordination for children and youth under 21 who experience traumatic brain injury. This project is in the planning phases and is an exciting opportunity to collaborate with others in the community who were not previously associated with the program, as well as to provide care to a previously unserved population.

This year the state program is also involved with the Community Access To Child Health (CATCH) grant. This grant identifies physician provider capacity issues in Colorado and how these issues relate to youth age 14 to 21 who are transitioning to adult status. They are moving from pediatric to adult health care providers, from student status to work or vocational status, and from their family's insurance to their own insurance.

Building infrastructure and identifying barriers to provider services will not only increase the number of families with children with special health care needs that are working with the state program but hopefully will afford better transition outcomes for all children with special health care needs. Many stakeholders are involved with this project including Part C, EPSDT, Project WIN, Project WINS, Family Voices, Colorado Project TRAIN, National Technical Advisor for Disabilities Program Navigators, Disability Program Navigators, and Project One Stop for Families.

c. Plan for the Coming Year

The target for FY 2005 is that 75.0 percent of all special needs children will report community based systems that can be easily accessed. Although data from SLAITS will begin to be collected in calendar 2005, the results will not be available until 2008.

The annual HERMAN document (see National Performance Measure 2, Last Year's Activities) will provide information regarding community-based services and resources for each region in Colorado. Information from 2004 will be entered into a database and analyzed during FY 2005.

The Medical Home Learning Collaborative, the Measuring and Monitoring Community-Based Systems of Care group and the transition group, working with the CATCH grant, will meet throughout the year and will also address the issue of community-based services. This issue is at the heart of many of the other national performance measures and will be both a family and infrastructure building activity for this year.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

SLAITS data from 2000-2002 reported that 3.3 percent of youth with special health care needs received all needed services to transition successfully into adult life. These data are collected for children up to age 18 years old and therefore do not represent all of the youth in Colorado, who are defined as 14-21 years old.

The annual HERMAN document will collect information regarding transition by all regional offices in Colorado. This document will provide the state program with each region's progress towards meeting contract performance and national performance measures as well as information regarding barriers to transition in their areas. This information will help the state program to build the infrastructure so that all youth with special health care needs can transition

into adult life successfully.

During FY 2003 the Colorado Department of Education began planning for the first longitudinal study to address the issues of transition for youth through the school system. The Health Care Program for Children with Special Needs will be allowed input and assistance with this study.

The Measuring & Monitoring Community-Based Systems of Care group met regularly and collected information on barriers to and issues around transition for youth with special health care needs. This group has bought rights to the Peregrine database, which provides information on providers in the state of Colorado and if they accept Medicaid and/or Child Health Plan Plus insurance. These data will be distributed and other data sources will be included to develop the best profile of issues affecting youth transition in Colorado.

b. Current Activities

The target for FY 2004 was set at 8.0 percent. SLAITS data will be collected in 2005-2007 so that this measure can be reviewed again in 2008. We anticipate that input to the survey from the state level will result in survey questions that address this issue more comprehensively than in the first SLAITS survey carried out in 2000-2002. The state Child Health Survey data does not contain useful information on this question. The Child Health Survey excludes children over the age of 14, and data from this survey will only be available for children who are 14.

Data from each regional office in Colorado will be collected in 2004 through the use of annual reports from the regional offices. Data includes information on transition and these data will be quantified, entered into a database and analyzed starting in the summer of 2005.

During FY 2004 data from the Colorado Department of Education's first longitudinal study on youth transition should become available.

The Health Care Program for Children with Special Needs will remain involved with the Community Access To Child Health (CATCH) grant, which addresses the issue of transition with youth with special health care needs ages 14 to 21 years. This project utilizes a broad-based collaborative community partnership to develop strategies to effectively implement the planning of this project. By utilizing this community partnership the state program not only facilitates the completion of this grant but has a voice in the activities centered around transition and access to care for all youth with special health care needs in the state. Data collection for the CATCH grant will be completed this year and analysis will begin in the first part of FY 2005.

c. Plan for the Coming Year

The target for youth transition for FY 2005 is set at 10.0 percent. The National Center for Health Statistics will start data collection for SLAITS in 2005. Data will be available for analysis in 2008. HCP will then compare the numbers regarding transition to those acquired in 2000. The Colorado Child Health Survey does not provide information on this measure.

Data acquired from the regional offices through the HERMAN document will be collected during 2005 and appended to data from 2004. Data analysis will allow the first comparison of transition in the state over time.

Data collection for the Community Access To Child Health grant projects will be completed by 2004 and analyzed and disseminated in 2005.

The Measuring and Monitoring Community-Based Systems of Care group will continue to meet and incorporate transition data into its meetings. Building infrastructure and planning around

medical home and community based systems of care will help youth transition into adult life successfully. Through this group the state program will continue to collaborate, incorporate new members, and address issues of transition.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

Increasing the proportion of two-year olds who have completed their immunizations to 90 percent has been a national and state objective for many years. For the last two quarters of 2002 and the first two quarters of 2003, the 4:3:1:3* rates for two-year-old children in Colorado were 64.7 percent, down sharply from the previous year's 75.4 percent. The target for FY 2003 (90 percent) was not met, although Colorado achieved 90 percent or greater for the 3 DTaP shots (93.5 percent), 3 Hib shots (90.7 percent), and 3 Hepatitis B shots (90.4 percent). Colorado attained a rate of 61.1 percent for the 4th DTaP, down from 75.5 percent the previous year. This specific immunization is largely responsible for the overall low immunization rate.

Nationally, the 4:3:1:3 rates are just 79.8 percent, and the 4th DTaP continues to be a problem for many states, including Colorado. For this same time period nationally the 4:3:1:3:3** rate is 77.9 percent, while Colorado's rate for the same measurement is 63.3 percent. This places Colorado 50th out of 50 states for its immunization coverage of 19-35 month olds.

Other problems that contributed to Colorado's inability in FY 2003 to achieve the 90 percent goal include geographic constraints, lack of financial support from the state, lack of health professionals, mobility of the population, and inability to perform reminder recall.

* The 4:3:1:3 series specifies 4 doses of DTaP; 3 doses of polio; 1 dose of MMR (measles, mumps, and rubella); and 3 doses of Hib.

** The 4:3:1:3:3 series specifies 4 doses of DTaP; 3 doses of polio; 1 dose of MMR (measles, mumps, and rubella); and 3 doses of Hib, 3 doses Hepatitis B.

b. Current Activities

The Immunization Program received funding from the Health and Human Services Preventive Health Block Grant to fund local health agencies engaged in expansion of clinical access and improving immunization services. These funds were awarded through an informal request for proposals and were in addition to the funds awarded for service delivery contracts supported by a grant from the National Immunization Program, Centers for Disease Control and Prevention. Additionally, agreements were established with local health agencies interested in performing quality assurance site visits in provider offices participating in the Vaccines for Children Program.

Current projects include performing GIS mapping of birth certificate data based on surrogates to low immunization coverage, i.e., mother's level of education, mother's income level, and birth order of the child. These surrogates to low immunization rates were identified through a literature review. Using these surrogates, program staff have identified possible pockets of need. The next step is GIS mapping of immunization data from a large county health department to determine if the surrogates did in fact identify areas of low immunization

coverage. This will help program staff determine the level of predictability of these surrogates for Colorado's population.

The 2004 Legislature approved a request for \$500,000 in funding for the Immunization Program. The money will support local health agencies engaged in community-based outreach clinics, identification of pockets of need, and a public information campaign. The funding began July 1, 2004 and will continue through June 30, 2005.

c. Plan for the Coming Year

Plans for FY 2005 include developing a collaborative strategic multi-stage planning process that integrates internal partners, external organizations, external providers, and external organizations and stakeholders. This dynamic process will involve identification of realistic goals and strategies for improving childhood immunization rates across the state. A steering committee will meet on a regular basis. The focus of different stages will include stakeholder barrier analysis, managed care analysis, VFC provider review, targeted surveys, and targeted focus group meetings.

Plans also include the development of process evaluation indicators based on nationally recognized best practice data. For example, one indicator is called "Implementation of strategies to improve vaccination coverage - Systems are used to remind parents / guardians, patients and health care professionals when vaccinations are due and to recall those who are overdue" (Standards for Child and Adolescent Immunization Practices, September, 2003, CDC). This indicator measurement would include determining the number of providers that routinely utilize any reminder/recall effort. The process evaluation indicators would be disseminated among geographically diverse local communities and providers for measurement. The data will be collected and summarized to determine baseline measures for specific process evaluation indicators, and specific strategies will be developed to improve the baseline measurements as appropriate.

Finally, we plan to identify various outcome evaluation indicators to further explain the status of vaccination coverage in Colorado. For example, analysis of Medicaid data indicates that 25 percent of children covered by Medicaid are up-to-date on required immunizations. Development and implementation of a research study to determine the accuracy of this rate would provide valuable information on children in Colorado. Data will be collected from schools and daycare centers through onsite data abstraction. Specific interventions will be designed based on the data indicators following analysis. Interventions will be implemented and additional measurements will be conducted.

A total of 10 of the 15 organized health departments have specific immunization activities that they will be carrying out using MCH funding in FY 2005.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

For calendar 2002, the teen birth rate objective was 29.0 and was easily met with a rate of 25.9. The Colorado rate actually increased slightly from 2001, when it was 25.4, but it stayed well below the target that had been set.

Since 1992, the rate has dropped 29 percent overall in the age group, from a high of 36.3 births per 1,000 teens. This decline is unprecedented and the lowest rate since statistics were

developed for the age group. The declines were observed for Blacks and non-Hispanics but are uncertain for Hispanics (because of problems estimating the number of Hispanic teen females). Hispanic fertility is now the driving force behind the Colorado rate, with almost 60 percent of all teen births occurring to Hispanic girls. (In this discussion, the terms Hispanic and Latina are used interchangeably).

There appear to be a number of factors contributing to the decline in the teen birth rate. State family planning programs used Title X monies to support services for teens. Title V monies also supported contracts with school-based health centers located in eight communities across the state. These programs provided health education to teens regarding sexual activity, promotion of abstinence, and pregnancy prevention.

The 2003 Youth Risk Behavior Survey carried out in Colorado reveals that among high school students surveyed, a total of 90 percent had never had sex or had not had sex in the last three months, or if they had, they had used a condom. This figure meets the Healthy People 2010 goal for this risk behavior. A total of 39.1 percent of students had ever had sex, down from 42.3 percent reported in the 2001 Youth Risk Behavior Survey. These figures should not be considered to be representative of all teens in the state, but they suggest a reduction in high-risk sexual behavior at least in the groups surveyed. *

During FY 2003, delays in reauthorization of the Title V Abstinence Education Grant led to delays in the Colorado Abstinence Education Program's implementation of its FY 2003 plan. Not until March 2003 could the program award 14 subcontracts to local organizations for the purchase of curricula and for teacher training. These grants provided training for at least 35 new abstinence educators. The program also funded an advertising agency to enhance and continue implementation of the "Say No Way" campaign. In addition, funding was provided to five local programs that offered a multi-faceted approach to abstinence education including curriculum-based classes, peer mentoring, and parent components.

* The 2003 Colorado Youth Risk Behavior Survey was carried out in 23 schools, with 757 participants. However, the data are not weighted, and the sample is insufficient to make general statements about all Colorado high school students. The 2001 YRBS was carried out in 32 schools, with 999 participants. The data from the earlier survey are also insufficient for results to be weighted.

b. Current Activities

The target for calendar 2003 for this measure remains at 29.0 births. While the reduction of the rate in 2001 to 25.4 suggests that a lower target could have been set, we were not certain if the sudden drop would be permanent. In addition, the high teen fertility rates among Latina girls, coupled with sustained in-migration of this population group, suggested that the overall rate would increase again.

An analysis in 2003 revealed that while rates for Hispanic teens who were born in Mexico were double those for U.S.-born Hispanic teens, Mexico-born Hispanic teens contributed only one out of every five Hispanic teen births. The rate among U.S.-born Hispanic teens was also higher than for any other U.S.-born ethnic or racial group. The teen birth rate in 2000 (the year when both Census data and birth data were available) was 29.9 overall; 46.6 for Black teens, 17.3 for non-Hispanic (White) teens, and 77.8 for Hispanic teens. For Hispanic teens born in the U.S., the rate was 64.8, and for those born in Mexico, Central America, and South America, it was 131.1. The rate of the U.S.-born Hispanic teens, coupled with the high number of teens, yielded a high overall birth rate for Hispanic teens that was principally due to the births among the teens who were born in the U.S. The contribution of teens born outside the U.S., despite their much higher rate, plays less of a part in the overall rate because the number of teen girls is smaller.

The state health department has been working with local Latino organizations to identify approaches for pregnancy prevention that are effective with this population, with the goal of sharing successful programs and approaches with others. A consultant was hired in March 2004 to conduct focus groups and one larger meeting with Latino/a community members and key community-based organization representatives in metro Denver. The project was aimed at U.S.-born teen Latinas whose parents may or may not be U.S.-born citizens. Questions were asked regarding known approaches to tackling Latina teen fertility, sociocultural attitudes and beliefs, and gaps in resources and knowledge. Participants included Latinas who had babies as teenagers and Latina teenagers who were pregnant; Latinos who fathered babies as teenagers; Latinas/os who have not had pregnancies or babies as teens; Latinos and Latinas whose children were/are teen parents; Latinos and Latinas whose children have not been pregnant nor are teen parents; and monolingual Spanish-speaking participants. Results will be reported in August 2004.

The Colorado Abstinence Education Program is funding 8 programs in 10 counties, all serving adolescents in grades 6 to 12, with particular attention to those populations more vulnerable to becoming pregnant while unmarried. One grantee is piloting a curriculum modification that provides 10 weeks of training for Latina girls and their families in preparation for their Quinceanera celebrations on their 15th birthdays.

c. Plan for the Coming Year

The target for calendar 2004 is 24.0, a substantially reduced goal. This new lower goal is set based on the experience of the recent decline in fertility and preliminary data for 2003 that reveal a continued drop in the number of births. With an improved focus on Latina teens resulting from the work done during 2004, we anticipate some progress in the future in reducing rates in this group. The results of the focus group analysis carried out in 2004 will provide the information necessary to create a strategy to address the issue of high teen Hispanic fertility. This strategy will be developed in the first part of FY 2005 and we anticipate beginning a targeted effort to reduce teen fertility in this group in the second half of FY 2005. Any actual impact on rates will not be seen until at least 2006 (FY 2007).

During FY 2005, the Colorado Abstinence Education Program will continue funding eight local programs to provide curriculum-based abstinence education in their communities. The program has also released a Request for Proposals to identify a social marketing firm to develop a strategic marketing plan for the 2004-2007 campaign to promote abstinence. The social marketing strategic plan will be developed by August 31, 2004 and implementation of new tools will begin in September 2004.

We will continue to support the Title X work to provide family planning to teens across the state. In addition, Title V will provide support to school-based health centers, which address high-risk behavior among teens.

A total of 10 of the 15 organized health departments are planning to focus on this performance measure during FY 2005.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments

The goal in FY 2003 was 35 percent, but it is assumed that the percentage has remained at 29 percent since 2001. The next screening for sealants is taking place in 2004. The Chopper

Topper Sealant Program provided over 5,000 sealants to 1,490 second grade children in qualifying schools (with over 70 percent free and reduced lunch participation). Nearly 1,800 children were screened representing 41 percent of the eligible children in the 5-county metropolitan area, which is the current targeted population. The thirty-five schools participating represents 45 percent of the schools eligible in the metro area.

b. Current Activities

The goal for FY 2004 is 35 percent. It is too early to tell whether this goal will be met. The screening for sealants in third graders is ongoing at this writing. The screening process is significantly more arduous than the first time due to a change in the methodology for collecting the data. The first round of oral health surveillance data on sealants (and decay) indicators conducted in 2001 did not meet the criteria for inclusion in the National Oral Health Surveillance System because a convenience sample was used. Therefore, a randomized method of selecting schools was developed and 50 representative schools chosen with the assistance of an oral epidemiologist. Letters explaining the screening were sent to the 50 principals with 17 schools declining to participate. An additional 17 schools were identified as replacements with 3 of those schools declining. Again, replacements were found, so it is anticipated that 48-50 schools participated by the end of June 2004. Utilizing Centers for Disease Control funding, a contract dental hygienist is working with volunteers and students to complete the screenings. Once the screenings are completed, an analysis of the data will occur and results sent to the CDC for inclusion in the National Oral Health Surveillance System (www.cdc.gov/NOHSS).

c. Plan for the Coming Year

In FY 2005, the goal remains at 35 percent for several reasons. Due to funding limitations, it does not appear that the Chopper Topper Program will be able to expand. A Sealant Expansion Plan is currently being drafted should funds become available. However, the new Ronald McDonald van is up and running, serving Adams County (Commerce City District 14) with slightly less than 400 children served and 1,300 sealants placed to date. The goal of 35 percent is a significant increase above current levels, so this goal remains "optimistically feasible." One significant barrier in expanding the sealant program, in addition to funding, is lack of support by the dental community. The Oral Health Program director is chair of the Sealant Task Force for the Association of State and Territorial Dental Directors. A survey was conducted in FY 2004 that indicated that 57 percent of states with school-based sealant programs had difficulties with the local dental community. The Oral Health Program director will be working with CDC on a "sealant consensus" conference in FY 2005 to address the perceived barriers.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

The rate of deaths to children aged 0-14 caused by motor vehicle crashes declined to 4.4 in 2002 (FY 2003), down sharply from 5.4 the previous year. The target had been set for 3.5, which was not met, but the rate was lower than in 2001 or 2000. A total of 42 children died in motor vehicle crashes in 2002. To meet the 3.5 goal, no more than 33 children should have died.

In October 2000, Colorado was one of only three states to receive a three-year booster seat campaign grant from CDC. This grant promoted booster seat use for children ages 4 to 8 through education of parents during the period October 2000 through September 2003. During

1995 to 2000, a total of 62 children ages 4 to 8 died in motor vehicle crashes in the state, an average of more than 10 per year. These children might have benefited from booster seat use, and use in this group was considered to have been at fairly low levels.

In 2002, the Colorado Legislature passed a child safety law requiring 4- and 5-year-olds over 40 pounds and under 55 inches to use booster seats in order to use seatbelts safely. The bill went into effect on August 1, 2003. It is anticipated that there will be fewer deaths, at least among 4- and 5-year olds, as knowledge of the law becomes better known and enforcement begins to have an impact. Between 1990 and 1994, the motor vehicle fatality rate for 4- and 5-year-olds averaged 4.7, while the rate declined to 3.9 (1995-2001) after the general seatbelt law was passed. We anticipate a further reduction in this rate in the future as a direct result of the booster seat law, which we may begin to see with 2003 data. Data for 2002, however, when the law was passed but not yet in effect, show a rate for this age group of 4.9, indicating a real need for the legislation. A total of 6 children died in motor vehicle crashes who were age 4 or 5 in 2002.

The campaign had a booth at the annual Cinco de Mayo festival in May 2003. Parents were encouraged to ride in the "Convincer," which simulates a 7-mile per hour crash, and educates parents about crash dynamics. The program also had a booth and similar setup at the Juneteenth festival, a Black community event, in Colorado Springs in 2003.

In June 2003, the campaign created a bookmark with the booster seat law requirements on one side and a picture of proper booster seat use on the other. Over 2,000 of these bookmarks and 50,000 educational brochures (in English and Spanish) were distributed widely through public health, police department offender classes, schools, low-income assistance programs, Head Start, recreation facilities, pediatricians' offices and a variety of community events. In addition, the Injury Prevention staff created a CD entitled "Colorado Booster Seat Project 2000-2003. A How to CD" highlighting the entire booster seat project. This CD is available on the web at www.cdphe.state.co.us/pp/injuryprevention. The special booster seat campaign was completed in September 2003.

b. Current Activities

The goal for FY 2004 remains at 3.5 deaths per 100,000 children.

In October 2003, Colorado was one of two states to receive a CDC cooperative agreement entitled "Colorado Community-Based Interventions to Reduce Motor Vehicle-Related Injuries." This four-year project will target two specific motor vehicle-related areas: 1) increased booster seat use among children ages 4-8 in child care facilities in El Paso county; and 2) enhanced seat belt enforcement in the two rural counties of Delta and Prowers (it is known that adults who don't buckle up often don't buckle their children up). Child care workers were among the biggest opponents of the Booster Seat Law (passed in 2002) and observational surveys, conducted by Colorado State University for the Colorado Department of Transportation in June 2003, indicated rural counties have some of the lowest seatbelt use rates in Colorado. The June observational survey revealed Colorado's overall seatbelt use rate to be 77.7 percent.

A document, "Traffic Safety Facts: Colorado Children Ages 4-8" is on the Injury Epidemiology website at www.cdphe.state.co.us/pp/inj.epi. It is also provided as an attachment to this section in an Adobe pdf file.

The Injury and Suicide Prevention program oversees the state SAFEKIDS Coalition. In March 2004, another SAFEKIDS chapter in Gunnison county was formed.

c. Plan for the Coming Year

We will continue to educate the public about the importance of car/booster seats and seatbelts through the CDC motor vehicle cooperative agreement. Baseline observational surveys will be conducted at child care centers and in Delta and Prowers counties followed by educational campaigns (these campaigns will be designed by the community coalitions that are being formed in 2004 with guidance from the state oversight coalition).

Colorado's ranking compared to other states on this measure in FY 2002, when the rate was 5.4, was poor. Out of 46 states reporting data, 33 had lower (better) rates than Colorado. The top 10 states had rates of 2.6 deaths per 100,000 or lower. This performance measure is one that Colorado needs to address very specifically to generate any improvement.

Local county Maternal and Child Health planning for FY 2005 emphasizes the need for objectives and activities to impact this measure, particularly in rural areas. Three of the organized health departments will be using MCH dollars specifically to focus on reducing motor vehicle deaths in their counties in the coming year.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Colorado's target of 85.0 percent of all women to be breastfeeding at hospital discharge was met in FY 2003. PRAMS 2002 data show that 85.5 percent of women initiated breastfeeding, the highest percentage ever attained in Colorado. The 2002 rate is an increase over and above the 2001 rate of 84.3, which had actually dropped from the previous year (85.2).

Using a survival analysis technique, we have analyzed our PRAMS data from initiation to 20 weeks after delivery. Through this method, we are able to better describe how breastfeeding patterns changed between 1997, the first year of PRAMS data, through 2001. Each year showed higher initiation rates from 1997 through 2000, with an apparent downturn in 2001. However, duration rates changed more dramatically over the period. In 1997, 20 percent of all mothers continued breastfeeding to at least 20 weeks. By 2001, the proportion increased to 32 percent, or one in three mothers continuing to at least 20 weeks. A chart showing these rates is attached to this section.

Another way to describe these patterns is to note that in 1997 one out of every two Colorado babies was breastfed for at least two months. Four years later, in 2001, one out of every two babies was breastfed for at least three months.

These changes suggest that the emphasis on duration placed by our breastfeeding programs has yielded very positive results. The WIC Program loans over 700 electric and pedal breast pumps to program participants statewide to support women's effort to continue breastfeeding. WIC is piloting a single-use giveaway breast pump program with preliminary results suggesting that women who own their own pump are both less likely to use formula, and more likely to delay the introduction of formula.

b. Current Activities

The Colorado target for FY 2004 is set at 87.0 percent for initiation. In addition we have a target of 50 percent at six months, in line with the Healthy People 2010 objective. Colorado's 2002 six-month rate is 39.1 percent (Ross Mothers' data), down substantially from the 2001 rate of 48.6 percent (although distinctly higher than the 28.9 percent rate found ten years before in 1992).

The recent fluctuation in initiation rates has given a clear message to lactation promoters and supporters statewide that breastfeeding efforts must be increased in order to meet the targets this year and next. The Colorado Breastfeeding Task Force revived a breastfeeding promotion committee in collaboration with the Colorado Physical Activity and Nutrition Program at the state health department. This committee has developed strategies and action steps to address breastfeeding needs in all sectors of Colorado communities. Some of these needs were identified from findings of the 2003 survey of maternity care practices related to breastfeeding. The strategies and action steps will be presented to communities in the fall of 2004 with seed money available for project implementation. A breastfeeding law stating that a woman has a right to breastfeed "wherever she has a right to be" further advances breastfeeding as the norm in Colorado. This law was passed in the spring 2004 legislative session, and will help pave the way for other breastfeeding support legislation that supports lactating women in the workplace.

This year the theme for World Breastfeeding Week in early August relates to exclusive breastfeeding. Because Colorado breastfeeding rates, particularly WIC rates, drop off rapidly in the first month, the State WIC Office is implementing an exclusivity campaign from August through October 2004. The message to mothers and families, will be "no bottles, no formula, no pacifiers" for at least the first month of life. This campaign and the giveaway breast pump project will be evaluated for their impact on duration.

Several WIC staff breastfeeding training opportunities are taking place in 2004. These included an April regional training on counseling pregnant women about breastfeeding using a three-step counseling approach and strategies that keep women breastfeeding. WIC will also host a breastfeeding management seminar for nurses and dietitians in late September.

c. Plan for the Coming Year

The target for FY 2005 for breastfeeding initiation is 87.0 percent.

To expand statewide breastfeeding efforts in diverse settings, we anticipate a variety of breastfeeding projects supported by mini-grant and larger grant opportunities. Pending funding, a breastfeeding support research project for Latina women is to take place in a Denver agency. The agency has found that 46 percent of Latina women report a combination of formula and breastfeeding as early as two weeks postpartum. The project will provide proactive telephone contact to mothers in the the first two weeks.

The southeastern region of Colorado has the lowest breastfeeding rates of the state. To improve the availability of lactation experts in that region, a Certified Breastfeeding Educator training is scheduled for October 2004. One hundred and ten individuals will be able to attend the training with preference given to those from the target region.

The Colorado Physical Activity and Nutrition Program's Colorado Breastfeeding Task Force subcommittee on breastfeeding promotion will revise and further develop a worksite information packet to support lactation in the workplace. The information will be made available on the web and through the mail.

The WIC Program accepted USDA funds to begin the development of several breastfeeding peer counselor pilot projects in WIC clinics around the state.

It is expected that the combined result of these complementary activities will lead to improved breastfeeding rates.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

The percentage of newborns born in 2002 who were screened for hearing loss was 96.2 percent, meeting the FY 2003 goal of 95.0 percent. This was the first year that Colorado achieved a 95.0 percent level, which had also been the goal for newborns born in 2001, when a 94.9 percent level was reached. Of 68,465 infants born, a total of 65,839 were screened in 2002. The rescreening rate was 87.2 percent for those who failed the initial screening.

Twenty-nine of Colorado's 64 counties achieved a screening rate of at least 95.0 percent. The previous year, just 10 counties had achieved such a high rate. Furthermore, 26 counties are considered to be very close to the 95.0 percent goal, with rates of at least 86 percent.

During FY 2003 particular attention was given to certain populations with less than optimal screening rates: home births, infants who for reasons of medical necessity were transferred to another hospital, infants born to Colorado mothers who delivered at out-of-state hospitals, and babies born to Latino families.

b. Current Activities

The target for FY 2004 continues to be a 95.0 initial screening rate and an 80.0 rescreening rate, which are both expected to be met.

Improvements in data integrity and reporting have continued from last year. An analysis of health disparities, particularly among Latino children, showed higher rates of confirmed hearing loss among Colorado Hispanics, as compared to Non-Hispanic Whites. The State Birth Defects Registry, Colorado Responds to Children with Special Needs, analyzed confirmed hearing loss data from 1996-2002; chi-square testing revealed a p value < 0.12. While this value is not significant, it does suggest that differences in hearing loss between the two groups should be closely watched, and that hearing screening among Hispanic infants should be actively pursued. We may be missing confirmed diagnosis in a proportion of Hispanic infants because initial analysis of the newborn hearing screening database suggests a poorer rate of second screens after a positive first screen. We are designing a formal study of risk factors for failing to achieve the second screen in these circumstances.

A social marketing plan focusing on improving hearing rescreening and follow-up rates for Latino babies has been completed. We also recently implemented a pilot project using the 14 Children and Youth with Special Health Care Needs Regional Offices to help locate babies who have failed two hearing screens and who have not received diagnostic assessment. Letters are being sent in English and Spanish to families of babies who failed two hearing screenings. As staffing permits, regional offices are calling families to encourage and arrange the diagnostic exams.

Beginning in June 2004, letters have been sent to families whose babies either were never screened before hospital discharge, or who failed the first screen. Letters next were sent to families with babies born at home, and babies born out-of-state who may not have had screenings.

The increase in the number of babies born at home and screened for hearing loss that was noted in FY 2003 continued in FY 2004. The new presence of portable hearing screening machines in the Children with Special Health Care Needs Regional Offices is thought to be a key reason for the improved screening rates in the home birth population. These machines can be borrowed by local lay midwives. In addition, notification of hearing screening results for babies transferred to other hospitals continued to improve, and a reciprocity agreement with

Wyoming's Newborn Hearing Screen Program was created to allow for sharing of data between the states. Finally, partnerships and outreach efforts with community organizations serving Colorado's Latino population, including El Grupo Vida and LARASA, have been expanded.

c. Plan for the Coming Year

We anticipate maintaining our 95.0 percent screening rate indefinitely, and maintaining a rescreening rate at or above 80 percent. Continuing development of the NEST/CHIRP (Newborn Evaluation Screening and Tracking)/ (Clinical Health Information Record of Patients) database should result in increased data integration, allowing for greater efficiencies and enhanced follow-up activities across multiple health programs, including the expansion of a letter notification program to all families of babies who missed the initial screening or a rescreening. We hope to create and distribute culturally competent promotional materials to raise awareness among Colorado Latinos of the importance and the availability of early hearing screening and intervention.

At the state health department Vital Records office in Denver many families obtain certified copies of birth certificates. We plan to run a Spanish language video on newborn screening (both hearing and metabolic) on a continuous loop in the waiting room.

A partnership with Kaiser Permanente is anticipated in FY 2005 that may yield some media exposure about health risks for the Latino population.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

A target of 15.0 percent was set for Colorado for FY 2003. Using data available from the American Academy of Pediatrics (AAP)*, an estimated 15.1 percent of children in Colorado did not have health insurance in 2002. Therefore, the target was not met, although it was nearly met. The total number of children uninsured for all children through age 18 equals an estimated 184,000. This measure is an infrastructure activity for the state MCH program.

Colorado's rate of uninsured children compared to other states is high. Only three states had the same or higher rates than Colorado in 2002: Florida (15.1 percent), Nevada (19.3 percent), and Texas (23.0 percent). A year ago there were nine states with rates higher than Colorado's rate. While other states are making progress in reducing the proportion of children without insurance, Colorado is losing ground. Furthermore, a total of 23 states, almost half, have fewer than 10 percent of their children without health insurance.

* American Academy of Pediatrics, Division of Health Policy Research, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment, Characteristics of Medicaid-enrolled and Uninsured Children, State Reports, 2002, October 2003.

b. Current Activities

The goal for FY 2004 remains at 15.0 percent. One program that is helping the state attain that level is the Child Health Plan Plus program, which is designed for children who are just above the Medicaid guidelines and who do not have other health insurance. Colorado's Child Health Plan Plus was established in 1998 and by the end of May 2003 a total of 49,422 children had enrolled, out of an estimated 69,200 eligible. Because of major state budget problems, the state legislature froze the average monthly enrollment of the Child Health Plan at 53,000, a

point that was reached in October, 2003. Beginning November 1, 2003, no new children could be added.

The 15.0 percent insurance rate is not expected to be met in FY 2004 because enrollment in the Child Health Plan Plus was capped, and because of the increasing number of children without insurance who do not qualify for the program (see Plans for the Coming Year). Program staff estimate that 1,000 children per month would be enrolling if the freeze were not in effect. The cap was lifted on July 1, 2004, which allows resumption of enrollment during the last three months of the federal fiscal year. This should increase the proportion of children with health insurance, although it may not be enough to meet the target for FY 2004.

Beginning in January 2004, the Health Statistics Section of the Colorado Department of Public Health and Environment began collecting data for a new Child Health Survey focused on children 1-14. This telephone survey asks over 100 questions, including information on health insurance. Data should begin to be available from this survey in the spring of 2005. We anticipate using this survey as our data source in the future.

c. Plan for the Coming Year

The goal for FY 2005 remains at 15.0 percent.

The 2000 Census revealed that one-quarter of all children under the age of 18 in the state were Hispanic, as compared to 18 percent in 1990, and many have parents who are undocumented or are themselves undocumented. Little real improvement in the percentage of children that are uninsured in the next few years is anticipated, because undocumented children are not eligible for any kind of public health insurance.

The poor economy since 2001 has undoubtedly contributed to the number and proportion of children who lack health insurance because their parents have lost their jobs.

During FY 2005, data from the Child Health Survey should begin to be available. We will be able to use that data as a better measure of the level of insurance or uninsurance for the age group 1-14. With two years of data we will be able to determine levels for large counties in the state. An increased amount of information that details specific problem areas should help policymakers and program planners develop strategies for addressing the need.

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

The proportion of children served in this group is estimated at 86.6 percent for FY 2003, not meeting the target of 97.0 percent. There were 233,467 children between the ages of 1 and 21 (at least age one but under age 21) who received a paid service through the Medicaid program, according to FY 2003 data from the Department of Health Care Policy and Financing. There were an estimated 36,000 children age one or older who were potentially eligible for Medicaid, but who were not enrolled and did not receive any service. Therefore, 233,467 children were covered out of 269,467 (233,467 plus 36,000), or 86.6 percent.

The estimate of the potentially eligible is difficult to make. How many children are "out there" who are actually eligible for Medicaid but who are not enrolled in the program? We know from National Performance Measure 13 that there are an estimated 184,000 children (age 0-18) in Colorado who do not have health insurance. Some of these children are eligible for Medicaid,

others are eligible for the Child Health Plan, and others not eligible for either program. We have been unable to determine a method to update the 36,000 number shown above and used in previous years as well, those who would be eligible for Medicaid.

Furthermore, the estimate of the potentially eligible in any year does not take into account children who may have other insurance but who are nevertheless eligible for some Medicaid services that are not covered by that insurance. It also does not include any recent population increases in children, which have continued to take place in the years since the census was done in 2000. Therefore, the estimate of those served overstates the proportion actually served because the denominator (those potentially eligible) excludes these groups of children.

b. Current Activities

The target for FY 2004 was reduced to 90 percent, because previous higher targets have not been met. However, the likelihood of meeting even the new reduced target may also be compromised because of the growing number of children who may be eligible for Medicaid but who are not yet enrolled. These children have parents especially impacted by the current poor economy. In addition, the inability of the Child Health Plan Plus to enroll more children because of its enrollment cap has probably been reducing the number of children enrolling in Medicaid, since applications for the Child Health Plan include an assessment of whether Medicaid is instead the appropriate insurer. With the lifting of the cap on July 1, 2004, more children should be enrolled in both programs.

In January 2004, the Child Health Survey was launched in the state, and we anticipate that this survey will provide better information on the extent of health insurance coverage, including Medicaid and the Child Health Plan Plus, among children. As this survey develops, it may be possible for us to better estimate the number of children who are potentially eligible for Medicaid. This will provide an improved denominator for this measure, and we should be able to better estimate service for these children.

c. Plan for the Coming Year

The goal for FY 2005 remains at 90.0 percent. As the state fiscal crisis eases, and the Child Health Plan Plus reopens enrollment, we anticipate an increase in the number of children receiving services from Medicaid simply because of the parallel enrollment process.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The proportion of very low birth weight births in calendar 2002 remained at 1.3 percent in Colorado, the same level as in six out of the seven most recent years. The FY 2003 target of 1.2 percent was not met in 2002.

Starting in 1975, the proportion of multiple births in the state increased slowly, from 1.9 percent to 2.3 percent in 1993. The next year the rate jumped to 2.9 percent; then increased gradually to a high of 3.2 percent in 2002. These births play a significant role in the rates of preterm and very low birth weight births. The increase in multiple births is related to an increased use of fertility drugs and assisted reproductive technologies, and Colorado is a leader in the nation in providing assistance to infertile couples.

A total of 901 out of 68,420 births weighed less than 1,500 grams, the definition of very low birth weight.

b. Current Activities

The target for FY 2004 is 1.2 percent. Data for 2003 will be used to determine the actual level, and preliminary data suggest that the target may not be met again.

The March of Dimes launched its five-year Prematurity Campaign in 2003, prompting an analysis at the state health department to examine the components of Colorado's prematurity rate. The state rate increased from 7.5 percent in 1990 to 9.4 percent in 2002. The analysis includes a breakdown of rates according to multiple or singleton gestation, mode of delivery (C-section), facility level, and exact gestational age. It appears that some of the increase in the prematurity rate is due to the increased incidence of multiple births, but that this is not the primary contributor to the increase. The analysis will be completed in the fall of 2004.

c. Plan for the Coming Year

The emphasis in Colorado is targeted toward reduction of low birth weight as opposed to very low birth weight. It is possible that some of the work that focuses on reducing low birth weight will also have an impact on very low birth weight. The target for FY 2005 remains at 1.2 percent.

Data from other states suggest that the percentage of multiple births has not yet reached its high. While Colorado had a rate of 3.2 percent in 2002, a majority of states have higher rates. The 2002 Massachusetts level was 4.9 percent and at least three other states are above 4 percent.

Given the widespread trend toward multiple births, and the association of prematurity with multiples, we can only expect an increasing rate of very low birth weight. The report, *Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado*, published in 2000, recommended convening a task force to discuss practice issues related to assisted reproduction (ART). However, MCH staff has begun to reconsider the wisdom of this approach for two reasons. First, it will be very difficult to impact medical practice in this area and, secondly, potential recipients of ART appear unlikely to alter their use of this technology if it affords their only option for conception, regardless of the risk. It may be more helpful, from the standpoint of primary prevention, to instill targeted messages about optimal ages for childbearing when women are younger. Therefore, the MCH program is exploring the possibility of utilizing this message within the broader context of preconception health and planning.

A total of eight of the 15 organized health departments are specifically targeting MCH funding toward addressing this performance measure during FY 2005.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

In 2002 there were 46 suicides among Colorado teens age 15-19, a rate of 13.6 deaths per 100,000 teens. The target for FY 2003 had been 13.0, so the goal was not achieved, even though rates lower than 13.0 had been realized in the two previous years.

It should be noted that Colorado's target is set at a relatively high level. The Healthy People 2010 goal is no more than 5 suicide deaths per 100,000 teens. If Colorado had achieved that rate in 2002, there would have been no more than 16 deaths among Colorado's 337,039 teens,

a difference of 30 fewer deaths.

A total of 26 of the 46 deaths were accounted for by firearms, 57 percent of all suicides.

In FY 2000, the Office of Suicide Prevention was established at the state health department. With a two-year, \$385,000 grant from the Substance Abuse/Mental Health Service Administration (SAMHSA), staff worked to address youth suicide prevention and related issues of youth substance abuse, violence and mental health for youth ages 10-19. Three pilot communities (Jefferson County, Mesa County, and the San Luis Valley) were selected to implement a youth suicide pilot prevention project. The project received a no-cost extension with carryover funding to continue work through August 2003. A strategic plan to address youth suicide prevention across Colorado was the goal of this project and was completed in October 2003.

The Office of Suicide Prevention conducted a number of other programs that indirectly impacted youth during the year. A statewide public awareness campaign including public service announcements for radio and television reached over 734,000; the Office cosponsored the second annual statewide Suicide Prevention Summit; suicide prevention information and outreach was provided to over 300,000 persons, and the office coordinated 45 trainers across Colorado who provided suicide intervention skills training to local community members. In addition, grants were provided to 14 local agencies for suicide prevention and education services. Local grantees utilized funds for a variety of activities including educating students and staff regarding suicide prevention at a local school for the deaf and blind and a runaway/homeless youth shelter, conducting advertising campaigns specifically targeting seniors and youth, developing a suicide survivor support groups for teens, and other related public awareness and gatekeeper training activities.

b. Current Activities

The target for the current year, FY 2004, is 12.5 deaths per 100,000 teens. Preliminary data for calendar 2003 show a large decline in teen suicides, and we are expecting the target to be easily met. However, data from the 2003 Colorado Youth Risk Behavior Survey among 757 students from 23 schools revealed that 19 percent had contemplated suicide, 15 percent had planned suicide, and 13 percent had attempted suicide. While these data are not representative of all Colorado high school students, they suggest the real presence of mental health issues that are very important and need to be addressed.

The Office of Suicide Prevention continues to coordinate efforts to reduce the number of suicides among teens by:

- * providing grants to support local community-based organizations and coalitions that are currently engaged in suicide prevention activities;
- * directing a public awareness campaign which may include a partnership with the American Foundation for Suicide Prevention and Anthill Marketing to adapt some of their youth suicide prevention PSAs to Colorado and to pilot these in the three communities that participated in the SAMHSA grant;
- * providing a training of trainers program for both SAFE:TEEN, a school-based program, and the Yellow Ribbon Suicide Prevention program;
- * co-sponsoring the second annual Prisms of the Heart Suicide Prevention Fundraiser; and
- * coordinating/collaborating with the Colorado Trust Suicide Prevention Initiative and the ten communities receiving suicide prevention.

c. Plan for the Coming Year

The FY 2005 target is fewer than 12.0 deaths per 100,000 teens, a target that has been met

once in the last six years, in 2001, when it was 11.4 deaths. The target is still more than double the Healthy People 2010 goal.

The Office of Suicide Prevention will continue to implement many of the initiatives referenced above that are outlined in its Suicide Prevention Plan that is available on the web at www.cdph.state.co.us/pp/suicide/suicide.pdf. State funding of \$272,000 is allocated for suicide prevention programs for state FY 2005, which began July 1, 2004.

The Child and Adolescent School Health Section along with the Office of Suicide Prevention determined that local public health departments should be involved in efforts to reduce the number of suicides in Colorado. Therefore, the two programs developed a suicide prevention template for local communities. The template incorporates evidence-based strategies that can be adopted or modified at the local level. Local health departments received the template as part of their MCH application process. Those with high teen suicide rates will be encouraged to use the strategies outlined in the template in their MCH grant applications.

In FY 2005, the Adolescent Health Program Manager and the Office of Suicide Prevention will continue to market the suicide prevention template to local public health agencies and other community-based organizations. Plans are underway to develop a technical assistance and training plan for local public health agencies that choose to address suicide prevention. The two programs also plan to encourage sharing and networking among local health departments and other community-based programs addressing suicide prevention.

In addition, the Injury Epidemiology Program of the Prevention Services Division received a 5-year grant from CDC in January 2004 to participate in the National Violent Death Reporting System. Detailed data will be available, linked between death certificates and medical examiner, police, and coroner reports. We anticipate that the information gained from this system will help us develop interventions in the future to reduce suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

A total of 74.6 percent of all very low birth weight infants (less than 1,500 grams) were delivered at Level III facilities during calendar 2002. The goal of 75 percent in FY 2002 (2001 data) was nearly, but not completely, met.

Analysis of 2002 data on a county level shows that 19 out of 64 counties had 100 percent of their very low birth weight births occurring in Level III facilities (17 counties had no very low birth weight births at all). These counties are all quite small, and the number of very low birth weight births they include is less than 5 percent of all such births in the state. Nonetheless, this represents an improvement from the previous year when just 11 counties attained a 100 percent rate. One other county, Douglas, had a rate of 94.3 percent, meeting not only the state goal of 75 percent but also the Healthy People 2010 goal of 90 percent.

The experience of the remaining 27 counties falls well short of the state goal for FY 2003, however. Denver County had 175 very low birth weight births to its residents, one out of every five very low birth weight births in the state, but the proportion of births that took place in Level III facilities was only 82.2 percent. In fact, Denver County contains five of the eight Level III facilities in the state, showing that proximity to high-level neonatal intensive care facilities is no guarantee of access. El Paso County, with one Level III hospital, attained a rate of 80.3 percent. Arapahoe County, with the other two Level III hospitals located outside Denver, attained a rate of 78.0 percent. All other counties had lower rates, and ten counties had fewer

than 50 percent of their births occurring in high-level facilities.

b. Current Activities

The target for FY 2004 remains at 75.0 percent.

We have been working with the Colorado Perinatal Care Council to inform hospitals and physicians about this issue during FY 2004, as well as in previous years. Our analysis of 1997-1999 data showed elevated infant mortality among infants born at Level Is and IIs compared to level IIIs, but acceptance of the findings has been slow.

Analysis using 2001 data also revealed that among Front Range residents, 40 percent of all very low birth weight births occurring in Level II hospitals took place in facilities that were within 5 miles of a Level III hospital. Furthermore, two out of every three very low birth weight births occurring in Level II hospitals took place in facilities within 10 miles of a Level III hospital. Therefore, it appears that the issue is defined by service patterns and competition among metropolitan-area hospital NICUs rather than by distance.

In the spring of 2004, new leadership in the Perinatal Care Council expressed interest again in this issue. MCH staff presented the information described above at the March meeting, including a discussion of a published study in the January 2004 issue of Pediatrics, supporting the benefits of very low birth weight delivery in Level III facilities. Data for 2000-2002 was also presented, again showing a mortality rate for infants born at Level IIs that exceeded the Level III rate by 38 percent, virtually the same difference as the previous 1997-1999 study. The Council was encouraged to adopt the recommendation from the Guidelines for Perinatal Care that all deliveries at less than 32 weeks gestation occur at Level III perinatal centers. The Council agreed to develop and disseminate a position paper on this topic.

c. Plan for the Coming Year

The target for FY 2005 remains at 75.0 percent.

MCH staff will continue to work with the Council to develop a position paper on this topic which can be used in an initial effort to change referral practices during FY 2005. The Council hopes to include other partners in promoting delivery of premature infants at level III hospitals.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments

During 2002, 79.1 percent of all pregnant women in the state began prenatal care in the first trimester. This level falls far short of the 85.0 percent target set for the state for FY 2003. In fact, 2002 marks the fifth year that Colorado's level was lower than the previous year's level, and the fifth year that Colorado's level was lower than the U.S. level. Only six other states have fewer women beginning first trimester care than Colorado.

Two factors are contributing toward the decline in the overall prenatal care rate. The proportion of women needing care who are Hispanic, especially the proportion of women who themselves

were born in Mexico, is growing rapidly. Since these women are less likely to begin care early because of financial barriers and problems gaining access, the overall rate is impacted because they contribute an increasing number of births each year. In 2002 a total of 11,478 births, one out of every six Colorado births, was to a mother who had been born in Mexico or Central or South America. In 1990, 1,700 births to women born in Mexico had comprised just one out of every 27 Colorado births.

The second factor is that the proportion of women obtaining early prenatal care is declining for each racial/ethnic group. For white Hispanic women, the 1997 proportion (the best year for all groups) was 69.6 while the 2002 proportion was 65.9, almost four percentage points lower. For black women, the proportions were 77.3 and 70.3 respectively, a decline of fully seven points. For white non-Hispanic women, the proportion was 87.9 in 1997; this declined to 86.2 in 2002.

An analysis at the county level reveals that only 16 counties out of 64 (one-quarter of the total) attained the 85.0 percent target in 2002. In 1997 a total of 23 counties had attained the 85.0 percent level.

In the fall of 2002, the state of Colorado expanded its Child Health Plan Plus coverage to include pregnant women of any age, anticipating coverage of up to 3,000 women annually. The program began accepting women, but in May 2003 the state budget crisis forced a suspension of enrollment. The program did not reopen enrollment in the remainder of the fiscal year, and only a few hundred women were served.

Medicaid data on emergency coverage of labor and delivery (for undocumented women) suggested a minimum of 4,000 births in 2000 and 2001 (more recent data are not available). This number alone comprised 6 percent of all Colorado births in those years. Prenatal care for undocumented women is not covered under Medicaid, and few payor sources exist for this population. The problem of coverage for the undocumented population was not solved in FY 2003, and the Child Health Plan Plus expansion did little to improve coverage for women who were eligible for government-sponsored programs.

b. Current Activities

The target for the current year remains at 85.0 percent. Plans to meet this target by increasing access to early prenatal care were compromised by the state's fiscal constraints until Governor Owens lifted the enrollment freeze for pregnant women in the Child Health Plan Plus program on July 1, 2004. This action should improve early prenatal care enrollment in 2004, but will have a greater impact on 2005 births. However, the sheer volume of births to women who cannot obtain insurance coverage because they are undocumented contributes a great deal to Colorado's low first trimester care coverage rate.

The decline in the Colorado economy since 2001 has also contributed to a loss of insurance coverage for many state residents. Colorado's progress on National Performance Measure 13, insurance for all children, is also compromised. Only three other states have a greater percentage of uninsured children than Colorado.

The state has elected to monitor this measure until attempts can be made to increase financial access to prenatal care for undocumented women.

c. Plan for the Coming Year

The target for next year has been lowered to 83.0 percent. The Healthy People 2010 goal is 90 percent, and most other states are making steady progress toward this goal. In 2002, 33 states had rates of 83.0 percent or greater.

It appears that Colorado has been unable to improve on this measure in recent years both because health insurance for low-income pregnant women was not assured and because health insurance was not readily available for pregnant undocumented women. These problems may both require national solutions. We have elected to monitor this measure until attempts can be made to increase financial access to prenatal care, especially for undocumented women. We are requesting technical assistance to help us develop creative ways to address the problem.

A total of 12 out of 15 local organized health departments will be specifically targeting their MCH funds toward this measure during FY 2005.

Figure 4a follows this section. It shows the major activities for each of the eighteen national performance measures.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Development of Newborn Evaluation Screening and Tracking (NEST) system linking screening and electronic birth certificate data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Screening of all occurrence births in the state for seven conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Ongoing evaluation of Supplemental Screening Program to determine if proportion of birth cohort screened increases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Linking electronic birth certificate with laboratory newborn screens to determine precise proportion screened.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support of tandem mass spectrometry at the University of Colorado Health Sciences Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				

1. Coordinate with families, agencies, and faith-based organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with Colorado Family Voices to track parent satisfaction with services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to support local parents financially and educationally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Launch public education outreach campaign regarding services available through the Health Care Program for Children with Special Needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Expand the number of medical home models in Colorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Coordinate public health/HCP care coordination with primary care practices in HCP local regions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with the Colorado chapter of the AAP to increase reimbursement for primary care providers, and help them with billing information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase dissemination of statistics and cost data to legislators, families, agencies and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work with the Medical Home Learning Collaborative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Analyze Peregrine database of providers for insurance plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Maintain access to public and private health insurance resources through local outreach activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide access to specialty care in rural service areas through HCP's clinic outreach program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to analyze available data on why children are uninsured through collaboration with Colorado Children's Campaign and Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Voices Colorado.				
4. Analyze Colorado Child Health Survey insurance data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continue to develop a system of services and supports for CSHCN through state and local agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collect and analyze data to ascertain availability of care for CSHCN from other partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. HCP providers will provide medical consultation to agencies that provide coordination services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Medicaid EPSDT Outreach will play role in building medical homes and assuring adequate services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Work with local Health Care Program offices concerning their ideas about youth to adult transition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with local adult specialty and primary care providers who see the youth who attend HCP clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analyze school district data to determine current youth to adult transition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with the Community Access to Child Health grant to focus on transition for youth in one community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Ensure that VFC/AFIX visits are conducted in private provider offices and community health centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Use GIS to map risk factors for low immunization rates to identify areas to target activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Explore creative strategies for supporting a statewide tracking system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with the Colorado Children's Immunization Coalition to explore strategies for educating parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop process evaluation indicators to be used across the state to measure immunization practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement a collaborative strategic planning process involving internal and external partners and stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Improve immunization baseline measurements throughout the state using process evaluation indicators based on nationally recognized best practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Identify outcome evaluation indicators to further explain vaccination coverage issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Support Title X work to target family planning services to teens across the state.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support school-based health centers, which address high-risk behavior among teens.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Focus on Latina teen fertility by identifying stakeholder attitudes and beliefs about the issue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with Hispanic organizations and stakeholders to identify best practice strategies to decrease Latina teen fertility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue the Abstinence Education Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Identify additional resources and other partners for the Chopper Topper sealant project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop surveillance system that contributes to the National Oral Health Surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Track several oral health status and risk indicators using the oral health surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identify sentinel schools for screening to assure a representative sample in the next cycle.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide technical assistance to local advisory committee meetings interested in instituting school-based sealant programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Maintain state health department website with updated safety information.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Document and provide data on a state and local level on rates of motor vehicle death.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Create local Safe Kids chapters around the state to reduce childhood injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct baseline observational studies of booster seats at child care centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Publish summary of hospital practices around breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Host breastfeeding management and support services seminar for RDs and RNs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate and publicize pilot program of single-use breast pumps.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase efforts to improve breastfeeding duration rates through workplace education.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increase issuance by WIC staff of exclusively breastfed "food packages" to infants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Maintain newborn hearing screening rate at 95 percent.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Improve data integrity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Extend hearing screening to subpopulations with low screening rates (home births and Hispanics).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue to develop CHIRP data system and obtain more data on disparities among Hispanics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue outreach and training efforts to lay midwives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Run Spanish language video at state health department birth certificate headquarters on importance of newborn hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Partner with Kaiser Permanente using the media to inform Latinos about health risks.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.				
1. Document and provide data at the state level for children without health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Encourage enrollment in CHP+ through local health agencies and community coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analyze new Child Health Survey data and health insurance coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate on committees of RWJ-funded Covering Kids and Families				

to improve policy on CHP+ administration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in internal planning group with the Office of Oral, Rural and Primary Care to identify current access to care issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Document and provide data for children receiving Medicaid services through IRIS (Integrated Registration and Information System).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participate on Covering Kids and Families project to improve policy that impacts access to Medicaid.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Document and provide data on very low birth weight in Colorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the Colorado March of Dimes in their Prematurity Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Document the impact of assisted reproductive technology on the incidence of very low birth weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue addressing ways to impact inadequate weight gain in pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Explore feasibility of encouraging childbearing before assisted reproductive technology techniques appear to be necessary to couples.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Document and provide data on teen suicide in Colorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide training, education, outreach and support across Colorado through the Office of Suicide Prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Work on increasing availability of mental health services in schools especially those with school-based health centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Encourage use of suicide prevention template at the local level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in National Violent Death Reporting System with the goal of developing interventions to reduce suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Provide data to the Colorado Perinatal Care Council showing improved outcomes for Level III deliveries.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support development and dissemination of Colorado Perinatal Care Council position statement on maternal transfer for gestations under 32 weeks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Document and provide data on a state and local level on Colorado's poor national ranking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Provide staff expertise for the Family Planning Medicaid waiver if project continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue efforts to promote insurance coverage for undocumented women and other low-income women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Seek technical assistance from MCHB to address prenatal care issues in Colorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The proportion of high school students reporting having drunk alcohol in the past month*

a. Last Year's Accomplishments

The target for FY 2003 was 50.0 percent. It was met with 48.4 percent of students reporting alcohol use in the 2003 Colorado Youth Risk Behavior Survey. While the survey results are not representative of all high school students, they are consistent with values found in 2001 (50.9 percent), and are used here as the best available data.*

We partner extensively with the state Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services to address youth alcohol, tobacco, and other drug use. ADAD develops, implements, and evaluates prevention programs on a statewide basis that address these issues, including reducing risk factors and increasing protective factors related to substance abuse. With Substance Abuse/Mental Health Service Administration and state monies ADAD funded 47 local programs in FY 2003. The Substance Abuse Prevention Block grantees are encouraged to impact multiple levels of the social structure, including individuals, families, groups, institutions, and communities of all major ethnic and cultural groups.

ADAD also funds the Rocky Mountain Center for Health Promotion and Education to manage the Regional Prevention Center (RPC). The RPC offers training and technical assistance that is responsive to cultural differences and the varying practical needs of communities throughout Colorado. Technical assistance and capacity-building efforts target underserved or unserved populations and address identified regional prevention needs.

In the last year the RPC developed a statewide profile and CD of alcohol, tobacco, and other drug-related social and health indicators by county. This document and the disk were organized to assist county and community level coalitions, planners, and providers to more clearly understand how the problems related to substance abuse present themselves in their particular part of the state.

School-based health centers (SBHCs) are another major component of our strategy to reduce alcohol use. SBHCs place a strong emphasis on preventing and reducing substance abuse among adolescents. Primary care providers in secondary schools utilize the Guidelines for Adolescent Preventive Services to identify and counsel students who are using drugs and alcohol. Many also locate drug and alcohol counselors on-site to deliver prevention curricula,

and to perform assessment, intervention and treatment for identified students. The strongest school-based models offer students in-school intervention and psychoeducational programs as an alternative to suspension from school for substance abuse infractions. School-based programs are widely considered to be the best approach for early identification and intervention with substance abuse behaviors.

* The survey results are not weighted data representing all Colorado high school students. A total of 757 Colorado high school students participated, from 23 schools. The results pertain to this group of students only.

b. Current Activities

The Alcohol and Drug Abuse Division at the Colorado Department of Human Services continues to coordinate efforts to reduce alcohol use among youth by:

- * supporting communities, through Substance Abuse Prevention Block Grants, to develop, implement, and evaluate prevention programs that address alcohol; tobacco; and other drug issues (ATOD);
- * utilizing Law Enforcement Assistance Funds to support impaired driving prevention programs for youth in selected schools and communities throughout Colorado;
- * sponsoring the Prevention Summit Series which aims to strengthen communication and interaction among state and local prevention providers, including those working to address ATOD, in order to build and sustain quality prevention and intervention program for children and youth in Colorado;
- * and continuing to fund the Regional Prevention Center to provide technical assistance and training to local communities.

The state health department has been collaborating with ADAD to develop a Best Practice webpage for alcohol use prevention. The webpage synthesizes prevention and intervention strategies and programs and interventions that are known to work for alcohol use prevention. The Best Practices website, which has over 40 health topics, provides a centralized resource of programs and strategies that work for program planners, professionals working in prevention, grantees, and local health departments.

The Prevention Services Division at the state health department began FY 2004 without specific funding to address youth violence or underlying risk factors. However, in December 2003 the Governor's Office decided to allocate \$4 million from the Job and Growth Tax Relief Reconciliation Act of 2003 to the division to fund youth service programs through June 2004. The one-time funding allowed the division to fund 105 community-based programs that target youth and their families for prevention and intervention strategies to reduce youth crime, violence and other high-risk behaviors. The programs include student dropout prevention programs, early childhood, youth mentoring and other programs designed to support children and youth to reduce negative outcomes. These were programs previously selected to receive Tony Grampas Youth Services Program dollars before the funding was vetoed due to the state budget shortfall.

School-based health centers continue to be an important factor in addressing alcohol and substance use among adolescents.

c. Plan for the Coming Year

The Alcohol and Drug Abuse Division in the Colorado Department of Human Services will continue to implement many of the initiatives referenced above. The state health department works very closely with ADAD and is collaborating with ADAD to submit a new State Prevention Framework/State Intervention grant to fund state and local prevention efforts.

The Director of the Adolescent Health Program has been meeting with the Project Director at the Regional Prevention Center to develop collaborative strategies to reduce alcohol use among youth. The two programs have discussed providing joint trainings and technical assistance to local communities. Additionally, the programs plan to cross reference indicators and intervention to see where there is duplication occurring. These activities will take place beginning in FY 2005.

The Tony Grampas Youth Services Program will receive \$3.4 million in state funding to support its programs during state fiscal year 2005, which began July 1, 2004. Because of state budget shortfalls in the previous two state fiscal years, no state funding was available for the program, although one-time funding from the federal Job and Growth Tax Reconciliation Act of 2003 supported community programs from December 2003 through June 2004.

State Performance Measure 2: *The proportion of all pregnancies that are unintended*

a. Last Year's Accomplishments

Colorado's objective for FY 2003 was a target of no more than 37.0 percent of all live births to be unintended.* PRAMS data for 2002 show a rate of 38.9 percent, exceeding the target level. (Note that while the measure says "pregnancies," the only data that are available refer to births).

New information on unintended births at the county level is now available on the health department's CoHID website. Users can query the PRAMS dataset for five years of surveys (1997-2001) to obtain county-level data on pregnancy intention and a variety of birth outcomes like prematurity and birth weight. In addition, pregnancy intention data is available according to a number of maternal characteristics: income, marital status, age, education, race, Medicaid, parity, and use of WIC. These data are very useful at the county level to describe high levels of unintended pregnancy for both married and unmarried women.

PRAMS data for 2002 show that no real change has occurred in the state in the percentage of unintended births since data were first collected in 1997. The percentage unintended during this period has varied between 37.9 and 39.8 percent, and there is no apparent trend in either direction.

* unintended is a term describing pregnancies a woman characterizes as either unwanted (pregnancy not wanted at any time, now or in the future) or mistimed (pregnancy not wanted until some time in the future) at the time of conception.

b. Current Activities

The target for FY 2004 is for no more than 36 percent of all births to be unintended.

Reducing the proportion of births that are unintended is dependent on many factors, one of which is access to effective contraception. A waiver to provide family planning services to low-income women (below 150 percent of the federal poverty guideline) was submitted to the Centers for Medicare and Medicaid Services (CMS) by the Colorado Department of Health Care Policy and Financing in 2000. The state health department MCH staff and Women's Health Section provided assistance in writing the original waiver and responding to questions sent back by CMS a number of times over many months. The latest version of the waiver proposal was submitted to CMS in February 2004 but another round of questions from CMS received in April 2004 prompted the Department of Health Care Policy and Financing to discontinue Colorado's waiver application.

The department has continued to sponsor trainings on contraceptive methods to allied health care providers and social service and faith-based human services staff, to support replication of Boulder County Health Department's intended pregnancy project in other areas of the state, and has started using the Parent Power curriculum from the National Campaign to Prevent Teen Pregnancy to encourage parent-child communication about sexuality.

c. Plan for the Coming Year

The target for FY 2005 is again for no more than 36 percent of births to be unintended.

The Women's Health Section will continue to sponsor trainings on contraceptive methods to allied health care providers and social service and faith-based human services staff, and to support replication of Boulder County Health Department's intended pregnancy project in other areas of the state. In addition, we plan to use the Parent Power curriculum from the National Campaign to Prevent Teen Pregnancy to encourage parent-child communication about sexuality, and to administer the Title X family planning program.

State Performance Measure 3: *The incidence of maltreatment of children younger than 18 (including physical abuse, sexual abuse, emotional abuse, and/or neglect)*

a. Last Year's Accomplishments

Colorado's target for 2003 had been set at 5.5 based on confirmed incidents of abuse per 1,000 children. Since the time the target was set, the data are available in a different way, and the rate we now use is the number of confirmed victims of abuse per 1,000 children, a figure which is higher. This change in methodology resulted in a rate of 7.4 in 2003, based on 8,633 victims among the population of 1,159,066 children age 0 through 17. This figure does not meet the target.

The Central Registry of Child Protection at the Colorado Department of Human Services reported a large increase in the number of victims of abuse between 2002 and 2003. In 2003, there were a reported 7,532 confirmed child victims of abuse, but the number increased to 8,633 children in 2003. This difference means that 1,101 more children were confirmed abused in 2003 compared to 2002.

Colorado has developed several programs that address the root causes of child abuse and neglect. The Colorado Children's Trust Fund was created in 1989 to promote prevention and education programs designed to lessen the occurrence and reoccurrence of child abuse and neglect and to reduce the need for state intervention in child abuse and neglect. The Colorado Children's Trust Fund is focused on parent education for both the at-large population and those identified as at-risk to perpetrate abuse. During 2003, the Colorado Children's Trust Fund also started a partnership with the Kempe Children's Foundation, a national organization focused on the prevention of child abuse and neglect.

Another program, the Nurse Home Visitor Program / Nurse Family Partnership, has been funded by Colorado's Tobacco Master Settlement since June 2000, and targets low-income women who are expecting their first child. Enrolled women are provided with ongoing frequent case management services until the child's second birthday. Nurses, trained in the model developed by Dr. David Olds, help participating women learn child development and

appropriate disciplinary techniques, and obtain community resources necessary for healthy family functioning. A 15-year follow-up of the participants from the original Nurse-Family Partnership pilot indicated a 79 percent reduction in child abuse and neglect compared to the control group. During FY 2003 there were 17 Nurse-Family Partnership sites across the state, serving 45 of Colorado's 64 counties. A total of 1,384 families were served in state fiscal year 2003, including 1,019 children. One-third (34.6 percent) of participants divulged a history of physical and/or emotional abuse at their initial intake to the program. These women are clearly at increased risk for perpetrating child abuse and neglect, and the program is expected to have a very positive impact on how they treat their children.

b. Current Activities

The target for 2004 is 7.4 substantiated cases of child abuse or neglect per 1000 children in Colorado. This target appears to be an increase from 2003, but the 2003 target referred to incidents and the 2004 target refers to individuals. The 2004 target is also set to be no higher than the actual experience of 2003.

The Colorado Children's Trust Fund has increased its public awareness activities and has expanded its partnership with the Kempe Children's Foundation. A crucial part of raising awareness is surveying public attitudes about the issue, and focus groups were conducted by the Colorado Children's Trust Fund and the Kempe Foundation to help tailor a message to broadcast across the state. During the focus groups, it was discovered that most people felt that child abuse was a critical issue with long-term consequences but did not know how to approach the situation when they witnessed it personally. Child abuse awareness spots that addressed this problem were shown on local television stations in three major Colorado markets: the Denver area, the Colorado Springs/Pueblo area and in Glenwood Springs.

The state health department was one of the sponsors of a teleconference held on April 8, 2004. "Child Abuse Prevention: Community Strategies and Innovations," was presented in Denver and at eight videoconference sites across the state.

For state fiscal year 2004, the Nurse Home Visitor Program funded 17 local agencies to implement the Nurse-Family Partnership model in 49 of the state's 64 counties, an increase of four counties over FY 2003. The agencies are expected to serve a total of 1,637 families.

As of July 1, 2004, the Nurse Home Visitor providers were expected to begin billing Medicaid for targeted case management services provided to Medicaid-eligible mothers. Targeted case management is defined as services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. The combination of tobacco Master Settlement funds and Medicaid revenue will allow the Nurse Home Visitor Program to serve more mothers and families statewide.

c. Plan for the Coming Year

The target for 2005 is also set at 7.4, no higher than the level found in 2003.

The Colorado Children's Trust Fund expects to resume funding to local programs by this time in some limited capacity. At the very least, the Colorado Children's Trust Fund will fund local training programs for staff of parent education programs.

The Colorado Children's Trust Fund is focused on the funding of best practices in the field of child abuse prevention. While robust longitudinal research only exists for one model of child abuse prevention (nurse home visitation), research has been conducted on other practices that aid parent education efforts in general. Also, qualitative research shows promising practices with regard to other efforts such as father education, and warrants further investigation. It is the

intent of the Colorado Children's Trust Fund to focus future funding only on those programs with a strong evidence base for reducing abuse and neglect.

Furthermore, the Nurse Home Visitor / Nurse Family Partnership Program expects to increase its caseload again during this year to 1,962 families served through 17 agencies in the same 49 counties. The increase is contingent on funding approval, however, that is unknown at the time of grant submission.

An application was submitted in May 2004 by the Women's Health Section for SPRANS grant funding to address maternal depression associated with pregnancy. If funded, the Colorado Perinatal Depression Project will develop a social marketing campaign to increase awareness of perinatal depression and to decrease the stigma surrounding it, so that women and their families will seek care. Over time, this project should contribute toward the reduction of child abuse that is associated with unaddressed maternal depression.

State Performance Measure 4: *The proportion of high school students reporting regular use of tobacco products*

a. Last Year's Accomplishments

The proportion of high school students who reported regular use of tobacco products on one or more out of the last 30 days was 34.4 percent in the Colorado Youth Tobacco Survey, conducted for the first time in 2000. The goal for FY 2003 had been set at 34.4 percent, the same level. The survey was conducted again in the fall of 2003 and the spring of 2004. Survey results will be available in 2005, so it is unknown if the target was met, but other data do indicate a decline.

The State Tobacco Education and Prevention Partnership (STEPP) relies on research from CDC and the National Task Force on Community Preventive Services, as well as recommendations from Colorado's Tobacco Use Prevention and Cessation Advisory Committee. Programs funded by STEPP use evidence-based strategies that include youth empowerment and advocacy, comprehensive school-based programs, prohibition of access to tobacco products by minors, and mass media education.

The most notable indicator of STEPP's success is reflected in cigarette sales data, which show that consumption of cigarettes in Colorado in the last two years declined at a rate more than double the national average. The national decline between 2000 and 2002 was 4.4 percent, while the decrease in Colorado was 9.6 percent. Colorado sales data for the first six months of 2003 show this trend continuing.

Youth cessation programs statewide produced similar outcomes. In FY 2003, 670 teenagers completed the Not on Tobacco Cessation Program offered in schools. Twenty-eight percent of participants reported quitting and an additional 60 percent reduced their use.

During FY 2003 51 Get R!EAL (Resist! Expose Advertising Lies) youth coalitions throughout Colorado participated in the Get R!EAL movement. More than 600 youth took part in youth-led advocacy activities that promoted efforts to reduce youth initiation and consumption of tobacco. In addition, more than 180 youth leaders and 50 adult sponsors attended the statewide annual youth summit that provided information on tobacco industry marketing.

In FY 2003, STEPP's most visible youth outreach initiative was the Get R!EAL Road Tour. The MTV-style Road Tour made face-to-face contact with over 25,000 teens throughout Colorado, educating them about tobacco industry marketing tactics and encouraging them to make educated choices about tobacco use. It traveled 21,000 miles through 49 counties. Evaluations

indicated that 91 percent of the youth reported that the information provided by the Road Tour was useful.

Other activities conducted by STEPP included school-based, college-based, and enforcement programs. A total of 167 schools in 38 school districts conducted activities to prevent initiation of tobacco use, and 15 college campuses implemented comprehensive tobacco control programs. The state Department of Revenue Tobacco Enforcement Unit conducted more than 2,600 compliance checks of retailers to prevent the sale of tobacco products to minors.

b. Current Activities

The FY 2004 goal is set at 29.3 percent of youth using tobacco.

In January 2003, due to state budget shortfalls, the program's appropriation for FY 2004 was reduced by 50 percent to \$7,347,618. Subsequently, the FY 2004 budget for the State Tobacco Education and Prevention Partnership (STEPP) was finalized at \$3,800,000, representing a 75 percent reduction in the anticipated appropriation. Because of this, many essential program components have been downsized or eliminated. Without resources to promote the services offered through STEPP, utilization of these services will likely decline and momentum toward achieving STEPP's 2005 goals will be slowed. The time lag for the impact to be realized is unknown.

Colorado focuses its tobacco control efforts on the principles of Best Practices. The Youth Programs Unit of STEPP currently funds four program areas to address youth smoking prevention and cessation. These areas are addressed through community-based, school-based, and college-based activities and youth empowerment activities. Joint efforts to address tobacco prevention are coordinated with the Department of Education.

c. Plan for the Coming Year

The FY 2005 goal is set at 26.3 percent of youth using tobacco.

Depending on the final details of the legislative appropriation of Colorado's Tobacco Master Settlement funds, the State Tobacco Education and Prevention Partnership will continue to work with currently funded programs to sustain their infrastructure and efforts, and increase their outreach. STEPP expects these activities to contribute to progress toward meeting our objectives.

State Performance Measure 5: The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers

a. Last Year's Accomplishments

During the 2002-2003 school year, there were 37 School-Based Health Centers (SBHCs) that served 52 schools with services available to 57,462 children and adolescents. Based upon total state enrollment of 751,862 public school students, this number indicates that 7.6 percent of all students, one out of every 13 public school students, had access to preventive and primary, physical and behavioral health services through the centers. School-based health centers were located in 10 of Colorado's 64 counties. The goal for FY 2003 had been 8.25 percent, which was not met, however.

In the spring of 2003, two new centers were added in the state. One was opened at Jefferson High School, the highest impact high school in the Jefferson County school district. Denver

Health also opened a new center at Rachel Noel Middle School in northeast Denver County, but closed a part-time center at Ford Elementary School and two full-time centers at East and Montbello High Schools.

During FY 2003, a new attempt was made to develop a mutually beneficial, sustainable business relationship between health maintenance organizations and SBHCs, including plans to reimburse for students covered by both public and private insurance. The partnership included Kaiser Permanente, Cigna Health Care, The Children's Hospital, Denver Health and Commerce City Community Health Services. The partnership was awarded a \$20,000 grant from the Rose Community Foundation to plan and test a sustainable HMO/School-Based Health Center collaboration to improve access to health services and measurable health outcomes for children and adolescents. A consultant was hired to draft a plan during the summer of 2002, and implementation was slated to coincide with the start of the fall 2002 public school year. Unfortunately, the internal needs of the SBHC partners changed and the plan was not implemented.

In February 2003, a five year, \$685,000 per year grant from the CDC's Division of Adolescent and School and Health was awarded to the state education department to support local school districts in enhancing their school health programming and services. Funds from this Coordinated School Health Infrastructure grant support a lead person at the state health department and at the education department for addressing the school-age population. The initiative is addressing four priority areas including prevention of obesity, reduction of tobacco use, and improving HIV, STD, and teen pregnancy prevention education in schools, and increasing the schools' response to the dangers of exposure to the sun.

b. Current Activities

The FY 2004 goal is 9.5 percent. Meeting this target would require access to school-based health for some 72,000 children and adolescents out of the 757,668 (Fall 2003) enrollment. Due to a variety of factors, including massive state budget cuts, growth in the number of schools with centers is clearly not keeping pace with the targets set several years ago, and the target for FY 2004 is not expected to be met.

In the fall of 2003, a planning grant request for applications was released to communities interested in establishing new school-based health centers. Communities could apply for up to \$10,000. Six communities responded and five submitted fundable applications: Weld School District 6 for two elementary schools; Harrison School District 2 for two elementary schools; Denver for one middle school; the University of Colorado Health Sciences Center for a Denver middle school; and Summit School District for a full-service SBHC at their middle school that may also serve elementary students. Two of these districts (Weld and Harrison) are new to SBHCs.

Title V funding is being provided during FY 2004 to directly support school-based health centers serving 19,000 students in ten counties. In addition, two state programs are funded that provide monitoring, technical assistance, and resources to local programs, as well as support to the Colorado Association of School-Based Health Centers.

c. Plan for the Coming Year

The goal for FY 2005 is 8.0 percent. This goal was reduced from the FY 2004 goal.

Growth of SBHCs has not kept pace with the objectives set for 2010. There are two primary reasons for this shortfall: funding cuts and budgetary uncertainty within Colorado and the federal governments; and continuing stress upon education systems due to standardized testing.

At this time, it appears likely that a total of five new SBHCs will open in the fall 2004, serving about 3,000 students. One of the centers that closed last year may reopen, adding another 500 students. Therefore, a total of 61,000 students would have access to SBHC services in school year 2004-2005, raising the proportion of the state's children with access to SBHCs from 7.6 percent to about 8.0 percent.

State Performance Measure 6: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services*

a. Last Year's Accomplishments

In FY 2003, a total of 28.3 percent (81,359/287,217) of Medicaid-eligible children received dental services, up 15 percent from the FY 2002 level of 24.6 percent. The highest percentage was in Pueblo with 43 percent, and the lowest was in the San Luis Valley with 16 percent of Medicaid-eligibles receiving dental services.

The new statewide percentage met the goal of 25.0 percent that had been set for FY 2003, and the annual target was met for the first time in four years.

This success cannot be attributed to any one factor; however, increased awareness among dental providers through the exhibit at the Rocky Mountain Dental Convention, an increase in dental providers participating in the State Dental Loan Repayment Program, and an increase in dental Medicaid providers (530 in FY 2003 compared to 430 in FY 2002) all contributed. The increase of 100 providers is also due to the enrollment of independent practice dental hygienists in Medicaid, pursuant to House Bill 01-1282, which allows dental hygienists to be Medicaid providers. In addition, six counties without any Medicaid providers in FY 2002 gained at least one provider in FY 2003. No counties lost all of their Medicaid providers.

In the State Dental Loan Repayment Program, a total of 18 dental providers (3 dental hygienists and 15 dentists) participated in the program. A total of 3,045 underserved patients (including 994 Medicaid and 131 Child Health Plan Plus) were seen.

b. Current Activities

The target for the current fiscal year was originally set at 26.0 percent. We anticipate that this goal will be met, as this was surpassed in the last fiscal year, so a revised goal of 29 percent was proposed. An interesting analysis was conducted by the Oral Health Program that indicates an upward trend in the number of eligibles seen in each age group from 3-5, 6-9, 10-14, 15-18, and 19-20. It points to the need to focus on children under the age of five and over 18 for dental care where the numbers served continue to be low.

A second analysis compares dental to medical visits by age group for FY 2001. An interesting trend occurs after age 10 years where more children are seen for dental visits than for periodic medical screenings. This is probably due to the decrease in number of immunizations required, and an increase in dental decay in permanent teeth requiring restorative care.

c. Plan for the Coming Year

The target for FY 2005 is 30 percent. The Oral Health Program is currently screening Head Start and Early Head Start children to establish baseline data on the oral health status of this population. It is the program's intent to begin emphasizing preventive oral health strategies among this population. In addition, through the State Oral Health Collaborative Systems funding from the Maternal Child Health Bureau, work has been ongoing to link oral health with

Early Child Care Systems and the Coordinated School Health project. The Oral Health staff presented a workshop on oral health at the Colorado Association for the Education of Young Children annual conference in April 2004, showcasing the need for preventive oral health measures. Finally, a series of trainings by the pediatric dentists at the University of Colorado School of Dentistry will teach general dentists how to provide dental care to very young children. These trainings were scheduled to begin in the summer and early fall of 2004.

State Performance Measure 7: *The rate of homicides among teens 15-19*

a. Last Year's Accomplishments

The target for FY 2003 for this measure was 5.5 homicide deaths per 100,000 teens age 15-19. Data for calendar 2002 reveal a rate of 5.6, just missing the target.

In the previous year, 2001, the homicide rate was 8.0, and the change to 2002 is a large improvement. A total of 26 adolescents died by homicide in 2001; the number dropped to 19 in 2002. However, to meet the goal, the number should have been 18 or fewer.

Homicide rates appear to be directly tied to gun violence, and in the decade of the 1990s, half or more of all teen homicides were by firearms. Out of the 19 deaths in 2001, 16 were by firearms, a high proportion.

Data from the 2003 Youth Risk Behavior Survey among high school students revealed that 17 percent of all youth had carried a weapon in the last 30 days; that 6 percent had carried a weapon to school; that 5 percent had carried a gun, and that 33 percent had been in a physical fight in the previous 12 months. While these data are unweighted, and reflect the experience of only the 757 students from 23 schools who participated in the survey, they provide an indication of the underlying level of violent behavior among students in high school.

In 2000, the Colorado General Assembly created the Division of Prevention and Intervention Services for Children and Youth, and moved several programs from other state agencies into the state health department to create an environment for better coordination, integration and streamlining the state's prevention programs. While two programs (Build a Generation and the Tony Grampas Youth Services Program) were transferred to the state health department to address youth crime, violence, and other high risk behaviors, the state budget shortfall then led to defunding both of these programs (approximately \$9.5 million) in July 2002.

In 2001, the Colorado Legislature enacted an "anti-bullying" bill. This legislation requires schools to create policies that address bullying behavior. Research findings support the value of policies and programs addressing bullying, especially when carried out over a number of years. Schools are not required to have anti-bullying programs, but many districts are interested in developing and implementing such programs.

b. Current Activities

The target for the homicide rate in FY 2004 is set at 5.0.

The Prevention Service Division began FY 2004 without specific funding to address youth violence. However, in December 2003 the Governor's Office decided to allocate \$4 million from the Job and Growth Tax Relief Reconciliation Act of 2003 to the division to fund youth service programs through June 2004. The one-time funding allowed the division to fund 105 community-based programs that target youth and their families for prevention and intervention

strategies to reduce youth crime, violence and other high-risk behaviors. The programs include student dropout prevention programs, early childhood, youth mentoring and other programs designed to support children and youth to reduce negative outcomes. These were programs previously selected to receive Tony Grampsas Youth Services Program dollars before the funding was vetoed due to the state budget shortfall.

School-based health centers also address the issue of violence among students in middle and high schools. Physical exams provided by the centers include a comprehensive health history and a student-completed history containing several questions about exposure to or involvement in aggressive behavior. The health care practitioner reviews the survey with the student to develop a plan for addressing the risk. Because behavioral health services are provided in school-based health centers, referrals for care are readily completed.

c. Plan for the Coming Year

The goal for FY 2005 remains at 5.0, the same as the FY 2004 goal.

The Tony Grampsas Youth Services Program will receive \$3.4 million in state funding to support its programs during state fiscal year 2005, which began July 1, 2004. Because of state budget shortfalls in the previous two state fiscal years, no state funding was available for the program, although one-time funding from the federal Job and Growth Tax Reconciliation Act of 2003 supported community programs from December 2003 through June 2004.

The Injury Epidemiology Program of the Prevention Services Division received a 5-year grant from CDC in January 2004 to participate in the National Violent Death Reporting System. Detailed data will be available, linked between death certificates and medical examiner, police, and coroner reports. We anticipate that the information gained from this system will help us develop interventions in the future to reduce homicide.

State Performance Measure 8: *The proportion of WIC children who are overweight*

a. Last Year's Accomplishments

This state performance measure was adopted in 2001; FY 2003 was only the second year of data for the measure. The FY 2003 target of 6.4 percent was not met, with 8.7 percent (2,860/32,878) of WIC children determined to be overweight in 2002. This measure is based on children between the ages of 2 and 5 years old with height for weight greater than or equal to the 95th percentile. Data for previous years showed proportions between 6.4 and 9.4, but there had been errors with the computer programs that calculated children's weights and heights.

During FY 2003 the Colorado WIC Program continued to address the increasing incidence of overweight in WIC children. After pilot testing a food package with lower fat milk (2%, 1% and fat free only) in FY 2002, the food package was introduced as the new standard food package as a part of the Colorado WIC Childhood Overweight Prevention Campaign at the State WIC Meeting in May 2003. In addition to education and promotion around switching to lower fat milk, the meeting offered a variety of speakers and topics related to the prevention of childhood overweight. These included family meal times, lowfat calcium choices and weight loss, fruits and vegetables as a part of a healthy diet, Latino beliefs about childhood weight and nutrition, and physical play as a part of everyday living.

Another part of the WIC Childhood Overweight Prevention Campaign is the development of educational materials for paraprofessional staff that contain practical information to use with WIC parents regarding behaviors associated with pediatric overweight. Three sets of

educational materials were created on lower fat milk and dairy choices, family meals and vegetables.

The WIC program continues to play a lead role in two Colorado Physical Activity and Nutrition (COPAN) task force groups: the Early Childhood Taskforce and the Breastfeeding Taskforce. These groups emphasize overweight prevention through healthy habit development in early years and breastfeeding promotion. The task forces provide an opportunity to work with other state programs and agencies concerned with infants and children and overweight. The COPAN Coalition has many strategies that focus on the goal of reducing overweight and obesity. Some of these strategies include providing caregivers with resources to adopt healthy lifestyle behaviors for their families; creating community environments that promote and support breastfeeding; and providing parenting and prenatal breastfeeding education programs that create awareness of the benefits of breastfeeding. These programs include evidence showing that breastfeeding contributes to lifetime overweight prevention.

Data available at the county level for WIC for calendar 2002 revealed that only two counties out of 32 participating in WIC had rates of overweight that met the Healthy People 2010 goal of 5 percent. Half the counties had rates in the range of 6.1 to 9.9 percent, exceeding the goal by at least 20 percent.

b. Current Activities

The target for FY 2004 is 8.5 percent. It was increased from the previous year's lower target after the discovery that the target had been based on erroneously low figures.

During FY 2004 the Colorado WIC Childhood Overweight Prevention Campaign continues to focus on families making the healthy switch to lower fat milk. Nine months after the rollout of the new lower fat milk standard food package for WIC participants, 48 percent of women and children 2-5 years of age who participate on the WIC program have switched to the lower fat milk food package. Local agency staff continues in the effort to educate families and to promote lower fat milk with the goal of 90 percent of women and children 2-5 years of age eventually receiving the lower fat milk food package. Along with the promotion of this lower fat milk food package local agency WIC staff have begun to encourage and promote activity for children and families on a regular basis. This message comes in addition to the nutrition messages that the WIC Program has always provided. In April 2004 WIC staff was trained using the Best Start 3-Step Counseling Strategy. This helps allow WIC staff to determine each participant's individual barrier to optimal health behavior and to address it in such a way as to encourage positive health choices.

In early FY 2004 WIC prepared a second annual summary paper for WIC professionals on childhood overweight and ideas to address the problem. Collaboration with the nutrition department at the University of Northern Colorado allowed nutrition students to use their creativity to contribute to the campaign. Students worked in groups to create information sheets focusing on juice consumption, fast food, activity, snacking, parental modeling of healthy behaviors, and portion control. These will be used in creating more educational materials with practical information to local agency staff to use with WIC participants (parents) as a part of the Colorado WIC Childhood Overweight Prevention Campaign.

The Colorado WIC program continues to play a role in the Colorado Physical Activity and Nutrition Early Childhood Taskforce and the Breastfeeding Taskforce. Both groups are focusing this year on creating toolkits that will help local communities begin efforts to promote breastfeeding, healthy food choices and behavior, and activity as obesity prevention measures. The Early Childhood Taskforce took the lead in coordinating a statewide videoconference in October 2003. The videoconference was sponsored by MCH, promoted by JFK Partners and titled, "Preventing Childhood Obesity: Laying the Groundwork for

Prevention." The videoconference drew over 130 participants from around the state and was very well received.

c. Plan for the Coming Year

The target for FY 2005 remains the same as for FY 2004: 8.5 percent or fewer of WIC children between the ages of 2 and 5 years old will have a BMI-for-age greater than or equal to the 95th percentile. During FY 2005, staff will continue work to standardize the lower fat milk food package as the norm for 90 percent of WIC participants older than 2 years of age. The Colorado WIC program will host the State WIC Meeting in the spring of 2005 where emphasis will be placed again on educating families on WIC about healthy lifestyle choices that will help to prevent overweight and obesity. Paraprofessional staff will receive materials with practical information to use with WIC parents, and professional staff will be updated with the third annual summary paper on childhood overweight and ideas to address the epidemic.

State Performance Measure 9: *The percentage of women with inadequate weight gain during pregnancy*

a. Last Year's Accomplishments

With the release of the state's report, *Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado in 2000*, the public health community began a long-term effort to reduce the large contribution to the number of low birth weight births made by the one in four women who fail to gain weight adequately during pregnancy. The analysis made clear that the state low birth weight rate (among singleton births) could be reduced by nearly a full percentage point if all women gained weight adequately. The direct relationship between a woman's weight gain during pregnancy and her baby's weight gain underlay this analysis.

PRAMS data for the year 2002, the most recent data available, show that 24.5 percent of all pregnant women failed to gain an adequate amount of weight. Using these data, the target for FY 2003 of 23.0 percent was not met.

Work during FY 2003 focused on the development of information and materials related to weight gain for both pregnant women and health care providers. We obtained the services of PRACO, a public relations advertising agency, in April 2003. By August, the firm had created an image for the project and had developed appropriate materials that were tested with target audiences (see attachment to this section). Printing of 12,000 complete provider packets and an additional 11,000 patient education brochures and 10,000 weight gain grids was completed in October 2003.

Additionally, a Health Watch report published by the Health Statistics Section in March 2003 provided more focus on the issue of adequate weight gain during pregnancy (www.cdphe.state.co.us/hs/briefs/Pregnancy_wgain2003final.pdf).

b. Current Activities

The current target for the proportion of women with inadequate weight gain remains at 23.0 percent.

The Women's Health Section determined that a social marketing approach to the problem would have the greatest chance of success with outreach and education. A committee of state staff and community stakeholders was convened to address what behavior needed changing, who comprised the target audiences, what were the various barriers to change, and how these

barriers could be reduced. Within the social marketing plan, provider training, outreach to key stakeholders, and the development of a website were then addressed in detail. The campaign is called "A Healthy Baby is Worth the Weight."

Along with presentations at key conferences and meetings, a small-scale provider outreach campaign was initiated during FY 2004. Outreach grants were awarded to seven local health departments. Each agency then identified an individual within the agency to function as the campaign coordinator for the county. The desired outcome for this initial outreach is to provide training to 100 prenatal health care providers (physicians, nursing staff, dietitians and other agency support staff) and to strengthen clinical practice skills such as weight assessment, counseling, and documentation related to weight gain in at least 10 prenatal care provider settings.

Additional goals for the outreach project include providing patient education materials and weight gain counseling to at least 500 pregnant women per grantee. Each agency coordinator will complete evaluation forms for data tracking and program assessment. Information to be evaluated includes the number of women receiving materials and counseling, the number and background of staff trained, pre- and post-testing of provider knowledge and clinical practice, and evaluation of the overall project outreach to identify barriers to implementation and areas of improvement.

Within the social marketing plan, outreach is included to collaborative partners such as WIC, Prenatal Plus, Nurse Home Visitor/ Nurse Family Partnership, and March of Dimes. Several of these community partners have statewide or regional meetings in FY 2004 where they will receive information and training on the campaign. Other business and industry partners will be explored in the near future as well.

The Women's Health Section continues to work on a consumer/provider friendly website. A domain name that is easy to remember and use will be purchased that will link providers and consumers to the website. Information will be relevant to identified concerns or misconceptions associated with prenatal weight gain and will include accurate information. Users will be able to calculate personal BMI values and receive information on appropriate weight gain for their BMI category. A printable weight gain chart and access to patient education materials, as well as "Ask the Dietitian" sections are planned for the site (see attachment to this section).

c. Plan for the Coming Year

The FY 2005 target for the proportion of women with inadequate weight gain remains at 23.0 percent.

Beginning in October 2004, we anticipate that the provider and consumer website will be fully operational. Plans to create a promotional item, such as a magnet or tear-off card, to inform consumers and providers of the Campaign's key messages and website address are being discussed. Outreach to healthcare providers and consumers will continue as discussed above under Current Activities. A strategy for developing a media campaign will also begin in late FY 2005.

The addition of a "weight gain during pregnancy" question to the PRAMS survey will allow us to better assess weight gain recommendations from health care providers. This question was added in January 2004 and will be collected from 2004 through 2007. The question asks if the pregnant woman was told to gain a certain amount of weight by her health care provider and how much that was. Another question helps determine if food insecurity is an issue in the household. The answers to these questions will help us assess the extent of the weight gain campaign's success (where every women should know her BMI and how much weight to gain)

and the extent of one of the barriers to adequate weight gain (food insecurity). Our long-term commitment to dealing with these issues will be informed and modified by the survey results.

A total of 7 of the 15 organized health departments plan to use MCH funding to directly target this measure during FY 2005.

State Performance Measure 10: *The rate of injury hospitalization among children 19 and younger*

a. Last Year's Accomplishments

The number of injury hospitalizations was 3,923 among all children age 19 or younger, out of a population of 1,292,626, yielding a rate of 303.5 per 100,000 using calendar 2002 data. The target rate was 271.0, so the target was not met. The rate the previous year, using 2001 data, had been 321.8. Therefore, although the target rate was not met in 2002, there was an 18.3 point improvement over the rate found the year before. The change in the rate actually represents a nearly 6 percent decline.

The decline in the rate can be attributed primarily to a 6 percent drop in unintentional injury, from 252.1 to 236.8 in the hospitalization rates. There was no real change in the motor vehicle injury hospitalization rate, however, between the two years.

An analysis at the county levels shows a wide variation in injury hospitalization rates. A total of eight counties (using 1998-2002 data) met the 271.0 target rate, while the remaining 56 had higher rates, and four had rates that were double the target.

The Injury Epidemiology Program at the state health department published "Injury in Colorado" in June 2002. This 218-page document has been available on the Internet at www.cdphe.state.co.us/pp/injepi/InjuryinColorado/injuryincolorado.html since then. It provides details on injury in Colorado, including deaths, hospitalizations, and traumatic brain injury. Publication of this information is an important population-based activity for the state health department.

The Injury Prevention Program in partnership with the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) and the Injury Prevention Advisory Committee (IPAC) produced the state Injury Prevention Strategic Plan for 2003-2008 in the spring of 2003. The plan serves as a guide for reducing the three leading causes of injury-related death and hospitalization in Colorado: motor vehicle, suicide and falls. This strategic plan can be viewed at www.cdphe.state.co.us/em/SEMTAC/semtachom.htm.

In June 2003, injury hospitalization data were added to the Colorado Health Information Dataset (CoHID). Approved users can query the dataset to determine mechanism of injury by sex, race, age, gender, and county of residence for the years since 1995. Addition of these data to the popular website broadens the information available to health data users.

b. Current Activities

The target for the current year, FY 2004, is 300.0 hospitalizations per 100,000 children, higher than the previous year's target of 271.0. The target was increased because recent data indicated that our targets had been unrealistically low. Since the rate achieved in FY 2003 was 303.5, it seems very possible that the new target of 300.0 can be met.

Data from the 2003 Colorado Youth Risk Behavior Survey reveal that among the 757 students from 23 schools who participated in the survey, 9 percent never or rarely wore a seatbelt, 13

percent drove after drinking alcohol in the last 30 days, and 29 percent had driven with someone else who had been drinking alcohol in the last 30 days. While this survey data is unweighted, and not a representative sample of all Colorado high school students, it suggests that many high school students are unnecessarily taking risks around motor vehicle injury.

The Colorado legislature, responding to the fact that motor vehicle injury rates and deaths have remained high in the last two years, introduced several bills during the 2004 legislative session. HB 04-1017 was passed in May 2004, strengthening the existing Graduated Driver's Licensing law by increasing the age at which a teen driver can get a learner's permit from 15 and a half to 16 years (unless they have had a driver's training course). In addition, a learner's permit will last for one year instead of the current six months. This law is effective July 1, 2004. It is possible that this change will reduce teen fatalities, although experience in other states indicates that limits on the number of passengers, which was not part of the final legislation, as well as other constraints, may have the greatest impact on teen driving.

In February 2004, MCH sponsored a statewide videoconference on increasing health and safety in child care. The videoconference was coordinated through the Healthy Child Care Colorado program and included an overview of strategies to increase health and safety in child care on the national, state and local levels. Over 100 people participated, with strong representation from the fields of both public health and early care and education.

In March 2004, the Injury Epidemiology Section created "Deaths and Hospitalizations Involving Teen Drivers in Colorado." This document is available at www.cdphe.state.co.us/pp/injury/prevention. It is also attached to this section.

The Child Fatality Review Committee maintains an active website (www.cdphe.state.co.us/pp/cfrc/cfrchom.asp) where its briefs on drowning, firearms, and motor vehicle fatalities are available. These briefs contain specific strategies for prevention. The Injury Prevention website (see previous paragraph) provides monthly safety-related flyers and houses the Colorado SAFE KIDS Coalition's factsheets highlighting motor vehicle and falls statistics as well as prevention information. The Injury Prevention/SAFE KIDS staff is currently working on a drowning factsheet.

c. Plan for the Coming Year

The target for FY 2005 remains at 300.0 hospitalizations per 100,000 children age 0-19.

With the passage of HB 04-1017 (see Current Activities above) in the spring of 2004, there is the expectation that motor vehicle injury rates of hospitalization will decrease.

In order to help support local community planning related to injury prevention, MCH consultants have created planning templates specifically related to early childhood passenger safety and teen motor vehicle safety. The templates include suggestions for measurable objectives as well as examples of activities based on best practices in the field of injury prevention.

Organized health departments in Colorado's largest counties were required to submit plans for FY 2005 regarding a variety of performance measures. Six of 15 departments chose to specifically target their MCH dollars toward activities that should impact injury rates.

The next section of the grant, Figure 4B, provides the major activities for each of the ten state performance measures.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The proportion of high school students reporting having drunk alcohol in the past month				
1. Evaluate data on substance abuse from the 2003 Youth Risk Behavior Survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the Regional Prevention Center to develop strategies to reduce alcohol use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with the Alcohol and Drug Abuse Division at the Colorado Department of Human Services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Utilize Law Enforcement Assistance Funds to support impaired driving prevention programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The proportion of all pregnancies that are unintended				
1. Use the Parent Power curriculum from the National Campaign to Prevent Teen Pregnancy to encourage parent-child communication about sexuality.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to work with Title X funded family planning projects on service delivery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through Enhanced PRAMS projects, target local pop.-based approaches to reducing unintended pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Document and make presentations available about the problem of unintended pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Analyze recent declines in teen fertility and the level of unintended teen pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The incidence of maltreatment of children younger than 18 (including physical abuse, sexual abuse, emotional abuse, and/or				

neglect)				
1. Fund social marketing campaign to encourage action to prevent child abuse.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Evaluate program effectiveness for the numbers of families served and the intensity of services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Coordinate with Colorado Department of Human Services to improve and increase data about child maltreatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Coordinate with Colorado Department of Human Services to increase data available about perpetrators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increase awareness of issues and best practices for local health and comm. groups by teleconference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Partner with evidence-based programs to increase training opportunities for local child abuse prevention programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Obtain SPRANS-grant funding for a campaign to increase awareness of perinatal depression and to decrease the stigma surrounding it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The proportion of high school students reporting regular use of tobacco products				
1. Continue support of Title V programs for kids and teens in local health agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide leadership for youth-driven tobacco prevention through the Youth Partnership for Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue the development and support of a number of new programs through the State Tobacco Education and Prevention Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Improve surveillance through the Youth Risk Behavior Survey and the Youth Tobacco Survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers				
1. Support local school districts to help plan school-based health centers in their communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Focus on the sustainability of school-based health centers beyond Maternal and Child Health funding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Document and provide data on school-based health centers for children in Colorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Address obesity, tobacco, and STDs through the CDC-funded Coordinated School Health Infrastructure grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services				
1. Work to have Nurse Family Partnership incorporate oral health education into home visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue the State Dental Loan Repayment Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop a state oral health plan to reduce oral health disparities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase access to oral health services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop a media campaign that will raise awareness of the importance of oral health.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The rate of homicides among teens 15-19				
1. Develop and implement strategies for creating safe and drug-free schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Develop and implement strategies for promoting healthy childhood development (Denver's model).	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Support SBHCs and their focus on mental health as appropriate avenues toward reducing teen violence.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support anti-bullying programs through the schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in National Violent Death Reporting System with the goal of developing interventions to reduce homicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The proportion of WIC children who are overweight				
1. Continue to train WIC staff around child nutrition and physical activity as obesity prevention measures.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide standardized lower fat milk food package to over 90 percent of participants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop educational materials for paraprofessional staff with practical information on pediatric overweight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with the Colorado Physical Activity and Nutrition Task Force, the Early Childhood Task Force, and the Breastfeeding Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) The percentage of women with inadequate weight gain during pregnancy				
1. Document and provide data at state and local level about the impact of inadequate maternal weight gain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote major marketing campaign, "A Healthy Baby is Worth the Weight," to local health departments and private providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue successful Prenatal Plus Program among Medicaid clients targeting at risk women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Develop a consumer and provider website as a part of the marketing campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of injury hospitalization among children 19 and younger				

1. Maintain website (www.cdphe.state.co.us/pp/cfrc/cfrchom.asp) through the Child Fatality Review Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Document and provide data on a state and local level data for injury hospitalization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analyze usefulness of injury prevention templates at the local level and evaluate effectiveness of local strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Facilitate learning groups with local health departments to discuss best practice injury prevention strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Toll-Free Hotline

The Family Healthline is a statewide information and referral service located at the Colorado Department of Public Health and Environment. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialist speaks fluent Spanish and English. Special arrangements are made for assisting the hearing-impaired and callers who speak other languages. During FY 2003 a total of 19,828 calls were received.

The Family Healthline specialist makes referrals usually within each caller's own community and in certain instances is able to establish a direct connection for the caller. Individuals often make repeat calls to the Healthline once they learn of the extent of the referral database and the expertise of the bilingual staff. The Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources. The Family Healthline works closely with the Covering Kids and Families program and in some cases, assists individuals in completing the revised joint Medicaid/Child Health Plan Plus/Colorado Indigent Care Program application form.

Each call to the Healthline is recorded in a database where demographic and other call information is stored. Monthly reports are generated that detail certain caller demographics (place of residence, Spanish-speaking, etc.) and purpose of the call (Medicaid assistance, immunizations, etc.). This database is useful for program planning efforts. The database software has the capacity to track whether a call is the result of a specific state or national campaign effort. Using the database, the Healthline specialist can refer back to the original call for greater efficiency and better customer service. The database is also used to prepare summary reports.

In July 2003, the Medicaid Agency decided to stop funding one of the Healthline resource specialists. With changes in their internal structure, the agency felt it no longer needed an outside referral service. The work of assisting Medicaid and CHP+ applicants complete the joint application was removed from the scope of work of the Family Healthline. One of the specialists was transferred to Medicaid, and her job was restructured. This change left the Family Healthline with only one specialist and MCH as the only funding source. Over that past year, the program has been monitoring the number and types of calls. The staff has also been in conversation with the state 211 line to see what type of

collaboration is possible. At this point the Colorado 211 network covers only a few of the state's 64 counties, but it is growing quickly. Once statewide coverage is achieved, the merger of the Family Healthline with the 211 network is a possibility.

Sudden Infant Death Program

The Colorado Sudden Infant Death Program, a statewide non-profit 501(c)3, should also be described. The primary purpose of the program is to provide early intervention through information and counseling to those persons affected by the sudden death of an infant. Program staff provide the majority of the family services (over 2,109 contacts in FY 2003) in addition to utilizing a statewide network of public health nurses, parents, and volunteers, to provide services to parents, relatives, friends, day care providers, etc. Over 190 of these contacts were over 30 minutes in length and 156 had a complexity of 4 or 5 (with 3 being the expected level of complexity). The mission of the Program includes assuring that emergency and other first responders understand SIDS and are able to provide accurate and appropriate information and referral resources to the family. The Program maintains a website at www.coloradosids.org. The site describes the organization, the services that it provides, and offers materials about SIDS.

In FY 2003, educational presentations were provided for 230 emergency responders (EMS and law enforcement officers), and 135 victim advocates. Sites include a long list of cities, and several presentations were provided to groups with statewide representation. Evaluations indicate that the presentations were well done and helpful to groups. Overall, the Program provided 68 educational presentations to 2,368 individuals involving 130 hours of classroom presentation and over 130 hours of travel and preparation time.

The program continues to promote educational efforts that focus on placing infants on their backs for sleeping while also providing "tummy time" for play. Some parents put their babies to bed on their backs when they first come home from the hospital, but fail to continue the practice for the first year of life.

The Program continues to be an active participant on the statewide Child Fatality Review Committee and is responsible for the review of every infant death coded to SIDS.

The program has become increasingly aware of a lack of risk reduction education being addressed at many hospitals where babies are born. A mailing was done in April 2004 to every hospital nursery in the state, providing new materials about risk reduction. In addition, a targeted mailing to all licensed child care providers in the state was carried out in the summer of 2004.

With the planned changes in the statewide Child Fatality Review Committee underway, there will be fewer opportunities for community education programs. The program recently contacted every newly elected coroner and sheriff in the state to provide current SIDS information and to offer educational presentations.

In calendar 2002, the most recent data available, there were 61 reported SIDS deaths in Colorado, for a rate of 0.89 per 1,000 births. All families were contacted by program staff within 48 hours of the death being reported.

F. TECHNICAL ASSISTANCE

Colorado's technical assistance needs are shown on Form 15. We are asking for help with five areas.

We need consultation clarifying HIPAA regulations and sharing of data between our state Medicaid agency, the Department of Health Care Policy and Financing, and the state health department. We are unable to obtain data we consider to be necessary for assessing the health status of the maternal and child health population. Furthermore, assistance is sought in developing ways to approach the agency to demonstrate that Medicaid programs could be modified in ways that would benefit women

and children in the state.

Another area where assistance is sought is in developing data sources for child and adolescent weight measurement. The determination of overweight and obesity requires information on height and weight. In addition, evidence-based intervention strategies for reduction of weight are also needed. This work would contribute to our state performance measure on childhood obesity.

Innovative ways to pay for prenatal care for undocumented women are also critical. Colorado women are increasingly unable to access care, in contrast to other states where the proportion of women obtaining first trimester care is improving.

Finally we seek assistance from a national expert in Hispanic teen fertility to provide training on how to reduce the high rate. While Colorado's teen birth rate has fallen, it is still well above the levels of a majority of the states.

V. BUDGET NARRATIVE

A. EXPENDITURES

Information on annual expenditures is contained in Form 3, Form 4, and Form 5. Some noticeable shifts are apparent between FY 2002 and FY 2003, as funds were shifted to enabling and population-based activities, decreasing the amount utilized for direct health care services (Form 5). At the same time, funding was increased for pregnant women and administration, and decreased for children 1 to 22 years old and children with special health care needs (Form 4).

Form 3

Total expenditures in FY 2003 were slightly higher than those budgeted for the year. The federal allocation was slightly higher (\$19,648) than budgeted (\$7,814,517 vs. \$7,794,869). In order to meet the required match level, we were able to capture additional state funds (\$14,737) for the slight increase in the federal allocation.

The original FY 2003 Application amount on line 3 included State and local MCH funds. At the time of the FY 2003 application, local MCH funds could not be shown separately due to computer software problems in the Electronic Reporting Package. Funds are now reported separately.

Form 4

Total expenditures for FY 2003 for pregnant women amounted to \$3.1 million, above the \$2.8 million that had been budgeted. Expenditures for children age 1 to 22 amounted to \$3.9 million, above the \$3.4 million that had been budgeted. Expenditures for children with special health care needs totaled \$5.5 million; below the \$6.7 million budgeted. The Colorado Department of Public Health and Environment elected not to become a HIPAA covered entity for medical claim transactions. As a result of the Department's HIPAA decision, the Health Care Program for Children with Special Needs discontinued paying for specialty medical services effective July 2003. The fiscal savings that accrued July through September 2003 were redirected to pregnant women, infants and children's activities. Expenditures for Colorado's federal allocations for preventive and primary care for children and for children with special health care needs were within the required proportions.

Form 5

Expenditures for enabling and population-based services were substantially increased (from \$3.7 million budgeted to \$3.8 million expended for enabling services and \$3.4 million budgeted to \$3.8 million expended for population-based services). Direct health care services were substantially decreased (from \$2.5 million budgeted to \$2.1 million expended). These changes resulted from the Department's HIPAA decision, shifting dollars and effort out of direct health care services. Infrastructure-building services were decreased by \$210,647 below the budgeted amount. This change took place as the result of a hiring freeze while Colorado experienced a revenue shortfall.

B. BUDGET

Budget information is contained in Forms 2, 3, 4, 5, and 10.

Form 2 shows the federal allocation as \$7,720,891 for FY 2005. Of these dollars, a total of 30.93 percent will be allocated for preventive and primary care for children, 33.92 percent will be allocated for children with special health care needs, and 9.44 percent will be spent on administration. These proportions meet the MCH Block grant requirements.

In addition, the form shows state funds of \$4,736,061 and local funds of \$1,483,633, meeting the requirement that the total amount, \$6,219,694, must equal three-fourths of the federal allocation. (In previous grants, state and local funds were combined on the state line because of software limitations that calculated the three-quarters based on the amount shown only on the state line.)

The state maintenance of effort from 1989 is \$4,736,061. The total state match for FY 05 is \$4,736,061, the same amount.

The total state match consists of state general funds in the amount of \$3,217,557 and cash funds in the amount of \$1,518,504 (genetics counseling fees, Colorado Children's Trust Fund and traumatic brain injury funds). Local funds that support prenatal and child health activities conducted at local health departments total \$1,483,633.

Under Other Federal Funds, the CISS grant line (Form 2, line 8c) includes both \$50,000 for CISS and \$100,000 for the MCHB State Early Childhood Comprehensive System Grant.

Centers for Disease Control (Form 2, line 8i) funds include \$350,000 for Early Hearing Detection and Intervention (EHDI) Tracking, Research and Integration with Other Newborn Screening Programs Grant. A number of program changes took place in FY 2004. The MCH Epidemiology Training Program ended, while the Asthma and the Children's Immunization Programs were reorganized out of the MCH Section. These programs formerly provided over \$4 million that appeared in this line in previous years.

Education (Form 2, line 8j) funds include \$30,000 from Colorado Department of Education's Individuals with Disability Act (IDEA), Part C funding. These funds are transferred to the state health department to support the MCH Children with Special Health Care Needs' statewide diagnostic evaluation clinics.

Under "Other" (Form 2, line 8k) we now show \$376,269 for Community-Based Family Resource and Support Centers, money that is received from the Department of Health and Human Services, Administration for Children and Families.

Under "Other" (Form 2, line 8k) also, the MCH Section is receiving \$300,000 of MCHB funds for the ISNSS (Promoting Integration of State Health Systems and Newborn Screening Services Systems for Monitoring and Ensuring Quality Services to Newborns and Children with or at Risk for Heritable Disorders).

The tobacco settlement funds for the Nurse Home Visitor Program were erroneously reported in Form 2, line 8k, for the FY 2004 MCH block grant application. These were cash funds directed by the Colorado Legislature and should not have been reported as Other Federal Funds. The ISNSS grant for \$300,000 has replaced the Nurse Home Visitor funds on Form 2, line 8k.

The Federal-State Block Grant Partnership total on Form 2 equals \$13,940,585, and the State MCH Budget Total, shown at the bottom of the form, equals \$15,246,854.

Form 5 reveals the most recent shift away from direct health care services. The Health Care Program for Children with Special Needs discontinued paying for specialty medical services effective July 2003. The Colorado Department of Public Health and Environment decided not to become a HIPAA-covered entity for medical claim transactions.

In FY 1997, the first year data were provided in these forms, the expenditures for direct health care equaled 35.8 percent of the total federal-state Block Grant Partnership; by FY 2005, 14.1 percent, well under half as much, was budgeted. Enabling services show a substantial increase over time, from 21.5 percent of FY 1997 expenditures to 32.6 percent budgeted for FY 2005. Population-based services show an increase as well from 14.7 percent in FY 1997 to 24.0 percent budgeted for FY 2005. Infrastructure-building service monies show a good deal of variability between years, but the proportion in FY 2005 of 29.2 percent is virtually the same as the proportion expended in FY 97, when it was 28.5 percent.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.