

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: ID

APPLICATION YEAR: 2005

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## **I. General Requirements**

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

## **II. Needs Assessment**

### **III. State Overview**

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

### **IV. Priorities, Performance and Program Activities**

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

### **V. Budget Narrative**

[A. Expenditures](#)

[B. Budget](#)

### **VI. Reporting Forms-General Information**

### **VII. Performance and Outcome Measure Detail Sheets**

### **VIII. Glossary**

### **IX. Technical Notes**

### **X. Appendices and State Supporting documents**

## **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**

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

### **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**

Idaho is in the process of establishing a contract with an outside organization to develop and implement the MCH 5 year needs assessment for Idaho. This process will include input from various organizations representing MCH populations. As always, MCH funded programs involve public input as appropriate for program direction and implementation. A good example of this activity over the past year has been the Children's Special Health Program's effort to obtain input from individuals and organizations on programmatic changes necessary to maintain program expenditures within budget. CSHP staff has met and/or communicated with major family support and advocacy organizations, including Idaho Parents Unlimited, Family Voices, Co-Ad, the State Independent Living Council, and the Consortium of Idahoans with Disabilities, an umbrella group composed of a variety of programs, agencies and organizations focused on disability issues in Idaho. CSHP also began a process of communicating with physician providers and district health departments last summer to allow adequate time to explain coming program changes and respond to comments and questions.

## **II. NEEDS ASSESSMENT**

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

### III. STATE OVERVIEW

#### A. OVERVIEW

##### Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and uninhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

##### Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 40th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.

/2004/ The 2001 estimated population for Idaho is 1,321,006.

***/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//***

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. ***/2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//***

***/2005/ Summary of Population by Region (Health District) for 2000 (April 1, 2000 Census)***

##### ***DISTRICT POPULATION PERCENT***

***District 1 250,984 19.40***

***District 2 100,533 7.77***

***District 3 191,297 14.78***

***District 4 344,355 26.61***

***District 5 162,397 12.55***

***District 6 156,906 12.13***

***District 7 160,132 12.38***

**/2005/ Summary of Population by Region (Health District) for 2003  
(April 1, 2000 Census)**

**DISTRICT POPULATION PERCENT**

**District 1 265,672 19.44**  
**District 2 100,348 7.34**  
**District 3 213,465 15.62**  
**District 4 369,002 27.01**  
**District 5 167,444 12.26**  
**District 6 158,266 11.58**  
**District 7 168,969 12.37**

**//2005//**

**Ethnic Groups**

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; (c) native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans reside on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2004/ Racial groups that comprised Idaho's population in 2000 were: (a) white, 91%; (b) black, .4%; (c) American Indian/Alaskan Native, 1.4%; (d) Asian, 0.9%; (e) Native Hawaiian/Pacific Islander, 0.1%; and (f) Other, 4.2%. Hispanics make up 7.9%.

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. **/2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//**

**Economic Information**

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho (\$36,023) was 9.2% lower than the national average (\$39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

**/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//**

## Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

***//2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//***

## Health Delivery System in Idaho

As a rural state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance when planning a health care system. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

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

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. ***//2005/ Bed capacity has increased to 3,326.//2005//***

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

***//2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//***

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary

care physicians per 100,000 population is 96.

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

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

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

***//2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//***

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

***//2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS systems that often serve as first encounter points for direct care. Poverty level and low-income populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//***

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for

reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/ migrant clinics in north Idaho.

***/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//***

***/2005/ During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care on-site has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 on-site community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//***

## Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000 through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

***/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//***

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/ Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

***/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5 years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//***

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving \$10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically calls each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

***/2005/ During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > \$10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area. //2005//***

## Impact on Health Outcomes

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

## Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement

strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program. We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

***//2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//***

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's taskforce was appointed to study and make recommendations on the long-term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's taskforce recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2003/ The number of providers providing vaccination data to IRIS increased to 100. To date there are over 139,814 patient records.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

***/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18./2005//***

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to Provide leadership for development and implementation of a sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

***/2005/ The Any Door Initiative has been piloted in one small office in health district 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in***

**accessing public health services even though they are applying through a social service center.//2005//**

**/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.**

**Another project that is included in the FFY 05' budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.**

**And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs.//2005//**

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

**/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//**

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

***/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred direct.***

***The Newborn Screening Program was recently expanded the newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia./2005//***

#### Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

- Infant mortality and low birth weight
- Adolescent pregnancy
- Vaccine preventable diseases
- Injuries
- Substance and physical abuse
- Investigation and control of "clusters" of reportable diseases and conditions
- Prenatal care utilization
- Children's access to health care coverage
- Risky behavior in adolescents
- Increased data capacity

## **B. AGENCY CAPACITY**

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9).

***/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Womens Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health./2005//***

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse who are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this collaborative effort.

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

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

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

#### Newborn Screening Program

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

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since

Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

***//2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//***

#### Children's Special Health Program

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

***//2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//***

The individuals providing program management and their qualifications are listed as follows:

#### Bureau of Clinical and Preventive Services

*//2003/* Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

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

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

*//2004/* Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

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

*//2003/* Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

***//2005/ Jared Bartsch, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//***

***//2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the***

***fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//***

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

/2004/ Judy Peterson, resigned in July of 2002, but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions.

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

***//2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger, R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//***

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

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

Bureau of Health Promotion

***//2005/ Name changed to the Bureau of Community and Environmental Health.//2005//***

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

***//2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//***

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

***/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on prevention falls and transitioning the child car safety seat program to other partners.***

***Note: Kaili has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//***

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.

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

#### Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

***/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//***

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for areas of medical underservice, barriers in access to health care, and identification of health disparities.

#### Bureau of Health Policy and Vital Statistics

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

Systems Manager.

/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.

/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.

/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing that is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.

***/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//***

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

Public Health Districts

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

## C. ORGANIZATIONAL STRUCTURE

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group follows.

Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the

program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program, provides newborn metabolic screening through a contract with the Oregon Division of Health Regional Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

***/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing at St. Luke's Children's Hospital./2005//***

Children

***/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho./2005//***

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

The Oral Health Program contracts with the district health departments to perform surveys of oral health status as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

***/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on college campuses./2005//***

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

***/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners./2005//***

Children with Special Health Care Needs.

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

***/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics./2005//***

All MCH Populations

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

The STD/AIDS Program provides HIV prevention education activities as well as counseling, testing, and epidemiological follow-up. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

The toll-free telephone referral service, Idaho CareLine, as it's called provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

## **D. OTHER MCH CAPACITY**

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

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

The Genetics Clinical Services coordinator position is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinates genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

There are a number of other programs within the Department of Health and Welfare that are tied in

varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

***//2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//***

In addition to having funding ties to MCH programs there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

***//2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//***

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments have very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

## **E. STATE AGENCY COORDINATION**

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

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

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

*//2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.*

***//2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing***

***discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//***

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

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

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

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

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

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

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

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

- a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
- b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
- c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
- d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
- e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
- f) Healthy Child Community, an interdepartmental group interested in promoting the health and well

being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.

- g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
- h) Idaho Breast and Cervical Cancer Alliance, dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
- i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
- j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
- k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. ***//2005/ This group is no longer a functioning partnership. //2005//***
- l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
- m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
- n) Idaho Governor's Council on Adolescent Pregnancy Prevention.
- o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
- p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
- q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths.  
/2004/
- r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding, volunteer networking and operation of the community health center dental clinics.
- s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
- t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
- u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
- v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho.
- w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.

## Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school

health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

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

#### Federally Qualified Health Centers/Community Health Centers

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

***//2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//***

#### Universities

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

***//2005/ The Immunization Program no longer contracts with these universities as this program is already implemented.//2005//***

## F. HEALTH SYSTEMS CAPACITY INDICATORS

### #01 HEALTH SYSTEMS CAPACITY INDICATOR

The rate of children hospitalized for asthma (10,000 children less than five years of age).

Hospital discharge data is currently not available in Idaho. The Idaho Asthma program is currently working with the three primary health plan insurance carriers in Idaho to obtain data for their clients.

### #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.

Available and included.

**#03 HEALTH SYSTEMS CAPACITY INDICATOR**

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

Available and included.

**#04 HEALTH SYSTEMS CAPACITY 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.

Available and included.

**#05 HEALTH SYSTEMS CAPACITY INDICATOR**

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

Available and included.

**#06 HEALTH SYSTEMS CAPACITY INDICATOR**

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

Available and included.

**#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.

Available and included.

**#08 HEALTH SYSTEMS CAPACITY INDICATOR**

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program."

Always 0 since CSHP only provides insurance coverage equivalent for children with no source of payment.

**#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.

Described on form 19.

**#09(B) HEALTH SYSTEMS CAPACITY INDICATOR #09(B)**

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Described on form 19.

**#09(C) HEALTH SYSTEMS CAPACITY INDICATOR**

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

Described on form 19.



## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted four years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

### **B. STATE PRIORITIES**

The following list is Idaho's top ten priority needs:

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.

4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

#### Issue: Access to Health Care

The most significant barrier that Idaho citizens face in accessing health care is a shortage of both primary care and specialty care providers. Although this issue is not specifically named in the top 10 priority issues for Idaho, it affects most in one form or another.

Forty-three service areas are designated as Primary Care Health Professional Shortages (HPSAs) in Idaho. In addition, there are 33 designated Dental Health Professional Shortage Areas and 6 designated Mental Health Professional Shortage Areas. Maps showing Idaho's primary care health professional shortage areas, dental health professional shortage areas, and mental health professional shortage areas are included as Figures 1, 2 and 3.

***//2005/ Currently, 80.6% designated Primary Health, 74.3% Dental, and 100% Mental Health Professional Shortage Areas.//2005//***

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

Year 2000 state legislation expanded the scope of the loan repayment program creating the Rural Health Care Access Program. The program was developed for the purpose of providing grants to improve access to primary care medical services in areas designated as primary care health professional shortage areas and medically underserved areas. Individual grant awards to governmental and not-for-profit entities in health professional shortage areas will be limited to \$35,000 per year for a maximum of three years. There are four categories of grant assistance to include recruitment and retention, tele-health projects, community health service development projects, and other activities related to improving health care access.

Year 2000 state legislation expanded the scope of the loan repayment program creating the Rural Health Care Access Program. The program was developed for the purpose of providing grants to improve access to primary care medical services in areas designated as primary care health professional shortage areas and medically underserved areas. The program has expanded to include access to primary dental care in 2002. Individual grant awards to governmental and not-for-profit entities in health professional shortage areas will be limited to \$35,000 per year for a maximum of three years. There are four categories of grant assistance to include recruitment and retention, tele-health projects, community health service development projects, and other activities related to improving health care access.

#### Issue: Unintended Pregnancy

The Reproductive Health Program provides an essential adjunct to the public health and preventive care delivery system in Idaho. In addition to pregnancy prevention services, the Reproductive Health

Program also provides comprehensive primary reproductive health care and health education services to its clients. The program provided services to 40,827 low income Idahoans in CY 2002. Services are provided through the public health districts and two Planned Parenthood clinics, and clinics are located in 37 (and occasionally 38) of Idaho's 44 counties. Low income, medically underserved women are the primary target population and the majority of the client's incomes are less than 100% of the federal poverty level.

A major objective of the program since FY 1998, has been to work with Medicaid to develop a 1115(a) waiver. The waiver would expand Medicaid eligibility to all women up to 150% of the federal poverty level and cover more than 80% of the women currently served by the program.

The program targets services to populations who may have difficulty accessing care. During CY 2002, the program served 6,278 Hispanic/Latinos. The program provides all educational material in English and Spanish, and strives to have bilingual staff available in all clinic sites. The program provides outreach to the Hispanic community, and provided funding for outreach into migrant camp through a contract with the Southwest District Health Department. More than 1,812 clients served speak only Spanish and required interpretation services.

Issue: Adolescent Pregnancy, Low Birth Weight, and Risky Sexual Behavior

Funded by Child Support Block Grant and state matching dollars, the Idaho Governor's Council on Adolescent Pregnancy Prevention was established in 1995. The Council developed and implemented a statewide campaign focused on delaying sexual activity by adolescents and then assessed the impact of the campaign on affecting the behavior and attitudes of Idaho teens. Consistent with a primary prevention strategy, the priority population was 10-14 year old males and females and their adult care givers. In tandem with this statewide effort, educational and enabling strategies were funded by the Abstinence Education Block Grant to sustain the message of abstinence through activities planned and conducted by local communities. Seven district health departments are contracted to facilitate and coordinate the planning and implementation of activities designed to delay the onset of sexual activity in teens by the local coalitions that currently operate in Idaho. ***//2005/ The Council is currently funded by TANF. Also, only six district health departments are contracted to facilitate and coordinate activities.***

***//2005//***

The Reproductive Health Program also provides significant statewide capacity to reduce adolescent pregnancy and the subsequent low birth weight deliveries through it's contracts for family planning services.

Issue: Substance Abuse and Physical Abuse

The Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, provides statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns. The public health districts continue to utilize the Perinatal Substance Abuse Prevention Protocols in Reproductive Health and WIC clinics.

***//2005/ The Reproductive Health Program contracts require agencies to have an active community-based advisory council. Working with clinic staff, these councils provided community education classes, developed brochures and advertisements to market services to the target populations. The Advisory Councils include representatives of the target populations and help assure services and educational materials are appropriate for the communities.//2005//***

The Reproductive Health Program has worked with the Council on Domestic Violence and Victim Assistance, the Ada County Victim Witness Program, and the Bureau of Children and Family Services to better coordinate services for minors and women facing violence and abuse. Training on child abuse screening, detection, referrals and reporting was provided by the State program for all the Reproductive Health program providers in CY 2002.

***//2005/ Under Title X, the Reproductive Health Program clinics are required to screen all minors for sexual coercion and encourage parental involvement in decision making. During CY 2003, 3,948 teens received specific counseling services to encourage parental involvement and identify supportive adults and community resources. 50,000+ women received public education information on family planning, women's health, and risk reduction.//2005//***

A major Department of Health and Welfare initiative is to integrate substance abuse into all programs. This may be as extensive as adding screening and counseling services to a program or as simple as making substance abuse information available at clinic sites. Progress by each program for this topic is monitored and reported to the Department Director's Office on a quarterly basis.

#### Issue: Access to Care - Oral Health

The Oral Health Program contracts with the seven district health departments to conduct population-based preventive oral health programs. These include a school fluoride mouth-rinse program which targets children in grades 1 - 6 who are at high risk of developing dental caries and live in fluoride deficient areas. Other program efforts include school-based preventive dental health education and oral health promotion in partnership with the district WIC Programs and through community-based activities. Special one time funding has been continued to facilitate and coordinate dental sealant projects and an early childhood caries prevention project.

#### Issue: Utilization of Prenatal Care

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

***//2005/In 2001, 62.4% of mothers reported that they did NOT go to a dentist or dental clinic for routine dental care during their most recent pregnancy (2001 PRATS). Mothers who intended to be pregnant were twice as likely to receive routine dental care during pregnancy compared with mothers who had an unintended pregnancy. Mothers 20 years of age or older were more likely to receive routine dental care during pregnancy (38.6 percent) than women 18-19 years of age (23.5 percent). Mothers with private insurance were over twice as likely to receive routine dental care during pregnancy as mothers utilizing Medicaid. In 2001, 40.7 percent of mothers who began prenatal care in the first trimester received routine dental care, compared with 25.1 percent of mothers who began prenatal care after the first trimester.//2005//***

## Issue: Immunization Rates

Idaho's immunization rates for the 19 - 35 month old population continue to be below the HP 2010 objective. The latest National Immunization Survey (2000) showed Idaho's rates have increased to 75%. The current Governor has made raising Idaho's rates to the 90% level a goal of his administration and has emphasized its importance by appointing a special position within his office to work on early childhood development and immunization issues. Therefore, the program continues to implement several additional strategies intended to impact reminder/recall for both providers and parents. The state program, through contracts and internal staff, performs the following endeavors: (1) link the WIC program with immunization through assessment of vaccination status and referral for needed vaccination of children receiving services from the WIC program; (2) implement CDC's AFIX (Assessment, Feedback, Incentive, and eXchange) protocol in the public health and private delivery systems. One major component of this protocol is to conduct CASA assessments (Clinical Assessment Software Applications) at both public and private clinic sites in an attempt to identify barriers to vaccination at each clinic site as well as to establish the actual immunization levels of the clinic's population; and (3) partner with birthing hospitals and public and private providers to increase the number of facilities with an immunization reminder/recall system. The AFIX protocol has also been initiated in contracts with migrant and community health clinics.

***//2005/ Idaho's immunization rate for the 19 - 35 month old population for 4:3:1 is 82.2%. This is a significant increase over last year's rate and is for the first time higher than the national average.//2005//***

## Issue: Child Mortality, Suicide, Morbidity and Mortality Due to Injury

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

The Bureau of Health Promotion, Injury Prevention Program, collaborates with the district health departments and the Idaho Transportation Department to promote use of motor vehicle occupant restraints for passengers of all ages. Funding for the Injury Prevention Program is a combination of MCH and Preventive Block Grant dollars.

***//2005/ The Bureau of Community and Environmental Health, Injury Prevention Program is working to transition the current child car safety seat program to state and local partners.//2005//***

This coming year the Injury Prevention Program will team with the Idaho Department of Health and Welfare's Division of Family and Community Services, the Department of Education, and SPAN-Idaho (the Boise State University-based group) to develop a comprehensive statewide suicide prevention plan.

***//2005/ The Suicide Prevention Plan project was completed in November 2003.//2005//***

## Issue: Epidemiology Capacity for the MCH Population

Infectious disease outbreaks and reportable conditions play a significant role in the major morbidity for the population of children less than 22 years of age in Idaho. The Office of Epidemiology provides services directly and through contracts with the public health districts. This approach builds capacity at the local level to respond to infectious disease threats as well as to conduct investigations and surveillance activities on reportable conditions such as elevated blood lead levels.

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

### 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

Idaho's newborn screening program is in the process of revising the newborn screening brochure, finalizing the SFY '04 contract with Oregon for lab and consultation services and informing providers of the \$1 dollar fee increase per test kit. With the expanded screening now available from tandem mass spectrometry available from the Oregon Public Health Laboratory we are identifying approximately twice as many infants with newborn metabolic diseases or around 16-20 per year. Idaho has no in-state physician specialist to provide care for these children, so we are in the process of evaluating options for ensuring at least some basic provision of care is provided throughout the state. One option will be to expand the current PKU clinics offered in the three regions of the state twice per year, to include more frequent clinics and provide access for children with other metabolic conditions.

#### b. Current Activities

The newborn screening brochure was revised, reprinted and began being distributed through the Oregon Public Health Laboratory (OPHL), and Idaho's manual for practitioners was completed and placed on the internet. In mid-May, the FY04 contract with the Oregon Public Health Laboratory was amended and finalized to include testing for CAH and hemoglobinopathies. Through a grant at Oregon Health and Science University (OHSU), the program has been provided a part-time person to undertake staff education at birthing facilities across the state before she begins work on a long term follow up project this fall. The transit time of blood specimens from Idaho to the OPHL has been dangerously poor from several facilities, and this temporary staff person is making contact with those institutions to offer information, technical assistance and education.

In April, an OHSU metabolic specialist was brought to Idaho by the program to present information on newborn screening and the technology of tandem mass spectrometry at a dinner meeting with pediatricians in Idaho Falls and grand rounds at the Eastern Idaho Regional Medical Center. The following week, a nurse educator from OHSU made the same trip to present to nurses, nurse managers and early intervention staff in eastern Idaho.

State staff are members of a March of Dimes committee that is examining newborn screening and genetics issues in Idaho, and the program funded a visit and presentation to the committee by the OHSU nurse educator mentioned above and an OHSU RD who specializes in metabolic conditions. The state program is sponsoring a conference call involving staff from Idaho's largest birthing facility with OHSU and OPHL staff in July to address collection and mailing issues within that facility's two Treasure Valley campuses.

#### c. Plan for the Coming Year

Provider education will continue to be a priority this coming year. Educational/information

presentations by Oregon Health and Science University (OHSU) staff will be scheduled in southwest and central regions of the state. The Idaho program manager and nurse educator from OHSU are scheduled to provide a newborn screening presentation to nurse managers from across the state at the 10th annual nurse manager's summit meeting this fall. Birthing facilities will be provided bi-annual practice profiles that enumerate transit times and collection errors so they have a basis of comparison over time concerning their newborn screening operations.

*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

Meetings with Idaho family advocacy/education groups, particularly Idaho Parents Unlimited (IPUL) and Family Voices, resulted in both endorsement of and support for CSHP's FY04 goal of utilizing an existing Parental Advisory Committee to provide family input in program activities. That goal has been modified to expand the committee beyond families enrolled in CSHP due to the program changes described in section (b) below. Family voices will be a critical component in such an expansion. Idaho's new Family Voices coordinator has been involved with CSHP on an informal basis for a number of years, and attended the 2001 triregional meeting in Phoenix as an Idaho team member; her existing knowledge of the program will expedite and strengthen Family Voices involvement with CSHP.

#### b. Current Activities

CSHP's state staff, which consists of two professionals and an administrative assistant, has been focused this year almost exclusively on transitioning the program from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. As of October 2004, CSHP will no longer contract with regional health departments and some 50 physician providers to organize and staff an average of 200 annual clinics in eight major diagnostic categories across the state, will no longer enroll insured children in the program, and will cease assisting with the payment of deductibles and co-pays for insured families. These changes have resulted in a great deal of understandable trauma, anger and confusion on the part of families and providers. In addition to responding to letters, emails and telephone calls from families, friends of families, and providers, and meeting with various advocacy groups to explain program changes, staff is working closely with health departments to privatize existing clinics after CSHP support ceases. That effort has been largely successful, with the expected loss of fewer than five clinics out of thirty presently being offered across the state.

The only direct services with which the program plans to remain involved will include the continued sponsorship of PKU and Cystic Fibrosis clinics, and the care coordination and payment of treatment for uninsured children. Beginning October 1, 2004, only children without health insurance and who meet CSHP's diagnostic criteria will be enrolled in the program. This most vulnerable pediatric population will receive care coordination through a contract with St. Luke's Regional Medical Center's Children's Specialty Center from a nurse who served for four years as a CSHP nurse coordinator. She will ensure that youngsters under her purview receive the medical and rehabilitative services necessary to stabilize or improve their specific medical condition. Bi-annual statewide PKU clinics will continue to be provided, along with a monthly Cystic Fibrosis clinic in Boise.

As the transition from the majority of direct services the program has provided these past decades is completed this fall, state CSHP staff will turn their efforts to the successful and ongoing accomplishment of national CSHCN performance measures which, due to the need for state staff to attend to a variety of transition issues, have received little attention this year.

### c. Plan for the Coming Year

As staff time needed to address CSHP transition issues decreases in the fall, renewed attention and support to forging new, expanded partnerships with IPUL and Family Voices will occur, and will be designed to help move the Idaho program further down the MCH pyramid to the enabling and infrastructure building levels. CSHP has already provided financial support to the state Family Voices Coordinator, who was an Idaho team member for the spring Champions for Progress Utah meeting, to attend a planning meeting with Washington Family Voices staff for assistance in a joint Family Voices/CSHP application to the Champions for Progress Center for an incentive awards grant. The grant will support the identification and training of parent leaders from across Idaho to begin the process of establishing a statewide network of parent meetings, workshops and mentors for families with special needs children.

CSHP will attempt to make it clear, through policy and action, to all relevant constituencies that the program values working in partnership with families, providers and other agencies/programs. It will begin to work with community professionals and families to support a comprehensive understanding and appropriate use of Idaho's medical and social service systems. State staff will devote attention to facilitating, encouraging and providing families with a variety of opportunities to develop competencies and confidence in working with issues, agencies and legislators on behalf of their children with special needs.

*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

Since national survey data yielded significantly different percentages for this performance measure (98% state program data vs 49.1% national), CSHP will pay increased attention to this measure the remainder of this year. It should be noted that state program data is derived from surveys of families enrolled in CSHP, and is limited to the families of the approximately 2100 youngsters actively receiving services from the program.

### b. Current Activities

CSHP's state staff, which consists of two professionals and an administrative assistant, has been focused this year almost exclusively on transitioning the program from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. As of October 2004, CSHP will no longer contract with regional health departments and some 50 physician providers to organize and staff an average of 200 annual clinics in eight major diagnostic categories across the state, will no longer enroll insured children in the program, and will cease assisting with the payment of deductibles and co-pays for insured families. These changes have resulted in a great deal of understandable trauma, anger and confusion on the part of families and providers. In addition to responding to letters, emails and telephone calls from families, friends of families, and providers, and meeting with various advocacy groups to explain program changes, staff is working closely with health departments to privatize existing clinics after CSHP support ceases. That effort has been largely successful,

with the expected loss of fewer than five clinics out of thirty presently being offered across the state.

The only direct services with which the program plans to remain involved will include the continued sponsorship of PKU and Cystic Fibrosis clinics, and the care coordination and payment of treatment for uninsured children. Beginning October 1, 2004, only children without health insurance and who meet CSHP's diagnostic criteria will be enrolled in the program. This most vulnerable pediatric population will receive care coordination through a contract with St. Luke's Regional Medical Center's Children's Specialty Center from a nurse who served for four years as a CSHP nurse coordinator. She will ensure that youngsters under her purview receive the medical and rehabilitative services necessary to stabilize or improve their specific medical conditions. Bi-annual statewide PKU clinics will continue to be provided, along with a monthly Cystic Fibrosis clinic in Boise.

As the transition from the majority of direct services the program has provided these past decades is completed this fall, state CSHP staff will turn their efforts to the successful and ongoing accomplishment of national CSHCN performance measures which, due to the need for state staff to attend to a variety of transition issues, have received little attention this year.

### c. Plan for the Coming Year

The medical home concept is still largely unknown or misunderstood in Idaho, by both providers and families, and significant education needs to take place with both of those groups. We are fortunate to have access to and the involvement of Dr. Nancy Mann, a developmental pediatrician at Idaho State University in Pocatello, to help ensure that such education takes place. Dr. Mann was the recipient of an AAP CATCH grant through which she designed and implemented a medical home training for family practice physicians, who outnumber pediatricians 4 to 1 in Idaho. The Idaho team that attended the May Champions for Progress meeting in Utah also met with national AAP medical home project staff who were in attendance, new and effective lines of communication were opened, and materials, information and guidance from the national staff will be utilized this coming year.

As part of CSHP's attempt to move the program down the MCH pyramid toward the infrastructure building level, the tools developed by Dr. Mann for her family practice education project will be reviewed in the coming months to determine which would be most appropriate for statewide provider information and education activities. The AAP Mentorship Network will also be used to provide additional technical assistance, training and distribution of medical home materials to providers, along with attempts to identify, recruit and utilize specific in-state providers to undertake one-on-one communication with private practice colleagues about the medical home concept.

Linkages have already been established with the directors of Idaho's AAP and AAFP, who have both indicated an interest in and willingness to participate in new educational efforts to promote the medical home concept through their organizations.

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

Percentages of children whose families have adequate private or public insurance to pay for the services they receive remained consistent with FY03 numbers, revealing that approximately

94% of the families with a child enrolled in CSHP had such insurance coverage. The percentage of uninsured children enrolled in the program at any given time, from which this data was derived, has tended to hover around the 6% to 10% levels for the past several years.

#### b. Current Activities

CSHP's state staff, which consists of two professionals and an administrative assistant, has been focused this year almost exclusively on transitioning the program from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. As of October 2004, CSHP will no longer contract with regional health departments and some 50 physician providers to organize and staff an average of 200 annual clinics in eight major diagnostic categories across the state, will no longer enroll insured children in the program, and will cease assisting with the payment of deductibles and co-pays for insured families. These changes have resulted in a great deal of understandable trauma, anger and confusion on the part of families and providers. In addition to responding to letters, emails and telephone calls from families, friends of families, and providers, and meeting with various advocacy groups to explain program changes, staff is working closely with health departments to privatize existing clinics after CSHP support ceases. That effort has been largely successful, with the expected loss of fewer than five clinics out of thirty presently being offered across the state.

The only direct services with which the program plans to remain involved will include the continued sponsorship of PKU and Cystic Fibrosis clinics, and the care coordination and payment of treatment for uninsured children. Beginning October 1, 2004, only children without health insurance and who meet CSHP's diagnostic criteria will be enrolled in the program. This most vulnerable pediatric population will receive care coordination through a contract with St. Luke's Regional Medical Center's Children's Specialty Center from a nurse who served for four years as a CSHP nurse coordinator. She will ensure that youngsters under her purview receive the medical and rehabilitative services necessary to stabilize or improve their specific medical condition. Bi-annual statewide PKU clinics will continue to be provided, along with a monthly Cystic Fibrosis clinic in Boise.

As the transition from the majority of direct services the program has provided these past decades is completed this fall, state CSHP staff will turn their efforts to the successful and ongoing accomplishment of national CSHCN performance measures which, due to the need for state staff to attend to a variety of transition issues, have received little attention this year.

#### c. Plan for the Coming Year

As CSHP begins to address statewide systems and infrastructure issues in FY05, it hopes to be a catalyst in bringing the need for adequate insurance for special needs children to the attention of insurers and legislators. Strategies will include partnering with relevant advocacy groups to initiate meetings with Medicaid and CHIP staff to specifically target special needs populations, exploring alternative sources of medical insurance for special needs children, and ensuring that CSHP continues to have sufficient resources to cover uninsured children who qualify diagnostically for program services.

The April Champions for Progress meeting provided an opportunity for the Idaho team to meet and visit with Bobby Peterson, author of Wisconsin's Health Insurance Guidebook. The Guidebook, and Mr. Peterson's ongoing activities in Wisconsin, will provide valuable resources and models for CSHP initiatives in Idaho designed to address these same issues.

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**

Efforts to initiate and implement new collaborative relationships with state family education/support organizations to impact this performance measure were begun but delayed due to the ongoing need to deal with issues surrounding the transition of CSHP from direct services (please see current activities).

**b. Current Activities**

CSHP's state staff, which consists of two professionals and an administrative assistant, has been focused this year almost exclusively on transitioning the program from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. As of October 2004, CSHP will no longer contract with regional health departments and some 50 physician providers to organize and staff an average of 200 annual clinics in eight major diagnostic categories across the state, will no longer enroll insured children in the program, and will cease assisting with the payment of deductibles and co-pays for insured families. These changes have resulted in a great deal of understandable trauma, anger and confusion on the part of families and providers. In addition to responding to letters, emails and telephone calls from families, friends of families, and providers, and meeting with various advocacy groups to explain program changes, staff is working closely with health departments to privatize existing clinics after CSHP support ceases. That effort has been largely successful, with the expected loss of fewer than five clinics out of thirty presently being offered across the state.

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**c. Plan for the Coming Year**

While CSHP has provided ongoing satisfaction information to providers through surveys conducted by contractors, that information was specific only to families enrolled in the program. As CSHP completes its transition from underwriting statewide clinics to addressing more infrastructure and systemic special needs issues, family satisfaction with community-based service systems will become an integral part of that process. The organizations with which initial meetings were held last year were notified about the need to delay further planning until CSHP's transition from direct services is completed this fall.

Some preliminary discussion has occurred with Family Voices and Idaho Parents Unlimited

staff about the need to include data from this area with the numerous other initiatives that CSHP will be undertaking with them in the coming year. Both IPUL and Family Voices have agreed to assist CSHP with identifying community individuals and groups that are already involved with families in various ways, and those local contacts will strengthen the program's efforts to expand these activities beyond existing CSHP enrollment. More specifically, CSHP will continue to build upon an existing and beneficial association with Idaho's early intervention program (the CSHP Manager has served for six years on the state Interagency Coordinating Council), provide educational/informational material for agency newsletters, and explore various ways to encourage family attendance at relevant meetings and conferences.

*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

While some four years ago an informal agreement was reached with the Idaho Division of Vocational Rehabilitation concerning the transition of special needs young adults from CSHP to school and/or work settings, such services have remained the weakest part of CSHP's program. Efforts need to be broadened to include other work and school settings, and it is anticipated that new partnership initiatives with a variety of state and community groups will help facilitate that process.

#### b. Current Activities

CSHP's state staff, which consists of two professionals and an administrative assistant, has been focused this year almost exclusively on transitioning the program from providing direct clinic, medical and therapy services to a more systems oriented, infrastructure building approach. As of October 2004, CSHP will no longer contract with regional health departments and some 50 physician providers to organize and staff an average of 200 annual clinics in eight major diagnostic categories across the state, will no longer enroll insured children in the program, and will cease assisting with the payment of deductibles and co-pays for insured families. These changes have resulted in a great deal of understandable trauma, anger and confusion on the part of families and providers. In addition to responding to letters, emails and telephone calls from families, friends of families, and providers, and meeting with various advocacy groups to explain program changes, staff is working closely with health departments to privatize existing clinics after CSHP support ceases. That effort has been largely successful, with the expected loss of fewer than five clinics out of thirty presently being offered across the state.

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As the transition from the majority of direct services the program has provided these past decades is completed this fall, state CSHP staff will turn their efforts to the successful and ongoing accomplishment of national CSHCN performance measures which, due to the need for state staff to attend to a variety of transition issues, have received little attention this year.

### c. Plan for the Coming Year

In addition to planned collaborative relationships with groups around the state that are also interested in special needs transition issues occur, the Idaho team that attended the May Champions for Progress meeting in Utah had the opportunity to meet with staff from Healthy and Ready to Work, and will utilize information and assistance available from that group. Resources available from HRTW's website alone will be of immediate assistance in terms of data and other important tools that can be used in planning strategies for this important performance measure.

Specific activities that CSHP state staff will be working on this coming year include encouraging ways to connect young people to other youngsters and adult mentors, working with the federally funded State Independent Living and Developmental Disabilities Councils to explore collaborative efforts, identifying and working with state condition-specific agencies and programs, connecting CSHP with youth leadership organizations such as 4-H, Special Olympics, community parks and recreation programs, and targeting other independence and social skill building organizations to propose a variety of collaborative possibilities.

*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

The Immunization Program completed provider education conferences. These are regional conferences held throughout the state, focused on increasing immunization awareness, administration and storage of immunizations, as well as how to talk to parents about the importance of immunizations. The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record to verify they are up-to-date.

The Immunization Program provided free vaccines to district health departments and private providers for the provision of immunizations to children. This activity combined with those described in the annual plan, did have a substantial impact on increasing the percent of children through age two receiving completed immunizations (4:3:1). The most recent National Immunization Program Survey revealed that Idaho's immunization rate (4:3:1) has increased from 75% to 82.2%. The Immunization Program also received increased funding to allow the program to offer pneumococcal conjugate vaccine to all children free of charge beginning in January 2001. The uptake of this vaccine has been tremendous. The program is also seeing an impressive rise in the number of children receiving the varicella (chickenpox) vaccine. This progress can be related to the amount of education provided by the program to providers as well as providers feeling empowered to educate parents.

### b. Current Activities

The Immunization Program worked with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no

cost. The program worked closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program focus areas included: parent education; provider education; reminder/recall; review and assessment of WIC clients

Local events will be taking place over the next several weeks as part of the back to school get kids up to date effort. Quality assurance reviews will continue. Planning for QAR visits to determine focus areas for the site reviews for coming year is underway. August is national immunization month.

### c. Plan for the Coming Year

The Immunization Program will continue to provide vaccines to all public and private providers in the state. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider. Finally, the program will develop a plan for working more directly with parents empowering them to take charge of their child's immunization status.

During FY 2005, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will maintain a registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series.

Additionally, during FY 2005, the Immunization Program will continue a population-based implementation program to increase hepatitis A immunizations by (1) targeting children 2 to 18 years of age to have two doses of hepatitis A vaccine; and (2) providing the vaccine at no cost as part of its general statewide distribution.

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

An effort is underway to change Idaho school and daycare laws to require a 2nd dose of MMR and a 5th dose of DTaP. This process will require approval by the Board of Health and Welfare and the Idaho legislature.

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

### a. Last Year's Accomplishments

A total of 10,777 teens, less than 20 years of age, received physical assessment, education and counseling through the Reproductive Health Program in CY 2003. Of those teens, 412 were less than 15 years of age. These are generally high risk youth who receive additional

counseling and risk assessment. Because these teens are at increased risk for unintended pregnancy, program records are audited to assure appropriate counseling is provided. The Idaho teen pregnancy rate continues to decline and was 49.0 in CY 2000, 46.3 in CY 2001 and 45.3 in CY 2003 for 15 - 19 year olds. The actual number of teen births increased slightly from 2,229 in CY 2001 to 2,438.

The program reviewed statistics of all active male and female clients ages 13-19, who have had an encounter with a medical provider for the purpose of receiving contraception to assure counseling was provided at each visit and abstinence and parental involvement counseling were included.

#### b. Current Activities

In Reproductive Health Program continues to make services to teens a priority. In addition to providing reproductive health medical services to teens, our contracts require agencies to provide community outreach to at-risk teens. The Public Health District agencies have conducted a wide variety of activities to meet this objective. In Health District I, The PEAK program continues to be a success story with local area high schools in encouraging abstinence through teen mentors. The district Family Planning coordinator and staff continue to be welcomed into local high schools to provide abstinence/contraceptive and STD education to 10th graders and in some cases 8th graders. In Health District II efforts are made to accommodate teens by scheduling appointments after school or at other convenient times. Rural offices utilize delayed pelvic exams in an effort to offer services when Nurse Practitioners are not available. Delaying the onset of sexual activity is the main purpose of the District II Adolescent Pregnancy Prevention (APP) program. APP facilitates several activities throughout the year to promote abstinence to area youth. Activities include a teen abstinence dance with the Boys and Girls Clubs of the Lewis Clark Valley, school and community presentations, media recognition, and the promotion of Teen Pregnancy prevention Month and Let's Talk Month. School nurses promote delaying the onset of sexual activity and abstinence as a healthy choice in school classes and presentations. Nurse Practitioners provide education and discuss abstinence as a birth control method with adolescents.

Health District III achieved the promotion of delaying initiation of sexual activity by adolescents by providing abstinence counseling services during individual client visits, by partnering with the Adolescent Pregnancy Prevention coordinator in promoting abstinence through the use of Bobby Petrocelli's Special event presentation on "10 Second Decision", and by providing support to clinic staff while they made education outreach presentations to area teens at local schools and other community centers. Outreach presentation topics included education and counseling on Male/Female and Teen Health and STD/HIV Prevention and Abstinence. Educational pamphlets on "Abstinence Think About it" , "Abstinence Facts", "101 Ways To say No" and "STD/HIV Facts" were distributed during these presentations.

Four of the district currently provide special "Teen Clinics" which include convenient hours and support services. Two of the Health Districts have formed Youth Coalitions where Health District nurses provide presentations to local schools on abstinence and reproductive health issues.

#### c. Plan for the Coming Year

The Reproductive Health Program will continue to provide family planning services to more than 10,000 teens less than 20 years of age. Services will include comprehensive physical examinations and age appropriate counseling, education and referrals. Parental involvement

and abstinence counseling will be provided to all teens. Four of the health districts will provide special "Teen Clinics" which include a variety of support services and access to a social worker.

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

During FY 2003, the MCH Oral Health Program contracted with each of the seven district health departments to conduct population-based preventive oral health programs. Through the district contracts, 57,555 individuals were served in FY 2003, including 343 children who received free dental sealants through school-based projects conducted at 10 schools in two health districts. The sealant project is targeted to students in grades 2 and 3 at schools with 50% or more of the children on the free and reduced school lunch program.

As part of the ongoing evaluation of the school fluoride mouth-rinse program, 629 third grade students were surveyed; 49.9 percent of this convenience sample of third grade children had one or more dental sealants in permanent molar teeth and 45.6% percent needed additional sealants.

b. Current Activities

MCH funding to conduct the current dental sealant projects is continuing during FY 2004. Resources identified through other community partners have enabled expansion of the project and reimbursement to community dentists for dental care when treatment needs are identified. Data from a convenience sample of 3rd grade students, collected as part of the ongoing evaluation of the school fluoride mouthrinse program, will again be used to evaluate progress toward achieving this MCH Performance Measure.

Since the survey is only conducted every four years the intervening years are based on small numbers of a convenience sample and is not necessarily representative of actual rates. The next comprehensive survey will be conducted in 2005, which will give a more accurate picture.

c. Plan for the Coming Year

During FY 2005, Title V support for district oral health programs, including the dental sealant projects, will be maintained at the current level. State and district representative data to evaluate the MCH dental sealant performance measure will be collected via the 2005 Idaho State Smile Survey of third grade students.

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 Injury Prevention Program contracted with health districts statewide to provide public risk reduction for motor vehicle related injuries.

In addition, the program worked with the Idaho Transportation Department and health districts to coordinate statewide efforts to promote motor vehicle, pedestrian, and bicycle safety statewide.

The Injury Prevention Program also facilitated injury prevention coalitions throughout Idaho comprised of partners from law enforcement, education, health care organizations, insurance companies, private industry, and the media.

MCH funding allowed the purchase of 200 child car safety seats that were distributed to low income parents and caregivers throughout Idaho.

#### b. Current Activities

The Injury Prevention Program contracted with health districts statewide to provide public risk reduction for child motor vehicle injury prevention programs. A focus area of the contracts includes a train the trainer program in which the public health districts trained community partners to teach parents/care givers to correctly install child care safety seats.

The Injury Prevention Program and health districts statewide are working to transition the distribution of child car safety seats, and the training necessary to install those seats correctly, to state and local partners. MCH funding allowed for the purchase of 200 child car safety seats that were distributed to low income parents and caregivers throughout Idaho.

#### c. Plan for the Coming Year

The Injury Prevention Program will continue to contract with health districts statewide to provide public risk reduction for children's motor vehicle related injuries. The program will contract with health districts to continue train the trainer programs in which community partners are trained to teach parents/care givers to correctly install child care safety seats. Child car safety seats will be distributed to low income families.

During the year the program will work with health districts to transition the program to community partners by FY07.

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

#### a. Last Year's Accomplishments

The Idaho WIC Program is taking the lead in Idaho's efforts to promote and support breastfeeding as the normal way to feed infants, exclusively for the first 6 months of life and to continue, with the addition of appropriate solid foods, for the first year of life and beyond. During FY03-04, Idaho continued working to implement recommendations outlined by the Idaho Breastfeeding Committee in their report, "Breastfeeding: Best for Idaho." Strategies included providing training opportunities for health professionals and breastfeeding information and support materials to hospitals, health clinics, WIC Programs, childcare centers, worksites, and physicians' offices. Statewide activities continue to be limited in scope due to funding constraints and limited staff resources dedicated to breastfeeding promotion and support work.

The CY2003 Idaho Breastfeeding Study data shows that 73.6% of Idaho's infants were exclusively breastfed at or near hospital discharge, a decrease of 0.7% from the CY2002 rate of 74.3%. Idaho's exclusive breastfeeding initiation rates over time have increased from 65.6% in FY96 to 73.6% in CY2003; however, the past two years have demonstrated a downward trend. This trend should be closely monitored to assure that this trend is reversed.

## b. Current Activities

FY 2003-2004 MCH/WIC Breastfeeding Promotion and Support in Idaho involve building systems for providing on-going breastfeeding support and lactation management education and information sharing that targets WIC staff, physicians, and health care professionals, and BEST START Breastfeeding Councils/Coalitions throughout Idaho.

FY'03-FY'04 accomplishments include:

- 1) Enhancement of Idaho WIC Program's breastfeeding promotion and support efforts through coordination and facilitation of a statewide Idaho WIC Breastfeeding Promotion and Support Work Group. Work accomplished by this group included the development of information fact sheets for participants; the provision of technical input on policy content and development; and implementation of the work/school breast pump project in local WIC agencies.
- 2) WIC IMAGE PROJECT components were implemented. Breastfeeding promotion and support print materials were created utilizing the WIC IMAGE branding strategies. An Employer/Employee Breastfeeding Support Resource Packet and the BEST START Breastfeeding Promotion materials catalog were developed. Both are being distributed throughout the state.
- 3) Idaho WIC BEST PRACTICES Grants system developed and implemented. Breastfeeding promotion and support grants were awarded to local agencies. A quarterly reporting system was developed and implemented to monitor the progress of and outcomes for these grants.
- 4) WIC staff throughout the state received advanced 3-Step Counseling Strategy Training.
- 5) Second Annual Breastfeeding Conference for Health Care Professionals and the Idaho Breastfeeding Councils and Coalitions Annual Dinner Meeting are planned. A Statewide Planning Committee was formed to provide direction and align identified training needs with conference speakers and topics.
- 6) Breastfeeding: Best for Idaho website content enhanced.
- 7) State Office provided guidance and support for World Breastfeeding Month activities through WIC agencies and Local Breastfeeding Councils and Coalitions throughout the state.
- 8) Idaho's 1st Annual Breastfeeding Conference for Health Care Professionals and the Idaho Breastfeeding Council and Coalition Dinner Meeting were successful in bringing together and training over 100 health care professionals from throughout Idaho. In addition, over 70 members of Idaho's Local Breastfeeding Councils and Coalitions came together to share local area accomplishments in 2002-2003 and to identify statewide needs related to increasing breastfeeding incidence and duration rates in Idaho.

## c. Plan for the Coming Year

In FY05, recommendations from the report, "Breastfeeding: Best for Idaho," will continue to be implemented and evaluated as resources are made available.

In FY05, the 3rd Annual Breastfeeding Conference for Health Care Professionals and the Idaho Breastfeeding Councils and Coalitions Annual Dinner Meeting will be held.

In FY04-05, breastfeeding promotion and support educational and promotional materials will be made available to Idaho's breastfeeding promotion and support partners.

In FY 05, a physician with expertise in lactation management in the NICU will provide training in

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

**a. Last Year's Accomplishments**

During Calendar Year 2003, 97 % of babies born in Idaho hospitals were screened for hearing at birth. The Council for the Deaf and Hard of Hearing is continuing to receive funds from a federal grant for the Early Hearing Detection and Intervention (EHDI) program in Idaho along with the Idaho Newborn Hearing Screening Consortium. The program works with the EHDI program to train hospital staff and audiologists in Idaho to assure that babies who do not pass the two-stage screening are referred promptly for and receive diagnostic testing.

2001 was the first full calendar year in which the project collected demographic data regarding hearing loss in newborns. Twenty-one infants were identified with permanent sensorineural hearing loss in 2001 and 13 have been identified in 2002. For 2002, there were also five infants identified with mixed hearing loss (permanent sensorineural loss and conductive hearing loss), and there are still sixty infants in the diagnostic process. Many have received hearing aids and are enrolled in early intervention programs. For CY 2003 21 infants were identified with a hearing loss. For the last quarter of CY 2003 100 % of infants referred for further testing received the diagnostic evaluation.

The Idaho Newborn Hearing Screening Consortium, in collaboration with and the support of the Idaho Bureau of Clinical and Preventive Services, is developing a sustainable system for early detection, intervention and follow-up of children born with diagnosed hearing loss.

**b. Current Activities**

In 2003 a Memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing was renewed and the council provided:

- (1) Monitoring and data collection;
- (2) Hospital support, recruitment, and community education;
- (3) Training; and
- (4) Consortium support in an effort to increase follow up to those families where the infant has not passed the newborn hearing screening.

**c. Plan for the Coming Year**

Continuing in FY 2005, the Title V agency will renew the memorandum of understanding with the Idaho Council for the Deaf and Hard of Hearing, to provide services related to the Idaho Newborn Hearing Screening. The Consortium's Early Hearing Detection and Intervention project will be in its 5th year of funding during FY 2005 of the Maternal and Child Health Block Grant. During year 5 Early Hearing Detection and Intervention will be supported by continued federal funding or State General Fund resources, integrated with the service delivery program for children age 0 to 3, meet or exceed JCIH benchmarks on a statewide basis, and have 80% of hospitals achieving at the JCIH benchmark levels or above on 3 of the four performance measures. (For year four only 42 % of hospitals are above the benchmark for 3 or all 4 of the measures)

Specific activities for the coming year include:

Monitor hospital performance related to coverage, referral rate, percentage of children receiving diagnostic evaluations, and early intervention services, and provide assistance as needed;

Increase family to family support and access to information to assist families.

Expand newborn hearing screening to other community-based sites, e.g. district health departments.

Increase and improve the participation of physicians in EHDI and in the provision of a medical home for infants with hearing loss.

Seek resources from private and public sources to support diagnostic services and necessary interventions, including fair payment for treatment and hearing aids.

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

#### a. Last Year's Accomplishments

To expand the number of providers, the Title V program investigated the feasibility of providing regional dental clinics for Medicaid and CHIP children. The program investigated developing contracts with private dentists to staff dental offices in each public health district catchment area.

The Title V agency worked with the Division of Medicaid on outreach activities related to the implementation of the Children's Health Insurance Program (CHIP). Those efforts lead to expansion of benefits for children under a new program called CHIP-B/Access Card.

#### b. Current Activities

The Idaho Children's Health Insurance Program (CHIP) expanded July 1, 2004 to include additional children and benefits. The new program is called CHIP-B. This program was developed to address the needs of uninsured children in Idaho. Family income must not exceed 185% of the federal poverty level. Enrollment is based upon expenditures and available funding and is eligible to all Idaho children under 19 years of age. Some participant cost-sharing is involved and parents are required to pay a \$15 per month per child premium to the State.

In addition, the CHIP Program is also offering an Access Card to address the needs of uninsured children. With the Access Card, the state subsidizes the parent's purchase of private insurance up to \$100/child/month, with a maximum of \$300/family/month. Parents may choose to buy insurance through an employer or a private insurance company. Parents must pay the balance of the premium, deductibles, and co-pays as applicable. The covered services are determined by the private insurance carrier and the family income must not exceed 185% of the federal poverty limit. Children must be under 19 years of age to be eligible for the CHIP Access Card.

#### c. Plan for the Coming Year

The Title V program will continue to work with the Division of Medicaid to promote the new CHIP-B program to eligible children. The Title V Program will continue to work with Medicaid to expand eligibility for medical services for women and children. The program will continue to utilize the Idaho CareLine to identify needs, locate services for families and make referrals for services. The Title V program will utilize grant funds to provide services, through contracts with public health districts, for needed services for women and children.

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

**a. Last Year's Accomplishments**

Promotion of the toll-free information and referral telephone service, CareLine, to the MCH, Infant Toddler and Medicaid populations (including CHIP referrals).

**b. Current Activities**

CSHP continues to work, through its clinic network and parent group, to increase the awareness of families about CHIP and Medicaid coverage.

CareLine continued to refer callers to Medicaid for CHIP enrollment, when appropriate.

**c. Plan for the Coming Year**

CSHP will continue to work, through its clinic network and parent group, to increase the awareness of families about CHIP and Medicaid coverage.

The Title V agency will continue to work with Medicaid on those limited outreach activities related to the implementation of the Children's Health Insurance Program that may be legislatively approved during the next session of the Legislature. It will collaborate with the district health departments and the regional offices of Health and Welfare in the coordination of health services between the two groups.

CareLine will continue to refer callers to Medicaid for CHIP enrollment, when appropriate.

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

**a. Last Year's Accomplishments**

Through contractors, the Reproductive Health Program provided family planning services to 38,541 low income women to reduce the rate of unintended pregnancy, which is associated with reducing low birth weight. The program provided counseling to women on preconception health and encouraged or provided all women folic acid supplements. The program also provided 10,000 women pregnancy testing and counseling. The 2,256 women with positive pregnancy tests results received additional counseling and referrals. All pregnant clients were screened for risk factors for low birth weight or poor pregnancy outcomes and were provided with appropriate education, counseling and referrals.

The Idaho WIC Program serves pregnant women who are nutritionally at risk by providing food and nutritional counseling to assure best possible birth outcomes. The Pregnancy Risk Assessment Tracking System (PRATS) provided data describing populations and risk factors that lead to low birth weight. PRATS is a survey of new mothers in Idaho, to establish a population based tracking system to identify selected maternal experiences and behaviors before, during and after pregnancy which may affect pregnancy outcomes and infant health. The reports were disseminated among medical providers to encourage accurate identification of risk factors and populations in need of services.

**b. Current Activities**

The Reproductive Health Program continued to provide family planning services through

contractors to reduce the rate of unintended pregnancies which has a direct link to reducing low birth weight. The Program also provides pregnancy testing and referral services to ensure early initiation of prenatal care. The program also screens all pregnant women for substance use and abuse and provides appropriate counseling, education and referrals. Because of increased violence during pregnancy and its impact on pregnancy outcomes, the district contractors use standard screening tools for family violence and screen all pregnant women.

The state WIC office serves pregnant women who are nutritionally at risk by providing food and nutrition counseling in an effort to ensure the best possible birth outcome.

The Pregnancy Risk Assessment Tracking System (PRATS) provides data describing populations and risk factors that lead to low birth weight. The reports are disseminated among the public health districts, obstetricians, and the Idaho Perinatal Project.

### c. Plan for the Coming Year

We will continue activities as described in last year's accomplishments report including the provision of family planning services to reduce the rate of unintended pregnancies. This will include offering pregnancy testing, education and referrals to ensure identification of risks and early initiation of prenatal care. Plans also include WIC services to pregnant women who nutritionally are at risk and reducing low birth weight by providing food and nutrition counseling to ensure the best possible birth outcomes. The PRATS survey will include additional questions and Hispanic participants to provide better data on risk factors for Hispanic women.

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

### a. Last Year's Accomplishments

The Adolescent Suicide Prevention Taskforce, which at one time was headed up by the Injury Prevention Program in the Division of Health, is no longer affiliated with the Department of Health and Welfare. It has been loosely formed under direction of Boise State University staff. It no longer receives any MCH funding.

The suicide death rate per 100,000 youth aged 15 to 19 has nearly doubled in the past 4 years from 13.4 in 1999 to 21.3 in 2001.

### b. Current Activities

Starting in April 2003, the Injury Prevention Program began working with the Idaho Department of Health and Welfare, Division of Family and Community Services, the Department of Education, and SPAN-Idaho (the Boise State University-based group) to develop a comprehensive statewide suicide prevention plan. The plan should be completed by December at which time the direction of a Suicide prevention program will be established and pending funding availability, implementation will begin.

### c. Plan for the Coming Year

***/2005/ The development of Idaho's Suicide Prevention Plan was completed in November 2003. There are no plans to remain involved with the implementation of the plan.***

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-*

**a. Last Year's Accomplishments**

The PRATS survey monitors utilization of neonatal intensive care services. This information is provided to groups that may influence decisions such as obstetricians closely monitoring pregnancies and ensuring transfers of their patients to facilities with neonatal intensive care units prior to delivery. The data may also influence regional medical centers to consider establishing a neonatal intensive care unit.

**b. Current Activities**

The PRATS survey monitored utilization of neonatal intensive care services and shared the data with groups that may influence decisions such as obstetricians.

**c. Plan for the Coming Year**

The PRATS survey monitors utilization of neonatal intensive care services. This information is provided to groups that may influence decisions such as obstetricians closely monitoring pregnancies and ensuring transfers of their patients to facilities with neonatal intensive care units prior to delivery. The data may also influence regional medical centers to consider establishing a neonatal intensive care unit.

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

**a. Last Year's Accomplishments**

In CY 2002, 82.1 percent of pregnant women in Idaho received prenatal care beginning in the first trimester. From 2001 to 2002, Idaho experienced increases in intensive care (care for women whom the number of visits exceeded the ACOG's recommendations by a ratio of observed to expected visits of at least 110 percent) from 25.7 to 27.3 percent, and adequate care from 47.5 percent to 48.2 percent. There were decreases in the rates of intermediate care (15.0 to 13.8 percent), inadequate care (10.9 to 9.8 percent) and no prenatal care (0.9 to 0.8 percent), from 2001 to 2002.

In CY 2003, the Reproductive Health Program provided pregnancy tests and counseling to 10,000 women in Idaho. Of those tests, there were 2,256 positive results. Those women received additional counseling and referral services. The importance of early prenatal care is stressed and presumptive eligibility for Medicaid can often be made at the same time as the pregnancy test to speed referrals. Reproductive Health clinics also provide information about good health practices during pregnancy (e.g. good nutrition, avoidance of smoking, drugs and exposure to chemicals and x-rays). This is typically accomplished through a combination of counseling and a packet of information materials sent with the client. Most of our contract clinics will also provide or write a prescription for prenatal vitamins.

The Pregnancy Risk Assessment Tracking System (PRATS) collects data on access, utilization and disparities for prenatal care and disseminates the reports among the public health districts, obstetrical providers and the Idaho Perinatal Project.

The WIC Program provides nutritional counseling and also emphasizes the importance of early prenatal care. Program staff will do referrals for prenatal care when not already initiated. The Idaho CareLine provided referrals for individuals seeking prenatal services.

**b. Current Activities**

The Reproductive Health Program continues to provide pregnancy testing, counseling and referrals for prenatal care. The Districts are involved with the Department's "Any Door" initiative which should facilitate not only prenatal referrals for pregnant women, but also referrals for child support, job services, food stamps, housing and other family supportive services. The WIC Program continues to serve additional pregnant women and provide counseling of risk factors influencing pregnancy outcomes. The Idaho CareLine is monitoring referrals and calls for prenatal services.

**c. Plan for the Coming Year**

During the coming year, the Reproductive Health clinics will continue to provide information about good health practices during pregnancy (e.g. good nutrition, avoidance of smoking, drugs and exposure to chemicals and x-rays). The program will also work with community clinics to expand services and encourage early access to prenatal care.

The Pregnancy Risk Assessment Tracking System (PRATS) will survey additional Idaho women to collect data on access, utilization and disparities for prenatal care.

The WIC Program will continue to provide nutritional counseling and also emphasize the importance of early prenatal care. Program staff will do referrals for prenatal care when not already initiated.

**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. Continue expanded screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Distribute practitioner's manual to providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide technical assistance/education to birthing facilities and midwives.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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
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. Utilize new partnerships with advocacy/support organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Survey families concerning inclusion/satisfaction.	<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
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. Utilize Dr. Mann's family practice curriculum.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Utilize national AAP materials and technical assistance.	<input type="checkbox"/>	<input checked="" 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
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. Continue outreach for identification/enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family Voices/IPUL collaboration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Distribute information from Health Insurance Guidebook.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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

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 satisfaction surveys and informing providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family Voices/IPUL collaboration.	<input type="checkbox"/>	<input checked="" 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

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. Renewed attention to IDVR agreement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family Voices/IPUL assistance with exploring new services and settings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Utilize information and assistance from Healthy and Ready to Work.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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

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. Provide free vaccine to all Vaccine for Children (VFC) providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Perform annual site visits to all VFC providers and conduct provider education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide parent, school and daycare education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Maintain an immunization registry.	<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
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide family planning services to teens through the public health districts.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Develop a relationship with community health centers. They become Title X compliant and access contraceptives through Idaho's multistate purchasing agreement.	<input checked="" 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
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Title V support for district oral health programs will be maintained at the current level.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. The Injury Prevention Program will continue to contract with health districts statewide.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Provide at least one statewide breastfeeding training/conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Establish an Idaho Breastfeeding Promotion and Support website.	<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
12) Percentage of newborns who have been screened for hearing before hospital discharge.				

1. Monitor hospital performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Match or exceed the national benchmarks set by JCIH.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Increase family to family support and access to information to assist families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Statewide Hi-Track newborn hearing screening data system will be linked with Part C Agency DATATOT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Expand newborn hearing screening to other community-based sites, e.g. district health departments.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase and improve the participation of physicians in EHDl and in the provision of a medical home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Seek resources from private and public sources.	<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"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Implement expanded CHIP coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work toward gaining expanded Medicaid coverage for young women of reproductive age.	<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
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Work with Medicaid to increase outreach activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CareLine will continue to refer callers to Medicaid for CHIP enrollment, when appropriate.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input 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. Alcohol, Tobacco and other Drugs initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide family planning services to reduce the rate of unintended pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide WIC services to pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Enhance data capabilities of PRATS.	<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
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. A suicide prevention plan was developed. It is posted on the Department of Health and Welfare website. Regional Health and Welfare offices are developing plans to implement locally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Division of Family and Community Services has some limited funding that will be directed to coordinating statewide activities.	<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
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. PRATS survey will monitor utilization of neonatal intensive care services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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. The Reproductive Health Program will provide pregnancy testing and referral for prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Pregnancy Risk Assessment Tracking System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The WIC program will provide nutritional counseling and information on other pregnancy risk factors.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The Idaho CareLine will provide referrals for prenatal care.	<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"/>

**D. STATE PERFORMANCE MEASURES**

State Performance Measure 1: *SP#1 - Proportion of all pregnancies seen in Reproductive Health clinics that are unintended.*

**a. Last Year's Accomplishments**

The Reproductive Health Program provided health education, assessment and medical services to 38,541 low income Idahoans in CY 2003. The isolation of many Idaho communities makes it difficult and expensive to provide these services. As a result, services are provided through the public health districts, and clinics are located in 37 of Idaho's 44 counties. The seven counties not served are very sparsely populated (Examples: Adams county population 3,746, Camas county population 991, and Clark county population 1,022.) These low income, medically under-served women are the primary target population and the majority of the client's incomes are less than 100% of the federal poverty level. Medical services provided to women include counseling, health education, blood pressure, urinalysis, hematocrit, physical examination, cervical cancer and STD screens as indicated.

The number of clients served by the program declined in CY 2003, due to the loss of Planned Parenthood of Idaho (PPI) as a contractor. Planned Parenthood decided to

withdraw from the state program due to limited funding and requirements to not charge clients below 100% of the poverty level and maintain a sliding fee schedule. PPI served 4,280 clients who were at or below 150% of the Federal Poverty level and the loss of these clients is reflected in the state's reduced service figures. The state is working to increase access to family planning services by networking with primary care clinics and other community organizations who serve low income reproductive aged women.

The delegate agencies have been exploring ways to reach more low income women and partner with other organizations that serve this population. Delegates have been encouraged to coordinate with existing services and support the development of needed services with agencies serving high risk and potentially underserved populations for reproductive health care.

Approximately 5% of the 20,270 Pap smears performed by the program are abnormal. In CY 2003 1,031 women received counseling, referrals and follow-up of their abnormal Pap smears; and 41 women received colposcopy services on-site. All positive Pap test results require documented follow up. Chart audits are done at the clinic level. One hundred percent (100%) of the records of women who had any dysplasia identified in a Pap smear have documentation of follow up treatment by an appropriate provider within six weeks of the date the Pap smear result was received.

In CY03, the Reproductive Health Program provided pregnancy testing, risk assessment, and referrals to 10,000 women. Of these women, 2,256 were pregnant and were also screened for substance use or abuse and provided appropriate education, counseling and referral to treatment and care coordination. This performance measure was met in CY03. The Statewide Perinatal Risk Assessment tool was used as a screening device.

## b. Current Activities

The Reproductive Health Program continues to offer comprehensive reproductive health services to women throughout Idaho through contracts with public health districts. The District agencies are currently exploring ways to reach more low income women and partner with other organizations that serve this population. Delegates have been encouraged to coordinate with existing services and support the development of needed services with agencies serving high risk and potentially underserved populations for reproductive health care.

Examples include: Health District I has supported development of a mobile van which serves the low income uninsured population in frontier communities in North Idaho. The Health District coordinates efforts with the local hospitals to expand family planning services and assure clinic reproductive health clients have access to primary care services. Health District II continues to offer a clinic for the uninsured that is located in the Health district in Lewiston. Clinics are held in the evenings and staff work to assure family planning and primary care needs of women are met. District III, in Caldwell, has been providing services on site to Farmway and Chula Vista Migrant camps. Clinical services are offered at the camps to women who lack transportation to health care or other community services. Each District III clinic site continues to have bicultural and bilingual staff available to assist Hispanic speaking clients. Health District IV, in Boise, has started an outreach clinic with the Ada County Juvenile Justice Program to provide reproductive health services to residents of their juvenile detention facility. Services include physical examinations, risk reduction counseling, STD screening and group presentations on health subjects. The projects conducted a client evaluation and found the vast majority of adolescents receiving services were very satisfied with their care and 25% of respondents planned to change risk behaviors because of the counseling and education.

In Twin Falls, District V has a Special Project to work with Family Health Services, a Primary Care clinic serving mostly low income Spanish speaking clients, to provide family planning

services. Family Health Services performs over 500 deliveries a year, but was not able to offer contraceptive services until this project began. The pilot project has been well received by staff and clients. District VI has also worked for 4 years with Health West, a Primary Care Clinic, and Idaho State University (ISU) School of Nursing to expand services to low income women in downtown Pocatello and this year in Lava and Downey Idaho. The past two years they have worked with the ISU Department of Medical Anthropology to identify Hispanic women who do not seek any health services and develop culturally appropriate services. Based upon focus group data identifying a need, District VII, in Idaho Falls, began a support group for overweight women, modeled after Weight Watchers.

### c. Plan for the Coming Year

The Reproductive Health Program will continue to contract with the seven Public Health Districts during the coming year. The program will also work to assure additional women are served through partnerships with other agencies serving the target population. If current efforts with community health centers are successful, the program hopes to identify additional new service providers in frontier communities and encourage participation in the program. This may include providing educational materials for women and supporting medical education for providers. The program will continue to fund services at two juvenile detention centers in Idaho. The program will also encourage through contract funding, outreach to migrant camps in three new communities.

## State Performance Measure 2: *SP#2 - Percent of positive pregnancy tests in Reproductive Health Program participants less than 20 years old.*

### a. Last Year's Accomplishments

The Reproductive Health Program worked to reduce teen pregnancy by providing preventive health services to at risk teens in Idaho. A total of 10,777 teens, less than 20 years of age, received physical assessment, education and counseling through the Reproductive Health Program in CY 2003. Of those teens, 412 were less than 15 years of age. These are generally high risk youth who receive additional counseling and risk assessment. Because these teens are at increased risk for unintended pregnancy, program records are audited to assure appropriate counseling is provided. The Idaho teen pregnancy rate was 51.0 in CY 1999, 49.0 in CY 2000, 46.3 in CY 2001 and 43.7 in CY 2002 for 15 - 19 year olds (performance measure 6). The actual number of teen births increased slightly from 2,229 in CY 2001 to 2,410 in CY 2002.

The program reviewed statistics of all active male and female clients ages 13-19, who have had an encounter with a medical provider for the purpose of receiving contraception to assure counseling was provided at each visit and abstinence and parental involvement counseling were included.

### b. Current Activities

The Public Health Districts agencies are conducting a wide variety of activities to meet this objective. In addition to providing medical services and pregnancy testing, the districts also provide community education and outreach to teens. In Health District I, The Peers Encouraging Abstinent Kids (PEAK) program continues to be a success story with local area high schools in encouraging abstinence through mentors. The District Family Planning coordinator and staff continue to be welcome in local high schools to provide abstinence/contraceptive and STD education to 10th graders and in some cases 8th graders. In Health District II efforts are made to accommodate teens by scheduling appointments after school or at other convenient times. Rural offices utilize delayed pelvic exams in an effort to

offer services when Nurse Practitioners are not available. Delaying the onset of sexual activity is the main purpose of the District II Adolescent Pregnancy Prevention (APP) program. APP facilitates several activities throughout the year to promote abstinence to area youth. Activities include a teen abstinence dance with the Boys and Girls Clubs of the Lewis Clark Valley, school and community presentations, media recognition, and the promotion of Teen Pregnancy prevention Month and Let's Talk Month. School nurses promote delaying the onset of sexual activity and abstinence as a healthy choice in school classes and presentations. Nurse Practitioners provide education and discuss abstinence as a birth control method with adolescents.

Health District III achieved the promotion of delaying initiation of sexual activity by adolescents by providing abstinence counseling services during individual client visits, by partnering with the Adolescent Pregnancy Prevention coordinator in promoting abstinence through the use of Bobby Petrocelli's Special event presentation on "10 Second Decision", and by providing support to clinic staff while they made education outreach presentations to area teens at local schools and other community centers. Outreach presentation topics included education and counseling on Male/Female and Teen Health and STD/HIV Prevention and Abstinence. Educational pamphlets on "Abstinence Think About it", "Abstinence Facts", "101 Ways To say No" and "STD/HIV Facts" were distributed during these presentations.

Other Health Districts have formed Youth Coalitions where Health District nurses provide presentations to local schools on abstinence and reproductive health issues.

Training on family violence and abuse was provided to District Health Department staff members at the May 2004

### c. Plan for the Coming Year

The Reproductive Health Program will continue to contracts with the Public Health Districts for medical services for teens. This will include providing comprehensive physical examinations and age appropriate counseling, education and referrals. The program will also continue to collaborate with other agencies to provide abstinence education for young teens and work with the Governor's Council on Adolescent Pregnancy Prevention to assure consistent messages and coordinated efforts during the coming year.

## State Performance Measure 3: *SP#3 - Use of the Idaho CareLine as a clearinghouse (information/referral service) of information for non-health related children's social and developmental services.*

### a. Last Year's Accomplishments

Continued development and implementation of the 211 system for statewide use. Monitored calls by call type to evaluate the volume MCH related calls.

### b. Current Activities

The 211 service is now operational statewide on all "land lines." Six wireless service providers have also implemented the 211 service for their customers [AT&T, Edge, Cricket, Nextel, Inland and Spring PCS (most areas)]. The remaining cell phone companies plan to implement the 211 service in the near future.

### c. Plan for the Coming Year

Finalize implementation of the 211 service through all phone service providers statewide.

**State Performance Measure 4: *SP#4 - Percent of child deaths reviewed by the Idaho Child Mortality Review Team.***

**a. Last Year's Accomplishments**

Year 2001 deaths were reviewed by CMRT; however, the plan to develop a 5 year report was described in last year's application was discontinued. The decision to not pursue the report was made for a number of reasons including staff resources and doubt on administration's part that any value would be added beyond what the individual annual reports completed to date will accomplish. This performance measure will be deleted and replaced for the 06' application.

**b. Current Activities**

The Child Mortality review team has been disbanded and will no longer be reviewing child deaths in Idaho.

**c. Plan for the Coming Year**

No plans to reimplement a Child Mortality Review Team at this time.

**State Performance Measure 5: *SP#5 - Doses of hepatitis A vaccine administered to children at kindergarten entry.***

**a. Last Year's Accomplishments**

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

A major focus of the Immunization Program this past year has been increased provider education. The program continues to grow annually making education even more imperative. Site visits were conducted at nearly all VFC provider offices throughout the state. These visits are focused on working directly with the clinic staff to make sure they are following the 18 Standards of Immunization Practices. The program provides technical assistance when necessary.

**b. Current Activities**

Hepatitis A vaccine is recommended for Idaho children, but not required. One of the focus areas for the coming year for the Immunization Program quality assurance reviews will be to educate providers on the importance of administering the Hepatitis A vaccine. Idaho schools are gearing up for getting kids enrolled for the new school year and up-to-date vaccine records

are part of the enrollment process. While Hep A is not required, the state program is working with schools around the state to ensure they recognize the value of the vaccine and encourage parents of their students to consider it.

The Program will provided vaccines to all public and private providers in the state including Hepatitis A. Regional and local training conferences were held to encourage, educate and reward providers for their efforts.

### c. Plan for the Coming Year

The Immunization Program will continue to educate providers about the importance of providing Hep A to all children 2 years of age and older when conducting site visits. The Program will also continue a population-based implementation program to increase hepatitis A immunizations by (1) targeting children 2 to 18 years of age to have two doses of hepatitis A vaccine; and (2) providing the vaccine at no cost as part of its general statewide distribution. The total number of doses of Hepatitis A is on the rise.

While not specifically targeting Hepatitis A, the program is involved with several activities, which will impact Hep A rates as follows:

The Immunization Program will continue to provide vaccines to all public and private providers in the state. The program will work directly with these providers to identify barriers to immunizations, thereby increasing childhood rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program will continue to work with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider. Finally, the program will develop a plan for working more directly with parents empowering them to take charge of their child's immunization status.

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

This performance measure will likely be changed following completion of the 5 year needs assessment.

## State Performance Measure 6: *SP#6 - Percent of children age 5 years who are caries-free in their primary teeth (have no decayed, missing or filled teeth due to tooth decay)*

### a. Last Year's Accomplishments

Each year, \$90,000 in Title V MCH Block Grant dollars is divided equally among the seven Health Districts to provide screening and referral, education and fluoride varnish to low-income, high-risk children. The ECC projects are conducted by dental hygienists employed by the Districts and target WIC clients, Head Start children, and those who are Medicaid/CHIP eligible. During FY 2003, a total of 3,117 children received one or more fluoride varnish applications (almost double the 1,643 children served in 2002) and 5,431 parents, teachers, dental and medical health professionals were served through education and community

outreach efforts. Hiring and retention of dental hygienists is an issue in two of the seven health districts and impacted the numbers served.

A convenience sample of 354 kindergarten-age low income children found that 34.2% percent were caries-free in their primary teeth. The data for 2003 is an estimate based on a small sample size and may not be representative of all low-income children in the State. It is also not comparable to the 2002 baseline data from a State-representative sample which included children of all income levels.

Since the mid 1980s, oral health has been integrated with the WIC Program in all seven Health Districts. WIC clients receive information on preventing BBTD via one-on-one counseling, pamphlets, class presentations and/or viewing of a videotape. During FY 2003, the Idaho WIC Program served 34,341 persons: 26,733 children and 7,608 women.

#### b. Current Activities

During 2004, the State Oral Health Program is again contracting with the District Health Departments to continue the population-based early childhood caries prevention fluoride varnish projects targeted to high risk, low-income children age birth to 5 years.

Project activities are built around one or more components of the Framework for Action outlined in the May 2000 Oral Health in America: A Report of the Surgeon General. Data on early childhood caries prevention activities, persons served and services provided is collected and reported quarterly by each Health District. Data on caries experience, prevalence of early childhood caries and treatment needs is also collected, using the ASTDD basic screening survey criteria and report form.

In 2003, the MCH Oral Health Program applied for and received a \$50,000 State Oral Health Collaborative Systems (SOHCS) grant to work with the Family Practice Residency Program of Idaho (FPRI) to integrate early childhood caries prevention with well-child care. The project intent is to build on training provided in 2003 by the University of Washington dental faculty, utilizing District Health Department staff to facilitate implementation, build dental and medical community awareness, and develop a dental referral network to assure project support and sustainability.

The project design and timelines have been revised from the original 2003 grant proposal. The proposed dental referral network, which was to be managed through a toll free telephone resource, the Idaho CareLine, didn't happen as planned and was a barrier to moving the project forward. A revised project period of July 1, 2004 through June 30, 2005 is proposed and a request to extend the grant duration accordingly beyond the end date of September 29, 2004 will be submitted to the funding agency. Contracts are now in place with two health districts for training, technical assistance and dental referrals. A community development consultant working with the project will be contracted with MCH dollars for additional hours and a contract with FPRI for project evaluation via electronic data and chart reviews is being negotiated. By July 1, 2005, it is expected that Idaho will have a model that can be replicated statewide for increasing children's access through physician-based early childhood caries prevention activities.

#### c. Plan for the Coming Year

In FY 2005, the \$90,000 in MCH dollars funding the Early Childhood Caries (ECC) Prevention Projects will be redirected to conduct an Idaho State Smile Survey of approximately 6,000 kindergarten, third and sixth grade students. The MCH funding will be reinstated in 2006. All seven Health Districts have stated their intent to continue conducting the ECC Projects during

2005, albeit at a reduced level.

**State Performance Measure 7: *SP#7 - Percent of investigations completed on children with elevated blood lead levels.***

**a. Last Year's Accomplishments**

There were 21 reported cases of elevated blood levels in children and all 21 were investigated to determine possible causes and recommendations were provided to families on methods to prevent future exposure. Elevated blood lead is now required to be reported within 3 days in Idaho.

**b. Current Activities**

The epidemiology program investigated all children with elevated blood lead levels and will continue to do so.

**c. Plan for the Coming Year**

The Office of Epidemiology will continue to collect elevated blood lead level reports as part of its surveillance activities. Efforts will be made to ensure investigation of such elevated results on children.

**State Performance Measure 8: *SP#8 - Percent of deaths attributed to SIDS that are autopsied.***

**a. Last Year's Accomplishments**

MCH funding for SIDS autopsies was discontinued effective July 1, 2003 primarily because the funds were rarely accessed and did not appear to influence whether or not an autopsy was performed. In viewing data for 2003, 13 out of 13 SIDS deaths were autopsied.

**b. Current Activities**

MCH will continue to monitor the percent of SIDS deaths that are autopsied.

**c. Plan for the Coming Year**

MCH will continue to monitor the percent of SIDS deaths that are autopsied.

**State Performance Measure 9: *SP#9 - Percent of CHIP eligible children who have enrolled in the program.***

**a. Last Year's Accomplishments**

Promotion of the toll-free information and referral telephone service, CareLine, to the MCH, Infant Toddler and Medicaid populations (including CHIP referrals). The CSHP program also encourages CHIP application for clients wishing to receive services from the program.



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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) SP#3 - Use of the Idaho CareLine as a clearinghouse (information/referral service) of information for non-health related children's social and developmental services.				
1. Maintain CareLine service and new 211 call number.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) SP#4 - Percent of child deaths reviewed by the Idaho Child Mortality Review Team.				
1. Review CY 2001 child deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

5) SP#5 - Doses of hepatitis A vaccine administered to children at kindergarten entry.				
1. The Immunization Program will continue to educate providers about the importance of providing Hep A.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) SP#6 - Percent of children age 5 years who are caries-free in their primary teeth (have no decayed, missing or filled teeth due to tooth decay)				
1. Support and direct efforts of the Idaho Oral Health Alliance (IOHA).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Population-based early childhood caries (ECC) prevention and school-based dental sealant projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) SP#7 - Percent of investigations completed on children with elevated blood lead levels.				
1. Investigate all reported cases of elevated blood lead levels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
8) SP#8 - Percent of deaths attributed to SIDS that are autopsied.					
1. CMRT encouragement to counties to continue performing autopsies on all SIDS deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
9) SP#9 - Percent of CHIP eligible children who have enrolled in the program.					
1. Investigate the feasibility of providing regional dental clinics for Medicaid and CHIP children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Increase the awareness of families about CHIP and Medicaid coverage through CSHP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. CareLine will continue to refer callers to Medicaid for CHIP enrollment, when appropriate.	<input type="checkbox"/>	<input checked="" 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"/>	

### E. OTHER PROGRAM ACTIVITIES

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and

management. Additionally, nutrition counseling will be provided through contracts with the district health departments for children in all MCH populations and specializing in children with special health care needs.

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

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

The Reproductive Health Program will work with the Council on Domestic Violence and Victim Assistance to promote the development of Sexual Assault Teams in major hospitals

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Patient blood values will be provided monthly and monitored for acceptable levels. The Program will continue to provide training opportunities for regional dietitians during FY 2004. CSHP nurse coordinators will participate in an annual meeting, which includes physician presenters and other staff from programs that touch upon or involve CSHP. The Program will continue to provide resources and support to children who are not covered by other sources of third-party payment.

The database software, IRIS, is specifically developed for information and referral purposes. The database is keyword driven making the database quickly accessible to the operator and is updated at least twice per year. The upgraded software allows for very intensive and specific information to be listed on each provider resource. The printing of paper directories for use by specific programs was also made available through the extended programming capabilities of the software upgrade.

The Perinatal Research Analyst/SSDI Manager will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP). The manager will collaborate with the Division of Medicaid, the Division of Welfare, and the Bureau of Health Policy and Vital Statistics to implement a data linkage between birth records, Medicaid-eligible files, and Medicaid-paid claims files.

During FY 2003, the Oral Health Program contracted with each of the seven district health departments to conduct population-based preventive oral health programs. Through the Title V funded school health projects, 47,588 individuals were served:

- 33,276 children participated in the school fluoride mouthrinse program. The program targets children in grades 1 through 6 who are at high risk of developing dental caries and live in fluoride deficient areas. Statewide, 80% of students enrolled at participating schools used the weekly fluoride rinse.

- 19,803 persons were reached through statewide school-based preventive dental health education programs for students and teachers. Classroom education reached 13,049 children and in-service training was provided to 604 teachers. 6,150 persons were impacted through community outreach efforts, including health fairs, education by volunteers, school nurse training and presentations to parents.

Quarterly conference calls and site visits to all seven health districts were conducted during FY 2003 to coordinate and monitor contract activities. Program participation was reported quarterly by the districts and compiled at the end of the contract year.

The MCH Oral Health Program continued to facilitate meetings of the Idaho Oral Health Alliance (IOHA). During FY 2003, efforts were directed to three of the State Oral Health Plan goals that resulted from the 2001 oral health summit:

- Goal #2: expand scope of dental hygiene practice. During FY 2003, the Oral Health Program provided information to the Idaho State Board of Dentistry regarding proposed changes to the dental hygiene practice statute and administrative rules, discussed the public health impact with the districts and participated in an issues forum at the Idaho Dental Hygienists' Association annual session.
- Goal #4: integration of oral health with primary medical care. The Oral Health Program facilitated meetings between University of Washington dental faculty, pediatric dentists, Medicaid, public health and the family practice residency program in an effort to build community support and sustainability. Another activity related to this goal was development of a fact sheet, in partnership with the Bureau of Health Policy and Vital Statistics, on dental care during pregnancy based on 2001 PRATS data. The PRATS fact sheet was distributed statewide via dentist, dental hygienist, perinatal and pediatric physicians' association newsletters, as well through the districts.
- Goal #6: fluoridation of community water supplies. During FY 2003, the Oral Health Program learned that a water operator had unilaterally discontinued fluoridating a community water supply. The district health department was notified and through their efforts, in partnership with their Board of Health and the City Council, new equipment was purchased and water fluoridation was reinstated. During FY 2003, the Oral Health Program also worked with Delta Dental Plan of Idaho to develop the Healthy Idaho Community Water Fluoridation Project, providing extensive resources and technical assistance.

## **F. TECHNICAL ASSISTANCE**

Technical assistance will be needed to plan and implement a health promotions/communications/marketing plan for newborn hearing screening.

Assessment of our program has shown a deficiency in achieving the recommended screening benchmark for number of infants who return for a rescreen when needed (Benchmark is set at greater than 70%, while our program is consistently showing rescreening rates of 50-55%). An initial study of regions with the lowest benchmarks did not show any correlation between low return rates and socioeconomic factors. Further studies are pointing to the need for public/parent education as vital to increasing the follow-up rescreen rates, with provider education also playing a vital role.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

#### Annual Expenditures

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

The expenditures in 2003 that were directed to Pregnant Women including 25% of the MCH administrative budget (\$20,095), Pregnancy Risk Assessment Tracking system (\$29,922), 25% of the Office of Epidemiology and Food Protection MCH budget (\$57,332), 20% of the Reproductive Health MCH budget (\$137,231), and 25% of the Idaho Careline MCH budget (\$6,932).

Funds used in FFY 03' for Infants < 1 Year Old included 25% of the MCH administrative budget (\$20,095), 25% of the Office of Epidemiology and Food Protection MCH budget (\$57,332), 25% of the Idaho Careline MCH budget (\$6,932), 50% of the Immunization local funds used for block grant match (\$428,500), funds to cover SIDS autopsies (\$4,750), newborn hearing screening (\$9,012), and 25% of the MCH funds spent by the Idaho Child Mortality Review Team.

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget (\$20,095), 25% of the Office of Epidemiology and Food Protection MCH budget (\$57,332), 25% of the Idaho Careline MCH budget (\$6,932), 50% of the Immunization local funds used for block grant match (\$428,500), the Oral Health Program (\$336,059), 40% of the MCH budget for Reproductive Health, Injury Prevention Program (\$2,150), 75% of the MCH funds for the Child Mortality Review Team (\$15,191), and Suicide Prevention (\$12,227).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget (\$20,095), 25% of the Office of Epidemiology and Food Protection MCH budget (\$57,332), 25% of the Idaho Careline MCH budget (\$6,932), and the Genetics Program (\$199,193). Funds for the Children's Special Health Program were the following \$729,000 MCH, \$600,250 state and \$542,409 local (Total \$1,872,051)

40% of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women older than 22 years of age. And \$299,668 in indirects was included in expenditures for the Administrative budget.

FFY 03' expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget (\$179,274), the Reproductive Health Program Budget and the Children's Special Health Program budget (\$1,872,051). The only program included under enabling services was the Idaho Careline (\$27,726). Programs included in the Population-Based Services category were Oral Health (\$336,059), Injury Prevention (\$2,100), Immunizations (\$857,000 - local match), Newborn Hearing Screening (\$9,012), Child Mortality Review Team (\$20,254), and Suicide Prevention (\$12,227). Programs included under infrastructure Building Services included: MCH Administration (\$80,379), Pregnancy Risk Assessment Tracking System (\$29,922), Office of Epidemiology and Food Protection (\$229,326), 10% of the Genetics Program (\$19,919), SIDS Autopsies (\$4,750), and the indirect budget (\$299,668).

## **B. BUDGET**

### Budget Narrative

To meet the match requirement the state will be utilizing \$1,000,000 in state general fund and \$1,540,821 local funds.

The priority areas for Idaho are CSHP, Reproductive Health, Oral Health, Epidemiology Services and Genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Epidemiology.

Last year we budgeted for an increase in spending on Perinatal assessment which is used to conduct the Idaho Pregnancy Risk Assessment Survey. This was in effort to increase the sample size to enable data to be evaluated at the health district level rather just statewide. Funds from last year's budget were also slated for the 5 year needs assessment and will be used during this second year of the grant cycle.

A new area that will be funded this coming grant cycle will be a perinatal project that will collect data on outcomes of lay midwife deliveries. Hospitals report stories of pregnant women and/or their newborns arriving at the emergency room of the local hospital seeking care in an emergency state after a failed home delivery, but there is currently no data to determine the frequency of this occurrence. \$40,000 dollars have been allocated for this project.

A part-time MCH special projects coordinator has been hired and will be included in the MCH Administration budget. This position has been involved with several projects including working with MCH programs on outcome measure development and reporting, establishing a relationship with community health centers for improving access to reproductive health services, and will be the lead position for the MCH 5 year needs assessment.

An MCH research analyst has been hired full time to focus on MCH program data needs. This position was originally funded part time and shared with another Bureau, but because of the volume of requests for assistance from MCH programs, the decision was made to establish a full time position. The position will work with MCH programs to assist with analyzing databases, development of surveys, and supporting data needs for program outcome measures. \$54,100 is allocated to cover personnel and operating for this position.

## **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.