

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **MA**

APPLICATION YEAR: **2005**

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

Massachusetts hereby attests to all of the Assurances and Certifications required for this Application. Copies signed for this application are on file with the Massachusetts Department of Public Health and are available upon request to either the Title V Director or the Department's Chief Financial Officer.

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

A public hearing will be held on */2005/ November 16, 2004 //2005//* in Framingham, to allow formal general public comment on the four federal block grants administered in full or in part by the MDPH: MCH Block Grant; Alcohol, Drug Abuse and Mental Health Services Block Grant; Preventive Health and Health Services Block Grant; and the Women, Infants and Children (WIC) State Plan.

Organizations and individuals concerned with maternal and child health who are encouraged to attend and present oral and/or written comments on the activities of the Bureau of Family and Community Health.

We plan to make the Application/Annual Report available to the public through the MDPH Home Page (as well as through TVIS). Additional comments will be solicited through that mechanism. We will be circulating the document widely to vendors, advocates, and MCH/CSHCN professionals.

/2003/ We have confirmed our tentative decision to rely on the MCHB/TVIS website as the primary public access point for the Block Grant. /2004/A limited web presence for the Application is being created to accommodate supplemental information referenced in the web-based Application and to promote use of the HRSA/MCHB website.//2004// /2005/ No further progress on a web presence occurred during FY04, but is now planned for FY05 as described above. //2005//

The BFCH and MDPH also encourage input and comment throughout the year as well. Our extensive participation in numerous advisory committees, community coalitions, and similar groups assure ongoing input from the public and ready access to the state Title V program by many people and organizations.

II. NEEDS ASSESSMENT

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

III. STATE OVERVIEW

A. OVERVIEW

The people of Massachusetts enjoy better overall health status and access to health care services than in many other states. These benefits derive in significant part from favorable natural resources, relatively high levels of income and education, a diverse economy, a history of strong legislative support for funding health and social service programs, and strong public health leadership both in state government and in community and advocacy organizations. The Bureau of Family and Community Health (BFCH) is the Title V program. As such, it plays a key role in assuring access to comprehensive multidisciplinary service networks and systems. It emphasizes public/private partnership and collaboration in building such networks and systems. A major focus is on the at-risk and underserved populations of the Commonwealth whose health status and access to care may be compromised.

//2005/ For the fourth consecutive year, the economic slow-down continues to affect the Massachusetts public and private economic sectors, with continued negative effects on many health programs. Public and private health programs have grappled with declining state revenues that fund MassHealth and other insurance programs and that support preventive and safety net health services. Private funding sources have diminished as foundations face diminished endowments and corporations have lower earnings. In FY04, the state budget anticipated a continued drop in tax revenues by continuing wide-spread cuts, including health and human services. Many MCH-related programs experienced continued or additional cuts in state funds that required reducing or eliminating service contracts: MCH primary care wrap-around services; MCH home visiting; school-based health centers; school health services; teen pregnancy prevention coalitions; family planning; sexual assault prevention and survivor services; substance abuse and AIDS/HIV services; Early Intervention medical respite; a new suicide prevention initiative; and a number of health promotion efforts, including virtually the entire state tobacco control program.

The DPH Family Health Services account, which funds family planning programs, rape crisis centers, poison control center, wrap-around services at community health centers, and other key MCH-related services was reduced in FY04 by 75% (from its FY03 level). Family planning services and rape crisis centers received some restoration of funding through a supplemental budget in December, 2003. Teen pregnancy prevention services, already cut in FY03, are now funded at about 10% of their FY01 level, ending this program model. Domestic violence programs were dramatically reduced, with the immigrant and refugee program (RISE) eliminated. FY04 funding for school health services and school-based health centers was reduced 42% from their original base levels. Funding levels for FY05 are better for all of these programs, except teen pregnancy prevention (which remains at less than 10% of its FY01 base), but none has been fully restored to FY03 original budget levels.

Funding reductions in substance abuse, mental health, mental retardation, and child welfare services (including a proposal to require parents on transitional assistance with preschool children to work) also adversely affected MCH populations. The FY04 appropriation for the state's wrap-around insurance program for children and youth (CMSP) was insufficient to support the existing caseload, resulting in a reduction in active caseload from 26,500 to 20,150. The Massachusetts Healthy Start prenatal health insurance program was transferred to Medicaid and the outreach, referral and follow-up component was eliminated. The Medicaid program for special immigrant/refugee populations was eliminated in July, 2003. Effective July 1, 2004, the Healthy Start and Children's Medical Security (CMSP) insurance programs have both been transferred to Medicaid and fully funded, with the CMSP waiting list of 14,000 children expected to be eliminated by August, 2004. //2005//

Massachusetts: Geography and Demographics

//2005/ No additional updates from previous years except as noted. //2005//

Massachusetts is the sixth smallest state in landmass, measuring just 150 miles in its longest direction. However, it ranks 13th in population (population of 6,349,097 in 2000 Census) and is relatively dense (768 people per square mile) and urbanized, with just 15.7% of residents living in rural areas. Ten percent of the population (589,141 in 2000, up 2.6% from 1990) lives in Boston, the

state capital and largest city, and half lives within the circumferential highway (Route 128) that defines metropolitan Boston. The next two largest cities are Worcester in central Massachusetts (pop. 169,759) and Springfield in the west (pop. 152,082, a decline of 3.1% since 1990). There are also numerous smaller cities, many of which are historically based in the mill industries. Rural areas predominate in the western section of the state, where the Berkshire Mountains separate many small towns with limited health services. Franklin County in the west, the only completely rural county, has just 79 people per square mile. Farming is still a significant industry in rural areas, with 6100 farms on 570,000 acres. Population has shifted somewhat over the past decade with an increasing number of people locating to smaller towns and suburbs.

The 2000 Census confirmed the previously noted trend in slower growth of population in the western, most rural part of state, (with the westernmost county of Berkshire actually losing 3.2% of its population) and higher population growth in the central and eastern part of state, particularly in the southeast. In eastern Massachusetts, there are 1500 miles of coastline on the Atlantic Ocean. Two islands, Nantucket and Martha's Vineyard, are located 16 and 5 miles off the Cape Cod shore. With a combined year-round population of approximately 20,000 and a summer population triple that size, these rural island communities face particular challenges in meeting their health care needs. The entire state is incorporated (there are no frontier areas) into 351 cities and towns, which are the functioning units for most local services, including public health, below the state level. There are no county health systems and other county functions, such as courts and corrections, are being converted to state administration. Massachusetts has an estimated population of 6,349,097 (2000 Census), an increase of 5.5% since 1990), of whom 1,618,141 (26%) are children and youth through 19 years of age and 1,464,584 are women ages 15-44. The state's overall population grew slowly in the 1990s and is projected to continue in this pattern through the next decade. However, the racial and ethnic demographics of the population are changing rapidly within this overall pattern. In 1997, the general population was 4.6% Black, 4.8% Hispanic and 2.3% Asian, and resident births in 1998 were 6.8% Black, non-Hispanic, 10.6% Hispanic, and 4.6% Asian. Between 1990-2000, both Hispanic and Black population growths are projected to have risen 41%. The predominant Hispanic ancestry groups in Massachusetts are Puerto Rican and Dominican. In aggregate, the increased population growth from 1990 to 2000 was due to an increasing presence of minority populations, concentrated in urban areas. While the percentage of whites declined by .7% to 85% of the overall population, there has been a significant increase in all minority populations. Of those identifying themselves as belonging to one race only, blacks now represent 5.4% of Massachusetts residents. The Asian population grew 70% to 261,722, comprising 3.4% of all residents. The Hispanic population grew 49% to 428,729 residents, and now represents almost 7% of the total population. In three cities, more than 50% of the population is Hispanic.

Estimates of immigrants and refugees vary widely due to the lack of firm data on recent immigration trends and inherently difficult issues in counting changing populations with language and cultural isolation. Massachusetts has the 7th largest refugee and immigrant population in the United States, according to the 2000 US census, which reports 12.2% of the state's population, was foreign-born (US=11.1%). Thirty-two percent of these residents were born in Europe, 30% in Latin America, and 26% in Asia. Almost 19% of residents speak a language other than English at home, with a third of these (6.2% of all residents) reporting they speak Spanish at home.

The BFCH Office of Immigrants and Refugees estimates, based on information from knowledgeable community sources in areas with significant newcomer populations, that the current overall numbers of immigrants and refugees may be over 15%. Southeast Asian, former Soviet Union residents, Brazilians, and refugees from the Balkans are among the fastest growing populations. One community expert has estimated a 490% increase in the Asian population in Worcester alone in the past decade. It is also reported that Lowell has the second largest Cambodian population in the country, second only to California.

State Department of Education data regarding numbers of students whose primary language is not English (PLINE) are useful indicators of overall immigrant patterns. ***/2005/ These data currently indicate that approximately 14% of all students grade K-12 have a primary language other than English, a percentage that has risen from 12% in 1993. A number of towns and cities have greater than 10% of their student body whose primary language is not English, and some have greater than 40%. The dominant languages are Spanish (51% of total PLINE), Portuguese (10.0%), Creole (Haitian) (4.5), Chinese (4.5%), Khmer (4.3%), and Vietnamese (4.2%). //2005// To***

reinforce the rise in the Hispanic population noted in the 2000 Census, almost 7% of Massachusetts schoolchildren speak Spanish as their first language. In three cities (Holyoke, Chelsea, and Lawrence) more than 50% of schoolchildren speak Spanish.

Massachusetts: Economy, Housing, Welfare Reform

Data from the 2000 Census show that 9.3% of residents (US=12.4%) and 11.6% of children under age 18 lived below the poverty level. Suffolk County, dominated by the state's largest city, Boston, had the highest poverty level, at 19%.

//2005/ The recession continues to adversely affect women and children. Unemployment, up to 5.4% in April 2003 (compared to a national rate of 6.0%), continued to rise, with poorer cities seeing significantly higher rates (e.g., New Bedford - 9.4%). The caseload of families receiving transitional assistance for needy families (TANF) continued an increase that began in 2002 (after 6 years of declining caseloads) through October 2003. It has since begun a slow decrease (4%) from a high of 49,735 in October 2003 to 47,861 in April, 2004. Caseload in Emergency Aid to the Elderly, Disabled and Children continued to increase, by 4.1% to 17,601 over the 12-month period 5/03 -- 4/04. Food stamp participation continues to increase more dramatically, up 9.6% to 153,183 in this same 12-month period. Because Massachusetts has a historically low food stamp participation rate, this increase may reflect the on-going effect of a simplified enrollment form and process, along with more intensive outreach efforts. However, the state supplemental food stamp program for legal immigrants remained closed due to budget constraints. The WIC caseload has also increased due to an increased emphasis on retention and outreach to minority and underserved populations.

Informal estimates of family well-being also show increased need. Statewide, emergency food programs reported a 78% increase in requests for food aid in 2002 and that 38 percent of their clients are children. Summer jobs for youth, an important contributor to positive youth development, have been further reduced or eliminated in most areas of the state due to cuts in state funding and less corporate support than in past years. //2005//

Massachusetts is a comparatively wealthy state and has benefited greatly from the strong economy of the late 1990s. There is a diversified economic base that includes health care, education, finance, insurance, telecommunications, computer technology, biotechnology, tourism, farming, and fishing. The state has the highest percentage of college-educated individuals and the third highest annual average pay (1998) in the nation. Unemployment had steadily declined for five years and was (May 2000) at a record low of 2.5% (US = 4.1%).

In fact, the actual financial status of a low-income family in Massachusetts is poorer than in many other states due to the high and rising cost of living, particularly housing.

//2005/ The Massachusetts economy has been in a downturn for the past three years and is only now slowly beginning to recover. In spite of a declining economy, residential rental and purchase prices continued to escalate substantially, increasing the state's critical shortage of affordable housing. A majority of the state's communities do not meet a long-standing state requirement for 10% of housing stock to be affordable and many are moving away from efforts at compliance. In 2003 the National Low Income Housing Coalition ranked Massachusetts the least affordable state for renting in the country. Boston rental housing costs rose 60% from 1998 to 2003. Statewide, over three-quarters of low-wage working families spend more than one-third of their income on housing. In addition to higher market-rate housing, fewer subsidized rental units are available as landlords find that they can now rent these units at market rate. In addition, the issuance of Section 8 vouchers, traditionally used by low-income and working class families to participate in the rental market, were frozen in the Spring 2003 due to overutilization and a cap on funding; it is anticipated that new vouchers will not be available until Winter 2005. The crisis in affordable housing has resulting public health implications in unsafe and unstable housing situations, including homelessness, and economic tradeoffs between paying for housing costs and food for some families. These effects are seen in the continuing growth in homelessness and food insecurity. The true number of homeless families is difficult to capture due to the lack of a centralized database. Also, the numbers of families who are doubled with family and friends are growing

based on anecdotal evidence, reports from school personnel and food pantries staff among others. Many families who are doubled up with relatives and friends do not consider themselves homeless, and frequently homeless families are discouraged from applying for shelter benefits because they believe they are ineligible. Data from the BFCH's welfare transition assistance program, FOR Families, shows that housing assistance is the most common reason that former TANF families are referred to them, followed by food insecurity.

The Department of Transitional Assistance's (DTA) family homelessness response program is the mechanism through which most homeless families must seek help. DTA provides funding to a network of family shelters across the state that collectively house about 1100 families. Families that are either presently receiving TANF benefits or meet Emergency Assistance income guidelines are eligible for placement into these family shelters if they also meet criteria for verified homelessness. While the number of family shelter beds has remained stable over the past several years, the demand has escalated to the point that these shelters are always filled. The criteria for eligibility for families being housed in motel rooms by DTA were tightened, resulting in a decrease in those numbers. In August 2003, there were a record 599 families temporarily placed in motels awaiting shelter placement and/or permanent housing. By July 2004 that number had been reduced to fewer than 100 families.

In addition to the immediate economic contributors to increased homelessness, many parents in these families have complex issues of substance abuse, mental health problems, and domestic violence that impede their abilities to secure jobs and housing. Approaches that include addressing these issues are needed. The growth in "motel families" was cause for substantial concern. Motel placements lack the structure and support services available in family shelters. The motels are typically not in the families' home communities and there may be limited access to public transportation. The logistics of getting children to school, staying connected with known health care providers, and making reconnections for housing in the home community can overwhelm families and they may become further isolated.

With the institutionalization of these motels, the voluntary sector and the state have stepped forward to provide some assistance. Local churches and homeless advocacy groups are assisting in food, clothing and transportation needs of families residing in motels in their communities. The state, with DTA and DPH in lead roles, has also responded. BFCH's FOR Families program, which originally contracted with DTA to provide assistance to families that are transitioning off TANF and then on assisting motel families, is shifting its priority population once again from families living in motels to families transitioning to permanent housing. The goal is to provide families with the supports and services necessary to maintain permanent housing and end cycles of homelessness caused by unaddressed health and social issues.

In May 2003, the Governor's Executive Commission for Homeless Services Coordination was created to address the issue of both individual and family homelessness. The Commission's report, released in November 2003, recommended that state agencies implement strategies and programs that assist families to obtain permanent housing more quickly, thus eliminating the need for lengthy and costly stays in motels and shelters. Four strategic goals have been identified and a steering committee created to develop long-term solutions. The state Title V Director serves as the MDPH representative on this committee. The strategies recommended included better assessment of the factors contributing to homelessness [e.g., poverty, substance abuse, mental health problems], referrals to local providers of health and human services, and supports for families as they transition to permanent housing. The number of shelter beds for homeless families was increased so that families can receive assistance with a range of needs in order to prepare them for a successful transition to permanent housing. The Governor and Legislature have committed to protect funding for shelters and other homelessness programs in state budget cuts.

In summary, as an April 2004 report by the Women's Union on behalf of the Massachusetts

Family Economic Self-Sufficiency Project puts it, there is an "Other Massachusetts:" "In one of the wealthiest states in the nation, more than 25% of workers have low-wage jobs that pay less than \$8.84 per hour, or \$18,387 per year working full-time. In a national center of higher education where postsecondary education is necessary for most jobs that pay family-sustaining wages, 37 percent of Massachusetts adults have only a high school diploma or less." //2005//

Massachusetts: Health Insurance and Health Services
Insurance Coverage and State Insurance Programs

//2005/ The most recent Massachusetts BRFSS data (2003 survey) found only 2.3% of children uninsured.//2005//

The 2002 bi-annual statewide survey of insurance status conducted by the Division of Health Care Finance and Policy reports reported that 3.2% of children under age 19 statewide were uninsured, a slight increase from 3.0% in 2000. Intra-state analysis showed that rates of child uninsurance in some large urban areas increased more substantially. In Lowell/Lawrence, uninsurance was 7.7% and in Boston 6.3%. The 2002 BRFSS survey found only 1.7% of children uninsured.

Massachusetts recognized the need to provide health insurance as a first step in assuring access over 15 years ago. Over this period of time, the Title V program has worked closely with the state Medicaid agency (Division of Medical Assistance / DMA) to develop a simplified, seamless enrollment process for both pregnant women and children.

Historical data on the insurance status of women and children summarized below include the recent efforts to enroll children and their parents in the expanded MassHealth (Medicaid) program, which includes Title XXI/Children's Health Insurance Program (SCHIP).

1. The US Census Bureau Current Population Survey, based on a three-year trend from 1995-97, showed that overall 9.4% of all children were uninsured, with 15.5% of children at or below 200% FPL and 6.5% of more affluent children lacking health insurance.
2. A 1998 state survey estimated overall lack of insurance at 8.1%, down from 11.4% in 1995. Among children, 12.3% of those who were low-income were uninsured, while only 1.9% of more affluent children lacked health insurance.
3. The Urban Institute's National Survey of America's Families (with 1996 data) showed similar results for children: 12.8% of low-income children lacked insurance, while only 2.3% of others did.
4. 1999 state Behavioral Risk Factor Surveillance Survey (BRFSS) data showed that the overall level of insurance coverage for children under 18 may be as high as 97.3%, but with approximately 14% of children in minority households with a parent without a high school degree being without insurance. [This was the first time that questions specific to child health insurance coverage had been included and were the only survey data available then that were collected after Title XXI expansion went into effect.] The 1999 BRFSS data have been confirmed by the findings from the bi-annual statewide survey on insurance status conducted by the state Division of Health Care Finance and Policy. It found that only 2.5% of all children under age 19 were uninsured, compared with 9.7% of all adults 19 - 65. Of children in families with incomes at or under 133% of the FPL, an estimated 6.3% were uninsured. The 4.4% of children at or below 200% of the FPL translated into an estimated 15,621 low-income children without insurance. The 2001 BRFSS data found only 1.8% of children uninsured.
5. The 2000 statewide survey on insurance status conducted by DHCFFP found that 3% of children under age 19 were uninsured. It also provided intra-state information on disparities among children. Hispanic children were most likely to be uninsured (5.5%), although they experienced a dramatic decline in uninsurance from 1998 to 2000, a 47% decrease from 10.5%. White (2.7%) and black (2.8%) children had equivalent uninsurance rates. The two areas of Massachusetts with the highest child uninsurance rates were the central (4%) and southeast (4.1%) regions. The urban areas with the highest concentrations of child uninsurance were Lawrence/Lowell (5.2%) and New Bedford/Fall River (5.0%). Infants were least likely to be uninsured (1.9%) and children ages 2-5 were most likely to be uninsured (3.6%). Uninsured children (13%) were more likely to have a medical condition or disability than are insured children (7%).

//2005/ SCHIP is best understood in Massachusetts as part of a comprehensive, combined plan

for the state's families that includes both expanded and new MassHealth (Medicaid) programs and two components - Healthy Start and Children's Medical Security Plan (CMSP) -- that were transferred to MassHealth (Medicaid) in FY04 but continued to be operated by the Title V program until July 1, 2004. Massachusetts implemented SCHIP as part of MassHealth (with a private insurance component that supports premium payments for eligible families to discourage 'crowd-out') in a seamless integration with expanded and revised eligibility criteria and streamlined enrollment procedures that were approved as part of its HCFA 1115 waiver. The combined MassHealth and DPH programs have been very successful in increasing enrollment of children. However, MassHealth has been the subject of particular state budget scrutiny because of its large (~25%) and growing share of the state budget. As a result of the severe state revenue shortfalls, major cuts in MassHealth benefits and eligibility (primarily for adults) have occurred in the past several years. In October 2002, DMA eliminated certain categories of non-mandated services for adult members, including eyeglasses, dentures and prosthetics. More significantly, as of March 2003, 36,000 low-income long term unemployed adults, including some women of childbearing age, were disenrolled when MassHealth Basic, a state benefit category, was eliminated. Most of the funding for these former beneficiaries was later restored, but the budget also stipulated that many MassHealth members contribute co-payments on some services. The mini-grant program jointly supported by DPH and DMA to facilitate the ability of community agencies to do outreach and enrollment for MassHealth and other insurance programs was terminated in FY03 due to funding cuts.

The Healthy Start program was transferred to the Division of Medical Assistance (DMA) through the FY04 budget, but continued to be operated by DPH for the year. Funding for the enrollment, referral and follow-up multi-lingual staff was eliminated, with only the enrollment function being transferred to Medicaid. DPH and DMA worked cooperatively on a state plan waiver to the Centers for Medicare and Medicaid Services (CMS), that was approved in Fall, 2003, for the implementation of the option allowing for the enrollment of women during pregnancy under SCHIP. This waiver enabled the state to obtain federal matching funds for Healthy Start-enrolled women. //2005//

Safety Net and Other Health Care Providers

/2005/ The continued state budget crisis, coupled with escalating health care costs and increases in the number of uninsured, is presenting significant challenges. To address the growing costs to the system, the administration is undertaking an effort to redesign the public insurance programs delivery system. Key to this is expected to be the development of a network of core community providers, with community health centers playing a central role. It is expected that by redirecting public insurance members to a network of core community providers costs can be better controlled; increased access can be achieved for the uninsured; and diverse populations groups throughout the state can have increased access to culturally and linguistically appropriate care. Currently the majority of Medicaid recipients are cared for within group practices, some of which are large and connected to hospitals. But others are small community-based practices; these may be eliminated in the redesign.

Hospitals continue to report financial difficulties, with over half operating at a deficit, and they remain concerned about the financial stability of the Uncompensated Care Pool (UCP), a \$350 million financing mechanism to assist hospitals and community health centers that treat large numbers of uninsured low-income patients. For the fourth year, the Pool is experiencing mounting shortfalls after a short period of financial stability after passage of state health care reform legislation in 1997. Both increased unemployment and MassHealth cuts leave more people without insurance and more patients requesting free care coverage for their hospital bills, thus exacerbating financial pressure on the Pool. The Pool also is affected by health care cost inflation. Not all hospitals benefit equally from the Pool. With the Pool's complicated formula for contributions and payouts, many hospitals, particularly suburban hospitals with smaller numbers of uninsured patients, are net payers. Despite a Commission convened by the former Governor to address new strategies for stabilizing the Pool, a number of legislative proposals, and strategies developed by the new administration, there is not consensus on the

best avenue for reform. For FY05, the Legislature has again appropriated funding to help stabilize the Pool on a short-term basis. It is expected that the Administration's public health insurance programs reform package (described above) will address and resolve issues related to uncompensated care.

A secondary issue relates to disproportionate-share hospital (DSH) fund distribution. During health care reform in 1997, two major hospital systems received permission to create managed care products for the Medicaid and uninsured populations. In addition, the hospitals receive a significant proportion of all DSH funds. The uninsured population has shifted in the years since and multiple hospitals are reporting significant numbers of Medicaid and uninsured patients, resulting in discussions about needing to significantly change the current distribution. This would require a resubmission of the Medicaid State Plan, as the current arrangement is part of the Commonwealth's 1115B waiver.//2005//

Concerns about the future supply of health care providers continue to rise in various sectors relevant to MCH services. Physicians' professional liability insurance issue is an increasing factor in supply considerations. Overall malpractice rates in Massachusetts rose 12.5% in 2002 (US average 9%) and will rise by 20% in 2003. Recent news reports highlighted one obstetrician-gynecologist who has stopped doing deliveries because his rates doubled to \$60,000 in 2003. A recent physician workforce study by the state medical association found that 40% of ob-gyn physician respondents are considering a career change due the practice environment, with professional liability costs being a major factor in their considerations. It also found that ob-gyn was one of five specialties identified by hospital medical staff presidents in which they are experiencing serious recruitment difficulties. Certified nurse midwives continue to increase, currently attending 14% of all births in the state. Nursing shortages continue to be a source of concern. The major state nursing association continues to press for a bill that would mandate specific nurse-to-patient ratios in hospitals, including on obstetrical and NICU units. Home health agencies serving both medically complex children on an ongoing basis as well as many families with newborn infants, continue to experience staffing problems. An estimated 25% of approved nursing hours for 700 children served by pediatric home nursing programs go unfilled because of inability to find nurses at the approved hourly rate. Home health agencies also report difficulties in recruiting and retaining qualified paraprofessional workers.

The Massachusetts health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are delivered by private health care providers and community-based non-profit organizations. Within each city and town, local government is responsible for developing and enforcing environmental and sanitary codes. Some larger health departments also provide screenings, public health and school nursing services, and other traditional public health core functions. MDPH contracts with a wide range of these providers (both private and public), using a competitive bid process, for most of its community-based services. All vendors with MDPH contracts must report on uniform performance measures that assure a culturally competent, family-centered, community-based approach. All are required to participate in the health improvement processes of their local Community Health Network Area (CHNA). MDPH also actively collaborates with local health departments through a Local Health Advisory Group and Local Health Institute to improve their infrastructures and provide training and technical assistance.

There are approximately 50 community health centers (CHCs) with over 100 service locations that are major providers of primary care and specialty services to at-risk and underserved populations; MDPH contracts with them for a wide range of primary care and MCH services. There are also a wide variety of other community-based health and human service agencies that provide other MCH services such as early intervention, WIC, home visiting, teen pregnancy prevention, family planning, and health promotion. Title V purchased services are integrated into MDPH primary care, school health, and CHC programs to assure a multi-disciplinary, comprehensive, family-centered care model whenever possible. Community health centers are the major safety net providers in the state, especially for the non-English-speaking, minority, uninsured and MassHealth (Medicaid) populations. In areas of the state without CHCs, providing comprehensive, multi-disciplinary services becomes more difficult; the Bureau therefore works actively to support the development of additional CHCs or to promote access

through other community-based agencies and providers.

/2005/ Over half of the entire Massachusetts population is enrolled in a managed care plan; these plans include capitated HMOs, preferred provider network systems, and other forms of MCOs (Managed Care Organizations). Private physician practices are widely distributed across the Commonwealth and a major source of medical care for children. Most are part of one or more MCOs. Collaboration with these providers is critical in assuring care for children, including children with special health needs. The BFCH and other MDPH Bureaus also work with these providers in relation to the identification of gaps in health care resources, and in relation to training, technical assistance and development of educational materials. The providers are key in providing on-going preventive and acute care and linkage to specialty services, especially for public insurance programs such as Healthy Start, Children's Medical Security Plan (CMSP), and MassHealth. MassHealth, the state Medicaid program, currently operates through contracting with 1,800 medical sites (including private physician practices) and all CHCs and hospitals are participating providers. If the redesigned system eliminates a significant number of these providers from the Medicaid and other public insurance programs, this could create a major disruption in services for the MCH population. Title V staff are active participants at the table and will continue to promote the need to assure access as well as transitional planning based on the changes made to assure minimal disruption in care. //2005//

B. AGENCY CAPACITY

The Bureau of Family and Community Health (BFCH) in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts.

MCH-related program areas within the Bureau are listed and briefly described in a Table organized by the MCH Population Groups that they primarily address. ***/2005/ This table is part of a Word document that is the attachment to this Part III, Section B (Agency Capacity). The Table is called "BFCH MCH-Related Programs, Brief Descriptions, and Services Provided" and is the first 11 pages of the file. //2005//***

The Bureau is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The programmatic divisions through which the Bureau carries out its mission are described in the next section, "Organizational Structure."

/2003/ During 2003 the Bureau continued with an intensive Strategic Planning initiative. Staff from every Division participated in on-going "Strategic Issue Teams," working on defined priority projects that address goals and objectives for each of the issues identified through the strategic planning process. In the spring, 2002, the Bureau began the process of systematically reviewing its current organizational structure. This is expected to result in some further programmatic realignment in early FY03. The function of the regional offices has been added to this review, with the goal of determining the most effective use of the offices and maximizing their contribution to the work of the Bureau and to local communities.

/2004/ In FY04, the Bureau will review the Strategic Plan and make revisions based on program needs, internal and external environmental changes, and resource availability. //2004//

/2005/ During 2002 and 2003, the Bureau carried out an intensive Strategic Planning initiative. Staff from every Division participated in on-going "Strategic Issue Teams," working on defined priority projects that address goals and objectives for each of the issues identified through the strategic planning process. The process included a systematic review and realignment of its organizational structure. The Bureau continues to review the Strategic Plan and make revisions based on program needs, internal and external environmental changes, and resource availability. //2005//

TITLE V IN MASSACHUSETTS

The philosophy of the Massachusetts Title V program is that in order to fully address the health needs

of mothers and children, systems, programs and services need to consider the health of the entire family, including the community. In the Bureau of Family and Community Health, all systems and programs begin with this philosophical approach -- addressing the needs of women, children and youth, including those with special health needs, within the context of the family. The state's philosophy simply stated is: "Healthy families lead to healthy children."

Figure 2 displays BFCH programs and activities schematically in relation to the levels of the "MCH Pyramid." The pyramid includes the core public health services delivered by MCH agencies hierarchically by levels of service from direct health care services (the tip of the pyramid) to infrastructure building services (the broad base of the pyramid). The Figure lists both generic functions and services carried out by MCH agencies that BFCH provides or assures, as well as specific Massachusetts programs and initiatives. Many programs carry out activities at more than one level of the Pyramid (e.g. primary care service providers also assist families with enrollment in WIC or offer other enabling services as well; population-based lead screening programs also provide direct client case management for children found to be lead poisoned). However, for this purpose, each program has been shown only at the level of the Pyramid that represents its primary or dominant focus based on the MCHB definitions for levels of services./2004/ This Figure is now included in the Word document that is the attachment to this Part III, Section B (State Agency Capacity) The Figure is called "The MCH Pyramid Core Public Health Services Delivered in Massachusetts by MCH" and is the last page of the file. //2004//

MDPH collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the Division of Medical Assistance (DMA)/2005/ **the state Medicaid agency** //2005//, the Department of Social Services (child welfare), the Office of Child Care Services, the Department of Mental Health, the Department of Mental Retardation, Department of Youth Services, Commission for the Blind, Commission for the Hard of Hearing, and the Division of Health Care Finance and Policy. Agencies outside EOHHS with which we actively collaborate include the Department of Education and the Department of Public Safety. Massachusetts is trying to maximize systems building and minimize the potential confusion brought by multiple state plans, service networks, and community coalitions, by coordinating the development of these activities and structures across state programs.

The /2005/ **Associate Commissioner, Director, Center for Community Health**, //2005// who is the Title V administrator, holds a senior leadership position within MDPH and is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. The Associate Commissioner also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers, as well as participating on multiple committees and taskforces addressing MCH issues in the state.

Our MCH Priorities and State Performance Measures clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.

C. ORGANIZATIONAL STRUCTURE

The Bureau of Family and Community Health (BFCH) in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. The Department of Public Health is part of the Executive Office of Health and Human Services. /2005/ (**See the organizational charts in the attachment to this Part III, Section C. (Organization Structure). As part of a larger re-organization of state government, Governor Romney undertook a major restructuring of the cabinet-level Executive Office of Health and Human Services, endorsed by**

the legislature. The goal of this reorganization is to be more responsive to providers, clients and communities by improving organizational efficiency, using technology more effectively to achieve coordination of services, and building on the current strengths in the system.

Administrative cost savings are being achieved by eliminating duplication. Core functions such as legal, human resources, budgeting, and information technology have been centralized at the EOHHS level. Three "offices" have been created within the EOHHS of which the Health Office includes Public Health, Acute Care Medicaid, Mental Health and Health Care Finance and Policy. Title V remains within Public Health.

In November, 2003 the MDPH was reorganized to combine the Department of Public Health with the Division of Health Care Policy and Finance and the Division of Medicaid's Office of Acute and Ambulatory Care. The identity of major units within each agency was maintained. Sally Fogerty, Massachusetts Title V director, assumed leadership responsibility for a new Center for Community Health within MDPH that includes the Bureau of Substance Abuse Services, the HIV/AIDS Bureau, the Office of Healthy Communities, the Office of Multicultural Health, and the Office of Tobacco Control, as well as the Bureau of Family and Community Health. In January, 2004 a second change occurred when the Assistant Secretary for the Office of Health left that role to become only the Commissioner of Public Health. At that time the DHCPF and Office of Acute and Ambulatory Care were transferred out. A new Assistant Secretary of the Office of Health was just appointed on July 5, 2004. It is expected that the MDPH reorganization will remain in place as a separate entity within the Office of Health. It is unclear if the Office of Acute and Ambulatory Care will remain within the Office of Health or move to the Office of Medicaid Policy.

The Bureau of Family and Community Health reports to the Associate Commissioner, Director, Center for Community Health. It is expected that during the next three months, the Center for Community Health will undergo a realignment to improve both functioning and program integration. The Title V programs will remain within the Center, although the Bureau of Family and Community Health is expected to be modified. Currently Sally Fogerty is continuing to serve as the Bureau Director.

The Bureau of Family and Community Health is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The Bureau includes seven programmatic divisions that reflect changes made as a result of our Strategic Planning process:

- Division for Special Health Needs (DSHN)**
- Division of Perinatal and Early Childhood Health (DPECH)**
- Division of Child and Adolescent Health Services (DCAH)**
- Division of Primary Care and Health Access (DPCHA)**
- Nutrition Division (including WIC)**
- Division of Community Health Promotion (DCHP)**
- Division of Violence and Injury Prevention (DVIP)**

The Bureau also includes the following Internal Support Centers:

- Applied Statistics, Evaluation, and Technical Services (ASETS) (previously the Office of Statistics and Evaluation (OSE))**
- Administration and Finance**
- Policy and Planning**

In addition to its central office, the Bureau maintains staff in five regional offices. Due to funding reductions, the Boston Regional Office will be integrated into the main BFCH offices in August, 2004. Many of these staff, such as the FOR Families coordinators and care coordinators in the Family and Community Support program (DSHN), provide direct services to

individuals and families. Others work closely with BFCH programs, providing regional and local training and technical assistance, information and referral to services, coordination of services for families, performance monitoring, and other capacity building activities, such as the regional Early Intervention specialists and public health nursing consultants. Each regional office has a manager, under whose leadership staff work closely with communities to develop a system of care that is responsive to the diverse needs of community members. These staff facilitate the systems building activities in local communities for all Bureau programs and services. //2005//

D. OTHER MCH CAPACITY

/2002/ Approximately 325 persons employed throughout the Department work on Title V programs; of these 239 are paid from Title V Partnership funds and the rest are paid from MCH-related accounts. Approximately 136 of the total are usually based in the six regional offices or other off-site locations; the others work out of our central office in downtown Boston. Brief biographical sketches of the Title V senior management team are included in Supplemental Document 5.3.2. Staff and parents working on Title V programs are listed in Table 1.5.1.3. This table includes all MCH-related staff and consultants. Senior Managers and Unit Directors are listed individually; others are grouped into general job function types by MCH population groups. Numbers of full-time equivalents and vacancies should be regarded as point estimates only. Data capacity is addressed further at Core Health Status Indicator #5 and in Supplemental Document 5.3.10 in the section that describes the Office of Statistics and Evaluation. Not counting short-term positions and service on task forces, the Bureau employs 21 parents who represent approximately 10 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in Figure 3 immediately following Table 1.5.1.3. /end of 2002/

/2003/ Approximately 306 persons employed throughout the Department work on Title V programs; of these 212 are paid from Title V Partnership funds and the rest are paid from MCH-related accounts. Approximately 102 of the total are usually based in the six regional offices or other off-site locations; the others work out of our central office in downtown Boston. Brief biographical sketches of the Title V senior management team are included in Supplemental Document 5.3.2. Staff and parents working on Title V programs are listed in Table 1.5.1.3. This table includes all MCH-related staff and consultants. Senior Managers and Unit Directors are listed individually; others are grouped into general job function types by MCH population groups. Numbers of full-time equivalents and vacancies should be regarded as point estimates only. Data capacity is addressed further at Core Health Status Indicator #5 and in Supplemental Document 5.3.10 in the section that describes the Office of Statistics and Evaluation. Not counting short-term positions and service on task forces, the Bureau employs 22 parents who represent approximately 11 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in Figure 3 immediately following Table 1.5.1.3. /end of 2003/

/2004/ As of June 30, 2003, approximately 278 persons (256 full-time equivalents) employed throughout the Department work on Title V programs; of these 198 (186 FTEs) are paid from Title V Partnership funds and the rest are paid from MCH-related accounts. Approximately 95 of the total are usually based in the six regional offices or other off-site locations; the others work out of our central office in downtown Boston. Due to the impact of the FY04 state budget on many of the Partnership programs, the numbers of staff, particularly those in regional offices, is expected to be reduced during

FY04.

Brief biographical sketches of the Title V senior management team are now available in the Word document attached to this section. The biographies are the first section of the Attachment. Table 1.5.1.3 is no longer included in the Application. Key data capacity elements are summarized in Health Systems Capacity Indicator #09 (See Form 19) The Supplemental Document is not attached.

Not counting short-term positions and service on task forces, the Bureau employs 23 parents who represent approximately 12 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section. The Figure is the last page of the document. //2004//

//2005/ As of June, 2004, approximately 235 persons (210 full-time equivalents) employed throughout the Department work on Title V programs; of these 157 (141 FTEs) are paid from Title V Partnership funds. The rest are paid from MCH-related accounts. Approximately 55 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impact of the FY04 state budget on many of the Partnership programs, another round of Early Retirement incentives in FY04, and the transfer of CMSP and Healthy Start outside the Department, the number of staff, particularly those in regional offices, has been significantly reduced over the past two years. It is not expected to increase noticeably during FY05; any growth will come from new or expanded federal grants and some additional state-funded consultant positions.

Brief biographical sketches of the Title V senior management team are available in the Word document attached to this section. The biographies are the first section of the Attachment. Key data capacity elements are summarized in Health Systems Capacity Indicator #09. (See Form 19.)

Not counting short-term positions and service on task forces, the Bureau employs over 20 parents who represent approximately 12 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section. The Figure is the last page of the document. //2005//

E. STATE AGENCY COORDINATION

The BFCH views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups. We have summarized these relationships in the master listing below, categorizing them by type of agency/organization. Many of the activities carried out through these relationships are noted throughout the Annual Report and

Annual Plan sections of this document as they related to specific performance measures or Title V priorities. The extensive listing that followed in the text in previous Applications has been moved to the Word document that is the Attachment to this Section. The Bureau works with a broad base of constituency groups many of whom relate to specific populations or issues. The following is a list of the major or key groups that the Bureau works with on MCH issues on a regular basis. See the attached file for details on relationships with public sector agencies, as well as a number of other private sector organizations and institutions.

Massachusetts Hospital Association

Massachusetts Medical Society

Massachusetts Nurses Association

Massachusetts Chapter of the American Academy of Pediatrics

March of Dimes

Latino Grocer Association

Massachusetts Food Association

Healthy Care Quality Partnership

Health Care Alliance

Federation for Children with Special Needs

Massachusetts League of Community Health Centers

Health Care for All

Delta Dental Foundation

Project Bread

Jane Doe, Inc. (Massachusetts Coalition Against Sexual Assault and Domestic Violence)

Massachusetts School Nurses Organization

Independent Living Centers

Conference of Boston Teaching Hospitals

Massachusetts Public Health Association

New England Coalition for Health Promotion and Disease Prevention

Disability Law Center

Adaptive Environments

Massachusetts Law Reform Institute

Massachusetts Society for the Prevention of Cruelty to Children

//2005/ Collaboration with Medicaid.

With the restructuring of Medicaid at the state level over the last two years, the Bureau has established partnerships with the Office of Medicaid, Office of Acute and Ambulatory Care, Office of Long-term Care, MassHealth Operations, and the MMIS and Enrollment and Eligibility Components. In every Division and throughout a significant portion of its programs, the Bureau works with one or more of the offices or components within EOHHS that are responsible for a Medicaid activity. This continues to assure that there is a comprehensive and integrative approach in the outreach, enrollment and services provided to MassHealth, including CommonHealth, recipients. This includes involvement in waiver development, MMIS purchasing, enrollment functions and development of standards of care and quality initiatives. The Bureau performs the eligibility function for the Kaileigh Mulligan program. The Bureau strives to maximize Federal reimbursement mechanisms including FFP and municipal Medicaid opportunities. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

See Forms 17, 18, and 19 for Health Systems Capacity Indicators reporting and tracking data.

A number of the Health Systems Capacity Indicators are also being tracked closely by the Commonwealth through National Performance Measures, our State Negotiated Measures, or Priority Need areas. Information about the data trends and programmatic efforts to better understand and / or

improve them can be found elsewhere in this Application. Information about activities related to our Priority Needs can be found in the Attachment to Part IV E (Other Program Activities). Those Indicators and their corresponding (or closely related Performance Measures) are listed below:

HSCI #01 (Hospitalizations for asthma, ages 0-4): Massachusetts Priority Need # 9.

HSCI #02 (periodic screening of infant Medicaid enrollees): SPM #03 [Note: HSCI #03 is not applicable to Massachusetts as all "SCHIP" infants are enrolled in Medicaid and are therefore reflected in HSCI #02.]

HSCI #04 (Adequate prenatal care using Kotelchuck Index): NPM #18 and Massachusetts Priority Need #1

HSCI #07 (Medicaid dental services, ages 6 -- 9): NPM #09; SPM #04; and Massachusetts Priority Need #3

HSCI #08 (SSI beneficiaries under 16 receiving rehabilitative services): NPM #02 - 06
Note: All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

HSCI #05 (Medicaid/non-Medicaid perinatal care indicators): NPM #08, 15, 17, and 18; SPM #01, 06, and 08; and Massachusetts Priority Needs #1, 6, and 10.

HSCI #06 (FPL covered by Medicaid, by age group): NPM #13 and Massachusetts Priority Need #6. (See also our State Overview narrative in Part III. A. for updated information about Medicaid and other public insurance programs in the Commonwealth.

HSCI #09A, B, and C (MCH Data Capacity): NPMs #01, 08, and 12; SPM #01, 08; and Massachusetts Priority Needs # 1, 2, 4, 5, and 9.

/2005/ Overall, the Health Systems Capacity Indicators illustrate that Massachusetts has a robust systems capacity. Trend data (where shown) indicate little change in recent years. A number of the indicators (#02, 08, and many of the items in #09A, B, and C) are at their highest possible rates or scores and have been there for some time. Those related to data systems linkages and infrastructure (#09), when not in place, are under active development.

Indicators related to pregnancy outcomes and to early childhood asthma continue to indicate need of improvement and are being addressed through a number of initiatives, federal grants, and partnerships with other public health colleagues, sister state agencies or programs, and/or private organizations and programs.

For two of the HSCIs, the quality or consistency of the data is worthy of note in looking at trends. The hospital discharge database (used for HSCI #01) remains in continuous change and improvement, with Observation Discharges and Emergency Room visits being added in recent years, but not for every data year. The multiple possibilities for capturing ICD codes at various levels (primary diagnosis, secondary, etc.) make these data more challenging to interpret over time than vital statistics. Our new Asthma Planning grant will help promote closer analyses. For HSCI #07, the reported percentage of Medicaid children and youth receiving any dental services continued to rise (64% in FY00, 73% in FY01, and 86% in FY02), before dropping significantly in FY03 to 46%. The increased rates may have reflected a number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. The apparent drop, however, is

due to a major correction in the data reporting methodology. Medicaid has informed us that the previous methodology overestimated rates of preventive dental services utilization. The previous years' data need to be recalculated for a more accurate time series. We are in the process of working with Medicaid to option the corrected data,if possible. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The overall health status and access to health care services of the MCH population in Massachusetts continues to improve in many areas. At the same time, however, there are some areas in which this generally positive progress has reached a plateau, or in which poorer outcomes have persisted. While improving overall, there continue to be significant disparities in outcomes and measures for some population groups. There are also some concerning trends, such as ***/2005/continued persistent health disparities and the increase in childhood obesity//2005//***, the growing number of very low birth weight births and the increasing perinatal mortality rate, that are confronting the state. These trends require further analysis and study to identify more clearly the underlying contributing factors and develop strategies for improvement. Because of wide and growing coverage of health services through MassHealth and CMSP, relatively little Title V funding is expended on direct services. Rather, BFCH efforts are primarily focused on enabling, infrastructure and population-based services to further improve accessibility and coordination of services.

Direct health care and enabling services: The health care delivery system in Massachusetts during the late 1990's was characterized by three major trends that had implications for providing accessible, quality services to infants, children, youth, and pregnant women:

- increased financial access to health services
- growing concerns about managed care from consumers, providers and legislators
- growing financial instability of the largely not-for-profit provider health care network.

/2005/ The decrease in revenues and resulting budget shortfalls in the early 2000's have seen an elimination of the successful outreach and enrollment collaborative initiatives of the BFCH and Medicaid. A steep rise in prenatal enrollments in Healthy Start within the past year and a growing wait list for CMSP both need to be monitored closely, and contributing factors identified. The FY05 state budget contains sufficient funding to eliminate the CMSP wait list and to serve the anticipated increase in Healthy Start enrollment. Financial access, however, is only the first step in assuring quality preventive services for mothers and children and CSHCN. Resources have been directed toward assuring the availability of comprehensive, community based, culturally competent services, with a strong network of safety net providers in the Community Health Centers and School Based Health Centers. This safety net has been stretched severely over the last year, with the elimination of one-third of the school based health centers. The loss of state funding for health care access outreach, referral and follow-up presents a growing concern about access and linkages to services. //2005//

/2005/ Through the medical home initiative, restructuring of care coordination services, and increasing work with private payers, a statewide system of care coordination, especially for CSHCN, is being developed. This system is a private-public partnership that builds on a broad range of services, agencies and programs that are resources to families. Other barriers to access to health care and related services continue to be cited by parents and other consumers, including flexibility in hours services are offered, lack of transportation, lack of providers who speak a language other than English (especially in mental health), and often a lack of knowledge of what resources are available. A lack of accessible providers is an issue in oral health; many areas are without pediatric dentists, dentists participating in Medicaid, and/or dentists willing or knowledgeable in the care of CSHCN. These barriers continue to be felt during this time of reduced resources.//2005//

Population based services: Virtually all newborns are screened for metabolic disorders, and parents are offered screening for 19 additional disorders and cystic fibrosis. Massachusetts has also made great progress in the numbers of newborns who have received hearing screenings prior to discharge from a birth center or hospital. ***/2005/ During fiscal year 2005, over 99% of all newborns will receive newborn hearing screenings. //2005//*** This is a significant achievement since the passage in 1998 of a state law providing for this service. School based health centers and enhanced school services are two other mechanisms for delivering population based services that expanded through the early 2000's. ***/2005/ Since 2003, they have experienced multiple state funding changes; this***

has resulted in a destabilization of the services. //2005//

Infrastructure building services: Collaboration and partnerships on the state and local levels have been historical and consistent priorities for the DPH. The establishment and growth in capacity of the Community Health Network Area Coalitions have brought new dimensions to this emphasis on partnerships. Numerous initiatives, programs, and new strategies and approaches to health and health systems issues have had successful impact as a result. Challenges remain, in particular the coordination and integration of the services system for at risk children from birth to age 3, and improvements in and strengthening of IT systems and data linkages to support efforts in all levels of the pyramid.

/2005/ Status of Progress on Measures for FY03 Annual Report

The status of Annual Performance Objectives for Massachusetts is summarized below.

National Performance Measures (18 total):

5 Annual Performance Objectives -- No new data for FY03 on these SLAITS measures (#02 - 06). MA scored better than national average for all but #06 (transition to adult services)

11 Annual Performance Objectives Met or Exceeded (#01, 07, 08, 10, 11, 12, 13, 14, 15, 16, and 18)

Of these, # 07, 08, 10, 11, 12, 13, and 16, improved; #01, 14, 15 and 18 were unchanged (#01 is at 100%).

2 Annual Performance Objectives Not Met (# 09 and 17), which got slightly worse. (The change in #09 was not statistically different from either the previous year's or the FY03 target rate.)

State Negotiated Measures (8 total):

5 Annual Performance Objective Met or Exceeded (#01, 05, 07, 08, and 10): #01, 05, 07, and 10 improved; #08 was unchanged.

3 Annual Performance Objective Not Met (# 03, 04, and 06)

Of these, #03 improved and just missed its target; #06 was essentially unchanged; and #04 showed a marked drop due to external causes.

SPM #07 has been de-activated as of FY04. Major changes underway to early childhood agencies and programs preclude a stable measure at this time.//2005//

B. STATE PRIORITIES

From its analysis of the Needs Assessment findings, the Bureau of Family and Community Health selected the following 10 Priority Needs. Many of the areas identified by the needs assessment that resulted in the identified priorities cut across more than one level of the pyramid. The level(s) of the pyramid that each priority addresses, and the population group(s) covered by the priority, are cross-referenced on the attached table. These priorities are not listed in any "ranked" order. All are considered to be equivalent priorities of BFCH.

Priority Need #1: Improve pregnancy outcomes, including a focus on pre-conceptual health. A majority of overall pregnancy outcomes in the state continue to improve and are lower than the U.S. rates in many instances. However, the continuing racial and ethnic disparities in perinatal outcomes, and the rising VLBW and perinatal mortality rates are cause for concern and continuation of vigilant efforts in this area. BFCH recognizes that a woman's health status prior to becoming pregnant a key variable in her pregnancy outcome. Health promotion activities, freedom from domestic violence, food security and good nutrition, access to primary care and family planning are all necessary components to overall good health to ensure a healthy family.

Priority Need #2: Reduce adolescent risk factors and risk-taking behaviors, including among adolescents with special health care needs. Adolescent births have declined overall, but the chlamydia rate among females 15 - 19 continues to rise. The experience of sexual violence has been highly associated with risk factors for STDs

including number of partners and drug and alcohol use. The prevalence of mental health problems and access to services as risk factors is a major concern. The suicide rate among both 15 - 19 year olds has not improved and for 10 - 14 year olds it increased in 1998. Unintentional injuries remain an area of concern, with a rising rate of motor vehicle crash deaths among 15 - 19 year olds. Many positive trends can be seen in declines in cigarette smoking, riding with a drinking driver, and many sexual risk behaviors.

However, the majority of high school students engage in some risk behaviors that pose serious threats to their health and safety. Also, risk behaviors tend to cluster together. Students who engage in one high-risk or health-compromising behavior are often likely to engage in other risk behaviors as well. This clustering also reveals the important interrelationships between one risk behavior (e.g. drinking) and other health consequences (e.g. dating violence).

//2005/ Due to significant funding reductions in all public health youth-related services, this remains a major priority of the Department and the Center. //2005//

Priority Need #3: Improve oral health for children and youth, particularly those depending on publicly funded oral health coverage and those with special health care needs.

Improvements in prevention and access to oral health care are critical needs for children and youth. Access to care for children covered through MassHealth is severely limited due to declining numbers of Medicaid-participating dentists; the availability of other safety net providers providing care to low income uninsured children is also in jeopardy. Children with special health care needs, particularly the large number covered by MassHealth, have even more restricted access to care. Prevention services such as fluoride mouthrinse programs for children in non-fluoridated communities and sealants are not widely implemented.

//2005/ Concern remains about access for Medicaid and the FY05 state budget requires the state to hire a third party administrator for the program. In addition, Medicaid is responding to a class action suit to expand access.//2005//

Priority Need #4: Enhance data systems and incorporate new technologies to support MCH service provision, data management, performance measurement and electronic service delivery, in a managed care environment.

BFCH has developed its capacity for electronic data collection and dissemination to a sophisticated level - for example, the implementation of Mass CHIP, a multi-database user-friendly web-based application that makes population health status data, data from other databases and demographic data publicly available. However, the efforts to implement such applications have also increased the awareness of the complexity, necessary skills, and costs of using these still-evolving technologies. A potential that remains largely unfilled is to create linkages among multiple databases to allow a more integrated analysis of maternal and child health status and services. A closely related issue is providing assistance in the availability of technology and knowledge capacity among local MCH providers and communities so that they can utilize developing applications.

//2005/ BFCH programs are part of the EOHHS integrated information, eligibility, and referral system, Virtual Gateway, which will enhance program enrollment between public insurance programs, WIC, EI, food stamps, and child care. The system will be piloted in July, 2004, and expected to expand to include all programs and additional functions during state FY05. //2005//

Priority Need #5: Develop and implement an integrated system for early risk identification, follow-up, referral, services, and family involvement for children ages birth to 3.

//2005/ The Bureau has a number of programs and services for the birth to three population, including Newborn Hearing Screening, FIRSTLink, Primary Care, WIC, EI Partnerships, Early Intervention, Growth and Nutrition, and other specialized services for CSHCN in this age group. During FY04 additional efforts have occurred with the federal Early Childhood funds supporting efforts of a legislative mandated council composed of the Commissioners of DOE, Office of Child Care Services, and Public Health. A plan was developed to begin the coordination of all state services -- from program standards, referral flow, screening protocols, provider training and technical assistance, performance measures, and especially data linkage. The legislature has created a new department for Early Education and Care to be established during the next year. It is unclear at this time what this will mean for the DPH

programs and the plan developed by the Council. It is expected that additional clarity will occur during the next several months.

Over the last several years, there has been a significant and continuing expansion in state and federal funding for other services for the birth to three population in Massachusetts, including the Mass. Family Network (Department of Education), Early HeadStart, expanded child care services, and other local and private provider initiatives. //2005//

Priority Need # 6: Assess the impact of health care delivery, insurance, immigration, and welfare systems changes on access to and quality of care for women, children and youth and on MCH service programs.

As responsibility for the structure of many programs affecting families and immigrants as devolved from the federal government to the states, Massachusetts has taken advantage of this flexibility to restructure its public insurance, welfare, and related benefit systems. To date, the results have been a significant increase in children and families insured through MassHealth (Medicaid), and a significant decrease in families receiving transitional assistance (welfare) and food stamps benefits. Immigrant women and families are still eligible to receive state-only benefits but are generally ineligible for federal benefits. The long-term impact of these massive system changes on health care utilization and health outcomes is still unknown.

Priority Need # 7: Develop and implement initiatives that address violence against women, children, and youth.

Domestic violence and sexual assault have far-reaching effects on maternal and child health populations. The Governor declared domestic violence a public health emergency in 1992 based on the alarming number of cases of domestic homicide. Yet this is only the most severe outcome of a range of violence experienced by women and children. Nationally, intimate partner violence is the single major cause of injury to women and is associated with many other serious health problems including depression, anxiety, post traumatic stress disorder, chronic pain, gastrointestinal disorders, substance abuse, HIV infection, suicide, and pregnancy complications. While there is an extensive network of services, it is insufficient to meet the need, with almost 4000 women being turned away from shelter or safe home services in 1999. In addition, an increasing body of literature demonstrates serious consequences for children who live in homes where there is intimate partner violence. In addition to the effects of witnessing violence, numerous studies show direct connections between domestic violence and child abuse. The relationship between sexual assault and suicide for adolescents is also being better elucidated.

Priority Need # 8: Develop and implement public health programs and policies that promote positive mental health for the MCH population, and collaborate to improve access to appropriate mental health services.

Across many diverse BFCH programs, mental health needs among the MCH population and a lack of mental health service capacity have been identified as critical issues. The state Department of Mental Health has limited resources and provides care to only those with severe chronic mental health diagnoses.

//2005/ Over the past two years a Governor's Commission has been meeting to identify the major issues, barriers, and gaps in services and to develop a plan for addressing the complex issues related to providing access to services and decreasing the number of children who remain stuck in residential services or hospitals due to lack of resources. //2005//

Priority Need # 9: Monitor and develop strategies to address childhood health conditions that are increasing in prevalence, including asthma and obesity.

Childhood health conditions continue to change in prevalence, complexity and range of related issues. A systematic, proactive approach is needed to monitor and study these changing health issues, and develop appropriate public health strategies to address them. Asthma and obesity are two current examples of health conditions with rising prevalence, significant health implications and impact, and considerable complexity. This priority need allows the flexibility to shift that focus as warranted.

//2005/ Utilizing CDC funding, state plans and initiatives are being developed in both of these

areas. USDA has provided targeted funding to focus on the Hispanic population. //2005//

Priority Need #10: Improve accessibility and utilization of MCH services, with emphasis on 1) cultural competency; 2) service availability in rural areas; and 3) increasing public knowledge about MCH services.

The BFCH makes every effort to assure that MCH services provided or funded by the Bureau are available where underserved, high-risk populations reside. However, BFCH has identified through focus groups and surveys that many residents are neither specifically aware of the resources available nor how to access needed services. Program participants and parents repeatedly stress the need for greater flexibility in service availability, including days and time of day. Also, although cultural competency in service delivery is emphasized in all BFCH programs, the lack of services, especially mental health and substance abuse services, in appropriate languages has also been identified as a major concern in the needs assessment process. Other traditional barriers to service access continue to be a challenge for Massachusetts families, including transportation. This is especially problematic in the more rural areas of the state, with the relative isolation of many residents.

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

Individual, manual cross-checking activities in cooperation with participating nurseries, to assure specimens were received from all babies, continued in 2003. Efforts continued to obtain satisfactory specimens from all babies from whom at least one unsatisfactory specimen was received. Any remaining babies were extensively tracked and efforts documented.

b. Current Activities

All newborns have blood spot specimens collected before hospital discharge and sent to the New England Newborn Screening Program (NENSP). Babies with initially unsatisfactory specimens elicit a telephone contact within 24 hrs notifying of the need for follow-up. The baby is flagged in the database to appear on a repeat specimen required list, and automatically unflagged when the repeat specimen is logged in. Staff monitor this list weekly and track and follow-up babies from whom repeat specimens do not arrive. Every newborn with abnormal results is tracked to a normal result or appropriate clinical care.

As part of ongoing quality assurance, electronic files are submitted to the NENSP from a selected hospital NICU, Community Health Center, and pediatric practices with data on all babies either in their nursery or being seen in their pediatric practice. These files are electronically matched to specimens received: non-matched babies are reported back (to get specimens).

Staff of programs in the Division for Special Health Needs and the Division of Perinatal and Early Childhood Health meet with New England Newborn Screening Program (NENSP) to maintain and strengthen the linkage between NENSP and BFCH programs, especially Care Coordination for CSHCN, Early Intervention (EI), and the Early Intervention Partnerships Program (EIPP) to assure follow-up of families of identified newborns and linkage to service. Staff of the Genetics program also meet regularly with this advisory committee to assist in policy development and explore ways to increase the linkage of genetics diagnostic centers with the NENSP and BFCH programs for families of children with identified conditions.

The Integrated Systems for CSHCN project implemented a process with the NENSP that adds specific language to the fax form sent to physicians to inform them of an out-of-range blood

screen for an individual newborn. This notification routinely informs the physician of the Community Support phone line for referring these infants and their families to EI, EIPP, Care Coordination, Family TIES and technical assistance. The NENSP also shares monthly aggregate data for infants in the hemoglobinopathies and cystic fibrosis programs with the Division for SHN.

The Newborn Hearing Screening Program has received legal access to link to EI data to ensure that children identified with hearing loss are enrolled in EI. Staff are working with further linkage with the PELL database.

c. Plan for the Coming Year

The Integrated Systems for CSHCN project and the NENSP will articulate a process for integrating NENSP data for all MA newborns who are screened, and implement a follow up process for infants identified through screening. The project will also establish a process for referrals from diagnostic centers to Care Coordination, EI and other MDPH programs and services. Linkage with birth defects surveillance data will also be clarified.

The Genetics program will print and disseminate "GeneSense" fact sheets as part of public health genetics educational campaign.

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

Through the Family Initiatives program, family members participated on all Division for Special Health Needs advisory committees. All parents received stipends and mentoring. They were asked for evaluations of how/whether skill building activities helped them in other areas of their lives over time. All participating parents were invited to become advisors to the department, with over 50 indicating interest in advising in a variety of areas, including development and review of the MCH Block Grant, programmatic development, and outreach.

Families of CSHCN provided substantial consultation to the development of a state mandated "Family Support Plan" to provide flexible supports to meet family identified needs and enhance community participation.

The Family TIES project received 2415 calls and 53,000 "hits" on its website. Staff posted 5 "questions of the month" to the website, including questions on mental health services, dental care and childhood obesity, and distributed 6500 brochures in English, Spanish and Portuguese, 3000 Resource Directories, and 12 newly developed fact/tip sheets on a range of topics including autism, mental health and medical home.

Family TIES co-sponsored the annual statewide parent/professional conference "Strong Families in Changing World," with 600 parents attending. Family TIES also surveyed 198 parents on understanding of and satisfaction with care in a medical home, available in English, Spanish and Portuguese.

The Early Intervention Parent Leadership Program (EIPLP) toll free line received 662 calls and 8 editions of the project newsletter "Parent Perspective" were written and disseminated to over 800 parents and professionals.

Parent Information Kits were distributed to approximately 815 parents of children with hearing loss and to professionals who provided services.

MDPH, New England SERVE, and the Alliance for Health Care Improvement have nearly completed the redesign and update of "Directions", the bilingual parent resource manual which will be targeted to families of CSHCN who receive insurance through the state's five largest nonprofit managed care plans.

The SSI Benefits program provided technical assistance (TA), information and referral calls to 100 parents statewide; increased the number of informed parents who applied for benefit programs (SSI, CommonHealth, Kaileigh Mulligan Program and MassHealth); and increased the number of 'peer advocates' to assist other families in navigating public benefits and services systems for CSHCN. Training programs included approximately 36 parent participants.

b. Current Activities

The Director of Family Initiatives co-chairs the Family Participation Working Group of the Consortium for CSHCN. The group showcases contributions of family organizations and supports opportunities for family involvement with member organizations. The Director also participates in an interagency planning group to develop and implement Family Support Plans.

Training programs on SSI/public benefits systems are presented directly to parent groups and parent leadership organizations to empower parents to negotiate for benefits and services for their children. Telephone TA, information, and referral further assist parents in navigating systems and advocating for their child's needs.

The SSI/Public Benefits resource line was restructured with added staff and written guidance to assist the Care Coordination program to handle the increased volume and enhanced TA for providers and parents through a central phone. Providers and families were mailed notice of the enhanced line.

A Public Benefits Specialist provides additional training and consultation with staff and parents as liaison to Boston Children's Hospital.

Parents and consumers actively participate in the UNHSP Advisory Committee and recommend program policies and procedures. Parent Outreach staff provides support, TA, and distributes, upon diagnosis, Parent Information Kits, with resources and specialty programs for families with newborns and young children with hearing loss.

Families participate in regional meetings to facilitate emergency preparedness. See the Attachment to this section for the 2004 Family TIES Survey and findings related to Emergency Preparedness for families of children with special health care needs.

A first printing of the Directions manual will be distributed to all MA pediatricians, which will ensure that families who need the manual will receive it directly from their child's PCP.

School-based Health Center (SBHC) standards address accessible services and parent satisfaction. The new funding cycle RFR required that all "provide effective care coordination for all SBHC users and all enrolled CSHCN based on written individualized care plans."

The Catastrophic Illness in Children Relief Fund Commission approved the creation of a Family Advisory Board to educate members of the Commission on the needs of families with CSHCN.

MassCARE families participate in decision-making services and activities through site visits,

focus groups and satisfaction surveys. Consumers also are paid program staff.

c. Plan for the Coming Year

The Family Initiatives Director will serve on the Title V Five-Year Needs Assessment Steering Committee, and parents will actively participate in determining priorities.

Families Initiatives staff will participate in planning for the Massachusetts Early Childhood Comprehensive Systems Grant.

Family Initiatives staff will participate in the Focused Monitoring Workgroup of EI system stakeholders to develop a statewide system of monitoring and accountability.

Family Initiatives will participate in an interagency collaboration to support emergency preparedness for CSHCN and other individuals with disabilities.

Family TIES will recruit and train "Project Associates" to expand training and information sharing opportunities.

The EIPLP staffing structure is being modified, increasing hours to ensure connection with more families and EI programs.

Family TIES and the EIPLP will collaborate to visit all EI programs to provide information, training, and support to families in natural environments.

A contract for Family TIES evaluation with Dr. Sara Bachman will be implemented.

The newborn hearing screening program will disseminate parent satisfaction surveys to approximately 3250 families to assess satisfaction with family-centered services to infant and young children from screening through EI.

SBHC staff will conduct site visits that include medical chart reviews to assess quality of individualized care plans.

The Catastrophic Illness in Children Relief Fund will recruit parents of CSHCN to participate in the Family Advisory Board and begin meeting.

Call volume on the Public Benefits statewide community support telephone line for CSHCN will increase. The program will expand the linkage of public benefits training and resource staff to other area hospitals.

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

The Medical Home Networking Project was replicated and well received in 3 additional regions in the state. CMEs were given to all physician participants, and a roundtable discussion was held to summarize and share lessons learned.

Care Coordinators and staff played key roles in planning and presenting an AAP/Shriners-sponsored "Every Child Deserves a Medical Home" training in Western Massachusetts. DPH developed a new regional resource guide for the training, which was attended by a record number of MDs. The Western Massachusetts Consortium for CSHCN grew out of the interest it

generated.

The UNHSP continued to work with Jane Stewart, MD, the Early Hearing Detection and Intervention (EHDI) champion and active member of the UNHSP Advisory Committee. Collaborated with Dr. Stewart to develop a survey that will be disseminated to primary care clinicians next year.

Home visitors in the FIRSTSteps program worked with enrolled families to ensure that the child had a primary care provider, and helped families access medical visits as needed. Nurses on the multidisciplinary team collaborated with the child's primary care provider to ensure a coordinated plan of care. This program ended in March 2003, and was replaced by the EIPP (see current activities).

Approximately 82% of CSHCN aged 1-18 who were seen at least once at a School-based Health Center reported having a medical home. Retrospective chart abstractions were evaluated in terms of the quality and clinical appropriateness of the information exchanged between primary care providers, parents and SBHC staff.

In the first 4 months of the school year, Essential School Health Service Programs (representing 510,490 students) referred a total of 70,915 students requiring care to their primary care providers. Of these, 5499 were students without primary care providers who were then linked to providers.

b. Current Activities

Care coordinators for CSHCN work in several large pediatric primary care practices across the state. They help primary care physicians design realistic, family-centered care plans and establish focused, streamlined office systems to improve the quality of care for CSHCN and their families. They help families optimize insurance coverage, access public benefits, find parent to parent support, and become better advocates for themselves and their children. They also attend school meetings and facilitate many aspects of youth-to-adult transition. Care Coordinators moved into 6 new primary care pediatric sites, bringing to 13 the total number of Medical Home practices, and program evaluation has begun. The SSI and Public Benefits Outreach provides centralized access and referral statewide.

Care Coordinators actively participate in the Care Coordination and Transition workgroups of the MA Consortium for CSHCN. The Directors of Family TIES and the Medical Home Project are members of the Consortium Steering Committee. The Director of Care Coordination/Medical Home Initiatives chairs the Consortium's Medical Home Steering Committee, which has launched a web-based survey of decision-makers in all medical schools and pediatric residency training programs to gather and share data concerning CSHCN-related medical education.

Through various parent organizations, Family TIES surveys families about their understanding of medical home concepts and requests referrals to physicians currently providing elements of medical home.

FIRSTLink and FOR Families programs assess whether CSHCN have a medical home and make referrals as needed. FOR Families staff followup to ensure that the referral is active and ongoing.

The EIPP has formal linkages with medical providers and hospitals for continuity of care. MCH nurses and social workers ensure that enrolled children and families receive comprehensive health assessments, with linkage to primary and specialty health care providers, and referrals to community-based services.

UNHSP verifies that each newborn/family is linked to a PCP and helps families with access and referral. AAP is actively represented on the UNHSP Advisory Committee and provides feedback on program guidelines and activities. The program also conducts outreach to primary care clinicians that serve families with children with hearing loss, with the assistance of Dr. Stewart (see past activities) and other PCPs.

School health programs and school based health centers work to strengthen the communication between students, family, and PCPs. They work with the Executive Committee of School Physicians to promote coordination between school personnel and PCPs. School districts are given sample emergency cards with the PCP's name to facilitate communication. ESHS/SBHC require that students be assessed/referred for primary care, dental provider and health insurance.

MassCARE offers care coordination and links to primary/specialty care to children with HIV.

c. Plan for the Coming Year

Family TIES staff will work directly with Care Coordinators to recruit and mentor families to develop Family Advisory Councils at the pediatric primary care practices.

Directions, a resource guide with expanded information about how to use a medical home will be distributed to providers and families.

An evaluation will be completed of the current medical home physician practice model, and a plan developed in response.

The Comprehensive School Health Manual revision will include the new school physician role template, which focuses on the school physician as a liaison to the community providers.

School Health will revise the physical examination form completed by the PCP prior to entry into school, every 3-4 years after, and annually prior to participation in competitive sports.

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

The SSI and Public Benefits Outreach, Training, Technical Assistance and Policy program provided 15 training programs in public health insurance benefits to 214 participants. Program staff responded to 258 statewide technical assistance requests through telephone and email. Training participants included hospital resource specialists, social workers, patient care coordinators and financial coordinators, as well as Parent Leaders of a Parent Initiative and a Family Leadership organization.

b. Current Activities

It is a mandate for all BFCH programs that have direct contact with children and families to screen for health care access and insurance coverage, and make referrals and provide assistance with enrollment and access as appropriate to the program and the family. In particular, SSI and Public Benefits Outreach, Care Coordination, EI, EIIP, FIRSTLink, school health and school-based health centers, FOR Families, and community health center based programs are key venues for this activity. The largest single service to families by Care

Coordination for CSHCN is assistance with accessing and optimizing health plan benefits.

Additional wrap-around coverage above or in place of insurance is available to families of CSHCN through the Special Medical Fund and the Catastrophic Illness in Children Relief Fund. Care Coordinators assist over 600 eligible families annually using the SMF, reimbursing costs of goods and services related to raising a child with special health care needs. The CICRF can provide direct funding to families whose insurance is inadequate to cover their medical expenses.

Family TIES coordinators provide information to parents and providers about insurance options, changes in programs and eligibility. Family Initiatives and Family TIES partner with Massachusetts Family Voices to disseminate information and train families about options.

The SSI Benefits program provides training on eligibility, application process and appeals for SSI, CommonHealth, Kaileigh Mulligan Home Care, and MassHealth to DPH Care Coordinators, hospital social workers, EI programs, health care providers, parent organizations, school personnel, state agencies, human service and advocacy agencies who help families in applying for benefits that include public insurance and managed care networks. Technical assistance is also provided through telephone and email. An annual mailing of updates on SSI eligibility criteria is made to over 500 key contacts, including pediatric primary health care settings.

SSI Benefits staff participates in bi-weekly meetings of the Children's Health Access Coalition, which continually assesses the percent of the population receiving adequate health coverage and actively monitors the effect of health insurance reform on groups including CSHCN. Staff also regularly participate in quarterly meetings of the Covering Kids and Families Coalition, which monitors and assesses the effect of federal and state health insurance reform on children, especially CSHCN.

Key staff have been identified and discussions are beginning to reestablish linkages to Medicaid long-term care programs that have been transferred to the Executive Office of Elder Affairs.

BFCH school health staff work closely with MassHealth to have all schools assess every child at entry for health insurance, and refer those who do not. This is a requirement for all public school districts and nonpublic schools with Essential School Health (ESHS) grants.

c. Plan for the Coming Year

Continue to assure minimal levels of coverage.

Actively participate in Executive Office of Health and Human Services (EOHHS) meetings to discuss and review various options being developed related to health care reform.

Enhance and further strengthen linkages and referral processes for CSHCN in SSI, Kaileigh Mulligan, and CommonHealth with the long-term care components of Medicaid that are now located in the Executive Office of Elder Affairs (EOEA).

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

Due to hiring constraints, the Care Coordination Program was unsuccessful in engaging a Medical Home Family Advisor last year to catalyze the creation of family advisory structures inside the primary care partner practices.

b. Current Activities

Family Initiatives, Family TIES and the EIPLP provide information and support to families to partner with community-based service systems including EI programs. Essential Allies training is offered to EI programs and community-based agencies.

Through the MASSTART program, 4 specialty providers are funded to provide consultation and training to families and school personnel statewide, allowing medically-involved, often technology-dependent children to attend public school. School personnel are trained on how to understand and meet the special needs of individual children and adolescents. Contracted vendors assist families and schools with developing Individualized Health Plans and Emergency Plans for school, to be incorporated into IEP of children who are medically-complex or technology-dependent. They also provide information, referral and community resources concerning services for children and adolescents assisted by medical technology.

The Massachusetts Consortium for CSHCN, of which DSHN staff are members of the Steering Committee and workgroups, has launched a new workgroup on Family Participation.

School-based Health Center standards include a Continuity of Care standard that specifies that SBHCs develop a collaborative relationship with students, their families, school health programs, and other health care providers in the child's community. SBHCs must also develop written policies to obtain student and/or parental consent to share information regarding the student's health care. An Access Standard specifies that SBHC services must be easily accessible and designed to eliminate or diminish barriers to care for students and to participation by parents or guardians. Additional sub-categories of standards include the requirement to administer a student survey to obtain feedback on satisfaction and the need to accommodate working parents.

MassCARE offers a community-based system of HIV specialty care throughout the state, with 8 community service systems and 3 regional perinatal centers. Services include primary and specialty care, access to clinical trials, support groups, and a network of activities for families.

See also NPMs 2, 3, and 4

c. Plan for the Coming Year

The Family Initiatives program will partner with a number of family organizations to raise the awareness of community-based systems of care to the principles of family-centered care. This increased awareness will assist community providers to make services more responsive to family needs and thus increase family satisfaction.

See also NPMs 2, 3, and 4

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

The Abstinence Education Media Campaign solicited feedback from special health care needs

participants and program providers to adapt messages as needed. It also ensured availability and access of education materials and collateral items for youth with special health care needs and their families.

DPH participated in the planning and implementation of the 3rd annual Youth Leadership Forum for high school juniors and seniors with disabilities. The FY03 YLF was a one-day leadership training program sponsored by the Governor's Commission on Employment of People with Disabilities and Harvard University in collaboration with other state agencies and organizations. 25 youth and 6 young adults who served as peer leaders participated.

b. Current Activities

The DSHN participates on the leadership team for the Massachusetts Partnership for Youth in Employment (MPYE), a federal grant to the Institute for Community Inclusion to improve transition and employment outcomes for youth with disabilities/special health needs. The grant will develop state level resource mapping, a cross-agency plan to braid state, local/federal resources, and fund and evaluate 8 community-based pilot projects that address identified gaps in services and resources.

The DSHN Deputy Director is an active member of the National Disability Mentoring Council, a federal grant to Partners for Youth with Disabilities (PYD) to promote mentoring programs for youth with disabilities across the nation. The Council serves as the primary advisory committee for the development of PYD mentoring initiatives. The Deputy Director also serves on the Evaluation and Dissemination sub-committees.

Through a CDC grant, the DSHN contracted with Boston University to form the Massachusetts Health and Disability Research Partnership (MHDRP), to develop resources to assess transition to adulthood for young people with disabilities. Two grant proposals were submitted to conduct a longitudinal study, recruiting adolescents from an urban health plan and the Massachusetts Hospital School. MHDRP established a MA Transition Advisory Board (M-TAB), a 17-member consumer group to advise on this project and related issues/activities. Focus groups are being conducted with adolescents with disabilities.

The DSHN Deputy Director participates on the planning committee for the 4th Youth Leadership Forum for high school juniors and seniors with disabilities, to be held in September 2004. MDPH will cosponsor this one-day forum, with the Governor's Commission on Employment of People with Disabilities, Harvard University, and Partners for Youth with Disabilities.

The SSI and Public Benefits coordinator is active in the statewide SSI Disability Coalition (bi-monthly meetings). Recent focus has been on the new information and resource materials on the Ticket to Work and Work Incentives Act. She is also an active member of the state Disability Determination Services Advisory Committee.

The SSI and Public Benefits program includes information and referral resources and training for agencies serving transitional youth re: 'Ticket to Work' updates, Protection and Advocacy for Beneficiaries of Social Security (PABSS) and Benefits Planning agencies in MA (Project Impact and BenePlan). Training and telephone/email TA are provided to agencies serving youth in transition such as ARCs, school systems, DMR, DMH, and community-based human service agencies. Information provided includes disability and income criteria for SSI and CommonHealth for transitioning youth.

The Family Initiatives Director and Family TIES training coordinator develop/deliver workshops on health care transition for families.

c. Plan for the Coming Year

Focus groups will be completed and an article drafted for submission to a peer-review journal. The M-TAB consumer advisory group will discuss findings and recommendations from the focus groups. Depending on funding, the longitudinal study to identify variables that affect transition outcomes for youth.

Five SBHCs will participate in a Kellogg-sponsored initiative which has as one of its objectives "to empower students to become advocates for their own health care needs". The Mass. Dept of Education "Comprehensive Health Education Curriculum Frameworks" will be implemented to encourage the attainment of health literacy and advocacy skills.

The Abstinence Education Media Campaign will distribute a minimum of 7,000 brochures and posters for youth with special health needs and their families, and provide referral services.

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

Among WIC enrolled children, 64.2% aged 24-29 months received their 4-3-1-3 series by 24 months of age and 77% children aged 12-17 received their 3-2-2 series by 12 months. (Note that this figure is lower than reported in previous years due to a change in the data analysis format and time period.)

FIRSTSteps home visitors provided families of high-risk infants and children (pregnancy to age 3) with education on the importance of immunization, assisted with access to well-child care, and monitored the child's immunization status. The Massachusetts Immunization Program (MIP) required these community-based staff to attend regional trainings to ensure current knowledge. MIP trained 92 staff and distributed materials including videos to an additional 68 staff. (This program ended in March 2003).

MIP provided an RN to meet with local pediatric program staff to assess current practices and implement MIP recommendations. The RN helped develop more effective reminder/recall systems; review and updating of immunization documentation in medical records, sustainable outreach strategies for patients with overdue immunizations.

Health Care Benefit Specialists provided information and referral to primary health care providers in the CMSP network. Specialists are multi cultural and multi lingual, thereby providing information that is appropriate and sensitive to the member and their household. In October 2003, severe budget constraints necessitated the creation of a wait list, elimination of emergency room benefits and Health Access/CMSP Health Care Benefit Specialists, who provided parents information and referral to primary health care providers.

b. Current Activities

All BFCH programs that interact directly with families of infants and young children are charged with assessing for health care access and the child's immunization status. Referrals and assistance with access to care are offered to families of children who are not fully immunized. Immunization assessment, education and referrals are provided at all certification and recertification visits. Routine immunization assessment and referral by WIC staff is a contract performance measure, monitored during annual evaluation of program's performance. WIC provides training, monitoring and evaluation of program activities, and technical assistance to programs with rates below the state average.

Bring a Book, Get a Book campaign, funded by the MIP, serves as an incentive for parents/caregivers to bring updated immunization records to their WIC appointment and receive a children's book.

The MIP Immunization nurses and specialist continue to conduct immunization assessments at contracted primary care provider agencies (typically community health centers). Immunization rates for 2-year olds are a performance measure under their Combined Primary Care Program (CPCP)-Pediatric contracts. Program staff coordinate assessments and follow-up with the immunization staff of the Boston Immunization Program for the 16 CPCP-Pediatric sites in Boston.

EI programs provide on-going information and resources to families on numerous well-child issues, including immunization schedules, during home visits and other aspects of service provision. Program based service coordinators work with families to provide well-child information and resources and to incorporate this information into the IFSP as needed. FOR Families home visitors facilitate referrals and obtaining immunization records for homeless children.

In the CMSP network, pediatric providers are expected to provide EPSDT periodicity schedule and immunization standards determined by MassHealth (Medicaid and SCHIP programs). Immunization is promoted through third party administrator for CMSP, as part of quality assurance and patient satisfaction measures, and through patient education materials given to parents. Provider reimbursement was increased for those preventive services provided in accordance with EPSDT periodicity schedules. Most immunization for this group is provided free by the Commonwealth.

c. Plan for the Coming Year

CMSP will be transferred from DPH to the EOHHS, MassHealth Office of Acute and Ambulatory Care. The incorporation of the CMSP program with other MassHealth programs will ensure that the children will benefit from all quality improvement measures and projects implemented by MassHealth for preventive services (including immunization). Regular discussions with the Office of Acute and Ambulatory Care assure a continued focus on meeting immunization guidelines and payment adjustments for the administration of vaccine.

DPH participates as member of the EOHHS Health Reform Planning Team to assure information related to meeting immunization standards is included.

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

a. Last Year's Accomplishments

The Teen Pregnancy Prevention coalitions provided a service model focused on positive youth development. Due to reductions in FY03 funding midyear, activities delivered by the Teen Pregnancy Prevention coalitions were limited. A total of 4,529 activities were delivered to youth and families by the 17 community coalitions, compared to an average of 7,500 activities in previous years. These activities included a focus on HIV/AIDS, STIs, human sexuality and tobacco use. Strategies to implement a new service delivery model were reviewed.

The Abstinence Education Media campaign broadcast television and radio health messages for youth and their families; distributed abstinence-related educational materials and media products to approximately 1000 providers; and posted and distributed public transit cards and posters.

Continued review, finalizing, and dissemination of the updated Adolescent Health Report.

Family Planning clinical sites provided state funded services to 15,880 adolescents in fiscal year 03, a 4% increase over fiscal year 02 (15,199 served). Family Planning vendor site assessments were conducted to ensure compliance with standards including specific standards on services to adolescents.

The Family Planning Program continued ongoing quarterly Education Director's meetings to provide technical assistance and support to programs (despite funding elimination).

Of all FIRSTSteps home visits, 69% included the provision of family planning education or referrals to family planning. All core training to home visitors and supervisors addressed both adolescent and family planning issues. (This program ended in March 2003)

SBHC clinicians have received extensive training on adolescent sexuality including the examination of motivational influences that encourage pregnancy. Through a collaboration with JSI Research and Training Institute SBHC clinicians have been trained in "stage of change counseling", motivational interviewing and various topics on adolescent sexuality.

Approximately 35% of SBHC visits of female clients ages 15-17 yrs. involved screening for pregnancy risk. Risk reduction/prevention counseling was provided as appropriate

b. Current Activities

The Abstinence Program develops/distributes health messages in various media, community events and conferences, and maintains a tracking system to support service provision and performance measures. Media developers engage faith-based organizations and community meetings in product development.

Adolescent pregnancy prevention programs were redesigned due to a 95% loss in funding. Challenge Fund programs closed mid-year. Six science-based teen pregnancy prevention programs were funded in the cities of Brockton, Chelsea, Holyoke, Lowell, Lynn and Springfield, communities with teen birth rates at least double the state's rate. Science-based programs being replicated include the Teen Outreach Program (TOP); Making Proud Choices; and California's Adolescent Sibling Pregnancy Prevention Program. After hiring and training in the curricula and youth recruitment, delivery of the curricula and services began in April 2004 with full implementation expected September 2004.

The Adolescent Health Report was completed and disseminated.

A statewide system of Family Planning (FP) agencies provides clinical services to adolescents. BFCH staff monitor service delivery and provide technical assistance to ensure compliance with program standards. The FP program works with Keep Teens Healthy, a Medicaid program providing family planning outreach to high-risk teens, and with the HIV/AIDS Bureau and John Snow, Inc (JSI) to offer training on behavioral risk assessment and sexual history.

Family planning services were reduced 41% in FY04, closing multiple sites, including a high-risk community that serves 50% teens. Services were reduced at other sites statewide. Analysis of interpregnancy interval data for teen mothers is contributing to understanding of need for family planning services by geography and maternal characteristics.

EIPP follows high-risk women and families in 9 communities from pregnancy through 1 year postpartum. Screening and education on health risk behaviors, especially related to reproductive health, with family planning referrals, are a core component. Of EIPP clients, 206 were teens under age 21 with at least 2 children.

SBHC clinicians screen adolescents for reproductive health behaviors, STIs (including HIV) and pregnancy risk. Adolescents at risk are evaluated further to formulate a risk reduction plan. SBHC clinicians are trained on "The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior" including Health/Social Intervention Training. Special programs each year during Pregnancy Prevention Month and SBHC "girls groups" inform

young women about healthy decision-making and delaying pregnancy.

With reductions necessitated by decreased funding, community health centers continue to provide services tailored for adolescents, including pregnancy prevention and family planning.

c. Plan for the Coming Year

Based on decreases in funding and increased city-town earmarks, the newly funded Teen Pregnancy Prevention programs will be adjusted, with additional cities/towns funded to implement science-based and other teen pregnancy prevention programs.

The Coordinated School Health Program, in collaboration with DOE's HIV Program, will sponsor a conference focused on HIV, STD and pregnancy prevention for Latino youth.

Through continued collaboration with JSI Research and Training Institute, SBHC clinicians will receive training on "client-centered techniques" and clinical courses pertaining to adolescent health and sexuality. Ensure that this training addresses differences in adolescent development for Black and Latino youth.

The Family Planning Program will complete a comprehensive statewide needs assessment that has incorporated health indicators for adolescents. Family planning services will be re-procured for FY06 and it is expected that the RFR will prioritize service provision to adolescents.

The Abstinence Education Media Campaign will broadcast television and radio health messages for youth and their families, including those with special health needs; distribute media products, and develop additional health education materials.

The Holyoke community health center is collaborating with community partners to initiate adolescent-specific health and social services.

Continue analysis of interpregnancy interval data in Pregnancy to Early Life Longitudinal (PELL) Database.

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

a. Last Year's Accomplishments

The Office of Oral Health, in collaboration with Essential School Health Services Program and the Massachusetts Department of Education conducted a statewide oral health survey of third grade school children. 3,439 children were screened. Survey results revealed that 54% of Massachusetts' third grade school children have at least one dental sealant on a permanent molar.

The Care Coordination Director and the Medical Director of the Medical Home Networking Project co-presented on "dental homes" to the Massachusetts Academy of Pediatric Dentistry and secured MAPD's commitment to participate in the MA Consortium for CSHCN.

CMSP's dental benefit included protective sealants for children. The CMSP reimbursement rate is similar to private industry contracted rates which reduces access problems due to low reimbursement rates. Of children in CMSP ages 7-9, 23% received dental sealants. Since CMSP is often used between instances of private health insurance coverage, many of the enrolled CMSP children may have already had dental sealants.

School Health and the Office of Oral Health collaborated to implement sealant programs in the schools. In the first four months of the school year, 18% of the 96 ESHS school districts reported participating in dental sealant program.

b. Current Activities

See also activities for SPM #4.

Report of the 2003 survey has been published, and gaps in services are being identified. The Office of Oral Health is working with school health officials and the dental institutions in Massachusetts to expand school-based and school-linked oral health programs.

A statewide dental sealant program is currently operational in 31 communities serving over 4000 high-risk school children.

Expanded school-based and school-linked dental sealant programs in rural communities and high risk areas now reach children in New Bedford, North and South Worcester Counties, Central Berkshire County and other parts of western Massachusetts, Boston, Chelsea and Lowell. Fourteen new school-sites recently instituted school-based or school-linked dental sealant programs.

Provider enrollment in the CMSP dental network (Wellpoint Dental) continues to be a priority. One-on-one meetings with potential providers, the Director of BFCH Health Access operations, and third-party administrator staff coordinate provider enrollment. Dental Education Materials are provided twice a year to members.

All contracted pediatric primary care sites provide screening and referral for oral health care, although one has reduced availability due to issues related to reimbursement and funding support for oral health care. Other providers also have fiscal concerns related to the service. BFCH staff continue to strategize and encourage implementation of oral health guidelines and to facilitate communication between contracting agency staff and appropriate oral health resources.

The ESHS programs require the development of a plan for oral health services which addresses 1) the assessment of oral health status as outlined by MDPH, 2) the provision of dental sealant programs either directly or through referrals, 3) implementation of school-based fluoride rinse programs in communities with non-fluoridated water, 4) review of vending machines, 5) school activities (events and fund-raisers) and food services with the goal of reducing sugar and starch intake, and 6) implementation of guidelines to ensure mouth-guard use in relevant contact sports. They also require that every child be assessed to determine whether he/she has a dental provider.

c. Plan for the Coming Year

Survey data will be evaluated and used by the Office of Oral Health to identify gaps in service. A plan to expand dental sealant programs to include high-risk communities where services currently are not available will be developed.

The revised Comprehensive School Health Manual will have a chapter devoted to oral health.

CMSP will be transferred from DPH to the EOHHS, MassHealth Office of Acute and Ambulatory Care. Wellpoint Dental will be retained until a contracting change necessitates that all CMSP children access dental services through MassHealth. Title V staff will work with the Acute and Ambulatory Care program to continue to expand the CMSP network and develop a

plan as required under FY05 state budget language to contract with a third party administrator for the state Medicaid oral health program.

Essential School Health and School-Based Health Center programs will be reviewed to assure inclusion of all oral health components. TA will be provided to schools with inadequate plans or upon request.

Continue to explore needs/gaps for children with special health care needs and develop plans to address them.

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 and Control Unit (IPCP) coordinated with WIC staff, during National Child Passenger Safety (CPS) Week (in February) and National Buckle Up America Week (in May), to send out CPS materials to WIC participants. The two programs also developed WIC Minutes on CPS for these two events. The minutes ran through the week for each event.

The CPS Technician in the IPCP participated in four child safety seat checkpoints.

The IPCP answered hundreds of calls on The Car-Safe Line, which provides general passenger safety to the public. Staff sent out materials as requested by the caller.

IPCP staff held five Partnership for Passenger Safety meetings.

IPCP staff updated several CPS materials, including the CPS Fact Sheet and the Child Safety Seat Loan, Rental, and Distribution Programs in Massachusetts list.

IPCP staff helped plan the 2nd Annual Moving Together Conference, in October 2002, which is the statewide bike/pedestrian conference, with two presentations focusing on motor-vehicle crashes involving bicyclists and pedestrians.

IPCP staff member attended the 2003 National Lifesavers Conference, held in early March 2003. This is the national highway safety conference.

FIRSTSteps home visitors provided information to parents on child/youth passenger safety and resources to obtain child safety seats with instruction for their proper use. (This program ended in March 2003)

SBHC clinicians attended mandatory MDPH-sponsored meetings during which programmatic injury prevalence data were presented and analyzed. Epidemiologic trends were discussed including location of injury and primary causes (stratified by developmental stage). Guidelines for prevention were reviewed using "Bright Futures" materials.

WIC distributed educational materials on child passenger safety to program participants as well as information on how to contact the Child Passenger Safety Technician and Fitting Station in their community to ensure the proper installation of car seats.

b. Current Activities

IPCP conducts or participates in many targeted activities related to motor vehicle safety, including:

- * maintain CPS Technician certification for at least 1 staff member through NHTSA's re-certification program (currently 2 CPS Technicians are on staff)

- * update/develop materials, including the Summer Safety Tip Sheets, with one focusing on child passenger safety

- * coordinate with WIC staff to send CPS materials to WIC participants
- * participate in 2 strategic planning sessions with the Governor's Highway Safety Bureau
- * participate in child safety seat checkpoints
- * host The Car-Safe Line, which provides general passenger safety info to MA residents
- * hold Partnership for Passenger Safety meetings
- * help coordinate a World Health Day event at MDPH, focusing on traffic safety, including booster seat raffle
- * plan and hold activities during National Child Passenger Safety Week and National Buckle Up America Week
- * partner with coalitions, such as the Greater Boston Safe Kids Coalition, Western MA Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and the Prevent Injuries Now Coalition
- * help plan the Annual Moving Together Conference that is a statewide bike/pedestrian conference, with one presentation focusing on motor-vehicle crashes involving bicyclists and pedestrians.
- * Staff attend the national highway safety conference (National Lifesavers Conference)

EI Service Coordinators and EI Partnership MCH Team member offer information to all families on their caseload on well-child and public health information, including car seat safety for young children. EI Transportation Services maintains safety standards for all young children enrolled in EI who are transported to services and home. Transportation Services staff sponsor training in which EI program staff and transportation company staff have become certified child car seat technicians.

FIRSTLink and FOR Families home visitors provide information to parents on child/youth passenger safety and resources to obtain child safety seats with instruction for their proper use.

Child/adolescent clinical preventive visits are one of the leading services provided in SBHCs. Clinicians have received training on guidelines for prevention (e.g., Bright Futures), screening instruments available (GAPS, HEADS), clinical interviewing/risk assessment skills, and effective strategies for intervention.

Educational materials on passenger safety are provided to parents and caretakers of WIC children.

The school health newsletter - Updates in School Health - contains articles on motor vehicular safety and prevention of driving under the influence of alcohol. It is distributed to 3500 superintendents, school nurses in all public and nonpublic schools, Boards of Health, and others.

Child Fatality Review Teams are operational in all counties. Designated BFCH staff participate actively.

c. Plan for the Coming Year

The IPCP plans a number of targeted activities:

- Coordinate four Partnership for Passenger Safety meetings.
- Develop a 5-year injury prevention strategic plan that focuses on traffic safety.
- Host the Car-Safe Line and distribute passenger safety information to Massachusetts residents.
- Help plan the 4th Annual Moving Together Conference, with at least one presentation on bicycle injuries related to motor-vehicle crashes.
- Update and develop new passenger safety related materials.
- Coordinate with WIC staff to distribute CPS materials to WIC participants. Coordinate with WIC staff to develop WIC minutes on CPS during National Child Passenger Safety Week and

National Buckle Up America Week.

- Participate in three child safety seat checkpoints.
- Publish articles on passenger safety issues.
- Have at least one staff person attend the 2004 National Lifesavers Conference.
- Coordinate passenger safety activities with coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and the Prevent Injuries Now Coalition.
- Improve collaboration and integration of CPS information and materials with other state agencies serving children.
- Include CPS information in each quarterly mailing of seasonal and new injury prevention information/materials to over 400 providers, including educators, fire and police, advocates, health care provides, and MDPH programs.

Through the revision of the Maternal-Newborn Regulations for hospital licensure, recommendations are being developed to incorporate child safety information in patient education materials.

WIC staff will participate on the Advisory Committee for the development of the Injury Prevention and Control state plan.

Revision and updating of the 600-page Comprehensive School Health Manual will be completed. The manual has a chapter on injury prevention, including motor vehicle safety, and will be available on the Internet.

Develop joint initiatives to promote driver and passenger safety with the Executive Office of Public Safety, building on the strengths of both agencies.

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

a. Last Year's Accomplishments

Statewide 68.7% of WIC enrolled mothers initiated breastfeeding for infants born in FY03, with 7 local programs above 80%, and 8 between 75% and 80%. As of June 2003, there were 8,539 breastfeeding women served by local WIC programs, which represents 31% of all infants on WIC, up from the 29.1% reported in June 2002.

20 WIC Programs were funded for the 'Mother to Mother' Breastfeeding Peer Counselor Program. More than 60 peer counselors provided services. The majority of these peer counselors have worked for at least 1 year, with many peer counselors having multiple years of service at their local programs. WIC received a grant from the Healthy Children Project for 36 hospital-grade electric breast pumps to distribute for loan programs to MA WIC sites.

In collaboration with the MA Breastfeeding Coalition (MBC), Nutrition Division staff developed, printed and distributed a breastfeeding brochure "You've Got What It Takes...Give Your Baby the Best" for prenatal women at hospitals and OB-GYN practices. Samples and ordering information were sent to all birthing facilities. More than 50,000 brochures were distributed to over 35 hospitals, birth centers and childbirth education programs.

Breastfeeding Guidelines for Hospital Breastfeeding Promotion and Support were completed and distributed to all MA birthing facilities via the MA Hospital Association to support current hospital licensure regulations around breastfeeding. Additional copies have been distributed upon request to individual health care providers, policy makers and nursing and medical educators.

The newly initiated EIPP's home visiting services for families during pregnancy and postpartum include a standardized breastfeeding education and support component.

The State Breastfeeding Coordinator, as the DPH representative to the MBC, participated in the following activities:

- * A complete revision of the Breastfeeding Resource Guide-2003 Edition, with over 1000 copies and distributed to healthcare providers working with prenatal and postpartum women and infants. (> 7,000 copies have been distributed free of charge since the Resource Guide was first developed in 1998)
- * Sponsored the gubernatorial proclamation for Mass. Breastfeeding Week--Aug.1-7, 2003, signed by Gov. Mitt Romney.
- * Sponsored a 'Breastfeeding--Friendly Business Award' and 'Breastfeeding--Friendly Employer Award' campaign during World Breastfeeding Week. Certificates and window decals were presented to retail businesses, public agencies and employers who support breastfeeding mothers and families by making mothers feel welcome in their establishments, or by providing workplace breastfeeding support programs for their employees when they return to work.
- * Planned the 2nd annual "Breastfeeding in the Bay State" Conference for health care providers.

b. Current Activities

"You've Got What It Takes...Give Your Baby the Best" has been translated into Spanish and Portuguese and is distributed to hospitals and birth centers statewide.

The State Breastfeeding Coordinator is an active participant in the MA Breastfeeding Coalition and participates in planning the annual "Breastfeeding in the Bay State" conference, and in the development of tools for health care providers to appropriately assess and promote breastfeeding in the hospital and primary care settings.

All pregnant women enrolled in WIC receive counseling on breastfeeding benefits; prenatal infant feeding groups emphasize benefits, initiation and management of breastfeeding.

Postpartum breastfeeding women in WIC receive additional breastfeeding education and support. Local WIC programs establish goals for breastfeeding initiation rates of women enrolled prenatally.

The State Breastfeeding Coordinator is working with MassHealth (Medicaid) staff to address issues of breast pump coverage for mothers/infants separated for medical reasons.

Breastfeeding training is routinely offered for WIC paraprofessional staff and WIC and primary care professional staff. Training is also open to community health personnel. WIC "Mother to Mother" Breastfeeding Peer Counselors and Breastfeeding Coordinators promote and support breastfeeding by offering frequent, timely counseling to pregnant and breastfeeding mothers.

WIC and CPCP staff collaborate and coordinate care for pregnant and breastfeeding women. Local WIC/Primary Care agreements are reviewed to ensure breastfeeding education and support are provided to all prenatal and breastfeeding women. Introduction of breastfeeding at the first prenatal visit is a performance measure for CPCP programs, which offer education and support.

WIC, the Nutrition and Physical Activity Unit and MaxCare are collaborating to finish and print of "Breastfeeding Works! Breastfed Babies in Child Care," a resource for child care providers. Piloting of this brochure and the corresponding training were completed with 3 groups of child care providers.

In collaboration with 18 perinatal advocacy/support organizations, MDPH implements the annual "Partners in Perinatal Health Conference," providing up-to-date training and multidisciplinary networking opportunities for all levels of perinatal care providers. Special

workshops always focus on breastfeeding (recent including "Why Johnny Can't Suck: The Impact of Birthing Practices on the Newborn and on the Breastfeeding Mother," and breastfeeding outreach to culturally diverse populations). The conference reaches a multidisciplinary audience of 450 providers. All participants received educational materials about the WHO Breastfeeding Code. The collaboration has also formed the 22nd and newest state Healthy Mothers, Healthy Babies Coalition.

Breastfeeding support is provided in the home by EIPP and FIRSTLink home visitors, with referrals to lactation consultants as needed.

c. Plan for the Coming Year

In collaboration with the Division of Health Care Quality and community partners, BFCH is reviewing/revising the Hospital Licensure Regulations for Maternal-Newborn Services. Regulations related to breastfeeding promotion and support are included in this review.

WIC and Primary Care will collaborate with the EIPP to ensure participants have access to breastfeeding promotion, education and support prenatally and throughout the breastfeeding experience.

WIC, MaxCare and the Office of Child Care Services will collaborate to provide regional trainings to child care providers statewide using the "Breastfeeding Works!" brochure and corresponding training.

WIC will participate in the USDA "Loving Support for Breastfeeding Peer Counseling" project, focusing on improving and enhancing the management component of the current breastfeeding peer counseling program.

The new EI Partnerships program has a particular emphasis on improving breastfeeding initiation and duration rates, including both prenatal and postpartum education, assessment, and support. A review of FY04 data shows that 67% of enrolled women breastfed at birth, but that all women are stopping breastfeeding by 6 months postpartum, an outcome that the program is seeking to change. In addition to the MCH RN providing breastfeeding support, funds have been dedicated in each of the programs for lactation consultant services.

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

a. Last Year's Accomplishments

More than 99% of newborns received hearing screening prior to discharge from a birthing facility. Outreach was conducted to families with newborns that did not pass their hearing screening. Training was provided to DPH approved audiological assessment/diagnostic centers on the Family Sign Language Program and Hearing Aid Choices and Recommendations.

b. Current Activities

The newborn hearing screening law and hospital licensure regulations require screening of all newborns. All birthing facilities have approved protocols for hearing screening, and results are tracked for the approximately 82,000 infants born in MA each year through the electronic birth certificate (EBC). Universal Newborn Hearing Screening Program (UNHSP) staff perform site visits at all birthing facilities, and provide TA as needed. The EBC and Childhood Hearing Data System provide outreach staff with the ability to systematically track families to ensure that all children identified through newborn hearing screening receive appropriate services, including

EI.

Over 90,000 program brochures are distributed in five different languages. Every family with a newborn receives a brochure, as well as clinicians and EI staff.

The UNHSP has approved protocols for 26 audiological assessment/diagnostic centers throughout the state. Designated representatives from each center meet three times per year and ongoing training is provided. Training on Auditory Dys-synchrony is provided by Marilyn Neult, Children's Hospital, Boston, and The Genetics of Hearing Loss is provided by Heidi Rehm, Harvard Medical School Center for Hereditary Deafness.

The Genetics program works with the UNHSP to integrate information on the genetics of hearing loss into programmatic activities and trainings.

The UNHSP Program is participating in on-going evaluation projects with MCHB and CDC to better understand reasons for Lost to Follow-up and issues of Family Satisfaction. UNHSP staff have contributed to writing study protocols/surveys, including stakeholder focus groups.

c. Plan for the Coming Year

Staff from the UNHSP will be carrying out three evaluation projects: 1) Family Satisfaction, 2) Lost to Follow-up, and 3) Medical Home Provider Survey.

Review existing hospital licensure regulations and program standards to assure that needed changes are included in the revised Perinatal Hospital Licensure Regulations now under development.

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

a. Last Year's Accomplishments

FIRSTSteps home visitors screened all referred children for health insurance status, and provided information, referral and assistance with enrollment as needed for any child without insurance. Only 2 of 472 enrolled children had no insurance coverage. (This program ended in March 2003)

In November 2002, due to severe budget constraints CMSP capped enrollment at 26,110, and began a wait list; 5,455 children were on the wait list as of June 30, 2003.

Massachusetts was granted an expansion of the SCHIP guidelines to include all "unborn children" born to non-qualified MassHealth mothers. This ensures that all Healthy Start mothers of these "unborn children" can receive comprehensive medical coverage throughout their pregnancy and that the state can receive federal matching of 65% for all services spent on this population.

MassHealth and CMSP use a single application to ensure that children are enrolled or referred to the appropriate programs, which also provides seamless coverage for the unborn child, who will remain enrolled SCHIP after birth.

b. Current Activities

A priority for all BFCH programs with direct family contact is to screen for health care access and insurance coverage, make referrals, and provide assistance to access coverage and care appropriate to the program and family. See also activities in NPM 2 and NPM 4.

Teen Pregnancy Prevention programs provide information and referrals, including print materials, on access to health care and services available to youth and families.

The Community Health Worker Network Project provides technical assistance, training, and support to community health workers (CHWs) in MA. All training and networking sessions include presentations, strategies and materials relevant to enrollment in state insurance programs for children and to health promotion and preventive care.

The EIPP conducts intermittent comprehensive health assessments of high-risk pregnant women and infants through one year of age. All children in the family are screened at each visit for health insurance status, and information, referral and assistance with enrollment are provided as needed for any child without insurance. In addition, nurse home visitors and family liaison staff assist families in problem solving, reducing barriers to health care access, and developing self-advocacy skills. A review of the current year's data shows that only 1 of 246 newborns had no health insurance.

It is a priority of the SBHC program to screen all children and families for health care access and coverage. The new funding cycle RFR encouraged and assisted SBHC vendors to attend "Reimbursement and Managed Care in SBHCs" training. This included an update on the Medicaid Program and a discussion of strategies to ensure that SBHC-enrolled students have health care access and coverage.

Training and TA on public benefits including SSI, CommonHealth, MassHealth and Kaileigh Mulligan continues and may increase the number of eligible children receiving public health insurance.

In CMSP, over 15,000 children were on the wait list at the end of June 2004. In October 2003, the premium levels increased for families with incomes between 150% and 400% FPL.

c. Plan for the Coming Year

Continue to provide ongoing technical assistance to SBHC vendors on developing collaborative relationships with Managed Care Organizations with the goal of increasing their capacity to bill for services.

Increased funding for Children's Medical Security Plan in FY05 will allow all children to be enrolled from the wait list (15,000+). The waitlist may have to be reinstated at some point in FY05 if the average cost of the new enrollees greatly exceed FY04 average costs.

Participate in EOHHS Health Reform planning, the development of revisions to the Medicaid State Plan, and re-procurement of Medicaid Managed Care services.

Assure that all existing and new programs continue to focus on enrolling all uninsured children in appropriate insurance plans.

Integrate the MDPH STEPS project into the Commonwealth's Virtual Gateway, in order to assure that all potentially eligible children are enrolled promptly in Medicaid or CMSP.

See also NPM #2 and NPM #4.

a. Last Year's Accomplishments

The Massachusetts Medical Home Providers Network or MMHP-Net, an ICHP-hosted listserv for clinicians participating in MA Medical Home efforts, distributed Medicaid eligibility and coverage information as well as prior approval templates to providers around the state.

FIRSTSteps and FOR Families home visitors assisted families in enrolling in and renewing their MassHealth membership as needed, and assessed if MassHealth eligible children were actually receiving needed health care services. They promoted the importance of preventive health care and actively assisted families to address barriers to utilization of care, such as transportation, language, child care, etc. (FIRSTSteps ended in March 2003).

b. Current Activities

BFCH funds outreach and care coordination activities in contracted CPCP sites, to address barriers to utilization and ensure that children get the care they need. Provider sites must have cultural and language diversity. Primary care sites are required to follow the Medicaid EPSDT and/or Bright Futures periodicity schedule for well child care. A graduate nursing intern is implementing a well child chart audit process. The rate of EPSDT services provided at contracting agencies is a performance measure.

Helping families and physicians optimize, upgrade, and fully utilize Medicaid coverage is a central focus of CSHCN Care Coordinators' activities. All 13 pediatric primary care practices in which Care Coordinators are located now have access to a set of standard templates to dramatically reduce time spent by physicians on recurring documentation tasks for prior Medicaid approval.

FOR Families staff follow up with homeless families to ensure that MassHealth eligible children actually received needed services.

EI assists families of enrolled children with barriers to access to care, and refers to Medicaid at enrollment if uninsured. Screenings/assessments are universally available for children 0-3 whose families request them. If ineligible, referrals are provided to other community services. 100% of eligible children enrolled in EI receive services provided by practitioners in more than one discipline, as defined by an IFSP. MassHealth reimburses these services for enrolled children.

FIRSTLink connects families with pediatric health care providers, and provides information and referrals to families to address barriers to getting to health care appointments.

The EIPP provides periodic health assessments and follow-up through the child's first year. Access to and utilization of primary and specialty health care is a primary focus, and well-child care will be a performance measure.

Family Planning has initiated a process in collaboration with Medicaid to develop a Medicaid waiver for family planning services. Meetings have begun with Medicaid and providers to explore options for expanding coverage for family planning services to adolescents.

School-Based Health Centers, in 46 schools statewide, provide a consistent source of primary health care in the most accessible environment. SBHC standards stipulate that families must

be offered assistance to determine their eligibility and enrollment in MassHealth. Preliminary data indicate over 6100 students served.

In FY04, CMS approved MassHealth's SCHIP inclusion of "unborn children" for Healthy Start. The MBR also became the single application for HSP, thereby ensuring that the "unborn child" has coverage as well as continued seamless MassHealth coverage after birth.

EOHHS reorganization to streamline administration of public insurance programs, including MassHealth, SCHIP, CMSP & the Free Care Pool provide better coordination of care as a member moves from 1 program to another depending on eligibility criteria.

c. Plan for the Coming Year

Family Planning will assist Medicaid to complete the family planning waiver request and submit to CMS for approval. If approved, the program will work to ensure its effective implementation in Massachusetts.

Five SBHCs will participate in a Kellogg-based initiative that includes as one of its objectives "to improve families' access to available health and social service resources". Activities will include collaboration with the Community Health Outreach Worker Program to improve recruitment, determination of eligibility and enrollment of vulnerable families to receive health services.

The EOHHS "virtual gateway" catalog, eligibility screening, and common application tools will begin to go live in July 2004, with staggered implementation of functionality over FY05. These tools present the public (for catalog and screening) and providers (for the common application) with streamlined access to multiple EOHHS services, including MassHealth, CMSP, Healthy Start, Women's Health Network, WIC, Substance Abuse Services, Food Stamps, and EI. The service tracking and electronic payment (STEPS) functionality for DPH programs has been integrated with the virtual gateway and will be implemented later in FY05. Over time, additional functionality and programs will be added, to ease access and track actual services provided to MA residents. For example, pregnant women and young children who apply for MassHealth or foodstamps will automatically be referred to WIC.

Other current activities will continue from FY04.

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

a. Last Year's Accomplishments

See also activities reported in NPMs # 8 and 18: SPMs # 1, 5, 6, 8, and 10; and Priority Need #1

FIRSTSteps home visitors provided high risk pregnant women with screening and education on nutrition, smoking, substance abuse, and other issues that impact birth outcomes. They also helped ensure that enrolled pregnant women received adequate prenatal care and attend scheduled visits. Home visitors assessed for pregnancy risk status, and referred to and monitored appropriate medical care for high-risk pregnant women. (The program ended in March 2003, and was replaced by the EIPP).

A variety of smoking cessation programs were available across the Commonwealth, as part of statewide, regional, and community-based tobacco control services and activities, with many focusing especially on pregnant women and women with young children. (see also SPM #5.)

Substance abuse treatment for pregnant women and their families are provided through a

number of models including outpatient, residential, shelters, and specialized detoxification services for pregnant women.

The Alcohol Screening and Assessment Program worked with prenatal care providers to strengthen capacity and skill in screening for substance use during prenatal care.

Healthy Start program Specialists followed-up with enrolled women by phone at the start of each trimester. These calls were made to reinforce information about prenatal care, focusing on the importance of regular visits, and to assess the woman's ability to access health care and information.

b. Current Activities

All BFCH programs that interact directly with pregnant women screen for access to prenatal care and enrollment in WIC, and make appropriate referrals and assistance with access as needed.

Community-based primary care sites provide comprehensive prenatal care with early identification, assessment and referral to high-risk perinatal care as indicated. Practice guidelines include assessment and referral for substance use and violence. There are joint specialty reviews of high-risk pregnancies and reviews of deliveries with poor birth outcomes conducted with pediatric providers. Patients are screened for and counseled on the use of tobacco. Care is family-centered and provided in the woman's primary language, when possible. Nutrition assessment and counseling is mandated in funded programs, and provided in the context of the full range of prenatal care, with referral to and coordination with WIC and other nutrition programs.

All pregnant women served by WIC receive a thorough nutrition assessment with the establishment of individualized care plans. Women are then prescribed and issued appropriate food packages. Women with poor weight gain patterns are monitored regularly and receive in-depth counseling and intervention plans. All prenatal women who smoke or resume smoking during pregnancy are referred to smoking cessation programs.

Participation in the first Boston Prematurity Summit, in collaboration with the March of Dimes, the Boston Public Health Commission, Northeastern University, Boston University School of Public Health and Boston area community health centers. The Boston Prematurity Summit provides a multidisciplinary forum for providers, legislators, consumers and other members of the community about risk factors, racial and ethnic disparities and the long term consequences of prematurity.

The MCH Nurse and/or social worker/Mental Health Clinician, as the primary provider in the new EI Partnerships program, provides periodic home visits to high-risk pregnant women and conducts comprehensive health assessments, with referrals and care coordination. Screening and counseling for prenatal health risk behaviors, as well as for domestic violence, are core components of the program. Collaboration with the Office of Multicultural Health resulted in cultural competency core. Current data show that 26% of enrolled pregnant women have a high-risk pregnancy, with 9% having a history of poor birth outcome including stillbirth or neonatal death, and 16% reporting violence in the home.

The Office of Oral Health is currently working with the March of Dimes to provide information on the potential associations between oral diseases and perinatal outcomes: pre-term low-birth weight infants. This association is currently under investigation.

c. Plan for the Coming Year

The Division of Perinatal and Early Childhood Health will collaborate with the Bureau of Substance Abuse Services to include FASD policies and FASD education and training for providers and staff in all BSAS residential programs for women and families.

Formalized coordination agreements between WIC and primary care are being implemented to ensure comprehensive, unduplicated timely nutrition services.

Analysis of factors related to VLBW such as multiple births will continue using the Pregnancy to Early Life Longitudinal (PELL) data system. Analysis of interpregnancy interval data in PELL as it relates to birth outcomes will continue, and encourage linkage with Medicaid data.

Developing, with support from the AMCHP Perinatal Disparities Action Learning Lab, statewide strategic workplan to address perinatal disparities statewide and partnering with 5 communities (Boston, Worcester, Lawrence, Brockton, and Springfield) to develop local workplans.

MDPH will be participating in the CDC/AMCHP-funded MATRICHS training to enhance capacity to use data to inform policy and programming in addressing perinatal disparities.

Collaborate with Center for Health Information Research and Evaluation to ensure racial, ethnic and language data is collected in compliance with DPH standards.

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

a. Last Year's Accomplishments

For the second year, MDPH received state funds to implement a suicide prevention program. The original intent was to build upon the foundation laid during the previous fiscal year. However, due to a state fiscal crisis, twice during the year the funds were reduced, curtailing the program's progress.

The Suicide Prevention Resource Directory was completed and over 500 copies were disseminated. The document was also made available electronically.

A suicide prevention training for first responders was held with 30 participants.

The state plan for suicide prevention was completed and approved by the Commissioners of Public Health and Mental Health.

The second annual suicide prevention conference was held, attracting 240 participants.

Conference proceedings of the first annual conference were completed and disseminated to all attendees.

An update to the 1996-98 data book was developed, "Suicide and Self-Inflicted Injuries in Massachusetts: 1999-2000." It includes data on youth (Youth Risk Behavior Survey data).

In September 2002, for Mental Illness Awareness Week and National Depression Screening Day, the Commissioners of Mental Health and Public Health sent guidelines for media reporting of suicide to print, radio and television media across the state.

The Department continued to co-chair the Suicide Prevention Working Group until April 2003.

Five community-based coalitions were funded to implement interventions and begin or enhance services for suicide survivors. Due to funding changes, minimal activities were conducted.

Although Teen Pregnancy Prevention programs were unable to serve in the capacity of previous years, referrals and information were disseminated at various community events.

In SBHCs, approximately 37% of visits of youth aged 15-19 involved screening for emotional/mental health indicators such as depression, suicidal ideation, and affect/stress. One-on-one counseling took place during 63% of these visits.

Much SBHC clinical training has been offered in the area of screening for depression and the range of co-occurring disorders associated with an increased risk for suicidality. One SBHC site participated in a joint screening project with a local MCO to enhance screening using the Reynolds Inventory, which is being pilot tested for broader use in the primary care setting.

b. Current Activities

Modest state support was received for FY 04, which enabled the program to hire a coordinator (full time) and assistant (half time) mid-way through the fiscal year. Efforts have focused on the completion of training modules begun in FY03 which were disrupted due to budget cuts; the inclusion of questions on the BRFSS; production of the third annual suicide prevention conference (attracting a capacity crowd of 330 people, and turning away over 200 registrants); updating information in the School Health Manual; sponsorship of training for an anticipated 170 gatekeepers, clinicians, health care providers and counselors; participation in the School Health Nurse Institute; and participation in an EOHHS inter-agency collaboration to prevent suicides among youth in residential facilities.

The School Health Institute is offering a workshop on mental health issues in school. A suicide prevention course will be offered in the SHI summer institute. Approximately 300 school nurses are expected to attend.

One area of special focus in the new SBHC funding cycle has been to increase access to and provision of mental and behavioral health services. Specific objectives include an increase in screening for depression and substance abuse. Additional objectives include training for school staff in depression symptom recognition. Two separate surveys are currently being analyzed to determine both the mental health services integration needs and the staff development needs of SBHC clinicians.

FOR families staff provide crisis intervention and screening and referrals for depression and other mental health concerns for homeless families, including children and youth.

EI Partnerships and FIRSTLink home visitors screen for depression and other mental health concerns, and make referrals as needed.

Articles on domestic violence, dating violence, sexual assault and suicide prevention have been included in the School Health Newsletter, with numerous resources. This 12-page newsletter has been mailed to 3500 recipients: superintendents, school nurses in all public and nonpublic schools, boards of health, and others.

c. Plan for the Coming Year

The Suicide Prevention Program was funded at a higher level in the FY05 state budget and will be staffed. Activities will include: sponsoring the fourth annual statewide conference; a bi-

monthly educational seminar series; continued implementation of the state strategic plan; continued technical assistance for the MA Coalition for Suicide Prevention; surveillance through the BRFSS; updating the Suicide Prevention Resource Manual; development of a web site; piloting the three trainings (youth gatekeeper, elder gatekeeper and emergency department staff); development of a speakers bureau; publication and dissemination of an updated data book; support of a pilot project to establish a survivor outreach program; and grant writing for expansion of activities.

The Coordinated School Health Program will collaborate with the American Psychological Association to plan a conference focused on suicide prevention among gay, lesbian and bisexual youth.

The revised Comprehensive School Health Manual, which contains a chapter on mental health and suicide prevention, will be disseminated to schools and placed on the Department's website.

In response to an increase in teen suicides, the Essex County Child Fatality Team will convene community-based planning efforts to ensure that mental health services for high-risk youth are coordinated at the community level. DPH staff and local staff from DPH funded programs including school health will participate.

A clinical training plan will be developed in response to the survey findings. One of the focus areas will be to foster greater competence in the area of prescribing and monitoring psychopharmacological medications.

If funded, implement the Massachusetts Perinatal Connections Project on perinatal depression and related mental health in mothers and their families.

Analyze MA youth health survey data on depression and suicide attempts among adolescents with disabilities.

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

a. Last Year's Accomplishments

Completed an assessment of current referral processes to determine the extent of expanded care developments at Level II facilities and whether such care capacity was affecting transfers to Level III facilities.

b. Current Activities

The Bureau is continuing to work with the Division of Health Care Quality, the Perinatal Advisory Committee, and other obstetric and neonatal clinicians to examine the question of appropriate care in Level II and Level III facilities. The Hospital Licensure Regulations for Maternal-Newborn Services are being reviewed for updating and modification. These regulations were developed in the late 1980's, and do not reflect many of the advances in maternal-fetal medicine and neonatology since that time. Some Level II facilities are seeking changes in the regulations to allow them to provide certain services currently only allowed in Level III hospitals. The literature and experience are divided on the safety of some of these practices. How changing policy and potentially the regulations will impact care and outcomes for VLBW infants is a major question with multiple facets to be considered. The capacity to monitor these effects will be critical.

All contracted primary care sites that provide prenatal care must have formal collaborations with tertiary care hospitals for referrals and coordination of high-risk perinatal care.

PELL data linked to EI program data were analyzed to track appropriate referral by birthweight and risks identifiable at birth. Analysis by level of hospital designation is underway and will be reviewed for appropriate referral of VLBW and other identifiable risks.

See also activities for NPM 15 re VLBW infants.

c. Plan for the Coming Year

The review and revision of the hospital licensure regulations for Maternal and Newborn Services will continue, with completion expected in the first half of FY2005.

With MA NICU directors, who are interested in linking NICU data with EI, births, and other PELL data to improve short and longer-term outcomes for VLBW babies, continue to develop the Neonatal Quality Improvement Collaborative (NeoQIC). Use PELL to understand birth and early developmental outcomes relation to hospital-level designation. Consider incorporating PELL-based monitoring into perinatal regulations.

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

a. Last Year's Accomplishments

The annual Partners in Perinatal Health Conference highlighted effective strategies for community outreach to engage women in timely prenatal care, creating a forum for addressing barriers racial and ethnic minorities face.

The Healthy Start Program paid for prenatal and postpartum coverage for women with incomes up to 225% FPL.

b. Current Activities

See also NPM #15.

First trimester enrollment in prenatal care is a contract performance measure for perinatal primary care sites (CPCP). Similarly, the percent of pregnant women enrolled in WIC early in pregnancy is also a contract performance measure. The coordination between WIC and perinatal primary care sites includes a protocol for cross-referrals to ensure early entry to both WIC and prenatal care.

WIC staff participate in the MassHealth Perinatal Quality Improvement Project to examine ways to improve and enhance quality of prenatal health care of MassHealth/WIC participants.

Due to budget constraints, the Healthy Start income threshold was decreased to 200% FPL.

In FY04, CMS approved MassHealth's SCHIP inclusion of "unborn children" for the Healthy Start Program. In October 2003, the MBR became the single application for both HSP and MassHealth. This has ensured that the majority of women at or below 200% FPL who were pregnant and would not otherwise qualify for MassHealth were identified and enrolled in HSP.

c. Plan for the Coming Year

The Healthy Start Program will be transferred from DPH to the EOHHS, MassHealth Office of Acute and Ambulatory Care. The incorporation of the HSP program with other MassHealth programs will ensure that HSP members will benefit from all quality improvement measures and projects implemented by MassHealth for prenatal care.

The current MDPH-funded perinatal primary care programs will be reassessed with the likely development of a new model. Ensure that the programs address health disparities by assessing the adequacy of current model and developing appropriate community based models.

Utilize the lessons learned from the AMCHP Learning Lab to eliminate health disparities in infant mortality to convene a sub group to identify strategies that are accomplishable and engage women in care early as a mechanism to decrease infant mortality disparities. Collaborate with Boston and Worcester Healthy Start programs to implement promising practices and assess the potential of bringing such strategies to scale.

Collaborate with Family Planning programs, WIC and MassHealth to identify structural strategies to increase early enrollment and target groups and areas with high disparities in early care.

Create a forum as an ongoing structural mechanism to identify barriers that delay care and lead to disparities and strategies that show promise in addressing infant mortality and poor birth outcome disparities.

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. Routine screening of all newborns for 10 treatable disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Optional screening for 19 additional metabolic disorders and cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Tracking of every newborn with abnormal results to a normal result or appropriate clinical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Regular quality improvement activities to assure all babies are screened and tracked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. BFCH & NENSP collaboration to assure ongoing linkages of families to comprehensive services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work toward improved integration of genetics and newborn screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Work toward integration of newborn blood, hearing, & risk screening, with tracking & linkage to care	<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
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. Extensive family participation in CSHCN programming through Family TIES & EI Parent Leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family members/consumers hired as paid staff/consultants to the state CSHCN programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Parents actively participate in multiple advisory groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Parent leadership support & training is provided, including stipends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. MA Medical Home Project provides increased opportunities for parent-professional partnering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Training on SSI/public benefits systems presented directly to parent groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Telephone technical assistance, information, and referral provided to parents and providers of CSHCN	<input type="checkbox"/>	<input checked="" 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
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. Care Coordinators for CSHCN are housed in primary care practices & get referrals from the practice and community sources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Medical Home Networking Project & other collaborations with MA Consortium for CSHCN promote the concepts of medical home as the standard of care for this population	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. All BFCH programs serving children screen/refer for a regular primary care provider	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. EI and other programs are charged to maintain effective coordination & collaboration w/child's medical home	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Integrated Systems for CSHCN links newborn screening & followup w/care coordination & medical home	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Collaboration with MCOs, including Medicaid, to promote medical home concept	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. MassCARE offers care coordination services & links to primary &	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

specialty care to all enrolled children with HIV				
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. All BFCH programs screen/refer for health care access and insurance coverage	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. SSI benefits, community support, & technical assistance program provides trainings on eligibility, application process and appeals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. State law mandates health care plans to cover newborn hearing screening and diagnostic follow-up	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Special Medical Fund pays for selected services not covered by insurance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The Catastrophic Illness in Children Relief Fund pays for medical expenses not covered by insurance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Care Coordination for CSHCN provides assistance w/accessing & optimizing health insurance benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Care Coordinators work with families & providers to make community based services more family friendly & accessible	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Care Coordination Program's Hospital Initiative provides TA & liaison to tertiary hospitals, assisting staff with referrals & d/c planning for infants & CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
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. Maintenance of the SSI/Public Benefits Outreach, Training & Technical Assistance program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Care Coordinators for CSHCN work in several large pediatric primary care practices across the state	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Care Coordinators in regional offices for CSHCN who are outside the designated primary care sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Active staff participation in the MA Consortium for CSHCN & its Steering Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Technical assistance to families & schools allows medically complex CSHCN to attend public school	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MassCARE offers a community based system of care for infants, children, & adolescents with HIV & their families	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Families are surveyed to assess satisfaction with primary care and issues for quality improvement	<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
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. SSI/Public Benefits program provides resources & training for agencies serving transitional youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Telephone/email technical assistance is provided to agencies serving youth in transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Workshops provided for families on health care transition through Family Initiatives	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Care Coordinators offer formal & informal training on youth-to-adult transition (Eng & Sp.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. SBHC programs for teens w/chronic health problems and all ESHS nurses foster responsibility and self-care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Participation in Transition Work Group of the MA Consortium for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
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. CMSP pays for preventive health care for children low income families not eligible for Medicaid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 54 community health centers offer primary care to children regardless of insurance or ability to pay	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. BFCH funds specialized outreach & care coordination in 31 pediatric primary care sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Immunization level is a contract performance measure for primary care and WIC sites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. All programs that work directly with children assess for immunization status & primary care access	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. All unimmunized children are referred by WIC staff as part of immunization assessment at enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Work with MA Immunization Program to ensure contracted providers have regularly updated information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. EI Partnerships & FOR families promote well-child care, including immunizations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. EI programs provide information on immunization to all families and refer when indicated	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Child care providers provide information on immunization to all families and refer when indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Maintain an Abstinence Education media campaign	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Teen Pregnancy Prevention coalitions in 17 communities with high teen birth rates thru FY03	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. New teen pregnancy prevention model for targetted communities for FY04+ to reflect 90% funding cut	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Comprehensive Family Planning clinical services, with specific standards for teens; fewer in FY04+ due to budget reductions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. School-based Health Centers provide comprehensive primary care including reproductive health care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Adolescent primary care sites offer specialized care including pregnancy prevention/family planning	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Most Essential School Health Services K-12 health education programs include reproductive health	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Home visiting programs screen for teen health risk behaviors and refer to family planning services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Training to the public & providers on legal and confidentiality issues regarding serving adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. CMSP dental benefits include protective sealants for children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Outreach and improved reimbursement rates for CMSP dental provider network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Leadership to improve oral health status with a focus on children and preventive services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. On-going surveillance of 3rd grade children's oral health status, including sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. A statewide dental sealant program in 21 communities serves over 3000 high risk school children	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Strong collaboration between Office of Oral Health and school health programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Dental services provided in community health centers & other contracted primary care sites	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Specialist oral health consultant promotes preventive dentistry services for CSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Child Fatality Review Teams operate in every county of the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participation in child safety seat checkpoints	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dissemination of educational materials on child passenger safety to consumers and providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Active participation in safety/injury prevention coalitions & working/advisory groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaboration with other programs serving children to update knowledge related to passenger safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Information/resources offered to pregnant women & parents of children in WIC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Perinatal/pediatric primary care & SBHCs provide education to clients on passenger/ MV safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Facilitation of Partnership for Passenger safety meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Maintain technical assistance capability by having at least one certified Child Passenger Safety Technician on staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Work with Executive Office of Public Safety to develop joint strategies and initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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. Multi-faceted approach to reach health care professionals, parents/extended family, & general public	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Breastfeeding Coordinator provides active leadership to promote breastfeeding statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Make available Guidelines for Promoting & Supporting Breastfeeding to all hospital maternity units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Nutrition Division routinely produces & disseminates educational materials to promote breastfeeding in WIC & primary care programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Educational materials given to pregnant women through Healthy Start & perinatal primary care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. WIC counsels all women on benefits of breastfeeding & actively encourages breastfeeding; offers peer counseling services & provides manual breast pumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Actively collaborate with the Mass. Breastfeeding Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8. Healthy Start pays for lactation consultant services & breast pumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Regular trainings for primary care & WIC professional & paraprofessional providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Perinatal home visiting program supports lactation consultants & intensive breastfeeding support	<input type="checkbox"/>	<input checked="" 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. All newborns receive hearing screening prior to birth facility discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The Universal Newborn Hearing Screening Program (UNHSP) reviews & approves all hospital protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. UNHSP staff conduct site visits to all hospitals & provide technical assistance as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Outreach staff track families to ensure that all children receive appropriate follow-up care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. UNHSP follow-up assures referrals to EI for infants who do not pass the screening	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Additional linkages, including Care Coordination for CSHCN & primary care, are made as needed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Public information materials, including parent information kits, are distributed	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Parent to parent support is offered to all families of children identified with hearing loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Revise Perinatal Hospital Licensure Regulations section related to newborn hearing screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. All BFCH programs screen for health insurance status, & refer & assist with enrollment as needed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Training & TA for community health workers on addressing barriers to health care access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with Medicaid/SCHIP on revised joint efforts to encourage & promote enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with providers to maintain awareness of programs & to facilitate enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work with community & advocacy groups to maintain awareness of programs & to facilitate enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Training and TA offered to providers and parents on SSI & public benefits that provide health insurance for CSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. See also activities for NPM #4, re CSHCN.	<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
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. 54 community health centers provide pediatric care & accept MassHealth	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. BFCH funds care coordination, & wrap-around services in 31 pedi and 18 adol primary care sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. EI services and some EIPP services are reimbursed by MassHealth; families are assisted with barriers to care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. School-based health centers provide care to children and youth in elementary, middle, & high schools; some visits reimbursed by MassHealth; enrollment assistance offered	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. School-based health services were reduced by at least 50% in FY04 due to state budget cuts and are only partially restored in FY05	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. FIRSTLink assists families of high risk newborns to enroll in MassHealth & access care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. FOR Families conducts outreach & addresses barriers to care to ensure MassHealth eligible children receive needed services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. School nurses, as well as other health professionals in the schools, provide indirect care for children on MassHealth and promote enrollment for eligibles	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Work with MassHealth to develop a waiver for Family Planning to expand income eligibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. See NPM 3 & 4 related to CSHCN, & NPM 13 related to insurance for children	<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. All programs that work with pregnant women screen for & assist with access to prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Comprehensive prenatal care provided in 54 community health centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. BFCH funds outreach, care coordination, & wrap-around services in 30 perinatal primary care sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Nutrition assessment/counseling is provided in perinatal care sites, in coordination with WIC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. WIC, in 159 sites statewide, provides nutritional assessment, counseling & food to pregnant women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. WIC & Primary care nutritionists screen & counsel women in nutrition & health risks, & refer for smoking cessation & other health & social service programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Training offered prenatal care providers in screening & brief intervention for substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8. Home Visiting programs assess for access to dental care & refer as appropriate	<input type="checkbox"/>	<input checked="" 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. CMSP pays for assessment & up to 20 outpatient behavioral health care visits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Screening, treatment, & referral for depression & other MH issues offered in adolescent primary care & SBHCs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Supportive and Healthy Communities for Gay and Lesbian Youth Program (SHCGLY)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. SHCGLY program restructured for limited, core services due to state FY04 budget cuts at DPH & DOE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Extensive training & TA to SBHC clinicians & school nurses in MH & suicide screening & prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work with Coalition for Suicide Prevention to implement Suicide State Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Sponsor trainings, a conference, & seminars on suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Update resources including the Suicide Data Book & the Mass. Suicide Preevention Resource Guide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. School nurses do assessment and referral for depression and other mental health issues for children in grades K-12. This is a requirement of the ESHS grants.	<input type="checkbox"/>	<input checked="" 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. Community perinatal primary care sites have formal agreements with tertiary care facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Perinatal primary care providers screen for risk conditions & refer to appropriate level of care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Data linkage/analysis to inform potential policy/regulations changes in hospital level requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Home visiting program screens for risk conditions & refer to appropriate level of care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Revisions to perinatal regulations to reflect current state of practice at Level II & Level III hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.					
1. Prenatal care provided in 30 community-based primary care sites	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. WIC services in 159 sites statewide refer for prenatal care at first contact with pregnant women	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Healthy Start pays for prenatal care for women ineligible for Medicaid (see FY04 changes)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Worcester and Boston federal Healthy Start programs integrated with BFCH programs and services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Forum established to identify barriers to getting early care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of pregnancies that are intended.*

a. Last Year's Accomplishments

Initiated a statewide needs assessment process for family planning in preparation for RFR process.

The MCHB-funded Family Connection Project was completed in two family planning sites to connect screening and treatment services for tobacco use, alcohol use, and unprotected sex through a case management system.

Family Planning presented its social marketing campaign to promote healthy sexual behaviors (no longer funded) to the annual Social Marketing in Public Health conference in June 2003. Abstract of campaign also published in social marketing journal.

BFCH implemented a pilot sharing arrangement among hospital physicians to improve women's access to termination services statewide; over 100 calls for assistance were received during the first 6 months of the project.

Family planning questions were incorporated into the 2004 BRFSS. Program materials were revised to include new contraceptive methods such as the Patch and the Nuva Ring. Completed program update on Serving Males in Family Planning.

b. Current Activities

Reproductive health clinical services are provided through a statewide system of family planning agencies. Services include comprehensive exams, pregnancy testing and options counseling, counseling on reproductive health issues, contraceptive provision including access

to emergency contraception, STD counseling, testing, diagnosis and treatment and HIV prevention and education, and referrals to related services such as primary care. As of July 2003, this service package and access to these services was greatly reduced due to reductions in state funding. BFCH worked with agencies to sustain a minimum level of services in high risk communities and ensure that referrals to other sites are provided as needed.

BFCH monitors programs and provides technical assistance to family planning agencies for compliance with program standards. Staff also hold biannual meetings and share information via the provider listserv.

Efforts are underway to improve access to emergency contraception for all women through emergency rooms and pharmacists. Integration of pharmacy student interns into family planning program staff.

BFCH staff coordinate the Abortion Advisory Committee, which provides a forum for clinicians, health care organizations, public health advocates and government agencies to advise MDPH on the implementation of legislative mandates and strategies that support comprehensive reproductive healthcare and reduction of unintended pregnancy.

Family Planning and MassHealth have initiated a process for a Medicaid waiver for family planning services. Options are being explored for expanding coverage to all men and women who are income eligible or who may lose MassHealth coverage for any reason.

FOR Families, EIPP, and FIRSTLink home visitors assess women to determine if they have adequate/appropriate family planning information, with referrals/follow-up made to family planning or primary care providers. All contracted primary care sites must provide/arrange for comprehensive family planning services.

c. Plan for the Coming Year

Release of Family Planning Needs Assessment, to be shared with providers and internal and external advisory groups.

Complete family planning vendor site assessments by fall 2004 in preparation for re-procurement of family planning funds.

Family Planning clinical services will be re-procured in FY05 with a start date of July 1, 2005, based on the needs assessment with the goal of focusing services to populations and communities most at risk of unintended pregnancy and STDs.

Family Planning will assist Medicaid to complete family planning waiver request and submit to CMS for approval. If approved, the program will work to ensure its effective implementation in Massachusetts.

Plan and develop 2006 BRFSS questions.

Implement process to review and revise all birth control brochures and to expand website.

Revise MDPH regulations to allow for the distribution of designated medications with state-funded family planning programs by designated staff.

a. Last Year's Accomplishments

b. Current Activities

Family planning agencies continue with the CDC Infertility Project (Chlamydia Project) which provides funding for universal Chlamydia screening in specific high-risk communities.

Collaboration continues between the Family Planning program and the Bureau of Communicable Disease Control's STD program to provide additional funding for Chlamydia treatment for Chlamydia Project participants.

Integrated MA multilingual STD educational materials into SFPA's (State Family Planning Administrators) STD/HIV Client Education Materials for Linguistically Diverse Populations.

c. Plan for the Coming Year

State Performance Measure 3: *Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.*

a. Last Year's Accomplishments

28% of CMSP clients received preventive services, identified by ICD codes for preventive visits and ICD for sick visit if accompanied by a preventive service modifier. Many providers who provide annual preventive services when a member accesses sick visits do not provide the preventive service modifier. Therefore, the percentage accessing preventive services reflected might undercount what is truly accessed.

In FY03, approximately 6% of SBHC visits to publicly insured children and youth ages 1-19 involved a preventive health service (based on reported procedure or diagnostic code).

FIRSTSteps home visitors stressed the importance of preventive health care with parents, and information and printed materials were provided. Referrals to local primary health care services were made, and assistance with access to care was provided, including transportation. (Program ended in March 2003.)

b. Current Activities

See NPPM #13 and #14 also.

CMSP pays for preventive health care services for children 0-18 who do not qualify for MassHealth (Medicaid and SCHIP programs). Health Care Benefit Specialists provide information and referral to primary health care providers in the CMSP network. Pediatric Providers are expected to use EPSDT periodicity schedule and immunization standards. Provider reimbursement was increased for those preventive services provided in accordance with EPSDT periodicity schedules.

School-based Health Centers (SBHC) sites are funded by prioritizing communities with documented limited access to primary care and high rates of poverty, using criteria deemed to serve as proxies for "vulnerability."

All WIC infants and children are assessed for on-going primary health care and immunization needs at each WIC certification/recertification visit. Referrals are made to health providers as

necessary.

FOR Families and EI Partnership Program (EIPP) programs assess children and youth to determine if they are enrolled in MassHealth or CMSP. They also assess the need for preventive [well-child] services, make referrals and conduct follow-up to ensure that well-child services are received as recommended according to the age of the child.

c. Plan for the Coming Year

CMSP will be transferred from DPH to the Executive Office of Health and Human Services, MassHealth Office of Acute and Ambulatory Care. The incorporation of the CMSP program with other MassHealth programs will ensure that the children will benefit from all quality improvement measures and projects implemented by MassHealth for preventive services.

In conjunction with the SBHC program, five communities will participate in a Kellogg-sponsored initiative to improve access to available health services.

FOR Families, EIPP and FIRSTLink will continue to assess and refer or follow-up as needed.

State Performance Measure 4: *Percent of children and youth enrolled in Medicaid or CMSP who receive preventive dental services annually.*

a. Last Year's Accomplishments

Services helped to support the purchase of portable dental equipment for these programs. The Office of Oral Health also facilitated the development of community linkages between CHC dental clinics, local Medicaid dental providers and school health services. Staff worked with school nurses and ESHS Nurse Leaders to implement dental sealant programs in targeted at-risk communities.

2003 Statewide Oral Health Survey of Third Grade school children screened a representative sample of 3,439 children. Survey revealed that 54% of Massachusetts' third-graders have at least one dental sealant. The survey identified gaps in service and areas where school-based sites could potentially increase access to preventive services for Medicaid and CMSP enrolled children.

Approximately 28 % of Medicaid eligible children under age 21 received dental services; this percentage includes members aged 0-3.

27% of CMSP Enrollees aged 4-18 received dental services. Since CMSP is often used between instances of private health insurance coverage and MassHealth, many of the enrolled CMSP children may have already had dental preventive services.

The Office of Oral Health hired three dental hygienists to improve access to oral health services for three groups of children at risk: Head Start/Early Head Start; Children with Special Health Care Needs; and low-income, Medicaid and SCHIP eligible children. Each hygienist is responsible for providing technical support and for the development of a strategic plan to improve oral health outcomes for their respective target population groups.

A partnership between the Massachusetts Head Start agencies and the Office of Oral Health was established. Two Head Start oral health forums were held and a statewide oral health survey of Head Start children was conducted. Over 1,300 children were screened. Information on the survey and other activities are listed in the following section.

A partnership among the New England states Offices' of Oral Health and Delta Dental has produced an oral health video targeting Head Start families. The specially designed video provides Head Start parents and caretakers with information on the "first dental visit".

b. Current Activities

School based dental sealant programs operate in 14 new sites in Western MA.

The Office of Oral Health (OOH) collaborates with Essential School Health Nurse Leaders (ESHNL) to identify children who do not have access to dental services. The Office provides TA and training to ESHNL in using the Basic Screening Survey protocol, a dental screening program designed for use by non-dental health professionals to identify oral health needs.

The OOH continues to collaborate with the MassHealth Dental Program to identify strategies to improve access and utilization of preventive services. A system of transportation to school-linked dental program sites is currently being developed.

Recognizing the value of SBHCs as a potential site for increasing access to dental care for low-income children, OOH offers clinical training to N.P.s. A presentation "School-Based Dental Health/Oral Health Screening Training" offers 'hands-on' training for the identification of children requiring sealants and/or further oral health evaluation.

The Office is collaborating with the state's Head Start agencies to develop a state action plan to improve the oral health for Medicaid and CMSP eligible children. Survey data are being used to identify gaps in care. Models for education, prevention and access are being developed. Tufts Univ. School of Dental Medicine has joined the partnership providing dental examination and prevention care on-site at Head Start agencies. Additional models of dental service delivery are being explored to address special access to care issues.

The Boston Oral Health Project and Partnership was established this year in partnership with the Boston Public Health Commission to address the special oral health needs of the low-income and Medicaid and SCHIP eligible children of Boston.

The hygienist consultant to CSHCN is working with the Care Coordination for CSHCN Project Manager and the MA Consortium for CSHCN and others to better understand the special oral health needs for CSHCN. This new position will lead to the development of a strategic plan to address the oral health needs of CSHCN.

Provider enrollment in the CMSP dental network continues to be a priority. Meetings with potential providers and third-party administrator staff coordinate provider enrollment.

Dental health education materials, complemented with child toothbrushes, are provided to children enrolled in WIC. Children in need of dental care are referred to appropriate resources. FOR Families home visitors assess MassHealth-enrolled children and youth to determine if they receive preventive dental care, with referrals/follow-up to ensure that preventive dental services are received.

c. Plan for the Coming Year

Using data from the two recent oral health surveys, the Office of Oral Health will collaborate with key stakeholders to complete the state oral health plan for Head Start/Early Head Start children, CSHCN and low-income Medicaid and CMSP eligible children.

The hygienist consultant to CSHCN will continue to work with the Care Coordination for CSHCN Project Manager and the MA Consortium for CSHCN to develop models for

implementation of the strategic plan.

The Office of Oral Health plans to expand dental sealant programs to schools and communities identified in 2003 Oral Health Survey where the percentage of children with at least one dental sealant is less than the state average.

Plans to expand school based health center capacity to provide comprehensive dental services are somewhat uncertain, due to budget reductions and reprocurement in FY04 and the closure of some sites. Oral health will remain a priority, but which SBHCs will have the capacity to provide dental services in FY05 remains to be determined.

The Office will also collaborate with the MDMA to investigate the potential for a third party administrator for the MassHealth Dental Program

CMSP will be transferred from DPH to the Executive Office of Health and Human Services, MassHealth Office of Acute and Ambulatory Care. Wellpoint Dental will be retained until a contracting change necessitates that CMSP children access dental services through MassHealth.

State Performance Measure 5: *The percent of women and adolescents who report not smoking during their current pregnancy.*

a. Last Year's Accomplishments

The QuitWorks program, a collaboration of the Department with all major plans linking providers and their patients who smoke to the state's cessation services, was expanded to OBGYNs in Massachusetts in FY 2003. Services and materials tailored for pregnant women who smoke are available.

FIRSTSteps home visitors provided families with education on the risks of smoking and exposure to environmental smoke. They referred family members to smoking cessation programs as indicated. 75% of pregnant women in the program reported they did not smoke. [Program ended in March 2003.]

The Teen Pregnancy Prevention programs collectively implemented a total of 73 tobacco use activities. These activities served approximately 850 youth. The Berkshire Coalition on Teen Pregnancy Prevention developed media materials focusing on tobacco cessation while pregnant.

In FY03, among 50 SBHC visits to female clients (ages 15-19) who were pregnant or had recently delivered, 9 visits involved screening/counseling for alcohol, tobacco or other drug use.

b. Current Activities

The tobacco control program serves women of child-bearing age and children through state and local programs. Local tobacco control programs seek to protect children from the harmful effects of secondhand smoke through smoke-free home campaigns, education and outreach, and enforcement of local regulations around the sale of tobacco products. Tobacco treatment services are offered through a statewide Helpline and website for smokers, and the QuitWorks program, a collaboration of the Department with all major plans linking providers and their patients who smoke to the state's cessation services. Services and materials tailored for pregnant women who smoke are available.

A QuitWorks Pediatric task group is adapting the QuitWorks program for pediatric practices, with a focus on the family. The program will be piloted in pediatric practices prior to launch in FY 2005. The QuitWorks program was adapted for use in Massachusetts's hospitals: 17 adopted the program in 2004 in many units, including some neonatal units.

Problem-oriented screening instruments that include elements of reproductive risk and substance abuse risk are among the comprehensive risk assessments conducted by clinicians in SBHCs. Clinicians are trained how to use effective clinical interventions such as counseling and anticipatory guidance to address identified risks, including tobacco use. Clinical training is offered through the JSI Research and Training Institute on counseling pregnant women students who smoke.

WIC refers pregnant women enrolled in WIC and parents/guardians of children on WIC who smoke to smoking cessation programs.

FIRSTLink and EI Partnership programs (EIPP) screen and provide brief interventions with all referred pregnant women, as part of the comprehensive health assessments conducted in periodic home visits. 21% of EIPP clients report tobacco use.

c. Plan for the Coming Year

Special tobacco control initiatives are planned, in collaboration with municipal, community and health care organizations in cities and regions in Massachusetts that experience the highest smoking rates among pregnant women. Multiple strategies will be used including media, policy/environmental, education, and treatment. The pediatric QuitWorks program will be launched with partners to assist pediatric practices to intervene with parents and adolescent who smoke and refer them for treatment.

FIRSTLink, FOR Families, EIPP programs will continue to screen/assess tobacco use and make referrals as needed.

As of July 5, 2004, per the Massachusetts Smoke-Free Workplace Law, all workplaces that have one or more employees must be smoke-free. Designated smoking areas or smoking rooms are not permitted, with limited exceptions. The MDPH has established a 1-800 complaint and information line, information for business owners, information for workplaces on cessation resources and the benefits of quitting smoking, and is using CDC funds to coordinate a public information campaign.

State Performance Measure 6: *The rate (per 1,000) of chlamydia cases among females aged 15 through 19.*

a. Last Year's Accomplishments

BFCH staff participated in an advisory group for the Division of Medical Assistance's Chlamydia Education Project. The project's goal was to educate MassHealth physicians to increase sexual history taking and Chlamydia screening for adolescent females ages 15-17 who are enrolled in MassHealth. The project will be completed in FY04.

Teen Pregnancy Prevention programs implemented 371 on-going primary prevention activities specifically focused on STI prevention. These activities served approximately 4,300 youth. For female clients aged 15-19, over 35% of SBHC visits to female clients in FY03 involved clinical assessment for STI/STD risk. An STI/STD diagnosis was reported in over 1.4% of visits to female clients; an estimated 8% of SBHC visits to female clients involved medical screening or treatment for chlamydia. [This estimate was based on specific clinician-ordered tests to

detect the chlamydia antigen (Procedural CPT codes) and chlamydia-related diagnostic codes. The estimate does not include less specific, ubiquitous urine or blood panels that may or may not have been ordered to detect chlamydia.]

b. Current Activities

Family planning agencies continue with the CDC Infertility Project (Chlamydia Project) which provides funding for universal chlamydia screening in specific high-risk communities.

Collaboration continues between the Family Planning program and the Bureau of Communicable Disease Control's STD program to provide additional funding for chlamydia treatment for Chlamydia Project participants.

Integrated MA multilingual STD educational materials into the State Family Planning Administrators' "STD/HIV Client Education Materials for Linguistically Diverse Populations."

SBHC clinical training is ongoing through collaboration with the STD/HIV Prevention Training Center. Clinicians receive "Chlamydia Tool Kits" with most recently developed CDC guidelines and protocol recommendations. Prevalence and demographic trends data is discussed at clinical provider meetings.

FIRSTLink, FOR Families, EIPP programs provide health education and guidance on avoidance of STIs and make referrals to health care and family planning providers.

The Teen Pregnancy Prevention programs are implementing programs that will reduce the incidence of unprotected sex, delay the initiation of sexual intercourse, provide sex education, including information on abstinence and contraception, and increase the use of condoms among youth ages 10-19. During FY04 it is expected that a total of 1,000 youth will receive direct services, with an increase expected for FY05.

Also see activities in NPM #08.

c. Plan for the Coming Year

Continue to explore ability of state laboratory to provide STD/HIV screening tests for family planning clinics at reduced cost, particularly the newer urine tests for chlamydia and rapid tests for HIV.

Implement a new screening Chlamydia urine test in all SBHC sites in collaboration with the MDPH State Lab Institute. The elimination of a requirement for refrigeration during transport will make the new technology much more accessible to remote SBHCs, removing a major barrier to widespread screening.

FIRSTLink, FOR Families, EIPP programs will continue to assess clients, provide health education and guidance on avoidance of STIs, and make referrals as needed.

State Performance Measure 7: *The degree to which the State assures that child care providers have access to qualified child care health consultants. (See checklist for components of measure)*

a. Last Year's Accomplishments

The Checklist by which this measure is scored is provided as an Attachment. The Checklist displays the components of the measure, the possible scores for each component, and how the FY03 total score was calculated. This Measure is being made Inactive effective for FY04, so no Current or Planned Activities for FY05 are being given. Significant changes underway in the Commonwealth related to early childhood education and care, including major reorganization of state agencies and their responsibilities, have made this an area of activity where a State MCH Performance Measure is not currently realistic. The areas of health and safety in child care settings, along with the larger issues of promoting optimal early childhood development and health will be addressed in our up-coming Five-Year Needs Assessment and new state performance measures considered as part of that process.

b. Current Activities

This Measure is being made Inactive effective for FY04, so no Current or Planned Activities for FY05 are being given. Significant changes underway in the Commonwealth related to early childhood education and care, including major reorganization of state agencies and their responsibilities, have made this an area of activity where a State MCH Performance Measure is not currently realistic. The areas of health and safety in child care settings, along with the larger issues of promoting optimal early childhood development and health will be addressed in our up-coming Five-Year Needs Assessment and new state performance measures considered as part of that process.

c. Plan for the Coming Year

This Measure is being made Inactive effective for FY04, so no Current or Planned Activities for FY05 are being given. Significant changes underway in the Commonwealth related to early childhood education and care, including major reorganization of state agencies and their responsibilities, have made this an area of activity where a State MCH Performance Measure is not currently realistic. The areas of health and safety in child care settings, along with the larger issues of promoting optimal early childhood development and health will be addressed in our up-coming Five-Year Needs Assessment and new state performance measures considered as part of that process.

State Performance Measure 8: The degree to which the State assures nutrition screening and education, with referrals to assessment, counseling and services as indicated, for pregnant women, children and adolescents.

a. Last Year's Accomplishments

The Checklist to score this measure (attached) displays the components of the measure, the possible scores for each component, and how the score was calculated. Selected details are below.

"Home Delivered Nutrition Education" training was implemented in MA WIC to deliver nutrition education in participants' homes and reinforce clinic services; materials included 4 postcard-delivered messages.

Two WIC programs started the "Parenting Connection" peer counselor project to respond to infant feeding and care challenges. A brochure, "Comforting a Crying Baby", was designed and printed in seven languages.

"Folic Acid: A Healthy Habit" was revised and reprinted in Spanish and English.

FOR Families home visitors assessed nutrition status & food security, and made referrals. With FOR Families, WIC provided on-site nutritional counseling to homeless families.

FIRSTSteps home visitors provided nutritional screening & education to 74% of their clients.

In FY03, 6% of SBHC visits by the MCH population involved screening/assessment for at least 1 nutrition-related indicator.

The Partnership for Healthy Weight's Screening, Diagnosis & Treatment Task Force surveyed pediatric clinicians (199 NPs and 676 MDs in 13 of Massachusetts 14 counties) to assess pediatric overweight screening, diagnosis, and treatment practices and identify service barriers.

Overweight Prevention developed a statewide plan to address overweight and obesity in MA through schools, community health care settings and worksites.

Healthy Choices funded 15 elementary schools to implement nutrition and physical activity before or after school programs.

A 5-A-Day conference helped establish 3 regional coalitions (Boston, Southeast and Western Massachusetts).

With Boston Medical Center, the Osteoporosis Awareness Program conducted formative research on young women's health, nutrition & physical activity related behaviors.

Of the school districts in the Essential School Health Services program, 30.5% held nutrition support groups in FY 03 and over 28,000 students were screened for BMIs. 14.2% in the sample had a BMI > 95th percentile. Essential School Health Services require (a) a protocol for nutrition screening, referral and follow-up for high risk students (b) a system for developing a school environment and policies to promote healthy eating and physical activity.

b. Current Activities

WIC participants receive nutrition assessment/counseling/education at certification, and a minimum of 1 follow-up education visit. High-risk clients receive monthly follow-up. Nutrition education is provided individually & in interactive hands-on group sessions.

Training is ongoing to nutrition staff as is monitoring/evaluation of nutrition services to ensure quality. WIC routinely translates education materials into multiple languages. WIC coordinates the Nutrition Workgroup Meeting (WIC/Primary Care nutritionists) & 3 ongoing task forces-- Nutrition Education, Breastfeeding Promotion and TOTE (Targeting Obesity Through Education)--for effective, comprehensive, culturally-appropriate nutrition services & educational materials.

WIC is implementing a 3-year USDA Special Projects Grant, "Touching Hearts and Minds: Using Emotion-Based Messages to Promote Healthy Behaviors".

Materials about food preparation & safety for homeless families or families in temporary housing were developed, printed and distributed.

ESHS programs continue to meet screening and referral and systems/policy standards. They must choose 1 Continuous Quality Improvement objective from 6, 3 of which address nutrition. School nurses receive BMI training, inform parents and execute nutrition/physical activity programs. BFCH expects receipt of 20,000 BMIs. SBHC training includes BMI monitoring & healthy weight promotion. SBHCs participate in the School Health Index assessment for an

ecologic approach to the problem of obesity prevention. A Nutrition, PE and Obesity survey of SBHC clinicians was analyzed and presented. SBHCs received "BMI Provider toolkits" and encouragement to join the "Jump Up and Go" project that targets middle schools, including the "Planet Health" curriculum. With MA DOE, the Coordinated School Health program is developing a model nutrition policy. These and other school-related initiatives are in the Massachusetts Overweight Prevention and Control Initiative (MOPCI) state plan, along with workplace, health care setting, and community initiatives. The various programs focus on intervention for individual overweight/at-risk children as well as policy/systems issues like vending machines and school bus advertising.

3200 5-A-Day Directories are being distributed.

Family Planning program standards include nutrition screening/referral and providing information on folic acid; monitoring and TA are provided at site visits.

FIRSTLink & EIPP screen for nutritional needs & food security, including infant feeding issues, and provide education & referrals to food resources including WIC, food stamps, pantries. FOR Families assess and refer homeless families. WIC provides on-site enrollment & counseling to homeless families.

The Partnership for Healthy Weight produced a Resource Guide for Pediatric Overweight Treatment Services in MA statewide to increase providers access to overweight treatment programs that adhere to quality standards.

c. Plan for the Coming Year

Staff at six local WIC programs will receive training to deliver emotion-based nutrition counseling and education to participants. These programs will pilot 30 different nutrition education materials/messages with mothers of children birth to three to determine the acceptability and effectiveness of this new approach to nutrition education and behavior change.

WIC nutrition staff will engage in on-going efforts to improve collaboration and promote unduplicated, comprehensive nutrition services between the WIC program and Early Intervention, Growth & Development, Primary Care and Head Start nutrition services.

Family planning services will be re-procured for FY06 and it is expected that the RFR will require agencies to comply with program standards that include nutrition screening and referral especially information on folic acid. Particular attention will continue to be paid to nutritional issues including calcium intake and weight monitoring.

The Partnership for Healthy Weight will promote Massachusetts' pediatric clinicians' familiarity with the Expert Committee's recommendations for the identification and management of childhood overweight by translating them into practical strategies for community-based healthcare delivery settings and disseminating them statewide.

The Screening, Diagnosis and Treatment Task Force of the Partnership for Healthy Weight will convene key partners and stakeholders (MCAAP, MHQP, MA League of Community Health Centers, Division of Medical Assistance, and WIC) to discuss expansion of third-party reimbursement for preventive and treatment services (including nutrition) for children and adults who are obese, overweight or at-risk for overweight.

BMI data will be evaluated and the MOPCI (including various school-related programs) internal work group will reach consensus on promising practices re overweight/at-risk children. School-related activities on both individual intervention and policy/systems issues will continue.

The Mass Moves program will finalize the physical activity inventory and post the information on a website for easy consumer access.

Continue to participate in the New England Council on Nutrition (NECON) and the implementation of the Healthy Weight Strategic Plan.

State Performance Measure 9: *No longer active*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 10: *The degree to which the State has developed and implemented comprehensive education, screening and referral protocols for violence against women and children. (Measured by a checklist)*

a. Last Year's Accomplishments

The Checklist by which this measure is scored is provided as an Attachment. It displays the components of the measure, possible scores for each component, & how the FY03 total score was calculated.

The Domestic Violence Screening, Referral & Information Program (DV SCRIP) was formed in FY02 to improve the quality of care provided to women/children served by MDPH funded programs. In FY03 DV SCRIP made significant progress towards the development of a comprehensive domestic violence program for use with MCH providers to provide education regarding screening, care, & referral for violence against women & children. The curriculum will "train to" best practice protocols specific to particular MCH populations.

DV SCRIP developed & disseminated a survey to assess MDPH MCH programs' current practices regarding screening & referral for violence against women/children. The results of the survey were used to inform the development of the DV SCRIP curriculum.

DV SCRIP provided ongoing leadership of the BFCH Advisory Group on domestic violence which will play a key role in the development of DPH domestic violence protocols.

Staff served on the leadership team of the Statewide Healthcare Awareness, Response, Resources & Education on Domestic Violence Project funded by a grant from the national Family Violence Prevention Fund. The project participated extensively on the National Standards Campaign Advisory Group in the development of the FVPF's Nat'l Consensus Guidelines on Identifying/Responding to DV Victimization in Health Care Settings published in FY03.

BFCH received a continuation grant from the CDC to support prevention of violence against women. The 2nd year was devoted to support for the curriculum development component of DV SCRIP.

The EI Partnership Program developed Standards of Care that require its providers to screen & assess clients for domestic violence & provide appropriate referrals.

The Health Care Working Group of the Governor's Commission on Sexual & Domestic Violence, chaired by MDPH staff, presented the FVPF national consensus guidelines on DV screening, which were endorsed by the Commission.

Efforts to improve community health centers' response to domestic violence continued.

The family planning staff met with Rape Crisis center staff to improve linkages & referrals & to educate them on emergency contraception.

The Family Connection Project screened postpartum WIC participants for quality of life issues including violence & offered case management to assist women who were interested in making changes in their lives. This demonstration project ended in March 2003.

In FY03, approximately 8% of SBHC visits to the MCH population involved surveillance for at least one aspect of violence or abuse. The violence assessment included screening for violent behavior or the witnessing thereof, & the possession of weapons. The abuse assessment included screening for sexual, physical, &/or emotional abuse.

b. Current Activities

BFCH funded programs providing direct services to women and children are increasingly addressing domestic violence within their programs through screening and referral. Working with and through the DV SCRIP program, provider training needs can be assessed, and training and technical assistance regarding domestic violence, safety issues, and best practice screening (including for homeless families) and protocols provided. As expectations for such screening are becoming formalized, programs are monitored for compliance with program standards, including specific protocols and standards on violence screening and prevention.

Three pilot trainings of the DV SCRIP curriculum have been completed this year. This curriculum provides participants with information regarding the dynamics of domestic violence, with specific attention to concerns that may arise for particular MCH subpopulations, and then provides information regarding screening and referral. This second component of the training includes important information regarding preparing your program for screening and safety issues for clients as well as for provider staff. The DV SCRIP curriculum is currently being reviewed by internal and external experts in violence against women issues and MCH to ensure comprehensiveness, accuracy and appropriateness for MCH providers. Based on feedback from the pilot participants, the Advisory Group, and external reviewers the curriculum is being revised to assure its utility.

Ongoing collaboration between the Family Planning & the Sexual Assault Nurse Examiner (SANE) Programs is including work on integrating emergency contraception into protocols. This collaboration has also included such things as presentations by the SANE director at family planning provider meetings, & the recruitment of family planning clinicians to be preceptors for SANE nurses.

WIC has also established a committee of state and local program staff to examine the issues related to implementation of a domestic violence screening policy in the WIC Program setting.

FIRSTLink, EIPP, and FOR Families home visitors and telephone responders screen for violence against women and children (including the homeless) and make appropriate referrals as necessary. In EIPP, 16% of participating women report violence within their home.

The School Health Unit, collaborating with the Violence Prevention Division, has completed a newsletter entitled Updates in School Health. This 12-page newsletter contains articles on domestic violence, dating violence, sexual assault and suicide prevention. Numerous pertinent resources are included. The newsletter has been mailed to 3500 recipients: superintendents, school nurses in all public and nonpublic schools, boards of health, and others.

c. Plan for the Coming Year

New procurement and contractual language and guidelines will be drafted that require violence against women and children issues to be addressed in all future RFRs and resulting new contracts with MCH providers. This work will build on the experience and model of the development of the EI Partnership procurement in FY03, in which domestic violence criteria were included and well defined in the RFR specifications, and on the best practice protocol recommendations being developed by the DV SCRIP project advisory group.

Over the next year, the WIC program will implement new requirements regarding domestic violence; programs will develop and implement DV policies and protocols, providers will receive training on the DV SCRIP curriculum, address domestic violence issues and make appropriate referrals.

In conjunction with the Boston Public Health Commission, a brief screening tool that addresses domestic violence, substance abuse and mental health issues will be replicated in community health centers statewide. Providers will be trained on the use of the tool and provided information on appropriate community resources for referrals.

Family planning services will be re-procured for FY06 and it is expected that the RFR will include updated program standards that strengthen the requirements regarding assessment and referrals for intimate partner violence, including an increased capacity of the family planning staff in community agencies.

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

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percentage of pregnancies that are intended.				
1. Reproductive health care is provided through a statewide family planning provider system	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Reproductive health services are also provided through primary care sites and School Based Health Centers (SBHC)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ongoing assessment of effects of closure of multiple sites due to funding reductions; produce Family Planning Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work to assure continuation of availability of basic reproductive health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Family Planning standards are set by MDPH; programs are monitored for adherence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Maintain an Abstinence Education media campaign	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Home visiting programs provide education, counseling, & referral to				

family planning services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Increase access to emergency contraception	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Collaborate with BSAS in youth substance abuse prevention and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Improve surveillance through questions added to the BRFSS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) No longer active				
1.	<input type="checkbox"/>	<input 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
3) Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.				
1. All BFCH programs that work with children assess for ongoing linkage to preventive/primary health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. SBHC clinicians receive ongoing training in barriers to access to & utilization of care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC certification and recertification include assessment of preventive care & immunizations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. See activities for NPM 13 & 14, and NPM 3 & 4 for CSHCN related to MassHealth & preventive 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of children and youth enrolled in Medicaid or CMSP who receive preventive dental services annually.				

1. The Office of Oral Health coordinates & provides leadership for oral health planning & activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Training & TA are provided to school nurses & SBHC clinicians re: screening for oral health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC distributes dental health education materials & child toothbrushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CHCs, SBHCs, ESHS, & other pedi primary care sites screen for oral health needs, & refer for care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Many CHCs and some SBHCs and ESHS sites offer preventive oral health care on site.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. EIPP and FOR Families assess and refer children for oral health needs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The Mass. Consortium for CSHCN has established new links with the state Academy of Pediatric Dentistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. See activities under NPM #9 also.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The percent of women and adolescents who report not smoking during their current pregnancy.				
1. Perinatal primary care providers screen and counsel pregnant women & refer to smoking cessation services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Training & TA are provided to prenatal care providers on screening & brief intervention for substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC & EI Partnerships assess pregnant women for smoking, and counsel & refer to smoking cessation services	<input checked="" 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The rate (per 1,000) of chlamydia cases among females aged 15 through 19.				
1. Screening, diagnosis, treatment & counseling on Chlamydia in statewide family planning clinic system	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaboration between Family Planning and STD program to expand coverage for Chlamydia treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Screening, treatment & counseling in SBHCs and funded primary care sites	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ESHS K-12 health education programs are encouraged to include				

reproductive health	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provider training & TA to increase skills in sexual history taking and Chlamydia screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Training to the public & providers on legal and confidentiality issues regarding serving adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. MassCARE clinics screen all enrolled women for STDs, including chlamydia, in conjunction with HIV testing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Home Visiting programs counsel women and teens on STDs and HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The degree to which the State assures that child care providers have access to qualified child care health consultants. (See checklist for components of measure)				
1. Toll-free 24 hr TA helpline is available for child care providers, licensers, & health consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Health & safety training/materials provided to CCRR agencies, CPCs, & early childhood conferences	<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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The degree to which the State assures nutrition screening and education, with referrals to assessment, counseling and services as indicated, for pregnant women, children and adolescents.				
1. All WIC participants receive nutritional assessments, counseling & referrals as needed	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Guidelines & standards for all BFCH direct service programs include nutrition screening, education & referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Combined meetings & ongoing training of WIC & MCH primary care nutritionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Multidisciplinary outpatient evaluation & treatment for children with growth delays are provided to promote proper health, development, & nutrition.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The SBHC RFR includes guidelines for nutrition screening, & guidelines are being developed for inclusion in other RFR contract conditions for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

services to women, children & adolescents				
6. Development of guidelines for the collection of BMI in school aged children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. The ESHS programs are beginning to do BMIs with a focus on grades 1, 4, 7, and 10.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The Coordinated School Health Program is developing a model school nutrition policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Implement the Massachusetts Partnership for Healthy Weight network to reduce overweight, obesity and weight-associated disease (initial focus on youth), through State Action Plan, environmental supports evidence-based strategies, and surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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) No longer active				
1.	<input type="checkbox"/>	<input 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
10) The degree to which the State has developed and implemented comprehensive education, screening and referral protocols for violence against women and children. (Measured by a checklist)				
1. All BFCH programs providing services to women/children are expected to screen and refer for violence	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Violence screening, education, & referral protocols are being included in BFCH RFR/contract conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Comprehensive curriculum for use by MCH providers regarding violence against women & children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Training using the comprehensive curriculum is provided to MCH providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Comprehensive screening protocols have been developed for MCH providers, including materials for preparing the program, assuring staff safety, & appropriate screening tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

E. OTHER PROGRAM ACTIVITIES

In addition to activities contributing to performance measures, a majority of Bureau programs conduct one-time and/or on-going activities directly focused on meeting one or more of the State's defined Priority Needs. A description of these activities is attached to this section of the application. Also in the attachment is a comprehensive list of the programs' service numbers for FY03, by MCH population categories.

F. TECHNICAL ASSISTANCE

//2005/ Massachusetts is making a specific request for Technical Assistance to assist in undertaking a CAST 5 Assessment. In the context of significant reductions in state resources and the restructuring of the Department into Centers (which are comprised of Bureaus, one of which includes the Title V agency), it is felt that such an assessment would be beneficial in providing a better understanding of what currently exists and what needs to be rebuilt or enhanced to assure strong MCH/CSHCN services. //2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

/2005/ Specific numbers and fiscal year references have been updated throughout this section and it now relates to FY03 Expenditures. The basic format and general information remain unchanged. Revisions made in previous years are no longer shown.

See the FY03 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide extensive additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding was so much higher than our federal allocation (6.1 to 1), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Three aspects of the Expenditures warrant narrative discussion:

1. The difference between the FY03 Unobligated Balance originally budgeted and the amount expended.

2. The difference between the total Partnership funding budgeted for FY03 and final expenditures (Form 3) and between FY03 and the previous year.

3. Several substantial differences between the amounts budgeted for FY03 and final expenditures by MCH Population Group (Form 4) and by Level of the Pyramid (Form 5)

1. The FY03 Unobligated Balance expended is substantially higher than the amount originally budgeted. We generally do not fully budget the sum of the new allocations and the carryover from the previous year; therefore the sum of lines 1 and 2 in any Budgeted Column is not the same as "Total Funds Available." The precise amount of carryover cannot be calculated at the time the new budget is prepared, as accounts payable extends for approximately 3 months after the close of the state fiscal year.

The other systematic difference between the Federal Budgeted and Expended Columns is that when showing the budget, the new federal award is shown in full (per instructions) and only the amount of unobligated carry-forward funds necessary to meet our program needs is budgeted. However, expenditures are always paid first with the "oldest" federal funds, not the new award. Therefore for expenditures, only the amount of the new grant needed to make all budgeted payments is actually expended. The final federal balance forward for FY03 was \$2,796,874, whereas only \$1,493,240 had been budgeted originally.

In FY03 there was approximately a 6% federal under-expenditure compared with the FY03 projected budget (a total of \$12,729,921 expended compared with \$13,565,991 budgeted). The difference was primarily due to a number of staffing vacancies that had been fully budgeted at the beginning of the fiscal year. In addition, alternative sources of funding (both one-time and long-term) for some Bureau costs were identified. This is an objective we had prioritized, but the specific savings can only be solidified as the state budget year moves forward. During FY03, additional alternative sources of funding for several program areas (particularly support services) continued to ease the final funding burden on the federal Block Grant.

Some other differences between Form 3 for FY03 and the previous year are highlighted below. The amount of State Funds expended in FY03 (\$78,191,530) was substantially lower than the amount originally budgeted (\$90,889,935). As discussed in our FY03 and FY04 Applications, the state budget has been extremely volatile in the last several years, with a number of accounts gaining or losing significant amounts and with the budget itself either late or reduced during the fiscal year as the state's revenue situation has worsened.

The executive branch reduced the state budget for FY03 (which began July 1, 2002) twice during the year after our final Partnership Budget was filed, due to a continuing worsening of the state's fiscal situation. Because most accounts had been substantially reduced in the

initial FY03 budget, only two state accounts that were part of the Partnership Budget were affected -- those supporting school health services and school-based health centers. However, they were dramatically reduced by 42%, from an original total of \$25,273,620 to a final level of \$14,577,331. The net impact of the cuts on programmatic services is discussed in relationship to Forms 4 and 5.

2. Form 4 (Budget by MCH Population Groups). Final FY03 Expended totals are significantly different from FY03 Budgeted totals for Infants, Children, and Administration. The overall lower amount, due entirely to state funding shifts, has been explained above. The lower Infant expenditure is principally due to the reduction in total "shared" expenditures by about \$1.3M from their initial budgeted level, due to staff vacancies, early retirements (as part of the forced emergency cuts during FY03), and some cost-shifting to non-Partnership accounts. These Shared costs (either budgeted or expended) are allocated across the MCH population categories in proportion to each category's share of direct costs. Thus the savings in Shared costs helps account for the lower expenditures in all categories, but because of the relatively small total for Infants, the effect is magnified enough to trigger the TVIS filter of a 10% difference. Direct expenditures for Infants (from both federal and state funds) only differed from the budgeted totals by approximately 7%.

The reduced expenditures for Children and Youth were the result of the massive cuts in state school health funding during FY03. The overall decrease in administrative expenditures reflects two different situations in FY03. The cuts in school health-related accounts resulted in sharp curtailing their contributions to administrative costs (including staff support) for the Bureau and the Department. In addition, the Bureau continued to be quite successful in both reducing overall administration costs and in shifting a number of them to other state and federal accounts that are not part of the Partnership budget. This trend in lower administration costs within the Partnership budget can also be seen in the proposed FY05 budget -- which is again lower.

3. Form 5 (Budgets by Level of the Pyramid). Final FY03 Expended totals are significantly different from FY03 Budgeted totals overall and particularly for Enabling Services and Infrastructure Building. The overall lower amount, due entirely to state funding shifts, has been explained above. For both Enabling Services and Infrastructure Building, the mid-year cuts to school health-related accounts were primarily responsible for the discrepancies. As approximately 25% of Enhanced School Health Services grants to cities and towns and 10% of School-Based Health Centers contracts are for Enabling Services activities, this reduction in state funds was a major contributing factor to the lower expenditure amounts. In addition, not all state CMSP insurance funding originally budgeted was expended during FY03. Because another significant proportion of the Enhanced School Health funds was targeted to improving school health services infrastructure (both through Title V agency staff support and substantial grants to over a hundred cities and towns to improve school nursing services), a major result of the loss of funds was this drop in Infrastructure Building expenditures. It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case is approximately 80% state funds (87% originally in FY03, 83% in FY04, and 80% in FY05). We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding. //2005//

B. BUDGET

/2005/ Specific numbers and fiscal year references have been updated throughout this section and it now relates to our FY05 Partnership Budget. The basic format and general information

remain unchanged. Revisions and updates made in previous years are no longer shown due to space constraints. Please refer to Forms 2, 3, 4, and 5.

The budget proposed for FY05 in Forms 2, 3, 4, and 5 contains some significant differences with those of previous years. The state FY05 budget was passed on time and the last sequence of veto overrides is concluding as this Application is submitted. Although the possibility still exists that emergency cuts or spending freezes will be instituted during the year, we expect that the FY05 budget will match FY05 expenditures when they are reported (unlike the situation described above for FY03). The differences with previous years have to do primarily with the transfer of two major and long-standing state health insurance programs for pregnant women and children -- Healthy Start and Children's Medical Security Program -- out of the Department of Public Health and the state Title V agency to the state Medicaid program, MassHealth.

The total Partnership budget of \$68,450,035 is made up of \$13,072,065 of MCH Block Grant funds (including carry-forward funds) and \$55,377,970 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding represents a FY05 State Match (\$3 state for every \$4 federal) of \$9,804,049 and State Over Match of \$45,573,931. The total state funds represent all or portions of 9 state accounts (Family Health Services, Early Intervention (2 accounts), Teen Pregnancy Prevention, Universal Newborn Hearing, Dental Health, School Health (including School-Based Health Centers), one Interagency account with Medicaid, and state administration). Details on the budgeted amount from each account are given in the Notes to Form 3.

The state revenue picture has continued to be strained and while the budget improved in FY05, restoring several MCH-related accounts, it continues to be below FY03 or earlier levels for most accounts. The total state funding is down from \$90,889,935 in FY03. After adjusting for the transfer of Healthy Start and CMSP (which both are funded at MassHealth at levels above FY04), the FY05 state MCH Partnership funding represents a reduction of almost \$13M. These cuts and changes from year to year are not uniform and certain types of services and population groups served will be affected more than others. Our oldest and core MCH state account, Family Health Services, the one that most closely resembles the federal block grant and was created originally as the state match, was initially cut by almost 70% in FY04. This account had contained the only state funding for family planning services, rape crisis centers, the poison control center, MCH primary care wrap-around services, and prenatal/infancy home visiting. After the FY04 cuts and modified budget language, it now only funds family planning services, rape crisis centers, and a small amount of MCH primary care wrap-around services. During FY04, \$2M was restored (for family planning and rape crisis centers) through a supplemental budget and in FY05 these programs have regained approximately 95% of their FY03 base funding. However, the account remains a narrower and essentially categorical one, rather than the broad-based one its name might suggest.

Details on the budgeted amount from each account, and the amount that it has changed from its FY04 level (if relevant) are given in the Notes to Form 3.

The \$116,104,568 of other Federal funds shown on Form 3 comes from over 25 different grants, which cover all of the categories of the categories on Form 2 except federal Healthy Start. It is important to note that we include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over \$36M, which is included in the \$116.1M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. These grants are of great importance in maintaining the breadth of the Bureau's MCH efforts and in continuing our history of innovation and integrated service delivery model development.

Not included in the budget forms is a substantial amount of state funding administered by the Bureau for MCH programs, but which cannot be listed as match by us because the funds are used for match for other federal programs (e.g. TANF or Abstinence Education) or which originate in other state agencies that wish to maintain their options to use the funds for match.

As we have a substantial amount of over-match, this is not a budget issue for the Bureau, but it does undercount the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans. Some of the accounts involved are fully MCH-related; the largest of these have been the bulk of the Teen Pregnancy Prevention Challenge Fund (\$2,978,786 in FY03, but only \$740,000 in FY05) and FOR Families (\$1,200,000; reduced from \$2.2M in FY03 and \$1.4M in FY04); both of these accounts are funded with state TANF funds. Other accounts include both MCH-related and other activities that are difficult to identify precisely or which are needed for potential match for other purposes. These include several state-funded accounts that address sexual assault, batterer intervention, violence and two that support community health center operations and initiatives.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and across types of services in a variable manner from year to year and that certain groups differ significantly in FY05 from their FY04 or earlier shares. This picture is misleading, however, because Forms 4 and 5 present the entire MCH Federal-State Partnership budget, which in our case is still approximately 80% state funds (down from 87% in FY03). While we have flexibility in allocating federal Block Grant funds, the proportion of the total State Partnership budget that comes from "categorical" state accounts continues to increase and the total, as noted above, can fluctuate significantly from year to year. A more accurate picture of our commitment to the MCH Populations may be seen in the tables in the Excel file that is the attachment to this Part 5, Section B (Budget). These tables present budget data for the federal and state portions of the Partnership budget separately over several years. A comparison of Forms 4 and 5 with these tables illustrates that virtually all of the year-to-year variation in the total and relative distribution of funds across population groups is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (and the disproportion cuts in some accounts), the impact of the state funding cuts is not felt equally across all of MCH population groups. The overall reductions in funding in categories from FY04 to FY05 are due to the loss of state funds (including transfers out of the Title V agency). These trends continue to place greater strain on the MCH Federal funds (which have not kept up with inflation over the same period) as the only source of flexible funding for many key MCH activities. This strain has previously been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. The FY05 budget, although better than FY04, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments. //2005//

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.