

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: MD

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

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

### **C. ASSURANCES AND CERTIFICATIONS**

Copies of signed assurances and certifications for Maryland will be maintained on file in the State Center for Maternal and Child Health's central office. Copies can be made available by contacting the Title V Coordinator, Center for Maternal and Child Health, Maryland Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, MD 21201.

### **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 notice was placed in the Maryland Register inviting the public to review and comment on the 2005 application. In addition, a flyer was mailed to MCH stakeholders (e.g., agencies, organizations, medical providers and advocacy groups) inviting them to comment on last year's application. The CMCH web site ([www.fha.state.md.us/mch](http://www.fha.state.md.us/mch)) also contains a link to the FY 2004 application narrative. In preparation for the upcoming needs assessment, Maryland will work to identify methods for improving public input and comment during the Title V application process.

## **II. NEEDS ASSESSMENT**

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

### III. STATE OVERVIEW

#### A. OVERVIEW

According to the U.S. Census, Maryland was home to 5,296,486 residents in 2000. Maryland is comprised of 23 counties and the City of Baltimore and is characterized by mountainous rural area in the Western part of the State, densely populated urban and suburban areas in the central and southern regions and flat rural areas on the Eastern Shore. The State borders West Virginia, Pennsylvania, Washington, D. C., Delaware and the Atlantic Ocean. Maryland has 9,837 square miles of land area, 623 square miles of inland waters and 1,726 square miles that constitute the Chesapeake Bay, the world's largest estuary. In 2000, Maryland ranked 19th in population and 6th in population density among states (including the District of Columbia) with 541.9 persons per square land mile.

Maryland's population grew by 10.8% as compared to an overall U.S. growth rate of 13.1% between 1990 and 2000. Montgomery and Prince George's counties, both part of the Washington D.C. suburbs, accounted for the majority of this population growth. Conversely, the population of Baltimore City decreased by 14% during this same time period. The majority of Maryland residents (79%) live in the major metropolitan areas that surround either Baltimore City or Washington D.C. The Baltimore-Washington D.C. combined Metropolitan Statistical Area constitutes the nation's fourth largest retail market.

//2004/ Politically and fiscally, Maryland has undergone significant changes since July 2002. Statewide elections resulted in the first two-party governing system in over thirty years including the election of a Republican Governor, Robert L. Ehrlich, Jr. Approximately thirty percent of the legislative body and 100% of all Senate and 33% of all House committee chairs are new. This, compounded by the severe fiscal crisis of the State, resulted in no new health initiatives and the elimination of multiple vacant positions primarily in the data and administrative classification. These position cuts were done to ensure that education (primary and secondary) and the most vulnerable populations: those in poverty, the disabled, those with mental health illnesses, or substance abusers would continue to receive services. These cuts have resulted in the MCH infrastructure being severely challenged.

Governor Ehrlich does not plan to finalize budget cuts for SFY 2004 until mid-July. He has also pledged to close a projected budget gap of \$700 million for the 2005 fiscal year entirely through cuts. A state hiring freeze has been in effect since October 2001. In the past year, Maryland's MCH Program has lost 12 permanent positions. //2004//

***//2005/ The state hiring freeze remains in effect. The state is facing a projected budget deficit of \$800 million for FY 2006. In preparation for the FY 2006 budget submission, Governor Ehrlich has directed the Department of Budget and Management to work with state agencies to take a results based approach to critically reviewing all programs. Programs that are not producing results are to be considered for reduction or elimination. It is currently difficult to predict the possible effects of this exercise on MCH programs. //2005//***

Age and Sex: According to the 2000 US Census, children and adolescents (1.5 million) under the age of 20 represented 28.2% of Maryland's population. Pre-teens and teens, between the ages of 10 and 19 represented more than one-half of the child population. Senior citizens, aged 65 and over, represented 11.3% of the population. An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 2000. Between 1995 and 1999, an average of 71,000 babies were born each year.

Race/Ethnicity: With the exception of Western Maryland, the State's minority racial and ethnic populations are rapidly increasing and comprise a significant portion of the population of each geographic area. Racial/ethnic minorities comprised an estimated 36% of Maryland's population in 2000, up from 28% in 1990. Of the 1.9 million minority residents in Maryland, African Americans represented 27.9% of the total State population in 2000. Hispanics, the fastest growing ethnic minority in Maryland, represented 4.3% of the total State population. Compared to the national average,

Maryland has a greater proportion of African-Americans (two times the average) and a lower percentage of Hispanics (one third of the average).

/2003/ U.S. Census data for 2000 indicate a significant increase occurred in the number of foreign immigrants residing in Maryland during the last decade. Nearly 228,000 foreign immigrants made Maryland their home during the 1990s. These new Marylanders largely (68.3%) settled in Montgomery or Prince George's counties; followed by Baltimore, Howard, Anne Arundel and Frederick counties. /2003/

/2004/ Maryland's Hispanic population continued to increase. In addition, increasing numbers of undocumented women and children, coupled with budgetary constraints, are straining the ability of local health departments and other providers to address unmet needs. //2004//

Economic Well-Being: According to the U.S. Census (using 1997 model base estimates), with a poverty rate of 9.5% for the overall population and 14.9% for children, Maryland had one of the lowest overall poverty rates in the nation. However, there are pockets of poverty throughout the State. In 1989, child poverty rates ranged from a low of 3.2% in Howard County to a high of 32.2% in Baltimore City. Poverty rates also varied by race/ethnicity. For example, the poverty rate for African Americans was twice the rate for Caucasian Americans. While the majority of regions in Maryland experienced an economic boom during the 1990's, the Eastern Shore and Western Maryland experienced a decrease in their economic prosperity. Still, Maryland hosts some of the wealthiest communities and jurisdictions in the nation. U.S. Census data for 1998 show that the State had the nation's 5th highest per capita income and the 3rd highest median household income. Census data for 1997 estimated that Marylanders had a median household income of \$ 45,289.

/2003/ U.S. Census data for Maryland indicate that both the total number of poor persons and the poverty rate rose between 1990 and 2000. The Census reported that 438,700 Marylanders (8.3% of the total population) lived in poverty in 1999, as compared to 385,300 (8.3% of the total population) in 1990. By jurisdiction, the poverty rate for individuals ranged from a low of 3.8% in Carroll County to a high of 22.9% in Baltimore City. The poverty rate for children under the age of 18 stood at 10.3% statewide in 1999 and ranged from a high of 30.6% in Baltimore City to a low of 3.8% in Howard County. Maryland continued to be ranked as the nation's third richest state with a median household income of \$52,868 in 1999. /2003/

Among all states, Maryland's workforce is the best educated. Almost a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2000. More than 146,455 businesses employ 2.29 million workers who earn an annual payroll of \$76 billion. Some 3,494 of these businesses employ 100 or more workers. Most Marylanders (86%) work in the widely defined service-producing sector. This category ranges from government to transportation-related professions, and from wholesale trade to the finance and insurance industry. Health care represents a \$17.0 billion industry in Maryland with per capita spending on health care reaching nearly \$3,316 in 1998.

Health Care Environment: The Urban Institute Monograph, titled "Health Policy for Low-Income People in Maryland, Highlights," April 1999, aptly describes Maryland's health care environment as follows: "A unique combination of bold innovation and strong regulatory involvement characterizes health care policy in Maryland. The State had used Medicaid rather than a separate state designed program to pursue coverage expansions for those with income up to 200% of FPL, including the recent Children's Health Insurance Program (CHIP), and had been aggressive in enrolling beneficiaries under capitated managed care. Maryland's group insurance market reforms were compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) before the federal law was enacted, and the State has arguably the strongest hospital market regulatory system and managed care consumer protections in the United States."

Health Status: In spite of Maryland's affluence and many positive attributes, health indicators for the State are mixed. Maryland's infant mortality rate stood at 8.3 in 1999, one of the highest in the nation. However, in 2000, Maryland's infant mortality rate reached its lowest level ever, falling to 7.4 deaths

per 1,000 births. The Center for Disease Control and Prevention (CDC) conducts the Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey that tracks health risks among adults (aged 18 and over) in the United States. According to the BRFSS, in 1998, the majority (86%) of adult Marylanders self-reported their health as good or excellent. The 1998 survey also found that one in three adult Marylanders was classified as overweight; slightly more than one in five was a smoker and most (72%) had visited a dentist within the past year. BRFSS data for 1997 indicated that three-quarters of adult Marylanders used seat belts on a regular basis; and 1.2% were identified as chronic drinkers (i.e., an average of two or more drinks per day). The Maryland Baseline Tobacco study conducted in 2000 found that statewide, one and five Maryland residents, 22% of youth and 21.8% of adults, were current users of one or more types of nicotine (e.g, cigarettes).

Maryland's 1.5 million children and adolescents are its most important and precious resource. According to the 2001 Kids Count Data Book published by the Annie E. Casey Foundation, Maryland, one of the nation's wealthiest states, ranked 19th on 10 indicators of child well-being. This is an improvement from 24th place as reported in the 1999 report. At least 12% of Maryland's children were defined to be at high risk for future failure as measured by six indicators including poverty, and lack of health insurance coverage. The poverty rate among African-American and Hispanic children in Maryland was two to three times the rate for Caucasian children. The consequences of child poverty are severe. Poor children are known to have higher death rates, increased chronic diseases such as asthma, and less access to health care services.

Maryland's infant mortality rate fell to a record low of 7.4 in 2000, but continued to remain higher than the national average. The 2000 rate was 11% lower than the 1999 rate of 8.3. Infant mortality disproportionately affects African American babies. (Maryland has identified the elimination of health disparities to be a priority). Maryland had 127 children ages 1-14 die during 1999. This represented a significant decline in the number of deaths (200) during the previous year. Injuries, many of them preventable, were the leading cause of death for this age group followed by cancer. There were 626 deaths of Maryland adolescents and young adults ages 15-24 in 1999. Preventable injuries (homicide, accidents, suicide) accounted for 72.2% of the deaths in this age group, while only 8% of the deaths were medically related.

/2004/ The infant mortality rate rose again in both 2001 and 2002, but still remains below the 1999 rate of 8.3 deaths per 1,000 births. //2004//

Two major environmentally linked health conditions - asthma and lead poisoning - are major causes of childhood morbidity. An estimated 95,000 Maryland children and adolescents have asthma. The asthma hospitalization rate for African American children (41 per 10,000) in 1999 was more than three times the rate for Caucasian children (13.5 per 10,000). Childhood lead poisoning (defined as a venous or capillary blood lead level  $\geq 20$  ug/dL) is a serious, but preventable, health problem that affected 555 Maryland children in 1999 alone. An additional 3,349 children were diagnosed with elevated blood lead levels (defined as a venous or capillary blood lead level  $\geq 10$  ug/dL). Obesity and obesity related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. Anecdotally, school health personnel and primary care providers are increasingly identifying depression and mental health disorders as problems among adolescents.

Access to Health Care: As of June 28, 2000, 15 of Maryland's 24 jurisdictions were either entirely or partially federally designated as medically underserved areas for primary care services. This occurs even though the ratio of primary care physicians to the population is higher in Maryland than the national average. Part of this higher representation is based on the high number of physicians employed by government research facilities, military and medical schools, in non-direct health care positions. Four of Maryland's twenty-four jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services.

The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland

Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded coverage for comprehensive health insurance for children up to the age of 19 and for pregnant women of all ages in families with incomes at/or below 200 percent of the Federal Poverty Level (FPL). MCHP has substantially increased access to comprehensive health care services for uninsured children and pregnant women in Maryland.

In FY 1997, prior to the implementation of MCHP in July 1998 as a Medical Assistance expansion program, approximately 18% of Maryland children and adolescents were enrolled in the Medical Assistance Program. It was projected that 60,000 children in families with incomes up to 200% of the poverty level would be become eligible for Medical Assistance through the MCHP expansion. Maryland's MCHP also provides services for pregnant women with incomes between 185% and 200% of the FPL. Within the first nine months of the Program, approximately 45,000 children and 200 pregnant women had enrolled in MCHP.

By June 2000, MCHP enrollment had reached 74,000. As of May 31, 2001, MCHP enrollment exceeded 88,000. This rapid growth in enrollment was due to an aggressive outreach campaign and cooperative relationships between DHMH programs, the Maryland State Department of Education and the private sector. The outreach campaign included: (1) screening all clients for MCHP eligibility at WIC sites; (2) distributing application forms at schools and targeting students enrolled in school lunch programs, and (3) using tray placemats at fast food establishments as an advertisement for MCHP.

/2003/ Effective July 1, 2001 Maryland initiated a separate children's health insurance program expansion, MCHP premium. This expansion covers uninsured children under age 19 in families whose income is above 200% but at or below 300% of the federal poverty level (FPL). Families pay a modest monthly premium. Coverage for pregnant women was also expanded to women with incomes between 200 and 250% of the FPL. Both Medicaid and MCHP recipients are enrolled in Health Choice, Maryland's managed care program. During Federal Fiscal year 2001, the number of children ever enrolled in MCHP exceeded 109,000 including 308 children enrolled in MCHP Premium. /2003/

/2004/ MCHP enrollment increased to 110,000 in federal fiscal year 2002. The Maryland Legislature enacted changes in the MCHP Premium Program in 2003. The Private Option Program was repealed and no new children will be allowed to enroll. The 200 currently enrolled children will continue to be served, but will be switched from their employer sponsored plans to HealthChoice. In addition, MCHP enrollees with incomes between 185 percent and 200 percent of poverty must now pay a family contribution. This change may further increase the need for local health department based preventive and primary care services. //2004//

***/2005/ Effective July 1, 2004, cuts to the MCHP Premium Program were restored by the Maryland General Assembly during the 2004 Session. In addition, Medicaid implemented changes in eligibility so that pregnant women enrolled in MCHP will now be allowed to continue to receive benefits at the sixth month redetermination even if their income exceeds the eligibility thresholds. This was done to ensure continuity of care and greater likelihood of a healthy birth outcome. Maryland submitted a waiver to allow non-eligible immigrant pregnant women access to prenatal care benefits, arguing that it was more cost-effective. However, the waiver request was denied. //2005//***

/2004/ In FY 2003, a problem with access to pediatric specialty care became apparent and articles describing the problem appeared in the Baltimore Sun. In the distant past, the CSHCN program supported a series of outreach specialty clinics held in local health departments around the State. With the expansion of Medical Assistance, and the initiation of HealthChoice and MCHP, these clinics were thought to be unnecessary. Unfortunately, pediatric provider rates fell so low that in many areas no pediatric specialty providers could be found who would accept Medical Assistance rates. A 2001 Department of Health and Mental Hygiene report documented that Maryland Medicaid reimbursement rates were, on average, about 36 percent of 2001 Medicare rates and that Maryland ranked 47th in physician reimbursement according to an American Academy of Pediatrics study of 1998/1999 rates. These access problem disproportionately affected the outlying areas of the State. The legislature

appropriated funds to increase provider reimbursement in 2002 legislative session. However, the recent cut-backs in MCHP eligibility may adversely affect access to specialty care for children in the income brackets affected. At the request of the Maryland Association of Health Officers, the possibility of recreating the Statewide network of pediatric specialty clinics is being explored. //2004//

More detailed MCH-related health status indicators are reported in the Needs Assessment Section and/or the Health Status Indicator Section. Other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment Section.

### State Health Agency Priorities

The mission of the Maryland Department of Health and Mental Hygiene is to protect and promote the health of the public by creating healthy people in healthy communities; to strengthen partnerships between state and local governments, the business community and all health care providers in Maryland; and to build a world class organization grounded in the principles of quality and learning, accountability, cultural sensitivity and efficiency. Legislation that passed during the 2000 Legislative Session addressed (1) the expansion of MCHP, (2) the creation of the Cigarette Restitution Fund Program, (3) maternal mortality and (4) lead screening. These four areas, along with the development and implementation of the State's Health Improvement Plan, serve as departmental priorities and are discussed below. During FY 2001, two of the priority areas have been addressed and implemented, expansion of MCHP to 300% FPL and the Health Improvement Plan.

/2003/ Following the events of September 11th, preparing for and responding to bio-terrorism threats became a major departmental priority for Maryland as in most other states. The State was recently awarded \$19.1 million in federal funds to help prepare for potential bio-terrorism threats and other health emergencies. At the State level, monies will be used to develop a coordinated statewide public health emergency response plan, upgrade laboratory facilities, improve emergency communication capabilities and conduct statewide emergency drills. Funds will also be distributed to local health departments and hospitals to fund local emergency drills, improve emergency communications and coordination systems, update disease reporting systems, and purchase protective supplies and equipment. Maryland began planning for bio-terrorism in 1998. /2003/

1. Implementation of a comprehensive anti-cancer/anti-tobacco program using funds from the National Tobacco Settlement- The first installment of funds received from the national tobacco settlement will be used by DHMH to implement a comprehensive anti-cancer/anti-tobacco program. This program, proposed by Governor Parris N. Glendening, is designed to help people currently addicted to tobacco products, as well as those who have developed cancer. The tobacco funds will support a myriad of projects to reduce tobacco use and combat cancer. The projects range from creating tobacco cessation and educational programs to funding cancer-related research in Maryland hospitals and institutes of learning. Outreach efforts and greater access to cancer screening and treatment will be implemented. Beginning in FY 2002, approximately \$80 million will be assigned to DHMH to administer. It is anticipated that this allocation will continue for an additional 18 years. The Title V program will collaborate in the development of (1) smoking cessation programs for children, adolescents, and pregnant women; and (2) asthma outreach and education initiatives.

2. Elimination of Health Disparities - DHMH has selected this as a priority and included objectives to address health disparities within the State's Health Improvement Plan for 2010. The State is addressing mortality disparities, including childhood deaths that are influenced directly or indirectly by environmental factors.

/2004/ The Maryland General Assembly passed legislation in 2003 requiring the DHMH to develop and implement a plan to reduce health care disparities based on race/ethnicity, gender and poverty. The legislation also encourages the development and implementation of higher and continuing education courses and seminars that address the identification and elimination of health care service disparities. A DHMH Work Group will be convened to address the Legislature's recommendations. Title V will be represented on the Work Group. //2004//

***//2005/ The 2004 Maryland General Assembly passed legislation calling for the establishment of an Office of Health Disparities and Minority Health in the Department of Health and Mental Hygiene. This Office which is headed by Dr. Carleissa Hussein, sponsored the first statewide conference on health disparities in June 2004. //2005//***

3. Prevention of Lead Poisoning Among Children - In January 2000, Governor Glendening declared that the State of Maryland must aggressively expand its efforts to protect children from the tragedy of lead poisoning. He announced a comprehensive plan to significantly reduce the likelihood that children in low-income neighborhoods, particularly in Baltimore City, will be exposed to toxic levels of lead. The State's comprehensive plan includes the implementation of a Statewide Lead Targeting Plan, which was recently developed by the MCH Program and an Interdepartmental Strategic Plan for preventing lead poisoning. Legislation passed during 2000 requires that children living in areas identified as high risk for lead poisoning are to receive blood lead testing at certain age intervals. The MCH Program plans to work closely with other State agencies and community partners to assure that high risk children are screened.

*//2004// Beginning in September 2003, all children entering school and living in at risk areas must be tested. //2004//*

***//2005/CMCH staff worked with a contractor to update Maryland's mandated lead targeting plan for identifying at risk areas for childhood lead poisoning. The targeting plan was refined and updated to reflect more recent data from the 2000 Census and other sources. As a result, several new areas of the state were identified as at risk for lead exposure. As a result, funds will be reallocated to local jurisdictions for lead screening in FY 2005. The numbers of jurisdictions affected increased from 18 to 20. //2005//***

4. Reduction of Maternal Mortality - In FY 1999, the MCH Program in conjunction with the Vital Statistics Administration undertook an analysis of maternal mortality in Maryland. This study found that: (1) maternal deaths are underreported, (2) domestic violence is a leading cause of maternal mortality, and (3) African-American women are two to three times more likely to die during pregnancy than Caucasian women. Beginning in July 2001, Maryland death certificates must indicate if a deceased woman was pregnant. This will assist the State in accurately documenting and monitoring maternal mortality. Through legislation passed in 2000, Maryland became one of 25 states to establish a maternal mortality review committee. The new law requires DHMH to identify maternal death cases, review records and data, consult with experts and make recommendations regarding the prevention of maternal death.

*//2004/ State health agency priorities for 2004 include health care reform, restructuring of the agency, emergency preparedness and the development of perinatal systems of care. The Secretary of Health, Nelson J. Sabatini, has identified health care reform as a priority and is calling for the provision of universal health care coverage for all families. A legislatively mandated Task Force has been appointed to study reorganization of the DHMH to improve service delivery. A final report is due by December 2004. Emergency preparedness and bioterrorism remain as an Agency priority. Finally, the Secretary is interested in advancing legislation to enhance and expand perinatal systems of care and has approved funding due this time of fiscal constraint to expand perinatal health activities. //2004//*

#### MCH/CSHCN Program Priorities

The MCH Program priorities for FY 2002 are as follows:

1. To refine the ten year MCH strategic plan (see Appendix B) with input from local health departments, health providers, family groups, community based organizations, advocacy groups and other MCH stakeholders.
2. To reduce maternal, infant and child mortality and to improve health outcomes through the implementation of maternal mortality, fetal and infant mortality and child fatality review processes; the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); and the

continuation of local health department based home visiting and care coordination programs.

***/2005/ In April 2004, Maryland released its first PRAMS Report describing women who delivered live born infants in 2001. The Maryland specific section of the survey included questions on assisted reproduction, contraceptive use, depression, oral health, bedrest during pregnancy, social services and seatbelt use. For the first time, Maryland specific data is available on such factors as the percentage of unintended pregnancies (42%), daily folic acid use prior to pregnancy (31%), physical abuse by a partner during pregnancy (4%), and moderate postpartum depression (20%). A copy of the full report is available on the CMCH website at fha.state.md.us/mch.***

***Maryland was one of five states selected to participate in an Action Learning Lab on perinatal disparities sponsored by the Association of Maternal and Child Health Programs (AMCHP). The Lab's purpose is to assist states to address racially and ethnically based perinatal disparities. The project was initiated in response to recent scientific findings linking higher risks to poor birth outcomes for African American women and infants to social and environmental factors such as chronic stress and racism. There is no funding attached to participation, however, AMCHP is willing to provide technical assistance to states in the form of expert consultation, etc. Maryland's planned approach is to collate existing data, collect additional data, raise awareness of the contribution of stress including racism to disparate perinatal outcomes and to seek funding to implement "best practices." //2005//***

3. To continue to enhance the data and epidemiological capacity of the MCH Program.

***/2005/ Refer to the SSDI Grant and Progress Reports for more detailed information. //2005//***

4. To expand the childhood environmental health capacity through (1) expansion of the lead poisoning prevention program and childhood asthma program and (2) analyses of the environmental public health infrastructure as it relates to children.

*/2003/ Maryland was awarded a three year Centers for Disease Control and Prevention (CDC) Asthma grant in October 2001. This grant's major objectives are to develop a statewide asthma plan; and to implement an asthma surveillance system. Both adults and children are the target populations. Legislation passed during the 2002 General Assembly mandates the establishment of the Maryland Asthma Control Program effective October 1, 2002. /2003/*

***/2005/ Maryland has applied for the CDC Asthma Part A Enhancement. At the writing of this application, MCH had not received the funding decision. //2005//***

5. To continue to provide direct medical services to pregnant women, children and CSHCN who are not eligible for MCHP.

6. To continue to administer the Universal Newborn Hearing Screening Program.

7. To continue to develop a statewide system of care for children with special health care needs, including enabling services such as respite care.

*/2003/ Added Program priorities for 2003 include:*

8. To prevent obesity among children and adolescents and to promote proper nutrition (including breastfeeding promotion) and physical activity.

9. To improve the health of women throughout the lifespan.

10. To prepare for the implementation of tandem mass spectrometry as an enhancement to the blood spot Newborn Screening Program. /2003/

*/2004/ To use tandem mass spectrometry to add disorders of the urea cycle, fatty acid oxidation and organic acid metabolism to the Maryland newborn screening panel. //2004//*

***/2005/ To continue to fully implement an expanded newborn screening panel of 32 disorders. //2005//***

*/2004/ Added Program priorities for 2004 include:*

11. To enhance the MCH Program's ability to deliver services and manage programs in a culturally

competent manner.

12. To develop a plan for addressing MCH health disparities

13. To improve access to early childhood health services

14. To enhance and expand perinatal systems of care

15. To increase community and family input in MCH planning, policy and program development processes. //2004//

***//2005/ Added Program priorities for 2005 include:***

***16. To develop a statewide plan for strengthening enabling and infrastructure-building services for CSHCN at the local level.***

***17. To recognize and address perinatal depression.***

***18. To recognize and address fetal alcohol syndrome.***

***19. To develop child abuse and neglect regional resource centers. //2005//***

***//2005/ In May 2004, the Center for Maternal and Child Health in collaboration with the Mental Health Association of Maryland, Inc. submitted an application for the HRSA Grant entitled - Perinatal Depression and Related Mental Health Problems in Mothers and Their Families. Recent Maryland PRAMS data for 2001 indicate that nearly 60% of mothers experienced some level of depression - 11% reported at least moderate depression, 7% reported being very depressed, and 1.9% reported needing help. The state is seeking grant funds to implement a comprehensive public information and provider information campaign to increase understanding of perinatal depression and to address the stigma of mental illness which often discourages individuals from seeking treatment.***

***Several bills introduced during the 2004 Legislative Session would have required Maryland hospitals to provide written information to new parents on postpartum depression and shaken baby syndrome. The bills failed, however, the Maryland Hospital Association is convening an Ad Hoc Committee to determine how best to distribute this information to families of newborns. Both the CMCH Director, Bonnie Birkel and the CMCH Medical Director, Maureen Edwards will be participants this Committee along with representatives from local hospitals and the Mental Health Association.***

***To address the problem of child abuse and neglect, the Family Health Administration is developing a pilot program to educate physicians about the signs of child abuse and neglect. Regional Centers for Child Abuse and Neglect will be developed to provide clinical expertise to physicians in underserved rural areas to assist in diagnosing and managing difficult child abuse and neglect cases. Components of the strategy will include recruitment of a local physician to be trained by a core faculty of expert child abuse and neglect pediatric consultants. The trained local clinical expert will provide consultation to primary care and emergency room physicians. These regional projects will be housed in local health departments. This model, which has been successfully implemented in several other states, is proposed for implementation in an initial region of the state in FY 2006.***

***Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Defects (FASD) as it is now also known, has recently become of greater concern to the state. Legislation passed in 2004 requires the DHMH, contingent upon the availability of funds, to establish a statewide multi-media campaign to educate Marylanders about Fetal Alcohol Syndrome and other effects of prenatal alcohol exposure. A FAS Workgroup has recently been appointed. Bonnie Birkel, the CMCH Director will represent Title V on the Workgroup. Ms. Bonnie Birkel recently attended a National Meeting sponsored by SAMHSA's Center for Excellence in FASD. The prevalence of FAS in Maryland is not known. The CDC estimates a Maryland prevalence of 0.3 to 0.4 per 1000 live births translating to 22-29 children born each year in Maryland with FAS. Three times as many children may be affected by alcohol related neurodevelopmental disorders and alcohol related birth defects. Prenatal alcohol exposure is one the leading preventable causes of mental retardation. //2005//***

Maryland's Title V Program uses both quantitative and qualitative methods to determine statewide priorities as well as to determine emerging needs and trends. Available MCH data (e.g., Vital Statistics reports, program data) is continuously reviewed and analyzed to determine the health status of the MCH population and unmet needs. Periodically, local needs assessments and evaluations are undertaken and used to guide planning and funding at both the State and local levels. Through the grants/contract monitoring process, site visits with MCH representatives in each jurisdiction often yield information and data on unmet MCH needs and emerging trends. Unmet needs are also identified by the Secretary and Legislature.

## **B. AGENCY CAPACITY**

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), hereafter referred to as the MCH Program, share responsibility for MCH Block Grant development and implementation. The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure.

The MCH Program is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statutes relevant to Title V program authority include the following:

Child Fatality Review Teams (HEALTH GENERAL, Article 5, SS701) -- Establishes multi-disciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Hereditary and Congenital Disorders Program (HEALTH GENERAL, Article 13, SS101) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Administratively placed within the OGCSHCN.

General Regulations For Hereditary Diseases (COMAR 10.52.01) (several programs related to genetic disorders are mandated in regulation rather than statute)- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations are administered by the OGCSHCN.

Program for Hearing Impaired Infants (HEALTH GENERAL, Article 13, SS601) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of infants at risk for hearing impairment. This Program is administratively placed in OGCSHCN.

Sickle Cell Anemia (HEALTH GENERAL, Article 18, SS 501) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. Informed consent is required for screening. This program is part of the newborn screening and follow up program administered by the OGCSHCN.

Screening for Treatable Disorders in the Newborn Child (COMAR 10.52.12)-- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Informed consent is required for screening. This program is administered by the OGCSHCN.

Screening for Sickle Cell Disease, Thalassemia and Related Conditions (COMAR 10.52.13)- Establishes a voluntary program for population based carrier screening for these conditions. This program does not include newborns or those thought to be at risk on clinical grounds. This program is

administered by the OGCSHCN.

Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14)-Establishes a program to offer biochemical maternal serum screening to identify mothers at increased risk for carrying a fetus with a neural tube defect or a chromosomal anomaly. This program is administered by the OGCSHCN.

Maryland Asthma Control Program (HEALTH GENERAL, Article 13, SS701) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (HEALTH GENERAL, Article 13, SS1201)-Establishes a program to review maternal deaths and develop strategies to prevent deaths. Support is provided by the CMCH.

Children's Environmental Health Advisory Council (HEALTH GENERAL, Article 13, SS501) -- Creates a Council which is charged to identify environmental hazards that may affect children's health and to recommend solutions. CMCH chairs and staffs the Council.

Lead Poisoning Screening Program (HEALTH GENERAL, Article 18, SS106) -- Establishes a Lead Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

Disease Prevention (HEALTH GENERAL, Article 18, SS107) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within CMCH and OGCSHCN.

Sentinel Birth Defects (HEALTH GENERAL, Article 18, SS206) -- Requires hospitals to report sentinel birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. OGCHSN is administratively responsible for the program.

School Health (EDUCATION, Article 7, SS401) -- Requires the Department of Education and the Department of Health and Mental Hygiene to jointly (1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation. School health activities are housed within CMCH.

***/2005/ Legislation passed during 2004 requires the Secretary of Department of Health and Mental Hygiene to establish and promote a statewide campaign on fetal alcohol syndrome and other effects of prenatal alcohol exposure. This activity will placed administratively in the Center for Maternal and Child Health. //2005//***

***/2005/ The following state mandates relevant to Title V program authority were inadvertantly left out of previous applications:***

***Program for Crippled Children (HEALTH GENERAL, Article 15, 125) - Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling". Administratively placed within the OGCSHCN.***

***Fetal and Infant Mortality Review (HEALTH GENERAL, Section 18-107) This activity is administratively place within CMCH.***

***Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this Program.***

***Family Planning (Family Law Article, Section 2-405) The Family Planning Program is required***

**to distribute a Family Planning brochure to all marriage license applicants.**

**CMCH is responsible for developing Perinatal Systems Standards which are incorporated in the following regulations:**

**COMAR 10.24.12 (State Health Plan: Acute Hospital Inpatient Obstetric Services)**

**COMAR 10.24.18 (State Health Plan: Specialized Health Care Services -- Neonatal Intensive Care Services)**

**COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Centers)//2005//**

MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The mission of the Center for Maternal and Child Health is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. Ms. Bonnie S. Birkel serves as the Center's director. As the attached organization chart shows, the Center is comprised of five divisions: Family Planning and Reproductive Health; Maternal and Perinatal Health; Child and Adolescent Health; Community Based Initiatives and Partnerships; and Administration, Planning and Epidemiology. The Federal Abstinence Education, Service System Development Initiative (SSDI), and Title X Family Planning grants are also administered by CMCH.

//2004/ A Women's Health Program was established in CMCH in 2001. Information about the Program was inadvertently left out of previous applications. See description below. //2004//

**//2005/ Changes at the federal level will result in the transfer of administrative responsibility for the Abstinence Education Program from DHMH to the Department of Human Resources (DHR). DHMH plans to work with DHR to ensure a smooth transition. //2005//**

The goal of the Family Planning and Reproductive Health Program is to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The target population includes clients in need of subsidized family planning services, with special attention to those who are uninsured and with incomes under 250% of federal poverty guidelines. The Program is consistent with federal and state mandates to lower the incidence of unintended pregnancy and promote the health of women of reproductive age (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title X of the U.S. Public Health Services Act of 1970). Program efforts are designed to (1) assure that Maryland communities offer family planning and reproductive health services to clients in need; and (2) develop a coordinated approach for assuring quality patient care services, educational activities, and evaluation efforts in order to improve reproductive health outcomes.

The Family Planning Program administers the following services: Family Planning Clinical Services, Reproductive Health Services that include colposcopy, cancer screening program and sexually transmitted disease treatment, the Healthy Teens and Young Adults program and the Adolescent Pregnancy Prevention Program. Program activities include the following:

1. Assuring reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices;
2. Providing an array of preventive health care services including contraceptive care, colposcopy services, reproductive health education and counseling, sexually transmitted disease services, HIV/AIDS prevention services, breast and cervical cancer screening, cardiovascular risk screening, and referrals for indicated health and social services;
3. Developing community-based outreach strategies for reaching and serving young people, both males and females, who are at risk for unintended pregnancies;
4. Organizing workgroups of health professionals and community members to set standards for

clinical care; and

5. Assuring compliance with Title X Federal Family Planning regulations and guidelines.

The goal of the Maternal and Perinatal Health Program is to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconception health, assuring early entry into prenatal care, and improving perinatal care. In collaboration with local health departments, hospitals, private providers, professional organizations and community groups, the Program works to assure and improve the quality of services for the 70,000+ infants born each year in Maryland. This Program oversees the maternal health programs of the MCH Block Grant. The Program is consistent with federal and state mandates to reduce infant mortality and promote the health of women and children (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title V of the U. S. Social Security Act of 1935). Program efforts are designed to improve the health of women of reproductive age and their newborns by assuring that comprehensive, quality maternal health care services, including outreach and education, are available and accessible to Maryland citizens in need. Program activities include the following:

1. Assuring access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetics screening, high-risk referral, home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care;
2. Support of a Toll Free Maternal and Child Health Hotline (1-800-456-8900) that assists pregnant women seeking prenatal care;
3. Funding of regional perinatal improvement activities (Crenshaw Perinatal Health Initiative);
3. Perinatal systems building in each jurisdiction including Fetal and Infant Mortality Review, provider education, and public awareness efforts;
4. Development of perinatal standards and support for Perinatal Center Review and Designation;
5. Administration of the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide survey that identifies and monitors selected maternal behaviors;
6. Promotion of Preconception Health including the use of folic acid preconceptually (Folic Acid Council);
7. Breastfeeding Promotion in cooperation with the Maryland Breastfeeding Promotion Task Force;
8. Maternal Mortality Review in cooperation with the Vital Statistics Administration and the State's Medical Society;
9. Funding for Sudden Infant Death Syndrome (SIDS) related educational and family support activities; and
10. Sponsoring Perinatal Health Conferences.

The goal of the Child and Adolescent Health Program is to promote and protect the health of Maryland's 1.5 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are available and accessible. This is accomplished through a comprehensive, integrated system of care that provides: (1) direct and enabling services to underinsured and uninsured children and (2) population based services to Maryland's children, adolescents and young adults who would be at risk if preventive public health measures and health messages were not available. The Program is responsible for developing policies and implementing primary prevention and early intervention strategies to improve the health of Maryland's children. Leadership, consultation, training and technical assistance are provided in several program areas including school and adolescent health, care coordination and home visiting, environmental health and child fatality review. The Program collaborates with numerous DHMH programs and other State agencies in the development of policies and programs. This Program also oversees the child and adolescent health components of the MCH Block Grant Program.

Programs administered by this Division include the Home Visiting and Care Coordination Program; the School Health Program; the Childhood Asthma Program; the Childhood Lead Screening Program; the Childhood Obesity Program; and the Adolescent Health Program /2003/ and the Maryland Asthma Control Program //2003//.

Program activities include the following:

1. Assuring access to child health services including medical care, risk assessment for families and adolescents, case management and home visiting, screening, referrals and assistance obtaining a medical home;
2. Facilitating the development of regional/community child and adolescent health plans;
3. Providing medical consultation and technical assistance to school health programs;
4. Teen pregnancy prevention;
5. Administering the Maryland Abstinence Education and Coordination Program;
6. Administering the Childhood Lead Screening Program and evaluating Maryland's Targeting Plan for Areas At Risk for Childhood Lead Poisoning to assure appropriate screening and testing of all children at risk for lead poisoning;
7. Implementing the Child Fatality Review (CFR) mandate;
8. Supporting the Children's Environmental Health Protection Advisory Council;
9. Administering the Maryland Asthma control program including development and implementation of both a statewide asthma plan and an asthma surveillance system;
10. Planning to prevent childhood overweight; and
11. Working with the Medical Assistance Program to increase enrollment in MCHP and other Medical Assistance Programs.

*/2004/* The goal of the Women's Health Program is to assess and address health issues that commonly, uniquely, or disproportionately affect women throughout their life span. This Program partners with other program areas to facilitate access to comprehensive preventive and primary care services that incorporate the unique needs of women. The Women's Health Program was established by issuance of an Executive Order by the former Governor, Parris Glendening in 2001. Funding was initially appropriated by the Legislature to staff the Office. However, this funding was cut due to fiscal constraints and staffing for the Program currently consists of one board certified obstetrician/gynecologist with in-kind support provided by other staff within CMCH. Program activities include:

1. Administration of the Women Enjoying Life Longer (WELL) Project, a three year project funded under the MCHB grant program, "Integrated Comprehensive Women's Health Services in State MCH Programs." The project is beginning its third and final year of implementation. The goal is to develop and test a model for integrating and coordinating preventive health services to promote wellness among women enrolled in family planning programs.
2. Publication of materials to promote and improve the health of women. Current publications include a booklet on postpartum depression ([www.fha.state.md.us/womenshealth/pdf/postpartum\\_booklet.pdf](http://www.fha.state.md.us/womenshealth/pdf/postpartum_booklet.pdf)) and a report on the health of Maryland women ([www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf](http://www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf)). *//2004//*

***/2005/ CMCH has made the commitment to sustain funding for the WELL Project. //2005//***

The Division of Community Initiatives and Partnerships is responsible for developing initiatives and strengthening community partnerships with community organizations, advocacy groups, universities and professional groups to improve maternal and child health. This Unit shares responsibility with other programs where community involvement, outreach and partnering are crucial to program success. Examples include Abstinence Education, Pregnancy Risk Assessment Monitoring System (PRAMS), Teen Pregnancy Prevention, Male Involvement, and Child Fatality Review.

The Division of Administration, Planning, and Epidemiology supports Center activities at the infrastructure building level. A major Division goal is to track and monitor the health and health needs of women and children. Responsibilities include data and epidemiological analyses, statewide and community needs assessment, programmatic evaluations, strategic planning, MCH technical assistance/consultation, contract monitoring and analyses as well as fiscal/administrative and personnel related activities. This Division also administers the SSDI grant and coordinates the development of multiple grants.

The mission of the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is: (1) to reduce death, illness and disability from genetic disorders, birth defects, chronic diseases and injuries and to improve the quality of life for these individuals, and (2) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. As the organization chart in Section 5.3 shows, the OGCSHCN is comprised of four divisions: Newborn Screening and Follow-Up, Birth Defects, Metabolic Disease Nutrition, and Specialty Care and Regional Resource Development. Administration of the Universal Newborn Hearing Screening Program is another responsibility of this Office.

The Division of Newborn Screening and Follow-Up screens babies for eight disorders, Biotinidase Deficiency, Branched Chain Ketoaciduria, Galactosemia, Homocystinuria, Hypothyroidism, Phenylketonuria, Tyrosinemia and Sickle Cell Disease. All babies born in Maryland, (70,000+ per year), are eligible for service. The Universal Infant Hearing Screening program is in this Division. This Division also includes Carrier Screening for sickle cell disease, Thalassaemia and Tay-Sachs Disease as well as AFP/triple Marker Screening to detect neural tube defects.

/2003/ Congenital Adrenal Hyperplasia was added to the screening panel in October 2001, bringing the number of disorders in the panel to nine. Maryland received an MCHB grant to enhance the Infant Hearing Screening Program and improve both data collection and cultural competency. /2003/

/2004/ The Department obtained two tandem mass spectrometers, sent staff for training, and switched over to tandem mass spectrometry for the detection of the current panel of 4 amino acid disorders. The laboratory is currently validating the analytes for the detection of the urea cycle disorders. As soon as the urea cycle disorders are added to the routine panel, work will begin on validating the acyl carnitine profile for the detection of additional organic acidurias and disorders of fatty acid oxidation. This will increase the number of disorders in the panel by approximately a factor of three. An expanded practitioners manual and parent information and informed consent materials are in production. //2004//

***/2005/ With the addition of tandem mass spectrometry for the detection of disorders of the urea cycle, fatty acid oxidation, and organic acid metabolism, the Department fully implemented an expanded newborn screening panel of 32 disorders in November 2003. //2005//***

The Division of Metabolic Disease Nutrition follows patients with genetic metabolic disorders like PKU or MSUD and provides case management, dietary therapy and a summer camp.

The Birth Defects Division includes the Birth Defects Reporting and Information System which collects data on the number of babies born with any of 12 common birth defects and provides information on the defects and services available.

The Division of Specialty Care includes the Children's Medical Services Program (CMS), the Regional Resource Development Program, the Medical Day Care Program, and the Genetic Services Program. The Division of Specialty Care includes the Children's Medical Services Program (CMS) which historically served as the payer of specialty services for a large population of children with special health care needs in the state. This program has undergone major changes in the last few years as a result of Medicaid expansion and the resulting redesign of the program. The Regional Resource component funds 14 local health departments for a variety of services including the provision of specialty clinics for uninsured and underinsured children, care coordination, assessment of family and community needs and service capacity building.

/2003/ Currently, 21 of the State's 24 local health departments receive grants to partially subsidize services to Children with special health care needs. /2003/

/2003/ Currently 15 of the State's 24 jurisdictions have OGCSHCN grants to develop respite care

initiatives. //2003/

//2004/ In FY 2002, respite care funds were awarded to 16 of the 24 jurisdictions and 17 were awarded funds in FY 2003. //2004//

**//2005/ In FY 2004, 16 of the 24 jurisdictions were awarded respite care funds. Four additional jurisdictions were awarded funds to support care coordination and specialty care. //2005//**

//2004/ The scarcity of specialty providers willing to take Medicaid rates in the outlying areas of the state and the failure of local hospital specialty clinics to break even has lead the Maryland Association of Local Health Officers to request an exploration of the re-creation of the statewide system of outreach specialty clinics. //2004//

Two Medical Child Care Centers are funded to serve children ages 6 weeks to three years of age with complex medical conditions and medical needs that cannot be met in traditional child/day care programs. As part of the interagency collaboration with Maryland's Early Intervention System, staff are involved in interagency coordination and liaison activities. A respite initiative has recently been developed as well as a plan for strengthening regional resources for families and providers.

Finally, the Genetic Services Program coordinates a statewide network of clinical genetic services at 3 centers, 14 general genetics outreach clinics, 6 sickle cell disease outreach clinics, and 2 hemophilia outreach clinics.

//2003/ The clinic system was rearranged to better serve the population in accordance with changing demographics in the State. One clinic was discontinued (Elkton) and 4 new clinics were added (Bel Air, Shipley's Choice, St. Agnes and Greenspring). **//2005/ In response to changing needs and fiscal constraints, the current clinic system includes 12 general genetics outreach clinics and one hemophilia outreach clinic. //2005//**

The Community Health Administration also administers a portion of Title V State matching dollars that are allocated to the local health departments through targeted funding. Maryland's 24 local health departments provide the core public health functions of assessment, policy development and assurance to citizens at the local level. The 24 local health departments receive annual basic public health funding (including Title V funds) from the DHMH through a Unified Grant Award process. Local health departments are the major service delivery arm for the DHMH and provide MCH services such as school health, family planning, home visiting and care coordination, immunizations, lead screening, fetal and infant mortality review, child fatality review, oral health services and maternal health services. Health Officers in each of Maryland's 24 jurisdictions are responsible for administering state and local health laws and regulations.

//2004/ Maryland is increasingly becoming a more diverse state. Recognizing this, the MCH Program has begun to strengthen its ability to provide culturally competent services. Although, MCH staff in most jurisdictions and at the State level represent diverse sectors of Maryland's population; and translation and other services are often provided to address linguistic and communication needs, more remains to be done. A training was conducted by the National Center for Cultural Competence for all MCH and family planning staff at the State level in April 2003 to reinforce the importance of cultural competence.

As planning progresses on the upcoming needs assessment, the MCH Program with the support of the National Center and others will be developing a plan for promoting cultural competence in all Title V funded programs. Organizational assessments will be conducted and additional trainings will be offered for MCH staff at the state and local levels. A Cultural Competence Advisory Group will be convened to oversee plan development and implementation. Maryland's Title V Program will be requesting technical assistance from MCHB to assist with this process. //2004//

## C. ORGANIZATIONAL STRUCTURE

The State of Maryland, Department of Health and Mental Hygiene (DHMH) is the designated Title V Agency. The Secretary of Health and Mental Hygiene, Dr. Georges C. Benjamin, who reports directly to Governor Parris Glendening heads DHMH. As the attached organizational chart shows, three Deputy Secretariats report to Dr. Benjamin: (1) Operations, (2) Public Health Services and (3) Health Care Policy, Finance and Regulations.

//2004// In November 2002, Maryland voters elected Robert L. Ehrlich, Jr. as Governor and Michael S. Steele as Lieutenant Governor. Governor Ehrlich is the first elected Republican Governor since Spiro Agnew's win in 1966. Nearly one-third of the 188 Maryland General Assembly members were either newly elected or won election in another chamber. All four committee chairmanships in the Senate changed and a new Speaker of the House was elected.

Governor Ehrlich appointed Mr. Nelson J. Sabatini as the new Secretary of Health and Mental Hygiene in March 2003. Mr. Sabatini formerly served as the Secretary of Health during the early nineties. Secretary Sabatini has stated that the Center for Maternal and Child Health is the lead state agency for all MCH related matters. //2004//

***//2005/ Secretary Sabitini has announced plans to leave his position within the next several months. A replacement has not yet been named, however, Mr. Sabatini has consented to remain available as an active consultant to the Governor and the Department. //2005//***

The Title V Program is administratively housed under the Family Health Administration within the Deputy Secretariat for Public Health Services. This Deputy Secretariat also is responsible for six other administrations: AIDS, Alcohol and Drug Abuse, Community Health (e.g., Immunizations, sexually transmitted diseases, and bioterrorism), Developmental Disabilities, Laboratories and Mental Hygiene; the Anatomy Board and the Office of the Chief Medical Examiner. Medical Assistance, the State's Medicaid Program, is located under the Health Care Policy, Finance and Regulation Secretariat. The Deputy Secretariat for Public Services is headed by Arlene Stephenson.

Administrative oversight for the Maternal and Child Health Block Grant was formerly the responsibility of the Community and Public Health Administration (CPHA). During FY 2001, DHMH evaluated CPHA to determine its efficiency and effectiveness. This was done because the three centers and 13 offices under CPHA actually represented more functions/responsibilities than many entire state health departments. The decision made during the spring of 2001 was to split CPHA into two administrations - one representing community and public health activities and the other representing family health related activities.

Effective July 2001, Dr. Russell Moy became the Director of Family Health Administration (FHA) and Ms. Joan Salim became the Deputy Director. All of the MCH related programs are located within the FHA. The organizational structure implemented February 2000 remains the same for the MCH programs. At that time, the former Office of Children's Health was split. The programs for primary and preventive care for children joined the former Office for Maternal Health and Family Planning to form the Center for Maternal and Child Health (CMCH). The programs for children with special health care needs (CSHCN) joined the former Office for Hereditary and Congenital Disorders to form the Office for Genetics and Children with Special Health Care Needs (OGCSHCN).

The Family Health Administration includes the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, the Office of Primary Care and the WIC Office. Other offices within the Administration closely linked with the core MCH offices are Oral Health, Health Promotion, Education and Tobacco Control, Injury Prevention and Public Health Assessment. Department organization charts identifying the programs at the Secretariat and FHA

levels are attached.

//2004// In May 2003, the Office of Chronic Disease Prevention and the Office of Injury Prevention and Health Assessment merged to establish the Center for Preventive Health Services within the Family Health Administration. This Center was created to strengthen coordination and raise the visibility of the Administration's prevention programs. //2004//

## D. OTHER MCH CAPACITY

Maryland's MCH Program, comprised of staff in the Center for Maternal and Child Health, and the Office for Genetics and Children with Special Health Care Needs, includes a highly skilled and diverse team of 42 public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the Downtown Baltimore offices of Maryland's State Office Complex. One nurse consultant is outstationed to Maryland's Eastern Shore at least 75% of the time. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

The Center for Maternal and Child Health is headed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and 25 years of experience in public health. She is responsible for MCH policy development and is official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

Susan R. Panny, M.D., oversees the work of the Office for Genetics and Children with Special Health Care Needs. Dr. Panny is certified by both the American Board of Pediatrics and the American Board of Medical Genetics. She has 30 years of experience in pediatrics and genetics and 20 years of experience in public health. She is an internationally known figure in newborn screening and public health genetics. She has served as the Director of the OGCSHCN since 2000, and prior to that had served as Director of the Office for Hereditary Disorders since 1984.

Maureen Edwards, M.D., M.P.H., serves as Medical Director for CMCH. Dr. Edwards holds board certification in neonatology and a masters degree in public health. Her prime responsibility is to oversee and provide medical consultation on policy and assurance matters for various CMCH programs. She is also the Center's legislative liaison. Dr. Edwards supervises the Center's medical staff, including the Medical Director for School and Adolescent Health, Dr. Cheryl DePinto, who is board certified in pediatrics and adolescent medicine; the Medical Director for the Family Planning Program, Dr. Evan Mortimer, a board certified obstetrician/gynecologist; and the Medical Director for Women's Health, Dr. Diana Cheng, a board certified obstetrician/ gynecologist. She also serves as Project Director for a CDC funded grant which is examining asthma from a public health perspective in Maryland and serves as chair of the Maryland Asthma Planning Task Force.

***//2005/ Jamie Perry, M.D., M.P.H. was hired as the Associate Medical Director of the Office for Genetics and Children with Special Health Care Needs. Dr. Perry is board certified in Pediatrics and Neurodevelopmental Disabilities and holds a Master of Public Health Degree. Dr. Perry assists Dr. Panny in overseeing the clinical and programmatic work of the OGCSHCN, with particular focus on programs in the Division of Specialty Care. //2005//***

Bernadette Albers, M.P.H., APRNCS, assists Ms. Birkel as the Assistant Director of CMCH. Ms. Albers holds a Master of Public Health degree and is board certified in community health nursing. She has over 25 years experience in the fields of public health and health administration. In addition to being responsible for CMCH's daily operations, she heads the Division of Administration, Planning and Epidemiology. This unit includes four master's trained nurse consultants (Jeanne Brinkley, Mary

O'Malley, Pamela Putman and Marie Erickson) who monitor contracts and provide technical assistance and consultation to Title V grantees on MCH issues (e.g., lead, adolescent health, asthma, obesity, school health). This unit also includes a master's trained health policy/research analyst who serves as the SSDI Project Director and Title V Coordinator (Yvette McEachern); a database administrator (Debbie Walpole); two fiscal administrators (Ellie Eines and Astria Boyd Millner); and support staff (Debbie Krome and Anita Goldman).

***//2005/ Mary O'Malley, a nurse consultant, retired in June 2004. Ms. O'Malley was responsible for early childhood health activities include lead screening and prevention activities as well as administration of Maryland's Early Childhood Systems Grant. Due to the state's fiscal situation and the continuing hiring freeze, Ms. O'Malley's position will not be filled. Plans are underway to hire a contractual administrator for the Early Childhood Grant.***

***Lead activities will now be handled by Jeanne Brinkley, a senior nurse consultant in the Center. Ms. Brinkley was also recently given responsibility for supervising the MCH nurse consultant team that includes Pamela Putman and Marie Erickson.***

***Audrey Regan was hired in April 2004 as the part-time (60%) Asthma Control Program Administrator. Her position is funded through the CDC Asthma Control Grant. Mr. George Weidner has replaced Astria Boyd Millner as the fiscal administrator for CMCH programs. //2005//***

Planning, evaluation and data analysis activities are provided by a MCH epidemiologist, a MCH database specialist, a health analyst, the Assistant Director for MCH and the birth defects database specialist and nurse consultants in the OGCSHCN. Yvette McEachern, M.A. has served as the SSDI Project Director for the past three years and also oversees development of the Title V application including data collection performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health analyst/statistician at the State level. Debbie Walpole, B.S. serves the MCH database manager/specialist and oversees CMCH database development and linkages; and data generation using SAS and other software. Ms. Walpole has worked for CMCH for the past three years. Bernadette Albers leads strategic planning efforts for the MCH Program and supervises grants development, including Title V.

***//2004/ William Adih, M.D., Dr.P.H. is the newly hired senior MCH epidemiologist, replacing Dr. Pankaja Panda who left state service to pursue a position with the federal government. Dr. Adih is a public health physician with extensive domestic and international experience in maternal and child health and reproductive health epidemiology. He provides epidemiological and data analysis support for the Center's activities. //2004//***

***//2005/ Debra Perry, MPH was hired for the newly created Title X funded position of Family Planning Epidemiologist. Ms. Perry received her MPH from the University of Michigan School of Public Health in Epidemiology and has worked provided epidemiologic support to various state and local agencies in Virginia and Maryland. Ms. Perry is a member of the state's Maternal and Child Health Needs Assessment Steering Committee and will be working closely with the Adolescent Health Needs Assessment Workgroup. //2005//***

In addition, data support and analysis is provided by the Vital Statistics Administration which is headed by an MCH epidemiologist, Dr. Isabelle Horon, and the Office of Injury Prevention and Public Health Assessment which is headed by Dr. Lori Demeter. Contractual services are also purchased when necessary to complete data, assessment and planning activities.

Andy Hannon, LCSW-C, supervises the Division of Community-Based Initiatives and Partnerships. Mr. Hannon has over 25 years experience in public health and in addition to his supervisory role, leads male involvement initiatives for CMCH. Other activities under his direction include the PRAMS Survey which is supported by three staff persons (Helen Espatillier, Laurie Kettinger and Jodi

Shaefer); and the Abstinence Education Program which is led by Christine Fogle. Ms. Fogle also serves as the Teen Pregnancy Prevention Coordinator for CMCH. Ms. Mary Johnson provides staff support to the Maryland Breastfeeding Promotion Task Force, the Children's Environmental Health and Protection Advisory Council and the Asthma Control Program. Ms. Johnson also leads community outreach efforts for CMCH.

//2004/ Joan Patterson, LCSW-C, was hired by Mr. Hannon as the CFR/FIMR Coordinator in May 2003. Ms. Patterson has a social work degree and extensive experience as a pediatric social worker. She provides staff support to the State Child Fatality Review Team, and monitors contracts that provide technical support to local CFR and FIMR teams. //2004//

The Title X Maryland Family Planning Program links and overlaps with MCH on a number of issues including preconception health care, teen pregnancy prevention and infant mortality reduction. Family Planning staff include a Program Chief, a Medical Director, several physicians and nurse practitioners who provide direct medical services and monitor contracts and program quality, and a program administrator.

//2004/ Ms. Victoria Young, LCSW-C, was hired as the new Chief of Family Planning in January 2003. Ms. Young has worked extensively in the area of child abuse and neglect. //2004//

In the OGCSHCN, Donna Harris, BS, the Deputy Director oversees all administrative and fiscal matters. Betty Smith handles contracts and procurement. Support services are provided by Marie Sapp, Sharon Burke and Chevria Meekins.

The Division of Newborn Screening is directed by Karen L. Funk. BS, RN, MEd. Ms. Funk has 35 years of neonatal intensive care nursing experience, 10 of them in a research setting. She provides the medically expert follow up for infants with abnormal blood spot screening results. She serves as Dr. Panny's deputy for clinical issues. She is also responsible for the major database of the OGCSHCN, which contains the linked data for the newborn blood spot and hearing screening programs, the long term follow up programs for sickle cell disease and metabolic disorders and the birth defects program. She is assisted in the sickle cell disease program by Adi Bello, BSN, RN who provides home visiting and clinical follow up and Marcia Diggs who handles the follow up database.

Jennie Cook, BS, MS, CCC-A provides the expert audiological follow up of infants suspected of having hearing loss. Theresa Thompson, BA, MA and Carol Fernandez, BA provide initial follow up of hearing screening results and handle the educational aspects of the infant hearing screening program. Eileen Cohen, BA, MA, CCC-SP, a speech pathologist who is the OGCSHCN Early Intervention specialist and liaison with medical assistance, provides consultation to hearing screening program.

Elizabeth Emerick, BA, MS, RD, LN and Mary Kalscheur, BA, MS, RD, LN are expert metabolic nutritionists, each with over 20 years of experience, and provide the dietary therapy and long term case management for children with metabolic disorders.

Anne Terry, BSN, MA, RN, serves as the Chief of the Birth Defects program, and is assisted by Rosemary Baumgardener, BA who serves as database manager.

Marion Luchau, BSN, RN provides the clinical expertise for Children's Medical Services, the fee for service portion of the CSHCN program. Barbara Greer is the CMS eligibility specialist and Terri Smiley provides clerical support. Joanne Johnson handles billing and assists Ms. Harris with the fiscal management of the Office.

***//2005/ Patricia Williamson, R.N., B.S.N., C.C.M., was hired to replace Marian Luchau who retired. Ms. Williamson has almost 15 years' experience working with CSHCN and their families. //2005//***

Mary Ann Kane- Breschi , BA is the CSHCN regional resources coordinator and the liaison with the teaching hospital "Centers of Excellence", the local health departments, Parent's Place and other CSHCN family support services. Eileen Cohen oversees this portion of the program and directs the medical day care program.

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and the continued awarding of a grant to Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. This service will be further enhanced with the implementation of regional resource centers throughout the state that will be staffed by parents of CSHCN who will be employed by Parents' Place with funding from OGCSHCN. This will enable parents to access resources and link with other parents.

/2003/ The OGCSHCN has hired the mother of a special needs child as a member of the professional staff. The regional resource center in Wicomico County serves the entire Eastern Shore and is a model for other regions. /2004/ The newly hired Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. //2004//

## **E. STATE AGENCY COORDINATION**

The organization charts contained in Section V, Supporting Documents, identifies the functions and staff that support Title V Programs. In addition, strong working relationships exist among a number of entities who support the planning and delivery of maternal and child health services in Maryland. The Office of Primary Care and Rural Health administers the AHEC through the University of Maryland and provides a variety of collaborative activities that are maximized with the inclusion of this office within the same Administration as the MCH Program. The Center for Immunization has developed a strong collaborative relationship with the Division of Child and Adolescent Health to improve childhood immunization rates.

/2004/ Organizational charts are attached to the section on Organizational Structure. //2004//

The Office of Oral Health (OOH) has developed a strong collaborative relationship with the MCH Offices. This is exemplified by the CMCH Assistant Director being requested to be an active consultant in the Statewide Oral Health Advisory Committee. This Committee is currently addressing access issues and developing a statewide child dental health assessment. The CMCH through the SSDI Grant recently funded a study of children enrolled in the Head Start Program to identify oral health needs. This study also includes a pilot component to evaluate oral health needs that are unique to CSHCN. The OOH is charged with the responsibility of conducting the oral health evaluation for the Medical Assistance Program. /2004/ The newly hired Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. //2004//

Maryland's Medical Assistance Program provides all the resources and personnel necessary to implement HealthChoice and MCHP. A collegial and collaborative relationship exists between this Program and the MCH Offices. This is particularly evident in policy discussions, sharing of client databases between each unit, and access to information on Medicaid eligibility status. The Department's Alcohol and Drug Abuse, Mental Hygiene and AIDS Administrations provide additional specialized support in the form of technical assistance, consultation, and results of their needs assessments/data collection efforts. /2004/ The OGCSHCN Early intervention specialist, who is a speech pathologist, spends two days a week with Medicaid preauthorizing OT, PT, audiological services, speech therapy and hearing aids. //2004//

MCH programs have strong collaborative partnerships with several teaching hospitals/universities in the state. Both JHU and UMAB have collaborated in the development of state and multi state conferences, and the design of research projects. The GWU School of Public Health and the Johns Hopkins School of Public Health have established an internship relationship where graduate preventive medicine fellows, MPH candidates and/or nurse practitioners have practicum experience in the MCH offices. In addition, the Chief of Clinical Nursing at GWU serves as the liaison to Ryan White Title II and IV committees. Johns Hopkins Hospital, the Kennedy- Kreiger Institute and University of Maryland Hospital and Children's National Medical Center partner with the OGCSHCN to deliver clinical genetic services as well as specialty care.

The private sector includes an array of birthing hospitals and centers as well as office-based obstetrical, pediatric, and primary care providers, managed care organizations, federally qualified health centers, and rural health networks. Specialty care needs are addressed through a network of community-based providers, tertiary care centers ("Centers of Excellence"), a genetics network, the Crenshaw network, and linkages with the Shriner's Hospital through the MCHB sponsored Choices Program.

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and the recent (FY 1999) awarding of a grant to Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. This service will be further enhanced with the implementation of regional resource centers throughout the State, which will enable parents to access resources and link with other parents.  
***/2005/ The OGCSHCN has continued yearly grants to Parent's Place which support a network of CSHCN parent representatives throughout the state. //2005//***

*/2003/* The OGCSHCN has hired the mother of a special needs child as a member of the professional staff. The regional resource center in Wicomico County serves the entire Eastern Shore and is a model for other regions. */2003/ /2004/* The newly hired Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. *//2004//*

Intra-agency and interagency collaboration will continue with the following programs and agencies: WIC, the Office of Primary Care and Rural Health, Title X Federal Family Planning Program, the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the Governor's Office for Children, Youth and Families (OCYF), the State Commission on Infant Mortality Prevention, the Governor's Council on Adolescent Pregnancy, the Children's Environmental Health and Protection Council, the Maryland Department of Human Resources, the Maryland State Department of Education, the Department of Juvenile Services, the Maryland Institute of Emergency Medical Services, the Office of the Chief Medical Examiner, and the Maryland Health Care Commission.

*/2003/* Collaboration has been strengthened between the MCH program and the Family Health Administration's Office of Chronic Disease Prevention on the issues of asthma and childhood obesity. The MCH Program also partnered with the State's Medical Society and the American College of Obstetricians and Gynecologists (ACOG) on postpartum depression. In addition, the CMCH and Center on Health Education and Tobacco Prevention partnered with ACOG on a smoking cessation and pregnancy initiative. */2003/*

*/2004/* The MCH Program continued as an active participant on the Early Childhood Mental Health Steering Committee. This Committee was jointly convened by the Mental Hygiene Administration in DHMH and the Maryland Department of Education to develop a plan for incorporating mental health services into early childhood programs statewide. The Maryland Asthma Planning Task Force, with funding from a CDC grant to the CMCH, continued its second year of operation. This Task Force includes representatives from several DHMH agencies include the Office of Chronic Disease Prevention and is charged to develop a statewide asthma plan. The MCH Program is the recipient of the CDC grant. A grant from the March of Dimes to the MCH Program allowed for the re-institution of

the Folic Acid Council in 2003. WIC co-chairs this Council along with the MCH Program. //2004//

***/2005/ At the request of the Maryland Department of Juvenile Services (DJS), the Center for Maternal and Child Health was involved in a review of the delivery of somatic health services in DJS. The review's purpose was to clarify policies and procedures related to the delivery of somatic health services, review credentials of health services staff, identify areas of concern regarding somatic health care in these facilities; and provide recommendations as appropriate to address issues related to the delivery of somatic health services. The Chief of School and Adolescent Health within CMCH was intimately involved in this review. //2005//***

The Title V agency will continue to strengthen its working relationship with non-governmental organizations including: the Medical and Chirurgical Society of Maryland, the Maryland Chapter of the American Academy of Pediatrics, the American College of Medical Genetics, the Maryland Ob-Gyn Society, the University of Maryland School of Medicine, Dentistry, Nursing and Social Work, the Johns Hopkins School of Medicine, the Johns Hopkins School of Hygiene and Public Health, the Maryland Association of HMOs, Planned Parenthood of Maryland and Metropolitan Washington, the Maryland Hospital Association, the Maryland Association of County Health Officers and numerous other local voluntary and communication based organizations.

The Title V agency will continue to support community-based organizations that have been working to improve the health of mothers and children, including the Maryland Coalition for Healthy Mothers and Healthy Babies, the Maryland Perinatal Association, the Maryland chapter of the national March of Dimes Birth Defects Foundation and numerous single disease oriented voluntary organizations.

MCH representation on numerous interagency councils, task forces, and committees will continue. These include the Governor's Council on Child Abuse and Neglect, the Coalition to End Childhood Lead Poisoning, the Governor's Lead Commission, the Promoting Safe and Stable Families Preservation Steering Committee, the High the Infants and Toddlers State Interagency Coordinating Council, the Maryland State School Health Council, various committees of the Maryland Chapter of the American Academy of Pediatrics, the Department of Human Resources Child Care Administration's Advisory Committee, OCYF's Healthy Families Maryland Initiative, the High Risk Infant Council, Department of Human Resources' Responsible Choices Task Force, the Advisory Council for Hereditary and Congenital Disorders, the Advisory Council for Hearing Impaired Infants, the Advisory Board of Cooley's Anemia foundation of Maryland, the Sickle Cell Disease Association of America, Neurofibromatosis Inc.-Mid Atlantic, the Maryland Alliance of PKU Families and the Maryland Hemophilia Foundation.

*/2003/ Since the last application, the MCH Program has also been represented on the following interagency groups: the Healthy Child Care Maryland Steering Committee, the Maryland Girl's Commission, the Healthy Homes Initiative, the Early Childhood Mental Health Steering Committee, the Ready at Five Strategic Planning Committee, The Judy Center Advisory Committee, the Maryland Home Visiting Collaborative, and TAMAR's Children (an intervention program for incarcerated women and their children). /2003/*

*/2004/ In 2003, the MCH Program became an active participant on the Leadership in Action Program (LAP) Team. This Team was convened by the Maryland Partnership for Children (includes the Secretaries of Health, Education and Human Resources) to address collaboration on early childhood issues in Maryland. MCH was also represented on the Early Head Start Policy Council and the Head Start Health Collaborative. //2004//*

***/2005/ MCH is also represented on the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, the Taskforce on Inclusive Child and After-School Care, and the Special Needs Advisory Council for HealthChoice. //2005//***

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

Below is a narrative description of Maryland's status on the required Health System Capacity Measures and Health Status Indicators. Data for each of the indicators is included on Forms 17, 18 and 19.

Health System Capacity Measure #01 -- The rate of children hospitalized for asthma per 10,000 children less than five years of age.

Following the receipt of a CDC grant in 2001, Maryland began implementation of a statewide asthma surveillance system and development of a statewide asthma control plan. Presently, two asthma surveillance reports have been published. The 2003 Maryland Asthma Surveillance Report indicates that statewide, 151, 000 Maryland children under the age of 18 have a history of asthma. Children under the age of 5 had the highest hospitalization rate of any age group at 37.2 hospitalizations per 10,000 population in 2002. Maryland's rate was lower than the national average in 2002, but higher than Healthy People 2010 goal of 25 hospitalizations per 10,000. Hospitalization rates for African Americans in 2002 were three times that of whites. The Statewide Asthma Control Plan completed in April 2004 identifies strategies for promoting proper outpatient management of asthma and decreasing inappropriate hospitalizations.

Health System Capacity Measure #02 -- The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. In Federal Fiscal Year 2003, over 90% of the 31,778 infants enrolled received a screen; up from 75% in FFY 1999. Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a Managed Care Organization of their choice and select a Primary Care Provider to oversee their medical care.

Health System Capacity Measure #03 -- The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen

Maryland's SCHIP Program, the Maryland Children's Health Program (MCHP), provides full Medicaid health benefits to children up to age 19, and pregnant women of any age who meet the income guidelines. MCHP enrollees obtain care from Managed Care Organizations (MCOs) through the Maryland HealthChoice Program. The Medicaid Program reports that in FFY 2003, 91.4% of the 395 infants enrolled received at least one periodic screen.

Health Systems Capacity Measure #04 -- The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

Maryland is not submitting data for the two indicators that require calculation of the Kotelchuck Index. As in past years, the MCH Program requested this data from the Vital Statistics Administration, but because of concerns about the formula used to calculate the Index, the information was not provided. The formula defines the first trimester of pregnancy as months one through four. Traditional definitions define the first trimester as months one through three.

Health Systems Capacity Measure #07 -- The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

These data are provided by the Maryland Medicaid Program. Increasing percentages of EPSDT eligible children have been receiving dental services. However, the percentages remain low, less than 50%, and the Maryland Legislature has asked the Program to develop a plan for increasing utilization

rates.

Health Systems Capacity Measure #08 -- The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

As of December 2003, according to the Social Security Administration, there were 12,172 Maryland children under the age of 16 receiving federally administered SSI payments. In 2003, none of these children received rehabilitative services from the State CSHCN Program since all qualified for these services through the Medicaid/MCHP Program. Medicaid/MCHP covers children up to 200% of the poverty level, the same income eligibility guidelines as Medicaid. Medicaid coverage in Maryland includes rehabilitative services.

Health Systems Capacity Indicator #05 -- Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

Data for this indicator is largely derived from birth records. For the year 2000, data is available from a linked Medicaid and birth record file. Maryland is not submitting data for the two indicators that require calculation of the Kotelchuck Index. As in past years, the MCH Program requested this data from the Vital Statistics Administration, but because of concerns about the formula used to calculate the Index, the information was not provided. The formula defines the first trimester of pregnancy as months one through four. Traditional definitions define the first trimester as months one through three. The data indicate that Medicaid enrolled women as compared to women with other types of insurance are almost twice as likely to have a baby that dies within the first year of life, less likely to receive early prenatal care and more likely to have a low birth weight baby.

Health Systems Capacity Indicator #06 -- The percent of poverty level for eligibility in the State's Medicaid programs for infants, children, Medicaid and pregnant women.

The Maryland Medicaid Program provides medical care coverage to low income infants, children and pregnant women. Pregnant women and infants are covered up to 185% of the poverty level. Children under the age of 19 are covered up to 100% of the federal poverty level. Children accounted for about 65% of Medicaid enrollment in FY 2002, but less than 22% of expenditures. The majority of children are enrolled in HealthChoice, Medicaid's managed care program.

Health Systems Capacity Indicator #06 -- The percent of poverty level for eligibility in the State's SCHIP programs for infants, children, Medicaid and pregnant women.

The Maryland Children's Health Program (MCHP) covers pregnant women of any age and children up to age 19 if they have a family income that is at or below 185% Federal Poverty Level (FPL) for children and up to 250% FPL for pregnant women. The Maryland Children Health Program Premium (MCHP Premium) covers uninsured children up to age 19, who have not dropped employer-sponsored health insurance within the previous six months, and who have paid the monthly premium payment per family. The family income standard for eligibility is at 200% through 300% FPL. Premiums vary by family size and income and range from \$41 to \$52 per month. For both, MCHP and MCHP Premium, assets are not considered in determining eligibility. In addition, MCHP and MCHP Premium beneficiaries receive health benefits through HealthChoice, Maryland's Medicaid Managed Care Program.

Health Systems Capacity Indicator #09A - The ability of the state to assure MCH Program access to policy and program relevant information

Maryland's MCH Program has direct access to several surveys and registries that yield rich information about the state's maternal and child health population. These include the state's hospital discharge records, an annual birth defects surveillance system, the BRFSS Survey and the PRAMS Survey. Birth and death records are linked by the Vital Statistics Administration and results are published in three year cohorts, the most recent covering the period 1999-2001. Newborn screening and birth record files have been linked and Medicaid and birth record files are linked periodically. WIC and birth record files are currently not linked due to concerns about HIPAA. Available data from linked files will be analyzed for the upcoming Title V needs assessment.

The Family Health Administration has identified data resource development including data sharing and linkages as one of its key priorities for FY 2004. The intent is to strengthen the FHA leadership's collective focus on health outcomes of FHA programs and services and to determine how these health outcomes may be captured by data. FHA is developing a plan for measuring and communicating program outcomes. An inventory of data resources within each Office has been drafted and opportunities for further data collaboration including linkages are being explored. This exercise will be very useful in assisting completion of the Title V needs assessment.

Health Systems Capacity Indicator # 09A -- The percent of adolescents in Grade 9 through 12 who reported using tobacco products in the past month.

Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. The surveys show that tobacco use by youth attending public high schools declined from 23% in the fall of 2000 to 17.6% in the fall of 2002.

The Maryland Adolescent Survey (MAS) is jointly sponsored by the State Departments Education; and Health and Mental Hygiene. Every two years, a sample of sixth, eighth, tenths and twelfth graders are surveyed to determine trends the use of alcohol, tobacco, and other drugs among adolescents. The most recent survey results for 2002 was completed by 33,979 students and represented 12 to 14% of the state's school enrollment. Reported findings included reductions in thirty day tobacco use rates for tenth and twelfth graders.

Maryland is slated to become a YRBS state in the near future following the passage of legislation during the 2004 Maryland General Assembly requiring the state to collect these data.

Health Systems Capacity Indicator #09C -- The ability of the state to determine the percent of children who are obese or overweight.

There is currently no database or surveillance system in Maryland that allows for the annual tracking and monitoring of obesity rates among children. Legislation passed in 2004 requires the state to begin participation in the YRBS surveillance system. This will eventually provide data on the obesity/overweight status of adolescents. On a periodic basis, the WIC Program has agreed to share data on the Body Mass Index of enrolled children with program staff in the Family Health Administration, including MCH.

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

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

This section describes Maryland's progress on required national and state performance measures and documents accomplishments, current activities and the plan for FY 2005. In FY 2003, Maryland's Title V Program served approximately 209,214 pregnant women, infants, children, including those with special health care needs and adults. The number served represents a significant increase since for the first time, the number of non-pregnant women receiving genetics services is included. As this report will show, Maryland was able to meet the majority of its target objectives for the 33 performance and outcome measures.

In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2002 . Therefore, for many performance measures, we were unable to report on progress for FY 2003. In several instances, the data for the year 2003 will not be available until June 2005 or later. As this data become available, it will incorporated into subsequent applications.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are intended, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are Program priorities as described in the next section. All activities and programs are linked to these outcome measures.

### **B. STATE PRIORITIES**

Form 14 contains Maryland's list of MCH Priority Needs for FY 2005. The priority needs are unchanged from last year's application as they continue to reflect needs based on the FY 2000 needs assessment as well as subsequent updates. Maryland has developed a MCH strategic plan to guide Title V MCH program planning and development over the coming decade. This working document is continually reviewed and refined based on findings from new and ongoing needs assessment activities.

While the priorities are numbered, the assigned numbers do not reflect their importance, but reflect the general relationship to where the priority falls within the MCH Service Pyramid. It should be noted that given the manner in which this list is constructed, many of these priorities were reorganized to closely reflect the order of the pyramid from direct services to infrastructure building activities. However, the MCH Program believes that all of the priorities are of equal importance and must be considered in relation to each other. Below is a discussion of the rationale for selection of each of the priority needs.

1. To improve access to quality health care, including substance abuse treatment and mental health care for women, mothers, infants and children/adolescents including children with special health care needs in Maryland.

The five year needs assessment indicated a need to expand this priority because accessing substance abuse treatment impacts on the receipt and maintenance of timely prenatal care, and affects pregnancy and birth outcomes. In addition, throughout the State, there was an expressed need to improve access to mental health services. Depression and other mental health issues were often mentioned as concerns for women prior to, during and following pregnancy. In addition, an

increasing need for mental health services was often identified as a problem for adolescents. This priority is linked to most of the performance measures which concern health or health status improvement including #4 (medical home for CSHCN), #11 (breastfeeding), #12 (uninsured children), and #16 (adolescent suicide) and #18 (prenatal care).

***//2005/ Since the 2000 assessment, activities to address perinatal depression have increased. CMCH published a pamphlet on perinatal depression in 2002 and Dr. Diana Cheng, author of the pamphlet, has conducted numerous workshops and trainings throughout the state to educate health providers. During FY 2004, CMCH in collaboration with the Mental Health Association of Maryland applied for federal funding to address perinatal depression. //2005//***

2. To improve access to oral health care for children, including instituting preventive environmental measures.

This priority was expanded to include preventive environmental measures since several Maryland jurisdictions still do not have fluoride in their water system either because of political action or because of the use of well water. [Recently one jurisdiction (with the worst dental caries rate in the State) elected to begin using fluoride for the first time in its history, while another jurisdiction stopped using fluoride due to costliness.] Access to dental care, independent of family income, continues to be an issue throughout the State and particularly in rural areas. Performance measure # 11 concerning dental sealants is directly linked to this priority.

3. To eliminate health disparities and reduce morbidity for pregnant women, mothers, infants, children and adolescents, including children with special health care needs.

This priority was revised to reflect the commitment of DHMH and the Title V Program to eliminating health disparities. A review of much of the vital statistics and hospital discharge data reflect significant differences between African-Americans and Caucasian-Americans on both morbidity and mortality. A concerted effort will be undertaken to determine the causative factors of key disparities, such as maternal and infant mortality, and asthma morbidity. This priority is linked to all performance and outcome measures.

***//2005/ As a result of participation in an AMCHP Action Learning Lab on Perinatal Disparities, CMCH has convened a statewide Perinatal Disparities Workgroup. This Workgroup will be developing a plan and reports to raise awareness about perinatal disparities. Existing data will be collated and new sources of data that measure the impact of stress and racism will be collected, where possible. Opportunities to capture funding for implementation of evidence based activities to reduce the disparities will be sought. //2005//***

4. To ensure that the genetic contribution to infant and children's mortality, morbidity and disability continues to be addressed within the Title V Program.

Even though over 8000 individuals are served yearly in three genetics centers and 12 outreach clinics, the Statewide needs assessment showed that most providers and the general population were unaware of the availability of genetics services in the State. The MCH Program will make a major effort to publicize these services. Infants identified as hearing impaired in the new Universal Infant Hearing Screening Program will be linked to genetic services. Linkages between genetics clinics and other CSHCN clinics will be improved.

***//2005/ With the expansion of newborn screening in Maryland from 9 disorders to 32 disorders, as well as the introduction of a commercial laboratory competing with the State laboratory to provide newborn screening in Maryland, it is imperative that the State-sponsored follow-up provided by the OGCSHCN, particularly the short-term follow-up, be maintained in Maryland. It is also critical that the infrastructure remain in place at the genetics specialty centers in order to appropriately evaluate the increased numbers of children identified with abnormal screening test results. //2005//***

5. To ensure healthy births by reducing the rate of low birth weight births.

This became a new priority in FY 2001 because of the persistent low birth weight among African-American newborns and its contribution to fetal and infant mortality. It is anticipated that the implementation of PRAMS will assist in identifying factors that can be modified through public health intervention. This is directly linked to the infant mortality outcome measure as well as performance measures # 8, 15, 17 and 18.

***//2005/ During FY 2005, all FIMRs will focus on LBW and VLBW babies born in non-tertiary care facilities to determine the decisions that result in this finding. Findings will be summarized in a final report to include recommendations. //2005//***

6. To prevent and/or reduce child, adolescent and CSHCN morbidity that results in a lack of school readiness, poor school performance and an increased school absenteeism.

Throughout the statewide needs assessment process, both qualitative and quantitative data revealed that morbidity is increasing among school aged children due to asthma, dental caries, mental health concerns and risk-taking behavior. Increasing morbidity contributes to a lack of wellness on the part of the students, and is linked to poor school performance. Significant numbers of adults expressed a concern that children were at risk and that the risks taking behaviors were increasing.

Asthma is currently a leading reason for school absenteeism in Maryland and it disproportionately affects African-American children. Secondary disabilities are increasing for CSHCN because many health care benefit packages do not understand that preventing further deterioration, rather than improving wellness, is the objective of many care plans. In addition, because of changing provider participation in HealthChoice and as a result changes in MCO participation, children in some areas of the State are having to travel greater distances for specialty care. Another issue confronting the State is that as more children receive a non-public or home schooling education, the school health screenings that routinely have occurred in public schools are missed. This priority was written to show the relationship between health, school readiness and school performance.

School readiness is priority focus of the Governor appointed Maryland Partnership for Children, Youth and Families. This group had spearheaded planning to develop systems in Maryland that support school readiness. The MCH Program also applied for the MCH Early Childhood Comprehensive Systems Grant to develop a plan for improving the health of young children in Maryland by promoting early childhood systems building and collaboration.

***//2005/ Maryland received an MCHB funded Early Childhood Grant and has begun the planning process. The intent is to link the perinatal and early childhood stages so that continuous systems of care are developed in Maryland.***

***The CMCH Medical Director for School and Adolescent Health spent considerable time developing guidelines for health emergencies in Maryland schools. //2005//***

7. To prevent, identify, screen and treat children for lead exposure and lead poisoning.

This DHMH priority is one of the most preventable health disparities confronting the State. Baltimore City has a disproportionate share of positive tests for lead poisoning among children when compared to the rest of the State. A recent study indicated that Baltimore City, which has high rates of childhood lead poisoning, also has low rates of school readiness and school success. This priority is linked to State performance measure 01 (lead screening) and is also identified as a MCH priority for the State's Managing for Results (MFR) process.

8. To reduce mortality rates for mothers, infants, children and adolescents.

Maryland has made a significant commitment to reduce maternal, infant and child mortality. Unfortunately, vital statistic data continue to indicate that the State's mortality rates are significantly higher than the nation and the Healthy People 2010 objectives. Health disparities in mortality also continue to persist. This need is reflected in State performance measure 02 - Percent of infant and child deaths reviewed. Priority 8 is linked to each of the Title V outcome measures.

9. To actively involve families, advocates and other stakeholders in the development and implementation of strategies to address MCH population needs.

Throughout the five year needs assessment, especially when discussions involved families of CSHCN, it was evident that parental and advocacy involvement are necessary. This was further expressed by the need to more effectively network for change.

***//2005/ CMCH plans to use needs assessment activities for the early childhood and Title V grants to identify family members and community leaders for an MCH Advisory Group. It is anticipated that focus groups and town/public meetings with parents, families and community leaders will assist in identifying participants for the Advisory Group. //2005//***

10. To improve the MCH public health information/surveillance, and epidemiological capabilities, including supporting local assessments.

The various assessments that the MCH Program performed or supported during the past two years have enabled the State to more accurately identify epidemiological needs and identify decisive steps to reach full epidemiological capacity. The statewide assessment enabled Maryland to more easily identify data elements and systems that are lacking, yet are needed to make sound public health programmatic decisions and policy. This priority was expanded to include the need for community assessments to be conducted at the local and regional level during the interim years between the major Title V needs assessments. This priority is linked to each of the performance measures in that data and information are required to adequately assess and monitor progress.

11. To develop performance and outcome measures, and thereby, ensure public accountability.

This priority reflects not only the expectations of the Title V Block Grant, but also the Maryland General Assembly. Maryland has implemented Managing For Results (MFR) that links program objectives, outcomes and budget allocations. The MFR plan is to be annually provided to the Department of Budget and Management (DBM). DBM has accepted the use of MCHB performance measures as the unit of measure for the MCH Program.

Maryland does not view this list as static or complete. Rather, as new knowledge is gained, the priorities will evolve to reflect the needs of Maryland's individuals and families. The five year needs assessment pointed to the need to further evaluate (1) the role of care coordination; (2) health delivery systems for adolescents and young adults, especially males in the 18-24 year old age group; (3) the health delivery systems for women when not pregnant, particularly those in the 18-24 year old age group; (4) the role of life-long learning and (5) the need to form partnerships beyond the traditional public health partnerships. The Title V Program is continuing to explore ways to examine these and other MCH issues during the interim needs assessment years.

## 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

Maryland continued its historical strength in providing a comprehensive program of state-sponsored services for genetic disorders. Maryland screened close to 100% of newborns and the OGCSHCN provided the necessary short-term follow-up for all infants with abnormal metabolic screens. In addition, the OGCSHCN provided longer-term follow-up services including case management, nutritional management, counseling, health education, and family support to 297 families with confirmed metabolic disorders in FY 03. The OGCSHCN continued to work closely with the major genetics specialty centers in the area to ensure that all babies needing a diagnostic evaluation received this, and that all children with confirmed disorders and their family members received the appropriate genetic services. In FY 2003, the genetics centers served over 7,200 individuals.

Maryland fully implemented tandem mass spectrometry for the detection of disorders of the urea cycle, fatty acid oxidation, and organic acid metabolism and began expanded newborn screening for 32 disorders in November 2003. The OGCSHCN began working with Pediatrix (formerly NeoGen) which became licensed to do first tier newborn screening in the State in 2003 in order to exchange data so that the OGCSHCN could continue to provide follow-up to all Maryland babies with abnormal newborn screening test results. Although Pediatrix provides screening for only a small proportion of the hospitals in the State at this time (5 out of 35 birthing hospitals), there have already been significant challenges to the comprehensive system of follow-up existing in Maryland prior to the introduction of a commercial laboratory.

Dr. Terry Davis from LSU came to Maryland and moderated several focus groups with providers and parents on the topic of communication efforts around newborn screening. Feedback on Maryland's educational materials related to newborn screening was obtained. Important information about ways to communicate with parents and physicians about newborn screening and the new disorders added to the Maryland panel was also gathered.

## b. Current Activities

The State screening lab and the OGCSHCN are continuing to gain experience with the detection and follow-up of infants with disorders detected by tandem mass spectrometry. The state screening lab and the OGCSHCN are working together to update the laboratory computer system (which populates the OGCSHCN follow-up database) to allow for expanded data entry and new reporting capability with the significant increase in the number of disorders screened for in Maryland.

A revised manual for pediatric providers that brings together comprehensive information about all of the disorders currently screened for in Maryland is in the final stages of completion, as is a shorter "cheat sheet" for rapid access to guidelines for following up abnormal newborn screens.

## c. Plan for the Coming Year

The OGCSHCN will continue to work with the State screening lab to gain experience with the detection and follow-up of infants with disorders detected by tandem mass spectrometry. There will also be continued collaboration on the updates to the computer system noted above. The OGCSHCN will continue its work with Pediatrix to ensure appropriate follow-up of all babies born in Maryland with abnormal newborn screening test results to the extent possible.

The manual and "cheat sheets" for pediatric providers will be printed and disseminated to all of the pediatric and family practitioner practice locations in the state. These will also be put on the OGCSHCN website. Maryland's current parent educational materials related to newborn screening will be updated based on feedback obtained through the focus groups described above to reflect the changes to the Maryland newborn screening program.

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

The National Survey of CSHCN estimated that 68.1% of Maryland families with CSHCN felt that they were partners in decision making and were satisfied with the services received, better than the national estimate of 57.5%. For Maryland children with functional limitations, this number dropped to 45.6% versus estimates greater than 70% for children with other types of health needs. Also of concern, fewer Hispanic families report that they are partners and are satisfied. Although Maryland's sample size was not large enough to show significance, this was also a finding on the national level.

The OGCSHCN continued to support Parent's Place of Maryland (PPMD), a non-profit, family-centered organization serving parents of children with disabilities. PPMD also houses the Maryland Chapter of Family Voices. The OGCSHCN supports PPMD in its efforts to educate parents/caregivers of CSHCN about health and related issues and to help them become advocates for their children. This is accomplished through a variety of mechanisms. PPMD conducts regular parent education courses and workshops throughout the state on health-related topics. PPMD provides individual assistance to families on effectively accessing health and related services by telephone, e-mail, and in face-to-face meetings. PPMD employs parents of children with special needs, and has a network of 7 part-time regional parent representatives throughout the state to work directly with families around health issues. In FY 2003, PPMD family representatives provided 777 individual contacts to assist 259 families of CSHCN. These numbers have at least doubled for FY 2004.

In order to promote family-centered care and professional collaboration at all levels of health care, the OGCSHCN has sought to employ and currently employs two parents of CSHCN, the Regional Resource Coordinator and the chief of our Birth Defects Program. Our Regional Resource Coordinator has been particularly active and effective in lending her expertise as a parent of a child with special needs in a number of venues such as serving as the Department of Health and Mental Hygiene designee on the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, and the Taskforce on Inclusive Child and After-School Care. In addition, PPMD has helped OGCSHCN stay abreast of family needs by sharing data with us. PPMD maintains an encounter database documenting what types of information and assistance families of CSHCN are seeking, and provides this data to OGCSHCN for needs assessment purposes.

A staff member in the OGCSHCN participates in the monitoring of Early Intervention services with the Maryland State Department of Education (MSDE). Part of this monitoring involves meeting with parents of children in the Early Intervention Program to assess satisfaction with services received. This enables MSDE to assure that parents have a role in improving the quality of services in the Early Intervention Program.

#### b. Current Activities

The OGCSHCN is working with PPMD to expand their current data collection system and develop a voluntary database of CSHCN in Maryland. The database will include identifying information, demographics, information about diagnosis, and about the types of services received and needed. Consent will be obtained to contact the families periodically to gather more detailed information about topics such as satisfaction with services and unmet needs. This database will be used for needs assessment purposes, and to give families of children

with a variety of special health care needs throughout the state the opportunity to have a voice in program and policy decisions to the extent possible. PPMD also hopes to use this database to assist with their development of a statewide Parent-to-Parent support network. The database will be housed and operated by PPMD, with the thought that this will increase family comfort in participating. PPMD will collaborate with partners and key stakeholders such as the Maryland AAP, the Centers of Excellence, and other parent groups to identify strategies for enrolling families of CSHCN in the database. Special outreach efforts will be made to collect information from subgroups such as ethnic/racial minority groups and lower income families.

The OGCSHCN is currently working with The Chesapeake-Potomac Spina Bifida Association and the Hemophilia Foundation of Maryland on needs assessments of the spina bifida population and the population of individuals with hemophilia in Maryland, respectively. These are two very different populations of CSHCN that have provided us with needs assessment data in the past, and we are particularly interested in gathering information about their changing needs over time.

### c. Plan for the Coming Year

The OGCSHCN will continue to support the above activities in the coming year. In addition, PPMD has plans to use a portion of its funding to develop a more in-depth training course for family members of CSHCN to assist them in taking their advocacy and leadership skills to another level, called "The Health Leadership Institute."

The OGCSHCN plans to conduct additional analyses of the National Survey of CSHCN and to share data with PPMD that might be useful for this organization's planning and programs. PPMD has already started to strategize about better ways to reach out to and support racial/ethnic minority families in the coming year. For instance, the most recently hired parent representative in their regional parent network has particular expertise in outreach to minority families. We would also like to strategize about methods of supporting families whose children have functional limitations.

*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 data from the National Survey of CSHCN continue to be our most accurate measure of the percentage of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home. According to this survey, an estimated 56.3% of CSHCN in Maryland receive coordinated, ongoing, comprehensive care within a medical home, greater than the national estimate of 52.6%. The data revealed that while 92.7% of Maryland CSHCN have a usual source of care and that doctors appear to do a good job providing family-centered care as defined by the survey, families reported significant problems with care coordination and communication between professionals and programs.

While the OGCSHCN was unable to sponsor any new programs or projects specifically focused on the medical home in the past year, the office has a long history of activities that support the medical home concept for CSHCN. The office works with the families of CSHCN who are identified and/or receive services through its programs to find a medical home to the extent possible. This includes children and their families identified through the newborn metabolic screening program, universal hearing screening program, and birth defects program, as well as children served in the Children's Medical Services specialty care payment program. The case management provided by our nutritionists in the metabolic disease nutrition program and our nurses in the sickle cell disease follow-up and Children's Medical Services programs can also

support providers in their efforts to create true medical homes for the children they serve. In addition, since we believe that children without medical insurance in Maryland are less likely to have a medical home, the OGCSHCN refers potentially eligible families to Medical Assistance and MCHP as well as other public programs that may provide pathways to securing funding for health care and related services such as SSI and DDA.

The OGCSHCN also supported a Complex Referral Clinic at Children's National Medical Center that provides primary care, consultation, and care coordination for Maryland children with particularly complex health conditions. This clinic functions as the medical home for some of the children it serves. In its first year, FY 2003, there were 77 visits to this clinic by 32 children.

#### b. Current Activities

As part of the Maryland Early Childhood Comprehensive Systems Grant from MCHB, the Center for Maternal and Child Health is contracting with the Maryland AAP to complete a medical home provider capacity assessment in Maryland. The Associate Medical Director of the OGCSHCN is a physician consultant on this grant. The OGCSHCN is in the process of looking at the available Maryland-specific data related to medical homes from the National Survey of CSHCN to better understand barriers to providing medical homes for CSHCN.

In addition, the OGCSHCN has given a small grant to Children's National Medical Center to support an educational program for Maryland providers related to improving primary care practice medical homes.

#### c. Plan for the Coming Year

The OGCSHCN will continue its efforts in the activities described above which support the medical home. The office will also work with the Maryland AAP to convene stakeholders for another attempt at some strategic planning around medical homes for CSHCN in Maryland, with the longer-term goal of submitting another grant related to medical home development.

The OGCSHCN gives yearly grants to the local health departments which are currently being used to support a variety of activities including respite care, care coordination, and community-based specialty care infrastructure. With the FY 2005 grant to Dorchester County, a rural county located on Maryland's Eastern shore, we plan to pilot the use of a public health nurse to team directly with local pediatric health care providers to provide care coordination for the CSHCN who most need this service in their practice, regardless of insurance status. This nurse will also collaborate with the Parent's Place of Maryland parent representative for that area, as well as other government and private organizations serving CSHCN. We hope that this will assist these practitioners in their efforts to provide medical homes for CSHCN in their practices.

*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 data from the National Survey of CSHCN continue to be our most accurate measure of the percentage of CSHCN whose families have adequate public or private insurance to pay for the services they need. An estimated 97.3% of Maryland CSHCN had insurance coverage at the time of the survey. While 88.1% of families overall indicated that their insurance usually or always met their child's needs, only 73.3% of families whose child had functional limitations reported this. Only 67.5% of Maryland CSHCN had "adequate" insurance as defined by this

survey. This is better than the national average of 59.6%, but significant room for improvement remains. Further analysis of insurance data from the National Survey of CSHCN is required to determine adequacy by insurance type.

The OGCSHCN continued to provide payment for specialty care and related services to CSHCN who were uninsured or without health insurance and had family incomes up to 200% FPL in Maryland in FY 2003. This was about 180 children, the majority of whom were unable to obtain health insurance due to their citizenship status. OGCSHCN continued to refer potentially eligible families to Medical Assistance and MCHP as well as other public programs that might provide pathways to securing funding for health care and related services such as SSI and DDA.

The OGCSHCN supported Parent's Place of Maryland (PPMD) in its efforts to help parents/caregivers of CSHCN become educated about health insurance and in doing so become better advocates for their children. PPMD developed and piloted five workshops for families related to insurance issues including "Choosing the Right Health Plan for Your Child with Special Health Care Needs," "Getting What Your Child Needs from Your Managed Health Care Plan," and "Strategies for Appealing Your Health Plan's Decision." PPMD family representatives also meet with the Special Needs Coordinators from each HealthChoice MCO at least quarterly to share information and resources regarding CSHCN. HealthChoice is Maryland's managed care program for medical assistance and MCHP clients.

The OGCSHCN continued grant support of Baltimore HealthCare Access, Inc., an agency of the Baltimore City Health Department whose main purpose is to assist Baltimore City residents enrolled in HealthChoice in accessing comprehensive health services through their managed care organization. Baltimore HealthCare Access, Inc. has placed special emphasis on access for children (and adults) with special health care needs, and has created a number of publications for families of CSHCN related to insurance and other health-related resources.

#### b. Current Activities

Beginning July 1, 2004, the freeze on enrollment in MCHP for families with household incomes between 200-300% of FPL will be lifted. In addition, families with household incomes between 185-200% FPL will no longer be required to pay premiums. Both of these measures should increase eligibility for the program.

PPMD is in the process of conducting focus groups with families of CSHCN who have private health insurance versus families of CSHCN who have public health insurance. Preliminary findings indicate that publicly insured families have greater difficulty with access to providers in rural/remote communities such as specialists and dentists, while privately insured families have greater problems with the scope of their benefits packages. The Director of the OGCSHCN sits on the Maryland Special Needs Children Advisory Council for the HealthChoice Program. This advisory council is planning to study the issue of provider availability and make recommendations to HealthChoice.

#### c. Plan for the Coming Year

In recent years, Children's Medical Services, the specialty care payment program run through the OGCSHCN, has had significant decreases in enrollment and funding. This has been related primarily to expansions in Maryland's state-operated public health insurance programs (medical assistance and MCHP). The Children's Medical Services program in its current form is costly to operate, however, and with limited dollars, it is not clearly cost-effective for the relatively small number of children that it serves. In FY 05, the OGCSHCN will develop a plan to decrease its costs for direct payment of specialty care through Children's Medical Services. This will include a plan to redistribute anticipated resources saved towards more community-based services

including enabling and infrastructure building services.

Also in the coming year, PPMD will conduct a complete series of the parent workshops developed on health insurance in each region of the state.

*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

The data from the National Survey of CSHCN continue to be our most accurate estimate of the percentage of CSHCN whose families report that community-based systems are organized so they can use them easily, 70.6% versus the national estimate of 74.3%. For CSHCN in Maryland with functional limitations, this number drops to 48.5%. We know that access to specialty providers and transportation in rural/remote communities in Maryland is perceived as a growing problem. Last year we continued to support infrastructure for selected outreach specialty clinics throughout the state in addition to wrap-around services in the major tertiary care centers for children (Centers of Excellence). In FY 2003, there were close to 1700 visits made to 25 outreach specialty clinics serving CSHCN, and over 90,000 visits made to specialty clinics at three Centers of Excellence.

With limited dollars, the OGCSHCN has focused much of its effort in recent years on supporting activities that provide information and referral to families of CSHCN throughout the state. The Office has continued to award grants to four Centers of Excellence in Maryland to support a Resource Liaison at each center whose function is to assist families with CSHCN to find needed resources both within the centers and in their community. In addition, a grant from the OGCSHCN continued to fund operation of the Regional Resource Center for Children with Special Needs in Wicomico County on Maryland's Eastern Shore. This center, located in the Wicomico County Free Library, staffs a Resource Coordinator for information and referral. It houses accessible computers for child and family use as well as books and audio/videotapes on a variety of special needs topics. Last year, OGCSHCN also continued to provide funding to Parent's Place of Maryland (PPMD) to support its information and referral line as well as its network of parent representatives throughout the state who are available to work one-on-one with families of CSHCN.

The availability of quality childcare and respite services for CSHCN within their communities remains a significant problem in Maryland. The OGCSHCN continued to support the operation of two medical day care centers which served 68 medically fragile infants and toddlers in FY 2003. These centers provide quality child care, nursing, and developmental services to children whose medical needs are too great to be served in traditional day care settings, allowing their caregivers to return to work. Also continued were grants to local health departments for the funding of a variety of respite services for 470 children in FY 2003.

The OGCSHCN works with the Maryland Early Intervention Program to monitor and assure quality of Early Intervention services for families in their communities. The OGCSHCN also distributes the federal match for the 3,956 MA eligible children in FY 2003 receiving Early Intervention case management.

#### b. Current Activities

The OGCSHCN continues to support the activities described above. In addition, PPMD has recently completed a comprehensive, searchable resource database to assist with information

and referral for Maryland families with CSHCN. Work is ongoing to post this database on the PPMD website for direct access by families and providers.

### c. Plan for the Coming Year

In FY 2005, the OGCSHCN will work with the local health departments, COEs, and other stakeholders to develop a plan for decreasing its costs for direct payment of specialty care through Children's Medical Services. This program has served relatively few children in recent years due to expansions in public health insurance, and is costly to operate. We will also create a plan to redistribute the anticipated resources saved towards more community-based services including enabling and infrastructure building services. It is anticipated that some resources will be available for expanding specialty care infrastructure in underserved areas of the state, while other resources will support an expanded network of enabling services such as CSHCN care coordination at the local level.

*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

According to the National Survey of Children with Special Health Care Needs, only 2.7% of Maryland families with CYSHCN felt that their child had received the necessary support and guidance to make a successful transition to all aspects of adult life, worse than the national average of 5.8%. Further examination of the data reveals that some of the individual components of transition captured in the survey are actually happening for around 30-50% of Maryland CYSHCN. We have hypothesized from this that some CYSHCN are receiving limited guidance and support in transition, but there is really a lack of a comprehensive approach to transition for most CYSHCN in our state.

The OGCSHCN continued to support a transition clinic for young adults with sickle cell disease at Johns Hopkins Hospital located in the Department of Internal Medicine. This clinic serves young adults with sickle cell disease from age 18 through age 21. In this clinic, they are cared for jointly by the pediatric and adult hematologists. At age 22, they transition fully to the adult hematology clinic. There are also support group activities for this population. The Office also supported transition activities for individuals served in the Comprehensive Hemophilia Treatment Center.

### b. Current Activities

The OGCSHCN is providing funding to support a monthly Transition Lecture Series hosted by the Kennedy Krieger Institute. This lecture series will be open to both families and providers and will include topics related to transition planning for CYSHCN such "Developmental Disabilities Administration Services," and "The Division of Rehabilitation Services (DORS) and the Workforce Technology Center." The lectures will be videotaped and copies will be available for any family to loan and view at home.

### c. Plan for the Coming Year

The OGCSHCN will continue to support the activities noted above. In addition, we plan to conduct focus groups with Maryland CYSHCN and their families to gather data on their knowledge of the critical elements of health care transition, their needs related to transition, and how they think pediatric and adult health care providers can best assist them with transition. We will include children/youth with a variety of disabilities and chronic conditions in the focus groups as we know that transition needs may be very different based upon a particular child's

anticipated level of independence as an adult. The OGCSHCN then plans to work with the Kennedy Krieger Institute and the Maryland AAP to create a brief transition pamphlet targeted at health care providers. The goal of this pamphlet is to raise awareness in the provider community of the critical issues related to transition for CYSHCN and provide an overview of the steps health care providers can take to assist families with transition. We plan to follow this pamphlet with more detailed materials in the future.

In addition, the OGCSHCN is supporting the Kennedy Krieger Institute to survey pediatric and adult health care providers in the community to find out what their needs are related to transition for CYSHCN. We are particularly excited about engaging adult providers and learning about transition from their perspective. We hope to find ways to increase the capacity of adult providers in Maryland who are skilled and comfortable in managing the needs of youth with a variety of disabilities and chronic conditions.

The OGCSHCN will also support Parent's Place of Maryland to develop and conduct workshops for families of CYSCHN on health care transition in the coming year.

*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

According to the CDC administered National Immunization Survey (NIS), in 2002, 80.8% of Maryland children under the age of three (i.e., ages 19-35 months) were fully immunized according to the 4:3:1:3 series. This percentage compares favorably with a national average of 77.5% for this time period and exceeds Maryland's target goal of 80% for this measure. More recent survey results covering several quarters in 2002-2003 indicate that even greater numbers of children were immunized (83.5%). Missed opportunities by physicians to provide immunizations and limited resources to adequately identify, track, monitor and to refer all under-immunized children are perceived barriers to the full immunization of all Maryland children before their third birthday.

The Community Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2003 included distribution of immunization educational materials to parents of every child born in the State, and continued development of ImmuNet, Maryland's statewide immunization registry. The Center also continued to administer the Maryland Vaccines for Children Program which offered free vaccine supplies to over 700 participating Maryland providers.

MCH staff continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, local health department clinics also continued to offer immunization services to Maryland children in need in 2003. MCH nursing staff in local health departments also educated families about the importance of immunization in home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff also determined the immunization status of their clients at every encounter and made appropriate referrals for service. The Healthy Child Care Maryland Steering Committee which was co-chaired by a nurse in the MCH Program continued to promote the need to educate child care providers about the importance of immunization.

## b. Current Activities

The Maryland Legislature established guidelines for creating and implementing a statewide immunization registry, ImmuNet. Over the past decade, DHMH has worked to plan the development of this statewide registry with the purpose of increasing vaccination levels in Maryland. During the current fiscal year, the Center for Immunization plans to begin pilot testing of software for ImmuNet. When fully operational, this registry will provide a consolidated vaccination record for children enrolled, offer the ability to forecast immunizations, provide reminder and recall notices, and print forms for schools, camps, and day care.

The Center for Immunization provides support for the Maryland Childhood Immunization Partnership, a coalition of groups and providers interested in improving immunization rates in Maryland. The partnership meets regularly and is a major stakeholder in the implementation of ImmuNet. The Title V Program recently re-joined this Partnership.

## c. Plan for the Coming Year

During the coming year, the Center for Immunization plans to fully implement ImmuNet. In addition, the Center for Immunization plans to develop and implement strategies to increase the immunization coverage rate as measured by the 4:3:1:3:3 series on the National Immunization Survey to 85% within the next five years from a baseline of 73% in 2001. Elimination of the six percentage point disparity in the vaccination rates among racial/ethnic groups will also be addressed. The MCH Program will continue to collaborate with the Center for Immunization on these objectives.

The Title V Program will also continue to support immunization outreach and education efforts provided by local health departments. Title V funds will continue to directly support Baltimore City's Immunization Registry, developed independently of ImmuNet. The Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. MCH staff identify children who are not up to date with their immunizations and refer them to a regular source of care.

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

## a. Last Year's Accomplishments

Maryland's teen pregnancy rate declined for the fifth year in a row, falling to a rate of 20.9 births per 1,000 teens aged 15-17 in 2002. This decline continued to be attributed to increased outreach and education efforts, including abstinence only education and improved access to contraceptive methods including emergency contraception and depoprovera.

Maryland's Title V and Title X family planning programs continued to work to reduce teen pregnancies by discouraging premature childbearing, promoting preconception health care, and employing holistic approaches to teen pregnancy prevention in 2003. MCH staff involved in teen pregnancy prevention included a teen pregnancy prevention coordinator who also serves as the abstinence education coordinator, an adolescent health coordinator and a pediatrician who oversees school and adolescent health issues.

Since 1970, the Title X Maryland Family Planning and Reproductive Health Program has provided comprehensive family planning, teen pregnancy prevention, preconception and preventive health services. In FY 2003, over 80 sites provided services to 70,000+ clients, about a third of whom were adolescents under the age of 20. Counseling regarding responsible sexual decision making including abstinence was offered to teen clients and parental involvement was encouraged. In many counties, significant efforts were made to provide

education, counseling and medical services to young men. Most adolescents were served at no cost. The Healthy Teens and Young Adult Program, a model program offering a holistic approach to teen pregnancy prevention, continued to operate in three jurisdictions with high teen pregnancy rates. These projects served over 6,000 adolescents in FY 2003.

The Title V supported Maryland Abstinence Education and Coordination Program (MAECP) continued to support 14 community-based after school programs serving 350 pre-teens and teens, ages 9 to 18 in FY 2003. These programs offered activities that promote positive self-esteem and alternatives to risky behaviors while promoting an abstinence message. MAECP also sponsored its annual conference in August 2003 with over 500 adolescents and parents attending. MAECP also coordinates activities with the Governor's Council on Adolescent Pregnancy (GCAP). GCAP works to reduce unplanned teen pregnancies through statewide planning and promotion of inter-agency collaboration. Title V was represented on this Inter-agency Council which planned the annual statewide Conference on Teen Pregnancy Prevention. This Council continued to fund Campaign for Our Children, a multi-media abstinence plus educational campaign established in 1987 to address Maryland's high teen birth rate.

The Teen Pregnancy Prevention Coordinator presented a series of four interactive workshops, Teens and Sex 101, developed in response to requests from health professionals working in abstinence education and other teen programs.

#### b. Current Activities

The Title V program participated in planning the 20th Governor's Council on Adolescent Pregnancy annual conference held in June 2004. This two day conference include a day for young parents that was filled with workshops that addressed parenting issues of concern.

Planning for the fourth annual Maryland Abstinence Education conference is well underway. The conference is planned for October 2004. The Department is aware that federal abstinence education funds have been transferred at the federal level and that in future at the state level these funds will be awarded to a sister agency, the Department of Human Resources. At the writing of the application, transitioning plans had not been finalized.

The State's teen pregnancy prevention coordinator continued to partner with staff in the Governor's Council on Adolescent Pregnancy to provide state and local workshops and seminars concerning adolescent pregnancy prevention and parenting. Workshops have focused mainly on male involvement and adolescent pregnancy within the Hispanic population.

#### c. Plan for the Coming Year

MCH plans for the coming year will include:

.Continued transfer of Abstinence Education to the appropriate agency or agencies. The October 2004 Abstinence Education Conference for parents and students will be held as planned.

.Examination of adolescent pregnancy issues by the Adolescent Workgroup reviewing need and capacity issues for the Title V needs assessment.

.Continued monitoring of the status of YRBS activities in Maryland.

.Continued participation on the Governor's Council on Adolescent Pregnancy including providing a representative for the annual Adolescent Pregnancy Prevention Conference.

.Continued administration of components of the Title X and Title V programs directed at

*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**

According to The 2000-2001 Survey of Oral Health Status of Maryland School Children, the most recent year for which data is available, 24% of of Maryland third graders received dental sealants. White children were almost twice as likely as African American children to have sealants. The survey also identified that 42% of children had untreated dental decay, three times the national average. The Eastern Shore had the highest untreated dental decay (54%) followed by the Central Maryland region (48%).

The DHMH Office of Oral Health (OOH) has lead responsibility for promoting the oral health of Marylanders. Since 1996, OOH has awarded competitive grants to local health departments for a variety of public oral health initiatives. In FY 2003, OOH supported school and community-based dental sealant programs, operational in twelve jurisdictions, served 3,500 children. Twenty of Maryland's 24 LHD operated some type of oral health program in 2002 ranging from limited preventive services to comprehensive clinical programs including restorative services. Last year, public health clinics located in Baltimore City and ten counties provided treatment services to 2,333 children; many of whom were Medicaid recipients. Finally local health departments partnered with schools and community programs to implement flouride rinse and tablet programs to school aged children.

The Office of Oral Health also began administering the P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) Program in 2003. This program was started in recognition of the potential underreporting of child abuse and neglect by dentists. This Program trains dental professionals to recognize and report signs of abuse and neglect in their patients and is patterned after a program first developed in Missouri. The Program involves a 90 minute presentation covering such topics as physical and behavioral indicators of abuse and neglect, documentation of suspected cases and legal issues. Information on domestic violence and elder abuse has also been added.

The 2000 Title V Needs Assessment identified inadequate access to oral health services, as a major unmet need for children, particularly those enrolled in Medicaid. Health Choice, Medicaid's managed care program, funds comprehensive dental services for eligible children and adolescents. However, the Program has experienced difficulties in recruiting and maintaining sufficient numbers of oral health providers. In FY 2003, OOH began administering Maryland Dent-Care, a loan repayment plan which offers non-taxable loans to dentists willing to serve Medical Assistance recipients. The goal is to increase the number of dentists who treat this population.

OOH continued to partner with MCH and other agencies in FY 2003 to develop policies, programs and activities. Title V continued to serve as a member of the DHMH Oral Health Advisory Committee which advises the Secretary on oral health related issues, particularly for children.

**b. Current Activities**

During the current fiscal year, OOH staff facilitated the development of a statewide Five Year Oral Health Plan. The Assistant Director for MCH participated in the strategic planning process providing input on MCH issues.

During the 2004 Maryland General Assembly Session, legislators once again passed a bill to address low dental health care utilization rates for children enrolled in Medicaid. In 2000, only 30% of children in Medicaid received dental care. The General Assembly had sought to increase dental service use rates by setting a utilization target of 70% for calendar year 2004. Use rates continue fall short of this target despite enhanced funding, and utilization of restorative care (fillings) is especially low at only about 10 percent. House Bill 1134 passed in 2004 and requires Medicaid MCOs to develop a process for improving access to therapeutic treatment. OOH and Medicaid have continued to monitor and track dental utilization rates for Medicaid enrolled children.

### c. Plan for the Coming Year

During 2005, the Office of Oral Health and the Oral Health Advisory Committee, on which Title V is a member, will continue to address unmet oral health needs for children. Future plans include:

- .Implementation of the Five Year Oral Health Plan. Objectives include improving access to services for underserved populations such as children enrolled in Medicaid, and improving dental public health capacity.

- .Broadening the scope of the Oral Health Advisory Committee.

- .Working with partners to develop creative ways to increase access to oral health care.

- .Educating the public about the importance of good oral health care and how it relates to total health.

Title V funds granted to the Baltimore City Health Department will continue to support the provision of dental health services to low income children and pregnant women.

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

Motor vehicle accidents remained the leading cause of death for children in 2002, a year in which 35 Maryland children under the age of 15 died in motor vehicle crashes. For the third year in a row, the numbers of deaths increased slightly while the rate remained the same (3 per 100,000).

In FY 2003, the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams legislatively mandated to review child deaths in Maryland including those caused by motor vehicle accidents. Several jurisdictions have identified motor vehicle accidents as a priority concern. A CFR coordinator was hired by CMCH Program in May 2003 to provide staff support to the State CFR team and coordinate training for local teams. In addition, a new MCH Epidemiologist was hired and given responsibility for providing epidemiologic support to the CFR Team. The 2002 Child Death Report prepared by CFR staff identified trends in deaths due to motor vehicle accidents.

State activities directed at preventing deaths due to motor vehicle accidents largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. As a result of aggressive enforcement of these laws, Maryland has an 89% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not

ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Office of Health Promotion and funded by the Maryland Department of Transportation. KISS's mission is to reduce the number of childhood injuries and deaths by educating the public on child passenger safety including the correct use of safety seats. Child safety seat inspections conducted in Maryland reflect that while an estimated 80% of the target population uses child safety seats; the vast majority (80-90%) of these seats are improperly installed. KISS continued to administer a child safety seat loaner program that provided seats to 1,355 low-income families in FY 2003. In addition, KISS offered child passenger safety certification training to 187 law enforcement personnel and others.

The Center for Preventive Health Services (CPHS), another sister agency in the Family Health Administration, funds local injury prevention programs, some of which address motor vehicle safety. CPHS also administers a project that links state crash and medical outcome data to identify the medical and financial consequences of motor vehicle crashes. CPHS uses this information to support preventive efforts.

#### b. Current Activities

Legislation passed in 2003 and effective as of October 1, 2003 requires that every child under 6 years of age, regardless of weight, and every child weighing 40 pounds or less, regardless of age, must be secured in an approved child safety seat. The KISS Program along with the Department of Transportation have provided outreach and education activities including safety seat checkpoints and public service announcements to educate families about the new law.

Noting an increase in the number of traffic fatalities between 1999 (598) and 2002 (661), the Maryland Department of Transportation launched a 12 month safety campaign to prevent traffic fatalities. During National Child Passenger Safety Month in February 2004, jurisdictions throughout the state participated in child safety seat checks and community outreach and education activities.

#### c. Plan for the Coming Year

In FY 2005, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle accidents.

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

#### a. Last Year's Accomplishments

More Maryland mothers are breastfeeding their babies at hospital discharge, both within the general and WIC populations. The percentage of mothers initiating breastfeeding at hospital discharge rose from 48.1% in 1991 to 61.0% in 2003. In April 2004, 52% of postpartum women enrolled in the WIC Program initiated early breastfeeding. Only 13% of comparable moms breastfed in 1991. However, Maryland early breastfeeding rates have not yet reached the Healthy People 2010 objective of 75%.

Last year, both the Title V and WIC Programs pro-actively promoted and supported breastfeeding efforts across the state. The MCH and WIC Programs were given lead

responsibility for re-convening the Maryland Breastfeeding Promotion Task Force . The Task Force's purpose is to identify strategies and coordinate efforts to increase Maryland breastfeeding rates. Dr. Maureen Edwards chairs the Task Force and staff support is provided by the Title V Program. Representatives include Medicaid, hospitals, universities, the State's medical society, the March of Dimes, and the African American Breastfeeding Alliance. Four subcommittees were designated: Workplace, Insurance, Health Professional Education, and Public Awareness.

In 2003, at the suggestion of the Task Force, the MCH Program updated, printed and disseminated the Maryland Breastfeeding Resource Guide. The Guide is geared to pregnant/postpartum women, hospitals and other health providers, and identifies breastfeeding resources including classes and support groups.

Title V funds continued to support breastfeeding initiatives in several local health departments. For example, the MCH Program in Harford County promoted breastfeeding through the use of peer counselors. Breastfeeding was promoted in Title V funded Improved Pregnancy Outcome Programs funded in each jurisdiction. The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC has a Breastfeeding Coordinator and WIC staff statewide have received training in Advanced Lactation education. The Medicaid Healthy Start Home Visiting and Case Management Program promoted breastfeeding to enrolled pregnant and postpartum women.

To address racial disparities in breastfeeding rates, MCH funding to the Healthy Mothers/Healthy Babies Coalition was awarded to African American Breastfeeding Alliance to support a peer counseling breastfeeding project in Baltimore City in FY 2003.

Following many unsuccessful attempts, Right to Breastfeed legislation has passed during the 2003 Maryland Legislative Session. DHMH supported this legislation which allows women to breastfeed in both public and private settings.

A proclamation was requested and successfully obtained from Governor Ehrlich, recognizing August as Breastfeeding Month in Maryland. Breastfeeding Month activities included hosting two satellite breastfeeding education programs, and local breastfeeding promotion fairs and events.

#### b. Current Activities

Title V continued to provide staff support to the Maryland Breastfeeding Promotion Task Force and its subgroups in 2004. The Workplace Committee is developing a toolkit for Maryland employers to assist them in supporting breastfeeding in the workplace. The Public Awareness Workgroup is developing a Speaker's Bureau.

To assist in further increasing breastfeeding rates among WIC enrolled women, the Maryland WIC Program was awarded additional funding from the U.S. Department of Agriculture to develop a new Breastfeeding Peer Counselor Initiative. The Program will begin the implementation of Breastfeeding Peer Counselor Initiative in FY 2005.

The MCH and WIC Programs, along with the Breastfeeding Task Force's Public Awareness Workgroup, are planning activities in support of August as Breastfeeding Month.

#### c. Plan for the Coming Year

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding. Plans for 2005 include:

1. Completion of a statewide plan which addresses promotion of breastfeeding in conjunction with the Maryland Breastfeeding Promotion Task Force. Limited staff support hindered completion of the Plan in 2004.
2. Analysis of breastfeeding data derived from Maryland's PRAMS Survey and other sources. Maryland is a new PRAMS state and the first PRAMS Report was released in March 2004. PRAMS data will be compared with data derived from the Newborn Screening and ROSS databases to assist in determining both early and late postpartum breastfeeding rates. These data analyses will also be used to support needs assessment and planning activities for the 2006 Title V application.
3. Implementation of a Maryland Breastfeeding webpage.
4. Seeking funding to address breastfeeding promotion activities.
5. Continued work on activities identified by subgroups of the Maryland Breastfeeding Promotion Task Force.

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

#### a. Last Year's Accomplishments

The percent of Maryland infants screened for hearing loss in FY 03 was 93.7%. The reporting of hospital screening test results has significantly improved since we began collecting the infant hearing screening data on the blood spot newborn screening lab slip in October 2002. An added wrinkle is that Pediatrix (formerly NeoGen) was licensed to provide first tier newborn metabolic screening in Maryland last year. Although Pediatrix provides screening for only small proportion of the hospitals in the State at this time (5 out of 35 birthing hospitals), there have been challenges obtaining the appropriate hearing screening data as well as the most up-to-date patient follow-up information from Pediatrix. The OGCSGCN has been working with Pediatrix to overcome these obstacles to the extent possible.

The OGCSHCN held an educational program for physicians in September 2003, attended by 126 persons, mostly pediatricians. This program included information on the importance of early identification of hearing loss and prompt follow-up, medical evaluation and management of hearing loss in children, early intervention and communication options, and the role of the audiologist. In addition, the OGCSHCN has supported two rounds of workshops for early intervention staff in order to enhance the capacity of the Maryland Early Intervention Program to provide services to infants with hearing loss and their families. The most recent workshops given in the fall of 2003 emphasized that unilateral hearing loss can lead to significant language delay.

The OGCSHCN supported The Maryland Hearing and Speech Agency to develop a tutorial and resource notebook, Maryland Keys to Communication, for families of children newly diagnosed with hearing loss. A grant was also given to this agency for the creation of a resource center for parents of infants and young children with hearing loss.

#### b. Current Activities

The OGCSHCN is working with a computer programmer on critical enhancements to the computer system/database that directly populates the hearing screening database. New additions for the universal newborn hearing screening (UNHS) program are to include improvements in the ability to extract and manipulate hearing screening data, lending much

needed improvement to our data reporting capacity.

The AAP Chapter Champion for the UNHS Program is surveying pediatricians in the state about their educational needs related to newborn hearing screening and their preferred educational approaches. Despite our educational efforts thus far, we have heard anecdotal reports that pediatricians are not following through with appropriate workup and referrals. We hope to gather the same type of survey data from ENTs.

Program data for FY 03 has also left us concerned that reporting of repeat screening has fallen off and/or some babies who need repeat screening are not getting this. For babies born in FY 03, the UNHS Program received results on only about 45% of babies for whom re-screening was recommended because of inadequate testing and/or they did not pass the initial screening. This is down from a high of 66% for the first half of 2002. We think that almost all of the babies who do not pass the screening in the hospital do get re-screened but many inadequately screened babies do not. Also of concern is that the age at definitive diagnosis for Maryland infants increased to 93.7 days in FY 03, from 90 days in CY 02. Some families are reporting that they have difficulty getting an appointment within the requested time frame. It is not clear whether the state has an insufficient number of audiologists or whether the available audiologists simply do not regard the screening, diagnostic evaluation, and follow-up of infants with sufficient importance and urgency. The OGCSHCN has had difficulty engaging licensed audiologists in Maryland, but is currently working with an audiology student to survey licensed audiologists to obtain more information about their current practices, education/training needs, and preferred modes of education.

#### c. Plan for the Coming Year

Despite the high numbers of infants screened in FY 03, there has been an increase in the proportion of infants leaving the hospital before they are adequately tested. In FY 03, re-screening was recommended for 11.6% of all infants as compared to 10.1% in CY 02. A priority for the coming year is to address this with hospital visitation and additional training of hospital personnel responsible for screening. Because we do not currently have the manpower to accomplish this, we plan to recruit and hire an audiologist (on contract using our Infant Hearing Screening Grant funds) if we can obtain an exemption from the State hiring freeze. The additional audiologist is also needed to interface with other audiologists in the community to begin to address the additional issues noted above related to re-screening, diagnostic evaluation, and reporting in a timely fashion.

We plan to use the information obtained from the survey of pediatricians and ENTs described above to develop additional educational activities for pediatric health care providers, with an emphasis on outlying parts of the state since last year's program was given in central Maryland. In addition, we will use the information obtained from the survey of audiologists in a similar fashion, although we plan to contract with the Maryland Hearing and Speech Agency to sponsor educational activities for audiologists, in hope that this organization will be perceived as a more acceptable educational source to audiologists than our office has been.

The OGCSHCN anticipates that the current work on the computer system will be completed in the coming year. We also plan to obtain additional programmer support to program the interface between our database and the Pediatrix database in order to facilitate the exchange of screening information.

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

#### a. Last Year's Accomplishments

In 2002, Maryland was one of twelve states to receive a HRSA State Planning Grant with the goal of developing options for state's uninsured population. The State Planning Grant Workgroup issued a report in 2003 estimating that 10% of Maryland children under age 18 (approximately 140,000) were uninsured in 2001-2002. The Report also cited that between 2000 and 2002, while the percentage of uninsured children remained stable, Maryland's total uninsured population grew from 600,000 (11.3%) to 690,000 (12.8%).

The State Planning Workgroup analyzed alternative models for making comprehensive health insurance coverage accessible to uninsured Marylanders. In collaboration with the Maryland Health Care Commission and researchers from the Johns Hopkins Bloomberg School of Public Health, DHMH's Office of Health Care Financing also identified and defined characteristics of the State's uninsured and key factors that affect Maryland businesses' decisions to offer, and employees' decisions to accept, health insurance. Additionally, DHMH carried out a comprehensive assessment of the costs associated with covering the uninsured.

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children. During federal fiscal year 2003, enrollment in MCHP exceeded 154,000. The Children's Medical Services Program within the OGCSHCN continued to provide coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The State's fiscal situation impacted the ability to continue and maintain Medicaid Program expansions to cover increasing number of uninsured children. Maryland expanded MCHP coverage through MCHP Premium in July 2001 cover to children in families with incomes between 200 and 300 percent of the Federal poverty level. Families are required to pay a premium for coverage. An estimated 14,000 additional children were thought to be eligible for MCHP Premium coverage. In 2003, the Maryland Legislature enacted changes in the MCHP Premium Program. The Private Option Program of MCHP Premium was repealed and no new children will be allowed to enroll. The 200 currently enrolled children continued to be served, but were switched from their employer sponsored plans to HealthChoice. In addition, co-pays were required for MCHP enrollees with incomes between 185 percent and 200 percent of poverty.

## b. Current Activities

The 2004 General Assembly repealed the 2003 restrictions to the MCHP Premium Program. This resulted in removal of the freeze on the enrollment for children in families with incomes between 200 and 300% of the federal poverty level. In addition, children whose families pay for coverage because their family income falls between 185 and 200% of the poverty level will no longer have to pay a premium to continue coverage. Medicaid and MCH Programs in local health departments are providing increased outreach to communities and families to inform them of changes to the law.

In addition, Medicaid implemented changes in eligibility so that pregnant women enrolled in MCHP will now be allowed to continue to receive benefits at the sixth month redetermination even if their income exceeds the eligibility thresholds. This is done to ensure continuity of care and greater likelihood of a healthy birth outcome. Maryland submitted a waiver to allow non-eligible immigrant pregnant women access to prenatal care benefits, arguing that it was more cost-effective. However, the waiver request was denied.

Health care reform continued to be high on the agenda of the Secretary of Health, Nelson J. Sabatini. Noting that Maryland's uninsured population has increased to an estimated 690,000 in 2002 from an estimated 600,000 in 2000, the Secretary has stated that one of his major goals is to find a way to provide affordable health insurance for uninsured families. Proposed reform strategies include reducing malpractice costs, reducing the number of insurance mandates, and making private insurance more affordable. The Secretary has called for a restructuring of the Medicaid Program to make it more efficient to allow coverage of greater numbers of Marylanders. This may mean offering a less comprehensive package of services or implementing a sliding fee scale for coverage of the working poor.

The State Planning Workgroup completed its work and presented a January 2004 Report on Options for Covering the Uninsured to the Maryland General Assembly. The Report focuses on identifying small group market and individual market options for working adults.

MCH staff in local health departments continued to conduct eligibility screening to enroll children in the MCHP Program.

### c. Plan for the Coming Year

In FY 2005, the Title V Program, including local health department based MCH programs, will continue to support the Medicaid Program in enrolling eligible children and adolescents. Coordinated outreach efforts with local health departments, community health centers, managed care organizations, and other public and private providers working with low income uninsured populations will continue. Outreach strategies will continue to include distribution of MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, community events and health fairs; and periodic media campaigns promoting the MCH Information and Referral Hotline. The MCH Hotline will continue to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

Title V staff plan to review reports and other materials generated by the grant's State Planning Grant Workgroup to complete the 2005 MCH needs assessment.

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

### a. Last Year's Accomplishments

The Maryland Medical Assistance Program serves as the major source of publicly sponsored health insurance coverage for children and adolescents lacking access to employer sponsored and private programs. Both Medicaid and MCHP, the state's SCHIP Program and a Medicaid expansion, provide access to a broad range of health care services for eligible low income children. In State fiscal year 2003, approximately 24% of Maryland children and adolescents under age 19 were enrolled in the Medicaid Program. This percentage includes enrollment in MCHP. Although the true number of eligibles is unknown, the Program estimates that over 90% of potentially Medicaid eligible children received a service paid by the Medicaid Program in FY 2003.

The MCH Program continued to support the Medicaid Program to enroll eligible children and adolescents in FY 2003. Outreach strategies include a grassroots information dissemination campaign involving collaboration with State agencies; advocacy and community-based groups and provider organizations; a general public media and advertising campaign; and streamlining of the application process. The State continued to coordinate its outreach efforts with local

health departments, WIC Program sites, community health centers, social services agencies, managed care organizations, and other public and private providers who have historically served uninsured low income populations. In addition, the OGCSHCN sends a postcard to the parents of all Maryland children who are new SSI recipients informing them of their eligibility for Medicaid.

The MCH Hotline number (1-800-456-8900) was advertised on bus and subway placards. MCH Hotline workers refer callers to sites that determine eligibility for Medical Assistance Programs as well as to other MCH programs and services. Families seeking coverage for CSHCN through the Children's Resource Line operated by OGCSHCN are also referred to Medical Assistance when appropriate. In addition, flyers containing eligibility information were distributed through schools, licensed day care centers, and Healthy Start programs.

#### b. Current Activities

The Family Health Administration and the Medicaid Program are in the process of finalizing a revised cooperative agreement in fulfillment of the federal requirement that state agencies that operate Medicaid, MCH, Family Planning and WIC must enter into respective interagency agreements. Maryland's agreement documents key areas of program coordination among the respective federally funded programs. The goal is to ensure efficient use of resources across all programs so that services provided to pregnant women, children and their families will result in improvements in health.

#### c. Plan for the Coming Year

Ongoing activities described will continue in FY 2005.

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

#### a. Last Year's Accomplishments

In 2002, 1,388 Maryland babies (2%) were born at very low birth weights. Disorders related to short gestation and low birth weight contributed to 22% of infant deaths in 2002. Maryland continues to have one of the nation's highest low birth weight birth rates. Maryland efforts to reduce low birth weight births and improve birth outcomes continued to focus on strategies such as (1) promoting access to family planning, preconception health and prenatal care services, (2) improving access to health insurance coverage, (3) decreasing smoking during pregnancy and (4) perinatal systems building including FIMR in 2003.

Family planning and prenatal care services continued to be offered by MCH programs in local health departments. Each local health department provided preconception health counseling, including folic acid promotion to family planning clients. Six of the 24 local health departments offered or supported prenatal care clinics which largely served uninsured and/or undocumented women in 2003. The MCH Hotline linked women with services that contribute to healthy birth outcomes. MCH staff in local health departments continued outreach and education to identify pregnant women and families eligible for Medical Assistance and MCHP. Pregnant women with incomes under 250% of the Federal Poverty Level are eligible for Medicaid/MCHP benefits.

Local health departments continued to collaborate with the Medical Assistance Program to improve health outcomes for pregnant women and infants by providing home visiting and care coordination services through Medical Assistance's Healthy Start Program. (This state funded program is not part of the federal Healthy Start Initiative). Healthy Start nurses provided case management, home visiting services, and referral to medical and social support services to at risk women enrolled in Medicaid, including women at risk for premature labor, a risk factor for low birth weight births. More than 16,000 at risk women were identified and referred by providers to the Healthy Start Program in FY 2003.

This past year, each local health department continued to receive Title V funding through the Improved Pregnancy Outcome (IPO) Program to address core public health functions that benefit all pregnant women and their newborns. IPO supports a perinatal coordinator in each jurisdiction to act as a liaison between the local community and both public and private health care providers. The goal is to establish coordinated, interdisciplinary approaches for assuring quality patient care services, educational activities, and community-based efforts directed at improving pregnancy and birth outcomes.

In 2003, Secretary Sabatini directed the MCH Program to develop a comprehensive, multi-faceted statewide perinatal health plan that includes protocols for triaging high risk pregnancies to perinatologists and development of revised standards of care the state's NICU units. The Initiative's goal is to reduce infant mortality and related factors.

#### b. Current Activities

In the area of preconception health, CMCH in collaboration with the WIC Program, re-instituted the Folic Acid Council with a grant from the March of Dimes. Under this grant and through collaboration with WIC, the Department of Health and Mental Hygiene has agreed to provide leadership and administrative support for continued folic acid-related activity in our State. These funds support for council meetings, and distribution of folic acid educational materials.

CMCH has lead responsibility for planning and organizing the state's fifth Perinatal Health Conference that was postponed in September 2003 due to Hurricane Isabelle. The Conference has been rescheduled for September 19-20, 2004. This two day conference has been renamed the David A. Nagey Perinatal Partnership Conference, in honor of Dr. Nagey, the former Director of the Perinatal Outreach Division of Johns Hopkins University School of Medicine and an internationally known expert on high risk pregnancies. Dr. Nagey, who died unexpectedly in 2002, co-chaired the 2001 Perinatal Conference. The theme of this year's conference is Primary Prevention Strategies in Perinatal Care. Day One is designed for professionals working with pregnant women and their infants, and will include workshops on low birth weight prevention, perinatal periods of risk, infections and perinatal health. Day two is geared to community members and will present information and resources for advocates, women, their partners and friends.

The Title V funded Crenshaw Initiative continues to support regional perinatal coordination efforts to reduce low birth weight and infant mortality as well as programs that are responsive to the recommendations of local FIMR programs. A common theme that defines these programs is enhanced communication and collaboration among perinatal providers for making system improvements. Current projects include: outreach to African American and immigrant women in Frederick County, a regional perinatal advisory group focusing on providing screening tools for perinatal infections. This Initiative is being expanded to include funding for the state's two major teaching universities to provide statewide availability of on-site and telemedicine consultation for high risk pregnancies to community-based providers throughout the state in order to improve the quality of perinatal care in Maryland.

### c. Plan for the Coming Year

Ongoing activities described above will continue in 2005. In addition, CMCH plans to partner with the March of Dimes to disseminate information about its campaign to reduce the numbers of premature births and to co-sponsor the November 2004 Prematurity Summit.

As a result of an increase in the number of infant deaths in 2003, Baltimore City has requested permission to reallocate Title V dollars to develop a new Infant Survival Initiative. Under this Initiative, maternal and infant health nurses will replicate the City's federal Healthy Start model and provide intensive home visiting and case management services to high risk pregnant women, infants and toddlers. These services will be provided outside the Healthy Start catchment areas. An advisory group process called BabyStat has been organized to monitor the Initiative's progress. The Initiative is projecting to serve 500 to 600 high risk families in FY 2005.

CMCH will also continue to sustain Folic Acid Council activities now that support from the March of Dimes is no longer available.

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

#### a. Last Year's Accomplishments

Homicide and suicide are leading causes of deaths among adolescents in Maryland. Twenty seven adolescents between the ages of 15 and 19 committed suicide in Maryland in 2002 a rate of 7.4 deaths per 100,000 youth aged 15-19. Suicide is linked to mental health issues, particularly depression, stress and loneliness. These mental health issues were identified as major problems for many Maryland adolescents during the FY 2000 needs assessment.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among youth ages 15-24. According to the Centers for Disease Control, the rate of suicide in youth (defined as ages 15-24), between 1989 to 1998, decreased more in Maryland than in any other state. For the past 12 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on youth suicide and other educational events. Funds are also awarded to local school districts to sponsor educational events. A full time Suicide Prevention Coordinator provides staff support for these activities.

Maryland was the first State in the nation to offer a toll free decentralized hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors using a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 14 year history, the hotline, has been very successful in intervening with youth considering suicide.

Maryland's Title V agency also continued to be represented on the Governor's Inter-Agency Workgroup on Youth Suicide Prevention. This workgroup and its subcommittee planned the annual conference and Youth Suicide Prevention month activities, organized public education activities, and developed special interest outreach programs for teens at high risk for suicide.

Title V funded a needs assessment survey to determine unmet needs in adolescent depression/suicide prevention programming. This survey will be administered to participants at the 2003 Suicide Prevention Conference. Recommendations for reducing the number of suicides and improving adolescent mental health included the need for more screening and early intervention programs, more mental health professionals serving children and teens, and

greater family and public awareness of teen mental health issues. Survey results will be incorporated into the Title V needs assessment.

#### b. Current Activities

The MCH Program's Adolescent Health Coordinator continues to be actively involved in suicide prevention activities under the leadership of MHA. Planning for the October 2004 adolescent suicide prevention conference is almost completed.

The Adolescent Health Coordinator along with the Suicide Prevention Coordinator in MHA as well as other adolescent health professionals participated in a kick-off activities for the MCHB Bullying Initiative. This event was held at the Johns Hopkins School of Public Health.

CMCH is the co-sponsor of the Fourth Annual School Health Disciplinary Program from August 2-6, 2004. This week long continuing education program provides intensive training on all components of coordinated school health including school health services, health education, nutrition and mental health. The target audience ranges from school administrators to school health nurses to mental health professionals.

Adolescent health issues, including mental health problems such as suicide and depression are being addressed by the Adolescent Workgroup for the Title V needs assessment.

#### c. Plan for the Coming Year

The Mental Hygiene Administration, in collaboration with the Governor's Interagency Workgroup on Youth Suicide Prevention and CMCH, will continue to plan and implement the annual statewide adolescent suicide prevention conference, periodic media campaigns and school based youth suicide prevention programs.

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

#### a. Last Year's Accomplishments

DHMH continued to work to improve hospital specific birth outcomes and to lower neonatal mortality rates by ensuring that all very low birth weight infants are born at the appropriate subspecialty center. In 2002, according to the Vital Statistics Administration, 86% of very low birth weight infants born in Maryland were delivered at high risk facilities; a slight decrease over the 2001 level. Strategies used included promotion of adherence to the Maryland Perinatal Systems standards, first released in 1995. These standards state that (1) all very low birth weight infants should be delivered in tertiary care centers (Level III, III+ and IV) and (2) the very low birth weight specific neonatal mortality rate for tertiary care centers should be lower than the average very low birth weight specific neonatal mortality rate for all Maryland hospitals. Technical assistance to improve performance and compliance with the standards is provided through site visits by a multi-disciplinary team that includes the CMCH Medical Director. Data from the Vital Statistics Administration is distributed periodically to each hospital to provide feedback on hospital specific mortality rates for low birth weight infants.

Seeking to further strengthen the state's perinatal care system, in FY 2003, Secretary Sabitini directed FHA to develop and implement a Perinatal Systems of Care Initiative to further improve birth outcomes in Maryland. CMCH was given lead responsibility for planning the

Initiative. This directive resulted in development of a plan that included (1) reviewing and updating perinatal care standards, and development of a collaborative partnership with the state's two academic medical centers to institutionalize a system of high risk outreach, consultation, referral and transport in Maryland.

#### b. Current Activities

Several actions have been taken during 2004 to implement the Perinatal Systems of Care Initiative. The State's Perinatal Clinical Advisory Committee reconvened in March 2004. This Committee has met twice to refine perinatal standards of care for hospital delivery and infant services. Two subcommittees have been formed. One to discuss obstetrical issues and the other to examine neonatal care issues. Dr. Maureen Edwards is the CMCH representative to this Committee. Other Committee members include representatives from the Commission on Infant Mortality Commission, the Maryland Hospital Association, and the Maryland Institute for Emergency Medical Services Systems (MIEMSS).

In FY 2004, Title V funding was provided to the University of Maryland School of Medicine to begin overseeing implementation of a long term plan for development of a comprehensive coordinated statewide perinatal care system. These will involve (1) assessing the need for high risk perinatal consultation, education, technical assistance and referral in each region, (2) conducting high risk consultation clinics, grand rounds and educational sessions, (3) developing a high risk referral and transport system, and (4) collecting, analyzing and monitoring perinatal care data.

Through a subcontract, Title V funding to the Johns Hopkins School of Medicine will also be used to provide perinatal consultation on high risk obstetric patients through regularly scheduled monthly on-site clinic sessions in three regions (Eastern Shore, Southern Maryland, Western Maryland). The University will also provide 24 hour risk assessment and clinical consultation for both emergent and nonemergent situations as well as provide continuing medical education tailored to the needs of local providers. This system of high risk perinatal outreach had been informally developed and pioneered by Dr. David Nagy at Hopkins. Following his recent untimely death, the system is now being formally institutionalized.

The Perinatal Outreach has also included funding to local health departments in Montgomery and Prince George's counties to provide prenatal care services for low income immigrant women. These counties were selected because of the high number of immigrant women seeking services. In addition, other counties continued to fund prenatal services for uninsured women using Title V funds in local health department formula grants.

#### c. Plan for the Coming Year

The Perinatal Systems of Care Initiative described above will continue in FY 2005. In addition, Title V funding to the University of Maryland will support a statewide telemedicine program that offers provider and patient education and outreach consultation. The provider education component will real time distance learning using the web based training curriculum, Living Text of Obstetrics. This telemedicine consultative component will also enhance direct perinatal provider outreach by allowing increased access to consultations and at the same time allowing rural patients to remain in their communities instead of traveling long distances. Piloting of this program will occur in selected rural jurisdictions before it is implemented statewide.

*beginning in the first trimester.*

#### a. Last Year's Accomplishments

Following a four year decline, early prenatal care percentages stabilized at 84.1% in 2002; 3 percentage points lower than in 1996. Early prenatal care percentages declined for women enrolled in both Medicaid and non-Medicaid programs and within certain regions, namely Western Maryland the counties surrounding Washington, D.C. In 2002, early prenatal care percentages were highest for non-Hispanic white women (90.8%) and lowest for Hispanic women (70.5%). By jurisdiction, early prenatal care percentages ranged from a low of 75% in Baltimore City to a high of 95% in Carroll County. For African American women, percentages ranged from a high of 91.2% in Howard County to a low of 67% in Frederick County.

The reasons for the decline remain unclear; however, there are suspected causes. The Director of the Vital Statistics Administration has suggested that the declines are the result of better reporting of prenatal care usage. The number of women reporting unknown has declined since 1998. Women in the unknown category were more likely to report having late or no prenatal care and better reporting has resulted in a more accurate profile of early prenatal care usage in Maryland. Anecdotal information derived from the FIMR meetings suggests that some managed care providers are requiring women to wait until the 12th week of pregnancy before seeking care. Physicians reportedly are less likely to accept new clients due to malpractice and reimbursement concerns.

Medicaid continued to cover the cost of prenatal care services for 23,000 eligible pregnant women with incomes up to 250% of the poverty level in FY 2003. This represented almost one-third of pregnant women in Maryland. Medicaid managed care organizations are required to provide an appointment and see enrolled women within ten days of their request for prenatal care. Prenatal care clinics continued to be offered in jurisdictions serving large numbers of undocumented and uninsured women. The MCH Hotline continued to refer pregnant women to private providers, community health centers, other sources of prenatal care in FY 2003.

The Title V funded Improved Pregnancy Outcome and Crenshaw Perinatal Health Programs also promoted prenatal care services. State and Medicaid funded Healthy Start nurses and other home visiting programs continued to promote access to early and continuous prenatal care as well as the need for screening for infections, especially among high risk pregnant women. Home visiting and case management services for pregnant women continued to be provided in every Maryland jurisdiction in 2003.

#### b. Current Activities

Maryland's growing population of undocumented pregnant women has resulted in a greater proportion of direct care once being provided or supported by LHDs. These women are not eligible for Medicaid covered prenatal care although the cost of delivery is covered under emergency Medicaid and their infants become eligible for coverage as new American citizens. The majority of immigrant women in need are Hispanic, but a sizable proportion are from Africa and Asia. Ten counties (Anne Arundel, Caroline, Dorchester, Howard, Montgomery, Prince George's, Somerset, Talbot, Wicomico and Worcester) have established public-private partnerships to assure access to care for immigrant pregnant women. Over 3,000 women were served in FY 2003, the majority in Montgomery and Prince George's County programs. Governor Ehrlich recently announced the supplemental awarding of additional Crenshaw funds (\$200,000) to Montgomery and Prince George's counties to provide care to increasing numbers of uninsured immigrant women in three jurisdictions -- Prince George's and Montgomery County.

Local newspapers are reporting that the rising malpractice premium rates are causing many

physicians to the leave the practice of obstetrics and that fewer medical students are choosing residencies in obstetrics. Med Mutual, the state's largest malpractice insurance company raised rates by 28% last year and plans to raise rates by 41% this year. As a result, Governor Ehrlich is calling for a rare special summer Maryland General Assembly Session to pass a malpractice reform bill. Malpractice reform legislation submitted by the Governor during the 2004 Legislature failed in the Maryland Senate. The reform legislation would have limited malpractice awards for pain and suffering; and was opposed by trial lawyers and consumer groups. The Governor has also appointed a Malpractice Task Force to a conduct a comprehensive review of Maryland's medical malpractice crisis.

**c. Plan for the Coming Year**

The MCH Program will continue to monitor access to prenatal care services in light of the looming medical malpractice crisis that appears to be disproportionately affecting obstetricians. The work of the Governor appointed Malpractice Task Force and any findings related to early prenatal care rates will be monitored.

Access to early and timely prenatal care services will be reviewed by the Pregnant Women and Infants Workgroup of the Title V Needs Assessment. Data is being analyzed to determine if rates have truly declined and if so, reasons for the decline. Recommendations for improving rates will be developed.

The Title V Program will continue to partner with several agencies and organizations that promote early prenatal care. These included the March of Dimes, Healthy Mothers/Healthy Babies Coalition, the Maryland Commission to Prevent Infant Mortality, and State Medical Professional associations. CMCH is co-sponsoring the March of Dimes Prematurity Summit to be held in November 2004.

**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. Support newborn screening for 32 disorders for all Maryland babies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide short-term follow up assuring that all abnormal or inadequate results are followed to resolution	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide parent educational materials on newborn screening in Maryland in multiple languages	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Support the State's designated metabolic, endocrine and hematology centers (small grants)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

5. Provide metabolic nutritionists in the OGCSHCN to provide case management and nutritional therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide provider education, including a detailed practitioner's manual for primary care providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Support the parent support groups with small grants and in-kind services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Enhance the laboratory computer system and follow-up database to accommodate expended screening	<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
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. Support Parent's Place to help parents of CSHCN become better advocates for their children through education and training	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support Parent's Place to provide direct assistance to families of CSHCN in accessing health and related services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support employment of family members of CSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Build a database of CSHCN in the State to obtain parent input into program planning and policy development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Strategize about outreach to minority families and families of children with functional limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support activities of single disorder groups including needs assessment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Participate in monitoring of Early Intervention services, including assessment of parent satisfaction	<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. Work with families of CSHCN receiving services through the OGCSHCN to find medical homes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Support medical home providers by providing case management for children with metabolic and hematologic disorders, and children in CMS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Refer potentially eligible families to MA, MCHP, and other public programs that may provide funding for health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Support Complex Referral Clinic, which provides medical home for some Maryland children with complex conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Examine Maryland specific data on medical home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Work with Maryland AAP to convene stakeholders for strategic planning around medical homes for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Pilot use of public health nurse in small county to team with local pediatric providers to provide care coordination for CSHCN in their practices	<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
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. Pay for specialty care and related services for CSHCN who are uninsured or underinsured with family incomes up to 200% FPL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Refer potentially eligible families to MA, MCHP, and other public programs that may provide funding for health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support Parent's Place to educate parents of CSHCN about health insurance and how to advocate for their children	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Support Baltimore HealthCare Access to assist families with CSHCN in HealthChoice to access comprehensive services from their MCO	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Support Parent's Place to conduct focus groups with privately vs. publicly insured families of CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop a plan to decrease costs for direct payment of specialty care and shift some resources towards care coordination and specialty clinic infrastructure	<input checked="" type="checkbox"/>	<input checked="" 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
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. Support specialty clinic infrastructure, both at the specialty centers and throughout the State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support Resource Liason at four Centers of Excellence, Resource Center on the Eastern Shore, and Parent's Place for outreach, information and referral to families and providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Support the operation of two medical day care centers serving medically fragile infants and toddlers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Work with the Maryland Early Intervention Program to monitor and assure quality of Early Intervention services for families in their communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

5. Support Parent's Place to create a comprehensive resource database for CSHCN that can be accessed by families and providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support local health departments to provide respite care for CSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Develop a plan to decrease costs for direct payment of specialty care and shift some resources towards community- based care coordination and specialty clinic infrastructure	<input checked="" 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
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. Support transition clinic activities and explore various models	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide specialty care coverage for young adults with special health care needs in CMS until age 22	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support monthly Transition Lecture Series for families and providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conduct focus groups with CYSHCN and their parents for needs assessment around health care transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support Kennedy Krieger to survey pediatric and adult health care providers around their needs related to health care transition for CYSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop brief Maryland specific educational pamphlet for providers on health care transition for CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Support Parent's Place to develop and conduct workshops for families of CYSHCN on health care transition	<input type="checkbox"/>	<input checked="" 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. Distribute educational materials to parents of every newborn in the State	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Fund immunization clinics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop Immunet, a statewide immunization registry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide insurance coverage for immunization through Medical Assistance and MCHP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Administer the Vaccines for Children Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Promote immunization through home visiting and early childhood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

programs				
7. Screen for immunization status in WIC and other programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provide outreach and education to the public and health providers to promote immunization	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide comprehensive family planning and reproductive health services to 25,000+ teens annually	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote abstinence through afterschool programs funded by the Maryland Abstinence Education Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Hold an annual abstinence education conference for adolescents and parents	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Fund three teen only programs offering holistic approach to teen pregnancy prevention (HTYA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support statewide multi-media abstinence plus educational campaign (CFOC)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Conduct training, outreach and education for providers and the community	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Hold annual statewide Conference on Teen Pregnancy Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Promote inter-agency collaboration through the Governor's Council on Adolescent Pregnancy	<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
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Fund a range of dental health services in local health departments	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Fund school based dental sealant programs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Administer a Loan Repayment Program for dentists serving low income populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Disseminate a Resource Guide of Discounted Dental Health services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Survey (periodically) oral health status of Maryland children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Participate on the DHMH Oral Health Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provide outreach and education to promote oral health awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Provide insurance coverage for dental health care through Medicaid and MCHP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Administer the P.A.N.D.A. Project	<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"/>
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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. Conduct state and local level child fatality review processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Enforce strict safety belt and DUI laws	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Require children of certain age and weight to use child passenger safety seats	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Educate the public about the correct use of child safety seats	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Fund local injury prevention programs supporting motor vehicle safety	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Monitor data trends	<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
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Foster collaboration by supporting the Maryland Breastfeeding Promotion Task Force	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Developing statewide plan to promote breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Passage of Right to Breastfeed legislation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Funding to support promotion activities (e.g., peer counseling programs)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Outreach, education and training for health providers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Dissemination of resource guide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promotion of breastfeeding in MCH home visiting and case management programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Payment for breast pumps by Medicaid Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Development of Breastfeeding Toolkit for Employers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Development of a Breastfeeding Speaker's Bureau	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Support hearing screening for all Maryland babies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide follow up assuring that all abnormal or inadequate results are followed to resolution	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide parent education materials related to hearing screening and hearing loss in multiple languages	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. Survey audiologists in the State and provide educational activities based on needs identified	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Survey pediatricians (and ENTs) and provide educational activities based on needs identified	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide education and training to hospitals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Enhance the follow up database for ease of reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with the Maryland Early Intervention Program	<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
13) Percent of children without health insurance.				
1. Provide health insurance coverage for eligible low income children through Medicaid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide health insurance coverage for eligible low income children through MCHP, a Medicaid expansio	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Refer families to services through MCH Hotline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide outreach and education to enroll children in Medicaid programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Offer preventive health services to uninsured on a sliding fee scale basis	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Refer families to community health centers providing services on a sliding fee scale basis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Provide coverage for eligible uninsured and underinsured children through the OGCSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Provide insurance coverage for eligible low income children through Medicaid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conduct outreach and education to promote assistance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote the MCH Hotline for referrals to services including Medicaid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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. Medicaid covers prenatal care for pregnant women with incomes up to 250% of poverty level	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Fund fetal and infant mortality review (FIMR) processes in every jurisdiction	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Fund and provide Family Planning and Reproductive Health Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Fund Nurse home visiting and case management services for at risk women in every jurisdiction	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support Perinatal Health Conferences to educate providers and families	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Promote access to prenatal care and insurance coverage through MCH Hotline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Support for Maryland Commission on Infant Mortality Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Offer prenatal care clinics in selected jurisdictions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Support initiatives to reduce smoking during pregnancy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Fund University based Perinatal Outreach Programs	<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. Fund (Mental Hygiene Administration) statewide Youth Crisis Hotline	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate in planning annual Mental Hygiene Administration sponsored Suicide Prevention Conference	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Fund (Mental Hygiene Administration)school based suicide prevention activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Inter-Agency Suicide Prevention Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Track and monitor injuries including suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support full-time Suicide Prevention Coordinator (Mental Hygiene Administration)	<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
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Review and update perinatal care standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide technical assistance to improve compliance with perinatal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. Designate perinatal centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Conduct site reviews of specialty perinatal centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Collect and analyze perinatal data	<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. Medicaid covers prenatal care for pregnant women with incomes below 250% of poverty	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. MCH Hotlines refers women to prenatal care sources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Nurse home visiting programs promote early prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Preconception health counseling is offered in family planning clinics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Local health departments offer prenatal care services for uninsured and undocumented women	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6. Fund prenatal care services for immigrant pregnant women	<input checked="" 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: *Percent of children aged 0-72 months screened for lead poisoning/exposure by blood testing***

**a. Last Year's Accomplishments**

Childhood lead poisoning prevention continued as a high priority area for Maryland in 2003. The former Governor's July 2000 Initiative on Lead Poisoning Prevention encouraged the coordination of three major agencies - DHMH, the Maryland Department of Environment (MDE), and the Maryland Department of Housing and Community Development (DHCD), and Baltimore City in the assessment, planning and implementation of primary and secondary efforts to reduce childhood lead poisoning.

MDE manages the state's Lead Surveillance System. Surveillance System data for 2002 indicate that 18.2% of Maryland children under age six were screened for lead poisoning/exposure by blood lead testing. Lead Surveillance data for 2002 indicate that testing increased statewide especially at ages 1 and 2 -- 33.8% of one year olds and 24% of two year olds were tested. The Medicaid Health Choice Evaluation indicated that between 2001 and 2002 the percentage of Medicaid children receiving lead test increased, rising from

38.3% to 42.2% at 12-23 months and from 30.2% to 35.8% at 24-35 months.

CMCH continued to expend funding for State and local lead poisoning prevention activities. Supplemental funding was awarded to local health departments for proposals designed to test the Targeting Plan which is a predictive model. Local Health Departments have traditionally provided outreach through various maternal and child health venues (e.g, nurse home visiting, WIC, and lead outreach/education). Title V funds also continued to support the Baltimore City Health Department's Childhood Lead Paint Poisoning Prevention Project, supporting outreach, community education, case management of children with elevated blood lead levels. This funding also enabled the Coalition to End Childhood Lead Poisoning to provide lead poisoning prevention awareness and case management activities in Baltimore City.

#### b. Current Activities

The Maryland Targeting Plan for Childhood Blood Lead Poisoning Plan serves as a basis for legislation passed by the Maryland General Assembly in 2000, HB1221 which enforces blood lead testing of all children ages 12 and 24 months residing in zipcodes deemed 'at-risk' in Maryland according to the Maryland Targeting Plan. More recent legislation passed by the Maryland General Assembly (HB 819) requires that beginning in September 2003, parents/guardians of children living in areas designated as 'at-risk' for lead poisoning, must provide documentation from a health care provider certifying that the child has undergone blood testing for lead poisoning. This law also requires health care providers caring for children in areas designated as 'at-risk' for lead poisoning, as determined by the Maryland Targeting Plan, to administer a blood test for lead poisoning of children at 12 month and 24 month visit.

In 2004, CMCH continued to work with a vendor, the University of Maryland at Baltimore County to update the state's lead targeting plan. The prior Targeting Plan was based on outdated 1990 Census data and the University used updated Census (2000), Medicaid and child lead registry data to revise the predictive model. The newly completed Plan has resulted in the CMCH reallocation of limited funds to areas of greater need as well as first time resources to two newly identified counties at risk as well as numerous other census tracts/zip codes.

CMCH is responsible for and has directed efforts towards implementation of HB819. These activities, to date, have included outreach and education to families, health care providers, child care providers, school health personnel, and early childhood programs. The Childhood Lead Screening Program within MCH has recently completed documents necessary for implementation of HB 819. These include a DHMH Blood Lead Test certificate, a resource and referral sheet, and a frequently asked questions brochure. These materials are being distributed to local health departments and to schools in cooperation with the Maryland State Department of Education. Input has been sought from all local jurisdictions regarding appropriate implementation strategies.

#### c. Plan for the Coming Year

Childhood lead poisoning remains a serious threat to the health of children in Maryland. MCH Program plans for FY 2005 include the continued provision of funding to promote lead awareness and blood lead testing through outreach and education in local health departments. Work will revolve around the implementation of HB 819 referenced earlier in this document.

The recent retirement of the nurse consultant responsible for lead issues was a difficult blow to the Lead Program because of her tremendous knowledge and expertise. Due to the state hiring freeze, this position will not be filled. Her responsibilities will now be handled by a senior nurse consultant in CMCH.

CMCH will continue to address lead issues by partnering with other agencies through various Councils and Workgroups. CMCH is represented on the Governor's Commission on Lead and is actively involved on its Health Subcommittee. CMCH attends monthly meetings of the Baltimore City Health Commissioner's Lead Stat Group to keep abreast of lead activities and trends in the City. CMCH also attends monthly meetings of the statewide Lead Partnership to review outreach and education needs to improve lead awareness. Finally, CMCH participates on the Interagency Committee on Lead Data which is chaired by the Department of the Environment and meets periodically to address data needs and resources.

## State Performance Measure 2: *Percent of Medical Assistance Women enrolled in the Family Planning Waiver Program Who Used at Least One Service During the Fiscal Year*

### a. Last Year's Accomplishments

The Maryland Medical Assistance Family Planning Program provides family planning related service coverage under a federal waiver for women who lose Medicaid coverage following their pregnancy-related period of eligibility (within two months of delivery). The Waiver's goal is to increase access to family planning services for low-income women. Access to family planning services improves the wellness of women and influences positive birth outcomes. Since family planning services have been documented to decrease unintended pregnancies and improve birth outcomes, this measure was selected as a new performance measure in 2001 as a means of monitoring access to family planning services. Title V's intent is to promote family planning as a primary prevention strategy for reducing infant mortality and other negative outcomes.

Women eligible for the Family Planning Waiver Program are covered for a limited package of health services. The services covered include office medical visits for family planning purposes; tubal ligation; contraceptive devices and supplies; laboratory tests related to family planning visits, including PAP tests and STD screening; and voluntary and confidential HIV testing. There are no co-payments for services covered under this program. Medical, fertility and abortion services are excluded.

The Waiver Program began enrolling recipients in November 1994. In federal fiscal year (FFY) 2003, Maryland's Medicaid Program received conditional approval to extend the waiver. The length of automatic program eligibility was decreased from five years to two years. In addition, the Program is required to ensure that Waiver Program enrollees have access to primary care services. All clients in the Maryland Medical Assistance Family Planning Program receive information about community health centers for primary care services. The community health centers accept the Family Planning Waiver card and also provide primary care services on a sliding fee basis.

Between state fiscal years (SFY) 2002 and 2003, the number of women enrolled in the Waiver Program increased from 62,730 to 66,053. In addition, the percentage of women enrolled who used their Waiver card for services rose slightly from 23.3% to 24.2%. Although some progress has been made, low use rates continue to plague the Program. Anecdotally, local health department-based family planning personnel continue to indicate that many women are not aware of their eligibility for services and therefore may not access services.

Because of the low rate of use, the Medicaid Program instituted additional outreach and education efforts to increase utilization. A letter and brochure explaining the Program is now mailed with each card along with a Title X Maryland Family Planning Program brochure. Title X clinic providers served more than 78,000 low-income women in 2003. These providers also screened clients for Waiver eligibility.

During the current fiscal year, the Maryland Family Pla

#### b. Current Activities

During the current fiscal year, the Maryland Family Planning Program has continued to work with the Medical Assistance Program to implement strategies for improving the utilization of family planning services by women enrolled in the Family Planning Waiver Program. In FY 2004, all Title X family planning providers were required to report on the numbers of Waiver clients screened. Letters and brochures accompanying the Waiver cards spelled out benefits and eligibility. These materials explained that there are no co-pays and that women are free to use any provider who will accept the card as payment in full. A toll free number was provided for recipients with questions or those wishing a referral.

#### c. Plan for the Coming Year

Efforts will continue in 2005 to promote wider use of the Waiver Program. Title X providers will be asked to report on the number of women with the card accessing services. Family Planning Program staff members will continue to collaborate with Medicaid staff members to educate providers about the benefits of the Waiver Program through regional meetings. Additionally, Family Planning administrators and clinicians will offer consultation to community health centers in an effort to increase awareness about the Waiver Program and support clinical services.

### State Performance Measure 3: *Asthma mortality rate (per 1,000,000) among children aged 1-14*

#### a. Last Year's Accomplishments

Asthma continues to be a serious, but controllable health problem for children and adolescents in Maryland. The Maryland Asthma Control Program estimates that 1 out of every 10 Marylanders has a history of asthma including 511,000 adults and 151,000 children. In an average year, asthma causes 8,000 hospitalizations, 32,000 emergency department visits, and 88 deaths in Maryland. Since 1993, 33 Maryland children between the ages of 1-14 have died from asthma. Asthma continues to disproportionately affects African-Americans and low-income individuals in Maryland.

The Title V Program began addressing the problem of asthma from a public health perspective in 1999 with the appointment of a half-time childhood asthma coordinator. The MCH's program involvement in asthma activities broadened during FY 2002 when Maryland was awarded a three year Centers for Disease Control and Prevention (CDC) grant for the development of a state asthma surveillance system and a Ten-Year Asthma Control Plan. The Maryland Asthma Control Program was created to oversee grant activities. (Legislation also passed in 2002 to statutorily establish the Maryland Asthma Control Program). Although the grant addresses both adults and children, the Program was administratively placed within CMCH.

Surveillance and planning activities proceeded in 2002 with the publication of the first statewide asthma surveillance report, and development of a draft Asthma Plan by the Maryland Asthma Planning Task Force in 2003. Focus groups and regional public meetings were held in 2003 to solicit community /public input on asthma issues in the Maryland for incorporation into the final asthma plan.

MCH funds also continued to support childhood asthma initiatives in four counties and Baltimore City in 2003. Initiatives focused on school based asthma surveillance, purchasing of asthma control products for low income children, coalition building and provider education.

During FY 2003, CMCH continued management of and staffing for the legislatively mandated Children's Environmental Health and Protection Advisory Council. The Council's purpose is to identify environmentally health hazards that may affect children's health and to recommend solutions to those hazards. The Council continued to implement its workplan which included asthma.

DHMH continued to seek additional funding to address critical chronic conditions such as asthma and in 2003 applied for the Steps to a Healthier U.S. (STEPS) grant. Maryland's application focuses on the three priority conditions identified in the RFA: diabetes, obesity and asthma.

#### b. Current Activities

The final Maryland Ten-Year Asthma Plan was submitted to the Secretary of Health and Mental Hygiene for his approval in FY 2004. The Maryland Asthma Planning Task Force was disbanded and replaced by a statewide asthma coalition that will oversee implementation of Task Force recommendations. Since the Maryland Asthma Control Program is an unfunded state mandate, CMCH submitted an application to the CDC for funding to implement sections of the 10 year asthma control plan.

Surveillance activities continued and a second asthma surveillance report was published in 2004, Asthma in Maryland 2003. Support for asthma surveillance was largely provided through a contract with the University of Maryland School of Medicine with CDC funding. An asthma module was added to the BRFSS in 2002 and the data will be available in 2004. The Asthma Program has arranged for the module to be continued next year. Data on asthma has also been collected by local school districts in Maryland and will be included in the 2004 asthma surveillance report to be published in 2005.

An unexpected cluster of asthma deaths in children was identified in the summer of 2003. The Project director contacted CDC for assistance in this cluster evaluation. CDC conducted a three-week site visit, and interviewed numerous individuals, such as families, providers and the Office of the Medical Examiner to obtain comprehensive information related to the deaths. The Maryland Asthma Control Program is awaiting the return of the CDC consultants to complete a control arm of the investigation and to initiate environmental sampling.

Several educational initiatives have or are being implemented. During World Asthma Day in May 2004, CMCH displayed outreach and education materials and hosted the University of Maryland's Breathmobile. An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Several health professional organizations in the state have been provided CDC funding to conduct trainings on the NIH asthma guidelines.

Maryland is re-applying for the STEPS Grant. The goal of the Maryland's STEPS initiative is to reduce the burden of chronic diseases including asthma and obesity. The state STEPS application targets four rural regions on the Eastern Shore, in Western Maryland and Southern Maryland. Separate STEPS application will be submitted by Baltimore City and Prince George's County.

A part-time asthma administrator was hired in 2004 to provide administrative support for

asthma activities. This position also coordinates the asthma component of the STEPS to a Healthier U.S. initiative (STEPS). This unique position ensures cooperation, facilitates a comprehensive approach, and maximizes the efficient use of resources for asthma within FHA.

### c. Plan for the Coming Year

During FY 2005, asthma surveillance activities will continue. In addition, pending receipt of additional funding from the CDC, implementation of recommendations in the State Asthma Plan will commence. The State Plan identifies two major goals and eleven broad objectives for addressing asthma in Maryland. The broad objectives are (1) to decrease the prevalence of asthma and the occurrence of its complications and (2) to decrease disparities in outcomes related to asthma. Initial priorities include providing training to child care providers, supporting the work of local asthma coalitions, collecting data on asthma in the workplace, educating providers, parents/patients and the public about asthma prevalence, treatment and best practice management and strengthening the infrastructure to address asthma in Maryland.

Baltimore City has some of the states worse asthma morbidity rates. Title V funding to the Baltimore City Health Department will continue to support the Childhood Asthma Program. This Program includes a direct service component whereby nurses provide in-home assessments and asthma management tools to low income families with children ages, 0-6. Asthma outreach and education are provided by an asthma health educator. The Program also assists with leadership for the Greater Baltimore Asthma Alliance.

## State Performance Measure 4: *Percent of local jurisdictions addressing the issue of respite for families of CSHCN*

### a. Last Year's Accomplishments

Respite care continues to be a significant need for Maryland families of CSHCN. The issue of respite comes up frequently in needs assessment activities on the local level, and according to the National Survey of CSHCN, 22% of families who reported needing respite in the 12 months prior to the survey indicated that they did not receive all of the respite care that was needed. Respite was identified as the 2nd highest area of unmet need in this survey.

Respite care funds were awarded to 17 out of 24 local jurisdictions in FY 03. Local health departments were successful in collaborating with families and community agencies to develop creative and cost-effective respite initiatives. While the majority of jurisdictions used monies to pay for respite care, two completed needs assessments related to respite care in their counties, two provided enabling services, and one focused its efforts on capacity building. The total number of children served was 470 at an average cost of \$254 per child. Of the children served, 154 received direct "respite hours" and 314 received support for camp. Respite care funds served families of children with a variety of special health care needs. Funding was also given in FY 03 to the Maryland Alliance of PKU Families to send 102 children to PKU camp.

### b. Current Activities

In FY 04, 16 jurisdictions were awarded respite care funds. With some unexpected funds in our budget, we were also able to provide supplemental respite grants to 10 of these jurisdictions.

The OGCSHCN's Regional Resource Coordinator, a parent of a child with special needs, is

the Department of Health and Mental Hygiene designee on the Governor's Caregiver Support Coordinating Council. She is currently working with this council on the Real Choice Respite Grant for Children. This grant comes from Maryland Medical Assistance with goals of identifying the target population of children with special needs and their families most requiring respite services, examining current state respite capacity, and developing a respite care model in the state for Medical Assistance.

### c. Plan for the Coming Year

Respite funding has been awarded to 15 out of 24 local jurisdictions thus far for FY 05. We have had a drop in the number of jurisdictions awarded respite grants over the past couple of years due to the lack of administrative capability to appropriately administer funds in these jurisdictions. We will continue to make funds available to any jurisdiction requesting them for FY 05, however. We may need to consider another method for distributing our respite dollars to all areas of the State in the future.

## State Performance Measure 5: *Percent of women who do not smoke during pregnancy*

### a. Last Year's Accomplishments

The percentage of pregnant women reporting smoking during pregnancy has been steadily declining in Maryland. Maryland birth certificate data for 2002 indicate that only 8% of pregnant women in Maryland reported smoking during pregnancy. However, data derived from the Maryland Prenatal Risk Assessment Database, indicate that low-income pregnant women were more likely than pregnant women in the general population to smoke prenatally. This database reported that 23% of pregnant women referred to local health departments through the Prenatal Risk Assessment process were tobacco users in FY 2003. (The Prenatal Risk Assessment Form is completed by health providers serving Medical Assistance and low income women in the State. The database includes approximately 22% of the State's pregnant women).

The Maryland Center for of Health Promotion, Education, and Tobacco Use Prevention has lead responsibility for smoking cessation activities in DHMH. This Center administers the Smoking Cessation in Pregnancy (SCIP) Program. SCIP is a multi-component program designed to help pregnant women stop smoking. It is a nurse driven intervention for patients receiving preconception and prenatal care services from local health departments or Medicaid managed care health providers. Pregnant smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." Cigarette Restitution Fund (CRF) grants awarded to each jurisdiction were also used to support this initiative.

Local health departments continued to promote smoking cessations during pregnancy as a part of preconception health counseling during family planning visits in FY 2003. Local health departments also continued to partner with groups such as the March of Dimes to educate pregnant women about the health risks linked to smoking during pregnancy. In 2003, CMCH continued collaborating with multiple intra and inter-agency groups, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to develop a statewide plan and initiative to reduce smoking during pregnancy.

### b. Current Activities

The Title V agency participated in a ACOG grant that implemented pilot smoking cessation programs for pregnant women in local health departments and private provider groups. Findings were presented at the Fall 2003 meeting of Maryland's ACOG Chapter.

Other ongoing activities, including the Smoking Cessation in Pregnancy Program continued in 2004.

### c. Plan for the Coming Year

Ongoing activities will continue in 2005. The CMCH, including the Office of Women's Health, plans to work more closely with the Cigarette Restitution Fund Program to promote smoking cessation among women, particularly during pregnancy.

## State Performance Measure 6: *Congenital syphilis rate in Maryland*

### a. Last Year's Accomplishments

Lowering the congenital syphilis rate was chosen as a State performance measure when the number of presumptive congenital syphilis cases in Maryland rose to an all time high of 60 in 1997. By 2001, the number of cases had declined to 5 and a rate of 6.8 per 100,000 live births. The rate decrease was largely attributed to increased provider education and outreach to at risk populations such as substance abusers and inmates of correctional facilities. A Congenital Syphilis Work Group, comprised of representatives from CMCH, local health departments, and the STD Control Program, was convened. This Work Group developed protocols for case management and tracking of women testing positive for syphilis. In addition, the Baltimore City Health Commissioner issued an order mandating that syphilis screening occur early in the first and third trimesters and at delivery.

Between 2001 and 2002, the number of reported cases once again began to rise, increasing in number from 5 to 16 cases. As a result, quality assurance efforts were expanded by identifying congenital syphilis cases as a priority for fetal and infant mortality review teams in FY 2003. FIMR programs were asked to review every case of congenital syphilis identified in their jurisdiction. Seven jurisdictions reviewed 16 cases, ten of which occurred in Baltimore City. FIMR coordinators who had a case of congenital syphilis in their county were invited to participate in a FIMR workshop on congenital syphilis held in May 2003. This workshop included basic information about congenital syphilis, and provided assistance to local FIMRs on how to prepare and review a congenital syphilis case. A report on the congenital syphilis case reviews, findings and recommendations is to be completed in FY 2004.

New regulations were issued in 2003 required physicians to test for syphilis at or near 28 weeks of gestation. In 2003, the number of cases declined to 12 and the congenital syphilis rate stood at 16.5 per 100,000 births.

### b. Current Activities

During FY 2004, the Title V Program continues to partner with the STD Control Program, the Baltimore City Health Department, the criminal justice system, the CDC, health care provider groups and others to further reduce the number of congenital syphilis cases. The MCH Program is awaiting findings from the FIMR Congenital Syphilis Report to determine further strategies needed to reduce this preventable disease.

### c. Plan for the Coming Year

The increase in the number of congenital syphilis cases between 2001 and 2002 remains as a concern and will continue to be monitored in FY 2005.

## State Performance Measure 7: *Percent of infant and child deaths reviewed by local teams*

### a. Last Year's Accomplishments

In 2002, there were 1,556 fetal, infant and child deaths in Maryland. Child Fatality Review is a Maryland mandate. In FY 2003, local teams reviewed 29% of child deaths with the purpose of identifying changes at the systems level to prevent future deaths. Activities were carried out by state and local level CFR teams and local level FIMR teams.

In 2003, Maryland's 18 local FIMR programs identified 1,241 cases of fetal or infant death through such sources as birth and death certificates, county vital statistics, Healthy Start home visiting forms and hospital records. One hundred eighty eight (188) cases of fetal or infant death were chosen for a full committee case review. Additionally, local FIMRs were successful in completing 119 maternal interviews representing 63% of the total cases reviewed. The special focus for last year was congenital syphilis and FIMR programs were asked to review every case of congenital syphilis identified in their jurisdiction. A total of 16 cases of congenital syphilis were reported in 2002 and all were reviewed.

During FY 2003, Title V continued to support a contract with the state medical society, MedChi to provide technical assistance to local FIMRs. MedChi in collaboration with CMCH produced and distributed a bi-monthly newsletter, convened a statewide FIMR Advisory group, and held three trainings for FIMR coordinators. One training, New Directions for FIMR in Maryland, addressed data gathering, planning and evaluation of FIMR programs and included a self -- assessment of preparedness for local community action among FIMRs. FIMR findings were grouped into twelve common themes. Prenatal care, provider issues and care coordination were the themes with the greatest number of findings and recommendations. FIMRs used their findings and recommendations as a basis for action.

Local child fatality review teams reviewed 266 cases in 2003. The Office of the Chief Medical Examiner studies deaths that are considered sudden and unexpected. These cases and information concerning the death are referred to the local CFR Team. Although, CFR is an unfunded mandate, by the end of FY 2003, 23 of the state's 24 jurisdictions had active CFR teams.

### b. Current Activities

During FY 2004, local FIMR teams have been asked to review all fetal and infant death cases of less than 1,500 grams (VLBW) occurring at non-tertiary care facilities. Additionally, local FIMR programs identified other issues to be investigated as a result of local reviews. These issues include domestic violence, racial disparities, smoking and substance abuse, undocumented immigrants, bereavement support, preterm labor and kick count, safe sleeping, undocumented immigrants and hospital protocols for parents with a loss.

The State CFR Team is addressing several priorities in 2004. These include providing training for local teams, examining disparities in child deaths, developing policy recommendations to reduce child deaths, and developing protocols to address near fatalities as required by law. The State is developing an OCME managed uniform online data collection system for entering and retrieving child death data. As a result, local teams will be able to expedite the CFR process by online reporting gathering of data and reporting of review results. Title V funding is being used to hire two graduate students to develop this online reporting system.

In April 2004, Dr. William Adih and Dr. Maureen Edwards provided a workshop on Child Deaths in Maryland at the 11th Annual Maryland Governor's Conference on Child Abuse and Neglect on April. The workshop highlighted the causes of childhood deaths and educated participants on how child deaths certified by the Medical Examiner are investigated.

### c. Plan for the Coming Year

The Center for Maternal and Child Health is committed to continuing to provide leadership for FIMR and CFR activities in FY 2005. This leadership is exemplified by CMCH allocation of Title V dollars to the State mandated, but largely unfunded CFR process. These federal dollars will continue to be combined with funds for FIMR and maternal mortality review activities under a contract with the State Medical Society. Because of the link between FIMR, CFR, domestic violence, and child abuse, one intent of this consolidation is to identify children and families at risk so that comprehensive preventive strategies can be developed.

The CFR Team plans to survey local teams to determine any additional technical assistance needs. LBW and VLBW births will remain as a priority focus area for FY 2005. In addition, FIMR staff and consultants have preliminarily discussed identifying racially based perinatal disparities as a second focus area.

## State Performance Measure 8: *The rate of deaths to children aged 1-4 caused by sickle cell disease*

### a. Last Year's Accomplishments

The OGCSHCN continued to operate the Sickle Cell Disease Follow-Up Program. The staff in this program help to ensure appropriate diagnosis and management of Maryland children with sickle cell disease through age 5 years. Children identified through newborn screening are referred for diagnostic evaluation and linked with a hematologist at one of the specialty centers. The nurse in the Program makes a home visit to families of newly diagnosed children for support and education around the important components of care for children with sickle cell disease. Genetic counseling is also provided. The Program works with the family, primary care provider, and specialists to ensure that all children receive prophylactic penicillin, appropriate immunizations, and other interventions as needed. This is facilitated by a system of comprehensive data collection from the PCP and specialists established by the Program. A health history of every Maryland child with sickle cell disease is maintained by the Program up to age 5 years in this database to ensure that there are no gaps in care. The Program is able to provide phone consultation to PCPs and families as needed, and the nurse will attend hematology clinic visits to provide further support and education to families requiring this. Grant monies also support hematology clinic infrastructure. The sickle cell disease related mortality rate for children aged 1-4 in Maryland continued its historically low level in FY 03, with zero deaths.

### b. Current Activities

There has been no progress in reviving a community based support group for sickle cell disease. Although the national Sickle Cell Disease Association of America recently moved its headquarters to Maryland, this organization is currently not supporting fledgling groups at the community level. When the local group existed, it partnered with the OGCSHCN to sponsor a number of outreach and educational activities for children with sickle cell disease and their families, including an annual picnic, holiday party, and summer camp. The Sickle Cell Disease Clinic at Johns Hopkins Hospital has recently hired a new social worker who is interested in reviving some of the special activities that had been supported by the OGCSHCN in the past. Plans are underway to hold an annual picnic this September, which is Sickle Cell Disease month.

c. Plan for the Coming Year

The OGCSHCN plans to continue the Sickle Cell Disease Follow-Up Program in its current form for the coming year. In addition, it has been some time since the Program's educational materials have been updated. We plan to review these materials and make changes/updates as needed. We will also continue to search for a community partner interested in organizing a summer camp experience for children with sickle cell disease next summer.

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

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of children aged 0-72 months screened for lead poisoning/exposure by blood testing				
1. Development and implementation of plan to reduce lead poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote screening including blood lead testing through education and outreach to providers and famil	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Passage of legislation mandating screening at certain ages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct blood lead testing surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Inter-agency collaboration on lead poisoning prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide case management for lead poisoned children	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Promote lead poisoning prevention awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Screen children for elevated blood lead levels	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of Medical Assistance Women enrolled in the Family Planning Waiver Program Who Used at Least One Service During the Fiscal Year				
1. Fund family planning and reproductive health clinical services statewide	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Medicaid covers family planning services for eligible low-income women through the FP Waiver	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Screen and refer women in family planning clinics to primary care resources	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Provide outreach and education to promote family planning and family planning waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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"/>
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STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Asthma mortality rate (per 1,000,000) among children aged 1-14				
1. Conduct asthma surveillance, including health disparities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop and implement statewide asthma plan for Maryland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote use of an asthma action plan	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Support school based education initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Chair and Staff a statewide Asthma Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Chair and staff the Governor's Children Environmental Health and Protection Council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote outreach and education to increase awareness of asthma as a public health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Support local health department based asthma initiatives	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Conduct needs assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Promote adherence to NIH Asthma Guidelines	<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
4) Percent of local jurisdictions addressing the issue of respite for families of CSHCN				
1. Provide grants to local jurisdictions to provide a variety of respite activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide grants to community-based support groups for camp for CSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide expertise for other respite initiatives in the State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Publicize the availability of respite services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of women who do not smoke during pregnancy				
1. Administer the Smoking Cessation in Pregnancy (SCIP) Program in local health departments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote smoking cessation during preconception health counseling sessions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with American College of OB/GYN and others to develop a				

plan to reduce smoking prior and during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor smoking during pregnancy through the Prenatal Risk Assessment Database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support smoking cessation programs through Cigarette Restitution Fund initiatives	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Fund community based programming to support smoking cessation in adults and children	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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
<b>6) Congenital syphilis rate in Maryland</b>				
1. Monitor trends in congenital syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the STD Program and others to reduce congenital syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Mandate FIMR review of all congenital syphilis cases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Educate health providers about timely syphilis and STD screening during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Mandate that syphilis screening occur at certain intervals during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
<b>7) Percent of infant and child deaths reviewed by local teams</b>				
1. Support FIMR activities through the Improved Pregnancy Outcome Program and Crenshaw Perinatal Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support the State Child Fatality Review Team as mandated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop and implement recommendations and systems changes based on FIMR and CFR activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide technical assistance for state and local maternal, fetal, infant and child fatality review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct FIMR and CFR in every jurisdiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Publish annual reports on fetal, infant and child deaths in Maryland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collect and compile data and findings from local reviews	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of deaths to children aged 1-4 caused by sickle cell disease				
1. Identify affected children through newborn screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Ensure diagnostic evaluation and linkage with hematologist	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide home visits and parent education	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide case management facilitated by extensive data collection from PCP and specialists	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support hematology clinic infrastructure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide educational materials to families and consultation to families and providers as needed	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Support recreational and educational activities for children with sickle cell disease and their families	<input type="checkbox"/>	<input checked="" 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

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers. The OGCSHCN will continue to operate the Children's Resource Line (1-800-638-8864). The Center for Maternal and Child Health continues to assist in both these efforts.

Web Sites: Both the Center for Maternal and Child Health ([www.fha.state.md.us/mch](http://www.fha.state.md.us/mch)) and the Office for Genetics and Children with Special Health Care Needs ([www.fha.state.md.us/genetics](http://www.fha.state.md.us/genetics)) to provide functional web sites. These web sites include information about all programs funded or provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of promoting wellness for Maryland women throughout the lifespan. Activities of this Office include the publication and dissemination of a reports (e.g., chartbook on the health status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of the MCHB funded WELL Project, a statewide model for integrating preventive health screening into family planning programs.

Childhood Obesity: The prevention of childhood obesity remains as a MCH priority for 2004. The collaborative partnership begun with the Office of Chronic Diseases in FY 2001 to address obesity through strategic planning, surveillance, provider, education and promotion of public awareness will continue. This will occur despite fiscal constraints that have prevented implementation of program plans. In May 2002, the MCH program sponsored a statewide meeting of childhood obesity experts and stakeholders to develop recommendations for addressing childhood obesity. The lack of a consistent data source for monitoring obesity was noted. Plans are to hold a second meeting to

further discuss potential need assessment and surveillance activities in FY 2004. The MCH program plans to vigorously pursue potential funding opportunities that become available. Other planned activities include partnering with a local University to develop an obesity prevention intervention targeted to Head Start Centers, working with a Nutrition Education Program to develop a social marketing campaign that promotes physical activity, and promoting public awareness through various media. Finally, the MCH Program plans to develop a performance measure which addresses childhood obesity during FY 2004.

***//2005/ Childhood obesity remains a priority. The Center for Preventive Health Services has lead responsibility for obesity initiatives and collaboration occurs with CMCH around childhood obesity activities. DHMH is applying for a STEPS grant and the Center for Preventive Health Services has received a CDC grant to develop a plan to reduce obesity rates in the state. The CMCH Chief of School and Adolescent Health is chairing the Childhood Obesity subroup. This grant will also support a statewide conference. //2005//***

Early Childhood Programs and Mental Health: Mental health related issues were identified as a major unmet need for both women and children during the 2000 needs assessment. As mentioned above, the Office of Women's Health has identified depressive disorders as one of its initial focus areas. Maternal depression, an important risk in the development of childhood mental health problems is being examined. The MCH Program become an active participant on the State's Early Childhood Mental Health Steering Committee established in late FY 2001. This Committee's charge is to develop a plan for integrating mental health services into existing early childhood programs. In March 2003, CMCH applied for a MCHB State MCH Early Childhood Comprehensive Systems (ECCS) Grant and we are awaiting the Bureau's funding decision.

***//2005/ Maryland was one of several states to be awarded a ECCS Grant in 2003. Maryland plans to develop an Early Childhood Health Strategic Plan. This Plan will ultimately be integrated with plans addressing the other four remaining critical components of early childhood - mental health, parent education, early child care and education, and family support -- to create an Early Childhood Comprehensive Systems Plan for Maryland.***

***A planning group, known as the ECCS CORE group, has been convened and consists of personnel from the Center for Maternal and Child Health, partners/collaborators involved in developing a previous statewide Early Childhood Action Agenda and key members from groups charged with other early childhood collaborative efforts. This ECCS Core group has met three times to advise the Project Director on processes for strategic planning and collaboration building. Technical assistance has also been sought through MCHB to determine an appropriate methodology for developing an early childhood collaboration model for Maryland given the current status of planning and collaborative efforts. The Core Group identified and recommended partners perceived as critical to the planning and collaboration processes.***

***The Project has recently suffered a temporary setback in the Project Director, a nurse consultant in CMCH with a wealth of knowledge and expertise, retired at the end of June 2004. CMCH is currently recruiting a full time Project Director. //2005//***

Conferences and Training: The MCH Program: CMCH recognizes the importance of enhancing public health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and special technical assistance workshops for local health departments.

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at

the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center will provide SIDS outreach and education as well as counseling to support families experiencing a SIDS death.

## **F. TECHNICAL ASSISTANCE**

Maryland's requests for technical assistance are detailed on Form 15.

The state requests continued assistance with ensuring cultural competency as we embark on the Title V capacity assessment in the early spring of 2005. The National Center for Cultural Competency has provided some initial support and guidance and we would like for this support to continue in the next fiscal year.

Additionally, assistance is sought for developing methodologies for reallocating scarce and limited resources in the face of competing and growing unmet service needs.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

This section describes Title V expenditures for FY 2003 and notes trends and shifts in expenditures over the past several years. During FFY 2003, the majority of the \$21,406,247 in Title V -- State partnership funds supported activities at the infrastructure and enabling levels (64.7%). These expenditures met the 30-30-10 budgeting requirement.

Several significant changes have occurred during the time period 1996-2004. First, the State of Maryland through the development of a fiscal data system has been able to monitor expenditures more effectively and efficiently. This has resulted in the expenditure of all funds during the first year of each grant cycle. Therefore, the Federal-State Title V Block Grant Partnership Total is more reflective of the actual dollars awarded and expended in the first year. This change began in FY 1998 and continues. In addition, beginning in FY 2000 the fiscal data system was refined to monitor more effectively funds within the pyramid itself. Periodically, additional refinements have been made to the system. The most recent one occurred in FY 2003 and resulted in greater accuracy in identifying both state and federal fiscal years expenditures.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continues to decrease as Maryland's Medical Assistance Program assumes greater fiscal role, including covering more CSHCN unique services. The second shift occurred during that same year, with enabling services increasing from 15% in 1998 to 25% in 1999 to a high of 56% in 2000. This service expenditure has been gradually decreasing since 2000, to the current level of 19% in 2003. The reason for this dramatic increase was the need for the health care system to absorb the dramatic shift in services. Many local health departments were initially reluctant to turn over all care coordination to the newly formed Managed Care Organizations (MCO). This concern has decreased as MCO case management has been instituted and a formal communication system has been established. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. The last shift has occurred as the State Title V Agency has educated and notified local health departments that Title V dollars should be allocated for population-based services and infrastructure development.

While dialogue began in 2000 during the last Title V Needs Assessment, it wasn't until FY 2002 that a significant shift began to occur. As a percentage of total federal expenditures, population-based services moved from 5% in 2001 to 16% in 2003, and infrastructure-based services shifted from 28% in 2001 and to 35% in 2003. This resulted in the continual decline of direct service dollars to a new low of 13% in 2002 and an increase in 2003 to 19%. This financial movement was accelerated by the events of 9-11-01 and the sudden and significant increase in bio-terrorism and emergency preparedness. It is the intent of the Title V Agency to evaluate the effectiveness of the allocation in improving health outcomes, particularly as it relates to enabling services.

In FFY 2003, it was anticipated that an increase in direct health care services would occur due to the closure of several MCO provider offices in areas of limited provider availability. Until a medical home could be reestablished, it was anticipated that local health departments, school based health centers and CSHCN tertiary care centers would become the safety net for these families. There is an inverse relationship between direct and enabling services; therefore, with an increase in direct services there would a decrease need for enabling services. It was anticipated that both population-based services and infrastructure building services would be maintained at approximately the same level for FY 2002 and FY 2003. While Maryland implemented an enhanced MCHP in July 2002 for families with incomes up to 300% of FPL, it was determined that these families historically did not receive services from local health departments; therefore, there would be no impact on direct services. Quarterly tracking of expenditures indicates that expenditures are mirroring the projected allocation.

## B. BUDGET

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, emerging research and standards of care affecting the health status of its populations. Maryland's Title V budget for FY 2005 totals \$21,372,400 including \$12,212,800 in federal funds and \$9,159,600 in state funds.

Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) level of poverty and estimated maternal and child (birth-21 years of age) population, (4) performance measures and outcome measures and (5) whether other funding or shortfalls become available. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2003, the MCH Budgets for FY 2005 were developed. During the 2004 Legislative Session, the FY 2005 budget was approved).

Throughout the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2004, it is proposed that funding for each Title V population will be distributed accordingly: Preventive and primary care for children -- 31%, CSHCN -- 31% and Administration -- 7%. In addition, throughout the two-year process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. For this FY 2005 application, the budget allocation is based on budgets developed during the summer of 2003 with slight revisions as a result of the legislative process.

The FFY 2005 budget also reflects a shift in funding from preventive and primary care services to children to services for mothers and infants as more local health departments allocated resources for improving declining maternal and birth outcomes. This effort has expanded to include prevention of low birth weight, particularly very low birth weight, as well as continuing to maintain the emphasis on preventing infant mortality. It is believed that through focusing on the risk factors that influence infant mortality, a more positive outcome will be realized.

Throughout the year, quarterly meetings are held between the MCH Offices and the Budget Personnel to determine current expenditure levels and expected expenditure for the remainder of the year. It is during these meetings that budget shortfalls and funds to be reallocated are identified. Throughout the year all contracts including LHD grants are tracked through the procurement process and subsequently monitored for appropriate and timely expenditures, and adherence to DHMH fiscal procedures.

The State share in MCH services is considerable, and more than meet the requirements for the State match. State appropriations dedicated to MCH related activities include early intervention services, immunizations, mental health and family planning services. Federal sources of MCH related dollars other than the block grant include early intervention, Part C; Centers for Disease Control and Prevention (immunizations and the public health infrastructure); abstinence education; family planning; WIC; HIV/AIDS; and SSDI (community assessments, enhancing data and epidemiological capacity). Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

This section contains a budget narrative which describes Maryland's proposed expenditure plan for the coming fiscal year. For FFY 2005, federal Title V funds in the amount of \$3.6 million will be allocated for programs and services for women and infants. These funds will be administered through the Maternal and Perinatal Health Program and will support infrastructure level activities, through the

Improved Pregnancy Outcome Program (IPO) and the Crenshaw Perinatal Health Initiative, to improve pregnancy and birth outcomes. IPO funds are provided to each local health department to support FIMR and other activities. Crenshaw funds are competitively awarded to local health departments to support innovative strategies. Funds will also partially support the new Perinatal Health System of Care Initiative, for which planning begun in FY 2003 to develop maternal health statewide infrastructure, assure appropriate care for high-risk pregnancies and assurance for standards of care.

Title V will also support local health department based home visiting and care coordination services for pregnant women and infants as well as other activities aimed at improving the health of pregnant women and infants including standards development, quality assurance, health promotion and outreach. Preventive and primary care services for pregnant women and children are administered by the Center for Maternal and Child Health. In addition, newborn screening activities are carried out by the Office for Genetics and CSHCN. Newborn Screening includes two major programs. The Newborn Screening Program screens newborns for 32 disorders that may cause mental retardation and/or serious medical problems unless treated soon after birth. The Universal Infant Hearing screening Program provides for early identification and follow-up of hearing impaired infants and infants at risk for developing a hearing impairment.

In FFY 2005, a total of \$3.8 million in federal funds are budgeted to support programs and services for children and adolescents. Funds will be awarded to local health departments to support a broad range of activities to improve the health of children and adolescents. Activities include home visiting, care coordination, child fatality review, school health, health screenings, immunizations, and health education/outreach. Funds will also be used to administer the Childhood Lead Screening Program to include promotion of increased blood lead testing in "at risk" areas of the State, and outreach and education to increase lead awareness. Grantees include local health departments and the Maryland Coalition to End Childhood Lead Poisoning. Finally, CMCH will use these funds to support programs and activities concerned with school and adolescent health, asthma education and outreach, childhood nutrition and obesity issues, and SIDS counseling, outreach and education.

The FFY 2005 budget includes \$4.1 million in federal funds only to support programs and services for CSHCN. These activities and programs will be administered by the Office for Genetics and Children with Special Health Care Needs. Direct care services to be funded include payment of specialty care for uninsured and underinsured CSHCN as well as two medical day care centers for medically fragile infants and young children. Funding will go to local health departments, Parent's Place of Maryland, and the Centers of Excellence for enabling services such as information and referral, care coordination/wrap-around services, and a variety of respite activities. Population-based services funded will include the newborn screening follow-up accomplished through the Office. Specialty medical centers and some local health departments will also receive funding to support specialty clinic infrastructure, with particular emphasis on neurodevelopmental, genetic, and hematologic services.



## **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.